FACT SHEET

2015/16 Estimates

ISSUE

The Ministry of Health's 2015/16 – 2017/18 Estimates were tabled on Budget Day, February 17, 2015.

KEY FACTS

The following budget adjustments were made to the prior year's Estimates:

- The Ministry Operating budget has increased due to the funding transfer from the Ministry of Children and Family Development for the transfer of their Nursing Support Services and the allocation of funding under the Economic Stability Mandate for general wage increases. These increases were partially offset by the funding transfer to the Ministry of Technology, Innovation and Citizens' Services for leased space and the reduction for the Core Review Net Savings. The budget lift in 2017/18 provided the Ministry with a 2.6% increase.

CRF Budget (in $000)	2015/16	2016/17	2017/18
s.17			

- The Ministry Capital budget for 2015/16 has increased by $5,342,000 due to the re-profiling of IM/IT CRF Capital forecast 2014/15 under-spending that was reflected in the CPS database as at Q3 2014/15.

Ministry Capital (in $000's)	2015/16	2016/17	2017/18
Budget 2014 - February	255	255	255
Re-profiling	5,342	-	-
Budget 2015 - February	$5,597	$255	$255

- The budgeted amounts for Capital Grants funding for Health Facilities have decreased by $131,132,000 in 2015/16, increased by $64,396,000 in 2016/17 and decreased by $137,563,000 in 2017/18. These adjustments are primarily the result of re-profiling based on timing of cash flows on various priority investment projects, s.13,s.17
s.13,s.17

Restricted Capital Grants (in $000's)	2015/16	2016/17	2017/18
Budget 2014 - February	509,994	494,635	494,635
Reprofiling	(86,532)	111,696	(252,998)
Budget Lift			115,439
s.13,s.17			
Budget 2015 - February	$378,862	$559,031	$357,076

FACT SHEET

FINANCIAL IMPLICATIONS

Allocation of Operating Expenses - $000's

Core Business	2014/15 Restated	2015/16 Estimates	% Change	$ Change
HEALTH PROGRAMS				
Regional Services	11,540,915	11,948,782	3.5%	407,867
Medical Services Plan	4,061,122	4,117,119	1.4%	55,997
PharmaCare	1,079,453	1,103,033	2.2%	23,580
Health Benefit Operations	42,181	43,075	2.1%	894
Vital Statistics	7,246	7,428	2.5%	182
Sub-Total	16,730,917	17,219,437	2.9%	488,520
EXECUTIVE AND SUPPORT SERVICES				
Minister's Office	719	725	0.8%	6
Stewardship and Corporate Services	221,522	224,271	1.2%	2749
Sub-Total	222,241	224,996	1.2%	2,755
Total – Ministry of Health	**$16,953,158**	**$17,444,433**	2.9%	**$491,275**

Allocation of Capital Expenses - $000's

	2014/15 February	2015/16 February	% Change	$ Change
Restricted Capital Grants				
2015/16	509,994	378,862	(25.7)%	(131,132)
2016/17	494,635	559,031	13.0%	64,396
2017/18	494,635	357,072	(27.8)%	(137,563)
CRF Capital				
2015/16	255	5,597	2,094.9%	5,342
2016/17	255	255	0.0%	0
2017/18	255	255	0.0%	0

Approved by:
Daryl Conner, Finance and Decision Support Branch; April 22, 2015
Manjit Sidhu, Finance and Corporate Services Division; April 23, 2015

FACT SHEET

Acupuncturist Mr. Mubai Qiu – Inappropriate Billing

ISSUE

Inappropriate billings by acupuncturist Mr. Mubai Qiu s.22

KEY FACTS

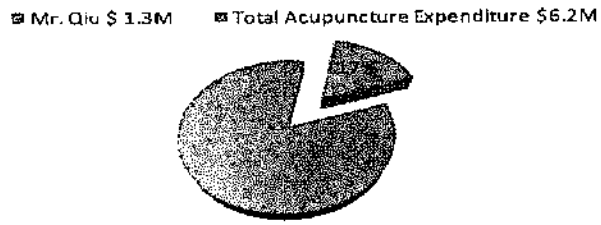
- Since April 2008, the Medical Services Plan (MSP) Supplementary Benefits Program contributes $23 towards the cost of a visit by a licensed acupuncturist, chiropractor, massage therapist, naturopath, and physiotherapist and for non-surgical podiatry. The limit is ten visits per annum summed across all providers. Eligibility for the program is limited to recipients of premium assistance. Premium assistance is available to individuals earning $30,000 or less per annum.
- Mr. Mubai Qiu is a registered acupuncturist with the College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC.
- Mr. Qiu has exceptionally high billings to MSP:
    - $1.28 million in 2011/12
    - $438,000 in 2010/11
    - $246,000 in 2009/10
    - $165,000 in 2008/09
- Mr. Qiu has been subject to two audits by the Billing Integrity Program (BIP). Under both BIP audits it was determined that none of Mr. Qiu's patient records constituted an adequate clinical record to support his billings to MSP.
- The first audit covered the period April 2008 to October 2010. The BIP audit team found a 100% error rate and concluded he had overbilled MSP by $632,684. The Ministry reached a settlement with Mr. Qiu requiring him to repay $100,000 to the Ministry, opt out from MSP (beneficiaries would instead bill MSP), maintain adequate clinical records and agreed that we (the Ministry) would not publish his name.
- Mr. Qiu's billings to MSP significantly increased in 2011/12, prompting a second audit covering the period of November 2010 to April 2012. The BIP audit team found a 100% error rate and concluded that he had overbilled MSP by $1,579,433, up and to April 2012, and is seeking full repayment, as well as de-enrollment.
- The College conducted an investigation of Mr. Qiu's practice, concurrent with BIP's second audit. As a result of the College's investigation, a public disciplinary hearing was held by the College in May 2013. In response, Mr. Qiu has filed for a stay of proceedings and petitioned the Supreme Court of British Columbia. The Supreme Court's case has been placed in abeyance.
- On December 5, 2013, a decision by the College hearing panel was reached; Mr. Qiu was reprimanded, his right to practice acupuncture was cancelled and he had to pay the College $11, 902.81 for disbursements.
- The Medical Services Commission (the Commission) held a hearing on March 25- 26, 2014, and a decision was reached on April 22, 2014. The Panel concluded that no benefits at all were rendered during the audit period (November 2010 to April 2012). Mr. Qiu owes the Commission $1,579,180, plus statutory surcharges, interest and audit and hearing costs.
- This case has been referred to the Richmond RCMP for suspected fraud. The allegations against Mr. Qiu include violation of:
    - Section 13 (3) of the *Medicare Protection Act* ("the *Act*") which states that practitioner are entitlement to payments only when they comply with the *Act*;
    - Section 27 (1) and (6) of the *Act* which requires a practitioner to keep records;

- Section 16 (2) of the *Medical and Health Care Services Regulations* which provides the definition of adequate clinical record; and
- Section 46 of the *Act* which states that a person who knowingly obtains or attempts to obtain payment of a benefit to which he or she is not entitled commits and offence.
- The RCMP investigation is still ongoing.

FINANCIAL IMPLICATIONS

The estimated costs for fiscal year 2011/12 associated with Mr. Qiu's billings to the health care system is approximately $1.3 million worth of services which on average works out to over 55,000 services or 150 services per day.

2011/12 Expenditure



Approved by:

Marie Thelisma, Billing Integrity Program; February 20, 2015

Manjit Sidhu, Finance and Corporate Services Division; February 24, 2015

FACT SHEET

Administration and Support (10% Target)

ISSUE

The Ministry of Health expects health authorities to keep administration and support expenditures to 10% (or less) of total expenditures.

KEY FACTS

- For the most recent fiscal year 2014/15, five of the six health authorities met the Ministry's expectation that administration and support expenditures should not be more than 10% of total expenditures.
- Health authority administration and support expenditures as a percentage of total expenditures for the past five fiscal years, 2010/11, 2011/12, 2012/13, 2013/14 and 2014/15 are presented below.

Health Authority	2010/11 Actuals (Post Audit)	2011/12 Actuals (Post Audit)	2012/13 Actuals (Post Audit)	2013/14 Actuals (Post Audit)	2014/15 Actuals (Pd. 13)
Fraser	8.8%	9.1%	9.2%	9.0%	9.3%
Interior	9.9%	10.3%	10.2%	9.9%	9.9%
Northern	12.2%	13.6%	13.6%	13.4%	13.3%
Provincial Health Services	9.3%	9.4%	9.1%	8.9%	9.0%
Vancouver Island	10.9%	10.0%	9.6%	10.0%	9.9%
Vancouver Coastal	9.1%	9.3%	9.5%	9.6%	9.5%

Footnote:
Denominational Affiliates are included above.

- Following several public references by former Minister of Health, Kevin Falcon, that health authorities' administrative costs should not be more than 10% of their respective total expenditures, preliminary funding letters issued to health authorities for fiscal years 2010/11, 2011/12, 2012/13, 2013/14 and 2014/15 have stated "The Ministry expects that all health authorities will continue to achieve efficiency savings in administration and support expenditures to reduce those expenditures to be equal to or less than 10 percent of total expenditures".
- The 2009/10 Budget and Fiscal Plan released by the Minister of Finance on February 17, 2009, stated that "health authorities will be required to achieve administrative savings of $25 million per year, approximately 2% of the health authorities' administration and support service costs. It is expected that a significant portion of these savings can be realized through innovation and lean-design approaches to health care delivery. Every dollar will be redirected to patient-care."
- The 2008 Throne Speech stated that "better coordination of patient services across the Lower Mainland will reduce administration costs. Those revenues (savings) will be redirected to patient services".

FINANCIAL IMPLICATIONS

Under Key Facts.

Approved by:
Gordon Cross, Regional Grants and Decision Support Branch; May 6, 2015
Manjit Sidhu, Finance and Corporate Services Division; May 7, 2014

FACT SHEET

Alzheimer's Drug Therapy Initiative

ISSUE

- The Alzheimer's Drug Therapy Initiative (ADTI) was launched in October 2007, to provide coverage with evidence development for the cholinesterase inhibitors, donepezil (Aricept®), galantamine (Reminyl®), and rivastigmine (Exelon®) for individuals with mild to moderate Alzheimer's disease.
- Five research studies were initiated to inform coverage decisions for the cholinesterase inhibitors. Some of the ADTI research studies were suspended in 2012 (due to the Ministry's data investigation), but these are now reinstated.
- Ongoing ADTI research studies will be completed in 2015. Afterwards, the Drug Benefit Council (DBC) will provide its expert recommendation based upon these study results and other inputs. The Ministry of Health will then make the drug coverage decisions expected later in 2015.
- Generic versions of donepzeil, galantamine, and rivastigmine (capsules) are covered through the ADTI as of April 1, 2014.

KEY FACTS

- The ADTI is the result of collaboration between the Ministry, the Alzheimer Society of BC, experts in dementia and geriatric care, researchers, drug manufacturers, clinicians and individuals affected by Alzheimer's disease.
- Since the launch in 2007, enhancements to the ADTI included the following:
  - extending the coverage period until the Ministry makes coverage decisions;
  - expanding coverage to include Extended Care hospitals;
  - including the rivastigmine transdermal patch as a treatment option;
  - compensating physicians for participating in the ADTI's research program; and
  - extending the Provincial Dementia Education Program to December 2012.
- As of September 30, 2014, over 30,000 British Columbians have been enrolled for coverage of a cholinesterase inhibitor drug (donepezil, galantamine, or rivastigmine) through the ADTI.[1]
- The ADTI included both physician education and research components, along with coverage of Alzheimer's medications. Recent key events included the following:
  - *September 6, 2012:* Ministry news release regarding an ongoing investigation of allegations of inappropriate contracting and data management practices. The ADTI was one of the impacted areas described in the news release.[2]
  - *October 4, 2012:* Upon written confirmation from the Ministry, researchers at the University of Victoria resume two of the four studies (the Caregiver Appraisal Study and the Seniors' Medication Study) involving primary data.
  - *December 11, 2012:* Upon written confirmation from the Ministry, researchers at the University of BC resume one study (the Clinical Meaningfulness in Alzheimer Disease Treatment (CLIMAT) involving primary data.
  - *December 11, 2012:* Upon written confirmation from the Ministry, education specialists at the University of BC resume the Provincial Dementia Education Program.
  - *October 2013:* The Ministry confirms that the investigation is complete, and the two remaining University of Victoria studies (the Utilization and Cost Project, and the Clinical Epidemiological Project) involving secondary data can be reinstated. The contracting process was completed in February 2014.

[1] PharmaNet, Medical Beneficiary and Pharmaceutical Services, February 2, 2015

[2] Ministry of Health News Release. *Ministry of Health taking immediate steps to respond to investigation.* September 6, 2012. Retreived on June 20, 2013 from: http://www2.news.gov.bc.ca/news_releases_2009-2013/2012HLTH0083-001302.htm

- *September 2014:* The secondary data file becomes available to the researchers.

- The current drug coverage was not affected by the investigation. Physicians caring for patients with Alzheimer's disease continued to apply for drug coverage through Special Authority. Patients with current Special Authority approval also continued to receive coverage until the listing decision is made.
- As a result of the investigation, the major expected milestones were revised:
  1. Researchers submit final report/recommendations to the Ministry — Summer 2015
  2. The Drug Benefit Council reviews and provides recommendations — Late 2015
  3. The Ministry completes listing decisions — Late 2015
- The Ministry has been preparing the necessary inputs to make the listing decision for the cholinesterase inhibitor drugs. Some of the inputs include: ADTI research studies, evidence from other published studies, and input from stakeholders, including researchers, clinicians, manufacturers, and patient groups.
- Stakeholders continue to be engaged and provided with updates as necessary.
- The call for patient input through *Your Voice* concluded on December 2, 2013. Fulsome responses were received from patients, caregivers, and patient groups.
- In November 2013, the Alzheimer Society of BC encouraged the public to lobby their MLA for continued coverage of cholinesterase inhibitors for Alzheimer's disease through ADTI. Most other jurisdictions across Canada provide coverage for the cholinesterase inhibitors when certain clinical criteria are met (i.e., Limited Coverage benefits).
- All health authorities accepted the Ministry's offer to provide coverage for residents in their Extended Care Hospitals.
- The Ministry began the coverage of generic versions of donepezil, galantamine and rivastigmine (capsules) through the ADTI, starting April 1, 2014.

FINANCIAL IMPLICATIONS

- The cost of the ADTI was originally budgeted in 2007 at $77 million over 3 years; $2.4 million was dedicated to research and $400,000 was awarded to the University of BC to deliver physician education.
- Due to the slower than expected uptake, actual ADTI drug costs are below the original budget.
- From October 2007 to September 30, 2014, the Ministry's total drug plan spending under the ADTI was approximately $64.7 million.[3]
- From October 2007 to March 2014, the Ministry spent $2.65 million on ADTI research and $0.64 million on dementia education for health professionals.
- The coverage of generic versions of donepezil, galantamine and rivastigmine (capsules) is projected to result in cost savings of $4 to $5 million per year compared to brand product list prices.[3]

Approved by:
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 11, 2015
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; February 24, 2015

[3] PharmaNet, Medical Beneficiary and Pharmaceutical Services Division, February 2, 2015

FACT SHEET
Audit and Investigation Function

ISSUE

Increasing the effectiveness of the Ministry of Health's audit and investigation function.

KEY FACTS

- The Ministry of Health is committed to detecting fraud and abuse of the BC health care system.
- The size and complexity of the health care system in BC is increasing. Total budgeted health care spending in BC has increased to over $18 billion per annum, including $4.2 billion for the Medical Services Plan (MSP); $1.1 billion for the PharmaCare Program; and $0.5 billion for the Alternate Payments Program. A comprehensive monitoring and audit program is critical to ensure the integrity of these key government programs and reduce the opportunity for waste and fraud.
- The Ministry continues to experience an increasing incidence of inappropriate billing by physicians and health care practitioners in the MSP Program, by Pharmacy operators in the PharmaCare Program, and inappropriate claims by non-eligible beneficiaries and residents.
- s.17

- The Audit and Investigation Branch (AIB) has budgeted 55 full-time employees (FTE) s.15 s.17

Fiscal	2014/15*	2013/14	2012/13	2011/12
Actual Recoveries (in millions)	s.17			
Billing Integrity Program				
PharmaCare Audit				
Eligibility, Compliance and Enforcement Unit – estimated 50%				
Deterrence Activities (Practitioners, Pharmacies and beneficiaries contacted)				
Billing Integrity Program				
PharmaCare Audit				
Eligibility, Compliance and Enforcement Unit				

*as at January 31, 2015

- In 2013/14, the Billing Integrity Program's first two hearings in many years were successful as were nine mediations leading to settlements and de-enrollments. During the period to date there were five further de-enrollments.
- The results of audit work are rolled up to inform regulation, policy, and systems, as well as to educate practitioners. AIB continues to contribute to the phased implementation of the BC Services Card and developing new business rules and processes to address risks associated with the card. Policy changes are underway in a number of areas.

FINANCIAL IMPLICATIONS

- s.17

-

Approved by:

David Fairbotham, Audit and Investigations Branch; March 23, 2015
Manjit Sidhu, Finance and Corporate Services Division; March 26, 2015

FACT SHEET

BC Patient Safety and Quality Council

ISSUE

In 2008, the BC Patient Safety and Quality Council was established to enhance patient safety, reduce errors, promote transparency and identify best practices to improve patient care. The Council provides advice and makes recommendations to the Minister of Health on matters related to patient safety and quality of health care in BC.

KEY FACTS

- The Council's initial 3-year term and funding commitment expired March 31, 2011.
- Approval was given to the Council for a renewed 3-year term from April 1, 2011, to March 31, 2014.
- The Minister of Health approved the Council's new 3-year term from April 1, 2014, to March 31, 2017. As agreed to, the Council will develop:
  - **Annual Operational Plans** specifically defining the Council's contribution to provincial health system priorities and identifying deliverables for the current fiscal year.
  - **Multi-year Strategic Plan** outlining the broader vision and long-term mission of the Council.
- The Council's 2014/15 Operational Plan reflects 6 strategic priorities including:

Priority Area	Related Activities
1. Fostering a Provincial Perspective	The Council will provide leadership to foster innovation and to promote collaboration and shared learning opportunities.
2. Advancing Capacity for Improvement	The Council will run the Quality Academy and will integrate quality improvement competencies into academic curriculum for health care providers.
3. Accelerating Improvement	The Council will create and support forums for shared learning (e.g., BC Quality Awards Program) and will work to build quality elements into clinical information systems.
4. Improving Transparency	The Council will complete external reviews of health care quality issues (as required) and support provincial public reporting of quality data.
5. Fostering Our Quality Culture	The Council will be a "learning organization" by ensuring that health care staff has access to resources and opportunities to work together and learn from each other.
6. Creating Value	Council activities will be implemented in a sustainable, efficient and cost-effective manner to provide good value to stakeholders.

FINANCIAL IMPLICATIONS

- Funding to support the Council is provided by the Ministry to the Provincial Health Services Authority.
- Beginning in 2011/12, additional annual funding of s.17 was allocated based on the requirements of the Council's 2011/12 – 2013/14 operational plan, increasing total annual funding to s.17
- Under the current three-year term, base funding has increased to s.17 annually to accommodate the National Surgical Improvement Program (NSQIP).

Approved by:

Gordon Cross, Regional Grants and Decision Support Branch; January 19, 2015
Manjit Sidhu, Finance and Corporate Services Division; January 22, 2015

FACT SHEET

Balanced Budget Financial Target

ISSUE

It is Ministry of Health policy that health authorities operate within balanced budgets to be consistent with the Ministry's requirement to adhere to the *Budget Transparency and Ministerial Accountability Act*.

KEY FACTS

All health authorities reported year-end surpluses for the fiscal year 2013/14 (except for Nisga'a Valley Health Board).

FINANCIAL IMPLICATIONS

- Table 1 shows 2013/14 health authority actual revenue and expenses, excluding their denominational affiliates.

Table 1: 2013/14 Actuals for Health Authorities

Health Authority	2013/14 Revenues ($ millions)	2013/14 Expenses ($ millions)	2013/14 Surplus/(Deficit) ($ millions)	Surplus/(Deficit) as a % of Revenue
Fraser	3,117.55	3,090.30	27.25	0.87%
Interior	1,930.65	1,896.84	33.80	1.75%
Northern	745.57	731.77	13.80	1.85%
Vancouver Coastal	3,167.71	3,127.18	40.53	1.28%
Vancouver Island	2,075.44	2,052.58	22.86	1.10%
Provincial Health Services	2,743.87	2,743.35	0.52	0.02%
Nisga'a Valley Health Board	17.61	17.90	(0.29)	-1.64%
Total	**13,798.39**	**13,659.92**	**138.47**	**1.00%**

- As at Quarter 1, for the 2014/15 fiscal year, Nisga'a Valley Health Board is projecting a deficit of $0.07 million while all other health authorities are projecting to balance their budgets.
- For 2014/15, health authorities and denominational affiliates report the following as at Quarter 4(unaudited):

FACT SHEET

	2014/15 Actual Surplus/ (Deficit) for 2014/15 as at Quarter 4 As at Mar 31/14 (in $ 000's)
Health Authority/Affiliate	Note 1

s.17

Total - All Health Authorities including denominational affiliates Note 1	11,318

Approved by:
Gordon Cross, Regional Grants and Decision Support Branch; April 24, 2015
Manjit Sidhu, Finance and Corporate Services Division; April 24, 2015

FACT SHEET

Birth by Non - BC Residents

ISSUE

Media article that birth tourism is on the rise in Vancouver and Richmond.

KEY FACTS

- In January 2015, the Vancouver Sun reported that birth tourism was on the rise in Vancouver and Richmond and quoted statistics showing non-resident birth numbers increasing up three-fold since 2009. The article alluded to passport, birth certificate and Medical Services Cards being obtained for babies.
- The Audit and Investigations Branch, Eligibility, Compliance and Enforcement Unit (ECEU), is aware of s.17 that provide room and board services to foreign pregnant women who choose to come to BC to give birth. These residences are referred to in the Asian community as "Baby Houses".
- These residences are utilized by two groups of individuals:
  - Individuals that are in Canada on a Temporary Resident document such as a tourist visa, work or study permit. These individuals come to Canada to deliver a baby, who by birth is then granted Canadian Citizenship status. These clients do not access Medical Services Plan (MSP) funded benefits, they declare themselves as self-pay at hospitals and to doctors. Any misuse by Temporary Document holders falls under the Canadian Citizenship Act and is the jurisdiction of the Federal Government. These cases are not reported to ECEU and are the responsibility of the Federal Government.
  - Individuals who have been granted Permanent Residence in Canada and are properly enrolled in the plan, but at some point cease to meet the definition of a resident under the *Medicare Protection Act*. They return to their country of origin, fail to communicate to MSP that they are no longer in BC and remain enrolled in the Plan. These individuals later return to BC to deliver a baby, and as they have active MSP coverage, all claims for the mother and child are billed to the plan. These individuals stay long enough to obtain a birth certificate, a Canadian passport and enrolment in MSP for the child, before returning to their country of origin.
- ECEU conducts regular reviews of individuals who cease to meet the definition of a resident under the *Medicare Protection Act*. ECEU reviews the MSP data to identify delivery claims without the normal pre and post maternity care claims, and newborn claims without the routine fee care codes for a period after birth. s.17

s.17

s.17

FINANCIAL IMPLICATIONS

- In fiscal 2013/14, the costs relating to non-resident births amounted to a total of s.17 for recovery by health authorities, PharmaCare and MSP. Recovery of ineligible payments is the responsibility of each program. s.17

s.17

- Of the amounts identified for recovery, it is unknown what proportion is related to "baby houses" but is thought to be small. The cases investigated did not involve the use of forged or counterfeit CareCards or BC Services Cards nor did they present sufficient evidence to warrant a referral to law enforcement (no suspected fraud).

Approved by:
David Fairbotham, Audit and Investigations Branch; May 6, 2015
Manjit Sidhu, Finance and Corporate Services Division; May 7, 2015
Stephanie Power, Medical Beneficiary and Pharmaceutical Services Division; April 20, 2015
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; April 21, 2015

FACT SHEET

Costs of Health Care

ISSUE

The Consolidated Revenue Fund (CRF) Health Sector budget represents 49.1% of the total Provincial CRF budget.

KEY FACTS

Costs Drivers in Health Care

- Growing population – over the period 2014 to 2018, BC's population is projected to grow by 5.1% to 4.863 million.
- Aging population – health services tend to be used at higher rates as the population ages. The BC population over 65 years of age is expected to grow from 785,300 in 2014 to 918,900 by 2018 (an increase of 133,600 or 17%). This also results in increased home care and residential care demands.
- Advancement in technology and testing, which expands ability to treat more people for existing conditions (i.e. hip replacements for older patients), and new and expensive treatments for previously untreatable conditions.
- Incidence of Chronic Disease (diabetes, renal failure, congestive heart failure).
- Rapidly rising drug prices – especially cancer drugs and increased utilization.
- Expanding treatment for developmental conditions (Autism, Fetal Alcohol Syndrome).
- Compensation pressures.
- Public Health emergencies.

Ongoing Management Strategies:

- Continuing consultation with leaders in the industry.
- Eight priority areas for service delivery action have been identified:
  - Provide patient-centred care;
  - Implement targeted and effective primary prevention and health promotion through a coordinated delivery system;
  - Implement a provincial system of primary and community care built around inter-professional teams and functions;
  - Strengthen the interface between primary and specialist care and treatment;
  - Provide timely access to quality diagnostics;
  - Drive evidence-informed access to clinically effective and cost-effective pharmaceuticals;
  - Examine the role and functioning of the acute care system, focused on providing inter-professional teams and functions with better linkages to community health care; and
  - Increase access to an appropriate continuum of residential care services.
- The 3-Year Service Plan for the Ministry is at http://bcbudget.gov.bc.ca/2015/sp/pdf/ministry/hlth.pdf

Background

The CRF Health Sector Estimates for 2015/16 is:

Ministry of Health	$17.444 billion
Other CRF Health Sector Budgets	
- Capital Funding	0.379
- Ministry of Children and Family Development	0.274
- Ministry of Social Development	0.127
- Ministry of Finance	0.006
Total CRF Health Sector Budgets	$18.230 billion

FACT SHEET

Allocation of Operating Expenses - $000's

Core Business	2014/15 Restated	2015/16 Estimates	% Change	$ Change
HEALTH PROGRAMS				
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Approved by
Daryl Conner, Finance and Decision Support Branch; April 23, 2015
Manjit Sidhu, Finance and Corporate Services Division; April 24, 2015

FACT SHEET

Extra Billing Audits

ISSUE

A number of private health clinics and Medical Services Plan (MSP) enrolled physicians may be privately charging persons either for a benefit under MSP or for matters in relation to one. This is referred to as "extra billing" and is prohibited under the *Medicare Protection Act* and the *Canada Health Act*.

KEY FACTS

- s.15

- The first extra billing audit focused on Cambie Surgery Centre (Cambie) and the Specialist Referral Clinic (SRC). Following the written notification in 2008 from the AIC, legal challenges ensued from January 2009 to September 2010, in which MSC's powers to undertake extra billing audits under the *Medicare Protection Act* were challenged under the Canadian *Charter of Rights and Freedoms*. The BC Court of Appeal rendered a decision on September 9, 2010, that cleared the way for the MSC to proceed with the Cambie and SRC audits.
- s.14,s.17

- The findings in the audit report resulted in the MSC applying for an injunction to stop the extra billing (currently subject to a constitutional challenge by the two clinics), and requesting a follow-up audit to establish whether double billing of a benefit occurred and, if so, whether the physicians involved financially benefitted from both sides of the double billing.
- The follow-up audit commenced in December 2012 and is continuing.s.14,s.17
  s.14,s.17

- s.13,s.14

- s.13,s.17

FINANCIAL IMPLICATIONS

The Ministry is subject to federal funding claw backs for instances of extra billing identified.

FACT SHEET

Approved by:
Marie Thelisma, Billing Integrity Program; April 23, 2015
Manjit Sidhu, Finance and Corporate Services Division; April 24, 2015

FACT SHEET

Fraser Health Authority

ISSUE

The Fraser Health Authority (FHA) is one of six health authorities created in 2001. The Ministry of Health provides annual operating funding directly to the FHA via the annual regional funding allocation. This funding represents the vast majority of the FHA's annual operating revenues.

KEY FACTS

- This Ministry's regional services funding represents the vast majority of the FHA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan, the Provincial Health Services Authority, and fees paid by patients and other health insurers (e.g., fees for services provided to non-residents of Canada; parking; and preferred accommodation).
- Working in cooperation with the FHA to provide health services within the FHA region are two denominational affiliates or hospital societies established per the *Hospital Act* (i.e., Menno Hospital and St. Michael's Centre). These denominational affiliates are separate legal entities, and each has its own board of directors and issues its own audited financial statements. The Ministry does not provide operating funding directly to the denominational affiliates; the FHA is responsible for allocating operating funding to the denominational affiliates. The financial results of the FHA and the denominational affiliates are consolidated in the Government Reporting Entity.

FINANCIAL IMPLICATIONS

- 2013/14 actual annual operating revenues: $3.118 billion (per 2013/14 audited financial statements, excluding denominational affiliates).
- 2013/14 actual operating surplus, including denominational affiliates: $26.572 million (per 2013/14 audited financial statements of FHA and the denominational affiliates).
- Regional Funding Allocation:
  - 2014/15 - $2.708 billion (per 2014/15 Final Funding Letter)
  - s.13,s.17
- Estimated FTEs (excluding Menno Hospital, St Michael's and other contracted agencies):
  - Union – 16,481
  - Non-Union/Management – 1,657
- Per 2013/14 Audited Financial Statements of FHA (Excluding Menno and St. Michael's):
  - Total Revenues $3,117.545 million
  - Total Expenses $3,090.296 million
  - Surplus $ 27.249 million
- With Menno and St. Michael's included, FHA overall reported a surplus of $26.572 million for 2013/14.

Approved by:
Gordon Cross, Regional Grants and Decision Support Branch; May 6, 2015
Manjit Sidhu, Finance and Corporate Services Division; May 7, 2015

FACT SHEET

Healthcare Benefits Trust – Rate Increases

ISSUE

The Healthcare Benefits Trust (HBT) provides group health and welfare benefits in the health sector and represents a material expense to the health authorities and other agencies. The year over year increases in premiums is monitored closely.

Key FACTS

HBT was established in 1979, for the purpose of providing group health and welfare benefits for eligible employees of agencies operating in the Health Sector. The primary benefits are Group Life, Accidental Death & Dismemberment, Extended Health, Dental, and Long Term Disability.

General Reasons for Rate Changes

1.	Inflation	Increase costs of goods and services.
2.	Utilization	Increase employee and dependent usage.
3.	Transfer of Costs	Due to policy changes of other programs such as to provincial MSP, Pharmacare and WorkSafe BC.
4.	New Treatments	Advancement in drug therapies & medical/dental technology.
5.	Benefit Plan Changes	Benefit plan enhancements, i.e. pay-direct prescription drug card.
6.	Reduced Hospitalization	Transfers cost from public system to private health plans.
7.	Demographics	Population health factors related to risk/exposure leading indicators.
8.	Claims Experience	Behavior of existing and new claims versus expectations.
9.	Investment	Rate of return realized on the assets invested in the market place.
10.	Wage Rate Changes	LTD benefit is a factor of current wages and future wage rate increases.
11.	Prevention	Early case management and healthy workplace strategies control time loss.

FINANCIAL IMPLICATIONS

Listed below are the rate changes at April 1 for the previous two fiscal years, the upcoming fiscal year, and the HBT estimates for the following two fiscal years. The rate changes represent the weighted average for health authorities, Providence Health Care and affiliates. Rates are subject to changes in coverage as negotiated in collective agreements.

	Actual			Estimates	
	April 1, 2013	April 1, 2014	April 1, 2015	April 1, 2016	April 1, 2017
Dental **Note 1**	-2.53%	-5.00%	-5.80%	4.50%	4.50%
Extended Health **Note 1**	-7.63%	-11.70%	-0.18%	7.00%	7.00%
LTD **Note 2**	-4.57%	-0.82%	-9.87%	-0.51%	-0.32%
Group Life	0.00%	-7.70%	-8.33%	0.00%	0.00%
AD&D **Note 3**	-16.70%	-20.00%	-20.00%	0.00%	0.00%

Note 1 – Dental and Extended Health premiums for the current year are determined based on individual employer claims experience or pooled claims experience for smaller employers for the previous year. There is no rolling average. Estimates for future years are based on expected trend rates.

Note 2 – LTD rate changes are based on an estimate of LTD claims and expenses. If the estimated cost of claims and expenses falls within an acceptable range then no rate change is proposed for the purposes of rate stability.

Note 3 – The percentage changes do not represent a material change in cost.

Additional Notes on Rate Changes:

- *Rate changes above do not include the potential impact of the Joint Benefit Trust for CBA, FBA and HSPBA beginning April 1, 2016. Bargaining is still in progress for the April 1, 2014 – March 31, 2019 NBA agreement.*
- *Rate changes above do not take into account the contribution holiday currently in place for the Health Authorities and Providence.*
- *Rate changes above do not include the impact of rate changes at other dates (eg. due to bargained plan design changes implemented part way through year)*

FACT SHEET

Approved by:
Catherine Hoefer, Compensation Analysis Branch; April 23, 2015
Daryl Conner, Finance and Decision Support Branch; April 23, 2015
Manjit Sidhu, Finance and Corporate Services Division; April 24, 2015

FACT SHEET

Health Authority Cash Management and Central Deposit Program

ISSUE

As highlighted in the Minister of Finance's Budget Speech 2015 (p. 6), the province will continue to "pursue savings from better cash management across the public sector, as recommended by the Auditor General". For the Ministry of Health, this means continuing to work with health authorities to maximize their cash holdings in Provincial Treasury's Central Deposit Program (CDP).

KEY FACTS

- In March 2014, the Office of the Auditor General (OAG) released its "Follow-up Report on Working Capital Management" regarding the control of cash in government and more specifically in the Schools, Universities, Colleges and Health (SUCH) sector agencies. The report is critical of government generally for failing to more aggressively control how the SUCH sector entities accumulate cash since it results in more borrowing and higher costs of borrowing for government. The OAG also reported out on its findings to the Legislative Assembly's Select Standing Committee on Public Accounts on June 25, 2014.
- The Ministry has revised its health authority financial policy manual to include direction that although health authorities are responsible for, and must meet the cash requirements necessary to manage their day to day operations, health authorities:
    - must, as cash equivalents or portfolio investments mature, deposit funds not required for day to day operations in the CDP;
    - shall, to the maximum extent possible, minimize cash on hand and maximize cash holdings within the CDP;
    - shall not make cash withdrawals in support of routine capital or priority initiative capital projects that are not approved and planned for within the Ministry approved Capital Plan; and
    - shall provide quarterly updates to the Ministry regarding their actual and forecast cash, cash equivalents, and portfolio investments for the current fiscal year, as well as projections for the following two fiscal years.

FINANCIAL IMPLICATIONS

The following table provides a "point in time" representation of health authority cash and investment holdings at Quarter 3, 2014/15 ($ millions). These amounts vary throughout the fiscal year as health authorities use cash of a variety of purposes, including their day-to-day payments.

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Summary of Cash, Cash Equivalents and Portfolio Investments
Cash Balance in Central Deposit Program
Cash and Cash Equivalents on Hand (Unrestricted)
Cash and Cash Equivalents on Hand (Restricted)
Portfolio Investment on Hand
Total Cash, Cash Equivalents, Portfolio Investments

Approved by:

Gordon Cross, Regional Grants and Decision Support Branch; April 23, 2015
Manjit Sidhu, Finance and Corporate Services Division; Apr 24, 2015

FACT SHEET

Health Authorities' Parking Fees

ISSUE

All health authorities charge for parking at their facilities (Including parking areas adjacent to Emergency Departments) and use parking fee revenue to cover the cost of providing parking spaces, with the remainder going to fund direct patient care.

KEY FACTS

- Most of the health authorities provide parking fee information on their websites. The fees vary from facility to facility and in some cases, such as Royal Jubilee Hospital, the parking fees can vary depending on where the vehicle is parked.
- Some examples of parking rates by health authorities include the following:
    - Fraser Health Authority: $4.25/hour and $45.00/week at Langley Memorial Hospital; and $4.25 for the first hour ($3.50 for each additional hour) and $45.00/week at Royal Columbian Hospital.
    - Interior Health Authority: $1.50/hour and $30.00/week at Kelowna General Hospital; and $1.50/hour and $36.00/week at Royal Inland Hospital.
    - Northern Health Authority: $0.50/hour, $18.00/3 day pass, and $30.00/week at University Hospital of Northern BC.
    - Vancouver Coastal Health Authority: $3.00/half hour and $64.50/week at Vancouver General Hospital; and $1.75/half hour and $35.25/week at Richmond Hospital.
    - Vancouver Island Health Authority: $2.25 for the first hour ($1.25 for each additional hour) and $26.75/week at Royal Jubilee Hospital; and $2.25 for first two hours ($1.25 for each additional hour) and $26.75/week at Nanaimo Regional Hospital.
    - Provincial Health Services: $3.75/hour and $68/week at BC Children's and Women's Hospital; and $3.75/hour and $55.00/week at the BC Cancer Agency.
- Health authorities provide financial relief to some users. Examples include:
    - renal dialysis patients permits are available at no charge due to life-sustaining treatment;
    - family caregiver permits are available at no charge;
    - discounted weekly/monthly passes for frequent hospital visitors/users;
    - free parking for volunteers;
    - financial hardship permits may be available on a case by case basis; and
    - exemption from parking enforcement in situations where visitors are unable to renew their parking time.

FINANCIAL IMPLICATIONS

- In 2013/14 health authorities reported parking revenues of $34.3 million from public and staff use. For 2014/15, health authorities have reported parking revenue of $35.6 million.
- Although this represents a relatively small proportion of health authority operating budgets, parking fee revenues cover the operating costs related to providing safe parking for the public and staff, for example, lighting, security patrols, snow clearing, and repaving.
- Any excess parking revenue supports direct patient care.

Approved by:

Gordon Cross, Regional Grants and Decision Support Branch; April 23, 2015
Manjit Sidhu, Finance and Corporate Services Division; April 24, 2015

FACT SHEET

Health Care Costs Recovery Act

ISSUE

Concerns have been raised by municipalities and other insurers as to why they are required to pay for health care costs where a personal injury has been caused by a negligent third party.

KEY FACTS

- The *Health Care Costs Recovery Act* (Bill 22) was passed May 29, 2008. The Regulation bringing the Act into force, April 1, 2009, was approved December 8, 2008.
- The Act allows BC to recover the past and future costs of health care provided to a beneficiary, where the costs are the result of personal injury caused by a third-party. It also allows government to expand the scope of health care costs it can recover to include medical care, hospital services, some continuing care services, ambulance services, PharmaCare and potentially other costs covered by provincially funded programs. The previous voluntary agreement with the Insurance Bureau of Canada allowed for the recovery of hospital costs only.
- Municipalities, if negligent, are no different than any other group or individual and should therefore be treated the same.
- The Act has resulted in the recovery of $5.6 million as at February 28 for fiscal year 2014/15, $5.6 million in health care costs for 2013/14, up from $5.3 million in 2012/13 and up from $2.4 million in 2009/10.
- The Province has participated in settlements of 13 class action law suits, recovering $2 million since April 2009. There is a potential to recover several million dollars from class action law suits.
- There are currently 27 class action law suits that the Ministry is participating in.
- The Act does not apply to health care costs associated with injuries resulting from the operation of motor vehicles, unless vehicles are insured out of province.

FINANCIAL IMPLICATIONS

- The incremental costs for the program are funded within the current Ministry budget.
- Actual revenue from fiscal 2009/10 – year to date February 28, 2015:

Revenue	
2009/10 -	$2.4M
2010/11 -	$3.8M
2011/12 -	$4.6M
2012/13 -	$5.3M
2013/14 -	$5.6M
YTD fiscal 2014/15 -	$5.6M

Approved by:

Ted Boomer obo Daryl Conner, Finance and Decision Support Branch; March 30, 2015
Manjit Sidhu, Finance and Corporate Services Division; April 1, 2015

FACT SHEET

Health Care Practitioner Media Request

ISSUE

Media request relating to the Health Care Practitioners Special Committee for Audit Hearings

KEY FACTS

- The Ministry of Health received a media request in December 2014 requesting "any decisions and reasons rendered by the Health Care Practitioners Special Committee for Audit Hearings as part of the Ministry of Health's Billing Integrity Program and any annual report with investigation summaries done for BIP. Date range is January 1, 2008 to October 10, 2014."
- In response to this request s.17 and notices under section 37 and/or 15 of the *Medicare Protection Act* will be provided in March 2015 and redacted in accordance with the *Freedom of Information and Protection of Privacy Act*.
- s.17 related to audits conducted during the requested time frame and included:
    - s.17
    -
    -
    -
- All the Audit Reports included a notice under Section 37(2) of the *Medicare Protection Act* to recover overpayment by the Medical Services Plan (MSP). s.17
s.17
-
s.17
- The Ministry is working with the respective Colleges to strengthen and communicate billing requirements.

FINANCIAL IMPLICATIONS

Since 2007, the Billing Integrity Program has conducted s.17
s.17 To date, the main errors identified during theaudits relate to lack of records to support the service billed to MSP. s.17
s.17

Approved by:
Marie Thelisma, Billing Integrity Program; March 11, 2015
Manjit Sidhu, Finance and Corporate Services Division; March 23, 2015

FACT SHEET

Inappropriate PharmaCare Billings

ISSUE

Concerns over the increase in inappropriate billing and possibly fraud in the PharmaCare Program, and the level of audit scrutiny.

KEY FACTS

- The PharmaCare audit office has identified an increase in inappropriate billing over the past few years.
- An article in the Vancouver Sun newspaper dated November 21, 2013, raised public concerns over the increase in inappropriate billing and possibly fraud in the PharmaCare Program, and the level of audit scrutiny.
- PharmaCare Audit is working to increase its ability to find and deter inappropriate billing, and has hired several extra staff members for this work.
- The Ministry of Health (the Ministry) is also working on strengthening its information systems, policies, regulations, and legislation to reduce the risk of inappropriate billing and increase its enforcement efforts.
- Overbilling may be due to mistakes or deliberate: proving fraud versus error is difficult. Anyone who may have information about inappropriate pharmacy practices or billing can contact the Ministry's PharmaCare toll free line or the College of Pharmacists.
- The Ministry takes concerns about inappropriate PharmaCare billing very seriously, and will take the actions necessary to enforce the requirements of the *Pharmaceutical Services Act*.

FINANCIAL IMPLICATIONS

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Approved by:
David Fairbotham, Audit and Investigations Branch; February 23, 2015
Manjit Sidhu, Finance and Corporate Services Division; February 27, 2015

FACT SHEET

Interior Health Authority

ISSUE

The Interior Health Authority (IHA) is one of six health authorities created in 2001. The Ministry of Health provides annual operating funding directly to IHA via the annual regional services funding allocation. This funding represents the vast majority of IHA's annual operating revenues.

KEY FACTS

The Ministry's regional services funding represents the vast majority of the IHA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan and fees paid by patients and other health insurers (e.g., fees for services provided to non-residents of Canada, parking, and preferred accommodation).

FINANCIAL IMPLICATIONS

- 2013/14 actual annual operating revenues: $1.931 billion (per 2013/14 audited financial statements).
- 2013/14 actual operating surplus: $33.802 million (per 2013/14 audited financial statements).
- Regional Funding Allocation:
  - 2014/15 - $1.552 billion (per 2014/15 Final Funding Letter)
  - s.13,s.17
- Estimated FTEs:
  - Unionized – 12,925
  - Non-unionized/Management – 932
- 2013/14 Audited Financial Statements:

Total Revenue:	$1,930.645 million
Total Expenses:	$1,896.843 million
Surplus	$ 33.802 million

Approved by:

Gordon Cross, Regional Grants and Decision Support Branch; May 6, 2015
Manjit Sidhu, Finance and Corporate Services Division; May 7, 2015

FACT SHEET

Interprovincial Hospital Rates

ISSUE

- The portability and accessibility provisions of the *Canada Health Act* require provinces and territories to compensate each other when their residents receive hospital treatment in other provinces and territories.
- The Interprovincial Health Insurance Agreement Coordinating Committee (IHIACC) negotiates hospital service fees between jurisdictions to recover costs for out-of-province in-patient admissions and most outpatient procedures.

KEY FACTS

- Each year, hospital financial and workload data collected by the Ministry of Health is processed by the Canadian Institute of Health Information and provides the basis for developing per diem (daily) rates to charge other provinces and territories for patients who receive hospital-based treatment in BC. Adjusted annually for inflation and cost increase forecasts, these rates are reviewed by provinces and territories through IHIACC and approved by provincial and territorial deputy ministers of health. The Ministry of Health's Regional Grants and Decision Support Branch represents the province and puts forward issues on behalf of the health authorities through IHIACC.
- Interprovincial/provincial in-patient rates typically vary between BC hospitals. The rate charged depends on costs associated with the level of care the patient received (either standard ward or an intensive care unit ward) for that hospital. Specific high cost out-patient procedures and the standard rate for most other out-patient services are billed at common rates for all provinces and territories.
- The approved hospital in-patient rates for BC hospitals vary between facilities although smaller hospitals outside urban areas use an average rate to simplify billing. While out-patient and high cost procedure service rates are common for all provinces and territories, the rates charged by other provinces and territories for hospital care provided to BC residents vary from the rates used for BC hospitals, due to hospital procedural cost differences in each province and jurisdiction.

FINANCIAL IMPLICATIONS

- The expenditure for out-of-province hospital billings for 2014/15 (i.e., the amount the province pays to other provinces and territories for treating BC residents) was $101.1 million. BC's revenue from billing other provinces and territories was $90.0 million in 2014/15 and was paid to the health authorities of the BC hospitals that provided the services.
- Rates and revenues for all provinces and territories will change each year as new data is used in the rate methodology calculations.

Approved by:
Gordon Cross, Regional Grants and Decision Support Branch; April 23, 2015
Manjit Sidhu, Finance and Corporate Services Division; April 24, 2015

FACT SHEET

Lower Mainland Consolidation Update

ISSUE

The Lower Mainland Consolidation (LMC) was initiated by the Ministry in July 2009. It involves consolidating corporate, clinical support, and back office functions to achieve efficiencies and savings across the four participating health organizations: Fraser Health Authority, Provincial Health Services Authority, Vancouver Coastal Health Authority, and Providence Health Care.

Based on the successes of the LMC initiative, an Operations Committee, with representatives from each of the health authorities, was formed to examine how Interior Health Authority, Northern Health Authority and Vancouver Island Health Authority can take advantage of the positive experiences of the current LMC initiative.

KEY FACTS

- The general functions or services being consolidated across the Lower Mainland as part of the LMC initiative (and the lead health organization responsible for each service), are as follows:

Vancouver Coastal Health Authority
  - Integrated Medical Imaging
  - Business Initiatives and Support Services

Providence Health Care
  - Biomedical Engineering Services
  - Health Information Management

Fraser Health Authority
  - Capital Projects, Facilities Management, Planning and Real Estate
  - Integrated Protection Services
  - Pharmacy Services

Provincial Health Services Authority
  - Information Management and Information Technology, not including Technical Services that are being consolidated for all health authorities by Health Shared Services BC
  - Pathology and Laboratory Medicine
  - Interpreting Services
  - Communication and Public Relations (originally included in LMC scope, but subsequently removed from LMC)

- LMC services are separate and distinct from services delivered by Health Shared Services BC, a stand-alone division within the Provincial Health Services Authority.
- The Ministry provides facilitation and has decision-making authority in the event that collaborative decision-making is not possible among the four participating health organizations. The Ministry is also responsible for performance monitoring and reporting support for the LMC.
- The project phase of LMC concluded at the end of 2012/13, and LMC departments transitioned into sustainment mode.
- The LMC Steering Committee evolved into the CEO Collaboration Council with the mandate to explore consolidation and collaboration opportunities on a provincial scope, and to address issues of governance.
- In early 2014, Leadership Council assumed the responsibilities of the Collaboration Council in overseeing the delivery provincial consolidation and collaboration opportunities and addressing issues of governance.

FACT SHEET

- An Operations Committee (OC), comprising VP-level representatives from the 7 health organizations, was appointed by Leadership Council and mandated to identify and address the remaining issues that constrain the effective operations of the shared services.
- To date, the OC continues to address complex organizational issues and variations with the goal of creating long term enablers for shared services.
- Some of the items that the OC is discussing include:
    - Assessing potential candidates for provincial expansion;
    - Budget management – addressing issues around budget governance, accountability and flexibility of moving resources across shared services;
    - Capital – exploring a common framework to enable the planning, prioritization and allocation of capital to shared services (LMC and HSSBC); and
    - Policy standardization – the harmonization of clinical and corporate policies and practices.

FINANCIAL IMPLICATIONS

In fiscal year 2013/14, LMC transitioned from its "project phase" into sustainment after having achieved over $75 million in annual savings. Most of the consolidated services have achieved their targets, and only Medical Imaging and Laboratory continue to pursue strategies to meet their savings goals.

Approved by:
Gordon Cross, Regional Grants and Decision Support Branch; April 23, 2015
Manjit Sidhu, Finance and Corporate Services Division; April 24, 2015

FACT SHEET

Medical Services Plan (MSP) Premiums

ISSUE

An overview of MSP Premiums and the impact of the 4% increase in MSP premiums rates.

KEY FACTS

- Each province and territory in Canada determines how its health care programs are funded. In BC, funding is obtained from general taxes, federal contributions and MSP premiums.
- The provincial government has increased funding for health care every year since 2001. Premium rate increases are necessary to assist in meeting steadily rising costs of BC's health care system.
- Effective January 1, 2015, MSP premium rates will be increasing by 4% (3rd year in a row that the rates have increased by 4%).
- For those insured persons with adjusted net income levels less than $30,000, the MSP premium rates are not impacted by the 4%. In addition, the regular premium assistance program was enhanced on January 1, 2010 to increase the adjusted net income by $2,000. As a result, those who qualify and whose incomes have remained consistent will pay lower rates than in 2005.
- For those insured persons with adjusted net income levels greater than $30,000, the monthly premium rate impacts as follows:

Adjusted Net Income Level	Monthly Premium Rates - effective Jan. 1, 2014			Monthly Premium Rates - effective Jan. 1, 2015		
	One Person	Family of Two	Family of Three or More	One Person	Family of Two	Family of Three or More
$0 - $22,000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
$22,001 - $24,000	$12.80	$23.20	$25.60	$12.80	$23.20	$25.60
$24,001 - $26,000	$25.60	$46.40	$51.20	$25.60	$46.40	$51.20
$26,001 - $28,000	$38.40	$69.60	$76.80	$38.40	$69.60	$76.80
$28,001 - $30,000	$51.20	$92.80	$102.40	$51.20	$92.80	$102.40
over $30,000	$69.25	$125.50	$138.50	$72.00	$130.50	$144.00
% increase				4.0%	4.0%	4.0%
$ increase				$2.75	$5.00	$5.50

- This 4% increase effective January 1, 2015 will contribute an estimated $93 million to government's revenue for fiscal year 2015/16.

Background

There are 2 assistance programs that offer subsidies to those in financial need that meet the residency and financial requirements to qualify.

- Regular premium assistance offers 5 subsidy level that is based on an individual's net income (or a couple's combined net income) for the preceding tax year, less deductions for age, family size, disability, and any reported universal child care benefit and registered disability savings plan income. If the resulting amount, referred to as 'adjusted net income' is $30,000 or less, assistance is available. Premium assistance may be provided retroactively to a maximum of six years from the date on which the request is received.
- In order to ensure fairness and equity for all applicants, as of January 1, 1989, a family's net income, as defined by line 236 on the federal tax return was concluded to be the most equitable factor in determining the level of assistance. MSP's use of line 236 is consistent with the Canada Revenue Agency who also uses Line 236 to calculate certain tax credits such as the Canada Child Tax Credit.

FACT SHEET

- Temporary premium assistance is 100% subsidy on a one time, short term basis to individuals and families who are not able to pay the MSP premiums due to unexpected financial hardship that could not reasonably have been budgeted for. This program is administered by the Ministry of Finance.

Statistics

Of the BC residents that are incurred under the MSP, as at September 2014, the % that is paying the full premium rates and % receiving premium assistances as follows:

- There are 4,642,107 BC residents that are insured under MSP.
- Of the total, 72.47% (3,364,117) pay the full MSP premium rate; and 20.26% (940,307) receive some form of premium assistance.
- For the premium assistance, 939,633 receive regular premium assistance and 674 receive temporary premium assistance.
- Ministry of Social Development assists 199,164 individuals with medical coverage. This medical coverage is provided to recipients of income assistance, hardship assistance, disability assistance, and refugee claimants who meet the MSP residency criteria.
- First Nations account for 2.98% (138,519) of residents insured under MSP. The First Nations premiums are paid by the First Nations Health Authority.
- The total seniors insured under the MSP is 812,062 (17.5%). Of the total seniors, 265,948 are under premium assistance.

Adjusted Net Income Level	Insured Persons at September 2014	% of total at September 2014
$0 - $22,000	774,607	16.69%
$22,001 - $24,000	51,594	1.11%
$24,001 - $26,000	45,140	0.97%
$26,001 - $28,000	37,257	0.80%
$28,001 - $30,000	31,709	0.68%
Subtotal - premium assistance	940,307	20.26%
Min. of Social Development	199,164	4.29%
First Nations	138,519	2.98%
Subtotal	1,277,990	27.53%
over $30,000	3,364,117	72.47%
Total	4,642,107	100.00%

FINANCIAL IMPLICATIONS

- The 4% increase in MSP premiums effective January 1, 2015 will contribute an additional $23 million to government's revenue in 2014/15 and $93 million in 2015/16.
- Effective January 1, 2016, MSP premium rates will be increasing by 4% (4th year in a row that the rates have increased by 4%). This increase will contribute an additional $24 million to government's revenue in 2015/16 and $96 million in 2016/17.

Approved by:
Bonnie Wong, Decision Support, HSWD & HSD Branch; April 24, 2015
Daryl Conner, Finance and Decision Support Branch; April 24, 2015
Manjit Sidhu, Finance and Corporate Services Division; April 24, 2015

FACT SHEET

Mental Health 120 Day Plan – Funding Specifics

ISSUE

Ministry of Health funding commitments in 2013/14 and 2014/15 to support the recommendations in its November 2013 report, Improving Health Services for Individuals with Severe Addiction and Mental Illness (SAMI).

KEY FACTS

- The Ministry provided a total of $5.75 million in one-time funding in 2013/14 to the Vancouver Coastal Health Authority (VCHA) to implement immediate actions such as creating an Assertive Outreach Team and two new Assertive Community Treatment teams.
- The Ministry allocated $20.25 million in base funding beginning in fiscal 2014/15 to support the needs, and strengthen approved services for this population including:
    - $2.5 million to the Provincial Health Services Authority to support the ongoing operation of a secure facility to provide stabilization, assessment and individual case planning services for SAMI and aggressive clients that is linked to the Burnaby Centre for Mental Health and Addiction;
    - $5.0 million to the Provincial Health Services Authority to implement, together with VCHA, the high-intensity contracted group homes;
    - $750,000 to VCHA (Providence Health Care) the Inner City Youth Mental Health Program for youth aged 16-24;
    - $2 million to VCHA to support the 9 Bed Acute Behavioral Stabilization Unit at St. Paul's Hospital, an Assertive Outreach Team in the Downtown Eastside, and clinical treatment and support for 39 beds at the Princess Housing Site; and
    - $10 million in matching funds to assist the five regional health authorities in strengthening approved services for this population as part of an overall incremental provincial approach.
- During the 2014/15 fiscal year, regional health authorities developed proposals/business plans related to the $10 million in matching funds. Proposals needed to be evidence-based and for net new services (i.e. not to subsidize existing services for this population). The Ministry reviewed and approved proposals/business plans for the following services:
    - Fraser Health Authority – two Assertive Community Act Teams (Surrey/North Delta and Abbotsford/Mission);
    - Interior Health Authority – two Assertive Community Act Teams (Kamloops and Kelowna) and a Crisis Response Team in Williams Lake;
    - Northern Health Authority – an Intensive Case Management Team, a RCMP Liaison Nurse in Prince George, and a Psychiatric Liaison Nurse function in the University Hospital of Northern BC Emergency department;
    - VCHA – two Assertive Community Act Teams and an Intensive Management Team (North Shore Youth Crisis Response Service); and
    - Vancouver Island Health Authority – three Intensive Case Management Teams (Mt. Waddington, Courtenay/Comox and Victoria) and a 14 bed Regional Tertiary Transitional Facility.

FACT SHEET

FINANCIAL IMPLICATIONS

- s.17

- In 2015/16, all SAMI initiatives/health authority proposals will be implemented and $20.25 million fully allocated.

Approved by:
Gordon Cross, Regional Grants and Decision Support Branch; April 24, 2015
Manjit Sidhu, Finance and Corporate Services Division; April 24, 2015

FACT SHEET

Ministry Spending Directives

ISSUE

Government has introduced spending directives in order to manage costs as efficiently as possible and to manage the overall budget. The Spending Directives have been included as a link on the Ministry of Health's website for easy access by all employees.

KEY FACTS

- In May of 2009, the Finance and Corporate Services Division issued initial directives to meet budget targets. These directives covered:
    - Office and Business Expenses (STOB 65)
    - Travel – In Province and Out of Province
    - Blackberry / Cell Phone use
    - Electronic Storage – Shared Drive / E-mail / Personal Drive
    - Printing, Faxing, Copying & Scanning
    - Single Workstation
    - Virtual Private Network / VPN / and Terminal Service (DTS)
    - Telephone expenses (STOB 59)
    - Legal Services
    - Videoconference Policy for Ministry Use
- These directives have continued, with the addition of:
    - In 2011/12 - Contract Management
    - In 2012/13 - Transfer Payments; Base Salaries and Overtime
- In October 2012, all directives were reviewed and updated as necessary to comply with a number of updates provided from the Chair of the Treasury Board.

Background

- Budget 2009 required ministries to eliminate discretionary spending in order to achieve budget targets for 2009/10. Ministries were to also consider how expenditures could be made differently and less expensively. To achieve this, the Ministry issued spending directives aimed at reducing expenditures in administrative areas.
- Since 2009, spending directives for contract management, transfer payments, base salaries and overtime have been added.

FINANCIAL IMPLICATIONS

Compliance with these directives has been monitored. In addition to these directives, in July 2014, the Deputy Minister of Finance issued a specific Ministry STOB 50 target for 2014/15. As a result of implementation and monitoring, savings of at least $10.3 million (including benefits chargeback) are expected in 2014/15.

Approved by:
Daryl Conner, Finance and Decision Support Branch; April 22, 2015
Manjit Sidhu, Finance and Corporate Services Division; April 23, 2015

FACT SHEET

Northern Health Authority

ISSUE

The Northern Health Authority (NHA) is one of six health authorities created in 2001. The Ministry of Health provides annual operating funding directly to the NHA via the annual regional funding allocation. This funding represents the vast majority of the NHA's annual operating revenues.

KEY FACTS

- This Ministry's regional services funding represents the vast majority of the NHA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan, the Provincial Health Services Authority, and fees paid by patients and other health insurers (e.g., fees for services provided to non-residents of Canada, parking and preferred accommodation).
- Working in cooperation with the NHA to provide health services within the NHA region is Wrinch Memorial Hospital (WMH), a denominational affiliate established per the *Hospital Act*. Denominational affiliates are separate legal entities, and each has its own board of directors and issues its own audited financial statements. The Ministry does not provide operating funding directly to denominational affiliates; instead, the NHA is responsible for allocating operating funding to WMH. The financial results of the NHA and WMH are consolidated in the Government Reporting Entity.

FINANCIAL IMPLICATIONS

- 2013/14 actual annual operating revenues: $745.570 million (per 2013/14 audited financial statements, excluding denominational affiliate WMH).
- 2013/14 actual surplus: $13.996 million (per 2013/14 audited financial statements, including denominational affiliate WMH).
- Regional Funding Allocation:
  - 2014/15 - $558.507 million (per 2014/15 Final Funding Letter)
  - s.13,s.17
- Estimated FTEs:
  - Unionized – 4,777
  - Non-Union/Management – 456
- 2013/14 Audited Financial Statements:

Total Revenues	$745.570 million
Total Expenses	$731.770 million
Surplus	$ 13.800 million (excluding WMH)

Approved by:
Gordon Cross, Regional Grants and Decision Support Branch; May 6, 2015
Manjit Sidhu, Finance and Corporate Services Division; May 7, 2015

FACT SHEET

Patient Focused Funding (BC Health Services Purchasing Organization)

ISSUE

- One-time funding of $250 million over two years ($80 million in 2010/11 and $170 million in 2011/12) was identified in the Ministry of Health's budget to establish Patient-Focused Funding (PFF) and create the BC Health Services Purchasing Organization (HSPO).
- In fiscal 2012/13, the Ministry provided approximately $50 million to continue PFF under the HSPO.
- s.17

- Building on the successes of PFF, in 2013/14 the Ministry introduced a Pay-for-Performance (P4P) funding methodology. The P4P funding methodology is being managed internally within the Ministry, and involves linking a portion of health authority base funding to performance against specific measures and targets (see separate P4P fact sheet).

KEY FACTS

- On April 1, 2010, the Ministry introduced PFF, under which a significant portion of eligible acute care funding was to have been based on actual workload performed. This change to provincial health care funding built on pilot projects implemented through the Lower Mainland Innovation and Integration Fund, which included emergency department P4P.
- The objectives of PFF included:
    - P4P in emergency departments whereby hospitals receive incentive payments to treat and release or admit patients from emergency departments within target times;
    - increasing the volume of MRIs across regional health authorities;
    - incenting health authorities to undertake more same day procedures where appropriate, i.e., to shift workload from an inpatient setting to outpatient settings where appropriate and undertaking HSPO/Ministry identified high priority surgical and other procedures; and
    - quality performance methodologies in selected hospitals across health authorities using the National Surgical Quality Improvement Project methodology.
- The HSPO has been dissolved as of fiscal 2013/14.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Gordon Cross, Regional Grants and Decision Support Branch; April 24, 2015
Manjit Sidhu, Finance and Corporate Services Division; April 24, 2015

FACT SHEET

PharmaCare Audit Sampling Methodology

ISSUE

Authority regarding the use of statistical sampling methods in the conduct of audits and calculation of overpayments for recovery by PharmaCare Audit under the *Pharmaceutical Services Act* needs to be clarified in a Ministerial Order.

KEY FACTS

- Under Part 5 of the *Pharmaceutical Services Act* (S35), PharmaCare Audit (PCA) is responsible for carrying out objective compliance audits of the PharmaCare Program to ensure pharmacy claims are valid and, where appropriate, recover overpayments.
- PCA uses statistical sampling methods to select a sample of claims for audit and extrapolate the exceptions identified in the sample over the pharmacy's claims population, to arrive at the overpaid amount to be recovered.
- The authority for PCA to utilize statistical sampling methods to calculate overpayments for recovery is set out in S44 of the *Pharmaceutical Services Act.* Under the Act, the Minister may make orders respecting the use of statistical methodologies for the purposes of making a determination and the order must be published.
- s.14,s.17
- s.17
- s.17
- s.13,s.17
- The contents of the Ministerial Order have been reviewed by EY as well as the Ministry's legal counsel. The Ministerial Order was signed on March 11, 2015, and will be published through the Ministry PharmaCare website in due course.

FACT SHEET

- s.13,s.17

FINANCIAL IMPLICATIONS
s.13,s.17

Approved by:
David Fairbotham, Audit and Investigations Branch; March 17, 2015
Manjit Sidhu, Finance and Corporate Services Division; April 10, 2015

Page 053 to/à Page 054

Withheld pursuant to/removed as

s.17

FACT SHEET

Provincial Health Services Authority

ISSUE

The Provincial Health Services Authority (PHSA) is one of six health authorities created in 2001. The Ministry of Health provides annual operating funding directly to the PHSA via the annual regional funding allocation. This funding represents the vast majority of the PHSA's annual operating revenues.

KEY FACTS

Regional services funding represents the vast majority of the PHSA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan, other health authorities, Foundations and fees paid by patients and other health insurers (e.g. fees for services provided to non-residents of Canada, parking and preferred accommodation).

FINANCIAL IMPLICATIONS

- 2013/14 actual operating revenue: $2.744 billion (per 2013/14 audited financial statements.)
- 2013/14 actual operating surplus: $0.520 million (per 2013/14 audited financial statements.)
- Regional Funding Allocation:
  - 2014/15 - $1.862 billion (per 2014/15 Final Funding Letter)
  - s.13,s.17
- Estimated FTEs:
  - Union –9,803
  - Non-Union/Management – 2,822
- 2013/14 Audited Financial Statements:

Total Revenues	$2,743.865 million
Total Expenses	$2,743.345 million
Surplus	$ 0.520 million

Approved by:
Gordon Cross, Regional Grants and Decision Support Branch; May 6, 2015
Manjit Sidhu, Finance and Corporate Services Division; May 7, 2015

FACT SHEET

Public Sector Energy Conservation Agreement Funding (2008/09 – 2010/11)

ISSUE

Update on the status of the Public Sector Energy Conservation Agreement (PSECA) funding.

KEY FACTS

- Between 2008/09 and 2011/12, capital funding for energy efficiency retrofits in the public sector was available to public agencies (including the health sector) through the PSECA. The funding was allocated to government agencies and crown corporations based on prioritized proposals.
- Budget 2008 committed $75 million over 3 years to help public sector organizations reduce provincial greenhouse gas (GHG) emissions, energy consumption and operating costs, as well as support government in achieving its goal of carbon neutrality.
- Projects funded in Phase 1, the first year of the funding (2008/09), were proposed by public sector agencies working with BC Hydro to address primarily electrical fixture upgrades, high efficiency lighting systems, as well as various other energy intensive building systems components.
- Projects funded in Phase 2, the second year of the funding (2009/10), expanded energy saving initiatives to include projects that would lower the consumption of natural gas, as well as would realize energy efficiencies in the information technology areas of the agencies or crown corporations involved.
- In Phase 3 of PSECA (2010/11), the third year of the funding (2010/11), the government committed $25 million in capital funding for energy retrofit projects across 4 categories:
  - $2 million for solar thermal projects to fund solar hot water and air systems;
  - $6 million for K-12 schools throughout the province for heating, ventilation and air-conditioning (HVAC) retrofits;
  - $12 million for district energy system projects; and
  - $5 million for an open call for proposals to all provincial public sector organizations, similar to the open calls in the first two years of the program.
- PSECA capital funds of $24.2 million were allocated by the Ministry of Finance to the Ministry of Health for individually approved projects within Phases 1, 2 and 3.
- The Ministry has released all the available funding to the health authorities, along with communication outlining directions for expenditures and reporting requirements for each project, by fiscal year.
- As of March 2015, out of 80 PSECA health sector projects, 2 are still underway:
  - Boiler Replacement project at BC Children's and Women's (C&W) Health Centre, which became part of the Energy Centre project;
  - Fame Boiler Stack Heath Recovery project at C&W Health Centre, planned for completion in the 2015/16 FY.

<u>Background</u>

- The first PSECA was created in 2007, as a partnership between BC Hydro and the Government of BC.
- In June 2010, the second PSECA agreement was signed between Terasen Gas, Inc. (now FortisBC) and the Government of BC for the purposes of increasing energy conservation and,

where feasible, expanding the use of alternative energy sources1 across public sector buildings in BC.

FINANCIAL IMPLICATIONS

- Following is the summary of PSECA projects as of March 2015:

PSECA Phase	Number of Projects	Total Provincial Funding ($ million)	Total Health Sector Funding ($ million)
Phase 1	31	$ 10.19	$ 12.17
Phase 2	30	$ 10.74	$ 11.80
Phase 3	19	$ 3.28	$ 5.49
Total to date:	**80**	**$ 24.21**	**$ 29.46**

- At the provincial level, over 3 years PSECA has supported 247 projects, created an estimated 500 jobs, saved taxpayers $12.6 million annually and reduced GHG emissions by 35,600 tonnes[2].

Approved by:
Shelley Moen, Capital Services Branch; April 23, 2015
Manjit Sidhu, Finance and Corporate Services Division; April 30, 2015

[1] Alternative energy source represent renewable energy sources that have limited environmental impacts, such as: wind, solar, micro-turbine, waste hear and other clean energy options.
[2] Ministry of Environment, PSECA http://www.env.gov.bc.ca/cas/mitigation/pseca.html

FACT SHEET

Top Five Health Authority Executive Compensation

ISSUE

In 2002, the province introduced legislation requiring public disclosure of executive contracts in addition to annual disclosure of the compensation of the top five executives.

KEY FACTS

- The attached information is a summary of the Executive Disclosure Statements, for the 2013/14 fiscal year, that are posted on the Province's website by the Public Sector Employers' Council Secretariat. This schedule provides the actual compensation levels for the top five executive positions of each health authority.
- Note that the amounts included in the "All Other Compensation" field includes vacation, severance and sick leave payout at retirement or conclusion of employment in addition to the employer contributions/payments/premiums for Employment Insurance, Canada Pension Plan, Worker's Compensation Board, Extended Health, Dental, Medical Services Plan, Group Life, Accidental Death & Dismemberment, and Long Term Disability.

Background

- Government has taken a number of actions in recent years to further align executive compensation with the priorities and fiscal principles of Government:
  - On July 10, 2014, Government provided direction on standards of conduct, including post-employment restrictions.
  - On June 11, 2014, Government implemented new taxpayer accountability principles.
  - In May 2014, Government revised disclosure guidelines to further clarify and enhance the transparency of the compensation paid to CEOs and the top four decision-makers at public sector entities. Disclosure now required of both accrued and paid compensation such as allowances and payment made upon retirement.
  - In 2002, the *Public Sector Employers Amendment Act* (Bill 66) was introduced, which included: limits on payout of accumulated sick leave and vacation leave; tighter rules on the approval of compensation plans; reduction of maximum severance from 24 to 18 months; severance limits for senior executives.
- Legislation requires that current contracts of senior executives must be filed with the Public Sector Employers' Council Secretariat.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Dan Bose, Senior Financial Accountant, February 27, 2015
Daryl Conner, Finance and Decision Support Branch; February 27, 2015
Manjit Sidhu, Finance and Corporate Services Division; April 10, 2015

FACT SHEET

Name	Principle Position	Base Salary	Incentive plan comp. paid	Pension	All Other Comp	Total	Total Prior Year
Fraser Health							
Murray, Dr. Nigel	President & CEO	$348,660	$30,000	$31,047	$34,316	$444,023	$444,023
Woods, Brian[1,2]	VP Corp. Serv & CFO	$218,196		$26,588	$251,467	$496,251	$349,800
Webb, Dr. Andrew	VP Medicine	$271,440		$24,170	$24,430	$320,040	$320,040
Crampton, Geoffrey[1,3]	VP People & Organization Dev	$971		$22,474	$286,197	$309,642	$297,282
Pelletier, Marc	VP Clinical Sup & Strategic Planning/ ICIO	$247,065		$22,000	$25,133	$294,198	N/A
Barker, Philip	VP Infomatics	$247,065		$22,212	$23,346	$292,623	$295,000
Van Buynder, Paul	VP Public Health & Chief MHO	$246,645		$20,371	$19,321	$286,337	N/A
Interior Health							
Halpenny, Dr. Robert	CEO	$315,900	$35,100	$32,459	$25,081	$408,540	$413,217
Etherington, Dr. Jeremy	VP Medicine & Qual.	$291,915		$26,994	$18,464	$337,373	$332,540
Neuner, Andrew	VP Comm. Integr.	$244,101		$22,573	$27,574	$294,248	$280,894
Johnston, John	VP People & Clinical Services	$249,776		$23,098	$15,740	$288,614	$272,176
Lommer, Donna	VP Residential & CFO	$244,101		$22,573	$16,761	$283,435	$280,895
Northern Health							
Ulrich, Catherine	President & CEO	$329,000		$35,173	$12,618	$376,791	$391,999
Chapman, Dr. Ronald	Chief Medical Health Off.	$272,474		$24,431	$13,196	$310,101	$264,197
McMillan, Michael	COO - Northern Interior	$220,409		$19,763	$12,833	$253,005	$252,933
Johnston, Dr Suzanne	VP Clinical Programs	$213,255		$19,165	$11,973	$244,393	$245,428
Lindstrom, Jane	VP Human Resources	$211,146		$18,933	$12,009	$242,088	$241,768
Provincial Health Services							
Coppes, Max	Pres., BC Cancer Agency	$501,796		$45,766	$13,794	$561,356	$331,182
Roy, Carl[4]	President and CEO	$288,930		$26,072	$33,228	$348,230	$316,905
Cranston, Lynda[5]	CEO	$133,713		$24,580	$95,420	$253,713	$437,735
Brunham, Dr. Robert	Prov. Exec. Dir. - BCCDC	$329,159			$35,606	$364,765	$364,765
MacDougall, Michael	Executive Vice President, PHSA and President, BCEHS	$273,089		$24,948	$28,424	$326,461	$322,032
Krystal, Arden	Chief Operating Officer	$273,976		$24,686	$21,722	$320,384	$306,928
Vancouver Coastal Health							
Ostrow, Dr. David	President & CEO	$351,264		$53,550	$14,571	$419,385	$441,926
Ackenhusen, Mary[6]	COO - Vancouver Acute	$271,572		$26,726	$43,110	$341,408	$339,630
O'Conner, Dr. Patrick	VP Medicine	$271,664		$24,297	$15,860	$311,821	$307,232
Coleman, Dr. Jeff	VP, Regl Programs	$271,664		$24,297	$18,859	$314,820	$314,068
Campbell, Duncan[7]	CFO & VP Systems	$16,711		$1,643	$32,573	$50,927	$347,203
Copping, Glen[8]	CFO & VP Sys Devel & Perform	$134,783		$6,543	$17,746	$159,072	N/A
Vancouver Island Health							
Stevenson, Lynn[9]	EVP, People, Org	$211,348		$19,838	$173,291	$404,477	$298,295
Waldner, Howard[10]	President & CEO	$57,995		$5,452	$150,690	$214,137	$420,971
Carr, Brendan[11]	President & CEO	$191,401	$22,864	$11,363	$161,960	$387,588	N/A
Crow, Richard	EVP & CMO	$263,991		$24,777	$26,154	$314,922	$315,226
MacKay, Catherine	EVP & COO	$262,578		$24,644	$23,828	$311,050	$311,915
Baldwan, Jatinder	EVP-Cief Medical	$251,680		$8,665	$33,533	$293,878	N/A
Boomer, Bill[12]	VP & CFO	$53,798		$4,064	$220,206	$278,068	$297,611
Kerrone, Kim[13]	VP & CFO	$226,029		$21,214	$39,635	$286,878	N/A
Providence Health Care							
Doyle, Dianne	President & CEO	$325,486		$28,821	$22,897	$377,204	$371,459
Sindelar, Robert	VP, Research & Academic Aff	$274,623		$23,355	$16,100	$314,078	$41,610
Sachedina, Zulie	VP, HR & Gen. Counsel	$228,234		$20,148	$18,694	$267,076	$265,022
Carere, Dr Ron	VP, Medical Affairs	$262,500			$1,105	$263,605	$281,277
Procter, Mary	VP, Finance	$224,567		$19,804	$11,027	$255,398	$251,211

FACT SHEET

Vancouver Coastal Health Authority

ISSUE

The Vancouver Coastal Health Authority (VCHA) is one of six health authorities created in 2001. The Ministry of Health provides annual operating funding directly to VCHA via the annual regional funding allocation. This funding represents the vast majority of VCHA's annual operating revenues.

KEY FACTS

- This Ministry's regional services funding represents the vast majority of the VCHA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan, the Provincial Health Services Authority, and fees paid by patients and other health insurers (e.g., fees for services provided to non-residents of Canada: parking; preferred accommodation, etc.).
- Working in cooperation with VCHA to provide health services within the VCHA region are two denominational affiliates or hospital societies established per the *Hospital Act*; i.e., Providence Health Care and Louis Brier Hospital in Vancouver. These denominational affiliates are separate legal entities, and each has its own board of directors and issues its own audited financial statements. (Two former denominational affiliates or hospital societies, R. W. Large Memorial Hospital in Bella Bella and Bella Coola General Hospital, were absorbed by VCHA as of April 1, 2014). The Ministry does not provide regional services operating funding directly to the denominational affiliates; VCHA is responsible for allocating a portion of its regional services operating funding to its denominational affiliates. The financial results of the health authority and the denominational affiliates are consolidated in the Government Reporting Entity.

FINANCIAL IMPLICATIONS

- 2013/14 actual annual operating revenues, including Providence Health Care but excluding the other denominational affiliates: $3.469 billion (per 2013/14 audited financial statements of VCHA and Providence Health Care).
- 2013/14 actual operating surplus, including all denominational affiliates: $40.859 million (per 2013/14 audited financial statements of VCHA and the four denominational affiliates).
- Regional Funding Allocation:
  - 2014/15 - $2.461 billion (per 2014/15 Final Funding Letter)
  - s.13,s.17
- Estimated FTEs: (including Providence Health Care, but excluding other denominational affiliates and contracted agencies):
  - Union – 17,619
  - Non-Union/Management – 1,602
- Per 2013/14 Audited Financial Statements of VCHA (Excluding Denominational Affiliates):
  - Total Revenues $3,167.707 million (including gain on sale of assets)
  - Total Expenses $3,127.175 million
  - Surplus $ 40.532 million
- With Providence Health Care, Louis Brier, R. W. Large, and Bella Coola included, VCHA overall reported a surplus of $40.859 million for 2013/14.

Approved by:
Gordon Cross, Regional Grants and Decision Support Branch; May 6, 2015
Manjit Sidhu, Finance and Corporate Services Division; May 7, 2015

FACT SHEET

Vancouver Island Health Authority

ISSUE

The Vancouver Island Health Authority (VIHA) is one of six health authorities created in 2001. The Ministry of Health provides annual operating funding directly to VIHA via the annual regional funding allocation. This funding represents the vast majority of VIHA's annual operating revenues.

KEY FACTS

- The Ministry's regional services funding represents the vast majority of VIHA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan, the Provincial Health Services Authority, and fees paid by patients and other health insurers (e.g., fees for services provided to non-residents of Canada, parking, and preferred accommodation).
- Working in cooperation with the health authority to provide health services within VIHA's region are two denominational affiliates or hospital societies established per the *Hospital Act;* i.e., Mount St. Mary Hospital in Victoria and St. Joseph's General Hospital in Comox. These denominational affiliates are separate legal entities, and each has its own board of directors and issues its own audited financial statements. The Ministry does not provide regional services operating funding directly to the denominational affiliates; VIHA is responsible for allocating a portion of its regional services operating funding to its denominational affiliates. The financial results of the health authority and the denominational affiliates are consolidated in the Government Reporting Entity.

FINANCIAL IMPLICATIONS

- 2013/14 actual annual operating revenues, excluding denominational affiliates: $2.075 billion (per 2013/14 audited financial statements of VIHA).
- 2013/14 actual operating surplus, including denominational affiliates: $22.881 million (per 2013/14 audited financial statements of VIHA and the denominational affiliates).
- Regional Funding Allocation:
  - 2014/15 - $1.714 billion (per 2014/15 Final Funding Letter)
  - s.13,s.17
- Estimated FTEs (excluding Mount St. Mary Hospital, St. Joseph's General Hospital and other contracted agencies):
  - Union – 11,364
  - Non-Union/Management – 1,229
- Per 2013/14 Audited Financial Statements of VIHA (Excluding Denominational Affiliates):

Total Revenues	$2,075.442 million
Total Expenses	$2,052.584 million
Surplus	$ 22.858 million

- With Mount St. Mary Hospital and St. Joseph's General Hospital included, VIHA overall reported a surplus of $22.881 million for 2013/14.

Approved by:

Gordon Cross, Regional Grants and Decision Support Branch; May 6, 2015

Manjit Sidhu, Finance and Corporate Services Division; May 7, 2015

FACT SHEET

Breast Cancer Screening

ISSUE

Update on BC's Screening Mammography Program (SMP), current screening rates in the province and the new SMP Screening policy.

KEY FACTS

- BC's SMP, run by the BC Cancer Agency (BCCA) under the Provincial Health Services Authority (PHSA), is a provincial program that provides breast screening services for women in BC to help with early detection of breast cancer.
- In Canada, it is estimated that participation in screening programs results in an average 40% reduced risk of breast cancer mortality.[1]
- In 2013, the SMP performed 287, 732 examinations and detected 1,385 cancers. There are 37 screening centres across the province and 3 mobile vans that visit over 120 smaller BC communities, including many First Nations communities.[2]
- The current breast cancer screening participation rate for women 50 to 69 years of age in BC is 52.6% (2014/15, Q3), which is below the national benchmark of 70% participation every 2 years (BC's target to achieve the benchmark is March 2017).[3] The BC rate is consistent with rates in other Canadian jurisdictions.[4]
- Participation in the SMP varies by region across the province. In 2013, participation rates were lowest in the Northeast Health Service Delivery Area in the Northern Health Authority at 37% and highest in the Richmond Health Service Delivery Area in Vancouver Coastal Health Authority 58%.[5]
- BC has one of the lowest incidence rates of breast cancer in the country, and is second only to Nova Scotia for the lowest mortality rate in the country.[6]

New SMP Breast Screening Policy

- The BC Provincial Breast Health Strategy was released in May 2010 with the goal of addressing several major challenges with respect to breast health, including improving the clinical pathway, acquiring better mammography equipment, and evidence-based prevention work.[7]
- A key component of the Strategy was a review of the BCCA's breast screening policy to ensure provincial screening recommendations aligned with the most recent research related to breast cancer screening. A revised breast cancer screening policy received approval from the Ministry of Health on February 4, 2014:
    - Women ages 50-74 will not require a referral from a physician and will be recalled once every two years.

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[1] 3 Coldman et al; Pan Canadian Study of Mammography Screening and Mortality from Breast Cancer; JNCI J Natl Cancer Isnt (2014) Cited in BC Cancer Agency. (n.d.). *Celebrating Twenty-Five Years of Breast Screening in BC*. Retrieved from http://www.screeningbc.ca/NR/rdonlyres/D302DDFE-474D-48F2-912D-F5612AA8B204/74095/SMP25thAnniversaryReportWeb13February2016.pdf

[2] BC Cancer Agency. (2014, November). *Screening Mammography Program 2014 Annual Report*. Retrieved from http://www.screeningbc.ca/NR/rdonlyres/D302DDFE-474D-48F2-912D-F5612AA8B204/73313/SMPAnnualReport2014WEBNovember2015.pdf

[3] Provincial Health Services Authority, Performance Measurement & Reporting: P4P Measure- *Percent of women aged 50-69 participating in biennial screening mammography, 2007/08-2009/10 – 2012/13 – 2014/15 (rolling 30 months)*. Retrieved from the BC Ministry of Health PAS Project #: 2015_0069. (*Note: Regular biennial screening participation is calculated using a 30-month cut-off period to accommodate any potential delays in scheduling screening mammography appointments. Women are only counted once in a 30-month period, regardless of the number of screenings).

[4] Canadian Partnership Against Cancer. (2014, March). *The 2014 Cancer System Performance Report*. Retrieved from http://www.cancerview.ca/idc/groups/public/documents/webcontent/sp_report_2014.pdf

[5] BC Cancer Agency, 2014

[6] Canadian Cancer Society. (2014, May). *Canadian Cancer Statistics 2014: Special Topic – Skin Cancers*. Retrieved from http://www.cancer.ca/~/media/cancer.ca/CW/cancer%20information/cancer%20101/Canadian%20cancer%20statistics/Canadian-Cancer-Statistics-2014--EN.pdf

[7] BC Cancer Agency, n.d.

  - Women with a first degree relative with breast cancer will have annual screening.
  - Women ages 40-49 are encouraged to talk to their doctor about the benefits and limitations of mammography. If mammography is chosen, it is available every two years. A doctor's referral is not needed but is recommended. They will be recalled once every two years.
  - Women ages 75 and over are encouraged to talk to their doctor about the benefits and limitations of mammography. If mammography is chosen, it is available every two to three years. A doctor's referral is not needed but is recommended.
- Age is the biggest risk factor for breast cancer. Over 80% of cancer cases occur in women age 50 years and older who have no risk factors other than age.[9] The Canadian Task Force on Preventive Health Care released the results of its own review of breast cancer screening guidelines in November 2011, indicating that routine screening for women aged 40 to 49 years is not recommended as it leads to unneccessary diagnostic testing and high false positive rates.[10]
- The Task Force recommendations were met with some concern by breast cancer advocacy groups across Canada. The BCCA took the Task Force recommendations into consideration when revising SMP guidelines.

Digital Mammography Equipment

- Digital Mammography conversion projects completing in regional health authorities during fiscal year 2014/15 include:
  - Kamloops Screening Centre (Interior Health): The $600,000 replacement was provincially funded and completed in August 2014
  - Vancouver Island Mobile Screening Unit: A $940,000 replacement mobile screening unit to serve Vancouver Island and the Squamish geographical regions was purchased in December 2014.

FINANCIAL IMPLICATIONS

- The SMP is funded by the PHSA through BCCA. The SMP contracts with regional health authorities and private community imaging clinics to provide screening mammography services throughout the province.
- s.13,s.17
- Since 2011, $10.4 million in health sector capital funding has been invested in Digital Mammography equipment upgrades with $4.7 million provided by the province and $5.7 from foundations and health authority internal sources.
- s.13,s.17
- Any future capital funding requests will be subject to PHSA providing the Ministry with an equipment replacement plan and availability of capital funding.

Approved by:
Doug, Hughes, Health Services and Quality Assurance Division; April 29, 2015
Gordon Cross obo Manjit Sidhu, Finance and Corporate Services Division; May 4, 2015

[9] Retrieved January 16, 2014 from http://www.screeningbc.ca/Breast/FactsMyths/default.htm
[10] Retrieved January 20, 2014 from http://www.canadiantaskforce.ca/recommendations/2011_01_eng.html

FACT SHEET

Colonoscopy Service Review

ISSUE

- In February 2015, the Ministry of Health initiated a service review into the provision of colonoscopy services in the province.
- The initiative will evaluate current service delivery models from the patient-centered perspectives of safety, access, appropriateness, acceptability, and effectiveness, and the system level perspectives of equity and efficiency.
- The service review will assist in quantifying demand for colonoscopy services in BC, propose recommendations for a sustainable provincial colonoscopy service model, and develop associated implementation action plans and frameworks.

KEY FACTS

- As of March 2015, approximately 36,500 patients were waiting for a colonoscopy in the Province of BC.[1] That is an increase of more than 8,000 patients since September 2014. (For more detail on colonoscopy wait times please see Fact Sheet – Colorectal Cancer Screening/Colonoscopy Services)
- The Canadian Association of Gastroenterologists (CAG) recommends a maximum wait time of two months (60 days) for colonoscopies performed as a result of a positive fecal immunochemical test (FIT).[2]
- CAG recommends that most symptomatic patients should also wait less than two months. CAG wait times are defined from the time of identification of symptoms or notification of the positive FIT test to the procedure.
- Concerns have been raised in BC over increasing wait times for access to colonoscopy services. Additionally, with the introduction of the BC Cancer Agency's Colon Screening Program (CSP), concerns have been raised in regard to how patients are prioritized for colonoscopies, with varying referral patterns impacting patient access to services.
- Gastroenterologists have raised the issue of Colon Screening Program (CSP) patients receiving colonoscopies sooner than symptomatic or other non-CSP patients.
- As CSP patients are referred to colonoscopy without having to wait for a specialist consultation appointment first, it is possible that, in some cases, CSP patients may be getting access more quickly.
- Work continues to ensure that access to colonoscopy for symptomatic patients is not adversely impacted by the CSP, however, the CSP implementation and overall patient demand for colonoscopy services is highlighting a need to better understand how all patients access services, the processes in place to manage demand (wait list management, appropriateness criteria), and how patient access to colonoscopies is tracked, monitored and managed.
- While the CSP is collecting program data that includes colonoscopy wait times, there is no central information system that can report on wait-times for colonoscopies performed outside the screening program.
- Historically, there has been no provincial monitoring of colonoscopy wait times in general.
- Outside the screening program, General Practitioner referral patterns, specialist case management practices and health authority booking models vary across the health system.

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[1] Monthly reports provided by email to Acute and Provincial Services Branch by Health Authorities.

[2] Paterson, W., Depew, W., Paré, P., Petrunia, D., Switzer, C., & Veldhuyzen van Zanten, S. (2006). Canadian consensus on medically acceptable wait times for digestive health care. *Canadian Journal of Gastroenterology, 20(6)*, 411-423. Retrieved from http://www.cag-acg.org/uploads/private/Pdf/waittimesconsensus_cjg.pdf

FACT SHEET

- Additionally, the collection of colonoscopy data across the province lacks standardized definitions, site collection processes, and established methods of reporting on volumes and wait times.
- The colonoscopy service review will work to address the issues identified above and to achieve the following high level objectives:
  1. Identify key performance data for colonoscopy services and document current baseline metrics.
  2. Evaluate the current colonoscopy service delivery system and identify current strengths and weaknesses.
  3. Identify opportunities to leverage best practices from experiences in other jurisdictions as well as from relevant initiatives (such surgical waitlist) within BC.
  4. Identify the key attributes of an effective, sustainable, patient centered colonoscopy services models.
  5. Develop evidence informed frameworks and action plans to guide implementation of a refined provincial colonoscopy models.
- The colonoscopy service review will encompass all publicly funded colonoscopy services: screening, diagnostic and therapeutic.
- In addition, the review will include consideration of potential operational impacts on other aspects of the system such as upper endoscopies, surgeries and diagnostic services as well as impacts to the broader system such as implications for primary care.
- To lead the work, three multidisciplinary working groups have been constituted, consisting of physicians, administrators and patients, representing rural and urban perspectives. The three working groups are:
  1. Analytics and Data Working Group
  2. Clinical Standards and Quality Working Group; and
  3. Service Model and Operations Working Group
- Each working group is currently finalizing their terms of reference and work plan.
- Phase 1 of the review is scheduled to be complete by October 2015.
- By the end of Phase 1, waitlist for colonoscopies will be better quantified, clinical standards around appropriateness will be refreshed and models for centralized referral of all colonoscopy patients will be considered.

FINANCIAL IMPLICATIONS

s.17

Approved by:
Doug Hughes, Health Services Policy & Quality Assurance Division; April 29, 2015

FACT SHEET

Colorectal Cancer Screening/Colonoscopy Services

ISSUE

The provincial Colon Screening Program (CSP), led by BC Cancer Agency (BCCA), was launched in 2013. Implementation monitoring by Ministry of Health staff continues. Wait times for colonoscopies for both symptomatic and cancer screening have been increasing. In February 2015, the Ministry initiated a service review into the provision of colonoscopy services in the province. (See Colonoscopy Service Review fact sheet.)

KEY FACTS

- On November 15, 2013, BCCA's provincial CSP was implemented in all health authorities for asymptomatic BC residents, ages 50-74 years.
- BCCA is responsible for the CSP's governance and oversight which includes: public awareness strategies, development of a registry to monitor patients registered in the program and enabling screening reminders/recalls, supporting primary care and specialist education and standards development, data collection, facilitating patient follow-up through the screening pathway, and reporting on overall program performance, including patient participation and patient outcomes.
- In addition to the April 1, 2013 implementation of the new publicly-funded fecal immunochemical tests (FIT) to replace the older test, the program includes a comprehensive patient pathway with screening reminders, health authority patient coordinators to help patients navigate their care after a positive FIT result and assistance in follow-up colonoscopy preparation.
- The program recognizes that family physicians are key influencers for patients in deciding to participate in cancer screening programs. The program relies on health authority expertise for the effective delivery of colonoscopies.
- BCCA established a clinical working group that monitors the positive predictive value of the FIT, using BC program data. In December 2014, the group pulled data from the CSP and will be reviewing in February 2015. This will help BCCA monitor the effectiveness of FIT.
- Approximately 50% of 50-74 year olds using the FIT test are registered in the CSP.[1] Screening testing for colon cancer ahs more than doubled since the introduction of FIT (from 17,282 guaiac tests in January 2013 to 37,345 FIT in March 2015).[2] Other jurisdictions such as Nova Scotia, New Brunswick, PEI, Quebec, Saskatchewan and Alberta are now using FIT in their Colon Screening Programs. Ontario is considering it for their colon screening program as well.
- Colorectal cancer screening can identify people who may have pre-cancerous lesions or polyps in their colon. After an initial positive FIT test, a subsequent colonoscopy can provide early detection and allow for these lesions and/or polyps to be removed, in some cases preventing the development of the disease entirely.
- Colon cancer is the 2nd deadliest cancer in BC. Every year, almost 3,000 new cases of colon cancer are diagnosed in BC; over 94% of these are in men and women age 50 or older[3].
- Screening has been proven to decrease colon cancer incidence and deaths. If diagnosed early, the five year survival rate is 90%[4].
- In 2015, an estimated 1,772 men and 1,431 women in BC will be diagnosed with colorectal cancer for a total of 3,203 people. An estimated 613 men and 542 women will die of the disease for a total of 1,155 people[5].

[1] CSP Steering Committee program update from BCCA February 2015.
[2] Monthly report provided to HSD from Medical Services Plan billing data
[3] BC Cancer Agency, retrieved on September 24, 2014 http://www.screeningbc.ca/Colon/GetScreened/Default.htm
[4] Ibid

FACT SHEET

Colonoscopy Services Review

- Concerns have been raised in BC over long wait times for access to colonoscopy services in health authorities. Increased colonoscopy referral rates, in part due to introduction of the FIT, have impacted most health authorities with pre-existing wait lists for non-screening (symptomatic) patients.
- At the present time, there is inconsistent methodology for gathering accurate data on colonoscopy volumes or wait times across the Province.
- Despite this challenge, the Ministry has asked all health authorities to provide their best available information on a monthly basis on their current colonoscopy bookings so that the Ministry can gain a better understanding of the issues regarding colonoscopy volumes. As of the end of Feb/March 2015, health authorities reported that approximately 36,500 people were waiting for colonoscopies in the province.

Health Authority	Estimated number of patients waiting (screening & non-screening)
Interior	11,599 (as of March 31, 2015)
Fraser	12,444 (as of March 31, 2015)
Vancouver Coastal	5,872 (as of February 28, 2015)
Island Health	6,599 (as of February 28, 2015)
Northern	No data provided
BC Total	**36,514**[6]

- Regional health authorities are currently performing approximately 9-10,000 colonoscopies per month across the province.[7]
- In February 2015, the Ministry initiated a service review into the provision of colonoscopy services in the province. (See Fact Sheet – Colonoscopy Service Review)
- The initiative will evaluate current service delivery models from the patient-centered perspectives of safety, access, appropriateness, acceptability, and effectiveness, and the system level perspectives of equity and efficiency.
- The service review will assist in quantifying demand for colonoscopy services in BC, propose recommendations for a sustainable provincial colonoscopy service model, and develop associated implementation action plans and frameworks.

FINANCIAL IMPLICATIONS

- The annual cost of the CSP depends primarily on the level of patient participation.
- The program costs include fees for practitioners, specialists and laboratory medicine services that are paid through BC's Medical Services Plan. Additional program expenditures related to FIT, increasing public awareness, developing a centralized participant registry and developing a system for data collection and monitoring are estimated to be in the range of $5 to $10 million annually, depending upon patient participation.
- It is anticipated that the service review will help inform the estimated ongoing cost requirements of providing colonoscopies for both symptomatic and cancer screening services.

Approved by:
Doug Hughes, Health Services Policy and Quality Assurance Division; May 06, 2015
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; May 8, 2015

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[5] BC Cancer Agency. *Estimated New Cancer Diagnoses for 2014 by Age at Diagnosis and Gender*, p.4. Retrieved on February 5, 2015 from: http://www.bccancer.bc.ca/NR/rdonlyres/A20EB9FB-0932-4BF4-BA34-141FA6DD5AF6/71144/BritishColumbia_20132028.pdf
[6] Monthly reports provided by email to Acute and Provincial Services Branch by Health Authorities.
[7] Monthly report provided to HSD from Medical Services Plan billing data.

FACT SHEET

Community Paramedicine

ISSUE

Community paramedicine (CP) is an innovative approach to the delivery of health care services that allows certain paramedics to apply their training and expertise in community-based, non-emergency care roles such as prevention, evaluation, triage, treatment, referral and advice.

KEY FACTS

- CP is intended to help address some of BC's pressing health issues such as:
  - Lack of access to primary care for medically underserved populations and / or in rural and remote communities;
  - Increasing patient needs and demand for health care services based on an aging population coping with chronic and sometimes complex conditions;
  - Shortages of health care providers; and
  - Recruitment and retention of paramedics in communities with low call volumes.
- CP programs have been successfully implemented in other jurisdictions, including: Canada (Nova Scotia, Alberta and Ontario); United States (Maine, Texas, Minnesota, North Carolina and Colorado); UK; and Australia.
- For the BC patient, it will mean delivering care that is patient-focused, delivering appropriate care in the appropriate place and/or ensuring that the patient is referred as needed to a health or social care professional.
- It will also assist patients in managing their own care and treatment in the community where safe and appropriate to do so.
- s.13,s.17

- Of the 26 health professions currently regulated in BC, Emergency Medical Assistant (EMA) is the only profession that is not self-regulating under the *Health Professions Act*. Instead, EMAs are regulated by government through the Emergency Medical Assistant Licensing Board under the *Emergency Health Services Act*.
- The Ministry of Health and BC Emergency Health Services (BC EHS) share responsibility for introducing community paramedics into BC's health care system. More specifically, BCEHS is the lead agency responsible for training, employing and deploying community paramedics consistent with the Ministry's strategic objectives and in collaboration with the Ministry and health authorities. The Ministry is responsible for ensuring that an appropriate regulatory framework is in place to enable CP.
- BCEHS is working with key stakeholders including the Ministry; health authorities including the First Nations Health Authority; the Ambulance Paramedics of BC (CUPE Local 873); Patients as Partners; the Rural Coordination Centre of BC, a committee that advises the BC government and the Doctors of BC; and the Union of BC Municipalities.
- The *Emergency Health Services Act* was significantly revised in 2013. The changes were substantive in terms of organization of the BCEHS and granted significant new authority to the Minister of Health. Notably, the amendments readily allowed for an expanded role for EMAs as community paramedics.
- Different provincial legislative frameworks apply to the regulation of EMAs across Canada. Meeting government's labour mobility obligations under the Agreement on Internal Trade will be a priority consideration as EMA regulation evolves in BC.

FACT SHEET

- CP will be implemented in a phased approach over a 4-year period, beginning with a Phase One – Soft Launch in April in one health authority, followed by a second health authority in May or June, and a third health authority in late summer.
- Potential communities for Phase One are under discussion with BCEHS and the health authorities, and will be brought to the Provincial Advisory Committee for confirmation.
- s.13,s.14

FINANCIAL IMPLICATIONS

BCEHS will provide for CP through funding it receives from the Provincial Health Services Authority.

Approved by:

Doug Hughes, Health Services Policy and Quality Assurance Division; April 2, 2015
Gordon Cross obo Manjit Sidhu, Finance and Corporate Services Division; April 9, 2015

FACT SHEET

Complex Chronic Diseases Program

ISSUE

Timely access to the Complex Chronic Diseases Program (CCDP), located at BC Women's Hospital and Health Centre, an agency of the Provincial Health Services Authority (PHSA).

KEY FACTS

Background

- In March 2011, the Ministry of Health announced a $2 million investment to support establishment of a clinic for patients with complex chronic diseases. The funds would also support research into the causes of, and best treatment practices for such diseases.
- In 2013, PHSA invested an additional $2 million to support the Complex Chronic Disease Program.
- CCDP focuses on a model of supportive care for symptom management for patients suffering from a variety of chronic complex diseases leading to disability.
- These are very complex patients with conditions of which the cause is unknown, but it is suspected that an infectious pathogen may play a role. Some of the most prevalent recognized conditions include Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), Fibromyalgia (FM) Syndrome and "Chronic" Lyme Disease, where there are patient populations with considerable symptomatic overlap with ME/CFS
- CCDP began seeing patients in June 2013. Interest and awareness increased significantly in the fall of 2013, generating many referrals from primary care practitioners.
- In April 2014, the CCDP Medical Director was relieved of her administrative/leadership duties and an interim leadership structure was put in place.

Program Model

- Upon the departure of the CCDP Medical Director, a renewed Program Leadership Steering Committee was formed, and the service delivery model of care was refreshed to support a more integrated, interdisciplinary, comprehensive and sustainable approach to the provision of assessment, care and follow-up of patients.
- The team-based leadership structure will continue for the next year until further clinician recruitment is completed and a suitable permanent candidate is identified.
- A Clinical Advisory Committee is providing guidance on clinical protocol development through review of all available best evidence in a consensus-building decision-making structure. The Committee has reviewed and approved a number of testing and key treatment protocols to date. More controversial areas of treatment are coming forward for discussion.
- Core membership of the Research Committee has been identified and three meetings have been held to date to develop a plan for identifying potential areas for research. Two research proposals are currently under review.

Waitlist and Strategies for Increasing Capacity

- CCDP is working towards recruitment of the full complement of physicians needed, including internal medicine specialists and general practitioners, to implement the new service delivery model at 100% capacity. The target date for 100% physician recruitment is March 31, 2016.
- It continues to be challenging to attract physicians who are interested in serving a very challenging population and working in an area of care affected by controversy. Physician recruitment for internal medicine providers is on target (40% of total) while recruitment for general practitioners is behind target (34% actual, 50% target). Aggressive recruitment strategies specific to family practice are actively underway.

FACT SHEET

- Recruitment for all expanded positions of the interdisciplinary team has been completed and a full-time nurse practitioner started January 2015.
- As of January 9, 2015, 1,470 patient referrals have been received with an average of 40 new referrals received on a monthly basis. Most referrals are identified as high priority due to the complexity/acuity of the patients; 1,324 patients are waiting for their first physician appointment.
- Since November 2014, as a result of the team and physician recruitment, new patient consultations and follow-up visits have increased significantly and are expected to meet targets. When the model is at 100% capacity, 960 new patient consultations per year are expected.
- With the new model of service delivery fully implemented, the waiting period for the first medical visit (based on existing and ongoing new referrals) is expected to be approximately 2.5 years.
- Telehealth is being used to support patient program orientation requirements and consultation.
- Patients are encouraged to continue to see their primary care providers to explore strategies to manage their conditions while waiting for entrance to the program.
- CCDP seeks to work closely with the patients' primary health care professional to strengthen their capacity to support the ongoing needs of their patients and facilitate transition back to their care. Progress on the transition of existing patients back to community providers continues and is an important aspect of the care management in order to create the capacity to deal with the patient waitlist. Pending work on physician education and strengthened communication with community care providers are key enablers.

Patient Concerns/Engagement

- BC Women's leadership reports that the number of patient complaints has declined over time, though there remains significant community interest in the program. The Program is also utilizing its webpage for communications with community stakeholders.
- The Program Community Advisory Committee has a new Lyme disease representative and quarterly meetings are planned. The Committee representatives have reported they are receiving good feedback about the care people are receiving at the clinic. Joint public education events are being considered for 2015.

FINANCIAL IMPLICATIONS s.13,s.17

Expenditures for the clinic were approximately $1.3 million in 2014/15 s.13,s.17

Approved by:
Doug Hughes, Health Services Policy and Quality Assurance Division; April 2, 2015
Gordon Cross obo Manjit Sidhu, Finance and Corporate Services Division; April 14, 2015

FACT SHEET

A GP for Me Initiative

ISSUE

Lack of access to a Family Physician (FP) creates health inequities for unattached patients.

KEY FACTS

- The number of patients who don't have a family physician (FP) in BC is estimated at 15.5% (~710,000 citizens) by the 2013 Canadian Community Health Survey (CCHS)[1] with approximately 4.6% of British Columbians (~209,000) looking for a regular FP.[2]
- Lack of access to a FP creates health inequities for unattached patients. Care is accessed through walk-in clinics or emergency departments, and may result in fragmented, expensive service with poorer outcomes. Lack of access has been identified as a public issue and led to the June 2010 Government commitment to provide, by 2015, a FP for any British Columbian who wishes one.
- The General Practice Services Committee (GPSC), a joint committee of the Ministry of Health and the Doctors of BC, partnered to create a suite of incentives and supports through the A GP for Me initiative. The suite strengthens the FP/patient relationship for those who currently have a FP, and aims to increase capacity and access for British Columbians who are currently unattached to a FP (unattached patients will become attached). The program builds on prototypes from 2010 in the White Rock/South Surrey, Prince George, and Cowichan Valley Divisions of Family Practice (Division) that have attached approximately 9,400 patients[3]. There are two components to the A GP for Me initiative suite of incentives and supports:

1. Practice Level Attachment Fee Supports[4] – Effective April 1, 2013
   - **Physician Registry**: FPs are required to submit a $0 Medical Service Plan fee code to access the suite of incentives. Registration commits the FP to: provide full-service family practice and longitudinal care to their patients; confirm the FP/patient relationship with their patients; and work with their local Division to develop community-specific supports to encourage patient attachment. As of December 31, 2014, 3,101[5] distinct FPs registered.
   - **Unattached Complex (high-needs) Patient Intake Incentive:** Patient populations include frail in residential care or in the community, cancer, high-needs chronic conditions, severe disability in the community, mental health/substance use, and maternity. Payment acknowledges time intensity to integrate new patients and develop clinical action plan(s). Physicians can bill $200 per patient. As of December 31, 2014, over 54,600 previously unattached complex patients received care from almost 1,900 FPs.
   - **Expanded Access to Complex Care Incentive:** The expanded incentive is to care for the high-needs frail patients who are time and resource intense and do not otherwise qualify for the current Complex Care fee. Physicians can bill $315 per patient per calendar year. As of December 31, 2014, just over 17,600 frail patients have received care under this fee from over 1,600 family physicians.
   - **Telephone Visits:** This fee intends to avert the need for a patient to be physically seen in the practice and increase access for other patients and/or address urgent problems, while avoiding emergency department visits. Physicians can bill $15 per call, to a maximum of 1,500 telephone

[1] Statistics Canada. CANSIM Table 105-0501 - Health indicator profile, annual estimates, Canadian Community Health Survey, 2013 sample.
[2] Statistics Canada, *Med Doc Lookers Pro=rated -2013_Client_unsuppressed.xlsx*, December 2014. Prepared with Ministry of Health business rules.
[3] http://agpforme.ca/across-bc/introduction
[4] Data source: Workforce Analysis, Health Sector Workforce Division. The data include physician claims for fee item 14074, 14075, 14076 and 14077 respectively covered by MSP. Data from April 1, 2013 to December 31, 2014, paid to December 31, 2014.
[5] Includes GPs who 'billed' for 14070 only.

consultations per FP per year. As of December 31, 2014, over 326,000 patients have received care through this initiative from more than 3,300 family physicians.

- **Conferencing Fees:** These fees enable communication with other healthcare providers to coordinate patient care planning to better serve attached patients. Physicians can bill $40 per 15 minute conference to a total of up to 4.5 hours per patient per calendar year. As of December 31, 2014, over 132,000 conferences took place for more than 64,000 patients.

2. Community Level Divisions of Family Practice Attachment Supports
   - Divisions enable FPs to participate collectively and cooperatively in engaging with their health authority, the Ministry, Doctors of BC, local municipalities and community groups. A Division coordinates with the health authority and other providers to help create community specific supports to build the FP practice capacity required for the initiative to succeed. Support examples include: Nurse Practitioner involvement in physician led unattached patient clinics or allied health care provider support to a community-specific high needs population. Bulk funding of up to $40 million has been allocated for 2013/14-2015/16 to develop and implement community patient attachment strategies. As of the end of March 2015, 33 of 34 Divisions indicated their intent to participate in the initiative. Of those, 30 Division's proposals have been approved and are now formally implementing their local plans. The three prototype communities are in the sustainability phase.
   - Many initiatives exist in health authorities, at the Ministry and within the physician committees that help support the A GP for Me initiative. Examples include: Integrated Primary Community Care (IPCC) Bilateral Agreements, Accelerated IPCC (aIPCC), NP4BC, Practice Support and Quality Improvement Program, IT Alignment, Patients as Partners, the Better at Home Program, Home Health Monitoring, After-hours Palliative Nursing Service, Senior's Action Plan, and partnerships with non-governmental organizations to provide access to patient self-management supports.

FINANCIAL IMPLICATIONS

s.17

Approved by:
Doug Hughes, Health Services Policy and Quality Assurance; May 11, 2015
Manjit Sidhu, Finance and Corporate Services Division; May 08, 2015

FACT SHEET

Government Commitment to 500 Additional Addiction Spaces

ISSUE

The BC government has committed to create and implement addiction space expansion that includes a significant role for the non-profit sector in the delivery of these new spaces by 2017 as committed in *Strong Economy, Secure Tomorrow*.

KEY FACTS

- In May 2013 the BC Government made a public commitment that recognizes additional addiction services are required in the province and is working with health authorities to plan and implement 500 additional substance use spaces in the province by 2017.
- In October 2013, the Ministry struck a provincial steering committee, with involvement from all health authorities, to guide the development of the response. Through the steering committee a plan for a three-phased approach for health authority planning and implementation was developed.
- On March 31, 2014, the health authorities submitted Preliminary Action Plans that identified high priority and immediate need substance use spaces to be achieved in phase 1 of this initiative (2014/15) based largely on existing planning processes.
- For phase 1 of this project (2014/15) health authorities have committed to creating approximately 100 new substance use beds.
- As of March 31, 2015, s.1 substance use beds have been created through this initiative. Unexpected delays such as not being able to identify a qualified vendor, necessary renovations, and human resource issues impeded the creation of 100 beds this fiscal year. However, health authorities are committed to creating these beds in the next two phases of the initiative.
- Through this initiative, Ministry and health authorities have been engaging with the non-profit sector and the First Nations Health Authority in the planning and implementation of the new spaces. This engagement will continue through phases 2 and 3 (2015/16 and 2016/17).
- s.13 new beds for phase one are being delivered by non-profit agencies.
- Phase 2 and 3 plans were submitted to the Ministry in March, 2015; planning for these phases was informed by the results of an extensive needs based planning process conducted by the Centre for Addiction Research BC (CARBC) and community consultations. The needs based planning results provided the health authorities with estimates of demand for various types of substance use services and a description of need by geographic area and amongst sub populations.
- Health authority planning for phases 2 and 3 has been informed by
    - Current utilization and substance use trend data;
    - The prioritization of models that are effective and cost-efficient;
    - Input gathered from key stakeholders including non-profit providers; and
    - The needs of youth, adults, older adults, as well as sub-populations such as First Nations and Aboriginal people and those with severe addictions and mental illness
- The Ministry will continue to monitor and evaluate implementation throughout the course of this initiative. This will allow for the tracking of progress and to identify any necessary alterations to health authority plans.

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FACT SHEET

FINANCIAL IMPLICATIONS

- Overall funding requirement associated with this initiative will depend on the type of substance use service spaces created.
- Resources to support Phase 1 2014/15 system enhancements were covered through existing health authority operating funding allocations.
- No new funding has been identified for this initiative and any increase related to Phases 2 and 3 represents a potential cost pressure to the Ministry/health authorities.

Approved by:
Doug Hughes, Health Services and Quality Assurance Division; May 8, 2015

FACT SHEET

HealthLink BC Core Services

BACKGROUND

- HealthLink BC is Canada's most comprehensive non-emergency health information service.
- HealthLink BC provides BC residents with access to non-emergency health information and advice, educates the public on self-care, diverts callers from acute healthcare resources to self-care where appropriate, and assists healthcare professionals where required. Many of HealthLink BC's services are also leveraged to assist specific populations and can easily be mobilized to provide provincial support for large-scale health concerns. The organization delivers information via telephone and web. Callers to 8-1-1 may speak with a Health Services Representative, Nurse, Dietician, or Pharmacist. Service is offered on a 24/7/365 telehealth platform.
- In 2010 HealthLink BC transitioned into the Ministry of Health from the Emergency and Health Services Commission. In 2013, a reorganization was undertaken to better align and integrate HealthLink BC resources and strategic priorities with those of the Health Sector IM/IT Division and the Ministry.

KEY FACTS

Navigation Services

A 24/7 telephone service providing way-finding and referral information for the public. From January 2014 to December 2014, 369,000 calls were answered by Navigation Services, an average of 1011 calls per day. Of these calls, about 74% were transferred to a nurse, 8% were transferred to a dietitian or pharmacist and about 2% were transferred outside of HealthLink BC[1]

Nursing Services

24/7 telephone access to registered nurses trained to provide confidential self-care health information and advice. From January 2014 to December 2014, nearly 273,000 calls were answered by Nursing Services, an average of 747 calls per day[2]. Nursing services also provides first tier support for the After Hours Palliative Nursing Service.

Dietitian Services

Telephone and e-mail access to registered dietitians providing nutrition information and consultation are available from 9 am to 5 pm, Monday to Friday. From January 2014 to December 2014, Dietitian Services answered 9,000 calls, averaging 36 calls per day[3] as well as, responded to 920 e-mail inquiries from professional dietitians and members of the public. Specialty dietician services include allergies, oncology and pediatrics.

Pharmacist Services

Telephone access to licensed pharmacists from 5 pm to 9 am daily for confidential information and advice on prescription and over-the-counter drugs. From January 2014 to December 2014, Pharmacist Services answered over 22,000 calls[4], an average of 61 calls per day.

Nicotine Replacement Therapy (NRT)

A telephone registration and information service for the BC Smoking Cessation Program. From January 2014 to December 2014, Navigation Services answered almost 85,000 NRT calls, an average of 236 per day[2]. Of the total number of calls 72,000 were NRT orders. Of these, 39,000 were original

[1] Symmetrics NVISION Data Mart (Project PPBS12-05)
[2] Symmetrics NVISION Data Mart (Project PPBS09-40)
[3] Symmetrics NVISION Data Mart(Telephony) / Data Cubes(Email volumes) (Project PPBS09-33)
[4] Pharmacist Monthly Report (Project PPBS09-36)

orders and 33,000 were refill orders. To February 16th, 2015 HealthLink BC has taken 333,832 orders[5].

HealthLinkBC.ca

A comprehensive and interactive public website with current, medically-approved information on more than 5,000 health and nutrition topics and 6,300 services in a searchable database. Residents can find tests and procedures online, check symptoms, find local resources and learn about healthier lifestyles. From January 2014 to December 2014, HealthLink BC's website received an average of over 12,000 visits per day[6].

BC HealthGuide Handbook

A free 400+ page handbook that covers more than 190 health topics and includes information on how to recognize and manage common health concerns, tips on home treatment, self-care options and provides information on when to seek guidance from a health professional. The handbook is available in four languages however there are no longer any English version handbooks available. A refreshed version of the BC HealthGuide Handbook is being considered for a future release.

HealthLink BC Files

A series of 215 fact sheets with BC specific information on public health topics. All HealthLink BC Files are available in English with most topics translated into French, Chinese, Punjabi, Farsi, Spanish and Vietnamese.

Knowledge Base, Decision Support and Client Record System

In 2013, HealthLink BC entered into a five year contract with Clinical Solutions for the provision of a new system software to support call logging, access to clinical resources, and delivering health content via the HealthLink BC website.

NOTE: Calls to all 8-1-1 HealthLink BC services are available in more than 130 languages.

HealthLink BC provides Nursing and Pharmacist Services to Yukon residents as well as access to HealthLinkBC.ca. Costs are recovered from the Yukon Government.

FINANCIAL IMPLICATIONS

HealthLink BC has a base operating budget for: 2014/15 of $31.5 million

Approved by:

Maria Root, HealthLink BC; February 17, 2015
Lindsay Kislock, Health Sector IM/IT Division; February 17, 2015
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; February 27, 2015

[5] Symmetrics NVISION Data Mart(Telephony) (Project PPBS12-05)
[6] Web Trends 8.5 , Jan 7, 2014

FACT SHEET

Mental Health Review Board

ISSUE

The government is committed to promoting health and safety for vulnerable adults designated as an involuntary patient under the *Mental Health Act*. The Mental Health Review Board (MHRB) conducts hearings to review and decide whether persons detained in or through any designated mental health facility in the Province should continue to be detained based on criteria in the Act.

KEY FACTS

- MHRB consists of a chair and currently has 82 members appointed by the Minister.
- There are five full-time staff on salary.
- Volume levels since April 2005 have increased substantially with a current annual level of 2001 applications in 2014 with 712 hearings completed (hearings are not held if the patient decides not to proceed with the hearing or the mental health facility releases the patient from detention before the hearing).
- Of the 712 hearings 83 patients were decertified.
- Margaret Ostrowski was reappointed Chair as of December2013 and her term will expire in December 2016.
- s.13

Background

- MHRB is an independent, quasi-judicial administrative tribunal established in April 2005 to conduct review panel hearings under the *Mental Health Act*. It is made up of a chair and members appointed by the Minister under the Act. The Board conducts hearings to review and decide whether persons detained in or through any designated mental health facility in the Province should continue to be detained based on criteria in the Act.
- MHRB is responsible (under the *Mental Health Act*) for conducting review panel hearings throughout BC. Detained psychiatric patients are entitled to periodic hearings within 14 and 28 day legal time limits.
- Review panels decide whether the patients who exercise their rights to a hearing should continue to be detained based on criteria in the *Mental Health Act*.
- Each panel has three board members: One legal (who usually chairs the hearing), one medical, and one member who must be neither a lawyer nor a physician.
- A review panel makes a decision on only one issue - whether the patient continues to meet the criteria to remain as an involuntary patient (*Mental Health Act, section 25(2)*). Unless a majority of the review panel is satisfied by the evidence that a patient meets the criteria for involuntary status as provided in the Act, the review panel must order that the person be discharged from involuntary patient status (section 25(4.1)).
- The review panel has no authority to decide other issues such as the appropriateness of the patient's treatment regime or whether the patient ought to be transferred to another hospital.

FINANCIAL IMPLICATIONS

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FACT SHEET

Approved by:
Doug Hughes, Health Services Policy and Quality Assurance Division; February 16, 2015
Gordon Cross, obo Manjit Sidhu, Finance and Corporated Services Division; April 9, 2015

FACT SHEET

Ombudsperson Investigation of Seniors Care

ISSUE

On February 14, 2012, the Ombudsperson publicly released her report on seniors' care, *The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)*, following an extensive three year investigation.

KEY FACTS

- In August 2008, the Ombudsperson publicly announced that she had launched investigation of seniors' care in BC based on complaints of administrative unfairness. The Ombudsperson indicated the Report would be released in two parts.
- The Ombudsperson released Part One of her report, entitled *The Best of Care: Getting it Right for Seniors in British Columbia (Part 1)* in December 2009 containing 3 findings and 10 recommendations. The Ministry of Health responded by taking action in a number of areas, including introducing a Residents Bill of Rights, development of educational material to improve the effectiveness of resident/family councils, implementation of the SeniorsBC website, and improvements in health authority information on services.
- The Ombudsperson continued her investigation throughout 2010 and 2011, and publicly released The *Best of Care: Getting it Right for Seniors in British Columbia (Part 2)* on February 14, 2012. The *Part Two Report* is organized into 4 main subject areas - home and community care, home support, assisted living, and residential care. The report is 400 pages long containing 143 findings and 176 recommendations on seniors' care, with half of the findings relating to the residential care sector.
- The findings and recommendations focus on administrative unfairness, protection for those who are vulnerable, access to services and information, consistent quality standards, complaints and concerns, and policy and regulatory changes for both publicly funded and private home and community care services.
- On February 14, 2012, the Ministry released *"Improving Care for B.C. Seniors- An Action Plan."* to address concerns expressed publicly and directly to the Minister of Health and the Ministry by families and care providers. The direction of the Action Plan was also informed by the findings and recommendations in the report on seniors' care by the provincial Ombudsperson.
- The Ministry has provided updates to the Ombudsperson on a regular basis, including:
    - May 2012 - an update on the status of completed recommendations.
    - October 2012 - a comprehensive summary of the progress on the Seniors Action Plan.
    - April 2013 - a 1-year update on completed actions from the Seniors Action Plan, as well as other related work over the past year to improve seniors' care in the province.
    - Following a commitment by the Minister of Health in February 2014 to take a second look at the Ombudsperson's report, responses provided in two parts:
        (1) on March 24, 2014 the Ministry met with staff from the Ombudsperson's Office and provided them with responses to 89 recommendations considered complete or where a significant amount of work has been initiated.
        (2) on May 9, 2014 the Ministry met again with staff from the Ombudsperson's Office and provided them with responses to the remaining 70 recommendations.
- On June 25, 2014 the Ombudsperson released her annual report and posted assessment tables on her website. The assessment tables include an assessment of progress made by the Ministry and each of the 5 regional health authorities on each recommendation in the Ombudsperson's reports.

  - The responses provided on March 24 are included in the Ombudsperson's assessment tables posted on her website and some have been presented as examples in the annual report from the office.
  - The responses provided on May 9 are included in the Ombudsperson's assessment tables posted on her website but are not reflected in the annual report.
- The following provides a summary of the status for the 176 recommendations from *The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)* from June2014:
  - 13 recommendations: *fully implemented;*
  - 9 recommendations: *implemented in part;*
  - 37 recommendations: *ongoing;*
  - 62 recommendations: *No Progress;*
  - 45 recommendations: *Response Received; Recommendation will be Considered*
  - 2 recommendations: *Not Accepted (#39 and #166); and*
  - 2 recommendations: *Timeline Passed.*
  - 6 recommendations that the health authorities are responding to individually.
- Ministry staff met with Ombudsperson staff in July and provided additional responses in October and November on 9 recommendations that the Ministry believes are fully implemented to address the remaining recommendations, the Ministry has developed a multi-year work plan and a governance structure with clear accountabilities and achievable timelines that is aligned with existing public commitments, the Ministry's Health System Strategy and relevant policy work that is underway.
- On April 1, 2015, the Ministry provided an update to the Ombudsperson on all outstanding recommendations for the Ombudsperson's 2015 annual report, expected to be released sometime before the end of May 2015.
- The Ministry believes it has completed work on an additional 22 recommendations, including the 9 mentioned above, most of which are from Year One of the work plan. There are 133 recommendations remaining, with 75 in Year Two, 36 in Year Three and 22 in Year Four.

FINANCIAL IMPLICATIONS

There will be resource implications, mainly for health authorities, associated with many of the individual projects. The costs for most would be absorbed by health authorities' operating budgets. Prior to proceeding with projects that have significant cost implications, there will be consultation and approval by senior executive in the Ministry and health authorities.

Approved by:

Doug Hughes, Health Services Policy and Quality Assurance Division; April 27, 2015

FACT SHEET

Portage Keremeos Facility (The Crossing)

ISSUE

Portage Montreal (officially known as Portage Program for Drug Dependencies Inc.), which offers residential drug treatment services for youth and adults in Quebec and other Canadian provinces has terminated the delivery of services at The Crossing at Keremeos as of March 5, 2015.

KEY FACTS

- On March 5, 2015, PHSA received notice that the Portage Program for Drug Dependencies Inc. was ceasing operations at The Crossing at Keremeos effective immediately.
- The 3 remaining youth in treatment were discharged with community-based transition plans as of February 27, 2015.
- PHSA worked closely with families and local health authorities to connect the small number of youth who were waiting for services at The Crossing with suitable care; health authorities worked quickly to ensure these children receive needed care as soon as possible.
- A working group with representatives from the Ministry of Health and PHSA is looking at building on the enhanced model of care that was developed for The Crossing at Keremeos.
- Portage's decision to terminate the delivery of services at The Crossing provides an opportunity to examine suitable options for the delivery of Tier 4/5 specialized residential care for youth with severe substance use issues in BC.
- The working group aims to have a plan for replacement residential treatment services for youth with severe substance use issues in BC developed by this summer.
- While planning for replacement services is underway the Ministry and PHSA are working with health authorities to develop short-term, client-tailored solutions to meet need in the interim; every effort will be made to avoid sending young people out of province.
- Funding that would have gone to the Crossing will be transferred to local health authorities, as needed, to ensure any child who is waiting for services receives the care they need.
- The Ministry's top priority is ensuring the delivery of the highest quality safe, effective evidence-based care for this high risk youth with severe substance use issues and their families.
- The Ministry and PHSA are working hard to expedite this process and recognizes the need for specialized residential treatment for youth with severe substance use issues in BC.

Background

- The Crossing at Keremeos was a provincial Tier 4 residential substance use program for youth aged 14 - 18 with severe substance use problems. It was located in a relatively remote setting outside of Keremeos; the program length was four to six months and patients were referred by their regional health authority.
- Provincial Health Services Authority (PHSA) involvement with Portage began in 2013 at the direction of the Ministry of Health. s.13

s.13

- The Ministry asked PHSA to work directly with Portage and regional health authorities to ensure the safety and effectiveness of the treatment program to meet the needs of youth with severe substance use issues through development of an enhanced model of care and a provincial access

protocol. PHSA was also asked to assume oversight for the program in April 2014, previously held by Vancouver Coastal Health and Fraser Health who terminated their involvement with Portage.

- s.13,s.17

- On March 5, 2015 the PHSA received notice that the Portage Program for Drug Dependencies Inc. was ceasing operations at The Crossing at Keremeos, BC effective immediately. PHSA asked Portage to provide a reasonable period of notice to allow for an effective transition, however this did not happen. PHSA has outlined its legal expectations regarding the termination of operations at the Crossing to Portage.

FINANCIAL IMPLICATIONS

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Approved by:

Doug Hughes, Health Services Policy and Quality Assurance Division, May 07, 2015

FACT SHEET

Supportive Recovery Homes

ISSUE

All private and public residences that provide Mental Health and Supportive Recovery housing, support and services, that meet the definition of assisted living under the *Community Care and Assisted Living Act* (CCALA), are required to be registered with the Ministry of Health's Assisted Living Registry.

KEY FACTS

- Supportive Recovery homes (SRHs) offer safe accommodation and low to moderate support, which is appropriate for adults recovering from substance use problems before they move back to independent settings in the community. Recovery homes are suitable for adults who require low to moderate support such as structured activities, group work and peer mentoring.
- SRHs are regulated under the *Community Care and Assisted Living Act.*
- All SRHs must register if they offer at least one prescribed service such as addiction meetings, stress and anger management training, or assistance with medications, and five hospitality services (meals, housekeeping, laundry, social and recreational opportunities and 24 hour emergency response).
- By law, any SRHs offering this level of service must be registered with the Ministry of Health Assisted Living Registry and meet provincial assisted living health and safety standards.
- Many businesses calling themselves supportive recovery homes offer a lower level of services for their clients, and are not required to be registered. However, they are still bound by municipal and criminal laws and regulations.
- If homes are not providing prescribed services, they are generally covered under the *Residential Tenancy Act.*
- As of February 12, 2015, there were 90 SRHs registered across BC. Another 36 homes have submitted applications for registration, which are being processed. There are 46 of the registered homes are in Surrey. The registered homes are listed on the assisted living registry web site.
- All registered SRHs are inspected before they are registered. Assisted living investigators can investigate complaints related to the health and safety of people living in the residence, which may also involve a site inspection.
- Registry staff can investigate if there is reason to believe a house is offering the level of service which requires it to register. If an operator is required to register and does not, a fine can be imposed under the Act, although this would involve a onerous court process.
- Following the murder of a Surrey resident, there was increased attention regarding the presence and consequences of SRHs in Surrey. In January 2014, the Opposition proposed a "Surrey Accord" to reduce crime in Surrey. One of the accord's five points was the regulation of SRHs.
- s.12
  s.12 a group of cross government Assistant Deputy Ministers met January 23, 2015 to discuss how to best work together to address sector issues, in particular problematic operators.
- s.17

- The Ministry of Justice (MOJ) advised that because their focus is on addressing criminal behaviour rather than housing, they have referred individuals to SRRs that have approved

psychosocial programs. Following discussions with the ministry, they have now amended their Approved Residential Resources policy to include registered SRRs, which means that Probation Officers can recommend registered SRRs to their clients.

- MoJ reported that they do not have any control over judiciary decisions to send someone to a SRR (registered/licensed or not).
- The Ministry has been working with MOJ with to ensure that the courts, police and parole officers are aware of registered SRHs and have access to a list of them.
- s.13

- The Ministry is also working with the City of Surrey, other municipalities, health authorities and operators to identify emerging safety issues, to develop strategies to manage unregistered homes s.15
- The Ministry is aware of at least one municipality in the lower mainland that appears to want to prohibit supportive recovery homes from operating in its community.
- The Ministry has attended one Parents Advisory Committee community meeting in Surrey to provide information related to SRHs and will explore other opportunities to work with lower mainland municipal authorities to increase understanding of the value of supportive recovery homes in their communities.
- Two supportive recovery homes required to register, currently allow children to live with their parent(s) who is receiving services. Neither of the two residences has been registered. s.1 s.13

Background

- In the 1990s, government licensed supportive recovery homes due to allegations of abuse, poor living conditions, and at least one death due to a drug overdose.
- In 2001, government ended the licensing requirement for SRHs, as very few operators could bring their homes into compliance with the prescriptive licensing regulations.
- In the absence of mandatory registration, MSDSI established a comprehensive approval process for SRHs to require a minimum standard of services for their clients.
- For SRHs that met these standards, MSDSI provided a daily per diem of $30.90 a day for clients who were in receipt of income assistance benefits from MSDSI.
- This amount is a premium on income or disability assistance benefits clients receive, recognizing the additional programs and services provided by SRHs.
- The Ministry and MSDSI worked closely together to create a registration process that supports safe options for people who are looking for supportive recovery services.
- In March 2013, the Ministry started registering SRHs and MSDSI changed their per diem funding policy to require funded SRHs to be registered or in the process of registering with the Ministry.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Doug Hughes, Health Services Policy and Quality Assurance Division; April 29, 2015

FACT SHEET

Surgical Services Strategy

ISSUE

Setting Priorities for the BC Health System (February 2014), and *BC Health System Strategy Implementation* (April 2014), reconfirms timely access to surgery as a key area of focus.

KEY FACTS

Strategic Framework for Surgical Services & Provincial Surgical Executive Committee-April 21, 2015

The Provincial Surgery Executive Committee (PSEC) was formed in the summer of 2014 to oversee this important area. Alignment with the BC Health System strategy was fundamental – to be patient centered rather than provider focused, and to use quality as the foundation. PSEC is comprised of 29 members including patients, surgeons, anesthesiologists, representatives from health authorities, Ministry of Health, BC Patient Safety and Quality Council, and Doctors of BC. PSEC determined the priority areas as:

- Developing the surgery policy paper, *Future Directions for Surgical Services in British Columbia*, published in February 2015. It focuses on improving timely access to appropriate surgical treatments and procedures and was built on five elements:
  1. understanding population and patient surgical health care needs;
  2. developing quality and sustainable surgical care delivery models;
  3. recruiting and retaining engaged, skilled health care providers;
  4. using IM/IT tools and processes as supports to allow innovation and effective coordination and delivery of surgical services; and
  5. using financial models to support the achievement of intended health system outcomes.
- Determining surgical services indicators and targets for the dimensions of quality starting with access and safety.
- Improving access to surgery by initially focusing on wait list management, addressing backlogs, and in future a revising the provincial waitlist management policy.
- Finishing foundational work including Surgery patient prioritization code review and the publication of Wait One data to the public website; and Implementing a provincial electronic surgical booking and wait time management solution.
- Building on the Clinical Care Management approach by developing standardized care pathways/evidence-based timelines for surgeries and implementing practice guidelines for consulting with patients on treatment options.
- Five Working Groups have been established to advance the strategy and act on the priorities:
  1. Vision and policy
  2. Prioritization Code
  3. Surgery Quality Indicators – starting with access and safety
  4. Surgery Booking and Wait Time Management Solution
  5. Clinical Care Management

Immediate Actions

In March 2015 PSEC was asked to identify immediate actions to improve access to surgery and to reduce wait times, ensuring alignment with the 3 year strategy. (see attached).

FINANCIAL IMPLICATIOS

To be determined.

Approved by:
Doug Hughes, Health Services and Quality Assurance Division, April 29, 2015

FACT SHEET

	Action	Description	Requirements	Timelines
1	Wait list assessment and management	Conduct a snapshot of wait lists at the provincial, health authority, and local site level, by specialty, of patients waiting > 52 weeks to determine the backlog. • Differentiate the backlog from ongoing demand. • Assess % of patients managed in turn to determine the effect of wait list management practices, such as pooled referrals.	Earlier this spring, the Ministry had contracted with Analysis Works to perform other work however given the priority on improving timely access to surgery, this work on assessment o wait lists using the Surgical Patient Registry has been given a higher priority. This eliminates the need to procure external software to do the assessment. With a goal of achieving consensus on analysis and modelling on a province wide basis, a collaborative and inclusive approach will be used between the health authorities, physicians, Ministry of Health and Analysis Works. Lessons learned from previ work in this area will be used for the next assessment.	Started April 2015
2	Identify Surge capacity	Health Authorities identify surge capacity in each of their health authorities.	May include extending service hours, revising seasonal closures, contracting out to private surgical centres using public funds.	April - May 2015
3	Match demand to surge capacity and schedule procedures	Match demand to capacity to deal with backlog of patients waiting	Robust plans in place to schedule patients for surgery	June - Sept 2015
4	Complete Prioritization Code review	Complete the update to the prioritizatio codes, implement across the health authorities, surgeons' offices, and Surgical Patient Registry	Working group meetings are scheduled to complete implementation plan	On track In place Sept 2015
5	Surgical Booking and Wait Time Management Solution	A province wide electronic solution that provides accurate synchronized information about who is waiting for su and how urgent their procedure is, links GPs to Specialists through e-referral (and back again), links to health authority OR booking systems, and allows for a patient portal for patients to know their status the continuum to surgery	Business case required - being developed May 2015. Align with approval and funding source decisions Summer 2015. Implementation plan in place by Fall 2015.	May – Dec 2015
6	Health authority identify point person/triage person that patients and family can call about questions they have on their journey		Health authorities determine who this will be; may require additional resources	June 2015
7	Create or identify surgical facilities that are used on a variable basis to address backlogs and targets	e.g. using underutilized capacity at some locations UBC	Operating funds for underutilized capacity (UBC, RIH) Health human resources (nurses, anesthesiology) Patient care capacity (beds)	June – Sept 2015
8	Confirm quality indicators and targets that support patient centered care, good wait list management, and improve access to safe and quality surgical c	Determine quality indicators, starting with access and safety relative to surgic services (e.g. % waiting > 52 weeks, % waiting >40 weeks, % patients Managed in turn in order of priority/urgency)	Working Group developing indicators and targets	Draft to PSEC May 2015 Final June 2015
9	Develop plan to address anesthesio and nursing surgical shortages	Overall cross system plan to address chronic shortages in certain health sector groups	May be one of the large action items coming out of the policy papers between HHR and Surgical	June 2015

FACT SHEET

Telemedicine Policy Review

ISSUE

Following an announcement by the Minister in June 2014, the Health Services Policy and Quality Assurance Division is completing a review of the use of telemedicine with a specific focus on the alignment of General Pracitioner telemedicine visits with current Ministry priorities and strategies.

KEY FACTS

- In 2011 the Medical Services Commission Tariff Committee removed the requirement that all telehealth visits must occur at a health authority facility in an effort to support physicians and patients far from a health authority facility.
- Since 2011, the Ministry of Health has seen significant increases in the frequency of billing for the General Practitioner (GP) telemedicine visit fee codes.
- The majority of these visits were delivered through private, internet-based service providers.
- This led to a number of concerns about whether telemedicine was being used to deliver care in the most appropriate and effective manner in BC, including concerns about the creation of a number of "virtual walk-in clinics".
- In June 2014, the Minister announced a review of Telehealth in BC. The review was to assess not only the challenges, but also the opportunities for health care services from private vendor telehealth platforms. The main goal of the review was to ensure the service is high quality and addordable for the health system.
- Current Ministry strategic directions support access to longitudinal, person-focused care including initiatives such a GP for Me[1] as well as delivering high quality care to rural and remote residents, including First Nations communities.
- The policy recommendations will ensure that GPs visits delivered via telemedicine are aligned to the Ministry's strategic direction and will benefit key populations.
- The process of developing policy recommendations included engagement with a number of stakeholders including the BC College of Physicians and Surgeons, the Joint Collaborative Committees as well as private vendors who offer telemedicine platforms.
- The policy recommendations have been created with the intention of providing clarity to the Ministry and its stakeholders in the development and alignment of policy and reimbursement models.
- When applied effectively and appropriately, telemedicine can act as an important enabling technology to support practitioners.
- A policy paper is being developed along with a broader Ministry Virtual Connected Care Strategy which will provide a long term vision and roadmap for Telemedicine in BC.

FINANCIAL IMPLICATIONS

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FACT SHEET

Approved by:
Doug Hughes, Health Services and Quality Assurance Division, April 2, 2015
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; April 13, 2015
Holly Moulton, obo Carolyn Bell, Health Sector Planning & Innovation Division; April 30, 2015

FACT SHEET

Urban Primary Care Redesign

ISSUE

In spring 2014, Vancouver Coastal Health (VCH) announced changes to its primary care program in Urban Vancouver to better meet the needs of clients. Primary care resources from the "Urban" clinics operated by VCH (Pine Clinic, Evergreen Community Health Centre, South Community Health Centre and Pacific Spirit Community Health Centre) and a portion of non-physician funding from Mid-Main were focused into a larger "Primary Care High Needs and Stabilization Clinic" at Raven Song Community Health Centre (this expanded clinic is designed to serve youth as well as adults with complex care needs).

KEY FACTS[1]

- Raven Song is open seven days a week, 12 hours a day, Monday to Friday, and on weekends: 10 a.m. - 6 p.m. with 24-hour on-call services available to a medical doctor or nurse practitioner.
- Raven Song serves about 3,500 vulnerable clients and will have capacity to serve an additional 2,500 people this year after three more physicians are hired.
- Primary care is provided by an interdisciplinary team working together: doctors, nurses, social workers, pharmacists and psychologists to best meet the needs of a medically complex client group.
- To support clients who have challenges attending appointments, Raven Song doctors and Nurse Practitioners also do outreach and home visits.
- Raven Song physicians are also now doing home visits to frail seniors as part of the Quick Response Team of Vancouver General Hospital's Emergency Department. Over the past 12 months, hospital admissions have been reduced by 2 seniors a day through the team's home visits, allowing more frail seniors to be at home with community supports where they recover better than in hospital.
- Early stats indicate both adult and youth are transitioning well to Raven Song clinics and services:
  - almost double the number of adults visited from November 1-December. 31 2014 than the previous year. (1,163 compared to 694); and
  - a fourfold increase in the number of youth who have visited from November 1-December 31, 2014 than the previous year. (449 compared to 91).
- Youth now have better access at Raven Song which offers 76 hours a week of youth clinic services, an increase of 22 hours over Pine Clinic.
- Most youth clinics are closed on holidays but Raven Song is open on holiday/stat days to support increased access.
- Raven Song (and Three Bridges) has services that were unavailable at Pine Clinic including mental health and addiction treatment.
- Doctors, nurse practitioners and nurses from Raven Song and Three Bridges do outreach care at youth detox, which is provided in South Vancouver.
- Follow-up primary care after youth detox is offered through these same clinicians unlike before when many high risk youth were unattached to primary care and lost connection with health care after detox.
- A Raven Song nurse practitioner for primary care youth outreach is attending at the East Vancouver Public Health Youth Clinic where sexual health and reproductive health only had been offered.

[1] Harari, Nellie, Operations Director Primary Care , Public Health, HIV/AIDS and Volunteer Programs – Vancouver Coastal Health, email Updated materials for Urban Primary Care Redesign factsheet, March 2, 2015

FACT SHEET

- Vulnerable youth continue to have easy access to primary care with several clinic choices throughout Vancouver:
    - Raven Song Community Health Centre at Ontario and Broadway;
    - Three Bridges Community Health Centre at Hornby near Davie;
    - South Community Health Centre at Knight near 48th;
    - Pacific Spirit Community Health Centre on West 43rd in Kerrisdale; and
    - East Van Public Health Youth Clinic (Robert and Lily Lee Family Community Health Centre).
- The primary care redesign has allowed former VCH contracted physicians to move to new practices and take on new patients under a fee-for-service model, increasing access to family doctors in Vancouver as a whole.
- About 4,500 or 70% of clients remained with their primary care physician under a fee-for-service model as part of the primary care redesign.
- 940 clients have moved to Raven Song for primary care services.
- 370 clients who were identified as not being vulnerable, were sent letters regarding fee-for-service primary care options and did not respond. VCH believes that these clients did not need their assistance in finding care and likely have found other options for care.
- It was recently discovered that about 92 primary care clients at Pacific Spirit Community Health Centre had not been sent letters about meeting their future primary care needs. Some of these clients had not been seen by a clinician at Pacific Spirit for more than a year. A Nurse Practitioner will be contacting them to support their transition with care options.

FINANCIAL IMPLICATIONS

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Approved by:
Doug Hughes, Health Services and Quality Assurance Division, April 2, 2015
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; April 14, 2015

FACT SHEET

Better at Home Program

ISSUE

To support seniors' independence, the Government of BC has committed $10 million per year in funding to the United Way of the Lower Mainland (United Way) to implement a non-medical home support program, the Better at Home Program, in up to 68 sites around the province.

KEY FACTS

Background

- On February 14, 2012, the Minister of Health announced $15 million funding to the United Way to develop and manage a provincial non-medical home support program for seniors. The new program was announced as one of the key actions in the Ministry of Health (MoH)'s *Improving Care for B.C. Seniors: An Action Plan*.
- On April 5, 2013, the Provincial Health Services Authority announced an additional $5 million to expand Better at Home. A further $2 million was provided in March 2014 for specific program enhancements, and $4 million was provided in March 2015 (not yet announced).
- Better at Home builds on the success of Community Action for Seniors' Independence, a partnership between the United Way and the Ministry to develop and evaluate community-based program models for delivering non-medical home support services to BC seniors.
- Non-medical home support includes simple services that will support seniors to live in their own home longer, such as light housekeeping, yard work, snow shoveling, grocery shopping, minor home repairs, friendly visiting and transportation to appointments.
- Services are provided by local non-profit organizations and delivered by a mix of volunteers and paid workers. Seniors are charged a fee for service on a sliding scale based on income.

Program Implementation and Evaluation

- Communities identified as Better at Home sites have a high percentage of seniors, many of whom are isolated and vulnerable. In addition, the United Way has sought input from seniors' organizations and other regional experts to help guide the site selection process.
- In each Better at Home site, an intensive community development and consultation process with service providers, health authorities, municipal government and other key local stakeholders helps assess community readiness for the program, determine which services are most needed in the community, and select a local non-profit organization to deliver the services.
- Initially, each local organization selected received $100,000 annually to operate the Better at Home program. The United Way has reviewed the funding model and each individual program funding may be increased based on the specific needs and capacity of each community. Better at Home services are designed to complement and coordinate with existing community services.
- In August 2014, the United Way completed an operational evaluation of Better at Home; this evaluation suggested that the program is working well and clients are generally satisfied, although more could be done to reach isolated seniors and keep clients connected to their communities.
- The evaluation also found that the most frequently used services are light housekeeping and transportation; that seniors would like access to a broader range of services, including some health services that are outside the scope of the program; that as demand for services increases, waitlists could develop without additional funding; and that adequate funding is key to program sustainability.
- The Ministry is also partnering with the Michael Smith Foundation for Health Research and the United Way on a research and evaluation plan for the Better at Home program to look at longer-term outcomes for clients and for the health care system.

FACT SHEET

- The United Way continues to develop and enhance the Better at Home program and is working to integrate the program with existing services for seniors and has developed new tools and resources to help build local program capacity.
- Currently, 67 Better at Home program sites have been funded to provide services in communities across the province; some program sites serve more than one community. Six new program sites received funding in the spring of 2015 to pilot test new models for delivering Better at Home services in rural and remote communities (please see Table 1) (not yet announced).
- On October 22, 2014, B.C.'s Seniors Advocate released her first report, *The Journey Begins: Together We Can Do Better*. This report cites "concerns about the capacity of the new *Better At Home* program."[1]

Table 1 - Funded Program Sites by Health Authority

Fraser Health	Logan Lake	Dawson Creek
Abbotsford	Nakusp (rural/remote pilot)	Fort St. John
Burnaby	North Okanagan (Vernon)	Fraser Lake (rural/remote pilot)
Chilliwack	Penticton	Gitxsan First Nation
Delta	Shuswap Region (Salmon Arm)	Granisle (rural/remote pilot)
Hope/Fraser Canyon	South Okanagan (Osoyoos)	Kitimat
Langley	Williams Lake	Prince George
Maple Ridge/Pitt Meadows	**Island Health**	Prince Rupert
Mission	Campbell River	Quesnel
New Westminster	Comox Valley	Terrace
Richmond	Cowichan Region (Duncan/Cowichan)	Vanderhoof (rural/remote pilot)
South Surrey/White Rock	Cowichan Tribes (Cowichan First Nation)	**Vancouver Coastal Health**
Stó:lō Territory (Stó:lō First Nation)	Nanaimo	North Shore (North Vancouver)
Surrey-Newton	North Island (Port Hardy)	Sea to Sky (Pemberton/Whistler)
Surrey-Whalley	Oceanside (Parksville)	Squamish Nation-Tsleil-Waututh Nation
Tri-Cities	Pender Island (rural/remote pilot)	Sunshine Coast (Sechelt)
Interior Health	Port Alberni	Vancouver DTES/Strathcona/Chinatown
Ashcroft/Cache Creek	Powell River	Vancouver Hastings-Sunrise
Castlegar	Salt Spring Island	Vancouver Kerrisdale/Oakridge/Marpole
Central Okanagan (Kelowna)	Victoria Esquimalt	Vancouver Kitsilano
Cranbrook	Victoria (James Bay)	Vancouver Mount Pleasant
Creston	Victoria Saanich	Vancouver Renfrew-Collingwood
Invermere (rural/remote pilot)	Victoria West Shore	Vancouver South
Kamloops	**Northern Health**	Vancouver West End

FINANCIAL IMPLICATIONS

- Government has provided $26 million in funding to the United Way ($15 million in 2011/12, $5 million in 2012/13 through the Provincial Health Services Authority, $2 million in 2013/14, and $4 million [not yet announced] in 2014/15) to expand and operate the Better at Home program in up to 68 sites.

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Approved by:
Arlene Paton, Population and Public Health Division; April 23, 2015
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; April 24, 2015

[1] www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2014/10/The-Journey-Begins-Together-We-can-Do-Better.pdf, p.3.

FACT SHEET

Academic Research Data Requests – Metrics

ISSUE

Marked improvements to processing times for academic data requests.

KEY FACTS

- The Ministry of Health data holdings are regarded as some of the best health data resources in the world. Health researchers from BC universities and abroad apply for access to administrative health data for use in research and statistical analysis pursuant to applicant privacy law and policy.
- The number of new requests received by the Ministry and by the Data Stewardship Committee is approximately 30 per year. For both the Ministry and Committee, there was a significant reduction in processing times between receipt and approval between 2010 and 2014[1]:
  - For the Ministry, the median number of days has dropped from 342 to 69 days.
  - For the Committee, the median number of days has dropped from 316 to 68 days.
  - For the Ministry, the maximum number of days has dropped from 633 to 250 days.
  - For the Committee, the maximum number of days has dropped from 746 to 232 days.
- The Ministry received 18 new applications by December 31, 2014, approved 27, with only one project submitted in 2014 waiting for approval within the prescribed approval timeline commitment for qualifying projects.
- The Committee received 13 new requests by December 31, 2014 and approved 21, with the remaining being processed in conjunction with the Ministry.

MoH DATA ACCESS REQUESTS – NEW PROJECTS (Medical Service Plan, Hospitalizations, etc.)					
YEAR	# Received	# Approved	Minimum	Maximum	Median
2010	12	10	142	633	342
2011	15	14	90	399	231
2012	20	19	47	198	99
2013	29	20	25	198	92
2014	18	27	12	250	69

DSC DATA ACCESS REQUESTS – NEW PROJECTS (PharmaNet and Heath Information Banks)					
YEAR	# Received	# Approved	Minimum	Maximum	Median
2010	20	20	31	746	316
2011	8	8	52	414	205
2012	7	6	36	125	56
2013	18	8	35	120	70
2014	13	21	35	232	68

FINANCIAL IMPLICATIONS

N/A

Approved by:

Shirley Wong (Kelly Moran), Information Management & Knowledge Services; February 3, 2015
Lindsay Kislock, Health Sector IM/IT Division; May 5, 2015

[1] All metrics from the Data Access Request Tracking System (DARTS)

FACT SHEET

BC Centre for Data Innovation

ISSUE

Ministry of Health's contribution to the BC Centre for Data Innovation initiative.

KEY FACTS

- At the December 2013 Data Effect Conference, the Minister of Health announced the establishment of a Working Group to conduct a review and make recommendations on the creation of a BC Centre for Data Innovation.
- The BC Centre for Data Innovation is a vision for the future that will foster innovation and collaboration between citizens, researchers, the private sector and government. Based on leading practices in security and privacy, the BC Centre for Data Innovation will provide a secure environment for data-driven innovation, transformative research and technology development.
- A joint working group of the Ministry of Health and the Ministry of Technology, Innovation and Citizens' Services was established to evaluate the potential for such a centre and to make recommendations that initially focus on the health sector but are extensible to broader, cross-sector data needs.
- The working group's report http://www.gov.bc.ca/citz/down/BC_Centre_for_Data_Innovation-FINAL.pdf proposes a multi-year, incremental approach to developing the BC Centre for Data Innovation and recommends a set of first steps or foundational activities towards realizing that vision.
- The recommendations do not commit government to any new funding, but establish a vision and value proposition for the BC Centre for Data Innovation and commit to broader consultations with additional stakeholders beyond the health sector.
- The Ministry of Health's foundational contribution is the provincial data platform work being led under the Strategy for Patient Oriented Research. BC is currently finalizing a business plan for the Support for People and Patient-Oriented Research and Trials Unit co-funded by the Canadian Institutes for Health Research and the BC Ministry of Health to support health sector priorities.
- The provincial data platform is a virtual federated data environment to enable data sharing across the health sector to support health system analysis.
- Key focus of the work is to:
    - Enable secure third party access to the Ministry's data warehouse, Healthideas, and to the health authorities' local data warehouses. It is unclear at this time which health authorities will be involved in the initial release of this service.
    - Streamline access request and approval processes in the health authorities
    - Provide secure storage for researcher's held data and clinical trial management tools and;
    - Enable collection and analysis of patient experience data

FINANCIAL IMPLICATIONS

The total funding for Strategy for Patient Oriented Research is outlined below:

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Approved by:
Kelly Moran, Information Management & Knowledge Services; January 20, 2015
Lindsay Kislock, Health Sector IM/IT Division; February 26, 2015
Ted Boomer, obo Manjit Sidhu, Finance and Corporate Services Division; March 6, 2015

FACT SHEET

BC - Yukon Panorama Project

ISSUE

BC is the leader in the implementation of a new pan-Canadian public health surveillance system called Panorama. Panorama is a necessary and key component in the renewal of BC's public health system and its antiquated information technology support applications. It is also required to appropriately support BC and the Yukon in the event of futures outbreaks like SARs or Avian Flu.

KEY FACTS

Scope

- Panorama is an integrated suite of public health system components consisting of these seven modules, all of which are complete and in production: 1) Vaccine and Inventory Management; 2) Immunization Management; 3) Family Health Management; 4) Communicable Disease Case Management; 5) Outbreak Management; 6) Work Management; and 7) Notifications Management.
- The Family Health module was developed and funded solely by BC's public health workers and encompasses prevention and promotion activities and development of interdisciplinary and collaborative action plans.

Schedule

- Panorama's provincial deployment project is now complete and was implemented in three deployment phases:
  - Phase 1: Inventory 2010/2011
  - Phase 2: Family Health and Immunization and on-boarding of remaining adoption community (Vancouver Coastal Health Authority) for inventory in July 2013
  - Phase 3: Case and Outbreak Management in September 2014 (Predominantly Complete, an external interface and Case subgroups (TB/STI) remain to be onboarded in a phased approach through September 2015).
- The project had several key dependencies which informed its ability to meet its schedule, including the active and committed involvement of Public Health end users and management resources within the Ministry and the deploying health authorities.

Background

- In 2004, the Federal Government asked Canada Health Infoway to assist in the development of a national public health surveillance system. BC joined other provinces, territories and federal partners to develop a vision for a Pan-Canadian public health solution. The development of Panorama was identified as a key component to the realization of this vision. BC has played a key leadership role nationally on the development of Panorama. In addition, BC has partnered with the Yukon Territory to implement a unique cross jurisdictional deployment as part of the Panorama project.
- Panorama is integral to the provincial strategy to renew our public health system and is a key component of the BCs eHealth vision. It is anticipated that now being fully implemented and having reached stablization, Panorama will improve the ability of public health professionals to work and share information across multi-disciplinary teams, regions, and jurisdictions, enabling our public health care providers to:
  - realize opportunities to coordinate public health service/program delivery and develop timely, effective, targeted care planning, awareness, prevention and promotion activities;
  - develop interdisciplinary action plans with individuals, families and maternal, infant, child, youth and adult health health care providers;

- efficiently manage immunization programs and vaccine inventory;
- identify, investigate and manage communicable disease cases and contacts, as well as communicable disease outbreaks and associated risks to the public's health;
- broadly communicate important public health information related to communicable diseases through alerts and notifications; and
- further enable research and analysis to support improved preparedness for future communicable disease outbreaks and risks to communicable diseases.

Deployment Challenges

As with the initial deployment of any complex enterprise solution there have been issues, particularly around end-user performance and functionality gaps. Governed by a steering committee of senior Ministry and Health Authority IT and Public Health representatives and supported by a clinical and operational support teams these issues are dealt with as high priorities. To address these key issues a dedicated performance team and approved program of continuous improvement are in place.

FINANCIAL IMPLICATIONS

$ in Millions

Ministry of Health Expenditures	2009/10 & Prior Actual	2010/11 Actual	2011/12 Actual	2012/13 Actual	2013/14 Actual	2014/15 Forecast	Total
Operating			8.64	23.38	27.34	9.84	69.19
Capital	24.77	9.19	3.65	0.68			38.29
Total	24.77	9.19	12.29	24.06	27.34	9.84	107.48

$ in Millions

Health Authorities Expenditures	2009/10 & Prior Actual	2010/11 Actual	2011/12 Actual	2012/13 Actual	2013/14 Actual	2014/15 Forecast	Total
Operating				2.23	2.98	11.76	16.97
Capital				0.75	4.12	3.72	8.59
Total	0	0	0	2.98	7.10	15.48	25.56
Grand Total	24.77	9.19	12.29	27.04	34.44	25.32	133.04

- Over an 8-year period, BC will have invested approximately $133 million in total. Funding has gone to:
  - Develop the BC-specific Family Health module;
  - Make significant product enhancements to ensure the system is tailored to BC & meets our unique clinical requirements;
  - Significant infrastructure development;
  - Replace, decommission and convert data from multiple antiquated systems; and
  - Configure test and deploy the full set of Panorama core functionality:
    - Vaccine and Inventory Management
    - Immunization Management
    - Family Health Management
    - Communicable Disease Case Mgmt
    - Outbreak Management
  - Development of iterfaces to other Health Sector assets including Client and Provider registries; Provicncial Lab Information System; BEST Audiology System; PARIS and Cambian Scheduler.
  - Five years of full production operations and sustainment (resources, licensing, infrastructure etc.)
- Canada Health Infoway is committed to reimburse $9.8 million of these costs.

Approved by:

Tracee Schmidt, Strategic Projects Branch, February 6, 2015
Lindsay Kislock, Health Sector IMIT Division; February 17, 2015
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; February 27, 2015

FACT SHEET

Consultations to Improve Health Information Management

ISSUE

In January 2015, the Ministry of Health started its consultation process to seek input to improve health information management. The Ministry is meeting with targeted stakeholders and the public over the next year on how to improve the management, protection and storage of personal health information in BC.

KEY FACTS

- The Ministry is developing a health information management policy framework in an effort to establish clear and consistent rules for the use and protection of personal health information in the public and private sectors.
- Health information is now governed by various pieces of legislation: the *Freedom of Information and Protection of Privacy Act* (for public bodies such as health authorities); the *Personal Information Protection Act* (for private bodies such as doctors' offices); the *E-Health (Personal Health Information Access and Protection of Privacy) Act* (for electronic information); and other information management provisions in legislation, regulation and policy. This assortment causes a highly complex and confusing system for anyone trying to use health information.
- The work to streamline the various health information legislation and policies is part of the Ministry's strategic priority document, *Setting Priorities for the B.C. Health System*[1]. The document recognizes the need to review health information legislation and policies in order to improve the overall health of the population, enhance the experience and outcomes of patients, and achieve the best outcomes for the healthcare dollar.
- Throughout 2015, the Ministry is engaging with stakeholders such as Patients as Partners; health authorities, including the First Nations Health Authority; Doctors of BC; the BC Nurses Union; and various health provider associations and health profession regulatory colleges.
- The Ministry will also be engaging with special interest groups, including the BC Civil Liberties Association and Positive Living BC along with conducting working group sessions with the Office of the Information and Privacy Commissioner and the Office of the Chief Information Officer.
- Members of the public will have an opportunity to join the conversation through GovTogetherBC, the province's online engagement portal. The public engagement portal will be ready later this year for the public to offer their input.

FINANCIAL IMPLICATIONS

The Ministry's engagement plan, created with input from the Government Communications and Public Engagement headquarters' engagement team, estimates the planned engagement will cost about $85,000. The funding allocation has been approved by the Ministry's Financial and Corporate Services Division. This allocation includes the cost of running the online and in-person engagement opportunities.

Approved by:
Heather Dunlop (Deb McGinnis), Health Information Privacy, Security and Legislation; February 5, 2015.
Lindsay Kislock, Health Sector IM/IT Division; February 17, 2015
Daryl Conner, Finance and Decision Support Branch; March 3, 2015

[1] The Ministry of Health's strategic document, "Setting Priorities for the B.C. Health System," is available at: http://www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BCHealth-Feb14.pdf

FACT SHEET

Data Stewardship Committee

ISSUE

The Data Stewardship Committee provides a forum for stakeholders in the health sector, including health care professionals, researchers, health authorities, and the general public to make decisions regarding data access from certain protected databases for a research purpose.

KEY FACTS

- The *E-Health* (Personal Health Information Access and Protection of Privacy) *Act* came into force November 2008 and governs the collection, use, and disclosure of personal health information in Health Information Banks, protected databases and databases designated by the Ministry.
- The Committee makes decisions regarding requests for the disclosure, for a health research purpose, from Health Information Banks and PharmaNet, and also for determining whether Health Information Banks may be exempt from a "disclosure directive" service that permits patients to block access to personal health information.
  - The Ministerial Order 156 from June 24, 2009, declared the Provincial Laboratory Information Solution Repository a Health Information Bank. The Ministerial Order 230 from July 10, 2014 repealed the existing order and replaced it with a new order designating the Provincial Laboratory Information Solution Repository a Health Information Bank.
  - On March 27, 2013, the Committee approved the recommendation to the Minister under Subsection 8(3) and 11(2) of the *E-Health Act* that disclosure directives under Section 8(1) do not apply to the Provider Registry if designated as a Health Information Bank under Section 3(1).
  - On April 24, 2013, the Committee approved the recommendation to the Minister under Subsection 8(3) and 11(2) of the *E-Health Act* that disclosure directives under Section 8(1) do not apply to the Client Registry if designated as a Health Information Bank under Section 3(1).
  - The Ministerial Order 229 from July 10, 2014, declared the Client Registry System/ Enterprise Master Patient Index a Health Information Bank.
  - The Ministerial Order 231 from July 10, 2014, declared the Provider Registry a Health Information Bank.
- The *Pharmaceutical Services Act* (May 31, 2012) consequently amended the *E-Health Act* to allow for the Committee to assume the role of the PharmaNet Stewardship Committee, which previously managed requests to access PharmaNet data.
- The *Pharmaceutical Services Act* and the amendments to the *E-Health Act* also restricted decision making authority of the Committee specifically to "a research purpose", as opposed to "health sector planning purposes" (as was previously the case).
- The Committee collaborates with the Information and Privacy Commissioner on requests to contact individuals to participate in health research.
- The Committee also plays an advisory role for the health sector on data for research purposes, including providing the venue for liaison with industry groups to support an innovation and change agenda, produce health benefits and raise revenue.

<u>Background</u>

- The Committee is created under the *E-Health Act* to make decisions on disclosure of information in, or derived from, Health Information Banks and protected databases for research purposes, including PharmaNet.

FACT SHEET

- The *Pharmaceutical Services Act* imposed a number of consequential amendments to the *E-Health Act* May 31, 2012, expanding the decision making scope of the Committee to include PharmaNet research data access and also dissolved the PharmaNet Committee.
- Upon Committee review and approval of a research data request, the Ministry's Chief Data Steward may disclose the requested information subject to conditions set by the Committee.
- Per Section 12 of the *E-Health Act*, the Minister of Health must appoint a Data Stewardship Committee consisting of not more than 12 persons:
  - one person from within the Ministry of Health of the Minister;
  - one person chosen as representative of either Regional Health Boards or the Provincial Health Services Authority;
  - one person nominated by the Council of the College of Physicians and Surgeons of British Columbia;
  - one person nominated by the Council of the College of Pharmacists of British Columbia;
  - one person nominated by the board of the college established under Section 15 (1) of the *Health Professions Act* for the health profession of the practice of nursing;
  - one person engaged in health research generally;
  - one person engaged in pharmaceutical research; and
  - up to three people chosen as representative of the general public.
- Dr. Bruce Carleton, Chair resigned effective January 12, 2015 and the search for new chair is underway.

Current Membership

Expiry Date	Current Terr Start	MO/OIC	1st App	Member	Position filled	Agency Board Commission
Sept 1/16	Sept 17/13	MO 235/13	2011	Kislock, Lindsay	Ministry of Health	DSC
Dec 31/15	Jan 28/14	MO 022/14	2014	Djurdjev, Ognjenka	Representative of PHSA	DSC
Dec 31/15	Dec 11/12	MO 261/12	2009	Epp, Michael	College of Physicians	DSC
Sept 1/16	Sept 17/13	MO 235/13	2010	Egli, Cameron	College of Pharmacists	DSC
Sep 1/16	Sep 1/14	MO 276/14	2013	Lau, Orvin	College of RN	DSC
Apr 1/16 (resigned 12/15)	Feb 26/13	MO 054/13	2009	Carleton, Dr. Bruce (Chair)	Health Research	DSC
–Dec 31/16	Oct 8/14	MO 352/14	2014	Mary De Vera	Pharmaceutical Researcher	DSC
Dec 31/15	Dec 11/12	MO 261/12	2010	Taylor, Ted	General Public	DSC
Dec 31/15	Dec 11/12	MO 261/12	2009	MacDonald, William	General Public	DSC
Dec 31/16	Feb 26/14	MO 051/14	2014	Hagkull, Tracey	General Public	DSC
Dec 31/15	Dec 11/12	MO 261/12	2009	Saunders, Dr. Robin	Pleasure of the Minister	DSC
Sep 1/16	Sep 1/14	MO 276/14	2013	Moran, Kelly	Chief Data Steward	DSC

FINANCIAL IMPLICATIONS

Fiscal Year 2014/15: Operating Budget - $52,000[1]

Approved by:

Kelly Moran, Information Management & Knowledge Services; January 29, 2015
Lindsay Kislock, Health Sector IM/IT Division; February 17, 2015
Bill Dallinger, Finance and Corporate Services Division; February 23, 2015

[1] HSIMT IMKS 2014/15 Budget

FACT SHEET

MAXIMUS BC – OAG Report and Data Security

ISSUE

- Ministry work to address recommendations in the Auditor General's 2013 performance audit, titled: "Health Benefit Operations – Are the Expected Benefits Being Achieved"? was only partially completed at the time of the Auditor General's one year follow up report.
- The Ministry is currently assessing the residual risks related to MAXIMUS' subcontractors, to determine whether additional aduit work is warranted.

KEY FACTS

- In February 2013, the Auditor General issued a report on his performance audit of the outsourcing arrangement with MAXIMUS for delivery of Health Insurance BC (HIBC) services.
- In June 2014, the Auditor General issued the "Follow-Up Report: Updates on the Implementation of Recommendations from Recent Reports", which contained the Ministry's self-assessment of progress in implementing the recommendations of the performance audit.
- The most publicly-sensitive findings relate to the Ministry's verification of MAXIMUS' compliance with privacy and security requirements in the contract. The Auditor General noted that his recommendations on this issue have only been partially implemented; full implementation is expected by the end of the current (2014/15) fiscal year.
- In his 2013 audit report, the Auditor General stated:
  "... two monitoring tools intended to identify privacy breaches were not implemented as expected. Further, the ministry has not verified that the service provider is complying with two key privacy contract terms."
  "Although I did not find any evidence of unreported breaches, this creates a risk that breaches are occurring without the ministry's knowledge."
- The two monitoring tools are automatic processes to notify the Province if the Service Provider appears to be copying or accessing data in an unusual manner; and, third party audits of MAXIMUS' compliance with incident reporting policies.
- The two key privacy contract terms that the Ministry could not demonstrate it has verified are that data access and storage are limited to Canada; and, that data access is segregated from the service provider's parent companies.
- The Ministry commissions an annual third party audit of MAXIMUS BC operations, and responded to the Auditor General's findings by expanding the scope of the annual audit.
  - During the 2012/13 audit, auditors reviewed the existing audit control framework and tests. Controls relevant to the concerns raised by the Auditor General were identified, and the auditors recommended changes in the scope of the annual audit as well as potential additional audit activities.
  - In the 2013/14 audit, the specific concerns of the Auditor General, noted above, were addressed for HIBC operations and the technical infrastructure directly managed by MAXIMUS BC. That audit work provided the Ministry with assurance that MAXIMUS - controlled systems are sufficiently designed to protect against such security breaches.
  - The remaining work is an assessment of the risks of security and privacy breaches related to MAXIMUS' subcontractors.
- The risk of subcontractor breaches is believed to be low. MAXIMUS' databases and applications use government Shared Services technology hosting services. The Ministry of Technology, Innovation and Citizens' Services (MTICS) contracts with Hewlett Packard Advanced Solutions for

those services, and is responsible for ensuring appropriate security is in place not only for MAXIMUS' applications, but also for other government programs.

- The Ministry is working with MTICS to understand their audit program and the level of assurance they currently receive on security and privacy. If necessary, the Ministry will work with MTICS to obtain additional specific assurance respecting the services provided to MAXIMUS BC.
- The only other technology subcontractor with potential access to BC data is the provider of HIBC's call centre infrastructure. Security risks are inherently lower for the call centre, as it does not provide access to the Medical Services Plan or PharmaCare databases that contain personal information.
- The call centre technology was transitioned from TELUS to Allstream and MAXIMUS Canada in mid-2014. MAXIMUS BC completed a security risk assessment of the new infrastructure during that transition. Security controls will be assessed further as part of the current year's audit of HIBC.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Guy Cookson, Business Management Office; February 6, 2015
Lindsay Kislock, Health Sector IM/IT Division; May 5, 2015

FACT SHEET

Ministry of Health Information Privacy Protection Program

ISSUE

- The Ministry of Health introduced a new health information privacy protection program in 2012. The objective of the program is to establish a proactive privacy protection framework that helps ensure the Ministry meets Government's core policy requirements while maturing a culture of information privacy awareness within the Ministry.
- The Ministry has value-based, ethical and legal obligations for the personal information in its control and/or custody. The goal of the privacy protection program is to establish the guiding principles and framework by which the Ministry and its staff will comply with these obligations, demonstrate corporate accountability for managing personal information and maintain its trust-based relationship with the citizens of British Columbia.

KEY FACTS

- In 2011, the Ministry designated the position of Executive Director, Health Information Privacy, Security and Legislation as Chief Privacy Officer. The Chief Privacy Officer has accountability for developing and managing the Ministry's information privacy protection program.
- In 2012, the Ministry engaged Deloitte to review the Ministry's data management practices, particularly regarding information privacy and security, and provide recommendations for enhancement. Deloitte's report included recommendations to develop a formal education and awareness program as well as Ministry-specific policies and guidelines for Ministry employees.
- The Ministry responded to the Deloitte report by building and launching a comprehensive education and awareness program under the leadership of the Chief Privacy Officer. The program provides guidance to Ministry employees on their roles and responsibilities in protecting British Columbians' personal information and preserving compliance with the aforementioned legal, ethical, and value-based obligations. The program is continually evolving to meet the needs of the Ministry and its employees.
- As part of the education and awareness program, in 2014 the Ministry launched a Ministry-specific privacy education module. Annual completion of the education module is mandatory for all Ministry employees; the completion rate for the module in its introductory year was greater than 95%.
- In 2014, the Ministry also launched a Ministry-specific privacy policy that must be read and acknowledged annually by all Ministry employees.
- As a component of the information privacy protection program, in 2013 the Ministry substantially improved its privacy impact assessment (PIA) process through a LEAN review. As a result of the Ministry's education and awareness program and the improved PIA process, the Ministry has seen a significant increase in the number of PIAs being completing—achieving a 45% rise in 2014 when compared with 2011. The improved PIA process has also led to a considerable reduction in the time it takes to complete a PIA; on average, PIAs are completed 64% faster since the LEAN review. Further, the Ministry is recognized by the Privacy and Legislation Branch of the Office of the Chief Information Officer as a leader in PIA compliance among both the large and social sector ministry categories.
- The Ministry's information privacy protection program is closely aligned with and complemented by the Ministry's information security and audit programs, which have also undergone recent enhancement as a result of the Deloitte report and the Ministry's commitment to continuous improvement.

- Finally, the Ministry's privacy protection program aligns with the policy and direction set by the Office of the Chief Information Officer and also follows the guidance set by the Information and Privacy Commissioner in her report on *Accountable Privacy Management in BC's Public Sector*[1].

FINANCIAL IMPLICATIONS

N/A

Approved by:

Deb McGinnis, Health Information Privacy, Security and Legislation Branch; February 20, 2015
Lindsay Kislock, Health Sector IM/IT Division; May 7, 2015

[1] Information and Privacy Commissioner of British Columbia. *Accountable Privacy Management in BC's Public Sector*, June 2014. Retrieved from: https://www.oipc.bc.ca/guidance-documents/1545

FACT SHEET

OAG Audit of Panorama

ISSUE

The OAG initiated a value for money (scope, schedule and budget) audit of Panorama in February 2014; initial findings have been delivered to the Ministry in January 2015 with a planned release date of May 2015. (See *BC-Yukon Panorama Project* fact sheet for further background detail)

KEY FACTS

Background

- BC has played a key leadership role nationally on the development of Panorama as Project Coordinator on behalf of the country. In addition, BC has partnered with the Yukon Territory, to implement a unique cross jurisdictional deployment as part of the Panorama implementation project.
- OAG audit was comprehensive, scope and criteria included scope, budget and timelines for both the National Build initiative and BC/Yukon implementation projects and included extensive document requests and individual interviews both at the Ministry and in the health authorities.
- BC played the coordinating role on behalf of the country, decisions related to scope, budget and timelines of the national build initiative were made at a National Steering Committee level and therefore should not be in scope for this provincial audit.

OAG – Key Findings

The initial OAG findings confirm that, like any long-running, large scale, multi-stakeholder tranformational initative that:

- The projects took longer then originally contemplated
- Some of the 'expected' scope items were not delivered
- There were quality issues
- The projects cost more then originally estimated

Response

- All major functionality has been delivered and is in production use in BC.
- Significant benefit now being realized by BC, including First Nations and Yukon.
- There is no alternative, comprehensive public health system available.
- Panaorama is a first generation (first of its kind globally, no road map), single shared national code base of an enterprise scale requiring significant business transformation, standards collaboration (nationally and in BC and Yukon) and complex technical infrastructure to deploy.
- In recognition of the need to consolidate expertise in the delivery of large scale transformational Health Sector iniatives (Panorama, BC Services Card, ePrescribing, etc.) the Ministry formed the Strategic Projects Branch to ensure necessary expertise, experience and resourcing for these lare scale projects.
- Challenges have been actively and aggressively addressed. Continuous improvements are on-going and will continue for the life of the product in alignment with the Public Health Strategic Framework.
- Platforms were upgraded in July addressing performance and stability issues.

FINANCIAL IMPLICATIONS

N/A

FACT SHEET

Approved by:
Tracee Schmidt, Strategic Projects Branch; February 6, 2015
Lindsay Kislock, Health Sector IM/IT Division; May 5, 2015

FACT SHEET

Partnering to Deliver the BC Services Card Program

ISSUE

On February 10, 2013, the Ministry of Health, in partnership with the Insurance Corporation of BC (ICBC) and the Ministry of Technology, Innovation and Citizens' Services (MTICS), launched the BC Services Card to replace the CareCard, and to support Government's vision of enbling citizens to safely and securely access multiple government services, both in person and on-line, through the creation of a security-enhanced photo ID.

KEY FACTS

- Legislative changes were made to the *Freedom of Information and Protection of Privacy Act* (FOIPPA) in June 2012 to designate MTICS as the Personal Identity Information Service Provider for the Province and to enable issuance of the BC Services Card. The Personal Identity Information Service Provider ensures the highest level of identity proofing and most current identity information is collected and stored in the Identity Assurance Service database that can then be used by a variety of government services to validate citizen's access.
- The Medical Services Plan (MSP) is the first service to use the BC Services Card and Identity Assurance Service. By February 2018, British Columbians will have to replace their CareCard with the BC Services Card as the primary credential for accessing health services within the Province. In addition, legislative changes introduced in 2011 will require regular renewal of enrolment in MSP linked to the card expiry and replacement of the BC Services Card for individuals.
- Most adult British Columbians will be required to renew enrolment in MSP and get a BC Services Card by 2018. Children less than 19 years old and adults 74 and older are currently exempt from the renewal process. MSP coverage will be cancelled for any adults aged 19-74 who fail to renew enrolment.
- The goals for the Ministry are to reduce health system misuse by regularly reconfirming MSP eligibility and enhance patient safety by ensuring health services are provided to the right person with the aid of photo identification that meets privacy and security industry best practice standards. Broader government needs are met by leveraging this widely distributed, highly secure, renewable credential to provide trusted access to a variety of on-line and in-person services.
- The ICBC driver licensing, front counter and advanced identity proofing services were leveraged to save money and increase convenience for British Columbians while also providing citizens the option to combine the BC Services Card with their driver's licence. ICBC provides identity proofing services for both the renewal of enrolment in MSP and for BC Services Card issuance. Service BC and ICBC authorized agents fulfil this function in rural parts of the province. Through an Integrated Program established between MTICS, MH, and ICBC under FOIPPA, citizens can now renew their driver's licence, renew enrolment in MSP and apply for a new BC Services Card in one counter visit.
- By March 1, 2015, the 2 millionth BC Services Card was issued, including:
    - 36% combo cards;
    - 44% for standalone photo; and
    - 20% non-photo.

- The initial BC Services Card investment was for $150 million[1] over six years (of this, $124 million[2] has been provided by the Ministry) to establish the new BC Services Card service and begin issuing cards to the public. s.12

s.12

s.12 Government intends to continue to leverage this investment as a foundational technology that can be used across many of its service offerings.

- As the BC Services Card Project progresses through implementation, the Ministry will shift focus toward examining additional uses for the card within the health sector. In addition to replacing the CareCard for in-person encounters, the chip technology and the Identity Assurance Service service could be used in the health system to securely access information and services. The Ministry of Health will look for opportunities to better connect health care providers throughout the system to patient information while also opening up communications and service delivery options for patients with an aim to improving health outcomes and health system efficiencies.

FINANCIAL IMPLICATIONS

- The initial phase one estimateof $150 million in operational costs over six years and capital cost of $10 million will provide for:
    - A new identity information service for government; and,
    - A secure, photo credential to access medical health services for BC residents.
- s.12

Approved by:
Tracee Schmidt, Strategic Projects Branch; February 5, 2015
Daryl Connor, Finance & Corporate Services Division; February 27, 2015
Lindsay Kislock, Health Sector IM/IT Division; May 5, 2015

[1] 2011 Approved BCSC Treasury Board Submission , 4th February, 2011
[2] 2011 Approved BCSC Treasury Board Submission , 4th February, 2011

FACT SHEET

2014/15 Service Plan Measures and Year-to-DatePerformance Results - Ministry of Health

ISSUE

Outline of the four Ministry of Health service plan measures and targets for fiscal year 2014/15, year to date performance results for 2014/15 and whether the targets were met based on partial year data.

KEY FACTS

1. *The proportion of communities that have completed healthy living strategic plans.* "Communities" includes cities, districts, municipalities, towns, townships, and villages. The measure focuses on the 160 communities in BC that have developed healthy living strategic plans.

Baseline (2011/12)[1]	2014/15 Target	2014/15 Actual	Target Met
13%	35%	48%	Yes

2. *Percent of family physicians participating in the "A GP For Me" full service family practice initiative.* A GP for Me is a program sponsored by the Ministry of Health and Doctors of BC to help support British Columbians who want access to a family doctor.

Baseline (2013)[2]	2014 Target	2014 Actual	Target Met
65% (calendar year)	75%	75%	Yes

3. *The number of people under 75 years with a chronic disease admitted to hospital (per 100,000 people of this age group).* Chronic diseases included in this measure are: Grand mal status and other epileptic convulsions, chronic obstructive pulmonary disease, asthma, diabetes, heart failure and pulmonary edema, hypertension and angina.

Baseline (2010/11)[3]	2014/15 Target	2014/15	Target Met
265	250	278 (partial year data to3rd quarter)	No

As of the first quarter for 2014/15 (December 31, 2014), the target has not been achieved. The reduction in the rate of hospitalizations for these chronic conditions has been much slower than expected. This gap may be due in part to the higher prevalence of chronic diseases in rural areas and the greater challenges for people with chronic diseases in accessing the services that help manage their conditions and prevent hospitalizations. Initiatives in communities across the province provide better care for people with chronic disease so they can remain as healthy as possible without requiring inappropriate acute services. However, these new models of community care have not yet impacted the rate of hospital admissions for chronic conditions as much as anticipated.

[1] https://hlth-sharepoint.gov.bc.ca/PI/MIB/MSRpts/Lists/Schedule/AllMeasures.aspx (Healthy Living)
[2] Data source: Medical Service Plan, Integreted Primary and Community Care Branch, Health Services Policy and Quality Assurance Division, Ministry of Health.
[3] https://hlth-sharepoint.gov.bc.ca/PI/MIB/MSRpts/Lists/Schedule/AllMeasures.aspx (ACSC)

4. *Percent of non-emergency surgeries completed within 26 weeks.* The measure includes all elective adult and pediatric surgeries.

Baseline (2013/14)[4]	2014/15 Target	2014/15 Actual	Target Achievement
90.6%	92%	87.3%	No

Although the 2014/15 target was not met, there has been a focus across the province to serve patients who have been waiting for longer periods for their surgeries. Specifically, in the first three quarters of 2014/15, there were a total number of 21,000 completed surgery cases for those who waited longer than 26 weeks; representing an increase of 23% from the same period last year.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Heather Davidson, Health Sector Planning and Innovation Division; May 5, 2015

[4] Baseline is for surgeries completed from April 1, 2012 to March 31, 2013. Target per cents are for surgeries completed in the fiscal year. Data source: Surgical Wait Times Production (SWTP), December 2014 (Site 127).

FACT SHEET

2014/15 – 2016/17 Service Plan Measures and Performance Results
Provincial Health Services Authority

ISSUE

Outlining the Provincial Health Services Authority (PHSA) service plan measures and targets for fiscal year 2014/15, and whether the targets were achieved based on partial year data (the first three quarters of 2014/15).

KEY FACTS

1. *Cancer Screening* - The percent of women aged 50 to 69 years participating in screening mammography once every 2 years.

Baseline (2013/14)	2014/15 Target	2014/15Actual	Target Met
51.4% (BC rate)	53.5%	52.5%	No

Data Source: Mammography: Screening Mammography Program of BC, Provincial Health Services Authority.
Data Note: This is measured within a rolling 30-month time frame to allow for appointments delayed past the two year period. Women are counted only once in each period regardless of how many mammograms they have.

In the last five years, the mammography participation rate has declined slightly as public debate about the value of screening mammography continues with new articles published on both sides of the debate. The international perspective on screening has moved towards supporting patient's informed decision-making about screening, with an emphasis on education of the benefits and harms. PHSA will continue to maintain easy access to screening services, and provide updated policy information to primary care providers and to women through ongoing recall reminders.

2. *Independent Dialysis* - Percent of dialysis patients on independent dialysis modalities (peritoneal dialysis and home haemodialysis).

Baseline (2010/11)	2014/15 Target	2014/15 Actual	Target Met
31%	33%	32.4%	No

Data Source: BC Renal Agency, Provincial Health Services Authority.

3. *Child and youth inpatient mental health services*– Percent of children admitted to an inpatient psychiatric unit bed within 42 days.

Baseline (2010/11)	2014/15 Target	2014/15Actual	Target Met
49%	70%	100% (up to December 31, 2014)	Yes

Data Source: Child and Youth Mental Health Database, Provincial Health Services Authority.

4. *Complex Paediatric Surgeries* – Percent of complex non-emergency paediatric hip surgeries completed within established benchmark time frame.

Baseline (2010/11)	2014/15 Target	2014/15 Actual	Target Met
42%	60%	87.5%	Yes

Data Source: BC Children's Hospital Database, Provincial Health Services Authority.

FACT SHEET

5. *Access to Maternity Care – Percentage of patients in active labour admitted within 45 minutes.*

Baseline (2013/14)	2014/15 Target	2014/15 Actual	Target Met
26%	35%	26.5% (up to December 31, 2014/15)	No

Data Source: BC Women's Hospital and Health Centre Database, Provincial Health Services Authority.

6. *Nursing overtime – Nursing overtime hours as a percent of productive nursing hours.*

Baseline (2010)	2014/15 Target	2014 Actual	Target Met
2.24% (calendar year)	*Maintain at or below 3.3%*	2.8%	Yes

Data Source: Ministry of Health. Based on calendar year. Health Sector Compensation Information System (HSCIS). Health Employers Association of British Columbia (HEABC).

FINANCIAL IMPLICATIONS

N/A

Approved by:

Heather Davidson, Health Sector Planning and Innovation Division; May 7, 2015

FACT SHEET

2014/15 – 2016/17 Service Plan Measures – Regional Health Authorities

ISSUE

Outlining the five health authority service plan measures and targets for fiscal year 2014/15, and the performance status for each health authority. The targets established and actuals achieved for 2014/15 are below; however, only partial year data are available for the measures and one measure does not have 2014/15 data yet.

KEY FACTS

1. *Proportion of communities that have completed healthy living strategic plans* - "Communities" includes cities, districts, municipalities, towns, townships, and villages.

Baseline (2011/12)	2014/15 Targets	2014/15 Actual	Target Met
IHA: 0%	IHA: 31%	IHA: 42%	Yes
FHA: 40%	FHA: 40%	FHA: 80%	Yes
VCHA:23%	VCHA:36%	VCHA:29%	No
VIHA :14%	VIHA:36%	VIHA:31%	No
NHA: 15%	NHA: 38%	NHA: 47% (up to December 31, 2014)	Yes

2. The *number of people with a chronic disease admitted to hospital per 100,000 people aged less than 75 years (ACSC admissions rate)* - "Chronic disease" includes chronic conditions such as Asthma, Chronic Obstructive Pulmonary Disease, Epilepsy, Heart failure and Pulmonary Edema, Angina Hypertension, Heart Disease and Diabetes.

Baseline (2009/10)	2014/15 Targets	2014/15 Actual	Target Met
IHA: 329	IHA: 275	IHA: 361	No
FHA: 234	FHA: 234	FHA: 245	No
VCHA:184	VCHA: 185	VCHA: 184	Yes
VIHA: 235	VIHA: 223	VIHA: 255	No
NHA: 460	NHA: 443	NHA: 410 (up to June 30, 2014)*	Yes

*Annual data not yet available. These are one quarter' data only and may not represent the annual result.

3. *Rate of people aged 75+ receiving long-term home health care and support, per 1,000 people* – This performance measure tracks the rate of seniors (aged 75+ years) who receive long term home health care services such as case management, personal care, assisted living and adult day services.

Baseline (2013/14)	2014/15 Targets	2014/15 Actual	Target Met
IHA: 115	IHA: 115	YTD results are not yet available.	Not available.
FHA: 77	FHA: 79		
VCHA: 91	VCHA: 93		
VIHA: 77	VIHA: 79		
NHA: 87	NHA: 90		

Data source: P.E.O.P.L.E. 2013 population estimates, BC Stats; Home and Community Care Minimum Reporting Requirements (HCCMRR) Data Warehouse, Business Analytics Strategies and Operations Branch, Health Sector Planning & Innovation Division, Ministry of Health.

4. *Percent of non-emergency surgeries completed within 26 weeks* – This performance measure tracks the proportion of non-emergency surgeries completed within 26 weeks, although many surgeries are completed in a much shorter time frame.

FACT SHEET

Baseline (2013/14)	2014/15 Targets	2014/15 Actual	Target Met
IHA: 88% FHA: 89% VCHA: 93% VIHA: 87% NHA: 93%	IHA: 91% FHA: 92% VCHA:93% VIHA:90% NHA: 93%	IHA:87.3% FHA:87.5% VCHA:91% VIHA:80.6% NHA: 93.4% (up to December 31, 2014)	No No No No Yes

Data source: Data source: Surgical Wait Times Production (SWTP), December 2014 (Site 127).

5. *Nursing overtime hours as a percent of productive nursing hours* – overtime is a key indicator of the overall health of a workplace.

Baseline (2010)*	2014 Targets	2014 Actual	Target Met
IHA: 3.0% FHA: 3.8% VCHA: 4.0% VIHA: 3.5% NHA: 4.9% (2010 calendar year)	IHA: <= 3.3% FHA: <= 3.3% VCHA: <=3.3% VIHA: <=3.0% NHA: <=4.0%	IHA: 3.5% FHA: 3.5% VCHA: 3.5% VIHA: 3.6% NHA: 5.3% (up to September 30, 2014)	No No No No No

Data source: Health Sector Compensation Information System (HSCIS), Health Employers Association of British Columbia (HEABC), January 15, 2015.

* Notes: 1. Measure is based on calendar year.
2. VCHA includes Providence HC.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Heather Davidson, Health Sector Planning and Innovation Division; March 5, 2015

FACT SHEET

Minister's Mandate Letter

ISSUE

Each year, the Minister of Health receives strategic direction from the Premier through the Minister's Mandate Letter. The Minister is accountable for achieving the priority actions contained in his Mandate Letter. The Ministry of Health tracks progress in achieving Mandate Letter initiatives on a quarterly basis.

KEY FACTS

#	Mandate Letter Initiative	Notes	Current Status[1]
1	Balance your ministerial budget in order to control spending and ensure an overall balanced budget for the province of BC.	• Budget management underway.	■On Track
2	Ensure services are delivered within health authority budgets.	• All health authorities have submitted balanced budget plans for 2014/15-2016/17.	■On Track
3	Continue our government's change and innovation agenda within the health care sector.	• The Innovation and Change Agenda has been incorporated into the health sector strategy (*Setting Priorities for the B.C. Health System*).	■On Track
4	Ensure full implementation of provincial mental health plan, *Healthy Minds, Healthy People* including the new investments announced last year that focus on improving services in the Lower Mainland.	s.17	■On Track
5	Finalize the St. Paul's and Royal Columbian Hospital revitalization plans.	• The Royal Columbian Hospital phase 1 business plan is complete. • The St. Paul's Hospital redevelopment concept plan is complete.	■On Track
6	Successfully conclude labour negotiations within the health sector for the 2014 round of collective bargaining within the Economic Stability mandate.	• A new Physician Master Agreement was ratified in December 2014. • Settlements have been achieved at the Health Sciences, Facilities, and Professional Residents of BC tables. • Negotiations with the Nurses Bargaining Association underway.	■On Track
7	Implement the changes contemplated in the *Laboratory Services Act* that was passed by the Legislature in the Spring 2014 legislative session.	s.12	■On Track
8	Create and implement addiction space expansion that includes a significant role for the non-profit sector in the delivery of these new spaces by 2017 as committed in Strong Economy, Secure Tomorrow.	• Phase 1 of the addiction space expansion plan is complete. • Development of Phase 2 and 3 plans is underway.	■On Track

[1] Status current as of May 6, 2015

FACT SHEET

#	Mandate Letter Initiative	Notes	Current Status[1]
9	Work with Treasury Board and the Ministry of Finance to develop a plan for hospice plan expansion and begin process of doubling the number of hospice spaces in BC by 2020.	• Analysis and planning work are underway.	■On Track
10	Publicly report on the status of the GP4ME program in preparation for the commitment to ensure every British Columbian who wants a GP has access to one.	• Regional public announcements by Divisions of Family Practice implementing patient attachment plans are ongoing. • Internal reporting activities are ongoing.	■On Track
11	Work with other provincial Ministers of Health to change the Canada Health and Social Transfer to become age adjusted in order to account for increased health care costs for BCns over the age of 65.	• The Council of the Federation has developed an options paper. s.16,s.17	■On Track
12	Work with the federal government to regulate the sale of e-cigarettes and flavoured tobacco to minors in BC or in the absence of a federal strategy, move to introduce legislation.	• The federal government has announced regulatory amendments to restrict flavoured tobacco. • The *Tobacco Control Amendment Act* was introduced to regulate the sale of e-cigarettes to minors in BC.	■On Track

FINANCIAL IMPLICATIONS

N/A

Approved by:

Heather Davidson, Health Sector Planning and Innovation Division; April 7, 2015

FACT SHEET

Michael Smith Foundation for Health Research

ISSUE

The Michael Smith Foundation for Health Research is the province's health research funding organization. As part of a greater emphasis on the needs of the healthcare system, the Foundation has been working closely with the Ministry of Health on a number of initiatives to support the health sector.

KEY FACTS

- The Government recognizes the important role played by the Foundation to attract researchers, support shared services among research institutions and contribute to improved health services and innovation in BC.
- In October 2008, government approved a revised mandate for the Foundation to continue to attract and retain highly qualified researchers, produce economic benefits for the province and more explicitly respond to healthcare system priorities. It also approved, in principle, a commitment to annual funding to support Foundation activities.

Background

- In March 2001, the Government of BC established the Foundation with a provincial mandate to help build BC's capacity for excellence in health services, population health, clinical and biomedical research.
- Since 2001, largely as a consequence of the Foundation's efforts, BC's share of research funds from the Canadian Institutes of Health Research (the main source of federal funding in this area) has grown more rapidly than that of any other jurisdiction: from 8.97% of the national total in 2001 to 14.35% in 2012[1].
- Heather Davidson, Assistant Deputy Minister, Health Sector Planning and Innovation Division sits on the Foundation Board of Directors as the government voting representative.
- The Foundation has funded 70 awards for teams, including research units, technology-methodology platforms, team development and team start-up, 19 awards for institutions, networks and shared networks and has funded more than 1,550 scholar and trainee awards[2].
- The Foundation has a strong focus on development of common resources for research across institutions and disciplines, and provides incentives for shared governance and use of resources. For example, there are currently 2 funded "shared services" resources ("platforms") that allow health researchers to share important data, expertise, and discoveries: PopData BC and BC Proteomics Network.
- While the majority of researchers and research funded by the Foundation in the lower mainland, there is health research and a range of researchers supported by the Foundation on Vancouver Island, in the Interior and Northern BC.
- The Foundation, working with the Ministry, began in 2012/13 to consult with relevant government partners, the health sector and the health research community to develop a provincial health research strategy. *Directions for Health Research in BC* is the culmination of extensive consultation and represents a positive convergence of support and agreement across a large, diverse and often highly competitive community of researchers.

[1] Data accessed from the CIHR website in December 2013.(http://webapps.cihr-irsc.gc.ca/funding/Search?p_language=E&p_version=CIHR). Analysis done by MSFHR

[2] Updated information email from Penny Cooper, Director, Impact Analysis, MSFHR, February 3, 2015

FACT SHEET

- At the request of the Ministry, the Foundation facilitated the development of BC's application submitted to the Canadian Institutes of Health Research for a Strategy for Patient-Oriented Reseach SUPPORT Unit.

FINANCIAL IMPLICATIONS
s.13,s.17

Approved by:
Heather Davidson, Health Sector Planning and Innovation Division; February 11, 2015
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services; March 20, 2015

FACT SHEET

Ministry of Health and Health Authority Planning

ISSUE

The Ministry of Health undertakes planning and reporting activities to establish clear direction and strategic objectives for the health system, and to ensure alignment with government priorities. These activities guide the Ministry and health authorities in making decisions to improve service delivery, achieve optimal health outcomes, and use resources in a way that promotes efficiency and accountability.

KEY FACTS

- The health system strategy, *Setting Priorities for the B.C. Health System*, sets out key principles and strategies to optimize service delivery and best use health system capacity to meet the population's health needs.
- Ministry service plan and annual service plan report ensures transparency and accountability to the public, as required under the *Budget Transparency and Accountability Act*, and in accordance with the *Taxpayer Accountability Principles*. The service plan is published each February in conjunction with the budget, while the annual service plan report is published in summer, coinciding with the release of Public Accounts.
- The Health Authority Mandate Letter is new for 2015/16 and articulates high level direction for the fiscal year that forms the basis for strategic priority setting within each health authority. The Health Authority Mandate Letter replaces the Government Letter of Expectation from previous years.
- The Health Authority Planning Directions are new for 2015/16 and form a foundational governance document between the Ministry and health authorities on their respective roles, strategic priorities, accountabilities, and deliverables. The planning directions align with the direction from the *Taxpayer Accountability Principles* and include information, expectations and deadlines regarding the following requirements:
    - Health Authority Service Plans: Service plans ensure transparency and accountability to the public by outlining goals, objectives and strategies for the year.
    - Detailed Service, Operational and Budget Plans (DSOBPs): DSOBPs expand on service plan objectives and strategies, including information on services to achieve population and patient health outcomes. DSOBPs detail the continuation and expansion of current activities, including targeted efforts to improve service delivery in priority areas.
    - Health Authority Annual Service Plan Reports: Service plan reports compare health authority performance results with the targets outlined in the service plan for a given fiscal year. These documents are a new reporting requirement.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Heather Davidson, Health Sector Planning and Innovation Division; April 7, 2015

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Withheld pursuant to/removed as

s.17

FACT SHEET

Strategy for Patient-Oriented Research

ISSUE

BC has submitted its business plan for the Strategy for Patient Oriented Research (SPOR) SUPPORT Unit to be co-funded by the Canadian Institutes for Health Research (CIHR) and the BC Ministry of Health to support health sector priorities.

KEY FACTS

- Patient-oriented research, as defined by CIHR, is the cornerstone of evidence-informed healthcare and refers to a continuum of research, from initial studies in humans to comparative effectiveness and outcomes research, and the integration of this research into the healthcare system and clinical practice.
- CIHR's vision of SPOR is to demonstrably improve health outcomes and enhance patients' healthcare experience through integration of evidence at all levels of the healthcare system. This presents an opportunity to make health research more responsive to system priorities focused on improved patient outcomes; the goal is to rebalance the dominant paradigm for determining health research priorities (currently, largely set by the health research community) so that these are based more on patients' needs.
- The Michael Smith Foundation for Health Research (MSFHR), the province's health research funding organization, co-facilitated, with the Ministry of Health, the development of BC's CIHR Strategy For Patient-Oriented Research (SPOR) SUPPORT Unit business plan.
- A delegation from BC met with CIHR's international peer review panel on January 29, 2015 to present BC's SPOR SUPPORT Unit business plan and to answer questions about it. Further discussions between the Ministry and CIHR will occur over Winter 2015 as part of CIHR's approval process.
- One of the key components of SPOR is the development of research centres referred to as SUPPORT Units; these units are meant to stimulate, facilitate, support, and enhance patient-oriented research in the jurisdictions they serve.
- The process is non-competitive; CIHR has worked with each jurisdiction, including BC, to refine and optimize the jurisdiction's proposal for its SUPPORT Unit.
- BC SPOR SUPPORT unit core functions, validated by Leadership Council will focus on:
  1. Data platforms and services *(Note: the data platform work is being closely linked to the inter-ministry work now underway, exploring options for a centre on data innovation.)*
  2. Real-world clinical trials
  3. Health systems, knowledge translation, and implementation.
  4. Cross-cutting Services:
     - Methods support and development
     - Consultation and research services
     - Training and career development)
- An Interim Governing Council (IGC), reporting to the Deputy Minister of Health, oversaw and approved the business plan. This Council had representation from all health authorities, research-intensive universities, government and patient representatives.
- The business plan development team who contributed directly to the development of the BC's SPOR SUPPORT Unit plan is made of experts who possess multiple strengths that span the priority areas of the SUPPORT Unit.

FACT SHEET

FINANCIAL IMPLICATIONS

- Treasury Board has approved $10 million over 5 years to support BC's SPOR SUPPORT Unit, of which MSFHR has already received $2 million in March 2014.
- Additionally, the MSFHR Board has approved that $10 million of funding already at the Foundation will go toward the SUPPORT Unit.
- The identification of other partner funding (e.g., repurposing existing service contracts or already planned investments) that may be eligible for CIHR match funding has occurred as part of the Business Plan development.

Approved by:
Heather Davidson, Health Sector Planning and Innovation; February 17, 2015
Daryl Conner obo Manjit Sidhu, Finance and Corporate Services; February 27, 2015

FACT SHEET

Transgender Human Rights Complaints

ISSUE

Nine Human Rights Complaints have been filed against the Province of BC on the grounds of sex. The complainants are seeking the removal of sex from all BC birth certificates

KEY FACTS

- Nine Human Rights Complaints have been filed at the BC Human Rights Tribunal challenging section 36(2) of the *Vital Statistics Act*, which states that among other things, a birth certificate must contain the sex of the person. The complainants' ultimate aim is to have sex removed from all BC birth certificates.
- The complainants allege that "since it is impossible to tell an individual's gender at birth, it is discriminatory to issue a birth certificate with that information on it." The complainants further argue that one's anatomical sex does not necessarily reflect one's gender identity, and having any sex marker on a birth certificate contributes significantly to the difficulties and distress experienced by transgender and other gender variant individuals.
- A Human Rights Settlement meeting is scheduled for August 2015. The Vital Statistics Agency is currently exploring the possible policy options with the Minister.

FINANCIAL IMPLICATIONS

Cost implications are yet to be determined.

Approved by:
Jack Shewchuk, Vital Statistics Agency; May 4, 2015
Heather Davidson, Health Sector Planning and Innovation Division; May 5, 2015
Lindsay Kislock Health Sector IM/IT Division; May 5, 2015

FACT SHEET

Vital Statistics Agency – Victoria Front Counter Closure

ISSUE

The Vital Statistics Agency's front counter services in the Victoria Office will cease effective July 1, 2015.

KEY FACTS

- Service BC opened a new office in Victoria on April 1, 2015; as a result the Vital Statistics Agency is currently seeking approval to discontinue provision of front counter operation in Victoria effective July 1, 2015.
- Service BC has a mandate to deliver multiple front counter services at 59 locations across BC; this includes the provision of application services for the Agency.
- The use of Service BC offices to provide Agency services aligns with the goals of *Citizens @ the Centre: BC Government 2.0* to encourage collaboration in the public service where it is integral to delivering quality service to citizens.
- It is expected there will be no client service impact as the newly opened Service BC office will be assuming basic front counter application services (Tier 1) and the Agency will continue to provide support for more complex service requests (Tier 2).
- The Agency will take the necessary steps to inform their clientele in a timely manner of this service change.

FINANCIAL IMPLICATIONS

N/A

Approved by:
Jack Shewchuk, Vital Statistics, May 4, 2015
Heather Davidson, Health Sector Planning and Innovation; May 5, 2015

FACT SHEET

Alternative Payments Program Overview

ISSUE

The Alternative Payments Program (APP) funds health authorities and other agencies to engage physicians on a service contract, salary or sessional basis in situations where the Fee-For-Service payment modality would be ineffective in attracting and maintaining adequate physician services.

KEY FACTS

- Funding provided to the health authorities and other agencies enables them to procure physician services through service contracts, salary agreements, or sessional arrangements (3.5 hour blocks of time) as per the Physicians Master Agreement. [1]
- Examples of clinical programs funded by APP are emergency rooms, oncology, psychiatry, pediatrics and primary care. [2]
- The approximate distribution of funding across APP funding modalities is 79% contract (for service contracts and salaries) and 21% sessions.[3]
- In a recent review of BC's 10,833 physicians, 3,389 physicians receive all or part of their income through APP funding.[4]
- As at December 12, 2014, APP funds 145 contract commitments[5] and 182,922 sessions[6][7] for physician services.
- APP funding has proven to be effective in stabilizing public access to primary care physician services in rural and remote communities like the Haida Gwaii, Hazelton, Dease Lake, Bella Coola, Bella Bella and other small communities where the normal fee-for-service payment mechanism would be considered inadequate due to small populations or financially too risky for physicians to commit to establish practices in those communities.
- APP funding has also proven to be effective in attracting and retaining highly skilled specialists to enable BC to build provincial centres of excellence such as: BC Cancer Agency, BC Children's Hospital, and BC Transplant.
- The Ministry provides annual APP funding commitment letters to health authorities to assist them with their planning. Within this overall commitment, the Ministry then enters into service specific APP funding agreements with health authorities to further specify service objectives that are aligned with the Government's strategic health care objectives and/or to strengthen value for money.
- Within the commitments of APP funding provided by the Ministry, health authorities then enter into contract, sessional or salaried compensation arrangements for services that have been agreed to with the Ministry. Health authorities must ensure that the arrangements they enter into with physicians are compliant with the Physician Master Agreement negotiated between the Government and the Doctors of BC for compensation of physician services as well as compliant with Ministry policies and directives applicable to APP funding.

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[1] 2012 Physician Master Agreement http://www.health.gov.bc.ca/msp/legislation/pdf/pma-consolidated-amendment-7.pdf

[2] Alternative Payments Program Policy Framework – updated Sept 2013, Chapter 1 Section 5 page 2 of 2. Retrieved on 2013-11-25 from http://www.health.gov.bc.ca/pcb/pdf/app_policy_framework.pdf

[3] Based on the 2014/15 APP Budget. Retrieved on January 12, 2015. Calculations : Z:\APP\APP LAN TEST\Financial Stewardship\APP Budget Book\Budget for Fact Sheets\Fact Sheet Jan 2015 APP Financials.xlsx

[4] Data Source: Physician Counts Summary Fiscal Year 2013/14.

[5] Based on the 2014/15 APP Budget. Retrieved on January 12, 2015. Calculations: \\coral\msp\APP\APP LAN TEST\Financial Stewardship\APP Budget Book\1415 Budget\Fact Sheets backup - Contracts and Contract Funding BreakDown at Dec 12th 2014.xlsx

[6] Based on the 2014/15 APP Sessional Expenditure Plans for December 12, 2014. Retrieved January 12, 2015. Calculations: \\coral\msp\APP\APP LAN TEST\Financial Stewardship\APP Budget Book\1415 Budget\Fact Sheets backup - Sessions and Sessional Funding BreakDown at Dec 12th 2014.xlsx

[7] Numbers change when funding is shifted from one payment modality to another

FACT SHEET

APP Review - 2015/16

The Ministry will be undertaking a full policy and administrative review of APP in 2015/16 to align APP with the Ministry's Health Human Resources Management Strategy and to respond to the Office of the Auditor General's report on Oversight of Physician Services.

FINANCIAL IMPLICATIONS

- The 2014/15 APP contract and sessional budget allocation as at February 3, 2015, was distributed as follows ($ = millions):

PAYMENT MODALITY	Fraser Health	Interior Health	Northern Health	Provincial Health Services	Vancouver Coastal & Providence Health	Island Health	Other Agencies*	Other Funding**	TOTAL
CONTRACT	$25.56	$19.72	$12.14	$134.12	$80.63	$33.92	$9.49	$47.46	$363.04
SESSIONAL	$14.69	$5.10	$5.42	$11.74	$32.78	$10.72	$3.33	$0.00	$83.78
NEW FUNDING	$0.22	$0.00	$0.09	$0.06	$0.45	$0.16	$0.00	$0.00	$0.98
TOTAL	**$40.47**	**$24.82**	**$17.65**	**$145.92**	**$113.86**	**$44.80**	**$12.82**	**47.46**	**$447.80**

*Other includes Nisga'a Valley Health Authority, University of British Columbia, Ministry of Children & Family Development, Ministry of Justice, Community Living BC, and Inspire Health commitments.

** Other Funding represents budget reserved for grid disputes and for additional planned contract-related commitments.[8]

- The APP budget represents approximately 11% of the total Medical Services Plan overall budget for physician services in the province.

Approved by:

Ted Patterson, Health Sector Workforce Division; February 22, 2015

Ted Boomer, obo Manjit Sidhu, Finance and Corporate Services Division; March 30, 2015

[8] Reference: Alternative Payment Program Budget Sheet - APP 2014-15 Budget retrieved on February 3, 2015 from \\Cora\MSP\APP\APP LAN TEST\Financial Stewardship\APP Budget Book\1415 Budget\APP 2014-15 Budget_CURRENT.xlsx

FACT SHEET

Auditor General's Report on Physician Services

ISSUE

An update on progress on the six recommendations in the Auditor General's Report on Physician Services.

KEY FACTS

- The Office of the Auditor General released a Report on Oversight of Physician Services in February 2014.
- The Report was critical of government's oversight of physician services, with the emphasis on concerns that the government was not ensuring that physician services were getting value for money.
- The report focused on fee-for-service and alternative payment modalities and concluded that:
  - Government is not ensuring that physician services are achieving value for money;
  - Government is unable to demonstrate that physician services are high-quality and cannot demonstrate that compensation for physician services is offering the best value; and
  - There are systemic barriers that hamper government's ability to achieve value for money with physician services.

Progress on the Report's six recommendations is as follows:

Recommendation One: Physician Performance Management: Implement a mandatory performance review process for physicians with defined measures and targets and reporting of aggregate results to the Legislature and public.

Progress:

- We are doing some important work through the Provincial Physician Quality Assurance Steering Committee to make improvements in terms of both Quality Assurance and Quality Improvement for physicians.
- We are in the process of implementing a provincial Credentialing and Privileging system that will ensure a consistent, standardized approach to the privileging across Health Authorities (x Reference PQA CAP Fact Sheet).
- Implementation, which includes a provincial set of privileging dictionaries which define standards for various medical procedures, will take place over the next three years.

Recommendation Two: Roles, Responsibilities and Accountabilities: Clarify roles and accountabilities for oversight of physician services and define the relationship and accountability of individual physicians to government for service quality and cost-effectiveness.

Progress:

- Subsequent to our Setting Priorities and Cross Sector Policy Papers, we are actively engaged with the Doctors of BC, health authorities and stakeholders to clarify the performance management accountability framework.
- The framework will be built on public reporting and grounded in a clear understanding of the roles, responsibilities and accountabilities of the various individuals and organizations involved in the delivery of health services.
- We expect to significant progress on this recommendation by the end of this calendar year.

FACT SHEET

Recommendation Three: Compensation Models: Rebuild physician compensation models to align with delivery of high quality, cost-effective physician services.

Progress:

- Again, there is no "perfect" physician compensation model.
- We are undertaking a strategic review of what compensation models appear to work most effectively in the variety of circumstances to in which physicians deliver services. This will act as a guide to ensure that any incremental changes to compensation models will reinforce incentives to deliver high quality, cost effective care.

Recommendation Four: Fee for Service and Alternative Payments As long a current compensation models continue, ensure the Ministry has influence to align funding health system priorities, revise fees and contracts on a regular basis to account for changes in practice and ensure health authorities adhere to negotiated rates and ranges and work together more effectively on contract issues.

Progress:

- A large scale review of the Payment Schedule was determined to be too unwieldy a process to undertake without first establishing an underlying framework to review the Schedule against.
- Efforts have been focused on developing the framework and process that will see components (Sections) of the Payment Schedule reviewed on an ongoing basis. Substantial progress will be made as the framework in Recommendation One is developed.
- A comprehensive review of the Alternative Payments Program is underway.

Recommendation Five: Physician Engagement Improve physician engagement and in particular improve the relationship between physicians and health authority administrators and report on results to physicians.

Progress:

- The Specialist Services Committee, a joint committee of the DoBC and the Ministry under the Physician Master Agreement, is actively consulting with physicians and health authorities to improve physician engagement.
- The work of the General Practice Services Committee on engagement of community physicians also continues.

Recommendation Six: Barriers to Regulation and Oversight Address barriers in the regulatory framework to facilitate collaboration between system partners to enable patient care of the highest quality and cost-effectiveness.

Progress:

- The Physician Assurance Steering Committee conducted a review of the legislative and regulatory framework and identified a number of gaps.
- The Ministry continues to review the findings and develop options for legislative and regulation changes.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Nancy South, Workforce Research & Analysis; May 8, 2015

Ted Patterson, Health Sector Workforce Division; May 8, 2015

FACT SHEET

BC Care Aide and Community Health Worker Registry

ISSUE

Overview and update on the Registry, and Health Care Assistant oversight.

KEY FACTS

- The BC Care Aide and Community Health Worker Registry has been operational since 2010, with a mandate of quality assurance and patient protection for those under the care of Health Care Assistants (HCAs).
- There have been many successes with the Registry model, namely the development and implementation of education recognition processes for HCA programs in BC. However, concerns regarding the Registry's ability to fulfill the patient protection mandate have surfaced from several sources, including the BC Ombudsperson, the BC Seniors Advocate, and an external review that was initiated by the Ministry of Health (the Ministry) and completed in 2013.
- In order to improve HCA oversight in the province, the Ministry is currently engaging stakeholders for the purpose of soliciting input with regards to how best to proceed with oversight for these health care workers. At this time, no one model for HCA oversight has been determined, though discussion will include the possibility of strengthening the existing Registry model or bringing the Registry under the purview of one of the nursing regulatory colleges.

Background

- The Registry was first established in January 2010, as a response to elder abuse incidents that received widespread public attention. It was developed with a mandate to protect vulnerable patients as well as to develop minimum standards of education and skill among health care assistants/aides. Although the Registry is not currently embedded in legislation or regulation, public employers are required to report every suspension or termination for alleged client, patient and/or resident abuse to the Registry. Publicly funded employers listed with the Registry must not employ HCAs who are not active registrants on the Registry. As the first of its kind in Canada, implementation of the Registry was established using a phased in approach. This allowed the process of registering and investigating allegations of abuse to occur while, at the same time, developing other longer term activities requiring significant stakeholder participation (e.g. education assessment processes).
- In June 2012, the Honourable Minister de Jong announced the Ministry's intent to conduct an external review of the Registry's operations in order to ensure the mandate to protect the public was being met. The review was conducted over the Fall and Winter of 2012/13, involving an extensive interview process with roughly 58 stakeholders closely involved with the Registry. The final report was received at the Ministry in February 2013. The report and the response, in form of the *Review of the BC Care Aide and Community Health Worker Registry: An Action Plan*, were publicly released on March 20, 2013, in response to an external review of the Registry model and operations. The Review Report, which was publicly released with the Action Plan, made several recommendations for improvement of the Registry model. The recommendations in the Review Report cover four broad areas for improvement:
  1. The enabling framework – broaden to include privately funded organizations.
  2. Strengthening the governance structure.
  3. Addressing gaps in the protection mandate.
  4. Reviewing the funding model.
- The resulting commitments in the Action Plan covered short, mid, and long term goals for improving the areas identified in the review recommendations. To date, progress on the goals outlined in the Action Plan includes:

- An assessment of private health care organizations that employ HCAs was completed in Spring 2014. The final report includes information on the number and type of private employers, the feasibility of mandating private employer participation, and potential mechanisms for a mandate.
- The feasibility of moving the criminal records check process to the Registry has been assessed. It was determined that in order for the Registry to conduct criminal record checks, legislation including the *Health Professions Act* and *Criminal Records Check Act* would require changes, and a new *Registry Act* would be needed. Therefore, at this time, the criminal record check process will remain the responsibility of the employer as determined by existing legislation.
- A Ministry representative was added to the Registry Advisory Committee. This will enable better lines of communication between the Ministry and Registry stakeholders. A dialogue on strengthinging the governance structure is part of the committee's upcoming work.
- Written procedural standards for Registry appointed investigators have been drafted, and are nearly finalized. These standards will be shared with employers and unions at the onset of an investigation, helping to create more consistency and transparency for investigative processes and costs.
- Implementation of the educational recognition processes for academic institutions and individuals without a BC HCA program certificate is currently underway. The educational processes comprise a critical component of the Registry's quality assurance and protection mandate by ensuring that registered HCAs possess the knowledge and skills to provide proper care. Due to the complexities involved, implementation of the educational processes will be phased, and full implementation will likely continue into 2015.

- In addition to the work taking place directly with the Registry, cyclical reviews of the HCA provincial competencies and curriculum are nearly complete. The review focused on the evolving role of HCAs, including their growing presence in acute settings, as well as an increased focus on Aboriginal health, dementia care, communication skills and abuse reduction. The revised 2015 curriculum will be released in Spring 2015.
- Since the Registry become operational in early 2010, investigation statistics include 351 reported cases of alleged abuse (164 suspensions, 187 terminations); of the 187 terminations, 98 cases went to the investigation process, 72 individuals were removed from the Registry uncontested, and 17 were reinstated to the Registry by the employer; of the 98 Registry investigations, 19 individuals were removed from the Registry, 49 individuals were reinstated to the Registry upon meeting conditions for additional education, 28 individuals were reregistered after allegations were determined to be unfounded, and 2 investigations are ongoing.

FINANCIAL IMPLICATIONS

The 2014/15 total budget for the Registry operations and development was $550,000.[1] Preliminary budget projections for 2015/16 indicate a total cost of $600,000. A more sustainable funding model was one of the recommendations that resulted from the Registry review; this one of many considerations that will factor into the decision on how best to improve the oversight model for HCAs in BC.

Approved by:

Kevin Brown, Workforce Planning & Management Branch; March 12, 2015.
Ted Patterson, Health Sector Workforce Division; April 1, 2015
Ted Boomer obo Manjit Sidhu, Finance and Corporate Services Division; April 9, 2015

[1] Budget totals can be found on Ministry of Health contract #2014-101.

FACT SHEET

BC Medical School Expansion

ISSUE

BC expanded and distributed the University of BC (UBC) undergraduate and postgraduate medical programs to educate more doctors across the province to better meet the health care needs of British Columbians.

KEY FACTS

BC's goal of distributing medical education throughout the province is to prepare future doctors for the challenges and benefits of medical practice in a variety of communities, including rural, remote, Northern and other underserved communities and to encourage physician trainees to consider practicing in these communities upon completion of training. BC is already experiencing early gains and positive trends in terms of physician numbers and practice locations across the province, and is seen as a best practice jurisdiction in regards to distributed medical education.

Undergraduate Training Spaces

In 2002/03, BC's annual intake of medical students was 128. The expansion and distribution of medical education doubled the number of first-year students to 256 in September 2007,[1] for a potential of 256 Canadian graduating medical students each year by 2011/12. The opening of the Southern Medical Program added a further 32 for a total of 288 Canadian graduating medical students each year by 2014/15.[2]

Postgraduate Residency Positions

- The Ministry of Health expanded postgraduate medical education (PGME, or residency) to keep pace with undergraduate program growth. A graduating medical student (physician) must complete a residency to be licensed for independent practice.
- In 2003, the Ministry funded 134 entry-level residency positions: 128 for Canadian medical graduates; 6 for International Medical Graduates (IMGs)[3].
- In 2013/14, the Ministry funded 330 entry level residency positions: 288 for Canadian medical graduates; 42 for IMGs – or a total resident population of 1200 (all Canadian medical graduates and IMGs in Family Medicine and specialties in years 1 through 7).[4]
- In 2014/15, the Ministry funded 338 entry-level residency positions: 288 for Canadian medical graduates; 50 for IMGs – or a total resident population of 1247 (all Canadian medical graduates and IMGs in Family Medicine and specialties in years 1 through 7)[5]
- In 2015/16, the Ministry expects to fund 346 entry-level residency positions: 288 for Canadian medical graduates; 58 for IMGs.[6]

Distributed Campuses

In 2004, university academic campuses for undergraduate medical education opened at Northern Health Sciences Centre (University of Northern BC), Medical Sciences Building (University of Victoria), and Life Sciences Centre (UBC). In January 2012, the Health Sciences Centre (UBC Okanagan) opened. Currently, there are 11 clinical academic campuses throughout the province's health authorities:

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[1] Office of the Premier. (2010). *News Release: UBC Clinical Teaching Facility Opens at KGH.* 2010 PREM0015-000073. Retrieved on January 27, 2014 from http://www2.news.gov.bc.ca/news_releases_2009-2013/2010PREM0015-000073.htm

[2] Ibid.

[3] Public Affairs Bureau, News Release 2005HEALTH0039-001058 November 18, 2005

[4] Funding Letter for Postgraduate Medical Education 2013/14 from Ted Patterson, ADM to Dr Gavin Stuart, Dean, Faculty of Medicine, University of BC, December 4, 2013 (draft). (Cliff #999405)

[5] Funding Letter for Postgraduate Medical Education 2014/2015 from Kevin Brown, Executive Director to Dr. Gavin Stuart, Dean, Faculty of Medicine, University of BC, December 5, 2015. (Cliff #1024561)

[6] International Medical Graduate Program (IMG-BC) Challenges Facing Canadians Studying Abroad, Briefing Document Prepared by the Ministry of Health, Ministry of Advanced Education, and UBC's Faculty of Medicine, December 2011, p.4

FACT SHEET

- Fraser Health - Royal Columbian Hospital/Surrey Memorial Hospital
- Interior Health - Kelowna General Hospital
- Northern Health - University Hospital of Northern BC (UHNBC)
- Provincial Health Services - BC Children's Hospital/BC Women's Hospital & Health Centre/BC Cancer Agency
- Vancouver Coastal Health - St Paul's Hospital/Vancouver General Hospital and related facilities
- Island Health - Royal Jubilee Hospital/Victoria General Hospital

FINANCIAL IMPLICATIONS

- Since 2007, the Ministry has allocated a total of $119.0 million to upgrade and expand UBC's clinical academic space as follows:
  - March 2007: $49.4 million – $34.5 million for new or renovated teaching space in clinical academic campuses and related facilities, and a further $14.9 million for an audiovisual information technology (AVIT) infrastructure. This investment allows faculty members to conduct classes with undergraduate medical students and postgraduate residents from any of the locations noted above and links virtual learning with the classroom setting.
  - May 2007: an estimated $22 million for clinical-academic space at Kelowna General Hospital.
  - February 2009: an estimated $16 million for clinical-academic space at Surrey Memorial Hospital, to be included in the new Critical Care Tower.
  - August 2010: an estimated $9 million for clinical academic space to be included in the BC Children's and Women's Hospital Redevelopment project.
  - April 2011: an estimated $1.6 million for clinical academic space to be included in the Hope Centre at Lions Gate Hospital.
  - March 2013: an estimated $10 million for a Learning and Development Centre at UHNBC to complete the space requirements for the clinical academic campus.
  - April 2013: an estimated $1.8 million for clinical academic space at Royal Inland Hospital in Kamloops to be included in the Clinical Services Building.
  - May 2014: an estimated $8.3 million for clinical academic space for the North Island Hospital Project (includes both the Campbell River and Comox Valley Hospitals).
  - January 2015: $0.9 million for clinical academic space at Vernon Jubilee Hospital.
- The Ministry program operating funding for PGME in 2014/15 is $123.1 million (includes IMG funding, Health Canada's contribution of $718,554 and $2.0 million reduction in residents' benefits). The operating funding for PGME in 2015/16 is estimated at $128.8 million.[7]
- Program operating funding for the *IMG-BC Program* and IMG residency positions in Family Practice and specialties is $12.3 million in 2014/15, including a $718,554 Health Canada contribution.[8] The operating funding for IMG in 2015/16 is estimated at $14.0 million.[9]

Approved by:

Kevin Brown, Workforce Planning & Management; February 19, 2015
Ted Patterson, Health Sector Workforce Division; April 1, 2015
Ted Boomer, obo Manjit Sidhu, Finance and Corporate Services Division; April 9, 2015
Shelley Moen, obo Manjit Sidhu, Finance and Corporate Services Division; May 5, 2015

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[7] Funding Letter for Postgraduate Medical Education 2014/2015 from Kevin Brown, Executive Director to Dr. Gavin Stuart, Dean, Faculty of Medicine, University of BC, December 5, 2015, Appendix 1. (Cliff #1024561)
[8] Budget Request 11/12. G:\Mgmt Team\BOOMER Ted\13-14\10 11 PGME 1 to 1 expanded to 21-22-growth for only 11-12 new rates June 14-13.xlsBEV IMG numbers
9 Ibid.

FACT SHEET

Dermatology Services in BC

ISSUE

An overview of challenges with respect to access to dermatology services in some regions in BC.

KEY FACTS

- Dermatology is the branch of medicine concerned with the study and clinical management of the skin, its appendages and visible mucous membranes, both in health and disease.[1] Dermatology is a specialty of the Royal College of Physicians & Surgeons of Canada and requires a five year residency program following graduation from undergaduate medical school.
- Media reports, advocacy by the Section Head of Dermatology at the Doctors of BC, and a letter writing campaign from the dermatologist community in the province, have focused on fee differentials between dermatologists and other specialty groups in BC and dermatologists in other provinces, and on expanding the number of dermatology residents in the University of BC (UBC) medical residency program. Other concerns include heavy workloads for dermatologists and wait lists for patients.
- Over the last five years, the number of practicing dermatologists in BC has remained fairly stable around 63, with the majority practicing in the Lower Mainland.[2]
- In 2013/14, full time dermatologists billed an average of $516,575 to Medical Services Plan. The highest billing dermatologist in BC billed over $1.3 million in 2013/14.[3]
- Among Canadian provinces, BC was 8 out of 9 provinces with information available for average fee for service dollars per fulltime equivalent (FFS-FTE) at $396,847 in the latest year available, 2012/13.[4] In the same year, BC was last in average fees for dermatology ($39.09) and for consultation fees ($47.87).[5]
- Dermatologists have not fared as well as other physician groups in BC in terms of negotiated fee increases over the past decade. Since 2000/01, fees increased on average for BC physicians by 26.9%, but only 21.6% for dermatologists.[6] These challenges with respect to fee increases are the result of an internal BCMA Tariff Committee process for allocation of funds to the various medical specialty groups.
- Basic Consultation fees for the section of Dermatology are currently set at $63.60, which is lower than the average amount billed across the different sections in BC for a similar basic consult fee ($135).
- In 2013, dermatologists were awarded a "recruitment and retention" increase of $1 million funded out of the $20 million specialist recruitment and retention fund negotiated under the 2012 Physician Master Agreement.[7]
- More recently, the Ministry allocated an additional $55 million towards the current Physician Master Agreement to help address funding disparities between medical specialties. This funding is to be allocated across all specialist groups. The amount going specifically to dermatology has not yet been determined.

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[1] Objectives of Training in Dermatology, Royal College of Physicians and Surgeons of Canada, 2009 (Reviewed 2012) www.royalcollege.ca/cs/groups/public/documents/document/y2vk/mdaw/~edisp/tztest3rcpsced000892.pdf

[2] Master files based on MSP Fee-For-Service Database for the last 5 years paid to Sept 30th of each year, Workforce Research & Analysis Branch, November 7, 2013

[3] Master files based on MSP Fee-For-Service Database for the last 5 years paid to September 30th of each year, Workforce Research & Analysis Branch, 2015

[4] National Physician database, CIHI, Table A.6.1, p 33, Released 2014 https://secure.cihi.ca/estore/productSeries.htm?pc=PCC476

[5] Physician Services Benefits Rates Report, CIHI, Table 1-11, p 33, Released 2014 https://secure.cihi.ca/free_products/PSBR-2011_2012_EN.pdf

[6] Nancy South, Workforce Research & Analysis Branch, Health Sector Workforce Division 2014

[7] Award of Eric J Harris Q.C. RE: 2012 Specialists Recruitment and Retention Fund Arbitration, May 8, 2013

- As of late February 2015, Health Match BC is expected to have approximately 25 postings for permanent dermatologists within their geographical regions: Fraser (11); Interior (5); Vancouver Island (6); Northern Health (2); and, Vancouver Coastal (1).[8]
- Some family physicians in BC have taken additional dermatology training abroad and are providing low acuity dermatology services.
- The Ministry works closely with the UBC Faculty of Medicine (FoM) to address dermatology supply issues through Postgraduate Medical Education (PGME) residency training:
  - Each year entry-level PGME residency training seats are determined by the Residency Allocation Subcommittee, comprised of representatives from the Ministry, UBC Faculty of Medicine and Health Authorities.
  - The number of seats allocated for each medical specialty is based on health human resource needs of the province, balanced within financial limitations. Expansion of dermatology and all other PGME resident training programs must also be carefully coordinated to ensure limited teaching resources are not overwhelmed, national accreditation standards are met, and that both clinical training quality and patient safety are maintained.
  - The number of Ministry funded entry-level PGME residency training seats for dermatology has expanded from one to three seats, and currently there are 15 dermatology residents in years one through five in the UBC Dermatology Residency Program.[9]
- The Dermatology Program Director at UBC FoM has stated that the lack of availability of supervisory capacity for residency training consequently limits the ability of UBC to quickly expand the number of dermatology residency seats in a manner consistent with the strict national accreditation standards of the Residency Program.
- The Residency Allocation Subcommittee encourages an active dialogue between the UBC Dermatology Residency Program and the Dermatology community in BC to explore the possibility of innovative residency training models which could provide capacity to provide additional residency training positions.
- It remains a challenge to encourage physicians to locate in communities of need, and for dermatologists to provide publicly funded services.
- Through a joint initiative of the Doctors of BC and the Ministry, a provincial Teledermatology program has been established. This is an excellent example of how the use of digital technology can significantly improve access to dermatological consults in urban, remote, and isolated communities in BC.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Nancy South, Workforce Research & Analysis Branch; May 8, 2015

Ted Patterson, Health Sector Workforce Division; May 8, 2015

[8] As at February 23, some health authorities are in the process of reviewing and validating vacancies advertised on the Health Match BC website to ensure they are legitimate vacancies.

[9] Personal communication with Lois Moen, UBC Faculty of Medicine, February, 2015

FACT SHEET

Health Human Resources Strategy

ISSUE

Development of a BC Health Human Resources Strategy.

KEY FACTS

- The Ministry of Health recognizes that, given our aging demographics and evolving health needs, the traditional acute care approach to delivering health care is not sustainable, both from a financial perspective and a patient-centered perspective.
- Research shows that the majority of the aging patient population, living with chronic comorbidities, wish to remain in their home, as compared to being treated in hospital.
- To support this significant shift in health service delivery (from hospital to community care), a provincial Strategy for Health Human Resources (HHR) has been drafted as a key enabling framework to produce an *engaged, skilled, well-led and healthy workforce* that can provide the best patient-centered care for British Columbians.
- To meet this vision, the strategy (currently out for consultation with external stakeholders) has identified a number of policy inputs at the three different levels of the health care system:
    - Practice Level (Micro)
        - HHR deployment focused on appropriate staff mix and skill management.
        - Optimize scopes of practice.
        - Provide inter-professional training to promote a team-based, collaborative culture.
        - Building motivation and engagement through effective change management leadership.
    - Organizational Level (Meso)
        - Systematic and holistic recruitment and retention of health care practices.
        - Improved disability management for health care practitioners.
        - Strengthen transition from education to practice for all health disciplines.
        - Streamline assessment and licensure of internationally educated physicians and nurses.
        - Build change leadership management and capacity within the health system through existing and new approaches to training and staff development.
        - Improve efforts to support a safe and health workplace culture through strengthened occupational health and safety and disability management approaches.
        - Leverage technology to support new models of care.
    - Provincial Level (Macro)
        - Ensure education programs and continuing professional development meets the needs of health care practitioners as well as the overall health system.
        - Streamline the structure of bargaining associations and labour negotiations to support health system change.
        - Develop a provincial integrated HHR planning model to improve forecasting capacity of future HHR needs.
        - Convene a new Standing Committee on HHR to drive this overall agenda forward.
- The strategy also identifies a number of key actions to address these policy inputs:
    - The Ministry, in collaboration with stakeholders, will establish a provincial HHR Framework.
    - Leadership Council will establish a Standing Committee on Health Human Resources (SCHHR) as BC's senior level HHR governance structure.
    - By September 2015, health authorities will complete an organizational change management assessment of their organization's current capacity.

- By September 2015, health authorities will complete an HHR management assessment (including physicians) of current capacity.
- The Ministry and Health Employers Association of BC will develop a new integrated HHR tool to improve HHR planning.
- By September 2015, the Ministries of Health and Advanced Education (AVED) will undertake an inventory of existing public and private post-secondary education and training programs, including clinical placement capacity.
- The Ministry and AVED will ensure curriculum for health care workers supports patient-centered, culturally sensitive and inter-professional cultures.
- Health authorities and stakeholders will form a task force to improve transition (from education) to practice for all new practitioners, including those from other countries.
- SCHHR will lead development of a leadership and management development framework for both senior management and senior executive management in the BC health system.
- SCHHR in collaboration with the Doctors of BC and health unions will implement an inter-professional, multilevel engagement strategy that builds from existing agreements and processes to support creation of inclusive, vibrant and health workplaces across the health sector.
- Health authorities will adopt the National Standard of Canada for Psychological health and Safety in the Workplace.
- Implementation of BC's Health Human Resources Strategy will ultimately enable accelerated progress toward transforming BC's health care system.

FINANCIAL IMPLICATIONS

To be determined.

Approved by:

Kevin Brown, Workforce Planning and Management; May 1, 2015

Ted Patterson; Health Sector Workforce Division; May 4, 2015

FACT SHEET

Health Sector Workforce Education and Training Spaces

ISSUE

The Ministry of Health works with the Ministry of Advanced Education (AVED) to ensure health education program delivery aligns with current and future health system needs. New education seats are distributed regionally based on identified needs, student demand, institutional ability to accommodate new seats, clinical placement capacity and AVED budget allocations. Any changes (including expansion, revision and distribution) are considered with respect to these principles and stakeholder input (e.g., health authority Chief Nursing Officers, Health Human Resources Strategy Council, postsecondary institutions, etc.). Between 2001/02 and 2014/15, AVED has added over 8,700 spaces in health and medical programs.[1]

KEY FACTS

Medical - The responsibility of funding medical education is shared between the two Ministries. AVED funds undergraduate medical education, while the Ministry funds postgraduate medical education and training (PGME). Since 2001, BC has more than doubled the number of first year spaces for the undergraduate medical education, increasing the annual student intake from 128 in 2003/04 to 288 in 2013/14.[2] Since 2003, the Ministry has expanded PGME (residencies) to keep pace with undergraduate program growth. In 2013/14, the Ministry funded 330 entry-level residency positions: 288 for Canadian medical graduates (CMGs); 42 for IMGs.[3] For 2014/15, the Ministry funded 338 entry-level residency positions: 288 for CMGs; 50 for IMGs.[4] In 2015/16, the Ministry expects to fund 346 entry level residency positions: 288 for CMGs and 58 for IMGs.

Nursing - Since 2001, BC has more than doubled the number of nurse training spaces, adding more than 4,500 new spaces to train Registered Nurses, Psychiatric Nurses, specialty nurses, nurses re-entering the workforce, Licenced Practical Nurses, and nurses with graduate degrees.[5] The Ministry is working closely with the First Nations Health Authority and other stakeholders to address a number of challenges around Certified Practice. Since August 2014, Northern Lights College (NLC) and the University of Northern BC (UNBC) have had discussions with government about the potential to deliver a Bachelor of Science in Nursing program in Fort St. John (as part of the Northern Collaborative Baccalaureate Nursing Program). As a result of these discussions and a preliminary discussion paper from UNBC, government has requested UNBC submit a formal program proposal that will most likely have UNBC and NLC collaborating on program delivery in Fort. St. John , with UNBC leasing space at the NLC campus. NLC students would get preferred access into the UNBC program. Initial costs are estimated to include $800,000 operating at UNBC and approximately $200,000 at NLC to assist in re-establishing first and second year science program pre-requisites. If approved the first intake would be September 2016 at the earliest (graduates of this program will help support the ongoing need for nurses in Northeastern BC).

Physiotherapist (PT)/ Occupational Therapists (OT)/ Speech Language Pathologists (SLP) - In 2010, first year PT spaces at University of BC (UBC) doubled to 80. In order to enhance northern/rural retention, AVED funded the establishment of the first Northern And Rural Cohort in 2011. With the first intake in 2012, 20 students received academic training at UBC, but completed most clinical placements in northern/rural communities, with UNBC serving as a clinical education hub for students and continuing education for professional PTs. The UBC OT program admits 48 funded first year students per year and

[1] Email from Kevin Perrault, AVED, October 7, 2014.
[2] Ibid; Funding Letter for Postgraduate Medical Education 2013/14 from Kevin Brown, A/ED to Dr Gavin Stuart, Dean, Faculty of Medicine, University of BC, March 10, 2014 (draft). (Cliff #999405)
[3] Funding Letter for Postgraduate Medical Education 2013/14 from Kevin Brown, A/ED to Dr Gavin Stuart, Dean, Faculty of Medicine, University of BC, March 10, 2014. (Cliff #999405)
[4] Funding Letter for Postgraduate Medical Education 2014/15 from Ted Patterson, ADM to Dr Gavin Stuart, Dean, Faculty of Medicine, University of BC. (letter is in draft form).
[5] AVED's health and medical education funding estimates note, January 27, 2015.

the UBC SLP program currently admits 23. However, the number of first-years slots for the UBC SLP program will grow from 23 to 36 by 2016.[6]

Midwifery - Starting in 2012/13, UBC was funded to expand its Midwifery program from 10 first year spaces to 20 first year spaces in 2013/14 (an additional 5 first year spaces in both 2012/13 and 2013/14).[7] BC is providing $680,000 for a new UBC program that provides a pathway for internationally educated midwives to become fully licensed to practice in BC. The program at UBC will accept 8 first-year students per year starting in January 2016 and will pilot in Spring 2015 with 4 students. Applicants will be individually assessed, and the program will be tailored for each student, recognizing midwifery qualifications and experience gained abroad.

Pharmacy - The Province invested $86.4 million in a UBC building for the Faculty of Pharmaceutical Sciences. This allowed the undergraduate pharmacy program to expand first year spaces by 72 to 224 in 2011.[8] UBC is moving forward with a 4 year Entry to Practice Doctor of Pharmacy Degree, and intends to phase out both its Entry to Practice Baccalaureate Pharmacy degree and its post-degree 20 month Doctor of Pharmacy programs. Today's pharmacists are taking on a more prominent and accessible front line role in the care of patients in rural and urban BC. The UBC curriculum changes provide a comprehensive and inter-professional approach that is required to help support the health care system in the delivery of safe, effective healthcare for BC.

Sonography – BC Institute of Technology (BCIT) currently offers a 2 year diploma program. In 2012 the Ministry, in partnership with AVED and BCIT, increased the September 2012 intake from 24 students to 30 through a one-time funding initiative. This high demand profession prompted an agreement between AVED and BCIT to provide ongoing base funding to support a regular intake of 30 Sonography students. There were a total of 27 full-time and part-time difficult to fill vacancies at the end of 2013 (includes cardiac ultrasound).[9] Clinical placement issues and wage disparity are cited as barriers to recruitment and retention.[10] The Ministry is working with the Provincial Imaging Council, BCIT and AVED to address the regional human resources needs.

Radiation Therapy - As the primary employer in BC, the BC Cancer Agency (BCCA) currently has no opportunities available for the 10 BCIT students set to graduate in 2014. The Ministry is working with AVED, BCCA, and other stakeholders and will be capturing projections for long term planning.

Medical Laboratory (ML) - Between 2001/02 and 2012/13, 239 new education spaces have been added in ML programs at UBC, BCIT, and the College of New Caledonia: 205 for medical laboratory technology and 34 for medical laboratory science.[11] Further expansion is dependent upon clinical capacity.

Medical Radiography Technology (MRT) - Between 2001/02 and 2012/13, 212 new spaces have been allocated to MRT diploma programs. In 2011, a new MRT program at College of New Caledonia began with its first cohort of 16 first year students. The Province has provided almost $3.4 million to Camosun College for start-up costs and will continue to provide approximately $591,000 annually for a new two-year MRT diploma program that started in 2012, with an annual intake of 16 students.[12]

FINANCIAL IMPLICATIONS

N/A

Approved by:

Ted Patterson, Health Sector Workforce Division; April 1, 2015

Daryl Connor, Finance and Corporate Services Division; April 20, 2015

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[6] News Release: B.C. funds additional spaces for speech therapists, September 16, 2014.

[7] Email from Paul Clarke, AVED, January 14, 2014 & BC Government Announcement. News Release: Funding helps midwives deliver for B.C. families, May 4, 2012

[7a] News Release by AVED, http://www.news.gov.bc.ca/Default.aspx?qp=&style=em&qt=midwives

[8] New UBC Pharmaceutical Building To Create Hundreds Of Jobs News Release July 16, 2010 & Email from Kevin Perrault, AVED - Jan 2014

[9] Data emailed from Camila Prado, Economist, HEABC, October 3, 2014.

[10] Data emailed from Jennifer Elliott Operations Director, Medical Imaging Department, St. Paul's, Mount Saint Joseph, Children's and Women's Hospitals, July 2013

[11] Email from Paul Clarke, AVED, January 14, 2014

[12] Ibid(Further expansion is dependent upon clinical capacity.)

FACT SHEET

Integrated Health Human Resources Planning

ISSUE

An overview of Integrated Health Human Resources Planning (IHHRP) inclusive of physicians, nurses and allied health professions for the BC's health care system.

KEY FACTS

- Workforce planning includes forecasting and modelling of future supply, mix and distribution, education and training strategies, and recruitment and retention strategies across a diverse range of health care professionals to meet current and future patient and population health needs.
- Workforce planning is a challenge for all jurisdictions in Canada. Appropriate planning is critical for sustainability of the health care system, as significant portions of provincial health care budgets are typically spent on workforce compensation. In 2013/14, the health sector compensation costs in BC were $12.8 billion[1] or 70% of the total Health Care Budget of $18.4 billion.[2]
- Challenges with respect to workforce planning include dependence on a diverse health care workforce of regulated and unregulated, unionized and non-unionized, and public and private providers and employer models; an aging population and workforce; and the increasing prevalence of chronic health conditions. Further, the market for many health professions is often international in scale (e.g., physicians).
- Historically the approach to workforce planning in many jurisdictions has been interest/silo based (e.g., physicians, nurses or allied health professions have separate "plans" or approaches) utilizing a simple "stock and flow" supply and demand forecasting model. However, to achieve a sustainable, quality health care system focused on patient and population needs, the Ministry of Health is shifting to an IHHRP approach that utilizes both supply/demand and population-needs based forecasting models.
- An IHHRP forecasting model needs to forecast number, type, and location of providers required to provide appropriate healthcare services throughout the province on an annual basis over a 5 and 10-year projection required to meet patient and population health needs.
- An IHHRP forecasting model should also assess the health system resource requirements from various perspectives (e.g., policy shifts, technology impacts, service delivery models, regulatory frameworks, changes in clinical practice and inter-professional teams) to proactively make sound decisions, effectively plan (e.g., education seat planning) and manage the health care workforce.
- As part of a Provincial Strategy for Health Human Resources, the Ministry is working with the Health Employers Association of BC to develop an integrated health human resources (HHR) forecasting model and tool that will support the overall health system planning and workforce strategies, including health authority operational needs, now and into the future.

Background

- Over the past 18 months, the Ministry has been engaged in several HHR initiatives to build capacity to support IHHRP:
  - Engagement of the health system on an approach to IHHRP;
  - Research and stakeholder engagement on population needs-based approaches/forecasting models and system level HHR planning;

[1] Public Sector Overview, Ministry of Finance, http://www.fin.gov.bc.ca/psec/publicsector/index.htm
[2] Budget and Fiscal Plan 2014/15-2016/17, p 99, http://bcbudget.gov.bc.ca/2014/bfp/2014_Budget_Fiscal_Plan.pdf

  - Piloted an environmental scan (e.g., tool/series of questions) of health authorities and Ministry program areas to inform future processes and current HHR planning; and
  - s.13

- Key IHHRP initiatives:
  - Development of an IHHRP Strategy that is inclusive of physicians, nurses and allied health professions;
  - Data architecture/software development (contract expertise to develop a population based forecasting tool and knowledge exchange to build internal capacity) – a forecasting tool will utilize key HHR/population data sources (e.g., Health Sector Compensation Information System and BC Health System Matrix) to generate various scenarios on a health care provider specific level and assist planners to understand emerging pressures at a provincial, regional and community level; and
  - Health sector engagement on IHHRP (e.g., Government, First Nations, employers, educators, unions, health care professionals, and others).

FINANCIAL IMPLICATIONS

Costs for developing Phase One of the IHHRP forecasting model and tool total $800,000 ($480,000 for fiscal 2014/15 and $320,000 for fiscal 2015/16).

Approved by:

Kevin Brown, Workforce Planning & Management Branch; February 19, 2015
Ted Patterson, Health Sector Workforce Division; April 1, 2015
Daryl Connor, Finance and Corporate Services Division; April 20, 2015

s.13

FACT SHEET

Medical On-Call Availability Program

ISSUE

The Ministry of Health provides funding through the Medical On-Call Availability Program (MOCAP) to health authorities to enable them to contract with groups of physicians to provide "On-Call" coverage necessary for hospitals to deliver emergency health care services to unassigned patients in a reliable, effective and efficient manner.

KEY FACTS

Call Group Level	Number of Call Groups by Type 2014/15:[1]
1	425
2	266
3	53
OSOC	11
Grand Total	**755**

- MOCAP requires physicians to provide on-call availability for a range of levels which include:[2]
  - On Site On-Call ($325,000 per annual and per call group) – physician group commits to have a member of their Call Group available on site 24 hours per day, 365 days per year. Physician groups in this category predominately include tertiary obstetrics, anesthesia and neonatology.
  - Level 1 – On-Call ($225,000 per annual and per call group) – physician group commits to have a member available by phone within 10 minutes and on site within 45 minutes, 24 hours per day, 365 days per year.
  - Level 2 – On-Call ($165,000 per annual and per call group) – physician group commits to have a member available by phone within 15 minutes and on site within 2 hours, 24 hours per day, 365 days per year.
  - Level 3 – On-Call ($70,000 per annual and per call group) – physician group commits to have a member available by phone within 15 minutes and on site within 16 hours, 24 hours per day, 365 days per year.
  - Call-Back ($250 per call back) – physician is not on-call but may be called and if available, paid for coming in.
- A key component of the MOCAP funding process was to be an annual review of a health authority's on-call needs and priorities for physician services by the health authority.
- In November 2007, the Ministry and Doctors of BC established a new annual review process to allocate MOCAP funding in a manner that is focused on health care service delivery priorities. In January 2008, the Parties further agreed to:
  - evaluation criteria to assist them with their MOCAP funding distribution priorities;
  - specific process and timeline for health authorities to follow when preparing their annual MOCAP funding distribution plan; and
  - a dispute resolution process for physicians to resolve disagreements they may have with health authority MOCAP funding allocation decisions.

[1] Consolidated 2014_15 call group list received data from Health Authorities Quarter 2 2014/2015. Physician Compensation Branch, Health Sector Workforce Division, BC Ministry of Health. Note: Call backs are based on usage and are reported at the end of fiscal. Z:\APP\APP LAN TEST\MOCAP\Redesign Implementation\Technical Clinical Committee\Call Group Lists - 2014\1415 MOCAP CALL GROUP LIST - TO MSP for coding.xlsx

[2] 2014 Physician Master Agreement, Schedule G – Medical On-Call/Availability Program (MOCAP), Article 1.6. pg. 177.

FACT SHEET

- In September 2009, Doctors of BC and government agreed to suspend the dispute resolution process until March 31, 2012. This suspension continues until June 1, 2013, under the 2012 Physician Master Agreement.
- In 2010/11, health authorities made a number of changes to manage their MOCAP commitments within their available MOCAP funding allocations. In all cases, their senior medical staff considered the changes to be compatible with providing effective and efficient emergency care to patients.
- The orthopedic surgeons, psychiatrists and anesthetists all expressed strong disagreement to the planned MOCAP funding changes and withdrew some on-call services April 1, 2010, to pressure health authorities into ceding to their MOCAP compensation demands.
- In a 2010 MOCAP backgrounder document commissioned by the Ministry, Dr. L. Klippert, Medical Consultant, noted BC's MOCAP program as the most generous "on call" program in the country, with higher rates and total expenditures per participating physician than other provinces.[3]
- In the 2012 Physician Master Agreement , the Government negotiated a review process, MOCAP Redesign Panel, to collaborate with the Doctors of BC in identifying and exploring potential changes to improve transparency, accountability, and effectiveness in the application of MOCAP funding. The Physician Services Committee approved the recommendation put forth by the panel.[4] A Provincial MOCAP Committee has been established with membership from both the government and Doctors of BC to oversee the implementation of the recommendations.
- The Provincial MOCAP Review Committee was created by PMA Agreement Section 17.4 in April 2014 which will oversee & guide redesign of MOCAP and transition to new MOCAP program.
- s.13

FINANCIAL IMPLICATIONS

Distribution of Provincial MOCAP budget:[5]

Fraser Health Authority	Interior Health Authority	Northern Health Authority	Provincial Health Services Authority	Vancouver Coastal Health Authority	Vancouver Island Health Authority	Nisga'a Valley Health Board	Unallocated Budget	Total Budget
$25,999,670	$24,832,348	$12,928,392	$13,584,580	$30,264,415	$20,187,291	$168,750	$2,734,554	**$130,700,000**

Health authorities MOCAP funding plans for 2010/11 have been carried forward into 2011/12, 2012/13, 2013/14, 2014/15 and 2015/16. s.13

s.13

Approved by:

Ted Patterson, Health Sector Workforce Division; February 22, 2015

Ted Boomer, obo Manjit Sidhu,Finance and Corporate Services Division, March 30, 2015

[3] Dr.Klippert, Lorne. *Medical On-Call Availability Program (MOCAP) – Options For Consideration.* December 29, 2010. p.4.

[4] Report of the MOCAP Redesign Panel (appointed under Section 17.4 of the 2012 Physician Master Agreement) to the Physicians Services Committee. May 14, 2013

[5] MOCAP 2014/15 Budget. Retrieved January 12, 2015 from Y:\J Kolbinson\MOCAP\FY 14_15 MOCAP Reporting HA's - Revised Nov 2014.xlsx

FACT SHEET

Medical Residency Positions

ISSUE

BC has more than doubled the total number of medical residency positions for Canadian Medical Graduates (CMGs) and International Medical Graduates (IMGs), including Canadians Studying Medicine Abroad (CSAs), to better meet the health care needs of British Columbians.[1]

KEY FACTS

- Medical training positions are based on the current and future health needs of British Columbians and the human resource requirements of the healthcare system. Positions are determined through a collaborative approach by the Ministry of Health, UBC Faculty of Medicine (FoM), health authorities, Doctors of BC, BC College of Physicians and Surgeons, and other health sector organizations through the Medical Human Resource Planning Task Force.
- The Task Force mandates its Residency Allocation Subcommittee to develop a 3 to 5 year rolling plan for the allocation of all Ministry funded residency positions (including both CMG and IMG positions) to the UBC postgraduate residency programs.[2]
- To align with Ministry and health authority priorities, the FoM maintains at least 60% of Canadian Resident Matching Service (CaRMS) entry-level positions in Family Medicine and the generalist specialties supporting primary health care (Internal Medicine, Pediatrics and Psychiatry).[3]
- The Ministry continues to expand and distribute postgraduate medical education (residency) incrementally to keep pace with undergraduate medical doctor program expansions.
- In 2014/15, the Ministry funded 338 entry-level residency positions: 288 for CMGs; 50 for IMGs; or a total resident population of 1247 (all CMGs and IMGs in Family Medicine and specialties in years 1 through 7).[4] In 2015/16, the Ministry expects to fund 346 entry-level residency positions: 288 for CMGs; 58 for IMGs.[5]
- BC is recognized as a world leader for distributed medical education and is already experiencing early gains in terms of physician numbers and practice locations across the province.

Canadian Medical Graduates

Graduating CMGs must access postgraduate medical education (residency) to complete their medical education and qualify for a full license for independent practice. In 2014/15, the Ministry funded 288 entry-level residency positions for CMGs. This is over a 100% increase from 128 entry-level residency positions for CMGs in 2003, when the stepped expansion began.[6]

International Medical Graduates[7]

Some IMGs must access residency to complete their medical education or qualify for independent practice in BC. In 2014/15, the Ministry funded 50 entry-level positions for IMGs: 44 entry-level positions in Family Medicine; 6 in generalist specialties including Internal Medicine, Psychiatry, and

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[1] UBC. Retrieved on November 26, 2012, from: http://mdprogram.med.ubc.ca/admissions/frequently-asked-questions/#General-A4 College of Physicians and Surgeons of British Columbia. Annual Report 2011. p. 12. Retrieved on November 27, 2012, from: https://www.cpsbc.ca/files/u6/2011-annual-report.pdf

[2] UBC Faculty of Medicine Medical Human Resources Planning Task Force – Residency Allocation Subcommittee: Terms of Reference, October 9, 2012, p.1

[3] International Medical Graduate Program (IMG-BC) Challenges Facing Canadians Studying Abroad, Briefing Document Prepared by the Ministry of Health, Ministry of Advanced Education, and UBC's Faculty of Medicine, December 2011, p3.

[4] Funding Letter for Postgraduate Medical Education 2013/14 from Ted Patterson, ADM to Dr Gavin Stuart, Dean, Faculty of Medicine, UBC, March 10, 2014(Cliff #999405)

[5] International Medical Graduate Program (IMG-BC) Challenges Facing Canadians Studying Abroad, Briefing Document Prepared by the Ministry of Health, Ministry of Advanced Education, and UBC's Faculty of Medicine, December 2011, p11.

[6] Office of the Premier (2010) UBC Clinical Teaching Facility Opens at KGH; Ministry of Health Services, UBC Faculty of Medicine, Interior Health, 2010 PREM0015-000073

[7] Ministry of Health, Health Sector Workforce Division, verified by B MacLean-Alley, Manager, January 20, 2014 via email.

Pediatrics. In 2015/16, the Ministry expects to fund 58 entry-level positions for IMGs: 52 positions in Family Medicine; 6 in generalist specialties. Specialty positions are determined yearly, based on teaching capacity. In 2006/07, the Ministry tripled the number of postgraduate entry-level positions for IMGs from 6 to 18.[8]

Canadians Studying Abroad

- CSAs wishing to return to BC to enter and complete residency are considered IMGs. They compete for IMG entry-level positions posted in the first iteration of the CaRMS match, and for unfilled IMG and CMG positions in the second iteration of the CaRMS match.
- After taking the Objective Structured Clinical Examination, CSAs may complete an optional 8 week clinical assessment (BC IMG Program), before competing for the BC positions for IMGs posted in CaRMS. In 2010, the FoM, Ministry of Advanced Education, and Ministry of Health agreed to a further expansion of IMG Family Medicine residency positions. Beginning in 2011, over several years, a total of 40 new entry-level positions in Family Medicine are expected to be added to the pre-existing 18 IMGs, for a grand total of 58 entry-level IMG positions. By 2016/17, at full expansion, 134 IMGs are expected to be in training at any given time.[9]

Distribution of the IMG Residency Positions (Family Medicine)

- The IMG Family Medicine residency positions were distributed to the Fraser and Vancouver Island Health regions in 2012/13 and 2013/14; and to Northern and Vancouver Coastal Health regions in 2014/15. IMG Family Medicine residency positions are to be distributed to Vancouver Island and Interior Health regions in 2015/16; and to Northern and Interior Health regions in 2016/17.
- All IMG residency positions include a Return of Service (ROS). Upon successful completion of Postgraduate Medical Education at UBC, an IMG agrees to practise medicine in a community in need. If an IMG chooses Family Medicine as their area of practise, the individual is required to complete a 2 year ROS. If an IMG chooses a Royal College Speciality as their area of practise, the individual is required to complete a 3 year ROS.

FINANCIAL IMPLICATIONS

- Ministry operating funding for postgraduate medical education (residency) in 2014/15 is $123.1 million (includes Health Canada's contribution of $718,554 and $2.0 million reduction in residents' benefits). The operating funding in 2015/16 is estimated at $128.8 million.[10]
- Of the $123.1 million, this includes $12.3 million[11] for the *IMG-BC Program* (Objective Structured Clinical Examination and 8 week clinical assessment) and IMG residency positions in Family Practice and specialties which includes $718,554 Health Canada contribution.[12]

Approved by:

Ted Patterson, Health Sector Workforce Division; April 1, 2015

Daryl Connor, Finance & Corporate Services Division; April 20, 2015

[8] International Medical Graduate Program (IMG-BC) Challenges Facing Canadians Studying Abroad, Briefing Document Prepared by the Ministry of Health, Ministry of Advanced Education, and UBC's Faculty of Medicine, December 2011, p3; verified by B MacLean-Alley, Manager

[9] Ibid, 2

[10] Funding Letter for Postgraduate Medical Education 2014/2015 from Kevin Brown, Executive Director to Dr. Gavin Stuart, Dean, Faculty of Medicine, University of BC, December 5, 2015, Appendix 1 (Cliff #1024561).

[11] Budget Request 11/12. G:\Mgmt Team\BOOMER Ted\13-14\10 11 PGME 1 to 1 expanded to 21-22-growth for only 11-12 new rates June 14-13.xls BEV IMG numbers

[12] Ibid, 2

FACT SHEET

Nurse Practitioners

ISSUE

Issues being raised locally and regionally include lack of provincial evaluation, professional continuing education and practice supports for Nurse Practitioners (NP) in community, role of NP as part of a multidisciplinary team, and in particular, integration with general practitioners (GPs), office space, overhead and benefits, disparity in NP contracts with health authorities across the province. The Ministry of Health is working to develop an action plan to advance and enable optimal utilization of NPs within BC's health care system.

KEY FACTS

- In BC, NPs are Masters' prepared or have equivalent clinical experience and education. NPs are educated to provide health care services to persons of all ages, including newborns, infants, toddlers, children, adolescents, adults, pregnant and postpartum women, and older adults, and may serve as the primary care provider to individuals and their families.
- NPs are Registered Nurses with advanced education, knowledge, and decision-making skills in assessment, diagnosis, and health-care management. They are authorized to perform the full range of nursing functions plus additional functions involving diagnosing, prescribing, ordering diagnostic tests, managing common acute and chronic illnesses, and referring patients to specialists.
- When NPs were introduced to BC, a number of benefits were identified, including: providing primary health care in areas which cannot support a GP or where there are orphan patients; and developing economical, effective, integrated, patient-centred models of delivering care, including prevention, education, and chronic disease management.
- As independent practitioners, NPs do not require an order from a physician to act, but work collaboratively with medical practitioners and other members of the health care team.
- Three categories of NPs are recognized in BC – Family, Adult, and Pediatric. Currently there are 317 practising NPs in the province (10 with full registration and 7 with provisional registration). There are also 31 non-practising NPs.[1] NPs are trained at the University of BC, the University of Victoria and the University of Northern BC, for a total capacity of 45 spaces annually. Training programs in BC presently only offer the NP Family category.
- Standards, competencies, guidelines, limits, and conditions for Family, Adult, and Pediatric NPs, are developed through the Nurse Practitioner Standards Committee (NPSC) of the College of Registered Nurses of BC (CRNBC). CRNBC Bylaws require the NPSC to be multi-disciplinary and include representation from the College of Physicians and Surgeons (GP and specialist), the College of Pharmacists, the public, and Government.
- In Fall of 2011, BC introduced Bill 10, the *Nurse Practitioners Statutes Amendment Act*. Twelve acts were amended and eleven were brought into force August 1, 2012 (the exception is for the changes to the *Mental Health Act*). Bill 10 removed a number of legislative barriers to NP practice and facilitated use of full NP scope of practice. On March 10, 2014, amendments to nine statutes to expand scope and opportunities for NPs were introduced as part of Bill 17. Bill 17 received Third Reading on April 29, 2014.
- In May 2012, the Government announced funding to support the further integration of NPs into BC's health system through the NP4BC program.[2] This initiative has committed to funding 135 new

[1] CRNBC website. Retrieved on March 20, 2015 from: https://www.crnbc.ca/crnbc/Statistics/Pages/Default.aspx
[2] BC Government. News release May 31, 2012: *B.C. funds more nurse practitioners positions*. Retrieved on November 19, 2013 from: http://www.newsroom.gov.bc.ca/2012/05/bc-funds-more-nurse-practitioner-positions.html

positions to support integrated primary and community care objectives (45 Full Time Equivalents (FTEs) per fiscal at an average salary of $116,000 per position, including benefits)[3]

- In October 2012, changes to the *Hospital Act* and *Hospital Insurance Act* Regulations provided the framework to enable NPs to admit and discharge patients.
- The Encounter Code Working Group (ECWG)[4] was established in April 2013 to revise the NP Encounter Codes and Resource Manual.[5] As of October 1, 2014, NPs are required by the Ministry to submit Encounter Records with these revised Encounter Codes.
- A workshop held on October 23, 2013, NP for BC: Advancing the Integration in Community-Based Primary Care identified the need for a clear action plan to move forward with NP integration in the province. On November 14, 2014, the Ministry hosted an internal "NP Integration Forum." The purpose of this meeting was to jointly confirm issues and barriers related to NP integration and establish an Action Plan moving forward to identify short and long term goals based on priority issues and on key recommendations from the October 2013 workshop. Next steps from this workshop included the creation of an NP Action Plan for moving forward.
- In March 2015, the Ministry contracted a consultant to draft a NP Action Plan to provide recommendations to the Ministry with options for moving forward with integration and sustainability of NPs in the province. s.13,s.17
- NPs were recently included under the New Classes of Practitioners Regulation under the Federal *Controlled Drugs and Substances Act*. The revised Nurses (Registered) and Nurse Practitioners Regulation includes the authority for NPs to order controlled drugs and substances (along with the ability to order MRIs). The regulations have been posted for a 3 month public consultation period.
- NPs are currently authorized to access limited personal health information on PharmaNet (only for the purpose of providing patient care), however the Ministry has committed to granting NPs full access to PharmaNet s.13,s.17
- CRNBC is in the process of the five-year review of NP scope with a timeline for completion and report to their Board by early 2016.

FINANCIAL IMPLICATIONS

s.13,s.17

Approved by:

Kevin Brown, Workforce Planning & Management Branch; April 28, 2015

Ted Patterson, Health Sector Workforce Division; April 29, 2015

Bonnie Wong, obo Manjit Sidhu, Finance and Corporate Services Division; May 8, 2015

[3] Ministry of Health. Nurse Practitioners Program. Retrieved on November 19, 2013 from: http://www.primaryhealthcarebc.ca/resource_np.html

[4] Members of this group included; NP leads and practicing NPs from each health authority, the BCNPA, Chief Nursing Officers Council, and CRNBC.

[5] The codes and manual have since been revised and are available online on the MSP website at http://www.health.gov.bc.ca/msp/infoprac/np/index.html

[6] Financial Implications confirmed by Bonnie Wong. February 2, 2015.

FACT SHEET

Nurse Practitioners for BC (NP4BC)

ISSUE

- In May 2012, the Government announced funding over three years to support the further integration of NPs into BC's health system through the NP4BC program.[1] This initiative has committed to funding 135 new positions since 2012 to support integrated primary and community care objectives (45 Full Time Equivalents (FTEs) per fiscal at an average salary of $116,000 per position, including benefits).[2]
- Health authorities were also expected to create 56 new NP positions in acute care setting over 2 years (20 positions in 2013/14 and 36 positions in 2014/15).[3] These 56 positions were not funded by the Ministry as part of the NP4BC program -s.13,s.17

s.13,s.17

KEY FACTS

- The Ministry has currently provided funding for 133.5 NP FTE positions through the NP4BC award process. Funding from the NP4BC program has also been used to provide one-time temporary housing and living allowances, as well as some limited funding for local operational costs.
- As of March 31 2015 health authorities have filled 24.25 acute care NP FTEs. See Appendix B.

NP4BC Funding Allocation

Health Authority	NP FTEs awarded	NP FTE positions filled (as of January 2015)	Vacancies	One- time funding provided for temporary housing and living allowance
Fraser	29.5	18.5	11	
Interior	21.4	14.4	7	Operational funding provided f Sorrento and Scotch Creek Hea Societies.
Vancouver Island	24	21	3	Incentive funding for 3 NP FTE positions in Port McNeill, Corte Island and Port Hardy
Northern	20	11	8	Incentive funding for 1 NP FTE i Atlin
Providence Health	8	8	0	
Provincial Health Services	11	11	0	
Vancouver Coastal H	19.6	17.6	2	
Total	133.5	101.5	31	4

[1] BC Government. News Release May 31, 2012: *B.C. funds more nurse practitioners positions.* Retrieved on November 19, 2013 from: http://www.newsroom.gov.bc.ca/2012/05/bc-funds-more-nurse-practitioner-positions.html

[2] Ministry of Health. Nurse Practitioners Program. Retrieved on November 19, 2013 from: http://www.primaryhealthcarebc.ca/resource_np.html

FACT SHEET

FINANCIAL IMPLICATIONS

The NP4BC program has closed; no new additional funding. Approved NP4BC positions will continue to be funded by the Ministry (ongoing funding). The Ministry is working on moving the funding from the current contracts and into the health authority global budget.

Approved by:
Kevin Brown, Workforce Planning & Management Branch; May 5, 2015
Ted Patterson, Health Sector Workforce Division; May 5, 2015

Page 159 to/à Page 160

Withheld pursuant to/removed as

s.16

FACT SHEET

Physician Expenditures

ISSUE

- Expenditures for physician services include: fee-for-service, Alternative Payments Programs, Medical On-Call Availability Program, Rural Programs, benefits and others. Across all programs, the average expenditure per physician in 2013/14 was $352,533.[1]
- Physician expenditures grow (or decline) as a function of negotiated settlements, changes in physician supply, policy changes (such as laboratory reform) and changes in patient utilization.

KEY FACTS

- In 2014/15, the budget for physician services is $3.894 billion, a 1.71% increase over the 2013/14 budget of $3.829 billion.[2] Actual expenditure in 2013/14 was $3.819 billion.

Table 1: 2013/14 Physician Services Expenditure by Category [3,4]

Category	Expenditure (Millions)	Proportion of Total	Increase over 2012/13
Fee for Service	$2,734	71.59%	2.90%
Alternative Payments Program	$432	11.31%	4.10%
Targeted	$306	8.01%	32.47%
Medical On-Call Availability Program	$129	3.38%	0.00%
Rural	$114	2.99%	14.00%
Benefits	$104	2.72%	4.00%
Total	$3,819	100%	5.15%

- Physician services budgets are approximately 23% of the Ministry of Health budget in 2013/14 and 2014/15.[5] A small portion of physician compensation is funded through health authority global budgets and not captured in these figures.
- Over the 13-year period 2001/02 to 2013/14, the annual total physician services expenditures grew by $1.6 billion from $2.2 billion to $3.8 billion .[6]
- Over the same time period, the compound annual average growth in physician services expenditures of 4.2%[7] is similar to that of provincial health function expenditures (4.1%) and exceeds that of provincial revenue (3.7%) and operating expense (2.9%).[8]
- Payments for fee-for-service grew by an compounded average annual rate of 3.2% from $1.79 billion to $2.73 billion.[9]

Inter-Provincial Comparisons

- 2012/13 statistics published by CIHI that compare fee schedule prices across Canada show that BC ranked sixth highest in average fees after Alberta, Saskatchewan, N.B, Manitoba, and N.S.[10]
- As of 2012/13, BC had the fourth highest payment per fee-for-service physician full-time equivalent in Canada at $316,076. This is behind Alberta ($400,862), Saskatchewan ($367,744) and

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[1] Source: Health Sector Workforce Division, Workforce Research and Analysis Branch (WRAB), 2015
[2] Ministry of Health, 2014/15 to 2016/17 Service Plan, February 2014.
[3] BC Public Accounts, 2013/14
[4] Targeted includes General Practice Services Committee, Specialist Services Committee, Shared Care Committee, Physician Information Technology Office, Primary Blended Sites,and Laboratory Re-investment.
[5] Ministry of Health, 2014/15 to 2016/17 Service Plan, February 2014.
[6] BC Public Accounts, 2013/14
[7] Source: WRAB using Medical Services Plan detail from Public Accounts of Province of BC (base year 2001/02). PV=2,201,532,145; FV=3,818,839,874, N=13, then i=4.20%
[8] Data sources: Tables A2.5 and A2.7 of 2014 Financial and Economic Review, July 2014.
[9] WRAB using Medical Services Plan detail from Public Accounts of the Province of BC, 2014. (base year 2001/02) PV=1,791,900,000; FV=2,734,000,000, N=13, then i=3.2%
[10] Physician Services Benefits Rate Report, 2012/13, Canadian Institute for Health Information, Table 1.1, 2014 https://secure.cihi.ca/free_products/PSBR_2012-2013_en.pdf

New Brunswick ($350,998) with the BC average slightly lower than the Canadian average of $317,649[11]

FINANCIAL IMPLICATIONS

N/A

Approved by:

Ted Patterson, Health Sector Workforce Division; April 1, 2015
Daryl Connor, Finance and Corporate Services Division; May 4, 2015

[11] National Physician Database, 2012/13, Data Release, Canadian Institute for Health Information, Table A.6.1 https://secure.cihi.ca/estore/productSeries.htm?pc=PCC476

FACT SHEET

Physician Supply Numbers

ISSUE

- Compared to other provinces, BC has a relatively good supply of physicians and growth in supply continues to outpace population growth.
- While there is continued use of the term "physician shortage", there is no agreed upon criterion to define what a shortage is, nor what a surplus is.
- There are some concerns regarding an aging workforce, reduced scope of practice and reduced productivity.
- BC is increasing its self-sufficiency in physician training while remaining an attractive destination for migrating physicians.
- The number of physicians in BC varies depending on the source referenced.
- The main sources of physician counts are the BC Ministry of Health, Canadian Medical Association and the Canadian Institute for Health Information (CIHI).

KEY FACTS

Physician Counts

- As of March 31, 2013, the Ministry counted 10,833 physicians under all Ministry payment sources (fee-for-service, sessions, service contracts and salaries)[1], an increase of 1.9% over 2012/13 (10,628).
    - Of those, 7,444 (69%) were fee-for-service only, 714 (6%) were on alternative payments only, and 2,675 (25%) were paid on some combination of fee-for-service and alternative payments.
    - This physician count is not precisely comparable to other Canadian jurisdictions due to variations in counting methods between provinces.
- As of January 2014, the Canadian Medical Association reported a total of 11,120 physicians for BC.[2]
    - 5,974 (54%) are Family Physicians and 5,142 (46%) are specialists.
    - 7,336 (66%) are male and 3,784 (34%) are female.[3]
- As of December 2013, CIHI reported a total of 10,372 physicians for BC.[4]
- The count recommended for quotation is the Ministry of Health count. The Ministry counts all physicians providing service during the fiscal year. CIHI counts all physicians residing in the province on December 31 of the calendar year.

Physician Supply – A Comparison

- In November 1999, the Canadian Medical Forum Task Force, representing a number of organizations and co-chaired by the President of the Canadian Medical Association and the President of the Association of Canadian Medical Colleges, endorsed a ratio of 180 to 190 physicians for every 100,000 people.[5]

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[1] Compensation and Negotiation Branch, Health Sector Workforce Division, January, 2014

[2] Canadian Medical Association Master file, January 2014. *Number of Physicians by Province/Territory and Speciality, Canada, 2014*. Retreived on February 17, 2014 from http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Statistics/01Spec&Prov.

[3] Canadian Medical Association Masterfile, January 2014. *Number of active physicians by age, sex and province/territory, Canada, 2014*. Retrieved on February 17, 2014 from http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Statistics/04AgeSexPrv.pdf

[4] CIHI. *Supply, Distribution and Migration of Canadian Physicians, 2013*.,data tables. Retreieved electronically January 22, 2015 from https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC2672

[5] Task Force on Physician Supply in Canada, Canadian Medical Forum Task Force, page 3, November 22, 1999, http://www.physicianhr.ca/reports/PhysicianSupplyInCanada-Final1999.pdf

- According to Canadian Medical Association, BC's ratio of 236 physicians per 100,000 people ranks third behind Nova Scotia (263) and Newfoundland & Labrador and Quebec (260).[6]

Physician Supply Issues

- Discussion of physician shortage is related less to the total number of physicians and more to changes in productivity and availability.
  - The physician workforce has grown consistently over the past decade.
  - The number of physicians increased by 32% from 8,234 in 2001/02 to 10,833 in 2013/14[7] outpacing the 12.8% growth in BC population over the same period of time.[8]
  - Average annual growth rates for physicians and population are 2.5% and 1.1% respectively over the same time period.[9]
  - The aging of the physician workforce could be an issue in the future as many are poised to retire and are reducing workload in the years prior to retirement. In 2014, the average physician age in BC was 51 years.[10]
- BC increased training capacity for physicians.[11]
  - By 2014/15, BC will have up to 288 graduating medical residents per year.
- In most years BC attracts physicians from the rest of Canada.
  - In 2013, the net gain of physicians to BC was 15, which followed a net gain of 95 in 2012, a net loss of 57 in 2011, and net gains of 34 in 2010, 93 in 2009, 56 in 2008, 26 in 2007.[12]
  - Alberta and Ontario are the originating provinces of most physicians migrating to BC.[13]

FINANCIAL IMPLICATIONS

N/A

Approved by:

Nancy South, Workforce Research & Analysis Branch; March 3, 2015

Ted Patterson, Health Sector Workforce Division; April 1 2015

[6] Canadian Medical Association Master file, January 2013. Population from Stats Can as at January 1, 2013.

[7] Compensation and Negotiation Branch, Health Sector Workforce Division, January 2014

[8] PEOPLE 2013, BC STATS, Ministry of Labour and Citizens' Services, BC population as at April 1, 2014 (4,616,626), at April 1, 2002 (4,094,296), Retrieved on January 22, 2015 from http://www.bcstats.gov.bc.ca/StatisticsBySubject/Demography/PopulationEstimates.aspx

[9] Source: Workforce Analysis Branch, 2015. These are compound average annual growth rates.

[10] Ibid, 4

[11] Office of the Premier. (2010). *News Release: UBC Clinical Teaching Facility Opens at KGH*. 2010 PREM0015-000073. Retrieved on February 18, 2014 from http://www2.news.gov.bc.ca/news_releases_2009-2013/2010PREM0015-000073.htm.

[12] Ibid, 4, p.51 & 77

[13] Ibid, 4, p. 77

FACT SHEET

Rural Practice Programs

ISSUE

Under the Physician Master Agreement (PMA), the BC Government funds a comprehensive range of programs developed and directed by rural physicians, health authorities, the Ministry of Health, and the Doctors of BC through the Joint Standing Committee on Rural Issues (JSC).

KEY FACTS

Nine of 12 rural programs have identified budgets totaling approximately $23.3 million. The 3 remaining programs - Rural Retention Program (RRP), Rural Continuing Medical Education (RCME), and Rural Incentive Fund (RIF) are funded based on utilization.

Budgeted Programs [1][2]

1. Rural Emergency Enhancement Fund (REEF)
   - REEF provides up to $200,000 per year in funding for eligible rural emergency departments to support fee-for-service physicians who collaboratively plan for and provide public access to emergency department services on a regular, scheduled basis.
   - Budget = $9.5 million
2. Rural General Practitioner Locum Program (RGPLP)
   - RGPLP provides locum physicians with opportunities to practice in rural BC and enables rural GPs who practice in a community with 7 or less physicians to secure subsidized relief for Continuing Medical Education (CME), vacation, and health needs.
   - Locums are paid a guaranteed daily rate of up to $900 per day and may receive an additional $100 per day for providing enhanced skills (e.g., emergency, anaesthesia, and obstetrics).
   - Locums are also paid a travel time honorarium of up to $600 and receive reimbursement for travel expenses.
   - Budget = $4.2million
3. Northern & Isolation Travel Assistance Outreach Program (NITAOP)
   - NITAOP provides funding for travel expenses and travel time honorariums to approved visiting specialists and general practitioners who deliver medical services to rural, isolated communities where the service is not available.
   - There are 2 components to NITAOP funding: the Physician Outreach Program (POP), which funds GP travel expenses and GP/specialist travel time honoraria; and the Northern & Isolation Travel Assistance (NITA), which funds specialist travel expenses.
   - Budget = $3.6 million for POP, while the NITA portion is covered by the Available Amount.
4. Rural Education Action Plan (REAP)
   - REAP supports the training needs of physicians in rural practice, provides undergraduate medical students with rural practice experience, and increases rural physician participation in the medical school selection process.
   - Budget = $2.8 million
5. Rural Specialist Locum Program (RSLP)
   - The RSLP enables core specialists (Anaesthesia, General Surgery, Internal Medicine, Orthopedics, Pediatrics, Psychiatry, Obstetrics and Radiology) in eligible communities to secure subsidized periods of leave from their practices for purposes such as CME, vacation, and health needs.

[1] 2014 Physician Master Agreement, Appendix C - 2014 Rural Practice Subsidiary Agreement

[2] Budget 2014/15 - \\Coral\MSP\Decision Support - MSP\Rural\FY14_15\Rural Budget History and One-time Funding Expenditures Dec 2014.xlsx

- The current list of RSLP eligible communities approved by the JSC is: Campbell River, Comox, Courtenay, Cranbrook, Dawson Creek, Ft. St. John, Kitimat, Nelson, Port Alberni, Powell River, Prince George, Prince Rupert, Quesnel, Salmon Arm, Sechelt, Smithers, Terrace, Trail, and Williams Lake. Locums receive a guaranteed daily rate of $1,200.
- They are also paid a travel time honorarium of $1,000 and receive reimbursement for travel expenses. Health authorities are responsible for providing accommodation.
- Budget = $1.25 million

6. Recruitment Contingency Fund (RCF)
   - RCF provides funding to assist health authorities in filling a vacancy that is, or is expected to be, especially severe. Funds can be used for advertising, interview visits, and relocation expenses.
   - Budget = $1 million
7. Isolation Allowance Fund (IAF)
   - IAF is available to physicians who provide necessary medical services in eligible Rural Subsidiary Agreement communities with fewer than four physicians and no hospital.
   - Budget = $600,000
8. Rural GP Anaesthesia Locum Program (RGPALP)
   - The RGPALP assists GPs with enhanced anaesthesia skills (GPAs) in eligible communities to secure subsidized leave for up to 10 days per year from their practices for purposes such as CME, vacation, and health needs. Locums are paid a daily rate of up to $1,000 per day, receive reimbursement for their travel expenses, and are paid a travel time honorarium of up to $600.
   - Budget = $250,000
9. Rural Scholarship Program
   - Provide rural scholarships (up to 20) to medical students or rural origin/interest to encourage practice in rural communities. (Commenced September 2014).
   - Budget = $100,000

Utilization-based Programs

1. Rural Retention Program (RRP)
   - The RRP encourages physicians to reside and practice in designated rural BC communities.
   - There are 2 components of the RRP: Fee Premiums (from 4.2 to a maximum of 30%) are paid to any physician who provides service in an eligible rural community, and Flat Fees (from $3,672 up to $31,365 annually) are paid to any physician who earns at least $65,000 per year and resides and practices for at least 9 months of the year in an eligible rural community.
2. Recruitment Incentive Fund
   - RIF provides up to $20,000 to a physician who is recruited to fill a vacancy, as per the health authority Physician Supply Plan, in an eligible rural community.
3. Rural Continuing Medical Education
   - RCME offers eligible rural general practitioners up to $5,720 per year and eligible specialists up to $7,800 per year to acquire and maintain medical skills and expertise for rural practice.

FINANCIAL IMPLICATIONS

The total budget for the rural programs is approximately $106.8 million. The utilization-based programs are forecast to cost approximately $76.7 million for 2014/15. The JSC's budget is $40.3 million effective April 1, 2014.

Approved by:

Ted Patterson, Health Sector Workforce Division; February 15, 2015
Ted Boomer obo Manjit Sidhu, Finance and Corporate Services Division; April 1, 2015

FACT SHEET

Workplace Violence in Health Care

ISSUE

The Ministry of Health working with key stakeholders to help strengthen workplace violence prevention in health care.

KEY FACTS

Summit on Workplace Violence in Health Care

- Following a letter from the Health Sciences Association, President Val Avery, the Ministry of Health convened a Summit on workplace violence in health care.
- The Summit took place on April 7, 2015 and provided a platform to explore best practices, as well as have a discussion around new ideas on how to deescalate violent situations and make work places safer.
- The Ministry is working on puting together an action plan that highlights both short-term goals and comprehensive long-term strategies using the Summit discussions as a guide, as well as ideas brought forward separately from unions and other stakeholders.
- The action plan is slated to be complete in the next several months.

Facility Staff Meetings

- The Ministry and the BC Nurses' Union agreed to look at ways to improve safety starting with four facilities:
    - Forensic Psychiatric Unit in Port Coquitlam
    - Hillside Centre in Kamloops
    - Seven Oaks Tertiary Mental Health in Victoria
    - Abbotsford Regional Hospital
- Meetings with frontline staff, management, union representatives, health authority executives and ministry representatives took place at each of these sites at these sites between April 22nd and May 5th.
- These meetings generated positive open discussion on workplace violence prevention.
- Information gathered form these meeting will be developed claboratively into tailored solutions for each site as well as part of a broader workplace violence prevention action plan in the near future.

Hillside Incident

- A nurse was assaulted by a patient on Wednesday April 15th at Hillside Centre in Kamloops.
- On April 17th the Minister of Health met with representatives from the Ministry, the BC Nurses Union, and Interior Health at Hillside to review the situation and put immediate measures in place to ensure staff and patients are safe in our facilities.
- A formal review of this incident is also being completed.
- To ensure staff and patient safety immediately, a plain clothes security guard was added to the staffing mix. This additional security will be on site 24 hours a day, 7 days a week to respond to incidents when needed, while an investigation into the incident takes place.
- In the longer term, the Ministry will be taking a holistic look at best practices to reduce violence including staffing levels, training requirements, safety measures and patient outcomes.

FACT SHEET

Current Successes

- In January 2011 the $37 million Health and Safety in Action initiative was launched which includes the Provincial Violence Prevention Education program to ensure health care workers' safety.
- This program provides health care workers and their managers the education and tools they need to prevent, defuse and/or deal with potentially violent situations to reduce their risk of injury and also to ensure that they feel safe in their workplaces.
- Early evaluations from the initial 17 sites the program was piloted at show a close to a 40% decrease in WSBC claims costs for injuries related to incidences of violence at those sites.
- The program is now implemented provincially. As of December 2014, almost 40,000 employees have completed the online violence prevention training modules and approximately 19,000 staff have completed the more in-depth classroom sessions.
- It is also regarded as a model program and has been reviewed by Alberta, Newfoundland and other provinces as best practice.
- In addition, as part for the last round of bargaining with health union, an Occupation Health and Safety and Violence Prevention Committee was formed. One of the main areas of focus for this committee has been updating violence prevention curriculum and modules.
- We have also implemented OHS Connect – an online community where anyone working in BC healthcare can collaborate on projects and share resources that deal with Occupational Health & Safety.
- And Ministry of Health policy requires health authorities assess the risk for violence and aggression in all facilities, and ensure there are safety plans and programs in place based on the level of risk.
- Over the last three years, the number of code whites have droped from 4,307 to 3,749; despite health authorities treating more and more patients each year. Code White calls represent 0.01% of over 30 million services provided to British Columbians.

Health Authority Initiatives and Programs Related to Violence Prevention

- Interior Health has developed new Violence Prevention Workplace Risk Assessments and standardized Code White responses and response teams, based on the level of risk and need.
- In Interior Health, the number of Code White incidents in acute care has decreased over the past three years, and that the rate of injuries to staff per incident is down. That is attributable to better prevention practices and training or more effective "hands off" interventions.
- Vancouver Coastal Health has recently committed approximately $2 million for violence education upgrades for staff working in high-risk environments to ensure they can remain safe regardless of the situation facing them.
- This funding also enabled Vancouver Coastal Health to expand its Violence Assessment team from two to six staff members.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Ted Patterson, Health Sector Workforce Division; May 6, 2015

FACT SHEET

Blood Glucose Test Strips - New Coverage Limits

ISSUE

Effective January 1, 2015, BC PharmaCare limits the number of blood glucose test strips (BGTS) it covers for a patient each calendar year. This change is based on research showing that more frequent blood glucose testing has a limited benefit for most people with diabetes who do not use insulin.

KEY FACTS

- PharmaCare provides coverage for BGTS to patients who medically require testing and who have received a certificate of training from an accredited Diabetes Education Centre, subject to annual quantity limits. There was no limit on the number of strips covered by PharmaCare for eligible patients -prior to 2015.
- In 2009 the Canadian Agency for Drugs and Technologies in Health (CADTH) reported that self-monitoring of blood glucose (SMBG) does not improve glycemic control in diabetes patients not treated with insulin; CADTH thus does not recommend routine use of SMBG for most of these patients.[1]
- Reducing the frequency of SMBG can have positive effects on patients and on the health system. Reduced SMBG can result in:
    - Decreased lifestyle disruption for patients
    - Greater focus on overall diabetes management, rather than monitoring
    - Significant savings for the health system
- In 2010, Medical Beneficiary and Pharmaceutical Services Division (MBPSD) developed and launched a multi-faceted education campaign promoting evidence-informed use of BGTS in British Columbia.
- In 2011, the Canadian Diabetes Association (CDA) published a commentary for healthcare providers recognizing that some limits on the number of BGTS reimbursed for patients on oral anti-diabetes medications may be reasonable.[2]
- In February 2014, MBPSD engaged with stakeholders (e.g., CDA, healthcare professionals, BC Pharmacy Association etc.) and discussed options to address the utilization of BGTS, including limiting the quantity of BGTS currently being reimbursed. The most recent examples of BGTS quantity limit policies that incorporate elements of both the CADTH and CDA recommendations, such as in Ontario and New Brunswick, were discussed in detail.
- Common aspects of the policies include: identification of patient categories eligible for BGTS coverage and their respective maximum annual BGTS limits, the need for exceptions to the annual allowance, and a list of exceptions.
- Following a review of the current PharmaCare BGTS coverage policy and the input from key stakeholders during the February 2014 engagement session, the Ministry announced a policy with BGTS quantity limits on November 27, 2014.
- These quantity limits are aligned with those recommended by the CDA and currently used in Ontario.
- Effective January 1, 2015, PharmaCare began applying the annual quantity limits of BGTS which will be reimbursed per patient per calendar year based on four categories of patients.

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[1] Optimal Therapy Recommendations for the Prescribing and Use of Blood Glucose Test Strips. Available online at: http://www.cadth.ca/media/pdf/compus_BGTS_OT_Rec_e.pdf

[2] Self-Monitoring of Blood Glucose in People with Type 2 Diabetes: Canadian Diabetes Association Briefing Document for Healthcare Providers (*Canadian Journal of Diabetes*; Sept 2011)

FACT SHEET

- The categories are determined by the type of diabetes-related medications a patient is taking, if any.
- When a claim is submitted for BGTS, PharmaNet reviews all claims submitted in the previous 180 days for anti-diabetes medications, whether or not the medications are covered by PharmaCare, and assigns the patient to one of the four categories.
- There may be exceptional clinical circumstances in which patients need additional test strips above their annual quantity limit.
- Requests for coverage of additional strips, up to the maximums indicated below, can be made through the PharmaCare Special Authority process by a patient's doctor or healthcare professional at an accredited Diabetes Education Centre.
- In the rare case that a patient has a medical need to test even more frequently, or if they take insulin and need to test more frequently, their endocrinologist can submit a request to PharmaCare for additional strips. Requests are considered on a case-by-case basis.
- The four patient BGTS categories and the associated annual quantity limits for BGTS are as follows:

Patient BGTS Category	Annual Quantity Limit	Annual Exception Limit
Managing diabetes with insulin	3,000	No additional allowance
Managing diabetes with anti-diabetes medications with a higher risk of causing hypoglycemia	400	100
Managing diabetes with anti-diabetes medications with a lower risk of causing hypoglycemia	200	100
Managing diabetes through diet/lifestyle	200	100

FINANCIAL IMPLICATIONS

It is anticipated that PharmaCare will save up to $1 million this fiscal year, and $4 million each year afterwards as a result of this new policy.

Approved by:

Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 11, 2015
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; February 25, 2015

FACT SHEET

Cambie Surgeries Corporation Legal Action

ISSUE

In January 2009, following an audit conducted by the Medical Services Commission (MSC) which found evidence of systematic violation of the *Medicare Protection Act* (MPA), Cambie et al commenced legal proceedings against the Ministry of Health, the MSC, and the Attorney General of BC (the government). The legal proceedings allege that sections of the MPA that prohibit extra billing and private insurance for Medcial Services Plan (MSP) benefits are in breach of the *Charter of Rights and Freedoms*. The matter is currently before the courts.

KEY FACTS

- The MPA is designed to preserve a publicly-managed and fiscally sustainable health care system for BC, in which access to medical care is based on need and not on an individual's ability to pay.
- The MSC has a legislative mandate to independently protect the integrity and sustainability of the health care system and uphold the MPA.
- Section 36 of the MPA gives the MSC the authority to audit private clinics for extra billing. Extra billing is the practice of charging beneficiaries for MSP benefits, or for matters relating to the rendering of benefits.
- s.14,s.15,s.17

- In January 2009, an action was filed in the Supreme Court of BC by the Canadian Independent Medical Clinics Association (CIMCA) and 5 private clinics, including Cambie Surgeries Corporation, asserting that the prohibitions on extra billing and private insurance in the MPA constitute a deprivation of rights guaranteed by sections 7 and 15 of the *Charter*.

<u>The Plaintiffs, the Trial Motions and the Trial Date</u>

- CIMCA and 4 of the private clinics dropped out of the litigation in July 2010. The Specialist Referral Clinic and s.22 patients were added as plaintiffs in late 2012/early 2013.
- In a counterclaim filed in February 2009, the MSC sought declarations that the Cambie Surgery Centre and the Specialist Referral Clinic have contravened and/or will contravene the MPA, along with interim and permanent injunctions restraining them from contravening these provisions.
- The audit report was released on July 18, 2012. The MSC filed an interim injunction application against both the Cambie Surgeries Corporation and the Specialist Referral Clinic (Vancouver) Inc. in early September 2012 with the intent of pursuing legal remedies claimed against the Cambie Surgery Centre and Specialist Referral Clinic in the 2009 counterclaim. The MSC also requested that its Audit and Inspection Committee undertake focused audits of the physicians who appear to have been involved in double or overlapping billing, where both patients and MSP were billed for, or in connection with, the same medical service.
- In October and November 2012, the plaintiffs filed 25 affidavits sworn by various patients and physicians, in response to the MSC injunction application. The MSC applied to strike out large parts of the affidavit material, and the plaintiffs applied to prohibit the MSC from bringing its interim injunction application.
- In January 2013, the plaintiffs filed a further amended claim and the defendants filed an amended response and three counterclaims, one on behalf of each of the Minister, the MSC, and the Attorney General.

FACT SHEET

- s.14

- The judge set up a timeline, permitting the trial to proceed in 2014.
- The Cambie trial was scheduled to start on September 8, 2014. In advance of the scheduled start of the trial, the plaintiffs approached government with a proposal to adjourn the trial in order to permit discussions aimed at a resolution of the litigation. Discussions proved unsuccessful.
- The case is expected to proceed to trial. No trial date has been set.

Discoveries Process

- Since 2012, the plaintiffs and government have been engaged in the discoveries process, which includes the discovery of documents, examination for discovery, interrogatories, and pre-trial examination of witnesses.
- The Ministry is under an ongoing legal obligation to provide all relevant documents to the Ministry of Justice so that government can discharge its legal duty for the discovery of documents.
- s.14

  s.14 Disclosure requirements extend to all electronic and hard copy documents such as reports, briefing notes, and correspondence as well as all e-mails held by any staff member in the Ministry that contain specific key words.
- The Ministry has been making efforts since 2012 to produce all relevant documentation created or held by staff in the Ministry from 2005 to present.
- Many of the issues that are relevant to the trial (such as wait times for surgery and extra billing) are broad areas of both historical and ongoing focus for large portions of the Ministry such as the Health Services Quality Assurance and Planning and Innovation Division. As a result, the Ministry has produced, and continues to produce, high volumes of documents that could potentially be relevant to the issues at trial.
- s.14

- Staff are currently engaged in a Ministry-wide, bi-weekly effort to disclose all new or amended documents to ensure continued obligations are met.
- s.14

FINANCIAL IMPLICATIONS

- Pursuant to the *Canada Health Act* BC faces a reduction in transfer funds from the federal government for any established instances of extra billing that the Province has allowed.
- To expedite the review of relevant documents, the Ministry agreed with the hiring of 4 law students who will work over the summer with the litigation team at the Ministry of Justice.

Approved by:
Lynn Stevenson, Associate Deputy Minister-Health Services, April 30, 2015

s.14

FACT SHEET

DPP-4 Inhibitor Drugs for Type 2 Diabetes

ISSUE

On August 5, 2014, PharmaCare changed its coverage of the dipeptidyl peptidase-4 (DDP-4) inhibitor drugs for treatment of Type 2 diabetes to cover linagliptin and saxagliptin and to delist sitagliptin.

KEY FACTS

- Building upon a comprehensive review completed by the Canadian Agency of Drugs and Technologies in Health, the Ministry of Health initiated a comprehensive therapeutic review of DPP-4 inhibitor drugs for treatment of Type 2 diabetes.
- Therapeutic reviews examine several drugs within a related therapeutic group to determine similarities and differences in benefit, risk and value.
- The review concluded that DPP-4 inhibitors have similar clinical efficacy and harms and coverage of DPP-4s should be based on best value for money.
- Alogliptin, a recently approved DPP-4 inhibitor, was not included in the therapeutic review as it was still under review by the Common Drug Review (CDR) at the time. CDR has now completed and the Ministry will now review alogliptin and alogliptin-metformin combination product.
- Based on the review findings that the three DPP-4 drugs are basically the same, the Ministry engaged the manufacturers of sitagliptin, linagliptin, and saxagliptin to seek the best value and to provide reasonable product choice.
- Discussions with manufacturers started in December 2013. All manufacturers were advised of the Ministry's approach i.e. to select the best value proposals. All manufacturers were given fair opportunity to submit their best value proposals and to have any other information considered.
- PharmaCare also requested and received recommendations on the DPP-4 inhibitor drugs from the expert Drug Benefit Council, and consulted with endocrinologists, patient advocacy groups, and physicians of BC.
- Effective August 5, 2014, PharmaCare changed its coverage of the DDP-4 inhibitor drugs:
  - Linagliptin (Trajenta®) remains a Limited Coverage benefit.
- Three new drugs are covered as Limited Coverage benefits:
  - linagliptin-metformin (Jentadueto™),
  - saxagliptin (Onglyza®), and
  - saxagliptin-metformin (Kombiglyze™).
- Two drugs are no longer covered for patients not already taking these medications:
  - Sitagliptin (Januvia®) and
  - sitagliptin-metformin (Janumet®).
- Patients with current Special Authority (SA) approved coverage for sitagliptin and sitagliptin-metformin will continue to have coverage until February 5, 2015.
- During a transition period ending February 5, 2015, patients currently taking sitagliptin or sitagliptin-metformin can choose to switch to another PharmaCare-covered DPP-4 inhibitor. These patients will have automatic SA coverage of linagliptin and saxagliptin products, and an additional SA request is not required when switching a patient to these products.
- If a patient is unable to tolerate both linagliptin and saxagliptin, reimbursement for sitagliptin will be considered on an exceptional basis through the SA process based on the specific circumstances of the patient.
- Representatives of Merck Canada Inc., the manufacturer of the delisted drugs, sitagliptin and sitagliptin-metformin have expressed concerns and disagreement about the delisting. All three

manufacturers were approached similarly and were provided a fair and transparent opportunity to submit their value proposals.

- s.13

- On August 12, 2014, the *Vancouver Sun* published an opinion piece by Robert Oliphant, President and CEO of the Asthma Society of Canada, claiming that the change in DPP-4 coverage was "therapeutic substitution policy" which had been shown to "disrupt treatment, destabilize sick patients, and often cause people to stop treatment all together."[1]
- On August 17, 2014, the *Vancouver Sun* published a response from Eric Lun, Executive Director, Drug Intelligence & Optimization Branch, Medical Beneficiary and Pharmaceutical Services Division, Ministry of Health, which emphasized that there is substantial evidence showing therapeutic substitution to be safe and effective, that other provinces and countries use therapeutic substitution routinely, and that the decision to change DPP-4 coverage will save PharmaCare millions of dollars a year, which will be used to fund other drugs and programs.2
- Following BC PharmaCare's decision to delist sitagliptin, the manufactuer of this drug Merck funded a survey of BC physicians called BC Voice. All 4,500 BC physicians in BC were invited to respond to the 10 minute survey. There were 332 (7%) respondents, who were paid $150 for completing the survey. The survey study results including a webcast of a result interpretation with an "expert" are publicly available at: http://bcvoice.ca/
  - The results are critical of the PharmaCare consultation and decision process and speculates on the potential negative patient impact.
  - While the survey study is presented with the appearance of using an academic research approach, there is many limitations to the "study", including:
    - Undisclosed influence by the study sponsor Merck
    - Potential conflict of interest by study expert panel members
    - Respondents were not provided with any context of the Ministry review process
    - Risk of respondent selection bias (respondents were paid $150 for participating)
    - Survey questions were leading, biased, and contained misinformation.

FINANCIAL IMPLICATIONS

- s.21
- The decision to add three DPP-4 drugs and delist two will save PharmaCare millions of dollars per year. The decision maximizes the value for money for products with similar efficacy and safety and allows the dollars saved to fund other drugs and certain devices like insulin pumps for diabetics.

Approved by:
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 11, 2015

[1] Robert Oliphant (August 12, 2014). "Opinion: Drug switch puts cash before patients." *Vancouver Sun*. Retrieved September 16, 2014, from http://www.vancouversun.com/health/Opinion+Drug+switch+puts+cash+before+patients/10110758/story.html
[2] Eric Lun (August 17, 2014). "Opinion: Drug substitution safe and effective." Vancouver Sun, retrieved September 16, 2014, from http://www.vancouversun.com/opinion/op-ed/Opinion+Drug+substitution+safe+effective/10126209/story.html.

FACT SHEET

Drug Shortages

ISSUE

While periodic shortages of both brand and generic prescription drugs are known to occur, there appears to be an increase in the frequency and duration of various drug shortages in recent years.

KEY FACTS

- Drug Shortages are a national and international issue with a number of contributing factors, including shortages of raw materials; process problems at specific manufacturing plants; the number of available suppliers; and quality control issues resulting in the recall of substantial lots; manufacturing plant shut downs; or Health Canada regulatory action (i.e., importation bans).
- Canada has experienced nation-wide shortages of a number of drugs which have been managed through federal/provincial/territorial efforts including the following:
    - In February 2012, there was a broad shortage of certain injectable drugs, including some drugs produced solely by Sandoz Canada. The shortage was due to reduced operation at the Boucherville-Quebec manufacturing site, in order to remediate the quality control process issues at the facility which were identified by the United States Food and Drug Administration, as well as other related logistical supply chain issues. As of January 2015, the Sandoz injectable drug shortage issue is still being managed and is not yet completely resolved.
    - Since September 30, 2014, Health Canada has imposed an import ban on products from seven sites in India. The ban applies to finished products and active pharmaceutical ingredients used to make finished products. Health Canada has designated some products to be medically necessary and requires independent testing before the products can be released back onto the market. These shortages are being managed and no urgent issues have been identified to date.
- The Ministry of Health is actively working with other provinces and territories, Health Canada, BC's health authorities, Health Shared Services BC, health professional associations and the colleges to manage shortage situations. The collaborative proactive actions taken to manage the drug shortages have been effective in minimizing potential patient care impacts in BC.
- In the community supply chain, the specific drug shortages vary from province to province. In BC, there are 198 reported drug shortages in the community supply chain as of May 5, 2015[1] (which represents a decrease from 296 recorded on January 13, 2015).
- The Ministry continues to share information about community supply chain drug shortages specific to BC with stakeholders including BC Pharmacy Association and ensures the best alternative drugs are available for PharmaCare program coverage during a drug shortage. The Ministry temporarily provides PharmaCare coverage for drugs not usually eligible for coverage. Through the Special Authority program, coverage may also be provided for compounded products. The BC Pharmacy Association shares the community supply chain shortage information with their members through e-bulletins.
- In March 2015, the Ministry launched a new Drug Shortages Web Page to provide up-to-date details on all shortages of drugs covered by PharmaCare as reported by BC community pharmacies and confirmed with manufacturers and wholesalers. (www.health.gov.bc.ca/pharmacare/drugshortages.html).

[1] Information Support, Health Insurance BC – drug shortages spreadsheet maintained by HIBC - Information Support

FACT SHEET

- The Ministry recognizes drug shortages are a complex issue and that collaboration among governments, manufacturers and suppliers is needed to effectively avoid, manage and mitigate them.
- BC is participating in a number of drug shortages task groups along with healthcare professionals, federal, provincial and territorial governments and industry to identify and develop strategies to manage drug shortages that impact jurisdictions in Canada.
- As of September 2014, BC is leading the Provincial/Territorial Drug Shortages Task Team for a two year term.
- In September 2014, BC is co-leading (with Health Canada) the Multi-Stakeholder Steering Committee on Drug Shortages in Canada for a two-year term.
- In 2011, the federal Minister of Health called on industry and health professional associations to provide public notification of drug shortages in Canada and an industry funded voluntary reporting system was launched at www.drugshortages.ca. The jurisdictions look forward to seeing continued revisions in the future to ensure it is reliable, timely and fulsome. A number of drug shortages working papers and toolkits have also been posted to this website in 2013.
- On February 10, 2015, the federal Minister of Health announced that the Government of Canada is moving towards a mandatory reporting system that requires all manufacturers to publicly report drug shortages. This supplements the Public Notification Register that had previously been launched on Health Canada's website that lists manufacturers that fail to voluntarily post their shortages. The Honourable Terry Lake and the Ministry are very supportive of these initiatives.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; May 7, 2015

FACT SHEET

Expensive Drugs for Rare Diseases

ISSUE

Expensive Drugs for Rare Diseases (EDRD) present a host of complex challenges, as these drugs are prohibitively expensive, often have limited clinical evidence to support their use, and benefit only a small number of patients.

KEY FACTS

- Because coverage of pharmaceuticals is not included in the *Canada Health Act*, drug coverage including EDRD drugs may vary from province to province. There are differing definitions of disease "rarity" depending on the respective country. Health Canada is considering an incidence rate of 50 people per 100,000 Canadians in its proposed Orphan Drug Regulation.[1]
- EDRD, as currently defined by the Ministry of Health, are defined as drugs to treat rare diseases with an incidence rate of 1.65 per 100,000 and with an annual cost of $50,000 or more per patient.
- Because of the rarity of the diseases, drugs being developed often do not have strong clinical evidence supporting their efficacy and/or safety. Study limitations may include few study subjects, the use of non-clinical endpoints (e.g., lab test instead of survival), or short term study follow up.
- Most EDRDs have only demonstrated an ability to slow the certain aspects of a disease (e.g. like a lab or physical performance result) rather than an increase in survival or cure.
- Companies developing such drugs usually price the product very high, arguing they need to recoup drug development costs from a small market but do not provide any transparency to justify such prices. The products are typically priced for governments or insurance companies and are far beyond any individual's or family's ability to pay.
- With such considerations of disease rarity, limited evidence, and high per-patient costs, EDRDs raises many ethical, clinical and financial issues for provincial payers.
- The Ministry has established a two year BC residency requirement for EDRD funding requests to be considered in BC.
- The Ministry seeks advice for EDRD coverage decisions from an arm's length independent Advisory Committee and several Clinical Subcommittees.
- The Advisory Committee includes expert clinicians who treat rare diseases in pediatrics and adults, a critical care medicine specialist, a health economics specialist, an ethics specialist, and representatives from health authority pharmacy and health authority administration.
- The Advisory Committee is responsible for evaluating patient-specific funding requests and forwards their recommendations to the Ministry for a funding decision.
- The Advisory Committee's evaluation may include, but is not limited to: natural disease history, clinical evidence, effectiveness/efficacy of the drug, alternative treatment options, specifics of individual case, expected treatment outcome, consequences if treatment is withdrawn or not provided, pharmacoeconomic evidence, budget impact, clinical guidelines, and ethical considerations.
- In April 2013, Health Canada began a consultation regarding a new Orphan Drug Regulation, intended to improve market access to drugs for rare diseases. The Ministry reviewed the draft and provided feedback to Health Canada in January 2014 through CADTH's Drug Policy Advisory Committee, which includes membership from all other public drug plans across Canada.

[1] Health Canada – An Orphan Drug Framework for Canada. (www.hc-sc.gc.ca/ahc-asc/media/nr-cp/_2012/2012-147a-eng.php).

- As of January 2015, the Ministry provides funding for the following s.22 on an exceptional, last-resort, case-by-case basis[2]:
  s.22

- In October 2013, the national Canadian Fabry Disease Initiative (CFDI) was renewed again. The CFDI began funding patients in 2006 as an F/P/T initiative. While the federal government supported the initiative from 2006 to 2009, they pulled their funding and support in 2009.
- In January, 2014, the Ministry decided not to fund eculizumab for atypical hemolytic uremic syndrome due to unclear clinical benefit and high drug costs (more than $700,000 per year per patient). This decision was supported by recommendations made by the national Common Drug Review and the Ministry's Drug Benefit Council.
- In summer 2014, the Ministry signed a Letter of Intent for ivacaftor (Kalydeco®), a drug developed to treat a specific group of cystic fibrosis patients. On behalf of BC and other public drug plans, Alberta led the negotiations with the manufacturer to try and achieve a substantial price reduction. The Ministry will provide funding for this drug through the EDRD program and the first funding recommendations from the EDRD Advisory Committee are expected in early 2015.
- On September 30, 2014, the P/T Health Minister's announced the establishment of an orphan diseases drug therapy working group led by Alberta, BC and Ontario. The group will explore how to manage the cost of rare disease drug therapies with evidence-based approaches.

FINANCIAL IMPLICATIONS

- The total drug costs for EDRD in 2013/14 were about $13 million.[3]
- The annual treatment costs for EDRD drugs per patient may range from $50,000 to over $900,000 and vary depending on the drug, weight of the patient and dosage regimen.

Approved by:
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 11, 2015
Jackie Redmond, obo Carolyn Bell, Health Sector Planning and Innovation Division; February 12, 2014
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; October 21, 2014

[2] 10.13-14 EDRD Case Tracking Document January 2014". Medical Beneficiary and Pharmaceutical Services Division, Ministry of Health. Accessed January 30, 2014.
[3] Financial & Corporate Services Division, Ministry of Health (13/14 year end financials).

FACT SHEET

Extra Billing – *Canada Health Act*

ISSUE

The *Canada Health Act* establishes criteria that provinces must meet with respect to "insured health services" (which include any medically required services of hospitals and medical practitioners) in order to receive full federal transfer payments and explicitly prohibits user fees and "extra billing" of patients for "insured services" and requires the federal government to deduct an amount equal to such charges from transfer payments to a province involved.

KEY FACTS

- The BC Government is committed to upholding the principles of the *Canada Health Act* and to our publicly funded health care system, in which access to medically necessary services is based on a patient's clinical need rather than ability to pay.
- The Act requires provinces to submit a financial statement each December showing the amount charged to patients through extra billing and/or user charges for the fiscal year ending 21 months previously (e.g., December 2014 for 2012/13).
- Amounts reported by BC to Health Canada on extra billing and/or user charges, and corresponding federal deductions for prior years were:
    - 2012/13 - $241,637 ($67,144 in reported patient charges and $174,493 additional Health Canada assessment based on specific findings in the Cambe Surgery Centre audits)
    - 2011/12 - $224,568 ($50,075 in reported patient charges and $174,493 additional Health Canada assessment based on specific findings in the Cambie Surgery Centre audits)
    - 2010/11 – $280,019 ($105,526 in reported patient charges and $174,493 additional Health Canada assessment based on specific findings in the Cambie Surgery Centre audits)
    - 2009/10 - $33,219
    - 2008/09 - $75,136
    - 2007/08 - $73,925
    - 2006/07 - $66,194
    - 2005/06 - $42,509
    - 2004/05 - $114,850
    - 2003/04 - $29,018
    - 2002/03 - $72,464
    - 2001/02 - BC declined to submit a report for 2001/02, with the result that Health Canada levied a deduction, apparently based on media reports about the extent of extra-billings by private clinics in BC.
    - 2000/01 - $4,610
- Reported extra-billing has generally been associated with private surgical facilities or specialist consultation services.
- The Ministry's Medical Beneficiary Branch follows up on all alleged cases of extra billing that are brought to its attention by writing to the physicians and clinics involved requesting refunds to patients of any inappropriate charges. Unresolved cases are referred to the Medical Services Commission for further review and/or action.
- On average, the Medical Beneficiary Branch investigates approximately 30 cases of extra billing annually.

FACT SHEET

FINANCIAL IMPLICATIONS

BC's requirement to report on extra billing and/or user charges annually to Health Canada results in a reduction to federal government health transfer payments.

Approved by:

Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; January 22, 2015

Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; January 30, 2015

FACT SHEET

Fair PharmaCare

ISSUE

Fair PharmaCare is BC's income-based drug plan. This plan covers the majority of BC residents who are eligible for PharmaCare benefits and offers assistance based on family net income.

KEY FACTS

- Introduced on May 1, 2003, Fair PharmaCare is BC's universal, income-based drug insurance plan. Fair PharmaCare financial assistance is based on three elements, which are calculated as a percentage of family net income (see table below for details):
  - Deductible: families are responsible for all drug costs until they reach their deductible.
  - Co-payment: after a family has reached its deductible, further drug expenditures are shared between PharmaCare and the family, with PharmaCare paying the larger portion.
  - Family maximum: the maximum amount a family will pay toward eligible drug costs in a year. Eligible drug costs above the family maximum are paid by PharmaCare.
- Families who have had at least a 10% reduction in family income may request adjustment of their deductible or family maximum through Health Insurance BC, the administrator of the PharmaCare program.
- Families with one or more members born before 1940 receive enhanced assistance. Enhanced assistance benefits are somewhat more generous than regular Fair PharmaCare benefits and were introduced to mitigate the impact of the change from an age-based plan to an income-based plan.

	Net Annual Family Income	Family Deductible	Patient Co-payment (% of eligible prescription drug costs)	Family Maximum
Fair PharmaCare	Less than $15,000	None - Government assists with drug costs immediately.	30%	2% of net income
	Between $15,000 and $30,000	2% of net income	30%	3% of net income
	Over $30,000	3% of net income	30%	4% of net income
Enhanced Assistance	Less than $33,000	None - Government assists with drug costs immediately.	25%	1.25% of net income
	Between $33,000 and $50,000	1% of net income	25%	2% of net income
	Over $50,000	2% of net income	25%	3% of net income

- To be eligible for Fair PharmaCare assistance, a registrant must: be a resident of BC; have medical coverage under the BC Medical Services Plan; have a Social Insurance Number and; file income taxes in Canada. Families may register for Fair PharmaCare by contacting Health Insurance BC via phone, mail, fax, or the PharmaCare website.
- Total registration for Fair PharmaCare has grown each year since 2003. As of the end of 2013/14, over 1.2 million families were registered.[1] The Medical Beneficiary and Pharmaceutical Services Division has undertaken several initiatives to encourage British Columbians to register for Fair PharmaCare, including:
  - The distribution of Fair PharmaCare information brochures and posters to pharmacies, Service BC Centres, employment and income assistance regional offices, health fairs and mental health service centres in BC.
  - Making Fair PharmaCare brochures available in English, Punjabi, and Chinese.

[1] PharmaNet, Medical Beneficiary and Pharmaceutical Services, September 3, 2014

FACT SHEET

- The addition of Fair PharmaCare brochures to MSP application kits.

Fair PharmaCare - Utilization and Expenditure Statistics (millions) [1]

(millions)	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
Total amount paid by PSD	$535.53	$555.59	$572.35	$584.54	$579.18	$567.34	$553.64
Number of beneficiaries	0.61	0.58	0.57	0.57	0.57	0.55	0.52
Total PCare Expenditure[2]	$946.78	$989.17	$1,032.10	$1,100.5	$1,109.8	$1,100.88	$1,076.15

- Results of a divisional simulation showed that over 300,000 BC families were made better off by the introduction of Fair PharmaCare.[3]
- The introduction of Fair PharmaCare resulted in a reduction in the Division's share of total community provincial (public and private) drug expenditure, to 41.5% in fiscal year 2003/04. The Division's share of prescription drug expenditures was 39.1% during 2013/14. In fiscal year 2013/14, Fair PharmaCare provided assistance to approximately 516,000 British Columbians on roughly 13.4 million prescriptions.[1]

Medical Beneficiary & Pharmaceutical Division (PharmaCare) share of Provincial Drug Expenditure claimed through Retail Pharmacies (millions)

(millions)	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/14
Total PCare Expenditure[2]	$946.78	$989.17	$1,032.10	$1,100.50	$1,109.80	$1,100.88	$1,076.15
Total Drug Exp in BC[1]	$2,270.21	$2,434.06	$2,574.14	$2,677.08	$2,732.49	$2,736.83	2,751.25
% PCare Expenditure	41.70%	40.64%	40.10%	41.11%	40.61%	40.22%	39.11%

FINANCIAL IMPLICATIONS

N/A

Approved by:

Glynis Soper, Health Sector Planning and Innovation Division; June 26, 2013
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; January 21, 2015
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; October 7, 2014

[2] Financial and Corporate Services, Ministry of Health
[3] PSD simulated the Fair PharmaCare claims adjudication for 2004 under the 2001 policy rules, using PharmaNet data in 2005.

FACT SHEET

Generic Drugs – Single-Sourced Listing Opportunities

ISSUE

Under some situations, the Province of BC will provide full coverage for only one drug product (single-sourced) to ensure cost-effectiveness for British Columbians, in accordance with the Province's Drug Price Regulation. As a result, other drug products in the same drug category that do not meet the regulated price will be "delisted" or deemed unaccepted for up to one year.

KEY FACTS

- In the spring of 2012, the Province passed the *Pharmaceutical Services Act*, and the Drug Price Regulation under the Act, received Cabinet approval in November 2012. Under this regulation, the cost of generic drugs was lowered to 25% of the brand name drug price on April 1, 2013, and to 20% on April 1, 2014[1]. The Regulation does not stipulate further reduction beyond 20% (or 35% for non-oral solids) of the brand name drug price.
- Despite the passing of the Regulation, many generic drug categories are provisionally listed at prices higher than the regulated price, due to lack of submission priced at or below our regulated price.
- According to a December 2014 report from Patented Medicine Prices Review Board, Canadian generic prices remain one of the highest among 12 different countries. One key highlight is that the mean international prices is 39% lower than that of Canada for drugs with estimated annual sales in Canada of $10 million or more[2].
- To encourage manufacturers to provide their best value for generic drugs, the Province offers one opportunity for manufacturers to submit their best price through the annual generic drug price confirmation process. Products that are listed or accepted will be covered during the pricing period (April 1 to March 31 of the following year). Products not listed or deemed unaccepted will not be considered for coverage until the next pricing period.
- This is a regular process that the Province has undertaken for many years.
- s.13,s.17

- The delisting is temporary and will last no longer than one year.
- The adoption of single-sourced listing opportunities in the Province has been successful in moderating drug prices. Recent examples include metformin and donepezil, which are expected to result in notable cost savings. s.13,s.17
  s.13,s.17
- For the 2015/16 pricing period, the Province reviewed all potential single-sourced listing opportunities that met the regulated price and the Province will be proceeding with seven single-sourced molecules. This will result in millions of dollars in estimated savings.
- The Province carefully evaluated and assessed the feasibility for each single-source listing opportunity. The following are some of the factors considered:
  - A clinical assessment to ensure minimal risk/impact for patients;
  - A review of recent and past performance of the manufacturer(s);

[1] Government of BC (2012). News Release: *New Drug price regulation to benefit B.C. families.* Retrieved on December 20, 2013 from: http://www2.news.gov.bc.ca/news_releases_2009-2013/2012HLTH0137-001844.htm

[2] Generic Drug in Canada 2013 (December 2014), Patented Medicine Prices Review Board. http://www.pmprb-cepmb.gc.ca/view.asp?ccid=1122

  - Obtaining a manufacturers' formal commitment to ensure a minimum of two months' supply available in the Province on or before the effective listing date and on an ongoing basis; and
  - Manufacturers' agreement to cover financial costs in the event of a temporary shortage.
- Advance notification to various stakeholders, prior to the effective date of the single-sourced changes, was provided.
- Single-sourced listing decisions in relation to the annual price confirmation process will be available in an upcoming PharmaCare Newsletter to ensure all pharmacies are informed.
- On May 20, 2014, the participating provinces and territories and Canadian Generic Pharmaceutical Association agreed on a three-year Tiered Pricing Framework, whereby the prices of new to the market, single-source generic drugs (supplied by only one manufacturer in Canada) would reduce to 75% or 85% (if a Product Listing Agreement does not exist) of the brand name drug price. A second entry in the market (resulting in two manufacturers) would drop prices to 50% of the brand name drug price. Entry of a third manufacturer would trigger a drop to 25% of the brand name drug price, for oral solids (or 35 % for all other drugs).
- Implementation of the Tiered Framework has taken place at the jurisdictional level, subject to the feasibility of integrating the Tiered Framework into existing jurisdictional policies, regulations and commitments.
- The Tiered Framework will not supersede any existing policies, regulations or commitments in the Province. In particular, the Tiered Framework price threshold ranges from 25% to 85%, which remains higher than the Province's regulated price (20% of the brand price).
- Despite the foregoing, the Province will provide manufacturers the opportunity to price match to a floor of 25% (35% for non-oral solids) of brand name drug price, for Tiered Framework drug categories. However, if a manufacturer submits below 25% or at the regulated price of 20% or below, then the Province is not obligated to allow higher priced products to price match, and are subject to delisting. This is in line with the Province's Drug Price Regulation.

FINANCIAL IMPLICATIONS

- Generic drug pricing initiatives are allowing the Province to be on track to achieving savings of approximately $115 million over the two year period (2013/14 and 2014/15)[3]. This includes the Pan-Canadian Competitive Value Price Initiative for Generic Drugs (drugs priced at 18% of the brand name drug).
- The Province is a proponent of generic drug products as PharmaCare spent approximately $208 million on multi-source drugs in 2013/14[4]. More importantly, multi-source drugs represented 73%of the total number of prescriptions subsidized by PharmaCare and 29% of PharmaCare's total drug expenditures in 2013/14[5].

Approved by:
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 10, 2015
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; February 25, 2015

[3] MBPSD Analysis of PharmaNet Data (May 2014)
[4] MBPSD Analysis of PharmaNet/HealthNet Data (Sept 2014)
[5] MBPSD Analysis of PharmaNet Data (Sept, 2014)

FACT SHEET

MSP for Spouses Sponsored in Canada for Permanent Residence

ISSUE

The Medical and Health Care Services Regulation permits spouses of eligible BC residents to be "deemed" residents for the purpose of enrolment in the Medical Services Plan (MSP). To be eligible, their application for permanent resident status under the 'Spouse or Common-Law Partner in Canada Class' must have been accepted by Citizenship and Immigration Canada (CIC) for processing.

KEY FACTS

- Individuals who sponsor an applicant for permanent resident status in Canada and the individual who is being sponsored must sign a declaration of responsibility as part of the application process. This requirement includes the applicants for permanent residence status under the Spouse or Common-Law Partner in Canada Class.
- The declaration confirms that the parties: (i) understand and (ii) take personal responsibility for the applicant's basic requirements, including medical needs not provided by public health, while awaiting final determination of the application by CIC. Individuals are advised to purchase private insurance to provide coverage during the interim period.
- A person must be a resident of BC to be eligible for publicly funded health care benefits. The *Medicare Protection Act* defines a resident as a person who is a citizen of Canada or is lawfully admitted to Canada for permanent residence, makes his or her home in BC, and is physically present in BC for at least six months in a calendar year. Individuals who hold visitor permits are not deemed eligible.
- Based on the preceding, Canadian citizens and persons with permanent resident status in Canada are eligible for benefits. In addition, certain non-permanent residents may be deemed residents, and thus considered eligible; for example, most holders of study or work permits, if the permits are valid for six or more months, and some applicants being sponsored for permanent residence under the 'Spouse or Common-Law Partner in Canada Class.
- Over the past years, it has been common for persons to experience delays in receiving their permanent resident status as the process of completing each stage to receive permanent resident status is complex and lengthy. CIC posts processing time on their website; applicants should refer to the website to understand how long the process may take. Currently, the approximate wait time for approval of permanent resident status is up to two years or more.
- Health Insurance BC receives over 70 applications per month (approximately 840 per year) for enrolment of a spouse under the deeming provision of the Regulation.[1]
- The Ministry of Health receives many appeals each year from individual's requesting medical coverage prior to receiving confirmation from CIC that their application for permanent residence is being processed.
- It is important to note that a person can receive the required medical and hospital services in BC before qualifying for provincial benefits, thus ensuring the person's health care needs are met. However, unless alternative health insurance has been obtained, and will help with payment, the cost of such services is the responsibility of the person and the person's sponsor.
- The Ministry acknowledges that processing delays at CIC may affect eligibility for MSP benefits. Those delays do not change the eligibility requirements. The necessary CIC documentation must be received by Health Insurance BC to confirm eligibility and complete enrolment in MSP.

[1] Health Insurance BC, 2014

FACT SHEET

FINANCIAL IMPLICATIONS

N/A

Approved by:

Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 20, 2015

FACT SHEET

MSP-Premiums and Premium Assistance Programs

ISSUE

The Medical Services Plan (MSP) insures medically required services provided by physicians and supplementary health care practitioners, laboratory services and diagnostic facilities. Under existing legislation, BC residents must pay premiums for MSP coverage; however, subsidies are available to low income beneficiaries that meet the requirements to qualify.

KEY FACTS

Premiums

- Each province and territory in Canada determines how its health care programs are funded. In BC funding is obtained from general taxes, federal contributions and MSP premiums.
- The provincial government has increased funding for health care every year since 2001. Premium rate increases are necessary to assist in meeting steadily rising costs of BC's health care system.
- Effective January 1, 2015, the unassisted monthly rates are $72.00 for one person, $130.50 for a family of two, and $144.00 for a family of three or more. Monthly premium rates for 2014 were $69.25, $125.50, and $138.50 respectively.
- Premium rates for those qualifying for Regular Premium Assistance remain the same as premium assistance rates that came into effect January 1, 2012.
- There are two assistance programs that offer subsidies to those in financial need that meet the residency and financial requirements to qualify.

Regular Premium Assistance Program

- Offers 5 subsidy levels based on an individual's net income (or a couple's combined net income) for the preceding tax year, less deductions for age, family size, disability and any reported Universal Child Care Benefit and Registered Disability Savings Plan Income. If the resulting amount, referred to as 'adjusted net income' is $30,000.00 or less, assistance is available. Premium assistance may be provided retroactively to a maximum of 6 years from the date on which the request is received.
- In order to ensure fairness and equity for all applicants, as of January 1, 1989, a family's net income, as defined by line 236 on the federal tax return was concluded to be the most equitable factor in determining the level of assistance. MSP's use of line 236 is consistent with the Canada Revenue Agency, who also use Line 236, to calculate certain tax credits such as the Canada Child Tax Credit.
- The Regular Premium Assistance Program was enhanced on January 1, 2010. At that time, the income threshold to qualify for each of the five available subsidy levels was increased by $2,000. As a result, those who qualify and whose incomes have remained consistent will pay lower rates in 2015 than in 2009.

Temporary Premium Assistance Program

- Offers a full subsidy on a short-term basis to individuals and families who are currently unable to pay MSP premiums due to unexpected financial hardship that they could not reasonably have budgeted for.

FACT SHEET

Statistics

- As of March 31, 2015, there were 952,054[1] BC residents subsidized by the premium assistance programs. The breakdown according to Regular or Temporary Premium Assistance is as follows:

  Regular Premium Assistance: [1]

Adjusted Net Income $0 – $22,000	789,379*
Adjusted Net Income $22,001 – $24,000	50,388
Adjusted Net Income $24,001 – $26,000	43,982
Adjusted Net Income $26,001 – $28,000	36,122
Adjusted Net Income $28,001 – $30,000	,30,352
TOTAL:	952,054 (includes TPA)

  Temporary Premium Assistance(TPA)[1]

  Fully subsidized: 1,831[2]

  **Includes 14,596 persons automatically receiving a full subsidy for six months following end of coverage through the Ministry of Social Development and Social Innovation.*

- With respect to premium accounts, each family is enrolled with MSP under a single account. An MSP premium account can include one or more persons. There are approximately 685,700[3] accounts receiving a premium subsidy. This amount includes approximately10,060[4] accounts automatically receiving a full subsidy for six months following end of coverage through the Ministry of Social Development and Social Innovation.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; April 21, 2015

1HIBC Reports RPDDWR0040-1 as at March 31, 2015

[1] 1HIBC Reports RPDDWR0040-1 as at March 31, 2015

[2] 1HIBC Reports RPDDWR0040-1 as at March 31, 2015

[3] 1HIBC Reports RPDDWR0040-1 as at March 31, 2015

[4] 1HIBC Reports RPDDWR0040-1E as at March 31, 2015

FACT SHEET

Pharmacy Termination

ISSUE

Termination of pharmacy agreements of pharmacies that offer inducements to methadone patients in order to capture their business.

KEY FACTS

- Currently, a pharmacy enrolled with PharmaCare that dispenses methadone, may bill PharmaCare on a daily basis the usual dispensing fee to a maximum of $10.00 and a $7.70 interaction fee. To qualify for interaction fees, the pharmacist must witness the ingestion of the methadone by the patient.
- The provision of methadone to patients can be a lucrative source of revenue for pharmacies. Offering of incentives of any kind to attract patients is contrary to the *Pharmaceutical Services Act*.
- Action has been taken, in the past, against a number of pharmacies and pharmacy owners for issues related to methadone dispensing such as improper billing of methadone claims and offering inducements.
- In 2010, as a result of media reports and physician complaints to the Medical Beneficiary and Pharmaceutical Services Division, the Ministry agreed to fund a joint investigation with the College of Pharmacists of BC (CPBC) into pharmacies in the Lower Mainland. A private investigation firm was appointed to conduct the investigations, which primarily used their employees working undercover.
- Letters of termination were sent, in stages, to all seven pharmacies that were subject to the undercover investigation, and proceedings against all seven have concluded.
- Three pharmacies owned by Dhanesh Raniga (New West Pharmacy in New Westminster, and Grandview Prescriptions and Downtown Pharmacy in Vancouver) requested an oral hearing and an independent decision maker was appointed. The hearing commenced in September 2013 and on June 2, 2014, after the Ministry's case was closed, the pharmacies submitted a Notice of Termination of enrollment for each pharmacy.
- Capital Care Pharmacy (located in Surrey) provided written representations to the Ministry on December 16, 2013, and an idependent decision maker was appointed for the written hearing. The decision maker rendered their decision on July 30, 2014, and concluded that enrollment should be terminated. The pharmacy filed a petition to judicially review the decision, and then subsequently agreed that their enrollment would be terminated on December 15, 2014. The judicial review was dismissed.
- During March 2014, termination letters were served on Good Morning Pharmacy, Abbott (Renuka) Pharmacy, and Whalley Pharmacy. Good Morning Pharmacy submitted written representations on May 2, 2014, and claimed that the pharmacy was sold subsequent to the investigation. Counsel for the Ministry met with the owner who provided evidence of a good faith arms-length contract of purchase after the investigation ended, and of steps taken to ensure staff are appropriately managed and comply with PharmaCare and CPBC requirements. The Ministry decided not to proceed with with the termination hearing against Good Morning Pharmacy. Abbott (Renuka) Pharmacy and Whalley Pharmacy, who are both owned by Nikhil Buhecha, submitted written representations on May 24, 2014, and the independent decision maker rendered their decision on October 22, 2014, to terminate enrollment of both pharmacies. The Ministry notified the pharmacies that they would be permitted to dispense to patients for 30 days to allow patients to transition to other pharmacies and the enrollment of both pharmacies be terminated on December 7, 2014.

FACT SHEET

- Section 45 of the *Pharmaceutical Services Act* (the Act) gives the Ministry authority to suspend payments to pharmacies. Since the investigation, and the Ministry has exercised this authority to suspend the payments of a number of pharmacies.
- s.14

FINANCIAL IMPLICATIONS

- s.14,s.17
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- s.14

Approved by:
Daryl Connor, obo Manjit Sidhu, Finance and Corporate Services Division; June 20, 2013
Dave Townsend, Health Sector Planning and Innovation Division; June 27, 2013
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 11, 2015

FACT SHEET

Provincial Retinal Diseases Treatment Program

ISSUE

On November 16, 2013, the Ministry of Health announced an expansion of the Provincial Retinal Diseases Treatment Program to include coverage for two new eye diseases. In addition, the program administration fee for retinal specialists was decreased.

KEY FACTS

- On June 1, 2009, the Ministry began its wet Age-related Macular Degeneration (AMD) Program, providing coverage for ranibizumab (Lucentis) and bevacizumab (Avastin), in addition to previously funded verteporfin (Visudyne) and Photo Dynamic Therapy.
- On November 16, 2013, the Ministry announced the renaming and the expansion of the Retinal Diseases Treatment Program to include coverage of ranibizumab and bevacizumab for two new indications: Diabetic Macular Edema (DME) and Retinal Vein Occlusion (RVO).
- On April 1, 2015, the Ministry announced the expansion of the Program to include aflibercept (Eylea) for the treatment of wet AMD when prescribed and administered by retinal specialists. The Program is currently sorting out the drug supply with community pharmacy.
- The Program has been extremely successful, treating more than 8,425 patients in 2012/13 and 12,417 in 2013/14 at a cost of approximately $13 million[1].
- Through the Program, coverage for wet AMD continues and most elements of the Program remain the same. Drug therapy for other retinal diseases other than wet AMD, DME and RVO are not covered. The Provincial Health Services Authority (PHSA) continues to manage the Program and drug coverage is not subject to Fair PharmaCare deductibles or co-payments.
- Retinal specialists continue to provide the provincial service through the Program and submit data into a provincial database. Retinal specialists are ophthalmologists with additional education specializing in retinal disease. Due to the need to be current in this rapidly evolving field, retinal specialists provide clinical expertise and expertise with retinal angiography to diagnose and monitor wet AMD, DME and RVO. All retinal specialists in BC have signed agreements with the PHSA to participate in the Program.
- Health providers and optometrists can refer new patients directly to a retinal specialist for diagnosis and treatment. Retinal specialists are available in all regional health authorities. Additional clinics have been added in response to provincial access concerns; for example, in Interior Health (Cranbrook, Vernon, Salmon Arm and Nelson) and Northern Health (Fort St. John, Prince George and Terrace). The Program will continue to monitor access for patients in collaboration with the health authorities and retinal specialists, and adjustments will be made if reasonable to do so.
- The Program continues to monitor drug safety and effectiveness of ranibizumab and bevacizumab, since all participating retinal specialists track the safety and effectiveness of each treatment dose that is administered. From ongoing surveillance by experts, PHSA and the Ministry, there are no discernible differences in drug safety or effectiveness between ranibizumab and bevacizumab.
- In January, 2015, three groups (the University of British Columbia, PHSA, and the retinal specialists participating in the Program) agreed to fund a new UBC-based research and evaluation unit. The unit will conduct ophthalmology research and some retinal Program evaluations to support decision makers and clinicians. For Program evaluations, the unit may evaluate various aspects of the Program such as drug efficacy, safety and/or cost-effectiveness. The funding contribution from PHSA is $60,000 per year for five years and comes from the Ministry's existing Program funding.

[1] PHSA utilization review (2014) of the program patient and treatment database managed by PHSA

- While there is general support by care providers, the Program has been criticized, by Novartis the manufacturer of ranibizumab and some patient groups, for covering the less expensive treatment bevacizumab as it is currently marketed for treatment of several cancers but prescribed off-label by doctors nationally and internationally to treat AMD, DME and RVO. Ranibizumab is more than 135 times more expensive than bevacizumab. Clinical evidence supports the use of bevacizumab. The latest research results into the efficacy and safety of bevacizumab compared to ranibizumab for wet AMD treatment come from the IVAN (two year results) study published in July 2013.[2] This study concluded that the vision improvement is the same for bevacizumab as it is for ranibizumab and there is no increased safety risk with bevacizumab. The IVAN study reinforces the similar efficacy results observed in a direct comparison of the two drugs published in the CATT trial.[3]
- All jurisdictional drug plans currently cover ranibizumab. BC, Manitoba, New Brunswick, Nova Scotia, Yukon and Veterans Affairs also currently cover bevacizumab.
- On October 24, 2014, representatives from PHSA and the Ministry met with BCSEPS (BC Society of Eye Physicians & Surgeons) to discuss concerns by some of their members including patient access to retinal specialists and the potential role of general ophthalmologists. A commitment was made to review whether there are any patient access issues for the following 3 areas: North Vancouver Island, Sunshine Coast and Northern Health. The Ministry and PHSA are still completing an assessment to determine whether or not program adjustments are needed. The assessment is taking longer than expected due to data extraction challenges and is expected to be completed in July/August 2015.
- For a public drug coverage program, this very high adoption rate demonstrates that the program provides an excellent public service. By comparison, the split between private drug coverage and PharmaCare drug coverage is roughly 65:35.

FINANCIAL IMPLICATIONS

- Vials of ranibizumab and bevacizumab contain enough drug for several doses, and can be prepared into multiple individual doses with bevacizumab costing $13 per treatment and ranibizumab costing $600 per treatment ($1,800 for an un-split vial).
- The Program cost for 2013/14 was approximately $13.0 million. Since fiscal 2010/11 to March 2014, the Program has cost approximately $51.2 million.[4] s.13,s.17
s.13,s.17

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- Funding for the Program is provided to the Provincial Health Services Authority through the PharmaCare budget.

APPROVALS

Approved by: Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; May 7, 2015
Approved by: Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; April 13, 2015

[1] IVAN Study Investigators. Alternative treatments to inhibit VEGF in age-related choroidal neovascularisation: two year findings of the IVAN randomisation controlled trial. www.thelancet.com published July 19, 2013 (http://dx.doi.org/10.1016/S0140-6736(13)61501-9)
3 CATT trial. Ranibizumab and bevacizumab for treatment of neovascular age-related macular degeneration: two-year results. www.aaojournal.com published online May 2, 2012 (doi:10.1016/j.ophtha.2012.03.053)
4 AMD Program costs – reviewed by Darlene Ell, Finance Sept 15, 2014
5 Medical Beneficiary and Pharmaceutical Services Division Budget Impact Analysis

FACT SHEET

Research - Ministry Funding

ISSUE

Research in the Medical Beneficiary and Pharmaceutical Services Division (MBPSD).

KEY FACTS

- Research is an inherent and important contributor to supporting the MBPSD program to operate a sustainable, evidence-informed, efficiently-managed, drug program that improves the health of British Columbians
- MBPSD is recognized by drug policymakers and researchers for its leadership in evidence-informed decision making that contributes to policies which improve health outcomes.
- MBPSD works to produce and facilitate relevant and timely evidence to support pharmaceutical policy development and evaluation, particularly evaluation of the real world cost-effectiveness of formulary drugs, quality assurance of the Special Authority Program, and development and evaluation of programs that support the appropriate use of medications for healthy outcomes. MBPSD also performs and facilitates research and evaluation on pharmacy practice.
- MBPSD uses its internal capacity and its partnerships with external funders and researchers to further strengthen the quality of evidence informing policy and planning for BC's drug program.
- Examples include the Canadian Agency for Drugs and Technologies in Health (CADTH), the Canadian Institutes of Health Research, the Drug Safety and Effectiveness Network (DSEN), the Canadian Institute for Health Information,and other researchers.
- MBPSD makes best use of existing research and builds constructive relationships with the research community to support research which directly informs or supports MBPSD to lead, innovate and manage the Province's drug program.
- Recent/current research activity include the following:
    - The Therapeutics Initiative (TI) was established in 1994 and is contracted through the University of BC Faculty of Medicine. In 2012, the Ministry restructured the agreement with the TI to fund health professional education and PharmaCare program evaluations, as well as three separate contracts to conduct clinical evidence reviews. In September 2012, the TI contract (education and evaluation) was suspended as part of the Ministry-wide data investigation. In October 2013 the investigation concluded and in February 2014 the contract was fully reinstated. To assist with the contract collaboration with the TI, a contract management committee and working groups were formed to jointly identify projects and establish a work plan to fulfill the education and research service requirements in the renewed contract.
    - The clinical evidence review contracts, some which included TI reviewers, were not affected during the suspension. The contract for Clinical Evidence Review services expired in May 2014. A new Request for Proposal (RFP) for these services has been developed and was posted on BC-Bid. The successful applicants were notified in February 2015, with the expectation of completing new contracts in March 2015.
    - The Alzheimer's Drug Therapy Initiative was created in 2007 to address the lack of clinical evidence to support PharmaCare coverage of cholinesterase inhibitors (donepezil, galantamine, and rivastigmine). A decision regarding PharmaCare coverage is expected to be made in late 2015.
    - The Common Drug Review (CDR), at CADTH, is a pan-Canadian process for conducting objective, rigorous reviews of the clinical, cost-effectiveness, and patient evidence for

drugs. The CDR also provides formulary listing recommendations to Canada's publicly funded drug plans.[1]

- The DSEN, established by the Canadian Institutes of Health Research in collaboration with Health Canada and other stakeholders, also provides evidence on drug safety and effectiveness for regulators and policy-makers.[2] MBPSD has submitted queries, at no cost to MBPSD, to the Network to help inform drug listings and policy.
- The BC Smoking Cessation Program is being evaluated by Ministry staff, and will determine the extent the Program succeeded in its intended aims of increasing the number of smokers who made a quit attempt, successfully quit, decreasing smoking-related illnesses, and decreasing smoking-related use of health services.
- The Academic Detailing Evaluation Partnership Team, funded by the Canadian Institutes of Health Research, is a pan-Canadian evaluation of academic detailing programs across Canada to determine the impact of academic detailing on prescribing.

FINANCIAL IMPLICATIONS

- The BC Ministry of Health's funding for CADTH to support the Common Drug Review, is $615,880 per year.
- The TI agreement is worth $550,000 per year and will expire March 31, 2016.[3]
- From October 2007 to March 2014, the Ministry spent $2.65 million on Alzheimer's Drug Therapy Initiative research.[4]
- RFP for Clinical Evidence Review services: The RFP was posted on September 18 and closed on October 16, 2014. The TI and other researchers have been notified of the opportunity to submit a proposal. The Ministry notified the successful applicants in February 2015 and is expected to complete new contracts in March 2015. In this RFP, the available funding for clinical evidence reviews was increased from $50,000 per reviewer per year ($250,000 per year) to approximately $133,000 per reviewer per year (based on up to 3 reviewers and/or $400,000 per year).
- DSEN: The Ministry does not fund DSEN. It is a federally funded program.

Approved by:
Jackie Redmond, obo Carolyn Bell, Health Sector Planning & Innovation Division; February 26, 2014
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; November 28, 2014
Barbara Walman, Medical Beneficiary and Pharmaceutical Division; February 11, 2015

[1] http://www.cadth.ca/en/products/cdr/cdr-overview (accessed 03dec2013)
[2] http://www.cihr-irsc.gc.ca/e/40269.html (accessed 03dec2013)
[3] TI-2004 Agreement, Modification #5
[4] Finance and Decision Support (October 2013)

FACT SHEET

Smoking Cessation Program

ISSUE

The Ministry of Health's BC Smoking Cessation Program is ongoing. An evaluation of this program was completed in early 2015.

KEY FACTS

- While BC has the lowest smoking rate in Canada at 16.2%, we have the fourth largest number of smokers (644,591) in Canada.[1]
- The Ministry's BC Smoking Cessation Program, launched September 30, 2011, helps BC residents stop smoking, by providing the choice of either a free supply of either nicotine gum or patches, or PharmaCare coverage of bupropion or varenicline, for up to 12 weeks. Non-prescription smoking cessation products are nicotine replacement therapies (NRT), and include nicotine gum, transdermal patches, lozenges and inhalers. Following the completion of a competitive tender, the Program provides coverage for one brand of nicotine gum (Thrive™) and one brand of nicotine patches (Habitrol®). The smoking cessation drugs that are available by prescription only are bupropion (Zyban®) and varenicline (Champix®).
- Each calendar year, eligible BC residents can get coverage for either one nicotine replacement therapy product or one prescription drug for a single course of treatment that lasts for up to 12 consecutive weeks (84 consecutive days). Patients receive a 28-day supply at a time, up to a maximum of three fills of 28 days each. All BC smokers and users of other tobacco products with active coverage through the province's Medical Services Plan (MSP) are eligible for nicotine gum or patches. The prescription drugs are covered through Fair PharmaCare, Plans B, C and G, and the usual PharmaCare plan rules apply, including deductibles and co-payments. On February 14, 2012, the Program expanded to all federally-insured patients with active MSP or PharmaCare coverage, providing additional coverage to supplement their existing federal drug benefits for smoking cessation aids. The Program has an expected seasonal pattern that includes a spike during launch and each January, with a decline during the rest of the year.
- The Ministry evaluated the Program through numerous avenues. This evaluation involved multiple areas of the Ministry, including Medical Beneficiary and Pharmaceutical Services Division, HealthLink BC, Population and Public Health Division, as well as BC Stats, the provincial statistical agency.
- An *impact* evaluation was conducted to determine the extent the Program has succeeded in its intended aims of reducing smoking rates among British Columbians (by increasing the number of quit attempts, and enabling successful quits). In February 2015, BC Stats completed a survey of more than 3,000 Program clients to determine the effectiveness of nicotine replacement therapy (NRT) gum or patch. s.13,s.17

s.13,s.17

s.13,s.17 Based on these results from Program NRT clients, the Program is effective in helping with smoking cessation..

[1] Canadian Community Health Survey, 2013. Extracted from Statistics Canada Website, CANSIM Table 105-0502. Prepared by Ministry of Health Surveillance and Epidemiology team, March 17, 2015

- An *operational (process)* evaluation was conducted to determine how well the Program was working. The Program was used by clients from all health authorities, and approximately 25% of smokers across the province have participated to date. s.13

s.13

- The Drug Safety and Effectiveness Network (DSEN) evaluated the following: 1) what is the real world comparative effectiveness, safety, and (ideally cost-effectiveness) of varenicline, bupropion, and nicotine replacement therapy for smoking cessation; and 2) does behavioural therapy increase effectiveness of pharmacologic smoking cessation methods and, if so, what type of behavioural therapy and with which agent(s)? In May 2014, the DSEN researchers concluded the following: (1) continue abstinence rates (CAR) at 12 months are better for bupropion, vareniciline, nicotine gum, compared to placebo, (2) CAR at 12 months are better for bupropion, varenicline, nicotine gum, nicotine patch plus an active behaviour support program compared to an active behaviour support program on its own, (3) no safety signal for cardiovascular events or suicides was identified, however, results should be interpreted with caution given the small number of trials reporting these outcomes and the low number of events available for analysis. The DSEN report was made publicly available by the researchers in December 2014.[2]
- Despite the recent decline in participation, the Program has provided coverage for a significant proportion (more than 25%) of BC smokers. From September 30, 2011 to October 31, 2014, almost 178,000 patients received smoking cessation aid (122,000 for nicotine gum or patches, and 74,000 for bupropion or varenicline), and the Ministry has invested approximately $34.4 million for drug coverage.[3]
- Coverage for nicotine replacement therapy products is available in Quebec and the Northwest Territories, in addition to BC. Coverage for at least one of bupropion or varenicline is available in all the provinces and in the Yukon, and the Northwest Territories.

FINANCIAL IMPLICATIONS

Total expenditure on drug coverage was $34.4 million[4]. (September 30, 2011 to October 31, 2014).

Approved by:

Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; May 6, 2015
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; February 24, 2015

[2] http://www.ottawaheart.ca/research_discovery/cardiovascular-research-methods-centre.htm (accessed 13jan2015)
[3] PharmaNet data, MoH, analysis by MBPSD POER, 2014
[4] PharmaNet data, MoH, analysis by MBPSD POER, 2014

FACT SHEET

Therapeutics Initiative

ISSUE

- The Therapeutics Initiative (TI) is an independent organization made up of physicians, pharmacists, and other researchers. It operates at arm's length from government and independently from the pharmaceutical industry and other vested interest groups.
- The TI is part of the Department of Anesthesiology, Pharmacology & Therapeutics at the University of BC (UBC) Faculty of Medicine. The TI is funded through an agreement between the Ministry of Health and the UBC Faculty of Medicine.
- In September 2012, the TI contract was suspended as part of the Ministry-wide data investigation. In October 2013, the investigation concluded and in February 2014, the contract with the UBC Faculty of Medicine was reinstated.
- The reinstated TI contract is managed collaboratively through a joint committee and working groups to identify projects and establish a work plan for the contract services.

KEY FACTS

- The Ministry makes PharmaCare coverage decisions based on a range of considerations including existing PharmaCare policies, programs, therapeutic options, resources and the evidence-informed recommendations of an independent advisory body called the Drug Benefit Council.
- Prior to the establishment of the national Common Drug Review (CDR) in 2003, the TI provided most reviews of drug submissions to the Council.
- The TI primarily provided clinical evidence reviews on new drugs before 2004 for consideration by the Ministry. The Council is responsible for making drug listing recommendations to the Ministry and the Ministry is ultimately the decision maker. Since 2003, the majority of newly patented drugs are reviewed by the CDR.
- In the 1990s and early 2000s, the TI contributed to a number of reviews of expensive, widely prescribed drugs that assisted PharmaCare in its decisions. Some examples include proton pump inhibitors for various gastrointestinal diseases, rofecoxib (Vioxx) for pain, pioglitazone and rosiglitazone for diabetes. Rofecoxib was later removed from the market and rosiglitazone was severely restricted, both due to safety concerns.
- The current Ministry contract with TI is to provide health professional education and PharmaCare program evaluations:
    - The major *education* deliverables are as follows: at least 12 Therapeutics Letters or podcasts per year, at least 4 educational events to health care professionals in the province per year, maintenance of a website for sharing evidence-based information, other education to support optional prescribing.
    - The major *evaluation* deliverables are as follows: conduct at least three pharmacoepidemiology program evaluations. For 2014/15, the topics for these program evaluations include statins for high cholesterol, proton pump inhibitors for gastrointestinal diseases, and a third topic will be selected in Feb/Mar 2015. The scope of the first two topics was expanded during the year and both are expected to be completed by March 2015.
    - The contract is managed collaboratively through a joint committee and working groups to identify projects and establish a work plan for the contract services.
- Through 2014, the Ministry contracted three UBC drug researchers, who are part of the TI, to provide Clinical Evidence Review services to inform the Ministry's drug review process.

FACT SHEET

FINANCIAL IMPLICATIONS

- The TI is partially supported by a Shared Cost Arrangement from the Ministry to UBC. The Shared Cost Arrangement was first established in 1994 and was renewed in 1999, 2004 and 2007.
  - From April 1, 1999, to March 31, 2004, total funding to the TI and the Faculty was approximately $700,000 per year.
  - From April 1, 2004, to March 31, 2011, total funding to the TI and the Faculty was approximately $1 million per year.
  - From April 1, 2011, to March 31, 2012, total funding to the TI and the Faculty was $850,000.
- In 2012/13, the Ministry restructured the contract with the Faculty to fund $550,000 for health professional education and PharmaCare program evaluations.
  - This contract was on hold from September 2012, to October 2013, due to the Ministry-wide privacy and data investigation, resulting in reduced funding for 2012/13 and 2013/14.
  - For 2012/13, the maximum funding was $475,518.
  - For 2013/14, the maximum funding was $335,817.
- In February 2014, the contract was reinstated after a contract modification was completed to incorporate new contract oversight and data oversight requirements. The contract will be in effect from February 11, 2014, to March 31, 2016.
  - For 2014/15, the maximum funding is $550,000.
  - For 2015/16, the maximum funding is $550,000.
- Separately, through a RFP, the Ministry contracted three reviewers to provide Clinical Evidence Review services. In 2013, each contract was valued at $50,000 per year.
- The Ministry contract with the UBC Faculty of Medicine for Clinical Practice Review services is valued at $85,000 per year. These reviews are completed by practicing general and specialist physicians and are used to inform the Ministry's drug review process.
- A new RFP for Clinical Evidence Review services was recently posted and UBC was invited to submit a proposal. The successful proponents of the RFP are expected to be notified later in February, 2015.

Approved by:
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 20, 2015
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; December 9, 2014

FACT SHEET

Travel Assistance Program

ISSUE

The Travel Assistance Program (TAP) helps alleviate some of the transportation costs for eligible BC residents who must travel within the province for non-emergency medical specialist services not available in their own community.

KEY FACTS

- In 2004, the Ministry assumed financial responsibility for TAP ferry travel subsidies. Payment is made to BC Ferries through the Ministry of Transportation and Infrastructure.
- There were 124,215 TAP approvals issued by the Ministry for the fiscal year 2014/15, an increase of 3.9% over 2013/14.[1] Of those approvals, 98.7% were for fully-subsidized ferry travel.

Approved Confirmation by Travel Mode – April 1, 2014 – March 31, 2015

Mode	Number	Percent	Escort	Percent	One Way	Percent	Vehicle	%
Air	1,556	1.3	839	53.9	171	11		
Angel Flight	7	0.0	7	100	1	14.3		
Bus	10	0.0	2	20	0	0.0		
Ferry	122,589	98.7	78,819	64.3	3,506	2.9	117,906	96.2
Rail	53	0.0	31	58.5	4	7.5		
TOTAL	124,215	100.0	79,698	64.2	3,682	3.0		

- Of the 37,275 unique patients who obtained a TAP confirmation number in 2014/15, 39.5% were seniors and 12.7% were on Premium Assistance (table below). Of those unique patients, 85.2% obtained between 1 and 5 travel confirmations during fiscal year 2014/15 and an additional 9.9% obtained between 6 and 10 travel confirmations.[2]

Patients by Range of Approved Confirmations – April 1, 2014 – March 31, 2015

Conf's per Patient	Number of Patients	% of Patients	Total Conf's	% of Conf's	Number of Seniors	% of Seniors	Number on PA	% on PA
1 to 5	31,772	85.2	62,465	50.3	11,910	37.5	4,066	12.8
6 to 10	3,693	9.9	27,475	22.1	1,895	51.3	418	11.3
11 to 20	1,350	3.6	18,843	15.2	711	52.7	167	12.4
21 to 30	276	0.7	6,757	5.4	124	44.9	40	14.5
>30	184	0.5	8,675	7.0	79	42.9	36	19.6
TOTAL	37,275	100.0	124,215	100.0	14,719	39.5	4,727	12.7

FINANCIAL IMPLICATIONS

Program budget for ferry travel in 2014/15 was $11,000,000. Expenditures for 2014/15 were $11,838,554 (including fares and fuel surcharge) resulting in the cost exceeding the budget by $838,554. Expenditures increased from $10,881,429 in 2013/14 , a year over year increase of 8.8%.

Approved by:

Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; May 4, 2015
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; April 23, 2015

[1] https://tap.hlth.gov.bc.ca/tap/faces/TravelAssistanceSummary.xhtml
[2] https://tap.hlth.gov.bc.ca/tap/faces/ApprovedConfirmationsPerPatient.xhtml

FACT SHEET

Varenicline (Champix) and BC Smoking Cessation Program Evaluation

ISSUE

Some critics question the safety of varenicline (Champix) and bupropion (Zyban), two prescription drugs covered by BC PharmaCare for smoking cessation, and call for more safety evaluations.

KEY FACTS

1. The Ministry of Health used its drug review process to assess coverage provided through the BC Smoking Cessation Program.
   - In April 2011, smoking cessation drugs (varenicline, bupropion, nicotine replacement therapies) were reviewed by the Drug Benefit Council (DBC). The DBC considered many sources of information including a report by the Common Drug Review (2007), comprehensive reports from CADTH (2010), and reports of adverse drug reactions from Health Canada. The evidence-informed recommendation from the DBC was that the Ministry should cover varenicline (Champix®) and bupropion (Zyban®) as Limited Coverage benefits (12-week course). DBC concluded that there did not appear to be many serious adverse events associated with these drugs, especially when combined with nicotine withdrawal.
   - In May 2011, Premier Clark announced that the Program would be launched in September 2011. The Ministry began planning for the evaluation of the Program prior to the launch.
   - In August 2011, Medical Beneficiary and Pharmaceutical Services Division established an internal working group to develop an evaluation plan for the Program. The Division also submitted a query to the Drug Safety and Effectiveness Network (DSEN) to evaluate the following: 1) What is the real world comparative effectiveness, safety, and (ideally cost-effectiveness) of varenicline, bupropion, and nicotine replacement therapy for smoking cessation? 2) Does behavioural therapy increase effectiveness of pharmacologic smoking cessation methods? If so, what type of behavioural therapy and with which agent(s)?
   - In September 2011, the Program was launched to provide British Columbians with the choice of a 12-week course of either nicotine gum or patches at no cost, or PharmaCare coverage of varenicline or bupropion.
   - From September 30, 2011 to October 31, 2014, almost 178,000 patients received smoking cessation aid (122,000 for nicotine gum or patches, and 74,000 for bupropion or varenicline), and the Ministry has invested approximately $34.4 million for drug coverage.[1]
2. Research studies continue to support that all covered drugs for smoking cessation under the Program are effective and safe.
   - In May 2013, the *Cochrane Database of Systematic Reviews* published its overview and network meta-analysis of pharmacological interventions for smoking cessation, and stated that based on the current evidence, none of the studied drugs (including varenicline, bupropion, and nicotine replacement therapy) appeared to have adverse events that would mitigate their use.
   - In October 2013, the *British Medical Journal* published a real-world safety study involving nearly 120,000 adult smokers in England. There were over 31,000 and 6,700 patients who were taking varenicline and bupropion, respectively, in this clinical trial. These researchers concluded that there is no evidence of an increased risk of suicidal behaviour in patients prescribed varenicline or bupropion compared to those prescribed nicotine replacement therapy.
   - In May 2014, the DSEN researchers concluded that continuous abstinence rate at 12 months was better for varenicline, bupropion and nicotine gum compared to placebo. DSEN's analysis found no safety signals for cardiovascular events or suicides; however, the results should be

[1] PharmaNet data, MoH, analysis by MBPSD POER, 2014

interpreted with caution given the small number of trials reporting these outcomes and the low number of events available for analysis. This report was posted online in December 2014.[1]

- In February 2015, another *British Medical Journal* publication found no evidence of an increased risk of suicide or attempted suicide, suicidal ideation, depression or death with varenicline.[2]

3. The Ministry has evaluated the NRT component of the Smoking Cessation Program, with assistance from BC Stats, the provincial statistical agency.
   - An *impact* evaluation was conducted to determine the extent the Program has succeeded in its intended aims of reducing smoking rates among British Columbians (by increasing the number of quit attempts, and enabling successful quits). In February 2015, BC Stats completed a survey of more than 3,000 Program clients to determine the effectiveness of nicotine replacement therapy (NRT) gum or patch. s.13,s.17
     s.13,s.17

     s.13,s.17 Based on these results from Program NRT clients, the Program is effective in helping with smoking cessation.
   - An *operational (process)* evaluation was conducted to determine how well the Program was working. The Program was used by clients from all health authorities, and approximately 25% of smokers across the province have participated to date. s.13,s.17
     s.13,s.17
4. Based on the Ministry's review to date, the Ministry continues to support PharmaCare coverage for varenicline and bupropion, as well as no-cost nicotine gum or patches.
   - In July 2013, Fall 2014, and January 2015, the Opposition raised questions regarding continued PharmaCare coverage for varenicline and cited reports of serious adverse effects. The Opposition also questioned the Ministry's decision to use DSEN, rather than Therapeutics Initiative (TI), for evaluation.
   - All academic researchers, including those from TI, may conduct drug safety research using BC data through the established Ministry process for data access.
   - There are benefits and risks with any drug. The Health Canada-approved product monograph for varenicline provides warnings about potential risks, and health care professionals need to discuss the appropriateness of varenicline as well as monitoring for a given patient.
   - s.13

FINANCIAL IMPLICATIONS

The cost of the smoking cessation survey to the Ministry is $89,500. The Ministry does not fund DSEN. It is a federally funded program, so there are no financial implications.

Approved by:

Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; May 6, 2015
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; February 25, 2015

[1] [1] http://www.ottawaheart.ca/research_discovery/cardiovascular-research-methods-centre.htm (accessed 13jan2015)
[2] Thomas KH et al. Risk of neuropsychiatric adverse events associated with varenicline: systematic review and meta-analysis. BMJ 2015;350:h1109 doi:10.1136/bmj.h1109 http://www.bmj.com/content/350/bmj.h1109

FACT SHEET

10-Year Tripartite First Nations Health Plan - Health Actions

ISSUE

Progress made on the implementation of the 2007 Tripartite First Nations Health Plan (TFNHP); signed in 2007 by the First Nations Leadership Council and the Governments of BC and Canada.

KEY FACTS

The TFNHP, is a 10-year agreement meant to improve the health status of First Nations people, with focus on governance and on health actions. Of the 30+ health actions listed (grouped into 7 strategy areas), approximately 1/3 are complete and 2/3 are in progress. Recent deliverables and key priorities for 2014/15 include:

Primary Care and Public Health

- The Ministry of Health and regional health authorities are working with the First Nations Health Authority (FNHA) on implementing innovative ongoing investments in improving Primary Care services for First Nations people. Examples include multi-disciplinary teams with physician/nurse practitioner leads and other professionals providing services to a number of communities; specialized Aboriginal patient navigators who assist with discharge planning; and integrated care teams working with clients and their families to promote upstream health and wellness.
- The Ministry and FNHA have developed a BC First Nations and Aboriginal healthy living framework; and the application of a First Nations and Aboriginal lens to the provincial rollout of the *Seek and Treat for Optimal Prevention of HIV/AIDS.*
- The Elder Safety Program supports injury prevention through the Strategies and Actions for Independent Living program is being adapted for First Nation communities. One component being produced in partnership with FNHA includes regional workshops (targeting 2,500 First Nations Elders) to train community leads and a Tai Chi video to support strength and balance.

Maternal and Child Health

- The Aboriginal Pregnancy Passport was printed in March 2014 and distributed province-wide (approximately 5,000 copies), to First Nation and Aboriginal woman as a guiding tool as they move through their pregnancy and first months of motherhood. *Promising Practices in First Nations and Aboriginal Maternal and Child Health Programs* is a new resource expected to be completed in spring 2015, which aims to support communities to expand successful programs, train/upgrade staff capacity, and better align programs and services for this population among different providers/funders.
- Implementation planning for the Tripartite First Nations and Aboriginal Children's Oral Health Strategy, Healthy Smiles for Life is underway and is designed to guide public health and community efforts to improve the oral health of children aged 0-18.

Health Human Resources

- The Health Human Resources Tripartite Strategic Approach will assist communities and regions with their own health human resources planning.
- A provincial cultural competency framework is being developed in partnership with FNHA, health authorities, Métis Nation BC, BC Association of Aboriginal Friendship Centres, and Health Canada.
- Indigenous Cultural Competency training is an 8 hour on-line course to enhance service provider cultural competency, with 500 seats available to each health authority and the Ministry annually. Since April 1, 2009, to January 2015, 695 Ministry staff have completed the training, contributing to the over 12,000 individuals in total trained across the province in the health system.

Mental Wellness and Substance Use

- In partnership with FNHA, Fraser Health is expanding hours available to deliver mobile detox and withdrawal management to a greater number of geographical regions as well as hiring a youth

coordinator in support of youth suicide prevention, intervention, and postvention. And Interior Health is working to increase mental health clinicians to First Nations communities, provide clinical support and capacity building to community-based Mental Wellness and Substance Use (MWSU) workers, and support multi-disciplinary teams through increased coordination efforts with community.

- Vancouver Coastal Health Authority, in partnership with FNHA, is developing a MWSU Specialist Community Assessment Team to increase capacity of services and target reducing suicide risk; and Northern Health Authority will also be focusing efforts on prevention and promotion activities to address MWSU challenges.
- As part of a strategy to prevent and respond to suicide in First Nation and Aboriginal communities, the Ministry, FNHA, Métis Nation BC and BC Association of Aboriginal Friendship Centres, have developed the Hope, Help and Healing toolkit, a community guide to suicide prevention, response and recovery. Roll out of this kit commenced April 2015.

Health Knowledge and Information

- The First Nations Client File, created through linkages with the federal Indian Registry and Ministry administrative databases, enables collaborative reporting, as well as data linkages for surveillance and evaluation of specific initiatives.
- The Tripartite Data Quality and Sharing Agreement expires in April 2015 with an automatic one year renewal. Options for an updated agreement will be developed.
- The First Nations Panorama Implementation Project, launched in 2013, is currently being deployed in 12 First Nation Health Service Organizations to support clinical service delivery to approximately 45 Nations. An additional 22 First Nation Health Service Organizations[1] are being established, which provide health services to an additional 35 Nations.

eHealth

- The capacity for two-way, live videoconferencing for clinical, administrative and health related educational and wellness encounters exist in approximately 150 First Nation communities in BC. On September 10, 2013, Tripartite partners launched the First Nations Telehealth Expansion Project in partnership with Canada Health Infoway, a key step in creating a fully integrated clinical telehealth network. Currently 100 communities receive educational services; 10 receive clinical services; and 50 communities on Vancouver Island receive TeleOphthalmology services.
- The First Nations Telehealth Expansion project will build and expand telehealth capacity and increase access to health, wellness and educational services over distance to approximately 45 First Nation communities by December 2015.

FINANCIAL IMPLICATIONS

The Ministry has committed funding of $100 million to 2019/20, for the development and implementation of the BC Tripartite Framework Agreement on First Nations Health Governance, which supports the First Nations Health Plan–Health Actions. As of the end of fiscal year 2014/15, $45 million has been provided to FNHA; as indicated in Schedule 2 Agreement, $10 million was provided by the Ministry in fiscal year 2014/15, and $11 million annually from 2015/16 to 2019/20.

Approved by:

Arlene Paton, Population and Public Health Division; March 20, 2015

Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; April 1, 2015

[1] FNHSO is the official term developed to meet the requirements to have a legal entity to meet the privacy and health governance requirements of Panorama. The term is used to describe the local/community based health services organizations who are being prepared for or who have implemented Panorama. They are presently the 'owners' of specific Panorama instances, and they may (or may not) have telehealth projects as well.

FACT SHEET

2014/15 Influenza Seasonal Program

ISSUE

To report on Government's response to the 2014/15 influenza season in BC.[1]

KEY FACTS

- BC's 2014/15 influenza immunization campaign launched on October 29th, 2014.
- In Canada, thousands of people are hospitalized and may die from influenza and its complications during years with widespread or epidemic influenza activity.[2] The influenza season in Canada usually runs from November to April.
- The influenza vaccine is recommended and provided free to children and adults who are at high risk for severe illness or death due to infection with influenza and anyone who may come into contact with these individuals. However, all British Columbians are encouraged to get immunized. The vaccine can be purchased privately for a nominal fee. Flu vaccines are provided at public health clinics, physician's offices, and pharmacies. The flu locator on ImmunizeBC.ca allows users to search for a clinic near to their geographical location to obtain the vaccine.
- For the 2014/15 flu season, demand has been similar to the 2013/14 flu season due to: the influenza immunization policy for employees in health care settings; inclusion of visitors to healthcare facilities in eligibility criteria; and increased media attention due to less effective influenza vaccine and cases of avian influenza in poultry farms in the Fraser Valley.
- In August 2014, vaccine manufacturer GSK reported that 60 percent[3] of influenza vaccine that was to be provided to BC failed quality control testing. The BC Centre for Disease Control secured replacement vaccine using other vaccine manufacturers.[4] BC, like all other Canadian jurisdictions, has enough influenza vaccine this year to meet demand.

Influenza Vaccines for 2013/14 Flu Season

- For the 2014/15 flu season, BC is offering four influenza vaccines: Fluviral® (for those >=6 months of age); Agriflu® (for those >=6 months of age); Fluad® (for those >=65 years of age); and Flumist® (instranasal vaccine for those 2 – 17 years of age).[5]
- Flumist®, the live-attenuated influenza vaccine delivered via nasal spray cannot be administered by pharmacists as nasal administration of vaccines is not within their scope of practice. Work is underway to address this issue within the Ministry.

Allocation of Influenza Vaccines[6]

- BC has purchased 1.46 million doses of vaccine for the 2014/15 season (an increase from 1.41 million doses of vaccine for the 2013/14 season) valued at $8.8 million.
- The amount of vaccine purchased is determined from previous year purchases and includes population and eligibility adjustments.[7]

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[1] For information concerning BC's Immunization Program see #1019841

[2] BC Ministry of Health, "Facts About the Influenza (the flu)", http://www.healthlinkbc.ca/healthfiles/hfile12b.stm

[3] BCCDC, [personal communication], Monika Naus, August 2014

[4] BCCDC [email], August 28, 2014

[5] Due to a manufacturing issue for the usual trivalent (protects against three strains) FluMist® vaccine, this year BC is using a quadrivalent (protects against four strains) FluMist® vaccine.

[6] BCCDC Pharmacy, [interview] Sinclair, Jim; Vaccine Inventory Manager, January 8, 2014

[7] BCCDC Pharmacy, [interview] Sinclair, Jim; Vaccine Inventory Manager, January 8, 2014

FACT SHEET

Vaccine Strain Mismatch[8]

- The BC Centre for Disease Control has reported that Influenza A (H3N2) has been the predominant subtype this season, with >99% of viruses assessed showing mismatch from the vaccine strain due to antigenic drift (variation in a virus due to mutations).[9]
- Preliminary assessments by the Canadian Sentinel Physician Surveillance Network estimate mid-season vaccine effectiveness at little to no protection (-8%)[10] against the H3N2 strain. The vaccine effectiveness is further complicated by interactions between virus and host factors that require additional investigation. Implications of low vaccine effectiveness: adjunct protective measures should be considered to minimize associated morbidity and mortality; and the World Health Organization is expected to swap out the existing H3N2 component of the influenza vaccine for the 2015/16 flu season.
- 2012/13 was the last season with predominant H3N2 activity. The vaccine was also considered a mismatch, with vaccine effectiveness of 45%[11] against H3N2. As the B-strain component of the vaccine is a match, it is anticipated that overall vaccine effectiveness will increase should BC see an rise in Influenza B toward the end of the season (this occurred last year).
- Vaccine effectiveness for 2013/14 was 74% against the predominant H1N1 strain.[12]

Avian Influenza (H5N2) in Fraser Valley Poultry Farms

- As of December 18, 2014, a total of 10 farms in the Fraser Valley have been affected by an avian influenza (H5N2) outbreak among poultry. To date, there have been no reports of avian influenza-related illness in humans associated with the current outbreak. During an outbreak of avian influenza in poultry, the risk to the general public is low.[13]

Avian Influenza (H7N9) Cases in BC

- Two cases of human infection with avian influenza (H7N9) were identified in BC in January 2015. These cases were not related to the Fraser Valley outbreak, were not a risk to the general public, and both individuals have since recovered.

Health Care Worker Policy and Visitors to Health Care Facilities

- Health care workers are required to be immunized or wear a mask for the duration of the flu season. During the 2013/14 influenza 80% of health-care workers were vaccinated, a 10% increase from 2012/13 flu season. In 2013, the Ministry of Health implemented a policy requiring all visitors to health care facilities to be immunized at no cost or to wear a mask. Individuals are not required to prove immunity but instead are expected to operate under the honour system.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Arlene Paton, Population and Public Health; February 19, 2015

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[8] Skowronski DM, Chambers C, Sabaiduc S, De Serres G, Dickinson JA, Winter AL, Drews SJ, Fonseca K, Charest H, Gubbay JB, Petric M, Krajden M, Kwindt TL, Martineau C, Eshaghi A, Bastien N, Li Y. Interim estimates of 2014/15 vaccine effectiveness against influenza A(H3N2) from Canada's Sentinel Physician Surveillance Network, January 2015. Euro Surveill. 2015;20(4):pii=21022. Available online: http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=21022

[9] BCCDC Information Bulletin, December 18, 2014

[10] See footnote 9.

[11] See footnote 9.

[12] BCCDC Annual Summary of Reportable Diseases. 2013. Retrieved on February 4, 2015, from: http://www.bccdc.ca/NR/rdonlyres/D8C85F70-804C-48DB-8A64-6009C9FD49A3/0/2013CDAnnualReportFinal.pdf

[13] BCCDC Information Bulletin, December 18, 2014

FACT SHEET

Alcohol - Liquor Policy Review and Health Impacts

ISSUE

Of the 78 recommendations contained in the *BC Liquor Policy Review: Final Report*, 18 are directly targeted at reducing the health harms from alcohol consumption.

KEY FACTS

- Alcohol remains the most widely-used psychoactive substance in the province, with close to 80% of British Columbians reporting drinking in the past year[1].
- While alcohol brings pleasure to many, its use is also associated with a number of health and social problems, including acute harms related to intoxication (e.g., overdose, injury, and violence) and harms resulting from long-term chronic use (e.g., certain cancers, cardiovascular diseases, and liver disease).
- Alcohol causes almost 10% of the total burden of illness in BC and Canada[2].
- Between 2002-2011, over 188,000 hospital admissions in BC were due to alcohol, a significant driver of health system costs[3]. Of these admissions, approximately 12,000 were children and teens.
- Although the impact of a depressed economy has slowed the rise in overall consumption, alcohol-related hospitalizations are still increasing, and are projected to overtake tobacco-related hospitalizations in 2016[4].
- In Canada the top three causes of death due to alcohol are malignant cancers, digestive diseases, and intentional injuries[5]; as a group, chronic diseases account for over 70% of all deaths due to alcohol in Canada[6].
- Alcohol generates approximately $1 billion in annual revenue for the provincial government[7]; however, its use also puts a significant burden on society and the economy through direct costs associated with the health care and criminal justice systems, and indirect costs involving lost productivity and social disruption.
- In 2002, the last year for which cost data are available, the direct costs of alcohol-related harms exceeded the direct revenue to the BC government by $65 million[8].
- The global evidence base indicates that the existence of legislation and regulations for alcohol (e.g., pricing, controls on availability) contributes to reducing alcohol-related injuries, chronic diseases, and dependence.
- The government has already committed to reducing alcohol-related harms through *Healthy Minds, Healthy People: A 10-Year Plan to Address Mental Health and Substance Use in British Columbia* (HMHP).

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[1] Health Canada. (2012). Canadian Alcohol and Drug Use Monitoring Survey. Accessed on September 23, 2014 from http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2012/tables-tableaux-eng.php#t7.

[2] Canadian Centre on Substance Abuse & Health Canada. (2007). Reducing Alcohol Related Harm in Canada: Toward a culture of moderation. Accessed on January 30, 2015 from: http://www.ccsa.ca/Resource%20Library/ccsa-023876-2007.pdf.

[3] BC Alcohol and Other Drug Monitoring Project. Number of Alcohol Attributable Hospital Admissions in BC, 2002-2011. Accessed on January 30, 2015 from: http://www.carbc.ca/LinkClick.aspx?fileticket=2JdD4uQ0pZM%3d&tabid=90&mid=775.

[4] Ministry of Health Services, Ministry of Children and Family Development. (2010). *Healthy Minds, Healthy People: a 10-year plan to address mental health and substance use in British Columbia.* ISBN 978-0-7726-6358-0.

[5] Shield, K., Kehoe, T., Taylor, B., Patra, J., Rehm, J. Alcohol-attributable burden of disease and injury in Canada 2004. *Int J Public Health.* (2012); 57(2): 391-401.

[6] Ibid.

[7] Lavaughn Larson, Manager Marketing & Social Responsibility, Liquor Distribution Branch, BC Ministry of Justice, personal communication, September 30, 2014.

[8] Thomas, G., Stockwell, T., Zhao, J., Reist, D., Martin, G., Zeisser, C. Alcohol Price Policies in British Columbia: Options for Reducing Alcohol-Related Health and Social Harms. Prepared for the British Columbia Ministry of Health, November 2011.

- Of the six milestones in HMHP, two are related to alcohol: reducing hazardous drinking, and delaying initiation of drinking by young people. Both milestones have been met ahead of schedule.
- On January 31, 2014, the Ministry of Justice released the *BC Liquor Policy Review: Final Report*, which contains 73 recommendations to modernize liquor policy in the province based on extensive public consultation[9]. The dominant theme is a balanced approach to protecting public health and safety while streamlining regulations and convenience.
- While the absolute moratorium on the number of liquor sales outlets in the province will be maintained as recommended by the Ministry of Health and others, implementing some of the Liquor Policy Review's recommendations may lead to a modest increase in availability, due to eased restrictions on licensing, Special Occasion Licences, and permitting alcohol sales in more public venues.
- There is a robust body of research evidence that indicates that alcohol-related problems and costs increase when alcohol becomes more physically or economically available[10].
- The impact of availability increases on population health should be offset by implementation of recommended and accepted pricing measures (minimum prices announced in June, 2014, and volumetric pricing - tying the price to the concentration of pure alcohol in the product – details yet to be announced).
- The Ministries of Health and Justice are working together to implement key recommendations in the category of Health, Safety, and Social Responsibility of the Liquor Policy Review. These include:
  1. Expanding public education about health and safety risks related to alcohol use, with particular emphasis on the harmful effects of binge drinking by youth and post-secondary students.
  2. Identifying and focusing all of Government's alcohol education initiatives.
  3. Providing easily understood information about Canada's Low-Risk Alcohol Drinking Guidelines to consumers in licensed establishments and liquor stores.
  4. Expanding and enhancing Serving it Right, the provincial government's responsible beverage service program.
  5. Developing an in-person educational program to educate licensees and their staff about the Province's liquor laws and how to operate their establishments in a responsible manner.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Arlene Paton, Population and Public Health Division; February 11, 2015

[9] BC Ministry of Justice. BC Liquor Policy Review: Final Report. Accessed on September 23, 2014 from: http://www2.gov.bc.ca/local/haveyoursay/Docs/liquor_policy_review_report.pdf.

[10] Babor, T. F., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Gruenewald, P., Hill, L., Holder, H., Homel, R., Osterberg, E., Rehm, J., Room R., and Rossow, I. (2010). Alcohol: No Ordinary Commodity. Research and Public Policy. 2nd Edition. Oxford University Press.

FACT SHEET

BC Tripartite Framework Agreement – Implementation

ISSUE

On October 13, 2011, the BC First Nations Health Council (FNHC), the federal government and the Province of BC signed the BC Tripartite Framework Agreement on First Nation Health Governance that paved the way for the federal government to transfer planning, design, management, and delivery of federally funded First Nations health programs to the First Nations Health Authority (FNHA).

KEY FACTS

- The Framework Agreement sets out specific commitments relating to:
  - the transfer of federal health programs to the new FNHA;
  - the planning, design, management, and delivery of First Nations health programs by FNHA;
  - the building of a more integrated health system for First Nations under the new health governance structure;
  - the active participation of Canada and BC in the new health governance structure as part of the wider health partnership with BC First Nations; and
  - the performance and accountability requirements of the parties.
- The Framework Agreement reinforces that duplication of services will not occur and a parallel health service delivery structure will not be created.
- The new "governance structure" is for health services that had previously been provided by the federal government and/or First Nations on reserve. These federal services included but were not limited to, select services in primary and public health, environmental health monitoring, maternal/child health and mental health and substance use.
- Health Canada has now evolved its role from *designer* and *deliverer* of First Nations health services to *funder and governance partner*.
- The Canada Funding Agreement (CFA) provides federal funding to FNHA to support the transfer of federal health programs and support the planning, design, management, delivery, and funding of health programs by FNHA. The total funding under the CFA is $4.7 billion over 10 years (began July 2, 2013, and expires March 31, 2023).
- The First Nations health programs and services previously provided by Health Canada were transferred in phases to FNHA. On July 2, 2013, headquarters functions and funding were transferred, including funding for Medical Services Plan (MSP) premiums. The remaining regional office programs, services and staff were transferred on October 1, 2013.

<u>Recent Progress on BC's Key Commitments</u>

- In accordance with a commitment made in the Framework Agreement to facilitate coordination and integration of First Nations' health programs and services, regional partnership accords have been signed between each of the regional health authorities and each regional caucus of the FNHC. The accords confirm the commitment of the partners to work collaboratively on actions within a shared agenda to improve the health of First Nations and Aboriginal people in their region. The Provincial Health Services Authority and FNHA have also developed a partnership accord to guide collaborative actions.
- A Health Partnership Accord was signed among the tripartite partners on December 17, 2012. The Health Partnership Accord describes the broad and enduring relationship; outlines the political commitments that form its foundation; and renews the commitment to work together to

eliminate disparities between the health status of First Nations and other British Columbians and build a better health system.

- The provincial government and FNHA have an agreement on the payment of MSP premiums through the group plan. FNHA took over from Health Canada as Group Administrator on behalf of First Nations in BC on July 2, 2013, and is working with the Ministry of Health to invest in improving access to primary care through the Joint Project Board.
- The Ministry and FNHA Joint Project Board is an executive level committee that supports the initiatives and priorities of the regions and supports integration of initiatives and services of the Province with those funded by FNHA, particularly focused on overcoming key policy barriers. The Joint Project Board is responsible for the development and implementation of an annual work plan describing key activities, responsibilities and timeframes.
- A Letter of Mutual Accountability was signed for 2014/15 by FNHA and the Ministry which articulated the mutual accountabilities, roles and responsibilities of both parties with respect to the planning, administration, delivery and monitoring of health services. The CEO of FNHA is now also a member of the health system's Leadership Council with the other CEOs of provincial health authorities and the Deputy Minister of Health.

FINANCIAL IMPLICATIONS

The Framework Agreement includes the provincial commitment of $100 million up to 2019/20 to support health actions outlined in the Transformative Change Accord: First Nations Health Plan and the TFNHP. Funding to date, and remaining funding up to 2019/20 are provided in the table below:

Fiscal Year	Amount
2006/07-2010/2011	$16.5 million (total)
2011/12	$4.0 million
2012/13	$6.5 million
2013/14	$8.0 million
2014/15	$10.0 million
Funds provided by end of 2014/15	**$45.0 million**
2015/16 through 2019/20	$11.0 million per year
Funds still to be disbursed	**$55.0 million**
Total Commitment	**$100.0 million**

Approved by:

Arlene Paton, Population and Public Health Division; February 17, 2015

Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; March 2, 2015

FACT SHEET

Drinking Water
Union of BC Municipalities Small Water System Recommendations

ISSUE

Union of BC Municipalities (UBCM) Small Water Systems Working Group has made a number of recommendations to government on making changes to how small drinking water systems are regulated. Government will address the UBCM recommendations, as well as recommendations made by other stakeholders, through an interministerial working group, with the goal of ensuring small water systems are supported to deliver safe drinking water to customers.

KEY FACTS

- The Ministry of Health is responsible for the *Drinking Water Protection Act* which regulates the construction and operation of drinking water systems. Water suppliers have the responsibility to deliver potable water to their users and health authorities issue permits to water suppliers to ensure these obligations are met.
- While much of the BC population receives treated drinking water from large water systems, there are over 4,000 known small water systems (SWS). It is estimated that there are thousands of additional SWS that remain unidentified and unregulated, posing potential health risks to their users.
- There are approximately 500 boil water notices on drinking water supply systems across the province. Most of these notices are long-term, and associated with very small, independent water systems.
- Small water system suppliers face many challenges to provide safe drinking water to their customers. Challenges include short falls in infrastructure, staffing, technical capacity, governance and financing.
- Several prominent organizations have reported on small water system challenges in BC. They have made recommendations to several ministries involved with regulating drinking water. These reports include: Internal Audit of the BC Office of the Comptroller General - Report on the Review of Drinking Water Resources (2012); the Office of the Provincial Health Officer; the UBCM SWS working group; the Office of the BC Ombudsperson – Fit to Drink: Challenges in Providing Safe Drinking Water in British Columbia, Special Report no. 32 (2008); and the (2002) Action Plan for Safe Drinking Water in British Columbia.
- s.13

FACT SHEET

- Government has initiated an interministry ADM steering committee and working group to develop several policies and implementation actions over the next two years as follows:
  1. Plan and implement UBCM's recommendations related to reducing the regulatory burden for water supply systems with less than five connections.
  2. Develop guidance for Ministry of Transportation and Infrastructure Approving Officers aimed at preventing the creation of unsustainable systems. Consistent guidance will also be developed for local governments for subdivision approvals within their authority.
  3. Investigate the feasibility of developing loan programs with financial institutions for existing small water systems needing investment to meet potable water standards.
  4. Explore requirements for registration of non-potable water conditions on land title.
  5. Build upon and promote education and outreach programs to ensure small water systems have access to technical and financial best practices and other educational resources.
- These actions have been outlined in a draft letter from Minister Lake to Al Richmond, Chair of UBCM Healthy Communities committee.

FINANCIAL IMPLICATIONS

- The Ministry does not provide direct financial assistance to water systems. Most SWS are not eligible for financing through the Ministry of Community, Sport and Cultural Development and SWS operators typically fund operations through user fees.
- Health authorities currently dedicate significant resources to monitoring small systems across the province.
- Implementing a comprehensive SWS strategy requires participation and resources from across government.
- The Ministry has provided $500,000 in 2014/15 one-time funding to the BC Water and Waste Association to implement the outreach and education component of the SWS work plan over the next two years.

Approved by:
Arlene Paton, Population and Public Health Division; April 13, 2015
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; April 16, 2015

FACT SHEET

Ebola Preparedness in BC

ISSUE

Preparation for the unlikely event of a case of Ebola Virus Disease (EVD) in BC.

KEY FACTS

- The 2014/15 outbreak of EVD is primarily in Liberia, Guinea and Sierra Leone in West Africa.[1]
- As of April 12, 2015, there have been 25,826 confirmed, probable and suspected EVD cases worldwide, including 10,704 reported deaths.[1]
- 864 of these cases have been in health workers, including 503 deaths.[1]
- In the US, there have been a small number of EVD cases in individuals arriving from West Africa and in healthcare workers who provided care to these individuals.[2]
- To date, there have been no confirmed cases of Ebola Virus Disease in BC or elsewhere in Canada.
- The Ebola virus is only spread through direct contact with infected bodily fluids such as blood, sweat, saliva, vomit, urine or faeces. An individual not displaying symptoms is not contagious.
- While it is very unlikely that BC will experience a case of EVD, it is a very serious, communicable disease that has a more than 50% fatality rate.[3] Therefore, it is imperative that BC be fully prepared out of an abundance of caution.
- In the fall of 2014, the Ministry of Health set up a Provincial Ebola Preparedness Task Force, co-chaired by Provincial Health Officer Perry Kendall and Associate Deputy Minister of Health Lynn Stevenson.
- Since that time, a tremendous amount of work has been done across the health system.
- A full suite of policies and guidelines have been developed that address the entire continuum of care for someone who may develop EVD, from identification and transportation through to treatment, discharge and management of those they may have come into contact with when they were ill.
- These policies and guidelines were developed by experts from across the health system under the Ebola Preparedness Task Force, from public health to laboratories, prehospital or ambulance services to emergency, acute care and infection prevention and control.
- Public Health continues to closely monitor travellers and health care workers who have recently returned from one of the affected countries in West Africa, to ensure that they can quickly and safely access care if needed. Currently, they are following approximately 5-7 people in BC at any given time.
- Each health authority has designated sites as a central care point for those who have a potential exposure to Ebola and who have developed symptoms. Anyone seriously ill with potential or confirmed EVD will be cared for at either Surrey Memorial Hospital or BC Childrens' Hospital.
- Rigorous standards are in place for the personal protective equipment needed for health care workers to care for anyone who may become ill with EVD. Health care workers across the province are undergoing training to ensure they can safely put on and take off this equipment, while providing the highest level of care to the patient.
- We are working closely with our federal partners, and with organizations that have volunteers or staff working in Ebola-affected countries, to proactively identify and contact returning health care workers or travellers, to ensure that they are properly monitored. There are also stringent border

[1] World Health Organization (2015) Ebola Situation Report - 15 April 2015 Retrieved April 17, 2015 from http://apps.who.int/ebola/current-situation/ebola-situation-report-15-april-2015

[2] US Centers for Disease Control and Prevention. Retrieved April 17, 2015 from: http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/united-states-imported-case.html

[3] World Health Organization (2014) Ebola Virus Disease. Retrieved April 17, 2015 from http://www.who.int/mediacentre/factsheets/fs103/en/

control processes in place. Those who are identified as potentially at higher risk for Ebola are required to stay within two hours of a designated facility, and are in daily contact with public health.

- This means that the likelihood of someone needing to be assessed for EVD, without prior contact with public health in BC, is extremely low.
- Out of an abundance of caution, some people have been tested for the Ebola virus in BC. Staff followed the accepted protocols in each of these cases, and post-case debriefings found that hospitals and staff worked admirably and safely to care for these patients.
- As more people return from Ebola-affected countries, we can expect that additional testing will be done. Once people arrive here in BC, they are monitored closely for the 21-day incubation period. Should they need to access medical care or develop symptoms at some point during that monitoring period, it is likely that EVD testing would be done, purely as a precautionary measure. This is entirely appropriate, and does not mean that health officials necessarily suspect Ebola.
- The Provincial Ebola Task Force has been in regular contact with a number of organizations and individuals across BC, including regulatory colleges, bargaining associations, Doctors of BC, BC Professional Firefighters Association and the Fire Chiefs Association of BC, to provide information and answer questions regarding our Ebola preparedness.
- The Task Force is also reaching out to municipalities and post-secondary institutions to ensure any questions they may have about the work underway in BC have been addressed.
- The Ministry is collaborating closely with public health officials in the federal government, other provinces and territories, and with BC's cross-border partners in the Pacific North West.
- An experimental Ebola vaccine has been developed by the Public Health Agency of Canada's National Microbiology Laboratory, and is currently undergoing clinical trials in Canada. the United States, Europe and Africa.[4]

FINANCIAL IMPLICATIONS

The Ministry has identified potential costs that could be incurred by people who are following direction from public health to stay within a certain distance from a designated health facility, and has developed a mechanism to ensure that any costs or loss of wages are not a barrier to following these protocols.

Approved by:
Arlene Paton, Population and Public Health Division; April 17, 2015

[4] Public Health Agency of Canada. Retrieved on April 17, 2015 from: http://www.phac-aspc.gc.ca/id-mi/vsv-ebov-fs-eng.php

FACT SHEET

Enterovirus D68

ISSUE

Sporadic cases of severe respiratory illness associated with enterovirus D68 in BC, with associated polio-like symptoms.

KEY FACTS

- Human enteroviruses include echoviruses, coxsackieviruses, polioviruses, rhinoviruses and the newer "numbered enteroviruses".[1]
- Enterovirus D68 (EV-D68) is a non-polio enterovirus first identified in California in 1962, and is rarely reported. EV-D68 is not a reportable infection in BC or the rest of Canada, leading to possible underreporting of the infection.[2]
- Between 2008 and 2010, EV-D68 was associated with several clusters of respiratory illness in Asia, Europe, and the United States that disproportionately affected children.[3]
- EV-D68 is transmitted through respiratory secretions and close contact with infected persons; however, as with other enteroviruses, EV-D68 may also be spread by fecal-oral transmission.[4]
- Since mid August 2014, there have been over 220 confirmed cases of EV-D68 in BC:
    - Two-thirds of the known infections have required hospitalization.
    - Five cases caused neurological problems (paralytic symptoms, weakness) [5], similar to cases seen in the US and other jurisdictions.[6,7]
    - As of January 2015, three people in BC who had contracted EV-D68 have died; in each case, public health officials are unable to determine whether cause of death was the direct result of EV-D68 infection, or rather the result of associated complications.[8]
- EV-D68 causes mild to severe respiratory illness; while a range of symptoms can be associated with this virus, EV-D68 is distinguished by its association with lower respiratory illness.[9]
- Mild cold-like symptoms include: runny nose, cough, and sneezing children with a history of asthma or wheezing appear to be at higher risk for serious complications. Some children require intensive hospital care (ICU admission and mechanical ventilation).[10]
- Infants, children and teenagers are more likely to get infections partly because they have not been previously exposed to as many kinds of enteroviruses as adults and have not developed immunity to these viruses. In Canada and the United States, enterovirus infections are more common during the late summer and fall.[11]
- Transmission occurs through respiratory secretions and close contact with infected persons; however, as with other enteroviruses, EV-D68 may also be spread by fecal-oral transmission.[12]

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[1] BC Centre for Disease Control (2014) Emerging Respiratory Virus bulletin: Enterovirus D68. Retrieved October 2, 2014 from http://www.bccdc.ca/NR/rdonlyres/389B353D-93EE-45E4-8B4D-C8F239ACBAE2/0/EmailText_ERVUpdate_EVD68_Corrected20140917.pdf
[2] Ibid
[3] Ibid
[4] Ibid
[5] Ibid
[6] BCCDC (2014) Emerging Respiratory Virus bulletin: Enterovirus D68. Retrieved October 2, 2014 from: http://www.bccdc.ca/NR/rdonlyres/5D13BE17-89F4-491C-966B-FCC0E4AEFC56/0/ERV_Update_EVD68_20141001.pdf
[7] Centre for Disease Control (2014) CDC Health Advisory: Acute neurologic illness with focal limb weakness of unknown etiology in children. Retrieved October 2, 2014 from http://emergency.cdc.gov/han/han00370.asp.
[8] CBC (2014) Enterovirus d68 linked to 3rd BC death. CBC News. Retrieved January 28, 2015 from http://www.cbc.ca/news/canada/british-columbia/enterovirus-d68-linked-to-3rd-b-c-death-1.2889020
[9] BC Centre for Disease Control (2014) Emerging Respiratory Virus bulletin: Enterovirus D68. Retrieved October 2, 2014 from http://www.bccdc.ca/NR/rdonlyres/389B353D-93EE-45E4-8B4D-C8F239ACBAE2/0/EmailText_ERVUpdate_EVD68_Corrected20140917.pdf
[10] BCCDC (2014) Enterovirus D68 Overview. Retrieved October 2, 2014 from http://www.bccdc.ca/dis-cond/a-z/_e/EnterovirusD68/overview/default.htm
[11] Ibid
[12] BC Centre for Disease Control (2014) Emerging Respiratory Virus bulletin: Enterovirus D68. Retrieved October 2, 2014 from http://www.bccdc.ca/NR/rdonlyres/389B353D-93EE-45E4-8B4D-C8F239ACBAE2/0/EmailText_ERVUpdate_EVD68_Corrected20140917.pdf

FACT SHEET

- While there is currently no vaccine for preventing EV-68, transmission of respiratory infections, including EV-D68, can be prevented by[13]:
  - washing your hands often with soap and water for 20 seconds,
  - avoid touching eyes, nose and mouth with unwashed hands;
  - avoid kissing, hugging and sharing cups or utensils with people who are sick;
  - covering your mouth with your elbow when you cough or sneeze,
  - clean and disinfect frequently touched surfaces, such as toys and doorknobs, especially if someone is sick; and
  - stay at home from work or school when sick.
- There is no specific treatment for EV-D68. Most people will get better on their own without any treatment.[14]
- The BC Centre for Disease Control is currently monitoring the situation with regional health authorities, and national and international agencies.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Arlene Paton, Population and Public Health Division; February 9, 2015

[13] Ibid

[14] BCCDC (2014) Enterovirus D68 Overview. Retrieved October 2, 2014 from http://www.bccdc.ca/dis-cond/a-z/_e/EnterovirusD68/overview/default.htm

FACT SHEET

Harm Reduction

ISSUE

Harm reduction is an essential part of a comprehensive response to problematic substance use that complements prevention, treatment and drug law enforcement.

KEY FACTS

Harm reduction refers to policies, programs and practices that prevent or reduce the adverse health, social or economic harms associated with the non-medical use of legal and illegal psychoactive substances and is a pragmatic way of preventing many of the costly, difficult-to-treat and preventable health harms associated with substance use, including: injuries, overdose deaths, HIV, hepatitis C, and other infections.[1] Expanding the reach and range of harm reduction services is a priority action in *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use* (2010) and in *From Hope to Health: towards an AIDS-Free Generation* (2012). In 2011, the BC Provincial Health Officer reported that over the past decade harm reduction policies and programs have helped to reduce rates of HIV among BC injection drug users.[2] BC has shown leadership in evidence-based harm reduction programs, including:

Supervised Injection

Vancouver's Insite is North America's first legal supervised injection site. Rigorous evaluation has demonstrated that Insite prevents overdose deaths,[3] prevents HIV risk behaviours such as needle sharing,[4] reduces public injecting[5] and also increases uptake of detox and addiction treatment services,[6] but does not increase drug-related crime. On September 30, 2011, the Supreme Court of Canada unanimously rejected an appeal from the federal government that could have forced Insite to close, and ordered the Federal Minister of Health to grant an immediate exemption permitting Insite's continued operation.[7] The Dr. Peter Centre in Vancouver also provides supervised injection services. The Dr. Peter AIDS Foundation and Vancouver Coastal Health (VCH) have applied for an exemption, in progress as of early 2015. On October 17, 2013, the federal government introduced "An Act to Amend the Controlled Drugs and Substances Act" as Bill C-2[8] (in Second reading in the Senate, as of April 2, 2015), which establishes processes and criteria beyond the BC guidelines for federal approval of new supervised injection services.[9]

Crack Pipe Mouthpiece Distribution

Plastic mouthpieces are distributed province-wide to protect those who smoke crack from exposure to communicable disease (e.g., hepatitis C).[10] VCH piloted the provision of safer crack smoking kits through

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[1] BC Ministry of Health. (2005). *Harm reduction: A BC community guide.* Victoria, BC: Retrieved January 20, 2014 at http://www.health.gov.bc.ca/library/publications/year/2005/hrcommunityguide.pdf

[2] Gilbert, M., Buxton, J., & Tupper, K. (2011). *Decreasing HIV infections among people who use drugs by injection in British Columbia.* Victoria, BC: Office of the Provincial Health Officer of British Columbia. Retrieved January 20, 2014 at: http://www.health.gov.bc.ca/library/publications/year/2011/decreasing-HIV-in-IDU-population.pdf

[3] Marshall, B. D. L., Milloy, M.-J., Wood, E., Montaner, J. S. G., & Kerr, T. (2011). Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: A retrospective population-based study. *The Lancet*, 377(9775), 1429-1437.

[4] Stoltz, J., Wood, E., Small, W., Li, K., Tyndall, M., Montaner, J., et al. (2007). Changes in injecting practices associated with use of a medically supervised safer injection facility. *Journal of Public Health*, *29*(1), 35-39.

[5] Wood, E., Kerr, T., Small, W., Li, K., Marsh, D. C., Montaner, J. S. G., et al. (2004). Changes in public order after opening of a medically supervised safer injecting facility for illicit injection drug users. *Canadian Medical Association Journal*, 171(7), 731-734.

[6] Wood, E., Tyndall, M. W., Zhang, R., Montaner, J. S., & Kerr, T. (2007). Rate of detoxification service use and its impact among a cohort of supervised injecting facility users. *Addiction*, *102*(6), 916-919.

[7] Boyd, N. (2013). Lessons from INSITE, Vancouver's supervised injection facility: 2003–2012. *Drugs: Education, Prevention and Policy*, *20*(3), 234-240.

[8] http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&DocId=6256959&File=30

[9] BC Ministry of Health (2012) *Guidance document supervised injection services BC.* Victoria, BC: Ministry of Health. Retrieved February 4, 2015 at http://www.health.gov.bc.ca/cdms/pdf/guidance-document-for-sis-in-bc.pdf

[10] Tortu, S., McMahon, J.M., Pouget, E.R. & Hamid, R. (2004). Sharing of noninjection drug-use implements as a risk factor for hepatitis C. *Substance Use & Misuse*, *39*(2), 211–224.

5 partner agencies starting in December 2011; evaluation of the pilot was completed in 2013[11] and VCH continues to fund the program.

Opioid Substitution Therapy (OST)

OST is a proven population health strategy for preventing and reducing HIV infections *and* a gold-standard treatment for chronic opiate (e.g., heroin) addiction.[12] BC's award-winning OST program has been scaled up to reach over 15,000 patients in 2013 (from fewer than 3,000 in the mid-1990s).[13,14]

Needle Distribution and Recovery

Providing sterile syringes to people who inject drugs is one of the most effective ways to reduce blood-borne pathogen transmission.[2] The BC Centre for Disease Control currently provides sterile syringes at over 330 distribution sites in BC.[15]

Alcohol Harm Reduction

Preliminary evaluations of managed alcohol programs (MAPs) have demonstrated improved health for long term, chronic alcohol dependent participants including those with a history of non-beverage alcohol use (e.g., hand sanitizer), and have reported decreases in participant emergency room visits and police encounters.[15] Evaluations of MAPs run by VCH and in Thunder Bay have shown reduced health harms and evidence of decreases in police calls and hospital use.[16] A research team funded by the Canadian Institutes of Health Research and led by the University of Victoria is fully evaluating 5 MAPs across Canada. Preliminary results are available for the Thunder Bay reseach site.[17] Further results will be available in 2016.

FINANCIAL IMPLICATIONS

Funds designated to the Harm Reduction Supplies Program for the "provision of harm reduction supplies to each health authority and their contracted needle distribution programs, in accordance with needs identified through local ordering."[18] Although recent estimates are not available for Canada, a US study estimated that the average lifetime cost of treatment for a case of HIV infection is US $385,200.[19]

Fiscal Year	PHSA designated funds
2012/13 to 2013/14	$1.7 million per annum[20]
2014/15	$3.1 million per annum[21]

Approvals:

Arlene Paton, Population and Public Health Division; April 17, 2015

Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; April 1, 2015

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[11] *Evaluation Report: Vancouver Coastal Health Safer Smoking Pilot Project* (2013) https://www.vch.ca/media/safer-smoking-pilot-2013.pdf

[12] Faggiano, F., Vigna-Taglianti, F., Versino, E., & Lemma, P. (2004). Methadone maintenance at different dosages for opioid dependence (Review). *Cochrane Database of Systematic Reviews*, 3(CD002208).

[13] Office of the Provincial Health Officer. (2014). BC opioid substitution treatment system: Performance measures 2012/2013. Victoria, BC: Office of the Provincial Health Officer. http://www.health.gov.bc.ca/pho/pdf/methadone-2012-13.pdf

[14] BC Harm Reduction Strategies and Services Committee. (2014). Policy Indicators Report. Vancouver, BC. Retreived January 29, 2015 at http://www.bccdc.ca/NR/rdonlyres/CA1F6011-1896-4E1D-9131-3A9407C5D78F/0/BCHRSS2012PolicyIndicatorsReportDRAFTJuly2014.pdf

[15] Podymow, T., Turnbull, J., Coyle, D., Yetisir, E. and Wells, G. (2006). Shelter-Based Managed Alcohol Administration to Chronically Homeless People Addicted to Alcohol. *Canadian Medical Association Journal*. 174(1) & Wilton, P. (2003). Shelter goes wet, opens infirmary to cater to Toronto's homeless. *Canadian Medical Association Journal*. 168 (7).

[16] Stockwell, T., Pauly, B., Chow, C., Vallance, K., & Perkin, K. (2013). *Evaluation of a managed alcohol program in Vancouver, BC*. CARBC Bulletin, 9, 1-8. http://www.carbc.ca/Portals/0/Home/CARBC%20Bulletin%209.pdf

[17] Pauly, B., Stockwell, T., Chow, C., Gray, E., Krysowaty, B., Vallance, K., & Perkin, K. (2013) Towards alcohol harm reduction: Priliminary results from an evaluation of a Canadian managed alcohol program. Victoria, BC: Centre for Addictions Research of BC. http://www.carbc.ca/Portals/0/PropertyAgent/1077/Files/423/thunderbaymapdec2013.pdf

[18] 2003/04 funding letter from Ministry of Health to PHSA sent April 1, 2003

[19] Schackman, B. R., Gebo, K. A., Walensky, R. P., Losina, E., Muccio, T., Sax, P. E., et al. (2006). The lifetime cost of current human immunodeficiency virus care in the United States. *Medical Care*, 44(11), 990-997.

[20] Supplies budget per PHSA Finance, January 8, 2014

[21] Supplies budget per PHSA Finance, October 31, 2014

FACT SHEET

Health Emergency Management (Provincial)

ISSUE

The BC health care system has a comprehensive emergency management program in place to increase its preparedness for a variety of hazards, such as earthquakes, fires and flooding.

KEY FACTS

The *Emergency Program Act*, the *Public Health Act*, Accreditation Canada Standards, and Health Services Management Policy require health organizations to develop effective emergency response and business continuation plans. The Ministry of Health, through the Emergency Management Unit (EMU), regional health authorities, BC Centre for Disease Control, BC Ambulance Service (BCAS), and Provincial Health Services Authority work collaboratively in setting provincial strategic and operational direction across the BC health system and within the health emergency management profession.

The EMU coordinates the Ministry's response and works cooperatively across all levels of government at the regional, national and international levels to better enable preparedness, response cooperation, and information sharing during emergencies and disasters. The EMU is currently implementing a number of initiatives aimed at improving health sector emergency preparedness. These initiatives, outlined in the EMU's Strategic Plan, include key priorities identified in conjunction with Health Emergency Management partner agencies and immediate operational requirements:

1) The maintenance of a 24/7 Ministry of Health Duty Officer program and ongoing refinement of an Emergency Communications strategy, which includes ETeam, BC Health Emergency Notification System, satellite phones, and other communications tools in partnership with health authorities and the BCAS, in order to establish a more comprehensive and organized approach to managing consequences and communicating during emergencies;
2) The maintenance of a fixed Health Emergency Coordination Centre (HECC) for the Ministry and the refinement of response coordination and communication mechanisms outlining the health sector's response to a major emergency or disaster, building on lessons learned from recent events. This includes the ongoing training and support of the volunteer Health Emergency Action Team that will be integral to sustain HECC operations during any major incident;
3) The implementation of an integrated Hazardous Substance Program to ensure that all health facilities that may receive patients contaminated with hazardous substances have the plans, equipment and training needed to provide care in a safe manner;
4) The continued development of a comprehensive training and exercise program for Ministry staff and to support health authority emergency management processes;
5) The development of a health surge capacity strategy that will support health care delivery in BC during an event that overwhelms health authority and provincial capacity, consistent with Federal/Provincial/Territorial plans;
6) The ongoing refinement of the Ministry of Health Business Continuity Plan, including a comprehensive business continuity plan for Executive Operations and key leadership structures within the Ministry; and
7) The development of an accountability framework for the reporting of health emergency management readiness and progress across the BC health system. This follows the consolidation of health emergency management programs within the health authorities to create Health Emergency Management BC (HEMBC) in April 2013. The consolidation resulted in the delegation of lead responsibilities and funding for some programs previously led by the EMU to HEMBC.

FACT SHEET

FINANCIAL IMPLICATIONS

N/A

Approved by:

Arlene Paton, Population & Public Health Division; February 6, 2015

FACT SHEET

Health Sector Pandemic Preparedness

ISSUE

A revised BC Pandemic Influenza Response Plan was released in 2012, building on the 2009 H1N1 Pandemic Influenza Response Plan, and on the lessons learned from that pandemic. The Plan is general in nature, and can be re-focused with specific information in the event of emerging pathogens. This is particularly relevant due to the emergence of H7N9 and MERS-CoV in 2013, the recent West African Ebola outbreak, and ongoing new and emerging threats requiring planning and vigilance.

KEY FACTS

- The Plan addresses a number of key areas of preparedness and response, including:
    - Revised and updated planning assumptions to help guide pandemic planning efforts;
    - Public health guidance for laboratories, surveillance, antiviral distribution, vaccine storage, distribution and security, and public health measures;
    - A provincial ethics framework;
    - Acute care guidelines and tool kit;
    - Infection control guidelines;
    - Human resources;
    - Communications and education;
    - Psychosocial plans for health care workers and the public; and
    - Remote and First Nations communities.
- The Plan is web-based to enhance accessibility and navigation and enables updates to be posted as new information becomes available. The scheduled review of the 2012 Plan will take place in 2015 and will incorporate the extensive learnings gleaned from the recent Ebola threat. It is anticipated that the revised plan will address and establish the readiness and response expectations for any communicable disease outbreak that may be faced in the province instead of focusing specifically on pandemic influenza as in the past. This new communicable disease planning will build on the momentum and knowledge gained from the Ebola response within the health system and will include extensive consultation with all key stakeholders to inform the future state of communicable disease preparedness in BC.
- In addition, the Ministry of Health worked jointly with Emergency Management BC, Ministry of Justice, to develop a new non-health, BC Pandemic Influenza Provincial Coordination Plan to replace the 2009 Pandemic Influenza Consequence Management Plan. The purpose of the BC Pandemic Influenza Provincial Coordination Plan is to describe the provincial government's strategy for cross-ministry coordination, internal and external communications and provincial government business continuity. The final BC Pandemic Influenza Provincial Coordination Plan forms a hazard specific annex of the Comprehensive Emergency Management Plan. This plan was completed in January 2015.
- There is also a standing committee of representatives from all health authorities, Health Shared Services BC and the BC Centre for Disease Control that meets monthly to receive updates on emerging threats, share regional pandemic planning information, and coordinate provincial pandemic training and exercise. This group was convened in May 2013 to address specific concerns surrounding H7N9 and the MERS-CoV.

FACT SHEET

- In 2013, health authorities in China notified the World Health Organization (WHO) that an avian influenza A(H7N9) virus was causing severe respiratory illness in humans. Concurrently, the WHO reported on confirmed cases in Europe and North Africa of a novel coronavirus (MERS-CoV). Both of these viruses remain a potential threat to North America. On March 23, 2014, the WHO published formal notification of an outbreak of Ebola virus disease in West Africa, and has since declared the epidemic to be a public health emergency of international concern. The high mortality rates associated associated with the aforementioned viruses, combined with constant new and emerging threats, have prompted health officials to enhance surveillance, diligence and preparedness activities.
- Preparedness activities currently being undertaken include:
    - Continuing with the Health Shared Services BC led working group to address various stockpile issues related to pandemics;
    - Continuing the work of the Provincial Ebola Task Force to prepare the system for a potential case of Ebola arriving in BC;
    - Reviewing the effectiveness of the provincial response to the ongoing Ebola threat;
    - Renewing the provincial pandemic planning to focus on an all hazard communicable disease approach;
    - Clarifying the roles of the various health agencies (BC Centre for Disease Control, Health Emergency Management BC, Emergency Management Unit, First Nations Health Authority, Health Authorities, etc) that support the Provincial Health Officer during public health emergencies;
    - Reviewing and updating individual health authority pandemic plans; and
    - Planning and facilitating communicable disease preparedness exercises.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Arlene Paton, Population & Public Health Division; April 27, 2015

FACT SHEET

Healthy Communities

ISSUE

To provide an overview of the Ministry of Health's approach to creating healthier communities; the places where people live, learn, work, play, and travel daily.

KEY FACTS

- A considerable body of scientific research has been compiled over the past two decades on how the health of populations is shaped by what takes place in communities. This includes: how communities are planned, spatially arranged, constructed, and used; the policies and laws they are governed by; exposure of citizens to toxins, violence, crime, disease, and injury risks; and the health and social behaviors of citizens of all ages. Communities are increasingly recognized as key settings for health promotion and prevention of chronic diseases and injuries. They are comprised of a number of smaller-scale settings including neighbourhoods, green space, schools, workplaces and home.
- In his 2006 report, An Ounce of Prevention Revisited, the BC Provincial Health Officer acknowledged the importance of a multi-faceted approach for dealing with the rise in chronic diseases and their risk factors in society. Such an approach supports the use of an array of evidence-based prevention interventions for various settings, including communities.
- Physical inactivity, unhealthy eating, tobacco smoking, alcohol misuse and other unhealthy behaviors are preventable contributors to chronic diseases. By adopting healthier lifestyles, citizens of all ages can improve and maintain good health and decrease their risk of acquiring a major chronic disease. Those with established chronic diseases may also benefit from appropriate physical activity, quitting tobacco use and healthy diets, and may recover their health.[1]
- Healthy communities provide citizens of all ages with opportunities in multiple environments to attain and maintain excellent health. Built environments that encourage outdoor physical activity and active transport (walking, cycling, transit), less motor vehicle use, good air quality and access to nutritious foods reinforce healthy living choices and help shape lifelong healthy behaviours. Built environments are conducive to good health when land use plans, public policies and development decisions support more compact and complete communities, mixed land use, higher residential density, accessible green space and proximity to everyday places where people live, work, learn, and play.[2]
- People of all ages benefit from outdoor physical activity and nature experiences, especially children. Myopia, overweight and obesity, conditions associated with vitamin D deficiency, stress and Attention Deficit Hyperactivity Disorder are known to be reduced by spending time in nature.[3]

Key activities of the Ministry include:

1. Healthy Families BC Communities (HFBCC) is an integral part of the Healthy Families BC Policy Framework and brings together local governments, non-governmental organizations and health authorities in innovative ways to create environments that encourage people to make healthier choices. The Ministry's 2012 province-wide consultations with elected officials and staff from 102 (54%) local governments and 25 national and provincial non-governmental organizations, and staff from all health authorities, yielded crucial feedback for HFBCC implementation planning. By

[1] Heart and Stroke Foundation of Canada. (2010). *A Heart and Stroke Foundation built environment toolkit for change.* With assistance of the Canadian Institute of Planners and the Canadian Urban Institute.
[2] Canadian Institute of Planners. *Healthy Communities Practice Guide.* Also, *Healthy Community Factsheets 1-3.*
[3] National Environmental Education Foundation USA. *Factsheet: Children's Health and Nature.*

partnering with health authorities, local governments are enabled to identify and prioritize local health issues and actions, and align with health promotion initiatives that prevent chronic diseases and promote healthy weights. The Ministry continues to support capacity building and the provision of tools and training through its partners. Examples include the *PlanH Program* offered through BC Healthy Communities Society and *the Community Health Profiles* that were developed by the Provincial Health Services Authority to provide local data for use by health authorities and local governments to encourage collaborative community health planning. Since the start of the initiative:

a. All of the regional health authorities have staff designated to work directly with local governments on health-related plans and policies, as well as programs and public events.[4]
b. 52% of communities have partnership agreements with their regional health authorities to improve the health and well-being of the communities.[5]
c. 43% of communities are implementing healthy living strategic plans in partnership with their respective health authorities.[5]
d. Since 2013, BC Healthy Communities has made available $650,000[6] for Healthy Communities Capacity Building Fund Grants to support healthy living (e.g. physical activity, healthy eating, social connectedness, tobacco reduction) through community planning, projects and policy development. One hundred and sixteen grants have been awarded.[4]

2. The Healthy Built Environment Alliance, formed in 2008, brings together the public health, design and land use planning professions to better understand the impact of the built environment on health and well-being. The Alliance, co-chaired by Vancouver Coastal Health and the Planning Institute of BC, fosters learning through shared expertise and networking on topics relevant to communities and regions, and continues to develop learning resources, such as the "Healthy Built Environment Resource Kit".

3. Since 2009, the Ministry has collaborated with the Child and Nature Alliance of Canada (CNAC), a national non-profit organization that promotes optimal child and family health by connecting children with nature and outdoor play and fostering lifelong environmental education. The 2011 joint Memorandum of Understanding signed by the Ministries of Health and Environment with CNAC supports work that reduces child obesity rates and enhances child health and healthy development in natural and built environments.

FINANCIAL IMPLICATIONS

The Provincial Health Services Authority has provided BC Healthy Communities funding of $0.5 million in 2011/12, $1.0 million in 2012/13, $1.0 million in 2013/14, and $.775 million in 2014/15.

Approved by:
Arlene Paton, Population and Public Health Division; May 5, 2015
Gordon Cross, Manjit Sidhu, Financial and Support Services Division; May 1, 2015
Jackie Redmond, obo Carolyn Bell, Health Sector Planning & Innovation Division; February 20, 2014

[4] R.A. Malatest & Associates Ltd. (2014) Evaluation of Healthy Families BC Communities: Initial Evaluation Report: May 2011-March 2014
[5] Ministry of Health (2014). 2014-15 HFBC Communities Q3 consolidated Report
[6] http://www.newsroom.gov.bc.ca/2014/05/government-invests-375000-for-healthy-communities.html, Retrieved Apr 14, 2015

FACT SHEET

Healthy Eating

ISSUE

Food is a prerequisite for, and a determinant of health. The food we eat defines to a great extent our health, growth, and development and our ability to function well in a complex world. Healthy eating promotes and supports social, physical and mental well-being for all people at all ages and stages of life and contributes to the overall health of individuals, families, and communities.

KEY FACTS

To ensure the greatest effectiveness, it is important that interventions support healthy eating across all settings particularly with children and youth in school so that all British Columbians are supported to make healthy choices in all environments. Healthy eating aligns with goal one in BC's Guiding Framework: *Healthy Living, Healthy Communities*. Key priority areas of focus include in the following:

Access and Availability of Healthy Foods

- Farmers' Market Nutrition Coupon Program - provides subsidies in the form of coupons to low-income pregnant women, families with children and seniors to buy select BC-produced foods at local farmers' markets. Coupon participants must receive nutrition and skill building classes to be eligible to receive coupons.
- Community Food Action Initiative (CFAI) - CFAI is a key program for all health authorities within the Food Security Core Program and is funded by the Ministry. The CFAI funding supports health authorities to fund community grants for community food action plans supporting local food access and food security.

Food Skills, Knowledge, Education & Awareness

- Food Skills for Families – the program teaches healthy eating and cooking skills with a focus on reaching Aboriginal, new immigrant, Punjabi, low income families and seniors. The success of this program demonstrates that building cooking and food preparation skills among adults improves healthy eating behaviors for participants and families.[1]
- Informed Dining - i a voluntary nutrition information program for restaurants in BC. Participating restaurants provide nutrition information in a brochure, menu insert, sign or poster at or before the point of ordering. As of March 11, 2015, 62 restaurant brands have fully implemented Informed Dining representing 2069 outlets in BC and 11,039 outlets nationally.[2] The mandated Informed Dining in Health Care program will require retail food service establishments in health authority owned and/or operated facilities implement the program by March 2016.
- Sodium & Sugary Drink Reduction - through the Healthy Families BC website (www.healthyfamiliesBC.ca), the Province has developed web content, blog and social media postings, TV advertising (Sodium City), contesting, and interactive tools (Sodium Sense & Sugary Drink Sense) to educate British Columbians on sodium and sugary drink reduction.

Healthy Food Environment Public Policy

- BC Trans Fat Regulation - was approved by government in February 2009, with the regulation coming into force on September 30, 2009. Food service establishments including restaurants, cafeterias, schools and institutions, are required to comply with the regulation. Environmental Health Officers monitor and enforce the regulation and health authorities are reporting trans fat compliance data semi-annually. Compliance rates range from 92 to 97%.[3]

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[1] The Conference Board of Canada. *What's to Eat? Improving Food Literacy in Canada*. Ottawa. The Conference Board of Canada, 2013.

[2] Ministry of Health, Population and Public Health Division

[3] BC Government. 2014. B.C. Trans fat Initiative Score Card. Retrieved May 6, 2014 from http://www.restricttransfat.ca/media/upload/file/trans-fat-initiative-score-card-april-2014.pdf

- Sodium Procurement Guidelines - the Ministry has established new provincial sodium guidelines for patient food services in all publicly-funded health care facilities. By 2016, adult general menus in acute and residential care will meet the guideline amount of 2,300 mg of sodium per day. The 2012/13 average daily sodium content of adult hospital diets was 2,822 mg of sodium per day.[4]
- Vending Guidelines - rhe Healthier Choices in Vending Machines in BC Public Buildings Policy restricts the sale of unhealthy foods and sugary drinks in BC Public Buildings, including health authorities, post-secondary institutions and crown corporations since 2006. The Policy was recently updated to align with the 2013 School Guidelines.

School Setting

The Ministry supports a suite of provincial school-based healthy living eating programs including Farm to School, BC School Fruit and Vegetable Nutritional Program, Fresh to You Fundraiser, and Action Schools! BC. These programs, along with the 2013 Guidelines for Food and Beverage Sales in BC Schools, help to create school environments that support healthy eating by offering greater access to healthy food and, increasing knowledge, attitude and skills about healthy eating.

FINANCIAL IMPLICATIONS

- BC School Fruit and Vegetable Nutritional Program - since 2010/11, the BC Agriculture in the Classroom Foundation has received $21.5 million in funding from the Provincial Health Services Authority (PHSA) and the Ministry to support the program:
    - PHSA has provided a total funding of $13.0 million from 2011/12 to 2014/15.
    - The Ministry has provided total funding of $8.5 million from 2010/11 to 2014/15 (Ministry funding includes $1.0 million in 2013/14 for the addition of milk to K-2 students).
- Farmers' Market Nutrition Coupon Program - to support this program, the Ministry provided the BC Association of Farmer's Market $750,000 in 2011/12 and 2013/14. PHSA also providing funding of $1.25 million in 2011/12 and $2.0 million in 2012/13.
- Community Food Action Initiative) - Health authorities combined, spent approximately $1.5 million annually towards this initiative.
- Food Skills for Families - to support this program, the Ministry provided $275,000 to the Canadian Diabetes Association in 2011/12. PHSA provided a total of $1.85 million from 2011/12 to 2014/15 to the Canadian Diabetes Association to further support this program.
- Informed Dining - as part of Healthy Families BC, Informed Dining was launched with a $1.9 million promotional campaign in 2011/12. PHSA provided a total of $1.25 million from 2011/12 to 2014/15 to the Heart and Stroke Foundation for program evaluation, implementation, and consumer education.

Approved by:

Arlene Paton, Population and Public Health Division; May 6, 2015

Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; April 30, 2015

[4] Ministry of Health, Population and Public Health Division

FACT SHEET

Healthy Families BC Policy Framework

ISSUE

The *Healthy Families BC Policy Framework: A Focused Approach to Chronic Disease and InjuryPrevention in BC* (HFBC Policy Framework) was released in May 2014.

KEY FACTS

- Healthy Families BC (HFBC) was initially developed in 2011 as part of the Ministry's Innovation and Change Agenda. It included a select number of priority prevention initiatives organized under four pillars.
- In 2013, the Minister of Health's Mandate Letter included a requirement to work with health authorities to develop a "preventative health plan" for the province.
- With this direction, the Ministry developed the new HFBC Policy Framework, which builds on the existing prevention platform and brand to include a full spectrum of chronic disease and injury prevention initiatives and address the growing burden of disease in BC.
- The HFBC Policy Framework sets policy direction for chronic disease and injury prevention across the following seven focused intervention streams:
    - Healthy Eating
    - Physical Activity
    - Tobacco Control
    - Healthy Early Childhood Development
    - Positive Mental Health Promotion
    - A Culture of Moderation for Alcohol Use
    - Injury Prevention
- It also serves to operationalize four goals in *Promote, Protect, Prevent: Our Health Begins Here. BC's Guiding Framework for Public Health* (the Guiding Framework, see Fact Sheet BC's Guiding Framework for Public Health).
- The HFBC Policy Framework outlines several key approaches health authorities are encouraged to employ when implementing this policy direction:
    - Use Multiple Tools of Influence - use a combination of levers across each focused intervention stream in order to most effectively shape behaviour and influence outcomes.
    - Tailor Action to Specific Times Across the Life Course - use a life course approach and focus attention on preconception, maternal and early childhood interventions to affect the trajectory of a child's life into adulthood; and, address specific gender and age groups with a high prevalence of risk behaviour (e.g., young men in the trades), or key transition periods, such as school transitions, pregnancy or hospitalization, where prevention or behavioural change is known to be more effective.
    - Deliver Within Key Settings - influence overall health and support healthy lifestyles through the design and development of healthy built environments.
    - Tailor Actions to Address Specific Health Disparities and Inequities, and Maximize Reach - use data in order to understand differences between certain populations and communities in order to appropriately develop supportive policies, scale the intensity of interventions, inform decision-makers within and beyond the health system and support efforts to address the underlying causes of disparity.
    - Shift Modifiable Behaviours Using Behavioural Science and a Range of Policy Tools - use data to understand the determinants of behaviour and apply educational and policy

interventions to improve health literacy and shift that behaviour or associated cultural norms or attitudes.

- It is also a key component of 'Setting Priorities for the BC Health System', the health system strategy that was published in February 2014.
- As part of this larger health system strategy, a performance management accountability framework is being built that includes clear roles and accountability mechanisms for health authorities.
    - The Guiding Framework identifies a number of performance measures, which will be used to help measure progress and success against the focused intervention streams in the HFBC Policy Framework.
    - Additional process or outcome measures may be set specifically for components of the HFBC Policy Framework as part of an Evaluation and Performance Framework.
    - The planning and evaluation of the HFBC Policy Framework will be supported by an effective program of surveillance, which will be guided by the Population and Public Health Surveillance Plan for BC.
- The implementation of the HFBC Policy Framework is supported by a marketing and engagement strategy with a provincial scope that ensures consistent messages and tools across all health authorities. This work builds on the existing foundation for HFBC, integrates current and new/expanded programs, and supports greater brand alignment, public awareness and engagement efforts.
- The HFBC Policy Framework also relies on stronger collaboration between health authorities, community partners and non-governmental organizations in order to successfully plan, design and deliver preventive interventions. The Ministry is working with the BC Healthy Living Alliance to forge and strengthen these non-governmental organizations relationships and service delivery mechanisms.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Arlene Paton, Population and Public Health Division; February 17, 2015

FACT SHEET

Healthy Weights and Preventing Obesity in Children and Youth

ISSUE

Factors affecting children and youth who are overweight and obese are complex. A comprehensive and integrated approach that reaches beyond lifestyle and individual behaviours is needed. Such an approach includes creating supportive environments, addressing health inequities and promoting mental well-being.

KEY FACTS

- *Results from the 2009 to 2011 Canadian Health Measures Survey* outlines the most recent Canadian statistics (no Provinical/Territiorial specific results) regarding overweight and obese children and adolescents. Data shows that most Canadian children aged 5-17 years were a healthy weight (66.4%); however approximately 20% were overweight and 12% were obese.[1] The most recent BC specific statistics regarding overweight and obese children and adolescents are available through the Canadian Community Health Survey 2004. Measured data shows 18% of children in BC aged 1 to 18 were classified as overweight and 9% as obese.[2]
- Healthy weights in children and youth remains a public health concern since being overweight or obese in early childhood significantly increases the likelihood of being overweight or obese in adolescence and adulthood, with accompanying health problems (e.g., type 2 diabetes, high cholesterol and sleep apnea).[3]
- A 2010 study showed that 95% of Canadian children with type 2 diabetes are obese and almost 40% already had at least one complication as a result of their obesity or diabetes, at an average age of only 13.5 years.[4]
- Weight-based discrimination has increased 66% in the past decade. Weight-based stigma affects individuals of all ages and has negative consequences on physical and psychological health. [5] Children who are overweight or obese are more likely to experience stigma and discrimination.[6]
- The causes of overweight and obesity are complex and are affected by a multitude of interrelated factors including genetics, socioeconomic status, social, cultural and environmental factors, and lifestyle.[7] Therefore, a coordinated approach to addressing healthy weights is required. Through the 2010 *Curbing Childhood Obesity: A Federal, Provincial, Territorial Framework for Action on Promoting Healthy Weights,* F/P/T Health and/or Health Promotion/Healthy Living, Ministers agreed to work collectively on three integrated strategies to promote healthy weights: 1) making childhood overweight and obesity a collective priority for action; 2) coordinating efforts on three key policy priorities including supportive environments, early action and nutritious food; and 3) measuring and reporting on collective progress.
- The Healthy Families BC Policy Framework promotes healthy weights by focusing on supportive environments, opportunities for physical activity, and access to healthy food.

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[1] Statistics Canada. (2012). *Overweight and obesity in children and adolescents: Results from the 2009 to 2011 Canadian Health Measures Survey*. p.4. Retrieved February 20, 2014, from http://www.statcan.gc.ca/pub/82-003-x/2012003/article/11706-eng.pdf

[2] Canadian Community Health Survey Public Use Microfile (PUMF). Retrieved on May 5, 2015 from http://www5.statcan.gc.ca/olc-cel/olc.action?lang=en&ObjId=82M0013X&ObjType=2

[3] Public Health Agency of Canada. (2010) *Curbing Childhood Obesity: A Federal, Provincial, Territorial Framework for Action on Promoting Healthy Weights*. Retrieved on January 21, 2013, from http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/framework-cadre/pdf/ccofw-eng.pdf

[4] Amed, S., et al. (2010). Type 2 diabetes, medication-induced diabetes, and monogenic diabetes in Canadian children: a prospective national surveillance study. *Diabetes Care, 33*(4): p. 786-91. Retrieved on February 20, 2014, from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2845028/

[5] Puhl, R., & Heuer, C. (2010). Obesity Stigma: Important considerations for public health. *American Journal of Public Health.* 100(6); p.1019-1028. Retrieved on February 20, 2014, from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2866597/

[6] Public Health Agency of Canada. (2011). *Obesity in Canada: A joint report from the Public Health Agency of Canada and the Canadian Institute for Health Information.* Retrieved January 22, 2013, from http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/oic-oac/assets/pdf/oic-oac-eng.pdf

[7] Ibid.

FACT SHEET

- The Ministry of Health is working with the Childhood Obesity Foundation to implement province-wide services for families with children already departing from a healthy weight trajectory. The ShapedownBC program, co-ordinated by BC Children's Hospital, provides medical, nutritional and psychological assessment, education and support for obese children, is now offered not only in the Vancouver area, but also by Fraser Health (Surrey/Langley), Island Health (Nanaimo)and Interior Health (Kamloops). MEND (Mind, Exercise, Nutrition, Do-it), a free community based program that supports overweight children and their families to adopt and maintain a healthy lifestyle is offered through recreation centres in 15 BC communities. Telehealth services at the Physical Activity Line and DietitianServices@HealthLinkBC were expanded in February 2015 to include healthy eating and active living coaching for at-risk families in rural and remote parts of the province.
- The Ministry is partnering with ChildHealth BC and the Childhood Obesity Foundation on the development of a comprehensive and coordinated approach for the implementation of policies, programs and services across a continuum of care to promote healthy weights and the management of overweight and obesity related health issues for children and youth in BC. This work recognizes provincial efforts to promote and support healthy weights, and identifies future considerations for strengthening the current approach.
- The Ministry supports a suite of provincial school-based healthy living programs including Farm to School, BC School Fruit and Vegetetable Nutritional Program, Fresh to You Fundraiser, and Action Schools! BC . These programs, along with the Guidelines for Food and Beverage Sales in BC Schools, help to create school environments that support healthy eating and promote healthy weights by offering greater access to healthy food and increasing knowledge, attitude and skills about healthy eating and physical activity.

FINANCIAL IMPLICATIONS

- The Provincial Health Services Authority provided $6.0 million in 2011/12, $2.0 million in 2012/13, and $2.47 million in 2013/14 to the Childhood Obesity Foundation to expand Shapedown across the province and launch MEND.
- s.17

Approved by:
Arlene Paton, Population and Public Health Division; May 6, 2015
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; May 8, 2015
Jackie Redmond, obo Carolyn Bell, Health Sector Planning and Innovation Division; February 24, 2014

FACT SHEET

Lyme Disease

ISSUE

There is considerable debate and disagreement between the international medical and patient communities related to the diagnosis and treatment of chronic complex illnesses, such as chronic Lyme disease.

KEY FACTS

- People may acquire Lyme disease after being bitten by a tick infected with the bacteria *Borrellia burgdorferi*. Lyme disease is reportable under the *Public Health Act* Communicable Disease Regulation.
- Less than 1% of the ticks tested by the BC Centre for Disease Control (BCCDC) carry this bacterium.[1] There are 2 types of ticks in BC that can carry Lyme disease: (1) *Ixodes pacificus* and (2) *Ixodes angustus*. They are not present in large numbers in BC, and a low percentage of them carry the Lyme-causing organism compared to ticks in eastern Canada and the US.
- Human cases of Lyme disease are rare in BC where the incidence rate is less than 0.5/100 000 per year.[2] There is no evidence to support an epidemic of Lyme disease in BC.[3] Early diagnosis and treatment of the disease is paramount, as the sooner treatment (with antibiotics) is begun following infection, the quicker and more complete the likely recovery.
- Concerns have been raised regarding transmission of the disease through blood donations and the lack of primary care physicians' knowledge of the signs, diagnosis and testing for Lyme disease. However, studies conducted by the BCCDC show physicians in BC are aware of the disease and treat appropriately based on suspicion. There has been no evidence that the bacterium that causes Lyme is transmitted through blood.
- In May 2010, Provincial Health Services Authority's Brian Schmidt produced a report at the request of the Deputy Minister of Health that recommended further research into what is known as chronic Lyme disease. BCCDC was not involved in this report. BCCDC studies show there is a low, stable rate of Lyme disease in BC, and large increases are not expected.

Diagnosis and Laboratory Testing

- Lyme disease should be diagnosed by a physician through a clinical evaluation of the patient's symptoms and risk of exposure to infected ticks. A blood test may also be administered (supported by laboratory testing by BCCDC), but this should not be interpreted in the absence of a clinical diagnosis.
- The BCCDC laboratory uses the accredited international test protocols (ELISA and Western Blot) that are used by all public health laboratories in the US and internationally. The international protocol for interpretation looks for three separate markers before identifying a positive for Lyme disease.
- Results of testing done by non-recognized means, such as that advertised by some independent for profit US Laboratories that only use one marker, should be viewed with caution due to the risk of false positive results.
- In the US, the Centers for Disease Control and Prevention and the Food and Drug Administration report that they "have become aware of commercial laboratories that conduct testing for Lyme disease by using assays whose accuracy and clinical usefulness have not been adequately

[1] BC Centre for Disease Control (2014). Lyme Disease. Available at: http://www.bccdc.ca/dis-cond/a-z/_l/LymeDisease/overview/Lyme+Disease.htm
[2] BC Centre for Disease Control (2014). British Columbia Annual Summary of Reportable Diseases. Available at: http://www.bccdc.ca/NR/rdonlyres/D8C85F70-804C-48D8-8A64-6009C9FD49A3/0/2013CDAnnualReportFinal.pdf
[3] Henry B, Morshed M. (2011) BC Medical Journal. 53(5): 224-229. Available at: http://www.bcmj.org/sites/default/files/BCMJ_53_Vol5_lyme.pdf

established." Basing diagnosis on results that cannot be validated may lead to inappropriate treatment and failure to investigate the true cause of patients' illness.

- Any British Columbian concerned about symptoms or exposure to Lyme disease can access diagnostic tests, publicly covered under the Medical Services Plan. Funding for testing using unrecognized means by unrecognized laboratories is not the responsibility of the Province.

Other Initiatives

- BCCDC continues to keep itself apprised of the most appropriate and effective laboratory testing practices to ensure accurate results and continues to monitor ticks, human and animal illness to determine if risk in BC is changing.
- BCCDC issues an alert every year to remind people of the low but real risk of Lyme disease in BC and encourage them to wear the appropriate clothing to protect themselves from tick bites when they are in areas where ticks live.
- BCCDC reminds physicians and public health providers of the need to be vigilant about the possible presence of Lyme disease as it can be difficult to accurately diagnose, especially in its early phases.

Complex Chronic Diseases Program (CCDP)

- CCDP focuses on a model of supportive care for symptom management for patients suffering from a variety of chronic complex diseases leading to disability. The CCDP clinic, located at BC Women's Hospital, began seeing patients in June 2013.
- CCDP serves very complex patients with conditions of which the cause is unknown, but it is suspected that an infectious pathogen may play a role. Some of the most prevalent recognized conditions include Myalgic Encephalomyelitis/Chronic Fatigue Syndrome, Fibromyalgia and "Chronic" Lyme Disease.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Arlene Paton, Population and Public Health Division; March 2, 2015

Doug Hughes, Health Services Policy and Quality Assurance; October 8, 2014

FACT SHEET

Methadone and other Opioid Substitution Treatment

ISSUE

Opioid substitution treatment (OST), in which patients are prescribed methadone or suboxone for maintenance purposes, is a highly effective means of treating opiate dependence. OST is a public health tool for improving health and safety outcomes such as reduced use of illegal drugs; reduced injections; and reduced needle sharing. Results include: lower incidence of HIV, hepatitis C and other serious injection-related infections requiring hospitalization such as endocarditis, abscesses, and other bacterial/fungal infections; and reduced crime and public disorder. The Province has approved Suboxone as an alternate opioid substitution therapy with limited coverage benefit by PharmaCare for patients who may not respond to or tolerate methadone. The Vancouver-based Study to Assess Longer-term Opioid Medication Effectiveness (SALOME) study is researching other substitution medications such as diacetylmorphine (i.e., heroin) and hydromorphone (i.e., Dilaudid™). A 2014 B.C. Supreme Court interim injunction required Health Canada to grant physicians with Providence Health Care the option of prescribing diacetylmorphine for former SALOME participants (through a federal Special Access Programme, at least until the case goes to a full trial in late 2015).

KEY FACTS

- In September 2010, the provincial government released a summary report from an independent review of BC's Methadone Maintenance System conducted by the University of Victoria's Centre for Addictions Research (CARBC), with assistance from the University of BC's Centre for Health Evaluation and Outcome Sciences. The summary report included key recommendations for improving the system.
- The CARBC review identified numerous strengths of BC's Methadone Maintenance System, and identified prescribing physician capacity (especially outside of the Lower Mainland), the delivery of the psychosocial services, and patient-centred care as among methadone maintenance the system's biggest challenges.
- Government released a written response to the report and a working group was tasked with implementation of the recommendations. Medical Beneficiary and Pharmaceutical Services Division (MBPSD), Health Services Policy and Quality Assurance Division (HSPQA) and Population and Public Health Division (PPH) in the Ministry of Health, along with the Ministry of Social Development and Social Innovation, comprise the committee.
- *Healthy Minds, Healthy People*[1] articulates 2 goals related to methadone: ensure people are retained in treatment after 12 months, and ensure physicians are adhering to recommended methadone maintenance prescribing guidelines.
- *From Hope to Health*[2] addresses the potential for opioid substitution therapy to ensure reduced risk for the transmission of HIV, increased adherence to treatment, and improved engagement of people into low-barrier health services.
- In May 2014, the Office of the Provincial Health Officer (PHO) released a report, *BC Opioid Substitution Treatment (OST) System Performance Measures 2012/2013*.[3] Following a previous report from 2013, the new PHO report presents recent data related to the prescribing, dispensing and financial aspects of methadone and Suboxone maintenance. Highlights include:

[1] http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf.
[2] http://www.health.gov.bc.ca/library/publications/year/2012/from-hope-to-health-aids-free.pdf.
[3] Office of the Provincial Health Officer. (2014). *BC opioid substitution treatment system: Performance measures 2012/2013*. Victoria, BC: Office of the Provincial Health Officer. Retrieved from: http://www.health.gov.bc.ca/pho/pdf/methadone-2012-13.pdf

  - an 8% increase in patients engaged in OST from 2011/12 to 2012/13, and a more than 66% increase from 2007/08 (from 9,466 to 15,754 patients)[4];
  - a slight increase in the number of authorized active methadone prescribers from 296 in 2007/08 to 344 in 2012/13.[5] The Ministry of Health is working with the College of Physicians and Surgeons to explore ways to increase OST prescribing capacity, which has not kept up with the corresponding increase in the patient population; and
  - the number of pharmacies dispensing methadone for maintenance purposes increased by 57% between 2007/08 and 2012/13, from 511 to 804 pharmacies.[6]
- The importance of patient involvement for improving engagement and retention in OST, thereby reducing risks of relapse to opioid use and blood-borne pathogen transmission via injection drug use, was highlighted at an OST health system partners event, convened by CARBC in March 2014, with planning support from both PPH and Patients as Partners initiative in HSPQA.
- The Ministry's MBPSD is currently reviewing OST pharmacy practices and payment structures for methadone dispensing; PPH and HSPQA are working with MBPSD to ensure that activities relating to this and all aspects of OST improvement are fully aligned with overall Ministry direction outlined in *Setting Priorities for the BC Health System.*
- In February 2014, the formulation of methadone dispensed in BC pharmacies through PharmaCare changed to a proprietary formulation called Methadose. The new Methadose formulation is the same medication, but is 10 times the concentration (10 mg/ml) of the previous methadone formulation (which was 1 mg/ml). Methadose is red-coloured and cherry-flavoured, and it does not require refrigeration. The Ministry has worked with the College of Physicians and Surgeons, the College of Pharmacists, the BC Centre for Disease Control and regional health authorities to disseminate information about Methadose to key health system and community partners, and monitor the transition to ensure patient satisfaction and continuity of care.

FINANCIAL IMPLICATIONS

- The Ministry of Health has a contract with the College of Physicians and Surgeons of BC to train and license physicians to prescribe methadone for maintenance purposes in the treatment of addiction. In 2014/15, this contract was for the amount of $465,000[7].
- Physician Services pays physicians who bill fee-for-service for opioid substitution treatment (methadone or Suboxone). In 2013/14, the total amount paid for this fee item was approximately $13.75 million.[8]
- The PharmaCare program covers opioid substitution treatment medications (methadone, and Suboxone as a Limited Coverage benefit). In 2013/14, the total amount paid for opioid substitution treatment pharmacy dispensing, ingredients and interaction costs was approximately $45.84 million.[7]

Approved by:
Arlene Paton, Population and Public Health Division; March 13, 2015
Ted Boomer, obo Manjit Sidhu, Finance and Corporate Services Division; April 2, 2015

[4] Ibid, p. 3.
[5] Ibid, p.5
[6] Ibid, p. 6.
[7] Source: Christine Voggenreiter, 2-1450, Director, Health Outcomes and Economic Analysis, Medical Beneficiary and Pharmaceutical Services
[8] Source: Carol Anne McNeill 2-1015, Manager, Payment Schedule Administration. Note: this is fee item T00039 Methadone or buprenorphine/naloxone treatment plus northern isolation allowance funding.

FACT SHEET

Needle Distribution and Recovery

ISSUE

The distribution and recovery of sterile syringes for people who inject illegal drugs is among the most effective measures for preventing the transmission of blood-borne pathogens such as HIV and hepatitis C, as well as complex and costly related infections.

KEY FACTS

- The World Health Organization, the Joint UN Programme on HIV/AIDS and the UN General Assembly endorse sterile needle distribution programs.[1,2] Research literature consistently shows that distribution and recovery of sterile syringes:
  - decreases the risk of HIV[3,4] and hepatitis C infection;[5,6]
  - increases opportunities for accessing additional health services such as primary care and treatment for drug dependence or mental illness;[7]
  - reduces the number of publicly discarded syringes found in parks, school yards, etc.;[8,9] and
  - does not result in increased crime rates in the neighbourhoods where they are located, when operated using best practice guidelines.[10]
- BC Centre for Disease Control (BCCDC) Harm Reduction Supplies Program distributes supplies that can reduce the risk of blood-borne and other infections to people who use illegal drugs, including:
  - needles and syringes;
  - alcohol swabs;
  - push sticks;
  - clean water for injection;
  - condoms and lubricant; and
  - plastic mouthpieces for crack pipes.
- BCCDC distributed approximately 4.53 million needles and syringes in 2007/08; 6.03 million in 2008/09; 5.29 million in 2009/10; 5.94 million in 2010/11; and 6.36 million in 2011/12; 6.95 million in 2012/13; and 8.82 million in 2013/14 to sites in BC.[11]
- No cure or vaccine exists for HIV. The lifetime costs of providing treatment for people who use injection drugs who are living with HIV greatly exceed the costs of providing harm reduction services.
- Additionally, clients receiving harm reduction services benefit from an improved quality of life.[12]

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1 World Health Organization. Policy Brief: Provision of sterile injecting equipment to reduce HIV transmission. Geneva. 2004

2 Canadian HIV/AIDS Legal Network. Sticking points: Barriers to access to needle and syringe programs in Canada. Toronto, Canada. 2007

3 Huo, D. , Bailey, S. L. , Hershow, R. C. & Ouellet, L. (2005). Drug use and HIV risk practices of secondary and primary needle exchange users. AIDS Education and Prevention. 17(2), 170–184.

4 Gibson, D. R. , Brand, R. , Anderson, K. , Kahn, J. G. , Perales, D. & Guydish, J. (2002). Two- to six fold decreased odds of HIV risk behaviour associated with use of syringe exchange. *Journal of Acquired Immune Deficiency Syndromes*. 31(2), 237-242.

5 Hagan, H. , et al. (1995). Reduced risk of hepatitis B and hepatitis C among injection drug users in the Tacoma syringe exchange program. *American Journal of Public Health*. 85(11): 1531-1537.

6 Commonwealth Department of Health and Aging. (2002). *Return on Investment in Needle & Syringe Programs in Australia*. Canberra: Commonwealth Department of Health and Ageing.

7 Hagan, H. , McGough, J. P. , Thiede, H. , Hopkins, S. , Duchin, J. & Alexander, E. R. (2000). Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors. *Journal of Substance Abuse Treatment*. 19(3), 247-252.

8 Doherty, M. C. , Junge, B. , Rathouz, P. , Garfein, R. S. , Riley, E. & Vlahov, D. (2000). The effect of a needle exchange program on numbers of discarded needles: a 2-year follow-up. *American Journal of Public Health*. *90*(6) 936-939.

9 Kate Ksobiech, K. (2004). Return rates for needle exchange programs: A common criticism answered. *Harm Reduction Journal*. *1*(2). Available online at: http://www. harmreductionjournal. com/content/1/1/2

10 Marx, M. A. , Crape, B. , Brookmeyer, R. S. , Junge, B. , Latkin, C. , Vlahov, D. , Strathdee, S. A. (2000). Trends in crime and the introduction of a needle exchange program. *American Journal of Public Health*. 12(90), 1933-1936.

11 Ashraf Amlani, Harm Reduction Epidemiologist, BC Centre for Disease Control (personal communication October 2, 2014): Ashraf.Amlani@bccdc.ca or 604-707-2562

12 Commonwealth Department of Health and Ageing. Return on investment in needle and syringe programs in Australia: Summary report. Canberra. 2002

FACT SHEET

- The highest rates of HIV infection are observed among people who inject drugs for non-medical purposes and who report sharing drug preparation or injection equipment. The use of illegal substances (or drugs) in BC, especially injection drug use, is a widespread health and social issue, requiring a comprehensive and coordinated response for the well-being of all citizens.
- Needle distribution and recovery programs have been in operation in BC since the early 1990s. BC's harm reduction services have embraced best practices to expand beyond a one-to-one needle/syringe exchange model, separating the distribution and recovery of sterile needles, and providing a wide array of other harm reduction supplies and services.
- BCCDC has direct responsibility for the Harm Reduction Supplies Program, which bulk purchases and distributes harm reduction supplies to more than 330 sites across the province, and also supports regional health authorities in planning and expanding harm reduction services for people who use drugs.
- The BC Ministry of Health document *Harm Reduction: A British Columbia Community Guide*[13] provides policy guidance to communities initiating and operating needle distribution and recovery and other harm reduction services.
- BC's *Healthy Minds, Healthy People—A Ten Year Plan to Address Mental Health and Substance Use*[14] in British Columbia articulates an action to expand the reach and range of harm reduction services, including but not limited to needle distribution and recovery.
- BC's strategic framework *From Hope to Health: Towards an AIDS-free Generation*[15] has a target of achieving equitable reach of harm reduction supplies proportionate to population density in each Local Health Area in the province by 2016. The first annual progress report "From Hope to Health: Towards an AIDS-free Generation Progress Report 2013/14" was released in February 2015.[16]

FINANCIAL IMPLICATIONS

- The BCCDC's 2014/15 budget for harm reduction is $2.2 million,[17] which includes funding for the "provision of harm reduction supplies to each health authority and their contracted needle distribution programs, in accordance with needs identified through local ordering"
- A 2006 US study estimated that the average lifetime costs of treatment for a case of HIV infection are US $385,200.[18]

Approved by:
Arlene Paton, Population and Public Health Division; February 24, 2015

[13] British Columbia Ministry of Health. (2005). *Harm reduction: A British Columbia community guide*. Victoria, BC: Ministry of Health. http://www.health.gov.bc.ca/library/publications/year/2005/hrcommunityguide.pdf
[14] Government of British Columbia. (2010). http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf
[15] British Columbia Ministry of Health. (2012). From hope to health: Towards an AIDS-free generation. Victoria, BC: Ministry of Health. http://www.health.gov.bc.ca/library/publications/year/2012/from-hope-to-health-aids-free.pdf
[16] From Hope to Health: Towards an AIDS-free Generation Progress Report 2013/14
[17] Katie Fenn, BC Centre for Disease Control: 604-707-2411; or katie.fenn@bccdc.ca
[18] Schackman BR, et al. 2006. The lifetime cost of current human immunodeficiency virus care in the United States. Med Care. 44:990-997.

FACT SHEET

Northeast Oil and Gas Human Health Risk Assessment

ISSUE

Human health risks associated with oil and gas exploration and development in northeastern BC.

KEY FACTS

- The Northeast Oil and Gas Human Health Risk Assessment is a three-phase project that will identify, explore and assess concerns about human health risks relating to oil and gas activities in northeastern BC.
- Phase One, conducted by Fraser Basin Council, canvassed the public, local governments, First Nations, and other groups and individuals in the northeast about their health concerns related to oil and gas activity. The Phase One report, released by government in June 2012, identified key issues of concern, including environmental exposure to contaminants (e.g., air and water quality), oil and gas operational issues (e.g., hydraulic fracturing), and institutional framework issues (e.g., monitoring and compliance).
- Phase Two of the Human Health Risk Assessment is now complete and the results were publicly released in March 2015. The contract was awarded to Intrinsik Environmental Sciences through a competitive procurement process. The Intrinsik team was composed of specialists in toxicology, epidemiology, medicine, air quality, water quality, and emergency response planning. In addition to Intrinsik, the companies that made up the team included RWDI Air Inc., Matrix Solutions Inc., Skystone Engineering Inc., McDaniel Lambert Inc., and Borden Ladner Gervais LLP. The team also included a three-member advisory panel, which provided an independent perspective on the design and approach of the Phase Two assessment, and the interpretation of the results.
- Phase Two included four tasks:

  Task 1: Information Collection and Issues Identification – completed spring 2013:
  - comprehensive review of existing scientific research, the Phase One report and other relevant reports

  Task 2: Human Health Risk Assessment – completed summer 2014
  - qualitative screening level risk assessment to identify potential oil and gas related emission sources in the region that present the greatest potential risk to human health and to prioritize scenarios for more detailed assessment in the quantitative assessment.
  - detailed quantitative human health risk assessment to investigate potential health risks posed to both aboriginal and non-aboriginal communities as a result of chemical exposures from oil and gas activities in local health areas 81, 60 and 59 (part of the Northern Health Authority).

  Task 3: Review of Regulatory and Policy Frameworks – completed summer 2014
  - review of the existing regulations designed to mitigate and manage the potential health risks of oil and gas activities in BC.

  Task 4: Recommendations–completed fall 2014
- Phase three of the project will report the findings and any suggestions for improvement that might be found. This includes a series follow-up sessions to discuss the study findings and recommendations in more detail.

FACT SHEET

FINANCIAL IMPLICATIONS

- The budget for Phase 2 is a fixed contract of $898,630 to June 30, 2014:
  - Fiscal Year 2012-13 $235,410;
  - Fiscal Year 2013-14 $498,090; and
  - Fiscal Year 2014-15 $165,130.

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Approved by:
Arlene Paton, Population and Public Health Division; March 26, 2015
Ted Boomer, obo Manjit Sidhu, Finance and Corporate Services Division; April 2, 2015

FACT SHEET

Seek and Treat for Optimal Prevention (STOP) HIV/AIDS

ISSUE

Ongoing monitoring and evaluation of BC's STOP HIV/AIDS Program.

KEY FACTS

- There is a strong association between increases in those receiving Highly Active Anti-Retroviral Therapy (HAART) and fewer new HIV diagnoses due to decreases in the amount of virus circulating within the population.[1] This is the cornerstone of the TasP concept.
- BC launched the STOP HIV/AIDS pilot in Vancouver and Prince George on February 4, 2010, with provincial funding totaling $48 million through to March 2013.
- Due to early evidence of success, on November 30, 2012, the Minister of Health announced province-wide funding to implement of the lessons learned from the pilot starting in April 2013.
- STOP HIV/AIDS is a real-world implementation of HIV TasP in BC, aimed at reducing HIV-related morbidity and mortality, reducing the number of new HIV infections and containing associated health system costs.
- To guide province-wide implementation, in December 2012, the Ministry released a strategic framework for health authorities: *From Hope to Health: Towards an AIDS-free Generation*. The five goals of the framework are:
  1. Reduce the number of new HIV infections in BC;
  2. Improve the quality, effectiveness, and reach of HIV prevention services;
  3. Diagnose those living with HIV as early as possible in the course of their infection;
  4. Improve quality and reach of HIV support services for those living with and vulnerable to HIV; and
  5. Reduce the burden of advanced HIV infection on the health system.
- The "Cascade of HIV Prevention and Care" featured in the document highlights multiple ways to better reach and engage people in prevention, testing, linkage to care, and treatment support.
- As of 2012, newly reported cases of HIV in the province had decreased to all-time lows due to:
  1. Success of evidence-based interventions like TasP, along with condom and safer drug use supply, distribution and recovery; and
  2. Decreased testing in non-STOP HIV/AIDS pilot authorities—diagnosing people is dependent on effective testing.
- Since STOP HIV/AIDS was implemented across BC, there has been an increase in newly reported HIV diagnoses in 2013 – there were 272 new diagnoses in 2013. Provincial rates may rise temporarily over the next few years before rates decrease again due to the preventative effects of HIV treatment and other evidence-based interventions. BCCDC has attributed this increase to sustained efforts to increase testing.[2]
- On May 12, 2014, the Provincial Health Officer released new provincial HIV Testing to encourage more British Columbians between the ages of 18 and 70 to get tested for HIV, and to support health care providers in including the offer of an HIV test during routine patient testing. Please see Fact Sheet – HIV Testing Guidelines for more information.
- From Hope to Health committed to annual progress reporting for three years, and the first progress report for fiscal year 2013/14 implementation is nearing completion.

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[1] Montaner, Julio SG et al. (2010) Association of coverage of highly active anti-retroviral therapy, population viral load, and yearly new HIV diagnoses in BC, Canada: a population-based cohort study. *The Lancet*. 376 (9740): 532-9.

[2] BC Centre for Disease Control (2014b) UPDATE: Final number of new HIV diagnoses for 2013, British Columbia.

- Outcomes of the first year of the STOP HIV/AIDS provincial program include:[3]
  - HIV testing has increased in every region of the province, which as expected, led to more HIV diagnoses in 2013/14 (288, an increase over 213 in 2012/13). This is largely due to outreach testing and routine offers of HIV testing in hospital and primary care.
  - In 2013/14, more people on HIV treatment were living with an undetectable viral load than in 2012/13, reducing transmission.
  - As of March 31, 2014, 90% of those diagnosed with HIV are linked to care, with 53% living with a suppressed viral load.
- This indicates that STOP HIV/AIDS activities are reaching the estimated 25% of people living with HIV who do not know they are infected,[4] as well as supporting better engagement of marginalized and vulnerable people in HIV testing, treatment and support.
- The largest burden of infection remains in men who have sex with men, comprising 63% of new infections in 2012 (149 cases), an increase from 58% in 2011.[5] However, the absolute number of new infections has decreased to 149 cases in 2012 from 170 cases in 2011.[6] The Provincial Health Officer, released the first annual report on the HIV epidemic in gay and bisexual men in August 2014.[7]
- In 2013, 9% of new HIV diagnoses were among people who use injection drugs, down from 12% in 2012 and 17% in 2010.[8] This trend has been decreasing since 2008.
- In 2013, 11% of new infections were among Aboriginal people—a group disproportionately affected by HIV, particularly Aboriginal women. This trend has been stable.[9]

FINANCIAL IMPLICATIONS

- Through the BC Centre for Excellence in HIV/AIDS (BCCfE) Drug Treatment Program, HIV drugs (such as HAART) are provided free of charge to any British Columbian living with HIV/AIDS. The Medical Beneficiary & Pharmaceutical Division contracts with the BCCfE (approximately $124 million in 2014/15)[10] for delivery of this program.
- Province-wide implementation of the STOP HIV/AIDS program will be supported by annual provincial funding totaling $19.9 million, allocated to the five regional health authorities, Providence HealthCare, the BCCfE, the Provincial Health Services Authority, and the Medical Beneficiary & Pharmaceutical Division.
- Recent evaluation by the BCCfE on STOP HIV/AIDS in BC has confirmed that significant costs to the system can be averted by diagnosing those living with HIV as early as possible in their infection.[11]

Approved by:

Arlene Paton, Population and Public Health Division; February 20, 2015

Gordon Cross obo Manjit Sidhu, ADM, Finance and Corporate Services Division; October 3, 2014

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[3] Ministry of Health (2014) *From Hope to Health: Towards an AIDS-free Generation – Progress Report 2013/14*. In development.

[4] Public Health Agency of Canada (2011) Estimates of HIV Prevalence and Incidence in Canada, 2011. Retrieved March 19, 2014 from: http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/estimat2011-eng.php.

[5] Ibid

[6] BCCDC (2014) HIV Annual Report 2012. Retrieved May 2, 2014 from: http://www.bccdc.ca/NR/rdonlyres/1B9A6F49-97E3-4C66-BF00-2EE0E3B0D51E/0/CPS_HIV_Annual_Report_2012.pdf

[7] Provincial Health Officer (2014) *HIV, Stigma and Society: Tackling a Complex Epidemic and Renewing HIV Prevention for Gay and Bisexual Men in British Columbia. Provincial Health Officer's 2010 Annual Report*

[8] BCCDC (2014) HIV Annual Report 2012. Retrieved February 11, 2015 from http://www.bccdc.ca/NR/rdonlyres/1B9A6F49-97E3-4C66-BF00-2EE0E3B0D51E/0/CPS_HIV_Annual_Report_2012.pdf

[9] Ibid

[10] Darlene El, Director, Decision Support, FCS, personal communication, September 23, 2014.

[11] Nosyk, B et al (2014) Costs of health resource utilization among HIV-positive individuals in British Columbia, Canada: results from a population-level study. *Pharmacoeconomics*. In press.

FACT SHEET

Tobacco

ISSUE

Tobacco-related illness is the leading cause of preventable death in Canada and smoking is the primary risk factor for the top three causes of death in Canada: diseases of the circulatory system, cancers and respiratory diseases.[1] This Fact Sheet outlines the current facts on tobacco and the range of initiatives designed to reduce tobacco use in BC.

KEY FACTS

The Ministry of Health's Tobacco Control Strategy aims to reduce the death and disease caused by tobacco by: a) stopping youth/ young adults from starting smoking; b) helping smokers to quit; and c) protecting people from exposure to second hand smoke. The Ministry is currently updating the 2004 Strategy. The Ministry also monitors emerging issues:

- BC has the lowest provincial smoking rate (16.2%; national rate is 19.3%[2]). Of those aged 12 and above in BC, 2.2% are regularly exposed to environmental smoke in their homes; national rate is 4.5%[3]. Exposure to environmental tobacco smoke in vehicles and public places for people aged 12 and above is 15.3% in BC and 16%[4] in Canada.
- Tobacco-related illness is the leading cause of preventable death in BC: over 6,000 deaths each year. Smoking kills more people in BC than all other drugs, alcohol, motor vehicle accidents, murder, suicide and HIV/AIDS combined.[5]
- Estimate of tobacco use costs for BC: $2.3 billion, including $607 million for direct health care.[6]
- Canadian Community Health Survey (2013) estimate for health authority smoking[7]:

Health Authority	**percent smoking** (ranked highest to lowest)	**Number of smokers** (ranked highest to lowest)
Northern	24.9 (1st)	57,650 (5th)
Interior	18.4 (2nd)	114,341 (4th)
Vancouver Island	18.0 (3rd)	116,954 (3rd)
Vancouver Coastal	15.9 (4th)	160,249 (2nd)
Fraser	13.4 (5th)	195,398 (1st)

Stopping Youth and Young Adults from Starting to Use Tobacco

- *Tobacco Control Act* prohibits the sale of tobacco to anyone under 19 years of age, restricts retail tobacco displays/promotions where youth have access and bans tobacco use on all public/private schools (with approvals for the ceremonial use of tobacco in an Aboriginal cultural activity). Health authorities enforce the Act.
- The Ministry has introduced legislation to regulate the sale, display and use of e-cigarettes and expects the federal government to also make regulatory improvements for e-cigarettes. The Ministry supports the federal announcement of a ban on flavoured tobacco in larger cigars.

Encouraging and Assisting Tobacco Users to Quit their Use of Tobacco Products

- BC Smoking Cessation Program - smokers can either get a free 12 week/calendar year supply of nicotine gum/patches or those on Fair PharmaCare can get a prescription for Zyban or Champix, (subject to deductibles). Since September 2011, 171,000 people have accessed the program

[1] Mortality Attributable to Tobacco Use in Canada and its Regions, 1998, Makomaski Illing, Eva M., Kaiserman, Murray J, Canadian Journal of Public Health January-February 2004
[2] Canadian Community Health Survey 2013
[3] Canadian Community Health Survey 2013
[4] Canadian Community Health Survey 2013
[5] Selected Vital Statistics and Health Status Indicators, Annual Report 2011, Vital Statistics Agency
[6] The Costs of Substance Abuse in Canada 2002, Canadian Centre on Substance Abuse 2006.
[7] Canadian Community Health Survey 2013

(some patients had both nicotine replacement and a prescription drug at various points in the program).[8] Registrants are also offered behavioural counselling through QuitNow – more than 11,000 people registering for QuitNow web, text and telephone support in the first year of the program.[9]

- QuitNow, available through 811, offers phone, web and text support to help smokers quit (through BC Lung, with a grant from the Ministry).
- Public Service Agency's *Quittin' Time* – Public service employees can receive both counselling support and 80% reimbursement of cessation products from Pacific Blue Cross.[10]
- Prescription for Health – family physicians can help at-risk populations (e.g., smokers).
- National 1-800 quitline/website is printed on all cigarette/cigarillo packages. Users are routed to their home jurisdiction (for BC, QuitNow Services).

Protecting People from Exposure to Second-hand Smoke

- The Act bans smoking in all indoor public/work spaces and near most public/workplace doors, open windows and air intakes.
- Smoke-free premises policies – all health authorities have smoke-free premises.
- Government supports municipal/regional tobacco bylaws, including restrictions in outdoor areas. Communities can expand the level of bylaw protection as their community's support increases.
- Children in care (foster children) must be in smoke-free homes and vehicles.
- The *Motor Vehicle Act* bans smoking in cars with children under 16 (fine: $109).
- WorkSafe BC environmental tobacco regulation limits second-hand smoke at work.
- Residential Care Regulation – bans staff smoking onsite/when supervising those in care.
- The BC Lung Association is working with housing stakeholders to increase the support and options for smoke-free housing in BC.

FINANCIAL IMPLICATIONS

- The Ministry provided a 2014/15 grant of $2.1 million to the BC Lung Association for QuitNow.
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- From October 2011 to 2015, Health Canada will fund call volume increases from the national 1-800 package change (Year 1 and 2 $308,000; Year 3 and 4 – up to $191,000).
- Total expenditure on drug coverage for the BC Smoking Cessation Program was $34.4 million[11] (September 30, 2011 to October 31, 2014)

Approved by:
Arlene Paton, Population and Public Health Division; April 23, 2015
Gordon Cross, obo Manjit Sidhu, Finance & Corporate Services Division; April 28, 2015

[8] PharmaNet data, MoH, analysis by MBPSD POER, 2014
[9] News release 'Celebrating the anniversary of the Smoking Cessation Program', October 4, 2012, as found at: http://www.newsroom.gov.bc.ca/2012/10/celebrating-the-anniversary-of-the-smoking-cessation-program.html
10 Quittin' Time Website http://www2.gov.bc.ca/myhr/article.page?ContentID=ef0e3003-bfa2-26c9-628c-f36572b7b0ee&PageNumber=2, as found February 19, 2014
[11] PharmaNet data, MoH, analysis by MBPSD POER, 2014

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