FACT SHEET

2016/17 Estimates

ISSUE

The Ministry of Health's 2016/17 – 2018/19 Estimates were tabled on Budget Day, February 16, 2016.

KEY FACTS

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

- The Ministry Operating budget has increased due to the funding transfers from the Ministry of Social Development and Social Innovation for the transfer of services provided to assist persons with developmental disabilities; from the Ministry of Finance for the Temporary Premium Assistance program; 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 an adjustment to the benefits rate in 2016/17. The budget lift in 2018/19 provided the Ministry with a 2.6% increase. However, including the adjustments noted above the total increase was 3.0%.

CRF Budget (in $000)	2016/17	2017/18	2018/19

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- The Ministry Capital budget for 2016/17 has increased by $3,693,000 from the amount reflected in Budget 2015, primarily due to the re-profiling of IM/IT CRF Capital under-spending ($3,918,000), partially offset by the removal of $225,000 in Tenant Improvement funding.
- The IM/IT CRF Capital re-profiling has been reflected in the CPS database as at Q3 2015/16.

Ministry Capital (in $000's)	2016/17	2017/18	2018/19
Budget 2015 - February	255	255	255
Re-profiling - 14/15 underspending	336	-	-
Re-profiling - forecast 15/16 underspending	3,582	-	-
Less: Tenant Improvement funding	(225)	(225)	(225)
Budget 2016 - February	**$3,948**	**$30**	**$30**

- The budgeted amounts for Capital Grants funding for health facilities have decreased by $53,176,000 in 2016/17, increased by $40,101,000 in 2017/18 and increased by $279,616,000 in 2018/19. These adjustments are primarily the result of re-profiling based on timing of cash flows on various priority investment projects within the ministry's updated 10-year capital plan.

Restricted Capital Grants (in $000's)	2016/17	2017/18	2018/19
Budget 2015 - February	559,031	357,072	357,072
Budget Lift - 2018/19	-	-	256,598
Re-profiling	(53,176)	40,101	23,018
Budget 2016 - February	**505,855**	**397,173**	**636,688**

FACT SHEET

FINANCIAL IMPLICATIONS

Allocation of Operating Expenses - $000's

Core Business	2015/16 Restated	2016/17 Estimates	% Change	$ Change
HEALTH PROGRAMS				
Regional Services	11,949,750	12,214,219	2.2%	264,469
Medical Services Plan	4,117,119	4,299,608	4.4%	182,489
PharmaCare	1,102,653	1,174,714	6.5%	72,061
Health Benefit Operations	43,385	44,298	2.1%	913
Vital Statistics	6,220	6,390	2.7%	170
Sub-Total	17,219,127	17,739,229	3.0%	520,102
EXECUTIVE AND SUPPORT SERVICES				
Minister's Office	725	729	0.6%	4
Stewardship and Corporate Services	225,610	227,998	1.1%	2388
Sub-Total	226,335	228,727	1.1%	2,392
Total – Ministry of Health	**$17,445,462**	**$17,967,956**	3.0%	**$522,494**

Allocation of Capital Expenses - $000's

	2015/16 February	2016/17 February	$ Change
Restricted Capital Grants			
2016/17	559,031	505,855	(53,176)
2017/18	357,072	397,173	40,101
2018/19	357,072	636,688	279,616
CRF Capital			
2016/17	255	3,948	3,693
2017/18	255	30	(225)
2018/19	255	30	(225)

Approved by:
Daryl Conner, Finance and Decision Support Branch; February 1, 2016
Manjit Sidhu, Finance and Corporate Services Division; March 8, 2016

FACT SHEET

Acupuncturist Mr. Mubai Qiu – Inappropriate Billing

ISSUE

Inappropriate billings by acupuncturist Mr. Mubai Qiu (Practitioner #32352).

KEY FACTS

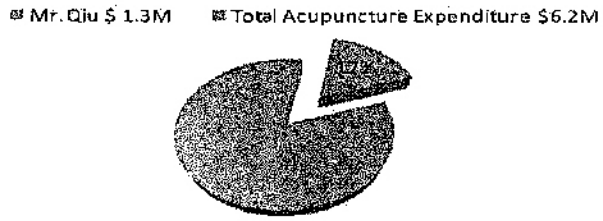
- Since April 2008, the Medical Services Plan (MSP) Supplementary Benefits Program contributes $23 towards the cost of a visit by a licensed acupuncturist, chiropractor, massage therapist, naturopath, and physiotherapist and for non-surgical podiatry. The limit is 10 visits per annum summed across all 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 2 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 BC. 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 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* 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; March 7, 2016

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, 5 of the 6 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 5 fiscal years, 2010/11, 2011/12, 2012/13, 2013/14,2014/15, and up to financial period 8 in 2015/16are 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 (Post Audit)	2015/16 Actuals (Period 8)
Fraser	8.8%	9.1%	9.2%	9.0%	9.3%	8.8%
Interior	9.9%	10.3%	10.2%	9.9%	9.8%	9.7%
Northern	12.2%	13.6%	13.6%	13.4%	13.3%	13.0%
Provinical Health Services	9.3%	9.4%	9.1%	8.9%	8.9%	9.3%
Vancouver Island	10.9%	10.0%	9.6%	10.0%	9.8%	9.8%
Vancouver Coastal	9.1%	9.3%	9.5%	9.6%	9.4%	9.8%

Footnote:

*Denominational Affiliates are included above.

** NHA has typically had higher administration and support expenditures than the other HAs. NHA indicates that it provides facility and community health services to more than two dozen communities servicing the northern two-thirds of the province, a region the size of France. Serving 300,000 people in the harsher northern climates carries a cost in transportation, facilities and energy while also preventing the realization of the economies of scale that other regions can take advantage of. When compared to similar northern, geographically vast, sparsely populated health regions, NHA compares favourably.

- 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, 2014/15, and 2015/16 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% 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; January 26, 2016
Manjit Sidhu, Finance and Corporate Services Division; January 27, 2016

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 $19 billion per annum, including $4.3 billion for the Medical Services Plan; $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 is identifying an increasing incidence of inappropriate billing by physicians and health care practitioners in the Medical Services Plan program, by pharmacy operators in the PharmaCare Program, and inappropriate claims by non-eligible beneficiaries and residents.
- In 2014/15, the Special Investigations Unit was established and includes Special Provincial Constables to detect and investigate suspected fraudulent activity.
- The Audit and Investigation Branch (AIB) currently has 47 employees (Billing Integrity Program: 19, PharmaCare Audit: 10, Eligibility, Compliance and Enforcement: 15 , Special Investigations Unit: 3).
- Actual recoveries as a result of AIB activities are summarized below:

Fiscal	2015/16*	2014/15	2013/14	2012/13	2011/12
Actual Recoveries (in millions)	**7,907**	**10,575**	**6,128**	**5,252**	**3,381**
Billing Integrity Program	3,985	5,874	2,194	1,645	1,186
PharmaCare Audit	2,765	3,152	2,848	2,487	1,475
Eligibility, Compliance and Enforcement Unit – estimated 50%	1,157	1,549	1,086	1,120	720

*as of Dec 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. In 2014/15, there was one further hearing and six 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

- AIB's budget has increased by approximately $1.2 million, from $3.6 million in 2011/12, to $4.8 million in 2015/16.
- Actual expenditures for 2014/15 were $5.6 million, with over $10 million in recoveries.

Approved by:

David Fairbotham, Audit and Investigations Branch; January 28, 2016
Manjit Sidhu, Finance and Corporate Services Division; January 29, 2016

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 years 2013/14 and 2014/15.

FINANCIAL IMPLICATIONS

Table 1 shows 2014/15, health authority actual revenue and expenses, excluding their denominational affiliates.

Table 1: 2014/15 Actuals for Health Authorities, including Providence Health Care, and First Nations Health Authority

	2014/15 Revenues ($ Millions)	2014/15 Expenses ($ Millions)	2014/15 Surplus/(Deficit) ($ Millions)	Surplus/(Deficit) as a % of Revenue
Fraser Health Authority	3,237.484	3,235.912	1.572	0.05%
Interior Health Authority	1,947.158	1,944.916	2.242	0.12%
Northern Health Authority	764.419	761.509	2.910	0.38%
Providence Health Care	853.603	853.425	0.178	0.02%
Provincial Health Services Authority	2,844.988	2,844.345	0.643	0.02%
Vancouver Coastal Health Authority	3,158.359	3,157.273	1.086	0.03%
Vancouver Island Health Authority	2,115.493	2,110.570	4.923	0.23%
Subtotal - HAs included in GRE	14,921.504	14,907.950	13.554	0.09%
First Nations Health Authority	429.600	394.927	34.673	8.07%
Total	**15,351.104**	**15,302.877**	**48.227**	**0.31%**

FACT SHEET

For 2015/16, health authorities and Providence Health Care report the following as at Quarter 3:

Health Authority Financial Operations Summary - YTD & Projections
Fiscal 2015/16
as at end of Quarter 3 (Period 8) - November 5, 2015

Health Authority	2014/15 YTD Spending As % of Annual Spending As at Quarter 3 Note 1	2015/16 YTD Spending as % of Projected Annual Spending As at Quarter 3 Note 1	2015/16 YTD Surplus/ (Deficit) As at Quarter 3 (in $ 000's) Note 2	2015/16 Projected Surplus/ (Deficit) for 2015/16 as at Quarter 3 To Mar 31/16 (in $ 000's) Note 2
Fraser Health Authority (excluding Affiliates)	59.59%	60.08%	(8,588)	-
Interior Health Authority	59.52%	59.26%	(5,061)	-
Northern Health Authority (excluding Affiliate)	59.28%	58.91%	(85)	-
Vancouver Coastal Health Authority Note 3	59.39%	58.95%	59,883	277,154
Providence Health Care	58.86%	61.68%	(3,820)	-
Vancouver Island Health Authority (excluding Affiliates)	59.31%	58.71%	3,529	-
Provincial Health Services Authority	57.38%	58.58%	(401)	-
Total - All Health Authorities including Providence Health Care Note 1 & 4	59.03%	59.20%	85,447	277,154

Notes:
1) The number of days up to the end of Quarter 3 in 2015/16 is 219 days (219/366 = 59.84%) while the day count up to the end of Quarter 3 in 2014/15 was 220 days (220/365 =60.27%).To ensure comparability of spend rates between 2015/16 and 2014/15, the 2014/15 YTD Quarter 3 spend rate has been adjusted to reflect a 219-day count.
2) All data from the 2015/16 Appendix C reports submitted by the HAs at the end of Quarter 3 (Period 8).
3) Vancouver Coastal Health Authority's projection includes estimated proceeds of $295M from the gain on disposal of Dogwood Pearson Lands under the RAEG program. Dogwood Lands were sold in April 2015, however, the Pearson sale is not expected to be completed until march 2016.
4) Total projected surplus does not include possible surpluses/deficits arising from Healthcare Benefit Trust actuarial gain/loss on event driven employee benefits.

Approved by:
Gordon Cross, Regional Grants and Decision Support Branch; January 14, 2016
Manjit Sidhu, Finance and Corporate Services Division; January 19, 2016

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 26 private residences 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.* s.15

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FINANCIAL IMPLICATIONS

- In fiscal 2014/15, the costs relating to non-resident births amounted to a total of $693,869.20 for recovery by health authorities, PharmaCare and MSP. Recovery of ineligible payments is the responsibility of each program. The health authorities recover approximately 50% of their amount outstanding, PharmaCare and MSP costs are recovered by the Ministry of Finance.

FACT SHEET

2014/15 Recovery Breakdown	
$693,869.20	
HA 85.58%	$593,838.77
MSP 14%	$99,665.67
PC 0.05%	$364.76

- 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; January 28, 2016
Manjit Sidhu, Finance and Corporate Services Division; February 2, 2016

FACT SHEET

Costs of Health Care

ISSUE

The Consolidated Revenue Fund (CRF) Health Sector budget represents 48.8% of the total Provincial CRF budget.

KEY FACTS

Costs Drivers in Health Care

- Growing population – over the period 2015 to 2019, BC's population is projected to grow by 5.2% to 4.931 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 819,600 in 2015 to 955,300 by 2019 (an increase of 135,700 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/2016/sp/pdf/ministry/hlth.pdf

Background

The CRF Health Sector Estimates for 2016/17 is:

Ministry of Health	$17.968 billion
Other CRF Health Sector Budgets	
- Capital Funding	0.506
- Ministry of Children and Family Development	0.231
- Ministry of Social Development &	0.130
- Ministry of Finance	0.006
Total CRF Health Sector Budgets	$18.841 billion

FACT SHEET

Allocation of Operating Expenses - $000's

Core Business	2015/16 Restated	2016/17 Estimates	% Change	$ Change
HEALTH PROGRAMS				
Regional Services	11,949,750	12,214,219	2.2%	264,469
Medical Services Plan	4,117,119	4,299,608	4.4%	182,489
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Sub-Total	17,219,127	17,739,229	3.0%	520,102
EXECUTIVE AND SUPPORT SERVICES				
Minister's Office	725	729	0.6%	4
Stewardship and Corporate Services	225,610	227,998	1.1%	2,388
Sub-Total	226,335	228,727	1.1%	2,392
Total – Ministry of Health	**$17,445,462**	**$17,967,956**	**3.0%**	**$522,494**

Approved by
Daryl Conner, Finance and Decision Support Branch; March 8, 2016
Manjit Sidhu, Finance and Corporate Services Division; March 8, 2016

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

- In 2008, the Medical Services Commission (MSC) referred seven extra billing clinic audits to the Audit and Inspection Committee (AIC). The AIC notified these clinics in 2008 and 2009 of their intent to audit. Since 2008, an additional five extra billing clinics were referred to the AIC.
- The first audit focused on the Cambie Surgery Centre (Cambie) and Specialist Referral Clinic (SRC). Legal challenges first ensued regarding MSC's powers to undertake extra billing audits. The BC Court of Appeal rendered a decision on September 9, 2010, confirming those MSC powers.
- The Billing Integrity Program (BIP) started the Cambie and SRC on-site audit in January 2011, and an interim report was presented to the MSC in May 2011. The MSC requested further information which warranted additional on-site audit work. The final audit report was issued in July 2012 and made public. The audit established (subject to significant information limitations):
  - extra billings totaling $0.5 million in private charges and $70,000 in MSP claims, out of a sample of 468 services, covering mainly August 2008, December 2010 and January 2011;
  - indications that the benefits themselves were privately charged for by the clinics to the beneficiaries (or their representative), and then billed again to MSP, by the physician; and
  - strong business relationships between the two clinics and their respective physicians (same patients, doctors and doctor shareholders).
- The report findings 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 follow-up audits of the rendering physicians to establish whether double billings of benefits occurred and, if so, whether the physicians involved financially benefitted from both sides of the double billing.

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- A warrant was obtained on October 5, 2015, to enable access to the records to determine the basis for payments to physicians.
- Cambie applied for an order to prohibit the audit from continuing. On November 2, 2015, the execution of the warrant was stayed.
- On November 25, 2015, Associate Chief Justice Cullen allowed execution of the warrant for the audit to take place.

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FACT SHEET

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FINANCIAL IMPLICATIONS

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

Updated and Approved by:
David Fairbotham, Audit and Investigations Branch, January 28, 2016
Manjit Sidhu, Finance and Corporate Services Division, January 29, 2016

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

- 2014/15 actual annual operating revenues: $3.237 billion (per 2014/15 audited financial statements, excluding denominational affiliates).
- 2014/15 actual operating surplus, including denominational affiliates: $1.230 million (per 2014/15 audited financial statements of FHA and the denominational affiliates).
- Regional Funding Allocation:
  - 2014/15 - $2.708 billion (per 2014/15 Final Funding Letter)
  - 2015/16 - $2.777 billion (per 2015/16 Funding Letter Update #2)
- Estimated FTEs (excluding Menno Hospital, St Michael's and other contracted agencies):
  - Union – 16,481
  - Non-Union/Management – 1,657
- Per 2014/15 Audited Financial Statements of FHA (Excluding Menno and St. Michael's):
  - Total Revenues $3,237.484 million
  - Total Expenses $3,235.912 million
  - Surplus $ 1.572 million
- With Menno and St. Michael's included, FHA overall reported a surplus of $1.230 million for 2014/15.

Approved by:
Gordon Cross, Regional Grants and Decision Support Branch; January 18, 2016
Manjit Sidhu, Finance and Corporate Services Division; January 19, 2016

FACT SHEET

Health and Welfare Benefits – Rate Increases

ISSUE

- Until April 1, 2016, Healthcare Benefits Trust (HBT) has been essentially the sole provider of group health and welfare benefits in the health sector. As of April 1, 2016 health and welfare benefits will be provided through a combination of HBT and, for certain bargaining associations, Joint Trusts.
- Health and welfare benefits represent a material expense to the health authorities and other agencies. The year over year increases in costs 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.

- Joint Trusts are scheduled to begin operation (receiving contributions and paying benefits) on April 1, 2016. As of April 1, 2016 there will be three Joint Trusts covering employees in each of Health Science Professionals Bargaining Association, Facilities Bargaining Association and Community Bargaining Association. The exact funding requirement for the Joint Trusts is being negotiated.

FINANCIAL IMPLICATIONS

- Listed below are the rate changes at April 1 for the previous 2 fiscal years. The rate changes represent the weighted average for health authorities, Providence Health Care and affiliates.

	Actual	
	April 1, 2014	**April 1, 2015**
Dental **Note 1**	-5.00%	-5.80%
Extended Health **Note 1**	-11.70%	-0.18%
LTD **Note 2**	-0.82%	-9.87%
Group Life	-7.70%	-8.33%
AD&D **Note 3**	-20.00%	-20.00%

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

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.

FACT SHEET

- Listed below are the actual rate changes at April 1, 2016 for the upcoming fiscal year and estimates for the following 2 fiscal years for employees not covered by a Joint Trust (nurses, excluded and Residents).

	Estimates		
	April 1, 2016	**April 1, 2017**	**April 1, 2018**
Dental	3.76%	8.81%	4.50%
Extended Health	18.37%	5.72%	5.00%
LTD	1.19%	0.00%	0.00%
Group Life	9.10%	0.00%	0.00%
AD&D	29.20%	0.00%	0.00%

- Recognizing that April 1, 2016 contributions to the Joint Trusts are in the process of being negotiated; no estimated rates can be provided at this time for the Health Science Professionals Bargaining Association, Facilities Bargaining Association, and Community Bargaining Association.

Approved by:
Catherine Hoefer, Compensation Analysis Branch; January 28, 2016
Daryl Conner, Finance and Decision Support Branch; February 1, 2016
Manjit Sidhu, Finance and Corporate Services Division; March 8, 2016

FACT SHEET

Health Authorities' Parking Fees

(Including Parking Areas Adjacent to Emergency Departments)

ISSUE

All health authorities charge for parking at their facilities 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 20, 2016

FACT SHEET

Health Authority Cash Management and Central Deposit Program

ISSUE

As highlighted in the Minister of Finance's Budget Speech 2015 (page 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 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 sector agencies. The report is critical of government generally for failing to more aggressively control how the schools, universities, colleges and health sector entities accumulate cash since it results in more borrowing and higher costs of borrowing for government. The Office of the Auditor General also reported out on its findings to the Legislative Assembly's Select Standing Committee on Public Accounts on June 25, 2014.
- The Ministry has provided direction that although health authorities are responsible for and must meet the cash requirements necessary to manage their day to day operations, health authorities:
  - shall, 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, 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 health authority cash and investment holdings at Quarter 3 (Q3) of fiscal year 2015/16 ($ millions). These amounts vary throughout the fiscal year as health authorities use cash for a variety of purposes, including their day-to-day payments.

	Q3 - 2015/16		2016/17	2017/18
Summary of Cash, Cash Equivalents and Portfolio Investments	Actual	Forecast to Year-end	Year end forecast	Year end forcast
Cash Balance in Central Deposit Program	916,766	945,735	s.13,s.17	
Cash and Cash Equivalents on Hand (Unrestricted)	398,608	356,852		
Cash and Cash Equivalents on Hand (Restricted)	278,605	146,381		
Portfolio Investment on Hand	59,620	50,321		
Total Cash, Cash Equivalents and Portfolio Investments	1,653,599	1,499,289		

Approved by:

Gordon Cross, Regional Grants and Decision Support Branch; January 20, 2016
Manjit Sidhu, Finance and Corporate Services Division; January 21, 2016

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 *Health Care Costs Recovery 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.
- The Act 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. As at January 19, 2016 of fiscal year 2015/16, there were 24 cases resolved with the Municipalities for a total recovery of $35,000.
- The Act has resulted in the recovery of health care costs of $4.8 million as at January 19, 2016 for fiscal year 2015/16, $6.1 million in 2014/15, up from $5.6 million in 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 $2.3 million since April 2009. There is a potential to recover several million dollars from class action law suits.
- There are currently 29 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 2009/2010 – year to date January. 19, 2016:

Revenue (in millions)	
2009/10	$2.4
2010/11	$3.8
2011/12	$4.6
2012/13	$5.3
2013/14	$5.6
2014/15	$6.1
YTD 2015/16	$4.8

Approved by:

Daryl Conner, Finance and Decision Support Branch; February 1, 2016
Manjit Sidhu, Finance and Corporate Services Division; March 8, 2016

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 was January 1, 2008 to October 10, 2014.
- In response to this request 15 Audit Reports and notices under section 37 and/or 15 of the *Medicare Protection Act* were provided in March 2015 and redacted in accordance with the *Freedom of Information and Protection of Privacy Act*.
- The 15 Audit Reports related to audits conducted during the requested time frame and included:
    - 8 Acupuncturists;
    - 3 Podiatrists;
    - 2 Massage Therapists; and
    - 2 Chiropractors.
- 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). Seven also included a notice under section 15 of the *Medicare Protection Act* to cancel a practitioner's enrolment with MSP.
- Of the 15 Audit Reports provided, 4 have been referred to the police and/or the Ministry of Health, Special Investigations Unit for investigation.
- The Ministry is working with the respective Colleges to strengthen and communicate billing requirements.

FINANCIAL IMPLICATIONS

Since 2007, the Billing Integrity Program has conducted over 24 audits of various health care practitioners. To date, the main errors identified during the audits relate to lack of records to support the service billed to MSP. In some cases audits have revealed intentional miss-billing. In this category of audits, overpayments valued at approximately $7.4 million have been identified.

Approved by:

Marie Thelisma, Billing Integrity Program; February 11, 2016
Manjit Sidhu, Finance and Corporate Services Division; March 7, 2016

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 find and deter inappropriate billing, and has in recent years hired several extra staff members for this work.
- The Ministry of Health 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

- The Ministry increased the PharmaCare audit budget from $568,000 in 2011/12 to $881,315 in 2015/16.
- The number of auditor full-time employees has been increased from five to eight and, in addition, a dedicated Pharmacist has been added.
- The Ministry has also implemented a Special Investigations Unit to focus on intentional over-billing and fraudulent activity.
- PharmaCare audits are identifying increasing audit recoveries, as shown below:

Fiscal Year	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16*
Audit Recoveries	$968,662	$1,341,874	$1,474,607	$2,487,306	$2,847,996	$3,151,859	$2,765,051

*as at December 31, 2015

Approved by:

David Fairbotham, Audit and Investigations Branch; January 28, 2016
Manjit Sidhu, Finance and Corporate Services Division; January 29, 2016

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

- 2014/15 actual annual operating revenues: $1.947 billion (per 2014/15 audited financial statements).
- 2014/15 actual operating surplus: $2.242 million (per 2014/15 audited financial statements).
- Regional Funding Allocation:
  - 2014/15 - $1.552 billion (per 2014/15 Final Funding Letter)
  - 2015/16 - $1.616 billion (per 2015/16 Funding Letter Update #2)
- Estimated FTEs:
  - Unionized – 12,925
  - Non-unionized/Management – 932
- 2014/15 Audited Financial Statements:

Total Revenue:	$1,947.158 million
Total Expenses:	$1,944.916 million
Surplus	$ 2.242 million

Approved by:
Gordon Cross, Regional Grants and Decision Support Branch; January 19, 2016
Manjit Sidhu, Finance and Corporate Services Division; January 20, 2016

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 2015/16 (i.e., the amount the province pays to other provinces and territories for treating BC residents) was $101.6 million. BC's revenue from billing other provinces and territories was $98.6 million in 2015/16 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 20, 2016
Manjit Sidhu, Finance and Corporate Services Division; April 21, 2016

FACT SHEET

MSP Premiums

ISSUE

An overview of the Medical Services Plan (MSP) Premiums and the impact of the 4% increase in 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, 2016, MSP premium rates increased by 4% (4th year in a row that the rates have increased by 4%). The projected additional MSP premium revenue to be received from this rate increase effective January 1, 2016 is: $24 million for the remainder of the 2015/16 fiscal year (January 1 – March 31, 2016); and $96 million for 2016/17.
- 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, 2015			Monthly Premium Rates - effective Jan. 1, 2016		
	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	$72.00	$130.50	$144.00	$75.00	$136.00	$150.00
% increase (for adjusted net income > $30,000)				4.2%	4.2%	4.2%
$ increase (for adjusted net income > $30,000)				$3.00	$5.50	$6.00

- Officially announced on the February 16, 2016 budget day, effective January 1, 2017, the MSP fee structure will change allowing single-parent families to save $75 a month.

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.

- 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 December 2015, the % that is paying the full premium rates and % receiving premium assistances as follows:

- There are 4,725,104 BC residents that are insured under MSP. Of the total, 72.86% (3,442,865) pay the full MSP premium rate; and 19.16% (905,380) receive some form of premium assistance.
- For the premium assistance, 904,663 receive regular premium assistance and 717 receive temporary premium assistance.
- Ministry of Social Development assists 203,662 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 2.87% (135,794) of residents insured under MSP. The First Nations premiums are paid by the First Nations Health Authority.
- Other – premium free assists 37,403 individuals with medical coverage. This medical coverage is provided to Corrections Branch and Refugee groups.
- The total seniors insured under the MSP is 886,423 (18.8% of the total insured persons). Of the total seniors, 307,438 are under premium assistance, which includes First Nations and Ministry of Social Development.

Adjusted Net Income Level	Insured Persons at December 2015	% of total at December 2015
Premium Assistance:		
$0 - $22,000	738,210	15.62%
$22,001 - $24,000	51,851	1.10%
$24,001 - $26,000	44,616	0.94%
$26,001 - $28,000	38,384	0.81%
$28,001 - $30,000	32,319	0.68%
Subtotal - premium assistance	905,380	19.16%
Min. of Social Development	203,662	4.31%
First Nations	135,794	2.87%
Other - premium free	37,403	0.79%
Subtotal	1,282,239	27.14%
over $30,000	3,442,865	72.86%
Total	4,725,104	100.00%

FINANCIAL IMPLICATIONS

- MSP premium revenue for fiscal year 2015/16 is projected to be $2.399 billion.
- The projected additional MSP premium revenue to be received from the MSP premium rate increase effective January 1, 2016 is: $24 million for the remainder of the 2015/16 fiscal year; and $96 million for 2016/17.

Approved by:

Daryl Conner, Finance and Decision Support Branch: February 1, 2016
Manjit Sidhu, Finance and Corporate Services Division; March 8, 2016

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 (PHSA) 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 s.13
    s.13
    - $5.0 million to the PHSA 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

- In 2014/15, health authorities incurred expenditures of $10.90 million out of the $20.25 million made available to support SAMI initiatives. Unspent funding primarily related to health authority proposals for matching funds which needed to be developed over the course of the year based on local needs and service gaps, and in consultation with key community partners including police departments. Prior to implementation, staff recruitment processes and start-up requirements had to be completed.
- In 2015/16, with the exception of the secure facility at the Burnaby Centre for Mental Health and Addiction 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; January 19, 2016
Manjit Sidhu, Finance and Corporate Services Division; January 20, 2016

FACT SHEET

Ministry of Health Historical Capital Spending

ISSUE

Capital funding provided to the health authorities by the Ministry of Health from 2001/02 to 2014/15.

KEY FACTS

- The Ministry provides health authorities with capital funding from different sources. Prior to April 1, 2009, debt-financed capital was provided through Prepaid Capital Advances (PCA). Effective April 1, 2009, PCAs were replaced by Restricted Capital Grants (RCG). This funding is now provided through the Capital Funding vote in Other Appropriations. Non-RCG funding is provided through the Ministry's consolidated revenue fund operating vote for minor construction, equipment and capital maintenance. In addition to funding provided by the Ministry, health authorities obtain capital funding from own-source revenues, Regional Hospital Districts (RHD), hospital foundations and auxiliaries. Since 2004/05 the province has also provided health capital on major projects through public private partnerships (P3).
- The following table summarizes capital funding provided to health authorities by the Province since 2001/02. It does not include capital contributions from other funding sources (i.e. RHDs, Foundations or health authority own-source revenues).

SUMMARY OF PROVINCIAL CAPITAL SPENDING FROM 2001/02 to 2014/15

($ in millions)

Fiscal Years	2001/02	2002/03	2003/04	2004/05[2]	2005/06[3]	2006/07[4]	2007/08[5]
PCA/RCG	182.71	117.00	140.00	185.00	311.09	327.04	417.73
P3 Debt (Restated)	-	-	-	67.10	127.80	119.40	182.00
Non-PCA/RCG Operating[1]	92.61	99.61	92.36	44.67	77.22	81.66	88.15
Total	**275.32**	**216.61**	**232.36**	**296.77**	**516.11**	**528.10**	**687.88**

Fiscal Years	2008/09[6]	2009/10[7]	2010/11[8]	2011/12[9]	2012/13[10]	2013/14[11]	Subtotal 01/02 - 13/14	2014/15[12]	Total 01/02 - 14/15
PCA/RCG	331.70	254.09	307.47	345.32	337.47	294.64	3,551.26	378.67	3,929.93
P3 Debt (Restated)	150.83	226.69	204.60	67.14	122.58	58.46	1,326.60	126.44	1,453.04
Non-PCA/RCG Operating[1]	85.90	80.50	80.50	80.61	120.83	113.63	1,138.25	81.08	1,219.33
Total	**568.43**	**561.28**	**592.57**	**493.07**	**580.88**	**466.73**	**6,016.11**	**586.19**	**6,602.30**

Notes to Table

1. Operating refers to Ministry funding provided to HAs through the consolidated revenue fund. Non-PCA/RCG operating expenditures include minor capital (less than $100,000) and asset maintenance.
2. 2004/05 total of $185 million excludes land transfer to Children and Women's Health Centre of BC ($106 million). P3 spending includes G&L Diamond Health Care Centre ($12 million) and Abbotsford Regional Hospital & Cancer Centre ($55.1 million, revised April 2008 for accounting change).
3. 2005/06 total includes $31 million spending from implementing the 2005 agreement on one-time funding to replace the Greater Vancouver Regional Hospital District funding and projects and commitments of HAs. P3 spending includes G&L Diamond Health Care Centre ($64 million) and Abbotsford Regional Hospital & Cancer Centre ($63.8 million, revised April 2008 for accounting change).
4. For 2006/07, P3 spending includes G&L Diamond Health Care Centre ($19 million) and Abbotsford Regional Hospital & Cancer Centre ($100.4 million, revised April 2008 for accounting change).
5. For 2007/08, P3 spending includes the Abbotsford Regional Hospital & Cancer Centre ($182 million).
6. For 2008/09, P3 debt spending includes Jim Pattison Outpatient Care and Surgery Centre ($56 million), Royal Jubilee Hospital Patient Care Centre ($56 million), Kelowna Vernon Hospital Expansion ($27 million). St. Vincent's Mortgage ($12 million) is not a P3; however, it is accessing provincial debt funding so it is included in the total.
7. For 2009/10, P3 debt spending includes Jim Pattison Outpatient Care & Surgery Centre ($64 million), Royal Jubilee Hospital Patient Care Centre ($75 million), Kelowna Vernon Hospital Expansion ($75 million), and Northern Cancer Centre ($13 million).
8. For 2010/11, P3 debt spending includes: Jim Pattison Outpatient Care & Surgery Centre ($51 million), Surrey Memorial Hospital ED and Critical Care Tower ($27 million), Kelowna Vernon Hospital ($55 million), Northern Cancer Centre ($1 million), and Royal Jubilee Hospital ($71 million).
9. For 2011/12, P3 debt spending includes: Surrey Memorial Hospital ED and Critical Care Tower ($42 million), Kelowna Vernon Hospital ($2 million), and Fort St. John Hospital ($23 million).

FACT SHEET

10. For 2012/13, P3 debt spending includes: Surrey Memorial Hospital ED and Critical Care Tower ($90 million), Interior Heart & Surgical Centre ($22 million), and Fort St. John Hospital ($10 million).
11. For 2013/14, P3 debt spending includes: Surrey Memorial Hospital ED and Critical Care Tower ($21 million) and Interior Heart & Surgical Centre ($37 million).
12. For 2014/15, P3 debt spending includes: Children's and Women's Hospital ($49 million), North Island Hospitals ($58 million) and Interior Heart & Surgical Centre ($19 million).

FINANCIAL IMPLICATIONS

- The following table identifies health sector capital spending as reported from all sources (i.e. Ministry funding, RHDs, foundations, auxiliaries, and health authorities own source revenues).

HISTORICAL HEALTH SECTOR CAPITAL SPENDING

Budget vs Actual

($ in millions)

Fiscal Year	01/02[1]	02/03[1]	03/04[1]	04/05[1]	05/06[1]	06/07[1]	07/08[1]	08/09[1]	09/10[1]	10/11[1]	11/12[1]	12/13[1]	13/14[2]	14/15[3]
Budget	N/A	N/A	N/A	326	756	666	819	924	1,025	1,161	841	879	886	847
Actual	275	422	420	568	848	760	881	892	927	916	732	742	690	900
Variance - over/ (under)	N/A	N/A	N/A	242	92	94	62	(32)	(98)	(245)	(109)	(137)	(196)	53

1. 2001/02 - 2012/13 - Actual as reported in 2013 Financial and Economic Review - August 2013 (Table A2.10).

2. 2013/14 - Actual as reported in 2015 Financial and Economic Review - July 2015 (Table A2.10)

3. 2014/15 - Budget amount from Budget and Fiscal Plan - 2014/15 to 2016/17;
   2014/15 - Actual as reported in 2015 Financial and Economic Review - July 2015 (Table A2.10)

- Comparable information for health sector capital spending is not available prior to 2002/03 when the regional health authority structure was implemented. Health sector capital forecasts and variances are not available prior to 2004/05.
- For the fiscal years from 2001/02 to 2014/15, total health sector capital spending was approximately $10.0 billion.

Total Health Sector Capital Spend (includes all funding sources)

($ in millions)

Fiscal Years	01/02[1]	02/03[1]	03/04[1]	04/05[1]	05/06[1]	06/07[1]	07/08[1]	08/09[1]	09/10[1]	10/11[1]	11/12[1]	12/13[1]	13/14[2]	14/15[2]	Total 01/02 - 14/15
Actuals	**275**	**422**	**420**	**568**	**848**	**760**	**881**	**892**	**927**	**916**	**732**	**742**	**690**	**900**	**9,973**

1. 2001/02 - 2012/13 Actual - as reported in 2013 Financial and Economic Review - August 2013 (Table A2.10)

2. 2013/14 Actual, 2014/15 Actual - as reported in 2015 Financial and Economic Review - July 2015 (Table A2.10)

- For the next 3 years (2016/17 to 2018/19), health sector capital spending is currently forecast to be approximately $2.9 billion, based on the Q3 2015/16 submission to the Ministry of Finance.

Approved by:
Joel Palmer, Capital Services Branch; January 25, 2016
Manjit Sidhu, Finance and Corporate Services Division; January 27, 2016

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 (the Ministry) website for easy access by all employees.

KEY FACTS

The Finance and Corporate Services Division has issued directives to meet budget targets. These directives cover:

- Office and Business Expenses (STOB 65)
- Travel – In Province and Out of Province
- Blackberry / Cell Phone use
- Electronic Storage – Shared Drive / Email / 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
- In 2011/12 – Contract Management
- In 2012/13 – Transfer Payments, Base Salaries and Overtime

Background

Ministries are requested to eliminate discretionary spending in order to achieve budget targets. Ministries must also consider how expenditures could be made differently and less expensively. To achieve this, the Ministry issues spending directives aimed at reducing expenditures in administrative areas.

FINANCIAL IMPLICATIONS

Compliance with these directives has been monitored. In addition to these directives, in July 2015, the Deputy Minister of Finance issued a specific Ministry STOB 50 target of $81.5 million, including $0.5 million for capital projects (down from $82.0 million in 2014/15).

Approved by:

Daryl Conner, Finance and Decision Support Branch; September 8, 2015
Manjit Sidhu, Finance and Corporate Services Division; April 20, 2016

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

- 2014/15 actual annual operating revenues: $764.419 million (per 2014/15 audited financial statements, excluding denominational affiliate WMH).
- 2014/15 actual surplus: $2.666 million (per 2014/15 audited financial statements, including denominational affiliate WMH).
- Regional Funding Allocation:
  - 2014/15 - $558.507 million (per 2014/15 Final Funding Letter)
  - 2015/16 - $572.318 million (per 2015/16 Funding Letter Update #2)
- Estimated FTEs:
  - Unionized – 4,777
  - Non-Union/Management – 456
- 2014/15 Audited Financial Statements:

Total Revenues	$764.419 million
Total Expenses	$761.509 million
Surplus	$ 2.910 million (excluding WMH)

Approved by:

Gordon Cross, Regional Grants and Decision Support Branch; January 19, 2016
Manjit Sidhu, Finance and Corporate Services Division; January 20, 2016

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.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.17

FINANCIAL IMPLICATIONS

s.17

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

FACT SHEET

Population Needs-Based Funding for Health Authorities

ISSUE

The Population Needs-Based Funding (PNBF) model is a funding methodology to determine how to divide a pre-determined pool of funds fairly and equitably between the five regional health authorities. The Ministry of Health retained KPMG and Preyra Consulting to undertake a review of the model. The review was completed by the end of February and KPMG completed follow-on, related funding analytical work by the end of March 2015.

KEY FACTS

- The Ministry's PNBF model is used to allocate funding to the Interior, Fraser, Vancouver Coastal, Vancouver Island, and Northern health authorities and is based on models for the acute care and home and community care (residential and community services) sectors.
- The PNBF model is not used to allocate funding to the Provincial Health Services Authority (PHSA). Funding for the PHSA is based on historical funding levels and the estimated growth of specialized provincial services such as transplant, renal, cancer, and cardiac care (life support programs).
- The model was originally developed by the Ministry in 2002 - it was reviewed and endorsed by an external group of academics in that year, by IBM in November 2004 and a joint Ministry/Health Authority Funding Methodology Review in 2004, and a review by external consultants in 2005/06. Population-based funding allocation methods are used in other jurisdictions including: Wales, Scotland, New Zealand, Saskatchewan, Ontario, etc. There is international recognition that developing funding models is complex, especially adjusting for regional costs.
- PNBF takes the following factors into consideration in determining funding allocations:
  - Population Demographics – The size, demographic composition and rate of change of regional populations by age, gender and socio-economic status determine the need for health care services.
  - Utilization – The utilization of health care services in the BC population varies significantly by age, gender, and socio-economic status and is estimated for each health authority.
  - Inter-Regional Flows – Since residents can receive services in other health authorities, the model reallocates work load to the health authorities providing the services.
  - Regional Costs – Adjustments are made to recognize the differences in the cost of delivering health care in the regions due to remoteness or the higher costs inherent in large, specialized acute care facilities.
- The Ministry has updated the model for 2011/12, 2012/13 and 2013/14, using its "Health System Matrix" approach:
  - The Ministry has developed an approach that identifies the actual health status of BC residents that incorporates major chronic conditions and information about health status that can be inferred from diagnoses and use of health care services.
  - Can assign every BC resident to one of 13 health status groups.
  - Analysis has shown that in the PNBF model the Health System Matrix health status groups are better at explaining health care utilization than the former SES groups.
- Inter-Regional Flows – since residents can receive services in other health authorities, the PNBF model can reflect a redistribution of workload that effectively reallocates funds to the health authorities providing the services; however, the data limitations discussed previously did not make workload redistribution possible in 2009/10 or 2010/11 model calculations.

FACT SHEET

- Regional Costs – adjustments are made to PNBF allocations for differences in the cost of delivering health care in different regions due to remoteness or the higher costs inherent in large, specialized acute care facilities (complexity).
- The role of a funding model is to provide a transparent, understandable, and practical methodology for allocating specific funds among health authorities. The model does not:
  - determine the Ministry budget or amount of health resources needed;
  - allocate funding for provincial-level services or the PHSA;
  - allocate funding for health services not provided by health authorities (MSP Physician Services, BC Ambulance, PharmaCare); and,
  - specify how the health authorities should spend their funds. Health authorities receive global funding and may move funds between sectors, as long as they meet the Ministry's expectations for the delivery of services as outlined in policies, standards of care, and performance agreements with the Ministry.
- Because the PNBF allocations include adjustments for patient flow between health authorities and other regional variations, it is not appropriate to use the funding allocations to produce *per capita* funding statistics:
- The review found that:
  - The model framework is (allocating funding based on estimating relative needs of populations and adjusting for unavoidable cost differences) is consistent with the approaches of needs-based models used in other juridictions.
  - Within the existing framework there are opportunities to refine the model in order to improve the fairness and clarity of the allocations, reduce bias against at risk population sub-sets, and better reflect cost structures.
  - Developing needs based models for Mental Health and Substance Use and Population Health and Wellness sectors will make the model more comprehensive.
  - Some potential model improvements are not practical at this time due to a lack of standard available data.
- The Ministry acknowledged the report findings and has tasked the Standing Committee on Finance and Corporate Issues to review specific findings and make recommendations to the Ministry on adjusting the model. A working group is actively engaged in the analytical work needed to enable the Standing Committee on Finance and Corporate Issues to make its recommendations.
- The Ministry is also continuing to examine alternative funding approaches.

FINANCIAL IMPLICATIONS

See above. The project was delivered within budget for a total contract price of $356, 500.

Approved by:

Gordon Cross, Regional Grants and Decision Support Branch; January 14, 2016
Manjit Sidhu, Finance and Corporate Services Division; January 19, 2016

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

- 2014/15 actual operating revenue: $2.845 billion (per 2014/15 audited financial statements.)
- 2014/15 actual operating surplus: $0.643 million (per 2014/15 audited financial statements.)
- Regional Funding Allocation:
  - 2014/15 - $1.862 billion (per 2014/15 Final Funding Letter)
  - 2015/16 - $1.888 billion (per 2015/16 Funding Letter Update #2)
- Estimated FTEs:
  - Union – 9,803
  - Non-Union/Management – 2,822
- 2014/15 Audited Financial Statements:

Total Revenues	$2,844.988 million
Total Expenses	$2,844.345 million
Surplus	$ 0.643 million

Approved by:
Gordon Cross, Regional Grants and Decision Support Branch; January 18, 2016
Manjit Sidhu, Finance and Corporate Services Division; January 19, 2016

FACT SHEET

Seismic Initiatives in the Health Sector

ISSUE

Update on the status of seismic initiatives in the health sector.

KEY FACTS

- Current initiatives in the BC health sector related to seismic preparedness and readiness include:
  - seismic screening assessments under the Ministry of Health's Facility Condition Assessment (FCA) Agreement with VFA Canada Corporation (VFA), 2012-2017, and
  - structural seismic assessments of health care facilities by the Lower Mainland Facilities Management using the Seismic Retrofit Guidelines developed by the Association of Professional Engineers and Geoscientists of BC (APEGBC).
- Under the 5-year FCA agreement with the Ministry, VFA will conduct seismic screening assessments of health facilities owned by health authorities as part of their overall facilities assessments.
  - The structural portion of the seismic assessment consists of a review of the relevant structural documents and a visual walk-through inspection. A VFA assessor reviews building age, materials of construction, lateral load resisting elements, building irregularities, separation from adjacent buildings and building importance and occupancy.
  - The non-structural portion of the seismic assessment evaluates any potential seismic hazards from non-structural components, such as falling hazards to life from masonry chimneys, parapets, veneer, canopies, ceilings and lights over exits and walkways, as well as falling hazards to the occupants from heavy components such as masonry partitions, non-safety glass in egress areas or storage shelves which may overturn in occupied areas.
  - Seismic assessments conducted by VFA can be used as an initial assessment for determining which building should be subjected to more detailed structural seismic evaluation.
  - As of December 2015, seismic assessments were completed on 64% of health facilities scheduled for seismic assessments (based on m^2), and the remaining assessments will be completed by August 2017. The average Structural Priority Index for the 197 buildings assessed is 18, which ranks as medium priority.
- Lower Mainland Facilities Management is working on a plan to assess non-structural and structural seismic requirements across the three health authorities: Vancouver Coastal (including Providence Health Care), Provincial Health Services and Fraser Health.
  - The objective of this plan is to determine the seismic risks to Lower Mainland health care facilities and to enable a strategic approach to mitigating these risks. The seismic condition of Lower Mainland health facilities and the cost required for the appropriate level of seismic risk mitigation will be integrated with all other facilities plans, projects and operating and capital expenditures.
  - Non-structural seismic mediation projects are extremely cost effective and have the potential to reduce risk of injury, significant damage and repair expenses, resulting in increased safety and reduced business disruption from earthquakes.
  - As of December 2015, 83 buildings on 23 campuses (38% of all planned assessments) have had seismic assessments completed and the following is the summary of their seismic risk levels:

FACT SHEET

Lower Mainland Facilities

Seismic Risk Summary (see descriptions below):	Low Risk	Medium Risk	High Risk	Total Assessed
# of Facilities:	16	20	47	83

- Structural seismic risk levels are based on the APEGBC Seismic Retrofit Guidelines. This is a relative scale, based on the estimated movement (displacement or drift) of the building exceeding a certain limit over a large suite of ground motions.

Risk Rating	Description
H1	*High 1* : Most vulnerable structure; at highest risk of widespread damage or structural failure; not reparable after event.
H2	*High 2* : Vulnerable structure; at risk of widespread damage or structural failure; not reparable after event.
H3	*High 3* : Isolated failure of building elements such as Unreinforced Masonry (URM) walls is expected; building likely not reparable after event.
M	***Medium*** : Isolated damage to building elements is expected; non-structural elements (such as bookshelves, lighting, etc.) are at risk of failure.
L1	*Low 1* : Low-level of vulnerability; would experience isolated damage; possible repairable after event.
L2	*Low 2* : Building can be used as a post-event shelter. Repairable damage may be present and some services may not be operational.
L3	*Low 3* : Building may have some damage to non-structural items but is otherwise fully operational.

Background

- Hospitals, blood banks and emergency treatment facilities are considered post-disaster buildings, which means they have to be designed to remain standing after a seismic event and with more seismic resistance (50% more) than other regular buildings (1990 National Building Code, 1992 BC Building Code).
- Where a health authority is undertaking a major renovation or expansion to an existing health care facility, planning and design will include all necessary seismic requirements as prescribed by building regulations. The size and scale of renovation to a building typically determines the application of the building code requirements.
- All new constructions are built to current BC Building Code, and any renovations in existing facilities will consider seismic upgrades as part of the project.

FINANCIAL IMPLICATIONS

Under the FCA Agreement, estimated cost of seismic screening assessments is approximately $950,000 for the 5-year term, or $190,000 per year.

Approved by:
Joel Palmer, Capital Services Branch; January 29, 2016
Manjit Sidhu, Finance and Corporate Services Division; February 2, 2016

FACT SHEET
Special Investigations Unit Activities

ISSUE

Implementation of the Ministry of Health's new Special Investigations Unit (SIU).

KEY FACTS

- The Ministry of Health is committed to detecting fraud and abuse in the BC health care system.
- The Ministry continues to experience an increasing incidence of inappropriate billing by physicians and health care practitioners in the Medical Services Plan (MSP) Program, by Pharmacy operators in the PharmaCare Program, and inappropriate claims by non-eligible beneficiaries and residents.
- In 2014/15, the SIU was established within the Audit and Investigations Branch to investigate suspected fraud and abuse within the above program areas.
- Files for investigation may be referred to the SIU by units within Audit and Investigations Branch: the Billing Integrity Program (physician and health care practitioner audits); PharmaCare Audit (pharmacy audits); and the Eligibility, Compliance and Enforcement Unit (MSP eligibility reviews).
- The SIU is not yet fully established. An experienced Manager has been appointed as well as a Compliance Auditor, one Special Investigator position was filled in August 2015, and there is one vacant Special Investigator position.
- The SIU is staffed with Special Provincial Constables (approved July 2014) with the powers to conduct criminal investigations, execute search warrants and prepare reports directly for Crown Counsel.
- Files continue to also be referred to the Police to determine whether there is an ability to conduct a Police investigation.
- Files with SIU and/or the Police at January 31, 2016 are summarized below:

File Source/Status	Billing Integrity Program	PharmaCare Audit	Eligibility, Compliance & Enforcement	Total
Total open suspected fraud files	**13**	**17**	**11**	**41**
Under active investigation by SIU	s.15			
Police investigation				
Referred to Crown Counsel*				
Files awaiting further review and possible investigation**				
Total fraud files received				

s.15

**A number of these files have also been referred to the Police to open a file and consider an investigation.
***Includes files opened to assist other enforcement agencies (Identity Theft or Fraud – are not included in this total).

- The SIU works closely with law enforcement officials as well as other Compliance and Enforcement Officers across government to deter fraud and abuse of government programs.

FINANCIAL IMPLICATIONS

SIU budget for 2015/16 is $219,000, and there are currently three employees.

Approved by:
David Fairbotham, Audit and Investigations Branch; January 28, 2016
Manjit Sidhu, Finance and Corporate Services Division; February 2, 2016

FACT SHEET

Top Five Health Authority Executive Compensation

ISSUE

Since 2001, the Province has continued to make improvements to the transparency and disclosure of financial and performance information relating to executive compensation.

KEY FACTS

The 2014/15 Executive Disclosure Statements for the top five Executives will be posted by the Public Sector Employers' Council Secretariat (PSEC). The Disclosure Statements provide the actual compensation levels for the top five executive positions of each health authority, Providence and St. Joseph's General Hospital. The amounts included in the "All Other Compensation" field includes vacation payout, paid leave, severance and sick leave payout at retirement or conclusion of employment, and transportation allowance. Benefits include employer contributions for statutory and health benefits. Appendix A includes details of significant changes.

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 2007/08, legislation requiring the disclosure of the salaries of public sector CEOs and the next four highest-ranking executives earning $125,000 or more in base pay was passed.
  - 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:
Daryl Conner, Finance and Decision Support Branch; July 6, 2015
Manjit Sidhu, Finance and Corporate Services Division; April 20, 2016

FACT SHEET

Name	Principle Position	Base Salary	Incentive plan comp. paid	Pension	Benefits	All Other Comp	Total	Total Prior Year
Fraser Health								
Marchbank, Michael	President & CEO	$71,379		$6,831	$9,346		$87,556	N/A
Murray, Dr. Nigel	President & CEO	$100,575		$9,054	$7,160	$36,468	$153,257	$444,023
Ostrow, David	Interim President & CEO	$140,284					$140,284	N/A
Pelletier, Marc	VP Clinical Sup & Strategic Planning/ ICIO	$247,065		$23,239	$22,905	$63	$293,272	$294,198
Morton, Roy	Interim VP Medicine & Regional Programs	$227,246		$21,379	$7,351	$9,529	$265,505	N/A
Van Buyder, Paul	VP Public Health & Chief MHO	$136,547		$12,669	$8,953	$9,170	$167,339	$286,337
Goldthorpe, Peter	VP Corporate Services & Facilities	$237,510		$22,341	$20,782		$280,633	N/A
Lee, Victoria	VP Population Health & Chief MHO	$232,571		$21,888	$19,476	$6,796	$280,731	N/A
Webb, Dr. Andrew	VP Medicine	$271,440		$25,532	$24,045		$321,017	$320,040
Barker, Philip	VP Infomatics	$247,065		$23,239	$22,882		$293,186	$292,629
Interior Health								
Halpenny, Dr. Robert	CEO	$315,900	$35,100	$34,130	$20,144	$5,083	$410,357	$408,540
Etherington, Dr. Jeremy	VP Medicine & Qual.	$291,915		$28,538	$16,142	$2,653	$339,248	$337,373
Neuner, Andrew	VP Comm. Integr.	$118,548		$11,146	$6,303	$7,367	$143,564	$294,248
Johnston, John	VP People & Clinical Services	$249,776		$24,418	$15,674	$244	$290,112	$288,614
Lommer, Donna	VP Residential & CFO	$244,101		$23,864	$15,889	$2,424	$286,278	$283,435
Brown, Susan	VP Acute Services	$244,101		$23,864	$16,438	$604	$285,007	N/A
Northern Health								
Ulrich, Catherine	President & CEO	$329,000		$35,156	$13,205		$377,361	$376,791
Chapman, Dr. Ronald	VP Medicine	$272,474		$25,961	$13,545		$311,980	$310,101
McMillan, Michael	COO - Northern Interior	$220,409		$21,001	$13,176		$254,586	$259,005
Allison, Sandra	Chief Medical Health Officer	$175,444		$17,043	$15,424		$207,911	N/A
Johnston, Suzanne	VP Clinical Programs	$95,361		$8,847	$3,570	$9,584	$117,362	$244,393
Lindstrom, Jane	VP Human Resources	$211,146		$20,118	$11,908		$243,172	$242,088
Provincial Health Services								
Coppes, Max	Pres., BC Cancer Agency	$400,000		$39,058	$21,618	$46,934	$507,610	$561,356
Roy, Carl	President and CEO	$311,501	$34,700	$29,763	$12,727	$21,126	$409,817	$348,229
Brunham, Dr. Robert	Prov. Exec. Dir. - BCCDC	$223,789			$28,981	$10,325	$258,095	$364,765
Krystal, Arden	Chief Operating Officer	$273,000		$25,982	$15,657	$9,240	$323,879	$320,384
Arnold, Leslie	President, BC Children's	$268,320		$24,499	$8,821	$6,195	$307,835	$313,693
Foster, Nick	Interim Vice President	$220,051		$20,739	$12,430	$13,877	$267,097	N/A
Lupini, Linda	Executive Vice President, PHSA and President, BCEHS	$271,237		$25,815	$13,023	$3,925	$314,000	N/A
Vancouver Coastal Health								
Ostrow, Dr. David	President & CEO			$9,505	$1,232	$96,697	$103,434	$419,385
Ackenhusen, Mary	President & CEO	$310,273		$29,402	$15,946	$5,783	$361,404	$341,408
O'Conner, Dr. Patrick	VP Medicine	$271,554		$25,733	$16,161		$313,448	$311,821
Eliopoulos, Vivian	COO - Vancouver Acute	$236,576		$22,442	$15,087	$3,470	$277,575	N/A
Case, Laura	COO - Vancouver Community	$201,350		$19,101	$16,074	$3,470	$239,995	N/A
Coleman, Dr. Jeff	VP, Regl Programs	$52,222		$3,739	$1,557	$600	$58,118	$314,820
Copping, Glen	CFO & VP Sys Devel & Perform	$271,554		$25,733	$14,880	$6,960	$319,127	$159,072
Vancouver Island Health								
Carr, Brendan	President & CEO	$314,964	$34,997	$32,624	$22,605	$7,372	$412,562	$387,588
Crow, Richard	EVP & CMO	$268,991		$26,151	$14,831	$12,224	$317,197	$314,922
MacKay, Catherine	EVP & COO	$262,825		$26,036	$16,240	$6,910	$312,011	$311,050
Baldwan, Jatinder	EVP-Chief Medical	$286,672		$29,335	$17,228	$11,513	$324,748	$293,878
MacNeil, Kathryn	EVP Quality, Safety & Experience	$19,127		$1,932	$2,876	$1,383	$25,318	N/A
Kerrone, Kim	VP & CFO	$254,228		$25,237	$16,459	$8,166	$304,090	$286,878
Providence Health Care								
Doyle, Dianne	President & CEO	$320,713		$30,612	$12,120	$10,338	$373,783	$377,205
Sindelar, Robert	VP, Research & Academic Aff	$278,068		$25,798	$11,198	$3,497	$318,561	$314,078
Sachedina, Zulie	VP, HR & Gen. Counsel	$214,673		$21,400	$8,629	$7,523	$252,225	$267,076
Caren, Dr Ron	VP, Medical Affairs	$262,500					$262,500	$263,605
Procter, Mary	VP, Finance	$219,523		$21,035	$11,220	$950	$252,728	$255,398
St. Joseph's General Hospital								
Murphy, Jane	President & CEO	$197,599		$20,131	$16,787	$3,800	$238,317	$232,627
MacDonald, Eric	VP Finance, Capital & Support	$159,760		$15,959	$16,249	$913	$192,881	$192,049

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

- 2014/15 actual annual operating revenues, including Providence Health Care but excluding the other denominational affiliates: $3.465 billion (per 2014/15 audited financial statements of VCHA and Providence Health Care).
- 2014/15 actual operating surplus, including all denominational affiliates: $1.363 million (per 2014/15 audited financial statements of VCHA and the two denominational affiliates).
- Regional Funding Allocation:
  - 2014/15 - $2.461 billion (per 2014/15 Final Funding Letter)
  - 2015/16 - $2.540 billion (per 2015/16 Funding Letter Update #2)
- Estimated FTEs: (including Providence Health Care, but excluding other denominational affiliates and contracted agencies):
  - Union – 17,619
  - Non-Union/Management – 1,602
- Per 2014/15 Audited Financial Statements of VCHA (Excluding Denominational Affiliates):
  - Total Revenues $3,158.359 million
  - Total Expenses $3,157.273 million
  - Surplus $ 1.086 million
- With Providence Health Care and Louis Brier included, VCHA overall reported a surplus of $1.363 million for 2014/15.

Approved by:

Gordon Cross, Regional Grants and Decision Support Branch; January 26, 2016
Manjit Sidhu, Finance and Corporate Services Division; January 27, 2016

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

- 2014/15 actual annual operating revenues, excluding denominational affiliates: $2.115 billion (per 2014/15 audited financial statements of VIHA).
- 2014/15 actual operating surplus, including denominational affiliates: $4.938 million (per 2014/15 audited financial statements of VIHA and the denominational affiliates).
- Regional Funding Allocation:
  - 2014/15 - $1.714 billion (per 2014/15 Final Funding Letter)
  - 2015/16 - $1.765 billion (per 2015/16 Funding Letter Update #2)
- 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 2014/15 Audited Financial Statements of VIHA (Excluding Denominational Affiliates):

Total Revenues	$2,115.493million
Total Expenses	$2,110.570 million
Surplus	$ 4.923 million

- With Mount St. Mary Hospital and St. Joseph's General Hospital included, VIHA overall reported a surplus of $4.938 million for 2014/15.

Approved by:

Gordon Cross, Regional Grants and Decision Support Branch; January 20, 2016
Manjit Sidhu, Finance and Corporate Services Division; January 21, 2016

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).

KEY FACTS

The 10-year TFNHP agreement, signed in 2007 by the First Nations Leadership Council and the Governments of BC and Canada, was intended to improve the health status of First Nations (FN) people, with a focus on governance and on health actions. Key deliverables and priorities for 2015/16 include:

Primary Care and Public Health

- The Ministry of Health and regional health authorities are working with the First Nation Health Authority (FNHA) on implementing innovative ongoing investments in improving Primary Care services for FN people. A Ministry FNHA Joint Project Board was established to oversee FN primary care programs. Twenty-three primary care projects have been approved to date including: multi-disciplinary teams with physician/nurse practitioner leads and other professionals providing services to communities; Aboriginal patient navigators who assist with discharge planning; and integrated care teams working with clients and families to support mental health and wellness.
- A working group has been focused on improving primary care access to rural and remote FN and Aboriginal communities by removing barriers to incentive programming.

Maternal and Child Health

- The Aboriginal Pregnancy Passport was printed in March 2014 and distributed province-wide to FN and Aboriginal women as a guiding tool through pregnancy and first months of motherhood. *Promising Practices in First Nations and Aboriginal Maternal and Child Health Programs* aim to support communities to expand successful programs, train/upgrade staff capacity and better align programs and services among different providers/funders.
- The Doula Support Program is a joint BC Association of Aboriginal Friendship Centres and FNHA initiative that offers funding for Doula services to expectant Aboriginal women and families.
- Implementation planning for the Tripartite First Nation and Aboriginal Children's Oral Health Strategy, Healthy Smiles for Life Strategy is underway. This Strategy is designed to guide public health and community efforts to improve the oral health of children aged 0-18.

Health Human Resources (HHR)

- The HHR Tripartite Strategic Approach will assist communities/regions with HHR planning.
- A provincial cultural safety and cultural humility framework is being developed in partnership with FNHA, health authorities and Health Canada.
- San'yas 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. To date over 800 Ministry staff and 15,400 allied health professionals have completed the training.

Mental Wellness and Substance Use (MWSU)

- Fraser Health, partnering with FNHA, 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.
- Interior Health, partnering with FNHA, is working to increase mental health clinicians to FN communities, provide clinical support and capacity building to community-based MWSU workers and support multi-disciplinary teams through increased coordination efforts with the community.

- Vancouver Coastal Health, partnering with FNHA, is developing a MWSU Specialist Community Assessment Team to increase capacity of services and target reducing suicide risk.
- As part of a strategy to prevent and respond to suicide in FN 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 initiated April 2015.

Health Knowledge and Information

- The First Nation Client File, created through linkages with the federal Indian Registry and Ministry administrative databases, enables collaborative reporting and data linkages for surveillance and evaluation of specific initiatives.
- The Tripartite Data Quality and Sharing Agreement expired April 2015 with an automatic one-year renewal. An Agreement Amendment was signed, extending it to April 2019.
- The First Nation Panorama Implementation Project is currently being deployed in 16 FN health service organizations[1] to support clinical service delivery to 48 Nations. Twenty-six other FN health service organizations are being established to provide health services to 36 additional Nations.

eHealth

- The capacity for two-way live videoconferencing exists in approximately 150 FN communities in BC. In September 2013 Tripartite partners launched the First Nations Telehealth Expansion Project in partnership with Canada Health Infoway, key to 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 FN Telehealth Expansion project is to build and expand telehealth capacity and increase access to health/wellness/educational services to approximately 45 FN communities by December 2015.

FINANCIAL IMPLICATIONS

The Framework Agreement includes providing funding up to 2019/20 to support the health provisions outlined in the Framework Agreement. 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 2015/16	**$56.0 million**
2016/17 through 2019/20	$11.0 million per year
Funds still to be disbursed	**$44.0 million**
Total Commitment	**$100.0 million**

Approved by:
Arlene Paton, Population and Public Health Division; January 28, 2016
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; February 2, 2016

[1] FNHSO is defined as a legal entity established by one or more First Nations that, under the necessary agreements, employs health staff to deliver services to member First Nations. Each FNHSO signs on to the Panorama information sharing agreement (ISA), and as such has a responsibility to jointly steward Panorama data as per the terms of the ISA and the data classification model described in the Panorama Data Governance Framework.

FACT SHEET

BC Tripartite Framework Agreement - Implementation

ISSUE

On October 13, 2011, the 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 Framework Agreement's 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.
- The Framework Agreement's governance structure, comprised of the Tripartite principals (provincial and federal Ministers of Health and the FNHC), the Tripartite Committee on First Nations Health, , and the First Nations Health Directors Association, supported the establishment of the FNHA and continues to ensure accountability and transparency.
- Health Canada has now evolved from operating these First Nations health programs to providing funding and support to the FNHA.
- The Canada Funding Agreement 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 Canada Funding Agreement is $4.7 billion over 10 years (began July 2, 2013; expires March 31, 2023).
- Health Canada programs for BC First Nations were transferred in a phased approach and are now fully operational under the FNHA. 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 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.

FACT SHEET

- A Health Partnership Accord was signed among the tripartite partners on December 17, 2012. The 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 Medical Services Plan 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 Ministry and FNHA Joint Project Board (JPB). Negotiations are underway between the FNHA and the Ministry to calculate a new agreement and billing rate for the period from April 16, 2016 onwards.
- The Ministry and FNHA JPB 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 JPB 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 October 21, 2015 by FNHA and the Ministry of Health which articulated the mutual accountabilities, roles and responsibilities of both parties with respect to the planning, administration, delivery and monitoring of health services. The 2016/17 Letter of Mutual Accountability is under development. 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. The FNHA also has representation on each of the Standing Committees reporting to Leadership Council in order to foster integration of health policy and services.

FINANCIAL IMPLICATIONS

The Framework Agreement includes provincial funding up to 2019/20 to support the Transformative Change Accord: First Nations Health Plan and the Tripartite First Nations Health Plan. 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 2015/16	**$56.0 million**
2016/17 through 2019/20	$11.0 million per year
Funds still to be disbursed	**$44.0 million**
Total Commitment	**$100.0 million**

Approved by:
Arlene Paton, Population and Public Health Division; January 25, 2016
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; February 2, 2016

FACT SHEET

Carrot Rewards

ISSUE

The BC Ministry of Health is collaborating with the Public Health Agency of Canada (PHAC) and Social Change Rewards Inc. (SCR) and its national non-government organization partners (Heart and Stroke Foundation, the Canadian Diabetes Association and YMCA Canada) to create a national healthy living mobile application (app) platform called Carrot Rewards.

KEY FACTS

- Carrot Rewards is an innovative mobile app platform designed to motivate people to make healthier behaviour choices by rewarding their actions with loyalty points from their preferred participating loyalty partner.
- Carrot Rewards was announced July 29, 2015, and the free app will be available for British Columbians to download to a mobile platform in February 2016.
- Once installed, participants will receive their choice of loyalty points for engaging in and completing specific health promotion activities that target the common risk and protective factors associated with maintaining healthy weights and combating chronic disease.
- The concept is to be loyalty point "agnostic" and the first point providers signed on are Aeroplan, Scene, Petro-points and More Rewards (Overwaitea Food Group).
- To start, the app will focus on the following intervention streams: healthy eating, physical activity, positive mental health, immunization, moderation of alcohol and tobacco cessation. Intervention streams will evolve over time in scope, complexity, and targeting capability based on the learnings from the performance measures and evaluation reports.
- The offers in the app will be developed and released in a multi-phased approach. The first phase will feature in-app activities including surveys, quizzes, planning and health information. Future phases will use advanced functionality that reward activities such as attending a gym or flu clinic, purchasing produce at a grocery store, or tracking behaviours through other linked devices (e.g., "wearables" such as Fitbit).
- Carrot Rewards has been developed by SCR in partnership with PHAC and the Ministry of Health. The Ministry provided funding to the Canadian Cancer Society (CCS), directing the BC Healthy Living Alliance (BCHLA) to support BC's participation in Carrrot Rewards.
- As part of the grant agreement, BCHLA has set out a formal funding agreement with SCR that ensures BC benefits from being the first province to participate in the healthy living rewards platform.
- Having BCHLA on board complements the national non-government organization supporters and ensures BC is addressing shared priorities towards reducing chronic disease and improving health outcomes.
- The Ministry provided funds with BCHLA support establishing the development infrastructure for Carrot Rewards app, acquiring users of the app and providing incentives for the app users.
- As a founding province, BC receives an exclusive three-month launch period with the Carrot Rewards app only available to British Columbians. Once this period of exclusivity is over, the app will be available to other provinces and territories.
- The Carrot Rewards uses a pay-for-performance funding approach – with costs incurred when an action is taken through the users of the platform.
- As it is based on usage, this model ensures that every dollar invested drives direct measurable results and allows for detailed information on the intervention performance, providing better insight for future opportunities and follow up to measure sustained behavior change.

FACT SHEET

- BCHLA is working closely with SCR and its in-house behavioural economist to set an evaluation framework that ties the usage to behaviour change in a measurable way over the short, medium and long term. This evaluation framework is also a mandatory element of the PHAC and SCR funding agreement.
- The app is confidential and completely private. British Columbians are invited as an opt-in and may remove the app at any time.
- There is a signed privacy impact assessment for the app and the highest level of security has been assured by SCR through their data management protocols. All data transfers will be through an encrptyed process and only aggregate reporting will be available to participating provinces and non-government organizations. There will be no release of personal identifers.

FINANCIAL IMPLICATIONS

- The Ministry has provided $2.5 million to CCS to work with BCHLA to become the first province to participate in Carrots Rewards.
- Carrot Rewards is cost-shared by PHAC ($5 million) and the Ministry funding provided to CCS to support BCHLA involvement on BC's behalf.
- PHAC is investing in app development and the initial sign up of British Columbians. As part of the benefits of going first, BC will receive a larger investment from PHAC for sign ups.

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Approved by:
Arlene Paton, Population & Public Health Division; January 28, 2016
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; October 22, 2015

FACT SHEET

Drinking Water – Union of BC Municipalities Small Water System Recommendations

ISSUE

The 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. It is estimated there are thousands of additional small water systems 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); Office of the Provincial Health Officer; UBCM Small Water Systems Working Group; Office of the BC Ombudsman – 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.
- The UBCM Small Water Systems Working Group made a number of recommendations to government on making changes to how small drinking water systems could be created, regulated and managed, with a goal that they remain sustainable in the future.
- The Ministry analyzed the recommendations for drinking water provided by UBCM and other stakeholders, and conducted an evidence review, jurisdictional scan and policy analysis. In general, actions to address small water systems fall into three broad categories: promoting sustainable small water systems; redefining small water systems and classes of water systems; and preventing the proliferation of future unsustainable small water systems.
- While the Ministry of Health and health authories can implement some strategies independently, others depend on collaborative efforts across several ministries and local governments. This includes: Ministry of Community, Sport and Cultural Development (MCSCD) (subdivision regulation and infrastructure programs), Ministry of Forests, Lands and Natural Resource Operations (oversight of water utilities and water user communities), and Ministry of Transportation and Infrastructure (MTI) (subdivision processes).

FACT SHEET

- Government has initiated an interministry ADM steering committee and working group to develop several policies and implementation actions over the next 2 years as follows:
  1. Plan and implement UBCM's recommendations related to reducing the regulatory burden for water supply systems with less than 5 connections.
  2. Develop guidance for MTI 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 letter from Minister Lake to Al Richmond, Chair of UBCM Healthy Communities Committee.
- MTI posted a request for proposals with BC Bid Resources for a contractor to develop a subdivision checklist on January 14, 2016. This checklist will help ensure small water systems meet the service and water quality requirements for users by identifying sustainability issues at subdivision.
- MCSCD reports they are actively looking into a loan programs with financial institutions and financial best management practices. Loans would only be provided to Small Water Systems who follow acceptable financial management practices.
- The Ministry has given a grant to the BC Water and Waste Association to develop and promote existing educational material as well as interactive training sessions for small water suppliers on financial best practices; non-potable policy; Small Water Systems Guidebook; elements of Point of Use/Point of Entry agreements; and ground water at risk of containing pathogens

FINANCIAL IMPLICATIONS

- The Ministry of Health does not provide direct financial assistance to water systems. Most small water systems are not eligible for financing through MCSCD and small water system operators typically fund operations through user fees.
- The health authorities currently dedicate significant resources to monitoring small systems across the province.
- Implementing a comprehensive small water systems strategy requires participation and resources from across government.
- The Ministry has provided $500,000 in a 2014/15 grant to the BC Water and Waste Association to implement the outreach and education component of the small water systems work plan over the next 2 years.

Approved by:
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; April 16, 2015
Arlene Paton, Population and Public Health Division; January 25, 2016

FACT SHEET

Fentanyl

ISSUE

Fentanyl has been associated with an epidemic of opioid overdose fatalities (and non-fatal overdoses, sometimes leading to hospitalization and brain injury) in BC in 2014 and 2015.

KEY FACTS

- Fentanyl is a synthetic opioid which is much more toxic than morphine and is particularly dangerous to those who are naïve opioid users.
- In recent years, BC has been experiencing an increase of fentanyl-detected deaths occurring in illicit circumstances: 13 deaths in 2012, 49 deaths in 2013, and 90 deaths in 2014.[1]
- This pattern has continued in 2015, with 465 apparent illicit drug overdose deaths, 30% of which involved fentanyl (approximately 140 deaths).[2]
- Over the past four years the percentage of drug overdose deaths in which fentanyl is detected has risen from 5% to 30%. Based on data from previous years, most of these deaths likely involved a mix of substances, with fentanyl as just one of the components.
- The total number of illicit drugs deaths in BC for 2015 was 465, an increase of 27% from the previous year. Mortality rates for 2015 are higher than they have been in recent years. Similar rates have not been seen since 1998.[3]
- Fentanyl overdoses in BC do not seem to be associated with diverted pharmaceutical medication, but rather with illicitly manufactured fentanyl (either produced locally or imported from abroad). The vast majority of overdoses in BC are a result of counterfeit prescription medications (i.e., "fake Oxy's") and heroin laced with fentanyl, or simply fentanyl held out to be heroin. While there is some diversion of fentanyl patches and subsequent extraction of the active ingredient, it accounts for a very small percentage of overdoses.
- Beginning in March 2015, the BC Centre for Disease Control, Vancouver Coastal Health Authority and the Vancouver Police Department led a campaign of public warnings about fentanyl, titled *Know Your Source? Be Drug Smart*. However, evidence suggests that public awareness campaigns will have a limited effect;[4,5] many people who hear warnings about fentanyl may feel they don't apply to them, as they believe they are purchasing heroin or oxycodone.
- Take-home naloxone is being scaled up in BC, to provide greater access to a medication that can reverse opioid overdoses (including fentanyl) and save lives. BC's Take Home Naloxone program provides overdose awareness and response training as well as naloxone kits. As of January 2016:
    - This program is currently available at 126 locations in BC.
    - Since it began in 2012, the program has trained 5,494 people to prevent, recognize and respond to opioid overdose (2,954 of those trained are people who use opioids and 2,190 are service providers and support persons of people who use opioids including spouses and other family members).
    - To date, 4,412 naloxone kits have been distributed.

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[1] Canadian Centre on Substance Abuse (2015) *CCENDU Bulletin: Deaths Involving Fentanyl in Canada*. Retrieved September 14, 2015: http://www.ccsa.ca/Resource%20Library/CCSA-CCENDU-Fentanyl-Deaths-Canada-Bulletin-2015-en.pdf

[2] BC Coroners Service (2015) Illicit Drug Overdose Deaths in BC 2006-2015. Retrieved January 19, 2016: http://www.pssg.gov.bc.ca/coroners/reports/docs/stats-illicitdrugdeaths.pdf

[3] BC Coroners Service (2015) Illicit Drug Overdose Deaths in BC 2006-2015. Retrieved January 19, 2016: http://www.pssg.gov.bc.ca/coroners/reports/docs/stats-illicitdrugdeaths.pdf

[4] Kerr, T., Small, W., Hyshka, E., Maher, L., & Shannon, K. (2013). 'It's more about the heroin': Injection drug users' response to an overdose warning campaign in a Canadian setting. *Addiction, 108*(7), 1270-1276.

[5] Miller, P. G. (2007). Media reports of heroin overdose spates: Public health messages, moral panics of risk advertisements. *Critical Public Health, 17*(2), 113-121.

- Over 373 overdose reversals have been reported to the program, and in all cases the person who overdosed survived.[6]

- On January 14, 2016 Health Canada announced its intention to amend the prescription drug list to make naloxone available without a prescription, allowing for improved emergency response to opioid overdose outside of hospital settings. Health Canada is requesting comments on this proposal by March 19, 2016. At that time, Health Canada intends to finalize the change, waiving the usual six-month implementation period.[7] BC supports this initiative.
- On January 8, 2016 Minister Terry Lake signed a ministerial order to amend Section 10 of the Emergency Medical Assistants Regulation to allow BC Emergency Health Services to request the licensing board to endorse the licence of a person who holds a license in the category Emergency Medical Assistant First Responders or Emergency Medical Responders to dispense and administer narcotic agonists (i.e., naloxone). These changes allow more types of first responder to administer naloxone (e.g., firefighters). For more information, see Naloxone fact sheet
- Rapid street drug testing (i.e., chemical analysis of drug samples) is a public health intervention that exists in a number of European countries and is part of provincial public health policy.[8] Providing access to street drug testing allows people to make more informed decisions about their drug use, and provides drug market surveillance and early warning opportunities for health authorities. Public health officials in BC are exploring options, opportunities and barriers to conducting a research pilot of a street drug testing intervention.
- Opioid substitution treatment (OST), in which patients are prescribed methadone or suboxone for maintenance purposes, is a highly effective means of treating opioid use disorder. Improvements to BC's OST system are ongoing. For more information, see Methadone and Other Opioid Substitution Treatment fact sheet.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Approved by: Arlene Paton, Population and Public Health Division; January 20, 2016

[6] Updated naloxone program information provided by Ashraf Amlani, BCCDC, January 19th, 2016 https://infograph.venngage.com/p/1974/naloxone-infograph

[7] Health Canada (2015) Health Canada Statement on Change in Federal Prescription Status of Naloxone. Retrieved January 19th, 2016. http://news.gc.ca/web/article-en.do?nid=1027679

[8] British Columbia Ministry of Health. (2005). *Harm reduction: A British Columbia community guide*. Victoria, BC: Ministry of Health. Retrieved September 14, 2015: http://www.health.gov.bc.ca/library/publications/year/2005/hrcommunityguide.pdf

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 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)** – is a key program for all health authorities within the Food Security Core Program and is funded by the Ministry. 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 and 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** - is 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 January 2016, 108 restaurant brands including quick service, sit-down, chains and health care facilities have fully implemented Informed Dining representing 2101 outlets in BC and 11,074 outlets nationally. [2] The mandated Informed Dining in Health Care program requires retail food service establishments in health authority owned and/or operated facilities to 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

- **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

[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

Officers monitor and enforce the regulation and health authorities are reporting trans fat compliance data semi-annually. Compliance rates range from 93 to 97%.[3]

- **Sodium Procurement Guidelines** - the Ministry established new provincial sodium guidelines for patient food services in all publicly-funded health care facilities. By March 2016, adult general menus in acute and residential care are to meet the guideline amount of 2,300 mg of sodium per day. The 2014/15 average daily sodium content of adult hospital diets was 2,390 mg of sodium per day.[4]
- **Vending Guidelines** - the 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, public post-secondary institutions and Crown corporations since 2006. The Policy was recently updated to align with the 2013 Guidelines for Food and Beverage Sales in BC Schools.

School Setting

- The Ministry supports a suite of provincial school-based healthy eating programs including Farm to School BC, BC School Fruit and Vegetable Nutritional Program 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 by offering greater access to healthy food while 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 Farmers' Markets $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 (CFAI)** - health authorities combined, spend 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; January 26, 2016
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; April 30, 2015

[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
[4] Ministry of Health, Population and Public Health Division

FACT SHEET

Healthy Families BC Policy Framework (Chronic Disease Prevention)

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
- 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 B.C. Health System', the health system strategy that was published in February 2014.

FACT SHEET

- 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 HFBC Policy Framework has targets against which to measure progress and success against the focused intervention streams .
    - 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 population health surveillance.
    - The implementation of the HFBC Policy Framework is supported by a marketing and engagement strategy with a provincial scope that is building towards consistent messages and tools across all health authorities in support of 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; January 28, 2016

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* outline 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%t 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 were obese and almost 40% already had at least 1 complication as a result of their obesity or diabetes, at an average age of only 13.5 years.[4]
- Weight-based discrimination has increased by 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 3 integrated strategies to promote healthy weights: 1) making childhood overweight and obesity a collective priority for action; 2) coordinating efforts on 3 key policy priorities including supportive environments, early action and nutritious food; and 3) measuring and reporting on collective progress.

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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

- Healthy Families BC, the government's comprehensive health promotion program, promotes healthy weights by focusing on supportive environments, opportunities for physical activity, and access to healthy food.
- The Ministry of Health is working with the Childhood Obesity Foundation and the Provincial Health Services Authority (PHSA) to implement province-wide services for families with children above a healthy weight. The Shapedown BC program, coordinated by BC Children's Hospital, provides medical, nutritional and psychological assessment, education and support for obese children. It is now offered not only in the Vancouver area at BC Children's Hospital, but also by Fraser Health (Surrey), Vancouver Coastal Health (Richmond), Vancouver 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 18 BC communities. The HealthLink BC Eating and Activity Program for Kids telehealth service was launched in February 2015 and includes a focus on healthy eating and active living coaching for at-risk families in rural and remote parts of the province.
- *British Columbia's Continuum for the Prevention Management, and Treatment of Health Issues Related to Overweight and Obesity in Children and Youth*, developed by ChildHealth BC and the Childhood Obesity Foundation, in collaboration with the Ministry, provides 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 to strengthen 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 and Action Schools! BC. These programs, along with the *Guidelines for Food and Beverage Sales in B.C. Schools*, help to create school environments that support healthy eating and promote healthy weights by offering greater access to healthy food and increasing knowledge, attitudes and skills related to healthy eating and physical activity.

FINANCIAL IMPLICATIONS

- PHSA 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.13,s.17

- Since 2006/07, PHSA has provided funding of $400,000 for the Shapedown BC program at BC Children's Hospital.
- In 2015/16, PHSA provided the following to regional health authorities to support delivery of Shapedown BC: Vancouver Coastal ($230,000), Fraser Health ($280,000), Vancouver Island Health ($230,000) and Interior Health ($230,000).
- Also, in the beginning of 2015/16, an additional $100,000 is being provided to support the Shapedown BC program for a total of $500,000 annually.

Approved by:
Jackie Redmond, obo Carolyn Bell, Health Sector Planning and Innovation Division; February 24, 2014
Arlene Paton, Population and Public Health Division; January 26, 2016
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; February 11, 2016

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Withheld pursuant to/removed as

s.12;s.13

FACT SHEET

Lead Testing in Public Schools Drinking Water

ISSUE

Lead in Drinking Water in public schools has recently received media attention in BC.

KEY FACTS

- Exposure to lead can be hazardous to human health and is most serious for young children because they absorb lead more easily than adults and are more susceptible to its harmful effects. According to Health Canada, even low level exposure may harm the intellectual development and behaviour in infants.
- Drinking water is one way in which people can be exposed to lead along with sources in food, contaminated soil, consumer products and leaded paint in older homes.
- The Guidelines for Canadian Drinking Water Quality suggests there is no safe level of lead and that the concentration in drinking water should be kept as low as reasonable achievable. The current guideline for lead in drinking water is a maximum acceptable concentration of 0.010 mg/L.
- Under the *Drinking Water Protection Act*, drinking water suppliers in BC are responsible for ensuring that the water they deliver is monitored to verify it is within acceptable limits for lead and other metals and to maintain water quality conditions that don't exacerbate health hazards. Property owners are responsible for sources of lead on their property and in their building systems.
- Most drinking water supply systems in BC have very low levels of lead. Lead typically gets into drinking water if it comes into contact with buildings containing lead pipes, lead solder, faucets, valves, and other components made of brass. The extent to which lead can get into water from plumbing depends on the materials used, the characteristics of the water (corrosiveness), and the time it spends in the plumbing.
- Lead in drinking water may be a concern with schools and other buildings built before the 1989 revision to the BC Plumbing Code restricting the use of lead in potable water lines.
- Given the risks to children, school districts should work with heath authorities to establish a plan to evaluate where lead risks may occur, as well as to mitigate risks that are identified.
- This is not a new issue; health authorities have been communicating with schools since the 1980s regarding appropriate measures to minimize impacts from lead plumbing.
- In response to the most recent events, the Provincial Health Officer has written a reminder to all school districts to test and manage lead in drinking water in schools in BC, and requested that all school districts review their policies and practices. Health authorities can be contacted if they have any concerns or questions.
- This issue may be managed through flushing programs that eliminate water that has accumulated lead overnight prior to the school day, along with confirmation sampling to ensure the flushing method is effective.

FINANCIAL IMPLICATIONS

The most cost effective solution for reducing risk from lead identified in water is to have active flushing programs in areas with corrosive water, install lead removal at points of use or use alternate water supplies. Longer term solutions may also be implemented, such as reducing corrosiveness of water supplies (cost born by the water supplier) and swapping out pipes and fixtures for new ones which contain low lead (cost born by the building owner).

FACT SHEET

Approved by:
Arlene Paton, Population and Public Health Division; March 10, 2016

FACT SHEET

Methadone and other Opioid Substitution Treatment

ISSUE

- Opioid Substitution Treatment (OST)—in which patients are prescribed methadone or buprenorphine/naloxone (brand-name, Suboxone) for maintenance purposes—is a highly effective means of treating opiate dependence. OST is also 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.
- In October 2015 the Province approved Suboxone as a regular coverage benefit by PharmaCare. Physicians can now prescribe Suboxone as a first line treatment for opioid use disorder. The Vancouver-based Study to Assess Longer-term Opioid Medication Effectiveness (SALOME) study researched other substitution medications such as diacetylmorphine (i.e., heroin) and hydromorphone (i.e., Dilaudid™), although findings have yet to be published.
- A 2014 BC 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 2016). See SALOME Fact Sheet.

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 the methadone maintenance system's biggest challenges.
- Government released a written response to the report and a working group was tasked with implementation of the recommendations. The Medical Beneficiary and Pharmaceutical Services Division (MBPSD), Health Services Policy Division (HSPD), and Population and Public Health Division (PPHD) in the Ministry of Health, along with the Ministry of Social Development and Social Innovation, comprise the committee.
- *Healthy Minds, Healthy People*[1] articulates two 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 OST to ensure reduced risk for the transmission of HIV, increased adherence to treatment, and improved engagement of people into low-barrier health services.
- In July 2015, the Office of the Provincial Health Officer released a report, *BC Opioid Substitution Treatment (OST) System Performance Measures 2013/2014*.[3] Following a previous report from

[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. (2015). *BC opioid substitution treatment system: Performance measures 2013/2014*. Victoria, BC: Office of the Provincial Health Officer. Retrieved on September 9, 2015 from: www.gov.bc.ca/opioidsubstitutionreport2013-14

2014, the new report presented data related to the prescribing, dispensing and financial aspects of methadone and Suboxone maintenance. Highlights included:

  - A 6% increase in patients engaged in OST from 2012/13 to 2013/14, and a 61% increase from 2008/09 (from 10,341 to 16,668 patients)[4];
  - A slight increase in the number of authorized active methadone prescribers from 284 in 2008/09 to 365 in 2013/14.[5] The Ministry of Health is working with the College of Physicians and Surgeons of BC (CPSBC) 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 61 percent between 2008/09 and 2013/14, from 546 to 881 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 2015, with planning support from PPHD and HSP.
- MBPSD is currently reviewing OST pharmacy practices and payment structures for methadone dispensing; PPHD and HSPD are working with MBPSD to ensure 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, which is the same medication, but is 10 times the concentration (10 mg/ml) of the previous methadone formulation (which was 1 mg/ml).
- In November 2015, a Vancouver methadone patient filed a civil claim in the BC Supreme Court against the BC government for fees paid from her income assistance cheques to pay for treatment at a clinic providing OST. The Ministry of Social Development and Social Innovation is working with Attorney General staff to respond.

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 OST (methadone or Suboxone). In 2014/15, the total amount paid for this fee item was approximately $14.69 million.[8]
- The PharmaCare program covers OST medications (methadone and Suboxone). In 2014/15, the total amount paid for OST pharmacy dispensing, ingredients and interaction costs was approximately $45.85 million.[9]
- In December 2015, PPHD contracted with the CARBC to work with OST patients to develop a handbook for new patients by March 31, 2016 (contract amount = $24,000).

Approved by:
Arlene Paton, Population and Public Health Division; January 21, 2016
Ted Boomer, Finance and Decision Support Branch; February 3, 2016

[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.
[9] Source: Christine Voggenreiter, 2-1450, Director, Health Outcomes and Economic Analysis , Medical Beneficiary and Pharmaceutical Services

FACT SHEET

Promotion of Physical Activity

ISSUE

Physical activity is one of the most important things British Columbians can do to maintain and improve their health and well-being. Research shows there is a direct link between child and youth participation levels in physical activity and lifelong health and well-being.[1] Physical activity is essential for healthy growth and development in children and a key component in helping to maintain healthy body weight, prevent injury, disease and disability, as well as improve flexibility, balance, strength and coordination.

KEY FACTS

- BC has the highest physical activity rates of any province in Canada, with 61% of British Columbians (aged 12 and over) physically active or moderately active during their leisure time[2] and is the leading province for children and youth (ages 5-17) using active transportation to and from school each day.[3]
- The 2015 ParticipACTION Report Card on Physical Activity for Children and Youth was released in June; entitled The Biggest Risk is Keeping Kids Indoors. This report card focused on children's play in nature and the outdoors. In alignment with the Report Card, a *Position Statement on Active Outdoor Play* was also released: 'Access to active play in nature and outdoors—with its risks—is essential for healthy child development. We recommend increasing children's opportunities for self-directed play outdoors in all settings—at home, at school, in child care, the community and nature.'
- The overall Physical Activity grade for Canada was a D-.
- To also note, 70% of children aged 3 to 4 get the recommended 180 minutes of daily activity at any intensity, while only 9% of 5-17 year olds get the 60 minutes of moderate to vigorous physical activity they need each day[4]
- Children and youth (between the ages of 5 and 19) in BC walk an average of 12,100 steps per day, which is higher than the national average of 11,600.[5]
- The economic burden of physical inactivity in BC (in direct and indirect costs related to health care and productivity losses) is conservatively estimated at $573 million annually.[6]
- The economic burden of obesity in BC (in direct and indirect costs related to health care and productivity losses) is conservatively estimated between $730 and $830 million per year.[7]
- The Canadian Society for Exercise Physiology released the updated Canadian Physical Activity and Sedentary Behaviour Guidelines[8] supported be the Public Health Agency of Canada and ParticipACTION.

Key Activities of the Ministry of Health

1. **The development and implementation of a provincial Physical Activity Strategy and Action Plan[9]:**
   - Development of the Physical Activity Strategy was guided by a Physical Activity Leadership Council comprised of key leaders and organizations across the province who worked collectively to

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[1] World Health Organization. (2010) *Global Recommendations on Physical Activity for Health.* pp.18-19. Retrieved on September 23, 2014 from http://whqlibdoc.who.int/publications/2010/9789241599979_eng.pdf

[2] Statistics Canada. (2013). *Physical activity during leisure time, by sex, provinces and territories (Percent).* CANSIM, table 105-0501 and Catalogue no. 82-221-X. Retrieved on September 17, 2015 from http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/health78b-eng.htm

[3] Active Healthy Kids Canada. (2013). *Are we Driving our Kids to Unhealthy Habits? 2013 Active Healthy Kids Canada Report Card on Physical Activity for Children and Youth.* p. 10. Retrieved on September 23, 2014 from http://www.activehealthykids.ca/2013ReportCard/en/

[4] ParticipACTION Report Card on Physical Activity for Children and Youth. (2015) Retrieved on September 21, 2015 from http://www.participaction.com/report-card-2015/report-card/

[5] Canadian Fitness & Lifestyle Research Institute. (2010). *Kids CAN PLAY! Physical Activity levels of Canadian children and youth in British Columbia.* p.1. Retrieved on October 2, 2014 from http://www.cflri.ca/media/node/972/files/CANPLAY%20Bulletin%202.10%20BC%20-%20EN.pdf

[6] Colman, R and Walker, S (2004) *The Cost of Physical Inactivity in British Columbia* (A report to the Ministry of Health Services), GPI Atlantic, page iii, http://www.health.gov.bc.ca/library/publications/year/2004/inactivity.pdf

[7] Colman, R (2001) *The Cost of Obesity in British Columbia*, GPI Atlantic, page 2, http://www.gpiatlantic.org/pdf/health/obesity/bc-obesity.pdf

[8] Canadian Society for Exercise Physiology. Canada's Physical Activity and Sedentary guidelines. Retrieved September 30, 2014 from http://www.csep.ca/english/view.asp?x=804

[9] http://www.health.gov.bc.ca/library/publications/year/2015/active-people-active-places-web-2015.pdf

determine the best approach to increasing physical activity rates. Provincial consultations were facilitated with people working in physical activity and related fields in order to identify key areas of focus for targeted action over the next 3 years.

- The Physical Activity Strategy is designed to guide and stimulate coordinated policies, practices and programs in physical activity that will improve the health and well-being of British Columbians, and the communities in which we live, learn, work and play. In keeping with the Healthy Families BC Policy Framework, the strategy uses a settings-based approach to building supportive environments:
  - Active People-strategies and opportunities that help all British Columbians to be physically active.
  - Active Places-well-planned and designed environments that support and encourage active living.

2. Oversight for implementation of initiatives and programs. Key examples include:

- Action Schools! BC (ASBC) is an initiative that provides opportunities for children and youth in grades K-9 to be more physically active. ASBC supports schools in implementing the Ministry of Education's Daily Physical Activity policy that requires grades K-7 students to complete at least 30 minutes of physical activity each day and grades 8-12 students to complete at least 150 minutes of physical activity each week. ASBC programming has not been available to BC schools in the 2015/16 school year while the Province refreshes the model of delivery. Programming is expected to resume in the spring of 2016.
- The BC Physical Activity Line, managed by the Health and Fitness Society of BC, is a telephone and website resource for evidence-based physical activity information and advice. Qualified exercise professionals provide physical activity information and professional guidance to individuals, health professionals and community health and fitness programs. In 2014/15, there was an average of 349 incoming calls and 181 outgoing per month (with no formal marketing of the line to the public).

FINANCIAL IMPLICATIONS

- The Ministry of Health provided funding of $6 million in 2011/12, and the Provincial Health Services Authority (PHSA) provided an additional $6 million in 2013/14 to ParticipACTION. The purpose of this funding is to leverage existing activities that align to the BC Physical Activity Strategy and enhance ParticipACTION's reach, access, and impact on improving the physical activity levels of British Columbians over the next three years (2015/16-2017/18).
- As part of the Healthy Families BC Strategy, PHSA provides $500,000 per year to the Health and Fitness Society of BC to support the BC Physical Activity Line.
- The Ministry provides an annual grant of $1.738 million for implementation of Action Schools! BC.
- PHSA provided one-time year end funding of $7 million (2013/14) to the BC Healthy Living Alliance to support implementation of the BC Physical Activity Strategy.
- PHSA provided one-time year end funding of $1.5 million (2013/14), as part of a total $4.5 million grant to the Centre for Hip Health and Mobility, to support physical activity programming for older adults.

Approved by:
Arlene Paton, Population and Public Health Division; January 26, 2016
Carolyn Bell, obo Teri Collins, Health Sector Information, Analysis and Reporting Division; February 2, 2016
Gordon Cross ,obo Manjit Sidhu, Finance and Corporate Services; October 14, 2014

FACT SHEET

Tobacco and Vapour Products Control Act

ISSUE

Vapour products (including electronic cigarettes, cartridges, components and substances) are a relatively new product that has gained popularity, particularly among young people. The evidence as to their benefits and harms has not been established. This Fact Sheet outlines the new legislation introduced in March 2015 to reduce youth uptake of vapour products and protect non-users from exposure to the product.

KEY FACTS

- The Minister of Health's mandate letter of June 2014 identified the regulation of vapour products as a part of the Minister's deliverables. The *Tobacco Control Amendment Act* expanded the scope of the *Tobacco Control Act* to permit the regulation of vapour and associated products. The Act received Royal Assent on May 14, 2015. The new *Tobacco and Vapour Products Control Act* will:
  i. Prohibit places where vapour products can be sold;
  ii. Prohibit or restrict retail vapour product displays and promotions to minors;
  iii. Prohibit or restrict the sale of vapour products to minors;
  iv. Prohibit the use of vapour products in public places and work places;
  v. Prohibit or restrict the use of vapour products on health board property;
  vi. Prohibit the use of vapour products on school property (kindergarten to grade 12); and
  vii. Enforce the new vapour product provisions by administrative penalty.
- While it may be years before the health impacts of vapour products are known, the protection of youth and the public is required until further research is completed. The new law seeks to stop youth from starting to use vapour products and protect people from second hand vapour exposure. Health authorities will enforce the new law and its regulations.
- Regulations are in the process of being drafted. The Ministry has completed the policy discussion paper outlining the proposed regulations and timing for bringing these in force. Subjects included:
  - vape-free premises (work and public spaces);
  - restrictions at retail (sales to minors, display and promotion restrictions);
  - health authority restrictions on tobacco and vapour product use; and
  - timing of implementation.
- The feedback has been collated and will be considered as the regulations are drafted.

FINANCIAL IMPLICATIONS

- In 2015/16, the Ministry allocated regional health authorities with $1.175 million for tobacco enforcement (an increase of $500,000 from 2014/15).
- The Ministry also provided regional health authorities with $1 million in 2015/16 for tobacco cessation/prevention.
- The Ministry provided $2.1 million to the BC Lung Association in 2014/15 for cessation services.

Approved by:

Arlene Paton, Population and Public Health Division; January 28, 2016
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; February 3, 2016

FACT SHEET

Tobacco Control

ISSUE

Tobacco-related illness is the leading cause of preventable death in Canada. Smoking is the primary risk factor for the top 3 causes of death in Canada: diseases of the circulatory system, cancers and respiratory diseases.[1] This fact sheet summarizes tobacco use statistics and government's actions 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 use by reducing tobacco use through 3 approaches: 1) stopping youth/young adults from starting smoking; 2) helping smokers to quit; and 3) protecting people from exposure to second-hand smoke.

Statistics

- BC has the lowest provincial smoking rate at 15.3%, compared with the national rate of 18.7[2].
- BC has lower rates of exposure to second-hand smoke compared with the national rate. Of those aged 12 and older, those regularly exposed to environmental smoke in their homes is 2.2% in BC and 4.5% in Canada. Exposure to smoke in vehicles and public places is 14.9% in BC and 16.4% in Canada.
- Tobacco-related illness is the single leading cause of preventable death in BC: there are over 6,000 deaths each year.
- The estimated economic burden of tobacco use for BC is $2.3 billion, including $607 million in direct health care costs.[3]
- Smoking rates and total number of smokers vary by health authority:

HA's	Smoking rate – %		Total number of smokers	
Northern	23.6 %	highest rate	54, 401	fewest smokers
Interior	19.2 %		117,654	
Island Health	16.8 %		109,236	
Vancouver Coastal	14.5 %		145,481	
Fraser	12.1 %	lowest rate	177,287	most smokers

Action-Stopping Youth and Young Adults from Starting to use Tobacco (Prevention)

- The *Tobacco and Vapour Products 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 exemptions for the ceremonial use of tobacco in an Aboriginal cultural activity). Health authorities enforce the Act.
- In 2015, amendments to the Act were made, extending the restrictions that apply to tobacco for sale/display to youth and public/work place use, to vapour products. The Ministry is currently developing regulations to support the Act. For information, see Fact Sheet *Tobacco and Vapour Products Control Act.*
- The Ministry supports the federal government's ban on flavoured tobacco in larger cigars.

Action-Helping Smokers to Quit (Cessation)

- BC Smoking Cessation Program – the Ministry provides smokers with no-cost nicotine replacement therapy (NRT) aids, and for those on Fair PharmaCare, insurance for prescription

[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] For all smoking rate and population statistics: Canadian Community Health Survey 2013/2014 Combined Sample

[3] The Costs of Substance Abuse in Canada 2002, Canadian Centre on Substance Abuse 2006.

quitting drugs. In January 2016, the program was expanded to include more options for NRTs, and now offers the patch, gum, inhaler and lozenges. The program was streamlined so smokers do not have to call 8-1-1- to register, but simply go to a local pharmacy. Since the program launch in September 2011, over 25% of smokers have used the program with a total expenditure of $38.2 million for drug coverage (to March 2015).[4]

- QuitNow - provides smokers with behavioural support to quit smoking through a variety of options: coaching support by phone, online or by text, quit guides and contests to encourage quit attempts.
- Since 2011, federal legislation requires all cigarette/cigarillo packages to include 1-800 quitline/website information.

Action-Protecting People from Exposure to Second-hand Smoke (Protection)

Second-hand smoke is a known contributor to illness and mortality.

- BC relies on legislation and regulation to eliminate tobacco smoke from key settings:
  - The Act bans smoking in all indoor public/work spaces and within 3 metres of most public/workplace doors, open windows and air intakes and schools.
  - The *Motor Vehicle Act* bans smoking in cars with children under 16.
  - WorkSafe BC regulation limits second-hand smoke at work.
  - Residential Care Regulation bans staff smoking on-site/when supervising those in care.
  - Provincial policy requires children in care (foster children) to be in smoke-free homes.
- In settings where the provincial government does not have jurisdiction, the Province encourages the implementation of smoke-free premises policies:
  - Health authorities have smoke-free premises, with smoking restricted to designated areas.
  - Local governments may enact bylaws that further restrict smoking in public places, including parks. Some bylaws extend the smoke-free buffer zone around doors, windows and air intakes to 7 metres.
  - Multi-unit housing (e.g., condos, apartments) – Individuals can access the website Smokefreehousingbc.ca for information.

FINANCIAL IMPLICATIONS

- In 2015/16, the Ministry of Health allocated regional health authorities $1.175 million for tobacco enforcement (an increase of $500,000 from 2014/15).
- The Ministry also provided regional health authorities with $1 million in 2015/16 for tobacco cessation/prevention.
- The Ministry provided $2.1 million to the BC Lung Association for cessation services in 2014/15.
- From October 2011 to March 2017, Health Canada will fund call volume increases from the national 1-800 package change (Year 1 and 2 $308,000; Year 3 to 5 – up to $191,000).

Approved by:
Arlene Paton, Population and Public Health Division; January 28, 2016
Blair Boland, obo Manjit Sidhu, Finance & Corporate Services Division; February 3, 2016

[4] PharmaNet data, MoH, analysis by MBPSD POER, 2015

FACT SHEET

BC Clinical and Support Services Society

ISSUE

The BC Clinical and Support Services (BCCSS) Society was established in September 2015, to enable a new governance model for clinical (laboratory) and shared support/business (non-clinical) services in BC.

KEY FACTS

- On October 1, 2015, the *Laboratory Services Act* (LSA) came into force. The LSA enables centralized governance, strategic planning, and funding for all publicly-funded laboratory services across the Province.
- In April 2015, government approved the creation of an independent society operating under a newly appointed board and board chair, which will report to the Minister of Health.
- Effective September 25, 2015, the Shared Services Organization Administration Society was repurposed into the BCCSS Society with an expanded mandate (as per its constitution) to:
  a) Promote health in BC by coordinating, managing and/or providing clinical, diagnostic and support services to BC's health care system for the benefit of all users of its health care system;
  b) Promote health in BC by establishing and maintaining one or more divisions which shall have such purposes and responsibilities determined by the Society from time to time for the coordination, management and provision of clinical, diagnostic and support services to BC's health care system for the benefit of all users of its health care system;
  c) Set priorities, prepare and submit budgets to the Minister of Health and allocate appropriate resources for the provision of services under its responsibility; and
  d) Do all things incidental and necessary for the achievement of the above purposes.
- A transitional board of directors was appointed, including: the Deputy Minister of Health, Stephen Brown (as interim Chair), and the two Associate Deputy Ministers of Health, Sabine Feulgen and Lynn Stevenson (as interim Vice-Chair). Rick Roger was appointed Board Chair, effective April 1, 2016.
- The BCCSS is in the process of undertaking governance and planning functions with at least two separate divisions – each led by an Executive Lead:
  - A clinical division – housing the recently established Agency for Pathology and Laboratory Medicine, which is responsible for provincial planning of the laboratory services system under the new LSA; and
  - A support services division – responsible for support services currently managed by Health Shared Services BC (HSSBC), under the auspices of the Provincial Health Services Authority.
- The structure of the BCCSS is designed to support a clear separation of the governance and stewardship role from the delivery and consumption of services for both the laboratory system and the non-clinical services provided by HSSBC – a key issue identified in a 2014 review by Ernest & Young, which recommended alternate governance models to enable HSSBC to achieve its full provincial mandate. This structure is also supported by the BC Association of Laboratory Physicians.
- Additional services that are provincial in nature and could benefit from central oversight and planning could be added to the BCCSS in the future.

FACT SHEET

Agency for Pathology and Laboratory Medicine (APLM)

- The APLM will aim to ensure that clinical laboratory services are sustainable, quality driven and continue to innovate to support BC's citizens and clinicians with access to the best laboratory services.
- Over the next 12 months, the APLM will develop a strategic business plan for the long term shifts envisioned for laboratory services in BC.
- To support the introduction of new laboratory tests and the review of existing laboratory tests, the Ministry requested the APLM to develop and implement a test review process. This process is conducted by the Test Review Committee (TRC), a standing operational unit reporting to the APLM.
- Established in early December 2015, the TRC is responsible for reviewing, evaluating and making evidence-based recommendations regarding the introduction, replacement or elimination of publicly-funded clinical laboratory tests. The TRC's mandate includes making recommendations on outpatient/fee-for-service tests as well as inpatient tests, globally-funded tests and out-of-province laboratory tests.
- The APLM will submit TRC test recommendations to the Ministry for decision.

Support Services Division

- Effective April 1, 2016, BCCSS assumed responsibility for HSSBC. Status quo shared services provided by HSSBC to the health authorities (e.g. supply chain management, technology services and financial and employee services) transferred from the Provincial Health Services Authority to the BCCSS, including approximately 2,100 employees of HSSBC.
- HSSBC staff were informed about the new Society in early November 2015, and in January 2016 employees and union representatives were informed about the transition plan. There was no job loss as result of the move. BCCSS is a health sector employer and the transition between organizations was seamless with no changes to terms and conditions, job descriptions, pay scales, benefits, seniority or service.
- This Division, in collaboration with the Ministry and the health authorities, will be responsible for optimizing the efficiency and effectiveness of provincial support services within the BC health system.

FINANCIAL IMPLICATIONS

- The net new costs associated with the establishment of BCCSS as a new Society and the establishment of the Clinical Services Division, including the Agency for Pathology and Laboratory Medicine will be accommodated from within the existing Ministry and health authority budget allocations. The 2016/17 budget requirement for BCCSS is currently pending finalization.
- BCCSS will be required to adhere to the same accountability and reporting requirements as established by the Ministry for the health authorities, including annual service plan reporting.

Approved by:
Jane Crickmore, Laboratory, Diagnostic and Blood Services Branch, Health Sector IMIT; February 4, 2016
Deborah Shera, Health Sector IMIT & Diagnostic Services; February 4, 2016
Manjit Sidhu, Finance and Corporate Services Division; April 15, 2016

FACT SHEET

CST Project Update

ISSUE

The Clinical and Systems Transformation (CST) Project has completed its review and replanning process, and has launched its design phase, while also preparing for the first implementation at Lions Gate Hospital and other Vancouver Coastal "Sea to Sky" sites. The project budget remains $842 million, with a scope that better reflects the clinical goals of the project – an outcome of the learnings realized through the re-plan work undertaken over the last year.

KEY FACTS

- The Clinical and Systems Transformation project team completed their re-planning work in April, and are now designing the clinical information system, and developing consistent clinical practices and workflows across the three organizations (Vancouver Coastal, Provincial Health Services Authority and Providence Health Care).
- As part of the replanning work, the project team identified some necessary clinical improvements to the project. These elements include:
    - Enhanced oncology for cancer care.
    - Ambulatory Care.
    - Behavioural Health – i.e., mental health and substance use services.
    - Bedside Medical Device Integration – the seamless integration of data from vital sign monitors, so that nurses do not need to manually input this data.
    - Provider documentation – the original scope envisioned that doctors would continue to document patient notes on paper, while the rest of the patient chart was electronic, a clear deficiency that would increase risk to patients.
    - Physician voice-recognition dictation.
    - Added resources for learning and training.
- Implementation is scheduled to begin spring 2017 at the first sites – Lions Gate Hospital and Sea-to-Sky facilities – building on the opening the new Regional Pharmacy Production Centre scheduled for this fall 2016.
- This will be followed by implementation at the BC Cancer Agency.
- The sequencing of implementation at sites after BC Cancer will be refined, based on the learnings from the first sites – implementation is always an iterative process of adjusting and fine-tuning.
- This is a true "enterprise" solution, designed to establish common workflows and practices for all three organizations. This clinical transformation will be an ongoing process over the next year.

Chronology

- April 2013 – CST Project begins with IBM.
- March 2015 – Health organizations and IBM agree to end contract.
- April – September 2015 – Project reset completed, with assistance of PriceWaterhouseCoopers.
- July 2015 – Cerner retained as new project partner.
- October 2015 – Replanning phase initiated with Cerner.
- February 2016 – Design and Configuration work begins.
- April 2016 – Review and replanning work completed.

Key Highlights of the Project Refresh

- A governance structure that ensures accountability, transparency and proactive risk management;

FACT SHEET

- External advisors on the Project Board with relevant industry experience to help inform decision-making;
- A shift in responsibility for project management and project delivery from a contracted service provider to the health organizations;
- A new agreement with the project's software provider Cerner;
- A new external project assurance function for formal, objective project oversight;
- An improved approach to the design of clinical workflows and configuration of the new clinical information system;
- A comprehensive review of the project scope for alignment with the CST clinical goals and clinical workflow; and
- Review, refinement and validation of the CST clinical goals and objectives and alignment of workstreams with financial objectives.

Design and Configuration Process Improvements:

- A pre-configured system – the foundation for the continuation of design work will be Cerner's pre-built "Model System," a fully functioning prototype based on global best practices from Intermountain Healthcare, one of Cerner's leading clients.
- Seeing our work as we go – building on the Model System, our design teams will be able to map our requirements from the first phase of design and make progressive, iterative improvements throughout the design and configuration process.
- A clear and robust validation process – with the ability to create prototypes of our new system, we are better able to identify and fix problems before they are set in stone – making validation an ongoing part of our process.
- New program and specialty liaison roles – these clinical informatics resources will be an important point of contact between the design teams and the clinical programs and specialty areas of our health organizations, bringing a systemic view and helping facilitate the transformation from design through to implementation.

FINANCIAL IMPLICATIONS

- Based on the original Business Case, the total cost of ownership of the CST project, including both one-time costs and regular ongoing operating costs, was estimated to be $842 million over 10 years. This was comprised of project costs of $480 million capital expenditure and $77 million operating for a total of $557 million net new project costs, plus a $285 million base spend over the 10 year period, primarily existing IT budget for the legacy systems or replacement systems.
- Total spending to date up to the launch of the design phase in February 2016 is $177 million.

Approved by:
Paul Shrimpton, Health IT Strategy Branch; April 29, 2016

FACT SHEET

ePrescribing, eDrug and the PharmaNet Modernization Project

ISSUE

- The Ministry is responding to two recent FOI requests for information regarding expenditures on and the status of "ePrescribing".
- The term "ePrescribing" has sometimes been used as shorthand for either the eDrug Project, or both the eDrug and PharmaNet Modernization Projects even though it was only one of several technical enhancements included in each project.

KEY FACTS

- Implementing Electronic Prescribing functionality (ePrescribing) is a key action in the 2015/16 Service Plan and in the *Setting Priorities for the BC Health System* plan, and it is also prominently featured in the IM/IT Policy Paper. ePrescribing will improve patient safety and health outcomes, by putting better information about prescribed, dispensed and unfilled prescriptions in the hands of care providers at the time of prescribing across all points of care in the healthcare system.
- ePrescribing functionality allows physicians to view a patient's prescribed and dispensed medication history and electronically submit prescriptions. These electronic prescriptions will then be accessed by any community pharmacist in B.C. through PharmaNet.
- Enabling ePrescribing was one objective of the eHealth Drug Project initiated in 2006. The other objectives of the eDrug Project were:
  - expansion of access to PharmaNet medication profiles – to other care settings, and via wireless;
  - expansion of medication profiles to include clinically-relevant data such as medications provided in hospital, allergies and intolerances;
  - provision of enhanced clinical and financial decision support tools to providers (e.g. clinical references and guidelines; real-time processing of special authority requests); and
  - integration with the Electronic Health Record.
- In mid-2008 when the eDrug project requirements had been defined, the Ministry decided that the cost and complexity of the project were too high. A major re-planning effort was started; the technical approach and scope were re-designed, and the continuing scope of work was transitioned to a new PharmaNet Modernization Project (PMP). Some of the development costs incurred up to that date were subsequently written off.
- PMP continued to implement ePrescribing functionality, in addition to two other components of the eDrug Project – namely, the expansion of access to PharmaNet medication profiles, and integration with the Electronic Health Record.

<u>Project Current Status:</u>

- The Ministry recently responded to a Freedom of Information request for materials prepared which document the outcome or results of any pilot projects related to the use of ePrescribing technologies, and the number of providers currently utilizing ePrescribing technologies.
- Most of the foundational technical work for ePrescribing has been completed, but it is not currently deployed to physicians and pharmacists in the province. ePrescribing implementation and end-user adoption was not contemplated within the scope of either the eDrug or PharmaNet Modernization projects.
- Engagement with physicians, pharmacists and their software vendors will be required to complete planning for a Province-wide roll out of ePrescribing. There is currently no specific timeline for full roll-out.

- Adoption of ePrescribing will require change to clinical practice for physicians. A considerable change management effort will be required to encourage uptake. It will likely take several years for large numbers of physicians to begin writing ePrescriptions.

Expenditures to Date on ePrescribing

- The Ministry has recently responded to a Freedom of Information request for the amounts paid to contractors working on ePrescribing between 2008 and 2015. Because the individual components of each project were not separately tracked, it is not possible to provide a confirmed cost for ePrescribing alone.
- The Ministry responded to the request with an estimate of the eDrug and PMP costs for contracted labour, licenses, hardware and software purchases that may be attributed to ePrescribing. Because the eDrug Project has at times been referred to as the "ePrescribing Project", all eDrug expenditures, and approximately 90% of PharmaNet Modernization Project expenditures were attributed to ePrescribing.

FINANCIAL IMPLICATIONS

s.13

Approved by:
Guy Cookson, Business Management Office, Health Sector IM/IT; April 5, 2016
Deborah Shera, Health Sector IMIT Division; April 7, 2016
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; April 2016

[1] eHealth Capital Projects Discussion Paper, September 2015 (internal ministry document)

FACT SHEET

IM/IT Enabling Strategy

ISSUE

- The Ministry of Health released three cross-sector discussion papers in 2015 that identify key service improvements in primary and community care, surgical services, and rural health. A number of these service improvement opportunities leverage information technology.
- As information management and information technology (IM/IT) is a strategic enabler of the health system's priorities, the Health Sector *IM/IT Enabling Strategy* was developed to outline how IM/IT will support these service improvement areas.
- The *Strategy* provides the health sector and partnered health organizations with a single strategic direction for guiding IM/IT resourcing and investment.

KEY FACTS

- The *Strategy* identifies three strategic priorities and three strategic enablers that must be advanced in order to support the priorities of the health system.

Strategic Priorities

1. **Health Information Exchange Services (HIE)** – to ensure care providers have access to patient health information at the point of service, to make informed clinical decisions. Health Information Exchange Services will also put in place the building blocks needed to enable the secure electronic transmission of health information to patients.
    - Health Information Exchange Services is considered the top priority of the strategy.
    - A vision, action plan and roadmap has recently been completed for advancing HIE capabilities across the sector over the next few years.
2. **Data Sharing for Decision Support** – to improve the secure access and use of health information for decision-making purposes.
3. **Patient-Centered Information and Technology**– to establish strategies that will articulate how the health sector will leverage technology (including telehealth and patient portals or personal health records) to provide patient-centered care.

Strategic Enablers

1. **Health Information Standardization** – to lead the development, adoption, and governance of health information standards, which plays a critical role in improving the quality and consistency of the health data needed to inform policy, funding and care decisions.
2. **IM/IT Governance and Investment** – to establish a single governing body for health sector IM/IT with authority in areas deemed to be of common or shared interest.
3. **Health Shared Services** – to improve administrative cost effectiveness and enhance service quality for all health authorities.

- *The Strategy* recommends 22 key actions. These recommendations were discussed with health sector partners and stakeholders through an engagement process over the summer of 2015.
- Work is currently underway to develop an IM/IT Action Plan that identifies specifically how the *Strategy* will be advanced by the Ministry and the health authorities over the coming years.
- Leadership Council's Standing Committee on IM/IT (SCIMIT) provides overall governance for health sector IM/IT in areas of common or shared interest and is ultimately responsible for implementing the *Strategy* and the associated IM/IT Action Plan.

- SCIMIT membership is comprised of the ADM of Health Sector IM/IT, the Ministry of Health's Chief Information Officer, and the Chief Information and Chief Medical Information Officers for each of the health authorities. The committee also includes the Chief Executive Officer of the Doctors of BC, the Chief Nursing Officer for VCHA and the Vice President of Operations for VIHA.

FINANCIAL IMPLICATIONS

s.13,s.17

Approved by:
Paul Shrimpton, Health IT Strategy Branch; January 28, 2016
Deborah Shera, Health Sector IMIT Division; January 28, 2016

FACT SHEET

OAG Audit of Panorama

ISSUE

On August 13, 2015, BC's Office of the Auditor General (OAG) released a report on its audit of Panorama. The audit includes scope, budget and timelines for both the National Build project and BC/Yukon implementation projects, and includes extensive document requests and individual interviews both at the ministry and in the health authorities. The audit states that:

- Panorama is $86 million (420%) over what was budgeted at the project outset and is over 5 years late.
- It does not have all of the functionality required to achieve the stated benefits of the system.
- Health authorities continue to be concerned about its impact on patient safety and health authority costs.
- Panorama is not, and likely will never be, a pan-BC system.

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.
- Panorama is the 1st of its kind globally, and it was known from the outset that a project of this size and scope was not going to be easy. There have been challenges, which through strong provincial and national leadership have been actively addressed.
- As challenges emerged, the project assessed options and the Panorama national governance committee decided on the most prudent course of action. At times, this impacted project requirements, extended schedules, and increased budgets. Such decisions were made in collaboration with health authorities in BC and our partner's nationally; BC did not act alone.
- While it is not perfect, what we have now is a powerful tool that has set us up to successfully respond to public health emergencies.
- A recent evaluation report developed with more than 40 interviews with BC public health personnel that use Panorama tells us Panorama has demonstrated benefits and is a marked improvement to the previous system.
- It provides the foundation to better protect the health of British Columbians and Canadians.

OAG – Key Findings:

There are 4 recommendations in the report that attempt to address these issues:

1. Commission and independent review of Panorama and alternative systems to identify the most cost-effective integrated approach to meet the current and future needs of public health in BC. (Partially accepted by Ministry)
2. Review Ministry project management practices to ensure future IT projects are managed in accordance with good practice. (Accepted by Ministry)
3. Review Ministry contract management practices to ensure future IT projects are managed in accordance with good practice. (Accepted by Ministry)
4. Review its current leadership practices and develop a collaborative leadership strategy for future IT projects. (Accepted by Ministry)

The Ministry, through its engagement with the Public Accounts Committee has developed and is committed to delivering on an action plan designed to address the key short-comings identified through the audit, and ensure the OAG's recommendations have been met.

FACT SHEET

Response

- Panorama was an extremely complex multi-stakeholder, multi-jurisdictional project, designed to nationally agreed to requirements including standardized data, business processes and naming conventions.
- A National Steering Committee, including BC health authority and public health representatives oversaw the development of Panorama.
- BC is the 1st province to fully implement Panorama, and as such has led the way in addressing implementation issues.
- All major functionality has been delivered and avaliable for production use in BC while Public Health works through adoption and consistant use of the system.
- Significant benefit is now being realized by BC, including First Nations and Yukon.
- There is no alternative, comprehensive, fully integrated public health system available.
- Panaorama is a 1st generation (1st 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.
- Key components of the Ministry's action plan are in progress including:
    - Development of a 3-5 year Panorama business plan to address any functionality or design issues: consultant hired to lead the business plan development with a June 2016 targeted completion.
    - Undertake an annual survey of Panorama end users to assess satisfaction, clinical benefit and adoption: design of assessment methodology commenced with a planned Spring 2016 launch; results early summer. This will also be an input to the business plan.
    - Undertake an annual environmental scan to evaluate other compatible public health products: developing a robust, repeatable methodology to perform a comprehensive assessment beginning spring 2016.
    - Strengthen project management and delivery structure: the Project Management Office has been given a refrehed mandate to better support excellence in project management. Structure to be used to achieve best practise.
    - Achieve best practise - developed industry standard processes, gates, documentation and approvals which will be reviewed by external experts.
    - Expert validation:
        - completed competitive procurement and engaged Ernst & Young on December 15, 2015;
        - external review of Ministry practise in managing large IT initiatives covering governance, contract and project management practise; and
        - evaluating models for panel of experts and developing terms of reference.
    - Health Sector Governance has been revised to ensure increased stakeholder engagement in Health Sector decision-making.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Tracee Schmidt, Strategic Projects Branch, Health Sector IM/IT; February 4, 2016

Deborah Shera. Health Sector IM/IT Division; March 17, 2016

FOR INTERNAL USE ONLY

QUESTIONS AND ANSWERS

Panorama

Ministry of Health

- **Panorama is a national public health data management, assessment and reporting system that will aid the coordination of public health and communicable disease management across Canada.**
- **It provides public health professionals with the tools they need to better protect the health of British Columbians and Canadians.**
- **BC had a positive track record in development of public health surveillance systems in Canada – which is why the province was asked to take the lead on developing this project on behalf of the federal, provincial and territorial governments.**
- **This has been an exceptionally complex project that needs to provide the capability to manage vital public health information in each province and territory.**
- **All major functionality has been delivered and is available for production use in BC. Panorama was implemented in a phased approach, with the first module – vaccine inventory –in use in BC for the past five and a half years and the next two modules – immunization and family health –implemented across the province summer 2013. The last major modules, case and outbreak were deployed September 2014. Public Health is currently working on provincial Outbreak policies prior to fully adopting the module while ensuring consistent use throughout the system.**

1. **What is Panorama?**
    - Panorama is a national public health data management, assessment and reporting system that aids in the coordination of public health and communicable disease management in Canada.
    - It provides public health professionals with the tools they need to better protect the health of Canadians.
    - A cross-Canada public health surveillance system once achieved helps Canada manage outbreaks through early detection, rapid verification and appropriate response to emerging disease threats.
    - It is an integrated suite of public health components, consisting of five major modules and two supplementary modules:
        i. Vaccine and inventory management (main)
        ii. Immunization management (main)
        iii. Family health management (main)
        iv. Communicable disease case management (main)
        v. Outbreak management (main)
        vi. Work management (supplementary)
        vii. Notifications management (supplementary)

QUESTIONS AND ANSWERS

Where are we at in its implementation?

- Here in BC, we have been in production for the past five and a half years, beginning with the vaccine inventory module and are the first jurisdiction to implement the full suite of Panorama functionality, with the final two main modules having been deployed in September 2014.
- The project has also successfully transitioned to cHealth Operations at Provincial Health Services Authority ensuring ongoing sustainment of this key provincial asset
- Quebec has also implemented its vaccine inventory module and has completed its phased immunization deployment.
- Ontario has completed its immunization deployment and continues its deployment inventory management module.
- All other participating jurisdictions have components in production as well.

2. How much has it cost?

- There are two financial components to the implementation of Panorama – the initial national product and the customization and implementation of the modules at the provincial level.
- For the national Panorama project, Canada Health Infoway has committed to contribute a maximum of $47,615,922 to BC. To date, BC has received $44,448,729 of that amount.
- For the BC - specific Panorama modules, Infoway is committed to contribute $9,818,165. Of that, BC has received $8,269,926.
- Over an eight-year period, BC has invested approximately $130 million total. That funding has gone to:
    - Develop the BC - specific family health module;
    - Make significant product enhancements to ensure the system is tailored to BC and meets our unique clinical requirements;
    - Deploy the vaccine inventory module;
    - Replace, decommission and convert data from multiple previous systems;
    - Configure test and deploy the full set of Panorama modules;
    - Development of interfaces to other Health Sector assets including Client and Provider registries; Provincial Lab Information System; BEST Audiology System; PARIS and Cambian Scheduler.; and
    - Five years of full production operations and sustainment (resources, licensing, infrastructure etc.).

3. Why did BC shoulder the brunt of the costs up front?

- In recognition of our leadership in development of public health surveillance systems in Canada, BC was asked by the national steering committee to take the lead on the development and implementation of Panorama for federal, provincial and territorial governments.

- In that role, much of the initial implementer costs were borne by BC. However, that also means that we have been able to benefit from Panorama before other jurisdictions.
- In addition, our investment in Panorama is mostly complete. As other provinces and territories move to develop and implement their systems, they will begin to shoulder the financial cost.
- The benefits and enhancements that those jurisdictions make as they implement their systems will also be shared with BC, as the program is a single code base shared platform.

4. Why did it take so long to get up and running?

- This has been an exceptionally complex project that needs to have the capability to manage vital public health information in each province and territory.
- As a result of the complexity and the increasing technical requirements to meet the project's goals, it became apparent that the project would take longer than initially thought.
- However, all modules are now up and running in BC, benefiting the public health community, and we are continuing to move forward with a program of continuous improvement and prioritization in alignment with the Public Health Strategic Roadmap.

5. How do you know that our health data stored in Panorama is secure?

- All information contained in the system will be protected in accordance with provincial and federal protection of privacy legislation.
- Each jurisdiction will be required to assess and manage privacy risk and take reasonable steps to protect any personal information that may be contained on the system.
- BC has completed a detailed privacy impact assessment, and worked with the Privacy Commissioner to ensure that all questions have been answered and there are no privacy concerns – the Commissioner is comfortable with the steps taken and security of the system.
- The security capabilities of the system will enable each jurisdiction to configure an implementation that is in compliance with their legislation, policy, standards, procedure and best practices.
- The data governance model for Panorama recognizes patient ownership of the data with Health Authority's controlling access and with data custodian responsibilities resting with the Provincial Health Services Authority.

6. Is any of our data stored in the United States?

- All of the health data stored in Panorama is owned by Shared Services BC, and is kept in the same place as the rest of BCs health data.
- None of it is stored outside of Canada.

QUESTIONS AND ANSWERS

7. **Why doesn't Vancouver Coastal Health participate in Panorama, if the whole point is to have a coordinated, nation-wide data management system?**
    - Vancouver Coastal Health (VCH) uses its own community and public health application called PARIS.
    - PARIS was developed just prior to the SARS outbreak in 2003, before the development of Panorama was planned.
    - Vancouver Coastal Health had just invested significant financial resources into PARIS, and the program is used to manage both public and community health resources. For that reason, VCH was allowed to be "grandfathered in" to the Panorama program.
    - They continue to use their PARIS system; however, an interface has been implemented allowing VCH information on investigations and outbreaks to be shared with Panorama, to facilitate this important outbreak management component. An immunization interface will be implemented in the near future furthering Panorama as the provincial immunization repository.
    - In addition, VCH has implemented the inventory management module in a limited capacity.

8. **On August 13, 2015, BC's Office of the Auditor General (OAG) released a report on its audit of Panorama. What were the recommendations and what is the Ministry doing to address them?**
    - There are four recommendations in the report that attempt to address identified issues:
        - Commission and independet review of Panorama and alternative systems to identify the most cost-effective integrated approach to meet the current and future needs of public health in British Columbia. (Partially accepted by Ministry)
        - Review Minitry project management practices to ensure future IT projects are managed in accordance with good practice. (Accepted by Ministry)
        - Review Ministry contract management practices to ensure future IT projects are managed in accordance with good practice. (Accepted by Ministry)
        - Review its current leadership practices and develop a collaborative leadership strategy for future IT projects. (Accepted by Ministry)
    - The Ministry has developed and presented an action plan to the standing committee on public accounts which was accepted
    - Key components of the Ministry's action plan are in progress including:
        - Development of a 3-5 year Panorama business plan to address any functionality or design issues:
            - Consultant hired to lead the business plan development with a June 2016 targeted completion.
        - Undertake an annual survey of Panorama end users to assess satisfaction, clinical benefit and adoption:

    - Design of assessment methodology commenced with a planned Spring 2016 launch; results early summer. This will also be an input to the business plan.
- Undertake an annual environmental scan to evaluate other compatible public health products:
    - Developing a robust, repeatable methodology to perform a comprehensive assessment beginning spring 2016.
- Strengthen project management and delivery structure:
    - The Project Management Office has been given a refreshed mandate to better support excellence in project management. Structure to be used to achieve best practise.
- Achieve best practise:
    - Developed industry standard processes, gates, documentation and approvals which will be reviewed by external experts.
- Expert validation:
    - Completed competitive procurement and engaged EY on December 15, 2015.
        - External review of Ministry practise in managing large IT initiatives covering governance, contract and project management practise.
    - Evaluating models for panel of experts and developing terms of reference.
- Health Sector Governance has been revised to ensure increased stakeholder engagement in Health Sector decision making.

Approved by:
Tracee Schmidt, Strategic Projects Branch, Health Sector IMIT; February 2, 2016
Paul Shrimpton obo Deborah Shera, Health Sector IMIT; February 9, 2016

FACT SHEET

Ombudsperson's Ministry of Health Investigation

ISSUE

On July 29, 2015, the Select Standing Committee on Finance and Government Services issued the terms of Special Directions and referred the matter of the 2012 Ministry of Health terminations to the Ombudsperson for investigation and reporting[1].

KEY FACTS

- The Ministry is committed to co-operating fully with the Ombudsperson's investigation and taking all possible efforts to comply with the Ombudsperson's request for records.
- The Deputy Minister of Health has taken steps to ensure the preservation of electronic and paper records related to the Ombudsperson's investigation, including directing all Ministry staff to both not delete any related records, whether or not they are considered transitory, and to complete online records management training. Other actions include:
    - In 2015, the Ministries of Health, Justice (JAG), and Transformation, Innovation and Citizens' Services (MTICS) initiated a process to preserve both electronic and paper records either created or collected by the investigation team ("investigation team").
    - The Ministry retained custody and control of the investigation team's electronic records, which are preserved in compliance with various standards that support the management of recorded information. Complete copies of the electronic records are also now in the possession of JAG and MTICS.
    - For the paper records either created or collected by the investigation team, the Ministry embarked on a project to catalogue those records. The paper records are housed in a secure location at MTICS, and access to the records is closely monitored and strictly controlled. The Ministry and JAG developed a protocol regarding prior authorization to access records; sign-in procedure to access records; location of access; and, documenting the copying or scanning of records.
- On November 27, 2015, the Ombudsperson sent a request for records to the Ministry. The information requested includes the following categories:
    - Policy and background documents;
    - Employees/contractors/research organizations;
    - Whistleblower complaint;
    - Reviews and investigations;
    - Response to implementation of recommendations;
    - Data and information sharing; and
    - Other records.
- The Ministry has released portions of the requested documents to the Ombudsperson in batches and fulfilled the entire request by the end of January 2016.
- The Ministry made arrangements to allow the Ombudsperson direct access to the records located at MTICS and/or to facilitate their retrieval.

FINANCIAL IMPLICATIONS

N/A

[1] https://www.bcombudsperson.ca/sites/default/files/files/UPDATES/FGS_2015-09-09_Special%20Directions%20to%20the%20Ombudsperson.pdf

Approved by:
Mariana Diacu, Health Information Privacy, Security and Legislation Branch; January 25, 2016
Deborah Shera, Health Sector IM/IT and Diagnostic Services Division; January 25, 2016

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.13,s.17

Items	2013/14 Actuals Millions $	2014/15 Projection Millions$	2015/16 Projection Millions$	Total Millions$
Patient Level Attachment Fee Supports		s.13,s.17		
14074 Unattached Complex	5.68			
14075 Complex Care Expanded	4.35			
14076 Telephone fee	3.92			
14077 Conference fee	2.68			
Subtotal	16.62			
Divisions of Family Practice Supports	8.84			
Total	25.46			

Notes:

1. Patient Level Attachment Fee Supports:
   2013/14 Actuals - Workforce Analysis, Health Sector Workforce Division. MSP data from April 1, 2013 to March 31, 2014, paid to January 30, 2015.
   2014/15 & 2015/16 Projections - GPSC projections (based on Nov 28, 2014 data) presentation. Presented at January 2015 GPSC.
2. Divsions of Family Practice Supports:
   2013/14 actuals & 2014/15 & 2015/16 projections - GPSC A GP for Me 2015_2016 Budget_Final.xlsx/Summary by Year, presented at Feb. 2015 GPSC.

Approved by:
Doug Hughes, Health Services Policy and Quality Assurance Division; May 11, 2015
Manjit Sidhu, Finance and Corporate Services Division; May 8, 2015

FACT SHEET

Access to Surgical Services

ISSUE

Timely access to health services is a key concern for patients and service providers. The Ministry of Health has been working for several years to improve timeliness of access to scheduled surgery, especially for patients waiting the longest.

KEY FACTS

- The volume of all surgeries performed (scheduled and unscheduled) increased by approximately 8% between 2010/11 and 2014/15; the volume of scheduled surgeries performed over the same period decreased by 1.5%.[1]
- As at December 31, 2015, there were 74,128 adult cases on the waitlist for scheduled surgery. This has increased by approximately 3% since March 31, 2011.[2]
- In 2015/16 (to December 31, 2015), the median wait time for all adult completed, scheduled surgeries in BC was 6.7 weeks. This has increased by 1 week between 2010/11 and 2014/15.

Table 1: Median Wait Times (weeks) for All Completed, Scheduled Surgeries (Adult) 2010/11 - 2015/16[3]

Fiscal Year	BC	FHA	IHA	NHA	VCHA	VIHA
2010/11	5.7	7.1	5.9	5.3	4.3	6.1
2011/12	5.6	6.3	5.6	5.4	4.4	6.7
2012/13	5.3	5.6	5.4	5.3	4.1	6.7
2013/14	5.6	5.9	5.6	5.0	4.7	6.9
2014/15	6.1	6.3	6.7	4.6	5.6	8.0
2015/16 (to 31st Dec '15)	6.7	6.7	7.1	5.0	6.1	8.0

- In the Ministry of Health Service Plan, the target for 2015/16 for the percentage of scheduled surgeries to be completed within the maximum established benchmark wait time of 26 weeks is 93%. As of December 31, 2015, overall provincial performance against this target is 86%, a 5% decrease since 2010/11.[4]
- In 2013, the Ministry implemented the Pay for Performance program (P4P), a financial mechanism to incent improvement in the quality of patient care and the timeliness and quality of health care data. While P4P is currently on hold, P4P measures are still used to understand performance regarding access to surgical services.

Table 2: Health Authorities' Performance on P4P Measures Related to Access to Surgical Services

Performance Measure	BC	FHA	IHA	NHA	VCHA	VIHA
Fixation of Hip Fractures (as of Dec 31, 2015) **P4P target: Not less than 90% waiting < 48 hours** Actual % waiting < = 48 hours [5]	93%	94%	91%	76%	93%	95%
Patients on the SPR for surgery (as of Q3 2015/16) **P4P target: No more than 2% patient waiting for 52 weeks or longer** Actual % waiting >= 52 weeks [6]	3.6%	3.1%	3.7%	1.4%	1.2%	6.7%

- The percentage of patients whose hip fracture was fixed within 48 hours has increased from 89% (as of September 30, 2013) to 93% (as of December 31, 2015).[7] The percent of patients waiting

[1] 2014/15 Access to Surgical Services Factsheet, 2000/01 to 2014/15, October 22, 2015, Project #2015_0717
[2] Surgical Wait Times Standard Report, Cases Waiting by HA & Procedure Group, Jan 13 2016, Project # 2016_0027
[3] Surgical Wait Times Standard Report, Cases Completed by HA & Procedure Group, Jan 13 2016, Project # 2016_0027
[4] Percent of non-emergency surgeries completed within 26 weeks, 2010/11 – 2015/16, Jan 11 2016, Project # 2016-0029
[5] Percent of Hip Fracture Fixation Surgeries completed within 48 hours, Jan 13 2016, Project # 2016_0023
[6] Percent of Patients on the SPR waiting longer than 52 weeks for surgery, Jan 13 2016, Project # 2016_0022
[7] Percent of Hip Fracture Fixation Surgeries completed within 48 hours, January 13 2016, Project # 2016_0023

52 weeks or Longer for scheduled surgery has decreased in BC from 9.6% at March 31, 2013 to 3.6% at December 31, 2015.[8]

Areas of Special Mention

The First Ministers' Meeting funding to strengthen health care in key priority areas was discontinued in 2014. BC continues to monitor the priority areas related to surgical services:

- **Knee Replacement** - both the number of patients on the waitlist and the wait time have increased significantly in the past 3 years. Between March 31, 2013 and December 31, 2015 the number of patients waiting for this procedure increased from 4,195 to 6,857 (63%), and the median wait time for cases waiting increased from 12.7 weeks to 19.3 weeks (52%) for the same period.[9]
- **Hip Replacement** - both the number of patients on the waitlist and the wait time have increased significantly in the past 3 years. Between March 31, 2013 and December 31, 2015 the number of patients waiting for this procedure increased from 2,207 to 3,532 (60%), and the median wait time for cases waiting increased from 10.4 weeks to 15.1 weeks (45%) for the same period.[10]
- **Cataract Surgery** - both the number of patients on the waitlist and the wait time have increased significantly in the past 3 years. Between March 31, 2013 and December 31, 2015 the number of patients waiting for this procedure increased from 12,452 to 19,238 (54%), and the median wait time for cases waiting increased from 6.4 weeks to 12.1 weeks (89%) for the same period.[11]

Strategic Framework for Surgical Services

- In July 2014, the Provincial Surgical Executive Committee (PSEC) was formed to provide strategic oversight for the planning and improvement of surgical services in BC, as outlined in *Setting Priorities for the BC Health System*. In February 2015, PSEC published the policy paper, *Future Directions for Surgical Services in British Columbia*. In June 2015, PSEC drafted the *3 Year Plan for Surgical Services* which outlined the actions necessary to deliver on the vision in Setting Priorities and Future Directions, and this 3 year plan was approved by the Standing Committee on Health Services and Population Health in September 2015.

Additional Surgeries

- In June 2015, the government announced $10 million to increase surgical capacity throughout the province during 2015/16, to help clearing backlogs and focused on patients who have waited more than 40 weeks for surgery.
- As of December 31, 2015, approximately 5,000 additional surgeries have been performed. Of these additional cases, 27% had waited 40 weeks or more, with the remainder being cases that had waited beyond the provincial target of 26 weeks, or beyond the clinical wait time benchmark for their diagnosis/clinical condition. There was a wide variety of types of surgery performed; Of note, were cataract surgeries and total joint (hip, knee, shoulder) replacement.[12]

FINANCIAL IMPLICATIONS

N/A

Approved by:

Doug Hughes, Health Services Policy Division; February 1, 2016
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; February 12, 2016
Carolyn Bell, obo Teri Collins, Health Sector Information, Analysis & Reporting Division; February 24, 2016

[8] Percent of Patients on the SPR waiting longer than 52 weeks for surgery, Jan 13 2016, Project # 2016_0022
[9] Surgical Wait Times Standard Report, Cases Waiting by HA and Procedure Group, Jan 13 2016, Project # 2016_0027
[10] Ibid.
[11] Ibid.
[12] Self reported by Health Authorities to Acute Provincial Services Branch

FACT SHEET

Burnaby Centre for Mental Health and Addiction

ISSUE

- The Burnaby Centre for Mental Health and addiction (BCMHA) provides tertiary care treatment and support services for people with complex combinations of mental health, substance use, physical health, and behavioural problems for whom appropriate treatment is not available, or who are unable to benefit from existing community treatment and service options.
- The 2013 provincial action plan *Improving Health Services for Individuals with Severe Addiction and Mental Illness (SAMI)* announced enhancements to the BCMHA services and continuum of care, including the addition of 14 new rehabilitation and recovery beds and 14 new acute secure beds.

KEY FACTS

Background

- A sub-population of individuals have a complex mix of problematic substance use, mental illness, and physical health, behavioural and social problems that are of sufficient severity to challenge the traditional service delivery system. Mainstream mental health and substance use (MHSU) treatment and other forms of community health care are not effective for this client population, as their behaviour is so complex, inappropriate and chaotic.
- To address this issue, in 2008, the Ministry of Health, through the Provincial Health Service Authority (PHSA) and Vancouver Coastal Health Authority (VCHA), developed the BCMHA, a 100 bed facility in Burnaby to provide assessment, stabilization and treatment to this client population.

Care Model and Access

- The BCMHA is a designated facility under the *BC Mental Health Act* and provides an integrated clinical approach through an interdisciplinary team comprised of psychiatrists, physicians, nurses, occupational therapists, social workers, a pharmacist, a dietician, recreational therapists, a psychologist, MHSU support workers, art therapists, music therapists, acupuncturists, and a physiotherapist.
- The care model is aligned with evidence-based practices and includes pharmacological management, including methadone maintenance. Referrals are managed through a provincial access protocol and come from health and criminal justice systems across the province.

External Review and Program Improvements

- In 2010, an external review was undertaken in response to questions concerning the safety of the clients and the effectiveness of the program. Under VCHA, who was responsible for the BCMHA at that time, the program and facility saw significant improvements between 2011 and 2014. These include a new service delivery model; improved substance use treatment capacity; more extensive, evidence-based programming; and improved staff training, certification and bed-utilization.

Role in the SAMI Action Plan

- In November 2013, the Ministry announced the provincial action plan *Improving Health Services for Individuals with Severe Addiction and Mental Illness (SAMI)*, which included funding to expand the BCMHA continuum of care through the addition of 14 acute secure beds, and 14 community-based rehabilitation and recovery beds. (For further details, see the Fact Sheet entitled *Severe Addictions and Mental Illness Action Plan*).
- To support this continuum, operational governance of the BCMHA was transferred from VCHA to the PHSA on December 19, 2014.

FACT SHEET

- 74 beds are currently in operation at BCMHA on Willingdon Avenue in Burnaby – a 23 bed Acute Stabilization Unit and two treatment units, with a total of 51 beds.
- To accommodate a more severe client population within the BCMHA, the PHSA relocated 26 beds from the existing site to a new community facility operated by Coast Mental Health Society (Hillside/Brookside), as of November 2014. This new, 40-bed facility is comprised of 26 existing beds, plus the 14 new rehabilitation / recovery beds on the Riverview lands.
- The BCMHA has recently undergone capital upgrading to improve security and increase capacity to enhance treatment for those patients involuntarily detained under the *Mental Health Act*.
- In addition, the development of 14 new BCMHA high intensity beds were to be located in a new enhanced care unit; s.13

s.13

- The additional beds would provide a slightly lower intensity program than the enhanced care unit but would meet the overall needs of the SAMI population.

Future Relocation

- Sale of the Willingdon Lands closed March 21, 2014 as part of Release of Assets for Economic Generation program and will require the relocation of a number of existing provincial programs, including the BCMHA to new locations.
- Shared Services BC has negotiated lease back arrangements for the Willingdon Lands. There is a three year lease back for the BCMHA to March 31, 2017 with an option to extend the lease for two more years to March 31, 2019.
- The recent enhancements to the BCMHA will be incorporated into the plan to relocate the Centre.
- An Executive Steering Committee, including the Ministry, was established to ensure new accommodation meets the specific requirements for the programs relocating from the Willingdon Site.
- A capital business plan was submitted to the Ministry in June 2015 to replace the BCMHA and build a new 105 bed provincial, tertiary MHSU facility on the Riverview lands (owned by BC Housing). This was approved in November 2015.
- The new facility, which was publicly announced in December 2015, will be built over the next four years, with a targeted completion date of March 2019.
- In the interim, the BCMHA will remain at the current site until accommodation is finalized and a full transition plan is implemented. When a new site is finalized, the health authorities and health care staff will work closely with the patients and their families to develop a thorough transitional care plan that will ensure that patients receive consistent services.

FINANCIAL IMPLICATIONS

- The Ministry provides annual funding of $19.2 million to PHSA to support and operate the BCMHA and the 40 bed community facility located on the Riverview lands.
- Funding to relocate the Centre for Mental Health and Addiction is included in the Ministry's ten-year capital plan.

Approved by:
Doug Hughes, Health Services Policy Division; February 2, 2016
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; February 9, 2016

FACT SHEET

Child and Youth Mental Health and Substance Use Acute Care Services Review

ISSUE

The Ministry of Health has completed a review of mental health and substance use (MHSU) acute care utilization by children and youth aged 0-24 years. The review was conducted to better understand service utilization and pressures on the child and youth acute MHSU use acute beds based services.

KEY FACTS

- In April of 2013, the Representative for Children and Youth (RCY) released the report *Still Waiting: First-hand Experiences with Youth Mental Health Services in BC*. One of the recommendations in *Still Waiting* was to conduct an assessment of hospital acute care bed use for transition-aged youth in BC, and develop a plan to address unmet needs.
- In response to the RCY report and based on direction provided by Ministry strategic policy documents (*Setting Priorities* and *Healthy Minds, Healthy People*), a review was initiated in fall 2014 of acute care services for children and youth diagnosed with a mental health and/or substance use issue.
- The main objective of the review[1] was to conduct an assessment of hospital acute care utilization between 2009/10–2013/14, across the health regions, by individuals aged 0–24 years who had been discharged from hospital with a MHSU diagnosis.
- Scope of the project included assessing the number of MHSU visits by individuals, aged 0-24 years. The review looked at in-patient admissions and available data addressing access and flow.
- The review did not identify the number of unique individuals accessing hospital acute services. Nor did the review assess community based services including crisis services or the quality of clinical care provided.
- In total, 83 hospitals were included in the review. Of these, 80 are defined as Acute Care (Inpatient/ Residential care), 1 Rehabilitative Care (Sunny Hill), 1 Extended Care (Queen's Park); and 1 Psychiatric Care (Riverview–closed 2012). Of the 83 hospitals, 76 were identified to have an emergency department.
- The review was done by analyzing hospital use data from the Discharge Abstract Database (DAD). MHSU hospital use/visit was identified if an individual aged 0–24 years was discharged from the hospital, including some inpatient cases where the patients were kept in the emergency department until discharge due to bed shortage with a primary diagnosis of one of the following six DAD diagnostic categories: Anxiety, depression, schizophrenia, bipolar, substance use and "*other*" mental health problem.
- Diagnoses that are listed in the "*other*" category include general groups of: Intentional Self-Harm; Psychosis not including schizophrenia; Obsessive Compulsive Disorder; Reaction to stress, and Adjustment Disorders; Eating Disorders; Personality Disorders; Intellectual and Developmental Disorders; Attention Deficit Hyperactivity Disorders; Conduct Disorder; as well as an number of miscellaneous diagnoses that do not fall into general groups.
- Analysis of the data was conducted solely at a provincial level and based only on available data through the DAD. As a result, there are a number of limitations to the analysis such as the inability to identify the unique number of individuals using hospital acute care services, the number of repeat visits by an individual, and a lack of regional analysis.

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[1]BC Ministry of Health. Analysis of the Utilization of Acute Care Mental Health and Substance Use Services in British Columbia by Children and Youth (Description of results and recommendations). April 2015. **Discharge Abstract Database, Health Sector Planning and Innovation Division, Ministry of Health.** Project # 2015_0010 Filename: ***Hospital Services for BC MHSU Patients 0910 to 1314.xlsm***

FACT SHEET

Key Findings

- According to the analysis, there has been a significant increase in the provision of hospital-based services across all regions in BC.
- Hospital visits by individuals aged 0–24 years have increased 43% between 2009/10 and 2013/14; 33% if patients who were kept in the emergency department until discharge due to lack of beds are excluded.
- Findings indicate a sharp increase in hospitalizations, across specific diagnostic groups of depression, anxiety, and substance use. Hospital visits for depression have doubled. In contrast, hospital visits -for schizophrenia and bipolar disorder have remained stable. *"Other"* mentalh healthproblems account for the largest number of hospital visits at 40%.
- Despite the high volume of hospital visits associated with the *"other"* mental health problem category, between 2009/10–2013/14, hospital visits in this category have only increased by 28% compared to anxiety, depression and substance use with an increase of approximately 69%, 99% and 82% respectively. Of note, Schizophrenia has not increased, and Bipolar has increased by less than 5%.
- In terms of flow, 76% of all hospitalizations were initiated through emergency departments in 2013/14, with *"other"* mental health problems followed by substance use and anxiety as the most common presenting problems. Approximately a quarter of all hospital visits resulted in a discharge from the emergency department without being placed in an inpatient setting.
- In 2013/14, almost half (45%) of all hospitalization stays were between 1-7 days (suggesting stabilization and crisis management), with approximately 30% in hospital stays between one week and one month.
- As many as 85% of hospitalizations were coded in the DAD as discharged home while 12% were discharged to another health authority MHSU service.
- The ages ranging between 15–24 years shows a significant pattern of need compared to those under 15 years. In 2013/14, 83% were by individuals 15-24 years of age, compared to 17% by 0-14 years of age, and 88% of the in-patient cases kept in the emergency department until discharge were by youth aged 15-24, compared to 12% by 0-14 years of age. Also, the number of visits for anxiety and depression is highest in 15-19 year olds, with visits for substance use becoming more frequent in older age groups.
- Results of this review are consistent with a recent Canadian Institute of Health Information report, *Care for Children and Youth with Mental Disorders,* 2015, which analyzed hospital usage between 2006/07–2013/14 by individuals aged 5–24 years.
- Results of the review are being used to inform the development of a protocol, in partnership with the Ministry of Children and Family Development, to improve transitions between acute care services and community based care.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Doug Hughes, Health Services Policy Division; February 1, 2016

Carolyn Bell, obo Teri Collins, Health Sector Information, Analysis & Reporting Division; February 10, 2016

FACT SHEET

Child and Youth Mental Health and Substance Use Collaborative

ISSUE

The purpose of the *Child and Youth Mental Health and Substance Use Collaborative* is to increase the number of children, youth, and their families receiving timely access to integrated mental health and substance use services and supports in BC.

KEY FACTS

- In June 2013, the Ministry of Health, the Doctors of BC, the Ministry of Children and Family Development (MCFD), the Ministry of Education (MoE), the Interior Health Authority, and children, youth and families developed a *Child and Youth Mental Health and Substance Use (CYMHSU) Collaborative* to improve access to child and youth mental health, and substance use services.
- The *CYMHSU Collaborative* is based on an established "structured collaborative" change model[1] as a method of rapid, continuous quality improvement in health care, and brings together children and youth with lived experience, their families, care providers and decision makers, to address important local issues, while contributing to the larger regional and provincial picture.
- The *CYMHSU Collaborative* is governed by a multi-sector steering committee that includes: Family physicians; psychiatrists; pediatricians; health leaders; and representatives from health authorities; the Ministry of Health, MCFD, and MoE; Shared Care Committee (Ministry and Doctors of BC) and Local Action Team co-chairs (LATs - individual teams focused on system barriers at the local community level).
- The work of the *Collaborative* is conducted through three committees (Mental Health Clinical Faculty, Substance Use Clinical Faculty and Steering Committee) that guide the work of Working Groups (individual working groups focused on specific issues) and LATs.
- Youth and parents – through Families Organized for Recognition and Care Equality (FORCE) – participate and provide leadership to the *Collaborative* in all aspects from the Steering Committee, to Working Groups to LAT.
- To date all health regions across BC are members of the *CYMHSU Collaborative*. Island Health was the first region outside of the Interior Health region to join the collaborative, followed by Fraser, Vancouver Coastal, and Northern Health regions.
- The *CYMHSU Collaborative* now includes over 1,800 participants and LATs in 65 communities[2].
- Working groups, sometimes in conjunction with LATs, collaborate with the Steering Committee, Mental Health Clinical Faculty, and Substance Use Clinical Faculty to create solutions for both structural and clinical system issues such as: Emergency Department Protocol, Information Sharing, Physician Compensation, Transitions – Youth to Adult, Youth and Young Adult Services, Specialist Support, Physician Recruitment and Retention, Telehealth/Rural and Remote, Evaluation and Measurement, and Schools.
- LATs address issues relevant to their local communities, as well as the broader strategic vision. For example, the White Rock South Surrey (WRSS) CYMHSU LAT held an event entitled "Breaking the Silence on Suicide — Let's talk about Prevention" in response to a request from the community through MCFD. At the event, two youth shared their powerful stories, and Dr. Carol-Ann Saari, child psychiatrist and David Lindskoog from SPEAC (Suicide Prevention, Education and Counselling) shared their knowledge and expertise on different aspects of suicide prevention, including awareness of signs and symptoms, the importance of the

[1] http://www.ihi.org/resources/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx
[2] CYMHSU Collaborative January 2016 Update http://www.sharedcarebc.ca/sites/default/files/CYMHSU%20Bi-Annual%20Update%20Jan2016%20FINAL_0.pdf

multi-disciplinary mental health care team, and resources available in the community. The event had 68 attendees, including youth, parents, school personnel and community partners.

- In 2015 the *CYMHSU Collaborative* won a national award for recognition of innovation and team-work. The award is co-sponsored by the *College of Family Physicians of Canada* and the *Canadian Psychiatric Association*.
- Provincial policy documents provide stewardship and guidance for the Collaborative. In 2014, the Ministry released *Setting Priorities for the BC Health System*, outlining a number of priorities, including the need to strengthen the interface between primary and specialist care and treatment, as well as examine the role and functioning of the acute care system, with focus on driving inter-professional teams and functions with better linkages to community health care.
- More recently, the *Collaborative* is considering how to align their efforts with the Mental Health and Substance Use Policy Paper *Establishing a System of Care for People Experiencing Mental Health and Substance Use Issues* (October 2015) that identifies the need to provide an integrated system of care.

FINANCIAL IMPLICATIONS

- The *CYMHSU Collaborative* is supported by the Shared Care Committee, a joint committee of Doctors of BC and the Ministry of Health.
- As of March 31, 2015, in partnership with Doctors of BC, the Ministry has invested $4.4 million in the *CYMHSU Collaborative*.

Approved by:
Doug Hughes, Health Services Policy Division; February 2, 2016
Darryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; February 22, 2016

FACT SHEET

Child and Youth Mental Health and Substance Use System of Care

ISSUE

A new Inpatient Addition and Renovations at DCDH is one of the highest priority projects in the Children and youth (C&Y) with mental health and or substance use (MHSU) problems require access to a continuum of evidenced-based care ranging from prevention, health promotion, early intervention, primary and community care to specialized tertiary care services. The Ministry of Health, with partner organizations, are responding to the MHSU needs of this population.

KEY FACTS

- An estimated 70% of mental health problems in Canada have their onset during childhood or adolescence[1]. Research indicates that half of all cases of mental disorder begin by age 14, and three quarters by age 24, while half of all people with a substance use disorder will have experienced substance use issues before the age of 20[2].
- The Ministry , through regional and provincial health authorities, provides a range of C&Y MHSU services including: Promotion, prevention, primary care and specialized early intervention (e.g. Early Psychosis Intervention), tele-health for clinical and educational purposes, crisis response services, youth substance use treatment including withdrawal management and supportive recovery, youth concurrent disorders programs, and residential treatment. Health authorities also provide MHSU outpatient, acute emergency and inpatient care, specialized and tertiary level care for C&Y. The Ministry of Children and Family Development (MCFD) provides a range of community-based specialized mental health services to children and their families.
- In total, there are 142 C&Y MHSU beds in BC[1]. Of these, 63 are designated child and youth (generally ages 5-18), with 29 acute MHSU inpatient beds and 34 specialized tertiary MHSU beds. There are an additional 79 community based youth (generally ages 15 -18) substance use beds (20 residential treatment, 16 supportive recovery, 4 transitional, 36 withdrawal management, and 3 supportive housing).
- Approximately 130,000 C&Y (aged 0-25) in BC can be identified as having used MHSU hospital acute and emergency services, and physician through encounter billings in 2013/14; according to available data from the Discharge Abstract Database (hospital use), the Medical Services Plan database (physician visits), the National Ambulatory Care Reporting System (emergency department visits), and PharmaNet (prescription drugs). This does not include individuals who may have accessed additional non-acute services, community services, or emergency response services outside the emergency department offered through health authorities, nor services offered via contract or through MCFD.
- Approximately 50% of the 130,000 C&Y identified are between the ages of 0-18[3], with the remaining between the ages of 19-25.
- In April 2013, BC's Representative for C&Y released the report *Still Waiting: First Hand Experiences with Youth Mental Health Service in BC*, identifying the need to increase specialized emergency mental health services, improve clients' ability to navigate the system of care, increase capacity of primary care to address C&Y MHSU services, ensure MHSU services are more

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[1] Government of Canada (2006) The human face of mental health and mental illness in Canada.
Retrieved from http://www.phac-aspc.gc.ca/publicat/human-humain06/index-eng.php

[2] Kessler, 2005; Davis, 2003; Vander Stoep A. et al, 2000; Carter EW & Wehby JH, 2003.

[1] Mental Health and Substance Use (MHSU) Bed Survey. (September 2015). September 2015 submissions to Community Mental Health and Substance Use Bed Inventory, Business Analytics Strategies and Operations Branch, Health Sector Information, Analysis and Reporting Division, Ministry of Health. Project: 2015_0689

[3] Child and Youth Mental Health and Substance Use: Service Utilization in the Health Sector for Fiscal Years 2009/10 to 2013/14. Prepared by: Business Analytics Strategies and Operations Branch, Health Sector Planning and Innovation Division, MoH, March 30, 2015for the CYMHSU Collaborative

youth-friendly, and improve transitions between the youth and adult services, and between acute and community care.

- In 2014, the Ministry released *Setting Priorities for the BC Health System*, outlining a number of priorities including the need to strengthen the interface between primary and specialist care and treatment, and examine the role and functioning of the acute care system, focused on driving inter-professional teams and functions with better linkages to community health care. Individuals with mental health and/ or substance use issues, including children and youth, were identified as key population of interest.
- There are a number of initiatives underway across BC enhancing the child and youth MHSU serving system.
- The Ministry, in partnership with the General Practice Services Committee (GPSC), supported by the Doctors of BC, has implemented a number of initiatives to increase capacity of primary health care physicians and specialists to support C&Y with MHSU problems. Initiatives include the development and implementation of clinical practice guidelines for family physicians and specialists regarding early diagnosis, intervention and support of MHSU concerns for C&Y (18 years and under), and additional focused training sessions and knowledge exchange activities through the GPSC.
- In June 2013, the Ministry in partnership with the Doctors of BC, MCFD, and Ministry of Education, as well as patients and families developed a C&Y MHSU Collaborative to build cross-ministry and sector relationships and collaboration, to improve access for C&Y and their families to integrated services. Activities include the establishment of Information Sharing Guidelines, and facilitating the expansion of telehealth capabilities between MCFD and health authorities.
- On February 4, 2015 the Ministry and MCFD launched an online map to make it easier for children, youth and families to locate MHSU services. This map provides a "one-stop shop" for BC families trying to navigate the system of supports and services around BC.
- In 2015, the Ministry and MCFD worked collaboratively with health authorities to create a refreshed provincial youth to adult mental health transition protocol. The new protocol has been approved and is currently being implemented across the province.
- Currently, MCFD and the Ministry are developing a provincial protocol to promote effective transitions for children and youth between acute and community MHSU services. This work incorporates findings from an internal review of CYMHSU acute care services.
- Fraser Health is currently developing a Child and Adolescent Psychiatric Stabilization Unit (CAPSU) with an additional ten beds to be completed in the Spring of 2017.
- The Ministry in partnership with MCFD is also working to implement tools, guidelines and education for front-line staff to identify parents with mental illness and/or substance use and/or intimate partner violence concerns where children's safety is at risk, and to link family members to supports/services through a family-centered approach. In 2014 the initiative was expanded from 2 pilot sites to 20 locations. Province-wide implementation is planned for 2016/17.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Doug Hughes, Health Services Policy Division; February 2, 2016
Gord Cross, obo Manjit Sidhu, Finance and Corporate Services Division; February 9, 2016
Carolyn Bell, obo Teri Collins, Health Sector Information, Analysis & Reporting Division; February 9, 2016

FACT SHEET

Colon Cancer Screening Program

ISSUE

- Update on the Colon Screening Program which was launched in November 2013.
- Wait times for colonoscopies for both cancer screening and symptomatic patients have exceeded target. In February 2015, the Ministry initiated a service review into the provision of colonoscopy services in the province (see Fact Sheet Colonoscopy Service Review).

KEY FACTS

Background

- Colon cancer is the second 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[1].
- Screening has proven to decrease colon cancer incidence and deaths. If diagnosed at the earliest stage, the five-year survival rate is over 90%[2].
- The Colon Screening Program is for individuals ages 50-74 years with no symptoms.
- Screening can identify people who may have pre-cancerous lesions or polyps in their colon.
- After an abnormal fecal immunochemical test (FIT), a colonoscopy can provide early detection and allow for lesions/polyps to be removed, in some cases preventing the development of the disease entirely.
- The BC Cancer Agency is responsible for governance and oversight of the Colon Screening Program, which includes public awareness strategies, screening reminders and monitoring of overall program performance and outcomes.
- Family physicians are key influencers for patients in deciding to participate in cancer screening programs.
- The Colon Screening Program relies on health authority expertise for the effective delivery of pre-colonoscopy assessment, colonoscopies and pathology reporting.

Colon Screening Program Statistics/Quality Management

- Overall, 426,320 patients have been registered into the Colon Screening Program since November 2013[3].
- Of these, about 5,294 patients have been diagnosed with high risk polyps, and over 650 have been diagnosed with colon cancer and are being treated[4]. Many of these patients may not have been diagnosed as early if the screening program had not been put in place.
- Approximately 67% of 50-74 year olds having a FIT are registered in the Colon Screening Program[5]. Screening for colon cancer has approximately doubled since the introduction of FIT (from 53,742 guaiac tests January – March 2013 to 103,154 FITs January to March 2015)[6].
- Half of all Colon Screening Program patients with an abnormal FIT result are having their colonoscopy within 64 days (target is 60 days)[7].
- The BC Cancer Agency established a clinical working group that monitors the positive predictive value of the FIT, using BC program data. Reviews to date indicate that at least 50% of patients referred for colonoscopy due to having an abnormal FIT result are having adenomas, or cancer identified at the time of colonoscopy.

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[1] BC Cancer Agency, January 2016 - http://www.screeningbc.ca/Colon/GetScreened/GetScreened.htm
[2] BC Cancer Agency, January 2016 - http://www.screeningbc.ca/Colon/GetScreened/GetScreened.htm
[3] BC Cancer Agency, January 2016
[4] BC Cancer Agency, January 2016
[5] CSP Steering Committee program update from BCCA February 2015.
[6] Monthly report provided to HSD from Medical Services Plan billing data (PAS #2016_0007).
[7] BC Cancer Agency, January 2016

- 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.

Colonoscopy Services Review

- In February 2015, the Ministry of Health initiated a service review into the provision of colonoscopy services in the province, aimed at evaluating 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 sustainable provincial colonoscopy services, and develop associated implementation and evaluation strategies.
- The first phase of the colonoscopy service review was completed between February to October 2015, and focused on evaluating current service delivery system, identifying strengths and weaknesses, and proposing potential actions to strengthen the system.
- Work is now underway to move forward with a streamlined implementation phase that is anticipated to take place over the next 18 months. The second phase of work will focus on achievable targeted actions, including improvements in waitlist management, quality and standards, and data. Final projects are to be confirmed with the health authorities and partners.
- For more information on the service review, see Fact Sheet Colonoscopy Service Review.

FINANCIAL IMPLICATIONS

- The annual cost of the Colon Screening Program depends primarily on the level of patient participation.
- The program costs include fees for practitioners, specialists and laboratory medicine services that are paid through Medical Services Plan.
- 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 Division; February 2, 2016
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; February 9, 2016
Carolyn Bell, obo Teri Collins, Health Sector Information, Analysis & Reporting Division; February 11, 2016

FACT SHEET

Emergency Health Services in BC

ISSUE

Overview of emergency health services provided in BC. BC Emergency Health Services (BCEHS) has the legislated mandate to provide British Columbians with access to pre-hospital emergency health care.

KEY FACTS

- Under the *Emergency Health Services Act*, BCEHS has exclusive jurisdiction in BC over emergency health and ambulance services.
- Under the oversight of BCEHS, the BC Ambulance Service is the primary provider of pre-hospital emergency care and medically necessary transport (ground and air) for British Columbians. BCEHS also oversees the Patient Transport Network which coordinates the transfer of acute and critically ill patients to the appropriate level of care both within and outside of BC.
- The BCEHS Resource Allocation Plan guides BC Ambulance Service dispatch decisions regarding the number and type of emergency medical resources (paramedics, first responders) that respond to different categories of ambulance calls. BC's Resource Allocation Plan has been reviewed 5 times since 1997.
- BCEHS has conducted a demand modelling study which finds its current service model unsustainable in terms of providing best practice in patient care. It predicts an annual 6% increase in demand for ambulance services in metropolitian areas from now until 2020.
- An Action Plan based on this research identifies a range of inititatives BCEHS will undertake to reduce response times, improve patient care, and ensure the sustainability of the service into the future.
- A business case addressing the resources required to improve the sustainability of BCEHS is being submitted to the Ministry of Health.
- In the interim, BCEHS added 8 ambulances and 34 FTEs in January 2016, to be based at ambulance stations in Langley, Surrey, Abbotsford and North Vancouver.

Ambulance Services

- In 2014/15, BCEHS paramedics responded to over 545,000 patient events, including more than 446,000 9-1-1 medical emergencies and 96,000 inter-facility patient transfers.
- An ambulance crew is dispatched to a patient event in BC, nearly every minute of the day.
- BCEHS paramedics respond to medical emergencies throughout the province, covering nearly 950,000 square kilometers, with a ground fleet of 599 vehicles (520 ambulances and 79 support vehicles).[1]

Air Ambulance Services

- The provincial air ambulance program provides critical transportation between hospitals and health care facilities across BC for patients requiring a higher level of care. In 2015 the air ambulance program responded to 6,758 air ambulance calls.[2]
- There are 4 dedicated helicopter air ambulances in the province: 2 in Vancouver, 1 in Prince Rupert, and 1 in Kamloops.
- 6 fixed-wing air ambulances are based in Vancouver, Kelowna and Prince George. BCEHS also utilizes approximately 40 charter carriers (both airplanes and helicopters) as required.

[1] BCEHS internal databases as of January 2016
[2] BCEHS internal databases as of January 2016

FACT SHEET

Community Paramedicine (CP)

- The CP program will utilize paramedics in an expanded role to improve access to health services for people living in rural and remote communities in BC.
- The program will provide various community-based services and resources including providing primary care in the home, health prevention, evaluation, referral, and advice.
- Government has committedto creating at least 80 new FTEs to support the implementation of community paramedicine programs between April 1, 2015 and March 31, 2019.
- The CP initiative has been rolled out in nine communities across BC so far.

First Responder Agencies

- First Responder services are an important element for the provision of pre-hospital care in BC, and the partnership between BCEHS, fire departments and other agencies in responding to emergency events is essential.
- All first responders performing emergency health services are required to be licensed by the Emergency Medical Assistant Licensing Board.
- First Responder agencies (local volunteers and professional fire departments) provide first responder services and basic life-saving techniques, while awaiting the arrival of an ambulance.
- Some municipalities have chosen to have first responders attend both urgent and routine (non-emergency) calls, while others have first responders attend only urgent calls.
- BCEHS is reviewing the current pre-hospital care model to determine the best way to integrate first responders in order to meet the needs of patients across BC.
- BCEHS participates with Metro Vancouver municipal stakeholders in the Regional Administrative Advisory Committee, which is working to define the role of first responders in medical emergencies.
- Local governments determine how to best allocate their funding and resources in terms of responding to calls.
- BCEHS announced a program in January 2016 that makes naloxone available to all paramedics and fire first responders in BC for opioid drug overdose emergencies. Fire departments in Surrey and Vancouver were the first to sign the necessary consent agreemen; 14 other fire departments have expressed interest since the announcement.

Collective Agreement

- BCEHS employees are represented by 3 unions – CUPE, BCGEU, and the BCNU.
- BCEHS is the employer for the Ambulance Paramedics of BC (CUPE Local 873).
- The Facilities Bargaining Association's Collective Agreement (BCGEU and CUPE 873) was ratified as of April 1, 2014, and will expire March 31, 2019.
- The Health Employers Association of BC and the Nurses Bargaining Association continue to negotiate for a renewed collective agreement.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Doug Hughes, Health Services Policy Division; February 1, 2016
Jodi Jensen, BCEHS; February 17, 2016

FACT SHEET

Expansion of Hospice Spaces by 2020

ISSUE

- In December 2015 the Minister updated Cabinet on the Strong Economy, Secure Tomorrow commitment to double the number of hospice spaces in the province by 2020, as indicated in the June 2015 mandate letter[1].
- This update reflected the work to date since the 2013 and 2014 mandate commitments to create a plan for hospice expansion, work with Treasury Board and the Ministry of Finance to develop a plan for hospice expansion[2], and double the number of hospice spaces in BC by 2020.

KEY FACTS

Hospice Spaces Baseline Measures

- The baseline measure for hospice beds is 375 beds. As of March 2015 it consisted of 87 acute/tertiary palliative care unit beds; and 288 community hospice beds.

Status to end of April 2016

- 27 community hospice and 2 acute/tertiary beds have been added to the bed total. The updated total number of beds is 404 beds – 315 community and 89 acute/tertiary.
- In 2015, 8 beds were opened in the Vancouver Island Health Authority (4 beds in Comox - completed July 2015; and 4 beds in Parksville - completed September 2015).
- In 2015/16, the Northern Health Authority increased the number of hospice beds by 11 beds through designating 9 community hospice and 2 acute/tertiary as palliative/end of life care beds.
    - Community Hospice Beds are in (1 bed in each location): Fort St. James; McBride; Fort Nelson; Chetwynd; Mackenzie; Smithers; Kitimat; Massett; Queen Charlotte City.
    - Acute/Tertiary Palliative Beds are in Fort St. John and Prince Rupert (1 bed at each location).
- In April 2016, the Fraser Health Authority opened 10 beds in Abbotsford at Holmberg House.

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[1] Government of BC. (2015). *Minister of Health Mandate Letter*. Retrieved on July 9, 2015 from http://www.gov.bc.ca/premier/cabinet_ministers/terry_lake_mandate_letter.pdf

[2] Government of BC. (2014). *Minister of Health Mandate Letter*. Retrieved on September 29, 2014 from http://www.gov.bc.ca/premier/cabinet_ministers/terry_lake_mandate_letter.pdf

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- Health authorities are also required to involve stakeholders (such as hospice societies) in their activities related to hospice spaces service planning.

Home-based Palliative Care Services

- Research increasingly suggests that Canadians prefer to die at home, or in their home communities instead of in hospital settings.
- Health authorities are working towards improving home-based palliative care services by adopting an integrated palliative approach to care.
- In this shared-care model, expert palliative care teams based in residential hospices, hospital palliative care units or in the community support local care teams, and share the care.
- An integrated palliative approach can be provided in all settings in the community where the person lives or is receiving care, including in the primary care provider's office, at home, in long-term care facilities, in hospitals, in free-standing hospice residences (often simply called hospices), and in urban, rural and remote settings, including Aboriginal communities.
- For example, in the Fraser Health Authority the End-of-Life Program in partnership with residential care developed and implemented a 4-hour educational workshop, integrating a palliative approach in dementia care, across all health authority owned and operated sites.

FINANCIAL IMPLICATIONS

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Approved by:
Doug Hughes, Health Services Policy Division; April 26, 2016

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 of Health struck a provincial steering committee, with involvement from all health authorities, to guide the development of the response.
- The initiative is being implemented in three phases over 3 fiscal years: Phase 1 (2014/15), Phase 2 (2015/16), and Phase 3 (2016/17).

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- As of March 31, 2016, 220 new substance use beds have been created through this initiative (76 were created in Phase 1 and 144 in Phase 2), or 44% of the total 500 bed target.
- Starting in April 2016, the Ministry implemented new bi-monthly monitoring processes to ensure that health authorities reach their bed targets by March 31, 2017. Monitoring efforts allow for the tracking of progress and the identification of any necessary alterations to health authority plans.
- Health authorities provided their first bi-monthly monitoring report on April 1, 2016. The next update is expected by June 1, 2016.
- The Ministry committed to provide bi-monthly progress reports on the provincial status of the initiative to the health authorities. The first progress report is expected to be provided to the health authorities by April 30, 2016.
- Throughout this initiative, the Ministry and health authorities have engaged with the non-profit sector and the First Nations Health Authority in the planning and implementation of the new spaces. This engagement will continue in Phase 3 (2016/17).
    - Of the 220 beds opened in Phase 1 and 2, 135 (61%) are being delivered in partnership with non-profits (36% of Phase 1 and 75% of Phase 2 beds).
- The proportion of substance use beds required to be created and implemented in each regional health authority was determined by the Ministry's Population Needs Based Funding model percentage allocations.
- Health authorities identified their high priority/immediate bed needs (i.e. bed type and location) for Phase 1 based on analysis of existing and previously completed planning processes.
- Health authority planning for Phases 2 and 3 was informed by the results of an extensive needs based planning process conducted by the Centre for Addiction Research BC 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.
- Specifically, health authority planning for Phases 2 and 3 has been informed by:
    - Current utilization and substance use trend data;

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- 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.

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- "Space" is defined as quantifiable bed-based substance use treatment/intervention services that are either directly provided by or funded (in part or all) by the health authorities.
- 'Bed-based' services considered in-scope include sobering and assessment, facility-based withdrawal management/detox, stabilization, residential treatment, supportive recovery, and tertiary level services.

Table 1: Number and Percentage of Beds Opened and Planned by Health Authority, as of March 31, 2016

Health Authority	Total Target	Phase 1 2014/15	Phase 2 2015/16	Total number and percent of beds opened for Phase 1 and Phase 2		Phase 3 2016/17
		Opened	Opened	Number opened	Percent of target	Number to reach target
Vancouver Island	93	16	39	55	59%	38
Vancouver Coastal	131	17	55	72	55%	59
Fraser	147	8	38	46	31%	101
Interior	85	16	0	16	19%	69*
Northern	30	5	12	17	57%	13
Provincial Health Services **	14	14	N/A	14	100%	N/A
Total	500	76	144	220	44%	280

** IHA bed number to reach target is 69; however, IHA will be opening 73 beds in phase 3. This is account for bed closures in previous phases.*

*** While PHSA was not originally included in the 500 bed commitment, PHSA opened 14 beds as part of the Severe Addictions and Mental Health (SAMI) Action Plan. These 14 beds are counted toward the overall 500 bed commitment and have been removed from regional Health Authority allocations according to the Population Needs Based Funding model formula.*

FINANCIAL IMPLICATIONS

s.13,s.17

Approved by:
Doug Hughes, Health Services Policy Division; April 26, 2016

FACT SHEET

Large Scale Staff Replacement

ISSUE

Local media reports have claimed that mass turnover through the change from one contracted service provider to another negatively influences the quality of services provided to residents in residential care facilities.

KEY FACTS

- The Ombudsperson launched an investigation of seniors' care in 2008, and publicly released The *Best of Care: Getting it Right for Seniors in British Columbia (Part 2)* on February 14, 2012. This report resulted in 176 recommendations on seniors' care.
- One of the recommendations outlined by the Ombudsperson's report is as follows: "The Ministry of Health works with the health authorities to develop safeguards to ensure that seniors in residential care are not adversely affected by large-scale staff replacement." (R170)
- To address this recommendation, the Ministry of Health developed a new policy (Policy 6.K, Large-Scale Staff Replacements) which is included in the Home and Community Care Policy Manual to ensure that the quality and safety of client care is maintained during a large scale staff replacement.
- Large scale staff replacement is defined in the policy as mass staff turnover through the change from one contracted service provider to another, or through a change in ownership.
- Health authorities must ensure service providers plan and manage the change process for clients where a service provider is planning a large scale staff replacement, consistent with the following requirements:
    - Ensure that maintenance of the quality and safety of the client's care is the priority throughout the process;
    - Provide the client with information about the upcoming change;
    - Offer clients and families an opportunity to meet with service provider staff to identify the key concerns in the changeover in staff; and
    - Ensure that the staff replacement does not happen until all clients are informed, and have had an opportunity to have their concerns heard.
- The policy was introduced on April 1, 2015 and applies to all publicly subsidized residential care facilities, both health authority owned and operated and contracted.

FINANCIAL IMPLICATIONS

N/A

Approved by:
Doug Hughes, Health Services Policy Division; February 1, 2016
Reviewed by Health Sector Workforce Division; February 4, 2016

FACT SHEET

Physician Assisted Dying

ISSUE

In February 2015, the Supreme Court of Canada (SCC) ruled in Carter v. Canada that the blanket prohibition against physician-assisted dying (PAD) set out in the *Criminal Code* is unconstitutional.

KEY FACTS

- The SCC declared that competent adults may obtain assistance to die from a physician when they clearly consent to the termination of life, and have a grievous and irremediable medical condition that causes enduring suffering that is intolerable to the person.
- The SCC indicated that the risks associated with PAD could be mitigated through a carefully designed and managed system of safeguards.
- The ruling was originally suspended for 1 year; however, following a petition to the SCC, federal, provincial and territorial governments were granted an additional 4 months to develop a regulatory regime, albeit with exceptions.
  - Quebec is exempt from the extension. Residents of Quebec may avail of PAD in accordance with existing provincial legislation.
  - From February 6, 2016 until June 6, 2016, individuals residing in the rest of Canada may access PAD via an application to their jurisdiction's superior court (e.g. the Supreme Court of BC).
- After June 6, 2016 sections of the Criminal Code (246(b) and 14) are void in so far as they prohibit PAD for those that meet the Carter criteria.

Challenges related to Federalism

- The development of a regulatory regime is complicated by the constitutional division of powers.
- The *Criminal Code* is within the jurisdiction of the federal government; however, jurisdictional overlap exists on matters related to health.
- The legislative and policy implications for provinces and territories will be significantly impacted by outstanding federal government decisions.
- The federal government is expected to solidify its position following the release of the final report of the Special Joint Committee on Physician Assisted Dying on February 26, 2016.
- Although Quebec has legislation that allows for physician-administered assistance in dying for capable adults, the impacts on the Quebec framework are dependent on the federal government's actions.

Special Joint Committee on Physician Assisted Dying

- On December 15, 2015, the newly elected federal government created a Special Joint Committee on Physician Assisted Dying.
- The Committee began hearings on January 18, 2016 and is mandated to consult experts and Canadians, and make recommendations on a federal response to PAD.
- The provincial/territorial (P/T) Expert Advisory Group on PAD and the Federal External Panel who have authored recent reports on PAD have both appeared before the Committee (see below for additional information on these bodies).
- The Committee's final report is expected on February 26, 2016.

P/T Expert Advisory Group on Physician Assisted Dying

- On August 14, 2015, participating jurisdictions appointed a nine member P/T Expert Advisory Group on PAD to provide non-binding advice to P/T ministers of Health and Justice on implementation within their respective jurisdictions.

FACT SHEET

- BC participated as an observer and was represented by Dr. Doug Cochrane, Chair of the BC Patient Safety and Quality Council.
- The Advisory Group's Final Report was publicly released on December 14, 2015.
- The 43 recommendations contained in the report are more permissive than the minimum requirements set out by the SCC. For example, it is recommended that access to PAD be based on decision-making capability, not a minimum age requirement for adulthood.

The Federal External Panel

- The 3-member External Panel was created on July 20, 2015 and mandated to consult Canadians and key stakeholders in order to recommend options for a federal legislative response to the Carter decision.
- At the request of the new federal government, the final report did not contain recommendations but instead provided an overview of consultations.
- The Panel's report was publicly released on January 18, 2016.

The College of Physicians and Surgeons of BC

- On January 21, 2016, the College approved interim guidance for physicians on PAD. The guidance is effective as of February 6, 2016.
- This guidance includes procedural safeguards that ensure basic eligibility criteria are met and vulnerable individuals are protected. These include a requirement that no less than 2 physicians assess a patient for eligibility; a 15 day waiting period to demonstrate a settled intention; as well as, guidance on when additional assessments are required to confirm capability and consent.
- Physicians with objections of conscience will not be forced to provide PAD related services, or provide a direct referral to another physician who provides the service.
- Physicians are to facilitate an effective transfer of care in a non-discriminatory manner (e.g. record transfer at the request of the patient) and provide sufficient information to patients to allow for informed choices.

The BC Select Standing Committee on Health

- On October 28, 2015, BC's Select Standing Committee on Health issued an Interim Report with recommendations on PAD.
- The Committee recommended that PAD be incorporated into the continuum of health services, including hospice and palliative care, was supportive of conscientious objections and direct patient referrals, and supported national harmonization of PAD services.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Doug Hughes, Health Services Policy Division; February 2, 2016

Holly Moulton, Operations Manager, IGR & Legislation; February 4, 2016

FACT SHEET

Provincial Approach to Dementia Care and Priorities

ISSUE

The Ministry of Health has been building on the 2012 *Provincial Dementia Action Plan for BC,* and continuing to work on improving care for people with dementia and their families through development of Seniors Services: A *Provincial Guide to Dementia Care in BC.*

KEY FACTS

- In 2013/14 there was an estimated 60,000 people with dementia in BC.[1]
- The impact of dementia will continue to grow as the proportion of seniors in BC increases over the next 10 to 15 years.
- In 2012, the Ministry released the *Provincial Dementia Action Plan* that outlined priorities for improved dementia care through health system redesign work aimed to support effective, appropriate, person-centred care for people with dementia. Notable achievements include the following:
    - Updated HealthLink BC, SeniorsBC and Home and Community Care websites and print resources with information on brain health, planning for healthy aging, and living with dementia.
    - Provided funding to support the expansion of the Alzheimer Society of BC's First Link® program. First Link® provides connections to learning, services and support to over 12,500 individuals diagnosed with dementia and their families in over 70 BC communities.
    - Provided funding for education of health care professionals in the P.I.E.C.E.S.™[2] dementia care program (Physical, Intellectual, Emotional health, Capabilities, Environment, Social self), which provides a systematic framework for detection, assessment and care planning using a person-centred approach. As of December 2015, over 1,500 health care providers had received training in P.I.E.C.E.S.™ across 226 facilities.
    - Implemented the 48/6 Model of Care for hospitalized seniors in our hospitals and all acute inpatient care settings. The 48/6 model focuses on screening and assessment in 6 key care areas, including cognitive functioning, and the development of a personalized care plan in 48 hours.
    - Supported research through a new BC Alzheimer's Research Award and the Djavad Mowafaghian Centre for Brain Health.

<u>Guide to a Provincial Approach to Dementia Care</u>

- To meet population and patient health needs, the Provincial Guide to Dementia Care in BC provides a comprehensive approach to the dementia journey, from diagnosis to end of life. It identifies priorities and actions for improving dementia care, builds on the 2012 Action Plan, and places dementia patients, their families and caregivers at the centre, as the overall approach to health care is becoming more patient-centric. Care for people with dementia and their families is being integrated into the redesign of services for seniors to ensure a coordinated approach that supports people to live safely in their homes for as long as possible, and remain supported in their communities.

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[1] *Source: Population Health Surveillance and Epidemiology, B.C. Ministry of Health, December 2014.* The Ministry uses data indicating the prevalence of Alzheimer's/dementia in a population. In 2013/2014 there were 59,551 individuals (not including the patients whose gender was unknown) with a diagnosis of Alzheimer's/dementia.The number used by the OSA (50,747) appears to represent the number of Alzheimer/dementia patients that were alive at the end of the fiscal year.

[2] http://www.piecescanada.com/

FACT SHEET

- The release of the Guide will be aligned to assist health authority planning for seniors service redesign over the next 3 years. Implementation is to be phased in.
- Priorities identified in the Guide are as follows:
  1) Increase public awareness and early recognition of cognitive changes;
  2) Support people with dementia to live safely at home for as long as possible and support caregivers;
  3) Improve quality of dementia care in residential care including palliative and end-of-life care; and
  4) Increase system supports and adoption of best practices in dementia care.
- 2 key priority actions already underway include:
  - Provincial Strategy to Address Wandering (also referenced in the Fact Sheet on Missing Seniors) – with actions that span from prevention through to the safe return of a person who has wandered. This strategy includes the following:
    - New resources for people with dementia and their families to prevent wandering from occurring;
    - A best-practice toolkit to prevent wandering within, and from, residential care settings;
    - Resources to help community members identify a person who has wandered, including resources to assist in their safe return; and
    - Resource information about dementia and common wandering behavior for police to assist in the location and safe return of someone who has wandered.
  - Renewal for a further 3 years of the provincial license for the P.I.E.C.E.S.™ dementia care education program (also referenced in the Fact Sheet on Resident to Resident Aggression) - an educational approach focussing on assessment and management of challenging behavioural and psychological symptoms of dementia. The renewed license extends the ability of the province to adapt this dementia care training to other areas of the health care system, in addition to residential care and tertiary mental health.

FINANCIAL IMPLICATIONS

- In March 2016 the Ministry renewed its licence for the P.I.E.C.E.S.™ dementia education program for a second 3-year term (2016–2019), renewing the Ministry's existing 2013–2016 license purchased in March 2013 (at a cost of $91,956 for each term).
- Funding of $25,000 was provided to each regional health authority for P.I.E.C.E.S.™ dementia care training sessions for health care providers in fiscal 2012/13, and a further $50,000 has been provided to each regional health authority for the 2013/14 and 2014/15 fiscal years.
- The Ministry and the Provincial Health Services Authority have provided a total of $10.7 million to the Alzheimer Society of BC's First Link® program to support individuals and families affected by Alzheimer's disease and dementia. (See Fact Sheet on First Link).

Approved by:
Doug Hughes, Health Services Policy Division; April 26, 2016

FACT SHEET

Renewal of Healthy Minds, Healthy People

ISSUE

Update on the renewal of the *Healthy Minds, Healthy People: 10 Year Plan to Address Mental Health and Substance Use in BC* (*Healthy Minds, Healthy People*).

KEY FACTS

Background

- In 2010, the Province released *Healthy Minds, Healthy People;* a guiding document for mental health and substance use services and policies in BC.
- During the May 2015 Estimates debate, the Minister of Health committed to reviewing *Healthy Minds, Healthy People* and posting a refreshed plan.
- In 2015 a newly formed Cabinet Working Group on Mental Health, chaired by Minister Rich Coleman, was created to and is currently taking stock of government's existing mental health programs and services, and developing a cross-system response to this challenging issue.
- This response will build on the significant and positive work already underway, including Ministry of Health plans and initiatives, to address mental health in BC, and consider how we can work in a more integrated way to do things better.

Progress and Current Status

- On October 8, 2015, the Ministry of Health released *Establishing a System of Care for People Experiencing Mental Health and Substance Use Issues*, a draft policy direction paper for the Ministry and health authorities.
- This paper proposes an integrated provincial mental health and substance use (MHSU) system of care, building from a strong primary and community care system with clear, patient-centred pathways to higher levels of care. (See System of Care Fact Sheet for more detail).
- The policy direction articulated in this paper represents the strategic direction and priorities for the MHSU system for the next 3 years, and will build on the work done to date through *Healthy Minds, Healthy People*, as well as the 120 day action plan to support the severely addicted and mentally ill (SAMI) population, and sets the strategic direction and priorities for the MHSU system for the next 3 years
- This paper is currently being refreshed based on feedback from health authorities and other system partners; once finalized, the paper will be posted on the Ministry's website.
- The MHSU system of care is a key component of the Ministry's strategic agenda, which identifies five areas for significant repositioning:
    - Improve access to primary care through a primary care home model;
    - Reduce demand on hospitals by improving care for systems;
    - Reduce demand on hospitals by improving care for those with mental health and substance use issues;
    - Improve access to surgical services and procedures; and
    - Improve delivery of rural health services.

Alignment with Other Sectors

- The MHSU system of care policy document describes the immediate priorities and policy direction for the health care system to better support patients and families experiencing mental health and substance use challenges.
- Going forward, this work will align with other key sectors and Ministry partners, including the work with Children and Families and Education to review and define child and youth mental health services.

- Additionally, Ministry and health authority efforts to improve care and access for patients and families will support cross-government deliberations, with respect to mental health through the Cabinet Working Group on Mental Health and associated ADM Working Group.

During the plan's first 4 years, 3 of 6 of six Milestones were met:

- **Milestone 3:** "by 2014, 10% **fewer** BC students will first use alcohol or cannabis before the age of 15" - our Ministry has **met and exceeded** this milestone: in 2013, of students who reported using alcohol and cannabis, only 65% had tried alcohol before age 15 (compared to 2008 baseline of 75%) and only 59% had first tried cannabis before age 15 (compared to baseline of 67%).[1]
- **Milestone 4:** "The proportion of British Columbians 15 years of age or older who engage in hazardous drinking will be reduced by 10% by 2015" – our Ministry has **met** this milestone a year early: in 2012, 23.1% of British Columbians reported hazardous drinking (i.e., above the Canadian Low-Risk Alcohol Drinking Guidelines), down from a baseline of 25.6%.[2]
- **Milestone 5:** "By 2015, the number of British Columbians who receive mental health and substance use assessments and planning interventions by primary care physicians will increase by 20%" – our Ministry has **met and exceeded** this Milestone: 98,750 assessments were completed by 2014; an increase of over 69% from the baseline of 51,033 assessments in 2009.[3]

Other Key Accomplishments

- The BC Healthy Connections/ Nurse Family Partnership program has engaged 180 vulnerable young families to date; a number that will grow to about 1,000 families over the next 18 months as the evaluation continues.[4]
- The Canadian Mental Health Association, BC Division offers a telephone-based service for parents and caregivers of children ages 3 – 12 with mild to moderate behaviour problems. Funded by the Ministries of Children and Family Development and Health, this coaching model teaches parents skills to manage their children's behaviours.[5]
- Through the Practice Support Program, 2,400 GPs have been trained using evidence-based guidelines for adult mental health (1,600), and child and youth mental health (800).[6]
- A Mental Health and Substance Use Forum was held on October 8, 2015.
- The policy objective on specialized mental health services has been confirmed and built into governance and planning expectations.

FINANCIAL IMPLICATIONS

- The Ministry of Health provided a total of $5.75 million in one-time funding in 2013/14 and beginning in 2014/15, allocated base funding of $20.25 million to health authorities to respond to the health needs of individuals with severe addictions and mental illness as part of the 120 Day Action Plan.
- The mental health and substance use sector operating expenditures for 2014/15 were approximately $1.42 billion, an increase of 67% over the 2000/01 total of $851.4 million.

Approved by:
Doug Hughes, Health Services Policy Division; April 26, 2016

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[1] Smith, A., Stewart, D., Poon, C., Peled, M., Saewyc, E., & McCreary Centre Society (2014). From Hastings Street to Haida Gwaii: Provincial results of the 2013 BC Adolescent Health Survey. Vancouver, BC: McCreary Centre Society

[2] Kate Vallance, Analyst, Centre for Addictions Research of BC, personal communication, January 20, 2014

[3] Data Source: Workforce Analysis, Health Sector Workforce Division, BC Ministry of Health. Data from January 1, 2014 to December 31, 2014, paid to December 31, 2014 and Data from January 1, 2009 to December 31, 2009, paid to December 31, 2009

[4] Donna Jepsen, Provincial Coordinator, Nurse Family Partnership Program, Ministry of Health, personal communication, April 27, 2015

[5] Julia Kaisla, Director Community Engagement, Canadian Mental Health Association- BC Division, personal communication, Oct 8, 2014.

[6] As of February 1, 2015. Liza Kallstrom. Doctors of BC, personal communication, Feb 24, 2015

FACT SHEET

Resident to Resident Aggression

ISSUE

Residents with cognitive impairment, such as dementia, may exhibit physical aggression as part of their disease process, and this behaviour may be directed towards other residents.

KEY FACTS

- Over 60%[1] of people living in residential care settings have dementia, and approximately 90% of people with dementia experience behavioral and psychological symptoms of dementia, such as aggression, agitation, and psychosis (delusions and hallucinations)[2].
- Residential care facilities balance the need to keep people safe with the human need for social interaction, freedom of movement and the routine of everyday life, including recreational opportunity and shared meals.
- Community care facilities licensed under the *Community Care and Assisted Living Act* (CCALA) and designated extended care and private hospitals regulated under the *Hospital Act* are responsible for reporting instances of aggression between persons in care to health authorities. Under each Act, definitions and reporting requirements differ somewhat.
- The Ministry receives quarterly reports from the health authorities on a number of data elements, including aggression between persons in care in facilities licensed under CCALA.
- The data received is the number of confirmed incidents by type of care (i.e., child day care, child/youth residential, mental health and long term care). Only confirmed incidents in licensed adult community care facilities, and designated extended care and private hospitals are reported in the tables below.

CCALA - Long Term Care

On December 1, 2013, the Residential Care Regulation (CCALA) was amended to add a reportable incident of "aggression between persons in care." The amendment ensured that aggression between persons in care would be reported as a separate incident, as previously these were included under the broader category of "aggressive or unusual behaviour" (behavior by a person in care towards another person in care that causes an injury that requires first aid, emergency care by a medical practitioner or nurse practitioner, or transfer to a hospital).

Health Authority	# Confirmed Incidents	# of Facilities
Fraser	52	64
Island	135	85
Interior	46	67
Northern	21	13
Vancouver Coastal	106	47
TOTAL	**360**	**276**

All information has been provided by health authority Community Care Facility Licensing (CCFL) programs for calendar year 2015

Hospital Act – Extended Care and Private Hospitals

- Under the Hospital Act Regulation, extended care and private hospitals designated under the *Hospital Act*, facilities are required to report "serious adverse events" to the Minister. A "serious adverse event" means an incident that:
  a) Took place in a hospital or private hospital;
  b) was the likely cause of, or likely significantly contributed to, severe harm to or the death of a patient;

[1] https://www.cihi.ca/en/quick-stats
[2] https://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1191

c) was not expected or intended to occur; and
d) was not caused by or related to an underlying medical condition of the patient.

Health Authority	# Confirmed Incidents	# of Facilities
Fraser	Not collected	26
Island	157*	22
Interior	9	18
Northern	5	12
Vancouver Coastal	15	24
TOTAL	**84**	**102**

All information has been provided by health authority Community Care Facility Licensing (CCFL) programs for calendar year 2015. * Island Health numbers include events with no harm, if excluded there are 55.

- In October, 2012, the Ministry released the Best Practice Guideline for Accommodating and Managing Behavioural and Psychological Symptoms of Dementia in Residential Care, A Person-Centered Interdisciplinary Approach. This guideline supports interdisciplinary, evidence-based, person-centered care to those experiencing behavioural and psychological symptoms of dementia.
- Health authorities are increasing awareness and training for staff on the care of people with complex physical and cognitive/mental health needs, and behaviour changes. The P.I.E.C.E.S.™ training program, available across all health authorities, provides staff with strategies to manage the behavioral and psychological symptoms of dementia. The P.I.E.C.E.S.™ program works to reduce the risk of aggressive behaviours between patients. Over 1,500 health care providers have received P.I.E.C.E.S.™ training across 226 facilities (residential care and tertiary mental health settings).
- A provincial strategy to address wandering is currently underway, and includes development of a best-practice toolkit to prevent wandering in residential care settings (which can be a contributing factor to aggressive behaviour between residents of a care facility). The toolkit is under development with completion anticipated Summer 2016. The Province is in the process of finalizing Seniors Services: A Provincial Guide to Dementia Care in BC, which builds on the 2012 Provincial Dementia Action Plan. The Guide includes priorities to improve the quality of dementia care in residential care facilities, as well as increasing system supports and best practices in dementia care.
- In alignment with the ministry's priority to better meet the needs of older adults, the Guide will include:
    - Standards of care that will guide the transition to residential care, should it be needed.
    - Steps to enhance dementia-specific quality standards of care in residential care.
    - Increase and sustain consistent dementia care training for health care professionals and caregivers – including cultural competency training – in all care settings.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Doug Hughes, Health Services Policy Division; April 26, 2016

FACT SHEET

Seniors' Information

ISSUE

The Seniors' Health Promotion team in the Ministry of Health develops and disseminates information about government programs, services and initiatives for seniors through a suite of print and web based resources. The information is designed to help seniors and those who care for them make informed decisions about care, to plan for healthy aging, and to understand how to navigate the system of care and supports for seniors in BC.

KEY FACTS

- In 2012, 32% of Canadian Internet users aged 65 and over used social networking sites, and 25.5% used the Internet to make telephone calls online.[1]
- In 2012, 56% of British Columbians aged 65 and over reported having used the Internet for personal non-business use in the past 12 months from any location.[2]
- In 2012, 61.9% of Canadian Internet users aged 65 and over used the Internet to search for medical or health-related information.[3]

Background

The Ministry has made ensuring access to high quality information about programs and services for seniors a priority. However, this is also an ongoing challenge, and has been identified as a major need by many seniors and experts; e.g.,.Premiers' Council on Aging and Seniors' Issues-2006; Ombudsperson's 2012 report on seniors' care; and Office of the Seniors Advocate's (OSA) March 2015 report, *BC Seniors Survey: Bridging the Gaps*, which indicates low awareness of seniors' programs, especially among low-income seniors, older seniors, and seniors in the north).

SeniorsBC.ca Website

Seniors, families and caregivers can easily access information about government programs, services, supports and benefits for older adults by visiting www.SeniorsBC.ca. The website is updated regularly to ensure accuracy and timeliness of information. The website provides information about provincial and federal government programs, services and benefits for older adults, including the following:

- Downloadable versions of resources such as the *BC Seniors' Guide, BC Elders' Guide, Healthy Eating for Seniors* handbook, the *My Voice* advance care planning guide and workbook, Elder Abuse Prevention Information kits, and Planning for Healthy Aging tools;
- Promotion of events such as World Elder Abuse Awareness Day, Seniors' Week, and the International Day of Older Persons; and
- Links to information and resources such as the OSA website, the new Aging Well section of www.HealthyFamiliesBC.ca, which encourages older adults to plan for a healthy older age, and home and community care (e.g., care and support options; how to access health care services; criteria for publicly subsidized services; accountability for health, safety and quality of care; and how to have concerns and complaints addressed).

BC Seniors' Guide and other publications

- Many older adults do not use the Internet to access information, and the Seniors' Health Promotion team and the OSA continue to receive requests for print resources. Other seniors embrace technology and increasingly make use of devices such as laptops, tablets and e-readers.

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[1] Statistics Canada. *Table358-0153 - Canadian Internet use survey, Internet use, by age group, Internet activity, sex, level of education and household income, occasional (percent),* CANSIM (database).

[2] Statistics Canada. *Table358-0152 - Canadian Internet use survey, Internet use, by age group and household income for Canada, provinces and census metropolitan areas (CMAs), occasional (percent),* CANSIM (database).

[3] *Ibid.*, 1

To reach as many seniors as possible, the Seniors' Health Promotion team produces print and electronic versions of key publications such as the *BC Seniors' Guide, Healthy Eating for Seniors* handbook and Elder Abuse Prevention Information kits, which are all available in English, Chinese, Punjabi and French.

- An updated 11th edition of the *BC Seniors' Guide* was recently completed, and this edition is now available in English, with translated versions expected by late spring 2016. In response to OSA's March 2015 *Bridging the Gaps* report, the latest edition of the *BC Seniors' Guide* highlights programs and services of particular interest to seniors with lower incomes. In addition, a new free e-book version has been developed (in English only), and is compatible with e-readers such as Kobo and Kindle. E-books can also be read on tablets, laptops, desktop computers and other devices. Free individual print copies of the *BC Seniors' Guide* are available by calling the OSA, toll-free at 1 877 952-3181, or 250 952-3181 in Greater Victoria. PDF and e-book versions can be downloaded at www.gov.bc.ca/seniorsguide.

Promotion and Distribution

In addition to the SeniorsBC website and print material, information resources are promoted to seniors and the public in a variety of ways to increase access and awareness across the province. Those avenues include the following:

- SeniorsBC e-Newsletter;
- HealthLinkBC.ca and 8-1-1;
- Office of the Seniors Advocate;
- Crown Publications Online Catalogue;
- HealthyFamiliesBC Twitter account;
- BC Public Libraries;
- Community-based events such as the BC Elders Gathering; and
- Other government and non-government partners, including Service BC, Service Canada, MLA offices, health authorities, seniors' groups and community agencies.

FINANCIAL IMPLICATIONS

- In 2014/15, the cost to reprint the *BC Seniors' Guide* was approximately $65,000.
- The new (11th) edition of the *BC Seniors' Guide* is estimated to cost approximately $500,000 in 2015/16.

Approved by:
Doug Hughes, Health Services Policy Division; February 1, 2016

FACT SHEET

2015/16 to 2017/18 Service Plan Measures – Ministry of Health

ISSUE

Outlining the five Ministry of Health Service Plan measures and the targets for fiscal year 2015/16, year-to-date performance results and whether the targets are met based on partial data.

KEY FACTS

1. *Percent of communities that have completed healthy living strategic plans.* "Communities" include cities, districts, municipalities, towns, townships, and villages. The measure focuses on the proportion of 162 communities in BC that has developed healthy living strategic plans.

Baseline (2011/12)[1]	2015/16 Target	2015/16 Actual[2]	Target Met
13%	45%	51%	Yes

2. *The percentage of B.C. students in grades 3, 4, 7, 10 and 12 who report that at school, they are learning to stay healthy.* This is a new performance measure for the Service Plan but is part of BC's Guiding Framework for Public Health. The Ministry, in partnership with health authorities and school districts, supports a number of targeted programs which provide comprehensive health resources for teachers and schools.

Baseline (2013/14)[3]	2015/16 Target	2014/15 Actual[4]	Target Met
46%	48%	44%	No

*The results from this indicator are obtained from the Ministry of Education's School Satisfaction Survey. As the survey is conducted between January to April of a calendar year, actual results for the 2015/16 year will not be obtained until the survey period is concluded and the results are analyzed. The actual results above represent the survey conducted during January-April, 2015.

Health authority staff have had limited opportunities to work with education partners to teach health subjects in the classroom. However, the Ministry of Education is in the process of redesigning the Kindergarten to grade 12 education curriculum, which will include a new physical and health education subject area. The Ministries of Health and Education are working with the regional health authorities to enhance resources and regional health-education partnerships that will support teachers in effectively delivering this new curriculum.

3. *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)[5]	2015 Target	2015 Actual[6]	Target Met
65% (calendar year)	80%	74%	No

The year-to-date data up to November 30, 2015 shows that the 2015/16 target is not being met. However, over the three years of the A GP for Me initiative, 77% of physicians participated[7] in the program representing more than 12% points above the baseline. The lack of growth in participation during the last year of the initiative may have been impacted by uncertainty related to funding beyond the initiative's original end date of March 2016 (incentive funding for 2016/17 was just announced December 2015). Moreover, the leveling off of physician participation in A GP For Me is consistent with the trend seen in participation in the use of the General Practice Services Committee incentive fees.

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[1] Data source: Healthy Living Branch, Population and Public Health, Ministry of Health

[2] Data up to September 30, 2015

[3] Data source: Satisfaction Survey, Knowledge Management Branch, Knowledge Management and Accountability Division, Ministry of Education.

[4] The results from this indicator are obtained from the Ministry of Education's School Satisfaction Survey. As the survey is conducted between January to April of a calendar year, actual results for the 2015/16 year will not be obtained until the survey period is concluded and the results are analyzed. The actual results above represent the survey conducted during January-April, 2015.

[5] Data source: Business Analytics Strategies and Operations Branch, Health Sector Information, Analysis & Reporting, Ministry of Health.

[6] Data up to November 30, 2015

[7] Data source: Workforce Analysis, Health Sector Workforce Division, Ministry of Health. Data is paid up to September 30, 2015.

4. *Percent of people admitted for mental illness and substance use who are readmitted within 30 days.* This is a new performance measure in the 2015/16 – 2017/18 Service Plan. With the release of *Healthy Minds, Healthy People*, a clear vision was established for addressing the complexities of mental illness and substance use. The measure focuses on the effectiveness of community-based supports to help persons with mental illness and substance use issues receive appropriate and accessible care and avoid readmission to hospital. Central to this effort is building a strong system of primary and community care which enhances capacity and provides evidence-based approaches to care.

Baseline (2013/14)[8]	2015/16 Target	2015/16 Actual[9]	Target Met
14.6%	13.8%	14.7%	Yes

This is a new service plan performance measure, established with aggressive targets, designed to focus on the effectiveness of community-based supports to help persons with mental illness and substance use issues receive appropriate and accessible care and avoid readmissions to hospital. Central to this effort is building a strong system of primary and community care which enhances capacity and provides evidence-based approaches to care. The results for this performance measure will continue to be monitored as the Ministry and health authorities begin to implement specific actions to support effective primary and community supports for this population group.

5. *Percent of scheduled surgeries completed within 26 weeks.* The measure includes all elective adult and pediatric surgeries.

Baseline (2013/14)[10]	2015/16 Target	2015/16 Actual[11]	Target Achievement
90%	93%	86%	No

The year-to-date second quarter data shows that 2015/16 target was not met. However, there has been a focus across the province to serve patients who have been waiting longer periods for their scheduled surgeries. For example, Vancouver Coastal and Northern Health reduced the number of patients waiting more than 52 weeks to just over 1% while Interior Health has reduced the number of patients waiting over 52 weeks from 5.1% during the first quarter of 2015/16 to 3.7% during the third quarter. Overall, during the first two quarters of 2015/16, more than 15,000 completed surgery cases were for those who had waited longer than 26 weeks, up from 13,000 cases recorded in the same period in 2014/15.

FINANCIAL IMPLICATIONS

N/A

Approved by:
Teri Collins, Health Sector Information, Analysis and Reporting Division; February 9, 2016

[8] Data source: Business Analytics Strategies and Operations Branch, Health Sector Information, Analysis and Reporting Division.
[9] Data for the quarter ending June 30, 2015
[10] 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 9, 2015 (Site 142).
[11] Data up to September 30, 2015

FACT SHEET

2015/16 to 2017/18 Service Plan Measures - Provincial Health Services Authority

ISSUE

Outlining the Provincial Health Services Authority (PHSA) service plan measures and the targets for fiscal year 2015/16, and whether the targets are achieved.

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)[1]	2015/16 Target	2015/16 Actual[2]	Target Met
51.4% (BC rate)	55.5%	52.4%	No

During the last five years, the mammography participation rate has declined slightly as questions continue to arise relating to the value of screening. 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)[3]	2015/16 Target	2015/16 Actual[4]	Target Met
31%	34%	32%	No

The target set by the BC Renal Agency and the renal network is aggressive, considering the significant barriers and drivers faced, as well as the annual attribution rate of patients on all forms of dialysis, including independent dislysis. As a result, the independent dialysis prevalence rate continues to be impacted by a number of factors, including an increase in transplant rates and the overall reduction in dialysis growth, leading to a corresponding reduction in independent dialysis update. Of note, this rate continues to be well above the national average of 22% for independent dialysis, according to the 2014 Canadian Organ Relacement Registry Report.

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

Baseline (2010/11)[5]	2015/16 Target	2015/16 Actual[6]	Target Met
42%	70%	92%	Yes

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

Baseline (2013/14)[7]	2015/16 Target	2015/16 Actual[8]	Target Met
26%	45%	44%	No

The percentage of admission within 45 minutes for active laboring patients was 30% for the 2014/15 year and has increased to 44% during the 2015/16 year. The BC Women's Hospital

[1] Mammography: Screening Mammography Program of BC, Provincial Health Services Authority. 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.
[2] Data up to December 3, 2015
[3] Data Source: BC Renal Agency, Provincial Health Services Authority
[4] Data for the quarter ending December 3, 2015
[5] BC Children's Hospital Database, Provincial Health Services Authority.
[6] Data up to December 3, 2015
[7] Data Source: BC Women's Hospital and Health Centre Database, Provincial Health Services Authority.
[8] Data up to December 3, 2015

continues to implement improvement initiatives that are being applied to further improve patient flow.

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

Baseline (2010)[9]	2015/16 Target	2015 Actual[10]	Target Met
2.24% (calendar year)	*Maintain at or below 3.3*	3.4%	No

Data for the third quarter shows that the 2015/16 targets are not being met. Although the annual overtime rate is showing slight upwards trending during the last three years, the annual rate for PHSA remaints the lowest among the health authorities in BC. However, a detailed review of nursing areas is being conducted.

FINANCIAL IMPLICATIONS

N/A

Approved by:
Teri Collins, Health Sector Information, Analysis and Reporting Division; February 9, 2016

[9] Data Source: Ministry of Health. Based on calendar year. Health Sector Compensation Information System (HSCIS). Health Employers Association of British Columbia (HEABC). January 14, 2016.
[10] Data is for quarter ending September 30, 2015

FACT SHEET

2015/16 to 2017/18 Service Plan Measures – Regional Health Authorities

ISSUE

Outlining the 5 regional Health Authority Service Plan performance measures, the targets for 2015/16, and the performance status. The targets established for 2015/16 and year-to-date actuals achieved are below.

KEY FACTS

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

Baseline (2011/12)[1]	2015/16 Targets	2015/16 Actual[2]	Target Met
IHA: 0%	IHA: 42%	IHA: 42%	IHA: Yes
FHA: 40%	FHA: 60%	FHA: 80%	FHA: Yes
VCHA: 23%	VCHA: 43%	VCHA: 64%	VCHA: Yes
VIHA: 14%	VIHA: 42%	VIHA: 36%	VIHA: No
NHA: 15%	NHA: 47%	NHA: 59%	NHA: Yes

All 5 health authorities achieved the target for this performance measure during 2014/15. While Island Health has not, to date, reached the 2015/16 target , the anticipated addition of the Strathcona Health Network into this initiative should result in Island Health meeting its target by the end of the year.

2. *Number of people with a chronic disease admitted to hospital per 100,000 people aged 75 years and over:* This is a new performance measure. It tracks the number of seniors with select chronic conditions who are admitted to hospital. "Chronic disease" includes chronic conditions such as Asthma, Chronic Obstructive Pulmonary Disease, Epilepsy, Heart failure and Pulmonary Edema, Angina Hypertension, Heart Disease and Diabetes.[3]

Baseline (2013/14)[4]	2015/16 Targets	2015/16 Actual[5]	Target Met
IHA: 3,536	IHA: 3,504	IHA: 3,788	IHA: No
FHA: 3,388	FHA: 3,352	FHA: 3,374	FHA: No
VCHA: 2,697	VCHA: 2,690	VCHA: 2,223	VCHA: Yes
VIHA: 2,735	VIHA: 2,728	VIHA: 2,295	VIHA: Yes
NHA: 4,129	NHA: 4,089	NHA: 4,592	NHA: No

Data for the 1st quarter shows that the 2015/16 targets are not being met. The complexity of this population, gaps in community based services for chronic disease management and patient difficulties navigating the services are some of the challenges identified by health authorities to meet these targets. However, in order to improve services, all health authorities have identified strategies including enhancing primary care and community based services, improving discharge planning and post-acute follow up, and working more closely with the Divisions of Family Practice to address the specific needs of this population.

3. *Percent of people admitted for mental illness and substance use who are readmitted within 30 days, 15 years of age or older:* This is a new performance measure. It focuses on the effectiveness of community-based supports to help persons with mental illness and substance use issues receive appropriate and accessible care and avoid readmission to hospital. Central to this effort is building a strong system of primary and community care which enhances capacity and provides evidence-based approaches to care.

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[1] Data Source: Healthy Living Branch, Population and Public Health Division. Data are collected by Health authorities from their eligible communities

[2] Data up to September 30, 2015

[3] Definition of chronic disease (ACSC) is based on 2011 CIHI Health Indicator technical notes. Age-standardized rates are per 100,000 population by PEOPLE 40 (PEOPLE 2015) and calculated using direct method based on 1991 Canada population.

[4] Data source: Discharge Abstract Database, Business Analytics Strategies and Operations Branch, Health Sector Information, Analysis and Reporting Division, Ministry of Health

[5] Data for the quarter ending June 30, 2015

Baseline (2013/14)[6]	2015/16 Targets	2015/16 Actual[7]	Target Met
IHA: 16.1%	IHA: 14.2%	IHA: 13.7%	IHA: Yes
FHA: 12.7%	FHA:12.6%	FHA: 12.8%	FHA: No
VCHA: 15.2%	VCHA: 14.6%	VCHA: 17.3%	VCHA: No
VIHA: 13.1%	VIHA:12.6%	VIHA: 13.3%	VIHA: No
NHA: 13.1% (2012/13)	NHA: 12.6%	NHA: 11.8%	NHA: Yes

This is a new service plan performance measure, established with aggressive targets, designed to focus on the effectiveness of community-based supports to help persons with mental illness and substance use issues receive appropriate and accessible care and avoid readmissions to hospital. Central to this effort is building a strong system of primary and community care which enhances capacity and provides evidence-based approaches to care. The results for this performance measure will continue to be monitored as the Ministry and health authorities begin to implement specific actions to support effective primary and community supports for this population group.

4. *Percent of scheduled 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.

Baseline (2013/14)[8]	2015/16 Targets	2015/16 Actual[9]	Target Met
IHA: 88%	IHA: 91%	IHA: 83%	IHA: No
FHA: 89%	FHA: 92%	FHA: 85%	FHA: No
VCHA: 93%	VCHA: 93%	VCHA: 91%	VCHA: No
VIHA: 87%	VIHA: 90%	VIHA: 82%	VIHA: No
NHA: 93%	NHA: 93%	NHA: 91%	NHA: No

The year-to-date 2nd quarter data shows that 2015/16 targets are not being met. However, there has been a focus across the province to serve patients who have been waiting longer periods for their scheduled surgeries. For example, Vancouver Coastal and Northern Health reduced the number of patients waiting more than 52 weeks to just over 1% while Interior Health has reduced the number of patients waiting over 52 weeks from 5.1% during the 1st quarter of 2015/16 to 3.7% during the 3rd quarter. Overall, during the 1st 2 quarters of 2015/16, more than 15,000 completed surgery cases were for those who had waited longer than 26 weeks, up from 13,000 cases recorded in the same period in 2014/15.

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)[10]	2015/16 Targets	2015 Actual[11]	Target Met
IHA: 3.0%	IHA: <= 3.3%	IHA: 4.2%	IHA: No
FHA: 3.8%	FHA: <= 3.3%	FHA: 4.1%	FHA: No
VCHA: 4.0%	VCHA: <=3.3%	VCHA: 4.1%	VCHA: No
VIHA: 3.5%	VIHA: <=3.3%	VIHA: 4.1%	VIHA: No
NHA: 4.9%	NHA: <=4.0%	NHA: 6.3%	NHA: No

Data up to the 3rd quarter shows that the 2015/16 targets are not being met. The specific reasons for the current overtime rates vary by health authority but relate to acute care patient flow, inpatient bed days and difficulties with recruiting and retaining specialty trained nurses. Consequently, the health authorities continue to refine their overtime reduction strategies, recruitment of nursing staff and attendance promotion programs.

[6] Data source: Discharge Abstract Database, Business Analytics Strategies and Operations Branch, Health Sector Information, Analysis and Reporting Division, Ministry of Health

[7] Data for the quarter ending June 30, 2015

[8] Data source: Data source: Surgical Wait Times Production (SWTP). January 11, 2016 (Site 142). Includes all elective adult and pediatric surgeries.

[9] Data up to September 30, 2015

[10] Data source: Health Sector Compensation Information System (HSCIS), Health Employers Association of British Columbia (HEABC), January 14, 2016. VCHA includes Providence HC.

[11] Data is for the quarter ending September 30, 2015

FACT SHEET

FINANCIAL IMPLICATIONS

N/A

Approved by:

Teri Collins, Health Sector Information, Analysis and Reporting Division; February 9, 2016

FACT SHEET

Automated Death Notifications

ISSUE

Through the Red Tape Reduction initiative, citizens have suggested that an automatic death notification to other government organizations would streamline the process and reduce the burden of having to provide a paper copy of the death certificate to several government bodies under one government.

KEY FACTS

- Certain organizations require proof of death for an individual when a family member or executor is cancelling the deceased's identification or benefit services. Some members of the general public have expressed frustration with the current, manual process of notification that must be followed to cancel the individual's driver's license, services card, or other benefit or service.
- A Bereavement Checklist has been developed by Service Canada and Service BC to assist the general public with the notification process to organizations requiring this information. The checklist is distributed online, through Service BC access centers, and by participating funeral homes.
- On November 27, 2015, the Government of BC received a Red Tape Reduction submission requesting the 6 page checklist be replaced with an automated process of electronic notification from the Vital Statistics Agency. The public benefit is the transfer of death notification responsibility from the family member or executor to the Province, reducing or eliminating the requirement of individuals to contact each organization on their own.
- Electronic notification by the Agency is already occurring with a number of federal and provincial organizations; however, a majority of organizations are not set up to process death notifications electronically and still require the manual submission of a death certificate. For example, the Vital Statistics Agency currently supplies the Canada Revenue Agency, BC Pension Corp, BC Elections and ICBC with a death notification, but some still request that the individual's death certificate be submitted.
- Many organizations will argue that it is prudent to continue relying on next of kin to substantiate the death of a relative as it reduces the number of "accidental" administrative deaths. If BC decides to rely on electronic notification of death, all receiving agencies will need to develop processes to ensure administrative deaths do not occur. This service, if further considered, would need to be supported and carefully implemented by relying government bodies.
- A cross-jurisdictional death notification project is currently being pursued by the Public Sector Service Delivery Council (Federal, Provincial, Municipal body) which is seeking support to address barriers to electronic notification. If successful, this could eliminate the bulk of the existing checklist, and will be carefully implemented over a number of years.
- In the interim, Service BC is working with Service Canada to review the current checklist and determine its usefulness, its audience, and to incorporate feedback received from citizens.

FINANCIAL IMPLICATIONS

Unknown until the scope of the project is further defined.

Approved by:
Jack Shewchuk, Vital Statistics Agency; February 22, 2016
Teri Collins, Health Sector Information, Analysis and Reporting Division; March 7, 2016

FACT SHEET

BC Centre for Data Innovation

ISSUE

Ministry of Health's contribution to the BC Centre for Data Innovation initiative that would enable a secure environment for data-driven innovation, transformative research and technology development.

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 (BCCDI).
- BCCDI 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, BCCDI 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[1] proposes a multi-year, incremental approach to developing BCCDI 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 BCCDI and commit to broader consultations with additional stakeholders beyond the health sector.
- The Ministry's foundational contribution is the provincial data platform work being led under the Strategy for Patient Oriented Research (SPOR). The Canadian Institute for Health Research has approved BC's business plan for the Support for People and and Patient Oriented Research and Trails Unit. This work is co-funded by the Ministry 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, health ideas, 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.
    - Enable collection and analysis of patient experience data.

Interim Governance Committee BC Centre for Data Innovation

Organization/Ministry	Position	Member
Health	Chief Administrative Officer	Sabine Feulgen (Co-Chair)
Technology, Innovation and Citizens' Services	Deputy Minister	John Jacobson (Co-Chair)
Government Communications and Public Engagement	Deputy Minister	John Paul Fraser
Energy and Mines	Deputy Minister	Elaine McKnight
Education	Deputy Minister	Dave Byng
Provincial Health Services Authority	President and CEO	Carl Roy
Research Universities' Council of B.C.	President	Robin Ciceri

[1] http://www.gov.bc.ca/citz/down/BC_Centre_for_Data_Innovation-FINAL.pdf

FACT SHEET

Guests and Secretariat

Organization	Position	Member
Technology, Innovation and Citizens' Services	Associate DM	Bette-Jo Hughes
Technology, Innovation and Citizens' Services	ADM	CJ Ritchie
Technology Innovation and Citizens' Services	Executive Director	Susan Stanford
Technology, Innovation and Citizens' Services	Director	Danielle Burton
Technology, Innovation and Citizens' Services	Director	Jeremy Coad

FINANCIAL IMPLICATIONS

The total funding for SPOR is outlined below:

- Ministry approved $8.9 million over five years to support BC's for SPOR, Support for People and Patient-Oriented Research and Trials (SUPPORT) Unit, of which the Michael Smith Foundation for Health Research (MSFHR) has already received $2 million in March 2014.
- In April 2014, the MSFHR Board approved a motion to reserve $10 million for the SPOR SUPPORT Unit with two provisos.
    - MSFHR be assured they will retain a seat on the Governing Council, and
    - MSFHR sign the Memorandum of Understanding (or Funding Agreement) with the SUPPORT Unit's home entity that delineates conditions for release of funding and reporting.

s.13,s.17

Approved by:
Kelly Moran, IMKS, Health Sector IAR; January 29, 2016
Teri Collins, Health Sector Information, Analysis and Reporting Division; February 9, 2016
John Kelly, obo Manjit Sidhu, Finance and Corporate Services Division; January 29, 2016

FACT SHEET

Data Management and Security Project

ISSUE

Implement the recommendations from the Deloitte Review and Privacy Commissioner's investigation of the privacy incidents at the Ministry of Health.

KEY FACTS

- In early 2012 the Ministry received allegations of inappropriate and unauthorized access to health data for research purposes. The internal investigation into these allegations led to the discovery of 3 health data breach incidents. In addition to the internal investigation, the Ministry:
  - Accepted and began implementing the Office of the Information & Privacy Commissioner's (OIPC) recommendations in response to the three breaches;
  - Hired Deloitte to consult and recommend enhancements to security and privacy protections of the Ministry's data systems and policies; and,
  - Undertook a LEAN business process improvement exercise for various data access business processes.
- Privacy Commissioner Elizabeth Denham released an Investigation Report (F13-02) on 3 breaches of personal health data that the Ministry reported to her office in September 2012.
- Health Minister Terry Lake has released a statement on the Commissioner's report indicating that the Ministry will be accepting and implementing all of the Commissioner's 11 recommendations.
- Of the 21 recommendations made by Deloitte and the Commission, 14 are completed. The remaining 7 recommendations are scheduled to all complete by March 2017.
- To ensure the commitment from Minister Lake is effectively met, the Ministry implemented a broad program of improvements in data management, security and privacy. There are projects underway or completed to address all recommendations in the OIPC and Deloitte reports. To date:
  - More than 280 Managers and Executives have completed Ministry specific mandatory privacy and data security training; this training is refreshed annually;[1]
  - All of the Ministry's divisions have reviewed and inventoried sensitive data and how it is secured and protected;
  - The Ministry has improved its data warehousing system; the system now allows logging and enhanced tracking of which employees are accessing which data;
  - The Ministry has implemented new control infrastructure for its data warehouse to limit access to, and movement of, sensitive information;
  - The Ministry developed easy-to-understand reference guides and other materials for staff on data security and privacy;
  - Implemented a senior level governance structure with responsibility for Information Management Standards, including security and privacy;
  - There is a well established relationship between privacy staff in the Ministry and the Privacy and Legislation Branch of the OIPC. Roles and responsibilities are clearly understood between the 2 organizations;
  - The Ministry has implemented an enhanced accountability model for access control, and implemented new policies and procedures to ensure access is granted on the least privilege/need to know basis; and

[1] Public Service Agency Learning Centre

- Where external parties are gaining access to health information, all forms of agreement include provisions to control how that data is used, and all agreements are reviewed by experts in the office of the Chief Data Steward for the Ministry.

- In addition to these completed tasks, the Ministry has a number of initiatives underway to address the recommendations, including:
  - The Ministry is in the final stages of work to transition from higher risk legacy systems to the more secure central data warehouse; the remaining legacy data warehouses are in the final stages of being transitioned;
  - The Ministry is in the process of implementing improved internal and external auditing programs to review the use of data; and,
  - The Ministry has significantly reduced the number of people accessing personally identifiable data, while enabling better access to de-identified data within the Ministry.

FINANCIAL IMPLICATIONS

Cost of implementing these changes are within the operating and capital budgets of the systems Division.

Approved by:

Kelly Moran, Information Management & Knowledge Services Branch; February 4, 2016
Teri Collins, Health Sector Information Analysis and Reporting Division; February 9, 2016
Daryl Connor, Finance and Corporate Services Division; February 22, 2016

FACT SHEET

Fraser Health Authority Review

ISSUE

- Ministerial Order 282 (M282) requires Fraser Health Authority (FHA) to submit quarterly reports to the Ministry of Health on service delivery outcome targets and operational and financial objectives identified in their Strategic and Operational Plan.
- The Health Sector Information, Analysis and Reporting Division reviews FHA's quarterly reports and provides quality assurance analysis guided by the dimensions of care quality contained within the BC Health Quality Matrix.

KEY FACTS

- In October 2013, the Minister of Health provided direction to FHA under M282 to undertake a review and develop a Plan to address service delivery, quality and financial issues within FHA .
- FHA submitted the Plan, covering 2014/15-2016/17 fiscal years, in May 2014 and it was made public in July 2014.
- The Plan focusses on the needs and effectiveness of the services for the regional population and health care providers and facilities, and FHA's operational management teams.
- As part of their review, FHA identified 10 key priority actions to ensure quality and sustainable service delivery across all sectors of healthcare, including:
    1. Capacity for care across all sectors;
    2. Quality and safety;
    3. Public health measures;
    4. Budget accountabilities;
    5. Staff and physicians;
    6. Patient centeredness;
    7. Governance;
    8. Operational organization and management;
    9. Lower Mainland collaboration; and
    10. Accountability.
- FHA closely monitors the first 5 priority actions using a suite of 30 quantitative performance indicators, which are published on the FHA website as part of the *Our Health Care Report Card*.
- Under M282 the FHA board is required to provide a progress report to the Minister every 3 months with the first report submitted on October 15, 2014, and the last report submitted on April 15, 2017.
- The reports must be submitted on:
    - October 15 – for the period spanning July 1 to September 30;
    - January 15 – for the period spanning October 1 to December 31;
    - April 15 – for the period spanning January 1 to March 31; and
    - July 15 – for the period spanning April 1 to June 30.
- The quarterly reports must describe in detail the extent to which the service outcome targets and operational and financial objectives identified in the Plan have been achieved within the reporting period.
- The Ministry monitors the progress of the FHA by completing an analysis of each quarterly report and tracking the service delivery activities and strategies committed to by FHA.
- Staff in the Division monitor the successes and challenges of FHA, by identifying trending in performance to determine progress over the full reporting period (from Q1 to present).

FACT SHEET

- Analysis focuses on highlighting variation in the performance reported by FHA, and using existing data collected by the Ministry, where possible, comparing the performance at FHA to the provincial average.
- In their first report, October 2014, FHA reported meeting targets in 14 of their identified 30 indicators.
- In January 2016, half way through the 3 year mandate for performance reporting to the Ministry, FHA is reporting meeting their targets in 9 of the 30 indicators.
- It should be noted that over the past 6 reports FHA has changed their target on 7 indicators for various reasons, including changes in the Ministry's P4P targets and national benchmarks.
    - As a result of the change in targets, performance improved on 1 indicator, worsened on 3 indicators, and was unchanged on 3 indicators.
- FHA continues to have challenges with **capacity for care across** the performance measures for Access, Effectiveness and Appropriateness. Notable problem areas are:
    - The alternate level of care days continues to trend away from the organizational target and has steadily increased over the first 5 of 6 quarterly reports.
    - FHA reports only 39.3% of emergency patients are admitted to hospital within 10 hours (organizational target is 55.0%).
    - FHA is showing small signs of improvement for long stay patients staying over 30 days; however, they are still over the organizational target by more than 10%.
    - FHA continues to invest in programs and strategies to improve capacity in their acute and community care facilities, with many activities aimed at areas outside the hospital that are expected to produce a positive impact on congestion.
- The majority of the performance measures monitoring **quality and safety** are on target or improving. FHA is performing better than the provincial average in percentage of hip fracture fixations completed within 48 hours, and hand hygiene compliance.
- FHA is trending in the right direction for 2 of the 3 **public health measures**, and has raised their standards of performance by increasing their target for the percent of 2-year olds with up-to-date immunizations and the percent of drinking water systems complying with microbial monitoring requirements. The percent of communities with completed healthy living strategic plans (80.0%) is nearly double the rate of the provincial average (48.0%) and the highest rate of all health authorities in the province.
- The **budget accountabilities** have increased since October 2014 for budget performance (how programs are performing against their approved budget), direct care hours per patient day, and expenditures per separation (the cost of providing health services to a patient admitted to hospital). As of period 8 (November 5, 2015) FHA is reporting a small year-to-date deficit but expects to break even by year end.
- FHA is meeting the target for 3 of 6 of their **staff measures**, but is trending in the wrong direction for WorkSafe BC rates (Claims Duration and Claims / 100 FTE).
- The Ministry is working with FHA to address ongoing challenges.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Ross Hayward, Performance Monitoring and Evaluation Branch; February 3, 2016

Teri Collins, Health Sector Information, Analysis & Planning & Reporting Division; March 7, 2016

FACT SHEET

Key Accomplishments in Enhancing Health Data Access

ISSUE

Ministry of Health key accomplishments in the last year to enhance and streamline timely and appropriate health data access for researchers, health authorities, and other public bodies and stakeholder organizations.

KEY FACTS

- The Ministry data holdings are regarded as some of the best health data resources in the world. Health researchers from Canadian universities apply for access to administrative health data through Population Data BC for use in research and statistical analysis pursuant to applicant privacy law and policy.
- Over the last year, the Ministry has successfully completed efforts to enhance the business lines for processing and managing health data access and use requests. These accomplishments include the following.

Academic Data Access Requests

- Ongoing partnership with Population Data BC under a service contract.
- Reduced application processing time to three months for eligible requests:
  - For the Ministry, the median number of days dropped from 231 to 42 between 2011 and 2015;
  - For the Data Stewardship Committee, the median number of days dropped from 205 to 59 between 2011 and 2015; and
  - Backlog eliminated.[1]
- Harmonized (standard, PharmaNet, and Client Registry) Data Access Requests application and review process implemented.
- Research Agreement Template implemented.
- The Committee received 24 new requests by December 31, 2015 and approved 21, with the remaining being processed in conjunction with the Ministry. One project has been rejected and one project was withdrawn.

Health Authorities and Other Public Bodies Requests

- Centralized intake.
- Implemented standardized data extraction with enhanced security measures.
- Implemented new procedures, accountability and enhancements to the template for Information Sharing Agreements, with a risk-based approach to Information Sharing Agreements remediation.
- Initiated a dialog with health authorities to identify opportunities for streamlining processes, forms, and agreement templates involving data access requests.
- The Ministry received 29 new applications by December 31, 2015, and approved 23. One project was rejected and two projects have been withdrawn by the applicants, leaving 3 pending applications.

For All Data Access Lines Above

- Updated web-presence on Health Data Central through BC Government Health portal.
- Enhanced and expanded Process documentation, agreement templates and forms and data dictionaries.
- Standardized review process, tracking and metrics for better case management.

[1] Metrics of data access requests are from Population Data Quarterly Reports.

- Improved the data access processes using the LEAN methodology.
- Implemented a web based case management system (JIRA) to replace the MS ACCESS base case management database (DARTS).

FINANCIAL IMPLICATIONS

N/A

Approved by:
Shirley Wong, obo Kelly Moran, IMKS, HSIAR; February 10, 2016
Teri Collins, Health Sector Information, Analysis and Reporting Division; February 11, 2016

FACT SHEET

Population Data BC, University of BC Service Agreement
Academic Research Data Services

ISSUE

Ministry of Health approvals for access to academic research data have been reduced from over a year to three months on average, leveraging the services agreement between the Ministry and Population Data BC.

KEY FACTS

- In the late 1980s, the Ministry established a relationship with the University of BC (UBC) to develop and administer the BC Health Linked Database. This research database contains copies of patient and provider level data from Ministry data sources including Medical Services Plan, Discharge Abstract Database and Home and Community Care. (Note: PharmaNet data is not included at this time).
- UBC extracts Ministry data for approximately 30 third party research projects per year. The BC Health Linked Database is now part of the holdings of Population Data BC, a multi-university research organization that leverages the database in their research advancement agenda. Population Data BC now operates the Secure Research Environment, a sophisticated server and data linkage architecture with audit and compliance mechanisms designed to enhance the privacy and security of the Ministry's data holdings stored at UBC.
- A services agreement between the Ministry and UBC has been in place since April 2011 (Fiscal Year 2011/12-2013/14) and allocates monies on a quarterly basis to defined service lines such as data acquisitions; data linking and cleaning; data request form intake; and data extraction services.
- A one year extension to the existing agreement, for fiscal year 2015/16, has been signed. Work is currently underway to negotiate a new three year agreement with Population Data BC that will complement the Strategy for Patient Oriented Research initiatives underway. Features of the services agreement include:
    - Client-driven service orientation;
    - Clarity in the data access process;
    - Priority setting practices; and
    - Knowledge transfer and data promotion.
- The Ministry strongly supports improved health and health service delivery as part of Government's innovation and change agenda priorities, and views the health research community as a strategic partner in advancing health benefits via academic research.
- The Ministry relies on UBC's services in order to maximize its long standing investment in Population Data BC and to maintain high standards for timely, accurate data extract services in support of health research.
- Reporting, monitoring, and performance management are routinely reviewed and UBC currently meets expectation under the services agreement.
- A few key accomplishments the Ministry shares with UBC under the services agreement are:
    - Enhanced intake and administration of research data requests.
    - Reduction of application processing time to three months for eligible requests.
    - Elimination of the entire backlog of data requests (30+).
    - Standardized documentation, including forms and data dictionaries.
    - Strengthened strategic partnership with UBC (and BC research community).

FACT SHEET

FINANCIAL IMPLICATIONS

$542,000 for Fiscal Year 2015/16.[1]

Approved by:

Teri Collins, Health Sector Information Analysis and Reporting Division; February 5, 2016
Kelly Moran, Information Management & Knowledge Services; November 16, 2015
Daryl Connor, obo Manjit Sidhu, Finance and Corporate Services Division; December 16, 2015

[1] HSIMT IMKS 2014/15 Budget

FACT SHEET

'Sex' Field on BC Birth Certificates

ISSUE

Human Rights complaints have been filed seeking the removal of the "Sex" field from BC birth certificates

KEY FACTS

- Nine complaints have been filed at the BC Human Rights Tribunal against the Vital Statistics Agency. The complainants are challenging section 36(2)(d) of the *Vital Statistics Act* which states that a birth certificate must contain "the sex of the person".
- The complainants are individuals who do not associate with male or female and seek to have the sex designation removed from all BC birth certificates. They 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."
- Due to the legislative requirement to include sex designation on birth certificates, the Agency cannot address the issue through a change to policy and must have the support of the Minister to make changes to the *Name Act*. The Minister requested that no settlement be made through the Human Rights Tribunal process and requested the issue go to hearing.
- The sex designation is still considered a biometric indicator; it is used by various identification agencies as an identity proofing tool. Organizations such as Passport Canada, Canada Border Services Agency, the Insurance Corporation of BC and Health Insurance BC are reviewing their use of this field but have not agreed to its removal from their documents at this time. s.13

s.13

- Discussions regarding the continued usage of this field are ongoing at the federal and provincial level as each jurisdiction faces the possibility of human rights complaints being filed against their identity proofing organizations.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Jack Shewchuk, Vital Statistics Agency, February 29, 2016

Teri Collins, Health Sector Information, Analysis & Planning & Reporting; April 19, 2016

FACT SHEET

Spousal Surnames

ISSUE

The Vital Statistics Agency receives a small number of complaints from married couples concerning the inability to assume their spouse's surname as well as keep their own foundation identity. The *Name Act* does not authorize the hyphenation or combination of the two existing surnames without going through the legal change of name process.

KEY FACTS

- The *Name Act* authorizes a person to assume a spouses surname upon marriage. This enables a complete change in the surname of one spouse to the surname of the other spouse.
- The use of hyphenated names or a combination of two surnames is the joining of two existing names into a new name that did not previously exist. As this does not align with the *Name Act*, a legal change of name is required. In 2015, approximately 1.6% of change of names were to hyphenate or combine existing surnames.
- The concern with BC allowing a hyphenated or combined surname is that not all identity systems have the capability of capturing both the foundation identity surname and an assumed married surname.
- The Office of the Chief Information Officer (OCIO) is developing an Identity Information Standard to address the various usages of foundation identity and assumed names across BC. The standard will require substantive consultation to assess the impact of implementation on government human and information management resources.
- While assumed, hyphenated names are being used in other provinces, the legislation is inconsistent and therefore the application of an "assumed name" is often left to secondary identity issuers such as driver's licensing and health card issuers.
- Two major Federal/Provincial identity initiatives are underway. The "Identity Linkage Project" being led by Immigration, Refugee, and Citizenship Canada, and, "Canada's Digital Interchange Project", a joint federal/provincial initiative. Both projects are substantially based on concepts within the OCIOs "Identity Information Standard" and will establish a consistent approach across Canada in the application of identity standards.
- No changes to the *Name Act* are advised until a provincial standard has been identified and there has been adequate time for ministries to assess the impact on their systems.

FINANCIAL IMPLICATIONS

Financial implications to be further evaluated once OCIO Identity Information Standard has been reviewed.

Approved by:
Jack Shewchuk, Vital Statistics Agency; January 27, 2016
Teri Collins, Health Sector Information, Analysis & Reporting Division; February 3, 2016

FACT SHEET

Status of Public Performance Reporting 2015/16

ISSUE

Outlining the status of public performance reporting by the Ministry of Health and health authorities.

KEY FACTS

- The Ministry's existing public performance reporting is comprised of the annual service plan report and a public surgical wait times website[1] that shows the wait times by adult and pediatric for almost all elective surgeries provided in the province. For the website, users can access information relating to the number of cases waiting and completed, by procedure, health authority, facility, and specialist.
- The Ministry also works closely with the Canadian Institute for Health Information (CIHI) to help facilitate the disclosure to the public, of health information from hospitals and health authorities in British Columbia. CIHI uses this information as part of their health system performance public website, *Your Health System*[2].
- This website presents comparative performance information from jurisdictions across Canada covering five main areas: access, quality of care, spending, health promotion and disease prevention, and health outcomes. Examples of measures available on the CIHI website are surgical wait-times, hospital readmission rates, in-hospital mortality rates and obesity. CIHI's reports allow the public to compare performance in BC to other provinces, communities and hospitals in Canada.
- All health authorities post some performance information on their websites, such as financial reports, housekeeping audits, and infection control reports. However, Fraser Health Authority, Vancouver Coastal Health Authority and Vancouver Island Health Authority provide the public with report cards or regular performance reports, which include measures such as:
  - Fraser Health Authority[3] - example measures:
    - Number of Admitted Patients Awaiting Inpatient Bed Placement (including emergency admissions)
    - Facility-Associated Clostridium Difficile Infection (CDI) Incidence
    - Direct Care Hours Per Patient Day (acute nursing inpatient)
  - Vancouver Coastal Health Authority[4] - example measures:
    - Emergency Patient Experience
    - Percent of Hip Fracture Fixations Completed Within 48 Hours
    - Emergency Patients Admitted to Hospital Within 10 Hours
  - Vancouver Island Health Authority[5] – example measures:
    - Hand Hygiene Compliance
    - Readmissions Rate
    - Surgical Wait Times
- Interior Health Authority reports publicly on quality care, particularly in the area of infection control such as hand hygiene audits by hospital and by ward. Depending on the particular area, this reporting is communicated through annual reports available on the health authority's website or on a quarterly basis[6]. Interior Health Authority also conducts regular patient experience surveys in health service areas such as Emergency, Diagnostic Imaging, Intensive Care Unit and Laboratory[7].

[1] https://swt.hlth.gov.bc.ca/
[2] http://yourhealthsystem.cihi.ca/
[3] http://www.fraserhealth.ca/about-us/transparency/reportcard/
[4] http://www.vch.ca/about-us/accountability/report-card/report-card
[5] http://www.viha.ca/about_viha/accountability/performance_measures/
[6] http://www.interiorhealth.ca/AboutUs/QualityCare/Pages/InfectionControl.aspx
[7] http://www.interiorhealth.ca/AboutUs/QualityCare/Pages/PatientSatisfactionSurveys.aspx

- Northern Health Authority does not have posted report cards due to resource constrains. However, the health authority posts in-depth analysis of public reports on specific performance topics, such as *Northern Surgical Services Review* and *Systemic Therapy Terrace and Kitimat Review*[8]. Northern Health Authority also publishes a consultation report on community accountability every other year[9].

FINANCIAL IMPLICATIONS

N/A

Approved by:

Teri Collins, Health Sector Information, Analysis and Reporting Division; February 9, 2016

[8] https://www.northernhealth.ca/AboutUs/NorthernHealthReports.aspx

[9] https://www.northernhealth.ca/AboutUs/NorthernHealthReports/CommunityAccountability.aspx

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. Seven of the nine complainants are non-binary individuals who do not associate with male or female (intersex, indeterminate and gender diverse). The Complainants' seek to have the sex designation removed from all BC birth certificates.
- The complaints initially proceeded within the Tribunal's settlement stream. However, the Vital Statistics Agency withdrew from settlement negotiations by direction of the Minister in August 2015.
- The Agency has filed formal responses to each of the complaints and must now make disclosure of all potentially relevant documents and provide a list of witnesses.
- The Agency's deadline for filing disclosure documents and Applications to Dismiss (ATDs) is March 10, 2016. The Agency does not anticipate filing dismissal applications for the Trans Alliance complaint or the seven complaints in which the complainant is a trans person who sought and was denied a birth certificate without a sex designation on it.

s.13

- Once disclosure is made and witness lists/statements of remedy are exchanged, the Human Rights Tribunal will set the matter down for hearing.
- It is estimated that the hearing will take 12-15 days. The Tribunal is currently booking hearings of the duration in late 2016 or early 2017.

FINANCIAL IMPLICATIONS

Cost implications are yet to be determined.

Approved by:
Jack Shewchuk, Vital Statistics Agency; January 26, 2016
Teri Collins, Health Sector Information, Analysis and Reporting Division; February 3, 2016

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

- Under the APP, funding is provided to the health authorities and other agencies which enables them to procure physician services through service contracts, salary agreements, or sessional arrangements (3.5 hour blocks of time) as per the Physician 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: 81% contract (for service contracts and salaries) and 19% sessions.[3]
- In a recent review of BC's 11,191 physicians who provided services in fiscal year 2014/15, 3,597 physicians received all or part of their income through APP funding.[4]
- As at January 31, 2016, APP funds 143 contract commitments[5] and 179,432 sessions[6,7] for physician services.
- APP funding has proven to be effective in stabilizing public access to primary care physician services in many rural and remote communities where the 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 physician 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 comply with Ministry and Government policies and directives applicable to APP funding.
- For service verification, evaluation and audit purposes, health authorities have a responsibility to transmit details of the services to the Ministry of Health the same as required for physicians

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[1] 2014 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 2015/16 APP Budget. Retrieved on February 25, 2016. Calculations: \\mario\APP\APP LAN TEST\Financial Stewardship\APP Budget Book\Budget for Fact Sheets_Estimates\2016 Estimates\NOTE 3 - Fact Sheet Budget backup calculations - updated.xlsx

[4] Data Source: Physician Counts Summary Fiscal Year 2014/15.

[5] Based on the 2015/16 APP Contract Expenditure Plans. Retrieved on February 25, 2016. Calculations: \\Mario\MSP\APP\APP LAN TEST\Financial Stewardship\APP Budget Book\Budget for Fact Sheets_Estimates\2016 Estimates\NOTE 5 - 2016 Estimates Stacked EP - Contracts.xlsx

[6] Based on the 2015/16 APP Sessional Expenditure Plans. Retrieved February 10, 2016. Calculations: \\Mario\MSP\APP\APP LAN TEST\Financial Stewardship\APP Budget Book\Budget for Fact Sheets_Estimates\2016 Estimates\NOTE 6 - 2016 Estimates Stacked - EP - Sessions.xlsx

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

billing fee-for-service.[8]

s.12,s.13

APP Review - 2015/16

- The Ministry is 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 address concerns raised in the Office of the Auditor General's report on *Oversight of Physician Services*, February 2014.
- The policy review is nearing completion and will inform discussions with the Doctors of BC as part of a PMA re-opener in 2016/17.
- Improvement with respect to administration of the APP are underway and ongoing.

FINANCIAL IMPLICATIONS

- The 2015/16 APP contract and sessional budget allocation as at January 31, 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	$31.06	$21.81	$15.03	$144.09	$85.45	$36.49	$9.53	$33.06	$376.52
SESSIONAL	$14.78	$5.39	$5.68	$12.58	$34.80	$11.85	$3.73	$0.31	$89.12
TOTAL	**$45.84**	**$27.20**	**$20.71**	**$156.67**	**$120.25**	**$48.34**	**$13.26**	**$33.37**	$465.64

* 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.[9]

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

Approved by:
Marie Ty, Compensation Policy and Programs Branch; March 1, 2016
Ted Patterson, Health Sector Workforce Division; February 2, 2016
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; March 3, 2016

[8] Reference: Physician Master Agreement - Alternative Payment Program – Contract and Sessional Templates, Article 15 - Reporting

[9] Reference: Alternative Payment Program Budget Sheet - APP 2014-15 Budget retrieved on February 4, 2016 from \\Mario\MSP\APP\APP LAN TEST\Financial Stewardship\APP Budget Book\1516 Budget\APP 2015-16 Budget - CURRENT - January 31.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 (see 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 make 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 as 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 Doctors of BC 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 Branch; July 2, 2015

Ted Patterson, Health Sector Workforce Division; July 9, 2015

FACT SHEET

BC Care Aide and Community Health Worker Registry

ISSUE

Overview and update on the BC Care Aide and Community Health Worker 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).
- BC has seen 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 and completed in 2013.
- In order to improve HCA oversight in the province, the Ministry engaged with stakeholders during a six-week period during January, February, and March 2015 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 included the possibility of strengthening the existing Registry model or bringing the Registry under the purview of one of the nursing regulatory colleges. All stakeholders consulted expressed support for the Ministry's interest in improving the oversight model for HCAs.
- In late fall 2015, the Minister directed Ministry staff to prepare and publish an Intentions Paper following up from the stakeholder consultation. The Intentions Paper will set out the direction government intends to follow respecting enhancements to HCA oversight and will invite more focused consultation. No date has been set for release of the Intentions Paper.

Background

- The Registry, the first of its kind in Canada, 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 of the Registry.
- A phased implementation approach was used. 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. An external review of the Registry model and operations 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 Review Report was received at the Ministry in February 2013. In response to the external review, the *Review of the BC Care Aide and Community Health Worker Registry: An Action Plan* (the Action Plan) was created. The Action Plan and the Review Report were publicly released at the same time in March 2013. The Review Report made several recommendations for improvement of the Registry model, covering four broad areas:
  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 was to enable better lines of communication between the Ministry and Registry stakeholders.
    - Written procedural standards for Registry appointed investigators have been completed, and are now shared with employers and unions at the onset of an investigation. This helps to create more consistency and transparency for investigative processes and costs.
    - The educational recognition processes for academic institutions and individuals without a BC HCA program certificate have now been fully implemented. 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. Recognition compliance site visits of educational institutions offering the HCA program are underway and due for completion in 2016.
- In addition to the work taking place directly with the Registry, cyclical reviews of the HCA provincial competencies and curriculum have been completed. The reviews 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 was released in August 2015.
- Since the Registry began operations in early 2010 to December 31, 2015, 430 cases of alleged abuse (215 suspensions, 215 terminations) have been reported by employers.[1] 116 of the terminations have gone to the investigation process, with 23 individuals permanently removed from the Registry, 53 reinstated upon meeting remedial conditions, 34 reinstated with no remedial conditions[2], and 6 investigations are ongoing[3]. In addition, of the terminations that did not go to the investigation process, 82 individuals were removed from the Registry uncontested (no dispute by union or individual), and 19 were reinstated through the employer/union grievance process.

FINANCIAL IMPLICATIONS

The 2015/16 total budget for Registry operations and development is $600,000.[4] A more sustainable funding model was one of the recommendations that resulted from the Registry review; this is one of many considerations that will factor into the decision on how best to improve the oversight model for HCAs in BC.

Approved by:
Mark MacKinnon, Professional Regulation & Oversight Branch; January 21, 2016
Ted Patterson, Health Sector Workforce Division; January 21, 2016
Daryl Conner, Finance and Corporate Services Division; February 3, 2016

[1] Email from Bruce Bell, Director, BC Care Aide and Community Health Worker Registry, January 15, 2016
[2] In these cases, the investigator found no abuse attributed to the HCA, or time away from work without pay was sufficient discipline.
[3] Ongoing investigations as of December 31, 2015 include 4 from 2015 plus 2 counted as terminations in 2014.
[4] Fiscal 2015/16 Contract #2016-068 with Health Match BC.

FACT SHEET

BC Medical School Expansion

ISSUE

In 2004, BC began to expand and distribute the University of BC's (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 is in the midst of an unprecedented medical education expansion, more than doubling the number of first-year seats for both undergraduate and postgraduate residency programs. New seats for training doctors have been added every year since 2003.
- BC is recognized as a best practice jurisdiction in regards to distributed medical education in Canada. BC's goal of distributing medical education and training across the province is to prepare future doctors for the challenges and benefits of medical practice in a variety of communities, including rural, remote, and underserved areas; and to encourage resident doctors to consider practising in these communities upon completion of training. BC is already experiencing early gains in the increased number of practising physicians, and practice locations across the province.

Undergraduate Medical Education Spaces

- In 2003, BC's annual intake of undergraduate medical students was 128. Expansion and distribution of medical education to the Northern and Island Medical Programs began in 2004. By September 2007 the number of first-year undergraduate students doubled to 256.[1]
- The opening of the Southern Medical Program in 2011 added another 32 spaces, for a total of 288 Canadian medical students graduating each year as of 2015.[2]

Postgraduate Residency Positions

- To keep pace with undergraduate program growth, the Ministry of Health expanded entry-level postgraduate medical education (PGME) spaces (residency positions). A graduating medical student must complete a residency to qualify for full licensure to practice independently.
- BC recognizes the need for primary care in the province; therefore, priorities were given to expanding residency positions in family medicine and generalist (Internal Medicine, Psychiatry and Pediatrics) specialty programs.
- In 2003, the Ministry funded 134 entry-level residency positions: 128 for Canadian medical graduates; 6 for International medical graduates (IMGs)[3]
- In 2016, the Ministry funded 346 entry-level residency positions: 288 for Canadian medical graduates; 58 for IMGs.[4] – or a total resident population of 1283 (all Canadian medical graduates and IMGs in Family Medicine and specialties in years 1 through 7).[5]

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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] Evaluation Studies Unit. Long-Term Outcomes Evaluation Report 2014-15, Physician Contribution to the Province. Vancouver, BC: University of British Columbia Faculty of Medicine; 2015.

[3] Public Affairs Bureau, (2005). News Release 2005HEALTH0039-001058.

[4] Ministry of Health. (2011). 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, p.4

[5] Ministry of Health, Funding Letter for Postgraduate Medical Education 2015/2016 from Kevin Brown, Executive Director to Dr. Dermot Kelleher, Dean, Faculty of Medicine, University of BC, October 15, 2015, Appendix 1 (Cliff #1040254).

FACT SHEET

Distributed Education and Training

- UBC's 288 first-year undergraduate medical program seats are distributed across the province at university academic campuses. 32 seats each are available at the Northern Medical Program (University of Northern BC), Island Medical Program (University of Victoria), and Southern Medical Program (UBC Okanagan). 192 first-year seats are for the Vancouver-Fraser Medical Program (UBC).[6]
- Currently, there are 11 clinical academic campuses throughout the province's health authorities:[7]
    - 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
- Postgraduate medical education (PGME) training programs are also delivered in hospitals and community based healthcare facilities distributed across the province in communities such as Nanaimo, Terrace, Prince George, and Chilliwack. [8]

FINANCIAL IMPLICATIONS

- Since 2007, the Ministry has allocated approximately $119.0 million in capital funding to upgrade and expand UBC's clinical academic space at various hospitals across the province.
- The Ministry makes a substantial investment in PGME each year. In 2015/16, the Ministry's program operating funding for PGME is $126.8 million (includes IMG-BC funding, and $2.0 million reduction in residents' benefits) - up from $43 million in 2003/04, when the Ministry began to increase funding to expand PGME.s.13,s.17

s.13,s.17

- Program operating funding for the *IMG-BC Program* and IMG residency positions in Family Practice and specialties is $14 million in 2015/16. s.13,s.17

s.13,s.17

Approved by:

Kevin Brown, Workforce Planning & Management Branch; February 1, 2016
Ted Patterson, Health Sector Workforce Division; February 2, 2016
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; February 22, 2016

[6] UBC Faculty of Medicine. (2015). *Program Sites*. University of British Columbia. Retrieved January 15, 2016, from http://mdprogram.med.ubc.ca/program-information/distributed-program-sites/
[7] [7] UBC Faculty of Medicine. (2015). *Campuses*. University of British Columbia. Retrieved January 15, 2016, from http://www.med.ubc.ca/about/campuses/
[8] Evaluation Studies Unit. (2015). UBC Faculty of Medicine Long-Term Outcome Evaluation: 2014-15 Annual Data Source Document. University of British Columbia, pg. 2.

s.13

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 5 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.
- In 2014/15 there were 69 dermatologists billing the Medical Services Plan (MSP); this is an increase over the 63 physicians that billed MSP in 2013/14.[2] Many of these additional physicians are new dermatologists to the Province.
- In 2014/15, full time dermatologists billed an average of $409,088 to MSP. The highest billing dermatologist was paid about $1.2 million by MSP.[3]
- According to the Canadian Institute for Health Information, among the 9 Canadian provinces which reported average fee for service payments per fulltime equivalent physician, BC ranked 7th at $430,523 in 2013/14, the latest year available.[4] In the same year dermatologists in BC ranked 7thout of 9th according to the Institute's Physician Services Benefit Rate Index (all services).[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 27.4%, but only 22.1% for dermatologists. Note, these percentages will have changed based on a recent increase awarded to dermatologists for the next 3 years through the 2014 Physician Master Agreement(PMA).[6] These challenges with respect to fee increases are the result of an internal Doctors of BC Tariff Committee process for allocation of funds to the various medical specialty groups.
- In 2013/14 basic consultation fees for the section of Dermatology were $64, which is lower than the average amount billed across the different sections in BC for a similar basic consultation fee ($139).
- 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 PMA.[7]

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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 (no Lab) based on MSP Fee-For-Service Database for the last 5 years paid to Sept 30th of each year, Workforce Analysis, Research & Evaluation Branch ,October 1, 2015

[3] Master file (no Lab) based on MSP Fee-For-Service Database for 2014/15 paid to September 30th , 2015, Workforce Analysis, Research & Evaluation Branch, 2015

[4] National Physician database, CIHI, Table A.6.1, Released 2015 https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC2963

[5] Physician Services Benefits Rates Report, CIHI, Table 1-11, p 35, Released 2015 https://secure.cihi.ca/estore/productSeries.htm?pc=PCC979

[6] Nancy South, October 1, 2015

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

- More recently, the Ministry allocated an additional $55 million towards the current PMA to help address funding disparities between medical specialties.[8] On December 21, 2015, adjudicator Stephen Toope released his decision on the allocation of disparity funding. Dermatology will receive $1.55 million, or $30,995 per full-time equivalent. These funds will be disbursed over the 2016/17, 2017/18, 2018/19 fiscal years[9].
- As of December 31, 2015, Health Match BC has 28 postings for permanent dermatologists within their geographical regions: Fraser (12); Interior (6); Vancouver Island (6); Northern Health (2); and, Vancouver Coastal (2).[10]
- 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 to help 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 1 to 3 seats, and currently there are 16 dermatology residents in years 1 through 5 in the UBC Dermatology Residency Program.[11]
- 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; January 25, 2016
Ted Patterson, Health Sector Workforce Division; February 3, 2016
Daryl Conner, Finance and Corporate Services Division; February 22, 2016

[8] 2014 PMA Agreement Appendix F article 1.6(a) sections (i;ii;iii)
[9] MoH Information Briefing Note Cliff #1046553
[10] https://www.healthmatchbc.org/Documents/HMBC-DTFPV-by-Specialty-Report-Final-2015.aspx
[11] Personal communication with Lois Moen, UBC Faculty of Medicine, September, 2015

FACT SHEET

Fort St. John Primary Care Compensation Model

ISSUE

The Ministry of Health, in collaboration with the Northern Health Authority and the North Peace Division of Family Practice, has developed a new prototype Primary Care Compensation Model to be implemented in Fort St. John in spring 2016.

KEY FACTS

- In July 2015, Fort St. John was identified as a candidate site to pilot the new Primary Care Compensation Model (the model).
- The model was designed in collaboration with the Northern Health Authority (NHA) and the North Peace Division of Family Practice, based on extensive consultations with local physicians.
- The model will replace the existing Fee For Service (FFS) compensation arrangements for physicians, and align to Northern Health Authority's Primary Care Home model, consistent with the Ministry's strategic priority.
- The model has been designed to address the physician recruitment and retention issues faced by Fort St. John, and to bring about improved patient outcomes at lower per capita cost by motivating physicians to:
    - focus on increasing care accessibility and continuity;
    - collaborate with other health professionals to provide wrap-around care;
    - encourage health promoting activities and preventive care among patients; and,
    - consider provincial and local health targets in their care decisions.
- The model features three primary payment components:
    - A base core payment, based on the number of patients attached to the practice and used to cover overhead expenses and professional fees including the hiring of other health professionals to care for patients;
    - A pay for panel care payment to cover the primary care needs of panel patients. Payment is based on a complexity index. This payment will cover the vast majority of primary care services patients can expect to receive in the Primary Care Home; and,
    - A quality, performance and activity payment, which pay physicians that achieve a set of locally and provincially defined performance targets up to $25,000 annually, and fee for service for care delivered to panel patients that fall outside the scope of the pay for panel care component. Examples include: perinatal and Medical On Call Availability Program (MOCAP), and services billed to third parties such as WorkSafeBC and ICBC.
- Physicians will continue to bill fee for service for care delivered to non-panelled patients.
- Six months after implementation, the model will undergo extensive evaluation to identify any adjustments that may be required, and to determine the feasibility of implementing the model at other pilot sites around B.C.

FINANCIAL IMPLICATIONS

- The program and administrative costs associated with implementing and maintaining the model will be estimated at the evaluation six months after implementation. s.13

s.13

Approved by:
Nancy South, Workforce Analysis, Research and Evaluation Branch; January 25, 2016
Marie Ty, Health Sector Workforce Division; January 25, 2016
Ted Patterson, Health Sector Workforce Division; February 2, 2016

FACT SHEET

Integrated Health Human Resources Planning

ISSUE

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

KEY FACTS

- HHR planning includes forecasting future supply, mix, and distribution of health care professionals to meet current and future patient and population health needs. It includes the education, training, recruitment and retention strategies to support and ensure the right number and kind of health care professionals are in the right place.
- HHR 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 2014/15, the health sector compensation costs in BC were $12.9 billion1 or 69% of the total Health Care Budget of $18.7 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).

Physician Resources Planning (Current State)

Physician resource planning currently is undertaken by the health authorities to support the Medical Advisory Committees (Medical Advisory Bylaws) and the Rural Practice Subsidiary Agreement's requirement in Appendix D to conduct a physician census or create a physician resource plan:

- The Divisions of Family Practice collect information on General Practitioner utilization and supply for those areas of the province covered by a division.
- For the most part, physician resource planning is done in isolation of nursing and allied health professions, as the health care system organizational structure and billing system separates physicians from other health care professionals.
- Medical Services Plan (MSP) data provides the age of physicians who practiced in 2014. From this the Ministry can determine who is likely to retire within the next 5 to 10 years. The table below shows the age of physicians likely to scale down their practice or retire within 10 years[3]:

Age Group	GPs	%	All Physicians	%
55-59	769	14%	1,371	13%
60-64	641	11%	1,172	11%
65-69	516	9%	898	9%
70+	352	6%	715	7%
55+	2,278	41%	4,156	40%
Total	5,596	100%	10,411	100%

- 4156 physicians (40% of all physicians who billed via MSP) are over the age of 55 and actively practicing. Of those, 2278 are GPs.

[1] Public Sector Overview, Ministry of Finance, http://www.fin.gov.bc.ca/psec/publicsector/index.htm, Accessed January 22, 2016.
[2] Budget and Fiscal Plan 2015/16-2017/18, p 95, http://bcbudget.gov.bc.ca/2015/bfp/2015_budget_and_fiscal_plan.pdf, Accessed January 22, 2016.
[3] Source: MSP Claim Data. Email communication – Jemal Mohamed. Workforce Analysis, Research and Economics Branch. Ministry of Health, Jan 21 2016.

- The Workforce Analysis, Research and Economics Branch also estimates that physicians receiving non-fee for service (i.e. Alternate Payments Program) have a similar distribution to MSP data.

Nursing and Allied Health Profession Planning (Current State)

- Health Employers Association of BC has annually provided the Ministry with rolling 4-year forecasts for publicly practicing nursing and allied health professions using the Health System Compensation Information System data. The most recent forecast was completed in Fall 2014.
- The Ministry also collaborates annually with health authorities for supply and demand information on the highest priority health professions. This forms the annual top 10 health priority professions listing. The 2015/16 Top 10 list includes: Registered Nurse-Specialty Nursing; Physiotherapist; Registered Nurse; Nurse Practitioner; Occupational Therapist; Respiratory Therapist; Ultrasonographer ; Medical Laboratory Technologist; Licensed Practical Nurse; and Health Care Assistant/Care Aide. **Note**: Physicians continue to be a priority but are not in the official top 10 list.
- The priority health professions are used to support the Ministry of Jobs, Tourism, Skills and Training's Labour Market Information Office in its development of the BC Labour Market Outlook report, the Ministry of Advanced Education in its post-secondary institution seat planning and funding allocation for health professions, and StudentAid BC's Loan Forgiveness Program.

Future Integrated HHR Planning

- 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 Integrated HHR Planning approach that utilizes both supply/demand and population-needs based forecasting models.
- As part of a Provincial Strategy for HHR, the Ministry is planning for the coordination of a Provincial HHR Plan in collaboration with health authorities to determine the optimal mix, distribution and number of physicians, nurses, and select priority allied health professions for BC over the next 3 years.
- The goals of this first plan for BC's health care workforce will be to engage health authorities and the ministry in a collaborative planning exercise, within a feasible planning horizon of 3 years. The plan will provide the ability to better proactively identify and manage workforce supply challenges. It will allow for the use of evidence-based, data-driven decisions to supply the right number, mix and type of health care professionals in the right communities in BC. It will allow for a provincial level coordination of HHR education and training, recruitment and retention strategies, as well as support the need for unique or individual HHR strategies where required.
- This will be an ongoing, annual planning exercise for BC's health care system. The scope is intended to grow as data and methodology to forecast supply of and demand for the health care workforce progresses. The introduction of the Integrated HHR Forecasting Tool in the next year will introduce a common methodology and provincial forecast of the health workforce.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Raeleen Siu, Workforce Planning & Management Branch; January 22, 2016
Kevin Brown, Workforce Planning & Management Branch; January 25, 2016
Kevin Brown, obo Ted Patterson, Health Sector Workforce Division; January 25, 2016

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 Planned Call Groups by Type 2015/16:[1]
1	430
2	267
3	52
OSOC	12
Grand Total	**761**

- MOCAP requires physicians to provide on-call availability for a range of levels which include:[2]
  - On Site On-Call (OSOC) ($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 2015/16 call group plan data received from Health Authorities in April 2015 and January 2016. Actual call backs data are based on usage and are reported at the end of the fiscal year.

[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 continued until June 1, 2013, under the 2012 Physician Master Agreement (PMA).
- In 2010/11, health authorities made a number of changes to manage their MOCAP commitments within their available MOCAP funding allocations. In all cases, health authority senior medical staff considered the changes to be compatible with providing effective and efficient emergency care to patients.
- 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 PMA, the Government negotiated a review process 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. In 2013 the Physician Services Committee approved recommendations to gather information to assess the call burden of different groups and to redesign the MOCAP program based upon that information.[4]
- The Provincial MOCAP Review Committee was then created by PMA Agreement Section 17.4 in April 2014 to oversee and guide the redesign and transition to an updated MOCAP program.
- The first activity of the redesign process is a data collection and analysis exercise to validate burden of providing on call services on a physician group and to develop a provincial tool that will allow for placement of the physician group at the appropriate funding level. This exercise is currently planned to commence during early 2016.

FINANCIAL IMPLICATIONS

Health authority MOCAP funding plans for 2010/11 have been carried forward into 2011/12, 2012/13, 2013/14, 2014/15 and 2015/16. The health authorities have been made aware that any over expenditures will need to be covered by their global operating budgets. Distribution of the provincial MOCAP budget for 2015/16 by health authority is as follows:[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**

Approved by:
Marie Ty, Compensation Policy and Programs Branch; January 14, 2016
Ted Patterson, Health Sector Workforce Division; January 24, 2016
Daryl Conner,obo Manjit Sidhu, Finance and Corporate Services Division; March 3, 2016

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3 Dr.Klippert, Lorne. Medical On-Call Availability Program (MOCAP) – Options for Consideration. December 29, 2010. p.4. Z:\APP\APP LAN TEST\MOCAP\07 MoH Reports\Program Evaluation Reports\MOCAP2 Draft Options(5) 10 Dec30 (3) - LK.doc

[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 2015/16 Budget. Retrieved June 30, 2015 from Z:\APP\APP LAN TEST\Financial Stewardship\MOCAP Budget\15-16\FY 15_16 MOCAP Budget - 20150630.xlsx

FACT SHEET

Medical Residency Positions

ISSUE

Since 2003, BC has more than doubled the total number of postgraduate medical education (PGME) or residency positions for Canadian Medical Graduates (CMGs) and International Medical Graduates (IMGs) to better meet the health care needs of British Columbians.[1]

KEY FACTS

- Entry-level (first-year) residency positions will have increased from 134 in 2003 to 346 positions in 2016: 288 positions for CMGs and 58 for IMGs.
- BC allocates residency positions 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 members of the Residency Allocation Subcommittee, which includes health authority Vice Presidents of Medicine, University of BC (UBC) Faculty of Medicine, and Ministry of Health. The Residency Allocation Subcommittee is responsible for developing a 3 to 5 year rolling plan for the allocation of all Ministry funded residency positions to the UBC PGME program.[2]
- To align with Ministry and health authority priorities, the UBC Faculty of Medicine maintains at least 60% of Canadian Resident Matching Service (CaRMS) entry-level positions in Family Medicine and the generalist specialties (Internal Medicine, Pediatrics and Psychiatry) supporting primary health care.[3]

Canadian Medical Graduates

- CMGs (and IMGs) must complete PGME training to qualify for full licensure to practise independently.
- BC has more than doubled the number of first-year residency positions for CMGs, from 128 in 2003 to 288 in 2011.

International Medical Graduates

- IMGs compete for IMG entry-level positions in the first iteration of CaRMS, and for unfilled IMG and CMG positions in the second iteration of the match.
- The residency selection process is based on fairness, objectivity, transparency and selection of the best candidates. There is no distinction between IMGs who are Canadian citizens choosing to study medicine abroad, and naturalized citizens or permanent residents that were educated in another country.[4]
- Before applying for a residency position in CaRMS, IMGs take the National Assessment Collaboration Objective Structured Clinical Examination. The examination tests knowledge, skills and attitudes in a series of mock clinical stations to assess IMGs' readiness for entrance into a Canadian residency program.[5]
- To further assess readiness, BC established the optional *IMG-BC Clinical Assessment Program* (CAP). The CAP provides IMGs with the opportunity to demonstrate clinical experience, and can help increase the chance of a successful residency match. To take less time away from IMGs participating

[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. (2012). Medical Human Resources Planning Task Force – Residency Allocation Subcommittee: Terms of Reference. p.1

[3] Ministry of Health. (2011). 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.

[4] Ministry of Health, (2016). Common Briefing Document: Canadians Studying Medicine Outside of Canada and Access to Postgraduate Medical Education in British Columbia.

[5] Medical Council of Canada (MCC). (2016). National Assessment Collaboration. MCC. Retrieved January 15, 2016 from http://mcc.ca/examinations/nac-overview/

in the CAP (i.e., for work, family, and training programs), in 2015 the CAP was reduced from 8 to 4 weeks, and the number of spaces increased from 60 to 100 per year.[6]

- Prior to expansion in 2003, 6 residency positions were reserved for IMGs. In 2006/07, the Ministry tripled the number of postgraduate entry-level positions to 18.[7] As of 2015/16, 58 entry-level positions were funded for IMGs in the province's priority specialities: 52 entry-level positions in Family Medicine, 6 in generalist specialties including Internal Medicine, Psychiatry, and Pediatrics.

Distributed Residency Training

- BC is recognized as a best practice jurisdiction for distributed medical education and training, and is already experiencing early gains in the increased number of practicing physician and practice locations across the province.
- Medical training has been distributed across the province to Prince George, Kelowna and Victoria. Distributed medical education prepares future doctors for the challenges and benefits of practicing in rural and remote communities, while also increasing access to more comprehensive services (i.e., provided by PGME residents) in these underserved areas.
- The eight new entry-level residency positions for IMGs in 2016 include three at the Kamloops' site, one at Vancouver-Fraser, one at St. Paul's Hospital, one at Rural Okanagan and two at Victoria.[8]
- Upon successful completion of PGME, residents selected into an IMG residency position must complete a Return of Service, usually in a rural/remote or underserved community. A resident completing a Family Medicine specialty is required to complete a 2 year Return of Service, and 3 years if practising in a Royal College Specialty.[9]

FINANCIAL IMPLICATIONS

- The Ministry of Health makes a substantial investment in PGME each year. In 2015/16, the Ministry's program operating funding for PGME is $126.8 million (includes IMG-BC funding, and $2.0 million reduction in residents' benefits) - up from $43 million in 2003/04, when the Ministry began to increase funding to expand PGME. s.13,s.17

s.13,s.17

- Program operating funding in 2015/16 is $14 million for the IMG-BC Program (National Assessment Collaboration Objective Structured Clinical Examination and 4 week clinical assessment) and IMG residency positions in Family Practice and specialties. s.13,s.17

s.13,s.17

Approved by:

Kevin Brown, Workforce Planning & Management Branch; January 25, 2016
Ted Patterson, Health Sector Workforce Division; February 2, 2016
Daryl Conner obo Manjit Sidhu, Finance & Corporate Services Division; February 22, 2016

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[6] Ministry of Health. (2015). Decision Briefing Note: IMG-BC Clinical Assessment (CAP): Program Revision (Cliff # 1037963)
[7] Evaluation Studies Unit. Long-Term Outcomes Evaluation Report 2014-15, Physician Contribution to the Province. Vancouver, BC: University of British Columbia Faculty of Medicine; 2015
[8] Lois Moen, IMG Information Request, Email Communication, January 13, 2016.
[9] International Medical Graduate Office. (2015). Eligibility. University of British Columbia. Retrieved January 18, 2015 from http://imgbc.med.ubc.ca/eligibility/

s.13

FACT SHEET

Nurse Practitioners

ISSUE

Local and regional issues continue to be raised regarding nurse practioner integration.

KEY FACTS

- Nurse Practitioners (NPs) were introduced to BC in 2005 and are Registered Nurses with advanced education (Masters' prepared and/or equivalent clinical experience/education). NPs are authorized to perform the full range of nursing functions plus additional functions including - assessment, diagnosing, prescribing, ordering diagnostic tests, managing common acute and chronic illnesses, and referring patients to specialists.
- As independent practitioners, NPs do not require an order from a physician to act, but may serve as the primary care provider and work collaboratively with other members of the health care team.
- 3 license categories of NPs are recognized in BC – Family, Adult, and Pediatric. Currently there are 397 practising NPs in the province.[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 (BC programs presently only offer the NP Family category).
- Standards, competencies, guidelines, limits, and conditions for Family, Adult, and Pediatric NPs, are developed through the NP 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 (general practitioner and specialist), the College of Pharmacists, the public, and Government.
- In Fall 2011, BC introduced Bill 10, the *Nurse Practitioners Statutes Amendment Act*. 12 Acts were amended and 11 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 9 statutes to expand scope 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 had committed to funding 135 new positions to support integrated primary and community care objectives (45 Full Time Equivalents) per fiscal at an average salary of $116,000 per position, including benefits).
- In October 2012, changes to the *Hospital Act* and Hospital Insurance Act Regulations provided the framework to enable NPs to admit and discharge patients.
- An Encounter Code Working Group (ECWG)[3] was established in April 2013 to revise the NP Encounter Codes and Resource Manual.[4] As of October 1, 2014, NPs are required by the Ministry to submit Encounter Records with these revised Encounter Codes. In January 2016, the Ministry hosted a follow up ECWG meeting with stakeholders to discuss the submission and use of encounter codes. This meeting gave the Ministry perspective from each health authority on the application and submission of encounter codes. The Ministry received positive feedback and established an ongoing link for communication between the health authorities and the Ministry.
- A workshop held on October 23, 2013, *Nurse Practitioners 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. Next steps included the creation of an NP Action Plan.

[1] CRNBC website. Retrieved on January 2016 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
[3] Members of this group included; NP leads and practicing NPs from each health authority, the BCNPA, Chief Nursing Officers Council, and CRNBC.
[4] The codes and manual have since been revised and are available online on the MSP website at http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/7-encounter-codes.pdf

FACT SHEET

- In 2015, the Ministry hired a consultant to develop an Action Plan to identify recommendations for priority issues of NP education/funding. The Ministry is currently reviewing these recommendations.
- Neo Natal NPs (NNPs) are advanced practice nurses with specialized education in neonatology. NNPs are recognized and regulated in six Canadian provinces, the United States, and Australia. Currently CRNBC does not have a regulatory framework for NNPs, and therefore NNPs cannot practice in the BC health system.
- Based upon an identified need in BC specifically at the Provincial Health Services Authority, the Ministry requested CRNBC to provide options for the regulation of NNPs in BC. The Ministry is currently reviewing the options for moving forward with implementation.
- NPs were recently included under the New Classes of Practitioners Regulation under the Federal *Controlled Drugs and Substances Act*.
- On December 3, 2015, Minister Terry Lake approved the updated Nurses (Registered) and Nurse Practitioners Regulation to include the authority for NPs to order controlled drugs and substances (and to order MRIs). These regulations are now in force; however, before NPs can move forward with these activities, CRNBC needs to establish the appropriate Standards, Limits and Conditions.
- The Ministry expanded access to enhance health care delivery through a pilot to allow NPs licensed by the CRNBC to access PharmaNet. As a result, NPs now have permanent access to PharmaNet.
- 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

As at March 31, 2015, the Ministry provided total funding of approximately $162 million to the health authorities for NP positions.

Summary of NP Funding - HAs base funding and MSP - NP4BC

($ in millions)	Actual										Projected	
	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	Total
HAs - Base Funding	1.17	8.47	16.99	16.99	16.99	16.99	16.99	16.99	16.99	16.99	16.99	162.57
One-time Funding	0.69	0.53	0.72	-	-	0.12	-	0.25	-	-	-	2.31
MSP - NP4BC	-	-	-	-	-	-	-	0.45	5.21	8.60	13.10	27.35
Total	1.86	9.00	17.71	16.99	16.99	17.11	16.99	17.69	22.20	25.59	30.09	192.24

**Approximately $17 million of this funding is included within the health authorities' base budgets. The 190 new NP positions will cost approximately $22.2 million annually ($15.7 million to be covered by the Ministry and $6.5 million to be covered by the health authorities).*[5]

NP Reporting - Actual YTD Operational Expenditures*: [6]

Health Authority	Actual Expenditures - Other
Fraser Health Authority	$540,000
Interior Health Authority	$171,485
Island Health	$445,864
Northern Health Authority	$216,066
Providence Health Care	$22,154
Provincial Health Services Authority	$376,834
Vancouver Coastal Health	$175,377
TOTAL	$1,947,780

**Other YTD actual expenditures up to and including November 2015 / *Expenses from both globally funded and MSP funded (NP4BC)*
**Examples of expenditures in this category include: professional development, seminars/conferences, and non-labour expenses such as medical/surgical supplies, drugs, supplies and sundry expenses i.e. cell phones, computers, minor equipment, and office furniture*

Approved by:

Kevin Brown, obo Ted Patterson, Health Sector Workforce Division; February 11, 2016
Daryl Conner, Finance and Corporate Services Division; March 3, 2016

[5] Financial Implications confirmed by Bonnie Wong February 2, 2016 and Pat Bruce, February 29, 2016.
[6] February 29, 2016, numbers verified to HA's third quarter projections by Pat Bruce, Budget Manager Finance & Decision Support.

FACT SHEET

Physician Expenditures

ISSUE

- Expenditures for physician services include: Fee-for-Service; Alternative Payments Program; Medical On-Call Availability Program; Rural Programs; targeted incentives (e.g., General Practice Services Committee payments); benefits; and other payments. Across all programs, the average expenditure per physician in 2014/15 was $345,724.[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 2015/16, the budget for physician services is $3.945 billion, a 1.30% increase over the 2014/15 budget of $3.894 billion.[2] Actual expenditure in 2014/15 was $3.869 billion.

Table 1: 2014/15 Physician Services Expenditure by Category[3],[4]

Category	Expenditure (Millions)	Proportion of Total	Increase over 2013/14
Fee for Service	$2,803	72.46%	2.53%
Alternative Payments Program	$438	11.31%	1.26%
Targeted	$280	7.24%	-8.43%
Medical On-Call Availability Program	$127	3.29%	-1.52%
Rural	$115	2.98%	1.50%
Benefits	$105	2.72%	1.44%
Total	$3,869	100.00%	1.31%

- Physician services budgets are approximately 23% of the Ministry of Health budget in 2014/15 and 2015/16.[5] A small portion of physician compensation is funded through health authority global budgets and not captured in these figures.
- Over the 14-year period 2001/02 to 2014/15, the annual total physician services expenditures grew by $1.7 billion from $2.2 billion to $3.9 billion .[6]
- Over the same time period, the compound annual average growth in physician services expenditures of 3.9%[7] is similar to that of provincial health function expenditures (4.0%) and exceeds that of provincial revenue (3.8%) and operating expense (2.9%).[8]
- Payments for fee-for-service grew by an compounded average annual rate of 3.1% from $1.79 billion to $2.80 billion.[9]

Inter-Provincial Comparisons

- 2013/14 statistics published by CIHI that compare fee schedule prices across Canada show that BC ranked seventh highest in average fees after Alberta, New Brunswick, Saskatchewan, Manitoba, Quebec, and Nova Scotia.[10]

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[1] Source: Health Sector Workforce Division, Workforce Analysis, Research and Evaluation Branch (WARE), Feb. 2016
[2] Ministry of Health, 2015/16 to 2017/18 Service Plan, February 2015.
[3] BC Public Accounts, 2014/15
[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, 2015/16 to 2017/18 Service Plan, February 2015.
[6] BC Public Accounts, 2014/15
[7] Source: WARE using Medical Services Plan detail from Public Accounts of Province of BC (base year 2001/02). PV=2,201,532,145; FV=3,869,000,000, N=14, then i=3.9%
[8] Data ssources: Tables A2.5 and A2.7 of 2015 Financial and Economic Review, July 2015.
[9] WARE using Medical Services Plan detail from Public Accounts of the Province of BC, 2015. (base year 2001/02) PV=1,791,900,000; FV=2,803,452,935, N=14, then i=3.1%
[10] Physician Services Benefits Rate Report, 2013/14, Canadian Institute for Health Information, Table 1.1, 2013-2014 https://secure.cihi.ca/estore/productSeries.htm?pc=PCC979

- As of 2013/14, BC had the sixth highest payment per fee-for-service physician full-time equivalent in Canada at $325,103. This is behind Alberta ($404,744), Saskatchewan ($366,410), New Brunswick ($352,765), Manitoba ($341,477), and Quebec ($330,954) with the BC average slightly lower than the Canadian average of $328,640[11]

FINANCIAL IMPLICATIONS

N/A

Approved by:

Nancy South, Workforce Analysis Research Evaluation; February 5, 2016
Nancy South, obo Ted Patterson, Health Sector Workforce Division; February 5, 2016
Daryl Connor, Finance and Corporate Services Division; February 22, 2016

[11] National Physician Database, 2013/14, 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 (CMA) and the Canadian Institute for Health Information (CIHI).

KEY FACTS

Physician Counts

- As of March 31, 2015, the Ministry counted 11,191 physicians under all Ministry payment sources (fee-for-service, sessions, service contracts and salaries).[1]
    - Of those, 7,594 (68%) were fee-for-service only, 778 (7%) were on alternative payments only, and 2,819 (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 2015, the CMA reported a total of 11,404 physicians for BC.[2]
    - 6,161 (54%) are Family Physicians and 5,243 (46%) are specialists.
    - 7,361 (65%) are male and 4,031 (35%) are female.[3]
- As of December 2014, CIHI reported a total of 10,692 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 CMA and the President of the Association of Canadian Medical Colleges, endorsed a ratio of 180 to 190 physicians for every 100,000 people.[5]
- According to the CMA, BC's ratio of 229 physicians per 100,000 people in 2014 tied for fourth with New Brunswick and Alberta, behind Nova Scotia (260) and Newfoundland & Labrador (248) and Quebec (239).[6]

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[1] Compensation and Negotiation Branch, Health Sector Workforce Division, February 2015.
[2] Canadian Medical Association Master file, January 2015. *Number of Physicians by Province/Territory and Speciality, Canada, 2015.* Retreived on November 18, 2015 from https://www.cma.ca/Assets/assets-library/document/en/advocacy/01-physicians-by-specialty-province-2015-e-rev.pdf.
[3] Canadian Medical Association Masterfile, January 2015. *Number of active physicians by age, sex and province/territory, Canada, 2015.* Retrieved on November 18, 2015 from https://www.cma.ca/Assets/assets-library/document/en/advocacy/04AgeSexPrv.pdf
[4] CIHI. *Supply, Distribution and Migration of Canadian Physicians, 2014.*, data tables. Retrieved electronically September 30, 2015 from https://secure.cihi.ca/estore/productFamily.htm?pf=PFC2964&lang=en&media=0
[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
[6] Canadian Medical Association Master file, January 2015. Retrieved from https://www.cma.ca/Assets/assets-library/document/en/advocacy/12-Phys_per_pop.pdf

FACT SHEET

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 30% from 8,234 in 2002 to 10,692 in 2014[7] more than doubling the 13% growth in BC population over the same period of time.[8]
    - 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.[9]
- BC increased training capacity for physicians.
    - 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. The opening of the Southern Medical Program added a further 32 first-year seats for a total of up to 288 graduating medical students each year by 2014/15.
    - To keep pace with the undergraduate medical program expansions, postgraduate medical education (residency positions) has also increased, from 134 in 2003 to 338 in 2014/2015. In 2015/16, the Ministry of Health expects to fund a total of 346 entry-level residency positions: 288 for Canadian medical graduates; 58 for International medical graduates.
    - BC's goal of distributing medical education throughout the province is to help 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.
- In most years BC attracts physicians from the rest of Canada.
    - In 2014, the net gain of physicians to BC was 46, which followed a net gain of 15 in 2013, a net gain of 95 in 2012, a net loss of 57 in 2011, and a net gain of 34 in 2010.[10]
    - Alberta and Ontario are the originating provinces of most physicians migrating to BC.[11]
- Since 2012, BC has gained more physicians returning from abroad than the province lost to physicians moving abroad. In 2014, BC had 40 physicians move abroad and 45 physicians arrive from abroad.[12] Of the 45 arriving from abroad, 19 were Canadian medical school graduates and 26 where graduates of foreign medical schools.[13]

FINANCIAL IMPLICATIONS

N/A

Approved by:

Nancy South, Workforce Research & Analysis Branch; February 5, 2016
Nancy South, obo Ted Patterson, Health Sector Workforce Division; February 5, 2016
Carolyn Bell, obo Teri Collins, Health Sector Information, Analysis and Reporting Division; February 12, 2016

[7] Ibid 4. CIHI has more historical physician data readily available than the Ministry. Hence the use of CIHI trends here.
[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] Ibid, 4
[10] Ibid, 4, Table Profile B.C.
[11] Ibid, 4, Table 10: Specialists migrating between Canadian jurisdictions who were in Canada on both December 31, 2013, and December 31, 2014
[12] Ibid, 4, Table Profile B.C.
[13] Ibid, 4, Tables Profile B.C., 17, 17.1

FACT SHEET

Population Based Funding

ISSUE

Summary of the status of the Population Based Funding Program (PBF), an alternative primary care physician funding model.

KEY FACTS

- PBF was developed as an alternative primary care funding model as supported by federal funds from Primary Health Care Transition Fund in 1998.
- PBF practices register patients, and an annual amount is paid to the practice based on the illness burden of each individual patient as opposed to fees for services rendered.
- Currently there are about 44,000 patients registered to eight participating practices (1% of the population)[1].
- The member practices do have the option of providing fee-for-service (FFS) to non-registered patients.
- The model is currently managed within the Compensation Policy and Programs Branch at the Ministry of Health.
- The active and former program site locations are as follows:

Number of Sites	2007	Changes between 2008-10	2016
Health Authority owned			
Fraser Health (Agassiz)	1	(1)	0
Interior Health (Chase, Logan Lake, Kamloops)	3	(3)	0
Vancouver Coastal Health (Pacific Spirit, Evergreen, Ravensong)	3	(3)	0
Vancouver Island Health (Ladysmith)	1		1
Society Owned			
James Bay	1	(1)	0
Physicians owned			
Abbotsford	1	(1)	0
Langley (Murrayville, Langley, Fort Family, Brookswood, Four Oaks)	5		5
Vancouver (Spectrum, UBC Family)	2		2
Total Sites	**17**	**(9)**	**8**

- There have been no sites added since 2007; however, other sites have indicated interest in joining the model and are being contemplated.
- Multiple evaluations of the model over the past years have yielded no conclusion on the effectiveness of the program. However:
  - A 2004 paper showed some evidence of lower use of acute care.
  - A 2008 review of the Fraser Health sites concluded that the model provided a "more suitable foundation for delivering team based care."
  - An internal Ministry study in 2012 showed that patients stay more persistently attached at PBF sites, and though not statistically significant due to inadequate sample sizes, PBF registered patients exhibited lower average lengths of stay in acute care.

[1] Source: Patient count fluctuates daily - DB2 table in the HIBC system: TPCPRT, copied daily to the data warehouse into a table of the same name.

- The model is more challenging to administer than FFS due to register management, both at the Ministry and site levels and the importance of accurate diagnosis coding that drives the revenue per patient.
- Physicians using the PBF model have expressed that it values their judgement more than FFS because it is not as directive as the fee items in the FFS system which dictate the service that must be provided to earn the fee.
- PBF funds other health care providers because, being patient focussed, it allows the physician owners to choose the health care human resources required to serve the registered patient population. Because of this, it has proved easier to increase practice capacity by adjusting human resources e.g., adding Nurse Practitioners or Registered Nurses.
- The outflow mechanism, the deduction from a patient's PBF funding for each FFS visit from physician practices other than the one they are registered to, is the business motivation to provide the full spectrum of care with extended access hours.
- PBF has effectively utilized Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses as part of the primary care team. The single revenue PBF source funds all health care providers at the primary care site as opposed to the more common method of inserting a health authority salaried NP into a FFS General Practitioner clinic.

FINANCIAL IMPLICATIONS

- The 2015/16 budget for the current sites is approximately $12.8 million.
- A limited Ministry evaluation showed the average annual primary care costs for a similar set of patients was $260 for PBF vs $240 for FFS.[2]

Approved by:
Marie Ty, Compensation Policy and Programs Branch; January 20, 2016
Ted Patterson, Health Sector Workforce Division; February 2, 2016
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; February 22, 2016

[2] Source: Atkinson Evaluation Study, 2012 (draft report)

FACT SHEET

Practice Ready Assessment for Family Physicians

ISSUE

Foreign-trained family physicians, which are licensed, practicing physicians in other countries, are often unable to qualify for a license to practice medicine in Canada.

KEY FACTS

- There are 3 pathways to licensure for foreign-trained family physicians who are licensed, practicing physicians in other countries:
  1. Retake postgraduate medical education in Canada;
  2. Graduate from an accredited postgraduate family medicine training program in a jurisdiction where the standards for accreditation of postgraduate training and the criteria for certification are judged comparable and acceptable in Canada (i.e. United States, United Kingdom, Ireland, and Australia); or
  3. Undergo a practice ready assessment in Canada for at least three months.
- The new Practice Ready Assessment (PRA-BC) pilot program for family physicians will support the third pathway in our province. Foreign-trained physicians or International Medical Graduates (IMGs), on this pathway undergo a rigorous competency-based, pre-practice assessment in Canada, and prior to qualifying for a provisional license to practice.
- PRA-BC will follow a standardized format approved by the Medical Council of Canada's National Assessment Collaboration. The format meets the medical regulatory authorities' provisional licensure requirements across Canada, due to changes to the *Agreement on Internal Trade* and increased labour mobility. The Collaboration consists of representatives from provincial health ministries, faculties of medicine, medical regulatory authorities, and IMGs from across Canada.
- The PRA-BC is funded by the Joint Standing Committee on Rural Issues, a joint committee of the Ministry of Health and Doctors of BC and will help address access to rural family physicians in BC by requiring successful applicants to provide a three year Return of Service in a rural community of need.
- PRA-BC assessed 14 IMG family physicians for practice-readiness in the Spring of 2015 and another 11 IMGs in the Fall of 2015, for a total of 25 practice-ready family physicians this year.
- Applicants undergo a two week orientation and series of clinical exams in Vancouver before undergoing a twelve week Clinical Field Assessment under the supervision of a fully licensed family physician in a rural BC community.
- The first and second cohorts of PRA-BC IMGs will be distributed across the province based on the following distribution scheme: Northern Health 11 IMGs; Interior Health 8 IMGs; and Vancouver Coastal 1 IMG.
- The Joint Standing Committee on Rural Issues has committed funding for the PRA-BC program until March 31, 2018. The PRA-BC program is expected to develop a long-term sustainability plan for consideration by the Joint Standing Committee by March 31, 2017 for implementation on April 1, 2018, that will address funding, program scope, governance and accountability.

<u>Background</u>

- Until 2012, the College of Physicians and Surgeons of BC conducted a paper-based assessment of foreign-trained physicians requiring a practice assessment.
- Due to changes to the Agreement on Internal Trade in 2009, the national College of Family Physicians of Canada began work on pathway 2, and the Collaboration began work on a practice assessment for family physicians.

- In 2013, the Collaboration finalized the PRA for foreign-trained family physicians. Also in 2013, the Collaboration began work on a PRA for foreign-trained general specialists, beginning with general internists and psychiatrists.
- South Africa declined to participate in the College of Family Physicians of Canada's process for evaluating equivalency of foreign medical education programs, and therefore foreign-trained family physicians from that country must now access a PRA if they wish to practice in Canada.

FINANCIAL IMPLICATIONS

- The BC Joint Standing Committee (JSC) on Rural Issues (a joint Ministry of Health-Doctors of BC committee) contributed $1 million for PRA-BC pilot start-up costs for 2014/15. This funding went towards hiring a project manager and a clinical director of clinical field assessment, to implement the pilot.

s.13,s.17

Approved by:
Kevin Brown, Workforce Planning & Management Branch; January 25, 2016
Ted Patterson, Health Sector Workforce Division; February 3, 2016
Darryl Conner, Finance and Corporate Services Division; February 22, 2016

FACT SHEET

Rural Emergency Enhancement Fund

ISSUE

In 2011, the Joint Standing Committee on Rural Issues (JSC) created the Rural Emergency Enhancement Fund (REEF) to support the provision of reliable, public access to Emergency Department (ED) services in rural hospitals across the province where services are provided by General Practitioners (GPs) on a Fee for Service (FFS) basis.

KEY FACTS

- Rural hospitals are reliant on local GPs to form groups (typically called a "rota") to provide emergency medicine services.
- In BC, there are 51 rural communities where GPs provide hospital ED services on a FFS basis.
- On April 6, 2009, the Government and Doctors of BC entered into an agreement, which provided an additional $20 million over 2 years (2010/11 and 2011/12) to the JSC to enhance and expand support for the delivery of physician services to British Columbians in rural areas.[1] The JSC allocated a portion of this funding to support rural EDs.
- On July 15, 2011, JSC announced the REEF program to encourage and support rural GPs who form groups who commit to maintain reliable public access to emergency services in rural BC hospitals.
- REEF provides funding of up to $200,000 per annum to physicians who work in health authority designated EDs that provide 24/7/365 public access to emergency services.[2]
- Funding is pro-rated, to correspond with health authority designated hours of public access, for EDs that are not open 24/7/365.
- An ED coverage plan is developed by the group of community physicians who provide full-service family practice and who are also prepared to commit to provide scheduled, public access to hospital emergency services in their communities.
- The plan is developed in collaboration with the health authority and must be signed off by the VP of Medicine (or designate) to ensure that it aligns with the health authority's broader plans for the provision and delivery of health care services in the community and surrounding area.
- Examples of the ways in which funding could be applied include, but are not limited to:
  - Hiring additional full- or part-time GPs with enhanced emergency skills;
  - Hiring additional health care professionals who may assist physicians in providing emergency services;
  - Incenting physicians to do weekend, holiday, and/or night shifts; and
  - Purchasing equipment.
- The maximum any one physician may receive under REEF is $65,000/year.[3]

FINANCIAL IMPLICATIONS

For 2015/16, the budget for REEF is $9.65 million.[4]

Approved by:
Marie Ty, Compensation Policy and Programs Branch, January 14, 2016
Ted Patterson, Health Sector Workforce Division; January 24, 2016
Daryl Conner, Finance and Corporate Services Division; February 22, 2016

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[1] 2009 MOA Article 2.03 (a) & (b)
[2] Rural Emergency Enhancement Fund (REEF) Policy - fhttp://www2.gov.bc.ca/assets/gov/health/practitioner-pro/reef-policy.pdf
[3] Rural Emergency Enhancement Fund (REEF) Policy - http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/reef-policy.pdf
[4] Physician Compensation Branch file: FY15_16 Rural Budget History and One-time Funding Expenditures December

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

Ten of thirteen rural programs have identified budgets totaling approximately $33.5 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. **Rural Emergency Enhancement Fund (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 = $9.65 million.
2. **Rural General Practitioner Locum Program (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 up to an additional $100 per day for providing required enhanced skills (e.g., emergency, anaesthesia, general surgery 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)** - 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 = $3.9 million for POP, while the NITA portion is covered by the Available Amount.
4. **Rural Education Action Plan (REAP)** - supports the training needs of physicians in rural practice, provides undergraduate medical students with rural practice experience, increases rural physician participation in the medical school selection process and provides rural scholarships (up to 20) to medical students of rural origin/interest to encourage practice in rural communities (commenced September 2014).
   Budget = $3.2 million
5. **Rural Coordination Centre of BC (RCCbc)** - links the JSC, rural physicians, rural communities and University of BC. Works to develop strong relationships between all facets of rural health care and works broadly through six areas of interest including education.
   Budget = $2.4 million
6. **Rural Specialist Locum Program (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. The current list of RSLP eligible communities approved by the JSC is: Campbell River, Comox, Courtenay, Cranbrook, Dawson Creek, Fort 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

7. **Recruitment Contingency Fund (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 = $1.825 million
8. **Isolation Allowance Fund (IAF)** - 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
9. **Rural GP Anaesthesia Locum Program (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/ day, receive reimbursement for their travel expenses, and are paid a travel time honorarium of up to $600.
   Budget = $250,000
10. **Supervisors of Provisionally Licensed Physicians (SPLP)** - provides funding to supervisors of provisionally licensed physicians to help alleviate the financial and related burdens experienced by physicians who travel and/or forego their own practice time to provide supervision to provisionally licensed, rural physicians.
    Budget = $6.2 million

UTILIZATION-BASED PROGRAMS

1. **Rural Retention Program (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.
   Budget = $61.11 million - expenditures under this program are forecast at $75.9 million for 2015/16.
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.
   Budget = $1.34 million - expenditures under this program are forecast at $1.5 million for 2015/16.
3. **Rural Continuing Medical Education** - 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.
   Budget = $5.04 million - expenditures under this program are forecast at $6.5 million for 2015/16.

FINANCIAL IMPLICATIONS

The total budget for the rural programs is approximately $110.8 million. The utilization-based programs' 2015/16 budget is approximately $67.5 million and the JSC's 2015/16 budget is $43.3 million.

Approved by:
Marie Ty, Compensation Policy and Programs Branch; January 16, 2016
Ted Patterson, Health Sector Workforce Division; February 1, 2016
Daryl Conner, Finance and Corporate Services Division; February 12, 2016

FACT SHEET

Specialty Nursing

ISSUE

Specialty Nursing (SN) is an ongoing priority for the Ministry of Health. With ongoing supply gap projections and the increasing demand from health authorities for SN education, there is an immediate need to improve coordination at the provincial level to develop intermediate and long-term supply and education strategies for SN.

KEY FACTS

SN refers to roles of Registered Nurses (RNs) who work in one of 20 SN areas as defined nationally by the Canadian Nurses Association (CNA), and who have gained in-depth post-basic training in a particular specialty practice area. The CNA offers voluntary, exam-based national certification[1] in these specialties for RNs licensed in Canada who meet specific practice, continuous learning and testing requirements.

SN Education in BC

- In BC, the BC Institute of Technology (BCIT) is the only publically funded post-secondary institution (PSI) that delivers education for the core specialties (Critical Care, Emergency Nursing, High Acuity Nursing, Neonatal, Nephrology, Occupational Health, Paediatric, Perinatal, and Perioperative). The University of Northern BC offers the rural acute nursing program that some health authorities access for their rural acute settings. Kwantlen Polytechnic University has historically provided *ad hoc* critical care education on a cost recovery basis. Douglas College offers the Mental Health Nursing Certificate Program.
- In 2015, the Ministry collected information from the health authorities to identify a provincial overview on the delivery of SN education and to obtain how they are currently addressing their regional needs for SN. Analysis of the current data confirms inconsistency in the approaches to SN education among and within the health authorities, and the need for improved coordination at the provincial level. The health authorities are presently accessing SN education either through:
    - Specialty education programs through a PSI within BC or Alberta (Grant McEwan, Mount Royal University or Grande Prairie Regional College);
    - 'In-house 'on-the-job training/orientation established by the employer (does not provide student with any credential or CNA recognized certification); or
    - A combination of these approaches.
- A variety of reasons have been identified for this variation, including: differences in patient complexity/acuity in different communities; ability of PSIs to meet health authorities' needs; differing levels of financial resources for development of in-house curriculum; level of PSI education too high or too low for need; and, proximity to education opportunities.
- In addition to other stakeholder meetings, in late Spring of 2015, a meeting was held in Vancouver with the Ministry, Ministry of Advanced Education (AVED), BC Nurses Union (BCNU), Health Employers Association of BC, and health authority Chief Nursing Officer and Vice President of Human Resources representatives, to discuss SN education issues, specifically the need for a provincial forecasting approach and immediate short-term and long-range SN education needs.
- As of January 2016, two working groups with the health authorities, AVED, the Ministry, and PSI are working together to mitigate the intermediate supply gap (2015/16 through 2018/19) inclusive of a provincial coordinated approach to projecting SN need in BC, and to create a long-term framework

[1] Specialty Nursing Certification by the CNA for RNs is distinct from Certified Practices, which are activities that RNs can carry out (e.g., diagnosis and treatment of a client) only after they have completed a certification program approved by the College of Registered Nurses of British Columbia (CRNBC). There are three certified practice components: Reproductive Health (sexually transmitted infections/contraceptive management), Remote Nursing Practice, and RN First Call.

for a provincial approach to SN education (entry to practice and post entry to practice requirements).

SN Workforce Projections in BC

- Significant funds and effort have been invested on various aspects of SN over the past several years. Consistently, forecasting data projects shortages for SN, and the majority of difficult to fill RN vacancies in BC occur in specialized practice settings.
- The Ministry and the health authorities are working together on a coordinated forecasting approach for SN projected need for 2016/17 and going forward.
- Information provided by the the health authorities and BCIT indicates that the number of SN FTEs required for 2015/16 will total 667. For 2016/17 the health authorities have identified a need for 829 FTEs through BCIT.

Labour and Negotiations

- In April 2015, the Ministry and the Health Employers Association of BC reached an agreement with BCNU and the Nurses Bargaining Association to address staffing challenges in health authorities, with about $5 million allocated towards SN training seats (152). As part of this agreement, the Ministry has also provided $1 million to assist Licensed Practical Nurses pursuing RN education and $2 million to provide new mobile technology to community nurses.
- On September 30, 2015, the Ministry received a "dispute", filed by Vancouver Costal Health and BCNU under the Settlement Agreement, asking the Ministry and AVED to find a resolution for the increase in SN education seats at BCIT and other institutions to meet health authority staffing demand and meet the requirements of the needed SN seats commencing April 1, 2016. As part of the provincial commitment, there is an established working group focused on mitigation of the current and intermediate supply gaps and the development of a provincial coordinated approach to projecting SN need in BC.
- In January, 2016, the Ministry, along with the health authorities, Health Employers Association of BC, and BCNU have jointly committed to work together to create 1,643 nursing positions, some of which will be SN, by March 31, 2016.

FINANCIAL IMPLICATIONS

- For 2015/16, one-time funding has been allocated by the Ministry to the health authorities for 152 FTEs as a result of the negotiated Settlement Agreement. Information provided by the health authorities and BCIT indicates that the number of SN FTEs required in 2015/16 will total 667 FTEs. Subtracting the 389 FTEs funded by AVED and 152 FTEs funded through the Settlement Agreement results in a total of 126 FTEs required for 2015/16 which are currently not funded by AVED, for a cost of approximately $1.6 million. s.13,s.17

s.13,s.17

Approved by:

Kevin Brown, Workforce Planning & Management Branch; February 5, 2016
Kevin Brown, obo Ted Patterson, Health Sector Workforce Division; February 5, 2016
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; February 24, 2016

s.13,s.17

FACT SHEET

Telepharmacy

ISSUE

To outline issues respecting the College of Pharmacists of BC bylaw requiring a Registered Pharmacy Technician (RPT) to be on-site at telepharmacy remote sites.

KEY FACTS

- The primary objective of telepharmacy is to provide pharmacy services in rural or remote communities where a traditional pharmacy is not available.
- Telepharmacy is the process in which a central pharmacy site operates one or more telepharmacy remote sites that are connected to the central pharmacy site via computer, video and audio link.
- Telepharmacy remote sites operate as a traditional pharmacy but without a pharmacist on-site.
- There are currently 11 telepharmacy remote sites across BC linked to five central pharmacy sites.
- This model for providing pharmacy services to rural and remote communities has been used since 2002.
- Prior to 2010, both pharmacy technicians and pharmacy assistants (PAs) were unregulated, and pharmacies were free to use either in their telepharmacy remote sites.
- Pharmacy technicians became regulated in 2010, at which time the College created bylaws requiring an RPT to be on duty at telepharmacy remote sites. Programs were then put into place to support PAs in becoming RPTs, with a deadline of December 2015.
- Under the bylaws, a remote site must not remain open, and prescriptions must not be dispensed, if an RPT is not present. This requirement has not yet been brought into force in order to provide time for the pharmacies to shift their operations to incorporate RPTs.
- Several telepharmacy remote sites staff PAs rather than RPTs to work alone, onsite.
- On June 8, 2015, the College sent reminder letters to telepharmacy managers indicating the bylaw requirement must be met by January 1, 2016. As of November 16, 2015, the College committed to asking the telepharmacy sites for their plans for complying with the bylaw.
- When the College issued its reminder letters, several stakeholders including Northern Health, Nisga'a Valley Health Authority, MLA's representing Skeena, Stikine, North Coast, and North Island, several telepharmacy operators, and a number of patients raised concerns with the College and the Ministry about the impending closure of some telepharmacy remote sites.
- Health authorities and pharmacy operators have stated that recruiting RPTs to comply with the College bylaws will be a significant challenge, and even if they were able to recruit RPTs, this would result in unmanageable sustainability costs.
- There were over 1,300 RPTs registered with the College as of June 2015. The number of PAs is unknown. There are no projections on supply of RPTs due to the profession being too new to have adequate historical data from which to forecast. However, there is an anticipated province-wide growth in demand due to changes in regulation, service delivery and expanded scope of practice.
- There are no standardized training requirements for PAs. The primary difference in training between PAs and RPTs is that the former focuses on administrative duties including bookkeeping and pharmacy billing and the latter focuses on technical production-oriented tasks such as dispensing and compounding.
- Federal legislation states no person other than a pharmacist may be in possession of narcotics, controlled drugs and targeted substances within a pharmacy at any time. All telepharmacy sites

have controlled drugs and substances. Therefore, telepharmacies with only PAs on site appear to not be aligned with this legislation.

- Under BC's *Health Professions Act*, dispensing drugs is a restricted activity which means it is a higher risk activity that must not be performed by any person in the course of providing health services, except registrants of a regulated profession that have been authorized to do so in their regulations. RPTs have been authorized to dispense drugs, amongst other restricted activities, under the Pharmacist Regulation. PAs have not, as they are not registrants of the College.
- The College's concerns include unregulated pharmacy personnel having access to sensitive patient records and drugs, in particular controlled drugs and substances. Although the Pharmacist at the central site reviews both the prescription and consults with the patient remotely, drugs must be dispensed by the personnel at the remote site.
- The risk to the public is an PA, who may have a varying degree of education/training, is responsible for the 'final check' at the remote site. Patient safety is at risk by having the wrong dose or drug dispensed to a patient, or incorrect patient data entered into patient records. Many drugs have similar names and are similar in appearance; a PA may not be aware of these subtle differences. A visual check via video by the centralized pharmacist is difficult to confirm. Additionally, the College cannot conduct criminal record checks or maintain a registry for PA, and the College has no disciplinary or investigative authority in respect of them.
- However, reducing access to pharmacy services in rural and remote areas is not consistent with the Ministry focus on rural and remote health as one of the priority areas for the BC health system.
- Given the length of time PAs have been working in telepharmacy remote sites, a reasonable expectation of legitimacy has been established by both retailers and the general public.
- Therefore, Ministry staff has been in touch with the College to gain a clearer understanding of the College's plans. The Ministry understands that the College recognizes the need to ensure continuity of patient care in rural and remote communities. With that in mind, the College is collaborating with each telepharmacy operator in order to create a plan to bring their respective pharmacies into compliance with the bylaws. The College has informed telepharmacy operators that they are extending the deadline for enforcing these bylaws to December 31, 2016. The Ministry is hopeful that this collaboration will allow time for reconsideration of the risk to public safety balanced with appropriate access to services; however, there is a short term risk of being out of compliance with applicable laws.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Mark Mackinnon, Professional Regulation and Oversight, January 21 2016
Ted Patterson, Health Sector Workforce Division; April 22, 2016

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 to the Minister from Val Avery, President of the Health Sciences Association, 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.
- Using the Summit discussions as a guide, as well as ideas brought forward separately from unions and other stakeholders, the Ministry is working on a refresh of the provincial violence prevention policy that will be used to establish both short-term and long-term strategies.

High-priority Health-care Sites

- Shortly after the Summit, the Ministry and the BC Nurses Union (BCNU) each committed $1 million toward safety improvements at a number of facilities that care for complex patients where there is a higher risk of violence against staff.
- Staff and leadership at 4 sites selected by the Ministry, health authorities and BCNU have identified priority actions to improve safety that will be carried out over the next few months.
- The 4 sites and a number of initiatives underway at each include:

Forensic Psychiatric Hospital in Coquitlam

- Replacing the distress system.
- Creating a co-ordinator position to develop and support formal mentoring programs for specialized units and new staff, with a focus on violence prevention.
- Enhancing orientation and training requirements.

Hillside Centre in Kamloops

- Increasing staffing levels to ensure staff can safely care for patients.
- Adding enhanced 24/7 mental-health worker positions.
- Introducing new and improved training and education, including sessions focused on interpersonal communication, respectful workplace practices and resolving conflict.

Seven Oaks Tertiary Mental Health in Victoria

- Introducing access to security, to help reduce the need for staff to perform hands-on patient restraint, and other high-risk activities.
- Adding a low-stimulation room, which provides a relaxing environment for agitated residents.
- Adding a clinical nurse supervisor position, to provide mentorship and further support care planning and staff education.

Abbotsford Regional Hospital

- Upgrading communication systems and panic buttons, ensuring staff have reliable access to help when they need it.
- Upgrading and adding security cameras in interview and triage areas, to further assist staff in acting quickly in case of violence or aggression.
- Enhancing access to seclusion room space to more appropriately care for patients that are aggressive, at risk of self-harm or at risk of elopement.

FACT SHEET

- The BCNU has written to the Ministry proposing that the parties consider further funding and expansion of the initiative to six further sites. A decision is expected on this proposal in early 2016.

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 close to a 40% decrease in WorkSafe BC 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 unions, an Occupation Health and Safety (OHS) 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 OHS.
- 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 3 years, the number of code whites has dropped from 4,307 to 3,749; despite health authorities treating more and more patients each year. Code White calls represents 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 3 years, and 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 2 to 6 staff members.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Rod Frechette, Agreements & Negotiations Branch; January 22, 2016

Ted Patterson, Health Sector Workforce Division; February 3, 2016

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 of Health's data investigation), but these were reinstated.
- All of the ADTI research studies were completed in 2015.
- The Drug Benefit Council (DBC) reviewed the results of the research studies along with other inputs, and provided its expert recommendation to the Ministry of Health.
- Effective April 1, 2016, PharmaCare will cover donepezil as a Limited Coverage benefit for patients with mild to moderate Alzheimer's disease who meet the Special Authority criteria.
- Patients who are intolerant to donepezil may be eligible for PharmaCare coverage for oral rivastigmine or galantamine through Special Authority.
- PharmaCare coverage is not available for switching cholinesterase inhibitors due to lack of effectiveness, as there is insufficient evidence of therapeutic benefit of one drug over another.
- Patients should be assessed on a regular basis to ensure continued therapeutic benefit. A renewal request for the cholinesterase inhibitor must be submitted to Special Authority six months after initiation of therapy and every year thereafter for continued Pharmacare coverage.
- The rivastigmine patch is not an eligible PharmaCare benefit.
- Patients with existing coverage of a cholinesterase inhibitor through the ADTI, including the rivastigmine patch, are automatically approved for continued coverage for their current cholinesterase inhibitor.
- Generic versions of donepezil, 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 start of the initiative in 2007 until August 2015, over 31,600 British Columbians in total have been enrolled for coverage of a cholinesterase inhibitor drug (donepezil, galantamine, or rivastigmine) through the ADTI. In 2014/15, approximately 13,200 individuals received coverage of a cholinesterase inhibitor drug 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]
    - *Late 2015:* The research studies are completed.

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[1] PharmaNet, Medical Beneficiary and Pharmaceutical Services, August 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 2015:* As part of the Ministry's usual drug review process, the Drug Benefit Council reviewed the cholinesterase inhibitors and provided a recommendation to the Ministry.
  - *April 1, 2016:* The Ministry announces the final PharmaCare coverage decision for the cholinesterase inhibitors (also effective April 1, 2016).
- 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 to plan for completion of the ADTI and announcement of the listing decisions in 2016.
- The Ministry used many inputs to make the listing decision for the cholinesterase inhibitor drugs. Some of the inputs include: Drug Benefit Council recommendation, ADTI research studies, evidence from other published studies, and input from stakeholders, including researchers, clinicians, manufacturers, patients, caregivers, and patient groups. The inputs have been made publicly available at: www.gov.bc.ca/pharmacare/AlzheimersDrugReview-reports
- General information about PharmaCare coverage of the cholinesterase inhibitor drugs is available at: http://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/what-we-cover/drug-coverage/drugs-requiring-pre-approval/alzheimersdrugs
- Stakeholders continue to be engaged and provided with updates as necessary.
- Most other jurisdictions across Canada provide coverage for the cholinesterase inhibitors when certain clinical criteria are met (i.e., Limited Coverage benefits).
- 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 March 31, 2015, the Ministry's total drug plan spending under the ADTI was approximately $66.8 million.[3]
- From April 2014 to March 2015, the Ministry's total drug plan spending under the ADTI was approximately $5.7 million.
- From October 2007 to March 2015, the Ministry spent $2.78 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; April 20, 2016
Ted Boomer, Finance and Decision Support; September 24, 2015

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

FACT SHEET

Attention Deficit Hyperactivity Disorder Drugs

ISSUE

Stakeholders are requesting that BC PharmaCare provide coverage to more once-daily medication alternatives for the treatment of Attention Deficit Hyperactivity Disorder (ADHD).

KEY FACTS

- There are currently no well substantiated estimates of the prevalence of ADHD in BC or Canada. In the US, the Centers for Disease Control found that in 2011 approximately 11% of children between 4 and 17 years of age have been diagnosed with ADHD by a health provider.[1] The prevalence was high in boys (15.1%) and in girls (6.7%).
- The majority of people diagnosed with ADHD as children continue to meet the criteria for ADHD as adults. The current prevalence estimate of ADHD in adults in the US is 4.4%.[2]
- ADHD is associated with impairments of cognitive, behavioral, emotional, occupational, academic, and social functioning, some of which are difficult to measure.
- Treatment of ADHD involves a combination of behavioral/psychiatric interventions and medications. ADHD medications most commonly used in Canada include:
    - Stimulants
        - Methylphenidate (Biphentin®, Concerta®, Ritalin, and Ritalin SR)
        - Dextroamphetamine (Dexedrine® and Dexedrine SR®)
        - Lisdexamfetamine (Vyvanse®)
        - Mixed salts amphetamine (Adderall XR®)
    - Non-Stimulants
        - Atomoxetine (Strattera®)
        - Guanfacine (Intuniv SR®)
- Currently, PharmaCare provides full coverage for:
    - Methylphenidate immediate release tablets and generics (Ritalin®)
    - Methylphenidate sustained release tablets (Ritalin SR®)
    - Dextroamphetamine immediate release tablets (Dexedrine®)
    - Dextroamphetamine sustained release capsules (Dexedrine SR®)
- PharmaCare covers methylphenidate extended release (Concerta®) tablets, a long-acting stimulant, for the treatment of ADHD in children as a Limited Coverage benefit with the following criteria:
    - For patients 6 to 18 years of age diagnosed with ADHD who require 12 hours of continuous coverage for significant and problematic disruptive behaviour or problems with inattention that interfere with learning; and
    - Have been previously tried on one of the following with unsatisfactory results: immediate- or sustained-release methylphenidate or immediate- or sustained-release dextroamphetamine.
- Physicians who choose to sign a Collaborative Prescribing Agreement for Concerta® can prescribe it without having to submit a Special Authority request for each patient.
- Concerta® and Biphentin® were reviewed by the Drug Benefit Council (DBC), who recommended that the Ministry provide coverage for a less costly agent in order to provide choice to patients who may benefit form a longer-acting alternative. DBC did not find significant differences in

[1] Attention-Deficit/Hyperactivity Disorder (ADHD), http://www.cdc.gov/ncbddd/adhd/data.html

[2] Kessler et al. The prevalence and correlates of adult ADHD in the United States: results from the National Comorbidity Survey Replication. Am J Psychiatry, 2006, 163(4):716-723.

efficacy or safety between these 2 products and neither had a clinical or safety advantage compared to existing drugs covered by PharmaCare.

- The Common Drug Review and the Ministry also reviewed Vyvanse®, Adderall XR®, Strattera®, and Intuniv XR®. The Common Drug Review recommends that these drugs not be listed due to uncertain clinical benefit compared to existing therapies and the short duration of the clinical studies. Subsequently, the Ministry also reviewed these products and decided not to provide coverage.
- In December 2015, BC physicians, the Canadian ADHD Resource Alliance, and the Centre for ADHD Awareness Canada issued a press release requesting PharmaCare coverage for all of the once daily, extended release medications (i.e., Adderall XR®, Intuniv XR®, Strattera®, and Vyvanse®).
- Their rationale for this request is that like most mental health conditions, medication treatment of ADHD is not a one size-fits-all scenario. As a result, they argue that having the widest possible range of medication treatment options allows for the best outcome. They also feel that the once daily medications are better tolerated, are more effective, have less abuse potential, and have improved adherence.
- Some requests also argue that BC coverage of these medications inferior compared to other provinces. Coverage for long-acting medications varies amongst provinces and territories. Many offer restricted (or limited) coverage or no coverage of these drugs.
- Although the requested drugs are not PharmaCare benefits, PharmaCare may consider and provide coverage on exceptional case-by-case basis (1,322 patients in 2015, PharmaNet).
- PharmaCare is currently reviewing the ADHD drug class and is preparing a review package for the DBC for their review and recommendations, possibly in the summer 2016.
- The materials for the DBC include numerous systematic reviews of published medical literature, Rapid Responses prepared by the Canadian Agency for Drugs and Technologies in Health in response to specific clinical questions as identified by PharmaCare staff, Canadian Agency for Drugs and Technologies in Health publications assessing the quality of various clinical practice guidelines on ADHD, inputs from clinicians and patients, per the usual DBC drug review process.
- No decision regarding the coverage of additional ADHD medications will be made until the DBC review is completed.
- Stakeholders who have recently written to the Ministry are or will be responded to advising that ADHD drug class review is underway and that their input will be included for consideration along with other inputs.

FINANCIAL IMPLICATIONS

In 2014/15, 47,700 British Columbians were dispensed ADHD medication at a cost of $34.24 million. PharmaCare provided coverage for 28,700 of these patients at a cost of $7.95 million.[3]

Approved by:

Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 1, 2016
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; March 3, 2016
Carolyn Bell, obo Teri Collins Health Sector Information, Analysis and Reporting Division; March 9, 2016

[3] PharmaNet, Medical Beneficiary and Pharmaceutical Services Division, January 26, 2016.

FACT SHEET

BC Services Card-Changes Affecting MSP as of February 2013

ISSUE

The BC Services Card (BCSC) was launched on February 10, 2013, and is expected to impact program areas within the Ministry of Health.

KEY FACTS

- As of February 10, 2013, amendments to the *Medicare Protection Act* and the Medical and Health Care Services Regulation have established the legal authorities to do the following:
    - Require most eligible adult beneficiaries to renew enrolment in the Medical Services Plan (MSP). This includes laying out the process for enrolment and renewal of enrolment of MSP for eligible residents, including requirements to submit enrolment forms, present at a front counter, present documentation in support of identity, and to confirm residency.
    - Set the requirements for acceptable documentation to confirm residency and identity.
    - To allow the Medical Services Commission (MSC) the authority to exempt a person from the regular requirements of enrolment or renewal of enrolment.
    - Ensure that all eligible residents pay health care premiums whether they renew enrolment or not.
    - Expand investigative powers of the MSC.
    - Create statutory reporting requirements for suspected misuse of the Personal Health Number.
    - To specify that renewal of enrolment is required by February 10, 2018 (for initial renewal by existing beneficiaries).
    - To remove fees for replacement cards.
    - To establish a duty on practitioners to verify enrolment prior to providing or charging for MSP services.
    - To establish a duty on practitioners, health authority employees, and diagnostic facility employees who suspect that a person is attempting to obtain MSP benefits to which they are not entitled, to report those suspicions to the MSC.
- The current phase of the BCSC program has four major MSP policy components which must be fully implemented by Spring 2018:
    - Two-Step MSP Enrolment: adds requirement for identity proofing.
    - Modified Enrolment/Renewal: for those who cannot comply with regular identity proofing.
    - Renewal and Cancellation: cyclical requirement to renew MSP and identity proof.
    - Secondary Target Populations: to ensure all beneficiaries have a BCSC prior to 2018.
- The four health policies are pre-requisites to meet overall BCSC program objectives including system design and deployment.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; January 27, 2016

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; and
    - Significant savings for the health system.
- In 2010, the Medical Beneficiary and Pharmaceutical Services Division developed and launched a multi-faceted education campaign promoting evidence-informed use of BGTS in BC.
- 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, the Division 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 are now reimbursed per patient per calendar year based on four categories of patients.
- The categories are determined by the type of diabetes-related medications a patient is taking, if any.

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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)

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- 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 4 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

- The table below shows the percentage change in total dispensed BGTS quantities in each patient category in the first year since the policy was implemented (2015 vs 2014):

Therapy	Percentage Change
Insulin	-1.36%
Insulin + Oral Agents	-2.39%
Oral Agents/Hypo	-40.29%
Oral Agents/Non Hypo	-33.28%
Lifestyle	-21.44%

- The Medical Beneficiary and Pharmaceutical Services Division will continue to monitor the impact of this new policy as data become available.

FINANCIAL IMPLICATIONS

- PharmaCare savings for calendar year 2015 are $6.02 million.
- Savings had been projected to be $3.4 to $4.3 million per year.

Approved by:

Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 3, 2016
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; February 22, 2016
Carolyn Bell, obo Teri Collins, Health Sector Information, Analysis and Reporting Division; February 29, 2016

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) alleging that sections of the *MPA* that prohibit extra billing and private insurance for Medical Services Plan (MSP) benefits are in breach of the *Charter of Rights and Freedoms* (the *Charter*). 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.
- In March 2008, the MSC ordered an audit of the Cambie Surgery Centre and the Specialist Referral Clinic (Vancouver) Inc. after having received numerous complaints that the clinics were charging patients for insured benefits in violation of sections 17 and 18 of the MPA. The audit found that the two Vancouver clinics were charging patients for, or in relation to, services that are benefits under the MSP.
- In January 2009, an action was filed in the Supreme Court of BC by the Canadian Independent Medical Clinics Association (CIMCA) and five 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 four of the private clinics dropped out of the litigation in July 2010. The Specialist Referral Clinic and five individual 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 overlapping billing, where both patients and MSP were billed for, or in connection with, the same medical service. These audits are commencing on January 18, 2016.
- 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.

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- 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 the defendants with a proposal to adjourn the trial in order to permit discussions aimed at a resolution of the litigation. Discussions proved unsuccessful and the trial was scheduled to start on March 2, 2015.
- In the weeks leading up the new trial date, the Ministry identified a large volume of potentially relevant documents. As a result, the defendants sought and obtained an adjournment of the trial.
- A trial date has now been set for June 6, 2016.

Discovery Process

- Since 2012, the plaintiffs and government have been engaged in the discovery process, which includes the discovery of documents, examination for discovery, 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.
- This requires an ongoing collection of information necessary to assess the strengths and weaknesses of the government case and the case of the opposing party, with a view to proceed to trial. Disclosure requirements extend to all relevant electronic and hard copy documents such as reports, briefing notes, and correspondence as well as all e-mails held by Directors, Executive Directors, and ADMs 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 Divisions.

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- Staff are currently engaged in a Ministry-wide, bi-weekly effort to disclose all new or amended relevant documents to ensure continued obligations are met. Disclosure obligations continue until the conclusion of the trial, which is expected to begin in June of 2016 and last up to six months.

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.

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Approved by:
Lynn Stevenson, Associate Deputy Minister-Health Services; January 28, 2016

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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. The Ministry of Health is co-leading a P/T Working Group on EDRDs, and the workplan was recently approved by the P/T Health Ministers in January 2016.

KEY FACTS

- EDRD, as currently defined by the Ministry of Health, are drugs used 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.
- Coverage of pharmaceuticals is not included in the *Canada Health Act*, and 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]
- 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 patients or short term follow up. Most EDRDs have only demonstrated to slow the certain non-clinical endpoints (e.g. lab test 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 development costs from a small market but do not provide any transparency to justify such prices. The products are typically priced far beyond any individual's or family's ability to pay.
- With such considerations of disease rarity, limited evidence, and high per-patient costs, EDRD raise many ethical, clinical and financial issues for provincial payers. Because of the poor evidence and cost challenges, these drugs are generally considered non-benefits. However, the Ministry may consider exceptional last-resort funding requests for certain drugs on a case-by-case basis.
- To review exceptional last-resort requests, the Ministry utilizes a review process which includes advice from an arm's length independent Advisory Committee and several Clinical Subcommittees. The Ministry also has established a two year BC residency requirement.
- 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 drug is withdrawn/not provided, pharmacoeconomic evidence, budget impact, clinical guidelines, and ethical considerations.
- As of January 2016, the Ministry provides funding for the following 13 EDRDs on an exceptional, last-resort, case-by-case basis:[2]
    - agalsidase alpha (Replagal® AF) for Fabry Disease;
    - agalsidase beta (Fabrazyme®) for Fabry Disease;
    - alglucosidase alpha (Myozyme®) for Pompe Disease;
    - canakinumab (Ilaris®) for Cryopyrin-Associated Periodic Syndromes;
    - eculizumab (Soliris®) for paroxysmal nocturnal hemoglobinuria (PNH);
    - galsulfase (Naglazyme®) for Mucopolysaccharidosis VI (MPS VI);

[1] Health Canada – An Orphan Drug Framework for Canada. (www.hc-sc.gc.ca/ahc-asc/media/nr-cp/_2012/2012-147a-eng.php).
[2] EDRD Case Tracking Document". Medical Beneficiary and Pharmaceutical Services Division, Ministry of Health.

- idursulfase (Elaprase®) for Mucopolysaccharidosis II (MPS II, Hunter's Syndrome);
- imiglucerase (Cerezyme®) for Gaucher Disease;
- ivacaftor (Kalydeco®) for cystic fibrosis G551D mutation;
- laronidase (Aldurazyme®) for Mucopolysaccharidosis I (MPS I);
- miglustat (Zavesca®) for Neimann Pick Type C;
- nitisinone (Orfadin®) for tyrosinemia type 1; and
- velaglucerase (VPRIV®) for Gaucher Disease.

Status Update on Specific EDRDs :

- **Soliris®:** In 2014, the Ministry decided not to fund eculizumab for atypical hemolytic uremic syndrome due to unclear clinical benefit and high drug costs. In May 2015, the Canadian Drug Expert Committee provided comments on proposed criteria but did not change the original recommendation in response to a "Request for Advice". In summer 2015, the pan-Canadian Pharmaceutical Alliance (pCPA) started negotiations with Alexion, the manufacturer. These negotiations are ongoing and a decision is expected in 2016. In 2015, the Patented Medicine Prices Review Board launched an allegation that eculizumab is excessively priced and not in compliance. The Patented Medicine Prices Review Board proceedings are continuing.
- **Vimizim®:** The Common Drug Review recommended to not fund this drug for Mucopolysaccharidosis IVA (Morquio A Syndrome) due to poor clinical evidence. In summer 2015, the pCPA decided not to negotiate with the manufacturer. In June 2015, the Ministry decided not to fund elosulfase alfa. On exceptional basis, some other jurisdictions have funded a few patients.
- **Kalydeco®:** Ivacaftor (Kalydeco®) is currently funded for cystic fibrosis patients with the G551D mutation. It is under review and being negotiated through the pCPA for two other indications.
- **Eleyseo®** and **Cerdelga®:** Taliglucerase alpha (Elelyso®) and eliglustat (Cerdelga®) to treat Gaucher disease are under review. Negotiations through the pCPA may be an option in the future.
- **Strensiq®:** Asfostase alfa (Strensiq®) is a treatment for pediatric-onset hypophostasia that is under review. Negotiations through the pCPA may be an option in the future.

P/T and F/P/T Activities:

- 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.
- In 2014, the Health Ministers established the P/T EDRD Working Group to explore the management of rare disease drug therapies with evidence-based approaches. BC, Alberta, and Ontario are the co-leads for this working group. In January 2016, the framework were approved by the Health Ministers. BC is leading the pricing theme, and will assess existing pricing strategies and establish a supporting network to draft fair pricing framework models and metrics.

FINANCIAL IMPLICATIONS

The total drug costs for EDRD in 2014/15 were approximately $15.7 million.[3] The annual treatment cost for EDRD drugs per patient may range from $50,000 to over $1 million, and vary depending on the drug, weight of the patient and dosage regimen.

Approved by:
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 1, 2016
Jackie Redmond, obo Carolyn Bell, Health Sector Planning and Innovation Division; February 12, 2014
Ted Boomer, obo Manjit Sidhu, Finance and Corporate Services Division September 24, 2015;

[3] EDRD Forecast". Medical Beneficiary and Pharmaceutical Services Division, Ministry of Health.

FACT SHEET

Hepatitis C Drug Coverage

ISSUE

- Hepatitis C virus (HCV) is a preventable, communicable disease which exhibits variable disease course and disease outcomes.
- Of newly infected patients, approximately 25% clear the infection spontaneously and the remainder develop chronic hepatitis C (CHC).
- In BC, an estimated 80,000 people are living with CHC. Of these, an estimated 25% self-resolve their infection and an estimated one-third are unaware. For those who do not self resolve their infection, many remain in stable sub-clinical disease for years or decades before the disease may advance. Because of this, it is therefore unknown how many may eventually need therapy.
- CHC morbidity is usually related to disease symptoms or cirrhosis and death is usually caused by end-stage liver disease or hepatic cancer.
- There are six genotypes of HCV. Most (55-65%) HCV infections in Canadians are Genotype 1. Genotypes 2 (14%) and 3 (20%) are the next most common.

KEY FACTS

- Prior to 2011, pegylated interferon (peginterferon or Peg-INF) plus ribavirin (RBV) was the "gold standard" treatment for patients with CHC. Approximately 40-50% of patients with genotype 1 CHC could expect to achieve an undetectable HCV viral load test 6 months after completing a successful course of Peg-INF/RBV (PR) therapy (called a sustained virologic response or SVR). Also, 80-95% with genotype 2 and 60-75% with genotype 3 could expect to achieve SVR.
- However, the major problem with PR-based treatments is tolerability. While second-generation protease inhibitor drugs have been developed which result in better SVR rates as compared to PR-regimens alone, many of these products have or will be discontinued due to the introduction of more effective therapies.
- Teleprevir (Incivek™), previously covered by BC PharmaCare, was discontinued in December 2014; boceprevir (Victrelis®) will be discontinued effective March 31, 2016, and simeprevir (Galexos®), is still available for the time being.
- In addition to coverage of PR therapy for genotype 1 patients, PharmaCare currently provides coverage for Victrelis (as of March 15, 2012), Galexos (as of October 28, 2014), sofosbuvir (Sovaldi™ as of March 24, 2015), ledipasvir-sofosbuvir (Harvoni™ also as of March 24, 2015) and ombitasvir, paritaprevir, ritonavir and dasabuvir (Holkira™ Pak as of July 28, 2015) as Limited Coverage drugs.
- Sovaldi was added for as an alternative to PR for genotype 2 and genotype 3 when PR is medically contraindicated, due to comparable treatment outcomes and its higher cost compared to PR.
- Harvoni was added as a first line alternative to PR-based combinations due to its increased efficacy, shorter course of therapy and improved tolerance.
- There is also other new drug combination for the treatment of CHC that does not require the use of PR: asunaprevir (Sunvepra®) with daclatasvir (Daklinza®), grazoprevir-elbasvir and ombitasvir-paritaprevir-ritonavir (Technivie).
- The Common Drug Review (CDR) completed review of Daklinza in September 2015 and this is under Ministry review. Asunapravir will be reviewed by the CDR once Health Canada Notice of Compliance is issued.
- Grazoprevir-elbasvir by Merck and ombitasvir-paritaprevir-ritonavir by Abbvie are under review by the CDR.
- Due to the variability in disease course of CHC, where some self-resolve or may not advance in their disease for several decades, PharmaCare's current coverage is only for patients with evidence of

liver fibrosis based on a liver fibrosis (F) stage score of 2 or higher (F score ranges from F0 = no fibrosis to F4 = cirrhosis). Prioritizing treatment for sicker patients who are at greatest risk is also a more cost-effective and affordable approach.

- To access coverage for medications for the treatment of CHC, a physician must submit a request to PharmaCare's Special Authority, providing patient-specific lab and diagnostic information, outlining how a patient meets the coverage criteria.

FINANCIAL IMPLICATIONS

- The cost of PR therapy is approximately $5,000 to $20,000 for a 12- to 48-week course of treatment.
- At manufacturer's list prices, the cost of treatment are as follows:
    - Victrelis is $48,500 for a 44-week course of treatment with PR;
    - Galexos is $47,000 for a 12-week course of treatment with PR;
    - Sovaldi is $57,000-$115,000 for a 12- to 24-week course of treatment with PR; and
    - Harvoni is $47,000 to $140,000 for an 8- to 24-week course of treatment.
- Although the cost per course of treatment for the newer drugs is very high, they are considered "cost-effective" from a pharmacoeconomic perspective because they are curative, thus offsetting downstream health system costs.
- In 2013, about 1,200 patients in BC were treated for HCV and PharmaCare spent about $25.2 million (assisting 94% of patients). In 2014 (when Sovaldi was approved in Canada in December 2013 and Harvoni in October 2014) only 1,122 patients were treated in BC but PharmaCare's spending decreased to $11.9 million (assisting 68% of treated patients).[1]
- Because of the large number of untreated HCV patients in BC, the issue of long-term drug therapy affordability is enormous. If 50,000 of the estimated 80,000 HCV patients in BC were treated with sofosbuvir at list prices, it would cost more than $3 billion.
- BC and Ontario led the Pan-Canadian Pharmaceutical Alliance negotiations with the manufacturer of Sovaldi,Harvoni and Holkira Pak to try to secure a lower price and address the long-term affordability of these therapies.
- From March 1, 2015 to November 30, 2015, PharmaCare paid $132.4 million on hepatitis C medications.[2] During the same time, the Ministry approved coverage for 3,500 patients on hepatitis C medications through the Special Authority program.[3]

Approved by:
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 9, 2016
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; February 24, 2016

[1] Source: MBPSD – PharmaCare Information, Policy & Economics Branch, March 2015.
[2] Source: MBPSD - PharmaCare Information, Policy & Economics Branch, January 2016.
[3] Source: MBPSD – Special Authority unit, January, 2016

FACT SHEET

Methadone Program

ISSUE

Administration of, and payment for, services provided for Methadone Maintenance Treatment (MMT).

KEY FACTS

- Methadone, a long-acting, orally effective synthetic opioid, is used as a substitute for heroin or other narcotics when treating opioid dependence.
- MMT involves the prescribing and dispensing of methadone, and the provision of psychosocial supports. Services are delivered through physicians, community pharmacists, privately funded methadone clinics, non-profit agencies and other means.
- MMT is widely regarded as an effective treatment for opioid addiction. Numerous studies have found that methadone treatment reduces harm associated with illicit opioid use and increases the social functioning and quality of life of patients.
- The College of Physicians and Surgeons of BC (CPSBC) administers the Methadone Maintenance Program (MMP) in BC under the authority of the *Health Professions Act* and the Bylaws under the Act, and in accordance with Health Canada's Drug Strategy and Controlled Substances Program.
- The Ministry of Health has a contract with the CPSBC to fund the administration of the MMP.
- Administration includes physician registration, obtaining authorizations from the federal Minister of Health for methadone prescribing by physicians, training, practice audits and publishing guidelines for the safe prescribing of methadone.
- Methadone is also subject to the Prescription Review Program administered by the CPSBC, whereby select drugs may be prescribed only in writing using a special duplicate prescription pad to reduce the potential for abuse or misuse.
- BC's MMP increased from approximately 1,900 clients in 1995/96 to 16,300 clients in 2014/15.[1] Physicians actively prescribing MMT decreased from 428 to 377 between 2001/02 and 2014/15 with individual active prescribers taking on increasing numbers of patients.[2]
- Community pharmacies of all types—independent, chain and franchise stores—throughout the province dispense methadone. The largest concentration is in the Lower Mainland.
- The College of Pharmacists of BC (CPBC) is responsible for ensuring (through mandatory training and practice audits, etc.) that pharmacists and pharmacy staff who provide services related to MMT know and apply the MMT principles and guidelines established in the CPBC professional practice policies and MMT Policy Guide.
- Registered pharmacists in BC are permitted to purchase and dispense methadone without the need for federal authorization.
- To address long standing concerns about the safety and consistency of compounded methadone, PharmaCare began covering Methadose® for MMT and pain. Methadose® is a commercial methadone 10 mg/ml oral solution approved by Health Canada.
- Effective, March 1, 2014, Methadose® became the only product dispensed for methadone maintenance that will be reimbursed by PharmaCare. PharmaCare continues to cover compounded methadone, and methadone tablets, for pain under exceptional circumstances.
- The CPBC MMT Policy Guide was revised in 2014 to reflect the dispensing of Methadose® and to address outstanding issues such as policy respecting the delivery of methadone to clients.

[1] PharmaNet data, MBPS Division, 25 June 2015. Includes methadone maintenance PINs, PharmaCare accepted claims.
[2] PharmaNet data, MBPS Division, 25 June 2015. PharmaCare accepted claims.

FACT SHEET

- Pharmacists dispensing maintenance methadone are reimbursed by PharmaCare for the drug cost up to the PharmaCare maximum price, a $10.00 dispensing fee, and a $7.70 interaction fee for dispensing when ingestion of the drug is witnessed by a pharmacist.
- The current method of reimbursement was introduced by PharmaCare in 2001 as part of an effort to increase the number of pharmacies dispensing methadone to improve access to methadone therapy as a harm reduction measure. This goal has been realized: in 2014/15, 809 BC pharmacies dispensed methadone, up from 280 in 2001/02[3]. In order to receive the $7.70 interaction fee, pharmacies must enroll as a Methadone Maintenance pharmacy with PharmaCare. The *Pharmaceutical Services Act* prohibits pharmacies from offering cash or incentives of any kind to clients, including methadone patients. Pharmacy billing and compliance respecting methadone dispensing are actively investigated by PharmaCare Audit and the CPBC.
- PharmaCare has struggled to find the right remuneration scheme to support optimal dispensing of maintenance methadone and has been dealing with cases of impropriety in methadone dispensing, such as improper billing of methadone claims and offering inducements.
- The Medical Beneficiary and Pharmaceutical Services Division (MBPSD) is reviewing PharmaCare's methadone payment policies to identify issues in the current program delivery model. The intent of this review is to engage in a dialogue with stakeholders, and highlight opportunities to implement changes to improve services and outcomes for patients while increasing value for money.
- As part of this review, MBPSD completed an information gathering excercise and prepared a report about PharmaCare's methadone related policies and, more broadly, MMT in BC. Since the report's release, representatives from 16 organizations, including regulatory colleges; methadone providers; patients and patient advocacy groups; and public bodies have been consulted.
- MBPSD has drafted a "What We Heard" document based on stakeholders' comments, concerns, and suggestions from these consultations. MBPSD will circulate this document, vet suggestions, and draft policy proposals before reengaging with stakeholders.

FINANCIAL IMPLICATIONS

PharmaCare's methadone maintainence related expendatures were approximately $43.0 million in 2014/15.[4] Since 2001, total related expenditures have grown at an average annual rate of 6.9% while the number of patients receiving MMT has grown at an average annual rate of 5.8%.[5]

Methadone maintenance program, PharmaCare expenditures ($million)

Fiscal year	Dispensing fee	Ingredient cost	Interaction fee	Total
2004/2005	$9.85	$3.00	$9.79	$22.64
2005/2006	$10.28	$3.11	$10.17	$23.56
2006/2007	$10.92	$3.31	$10.80	$25.03
2007/2008	$11.97	$3.55	$12.48	$28.00
2008/2009	$13.09	$3.90	$11.51	$28.49
2009/2010	$14.24	$4.33	$13.60	$32.17
2010/2011	$16.50	$4.80	$14.73	$36.03
2011/2012	$19.06	$5.19	$16.03	$40.28
2012/2013	$20.36	$5.35	$17.39	$43.10
2013/2014	$20.66	$5.19	$17.87	$43.72
2014/2015	$20.40	$4.53	$18.04	$42.97

Source: PharmaNet/HealthNet data

Approved by:
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; January 27, 2016
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; July 13, 2015
Jackie Redmond, obo Carolyn Bell, Health Sector Planning & Innovation Division; February 3, 2014

[3] PharmaNet data, MBPS Division, 25 June 2015. Includes methadone maintenance PINs, PharmaCare accepted claims.
[4] PharmaNet data, MBPS Division, 25 June 2015. Includes methadone maintenance PINs.
[5] PharmaNet data, MBPS Division, 25 June 2015, Includes methadone maintenance PINs, PharmaCare accepted claims.

FACT SHEET

Opioid Misuse

ISSUE

Opioids are useful medications for the treatment of pain. However, misuse of prescription opioids is associated with serious harms, including addiction, overdose, and possibly death, placing a significant burden on individuals and their families, health and social services systems, and public safety systems.

KEY FACTS

- The Ministry of Health supports appropriate pain management but recognizes the risks associated with prescription opioid misuse.
- Programs and activities aimed at reducing the abuse and misuse of prescription opioids are provided through a combination of PharmaNet, PharmaCare, and in collaboration with the College of Physicians and Surgeons of BC (CPSBC) and College of Pharmacists of BC.
- The PharmaNet prescription database allows health professionals to review a patient's medication history to watch for usage irregularities as potential fraud or abuse.
- A subset of PharmaNet data is used by CPSBC's' Prescription Review Program to ensure secure and appropriate prescribing of drugs like opioids. Results are shared with the College's Prescription Review Committee. Where the results of these reviews demonstrate potentially problematic prescribing, individual physicians may be requested to participate in additional education for the prescribing of these types of medications.
- In November 2015, CPSBC announced that it is drafting a new professional standard requiring all physicians to have access to PharmaNet and to review a patient's PharmaNet profile before prescribing any opioid medications for them. The new standard is expected to come into effect in 2017.
- The Controlled Prescription Program, delivered in partnership between CPSBC, the College of Pharmacists of BC, and the Ministry, requires prescriptions for designated prescription opioids and controlled drugs to be written on duplicate prescription pads specially designed to reduce potential for prescription forgeries.
- PharmaCare programs, activities, and strategies are aimed at decreasing opioid abuse include:
  - The Restricted Claimant program limits PharmaCare coverage of certain "at risk" patients to a single prescriber and/or a single pharmacy for medications with a potential for abuse.
  - Limiting the supply of covered opioids to a maximum of 30 days per fill. Prescriptions written for more than a 30 day supply are not paid for.
  - Use of a trends report to regularly examine the use of covered opioids.
  - Coverage of drugs to assist with addictions, including methadone and buprenorphine/naloxone (Suboxone®). The Ministry works with the College and other stakeholders to administer the BC Methadone Maintenance Program.
  - Discontinuation of coverage for long-acting oxycodone (OxyContin®) in March 2012 and beginning of exceptional case-by-case coverage of a more abuse deterrent oxycodone product (OxyNeo®). PharmaCare is currently reviewing generic versions of long-acting oxycodone for possible coverage in place of brand OxyNeo®.
- In March 2013, the National Advisory Council on Prescription Drug Misuse released the report "First Do No Harm: Responding to Canada's Prescription Drug Crisis".[1] The report presented 58 short and longer-term recommendations aimed at addressing the harms caused by the misuse of prescription medications, including opioids.

[1] National Advisory Council on Prescription Drug Misuse. (2013). *First do no harm: Responding to Canada's prescription drug crisis.* Ottawa: Canadian Centre on Substance Abuse.

FACT SHEET

- In August 2013, the Provincial Academic Detailing Service's launched a topic on "Opioids in Chronic Non-Cancer Pain: The Basics". The topic provides a structured approach to safely using prescription opioids in patients with chronic non-cancer pain and is being presented to physicians, nurse practitioners, pharmacists, and other health professionals.
- The Medical Beneficiary and Pharmaceutical Services Division is also involved in intra and inter-ministerial, and national work aimed at optimizing the appropriate use of prescription opioids for pain and minimizing the misuse of opioids. This work includes participation in the federal/provincial/territorial Prescription Monitoring Network set up to share information and enhance the capacity of all provinces and territories to monitor and improve the prescribing of opioids and address misuse and abuse issues.
- Beginning in summer 2015, there have been many media reports of opioid overdoses and overdose-related deaths attributed to fentanyl-tainted street drugs. For these, it appears from media reports that the source of fentanyl was illicitly produced, rather than from prescriptions.
- In October 2015, BC PharmaCare broadened the coverage criteria for Subxone (buprenorphine/naloxone) by making it a regular benefit rather than a limited coverage benefit. Suboxone is an alternative to methadone but may not be appropriate for all clients. Currently, CPSBC has restricted the prescribing of Suboxone to only physicians who can prescribe methadone to ensure the appropriate use of these medications. Some stakeholders are urging the College to loosen its restriction to allow more physicians to prescribe it. The College is reviewing the request and is expected to respond later in 2016.
- The Ministry, the BC Centre for Disease Control, and the health authorities are working to expand the availability of naloxone take home kits for emergency use in reversing opioid overdoses, including those associated with fentanyl. The kits are being distributed to individuals deemed to be a high risk for opioid overdose.
- In January 2016, Health Canada announced that it is recommending an amendment to the Prescrition Drug List allowing for the non-prescription use of naloxone for emergency use for opioid overdoses outside of hospital settings. If Health Canada finalizes this federal change, then the College of Pharmacists of BC and the Ministry of Health will need to work together to amend BC's provincial drug scheduling regulations. This change will help to increase the availabity of naloxone for the treatment of opioid doses. At this time, the timeline for this work is not known.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 1, 2016

FACT SHEET

Pan-Canadian Pharmaceutical Alliance (Brand and Generic Drugs)

ISSUE

Pan-Canadian Pharmaceutical Alliance (PCPA) for brand and generic drugs (formerly the pan-Canadian *Pricing* Alliance).

KEY FACTS

- On August 6, 2010, at a meeting of the Council of the Federation, Premiers agreed to establish a pan-Canadian purchasing alliance to consolidate public sector procurement of common drugs, medical supplies and equipment, where appropriate. The alliance is intended to leverage the combined purchasing power of public drug plans in multiple jurisdictions, leading to lower drug costs, increased access to drug treatment options and increased consistency of listing decisions across participating provinces and territories (P/Ts).
- At the July 26, 2012, meeting of the Council, Premiers further affirmed their support and commitment to the alliance and agreed to accelerate and expand the alliance work on brand name drugs. The Council also recommended that P/Ts expand the alliance to include a Competitive Value Price Initiative for Generic Drugs. In May 2014, the P/Ts agreed in principle with the Canadian Generic Pharmaceutical Asssociation to implement a Tiered Pricing Framework. This is in addition to the the commitment to lower the price of 18 generic drugs to 18% of the brand price by 2016.
- On September 30, 2014, the P/T Health Ministers announced a new Office to support the work of the PCPA[1]. The Office of the PCPA was launched Spring 2015 in Ontario and final recruitment of staff is in progress. The establishment of the Office of the PCPA was supportd by the IBM report (which was commissioned by the P/Ts to recommend formal processes and governance structures[2]).
- Quebec also joined the PCPA in late 2015. Quebec is participating in PCPA negotiations (old and active), where possible.
- The new federal Minister's mandate letter includes pharmaceuticals as a top priority: *"Improve access to necessary prescription medications. This will include joining with provincial and territorial governments to buy drugs in bulk, reducing the cost Canadian governments pay for these drugs, making them more affordable for Canadians, and exploring the need for a national formulary"*[3].
- On January 19, 2016, the federal government drug plans will join the PCPA which we anticipate will provide additional negotiating power to lower prices for prescribed drugs (brand and generic), increased intelligence on negotiations with manufacturers, and improve its position as a national regulator.
- Health Canada's transition to PCPA is expected to be relatively seamless given the federal government follows similar drug review standards that PTs currently follow.
- There will be no added risk to federal participation of downloading costs to the province as pharmacare is not the first payer for BC residents covered by the federal plans.

Brand Drugs

- PCPA has achieved multi-million dollars in savings, for the participating P/Ts. The success of the PCPA is largely due to participating P/Ts' commitment to approach the collaboration as a united front, rather than individually. The formal jurisdictional leads are Ontario and Nova Scotia. Any savings achieved through this approach is not intended to be at the expense of private insurers or out-of-pocket payers.

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[1] Provinces and territories talk health care; CNW; September 30, 2014; http://www.newswire.ca/en/story/1420290/provinces-and-territories-talk-health-care

[2] Pan Canadian Drugs Negotiations Report: http://www.canadaspremiers.ca/phocadownload/pcpa/pan_canadian_drugs_negotiations_report_march22_2014.pdf

[3] http://pm.gc.ca/eng/minister-health-mandate-letter

- Existing drug review processes remain the same; the PCPA is not intended to bypass existing evidence-based drug reviews (which support appropriate use of safe drugs).
- As of December 31, 2015, PCPA completed negotiations for 89 brand products. 24 products are under active negotiations, led by various P/T.

Generic Drugs – please refer to Generic Drugs Fact Sheet for further details.

National PharmaCare Model

- In July 2015, Premiers directed Health Ministers to commission a research body to undertake further analysis on approaches to pharmacare in other jurisdictions and assess how these models could inform more cost-efficient and accessible health systems for all Canadians.
- The Council of the Federation Secretariat has completed a Request for Quotation process to commission a research body to undertake the pharmacare research directed by Premiers. The Request for Quotation was sent to 8 vendors, and after reviewing the 3 submissions received, the Secretariat has subsequently signed a contract with the Institute on Governance. The Secretariat has also provided $50,000 to fund this initiative. The deadline for the final report to Premiers is March 31, 2016. A status update was brought to Ministers at the January 2016 Health Minister's Meeting.
- The development of a report on pharmacare is being commissioned with the goal of providing Premiers with evidence-based information on the international approaches to pharmacare and how key findings and principles could inform more cost-efficient and accessible health systems for all Canadians.
- This high-level information is sufficient for early stage discussions, however, BC suggests that a more comprehensive approach is required that includes identifying and characterizing the problem (gaps and opportunities) which we are trying to address as other or new pharmacare models are considered.

FINANCIAL IMPLICATIONS

- According to the Canadian Institute for Health Information, all territorial P/T government drug plans (except Quebec, Northwest Territories and Nunavut) that have taken part in the alliance spent a combined $7.8 billion on prescription drugs in 2012[4].
- As of March 31, 2015, these collaborative efforts between P/Ts have resulted in 63 completed joint negotiations on brand name drugs and price reductions on 14 generic drugs. This has resulted in an estimated $490 million in combined savings annually[5].

Approved by:
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; January 27, 2016

[4] "National HealthExpenditure Trends, 1975 to 2014." *Canadian Institute for Health Information*. October 2014. Available Online: http://www.cihi.ca/web/resource/en/nhex_2014_report_en.pdf

[5] The pan-Canadian Pharmaceutical Alliance, http://canadaspremiers.ca/en/initiatives/358-pan-canadian-pharmaceutical-alliance

FACT SHEET

Polypharmacy

ISSUE

Polypharmacy is the use of multiple medications by an individual. It is a problem when the benefits of using multiple medications are outweighed by the negative effect of the sheer number of medications. It is more likely to occur in the elderly.

KEY FACTS

- Polypharmacy is rapidly increasing in affluent populations worldwide, posing an increasing challenge for patients, their families and care providers.[1,2]
- Polypharmacy is linked to heightened risks such as adverse drug reactions, non-adherence, functional and cognitive decline, and falls.[3]
- Although an identified specific threshold for the number of medications to define polypharmacy has not been validated, it is known that the risk of drug-related problems increases with the number of medications used.[4] Five or more medications are often a prompt for a medication review.
- In a study conducted in 2008, 27% of Canadian seniors reported taking 5 or more medications on a regular basis; for people older than 85 years, 41% reported taking 5 or more medications.[5]
- On January 28, 2016, the "2nd National Stakeholder Meeting Stakeholder Meeting to Increase Safe and Approrpirate Medical Therapy for Older Men and Women Across Canada" took place. The meeting was organized by a research group from Université de Montréal and was funded by a Canadian Institutes of Health Research (CIHR) grant. Over 100 representatives from stakeholder groups attended to share best practice and ideas. There were discussions on creating a national network on deprescribing, for the purposes of knowledge sharing and creating synergy. The group also identified the need to garner support from federal government.
- The Ministry of Health supports activities aimed at optimizing the use of drugs. This includes healthcare professional education activities on polypharmacy provided by the Doctors of BC, the Therapeutics Initiative (TI), and the CLeAR initiative (see below for more details). The Ministry, through PharmaCare, also provides funding for pharmacists to conduct medication reviews (see "Pharmacy Medication Management Services" Fact Sheet).
- The Doctors of BC's Shared Care Polypharmacy Risk Reduction Initiative aims to reduce risks of polypharmacy (confusion, falls, adverse drug reactions) in the elderly by providing physicians with tools and strategies to reduce medications for improved safety and quality of life.[6] It is being implemented in three phases, focusing on prescribing in the following care settings: 1) residential care; 2) acute care and transitions (currently underway); and 3) community-based/primary care.
- In September 2014, TI published its 90th Therapeutics Letter on "Reducing polypharmacy: A logical approach".[7] The newsletter describes 7 steps that health professionals, patients and their families can employ to become adept at de-prescribing. This work is funded by the Ministry. TI also has a podcast on polypharmacy at: http://www.ti.ubc.ca/podcast/ti-podcast-letter-90-reducing-

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[1] Schuling J et al. Deprescribing medication in very elderly patients with multimorbidity: the view of Dutch GPs. A qualitative study. BMC Family Practice 2012; 13:56. www.biomedcentral.com/1471-2296/13/56/

[2] Hockey D. Carry on prescribing: who is responsible for co-ordinating patients' medication. The King's Fund blog, Nov. 29, 2013. www.kingsfund.org.uk/blog/2013/11/carry-prescribing-who-responsible-co-ordinating-patients-medication

[3] Frank C, et al. Deprescribing for older adults. CMAJ 204; DOI:10.1503/cmaj.131873.

[4] Viktil, K et al. Polypharmacy as commonly defined indicator of limited value in the assessment of drug-related problems. Br J Clin Pharmacol 2007; 63:187-195. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2000563/

[5] Reason B et al. The impact of polypharmacy on the health of Canadian seniors. Family Practice 2012; 29: 427-432. DOI:10.1093/famprac/cmr124 http://fampra.oxfordjournals.org/content/early/2012/01/05/fampra.cmr124

[6] http://www.sharedcarebc.ca/initiatives/polypharmacy

[7] http://ti.ubc.ca/letter90

polypharmacy-logical-approach# and polypharmacy is often included as a topic in the educational sessions they provide to physicians and pharmacists.

- In June 2013, the BC Patient Safety and Quality Council invited residential care homes to join a "Call for Less Antipsychotics in Residential Care" (CLeAR) initiative. This voluntary quality improvement initiative offered support through resources, improvement coaching, an opportunity to collectively learn and problem solve, as well as development of new strategies to improve care for residents and their families. From October 2013 to December 2014, many care homes achieved a steady decline in antipsychotic use that led to evidence of residents' improved health. A full report on CleAR is available in *The Journey Towards Dignity & Resident-Centered Care: Summary Results from the Call for Less Antipsychotics in Residential Care*. Based on the success of CLeAR, the Council initiated second wave for BC residential care homes in October 2015.
- PharmaCare reimburses pharmacists for conducting Medication Reviews, a one-on-one appointment between a patient and pharmacist where medication information is gathered, validated, summarized and reviewed.[8] Patients who have taken at least 5 different medications in the previous 6 months and demonstrate a clinical need for service are eligible for the service.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Barbara Walman, Medical Beneficiaries and Pharmaceutical Services Division; February 1, 2016
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; October 7, 2014
Randi West, obo Carolyn Bell, Health Sector Planning and Innovation Division; October 9, 2014

[8] Factsheet - Pharmacy Medication Management Service, June 2015

FACT SHEET

Provider Enrollment

ISSUE

Denial of enrollment of pharmacies wishing to submit claims to PharmaCare pursuant to the Provider Regulation.

KEY FACTS

- The Provider Regulation, under the *Pharmaceutical Services Act*, came into force on December 1, 2014. The goal of the Regulation is to protect the integrity of expenditures of the PharmaCare program by ensuring there is a transparent and consistent means by which provider eligibility for enrollment may be assessed.
- The Regulation prescribes the criteria a pharmacy or device provider must meet to be enrolled as a provider. The prescribed criteria state that a pharmacy or device provider is ineligible for enrollment if an owner or manager has:
    - an outstanding audit amount owing to a public insurer;
    - a conviction, an order, or is under prosecution for an information or billing contravention;
    - billing privileges cancelled, or currently suspended at another site;
    - convictions for fraud under the *Criminal Code*, drug trafficking or offences under the *Controlled Substances and Drugs Act* within the previous six years;
    - a judgement entered against him or her in the last 6 years regarding business activities related to the site or the provision of benefits; and
    - had his or her registration with a regulatory body cancelled or suspended.
- If satisfied that the applicant meets the prescribed criteria, the Minister may enroll the applicant, unless the Minister is of the opinion that it would not be in the public interest to do so.
- The intent of the Regulation is not to be punitive or to limit the number of providers in BC, but to give the Province a means to exercise discretion before entering into a business relationship that may not be in the public interest.
- All pharmacies and device providers intending to submit claims to PharmaCare must enroll under the terms of the Regulation. The *Pharmaceutical Services Act* states that all current agreements will terminate 180 days after the Regulation comes into force. Therefore, all providers who were enrolled prior to the Regulation coming into force had to enroll under the Regulation prior to June 1, 2015.
- Prior to enacting the Regulation, the Ministry consulted with the College of Pharmacists of BC, the BC College of Physicians and Surgeons, the BC Pharmacy Association, the Neighbourhood Pharmacy Association of Canada (formerly the Canadian Association of Chain Drug Stores) and the Prothesthetic and Orthotic Association of BC. None of these groups opposed the Ministry's intent to better define the roles, responsibilities, and obligations of PharmaCare providers.
- The Ministry reviewed almost 1,300 applications for enrollment under the Regulation. The result of the review was a recommendation that 47 pharmacies be provided with notice of the Ministry's intent to deny enrollment. The recommendations were reviewed by the Assistant Deputy Minister, Medical Beneficiary and Pharmaceutical Services Division (MBPSD), Ministry of Health, who has been delegated through a Ministerial Order the authority to refuse enrollment.
- Letters advising pharmacy owners of the Ministry's intent to deny enrollment were sent to all 47 pharmacies. The Regulation allows the applicant 21 days to respond, in writing. The Assistant Deputy Minister, MBPSD, after considering the responses either confirms or reverses the decision to deny enrollment of each pharmacy. The applicants are provided with written notice of these decisions.
- As of March 2016, 21 pharmacies have been denied enrollment, and limits and conditions have been placed on the enrollment of 16 pharmacies.

FACT SHEET

- A small number of the 47 pharmacies were provisionally enrolled for a time limited period in order for the Assistant Deputy Minister, MBPSD, to properly consider the documentation and information they provided.
- A pharmacy refused enrollment in the PharmaCare programis not authorized to submit claims on behalf of PharmaCare beneficiaries for reimbursement. The pharmacy is still permitted to dispense medications to cash payers or for reimbursement via private insurers, though in cases where PharmaCare enrollment has been terminated the pharmacies involved have usually ceased operations.
- PharmaCare clients that previously filled prescriptions at pharmacies that have subsequently been denied enrollment are not be able to use these pharmacies to fill PharmaCare-covered prescriptions. Instead, they have to find new pharmacies which are enrolled with PharmaCare, or pay for the prescription out of pocket.
- PharmaCare clients can choose which enrolled pharmacy they want to use to fill their prescriptions. The Ministry publishes a list of pharmacies on its website to inform PharmaCare clients which pharmacies are not enrolled in the PharmaCare Program due to their applications being denied or their enrollments cancelled. This list is regularly updated.[1]
- The Ministry is committed to making sure patients have a seamless move to a new pharmacy nearby and is working with a host of regulatory bodies, associations and agencies.
- The Ministry contacted patients using the affected pharmacies by mail to give them time to transfer their prescriptions to nearby pharmacies, and also contacted their prescribing doctors.
- All of the affected pharmacies are in areas with several other nearby pharmacy options for patients. No patient will have to travel farther than a few city blocks to their new pharmacy.
- Prior to the Regulation coming into force, action had been taken 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 MBPSD, the Ministry agreed to fund a joint investigation with the College of Pharmacists of BC 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 8 pharmacies that were subject to the undercover investigation. An independent decision maker was appointed to conduct hearings and proceedings against seven of the pharmacies have concluded.

FINANCIAL IMPLICATIONS

The Ministry has retained legal counsel from the Ministry of Justice to act in its interest throughout the process to deny enrollment, and any judicial review proceedings that may be instituted.

Approved by:
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; April 5, 2016

[1] Available at: http://www2.gov.bc.ca/gov/DownloadAsset?assetId=41ACF0776C2E41F4A8AB4782D5E23792

FACT SHEET

Provincial Retinal Diseases Treatment Program

ISSUE

BC's Provincial Retinal Diseases Treatment Program provides coverage of the several drugs preventing blindness and improving vision for nearly 15,000 British Columbians to date. Compared to other provincial jurisdictions, the program approach used in BC is extremely cost-effective and is very comprehensive. While very successful, the program has received concerns for funding the drug bevacizumab for an "off-label" use and for restricting the funding of treatments provided by only participating retinal specialists. Alberta has recently launched a similar program, which also includes funding bevacizumab and also restricting treatment funding to retinal specialists.

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 Program to include coverage of ranibizumab and bevacizumab for two new indications: Diabetic Macular Edema (DME) and Retinal Vein Occlusion (RVO).
- The Ministry announced the expansion of the Program to include aflibercept (Eylea) for the treatment of wet AMD on April 1, 2015 and DME and RVO on July 1, 2015. Drug therapy for other retinal diseases other than wet AMD, DME and RVO are not covered.
- The Program is currently undertaking quality assurance work with the drug supply chain.
- The Provincial Health Services Authority (PHSA) continues to manage the Program and drug coverage is not subject to Fair PharmaCare deductibles or co-payments.
- The Program provides coverage when the drugs are prescribed and administered by retinal specialists who have signed agreements with PHSA to participate in the Program and submit data into a provincial database. Retinal specialists are ophthalmologists with additional education specializing in retinal disease, provide clinical expertise and expertise with retinal angiography to diagnose and monitor wet AMD, DME and RVO. Health providers and optometrists can refer new patients directly to retinal specialists for diagnosis and treatment. Retinal specialists are available in all regional health authorities.
- On October 24, 2014, representatives from PHSA and the Ministry met with the 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 patient access and make Program adjustments as needed. The review found that 96% of all retinal drug treatments in BC were provided through the program, suggesting that the program provides excellent public coverage overall. By comparison, for other drugs, PharmaCare pays for about 35% of total drug expenditures in BC, whilst the remainder is funded privately.
- The Program will continue to monitor access and conduct any additional assessments in collaboration with the health authorities and retinal specialists, and adjustments will be made if necessary and reasonable to do so.
- The Program continues to monitor drug safety and effectiveness of retinal treatment drugs, 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 among the drug treatments.
- In January 2015, 3 groups (the University of BC, PHSA, and the retinal specialists participating in the Program) agreed to fund a new University of BC-based research and evaluation unit. The unit will conduct ophthalmology research and some retinal Program evaluations (drug efficacy, safety and

cost effectiveness) to support decision makers and clinicians. The funding contribution from PHSA is $60,000 per year for 5 years and comes from the Ministry's existing Program funding.

- 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 into the efficacy and safety of bevacizumab compared to ranibizumab for wet AMD come from the IVAN (2 year results) study published in July 2013.[1] 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 2 drugs published in the CATT trial.[2] A recent real world safety study conducted using patient data from the BC Program has concluded that single or repeated doses of intravitreal bevacizumab were not shown to increase the risk of myocardial infarction or stroke in patients wet AMD.[3]
- All jurisdictional drug plans currently cover ranibizumab. BC, Alberta, Manitoba, New Brunswick, Nova Scotia, Yukon and Veterans Affairs also currently cover bevacizumab.
- On October 1, 2015, Alberta announced a retinal disease program very similar to the one in BC, including covering bevacizumab and restricting the program treatments to retinal specialists.
- Canadian Agency for Drugs and Technologies in Health (CADTH) has recently completed a therapeutic review of the retinal drugs (bevacizumab, aflibercept and ranibizumab). The review recommends bevacizumab as the preferred initial therapy and recommends ranibizumab and aflibercept as alternative options in patients who do not respond or are intolerant to bevacizumab. The recommendations support BC's program approach. Novartis has submitted a formal complaint to Health Canada against CADTH for recommending off-label bevacizumab, lack of transparency/pharmacovigilance and undermining the Canadian drug approval process.

FINANCIAL IMPLICATIONS

- The Program has been extremely successful, treating nearly 15,000 patients in 2014/15 at a cost of approximately $11.5 million[4] and since 2010/11 to March 2015, approximately $63.3 million.[5]
- Vials of retinal drugs 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) and aflibercept costing $400 per treatment.
- The coverage approach for retinal drugs was unique in Canada, although other provinces (Alberta) are now also using the same approach. For example, if BC had followed other provinces like Ontario that provide coverage for ranibizumab only without preparation of multiple doses from one vial and using bevacizumab, the Program would be unaffordable costing more than $83 million per year for treating wet AMD only, or more than $156 million per year for all 3 indications.
- In 2015/16, the Program is expected to cost $14.5 million.[6] Funding for the Program is provided to the PHSA through the PharmaCare budget.

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[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)

2 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)

[3] Etminan M. et al. Risk of Myocardial Infarction and Stroke with Single or Repeated Doses of Intravitreal Bevacizumab in Age-Related Macular Degeneration. Am J Ophthalmol.2015 Dec 14. pii:S0002-9394(15)30005-2 (doi:10.1016/j.ajo.2015.11.030.) http://www.ncbi.nlm.nih.gov/pubmed/26701272

[4] PHSA utilization review (2015) of the program patient and treatment database managed by PHSA

5 AMD Program costs – reviewed by Darlene Ell, Finance, Sept 16, 2015

6 Medical Beneficiary and Pharmaceutical Services Division Budget Impact Analysis

FACT SHEET

Approved by:
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 1, 2016
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; February 24, 2016

FACT SHEET

Reference Drug Program Modernization

ISSUE

- The Reference Drug Program (RDP) modernization will include the introduction of 3 new RDP categories and modifications to 3 existing RDP categories.
- The modernization is estimated to result in significant savings to the PharmaCare Program enhancing the ability to pay for other innovative drugs such as the new hepatitis C drugs.

KEY FACTS

Background

- The RDP, introduced in 1995, is a PharmaCare policy to encourage cost-effective prescribing for common medical conditions.
- Under RDP, drugs that treat the same disease are grouped together into therapeutic categories called RDP categories. The drugs in a RDP category may have different active chemical ingredients but have the same clinical benefit(s) and risks and may differ in cost.
- Clinical safety and effectiveness evidence supports the therapeutic class pricing concept of RDP, with ongoing support that therapeutic class pricing is a viable policy approach to achieve savings without negative clinical impacts. There is also support from the long-standing hospital therapeutic interchange policies that are based on the same premise in place for decades.
- Drugs in each RDP category are either reimbursed fully (reference drugs) or partially (non-reference drugs) based on cost-effectiveness.
- Each RDP category has one or more drugs considered as reference drugs which are reimbursed fully according to the manufacturer's list price plus markup subject to a patient's usual plan rules and deductibles. Among the reference drugs, 1 drug in each RDP category is designated the reference drug comparator. The non-reference drugs in each RDP category are partially covered up to the reference drug comparator price. For the drugs that are partially covered, the balance of the cost is the patient's responsibility.
- If a patient has a specific medical condition that prevents him/her from taking any of the reference products in a RDP category (e.g., a drug-to-drug interaction, drug intolerance, or a previous treatment failure), a practitioner may apply for Special Authority consideration for full coverage of one of the non-reference drugs in the RDP category.
- There are currently 5 RDP categories introduced in 1995 and 1997:
  - nonsteroidal anti-inflammatory drugs (NSAIDs) (in 2010, the reference drug comparator was changed from naproxen to ibuprofen);
  - histamine 2 receptor blockers (H2 Blockers);
  - nitrates;
  - angiotensin converting enzyme inhibitors (ACEIs); and
  - dihydropyridine calcium channel blockers (CCBs).

RDP Modernization:

- The Ministry of Health 2014/15-2016/17 Service Plan outlines the strategic priorities including ensuring value for money and evidence informed access to clinically effective and cost-effective pharmaceuticals as well as leveraging programs such as Low Cost Alternative and RDP to achieve the best therapeutic value and price for publically funded pharmaceuticals.
- In the 20 years since the launch of the RDP, drug prices have decreased with the introduction of more generic products. In July 2012, the Provincial/Territorial Premiers provided the Health Care Innovation Working Group of the Council of the Federation direction to achieve better prices for

generic drugs. This ongoing work is resulting in lower price points for common generic drugs (ie., 18% of brand pricing) which support RDP modernization.

- RDP modernization is based on Drug Benefit Council (DBC) recommendations and input from clinician experts. DBC reviewed RDP policy, systematic reviews, an environmental scan, clinical evidence of various therapeutic classes, utilization, budget impact assessments, and clinical practice reviews at the May 5, 2014 and September 15, 2014 meetings. The DBC recommendations support the foundation and policy approach of RDP and recommended that the Ministry should consider creating new categories and optimizing pricing within existing categories. The DBC also supports the Ministry in seeking to provide drug coverage based on the best value for money.
- Modernization will include the introduction of 3 new therapeutic categories:
  - Angiotensin Receptor Blocker (ARB) – treats high blood pressure; alternative to ACEI;
  - Statin – treats high cholesterol;
  - Proton Pump Inhibitor (PPI) – treats gastrointestinal issues (i.e., reflux); alternative to H2 Blocker.
- Modification of 3 existing therapeutic categories:
  - ACEI – treats high blood pressure;
  - CCB – treats high blood pressure;
  - H2 Blocker – treats gastrointestinal issues, including reflux.
- An order in council to add the 3 new RDP categories to the price regulations within the *Pharmaceutical Services Act* was approved on December 15, 2015. The new categories while stated to be effective as of January 1, 2016 will not officially take effect until later in 2016 after several implementation steps.
- Feedback obtained from initial stakeholder engagement sessions were taken into consideration leading to adjustments to the initiative. Key implementation steps include: (1) a separate price submission process in early 2016 to allow manufacturers with non-reference products to match the reference drug price; (2) plans to continuing existing coverage (grandfathering) for some complex patient populations; and (3) plans to engage stakeholders further.
- A 6 month transition period (expected from June to November 2016) will be provided to give patients sufficient time to review their drug regimens through either a regularly scheduled physician visit or a community pharmacist visit for therapeutic substitution consideration. During the transition period current patient coverage in the 6 therapeutic classes will be maintained.

FINANCIAL IMPLICATIONS

- The goal of the redesign is to make the PharmaCare program more effective based on evidence while maintaining safety. Modernization of the RDP has the potential to achieve a cost savings to PharmaCare of up to $27 million over 3 years[1] - valuable health care dollars to reinvest in new therapies.
- With RDP modernization, some patients prescribed a non-reference drug may need to pay more if they decide not to switch to a fully covered reference product(s).

Approved by:
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 1, 2016
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; December 29, 2015

[1] Budget Impact Analysis completed by the Economic Analysis unit of Policy, Outcomes, Evaluation & Research, MBPSD

FACT SHEET

Research - Ministry Funding

ISSUE

Research on pharmaceuticals or related topics 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 (CIHR), 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 for these services was developed and posted on BC-Bid. The successful applicants were notified in February 2015 and the contract with the 3 successful applicants are signed and will expire in 2018. The TI is one of the successful proponents and the other 2 are Medlior and ReVue.
    - 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 announced in 2016.

- 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 CIHR 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 Ministry asked BC Stats to survey clients who had previously participated in the BC Smoking Cessation Program, in order to determine the effectiveness of nicotine replacement therapy (NRT) gum or patch. The survey was conducted in 2015, and 27% percent of program participants surveyed who used nicotine replacement therapy quit smoking. The survey report is available at: http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pharmacare/pharmacare-publications#studies .
- The Academic Detailing Evaluation Partnership Team, funded by the CIHR, 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] Discussions are ongoing for a contract amendment starting April 1, 2016
- From October 2007 to March 2015, the Ministry spent $2.78 million on Alzheimer's Drug Therapy Initiative research.[4]
- Request for Proposal for Clinical Evidence Review services: 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.
- The cost of the BC Stats NRT survey was $89,500.

Approved by:
Barbara Walman, Medical Beneficiary and Pharmaceutical Division; February 1, 2016
Ted Boomer, obo Manjit Sidhu, Finance and Corporate Services Division;September 18, 2015
Jackie Redmond, obo Carolyn Bell, Health Sector Planning & Innovation Division; February 26, 2014

[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 (September 2015)

FACT SHEET

Smoking Cessation Program

ISSUE

Effective January 1, 2016, the Ministry of Health's BC Smoking Cessation Program was expanded to include new nicotine replacement therapy products (lozenge and inhaler in addition to gum and patch). The registration process was also streamlined and is done exclusively at community pharmacies. An evaluation of this program was completed in early 2015, with additional evaluations being planned in the future, considering the recent program changes.

KEY FACTS

- BC continues to have the lowest smoking rate in Canada at 14.3% in 2014,which represents a decrease from 16.2% in 2013. The national smoking rate was 18.1% in 2014.[1]
- The Ministry's BC Smoking Cessation Program, launched September 30, 2011, helps BC residents stop smoking, by providing the choice of either a no cost supply of either nicotine replacement therapy, or PharmaCare coverage of prescription drugs bupropion (Zyban®), or varenicline (Champix®), 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 the first competitive tender, between September 30, 2011 and December 31, 2015, the Program provided coverage for one brand of nicotine gum (Thrive™) and one brand of nicotine patches (Habitrol®). Following the completion of the second competitive tender, as of January 1, 2016 the Program provides coverage for one brand of nicotine gum (Nicorette®), one brand of nicotine patches (Nicoderm®), one brand of nicotine lozenge (Nicorette®), and one brand of nicotine inhaler (Nicorette®).
- Each calendar year, eligible BC residents can get coverage for either one NRT 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 3 fills of 28 days each. All BC smokers and users of other tobacco products with active coverage through the province's Medical Services Plan 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 Medical Services Plan 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. Additional evaluations are being planned, considering with the recent program changes.
- 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 NRT gum or patch. Of those who used the Program NRT 27% quit smoking. Cigarette consumption since using the Program was determined and 76% of respondents reported that they were smoking less than before using the Program. There were 71% of respondents who made at least one quit attempt by stopping smoking

[1] Canadian Community Health Survey, 2014. Extracted from Statistics Canada Website. Prepared by Ministry of Health Surveillance and Epidemiology team, June 17, 2015

for at least 24 hours. There were more respondents (52%) who remained smoke free for more than 30 days after using the Program (65% reported that they strongly agreed/agreed that the Program helped, or is helping, them quit smoking. 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. Based on the evaluation, the Ministry implemented changes to streamline the operations of the Program. Starting January 1, 2016, NRT products covered by the Program are available directly through pharmacies. As a result, patients no longer need to register by calling HealthLinkBC (8-1-1). The Program is also available only through pharmacies (i.e., mail order has been discontinued).
- 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 March 31, 2015, over 187,000 patients received smoking cessation aid (129,800 for nicotine gum or patches, and 77,900 for bupropion or varenicline), and the Ministry has invested approximately $38.2 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 $38.2 million. (September 30, 2011 to March 31, 2015).
- The cost of the BC Stats NRT survey was $89,500.

Approved by:
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; January 27, 2016
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; July 13, 2015

[2] http://www.ottawaheart.ca/research_discovery/cardiovascular-research-methods-centre.htm (accessed 13jan2015)
[3] PharmaNet data, MoH, analysis by MBPSD POER, 2015

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 contracted services.
- The reinstated TI contract will expire March 31, 2016. Discussions are ongoing for a new contract (an amendment to the existing contract) to start April 1, 2016.
- The Ministry has a separate contract with the TI to provide Clinical Evidence Review services to inform the Ministry's drug review process.

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. Today, 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 one, with a target of 3 per year, pharmacoepidemiology program evaluations. For 2014/16, the topics for these program evaluations included the following: statins for high cholesterol, proton pump inhibitors for gastrointestinal diseases, and a rapid monitoring tool.
- From 2011 to 2014, the Ministry signed contracts with three UBC drug researchers, following a request for qualifications (RFQ) process, who are part of the TI, to provide Clinical Evidence Review services to inform the Ministry's drug review process.

FACT SHEET

- In 2014, following the expiry of the earlier RFQ contracts, the Ministry of Health posted a request for proposal process on BC Bid. One of the UBC drug researchers, who is a member of the TI, won a new 3 year contract to deliver the next round of Clinical Evidence Review services to inform the Ministry's drug review process. The contract was signed and came into effect in June 2015.

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.
- The Ministry and UBC are currently discussing a new contract (amendment) for 2016-2019.
- In 2013, the 3 RFQ contracts, between the Ministry and UBC drug researchers, who are part of the TI, to provide Clinical Evidence Review services, were each valued at $50,000 per year.
- The new 3 year request for proposal contract with one of the UBC drug researchers, who is a member of the TI, will be in effect from June 22, 2015, to April 26, 2018, with a one time option to extend the contract for 2 years.
  - For 2015/16, the maximum funding is $170,000.
  - For 2016/17, the maximum funding is $170,000.
  - For 2017/18, the maximum funding is $170,000.

Approved by:
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 1, 2016
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; July 13, 2015

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®), 2 prescription drugs covered by BC PharmaCare for smoking cessation, and call for more safety evaluations.

KEY FACTS

The Ministry of Health used its drug review process to review the efficacy and safety of the drugs covered through the BC Smoking Cessation Program.

- In April 2011, smoking cessation drugs (varenicline, bupropion, nicotine replacement therapies (NRTs)) 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 the Canadian Agency for Drugs and Technologies in Health (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 (MBPSD) established an internal working group to develop an evaluation plan for the Program.
- In August 2011, MBPSD submitted a query to the Drug Safety and Effectiveness Network (DSEN) to evaluate the effectiveness and safety of varenicline, bupropion, and NRTs.
- In September 2011, the Program was launched to provide the choice of a 12-week course of no-cost nicotine gum or patch, or PharmaCare coverage of varenicline or bupropion. As of January 1, 2016 the Program provides coverage for additional NRT products (i.e. gum, patch, lozenge, inhaler); the Program continues to provide coverage for varenicline or bupropion.
- From September 30, 2011 to March 31, 2015, over 187,000 patients received a smoking cessation aid (129,800 for nicotine gum or patches, and 77,900 for bupropion or varenicline), and the Ministry has invested approximately $38.2 million for drug coverage.[1]

Research studies continue to support that all covered drugs for smoking cessation under the Program are effective and safe. There are several recent large-scale (country-wide) studies that provide real-world information on effectiveness and safety.

- In May 2012, the *British Medical Journal* published a systematic review and meta-analysis with 22 trials and over 5,000 patients taking varenicline. They found no significant increase in cardiovascular adverse effects associated with varenicline.[2]
- In May 2013, the *Cochrane Database of Systematic Reviews* published its overview and network meta-analysis of smoking cessation therapies. None of the studied drugs (including varenicline, bupropion, and NRT) appeared to have adverse events that would mitigate their use.[3]
- In October 2013, the *British Medical Journal* published a real-world safety study involving nearly 120,000 adult smokers in England (>31,000 using varenicline, > 6,700 patients using bupropion). 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 NRT.[4]

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[1] PharmaNet data, MoH, analysis by MBPSD POER, 2015

[2] Prochaska JJ, Hilton JF. BMJ 2012 http://www.bmj.com/content/344/bmj.e2856.long (accessed 19jan2016)

[3] Cahill et al. DOI: 10.1002/14651858.CD009329.pub2 http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009329.pub2/abstract (accessed 19jan2016)

[4] Thomas KH et al. BMJ 2013;347:f5704 http://www.bmj.com/content/347/bmj.f5704.full.pdf+html (accessed 19jan2016)

- In May 2014, DSEN concluded that continuous abstinence rate at 12 months was better for varenicline, bupropion and nicotine gum compared to placebo. There were no safety signals for cardiovascular events or suicides; however, this should be interpreted with caution given the small number of trials and the low number of events available for analysis.[5]
- In March 2015, a *British Medical Journal* publication found no evidence of an increased risk of suicide or attempted suicide, suicidal ideation, depression or death with varenicline. This was a study with 44 trials and 11,146 patients, and the most comprehensive published systematic review of neuropsychiatric effects associated with varenicline to date.[6]
- In June 2015, the *British Medical Journal* published a study using data from the whole population of Sweden (>69,000 patients on varenicline). The analysis showed that varenicline was not associated with significant hazards of suicidal behaviour or other specified negative outcomes.[7]

The Ministry and BC Stats evaluated the NRT component of the Smoking Cessation Program.

- An *impact* evaluation was conducted to determine whether Program NRT reduced smoking rates among British Columbians. In 2015, BC Stats completed a survey of >3,000 Program clients. 27% of those who used Program NRT quit smoking. Based on these results, Program NRT is effective for smoking cessation.[8]
- An *operational (process)* evaluation was conducted to determine how well the Program was working. Approximately 25% of smokers across the province have participated. Based on this evaluation, the Ministry streamlined the Program. In January 1, 2016, NRT products covered by the Program are available only through pharmacies. As a result, patients will no longer need to register by calling HealthLinkBC (8-1-1) and direct mail distribution has been discontinued.
- Additional evaluations may be planned in the future, considering these recent program changes.

Based on the Ministry's review to date, the Ministry continues to support PharmaCare coverage for varenicline and bupropion, and no-cost NRT products (i.e. gum, patch, lozenge, inhaler).

- In July 2013, Fall 2014, January, May and June 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, for evaluation.
- All academic researchers, including those from Therapeutics Initiative, 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.
- The Ministry is monitoring the class action lawsuit regarding varenicline safety. The action has been stayed as against the manufacturer Pfizer. The legal process is continuing.

FINANCIAL IMPLICATIONS

The cost of the BC Stats smoking cessation NRT survey to the Ministry was $89,500.

Approved by:

Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 2, 2016
Carolyn Bell, obo Teri Collins, Health Sector Information, Analysis and Reporting Division; February 5, 2016
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; July 13, 2015

[5] http://www.ottawaheart.ca/research_discovery/cardiovascular-research-methods-centre.htm (accessed 13jan2015)
[6] Thomas KH et al. BMJ 2015;350:h1109 doi:10.1136/bmj.h1109 http://www.bmj.com/content/350/bmj.h1109 (accessed 17jun2015)
[7] Molero, Yasmina et al. BMJ 2015;350n2388. http://www.bmj.com/content/bmj/350/bmj.h2388.full.pdf (accessed 17jun2015)
[8] http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pharmacare/pharmacare-publications#studies

FACT SHEET

Positioning Genomics in the Healthcare System

ISSUE

BC has emerged as a leader in genomic health research nationally and internationally, particularly in the area of health genomics.

KEY FACTS

- The BC Technology Strategy, #BCTECH, contains strategic actions including facilitating, through Genome BC, turning important insights from genomics into new diagnostic and treatment services.
- For BC to build upon its genomic successes and improve clinical outcomes, it will be important to have a clear framework for genomic services in the health system, specifically one that supports an integrated research and innovation ecosystem.
- The Ministry of Health, in consultation with experts will develop a genomic road map, on how to support genomic research and its translation into improved patient care and patient outcomes.
- Development of this framework is underway in collaboration with Genome BC and other key stakeholders and will be complete within the next 3-6 months.

Background

Over the past 15 years, BC has emerged as a leader in genomic health research nationally and internationally.[1] The province has invested in Genome BC to support genomic research projects, and in the Michael Smith Foundation for Health Research to support and to attract researchers who contribute to genomic research.

The investment in genomics has positioned BC well for application of genomics in the emerging field of precision or personalized medicine, in which variation in the human genome can be linked to a patient's susceptibility to disease or response to treatment, allowing for earlier and more nuanced diagnosis, more accurate prognosis, delivery of treatment strategies tailored to the characteristic of the individual patient, and in many cases prevention of disease. Jurisdictions around the world are recognizing the potential of personalized medicine for transforming health care and as a foundation for economic growth.[2,3,4]

With a strong and vibrant group of genomic experts and sequencing core facilities, some of the best patient registries in the world, electronic health records, new investment in the Strategy for Patient Oriented Research (SPOR) data platform and a lively research and innovation ecosystem, BC has many of the ingredients required to be a leader in the implementation of genomics in clinical practice.

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[1] Bibliometric Analysis on genomic Research in Canada focusing on British Columbia, 1981-2011. Science-Metrix, January 2014.

[2] U.S. White House. Fact sheet: President Obama's precision medicine initiative [homepage on the Internet]. c2015. [cited 2016 Jan 29]. Available from: www.whitehouse.gov/the-press-office/2015

[3] Genomics England. The 100,000 genomes project [homepage on the Internet]. c2015. [cited 2016 Jan 29]. Available from: www.genomicsengland.co.uk/the-100000-genomes-project

[4] OECD International Futures Project, The bioeconomy to 2030: Designing a policy agenda [homepage on the Internet]. c2009. [cited 2016 Jan 29]. Available from:www.oecd.org/futures/long-termtechnologicalsocietalchallenges/thebioeconomyto2030designingapolicyagenda.htm

FACT SHEET

To secure BC's position in this globally competitive field, the BC government has developed the BC Technology Strategy, #BCTECH, which is a multi-pronged strategy to support BC's tech industry, including the life sciences, with the tools, funding, and resources needed to expand and grow in BC. The strategy recognizes the importance of a strong research environment as the foundation for innovation as well as the need for supports for developing entrepreneurs to bridge the gap between innovation and commercial application.

A robust genomic strategy will also require attention to unique challenges to the application, uptake and commercialization of genomic discoveries into the health system.

Rapid advances in genetic testing and related technologies (accompanied by some cost reductions in specific tests/technologies) have resulted in heightened demand for genetic tests and related services and increased use in relation to an ever broader range of rare and common diseases. The introduction of genomic tests represents important new developments in the diagnosis and treatment of disease. The successful translation of promising genomic research into clinical practice requires attention to a range of issues including: the quality and reliability of genomic testing and interpretation, education for health professionals and patients, assessment of clinical meaningfulness and cost effectiveness, attention to the public/private mix for funding and delivery of genomic services, adequacy of bioinformatics, legal issues regarding privacy and genetic discrimination and other ethical issues. Public acceptance of genomic technologies cannot be assumed and is an important underlying issue.

FINANCIAL IMPLICATIONS

s.13

APPROVALS

Approved by: Victoria Schuckel, A/Executive Director: April 27, 2016

FACT SHEET

Health Accord – FPT Shared Health Agenda

ISSUE

The federal Health Minister has been mandated to engage provinces and territories (PTs) in the development of a new multi-year Health Accord, including a long term funding agreement. Federal, provincial and territorial (FPT) Health Ministers met in Vancouver on January 20-21, 2016, and discussed shared priorities for immediate action, leading toward a new Health Accord.

KEY FACTS

Federal Funding for Health Care

- In July 2015, Premiers agreed that the federal share of health care costs through the Canada Health Transfer should represent a minimum of 25% of all health care spending by PTs.
- At the January 21st FPT Health Ministers' Meeting, PT Ministers reaffirmed this position to the federal Health Minister. The federal Minister agreed that new resources are needed and confirmed the federal government's commitment to work toward a long-term funding arrangement with PTs.
- The federal Minister has indicated that a long-term funding arrangement could include bilateral agreements between the federal and individual PT governments, which would take into account the different circumstances of jurisdictions.
- Negotiation on a funding agreement with the federal government, including any changes to the Canada Health Transfer, will require further discussions at the FPT level including Premiers, Finance Ministers, and Health Ministers.
- PT Health Ministers agree that increased federal funding for health care is required; however, they disagree on the method of distribution for the funding. Some provinces, including BC, have advocated for distribution that considers the impact of an aging population, while others, e.g. Alberta, favour a per-capita distribution.

Shared Health Agenda

- FPT Ministers have agreed to work on the following immediate priorities: Pharmaceuticals, Community Care, and Innovation.
- Discussions will continue over the coming months at the Minister, Deputy Minister, and staff levels to clarify deliverables and advance work in these areas.

Pharmaceuticals

- FPT Ministers will work collaboratively to enhance the affordability, accessibility and appropriate use of prescription drugs. This includes reducing pharmaceutical prices, improving prescribing practices, and improving coverage and access.
- Ministers agreed to create a new working group focused on improving equitable and appropriate access to pharmaceuticals. The group will be co-led by Ontario, BC and Alberta, and the federal government will also participate.
- Jurisdictions are working toward a fair pricing strategy and more consistent assessments of drugs and coverage decisions for expensive drugs that are used to treat rare diseases. Work will focus on access, evidence of effectiveness, communication, and pricing.

Community Care

- FPT Ministers recognized the impacts to health systems of aging populations, as well as growing rates of chronic disease and mental illness.

- FPT Ministers will consider ways to expand access to services at home, and agreed to pursue a shift of health-care systems from a focus on institutions toward providing more care in the home and community. This is in alignment with BC's strategic priorities.
- The federal government's election platform included a commitment to provide $3 billion in funding over 4 years to PTs for home care services, including in-home caregivers, financial support for family care, and palliative care. Collaborative work on community care going forward will build on the work of PTs, along with this committed federal investment.

Innovation

- FPT Ministers agreed on the importance of service delivery innovation to improve quality of care and value for money in health services.
- Ministers will consider how existing pan-Canadian and provincial health organizations can better support system transformation.
- Ongoing collaborative work will focus on the adoption and spread of proven innovations, as well as the role of health information, data analytics, digital health and technology management.

FINANCIAL IMPLICATIONS

- See separate fact sheet on Federal Health Transfers.

Approved by:
Heather Davidson, Partnerships and Innovation Division; February 5, 2016

FACT SHEET

Lyme Disease

ISSUE

- There is considerable debate and disagreement between patient advocacy groups and a minority of physicians and the broader medical community related to the existance, diagnosis and treatment of "chronic Lyme disease".
- The Public Health Agency of Canada is planning a "consensus conference" later this year that will engage Lyme advocacy groups, public health practitioners and infectious disease specialists with the intent of forging a consensus on how to diagnose and treat Lyme disease. This may well lead to media questioning and a refocus on ongoing disagreements.

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 recovery.
- Even after effective antimicrobial treatment, in the absence of any evidence of ongoing infection, 10-20% of individuals who had active established Lyme disease will report ongoing symptomatology. The underlying cause is thought to be some as yet undefined immune system disregulation.
- Concerns have been raised regarding 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. In May 2010, Provincial Health Services Authority's Brian Schmidt produced a report at the request of the then Deputy Minister of Health that recommended further research into "chronic Lyme disease". BCCDC was not involved in this report, which was not peer-reviewed.
- Partly, as a result of this report and following previous recommendations from the Provincial Health Officer, the Ministry of Health and the Provincial Health Services Authority invested significant funds to develop a Complex Chronic Disease Clinic and associated research program.

<u>Diagnosis and Laboratory Testing</u>

- Early, acute Lyme disease should be diagnosed by a physician through a clinical evaluation of the patient's symptoms and risk of exposure to infected ticks. Treatment is not dependent on blood tests at this stage.
- Blood tests for Borrelia antibodies may be used to assist in the diagnosis of suspect established Lyme disease (supported by laboratory testing by BCCDC).

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[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-48DB-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

FACT SHEET

- The BCCDC laboratory uses the accredited 2 step international test protocols (ELISA and Western Blot) that are used by all public health laboratories in the US and internationally.
- Results of testing done by non-recognized means, such as that advertised by some independent for profit US Laboratories that use in-house or non-standarized interpretations should be discouraged as recent published evidence shows that they are no better at picking up Lyme disease than are approved tests, but will find "Lyme disease" in up to 57% of healthy, uninfected people. In the BC context this will lead to exceedingly high rates of false positive test 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 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.

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:

Dr. Perry Kendall, Provincial Health Officer, January 19, 2016