Health System Overview – Structure, Governance and Funding

OVERVIEW

The Ministry of Health (the Ministry) works in collaboration with the health authorities, as well as a range of professional colleges, associations, post- secondary institutions, and health unions to establish a clear direction and set strategic objectives for the health system, and to ensure quality, patient centred care is delivered at the right time, in the right facility, and by the most appropriate health care professional.

While health service delivery is predominantly a provincial/territorial responsibility the federal government does sets and administer national principles for the health system, ensuring provinces act in accordance with the *Canada Health Act* as a requirement for the flow of federal transfer funds to the provinces. It also funds and/or delivers health services to certain groups, including: First Nations living on reserves, Inuit, serving members of the Canadian Forces, eligible veterans, inmates in federal penitentiaries, and some refugee claimants. In addition it manages the Public Health Agency of Canada, Canadian Food Inspection Agency, Canadian Institutes of Health Research, and Patented Medicine Prices Review Board.

STRUCTURE

The BC health delivery system is dominated by three structural elements: the Ministry of Health, Health Authorities, and Physicians.

The BC health system is a provincial system of regionally delivered services. Five health authorities provide services in different geographical regions of the province with a sixth health authority, Provincial Health Services, providing province-wide services in a number of specialty areas. Additionally, the First Nations Health Authority is focused on improving health outcomes for First Nations people in British Columbia. For planning, reporting and assessment purposes, the regional health authorities have been divided into Health Service Delivery Areas (HSDA), which then are sub-divided into Local Health Areas (LHA). There are 16 HSDAs and 89 LHAs across British Columbia. To allow more specific local service planning the LHAs are sub- divided into Community Service Delivery Areas (CSDAs) that will provide a more accountable provincial picture of what improvement is being achieved across metro, urban/rural, rural and remote communities.

In addition to these three structural elements there are other key organizational players in the health system including Professional Colleges, Post- Secondary Institutions, and Health Sector Unions.

HEALTH SYSTEM ROLES AND RESPONSIBILITIES – MINISTRY OF HEALTH

Ministry of Health Roles and Responsibilities

- Has overall responsibility for achieving meaningful health outcomes for individuals/populations and a quality service experience (person and family centred health care, accessibility, appropriateness, acceptability, safety, efficiency and effectiveness) for all British Columbians.
- Sets strategic and policy direction for the health system for health service delivery, health human resources, digital/IMIT/technology, organizational capacity; establishes accountability and planning for action; as well as monitoring, evaluating and reporting on the health systems performance.
- Directly manages a number of provincial health programs including: Medical Services Plan, PharmaCare, BC Vital Statistics Agency, and HealthLinkBC.
- Allocates funding for the health system.

Deputy Minister – Stephen Brown

The Office of the Deputy Minister is in charge of all matters relating to publicly funded health care services and is responsible for the policy, legislative and organizational framework within which publicly funded health care services are provided to British Columbians. The Deputy Minister acts as the agent of the Minister of Health in carrying out the office's responsibilities and supports the Minister in his or her duties.

Health System Overview – Structure, Governance and Funding

Associate Deputy Minister, Health Services – Lynn Stevenson
Associate Deputy Minister, Corporate Services – Sabine Feulgen

The Offices of the Associate Deputy Ministers, Health Services and Corporate Services, provide oversight to individual Assistant Deputy Ministers in meeting their divisional accountabilities, facilitate value-added coordination and linkages between divisional strategic agendas, and ensure effective communication and linkages within the Ministry. The Associates provide leadership and direction to key priority projects as outlined in the Ministry's Strategic Plan.

Population and Public Health Division – Arlene Paton

The Population and Public Health Division sets the foundation for the delivery of high quality public health promotion, protection and prevention services to improve the health and well-being of all British Columbians, by establishing legislative and policy frameworks for public health services and programs and population health improvement.

Primary and Community Care Policy Division – Doug Hughes

The Primary and Community Care Policy Division sets the foundation for the delivery of high quality health services by establishing patient centered health services policy for primary and community care, and undertaking activities to ensure quality care is delivered.

Hospital, Diagnostic and Clinical Services Division – Ian Rongve

The Hospital, Diagnostic and Clinical Services Division provides strategic oversight, policy development and evaluation for laboratory services and diagnostic services, blood services, genomic/genetic testing and related services, acute care services, virtual care services, home health monitoring and HealthLink BC.

Pharmaceutical Services Division – Barbara Walman

The Pharmaceutical Services Division is responsible for the overall coordination, decision making, and performance of the province's publicly-funded drug program.

Clinical Integration and Regulation – David Byres

The Clinical Integration and Regulation Division is responsible for the development of policy, regulation and oversight to ensure the effective integration of clinical practice, education, and health human resource planning.

Health Services Workforce Planning, Compensation and Beneficiary Services Division– Ted Patterson

The Health Sector Workforce Planning, Compensation and Beneficiary Services Division is responsible for the overall coordination, decision making, and performance of the province's publicly-funded medical services in addition to the workforce strategies that contribute to effectively meeting patient and population health needs and improving patient outcomes through efficient delivery of health services.

Partnerships and Innovation Division – Heather Davidson

The Partnerships and Innovation Division has responsibility for managing health research policy and priorities, promoting health research translation and innovation and managing legislative and regulatory initiatives and developing the annual legislation plan for the Ministry.

Health System Overview – Structure, Governance and Funding

Health Sector Information, Analysis and Reporting Division – Teri Collins

The Health Sector Information, Analysis and Reporting Division leads key information management functions including data stewardship, governance, security, access; analytics and reporting, quality assurance, performance measurement and evaluations functions.

Health Sector Information Management/Information Technology Division – Deborah Shera

The Health Sector Information Management/Information Technology Division provides sector-wide leadership for IM/IT planning, policy and business solutions.

Finance and Corporate Services Division – Manjit Sidhu

The Finance and Corporate Services Division supports Ministry of Health programs and health authorities by assisting program areas and health authorities in meeting their strategic goals and operational plans, identifying efficiencies and ensuring compliance with relevant legislation, regulations and central agency directives.

Strategic Management and Organizational Development Division – Debbie Godfrey

The Strategic Management and Organizational Development Division is responsible for strategic management and health sector planning, organizational development and capacity building, and executive operations and ministerial liaison.

Office of the Provincial Health Officer – Dr. Perry Kendall, Provincial Health Officer

The Provincial Health Officer is the senior medical health officer for BC and provides independent advice to the Ministry of Health and the public on public health issues and population health.

Office of the Seniors Advocate – Isobel Mackenzie, Seniors Advocate

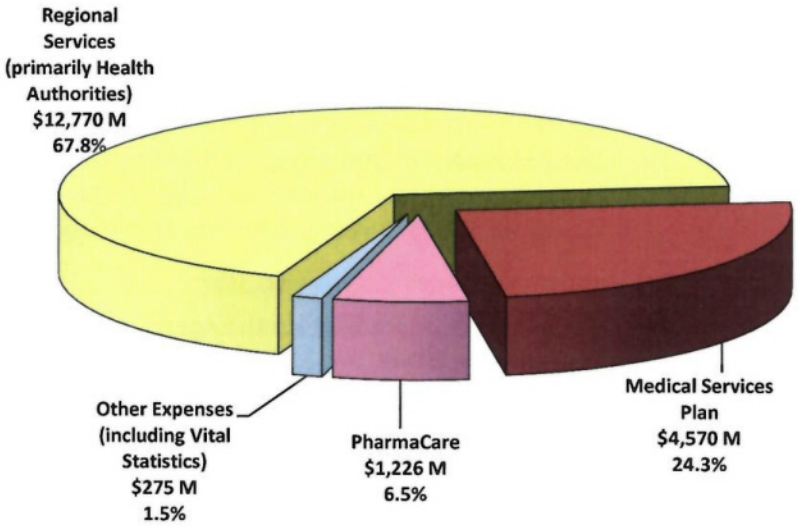
The Seniors Advocate is an independent advisor to the Minister of Health and the voice of seniors in BC.

HEALTH BUDGET MANAGEMENT

Minister of Health's Mandate Includes:

- *Balance the Ministerial Budget.*
- *Ensure services are delivered within health authority budgets.*

- Ministry of health 2017/18 budget - $18,840M
- $4.2 B in total new funding will be provided to the Ministry over the 3 year fiscal plan period; the remainder of government appropriations total less than $1 B over the same timeframe
- Equates to an average annual funding growth rate for the Ministry of Health of 3.6%; the average growth rate for the remainder of government appropriations is 0.5%
- Much of the funding provided to Health in Budget 2017 is to support wage increases (under the 5 year 2014 Economic Stability Mandate)



Health System Overview – Structure, Governance and Funding

- The Ministry of Health funds three major areas:
  - Regional Services (funding for health authorities and other regional services),
  - Medical Services Plan (fees paid for physician, specialist, surgeon and diagnostic services), and
  - PharmaCare (coverage for the cost of prescription drugs, medical supplies, and pharmacy services).
- Growth in funding allocations to health authorities remains steady over the three year fiscal plan period.
- Medical Service Plan (MSP) costs grew by an estimated 4.3% in 2016/17 and a similar growth rate, primarily volume related, is projected year over year for the fiscal plan period.
- PharmaCare costs increased by an estimated 2.6% in 2016/17. The growth rate continues to increase year over year, albeit slowly, due to volume and the ongoing pressure to approve expensive new drugs.
- Other expenses include Ministry executive and corporate services, the outsourced contract to administer medical coverage through MSP and drug coverage under PharmaCare, and Vital Statistics.

HEALTH SYSTEM ROLES AND RESPONSIBILITIES – HEALTH AUTHORITIES

Regional Health Authority Roles and Responsibilities

- Meets performance objectives set out by Ministry.
- Identifies population health needs in its region.
- Plans, delivers, monitors and reports on health services.
- Coordinates appropriate programs and services in population, public health, primary and community care; diagnostic and pharmaceutical services; hospital services.
- Ensures programs and services are properly managed and funded, accountability for the delivery of health human resource management and digital/IMIT/technology in its region, and works with both the Provincial Health Services Authority and its agencies, as well as the First Nations Health Authority.

First Nations Health Authority Roles and Responsibilities

- Responsible for planning, management, service delivery and funding of health programs, in partnership with First Nations communities in BC.
- Guided by the vision of embedding cultural safety and humility into health service delivery, the FNHA works to reform the way health care is delivered to BC First Nations through direct services, provincial partnership collaboration, and health systems innovation.
- work does not replace the role or services of the Ministry of Health and Regional Health Authorities. FNHA collaborates, coordinates, and integrates our respective health programs and services to achieve better health outcomes for BC First Nations in rural and urban settings.

Provincial Health Authority Roles and Responsibilities

- Meets performance objectives set out by Ministry.
- Identifies provincial population health needs related to its services.
- Plans, delivers, monitors and reports on health services.
- Coordinates and/or delivers specialized health services including BC Cancer Agency, BC Centre for Disease Control, BC Children's Hospital and Sunny Hill Health Centre for Children; BC Emergency Health Services, BC Renal Agency, BC Transplant, BC Women's Hospital and Health Centre, Cardiac Services BC, Perinatal Services BC as well as a range of other specialized services and programs.
- Ensures programs and services are properly managed and funded, accountability for the delivery of health human resource management and digital/IMIT/technology in its region, and works with both the Provincial Health Services Authority and its agencies, as well as the FNHA.

BC Clinical and Support Services Society

- BCCSS has accountability for the Agency for Pathology and Laboratory Medicine, the Provincial Blood Coordinating Office, and specific underlying support services that are provided to BC's six health authorities, including Supply Chain, Accounts Payable, Accounts Receivable, Payroll, Employee Records and Benefits, and Technology Services.

Health System Overview – Structure, Governance and Funding

HEALTH AUTHORITY FUNDING

- Five regional health authorities described as Northern, Interior, Vancouver Coastal, Fraser, and the Islands and the Provincial Health Services Authority (PHSA) deliver the majority of publicly funded health care services through hospitals and other health care facilities.
- A number of non-profit hospital societies also provide health care services in partnership with the regional health authorities. Province Health Care (PHC) is the largest, primarily delivering services on behalf of Vancouver Coastal. It also operates the BC Centre for Excellence in HIV/AIDS.
- Allocation of funds to each regional health authority considers population size; demographics including health status; acute care services profile; and the mix between urban and rural health care delivery.
- PHSA plans and provides specialized, province wide health care services including cancer care, transplant, and ambulance services. PHSA also operates the BC Centre for Disease Control which supports public health surveillance programs.
- The First Nations Health Authority (FNHA) receives funds from both the federal government and the provincial government to support community based services for the aboriginal population.

Ministry of Health Organizational Chart

June 13, 2017

Deputy Minister
Ministry of Health
Stephen Brown

Health Communications, GCPE
Sarah Plank, Director-Strategic Communications
Kristy Anderson, Director-Media Relations

Provincial Health Officer
Dr. Perry Kendall

Seniors Advocate
Isobel Mackenzie

Associate Deputy Minister
Health Services
Lynn Stevenson

Strategic Management and Organizational Development
Debbie Godfrey

Associate Deputy Minister
Corporate Services
Sabine Feulgen

Population & Public Health Division
Arlene Paton

- Healthy Living & Health Promotion
  Matt Herman
- Public Health Services Branch & Office of Aboriginal Health
  Warren O'Briain
- Health Protection
  Tim Lambert
  - Emergency Management Unit
    John Lavery/ Kathryn Forge

Primary and Community Care Policy Division
Doug Hughes

- Primary Care Access
  Shana Ooms
- Mental Health and Substance Use
  Keva Glynn
- Seniors Services
  Sharon Stewart
- Performance and Issues Management
  Thomas Guerrero

Hospital, Diagnostic and Clinical Services Division
Ian Rongve

- Acute and Provincial Services
  Brendan Abbott
- Perioperative Services
  Marilyn Copes
- Laboratory, Diagnostic & Blood Services
  Jane Crickmore and A/Tricia Braidwood-Looney
- Genetics Services
  Carolyn Bell
- HealthLink BC
  Marie Root
- Virtual Care Strategy
  Greg Leake

Health Sector Workforce Planning, Compensation and Beneficiary Services Division – Ted Patterson

- Strategic Priorities, Planning and Engagement
  Mark Armitage
- Compensation Policy & Programs
  Marie Ty
- Negotiations and Agreements
  Rod Frechette
- Medical Beneficiary
  Stephanie Power

Chief Nurse Executive: Clinical Integration, Regulation & Education Division - David Byres

- Education, Recruitment and Retention Initiatives
  Kevin Brown
- Professional Regulation and Oversight
  Mark MacKinnon
- Chief Nursing Office
- Emergency Medical Assistants Licensing
  Richard Simpson

Partnership and Innovation Division
Heather Davidson

- Research
  Victoria Schuckel
- Legislation & Intergovernmental Relations and Knowledge Management
  Kevin Samra
- Innovation
  Vacant

Organizational Development
Eddy Piasentin

Planning & Reporting
Tim Woolfrey

Strategic Management
Erica Meldrum

Corporate Engagement
Regan Hansen

Pharmaceutical Services Division
A/Mitch Moneo

- Drug Intelligence & Optimization
  Eric Lun
- PharmaCare Information, Policy & Evaluation
  Mitch Moneo
- Business Management, Supplier Relations & Systems
  Kelly Uyeno

Health Sector Information, Analysis & Reporting
Teri Collins

- Business, Services & Transformation
  Colleen Sparks
- Data Management & Stewardship
  Andrew Elderfield
- Integrated Analytics: Hospital, Diagnostic & Workforce
  Nancy South
- Integrated Analytics: Community & Cross Sector
  ChristineVoggenreiter
- Performance Monitoring & Evaluation
  Ross Hayward
- Vital Statistics Agency
  Jack Shewchuk

Health Sector IM/IT Division
Deborah Shera

- Business Management Office
  Guy Cookson
- Business Transformation
  Alison Pearce
- Health Information Privacy, Security & Legislation
  Mariana Diacu
- Health IT Strategy
  Paul Shrimpton
- HIBC Procurement Office
  Vacant
- Information Technology Services
  Jeff Aitken
- Strategic Projects
  Brad Kocurek

Finance and Corporate Services Division
Manjit Sidhu

- Finance & Decision Support
  Daryl Conner
- Regional Grants, Decision Support
  Gordon Cross
- Capital Services
  Joel Palmer
- Audit & Investigation
  Marie Thelisma
- Business Financial Transformation
  Kerri Harrison
- Facilities
  (Fiona Miyoshi)

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 since 2014. Fentanyl is now associated with the majority of illicit drug overdose deaths.

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 (i.e., people not accustomed using opioids).
- In recent years, BC has been experiencing an increase of fentanyl-detected deaths occurring in illicit circumstances: 13 in 2012, 49 in 2013, 91 in 2014, and 151 deaths in 2015.[1] This pattern continued in 2016, with 374 fentanyl detected illicit drug overdose deaths from January 1 to October 31, a 197% increase over deaths (127) in the same period in 2015. The total number of deaths that occurred in 2016 where fentanyl has been detected will not be available until March 2017. In 2016, 914 people died from an illicit drug overdose; as of January 31, 2017, a further 116 people have died.
- Over the past 5 years the percentage of drug overdose deaths in which fentanyl is detected has risen from 5% to 60%. 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 2016 was 914, an increase of more than 79% from 2015. Mortality rates for 2016 are higher than they have been in recent years, well exceeding a previous period of high mortality rates seen in 1998.[2] This significant increase in drug-related overdoses and deaths prompted B.C.'s Provincial Health Officer Dr. Perry Kendall to declare a public health emergency on April 14, 2016. And on July 27, 2016, Premier Christy Clark established a Joint Task Force on Overdose Response led by Dr. Kendall and Clayton Pecknold, director of police services.
- 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.
- In March 2015, the BC Centre for Disease Control, Vancouver Coastal Health and the Vancouver Police Department led a campaign of public warnings about fentanyl, titled *Know Your Source? Be Drug Smart*. However, evidence suggests public awareness campaigns will have a limited effect;[3,4] many people who hear warnings about fentanyl may feel they don't apply to them, as they believe they are purchasing heroin or oxycodone. The province continues a social media and public awareness campaign on the dangers of illegal street drugs and how to recognize and respond to an overdose.
- In January 2017, the province identified the substance carfentanil (a synthetic opioid 100 times more potent than fentanyl and normally used as a sedative for large animals such as elephants) is circulating in street drugs.
- Take-home naloxone is expanding in BC, providing greater access to a medication that can reverse opioid overdoses (including fentanyl) and save lives. BC's Take Home Naloxone program provides

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[1] BC Coroners Service (2016) Fentanyl-Detected in Illicit Drug Overdose Deaths January 1, 2012 to October 31, 2016. Retrieved February 14, 2017: http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/fentanyl-detected-overdose.pdf

[2] BC Coroners Service (2016) Illicit Drug Overdose Deaths in BC January 1, 2007 to August 31, 2016. Retrieved October 6, 2016: http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/illicit-drug.pdf

[3] 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.

[4] 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.

overdose awareness and response training as well as naloxone kits. As of February 15, 2016, this program is currently available at 417 locations in BC; to date, 22,021 naloxone kits have been distributed; and over 3,765 overdose reversals have been reported to the program.[5]

- In BC, naloxone is available without a prescription and there are no restrictions on where it can be sold; its costs are not currently covered by PharmaCare. This is the latest development in a series of recent changes to the regulation of naloxone[6]:
  - March 24, 2016, Health Canada announced a change in naloxone's prescription-only status, making it available for people who are not themselves at risk of opioid overdose.
  - January 8, 2016, Minister Terry Lake signed a ministerial order expanding the types of first responders who can dispense and administer naloxone. These changes allow firefighters to administer naloxone once they have received training.
  - July 6, 2016, the federal Minister of Health signed an Interim Order authorizing the immediate importation of intranasal naloxone from the US.
  - September 2016, firefighters at 46 fire departments across BC are able to carry and administer naloxone and all ambulance crews in BC carry and administer naloxone.[7]
  - October 2016, the College of Pharmacists of BC and Ministry of Health descheduled naloxone, allowing for its distribution and sale in any location, not just pharmacies
  - October 7, 2016, an amendment to the *Health Protections Act* regulations is in progress that would allow any health professional to administer naloxone.
  - January 20, 2017, Minister Lake signed an interim ministerial order to ensure naloxone is available and may be administered in outpatient settings and publicly accessible areas within and adjacent to a hospital, in case of opioid overdose. Health Canada has since amended the Prescription Drug List to allow naloxone to be administered anywhere by anyone to reverse an opioid overdose.
- Rapid street drug testing, or "drug checking" (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 drug checking allows people to make more informed decisions about their drug use, and provides drug market surveillance and early warning opportunities for health authorities. A pilot test is being conducted at Insite to identify fentanyl in street drug samples using a dipstick.
- The Canada Border Services Agency has reported success intercepting fentanyl entering Canada, and the RCMP and some municipal police departments have reported multiple seizures of fentanyl and detection of other substances.
- Health Canada has restricted six chemicals used in the production of fentanyl to render the unauthorized importation and exportation of these chemicals illegal.
- The RCMP and Chinese Ministry of Public Security announced joint efforts to curb importation of fentanyl into Canada.
- Opioid substitution treatment, 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 opioid substitution treatment system are ongoing.[9]

FINANCIAL IMPLICATIONS

- The Ministry of Health provided $20,000 to College of Pharmacists of BC in 2015/16 to prepare educational materials and train BC pharmacists in how to dispense naloxone (which includes training of the customer about how to administer the injectable medication in an opioid overdose emergency).

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[5] Updated naloxone program information provided by BCCDC, January 2016 https://infograph.venngage.com/publish/2245254a-ccaa-461b-87ec-ec97a4840525

[6] For more information, see Naloxone fact sheet.

[7] BCCDC/Dr. Jane Buxton personal communication April 2016

[8] BC 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

[9] For more information, see Methadone and Other Opioid Substitution Treatment fact sheet.

FACT SHEET

- As of February 22, 2017, over $100 million dollars has been earmarked to respond to the public health emergency.

Approved by:
Arlene Paton, Population and Public Health Division; February 21, 2017
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; February 22, 2017

FACT SHEET

Joint Task Force on Overdose Response

ISSUE

The Joint Task Force on Overdose Response provides leadership and expert advice to the Province on emergency actions to prevent and respond to drug overdoses in BC while ensuring integration between Health and Public Safety system responses.

KEY FACTS

- In April 2016, the Provincial Health Officer declared a public health emergency under BC's *Public Health Act* due to an unprecedented increase in opioid overdose deaths.
- In 2016, 922 individuals died of an apparent illicit drug overdose in BC, an 80.8% increase over 2015 when 510 such deaths occurred.[1] Over the past 5 years, the percentage of drug overdose deaths in which fentanyl is detected has risen from 5% to 60%.[2]
- In July 2016, Premier Christy Clark announced the creation of the Joint Task Force on Overdose Response to lead BC's integrated response to the emergency across the public health and public safety sectors. The Joint Task Force is led by Provincial Health Officer Dr. Perry Kendall and Clayton Pecknold, Director of Police Services. Membership includes representatives from both public health and public safety sectors:

	Agency	Name	Title
Co-Chairs	Office of the Provincial Health Officer	**Perry Kendall**	Provincial Health Officer
	Ministry of Public Safety and Solicitor General	**Clayton Pecknold**	ADM and Director of Police Services
Members	Ministry of Health	**Arlene Paton**	ADM, Population and Public Health
	Vancouver Coastal Health	**Patty Daly**	VP, Public Health and Chief MHO Officer
	BC Coroners Service	**Lisa Lapointe**	Chief Coroner
	Vancouver Police Department	**Laurence Rankin**	Deputy Chief Constable
	RCMP (E Division)	**Brian Cantera**	Deputy Criminal Operations, Specialized Investigative & Operational Police Services

The Joint Task Force oversees 6 health- related task groups (i.e., treatment, surveillance, public engagement, naloxone, supervised consumption services and drug checking, and logistics and psychosocial supports) to support the provincial response. The priority areas are:

1. Immediate response to an overdose by expanding naloxone availability and the reach of supervised consumption services in the province.
   - Since 2012, the BCCDC has distributed 30,148 naloxone kits through the BC Take Home Naloxone program, and the kits have been used to reverse 5,483 overdoses.[3]
   - In December 2016, the Minister of Health signed a Ministerial Order under the *Emergency Health Services Act* and *Health Authorities Act* to activate overdose prevention services. Over 20 overdose prevention sites have opened across the province.
   - Health authorities continue to work toward submitting applications to Health Canada to expand the number of supervised consumption services in the province.
2. Preventing overdoses by improving treatment options for people with opioid dependence and exploring drug checking services and improving health professional education and guidance.
   - In January 2017, the Province committed $10 million to provide 60 residential treatment beds and 50 intensive outpatient treatment spaces over the next year. The new beds are in addition to government's commitment to open 500 new beds.

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[1] BC Coroners Service. (2017). Illicit Drug Overdose Deaths in BC: January 1, 2007 – January 31, 2017. Retrieved February 20, 2017, from: www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/illicit-drug.pdf.

[2] BC Coroners Service. (2016). Fentanyl-Detected Illicit Drug Overdose Deaths: January 1, 2012 to October 31, 2016. Retrieved February 20, 2017, from: www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/fentanyl-detected-overdose.pdf.

[3] BC Centre for Disease Control. (2017). Take Home Naloxone Program in BC. Retrieved February 20, 2017, from: https://infograph.venngage.com/publish/2245254a-ccaa-461b-87ec-ec97a4840525.

- On February 7, 2017, the Province announced $5 million for the BC Centre on Substance Use plus $1.9 million in ongoing funding. The Centre developed the Guideline for the Clinical Management of Opioid Use Disorder that takes effect June 5, 2017.[4]
- The BC Centre on Substance Use is reviewing evidence on street drug checking and will provide recommendations for how this type of service could be modeled in BC.

3. Public education and awareness about overdose prevention and response through public awareness campaigns.
   - Comprehensive resources continue to be made available for teachers, parents, friends, family, drug users, and anyone wanting more information on the public health emergency.
4. Monitoring, surveillance, and applied research by improving timely data collection, reporting, and analysis to inform action, evaluating implementation, and applied research.
   - Enhanced population health surveillance activities are providing detailed information about overdoses and risk factors to enable targeted interventions and evaluation.
   - Provincial Health Services has increased the capacity of provincial toxicology labs to test blood samples for opioids and other substances through the purchase of a mass spectrometer.
5. Improving the scheduling of substances and equipment under the *Controlled Drugs and Substances Act* and the Precursor Control Regulations by regulating drug manufacturing equipment such as pill presses, regulating precursors.
   - In December 2016, the federal government proposed amendments (Bill C-37) to provide additional tools to support health and law enforcement officials to reduce harms associated with problematic substance use in Canada. Among other things, Bill C-37: restricts possession, production sale, importation, or transportation of anything intending to be used to produce or traffic a controlled substance as well as creates a regulatory scheme for the importation of pill presses and encapsulaters; and creates new provisions which will permit the Minister of Health Canada to quickly schedule and control dangerous new substances on a temporary basis.
6. Improving federal enforcement and interdiction strategies by working with the Canada Border Services Agency to increase enforcement activities to interdict the importation of illicit drugs.
   - The Joint Task Force continues to work with police and law enforcement to support the expansion of interdiction efforts including the co-ordination of efforts to intercept, detect, and investigate illegally imported fentanyl and precursors.
7. Enhancing the capacity of police to support harm reduction efforts related to street drugs by providing training to support safe fentanyl identification and handling practices.
   - The Ministry of Public Safety and Solicitor General continues to work with the RCMP and municipal police departments to ensure that appropriate information is available to police services to formulate local operational policy and ensure that they have the supports to work with community partners to decrease opioid overdose deaths.
   - All police agencies in BC continue to train members to administer intranasal naloxone in cases of opioid overdose. The Ministry of Public Safety and Solicitor General has secured ongoing funding to support police departments contingent on members agreeing to administer naloxone to citizens who overdose.

FINANCIAL IMPLICATIONS

Over $100 million in provincial funding has been earmarked to respond to the public health emergency.[5]

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[4] BC Centre on Substance Use. (2017). A Guideline for the Clinical Management of Opioid Use Disorder. Retrieve February 20, 2017, from : www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/bc_oud_guidelines.pdf.

[5] https://news.gov.bc.ca/factsheets/factsheet-comprehensive-mental-health-and-substance-use-services-in-bc

FACT SHEET

Approved by:
Arlene Paton, Population and Public Health Division; February 24, 2017
Blair Boland, obo Manjit Sidhu, Finance and Corporate Services Division; February 28, 2017

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.

KEY FACTS

- 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.
- In June 2016, the College of Physicians and Surgeons of BC removed the requirement for physicians to have a special federal exemption in order to prescribe Suboxone (although an exemption is still required for methadone, as per the federal *Controlled Drugs and Substances Act*).
- In July 2016, the College of Physicians and Surgeons of BC released new clinical guidelines for physicians who want to prescribe methadone or buprenorphine for treatment of opioid use disorders.[1]
- 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™). Study findings (published on April 6, 2016[2]) indicate injectable hydromorphone is as safe and effective as injectable diacetylmorphine.
- Diacetylmorphine is not an approved product in Canada for treatment of opioid use disorders. Hydromorphone is an approved product in Canada, but it is only approved for use in pain management; however, hydromorphone could be used by prescribers "off label" for opioid substitution. The SALOME study findings support having both hydromorphone and diacetylmorphine available as options to treat opioid use disorder, recognizing both are likely to remain a limited option for patients who have not responded to other treatments.
- 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.
- In July 2015, the Office of the Provincial Health Officer released a report, *BC Opioid Substitution Treatment (OST) System Performance Measures 2013/14*.[3] Following a previous report from 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

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[1] https://www.cpsbc.ca/files/pdf/MBMT-Clinical-Practice-Guideline.pdf

[2] Oviedo-Joekes, E., Guh, D., Brissette, S., Marchand, K., MacDonald, S., Lock, K., ... & Marsh, D. C. (2016). Hydromorphone Compared With Diacetylmorphine for Long-term Opioid Dependence: A Randomized Clinical Trial. JAMA psychiatry.

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

[4] Ibid, p. 3.

[5] Ibid, p.5

and Surgeons of BC to explore ways to increase OST prescribing capacity, which has not kept up with the corresponding increase in the patient population.
    - The number of pharmacies dispensing methadone for maintenance purposes increased by 61% 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 HSPD.
- Ministry of Health is currently reviewing OST pharmacy practices and payment structures for methadone dispensing and other aspects of OST improvement to fully align 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 has changed its income assistance policies for supporting clients with substance use problems, such that it is no longer using funds from clients income assistance disbursements to pay OST clinic fees. The Ministry of Social Development and Social Innovation is working with Attorney General staff to respond to the legal action.

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, the Ministry contracted with the Centre for Addiction Research BC to work with OST patients to develop a handbook for new patients (contract amount = $24,000); the handbook is being finalized and will be released shortly.

Approved by:
Arlene Paton, Population and Public Health Division; November 7, 2016
Ted Boomer, Finance and Decision Support Branch; February 3, 2016

[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

Naloxone Regulatory Changes Summary

January 15 2016
- BC: Amendment to the Emergency Medical Assistants Regulation to enable first responders to dispense andadminister naloxone under the direction of a medical practitioner

March 22, 2016
- Federal: Health Canada changes prescription drug list allow naloxone to be available without a prescription if it is indicated for emergency use for opioid overdose outside hospital settings

March 23, 2016
- BC: Brought into force an amendment to the Drug Schedules Regulationto move naloxone from Schedule I (prescription only), to Schedule II(behind the counter) outside of hospital settings to align with changes by Health Canada.

July 5, 2016
- Federal: Minister Philpott signed special Interim Order on July 5, 2016, to allow for the importation of a version of intranasal naloxone from the United States while Health Canada was conducting the expedited review.

September 20, 2016
- BC: Brought into force an amendment to the Drug Schedules Regulation to unschedule naloxone for emergency use outside of hospital settings

October 3, 2016
- Federal: Health Canada authorizes the imporation of naloxone nasal spray (previously authorized under an Interim Order July 5th, 2016).

October 14, 2016
- BC: Brought into force an amendment to the Health Professions General Regulation to enable anyone to administer naloxone to someone appearing to be suffering from an opioid overdose.

December 9, 2016
- BC Ministerial Order creatingt overdose prevention services for the purpose of monitoring persons who are at risk of overdose, and providing rapid intervention as and when necessary, as ancillary health services, in any place there is a need for these services, as determined by the level of overdose related morbidity and mortality.

January 20, 2017
- BC: Ministerial Order clarifying that "hospital setting" does not include publically accessible areas within or adjacent to public hospitals, directing health authorities to ensure that naloxone is available and may be administered in outpatient settings and publicly accessible areas within and adjacent to a hospital.

January 26 2017
- BC Brought into force amendments to the Health Professions General Regulation and the Drug Schedule regulation qualifier that read “except when indicated for emergency use for opioid overdose”, removing the text “outside hospital settings”

February 2, 2017
- Federal: Health Canada amends prescription drug list qualifier to read "Except when indicated for emergency use for opioid overdose.," removing the text "outside hospital settings."

FACT SHEET

Supervised Consumption and Drug Checking Task Group

ISSUE

The Supervised Consumption and Drug Checking Task Group is responsible for providing the Health System Steering Committee on Overdose Prevention and Response with recommendations about coordinated approaches to delivering supervised consumption services and drug checking services.

KEY FACTS

- Expanding the reach of supervised consumption services is an important part of the government's response to the Opioid Overdose Public Health Emergency.
- Supervised consumption services are an evidence-based public health strategy to reduce the harms associated with non-medical injection drug use.
- Supervised consumption services can help reduce the transmission of blood borne illnesses, link marginalized individuals with complex chronic disorders to primary care, prevent serious infections, improve uptake of substance use treatment, and prevent overdose deaths.
- In response to the Public Health Emergency, all health authorities are developing applications to Health Canada seeking federal exemptions under Section 56 of the *Controlled Drugs and Substances Act* to operate supervised consumption services.

Supervised Consumption Services

- The BC Centre on Substance Use has developed draft operational guidelines for supervised consumption services based on available scientific evidence, policies, and procedures in place in BC.
- The Office of the Provincial Health Officer has developed a guidance document for community organizations and landlords about overdose prevention in supportive housing and homeless shelters.
- On December 31, 2016, Fraser Health submitted 2 applications to Health Canada for supervised consumption services in 2 locations in Surrey at the Quibble Creek Sobering and Assessment Centre (94A Avenue) and at a site near the Lookout shelter and clinic at 135A Street. Feasibility assessments are planned for 2017 for SCS in other Fraser Health municipalities.
- Interior Health has recently completed their consultation process with the communities of Kelowna and Kamloops and intends to finalize applications for mobile services in these communities shortly.
- On January 3, 2017, Island Health submitted an application for supervised consumption services in Victoria, at 941 Pandora Avenue. Island Health is considering additional applications for services in Victoria and Nanaimo.
- On October 31, 2016, Vancouver Coastal Health submitted applications to Health Canada for 2 supervised consumption sites in Vancouver at the new Downtown Eastside Mental Health and Substance Use Drop-In Centre - Powell Street Getaway (528 Powell Street) and the Heatley Integrated Health Centre (330 Heatley Street). Additional applications are in development and Insite's hours have been expanded to 24 hours during peak periods.

Drug Checking

- Drug checking services provide technology for people who use drugs to test the composition of their drugs and identify potential adultarants.
- A pilot study conducted at Insite found fentanyl in 84-85% of drugs voluntarily tested.[1]

[1] Vancouver Coastal Health. August 31, 2016. 86% of drugs checked at Insite contain fentanyl. [News Release]. Available at: http://www.vch.ca/about-us/news/news-releases/86-of-drugs-checked-at-insite-contain-fentanyl%20

- The BC Centre on Substance Use is currently completing an evidence review of drug checking technologies, applications and issues, and will develop recommendations for review.

Federal Engagement

- On December 12, 2016, the federal government introduced Bill 37, which if passed, will simplify the application process for supervised consumption services.

FINANCIAL IMPLICATIONS

- Health authorities provide for supervised consumption services as part of their operating budget. An additional $710,000 from Joint Task Force funding has been allocated for service location renovation and/or purchase of mobile service vehicles:
    - Vancouver Coastal Health - $142,000
    - Fraser Health - $142,000
    - Interior Health - $142,000
    - Northern Health - $142,000
    - Vancouver Island Health - $142,000
- $24,400 has been awarded in a contract to the BC Centre on Substance Use to complete an evidence review of drug checking technologies.

Approved by:
Arlene Paton, Population and Public Health Division; February 23, 2017
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; March 21, 2017

FACT SHEET

Acute and Terticary Care Mental Health and Substance Use Beds

ISSUE

A range of mental health and substance-use (MHSU) acute and tertiary care options are available for individuals with severe MHSU problems, in order to respond appropriately and in a timely fashion to an individual's service needs and intensity.

KEY FACTS

- A small proportion of people experience severe and complex mental health and/or substance-use problems, which require more intensive service approaches.
- Health authorities provide acute and tertiary level services for people with serious MHSU disorders. People experiencing acute or longer term serious mental illness and/or substance-use disorders require access to these services to stabilize and support longer-term recovery, if required.
- Patients with a mental health diagnosis have an average length of stay (ALOS) of 14 days for involuntary admissions, and 12 days for voluntary admissions[1] within acute MHSU beds. ALOS within Tertiary MHSU beds is considerably longer, and ranges from 3 - 24 months. As shown in Table 1, there are 744 acute care, and 1,249 tertiary mental health and substance-use beds in the province. Of the tertiary beds, 190 are forensic psychiatric beds.

Table 1: Mental health and substance-use acute and tertiary beds in BC, September 2016[2,3]

Health Authority	Acute MHSU Beds	Tertiary MHSU Beds
	2016	2016
IHA	99	158
FHA	206	267
VCHA	215	213
VIHA	159	178
NHA	65	69
PHSA		364
BC Total	**744**	**1,249**

- Of these 1,249 Tertiary MHSU beds, 826 are specialized Tertiary Care Mental Health beds developed as part of the Riverview Redevelopment.

Table 2: Riverview redevelopment beds by health authority[4]

Health Authority	Allocated Beds
Northern Health	65
Interior Health Authority	150
Vancouver Island Health Authority	129
Fraser Health Authority	267
Vancouver Coastal Health Authority (includes 25 provincial refractory beds)	215
Total	826

Acute Care Beds

- Health authorities provide acute care inpatient treatment to adults and youth experiencing mental illness, concurrent MHSU problems, and the acute stages of withdrawal from alcohol or other drugs.
- These specialized MHSU hospital inpatient beds are usually short-term in nature providing assessment, treatment and stabilization; most are located in facilities designated under the *Mental*

[1] *Hospitalization of Mental Health Patients in BC With Involuntary/Voluntary cases from 2006/07 - 2013/14*; Business Analytics Strategies and Operations Branch, Health Services Planning and Innovation Division, Ministry of Health. Project 2015_0043. Data extracted on January 13, 2015.
[2] MHSU Bed Survey, September 30, 2016, Project 2016_0202, HSIARD
[3] Ministry has only recently begun collecting acute and tertiary mental health and substance use bed data; therefore, there is no comparison across years.
[4] Correspondence from FCS - Regional Grants and Decision Support.

Health Act. MHSU acute beds include inpatient treatment (adult, youth, geriatric), designated observation units, psychiatric intensive care units, short-term assessment, early psychosis intervention, and acute behavioural stabilization units.

- There are no dedicated substance-use acute care beds[5]; however, individuals experiencing the acute symptoms of withdrawal from alcohol or other drugs are treated within acute care medical units.

Tertiary Care Beds

- Tertiary care beds meet the needs of individuals who require more intensive, long-term and/or specialized treatment, and have not been successfully treated in the primary and secondary mental health system. Services include: assessment, treatment including stabilization of acute symptoms not resolved in other settings; and rehabilitation focusing on psychosocial rehabilitation and recovery.
- MHSU tertiary beds include in-patient (acute, rehabilitative, geriatric), residential care, and eating disorder, neuropsychiatry, mood disorders, addictions/concurrent, refractory psychosis, child and youth, and forensic services.
- In November 2013, the Ministry announced the provincial action plan *Improving Health Services for Individuals with Severe Addiction and Mental Illness,*which included funding to expand the continuum of the Burnaby Centre for Mental Health and Addiction, a tertiary care MHSU facility. On December 19, 2014, to support this continuum, Vancouver Coastal Health transferred the operational governance of the Centre to the Provincial Health Services Authority (PHSA).
- To accommodate a more severe client population within the Centre, 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. An additional 20 acute stabilization beds were developed at the Centre and operational as of April, 2016.[6]
- Forensic psychiatric hospital beds are located at a secure, inpatient 190 bed facility that provides court-related forensic psychiatric assessment, treatment, and community case management to adults experiencing MHSU problems who are in conflict with the law. Specialized forensic mental health teams work to enable the re-integration of individuals back into the community.
- Initial provincial standards for mental health tertiary care facilities designated under the *Mental Health Act* have been drafted by the PHSA in partnership with regional health authorities and the Ministry, these standards are expected to be completed by June 2017.
- In February 2015, the Office of the Auditor General initiated a review of adult tertiary level services in BC. The final draft report "*Access to Adult Tertiary Mental Health and Substance Use Services*" was released in May, 2016, and contains 10 recommendations.[7]

FINANCIAL IMPLICATIONS

The MHSU sector operating expenditures for 2015/16 were approximately $1.45 billion. This equates to an increase of more than 71% over the 2000/01 total of $851.4 million.

Approved by:

Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; March 15, 2017
Heather Richards, obo Teri Collins, Health Sector Information, Analysis and Reporting Division; March 22, 2017
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; May 9, 2017

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[5] Mental Health and Substance Use (MHSU) Bed Survey. (September2016). Business Analytics Strategies and Operations Branch, Health Sector Information, Analysis and Reporting Division, Ministry of Health. Project:2016.0202.
[6] See Fact Sheet - Burnaby Centre for Mental Health and Addiction
[7] See Fact Sheet - OAG–Access to adult tertiary care mental health and substance use services.

FACT SHEET

Centre for Mental Health and Addictions Replacement Project

ISSUE

Update on the status of the Centre for Mental Health and Addictions (CMHA) Replacement Project.

KEY FACTS

Scope

- The CMHA Facility Replacement project is a new 105-bed, 20,800 square metre mental health building for the Severely Addicted and Mentally Ill (SAMI) patient population, to be constructed on the current location of Unit 8 on the Riverview Lands in Coquitlam.
- This new facility replaces the existing CMHA located on the Willingdon Lands in Burnaby, a site that was sold as part of the provincial government's Release of Assets for Economics Generation initiative.
- The new CMHA will increase bed capacity from 88 to 105 beds and be procured as a design-build project.[1]

Budget

- In October 2015, government approved the CMHA Replacement Project with a total capital budget of $100.86 million including a project reserve of $3.32 million.

Schedule

- On May 3, 2016, a Request for Qualifications was issued seeking qualified companies to design and build the CMHA.
- On October 3, 2016, Government announced the following 3 shortlisted proponents:
    - Graham Design Builders LP
    - PCL Constructors Westcoast Inc.
    - EllisDon Corporation-Parkin Architects Limited
- On October 6, 2016, a Request for Proposals was issued to the three shortlisted proponents.

Current Status

- The procurement process is underway with award of the design-build contract planned for April 2016.
- The construction schedule will be determined by the successful design-build proponent.
- Construction is estimated to start in 2017 and complete in 2019.

Background

- The CMHA provides assessment, diagnostic and medium-term treatment services to a wide range of clients who present with complex mental health and addiction issues. The continuum of services ranges from comprehensive, inter-disciplinary assessment of medical and psychiatric and substance use disorders, to medium term therapeutic and rehabilitation activities.
- To allow for planning and relocation of the CMHA from the Burnaby site, the Ministry of Technology, Innovation and Citizens' Services (MTICS), the landlord on behalf of the Provincial Health Services Authority (PHSA), entered into a 3-year lease expiring March 31, 2017, with an option to extend the lease for up to 2 years. This results in a lease expiry date of March 31, 2019, when the new owners have a right to evict MTICS/PHSA as their tenant, potentially resulting in the

[1] The 88 beds at the Burnaby CMHA was to include a new 14-bed high intensity treatment unit. PHSA has been unable to secure a building permit from the City of Burnaby for the needed renovations for these beds. As a short term alternative, 20 acute stabilization beds were operational on the Burnaby site on May 23, 2016. This brings the total number of beds in operation at the Burnaby site to 94. The high intensity beds will be incorporated into the replacement CMHA as planned.

displacement of the CMHA. PHSA has requested MTICS negotiate a further extension to the Willingdon lease for an expiry date of December 31, 2019.

- The BC Rental Housing Corporation is the owner of the site and BC Housing is leading the overall master planning for the redevelopment of the Riverview site. BC Housing is also the lead with respect to the First Nation consultation process for the Riverview lands.
- On December 17, 2015, the Province released "A vision for Renewing Riverview Lands" which lays out a master development plan for a comprehensive mixed-use community that will include a health care district as well as market and supportive housing.
- A Project Board was established to provide oversight on the CMHA project, and includes representation from BC Housing.

FINANCIAL IMPLICATIONS

The capital budget for the CMHA replacement project is $100.86 million and includes a project reserve of $3.32 million. The capital funding for this project will be provided entirely by the Province.

Approved by:
Joel Palmer, Capital Services Branch; February 14, 2017
Manjit Sidhu, Finance and Corporate Services Division; March 16, 2017

FACT SHEET

Child and Youth Mental Health and Substance Use System of Care

ISSUE

Children and youth (C&Y) with mental health and or substance use (MHSU) problems require access to a continuum of evidence-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 begin during childhood or adolescence[1]. Research indicates half of all cases of mental disorder start 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].
- In 2013, approximately 130,000 C&Y (aged 0-25) in BC used acute and emergency services, or saw a primary care physician for an MHSU issue[3]. Approximately 50% of the 130,000 C&Y identified are between the ages of 0-18[4], with the remaining between the ages of 19-25.
- In BC, ensuring the mental wellness of children and youth is a collective responsibility. In terms of service provision in the community and acute settings, the Ministry of Children and Family Development (MCFD) and the Ministry share responsibility. The Ministry of Education and school districts also play fundamental roles in mental wellness.
- MHSU services funded by the Ministry are provided through the Provincial Health Services Authority and regional health authorities , which may partner with external service providers. C&Y community mental health services are provided by the MCFD.
- MHSU services and supports in BC are provided along a continuum from health promotion and prevention through to early intervention and treatment, and are represented by a 5-tiered model.[5]
- Treatment is most commonly offered in outpatient settings. Outpatient treatment is traditionally recommended for youth with less severe MHSU problems. Evidence suggests that more severe cases can be treated in outpatient settings as well.
- Early Psychosis Intervention (EPI) programs are available in each health authority, and provide early detection of developing mental disorders, rapid assessment, and treatment for young people (usually ages 13-30) who have had their first episode of psychosis. EPI is oriented toward the early recognition of psychosis and the provision of timely comprehensive treatments that are stage and age-appropriate.
- Residential treatment is generally for youth with severe MHSU disorders where their MHSU and/or medical needs requires a structured environment to enable recovery.
- In total, there are 181 C&Y MHSU beds in BC. Of these, 78 are specialized acute (30) and specialized tertiary MHSU inpatient beds (48) for C&Y (generally ages 5-18) and 103 are community-based youth (generally ages 15-18) beds (14 eating disorders residential treatment, 20 substance use residential treatment, 26 supportive recovery, 4 substance use transitional services, 36 withdrawal management, and 3 supported housing)[6].
- There are a number of initiatives underway across BC to enhance the C&Y MHSU serving system: a new

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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.

[3] 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), Project 2015_0123.

[4] C&Y MHSU: 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, 2015 for the CYMHSU Collaborative, Project 2015_0123.

[5] See Mental Health and Substance Use Services Overview Fact Sheet

[6] MHSU Bed Survey, September 30, 2016, Project 2016_0202, HSIAR

10-bed inpatient unit at the HOpe Centre will open in 2017, and provide specialized, intensive services for youth aged 13-18 living with MHSU challenges; a 10-bed Child and Adolescent Psychiatric Stabilization Unit at Surrey Memorial Hospital will open in 2017 to provide short-stay assessment and crisis stabilization for urgent access to psychiatric care; and the reopening of the renamed Ashnola at The Crossing will offer a 22-bed program to provide intensive residential substance-use treatment for youth and young adults aged 17-24 (March 2017).

- Renfrew House, a 6-bed youth group home, that opened in 2014, offers housing, social supports and clinical care for youth, with $1.5 million in annual government support.
- The C&Y MHSU Collaborative has health-care providers and other community members working together as part of 64 local action teams in all health regions to improve care and increase access to services and supports for children, youth and families struggling with MHSU issues. As of March 31, 2016, the Ministry, in partnership with Doctors of BC, has invested about $10.2 million in the collaborative since 2013.
- In 2015, the Ministry and MCFD launched an online map to make it easier for children, youth and families to locate MHSU services and 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 protocol is now being implemented across the province. Currently, the Ministry and MCFD are working to develop another provincial protocol to promote effective transitions for children and youth between acute and community MHSU services.
- The Ministry is working in partnership with MCFD to implement tools, guidelines and education for front-line staff to identify parents with MHSU 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 2017-18.
- Foundry is launching 5 integrated youth centres (Kelowna, Campbell River, Prince George, North Shore Vancouver and Abbotsford) in addition to the existing Granville Youth Health Centre.

FINANCIAL IMPLICATIONS

- The Ministry provided $3 million to the InnerChange Foundation in March 2015, and $500,000 in base funding to each regional health authority to support 5 integrated youth centres. In February 2017, the Province announced $2.8 million per year to support up to 5 additional centres for total of up to 11 centres.
- Beginning in 2017/18, the Ministry will provide $750,000 annually, for the provision of a new online counselling resource, Youth Bounce Back, which will be based on the success of the adult-oriented program. This resource will serve an anticipated 3,000 youth per year with evidence-based, online therapy services for mental-health concerns, such as mild to moderate depression or anxiety.
- Beginning in 2017/18, the Ministry will provide $4.3 million, annually, to health authorities to establish up to 28 highly specialized treatment beds for youth who are struggling with severe substance use disorders.
- Beginning in 2017/18, MCFD will receive an additional $15 million, annually, to help bolster community-based C&Y mental-health teams and expand the resources, mental-health counselling and treatment options.

Approved by:

Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; March 15, 2017
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; March 21, 2017
Heather Richards, obo Teri Collins, Health Sector Information, Analysis & Reporting Division; March 27, 2017

FACT SHEET

Community Mental Health and Substance Use Beds

ISSUE

A range of mental health and substance use community residential treatment, residential care, and supported housing options are available for individuals with mental health and/or substance use problems in order to respond appropriately to an individual's service needs.

KEY FACTS

- A stable, supportive living environment is an important determinant of both physical and mental health and well-being. People who are struggling with substance use or their mental health require options to support their recovery and live effectively in their communities.
- Health authorities provide a wide range of community mental health and substance use programs for people with serious mental and or substance use disorders. These include short-term, intensive residential programs such as withdrawal management and substance use residential treatment programs, and longer-term housing such as community residential care, family care homes, and supported housing.
- Through a partnership with BC Housing and Health Authorities, the BC Housing Health Services Program provides increased access to safe and affordable housing directly managed or funded through BC Housing for individuals with mental health and/or substance use problems.
- As shown in Table 1, mental health beds have increased by 153 percent since 2001, and substance use beds have increased by 206 percent since 2003.

Table 1: Mental health and substance use community residential beds in BC by region, September 2016

Health Authority	Substance Use Beds		Mental Health Beds	
	2003[1]	2016[2]	2001[3]	2016[2]
IHA	121	151	548	1,111
FHA	286	380	1,498	3,355
VCHA	173	1,514	1,769	5,782
VIHA	113	495	930	1,671
NHA	181	97	195	441
PHSA		34		151
BC Total	**874**	2,671	**4,940**	12,511

[1] *Health authority survey;*
[2] *MHSU Bed Survey, September 30, 2016, Project 2016_0202, HSIARD*
[3] *Health authority survey (note: excludes data on Rental Subsidies, Community Crisis Stabilization Units and Emergency Shelter or Short Stay Crisis Residential Care beds)*

Mental Health Community-based Care

Health authorities provide community mental health care through 3 main programs: licensed community residential care facilities, family care homes, and community crisis stabilization beds. Community residential care facilities are licensed under the *Community Care and Assisted Living Act* for individuals who cannot live independently. These facilities range in size from 6 to 30 beds. Family care homes, while unlicensed, also provide care for individuals who cannot live independently and require supports in a family setting. Family care homes accommodate up to 2 residents, and have to meet requirements set out by each health authority. Community crisis stabilization beds are a community-based alternative to inpatient crisis stabilization for voluntary patients benefitting from a community and more home-like setting.

Substance Use Intervention and Treatment Beds

Health authorities are responsible for providing substance use services in a variety of community residential settings. Community substance use treatment and intervention services include:

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- **Sobering and assessment**: Short-term (less than 24 hours) safe place for people under the influence of substances. Monitoring of health is provided as it relates to acute intoxication.
- **Adult and youth withdrawal management**: A hospital, community residential (non-hospital), or a supportive residential setting, where Individuals going through the acute stages of withdrawal from substances are medically monitored or supervised.
- **Adult and youth transitional services**: A temporary residential, substance-free setting that provides a safe, supportive environment for individuals who are experiencing substance use problems, and requiring short- to medium- term supports.
- **Adult and youth residential treatment:** Time-limited, live-in intensive treatment for individuals who are experiencing substance use problems, and whose assessment indicates that they will be effectively served through intensive treatment. Settings are usually licensed under the *Community Care and Assisted Living Act*. Programs generally range from 30-90 days.
- **Adult and youth supportive recovery:** A temporary residential, substance-free setting that provides a safe, supportive environment for individuals who are experiencing substance use problems and require time-limited supports. These beds meet the needs of individuals who are preparing to enter residential treatment, or those who have left more intensive residential treatment but who require additional support to reintegrate into the community, or for those requiring a longer term structured environment while preparing to transition into a more stable lifestyle.[1]

Mental Health and Substance Use Supported Housing

Health authorities provide a significant number of mental health and substance use supported housing units for people with severe mental health and substance use disorders, however not all housing available to clients in BC are funded by health authorities. Supported housing services are delivered through an array of configurations that include 3 core components: Affordable and safe permanent housing, home support services, and mental health and substance use clinical case management services. Models include clustered supported housing, congregate care, wet housing for clients with severe substance use problems, and scattered supported housing such as the Supported Independent Living Program. Supported housing is not regulated by the Assisted Living Registrar.

Role of BC Housing

BC Housing is responsible for providing access to safe, affordable and appropriate mainstream housing for people in greatest financial need, including subsidized housing for individuals with mental health and substance use problems.

FINANCIAL IMPLICATIONS

The mental health and substance use sector operating expenditures for 2015/16 were approximately $1.45 billion. This equates to an increase of more than 71% over the 2000/01 total of $851.4 million.

Approved by:

Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; March 16, 2017
Christine Voggenreiter, obo Teri Collins, Health Sector Information, Analysis and Reporting Division; March 17, 2017
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; March 31, 2017

[1] See Government Commitment to 500 Additional Addiction Spaces fact sheet.

FACT SHEET

Mental Health and Substance Use Crisis Intervention Services

ISSUE

Police agencies throughout BC are reporting increases in the number of police calls due to mental health and/or substance use (MHSU) crisis (a MHSU crisis is defined as an acute disturbance of thinking, mood, behaviours or social relationships that requires an immediate intervention). Health authorities and police departments are increasingly developing protocols and guidelines to ensure a more integrated approach to MHSU crisis intervention.

KEY FACTS

Current Array of Health Authority Crisis Intervention Services

- **Crisis lines** are a telephone service provided by paid and volunteer staff, operating 24/7, offering emotional support, crisis and suicide assessment/intervention and resource information. Health authorities provide funding to support 10 regional crisis centres. In addition, the Provincial Health Services Authority (PHSA) provides funding support to the Crisis Line Association of BC in the operation of the 2 provincial network lines (1-800-SUICIDE and 310-Mental Health Support). The 10 regional crisis centres in the province collectively answer over 120,000 MHSU calls each year.
- **Mobile crisis outreach** consists of partnerships between health authority MHSU services and local police departments to provide outreach to individuals experiencing mental health crises. There are 5 joint MHSU-Police mobile crisis response teams based out of Kamloops, Prince George, Surrey, Vancouver, and Victoria (e.g., Integrated Mobile Crisis Response Team serves southern Vancouver Island).
- **Community Crisis Stabilization Units** are licensed facilities under the *Community Care and Assisted Living Act* and provide 24/7 assessment, treatment, stabilization, and referral for follow-up services, with a primary focus on psychiatric treatment. There are 62 community crisis stabilization beds in BC[1] (e.g. Surrey Community Residential Emergency Short Stay Treatment).
- **Crisis Residential Care Units** provide short-term crisis stabilization services for people with MHSU problems who are having acute psychosocial crises, such as eviction, job loss, or substance use overdose temporarily impacting their daily functioning. MHSU staff (available 24/7), assist clients in resolving their immediate crises. Currently there are 54 beds that provide this crisis stabilization.[2]
- **Sobering and Assessment Beds** provide short-term (< 24 hours) safe places for people under the influence of substances to receive observation, supervision and support while sobering up and linking to appropriate supports for housing and treatment services. There are 60 sobering and assessment beds in the province (25-Quibble Creek, Surrey, 20-Victoria, and 15-Vancouver Detox Centre).[2]
- **MHSU services in hospital emergency departments** provide specialized assessment, treatment, crisis intervention and linkage to community resources to emergency department patients. Care is provided by MHSU staff such as psychiatric nurses and social workers (e.g., about 7,500 patients a year are assessed and treated at the emergency department[2] in Surrey).
- **Acute Care Short-Term Assessment Units** within a hospital (up to 48 hours) provide specialized assessment and crisis intervention for people who require a brief inpatient stay in order to stabilize (e.g., psychiatric emergency services at Archie Courtnall Centre in Victoria includes 4 brief-stay inpatient rooms).[2]
- **Designated Observation Units** in rural hospitals designated under the *Mental Health Act* to stabilize and treat involuntary patients for up to a maximum of 7 days. If more time is needed, patients may

[1] MHSU Bed Survey. (March 2016). March 2016 submissions to Community MHSU Bed Inventory, Business Analytics Strategies and Operations Branch, Health Sector Information, Analysis and Reporting Division, Ministry of Health. Project: 2016_0202

[2] Retrieved from: http://www.fraserhealth.ca/about-us/media-centre/news-releases/news-releases-archive/-0/surrey-memorial-hospital-s-new-mental-health-and-substance-use-emergency-zone April 27 2015

be transported to the nearest designated mental health facility for completion of treatment (e.g., Fort Nelson General Hospital and Wrinch Memorial Hospital in Hazelton).

- **Discharge planning from hospital-based services** is completed in all hospitals with clients and their families to assist them in avoiding and/or handling future crisis situations. Fraser Health offers classes run by trained peer facilitators who assist people to create their own recovery and crisis plans.

Provincial Ministry Initiatives to Enhance Current Continuum

- Enhanced crisis response services as part of the provincial action plan "Improving Health Services for Individuals with Severe Addiction and Mental Illness", such as:
  - An Acute Behavioural Stabilization unit at St. Paul's Hospital with 5 beds and 4 secure rooms.[2]
  - An Assertive Outreach Team, in partnership with the Vancouver Police Department, offers outreach for patients with the most severe and complex needs from St. Paul's and Vancouver General Hospitals' emergency departments.
  - Psychiatric Nurse Liaison Programs, established in Northern Health and Fraser Health emergency departments,[3] provide assessments, interventions, and linkage with community resources.
- The development of new guidelines to improve the interfaces between MHSU and police services. The Ministry of Health, in partnership with the Ministry of Justice, is developing a provincial toolkit to guide health authorities and police agencies in the development of joint protocols/agreements at various interface points, such as situations where an individual has wandered from a health care facility, or when a family calls police due to concerns about a potentially suicidal individual. Joint MHSU-police response teams and information sharing are overarching interface points. The establishment of local protocols between health and police agencies is expected to strengthen the use of effective, efficient and integrated responses to support people with MHSU problems who come into contact with police. Target completion of guidelines - June 2017.
- Enhanced crisis lines in BC - The Ministry has established a provincial advisory committee consisting of the PHSA , regional health authorities, the Ministry of Children and Family Development, Crisis Line Association of BC and regional crisis centres to follow through on actions identified in *An Implementation Plan for the Establishment of an Enhanced and Efficient Provincial Network*. Progress includes the development of a unified call record for use in all of the regional crisis centres, and creation of common training modules and standards for crisis line workers.

FINANCIAL IMPLICATIONS

- In a report developed by PHSA[4] operating budgets for the province's 12 MHSU crisis lines that are partially or fully funded by health authorities totaled approximately $3.4 million in 2014/15. According to the report, health authority funding accounted for almost $2.1 million, or 61% of the revenue necessary to support these Crisis Lines. The remaining 39% was provided through donations and other fund raising initiatives.
- In addition, PHSA provided $180,000 to the Crisis Line Association of BC in 2014/15 and 2015/16 to support 1800SUICIDE and 310MENTAL Health Support networks, which use routing technology to direct calls to the nearest crisis line network partner.

Approved by:
Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; February 28, 2017
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; March 9, 2017

[3] Retrieved from: http://www.fraserhealth.ca/about-us/media-centre/news-releases/news-releases-archive/-0/surrey-memorial-hospital-s-new-mental-health-and-substance-use-emergency-zone April 27 2015
[4] "PHSA Inventory of Health Authority Funded Crisis and Information and Support Lines Report" provided to the Ministry of Health (not public document)

FACT SHEET

Mental Health and Substance Use Expenditures

ISSUE

BC has made mental health and substance use services a priority, as evidenced by a commitment to best practices, a significant increase in total financial expenditures for the mental health sector and the provision of protected capital funding for the redevelopment of the province's tertiary mental health resources.

KEY FACTS

- In November 2010, the Province released a 10-year plan to address mental health and substance use with a focus on prevention of problems, early intervention, treatment and sustainability. To ensure mental health and substance use services are evidence-based and cost-effective, BC is focusing on delivering programs more efficiently and effectively.
- Mental health and substance use services are delivered by the health authorities. The integration of the continuum of community and hospital mental health services at the health authority level reflects best practice recommendations, and the alignment of substance use services with mental health services offers new opportunities for improving service access and responsiveness.
- Expenditures related to the Mental Health and Substance Use service sector occur across the health care systems' continuum of care, including:
    - acute care services;
    - the continuum of community-based mental health and substance use services;
    - specialized services managed by the Provincial Health Services Authority (Riverview Hospital[1] and Forensic Psychiatric Hospital and community clinics);
    - PharmaCare;
    - physician services (general practitioners and psychiatrists, salaried and sessional); and
    - work being undertaken with the Centre for Addictions Research of BC to develop evidence-based information to support health authorities in the ongoing implementation of mental health and substance use reform.

FINANCIAL IMPLICATIONS

- The mental health and substance use sector operating expenditures for 2015/16 were approximately $1.45 billion[2]. This equates to an increase of more than 71% over the 2000/01 total of $851.4 million.
- In addition, capital funding is provided to support provincial tertiary redevelopment, as well as other mental health projects.

[1] Riverview Hospital ceased operations in July 2012.
[2] Includes estimated expenditures incurred by the Ministry of Health / Health Authorities only (i.e. excludes MHSU expenditures incurred by the Ministry of Children and Family Development).

FACT SHEET

Mental Health and Substance Use Operating Expenditures

	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	Increase since 2000/01
Operating Expenditures (in $ millions)	851.4	903.2	982.1	996.5	997.2	1,058.5	1,099.7	1,151.4	1,215.9	1,244.6	1,302.7	1,349.8	1,351.9	1,366.8	1,421.3	1,458.8	*607.4*
Year to Year Increase (%)		6.1%	8.7%	1.5%	0.3%	5.9%	3.9%	4.7%	5.6%	2.4%	4.7%	3.6%	0.2%	1.1%	4.0%	2.6%	71.3%

Mental Health and Substance Use Capital Expenditures

	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	Capital Expenditures since 2000/01
Capital Expenditures (in $ millions)	3.2	6.6	4.7	5.1	10.7	16.7	13.8	6.4	12.2	9.9	9.9	39.5	33.7	11.1	25.4	21.2	*230.1*

Approved by:

Gordon Cross, Regional Grants and Decision Support Branch; October 18, 2016

Manjit Sidhu, Finance and Corporate Services Division; October 31, 2016

FACT SHEET

Mental Health and Substance Use Services Overview

ISSUE

Overview of provincial and regional mental health and substance use (MHSU) services in BC.

KEY FACTS

- The Ministry of Health is responsible for community, acute and tertiary child, youth and adult MHSU services, as well as Ministry programs (i.e. MSP, PharmaCare), and services provided by physicians (general practitioners and psychiatrists).
- Services funded by the Ministry are provided generally through provincial and regional health authorities, and contracted service providers. Child and youth community mental health services are provided by the Ministry of Children and Family Development.
- The MHSU system is comprised of a broad range of service providers including psychiatrists, family physicians and nurse practitioners, registered nurses, social workers, psychologists, MHSU clinicians, support workers, and a range of allied health professionals.
- An estimated 12.6%[1] of children and youth in BC at any given time, and approximately 19.6% to 26.2%[2] of BC adults annually will experience a MHSU disorder.
- Available Ministry utilization data[3] indicates that there are approximately 814,000 individuals (children, youth and adults) in BC that have accessed MHSU services from a physician or hospital (including emergency departments) in 2013/14. Approximately 8% were ages 0-18; 22% were ages 19 – 35; 51% were ages 36 – 65; and 19% were 66 years and older.
- In 2015, the Ministry released *Primary and Community Care in BC: A Strategic Policy Framework* identifying individuals with mental health and/or substance use problems as a priority population.
- A core component of the Ministry's strategic agenda is to improve integration of MHSU services, particularly with primary care, through the use of interdisciplinary teams. Work is ongoing to develop an integrated system of community-based MHSU 'specialized community services programs' across all Health Geographic Service Areas.
- MHSU services and supports in BC are provided along a continuum from health promotion and prevention through to early intervention and treatment, and are represented by a 5-tiered model (see figure 1). The tiers represent levels of service need according to the acuity, chronicity and complexity of an individual with mental health and/or substance use problems.

Tier 1 "Mental Health & Wellness Promotion/Problematic Substance Use Prevention" services are designed to build the capacities of all British Columbians, individuals and families, to improve their ability to cope with adversity and to create supportive community environments. Programs and services include health promotion, health literacy activities and resources that aim to help achieve and maintain positive mental wellbeing, healthy lifestyles, and effective approaches to stress management, supportive social networks, and stigma reduction. For example mincheck.ca and heretohelp.ca provide navigational and informational resources.

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[1] Waddell et al. (2014). *Child and Youth Mental Disorders: Prevalence and Evidence-Based Interventions*. A Research Report for the BC Ministry of Children and Family Development. Children's Health Policy Centre, Simon Fraser University.

[2] Bijl, R. V., de Graaf, R., Hiripi, E., Kessler, R. C., Kohn, R., Offord, D. R., & Wittchen, H. U. (2003). The prevalence of treated and untreated mental disorders in five countries. *Health Affairs*, *22*(3), 122-133.;Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005b). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*(6), 617-627.;Slade, T., Johnston, A., Oakley Browne, M. A., Andrews,
G., & Whiteford, H. (2009). 2007 National Survey of Mental Health and Wellbeing: methods and key findings. *Australasian Psychiatry, 43*(7), 594-605.

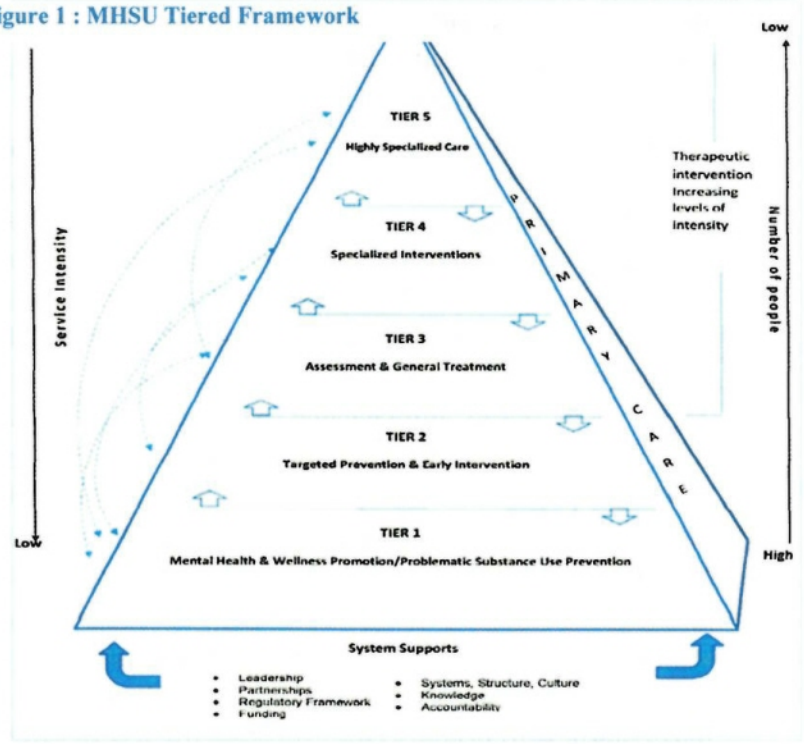
[3] Mental Health and Substance Use – Updated Patient Population Cohort (January 7, 2016). Prepared by: Business Analytics Strategies and Operations Branch, Health Sector Information Analysis and Reporting Division

FACT SHEET

Tier 2 "Targeted Prevention & Early Intervention are activities focused on vulnerable populations at risk of developing MHSU problems, with the goal of identifying issues and providing links to appropriate support at an early stage. Current examples include targeted prevention and risk/harm reduction strategies, such as the Early Psychosis Intervention program and the Healthy Minds/Healthy Campuses initiative.

Tier 3 "Assessment & General Treatment" is focused on individuals with identified MHSU use problems, but who may not necessarily require intensive services. This tier may serve as a linkage to higher tier services. Activities include comprehensive assessment and diagnosis, risk/crisis management, and care planning. Other Tier 3 services include integrated primary and community MHSU care teams, and a range of community-based services, such as supportive counselling, sobering services, withdrawal management and MHSU outreach services.

Figure 1 : MHSU Tiered Framework



Tier 4 "Specialized Interventions" are targeted to individuals who require treatment or specialized approaches for diagnosed disorders and substance dependence, delivered by regulated professionals with appropriate training. Activities include but are not limited to acute inpatient services, intensive outreach, medically managed withdrawal management, and crisis intervention/emergency response. Specific program examples include intensive case management teams; day treatment; supportive recovery services; residential SU treatment; psychosocial rehabilitation services; mobile crisis response units, and crisis stabilization beds.

Tier 5 "Highly Specialized Care" is designed for individuals who are experiencing highly acute, chronic and/or complex mental illness and/or substance dependence. Examples include tertiary care assessment and rehabilitation, Assertive Community Treatment, and forensic psychiatric services (in-patient and outpatient clinics).

FINANCIAL IMPLICATIONS

The MHSU sector operating expenditures for 2015/16 were approximately $1.45 billion. This equates to an increase of more than 71% over the 2000/01 total of $851.4 million.

Approved by:
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; November 15, 2016
Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; February 28, 2017

FACT SHEET

Mental Health Act Overview

ISSUE

At times, the level of severity of a person's mental illness may require inpatient psychiatric care on an involuntary basis. The *Mental Health Act*[1] outlines the legislative requirements for involuntary care and those facilities in BC that have been designated to provide this level of care. The main purpose of the Act is to provide authority, criteria and procedures for involuntary admission and treatment, while safeguarding individual rights.

KEY FACTS

- The Act, updated in 2005, sets out the authority, criteria and procedures for involuntary admission and treatment of people with mental disorders in designated mental health facilities. The Act also contains protections to ensure these provisions are applied in an appropriate and lawful manner.
- Facilities designated under the Act, as of March 4, 2015, include: 24 Provincial mental health facilities providing specialized inpatient treatment, tertiary care, and/or treat subpopulations; 38 Psychiatric Units in health authorities providing inpatient treatment; and 9 Observation Units are short-stay, stabilization and/or transfer, in rural hospitals.[2]
- In 2014/15, a total of 25,187 individuals admitted to BC hospitals received health care for mental illness and substance use problems, an increase of 32% since 2006/07. Of these individuals, a total of 11,546 (46%) received voluntary mental health treatment, while 13,641 (54%) received involuntary mental health treatment. The number of individuals receiving voluntary treatment increased by 8%, while those receiving involuntary treatment increased by 62% over the 8-year period from 2006/07 to 2014/15[3].
- The involuntary treatment rate per 100,000 BC residents grew from 192 to 291 from 2006/07 to 2014/15 (52%).[4] These increases may be impacted by increased patient complexity including those with concurrent disorder and severe substance use problems, the aging population of those with mental illness, as well as initiatives to help reduce stigma, resulting in proper identification of individuals requiring treatment.
- During this time period, average length of stay has decreased slightly for involuntary patients from 17 to 14 days, while increasing for voluntary patients from 10 to 12 days.[5]
- In 2014/15, 2,174 people discharged from hospital were on Extended Leave provisions under the Act. This number has increased by 1,330 (150%) since 2008/09.[6] Clients on Extended Leave over 12 months are informed of their right to a review at least once a year.
- A person can only be involuntarily admitted under the Act if all 4 admission criteria are met: 1) is suffering from a mental disorder that seriously impairs the person's ability to react appropriately to his or her environment, or to associate with others; 2) requires psychiatric treatment in or through a designated facility; 3) requires care, supervision and control in or through a designated facility to prevent the person's substantial mental or physical deterioration, or for the person's own protection or the protection of others; and 4) Is not suitable as a voluntary patient.
- The completed medical certificate provides authority for anyone, including ambulance personnel, police or, if the physician believes it is safe, relatives or others, to take the person to a designated mental health facility.

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[1] Mental Health Act [RSBC 1996] Chapter 288, current to June 12, 2013. Electronically accessed June 24, 2013. http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96288_01

[2] http://www.health.gov.bc.ca/healthy-minds/pdf/designations-list.pdf

[3] Hospital Discharges w MH Dignosis Treated Involuntarily 2006-2014-with Age Category-by case count; BASO Project2016-0164; Extracted Jan 2016

[4] ibid.

[5] Ibid.

[6] Hospital Discharges with MH Diagnosis Treated Involuntarily 2002-2014-with Age Category-by case count; Extended Leave Table 1 PID; PAS2016-0164; Extracted January 2016.

- To provide legal authority for an involuntary admission for an initial 48-hour period, a medical certificate must be completed by a physician. A second medical certificate by a different physician must be completed within 48 hours of admission; otherwise the patient must be discharged or admitted as a voluntary patient. Subsequent medical certificates must be renewed by the end of the first, second and fifth month of admission; and then at subsequent 6 month intervals.
- Section 37 of the Act permits the director of the designated mental health facility to place an involuntary patient on Extended Leave from the facility. Leave means that a patient is authorized to be absent from the facility to live in the community providing appropriate support services exist to meet the conditions of Extended Leave. Patients on Extended Leave often have histories of frequent relapses as a result of repeated non-compliance with medical treatment and other care arrangements, and are required to follow conditions of leave as outlined in a comprehensive plan.
- The Act also contains protections to ensure that the provisions are applied in an appropriate and lawful manner. For example, hospital staff must inform involuntary patients verbally, and provide written notification of their rights promptly upon admission, including the right to have their involuntary admission reviewed by a Review Panel and the right to retain legal counsel.
- The Mental Health Review Board is an independent, quasi-judicial administrative tribunal, established in April 2005, which conducts review panel hearings under the Act upon request by the client. It is made up of a chair and members appointed by the Minister under the Act. The Board conducts hearings to review and decide whether persons detained in or through any designated mental health facility in the province should continue to be detained, based on criteria in the Act (for further information, see the Fact Sheet entitled *Mental Health Review Board*).
- The Ministry developed a Guide to the Act which answers common questions about the Act and is available on the website at: www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf.
- In 2011, the Ministry and health authorities conducted the first BC Mental Health and Substance Use Survey of individuals who experienced a short-stay inpatient service. Feedback was provided by 6,615 people (65% response rate) who were recently discharged from one of 102 short-term mental health or substance use treatment facilities in BC.[7] While there are some areas for improvement, 87% of mental health patients and 95% of substance use clients rated the overall quality of their care as good, very good, or excellent.[8]
- In September 2016, 2 individuals launched a Charter Challenge in the BC Surpreme Court to challenge the criteria of the Act to allow involuntary psychiatric treatment without patient consent. The notice of the civil claim suggests that forced psychiatric treatment violates a person's human rights. Community Legal Assistance Society is representing the plaintiffs. The Ministry of Attorney and justice, in partnership with the Ministry of Health, will be defending the legal challenge and is presently drafting a response to the Notice of Civil Claim. It is expected that it will take about 2 years (2018) until the Supreme Court will hear the case.

FINANCIAL IMPLICATIONS

There will be legal costs associated with the Charter Challenge

Approved by:

Sharon Stewart, oboDoug Hughes, Health Services Policy Division; November 15, 2016
Teri Collins, Health Sector Information, Analysis & Reporting Division; November 2016

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[7] R.A. Malatest & Associates Ltd. *Patient Experiences with Short-Stay Mental Health and Substance Use Services in BC: 2010 -2011*. p. 6. November 1, 2011. Retrieved electronically June 24, 2013, from: http://www.health.gov.bc.ca/library/publications/year/2011/BCMHSU-DescriptiveReport-2011.pdf
[8] Ibid. p. 7

FACT SHEET

Severe Addictions and Mental Illness (SAMI) Action Plan

ISSUE

Individuals with severe addiction and mental illness (SAMI) have unmet service needs that are resulting in risk to clients and providers, high use of police, corrections and emergency services, high rates of homelessness, and concerns for public safety. In response, the Government developed an Action Plan with immediate and longer-term actions to improve outcomes for this client population.

KEY FACTS

Provincial Action Plan

- The November 2013 report and provincial Action Plan: "Improving Health Services for Individuals with Severe Addiction and Mental Illness" was developed to reduce barriers and service gaps, and support evidence-based solutions for this high-needs client population.
- The plan is designed to meet the needs of a specific subset of people with the most complex form of SAMI who present a greater risk to themselves and/or others, and cannot be successfully supported by mainstream mental health and substance use services.
- It was developed in response to concerns and recommendations outlined by the Vancouver Police Department (VPD) in their September 2013 report *Vancouver's Mental Health Crisis: An Update Report*, which were also supported by the City of Vancouver and Vancouver Coastal Health.[1]
- In December 2013, the Ministry of Health developed a 120 day Action Plan in consultation with health authorities, with a commitment to complete most actions within 120 days.[2]
- Key immediate accomplishments within the 120 days included the development of:
    - A first in BC Assertive Outreach Team that, in partnership with the VPD, supports high needs patients from St. Paul's and Vancouver General Hospitals emergency departments.
    - A new 9-bed[3] Acute Behavioural Stabilization Unit at St. Paul's Hospital.
    - 2 new (ACT) Teams.
    - The expansion of the Inner City Youth teams program, doubling its capacity.

Current Status

- 3 key actions were completed in 2014/15 related to new beds:
    1. Opening of 14[4] new adult rehabilitation and recovery beds (Riverview - Brookside/Hillside);
    2. Opening of 6 new youth group home beds (Renfrew House); and
    3. Launch of concurrent evaluations of these new beds (included in the Coast Mental Health contracts).
- The development of 14 new secure high intensity beds at the Burnaby Centre, originally planned for 2015, has been delayed. The Provincial Health Services Authority (PHSA) has been unable to secure a building permit from the City of Burnaby for the needed renovations. As a short term alternative, an additional 20 Acute Stabilization Unit beds have been developed and were fully operational on the Burnaby site in April 2016. The original high intensity beds will be incorporated into the new provincial facility to be built on the Riverview lands by 2019.[5]

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[1] VPD. (2013). *Vancouver's Mental Health Crisis: An Update Report*,.p.2. Retrieved on January 27, 2014 from http://vancouver.ca/police/assets/pdf/reports-policies/mental-health-crisis.pdf

[2] Ministry of Health. (2013). *Improving Health Services for Individuals with Severe Addiction and Mental Illness.* Retrieved on January 27, 2014 from http://www.health.gov.bc.ca/library/publications/year/2013/improving-severe-addiction-and-mental-illness-services.pdf

[3] This unit includes five in-patient beds plus four secure rooms.

[4] Note Brookside / Hillside is a 40 bed facility; 14 of the beds are new via the SAMI Action Plan while 28 are relocated beds from the BCMHA to accommodate a more complex client population / new 14 bed secure unit (since changed to 20 Acute Stabilization Unit beds).

[5] See Burnaby Fact Sheet for further details.

- A key deliverable for 2014/15 was the strengthening of services for this client population by each regional health authority:
  - **Fraser Health Authority:** 2 new ACT teams, serving approximately 170 new clients, are in full operation serving the Surrey/North Delta and and Abbotsford/Mission area since June 2015.
  - **Vancouver Coastal Health Authority:** 2 new ACT teams within Vancouver serving approximately 170 new clients (approved in 2013). A new Intensive Case Management Team for youth opened in February 2015, serving about 100 clients annually.
  - **Interior Health Authority:** 2 new ACT teams serving Kamloops and Kelowna have been implemented as of April 2015. These teams serve about 170 individuals annually. The capital improvements of a secure room in the Williams Lake Hospital (Cariboo Memorial Hospital) was completed in the summer of 2016. The secure room, supported by a Crisis Response Team, meets Ministry standards and has been designated as a Designated Observation Unit under the *Mental Health Act* as of January 2017.
  - **Vancouver Island Health Authority:** A new 14 bed transitional Regional Tertiary Care Facility opened in March 2015. In 2015, 3 Intensive Case Management Teams were implemented in Mount Waddington, Victoria (March) and Courtenay/Comox (April), serving approximately 150-195 individuals annually.
  - **Northern Health Authority:** In the Spring of 2015, 3 Intensive Case Management Teams were developed in the Northern Interior, North East and the North West Service Delivery Areas, and a Psychiatric Liaison Nurse rotation based in the Acute Care Emergency Departments in Prince George, Fort St. John and Prince Rupert.
- The Ministry continues to regularly monitor the outcomes of the SAMI Action Plan, meeting with key partners to discuss progress, identify risks and develop mitigation plans as needed.

SAMI Services in Richmond

In 2014/15, concerns were raised in Richmond about the lack of available targeted services for those with severe addiction and or mental illness. In response, the Vancouver Coastal Health Authority (VCHA) has allocated 15 spaces in existing ACT teams for Richmond clients. It is also conducted an Options Analysis to determine the best outreach model for addressing gaps in Richmond's mental health and substance use continuum and the development of an ACT team for Richmond is under consideration.

FINANCIAL IMPLICATIONS

Beginning in 2014/15, the Ministry provided additional annual funding of $20.25 million to better meet the needs and strengthen services for this SAMI population. Funding was allocated as follows:

- $2.0 million to VCHA to support the 9 Bed Acute Behavioural 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;
- $10 million in matching funds to assist the 5 regional health authorities to strengthen services;
- $5 million to support group homes (PHSA – $3.5 million and VCHA - $1.5 million);
- $2.5 million to PHSA to operate the new 14 high intensity beds (since changed to 20 Acute Stabilization Unit Beds as previously stated); and
- $0.75 million for Providence Health Care to operate a youth program connected to St. Paul's.

Approved by:

Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; March 16, 2017
Heather Richards, obo Teri Collins, Health Sector Information, & Analysis Reporting Division; March 21, 2017
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; March 31, 2017

FACT SHEET

Youth and Young Adults with Mental Health and/or Substance Use Issues

ISSUE

Youth and young adults with mental health and or substance use issues have been identified as a priority population for enhanced policy and programming. The Ministry of Health is responding to the needs of this population by working collaboratively with key partner ministries and organizations.

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]
- Despite needing mental health and substance use (MHSU) supports, youth and young adults (YYAs) tend to access help through primary care, or other social supports such as education, housing, and vocational services.[3] This is largely due to stigma, and because MHSU services often do not respond to the distinct needs YYAs.[4]
- Recent reports highlight the system challenges facing YYAs struggling with MHSU issues in BC. The Representative for Children and Youth's April 2013 report, *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.*[5], and the November 2014 Select Standing Committee on Children and Youth *Interim Report: Youth Mental Health in British Columbia*[6], identify the difficulty YYAs face when navigating services across both the child and youth, and adult systems.
- In 2013/14, approximately 130, 000 children and youth aged 0 – 25 accessed hospital and physician services for MHSU in BC.[7] Recent analysis indicates 19 – 25 year olds make up approximately half of these help-seeking individuals aged 0 – 25.[7]
- According to an internal review of child and youth acute care services, between 2009 and 2013 BC saw an increase of 43% in the number of MHSU hospital visits by children and YYAs aged 0-24. Hospital visits by individuals with anxiety and depression concerns was highest in 15-19 year olds, with visits for substance use concerns becoming more frequent in older age groups.[8]
- The Ministry, along with cross-ministry and community partners, and regional and provincial health authorities, has embarked on a number of initiatives to improve services for YYAs.
- The Ministry and the Ministry of Children and Family Development recently developed a Youth Mental Health Transition Protocol. The protocol aims to ensure all youth who require mental health and/or substance use services beyond 19 years of age are effectively transitioned from child and youth mental health services to appropriate adult services using the principle of "best-fit", rather than chronological age.The protocol is currently being implemented across all regions.
- In June 2013, the Ministry and the Doctors of BC, through the BC Shared Care committee, funded the development of a Child and Youth MHSU Collaborative. The Collaborative brings together youth with lived experience and their families, care providers and decision makers to address

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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.

[3] Mental Health Commission of Canada (2015) *Taking the Next Step Forward: building a responsive mental health and addictions system for emerging adults*

[4] Dooley & Fitzgerald, 2013; Casanueva et al, 2011; Manion, Davidson, Clark, Norris & Brandon, 1997.

[5] Still Waiting: First-hand experiences with youth mental health services in BC. April 2013. BC Representative for Children and Youth.

[6] Select Standing Committee on Children and Youth released their *Final Report: Youth Mental Health in British Columbia*

[7] Carolyn Bell, Planning and Innovation Division, Ministry of Health to the CYMHSU Collaborative Learning Session 5, April 8,9 2015.

[8] 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*

important local issues, while contributing to the larger regional and provincial picture. In 2015 the Collaborative created a YYA Working Group to identify and address specific areas of concern.

- In 2015, the Ministry released *Primary and Community Care in BC: A Strategic Policy Framework* to steward discussion and movement towards integrated primary care efforts.
- In June 2015, the BC Integrated Youth Services Initiative was established to improve mental health, substance use, and primary care access and care for YYAs in communities across BC. The initiative hopes to ease transition points for youth and their families, and improve mental health and wellness by combining integrated services with youth-friendly regional store-fronts, and using e-services such as a web-based virtual clinic and a phone help line.
- Jointly, the Ministry and the Graham Boeckh, St Paul's Hospital, and InnerChange Foundations provided funding for a prototype phase of the BC Integrated Youth Services Initiative, currently underway to implement 5 pilot integrated youth MHSU service hubs in communities across BC.
- Improving services for YYAs has also become a priority across Canada. In September 2015, the Mental Health Commission of Canada released *Taking the Next Step Forward Building a Responsive Mental Health and Addictions System for Emerging Adults*, outlining a number of recommended principles to improve services for YYAs.
- In 2015, at the direction of Canadian Health Ministers, a Provincial Territorial (P/T) Working Group on MHSU was established. Chaired by BC and comprised of experts from every P/T, the working group developed *Towards Integrated Primary and Community Mental Health and Substance Use Care for Youth and Young Adults: A Compendium of Current Canadian Initiatives and Emerging Best Practices*, to help identify innovative practices and new ways of working in the provision of services to YYAs. s.13

s.13

- In the fall of 2013, the Select Standing Committee on Children and Youth agreed to undertake an initiative to examine child and youth mental health in BC. The Committee released its final report in January 2016, and identified 23 recommendations to improve child and youth mental health services. Recommendations include making multi-year funding available for integrated service delivery programs, focus on "hub" site approaches, and develop a specific plan for transition-aged youth and young adults.

FINANCIAL IMPLICATIONS

- In 2014/15, the Ministry provided $3 million to the InnerChange Foundation to develop and implement 5 pilot integrated youth MHSU service hubs in communities across BC, through partnerships with non-profit service delivery partners.
- The Ministry will allocate $500,000 per health authority per annum for operating costs for the 5 pilot integrated youth MHSU service hubs.

Approved by:
Sharon Stewart, obo Doug Hughes, Health Services Policy Division; November 3, 2016
Jack Shewchuk, obo Teri Collins, Health Sector Information Analysis and Reporting Division; November 7, 2016
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; November 15, 2016

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

- Year over year, more surgeries are being performed in BC. Approximately 572,000 surgeries were performed in 2015/16, a 36% increase since 2000/01.[1] Approximately 235,000 (41%) of these were completed from the surgical waitlists (scheduled surgeries) in 2015/16.[2]
- As of December 31, 2016, there were 80,617 adult cases and 5,184 paediatric cases on the waitlist for scheduled surgery. The waitlist has increased approximately 12% for adult cases, and 7% for paediatric cases since March 31, 2012.[3]
- As of December 31, 2016, the median wait time for all adult completed, scheduled surgeries in BC for 2016/17 was approximately 7 weeks. This has increased 1.4 weeks since 2011/12[4].
- As of December 31, 2016, the median wait time for all paediatric completed, scheduled surgeries in BC for In 2016/17 was 6.3 weeks. This increased 0.3 weeks between 2011/12 and 2015/16.[5]

Table 1: Median Wait Times (Weeks) for All Completed, Scheduled Surgeries (Adult and Pediatric) 2011/12 - 2016/17 (as of December 31, 2016)[6]

Fiscal Year	BC		FHA	IHA	NHA	VCHA	VIHA
	Pediatric	Adult	Adult				
2011/12	6.0	5.6	6.3	5.6	5.4	4.4	6.7
2012/13	4.7	5.3	5.6	5.4	5.3	4.1	6.7
2013/14	5.3	5.6	5.9	5.6	5.0	4.7	6.9
2014/15	5.3	6.1	6.3	6.6	4.6	5.6	8.0
2015/16	5.0	6.9	6.7	7.6	5.0	6.1	8.0
2016/17 (to Dec. 31, 2016)	6.3	7.0	7.1	7.9	5.1	6.1	8.0

- The 2015/16 Ministry of Health Service Plan target for the percentage of scheduled surgeries to be completed within a 26 weeks wait time was 93%. Overall provincial performance against this target for 2015/16 was 86%, compared to the 90% baseline in 2013/14.[7]
- New performance targets have been set by the Ministry that no more than 5% of patients will wait more than 40 weeks for surgery in 2016/17, and no more than 5% of patients will wait more than 26 weeks for surgery in 2017/18. As of December 31, 2016, 11% of surgical cases in BC have been waiting more than 40 weeks.[8]
- As of December 31, 2016, the percentage of patients in BC whose hip fracture was fixed within 48 hours was 87%. This has decreased from 92% in 2015/16.[9]
- In light of this performance the Ministry has developed a Strategic Framework for Surgical Services.

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[1] 2015/16 Access to Services Factsheet, Surgical Patient Registry (SPR), Project # 2016_0534, HSIAR.
[2] 2016/12 Standard Report Cases Completed, SPR, Project # 2016_0005, HSIAR.
[3] Q3 Surgical Performance Monitoring Report, Jan. 10 2017, SPR, Project # 2017-0015.
[4] 2016/12 Standard Report Cases Completed, SPR, Project # 2016_0005, HSIAR.
[5] Ibid.
[6] Ibid.
[7] Q3 Surgical Performance Monitoring Report, Jan. 10 2017, SPR, Project # 2017-0015.
[8] Ibid.
[9] Ibid.

FACT SHEET

Strategic Framework for Surgical Services

- The Provincial Surgical Executive Committee refreshed the *3 Year Plan for Surgical Services* in April 2016. In order to accelerate action on the Plan, in May 2016, Leadership Council recommended focused implementation at 11 selected sites across the province.
- A provincial Steering Committee was formed in July 2016, to oversee implementation and monitor progress. Deliverables and *Measures of Success* were established for the Ministry, health authorities, and early adopter sites.
- Implementation of the surgical strategy is underway at early adopter sites, with continued monitoring of targets and *Measures of Success*.

Table 2: Percent of Hip Fracture Fixation Surgeries Completed within 48 hours[10]

Fixation of Hip Fractures (to December 31, 2016) Previous P4P target: Not less than 90% waiting < 48 hours						
Fiscal Year	**BC**	**FHA**	**IHA**	**NHA**	**VCHA**	**VIHA**
2013/14 (this P4P measure started from 1st September 2013)	91%	86%	92%	83%	93%	94%
2014/15	92%	91%	92%	80%	94%	94%
2015/16	92%	93%	91%	79%	92%	95%
2016/17 (to December 31, 2016)	87%	90%	84%	74%	86%	88%

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 wait times for knee replacement, hip replacement, and cataract surgery. Wait times for these procedures are also published on the Canadian Institute for Health Information website and the yearly *Wait Times for Priorities Procedures in Canada* report.
- For all 3 procedures the number of adult completed, scheduled cases has increased in the past 5 years, but the percentage of cases completed within 26 weeks has decreased. [11]

Table 3: Number of Cases Completed and Percentage Completed within 26 Weeks for Areas of Special Mention (Adult Cases)

	Total Number of Cases Completed, Adult[12]		Percentage of Cases Completed within 26 Weeks[13]	
	2011/12	**2015/16**	**2011/12**	**2015/16**
Knee Replacement	7,015	7,979	74%	47%
Hip Replacement	4,875	5,511	81%	60%
Cataract Surgery[14]	50,935	55,110	91%	80%

FINANCIAL IMPLICATIONS

N/A

Approved by:

Ian Rongve, Hospital, Diagnostic and Clinical Services Division; February 10, 2017

Nancy South, oboTeri Collins, Health Sector Information, Analysis & Reporting Division; February 20 2017

[10] Q3 Surgical Performance Monitoring Report, Jan. 10 2017, SPR, Project # 2017-0015.

[11] Ibid..

[12] Q3 Surgical Top 15 Report, Jan. 11 2017, SPR, Project # 2017-0016.

[13] Q3 Surgical Performance Monitoring Report, Jan. 10 2017, SPR, Project # 2017-0015.

[14] Canadian Institute for Health Information measures percent of cataract surgeries completed within 16 weeks instead of 26 weeks.

FACT SHEET

Surgical Services Strategy

ISSUE

Improving access to surgery is a key priority in BC, as outlined in the Ministry of Health strategy document *Setting Priorities for the BC Health System (Setting Priorities)* and the policy paper *Future Directions for Surgical Services in British Columbia (Future Directions).*

KEY FACTS

Provincial Surgical Executive Committee

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. PSEC members include patients and clinicians, as well as representatives from the Ministry of Health, the Health Authorities, Doctors of BC, and the BC Patient Safety and Quality Council.

Strategy Development

- In June 2015, PSEC drafted the *3 Year Plan for Surgical Services 2015–2018* (*3 Year Plan*), outlining the goals and strategies necessary to deliver the vision outlined in *Setting Priorities* and *Future Directions.* It was endorsed by the Standing Committee on Health Services and Population Health in September 2015.
- The *3 Year Plan* was updated in April 2016, following the release of the *Policy Directive and Strategy Map – Services for patients requiring surgery*.
- In May 2016, in order to accelerate action on the plan, Leadership Council recommended focused implementation of the surgical strategy at selected sites across the province.
- Lessons from the early adopter sites will be used to recommend any mid-course correction (if required), with a refreshed *3 Year Plan* ready by June 2017.

Implementation/Actions

- A provincial Steering Committee was formed in July 2016 to oversee implementation and monitor progress.
- Deliverables and Measures of Success were established for the Ministry, health authority, and early adopter sites for July-December 2016, January-June 2017, and July-December 2017. The early adopter sites are:

Health Authority	Site 1	Site 2
PHSA	BC Children's Hospital	
VCHA	Vancouver General Hospital	St. Paul's Hospital
FHA	Royal Columbian Hospital	Eagle Ridge Hospital
IHA	Kelowna General Hospital	Royal Inland Hospital
VIHA	Victoria General Hospital	Royal Jubilee Hospital
NHA	Mills Memorial Hospital, Terrace	Kitimat General Hospital & Health Centre

Strategies & Goals	Actions & Progress
Improve timely access to appropriate surgical procedures	• In February 2017, $25 million in additional one-time funding for 2017/18 was announced to support BC's strategy for surgical services. Health authorities will use the additional funding to reduce the backlog of patients waiting for surgeries. The exact number of extra surgeries is still to be determined. • More than 5,000 additional surgeries performed in 2015/16 with $25M investment • New performance targets set: o No more than 5% of patients will wait more than 40 weeks for surgery in 2016/17 o No more than 5% of patients will wait more than 26 weeks for surgery in 2017/18 • Health Authority's Detailed Operational Plans were submitted in June 2016, including information on plans to meet new targets

FACT SHEET

Strategies & Goals	Actions & Progress
Surgical waitlists are managed optimally and proactively	• Codes used to prioritize patients for scheduled surgery updated and implemented in Fall 2015. • Standardized approach to analysis, modelling and monitoring of wait times and waitlists across the province developed in Fall 2016. • New provincial wait list management policy developed in Fall 2016, which brings changes to improve standardization, transparency, patient choice, and optimal wait list management, including: o Primary accountability for surgery scheduling and waitlist management rests with health authorities. o Clear process and point of contact for patients. o Increased information flow supporting the patient's journey to surgery (e.g. notifications, patient education). o Standards for time to complete key process steps. • The policy was issued in Final draft in November 2016 for implementation at the early adopter sites and to be effective across the province April 1, 2017. • Production of Wait One information in Fall 2017. • Refresh of Ministry waitlist web pages and online tools in Fall 2017.
Improve the patient experience of care, patient-centred choice, reduce unwarranted variation	Approach developed to expand Enhanced Recovery After Surgery (ERAS) across the province. Several examples of pooled referrals underway or in planning, leveraging funds from the Specialist Services Committee. These exist in Kelowna (orthopaedics), Kamloops (general surgery), Burnaby (central intake), and Victoria (planned expansion of Rebalance.)
Performance monitoring	• PSEC recommended surgery quality indicators to the Standing Committee on Performance Measurement, Analytics and Evaluation in Summer 2016 • The Ministry is developing a monitoring and evaluation framework for the surgical strategy. Monitoring reports will be produced quarterly, starting July 2017. Evaluation of the surgical strategy will occur annually to progressively measure success across immediate, medium-term and long term outcomes.
Information solutions for enhanced surgical flow	Development of opportunity assessment of technology to support the flow of information, procurement through BCCSS, and evaluation criteria established at the outset.
BC has the right number and types of surgical health care providers to meet its needs	• Health Human Resources strategies initially focused on Anesthesiology and anesthesia assistants; and specialized surgical nursing. • Forum held in September 2016 to inform Ministry policy direction in 2 areas in perioperative services: care models and OR nursing specialty training.
Reduce per capita cost for surgical services	Joint initiative between the Ministry and health authorities to collect costing information on Cataract, Hip and Knee Replacement Surgeries completed using standardized template for data collection.

Next Steps

- Continued implementation of the surgical strategy at early adopter sites, as well as continued monitoring of targets and *Measures of Success.*
- PSEC to refresh the *3 Year Plan* using the lessons learned from the early adopter sites.
- Development of communication, engagement, and change management plans.

FINANCIAL IMPLICATIONS

The *Policy Directive and Strategy Map* indicates achievements should occur within existing budgets. Consistent feedback has been that the Plan requires net new investment and sustained funding.

Approved by:

Ian Rongve, Hospital, Diagnostic and Clinical Services Division; February 14, 2017
Teri Collins, Health Sector Information, Analysis and Reporting Division; February 21, 2017
Ted Patterson, Health Sector Workforce Division; March 6, 2017
Brad Kocurek, obo Deborah Shera, Health Sector IM/IT Division; March 6, 2017
Gordon Cross obo Manjit Sidhu, Finance and Corporate Services Division; April 3, 2017

FACT SHEET

Health Human Resources Planning

ISSUE

An overview of Health Human Resources (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 education, training, recruitment and retention strategies needed to support and ensure the right number and kind of health care professionals are in the right place at the right time.
- HHR planning is a challenge for all jurisdictions in Canada. Appropriate planning is critical for the 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 billion[1] 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).
- *Setting Priorities for the BC Health System* set the strategic direction for the health sector, including a HHR strategy which emphasizes this key action: "Develop and implement an integrated provincial workforce strategy linked to regional and health service are health workforce plans and build on supporting both individual and team-based practice ... as appropriate to best meet patient needs."
- *Enabling Effective Quality Population & Patient Centred Care: A Provincial Approach for Health Human Resources* (2015) outlined an overall strategy for HHR that proposes a provincial approach for HHR, including: the shift from provider-centric to patient-centred care, and the indicated need for an HHR strategy that plans effectively for this shift and patient and population needs.
- HHR Planning and Five Priorities: over the next three years, health authorities will be expected to make significant progress on implementing the Ministry's five strategic priority areas, as outlined in the Health Authority Mandate Letters and accompanying documents. This includes the requirement for health authorities to address a number of specific HHR actions and deliverables pertaining to each health system priority. Specifically, health authorities are asked to complete a strategic gap analysis and three-year action plan which brings forward recommendations and actions for that are related to recruitment, training, and retention of physicians, nurses, and other health professionals.

<u>2016/17 Provincial HHR Plan</u>

- The vision of provincial HHR planning in BC is to create a single process for provincial HHR planning that aligns the supply, mix and distribution of the health workforce to meet patient and population health needs across local, regional and provincial levels.
- The objectives of the plan include: 1) Effective planning for patients at the centre; 2) A stronger collective voice for HHR strategies; 3) Data-driven, evidence-based decision making; 4) Establishment of an annual provincial HHR planning process.

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[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.

FACT SHEET

- Health Authority Mandate Letters: On May 02, 2016 instructions were sent out to health authorities as part of the bilateral agreement between health authorities and the Ministry. Health authorities are asked to prepare a comprehensive three-year submission in support of their overall service delivery objectives and operational health system needs. In addition, The Plan coordinates the HHR deliverables of the Ministry's five (5) strategic priority areas.
- The 2016/17 Provincial HHR Plan deliverables include: 1) Validation of current health workforce demographics, including community and facility-based physicians; 2) Projection of future workforce supply and demand over 3 years; 3) Strategic gap analysis and three-year action plan for HR strategies in the areas of recruitment, retention, education and training.
- The 2016/17 Provincial HHR Plan is the beginning of an ongoing, annual planning exercise for BC's health care system.
- The Ministry is shifting from silo-based workforce planning and forecasting methodologies (simple "stock and flow" models) to an integrated planning approach that utilizes supply, demand and population-needs based forecasting models in order to achieve a sustainable health care system focused on patient and population needs.
- It is anticipated that future HHR planning cycles will see the introduction of a provincial forecasting methodology, increased integration across professions, the inclusion of private sector/contracted workforce data, expansion of the scope of professions included, expansion of planning time horizon to 5 and 10 years, and a continuous improvement process.

FINANCIAL IMPLICATIONS

N/A

Approved by:
Raeleen Siu, Workforce Planning & Management Branch; May 4, 2016
Kevin Brown, Workforce Planning & Management Branch; May 4, 2016
Ted Patterson, Health Sector Workforce Division; June 7, 2017

FACT SHEET

Primary Care Access

ISSUE

Primary Care Access is a key priority within the Ministry of Health, which proposes to build on the collaborative work of the past decade to establish an integrated and well-coordinated system of team-based primary and community care that provides quality patient-centred primary health care that effectively meets the changing needs of British Columbians.

KEY FACTS

- Efforts have been underway in the province for many years to develop a system of primary and community care; early work focused on establishing foundational elements supporting improvements to care for patients with chronic diseases, and developing structures such as the Divisions of Family Practice, while more recent initiatives have included A GP for Me and Nurse Practitioners for BC, each further advancing team-based approaches as part of the solution.
- Approximately ¾ of all eligible practicing family physicians participated in A GP for Me over the 3 years of the initiative. The Divisions of Family Practice report over 178,000 patients were attached during the initiative. In addition, there were over 130,000 patients prevented from becoming unattached; patients were matched with another GP when their GP retired or left the practice.[1]
- While the number of family physicians in BC has grown over the last 5 years at a rate outpacing population growth, and BC is training and graduating more physicians than ever before, a proportion of British Columbians report not having a regular medical doctor. The number of people without a regular family physician in BC was estimated at 15.1%[2] (~700,000 people) in 2014, down slightly from 15.5%[3] without a family physician in 2013.
- Several factors influence primary care capacity and subsequently access including: the number and geographic distribution of primary care providers, supply of new providers (education, training, retention, and international education and graduate policies), practice styles and patterns, and demographics including retirements.
- The majority of British Columbians have a continuous primary care relationship, but some find it difficult to access care and some experience care that is fragmented across multiple providers and places. A recent study[4] found only 24% of family physicians in BC were providing full-service family practice.
- Despite advancements in BC over the last 5 years, there is still a need to focus on improving access to primary care, including meeting the mandate from the Minister of Health's 2015 Mandate Letter To work with the Doctors of BC, College of Physicians and Surgeons, College of Registered Nurses and the Association of BC Nurse Practitioners to continue to strengthen primary care access for BC patients across the province, including the addition of new physicians and nurse practitioners.
- Over the coming years, building on the significant work completed to date, partners will work together to establish an integrated and well-coordinated system of team-based primary and community care across the 61 geographic health service areas (metro, urban/rural, and rural/remote service areas) to provide quality primary health care that effectively meets the changing needs of patients and populations.

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[1] Ministry of Health, Final Evaluation of A GP for Me, Final Report. October 2016.
[2] Statistics Canada, Canadian Community Health Survey, 2013 and 2014 Share Files. July 2015. Prepared with Ministry of Health business rules.
[3] Statistics Canada. CANSIM Table 105-0501-Canadian Community Health Survey, 2013 & 2014 samples. Calculated as (100% - % with a regular MD).
[4] McGrail K, Lavergne R, Lewis SJ, Peterson SL, Barer M, Garrison SR. Classifying physician practice style: a new approach using administrative data in BC. Med Care. 2015 Mar;53(3):276-82.

FACT SHEET

- The initiative will be underpinned by a clear understanding of the health needs of the specific patient population in each geographic service area focused on population health, short-term illness, long-term illness or disability (including chronic illnesses, frailty, mental health and/or substance use, cancer care), and end of life care.
- Further work to improve access to primary care includes the establishment of networks of Patient Medical Homes (full-service family practices) linked with health authority and relevant government and community-delivered primary care services. Patient Medical Homes will use an interprofessional, team-based and person-centred approach to meet the majority of patients' primary health care needs.
- In addition, specialized community care programs will be developed for 4 populations: complex medical patients and/or frail elderly (including dementia, palliative, and end of life care); people with moderate-to-severe mental health and/or substance, or comorbidity; perioperative surgical services; and, cancer care services (provided through the BC Cancer Agency).
- Where services are provided outside the family practice, simple and clear pathways will be established to make it easier for patients, families and service providers to navigate and access services specific to patients' needs in a timely manner and support them as they transition to and from specialized community care programs.
- Teams of health care professionals will meet the majority of patients' primary health care needs by offering a full range of primary care services to a defined group of patients, and as part of a system of care for all people in a defined geographic area. Examples of proposed services include:
    - Health promotion and illness prevention;
    - Primary reproductive care;
    - Chronic disease prevention and management;
    - Care for mild to moderate mental health and substance use;
    - Coordination and access to rehabilitation;
    - Support for hospital care and care provided in-home and in long-term care facilities;
    - Support for the terminally ill;
    - Primary care for older adults with frailty/complexity;
    - Information and tools to support self-management;
    - Shared care for complex conditions and/or frailty; and
    - Maintenance of single and comprehensive patient record.
- The Ministry is currently working with a number of Proof of Concept communities (Kelowna, Kamloops, Mission and 100 Mile House) to test the concept of a Nurse in Practice as a means to increase capacity and access to primary health services and build the Patient Medical Home. Learning from these communities will help move the province towards are more integrated system that meets the needs of patients.

FINANCIAL IMPLICATIONS

The Ministry is currently developing a sustainable funding framework for the strategic priorities, including primary care access. As part of this, the Ministry is working with the Doctors of BC through the General Practice Services Committee to realign funding and resources to better meet this strategic priority.

Approved by:

Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; February 21, 2017
Nancy South, obo Teri Collins, Health Sector Information, Analysis and Reporting Division; March 7, 2017
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services; March 9, 2017

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, 2016, the Ministry counted 11,508 physicians under all Ministry payment sources (fee-for-service, sessions, service contracts and salaries).[1]
    - Of those, 7,745 (67%) were fee-for-service only, 803 (7%) were on alternative payments only, and 2,960 (26%) were paid 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 2016, the CMA reported a total of 11,153 physicians for BC.[2]
    - 6,050 (54%) are Family Physicians and 5,101 (46%) are specialists. 2 were identified as Medical Scientists
    - 7,024 (63%) are male and 4,126 (37%) are female.[3]
- As of December 2015, CIHI reported a total of 10,917 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 CIHI, BC's ratio of 232 physicians per 100,000 people in 2015 was fifth, behind Nova Scotia (261), Newfoundland & Labrador (243), Quebec (242) and Alberta (237).[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, 2016.* Retrieved on January 24, 2017 from https://www.cma.ca/Assets/assets-library/document/en/advocacy/01-physicians-by-specialty-province-e.pdf
[3] Canadian Medical Association Masterfile, January 2016. *Number of active physicians by age, sex and province/territory, Canada, 2016* Retrieved on January 24, 2017 from https://www.cma.ca/Assets/assets-library/document/en/advocacy/04AgeSexPrv.pdf
[4] CIHI. *Supply, Distribution and Migration of Canadian Physicians, 2015*, data tables. Retrieved electronically August 25, 2016 from https://secure.cihi.ca/estore/productSeries.htm?pc=PCC34
[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] [6] CIHI. *Supply, Distribution and Migration of Canadian Physicians, 2015*, data tables. Retrieved electronically August 25, 2016 from https://secure.cihi.ca/estore/productSeries.htm?pc=PCC34

FACT SHEET

Physician Supply

- 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 33% from 8,234 in 2002 to 10,917 in 2015[7] more than doubling the 14% 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 2015, the average physician age in BC was 51 years.[9]
- In 2002, the provincial government committed to funding expansion and distribution of the University of BC's undergraduate and postgraduate medical education programs to educate more doctors across the province to better meet the health care needs of British Columbians
    - BC increased the annual intake of first-year undergraduate medical students from 134 in 2003 to 288 in 2011.
    - In 2016/17, the Ministry funded 346 entry-level residency positions: 288 for Canadian Medical Graduates; 58 for International Medical Graduates, up from 134 in 2003.
- To align with Ministry and health authority priorities and support primary care in BC, the University of BC maintains at least 60% of Canadian Resident Matching Service entry-level positions in Family Medicine and the generalist specialties (Internal Medicine, Psychiatry and Pediatrics).[10]
- BC's goal of distributing medical education throughout the province is to help prepare future doctors for the challenges and benefits of practicing in rural, remote, and underserved communities; enhance health care service capacity across the province (these residents in training provide direct patient care); and encourage these physicians to establish a practice in the communities where they've been educated and trained.
- In most years BC attracts physicians from the rest of Canada.
    - In 2015, the net gain of physicians to BC was 78, which followed a net gain of 46 in 2014, a net gain of 15 in 2013, a net gain of 95 in 2012, and a net loss of 57 in 2011.[11]
    - Alberta and Ontario are the originating provinces of most physicians migrating to BC.[12]
- Since 2012, BC has gained more physicians returning from abroad than the province lost to physicians moving abroad. In 2015, BC had 20 physicians move abroad and 57 physicians arrive from abroad.[13] Of the 57 arriving from abroad, 34 were Canadian medical school graduates and 23 were graduates of foreign medical schools. [14]

FINANCIAL IMPLICATIONS

N/A

Approved by:

Kevin Brown, Workforce Planning & Management Branch; November 15, 2016
Marie Ty , Compensation Policy and Programs; January 24, 2017
Ted Patterson, Health Sector Workforce Division; January 24, 2017
Nancy South, obo Teri Collins, Health Sector Information, Analysis and Reporting Division; January 27 2017

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[7] Ibid 4. CIHI has more historical physician data readily available than the Ministry. Hence the use of CIHI trends here.
[8] PEOPLE 2015, BC STATS, Ministry of Labour and Citizens' Services, BC population as at July 1, 2015 (4,683,139), at April 1, 2002 (4,100,161), Retrieved on January 24, 2016 from http://www.bcstats.gov.bc.ca/StatisticsBySubject/Demography/PopulationEstimates.aspx
[9] Ibid, 4
[10] 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.
[11] Ibid, 4, Table Profile B.C.
[12] Ibid, 4, Table 10: Specialists migrating between Canadian jurisdictions who were in Canada on both December 31, 2013, and December 31, 2014
[13] Ibid, 4, Table Profile B.C.
[14] Ibid, 4, Tables Profile B.C., 17, 17.1

EXECUTIVE SUMMARY

In July 2015 the Select Standing Committee on Finance and Government Services passed a motion to

> *"... refer the Ministry of Health terminations file to the Ombudsperson for investigation and report as the Ombudsperson may see fit; including events leading up to the decision to terminate the employees; the decision to terminate itself; the actions taken by government following the terminations and any other matters the Ombudsperson may deem worthy of investigation. The Committee trusts that his investigation can conclude in a timely manner."*

The Committee subsequently issued Special Directions on September 9, 2015 that outlined the subject matter of the investigation. This report is the result of that referral from the Committee.

INVESTIGATIVE APPROACH

This investigation marked the first time in the history of the Ombudsperson that we have conducted an investigation under section 10(3) of the *Ombudsperson Act*. The breadth and complexity of the subject matter of the referral required a thorough and careful investigative approach.

We obtained millions of records from many different provincial government ministries and agencies, as well as records from other public bodies and individuals. From these records, we identified and reviewed those which were relevant to our investigation. We summonsed 130 witnesses who provided evidence to us under oath.

We assessed both the documentary records and sworn testimony to develop a draft report. Each individual and authority the Ombudsperson determined may be adversely affected by the report was then given the opportunity to make representations with regard to the portion of our draft report that related to them. We took these representations into account in determining the content of the final report.

ANALYTICAL FRAMEWORK

In the Special Directions the committee set out its expectation that we would investigate:

> *the events leading up to the terminations, the terminations themselves, decisions to suspend and/or reinstate data access and actions taken by Government following the terminations*

and in doing so, make findings about the involvement of various government ministries, agencies and members of the executive council in those decisions. We interpreted these Special Directions as broadly as necessary to enable us to obtain a full understanding of the relevant issues set out by the committee, and any additional matters that we determined in the course of our investigation were necessary to examine.

When assessing and drawing conclusions about government conduct we relied on the terms of the Special Directions which allow the Ombudsperson to make the findings and recommendations he considers appropriate.

Our investigation was fact-finding in nature, and this is reflected in the conclusions we reached.

When we assessed the investigations and the decisions about employee conduct, we looked to the existing case law which describes the factors that should be considered when determining whether it is appropriate to dismiss an employee for just cause. Where necessary, we also made reference to existing government policy such as the Standards of Conduct for public service employees, the Public Service Agency's Executive Accountability Framework and the Core Policy and Procedures Manual.

While the report contains a significant focus on the actions of individuals in determining what happened and why, it is important to emphasize that no individual decision and no single person is responsible for what occurred. This investigation uncovered a number of systemic problems, many of which contributed to the outcomes that occurred. Ultimately, the purpose of this report is not to lay blame. It is to provide an accounting of the facts as we found them, to identify the systemic factors that we believe contributed to the events that unfolded in 2012 and subsequently and, where appropriate, to make recommendations for redress, improvement and reconciliation.

STRUCTURE OF REPORT

This report is primarily focused on factual matters - the "who, what, when and why" of the investigations and the decision-making process. It often refers to evidence we obtained under oath from witnesses who participated in the various investigations and the decision-making processes that resulted from those investigations. In many cases, we decided that it was best to let the witnesses' evidence speak for itself.

Consistent with the Ombudsperson's role, we have also analysed the evidence and drawn conclusions about the conduct we describe. Key findings can be found at the end of Chapters 5 through 17. Based on the report and findings, 41 recommendations are made.

UNDERSTANDING THE MINISTRY OF HEALTH IN 2012: BACKGROUND AND CONTEXT

We describe the development of the Pharmaceutical Services Division (PSD) at the Ministry of Health and outline what we understand to be the broader policy rationale for that division's focus, up to 2012, on evidence-based research on pharmaceuticals and evaluation of pharmaceutical policy. We describe how PSD was structured to achieve these policy goals, and the extent to which these goals relied on the use of administrative health data. We describe some specific research initiatives that PSD supported and set out the history and evolution of the Therapeutics Initiative.

We then describe three existing organizational factors at the Ministry of Health that, in our view, contributed to the way in which the investigation into employee conduct unfolded. These factors include a chronic lack of clear policy direction around data use that helped foster a risk-averse approach to sharing administrative health data; a culture of suspicion about the propriety of contracting practices that emerged following an instance some years before of a criminal act in the eHealth area; and a significant number of personnel changes at the executive level in the span of two years that had a detrimental impact on the ministry's institutional memory.

THE COMPLAINT

The Ministry of Health's review of the allegations of employee misconduct began at the end of March 2012 when it received a copy of a complaint that had been made to the Auditor General. The complainant had a sincere belief in relation to the allegations she made, but she was uninformed and mistaken about the facts. She named specific employees and external contractors who were alleged to have engaged in wrongdoing in relation to contracting and data practices.

Although this complaint was almost entirely inaccurate, the ministry did not assess its factual validity at the outset. Instead, the ministry asked a fairly inexperienced employee to conduct an initial review of the complaint. The complainant then became deeply embedded in this initial review and expanded the scope of her original complaint. The purpose of the review was to better explain the complainant's concern, but it was not necessarily well understood by others that the initial review did not analyze or validate the complaint.

MINISTRY OF HEALTH INVESTIGATION ESTABLISHMENT AND COMPOSITION

Following the work of the initial review, Ministry of Health executives concluded that an investigation was necessary. That work began at the end of May 2012, when three Assistant Deputy Ministers in the ministry approved the terms of reference appointing a lead investigator who was then a director of privacy investigations on the staff of the Chief Information Officer, and other members of an investigation team.

The terms of reference for the investigation did not clearly define its scope, and it quickly expanded beyond the original purposes for which it was established. The terms of reference contemplated a one month investigation completed by the end of June 2012. The investigation continued for approximately 16 months during which time numerous individuals joined and left the investigation team. This included an investigator from the BC Public Service Agency and staff from the Ministry of Health. While the investigation was represented as being external to the Ministry of Health, functionally this was not the case.

MINISTRY OF HEALTH INVESTIGATION THROUGH THE FIRST EMPLOYMENT SUSPENSIONS: JUNE AND JULY 2012

One week after the investigation began, the Ministry of Health suspended data access for individuals identified in the original complaint. These suspensions were unrelated to the suspected privacy breaches that the Ministry of Health reported to the Information and Privacy Commissioner later that summer.

Five of the initial data suspensions were not based on any evidence of improper data use that would support a valid suspicion. Before making the decision to suspend data access, the decision-makers did not properly assess and document whether, in relation to each individual whose data access was suspended, there was any evidence which, if true, posed a risk of improper use of data. The ministry did not give the individuals adequate explanations about the basis for the data access suspensions.

Some of the people who had their data access suspended were ministry contractors. The ministry delayed its investigation into the actions of the contractors and, as a result, their suspensions remained in place for over a year.

Following the initial data access suspensions, the investigators continued to gather evidence, and they conducted informal interviews and reviewed emails and contracts. The investigators' evidence-gathering process was undisciplined and suffered from a lack of organization, effective senior management oversight, clear policy guidance and subject matter expertise.

The investigators undertook a mass review of email and categorized emails they viewed as suspicious into categories of wrongdoing. The investigators' approach to reviewing emails was ineffective and it appeared they were focused on trying to build a case and were not engaged in a neutral fact-finding exercise. The investigators did not approach this part of their investigative work with suitably open minds and an understanding of the relevant program areas and this impaired the reliability of their work.

In early July 2012 the investigators created a first draft of an Internal Review report describing the wrongdoing they believed they had uncovered. This draft report itemized a series of conclusions which were unsupported by evidence. Many of the report's purported findings merely reiterated several of the complainant's allegations and did not reflect the outcome of robust investigation or clear analysis. The draft Internal Review report also listed a series of recommendations related to contracting practices, data use, and the conduct of employees, but these recommendations did not arise from a careful assessment of the evidence.

The draft report was amended periodically, but it continued to reflect the influence of the complainant's perspectives and the investigation team's unsupported belief that there was widespread misconduct within the ministry. Officials in the ministry interpreted the early reports in a variety of ways, many of which did not reflect the true stage of the investigation at that time. The conclusions set out in the drafts of the Internal Review report influenced the direction of the investigation. These same report drafts, including one that contained a "relationship web", were used to brief senior executives within the ministry, the Comptroller General and the RCMP. They were also used to support the employment and contract terminations that followed.

At the end of June 2012, the Ministry of Health, with the advice of the B.C. Public Service Agency (PSA), decided to suspend three employees, Dr. Malcolm Maclure, Dr. Rebecca Warburton and Mr. Ron Mattson. On July 17, 2012 these employees were notified that they were suspended without pay pending investigation.

The PSA's recommendation and the Ministry of Health's decision to suspend the employment of Dr. Maclure, Dr. R. Warburton and Mr. Mattson were made without an evidentiary basis and without clear consideration of whether lesser measures were available to mitigate any perceived risks. Further, the Ministry of Health lacked the contractual or statutory authority to suspend excluded employees without pay, and as such, the suspensions were contrary to law. At the time, PSA had a long-standing practice to suspend excluded employees without pay, but this practice ran contrary to legal advice it had received.

Following his suspension, Dr. Maclure asserted that the Ministry of Health had constructively dismissed him from his employment and as a result, the ministry did not formally terminate his employment. Dr. Maclure ought not to have been constructively dismissed.

MINISTRY OF HEALTH INVESTIGATION CONTINUES THROUGH THE EMPLOYMENT TERMINATIONS: AUGUST-OCTOBER 2012

In August and September 2012, the investigators uncovered three suspected privacy breaches and later reported them to the Information and Privacy Commissioner.

At the end of July 2012, the Ministry of Health suspended data access for Ramsay Hamdi. The Ministry of Health acted reasonably when it suspended Mr. Hamdi's data access while it made further inquiries.

Throughout August 2012, the Ministry of Health suspended more employees without pay on the recommendation of the Public Service Agency. Ramsay Hamdi and David Scott were suspended at the beginning of August without pay. A few weeks later Robert Hart and Roderick MacIssac were also suspended without pay. The decisions to suspend each of these four employees resulted from a procedurally flawed and improper process.

Mr. MacIsaac, Mr. Hamdi and Mr. Scott all worked in bargaining unit positions and thus were members of the BC Government and Service Employees' Union. We reviewed the basis on which these employees were suspended. The Ministry of Health did not have valid grounds to conclude that these employees posed a serious risk and their suspensions were improper. Contrary to appropriate labour relations practices, the Public Service Agency did not consider whether lesser measures than suspensions could address any perceived risk to the ministry.

The Public Service Agency and the Ministry of Health did not have a sufficient basis to conclude that the suspension of Mr. Hart was warranted. As with the three excluded employees suspended in July, Mr. Hart's suspension without pay pending investigation was not authorized by a term of his employment contract or the *Public Service Act* and was contrary to law.

In August 2012, then-Deputy Minister of Health, Graham Whitmarsh, assumed a greater role in respect of the investigation. He briefed John Dyble, Deputy Minister to the Premier and Michael de Jong, Minister of Health. He also started to meet with the investigation team on a weekly basis to receive progress reports about the investigation.

Throughout August 2012, a significant part of the work conducted by the Ministry of Health investigation team was interviewing the employees under investigation as well as other employees in the ministry. These interviews were conducted primarily by the lead investigator and the PSA's investigator, with contributions from two other members of the investigation team. We reviewed the records of these interviews and spoke with the members of the investigation team as well as some of the people who were interviewed.

In conducting many of the interviews, the Ministry of Health investigation team:

- provided insufficient notice of the allegations made against employees
- did not provide employees under investigation with adequate particulars of the case against them, including in relation to appropriate document disclosure, contrary to legal advice
- did not display a suitably open mind
- did not appropriately consider the evidence the witnesses provided
- did not accurately characterize the information they gave to witnesses in interviews

From listening to the recordings of those interviews, we found that the employees who were dismissed were generally co-operative and responsive in the interviews.

While the conduct of the interviews themselves was the responsibility of the investigators, executives at the Ministry of Health and the Public Service Agency who were responsible for the conduct of the investigators did not ensure that the interviews were conducted fairly. The Ministry of Health did not provide the investigation team with a structure for conducting the interviews, or take substantive action when concerns about the interviews were brought to their attention.

In addition, the Public Service Agency did not provide their staff members adequate training or policies to guide the way in which the interviews were conducted.

At the end of August 2012, the lead investigator and the Director of the Investigations and Forensics Unit of the office of the Comptroller General contacted the RCMP about the ongoing Ministry of Health investigation. When they met on August 27, 2012 the RCMP told them they would not make a decision about whether to investigate until they received a final report from the government investigators and in light of the RCMP's capacity at the time the report was received.

EMPLOYEE DISMISSAL DECISIONS AND PUBLIC ANNOUNCEMENT

Beginning on September 6, 2012, the Ministry of Health terminated the employment of six public servants, asserting that it had just cause. The decisions to terminate the employment of Dr. R. Warburton, Mr. Mattson, Mr. Hart, Mr. Hamdi, Mr. Scott and Mr. MacIsaac were made by Deputy Minister Whitmarsh as the statutory decision-maker under section 22(2) of the *Public Service Act*.

The ministry did not have sufficient evidentiary basis to dismiss any of the employees for just cause. We determined that none of the dismissed employees engaged in conduct sufficient to support their terminations. Furthermore, in deciding whether to dismiss any of the employees,

the ministry gave inadequate consideration to whether their conduct had been condoned.

The process by which human resources advice was to be provided by PSA broke down and this contributed to the problems with the dismissal decisions. An investigative report was not prepared and separate advice about the appropriate consequences of the investigation was not provided. Furthermore, the weekly meetings comprised of many senior officials of the Ministry of Health and PSA effectively sidelined the PSA investigator and human resources specialist and disrupted the regular process. There was no good reason for the process to be as rushed as it was.

There was confusion about the provision of legal advice regarding the dismissals. Ministry of Justice lawyers had reviewed the dismissal letters of the excluded employees, but had not been asked by PSA or Ministry of Health to provide legal opinions on the question of just cause for dismissal for any of the dismissed employees. The Deputy Minister of Health was aware of the lawyer's review of the letters and had a mistaken belief that legal advice on just cause had been provided.

On September 6, 2012, the Ministry of Health issued a news release announcing the existence of an investigation of inappropriate conduct, contracting and data management practices in the ministry. The news release announced the four dismissals that had taken place and that three other individuals had been suspended. While the news release did not contain individuals' names, the identity of the fired and suspended employees soon became known publicly.

The news release stated the fact that the RCMP had been asked to investigate and were provided with interim results of the investigation. The decision to include the reference to the RCMP was debated by the ministry, Government Communications and Public Engagement, and Ministry of Justice up until the final moments before the public announcement was made, but Minister MacDiarmid was not told about this debate or about the legal advice the ministry received before making the announcement.

Including this reference to the RCMP was misleading because the RCMP had advised the ministry that they would not even make a decision about whether to investigate until a final report was received from the ministry investigation.

THE MINISTRY OF HEALTH'S RESPONSE TO THREE SUSPECTED PRIVACY BREACHES

As the Ministry of Health investigation continued, the investigation team discovered three suspected privacy breaches involving personally-identifiable administrative health data. The ministry believed that administrative health data had been shared improperly with three separate individuals: Mr. Mark Isaacs, a contractor who ran a company called Quantum Analytics, Dr. Bill Warburton and Mr. Roderick MacIsaac. These alleged breaches were subsequently reported to the Office of the Information and Privacy Commissioner in August and September 2012. We investigated the ministry's understanding of these privacy breaches because they were relevant to three of the termination decisions and how the ministry handled the contract with Mr. Isaacs.

The Information and Privacy Commissioner found that the three privacy breaches occurred because the ministry failed to translate privacy and security policies into meaningful business practices.

The focus of the Information and Privacy Commissioner's report was on whether the person providing the information committed a privacy breach. The recipient of the information in one of the first privacy breaches was Mr. Isaacs and he acted appropriately.

In the privacy breach involving Mr. MacIsaac, he was improperly provided with the information but was authorized to receive the information and did so in his capacity as a ministry employee. He was also a PhD student who intended to obtain and use an anonymized dataset for his PhD thesis, but that was to take place at a future time.

MINISTRY OF HEALTH INVESTIGATION INTO EMPLOYEES CONTINUES AFTER THE TERMINATIONS: SEPTEMBER 2012 – OCTOBER 2013

The Ministry of Health investigation continued after the dismissal decisions in September 2012. The scope of the investigation expanded to focus on additional public servants who were subjected to interviews. Many of the interviews were conducted in an unfair manner similar to what had occurred with the earlier interviews.

In June and September 2013, government and the BCGEU settled the grievances that had been filed by Mr. Hamdi, Mr. Scott and Mr. MacIsaac following their terminations. The grievances were settled on the basis of information provided by the province to the BCGEU before the Public Service Agency recognized the significant flaws in the investigation process. As such, these employees did not have a fair opportunity to have their claims fully considered on the merits.

Between September 2012 and July 2013, the lead investigator maintained regular contact with the RCMP and provided them with material that the investigation team had compiled. This included providing the RCMP with a set of discs containing personally-identifiable federal health data that the ministry held in accordance with an agreement with Statistics Canada. The ministry was, at the time, under no legal obligation to provide this information. The Ministry of Health's decision to voluntarily provide the federal health information to the RCMP was improper and contrary to legal advice.

MINISTRY OF HEALTH INVESTIGATION INTO CONTRACTORS AND EXTERNAL RESEARCHERS

While its investigation continued, the Ministry of Health conducted a parallel investigation into contractors and external researchers who were linked in some way to employees already suspected of wrongdoing. This led the ministry to make more decisions to both suspend the researchers' individual data access and suspend and cancel a number of health research contracts.

In most cases the decision to suspend access to administrative health data was made in the absence of any evidence of inappropriate conduct and based on suspicion alone. The data access suspensions caused the individuals to be unable to carry out employment or other obligations.

The ministry's decisions to suspend the contracts with the University of British Columbia and the University of Victoria that related to the work of the Therapeutics Initiative, the Education for Quality Improvement in Patient Care (EQIP) initiative and the Alzheimer's Drug Therapy Initiative (ADTI), were made without any evidence of wrongdoing and were arbitrary. Despite the investigators' suspicions the ministry never had, or obtained, any evidence that Dr. Colin Dormuth engaged in misconduct of any sort. The same was true for the ministry's decision to suspend and effectively terminate its contract with Blue Thorn Research and Analysis Group Inc.

Neither the investigators, nor the senior executives who made the suspension decisions, gave adequate consideration to the impacts of those suspensions on health research, ministry objectives and the livelihoods and reputations of those they targeted. In addition, the ministry unduly delayed its investigation into the concerns that led it to make the suspension decisions, thereby increasing individual and organizational harms.

In 2012, the ministry had a contract with Quantum Analytics Inc. (QA) for an information tool called Quantum Analyzer, which used administrative health data to display, graph, compare and download health information in anonymized and summary form. QA was owned and operated by Mr. Isaacs. The ministry suspended and then terminated its contract with QA following the data breach in which Mr. Isaacs was involved, despite Mr. Isaacs having done nothing wrong and, in fact, having acted completely appropriately when he discovered that he was improperly provided personal health information. The ministry inappropriately continued to use his Quantum Analyzer software after purporting to suspend the contract.

WINDING UP THE MINISTRY OF HEALTH INVESTIGATION AND SETTLING THE LITIGATION

In June 2013 Stephen Brown was appointed Deputy Minister of Health. Shortly after his appointment he was briefed on the investigation and began to question the usefulness of continuing the investigation. By October 2013 he had directed the investigators to discontinue the investigation. At the same time, Mr. Brown received legal advice from government's outside counsel about the best approach to dealing with the lawsuits brought by the dismissed employees and Dr. W. Warburton. On the basis of that advice, the ministry instructed its lawyers to try to settle the lawsuits. Settlements were subsequently reached in all of the lawsuits and government's lawyer provided opinions supporting the settlement in all of the cases.

By late 2013 government had sufficient information (notwithstanding the outstanding Comptroller General report and some of the ongoing litigation) to raise serious questions about whether the ministry's investigation had been

fair. The ministry did not initiate a comprehensive review and reassessment at that time to determine whether people had been treated unfairly.

When employees were suspended in July and August 2012, their personal effects were boxed up and some of the employees' belongings were lost. The Ministry of Health did not ensure that the fired employees and one contractor had adequate opportunity to identify personal belongings from their offices.

OFFICE OF THE COMPTROLLER GENERAL INVESTIGATION AND REPORT

Before its formal investigation began, the Ministry of Health contacted the Office of the Comptroller General to advise it of the complaint it had received. The Investigations and Forensics Unit (IU) of the OCG began to monitor the Ministry of Health investigation and in October 2012 commenced a formal investigation of its own to "confirm or dispel" the allegations in the original complaint. At the beginning of its investigation, the IU adopted a collaborative approach with the Ministry of Health investigation team.

In April 2015 the IU produced a draft report on the matters it had investigated, which it then provided to the RCMP. The RCMP reviewed the report but declined to conduct a criminal investigation. The IU finalized its report on June 25, 2015.

Overall, the IU did not satisfy the objectives set out in its investigation terms of reference. The absence of guidelines or a protocol between the IU and the ministry investigation team created objectivity risks when the two collaborated. The IU investigation also suffered from a number of gaps in its investigation process that undermined the accuracy of the conclusions contained in its report.

Prior to finalizing the report, the IU did engage in a quality control process but it was not sufficiently robust. In any event, the quality control reviewer indicated the IU report was more in the nature of a summary working paper than a final report.

In April 2015 the IU had provided a copy of the draft report to the Ministry of Health. The ministry failed to comment on the report before it was finalized in June 2015. This was a missed opportunity for both the IU and the ministry to identify and rectify issues with the report before it was finalized. In July 2015, after the report had been finalized and the assignment wound up, the Office of the Comptroller General was told that the Ministry of Health had concerns the IU report contained inaccuracies, based on legal advice the ministry received from its counsel that the report contained statements that were untrue, and warned of the risk of defamation if the report were to be released. The IU report was subsequently leaked to the media. After the completion of the IU's investigation, the Ministry of Finance hired KPMG to conduct a "strategic initiatives review" of the IU. KPMG has recommended a number of steps to improve the IU. The KPMG report highlighted many of the same internal process gaps we identified. The Ministry of Finance has taken steps to begin implementing the KPMG recommendations.

GOVERNMENT'S INTERACTIONS WITH THE FAMILY OF RODERICK MACISAAC

Mr. MacIsaac died four months after he was fired from his co-op position with the Ministry of Health. He never had the opportunity to truly understand why he was fired, and after his death his family continued to search for answers.

The BC Coroners Service investigated Mr. MacIsaac's death and took possession of Mr. MacIsaac's personal laptop. The Coroners Service obtained specialized computer recovery assistance from the RCMP who located a document written by Mr. MacIsaac that described his experience during the Ministry of Health investigation. The Coroners Service made Mr. MacIsaac's family aware of the document but did not provide it to them. Instead, they read a redacted version of the document to them over the phone. When the laptop was returned to the family, they could not find the document until they used specialized software and wondered whether it had been deliberately deleted. We concluded neither the Coroners Service nor the RCMP deleted the document.

On September 30, 2014, Mr. MacIsaac's sister Ms. Linda Kayfish held a press conference calling for government to apologize and explain the reasons for her brother's firing. In the days that followed, Premier Clark, Minister Lake and Deputy Minister Brown apologized for the manner in which Mr. MacIsaac had been treated.

MCNEIL REVIEW AND REPORT

On October 3, 2014, government announced that it had asked Marcia McNeil to conduct a review of the public service response to the allegations against the Ministry of Health employees who were fired in 2012. The resulting report was credible and highlighted many of the same investigative process problems that we have found in our own investigation. However, the hurried manner in which the terms of reference of Ms. McNeil's review were developed meant they needed to be amended shortly thereafter. That created confusion about the purpose of the review which was compounded by public statements by the Premier and Minister of Health that were over-broad in expressing the purpose and anticipated outcome of the review.

Ms. McNeil's review resulted in the Public Service Agency making a number of improvements to its investigative and advisory processes.

IMPACT ON MINISTRY OF HEALTH STAFF AND HEALTH RESEARCHERS

The impacts on individuals arising from the investigations conducted by the Ministry of Health and the Office of the Comptroller General were widespread.

For those most directly involved, the investigations, together with the announcement of an RCMP investigation, resulted in fear, anxiety, loss of income and financial uncertainty, harm to reputation and careers, harm to relationships and, in some cases, health problems.

The investigations also had negative organizational impacts within the Ministry of Health, some of which still exist. We recount how some employees thought the investigation and the events which followed caused a loss of productivity, morale and engagement within the ministry.

The investigations also impacted public health research, evaluation, educational initiatives and analysis that the Ministry of Health was supporting in 2012. Research projects conducted within the ministry and by outside researchers were delayed or ended due to the inability to access data.

RECOMMENDATIONS

Forty-one recommendations to address the findings and conclusions are set out in this report. Those recommendations fall under two broad categories: individual and systemic.

INDIVIDUAL RECOMMENDATIONS

The individual harms caused by the events described in this report are not easily remedied. Nonetheless, government can and should take further steps to provide remedies to these individuals. Apologies to individuals affected by government's investigations and decisions are recommended, in addition to making an overall public apology. In recognition that its conduct has caused harm to identifiable individuals *ex gratia* payments to several people are recommended.

Two steps to honour the memory of Mr. Roderick MacIsaac are recommended:

- an endowment for a scholarship for doctoral students at the University of Victoria be funded, and
- an annual Ministry of Health staff award for excellence in training, mentoring and supporting co-op students be established.

SYSTEMIC RECOMMENDATIONS

Recommendations that relate to the systemic issues encountered in this matter are made. Many of these systemic recommendations are aimed at preventing the events described in this report from recurring, and as such they relate to:

- standards for the conduct of public service investigations
- employment standards of conduct
- data access suspensions
- public service employment suspension and dismissal decisions
- obtaining and responding to legal advice
- BC Coroners Service policy.

In addition, some of these systemic recommendations are aimed at remedying some of the broader impacts of the investigation. They include:

- public interest disclosure legislation
- organizational reconciliation in the Ministry of Health
- evidence based research, evaluation and decision making

CONCLUSION

The Select Standing Committee referred this investigation to our office in July 2015 with the expectation that we would be able to answer many of the significant questions that remained about the 2012 Ministry of Health investigation and subsequent events. This report describes, in significant detail, our understanding of when, why and how these events unfolded as they did. While our report has focused on a particular series of events, the circumstances of this case offer important lessons for the B.C. public service as a whole.

Ombudsperson Recommendation Summary

	Recommendations Pertaining to Employees, Contractors and Researchers	Date
Ex Gratia Payments		
1	By June 30, 2017, government make an *ex gratia* payment in the amount of $75,000 to each of Dr. Malcolm Maclure, Dr. Rebecca Warburton, Ron Mattson, Robert Hart, Ramsay Hamdi, David Scott, and the estate of Roderick MacIsaac.	June 30, 2017
2	By June 30, 2017, government make an *ex gratia* payment in the amount of $50,000 to each of Mark Isaacs, Dr. Colin Dormuth and Dr. William Warburton.	June 30, 2017
3	By June 30, 2017, government make: a. an *ex gratia* payment in the amount of $15,000 to each of six public servants who were also subjects of the investigation; and b. in the case of the three individuals in paragraph (a) who were disciplined, reverse the financial impact of that discipline and remove the disciplinary findings from their employment record.	June 30, 2017
4	That government: a. By September 30, 2017: i. Establish a compensation fund in an amount not less than $250,000 ii. Identify and contact individuals (other than individuals identified in the other *ex gratia* payment recommendations) who were employees, associates or research subcontractors of: 1. Resonate 2. Blue Thorn Research and Analysis Group 3. The Therapeutics Initiative who were impacted by the data and contract suspensions and cancellations and invite them to make applications to the fund. b. By March 31, 2018, make *ex gratia* payments to the applicants from the fund on a fair and equitable basis, taking into account the impact the data and contract suspensions and cancellations had on them.	September 30, 2017 March 31, 2018
5	By June 30, 2017, government make an additional ex gratia payment in the amount of $50,000 to each of Ron Mattson and Mark Isaacs.	June 30, 2017
Re-Opening the Settlement of Grievances		
6	If by June 30, 2017, the BCGEU, following consultation with David Scott, Ramsay Hamdi, and a representative of the estate of Roderick MacIsaac, approaches government about revisiting any or all of the June and September 2013 grievance settlements, that government: a. Enter into good faith negotiations with the BCGEU concerning the replacement of the existing settlements with new settlements, and b. If new settlements cannot be reached (or the parties prefer this option as their primary option), make its best efforts to work with the BCGEU to develop a Statement of Agreed Facts concerning the circumstances of the dismissals, which Statement the parties can agree to place before a labour arbitrator pursuant to the collective agreement, in order to allow for a proper adjudication of damages. Whether the existing settlements would terminate upon tendering the Statement of Agreed Facts, or after the labour arbitrator's decision, can be addressed by the parties as a matter of labour law.	June 30, 2017
Apologies		
7	By May 31, 2017, government make a public statement that acknowledges and apologizes for the harm caused by the Ministry of Health investigation and the decisions that resulted, including the employee suspensions, employee discipline and terminations, contract suspensions and terminations, and unwarranted data suspensions.	May 31, 2017

Ombudsperson Recommendation Summary

	Recommendations Pertaining to Employees, Contractors and Researchers	Date
8	By July 31, 2017, government issue a personal apology to each of Dr. Malcolm Maclure, Dr. Rebecca Warburton, Ron Mattson, Robert Hart, Ramsay Hamdi, David Scott, Dr. William Warburton, the family of Roderick MacIsaac, Mark Isaacs, Dr. Colin Dormuth, Contractors 1 and 2, and the six public servants referred to in recommendation R3.	July 31, 2017
9	By March 31, 2018, the Ministry of Health issue a written apology to each of the individuals to whom an *ex gratia* payment is made from the compensation fund established in recommendation 4.	March 31, 2018
10	By March 31, 2018, the Ministry of Health issue a written apology to each person not included in the above recommendations, to whom it sent a data demand letter in 2012 and 2013 as a consequence of the investigation.	March 31, 2018
	Personal Property of the Terminated Employees	
11	By May 31, 2017, the Ministry of Health make arrangements for each of Dr. Malcolm Maclure, Dr. Rebecca Warburton, Ron Mattson, Robert Hart, Ramsay Hamdi, David Scott, Dr. William Warburton and a representative for the estate of Roderick MacIsaac to review the contents of the boxes of material packed up from their offices for the purpose of identifying, and having returned to them, any books, papers, articles or other personal belongings.	May 31, 2017
	Investigation Conducted by the Investigation and Forensic Unit of the Office of the Comptroller General	
12	By June 30, 2017, government issue a public statement confirming that the ministry has withdrawn the final report of the Investigation and Forensic Unit, and acknowledge that the report contains inaccuracies and will not be relied on.	June 30, 2017
13	By June 30, 2017, the Ministry of Finance send a letter of apology to each of the individuals named in the report of the Investigation and Forensic Unit, who it notified following the unauthorized disclosure of the report, confirming that the ministry has withdrawn the report and that the report will not affect the ability of those individuals to work for or with government in the future should they wish to do so.	June 30, 2017
14	By June 30, 2017, government make an additional *ex gratia* payment in the amount of: a. $25,000 to Dr. Malcolm Maclure b. $25,000 to Dr. Rebecca Warburton	June 30, 2017
	Honouring Roderick MacIsaac's Memory	
15	By September 30, 2017, government provide funding in the amount of $500,000 to endow a scholarship for PhD candidates at the University of Victoria.	September 30, 2017
16	By September 30, 2017, the Ministry of Health establish an annual staff award for excellence in training, mentoring and supporting co-op students.	September 30, 2017
	Standards of Conduct for Public Service Employees	
17	By March 31, 2018, the Public Service Agency develop and implement a policy framework for assessing situations to determine whether a real or perceived conflict of interest exists. The framework should: a. Require employees to disclose circumstances that may give rise to a real or perceived conflict of interest, including any outside remunerative work. b. Specifically require issues of conflict of interest to be addressed at the outset of employment and on an ongoing basis where the employee's job function or less than full-time employment necessarily contemplates external remunerative work or external affiliation. c. Where a disclosure is made by an employee under paragraph (a), the employer shall identify the specific work duties of the employee and the underlying government interests that are relevant to the circumstances.	March 31, 2018

Ombudsperson Recommendation Summary

	Recommendations Pertaining to Employees, Contractors and Researchers	Date
	i. Identify the specific personal interests of the employee that are relevant to the circumstances. ii. Analyze whether those interests conflict, or could be perceived to conflict, in a way that impairs the employee's ability to act in the public interest, undermines the public's confidence in the employee's ability to discharge work responsibilities, or undermines the public's trust in the public service. iii. Decide whether the circumstances give rise to a perceived or actual conflict of interest, and, if they do, consider whether there are steps that government or the employee must take to address or mitigate the conflict such that it does not pose an unacceptable risk to government or the public interest. iv. Document, on the employee's personnel file, and elsewhere as is required in the circumstances, the reasons for the conclusion reached and the directions, if any, to be followed. A copy of the reasons should be provided to the employee. v. To the extent reasonable and necessary, be transparent within the organization about how the conflict of interest has been addressed so that misunderstandings are minimized.	
18	By March 31, 2018, every ministry and government agency whose employees are subject to the public service Standards of Conduct assign a senior and fully trained staff member the task of assessing and providing advice to the employee and their supervisor about disclosed prospective conflicts of interest in their organization.	March 31, 2018
	Standards for the Conduct of Public Service Investigations	
19	By March 31, 2018, the Public Service Agency revise its existing Accountability Framework for Human Resource Management to ensure a clear allocation of responsibility among senior executives of PSA and of line ministries responsible for ensuring that any internal human resource investigations occurring under their leadership: a. are conducted in accordance with the principles of administrative fairness, b. have a clearly articulated scope and focus, both of which are reassessed on a regular basis, and c. have appropriate lines of reporting.	March 31, 2018
20	By March 31, 2018, the Public Service Agency undertake, and publish the results of, an independent compliance review of its investigatory policies established in response to the McNeil Review.	March 31, 2018
21	By September 30, 2017, to ensure that the principles of administrative fairness are appropriately exercised by the Investigation and Forensic Unit (IU): a. The IU implement a program of ongoing professional development on administrative and procedural fairness for its investigators and any employees leading an investigation. b. The IU revise its draft policies and procedures manual to adequately integrate the principles of administrative fairness into its investigative approach. c. The Comptroller General review each investigative plan developed by the IU to ensure that the plan's scope is appropriate, and within jurisdiction, and the office can adequately resource the investigation as set out in the plan. d. The Comptroller General reassess the investigative plan on a regular basis, in consultation with the IU, and authorize adjustments to investigative scope or resources as necessary.	September 30, 2017

Ombudsperson Recommendation Summary

	Recommendations Pertaining to Employees, Contractors and Researchers	Date
22	By September 30, 2017, the Ministry of Finance provide a report to the Auditor General on the progress of implementing each recommendation of the KPMG report. Such reporting is to continue quarterly or on such other schedule and for as long as specified by the Auditor General.	September 30, 2017
	Referring Matters Under Investigation to the Police	
23	By March 31, 2018, the Ministry of Justice develop: a. for approval by the Head of the Public Service, a new procedure regarding reporting employee misconduct in non-emergency situations to the police, b. and implement training for public service investigators who, as part of their duties, report potential crimes to the police. This training should focus on: i. the factors to consider in determining whether to report a potential crime to the police, and ii. what information is appropriately shared with the police, particularly in the absence of a legal requirement to do so.	March 31, 2018
	Data Access Suspensions	
24	By December 31, 2017, following consultation with the Information and Privacy Commissioner, the Ministry of Health create new guidelines for making decisions about suspending access to administrative health data. The guidelines should address the flaws in ministry practice that we identified in this report including better defining the threshold for data suspensions in cases where there is only an unconfirmed suspicion of a data breach.	December 31, 2017

	Public Service Employment Suspension and Dismissal Decisions	Date
	Dismissal for Just Cause	
25	By June 30, 2017, the Public Service Agency (PSA) and the Head of the Public Service develop and implement a policy that requires the following steps to take place before a Deputy Minister dismisses an employee for just cause under section 22(2) of the *Public Service Act*: a. In relation to excluded employees, the PSA obtain a written legal opinion about whether there are sufficient grounds to support the termination. The PSA should provide its lawyer with sufficient background and file material for the lawyer to assess the evidentiary strength of the government's just cause position. b. In relation to included employees, the PSA obtain written senior labour relations advice about the strength of government's just cause position from one of its senior labour relations advisors. The PSA should provide its advisor sufficient background and file material for the advisor to assess the evidentiary strength of the government's just cause position. c. The Deputy Minister with authority to dismiss, be required to review and consider the PSA's advice, and the legal advice, prior to making a decision about whether to terminate an employee for cause. Such consideration should be confirmed in writing.	June 30, 2017
	Suspensions Without Pay of Excluded Public Servants	
26	Effective immediately, government cease its practice of suspending excluded employees without pay pending an investigation in the absence of authority in the *Public Service Act* to do so.	April 6, 2017

Ombudsperson Recommendation Summary

	Public Service Employment Suspension and Dismissal Decisions	Date
Oversight of Dismissal Decisions		
27	By March 31, 2018, government introduce legislation for consideration by the Legislative Assembly to amend the *Public Service Act* to provide the Merit Commissioner with the authority to: a. Conduct reviews of all public service dismissals for just cause, to ensure adherence to public service standards and legal requirements. Such reviews are to take place following the completion of all labour relations or litigation proceedings related to the termination. b. Publicly report the results of these reviews, along with whatever recommendations the Merit Commissioner considers appropriate in the circumstances.	March 31, 2018
Announcements About Employee Discipline		
28	By June 30, 2017, the Public Service Agency and Government Communications and Public Engagement make public their policies regarding internal and external communications about personnel matters.	June 30, 2017
29	By June 30, 2017, the Public Service Agency and Government Communications and Public Engagement develop and make public a policy on announcing police referrals related to the conduct of a public servant. The policy should clearly state that unless there is an immediate risk to public health, safety or other similar exceptional circumstances, government should not publicly announce that it has referred the conduct of a public servant to the police prior to Crown Counsel approving charges.	June 30, 2017
Ensuring Effective Executive Transitions		
30	By September 30, 2017, the Public Service Agency provide a report to the Head of the Public Service on ensuring excellence in executive transitions so that senior executives new to their portfolio are appropriately and effectively supported to immediately carry out their new responsibilities.	September 30, 2017
Obtaining and Responding to Legal Advice		
31	By March 31, 2018, the Head of the Public Service establish written protocols that address: a. Who has the authority to decide that government will not follow risk-based legal advice; b. The process to be used when ministries decide to act contrary to legal advice, including how decisions in such situations are to be escalated, disputes resolved and outcomes documented; and c. The process to be followed when limited legal advice is obtained, including who needs to be advised that the scope of the advice is limited.	March 31, 2018
Public Interest Disclosure Legislation		
32	By March 31, 2018, government introduce, for consideration by the Legislative Assembly, public interest disclosure legislation that provides for the reporting, assessment, fair investigation, resolution and independent oversight of allegations about wrongful conduct within the government of British Columbia.	March 31, 2018
Organizational Reconciliation at the Ministry of Health		
33	By September 30, 2017, and following consultation with the BCGEU and BC Excluded Employees' Association, and in a manner consistent with its privacy obligations, the Ministry of Health develop and implement a carefully designed organizational reconciliation program with the goal of re-establishing positive, respectful professional relationships with staff and contractors who will productively support the mandate of the ministry moving forward. This program should:	September 30, 2017

Ombudsperson Recommendation Summary

	Public Service Employment Suspension and Dismissal Decisions	Date
	a. build on the recent ministry initiatives to support employee morale and engagement, invite the participation of ministry staff and contractors, b. involve the active participation of management, c. include clear objectives and deliverables, and d. be completed within 12–18 months by providing a final report to all ministry staff and contractors.	
	An Evidence-Informed Approach to Pharmaceutical Management	
34	By September 30, 2017, the Ministry of Health review and assess the extent to which the termination of evidence-based programs during the internal investigation may have created gaps that now remain in providing evidence-informed, safe, effective and affordable drug therapy and related health care services to British Columbians.	September 30, 2017
35	By December 31, 2017, to the extent that such gaps are found to exist as a result of the review under the preceding recommendation, the Ministry of Health publicly release a plan, with a reasonable timeline and transparent objectives and deliverables, to address the gaps.	December 31, 2017
	Positive Affirmation of Evidence- Informed Approaches	
36	By March 31, 2018, government establish a new category of Premier's Awards (in addition to the existing categories of leadership, innovation, legacy and partnership) to recognise public servants whose work is outstanding in the area of evidence-based or evidence-informed policy or program development.	March 31, 2018
	UBC's B.C. Academic Chair in Patient Safety	
37	By March 31, 2018, government grant $200,000 to the University of BC(UBC), Faculty of Medicine, Department of Anaesthesiology, Pharmacology & Therapeutics.	March 31, 2018
38	By March 31, 2018, UBC and the government meet to discuss the sufficiency of the 2005 endowment regarding patient safety.	March 31, 2018
	BC Coroners Service Policy on Disclosure of Estate Records	
39	By September 30, 2017, the BC Coroners Service develop a policy about disclosure, to a deceased's family or personal representative, of documents discovered on the deceased person's electronic devices, including password-protected and cloud-stored documents.	September 30, 2017
	Government's Consideration of Recommendations	
40	By April 20, 2017, government provide, in a single document, a response to each of the preceding recommendations, including stating whether it does or does not accept the recommendation. In the event government is of the view it cannot give due consideration to any particular recommendation within that time, it may identify the recommendation, the reason further time is required and the timeline within which it will respond.	April 20, 2017
	Ongoing Monitoring	
41	By April 30, 2018, government provide a written status report to the Ombudsperson on the implementation of the recommendations made in this report, and at such other times as required by the Ombudsperson.	April 30, 2018

FACT SHEET

Assisted Living – Seniors Residences

ISSUE

The government is committed to promoting health and safety for vulnerable adults receiving assisted living services under the *Community Care and Assisted Living Act* (CCALA). Seniors residences are one type of assisted living that is regulated by the CCALA.

KEY FACTS

- Assisted living is housing which supports adults by providing 1 or 2 prescribed services (i.e., medication management, daily living assistance) and five hospitality services (meals, housekeeping, laundry, recreation, emergency response system).
- Residences which meet the CCALA definition of assisted living are required to be registered with the provincial assisted living registrar, regardless of whether they are publicly subsidized.
- As of February 2017, 218 assisted living residences for seniors (both publicly subsidized and private pay) have been registered with a total of 8,017 registered publicly subsidized and private pay units (56% of these are publicly subsidized).[1]
- The total number of publicly subsidized assisted living units in BC as of February 2017, was 4,464: 1,393 in Fraser Health Authority, 931 in Interior Health Authority, 993 in Vancouver Island Health Authority, 288 in Northern Health Authority, and 859 in Vancouver Coastal Health Authority.[2]
- Since September 2012, high level information from substantiated complaints has been posted on the Ministry of Health's Assisted Living Registry (ALR) website.
- From January 1 to December 31, 2016, the ALR received 48 complaints about seniors' residences, with 115 different health and safety issues.
- 4 of the 48 complaints were substantiated after investigation; 2 reports have been posted and 1 will be posted on the ALR website.
- In 2016, the ALR conducted a total of 18 site inspections at seniors' assisted living residences. 14 inspections were related to a health and safety concern, 3 inspections were pre-registration, and 1 inspection was of a possible unregistered residence.[3]
- The ALR received and investigated 395 serious incident reports in seniors' assisted living residences in 2016.[4]
- As of February 3, 2017, the ALR has 19 complaints regarding seniors' assisted living residences under investigation.[5]

Background

- The CCALA, which came into force in 2004, established an Assisted Living Registrar to oversee registration and respond to concerns about health and safety in assisted living residences.
- In January 2012, the registry operations were moved into the Ministry to ensure alignment of the Registrar's work. The Assistant Deputy Minister of the Primary and Community Care Policy Division was appointed as the Assisted Living Registrar.
- The ALR is responsible for registering assisted living residences, and responding to complaints or other information that indicates residences are being operated in a way that does not ensure the health and safety of the residents, or that an unregistered assisted living residence is being operated. Anyone with a concern can complain to the registry. Registry staff conduct investigations that are remedial in nature.

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[1] Assisted Living Database, February 10, 2017
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Assisted Living Database, February 3, 2017

FACT SHEET

- In 2016, government amended the CCALA to increase flexibility and allow more than 2 prescribed services to be provided in assisted living. This change was made in response to recommendations by the Seniors Advocate and other stakeholder groups, who were of the opinion that people who could still live safely in assisted living were being moved into residential care prematurely.
- The amendments to the CCALA also included enhancements to the registrar's inspection and enforcement powers, and increased protections for residents. The amendments will be brought into force once assisted living regulations have been developed, and are ready to be implemented.

FINANCIAL IMPLICATIONS

- The monthly client rate for publicly subsidized assisted living units is set at 70% of the client's after-tax income, subject to the minimum and maximum rate. The maximum rate is based on a combination of market rent for housing and hospitality costs for that geographic area, plus the actual cost of personal care services for the client.
- As of January 1, 2017, the minimum monthly rate for publicly subsidized assisted living services is $931.50 per month for a single client, and $1501.80 per month for a couple.
- The minimum monthly rate is adjusted each year to reflect the changes in the federal supplements (OAS/GIS) as of July 1 of the previous year.
- Client rates are reviewed annually based on income information received from the Canada Revenue Agency. In the fall of each year, health authorities notify clients of their new client rate, effective January 1 of the following year.
- Clients that do not consent for the Canada Revenue Agency to release income information to the Ministry to establish the client rate are charged the maximum client rate for assisted living services.
- Clients who believe that payment of their client rate will cause them serious financial hardship can apply to their health authority for a temporary rate reduction of their client rate.
- Clients in publicly subsidized assisted living units are responsible for paying for certain costs, such as Medical Services Premiums, Fair PharmaCare coverage, personal telephone, and cable television. However, low-income clients pay nothing for Medical Services Premiums, and pay no more than $250 per year for their PharmaCare costs, depending on their income. In addition, there may be charges in different settings for other optional services or activities, such as transportation, or help with errands that are not considered hospitality or personal care services.

Approved by:
Sharon Stewart, obo Doug Hughes, Primary and Community Care Division; February 17, 2017
Christine Voggenreiter, obo Teri Collins, Health Sector Information, Analysis and Reporting Division; February 23, 2017
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; May 9, 2017

FACT SHEET

Client Rates for Residential Care Services

ISSUE

Clients receiving subsidized long-term residential care services pay an income-based monthly rate. The rates are updated annually, based on the client's income information from the Canada Revenue Agency, subject to a minimum and maximum monthly rate. Clients receiving short-term residential care services pay a fixed daily rate.

KEY FACTS

Income-Based Client Rates

- Clients receiving long-term residential care or family care home services pay a monthly client rate based on 80% percent of their after tax income towards their housing and hospitality costs, subject to a minimum and maximum monthly rate.
- As of January 1, 2017, the minimum monthly client rate is $1,104.70. The minimum rate is adjusted annually based on changes to the Old Age Security/Guaranteed Income Supplement rate as of July 1 of the previous year.
- As of January 1, 2017, the maximum client rate is $3,240 per month. The maximum client rate is adjusted annually based on changes to the Consumer Price Index over the previous year.

Fixed Client Rates

- Clients receiving short-term residential care services for respite care, convalescent care, or hospice/end-of-life care are assessed at a fixed daily rate, based on the minimum monthly rate for long-term residential care services.
- As of January 1, 2017, the fixed daily rate for short-term residential care services is $36.30.

Minimum Residual Income

- Client rates are calculated so that most clients receiving residential care services retain a minimum residual income amount to cover personal expenses, such as personal toiletry items or over-the-counter medications.
- On February 1, 2012, the Government of BC increased the minimum residual income amount from $275 per month to $325 per month. The increase in the minimum residual income amount ensures that the additional Old Age Security/Guaranteed Income Supplement benefits are not counted as income when assessing client rates. When implemented, this was the highest minimum residual income amount in Canada.

Temporary Reduction of the Client Rate

- If payment of the assessed client rate would cause the client or their spouse/dependents serious financial hardship, the client can apply to their health authority for a temporary reduction of their client rate.[1]
- In 2013, the temporary rate reduction process was revised, based on a standardized approach to ensure consistency across the province, to make the process more fair and transparent for clients, their family members and caregivers, and the public.

Background

- On February 1, 2010, the Government of BC introduced a more equitable client rate structure which was phased in over the following 2 years. Prior to the rate restructuring, lower-income clients were paying a higher percentage of their income in relation to higher-income clients. The

[1] See Home and Community Care Temporary Rate Reductions fact sheet.

revised client rate structure ensures that clients who can least afford the cost of residential care services are not unreasonably charged.

- Client rates are intended to cover housing and hospitality costs, including meals, routine laundry and housekeeping. Health authorities cover the cost of care, such as nursing, in all publicly subsidized residential care facilities.
- The rate setting methodology for clients receiving residential care services is set out in the Continuing Care Fees Regulation, the Hospital Insurance Act Regulations, and the Home and Community Care Policy Manual.
- Client rates are updated annually by the automated Health Authority Rate System, using income information obtained from the Canada Revenue Agency with the client's prior consent.

FINANCIAL IMPLICATIONS

Health authorities reported revenues of approximately $177 million in 2015/16, related to health authority owned and operated residential care facilities. Based on this information, the estimated total amount of residential care client rate revenue is $485 million annually.

Approved by:
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; November 29, 2016
Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; February 17, 2017

FACT SHEET

Residential Care Staffing Review Report

ISSUE

- A number of events in BC, culminating in the posting of the Office of the Seniors Advocate's (OSA) *Residential Care Facilities Quick Facts Directory* in January 2016, which indicated that 81% of facilities were operating below 3.36 direct care hours per resident day (HPRD), have brought to light concerns about the progress in implementing the Ministry of Health staffing guideline in residential care facilities and the impact on quality of care and residents.
- The OSA released a 2017 version of their *Residential Care Facilities Quick Facts Directory* in January 2017, which shows the percentage of facilities operating below 3.36 HPRD has increased. Some of the change may be attributed to differences in reporting from one year to the next (e.g., 1 health authority included special care units (which have higher staffing levels) in the 2016 report, but not in the 2017 report.
- The Minister of Health asked Parliamentary Secretary Darryl Plecas to work with the OSA and Ministry staff to examine quality of care, staffing levels and funding in residential care facilities, and report back to him.
- Ministry staff worked in collaboration with key stakeholders to undertake: Key/Expert Interviews (including Alberta and Ontario); Document Acquisition and Review; Health Authority Current State Questionnaire; Literature Review; Data Analyses; and Application of the Residential Care Staffing Framework Staffing Model.
- A *Residential Care Staffing Review Report* was released on March 9, 2017, in conjunction with *An Action Plan to Strengthen Home and Community Care for Seniors*. The purpose of the Report was to determine what, if any, changes needed to be made in the residential care system to ensure consistency, transparency and accountability across the province in meeting resident's needs, sustainability and align with the Ministry's focus on patient-centered care in the community.
- A literature scan was conducted that involved a search for long-term care in conjunction with quality, staffing and budget. Similar to findings from a 2007/08 search, the literature review findings identified facility staffing decisions should be made based on evidence-based staffing frameworks that incorporate variables that positively affect resident and staff outcomes. Other articles reviewed indicated that, in general, staffing levels were predictors of care quality and increased staffing levels could improve care and resulted in better outcomes or decreased severity of deficiencies. Findings also indicated nursing staff affects the quality of care in facilities; staffing stability is associated with better patient outcomes and likewise, staffing instability with poorer outcomes; staffing challenges that negatively affect quality include director of nursing turnover, staff turnover, changes in staffing pattern (e.g., decrease in staffing levels or change in staffing mix), high levels of absenteeism; limited time available to train staff; and effectiveness of minimum staffing standards is unknown and staffing should be allocated according to particular resident needs.
- The Jurisdictional Review found that both Alberta and Ontario have standard province-wide funding models using interRAI organizational outputs (Resource Utilization Groups and Case Mix Index); Alberta talks about 2 measures - 3.02 worked hours or 3.67 paid hours; and Ontario does not have a target for HPRD, but rather monitors quality through inspections and using interRAI Quality Indicators.
- Input from health authorities and industry indicated health authority concerns about lack of clarity on contracted site operating costs, provincial policies being implemented without additional funding (e.g. basic wheelchairs), and the cost of collective agreement negotiations and generous entitlements for vacation and sick leave in collective agreements. Industry's concerns are about the need to increase funding for HPRD, lack in consistency between health authorities in

approaches to provision of services; differing definitions of direct care hours, challenges attracting and retaining staff, policies being implemented without additional funding (e.g. basic wheelchairs), and inconsistent interpretation of regulations and licensing.

- The Report action plan calls for the implementation of the 16 actions as follows:

Category	Action	Proposed Timeline
Funding and Staffing	1. Finalize a report, in collaboration with CIHI, to better understand the demand for home health, assisted living and residential care services (including the different profiles of clients using RAI assessment and service episode data) given the changes taking place in the home and community care system, and to inform required changes to existing residential care service models.	May 2017
	2. Confirm the definition of direct care hours per resident day.	July 2017
	3. Establish a baseline for: hours per resident day, client case mix, other identified residential care costs.	Sept. 2017
	4. Work with health authorities and industry to create and implement an interim targeted process that would increase hours per resident day for areas with identified gaps until a costing review has been completed and the funding model has been updated to incorporate client complexity.	Oct. 2017
	5. Move towards a province-wide standard residential care funding model, with a lens to incorporate resident complexity (using RUGs and case mix index from RAI assessments), quality of care and flexibility.	Jan. 2018
	6. Complete an analysis of percentage of casual and part-time positions that can potentially be converted to regular full-time positions in residential care facilities.	June 2017
	7. Develop an interim strategy to address immediate high-priority vacancies in residential care facilities.	June 2017
	8. Develop a health human resources plan to ensure supply of staff will meet the needs of the residential care sector. The plan will include targeted recruitment activities and seat-planning in post-secondary programs.	Nov. 2017
Quality of Care	1. Prioritize key quality of care initiatives in residential care and facilitate a coordinated approach that promotes consistency and standardization, yet allows for flexibility given varying needs across facilities.	April 2018
	2. Bring into force Part 3 (care facility admission) of the *Health Care (Consent) and Care Facility (Admission) Act* to protect vulnerable adults. This work will include revising the residential care admission policy to be more person and family-centred.	April 2018
	3. Develop and implement palliative and dementia care policy including requirements and targets for staff education.	April 2018
Accountability	1. Incorporate the requirement to increase hours per resident day through annual bi-lateral agreements between the Ministry and health authorities.	April 2017
	2. Monitor health authority progress on achieving the 3.36 hours per resident day and produce annual reports for Leadership Council.	April 2018
	3. Develop and implement a policy to mandate accreditation for all residential care facilities.	April 2018
	4. Develop and implement performance measures that support quality of care and quality of life outcomes using outputs from RAI assessment and survey data including quality indicators.	April 2018
	5. Develop and implement a process and policy for monitoring, reporting and evaluation processes related to resident need, funding, service delivery and operations, building on experience from other provinces such as Alberta and Ontario to assess whether quality, funding and staffing policies and goals are being achieved.	April 2019

FINANCIAL IMPLICATIONS

- In 2009, the incremental cost to achieve an average of 3.36 total direct care staffing levels for each health authority was estimated at about $215 million annually. By 2011/12, health authorities reported a total of $85.62 million being re-invested into residential care due to the change in the residential care client rate structure, of which $52.51 million was invested in increasing nursing, allied health, and care aide staffing levels. Health authorities have maintained that level of investment and reported small growth in the subsequent years. As of 2015/16, the health authorities reported the annual incremental investment had reached $90.60 million. In 2016, based on current staffing levels and costs, it was estimated that incremental annual funding of $113.7 million would be required to fully achieve an average of 3.36 hours per resident day by health authority, with an increase of approximately 1,511 FTEs (includes 886.7 care aides).

FACT SHEET

- On March 9, 2017, government announced a significant funding boost to strengthen care for BC seniors to support the actions identified in the review of residential care services, as well as other key action areas identified in the Home and Community Care Action Plan. The Province is investing $500 million over the next 4 years as part of a Ministry of Health action plan to improve home and community supports and quality of care for older British Columbians. Over the next 4 years, year-over-year funding increases from the Ministry will enable each health authority to reach an average of 3.36 direct-care hours per resident day across both publicly administered and contracted residential-care facilities. Increased staffing levels will also address a key recommendation from the Ombudsperson's Best of Care (Part 2) report on seniors' care.

Approved by:
Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; May 14, 2017
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; May 29, 2017

FACT SHEET

Seniors' Information

ISSUE

The Ministry of Health develops and disseminates information about government programs, services and initiatives for seniors through a suite of print-based 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]; 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]; and 61.9% of Canadian Internet users aged 65 and over used the Internet to search for medical or health-related information.[3]
- 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 March 2015 report, *B.C. Seniors Survey: Bridging the Gaps*, which indicates low awareness of seniors' programs, especially among low-income seniors, older seniors, and seniors in the north).

Seniors BC 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 and Elder Abuse Prevention Information kits,
    - Promotion of events such as World Elder Abuse Awareness Day (WEAAD), Seniors' Week and the International Day of Older Persons,
    - Links to information and resources such as the Office of the Seniors Advocate website, the new Aging Well section of Healthy Families BC.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 Office of the Seniors Advocate continue to receive requests for print resources. Other seniors embrace technology and increasingly make use of devices such as laptops, tablets and e-readers. To reach as many seniors as possible, the Seniors' Health Promotion team produces both print and electronic versions of key publications such as the

[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

BC Seniors' Guide, the *Healthy Eating for Seniors* handbook and Elder Abuse Prevention Information kits, which are all available in English, French, Chinese and Punjabi.

- An updated 11th edition of the *BC Seniors' Guide* was released earlier this year. In response to the Office of the Seniors Advocate's March 2015 *Bridging the Gaps* report, the 11th 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 Office of the Seniors Advocate, 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.ca 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:
    - HealthLinkBC.ca and 8-1-1;
    - Office of the Seniors Advocate;
    - Crown Publications Online Catalogue;
    - HealthyFamiliesBC Twitter account;
    - The Aging Well website (www.healthyfamiliesbc.ca/aging-well)
    - 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 cost to complete the new (11th) edition of the *BC Seniors' Guide* in English, French, Chinese and Punjabi was approximately $580,000 (including updating, editing, translation, printing, and the e-book) in 2015/16.

Approved by:
Sharon Stewart, obo Doug Hughes, Health Services Policy Division; October 30, 2016
Maria Furmek, obo Manjit Sidhu, Finance and Corporate Services Division; November 2, 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 5 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 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 2 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.
- Legal action around Cambie is still ongoing. The audits of the remaining extra billing clinics have been directed to become a priority for BIP to complete.

<u>Remaining Audits</u>

- In 2013, a letter was sent to the remaining ten clinics, which followed-up on the audit notification they received in 2008. This 2013 letter informed them that an audit of their clinic is still planned. To date, there has been no further correspondence with the clinics.
- The next audit to be scheduled is s.15 . BIP is in the process of drafting an audit plan.

<u>Other Private Clinic Audits</u>

Clinic	AIC Approval Date
s.15	

FACT SHEET

- s.15

FINANCIAL IMPLICATIONS

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

Approved by:
Marie Thelisma, Audit and Investigations Branch; February 10, 2017
Manjit Sidhu, Finance and Corporate Services Division; March 16, 2017

FACT SHEET

Extra Billing – *Canada Health Act*

ISSUE

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

KEY FACTS

- The BC Government is committed to upholding the principles of the *Canada Health Act* and to our publicly funded health care system, in which access to medically necessary services is based on a patient's clinical need rather than ability to pay.
- The Act requires provinces to submit a financial statement each December showing the amount charged to patients through extra billing and/or user charges for the fiscal year ending 21 months previously (e.g., December 2016 for 2014/15).
- Amounts reported by BC to Health Canada on extra billing and/or user charges, and corresponding federal deductions for prior years were:
  - 2014/15 - $184,508 s.17
    s.17
  - 2013/14 - $204,145
    s.17
  - 2012/13 - $241,637
    s.17
  - 2011/12 - $224,568
    s.17
  - 2010/11 – $280,019
    s.17
  - 2009/10 - $33,219
  - 2008/09 - $75,136
  - 2007/08 - $73,925
  - 2006/07 - $66,194
  - 2005/06 - $42,509
  - 2004/05 - $114,850
  - 2003/04 - $29,018
  - 2002/03 - $72,464
  - 2001/02 - BC declined to submit a report for 2001/02, with the result that Health Canada levied a deduction, apparently based on media reports about the extent of extra-billings by private clinics in BC.
  - 2000/01 - $4,610
- Reported extra-billing has generally been associated with private surgical facilities or specialist consultation services.
- The Ministry's Medical Beneficiary Branch follows up on all alleged cases of extra billing that are brought to its attention by writing to the physicians and clinics involved requesting refunds to patients of any inappropriate charges. Unresolved cases are referred to the Medical Services Commission for further review and/or action.

- On average, the Medical Beneficiary Branch investigates approximately 30 cases of extra billing annually.

FINANCIAL IMPLICATIONS

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

Approved by:
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 15, 2017
Brenda Rafter, obo Daryl Conner, Finance and Corporate Services Division; February 20, 2017

FACT SHEET

IHealth

ISSUE

IHealth is the Vancouver Island Health Authority's (Island Health) version of a health authority wide electronic health record (EHR). IHealth was implemented at Nanaimo Regional General Hospital (NRGH) and Oceanside Medical Centre and Dufferin Place in early 2016.

KEY FACTS

- Following implementation, the local medical staff association (MSA) raised concerns regarding medication and other errors. These concerns were raised to administration and media.
- This led to a quality and safety review conducted by Dr. Doug Cochrane, chair of the BC Patient Safety Quality Council. In November 2016, the Ministry of Health received and released Dr. Doug Cochrane's review.
- The report concluded the IHealth system should remain in place and Island Health, with medical staff, should jointly revalidate the order entry and clinical documentation functions of IHealth and refine these processes where appropriate to achieve the common goal of better and safer patient care.
- The report made 26 recommendations in the areas of improved safety, efficiency and future implementation. The recommendations included the establishment of an Oversight Committee to be co-chaired by the Ministry of Health and Island Health, with local medical staff representation. The committee would to oversee the 2 recommendations on validation of the order entry and clinical documentation capabilities.
- Since the report was issued, internal medicine physicians have continued to raise issues about the Computerized Provider Order Entry (CPOE) component of IHealth. CPOE enables health care providers to electronically enter orders for services, such as diagnostic tests, medications or surgery, rather than through traditional methods, which relied on paper, verbal communications, telephone or fax.
- In February 2017, Island Health's Board agreed to suspend CPOE while the work of the Oversight Committee was taking place. When planning for the safe suspension of CPOE, it was determined that CPOE could not be separated from the other functions of IHealth without putting patient safety at risk. As a result, NRGH leaders requested new ways of supporting, and not suspending, CPOE.
- This request caused further local tension with some members of internal medicine reverting to writing paper orders. One internal medicine physician was issued a 24-hour suspension – for a variety of concerns.
- During the first week of May, an emergency meeting of the Health Authority Medical Advisory Committee (HAMAC) was held. The HAMAC recommended that recent practices related to paper orders should cease and that physicians "be required to enter orders for their patients directly into the EHR and utilize the supports offered by Island Health as a condition of continuing to be able to provide services at NRGH."
- Island Health board accepted the HAMAC resolution. A message was sent out to all staff and physicians at NRGH discussing the risks associated with writing paper orders, providing information about the HAMAC motion, discussing why other hospital wards cannot transition to paper orders like the ICU and Emergency Department, and indicating Island Health does not intend to use discipline to resolve the situation.
- Supports now in place to support internal medicine in using the EHR include:
    - elbow-to-elbow support from a nurse informaticist;

  - scheduled and on-demand 1:1 coaching;
  - a specialist in internal medicine is available to assist these physicians with their patients to allow the physician to spend additional time with a nurse informaticist if they chose to do so;
  - special computer orders that physicians can use if they are having trouble ordering or they are not sure what happened with their order;
  - 24-hour assistance available through an on-call nurse informaticist; and
  - the formation of a new EHR Quality Council formed to oversee changes and improvements to the EHR.
- On June 1st , the MSA, supported by the outgoing president of Doctors of BC, held a media conference at which they voiced their continued concerns regarding CPOE and asked that Island Health allow internal medicine to use paper orders like their colleagues in the ICU and Emergency Department. Island Health continues to maintain its position that internal medicine needs to use CPOE to ensure patient safety.

IHealth Background

- Island Health's IHealth system is based on Cerner's (US-based company) Model System configuration, based on Cerner's latest code version. The total investment into IHealth is $174 million.
- A Cerner-based EHR system was added to 230 new acute care facilities and 30,000 new hospital beds across 35 countries in 2015.
- Of the 7 Canadian health care organizations that have implemented advance EHR capability, 4 are Cerner clients.
- There are 34 Canadian health systems using Cerner-based CPOE, representing 3,835 physician partners.

FINANCIAL IMPLICATIONS

N/A

Approved by:
Ian Rongve, Hospital, Diagnostic and Clinical Services Division; June 14, 2017

FACT SHEET

Emergency Health Services in BC

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, in January 2016 BCEHS added 8 ambulances and 34 FTEs to be based at ambulance stations in Langley, Surrey, Abbotsford, and North Vancouver.
- Additionally, 2 more ambulances for Maple Ridge and Tri-Cities region were announced in September 2016.

Ambulance Services

- In 2015/16, BCEHS paramedics responded to over 571,000 patient events, including more than 474,000 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 608 vehicles (529 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 7,000 air ambulance calls.[2]
- There are 4 dedicated helicopter air ambulances in the province: 2in 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 committed to creating at least 80 new FTEs to support the implementation of community paramedicine programs between April 1, 2015 and March 31, 2019.
- Community paramedics have been hired in 23 communities across BC so far and orientation is underway. Included in the 23 communities are 9 prototype communities which have completed the orientation process, and are moving ahead with providing CP services.

First Responder Agencies

- First Responder services are an important element for the provision of pre-hospital care in BC, and the partnership is essential between BCEHS, fire departments, and other agencies in responding to emergency events.
- 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 agreement. A total of 53 fire departments have joined the program as of October 3, 2016.

Collective Agreement

- BCEHS employees are represented by three unions – CUPE, BCGEU, and 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:
Jodi Jensen, BCEHS; October 24, 2016
Sharon Stewart, obo Doug Hughes, Health Services Policy Division; October 28, 2016

FACT SHEET

Emergency Health Services Treat and Release

ISSUE

BC Emergency Health Services (BCEHS) is developing a "secondary triage" function to address the issues of growing demand that will include clinical practice supports, policies and guidelines to specify the conditions under which transport to a recognized facility is not required (Treat and Release).

KEY FACTS

- BCEHS front line resources are at or beyond capacity due to increasing demands for service, and the current practice in which nearly every 911 call results in an ambulance being dispatched and the patient transported to hospital. This approach compromises the ability to provide the most appropriate skills and resources for patients and respond quickly to emergency calls.
- All BCEHS 911 calls are assessed over the telephone using the Medical Priority Dispatch System. Based on the acuity of the patient, BCEHS either;
    - Dispatches an ambulance to transport the patient to hospital, or
    - Redirects the least serious, non-emergency callers, to the HealthLinkBC 811 Nurse Line service for clinical advice and health system navigation.
- For the growing population of aging patients, those managing long-term chronic conditions and those with less acute illnesses and injuries, a visit to the emergency department is often not the best way to meet the patient's needs.
- Patients in need of urgent hospital care will always be transported by ambulance. However, BCEHS can offer a number of better care alternatives for patients and manage demand on emergency departments through alternative clinical responses, including the following:

Response	Description
"Hear and Advise" (or Self-Care)	With appropriate clinical guidance over the telephone, either provided by BCEHS or by a third party service (e.g. HealthLink BC), patient is able to manage their condition without need for healthcare services or transport.
"Hear and Treat" (or Self-Transport)	With appropriate clinical guidance over the telephone, either provided by BCEHS or by a third party service (e.g. HealthLink BC), patient is able to make their own way to the appropriate healthcare service (whether primary, community, or emergency service) and does not require ambulance transport.
"Hear and Refer"	Based on a telephone assessment, patient does not require immediate medical care and can be formally referred by BCEHS to a primary or community service available from their local health authority or other service provider. Patient does not require ambulance transport.
"Alternative Transport"	Patient requires medical care and transportation to the appropriate healthcare service now, but does not require paramedic care during transport. Alternative transport (e.g. taxi) can be arranged by BCEHS.
"See and Treat" (or "Treat and Discharge")	A paramedic is dispatched to assess the patient on scene. If possible, the paramedic provides treatment on scene and formally discharges the patient so they avoid a visit to hospital. If assessment shows that transport is required, the patient is taken by ambulance.

- These alternative responses offer a better patient experience, connecting patients with primary and community care, providing care closer to home, and avoiding the inconvenience of unnecessary emergency department visits.
- To ensure BCEHS can effectively and safely select the most appropriate clinical response, it needs to introduce a new function of "secondary triage." Medical Priority Dispatch System assessment will continue to be used to rapidly identify patients with time-critical need for an ambulance, and identify those patients that can be targeted for secondary triage.
- The secondary triage team will be comprised of an Advanced Care Paramedics and Registered Nurses who will call back targeted patients to conduct a detailed clinical assessment using structured tools.

FACT SHEET

- This assessment will identify patients whose clinical circumstances merit an increased priority of ambulance response (e.g. deterioration, pain, physical environment, etc.).
- This assessment will also identify patients whose needs can be met by alternative clinical responses.
- The secondary triage team will provide clinical oversight to all decisions that impact ambulance dispatch priorities, including non-ambulance responses. In the absence of direct intervention by the secondary triage team, ambulances will continue to be dispatched.
- The "secondary triage" does not replace the Emergency Physician Online Service (EPOS). Rather it is contemplated to work closely with EPOS. EPOS will continue to provide real time clinical advice to all Emergency Medical Assistants as required and to First Responders where agreements exist.
- Evidence from other jurisdictions shows that more than 10% of all 911 calls can be fully resolved at the scene. This avoids unnecessary transport to emergency departments, improving the patient experience, relieving emergency department congestion, and ensuring ambulances and crews are more available for timely response to life-threatening calls.
- Based on clinical evidence, BCEHS will develop clinical practice supports and guidelines to enable paramedic crews to Treat and Release patients where it is appropriate and safe to do so.
- These practice supports and guidelines will consider the license level of the attending paramedic, and whether the patient was previously assessed by secondary triage. BCEHS will continue to transport all patients where the attending crew is Emergency Medical Responder level.
- Where appropriate, clinical protocols will also include direct follow up with the patient by the secondary triage team to monitor the patient status and modify the clinical response if required. This will also be used to refine and improve the clinical protocols.
- Introducing secondary triage will result in significant changes to the patient experience of calling 911. A strategic communications plan will be developed to introduce these changes to the public, and measures of patient satisfaction established to evaluate the effectiveness of these changes.
- Additional stakeholder communication will be developed for health authorities, first responders, and police to identify changes in practice and expectations when interacting with BCEHS.
- Implementation will require training and supports for emergency medical dispatchers, paramedics, and secondary triage staff to ensure standardization of interactions with the public and stakeholders.
- The Ministry will ensure this type of care can be provided safely and effectively through appropriate regulatory and policy oversight.

FINANCIAL IMPLICATIONS

BCEHS has identified resources within the 2020 Action Plan and Business Plan to phase in the implementation of treat and release and the clinical triage system to support this practice. The cost for the first year of implementation is $1.7 million.

Approved by:
Ian Rongve, Hospital, Diagnostic and Clinical Services Division; February 10, 2017
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; March 27, 2017

FACT SHEET

Emergency Department Access

ISSUE

Timely access to urgent/emergency services is important to both patients and care providers. Emergency Department (ED) crowding is impacted by patient flow within the hospital, inpatient bed capacity/availability, and access to primary, community and residential care services. The Ministry of Health is working closely with health authorities and clinicians to improve access to high quality care in EDs.

KEY FACTS

ED Visit Volumes

Between 2010/11 and 2015/16, ED visits have been increasing at the highest rate in Fraser and Vancouver Island Health Authorities (23%). Moreover, both health authorities are seeing the greatest annual growth rate in visits during this period (just over 4% each year, compounded annually). For the province overall, the average annual growth rate in ED visits during this period was 3.28%.

Table 1: ED Visits by Health Authority, 2010/11 and 2015/16[1]

Health Authority	ED Visits, 2010/11	ED Visits, 2015/16	Percent Change	Avg. Annual Growth Rate 2010/11 to 2015/16)
Interior Health Authority	425,250	485,188	14.09%	2.67%
Fraser Health Authority	546,079	674,277	23.48%	4.31%
Vancouver Coastal Health Authority	356,068	418,494	17.53%	3.28%
Vancouver Island Health Authority	315,405	388,105	23.05%	4.24%
Northern Health Authority	267,912	280,515	4.70%	0.92%
Provincial Health Services Authority	40,578	46,607	14.86%	2.81%
British Columbia	**1,951,292**	**2,293,186**	**17.52%**	**3.28%**

ED Wait Times

- Based on the National Ambulatory Care Reporting System data for 2015/16, BC is meeting Canadian Association of Emergency Physicians nationally recommended time frame for the indicators (see below) which relate to the efficiency of services in the ED:
  - Time waiting for physician initial assessment in ED.
  - Lengths of stay for high acuity patients discharged directly from the ED.
- The busiest EDs in the province are all meeting (or close to meeting) nationally recommended timeframes for the time it takes to see a physician in the ED, and the time it takes to be treated and discharged.
- BC is not meeting the nationally recommended time frame for the following indicators:
  - Time waiting for inpatient bed after decision to admit; and
  - Total length of stay for ED patients admitted to hospital.

Actions to Improve Access

- The Ministry and health authorities have initiated the following actions to improve access to high-quality care in EDs across the province:
  - Investment in ED Information Systems.
  - Implementation of the National Ambulatory Care Reporting System at 29 EDs to allow in-depth analysis of ED utilization and patient length of stay.
  - Implementation of clinical care guidelines, in particular for stroke- and sepsis-affected patients.

[1] Source: OASIS/HAMIS, Health Sector Information, Analysis and Reporting Division, Ministry of Health

- Use of Clinical Decision Units for patients requiring a short stay (typically less than 24 hours) for clinical observation and treatment (as opposed to admitting these patients to an inpatient bed).
- Use of Fast Track or Rapid Assessment Zones for efficiently and cost-effectively assessing and treating low-acuity patients.
- Implementation of LEAN and patient flow initiatives in the ED and in the rest of the hospital.
- The Emergency Services Advisory Committee, comprised of emergency physicians and administrators from each health authority (including First Nations Health and Provincial Health Services), Doctors of BC, CIHI, UBC Faculty of Medicine, BC Patient Safety & Quality Council and the Ministry, has struck a group to explore options to decrease ED crowding and wait times.
- EDs are a key entry point of admission to a hospital. Given the capacity concerns in hospitals across the province, the Emergency Services Advisory Committee will be focusing on avoidable admissions from EDs over the next year.

- The Ministry and health authorities have also established initiatives to improve access to integrated primary and community care services, and help decrease avoidable ED visits including:
  - Mental Health and Substance Use Assertive Community Treatment (ACT): ACT teams support clients to maintain stable housing and self-management skills, engage in substance use treatment and recovery, and make healthier lifestyle choices.
  - Mental Health and Substance Use Acute Home Based Treatment (AHBT): Multi-disciplinary AHBT team provides home- based recovery oriented care, and support for clients and their families providing an alternative to hospital care.
  - BreatheWell at Home: An integrated model of care for clients with Chronic Obstructive Pulmonary Disease providing assessment; medical oversight; an enhanced home-based inter-professional care team; acute care practice/protocols; patient and provider education; medication management; and self-care support.
  - Home First: Enhanced community supports to help seniors with complex health care needs to be discharged from hospital and live safely at home, avoiding further hospitalization, and delaying or avoiding admission to residential care.
  - Familiar Faces: Interdisciplinary teams develop integrated shared care plans for clients with complex medical and mental health/addiction issues who make frequent ED visits.

FINANCIAL IMPLICATIONS

Since 2001, the BC Government, together with regional hospital districts and hospital foundations, have committed over $541 million to improve and expand more than 40 EDs across the province.

Approved by:
Ian Rongve, Hospital, Diagnostic and Clinical Services Division; February 15, 2017
Nancy South, obo Teri Collins, Health Sector Information, Analysis & Reporting Division; March 1, 2017
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; March 8, 2017

FACT SHEET

PharmaCare Overview

ISSUE

The PharmaCare program helps eligible BC residents with the costs of eligible prescription drugs, designated medical supplies and pharmacy services.

KEY FACTS

- PharmaCare is BC's drug insurance program and provides financial assistance to BC residents for eligible prescription drugs and medical supplies including:
    - drugs prescribed by physicians, surgeons, dentists, optometrists, midwives, podiatrists, naturopathic physicians or nurse practitioners;
    - insulin, needles, syringes, insulin pump supplies and blood glucose monitoring strips for people with diabetes;
    - insulin pumps for children and young adults; and
    - certain ostomy supplies, permanent prosthetics and children's orthotic devices.
- In 2015/16, PharmaCare expenditures were approximately $1.172 billion. PharmaCare's budget for 2016/17 is $1.175 billion. These amounts include benefits to British Columbians as well as additional payments and recoveries.
- PharmaCare is one of the best examples of drug coverage in Canada.[1] The quality of PharmaCare stems from the combination of comprehensive coverage for the province's residents and the drugs needed to achieve real health benefits.

Plan	Coverage Expenditures 2015/16	Approximate # of Beneficiaries 2015/16
Fair PharmaCare(Plan I) ($497.46 million regular; $182.20 million enhanced assistance).[2]	$679.66 million[2]	479,000[2]
Permanent Residents of Licensed Residential Care Facilities (Plan B)	$39.81 million[2]	30,000[2]
Recipients of BC Income Assistance (Plan C)	$368.37 million[2]	173,000[2]
Cystic Fibrosis (Plan D)	$1.70 million[2]	300[2]
Children in the At Home Program (Plan F)	$5.57 million[2]	3,000[2]
No-Charge Psychiatric Medication (Plan G)	$29.77 million[2]	35,000[2]
Medication Management Services (Plan M)	$17.51 million[2]	631,000[3]
BC Palliative Care Drug Plan (Plan P)	$19.37 million[2]	12,000[2]
Smoking Cessation (Plan S)	$11.84 million[2]	63,000[2]
The BC Centre for Excellence in HIV/AIDS (Plan X)	$123.32 million[4]	7,000

<u>Evidence-based Drug Decisions</u>

- PharmaCare has a rigorous drug review process for determining whether new drugs should become benefits.
- BC is recognized as an international leader in ensuring that drug coverage decisions are based on demonstrated evidence that a drug provides real health benefits.[5]
- BC's outcome-based approach to drug coverage helps control spending while ensuring that patients have access to the drugs they need to improve their health.

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[1] Saul, D. (2004). "National Pharmacare: A Pill Not Easily Swallowed." *U of T Medical Journal, 82*(1): 14-15.
[2] PharmaNet data, Health Sector Information, Analysis and Reporting, Oct 27, 2016.
[3] This figure refers to patients with claims (paid or unpaid) for service events reimbursed under Plan M, October 27, 2016
[4] Financial and Corporate Services, Ministry of Health.
[5] November 2006. "Aging Well in British Columbia." Premier's Council on Aging and Seniors' Issues Report.

FACT SHEET

FINANCIAL IMPLICATIONS

- In fiscal year 2015/16, PharmaCare:
  - accounted for approximately 6.77% of Ministry of Health expenditures;[6] and
  - had an average cost per capita of $250.[7]
- Cost drivers for PharmaCare include:
  - increasing use of drug treatments outside of hospitals;
  - introduction of newer, more expensive drug therapies; and
  - demand increases due to an aging population and an increasing number of people living with chronic diseases.

Approved by:
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Jack Shewchuk, obo Teri Collins, Health Sector Planning and Innovation Division; November 4, 2016
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; November 16, 2016

[6] Financial and Corporate Services, Ministry of Health.
[7] Public Accounts figure of $1,171.63 billion divided by 4.6831 million, BC Statistics Population estimates for 2015.

FACT SHEET

Fair PharmaCare

ISSUE

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

KEY FACTS

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

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

- To be eligible for Fair PharmaCare assistance, a registrant must: be a resident of BC; have medical coverage under the BC Medical Services Plan; have a Social Insurance Number and; file income taxes in Canada. Families may register for Fair PharmaCare by contacting Health Insurance BC via phone, mail, fax, or the PharmaCare website.
- Total registration for Fair PharmaCare has grown each year since 2003. As of the end of 2015/16, over 1.2 million families were registered.[1] The Medical Beneficiary and Pharmaceutical Services Division has undertaken several initiatives to encourage British Columbians to register for Fair PharmaCare, including:
  - The distribution of Fair PharmaCare information brochures and posters to pharmacies, Service BC Centres, employment and income assistance regional offices, health fairs and mental health service centres in BC.
  - Making Fair PharmaCare brochures available in English, Punjabi, Chinese, French, Farsi, Korean, Vietnamese and Filipino.
  - The addition of Fair PharmaCare brochures to MSP application kits.

[1] PharmaNet, Health Sector Information, Analaysis and Reporting, October 27, 2016

FACT SHEET

Fair PharmaCare - Utilization and Expenditure Statistics (millions) [1,2]

(millions)	2009/20	2010/20	2011/20	2012/20	2013/20	2014/20	2015/1
Total amount paid by PSD	$572.3	$584.5	$579.1	$567.3	$553.6	$552.7	$679.6
Number of beneficiaries	0.57	0.57	0.57	0.55	0.52	0.50	0.48
Total PCare Expenditure[2]	$1,032.1	$1,100.	$1,109.	$1,100.8	$1,076.1	$1,078.9	$1,171.6

- Results of a divisional simulation showed that over 300,000 BC families were made better off by the introduction of Fair PharmaCare.[3]
- The introduction of Fair PharmaCare resulted in a reduction in the Division's share of total community provincial (public and private) drug expenditure to 41.5% in fiscal year 2003/04. The Division's share of prescription drug expenditures was 36.9% during 2015/16. In fiscal year 2015/16, Fair PharmaCare provided assistance to approximately 479,000 British Columbians on roughly 13.4 million prescriptions.[1]

Medical Beneficiary & Pharmaceutical Division (PharmaCare) share of Provincial Drug Expenditure (millions)

(millions)	2009/20	2010/20	2011/20	2012/20	2013/20	2014/20	2015/1
Total PCare Expenditure[2]	$1,032.	$1,100.	$1,109.	$1,100.	$1,076.	$1,078.	$1,171.
Total Drug Exp in BC[1]	$2,574.	$2,677.	$2,732.	$2,736.	$2,751.	$2,854.	$3,171.
% PCare Expenditure	40.10%	41.11%	40.61%	40.22%	39.11%	37.80%	36.94%

FINANCIAL IMPLICATIONS

N/A

Approved by:

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Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; November 10, 2016

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

FACT SHEET

Generic Drug Prices

ISSUE

PharmaCare covers generic drugs as part of BC's Low Cost Alternative Program. Currently, the major factors influencing the price of generic drugs are the: Drug Price Regulation (as defined in the *Pharmaceutical Services Act*), market competition and supply, and the pan-Canadian Pharmaceutical Alliance (pCPA) Generics Initiative which includes the Tiered Pricing Framework (TPF).

KEY FACTS

- In 2008, the Pharmaceutical Task Force recommended that the Province pursue a negotiated solution to rationalize generic pricing and pharmacy compensation prior to taking unilateral action on those matters.
- On July 7, 2010, BC entered into a Pharmacy Services Agreement with the BC Pharmacy Association and Canadian Association of Chain Drug Stores. However, the estimated value from the Agreement did not materialize and BC terminated the Agreement in February 2012.
- In November 2012, BC passed the *Pharmaceutical Services Act* which defined the Drug Price Regulation. Under the Regulation, the pricing of generic drugs was lowered to 25% of the brand name drug price on April 1, 2013, and to 20% on April 1, 2014 (35% for non-oral solids).[1] The Regulation does not stipulate any further price reductions. As a result of the Regulation, BC now has some of the lowest generic drug prices in the country as others are generally 25% to 35% of the brand price.
- Under the Regulation, there are a few exceptions to the 20% pricing requirement:
  - Non Oral Solid Drugs - non-oral and non-solid drugs (e.g. suppositories, inhalers) may be more costly to produce than tablets and capsules. These drugs were reduced to 35% of the brand price on April 2, 2012, and remain unchanged.
  - Non-benefit Drugs - the Regulation only sets prices for drugs covered by PharmaCare.
  - Drugs Subject to Special Conditions - a manufacturer may request an exemption due to high production costs. In some cases, the Minister of Health may list the product at the higher price (greater than the regulated price) to ensure patient access. However, if another product becomes available at a lower cost, the higher priced product may be delisted or deemed unaccepted.
- BC has been successful in lowering the cost of generic drugs for British Columbians. In fact, over the 2-year period (2013/14-2014/15)[2] alone, BC exceeded the $110 million savings target, which includes implementation of the pCPA Generics Initiative.
- The Regulation was amended on April 1, 2017. Key improvements to the Regulation include the elimination of the annual price confirmation process, accepting submissions for exclusive listings, and relaxing the delisting practice. These improvements better align BC's generic drug pricing processes with that of other provinces.
- Exclusive listing submissions will be accepted for review from generic suppliers who lower their price to the Maximum Accepted List Price (20%/35% of brand) or less. Once approved, the drug submitted will be the sole generic drug listed in that category for a coverage period of up to 12 months. The Ministry requires suppliers meet additional supply requirements to avoid concerns around a patient's ability to access these medications. All other generic competitors will be delisted during this period which is consistent with previous practice prior to the passing of the amendment to the Regulation.

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

[2] MBPSD Analysis of PharmaNet Data (May2014)

FACT SHEET

pCPA Generics Initiative

- Through the pCPA Generics Initiative, BC has taken a collaborative approach with other jurisidictions to reduce prices for 18 commonly-used generic drugs, These drugs are listed at 18% of the brand name price[3]. Drugs covered by the Initiative are: (1) *Atorvastatin, (2) Ezetimibe*[4], (3) *Rosuvastatin, (4) Simvastatin*-used to treat high cholesterol; (5) *Clopidogrel*-used to treat cardiovascular conditions; (6) *Amlodipine, (7) Ramipril*-used to treat elevated blood pressure and other cardiovascular conditions; (8) *Omeprazole, (9) Rabeprazole*-used to treat a variety of gastrointestinal conditions; (10) *Pantoprazole*-used to treat a variety of gastrointestinal conditions including reflux; (11) *Citalopram*-used to treat mental health conditions such as depression; (12) *Olanzapine*-used to treat mental health conditions such as schizophrenia or psychosis; (13) *Quetiapine*-used to treat mental health conditions such as schizophrenia, depression, bipolar disorder; *(14) Venlafaxine*-used to treat mental health conditions such as depression, anxiety, panic disorder; (15) *Donepezil*-used to treat Alzheimer's Disease; (16) *Metformin-u*sed to treat diabetes; (17) *Gabapentin*-used to treat epilepsy; and (18) *Zopiclone*-used to treat insomnia.
- In addition to the above generic drugs, the pCPA and Canadian Generic Pharmaceutical Association agreed to a 3-year TPF that took effect on April 1, 2014, whereby the prices of new-to-market, single-source generic drugs (supplied by only 1 generic manufacturer in Canada) will be priced at 75% of the brand name drug price (85% if a Product Listing Agreement for the brand name product does not exist). A second entry in the market (resulting in 2 manufacturers) would drop prices to 50% of the brand name drug price. Entry of a third manufacturer would trigger a drop to 25% of the brand name drug price for oral solids (or 35% for all other drugs). The TPF does not supersede any existing policies, regulations or commitments in BC. Specifically, the TPF will not prevent BC from accepting pricing below that defined in the TPF. Any issues related to implementation of the TPF are now managed through the pCPA Office.
- In September 2016, pCPA and the CCPA agreed to a bridging arrangement to extend the TPF for an additional year (to March 31, 2018) in exchange for further reductions of 6 of the aforementioned 18 common generic drugs. The 6 molecules were reduced in price from 18% to 15% of brand. The purpose of the the 1-year extension is to give time for the pCPA to conduct an evaluation of the Generic Initiative, as well as explore the future of generic pricing in Canada.

FINANCIAL IMPLICATIONS

PharmaCare spent approximately $208 million on multi-source drugs in 2015/16[5]. Multi-source drugs represented 77% of the total number of prescriptions subsidized by PharmaCare and 23% of PharmaCare's total drug expenditures in 2015/16.[6]

Approved by:

Brenda Rafter, obo Manjit Sidhu, Finance and Corporate Services Division; November 3, 2016
Mitch Moneo, obo Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; May 15, 2017

[3] The pan-Canadian Pharmaceutical Alliance, Canada's Premiers: http://www.canadaspremiers.ca/en/initiatives/358-pan-canadian-pharmaceutical-alliance.
[4] Not covered by PharmaCare; it was included due to higher estimated savings in other jurisdictons compared to BC's proposed alternative.
[5] MBPSD Analysis of PharmaNet Data, (Oct 2016)
[6] MBPSD Analysis of PharmaNet Data, (Oct 2016)

FACT SHEET

Reference Drug Program Modernization

ISSUE

- Reference Drug Program (RDP) modernization included 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.
- Patients on a non-reference drug will only be provided partial coverage; in order to obtain full coverage, patients will need to consider switching to a safe and efficacious fully covered drug.

KEY FACTS

- 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 (i.e., 18% of brand pricing) which support RDP modernization.
- RDP modernization is based on Drug Benefit Council (DBC) recommendations and input from clinician experts. The 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 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 included the introduction of 3 new therapeutic categories:
  - Angiotensin Receptor Blocker (ARB) – treats high blood pressure; alternative to ACEI;
  - Statin – treats high cholesterol; and
  - 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; and
  - 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, did not officially take effect until December 1, 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 included: (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 continue existing coverage (grandfathering) for some complex patient populations; and (3) plans to engage stakeholders further.

- A 6-month transition period (that started in June and continued to the end of November 2016) gave 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 six therapeutic classes was maintained.

Background

- The RDP program, introduced in 1995, is a PharmaCare policy to encourage cost-effective prescribing for common medical conditions.
- Under the RDP, drugs that treat the same disease are grouped together into therapeutic categories called RDP categories. The drugs in an 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 the 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, one 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 an 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: (1) nonsteroidal anti-inflammatory drugs (in 2010, the reference drug comparator was changed from naproxen to ibuprofen); (2) histamine 2 receptor blockers (H2 Blockers); (3) nitrates; (4) angiotensin-converting enzyme inhibitors (ACEIs); and (5) dihydropyridine calcium channel blockers (CCBs).

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.

Approved by:
Barbara Walman, Medical Beneficiary and Pharmaceutical Services Division; February 9, 2017

[1] Budget Impact Analysis completed by the Economic Analysis unit of Policy, Outcomes, Evaluation & Research, Medical Beneficiary and Pharmaceutical Services Division