B124 Recognition and Regulation of Physician Assistants Central Coast RD

Whereas the BC Ministry of Health has undertaken operational reforms in an attempt to revitalize the primary care system, but communities across the province still experience physician shortages and other significant primary care challenges;

And whereas physician assistants (PAs) are qualified health professionals whose role is to provide a broad range of medical services under physician supervision; who are licensed to practice in many provinces across Canada, as well as in the Canadian Armed Forces; and who are recognized by the Canadian Association of Physician Assistants and the British Columbia Medical Association (Doctors of BC);

Therefore be it resolved that UBCM strongly encourage the provincial Ministry of Health to recognize and regulate physician assistants so that they may practice in BC, with establishment of an appropriate system for liability coverage, and regulatory oversight by an organization similar to the College of Physicians and Surgeons of BC, as one of the steps toward meeting health care demands and alleviating physician shortages in all areas of the province.

Resolutions Committee recommendation: No Recommendation

Convention decision: Endorsed

Not included in pre-Convention conveyance.

RESPONSE: Ministry of Health

BC has closely monitored the experience and implementation of physician assistants in other provinces in Canada since 2008. The decision to introduce a new profession requires thoughtful analysis of gaps in current care models, patient needs, and whether the use of existing health care professions can address those gaps or needs. To date, there is little evidence to suggest that gaps in care cannot be filled by existing health care professionals such as nurse practitioners.

Since 2005, nurse practitioners have provided services in the publicly-funded health care system in BC. Nurse practitioners are registered nurses with advanced education. They are authorized to perform the full range of nursing functions plus additional functions of assessment, diagnosing, prescribing, ordering diagnostic tests, managing common acute

and chronic illnesses, and referring patients to specialists. As independent practitioners, nurse practitioners do not require a physician's order to act and may serve as the primary care provider in collaboration with other members of the health care team.

The Ministry has ongoing discussions with other provinces that have introduced physician assistants. With small numbers and inconsistent distribution, the physician assistant profession in Canada remains relatively new. However, BC will continue to monitor as health system evolves and consider whether introduction of this new profession would meet patient care needs more effectively than through existing professions.

Division ADM: Ted Patterson, Health Sector Workforce Division
Program ED: Kevin Brown, Workforce Planning & Management Branch, HSWD
Drafter: Miranda Mason
Date Approved: November 17, 2016
Filename with Path: M:\Clinical\Admin 100-499\Executive Services 280\20 BNs, Bullets & ADM Asgnmts\2016\ADM Assignments\UBCM Resolutions\1071032 B124 UBCM Post Conv Resolution - Narrative Response - AED APRVD.docx

From:	Docs Processing HLTH:EX
To:	McCormick, Erika HLTH:EX; Jukes, Shaina HLTH:EX
Cc:	Docs Processing HLTH:EX; O"Brien, Kellie HLTH:EX; Will, Jordan HLTH:EX; Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX
Subject:	1073330 - MO Request for Info Bullets re CAPA Awareness Day in Victoria
Date:	November 25, 2016 10:40:54 AM
Attachments:	1073330 MO Info Bullets - CAPA.docx
Importance:	High

Hi Erika & Shaina:

Attached are information bullets prepared by HSWD in response to your request below, and approved by Ted Patterson, ADM.

Thanks so much,

Kathy Simonson
Program Coordinator / Executive Operations / DMO / Ministry of Health
5-3 1515 Blanshard St, Victoria BC V8W 3C8
Telephone 250 952-0998
kathy.simonson@gov.bc.ca

From: McCormick, Erika HLTH:EX
Sent: Tuesday, November 8, 2016 8:22 AM
To: Docs Processing HLTH:EX
Subject: MO Request for Info Bullets re PA Awareness Day in Victoria

Hey Docs,

Can we please get meeting material for Kellie for her meeting with the Canadian Association of Physician Assistants? We will need by November 30th at the latest.

Thank you,

Erika

From: Natalie St-Pierre [mailto:NSt-Pierre@capa-acam.ca]
Sent: Tuesday, November 8, 2016 5:30 AM
To: McCormick, Erika HLTH:EX
Subject: RE: PA Awareness Day in Victoria

Hi Erika,

Are you referring to the PA Awareness Event or for our meeting with Kellie O'Brien?

For our meeting with Kellie the following individuals will be attending:

Patrick Nelson, Executive Director

Chris Rhule, National President

Natalie St-Pierre, Director, Communications and Stakeholder Relations

Agenda – just to have a follow-up conversation regarding the value that PAs can add to the BC healthcare system and to discuss the results from the Conference Board of Canada study. I am happy to provide you with a slide deck for background information.

Natalie

Natalie St-Pierre
Director, Communications and Stakeholder Relations / Directrice des communications et des relations avec les parties prenantes
Canadian Association of Physician Assistants/ Association canadienne des adjoints au médecin
613-854-0675
www.capa-acam.ca

INFORMATION BULLETS

Cliff#1073330 – Kellie O'Brien, Ministerial Assistant to the Honourable Terry Lake, Minister of Health (cross reference Cliff 1065200, 1058140)

REQUEST

- Material for meeting with Canadian Association of Physician Assistants (CAPA) to discuss the value that physician assistants (PAs) can add to the British Columbia health care system, and a Conference Board of Canada report on PAs.[1] CAPA attendees include:
    - Patrick Nelson, Executive Director
    - Chris Rhule, National President
    - Natalie St-Pierre, Director, Communications and Stakeholder Relations

BACKGROUND

- CAPA is the national organization that advocates for PAs in Canada. PAs have been introduced in the publicly-funded health care systems in four provinces in Canada – Ontario, Manitoba, New Brunswick and Alberta. CAPA continues to lobby BC and other provinces to introduce PAs into provincial health care systems.
- Ministry of Health (Ministry) staff met with CAPA representatives in early 2015 on behalf of the Honourable Terry Lake, Minister of Health, to discuss CAPA's concerns. The Ministry position has not changed since the meeting in that BC has no plans to introduce PAs.
- In 2016, the Conference Board of Canada issued two reports of a series on PAs[2]:
    1) *Value of PAs: Understanding the Role of PAs Within Health Systems* [3](funded by the Royal College of Physicians and Surgeons of Canada, College of Family Physicians of Canada, Alberta Health Services and CAPA) describes the role and impact of PAs in Canada's health care system.
    2) *Gaining Efficiency: Increasing the Use of PAs in Can*ada (funded by CAPA) focuses on the financial impact of PAs on Canada's health care system. Preliminary comments from the Workforce Analysis and Research Evaluation Branch in the Ministry identify some observations and concerns with the report (see Appendix 1).
- CAPA has scheduled a Physician Assistant Awareness event in Victoria, BC, on December 1, 2016. According to the CAPA news bulletin[4], the Victoria event *"coincides with a provincial government caucus meeting, providing an ideal opportunity to educate MLAs about PAs and the value they can provide to the BC healthcare system."*
- In 2014 and 2015, BC thoroughly researched the possibility of introducing PAs as a new health care provider in the BC health care system. The decision to introduce a new

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[1] Gaining Efficiency: Increasing the Use of Physician Assistants in Canada, Conference Board of Canada, October 2016
[2] News Release (October 24, 2016) Increasing the Use of Physician Assistants Could Lead to Significant Cost Savings for the Canadian Health Care System, Conference Board of Canada. http://www.conferenceboard.ca/press/newsrelease/16-10-24/increasing_the_use_of_physician_assistants_could_lead_to_significant_cost_savings_for_the_canadian_health_care_system.aspx
[3] Value of Physician Assistants: Understanding the Role of Physician Assistants Within Health Systems, Conference Board of Canada, June 2016
[4] PA News Bulletin, October 25, 2016, Issue 21: https://capa-acam.ca/wp-content/uploads/2016/10/Oct_news_bulletin_2016_FINAL.pdf

profession requires thoughtful analysis of gaps in current care models and patient needs. It is not clear that PAs can uniquely address gaps in patient and population health needs that cannot be addressed by other health professionals currently in place in BC.

- Health care professionals, such as nurse practitioners (NPs) or other registered nurses, have overlapping scopes of practice with PAs, and have the potential to perform the services that would be provided by PAs. In BC, NPs were initially introduced in primary and community care, but more recently are employed in acute inpatient care settings. Potential exists for NPs to be integrated into inter-professional care teams in any medical or surgical service.
- Ministry staff have ongoing discussions with provinces that have introduced PAs. With small numbers and patchy distribution, the profession remains in its infancy in Canada. More Canadian research and experience is required on the effect of PAs on patient outcomes and health system performance.

ADVICE:

- BC has an obligation to ensure that maximum value is derived from our existing health professionals prior to introducing a new health profession.
- BC's approach to address gaps in patient health care needs includes optimizing deployment of existing health care providers in the system whose scopes of practice overlap with that of PAs such as NPs. To date, no evidence supports the view that gaps in care in BC cannot be filled by existing health care professionals.
- BC recognizes the valuable role PAs have in some provinces. BC has closely monitored the experience and implementation of PAs in Canada since 2008. BC will continue discussions with other Canadian jurisdictions on their experience with the implementation of PAs in the publicly-funded health care system.

Division ADM: Ted Patterson, ADM, Health Sector Workforce Division
Program ED: Kevin Brown, Executive Director, Workforce Planning & Management Branch, HSWD
Drafter: Shelly Anderson, Senior Policy Analyst
Date Approved: November 23, 2016
Filename with Path: \\plane\s15003\Clinical\Admin 100-499\Executive Services 280\20 BNs, Bullets & ADM Asgnmts\2016\Bullets, Meeting Advice\1073330 MO Info Bullets - CAPA Mtg w Kellie O'Brien - ED APRVD.docx

1073330 Appendix 1

Preliminary comments on *Gaining Efficiency: Increasing the Use of Physician Assistants in Canada* provided by Kevin Fung, Labour Economist, and Eric Larson, Director, Workforce Analysis and Research Evaluation Branch, Ministry of Health:

Highlights of the report:

- Cost-savings for PAs can only be realized if the substitution rate (PA Productivity) between PA and Physicians is 29 percent for primary care, 21 percent for orthopaedics, and 25 percent for emergency medicine and 19 percent for "other specialities," The whole analysis relies on this assumption.
    - These "productivity thresholds" are derived by taking the ratio of the average hourly earnings of a PA to physicians to average annual FFS billing per FTE from CIHI, augmented by average weekly wage growth from the NAICS 6211 (Professionals Working in the Offices of Physicians)
    - According to their expert panel, this is feasible.
    - One US study showed that 85 percent of a primary care physician's time can be replaced by a PA and another Australia studies says that 62 percent of emergency room physician time can be replaced by PAs.
- Efficiency gains range from $22.4 million (25 percent PA Productivity) to $1.1 billion (45 percent PA productivity).

Feedback about the report:

- It's unclear what the difference in scope of practice is between an NP and a PA, so the benefits of adding another regulated profession to the BC workforce are similarly unclear.
- Using the average annual FFS billing per FTE includes overhead and fixed costs incurred by physicians. I am not sure if the "productivity threshold" should be derived from that.
    - The wages of a PA reflect the PA's productivity (marginal product of labour)
    - The wages derived from physicians billing DO NOT reflect physician productivity. It reflects its productivity + overhead cost.
    - The article does not account for the fact that, if a PA works within an existing family practice, it may increase the practice's overhead costs. Further, if PAs practiced by themselves WITHOUT a physician, they would incur overhead costs and would likely demand higher wages. The overhead cost is borne by the physician and not the PA; thus that is one reason why physicians command much higher "wages" than PAs.
    - The productivity threshold should be MUCH higher than what they have stated. In my opinion, it is comparing apples to oranges here.
    - Since the crux of the whole analysis is based on the "productivity threshold", I am not confident about their quantified productivity gains.
- Their expert panel thinks the replacement ratio is feasible, but my concern is that the scope of practice for a PA is DEPENDENT on the relationship of the physician. The average productivity gain might actually be lower.

From: s.17
To: DMOFFICE, HLTH HLTH:EX
Cc: s.17
Subject:
Date: January 11, 2019 11:48:59 AM
Attachments: image001.png

HLTH DMO to HHRLR – s.s. –

Good day Sir or Madam,
s.17

s.17 . It is my understanding that PAs are not currently able to practice within the province (aside from Canadian Forces PAs providing care strictly to active members of the Canadian Forces). s.17
s.17

s.17

I am asking whether PA practice approval is under serious scrutiny by the BC Department of Health with a plan to enact the appropriate legislation in the foreseeable future or not. Further to this, s.17
s.17

I would look forward to your reply on this matter and would be happy to discuss further at your convenience should you have any questions on the matter. I am available by cell phone at s.22 or by the below email contact.

Sincerely,
s.17

From: Cramb, Lorrie HLTH:EX
To: Murray, Ryan HLTH:EX; Clarke, Paul HLTH:EX; Brown, Kevin HLTH:EX; Bossert, Jess HLTH:EX
Subject: Article- Physician Assistants FYI
Date: January 2, 2019 8:19:00 AM

YEAR IN REVIEW: Pressure builds for B.C. to recognize physicians assistants
Vernon Morning Star
Tuesday, January 01, 2019
By Parker Crook

Lorrie Cramb, MEd, RD
Director, Allied Health Workforce Development
Health Human Resources and Labour Relations Division
Ministry of Health|3 - 1, 1515 Blanshard St, Victoria, BC V8W 3C8
PO Box 9650 STN PROV GOVT Victoria BC V8W 9P4
Tel: 250.952.1124 Cell: 250.507.0256

FACT SHEET

Physician Assistants

ISSUE

Stakeholders including physicians, Doctors of BC, health authority VPs of Medicine, and Canadian Association of Physician Assistants advocate for the introduction of Physician Assistants (PAs) in BC.

KEY FACTS

- PAs are a relatively new health profession in Canada, although they have been trained and employed by the Canadian Forces for over 40 years[1]. They have been part of the health care workforce in the US for 50 years. [2] PAs practice medicine under the direction and supervision of a licenced physician. PAs act as physician extenders whose scope of practice is dependent on the scope of the supervising physician.
- A PA's role may involve interviewing patients, taking medical histories, conducting physical exams, requisitioning/interpreting test results, diagnosing illness, counselling on health issues, assisting in surgery, and prescribing treatments/medications.[3]
- Ontario, Alberta, Manitoba and New Brunswick have introduced PAs into their health care workforces.
- Introduced over 8 years ago in Ontario, there are now over 300 PAs employed in the province, representing approximately 60 percent of the 500 total in Canada.[4]. PAs are registered or regulated in Alberta, Manitoba and New Brunswick by the regulatory colleges for physicians. They remain unregulated in Ontario but work under the authority of physicians. The majority of PAs in Canada are funded by health authorities and Ministries of Health.
- Ontario and Manitoba are the only two provinces with training programs for PAs in the Faculties of Medicine at University of Manitoba (Winnipeg), McMaster University (Hamilton, Ontario), and the Northern Ontario School of Medicine (Thunder Bay/Sudbury) with the University of Toronto. These training programs provide about 69 potential PAs for the workforce in Canada each year.[5]
- It has been proposed that PAs could supplement medical services in the following areas in BC:
    - Rural health care – communities with no or limited physician resources;
    - First Nations health care – First Nations communities, and career option for First Nations people;
    - Primary health and community care – interprofessional teams (including nurse practitioners, pharmacists, physiotherapist, others) and in residential care;
    - Emergency departments;
    - Surgical care – orthopedics; and
    - Acute care – hospitalist or general internal medicine program.
- In 2009, a PA Steering Committee composed of representatives from health authorities, College of Physicians and Surgeons of BC (CPSBC), University of BC Faculty of Medicine, Doctors of BC, Department of National Defence, and Ministry of Health, recommended that the Ministry consider introducing PAs in hospitalist programs to support general medical and surgical units.

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[1] Canadian Association of Physician Assistants. (2018). PA Facts. In Canadian Association of Physician Assistants. Retrieved September 28, 2018, from https://capa-acam.ca/about-pas/pa-fact-sheet/

[2] American Academy of Physician Assistants website: https://www.aapa.org/about/history/

[3] HealthForce Ontario. (April 18, 2007). *Defining the Physician Assistant Role in Ontario*. https://www.slideshare.net/samueljack/defining-the-physician-assistant-role-in-ontario

[4] CAPA Physician Assistant Fact Sheet. Retrieved electronically, September 28, 2018 from: https://capa-acam.ca/about-pas/pa-fact-sheet/.

[5] S Anderson: "Ontario has up to 54 seats in both programs (NOSM - about 30 seats (34 in 2014), McMaster - 22 seats; Manitoba increased seats from 12 to 15 in 2016" Bulletin June 15,2017, HealthForceOntario https://capa-acam.ca/wp-content/uploads/2017/06/2017-PA-Career-Start-Bulletin-FINAL.pdf, PA Program University of Manitoba http://umanitoba.ca/faculties/health_sciences/medicine/education/paep/faq.html

- In 2010, at the Ministry's request, CPSBC developed a draft regulatory framework for PAs and submitted a cost estimate for implementation if/when the Ministry was to proceed. Fraser Health Authority signed an affiliation agreement with MEDEX Northwest, University of Washington's PA training program, expecting to accept students on clinical placements in acute care settings in anticipation of implementation of a regulatory framework.
- Doctors of BC and the Ministry established a joint committee to inform how PAs could be introduced into BC's health care system. The University of BC, Justice Institute of BC, and other stakeholders held discussions on development of a joint proposal for a PA education program in BC. Work on these two initiatives did not advance beyond preliminary discussions in 2010.
- In January 2014, the Minister of Health directed Ministry staff to explore the practical considerations for introducing PAs in BC. A draft concept paper[6] identified and discussed considerations, including practice settings and overlapping roles, an appropriate legislative and regulatory framework, a funding model, employment and labour relations implications, and education and training.
- The PA role overlaps substantially with existing nursing roles, such as nurse practitioners and registered nurses with certified practice credentials, and family physician roles such as hospitalists or surgical assistants.
- The introduction of a new health provider role requires careful consideration and management in order to understand and address the inevitable team function issues that emerge from overlapping scopes of practice. The associated effort is likely to be far more extensive than suggested by advocates, and the presence of PAs may serve to undermine and confuse efforts to improve integration of existing health care professionals.
- At this time, patient and population health care needs are able to be addressed with the skill sets of existing health care professions in BC. There are no known care gaps that can only be addressed by PAs. The Ministry has an obligation to British Columbians to optimize the scopes of practice of existing health care professionals such as nurse practitioners.

FINANCIAL IMPLICATIONS

N/A

Approved by:
Kevin Brown, Workforce Planning and Development Branch; September 26, 2018
Kevin Brown obo David Byres, Clinical Integration, Regulation and Education Division; September 26, 2018
Kiersten Fisher obo ADM Teri Collins, Health Sector Information Analysis and Reporting Division; October 9, 2018

[6] Concept Paper: Introducing Physician Assistants Into British Columbia's Health Care System, Draft for Discussion, Ministry of Health, October 24, 2014

From: Lowe, Tracey HLTH:EX
To: Cramb, Lorrie HLTH:EX; Bossert, Jess HLTH:EX
Cc: Brown, Kevin HLTH:EX; Ghesquiere, Breanne J HLTH:EX
Subject: FW: For Your Review: HLTH Media Request: Physicians Assistants
Date: October 12, 2018 2:29:46 PM
Attachments: image001.png

Hi Lorrie and Jess, I am hoping you can have a look at this request from GCPE….pls let me know..thanks

Tracey Lowe | A/Executive Coordinator
Clinical Integration, Regulation and Education
Ministry of Health
Ph: 250 952-2629
Email: tracey.lowe@gov.bc.ca
Ministry of Health | PO Box 9639 STN PROV GOVT | Victoria BC | V8W 9P1

From: Ghesquiere, Breanne J HLTH:EX
Sent: October 12, 2018 2:25 PM
To: Lowe, Tracey HLTH:EX
Subject: RE: For Your Review: HLTH Media Request: Physicians Assistants

He is around but prepping for his 2:30 and has meetings until 4.

Bre Ghesquiere
Branch Administrator
Workforce Planning and Development | Clinical Integration, Regulation and Education Division
Ministry of Health
PO Box 9650 Stn Prov Govt | Victoria BC V8W 9P4
Ph: 778 698-2586
Email: Breanne.Ghesquiere@gov.bc.ca

From: Lowe, Tracey HLTH:EX
Sent: Friday, October 12, 2018 2:18 PM
To: Ghesquiere, Breanne J HLTH:EX
Subject: Fwd: For Your Review: HLTH Media Request: Physicians Assistants

Hi Bre- is Kevin around ? GCPE is asking. Sorry for the rush. Thanks !

Sent from my iPhone

Begin forwarded message:

> **From:** "Lowe, Tracey HLTH:EX" <Tracey.Lowe@gov.bc.ca>
> **Date:** October 12, 2018 at 1:26:14 PM PDT
> **To:** "Brown, Kevin HLTH:EX" <Kevin.Brown@gov.bc.ca>, "Prodan-Bhalla, Natasha L HLTH:EX" <Natasha.Prodan-Bhalla@gov.bc.ca>
> **Cc:** "Ghesquiere, Breanne J HLTH:EX" <Breanne.Ghesquiere@gov.bc.ca>, "Sheppard, Jenifer A HLTH:EX" <Jenifer.Sheppard@gov.bc.ca>, "Byres, David W HLTH:EX" <David.Byres@gov.bc.ca>
> **Subject: FW: For Your Review: HLTH Media Request: Physicians Assistants**

Hi, just received this – can you pls review the below information for GCPE on this – please see the request at the end of the email..thanks! Sorry for the short timeline..thanks!

Tracey Lowe | A/Executive Coordinator
Clinical Integration, Regulation and Education
Ministry of Health
Ph: 250 952-2629
Email: tracey.lowe@gov.bc.ca
Ministry of Health | PO Box 9639 STN PROV GOVT | Victoria BC | V8W 9P1

From: Murray, Heather HLTH:EX
Sent: October 12, 2018 1:23 PM
To: Booth, Kristen GCPE:EX <Kristen.Booth@gov.bc.ca>; Lowe, Tracey HLTH:EX <Tracey.Lowe@gov.bc.ca>
Cc: Heinze, Laura R GCPE:EX <Laura.Heinze@gov.bc.ca>
Subject: RE: For Your Review: HLTH Media Request: Physicians Assistants

Hi there – yes, looping in Tracey as she can respond to this from CIRE. Thanks, Heather.

From: Booth, Kristen GCPE:EX
Sent: Friday, October 12, 2018 1:06 PM
To: Murray, Heather HLTH:EX
Cc: Heinze, Laura R GCPE:EX
Subject: For Your Review: HLTH Media Request: Physicians Assistants

Hi Heather,

I'm not sure if you're the right individual to send this to, but hopefully you can redirect if you're not!

We've had a media request regarding Physician Assistants and I'm hoping you can give the below draft response a review and feedback. The reporter's deadline was yesterday, so if possible feedback by 2pm today would be appreciated.

Thanks,
Kristen

As a part of the Primary Health Care Strategy announced Spring 2018, the Ministry is increasing the number of nurse practitioners in B.C. as a key part of our overall approach to ensure British Columbians have better access to primary health care. The Ministry of Health is funding 200 new nurse practitioner positions within Primary Care Networks throughout B.C. and creating an additional 30 new nurse practitioner education seats in three B.C. post-secondary institutions (an increase of 66 per cent). As valuable members of the primary care team, increasing the numbers of nurse practitioners will contribute to the multi-faceted approach to close the primary care gap in B.C. Additionally, acknowledging the initial priority on addressing the shortage of general practitioners in the province, Government will fund up to 200 new general practitioners to work in the team-based care model, and provide opportunity for every family medicine resident to work in a renewed primary care system in which they can focus on patient-centred medicine.

The roles of primary care nurse practitioners and physicians complement one another and they often work in teams to strengthen the level of care they provide to

patients. Working in teams, health care providers can offer longer or more convenient hours, deliver additional services like patient education, provide patients with support in self-managing their healthcare, offer maternity care that transitions into family health care, and as a team, be responsible for coordinating their patients' care.

Physician Assistants (PA)s are not currently a regulated health profession in B.C. While we recognize that PAs provide value and benefits to patients in jurisdictions where they are currently deployed, the introduction of a new health profession requires careful consideration and management, and significant resources to properly understand and address the issues that emerge from overlapping scopes of practice. There is no plan to implement PAs at this time, as Government's new primary health-care strategy commits to building on the best practices and solutions that already exist within the health-care system, but have yet to be fully leveraged throughout the province. However, the Ministry continues to connect with other jurisdictions to monitor and observe the use of PAs in their systems of care.
In regards to billing to MSP, only doctors are allowed to submit fee-for-service claims to MSP.

Request

1. Is the Ministry studying PAs as part of a future team-based model of care? If so, when can BC patients expect rollout?
2. What are the obstacles to adding physicians assistants or nurse practitioners into the mix? I hear from administrators on the Peninsula that NPs cannot bill MSP, which is one obstacle. Would PAs have the same issue?

From:	Booth, Kristen GCPE:EX
To:	Thorneloe, Meghan HLTH:EX; Brown, Kevin HLTH:EX; Ty, Marie HLTH:EX; Hart, Bob HLTH:EX
Cc:	Heinze, Laura R GCPE:EX
Subject:	FW: HLTH Media Request: Physicians Assistants
Date:	October 11, 2018 2:10:30 PM

Hi everyone,

Thanks for your help on this, below is a revised draft for your approval based on all the feedback received.

Thanks,
Kristen

As a part of the Primary Health Care Strategy announced Spring 2018, the Ministry is increasing the number of nurse practitioners in B.C. as a key part of our overall approach to ensure that accessing primary care is not such a struggle for British Columbians. The Ministry of Health is creating 200 nurse practitioner jobs, securing nurse practitioners' employment in primary care settings throughout B.C., and creating an additional 30 new nurse practitioner education seats in three B.C. post-secondary institutions (an increase of 66 per cent). As valuable members of the primary care team, increasing the numbers of nurse practitioners will contribute to the multi-faceted approach to close the primary care gap in B.C. Additionally, acknowledging the initial priority on addressing the shortage of general practitioners in the province, Government will fund up to 200 new general practitioners to work in the team-based care model, and provide opportunity for every family medicine resident to work in a renewed primary care system in which they can focus on patient-centred medicine.

The roles of primary care nurse practitioners and physicians complement one another and they often work in teams to strengthen the level of care they provide to patients. Working in teams, health care providers can offer longer or more convenient hours, deliver additional services like patient education, provide patients with support in self-managing their healthcare, offer maternity care that transitions into family health care, and as a team, be responsible for coordinating their patients' care.

While we recognize that Physician Assistants (PA)s provide value and benefits to patients in jurisdictions where they are currently deployed, the introduction of a new health profession requires careful consideration and management, and significant resources to properly understand and address the issues that emerge from overlapping scopes of practice. In that regard, the Ministry of Health has considered in depth the option of implementing PAs and concluded that the PA role overlaps substantially with existing nursing roles, such as nurse practitioners and registered nurses with certified practice credentials, and family physician roles such as hospitalists or surgical assistants. There is no plan to include them as part of the primary care teams yet, but the Ministry continues to connect with other jurisdictions to monitor and observe the use of PAs in their systems of care.
In regards to billing to MSP, currently Nurse Practitioners and PAs are unable to bill directly to MSP as Billing MSP Fee For Service for services that are medically necessary is restricted to Medical Doctors. To accommodate this, Nurse Practitioners bill to Alternative Payment Plan. There are no plans as of yet to expand the MSP billing privileges.

Request

1. Is the Ministry studying PAs as part of a future team-based model of care? If so, when can BC patients expect rollout?
2. What are the obstacles to adding physicians assistants or nurse practitioners into the mix? I

hear from administrators on the Peninsula that NPs cannot bill MSP, which is one obstacle. Would PAs have the same issue?

FOI Request CFR HTH-2019-90836 Revised

Links to third party documents and articles located during the search.

https://www.conferenceboard.ca/e-library/abstract.aspx?did=5479

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4865356/

https://www.google.ca/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=2ahUKEwjAk-6uydfgAhVXqp4KHeaXDEAQFjACegQIBBAC&url=https%3A%2F%2Fwww.paconsortium.ca%2Ffile%2F899%2Fdownload%3Ftoken%3Dalg1fykd&usg=AOvVaw1Quh02WDCCzY-Ql7eOeDr0

https://capa-acam.ca/wp-content/uploads/2014/08/2015-Timmermans-Laurant-PAs-medical-ward-care.pdf

https://umanitoba.ca/faculties/health_sciences/medicine/education/paep/media/2016_Physician_Asst_Handbook_2015_final.pdf

https://www.ncbi.nlm.nih.gov/pubmed/27367866

https://www.conferenceboard.ca/e-library/abstract.aspx?did=8107&AspxAutoDetectCookieSupport=1

https://www.conferenceboard.ca/temp/6298f44b-78ef-4686-820c-1aea2116b84a/8347_PhysiciansAssistants_RPT_.pdf

http://www.cphm.ca/uploaded/web/Legislation/CA%20PA/Clinical%20and%20Physician%20Assistant%20Prescribing%20Authority%20July%2029%202014.pdf

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4507837/

https://news.gov.mb.ca/news/index.html?item=36900

https://capa-acam.ca/wp-content/uploads/2016/10/Oct_news_bulletin_2016_FINAL.pdf

https://www.aagbi.org/sites/default/files/PA%28A%29%20Review_FINAL%2016MAR2012_0.pdf

http://www.wrha.mb.ca/Professionals/familyphysicians/files/PA_report_Dec-14.pdf

http://www.wrha.mb.ca/professionals/familyphysicians/files/Phase_2_MPAN_Report_Sep2013.pdf

http://www.pcam.ca/wp-content/uploads/2015/09/TDSLAW-2012839-v3-DRAFT_WRHA_PCAM_CBA_.DOCX-2.pdf

https://www.therecord.com/opinion-story/7039609-physician-asistants-can-make-a-difference-in-emergency-rooms/

http://healthydebate.ca/2016/03/topic/health-professional-regulation

https://www.peninsulanewsreview.com/news/physician-assistants-say-they-can-help-b-c-health-care-woes/

From: WPD Workforce Planning and Development Branch HLTH:EX
To: michael.evans@internationalsos.com
Subject: Ministry of Health Response - 1127719
Date: February 6, 2019 4:04:00 PM

1127719 280-30(C)

Dr. Michael Evans
michael.evans@internationalsos.com

Dear Dr. Evans,

Thank you for your email of January 11, 2019 regarding Physician Assistant (PA) practice in BC. I am pleased to respond on behalf of the Ministry of Health (the Ministry).

While we appreciate the role your company has in providing appropriate medical assistance for various international projects, PAs have not yet been introduced into BC's health care system. At this time, there is no existing regulatory mechanism in place to allow PAs to practice to a limited scope under your clinical governance.

The Ministry is aware that PAs are able to practice in some other jurisdictions and is continuing to monitor the situation closely. Having said this, the Ministry is not actively working to integrate the role within BC's health care system.

The introduction of a new health profession requires careful consideration. There are no known care gaps that can only be addressed by PAs and ultimately, government has concluded that the PA role overlaps substantially with existing nursing roles, such as nurse practitioners, registered nurses with certified practice credentials, and family physician roles such as hospitalists or surgical assistants. The Ministry's current focus is to optimize the scopes of practice of existing health care professionals and enable team-based practice that puts the patient at the centre of care.

I hope this information is helpful to you. Thank you for taking the time to write.

Sincerely,
Kevin Brown, Executive Director
Workforce Planning and Development
Health Human Resources and Labour Relations Division
Ministry of Health

A Brief History of the Emerging PA Profession in Canada

Physician Assistants have been active in the Canadian military since the 1950s and in civilian US healthcare since the 1960s, but were only introduced to civilian healthcare in Ontario in 2006. As of 2016, over 50 civilian PAs graduate annually in Ontario, and there are over 600 Canadian Certified PAs in the country.

The Early Years

1950s and 1960s
The Canadian military begins using mid-level healthcare providers. These providers are recognized under a variety of terminologies (e.g. group 3 medics, 6B medical assistants).[1]
The first civilian PA program is established at Duke University in the United States in 1965.[2]

1984
The first class of "Physician Assistants" graduates from the Canadian Forces Medical Services; they are re**co**gnized as the first trained PAs in Canada. [3]

1999
Canadian Certified Clinical Assistants are regulated by the College of Physicians and Surgeons of Manitoba (CPSM). [4] Under the Medical Act, clinical assistants, and later physician assistants, could be licensed.[5] The recognition of the need for national cohesiveness of the profession culminates in the creation of the national Canadian Association of Physician Assistants (CAPA).[6]

2001
With help from the Canadian Forces Medical Services Schools, a national Occupational Competency Profile (OCP) is developed for civilian PAs. This profile was later adopted by the Canadian Forces as well.

2003
The Canadian Medical Association (CMA) recognizes Physician Assistants as health professionals and the PA Certification Council (PACC) is formed. The CMA's accreditation process this year included PAs.[7] The provincial Medical Act in Manitoba recognizes the employment of clinical assistants in surgical and medical specialties. [8]

2004
Canadian Forces Health Services School PA education program becomes the first accredited PA program in the country.[9]

2005
The first Physician Assistant Entry to Practice Certification Exam (PA Cert Exam) is conducted, confirming a national standard for quality for PAs in Canada.[10]

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[1] Physician Assistant Toolkit: A resource for Canadian Physicians, Dec 2012, CMA and CAPA https://www.cma.ca/En/Pages/SearchPage.aspx?k=pa%20toolkit
[2] http://www.pahx.org/period02.html
[3] https://capa-acam.ca/about-pas/history/
[4] https://capa-acam.ca/about-pas/history/
[5] https://capa-acam.ca/pa-employers/legislation/
[6] https://capa-acam.ca/about-pas/history/
[7] https://www.oma.org/resources/documents/2009paomastatement.pdf
[8] https://www.healthforceontario.ca/UserFiles/file/AHP/Inside/PA-toolkit-april-2007-en.pdf
[9] https://capa-acam.ca/about-pas/history/
[10] http://www.caopa.net/en/Definition__51/

A Brief History of the Emerging PA Profession in Canada

2006
The Ministry of Health and Long-Term Care for Ontario (MOHLTC) includes PAs in Ontario's healthcare system.

2007
MOHLTC begins Phase I of a Demonstration Project to evaluate the impact of PAs, Nurse Practitioners (NPs), and acute care nurse specialists on the Ontario health care system. PAs join teams in hospital Emergency Departments and contribute to the positive outcomes of shorter wait times. Phase II of the PA demonstration project places more PAs in a greater variety of areas (physician offices, hospitals, long-term care facilities, and community health centres) to evaluate their effectiveness in the Ontario healthcare system.

The Manitoba Medical Association releases a policy statement on Physician Assistants, indicating support of the role of the Physician Assistant. [11]

2008
Two civilian PA programs are opened: McMaster University (Hamilton, Ontario)[12] and University of Manitoba (Winnipeg, Manitoba).[13]

2009
An updated form of the National Competency Profile and Scope for Canadian physician assistants (CanMEDS-PA) is released and Manitoba amends the legislation to identify certified Clinical Assistants as "Physician Assistants". New Brunswick announces the licensing of PAs by the College of Physicians and Surgeons under the Medical Act.[14]

2010
The third civilian PA program in Canada is launched at the University of Toronto. The Consortium of PA Education (University of Toronto, Northern Ontario School of Medicine, and the Michener Institute of Education at UHN) welcomes its first class of students. The PA programs at the University of Manitoba and McMaster University are accredited by CMA Conjoint Accreditation Services[15] and graduate their first cohort of students. [16,17] New Brunswick releases Regulation 14, which allows the provincial government to dictate PA terms of practice.[18]

2011
The BScPA Program at the University of Toronto is accredited by CMA Conjoint Accreditation Services.

2012
The Consortium of PA Education celebrates the convocation of the first cohort of students in the BScPA Program at the University of Toronto.

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[11] http://www.winnipeghealthregion.ca/careers/careersinhealth/pa.html
[12] http://fhs.mcmaster.ca/physicianassistant/
[13] https://www.docsmb.org/physician-assistants
[14] https://capa-acam.ca/about-pas/history/
[15] https://capa-acam.ca/about-pas/history/
[16] https://www.docsmb.org/physician-assistants
[17] http://fhs.mcmaster.ca/physicianassistant/
[18] https://capa-acam.ca/pa-employers/legislation/

FACT SHEET

Physician Assistants

ISSUE

Stakeholders including physicians, the Doctors of BC and some health authority Vice Presidents of Medicine have advocated for the introduction of Physician Assistants (PAs) in BC.

KEY FACTS

- PAs are often described as a form of "physician extender" and are dependent health care professionals licensed to practice medicine within the scope of practice of a supervising physician.
- A PA can interview patients, take medical histories, conduct physical exams, requisition tests/interpret test results, diagnose illness, counsel on health issues, assist in surgery, and prescribe treatments/medications.[1]
- Ontario, Alberta, Manitoba and New Brunswick introduced PAs into their health care workforces. The number of PAs is increasing with over 200 PAs employed in Ontario[2] representing 2/3rd of the total in Canada. PAs are regulated in Manitoba and New Brunswick by the regulatory colleges for physicians.
- Ontario and Manitoba are the only 2 provinces with training programs for PAs in the Faculties of Medicine at University of Manitoba (Winnipeg), McMaster University (Hamilton, Ontario), and the Northern Ontario School of Medicine (Thunder Bay/Sudbury) at University of Toronto. These training programs provide about 65 potential PAs for the workforce in Canada each year.[3][4][5]
- Formerly, only Canada's Department of National Defence trained and employed PAs for health service delivery.
- PAs have been part of the health care workforce in the USA for over 45 years.[6]
- PAs could conceivably supplement medical services in a number of areas in BC:
  - Rural health care – in communities with no or limited physician resources;
  - Aboriginal health care – in aboriginal communities, and with training-up of aboriginal health workers;
  - Primary health and community care – as a resource, along with nurse practitioners (NPs), pharmacists, and others in inter-professional practices and residential care;
  - Emergency departments;
  - Surgery – e.g., orthopedics; and
  - As part of a hospitalist program to better support general internal medicine units.
- In June 2009, a PA Steering Committee composed of representatives from health authorities, College of Physicians and Surgeons of BC (CPSBC), University of BC Faculty of Medicine (UBC), Doctors of BC, Department of National Defence, and Ministry of Health, recommended that the Ministry consider introducing PAs in hospitalist programs to better support general medical and surgical units.

---

[1] HealthForceOntario. (April 18, 2007). *Defining the Physician Assistant Role in Ontario*. Retrieved January 31, 2014 from: http://www.healthforceontario.ca/UserFiles/file/AHP/Inside/PA-role-april-2007-en.pdf

[2] Physician Assistants in Ontario, HealthForceOntario website, Retrieved Jan 21, 2016: http://www.healthforceontario.ca/en/M4/Ontario's_Physician_Assistant_Initiative

[3] FAQs, HealthForceOntario website, Retrieved Jan 21, 2016: http://www.healthforceontario.ca/en/M4/Ontario%27s_Physician_Assistant_Initiative/Frequently_Asked_Questions

[4] PA Program, University of Manitoba website, Retrieved Jan 21, 2016 http://umanitoba.ca/faculties/health_sciences/medicine/education/paep/faq.html

[5] S Anderson: "Ontario has up to 54 seats in both programs – NOSM has about 30 seats (up to 34 in 2014), McMaster has 21-22 seats; Manitoba has a steady 12 seats "

[6] The American Academy of Physician Assistants website: http://www.aapa.org/the_pa_profession/history.aspx

FACT SHEET

- In 2010, at the Ministry's request, CPSBC developed a draft regulatory framework for PAs and submitted a cost estimate for implementation if/when the Ministry were to decide to proceed.
- In 2010, Doctors of BC and the Ministry agreed to establish a joint committee to inform how PAs could be introduced into BC's health care system. Other priorities including the Physician Master Agreement and implementation of nurse practitioners overtook this work, with no further progress beyond preliminary discussions.
- In 2009, Fraser Health Authority signed an affiliation agreement with MEDEX Northwest, University of Washington's PA training program, and expects to accept students on clinical placements in acute care settings when/if the CPSBC's regulatory framework is implemented.
- The University of BC, Justice Institute of BC, and other stakeholders have had discussions on development of a joint proposal for a PA education program in BC, but these discussions are not currently active.
- In January 2014, the Minister directed Ministry staff to examine the practical considerations for introducing PAs in BC. Ministry staff prepared a draft Concept Paper to identify and discuss these considerations which include: practice setting and overlapping roles, an appropriate legislative and regulatory framework, funding model, employment and labour relations implications, education and training, etc.
- The Ministry is developing an integrated health human resources strategy and is undertaking broad consultation on the strategy. Our approach toward health human resource planning is to understand population health needs across BC's diverse geography so that we can design health service delivery models that align the skill sets of health care providers required to meet those needs. It is from this understanding that any change in the composition of health care providers should be considered.
- The introduction of a new profession or provider role requires careful consideration and management in order to understand integration challenges and what is required to address the inevitable issues that emerge for team functioning based on overlapping scopes of practice. Introduction of a new profession is likely to be far more intensive than is suggested by advocates, and may serve to undermine and confuse efforts to better integrate existing health care professionals.
- For example, the PA role would substantially overlap with existing nursing roles such as nurse practitioners, certified practice Registered Nurses, First Assist Nurses in operating rooms, and other provider roles such as General Practice physicians working as hospitalists or surgical assistants.
- At this time it is not clear that PAs can uniquely address gaps in patient and population health needs that cannot be addressed by other health professionals currently in place in BC, such as nurse practitioners (NPs).

FINANCIAL IMPLICATIONS

N/A

Approved by:

Kevin Brown, Workforce Planning & Management Branch; November 2, 2016
Ted Patterson, Health Sector Workforce Division; November 9, 2016

FACT SHEET

Physician Assistants

ISSUE

Stakeholders including physicians, Doctors of BC, health authority VPs of Medicine, and Canadian Association of Physician Assistants advocate for the introduction of Physician Assistants (PAs) in BC.

KEY FACTS

- PAs are a relatively new health profession in Canada, although they have been trained and employed by the Canadian Forces for over 40 years[1]. They have been part of the health care workforce in the US for 50 years. [2] PAs practice medicine under the direction and supervision of a licenced physician. PAs act as physician extenders whose scope of practice is dependent on the scope of the supervising physician.
- A PA's role may involve interviewing patients, taking medical histories, conducting physical exams, requisitioning/interpreting test results, diagnosing illness, counselling on health issues, assisting in surgery, and prescribing treatments/medications.[3]
- Ontario, Alberta, Manitoba and New Brunswick have introduced PAs into their health care workforces.
- Introduced over 8 years ago in Ontario, there are now over 300 PAs employed in the province, representing approximately 60 percent of the 500 total in Canada.[4]. PAs are registered or regulated in Alberta, Manitoba and New Brunswick by the regulatory colleges for physicians. They remain unregulated in Ontario but work under the authority of physicians. The majority of PAs in Canada are funded by health authorities and Ministries of Health.
- Ontario and Manitoba are the only two provinces with training programs for PAs in the Faculties of Medicine at University of Manitoba (Winnipeg), McMaster University (Hamilton, Ontario), and the Northern Ontario School of Medicine (Thunder Bay/Sudbury) with the University of Toronto. These training programs provide about 69 potential PAs for the workforce in Canada each year.[5]
- It has been proposed that PAs could supplement medical services in the following areas in BC:
    - Rural health care – communities with no or limited physician resources;
    - First Nations health care – First Nations communities, and career option for First Nations people;
    - Primary health and community care – interprofessional teams (including nurse practitioners, pharmacists, physiotherapist, others) and in residential care;
    - Emergency departments;
    - Surgical care – orthopedics; and
    - Acute care – hospitalist or general internal medicine program.
- In 2009, a PA Steering Committee composed of representatives from health authorities, College of Physicians and Surgeons of BC (CPSBC), University of BC Faculty of Medicine, Doctors of BC, Department of National Defence, and Ministry of Health, recommended that the Ministry consider introducing PAs in hospitalist programs to support general medical and surgical units.

---

[1] Canadian Association of Physician Assistants. (2018). PA Facts. In Canadian Association of Physician Assistants. Retrieved September 28, 2018, from https://capa-acam.ca/about-pas/pa-fact-sheet/

[2] American Academy of Physician Assistants website: https://www.aapa.org/about/history/

[3] HealthForce Ontario. (April 18, 2007). *Defining the Physician Assistant Role in Ontario*. https://www.slideshare.net/samueljack/defining-the-physician-assistant-role-in-ontario

[4] CAPA Physician Assistant Fact Sheet. Retrieved electronically, September 28, 2018 from: https://capa-acam.ca/about-pas/pa-fact-sheet/.

[5] S Anderson: "Ontario has up to 54 seats in both programs (NOSM - about 30 seats (34 in 2014), McMaster - 22 seats; Manitoba increased seats from 12 to 15 in 2016" Bulletin June 15,2017, HealthForceOntario https://capa-acam.ca/wp-content/uploads/2017/06/2017-PA-Career-Start-Bulletin-FINAL.pdf, PA Program University of Manitoba http://umanitoba.ca/faculties/health_sciences/medicine/education/paep/faq.html

- In 2010, at the Ministry's request, CPSBC developed a draft regulatory framework for PAs and submitted a cost estimate for implementation if/when the Ministry was to proceed. Fraser Health Authority signed an affiliation agreement with MEDEX Northwest, University of Washington's PA training program, expecting to accept students on clinical placements in acute care settings in anticipation of implementation of a regulatory framework.
- Doctors of BC and the Ministry established a joint committee to inform how PAs could be introduced into BC's health care system. The University of BC, Justice Institute of BC, and other stakeholders held discussions on development of a joint proposal for a PA education program in BC. Work on these two initiatives did not advance beyond preliminary discussions in 2010.
- In January 2014, the Minister of Health directed Ministry staff to explore the practical considerations for introducing PAs in BC. A draft concept paper[6] identified and discussed considerations, including practice settings and overlapping roles, an appropriate legislative and regulatory framework, a funding model, employment and labour relations implications, and education and training.
- The PA role overlaps substantially with existing nursing roles, such as nurse practitioners and registered nurses with certified practice credentials, and family physician roles such as hospitalists or surgical assistants.
- The introduction of a new health provider role requires careful consideration and management in order to understand and address the inevitable team function issues that emerge from overlapping scopes of practice. The associated effort is likely to be far more extensive than suggested by advocates, and the presence of PAs may serve to undermine and confuse efforts to improve integration of existing health care professionals.
- At this time, patient and population health care needs are able to be addressed with the skill sets of existing health care professions in BC. There are no known care gaps that can only be addressed by PAs. The Ministry has an obligation to British Columbians to optimize the scopes of practice of existing health care professionals such as nurse practitioners.

FINANCIAL IMPLICATIONS

N/A

Approved by:
Kevin Brown, Workforce Planning and Development Branch; September 26, 2018
Kevin Brown obo David Byres, Clinical Integration, Regulation and Education Division; September 26, 2018
Kiersten Fisher obo ADM Teri Collins, Health Sector Information Analysis and Reporting Division; October 9, 2018

[6] Concept Paper: Introducing Physician Assistants Into British Columbia's Health Care System, Draft for Discussion, Ministry of Health, October 24, 2014

From:	Bossert, Jess HLTH:EX
To:	Lowe, Tracey HLTH:EX; Cramb, Lorrie HLTH:EX
Cc:	Brown, Kevin HLTH:EX; Ghesquiere, Breanne J HLTH:EX
Subject:	RE: For Your Review: HLTH Media Request: Physicians Assistants
Date:	October 12, 2018 2:41:15 PM
Attachments:	image001.png

Okay, thanks Tracey.

From: Lowe, Tracey HLTH:EX
Sent: Friday, October 12, 2018 2:41 PM
To: Bossert, Jess HLTH:EX; Cramb, Lorrie HLTH:EX
Cc: Brown, Kevin HLTH:EX; Ghesquiere, Breanne J HLTH:EX
Subject: RE: For Your Review: HLTH Media Request: Physicians Assistants

Please ignore…all is good with GCPE..thanks Jess

Tracey Lowe | A/Executive Coordinator
Clinical Integration, Regulation and Education
Ministry of Health
Ph: 250 952-2629
Email: tracey.lowe@gov.bc.ca
Ministry of Health | PO Box 9639 STN PROV GOVT | Victoria BC | V8W 9P1

From: Bossert, Jess HLTH:EX
Sent: October 12, 2018 2:32 PM
To: Lowe, Tracey HLTH:EX ; Cramb, Lorrie HLTH:EX
Cc: Brown, Kevin HLTH:EX ; Ghesquiere, Breanne J HLTH:EX
Subject: RE: For Your Review: HLTH Media Request: Physicians Assistants

Hi Tracey – Yes, we can take a crack at this. Is end of day okay?

From: Lowe, Tracey HLTH:EX
Sent: Friday, October 12, 2018 2:30 PM
To: Cramb, Lorrie HLTH:EX; Bossert, Jess HLTH:EX
Cc: Brown, Kevin HLTH:EX; Ghesquiere, Breanne J HLTH:EX
Subject: FW: For Your Review: HLTH Media Request: Physicians Assistants

Hi Lorrie and Jess, I am hoping you can have a look at this request from GCPE….pls let me know..thanks

Tracey Lowe | A/Executive Coordinator
Clinical Integration, Regulation and Education
Ministry of Health
Ph: 250 952-2629
Email: tracey.lowe@gov.bc.ca
Ministry of Health | PO Box 9639 STN PROV GOVT | Victoria BC | V8W 9P1

From: Ghesquiere, Breanne J HLTH:EX
Sent: October 12, 2018 2:25 PM
To: Lowe, Tracey HLTH:EX <Tracey.Lowe@gov.bc.ca>
Subject: RE: For Your Review: HLTH Media Request: Physicians Assistants

He is around but prepping for his 2:30 and has meetings until 4.

Bre Ghesquiere
Branch Administrator
Workforce Planning and Development | Clinical Integration, Regulation and Education Division
Ministry of Health
PO Box 9650 Stn Prov Govt | Victoria BC V8W 9P4
Ph: 778 698-2586
Email: Breanne.Ghesquiere@gov.bc.ca

From: Lowe, Tracey HLTH:EX
Sent: Friday, October 12, 2018 2:18 PM
To: Ghesquiere, Breanne J HLTH:EX
Subject: Fwd: For Your Review: HLTH Media Request: Physicians Assistants
Hi Bre- is Kevin around ? GCPE is asking. Sorry for the rush. Thanks !

Sent from my iPhone

Begin forwarded message:

From: "Lowe, Tracey HLTH:EX" <Tracey.Lowe@gov.bc.ca>
Date: October 12, 2018 at 1:26:14 PM PDT
To: "Brown, Kevin HLTH:EX" <Kevin.Brown@gov.bc.ca>, "Prodan-Bhalla, Natasha L HLTH:EX" <Natasha.Prodan-Bhalla@gov.bc.ca>
Cc: "Ghesquiere, Breanne J HLTH:EX" <Breanne.Ghesquiere@gov.bc.ca>, "Sheppard, Jenifer A HLTH:EX" <Jenifer.Sheppard@gov.bc.ca>, "Byres, David W HLTH:EX" <David.Byres@gov.bc.ca>
Subject: FW: For Your Review: HLTH Media Request: Physicians Assistants

Hi, just received this – can you pls review the below information for GCPE on this – please see the request at the end of the email..thanks! Sorry for the short timeline..thanks!

Tracey Lowe | A/Executive Coordinator
Clinical Integration, Regulation and Education
Ministry of Health
Ph: 250 952-2629
Email: tracey.lowe@gov.bc.ca
Ministry of Health | PO Box 9639 STN PROV GOVT | Victoria BC | V8W 9P1

From: Murray, Heather HLTH:EX
Sent: October 12, 2018 1:23 PM
To: Booth, Kristen GCPE:EX <Kristen.Booth@gov.bc.ca>; Lowe, Tracey HLTH:EX <Tracey.Lowe@gov.bc.ca>
Cc: Heinze, Laura R GCPE:EX <Laura.Heinze@gov.bc.ca>
Subject: RE: For Your Review: HLTH Media Request: Physicians Assistants
Hi there – yes, looping in Tracey as she can respond to this from CIRE. Thanks, Heather.

From: Booth, Kristen GCPE:EX

Sent: Friday, October 12, 2018 1:06 PM
To: Murray, Heather HLTH:EX
Cc: Heinze, Laura R GCPE:EX
Subject: For Your Review: HLTH Media Request: Physicians Assistants

Hi Heather,

I'm not sure if you're the right individual to send this to, but hopefully you can redirect if you're not!

We've had a media request regarding Physician Assistants and I'm hoping you can give the below draft response a review and feedback. The reporter's deadline was yesterday, so if possible feedback by 2pm today would be appreciated.

Thanks,
Kristen

As a part of the Primary Health Care Strategy announced Spring 2018, the Ministry is increasing the number of nurse practitioners in B.C. as a key part of our overall approach to ensure British Columbians have better access to primary health care. The Ministry of Health is funding 200 new nurse practitioner positions within Primary Care Networks throughout B.C. and creating an additional 30 new nurse practitioner education seats in three B.C. post-secondary institutions (an increase of 66 per cent). As valuable members of the primary care team, increasing the numbers of nurse practitioners will contribute to the multi-faceted approach to close the primary care gap in B.C. Additionally, acknowledging the initial priority on addressing the shortage of general practitioners in the province, Government will fund up to 200 new general practitioners to work in the team-based care model, and provide opportunity for every family medicine resident to work in a renewed primary care system in which they can focus on patient-centred medicine.

The roles of primary care nurse practitioners and physicians complement one another and they often work in teams to strengthen the level of care they provide to patients. Working in teams, health care providers can offer longer or more convenient hours, deliver additional services like patient education, provide patients with support in self-managing their healthcare, offer maternity care that transitions into family health care, and as a team, be responsible for coordinating their patients' care.

Physician Assistants (PA)s are not currently a regulated health profession in B.C. While we recognize that PAs provide value and benefits to patients in jurisdictions where they are currently deployed, the introduction of a new health profession requires careful consideration and management, and significant resources to properly understand and address the issues that emerge from overlapping scopes of practice. There is no plan to implement PAs at this time, as Government's new primary health-care strategy commits to building on the best practices and solutions that already exist within the health-care system, but have yet to be fully leveraged throughout the province. However, the Ministry continues to connect with other jurisdictions to monitor and observe the use of PAs in their systems of care.
In regards to billing to MSP, only doctors are allowed to submit fee-for-service claims to MSP.

Request

1. Is the Ministry studying PAs as part of a future team-based model of care? If so, when can BC patients expect rollout?
2. What are the obstacles to adding physicians assistants or nurse practitioners into the mix? I hear from administrators on the Peninsula that NPs cannot bill

MSP, which is one obstacle. Would PAs have the same issue?

From: Lowe, Tracey HLTH:EX
To: Prodan-Bhalla, Natasha L HLTH:EX; Brown, Kevin HLTH:EX
Cc: Ghesquiere, Breanne J HLTH:EX; Sheppard, Jenifer A HLTH:EX; Byres, David W HLTH:EX
Subject: RE: For Your Review: HLTH Media Request: Physicians Assistants
Date: October 12, 2018 2:38:51 PM

Thanks for your response – all is good. Thanks

Tracey Lowe | A/Executive Coordinator
Clinical Integration, Regulation and Education
Ministry of Health
Ph: 250 952-2629
Email: tracey.lowe@gov.bc.ca
Ministry of Health | PO Box 9639 STN PROV GOVT | Victoria BC | V8W 9P1

From: Prodan-Bhalla, Natasha L HLTH:EX
Sent: October 12, 2018 2:08 PM
To: Lowe, Tracey HLTH:EX ; Brown, Kevin HLTH:EX
Cc: Ghesquiere, Breanne J HLTH:EX ; Sheppard, Jenifer A HLTH:EX ; Byres, David W HLTH:EX
Subject: RE: For Your Review: HLTH Media Request: Physicians Assistants

I reviewed already. Thanks.

N

Natasha Prodan-Bhalla, DNP, MN, NP (A), BScN
Executive Director, Nurse Practitioners & Primary Health Care
Nursing Policy Secretariat
Clinical Integration, Regulation and Education Division
Ministry of Health
PO Box 9650 Stn Prov Govt
Victoria, BC V8W 9P4
Mobile: (250) 413-7507

Acknowledging the traditional lands on which we live, work and play

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From: Lowe, Tracey HLTH:EX
Sent: Friday, October 12, 2018 1:26 PM
To: Brown, Kevin HLTH:EX; Prodan-Bhalla, Natasha L HLTH:EX
Cc: Ghesquiere, Breanne J HLTH:EX; Sheppard, Jenifer A HLTH:EX; Byres, David W HLTH:EX
Subject: FW: For Your Review: HLTH Media Request: Physicians Assistants
Importance: High

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Tracey Lowe | A/Executive Coordinator
Clinical Integration, Regulation and Education
Ministry of Health
Ph: 250 952-2629
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Ministry of Health | PO Box 9639 STN PROV GOVT | Victoria BC | V8W 9P1

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Sent: October 12, 2018 1:23 PM
To: Booth, Kristen GCPE:EX <Kristen.Booth@gov.bc.ca>; Lowe, Tracey HLTH:EX <Tracey.Lowe@gov.bc.ca>
Cc: Heinze, Laura R GCPE:EX <Laura.Heinze@gov.bc.ca>
Subject: RE: For Your Review: HLTH Media Request: Physicians Assistants
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Cc: Heinze, Laura R GCPE:EX
Subject: For Your Review: HLTH Media Request: Physicians Assistants
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As a part of the Primary Health Care Strategy announced Spring 2018, the Ministry is increasing the number of nurse practitioners in B.C. as a key part of our overall approach to ensure British Columbians have better access to primary health care. The Ministry of Health is funding 200 new nurse practitioner positions within Primary Care Networks throughout B.C. and creating an additional 30 new nurse practitioner education seats in three B.C. post-secondary institutions (an increase of 66 per cent). As valuable members of the primary care team, increasing the numbers of nurse practitioners will contribute to the multi-faceted approach to close the primary care gap in B.C. Additionally, acknowledging the initial priority on addressing the shortage of general practitioners in the province, Government will fund up to 200 new general practitioners to work in the team-based care model, and provide opportunity for every family medicine resident to work in a renewed primary care system in which they can focus on patient-centred medicine.

The roles of primary care nurse practitioners and physicians complement one another and they often work in teams to strengthen the level of care they provide to patients. Working in teams, health care providers can offer longer or more convenient hours, deliver additional services like patient education, provide patients with support in self-managing their healthcare, offer maternity care that transitions into family health care, and as a team, be responsible for coordinating their patients' care.

Physician Assistants (PA)s are not currently a regulated health profession in B.C. While we recognize that PAs provide value and benefits to patients in jurisdictions where they are currently deployed, the introduction of a new health profession requires careful consideration and management, and significant resources to properly understand and address the issues that emerge from overlapping scopes of practice. There is no plan to implement PAs at this time, as Government's new primary health-care strategy commits to building on the best practices and solutions that already exist within the health-care system, but have yet to be fully leveraged throughout the province. However, the Ministry continues to connect with other jurisdictions to monitor and observe the use of PAs in their systems of care.
In regards to billing to MSP, only doctors are allowed to submit fee-for-service claims to MSP.

Request

1. Is the Ministry studying PAs as part of a future team-based model of care? If so, when can

BC patients expect rollout?
2. What are the obstacles to adding physicians assistants or nurse practitioners into the mix? I hear from administrators on the Peninsula that NPs cannot bill MSP, which is one obstacle. Would PAs have the same issue?

From:	Heinze, Laura R GCPE:EX
To:	Booth, Kristen GCPE:EX; Thorneloe, Meghan HLTH:EX; Brown, Kevin HLTH:EX; Ty, Marie HLTH:EX; Hart, Bob HLTH:EX
Subject:	RE: HLTH Media Request: Physicians Assistants
Date:	October 11, 2018 4:49:13 PM

Hi all,

Just wanted to follow up on this one – any edits?

Thx

Laura

From: Booth, Kristen GCPE:EX
Sent: Thursday, October 11, 2018 2:10 PM
To: Thorneloe, Meghan HLTH:EX; Brown, Kevin HLTH:EX; Ty, Marie HLTH:EX; Hart, Bob HLTH:EX
Cc: Heinze, Laura R GCPE:EX
Subject: FW: HLTH Media Request: Physicians Assistants

Hi everyone,

Thanks for your help on this, below is a revised draft for your approval based on all the feedback received.

Thanks,
Kristen

As a part of the Primary Health Care Strategy announced Spring 2018, the Ministry is increasing the number of nurse practitioners in B.C. as a key part of our overall approach to ensure that accessing primary care is not such a struggle for British Columbians. The Ministry of Health is creating 200 nurse practitioner jobs, securing nurse practitioners' employment in primary care settings throughout B.C., and creating an additional 30 new nurse practitioner education seats in three B.C. post-secondary institutions (an increase of 66 per cent). As valuable members of the primary care team, increasing the numbers of nurse practitioners will contribute to the multi-faceted approach to close the primary care gap in B.C. Additionally, acknowledging the initial priority on addressing the shortage of general practitioners in the province, Government will fund up to 200 new general practitioners to work in the team-based care model, and provide opportunity for every family medicine resident to work in a renewed primary care system in which they can focus on patient-centred medicine.

The roles of primary care nurse practitioners and physicians complement one another and they often work in teams to strengthen the level of care they provide to patients. Working in teams, health care providers can offer longer or more convenient hours, deliver additional services like patient education, provide patients with support in self-managing their healthcare, offer maternity care that transitions into family health care, and as a team, be responsible for coordinating their patients' care.

While we recognize that Physician Assistants (PA)s provide value and benefits to patients in jurisdictions where they are currently deployed, the introduction of a new health profession requires careful consideration and management, and significant resources to properly understand and address the issues that emerge from overlapping scopes of practice. In that regard, the Ministry of Health has considered in depth the option of implementing PAs and concluded that the PA role overlaps substantially with existing nursing roles, such as nurse practitioners and registered nurses with certified practice credentials, and family physician roles such as hospitalists or surgical assistants. There is no plan to include them as part of the primary care teams yet, but the Ministry continues to connect with other jurisdictions to monitor and observe the use of PAs in their systems of care.

In regards to billing to MSP, currently Nurse Practitioners and PAs are unable to bill directly to MSP as Billing MSP Fee For Service for services that are medically necessary is restricted to Medical Doctors. To accommodate this, Nurse Practitioners bill to Alternative Payment Plan. There are no plans as of yet to expand the MSP billing privileges.

Request

1. Is the Ministry studying PAs as part of a future team-based model of care? If so, when can BC patients expect rollout?
2. What are the obstacles to adding physicians assistants or nurse practitioners into the mix? I hear from administrators on the Peninsula that NPs cannot bill MSP, which is one obstacle. Would PAs have the same issue?

From: Rindler, Sydney HLTH:EX
To: Sehic, Liza JTST:EX
Cc: Krystalowich, Katharine HLTH:EX; Vatne, Brian R HLTH:EX; Blackie, Doug HLTH:EX
Subject: RE: Job Profiles - Nurse practitioner and Physician Assistant
Date: November 30, 2016 2:31:08 PM
Attachments: Profession profile info for JTST Nov 17 2016.docx

Hello Liza,

Please find the information you requested for your WelcomeBC Job profiles.

I apologise that it has taken so long to get this back to you, and hope this information is useful to you.

Thanks for your patience,
Sydney

From: Sehic, Liza JTST:EX
Sent: Thursday, November 17, 2016 4:30 PM
To: Rindler, Sydney HLTH:EX
Cc: Krystalowich, Katharine HLTH:EX
Subject: RE: Job Profiles - Nurse practitioner and Physician Assistant

Hi Sydney,

I can try to push the deadline for early next week as you are just waiting for approval. Then it will be just a matter of copy and paste for me.

Thanks,
Liza

From: Rindler, Sydney HLTH:EX
Sent: Thursday, November 17, 2016 4:28 PM
To: Sehic, Liza JTST:EX
Cc: Krystalowich, Katharine HLTH:EX
Subject: RE: Job Profiles - Nurse practitioner and Physician Assistant

HI Liza,
Unfortunately, the information we have gathered has not yet been looked at by our manager/directors, s.22 Just wanted you to know, as I am not sure whether it will be ready tomorrow. Apologies!
Sydney

From: Sehic, Liza JTST:EX
Sent: Tuesday, November 15, 2016 2:11 PM
To: Rindler, Sydney HLTH:EX
Cc: Krystalowich, Katharine HLTH:EX
Subject: RE: Job Profiles - Nurse practitioner and Physician Assistant

Thanks you very much Sydney.

Liza

From: Rindler, Sydney HLTH:EX
Sent: Tuesday, November 15, 2016 9:59 AM
To: Sehic, Liza JTST:EX
Cc: Krystalowich, Katharine HLTH:EX
Subject: RE: Job Profiles - Nurse practitioner and Physician Assistant

Hi Liza,

As previously indicated, here is the information for Nurse Practitioners and Naturopathic Physicians. We are still working on the remaining professions, and will try to provide that information by the end of the week. I will let you know if the information is not ready to send you by Friday.

I hope this is helpful.

Sydney

Nurse Practitioners

To practise as a registered nurse practitioner (NP) in BC, an NP must be registered with the College of Registered Nurses of BC (CRNBC). CRNBC registers NPs in one of three streams of practice: family, adult and pediatric.

Potential applicants must undertake the following steps to be eligible for registration:
• Complete an online pre-assessment questionnaire and application
• Submit education and certification/registration documents for review
• Complete the Competency Assessment Process
• Complete a written exam and an objective structured clinical examination (OSCE)

The BC Nurse Practitioner Association and the Association of Registered Nurses of British Columbia support and advance the professional interests of BC NPs.

Naturopathic Physicians

The College of Naturopathic Physicians of BC (CNPBC) is the regulatory body for naturopathic physicians. The CNPBC requirements for registration:
• Three years liberal arts or sciences study in an accredited college or university approved by the Board
• Graduation from an accredited naturopathic medical school
• Completion of Naturopathic Physician Licensing exams
• Completion of Jurisprudence and Oral/Practical exams

The BC Naturopathic Association (BCNA) is the voluntary organization that advocates for the professional and economic interests of NDs.

From: Rindler, Sydney HLTH:EX
Sent: Monday, November 14, 2016 10:40 AM
To: Sehic, Liza JTST:EX
Cc: Krystalowich, Katharine HLTH:EX
Subject: RE: Job Profiles - Nurse practitioner and Physician Assistant

Hello Liza,

We have pulled some information from our internal documents on NPs and naturopathic physicians. We don't have registration information for the remaining professions you mentioned, (chiropodist, orthoptist, osteopathic physician, podiatrist), but we do have a co-worker s.22
s.22 who is knowledgeable about PAs and podiatry. Hopefully we will be able to send the NP, ND, PA, and podiatrist info to you sometime this week, or as soon as we are able to have one of our managers review the information we have gathered to date

Given that there has been a delay in our original anticipated response time, I just want to make sure we aren't duplicating efforts you've already made in regards to gathering information about chiropodist, orthoptist, osteopathic physician, and podiatrist professions. We can research those websites if you haven't already pulled the information together.

Thank you,

Sydney

From: Krystalowich, Katharine HLTH:EX
Sent: Wednesday, November 2, 2016 3:14 PM
To: Sehic, Liza JTST:EX
Cc: Rindler, Sydney HLTH:EX
Subject: RE: Job Profiles - Nurse practitioner and Physician Assistant

Hi Liza, I will see what we have for these professions as well but we may not have information on some of them.

Katharine

From: Sehic, Liza JTST:EX
Sent: Wednesday, November 2, 2016 2:49 PM
To: Krystalowich, Katharine HLTH:EX
Subject: RE: Job Profiles - Nurse practitioner and Physician Assistant

Not a problem Katherine. I really appreciate it.

I came across NOC 3125 (Other Professional Occupation in Health Diagnosing and Treating) which

used to be address Naturopathic Physicians, is now one NOC that encompasses chiropodist, orthoptist, osteopathic physician, podiatrist and naturopathic physician. I would be grateful if you could take a look at this one as well. I have attached the old description which only addresses naturopathic physicians. Please let me know if this is doable as well. Of course, the deadline can easily be extended.

Cheers,
Liza

From: Krystalowich, Katharine HLTH:EX
Sent: Wednesday, November 2, 2016 2:40 PM
To: Sehic, Liza JTST:EX
Subject: RE: Job Profiles - Nurse practitioner and Physician Assistant

Hi Liza, will try to provide something by end of day Friday but would early next week work?

From: Sehic, Liza JTST:EX
Sent: Tuesday, November 1, 2016 2:59 PM
To: Krystalowich, Katharine HLTH:EX
Subject: RE: Job Profiles - Nurse practitioner and Physician Assistant

Thanks a lot!!!

Would it be possible this week?

Liza

From: Krystalowich, Katharine HLTH:EX
Sent: Tuesday, November 1, 2016 2:58 PM
To: Sehic, Liza JTST:EX
Subject: RE: Job Profiles - Nurse practitioner and Physician Assistant

Hi Liza, we can complete this for you. When do you need the information?

From: Sehic, Liza JTST:EX
Sent: Tuesday, November 1, 2016 2:55 PM
To: Krystalowich, Katharine HLTH:EX
Subject: Job Profiles - Nurse practitioner and Physician Assistant

Hi Katherine,

It was a pleasure to meet you yesterday. I was wondering who I should contact to get some information about Job profiles for newcomers.

We are updating the job profiles to 2011 NOC codes on WelcomeBC site and noticed that NOC 3124, which used to be for Midwives, now includes Nurse Practitioners and Physician Assistants. Would

you (or someone who you refer me to) write a paragraph or two about how newcomers can get qualified in BC to become a nurse practitioner and physician assistant. I have attached the job profile that we wrote for Midwives for your reference. I have highlighted in the document where we need to include Nurse Practitioners and Physician Assistant information.

Please let me know if you need more information. I can give you a quick call.

Thanks,
Liza

Liza Sehic
Program Manager, Foreign Qualifications Recognition
Ministry of Jobs, Tourism and Skills Training
Mobile: 778-678-1649
Email: liza.sehic@gov.bc.ca

Orthoptist

Licensing/Registration: Canadian Orthoptic Council (COC)

Canadian Orthoptic Council: http://www.orthopticscanada.org/index

An orthoptist is an eye care/health professional with a specialized body of knowledge in vision science with an emphasis on binocular vision, ocular motility and related disorders of vision.

International applicants:
If the applicant is American or British certified, it is possible to take the examinations without further Canadian training, providing applicant has a university degree in addition to orthoptist certification.

International applicants (other than USA, GB, or France) in which orthoptics are a regulated profession must submit:

- Evidence of a university or college baccalaureate degree;
- Evidence of at least 24 months of training in orthoptics;
- Proof of certification as an orthoptist.

Applicant must be in good standing with council, organization, or university of the original certificate.
Documentation must be translated into French or English and be notarized.
Proof of English language proficiency must be provided.
Upon acceptable review of documents, candidate will be granted a letter of eligibility for admission to an accredited training program in Canada, and will be asked to sturdy a minimum of 6 months (until judged ready to take examinations).

Chiropodist

Not a recognized profession in BC.

Physician Assistants

BC has not introduced Physician Assistants into the publicly-funded health care system. Therefore, there are no job opportunities for Chiropodists in the publicly-funded health care system.

Osteopathic Physician

Osteopathic physicians must register with the College of Physicians and Surgeons of British Columbia in order to practice in BC.

To be granted osteopathic registration with the College of Physicians and Surgeons of British Columbia, an applicant must:

- be a graduate of a school or college of osteopathic medicine accredited by the American Osteopathic Association, acceptable to the Registration Committee,
- have successfully completed
    - postgraduate training and certification in a program accredited by the American Osteopathic Association, acceptable to the Registration Committee, and
    - the three-part comprehensive osteopathic medical licensing examinations administered by the United States National Board of Osteopathic Medical Examiners, and
- be legally entitled to live and work in Canada.

https://www.cpsbc.ca/for-physicians/registration-licensing/applying/independent/osteopathic

http://osteopathic.bc.ca/registration.htm

Podiatrist

A podiatrist is a doctor of podiatric medicine (DPM), also known as a podiatric physician or surgeon. Podiatrists diagnose and treat conditions of the foot, ankle, and related structures of the leg.

Podiatrists in British Columbia receive their training in the United States - they are not medical doctors with a subspecialty, they are doctors of podiatry with a very specific scope of practice.

Podiatrists wishing to practice the profession of podiatric medicine in BC must first be admitted and registered by the regulatory body, the College of Podiatric Surgeons of British Columbia (CPS-BC).

The requirements for full registration in BC are:

(a) graduation with a Doctor of Podiatric Medicine degree from one of the nine recognized podiatric medical educations in the United States
(b) successful completion of the examinations conducted by the United States National Board of Podiatric Medical Examiners, Parts I, II and III
(c) successful completion of the jurisprudence examination required by the registration committee

(d) evidence satisfactory to the registration committee of the good character of the person consistent with the responsibilities of a registrant and the standards expected of a registrant.
(e) at least one of the following:
- registration in the active membership class of the former British Columbia Association of Podiatrists continued under the Podiatrists Act or the equivalent thereof, and practice of podiatric medicine as described in the Regulation or the equivalent thereof, in British Columbia or another jurisdiction recognized by the board for the purposes of this section, since July 1, 2002;
- registration in the active membership class of the former British Columbia Association of Podiatrists continued under the Podiatrists Act or the equivalent thereof, and practice of podiatric medicine as described in the Regulation or the equivalent thereof, in British Columbia or another jurisdiction recognized by the board for the purposes of this section, since July 1, 2005, and successful completion of at least one year of accredited postgraduate training satisfactory to the registration committee;
- successful completion of at least two years of accredited postgraduate training satisfactory to the registration committee

Commented [RSH1]: Not sure if this level of detail is required.

http://www.bcpodiatrists.ca/licensing

http://www.bcpodiatrists.org/sites/default/files/PDF/Bylaws.pdf

Naturopathic Physicians (*provided to JTST November 15th*)

The College of Naturopathic Physicians of BC (CNPBC) is the regulatory body for naturopathic physicians. The CNPBC requirements for registration:
• Three years liberal arts or sciences study in an accredited college or university approved by the Board
• Graduation from an accredited naturopathic medical school
• Completion of Naturopathic Physician Licensing exams
• Completion of Jurisprudence and Oral/Practical exams

The BC Naturopathic Association (BCNA) is the voluntary organization that advocates for the professional and economic interests of NDs.

http://www.cnpbc.bc.ca/

http://www.bcna.ca/

Nurse Practitioners (*provided to JTST November 15th*)

To practise as a registered nurse practitioner (NP) in BC, an NP must be registered with the College of Registered Nurses of BC (CRNBC). CRNBC registers NPs in one of three streams of practice: family, adult and pediatric.

Potential applicants must undertake the following steps to be eligible for registration:
- Complete an online pre-assessment questionnaire and application
- Submit education and certification/registration documents for review
- Complete the Competency Assessment Process
- Complete a written exam and an objective structured clinical examination (OSCE)

The BC Nurse Practitioner Association and the Association of Registered Nurses of British Columbia support and advance the professional interests of BC NPs.

REVIEW OF ANESTHESIA ASSISTANT TRAINING AND EDUCATION IN BC

Final Report

for

BC Ministry of Health

Submitted by:
Pat Semeniuk, Consultant
November 4, 2016

Table of Contents

Acknowledgements

I would like to acknowledge the many people that contributed information to this review. In particular I would like to acknowledge:

- the health authorities and specifically the Anesthesiology Departments that contributed information about practice, insights and suggestions for Anesthesia Assistant training and education in BC.
- the BCSAA, the BCAS, the BCRT for providing valuable information.
- the CSRT for sharing an early draft of their AA Competency Validation report as I first started this review and for sending a final copy as soon as the final document was released.
- the Thompson Rivers University AA program who met with me, provided documents that I asked for plus those that they thought I would find useful, and answered the many questions that arose during the months that I conducted this review.
- the AA education programs across Canada who described their programs, shared some of their evaluation tools, connected me with their key hospital stakeholders, and answered additional questions that arose during the writing of the report.

Alberta Health Services
Roberta Dubois, Professional Practice Leader, Senior Practice Leader Responsible for Service and Equipment, Health Professions Strategy and Practice, Alberta Health Services

Algonquin College
Ali McLean, Coordinator, Anesthesia Assistant Graduate Certificate Program, School of Health and Community Studies, Algonquin College

The Ottawa Hospital
Gabriel Caporale, AA, Liaison with Algonquin College

BC Society of Anesthesia Assistants
BCAA Chair, Mandy Tandy, AA Supervisor, VGH
Board member, Kyle Mcadam, AA, Royal Columbian Hospital

BC Society of Anesthesiology (BCAS)
Dr. Sukh Brar, President, BCAS, and Anesthesiologist, Royal Columbian Hospital
Dr. Kallie Honeywood, Liaison BCAS and TRU Advisory and Curriculum Committee Member, Anesthesiologist, Vernon Jubilee Hospital
Dir. Roland Orfaly, BCAS, and Anesthesiologist, Royal Columbian Hospital

BC Society of Respiratory Therapists
Mike Giesbrecht, RT; President, BSRT; Manager High Acuity and Respiratory Therapy, Fraser Health Authority

Canadian Society of Respiratory Therapists (CSRT)
Christiane Menard, Executive Director
Carolyn McCoy, Director of Accreditation

College and Association of Respiratory Therapy of Alberta
Bryan Buell, Executive Director, College and Association of Respiratory Therapy of Alberta

College of Nurses of Ontario
Anthony Derro, Practice Consultant
Rola Moghabghas, Advanced Practice Consultant

Fanshawe College, London, Ontario
Paul Williams, Program Coordinator, Anesthesia Assistant Graduate Certificate Program

Michener Institute of Education at University Hospital Network
Susan Dunington, Anesthesia Assistant Professor, Michener

University Health Network
Ana Lopez Filici, AA, Manager, Anesthesia Clinical Services, Practice Leader, Anesthesia Assistants

l'Ordre professionnel des inhalothérapeutes du Québec (OPIQ)
Marise Tetreault, Coordinator, Professional Development
Jocelyn Vachon, President

Thompson Rivers University
Jean Crow, Program Administrator, Science, Open Learning
Les Matthews, Associate Professor of Respiratory Therapy; Anesthesia Assistant Program Coordinator; Director, Centre for Respiratory Health and Sleep Sciences
John Patton, RT, AA, Open Learning Faculty
Dave Sheets, Faculty, Respiratory Therapy Program; Academic Coordinator Open Learning Health Sciences, Faculty of Science
Dr. Lawrence Takeuchi, Anesthesiologist, Consultant

University of BC Department of Anesthesia, Pharmacy and Therapeutics
Dr. Roanne Preston, UBC Department Head of Anesthesiology, Pharmacology and Therapeutics, member of TRU AA Advisory Committee

University of Toronto
Tammy Chan**,** Associate Registrar, Admissions, Recruitment & Programs, Lawrence S. Bloomberg Faculty of Nursing

Winnipeg Regional Health Authority
Faylene Fung, FCSRT, Clinical Assistant- Anesthesia, Department of Anesthesia

Bruce Knoll, RRT, Regional Manager, WRHA Anesthesia/Surgery Programs
Mark Ratz, Clinical Assistant – Anesthesia, Lead; Chair Anesthesia Assistant Section – Canadian Anesthesiologists Society

HEALTH AUTHORITIES

BC Children's Hospital
Peter Baxter, AA Supervisor
Cheryl Davies, Chief Operating Officer
Dr. Norbert Froese, Head, Department of Pediatric Anesthesia

BC Women's Hospital
Dr. James Brown, Anesthesiologist
Linda Lemke, Chief Operating Officer

Fraser Health
Rob Dosil, AA Supervisor, Surrey Memorial Hospital
Dr. Dean Jones, Regional Medical Director, Anesthesiology Services and Anesthesiology Department Head, Delta Hospital
Glenn Marcus, Director, People Services
Kyle Mcadam, AA, Royal Columbian Hospital
Dr. Roy Morton, Vice President, Medicine
Janet Murphy, Director, Professional Practice
Lorraine Prysunka, Director, Surrey Memorial Hospital
Dr. John Ramsden, Anesthesiology Department Head, Royal Columbian Hospital

Interior Health
Rod Adams, AA, Kelowna General Hospital
Denise Dunton, Surgical Services Clinical Leader
Mal Griffin, Vice President, Human Resources
Dr. Aaron Jackson, Head of Anesthesia, Kelowna General Hospital
Glen McCrae, Chief Nursing Officer
Dr. Alan Stewart, Vice President, Human Resources

Island Health
Fiona Hughes, OR RT, Victoria General Hospital
Joanne MacLaren, Director, Professional Practice
Dawn Nedzelski, Chief Professional Practice and Chief Nursing Officer
Dr. Tom Ruta, Department Head, Anesthesia; Medical Director, Surgical Services

Northern Health
Penny Anguish, Interim Chief Operating Officer, Northern Interior and Chief Nursing Executive
Dr. Ronald Chapman, Vice President, Medicine

Kim Ewan, Director of Perioperative and Ambulatory Services
Richelle Maser, Chief Respiratory Therapist, University Hospital of Northern BC
Dr. Shehzad Mehmood, Department Head, Anesthesia
Jan O'Neil, Peri op Leader, University Hospital of Northern BC
Suzanne Watson, Professional Practice Lead, Rehab

Providence Health
Irfaan Ali, RRTA, Anesthesia Assistant Supervisor
Dr. Ron Carere, Vice President, Medical Affairs
Leanne Heppell, Vice President, Patient Experience, Acute Care and Chief of Professional Practice and Nursing
Dr. Jim Prentice, Director, Anesthesia Equipment and Technology, Director Anesthesia Assistant Program
Zulie Sachedina, Vice President, Human Resources and General Counsel

Vancouver Coastal
Andrea Bisiallon, Director, Vancouver Acute
Deb Blaney, Executive Director, Employee Engagement
Sally Breen, Director, Clinical Education
Vivian Eliopoulos, Chief Operating Officer, Vancouver Acute
Jo Clark, Director, Professional Practice
Dr. Mitch Giffin, Anesthesiologist
Kristy Hamada, AA Clinical Educator
Anne Harvey, Vice President, Employee Engagement
Barb Lawrie, Vice President, Professional Practice and Chief Clinical Information Officer
Dr. Brad Merriman, Anesthesiologist
Dr. Patrick O'Connor, Vice President, Medicine
Mandy Thandi, AA Supervisor
Dr. Hamed Umedaly, Chief of Anesthesiology

First Nations Health Authority
Becky Palmer, Chief Nursing Officer
Dr. Charl Bordenhorst

PHSA
Sherry Hamilton, Chief Nursing and Liaison Officer
Arden Krystal, Vice President, Patient and Employee Experience

Executive Summary

The purpose of this project was to provide an external objective gap analysis to determine the provincial/regional entry to practice Anesthesia Assistant (AA) competencies needed within the BC health care system. The project was to include a review of Anesthesia Assistant (AA) training and education in BC, and to identify any potential gaps related to entry to practice competencies and current workplace practices and requirements, including recommendations for addressing any potential gaps identified. .

The review was conducted between June 3 and September 30, 2016. The methodologies utilized to collect information included a review of AA duties and competencies developed at a national level; an environmental scan of the education requirements for the practice of anesthesia assistance across Canada; interviews with AA education program leaders across Canada; interviews with BC stakeholders; an assessment of the Thompson Rivers University (TRU) program and processes; a review of the health authority training and education pathways to AA practice, and several meetings with the Vancouver General Hospital Anesthesia Care Team leaders.

The Canadian Anesthesiologists' Society (CAS) has defined the technical, clinical and administrative duties of an AA. CAS's position is that individuals working as AAs are optimally experienced health care professionals who have pursued a defined period of didactic and clinical training specific to the competencies required of AAs and are credentialed in Canada. Furthermore, the academic curriculum must cover pertinent areas of physiology, pharmacology, technical and professional aspects of AA practice. AAs work under the direct supervision of the attending anesthesiologist and execute medical orders and directives as prescribed by the attending anesthesiologist. Anesthesiologists, in conjunction with other AA educators, must have involvement in curriculum design, course content, and the teaching and assessment of AA trainees.

An interprofessional group facilitated by the Canadian Society of Respiratory Therapists developed a National Educational Competency Framework for Anesthesia Assistance Education that was endorsed by Canadian Society of Respiratory Therapists, the Canadian Anesthesiologists' Society, the Academic University Departments of Anesthesia and the National Association of PeriAnesthesia Nurses of Canada in 2011. The framework is organized by competencies, performance indicators and the foundational knowledge required. The framework was validated in 2016 and is intended for use as a guide for the design and maintenance of AA education programs. It is also intended as guide for employers to use for AA performance appraisal, professional development and recruitment. Rollout of the validated framework and competency indicators has not yet occurred in BC [1]Overall,

[1] AA training at Thompson Rivers University has used the CSRT National Educational Competency Framework to guide program revisions since 2014

consensus on the level of competency indicators to be expected of graduates of an AA education program has yet to be established.

Requirements for practice in Anesthesia Assistance vary across Canada. BC, Saskatchewan, Manitoba, Ontario, New Brunswick, Nova Scotia and Newfoundland all require completion of a specialized education program as entry to practice into the role. Respiratory Therapy (RT) diploma programs in Quebec include specialized theory and clinical practice in the OR. As a result Quebec does not require additional formal education for RTs to work in the ORs assisting anesthesiologists. Alberta does not require additional specialty education for Respiratory Therapists to work as a Clinical Specialist – Anesthesia OR.

The title "Anesthesia Assistant" is not protected. RNs and RTs practicing as AAs in Saskatchewan, Ontario, New Brunswick, Nova Scotia and Newfoundland are regulated by their respective regulatory bodies. The College of Physician and Surgeons of Manitoba regulates the practice of Clinical Assistants - Anesthesiology in that province. Currently, RTs are not regulated in BC.

Five education programs are offered in Canada. The Michener Institute of Education at University Hospital Network, Algonquin College, Fanshawe College, and TRU Open Learning all offer postgraduate Anesthesia Assistant certificate programs. In Manitoba the Winnipeg Regional Health Authority offers an in-house Anesthesia Clinical Assistant program in collaboration with the University of Manitoba and anesthesiologists in the health authority.

Program Admission

Admission requirements for the Ontario programs include current registration with a College of Respiratory Therapy or a College of Nursing and two years of equivalent recent critical care experience plus a letter from a Chief of Anesthesiology indicating the department will support the applicant's clinical practicum.

Candidates considered for admission to the Manitoba program include RNs licensed in Manitoba; International Medical Graduates (IMGs), Physician Assistants (PA's) with recent experience in anesthesia/emergency/critical care and graduated from a university recognized by the College of Physician and Surgeons of Manitoba (CPSM); Registered Respiratory Therapists. All applicants must have two years of critical care or anesthesia related operating room experience within the past five years; and have successful completed the CPSM Registered Clinical Assistant Examination.

Applicants for the TRU program must have a qualification as a RT or RN with critical care experience or an equally qualified individual with proof of professional licensure, plus one year of postgraduate clinical experience and a letter from an anesthesiologist recommending the candidate's suitability. Students will also complete an entrance exam testing for baseline knowledge and assess the need for

additional supplementary coursework. Students are responsible for finding a clinical affiliate willing to provide the clinical practicum experience.

Program delivery

The Michener program is delivered over three consecutive academic semesters. Semester 1 is delivered online and ends with a one-week residency. Semester 2 is delivered online and face-to-face and concludes with a two-week residency. Anesthesiologists are involved in the lectures, labs and simulations in both semesters. The final semester is a 12-week clinical practicum followed by a final written examination.

Algonquin's program is delivered online and face-to-face over a twelve-month period. During Semester 1, students complete online courses and attend a weekly lab session and participate in an end of semester simulation session. During Semester 2, students continue with online theory and attend a weekly lab session consisting of lectures delivered by anesthesiology residents and participate in simulations. The final semester is a 350-hour clinical practicum.

Fanshawe's program is classroom-based, led by a contracted program medical director and supported by a full time program administrator. Classes are conducted one-day-a week over two semesters. Anesthesia Assistants teach the equipment courses and conduct the labs in Semester 1. Anesthesiologists teach the classes and labs in Semester 2. The final semester is a 320-hour clinical practicum.

The Manitoba program is led by an Anesthesiologist Medical Director and supported by a Regional Manager and a Lead Anesthesia Clinical Assistant. Trainees are hired into a 12-month program conducted at WRHA that consists of approximately 165 self-study modules. Each module lists the learning objectives, pre-requisite knowledge, references, competencies, advanced topics for discussion with an attending anesthesiologist, and questions for the trainee to answer. Trainees follow a weekly schedule for the 12-months. The schedule identifies the modules required to be completed each week, clinical time, non-clinical study time, and additional internal courses that trainees must complete. Simulation lab sessions are conducted quarterly and Objective Structured Clinical Examinations (OSCE's) are conducted over the course of the program.

The TRU program is self-paced and delivered entirely by distance until students enter a clinical practicum. It is unique in this regard. It does, however, expect 560 clinical hours in the practicum, which is substantially more than other programs.

Provincial context

A review of the training and education pathways in BC health authorities revealed variations in expectations and practices. The scope of AA practice varies among health authorities, as does the development of medical directives and AA policies and procedures for practice. There were gaps in awareness of the CAS Position Paper on Anesthesia Assistants and the CSRT Competency Framework

for AA education. The lack of RT regulation further complicates defining the scope of AA practice in BC. Despite the 2014 arbitration award there are still different points for an RT to enter into an AA role in the OR. A self-paced program that allows up to thirty weeks to complete the web based courses and takes students on average two to three years to complete does not produce graduates in a timely manner but it may be more accessible to professionals studying while maintaining full-time employment.

It is not that health authorities have developed internal training programs that are teaching to a higher level of competencies than TRU. Rather, some health authorities are trying to expedite the training of AAs to meet vacancy needs. VGH is adapting the Manitoba program in an effort to provide a high quality in-house program that engages anesthesiologists and experienced AAs in the education process to produce graduates within an eight-month window consisting of two months of guided self-study and six months of full time courses and clinical learning. Northern Health is working with TRU to expedite an employee's completion of the courses and the clinical practicum in an eight to ten months' time frame. The employee is on full time salary while completing the program.

BC stakeholders want a robust provincial Anesthesia Assistant education program that prepares graduates for practice in BC, meets national accreditation standards, and prepares students to successfully complete a national AA certification exam. Anesthesiologists want input into an AA curriculum and involvement in the teaching and assessment of students. Stakeholders want a program that is delivered to cohorts of students online and face-to-face that provides hands-on training prior to the clinical practicum.

The following recommendations are made to the Ministry of Health and to the Ministry of Advanced Education regarding a BC Anesthesia Assistant education program. The recommendations are organized by the key issues to be addressed.

1. **Agreement on competency performance indicators for new graduates**

    - Create a Task Force with representation from anesthesiology department heads or designates, the BC Anesthesiologists' Society, and the BC Society of Anesthesia Assistants to clarify the competency performance expectations for graduates of a BC AA Education program. The Canadian Anesthesiologists' Society's list of Anesthesia Assistant duties and the Canadian Society of Respiratory Therapists National Competency Framework for Anesthesia Assistance would be the framework for this discussion.

2. **Program leadership**

    - Consideration should be given to the benefit of introducing the role of a Program Medical Director with an academic affiliation to a medical school.

3. **Sustaining a made in BC AA education program**

- Enrolment of a critical mass of students is required on a regular basis to sustain a high quality, cost effective education program that will meet the current and evolving needs for AAs in the BC health authorities..

4. Recruitment of mid-career professionals to pursue specialty education

- The Ministry of Health and the health authorities should explore initiatives that will help to mitigate the AA recruitment and retention issues.

5. BC curriculum and program delivery model

- A provincial education program needs to be delivered in a way that addresses the needs of students and ensures learning outcomes are met by graduates. This may involve a learning model that combines online as well as face-to-face with lectures, labs and simulations conducted prior to the clinical practicum.

- Consideration should be given to developing a flexible learning model that may include a direct stream for delivering the program to cohorts of students over three consecutive semesters so that the program can be completed in less than one year, and other streams to ensure opportunity for students who cannot afford to stop working to attend classes.

- The program needs to be accessible to students from all of the health authorities.

- A BC AA Program Advisory/Quality Committee with stakeholder representation from the health authorities needs to provide the direction for the design, delivery and ongoing evaluation of the program.

6. Clinical practicum

- The program should work with all of the health authorities to establish geographical practicum cluster partners so that a core set of practicum rotations is provided for all students.

- The program should involve anesthesiologists as guest lecturers in the courses.

- The program needs to establish clear guidelines for the practicum that include roles and responsibilities of the academic institution and the practicum sites, the competencies to be achieved during the practicum, the criteria for student evaluation, the template for the daily student log, and copies of the evaluation tools to be used by the mentors.

7. Program accreditation

- The education program needs to meet the CSRT AA program accreditation standards.

- The program must prepare students to write the national certification exam upon graduation.

1. Project Objectives

The purpose of this project was to provide an external objective gap analysis to determine the provincial/regional entry to practice Anesthesia Assistant (AA) competencies needed within the BC health care system. The project was to include a review of Anesthesia Assistant (AA) training and education in BC, and to identify any potential gaps related to entry to practice competencies and current workplace practices and requirements, including recommendations for addressing any potential gaps identified.

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2. Methodology

The methodologies utilized to collect information for review and analysis included a literature review; an environmental scan; interviews with key informants in Canada; a review of TRU including interviews with staff and selected committee members, a site visit, and a review of program documents; and interviews with BC stakeholders.

Literature Review

- Canadian Anesthesiologist's Society Guidelines for Anesthesiology Practice
- Canadian Anesthesiologist's Society Position Paper on Anesthesia Assistant
- Canadian Society of Respiratory Therapists National Education Competency Framework for Anesthesia Assistance, 2011 and 2016 documents
- Canadian Society of Respiratory Therapists Discussion Paper on Anesthesia Assistants and Advanced Practice Roles
- Report and recommendations from the Ontario Committee on Transforming the Delivery of Operative Anesthesia Services in Ontario
- Report from the Ontario Anesthesia Care Team Implementation Advisory Committee
- BC MoH and Provincial Surgical Services Executive Cross Sector Policy Discussion Paper
- BC Society of Anesthesia Assistants Terms of Reference

Environmental Scan

Canada

- Requirements for practice in each province
- Interviews with key informants
  - Executive Director, Canadian Society of Respiratory Therapists
  - AA Education program leaders/coordinators
  - College of Nurses of Ontario
  - Associate Registrar, Lawrence S Bloomberg Faculty of Nursing, University of Toronto

- Executive Directors, Colleges of Respiratory Therapy in Quebec and Alberta
- Alberta Health Services Practice Leader

Scan of anesthesia assistance roles, education and certification outside of Canada

Thompson Rivers University AA Program

- Web site review
- Terms of reference and minutes of the Program Advisory Committee and the Program Curriculum Committee
- Site visit
- Interviews with individual staff members
- Review of documents and progress reports
- Interviews with members of the Program Advisory and Curriculum Committees
- Review of TRU Open Learning Faculty Collective Agreement

Stakeholder Interviews

Health Authority stakeholders

- VP medicine or designate
- VPs of Human Resources or designate
- Chief Nursing Officers or designate
- Chief of Anesthesiology or anesthesiologist lead for AA practice
- AA supervisors
- Professional practice leaders
- Review of expected competencies of a new graduate

Other stakeholders

- BC Anesthesiology Society
- BC Society of Anesthesia Assistants Executive
- UBC Department Head of Anesthesiology, Pharmacology and Therapeutics
- President of the BC Society of Respiratory Therapists

VGH interviews and documents

- VP Medicine
- VP Employee Engagement
- Chief of Anesthesiology
- Current and former AA program directors
- Chief Nursing Officer
- AA supervisor
- AA clinical educator
- Professional Practice Director

- Review of sample of revisions being made to the Manitoba manual

3. Anesthesia Assistant Practice Defined

The Canadian Anesthesiologist Society (CAS) has defined the duties of an Anesthesia Assistant and the Canadian Society of Respiratory Therapy (CSRT), through interprofessional collaboration, has defined the competencies and indicators for Anesthesia Assistant Practice. (Canadian Journal of Anesthesiology Position Paper on Anesthesia Assistants, 2015; and CSRT National Competency Framework in Anesthesia Assistance, 2016)

3.1 Canadian Anesthesiologists' Society Guidelines to the Practice of Anesthesia

The Canadian Anesthesiology Society's 2016 "Guidelines to the Practice of Anesthesia" (Merchant *et al*, 2016:86-112) defines the independent practice of anesthesia as a specialized field of medicine practiced by physicians with appropriate training in anesthesia.

> *"The anesthesiologist's primary responsibility is to the patient receiving care. The anesthesiologist or an anesthesia assistant supervised by the anesthesiologist shall remain with the patient at all times throughout the conduct of all general, major regional, and monitored intravenous anesthetics until the patient is transferred to the care of personnel in an appropriate care unit. Before delegation of care of the patient to an anesthesia assistant the anesthesiologist must ensure that the patient's condition is stable and that the anesthesia assistant is familiar with the operative procedure and the operating room environment and equipment. Simultaneous administration of general, spinal, epidural or other major regional anesthesia or sedation level 4-6 (Ramsay Sedation Level) by one anesthesiologist for concurrent diagnostic or therapeutic procedures on more than one person is unacceptable. Under specific circumstances it may be appropriate for one anesthesiologist to supervise more than one case wherein solely Ramsey Sedation Scale (RSS) 1-3 sedation is administered, provided that an appropriately trained, qualified, and accredited individual, approved by the health care institution, is in constant attendance with each patient receiving care." (p.94)*

3.2 Canadian Anesthesiologists' Society Position Paper on Anesthesia Assistants

The 2016 CAS "Position Paper on Anesthesia Assistants" supports the "*Anesthesia Care Team (ACT) concept of care in which the specialist anesthesiologist practices with the assistance of a group of medical and paramedical personnel, including dedicated, trained and certified Anesthesia Assistants.*" The Position Paper states that "*the introduction of Anesthesia Assistants (AAs) into the ACT and the extent of their clinical activities must be under the direct responsibility of anesthesiologists, specifically the Chief of Anesthesiology at the clinic, hospital, regional and/or provincial levels.*" The Position Paper further states, "*The responsible physician must be available to intervene should it be necessary*." Specific guidelines for the delegation of some aspects of monitoring and management of obstetrics regional analgesia are also included in the Position Paper.

CAS recommends that education programs that train RNs, RTs or International Medical Graduates must include pertinent aspects of physiology, pharmacology, and technical and professional aspects of AA practice. The CAS does not review and accredit AA training programs; however, they recommend that anesthesiologists and others have input into the design of course content, teaching and assessment of trainees, to ensure program delivery is consistent with the current AA scope of practice. .

Three distinct areas of AA duties during the perioperative period in the operating room and in remote anesthesia locations are outlined in the Position Paper.

1. Technical duties relate to anesthesia workstations, intubation/airway devices, fiberoptic endoscopes, physiological monitors and infusion devises.

    - Clinical duties relate to assisting the anesthesiologists with all aspects of the anesthetic plan including assessment; insertion of devices; assistance with diagnostic procedures; regional anesthesia procedures for nerve block; difficult intubations and airway management; positioning; administration of pharmacological agents; monitoring; transfer of patients; providing diagnostic data; preparation of equipment; evaluating and monitoring patients and administering medication for procedural sedation; and assisting and performing massive transfusion of blood products.

    - Administrative duties include maintenance of anesthesia equipment, participating in health technology assessment, coordinating the servicing and repair of the equipment, maintaining inventory, sourcing supplies and equipment, assisting with capital equipment budget planning and quality assurance and research.

See Appendix A for Canadian Anesthesiology Society Anesthesia Assistant Duties.

3.3 Canadian Society of Respiratory Therapists National Competency Framework in Anesthesia Assistance

Since 2002 the Canadian Society of Respiratory Therapists (CSRT) has been working collaboratively with stakeholders to define the scope of activities and duties of Anesthesia Assistants.

Rapid evolution of the AA role occurred in Ontario between 2005-2009 when the Ministry of Health and Long Term Care (MoHLTC) introduced the Anesthesia Team Model of Care with the aim of improving access to anesthesia services in Ontario in a cost efficient and effective manner. ("Report and Recommendations of the Operative Anesthesia Committee, 2006; A Plan to Evolve the Anesthesia Care Team Model in Ontario", 2009). During this time CSRT engaged educators, clinical practice representatives as well as national professional organizations such as CAS, the Association of Canadian University Departments of Anesthesia (ACUDA) and the National Association of Association of PeriAnesthesia Nurses of Canada (NAPANc), the Canadian Nurses Association (CNA) and the National Alliance of Respiratory Therapists Regulatory Bodies (NARTRB) to define the Foundational Knowledge required for the safe and competent practice of Anesthesia Assistants in Canada.

In 2009, the Canadian Anesthesiologists' Society, through a continued collaborative inteprofessional approach, built on the CSRT Foundational Knowledge document to develop the National Educational Framework for Anesthesia Assistants. This document was endorsed by the CSRT, CAS, ACUDA, and NAPANc in 2010. CSRT then facilitated the development of performance indicators for the "National Educational Framework for Anesthesia Assistants". The result was a then-unvalidated National Competency Framework for Anesthesia Assistants that was distributed to all Anesthesia Assistant education programs for guidance in reviewing and revising their curricula.

In 2015-2016, CSRT led a working group with representation from various practice and regions. Participants included representatives from CAS, ACUDA, the CSRT board, and Anesthesia Assistant education programs; practicing Anesthesia Assistants across Canada including Quebec and a Clinical Assistant – Anesthesia (Manitoba); exam specialists; and the Council on Accreditation for Respiratory Therapy Education (CoARTE). The purpose of the group was to validate the Anesthesia Assistant competency framework to ensure that it reflected current practice, to establish an Anesthesia Assistant certification exam, and to establish a national accreditation process for Anesthesia Assistant education programs. A validation survey was distributed to over 1,500 Anesthesia Assistants practicing in Quebec and across Canada. See Table 1 for participation rates (CSRT, 2016 a).

Table 1: CSRT Anesthesia Assistant Competencies Validation Survey Participation Rate

Province	Total Practicing AAs	Total Responses	Response Rate
British Columbia	75	43	57.3%
Alberta	75	31	41.3%
Saskatchewan	7	7	100%
Manitoba	12	7	100%
Ontario	164	80	45.3%
Quebec	1,210	272	22.5%
Nova Scotia	23	5	21.7%
New Brunswick	12	12	100%
Newfoundland	9	8	89%
PEI, NWT, Yukon	0	0	
Total	1,584	465	

Ninety percent of the respondents from Quebec and 86% of the respondents from all other provinces were respiratory therapists (RTs). Most indicators were performed weekly, daily or several times a day and were rated as causing moderate or considerable harm, if omitted or performed incorrectly. The survey revealed differences from the RT program in Quebec and the AA programs in the rest of Canada. Since AA education programs do not exist in Quebec, the data from the survey validation is based on individuals practicing outside Quebec.

The CSRT National Competency Framework for Anesthesia Assistance has now been validated; a blueprint for an interprofessional certification exam has been established, and an interprofessional accreditation process for AA education programs have been confirmed (CSRT 2016 b). The requirements for anesthesia assistants are divided into three levels: Competency, Performance Indicators and Foundational Knowledge. The performance indicators allow for the assessment and measurement of the performance of each competency. The foundational knowledge outlines the information that an anesthesia assistant must know and comprehend in order to safely perform each competency. Bloom's Taxonomy is used for the list of performance indicators for the Professional, Organizational and Clinical competencies. The clinical competency performance indicators relate to:

- Pharmacological agents
- Operation of anesthesia equipment
- Monitoring of the patient's physiological status
- Providing preoperative care

- Managing the patient's airway
- Assisting with the administration of general anesthesia
- Delivering regional anesthesia
- Delivering procedural sedation
- Managing post-operative care
- Assisting with pain management
- Performing crisis management
- Administering blood products
- Assisting with the delivery of anesthesia in special circumstances.

See Appendix B for a Table of the CSRT AA performance indicators associated with these competencies.

Implementation of the CSRT anesthesia assistant program accreditation process will begin in 2018. The plan is to schedule the reviews to align with the timing of the RT Program accreditation reviews. The Thompson Rivers University Anesthesia Assistant Program is scheduled, in 2018, to be the first educational program to participate in this accreditation process. A certification exam for graduates of anesthesia assistant education program will commence the same year.

CSRT reports that 95% of practicing AAs in Canada are RTs. Anesthesia Assistant education programs graduate about 25-30 AAs annually (Personal communication, Christiane Menard, Executive Director, CSRT, August 30, 2016).

4. Regulation and Education Requirements in Canada

The title Anesthesia Assistant (AA) is not a protected title in Canada. Many AAs and the Canadian Anesthesiology Society (CAS) take the position that the additional tasks and duties require significant increase in the knowledge, skills, judgment and responsibility, and that the level of care associated with additional risk to the patient warrants special regulatory parameters. A CSRT Discussion Paper on Anesthesia Assistants and Advanced Practice Roles published in 2010 examined the evolving role of the AA to order to inform policy decisions regarding education, entry to practice, and regulation in the public interest, including investigating the implications of adding an advanced/expanded class of regulation. (CSRT, 2010). Representatives from several regulatory Colleges felt that the role could be regulated within existing RN and RT regulations and that the practitioners did not need to be regulated differently. The report suggested that the AA role would benefit from consistent national approaches to protect the public, specifically making eight recommendations (p. 53). A ✓mark adjacent to a recommendation indicates that the recommendation has been or is in process of being implemented across Canada.

1. ✓AAs be a member of a regulated health profession
2. There be a standardized scope of practice for AAs
3. ✓ There be an AA competency profile /foundational knowledge document on which education and evaluation is based
4. The title AA be protected
5. Levels of supervision be clarified
6. Consistent authorizing mechanisms be developed
7. ✓Educational programs be accredited
8. ✓There be a minimum criteria for entry into the AA educational program

4.1 Manitoba

In Manitoba anesthesia assistants are called Clinical Assistants – Anesthesia and are regulated by the College of Physicians and Surgeons of Manitoba (CPSM). The Manitoba perspective is that Clinical Assistants – Anesthesia are in a "physician extender role." The CPSM requires all clinical assistants to successfully complete a Registered Clinical Assistant Exam prior to entry into the Manitoba Anesthesia Clinical Assistant education program. All graduates must be registered with the CPSM to practice. RTs and RNs who have become Clinical Assistants – Anesthesia are not required to maintain their registration with those respective regulatory bodies. See Appendix C.1 for a copy of the Winnipeg Regional Health Authority job description.

4.2 Quebec

Respiratory Therapy is a regulated profession in Quebec. The Respiratory Therapy Diploma program curriculum in Quebec includes 150 hours of theory specifically related to anesthesia and 300 hours of practice in the ORs. Final exams include the assessment of competencies related to practice in the role of an anesthesia assistant in the OR. Quebec has its own competency profile for RTs that include these competencies. L'Ordre professionnel des inhalothérapeutes du Québec (OPIQ) is in the process of reviewing the alignment of the Quebec competency profile with the recently validated National AA competency profile. In some areas there will be no alignment because of Quebec legislation, e.g. RTs cannot perform arterial punctures.

For more than 20 years Quebec has informally had a standard of one Respiratory Therapy anesthesia assistant per Operating Room working under the supervision of the Anesthesiologist. Operating rooms budget for this practice. The College of Respiratory Therapist in Quebec describes the anesthesia assistant role in the OR as a "copilot to the anesthesiologist." Outside the ORs they assist in endoscopy, GI, bronchoscopy, oncology, cardioversion, short stay, electroconvulsive therapy.

At the request of the Quebec Ministry of Education and the Quebec Ministry of Health the OPIQ conducted focus groups with RTs in order to collect data on the contemporary clinical practice of RTs working in anesthesia. OPIQ reported the highlights as follows:

1. "Ability and easiness" is mainly acquired through experience over years. For some RTs, ability and easiness also came after completing a post graduate program
2. Insufficient clinical exposure during basic RT education was identified as a problem. There was a lack of knowledge in some theoretical elements of the program such as physiopathology and pharmacology.

The OPIQ shared the data with the two provincial ministries and make the recommendation that additional hours be added to the RT diploma program to teach more theory on patient co-morbidities, pathology and associated pharmacology in the management of an anesthetized patient and to double the clinical practice hours in the OR. To date there has been no action from either ministry. (Personal communication with Jocelyn Vachon, and Marise Tetreault, September 8 and 25, 2016)

4.3 Alberta

Respiratory Therapy is a regulated profession in Alberta. The RT diploma curriculum follows the national RT profile that includes AA competencies. Students have a four-week rotation through the OR where they perform intubations, establish IVs, and maintain machines.

The College and Association of Respiratory Therapists of Alberta (CARTA) reports that there are approximately 80-84 RTs working in ORs in Alberta under the following job descriptions: anesthesia technician, anesthesia technologist, and respiratory therapist.

Respiratory Therapists Level 2 work to their full scope of practice assisting anesthesiologists in the OR. The larger centres in Calgary and Edmonton have site-specific RT2 job descriptions for that role in the OR. See Appendix C.2 for a copy of the Calgary RT2 job description. A generic AHS RT 2 job description for the OR is anticipated within the next year.

Alberta Health Services provides in house training. New RT hires to the OR self-assess against the AA competencies and orientation is based on this self-assessment. Larger centres provide a three-week competency based orientation that includes a package of education modules developed by anesthetists and RT2 working in the OR. The modules are built on the underlying AA competencies defined by CSRT.

CARTA has a mandatory continuing competency program for their members. Members complete an annual competency assessments determining their strengths and learning needs, and undertake measures to meet these learning needs. RTs working in the OR self-assess to a list of specialized competencies and restricted activities defined by CARTA.

CARTAs' executive director reported that there is a perception among anesthesiologists that specific training for RT2 working in the ORs would be helpful (Personal Communication, Bryan Buell, August 19, 2016).

4.4 Ontario

The 2009 Report of the Anesthesia Care Team (ACT) Implementation Advisory Committee titled "A Plan to Evolve the Anesthesia Care Team Model in Ontario" proposed "*an ACT be permanently established within the Province of Ontario as an Anesthesiologist led anesthesia care model that includes Anesthesia Assistants and other team members (NP –A, RN, RT, ORT) as deemed appropriate within any given practice setting" (p.8). The working group recommended that "clear distinction should be made between the AA and Operating Room Respiratory Therapist roles ….and that there be* ***additional training and education*** *requirements for the AA ….. the AA role is differentiated from that of the NP-A in that the AA is largely focused on intra-operative care while the NP-A clinical role is focused on the pre and post operative aspects of the patient experience.*" (p.21) The Advisory Committee proposed protection of the AA and NP-A title by the College of Respiratory Therapy of Ontario and the College of Nursing of Ontario. Currently the title of Anesthesia Assistant is not a protected title in Ontario or anywhere else in Canada.

Those working as Anesthesia Assistants in Ontario must have completed an Anesthesia Assistant certificate program. Respiratory Therapists and Registered Nurses who have completed Anesthesia

Assistant Certification Programs in Ontario are regulated as RTs and RNs by their respective regulatory bodies.

Nurse Practitioner (NP) – Anesthesia

The University of Toronto Bloomberg Faculty of Nursing in collaboration with the Department of Anesthesia at the University of Toronto developed a post Nurse Practitioner diploma in anesthesia care. Only three students graduated from the program receiving diplomas in 2013. Due to a lack of demand, the University of Toronto officially discontinued the program in June 2016 (Personal communication, Tammy Chan, Associate Registrar, Bloomberg Faculty of Nursing, August, 26, 2016). The College of Ontario (CNO) reported that only one NP self-identified Anesthesia as his/her primary practice during the 2016 registration process (Personal Communication, Rola Moghabghab, August 22, 2016)

4.5 British Columbia

As a result of a 2014 arbitration award, RTs in BC must have completed an Anesthesia Assistant Certification Education Program or have the equivalent education and training to be considered for an AA position. See Appendix C.4 for a sample AA job description in BC (copy of the VGH AA job description).

Currently there is no regulation of Respiratory Therapists in BC. AAs are functioning under delegation and the direct supervision of anesthesiologists.

Anesthesia Assistants in BC formed a BC Society of Anesthesia Assistants (BCSAA). The mission of the society is to foster and focus the development of the AA profession, through advocacy, education, and mentorship. (BCSAA Terms of Reference, 2014) The responsibilities of the society are to:

- Enhance and encourage professional development,
- Advocate for the profession through fair and equilateral wages/benefits,
- Educate colleagues, health authorities, and the community of the profession.

A rift has arisen between the BCSAA and the BC Society of Respiratory Therapists (BCSRT) regarding the proposed new regulations. BSSAA describes the biggest differences in AA practice from RT practice are the administration of pharmacologic agents, maintaining an anesthetic, anticipating surgical conditions, patient evaluation and management of the patient while under anesthetic. BCAS has supported BCSAA regarding the need for a defined and regulated AA profession distinct from Respiratory Therapy. BCAS also supports a change in title from Anesthesia Assistant to Anesthesia Physician Assistant. (Personal Communication, Drs. S. Bahr and R. Orfaly, July 12, 2016) Some anesthesiologists believe that there is confusion and a conflict of interest with trying to keep AAs "under" the RT College.

4.6 Other Provinces: Newfoundland, Saskatchewan, New Brunswick, Nova Scotia and PEI

To practice as an AA in Newfoundland the person must have completed a recognized AA program. A RT can work in the OR without an AA certificate but their scope of practice is limited. They cannot administer drugs unless under direct anesthesia supervision, mix up medications for infusions, or relieve the anesthesiologist for breaks. (Personal communication, Dave Sheets, September 23, 2016)

To practice as an AA in Saskatchewan the RT must be enrolled in the TRU AA certificate program, and have successfully completed all entrance exams and core courses. (AA job postings on job sites, Sept 25, 2016)

Completion of an AA education program is a requirement for employment in New Brunswick and Nova Scotia. (Personal communication, Christiane Menard, September 26, 2016)

There is no Anesthesia Assistant role in Prince Edward Island.

5. Anesthesia Assistance – International Scan

5.1 United States

5.1.1 Certified Registered Nurse Anesthetists (CRNAs)

Certified Registered Nurse Anesthetists (CRNAs) in the US are advanced practice registered nurses (APRNs) licensed as independent practitioners. CRNAs practice both autonomously and in collaboration with a variety of health practitioners on the interprofessional team to deliver high-quality, holistic, evidence-based anesthesia and pain care services (American Association of Nurse Anesthetists, (AANA), 2013). CRNAs enter the profession following successful completion of a 24-36 month graduate or postgraduate accredited education program and after passing the National Certification Examination administered by the Council on Certification of Nurse Anesthetists (COA). There are over 115 accredited nurse anesthesia programs in the U.S. utilizing more than 2,500 active clinical sites. (Council on Accreditation of Nurse Anesthetist Education Programs, 2016). All programs include clinical training in university-based or large community hospitals.

Education, experience, state and federal law, and facility policy determine the scope of nurse anesthetist practice. Nurse anesthetist practice may include, but is not limited to:

- Performing a comprehensive history and physical;
- Conducting a pre-anesthesia evaluation;
- Obtaining informed consent for anesthesia;
- Developing and initiating a patient-specific plan of care;
- Selecting, ordering, prescribing and administering drugs and controlled substances; and
- Selecting and inserting invasive and noninvasive monitoring modalities.

Unless a hospital is located in a state that has chosen to opt out of the nurse anesthetist supervision requirements, a nurse anesthetist administering general, regional and monitored anesthesia must be supervised either by the operating practitioner who is performing the procedure, or by an anesthesiologist who is immediately available (American Society of Anesthesiologists, 2014).

CRNAs provide acute, chronic and interventional pain management services, as well as critical care and resuscitation services; order and evaluate diagnostic tests; request consultations; and perform point-of-care testing. CRNAs plan and initiate anesthetic techniques, including general, regional, local and sedation. Nurse anesthetists respond to emergency situations using airway management and other techniques; facilitate emergency and recovery from anesthesia; and provide post-anesthesia care, including medication management, conducting a post anesthesia evaluation, and discharge from the post-anesthesia care area or facility.

The practice of CRNAs is regulation by state boards of nursing.

The American Association of Nurse Anesthetists (AANA) and the COA support practice-oriented doctoral degree education for entry into nurse anesthesia practice by 2025.

5.1.2 Certified Anesthesiologist Assistants

Certified Anesthesiologist Assistants (CAAs) practice within the Anesthesia Care Team under the direction of an anesthesiologist (American Academy of Anesthesiologist Assistants, 2016). CAAs work exclusively within the Anesthesia Care Team model.

AAs complete a didactic and clinical program at a graduate school level. Admission requirements include a baccalaureate degree with premedical coursework. AA education includes the delivery and maintenance of quality anesthesia care and advanced patient monitoring techniques. AAs administer drugs, obtain vascular access, apply and interpret monitors, establish and maintain patient airways, and assist with preoperative assessment.

An anesthesiologist assistant program must be supported by an anesthesiology department of a medical school that is accredited by the Liaison Committee on Medical Education. The anesthesiology department must have the educational resources internally or through educational affiliates that would qualify it to meet the criteria of the Accreditation Council for Graduate Medical Education or its equivalent. (American Academy of Anesthesiologist Assistants (AAAA), 2014)

The Commission on Accreditation of Allied Health Education Programs accredits AA training programs. The ASA is a member of this accrediting group and participates in the accreditation processes for Anesthesia Assistants, Respiratory Therapists and Emergency Medical Technical-Paramedics.

A National Commission for Certification of Anesthesiology Assistants administers the AA certification exam in collaboration with the National Board of Medical Examiners. (AAAA, 2016)

5.2 United Kingdom

5.2.1 Operating Department Professionals

Operating Department Professionals (ODPs) provide care for patients during the anesthesia (pre-operative), surgical (intra-operative) and recovery (post operative) phases. During the "anesthesia state" OPDs prepare the drugs and equipment needed for the patient to undergo anesthesia. OPDs stay with the patient throughout their surgical intervention. OPDs work closely with the anesthesiologist to maintain the patient's airway. During the surgical stage ODPs prepare the sterile instruments and equipment working with the surgeon. At other times the ODPs work in a circulating role during the surgery. ODPs check on the patient in the recovery room providing airway management, if needed, and monitoring the patient's physiological signs. The ODP will give

treatment such as the administration of prescribed drugs or other procedures allowing the patient to fully recover from the effects of anesthesia. A Diploma in Higher Education or a degree in Operating Department Practice is required to work as an ODP. (National Health Services Health and Care Professions Council, 2016)

5.2.2 Physicians' Assistants

The role of Physicians' Assistants (Anesthesia) (PA (A)'s) was introduced in 2004. The role works within the anesthesia team under the direct supervision of a Consultant Anesthetist. PA (A)'s are fully trained professions such as ODPs or RNs that have completed a Physicians' Assistant (Anesthesia) Postgraduate Diploma. There are currently about 150 PA (A)s across the UK. The Royal College of Anesthetists (RCoA) and the Association of Anesthetists of Great Britain and Ireland (AAGBI) issued a joint statement of the Scope of Physicians' Assistants in 2016. (ROCA and AAGBI, 2016). The statement acknowledged that the issue of non-physician anesthetists has polarized opinion within the specialty particularly related to the absence of statutory registration and regulation of the PA's, scope of practice, supervision, development of these enhanced roles and the potential impact on training opportunities for medically qualified anesthetists. The position of the AAGBI and RCoA is that registered, regulated PA (A)s, supervised by medically qualified anesthetists, can make a valuable contribution towards a sustainable anesthetic workforce. The Association of Physicians' Assistants, RCoA, and AAGBI have collaboratively drawn up an agreed scope of practice on qualification that acknowledges and addresses many of the concerns. Until statutory registration and regulation are achieved, the AAGBI and RCoA only recognizes PA (A)'s who have qualified by having completed the approved UK training program and have subsequently been entered on the voluntary register.

The approved Physicians Assistant (Anesthesia) Postgraduate Diploma program is a full time 27 month distance learning and face-to-face program offered by the Birmingham University College of Medical and Dental Sciences Graduate School. Admission requirements are:

1. Registered health care practitioners (RNs or ODPs) with one or both of the following:
- At least three years full time, post qualification work experience in a relevant area
- A first degree in a health related subject

- New entrants to health care (graduates or graduate equivalent) require:
- A biomedical science or biological science background
- Preferably a second class Honours degree or better, or other evidence of recent and successful academic activity
- A demonstrable commitment to a career in health care

The education program consists of 12 two-month blocks of teaching. Each block lasts approximately 35 days and consists of directed self-study, small group teaching, clinical skills teaching and workplace experience. A typical week may consist of: 1 two hour tutorial, 2-3 days in a clinical area,

½ day clinical skills training and 1 ½ days of self-directed study working through the e-lectures. The weekly teaching and tutorials are delivered from a consultant anesthetist and through the university elearning interface.

The teaching blocks include:

- Introduction to clinical practice 1
- Introduction to clinical practice 2
- Introduction to anesthesia
- Physics in anesthesia
- The anesthesia machine and monitoring
- The heart and circulation
- The airways and lungs
- The kidneys, liver, endocrine system and blood
- The brain and nervous system
- Clinical history and examination
- Management of life-threatening emergencies
- Advanced practice

Successful graduation requires passing assessments at eight and twenty four months that consists of multiple choice exams, clinical skills workbook completion, record of in-house training experience, tutor assessments and at 24 months a final OSCE examination takes place at the Royal College of Anesthetists in London. Gradates then complete a three-month probationary period in their facility.

Promotion of the education program is carried out through the individual National Health Service Trusts that support Physicians' Assistant training. The Trust and the University individually assess applications. Shortlisted applicants are interviewed by a Trust panel that includes consultant anesthetists. Students remain employees of the Trust through the 27 months of the program.

5.3 Scotland

Two streams of training for Anesthesia Assistance exist in Scotland: 1) Operating Department Professionals who complete a nationally recognized program leading to the Diploma (HE) in Operating Department Practice and who are regulated by the Health Professions Council; and 2) AAs who are RNs regulated by the Nursing and Midwifery Council. (NHS Education for Scotland, 2011)

Core competencies for anesthesia assistance practice were developed in 2011 to address the issues of quality and consistency of education of AAs in Scotland. The core competency framework consists of two parts: 10 general competencies and 10 specialty specific competencies. The competencies are meant to build on induction and orientation. The competencies do not include a number of

mandatory training courses such as lifting and transfer of patients, basic life support, ACLS, venipuncture and cannulation, IV therapy, safe blood transfusions and medical devices.

The general competencies are organized as follows: background knowledge/core skills; pre-operative, intraoperative, and post-operative; and emergency management. The specialty specific competencies identify the competencies needed to practice independently in each specialty. Individual are expected to use these competencies with a personal development plan. A nine-month timeframe of education and training is suggested by the Scottish Multiprofessional Anaesthetic Assistants Development Group (SMAAD) with a further consolidation period undertaken during independent practice.

NHS Quality Improvement Scotland recognizes both a registered ODP qualification and completion of core competencies identified in the 2011 document. Nurses employed as AAs need a nominated consultant anesthetist sign off of all the competencies. Certificates are issued either after completion of a recognized course provided by the Health Education Institute or completion of a portfolio following an in-house program conducted under clinical supervision.

A Scottish Multiprofessional Anaesthetic Assistants Development (SMAAD) group with representatives from key stakeholders from across Scotland meet regularly to endorse programs of education offered by Higher Education Institutions and maintains registers of 1) Nominated Anesthetists in every hospital who can sign off on AA competencies and applications for certification; 2) clinical supervisors; and 3) AAs who have been certified as meeting the competencies. The group regularly reviews the competency framework.

5.4 New Zealand and Australia

Both Anesthetic Technicians and Registered Nurses provide assistance to anesthetists in New Zealand and Australia.

The Australian and New Zealand College of Anesthetists (ANZCA) position statement on "Assistance for the Anesthetists" outlines the scope of assistance, underlying principles for assistance, educational requirements, and core competencies. (ANZCA, 2016) The principles underlying this position are that *"the presence of a trained assistant for the anesthetist is essential:*

- *During preparation for and induction of anesthesia. The assistant must remain under the immediate direction of the anesthetists until instructed that this level of assistance is no longer required.*
- *During the maintenance of anesthesia an assistant must be immediately available.*
- *At the conclusion of anesthesia."*

The expectation is that an anesthesia assistant is allocated to the anesthetist for every case where anesthesia is administered and is exclusively responsible to that anesthetist.

Educational requirements include courses that include at least 12 months of full time equivalent clinical experience. Requirements for education programs must include:

- Input from anesthetists in curriculum development, preparation and delivery of relevant lectures, practical supervision and assessments.
- Theoretical instruction and assessment on elements of the basic sciences appropriate to anesthesia, including physiology, pharmacology; anatomy; clinical measurement; and microbiology.
- Teaching and assessment on non-technical skills, including: communication; cultural competence; working in a team environment; and situational awareness.
- Supervised practical experience in anesthetizing locations documented in a logbook describing the type of instruction received and the competencies demonstrated.
- Assignments and/or learning activities appropriate to the curriculum.
- Assessments that confirm the participants can demonstrate the knowledge and skills articulated in the core competencies, including but not limited to a combination of direct observations and examinations.
- Certification in assisting the anesthetist with the safe handling of controlled/restricted drugs.

Core competencies for an anesthetic assistant include:

- Standards for practice related to anesthesia standards and protocols; workplace and occupation health and safety regulations; liaison with the health care team; and legal responsibilities
- Anesthesia equipment including: delivery systems and ventilators; monitoring equipment including ultrasound devices; airway devices including fibreoptic instruments; intravascular devices; and infection control and sterilization and prevention of pollution
- Safety principles to reduce potential hazards from electricity, radiation, lasers, gas cylinders and pipelines, and biological fluid exposure.
- Anesthesia techniques
    - Preparation and participation in safety checklists
    - Patient positioning
    - Patient transfer
    - Monitoring
    - Induction
    - Securing the airway
    - Maintenance
    - Emergence
- Regional and local anesthesia techniques

- Sedation principles and analgesia for diagnostic and interventional procedures
- Assist with invasive techniques including insertion of peripheral, central venous and pulmonary artery catheters and arterial lines and understanding the management of these lines; assist with ultrasound techniques for nerve and vascular location; rapid infusion devices
- Therapeutics: assist with the preparation of drugs, fluids, and therapeutic substances as directed by the anesthetist
- Emergency care: assist with CPR, management of difficult airway, cardiac defibrillation and cardioversion, massive blood transfusion, anaphylaxis, and malignant hyperthermia.
- Postoperative pain – understanding pain alternatives

New Zealand Pathway

Anesthesia Technicians (AT's) provide anesthesia assistance in NZ. The Medical Sciences Council of New Zealand (MSC) established requirements for the registration of Anesthesia Technicians in 2012. RNs who work in anesthetic nursing can continue to perform an anesthetic nursing role but cannot use the title of AT unless they have completed an AT program.

Candidates for the role of AT must have successfully completed: a Diploma of Applied Science (Anesthetic Technology) at the Auckland University of Technology; a specific number of clinical hours in an MSC accredited training hospital, and passed the New Zealand Anesthesia Technicians Society registration exam. Clinical training is conducted over 1.5 to 3 years of full time employment. Trainees who have previous health professional training such as nursing may require a lesser amount of supervised clinical practice, if they have worked in peri-operative, post anesthetic care unit, emergency, or intensive care for surgical ward nursing specialties. These applicants require between 1.5 to 2 years of clinical practice during the program. The registration exam consists of up to 17, seven to nine minute Objective Structured Clinical Examinations (OSCEs).

Australia

Australia has both technicians and assistants who provide assistance to anesthetists. The Australian Anesthesia Allied Health Practitioners (AAHHP) is in the process of developing a nationally recognized training program. Work is underway to develop a voluntary registration process.

6. Anesthesia Assistant Education Programs in Ontario and Manitoba

Anesthesia Assistant Education programs are offered in three provinces in Canada: Ontario, Manitoba and British Columbia. The Michener Institute of Education at University Health Network in Toronto, Fanshawe College in London and Algonquin College in Ottawa offer post diploma certificate programs that are conducted over three consecutive academic terms. The Winnipeg Regional Health Authority in collaboration with anesthesiologists affiliated with the University of Manitoba conduct a one year in-house Anesthesia Clinical Assistant Program. Thompson Rivers University offers a distance education program with flexible intakes and flexible time lines for course and clinical practicum completion.

6.1 Michener Institute Anesthesia Assistant Graduate Certificate Program

Michener Institute has been offering a three term AA Education Program since 2006. Students receive a Certificate upon successful completion of the program. The Ontario Ministry of Health and Long Term Care (MoHLTC) funds the Michener Institute. In January 2016 the Michener Institute integrated with the University Health Network (UHN) to become The Michener Institute of Education at UHN thus embedding the school within a hospital network.

In anticipation of CSRT implementation of program accreditation and a national certification exam, Michener Institute made the decision in September 2016 to incorporate a final exit examination at the end of the program. The program believes that "an exit exam will assist the students to prepare for the national exam as well as ensure Michener's standard of academic excellence for the accreditation process." (Personal communication, Susan Dunington, October 3, 2016)

6.1.1 Leadership and Faculty

The Michener AA Program Medical Director is also the UHN Medical Director for AAs at University Health Network. A full time professor and clinical liaison support the program. Departments of Anesthesia in Ontario support the Anesthesia Care Team Model and AAs therefore they engage in the education of AAs. Lectures and labs are conducted by anesthesiologists in Semester 2.

6.1.2 Michener AA Admission Requirements

Admission is open to applicants from Ontario and across Canada who meet the following criteria:

- Registered Respiratory Therapist (RRT) or Registered Nurse (RN) with 2 years or full time equivalent (>4000 hours) critical care experience within the past 4 years (ICU, ER, NICU, PACU).

- Letter from the Chief of Anesthesia of a base site indicating the department will support the applicant's clinical practicum.

6.1.3 Tuition

The current tuition is $4,286/term x 3 terms + $238 student fee for a total of $13,096. Most students who enroll in the program are self-funded. Students from UHN can apply for bursaries from UHN and the MoHLTC.

6.1.4 Student Intakes

The program is offered once a year with an enrolment capacity of 15 students per intake.

6.1.5 Program Overview

Semester 1

Semester 1 is conducted over 14 weeks: 13 weeks of online theory followed by a one-week residency at the end of the semester.

Pharmacology, anesthesia devices, anesthesia monitoring and airway management are the focus of Semester 1. The objectives of Semester 1 are related to exploring the pharmacological principles of anesthesia and categorizing the clinical manifestation of pharmacological agents used in anesthesia; developing technical expertise associated with the anesthesia gas machine and pollution control systems; and the development of technical and clinical expertise in the use of physiological monitoring equipment. Students are required to complete weekly assignments.

Students consolidate their learning during the one week residency. Students are assigned mock patients, work in the labs with equipment, develop patient management plans for anesthetized patients, and conduct a research project. Students are required to write an exam at the end of the semester.

UHN is not involved in the teaching Semester 1.

Semester 2

Semester 2 is conducted over 14 weeks: thirteen weeks of online theory and one day per week on campus followed by a 10-day residency at the end of the term. The focus of the semester is on developing student competencies related to evaluating the pre, peri and postoperative patient, advanced airway management, assisting with pharmacological therapy, maintaining fluid therapy, assisting with the administration of peripheral nerve blocks, spinal anesthetics and epidurals, assisting with the administration and maintenance of general anesthesia for stable patients; performing procedure sedation, and managing special anesthetic considerations.

Faculty teaching the weekly Semester 2 classes are anesthesiologists from UHN, Sunnybrook, Sick Kids and Mount Sinai hospitals. Anesthesiologist faculty are paid $100/hour. Mornings are spent in the classrooms. Students present cases based on the topic presented by an anesthesiologist the previous week. The sessions are interactive with the anesthesiologist providing feedback and teaching during the presentations. An anesthesiologist presents a new topic and students are assigned cases for the following week's presentations. An anesthesiologist and the program coordinator conduct afternoon simulation labs. Teams of two to three students re-enact the cases that were presented in the morning. The program coordinator defined the simulation protocol as follows:

- "Get information from patient pre op
- Check equipment and drugs
- Apply monitoring
- Start IV
- Then team puts the patient to sleep
- Manage airway
- Focus on communication and teamwork
- Crisis management"

In the midst of the simulation a crisis is introduced that will require the team to diagnose and treat. Other teams watch each other's simulation cases from an observation room. The anesthesiologist conducts a scenario debrief after each case is completed. The Program Coordinator debriefs on the equipment. All simulations are recorded and posted on the website for review by the students.

Homework: Cases presented the previous Friday are revised by the students and sent back to be posted on the website. Teams work on case presentations for the following Friday based on the new topic presented in the morning.

10-day residency

Lectures are conducted by anesthesiologists to fill in gaps. Lecture topics include: anesthesia for the elderly, advanced cardiac life support (ACLS), Neonatal resuscitation, Pediatric Advanced Life Support (PALS), and anesthesia outside the Operating Room. Simulations continue including ACLS, PALS, and Crisis Management scenarios, etc.

Student evaluation

Student evaluation occurs during the two-week residency:

- 25% of the mark is based on peer, self and faculty assessment
- 25% of the mark is based on presentations on clinical research topics approved by the anesthesiologist, e.g. new drug, new technique, something controversial in the literature.

- 50% of the student's mark is based upon performance during two unique 45-minute simulations. The Program Head, a Surgeon and the Program Coordinator conduct these simulations. The protocol simulation steps are:
  - A pre-op assessment or handover
  - Take over care
  - Check equipment
  - Communicate with everyone
  - Crisis occurs: Oxygen problem or hypotension
  - Call for help
  - Early intervention (diagnose and treat)
  - Think about differential

The anesthesiologist conducts a student debrief in the anteroom. The anesthesiologist, the surgeon and a remote assessor score the student. The scores are merged.

Semester 3: Clinical Practicum

The clinical is conducted over a minimum of 12 weeks (60 shifts) including a minimum 2-week elective rotation external to the assigned base site. Michener arranges rotations across sites. Rotations must include adult general anesthesia, cardiac, obstetric, pediatric, and regional anesthesia. Students must complete the clinical component of the program within a six-month period.

Course competencies to be achieved with adult and pediatric patients include:

- Evaluation of the pre, peri and post operative patient
- Advanced airway management
- Assisting with pharmacological therapy
- Maintaining fluid therapy
- Assisting with the administration of peripheral nerve blocks, spinal anesthesia, and epidurals
- Assisting with the administration and maintenance of general anesthesia for stable patients
- Performing procedural sedation
- Managing special anesthetic considerations

Students choose a primary and secondary mentor for their clinical practicum. The Program Medical Director liaises with the primary mentor for each student. Mentors are generally anesthesiologists who teach in the program. All mentors receive a copy of the mentor guidelines in advance of the clinical practicum. Mentors are not paid for this role.

Clinical Logs

Students have a clinical logbook for each of the five rotations. The clinical logbook contains several sections

- Basic skills
- Drugs/consequences daily for every case
- Crisis management section
    - Mentor goes over section – e.g. rational behind hypotension in the OR and what to do to rectify
- Topics for discussion with the anesthesiologist
- Daily feedback form for completion by the mentor
- Biweekly reflections – sent to Michener throughout the practicum

The logbook is signed off by the main mentor and the Chief of Anesthesiology and sent to the Michener Program Medical Director for final review and sign off.

UHN reported that previous challenges liaising with Michener regarding students' practicum will likely be addressed through the new UNH/Michener partnership. Specifically UHN wants direct input into addressing gaps in the didactic portion of the program and would like students to be in the practice setting earlier. (Personal Communication with Ana Lopez Filici, AA, Practice Leader Anesthesia Assistants and Manager of Anesthesia Clinical Services, University Health Network, June 27, 2016).

UHN conducts extensive orientation and further training of new AA graduates to prepare them for practice at their sites. See Appendix C.3 for a copy of the UHN Anesthesia Assistant Job Description and Appendix D for a description of practice at UHN.

6.2 Algonquin College Anesthesia Assistant Graduate Certificate Program

The AA Graduate Certificate Program was initiated in 2011. Located in Ottawa, the program enrolled two intakes of students before program funding was not renewed. In 2015, The Ottawa Hospital asked Algonquin College to reopen the program. Program faculty updated the equipment content, a new reference text was selected, terminology and drug information was updated, and a number of selected anesthesiologists reviewed the updates to the program in preparation for an intake of students in January 2016.

6.2.1 Leadership and Faculty

A Program Coordinator and a RN/AA faculty member lead the program. There is no Program Medical Director.

6.2.2 Admission Requirements

Admission is limited to applicants with an Ontario College Advanced Diploma in Respiratory Therapy with current certification of membership in the College of Respiratory Therapists and two years of

full time experience OR a Bachelor of Science of Nursing degree with current certificate of competence form the Ontario College of Nurses, and 2 years full time equivalent hours of critical care experience within the last four years (ICU, ER, NICU, PACU).

6.2.3 Tuition

Current tuition is $14,776.66 for the entire program. Books and supplies cost another $750. Students pay the full tuition themselves. The program is designated as a full time program by Algonquin College so that students can apply for an Ontario Social Security allowance. Health Force Ontario provides students with a $1,500 loan. The Ottawa Hospital Anesthesiology Department and Respiratory Therapy Department each funded a portion of the tuition.

6.2.4 Program Intakes and Student Profiles

The current program is being conducted between January and December 2016 with an enrolment of seven students. Most students are working full time while enrolled in the program. Two were already working as Anesthesia Technicians in the OR, two are RNs, and five are not working in an OR.

6.2.5 Program Overview

Semester 1: January-April

The Semester 1 courses are:

- Anesthesia equipment
- Introduction to Anesthesia
- Anesthesia Laboratory 1

The bulk of the learning in Semester 1 is online with weekly readings, assessments, and mid-term exams. Labs are conducted once a week on campus. The culmination of the weekly clinical lab sessions is two simulation sessions. There is no overall exam at the end of the semester.

Semester 2: May- August

The Semester 2 courses are:

- Applied Anesthesia
- Anesthesia Laboratory
- Anesthesia Department Administration
- Pharmacology for the Anesthesia Assistant

A contracted anesthesiologist and an AA faculty member conduct the lab sessions in Semester 2. Post graduate level 4 and 5 anesthesiology residents conduct the lecture sessions in Semester 2.

Ten Saturday lab sessions consisting of morning lectures conducted by anesthesiology residents and afternoons where small groups rotate through simulations and oral scenario reviews.

Semester 3: Clinical Practicum: Sept – December

The practicum is 350 hours (9 weeks) in length. Students are expected to work at least three consecutive days a week in the OR working through the practicum objectives. The program faculty feel that this does not provide sufficient time for the practicum. Algonquin College did not permit a longer practicum without a formal major approval process. Students not funded for the practicum and those working part or full time find it very difficult to book off for three consecutive days/week for nine weeks. All students must rotate through all services regardless of previous OR experience.

It was intended that each student be assigned one primary anesthesiologist mentor and two to three others who would support the student. Students rotate through five sites. At some sites it has been difficult to find a primary mentor. The Program Coordinator schedules student rotations across sites.

6.2.6 Clinical Logs

Students keep daily logs that include the surgery, the patient history, "how the case went", issues, observations and discussion points with the anesthesiologist. Every two to three weeks students send their daily logs to the program coordinator who reviews whether each student is getting an appropriate variety of cases. Daily assessments are conducted by the attending anesthesiologist who rates the student on seven categories: admission assessment; treatment plan development and implementation; procedural skills; knowledge base; documentation; observations and time; communication and interpersonal skills. The rating scale is fail, needs improvement, meets expectations, exceeds. (See Appendix D1: Sample Evaluation Tool: Algonquin College). Students set daily goals for their practicum. The program coordinator discusses the evaluation with the anesthesiologist and the student. By the end of the nine weeks students are expected to demonstrate that they are meeting competency expectations. A clinical practicum can be extended if needed.

Improvements that the faculty want to make include increasing the practicum to 16 weeks, securing better placement support within The Ottawa Hospital and rotations that include a week in each specialty area.

6.3 Fanshawe College Anesthesia Assistant Graduate Certificate Program

Fanshawe College in London, Ontario has been offering a 45-week three-semester classroom based Anesthesia Assistant Graduate Certificate Program since 2008. The program can accommodate up to 10 students in each cohort. When the program first started the majority of the students were those working in AA roles in the OR but had not completed a formal AA education program.

6.3.1 Leadership and Faculty

The Program Medical Director is an anesthesiologist with an academic affiliation with the Western University Anesthesia and Perioperative Medicine Program. The Director has been in this contracted role since the initial startup of the program. A full time Coordinator administers the program. Program faculty are local anesthesiologists.

6.3.2 Admission Requirements

The requirements for admission are:

- a Respiratory Therapy Ontario College Advanced Diploma with current certificate as member of the College of Respiratory Therapists of Ontario,

OR

- a Bachelor of Science in Nursing Degree or Nursing Diploma with a current certificate of competence from the College of Nurses of Ontario,

AND

- 4000 hours of work experience as an RT or RN within the last 5 years as a RT or an RN. It is recommended that applicants should have experience in critical care areas such as the operating room, ICU or PACU. Applicants complete a pre-admission assessment evaluation.

6.3.3 Tuition and Student Profile

Current tuition is $5,300 per semester for a total of $15,900 for the program.

Hospitals in the area stopped sponsoring current staff in the OR once all their practicing AAs had completed an AA education certificate program. Students now self-fund their tuition and practicum. None of the students admitted into the program over the past two years was employed in an OR. The mix of RTs and RNs in the program has been changing with double the number of RNs than RTs enrolled in the current academic year. Students come from Toronto, the Hamilton area, Barrie, Scarborough and London to attend the program. Graduates are typically successful finding full time AA positions, usually at the practicum site.

6.3.4 Program Overview

Courses are classroom based conducted on site one day a week during the two fifteen week terms followed by a 320-hour clinical practicum.

Semester 1 Courses

Semester 1 theory and labs focus on anesthesia equipment and procedures and is taught by contracted Anesthesia Assistants.

- Anesthesia Theory and Equipment
- Cardiopulmonary Management
- Laboratory Procedures 1

Semester 2

- Anesthesia Pharmacology
- Principles of Anesthesia Care
- Case Study Management
- Laboratory Procedures

During Semester 2 anesthesiologists teach anesthesia pharmacology, principles of anesthesia care, case studies and labs. A group of 25-30 anesthesiologists representing different areas of specialty and interest teach the content or the courses. Anesthesiologists are paid an honorarium. Anesthesiologists send their material and suggested exam questions to the Coordinator who constructs tests, mid-term and final exams with this information. The cost for the anesthesiologists' delivery of Term 2 content is $15,000.

Semester 3: Clinical Practicum

The clinical practicum is 320 hours in length. Students who can attend the practicum full time can complete this requirement in eight weeks; however, most students complete the practicum between 6 and 12 months.

Clinical practicum capacity at London Health Sciences Center is up to 12 students at any one time. The Program Medical Director liaises directly with the Chief of Anesthesiology at each practicum site. Departments of Anesthesiology are paid $3000 per practicum student. The Chief of Anesthesiology at the site coordinates a practicum schedule for the student. Generally a student's practicum is at their current employment site. A Clinical Practicum Guideline outlining the roles of the Program Medical Director, the attending anesthesiologist, the program coordinator, the student, and the site coordinator are given to the student and the practicum site. The document includes tools for the assessment of competencies related to workstations, procedures, perioperative assessment, induction, intubation, line insertion, blood products, procedural sedation, regional anesthesia, post anesthesia care, pre, intra and post cooperative issues, and discussion topics for different patient populations that should take place with the anesthesiologist.

6.3.5 Clinical Logs

Students keep a daily clinical logbook that matches the desired practicum outcomes. Students log the daily procedures and discussions with the attending anesthesiologist. The attending anesthesiologist signs off the daily log. At the end of the practicum, the Program Medical Director reviews the log to ensure all objectives have been met and signs off that the student has met the

practicum competencies. If the logbook is deemed to be incomplete the student is sent back for an extension of the practicum.

6.4 Winnipeg Regional Health Authority Anesthesia Clinical Assistant Program

Anesthesia Clinical Assistants in Manitoba are now officially called Clinical Assistants- Anesthesiology in compliance with the College of Physician and Surgeons of Manitoba terminology for all clinical assistants on their registry.

The scope of practice in Manitoba is based on the CAS Position Paper on Anesthesia Assistants.

Clinical Assistants - Anesthesiology work as "physician extender members" of the Anesthesia care team. They are educated in a post-graduate, vocational/occupational-specific model, acquiring knowledge and developing skills and judgment relevant to the practice of Anesthesia. This includes:

1. Expertise in equipment, monitors, machines, airway management devices, vascular access and regional block procedures
2. Pre-emptive, resuscitative and maintenance interventions, and drugs necessary for safe conduct of a general or regional anesthetic
3. Sufficient familiarity with the maintenance phase of anesthesia to be left in charge of the care of the patient for various periods of time deemed appropriate by the attending physician
4. Algorithmic resuscitative interventions for unexpected catastrophic events occurring during the provision of anesthesia
5. Assessment and care of patients in pre & post anesthesia settings, off-site locations, acute/chronic pain service settings, labor wards, and ICU's under the direct supervision of the attending physician
6. Patient transport
7. Delegated administrative duties such as data collection for QA and research activities

The anesthesiologist supervision responsibilities include:

1. MD directs and reviews the work, clinical records and practice of the Clinical Assistant – Anesthesia;
2. MD assigns duties (must be able to perform themselves), Clinical Assistant – Anesthesia performs delegated duties (must have been adequately trained);

3. Clinical Assistant - Anesthesia complies with all the directions/orders of the MD and the rules/regulations of the CPSM;

4. Physician is onsite, immediately available, and may designate substitute supervising MD.

Clinical Assistants – Anesthesiology have a dual reporting relationship to the Program Medical Director and to a Regional Manager, Anesthesia/Surgery Programs at WRHA.

Clinical assistants and physician assistants on the College of Physicians and Surgeons of Manitoba registry formed their own union in 2015.

6.4.1 Education Program

Leadership

The Manitoba program is under the leadership of an Anesthesiologist Program Director, supported by a WRHA Regional Manager and Anesthesia Clinical Assistant Lead.

Admission Requirements

Requirements for admission to the program are:

1. Registered Nurse (RN) licensed to practice in Manitoba, or

2. International Medical Graduate (IMG), Physician Assistant (PA) with recent experience in Anesthesia/Emergency/Critical Care, graduated from a recognized and accredited university/college acceptable to the College of Physicians and Surgeons of Manitoba, or

3. Registered Respiratory Therapist (RRT);

AND

- Two years of critical care or anesthesia-related operating room experience within the past 5 years; and
- Eligible for registration with the College of Physicians and Surgeons of Manitoba (CPSM) as a Clinical Assistant. New CPSM regulations require all applicants to the program to successfully complete a CPSM Registered Clinical Assistant Examination to be considered for the education program.

Program Overview

This one year training program was initially designed and built by Dr. Judy Littleford in 2006 with input from anesthesiologists affiliated with the university.

The program is designed to prepare individuals with background training in Nursing, International Medical Graduates (IMGs), Respiratory Therapy and Physician Assistants to assume non-physician, anesthesia care team professional roles in Winnipeg. See Appendix C1 for the WRHA Clinical Assistant- Anesthesia job description. The program prepares trainees to work at all WRHA sites. Graduates of the program do not receive a certificate from an educational institution. They receive a certificate from WRHA. Graduates join the CPSM register upon successful completion of the program.

The program is conducted on an as needed basis. The last cohort of three students graduated in 2014. Manitoba is about to run its 5th cohort of trainees starting in February 2017. Between three to four trainees are enrolled in each intake.

Selection of Applicants

Due to the number of steps in the application process it takes approximately five months to recruit an applicant for training. Over 100 individuals applied for the 2016-17 program. Over 75 met the initial qualifications. The next step was to obtain references regarding the applicant's teamwork skills, situational awareness, and decision-making skills. Reference letters had to be based on referees' direct observations of the candidate. Applicants wrote an essay indicating why they were interested in the training and completed a self-assessment of their non-technical skills. The final step in the application process is successful completion of the Registered Clinical Assistant Exam.

Tuition

There is no tuition fee. Students are paid a trainee salary of $60,000 over the 12 months of the program. The annual salary of a new graduate Clinical Assistant – Anesthesiology is approximately $105,000.

Modular Curriculum

The program consists of a modular curriculum. There are approximately 165 modules that were initially developed by anesthesiologists (as part of their academic commitments). Each module follows a template listing objectives, pre-requisite knowledge, references, competencies, advanced topics for discussion, and questions that were developed by faculty. The modular categories are:

- Airway
- Anesthesia considerations
- Assessment
- Cannulation/injection procedures
- Clinical management
- Equipment
- Monitors and monitoring
- Pediatric anesthesia

- Pharmacology and physiology
- Protocols, policies, and guidelines
- Regional analgesia and pain management

Trainee schedules are prepared a month in advance, identifying the modules to be completed each week, rotations, work shifts, and classes and labs to attend. For the first 3-4 months trainees are assigned an anesthesiologist to work with each week. The trainees follow the anesthesiologist to the facilities they are working in during the week. The trainees are expected to complete the modules in the evenings and to discuss the learning from that week's modules with the anesthesiologist.

During non-clinical weeks trainees are in lectures and in simulations. Education sessions include orientation; equipment, monitors and devices seminar series; talk rounds; 4 simulator lab sessions using 12 scenarios; and 4 Objective Structures Clinical Examination (OSCE) sessions using 24 scenarios.

Courses are taught on basic EKG interpretation and arrhythmia analysis (ICU RN educator); procedural sedation (Cl. A-Anesthesia); blood transfusions, blood alternatives and blood reactions (Cl. A- Anesthesia and Anesthesiologist); neonatal resuscitation protocol (CL. A - Anesthesia and Anesthesiologist), and advanced cardiac live support (Cl. A - Anesthesia and Anesthesiologist).

Two Clinical Assistants – Anesthesiology are assigned to preceptor the trainees through the program. This preceptor team makes up the student schedules, meets with the students every two to three weeks, conducts the learning labs and OSCEs, and discusses trainee progress and supports them to keep them on schedule. This role is taken on while the preceptors continue in their regular rotations.

Trainees complete self-assessments. Preceptors evaluate trainees quarterly. Trainees are evaluated in the simulation lab. Trainees must obtain a pass rating on five regularly scheduled evaluation tools consisting of non-technical skills, an elective routine case, a second routine case, technical skills global rating, preoperative assessment, and professionalism and humanism.

Satisfactory completion of the program is dependent upon the trainee acquiring and demonstrating the following:

- Basic scientific and clinical knowledge relevant to performance of the tasks listed in the job description
- Technical proficiency in clinical skills (airway lab, simulator, observed daily in the clinical area)
- Pass ratings on five regularly scheduled anesthesia evaluation tools
- Successful completion of the Advanced Cardiac Life Support, Neonatal resuscitation protocol, and Bloody Easy programs
- Facility in simulator sessions
- Facility in OSCE (24 stations in total, 6 per session distributed 4 times throughout the year)
- Passing grade on the ACA written challenge examination.

The scope of practice for the Cl. A - Anesthesia in Manitoba is greater than in other provinces. A Cl. A -Anesthesia can be in a room by themselves with the attending anesthesiologist in the next room and immediately available. The Cl. A - Anesthesia can change treatment modalities in discussion with the attending anesthesiologist. The CPSM dictates when the anesthesiologist needs to be in the room. Anesthesiologists cannot delegate activities that they themselves are not competent to perform.

A new Program Medical Director has recently been hired. The program is in the process of being put online for the upcoming February trainee cohort. The Cl A - Anesthesia Program Lead believes that in the future it may be possible for the program to be offered to out of province students.

7. Thomson Rivers University Anesthesia Assistant Post Diploma Certificate Program

The Anesthesia Assistant Post Diploma Certificate Program offered by Thompson Rivers University was first developed in the mid 1980's in response to the need for Respiratory Therapists and Registered Nurses across Canada to be educated as Anesthesia Assistants while continuing to work without having to leave their home sites.

Concerns regarding the currency of the courses and gaps in the curriculum surfaced in the BC community more than four years ago. Anesthesiologists and AAs wanted course content added to the program, including the delivery of some content face-to-face by anesthesiology experts and more TRU monitoring/liaison with sites during the students' clinical practicum. There was also a need to align the curriculum to the 2011 National AA Competency Framework (CSRT, 2011).

The Program Advisory Committee supported TRU's recommendation that admissions to the program be suspended until revisions were in place. Students already enrolled in the program were to continue in the "old program"; however, admissions to a "new program" were suspended between September 1, 2014 and July 1, 2015. BCAS later withdrew its support for the TRU revision.

7.1 Leadership

The AA Program is under the leadership of an Academic Coordinator, Open Learning Health Sciences, Faculty of Health Sciences. A temporary Program Coordinator joined the leadership team in 2015 "to get the curriculum back on track." There is no designated Medical Director of the program, although anesthesiologists are on the PAC and provide advice. An Open Learning Program Administrator, Science, supports the program. In early 2016 a local anesthesiologist was hired as a consultant to review and edit the revised and new courses.

7.2 Faculty

The Open Learning Faculty Collective agreement states that course faculty are hired to teach specific courses on an ongoing basis as long as that course is active. Two AA faculty members alternated teaching the three courses in the old program and will continue teaching these revised courses in the new program.

Faculty postings for new courses are up on the TRU website for one week. The Program typically emails the posting to those who are qualified and may be interested in the position. Legal and union requirements do not support the hiring of out of province faculty. Current program faculty members

who meet the qualifications to teach the course have the right of first refusal by seniority if they apply to teach a new course.

7.3 Admission Requirements

The learning objectives for the program are not online but are available from the program advisor.

Requirements for admission to the program are:

- Qualification as a Respiratory Therapist or Registered Nurse with critical care experience, or an equally qualified individual (proof of professional licensure is required);
- At least one year of post-graduate clinical experience;
- A letter from an anesthesiologist, recommending the candidate's suitability.
- Students are solely responsible for finding a clinical affiliate that will provide the clinical practicum. TRU arranges legal affiliation and faculty oversight for the site.

A pre-entrance exam is required to determine the student's course of studies. Students who do not pass all the subject areas of the pre-entrance examination either must take the corresponding course(s) that relate to the failed subject area, or, alternatively, take all four support courses rather than writing the pre-entrance examination. Applicants who pass all subject areas of the exam directly enter the core courses. These core courses are to be completed prior to the clinical practicum.

7.4 Tuition

The tuition for BC students enrolled in the new program is estimated to be $7,200. The tuition for out of province students is estimated at $8,000.

7.5 Student Enrolment

TRU reported that most students entering the program are already working in the OR. Students have taken two to three years on average to complete the three courses plus practicum in the "old program."

Fifty-seven students graduated between 2012 and 2016. The numbers of students graduating each year has dropped from twenty-three students in 2012 to an average of ten to twelve per year in 2013, 2014 and 2015. Fifty five percent of the graduates over these years were BC students. Out of province graduates were from Newfoundland (5), New Brunswick (5), Saskatchewan (4) and Ontario (12).

As of May 2016 there were 39 students enrolled in both the old and new program. The ratio of BC students (5) to out of province students (12) enrolled in the new program has dropped. Students who enrolled in the program after the summer of 2015 are required to take the new program.

7.6 Stakeholder Engagement

7.6.1 Program Advisory Committee (PAC)

The Terms of Reference are the standard terms for all Open Learning Advisory Committees. (Thompson Rivers University Open Learning Division Anesthesia Assistant Post Diploma Program. Guidelines for Effective Program Advisories, no date)

Membership on the PAC is from across Canada representing diverse interests and practices with varied priorities. BC members include a BCAS anesthesiologist liaison; the UBC Department Head of Anesthesiology, Pharmacology and Therapeutics; the Head of the VGH Department of Anesthesia; the SPH Director of the PHC Anesthesia Assistant Program; the president of the BC Society of Respiratory Therapists (BCSRT): and AAs from SPH, Children's and the Royal Columbian Hospital. Out of province members include an Anesthesiologist from Saskatchewan and AAs from Mount Sinai, St. John, and Saskatoon. There is no formal chair of the PAC.

Recommendations for program improvements were made by the PAC in early 2014. At the September 3, 2014 meeting the PAC supported the decision to suspend enrolment in the program. Enrolment in the Program was suspended in September 2014. Subsequently there were no further Advisory Committee meetings held until May 11, 2016, although most members of the PAC were members of the new Program Curriculum Committee (PCC). During the May 2016 meeting the PAC received updates on student enrolments and graduates and a PCC report.

7.6.2 Program Curriculum Committee (PCC)

The first meeting of a newly formed Program Curriculum Committee (PCC) occurred on April 17, 2015. There is no designated committee Chair. The minutes of the first PCC read: "The committee is intended to be a working committee where members have access to copyright materials and become part of the curriculum development team, and was implemented as a result from feedback from the community. All non-members of the PCC, as program stakeholders, will: (1) receive regular updates on program growth and development, and (2) have opportunity to provide program feedback. The committee will set up lines of communication to enable effective communication to all of its stakeholders." (Program Curriculum Committee minutes, April 17, 2015)

The Terms of Reference for the Program Curriculum Committee were documented in the October 9, 2015 PCC minutes as follows:

- Provide feedback on proposed new courses by reviewing course blueprints. Feedback is provided to the course development team (faculty developer /consultants, and instructional designer).
- Provide revision recommendations based on supplied briefing reports (includes students and faculty feedback).
- Incorporate feedback to advise on future program revisions.

Membership on the committee is limited to the lower mainland. The PCC meets at least once in person and once by teleconference each year.

Members of the PCC include a Vernon Anesthesiologist representing the BCAS, a SPH anesthesiologist, the TRU anesthesiologist consultant mentioned earlier and AAs representing FHA, SPH, VGH and BCCH. A VGH anesthesiologist resigned from the committee in 2016. TRU administration, faculty, and instructional design staff attend the PCC meetings.

The process for committee membership input into the curriculum was discussed at the June 12, 2015 PCC meeting. TRU found it difficult to recruit anesthesiologist and AA course writers from BC, and members gave feedback that the TRU reimbursement fee, as set out in the collective agreement, for course development would be inadequate to entice BC anesthesiologists as course writers. Eventually former TRU graduates working in Ontario and Nova Scotia were recruited as course writers, and a temporary Program Coordinator was added to the Program Team.

7.7 Revised Program

The program has been revised from three courses to eight courses. A 16-week clinical practicum continues to be required following completion of the courses.

All courses continue to be offered through a web based and online distance delivery model. There are no classroom or laboratory sessions offered in the program.

The program continues to be continuous entry enrolment; that is, a qualified student may enroll in the course beginning at any time. Six of the courses are self-paced web courses. Each is designed to take 13 weeks, but students can take up to 30 weeks for completion. Two online courses are paced and must be completed within 16 weeks from the start date. Students have up to three years to complete the full program.

7.7.1 Program Revisions

The Program is now mapped to the CSRT National Competency Framework for Anesthesia Assistance. The new program consists of eight courses. See overview below:

1. An equipment course was subdivided into 3 courses

- 4001: Anesthesia workstations (web)
- 4003: Airway management (web)
- 4005: Anesthesia adjunct equipment (web)

2. Revisions to the old courses

- 4011: Hemodynamic and Physiological Monitoring Course (web)
- 4101: Clinical Practicum (to be revised after all new and revised web and online courses have been completed)

3. Addition of new courses

- 4021: Pharmacology and Principles of Clinical Anesthesia (cohort based and online)
- 4031: Clinical Anesthesia and Special Considerations (cohort based and online)
- 4061: Anesthesia Assistant Professional Practice (web)
- 4071:Research Skills for Anesthesia Assistants (web)

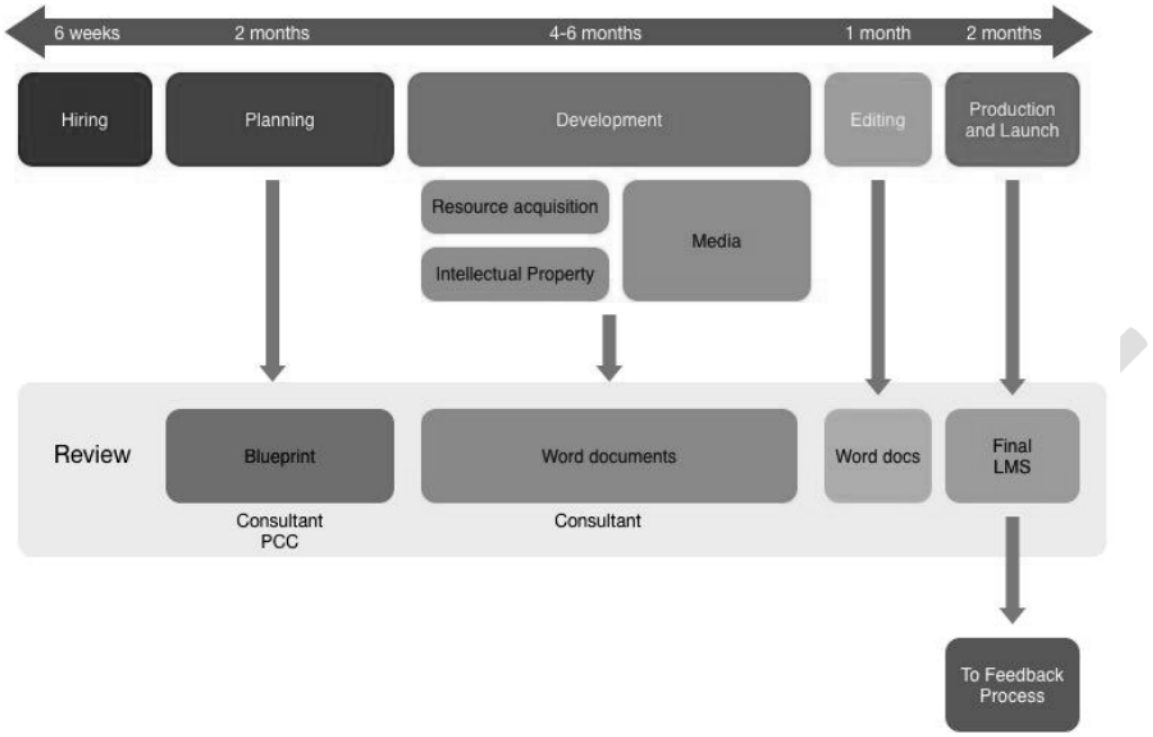
The general guide regarding the number of hours a student could expect to spend on a course in the old program was 60-80 hours per course plus the 16-week practicum. It took students on average two to three years to complete the old program within the old delivery model. Currently there is no guideline regarding the number of hours the average student can expect to spend in each of the courses in the new program, although all students have access to the TRU OL Student handbook that will provide tips and resources on how to be successful in distance education. The impact of continuing the course offerings in the current delivery model has not been assessed.

7.7.2 Course Revision Process

The course development and revision process has been in progress for more than two years.

Thompson River University's Open Learning **Course Development Process** consists of five major stages described in Figure 1: hiring of course developer, blueprint plan, development, editing, and production and launch. Factors that may cause delays are: resources copyright, writing development, media, editing, reviews, production, and delivery.

Figure 1: Open Learning Course Development Process [2]



Course development teams for each course consist of a course developer or reviser, a course consultant, an instructional designer, and editors.

Course developers are paid $8500 per course whether the person is an Anesthesia Assistant or an Anesthesiologist. Course consultants are paid $1500/course.

Course developers and those doing revisions are all Anesthesia Assistants except for the new Research Skills for Anesthesia Assistants course. A UBC research methodology expert is developing this course. It should be noted that all the AA course developers are past TRU graduates currently employed outside of BC. TRU reported that they were unable to recruit developers from within BC. TRU recently contracted an anesthesiologist in Kamloops to review and edit six of the courses.

TRU will continue utilizing the regular Open Learning course evaluation tools to evaluate the new and revised course. Open Learning course evaluation consists of faculty feedback and a course satisfaction survey administered to students upon completion of a course. The course satisfaction tool assesses the following:

- Whether the course meets student's expectations;

[2] Thompson Rivers University Anesthesia Program Revision A, June 17, 2016

- Overall satisfaction with financial services, library resources, technical support, student services, registration process for exams;
- Number of additional courses students are planning to take;
- Student willingness to recommend an OL course to their peers;
- Additional resources that would have helped the student to better succeed; and
- Additional services that student would "like".

7.7.3 Course Production Status

The target date for completion of all course revisions and development is January 2017. As of June 2016 the following new and revised courses had reached the production stage:

- Anesthesia Workstations
- Pharmacology and Principles of Clinical Anesthesia
- Clinical Anesthesia and Special Considerations

Course outlines include updated textbooks. No reference articles are identified in the course outlines.

7.8 Clinical Practicum

The requirements for approval of clinical affiliates for a student's practicum are described in the TRU Anesthesia Assistant Program Clinical Practicum Handbook are as follows:

1. Case Load
   The hospital must have sufficient depth and breadth of clinical cases to enable the student to experience the majority of objectives listed in the clinical objectives.

2. Clinical Mentor
   Ideally, an experienced Anesthesia Assistant and Anesthesiologist would be committed to teaching the student. Should the facility not have an Anesthesia Assistant, the Anesthesiologist would have to oversee the entire rotation. The clinical mentor(s) must have sufficient time available for teaching and evaluation of the student.

3. Student Evaluation
   During the clinical practicum, the student must receive ongoing formative feedback that culminates in a summative evaluation.

4. Learning Resources
   The student must have access to current texts, journals, and reference materials relevant to the rotation.

5. Length of Rotation
   The clinical practicum is 16 weeks (560 hours) in duration and should be completed consecutively. Any deviation from this policy must be discussed with TRU before the rotation starts.

6. Student Records
   The clinical affiliate will keep student records during the rotation and must keep these for a one year period following completion of the practicum. Permanent records are maintained at TRU.

7. Clinical Rotation Evaluation
   The clinical site will ensure that the student receives an exit interview for the purpose of giving feedback on his/her experience.

8. Liability
   As a registered student at TRU, they are covered by the Universities blanket insurance policy. WCB coverage does not extend between provinces.

7.8.1 Anesthesia Assistant Clinical Practicum Handbook

A Clinical Practicum Handbook has been created by the Program Administrator to be sent to new and prospective clinical sites to provide general information about the program and the Clinical Practicum. The Manual contains the following information:

- Aim of the clinical practicum
  - Practicum objectives
- Information about practicum length
- Clinical practicum grading
- Site requirements
- Liability
- Roles and responsibilities of the TRU program administrator, the Open Learning faculty member clinical liaison, site preceptor, and student.

7.8.2 Clinical Practicum Guide

Students receive a Clinical Practicum Guide for their practicum. An electronic copy is sent to the preceptor.

The practicum consists of eight core areas that the student must successfully complete:

- Professional Competencies
- Anesthesia Equipment
- Patient Assessments

- Pharmacology
- Regional Anesthesia
- Pediatric Considerations
- Clinical Management
- Special Considerations

The Clinical Practicum Guide is organized in sections that the student is expected to complete in sequence. Included in each section are topics for consideration and discussion with the anesthesiologist. An anesthesiologist signs off each section indicating whether the student has demonstrated the competencies for that core area.

Students keep case logs documenting a minimum of 100 different surgical cases and are required to get an anesthesiologist to sign off on the log.

The Practicum is the equivalent of 16 full time weeks. The clinical practice has a maximum completion time of 30 weeks. The training may be accomplished in less time, where a student has previous experience as an Anesthesia Assistant. Training time is determined in consultation with TRU at the start of the practicum. The clinical practicum for Children's RTs employed in the OR who have completed the core courses is a two to three week adult OR experience at St. Paul's Hospital.

The clinical practicum guideline indicates that students require OR rotations across general surgery, cardiac, neuro, vascular, and pediatric surgery.

Students are expected to be self-directed in ensuring that they seek and achieve the objectives for the curriculum, although TRU notes they have a faculty member assigned to them who is available for consultation and assistance.

Students are not required to train at more than one site unless necessary to obtain the required course and program learning outcomes..

Open Learning practicum faculty are paid for 5 hours of time to support a student's practicum regardless of length. This translates to approximately 1.5 hours with the student pre practicum to facilitate the student's understanding of their responsibilities during the practicum; a mid-point evaluation and a review of the evaluation reports. A document is filled out for the student's initial plan.

Practicum Evaluation

A mid-term evaluation is completed by the clinical preceptor, reviewed by the student and forwarded to the faculty member assigned to the student. See Appendix F Mid Term Evaluation Form. At this point a decision is made by the site and TRU whether the student proceeds further.

The final evaluation is completed by the Medical Director or designate preceptor who determines whether the student has met the objectives of the practicum and is competent to perform the AA role. Students do not complete a written evaluation of their clinical practicum experience.

8. Anesthesia Assistant Training and Education Pathways in BC

The job qualifications for the AA role in BC were determined in a 2014 arbitration award:

1. Graduation from a recognized school of Respiratory Therapy
2. Completion of an accredited post-graduate Anesthesia Assistant Program and three years recent, related acute care experience, or an equivalent combination of education, training and experience
3. Comprehensive knowledge of current anesthesia theory and practice and knowledge of the Canadian Anesthesiologist Society clinical practices guideline.

8.1 BC Children's Hospital

Eight AAs are employed at BCCH including four who are in training. Three of the four are enrolled in TRU courses and the fourth is in internal pre TRU training.

8.1.1 Recruitment of AAs

RTs with pediatric experience are recruited to the OR. These new hires work for approximately seven to eight months in the OR before being sponsored to enroll in the TRU courses.

8.1.2 AA practice at Children's includes:

- Airway management
  - Adjuncts
  - Bag mask
  - Oropharyngeal
  - Nasopharyngeal
  - Laryngeal mask airway
  - Intubating
- Assisting with difficult intubation
- Set up of secondary pain medications
- Help set up for epidurals or blocks
- IV insertion or helping
- Art line insertions and teaching
- Ventilation – set up vent machine
- Set up equipment
- Medication – help out with set up and under the anesthesiologist supervision draw up and check with the anesthesiologist (no drawing up of meds until talk with anesthesiologist)
- Cell saving

- Radiology
  - CAT Scan
  - Nuclear medicine where child needs to be still – sedation
  - Cardiac catheter lab
- Analgesia in burn rooms
- Off site at VGH if staff are needed for a difficult airway, radiology, or lithotripsy on a pediatric patient
- Cancer agency – sedation for children getting radiation

Guidelines for AA practice and procedures are under development.

8.1.3 BCCH Pathway to an AA Certificate

The BCCH training pathway is as follows:

Months 1-3: The first 2.5 months the new hire is supernumerary. A general AA orientation manual is used as a guide. The first week is spent with the AA supervisor learning more about fluids and medication. References are provided. Time is spent in rooms with an Anesthesiologist where informal teaching takes place. The supervisor checks in with the anesthesiologist at the end of the day and gets feedback on the new hire's level of knowledge. Skills development includes:

- Medications
- Anesthesia machines
- IV insertion
- Arterial line insertion
- Expectations of role
- Insertion of endotracheal tubes
- Trouble shooting machines
- Set up of pediatric equipment

AA staff provides feedback on the RT's progress and at three months the supervisor completes a performance evaluation identifying the individual's strengths and weaknesses determining the need for additional in-house training and whether the individual should stay supernumerary or move into a staff rotation. If ready, the individual is put into a staff rotation where the focus is still on learning.

8.1.4 TRU Program

The AA supervisor continues to conduct regular check-ins with the new hire for the next three to four months to review progress. At seven to eight months, the RT indicates a readiness to take the TRU program and the individual is sponsored to take the courses. It takes 1.5 years on average for the individuals to complete the full TRU program and during that time the student is continuing to learn and increase competencies with pediatric patients in the practice setting. Course study is on the

employee's own time. BCCH values the knowledge students gain in the TRU courses, filling in gaps that would not have been covered in the basic RT education program. Students have reported that the content has been very relevant.

8.1.5 Clinical Practicum

BCCH does not require the AAs in training to do a pediatric practicum as the organization recognizes the learning and competencies that the person has gained first in the initial pre TRU enrolment phase and during the time they have been actively enrolled in the TRU courses. The practicum for their staff does include a short adult rotation at SPH.

BCCH reported that the practicum standards are not clear enough. Some would like to see the practicum portion of the program be "tighter" so that the student presents/or demonstrates evidence of having met the competencies for the program. BCCH is not aware that there is any pediatric content in the hemodynamics course.

8.2 BC Women's Hospital

8.2.1 AA practice

There are 2.25 FTEs (4 AAs) employed at Women's: one AA is on shift for 12 hours 7 days/week.

Three of the AA staff have been completed the TRU education program and one had a medical qualification from another country. A business case has been prepared by the Anesthesiology Department to gradually increase the numbers of AAs to support 24/7 coverage. The case is based on "improving patient safety," e.g. providing capacity to provide prophylactic cell salvage for women undergoing caesarean section who have risk factors for hemorrhage; immediate availability of a trained assistant to the situation of an unanticipated difficult airway. AAs also improve the quality of the service provided by improving OR patient turnover and throughput for elective and emergency cases. This increase in staffing is anticipated to take several years and ideally would coincide with staffing for the new hospital. (Personal communication, Dr. James Brown, September 15, 2016)

Current AAs practice at BCWH includes:

- Perform safety checks: equipment, machines, supply chain, equipment, drugs
- Preparation of airway equipment
- Preparation of and assistance with difficult airways and maintenance of difficult airway cart
- Set up room for monitoring
- Set ventilation setting under direct supervision
- IVs
    - Insert difficult IVs (assist nursing staff with difficult IVs)

  - Set up infusions
  - Set up art lines
  - draw arterial blood gases
  - Blood product checks
  - Set up of rapid transfusioner, blood/fluid warmer
- Drugs
  - Stock emergency drugs
  - Draw up and check emergency drugs
  - Draw up other drugs under direction of the anesthesiologist
  - On occasion administer drugs on direct request from anesthesiologist
  - Administration of pre-op medication (e.g. midazolam for an anxious patient under direct consultation with anesthesiologist)
- Peri-op safety in emergency situation
- Patient assessment in the gynecological ORs where there are no residents. It was reported that there is an option for the AA to conduct patient assessment (history and physical examination of airway and relevant systems) and to identify any issues that may need investigation (e.g. blood tests, ECG). This helps to prevent delays in the OR slate. The Anesthesiologist is then able to perform a focused history and exam. This facilitates a team approach where both the anesthesiologists and the AA can discuss the patient and the plan. These discussions during elective gynecological cases are seen as important AA learning opportunities. These discussions of clinical decisions and thought processes improve shared understanding, which increases the efficiency of AAs and anesthesiologists to function as a team in emergency situations.

Funding has been secured to provide continuing education for AAs: 4 x 4hour sessions annually. The department of anesthesia provides these sessions.

8.2.2 TRU program participation

The last new hire was 18 months ago. This was a temporary appointment to cover a maternity leave. Currently there are no BCWH sponsored students enrolled at TRU and no unsponsored students are doing a clinical practicum at the hospital.

8.3 Fraser Health

8.3.1 AA Practice

There are seven FTE positions across Fraser Health: five at Surrey Memorial Hospital (SMH): two at Royal Columbian Hospital (RCH). The second RCH position is new. The Vice President, Medicine reported that there is a need for more AA positions at SMH, RCH, and Abbotsford.

The five positions at Surrey Memorial Hospital include an AA Supervisor for fifteen ORs and the Jimmy Pattison Pavilion. Coverage is seven days/week from 0700-0130. There is no sick time or relief coverage. Historically, AAs at this site had on the job training and then were sponsored to complete the TRU program. AAs work in every OR with assignments prioritized to heavy and high-risk surgical cases. Examples of supports to anesthesiologists include: Insertion of IVs and arterial lines; assist with central line and swan gantz insertion; cell saving; drawing up medications; and assisting in the Trauma Room. AAs also perform point of care blood testing. AAs assist with procedural sedation in the JP pacemaker clinic where patients are administered propofol, versed, fentanyl as per the attending anesthesiologist's orders.

Royal Columbian Hospital introduced the AA role into the ORs in 2015 with the creation of one AA position. A 2014 TRU graduate was hired into this position working a 0700 - 1500 shift Monday through Friday. Fifty percent of the individual's time is spent in the OR supporting anesthesiologists and 50% outside the OR supporting anesthesiologists with interventional work such as electrophysiology, cardiac ablation, aneurysm coilings; GI, high risk bronchoscopies; cardioversion, electroconvulsive therapy, transesophageal echograms; accompanying anesthesiologists for high risk Intubations and extubations in the ICU; and responding to calls to the ER for trauma patients.

A review of AA practices was conducted by the Professional Practice Department in 2013. Standards for AA practice were implemented as well as ongoing education for higher risk activities. Policy and Procedure manuals were developed in collaboration with the AA supervisor. An annual drug knowledge competency test is about to be implemented.

8.3.2 Recruitment of AA

There is no specialty education funding allocated for RTs to train for an AA role in Fraser Health.

8.3.3 TRU Program - Clinical Practicum

8.3.3.1 Surrey Memorial Hospital (SMH)

The last student practicum was in 2011-12: notably, this is before the revisions that the clinical course is currently undergoing. SMH has never had a student who was not already working in the OR. The AA Supervisor reported that most students need more than a 16-week practicum. Students

rotated through SMH, pediatrics, and cardiac (SPH.) At the time there was minimal interaction between TRU faculty and the site regarding the student's performance.

The AA Supervisor reported that prior to a practicum students from the pre-revision TRU program needed a "better grasp regarding the administration of general anesthesia and what it means; should be able to explain fluid balance; need to apply the knowledge to case studies; more application of knowledge; understand the hemodynamics during laparoscopic procedures in the belly; and understand major surgery."

The focus of the **Orientation/transition** post practicum is to support the AA to gain proficiency in understanding the cases and when to give drugs. Graduates need an additional eight to twelve weeks orientation/practice post practicum in order to become independent. New graduates do not work alone for the first eight weeks and are not assigned night shifts alone for an even longer period of time.

8.3.3.2 Royal Columbian Hospital (RCH)

RCH recently provided a short neurosurgical rotation for a student enrolled in a practicum at SPH.

RCH anticipated that they would be successful recruiting an experienced Anesthesia Assistant to fill a newly created second AA position that was posed in September 2016.

8.4 Interior Health

8.4.1 AA Practice

Interior health has thirteen FTE AAs across the Kelowna, Kamloops and Vernon sites. The Chief of Anesthesiology at each site is responsible for AA practice at the respective site. There are no AA supervisor positions in the health authority. AAs report to the OR Manager in the respective sites. Interior Health is in the process of planning for the future introduction of AAs into three additional hospital sites

The Interior Health Surgical Services Clinical Leader chairs an AA Working Group consisting of AAs and a clinical practice standards coordinator whose mandate is to develop AA practice standards, procedures, and processes for approval of education requests.

8.4.2 Interior Health pathway to TRU Education

Interior Health's Professional Practice Department allocates annual specialty education funding for RNs, LPNs, perianesthesia and AA education based on recruitment needs. Funding includes tuition, textbooks, travel and clinical practicum.

Regional AA workforce forecasts are based on anticipated vacancies arising from turnover and the introduction of the AA role into new sites. Requests for expressions of interest (EOI) for AA education are sent to all the RTs employed in the health authority. The OR manager, the OR educator and an AA screen candidates for potential sponsorship. Planning takes into account the three-year time frame that previously sponsored RTs have taken to complete the education program. There is no guarantee of employment upon completion of the program. Currently two RTs are completing the courses in the "old Program" and three are starting the "new program" this fall.

8.4.2.1 Clinical Practicum

Liaison with TRU during a practicum is through an AA at the site. Anesthesiologists are eager to help with a student's practicum.

Several sources in the health authority reported that that graduates from TRU program are well trained.

In Kelowna, the Anesthesiologist clinical lead for Anesthesia Assistants is accountable for the final sign off of the student's achievement of the practicum objectives.

8.5 Island Health

8.5.1 AA practice

There are twelve AA FTEs positions across three Island Health sites: six at the Royal Jubilee, four at Victoria and two at Nanaimo Regional Hospital.

There is no designated Medical Director for AAs at Island Health.

AAs practice predominantly in the OR assisting in more complex adult and pediatric cases where special monitoring/interventions may be required. AAs also participate in the support of the anesthesiologist during patient transfers from the OR to PACU and ICU/PICU.

AAs in Victoria work 0730-2300 and are on call for difficult cases on the weekends. Some AAs in Victoria rotate between sites.

8.5.2 Internal training pre TRU program

New hires are RTs who are mentored by other RTs and AAs upon entry to the OR, slowly getting oriented and learning on the job. Anesthesiology residents are involved in their training. There is no formal orientation program for new AA hires.

8.5.3 Island Health Pathway to an AA certificate

Some AAs were grandfathered into their positions. Completion of the TRU program was not mandatory. AAs were assisted with some tuition funding. Most have completed the TRU program while some started courses a few years ago but have not finished all of them.

With low AA turnover, there is minimal recruitment of RTs into AA positions and training.

8.5.3.1 Clinical Practicum

TRU does not have an ongoing formal relationship/communication with the Island Health Medical Director of Anesthesia Services. As a result the Medical Director felt that opportunities for maximizing the potential of what the TRU program offers are being lost. The practicum is initiated by the person in training and it follows the expectations set by the TRU practicum guidelines.

Students enter their practicum with the TRU Clinical Objectives Logbook. The RT department drafts their clinical schedule. There is no designated anesthesiologist or AA mentor assigned to the student.

Island Health reported that separating "working in the OR as staff" and being able to take on a student role in a practicum phase is difficult. Systems for anesthesiologist sign-off of the practicum competencies have not been developed.

8.6 Northern Health

8.6.1 AA Practice

As a result of a peri operative services improvement project conducted at the University Hospital of Northern BC, the decision was made to introduce the Anesthesia Assistant role in the ORs at the site.

8.6.2 NH Pathway to an AA Certificate

Efforts to recruit a certified anesthesia assistant into the new position were unsuccessful. The decision was made to hire an internal RT applicant as a trainee "without prejudice." The TRU AA program administrator and a faculty member worked with the site, specifically the site RT Practice leader and the then Anesthesiology Department Head to design an accelerated program for a "student." Planning commenced more than eight months ago. An internal RT applicant was hired in June 2016 and immediately started the TRU courses. The student is being paid full time to study to complete the courses and the practicum. TRU has committed to UHNBC that they will guide the student through the courses and the practicum so that all available courses and the practicum can be completed by February 2017. (Not all courses will be available for enrolment until early 2017. The RT was introduced into the OR two days per week during August and September to become oriented to the OR, to perform RT duties such as assisting the anesthesiologist with airways, intubation, IV starts,

and insertion of arterial lines, and to build trust with the anesthesiologists. The student studied the other three days of the week.

A TRU faculty member is tailoring the practicum to their assessments of the student. Practicum rotations will be at UHNBC, Kamloops and Kelowna. The student entered a short practicum at Kamloops the first week of October.

To date, the new Department Head of Anesthesia is not involved currently in the planning, mentoring or monitoring of the trainee.

8.7 Providence Health Care

8.7.1 AA Practice

There are eight AA FTEs positions at St. Paul's Hospital (SPH) for fourteen ORs. AAs work the Monday to Friday day shift. One person works a weekend day shift. There is an AA on call seven days a week.

AAs employed at SPH are RTs and IMGs who have completed an AA certification program.

SPH has a designated Program Medical Director and an AA Supervisor for AA practice at the site. Both the Program Medical Director and the AA supervisor are members of the TRU Advisory and Curriculum Committees.

The priority allocations of AA resources are difficult airways and cardiac rooms. AAs are utilized during heart transplants, difficult cases, big vascular cases, monitoring regional blocks prior to the patient entering the operating room and assisting the anesthesiologists with blocks outside the OR. AAs also provide break relief for anesthesiologists for stable patients. Outside the OR, AAs assist the anesthesiologist in cardiac procedure rooms: electrophysiology, ablation, implantable devices; MRI, radiology and the GI clinic.

A swing room demonstration project conducted with one surgeon, one anesthesiologist and one AA resulted in a 70% increase in productivity. The Program reported that an additional five FTEs are required for efficiencies in anesthesiology services.

AAs report operationally to the OR Operations Leader.

8.7.2 Recruitment of AAs

There is very low turnover of AAs in the organization. It is anticipated that an increase in Royal Columbian Hospital utilization of AAs would impact AA retention at SPH. AAs applying to SPH must have completed an AA education program. At the time of this review SPH had one AA vacancy relief

posting and were expecting a second one in January 2017. SPH anticipated that the current vacancy will be filled by an applicant who has completed an AA certificate program.

8.7.3 TRU Program

8.7.3.1 Clinical Practicum

Each year SPH offers between two to four unsponsored students a practicum at their site, coordinating a pediatric rotation at BCCH, a neuro rotation at RCH, and most recently a thoracic rotation at VGH. Discussions are taking place with SMH regarding potential rotations through that site as well.

Students start their practicum with an orientation to the equipment and the ORs. The next twelve weeks are spent with anesthesiologists where the focus is on achieving the competencies listed in the five sections of the Practicum Guideline. Students spend the final two to three weeks with an AA staff member and carry a pager. The AA supervisor reported that the student practicum should be longer.

The Program Medical Director conducts the final practicum evaluation and sign-off on the student's achievement of the practicum competencies.

Orientation for new AA hires

New hires are paired with others AAs for the first month where the focus is on competencies related to equipment and patient hemodynamics. There is a weekly evaluation of the individual's progress in achieving these competencies.

8.8 Vancouver Coastal Health

8.8.1 AA Practice

There are currently thirteen FTE positions at Vancouver General Hospital, one FTE at Richmond Hospital (RH) and one FTE at Lions Gate Hospital (LGH).

The VGH staffing is 24/7 with twelve-hour shifts. There are currently three AA vacancies at VGH.

AAs at VGH are supported by a full time AA Supervisor and a full time AA clinical Educator. An anesthesiologist is assigned as the medical director for AAs at the site.

AAs at each site have an indirect reporting relationship to the site RT Practice Lead and a direct reporting relationship to the OR Manager.

VGH practice was defined as including the following:

- Setting up rooms
- Assisting with difficult airways
- Assisting with hemodynamic issues
- Assisting the Anesthesiologist with any case that may be considered critical
- Assisting with all cardiac cases, transplant cases, traumas
- Assisting in all OR codes
- Assisting in the management of malignant hyperthermia
- Cell saving
- Operating all anesthesia equipment
- First line anesthesia equipment troubleshooting
- Outside OR
    - Assisting with assessment of patients to be transferred from ICU to the ORORR
    - PACU – as an AA resource to RNs for Acute Respiratory Distress Syndrome, ventilation issues, COPD patients, and assisting returning patients to the OR
    - Catheter lab – 3 days/week assisting anesthesiologist when patient requires anesthesia
    - Assisting anesthesiologist with Extracorporeal Membrane Oxygenation
    - Assisting anesthesiologist with Transthoracic Aortic Valve Implantation (TAVI)
        - Aortic value in catheter lab
        - Procedural sedation

RH and LGH

- Assisting with difficult airways
- Providing break relief for anesthesiologists
- Assisting with cell saving at RH

An AA is expected to look at the cases on the OR slate and have an idea of the requirements and the anesthetic that will be administered, see the patient pre-op, review the chart, identify the relevant information impacting the delivery of the anesthetic, and develop a plan that anticipates what assistance the anesthesiologists will need from the AA.

8.8.2 AA Pathway

In the past, VGH sponsored RTs through the TRU program by funding tuition and the clinical practicum. More recently, VGH began exploring the possibility of offering an in-house adaptation of the Manitoba ACA program as a short term solution to meet their needs in preparing RTs for practice as AAs in their ORs. The surgical services administration supported the plan to offer a hybrid program that would provide quality education, involve anesthesiologists in teaching, and address urgent vacancies in the short term. The initial intent was to develop content that could be given to TRU to integrate into the revised program.

8.8.3 Status of Proposed VGH Program

VGH has been utilizing the Manitoba framework to develop a VGH program. VGH is proposing an eight-month in-house program that will consist of two months of independent self-study followed by a six-month full time apprenticeship.

VGH has invested the following resources into the development of the program:

- VGH Surgical Services funded dedicated time of two anesthesiologists to review the curriculum, liaise with other anesthesiologists to rewrite some modules and to conduct the final editing of modules
- Anesthesia Assistant Supervisor to oversee curriculum development and organization of the program
- Anesthesia Assistant Clinical Educator to assist in the curriculum development and who would be dedicated full time to the program during the apprenticeship.

The Manitoba modules have been reorganized into a sequence of integrated courses. About 40-50% of the modules have been reviewed and revised as needed.

Content to be included in the two months of independent self-study includes:

- Introduction to anesthesia
- The anesthesia machine
- Pharmacology and Physiology
- Anesthesia Monitoring

During the six-month apprenticeship trainees will continue to complete six courses while in the clinical environment:

- Pre-operative evaluation and assessment Introduction to anesthesia
- Regional Anesthesia
- Hemostasis
- Intraoperative Clinical Management
- Anesthesia Specialty Services
- Protocols, Policies and Record Keeping

Clinical learning opportunities will be provided in:

- General Surgery and hepatobiliary surgery
- Neurosurgery
- Vascular Surgery
- Thoracic Surgery
- Cardiac Surgery

- Trauma Surgery
- Transplant Surgery
- Urologic Surgery
- Orthopedic Surgery
- Plastic Surgery
- Ear, Nose and Throat Surgery
- Gynecological Surgery
- Pediatrics
- Obstetrics
- Difficult airways and airway emergencies

Pediatric and obstetrical clinical experiences will be provided at other facilities.

Evaluation of the didactic studies will be through a series of quizzes and a final examination. Each course will have a final exam. Trainees will write one final exam at the end of the apprenticeship. Trainees will keep a daily log of technical and non-technical skills that is reviewed and signed off by the attending anesthesiologist. Vigilance, Professionalism and Humanism will also be assessed on a regular basis. A trainee self assessment tool will also be used. These assessment tools have been adapted from the Manitoba program.

While VGH Professional practice leadership and the Chief of Anesthesia would like to see RNs also included in Anesthesia Assistant roles, only RTs are being considered for this program at this time. VGH has proposed a trainee job description that has been reviewed by the Health Sciences Association. The HR Department is currently navigating the job description through the HEABC approval process.

The Senior Executive Team has approved funding to run the program with three trainees. Funding is to pay the trainee salaries during the six months of the full time program and to cover some anesthesiology time for the development of modules and teaching in the program.

Recruitment of candidates is pending HEABC approval of the trainee job description. It is the intent to recruit in-house RTs into the program.

8.8.4 Current Status

No final decision has been made by mid-September regarding starting date. Some of the activities required to build and implement the program are:

- Identify the anesthesiology department team that will assist in finalizing and operationalizing the program
- Establish mechanisms to facilitate release time for anesthesiologists to review and revise the remaining modules

- Establish overall learning objectives for the program
- Ensure alignment of the modules and learning objectives to the national AA Competency Framework and Indicators
- Identify textbooks and references that will be accessible to the trainees
- Establish what content will be taught by lecture and by whom
- Plan and schedule laboratory and simulation learning experiences
- Establish weekly schedule of modules to be completed, clinical rotations, laboratory experiences, and simulation learning experiences
- Define roles and responsibilities of anesthesiologist preceptors
- Build program evaluation plan

9. Issues and Recommendations

The presence of an Anesthesia Assistant on the Anesthesia Care Team working under the supervision of an anesthesiologist is seen as contributing significantly to patient safety and OR efficiencies. Many BC stakeholders want an increase in the number of AAs to support anesthesiologists practicing in the health authorities. BCAS recommends a staffing ratio of one AA to four anesthesiologists in the ORs. Some health authorities are considering the introduction of the AA role into additional hospital sites.

Stakeholders want a robust accredited provincial Anesthesia Assistant education program that prepares graduates for practice in BC as well as to successfully complete the new national AA certification exam. Anesthesiologists want input into an AA curriculum and involvement in the teaching and assessment of students.

The following recommendations are based on the environmental scan, interviews with stakeholders, document reviews, and a critical analysis of the findings.

The recommendations are organized by the key issues to be addressed.

1. **Agreement on competency performance indicators for new graduates**

   Issue: The competency performance indicators expected of a new graduate of an AA program have not been clarified/endorsed by anesthesiology stakeholders in BC.

   Recommendation:

   - Create a Task Force with representation from anesthesiology department heads or designates, the BC Anesthesiologists' Society, and the BC Society of Anesthesia Assistants to clarify the competency performance indicators for graduates of a BC AA Education program. The Canadian Anesthesiologists' Society's list of Anesthesia Assistant duties and the Canadian Society of Respiratory Therapists National Competency Framework for Anesthesia Assistance would be the framework for the discussion.

2. **Program leadership**

   Issue: The credibility of an AA education program among BC stakeholders is influenced by the content expertise of the program leader.

   Recommendation:

   - Consideration should be given to the benefit of introducing the role of a Program Medical Director with an academic affiliation to a medical school.

3. **Sustaining a made in BC AA education program**

Issue: Sustaining a high quality and cost effective AA education program targeted specifically to BC.

Recommendation:

- Enrolment of a critical mass of students is required on a regular basis to sustain a high quality, cost effective education program that will meet the current and evolving needs for AAs in the BC health authorities.

4. **Recruitment of mid career professionals to pursue specialty education**

Issue: Incentives for experienced RTs to pursue an AA career.
It was reported that self-sponsorship is a disincentive for RTs to pursue AA education. Some stakeholders felt that two to three years is too long for students to complete an AA education program. A shorter training cycle is required to meet unanticipated vacancies and/or an increased demand for AAs in BC. Some health authorities have begun expediting completion of an AA education program by paying selected RT candidates a full time salary, tuition and books with the expectation that all of the courses and the clinical practicum will be completed within 8-10 months of the start date. These exceptions are being done through "without prejudice" agreements between the Health Sciences Association and the individual health authorities.

Recommendation:

- The Ministry of Health and the Health Authorities should explore initiatives that will help to mitigate the AA recruitment and retention issues.

5. **BC curriculum and program delivery model**

Issue: A BC curriculum needs to be focused on preparing graduates for current and evolving AA practice in the BC environment.
Issue: A self-paced distance delivery program may be best targeted at an audience of mostly RTs working full time as AAs in the ORs and who had not received any formal education for the role;

Recommendations:

- A provincial education program needs to be delivered in a way that addresses the needs of students and ensures learning outcomes are met by graduates. This may involve a learning model that combines online as well as face-to-face with lectures, labs and simulations conducted prior to the clinical practicum.

- Consideration should be given to developing a flexible learning model that may include a direct stream for delivering the program to cohorts of students over three consecutive semesters so that the program can be completed in less than one year, and other streams to ensure opportunity for students who cannot afford to stop working to attend classes.
  - The program needs to be accessible to students from all of the BC health authorities.
  - A BC Program Advisory/Quality Committee with stakeholder representation from the health authorities needs to provide direction for the design, delivery and ongoing evaluation of the program. See Appendix F for further suggestions regarding terms of reference, potential format for the delivery of a program, practice partners' clusters, and program evaluation.

6. Clinical practicum

Issue: A consistent, high quality practicum experience is required for students to be prepared to work anywhere in BC as well as to successfully pass a national certification exam.

Recommendations:

- The program should work with the health authorities to establish geographical practicum cluster partners so that a core set of practicum rotations is provided for all students.
- The program should involve anesthesiologists as guest lecturers in the courses.
- The program should provide clear guidelines for the practicum that include roles and responsibilities of the academic institution and the practicum sites, the competencies to be achieved during the practicum, the criteria for student evaluation, the template for a daily student log, and copies of the and evaluation tools to be used by the mentors.

7. Program accreditation

Issue: AA education program standards have been set by CSRT for implementation in 2018. The quality and national reputation of a BC education program will be measured by its success in meeting these standards and in the results of graduates' writing the national certification examination.

Recommendations:

- The education program needs to meet the CSRT AA program accreditation standards.
- The program must prepare students to write the national certification examination upon graduation.

10. Appendices

Appendix A – Canadian Anesthesiologists' Society Anesthesia Assistant Duties

Technical Duties
T. 1. Set up, test, calibrate and operate physiologic monitors such as anesthesia workstations, intubation/airway devices, fiberoptic endoscopes, physiologic monitors and infusion devices. • To ensure the safety of equipment, perform equipment checks as indicated and maintain records of problems. • Replace and change anesthetic equipment supplies as per routine maintenance schedule. • Maintain the stock of drug supplies and equipment at anesthesia workstations.
T. 2. Troubleshoot anesthetic equipment. • Correct problems discovered, and/or follow up with Biomedical engineering technicians or service representative.
T.3. Monitor trace gas pollution levels.
T. 4 Maintain and stock pediatric, difficult intubation, hemodynamic and malignant hyperthermia carts.
T.5 Participate in the operating room infection control program by performing duties such as maintaining cleanliness in anesthetic equipment in accordance with quality assurance programs. Maintain measures, according to established procedures, to minimize operating room pollution.
Clinical Duties
C.1. Assist with all aspects of the anesthetic care plan formulated for a particular patient. Including pre-operative optimization, induction, and maintenance of the anesthetic. Assist with the alteration of anesthetic levels, administration of adjunctive treatments, emergence and continuity of care into and during the post-operative period.
C.2. Assist in the preparation of the patient for surgery and perform pre-operative assessments as requested by the anesthesiologist.

C.3. Assist with or perform the insertion of devices such as oro or nasogastric tubes, Intravenous, and intra-arterial catheters.
C. 4. Assist with the insertion of pulmonary artery catheters and central venous catheters.
C. 5. Assist with the performance of transesophageal echocardiography, transthoracic echocardiography, or other ultrasonography.
C. 6. Assist with regional anesthesia procedures including the performance of ultrasonography for nerve blocks.
C.7. Assist with or perform airway management, including insertion of laryngeal masks, Tracheal intubation, and mask ventilation.
C. 8. Assist in the positioning of the patient under the direction of the anesthesiologist.
C. 9. Adjust therapies (e.g., ventilation, temperature control devices, etc.) as directed by the Anesthesiologist.
C. 10. Administer prescribed pharmacological agents to the patient under the direction of the Attending anesthesiologist, observing for side effects and efficacy of treatment.
C. 11. Assess the patient's physiological status during anesthesia by performing duties such as monitoring vital signs and anesthetic gases and advising the anesthesiologist of the patient's status.
C. 12. Assist at emergence from anesthesia by performing duties such as aspirating secretions from the trachea and pharynx, removing laryngeal mask airways, and tracheal extubation of the patient. Remove monitoring equipment after surgery.
C. 13. Assist with the transfer of ventilated and/or anesthetized patients between areas of the hospital as required.
C. 14. Transfer post-operative patients to the Post Anesthesia Care Unit (PACU) under the direction of the anesthesiologist.
C. 15. Monitor patient progress in the Post Anesthesia Care Unit, update anesthesia monitoring records, and report patient status to the anesthesiologist, in collaboration with the PACU staff, as requested.
C. 16. Provide diagnostic data for the anesthesiologist by performing duties such as blood sampling and analysis, pulmonary functioning testing, end tidal carbon dioxide monitoring, pulse oximetry, and transcutaneous monitoring.

C. 17. Prepare fiber-optic bronchoscopes and other equipment as required, and assist the anesthesiologist during bronchoscopy with equipment set-up, preparation of and instillation of medication, and sample procurement.
C. 18. Assist the anesthesiologist with difficult intubations.
C. 19. Assist the anesthesiologist with cases in locations out of the operating room.
C. 20. Respond to cardiac arrests in OR, PACU or other locations according to hospital procedures and policies.
C. 21. Perform initial resuscitation in life-threatening situations according to established protocols (i.e. Basic Cardiac Life Support/Advanced Cardiac Life Support, Malignant Hyperthermia, Neonatal Resuscitation Program, and Pediatric Advanced Life Support), while awaiting arrival of the responsible Anesthesiologist.
C. 22. Evaluate and monitor patients and administer medication for procedural sedation as defined in the guidelines of the CAS.
C. 23. Assist/perform administration of massive transfusion of blood products per hospital protocols
Administrative Duties
A.1 In conjunction with the Anesthesiology and Biomedical Engineering Departments, maintain a variety of anesthetic equipment by performing duties, such as receiving and assessing equipment, testing and identifying malfunctions and determining whether repairs should be made on-site or equipment returned to vendor. Carry out minor maintenance following manufacturer's and Canadian Standards Association guidelines and verify vendor repairs to ensure equipment is operating in a safe and effective manner.
A.2 Participate in health technology assessment, including (where appropriate) meeting with medical device and pharmaceutical sales representatives to organize trials and evaluations of new equipment and drugs according to hospital protocol. Gather and collate feedback and participate in purchase decisions.
A.3 Arrange and co-ordinate the servicing and repair of equipment.
A.4 Communicate and act as a liaison with supply companies.

A.5 Maintain supply inventory.
A.6 Source out supplies and equipment
A.7 Assist the Department of Anesthesia with capital equipment budgets by conducting equipment needs assessments and research.

Appendix B – Canadian Society of Respiratory Therapists National AA Performance Indicators

Validated June 2016

Section 1: Professional and Organizational Competencies
A. Professionalism
1. Use professional language, behavior, and attire. 2. Function within professional, medical, legal and ethical guidelines/regulations. 3. Adhere to training institution's mission, vision and values. 4. Demonstrate dependable and self-directed behavior in assuming responsibilities. 5. Accept constructive criticism and act on it in a professional manner.
B. Effective Communication
1. Communicate effetely with physicians, staff and patients. 2. Maintain documentation and records.
C. Critical Thinking and Reasoning
1. Demonstrate critical judgment in professional practice. 2. Adjust to unexpected circumstances. 3. Respond appropriately to changing situations. 4. Adhere to quality assurance guidelines. 5. Demonstrate problem solving skills. 6. Anticipate problems. 7. Recognize the early signs of a changing situation. 8. Continually assess situations. 9. Foresee adverse outcomes. 10. Demonstrate planning skills. 11. Implement plans, decisions and procedures. 12. Demonstrate evaluation skills. 13. Troubleshoot equipment. 14. Prioritize work. 15. Recognize a fixation error.

D. Health and Safety
1. Carry out procedures and operations with respect to WHMIS 2. Use personal protective equipment as warranted. 3. Utilize infection control procedures. 4. Adhere to manufacturer and CSA specifications and guideline is the use of proper equipment. 5. Employ manufacturer's recommendations for cleaning and disinfecting equipment.
E. Evidence Informed Practice
1. Discuss research design, data collection and analysis. 2. Evaluate research by level of evidence classification**.**
F. Administrative duties
1. Apply cost containment practices per institution guidelines 2. Participate in equipment preventative maintenance as per manufacturer and CSA specifications 3. Adhere to quality assurance guidelines
G. Commitment to Learning
1. Participate in lifelong learning and ongoing training required to maintain competency of practice
2. Participate in the education of students and other health professionals.
Section 2: Anesthesia Assistant Competencies
A. Administer prescribed pharmacological agents under the direction of the attending anesthesiologist
1. Assess the patient's pharmacological requirements in consultant with the attending anesthesiologist.
2. Prepare prescribed agents.
3. Demonstrate the administration of prescribed agents.
4. Titrate prescribed agents to patient response.
5. Recognize complications and take corrective action.
6. Demonstrate an understanding of the implications of pre-operative medication on the intra-operative course.
B. Operate Anesthesia equipment
1. Predict potential hazards of anesthesia gas delivery.

2. Prepare the anesthesia workstation.
3. Operate the anesthesia workstation.
4. Troubleshoot the anesthesia workstation.
5. Perform anesthesia workstation checkout.
6. Perform appropriate patient ventilation using the anesthetic machine.
7. Describe a quality insurance program for anesthesia equipment.
8. Demonstrate ancillary equipment checks, maintenance, troubleshooting and antisepsis techniques.
C. Monitor the patient's psychological status
1. Prepare hemodynamic monitoring systems in anesthesia.
2. Insert arterial lines.
3. Assist with insertion of CVP lines.
4. Prepare noninvasive monitoring.
5. Apply noninvasive monitors.
6. Interpret results of monitoring.
7. Perform arterial blood sampling.
8. Perform venous blood sampling.
9. Analyze blood samples at point of care.
10. Interpret blood results and propose corrective action.
D. Provide preoperative care
1. Conduct patient interview.
2. Perform a preoperative assessment and convey it to the attending anesthesiologist in a concise, organized report.
3. Provide preoperative care.
E. Manage the patient's airway
1. Perform airway assessments.
2. Prepare equipment for all airway management techniques.
3. Perform airway management.
4. Perform under direct supervision of the anesthesiologist the following procedures: • bag/mask ventilation • insertion of oropharyngeal/nasopharyngeal airway • endotracheal/nasotracheal intubation

• laryngeal mask airway insertion
5. Perform the Sellick technique.
6. Assist/perform difficult airway management under the direct supervision of the anesthesiologist: • awake intubation • double lumen endotracheal tube insertion • rapid sequence induction
F. Assist with the Administration of General Anesthesia
1. Prepare all equipment necessary for the anesthetic.
2. Prepare appropriate intravenous administration equipment.
3. Demonstrate correct IV insertion techniques.
4. Evaluate the patient.
5. Apply techniques for the induction of anesthesia.
6. Position the patient with respect to surgical requirements, patient limitations, airway and the minimizing of pressure points.
7. Monitor patient status during anesthesia and at emergence.
8. Recognize complications and take corrective action.
9. Recognize a patient emergency and assist with managing the critical event.
10. Practice maintenance of general anesthesia.
11. Practice discontinuation of anesthesia.
12. Transfer patient for post-operative care.
G. Deliver Regional Anesthesia
1. Position patient properly for regional procedure.
2. Demonstrate the administration of prescribed local anesthetic.
3. Assist in the administration of epidural anesthesia.
4. Assist in the administration of spinal anesthesia.
5. Assist in the administration of peripheral nerve block, including utilizing appropriate equipment. (e.g. ultrasound)
6. Recognize complications and take appropriate corrective action.
H. Deliver Procedural Sedation
1. Perform pre-operative assessment and discuss with attending physician as per protocol.
2. Apply monitors for procedural sedation addressing the needs of specific procedures.
3. Administer procedural sedation.

I. Manage Post Anesthesia Care
1. Assess the patient in the recovery room.
2. Recognize post-operative complications and take correction action.
J. Assist with pain Management
1. Assess the patient's postoperative pain.
2. In consultation with anesthesiologist, formulate a multimodal approach to the treatment of postoperative pain.
3. Recognize complications that are associated with postoperative pain management and in consultation with anesthesiologist, prepare a plan of corrective actions.
4. Recognize the requirements for the safe administration of intravenous narcotics.
5. Recognize the side effects associated with neuraxial analgesia and perform corrective actions if necessary.
K. Preform Crisis Management
1. Recognize a critical event and indicate appropriate supportive and correct action.
2. Monitor patient to assess efficacy of interventions and revise treatment plans as appropriate.
L. Administer Blood Products
1. Crosscheck blood products.
2. Prepare equipment for the administration of blood products.
3. Assist with cell salvage.
M. Assist with the Delivery of Anesthesia in Special Circumstances
1. Assist the attending anesthesiologist with the delivery of anesthesia to patients with specific conditions.
2. Assist the attending anesthesiologist with the delivery of anesthesia in satellite sites

Appendix C – Job Descriptions

C.1 Winnipeg Regional Health Authority Clinical Assistant Job Descriptions

Anesthesia Clinical Assistant Position Guidelines (Edited December 3, 2015)

A. Description of the Position

The Anesthesia Clinical Assistant (ACA) is an allied health professional, qualified by advanced academic and clinical education to provide anesthetic care under the immediate supervision of a fellowship-trained Anesthesiologist or a physician trained in Anesthesiology and credentialed to practice the specialty in a Winnipeg Regional Health Authority (WHRA) facility. The ACA executes complementary and supplementary therapeutic interventions and monitoring tasks that allow the physician Anesthesiologist to use his or her own skills more efficiently and effectively.

The role of the ACA within any given anesthesia service will be:

- Dependent on the nature of the services that the hospital/facility provides,
- Defined by the job description approved by the CPSM,
- Consistent with the vision and position of the Canadian Anesthesiologists' Society

B. Job description

The scope of practice of the ACA is defined by the scope of practice of the supervising physician Anesthesiologist and includes those tasks & responsibilities that the Anesthesiologist is capable of performing and comfortable delegating, and the ACA is competent to perform.

The supervising physician Anesthesiologist must remain immediately available for direct patient care, maintain patient involvement, and not be engaged in any other direct patient care activity that involves either: personally administering sedation, general, neuraxial or regional anesthesia or while supervising anyone else in the conduct of general, neuraxial or regional anesthesia. Physician trainees may be capable of certain aspects of autonomous patient care but do not influence the requirements for ACA supervision. The conduct of care and the anesthetic medical record (or consult) should demonstrate the Anesthesiologist's direct involvement. There may be rare circumstances, reserved exclusively for emergent situations, where the supervising Anesthesiologist is temporarily engaged in direct patient care activity until another attending Anesthesiologist becomes available.

Anesthesiologist:

Provide assessment of the patient's health status as it relates to the relative risks

An Anesthesia Clinical Assistant may, under medical direction from the attending Anesthesiologist:

1. Be involved with anesthetic management of the patient during performance of the operative procedure,
2. Perform diagnostic laboratory and related studies as appropriate (i.e. draw venous blood samples, conduct spirometry testing, operate a rapid blood analyzer, record an ECG),
3. Establish peripheral venous access,
4. Institute non-invasive physiologic monitoring modalities,
5. *Assist* with/perform arterial puncture for the purpose of blood sampling and/or vessel cannulation,
6. *Assist* the attending Anesthesiologist with;
    i. Establishment of central venous access,
    ii. Institution of invasive physiologic monitoring modalities,
    iii. Application, manipulation, and interpretation of data from routine & advanced monitoring techniques,
    iv. Institution and maintenance of regional blocks and catheters,
    v. Elective/emergent complex airway management,
    vi. Acute/chronic pain management,

Anesthesia Clinical Assistant Position Guidelines (Edited December 3, 2015)

7. *Assist* the responsible Anesthesiologist with all aspects of the anesthesia care plan formulated for a particular patient (preanesthetic preparation, induction, maintenance, alteration of anesthesia levels, administration of adjunctive treatment, emergence & continuity of care into, and during, the post operative period),
8. *Temporarily* execute the maintenance phase of the anesthesia plan based on the health status of the patient (i.e., administer pharmacologic agents, manage the airway, monitor and record vital signs, support life functions, use mechanical support devices, manage fluid, electrolyte & blood component therapy), in consultation with the responsible Anesthesiologist (who remains immediately available and accountable for the anesthetic management of the patient),
9. Recognize and initiate appropriate corrective action as required to counteract problems that may develop during implementation of the anesthesia plan, in consultation with the responsible Anesthesiologist,
10. *Assist* members of the Anesthesia care team with the management of life-threatening situations (recognition, evaluation, response) as directed by the responsible Anesthesiologist,
11. Perform initial resuscitation in life-threatening situations according to established protocols (i.e. BCLS/ACLS, MH, NRP, PALS), while awaiting arrival of the responsible Anesthesiologist,
12. Setup, calibrate, maintain and troubleshoot machines, devices and physiologic monitors used in preanesthetic evaluation, pain management and anesthetic/resuscitative care,
13. Prepare and administer drugs commonly used in anesthetic practice by protocol and/or as directed by the responsible Anesthesiologist,
14. *Assist* in the performance of anesthesia-related duties in intensive care units, labor & delivery units, off-site anesthetizing locations, pain clinics, and other settings, as appropriate,
15. Provide for safe transport of a patient between acute care settings,
16. *Assist* in the orientation, education and clinical instruction of others,
17. Perform delegated administrative duties in an Anesthesiology Department such as data collection for quality assurance and clinical research activities, maintenance of computerized databases, evaluation, ordering and management of supplies & devices,
18. Adhere to all workplace health policies, safe practices and regulations,
19. Establish and maintain productive and cooperative working relationships,
20. Maintain registration with the CPSM and membership in the CAS,
21. Regularly undertake (and maintain a log of) continuing educational activities that enhance the professional AA role,
22. Demonstrate competence in an annual performance review of Knowledge, Clinical skills, Judgment, and Non-technical skills (Task management, Team work, Situation awareness, Decision making).

C. Admission Requirements

1. Registered Nurse (RN) or Registered Respiratory Therapist (RRT) licensed to practice in Manitoba, or previously practicing (in country of origin) International Medical Graduate (IMG) with experience in Anesthesia/Emergency/Critical Care, graduated from a recognized and accredited university/college acceptable to the CPSM,
2. Two years critical care or anesthesia-related operating room experience within the past 5 years,
3. Three letters of recommendation, each addressing a different aspect of the applicant's suitability for study leading to a career as an ACA;
    a. One from a physician who, by virtue of a close working relationship with the applicant in the acute care setting, can provide a detailed account of the applicant's aptitude in the non-technical skills of Task management, Team work, Situation awareness and Decision making (Appendix II),

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   b. One from the applicant's present, or immediately previous, supervisor knowledgeable about the applicant's character, work habits, and professional conduct in connection with patients and interdisciplinary colleagues (Appendix III),
   c. One from someone familiar with the applicant's performance and performance potential, in terms of academic knowledge, technical/clinical skills, judgment, and response to teaching,
4. Evidence of manual skill with a computer; facility within the Microsoft office environment; ability to execute on-line computer search strategies; access to an Internet email account,
5. Eligibility for registration with the CPSM as a non-certified Clinical Assistant (CA),
6. One page, typed letter outlining personal & professional reasons for wanting to become an ACA,
7. Excellent written and verbal communication skills; Applicants for whom English is a second language must provide proof of proficiency in an English language assessment, including spoken and written medical terminology,
8. Successful completion of a pre-entrance assessment, the purpose of which is to review the applicant's baseline knowledge and skill level in order to determine if the curriculum as provided and the proposed duration of study (minimum 6 months [funded], maximum one year) would, in all likelihood, allow the applicant to acquire the appropriate knowledge/skills/judgment to pass an ACA challenge exam (written, technical and non-technical skills assessment) and fulfill all aspects of the ACA role described above.
9. Willingness to accept the training period as probationary (performance evaluations conducted at 1, 3 and 6 months, ± 9,12 months) and the offer of a permanent position in the WRHA Anesthesia Program as contingent upon successful completion of an ACA challenge exam (RCA part II).
10. Successful completion of the RCA part I exam prior to completion of the training program

D. Definitions

The **attending Anesthesiologist** is:

i. A physician,
ii. Fellowship-trained to deliver anesthesia services as described by the Canadian Anesthesiologists' Society (CAS) and the Royal College of Physicians and Surgeons of Canada (RCPSC) or, fully credentialed by the WRHA and currently practicing Anesthesia in an acute care facility operated by the WRHA,
iii. Licensed, qualified and legally authorized to practice medicine as an Anesthesiologist.

The **Anesthesia Clinical Assistant** is:

i. An allied heath professional,
ii. Qualified by advanced academic and clinical education to provide anesthetic care under the immediate supervision of a fellowship-trained Anesthesiologist.

E. Responsibilities

The **attending Anesthesiologist** engaged in medical direction of an ACA remains responsible for:

i. Pre anesthesia medical evaluation of the patient,
ii. Formulation, prescription and implementation of the anesthesia care plan,
iii. Personal participation in the most demanding procedures of the plan (i.e. performance of regional blocks/insertion of regional catheters, induction, emergence),
iv. Monitoring the course of anesthesia administration at frequent intervals,

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v. Remaining physically available for consultation and immediate treatment of emergencies,
vi. Providing indicated post anesthesia care,

The **Anesthesia Clinical Assistant:**

i. Executes complementary and supplementary therapeutic interventions and monitoring tasks that allow the physician Anesthesiologist to use his or her own skills more efficiently and effectively,
ii. Works exclusively within the Anesthesia Care Team environment,
iii. Reports directly to the attending Anesthesiologist.

The following excerpt is taken from "CAS Guidelines to the Practice of Anesthesia 2005"

Responsibilities of the Chief of Anesthesia

1. To be aware of the current *CAS Guidelines to the Practice of Anesthesia*, the requirements of the Canadian Council on Health Services Accreditation and the requirements of the provincial licensing authority as they relate to anesthesia.
2. To ensure that written policies with respect to the practice of anesthesia are established and enforced.
3. To evaluate the qualifications and abilities of the physicians providing anesthetic care and of other health professionals providing ancillary care. This includes (but is not restricted to) the recommendations of clinical privileges for physicians with anesthetic responsibilities and annual review of these privileges.
4. To monitor systematically the quality of anesthetic care provided throughout the health care facility. This should include chart reviews and internal audits or more detailed reviews when indicated.
5. To ensure that records are kept for all anesthetic procedures. These records should allow for evaluation of all anesthetic care in the hospital.
6. To carry out such other duties as the governing body of the hospital may delegate to ensure safe anesthetic care.
7. To promote institutional compliance with applicable CSA Standards

Privileges in Anesthesia

All physicians applying for privileges in anesthesia must demonstrate satisfactory completion of postgraduate training in a department of anesthesia that has a residency program approved by the Royal College of Physicians and Surgeons of Canada.

Physicians with anesthetic privileges should possess the knowledge and technical skills necessary for the practice of anesthesia.

These include the ability:

1. To provide pre-anesthetic evaluation of the patient and determine appropriate anesthetic management
2. To render the patient insensible to pain for the performance of surgical operations and obstetric procedures
3. To monitor and support the vital organ systems during the peri-operative period
4. To provide immediate post-anesthetic management of the patient
5. To provide resuscitation and intensive care when indicated
6. To provide relief of acute and chronic pain.

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The Canadian Anesthesiologists' Society recognizes the formal job designation "Anesthesia Assistant". Anesthesia assistants must have undergone specific training in anesthesia assistance. The scope of practice for anesthesia assistants working in a specific institution must also be approved by the department of anesthesia, the local hospital administration and/or the Medical Advisory Committee (Council of Physicians). Furthermore, anesthesia assistants, like other hospital employed health professionals, must be covered by the hospital liability insurance. Duties and tasks delegated to anesthesia assistants must be consistent with existing governmental regulations, the policies and guidelines established by professional regulatory agencies, and the local hospital policies.

C.2 Calgary RT2 OR Job Description

Position Description

Alberta Health Services	**Therapist II/ Clinical Specialist – Anesthesia/ OR**	
	Applicability: Respiratory	**Revised Date:**
Service:	Therapist II/ Clinical Specialist – Anesthesia/ OR	**Originating Date:**
Section:	Respiratory	01 January 2006
Approved by:		**Next Review Date:**
Originator:		02 October 2012

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The electronic copy should always be considered the current copy.**

Position Summary

The position is a clinical practitioner who provides clinical/technical support and routine/preventative maintenance of anesthesia related equipment at RDRHC. Operating Room (OR). The position also provides patient care and assistance to the OR theaters and Post – Anesthesia Recovery Room (PARR) as required.

1.0 Duties and Responsibilities

1. Provides technical assistance to the OR and PARR in all areas relating to anesthesia including but not limited to:
    a. Daily set up and verification of anesthetic machines and related equipment
    b. Organizes and performs, when applicable, preventative maintenance on all anesthesia related equipment
    c. Calibrates and performs Quality Control on equipment including rapid point coagulation machine, infusion pumps, suction equipment etc. Performs or arranges for necessary repairs
    d. Trouble shoots and resolves unscheduled maintenance and equipment application problems
2. Provides clinical assistance to the OR and PARR including but not limited to:
    a. Set up and insertion of arterial lines
    b. Hemodynamic monitoring
    c. Ventilator management
    d. Airway management
    e. Medication administration

   f. Arterial blood gas sampling and analysis – punctures and drawing form lines
   g. Assist with difficult intubations
   h. Assist with resuscitation
   i. Assist with bronchoscopies
3. Works with a minimum amount of supervision and direction
4. Establishes policies and procedures related to services provided in the designated area
5. Organizes and provides instruction and evaluation of Respiratory Therapy Students
6. Orders and organizes inventory of anesthesia related supplies and disposable equipment
7. Provides input and recommendation on new procedures, equipment and instrumentation
8. Assists with budget preparation
9. Communicates area needs to OR area management and when applicable to the Manager, Acute Care, Respiratory Health Services
10. Acts as liaison in regards to sales and service representatives
11. Organizes and conducts inservice training for Nurses, Anesthetists and Respiratory Therapists in areas relating to anesthesia systems and related topics
12. Participates in the orientation and training of new staff
13. Ensures that all documentation regarding maintenance, repairs and quality control of anesthesia and related equipment is complete and meets standards
14. Performs the duties of a Respiratory Therapist I in the general hospital setting when required
15. Performs the duties of Senior Respiratory Therapist for the hospital in the absence of other department senior staff or the absence of a staff designated "in charge"

2.0 Most difficult and/or complex aspects of the position

Must demonstrate strong organizational skills and sound judgment in carrying out maintenance programs and patient care. Must be adaptable to provide service in an atmosphere of numerous interruptions, failure to perform duties to a high standard could result in failure of anesthetic equipment or substandard patient care with the potential for severe negative outcomes.

3.0 Qualifications

1. Registered Respiratory Therapist in good standing with College & Association of Respiratory Therapists of Alberta (CARTA)
2. Minimum 3 years experience as a Registered Respiratory Therapist
3. At least one year experience in anesthesia

C.3 UHN Anesthesia Assistant Job Description

University Health Network

JOB DESCRIPTION

JOB TITLE	**Anesthesia Assistant (AA)**	**DATE APPROVED**	**September 20, 2013**
DEPARTMENT	**Department of Anesthesiology**	**SALARY GRADE**	**D9**
SITE	All Sites	**JOB NUMBER**	**0684_00**
REPORTS TO	Manager - Anesthesia Clinical Services	**UNION/NON-UNION**	**Non Union**

I. JOB SUMMARY

The **ANESTHESIA ASSISTANT (AA)** is an advanced practice healthcare professional and integral member of the Anesthesia Care Team (ACT). The Anesthesia Assistant provides and/or assists with all aspects of the anesthetic care of the surgical and non-surgical patient by the authority of medical directives, best practice protocols and policies, and written or verbal orders. As such, the Anesthesia Assistant serves as a bona fide extension of the Anesthesiologist; only an Anesthesia Assistant, Anesthesiologist or Anesthesia Fellow/Resident is authorized to manage the anesthetic care of a patient. Anesthesia Assistants make decisions as to a patient's fitness to undergo anesthetic sedation; they take the initiative to formulate a plan to optimize a patient's condition prior to these procedures, and customize medications and monitoring to the patient's needs. They must understand the complexity and course of the surgical/diagnostic procedure and anticipate changes to the patient's anesthetic that may be required. As such, they must be able to recognize hemodynamic changes, along with patient instability, ventilation or airway emergencies, and adverse reactions to medications; and initiate corrective action as per medical directives, while notifying the attending Anesthesiologist. Their role ranges from primary care provider in ophthalmology, plastic and orthopedic surgeries under regional anesthesia, to maintaining general anesthesia of stable patients, and assisting anesthesiologists with complex patient management. The Anesthesia Assistants at UHN provide their expertise in various sites including TWH, TGH, PMH, Women's College Hospital and The Kensington Eye Institute. As well they work under remote supervision in Echocardiology and Cardiac Catheterization labs to ensure safe and effective anesthetic care. Anesthesia Assistants at UHN are unique from those in other institutions as they have a higher level of responsibility and are certified to care for ASA Class 4 patients (severe systemic disease which is a constant threat to life).

II. DUTIES AND RESPONSIBILITIES

1.0 Providing Anesthetic Support for Preoperative Care Units at TGH TWH and WCH

1.01 Conducts a health assessment and anesthetic history to assess and confirm patient fitness for anesthesia by documenting a system-by-system health review, anesthetic history, allergies, current medications, physical assessment, and airway assessment (including assessing for difficulty in ventilation and intubation)

1.02 Documents and interprets the significance of clinical lab investigations and other diagnostic tests.

1.03 Determines the American Society of Anesthesiologists (ASA) Physical Status Classification

1.04 Explains the pre-, intra- and post-anesthetic care plan to the patient and associated medical staff

1.05 Discusses any co morbidities or risks with Anesthesiologist and surgeon/cardiologist and jointly decides on patient management. Performs diagnostic tests and lab work as required

1.06 Prepares and/or troubleshoots invasive hemodynamic monitoring lines.

1.07 Prepares and maintains complex anesthesia devices, machines, and physiologic monitors used during the perioperative period and/or for anesthetic/resuscitative care, including ECG, BP, end-tidal CO2, and O2 saturation monitoring equipment, entropy monitoring, glidescope or C-MAC specialty airway equipment for intubation, bronchoscopes, blood/fluid warmers, and rapid infusers.

1.08 Selects and prepares anesthetic medications based on surgical and patient specific considerations and type of anesthesia. This includes benzodiazepines, opioids, induction agents, muscle relaxants, antibiotics, anticoagulants, reversal agents, and volatile agents.
1.09 Establishes peripheral venous access and arterial access if appropriate
1.10 Assists with the administration of peripheral nerve and neuraxial anesthesia.
1.11 Operate ultrasound machines and nerve stimulators to help identify specific nerves for regional anesthesia
1.12 Throughout the pre-operative period monitors for bradycardia, hypotension, hypoxia, hypercarbia, local anesthetic toxicity, allergic/anaphylactic reactions, hypertension; activating medical directives if required.

2.0 Provision of Anesthesia Care Intraoperatively for the Operating Rooms at TGH, TWH, WCH, KEI

2.01 Institutes/Maintains Anesthesia Care Plan and/or Provides Anesthesia Support
2.02 ***Provision of Conscious Sedation by Anesthesia Assistants as defined in UHN policy 38.40.001*** Anesthesiologist responsible for patient must be accessible by phone, but is not routinely present in the room and may leave area. This applies to the following cases:
- **TWH DSU, KEI**:Ophthalmology: Retinal, Cataract, Corneal transplant, and Glaucoma surgery
- **TWH Main OR**: Plastics, Orthopedics, Deep Brain Stimulation (DBS)
- **TGH Main OR**: Arterial-venous fistula creation, Cardiac: Pacemaker and Defibrillator insertion
- **WCH Main OR**: D &C procedures, uterine ablations

2.03 Institutes non-invasive monitoring including ECG, NIBP, pulse oximetry, ETCO2, oxygen saturation
2.04 Positions patient for surgery, ensuring pressure points are supported
2.05 Prepares and administers sedation and other medications as per the anesthesiologist's orders and medical directives.
2.06 Assesses patient's response and monitors for possible reactions.
2.07 Assists with the administration of peripheral nerve and neuraxial anesthesia if performed in the OR
2.08 Manages fluid, electrolyte and blood component therapy (and assesses patient's response)
2.09 Administers oxygen therapy as indicated and prescribed.
2.10 Documents all verbal or telephone orders according to the College standards and hospital policies.
2.11 Continuously monitors and documents patient's vital signs, level of consciousness, airway patency, ECG changes, and respiratory status, enacting medical directives when indicated.

3.0 Provision of General Anesthesia as defined in UHN policy 38.40.002 – Monitoring of Stable Patients Under General Anesthesia by Anesthesia Assistants – TGH, TWH, PMH, WCH

3.01 Maintains and monitors general anesthesia after handover from Anesthesiologist
3.02 Continuously maintains and assesses respiration, depth of anesthesia, hemodynamic stability and ECG changes, blood loss, urine output, and patient positioning
3.03 Continuously maintains and assesses oxygenation and ventilation
3.04 Documents on the Anesthesia Record: heart rate, blood pressure, oxygen saturation, end-tidal carbon dioxide, airway pressure (positive pressure ventilation for ventilated patients) or respiratory rate (spontaneously breathing patients), temperature, central venous pressure, pulmonary artery catheter.
3.05 Maintains general anesthesia by administering inhaled volatile agents to maintain a minimum alveolar concentration (MAC) as per policy and orders.
3.06 Administers additional anesthetic medications in the case of abrupt increase in level of surgical stimulation, as per policy, this may include propofol boluses and/or increase of volatile agents.
3.07 Maintains analgesia using opioids as per orders; titrates neuro-muscular blocking agents as per orders
3.08 Maintains normovolemia and temperature homeostasis
3.09 Monitors and maintains patient physiological parameters and enacts medical directives, informing Anesthesiologist as necessary.

4.0 Assistance to Anesthesia - Anesthesiologist in room, requiring support with procedures or specialized equipment – all sites

4.01 Sets up non-invasive physiologic monitoring including ECG, NIBP, pulse oximetry, ETCO2, temperature
4.02 Sets up and supports the insertion of arterial, central venous, and pulmonary arterial lines.
4.03 Performs arterial blood sampling, i.e. drawing/analyzing arterial blood samples, activated clotting time
4.04 Prepares local anesthetics, equipment, and positions patients, supporting the administration of peripheral nerve and neuraxial anesthesia
4.05 Provides clinical support with elective and/or emergent complex airway management. This includes set up of specialty airway equipment including glidescope, C-MAC, Clarus Videoscope, and bronchoscopes
4.06 Prepares and delivers ventilatory adjuncts, e.g. inhaled specialty gases/aerosols, nitric oxide, Flolan. single lung CPAP, double lumen endobronchial tubes.
4.07 Performs cardiac output measurements.
4.08 Sets up and performs intraoperative autologous blood salvaging
4.09 Provides clinical and technical expertise for respiratory and anesthesia equipment including troubleshooting of Anesthesia Gas Machine, patient monitoring equipment, and specialized anesthesia equipment.
4.10 Supports all cardiac arrests, emergencies, and assists with any situation in which patient safety is at risk.

5.0 Provision of Anesthesia Care for the Postoperative Period: Providing and/or Assisting with Postoperative Care at TGH, TWH, WCH, PMH, KEI

5.01 *Post conscious sedation*
- *5.01.1* Monitor and document patients post anesthetic status.
- *5.01.2* Prompt identification, communication and management of any concerns, complications and/or crises in consultation with the responsible Anesthesiologist.

5.02 *Postoperative Care Unit*
- *5.02.1* Initiation and monitoring of non- invasive ventilation (BIPAP, CPAP, Boussignac mask, Heliox administration) to assist in the emergency and routine management of patients.
- *5.02.2* Initiates, administers, monitors, titrates and discontinues mechanical ventilation to ensure optimal patient ventilator care as per orders and medical directives
- *5.02.3* Determines readiness for weaning and performs extubation as per medical directive.

6.0 Provision of Conscious Sedation as defined in UHN policy 38.40.001 – Conscious Sedation by Anesthesia Assistants - Cardiac Catheterization Lab and Echocardiology Lab – TGH, TWH

(Anesthesiologist may provide remote supervision and is not usually present in procedure room)

6.01 Institutes non-invasive physiologic monitoring, including. ECG, NIBP, pulse oximetry, $ETCO_2$, temperature
6.02 Establishes peripheral venous access and if indicated inserts arterial line
6.03 Institutes/maintains optimal level of anesthesia/sedation and Anesthesia Care Plan in accordance with medical orders, directives and policies
6.04 Provides continuous monitoring and evaluation of patient's status and response to surgery
6.05 Administers IV medications including sedatives, narcotics, general anesthetics, and anti-emetics; manages fluid, electrolyte and blood component therapy, evaluating the patient's response
6.06 Prompt identification, communication and management of any concerns, complications and/or crises (as per UHN Medical Directive – Management of Bradycardia, Hypotension and Hypertension in Patients Receiving Conscious Sedation by Anesthesia Assistants (MDA001)
6.07 Regulates inotropes, beta-blockers and other cardiac medications as per orders
6.08 Administers antibiotics and anti-emetic medications as required.
6.09 Monitors the patient during transport to post-anesthetic care unit in cath. lab or echo lab
6.10 Provides patient education and discharge instructions and determines readiness to be discharged in echo lab

7.0 Provides Assistance with Peripheral and Neuraxial Blockade in the Regional Block Room at TWH, TGH, WCH

7.01 Prepares patients by inserting a peripheral IV, providing oxygen and attaching monitoring equipment i.e. ECG, non-invasive blood pressure, end-tidal carbon dioxide and respiratory rate monitoring equipment
7.02 Administers sedation as per Conscious Sedation policy 38.40.001
7.03 Prepares and tests ultrasound machines for functionality
7.04 Prepares and administers local/regional anesthesia as per Anesthesiologist's directions
7.05 Manipulates peripheral nerve stimulator for assessment of nerve block efficacy as per Anesthesiologist
7.06 Continuously monitors and evaluates the patient's status, response to procedure and anesthesia/sedation
7.07 Monitors patient status and hemodynamic response to spinal anesthetic, and proactively treats with fluid and/or vasopressor medications as per medical directives.
7.08 Prepares and monitors patient for transport to Operating Room
7.09 Monitors and maintains ketamine infusions for chronic pain

8.0 Provide Assistance in Medical Imaging Units (TGH, TWH, PMH) and During Gamma Knife Procedures at TWH

8.01 Coordinate patient treatment plan with multidisciplinary team: Anesthesiologist, physicians and technicians.
8.02 Prepares Anesthesia Gas Machine, monitors, drugs and equipment for total IV anesthesia.
8.03 Applies and monitors non-invasive, MRI compatible monitoring equipment.
8.04 Establishes peripheral intravenous access for the delivery of medication and fluid.
8.05 Inserts or assists in airway management including intubation using direct laryngoscopy, fiberoptic bronchoscope, C-MAC or glidescope.
8.06 Monitors the patient during treatment and transport within the hospital i.e. MRI suite, CT, angiography, and recovery (may take over care and monitoring of patient while Anesthesiologist leaves the area).
8.07 In recovery area assists with extubation and oxygen administration.

9.0 Anesthesia Crisis Management

9.01 Identifies anesthetic/medical crisis and informs responsible Anesthesiologist
9.02 Initiates appropriate treatment i.e. Basic and/or Advanced Cardiac Life Support protocols, Malignant Hyperthermia protocols while awaiting arrival of the attending Anesthesiologist as per medical directives and delegated controlled acts.
9.03 Assists the attending Anesthesiologist with crisis management once they arrive.

10.0 Clinical Education

10.01 Manages and coordinates the UHN Anesthesia Simulation Centre including operating and developing low- and high-fidelity simulations for over 20 critical care groups from UHN such as ACLS, ECLS training, and emergency airway management for Fellows, ICU nurses, RTs, technicians, cardiologists and other multidisciplinary teams.
10.02 Supervises anesthesia medical students during intravenous and arterial line insertions in POCU
10.03 Provides clinical education and mentorship for students of RT and Anesthesia Assistant programs; Anesthesia Medical Students, Residents, Fellows, and Clinical Clerks; Nursing; and other health care professionals.
10.04 Provides orientation to Anesthesia residents and fellows at start of their rotation.
10.05 Provides teaching and evaluation of new AAs undergoing the in-house conscious sedation course.
10.06 Provides orientation for new OR nurses on airway equipment, invasive monitoring, and the gas machine.
10.07 Participates in teaching sessions related to Respiratory Therapy and Anesthesia equipment for members of ACT including physicians, residents, fellows, and nurses

10.08 Collaborates with interprofessional team members to identify educational programs for health care staff
10.09 Participates in the education of other members of the ACT (Anesthesia fellows, residents and staff), nurses and other interprofessional team members (radiology staff, attendants, sonographers)
10.10 Provides ventilator modes and respiratory therapy equipment orientation to PACU/POCU nurses
10.11 Provides POC training on blood gas machines for OR and PACU nurses, anesthesia fellows and residents
10.12 Supervises and trains students of the Michener Institute RT Program and the Anesthesia Assistants Program.

11.0 Research

11.01 Promotes research based practice and knowledge/skills
11.02 Collects research data/findings and applies results to achieve desired outcomes.
11.03 Participates in Anesthesia studies and research with blood sample collection and data accumulation
11.04 Initiates Anesthesia Assistant based research investigating the AA role as it relates to interprofessional groups and using the findings to promote interprofessional collaboration and education

12.0 Performs cross-functional duties as assigned and/or requested

12.01 Members of Allied Health Professional Advisory Committee, Anesthesia Business Unit, Perioperative Services Leadership Committee, TGH/PMH Perioperative Quality/Patient Safety Committee, Sterilization and Processing Perioperative Committee, Perioperative Capital/Contract Committee.
12.02 Collaborates, recommends and develops best practice guidelines with Infection Prevention and Control (IPAC) to ensure safe anesthesia practice.
12.03 Performs blood glucose and PT/INR point of care daily quality assurance, troubleshooting and maintenance in accordance with College of American Pathologists (CAP) and Ontario Lab Association (OLA) to support the OR departments at TGH and TWH.

13.00 Works in compliance of the Occupational Health & Safety Act and its regulations, reporting hazards, deficiencies and contravention's of the Act, in a timely manner.

III. KNOWLEDGE (Bona Fide Occupational Requirement(s)

Education:

- At minimum, completion of a 3 year community college program in Registered Nurse or Registered Respiratory Therapist or recognized equivalent required.

Completion of Anesthesia Assistant Graduate Certificate (29 weeks Didactic, 3 weeks Residential, 12 weeks Clinical)

- Basic Cardiac Life Support (BCLS)
- Advanced Cardiac Life Support (ACLS)
- Bachelor's Degree an asset
- Ability to perform without direct supervision
- Effective communication skills
- Ability to work in a team focused healthcare environment
- Commitment to personal and professional development
- Excellent teaching skills
- Excellent decision-making, problem solving and time management skills required
- Ability to demonstrate good judgment and multi-task.
- Effective organizational and interpersonal skills

Experience

- At minimum Over 2 years up to and including 3 years practical and related experience and/or 2 years on-the-job training required.

Professional Affiliations/Memberships:

- General Registration in Good Standing with the College of Respiratory Therapy of Ontario (CRTO) or College of Nurses of Ontario (CNO) required
- Membership in Canadian Anesthesiologists' Society (CAS) recommended
- Membership in Canadian Society of Respiratory Therapists (CSRT) an asset
- Membership in Respiratory Therapy Society of Ontario (RTSO) an asset

IV. LEADERSHIP: SUPERVISING & DEVELOPING PEOPLE

How many employees/students receive direction from this job: 1 to 9 employees.

Select the primary leadership functions of the role:

☒ Provides orientation	☒ Acts as a resource/role model	☒ Facilitates and resolves problems
☒ Prioritizes/monitors work of work	☒ Identifies training requirements	☒ Makes recommendation on quantity/quantity
☒ Communicates assignments procedures	☒ Coaches/influences/encourages	☒ Shows others how to perform certain work
☒ Provides information for PES discipline/promotion	☒ Provides work guidance/advice	☐ Makes recommendation on
☐ **Other,** please specify		

V. CONTROL OF WORK ACTIVITIES

Volume of work/changes in task priorities changes frequently with no advanced warning

VI. INSTRUCTIONS RECEIVED

Receives direction by following broad policies or general objectives

VII. PLANNING

The scope/complexity of planning involves making decisions linked to dept./patient objective

VIII. CONTACTS

Use the scale below to indicate the primary contact(s) and the rate of occurrence by selecting 0 = N/A; 1 = Occasional; 2 = Regular; 3 = Frequent

Internal Contacts:

2 Support Staff	1 Management	3 Patients	3 Nurses
3 Medical Staff	2 Students	0 Volunteers	0 **Other**, please specify

External Contacts:

1 Vendors/Suppliers	2 Learning Institutions	0 Contractors	1 General Public
0 Government Reps	1 Pharmaceutical Companies	0 Referral Facilities	0 Funding Agencies
0 Community Agencies	3 Family Members/Significant Others	0 **Other**, please specify	

Select the nature of the above contacts (check all that apply):

☒ Identifies solutions	☒ Provides recommendations	☒ Influences others	☒ Negotiates
☒ Interprets information	☒ Explains/screens information	☒ Persuades others	☒ Educates others
☐ Arranges appointments	☒ Obtains/provides information	☒ Identifies problems	☒ Motivates others
☒ Coordinates schedules	☒ Participates in open exchange	☒ Conducts presentations	☒ Convinces others
☐ Secures understanding with senior level stakeholders		☒ Provides guidance/advice	
☐ **Other**, please specify			

IX. IMPACT OF ERROR

Potential errors are both judgemental and abstract and may have substantial consequences. These errors will have far reaching impact on client/org'n

Select the type of impact that may occur as a result of an error:

☒ Harm to individuals	☒ Substantial disruption in service	☒ Damage to property	☒ Lawsuit
☒ Damage to equipment	☒ Damage UHN reputation/image	☐ Minimal disruption in service	☒ Financial loss
☐ Terminal loss beyond repair	☐ **Other**, please specify		

X. PROBLEM COMPLEXITY

Select the primary statement below that best reflects the work being performed. Choose only one.

- ☐ Work consists of clear-cut/closely related tasks, where actions to be taken are readily apparent.
- ☐ Work involves several/sequential steps/processes with limited choices, requiring some judgment and discretion.
- ☐ Work involves applying some specialized practice/procedure which is largely predetermined/moderately structured.
- ☐ Work involves applying specialized practice/procedure, requiring some innovation and flexibility.
- ☒ Work involves applying different/indirectly related processes/methods/techniques, requiring selecting appropriate course of action from a limited number of established alternatives.
- ☐ Work consists of a variety of tasks requiring different/unrelated processes/methods applied to a range of activities or requiring substantial depth of analysis.
- ☐ Work consists of a broad range of different/unrelated processes/methods applied to a broad range of activities having a significant impact of the development of major aspects of program administration.
- ☐ Work consists of broad functions/processes which have major direct controlling impact on all aspects/phases of processes within a site. Overall influence exerted contributes directly to program success/long-term impact.
- ☐ Work consists of multidimensional functions across sites which have a major direct controlling impact on all aspects of the organization. Involved in setting non-existent precedents.

XI. DEXTERITY DEMANDS

Job requires using considerable accurate coordination, where speed and eye/hand coordination are required from 76% up to 100% of the workday of the workday.

- **- reading and drawing from drug ampoules**
- **- creating different dilutions of drugs/IV infusions**
- **- inserting IVs and arterial lines into patients**
- **- injecting patients with local anesthetic during anesthetic blocks and operating peripheral nerve stimulator**
- **- bag/mask ventilation and endotracheal intubation**
- **- operating infusion pumps**
- **- blood sampling from arterial lines, IV lines and venipuncture procedures**
- **- administration of vapour anesthetics**
- **- operation of anesthetic gas machine during general anesthesia and conscious sedation procedures**
- **- scanning and recording drug administration in electronic charting**
- **- assisting with insertions of central venous lines and pulmonary arterial catheters**

XII. MENTAL/SENSORY EFFORT (CONCENTRATION):

Use the scale below to indicate the type/level of mental/sensory (fixed and focused mental/visual/auditory concentration) effort required by the job: 0 = N/A; 1 = Normal; 2 = Above Average; 3 = Considerable;
4 = Extended; 5 = Continuous

5 Monitoring instruments	3 Operating a PC	4 Inputting data	0 Proofreading	3 Reviewing complex documents
5 Listening for details	4 Interviewing	1 Composing documents/reports	☐ **Other**, please specify	

XIII. PHYSICAL EFFORT

Use the scale below to indicate the type/occurrence of physical effort required by the job: 0 = N/A; 1 = Up to 25%;

2 = From 26% up to 50%; 3 = From 51% up to 75%; 4 = From 76% up to 100%

3 Sitting	3 Pulling	0 Kneeling	2 Crouching	0 Driving	3 Repositioning patients
4 Walking	3 Pushing	0 Lifting from ankle	3 Trunk twisting	3 Bending	2 Being in static position
3 Standing	0 Gripping	2 Lifting from waist	2 Assisted lifting	0 Climbing	3 Reaching below the shoulders
0 Operating a forklift		3 Lifting from shoulders		3 Reaching forward	2 Reaching above the shoulders
2 Independent lifting		2 **Lifting of weights** not exceeding 10 kg		☐ **Other**, please specify	

XIV WORKING ENVIRONMENT

The work area(s) may be best characterized as:

☒ Clinical	☐ Outdoors	☐ Patient Home	☒ Patient Care	☐ Closed Office	☐ Open Office	☐ Laboratory
☐ Kitchen	☐ Classroom	☐ Public Space	☐ **Other**, please specify			

Use the scale below to indicate the level of disagreeable exposure: 0 = N/A; 1 = Normal; 2 = Above Average;
3 = Considerable; 4 = Extended/Significant; 5 = Continuous

To which of the following hazards/disagreeable work conditions is the job be exposed:

1 Dirt	3 Noise	3 Poor lighting	4 Infectious Diseases	2 Difficult/Abusive Behavior
1 Dust	2 Odors	3 Lack of privacy	3 Radio Active Materials	5 Bio-hazardous Materials
4 Fumes	4 Bodily Fluids	2 Poor Ventilation	☐ None of the above	☐ **Other,** please specify

XV. APPROVALS

DEPARTMENT:	**Enter Name**	**Enter Title**	**Enter Date**
HR DEPARTMENT:	**HR use only**	**HR use only**	**HR use only**

C.4 VGH Anesthesia Assistant Job Description

Vancouver Coastal Health
Promoting wellness. Ensuring care.

JOB DESCRIPTION

JOB TITLE	JOB CODE
1. Anesthesia Assistant	2. 004476

Pay Rate	Grid 11
Classification	65350 (MOU)
Bargaining Unit	Health Science Professionals Bargaining Association
Work Location/Union	Vancouver General Hospital, UBC Hospital, Richmond Hospital, Lion's Gate Hospital (HSA)
Program/Department	
Operations	Anesthesia Services, Perioperative Services
Corporate Practice	N/A
Supervisor's Title	
Operations	Senior Anesthesia Assistant/Director Perioperative Services
Supervises	Nil
Date Established	September 13, 2006
Last Revision Date	November 15, 2011, October 14, 2014

JOB SUMMARY

Practices in accordance with the standards of practice and guidelines as outlined by the Canadian Anesthesiologists' Society (CAS) as well as within a client and family centred care model and the vision and values of the organization. Provides technical support and clinical assistance with induction, maintenance and recovery phases of anesthesia by working both under the direct clinical supervision of the Anesthesiologist and as a member of an integrated surgical team. Assists the Anesthesiologist in developing and implementing the anesthesia care plan and monitors physiological responses of patients to the induction of anesthesia during surgery. Ensures effective and safe patient care. Demonstrates continuous improvement and best practice approach in anesthesiology assistant practice. Operates, prepares and maintains anesthesiology equipment. Maintains and advances own clinical competence. Participates on designated hospital committees/teams and approved research projects as assigned.

EXAMPLES OF DUTIES & RESPONSIBILITIES

1. Prepares patient for surgery by performing and/or assisting with anesthesia assessment of patients prior to surgery. Consults with the Anesthesiologist to establish an anesthetic plan for patient management. Ensures that pharmacological agents and equipment are prepared prior to the patient entering the Operating Room. Establishes patient monitoring and records patient's vitals prior to the induction of anesthesia.

2. Performs insertion of arterial lines, intravenous lines, and femoral lines. Assists with the insertion of central lines, placement of pulmonary artery catheters, and placement of epidural catheters and catheters for regional anesthesia. Under the direction of the Anesthesiologist assists with and/or performs endotracheal intubation utilizing a bronchoscope, standard laryngoscopy and advanced airway equipment such as fibreoptic equipment, lighted stylettes, Glidescopes, and Bullard laryngoscope. Assists the Anesthesiologist in performance of anesthetic block and conscious sedation procedures by preparing the pharmacological agents. Administers local anesthetics as directed. Monitors patients for effectiveness and complications of the procedure such as any adverse reactions to the anesthetic agents. Documents in the anesthesia record and patient chart as part of care plan. Calibrates the bronchoscope during and after the procedure.

3. Initiates mechanical ventilation and titrates medical gases according to patient requirements. Initiates and adjusts anesthesia vapor agents in consultation with the Anesthesiologist. Monitors hemodynamics during insertion of invasive monitors. Initiates specialty gases such as Nitric Oxide on request of the Anesthesiologist. Ensures patient's airways remain patent by performing bronchial hygiene. Adjusts ventilation modalities as required to ensure adequate patient ventilation and oxygenation.

4. Checks and administers blood products, under the direction of the Anesthesiologist, to met patient requirements utilizing rapid infusion equipment and in accordance with established transfusion practices. Monitors patient's vital signs pre and post transfusion for adverse reactions. Performs cell saving and blood salvaging functions during surgery as requested by Anesthesiologists and surgeons by methods such as setting up and operating cell saver equipment to collect the patient's blood shed, cleanse and recycle the elements of blood to the patient during surgery.

5. Assists with patient emergence from anesthesia by providing airway maintenance such as aspiration of secretions from the trachea and pharynx, and patient extubation, discontinuing monitors and removing anesthesia equipment after surgical procedures. Assists the Anesthesiologist in transporting patient to recovery room or other designed areas by accompanying and monitoring patient's respiratory status during transport.

6. Initiates and provides ventilatory support to patients in the recovery room by performing duties such as administering and adjusting ventilation to ensure safe and appropriate application of ventilation and maintenance of a clear airway. Communicates with the Anesthesiologist to develop a care plan for patients requiring long term ventilation.

7. Assists the Anesthesiologist with intraoperative echocardiographs by performing such duties as preparing patient for procedure, entering patient data, assisting with probe insertion, and maintaining and ordering equipment.

8. Attends and assists all airway emergencies requiring anesthesiology intervention in all areas of the hospital. Attends perioperative cardiac arrests and assists the Anesthesiologist in providing airway, ventilatory, and circulatory support.

9. Consults with and collaborates with peers and other care professionals in the identification and resolution of patient/family care issues, coordination and integration of care by maintaining ongoing contacts, promoting a sharing of responsibility and creating an environment for ongoing dialogue around care of patients transferring to recovery room. Participates in interdisciplinary rounds and client care conferences with the client/family. Acts as patient advocate to protect and promote patient's rights to autonomy, respect, privacy, dignity and access to information.

10. Maintains awareness of current anesthesia practices and guidelines. Assists in making recommendations for the purchase of new equipment/technical upgrades through methods such as reviewing and evaluating technical literature/material, identifying new or revised procedures/equipment to improve operations, arranging and attending supplier demonstrations as required, providing recommendations regarding capital

equipment needs, and submitting to Supervisor. Maintains and tracks anesthesia equipment utilized outside the perioperative environment. Maintains inventories of supplies, gases, and other material and orders supplies when necessary to meet operational needs.

11. Participates in students' clinical experience by performing duties such as demonstrating procedures to ensure proper exposure to all clinical activities within the Operating Rooms, gathering feedback from students regarding their experience, and forwarding to Supervisor for quality improvement. Guides clinical experience of assigned new staff and provides input as requested on individual's progress in achieving established clinical practice guidelines and standards of practice.

12. Participates in quality control program and continuous quality improvement programs by performing duties such as participating on designated committees, identifying and troubleshooting problems and unclear policies, and independently resolving technical difficulties in order to ensure quality service standards. Implements new procedures/systems/protocols as approved. Participates in monitoring standards by completing audits and evaluations on patient charts to ensure safe and effective anesthesia practices.

13. Performs scheduled and routine maintenance and repairs on a variety of anesthetic and cell saving equipment or arranges repairs by performing duties such as receiving and assessing equipment, testing, and identifying malfunctions. Completes minor maintenance following manufacturers and Canadian Standards Association (CSA) guidelines and verifies vendor repairs with Biomedical Engineering Department to ensure equipment is operating in a safe and efficient manner.

14. Maintains a variety of records through methods such as gathering information, entering data into computerized databases and/or recording information into approved formats, coding and manipulating databases to generate reports, compiling statistics including analyzing trends and accounting for variances, and summarizing information into written reports as requested.

15. Participates in assigned area infection control program by performing duties such as assessing infection control in anesthetic equipment and disinfecting and sterilizing equipment to safety standards in accordance with quality assurance program.

16. Participates on designated unit-based, program and professional committees/teams through methods such as attending meetings, drafting/revising patient care documentation methods/forms for review by committee/team and providing written/verbal input to promote improvements to client and family care, and the efficient and safe operation of the assigned area. Identifies and reports unsafe practice/professional conduct, in accordance with professional standards and organization policies.

17. Participates in approved anesthesia and interdisciplinary research and special projects in collaboration with supervisor/team members and other health care professionals, through methods such as collecting data, integrating and interpreting data, summarizing information, and/or providing verbal updates for review and further analysis by principal researcher, research team and/or project coordinator.

18. Sets measurable goals and objectives within a team or individual environment, incorporating the hospital's vision and values, goals and corporate plan, through methods such as maintaining and updating own knowledge of clinical and professional development within area of practice, and developing plan in collaboration with Supervisor and Department of Anesthesia for professional development; reviews progress to ensure goals are achieved within established time frames.

19. Carries out responsibilities in accordance with health and safety requirements. Immediately reports unsafe situations by notifying supervisor or other appropriate personnel.

20. Performs other related duties as assigned.

QUALIFICATIONS

Education & Experience

Graduation from a recognized Anesthesia Assistant Program plus current certification in Advanced Cardiac Life Support (ACLS). Eligible for membership with the Canadian Anesthesiologists' Society (CAS).

Knowledge, Skills & Abilities

Comprehensive knowledge of current anesthesia assistant theory and practice within a client/family centered model for care.
Broad knowledge of the CAS clinical practice guidelines for Anesthesia Assistants.
Broad knowledge of research process and methodology.
Demonstrated ability to plan and implement plans of care in relation to client/family priorities.
Demonstrated ability to assess client responses to care, and to respond appropriately.
Demonstrated ability to adjust to new or unexpected events.
Demonstrated ability to deal with conflict situations.
Demonstrated ability to use departmental and hospital policy and procedure manuals.
Demonstrated ability to communicate effectively, both verbally and in writing.
Demonstrated ability to communicate with and deal effectively with clients and their families, co-workers, physicians, other health care staff and staff of outside agencies.
Demonstrated ability to work independently and in collaboration with others as a member of the interdisciplinary team.
Demonstrated ability to establish workload prioritizes in collaboration with others.
Demonstrated skill in CPR techniques.
Demonstrated skill in the use of medical equipment and supplies appropriate to the clinical area.
Demonstrated skill in techniques appropriate to the clinical area.
Demonstrated computer skills including the ability to effectively use a computerized patient care information system.
Demonstrated physical ability to carry out the duties of the job.

Debbie Jeske	November 15, 2011
Operations Signature	*Date*

Appendix D – University Health Network (UHN) Orientation and Training Upon Hire

Applicants for AA positions at UHN must be licensed RTs or RNs who have successfully completed an AA education graduate certificate program. Staff at UHN are not unionized. The MoHLTC funds fourteen of the thirty-one AA positions at UHN. Of the thirty-one AAs employees, twenty six are RTs and five are RNs. 85% of AA practice at UHN is clinical, 10% technical and 5% administrative. AAs rotate across all sites. Respiratory Technicians are employed in the OR to check machines and other equipment, stock rooms with supplies and perform equipment maintenance.

The duties and responsibilities outlined in the AA job description include the following activities:

- Provide aesthetic support for preoperative care units
- Provide anesthesia care intraoperatively for the operating rooms
- Provide general anesthesia as defined by policy, monitoring stable patients under general anesthesia
- Assist anesthesiologist in room, requiring support with procedures or specialized equipment
- Provide anesthesia care for the post-operative period providing and/or assisting with post-operative care
- Provide conscious sedation as defined by policy in the Cardiac Catheterization lab and Echo cardiology lab
- Provide assistance with peripheral and neuraxial blockage in Regional Block Rooms
- Provide assistance in medical imaging units and during gamma knife procedures
- Anesthesia crisis management
- Participate in clinical education
- Conduct research.

Orientation for new hires includes

- Orientation to every area (there is a teaching package for every area)
- New AAs shadow AAs for a couple of weeks in each area
- Orientation for conscious sedation is twelve weeks for external hires
- It takes 6-12 months before a new hire is fully independent
- AA hires that did not do their student practicum at UHN require 1 year of orientation before being fully independent

AAs who have successfully completed an AA education program, additional UHN specialty training, passed specialty practice exams are certified to provide conscious sedation for the following cases;

- ophthalmology: retinal, cataract, corneal transplant, and glaucoma surgery
- Plastics
- Orthopedics
- Deep brain stimulation

- Arterial-venous fistula creation
- Cardiac: pacemaker and defibrillation insertion
- Dilation and curettage procedures
- Uterine ablation

AAs must obtain UHN certification to do maintenance of general anesthesia. This involves passing an entry to practice exam and successfully passing simulations with the anesthesia medical director.

Additional UHN certification is required for AAs to practice remotely in the echo and cardiac labs. An anesthesiologist covers from the OR, is consulted between cases and can be called in an Emergency.

UHN conducts an annual AA continuing education simulation where the medical director reviews critical case scenarios that don't routinely occur. This simulation is conducted with groups of three to four AAs one afternoon/week/ 3 weeks. Sign off on the simulation is by the Medical Director. An annual review of general anesthesia is conducted because so much of AA practice is independent. AAs spend three days with anesthesiologists in three different areas. UHN sponsors an annual AA Professional Development Education Day for all AAs in the province.

Appendix E – Thompson Rivers University Open Learning Anesthesia Assistant Mid-Term Evaluation Form

THOMPSON RIVERS UNIVERSITY
OPEN LEARNING DIVISION

Student Name: _____ Date: _____
Supervising Physician(s): _____
Circle appropriate number. Space for comments on page 4.

Criteria	**Needs**	**Adequate**	**Good**	**Very Good**	**Excellent**
Knowledge	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
Basic Sciences	Lacking in basic science knowledge; persistent difficulty in applying basic science principles to patient care.		Applies basic science knowledge to patient care in the majority of cases.		Exceptional level of basic science knowledge, consistently applied to patient care.
Clinical Knowledge	Lacks appropriate clinical knowledge to define priorities in diagnosis and management of clinical problems.		Level of clinical knowledge enables resolution of common clinical situations on a consistent basis.		Exceptional level of clinical knowledge enables resolution of common, complex, and uncommon clinical situations.
Equipment: Anesthesia machines, monitors, supplies	Lacks appropriate knowledge to check, troubleshoot or undertake preventative maintenance. Ignores responsibilities in this area. Lacks desire to learn about new technology.		Level of knowledge enables resolution of common technical problems on a consistent basis. Participates in QA activities, Maintains records of QA findings. Assumes responsibility for layout, organization, storage of anesthesia supplies.		Exceptional level of knowledge. Takes initiative. Remains current with device alerts, communicates same to Department, interacts with suppliers, biomedical engineering, service representatives. Establishes PM programs.
Skills	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
Clinical Data Gathering	History is frequently inaccurate; important information missing.		History is usually complete, accurate, and systematic.		History is virtually always precise and thorough, even in most complex cases.
Physical Examination	Examination incomplete. Deficiencies often result in inaccurate diagnosis and/or management		Examination is usually complete. Recognition of most findings allows for proper diagnosis and management.		Examination is almost always complete and thorough. Recognition of virtually all findings allows for expert diagnosis and skilled management even in complex cases.

Skills	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
Preoperative Assessment	Disorganized. Essential information missing.		Establishes effective rapport. Attentive to patient concerns. Thorough pre-anesthetic assessment		Assessment includes summation of anesthetic, patient & surgical considerations and their influence on conduct of anesthetic, including alternatives.
Diagnostic/ Therapeutic Planning	Plan is frequently incomplete or inefficient, little attention to preventive measures.		Plan is appropriate and reflects current standards. Usually pays attention to preventive measures.		Plan is virtually always complete and efficient. Consistently pays attention to preventive measures.
Technical	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
Procedural assistance	Easily distracted. Unfamiliar with procedure, supplies, equipment. Awkward, tentative, unhelpful.		Independent room setup. Gathers necessary supplies & equipment for specific procedures, prepares for off-sites. Attentive, competent assistance with induction, maintenance, emergence, disposition. Thorough handover.		Expert assistance including resuscitation and complex cases. Exhibits intuition and insight. Anticipates.
Procedures	Is rough, many unnecessary moves, inappropriate use of instruments. Hesitant, deficient knowledge. Inadequate procedural skills, preventing the safe practice of assigned anesthesia duties		Careful handling of tissues, efficient time/motion, knowledgeable about instruments & supplies, demonstrates forward planning, knows procedural steps. Overall ability consistent with competent execution of assigned procedures.		Meticulous; handles tissues with extreme care and a minimum of trauma. Skills are exceptional, placing AA in top 10% of cohort. Demonstrates advance planning, strategic use of assistants, familiarity with all aspects of procedure. Knows alternatives
Communication	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
Communication with Attending Anesthesiologist	Disorganized, omits pertinent information, gets flustered in emergencies.		Relevant information communicated, some prompting required, able to organize thoughts, uses appropriate terminology.		Demonstrates consistent ability to articulate relevant information in a complete, succinct, logical, timely manner, both electively and emergently.

Patient Relationships	Lacks communication skills; cannot or does not explain investigation and management to patients. Unprofessional manner.		Good rapport. Explains Dx and Rx. Communicates his/her concern for the patient. Professional manner.		Establishes exceptional rapport. Always puts patients at ease. Excellent listening skills and concern for patients. Consistently professional.
Team Relationships	Behavior interferes with satisfactory performance. Lacks ability to get along with other members of team. Undermines team operation.		An active member of the team who works well with other members. Appropriate instructions to and rapport with nurses and allied staff.		An active member of the team whose leadership qualities are recognized by others; is always able to achieve best results in difficult situations without antagonizing others.
Professional	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
Judgment and Decision-Making	Often incomplete, inaccurate or illogical; frequent difficulty in arriving at decisions. Does not use all information available.		Judgments usually complete and sound. Decisions arrived at appropriately. Makes use of available information.		Consistently arrives at correct decisions even on highly complex matters without delay. Analyses all available information.
Responsibility	Not dependable; does less than prescribed work; needs repeated reminders.		Dependable, reliable, honest, and forthright in all information and facts; prompt, appropriate follow -up of patients.		Consistently displays exceptional attention to duties. Prepared to give extra time willingly.
Self-Assessment Ability	Unaware of own limitations; evasive in accepting responsibility for errors; does not seek feedback; unable to request required assistance; unable to take or give advice gracefully.		Aware of own limitations; seeks assistance and/or feedback to overcome/compensate for limitations;accepts advice graciously. Subsequent performance indicates that feedback used to overcome deficiencies.		Consistently displays professional behavior and recognizes own limitations. Raises constructive questions; seeks feedback to further excel, and always accepts criticism positively.

Overall Performance (circle one)	(1) Needs Improvement	(2) Ade-quate	(3) Good	(4) Very Good	(5) Excellent

Describe any **outstanding** features demonstrated.

_____

_____

_____

Describe any **improvements** that are required.

_____

_____

_____

Describe any **difficulties** you might foresee this student having in the future.

_____

_____

_____

Comments:

_____

_____

_____

_____

We have reviewed and discussed this assessment with the student.

Date:_____

Primary Supervising Physician(s)

Signature(s): _____ Print: _____

_____ Print: _____

Student: _____

Appendix F – Program Advisory/Quality Committee Considerations

In addition to the standard terms of reference for a Program Advisory Committee, a Program Advisory/Quality Committee can provide input into the design, delivery and evaluation of an AA education program. Additional task for the committee could include the following.

- Reach consensus on competency indicators students will be expected to have achieved by the end of the program;
- Provide feedback on the program's strategic plan;
- Review the admission requirements for the program;
- Receive reports on program preparation for accreditation and provide feedback;
- Review and provide feedback on clinical practicum evaluation tools;
- Provide input on program evaluation tools, receive course and practicum evaluation reports and provide suggestions for program improvement;
- Facilitate partnerships between the academic program and clinical practicum clusters; and,
- Facilitate the use of clinical labs for practice with anesthesia equipment, performing procedures, and medium and high fidelity simulated case scenarios prior to the clinical practicum.

Subject to the advice of the Program Advisory/Quality Committee the program could be organized as follows:

Semester 1

- Orientation to program: 3-4 days: classroom and labs at clinical partner site
- Online theory
- 1 week residency at end of semester: labs, lectures, end of term exam and prep for semester 2 (facilitate by 1-2 faculty members including the Program Medical Director)

Semester 2

- Online theory including electures by anesthesiologists
- Mid-term one week residency: lectures by anesthesiologists, case scenario simulations, shadow day in OR
- 1 week residency at end of the program: consolidation of learning, preparation for practicum, medium and high fidelity simulations, feedback from assessors, development of learning plans

By the end of semester 2 students would be at a higher level of competencies than current TRU students entering a practicum. This would address the concern of some AA supervisors that the 16 week practicum was not long enough.

Semester 3: Clinical Practicum: 14 weeks

- Clinical practicum clusters practice partners
  - Anesthesiology department has a designated anesthesiologist lead for AA practice at the site;
  - A minimum number of AAs are practicing at the site

- Core set of rotations for all students
- Guest lectures are also mentors
- Potential clusters:
  - Lower Mainland: SPH, VGH, RCH, SMH, Children's, Women's
  - Interior/Northern: Kelowna General and Royal Inland
  - Island: Victoria General, Royal Jubilee and Nanaimo General
- Designated cluster coordinators facilitate rotations within each cluster

Additional information to be included in the clinical practicum guidelines:

- Role of mentor, AA lead, attending anesthesiologists in each rotation;
- Role of cluster coordinator;
- Role of program coordinator;
- Mentor orientation guide;
- Additional student reading for the practicum rotations and discussions with the attending anesthesiologists;
- Guidelines for weekly objectives that align with the clinical practicum objectives that are developed by the student in consultation with the mentor (anesthesiologist) and supported by the AA supervisor or designate;
- Daily logbook template for documenting cases, discussions with anesthesiologist and attending anesthesiologist;
- Regular mentor ratings of student knowledge, technical and behavioral skills and identification of strengths and opportunities for improvement; and
- Final clinical practicum evaluation tool to be completed and signed off by the mentor.

An ongoing evaluation and quality improvement process is needed to ensure that the program objectives are being achieved, the program is meeting the needs of stakeholders in BC and that the program meets national accreditation standards.

- Courses need to be evaluated on a regular basis by core faculty, guest faculty, students, and clinical practicum sites.
- Feedback on the clinical practicum should be obtained from students, anesthesiologists, program medical directors, mentors and AA supervisors. Sites need to provide feedback on the readiness of students for the practicum and make suggestions for improvements, if necessary.

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From:	Krystalowich, Katharine HLTH:EX
To:	Vatne, Brian R HLTH:EX
Cc:	Rindler, Sydney HLTH:EX
Subject:	WorkBC career profiles
Date:	November 4, 2016 12:40:31 PM
Attachments:	Job Profiles - Nurse practitioner and Physician Assistant.msg RE Job Profiles - Nurse practitioner and Physician Assistant.msg

Hi Brian, as discussed the other day, Sydney and I are responding to a request from Liza Sehic at JTST for information on how newcomers to BC can register as an: NP, ND PA, chiropodist, orthoptist, osteopathic physician, and podiatrist. The information is for their WorkBC career profiles (NOC). I have attached emails from Liza which include the draft NOC's she sent me.

Sydney and I pulled information from internal documents on NPs and naturopathic physicians but don't have registration information for the remaining professions. We could probably get the information from websites but so could JTST.

Nurse Practitioners

To practise as a registered nurse practitioner (NP) in BC, an NP must be registered with the College of Registered Nurses of BC (CRNBC).CRNBC registers NPs in one of three streams of practice: family, adult and pediatric.

Potential applicants must undertake the following steps to be eligible for registration:

- Complete an online pre-assessment questionnaire and application
- Submit education and certification/registration documents for review
- Complete the Competency Assessment Process
- Complete a written exam and an objective structured clinical examination (OSCE)

The BC Nurse Practitioner Association and the Association of Registered Nurses of British Columbia support and advance the professional interests of BC NPs.

Naturopathic Physicians

The College of Naturopathic Physicians of BC (CNPBC) is the regulatory body for naturopathic physicians. The CNPBC requirements for registration:

- Three years liberal arts or sciences study in an accredited college or university approved by the Board
- Graduation from an accredited naturopathic medical school
- Completion of Naturopathic Physician Licensing exams
- Completion of Jurisprudence and Oral/Practical exams

The BC Naturopathic Association (BCNA) is the voluntary organization that advocates for the professional and economic interests of NDs.

Let me know if you want to discuss/ change anything.

kk

Doxtator, Mandy HLTH:EX

From: Hart, Bob HLTH:EX
Sent: Friday, December 7, 2018 9:10 AM
To: Fabian, MC HLTH:EX; Ty, Marie HLTH:EX; Shen, Lei HLTH:EX; Gavin, Duncan HLTH:EX; Louie, Betty HLTH:EX
Subject: RE: Physician Assistants (PA's)

Follow Up Flag: Follow up
Flag Status: Completed

This may not go away but it's all good info.

Bob Hart
Director, MSP Payment Schedule
Compensation Policy and Programs
Health Human Resources and Labour Relations Division
Ministry of Health 250-952-1204

From: Fabian, MC HLTH:EX
Sent: Thursday, December 06, 2018 3:12 PM
To: Ty, Marie HLTH:EX; Shen, Lei HLTH:EX; Gavin, Duncan HLTH:EX; Louie, Betty HLTH:EX; Hart, Bob HLTH:EX
Cc: Foster, Carol HLTH:EX
Subject: FW: Physician Assistants (PA's)

Hi All,

See below – I did get this response ok'd from Prof Regulation folks.
As DoBc is advocating for PA's and this response could get shared, I wanted to be sure wording was accurate.

Carol, please can you cancel December 18th meeting.

Thanks,

MC

From: Fabian, MC HLTH:EX
Sent: December 6, 2018 3:03 PM
To: Dadachanji, Shiroy HLTH:EX ; 'Grant, Juanita'
Subject: RE: Physician Assistants (PA's)

Hi Both,

I did some asking around here in the area with the folks that deal more with this portfolio.

Fortunately one less thing for us to worry about for now i.e. remuneration of PA's.

MOH is focused on significantly increasing existing health care professionals, especially nurse practitioners, and maximizing use of their skills. As such, there is no present plan for PA's

Thanks for checking in and for your good questions.

Cheers,

MC

From: Fabian, MC HLTH:EX
Sent: November 28, 2018 2:24 PM
To: Dadachanji, Shiroy HLTH:EX <Shiroy.Dadachanji@gov.bc.ca>; 'Grant, Juanita' <jgrant@doctorsofbc.ca>
Subject: RE: Physician Assistants (PA's)

Hi Both,
Good questions, and comments.
We will discuss here in MSP and get back to you.
s.22
MC

From: Dadachanji, Shiroy HLTH:EX
Sent: November 27, 2018 6:53 PM
To: 'Grant, Juanita' <jgrant@doctorsofbc.ca>
Cc: Fabian, MC HLTH:EX <MC.Fabian@gov.bc.ca>
Subject: RE: Physician Assistants (PA's)

Hi Juanita,

I'll have to read that blog statement, but as an initial response, I think this is more of a policy issue for MSP/MSC than a BIP issue. I've cc'd MC on this email.

Based on my interpretation and understanding of the payment schedule, the use of PAs would not be billable in the same way as the use of trainees. The billing for services by trainees is dictated by C.18 of the Payment Schedule. It does not contemplate PAs in any way, and therefore would not be appropriate. Section C.20 ("Delegated Procedures") does contemplate use of "a medical assistant in the employ of a medical practitioner." The statements made under C.20 would seem more appropriate to the use of PAs, except as you've pointed out the PAs in the anaesthesiologists' case are salaried by the hospital and not under the employ of the practitioner. There is also a statement under C.20 which restricts delegation to procedural services, not visit type services ("which may not be delegated").

MC do you have thoughts on this?

Thanks,
Shiroy

From: Grant, Juanita [mailto:jgrant@doctorsofbc.ca]
Sent: Tuesday, November 27, 2018 9:59 AM
To: Dadachanji, Shiroy HLTH:EX
Subject: Physician Assistants (PA's)

Hi Shiroy: I was reading our President's latest blog on PA's and the DoBC's endorsement of them. s.22

At the Anaesthesia A&B session I attended in Surrey a month ago, the Anesthetists mentioned that Surrey Memorial is using PA's for anaesthesia. A question came up during the billing for residents slide. As the Anethetists are expected to directly supervise the PA's, a question was asked in regards to billing for this supervision. s.22
s.22

Has the BIP had any discussion on the use of PA's and how physicians are to be remunerated for supervising them? Could this be billed in the same fashion as the residents billing?

Thank you.

Juanita
s

Juanita Grant
Manager, Audit & Billing
T 604 638 2829 F 604 638 6054 TF 1 800 665 2262
115 – 1665 W Broadway Vancouver BC V6J 5A4

Doxtator, Mandy HLTH:EX

From: Hart, Bob HLTH:EX
Sent: Monday, February 11, 2019 4:52 PM
To: Hart, Bob HLTH:EX
Subject: Copy for HTH 2019 - 90836 FW: Physician Assistants (PA's)

For the file.

Bob Hart
Director, MSP Payment Schedule
Compensation Policy and Programs
Health Human Resources and Labour Relations Division
Ministry of Health 250-952-1204

From: Gavin, Duncan HLTH:EX
Sent: Thursday, November 29, 2018 4:44 PM
To: Louie, Betty HLTH:EX; Fabian, MC HLTH:EX; Hart, Bob HLTH:EX; Ty, Marie HLTH:EX; Shen, Lei HLTH:EX
Subject: RE: Physician Assistants (PA's)

There doesn't appear to be an association of PA's in BC, but there is a Canadian one. Their website has an advocacy link for PA's in BC, which links to a number of reports from the Conference Board of Canada it appears they commissioned to support their position.

https://capa-acam.ca/pa-news/physician-assistants-are-making-health-care-accessible-why-not-in-b-c/

Journal article from Canadian Family Physician. A lot of worthwhile historical and interjurisdictional background: http://www.cfp.ca/content/57/3/e83

CMA advocacy document for PA's, provides a lot of detail on their roles in different settings i.e. emerg med, orthopaedics, primary care, neurosurgery, etc. https://www.cma.ca/Assets/assets-library/document/en/advocacy/PA-Toolkit-e.pdf

---

From: Louie, Betty HLTH:EX
Sent: Thursday, November 29, 2018 7:32 AM
To: Fabian, MC HLTH:EX; Hart, Bob HLTH:EX
Cc: Ty, Marie HLTH:EX; Shen, Lei HLTH:EX; Gavin, Duncan HLTH:EX
Subject: RE: Physician Assistants (PA's)

Interesting article for you here.

https://vancouversun.com/news/local-news/pressure-on-government-to-recognize-physician-assistants

Betty Louie
Manager, MSP Unit

Compensation Policy and Programs Branch, MoH
P.O. Box 9649 |Victoria BC V8W 9C4
Betty.Louie@gov.bc.ca| p 250 952-1706 | f 250 952-1417

From: Fabian, MC HLTH:EX
Sent: Thursday, November 29, 2018 4:22 AM
To: Hart, Bob HLTH:EX
Cc: Ty, Marie HLTH:EX; Louie, Betty HLTH:EX; Shen, Lei HLTH:EX; Gavin, Duncan HLTH:EX
Subject: Re: Physician Assistants (PA's)

s.22

From: Fabian, MC HLTH:EX
Sent: November-29-18 4:14 AM
To: Hart, Bob HLTH:EX
Cc: Ty, Marie HLTH:EX; Louie, Betty HLTH:EX; Shen, Lei HLTH:EX; Gavin, Duncan HLTH:EX
Subject: Re: Physician Assistants (PA's)

As background, this is the info that initiated the questions:

https://www.doctorsofbc.ca/news/advocating-physician-assistants-bc

https://www.doctorsofbc.ca/policy-statements/health-human-resources/physician-assistants

Reading up on this more, I suspect this has been discussed elsewhere in Branch/Division/MOH, but it will be good to have a brief meeting to discuss which has been arranged in a couple weeks. I might ask my counterparts in other P/T's how they are being funded.

From: Hart, Bob HLTH:EX
Sent: November-28-18 5:11 PM
To: Fabian, MC HLTH:EX; Foster, Carol HLTH:EX
Cc: Ty, Marie HLTH:EX; Louie, Betty HLTH:EX; Shen, Lei HLTH:EX; Gavin, Duncan HLTH:EX
Subject: RE: Physician Assistants (PA's)

Found some stuff for my clarification around the issue……..might be of interest. Ignore if you're versant in the topic

> **Physician Assistants – Anesthesia (apparently there are different types of PA's)**
>
> **In the United Kingdom, a physicians' assistant (anaesthesia), abbreviated to PA(A), is a healthcare worker who provides anaesthesia under the medical direction and supervision of a consultant anaesthetist.[1]**
>
> **PA(A)s are not medical doctors, and enter the role by completing a 27 month full-time training programme which leads to the award of a postgraduate diploma. To be eligible, a candidate must have a previous degree in a biomedical or science subject, or recognised previous healthcare experience in another role. [2]**

Despite the similarity of the name, the role is distinct from physician associate, which refers to a non-medical practitioner who works in areas of medicine other than anaesthesia. [3]

Physician Assistants – General

Physician Assistants (PAs) are medical professionals who diagnose illness, develop and manage treatment plans, prescribe medications, and often serve as a patient's principal healthcare provider. With thousands of hours of medical training, PAs are versatile and collaborative.

A PA has a supervising physician, who may or may not work in the same building of practice. PAs only take on the "assistant" role during surgery, but all other settings involve the PA seeing their own patient. In the United States, PAs are nationally certified and state licensed to practice medicine. A certified PA may add "C" at the end of his/her postnominal credentials. PAs are trained with the medical model and complete these qualifications in less time than a traditional medical degree. The educational model for PAs is based on the fast-tracked training of physicians during World War II. In Canada, Canadian Certified Physician Assistant (CCPA) is the credential awarded upon licensure.

History in Canada

As of October 2015, there are approximately 400 PAs working in healthcare settings in Canada. The first formally trained PAs graduated in 1984 from the Canadian Forces Medical Services School at Borden, Ontario. The Canadian Medical Association (CMA) recognized the PA as a health professional in 2003.[69]
The first civilian PA education programs were launched in 2008 at the University of Manitoba and McMaster University. In 2010, a third civilian program was launched by the Consortium of PA Education (University of Toronto, Northern Ontario School of Medicine, and The Michener Institute).
PAs are currently practicing across Canada in the Canadian Armed Forces and are working in the public health care system in the provinces of Manitoba, Ontario, New Brunswick and Alberta. PAs are regulated in Manitoba and New Brunswick by the respective provincial college of physicians and surgeons. In both Ontario and Alberta, the profession is not regulated. However, the Ontario Minister of Health has recommended that a mandatory registry be established which would be governed by the College of Physicians and Surgeons of Ontario. In Alberta, a voluntary registry has been established for PAs under the College of Physicians and Surgeons of Alberta. PAs are permitted to practice, by way of delegation, under the provincial Medical Act. PAs are represented by the Canadian Association of Physician Assistants, which had formed in October 1999 as the "Canadian Academy of Physician Assistants"

As an aside, I understand that "surgeons" in the United Kingdom may not necessarily be physicians? Is this something we may end up seeing in Canada as well?

Bob Hart
Director, MSP Payment Schedule
Compensation Policy and Programs
Health Human Resources and Labour Relations Division
Ministry of Health 250-952-1204

From: Fabian, MC HLTH:EX
Sent: Wednesday, November 28, 2018 2:27 PM
To: Foster, Carol HLTH:EX
Cc: Ty, Marie HLTH:EX; Hart, Bob HLTH:EX
Subject: FW: Physician Assistants (PA's)

Please can you arrange a half hour meeting with Marie, Bob, Betty, Lei, Duncan and myself s.22
Thanks

From: Fabian, MC HLTH:EX
Sent: November 28, 2018 2:24 PM
To: Dadachanji, Shiroy HLTH:EX ; 'Grant, Juanita'
Subject: RE: Physician Assistants (PA's)

Hi Both,
Good questions, and comments.
We will discuss here in MSP and get back to you.
s.22
MC

From: Dadachanji, Shiroy HLTH:EX
Sent: November 27, 2018 6:53 PM
To: 'Grant, Juanita' <jgrant@doctorsofbc.ca>
Cc: Fabian, MC HLTH:EX <MC.Fabian@gov.bc.ca>
Subject: RE: Physician Assistants (PA's)

Hi Juanita,

I'll have to read that blog statement, but as an initial response, I think this is more of a policy issue for MSP/MSC than a BIP issue. I've cc'd MC on this email.

Based on my interpretation and understanding of the payment schedule, the use of PAs would not be billable in the same way as the use of trainees. The billing for services by trainees is dictated by C.18 of the Payment Schedule. It does not contemplate PAs in any way, and therefore would not be appropriate. Section C.20 ("Delegated Procedures") does contemplate use of "a medical assistant in the employ of a medical practitioner." The statements made under C.20 would seem more appropriate to the use of PAs, except as you've pointed out the PAs in the anaesthesiologists' case are salaried by the hospital and not under the employ of the practitioner. There is also a statement under C.20 which restricts delegation to procedural services, not visit type services ("which may not be delegated").

MC do you have thoughts on this?

Thanks,
Shiroy

From: Grant, Juanita [mailto:jgrant@doctorsofbc.ca]
Sent: Tuesday, November 27, 2018 9:59 AM
To: Dadachanji, Shiroy HLTH:EX
Subject: Physician Assistants (PA's)

Hi Shiroy: I was reading our President's latest blog on PA's and the DoBC's endorsement of them s.22

At the Anaesthesia A&B session I attended in Surrey a month ago, the Anesthetists mentioned that Surrey Memorial is using PA's for anaesthesia. A question came up during the billing for residents slide. As the Anethetists are expected to directly supervise the PA's, a question was asked in regards to billing for this supervision. s.22

Has the BIP had any discussion on the use of PA's and how physicians are to be remunerated for supervising them? Could this be billed in the same fashion as the residents billing?

Thank you.

Juanita
s

Juanita Grant
Manager, Audit & Billing
T 604 638 2829 F 604 638 6054 TF 1 800 665 2262
115 – 1665 W Broadway Vancouver BC V6J 5A4

From: Fabian, MC HLTH:EX
To: Hart, Bob HLTH:EX; Doxtator, Mandy HLTH:EX
Subject: FW: PA"s
Date: Wednesday, February 27, 2019 11:18:02 AM

From: Fabian, MC HLTH:EX
Sent: December 6, 2018 2:53 PM
To: Younker, Katherine E HLTH:EX <Katherine.Younker@gov.bc.ca>
Subject: RE: PA's

Thanks!

From: Younker, Katherine E HLTH:EX
Sent: December 6, 2018 2:23 PM
To: Fabian, MC HLTH:EX <MC.Fabian@gov.bc.ca>
Subject: RE: PA's

Hi,

I think this one is better and the suggested edits are in green.

Hi Juanita,

I did some asking around here in the area with the folks that deal more with this portfolio.

Fortunately one less thing for us to worry about for now i.e. remuneration of PA's.

MOH is focused on significantly increasing existing health care professionals, especially nurse practitioners, and maximizing use of their skills. As such, there is no present plan for PA's

Thanks for checking in and for your good questions.

Cheers,

MC

Thanks,

Kathy

From: Fabian, MC HLTH:EX
Sent: December 6, 2018 1:59 PM
To: Younker, Katherine E HLTH:EX <Katherine.Younker@gov.bc.ca>
Subject: RE: PA's

I have already edited my own version. Edit suggestions welcome.

Hi Juanita,

I did some asking around here in the area with the folks that deal more with this portfolio.

Fortunately one less thing for us to worry about for now i.e. remuneration of PA's.

MOH is focused on significantly increasing existing health care professionals, especially nurse practitioners, and PA's are presently not funded by MOH in BC.

Thanks for checking in and for your good questions.

Cheers,

MC

From: Fabian, MC HLTH:EX
Sent: December 6, 2018 1:42 PM
To: Younker, Katherine E HLTH:EX <Katherine.Younker@gov.bc.ca>
Subject: RE: PA's

Many thanks Kathy – this is most helpful.

This was a casual email trail between a just a few folks and I want to try keep response as informal and brief as possible.

Based on info you provided, how does this sound?:

Hi Juanita,

I did some asking around here in the area with the folks that deal more with this portfolio.

Fortunately one less thing for us to worry about for now i.e. remuneration of PA's.

MOH is focused on significantly increasing existing health care professionals, especially nurse

practitioners, and there is no present plan for PA's

Thanks for checking in and for your good questions.

Cheers,

MC

From: Younker, Katherine E HLTH:EX
Sent: December 6, 2018 1:06 PM
To: Fabian, MC HLTH:EX <MC.Fabian@gov.bc.ca>
Cc: MacKinnon, Mark HLTH:EX <Mark.MacKinnon@gov.bc.ca>
Subject: RE: PA's

Hi Dr. Fabian,

Thanks for sharing that link. I do remember seeing it on Twitter on PA day.

As per our conversation yesterday, when we have been responding to queries related to physician assistants, this is the type of response we have provided. I'm sure you can use this to develop some messaging. I'm happy to look over any response if you wish.

> *The Ministry of Health has developed a healthcare strategy which has several components. As part of the healthcare strategy, government will establish primary care networks, urgent primary care centres, and community health centres. More information about these initiatives can be found in the following news release:*
>
> *https://news.gov.bc.ca/releases/2018PREM0034-001010*
>
> *Initial priority was placed on addressing the shortage of general practitioners in the province. Government will fund up to 200 new general practitioners to work in the team-based care model, and provide opportunity for every family medicine resident to work in a renewed primary care system in which they can focus on patient-centred medicine. The government will also create 200 new nurse practitioner (NP) positions, and increase the number of NP education seats by 66%. It does not specifically address physician assistants (PA) in this strategy in BC.*
>
> *The introduction of a new health profession requires careful consideration and management, and significant resources in order to properly understand and address the inevitable team function issues that emerge from overlapping scopes of practice. In that regard, the Ministry of Health (the Ministry) has considered in depth the option of implementing PAs. Ultimately, government concluded that the PA role overlaps substantially with existing nursing roles, such as nurse practitioners, registered nurses with certified practice credentials, and family physician roles such as hospitalists or surgical assistants.*

The Ministry is committed to optimizing the scopes of practice of existing health care professionals to enable efficient and effective use of resources. Government's new primary health-care strategy commits to building on the best practices and solutions that already exist within the health-care system, but have yet to be fully leveraged throughout the province.

You also might find it useful to see what the Minister of Health said about physicians assistants recently during question period. Draft transcript from Hansard below, I've highlighted 'physician assistant' for ease of reading. The site link for the transcript is: https://www.leg.bc.ca/documents-data/debate-transcripts/41st-parliament/3rd-session/20181023am-House-Blues .

Draft Transcript

THIRD SESSION, 41ST PARLIAMENT (2018)

TUESDAY, OCTOBER 23, 2018

Morning Sitting

ACCESS TO FAMILY PHYSICIANS AND REFORMS TO PRIMARY HEALTH SYSTEM

S. Furstenau: And now for something completely different.

Graphs from the *MSP Physician Resource Report* indicate the total expenditure for general practice doctors has increased significantly since 2005, but the average number of patients treated per physician has dropped. The government's policy changes over the last ten years have led to more doctors, fewer working days treating fewer patients.

The data focuses on quantity of care but not quality. In many cases, doctors seeing fewer patients is a positive change, as it indicates they are spending more time with each individual. For people struggling with multiple or complex conditions, this added assistance is essential. With doctors striving to create healthier work-life balance, the policies used to address the doctor shortages of the 1970s are no longer relevant.

Family doctors play a vital role in our well-being, and they deserve a policy framework that lets them treat patients in a manageable, fulfilling and effective manner. To the Minister of Health: what concrete steps is he taking to modernize our province's approach to the doctor shortage? Has he considered a role for physician assistants in that future?

Hon. A. Dix: Thank you to the member for her question. I think at the heart what we're trying to do, particularly with respect to primary care, is bringing team-based care everywhere in British Columbia. That means doctors and nurse practitioners and physiotherapists and pharmacists and LPNs — everyone working together in teams to provide better care for patients, which is the goal in the long run. But it will also provide better work-life balance and supports for doctors working in the system, both from one another and from other professionals working in the health care. That's the first thing.

The second thing is, when I talk to doctors, one of their real concerns is the increasing time that they have to spend finding appropriate services, whether it be for mental health and addictions or for frail elderly. That's why we're putting in place one-stop shopping for doctors, for specialized services to improve both their quality of life and the quality of care and ensure they can spend the maximum amount of time during their day with patients.

[1040]

I think the third set of things that we have to do in a modern age is to greatly improve the use of digital technologies in some of our partnerships, including with great B.C.-based companies such as Telus, to do exactly that. Finally, we do need to, in these circumstances, add

and ensure they can spend the maximum amount of time during their day with patients.

I think the third set of things we have to do in a modern way is to greatly improve the use of digital technologies. Some of our partnerships, including with great B.C.-based companies such as Telus, do exactly that. Finally, we do need, in these circumstances, to add more resources. It's why we are adding more family practice doctors, more nurse practitioners, more pharmacists and other professionals to staff these teams to provide more supports. Physician assistants, which the member mentioned, could play an important role in all of that, and they are use in other provinces.

We're focusing right now on dramatically increasing the use of nurse practitioners. We've had nurse practitioners, as a result of the efforts of the former government, since 2005. However, in 2017, we were 12th and 13th in their use. We need to do better, and we will.

Let me know if there is any other information you need.

Regards,

Kathy

From: Fabian, MC HLTH:EX
Sent: December 5, 2018 1:26 PM
To: Younker, Katherine E HLTH:EX <Katherine.Younker@gov.bc.ca>
Cc: MacKinnon, Mark HLTH:EX <Mark.MacKinnon@gov.bc.ca>
Subject: PA's

Hi Katherine,

FYI as briefly discussed:
https://www.doctorsofbc.ca/news/advocating-physician-assistants-bc

Thanks for providing a generic response sentence for me relating to enquiries I have had … to do when you have time.

MC

Dr. MC Fabian FRCPC FRCSC FACS
Senior Medical Consultant CPPB
Ministry of Health

From:	MacKinnon, Mark HLTH:EX
To:	Byres, David W HLTH:EX
Cc:	Brown, Kevin HLTH:EX; MacKinnon, Mark HLTH:EX
Subject:	FW: Meeting Request - Physician Assistant Discussion
Date:	Monday, October 23, 2017 4:41:20 PM
Attachments:	FW 1020502 - IBN for Minister Meeting (Nov 26) re Physician Assistants (XREF 1012579).msg FW PSSAC Document.msg

Hi there,
Just checking whether you also received this, and whether you have any interest in meeting with them.
Kevin did some work on this a couple of years ago (first attachment). I've also attached a second document prepared by/for the Michael Smith Foundation.
Thanks,
M

From: Natalie St-Pierre [mailto:NSt-Pierre@capa-acam.ca]
Sent: Monday, October 23, 2017 4:10 PM
Cc: 'Geoff Ascent GR'
Subject: Meeting Request - Physician Assistant Discussion

Good Afternoon,
We are making outreach to you on behalf of the Canadian Association of Physician Assistants to request the opportunity to meet with you so that we can discuss the introduction of Physician Assistants (PAs) in British Columbia and to share information pertaining to their value. PAs are working across Canada in the Canadian Armed Forces and in the public healthcare system in Manitoba, Alberta, Ontario and New Brunswick. In these jurisdictions PAs are improving access to care in a cost-effective manner.
The Conference Board of Canada recently published a series of reports demonstrating the value of PAs in healthcare. I invite you to consult these reports at your leisure. Included below are links to the published reports:
http://www.conferenceboard.ca/e-library/abstract.aspx?did=8347
http://www.conferenceboard.ca/e-library/abstract.aspx?did=8107
http://www.conferenceboard.ca/e-library/abstract.aspx?did=9090
On November 6 and 7 we will be visiting Victoria. It would be sincerely appreciated if you could spare some time to meet with our National President and Executive Director. We are hosting 2 events while we are there: however, we are available all day November 6 before 5 pm and on November 7 from 9 – 1 pm. Please let me know if there is a time which would suit you.
Geoff Ingram will be following up this week but in the meantime you can reach me at 613-854-0675 or via email at: nst-pierre@capa-acam.ca
Regards,
Natalie St-Pierre
Director, Communications and Stakeholder Relations / Directrice des communications et des relations avec les parties prenantes
Canadian Association of Physician Assistants/ Association canadienne des adjoints au médecin
613-854-0675
www.capa-acam.ca

can correct our records. Please then delete the original message and all attachments. Thank you for your cooperation.
NOTE DE CONFIDENTIALITÉ : Ce message et les documents qui y sont joints sont destinés exclusivement à l'usage de la personne à laquelle ils sont adressés et peuvent contenir des renseignements protégés ou confidentiels. Toute divulgation non autorisée est strictement interdite. Si vous avez reçu ce message par erreur, veuillez nous en informer immédiatement, par téléphone en composant le 613-248-2272 ou par retour de courrier électronique, afin que nous puissions corriger nos dossiers. Veuillez ensuite détruire le message original et tout document joint. Merci de votre collaboration.

From:	Brown, Kevin HLTH:EX
To:	Siu, Raeleen FIN:EX; McLachlan, Debbie HLTH:EX; Blackie, Doug HLTH:EX; Robson, Victoria J HLTH:EX
Cc:	Anderson, Shelly HLTH:EX; Jodouin, Laurianne HLTH:EX; MacKinnon, Mark HLTH:EX
Subject:	FW: 1020502 - IBN for Minister Meeting (Nov 26) re Physician Assistants (XREF 1012579)
Date:	Thursday, November 20, 2014 1:31:40 PM
Attachments:	1020502 - Appendix A-Concept Paper.docx 1020502 - IBN - Physician Assistants.docx
Importance:	High

Here is the final package on the PA issue. Briefing Minister next week. Great team effort with Shelly and Laurianne, nicely done!

K

From: Murray, Heather HLTH:EX
Sent: Thursday, November 20, 2014 11:52 AM
To: Brown, Kevin HLTH:EX; Jodouin, Laurianne HLTH:EX
Subject: FW: 1020502 - IBN for Minister Meeting (Nov 26) re Physician Assistants (XREF 1012579)
Importance: High

FYI – final sent to the MO. Thx, H.

From: Docs Processing HLTH:EX
Sent: Thursday, November 20, 2014 11:43 AM
To: HLTH Ministers Office
Cc: Foran, Grace E HLTH:EX; Stearn, Anne HLTH:EX; Murray, Wendy HLTH:EX; O'Callaghan, Jacqueline HLTH:EX; Casanova, Tamara HLTH:EX; Docs Processing HLTH:EX; Jabs, Ryan GCPE:EX; Belanger, Matthew GCPE:EX
Subject: 1020502 - IBN for Minister Meeting (Nov 26) re Physician Assistants (XREF 1012579)
Importance: High

Hello,

Attached is the above mentioned briefing note and related document prepared by HSWD for Minister's Meeting on November 26, 2014. It has been approved by Ted Patterson, ADM, and reviewed by Anne Stearn on behalf of Grace Foran.

Jessica King
Documents Processing Unit / Deputy Minister's Office / Ministry of Health
PO Box 9639 STN PROV GOVT Victoria BC V8W 9P1
Telephone 250 952-2636

Concept Paper

Introducing Physician Assistants Into British Columbia's Health Care System

Draft for Discussion

October 24, 2014

Table of contents

INTRODUCTION

The government's priority is to ensure that British Columbians have access to timely health care services that contribute to the health of the population within a sustainable cost structure.

A key action the Ministry of Health is undertaking is to develop and implement an integrated provincial workforce strategy linked to regional and local health service area health work force plans and built on supporting both individual and team based practice, as appropriate to best meet patient needs.

As there is growing interest in a potential role for Physician Assistants (PAs) in the BC health system, this paper describes who PAs are, what they do, where they do it, the ways PAs can add value to patient-centred care.

In other Canadian jurisdictions, PAs have been added to the health care team to improve health care delivery and contribute to health services. This paper identifies where PAs could add value in BC's health care system, given BC's strategic key areas of focus for the health sector. The paper also sets out the various considerations for planning that would be required to introduce PAs in BC.

Part 1: Context

1.1 Physician Assistant – Definition and Scope of Practice

In recent years, there has been growing interest in a potential role for PAs in the BC health system. This interest has been stimulated by successful demonstration projects in Manitoba, Ontario, New Brunswick, and recent introduction of a demonstration project in Alberta. It is also stimulated by the potential 'value-add' that PAs might bring to BC's health system at a time when the province is aiming to meet the population health, patient and service priorities within the fiscal objectives of government for a financially sustainable health care system.

PAs were first introduced in the United States where they have become an established provider of medical services. In the US health system, the role of PA developed chiefly to supplement the work of physicians, to extend access to medical services, and to substitute for physicians in an expanding number of clinical tasks.

What is a Physician Assistant (PA)?
PAs are clinicians who practice medicine under the supervision of a licensed physician and work within the scope of practice of the supervising physician(s). In American jurisdictions, PAs have their own license and they require authorization of a physician to work. Typically, the supervising physician can extend a PA's scope of practice as an exercise of the physician's delegation authority.

As a result, PAs are dependent practitioners who must work in close relationship with one or more supervising physicians. They are professionals who are academically prepared in the

medical model in a university level program affiliated with a medical school, where they are educated as generalists and in a collaborative approach to health care.

What do PAs do? How do they work?
The work of a PA is clear from the name – PAs support physicians in a wide range of health care settings. They perform some of the same tasks performed by their physician supervisors within the scope of the individual PA's license and practice authorization delegated by a physician. Responsibilities may including interviewing patients, taking medical histories, conducting physical examinations, requisitioning tests/interpreting test results, diagnosing illness, counselling on health issues, assisting in surgery, performing interventions (e.g. suturing) and prescribing treatments, including medications. PA duties may also include informing and educating patients on how to manage their health and undertaking administrative tasks such as writing admission orders for patients, arranging both in-hospital and out-of-facility consultations, and coordinating referrals for other services such as home nursing.

Supervising physicians and PAs work together interdependently. Their relationship is one of mutual trust and respect in the clinical setting. The decision about the extent of clinical tasks a PA can do is determined by the supervising physician's assessment of the PA's clinical competencies, skills and experiences within the supervising physician's practice setting. What a PA does in practice depends on the setting in which the PA works, the PA's experience and the responsibilities delegated by the PA's physician supervisor.

PAs also mirror the supervising physician's practice in terms of practice venue, which may include office, hospital, residential care facilities, community care clinic and community health centres, rehabilitation centres, and may work on call as part of their duties. In some US settings, PAs work in satellite offices with the supervising physicians working in different communities.

Scope of practice
A PA's scope of practice is determined on an individual basis and formally outlined in a practice contract or agreement between the supervising physician and the PA, and where relevant, the facility where the PA will work.

- Activities may include conducting patient interviews, histories and physical examinations; diagnosing and treating illnesses, performing selected diagnostic and therapeutic interventions or procedures; and counseling patients on preventive health care.
- A PA's scope of practice may also include patient education, research and administrative services.

As a dependent practitioner, all tasks must be within the scope of the PA's license and as delegated to the PA by the supervising physician. The type of work delegated, and the extent of direct supervision of the PA, is based on the physician's assessment of the PA's individual competencies, skills and experience in that practice setting. Further, only work within the physician's own scope of practice can be delegated to a PA. For example, PAs are able to provide only those medications that the supervising physician would normally prescribe, and that the supervising physician has assessed the PA as competent to provide under delegation. Typically, the relationship between the PA and the supervising physician is the essential

determinant of each PA's individual clinical role, within the context of the PA's license, competencies and the PA scope of practice.

In general, PAs see the same types of patients as a physician but services provided by PAs to patients are more routine and less complex than those provided by the physician. Specialized procedures (e.g., insertion of central access lines and chest tubes, invasive diagnostic procedures, ambulatory surgery) performed by PAs may be specific to a particular clinical field or setting, and not unlike to those undertaken by physicians PAs undertake these procedures only when they have had adequate formal or informal postgraduate training.

There are different levels of supervision: *prospective* where the physician and PA decide the scope of the PA role before the working relationship begins; *concurrent* where the role evolves continuously with the physician providing supervision and support simultaneously, either by being available side by side for regular consultation, or via phone, telemedicine or distant supervision – not necessarily onsite; and *retrospective* where patient quality measures are reviewed at the end of each shift or cycle of care.

Function(s) that PAs can fulfill as part of their role

Physician extender – clinical tasks are delegated by physician supervisor(s) as appropriate to PAs education, experience, formal and informal training, and physician experience in the clinical area. As described in the above section, daily responsibilities may include a broad range of clinical activities. PAs may also perform administrative tasks, including: write admission orders for patients and arrange both in-hospital and out-of-facility consultations, complete dictations, and assist with medical forms.

Skilled interventions –Examples of interventions PAs have done in other jurisdictions include: advanced airway management, intubation, central lines, lumbar puncture, fracture/dislocation reduction and immobilization, nasal packing, removal of ocular foreign bodies, suturing and incision & drainage.

Care coordination – coordinate with other team members and/or other services. Examples include: assist with triage of referrals, see and evaluate consultations for pre-operative and post-operative follow ups, obtain patient consents for treatment, assist with research and development of patient education materials. Additionally, PAs may coordinate patient appointments, schedule follow-up visits, visit patient at home or in residential care.

Patient education – PAs may also educate patients and provide information specific to a patient's condition or illness including how patients can better manage their own care away from a clinical setting, treatment plan, diagnostic tests, and/or follow-up visits.

1.2 PAs in Canada

Approximately 200 PAs are practicing in the publicly funded health care system across Canada. Approximately 130 PAs practice in the Canadian military. The number of PAs practicing in private organizations, primarily in resource extraction industries is unknown.

In 2003, Manitoba was the first province to employ a PA. The first non-military graduates from Canadian university PA programs graduated in 2010.

Certification
The Physician Assistant Certification Council of Canada (PACCC), a Council of the Canadian Association of Physician Assistants (CAPA), administers and oversees certification of PAs in Canada. The Certified Canadian Physician Assistant (CCPA) designation is recognized as the national standard and is obtained on successful completion of the Physician Assistant Entry to Practice Certification Exam (PA Cert Exam) or granted upon validation of being a US graduate of an Accreditation Review Commission (ARC) program and certified by the National Commission of Certification for Physician Assistant (NCCPA), and a declaration that the PA's name appears on the National Physicians Data Bank (NPDB) Report.

To maintain CCPA designations, PAs must complete 250 continuing professional development credits in a five-year cycle. While Canadian certification is not a requirement for practice in any province (i.e. it does not confer a license to practice as a PA), most employers deem it a requirement for employment.

Education and Accreditation
University of Manitoba established a PA education program with a master's degree in 2008. Two undergraduate programs were established in Ontario; McMaster University in 2008 and the Consortium for PA Education program, run by University of Toronto, Northern Ontario School of Medicine and Michener Institute in 2010.

The Canadian Forces PA program is restricted to serving members and grants a degree in collaboration with the University of Nebraska Medical Center.

In 2009, CAPA, in conjunction with the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada and the Canadian Family Practice College developed a national competency standard based on the CanMEDS framework. All four PA education programs are 24 to 25 months in duration and deliver curricula that support the CAPA's scope of practice and national competency profile for PAs.

Accreditation of the four Canadian PA education programs is provided through the Canadian Medical Association's (CMA) Conjoint Accreditation Services.

Regulation
Four provinces have regulatory arrangements that allow PAs to practice. PAs working in these provinces are granted permission to practice by way of their respective medical act, which allows

a physician to delegate to a qualified individual. Of the four jurisdictions, Manitoba and New Brunswick regulate practice and license PAs through their Colleges of Physicians and Surgeons. Alberta has a voluntary registry for PAs and PAs practice under the authority of a regulated physician. Ontario uses the delegated authority provision to authorize PAs to practice.

Employment
In Canada, PAs are typically employed by a hospital or organization such as community health centre, community clinic, or physician group practice. It is unknown how many individual physicians employ PAs currently. Average salary for PAs employed in Canadian provinces varies from $85,000 to $115,000.

Billing
Provincial fee schedules do not allow billing for services provided by PAs at this time (i.e. PAs cannot obtain a billing number and their employers may not submit billings for services the PAs provide).

Current status by province

Manitoba

In 2003, two PAs were introduced in a pilot project in orthopedic surgery in Concordia Hospital in Winnipeg, Manitoba. Since then, PAs have been introduced in most clinical areas in acute care hospitals and primary care. In recent years, new positions for PAs were created outside of Winnipeg in the regional health authorities: in emergency departments, surgery and primary care in Dauphin, Portage la Prairie, MacGregor, Selkirk, Thompson, Brandon and Winkler.

Currently, approximately 50 PAs work in acute and primary care. The starting salary range is $80,000 to $100,000. Additional salary applies to positions that involve shift work, on-call responsibilities and overtime.

PAs are regulated through the College of Physicians and Surgeons of Manitoba. PAs are associate members of the College regulated under the *Medical Act*.

In 2008, Manitoba opened a two year Master's level PA Education Program at University of Manitoba and accepts 12 students each year.

Ontario

In May 2006, Ontario announced the Physician Assistant role as part of an overall human resources strategy. The PA initiative, co-led by the Ministry of Health and Long Term Care and the Ontario Medical Association, introduced PAs in six demonstration projects in interprofessional teams in emergency departments in 2007. In 2008, 50 PAs were introduced in health care teams in 20 hospitals in areas including internal medicine, emergency, orthopaedics/orthopaedic surgery, general surgery, complex continuing care, five PAs in primary care centres, and six PAs in diabetes and long term care directly employed by physicians. The

PA demonstration projects in hospitals, emergency departments, and primary care were expanded around the province.

Currently, 140 PAs are working in primary care and acute care throughout Ontario. The starting salary range is $75,000 to $85,000.

PAs are not regulated as a self-regulating profession in Ontario. The Ontario *Regulated Health Professions Act* which governs the medical profession, permits delegation of controlled acts through medical directives.

In 2008, McMaster University opened a PA education program and accepts 21 students; in 2010, the consortium of University of Toronto, Northern Ontario School of Medicine and Michener Institute opened a PA education Program. Both programs are two year undergraduate programs.

New Brunswick

The New Brunswick Department of Health announced an employment initiative for PAs in emergency departments in late 2010. Two PAs began working in the emergency department of Dr Everett Chalmers Regional Hospital in Fredericton in early 2012. The starting salary range for PAs in New Brunswick is $71,000 to $86,000 based on years of experience. PAs are regulated through the College of Physicians and Surgeons of New Brunswick.

Alberta

In October 2013, Alberta Heath Services (AHS) announced a two-year PA demonstration project to integrate PAs in health care teams in high needs locations throughout the province to evaluate the impact of the profession as functioning members of the collaborative health care team. The Project is expected to enhance AHS's ability to deliver safe and effective care to patients throughout Alberta and to help AHS develop sustainable workforce strategies in the future. Beginning in August 2013, ten PAs have been hired in Milk River, Bassano, Beaverlodge, Red Deer, Calgary and Edmonton. The starting salary range is $79,500 to $99,500.

Other provinces

At this time, the remaining provincial/territorial Ministries of Health have either no official position or no plan to include PAs as part of their health care teams. However, in a recently published article, the Canadian Association of Physician Assistants (CAPA) notes discussions regarding the introduction of PAs are occurring in Nova Scotia, Prince Edward Island, Newfoundland and Labrador, and Quebec.

See **Table 1** for an At-a-Glance overview of PA status in Canadian provinces.

See **Appendix A** for an environmental scan summarizing United States, Canadian, and international jurisdictions' experience with PAs as well as a sampling of research evidence supporting the PA role.

Table 1. At-A-Glance: Physician Assistants in Canada

	Ontario	Manitoba	Alberta	New Brunswick
Strategic Approach	In 2006, Ontario announced the Physician Assistant role with the creation of HealthForceOntario[1], government's overall health human resources strategy. The PA initiative, co-led by the Ministry of Health and Long Term Care (MOHLTC) and the Ontario Medical Association (OMA), was launched in two phases: 1) 2007 – 6 PAs introduced in demonstration projects in interprofessional teams (including nurse practitioners) in emergency departments 2) 2008 – 50 PAs introduced in health care teams in 20 hospitals in areas including internal medicine, emergency, orthopaedics/orthopaedic surgery, general surgery, complex continuing care; 5 PAs in primary care centres, and; 6 PAs in diabetes and long term care directly employed by physicians. Certified PAs were recruited from retired Canadian Forces-trained and US-trained PAs, and international medical graduates who completed a PA competency based assessment and integration process. A PA Education Program in McMaster University in Hamilton started in 2008. Since 2008, demonstration projects continued to expand in hospitals, emergency departments, and primary care around the province.	In 2003, first two formally recognized PAs introduced in orthopaedic hip and knee surgery at Concordia Hospital in Winnipeg in response to increased demands on orthopaedic surgical services. Since then, PAs were introduced in emergency departments, many clinical areas in acute hospitals and in primary care in Winnipeg and in acute or primary care in all health regions in Brandon, Selkirk, Dauphin, Portage la Prairie, MacGregor, Winkler, and Thompson. Since first graduates in 2010, Manitoba retains 87% of 46 graduates from the University of Manitoba PA program.	In 2013, Alberta Health Services (AHS) announced a 2 year demonstration project integrating PAs into several AHS facilities to evaluate the impact of the profession as functioning members of the collaborative health care team. The project is expected to enhance AHS' ability to deliver safe and effective care to patients throughout Alberta and to help AHS develop sustainable workforce strategies in the future. Ten PAs are evenly distributed in high needs locations throughout the five health zones.	In 2012, introduced 2 PAs in emergency department following amendment of *The Medical Act* in 2009 to include and allow licensing of PAs.

[1] HealthForceOntario is funded by the Ministry of Health and Long Term Care and Ministry of Training Colleges and Universities in Ontario.

	Ontario	Manitoba	Alberta	New Brunswick
Current Workforce	140 PAs throughout the province in a variety of health care settings in acute care in internal medicine, emergency, orthopaedics/orthopaedic surgery, general surgery, complex continuing care, and primary care in Family Health Teams, Community Health Centres, Aboriginal Health Access Centres, and long term care.	Approx. 50 PAs throughout Manitoba in acute care (emergency department, cardiology, oncology, general surgery, orthopaedics, plastic surgery, neurosurgery, rehabilitation, internal medicine, vascular medicine) and primary care.	10 PAs in specialties including ICU, surgery, orthopaedics, stroke rehabilitation, and hospital medicine in urban areas (Edmonton, Calgary and Red Deer) and primary care in rural areas (Milk River, Bassano, Beaverlodge).	2 PAs in emergency department of Dr Everett Chalmers Regional Hospital in Fredericton
Regulation	Unregulated. The Ontario *Regulated Health Professions Act* governs the medical profession and permits delegation of controlled acts through medical directives.	Regulated by the College of Physicians and Surgeons of Manitoba (2009) as associate members under the *Medical Act.* Since 1999, Manitoba employs clinical assistants. In 2003, the *Medical Act* recognized certified clinical assistants to be employed in medical and surgical specialties. In 2009, legislation changed to recognize title of physician assistant as distinct from clinical assistant.	Unregulated. In 2010, College of Physicians and Surgeons of Alberta (CPSA) passed a bylaw allowing PAs to operate under the responsibility of a regulated member of the College. Minister of Health intends to recommend to Cabinet that the *Health Professions Act* be amended to include PAs as a regulated profession registered/governed by the CPSA	Regulated by the College of Physicians and Surgeons of New Brunswick under *Medical Act* (2009).
Education	McMaster University and the consortium of University of Toronto, Northern Ontario School of Medicine & Michener Institute established 2-year undergraduate programs in 2008 and 2010. McMaster accepts 21 students annually. University of Toronto accepts 22 students annually and has a focus on rural, remote and underserved communities.	University of Manitoba established Master's level PA education program in 2008 and accepts 12 students annually.	-	-
Payment Model(s)	Initially, funds for demo projects flowed directly from	Salaried by regional health authorities – in	Salaried by Alberta Health Services.	Salaried by health authority.

	Ontario	Manitoba	Alberta	New Brunswick
	MOHLTC to the lead agency (Ontario Hospital Association, OMA, Association for Community Health Centres) Currently, paymaster for all PA positions is HealthForceOntario Marketing and Recruitment Agency, and funds go to the employers (physicians) who pay the PA directly. The "integration plan" for funding PAs in regular streams of clinical funding and other opportunities includes multiple models: 1) Ministry funds extension of demonstration projects, Family Health Teams, specific physician-PA funding arrangements; 2) Hospital global budgets in acute care; 3) Physician-employed PAs in long term care (supervising physicians bill OHIP for services and receive a per diem from the Long-Term Care home for Medical Director duties). [2] Career Start program – 50:50 cost sharing for 2 years for new grads in 2013 in priority areas; cost sharing for 1 year for 2014 grads.	hospitals, rural and urban FFS practices.		
Starting Salary / Contracted or Employee	$75,000 – 85,000 Contracted and Hospital Employees	$75,000 – 100,000 Employed by regional health authorities	$79,500 – 99,500 Employed by Alberta Health Services	$71,000 – 86,000 Employed by regional health authorities
Unionized (Yes/No)	No	No	No	No

[2] Neither the PA nor the employer (supervising physician or otherwise) may bill OHIP for the PA's work. However, employers may use OHIP billings as a revenue source for their portion of the cost share for government-supported PA positions. For employers who do not access or qualify for government-supported PA project funding, the revenue stream that would pay for the PA is likely to involve OHIP billings.

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Appendix A

Environmental Scan

History and Experience with Physician Assistants

History of the Physician Assistant role

The first mention of physician extenders in the literature originates from Germany where the military used “felders” as medical assistants. Peter the Great introduced “medical assistants” into the Russian military in the 17th century and China utilized over 1.3 million "barefoot doctors", an early iteration of the PA, to improve the delivery of health care in the 1960’s.

However, the predominant and sustained growth of the PA profession has occurred in the United States.

UNITED STATES EXPERIENCE

The history and evolution of Physician Assistants (PA) in the United States is well documented.

PAs were introduced in the mid-1960’s to address the nationwide shortage and maldistribution of physicians in primary care and to increase access to health care for people in under-served areas but their use subsequently spread to other settings such as hospitals, emergency departments, nursing homes and clinics, and into specialty areas such as surgery. In the early years, medics trained as first responders in the Viet Nam War provided a “ready-made” supply of providers who were seeking opportunities to utilize their skills.

Initially, the role consisted of helping provide basic medical services to patients under the supervision of a licensed physician. They were legally required to work with the physician. Today, their role has evolved to encompass a range of comprehensive medical responsibilities, and together with the physician, they are considered to make up the “day to day working dyad in virtually all primary care practices”.

PAs are trained to perform many of the uncomplicated core primary care medical tasks that a physician would otherwise perform. However, it is up to the supervising physician to decide on what level of responsibility the PA will exercise, and this will be based on their level of experience, skill level and the type of working relationship they have with the physician. Institutions where they practise and are employed have the right to limit the scope of the PA’s activities.

In essence, current PAs in the USA are fully trained professionals who take on a role equivalent to that of a medical resident/junior doctor for their entire career.

PAs are now a major component of the US health care system. The scope of practice is in accordance with State by State legislative requirements in the US. PA practice ranges from general medicine in under-served rural and urban settings to highly specialized secondary and tertiary care, for example, at such prestigious hospitals as the Mayo Clinic with over 250 PAs, and the Johns Hopkins Hospital, with more than 300 in their system.

On the other hand, NPs practice across the continuum in various settings, where they assess, diagnose and manage a variety of acute and chronic conditions NPs are increasingly setting up nurse-led clinics in secondary settings such as outpatient or drop-in clinics (US, UK) or primary care (UK NHS walk-in centres; nurse-led clinic, US and Ontario). There are approximately 250 nurse-led clinics in the US; while nurse-run, many clinics recruit physicians to come in on appointed days as part of their professional team, e.g. internist, psychiatrist, pharmacist).

It is important to note that not all PAs perform all tasks and activities. Activities performed by the PA are subject to government legislation and regulations, the policies of the PA's employer, and, most importantly, the direction of the supervising physician. Specialized procedures (e.g., insertion of central access lines and chest tubes, invasive diagnostic procedures, ambulatory surgery) are specific to a particular clinical field or setting, not unlike those undertaken by physicians and PAs undertake these when they have had formal or informal postgraduate training.

Education programs to train for PAs were also introduced in the US in the mid 1960's. By 1971, the US government was providing funding to expand the PA training programs and the American Medical Association started work on national certification and codification of PA practice characteristics.

Today, the United States has 170 accredited PA education programs and the medical and surgical services delivered by PAs are covered by Medicare, Medicaid, TRICARE (program that provides civilian health benefits for military personnel, military retirees, and their dependents, including some members of the Reserve Component), and nearly all private payers.

Education focus

From the inception of PA education programs in the US in the 1960s until now, the aim has been to offer intense medical education to people with or without previous medical experience. Graduates are trained to perform many of the tasks previously reserved for physicians, enabling them to assist overworked physicians and extend services to underserved patients. Programs provide a broad based medical education, with a generalist focus, that graduates can apply to a wide spectrum of medical areas and all sections of the population.

PA educational programs have been innovative in medical training methods, incorporating a focus on distance learning methods, problem based and case based types of education, expanded geriatric assessment and a return to medical home visits, an emphasis on broader patient education and a focus on the development of research skills. There has also been an integration of a strong psycho-social emphasis to ensure that PA graduates have competent interpersonal skills.

The typical PA program is 24-27 months long with 1 year classroom and laboratory instruction in the basic medical and behavioral sciences (such as anatomy, pharmacology, pathophysiology, clinical medicine, and physical diagnosis), followed by clinical rotations in internal medicine, family medicine, surgery, pediatrics, obstetrics and gynecology, emergency medicine, or geriatric medicine.

Competition for PA training positions in the US is intense. The majority of students accepted into PA programs have approximately 45 months experience working in the health care system prior to admission to the training program, an element that educators state is a very important indicator for successful attainment of competency as a PA.

Educational programs are certified by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). Upon graduating, PAs write the Physician Assistant National Certifying Examination (PANCE). The exam was developed by the National Commission on Certification of Physician Assistants (NCCPA). Only candidates who have graduated from an accredited PA program are eligible to take the exam. All states require passage of the PANCE for state licensure but forty-six states do permit new graduates to practice prior to passing the PANCE.

Once certified, the PA must complete a continuous six-year cycle to maintain certification. In addition, they must annually earn 100 approved CME hours, reregister their certificate with the NCCPA (second and fourth years), and by the end of the sixth year, recertify by successfully completing either the Physician Assistant National Recertifying Examination (PANRE) or Pathway II.

Several programs have stood out over time as leaders in PA education. One of particular note for BC is the MEDEX Northwest at the University of Washington.

MEDEX Northwest, the PA Program in the School of Medicine at the University of Washington, is a regional program based in Seattle that has educated PAs for over 40 years. MEDEX Northwest currently operates four distributed classroom sites as a strategy to better serve potential students throughout the five-state northwest service region (includes Alaska), and ultimately, to best serve the patients in those communities. Clinical training takes place throughout the service region.

The MEDEX Northwest program is committed to educating experienced health personnel from diverse backgrounds and provides a broad curriculum that focuses on primary care with an emphasis on underserved populations.

MEDEX Northwest accepts approximately 125 students including Canadians each year for undergraduate and Master's level degrees combined.

Regulation

PAs are licensed in all 50 states by their state Medical Board. The Medical Board rules define the medical functions a PA may perform under the supervision of a licensed physician. Requirements for licensure as a physician assistant include:

- Graduation from an approved PA program
- Verified practice history
- Passage of the NCCPA National Board Exam
- Verification of Federation of State Medical Boards disciplinary history (not yet required by all states).

In addition to state medical boards, there are multiple organizations that oversee the profession.

- The Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) protects the interests of the public and PA profession by defining the standards for PA education and evaluates PA educational programs within the United States to ensure their compliance with those standards.

- The National Commission on Certification of Physician Assistants (NCCPA) is the credentialing organization for physician assistants in the United States. Established as a not-for-profit organization in 1975, NCCPA protects the public by assuring that certified physician assistants meet established standards of knowledge and clinical skills upon entry into practice and throughout their careers. Every U.S. state, the District of Columbia and the U.S. territories rely on NCCPA certification criteria for licensure or regulation of physician assistants.

- The Association of Physician Assistant Programs (APAP) is the national organization in the United States representing PA educational programs. APAP's mission is to pursue excellence, foster faculty development, advance the body of knowledge that defines quality education and patient-centered care, and promote diversity in all aspects of physician assistant education.

- Lastly, the American Academy of Physician Assistants (AAPA) is the only national professional society that represents all physician assistants in every area of medicine. It has 57 chartered chapters in 50 states, the District of Columbia, Guam, and the federal services. Their mission is to promote quality, cost effective, accessible health care, and to promote the professional and personal development of physician assistants. They also collect and analyze data to track the growth and changes in the physician assistant profession. The data are collected from various projects that are maintained throughout the year by the AAPA Division of Data Services and Statistics. The most important of these activities is AAPA's Annual Census Survey of PAs.

Integration of PAs into the Health Care System

In the US, demand for PAs is directly proportional to the demand physicians make for them. Benefits cited by physicians include: decreased workload, increased productivity for physicians, improved quality of care, decreased patient wait times, better patient education, and cost-effectiveness.

Health Maintenance Organization (HMOs) in the US recognized early on that using PAs could be cost effective as most PAs in primary health care settings can provide 80% or more of the services provided by a family physician at the same level of quality. At the same time, the

average salary of PAs working full time in primary care is significantly less than the salary for a primary care physician for providing the same care.

Practice settings in the United States

Early PA training programs aimed to prepare PAs for roles in the primary care sector. Estimates are that in the early years 43 per cent of PAs worked in primary care areas of family medicine, general internal medicine, and general paediatrics, but that figure began decreasing in the mid-1970s with the emergence of roles for PAs in subspecialty practice and surgical assisting.

The 2010 AAPA Physician Assistant Census Report found 24.3 per cent of PAs worked in family medicine; 26 per cent in surgery, with orthopaedics and cardiovascular specialties most common; 5.8 per cent in paediatrics; and 19.5 per cent in internal medicine with cardiology, oncology and gastroenterology specialties most common.

In the hospital environment, PAs tend to practise in mainly specialty and sub-specialty areas such as neonatology, surgery, intensive care and other specialties. They have been shown to be effective in assuming those responsibilities normally assigned to residents and house officers. Typically their duties would encompass the standard tasks for a house officer. However, if the PA's experience and training warrants it, the hospital credentials committee can approve an extension of those duties. Examples include duties associated with bone marrow aspiration, thoracentesis, lumbar puncture, coronary angiography, joint injections, liver biopsies, invasive radiological procedures and other technical procedures.

PAs were more likely than NPs to work in surgery and emergency departments. Also, in the US, PAs appear to be moving to the more lucrative procedural or technically oriented specialty work, where high volumes of routine work can easily be delegated to a PA specifically trained for these tasks. For example, the Mayo Clinic and the John Hopkins Hospital make extensive use of PAs.

PA practice in US military service

Battlefield medics and naval surgeon's assistants have a long history. Advanced practice by military medics led directly to the creation of the PA role, first within the US military and then in the civilian health system. The scope of practice of military PAs covers a number of areas and specialities.

Similar to the civilian PA role, military PAs can manage about 80 per cent of the patients with disease or injury seen by the leading physician. On average, the PA will see about 25 patients a day, reducing waiting time and pressure on the physician.

The Veterans Health Administration (VHA) System in the US employs the largest number of PAs, providing care to over 6 million discharged veterans. The VHA PAs work across medical services including surgery, mental health and other services and care is mostly provided to the elderly with significant chronic disease. The care is usually inpatient and specialist oriented. About 31per cent of the VHA PAs had previously served in the military.

Nurse practitioners

In the US, the key issue for NPs in recent years has been empanelment by managed care organizations and insurance carriers, that is, the ability to contract with and obtain their own provider numbers for reimbursement from third party payers. This issue is related to both access and visibility. Empanelment provides a major impetus for NPs to seek out patients in traditionally underserved communities and neighborhoods. Empanelment also permits appropriate counting of the services provided by NPs, which now are often reported as being provided by supervising physicians. As a result, NPs' services are often significantly underestimated because they are recorded as being provided by their collaborating physicians. (In many US states, despite being licensed as autonomous professionals, NPs are still required to operate under a delegated practice model to be able to bill for services. Only 16 states allow NPs to bill directly).

CANADIAN EXPERIENCE WITH PHYSICIAN ASSISTANTS

The Canadian experience with PAs has been very different than in the US and only spans ten years in the publicly funded health care system.

Brief History and Role of Physician Assistants

Early type medical assistants have been part of the Canadian Forces Health system for over 100 years. They have origins with sick-berth attendants working in the Royal Canadian Navy in the 1900s and in other services throughout the 20th century. In 1984, the Canadian Armed Forces adopted this model and labeled these advanced trained medics as PAs. These senior-level medical personnel provide primary care to armed force members and in some cases to civilians in remote operations and on military missions.

In the late 1980's, professionals working under a range of titles, but performing functions similar to that of a PA, were being added to Canadian hospital health care teams. Health care managers in Canada pointed to the medical manpower shortage across Canada as well as the changes to the resident training programs and contractual agreements restricting the hours of work for residents as the primary reasons for the introduction of these "alternative or complementary" providers to the health care team.

The term 'physician extender' was used to describe any provider who performed medical diagnosis and treatment under supervision or delegation of function from a licensed physician. Several locations used registered clinical assistants (RCAs), with functions similar to PA or a scope of practice more similar to a house medical officer or medical resident. Advance practice nurses working as first assistants were often included in the description of physician extenders, as well as nurses working in remote locations, and in particular nurses working in extended roles providing services in First Nations communities.

Manitoba began officially using registered clinical assistants (RCAs) around 1999, when the Winnipeg Regional Health Authority employed 14 RCAs in their tertiary hospitals, twelve of whom were international medical graduates (IMGs).

Alberta also began using clinical assistants in the late 1990's. In Calgary, all clinical assistants were IMGs who had been assessed by the Alberta IMG program to be 'resident ready' and in Edmonton, the CAs were also IMGs who were selected following a 4 month assessment and orientation program. CAs working in this restricted practice environment, worked under a special license by the Alberta College of Physician and Surgeons.
In May 2003, PAs were included in the Canadian Medical Association's (CMA) conjoint accreditation process.

Since 2005, the PA Certification Council of Canada (PACCC), which is an independent council of the Canadian Association of Physician Assistants (CAPA), is responsible for the development of PA national standards and the administration of PA certification exams in Canada.

Education
In conjunction with the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada (RCPSC) and the Canadian Family Practice College (CFPC), CAPA developed a national competency standard based on the CanMEDS Framework in 2009. PACCC has been working closely with the RCPSC and the CFPC to facilitate alignment of continuing professional development (CPD) programs for physicians and PAs. PACCC works in conjunction with the CPFC for CAPA members to track their CPD status.

Until 2008, the military program at the Canadian Forces Medical Services School, located at CFB Borden in Ontario, was the only PA training program in Canada. It grants a degree in collaboration with the University of Nebraska Medical Center. There are now three Canadian university programs training PAs; University of Manitoba, McMaster University, and the Consortium for PA Education from University of Toronto, Laurentian University and Michener Institute in Ontario.

EXPERIENCE FROM OTHER COUNTRIES

Most international PA trials to date are pilots that have modelled their PA health worker role on the USA model. Countries where US-trained PAs have been imported to trial the role include United Kingdom (England, Scotland), Australia, and New Zealand.

In contrast, The Netherlands chose to build their PA career through governmental mandate with assistance from US consultants. In 2013, they celebrated 10 years of success which now includes 5 PA programs, over 800 PAs and full regulation.

UK/Scotland

Like the USA, one of the main drivers for exploring physician support roles in the UK, was shortages of doctors, or reductions in availability of "doctors hours" as a result of the European Working Time Directive (EWTD) and recruitment. UK also notes PAs were recruited in response to problems with recruitment and retention of nursing and other health professionals.

The UK, Department of Health, conducted a PA trial in a variety of settings, in two phases. Phase 1 took place in 2003: two general practices in an under-serviced urban area employed US-

trained PAs on a trial basis (appointed for a fixed-term contract of two years and provided a salary of approximately $61,460 USD plus relocation costs). In Phase two in 2004, a further twelve PAs were employed and deployed in general practices, accident and emergency departments, and GP referral centres. As the PAs were distributed across primary and secondary settings, the range and complexity of their tasks differed.

Findings of the UK trial project:

An evaluation of the pilots undertaken in 2005 by the University of Birmingham found:

- There was high patient satisfaction arising from continuity of care by PAs in primary care
- Patients appreciated PAs good communication skills
- There was considerable similarity between the work that could be done by doctors (GPs and medical residents in various stages of their training), PAs and NPs
- PAs in the pilot were confident, experienced and proactive (authors note that might not be representative of all PAs)
- Some PAs in the pilot project felt hindered by being unable to prescribe
- The PA-supervisor relationship was difficult to maintain if there was a lack of regular contact
- It was most helpful if PAs had well-honed skills in the clinical area they were working in
- PAs fitted in best where the organisation was prepared and a good induction was provided
- Although PAs had lower salary costs when compared with doctors, in some cases they had longer consultation times and generated a lower volume of activity.

In 2006, the UK Department of Health produced *The Competence and Curriculum Framework for the Physician Assistant,* revised in 2010. The document sets the standards for education, training and assessment of PAs in England.

Training
Training for PAs is currently being delivered by the University of Aberdeen, University of Birmingham, and St George's Medical School at the University of London. Applicants need a science-orientated first degree; health professionals in nursing, physiotherapy or working as a paramedic may also apply. Programs are usually developed in conjunction with the local/regional NHS organizations.

Registration
All practicing PAs are recommended to register on the PA Managed Voluntary Register.

Regulation
PAs aim to have statutory registration in the future; work is underway to facilitate this.

Scotland trial project
In Scotland, the NHS ran a pilot from November 2006 to October 2008. Fifteen US-trained PAs worked in Scotland at some period during those 24 months in four health boards in a variety of settings: primary care, out of hours clinic, emergency medicine, intermediate care, orthopedics, and an acute receiving unit. Pilot settings were not based on areas of clinical need.

Findings of the Scotland PA trial project:

Safety:
PAs appeared safe when working under medical supervision. All patients interviewed were satisfied with PAs, several noting that they appreciated PA's communication skills.

Effectiveness:
PAs' thought they had not been able to work to the scope and level they would do in America. Inability to prescribe was a hindrance; this was more of a hindrance in primary care and the out of hours clinic than in emergency medicine and other hospital settings.

PAs usually spent longer time with patients as patient education was reported as a feature of PA training. PAs were reported to provide continuity in busy settings and to be an educational resource for other staff. Most interviewees reported PAs were working in a range from similar to a nurse practitioner to similar to a mid-level/generalist doctor.

The valued distinctive features of PAs were: generalists with a background of medical training, confident and autonomous within their scope of practice, can do differential diagnosis, communication skills, confident in dealing with uncertainty.

Medical supervision arrangements varied from close to formal/ distant relationships. PAs reported working most effectively, and were most satisfied, where there was a distinct gap in a team that they felt they could fill; they were less able to do this in primary care, compared with other settings, it is reported there was greater overlap with nurses in primary care and more confusion regarding what PAs could/should do.

Cost-effectiveness:
Teams noted that PAs brought a level of skills and attitudes that overlapped with other roles. Thus PAs were described as complementing team skill-mix, rather than as a potential direct replacement for other staff members.

There would be costs in developing education, accreditation and support structures. The time spent by supervising doctors, with PAs, was also noted as a cost.

Australia

Similar to other countries, Australia looked to trials of PAs in response to medical workforce shortages.

The first trial began in 2008, initiated by the South Australian Department of Health, where four US-trained PAs were employed in three urban teaching hospitals, in placements that were identified as areas of clinical need:

- Two PAs in the department of surgery at Queen Elizabeth Hospital
- One PA in the department of anaesthesia at Royal Adelaide Hospital, and
- One PA in the paediatric Outpatients Clinic at Flinders Medical Centre.

Evaluation of the trial conducted by an independent consultant found that even though governance frameworks were established, the Steering Committee had to delay implementation by 6 months because of unforeseen issues, largely around limited understanding of the role of the PA in an Australian context and creating employment contracts that specified remuneration. At the Queen Elizabeth Hospital, it took 13 months to establish a policy that allowed the introduction of PAs.

Scope of practice was a major hindrance throughout the trial as it was difficult obtaining authority for the PAs to prescribe medications and order radiology tests. As such, PAs were not able to carry out tasks for which they were certified in the US. Recruitment difficulties also impeded start up.

Findings of the South Australia trial:

The evaluation findings were largely descriptive and report that the three PAs made a positive contribution:

- Waiting lists decreased, increases in patient throughput, PA involvement in audit processes identified compromised patient care which resulted in amended protocols.
- Patients were either satisfied or very satisfied with care provided.

The consultant also noted nursing staff were concerned about impacts on career opportunities, believing PA roles could be performed by NPs with the appropriate training resources and time, and PAs potentially competed for work currently undertaken by specialist nurses.

Consultants concluded it is difficult to ascertain whether improvements observed from the trial were due to the unique skills of the PA, the simple presence of additional staff members, or other factors.

In Queensland, a 12-month pilot was established in 2009 to assess the effectiveness of five US-trained PAs distributed across four sites, including rural and remote areas, and both primary and secondary care settings:

- One in the Interventional Cardiology Unit of Princess Alexandra Hospital in Brisbane
- Two at the Cooktown Multi-Purpose Health Service serving an aboriginal population
- One in the emergency department at the Mt Isa Hospital, and
- One at a GP clinic and local hospital at Normanton.

PAs were recruited for their demonstrated experience and resilience in dealing with new situations. They were remunerated at a salary equivalent to that of an NP.

Findings of the Queensland trial:

Similar to the South Australia trial, there were delays in setting up the Queensland trial: recruitment was made difficult by budgetary constraints and barriers experienced were similar to the SA trial. Early on, PAs needed to become familiar with differing scopes of practice and patterns of work between Australia and the US, and with different medication names, doses and

laboratory values. Later, supervisors ran into the need for a regulatory framework, as PAs were restricted in practice by not having a Medicare provider and prescriber number – an obstacle also noted in the SA trial.

Evaluation findings note an increase from 32 per cent to 50 per cent in the proportion of staff (pre and post-staff survey responses) who felt that the PA role complemented the health care system and existing positions.

Education- Australia
The University of Queensland launched a PA programme in 2009 with an enrollment of 20 students; however the program was subsequently closed to students in 2011. This decision was based on a lack of support from the Dean of School of Medicine as well as uncertainty about the future of a PA workforce in Australia (and the associated financial risk).

As of 2014, only one other Australian PA program exists at the James Cook University School of Medicine in Townsville. A number of other institutions are considering a PA program however their decisions are on hold pending the creation of a country-wide regulatory process.

New Zealand

A 12 month trial with two US trained PAs in general surgery was undertaken by the Counties Manukau District Health Board in 2010. Evaluation findings found that PAs had a positive impact on operating room efficiency and productivity, patient safety was not compromised, PAs improved the speed of treatment by taking on a first-responder role in emergencies, PAs adopted a range of roles and activities which extended beyond what was formally agreed at the start of the trial, and staff members, specifically nurses, who worked with PAs reported that PAs improved their teams' communication, teamwork, organisation, job satisfaction, and trust while reducing stress levels and workload.

Health Workforce NZ (HWNZ) has been conducting a second PA pilot focused on primary and ambulatory care. Currently 7 US trained PAs are completing two years of service in small cities and towns. Six PAs are assigned to the Hamilton area in the central area of the North Island and one PA is working in a rural emergency room in the community of Gore on the South Island. HWNZ is working with the Medical Council of New Zealand and the New Zealand Medical Association to create a regulatory process for PAs in New Zealand

SUMMARY AND ANALYSIS OF FINDINGS FROM ENVIRONMENTAL SCAN

Why did the PA role develop?
Across jurisdictions, it would seem that the PA role was introduced to deal with shortages of general practice physicians.

The modern PA role developed in the US in the 1960s in response to physicians having pulled away from general practice towards specialty practice, with the result that many communities had lost access to primary care physicians, particularly in rural areas. Additionally, PAs were

hired to enable regulatory compliance with legislated reductions in the number of hours to 80 per week worked by medical residents. Similarly, the UK, Australia and Canada wanted PAs to address access issues and needed to comply with changes to medical residents' working hours under legislated restrictions.

More recently, the focus has shifted to addressing system gaps – particularly to ensure continuity for patients in often very disjointed service delivery systems, and as an innovation to tackle system issues such high rates of hospitalization, repeat emergency department visits, long hospital stays, wait times for appointments and/or surgery or other interventions, as well as serious deficits in the patient's experience with health care services.

Success of the PA role can also be attributed to innovations in medical education and to the availability of "second career" individuals with prior health care experience who are highly likely to choose the PA career. Basically, within 2 years of intensive training added on to the individual's prior health care experience, faculties of medicine can now produce a skilled professional with the diagnostic capability and interpersonal skills needed for practice in modern, complex health care environments, who can practice safely and work collaboratively with other professionals in team-based environments.

Evidence Supporting PA Role

Evidence across jurisdictions is consistent. Over 40 years US experience and recent evaluations of trials in the UK/Scotland, Australia, New Zealand, as well as pilots in the provinces of Manitoba, New Brunswick, and Ontario, clearly show that PAs are:

- Safe, with fewer medical malpractice cases against them in the USA than physicians,
- Viewed as communicative and interactive by patients,
- A cost-effective addition to teams,
- More likely to work in areas of health professional shortage than doctors, (but less so than NPs); and,
- Capable of performing many of the routine functions in a general medical practice.

Key attributes of PAs are their diagnostic ability, communication and interpersonal skills, focus on interprofessional and team-based care, and their focus on patient safety.

Sampling of evidence from studies/evaluations of PA role

Effectiveness

- A study of emergency department care found no difference in the level of competence between the PA, resident and attending physician; another study also found marked improvement in outcome measures after the introduction of PA. Transfer times decreased as follows: to OR by 43%, to intensive care by 51%, and to hospital units by 20%.
- Use of a gerontologist PA in a nursing home reduced both the number of hospital admissions and days in hospital.

- Manitoba pilot on orthopedic surgery found PAs free GPs from working in operating rooms, and a double operating room model can increase surgical throughput by 42% and decrease wait times (44 weeks to 30 weeks), freeing up to 204 hours/year for an orthopedic surgeon.
- A pilot project in a 92-bed extended care facility demonstrated that a PA, providing acute medical care and alternating routine visits with a physician, was able to reduce annual hospital admissions by 38%, days of acute hospitalization by 68%, and total Medicare expenditures by $74,000 (US dollars).

Patient satisfaction

Patient surveys and studies report satisfaction with the care received by PAs including quicker appointments, better attention to patients and follow up care. In general, reported patient satisfaction with PAs has been consistently high, whether in their own right, or whether compared with physicians and/or NPs. As far as patients were concerned, the NP or PA does as good a job as the doctor.

PA 'productivity'

There is an evidence base of US literature on PA 'productivity' dating back to the 1970s. Early work suggested that the substitution ratio of PAs and NPs for family physicians was between 0.5 and 0.75, meaning that one PA could "replace" one half to three quarters of a physician. A later analysis of productivity data refined the ratio to 0.83. It is now generally accepted that PAs and NPs can handle between 80-85% of an average family physician's workload.

Costs and Benefits

Health workforce and policy analysts have been interested in the cost effectiveness of PAs since they were first introduced in the 1960s. A recent review by Hooker (2000) of the economic aspects of the PA role looked at the economics of PA practice (in US context, utilizing US salary and practice costs). His findings were:

- A PA can perform at least 75% of a primary care physician's tasks at a cost of 44% of the physician's salary (based on 1999 salary information);
- A PA can safely assume at least 83% of primary care visits without direct physician supervision;
- Cost-benefit analyses of PA-delivered primary care suggest the use of resources is less than physicians, under comparable circumstances;
- The cost of training a PA is approximately one fifth that of a physician;
- Owing to the difference in the length of education between PAs and physicians, the PA provides 5 years of patient care valued at $380,000 (USD 1999 rates) before the physician completes a primary care residency, and enters health care practice.

He concluded that these factors, plus the compensation-to-production ratio (this compares the salary and benefit cost to employ a PA [compensation] with the revenue generated for their services) establish the PA as one of the most cost-effective health care clinicians from the employer's perspective.

Another study found that primary care practices that used more PAs/NPs in care delivery realised lower practitioner labour costs per visit than practices that used less. They found that although

estimated labour cost savings per visit were very low, in terms of a few dollars, the net savings to a managed care organisation (MCO) are substantial.

Summary

s.13

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 1020502

PREPARED FOR: Honourable Terry Lake, Minister of Health - **FOR INFORMATION**

TITLE: Physician Assistants

PURPOSE: To provide information on work done by the Ministry on the potential for introducing Physician Assistants in British Columbia.

BACKGROUND:
Physician Assistants (PAs) are health care professionals who provide medical services under the supervision of a licensed physician. PA's are typically trained through medical programs and can interview patients, take medical histories, conduct physical examinations, requisition tests and interpret test results, diagnose illnesses, counsel on health issues, assist in surgeries, and prescribe treatments/medications.

In February 2014, the Minister directed Ministry of Health (Ministry) staff to examine the practical considerations for introducing PAs in BC. Ministry staff have prepared a draft Concept Paper to identify and discuss these considerations (attached as Appendix A).

DISCUSSION:
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s.13

ADVICE:

s.13

Program ADM/Division:	Ted Patterson**, A/**ADM, Health Sector Workforce Division
Program ED/Branch/Div:	Kevin Brown, Executive Director, Workforce Planning & Management, HSWD
Program contact:	Laurianne Jodouin
Date:	November 20, 2014

From:	Patterson, Ted HLTH:EX
To:	Brown, Kevin HLTH:EX; MacKinnon, Mark HLTH:EX
Subject:	FW: PSSAC Document
Date:	Monday, April 13, 2015 11:05:27 AM
Attachments:	Wong Farrally Utilization_of_Nurse_Practitioners_and_Physician_Assistants2013.pdf image001.png image002.jpg image003.png image004.png

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Fyi – found this in old emails. May be of interest.

Ted Patterson
Assistant Deputy Minister

From: Fern Logan [mailto:FernL@heabc.bc.ca]
Sent: Thursday, April 10, 2014 1:38 PM
To: XT:Carere, Ron HLTH:IN; Hughes, Doug J HLTH:EX; XT:HLTH Etherington, Jeremy HLTH:IN; Fern Logan; Frechette, Rod HLTH:EX; XT:Miller, Georgene FIN:IN; XT:HLTH Gray, Steve; McQuillen, Kelly SDSI:EX; Brown, Kevin HLTH:EX; Posgate, Libby HLTH:EX; Martin Wale; Michael Murray; XT:HLTH Russell, Mike; XT:HLTH O'Connor, Patrick; XT:HLTH Chapman, Ronald; Sulaiman Tabesh; XT:MacDonald, Susan EHS:IN; Taj Baidwan; Patterson, Ted HLTH:EX; XT:HLTH Ward, Tom; XT:HLTH Webb, Andrew
Subject: PSSAC Document

Distributed on Behalf of Dr. Ronald Chapman.

Fern Logan

Administrative Assistant
Physician Services
604.742.5507
200 – 1333 West Broadway,
Vancouver, BC V6H 3W1

heabc.bc.ca HEABC Twitter HEABC Linkedin

BCHealthCareAwards.ca Excellence in BC Health Care Awards Twitter Excellence in BC Health Care Awards Facebook Excellence in BC Health Care Awards YouTube

Save the date - HEABC's AGM & the *Excellence in BC Health Care Awards* luncheon are on Monday, June 23. More info on AGM registration & awards luncheon tickets will be posted on heabc.bc.ca in the coming weeks.

From: Byres, David W HLTH:EX
To: MacKinnon, Mark HLTH:EX
Cc: Brown, Kevin HLTH:EX; Younker, Katherine E HLTH:EX
Subject: Re: Meeting Request - Physician Assistant Discussion
Date: Wednesday, November 8, 2017 1:03:05 PM

Thanks. I did speak with Lynn a week or so when you brought their note to my attention and confirmed not an interest at this time.

David W. Byres, DNP, MSN, RN, CHE
Chief Nurse Executive
Assistant Deputy Minister
Clinical Integration, Regulation & Education Division
Ministry of Health
PO Box 9639 Stn Prov Govt
Victoria, BC V8W 9P1
Office: (250) 952-1615
Cellular (778) 678-7264
Assistant: Lynn.Carnegie@gov.bc.ca **Phone:** 250 952-1123 | **Cellular:** 250 208-5361

From: MacKinnon, Mark HLTH:EX
Sent: November-06-17 12:05 PM
To: Byres, David W HLTH:EX
Cc: Brown, Kevin HLTH:EX; Younker, Katherine E HLTH:EX; MacKinnon, Mark HLTH:EX
Subject: RE: Meeting Request - Physician Assistant Discussion

Hi there,

Kathy Younker and I met earlier today with Trevor Stone (President) and Natalie St-Pierre (Director, Communications and Stakeholder Relations) from the Canadian Association of Physician Assistants. They have identified BC as one of their priorities for getting agreement to introduce PAs.

I stated the following:

- This is not a new concept in BC – it was considered a couple of years ago, and a decision was made to not introduce PAs at that time.
- Government is not actively considering introducing any new professions that are not already in the pipe;
- Government's current focus is on optimally using the professions that already exist in BC;
- The Ministry is heavily invested in the current direction and resulting initiatives;
- I've not seen any indications that government intends to revisit PAs.

They asked what I thought it would take for this to change, I indicated that I would need direction to reprioritize. They then asked who in the Ministry makes those kinds of decisions. I indicated that Stephen and Lynn are the most senior decision-makers within the Ministry for issues like this.

Trevor and Natalie appear to be committed to finding a way to convince BC decision-makers to introduce PAs, stating something to the effect that "now is the perfect time to introduce PAs".

As a result, it may be that they reach out to Stephen and Lynn's offices.

M

From: Byres, David W HLTH:EX
Sent: Tuesday, October 24, 2017 7:46 AM
To: MacKinnon, Mark HLTH:EX
Cc: Brown, Kevin HLTH:EX
Subject: Re: Meeting Request - Physician Assistant Discussion

tx. I don't have an interest in meeting with them at this time.

David W. Byres, DNP, MSN, RN, CHE
Chief Nurse Executive
Assistant Deputy Minister
Clinical Integration, Regulation & Education Division
Ministry of Health
PO Box 9639 Stn Prov Govt
Victoria, BC V8W 9P1
Office: (250) 952-1615
Cellular (778) 678-7264
Assistant: Lynn.Carnegie@gov.bc.ca **Phone:** 250 952-1123 | **Cellular:** 250 208-5361

From: MacKinnon, Mark HLTH:EX
Sent: October-23-17 4:41 PM
To: Byres, David W HLTH:EX
Cc: Brown, Kevin HLTH:EX; MacKinnon, Mark HLTH:EX
Subject: FW: Meeting Request - Physician Assistant Discussion

Hi there,

Just checking whether you also received this, and whether you have any interest in meeting with them.

Kevin did some work on this a couple of years ago (first attachment). I've also attached a second document prepared by/for the Michael Smith Foundation.

Thanks,

M

From: Natalie St-Pierre [mailto:NSt-Pierre@capa-acam.ca]
Sent: Monday, October 23, 2017 4:10 PM
Cc: 'Geoff Ascent GR'
Subject: Meeting Request - Physician Assistant Discussion

Good Afternoon,

We are making outreach to you on behalf of the Canadian Association of Physician Assistants to request the opportunity to meet with you so that we can discuss the introduction of Physician Assistants (PAs) in British Columbia and to share information pertaining to their value. PAs are working across Canada in the Canadian Armed Forces and in the public healthcare system in Manitoba, Alberta, Ontario and New Brunswick. In these jurisdictions PAs are improving access to care in a cost-effective manner.

The Conference Board of Canada recently published a series of reports demonstrating the value of PAs in healthcare. I invite you to consult these reports at your leisure. Included below are links to the published reports:

http://www.conferenceboard.ca/e-library/abstract.aspx?did=8347
http://www.conferenceboard.ca/e-library/abstract.aspx?did=8107
http://www.conferenceboard.ca/e-library/abstract.aspx?did=9090

On November 6 and 7 we will be visiting Victoria. It would be sincerely appreciated if you could spare some time to meet with our National President and Executive Director. We are hosting 2 events while we are there: however, we are available all day November 6 before 5 pm and on November 7 from 9 – 1 pm. Please let me know if there is a time which would suit you.

Geoff Ingram will be following up this week but in the meantime you can reach me at 613-854-0675 or via email at: nst-pierre@capa-acam.ca

Regards,

Natalie St-Pierre
Director, Communications and Stakeholder Relations / Directrice des communications et des relations avec les parties prenantes
Canadian Association of Physician Assistants/ Association canadienne des adjoints au médecin
613-854-0675
www.capa-acam.ca

From:	Thorneloe, Meghan HLTH:EX
To:	Byres, David W HLTH:EX
Cc:	Westgate, Brian A HLTH:EX; Younker, Katherine E HLTH:EX; MacKinnon, Mark HLTH:EX; Brown, Kevin HLTH:EX
Subject:	FW: Seeking info on application for designation
Date:	October 12, 2018 10:27:02 AM

Hi all, sending this along as it may be of interest to some/all.
I am currently responding to this in eApps. Note the signature – Canadian Ass'n of Physician Assistants. In addition to this letter, this person has called us today asking for a response that she can give at a board meeting next week.
David, do you have an interest in seeing this eApp given the context, or should we continue with our standard response?
Thank you
Meghan

From: Andrea Tiwari [mailto:atiwari@capa-acam.ca]
Sent: Tuesday, October 2, 2018 8:06 PM
To: PROREGADMIN HLTH:EX
Subject: Seeking info on application for designation

Good Morning,
I'm wondering if your office can provide any guidance documents on the steps a health association must complete in order to apply for designation of its profession under the Health Professions Act? I'm looking for forms or information on process, requirements, timelines etc.
Thanks in advance for any help you can provide.
Kind regards,
Andrea

Andrea Tiwari
Director, Communications and Stakeholder Relations
Canadian Association of Physician Assistants
Directrice des communications et des relations avec les parties prenantes
Association canadienne des adjoints au médecin
877 744 2272 | atiwari@capa-acam.ca | capa-acam.ca | @CAPAACAM

From:	Thorneloe, Meghan HLTH:EX
To:	Czapska, Joanna HLTH:EX
Subject:	RE: To assist with eApp
Date:	Friday, October 12, 2018 10:42:39 AM
Attachments:	1116062 s.22 implementation of physician assistant.docx

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From: Czapska, Joanna HLTH:EX
Sent: Friday, October 12, 2018 10:22 AM
To: Thorneloe, Meghan HLTH:EX
Subject: RE: To assist with eApp

Hi Meghan,

I just came across a doc on LAN (Pro Regulation Standard Responses - 2018-10-04), that includes info on physician assistants (p.7) which I could add to the letter, feel free to send the eApp back to me and I can add if needed, Thank you,

Joanna

From: Thorneloe, Meghan HLTH:EX
Sent: Wednesday, October 10, 2018 4:44 PM
To: Czapska, Joanna HLTH:EX
Subject: RE: To assist with eApp

Sounds good, thanks Joanna. No significant rush!

From: Czapska, Joanna HLTH:EX
Sent: Wednesday, October 10, 2018 4:43 PM
To: Thorneloe, Meghan HLTH:EX
Subject: RE: To assist with eApp

Thanks for sending Meghan, I'll review the docs tomorrow morning and will be in touch if I need to clarify anything,

Best!

From: Thorneloe, Meghan HLTH:EX
Sent: Wednesday, October 10, 2018 4:40 PM
To: Czapska, Joanna HLTH:EX
Subject: To assist with eApp

Hi Joanna,

The attached pieces of correspondence are similar to the request I've sent you in eApps. I hope they are of help, but if not please feel free to pop by anytime.

Thank you!

Meghan Thorneloe | Director, Regulatory Initiatives
Professional Regulation and Oversight Branch
B.C. Ministry of Health
Phone: 250-952-3278 | Cell: 250-893-7219
Email: Meghan.Thorneloe@gov.bc.ca

1116062

August 23, 2018

s.22

Dear s.22

The Honourable John Horgan, Premier of British Columbia, has asked me to thank you and respond to your email of June 9, 2018, regarding your question about examining the fit of Physician Assistants (PAs) in BC. I apologize for the delay in my response.

As you noted, on May 24, 2018, the government launched a new primary healthcare strategy to deliver faster and improved access to healthcare for British Columbians. At the heart of the strategy is a focus on team-based care that places patients at the centre of healthcare delivery.

Initial priority was placed on addressing the shortage of general practitioners in the province. Government will fund up to 200 new general practitioners to work in the team-based care model, and provide opportunity for every family medicine resident to work in a renewed primary care system in which they can focus on patient-centred medicine. As you noted, government will also create 200 new nurse practitioner (NP) positions, and increase the number of NP education seats by 66%.

As part of the healthcare strategy, government will establish primary care networks, urgent primary care centres, and community health centres. More information about these initiatives can be found in the following news release:

https://news.gov.bc.ca/releases/2018PREM0034-001010

The introduction of a new health profession requires careful consideration and management, and significant resources in order to properly understand and address the inevitable team function issues that emerge from overlapping scopes of practice. In that regard, the Ministry of Health (the Ministry) has considered in depth the option of implementing PAs. Ultimately, government concluded that the PA role overlaps substantially with existing nursing roles, such as nurse practitioners, registered nurses with certified practice credentials, and family physician roles such as hospitalists or surgical assistants.

The Ministry is committed to optimizing the scopes of practice of existing health care professionals to enable efficient and effective use of resources. Government's new primary health-care strategy commits to building on the best practices and solutions that already exist within the health-care system, but have yet to be fully leveraged throughout the province.

I trust you will find this information helpful. Thank you for bringing your concerns to our attention.

Sincerely,

Mark MacKinnon
Executive Director
Professional Regulation & Oversight
Ministry of Health

pc: Honourable John Horgan

From: Czapska, Joanna HLTH:EX
To: Bourke, Lorna J HLTH:EX
Subject: RE: Pro Regulation Standard Responses updated 2018-10-04
Date: Friday, October 12, 2018 11:00:00 AM

Thanks Lorna!

From: Bourke, Lorna J HLTH:EX
Sent: Friday, October 12, 2018 10:41 AM
To: Bennett, Christopher HLTH:EX; Bourke, Lorna J HLTH:EX; Chu, Mary HLTH:EX; Czapska, Joanna HLTH:EX; Kennedy, Jaclyn HLTH:EX; MacKinnon, Mark HLTH:EX; Remington, Brian HLTH:EX; Ren, Feixue HLTH:EX; Rodger, Thomas M HLTH:EX; Saville, Amanda HLTH:EX; Smith, Leah M HLTH:EX; Thorneloe, Meghan HLTH:EX; Westgate, Brian A HLTH:EX; Younker, Katherine E HLTH:EX
Subject: Pro Regulation Standard Responses updated 2018-10-04

Hello,

The Pro Regulation Standard Responses document on the LAN has been updated by Kathy (Physician Assistant applying for regulation piece).
You can find the updated document here:

Y:\Correspondence (280-30_320-30)\Pro Regulation Standard Responses- 2018-10-04.docx

Thank you,

Lorna Bourke
Branch Administrator
Professional Regulation and Oversight
Clinical Integration, Regulation and Education Division
Ministry of Health

Lorna.Bourke@gov.bc.ca
(778) 974-4382 (office)

From:	Thorneloe, Meghan HLTH:EX
To:	Byres, David W HLTH:EX
Cc:	MacKinnon, Mark HLTH:EX
Subject:	RE: Seeking info on application for designation
Date:	Friday, October 12, 2018 3:58:23 PM
Attachments:	1122566 Tiwari - Canadian Association of Physician Assistants EMAIL RESPONSE.docx

Hi David, attached is the response for your information. We have updated our standard/recently used wording, and will have this sent out.

Thank you

Meghan

From: Byres, David W HLTH:EX
Sent: Friday, October 12, 2018 10:44 AM
To: Thorneloe, Meghan HLTH:EX
Cc: Westgate, Brian A HLTH:EX; Younker, Katherine E HLTH:EX; MacKinnon, Mark HLTH:EX; Brown, Kevin HLTH:EX
Subject: Re: Seeking info on application for designation

I am happy to review it if helpful but would respond as per usual.

David W. Byres, RN, DNP, MSN, CHE
Chief Nurse Executive
Assistant Deputy Minister
Clinical Integration, Regulation & Education Division
Ministry of Health
PO Box 9650 Stn Prov Govt
Victoria, BC V8W 9P4
Cellular (778) 678-7264
Assistant: Jenifer.Sheppard@gov.bc.ca **Phone:** 250 952-1266

From: Thorneloe, Meghan HLTH:EX
Sent: October-12-18 10:27 AM
To: Byres, David W HLTH:EX
Cc: Westgate, Brian A HLTH:EX; Younker, Katherine E HLTH:EX; MacKinnon, Mark HLTH:EX; Brown, Kevin HLTH:EX
Subject: FW: Seeking info on application for designation

Hi all, sending this along as it may be of interest to some/all.

I am currently responding to this in eApps. Note the signature – Canadian Ass'n of Physician Assistants. In addition to this letter, this person has called us today asking for a response that she can give at a board meeting next week.

David, do you have an interest in seeing this eApp given the context, or should we continue with our standard response?

Thank you

Meghan

From: Andrea Tiwari [mailto:atiwari@capa-acam.ca]
Sent: Tuesday, October 2, 2018 8:06 PM
To: PROREGADMIN HLTH:EX
Subject: Seeking info on application for designation

Good Morning,

I'm wondering if your office can provide any guidance documents on the steps a health association must complete in order to apply for designation of its profession under the Health Professions Act? I'm looking for forms or information on process, requirements, timelines etc.

Thanks in advance for any help you can provide.

Kind regards,
Andrea

Andrea Tiwari
Director, Communications and Stakeholder Relations
Canadian Association of Physician Assistants
Directrice des communications et des relations avec les parties prenantes
Association canadienne des adjoints au médecin
877 744 2272 | atiwari@capa-acam.ca | capa-acam.ca | @CAPAACAM

From:	PROREGADMIN HLTH:EX
To:	"Andrea Tiwari"
Bcc:	PROREGADMIN HLTH:EX
Subject:	RE: Seeking info on application for designation
Date:	Friday, October 12, 2018 4:15:23 PM

1122566 280-30(C)
Ms. Andrea Tiwari
Director, Communications and Stakeholder Relations
Canadian Association of Physician Assistants
atiwari@capa-acam.ca
Dear Ms. Tiwari:
Thank you for your email of October 2, 2018, and phonecall of October 12, 2018, regarding the process for applying for designation of a health profession under the *Health Professions Act* (HPA). I am pleased to respond on behalf of the Ministry of Health (the Ministry).

As you may be aware, in British Columbia, there are 26 regulated health professions, of which 25 are governed by 20 regulatory colleges under the HPA. The HPA is an 'umbrella' statute that provides a common regulatory framework for health professions in BC.
Part 2 of the HPA includes provisions that enable the designation of health professions. In accordance with section 7 (1), a health profession association seeking designation of its health profession under the HPA must apply to the Minister of Health (the Minister). Section 7 (3) (c) sets out the Minister may conduct an investation to determine whether the health profession should be designated. Section 12 (1) enables the Lieutenant Governor in Council, on the advice of the Minister, to designate a health profession for the purposes of the HPA.
Any profession applying for designation under section 7 (1) of the HPA must make a case to the Minister that it is in the public interest to designate the health profession. For the purpose of the HPA, the public interest criteria focus on the extent to which the practice of a health profession may involve a risk of physical, mental, or emotional harm to the health, safety, or well-being of the public. The public interest criteria can be found in Part 3 of the Health Professions Designation and Amalgamation Regulation.

In addition to meeting the public interest criteria, the occupation applying for designation must meet the HPA definition of a health profession:

> "Health profession" means a profession in which a person exercises skill or judgement or provides a service related to (a) the preservation or improvement of the health of individuals, or (b) the treatment or care of individuals who are injured, sick, disabled or infirm.

Before any decision is made to regulate a profession, the Minister will consider a full range of options, including non-regulatory options, before identifying whether formal regulation is the best option to protect the public from harm. Consideration is given to the principles of right-touch regulation, which state that regulation should aim to be: proportionate, consistent, targeted, transparent, accountable, and agile. For more information on right-touch regulation please see the following: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015
The designation of a new health profession requires careful consideration and management to determine whether the health profession should be designated under the HPA, and significant financial and staffing resources in order to properly understand and address the inevitable team function issues that emerge from overlapping scopes of practice. The Ministry is committed to optimizing the scopes of practice of existing health care professionals to enable efficient and effective use of resources.
Government is not at this time considering any new applications for designated health professions other than those currently under review. In addition, current government policy supports the development of regulatory colleges formed by coalitions or groups of similar or related health care

professionals, rather than by single professions.
I trust you will find this information helpful. I appreciate the opportunity to respond.
Sincerely,
Meghan Thorneloe, Acting Executive Director obo
Mark MacKinnon
Executive Director
Professional Regulation & Oversight
Ministry of Health

From: Andrea Tiwari [mailto:atiwari@capa-acam.ca]
Sent: Tuesday, October 2, 2018 8:06 PM
To: PROREGADMIN HLTH:EX
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Andrea Tiwari
Director, Communications and Stakeholder Relations
Canadian Association of Physician Assistants
Directrice des communications et des relations avec les parties prenantes
Association canadienne des adjoints au médecin
877 744 2272 | atiwari@capa-acam.ca | capa-acam.ca | @CAPAACAM

From: Czapska, Joanna HLTH:EX
To: PROREGADMIN HLTH:EX
Subject: RE: Seeking info on application for designation
Date: Monday, October 15, 2018 11:21:41 AM

Thanks! ☺

From: PROREGADMIN HLTH:EX
Sent: Monday, October 15, 2018 11:18 AM
To: Czapska, Joanna HLTH:EX
Subject: FW: Seeking info on application for designation

FYI, thanks so much for your quick work on this on Friday!

Meghan

From: Andrea Tiwari [mailto:atiwari@capa-acam.ca]
Sent: Friday, October 12, 2018 7:52 PM
To: PROREGADMIN HLTH:EX
Subject: RE: Seeking info on application for designation

Hello Meghan,
Thanks very much for the reply and additional information.

Kind regards,
Andrea

From: PROREGADMIN HLTH:EX [mailto:PROREGADMIN@gov.bc.ca]
Sent: October 12, 2018 7:15 PM
To: Andrea Tiwari
Subject: RE: Seeking info on application for designation

1122566 280-30(C)

Ms. Andrea Tiwari
Director, Communications and Stakeholder Relations
Canadian Association of Physician Assistants
atiwari@capa-acam.ca

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I trust you will find this information helpful. I appreciate the opportunity to respond.

Sincerely,

Meghan Thorneloe, Acting Executive Director obo
Mark MacKinnon
Executive Director
Professional Regulation & Oversight
Ministry of Health

From: Andrea Tiwari [mailto:atiwari@capa-acam.ca]
Sent: Tuesday, October 2, 2018 8:06 PM
To: PROREGADMIN HLTH:EX
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Canadian Association of Physician Assistants

Directrice des communications et des relations avec les parties prenantes
Association canadienne des adjoints au médecin

877 744 2272 | atiwari@capa-acam.ca | capa-acam.ca | @CAPAACAM

From: Thorneloe, Meghan HLTH:EX
To: Kennedy, Jaclyn HLTH:EX; Ren, Feixue HLTH:EX
Subject: Physician assistants say they can help B.C. health care woes
Date: Monday, October 22, 2018 11:21:33 AM

FYI
https://www.peninsulanewsreview.com/news/physician-assistants-say-they-can-help-b-c-health-care-woes/

From:	Younker, Katherine E HLTH:EX
To:	MacKinnon, Mark HLTH:EX
Cc:	Westgate, Brian A HLTH:EX; Thorneloe, Meghan HLTH:EX; Smith, Leah M HLTH:EX
Subject:	FYI: CNW | Physician assistants descend on Victoria to urge NDP government to start using PAs to address gaps in care
Date:	Tuesday, October 23, 2018 11:36:05 AM

Subject: CNW | Physician assistants descend on Victoria to urge NDP government to start using PAs to address gaps in care

https://www.newswire.ca/news-releases/physician-assistants-descend-on-victoria-to-urge-ndp-government-to-start-using-pas-to-address-gaps-in-care-698002851.html

From: Thorneloe, Meghan HLTH:EX
To: MacKinnon, Mark HLTH:EX; Westgate, Brian A HLTH:EX; Smith, Leah M HLTH:EX; Younker, Katherine E HLTH:EX
Cc: Czapska, Joanna HLTH:EX
Subject: FW: draft transcript - physician assistants question QP
Date: Friday, October 26, 2018 5:12:49 PM

Interesting snippet from QP below, thanks Joanna for catching this.

Meghan

From: Czapska, Joanna HLTH:EX
Sent: Tuesday, October 23, 2018 11:58 AM
To: Thorneloe, Meghan HLTH:EX
Subject: draft transcript - physician assistants question QP

Hi Meghan,
Please see the draft transcript from Hansard below, I've highlighted 'physician assistant' for ease of reading. The site link for the transcript is: https://www.leg.bc.ca/documents-data/debate-transcripts/41st-parliament/3rd-session/20181023am-House-Blues . Once the video is up I will check the draft transcript against it. Thanks! Joanna

Draft Transcript

THIRD SESSION, 41ST PARLIAMENT (2018)

TUESDAY, OCTOBER 23, 2018

Morning Sitting

ACCESS TO FAMILY PHYSICIANS AND REFORMS TO PRIMARY HEALTH SYSTEM

S. Furstenau: And now for something completely different.

Graphs from the *MSP Physician Resource Report* indicate the total expenditure for general practice doctors has increased significantly since 2005, but the average number of patients treated per physician has dropped. The government's policy changes over the last ten years have led to more doctors, fewer working days treating fewer patients.

The data focuses on quantity of care but not quality. In many cases, doctors seeing fewer patients is a positive change, as it indicates they are spending more time with each individual. For people struggling with multiple or complex conditions, this added assistance is essential. With doctors striving to create healthier work-life balance, the policies used to address the doctor shortages of the 1970s are no longer relevant.

Family doctors play a vital role in our well-being, and they deserve a policy framework that lets them treat patients in a manageable, fulfilling and effective manner. To the Minister of Health: what concrete steps is he taking to modernize our province's approach to the doctor shortage? Has he considered a role for physician assistants in that future?

Hon. A. Dix: Thank you to the member for her question. I think at the heart what we're trying to do, particularly with respect to primary care, is bringing team-based care everywhere in British Columbia. That means doctors and nurse practitioners and physiotherapists and pharmacists and LPNs — everyone working together in teams to provide better care for patients, which is the goal in the long run. But it will also provide better work-life balance and supports for doctors working in the system, both from one another and from other

professionals working in the health care. That's the first thing.

The second thing is, when I talk to doctors, one of their real concerns is the increasing time that they have to spend finding appropriate services, whether it be for mental health and addictions or for frail elderly. That's why we're putting in place one-stop shopping for doctors, for specialized services to improve both their quality of life and the quality of care and ensure they can spend the maximum amount of time during their day with patients.

[1040]

I think the third set of things that we have to do in a modern age is to greatly improve the use of digital technologies in some of our partnerships, including with great B.C.-based companies such as Telus, to do exactly that. Finally, we do need to, in these circumstances, add

and ensure they can spend the maximum amount of time during their day with patients.

I think the third set of things we have to do in a modern way is to greatly improve the use of digital technologies. Some of our partnerships, including with great B.C.-based companies such as Telus, do exactly that. Finally, we do need, in these circumstances, to add more resources. It's why we are adding more family practice doctors, more nurse practitioners, more pharmacists and other professionals to staff these teams to provide more supports. Physician assistants, which the member mentioned, could play an important role in all of that, and they are use in other provinces.

We're focusing right now on dramatically increasing the use of nurse practitioners. We've had nurse practitioners, as a result of the efforts of the former government, since 2005. However, in 2017, we were 12th and 13th in their use. We need to do better, and we will.

From: Thorneloe, Meghan HLTH:EX
To: Kennedy, Jaclyn HLTH:EX
Subject: RE: PRO Intro PPT for Mark Armitage
Date: Friday, November 23, 2018 3:40:37 PM

Hi Jaclyn, someone else is currently editing the document. To avoid having a number of different versions, I will include my comments here.

- Anaesthesia Assistants (AAs) s.13
  s.13
    - AAs are a group of professionals who are primarily Respiratory Therapists (about 95%) but may also have a background in Registered Nursing (the other 5%)

s.13

- Physician Assistants
    - Numerous pieces of correspondence have come in recently requesting that government regulate Physician Assistants

s.13

- Did I miss anything with my name on it?

From: Kennedy, Jaclyn HLTH:EX
Sent: Friday, November 23, 2018 12:14 PM
To: Smith, Leah M HLTH:EX; Thorneloe, Meghan HLTH:EX; Westgate, Brian A HLTH:EX; Younker, Katherine E HLTH:EX; Bennett, Christopher HLTH:EX
Cc: MacKinnon, Mark HLTH:EX
Subject: PRO Intro PPT for Mark Armitage

Good afternoon all
Chris and I have been working on a PPT for Mark's intro briefing with Mark Armitage on Tuesday

(November 27).
Mark's asked me to get each of you to have a look at it from your respective work portfolios and let me know if I'm missing anything.
Where I need specific info from you for speaking notes, I've put your name in all caps – these are mostly in the "Current initiatives" slides.
The "Current Issues" and "Initiatives – Not Active" slides also need your input. Feel free to make changes directly on the PPT or email me with comments.
Z:\Professional Regulation\Reference Materials\November 2018 Briefing for Mark Armitage.pptx
Please let me know once you're finished reviewing. I'm aiming to finalize the ppt by **Monday mid-day** to ensure Mark has sufficient time to review. Apologies for the tight turnaround!
Thank you
Jac

Jaclyn Kennedy
Manager, Professional Regulation Policy
Professional Regulation and Oversight
Health Human Resources and Labour Relations Division
Ministry of Health
P: 778 974-5002
E: Jaclyn.Kennedy@gov.bc.ca

From: MacKinnon, Mark HLTH:EX
Sent: Tuesday, November 20, 2018 1:32 PM
To: Bennett, Christopher HLTH:EX; Kennedy, Jaclyn HLTH:EX; Smith, Leah M HLTH:EX; Thorneloe, Meghan HLTH:EX; Westgate, Brian A HLTH:EX; Younker, Katherine E HLTH:EX
Cc: MacKinnon, Mark HLTH:EX
Subject: PRO 101 Aug 15 17.ppt

Hi folks,

With yesterday's announcement, we will need to prepare to brief our new ADM. My current plan is to use this deck as my starting point, and recognize that it will need quite a lot of updating.

I'm probably going to have to get some help from Chris on parts of it, and would like suggestions from each of you in respect of updated content for the deck as a whole.

I haven't yet had a first briefing scheduled with Mr. Armitage, but it will probably be soon, so I'd like to try to have this in fairly good shape by the end of the week.

Thanks,

M

Professional Regulation and Oversight

Introductory Briefing for Mark Armitage

November 27, 2018

BRITISH COLUMBIA

Session overview

- Professional Regulation and Oversight (PRO) Team
- Purpose and core functions
- Landscape
  - Relevant legislation
  - Key stakeholders
- Current issues
- Recent and current initiatives
  - Items requiring near-term direction/decision
- Vision for professional regulation in BC

BRITISH COLUMBIA

Purpose

- PRO Branch develops and implements strategies for the regulation and oversight of health professions to ensure the consistent provision of safe, quality healthcare for all British Columbians.
- The aims of our regulatory model are to ensure **safety** and **quality**, balanced with patient choice.

BRITISH COLUMBIA

Core Functions

- Legislation, Regulation and Policy
  - Establish and maintain a comprehensive legislative, regulatory and policy framework for the regulation and oversight of health professions in BC.
- College Bylaws
  - Review, make recommendations and file college bylaws in response to a request for amendment by a College or at the direction of the Minister.
- Oversight/Monitoring of regulatory colleges
  - Establish and maintain a College Oversight Model to ensure routine, ongoing monitoring and assessment of regulatory college performance.

BRITISH COLUMBIA

Landscape: Legislation & Regulation

- *Health Professions Act* (HPA)
  - HPA General Regulation
  - The 'scope of practice' and 'restricted activities' of each health profession designated under HPA are prescribed in health-profession-specific regulations
- *Emergency Health Services Act* (EHSA)
- *Pharmacy Operations and Drug Scheduling Act* (PODSA)
  - Drug Schedules Regulation

BRITISH COLUMBIA

Landscape: Regulatory colleges

- 26 regulated health professions, 25 are governed by 20 regulatory colleges.
- Colleges vary significantly in size:
  - Smallest: 85 registrants (Podiatric Surgeons)
  - Several under 1,000 registrants
  - Largest: Over 57,000 registrants (newly amalgamated nursing umbrella college).
- s.13

Landscape: Key Stakeholders

- BC Health Regulators/Regulatory colleges (20)
- HCA registry
- EMAL Board/Branch
- BCEHS
- Health Professions Review Board
- Professional associations
- Unions (CUPE 873, BCNU, HEU, HSA)
- Health Authorities
- CNO Council

BRITISH COLUMBIA

Current Issues

s.13

- Physician Assistants

s.13

Current Strategic Issues

s.13

Recent initiatives (2017 – 2018)

- New provisions in the HPA to enable:
  - Appointment of an administrator
  - Amalgamation of colleges
- Amalgamation of nursing profession colleges
- Regulatory governance training with registrars and boards
- D&T designation
- Health care assistants

BRITISH COLUMBIA

Current Initiatives (Core Business)

s.13

Current Initiatives (Strategic Priorities)

s.13

BRITISH COLUMBIA

Current Initiatives (Strategic Priorities)

s.13

BRITISH COLUMBIA

Current Initiatives – s.13

s.13

Page 253 of 268 to/à Page 255 of 268

Withheld pursuant to/removed as

s.13

Trends in Professional Regulation

- Public expectation is changing
  - Increased transparency and accessibility
  - Proactive regulatory practice
  - Evidence and data (including about regulator performance)
- Right touch regulation
  - Proportionate and risk-based regulatory practice & oversight
  - Flexible/agile
- Challenge of technology and artificial intelligence
- Good governance
  - Competency-based boards
  - Role clarity
  - Balance of professional and public members

A Possible Vision

s.13

BRITISH COLUMBIA

A Possible Vision

s.13

Thank you

- Questions?
- Comments?
- Topics for more detailed briefings?

BRITISH COLUMBIA

From: Younker, Katherine E HLTH:EX
To: Fabian, MC HLTH:EX
Cc: MacKinnon, Mark HLTH:EX
Subject: RE: PA"s
Date: Thursday, December 6, 2018 1:06:00 PM

Hi Dr. Fabian,

Thanks for sharing that link. I do remember seeing it on Twitter on PA day.

As per our conversation yesterday, when we have been responding to queries related to physician assistants, this is the type of response we have provided. I'm sure you can use this to develop some messaging. I'm happy to look over any response if you wish.

> *The Ministry of Health has developed a healthcare strategy which has several components. As part of the healthcare strategy, government will establish primary care networks, urgent primary care centres, and community health centres. More information about these initiatives can be found in the following news release:*
>
> *https://news.gov.bc.ca/releases/2018PREM0034-001010*
>
> *Initial priority was placed on addressing the shortage of general practitioners in the province. Government will fund up to 200 new general practitioners to work in the team-based care model, and provide opportunity for every family medicine resident to work in a renewed primary care system in which they can focus on patient-centred medicine. The government will also create 200 new nurse practitioner (NP) positions, and increase the number of NP education seats by 66%. It does not specifically address physician assistants (PA) in this strategy in BC.*
>
> *The introduction of a new health profession requires careful consideration and management, and significant resources in order to properly understand and address the inevitable team function issues that emerge from overlapping scopes of practice. In that regard, the Ministry of Health (the Ministry) has considered in depth the option of implementing PAs. Ultimately, government concluded that the PA role overlaps substantially with existing nursing roles, such as nurse practitioners, registered nurses with certified practice credentials, and family physician roles such as hospitalists or surgical assistants.*
>
> *The Ministry is committed to optimizing the scopes of practice of existing health care professionals to enable efficient and effective use of resources. Government's new primary health-care strategy commits to building on the best practices and solutions that already exist within the health-care system, but have yet to be fully leveraged throughout the province.*

You also might find it useful to see what the Minister of Health said about physicians assistants recently during question period. Draft transcript from Hansard below, I've highlighted 'physician assistant' for ease of reading. The site link for the transcript is: https://www.leg.bc.ca/documents-data/debate-transcripts/41st-parliament/3rd-session/20181023am-House-Blues .

THIRD SESSION, 41ST PARLIAMENT (2018)

TUESDAY, OCTOBER 23, 2018

Morning Sitting

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We're focusing right now on dramatically increasing the use of nurse practitioners. We've had nurse practitioners, as a result of the efforts of the former government, since 2005. However, in 2017, we were 12th and 13th in their use. We need to do better, and we will.

Let me know if there is any other information you need.

Regards,

Kathy

From: Fabian, MC HLTH:EX
Sent: December 5, 2018 1:26 PM
To: Younker, Katherine E HLTH:EX <Katherine.Younker@gov.bc.ca>
Cc: MacKinnon, Mark HLTH:EX <Mark.MacKinnon@gov.bc.ca>
Subject: PA's

Hi Katherine,

FYI as briefly discussed:
https://www.doctorsofbc.ca/news/advocating-physician-assistants-bc

Thanks for providing a generic response sentence for me relating to enquiries I have had … to do when you have time.

MC

Dr. MC Fabian FRCPC FRCSC FACS
Senior Medical Consultant CPPB
Ministry of Health

From:	Taylor, Coral L HLTH:EX
To:	Taylor, Coral L HLTH:EX; Younker, Katherine E HLTH:EX
Subject:	Conversation with Taylor, Coral L HLTH:EX
Date:	Wednesday, January 16, 2019 1:44:00 PM

Taylor, Coral L HLTH:EX 1:32 PM:

Hi Kathy. I was told from your team yesterday that you would be the Pro-Reg contact regarding Physician Assistants. I've drafted a response to some correspondence but would appreciate your eyes to review the content from the regulation lens. It will be sent to you via eapps shortly. Hope that's ok.

From: Younker, Katherine E HLTH:EX
To: Gregg, Andrea HLTH:EX
Subject: FW: s.17
Date: Thursday, January 17, 2019 3:16:00 PM
Attachments: image001.png

Hi Andrea,

This is coming your way.

Thanks,

Kathy

From: s.17
Sent: January 11, 2019 11:49 AM
To: DMOFFICE, HLTH HLTH:EX <HLTH.DMOFFICE@gov.bc.ca>
Cc: s.17
Subject: s.17

HLTH DMO to HHRLR – s.s. –

_____

Good day Sir or Madam,

s.17

s.17 It is my understanding that PAs are not currently able to practice within the province (aside from Canadian Forces PAs providing care strictly to active members of the Canadian Forces). s.17
s.17
s.17

s.17

I am asking whether PA practice approval is under serious scrutiny by the BC Department of Health with a plan to enact the appropriate legislation in the foreseeable future or not. Further

to this, s.17
s.17

I would look forward to your reply on this matter and would be happy to discuss further at your convenience should you have any questions on the matter. I am available by cell phone at s.22 or by the below email contact.

Sincerely,

s.17

From:	PROREGADMIN HLTH:EX
To:	s.22
Cc:	Minister, HLTH HLTH:EX
Bcc:	PROREGADMIN HLTH:EX
Subject:	RE: s.22 / Physician Assistant
Date:	Wednesday, February 6, 2019 10:55:00 AM

1127839

s.22

Dear s.22

The Honourable Adrian Dix, Minister of Health, has asked me to thank you and respond to your e-mail of January 14, 2019 regarding your inquiry into legislation to allow physician assistants to work in British Columbia (BC).

As you may be aware, in Canada, health services, including regulation of health professionals, are regulated by provincial legislation. Each province is responsible for regulating its own health professionals and establishing its own regulatory framework to govern those professionals.

In British Columbia, there are 26 regulated health professions, of which 25 are governed by 20 regulatory colleges under the *Health Professions Act* (HPA). The HPA is an 'umbrella' statute that provides a common regulatory framework for health professions in BC.

The designation of a new health profession requires careful consideration and management, and significant resources in order to properly understand and address the inevitable team function issues that emerge from overlapping scopes of practice. In that regard, the Ministry of Health (the Ministry) has considered in depth the option of implementing physician assistants. Ultimately, government concluded that the physician assistant role overlaps substantially with existing nursing roles, such as nurse practitioners, registered nurses with certified practice credentials, and family physician roles such as hospitalists or surgical assistants.

The Ministry is committed to optimizing the scopes of practice of existing health care professionals to enable efficient and effective use of resources. Government's *new primary health-care strategy* commits to building on the best practices and solutions that already exist within the health-care system, but have yet to be fully leveraged throughout the province. Government is not at this time considering the introduction of physician assistants in BC.

I trust you will find this information helpful. Thank you for bringing your concerns to our attention.

Sincerely,

Mark MacKinnon
Executive Director
Professional Regulation & Oversight
Ministry of Health

From: s.22
Sent: Monday, January 14, 2019 10:41 AM
To: Dix.MLA, Adrian <Adrian.Dix.MLA@leg.bc.ca>
Cc: s.22
Subject: s.22 / Physician Assistant

Dear Minister,

s.22

Unfortunately, we've come to discover that physician assistants are unable to work in British Columbia. While we've seen news stories and press releases advocating a potential change in this policy, we've seen nothing concrete in terms of action. I'm curious if you, as the Minister of Health, have any additional insight on the matter or if it's on your legislative agenda. Would you expect recognition in the near future?

Thanks for your help.

Best,
s.22

From:	Younker, Katherine E HLTH:EX
To:	Kennedy, Jaclyn HLTH:EX; MacKinnon, Mark HLTH:EX
Subject:	RE: 1127839 s.22 ED Email Resp. OBO Minister - Inquiry into physician assistants legislation - DRAFT
Date:	Wednesday, February 6, 2019 2:24:00 PM

Hi Jaclyn,

Most certainly- I don't own the list so please do and can change the date and let others know that you updated it?

Thanks,

Kathy

From: Kennedy, Jaclyn HLTH:EX
Sent: February 6, 2019 1:36 PM
To: MacKinnon, Mark HLTH:EX <Mark.MacKinnon@gov.bc.ca>
Cc: Younker, Katherine E HLTH:EX <Katherine.Younker@gov.bc.ca>
Subject: RE: 1127839 s.22 ED Email Resp. OBO Minister - Inquiry into physician assistants legislation - DRAFT

Thanks Mark!

Kathy, a few of these changes could apply to future corro on physician assistants – let me know if you'd like me to update the standard corro resource ☺

Cheers
Jac

From: MacKinnon, Mark HLTH:EX
Sent: Wednesday, February 6, 2019 9:04 AM
To: Kennedy, Jaclyn HLTH:EX; Younker, Katherine E HLTH:EX
Subject: 1127839 s.22 ED Email Resp. OBO Minister - Inquiry into physician assistants legislation - DRAFT

FYI – just a couple of tracked changes in the version I have approved.

Thanks,

M