FACT SHEET

Capital Commitments from the Election Campaign versus Ministry Of Health Existing Capital Plan

ISSUE

The Premier's Office has requested information regarding capital commitments from the 2017 election campaign not already included in the Ministry of Health (HLTH) 10-Year Capital Plan.

KEY FACTS

- The projects listed below in Table 1 are 2017 election campaign commitments not currently included in the HLTH 10-Year Capital Plan (2017/18 to 2026/27).

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- The capital projects listed in Table 2 were not identified as election campaign commitments but are identified as priorities for consideration for Budget 2018.

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FACT SHEET

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Approved by:
Shelley Moen, Capital Services Branch; October 30, 2017
Manjit Sidhu, Finance and Corporate Services Division; October 30, 2017

FACT SHEET

Access to Emergency Services in Rural and Remote Communities

ISSUE

To provide an overview of the challenges British Columbians, who live in rural/remote and northern communities face in accessing emergency health services.

KEY FACTS

Definition

- A rural community is a non-urban area where most medical care is provided by a small number of General Practitioners (GPs)/Family Practitioners (FPs) with limited or distant access to specialist services, and high technology health care facilities.[1]
- A rural population can also refer to persons living outside urban centres with a population of 1,000 and outside urban areas with 400 persons per square kilometre.[2]

BC Emergency Health Services (BCEHS)

- BCEHS has the legislated mandate to provide pre-hospital emergency care and inter-facility patient transfer services.
- BCEHS provides direct service through the BC Ambulance Service and the BC Patient Transfer Network.
- BCEHS paramedics respond to medical emergencies throughout the province, covering nearly 950,000 square kilometers. In most of the province, population density is low. In rural BC, population and 9-1-1 call volumes are too low to sustain full-time staffing.
- There are 112 rural/ remote stations:
  - 45 are staffed with a combination of full-time paramedics and paramedics scheduled on-call (Fox shifts) or standby (Kilo shifts, carrying a pager)
  - 67 are staffed solely with paramedics on a pager from the community.
- Currently, on-call paramedics are paid $2.00/hour to carry a pager, or approximately $12.00/hour to be on standby at the station. If dispatched, they receive their paramedic rate of pay for a guaranteed number of hours.
- Paramedic staff levels are generally correlated with call volumes. Typically the stations staffed solely with Kilo shifts have less than 240 calls in their area annually.
- Historically there have been significant gaps in pre-hospital emergency coverage in rural BC, as ambulances can be out of service due to a lack of available paramedic staffing.
- Due to the low call volume and the compensation model, many part-time paramedics take on additional employment which may further restrict their availability.
- As an interim solution to improve staffing in rural and remote communities, BCEHS recently introduced a guarantee of 4 hours pay for all Kilo shifts that do not get a callout during their shift. This initiative has had a positive response and resulted in improved staffing levels and ambulance availability in rural communities.
- BCEHS is implementing the Community Paramedicine Initiative which includes expanded roles for paramedics in rural and small urban communities. This initiative is introducing a minimum of 80 new FTEs with a phased approach between April 1, 2015 - March 31, 2019. This is contributing to improved care and more stable paramedic staffing levels in rural and remote areas.

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[1] (Rourke J. In search of a definition of 'rural'. Can J Rural Med. 1997; 2(3): 113-115) from http://www.health.gov.bc.ca/library/publications/year/2002/rapupdate.pdf

[2] Statistics Canada, 2011 Census of Population - http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo62k-eng.htm

- The first phase began in 2015 with 9 prototype communities: Chetwynd, Fort St. James, Hazelton, Creston, Princeton, Cortes Island, Port Hardy, Tofino and Ucluelet. The majority of these communities have hired community paramedics, completed orientation, and are now delivering services.
- Provincial roll-out of community paramedicine is now underway, including 19 communities in Northern BC, 31 in the interior, 19 on Vancouver Island, 6 in the Vancouver Coastal area, and 1 in Fraser.
- As of August 16, 2017, 84 community paramedics have been hired into 63 of the communities.
- The population base in many rural communities has decreased, removing opportunities for entry-level training and development, and making recruitment and staffing of units even more difficult. Through the Community Paramedicine Initiative, paramedics have an opportunity to keep up their training and skills, while getting regular employment opportunities.

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- For patients requiring a higher level of care, a working group has been struck, which includes the Doctors of BC, BCEHS, heath authorities, and the Ministry to improve pre-hospital and inter-hospital services.

FINANCIAL IMPLICATIONS

N/A

Approved by:
Barb Fitzsimmons, Chief Operating Officer, BCEHS, September 7, 2017
Linda Lupini, Executive Vice-President, BCEHS, September 7, 2017
Ian Rongve, Hospital, Diagnostic and Clinical Services Division; September 11, 2017

FACT SHEET

Emergency Department Capital Upgrades and Renovations

ISSUE

Update on the status of Emergency Department (ED) capital upgrades and renovations in BC.

KEY FACTS

- Since 2001, $636 million in health sector capital funding has been invested to improve and expand over 40 EDs across the province.
- Capital projects, both completed and currently underway are enhancing the physical structure of the province's EDs, as well as addressing challenges such as acute care capacity.

Background

- Since 2006, the province has focused on improving timely access to ED services.
- The solutions to ED congestion and overcrowding (overcrowding occurs when admitted patients remain in ED beds awaiting admission to other parts of the hospital) are multifaceted and must build on a whole systems approach.

FINANCIAL IMPLICATIONS

N/A

Approved by:
Mark Bell obo Shelley Moen, Capital Services Branch; October 5, 2017
Manjit Sidhu, Finance and Corporate Services Division; October 10, 2017

FACT SHEET

Isolation Allowance Fund

ISSUE

The Isolation Allowance Fund (IAF) is a stipend available to physicians in very isolated rural communities for recognition of the emergency care they provide with little support.

KEY FACTS

- Physicians providing the full range of necessary medical services required in eligible communities under the Rural Practice Subsidiary Agreement with fewer than 4 physicians and with no hospital, who do not receive Medical On-Call Availability Program, Call-Back or Doctor of the Day payments are eligible for payments under the IAF.
- The amount of the stipend per physician is calculated on an annual basis using a weighted point value based upon the number of physicians available in the community and relative degree of isolation of the community as determined by the Joint Standing Committee on Rural Issues through an annual rural isolation point assessment process. In 2016/17, the stipends ranged from $13,428.08 to $64,124.57.[1]
- In 2016/17, there were 11 communities (18 physicians) eligible for IAF payments.[2]

Background

- The 2004-2007 Working Agreement between the Ministry of Health and Doctors of BC allocated a base transfer of $600,000[3] from the Medical On-Call Availability Program budget to establish the IAF. The purpose of the IAF is to assist in the attraction and retention of local physician services for smaller communities. The application of the IAF is governed by the Joint Standing Committee on Rural Issues, a joint committee comprised of representatives of the Doctors of BC, rural physicians, the Ministry of Health, and health authorities.

FINANCIAL IMPLICATIONS

- The 2016/17 IAF expenditure at March 31, 2017, was $600,000 (unaudited).[4]
- The 2017/18 budget for the IAF is $600,000.

Approved by:
Marie Ty, Compensation Policy and Programs Branch; October 5, 2017
Ted Patterson, Workforce Planning, Compensation and Beneficiary Services Division; October 6, 2017
Jason Butler, CFO, Finance and Corporate Services Division; October 11, 2017

[1] Compensation Policy and Programs, Isolation Allowance Fund (IAF) 2016/17, as at September 21, 2017.
[2] Ibid.
[3] Isolation Allowance Fund (IAF) Policy
[4] As per Rural Health Summary of Expenditures March 31, 2017 worksheet (Unaudited).

FACT SHEET

Mills Memorial Hospital Replacement

ISSUE

Update on the Mills Memorial Hospital (MMH) replacement.

KEY FACTS

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- The 1959 facility contains undersized operating rooms that limit the number and scope of surgeries performed. In addition, the layout does not provide good separation between inpatients and ambulatory services and infection control is difficult due to challenges in strictly separating sterile from dirty equipment.

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- NHA anticipates that, when complete, the new MMH would provide services to accommodate the expected economic development in Terrace and surrounding areas as well as allow MMH to fully realize its role as a hub for clinical services in the northwest.
- Centralization of health care services will allow the new MMH to focus upon expanded services in surgery, trauma and critical care, internal medicine and diagnostics (e.g. MRI). Recent reports done for NHA on surgical services and trauma accreditation recommend northwest centralization of these services in Terrace.
- Due to existing wait times for MRIs NHA has completed the installation of new MRIs at MMH (August 2017) and Fort St John Hospital (September 2017) and a replacement MRI at the University Hospital of Northern BC (May 2017).

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Next Steps

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Background

- MMH was constructed in 1959 with a major expansion in 1975. It is a fully accredited acute care facility serving Terrace and its surrounding area. The hospital provides 24/7 access to services that

include a psychiatric unit, the only inpatient unit in the northwest, surgical suites, ICU and an extensive day-care service.

- MMH delivers health care services to the entire northwest region of the province, including medical and general surgical services, emergency care, ambulatory services and visiting specialist programs.
- In 2006, a new emergency room, an intensive care unit and a new CT scanner were added.
- In 2008, NHA informed the Ministry of their concerns over high maintenance costs, decreased ability to retain staff and potential hospital infrastructure failure.
- The Ministry is aware of functional deficiencies at MMH and that a capital project will likely be required to resolve these deficiencies.

FINANCIAL IMPLICATIONS

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Approved by:
Mark Bell obo Shelley Moen, Capital Services Branch; October 5, 2017
Manjit Sidhu, Finance and Corporate Services Division; October 5, 2017

FACT SHEET

Northern Isolation Travel Assistance Outreach Program

ISSUE

- The Northern Isolation Travel Assistance Outreach Program (NITAOP) provides funding for travel expenses and travel time honorariums for approved visiting specialists and family/general practitioners who deliver medical services in eligible rural communities where the service does not exist.
- The NITAOP program is recognized by as a key means of obtaining important physician services for smaller rural BC communities.

KEY FACTS

- The number of visits utilized in 2016/17 was approximately 4,442.[1] In 2016/17, 110,634 patients were seen under the program.[2] Claims are still being processed for fiscal 2016/17.
- Expenditures under the NITAOP program increased from $1.1 million in 1999/2000[3] to $5.0 million in 2016/17.[4]
- The Joint Standing Committee on Rural Issues (JSC) is currently conducting an evaluation of the NITAOP. The preliminary results indicate that the NITAOP provides service to over 100,000 patients annually in rural BC.

Background

- NITAOP has been in place since 1998.
- The NITAOP is a combination of 2 programs:
    - The Northern Isolation Travel Assistance Program provides funding for specialist travel expenses.
    - The Physician Outreach Program provides funding for general/family practitioners travel expenses and the travel time honoraria for both the specialists and the general/family practitioners.
- The JSC, comprised of Doctors of BC, health authorities and government representatives, oversees the management of the NITAOP program. The JSC has made a number of changes to the NITAOP program over the years to facilitate the effective and efficient application of funding of this valuable program including:
    - In 2009/10 the JSC changed its funding policy to enable health authorities to re-allocate approved but unused NITAOP visits across communities.
    - The JSC has also applied increasing funding amounts year over year to further support required itinerant physician services to smaller rural communities who are reliant on these services.

FINANCIAL IMPLICATIONS

- The 2017/18 budget for the Physician Outreach Program is $4.5 million. The 2016/17 unaudited expenditures at September 30, 2017, were $3.57 million[5].
- The Northern Isolation Travel Assistance Program budget is incorporated in the Fee-for-Service available amount. The 2016/17 expenditures were $1.46 million as at September 30, 2017.[6]

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[1] JSC Rural Programs Financial Reports, NITAOP Utilization Summary 2016/17, as at August 17, 2017 provided by Rural Practice Programs, Compensation, Policy and Programs Branch. October 4, 2017 (1,361 + 130 + 1,523 + 9 + 580 + 839 =4,442)

[2] JSC Rural Programs Financial Reports, NITAOP Utilization Summary 2016/17, as at August17, 2017 provided by Rural Practice Programs, Compensation, Policy and Programs Branch. October 4, 2017 (21,094 + 60,766 + 3,179 + 72 + 13,350 + 12,173 = 110,634)

[3] NITAOP Funding Summary 1999/2000 to 2001/02 provided by Rural Practice Programs, Compensation, Policy and Programs Branch 2016-05-04.

[4] HIBC Payments 2005-06 to 2016-17

5 JSC Rural Programs Budget as at September 30, 2017, per Liz Dowlsey email

[6] Ibid

FACT SHEET

- Claims are still being processed for fiscal 2016/17.

Approved by:
Marie Ty, Compensation Policy and Programs Branch; October 5, 2017
Ted Patterson, Workforce Planning, Compensation and Beneficiary Services Division; October 6, 2017
Jason Butler, CFO, Finance and Corporate Services Division; October 11, 2017

FACT SHEET

Primary Care Access in Rural and Remote Communities

ISSUE

British Columbians in rural and remote communities face unique challenges in accessing primary health care services. Examples include geographic constraints of small, widely dispersed, fluctuating populations, increased impacts of both social determinants and prevalence of chronic health conditions, and health human resource shortages due to issues with recruitment and retention.

KEY FACTS

- The rural and remote BC population includes many First Nations and Aboriginal peoples. The rural and remote population experiences poorer health outcomes and socio-economic status than their urban counterparts. Rural British Columbians die 5 years sooner on average compared to citizens in urban areas of the province, and are more likely to die prematurely from circulatory diseases, all injuries, poisonings, motor vehicle accidents and suicide.[1]
- The 2017 Minister's mandate letter identifies "the provision of team-based primary care" and "improved rural health services" as priorities.
- Government is committed to making the health-care system work for British Columbians. We will do this through redefining how services are designed and delivered, coordinated and linked across the system to improve patient-centered care, by optimizing health human resources and digital technologies, and through different approaches to compensating health care providers in order to create an integrated system of care.
- Creating an integrated system of care that works for British Columbians in rural and remote communities is a priority for this government. Government is committed to providing people with care when they need it, where they need it, and to finding local solutions to meet the health care needs in rural communities.
- The foundation of an integrated system of care is the delivery of patient-centered primary care services by interdisciplinary teams. Primary care is the first point of contact for most patients in the health system, and the majority of patient visits are in a primary care setting. The Ministry is working with health system partners including health authorities and Doctors of BC to develop innovative ways of improving primary care services in rural and remote communities to ensure improved access and quality of health services for rural and remote citizens, and in particular First Nations peoples.
- Innovative prototype models of primary care in both rural and remote communities are being developed in partnership between health authorities, Doctors of BC and Divisions of Family practice including Port Hardy, and Port McNeil in Island Health and the Kootenay Boundary Primary Care Network in Interior Health.
- Through the Joint Ministry of Health – First Nations Health Authority Project Board (Joint Project Board), 3 prototype projects are underway in rural First Nations communities to improve primary care access. These prototypes focus on innovative team-based care and provide services to underserved populations. Innovations to improve primary care access in rural and remote communities include:
    - Low risk maternity services (services without surgical cesarean section backup) close to home are being offered in some rural communities where the practice is safe and sustainable. These services require participation and partnership between physicians and the health authority, and midwives and follow strict risk assessment and treatment protocols. One example of this is on the island of Haida Gwaii, where midwifes carefully

[1] Kulig, J.C. & Williams, A.M. (2011). Health in Rural Canada. UBC Press, Vancouver.

screen women to identify birth risks and inform them of the risks of birthing on-island, without caesarian-section back up. There is a strong commitment from the local health care team to support on-island births[2].

- In January 2014, Seabird Island Band also implemented an innovative community based midwifery program for low-risk women and families during pregnancy and up to 6 weeks postpartum.[3]
- The Joint Standing Committee on Rural Issues, a joint Ministry of Health and Doctors of BC committee, is funding the Rural Coordinating Centre of BC to work with health authorities to establish Rural Surgical Obstetrical Networks with the aim of improving access to maternity care services (including surgical cesarean section backup) and to sustain surgical skills and services in rural and remote communities[2].
- Increasing access to primary care services for people living in First Nations communities and rural and remote communities using digital technology including the development of a virtual care strategy [4] telehealth and telepharmacy[5].
- Continued implementation of the Community Paramedicine program[6] in 76 rural communities to provide a local resource for health promotion, prevention and support older adults in monitoring and managing chronic conditions.

- The Ministry of Health, in partnership with health authorities, divisions of family practice, and local community agencies will be examining the need for and role of Urgent Care Services in rural and remote communities. The potential effect on current rural services is part of the considerations and planning for services will involve the communities and their providers.
- The Ministry has undertaken the development of a rural impact toolkit that will enable an evidence-based, standardized approach (rural lens) to the consideration of rural health issues in policy and program development. Using the lens in the development and implementation of the Primary Care Home model, pathways to specialized care teams and other rural and remote specific policy areas will support a standardized approach to identify rural specific impacts, and unintended consequences.
- First Nations Health Authority has undertaken substantial geographical mapping of communities and their access to various primary health care services, including primary and maternity care, in order to look for opportunities for improvements[7].

FINANCIAL IMPLICATIONS

N/A

Approved by:
Shana Ooms obo Ted Patterson, Primary and Community Care Policy Division; October 11, 2017

[2] Fact Sheet- Rural and Remote Maternity Care
[3] Seabird Island Band Midwifery Program. Retrieved from: www.seabirdisland.ca/index.php/service/midwifery/
[4] Fact Sheet - Virtual Care Strategy
[5] Fact Sheet - Telepharmacy
[6] Fact Sheet - Community Paramedicine
[7] Fact Sheet - First Nations Health - Tripartite First Nations Health Plan

FACT SHEET

Private Clinics

ISSUE

Health care services in BC have long been provided through a mix of public, non-profit and private for-profit providers. Private providers include privately owned residential care facilities, community pharmacies, and physician practices.

KEY FACTS

- Since 2002, the Ministry policy[1] has allowed health authorities (HAs) to purchase outpatient clinical services from private diagnostic and medical/surgical clinics, in addition to providing these services directly, as long as quality, cost-effectiveness and accountability requirements are met. This change does not represent creation of a second tier of health care funded on a private-pay basis. Health care services delivered through contracts with private clinics are fully funded by government, as required by the *Canada Health Act*[2]. The MSP pays the physician fees associated with such services, while the HAs fund facility costs for contracted services.
- Quality of care for purchased services is the responsibility of both the College of Physicians and Surgeons of BC (the accreditation and regulatory body) and the contracting HA. The Patient Service Delivery Policy is being used by HAs to provide short-term relief for capacity pressures; and to re-direct less complex surgical procedures so that hospital operating rooms are available to deal with more complex, priority procedures, such as hip and knee replacements.
- In 2007 Ministry staff reviewed, in consultation with HAs, the Ministry policy and processes as well as HA experience, concerning HA contracting with private facilities for medical/surgical or diagnostic imaging services. HAs have provided a copy of current contracts and confirmation of procedure volumes and payments for 2015/16:
  - 2005/06: 7,447 contracted day surgery cases and 1,782 MRI scans.
  - 2006/07: 8,675 contracted day surgery cases[3] and 1,671 MRI scans.
  - 2007/08: 8,495 contracted day surgery cases[4] (2.4%) out of 356,458[5] total day surgery cases and 2,666 MRI scans.
  - 2008/09: 7,233 contracted day surgery cases[6] (1.9%) out of 372,173 total day surgery cases and 256 MRI scans.
  - 2009/10: 6,202 contracted day surgery cases[7] (1.6%) out of 378,953 total day surgery cases.
  - 2010/11: 6,666 contracted day surgery cases[8] (1.7%) out of 394,983 total day surgery cases.
  - 2011/12: 8,912 contracted day surgery cases[9] (2.2%) out of 412,431 total day surgery cases.
  - 2012/13: 7,839 contracted day surgery cases[10] (1.9%) out of 412,850 total day surgery cases.
  - 2013/14: 5,502 contracted day surgery cases[9] (1.3%) out of 424,401 total day surgery cases.

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[1] Patient Service Delivery Policy - Communiqué 2002-37

[2] *Canada Health Act 1985 [Amended June 29,2012].* http://www.hc-sc.gc.ca/hcs-sss/medi-assur/cha-lcs/index-eng.php *Last accessed February 26, 2016*

[3] Discharge Abstract Database, Project # 2008_0991, Feb 10, 2009, Health Systems Planning Division, Ministry of Health Services (the Ministry).

[4] Discharge Abstract Database, Project # 2008_0991, Feb 10, 2009, Health Systems Planning Division, the Ministry.

[5] All total day surgery cases are from: Discharge Abstract Database, Project #2014_1358, October 15, 2014, Planning and Innovation Division (PID), the Ministry.

[6] Discharge Abstract Database, Project # 2009_0577,Sept 23, 2009, Health Systems Planning Division, the Ministry.

[7] Discharge Abstract Database, Project # 2010-0524, Sept 21, 2010, Health Systems Planning Division, the Ministry.

[8] Discharge Abstract Database, Project # 2011_574, Oct 25, 2011, Priority Projects Branch, PID, the Ministry.

[9] Discharge Abstract Database, Project # 2012_841, Nov 15, 2012, Priority Projects Branch, PID, the Ministry.

[10] Discharge Abstract Database, Project # 2013_0977, Oct 10, 2013, Priority Projects Branch, PID, the Ministry.

[9] Discharge Abstract Database, Project # 2014_1201, Oct 23, 2014, Priority Projects Branch, PID, the Ministry.

[10] Discharge Abstract Database, Project # 2015_0854, Dec 14, 2015, Business Analytics Strategies and Operations Branch, Health Sector Planning and Innovation Division, the Ministry.

[11] Discharge Abstract Database, Project # 2016_0726, Dec 20, 2016, Hospital and Diagnostic Analytics Branch, Health Sector Information, Analysis and Reporting, the Ministry.

[12] *Discharge Abstract Database (DAD) Reporting Compliance Report for Fiscal Year 2016/2017 - FINAL*

  - 2014/15: 5,513 contracted day surgery cases[10] (1.3%) out of 434,342 total day surgery cases.
  - 2015/16: 7,312 contracted day surgery cases [11] (1.6%) out of 452,071 total day surgery cases.
  - 2016/17: 11,485 contracted day surgery cases[12] (2.5%) out of 462,139 total day surgery cases.
- The 5 regional HAs (Vancouver Island, Interior, Northern, Vancouver Coastal and Fraser) contract out similar types of procedures including ophthalmic, urological, orthopedic, plastic, ear, nose and throat, and general and dental surgery.
- The Provincial Health Services Authority has used the Patient Service Delivery Policy for the Community Dental Partners Program. This program is operated by BC Children's Hospital on behalf of the Ministry of Health and the Ministry of Social Development and Social Innovation (MSDSI) and covers facility costs in private clinics throughout the province for MSDSI clients (Healthy Kids Dental Program - for children up to 10 years of age whose parents/guardians receive Medical Services Plan premium assistance, and to adult MSDSI clients with severe mental or physical disabilities), who require a general anesthetic for restorative dental care**.** The program has been very well managed from the start by BC Children's Hospital and has increased cost-effective access to these services throughout the province.
- WorkSafe BC also procures surgical services from 17 private for-profit providers across the province. For the period April 1, 2016 to March 31, 2017, WorkSafe BC procured 2,246 individual procedures including (but not limited to) knee, ankle, foot, hand, shoulder, spine surgeries; hernia repair; hardware removal; etc.

FINANCIAL IMPLICATIONS

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Approved by:
Gordon Cross, Regional Grants and Decision Support Branch; August 22, 2017
Manjit Sidhu, Financial and Corporate Services Division; August 22, 2017

FACT SHEET

Richmond Hospital Replacement of North Tower

ISSUE

Update on the proposed replacement of the North Tower at Richmond Hospital (RH).

KEY FACTS

- The Vancouver Coastal Health Authority (VCHA) advises the North Tower at RH is in need of urgent replacement as it no longer meets quality of care standards, building code or seismic standards and is well beyond its useful life (Facility Condition Index =.79).
- In June 2016, government announced plans to proceed with a concept plan in support of potential development of a new replacement patient care tower at RH.
- In January 2017, VCHA submitted a concept plan to the Ministry of Health for a new acute care facility at RH that is consistent with the High Level Master Plan (HLMP) and proposes the following:

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Background

- Since 2001, there have been over $100 million in capital investments made at RH.
- RH opened in 1964 (North Tower) with additions in 1980 (South Tower), and 1997 (Westminster Tower).
- RH is a large community hospital serving the needs of residents in Richmond, Delta, as well as travelers using the Vancouver International Airport and BC Ferries.
- Services provided at RH include Emergency, Ambulatory Care, Diagnostics, Intensive Care and Coronary Care, Maternity, Psychiatry and Surgery.
- It is a teaching hospital affiliated with the University of BC.
- The Emergency Department is classified as a Level 3 trauma centre, opens 24/7, and sees more than 50,000 patients annually.
- In 2013, the Richmond Community of Care HLMP was undertaken to produce an Integrated Service and Master Concept Plan that forecasts needs to 2030. The HLMP was completed in March 2015.
- In February 2014, a structural assessment of the North Tower was conducted and the building was assigned a rating of H1. This rating is defined as: most vulnerable structure; at highest risk of widespread damage or structural failure after an earthquake.
- The North Tower houses 108 of the 231 inpatient acute care beds as well as the surgical suites, sterile processing, medical imaging and the pharmacy.

FINANCIAL IMPLICATIONS

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- Of this amount, VCHA has notionally allocated $30 million toward the capital cost from proceeds of the Pearson Dogwood land sales. The RH Foundation has committed to a $40 million fundraising campaign toward the cost of the project.
- A retired family doctor has joined other families and organizations to pledge a total potential gift of $25 million to the RH Foundation to support a vision for a new acute care building at RH.
- As of July 2017, no provincial capital funding has been approved to permit a replacement or large scale expansion project to proceed. Advancement of a proposed new acute care facility at RH would be subject to prioritization by VCHA, the Ministry and available capital funding.

Approved by:
Mark Bell, Capital Services Branch; July 5, 2017
Manjit Sidhu, Finance and Corporate Services Division; July 7, 2017

FACT SHEET

Rural Emergency Enhancement Fund

ISSUE

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

KEY FACTS

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

FINANCIAL IMPLICATIONS

- The 2017/18 budget for REEF is $9.65 million.[4]
- For 2016/17, the REEF expenditure at March 31, 2017 was $9.7 million (unaudited).[5]

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[1] 2009 MOA Article 2.03 (a) & (b)
[2] Rural Emergency Enhancement Fund (REEF) Policy - fhttp://www2.gov.bc.ca/assets/gov/health/practitioner-pro/reef-policy.pdf
[3] Rural Emergency Enhancement Fund (REEF) Policy - http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/reef-policy.pdf
[4] JSC Rural Programs Financial Report: FY 2017/18
[5] JSC Rural Programs Financial Report: FY 2017/18

FACT SHEET

Approved by:
Marie Ty, Compensation Policy and Programs Branch; October 5, 2017
Ted Patterson, Workforce Planning, Compensation and Beneficiary Services Division; October 6, 2017
Jason Butler, CFO, Finance and Corporate Services Division; October 12, 2017

FACT SHEET

Rural Programs and Joint Standing Committee on Rural Issues

ISSUE

- Recruiting and retaining physicians in smaller, rural communities is a challenge across Canada. The BC Government funds a comprehensive range of programs developed and directed by rural physicians, health authority, Ministry and Doctors of BC staff through the Joint Standing Committee on Rural Issues (JSC) to assist rural BC communities recruit and retain physicians.
- The JSC was established under formal agreement between the Government and Doctors of BC in 2001 (2001 Rural Subsidiary Agreement for Physicians in Rural Practice) to enhance the delivery of rural health care. The DoBC and the Ministry both appoint 5 voting members to the Committee. Each entity appoints a Co-Chair for the Committee. The JSC meets a minimum of 6 times per year.
- The goal of the JSC is to enhance the availability and stability of physician services in rural and remote areas of BC by addressing some of the unique, demanding and difficult circumstances encountered by physicians practicing and living in these areas.
- The JSC has established a suite of 13 rural programs designed to assist and support physicians in rural practice.

KEY FACTS

- The JSC oversees the development and application of rural programs identified within the Rural Subsidiary Agreement section of the provincial Physician Master Agreement. The rural programs include:
  1. Rural Retention Program (RRP)
  2. Rural Continuing Medical Education (RCME)
  3. Rural Emergency Enhancement Fund (REEF)
  4. Recruitment Incentive Fund (RIF)
  5. Recruitment Contingency Fund (RCF)
  6. Isolation Allowance Fund (IAF)
  7. Northern and Isolation Travel Assistance Outreach Program (NITAOP)
  8. Rural GP Locum Program (RGPLP)
  9. Rural GP Anaesthesia Locum Program (RGPALP)
  10. Rural Specialist Locum Program (RSLP)
  11. Rural Education Action Plan (REAP)
  12. Supervisors of Provisionally Licensed Physicians (SPLP)
  13. Rural Co-ordinating Centre of BC (RCCbc) – a forum to support rural physicians in their on-going professional development.
- The JSC also helps sponsor a specialized recruiting agency “Health Match BC,” to assist rural BC communities in recruiting physicians.
- The JSC has implemented a number of updates and changes to these rural programs since they were initially established in order to further strengthen support for more rural, isolated and vulnerable communities.
- There are 180 communities identified under the Rural Subsidiary Agreement. In order to receive benefits under a rural program, the community and/or physician(s) must meet the eligibility criteria of the particular rural program.

FINANCIAL IMPLICATIONS)

The rural program forecast for 2016/17 is $134.8 million as at December 31, 2016.

FACT SHEET

Approved by:
Marie Ty, Compensation Policy and Programs Branch; January 3, 2017
Ted Patterson, Health Sector Workforce Division; February 8, 2017
Daryl Conner, Finance and Corporate Services Division; February 20, 2017

FACT SHEET

Travel Assistance Program

ISSUE

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

KEY FACTS

- In 2004, the Ministry assumed financial responsibility for TAP ferry travel subsidies. Payment is made to BC Ferries through the Ministry of Transportation and Infrastructure.
- There were 133,815 approvals issued by the Ministry for the fiscal year 2016/17, an increase of 3.98% over 2015/16.[1] Of those approvals, 98.7% were for fully-subsidized ferry travel.

Approved Confirmation by Travel Mode – April 1, 2016 – March 31, 2017

Mode	Number	Escort	One Way	Vehicle
Air	1,642	792	187	
Angel Flight	9	6	0	
Bus	9	1	1	
Ferry	132,096	83,930	3,611	126,875
Rail	59	37	1	
TOTAL	133,815	84,766	3,800	

- Of the 39,086 unique patients who obtained a TAP confirmation number in 2016/17, 41.4% were seniors and 13% were on Premium Assistance (table below). Of those unique patients, 84.7.2% obtained between 1 and 5 travel confirmations during fiscal year 2016/17, and an additional 10% obtained between 6 and 10 travel confirmations.[2]

Patients by Range of Approved Confirmations – April 1, 2016 – March 31, 2017

Conf's per Patient	Number of Patients	% of Patients	Total Conf's	% of Conf's	Number of Seniors	% of Seniors	Number on PA	% on PA
1 to 5	33,108	84.7	65,200	48.7	13,001	39.3	4,297	13.
6 to 10	3,893	10	29,094	21.7	2,074	53.3	468	12
11 to 20	1,552	4	21,468	16	850	54.8	207	13.3
21 to 30	329	0.8	8,095	6	169	51.4	53	16.1
>30	204	0.5	9,958	7.4	90	44.1	40	19.6
TOTAL	39,086	100.0	133,815	100.0	16,184	41.4	5,065	13

FINANCIAL IMPLICATIONS

- For 2016/17, budget was $13.0 million and expenditure at March 31, 2017 was $12.2 million (unaudited).
- For 2017/18, budget is $14.0 million

Approved by:

Mark Armitage obo Ted Patterson, Workforce Planning, Compensation & Beneficiary Services; August 16, 2017
Manjit Sidhu, Finance and Corporate Services Division; August 21, 2017

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