Murray, Heather HLTH:EX

Sept 29

From: Pokorny, Pete
Sent: September 2
To: Ackenhusen,
Cc: Gold, Crystal
Subject: Re: thoughts

Thanks, Mary. Yes....good timing to chat about this. Copying Crystal to help set up a time.

Peter Pokorny
Associate Deputy Minister
Corporate Services
Ministry of Health
(778) 698-8046

On Sep 28, 2020, at 9:13 PM, Ackenhusen, Mary HLTH:EX <Mary.Ackenhusen@gov.bc.ca> wrote:

Hi Peter

s.13

Given the challenges of PPE, I wonder if you have time to chat a bit about this –

s.13

Do you have time for a short call to talk about if this would be a need that we could help address?

Thanks
Mary

Murray, Heather HLTH:EX

From:	Moulton, Holly HLTH:EX
Sent:	September 29, 2020 7:43 AM
To:	hlth Executive Committee
Cc:	hlth Key Contacts
Subject:	COVID-19 Fall/Winter Preparation SEPT 28 Update
Attachments:	COVID 19 FALL WINTER PREPARATION SEPT 28 UPDATE.docx
Categories:	Printed for Review/Meeting Material

Please find attached a revised Covid-19 Fall/Winter Preparation document. Please note that content has not changed just formatting and hyperlinks added to page 3 for ease of use.

Thank you.
Holly

HEALTH SECTOR PLAN FOR FALL/WINTER 2020/21 MANAGEMENT OF COVID-19

Ministry of Health
Update 1: W/C September 28, 2020

HEALTH SERVICES KEY ACTIONS

In all cases the leads will report through to Steve (Steve will link with and keep Bonnie informed and engaged in any decision making); all leads must engage with and keep informed Ian/CHREM and the VP COVID-19 team and respond promptly to any guidance/requirements for coordination/reporting requirements. Peter Pokorny will be the key support to Steve in moving the COVID-19 fall winter preparation forward. David Byres will be the key support to Steve in focusing on other non-COVID 19 health service issues.

Significant work has been underway over summer using the draft of the action plan that was circulated in advance of the final published version on September 9,2020. Objective is to now consolidate and complete that work in the most efficient and effective way possible within the September 28 – November 7, 2020 timeframe, so as to be as strongly prepared as we can be by the end of October using the action plan as our reference point. In early November we will take stock of where we are and what further actions need to follow in November/December. This will align with the establishment of the newly elected government and any additional or different direction they may wish to provide based on our status.

Any CEOs or lead(s) experiencing challenges must link with Steve immediately to problem solve issue. Steve will link in others as required.

David Byres will work directly with FNHA on what is and how best to support their preparation for fall/winter Covid-19 management.

The 24 actions set out in plan are grouped into five domains:

- **Population and Public Health**
- **Primary and Medical Specialist Community Care**
- **Specialized Community Services**
- **Laboratory Services**
- **Hospital Services**

- A six-week plan has been developed with weekly deliverables/milestones linked to the implementation of the action at a service level.
- The MOH ADM/HA VP COVID 19 working group will meet weekly on a Friday morning between 8:00am – 10:00 am to review progress/issues; a report out will be prepared by CHREM between 10:00am and 2:--pm; Steve, Pete, David, Ian to review 2:00 pm – 3:00 pm each Friday; any concerns will be immediately communicated back to the leads.
- MOH Senior Executive will meet each Monday morning 7.30 – 9.30am and Leadership Council will meet each Monday morning 10.00 -12.00 am (starting October 5) to review status and problem solve any challenges.
- Other key sectors will be engaged in a weekly process over the coming week starting with the health unions
- This first update sets out the actions and weekly deliverables/milestones. The purpose of this document and process is for **macro-level oversight and coordination of the fall/winter plan by MOH SET/HA COVID 19 VPs and Leadership Council**. Each HA will already have a complementary and more detailed operational plan that should link with this macro level coordination process.

ACTIONS

Population and Public Health

1. Engage population and individuals to maintain control measures
2. Guidance for commercial, public and domestic settings on control measures
3. Testing, contact tracing and case management
   - 3.1 Daily testing capacity/wait times
   - 3.2 Contact tracing & case management capacity
   - 3.3 Use of contact tracings app(s)
   - 3.4 IMIT tools for integrated information capture and reporting
4. Flu immunization
5. Preparation for COVID 19 immunization

Primary Care

6. Primary care readiness for routine and COVID care delivery
7. Primary care guidelines and pathways for COVID patients
8. Healthy@Home for higher risk patients
9. Preparation for acute respiratory care centres

Specialized Community Care

10. HCC
    - 10.1 IPC
    - 10.2 Increased care to keep individuals out of LTC proactively
    - 10.3 Increased care to allow individuals to defer admission to LTC for fall/winter (incl recruitment)
11. LTC preparation
    - 11.1 Visitor policy and management
    - 11.2 FluzoneHD immunizations
    - 11.3 Policy on admission, transfer, absences linked to community-based risk analysis
    - 11.4 IPC
    - 11.5 Single site on going management and resolution of issues
    - 11.6 New contract framework
    - 11.7 Recruitment initiative
12. Support and care for vulnerable populations

Lab Services

13. 20k daily processing capacity
14. Industrial/business testing (as requested)
15. Serological (as available and relevant)

Hospital Care

16. IPC
17. Transportation, testing, and support in rural BC
    - 17.1 Paramedic capacity
    - 17.2 Medical transportation capacity
    - 17.3 Short term housing

- 17.4 Virtual care (rural)
- 17.5 Testing access (rural)

18. Surge bed capacity
19. Community capacity to support hospital care if needed
20. Hospital care management
    - 20.1 ED pathways
    - 20.2 Visitor policy (acute)
    - 20.3 Bed management
    - 20.4 COVID-19 Cohorted Units
    - 20.5 Critical Care
21. Critical care capacity
22. Hospital@home
23. Hospital HHRM
    - 23.1 HA hiring status
    - 23.2 Preparation for redeployment

Logistics

24. PPE

POPULATION AND PUBLIC HEALTH ACTIONS

PREVENTION

1. **Individual and population engagement in maintaining essential control measures to suppress transmission is high (MOH Lead Lori H; BCCDC Lead Reka G; GCPE Jean Marc)**

MOH/BCCDC/GCPE DELIVERABLE OCTOBER 30

Tailored engagement and communication strategies and materials focused on specific populations or geographic areas for approval; campaign plan for implementation over the fall and winter.

Sept 28

- **Project team** established
- Draft **analysis** completed of major areas, populations and/or activities linked to transmission
- Review and outline of **messaging to date**
- Review and outline of any **communication materials**

Oct 5

- Segmented **analysis of major areas**, populations and/or activities linked to **transmission** completed
- Draft **outline of targeted engagement and communication** strategies

Oct 13

- Detailed outline of **engagement and communication strategies, timelines, budget**

Oct 19

- Draft **communications materials** developed

Oct 26

- Draft **communication materials** developed

Nov 2

- Draft **communication materials** developed

2. Enhanced guidance has been provided as needed for commercial, public and domestic settings to reduce virus transmissions indoors during the fall/winter (MOH Lead Lori H; BCCDC Lead Reka G; GCPE Jean Marc)

MOH/BCCDC/GCPE DELIVERABLE OCTOBER 30

Tailored guidance, communication, and engagement strategies and materials for use in targeted commercial, public and domestic settings

Sept 28

- **Project team** established
- **Draft analysis** completed of key commercial, public and domestic situations linked to virus transmission
- Review and **outline of guidance** to date
- Review and **outline of communication/engagement strategies and campaign** targeting these settings to date

Oct 5

- **Final analysis** completed including settings; review of guidance documents and any communication strategies
- **Recommendations, prioritization, timelines** for settings that would benefit from revised or new guidelines and or communication/engagement strategies

Oct 13

- **Draft** guidelines, communication and engagement **materials** for prioritized settings

Oct 19

- **Draft** guidelines, communication and engagement **materials** for prioritized settings

Oct 26

- **Draft** guidelines, communication and engagement **materials** for prioritized settings

Nov 2

- **Draft** guidelines, communication and engagement **materials** for prioritized settings

3. Testing, contact tracing and case management

3.1 Expanded community COVID-19 testing, contact tracing and case management is in place and working effectively and within timelines that seem reasonable to the public for testing and with 72 hours for contact tracing:

Adequate community based capacity to provide up to 20,000 tests per day provincially (appropriately distributed across regions and communities) with less than a 20 min wait (MOH Leads Lori H and Mark A; RHA Leads:...)

Sept 28

- MOH/PHO reviews strategy, guidance, and communication **strategy for testing** and type of testing to be used fall/winter
- MOH to identify potential range of **professionals** who could additionally deliver testing and sets out an approval/engagement process for completion in six weeks
- RHAs provide a detailed list and capacity (target number of tests administered per day within 20 mins) of **testing sites** in place and planned to be in service by the end of October

Oct 5

- **LC reviews and signs off** testing strategy; distribution and total capacity of testing; expansion of professionals able to do testing
- RHAs complete review to further **streamline** and develop their **regional testing strategies** to be able to meet maximum capacity with a "public friendly" process and a high efficiency processing line
- RHAs set out **plan to review and modify** each of their testing sites over the next four weeks

Oct 13

- MOH **update** on approval/engagement process for additional **professionals**
- RHAs **review sites and modify** as needed

Oct 19

- MOH **update** on approval/engagement process for additional **professionals**
- RHAs **review sites and modify** as needed

Oct 26

- MOH **update** on approval/engagement process for additional **professionals**
- RHAs **review sites and modify** as planned

Nov 2

- MOH **approval** for **professionals**
- RHAs **review sites and modify** as planned

3.2 Adequate community based contact tracing and case management capacity to support X,000 of contacts under active public health monitoring within the 72 hour target (appropriately distributed across regions and communities) (MOH Leads Lori H and Mark A; RHA Leads:...)

Sept 28

- MOH SET and LC to review/revise contact tracing **staffing targets**
- MOH/VP COVID-19 leads **review recruitment/hiring criteria, process** and make modifications to improve efficiency and effectiveness. Reset weekly targets for next five weeks aligned with LC decision.

Oct 5

- MOH SET and LC reviews **weekly results**
- Ongoing monitoring, reporting and **issues mitigation** on contact tracing recruitment and hires in place

Oct 13

- MOH SET and LC reviews **weekly results**
- Ongoing monitoring, reporting and **issues mitigation** on contact tracing recruitment and hires in place

Oct 19

- MOH SET and LC reviews **weekly results**
- Ongoing monitoring, reporting and **issues mitigation** on contact tracing recruitment and hires in place

Oct 26

- MOH SET and LC reviews **weekly results**
- Ongoing monitoring, reporting and **issues mitigation** on contact tracing recruitment and hires in place

Nov 2

- MOH SET and LC reviews **weekly results**
- Ongoing monitoring, reporting and **issues mitigation** on contact tracing recruitment and hires in place

3.3 Digital contact tracing application have been assessed and are in place as an enhancement to traditional contact tracing (MOH Lead Corrie B; BCCDC Lead Reka G)

Sept 28

- Complete engagement with and evaluation of federal application (COVID Alert) with recommendations to PHO/LC; identify any other currently potential/viable **applications**

Oct 5

- LC/PHO **decision** to move forward or not with one or more applications

Oct 13

Oct 19

Oct 26

Nov 2

3.4 Technological tools to permit timely, integrated and co-ordinated information capture for case and contact management database are in place across regions and linked to BCCDC to enable a rapid public health response when required along with enhanced reporting and analysis capacity through to the PHO/DM (MOH Lead Corrie B; HA Leads:...)

Sept 28

- Confirm PHO/BCCDC/Public Health; Regional HA SET; DMO **requirements**; interface requirements with contender solution

Oct 5

- **Demo** contender solution with PHO/BCCDC/Public Health; Regional HA SET; DMO
- Complete work with contender and prepares **decision note**

Oct 13

- PHO and LC **approval**
- Finalize procurement and contractual terms and **sign**
- Commence **build** of solution

Oct 19

- Continue **build** of solution

Oct 26

- Continue **build** of solution

Nov 2

- **Implement** solution

4. **A community fall flu immunization campaign is implemented with a target of providing 1.97M immunizations with ease of access for the public (appropriately distributed across regions and communities) (MOH Lead Lori H; BCCDC Lead:...; RHA Leads...)**

Allocation:

- FHA 609,500
- IHA 310,100
- NHA 75,200
- VCHA 494,200
- VIHA 324,500
- PHSA 151,500

Key Community Partners:
GPs
Pharmacists

Sept 28

- Drafting **immunization operational action plan** establishing timing, locations, staffing, and distribution mechanisms across health authority regions

Oct 5

- **Update** on action plan to **MOH SET and LC**
- Complete **immunization operational action plan**
- Drafting **communications and promotion plan and materials**

Oct 13

- **MOH SET and LC signs off** operational action plan and communications plan/materials
- Ensure **logistics in place** for distribution, providers, PPE

Oct 19

- Ensure **logistics in place** for distribution, providers, PPE

Oct 26

- Launch **communications and engagement plan**
- Ensure **logistics in place** for distribution, providers, PPE

Nov 2

- **Commence flu immunizations**
- Prepare for **weekly report outs** starting November 9

5. A patient prioritization policy for immunization and plan to build out capacity and supplies is in place with Regional Health Authorities prepared for a large-scale immunization campaign across the province over a six-month timeframe contingent on a vaccine becoming available. (MOH Lead Lori H; BCCDC Lead Reka G)

Planning to commence in November/December

BCCDC has built out additional capacity to sustain and strengthen ability to respond to the crisis (BCCDC Lead: Reka G)

Sept 28

- **BCCDC provides plan** to PHO/DM for discussion

Oct 5

Oct 13

Oct 19

Oct 26

Nov 2

PRIMARY CARE AND MEDICAL SPECIALIST CARE ACTIONS

6. **Primary Care Networks (PCNs) are well prepared for the fall/winter Covid-19 response as well as for routine care of their patients, ensuring access to both virtual and in-person care of patients as appropriate, with an additional focus on identifying/supporting vulnerable populations as well as supporting the fall/winter flu immunization plan. Where no PCN is in place, Regional H. (MOH Lead: Ted P; RHA Leads:...)**

Key Community Partners:
DoBC/GPSC
Divisions of Family Practice
PCNs and UPCCs
GPs and Primary Care Practitioners

Sept 28

- Meeting of project working group to clearly identify and resolve any outstanding **issues**, reaffirm **priority areas** for focus/planning and attached **funding** and efficient mechanisms for review/approval of requests
- Clarify **access to PPE** and mechanisms
- Initiate **engagement with CPS** regarding professional expectations for primary care physicians if required
- Develop **enhanced communications and engagement strategy** for GP practices to keep them informed of developments and relevant information on COVID-19 as well as local transmission information

Oct 5

- **MOH SET and LC reviews** proposal
- Issue a refreshed memo providing **guidance to PCNs, Divisions/HAs** on priority areas, balancing virtual and in-person care, communication to patients, funding, and proposal/approval mechanisms, PPE access

Oct 13

- Active **engagement with PCNs, HAs/Divisions** to ensure shared understanding and agreement on directions for fall/winter
- **Pathways (GPSC) virtual physician service directory** (linked with HealthLink BC) and public communications plan complete and ready for launch

Oct 19

- Active **planning** underway across PCNs, Divisions/HAs

Oct 26

- Active **planning** underway across PCNs, Divisions/HAs

Nov 2

- Launch **public communication**

7. Primary Care Practitioners understand and consistently utilize community patient care guidelines and practices for COVID-19 positive or suspected patients that include rapid referral pathways to testing, observation, and/or higher levels of care (including specialized community services programs) as required (MOH Lead Ted P; RHA Leads:...)

Key Community Partners:
DoBC/GPSC
Divisions of Family Practice
PCNs and UPCCs
GPs
Primary Care Practitioners

Sept 28

- **Guidelines** under review and development
- RHAs development of CHSA specific directions for accessing testing and higher levels of care (specialized community services or acute hospital care) underway

Oct 5

- **Guidelines** under review and development
- RHAs development of **CHSA specific directions for accessing testing and higher levels of** care (specialized community services or acute hospital care) underway

Oct 13

- **Guidelines** under review and development
- RHAs development of **CHSA specific directions for accessing testing and higher levels of** care (specialized community services or acute hospital care) underway

Oct 19

- **Guidelines** approved by Clinical Reference Group
- Linked **guidelines and pathways** are reviewed and **signed off** by working group
- **Communications strategy** and dissemination plan developed

Oct 26

- Review and **sign off by MOH SET and LC**
- **Prepare** for dissemination

Nov 2

- Dissemination of guidance underway; posted to BCCDC website; distributed through GPAC and other professional channels

8. **Healthy@Home care initiative is implemented across all regions with operational and patient care clinical guidelines and operational criteria (including virtual care) focused on the health and safety of older patients and/or individuals who are more likely to experience a serious form of the illness due to underlying chronic medical conditions focused on both preventative care as well as care pathways if they become COVID-19 positive (MOH Lead Ted P; PHSA Lead Maureen O'D; RHA Leads:...)**

Key populations:

1. Cardiac patients
2. Diabetic patients
3. Respiratory patients (COPD, Cystic Fibrosis)
4. Moderate to complex co-morbid medical patients
5. Oncology patients
6. Renal patients
7. Transplant patients
8. Frail Seniors

Key Action Community Partners:

Clinical reference groups
Regional Health Authority Ambulatory Care Programs,
Community Medical Specialists
PCNs/GPs
Primary Care Practitioners

Sept 28

- MOH SET/LC discussion of **Healthy@Home concept and challenges/opportunities**
- **Working group** established
- **Healthy@Home program outline/description**
- **Guidelines** either under review (existing) or in development (new) to cover proactive care to prevent/reduce hospital admissions and responsive care if a patient becomes COVID-19 positive

Oct 5

- **Guidelines** either under review (existing) or in development (new)
- RHAs develop **regional plans** to implement Healthy@Home program
- Regional **provider and patient identification** processes established

Oct 13

- **Guidelines** either under review (existing) or in development (new)
- RHAs develop **regional plans** to implement Healthy@Home program
- Regional **provider and patient identification** processes established
- **Communication**/engagement strategy developed

Oct 19

- **Guidelines** either under review (existing) or in development (new)
- RHAs develop **regional plans** to implement Healthy@Home program
- Regional **provider and patient identification** processes established
- **Provider** (GPs and Medical Specialists) engagement commences

Oct 26

- **MOH SET and LC sign-off**
- **Prepare** for launch
- Provider **engagement** underway

Nov 2

- **Provider engagement** continues and patient engagement commences
- **Public communication**

9. UPCCs and specific primary care clinics have been identified and are prepared to operate as "acute respiratory care centres" for the coming fall/winter flu/COVID-19 season within 5 working days if asked by the RHA to meet assessment, testing and short-term 14 day care needs of COVID-19 patients (MOH Lead: Ted P; RHA Leads: Yasmin J, Kelly G, Norm P, Jason G, Jamie B)

Key Community Partners:
PCNs/Primary Care Clinics
DoB/GPSC, Divisions of Family Practice
UPCCs
GPs
Primary Care Practitioners

Sept 28

- **LC discuss** the use, scope and timing of using UPCCs as "acute respiratory assessment centres"
- MOH Primary Care to **engage with GPSC, Divisions, PCNs** to discuss the use, scope and timing of using UPCCs and specific primary care clinics as "acute respiratory assessment centres" if there are high levels of COVID-19 positive in the community

Oct 5

- MOH Primary Care to **engage with GPSC, Divisions, PCNs** to discuss the use, scope and timing of using UPCCs and specific primary care clinics as "acute respiratory assessment centres" if there are high levels of COVID-19 positive in the community

Oct 13

- **Feedback** from community discussions reviewed at **LC and direction provided** on moving forward

Oct 19

- RHA/Divisional/PCN **planning** as required

Oct 26

- RHA/Divisional/PCN **planning** as required

Nov 2

- RHA/Divisional/PCN **planning** as required

SPECIALIZED COMMUNITY CARE SERVICES ACTIONS

10. Home and Community Care

10.1 Home and Community Care Services have appropriate IPC standards in place (MOH Lead Teri C; RHA Leads:...)

a) (i) IPC standards developed for the spring phase of the pandemic have been reviewed and any revisions to strengthen standards and guidelines have been made
(ii) Health authority and community agency are prepared and have capacity (including additional staff) to fully implement IPC standards
(iii) There are processes and capacity in place to follow-up and review after any outbreaks and apply lessons learned across delivery agencies

Key Community Partners:
Contracted Service Providers
Health Service Delivery Staff
CBA

Sept 28

- MOH compiles a **comprehensive list** of existing and proposed **IPC** standards/guidelines for health sector as a whole
- MOH completes initial **review** of which should be updated and prioritize focus

Oct 5

- MOH/RHAs review standards/guidelines to make **final decision** on any gaps or that require revision
- **Draft or update** standard/guideline documents as needed
- **Communication and engagement** with service delivery management and staff
- RHAs undertake **program-based assessment** of practice to identify gaps or need for improvement including additional staff

Oct 13

- **Draft or update** standard/guideline documents
- RHAs continue **program-based assessment** of practice to identify gaps or need for improvement including additional staff

Oct 19

- **Draft or update** standard/guideline documents
- RHAs continue **program-based assessment** of practice to identify gaps or need for improvement including additional staff

Oct 26

- RHA **assessment of current IPC performance** and development of implementation specific mitigation plans as required
- MOH/RHAs agree ongoing **monitoring, audit and reporting protocols**

- MOH/RHAs agree **outbreak review protocols and processes**

Nov 2

- Consistent **implementation** underway
- **Monitoring, audits, and reporting** commence

10.2 Options for individuals to remain at home with supports are in place over the coming year as an alternative or to defer admission to Long-Term Care/Assisted Living during the COVID-19 pandemic. Additional staff recruitment is underway to ensure adequate capacity.

10.3 Learnings from local initiatives (such as the Vancouver Coastal Health's *Personalized Stabilization and Support Program*) are identified and programs implemented to proactively better support individuals aging at home as an alternate to long term care with additional staff capacity in place as needed.

Key Action Partners:
Isobel/OSA
Regional HAs
Agencies

Sept 28

- (b1) **Scope of program** and target demographic determined (including services provided, characteristics of who can be hired etc.).
- (b2) Provision for IADLs in Home Support utilizing CHW1s: **Review Island Health CHW1 pilot** including evaluation.
- (b2) Increased **Access to Short Term HCC Services**: Review VCH Patient Stabilization and Island Health Enhanced Discharge Programs.

Oct 5

- (b1) **Eligibility criteria** for program and assessment tools and process established.
- (b2) Provision for IADLs in Home Support utilizing CHW1s: **Draft DBN on labour challenges** in community sector with options to address.
- (b2) Increased Access to Short Term HCC Services: Identify specific **expectations for reablement** services.

Oct 13

- (b1) **Funding** model confirmed.
- (b1) Proposed project and policy for **approval** (including analysis of risk and liabilities as well at options for mitigation).
- (b2) Increased Access to Short Term HCC Services: Draft **Policy**

Oct 19

- (b1) **Draft program package complete** for DM approval including:

- Policies and guidelines
- Monitoring and reporting indicators
- Communication and implementation plan.

- (b2) Provision for IADLs in Home Support utilizing CHW1s: Develop **provincially standard orientation for CHW1 role.**
- (b2) Provision for IADLs in Home Support utilizing CHW1s: Develop **Evaluation Criteria.**
- (b2) Provision for IADLs in Home Support utilizing CHW1s: Executive **Approval of Policy**
- (b2) Increased Access to Short Term HCC Services: Executive **Approval of Policy.**
- (b2) Increased Access to Short Term HCC Services: Develop **Evaluation Criteria**

Oct 26

- **LC review and discussion**
- RHA **engagement with program managers and staff**

Nov 2

- RHA **engagement with program managers and staff**
- **Public communication**
- Begin **implementation**

11. Long Term Care and Alternative Living Sites are well prepared for ongoing COVID-19 response and management over the fall/winter period (MOH Lead Teri C; RHA Leads:...)

11.1 Visitor policy and practices have been reviewed to optimize safety of residents balanced with harm caused by ongoing separation from family and friends

Key Action Partners:
BCCP/DCPA
Regional HAs
Agencies
Staff

Sept 28

- **Review current guidelines** on family/social visitation and recommend changes
- Identify the appropriate **legal authority** upon which visitor restrictions and ensure consistently applied in all HA

Oct 5

- Develop **supplemental document or interpretive guide** in alignment with acute care for essential visits
- Develop **risk-based criteria** for visitor restrictions in fall/winter

Oct 13

- Determine an **appeals process/avenue** for complaints in both private and public settings and develop public-facing accessible materials

- Develop **fair procedures** that will apply if a visitor is at **risk of losing** their essential or family/social visitor status.

Oct 19

- Prepare an initial **response to OSA** concerns/provide written response to survey

Oct 26

Nov 2

- Provide **written response to Ombudsperson** letter & recommendations

11.2 Fluzone-HD immunizations are available, coordinated through BCCDC, for all Long-Term Care residents:

FHA	13,920
IHA	10,030
NHA	1,610
VCHA	9,550
PHSA	480

Key Action Partners:
BCCDC
BCCP/DCPA
Regional HAs
Agencies

Sept 28

- Drafting **Fluzone HD immunization operational action plan** establishing timing, locations, staffing, and distribution mechanisms across health authority regions/sites

Oct 5

- **Update** on action plan to **MOH SET and LC**
- Complete immunization **operational action plan**
- Drafting **communications and promotion plan and materials**

Oct 13

- **MOH SET and LC signs off** operational action plan and communications plan/materials
- Ensure **logistics** in place for distribution, providers, PPE

Oct 19

- Ensure **logistics** in place for distribution, providers, PPE

Oct 26

- Launch **communications and engagement plan** with LTC/AL sites
- Ensure **logistics** in place for distribution, providers, PPE

Nov 2

- **Commence flu immunizations**

- Prepare for **weekly report outs** starting November 9

11.3 Policies that guide the admission, transfer and absences from Long-Term Care/Assisted Living have been reviewed and, amended as required to include risk-based criteria to guide when policy restrictions will be implemented

Key Action Partners:
Isobel/OSA
BCCP/DCPA
Regional HAs
Agencies

Sept 28

N/A

Oct 5

- **Review temporary policy adjustments** made in the Spring and consult with HAs on impact/effect – did the restrictions achieve the intended outcome? Were they implemented at the right time?
- **Review recommendations** from Ernst & Young Report

Oct 13

- Develop **risk-based criteria** for policy restrictions in fall/winter (admissions, transfers, absences)

Oct 19

- **Consult** with HAs, OSA and Industry Associations (BCCPA, DHA, BCSLA) on risk based criteria to identify unintended consequences and required mitigation

Oct 26

- Obtain Executive **Approval,** in consultation with PHO

Nov 2

- **Communicate** policy direction to sector

11.4 Infection Prevention and Control
a) Requirements are in place for monitoring and reporting on Infection Prevention and Control practice across all Long-Term Care/Assisted Living sites
b) There are processes and capacity in place to follow-up and review after any outbreaks and apply lessons learned across delivery agencies

Key Action Partners:
BCCP/DCPA
Regional HAs and MHOs

Sept 28

- MOH compiles a comprehensive list of existing and proposed IPC standards/guidelines for health sector as a whole
- MOH completes initial **review** of which should be updated and prioritize focus

Oct 5

- MOH/RHAs **review standards/guidelines** to make final decision on any gaps or that require revision
- **Draft or update** standard/guideline documents as needed
- **Communication and engagement** with service delivery management and staff
- RHAs undertake **program-based assessment of practice** to identify gaps or need for improvement including additional staff

Oct 13

- **Draft or update** standard/guideline documents
- RHAs continue **program-based assessment of practice** to identify gaps or need for improvement including additional staff

Oct 19

- **Draft or update** standard/guideline documents
- RHAs continue **program-based assessment of practice** to identify gaps or need for improvement including additional staff

Oct 26

- RHA **assessment of current IPC performance** and development of **implementation specific mitigation plans** as required
- MOH/RHAs agree ongoing **monitoring, audit and reporting protocols**
- MOH/RHAs agree **outbreak review protocols and processes**

Nov 2

- Consistent **implementation** underway
- **Monitoring, audits, and reporting commence**

11.5 Single-site working directive has been reviewed and unforeseen negative consequences have been mitigated

Sept 28

- MOH **reviews status of single site working directive** with HAs, providers, and unions to identify any unforeseen negative consequences and mitigating strategies. Prepare to discuss with LC

Oct 5

- **LC discussion and direction** on any mitigating strategies

- MOH work with partners on **mitigation strategies** for key issues, barriers and/or negative consequences

Oct 13

- MOH work with partners on **mitigation strategies** for key issues, barriers and/or negative consequences

Oct 19

- MOH work with partners on **mitigation strategies** for key issues, barriers and/or negative consequences

Oct 26

- MOH work with partners on **mitigation strategies** for key issues, barriers and/or negative consequences

Nov 2

- Update of progress to LC
- MOH work with partners on **mitigation strategies** for key issues, barriers and/or negative consequences

11.6 A new provincial template contract structure creating equitable wage rates and funding and clear requirements for quality, including safety in under development (to be in effect for April 1, 2021) (also includes additional MOH Leads: Mark A, Philip T)

Key Action Partners:
BCCP/DCPA
Regional HAs
FBA

Actioned already:

- MOH retained Ernst & Young (EY) to assist in developing new funding model and template contract.
- Jurisdictional scan on funding models completed by EY.
- Interviews with diverse stakeholders to inform new contract and funding mode.
- MOH initiated online reporting tool for LTC, reviewing data

Sept 28

- MOH initiate **legal analysis** s.13; s.14

s.13; s.14 Establish a working group key partners

- Finalize **draft project plan** based on review of Ernst & Young report on funding for LTC sector. Initiate analysis of existing contract templates Initiate financial modelling for level wage options Initiate evaluation of safety impact of single site order

Oct 5

- **Briefing to LC**

- MOH consult with HEABC on **single site transition framework (SSTF) and collective agreement implications**

Oct 13

- MOH consult with HEABC on **single site transition framework (SSTF) and collective agreement implications**

Oct 19

- MOH prepare **briefing** on SSTF and collective agreement implications
- MOH complete **evaluation of safety impact**

Oct 26

- **Update briefing to LC**
- MOH initiates **engagement plan for LTC** sector on permanent single site model

Nov 2

- Collect **feedback** from partners and stakeholders on the proposed path forward.

11.7 Recruitment of additional staff for Long Term Care is substantively underway with aggressive monthly targets for getting new staff in place (additional HA Lead: Mark A):

a) Provincial recruitment initiative actively targets displaced workforces in BC from the hospitality, food services, retail and tourism sectors as well as other interested individuals to be employed and trained within the Long-Term Care sector. This will be in both direct patient care (Care Aides) and in-direct patient care (food services, cleaning, security etc.) with potential to also refer to home care sector contingent on response

Key Action Partners:
BCCP/DCPA
Regional HAs
Recruitment Solutions
FBA

b) Implement and market the alternate registration pathway for qualified, out-of-province Health Care Aides to enable health authorities and affiliates to efficiently hire qualified Health Care Aides to meet staffing needs, while ensuring standard orientation program requirements are in place and delivered by employers

Key Action Partners:
Teri
BCCP/DCPA
Regional HAs
Recruitment Solutions
FBA

c) Ministry of Health (Health Sector Workforce and Beneficiary Services Division) will work closely with employers and the Facility Bargaining Association (FBA) Recruitment and Retention Committee on other action-oriented strategies to recruit and retain Care Aides in the Province.

Key Action Partners:
BCCP/DCPA
Regional HAs
Recruitment Solutions
Agencies
FBA

Actioned:

- EOI opened September 9, 2020 – 7902 EOIs received to date
- Jan-Sept candidates qualified for expedited pathway 192 with 163 registered for processing
- HEABC-FBA Joint Care Aide Recommendation Report Working Draft completed

Sept 28

- **Review approach** and sign off by DM – including expansion to include home care and number of positions available
- **Update to LC**
- Establish **cross sector steering committee**: RHAs, BCCP, DCP, FBA
- **EOI candidates contacted** for initial program screening
- Collection of **baseline/vacancy data** across sector
- Establish **reporting mechanism** for reporting out weekly on progress
- **Job description and classification** work completed
- Analysis of cost to close **differential between FBA and CBA** rates sooner than 2021
- Agree **expedited hiring process** with RHAs and agencies
- Continued marketing of expedited pathway
- **HEABC-FBA Report** submitted to MOH

Oct 5

- **Update to LC**
- **Eligible candidates made available** to regional employers based on geography and area of interest
- **Review modular approach to training** and sign off approach and scheduled launch by DM, AEST and PSI as needed
- Continued **marketing** of expedited pathway
- MOH **response to report** submitted to committee

Oct 13

- **Update to LC**

- **Eligible candidates made available** to regional employers based on geography and area of interest
- Commence **weekly reporting** of hiring/region
- **Modular training approach under development**
- Continued **marketing** of expedited pathway
- **HEABC-FBA-MOH joint action plan** developed

Oct 19

- **Update to LC**
- **Eligible candidates made available** to regional employers based on geography and area of interest
- **Weekly reporting** of hiring/region
- **Modular training** approach under development
- Continued **marketing** of expedited pathway
- Commence **implementation** of action plan

Oct 26

- **Update to LC**
- **Eligible candidates made available** to regional employers based on geography and area of interest
- **Weekly reporting** of hiring/region
- **Modular training** approach under development
- Continued **marketing** of expedited pathway
- **Implementation of action plan**

Nov 2

- **Update to LC**
- **Eligible candidates made available** to regional employers based on geography and area of interest
- **Weekly reporting** of hiring/region
- **Modular training** approach under development
- Continued **marketing** of expedited pathway
- **Implementation of action plan**

12. **Ensure provision of services to serve community care and targeted groups of vulnerable populations being housed in provincial shelters and congregate housing during the COVID-19 pandemic**

Key Action Partners:
Ted/Primary Care
Ministries of Social Development & Poverty Reduction, Housing, Mental Health and Addictions

Sept 28

- Develop **guidance** for RHAs and agencies for fall/winter and funding levels
- Commence development of **guidelines for Rx Alternative strategy**

Oct 5

- **LC reviews** guidance/funding and provides direction
- MOH/RHAs agree **monitoring and reporting** mechanisms

Oct 13

- Commence **implementation and reporting**

Oct 19

- **Rx Alternatives implementation** commences

Oct 26

Nov 2

LABORATORY TESTING CAPACITY ACTIONS

13. COVID-19 NAT testing capacity of approximately 20,000 daily processing, including testing for flu, is in place (MOH Lead: Mitch M; PHSA/LAB Agency Lead:...; RHA Leads:...)

Key Action Partners:
BCCDC
HSA

Actioned:

- Engaged with PLMS, lab leaders, EOC and others regarding the Surge business plan and activities on the ground. Reviewed Surge recovery plan to understand shortfalls and gaps.
- Completed agreement to increase LifeLabs' contribution to the provincial capacity target of 20,000 tests/day by October 1, 2020 by entering into a short-term agreement with the possibility of extension.
- Health Gateway (HG) includes COVID-19 Lab Results for citizens to access (positive and negative results) (HSIMIT)

Sept 28

- MOH/PHSA establish a working group with governance structure to **integrate the pre-analytics work done at collection centres with the laboratory system.**
- PHSA provide support to **Valley Medical** (procurement of kits and reagents) the Panther non-fusion equipment into function which could provide additional COVID testing capacity in Interior Health
- Consideration of **testing modality options** within surge plan (saliva, nasal swab, other)

Oct 5

- **LC reviews surge plan**
- MOH actively **monitors implementation** of the PLMS surge plan, including initiatives related to:
  - procurement of additional infrastructure, equipment and facilities by monitoring the transfer of capital funding to PHSA/HAs
  - exploring potential for sample pooling and its potential contribution to enhance the provincial capability to deliver 20,000 tests/day by October 1, 2020
  - developing enhanced workflows
  - implementation of bidirectional interface
  - enhancing HHR by working with responsible ministry divisions
  - Identify risks and mitigation strategies.
  - Incorporate the actions identified and resulting from the Deloitte workshop for the laboratory services

Oct 13

- MOH actively **monitors implementation** of the PLMS surge plan and reports out on system test lab processing capacity from end of previous week

Oct 19

- MOH actively **monitors implementation** of the PLMS surge plan and reports out on system test lab processing capacity from end of previous week
- MOH **finalize citizen flow and enabling technology solutions linked to Health Gateway (HG)** providing COVID-19 Lab Results for citizens to access (positive and negative results) (HSIMIT)

Oct 26

- MOH actively **monitors implementation** of the PLMS surge plan and reports out on system test lab processing capacity from end of previous week
- MOH **announcement on Health Gateway**
- HAs begin **regional communication** to citizens re access to Health Gateway

Nov 2

- **Assessment of lab processing capacity** against 20,000 daily capacity target and identification of additional action if required

14. Availability to work with large scale industrial and/or business sectors if they develop evidence-based proposals to introduce testing linked to their businesses to both support and ensure alignment with provincial guidelines and practice

Key Action Partners:
BCCDC

Actioned:

- DBNs in approvals to confirm Ministry position and next steps regarding private pay asymptomatic testing (by private accredited labs); provision of asymptomatic testing by industry for employees; and provision of serology testing by the private sector.
- Identification of 8 potential models for industry's provision of asymptomatic testing, and the regulatory requirements and obligations associated with each.
- Discussions with Diagnostic Accreditation Program to confirm DAP accreditation requirements for accredited facilities, lab-assisted and non-lab assisted testing, diagnostic vs non-diagnostic (screening) tests, and point of care testing.
- Discussions with industry to better understand the model they are proposing and clarify for them the legislative and regulatory obligations.
- Working with BCCDC and PLMS to develop information, including a questionnaire or "requirements" tool, for posting on the BCCDC website to assist labs and other businesses wanting to be listed on the BCCDC webpage of labs providing private pay testing.

Then as needed:

- Draft, with PMLS, information clarifying the requirements for organizations wanting to provide private pay testing in BC and be listed on the BCCDC website

- Respond to industry, addressing specific questions and proposals for providing asymptomatic testing on private pay basis
- Monitor Health Canada approvals of new tests, including antigen tests, and incorporate into BC information
- Monitor developing PT approaches to testing and private pay testing for potential approaches in BC

15. As available, ability to assess the true extent of COVID-19 infections at a population level by means of a systematic and representative serological survey of communities to determine susceptibility and immunity if such testing is validated (additional MOH Lead: Lori H)

Key Action Partners:
BCCDC

BCCDC is still in discussion with Public Health Leadership on the scope of serological investigations to be conducted and what it will tell us given the estimated seroprevalence being very low

BCCDC advises that "answering the question of a representative population seroprevalence at this time will mean testing tens of thousands of individuals of whom 99% will likely be negative."

No further action at this time

HOSPITAL CAPACITY & SERVICES ACTIONS

These actions link to all hospitals but in the coming several weeks there should be a strong focus on the 19 Covid-19 hospital sites (MOH Lead: Teri C; HA Leads:...)

16. a) Standards and practices for Hospital Infection Prevention and Controls Review have been reviewed and any revisions made and clearly communicated across hospitals
    b) Health authorities are implementing the standards and practices across all of their hospitals
    c) Health authorities have established practices for monitoring and reporting on consistent Infection Prevention and Control practices across all hospital sites through to their Executive, PHO and Ministry of Health

Key Action Partners:
DoBC/Hospital Based Physicians
FBA, HSA, NBA
Health Staff

Sept 28

- MOH compiles a **comprehensive list of existing and proposed IPC standards/guidelines** for health sector as a whole
- MOH completes **initial review** of which should be updated and prioritize focus
- MOH and HAs scope out a **communication and engagement strategy** for hospital-based management, physicians, and staff on self management/protection away from work and IPC at work

Oct 5

- MOH/HAs **review standards/guidelines** to make final decision on any gaps or that require revision
- **Draft or update** standard/guideline documents as needed
- MOH and HAs **finalize communication and engagement strategy** for hospital-based management, physicians, and staff on self management/protection away from work and IPC at work
- HAs undertake **hospital-based assessment of practice** to identify gaps or need for improvement including additional staff starting with nineteen COVID-19 sites

Oct 13

- **Draft or update** standard/guideline documents
- HAs undertake **hospital-based assessment of practice** to identify gaps or need for improvement including additional staff starting with nineteen COVID-19 sites
- Commence ongoing **communication and engagement** with hospital-based management, physicians, and staff on self management/protection away from work and IPC at work

Oct 19

- **Draft or update** standard/guideline documents

- HAs undertake **hospital-based assessment of practice** to identify gaps or need for improvement including additional staff starting with nineteen COVID-19 sites

Oct 26

- **HA assessment of current IPC performance across nineteen COVID-19 sites** and development of implementation specific mitigation plans as required
- MOH/HAs agree ongoing **monitoring, audit and reporting protocols**
- MOH/HAs agree **outbreak review protocols and processes**

Nov 2

- Consistent **implementation** underway
- **Monitoring, audits, and reporting** commence

17. The Rural, Remote and Indigenous Community Framework in collaboration with BC Emergency Health Services, Regional Health Authorities and the First Nations Health Authority is fully implemented to provide more in-community support and testing, timely access to primary and urgent hospital care:

17.1 Paramedic capacity linked to transportation and travel vent capacity/skills is addressed.
17.2 Medical transportation options are in place.
17.3 Short term housing and accommodation options for COVID-19 patients in rural and remote locations close to hospital care are in place.
17.4 Continued use of virtual doctor of the day programs are in place
17.5 Access to testing for rural areas in place.

Key Action Partners:
BC Ambulance/PHSA
Regional Health Authorities
Rural Primary Care
FNHA
APBC

Actioned:

- (c) Health authority plans submitted to MOH (Current Status: *Complete).*
- (c) Health authorities to establish transport plans from rural communities (Current Status: *Complete).*
- (c) Health authorities to implement CCCs proximally to larger acute care centers (Current Status: *Complete).*
- (c) MoH to communicate funding to health authorities (Current Status: *Complete).*
- (a)(b) BCEHS draft fall/winter staffing plan (Current status: *On Track).*

Sept 28

- Prepare update BN for **LC on overall status of implementation** by health region (a)-(e)

Oct 5

- LC to review status note and provide any direction required

Oct 13

Oct 19

Oct 26

Nov 2

- (a)(b) BCEHS staff deployed

18. Health authorities have practical plans in place to operationalize surge capacity across their hospitals with fully developed health human resource preparation and deployment plans for the fall and winter

Key Action Partners:
Regional Health Authorities
Hospital based physicians
FBA, HAS, NBA
Health Staff

Actioned

- HAs have completed an **initial assessment of actions** lined to implementing surge capacity against 4 scenarios

Sept 28

- MOH **modifies daily reporting on hospital occupancy against detail on COVID-19 sites** and then other hospitals to provide a more accurate picture of current status
- MOH establishes **protocols and process routines for review of current hospital occupancy** status with each HA
- HAs complete **detailed planning for adding surge bed capacity across nineteen COVID-19 sites** and other hospitals as required for scenarios 1-3; complete a contingency assessment for scenario 4

Oct 5

- **Implement new daily reporting** format
- HAs **complete detailed planning for adding surge bed capacity across nineteen COVID-19 sites** and other hospitals as required for scenarios 1-3; complete a contingency assessment for scenario 4

Oct 13

- **LC review of overall plans** for adding surge capacity and mitigation strategies to close any gaps

Oct 19

- On going **site-based preparation**

Oct 26

- On going **site-based preparation**

Nov 2

- On going **site-based preparation**

19. GP and Nurse Practitioner availability established to potentially:
    a) Provide shift coverages for hospitalists (who may be redeployed to critical care and respiratory/COVID-19 care) if there is a significant re-surge of COVID-19 admissions to a hospital using short-term alternative payment contracts to support non-fee for service work.
    b) Provide care for Long Term Care sites if needed.
    c) Provide primary care for patients with COVID-19 through designated Urgent and Primary Care Centres and clinics (respiratory care centres).

(additional MOH Leads: Ted P and Mark A)

Key Action Partners:
Divisions of Family Practice and PCNs

Actioned

- Spring approach to canvassing GPs/NPs reviewed and updated to incorporate learnings for Fall/Winter, September 25

Sept 28

- Contacts re-established in each regional health authority and a **new communication** to GPs and NPs drafted and signed by Ministry, Doctors of BC and NNPBC, October 2
- First **request** to identify available GPs/NPs sent out through GPSC to Divisions of Family Practice, to NPs through NNPBC, October 2

Oct 5

- Second **request** to canvass for available GPs/NPs to be sent out through GP and NP channels, Oct 9
- Clear requirements in place for **appropriate privileging and credentialing; compensation, etc.**, October 9

Oct 13

Oct 19

Oct 26

- Up-to-date GP/NP **inventories in place in each regional health authority**, October 30 with clear process and information for licensure, privileging and credentialing; compensation arrangements

20. RHAs manage in-patient bed occupancy and bed capacity (including implementing surge bed capacity) to ensure ability to respond to COVID-19 surge aligned with modelling and analysis:
COVID-19 hospital care structures and functions implemented for fall/winter management of COVID-19 transmission:

20.1 Emergency Department COVID-19 and Routine Pathways (respiratory/non respiratory).
20.2 Visitor policies in place.
20.3 ALC and other bed management processes in place
20.4 COVID-19 "Cohorted" Wards.
20.5 Critical Care (ICU/High Acuity Units) staffed and operational

Key Action Partners:
Regional Health Authorities
Hospital Based Physicians

Sept 28

- Review and document **preparation of nineteen COVID-19 hospital sites against (i), (ii), (iii), (iv), and (v)**
- (ii) Drafting **Visitor and Essential Visitor Interpretive Guidance - Acute Care**

Oct 5

- **Complete review** and document preparation of nineteen **COVID-19 hospital sites against (i), (ii), (iii), (iv), and (v)**
- **(ii) Final Visitor and Essential Visitor Interpretive Guidance - Acute Care** and hospital management and staff **communication plan** developed

Oct 13

- **LC review** of COVID-19 site readiness document
- (ii) **Communication** of Visitor and Essential Visitor Interpretive Guidance - Acute Care to hospital management and staff

Oct 19

- HAs undertake **mitigation actions** as required

Oct 26

- HAs undertake **mitigation actions** as required

Nov 2

- **COVID-19 site planning completed**

21. RHAs have built out ICU, HAU, ventilator capacity to at least high-level scenario

a. Capacity and equipment availability and needs are actively being monitored across hospital sites working with the Critical Care Clinical Working Group and PHSA Provincial Clinical Standards and Coordination team on allocation and use of ventilators to care for COVID-19 patients.

b. PHSA ensures a provincially coordinated approach to Biomedical support services

Actioned:

- Ethics Allocation Framework: FINAL version approved.

Sept 28

- Pandemic Mechanical and Fleet Ventilation Logistics **Working Group** (PMF VLWG)
  - TOR Drafted
  - Members invited
- PHSA implements a provincially coordinated approach to **Biomedical support services**

Oct 5

- PMF VLWG functioning
- **Identify any distribution issues**
- Incorporate **daily reporting** on ventilator capacity linked to **COVID-19 site reports** (including utilization, equipment or staff issues)

Oct 13

- **Report to LC** any issues/concerns

Oct 19

- HAs take **mitigation actions** as required

Oct 26

Nov 2

22. The "hospital@home" model (adopted from Australia) is underway for implementation in fall/winter of 2020/21 across primary COVID-19 hospital sites BC to reduce pressure on hospital inpatient medical beds and provide care closer to home in community settings.

a) Operationalize and build out H@H model – Prototype Sites (Island Health, NHA)
b) Operationalize and build out H@H model – Provincial Expansion (Interior Health, FHA, VCHA)

Key Action Partners:
HEABC

Actioned

- Project team for prototype sites already working

Sept 28

- **Interim policy framework** established
- **Labour Engagement and Readiness** completed
- **Physician compensation framework** completed

Oct 5

- **LC briefed** on launch of two prototype sites
- Establish MOH/RHA **working group to plan for provincial expansion** across COVID-19 sites

Oct 13

Oct 19

Oct 26

Nov 2

- **Prototypes launched VIHA and NHA**

23. Health human resource capacity is adequate for fall/winter high-level scenario (additional MOH Lead: Mark A)

23.1 Health Authority hiring status

a) All new nursing and allied health graduates have been offered employment and effective transition to practice supports and mentoring.
b) Health Employers Association of British Columbia (HEABC), through Recruitment Solutions (aka Health Match BC) is actively marketing and recruiting nurses and allied health within the province, nationally and internationally.

23.2 Preparation for redeployment

a) HEABC and Recruitment Solutions have developed virtual training materials and employer onboarding information to standardize and expedite nurses being job ready
b) Preparation completed for redeployment of staff in the fall/winter if required to meet surge in demand:
    i. Adequate respiratory/vent capable and critical care staff to meet projected demand for high level scenario;
    ii. Assessment and plans to attend to age and underlying health status of health care and support workers (including discussions with staff who are pregnant) as to where they might best and most safely be deployed so as not working as "cohorted" staff with COVID-19 patients;
    iii. Orientation material and processes in place as needed to support assigned staff from community to hospital care;
    iv. Canvas specialist availability (surgeons, anaesthetists, medical specialists from outpatient clinics) to provide shift coverages if a there is a significant surge in

inpatients. Use as needed short-term alternative payment contracts to support non-fee for service work

Key Action Partners:
HEABC, FBA, NBA, HSA, DoBC

Sept 28

Oct 5

- **Report out to LC on (a)-(c)**
- **Report out to LC on (d) against COVID-19 sites**

Oct 13

Oct 19

Oct 26

Nov 2

LOGISTICAL SUPPORT SERVICES ACTIONS

24. **Recommended Personal Protective Inventory targets and other key supply needs are in place for the fall/winter**

MOH Lead: Peter P and Ian R; PHSA Lead:….; RHA leads…)

Key Action Partners:
Agencies, Health Unions and DoBC

Sept 28

- PHSA/MOH bilateral **reviews current status pf PPE preparedness** for fall/winter

Oct 5

- **Report out to LC**

Oct 13

Oct 19

Oct 26

Nov 2

Murray, Heather HLTH:EX

From: Pokorny, Peter HLTH:EX
Sent: September 29, 2020 2:46 PM
To: Gold, Crystal HLTH:EX
Subject: Re: PPE Reports for the Week of September 25

Can you please print for me? Need them for PHSA bilateral tomorrow. Thanks!

Peter Pokorny
Associate Deputy Minister
Corporate Services
Ministry of Health
(778) 698-8046

On Sep 29, 2020, at 2:42 PM, Bell, Carolyn P HLTH:EX <Carolyn.Bell@gov.bc.ca> wrote:

Hi Peter, attached are the latest drafts from KPMG on weekly actual inventory and usage, projected use and stock piling for PPE and Critical Supplies. I am meeting this afternoon with KPMG to further refine the detailed inventory and it will be updated with when new inventory numbers come in this week form PHSA. The KPMG report for DM PPE Stockpile is being refreshed on Thursday.

Carolyn Bell, Executive Director/ Logistics Strategy/COVID Response and Health Emergency Management Division/BC Ministry of Health/office: 778-698-1755/cell: s.17

<Detailed Inventory Analysis.pptx>
<DRAFT_Deputy Minister Bi-Weekly PPE Stockpile Critical Supply Report_2020.09.25.pptx>
<Project Sigma - Appendix 1 09252020.xlsx>

Murray, Heather HLTH:EX

From: Pokorny, Peter HLTH:EX
Sent: September 29, 2020 3:02 PM
To: Bell, Carolyn P HLTH:EX
Subject: s.16

Can you just swing by?...I'm in a meeting but come on in. Thanks.

From: Bell, Carolyn P HLTH:EX <Carolyn.Bell@gov.bc.ca>
Sent: September 29, 2020 2:47 PM
To: Pokorny, Peter HLTH:EX <Peter.Pokorny@gov.bc.ca>
Cc: Rongve, Ian HLTH:EX <Ian.Rongve@gov.bc.ca>; Vandermolen, Chad HLTH:EX <Chad.Vandermolen@gov.bc.ca>; Vowles, Wendy M HLTH:EX <Wendy.Vowles@gov.bc.ca>; Gold, Crystal HLTH:EX <Crystal.Gold@gov.bc.ca>
Subject: s.16

I am in my office most of the rest of the afternoon on the 5th floor if you want to pop down or Crystal can find us a time

From: Pokorny, Peter HLTH:EX <Peter.Pokorny@gov.bc.ca>
Sent: September 29, 2020 1:30 PM
To: Bell, Carolyn P HLTH:EX <Carolyn.Bell@gov.bc.ca>
Cc: Rongve, Ian HLTH:EX <Ian.Rongve@gov.bc.ca>; Vandermolen, Chad HLTH:EX <Chad.Vandermolen@gov.bc.ca>; Vowles, Wendy M HLTH:EX <Wendy.Vowles@gov.bc.ca>
Subject: s.16

Let's chat quickly prior to responding. Thanks.

Peter Pokorny
Associate Deputy Minister
Corporate Services
Ministry of Health
(778) 698-8046

On Sep 29, 2020, at 1:28 PM, Bell, Carolyn P HLTH:EX <Carolyn.Bell@gov.bc.ca> wrote:

s.16

Murray, Heather HLTH:EX

From: Rongve, Ian HLTH:EX
Sent: September 29, 2020 4:16 PM
To: Pokorny, Peter HLTH:EX; Bell, Carolyn P HLTH:EX
Subject: Fwd: Burnaby Company Becomes the First Canadian-Made N95 to Receive Health Canada Authorization
Attachments: First Canadian Made N95 Authorized by Health Canada Sept 28 2020.pdf; ATT00001.htm

Can Melinda look into this.

Sent from my iPhone

Begin forwarded message:

> **From:** Steve Vander Wal <Steve.VanderWal@hkstrategies.ca>
> Date: September 29, 2020 at 4:05:20 PM PDT
> **To:** "Minister, HLTH HLTH:EX" <HLTH.Minister@gov.bc.ca>, "DMOFFICE, HLTH HLTH:EX" <HLTH.DMOFFICE@gov.bc.ca>, "Rongve, Ian HLTH:EX" <Ian.Rongve@gov.bc.ca>
> **Subject: Burnaby Company Becomes the First Canadian-Made N95 to Receive Health Canada Authorization**
>
> [EXTERNAL] **This email came from an external source. Only open attachments or links that you are expecting from a known sender.**
>
> I wanted to flag this announcement that Vitacore Industries Inc. has become the first Canadian company to receive Health Canada authorization to produce N95 equivalent respirators on home soil.
>
> With its production facility based in Burnaby, B.C., Vitacore is creating the new standard for PPE with a mission to protect frontline workers and an aim to use a Canadian supply chain and sustainably produced materials. It's integrated facility produces raw materials and finished products and is equipped to supply its CAN95 respirators on demand at an output of 1.2M units per month directly to the healthcare industry, with plans to scale up to 10M units per month.
>
> Please let me know if you have any questions.
>
> **Steve Vander Wal**
> Vice President
> steve.vanderwal@hkstrategies.ca
> M: +1 778 231 5805
> **Hill+Knowlton Strategies**
> 885 Dunsmuir Street, Suite 558
> Vancouver, BC, V6C 1N5

News Release

VITACORE'S CAN95 BECOMES THE FIRST CANADIAN-MADE RESPIRATOR TO RECEIVE HEALTH CANADA AUTHORIZATION

For more information on Vitacore and its PPE products visit vitacore.ca. For interview requests and assets, please see the media contact below.

About Vitacore Industries Inc.

Vitacore Industries is driven by innovation to provide Canadian healthcare professionals and families with critical personal protective equipment. With the first and only Canadian made N95 equivalent respirator (CAN95) to receive Health Canada authorization for production in Canada, Vitacore is creating the new standard for PPE with a mission to protect frontline workers and an aim to use a Canadian supply chain and sustainably produced materials. Visit vitacore.ca to learn more.

-30-

Media Contacts:

Laurie Fletcher
Citizen Relations (on behalf of Vitacore)
vitacorepress@citizenrelations.com
647-522-2941

Michelle Donovan
McMaster University
donovam@mcmaster.ca
905-512-8548

Gold, Crystal HLTH:EX

From: Oliver, Chrissy EMBC:EX
Sent: September 29, 2020 3:18 PM
To: Halls, Lori D EMBC:EX; Kot, Jill CITZ:EX; Pokorny, Peter HLTH:EX; Gaber, Leon EMBC:EX; Lansdell, Hayden CITZ:EX; Sadler, Bobbi CITZ:EX; Bell, Carolyn P HLTH:EX; Campbell, Tracy AG:EX
Cc: Roe, Sandra EMBC:EX; Fraser, Agnes EMBC:EX; Molyneux, Jennifer CITZ:EX; Korchinski, Jaime CITZ:EX; Boudhane, Nouria CITZ:EX; Gold, Crystal HLTH:EX; Schmidt, Tracee CITZ:EX
Subject: Agenda and Materials for September 30 Supply Chain PPE
Attachments: 092520 PPE and Cleaning Supplies Catalogue.pdf

Categories: Printed for Review/Meeting Material

Please see agenda and attached materials, in preparation for the Supply Chain PPE meeting at 10:30 tomorrow.

Agenda:

Item	Lead
Review TB Report	Tracee
Supply Hub Updates For Approval	Leon/Chrissy
Supply Hub Sales Update	Chrissy
DM Comments/Questions	Lori/Jill/Peter

COVID-19
IN BC

Personal Protective Equipment (PPE) and Cleaning Supplies Catalogue

Provincial Supply Chain Coordination Unit

Stay Informed Via These Resources:
www.gov.bc.ca/Covid-19 | *www.bccdc.ca* | **1-888-COVID19**
Symptom Self-Assessment:
covid19.thrive.health

BRITISH COLUMBIA

Contents

Introduction

As global shortages continue during the COVID-19 pandemic, the Province is working to buy and distribute Personal Protective Equipment (PPE) and cleaning supplies to the public sector and social service organizations. The following organizations are eligible to submit a request to purchase PPE and cleaning supplies from the Supply Hub:

- First responders (e.g., fire departments, police services, ambulance services);
- Local governments;
- First Nation governments and Indigenous organizations;
- Entities in the Government Reporting Entity, as defined in the Budget Transparency and Accountability Act; and
- Broader public sector and other entities, including public and private social service providers such as the following:
  - Contracted social service providers
  - Substance use and additions services including outreach
  - Residential and care facilities for substance use, addictions, and mental health services
  - Transitional, social and supportive housing
  - Single-room occupancy housing (SROs) and emergency shelters
  - Food banks, community kitchens, voluntary and community service providers
  - Child care providers
  - Independent schools (e.g., private (K-12) education
  - Critical incident service responders and workplace inspection entities
  - Victim services organizations
  - Community services and outreach for immigrants, refugees, vulnerable populations;

Please visit the B.C. COVID-19 Supply Hub to submit a request for PPE. If you are unsure if you are eligible to purchase from this site, please contact COVID19request@gov.bc.ca

Goods will be allocated based on priority, need, and available supply. This list will be updated as supply levels change.

To see a list of supplies appropriate for a particular activity, review the guidance developed by BC's Provincial Health Officer and WorkSafeBC on how to best mitigate risk of infection.

Check the BC Centre for Disease Control for appropriate procedures for safe use, cleaning and disposal of PPE.

Gloves

Nitrile Gloves

Please note that these nitrile gloves come from various vendors and are not for clinical purposes.

Sample image provided. Actual product may vary due to availability

Product Numbers: 7570102031 (Small) | 7570102046 (Medium) | 7570102047 (Large)

Sizes Available: Small, Medium, Large

Unit of Measurement Sold:
S: Case (2000) - 10 boxes/case | Box (200)
M/L: (1000) - 10 boxes/case | Box (100)

Description: Powder – free | Non – sterile, disposable | Single-use

Colour: Blue

Supplier Locations: British Columbia

Made in: Malaysia and China

Vinyl Gloves

Please note that these vinyl gloves come from various vendors and are not for clinical purposes.

Sample image provided. Actual product may vary due to availability

Product Number: 7570102041 (Small), 7570102042 (Medium), 7570102013 (Large), 7570102044 (XL)

Sizes Available: Small, Medium, Large, Extra Large

Unit of Measurement Sold:
Case (1000) – 10 boxes/case | Box (100)

Description: Powder-free | Non-sterile | Latex Free | Single Use

Colour: Clear

Supplier Locations: Canada

Made in: China

Disinfectant Wipes

» Disinfectant Wipes

Product Uses: ViroBan Plus will clean and disinfect hard, non-porous surfaces of: cabinets, chairs, computers, countertops, desks, desktops, doorknobs, fax machines, garbage cans, headsets, keyboards, railings, seats, sinks, tables, tabletops, telephones, trashcans, appliance exteriors, bathroom and kitchen faucets, bathtubs, shower doors and stalls and stove tops.

Product Number: 7570103050

Unit of Measurement Sold:
Canister (160 wipes)
Case (12 canisters)

Description: Kills 99.9% of bacteria in 60 seconds | Cleans, disinfects & deodorizes | All purpose cleaner | Cleans without scratching surfaces | Alcohol, Solvent and Bleach free

Size: 15.2cm x 16.5cm

Active Ingredients:

Alkyl (60% C14, 30% C16, 5% C12, 5% C18) dimethyl benzyl ammonium chloride	0.14% w/w
Alkyl (68% C12, 32% C14) dimethyl ethyl benzyl ammonium chloride	0.14% w/w

Supplier Location: Delta, B.C.

Made in: Canada

Masks

» Level 1 Surgical Disposable Mask

Description: Protection against air-borne pollutants | 3-ply, form fitting design | Fluid repelling | 4-fold design for comfortable fit | Strong polyester elastic ear loops | Disposable, for single use only

Product Number: 7570105010

Unit of Measurement Sold: Box (50)
Case (2000) – 40 boxes/case

Class: Class 1, According to Annex V of Directive 93/42/EEC

ASTM: ASTM F2100 Level 1

EN Standards: EN 14683, Type II

Size: Folded: 17.8cm x 9.4cm
Unfolded: 17.8cm x 16.5cm

Supplier Location: Kelowna, B.C.

Made in: Canada

» Level 3 Procedural Protective Mask

Product Number: 7570105001

Unit of Measurement Sold: Box (50)

Description: Ear loop face masks |
3 layers filtration | Melt blown filter cloth |
Non woven face mask 3 ply

ASTM: ASTM F2101-19

EN Standards: EN 14683:2019

Size: 17.5 x 9.5 cm

Supplier Location: Kelowna, B.C.

Made in: China

Hand Sanitizer

Liquid Hand Sanitizer

Spray triggers available for purchase when ordering this product.

Product Number: 7570103020

Product Form: Liquid

Available in: 355mL bottles with flip-top lid

Unit of Measurement Sold:
Case (24) - 24x355mL bottles/case

Product Description:
80% ethanol liquid-based hand sanitizer

Colour: Clear **Odour:** None

Supplier Location: Vancouver, B.C.

Made in: Canada

Irving Liquid Hand Sanitizer

Product Number: 7570103061

Product Form: Liquid with glycerin moisturizer

Available in: 946mL bottle

Unit of Measurement Sold: Each - 946mL
Case (12) - 12 x 946mL bottles

Product Description:
73% Isopropanol base and glycerin moisturizer

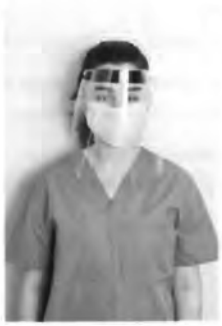
Colour: Colourless **Odour:** Characteristic

Supplier Location: New Brunswick.

Made in: Canada

Face Shields

» Face Shields

Product Number: 7570104010

Unit of Measurement Sold:
Case (48)
Box (12)

Description: This is a lightweight 2 oz face shield that allows for good peripheral vision while acting as a barrier against splashes in the work environment. Product is one size fits all and does not need adjustment. The shield provides coverage down past the neck, but does not impede mobility

Material: PET and Polypropylene

Colour: Clear PET – Black PP

Material Thickness: .016" / .020"

Part Weight (average): 2 oz

Product Dimension: 7" x 6" x 11" tall

Supplier Location: Langley, B.C.

Made in: Canada

Goggles

» Goggles

Product Number: 7570104001

Unit of Measurement Sold:
Case (150) – 10 boxes/case
Box (15)

Description: The lens is designed with high-definition reinforced transparent material to keep the field of vision clear.

Features: Medical-grade goggles | Professional protection | High-definition fog prevention | Good air permeability | Comfortable to wear | Ergonomic fit design

Supplier Location: Vancouver, B.C.

Made in: China

Gowns

» Level 3 Isolation Gowns

Description: This over-the-head, tear-away protective gown is made of clear, silver-tinted polypropylene material with open-back for breathability and comfort. Coverage on the front and sides provides protection from high fluid levels and blood borne pathogens.

Product Number:	**Sizes Available:**
7570104021	Small/Medium
7570104022	Large/XL

Unit of Measurement Sold: Case - 100/case

North American Standards:
Level 3: AATCC and AATCC 127

Features: 1.5 mil full gauge impervious polyethylene | Non-sterile, disposable/Single-Use | Degradable/Sustainable | Comfort-fit with tear-away notches | Half-Back with thumbholes | Transparent with light silver tint

Small/Medium Gown Size: Arm span: 68" | Length: 41.5" | Chest: 27"

Large/XL Gown Size: Arm span: 68" | Length: 41.5" | Chest: 27"

Supplier Location: Delta, B.C.

Made in: Canada

The gowns available for sale DO NOT have any print, wording or designs. They are strictly transparent with a light silver tint.

Bleach

» Bleach 6% and 12% Sodium Hypochlorite

Product Number:	Available in:
7570103030	6% sodium hypochlorite
7570103031	12% sodium hypochlorite

Unit of Measurement Sold: Case – 3 x 5L/case

Product Description: Liquid bleach | 6% or 12% sodium hypochlorite when packed | Disinfects and remove stains | Bleaching agent for laundry | Hard surface disinfectant that can be used in households, hospitals, dental clinics, medical clinics and nursing homes | NSF/ANSI certified

Format: 5L

Appearance: Clear Liquid

Colour: Greenish-yellow

Odor: Chlorine

Shelf Life: 18 months

Supplier Location: Quebec, Canada

Made in: Canada

Safety goggles and gloves are recommended when using this product.
Please review the safety data sheets prior to ordering:

- LAVO 12% Bleach Safety Data Sheet (PDF)
- LAVO 6% Bleach Safety Data Sheet (PDF)
- LAVO 6% Bleach Technical Data Sheet (PDF)

Industrial Cleaner

» BNAC Degrease and Clean

Product Description: BNAC Degrease & Clean, has been designed to, quickly penetrate soils, dirt and contamination grease, oils and pigments. This product is safe to use on any surface. This unique and carefully chosen blend of non-ionic organic plant matter enables BNAC Degrease & Clean to out perform similar to traditional solvent cleaners.

Product Number: 7570103040

Product Form: Liquid Blend

Available in: 4L bottle

Unit of Measurement Sold: Case – 4/case

Product Uses: Product used to clean floors, walls, mechanical shops, oil spills, carbon, grease, exterior driveways, concrete, cars, motorcycles, painted surfaces, and age from building exteriors.

Supplier Location: Coquitlam, B.C.

Made in: Canada

Safety goggles and gloves are recommended when using this product.
Please review the safety data sheet prior to ordering:

- BNAC DegreaseClean Safety Data Sheet (PDF)

Disinfectant Cleaner

» Eliminator DS Ready-To-Use Disinfectant

Product Description: Designed specifically as a general non-acid cleaner and disinfectant for use in hospitals, nursing homes, schools, hotels and restaurants as well as for use in industrial and institutional food processing establishments, kennels, veterinarians and animal hospitals.

Product Number: 7570103011

Product Form: Liquid **Available In:** 4L

Colour: Yellow **Odour:** Lemon

Unit Measurement of Sale: 4-4L / case

Product Uses: Formulated to disinfect hard non-porous, inanimate surfaces such as floors, walls, metal surfaces, stainless steel surfaces, porcelain, glazed ceramic tile, plastic surfaces, bathrooms, shower stalls, bathtubs and cabinets

Supplier Location: Morinville, Alberta

Made in: Canada

Safety goggles and gloves are recommended when using this product.
Please review the safety data sheets prior to ordering:

- Eliminator DS Disinfectant Safety Data Sheet (PDF)
- Eliminator DS Disinfectant Technical Data Sheet (PDF)

Disinfectant Cleaner (continued)

Quat-Shot Disinfectant Cleaner (3.78L and 946mL)

Product Description: Quat-Shot is made up of quats (quaternary ammonium compounds) which are potent disinfectant chemicals engineered to kill germs and viruses, such as the the rotovirus (aka SARS associated coronavirus). Quat-Shot is designed specifically as a general non-acid cleaner and disinfectant for use in homes, hospitals, long-term care centres, schools, hotels and restaurants, as well as for use in industrial and institutional environments such as airliners, food processing establishments, kennels, veterinarian offices, and animal hospitals. Quat-Shot is formulated to disinfect hard non-porous, inanimate surfaces such as floors, walls, metal surfaces, stainless steel, porcelain, glazed ceramic tiles, plastic surfaces, bathrooms, shower stalls, bathtubs and cabinets.

Spray triggers available for purchase when ordering the 946mL product.

Product Number: 7570103001 (3.78L) | 7570103002 (946mL)

Product Form: Clear liquid

Available in: 3.78L and 946mL bottle

Unit Measurement of Sale: Each (3.78L and 946mL) | Case (4 x 3.78L) | Case (12 x 946mL)

Features and Benefits: Multi-purpose cleaner, deodorizer, disinfectant, mildewstat, virucide, fungicide

Colour: Green **Foam:** Moderate

Odour: Baby powder fragrance

pH: 11.7 **Made in:** Canada

Supplier Location: Delta, B.C.

Safety goggles and gloves are recommended when using this product.
Please review the safety data sheet prior to ordering:

- Quat-Shot Disinfectant Safety Data Sheet (PDF)

Gold, Crystal HLTH:EX

From: Bell, Carolyn P HLTH:EX
Sent: September 29, 2020 4:23 PM
To: Rongve, Ian HLTH:EX; Pokorny, Peter HLTH:EX
Subject: RE: Burnaby Company Becomes the First Canadian-Made N95 to Receive Health Canada Authorization

s.13; s.17

From: Rongve, Ian HLTH:EX <Ian.Rongve@gov.bc.ca>
Sent: September 29, 2020 4:16 PM
To: Pokorny, Peter HLTH:EX <Peter.Pokorny@gov.bc.ca>; Bell, Carolyn P HLTH:EX <Carolyn.Bell@gov.bc.ca>
Subject: Fwd: Burnaby Company Becomes the First Canadian-Made N95 to Receive Health Canada Authorization

Can Melinda look into this.

Sent from my iPhone

Begin forwarded message:

> **From:** Steve Vander Wal <Steve.VanderWal@hkstrategies.ca>
> **Date:** September 29, 2020 at 4:05:20 PM PDT
> **To:** "Minister, HLTH HLTH:EX" <HLTH.Minister@gov.bc.ca>, "DMOFFICE, HLTH HLTH:EX" <HLTH.DMOFFICE@gov.bc.ca>, "Rongve, Ian HLTH:EX" <Ian.Rongve@gov.bc.ca>
> **Subject: Burnaby Company Becomes the First Canadian-Made N95 to Receive Health Canada Authorization**
>
> **[EXTERNAL] This email came from an external source. Only open attachments or links that you are expecting from a known sender.**
>
> I wanted to flag this announcement that Vitacore Industries Inc. has become the first Canadian company to receive Health Canada authorization to produce N95 equivalent respirators on home soil.
>
> With its production facility based in Burnaby, B.C., Vitacore is creating the new standard for PPE with a mission to protect frontline workers and an aim to use a Canadian supply chain and sustainably produced materials. It's integrated facility produces raw materials and finished products and is equipped to supply its CAN95 respirators on demand at an output of 1.2M units per month directly to the healthcare industry, with plans to scale up to 10M units per month.
>
> Please let me know if you have any questions.
>
> **Steve Vander Wal**
> Vice President

Gold, Crystal HLTH:EX

From: Kellow, Hayley [PHSA] <hayley.kellow@phsa.ca> on behalf of Morin, Benoit [PHSA] <benoit.morin@phsa.ca>
Sent: September 29, 2020 5:48 PM
To: Brown, Stephen R HLTH:EX; Byres, David W HLTH:EX; Pokorny, Peter HLTH:EX; Helmuth, Antje HLTH:EX
Cc: Quirk, Ron EHS:IN; XT:Wilson, Donna HLTH:IN; XT:HLTH Chan, Thomas; McPherson, Kendra [PHSA]; XT:Wannamaker, Susan EHS:IN; XT:Morin, Benoit HLTH:IN; XT:ODonnell, Maureen HLTH:IN; XT:Edgeworth, Jaci HLTH:IN; XT:Flatt, Alexandra HLTH:IN; Hewlett, Cheryl A HLTH:EX; Cerna, Carolina [PHSA]
Subject: RE: PHSA/MoH Bilateral meeting
Attachments: PPE & Critical Supplies On Hand and Stockpiling Report - Sep 28.pdf; 2020-09-22 PPE Bulk Purchase Target with delivery dates.pdf

Importance: High

Message sent on behalf of Benoit Morin, President & CEO, PHSA

Hello All,

In preparation for the PHSA and MoH Bilateral Meeting on Wednesday 30th September, please find attached the following items relating to item B on the agenda:

- PPE & Critical Supplies On Hand and Stockpiling Report
- PPE Bulk Purchase Target with Delivery Dates Report

Warm regards,

Hayley Kellow
Interim Executive Assistant to Benoit Morin, President & CEO
Provincial Health Services Authority

Provincial Health Services Authority
Province-wide solutions. Better health.

RESPECT AT PHSA

Office: #200 – 1333 West Broadway, Vancouver, BC V6H 4C1
Phone: 604-675-7497 (Ext. 557497) | Email: hayley.kellow@phsa.ca | www.phsa.ca | jobs.phsa.ca

Page 066 of 231 to/à Page 069 of 231

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s.13

Gold, Crystal HLTH:EX

From: Tang, Lydia HLTH:EX
Sent: September 30, 2020 9:36 AM
To: Bell, Carolyn P HLTH:EX; tony.bamford@fnha.ca; Everett, Kirsten F HLTH:EX; XT:Pica, Fernando HLTH:IN; XT:Simmers, Brian HLTH:IN; Brittany Deeter; 'april.macnaughton@fnha.ca'; XT:Liggett, Brenda HLTH:IN; 'melinda.mui@phsa.ca'; 'Dean.Chittock@vch.ca'; XT:HLTH De Croos, Mark; XT:Bayzand, Laurence EHS:IN; 'andrew.pattison@interiorhealth.ca'; Schmid, Victoria; Danyluk, Quinn [FH]; Vowles, Wendy M HLTH:EX; Liu, Reuben [PHSA]
Cc: Pokorny, Peter HLTH:EX; Poonam Rajappa; Mui, Melinda [PHSA]; Grant, Kristen L HLTH:EX
Subject: RE: Supply Chain/Logistics Meeting
Attachments: 2020 09 30 SC Log Com Agenda.docx

Hi all,

Attached is the agenda for today's Supply Chain meeting. Please let me know if you have any items you'd like to add.

Thanks,
Lydia

-----Original Appointment-----
From: Bell, Carolyn P HLTH:EX <Carolyn.Bell@gov.bc.ca>
Sent: July 27, 2020 11:41 AM
To: Bell, Carolyn P HLTH:EX; tony.bamford@fnha.ca; Everett, Kirsten F HLTH:EX; XT:Pica, Fernando HLTH:IN; XT:Simmers, Brian HLTH:IN; Brittany Deeter; 'april.macnaughton@fnha.ca'; XT:Liggett, Brenda HLTH:IN; 'melinda.mui@phsa.ca'; 'Dean.Chittock@vch.ca'; XT:HLTH De Croos, Mark; XT:Bayzand, Laurence EHS:IN; 'andrew.pattison@interiorhealth.ca'; Schmid, Victoria; Danyluk, Quinn [FH]; Vowles, Wendy M HLTH:EX
Cc: Pokorny, Peter HLTH:EX; Poonam Rajappa; Mui, Melinda [PHSA]; Grant, Kristen L HLTH:EX; Tang, Lydia HLTH:EX
Subject: Supply Chain/Logistics Meeting
When: September 30, 2020 1:30 PM-2:00 PM (UTC-08:00) Pacific Time (US & Canada).
Where: Skype Meeting

July 27th update:

Going forward, this meeting will be scheduled from Carolyn Bell's calendar.

June 5th update:

This meeting series will continue as of June 8th on Monday, Wednesday and Fridays. Thank you

June 2 Update:

As discussed at yesterday's meeting, we have condensed the Supply Chain and Logistics Committee distribution list. Going forward, if you would like an alternate please contacts us, **do not forward this meeting invitation**.

Please refer to the SharePoint site below to access your Daily Dashboards.

https://hiportal.phsa.ca/reports/powerbi/SC/PHSA%20Supply%20Chain%20Dashboard/Supply%20Chain%20COVID19%20Dashboard

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Join Skype Meeting

Trouble Joining? Try Skype Web App

Join by phone

Local - Victoria: s.15; s.17	(BC, Canada)	English (United States)
Local - Vancouver: s.15; s.17	(BC, Canada)	English (United States)
Toll-Free s.15; s.17	(BC, Canada)	English (United States)
Local - Kamloops: s.15; s.17	(BC, Canada)	English (United States)
Local - Prince George: s.15; s.17	(BC, Canada)	English (United States)
Local - Nelson: s.15; s.17	(BC, Canada)	English (United States)

Find a local number

Conference ID: s.15; s.17

Forgot your dial-in PIN? | Help

Would like to discuss the "strategy" below and the role of attendees in this approach:

1. **Buy Some Time** - Look closely at the expected delivery dates for the key supplies that we know to be in shortage (e.g. N95 respirators) and assess the likelihood of failed delivery. If high (which I think is what we can expect), what are our alternate sources? Find alternate suppliers and/or make an emergency request to Federal government to buy us as much time as possible.
2. **Conserve** - Establish clarity on appropriate use of PPE in all clinical situations and require strict and consistent adherence by health authorities/hospitals/health care workers. Policy is to be informed by evidence, safety, and the need for conservation.
3. **Assess Need** - Use epidemiological modelling and the "appropriate use" policy (#2 above) to estimate PPE needs by health authority (by volume and by timeframe).
4. **Assess Inventory** - Confirm a solid understanding of PPE inventory/supply in BC, including PHSA warehouses and health authority/facility supply.
5. **Predict Pinch Points** - Based on our modelling of need and our inventory (#3 and #4 above), when and where do our key pinch points arise?
6. **Establish Plan for Supply** – Place orders and/or communicate our needs to the Federal government to access their bulk procurement. Monitor risk of failed delivery closely.
7. **Contingency Plans** – What is our plan if supplies do not arrive? Ranging from the simple balancing of supplies across health authorities based on regional need to a scenario where we are accepting that supplies will not be available and we have to re-use or take other drastic measures around use.

Supply Chain/Logistics Committee

Date: September 30, 2020
1:30 to 2 p.m.

Members				
☐Brenda Liggett (FHA)	☐April MacNaughton (FNHA)	☐John Jinn (PHC)	☐Victoria Schmidt (VIHA) Krystal for Victoria	☐Carolyn Bell (MOH)
☐Quinn Danyluck (FHA)	☐Poonam Rajappa (FNHA)	☐Brian Simmers (PHC)	☐Dean Chittock (VCHA)	☐Wendy Vowles (MOH)
☐Tony Bamford (FNHA)	☐Karen Bloemink (IHA)	☐Melinda Mui (PHSA)	☐Fernando Pica (VCHA)	☐Lydia Tang (MOH)
☐Brittany Deeter (FNHA)	☐Mark De Croos (NHA)	☐Laurence Bayzand (PHSA)	☐Kirsten Everett (MOH)	☐Kristen Grant (MOH)

September 30, 2020 Agenda

#	ITEM	LEAD	
1	Roll call	All	
2	Agenda Review, addition items and approval of meeting agenda, action items from last meeting	Carolyn	
3	MOH Update: -Stockpile planning -PPE for physicians -Provincial approach for Category 3 and 4 donations and equipment in Has -Testing budget	Carolyn	
4	PHSA Update	Melinda	
5	Allocation formula	Fernando	
6	KPMG supply sources and opportunities	Carolyn	
7	Wrap-up	All	

Allocation Table

#	ITEM	For allocation this week
	1860 N95 masks	Yes
	1860s N95 masks	Yes
	S/M/L Nitrile Gloves	Yes
	1L Deb 807	Yes

	Needles Blunt Fill 18G X 1.5"	Yes
	Syringes 3ml LL without needles	Yes

Decisions

ITEM	Owner

Action Items and Issues Log

ITEM	Date	Action
s.13; s.16		

Gold, Crystal HLTH:EX

From: Cerna, Carolina [PHSA] <carolina.cerna@phsa.ca> on behalf of Morin, Benoit [PHSA] <benoit.morin@phsa.ca>
Sent: September 30, 2020 10:42 AM
To: XT:Morin, Benoit HLTH:IN; XT:Ulrich, Cathy HLTH:IN; Bell, Carolyn P HLTH:EX; Byres, David W HLTH:EX; XT:Dawkins, Laurie GCPE:IN; Gustafson, Reka [BCCDC]; Rongve, Ian HLTH:EX; 'IHEOCDirector@interiorhealth.ca'; XT:Lavery, John HLTH:IN; XT:MacNeil, Kathryn HLTH:IN; Diacu, Mariana HLTH:EX; Moneo, Mitch HLTH:EX; HLTH COVIDAnalytics HLTH:EX; Pokorny, Peter HLTH:EX; XT:HLTH Prentice, Cathy; XT:Dalton, Fiona HLTH:IN; XT:Jock, Richard HLTH:IN; Brown, Stephen R HLTH:EX; XT:Brown, Susan PSA:IN; XT:Manning, Tim HLTH:IN; XT:Lee, Victoria HLTH:IN; XT:HLTH Eliopoulos, Vivian; Vowles, Wendy M HLTH:EX
Subject: Daily Dashboard - September 30, 2020
Attachments: 2020-09-30 Provincial Dashboards -- COVID Dashboard_V2.xlsx

Message sent on behalf of Benoit Morin, President & CEO, PHSA

Good Morning,

Please find attached the Daily Dashboard for Wednesday, September 30, 2020

Kindly fan out as required.

Thank you.

Carolina Cerna
Manager, CEO Office Administration and Executive Assistant to Benoit Morin, President & CEO
Provincial Health Services Authority

Provincial Health Services Authority
Province-wide solutions. Better health.

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Office: #200 – 1333 West Broadway, Vancouver, BC V6H 4C1
Phone: 604-675-7497 (Ext. 557497) | Email: carolina.cerna@phsa.ca | www.phsa.ca | jobs.phsa.ca


Provincial Health
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Supply Chain Dashboard: https://hsportal.phsa.ca/reports/powerbi/SC/PHSA%20Supply%20Chain%20Dashboard/Supply%20Chain%20COVID19%20Dashboard

Page 077 of 231 to/à Page 079 of 231

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report run time: 9-30-2020 8:03 AM
time range: 9-29-2020 12:00 AM
to 9-30-2020 12:00 AM
date 2020-09-29
As reported as of 0900am each day; data prior to March 25/20 is incomplete

Gold, Crystal HLTH:EX

From: Oliver, Chrissy EMBC:EX
Sent: September 30, 2020 11:50 AM
To: Halls, Lori D EMBC:EX; Kot, Jill CITZ:EX; Pokorny, Peter HLTH:EX; Gaber, Leon EMBC:EX; Lansdell, Hayden CITZ:EX; Sadler, Bobbi CITZ:EX; Bell, Carolyn P HLTH:EX; Campbell, Tracy AG:EX
Cc: Roe, Sandra EMBC:EX; Fraser, Agnes EMBC:EX; Molyneux, Jennifer CITZ:EX; Korchinski, Jaime CITZ:EX; Boudhane, Nouria CITZ:EX; Gold, Crystal HLTH:EX; Schmidt, Tracee CITZ:EX
Subject: RE: Agenda and Materials for September 30 Supply Chain PPE

Record of decisions and actions coming out of today's meeting for your reference.

Action/Decision	Lead	Timeframe
Action: Draft of Oct. 31 TB Report to be provided to DMs by Oct. 9 followed by discussion at the Oct. 14 Supply Chain PPE meeting. Meeting to be scheduled with DW for week of Oct. 19.	Leon	Oct. 9
Decisions: Supply Hub DMs provided approval to proceed with the following updates to the Supply Hub Order Request Form and Catalogue: • Add N95s and make available for sale – Price confirmed at s.17 • Add XL Nitrile Gloves and make available for sale • 1L Disinfectant, Trigger sprayer references, XL Nitrile gloves and N95s all added to catalogue. Future Supply Hub Updates will be sent via email to DMs for approval. Approval received to proceed with an email from Leon, to Supply Hub Stakeholders notifying of availability of N95s, Trigger Sprayers and XL Gloves.	Chrissy	Oct. 2
Action: Leon to send to DMs, for info, s.13 s.13 when available.	Leon	Oct. 2

From: Oliver, Chrissy EMBC:EX
Sent: September 29, 2020 3:18 PM
To: Halls, Lori D EMBC:EX <Lori.D.Halls@gov.bc.ca>; Kot, Jill CITZ:EX <Jill.Kot@gov.bc.ca>; Pokorny, Peter HLTH:EX <Peter.Pokorny@gov.bc.ca>; Gaber, Leon EMBC:EX <Leon.Gaber@gov.bc.ca>; Lansdell, Hayden CITZ:EX <Hayden.Lansdell@gov.bc.ca>; Sadler, Bobbi CITZ:EX <Bobbi.Sadler@gov.bc.ca>; Bell, Carolyn P HLTH:EX <Carolyn.Bell@gov.bc.ca>; Campbell, Tracy AG:EX <Tracy.Campbell@gov.bc.ca>
Cc: Roe, Sandra EMBC:EX <Sandra.Roe@gov.bc.ca>; Fraser, Agnes EMBC:EX <Agnes.Fraser@gov.bc.ca>; Molyneux, Jennifer CITZ:EX <Jennifer.Molyneux@gov.bc.ca>; Korchinski, Jaime CITZ:EX <Jaime.Korchinski@gov.bc.ca>; Boudhane, Nouria CITZ:EX <Nouria.Boudhane@gov.bc.ca>; Gold, Crystal HLTH:EX <Crystal.Gold@gov.bc.ca>; Schmidt, Tracee CITZ:EX <Tracee.Schmidt@gov.bc.ca>
Subject: Agenda and Materials for September 30 Supply Chain PPE

Please see agenda and attached materials, in preparation for the Supply Chain PPE meeting at 10:30 tomorrow.

Agenda:

Item	Lead
Review TB Report	Tracee
Supply Hub Updates For Approval	Leon/Chrissy
Supply Hub Sales Update	Chrissy
DM Comments/Questions	Lori/Jill/Peter

Gold, Crystal HLTH:EX

From: Su, Ken <kennethsu@kpmg.ca>
Sent: September 30, 2020 12:40 PM
To: Bell, Carolyn P HLTH:EX
Cc: Mui, Melinda [PHSA]; Gaber, Leon EMBC:EX; Pokorny, Peter HLTH:EX; James, C.J.; Shaw, Alex; Lukac, Valerie
Subject: Re: pricing for health quality N95's

Carolyn,

Thanks for the note.

To confirm this is just specific to Medical N95 respirators.

s.13; s.17

Our team will commence immediately to get updated pricing for Medical N95s from the suppliers but we do need to make the reach outs and await their quotes.

Please let us know when you'd like to have this data on Medical N95s and we will do what we can based on what you advise.

As well, to ensure we're looking at the same historically presented data, could you also send the final table post-edits for our reference?

Thanks and best regards,

Ken

are reaching out to vendors

Get Outlook for Android

From: Bell, Carolyn P HLTH:EX <Carolyn.Bell@gov.bc.ca>
Sent: Wednesday, September 30, 2020, 11:38
To: Su, Ken
Cc: Mui, Melinda [PHSA]; Gaber, Leon EMBC:EX; Pokorny, Peter HLTH:EX
Subject: pricing for health quality N95's

Hi Ken, Leon is going to need an estimate of current international pricing for medical grade N95s (similar to what you prepared for our Minister to announce prior to Estimates in July); the range of pricing associated with the quantity is important (to show benefits of bulk purchases) and air/sea freight make a difference. We need it asap for a briefing with DM's. Melinda, this is the same table that we had in the Q and A's for the minister that Thom edited.

Can your team update the table from July?

Carolyn Bell, Executive Director/ Logistics Strategy/COVID Response and Health Emergency Management Division/BC Ministry of Health/office: 778-698-1755/cell: s.17

Murray, Heather HLTH:EX

From: Faizel Kathrada <faizel@lahsourcing.com>
Sent: September 30, 2020 12:34 AM
To: Pokorny, Peter HLTH:EX
Subject: Re: [WARNING: UNSCANNABLE EXTRACTION FAILED]Re: Invoice 919 - PHSA.pdf

Hi Peter, hope you are well.

Just following up to see if you had a chance to look into this.

Best regards,

Faizel Kathrada
CEO
19 Dallas Rd, suite 102
Victoria, BC V8V 5A6
CANADA
(604)354-6052
www.lahsourcing.com
www.shoprhino.com

LAH SOURCING LTD

On Aug 6, 2020, at 3:24 PM, Pokorny, Peter HLTH:EX <Peter.Pokorny@gov.bc.ca> wrote:

Hi Faizel – thanks for reaching out. I will look into this and get back to you.

Thanks,
Peter

Peter Pokorny
Associate Deputy Minister
Ministry of Health
(778) 698-8046

From: Faizel Kathrada <faizel@lahsourcing.com>
Sent: August 5, 2020 12:48 AM

Page 091 of 231 to/à Page 103 of 231

Withheld pursuant to/removed as

s.17 ; s.21

Murray, Heather HLTH:EX

From: Byres, David W HLTH:EX
Sent: September 30, 2020 7:49 AM
To: Brown, Stephen R HLTH:EX; Rongve, Ian HLTH:EX
Cc: Pokorny, Peter HLTH:EX; Moulton, Holly HLTH:EX; Murray, Heather HLTH:EX; Chandler, Breanna HLTH:EX
Subject: Fw: EMBC Policy 5.13 - security checkpoint approval

fyi

David

From: Behn Smith, Daniele HLTH:EX
Sent: September 30, 2020 07:06
To: Halls, Lori D EMBC:EX; Peterson, Dave EMBC:EX
Cc: Henry, Bonnie HLTH:EX; Byres, David W HLTH:EX
Subject: EMBC Policy 5.13 - security checkpoint approval

Good afternoon,

Dr. Henry has asked that I share the following with you.

As you are both aware, some First Nations have determined that security checkpoints are critical interventions in their response to COVID-19.

Our office is committed to the principles of UNDRIP and supporting Indigenous self-determination.

To this end, we agree that Nation-initiated security checkpoints that oversee movement in and out of First Nations communities, are a valid intervention during the COVID-19 pandemic.

We intend to share this information with the First Nations Leadership Council as part of the health update on Thursday's FNLC call. We will also communicate this to the Sub-Health Screening Table via email.

Many thanks,

Murray, Heather HLTH:EX

From:	Twyford, Philip HLTH:EX
Sent:	September 30, 2020 10:32 AM
To:	Brown, Stephen R HLTH:EX; Pokorny, Peter HLTH:EX
Cc:	Cross, Gordon HLTH:EX; Klotz, Peter HLTH:EX
Subject:	TBS direction on 2021/22 Hlth Caseload Submission
Attachments:	Budget 2021 Treasury Board Submission Template - Caseload Requests.docx
Categories:	Printed for Review/Meeting Material

I spoke with TB staff this morning about the 2021/22 Health budget submission. There will be a two stage process for the budget submission for Health this year. We are one of a small group of ministries invited to bring forward a TB submission on caseload, and will receive direction on the priority budget submission later in the fall after Cabinet is formed.

For the caseload submission for Health we have received the Budget Template (attached) and received direction that the draft will be due in November and that this should include:

- Continuing commitments related to the COVID-19 TB Submission, $1.9 B;
- Caseload and growth taking into account the budget growth already provided in the current 3 year budget plan; and,
- Remaining MSP SSNM requirements

The intent is to have the caseload budget requirements identified and factored into the budget plan to understand the remaining budget room for government commitments and priorities.

We are working on a draft now based on the above and will bring the outline draft forward for discussion next week before we go too far into this.

Philip

Philip Twyford, CPA, MBA, C.Dir
Assistant Deputy Minister and Executive Financial Officer
Finance & Corporate Services Division
Ministry of Health
(c) (250) 516-0268

Page 107 of 231 to/à Page 111 of 231

Withheld pursuant to/removed as

s.12 ; s.13

Murray, Heather HLTH:EX

From: Barclay, Corrie A HLTH:EX
Sent: September 30, 2020 12:44 PM
To: Twyford, Philip HLTH:EX; Pokorny, Peter HLTH:EX
Cc: Glazer, Brad R HLTH:EX
Subject: FW: C-19 Capital Investment Request
Attachments: 1177894 FHA 2020-21 C-19 IMIT Invest Request - VL FHA.docx; Digital and IMIT Investment Approval Request Template.docx; C19 Digital Investment IMIT Exec Summary Pres.pptx

Categories: Printed for Review/Meeting Material

Hi Peter and Philip

Attached is the package I would like to send out to HA's as a follow up to the memo Philip sent with their budget for COVID. Can you let me know if you have any feedback or concerns.

Thanks
Corrie

This an example of the prepared mailout. This one is destined for Victoria Lee, with cc to Brenda Liggett and Gregor McWalter.

Good afternoon.

I am writing in follow up to the September 18, 2020 COVID-19 Funding Letter sent to you by Philip Twyford, Assistant Deputy Minister and Executive Financial Officer, Finance and Corporate Services, to outline the process to request approval for COVID-19 funding to be invested in digital and IM/IT initiatives.

The attached package provides context and specific instructions. If you have any questions, please do not hesitate to contact Brad Glazer at Brad.Glazer@gov.bc.ca.

Thank you,
Corrie

Corrie Barclay
ADM | Health Sector IM/IT Division | Ministry of Health
P: 778.974.2796 C:s.17
| Corrie.Barclay@gov.bc.ca

BRITISH COLUMBIA

1177894
Sent by email

September 30, 2020

Ms, Victoria Lee
President and Chief Executive Officer
Fraser Health Authority
Central City Tower 400 - 13450 102nd Ave
Surrey BC V3T 0H1

Dear Ms. Lee:

Further to the *COVID-19 Funding Letter* sent to you by Philip Twyford, Assistant Deputy Minister, Finance and Corporate Services, on September 18, 2020, I am writing to provide additional information on the process to invest your COVID-19 funding in Digital and IM/IT initiatives.

This investment approval process will increase our collaborative efforts and collective provincial response to manage COVID-19. By increasing transparency and coordinating our investments, we will minimize duplication, and accelerate the availability of required enabling digital tools. Once available, the tools will be promoted for use across all Health Authorities within the Provincial Digital Toolkit.

The COVID-19 Digital and IM/IT investment approval process will be administered through the Provincial Digital Investment Office (DIO). The DIO will work with Health Authorities to ensure an expeditious process (depicted in Appendix A). Accompanying this letter is a simple and straightforward Investment Approval Package. Please complete an Investment Approval Package for each proposed investment and submit it to the DIO at HLTH.DIO@gov.bc.ca.

If you or your staff require further information or have any questions, please contact Brad Glazer at brad.glazer@gov.bc.ca or 778-698-9484.

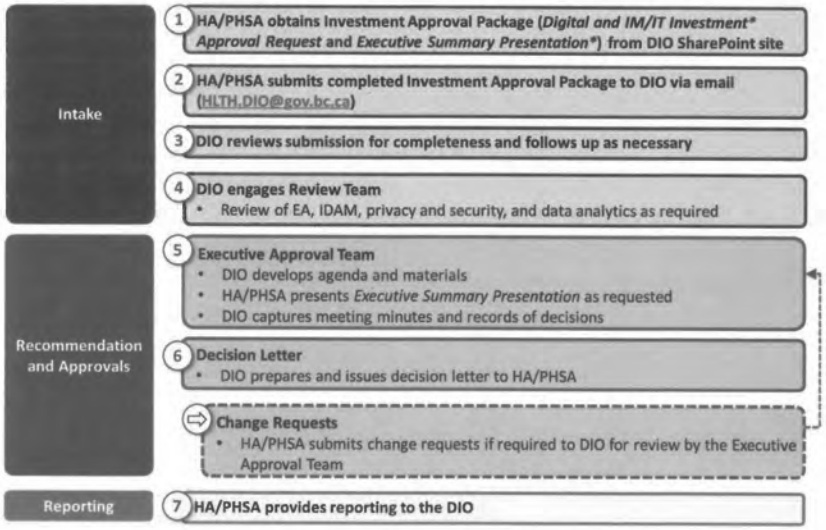
Regards,

CBarclay

Corrie Barclay
Assistant Deputy Minister
Health Sector IMIT, Ministry of Health

pc: Mr. Peter Pokorny, Associate Deputy Minister, Corporate Services, Ministry of Health
Mr. Philip Twyford, Assistant Deputy Minister and Executive Financial Officer, Finance and Corporate Services, Ministry of Health
Ms. Shannon Malovec, Chief Digital Innovation Officer, PHSA
Ms. Brenda Liggett, Chief Financial Officer and VP System Optimization, FHA
Mr. Gregor McWalter, Chief Information Officer, FHA

Appendix A: COVID-19 Digital and IM/IT Investment Approval Request Process



*Documents are included on the DIO SharePoint in this folder:
https://hlth.sp.gov.bc.ca/sites/HLTH3/HSIMT/Collab/Templates/Forms/AllItems.aspx

Date Submitted: yyyy/mm/dd

Digital and IMIT Investment Approval Request

Instructions:

- *The intent of this document is to obtain high-level information to support decision making.*
- *Once you have completed this document, remove the instructions in red italicized text.*
- *Keep your answers concise and ensure that this document does not exceed 4 pages in length (excluding optional appendices that you may choose to provide).*

1. Investment Summary

Lead Health Authority/Agency	
Other Contributing Agencies	
Business Sponsor Name and Title	
Primary Contact Name and Title	
Investment Portfolio (see Appendix A)	*Include sub-portfolio if applicable (see Appendix A – Investment Portfolios)*
Total Project Value	
Total Capital	
Total Operating	
Date Funding Decision Required	
Estimated Start (Month/Year)	
Estimated Finish (Month/Year)	
Priority *(see Appendix B – Priority Definitions)*	

2. Investment Description

3-5 sentences describing the initiative concisely to a non-technical audience.

3. Business Problem

Business Problem – Summary Statement

What is the problem? Who is affected? Why does this need to be solved now?

4. Proposed Solution

Recommended Option

Describe the recommended option and how it solves the problem.

Expected Outcomes & Benefits of Recommended Option

What are the expected outcomes? How will this benefit the citizens of B.C. and/or care providers in B.C.? When will outcomes be realized?

Current Status of Project

Describe the status of the project and any work already completed.

Client Focus
Describe how this initiative will meet patient and/or provider needs, support equitable access, and enable a person-centred and integrated system of care.

Scalability
Describe how this initiative will optimize the use of resources and reduce the risk of duplication, including whether this initiative has the capability to scale provincially.

Sustainability
Describe how this option contributes to stable and sustainable infrastructure, and to digital enablement.

Enterprise Architecture and Interoperability
Describe the business process that this solution will form a part of, and how the solution assists with digitizing that process. Does, or should, the solution interact or share data with any other systems within or outside the health authority? Explain how the solution aligns with, or will be made to align with, the Ministry and Sector enterprise architecture ecosystem requirements articulated under the Digital Health Initiative.

Privacy and Security
Describe how this project will ensure compliance with Ministry and Sector privacy and security policy, standards, and legislation.

Identity and Access Management
Describe the proposed identity and access management solution and demonstrate how it aligns to the Health Sector IDAM Strategy and related IDAM Conceptual Architecture *implications.*

Data and Analytics
If the proposed project involves the capturing of data, describe how that data will be made available for secondary use analyses, including by stakeholders external to your organization where appropriate (e.g., BCCDC, MoH).

5. Proposed Approach

Proposed Approach
Provide a few brief sentences describing the proposed approach for delivering the proposed solution.

Dependencies and Other Considerations
Identify the dependencies or other considerations that may impact the success of the initiative.

Stakeholders
Identify key stakeholders to be involved in this project.

6. Strategic Alignment

Strategic Alignment
How does this project align with the Digital Health Strategy and other Sector strategies?

Investment Portfolio
State the investment portfolio or sub-portfolio to which this initiative is primarily aligned (see Appendix A).

Date Submitted: yyyy/mm/dd

7. Estimated Cash Flows

Project Costs	Prior years	FY20/21 CAPEX	FY20/21 OPEX	FY21/22 CAPEX	FY21/22 OPEX	FY22/23 CAPEX	FY22/23 OPEX
Total	$-	$-	$-	$-	$-	$-	$-

Funding Available	Prior years	FY20/21 CAPEX	FY20/21 OPEX	FY21/22 CAPEX	FY21/22 OPEX	FY22/23 CAPEX	FY22/23 OPEX
Source 1	$-	$-	$-	$-	$-	$-	$-
Source 2...	$-	$-	$-	$-	$-	$-	$-
Total	$-	$-	$-	$-	$-	$-	$-

List all sources of existing funding including partner organizations, adding rows if necessary. Leave blank if no other funding sources are available.

Funding Requested	FY20/21 CAPEX	FY20/21 OPEX	FY21/22 CAPEX	FY21/22 OPEX	FY22/23 CAPEX	FY22/23 OPEX
Total	$-	$-	$-	$-	$-	$-

Total project costs minus total funding available

8. Key Milestones

Key Milestones

Provide a bullet-point summary of key project milestones and target dates

9. Key Risks

Key Risks	Probability	Impact	Mitigation
Brief description, add rows as necessary for additional risks	*Low / Medium / High*	*Low / Medium / High*	How will risks be mitigated?

10. Alternative Analysis

What are the likely consequences if funding is not provided? Include costs, risks, and business impacts.

Date Submitted: yyyy/mm/dd

Appendix A – Investment Portfolios

Investment Portfolio 1. Patient Empowerment **Focus:** Investments primarily align with DHS Pillar 1 **Investment Objectives:** • Empowers Patients • Advances Innovation	**Investment Portfolio 2. Primary, Community and Specialist Care Transformation** **Focus:** Investments primarily align with DHS Pillar 2 **Investment Objectives:** • Values Team Care Experience • Enhances Patient and Provider Experience • Supports Integrated System of Care
Investment Portfolio 3. Acute Care – Clinical Information Systems **Focus:** Investments primarily align with DHS Pillar 3 **Investment Objectives:** • Reduces Technical Debt • Reduces IT or Business Operation Spending • Improves Productivity of IT or Business Operations • Enables Digital Health Care Ecosystem • Enhances Provider Experience	**Investment Portfolio 4. Advance Analytics Capabilities** **Focus:** Investments primarily align with DHS Pillar 4 **Investment Objectives:** • Advances Analytics • Enhances Decision Support
Investment Portfolio 5. Enhance Foundational Clinical Systems **Focus:** Investments primarily align with DHS Pillar 5 **Investment Objectives:** • Enhances Foundational Clinical Systems • Supports Integrated System of Care **Sub-portfolios:** • 5.1.1 Pharmaceutical • 5.1.2 HIBC • 5.2 Registries • 5.3 Laboratory Transformation • 5.4 Public Health and COVID-19	**Investment Portfolio 6. Foundation** **Focus:** Investments primarily align with DHS Foundation and Technical Debt **Investment Objectives:** • Reduces Technical Debt • Reduces Risk (Operational Failure, Legal, Security) • Strengthens Privacy • Enables Compliance • Improves Productivity of IT or Business Operations **Sub-portfolios:** • 6.1 Provincial Information Exchange Services • 6.2 Identity and Access Management / BC Services Card • 6.3 HA Infrastructure (Hosting, Network, Cloud and Commercial Services) • 6.4 Privacy and Security • 6.5 Digital Health Strategy Office • 6.6 Corporate Business Systems (ERP, ADT, Payroll, Transcription)

Date Submitted: yyyy/mm/dd

Appendix B – Priority Definitions

Critical	• Project has very high alignment with Ministry and Health Authority strategy • Project is of critical importance and required urgently for service operations continuity • Project driven by provincial mandates, regulatory, security, compliance and risk requirements • Project risk impact is identified as "significant" and the risk likelihood is "very high" • Infrastructure risk indicates that components are highly complex to recover, no backup available, little to no vendor support, no security patching • Project has a critical impact on patient care and a high impact on stakeholder user experience and business processes
High	• Project has high alignment with Ministry and Health Authority strategy • Project is of high importance and is required with high urgency for service operations continuity (improve effectiveness) • Projects primarily driven by service improvements issues (remediation/problem/outage driven) • Project risk impact is identified as "major" and the risk likelihood is "high" • Infrastructure risk indicates that components are highly complex to recover, warranty or cold spares offsite, partial back up available, on vendor security patching available • Project has a high impact on patient care and high impact on stakeholder user experience and business processes
Medium	• Project has moderate alignment with Ministry and Health Authority strategy • Project is of moderate importance and makes service operations more efficient improves on normal service operations) • Driven by alignment to short-term and long-term IT and health objectives and improves overall customer value, and results in cost savings in the short-medium term • Project risk impact is identified as "moderate" and the risk likelihood is "moderate" • Infrastructure risk indicates that components are of medium complexity to recover, cold spare onsite, and partial back up available • Project has a moderate impact on patient care and moderate impact on stakeholder user experience and business processes
Low	• Project has moderate/minimal alignment with Ministry and Health Authority strategy • Project is desirable but non-essential/not urgent and of moderate/low importance • Driven by long term IT and health objectives and long-term cost savings and improving customer value. Does not directly impact end users • Project risk impact is identified as "minor" or "minimal" and the risk likelihood is "low/very low" • Infrastructure risk indicates that components are of low or medium complexity to recover, warm spare offsite and onsite, and back up available • Project has a low to no impact on patient care and moderate/low impact on stakeholder user experience and business processes


COVID-19 Digital IMIT Investment Approval Request – Executive Summary Presentation
[INSERT Project Name]
[INSERT Agency Name]
[INSERT Date]
BRITISH COLUMBIA

Investment Description:
3-5 sentences describing the initiative concisely to a non-technical audience

[Project Name]

Investment Summary

Lead Health Authority/Agency	
Other Contributing Agencies	
Business Sponsor	*Include name and title*
Primary Contact	*Include name and title*
Investment Portfolio	
Total Project Value	
Total Capital	
Total Operating	
Date Funding Decision Required	
Estimated Start	*Month/Year*
Estimated Finish	*Month/Year*
Priority	

Business Problem

Business Problem - Summary Statement
What is the problem? Who is affected? Why does this need to be solved now?

[Project Name]

Proposed Solution

Recommended Option
Describe the recommended option and how it solves the problem.

Expected Outcomes & Benefits of Recommended Option
What are the expected outcomes? How will this benefit the citizens of B.C. and/or care providers in B.C.? When will outcomes be realized?

Due Diligence Checklist
Summarize how your initiative addresses the following due diligence criteria as described in the Digital and IMIT Investment Approval Request Template:
- *Enterprise Architecture and Interoperability*
- *Privacy and Security*
- *Identity and Access Management*
- *Data and Analytics*

[Project Name]

Proposed Approach

Proposed Approach
Provide a few brief sentences describing the proposed approach for delivering the proposed solution.

Dependencies and Other Considerations
Identify the dependencies or other considerations that will impact the success of the initiative.

Stakeholders
Identify key stakeholders that will be involved in this project.

Strategic Alignment

Strategic Alignment
How does this project align with the Digital Health Strategy and other Sector strategies?

Funding Request

Project Costs	FY20/21 CAPEX	FY20/21 OPEX	FY21/22 CAPEX	FY21/22 OPEX	FY22/23 CAPEX	FY22/23 OPEX
Total						

Funding Available	FY20/21 CAPEX	FY20/21 OPEX	FY21/22 CAPEX	FY21/22 OPEX	FY22/23 CAPEX	FY22/23 OPEX
Source 1						
Source 2...						
Total						

List all sources of existing funding including partner organizations, adding rows if necessary. Leave Blank if no other funding sources are available.

Funding Requested	FY20/21 CAPEX	FY20/21 OPEX	FY21/22 CAPEX	FY21/22 OPEX	FY22/23 CAPEX	FY22/23 OPEX
Total						

Total project costs minus total funding available.

Murray, Heather HLTH:EX

From:	Gaber, Leon EMBC:EX
Sent:	September 30, 2020 2:10 PM
To:	Kot, Jill CITZ:EX; Halls, Lori D EMBC:EX; Pokorny, Peter HLTH:EX
Cc:	Bell, Carolyn P HLTH:EX; Schmidt, Tracee CITZ:EX; Chandler, Alex EMBC:EX; Tyson, Greg EMBC:EX; Fletcher, Cassandra CITZ:EX; Sadler, Bobbi CITZ:EX
Subject:	TBS PPE report - Sept 10-23
Attachments:	TBS PPE Report Sept 10 - 23 2020.docx
Categories:	Printed for Review/Meeting Material

Good afternoon everyone. Further to our meeting this morning, attached is the TBS report on our PPE initiative for the reporting period of September 10 – 23. I will be providing this report to treasury board staff by the end of the day.

Cheers
Leon

Leon Gaber | Provincial Lead | Provincial Supply Chain Coordination Unit
Emergency Management BC
Ministry of Public Safety & Solicitor General
250-812-1809

Page 127 of 231 to/à Page 129 of 231

Withheld pursuant to/removed as

s.12 ; s.13 ; s.17

Murray, Heather HLTH:EX

From: Armitage, Mark W HLTH:EX
Sent: September 30, 2020 4:52 PM
To: Brown, Stephen R HLTH:EX
Cc: Moulton, Holly HLTH:EX; Pokorny, Peter HLTH:EX
Subject: FW: Final Documents for Announcement
Attachments: Web Page Draft - New Contracts (ID 337587).docx; NEW - letter on contracts (ID 362935).docx; Q and A Simplified Service Contract (ID 363183).docx; Q and A - physician contracts (combined) (ID 362952).docx; Simplified Short Term COVID Contract fact outline.docx; Existing and NTP FP AP Contracts ppt deck.pptx

Importance: High

Hi Steve,

As discussed, attached are the package of documents that have been prepared for the DoBC internal announcement to their members tomorrow, Thursday October 1, 2020 regarding the new GP and simplified Covid contracts. In addition, I have attached the ppt deck that was developed for Peter and the Minister in late August. I anticipate using the attached deck at a couple of webinars next week.

The announcement is slated to be sent out tomorrow. If you have any questions/concerns please let me know.

Thanks

Mark

Mark Armitage MPA BSW
Assistant Deputy Minister
Health Sector Workforce and Beneficiary Services Division | Ministry of Health
1515 Blanshard St., Victoria, B.C. | T: 250-952-3519

Outline for Web Page – Contracts

Intro – content to follow
see outline of page provided in separate document.

The below compromises the big piece.

FAMILY PHYSICIANS (title)

Group Contract for Practicing Full Service Family Physicians (links to content below)

What is it?
A new hours based contract for a group of at least three family physicians. The contract template is available here. (link to follow)

Who is it for?

The contract is for full service family physicians with established patient panels who work together to provide community longitudinal care.

It is also available to individual physicians who are not in the same clinic but are located in the same Primary Care Network (PCN) and are prepared to work together as a group to provide the services and patient access required under the contract.

The contract is not available to physicians in solo practices.

Length of contract

The duration of the contract is three years. It provides either party the option of terminating without cause with six months' notice.

Payment and Expectations

Expectations

Primary Care Network and Patient Medical Home. Physicians must participate in an existing PCN or commit to actively support the development of a PCN in the community, and they must agree to provide community longitudinal primary care services aligned with the principles of a Patient Medical Home.

Quality Improvement. All physicians under the contract must participate in the GPSC's Quality Improvement (QI) initiatives, which include panel management and use of the Patient Experience Tool. Physicians who complete the QI activities required by the contract over the course of a year qualify for a payment of $20,000 per full-time physician, prorated for part-time.

Hours Requirement. A full-time physician is expected to work 1,680 hours per year. Each physician under the contract must commit to working a minimum of half time or 840 hours per year.

Payment

Payment is based on the services provided by all of the physicians. However, payments are made to the clinic to encourage funding of common expenses, encourage team-based practices and provide flexibility in allocating funds among the physicians.

Physicians within a clinic must enter into a separate group governance agreement that sets out how they will work together and allocate the funding among them. For a guideline on what should be included in such an agreement, please click here.

Physicians are required to cover overhead costs from the payments they receive under the contract.

In the first year, the clinic is guaranteed minimum funding of at least $289,664 for the year per full time physician, up to a maximum of $329,664 (assuming successful completion of Quality Improvement requirements) based on the physician's FFS billings from the 2019 calendar year, adjusted for PMA increases. At the end of the first year the Ministry calculates the value of the contract as per the formula, and if it exceeds the first year guarantee the clinic is paid the difference. The first year value of the contract will also determine the initial value of the contract for the second year.

In subsequent years, payments to the clinic per full-time physician will range from $269,664 to $329,664 subject to annual increases. The amount is based on three criteria which are related to the services that all of the physicians provide:

1. **The number of hours worked.** A full-time physician is required to work at least 1,680 hours per year. The minimum payment to the clinic for a full time equivalent physician who works 1,680 hours is $269,664 per year.

2. **The number and complexity of attached patients served by the clinic.** A full-time equivalent physician is expected to manage a panel of 1,250 attached patients of average complexity. The clinic's actual expected panel size is adjusted to account for the complexity of patients on the clinic's panel. Payment rates increase within the payment range by exceeding expected panel

size/complexity. The maximum additional annual payment to the clinic for a full-time equivalent physician who exceeds the expected patient panel size by 13.9% or more is $40,000 per year.

- For instance, if a clinic's attached patient panel is 10% more complex than the BC average for attached patients (as measured by Adjusted Clinical Group ratings), the clinic's expected patient panel is reduced by 10%. If the clinic's actual attached patient panel for the year is 14% higher than the expected panel the minimum payment is increased by $40,000.

- Payments for exceeding the expected patient panel size are tiered as follows:
  - $10,000 per FTE for exceeding the expected patient panel by at least 3.5%
  - $20,000 per FTE for exceeding the expected patient panel by at least 6.9%
  - $30,000 per FTE for exceeding the expected patient panel by at least 10.4%
  - $40,000 per FTE for exceeding the expected patient panel by at least 13.9%

- The Clinic's expected patient panel may also be reduced as a result of a high volume of services provided to unattached patients and for clinical teaching based on a local agreement with the regional health authority as guided by the Ministry.

3. **Participation in Quality Improvement activities.** All physicians under the contract are required to participate in quality improvement (QI) activities that have been approved by the GPSC. Physicians who complete these QI activities over the course of a year qualify for an additional payment of $20,000 (prorated for partial FTE's). For more information on QI programs, click here. https://gpscbc.ca/what-we-do/practice-supports/psp

Physicians are also entitled to bill separately for services that are outside the scope of the contract, including:

- Services provided in the clinic to third parties (such as WSBC, ICBC and the Armed Forces).
- Services provided outside of the community primary care setting (e.g. services provided in a hospital setting).
- Specialized services provided to referred patients who are not attached to the practice, and
- GPSC networking fees and fees for the Long Term Care Initiative (previously known as the Residential Care initiative).

Time spent for services that are outside the scope of the contract and billed under FFS cannot contribute to the contract's hours requirement.

The clinic is paid for the services in equal bi-weekly or monthly installments on the basis of the expected payment to the clinic for the year. At the end of each year, the Ministry will review the compensation elements and reconcile the payments to the clinic on the basis of the actual contract activity for the year. This may require the Health Authority to provide additional funding to the clinic, or require the clinic to reimburse the Health Authority based on the year end analysis.

Administration

The contract is administered by the Health Authority.

Where a clinic indicates interest in participating in the new contract, the Ministry will analyze the practice and provide the physicians in the clinic with a determination of the first year payment guarantee.

The contract is available to all group clinics who meet the criteria, but priority consideration will be given to clinics who provide services in an announced Primary Care Network.

How to know if the contract is right for you

This could be a good fit if you are working in a group clinic providing longitudinal family service and have already aligned or are interested in aligning with the principles of the Patient Medical Home. You have also either started or are interested in being part of a Primary Care Network and have already been working or are interested in working to define your patient panel.

The contract may be less attractive to physicians who do substantial work outside of the office or who provide a significant amount of services to patients for whom they are not the full-service family practice MRP (e.g. in-patient, ER coverage, MAID provision, GP-Oncology, etc.) or to high volume FFS physicians.

How to prepare the practice for the transition

You can prepare for possible transition by connecting with a Practice Support Program coach, and getting started on panel management

Contact for more information

For more information on the new Group Contract for Practicing Full Service Family Physicians, email negotiations@doctorsofbc.ca.

Individual Contract for New-to-Practice Family Physicians (link to content below)

What is it?

An hours based contract for individual family physicians who do not have a patient panel and wish to join an existing group practice to build a panel of attached patients. The contract template is available here. (link to follow)

Who is it for?

The contract is for individual physicians who do not have an established practice with their own patient panel. It is available to physicians who meet the following criteria:

- The physician is prepared to provide community longitudinal family practice services.
- The physician does not have an established patient panel, and
- The physician is prepared to join a full-service group clinic.

Length of contract

The contract duration is for a maximum of 2 years and provides either party the option to terminate without cause with 6 months' notice.

Subject to the agreement of the other physicians in the clinic, a physician may also terminate the contract on 60 days' notice where the physician's earnings will increase by changing payment modalities as follows:

- Where the physician works in a clinic that is paid under the Group Contract for Practicing Full Service Family Physicians and the physician's income will increase by joining the in-practice contract, the physician may terminate the NTP contract and join the other physicians under the in-practice contract.

- Where the physicians works in a clinic where the other physicians are paid under FFS and the physician's income will increase by moving to FFS the physician may terminate the NTP contract and move to FFS on the condition that the physician continues to provide the services for the balance of the term of the contract.

Payment and Expectations

Expectations

The new-to-practice physician and the physicians in the clinic must agree to provide community longitudinal primary care services aligned with the principles of a Patient Medical Home and either participate in an existing Primary Care Network (PCN), or commit to actively support the development of a PCN in the community where one is planned.

The physicians in the clinic must also agree to include the new physician in the practice. The NTP contract requires that clinic physicians and the new physician sign a Practice Agreement that outlines how they will co-ordinate their work to provide services to patients and they must provide that agreement to the Health Authority to confirm that the Practice Agreement supports or enables the NTP physician in meeting their contractual obligations.

The new physician must agree to act as the regular and most responsible primary care provider for a balanced patient panel of at least 800 new patients by the end of the first year of the contract and 1,250 by the end of the second year.

Payment

Payment under the contract is based on hours worked and made directly to the physician for longitudinal family practice services provided in the clinic. The contract requires a full-time physician to provide a minimum of 1680 hours of service to a maximum of 2100 hours of service per year. The minimum contribution of a physician working under a part time adjusted contract is half time (a minimum of 840 hours per year).

The annual compensation for a full time physician varies from year to year as follows:

- Year 1: $279,664 (which includes a $10,000 year end bonus for completing QI training activities in year 1)
- Year 2: $295,457 (base rate, plus $20,000 for ongoing QI activities, plus a 2% annual increase effective April 1, 2021)

The physician is entitled to bill FFS separately for services outside the scope of the contract, including:

- Services provided outside of the clinic.
- Services provided to third parties.
- Specialized services provided to referred patients who are not attached to the practice, and
- GPSC networking fees and fees for the Long Term Care Initiative.

Time spent for services that are outside the scope of the contract and billed under FFS cannot contribute to the contract's hours requirement.

A physician under the contract is required to contribute to the overhead costs of the clinic at the rate set out in the Practice Agreement.

Administration

The contract is administered by the regional health authority.

How to know if the contract is right for you

You are an individual general practitioner who is interested in income security while establishing a full-service family practice and building your own patient panel within a community group clinic.

For newly practicing physicians interested in providing community longitudinal care this provides an opportunity for a stable income while building a practice panel.

Contact for more information

For more information on the Individual Contract for New-to-Practice Family Physicians, email negotiations@doctorsofbc.ca.

Simplified COVID Service Contract

What is it?

A short-term alternative payment contract option available to most FFS physicians whose income is impacted by COVID-19. The contract template is available here.

Who is it for?

The contract is available to physicians who are currently paid by FFS and who expect to experience an ongoing reduction in the volume of services they deliver during the COVID pandemic.

The contract is not available to the following groups of physicians who have the option of other AP contracts set out on this page:

- Anesthesiologists (link to anesthesiologists section)
- Emergency Medicine Physicians (link to Emergency section)

Length

The contract duration is a minimum of six months and can cover a term to end no later than December 31, 2021 and provides either party the option of terminating without cause with sixty days' written notice.

Where a contracted physician finds that the services increase to the point they can generate a better income under FFS, the physician may terminate the contract and move back to FFS on five days' written notice if they commit to continue to provide the same services for the balance of the contract term. However, physicians will not be able to switch back and forth between payment modalities on a repeat basis.

Payment and expectations

The contract is generic with respect to the services expected but requires physicians to continue to provide the same kind of services that they have historically provided under their FFS arrangement, or if new to practice, that are typically provided by a FFS physician. Physicians are required to continue to provide in-person patient care as needed, this contract cannot be used for virtual care only.

The contract covers all of the physician's services over the contracted period including:

- Direct and indirect patient care
- Clinically related teaching and clinically related research
- Clinical Administrative services including reporting of hours
- Up to an additional 5% of hours worked to support activities necessary for clinical service redesign of the physician's practice/clinic in order to address the impacts of COVID-19 on service delivery, clinical processes and patient flow

Physicians must bill and assign to the health authority all FFS and third party billings except that physicians may retain those FFS billings for services funded by WorkSafeBC, with those services not counted towards the hours in the contract.

Payments under the new contract are based on hours worked and are paid at 90% of the range that applies to the applicable Practice Category for Service Contracts under the Physician Master Agreement based on 1680 hours worked in a year. Note that some of these rates will be increased retroactively to incorporate increases currently being determined by the Allocation Committee and the After-Hours Adjudication panel. Physicians bill for each hour worked up to a maximum of 1,867 hours per year.

The contract is effective the first day of its term once it is signed. There is no retroactive payment.

Administration

The contract is an agreement between a regional health authority and an individual physician. Health authorities may also consider entering into a group contract with physicians who provide the same services in a facility.

How to know if the contract is right for you
This contract may be of interest if your practice continues to see reduced patient volumes and access due to COVID-19.

In order to assess the value of the contract, physicians should consider their anticipated workload and income under the FFS model to determine if it exceeds the value of the Simplified COVID Service Contract.

Contact for more information

For more information, email negotiations@doctorsofbc.ca.

Group Anesthesiology Alternative Payment (AP) Contract

What is it?

This template contract was established in 2018 and continues to be available to a group of anesthesiologists within a facility. The contract template is available here. (link to follow)

Who is it for?

The contract is an agreement between the health authority and a group of anesthesiologists who provide anesthesiology services within a facility.

The contract is not available to individual anesthesiologists.

Length of contract
The contract is for a duration of three years and provides either party the option of terminating without cause with six months' notice.

Payment and expectations

The Group Anesthesiology AP Contract specifies different hourly rates of pay based on the time the service is delivered (day, evening, or weekend), and on the facility where the services are delivered (level 1, 2, or 3). Additionally, a bonus of up to 10% may be paid for meeting performance targets that are set by the health authority in consultation with the group of anesthesiologists. For details on payment, click here (Appendix X)- to follow

For services provided to WorkSafeBC patients, if payment from WorkSafeBC exceeds the applicable hourly rate paid for time under the contract, the difference between the contract rates and the WorkSafeBC payments will be paid to the physician once received by the health authority..

Administration

Prior to committing to a contract, Ministry of Health representatives will work with anesthesiologist groups to estimate payment levels for physicians under the contract based on an agreed-upon schedule for the services.

Services provided under the Group Anesthesiology AP Contract require encounter reporting as well as monthly invoicing to the health authority.

How to know if the contract is right for you
You are part of a group of anesthesiologists who want to work together and with the health authority, and will commit to providing anesthesia services at your hospital on a pre-determined schedule with a high degree of certainty. The incentive payments for the group are tied to availability to fill the schedule.

Your group of physicians must also be prepared to collaborate with the health authority on quality improvement and human resource planning/recruitment.

Contact

For more information on the New Group Anesthesiologist AP Contract, email negotiations@doctorsofbc.ca

Emergency Medicine

Group Emergency Medicine Service Contracts

What is it?
Emergency Medicine physicians who are presently paid under the FFS model have the option of negotiating a group service contract with the Health Authority based on the Group Template Service Contract found in the 2019 Physician Master Agreement

Who is it for?

The hourly based contract is available to groups of Emergency Medicine physicians who are currently paid under the FFS model. The contract template is available here. (link to follow)

Length of contract
The contract is for a duration of three years and provides either party the option of terminating without cause with 6 months' notice.

Pay and expectations
The rates of pay per full time equivalent for a maximum of 1680 hours of emergency medicine services in a year, including time spent providing indirect patient care at the beginning and end of each shift, are $332,493 for physicians with FRCPC, CCFP (EM) and ABEM certification and $296,068 for General Practitioners without CCFP (EM) certification. Please note that these rates will increase retroactively once the additional funding negotiated in the 2019 PMA is allocated among alternative paid physician groups.

The parties at the local level will need to negotiate the specific service deliverables and the number of full time equivalent physicians funded under the contract within the parameters of the Physician Master Agreement. Staff from the Economics, Advocacy and Negotiations Department are available to assist in these negotiations

How to know if the contract is right for you
Where a group of Emergency Medicine physicians believe that it is in their longer term economic interest to commit to an hourly based contract rather than the FFS model, they should consider this AP contract.

Contact for more information

For more information on the Group Emergency Medicine AP Contract, email negotiations@doctorsofbc.ca.

Simplified Short Term Service Contract – COVID

Q1: How will I know if the Simplified Service Contract is a good fit for me?

A1: Physicians considering transitioning to the Simplified Service Contract should consider their experience with service volume reductions over the past several months and their expected service volumes over the coming months in order to compare with the hourly rates and maximum payments under the Simplified Service Contract.

Q2: What is the term of a Simplified Short Term Service Contract?

A2: The maximum term of the contract is until December 31, 2021. Shorter terms (e.g. 6 months) can be determined at the local level between the Physician and Health Authority.

Q3: Why are anesthesiologists and emergency physicians ineligible for the Simplified Short Term Service Contract?

A3: The Ministry of Health has a policy objective of transitioning Anesthesia and Emergency Physician groups away from FFS to long term alternative payment arrangements. The Ministry of Health will offer anesthesia and emergency groups long term service contracts that are consistent with other contracted anesthesia and emergency groups.

Q5: Does the Simplified Short Term Service Contract require/guarantee a certain number of hours of service?

A5: No. The Simplified Short Term Service Contract establishes an hourly rate of pay. Physician's working under the contract are required to provide the services that they have historically provided. The maximum number of hours of Service to be paid under this contract is 1,867 hours per year.

Q6: Aside from FFS billings for services provided to WorkSafeBC patients, are any other FFS billings allowed?

A6: No. Fees for any other services provided under the contract are to be billed and assigned to the Health Authority.

Q7: Can physicians switch back and forth between the Simplified Short Term Service Contract and FFS on multiple occasions?

A7: Physicians are free to terminate the contract with 5 days' notice and return to FFS but it is not envisioned that physicians transition multiple times between the compensation modalities during the period they are available (i.e. up to December 31, 2021).

Q8: How is this Simplified Short Term Service Contract different from a conventional Service Contract under the PMA?

A8: The Simplified Short Term Service Contract is different in three main ways:

- While initially based on the Template Service Contract found in the PMA, the Simplified Service Contract has eliminated many of the provisions given the short term nature of the contract.
- Deliverables under the Simplified Service Contract are set as those that have been historically provided rather than negotiated at the local level.
- Payments under the Simplified Service Contract are on the basis of an hourly rate rather than an annual rate.

Q9: How much can I earn under the Simplified Short Term Service Contract?

A9: The Simplified Service Contract utilizes a hourly payment rate that is based on the midpoint of the Service Contract Payment Range (90% of the maximum of the payment range) for the Applicable Practice Category divided by 1680 hours of Service. The maximum number of hours of Service to be paid under this contract is 1,867 hours per year.

The hourly rates as of April 1, 2019 can be found here

These rates will be retroactively adjusted to account for the April 1, 2020 general increase and the application of increases pursuant to the After Hours Adjudication and the 2019 Allocation Committee processes once they have been completed.

Q10: How does the Simplified Short Term Service Contract address time spent waiting for the clearance of aerosolize particles in the OR?

A10: Surgeons can bill time waiting for clearance of aerosolized particles in the OR under the contract. The start time of the service would begin when the surgeon first sees the patient and ends when the last duties associated with the patient ends.

Q11. Can the Simplified Short Term Service Contract be applied retroactively to the start of COVID?

A11: No, the contract is only available on a go-forward basis.

Q12: Can a physician provide virtual care services under the Simplified Short Term Service Contract?

A12: Yes, services delivered on a virtual basis are permitted under the contract. However, the contract requires the Physician to provide services in accordance with the standards of medical practice. The College of Physicians and Surgeons expects Physicians to adhere to the Telemedicine Practice Standard which requires Physicians to conduct in-person physical examinations where required/appropriate for the provision of quality health care.

Simplified Short Term COVID Contract

Background

1. Shortly after BC began preparing for the impact of the COVID pandemic in spring of 2020, the CEO of Doctors of BC engaged with senior officials in the Ministry of Health to develop collaborative strategies to enable physicians to effectively address the emerging health care crisis. Among the issues discussed was the need to address the impact of the reduced demand for clinical services during the crisis on physicians' FFS income. The Ministry agreed to work with Doctors of BC to develop a suite of hourly based contract options available to FFS physicians in order to ensure a continuity of services through the pandemic period.

2. One of these options is to provide affected FFS physicians with the ability to move to an hourly based payment contract which provides a stable source of revenue as their FFS income declines.

3. Doctors of BC convened the Statutory Negotiations Committee (SNC) to carry out the consultations with the Ministry, supported by Doctors of BC staff. The members of the SNC are:
   a) Dr. Trina Larsen Soles – Chair
   b) Dr. Fred Kozak
   c) Dr. Hymie Fox
   d) Dr. David Wilton
   e) Dr. Michael Moran

4. The Ministry consulted with the SNC on 3 occasions in June and July, 2020 and accepted the majority of its recommendations.

Outline of the Simplified COVID Service Contract

5. The new COVID Service Contract is supported by the Ministry of Health, but is an agreement between an individual physician and the Health Authority to provide physician services. The Ministry plans to make it available to any individual physician who is currently paid under a Fee for Service arrangement, whether working as a part of a group or individually with the exception of the following:

   a) Anesthesiologists
      i) The Ministry feels that FFS anesthesiologists whose income is affected by the pandemic should opt for the recently developed group AP Anesthesiologist contract

   b) ER Physicians
      i) The Ministry feels that FFS ER physicians whose income is affected by the pandemic should opt for the standard group AP contract that applies in many other ER departments.

6. The COVID Service Contract is a simplified version of the Service Contract template in the PMA. It has been designed to minimize the involvement by the local parties on contract issues so that it can be implemented easily and quickly, recognizing that a large number of physicians may seek out these contracts at the same time. As a result, the contract requires the physician to provide "services that they have historically provided" and sets out a generic description of the following deliverables:
   a) Direct Patient Care
   b) Indirect Patient Care
   c) Clinically-related teaching and clinically related research
   d) Clinical Administrative Services

7. The contract also permits physicians to bill up to 5% of their hours directed to activities necessary for clinical service redesign of the practice in order to address the impacts of COVID-19 on service delivery, clinical processes patient flow.

8. The duration of the contract is flexible, up to December 31, 2021, and provides either party the option of terminating it without cause with 60 days' notice. A physician may also terminate the contract on 5 days' notice and return to FFS if the physician agrees to continue to provide the same services for the balance of the term of the contract.

9. Physicians under the contract are paid by the hour for each hour they provide services under the contract. The hourly rate is 90% of the maximum of the practice category rate in the PMA for Service Contracts based on 1,680 hours per year. Physicians may bill up to a maximum of 1,867 hours in a year, and therefore may earn up to the maximum annual rate as set out in the PMA for Service Contracts.

10. In addition to payments under the contract, the physician is entitled to bill FFS separately for services provided on behalf of WorkSafeBC. Time spent on such services is not counted towards the hours in the contract.

11. Apart from services to WorkSafeBC, the physician is required to bill MSP and any third party for each service provided and assign the billings to the Health Authority. The physician is also required submit simplified encounter records for the services provided.

SUBJECT LINE and TITLE: New Contract options for BC Physicians

October 1, 2020

Dear Colleagues:

Over the last year, the BC Ministry of Health has consulted with Doctors of BC as it developed new contract options for physicians. The dialogue was positive and collaborative, with the Ministry recognizing many of the key components important to physicians in delivering quality patient care.

The consultations are now concluded, and the Ministry is announcing contract options that will provide:

- More choice for established and new-to-practice family physicians who want to move away from Fee-for-Service (FFS), and
- Support for physicians whose FFS practices continue to be significantly destabilized due to conditions resulting from COVID-19.

It is acknowledged that the new contracts for family physicians may not be a good fit for everyone, but we believe they are reasonable options for some physicians, depending on your goals, the nature of your practice, and your community's health system service delivery approach. The options are aligned with the Ministry's and Doctors of BC's shared direction on Primary Care and support a plurality of payment options for physicians, to match practice styles and circumstances. Ultimately, this is about providing something doctors have been asking for – greater choice in how you are paid and the way you provide care. The new options will be added to the existing suite of contracts that the Ministry continues to develop with input from Doctors of BC.

The new COVID contracts are intended to be a short term option for FFS physicians whose volumes have been significantly reduced to ensure the continuity of public services throughout the pandemic.

The Ministry of Health and Health Authorities are presently preparing for intake for the new contracts. Physicians who are interested in moving to a new contract will be able to submit their expression of interest in the latter part of October. In the interim, we encourage interested physicians to participate in the webinar(s) noted below.

The following provides a high-level overview of the new contract options. We encourage you to visit the Doctors of BC dedicated web page (to come) for more detailed information to help you decide if the contracts might be a good fit for you.

Group Contract for Practicing Family Physicians

This contract is available to groups of practicing physicians with established patient panels working together in community-based clinics providing longitudinal patient care. It is also available to individual doctors who are not in the same clinic but are located within the same Primary Care Network (PCN).

Both the group contract and the New-to-Practice contracts (below) are designed to support the expansion of patient-centered, team-based care models. This is why clinics who wish to participate in the contract should be aligned or intend to align with the principles of the Patient Medical Home and must commit to actively support the implementation of PCNs.

Compensation is based on hours worked, the number and complexity of attached patients, and participation in Quality Improvement activities. Physicians have the option to earn additional income through work outside the clinic (e.g. in-hospital care), for services provided to third parties (e.g. WorkSafeBC and ICBC) and/or for specialized services referred by other physicians outside the clinic.

The contract compensates physicians for all time spent on the full spectrum of comprehensive primary care services, rather than just those services covered by MSC fees. As a result it provides physicians with greater clinical freedom to provide appropriate care to patients – for example, it funds physicians for activities related to prevention of illnesses and co-ordination of care with other providers. It also provides an initial payment guarantee in the first year so that physicians can redesign their business model to match the new contract.

Where a clinic indicates interest in participating in a contract, the Ministry will analyze the practice and provide the physicians in the clinic with a determination of the first year payment guarantee. Future payments will be determined based on hours worked, the number and complexity of attached patients, and confirmed participation in quality improvement activities during the first year of the contract..

Individual Contract for New-to-Practice Family Physicians

The hourly based contract provides income security for individual family physicians who wish to join a clinic and create a new patient panel.

Like the contract for established physicians, it provides options to earn additional income by providing services outside the clinic and contract requirements. When the panel size and composition warrants, physicians can transition to either FFS or to a group contract with the clinic where they work.

Simplified Temporary COVID-19 Service Contracts

The short-term contract, available to most family and specialist physicians paid by FFS, is designed specifically to provide a stable income when practices experience lower patient volumes due to COVID impacts. Depending on the level of impact of the pandemic, particularly in the event of future surges, it may be a better option for some physicians than remaining on FFS.

Physicians can continue with the contract until the number of patient visits return to normal and/or they are able to restructure their practices, but no longer than December 31, 2021. Physicians can terminate the contract and move back to FFS on five days' notice when service volumes recover.

The services covered under the contract will be those that physicians have historically provided, as well as compensating physicians for time spent on practice redesign. The hourly rate is based on the midpoint of the Service Contract payment range under the Physician Master Agreement divided by 1680 hours of service. Physicians are also able to bill fee for service for services to patients funded by WorkSafeBC.

More information

We have developed a number of resources to provide you with detailed information on all the new contracts, and I encourage you to take some time to learn more:

- Visit the dedicated web page (TBD) on the Doctors of BC website, to find detailed information on the new contracts organized by physician groups a physician Q & A, and resource materials.

- Attend a webinar. We are offering two separate webinars: one to discuss the family practice contracts and one to discuss temporary COVID-19 contracts. Invitations to these webinars will be sent out shortly.
    - The Family Practice contracts webinar will take place Tuesday, October 6th for one hour beginning at 6pm
    - The Temporary COVID-19 contracts webinar will take place Wednesday, October 14th for one hour beginning at 6pm

- Please email the negotiations department if you have any questions at negotiations@doctorsofbc.ca

I hope you will review the contract options that government is offering and the resource information available to you, and make your own determination as to whether one of them is a good fit for your practice model. The primary care contracts are a first step in offering additional alternatives to Fee-for-Service primary care work, and the short term COVID-19 contracts will hopefully work for physicians adversely affected by the pandemic.

As always, I thank you for everything you are doing to support patients and their families at this difficult time. And I wish to acknowledge the commitment and professionalism of so many physicians as you find your path through this pandemic. We are all in this together, and our success so far is due to your dedication and hard work.

I welcome your comments and questions, please e-mail me at president@doctorsofbc.ca

Sincerely,

KRoss

FAQs

General information on contracts

What are the benefits of the new contracts?

- They provide physicians with more choice regarding how they are compensated and how they choose to practice. This supports the Ministry's and Doctors of BC's commitment to a plurality of payment options to match physicians' individual practice styles and circumstances, something physicians told us they wanted.
- Both new family physicians contracts are specifically designed to support the Patient Medical Home/PCN model of practice, so they respond to a developing need among our family practice physicians and are aligned with GPSC priorities.
- The 'family physician' contracts compensate for the care provided to patients within a specific time frame, not specific services. This gives physicians greater clinical freedom to provide appropriate care to patients, especially for services not specifically covered by MSP fees . It also compensates physicians for time spent on preventative care activities, coordination of care, etc. The contract also provides an initial payment guarantee in the first year so that the physicians can redesign their business model to match the new contract.
- A particular benefit of the 'New to Practice' contract is that it provides stable funding to physicians whose practice (patient count) is in its initial stages of growth. (e.g. the physician has two years of continuous income to build the practice up to 1250 patients, which is considered a full panel)
- The 'COVID' contract is designed specifically to provide a stable income when volumes decline due to COVID impacts. For some physicians, this may be a better option than staying on FFS. The COVID contract might provide better protection for family doctors whose business capabilities limit their access to virtual care.

Were these contracts the result of a formal negotiation between the Ministry of Health and Doctors of BC? Why was there no ratification vote?

- The Ministry consulted Doctors of BC, but this was not a formal negotiation.
- Government and Health Authorities have the right to develop and offer new compensation contracts to physicians as long as they are not in conflict with the provisions of the Physician Master Agreement.
- In the 2019 PMA negotiations, the Parties agreed to a consultation process whereby government is required to consult with Doctors of BC if it intends to introduce a new physician compensation model for widespread implementation.

- In August, 2019, government invited Doctors of BC to begin consultation under the new process to develop a new Alternative Payment (AP) contract for practicing family physicians who provide full-service family practice in community based clinics.

Did physicians have direct input?

- In September 2019, the Board appointed five members to represent physician interests in the consultation with government. The group was chaired by former Doctors of BC president, Dr Trina Larsen Soles.

What is the position of Doctors of BC regarding the new contracts?

- Doctors of BC believes the contract may be a reasonable alternative to Fee-for-Service for some physicians wanting to change the way they practice, depending on their goals for the future and the nature of their current practice.
- Detailed information on the contracts is available on the Doctors of BC website (link). If you have remaining questions, e-mail us at negotiations@doctorsofbc.ca

Group Contract for In Practice Family Physicians

Who is eligible for this contract?

- It is available for groups of 3 or more family physicians who are currently in practice with established panels and who work together in a clinic providing longitudinal care.
- It is also available to individual physicians who are not in the same clinic but are located in the same primary care network and are prepared to work together to provide the services under the contract.
- It is not available to solo practitioners.

Why is the contract not open to solo practitioners?

- The contract is part of a broader strategic direction that encourages the development of primary care networks (PCNs) and physician practices that align with the principals of the patient medical home (PMH)
- In fact, the contract requires physicians to align their services with the principles of the PMH. Physicians must participate in existing Primary Care Network (PCN) or commit to actively support the development of a PCN in the community, where one is planned.

What if I start the contract, and realize it is no the right fit for me. What happens then?

- Under the NTP contract, the Physician can terminate the contract with six months notice to the Health Authority. However, if the Physician agrees to continue to provide the services on a Fee for Service basis as part of the group, the notice period is shortened to sixty days.
- An individual member of the group is able to terminate the contract with six months notice. Of note, the physicians' group governance agreement may contain provisions that address the circumstance of a member of the group terminating the contract.

Physicians can bill FFS for some services outside of the contract? What are those services?

Insert from Web site/letter

Who actually holds the contract and what are the deliverables?

- The contract is held by the physicians and the health authority.

  Deliverables include: comprehensive in-office primary care to both attached and unattached patients, a commitment to track and report on patient access measures, a requirement for physicians to engage in panel management and a choice of other Quality Improvement (QI) activities supported by the General Practice Services Committee (GPSC), and clinical administrative services including reporting activities.

The contract requires physicians to form a group governance agreement. Can Doctors of BC provide support in creating such an agreement?

- While Doctors of BC cannot provide members with legal or accounting advice, we have prepared a guidance document to support physicians in doing this work.
- The document identifies a framework of issues for consideration in a group governance agreement for members to take to their own legal and tax counsel.
- The group governance framework can be found here:

What supports will be available to me to ensure I know what I am entering into, and to address questions and issues that may come up along the way?

- Doctors of BC has a team of staff able to support physicians on questions related to the new contract. The Government has also committed to provide physicians with estimates of contract payments prior to the physicians entering into the contract.

How is payment made to physicians?

- Payments are made to the physician group. It is the responsibility of the physician group to determine how to allocate the payments among themselves.
- Physicians and their health authority will determine whether payment will be made on a biweekly or monthly basis. Payments are made on equal installments throughout the year.

Should the group be considered a partnership?

- It was not intended that physicians under the contract must create a partnership. We advise physicians to seek accounting advice regarding how payments are distributed and costs are covered.

Why isn't a Population Based Funding (PBF) Contract available?

- The Ministry and Doctors of BC focused these consultations on the new family practice contract options, as the Ministry is able to apply the new compensation model more broadly and quickly than PBF.
- Government is expected to re-engage its consultations on the PBF contract in the fall of 2020.
- Ultimately, the goal is to have a suite of contract options for physicians to choose from – the new options recently announced is just the start of this work.

How will I know if this is a good option for me? Where can I get more clarity on the financial impacts for me and my practice?

- Check out the information on the Doctors of BC dedicated web page (insert link). It includes some considerations to help you decide if this contract may be a good fit for you.
- Once you have reviewed all the material and determined that there is an interest in pursuing this, Ministry will work with you to share an analysis of both the first year guarantee income for the clinic, as well as an estimate of the payments under the contract in the second year of the contract.

How is the First Year Guarantee Income determined?

- The Ministry will provide a First Year Guarantee Income to the practice based on the greater of the historical FFS billings of physicians in the practice to a maximum of $329,664 per physician, or $289,664 per FTE working under the contract.
- The Ministry will assess the value of historical MSP billings for each physician in the practice over the 2019 calendar year, or the most recent calendar year, whichever is greater, inflated by applicable PMA increases.
- At the end of the first year of the contract, the Ministry will conduct a reconciliation process and will apply the second year payment calculation approach to the first year of the contract. This may result in a retroactive increase to the contract on the basis of the practice's panel size and composition.
- The reconciliation will also account for the hours of service reported by physicians over the first year of the contract. If physicians fail to provide the minimum hours of service per FTE, the first year payment rate will be retroactively reduced and physicians will be required to make a reconciliation payment to the Health Authority.

I work part time, will the contract be an option for me?

- Yes, the contract will accommodate physicians working on a part time basis. However, in order to support continuity of care for attached patients, the least amount of part time work under the contract is 0.5 FTE.

How is patient complexity measured in the contract?

- Complexity is measured by the in-community GP FFS costs for patients in an Adjusted Clinical Group (ACG).
- ACG's are a series of mutually exclusive health status categories defined by morbidity, and age, and gender as defined by the Johns Hopkins University ACG classification system in place as of the date of signing of the Contract.
- Each patient is placed into one ACG category using a rolling 12-month diagnosis history as measured by ICD-9 codes submitted as part of Encounter Reporting or FFS billing.

How does the contract account for services delivered to patients who are not attached to a physician in the practice, such as walk-ins or referred patients (i.e. unattached patients)?

- This may vary under the contract depending on the circumstance.
- Physicians are able to bill FFS for unattached patients who are not residents of BC and for BC patients who are referred to the clinic for 'specialized' services, such as maternity care.
- Services provided to unattached patients who are BC residents who have not been referred for specialized services fall within the scope of the contract.
- The physicians and health authority are able to locally negotiate a reduction in the clinic's panel size expectation to account for the workload associated with such services.

How does the contract account for Quality Improvement activities?

- The contract describes several QI initiatives in which physicians are expected to participate. They are expected to provide no more than 1 hour of QI services per week.
- Participation in QI activities will result in an additional $20,000 per year per full time equivalent payment to the practice.
- Payments are not related to QI outcomes.

How many hours is a full time physician expected to work under the contract?

- A full time equivalent physician is expected to work a minimum of 1680 hours to a maximum of 2100 hours per year in order to receive full payment under the contract.
- At the end of each year of the contract, a reconciliation process will take place to ensure that the minimum hours of service have been provided by the physicians working under the contract.

Is their negation or are there outflows under the contract?

- No. Patients are free to see other family physicians without penalty to the physicians under the contract. Physicians are required to have attachment conversations with each attached patient outlining the following items:

  As your primary care provider I, along with my practice team, agree to:

  - Provide you with safe and appropriate care
  - Coordinate any specialty care you may need
  - Offer you timely access to care, to the best of my ability and as reasonably possible in the circumstances
  - Maintain an ongoing record of your health
  - Keep you updated on any changes to services offered at my clinic
  - Communicate with you honestly and openly so we can best address your health care needs

  As my patient I ask that you:

  - Seek your health care from me and my team whenever possible and, in my absence, through my colleague(s)
  - Name me as your primary care provider if you have to visit an emergency facility or another provider
  - Communicate with me honestly and openly so we can best address your health care needs

What are the expectations regarding after hours service delivery?

- At the outset, physicians and the health authority will locally negotiate the clinic's operating hours as well as daily physician staffing levels.
- Physicians also agree to coordinate with the Health Authority and other practitioners in a PCN in order to provide flexible scheduling as required for extended hours of service, when and if physicians agree to provide such extended hours of service.

How are locums treated under the contract?

- Physicians working under the contract have the option of deploying locums in two ways:
  - a locum can be compensated under the contract by the physicians if the locum reports hours of service under the contract.
  - a locum can be compensated on a FFS basis if the locum does not report hours of service under the contract.

How is Physician Accountability managed under the contract?

- As physicians are able to bill for time under the contract and FFS for eligible services on the same day, there are enhanced reporting requirements (see below) to prevent double billing. Double billing occurs when a physician claims time under the contract for services that are also billed on a FFS basis. Physicians have multiple reporting responsibilities under the contract, including:
  - quarterly reporting on hours of service provided by individual physicians for each day of work

- reporting on each patient encounter utilizing a simplified set of encounter codes rather than MSP fees
- reporting on daily start and stop times while estimating hours of service per day through Teleplan
- Including start and stop times of patient encounters on eligible FFS claims when providing FFS services on the days that the physician is also providing services under the contract.

- Time spent on reporting responsibilities are Clinical Administrative Services and are thus compensated within the scope of the contract.

Will rural physicians working under the contract receive Rural Retention Program premiums?

- Yes, rural physicians will receive additional payments equivalent to the Rural Retention Program Fee Premium and Flat Premium for the applicable community.

Are physicians paid for their administrative activities under the contract?

- Time spent on administrative activities related to patient care, Quality Improvement, and reporting responsibilities are compensated under the contract.
- Time spent on managing the group practice (e.g. group governance discussions) or clinic operational activities (e.g. negotiating an office lease or hiring clinic staff) is not compensated under the contract.

How does the contract account for maternity services?

- Time spent providing prenatal and postnatal services in the clinic to attached patients of physicians within the group is a compensable Service under the Contract. The provision of prenatal and postnatal services in the clinic to referred patients is not a compensable service under the contract and are billable on a FFS basis.
- Time spent providing delivery services outside of the office for attached or referred patients is not a compensable service under the contract and is billable on a FFS basis.
- Physicians working under the contract are eligible to bill the GPSC's Maternity Network Fee.

New to Practice (NTP) Physician Contract

Please review the information in the section for established family physicians. The questions and answers in this section apply specifically to NTP physicians, those who intend to establish a patient panel with the intent of joining or creating a group practice.

How does this contract for NTP physicians differ from the previous one?

- The revised NTP contract better conforms with the new group contract for established family physicians. The changes include:

  - a new (higher) annual payment rate
  - payment for Quality Improvement activities
  - the ability to transition to the new group contract for in practice family physicians when the panel size and composition warrants
  - limiting the services to primary care services provided in the community
  - removing the number of days of work requirement from the contract deliverables

Why does the NTP Contract require the physician to join or create a group practice?

- The NTP contract, like the one for established family physicians, supports government's strategic direction encouraging the development of team-based care through primary care networks, and alignment of practices with the principals of the patient medical home.
- It also offers NTP physicians mentorship at the start of their practice.

Why does the contract require the physician to enter into a practice agreement?

- The Practice Agreement is part of the NTP contract in order to:
  - Ensure alignment between the physician and other practitioners in group
  - Include a commitment to cross coverage arrangements of patients served by the practice
  - Identify the NTP physician's expected schedule
  - Outline the NTP physician's overhead contribution
  - Describe the nature of the services to be provided by the NTP Physician

How will I know if this is a good option for me?

- Check out our dedicated web page for things to consider in determining if this contract is a good fit.
- Generally, it is a good option for family physicians who want to build a new patient panel and are seeking a stable source of income and mentorship of other physicians as they do so.

What are the attachment requirements under the contract?

- The attachment targets for the physician are 800 patients by the end of the first year of the contract and 1,250 patients by the end of the second year of the contract.

- The physician is expected to establish a panel of patients of a similar nature to other practitioners in the practice, unless otherwise agreed to by the physician, health authority, and other practitioners in the practice.
- The physician and health authority are able to locally negotiate a reduction in the physician's target panel size to account for the workload associated with patient complexity, clinical teaching and services to unattached patients.

Can the NTP physician take over a panel from a retiring physician?

- Yes. However, the NTP physician will also be required to accept some patients from waitlists maintained by the applicable Division of Family Practice or Health Authority.

How does the contract account for patient complexity?

- The panel size targets described in the contract are for patients of average complexity. If the physician's panel size is expected to be of higher complexity, the physician and health authority are able to reach agreement to lower the panel size.

How does the contract account for Quality Improvement activities?

- The contract describes several QI initiatives in which the physicians are expected to participate. Physicians are expected to provide no more than 1 hour of QI services per week. At the end of the first year, a full-time physician who participates in all designated QI activities for that year and meets the attachment target is entitled to a one-time payment on $10,000.
- In the second year, a physician who participates in all designated QI activities is eligible for ongoing payments which total $20,000 in addition to the hourly pay for the contracted services.

Family Physician Group Contract Initiative

September, 2020

BRITISH COLUMBIA

Group Contract for In Practice FPs

- Contract between Physician Group and Health Authority
  - Minimum of three physicians in a group
  - Not available to solo practitioners
  - No requirement to co-locate; Individual practices in same PCN may form a group
- Available throughout BC (not just PCN communities)
- Physicians are to align with PMH and PCN principles
- 3 year term with 6 month notice of termination
- Physicians responsible for Overhead & Management of Practice

BRITISH COLUMBIA

Group Contract for In Practice FPs

- Full Time Equivalent is defined as 1680 to 2100 hours
- Minimum commitment of 0.5 FTE is required
- Payment range for 1 FTE is $269,664 to $329,664 plus limited FFS
  - Base Rate – $269,664
  - QI - $20,000
  - Volume/Acuity – Up to $40,000
- Contract sets out the following Services:
  - Comprehensive primary care services in community clinics
  - Access & Attachment services
  - Quality Improvement services
  - Clinical Administrative services
  - Clinical Teaching services (optional)

BRITISH COLUMBIA

Group Contract for In Practice FPs

- Comprehensive Primary Care Services in Community (PMH)
  - Health Promotion
  - Minor and episodic illness treatment
  - Chronic Disease Management
  - Mgmt & coordination of care across spectrum of primary & tertiary care
  - Primary and reproductive care
  - Primary Mental Health and Substance Abuse services
  - Support for terminally ill
  - Participation in multidisciplinary teams

BRITISH COLUMBIA

Group Contract for In Practice FPs

- Access & Attachment Services
  - Attachment conversations with new and existing patients
  - Physicians to submit attachment code for all attached patients
  - Ministry to develop attachment verification tool
- Track and report on 3rd available appointment
- Locally negotiate clinic operating hours & daily staffing levels
- Extended hours coordination with PCN
- Cross coverage within the practice
- Max. of 90 hours over 2 weeks
- Annual review of physician panels by Ministry of Health

Group Contract for In Practice FPs

- Quality Improvement Services
  - **GPSC Patient Experience tool** – starting Yr 1 and ongoing during term
  - **Panel Management** – completing Yr 1 and ongoing during term
  - FT physicians (>0.75 FTE) are required to participate in at least two other QI activities
  - PT physician (< 0.75 FTE) are required to participate in one other QI activities
  - One hour per week of time spent on QI can count towards contract hours requirement

BRITISH COLUMBIA

Group Contract for In Practice FPs

- Eligible FFS billings for:
  - Certain services provided in the clinic.
    - Payments from third parties, such as:
      - WSBC
      - ICBC
      - Services to non-BC residents
      - Non-insured services (e.g. medical/legal)
    - Specialized services to patients who are referred by practitioners outside the clinic (i.e., patients not attached to the clinic)
  - Services provided in Hospital or other facilities
  - GPSC Network (e.g. Inpatient, Maternity and Residential Care Initiative)
  - Time spent providing services cannot be counted towards contract hours requirement.

Group Contract for In Practice FPs

- Health Authority makes payments to the Clinic
- Clinic determines distribution of payments to individual physicians
- First year payment:
  - Initial Income Guarantee is based on the higher of:
    - 2019 FFS to a maximum of $329,664 per FTE, or
    - $269,664 per FTE plus $20,000 for QI
  - Reconciliation process:
    - Within 120 days following end of first year
    - May retroactively increase year 1 payment based on year 1 contract panel and complexity
    - Year 1 payment to be retroactively adjusted if FTE hours commitment is not met or QI required activities are not completed

BRITISH COLUMBIA

Group Contract for In Practice FPs

- Second and subsequent years of the contract, payment is based on:
  - Hours worked
  - Panel size and complexity
  - Participation in Quality Improvement Activities.
- Annual reconciliation process to assess and adjust contract value:
  - Retroactive adjustments
  - Adjustments may result in increases or decreases in contract value

BRITISH COLUMBIA

Group Contract for In Practice FPs

- Panel Size Expectation (PSE) is 1,250 patients of average complexity
- Complexity is measured by:
  - Categorizing attached patients into Adjusted Case Groups (ACG)
  - Determining average in-community FFS costs by ACG
- PSE is adjusted upwards or downwards to the extent by which the physicians' actual panel's complexity differs from the average complexity of all attached patients in BC
- Physicians may also negotiate adjustments to the PSE to account for:
  - Services provided to unattached BC residents
  - Clinical Teaching services

BRITISH COLUMBIA

Group Contract for In Practice FPs

- Physician Accountability is managed by:
  - quarterly reporting on hours of service for each day of work
  - patient encounter reporting using simplified encounter codes rather than MSP fees
  - reporting via Teleplan on daily start and stop times and estimated hours spent providing services under the contract
  - reporting start and stop times on permitted FFS claims
- MSC auditing authority is imported into the contract
- HA may initiate an audit but may not review EMR

Group Contract for In Practice FPs

- Requires Group Practice Agreement
  - Distribution of payments
  - Allocation of clinic costs
  - Other clinic operations and management issues
- Doctors of BC to provide framework of issues for consideration
- Physicians need independent legal and accounting advice

BRITISH COLUMBIA

New To Practice (NTP) Contract

- Context
  - Govt introduced NTP contract in 2018 after consulting with Doctors of BC
  - Payment rates were key outstanding issue in 2018 consultations
  - Doctors of BC was neutral, BCFD and Profession expressed concern
  - Little uptake of the contract over last 2 yrs
  - NTP contract is seen as key to meeting attachment needs in BC
  - Govt consulted with Doctors of BC to revise the NTP contract
  - Revised NTP Contract announced together with Established GP Contract

New To Practice (NTP) Contract

- Contract between Individual Physician and Health Authority
- NTP Physician must join a group practice & sign a Practice Agreement
  - Group could be established practice paid on FFS or AP basis
  - Group could be other NTP physicians
- Available throughout BC (not just PCN communities)
- Physicians are to align with PMH and PCN principles
- 2 year term
- Physicians responsible for Overhead

BRITISH COLUMBIA

New To Practice (NTP) Contract

- Base payment rate for Full time is $269,664
- Additional payments:
  - Year 1 bonus of $10K for QI and meeting attachment target (800 patients and completed QI activities.
  - Year 2 payment of an additional $20K for QI; same criteria as In-Patient Contract
- Payments to increase by 2% in 2021/22
- Limited FFS billings (same as In Practice Contract)
  - Third Party (e.g. WSBC) and specialized services referred by practitioners from outside the clinic (i.e., patients not attached to the clinic)
  - Services provided in Hospital or other facilities
  - GPSC Network (e.g. Inpatient, Maternity) and Residential Care Initiative fees

BRITISH COLUMBIA

New To Practice (NTP) Contract

- Practice Agreement is required element of NTP Contract
  - Ensures alignment between NTP physician and other practitioners in group
  - Includes commitment to cross cover the NTP Physician
  - Identifies the NTP Physician's expected schedule
  - Outlines the NTP Physician's overhead contribution
  - Describes the nature of the services to be provided by the NTP Physician
- NTP Physicians may also be asked to enter into other agreements:
  - Group Governance Agreement, or
  - Associates Agreement

New To Practice (NTP) Contract

- Full Time Equivalent is defined as 1680 to 2100 hours
- Minimum commitment of 0.5 FTE is required
- Maximum of 90 hours over two weeks is permitted
- Attachment Targets
  - 800 in year 1
  - 1,250 in year 2

New To Practice (NTP) Contract

- NTP Contract Services align with Group In Practice Contract Services:
  - Comprehensive primary care services (longitudinal care) in community clinics
  - Attachment services
  - Quality Improvement services
  - Clinical Administrative services
  - Clinical Teaching services (optional)
- Transition to Group In Practice Contract
  - End of year 2, or
  - With 60 days notice if panel size and composition warrants

BRITISH COLUMBIA

New To Practice (NTP) Contract

- Physician Accountability is same as In Practice Group Contract:
  - quarterly reporting on hours of service for each day of work
  - patient encounter reporting using simplified encounter codes rather than MSP fees
  - reporting via Teleplan on daily start and stop times and estimated hours spent providing services under the contract
  - reporting start and stop times on permitted FFS claims
- MSC auditing authority is imported into the contract
- HA may initiate an audit but may not review EMR

Implementation

- Ministry Executive have been briefed.
- DoBC Board and the Family Doctors of BC (SGP) have been briefed and are supportive of the contracts
- Proposed joint messaging from MoH and DoBC the week of September 7 – 11th.
- Physicians webinars the week of September 14 – 18th
- Physicians to contact Health Authority to express interest
- Ministry to provide analysis to GPs of compensation under the Contract

BRITISH COLUMBIA

Murray, Heather HLTH:EX

From: Pokorny, Peter HLTH:EX
Sent: September 30, 2020 5:25 PM
To: Hrycuik, Lorie HLTH:EX; Rongve, Ian HLTH:EX; Bell, Carolyn P HLTH:EX; Danyluk, Quinn [FH]; Everett, Kirsten F HLTH:EX; Sagar, Brian HLTH:EX; Ackenhusen, Mary HLTH:EX
Subject: PPE Testing - Research

Hi all – The Ministry's Partnership and Innovation Division has smart people, research networks, and capacity to look at challenges and issues across the health system. I was chatting with Mary Ackenhusen recently about research questions that might support our efforts (and innovation) around COVID response, and my favourite topic of PPE came up. There were a range of issues discussed, but one that popped out for me as an interesting topic is our approach and capacity for PPE assessment and testing in BC. s.13
s.13

I'll turn it over to Mary to reach out to you individually and/or collectively, but thanks in advance for the time and insight you'll provide. After some introductory discussions, I'm hoping we can get together to frame out some ideas and options for further research.

Thanks,
Peter

Peter Pokorny
Associate Deputy Minister
Corporate Services
Ministry of Health
(778) 698-8046

Gold, Crystal HLTH:EX

From:	Grant, Kristen L HLTH:EX
Sent:	September 30, 2020 2:01 PM
To:	Bell, Carolyn P HLTH:EX; tony.bamford@fnha.ca; Everett, Kirsten F HLTH:EX; XT:Pica, Fernando HLTH:IN; XT:Simmers, Brian HLTH:IN; Brittany Deeter; 'april.macnaughton@fnha.ca'; XT:Liggett, Brenda HLTH:IN; 'melinda.mui@phsa.ca'; 'Dean.Chittock@vch.ca'; XT:HLTH De Croos, Mark; XT:Bayzand, Laurence EHS:IN; Schmid, Victoria; Danyluk, Quinn [FH]; Vowles, Wendy M HLTH:EX; XT:Bloemink, Karen HLTH:IN; Liu, Reuben [PHSA]
Cc:	Pokorny, Peter HLTH:EX; Poonam Rajappa; Mui, Melinda [PHSA]; Tang, Lydia HLTH:EX
Subject:	FOR INFORMATION Supply Chain/Logistics Meeting - UK PPE Strategy

Hello Supply Chain/Logistics Committee,

Please find the link to the recently released UK PPE Strategy as discussed in today's Supply Chain/Logistics Committee meeting.

https://www.gov.uk/government/publications/personal-protective-equipment-ppe-strategy-stabilise-and-build-resilience/personal-protective-equipment-ppe-strategy-stabilise-and-build-resilience

Warm Regards,
Kristen

BRITISH COLUMBIA

Kristen Grant
Sr. Policy Analyst, Logistics Strategy
COVID Response & Health Emergency Management Division
Ministry of Health
PO Box 9639 Stn Prov Govt, Victoria BC V8W 9P1
Tel: (236) 478-1270

GOV.UK

OGL

Gold, Crystal HLTH:EX

From: Brown, Stephen R HLTH:EX
Sent: October 1, 2020 7:28 PM
To: Pokorny, Peter HLTH:EX
Subject: FW: RE: For Stephen Brown - This email may require your attention

From: Allan from Globalla PPE Products <allan.fletcher@vandamanwebcreations.com>
Sent: September 13, 2020 10:58 AM
To: Brown, Stephen R HLTH:EX <Stephen.Brown@gov.bc.ca>
Subject: Re: RE: For Stephen Brown - This email may require your attention

Hi Stephen,

I was wondering if you had a chance to review my previous emails with the details of the PPE products.

Please review and let me know if you would be interested in acquiring any of the following PPE products at the most competitive prices;

Products
NIOSH Approved N95 Respirators
KN95 Respirators
Nitrile Gloves
Gowns (Level 1 to Level 2)
Medical Infrared Thermometer

Looking forward to hearing from you.

Regards,
Allan Fletcher
514-971-7886
afletcher@globallagroup.com

Globalla Inc.
905 Hodge St.
St-Laurent, Quebec
Canada
H4N 2B3

globallagroup.com

Unsubscribe here

From: Allan Fletcher
Sent: 09 Sept 2020 10:10 AM
To: Stephen Brown < stephen.brown@gov.bc.ca >
Subject: RE: For Stephen Brown - This email may require your attention

Hi Stephen,

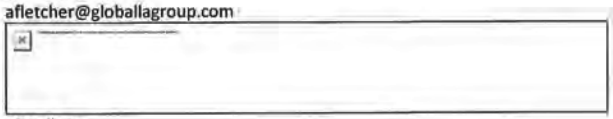
This is the follow-up email regarding an opportunity to collaborate with you for supplying PPE products.

I was trying to reach out to you to check if you would be interested in acquiring PPE supplies.

Please refer below email for price and other details and let me know if there's a requirement.

Thank you and have a great day!

Regards,
Allan Fletcher
514-971-7886
afletcher@globallagroup.com



Globalla Inc.
905 Hodge St.
St-Laurent, Quebec
Canada
H4N 2B3
globallagroup.com

From: Allan Fletcher
Sent: 8 Sept 2020 10:10 AM
To: Stephen Brown < stephen.brown@gov.bc.ca >
Subject: For Stephen Brown - This email may require your attention

Hi Stephen,

My name is Allan Fletcher. I represent Globalla – that supplies a host of PPE Products such as 3 Ply Disposable Masks, **NIOSH Approved** N95 Respirators, Nitrile Gloves to name but a few.

Globalla works in partnership with many organizations like yours to deliver PPE products efficiently and most importantly, cost-effectively.

Our products:

Products	Price	Delivery
NIOSH Approved N95 Respirators	s.17	
KN95 Respirators		
Nitrile Gloves		
Gowns (Level 1 to Level 2)		
Medical Infrared Thermometer		

Stephen, We are approaching the fall season and many businesses have employees returning to work to their work, as well as schools at all levels, will be returning to classes, so everyone will require protection in order to stay safe and the demand for masks is increasing every day!

So why not give us a try on your next purchase and allow us to help you.

Thank you for your consideration.

Regards,
Allan Fletcher
514-971-7886
afletcher@globallagroup.com

Globalla Inc.
905 Hodge St.
St-Laurent, Quebec
Canada
H4N 2B3
globallagroup.com

Murray, Heather HLTH:EX

From: Pokorny, Peter HLTH:EX
Sent: October 1, 2020 8:53 AM
To: Bell, Carolyn P HLTH:EX; Rongve, Ian HLTH:EX
Subject: RE: PPE on hand and stockpiling report MASTER.xlsx

I'll fill you guys in when we meet later today...

From: Edgeworth, Jaci [PHSA] <Jaci.Edgeworth@phsa.ca>
Sent: October 1, 2020 8:50 AM
To: Bell, Carolyn P HLTH:EX <Carolyn.Bell@gov.bc.ca>
Cc: Pokorny, Peter HLTH:EX <Peter.Pokorny@gov.bc.ca>
Subject: PPE on hand and stockpiling report MASTER.xlsx

Hi Carolyn,

I wanted to share the attached document with you - PPE on hand and stockpiling report. We used a version of this report for our bilateral meeting earlier this week. I think the report format was useful and there was a request was to calculate days on hand based on the model (vs historical usage).

There are three sections to the report.

Section 1: days on hand
- You now can see days on hand calculated based on the model and based on the actual usage for the past 30 days.

Section 2: PPE & critical supplies stockpiling targets and sourcing complete
Section 3: PPE & critical supplies delivery schedule

We will produce this report every Friday.
- The full report will be provided to you and Peter.
- The on hand section will be included in the weekly supply chain executive summary report that is shared with the HA CEO's.

Let me know if you have any thoughts/feedback. You will receive this report with updated numbers tomorrow and we will use this as our internal master reporting document going forward.

Thanks,
Jaci

Best regards,

Jaci Edgeworth
Vice President & Chief of Staff, CEO Office
Provincial Health Services Authority

Office: #200 – 1333 West Broadway, Vancouver, BC V6H 4C1
Phone: 604-875-7148 (Ext. 557148) | Mobile: 604-834-0115
Email: jaci.edgeworth@phsa.ca| www.phsa.ca | jobs.phsa.ca

Provincial Health Services Authority

RESPECT AT PHSA

Murray, Heather HLTH:EX

From: Barclay, Corrie A HLTH:EX
Sent: October 1, 2020 9:42 AM
To: Pokorny, Peter HLTH:EX
Cc: Twyford, Philip HLTH:EX; Glazer, Brad R HLTH:EX
Subject: Re: C-19 Capital Investment Request

Thanks Peter

Will update financial package and ensure quick decisions and no impact or delays.

s.13

Corrie

Sent from my iPhone

> On Oct 1, 2020, at 9:36 AM, Pokorny, Peter HLTH:EX <Peter.Pokorny@gov.bc.ca> wrote:
>
> Thanks, Corrie.
>
> I don't have any concerns, subject to the following:
> s.13
>
> Thanks,
> Peter

From: Barclay, Corrie A HLTH:EX <Corrie.Barclay@gov.bc.ca>
Sent: September 30, 2020 12:44 PM
To: Twyford, Philip HLTH:EX <Philip.Twyford@gov.bc.ca>; Pokorny, Peter HLTH:EX <Peter.Pokorny@gov.bc.ca>
Cc: Glazer, Brad R HLTH:EX <Brad.Glazer@gov.bc.ca>
Subject: FW: C-19 Capital Investment Request

Hi Peter and Philip

Attached is the package I would like to send out to HA's as a follow up to the memo Philip sent with their budget for COVID. Can you let me know if you have any feedback or concerns.

Thanks
Corrie

This an example of the prepared mailout. This one is destined for Victoria Lee, with cc to Brenda Liggett and Gregor McWalter.

Good afternoon.

I am writing in follow up to the September 18, 2020 COVID-19 Funding Letter sent to you by Philip Twyford, Assistant Deputy Minister and Executive Financial Officer, Finance and Corporate Services, to outline the process to request approval for COVID-19 funding to be invested in digital and IM/IT initiatives.

The attached package provides context and specific instructions. If you have any questions, please do not hesitate to contact Brad Glazer at Brad.Glazer@gov.bc.ca.

Thank you,
Corrie

Corrie Barclay
ADM | Health Sector IM/IT Division | Ministry of Health
P: 778.974.2796 C: s.17
| Corrie.Barclay@gov.bc.ca

Page 216 of 231 to/à Page 218 of 231

Withheld pursuant to/removed as

s.13 ; s.16

Gold, Crystal HLTH:EX

From: Cerna, Carolina [PHSA] <carolina.cerna@phsa.ca> on behalf of Morin, Benoit [PHSA] <benoit.morin@phsa.ca>
Sent: October 1, 2020 10:41 AM
To: XT:Morin, Benoit HLTH:IN; XT:Ulrich, Cathy HLTH:IN; Bell, Carolyn P HLTH:EX; Byres, David W HLTH:EX; XT:Dawkins, Laurie GCPE:IN; Gustafson, Reka [BCCDC]; Rongve, Ian HLTH:EX; 'IHEOCDirector@interiorhealth.ca'; XT:Lavery, John HLTH:IN; XT:MacNeil, Kathryn HLTH:IN; Diacu, Mariana HLTH:EX; Moneo, Mitch HLTH:EX; HLTH COVIDAnalytics HLTH:EX; Pokorny, Peter HLTH:EX; XT:HLTH Prentice, Cathy; XT:Dalton, Fiona HLTH:IN; XT:Jock, Richard HLTH:IN; Brown, Stephen R HLTH:EX; XT:Brown, Susan PSA:IN; XT:Manning, Tim HLTH:IN; XT:Lee, Victoria HLTH:IN; XT:HLTH Eliopoulos, Vivian; Vowles, Wendy M HLTH:EX
Subject: Daily Dashboard - October 1, 2020
Attachments: 2020-10-01 Provincial Dashboards -- COVID Dashboard.xlsx

Message sent on behalf of Benoit Morin, President & CEO, PHSA

Good Morning,

Please find attached the Daily Dashboard for Thursday, October 1, 2020.

Kindly fan out as required.

Thank you.

Carolina Cerna
Manager, CEO Office Administration and Executive Assistant to Benoit Morin, President & CEO
Provincial Health Services Authority

Provincial Health Services Authority
Province-wide solutions. Better health.

RESPECT AT PHSA

Office: #200 – 1333 West Broadway, Vancouver, BC V6H 4C1
Phone: 604-675-7497 (Ext. 557497) | Email: carolina.cerna@phsa.ca | www.phsa.ca | jobs.phsa.ca

Date: 2020-03-30

report run time: 10/1/2020 7:30:00 AM
time range: 9-30-2020 12:00 AM
to 10-1-2020 12:00 AM

Date: 2020-09-30

report run time: 9-30-2020 9:57 PM
time range: 9-30-2020 12:00 AM
to 10-1-2020 12:00 AM

date 2020-09-30

As reported as of 0900am each day; data prior to March 25/20 is incomplete

Gold, Crystal HLTH:EX

From:	Tang, Lydia HLTH:EX
Sent:	October 1, 2020 4:18 PM
To:	Bell, Carolyn P HLTH:EX; tony.bamford@fnha.ca; Everett, Kirsten F HLTH:EX; XT:Pica, Fernando HLTH:IN; XT:Simmers, Brian HLTH:IN; Brittany Deeter; 'april.macnaughton@fnha.ca'; XT:Liggett, Brenda HLTH:IN; 'melinda.mui@phsa.ca'; 'Dean.Chittock@vch.ca'; XT:HLTH De Croos, Mark; XT:Bayzand, Laurence EHS:IN; Schmid, Victoria; Danyluk, Quinn [FH]; Vowles, Wendy M HLTH:EX; XT:Bloemink, Karen HLTH:IN
Cc:	Pokorny, Peter HLTH:EX; Poonam Rajappa; Mui, Melinda [PHSA]; Grant, Kristen L HLTH:EX
Subject:	RE: Supply Chain/Logistics Meeting
Attachments:	2020 10 02 SC Log Com Agenda.docx

Hi all,

Attached is the agenda for tomorrow's Supply Chain meeting. Please email Kristen.Grant@gov.bc.ca if you have any items you would wish to add.

Thanks,
Lydia

-----Original Appointment-----
From: Bell, Carolyn P HLTH:EX <Carolyn.Bell@gov.bc.ca>
Sent: July 27, 2020 11:41 AM
To: Bell, Carolyn P HLTH:EX; tony.bamford@fnha.ca; Everett, Kirsten F HLTH:EX; XT:Pica, Fernando HLTH:IN; XT:Simmers, Brian HLTH:IN; Brittany Deeter; 'april.macnaughton@fnha.ca'; XT:Liggett, Brenda HLTH:IN; 'melinda.mui@phsa.ca'; 'Dean.Chittock@vch.ca'; XT:HLTH De Croos, Mark; XT:Bayzand, Laurence EHS:IN; 'andrew.pattison@interiorhealth.ca'; Schmid, Victoria; Danyluk, Quinn [FH]; Vowles, Wendy M HLTH:EX
Cc: Pokorny, Peter HLTH:EX; Poonam Rajappa; Mui, Melinda [PHSA]; Grant, Kristen L HLTH:EX; Tang, Lydia HLTH:EX
Subject: Supply Chain/Logistics Meeting
When: October 2, 2020 1:30 PM-2:00 PM (UTC-08:00) Pacific Time (US & Canada).
Where: Skype Meeting

July 27th update:

Going forward, this meeting will be scheduled from Carolyn Bell's calendar.

June 5th update:

This meeting series will continue as of June 8th on Monday, Wednesday and Fridays. Thank you

June 2 Update:

As discussed at yesterday's meeting, we have condensed the Supply Chain and Logistics Committee distribution list. Going forward, if you would like an alternate please contacts us, **do not forward this meeting invitation**.

Please refer to the SharePoint site below to access your Daily Dashboards.

1

https://biportal.phsa.ca/reports/powerbi/SC/PHSA%20Supply%20Chain%20Dashboard/Supply%20Chain%20COVID19%20Dashboard

Join Skype Meeting

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Local - Vancouver: s.15; s.17	(BC, Canada)	English (United States)
Toll-Free: s.15; s.17	(BC, Canada)	English (United States)
Local - Kamloops: s.15; s.17	(BC, Canada)	English (United States)
Local - Prince George: s.15; s.17	(BC, Canada)	English (United States)
Local - Nelson: s.15; s.17	(BC, Canada)	English (United States)

Find a local number

Conference ID: s.15; s.17

Forgot your dial-in PIN? | Help

Would like to discuss the "strategy" below and the role of attendees in this approach:

1. **Buy Some Time** - Look closely at the expected delivery dates for the key supplies that we know to be in shortage (e.g. N95 respirators) and assess the likelihood of failed delivery. If high (which I think is what we can expect), what are our alternate sources? Find alternate suppliers and/or make an emergency request to Federal government to buy us as much time as possible.
2. **Conserve** - Establish clarity on appropriate use of PPE in all clinical situations and require strict and consistent adherence by health authorities/hospitals/health care workers. Policy is to be informed by evidence, safety, and the need for conservation.
3. **Assess Need** - Use epidemiological modelling and the "appropriate use" policy (#2 above) to estimate PPE needs by health authority (by volume and by timeframe).
4. **Assess Inventory** - Confirm a solid understanding of PPE inventory/supply in BC, including PHSA warehouses and health authority/facility supply.
5. **Predict Pinch Points** - Based on our modelling of need and our inventory (#3 and #4 above), when and where do our key pinch points arise?
6. **Establish Plan for Supply** – Place orders and/or communicate our needs to the Federal government to access their bulk procurement. Monitor risk of failed delivery closely.
7. **Contingency Plans** – What is our plan if supplies do not arrive? Ranging from the simple balancing of supplies across health authorities based on regional need to a scenario where we are accepting that supplies will not be available and we have to re-use or take other drastic measures around use.

Supply Chain/Logistics Committee

Date: October 2, 2020
1:30 to 2 p.m.

Members				
☐Brenda Liggett (FHA)	☐April MacNaughton (FNHA)	☐John Jinn (PHC)	☐Victoria Schmidt (ViHA) Krystal for Victoria	☐Carolyn Bell (MOH)
☐Quinn Danyluck (FHA)	☐Poonam Rajappa (FNHA)	☐Brian Simmers (PHC)	☐Dean Chittock (VCHA)	☐Wendy Vowles (MOH)
☐Tony Bamford (FNHA)	☐Karen Bloemink (IHA)	☐Melinda Mui (PHSA)	☐Fernando Pica (VCHA) Maureen for Fernando	☐Lydia Tang (MOH)
☐Brittany Deeter (FNHA)	☐Mark De Croos (NHA)	☐Laurence Bayzand (PHSA) Reuben for Laurence	☐Kirsten Everett (MOH)	☐Kristen Grant (MOH)

October 2, 2020 Agenda

#	ITEM	LEAD	ACTION
1	Roll call	All	
2	Agenda Review, addition items and approval of meeting agenda, action items from last meeting	Carolyn	
3	MOH Update	Carolyn	
4	PHSA Update	Melinda	
5	Allocation formula	Fernando	
6	Wrap-up	All	

Allocation Table

#	ITEM	For allocation this week
	1860 N95 masks	Yes
	1860s N95 masks	Yes
	S/M/L Nitrile Gloves	Yes
	1L Deb 807	Yes
	Needles Blunt Fill 18G X 1.5"	Yes
	Syringes 3ml LL without needles	Yes

Decisions

ITEM	Owner

Action Items and Issues Log

ITEM	Date	Action
Longer-term nitrile gloves allocation discussion	Sept. 2020	For discussion on Friday