2024 ESTIMATES NOTES – Table of Contents

2024 ESTIMATES NOTES – Table of Contents

2024 ESTIMATES NOTES – Table of Contents

2024 ESTIMATES NOTES – Table of Contents

2024 ESTIMATES NOTES – Table of Contents

LEGISLATIVE SESSION – ESTIMATES NOTE

A-01

Canada Health Transfer and Bilateral Funding Agreements

Topic: Status of the Canada Health Transfer (CHT) and other bilateral funding agreements, including the Working Together to Improve Health Care in Canada Agreement and Aging with Dignity Funding Agreement.

Key Messaging and Recommended Response:

- **BC and Health Canada signed the Working Together to Improve Health Care for Canadians Agreement on October 10, 2023, which includes available funding of approximately $407 million per year for three years.**
    - **$82 million in each of the three years is targeted to mental health and addictions in the new agreement, continuing from the prior Home and Community Care and Mental Health and Addictions (HCCMHAS) funding agreement from 2017.**
    - **The majority of the funding ($325 million in 2023/24) will support the health workforce, including implementation of nurse patient ratios; addressing diagnostic and treatment backlogs; and/or assisting with modernizing health data systems.**
- **BC and Health Canada signed the Aging with Dignity Bilateral Agreement on February 12, 2024, which includes available funding of approximately $163 million per year for four years and $81 million in the fifth year.**
    - **Planned expenditures include $74 million in 2023/24, $90 million in 2024/25, and $82 million 2025/26 and 2026/27 is targeted to home and community care in the new agreement, continuing from the prior HCCMHAS funding agreement from 2017.**
    - **The remaining planned expenditures increase over the five-year period from $76 million in 2024/25 to $110 million in 2027/28 includes long-term care (LTC) funding that was previously announced as part of the federal government's 2021 Budget. A large portion of this will be used to continue to stabilize and support the LTC workforce.**
- **These two bilateral agreements are part of the Working Together to Improve Healthcare in Canada federal funding agreement.**

- **In Budget 2024, BC is investing nearly $10 billion over three years to strengthen our health care system, including cancer care, seniors care, mental health and addictions services, and planning for in-vitro fertilization.**
- **This builds on the significant investments made since 2017 to improve health care for all British Columbians.**

NOTE: COPIES OF THE BILATERAL AGREEMENTS ARE IN THE SUPPLEMENTAL BINDER.

CURRENT SITUATION

- BC and Health Canada have signed both bilateral federal funding agreements that are part of the Working Together to Improve Healthcare for Canadians federal funding package.
- The Working Together to Improve Health Care for Canadians Agreement was signed on October 10, 2023, and includes approximately $407 million per year for three years of new funding.
- $82 million of that is part of the previous HCCMHAS funding from 2017 that is targeted to mental health and addictions in the Working Together Agreement.
- The majority of the funding ($325 million) will support the health workforce, including implementation of nurse patient ratios; addressing diagnostic and treatment backlogs; and/or assisting with modernizing health data systems.
- The targeted funding is to be used in some or all of the following priority areas:
    - Expanding access to family health services, including in rural and remote areas;(BC is not funding this area)
    - Reducing backlogs and better support BC's healthcare workers;
    - Modernizing how we track and report health data; and,
    - Improving access to mental health and addictions services.
- The Aging with Dignity Agreement was signed on February 12, 2024, and includes $163 million per year for four years and $81 million in the fifth year.
- This includes $74 million in 2023/24, $90 million in 2024/25, and $82 million 2025/26 and 2026/27 and is part of the previous HCCMHAS funding from 2017.
- The remaining funding allocation increases over the five-year period from $89 million in 2023/24 to $110 million in 2027/28 and includes LTC funding that was previously announced as part of the federal government's 2021 budget.
- Due to the timing of the federal funding announcement and the agreement not being finalized until late in the fourth quarter of fiscal 2023/24, BC and Health Canada have agreed to carry forward Aging with Dignity funds into the following fiscal years until 2026/27.
    - BC will carry forward the $89 million available for Long Term Care from 2023/24, $86 million from 2024/25, $59 million from 2025/26, and $29 million in 2026/27 to be spent over the final three years of the agreement as $108 million in 2025/26, $111 million in 2026/27, and $110 million in 2027/28, fully expending the available funding.
- The funding will be used to expand home and community care services, strengthen oversight and reporting to provide safer, more personalized care, support the delivery of LTC, and improve the availability and quality of dementia care, palliative care, and end-of-life care. Specific examples include:
    - Implementation of the LTC@Home pilot program to provide technology-enabled remote support in participants own homes;
    - Education and training to enhance dementia care;
    - Development and implementation of the Integrate interRAI Reporting System; and
    - Continue to work on stabilizing the LTC workforce.
- Federal plans for the Personal Support Worker funding have still not been shared with provinces and territories and will be added into this agreement as an amendment once finalized.

- For BC's Budget 2024, the revenue assumptions for the Canada Health Transfer and other health related federal government transfers total nearly **$7.8 billion** for 2024/25, including:
  - $7.153 billion for the Canada Health Transfer;
  - $90 million for Home and Community Care;
  - $76 million for Long-term Care;
  - $82 million for Mental Health and Substance Use;
  - $295 million for Health Workforce and backlogs;
  - $30 million for Modernizing Health Systems; and
  - $10 million for the Workforce Development Agreement.
- The recent announcement for the Aging with Dignity bilateral agreement is **not** included in the revenue assumptions for Budget 2024 due to timing.
- Further details regarding federal plans for the Indigenous Health Equity Fund are being communicated directly to Indigenous organizations by Indigenous Services Canada, including to the First Nations Health Authority, with limited information being shared by Health Canada.

FINANCIAL IMPLICATIONS

In 2023/24, the Ministry is forecast to receive approximately $7.113 billion from the CHT and approximately $492 million in additional federal funding, which accounts for just over 24% of health spending.

KEY BACKGROUND

- Federal funding for health care is primarily provided through the CHT.
- Since 2017, the CHT growth rate/escalator has been based on Gross Domestic Product growth (with a floor of 3%).
- Intergovernmental Communications

- The HCCMHAS 10-year Agreement started in 2017/18 and, in August 2021, BC and Canada agreed to amend the HCCMHAS to allow for a one-time payment of approximately $135 million in Safe Long-Term Care funding.
- The first 5-year term of the HCCMHAS Agreement was set to expire on March 31, 2022. To ensure continuity of existing programs, Health Canada and PTs negotiated a 1-year extension of the HCCMHAS, with $163.966 million in BC funding for 2022/23.
- On February 7, 2023, Premiers were presented with a federal offer on health care spending, including tailored bilateral agreements including the remaining 4 years of HCCMHAS, and Premiers accepted the offer on February 13, 2023, subject to final bilateral agreements.

Intergovernmental Communications

- Between 2023/24 and 2027/28, BC will receive bilateral funding of nearly $2 billion, starting in 2023/24 with $481 million.
- The $481 million includes $407 from the Working Together Agreement and $74 million from the Aging with Dignity Bilateral Agreement.
- An additional $1.7 billion for all PTs to support personal support workers working conditions and wages was announced as part of the Aging with Dignity Bilateral Agreement in February 2023, however, further details including PT allocations are still outstanding from Health Canada and the current action plans have been developed without consideration for this element.

Intergovernmental Communications

- The $74 million does not represent the full amount available for 2023/24, but due to the timing of the federal funding announcement and the agreement not being finalized until late in the fourth quarter of fiscal 2023/24, BC and Health Canada have agreed to carry forward Aging with Dignity funds into 2026/27.
- BC plans to carry forward $89 million from 2023/24, then $86 million from 2024/25, $59 million from 2025/26, and $29 million from 2026/27. This shifts the balance of the spending to the latter three years of the agreement but does provide a plan to fully utilize the available funding.

Table 1: Actual Funding Allocations Based on Signed Aging with Dignity Agreement

Initiative	Incremental Investments					Total
	2023-24	2024-25	2025-26	2026-27	2027-28	
Total available Funding	**163**	**163**	**163**	**163**	**81**	**733**
Home and Community Care planned expenditure	**74**	**90**	**82**	**82**	**N/A**	**328**
Long-term Care planned expenditure	**0**	**76**	**108**	**111**	**110**	**405**
Total planned carry forward into next fiscal year	**89**	**86**	**59**	**29**	**0**	

Advice/Recommentations; Government Financial Information; Intergovernmental Communications

- The first bilateral agreement covers the 4 shared health priorities and delivers new funding in tandem with the remaining 4 years of funding from the mental health and substance use portion of the HCCMHAS.
- The second agreement focuses on the separate fifth priority of Aging with Dignity, combining the funds offered for LTC with the remaining 4 years of the home and community care portion of the HCCMHAS.

Table 2: Summary of Canada Health Transfer and Additional Federal Funding as Percentage of BC Health Sector Spend

Ministry of Health
Confidential: Advice to Minister - Canada Health Transfer

($ millions)	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
Canada Health Transfer	**5,004.00**	**5,204.00**	**5,467.00**	**5,678.00**	**5,865.00**	**6,176.00**	**7,113.00**	**7,153.00**	Government Financial Information	
Additional Federal Funding			**9.78**	**1,628.65**	**359.08**	**173.75**	**491.67**	**583.07**		
Total Federal Funding (Note 1)	**5,004.00**	**5,204.00**	**5,476.78**	**7,306.65**	**6,224.08**	**6,349.75**	**7,604.67**	**7,736.07**		
Year over Year % Change		4.00%	5.24%	33.41%	-14.82%	2.02%	19.76%	1.73%		
Total Health Sector Spend / Budget (Note2)	**20,927.00**	**22,159.00**	**23,456.00**	**25,613.00**	**27,591.00**	**30,322.00**	**31,466.00**	**35,944.00**		
Year over Year % Change		5.89%	5.85%	9.20%	7.72%	9.90%	3.77%	14.23%		
Canada Health Transfer as a percentage of Health Sector Spend	23.9%	23.5%	23.3%	22.2%	21.3%	20.4%	22.6%	19.9%		
Total Federal Funding as a percentage of Health Sector Spend	23.9%	23.5%	23.3%	28.5%	22.6%	20.9%	24.2%	21.5%		

Note 1
Additional Federal funding is recognized in the year received.

Note 2
2017/18 - 2022/23 is from Public Accounts.
2023/24 - 2025/26 is from BC's 2024/25 Budget and Fiscal Plan.

LAST UPDATED

The content of this estimates note is current as of March 11, 2024, as confirmed by Darlene Therrien.

APPROVALS

2024 02 28– Steve Ward obo Rob Byers, Finance and Corporate Services Division
2024 03 11 - Darlene Therrien, Intergovernmental Relations
2024 03 11 - Jonathan Dubé, Associate DM, Health System Operations

LEGISLATIVE SESSION – ESTIMATES NOTE

In Plain Sight Report Recommendations - Implementation

Topic: The report 'In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in BC Health Care' (IPS) was released publicly on November 30, 2020, identifying 24 recommendations to address systemic Indigenous-specific racism in the health system.

Key Messaging and Recommended Response:

- **We know systemic racism exists and it is damaging to the health and wellness of people in our province, especially Indigenous people.**
- **We acknowledge we cannot move fast enough to respond to historic and ongoing Indigenous-specific racism.**
- **Everyone in British Columbia deserves to feel safe and supported when accessing health services.**
- **We need safe and effective processes for resolution, healing, and learning, which is why the Province is taking action to embed cultural safety and hardwire anti-racism into organizational responses to harm in healthcare, including BC's Patient Care Quality process.**
- **That's also why we are implementing the 24 recommendations made in the In Plain Sight Report. An update on our progress to date was released on October 6, 2023.**
- **Profound systems transformation takes time, dedication and ongoing work to ensure cultural safety and humility is embedded and racism is eradicated.**
- **While we have more work to do, we are making significant progress implementing the In Plain Sight recommendations.**

CURRENT SITUATION

Recommendation #1

- The Minister of Health issued an apology statement to Indigenous people on November 30, 2020. On December 1, 2020, a joint written apology on behalf of all Board Chairs and CEOs from the health authorities was issued. On May 11, 2021, written apologies were also issued by the BC College of Nurses and Midwives, the College of Physicians and Surgeons of BC, the College of Dental Surgeons of BC, and the College of Pharmacists of BC.
- In 2022-2025 collective agreements, health employers and health sector unions and bargaining associations agreed to a new Memorandum of Agreement (MOA) acknowledging the pervasive harms of colonialism faced by Indigenous peoples and committed to working together to take a comprehensive system-wide approach to confronting Indigenous specific-racism and cultural safety.

LEGISLATIVE SESSION – ESTIMATES NOTE

Recommendation #2

- The ***Health Professions and Occupations Act*** passed royal assent on November 22, 2022.
- On June 2, 2022, the ***Anti-Racism Data Act*** **(ARDA)** became law in BC.
- In Summer 2023, the Ministry of Attorney General conducted community-led public engagement sessions for the ***Anti-Racism Act***. Release of an Engagement Report summarizing engagement feedback is targeted for early 2024, and the Act is expected to be introduced in Spring 2024.
- 2021 – ***Human Rights Code*** amended to include Indigenous identity as a ground for discrimination.
- The ***Public Interest Disclosure Act*** became applicable to all health authorities on June 1, 2023, supporting whistleblower protections and a "Speak Up Culture". Health authorities are instituting appropriate policies or procedures to support application and implementation of the Act.

Recommendation #5

- In October 2022 Health Quality BC (HQBC) hosted a workshop and public lecture on restorative processes in quality improvement and complaints-focused learning, which resulted in a collaborative 'Restorative Circle' working group. The Circle hosted a Leadership Symposium in November 2023 to advance structural changes to BC's patient care and quality processes.
- HQBC in partnership with the In Plain Sight Task Team published the "Sharing Concerns: Principles to Guide the Development of an Indigenous Patient Feedback Process". This publication identifies core principles of a safe, accessible, and meaningful patient complaints process.

Recommendations #6, #17 – The signatories to the 2018 *Memorandum of Understanding: Tripartite Partnership to Improve Mental Health and Wellness Services and Achieve Progress on the Determinants of Health and Wellness* are extending the implementation period to April 2, 2025 (pending approval).

Recommendation #7 – Métis Nation BC (MNBC) and the Ministry have bi-monthly bilateral meetings. A Health, Mental Health and Harm Reduction Table has been established between MNBC, MoH, MMHA, and MIRR. MNBC has signed Letters of Understanding have been signed with all six provincial health authorities.

Recommendation #8 – The HSO (Health Standards Organization) BC Cultural Safety and Humility Standard was published in June 2022, co-developed with the First Nations Health Authority (FNHA). The CSH Standard is currently being used to help guide health system organizations as they work towards improved cultural safety and humility, with the intent that this standard will subsequently become part of the suite of standards that Accreditation Canada uses to assess and accredit health care organizations. In January 2023 the Ministry of health established an internal working group to develop an implementation plan for operationalizing the Standard within the Ministry. In January 2024, the working group began discussing how to support the implementation plan.

Recommendation #9 – The Tripartite Data Quality & Sharing Agreement (TDQSA) has been extended to April 2024 and FNHA and the Ministry are collaborating on the development of a new agreement to replace the TDQSA, in alignment with DRIPA. A provincial Indigenous Cultural Safety Measurement working group has been established to improve data sharing across the system, determine a balanced indicator set to measure cultural safety across the system, and develop a standardized systemic performance monitoring dashboard.

Recommendation #15 – As part of the established response to the COVID-19 pandemic, the collaboratively developed *Rural, Remote, First Nations and Indigenous COVID-19 Response Framework* continues to support medical transportation and ambulance services for communities.

Recommendation #13 - In January 2021, the role of Associate Deputy Minister of Indigenous Health and Reconciliation was created to lead the implementation of the recommendations in collaboration with Indigenous, health system, and provincial ministry partners. This was the first time an Indigenous person had been appointed as an Associate Deputy Minister in the BC public service. The role is currently vacant.

Recommendation #14 - All HAs have at least 2 Indigenous Board members. All HAs including PHSA, and Providence Health Care, have established and filled Vice President, Indigenous Health positions and have built up Indigenous health and cultural safety teams. Through the Ministry's collaboration with the VPs of

LEGISLATIVE SESSION – ESTIMATES NOTE

Indigenous Health, BC's Health Human Resources Strategy includes targeted strategies to support and protect Indigenous people as both patients and providers, with the goal of eliminating Indigenous-specific racism.

Recommendations #18, 20, 21, 22 and 23

- The Ministry of Health is working with the Ministry of Advanced Education and Skills Training (AEST) on a collaborative process to advance implementation of the recommendations specific to post-secondary education institutions.
- In March 2023, Health Quality BC and the MoH hosted a provincial dialogue on cultural safety and humility training and education with the aim to develop a guide with standardized learning expectations and outcomes at a provincial level. This guide is currently in development.
- A new medical school is being established at SFU and curriculum will be designed to embed and equalize Indigenous knowledge systems.

Recommendation #19 - The Ministry provided $0.550 million in 2021/22 for 5 years of support to the National Collaborating Center for Indigenous Health (NCCIH) as a centre for anti-racism, cultural safety and trauma-informed standards, policy, tools, and leading practices. NCCIH is also working with health authorities to develop tools and resources to support the implementation of the CSH Standard.

Recommendation #24 - A Task Team was formed and launched on May 12, 2021, with MNBC, FNHA, First Nations Health Council, First Nations Leadership Council and system partners who hold expertise in the BC health care system, cultural safety and humility, experience with Indigenous engagement and addressing Indigenous-specific anti-racism. Task team's mandate was for a minimum 24-month term. The Task Team concluded on June 27, 2023, and a full report on progress towards implementation of the 24 recommendations was publicly released in October 2023.

FINANCIAL IMPLICATIONS

Budget 2021 provided $15 million annually over three years to support the work of the In Plain Sight Task Team, culturally safe health services and more Indigenous liaisons in each regional HA to improve health access and services for Indigenous peoples.

KEY BACKGROUND

- In June 2020, the Minister of Health commissioned an independent review into allegations of racism in the BC emergency department setting, as well as the broader health system. The review concluded with both a full and summary report and a data report released in February 2021.
- Additional steps taken, in alignment with IPS and provincial response, included:
  - 5 new Indigenous health liaison positions funded in each HA with 2 additional positions at Providence Health Care, for a total of 32 net new positions.
  - Medical bylaws are under review by the Ministry, and revisions will be implemented collaboratively, for consistent cultural safety and humility standards for medical staff privileges.
- The independent review toll-free number and email address has been transferred to the Office of the Ombudsperson and will be maintained as a reporting resource while processes for effective system complaints processes are strengthened.

LAST UPDATED

The content of this estimates note is current as of February 9, 2024 as confirmed by Diana Clarke, Sr. Executive Director, Indigenous Health and Reconciliation Division.

APPROVALS

2024 02 14 - Peter Klotz, Finance and Corporate Services Division
2024 02 20 - Diana Clarke, Indigenous Health and Reconciliation

LEGISLATIVE SESSION – ESTIMATES NOTE

B-02

Indigenous Health Funding

Topic: The Ministry of Health allocates annual funding to health authorities, the First Nations Health Authority (FNHA), the BC Association of Aboriginal Friendship Centres (BCAAFC), and Métis Nation BC (MNBC) to support the advancement of Indigenous health and wellness initiatives.

Key Messaging and Recommended Response:

- **The Ministry of Health continues to invest in the advancement of Indigenous health and wellness initiatives. This includes:**
- **Annual funding to health authorities, the First Nations Health Authority (FNHA), the BC Association of Aboriginal Friendship Centres (BCAAFC), and Métis Nation BC (MNBC).**
- **The implementation of the 24 recommendations made in the In Plain Sight (IPS) Report. An update on progress to date was released on Oct. 6, 2023.**
- **Aligning BC's Health Human Resources Strategy (HHR) with UNDRIP, the Declaration Act, IPS and BC's Cultural Safety and Cultural Humility Standard.**
- **First Nations primary care centres - since 2018 we've opened/launched the Williams Lake First Nations Wellness Centre and Sts'ailes Community Care Campus, and primary care networks in the community of Lheidli T'enneh and First Nations Virtual Doctor of the Day and the First Nations Virtual Substance Use and Psychiatric Service.**
- **Establishing additional Indigenous patient support positions, Indigenous Patient Navigators, cultural competency training, and developing robust Indigenous data and reporting as part of BC's 10-year Cancer Action Plan.**

CURRENT SITUATION

Health Authorities

$10.4 million annual base funding was allocated to health authorities ($4.9 million beginning in 2020/21 and $5.5 million beginning in 2021/22) for priorities aligned with the IPS Sight recommendations including: 1) Indigenous recruitment and retention; 2) improving the complaints system; 3) furthering Cultural Safety and Humility and, 4) an additional 32 Indigenous Health Liaison positions.

First Nations Health Authority (FNHA)

- The Ministry supported the *Tripartite Framework Agreement on First Nations Health Governance* (2011) with contributions to FNHA of $100 million from 2006/07 - 2019/20. The Ministry also provided a lump sum of $22 million to further support the FNHA for various health actions programs under the Indigenous Sport, Physical Activity & Recreation Council and other organizations.
- The Ministry commits up to $15.33 million annually to support 27 Nation-based projects through a Joint Ministry-FNHA Project/Priorities Board.

- The FNHA funding letter supports the partners' annual Letter of Mutual Accountability (LMA).
- The Ministry provided FNHA $3.6 million in 2021/22 for Doctor of the Day programs and for Substance Use and Psychiatry programs and service delivery.
- For 2023/24, the Ministry provided $42.18 million (excluding JPB) base funding including:
  - $10.750 million to support Indigenous Treatment and Land-Based Healing Services
  - $10.313 million to support Primary Care Strategy
  - $8 million to support Indigenous Health and Culturally Appropriate Services
  - $7.730 million to support Mental Health and Addictions Services
  - $1.902 million to support Primary Care Networks
  - $1 million to support Traditional Healing and Wellness Strategy
  - $0.720 million to support Health Authority Liaison
  - $0.595 million to support Cultural Safety & Humility
  - $0.473 million to support Primary Care
  - $0.250 million to support Aboriginal Land-based Substance Use
  - $0.250 million to support Aboriginal Suicide & Critical Incident Response Team Expansion
  - $0.196 million to support Health Human Resources Strategy
- In 2020/21 The Ministry Provided FNHA $1.23 million for the COVID-19 Pandemic Response. In 2021/22, The Ministry provided FNHA $16.68 million COVID-19 Funding, including $5.88 million to support COVID-19 Contact Tracers, and $10.8 million to support Rural Remote Collaborative.
- In 2022/23, the Ministry also provided funding to support First Nations Harm Reductions ($4.0M, First Nations Treatment Centers, $35 million, Stas'ailes Community Care Center $13 million, Tripartite Memorandum of Understanding $5.015 million).

BC Association of Aboriginal Friendship Centres (BCAAFC)

The Ministry provides BCAAFC with a grant of $0.2 million to support projects and initiatives benefiting urban and off-reserve Indigenous populations.

Métis Nation BC (MNBC)

- The Ministry provides MNBC with an annual $825,000 grant through 2024/25 to support health and wellness initiatives benefiting Métis peoples and communities in BC including partnership development, supporting the Métis Public Health Surveillance Program, facilitating Métis participation across the spectrum of Indigenous engagement, working relationships with health partners, and collaboration on implementing In Plain Sight recommendations.
- The Ministry provided MNBC with a $1 million one-time grant in 2023/24 to support the development of a Métis Health and Wellness Strategy and Plan to advance Métis health and wellness priorities and support collaboration with the Province on the DRIPA Action Plan.

National Collaborating Centre for Indigenous Health (NCCIH)

- $0.550 million in 2020/21 to support NCCIH's work with health system partners to develop tools, strategies, training, and resources to enhance culturally safe service delivery and practices across the BC health system. Support for the NCCIH aligns with Rec. #19 from the IPS report.
- $0.850 million in 2021/22 to NCCIH through the University of Northern BC to work with health authorities and health system partners to advance initiatives related to the Cultural Safety and Humility standard, Indigenous Cultural Safety measurement, and education and training.

Memorandum of Understanding on the Determinants of Health and Wellness

- The 2018 tripartite *MoU – Tripartite Partnership to Improve Mental Health and Wellness Services and Achieve Progress on the Determinants of Health and Wellness* provides provincial support through the Ministry, MMHA, Children and Family Development (MCFD), and Indigenous Relations and Reconciliation (MIRR).
- $5.0 million in 2018/19 and 2019/20 to support the Tripartite Partnership to Improve Mental Health and Wellness, as part of BC's $10 million commitment to support planning and implementation of Nation-based plans and initiatives.

- In 2019, the Province provided $20 million (matched by FNHA) to build and revitalize First Nations treatment centres across the Province. Federal Budget 2021 provided an additional $20 million from the Government of Canada to support this initiative, for a final tripartite allocation of $60 million.[1]

FINANCIAL IMPLICATIONS

In 2022/23 the Ministry provided the following funding as identified above to support Indigenous Health:

- $124.208 million to the FNHA
- $10.4 million to the health authorities
- $0.200 million to the BC Association of Aboriginal Friendship Centres
- $1.825 million to MNBC

KEY BACKGROUND

The Ministry provides ongoing financial supports for Indigenous-specific health and wellness initiatives through mandated Ministry service planning and for prior obligations, including:

- Funding to health authorities/other organizations for Indigenous health services and initiatives;
- Implementation of the In Plain Sight (IPS) recommendations and collaboration on the *Declaration on the Rights of Indigenous Peoples Act* (DRIPA) Action Plan.

LAST UPDATED

The content of this estimates note is current as of February 9, 2024 as confirmed by Diana Clarke, Sr. Executive Director, Indigenous Health and Reconciliation.

APPROVALS

2023 01 24 - Diana Clarke, Indigenous Health and Reconciliation
2024 02 20 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division

[1] Indigenous Services Canada. (2021, August 14). *Government of Canada highlights funding for Indigenous communities to support critical infrastructure*. Retrieved September 15, 2023 from: https://www.canada.ca/en/indigenous-services-canada/news/2021/08/government-of-canada-highlights-funding-for-indigenous-communities-to-support-critical-infrastructure.html

LEGISLATIVE SESSION – ESTIMATES NOTE

B-03

Ministry Declaration Act Action Plan Commitments

Topic: The Declaration Act Action Plan commits the government to completing specific deliverables to enable true and lasting reconciliation with Indigenous peoples.

Key Messaging and Recommended Response:

- **BC passed the Declaration on the Rights of Indigenous Peoples Act (DRIPA) in November 2019 to establish the UN Declaration on the Rights of Indigenous Peoples (UNDRIP) as a framework for true and lasting reconciliation as per the Truth and Reconciliation Commission of Canada.**
- **The Action Plan attaches responsibility for the delivery of each action with the appropriate ministries.**
- **We released the 2022-23 DRIPA Annual Report on Progress in June 2023.**
- **Several actions are being undertaken by the Ministry of Health in partnership with the Ministry of Mental Health and Addictions, this includes:**
- **The implementation of the 24 recommendations made in the In Plain Sight (IPS) Report. An update on progress to date was released on Oct. 6, 2023.**
- **Aligning BC's Health Human Resources Strategy (HHR) with UNDRIP, the Declaration Act, IPS and BC's Cultural Safety and Cultural Humility Standard. This includes the following HHR strategic actions:**
    - **Action 10 - Provincial Organizational Standard for Cultural Safety and Cultural Humility**
    - **Action 11 - Indigenous Employee Experience Advisors and Development Funding**
    - **Action 45 - Indigenous Leader Recruitment and Support Initiative**
    - **Action 46 - Indigenous-Specific Recruitment Strategy**
    - **Action 54 - Cultural Safety and Humility Training Expansion**
    - **Action 66 - Master of Nursing in Indigenous Health Implementation**
- **We are working with the First Nations Health Authority to develop First Nations primary care centres that are led by First Nations. There are currently two operating First Nations primary care clinics in the province, with more to open over the next two years; since 2018, together we've opened/launched the Lu'ma**

Medical Centre and the Williams Lake First Nations Wellness Centre and have initiated work on the Sts'ailes Community Care Campus.

- **The Action Plan reflects the voices of Indigenous Peoples affected by cancer. We are committed to establishing additional Indigenous patient support positions (there are currently six - one at each of the regional cancer centres), Indigenous Patient Navigators to help patients who identify as First Nations, Metis or Inuit receive supportive care that is trauma informed and culturally safe. We are also committed to enhancing cultural competence by increasing the uptake of formal cultural competency training, such as the San'yas Indigenous Cultural Competency training, by healthcare workers, and to collaborate with Indigenous partners to develop robust Indigenous data and reporting to drive quality improvement.**
- **In addition, the Ministry of Health worked for over a year in consultation and cooperation with numerous Indigenous leadership groups to draft the Health Professions and Occupations Act (HPOA), previously known as Bill 36.**
- **The goal of the HPOA is to ensure that BC's health-care system continues to provide the best possible care to the people and families that live in this province, and it does that by strengthening protections for patients.**
- **In response to a recommendation made in the In Plain Sight report, the HPOA received royal assent in the BC Legislative Assembly on November 24, 2022, with provisions to address Indigenous-specific racism in the health-care system.**
- **The HPOA is just one facet of the fight against Indigenous-specific racism in the healthcare system, it makes numerous changes to how health professionals are regulated in this province with significant focus on dealing with discrimination and cultural safety and humility.**
- **The HPOA now has an explicit linkage to the BC Human Rights Code, which includes the protected ground of "Indigenous identity."**
- **Through the HPAO, our government has defined anti-Indigenous racism as a harm, for the first time in history.**

CURRENT SITUATION

- BC passed the Declaration on the Rights of Indigenous Peoples Act (DRIPA) in November 2019 to establish the UN Declaration on the Rights of Indigenous Peoples (UNDRIP) as a framework for true and lasting reconciliation as per the Truth and Reconciliation Commission of Canada.
- The DRIPA Action Plan was released March 30, 2022 with a five-year timeline. The Action Plan attaches responsibility for the delivery of each action with the appropriate ministries.
- The 2022-23 DRIPA Annual Report on Progress was released in June 2023 in a completely online format to improve public accessibility.
- The following DRIPA Action Plan actions are being led by the Ministry of Health. Several actions are being undertaken in partnership with the Ministry of Mental Health and Addictions (MMHA):
  - **3.7** - Implement recommendations made in the In Plain Sight: Addressing Indigenous-specific racism and discrimination in BC health care report, striving to establish a health care system in BC that is culturally safe and free of Indigenous-specific racism.
  - **4.7** - Demonstrate a new and more flexible funding model and partnership approach that supports First Nations to plan, design and deliver mental health and wellness services across a full continuum of care and to address the social determinants of health and wellness. (MMHA)
  - **4.8** - In alignment with the tripartite health plans and agreements, continue to strengthen and evolve the First Nation health governance structure in BC to ensure First Nations are supported to participate as full and equal partners in decision-making and service delivery at local, regional, and provincial levels, and engage First Nations and the Government of Canada on the need for legislation as envisioned in the tripartite health plans and agreements. (MMHA)
  - **4.10** - Prioritize the implementation of Primary Care Networks, the First Nations-led Primary Health Care Initiative, and other primary care priorities, embedding Indigenous perspectives and priorities into models of care to increase Indigenous Peoples' access to primary care and other health services, and to improve cultural safety and quality of care.
  - **4.14** - Increase the availability and accessibility of resources to Indigenous partners in COVID-19 pandemic health and wellness planning and response, including the implementation of the Rural, Remote, First Nations and Indigenous COVID-19 Framework[1] to ensure access for all Indigenous Peoples to immediate and culturally safe and relevant care closer to home. (MMHA)
  - **4.26** - Strengthen the health and wellness partnership between Métis Nation BC, the Ministry and the MMHA and support opportunities to identify and work to address shared Métis health and wellness priorities. (MMHA)
- The Ministry is a supporting partner for the following actions being led by other Ministries:
  - **4.11** - Increase the availability, accessibility, and the continuum of Indigenous-led and community-based social services and supports that are trauma-informed, culturally safe, and relevant, and address a range of holistic wellness needs for those who are in crisis, at-risk or have experienced violence, trauma and/or significant loss. (Ministry of Public Safety and Solicitor General, HLTH, MMHA)
  - **4.13** - Increase the availability and accessibility of culturally safe substance use services, including through the renovation and construction of Indigenous-run treatment centres and the integration of land based and traditional approaches to healing. (MMHA, HLTH)

FINANCIAL IMPLICATIONS

Financial implications for specific actions (e.g., implementing In Plain Sight recommendations) are detailed in the Indigenous Health Funding Fact Sheet.

KEY BACKGROUND

The Ministry is a party to several commitments, partnerships and activities that support the achievement of elements of the DRIPA Action Plan:

[1] https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/emergency-preparedness-response-recovery/gdx/rural-and-remote-covid-19- response-framework.pdf

- The Métis Nation Relationship Accord (2006) set out objectives to address health, housing, education, economic opportunities, Métis identification and data collection as well as any opportunities for engaging in a tripartite relationship with the federal government. The Accord was renewed in 2016 (MNRA II) and includes the following additional areas of focus: children and families, information sharing, justice, and wildlife stewardship. In October 2021, BC and MNBC signed a Letter of Intent to outline the collective intent to advance their relationship.
- Collaborative implementation of the British Columbia *Tripartite Framework Agreement on First Nations Health Governance* (2011).
- 2015 *Protocol on the Social Determinants of Health* with the First Nations Leadership Council.
- 2015 *Declaration of Commitment to Cultural Safety and Humility in Health Services* supporting implementation of a change leadership strategy to embed cultural safety in the health system.
- 2016 bilateral Memorandum of Understanding – *A Regional Engagement Process and Partnership to Develop a Shared Ten-Year Social Determinants Strategy for First Nation Peoples in BC*.
- 2018 Tripartite MoU – *Tripartite Partnership to Improve Mental Health and Wellness Services and Achieve Progress on the Determinants of Health and Wellness,* supporting community-driven, Nation-based initiatives to improve mental health and wellness. The Ministries of Health, MMHA, Children and Family Development, and Indigenous Relations and Reconciliation are signatories to the MoU which will be extended to April 2, 2025 (pending approval).
- Engaging Indigenous partners in health system planning and implementation processes, including working to integrate First Nations team-based supports (Indigenous Patient Liaisons, Elders, and other resources) into primary care networks and health care settings, and establishing up to 15 First Nations Primary Health Care Initiative sites.
- Partnering with the Office of the Provincial Health Officer, FNHA, and MNBC to enhance population health and wellness monitoring and reporting through the Population Health and Wellness Agenda, the baseline report[2] of which was released publicly on June 3, 2021. The Métis Public Health Surveillance Program Baseline Report[3] was released on February 3, 2022.

LAST UPDATED

The content of this estimates note is current as of February 9, 2024 as confirmed by Diana Clarke, Sr. Executive Director, Indigenous Health and Reconciliation.

APPROVALS

2024 02 09 – Diana Clarke, Indigenous Health and Reconciliation

[2] https://www.fnha.ca/Documents/FNHA-PHO-First-Nations-Population-Health-and-Wellness-Agenda.pdf
[3] https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/annual- reports/pho_metis_report_2021c_f3.pdf

LEGISLATIVE SESSION – ESTIMATES NOTE

C-01

Budget 2024 Overview

Topic: Health care is a top priority for the province and government will continue to make significant investments to support the public health system in BC and ensure people can access the care they need when they need it.

Key Messaging and Recommended Response:

- ***Budget 2024* provides new funding of $9.978 billion over the next three years to support health care services.**
- **The 2024/25 budget for health is $32.857 billion, which represents an almost $16.7 billion increase since 2016/17.**

CURRENT SITUATION

- *Budget 2024* provides new funding of **$9.978 billion** over the next three years to support health care services. These investments support meaningful health outcomes and quality health services for BC's population.
- *Budget 2024* prioritizes investments first put in place during the pandemic to protect British Columbians with over **$3 billion** over the plan to support ongoing costs for measures previously funded through one-time pandemic contingencies.

Operating ($ millions)	2023/24	2024/25	2025/26	2026/27
Budget 2023 Restated	**$28,673.508**	**$29,887.097**	**$30,669.129**	**$30,669.130**
Budget 2024		**32,857.312**	**33,751.847**	**34,594.515**
Budget 2024 vs Budget 2023				
Plan over Plan $ Change		**$2,970.215**	**$3,082.718**	**$3,925.385**
Plan over Plan % Change		9.94%	10.05%	12.80%
Year over Year $ Change		**$4,183.804**	**$894.535**	**$842.668**
Year over Year % Change		14.59%	2.72%	2.50%

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

Improving Health Services – Budget 2024 Fiscal Plan Incremental Increases

- *Budget 2024* provides new funding of **$9.978 billion over three years** to support improved health care. This includes:

Operating ($ millions)	2024/25	2025/26	2026/27	Total
General Health Services	$ 407.415	$ 414.410	$ 1,238.124	$ 2,059.949
COVID-19	1,011.170	1,015.036	1,014.742	3,040.948
Seniors Care	44.998	145.563	163.034	353.595
Cancer Care	90.000	90.000	90.000	270.000
Mental Health & Addictions	36.778	37.962	39.739	114.479

Operating ($ millions)	2024/25	2025/26	2026/27	Total
Other Investments:				
Ministry staffing – Seniors	0.697	0.697	0.697	2.091
Public Safety Programs NCC	3.464	3.357	3.357	10.178
SFU Medical School	2.110	2.110	2.110	6.330
Shared Recovery Wage	1,373.583	1,373.583	1,373.583	4,120.749
HLTH Total	**$ 2,970.215**	**$ 3,082.718**	**$ 3,925.386**	**$ 9,978.319**
HLTH IVF Contingencies	**-**	**$ 34.000**	**$ 34.000**	**$ 68.000**

Health Core Service Caseload

- *Budget 2024* provides **$2.060 billion** over the fiscal plan to support caseload demands due to a growing and aging population and inflationary pressures for meaningful health outcomes and quality health services for British Columbia's population.
- Healthcare in BC is primarily demand-driven to meet continually increasing population healthcare needs across the province in a safe, timely, and effective way.
- This incremental funding will allow HLTH to meet the health care needs of a growing and aging population and address higher than forecast inflationary pressures.

Ongoing COVID-19 Costs

- Government recognizes the significant stresses and strains on the health system, the health care workforce, and British Columbians over the last four years and the on-going challenges caused by the COVID-19 pandemic.
- Though the COVID-19 virus has shifted from pandemic to endemic, the health care system is still feeling the effects of the pandemic and the on-going pressures of COVID-19 as a new annual respiratory virus.
- In *Budget 2024*, government is providing incremental a base budget of **$1.011 billion** in 2024/25 and a total of **$3.041 billion** over the three-year fiscal plan to support on-going COVID-19 related spending. This funding includes:
    - COVID-19 vaccination costs and influenza vaccination programs;
    - provision of personal protective equipment for healthcare workers;
    - on-going COVID -19 lab testing capacity; and
    - for people living in rural, remote, and indigenous communities, continuation of improved medical transportation options, access to virtual care, and increased mental health supports.

Cancer Care

- New funding of **$270 million** over three years will make progress on BC's three-year Cancer Action Plan (the Plan), with a focus on:
    - improving access to prevention, screening, and diagnostics.
    - increasing capacity to deliver cancer treatments.
    - continuing system-wide planning for the future.
- Building on investments in *Budget 2023,* this funding will deliver system improvements that better meet the needs of cancer patients, their families, and the workforce that supports them.

Seniors Care

- *Budget 2024* includes investments of **$354 million** over three years to strengthen home and community care services for seniors.
- This funding will support seniors to age safely and comfortably in their homes, helping maximize their quality of life, dignity, and independence.
- By improving the quality and accessibility of home- and community-based services, these investments will also reduce pressure on other parts of the health care system, including hospitals and long-term care.

In Vitro Fertilization

- To support people who need help on the path to parenthood, BC will immediately begin work to establish a program to help with the cost of in-vitro fertilization (IVF) services.
- Starting April 1, 2025, BC will launch the new publicly funded IVF program, funding both treatment and medication for a single cycle of treatment.
- *Budget 2024* sets aside total funding of **$68 million** in contingencies in 25/26 to 26/27 to support these measures.
- An expert clinical group will be constituted in 2024 to assist in the creation of publicly funded IVF services including age considerations, service delivery options, and care pathways to access the service throughout BC.

ImmsBC

- Funding for ImmsBC was contemplated separately from Budget 2024 and a decision letter is forth coming.
- ImmsBC, also known as the Get Vaccinated system, enabled public health to mobilize COVID-19 vaccinations rapidly during the pandemic by notifying citizens about their vaccine eligibility, giving them a convenient way to book appointments online, and supporting real-time, consolidated reporting of vaccination metrics for all of BC.
- Over 4 million people across the province are already registered with the ImmsBC platform.
- Since April 2021, ImmsBC has supported the successful rollout of COVID-19 vaccines, resulting in the completed primary immunization series in 90.7 percent of people in BC aged 12 years and older. To date, over 16 million doses of COVID-19 vaccine have been administered in BC since December 2020.
- Retention and expansion of ImmsBC will also support increased access to immunization services for individuals across the province, providing citizens a modern and convenient way to receive reminders and book vaccinations.

Shared Recovery Wage Mandate

- The Ministry of Health (HLTH) received incremental funding of **$4.121 billion** over 3 years to fund compensation increases related to various collective agreements in the health sector.
- **$1.374** billion per year includes:
    - **$907 million** for nurses bargaining.
    - **$173 million** for Cost-of-living adjustment for unionized employees.
    - **$127 million** for HEABC Community Health Bargaining Association.
    - **$53 million** for ambulance, paramedics, dispatchers
- Shared Recovery Wage Mandate increases represent all recent ratifications impacting wage cost over the next three years.

Capital Plan

- Capital spending on infrastructure in the health sector will total **$13.0 billion** over the next three years.
- These investments support new major construction projects and upgrading of health facilities, additional long-term care beds and investments to improve access to primary care.
- These investments are supported by funding from the Province as well as other sources, such as regional hospital districts and foundations.

Examples of health sector capital investments in *Budget 2024*

- **$2.9 billion** toward a net-new hospital and integrated cancer centre in Surrey. The hospital will include 168 inpatient beds, an emergency department, a medical imaging department including CT and magnetic resonance imaging (MRI), a surgical suite, a pharmacy, and a laboratory. The cancer centre will include an oncology ambulatory care unit, chemotherapy, radiation therapy, functional imaging, a new cyclotron and space for six linear accelerators. Construction started in 2023 and is expected to be complete in 2029.
- **$2.2 billion** toward a new St. Paul's Hospital at the Station Street site in Vancouver, which will include capacity for 548 inpatient beds, a new and larger emergency department, a surgical suite, consolidated

specialty outpatient clinics and an underground parkade. Construction started in March 2021 and the project is expected to be complete in 2027.

- **$1.7 billion** for Burnaby Hospital Redevelopment Phase 2 and BC Cancer Centre, which will construct a new inpatient tower and integrated cancer centre. The 12-storey inpatient tower will include 160 beds and an expanded medical imaging department. The new BC Cancer Centre will include an oncology ambulatory care unit, chemotherapy chairs, radiation therapy with space for five linear accelerators, room for two PET/CT scanners, and an oncology pharmacy. Construction is expected to start in 2025 and the project is expected to be complete in 2030.
- **$1.6 billion** for Long-Term Care facility redevelopment or replacement projects that will provide 1,691 beds built to modern standards in Vancouver, Colwood, Abbotsford, Richmond, Nanaimo, Delta, Campbell River, and Cranbrook.
- **$1.4 billion** to replace the Cowichan District Hospital in Duncan with a new 204 bed hospital on a greenfield site in North Cowichan. The replacement hospital will increase inpatient beds and emergency department treatment spaces. Construction started in 2022 and the project is expected to be complete in 2027.
- **$1.2 billion** for Phases 2 and 3 of the Royal Columbian Hospital Redevelopment. Phase 2 is an 11-storey, 388-bed, acute care tower including critical care and maternity, a new and expanded emergency department, a new surgical and interventional suite and an underground parkade. Construction on the tower started in 2020 and is expected to be completed in 2025, with Phase 3 renovations completing in 2026.
- **$861 million** for the redevelopment of Richmond Hospital. The redevelopment is a multi-phased project that includes a new 216 bed acute care tower, which will replace the original North Tower (opened in 1964). The redevelopment will result in a total of 353 inpatient beds on the campus. Phase 1 is underway and procurement for the new tower (Phase 2) is planned to start in 2024 with the tower anticipated to be open for patients in 2028. Renovations to the South Tower and demolition of the North Tower will follow, completing in 2031.
- **$683 million** toward construction of a state-of-the-art Clinical Support and Research Centre (CSRC) built next to the new St. Paul's Hospital. The CSRC will include specialty medical services in addition to extensive research facilities, corporate support and childcare. Construction is planned to begin in 2025 and the project is expected to be completed in 2029.
- **$683 million** for Phase 1 of the Burnaby Hospital Redevelopment, which involves construction of a new six-storey, 83-bed patient care tower and a new energy centre, as well as renovation and expansion of existing buildings. Project scope includes medical and surgical inpatient services, outpatient services, a consolidated maternity/ labour and delivery unit, a mental health and substance use inpatient unit, and additional operating rooms. Construction started in 2021 and the patient care tower is expected to open to patients in summer 2025 with renovations and expansions to existing buildings completing in phases from 2026 to 2028.
- **$633 million** toward the replacement of the Mills Memorial Hospital in Terrace. The new hospital will include 83 inpatient beds. There will be four operating rooms and 20 emergency department treatment spaces. The project also includes the relocation and expansion of the Seven Sisters regional mental health facility. Construction started in 2021. The new Seven Sisters is complete and expected to open to patients in February 2024. The new hospital is expected to open to patients in early 2025, with completion of the entire project, including demolition and site works, by 2026.
- **$590 million** for the Replacement of the Dawson Creek and District Hospital. The new hospital will include 70 inpatient beds, an increase of 24 beds. The project also includes an expansion of the emergency department, surgical and operating space, and ambulatory care services. Construction of the new hospital started in 2023 and the project is expected to be complete in 2027.
- **$367 million** for the redevelopment of the Cariboo Memorial Hospital in Williams Lake, which includes construction of a three-storey addition and renovation of vacated spaces in the existing hospital. The redeveloped hospital will include 53 inpatient beds, an increase of 25 beds, and a larger emergency department. Construction started in 2023 and the new addition is expected to open in 2026. The renovations are planned to begin in 2026 and be completed in 2029.

- **$267 million** for a new Centre for Children and Youth Living with Health Complexity will be built at Slocan Street and 21st Avenue in Vancouver. The facility will include 16 two-bedroom family suites for Staying Services which provide short stays in a home-like environment with a care-by-parent model while transitioning between the hospital and home, learning new care techniques, or adjusting to new equipment. Construction is expected to start in 2025 and the project is expected to be complete in 2028.

Cost Drivers in Health Care

- BC's healthcare system faces increasing demand due to a growing and aging population:
    - From 2024 to 2027, BC's population is projected to increase by 4.3% (growing from 5.482 million to 5,719 million).
    - The number of British Columbians aged 65 and over is projected to increase by 10.3% from 1.142 million in 2024 to 1.259 million by 2027, significantly impacting the healthcare system.
- Technology - advancement in technology and testing expands the ability to treat more people for existing conditions (e.g. hip replacements for older patients), and new and expensive treatments for previously untreatable conditions.
- Chronic disease – managing incidents of chronic disease (e.g. diabetes, renal failure, congestive heart failure).
- Drug costs – rapidly rising drug prices, especially cancer drugs and increased utilization.
- Developmental conditions - expanding treatment for developmental conditions (e.g. autism, fetal alcohol syndrome).
- Compensation pressures – negotiated compensation agreements covering six health sector bargaining units (e.g. resident doctors of BC, nurses, ambulance paramedics).
- Public health emergencies – preparing for and managing critical situations of a temporary nature that seriously endanger the lives, health and/or safety of the population.

LAST UPDATED

The content of this estimates note is current as of February 12, 2024 as confirmed by Stephen Ward.

APPROVALS

2024 02 22 – Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

C-02

Air Conditioning Program

Topic: Portable Air Conditioner Program for vulnerable populations who may be at risk during extreme heat emergencies.

Key Messaging and Recommended Response:

- **On June 28, 2023, the Province committed to providing $10 million for BC Hydro to expand its Energy Conservation Assistance Program (ECAP) to include free, publicly funded portable air conditioners (AC) to help people stay safe during extreme heat emergencies.**
- **As of March 31, 2024, 5,864 eligible applications have been received by BC Hydro. Of these 4,747 applications have qualified for an AC install, resulting in the installation of 4424 air conditioners since program inception.**
- **The Ministry of Health is pleased with the strong uptake of the program and installation progress thus far.**
- **At the time of announcement, 8,000 AC units was an estimate. We will continue to invest in this program as per the original funding commitment.**

CURRENT SITUATION

- On June 28, 2023, the Province committed to providing $10 million for BC Hydro to expand its Energy Conservation Assistance Program (ECAP) to include free, publicly funded portable air conditioners (AC) to help people stay safe during extreme heat emergencies.
- It was announced that BC Hydro expects to install 8,000 ACs over 3-years for people who have low incomes and/or referrals of home health clients through the regional health authorities and First Nation community nurses. BC Hydro projects the program being fully subscribed before the 3-year timeframe.
- On August 15, 2023, the Program was expanded to include FortisBC's customers. This Program expansion follows the same qualification requirements as BC Hydro's program and is integrated with FortisBC's ECAP.
- As of March 31, 2024, 5,864 eligible applications have been received by BC Hydro. Of these 4,747 applications have qualified for an AC install, resulting in the installation of 4424 air conditioners since program inception.
- BC Hydro is planning to promote the program in the Spring to encourage early applications ahead of the program's peak season.
- BC Hydro is implementing program changes to improve application processing and installation capacity in anticipation of the peak season.

FINANCIAL IMPLICATIONS

- The $10 million in program funding has been integrated into the existing cost sharing agreement between the Ministry of Energy, Mines and Low Carbon Initiatives (EMLI) and BC Hydro.
- This agreement, which currently encompasses residential and commercial retrofits, covers the 2023/24 fiscal year and spans the subsequent two fiscal years, subject to fund availability.
- Of the $10 million of program funding, $4 million has been spent and $1.5 million has been committed to planned AC installations.

KEY BACKGROUND

- In June 2021, BC faced an unprecedented heat dome, in response the Chief Coroner conducted a review, leading to a recommendation to conduct a review on issuing cooling devices as medical equipment for those most vulnerable during extreme heat events.
- As a result of the review and the extreme weather conditions BC continues to experience, the province launched an initiative aimed at protecting British Columbians, with a particular focus on reaching those most vulnerable to health impacts from extreme heat emergencies. The Program builds on extreme heat initiatives rolled out in 2022, including the launch of the BC Heat Alert and Response System (BC HARS).
- The Program, together with other health emergency supports, was introduced following engagement among vulnerable populations, emergency planners, rights holders, and other stakeholders to understand how to better protect people most at risk to injury and death during extreme heat emergencies.

LAST UPDATED

The content of this estimates note is current as of April 3, 2024, as confirmed by Amy Van Reeuwyk.

APPROVALS

2024 02 08 – Tamara Stobart, Finance and Corporate Services Division
2024 04 03 – Rob Byers, Finance and Corporate Services Division

C-03

LEGISLATIVE SESSION – ESTIMATES NOTE

COVID-19 Operating Expenditures

Topic: In March 2020, the Public Health Officer (PHO) declared a state of emergency due to the COVID-19 pandemic. Though the virus is now endemic, there is still a need to fund on-going programs and services for the prevention of and response to COVID-19 to protect those who are most vulnerable to illness and future variants.

Key Messaging and Recommended Response:

- **Since the beginning of the pandemic in March 2020, the Ministry of Health made significant efforts and investments to respond and minimize the risk of COVID-19 to British Columbians, maintain service levels, and minimize the negative impacts to BC's health care system.**
- **Our government recognizes the significant stresses and strains on the health system, the health care workforce, and British Columbians over the last four years and the on-going challenges caused by the COVID-19 pandemic.**
- **We continue to take measures to respond to the COVID-19 health pandemic.**
- **The Ministry of Health, health authorities (HAs) and other front-line health care service delivery organizations continue to incur costs to support BC's response efforts for the impact from COVID-19 and other seasonal respiratory illnesses in Fall/Winter 2023/24.**
- **Though the COVID-19 virus has shifted from pandemic to endemic, the health care system is still feeling the impact and the on-going pressure both from individuals seeking care, as well as increased staff illness.**
- **There is still a need to fund on-going programs and services for the prevention of and response to COVID-19 to protect those who are most vulnerable to illness and future variants as well as for broader impacts to the health care system.**
- **In Budget 2024, our government is providing base budget funding of $1.011 billion in 2024/25 and a total of $3.039 billion over the three-year-fiscal plan to support on-going COVID-19 related spending.**

CURRENT SITUATION

- Budget 2024 is providing funding of $1.011 billion in 2024/25 and a total of $3.039 billion over the 3-year fiscal plan to support on-going COVID-19 related spending.
- In 2023/24, HLTH was provided access to $875 million from Pandemic Recovery Contingencies for up to $875 million to respond to the health-care requirements of COVID-19.

LEGISLATIVE SESSION – ESTIMATES NOTE

FINANCIAL IMPLICATIONS

As of March 31, 2024, HLTH is forecasting to have spent $7.636 billion on COVID-19 operating expenses.

- $0.025 billion – 2019/20
- $2.265 billion – 2020/21
- $2.194 billion – 2021/22
- $1.556 billion – 2022/23
- $1.597 billion – forecast as of December 31, 2023

KEY BACKGROUND

HLTH has continued funding actions and support programs in collaboration with HAs in response to COVID-19:

- Since the beginning of the pandemic in March 2020, HLTH made significant efforts and investments to respond and minimize the risk of COVID-19 to British Columbians, maintain service levels, and minimize the negative impacts to BC's health care system.
- Government recognizes the significant stresses and strains on the health system, the health care workforce, and British Columbians over the last four years and the on-going challenges caused by the COVID-19 pandemic.
- Though the virus is now endemic, there is still a need to fund on-going programs and services for the prevention of and response to COVID-19 to protect those who are most vulnerable to illness and future variants (e.g. vaccination, treatment, and public health capacity) as well as for broader impacts to the health care system (e.g. higher cost for staffing due to increased levels of sickness, overtime, and hospital occupancy)
- Investing in effective COVID-19 response, while keeping people safe and supporting the healthcare system, is also investing in economic recovery, and contributing to putting the province on the pathway to sustainable growth and development.

Significant On-going COVID-19 Ministry Costs:

Provision of Personal Protective Equipment for Healthcare Workers

- Provincial requirements effective on October 3, 2023 for the fall/Winter respiratory season require the use of face masks in all patient care areas of health care facilities.
- Implementing measures to protect staff and patients such as use of medical masks, eye protection and other PPE will be an ongoing activity during peak respiratory periods and in settings where there are higher risks (e.g., acute care, LTC/AL, home care, and primary care).

Rural Remote Collaborative and Ground/Air Ambulances

- For people living in rural, remote, First Nations and Indigenous communities, continuation of improved medical transportation options including air and ground ambulances, access to virtual care, and increased mental health supports.

COVID-19 Influenza Vaccination Programs

- The federal government has informed BC that it will no longer fund the cost of COVID-19 vaccine doses starting in 2025. This creates an additional cost for the government to manage.

On-going COVID -19 Lab Testing Capacity

- BC's COVID-19 testing guidelines have evolved since 2020. Today testing is recommended for symptomatic individuals where a positive result would impact treatment or care. Testing continues in the HAs. ED testing utilization remains high. Pre-surgical screening COVID-19 testing has been normalized in the HAs.

LAST UPDATED

The content of this estimates note is current as of February 12, 2024 as confirmed by Stephen Ward.

APPROVALS

2024 02 12 – Stephen Ward, Finance and Corporate Services Division
2024 02 20 - Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

C-04

Extra-billing - Audits and Canada Health Transfer Penalties

Topic: Several private health clinics and Medical Service Plan enrolled physicians are privately charging patients for services in contravention of the *Medicare Protection Act* (MPA) and the C*anada Health Act* (CHA). This is referred to as "extra-billing" and is prohibited under the MPA and CHA.

Key Messaging and Recommended Response:

- **Each year, BC is required to submit a report to Health Canada, quantifying the total extra-billings for a prior fiscal year. HC assesses CHT penalties based on the reported extra-billings, and federal funding is reduced in the following fiscal year as a CHA compliance deduction.**
- **To demonstrate BC's ongoing commitment to uphold the principles of the CHA and eliminate extra-billing, BC has taken a number of actions, including, contracting with private surgical clinics to bring private surgical services back into the public system, reducing wait times and increasing access.**
- **To ensure compliance, the Ministry has completed 12 audits of private surgical clinics.**
- **BC has been assessed approximately $18.24M in net penalties since March 2018.**
- **In January 2024, BC reported $18,118,721 in extra-billing and user charges for the 2021/22 fiscal. This includes $11.27M in respect of user charges levied for medically necessary diagnostic services.**
- **As a result of BC's corrective actions to eliminate extra-billing and user charges, in March 2024, Health Canada issued BC a total reimbursement in the amount of $22,405,749. This amount includes $15,743,338 in respect of fiscal 2021/22, which comprises a partial reimbursement (85%) in respect of user charges levied for medically necessary diagnostic services, and a 90% reimbursement in respect of extra-billing.**

CURRENT SITUATION

- In accordance with Health Canada (HC) requirements, the province will continue extra-billing audits with the expectation the province will receive the Canada Health Transfer (CHT) funds previously withheld by the Federal Government.
- On April 1, 2020, the Federal Diagnostics Services Policy came into effect. Commencing December 2022, the province is required to report on extra-billing and user charges associated with medically necessary diagnostic services to HC.

- Advice/Recommentations Section 18.1 expands the current prohibition against approved facilities charging for medically necessary diagnostic services that are benefits under the MPA or the *Hospital Insurance Act* to include unapproved facilities. Adv Advice/Recommentations
- The Reimbursement Policy requires that any reimbursement must occur within two years of the date of the original deduction, otherwise BC will forfeit a portion of it's deduction permanently.

FINANCIAL IMPLICATIONS

- If BC is subject to a CHT deducing in the amount reported in this filing, BC will have been assessed:

Fiscal Year	Payment Date	Total Penalties Assessed Since Mar -18	Total Reimbursement to Mar-20	Total Reimbursement to Mar-21	Total Reimbursement to Mar-22	Total Reimbursement to Mar-23	Total Reimbursement to Mar-24	Net Penalties Assessed Since Mar-18
2021/22	24-Mar	18,118,720.87					(15,743,337.98)	2,375,382.89
2020/21	23-Mar	23,110,530.54				(13,933,354.00)	(6,542,928.09)	2,634,248.45
2019/20	22-Mar	13,275,823.00			(11,948,241.00)	(1,194,824.00)	(119,482.20)	13,275.80
2018/19	21-Mar	13,949,979.00		(9,188,971.00)	(4,284,907.00)	(428,491.00)		47,610.00
2017/18	20-Mar	16,753,833.00		(11,992,825.00)	(4,284,907.00)			476,101.00
2016/17	19-Mar	16,177,259.00	(8,088,630.00)	(3,327,622.00)				4,761,007.00
2015/16	18-Mar	15,861,818.00	(7,930,909.00)					7,930,909.00
Totals		**117,247,963.41**	**(16,019,539.00)**	**(24,509,418.00)**	**(20,518,055.00)**	**(15,556,669.00)**	**(22,405,748.27)**	**18,238,534.14**

- In 2021/22 BC health authorities paid $33.5 million in contracts with private clinics to provide beneficiary services and increase access. These contracts require that partner clinics do not engage in extra-billing of any kind.
- In 2022/23 BC health authorities paid $23.8 million in contracts with private clinics to provide beneficiary services and increase access. These contracts require that partner clinics do not engage in extra-billing of any kind.
- In January 2024, BC reported $18,118,721 in extra-billing and user charges for the 2021/22 fiscal. This amount includes $11.27 million in respect of user charges levied for medically necessary diagnostic services.
- As a result of BC's corrective actions to eliminate extra-billing and user charges, in March 2024, HC issued BC a total reimbursement in the amount of $22,405,749. This reimbursement amount comprises $15,743,338 in respect of fiscal 2021/22, $6,542,928 in respect of fiscal 2020/21 and $119,482 in respect of fiscal 2019/20.

KEY BACKGROUND

- Each year, BC is required to submit a report to HC, quantifying the total extra-billings for a prior fiscal year. HC assesses CHT penalties based on the reported extra-billings, and federal funding is reduced in the following fiscal year as a CHA compliance deduction.
- In October 2018, the enforceability of the Bill 92 provisions of the MPA was challenged in Court in Cambie Surgeries Corporate v. British Columbia (Attorney General).
- On September 10, 2020, the Honourable Mr. Justice Steeves delivered his reasons for judgement in the Cambie trial. The decision ruled in the province's favour on all counts; all sections of the MPA being challenged were upheld. Cambie promptly appealed the decision.
- In October 2020, following the trial decision, Cambie applied to the Court of Appeal for a new injunction that would continue to prohibit the province from enforcing certain provisions of the MPA until such time as the appeal was heard.
- On December 8, 2020, Justice Hunter of the Court of Appeal issued a limited form of injunction which prohibited the Medical Services Commission (MSC) from taking action against clinics or physicians in connection with private-pay surgeries where the patients' surgery had been scheduled in the public system for a date beyond the Ministry wait time benchmarks, or where a surgery had not taken place in the public system by the date set according to such wait time benchmarks. This injunction was originally in effect from December 8, 2020, until June 18, 2021. On July 6, 2021, the injunction was further extended until September 30, 2021.
- On July 15, 2022 BC Court of Appeal dismissed Cambie's appeal, upholding the original judgement.

- In 2021/22 BC's health authorities contracted with 8 private surgical clinics and their medical practitioners to only provide contracted surgical services, bringing private surgical services back into the public system.
- On April 1, 2020, the Federal Diagnostics Services Policy came into effect. This policy aims to ensure patients do not face charges for medically necessary diagnostic services such as (but not limited to) magnetic resonance imaging (MRI) and computed tomography (CT) scans, regardless of where the services are provided. As of April 1, 2020, any province that has not eliminated patient charges for medically necessary diagnostic scans is subject to mandatory deductions under the terms of the CHA.
- In December 2022, the province commenced reporting on extra-billing and user charges associated with medically necessary diagnostic services to HC.

Audit Activity

- Audits identify the extent of patient charges by physicians and private clinics for insured health services in BC. Audits of private clinics assess compliance with the principles set out in sections 18 and 19 of the CHA, and more specifically sections 17 and 18 of the MPA with respect to extra-billing.
- In August 2021 the Billing Integrity Program conducted an audit of Cambie's compliance with the Injunction Order. The audit report was submitted to the MSC in January 2022.
- The Billing Integrity Program has completed twelve extra-billing audits as part of the initial reporting requirements to HC.
- The MSC issued the final audit report, accompanied by a letter from the MSC Chair, to each facility. No recovery is expected.
- An audit plan for diagnostic facilities has been developed Advice/Recommentations

  Advice/Recommentatio
- Advice/Recommentations

CHT Penalties

Amounts reported to HC on extra-billing and/or user charges, and corresponding federal deductions were:

Fiscal Year	Reported Patient Charges	Result of Onsite Audits	Charges related to medically necessary diagnostic services	Additional Health Canada Assessment*	Total
2021/22	$0	$6,848,504.87**	$11,270,216		$18,118,720.87
2020/21	$157	$5,945,064.04	$17,165,309		$23,110,530.54
2019/20	$95	$13,275,728			$13,275,823
2018/19	$200	$13,949,779			$13,949,979
2017/18	$1,561	$16,752,272			$16,753,833
2016/17	$7,533	$16,169,726			$16,177,259
2015/16	$1,980	$592,173		$174,493	$768,646
2014/15	$10,015			$174,493	$184,508
2013/14	$29,652			$174,493	$204,145
2012/13	$67,144			$174,493	$241,637
2011/12	$50,075			$174,493	$224,568
2010/11	$105,526			$174,493	$280,019

* Based on specific findings in Cambie.

**includes $31,144.87 in charges found to be non-compliant with the Cambie Injunction

Relevant Legislation

- The CHA explicitly prohibits user fees and extra-billing of patients for insured services.
- Sections 17 and 18 of BC's MPA prohibit enrolled physicians from charging patients for Medical Service Plan insured services, as outlined in the MPA's Payment Schedule.

- Under the MPA, the Ministry has authority to audit enrolled physicians. The Ministry delegates this authority to the MSC.
- The Audit Inspection Committee (AIC) approves audit referrals based on delegated authority from the MSC. Approved audits are conducted by the Billing Integrity Program within the Ministry's Audit and Investigations Branch. Completed audit reports are presented to the AIC which provides recommendations and forwards the reports to the MSC for approval.

Release of Information - This information may be disclosed to the public.

LAST UPDATED

The content of this fact sheet is current as of March 22, 2024 as confirmed by Anne Schuetze.

APPROVALS

2024 02 15 – Kristy Anderson, Hospital & Provincial Health Services Division
2024 03 22 – Anne Schuetze, Finance and Corporate Services Division
2024 04 03 – Rob Byers, Finance and Corporate Services

LEGISLATIVE SESSION – ESTIMATES NOTE

C-05

Health Authority - Corporate Expenditures

Topic: An overview of health authority Corporate Expenditures.

Key Messaging and Recommended Response:

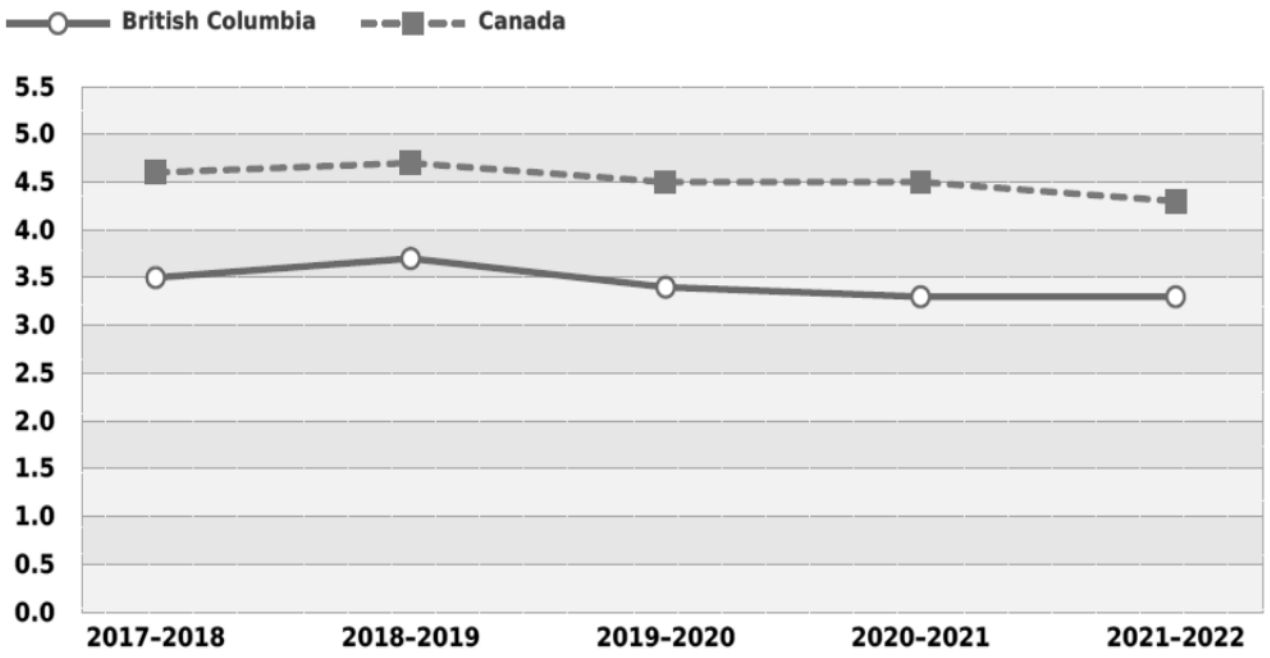
- **Health authorities are committed to fiscal responsibility, transparency, and accountability and comply with annual government reporting requirements under the *Budget Transparency & Accountability Act*, including publication of annual budgets and estimates, public accounts, quarterly reports, services plans, annual reports, and major capital plans.**
- **Corporate expenditures on the health authority financial statements are more than just administration costs and include expenditures on human resources, financial services, capital planning, communications, information management, technology, risk management, medical administration, and emergency service planning.**
- **Corporate expenditures increase due to many factors including investments in clinical information systems and virtual health infrastructure to support the delivery of health services, new hospital development projects and health human resource initiatives including implementation of UBC faculty of medicine seat expansion, new regulations to enhance work of paramedics, first responders to address staffing shortages.**
- **However, the Canadian Institute of Health Information (CIHI) identified BC's 2021/22 Corporate Services Expense Ratio of 3.3%, as being the 3rd lowest in the country (behind Alberta and New Brunswick). CIHI identifies the ratio as administrative service expense (including finance, administrative, human resources, and communications expenses) in proportion to total expenses.**

CURRENT SITUATION

The Canadian Institute for Health Information (CIHI) monitors a metric called "Corporate Services Expense Ratio" (CSER) which provides a measure of what jurisdictions across Canada are spending on administration as a percentage of total health costs. It includes all levels of Canadian Health Care and B.C's rate is 3.3%, compared to Canada's 4.4%. BC has the 3rd lowest rate in the country (behind Alberta and New Brunswick).[1] BC's CSER has shown a downward trend since 2016/17. CIHI information for 2022/23 is not currently available.

[1] Health spending: Indicators | CIHI

Trend Over Time: Corporate Services Expense Ratio (Percentage)



(Source: Canadian Institute for Health Information.)

KEY BACKGROUND

- The increase in corporate expenditures is linked to several factors including changes in healthcare technology and service delivery captured under corporate or administration (e.g. virtual care and IT services), infrastructure planning and development, wage increases for unionized and other staff providing corporate services, and accounting transactions from year to year (actuarial adjustments).
- The need to invest in modern healthcare infrastructure, including the construction and maintenance of IT systems and cybersecurity, and communication networks, has contributed to the increase in corporate expenditures. These investments are crucial for ensuring the delivery of modern, high-quality healthcare services.
- Examples of Corporate Expenditures in 2022/23 include:
    - $77 million to information technology in Vancouver Coastal Health (VCHA). $55 million went toward the activation of CST Cerner a clinical information system at Vancouver General Hospital and UBC Hospital, the largest successful activation of CST Cerner in North America, training of more than 10,000 staff and the addition of hundreds of new workstations as well as data centre operations.
    - $26 million to support various initiatives related to clinical services at Fraser Health (FHA). This includes FHA's Virtual Psychiatry Unit (VPU)B.C.'s first virtual psychiatry unit.
    - $18.7 million (capital and operating) in additional cyber security investments by PHSA for the Cybersecurity Modernization Program in response to the Office of the Auditor General and third-party reviews. (Note: The Ministry provided an additional $23.4 million in 2023/24 to further support the program.)
    - $8 million for increased corporate expenses related to the new St. Paul's Hospital development project, e.g., information technology, design and consultants related to the planning phase.
    - $5 million was spent on retro payments for VCHA unionized staff in salaries, wages, and employee benefits due to the new collective agreements.

- $14 million in FHA to support services that enhance clinical services including expanded recruitment, retention, and retraining services; repatriation of housekeeping and food services; and growth in support teams for primary care. Health Authorities are also planning and managing more major capital projects than ever before. Government is investing billions into new and expanded infrastructure including hospitals, long-term care, and more to support healthcare delivery. Budget 2024 provides for capital funding of $13 billion over three years to support the health sector.

FINANCIAL IMPLICATIONS

Table 1: Corporate Services Expenditures by HAs

HAs	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
FHA	233.869	253.985	275.907	288.736	339.836	370.735	479.820
IHA	142.712	145.294	153.436	163.374	180.032	201.684	221.842
NHA	65.127	66.231	71.061	74.834	80.277	90.431	107.398
VCHA	300.600	319.165	340.300	366.000	381.000	414.200	539.800
VIHA	169.834	186.635	187.047	195.033	213.319	240.838	293.518
PHSA	265.444	282.899	707.090	735.453	983.380	1,022.961	1,311.684
Totals	**1,177.586**	**1,254.209**	**1,734.841**	**1,823.430**	**2,177.844**	**2,340.849**	**2,954.062**

Notes:
1. Significant 2018/19 increase in the Corporate Sector is a result of BCCSS reported under PHSA, effective April 1, 2018.
2. Per health authority audited financial statements.

LAST UPDATED

The content of this estimates note is current as of March 15, 2024, as confirmed by Peter Klotz.

APPROVALS

2024 04 03 – Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

C-05

Health Authority Corporate Expenditures

Topic: An overview of health authority Corporate Expenditures.

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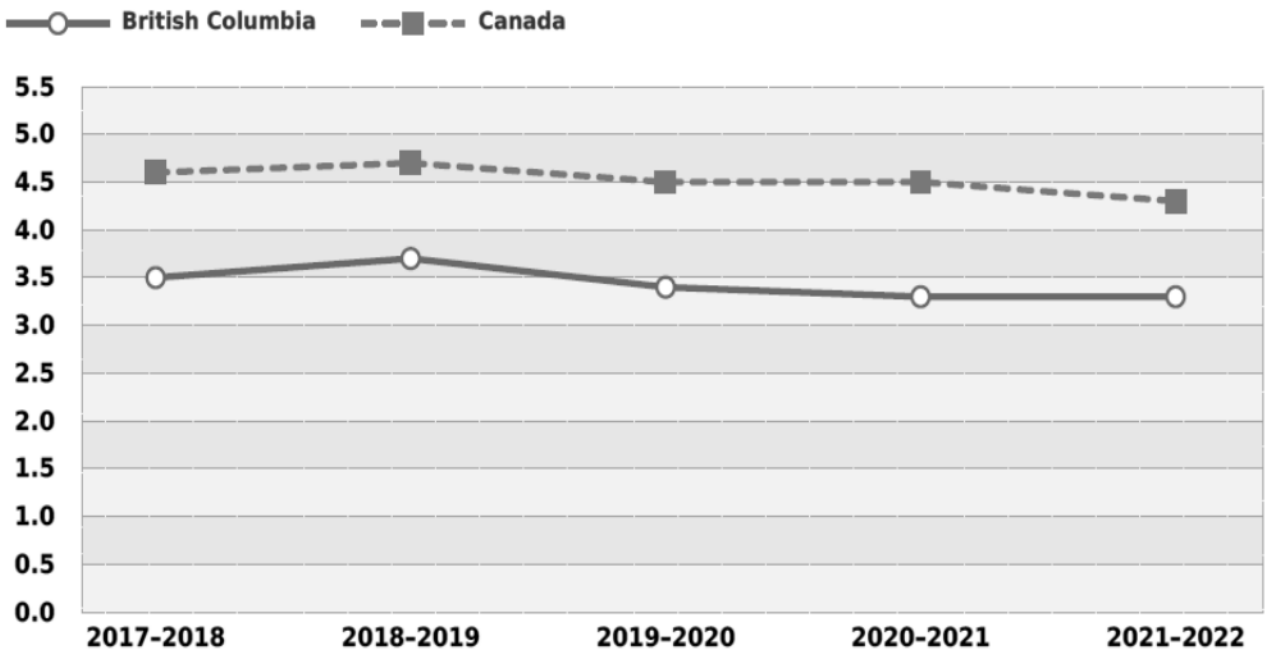

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FINANCIAL IMPLICATIONS

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2. Per health authority audited financial statements.

LAST UPDATED

The content of this estimates note is current as of March 15, 2024, as confirmed by Peter Klotz.

APPROVALS

2024 04 03 – Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

C-06

Health Authority - Executive Compensation

Topic: Public sector employers are required to disclose annually all compensation paid to the Chief Executive Officer (CEO) and the next 4 highest ranking or paid executives with decision-making authority.

Key Messaging and Recommended Response:

- **Executive Disclosure Statements for each health authority and Providence Health Care are posted in conjunction with the release of the Public Accounts.**
- **The statements disclose the annual compensation paid to the CEO and the next 4 highest paid executives with decision-making authority.**
- **Across the regional health authorities (HA), increases to salaries for executive's trends below public sector bargaining mandates. Increases trend less than 2% per year since 2017, for a total of approximately 10%, which is roughly 8% below public sector.**
- **The number of HA executives has remained stable since 2017, with the exception of adding VPs of Indigenous Health, bringing the total from 64 to 70.**
- **Of note, the 20 top paid salaries at PHSA are not administrators, they are clinicians. Our government is committed to ensuring we're paying doctors, including specialists, competitive salaries to ensure patients in our province continue to have access to the quality health care they deserve.**

CURRENT SITUATION

- The 2022/23 Executive Disclosure Statements for each health authority and Providence Health Care was posted by the Public Sector Employers' Council Secretariat (PSEC) and each of the health organizations in conjunction with the release of the Public Accounts and Service Plan Reports.
- The disclosure statements provide the base salary, employer contributions for statutory, pension, and health benefits and any other personal benefits provided, such as severance and sick leave payouts at retirement or conclusion of employment and vacation payouts. The objective is to disclose everything that a reasonable person would view as compensation.

FINANCIAL IMPLICATIONS

The following is a summary of the information that has been made public, in coordination with the release of the province's Public Accounts.

Name	Principle Position	Base Salary	Pension	Benefits	All Other Comp	Total 2022/23	Total 2021/22	Total 2020/21
Fraser Health								
Lee, Dr. Victoria	President & CEO	$364,592	$33,943	$32,593	$16,053	$447,181	$410,012	$406,144
Belle, Dr. Ralph	VP, Medicine	$299,345	$27,869	$29,955	$440	$357,609	$338,228	$271,531
Leith, Laurie	VP, Regional Hospitals & Communities	$289,197	$26,924	$29,550	$563	$346,234	$300,076	$298,982
Kelly, Dermot	VP, Community Hospitals & Health Services	$247,695	$23,060	$28,023	$1,175	$299,953	$0	$0
Dempster, Linda	VP, Patient Experience	$256,523	$0	$25,258	$245	$282,026	$266,301	$0
Brodkin, Elizabeth	VP, Population & Public Health and Chief Medical Health Officer (on LTD as of September 21, 2022)	$236,664	$21,812	$21,524	$40	$280,040	$353,447	$330,683
Interior Health								
Brown, Susan	President & CEO	$351,327	$34,379	$30,572	$33,369	$449,647	$441,445	$420,255
De Villiers, Albert S	Medical Health Officer (last day: February 7, 2023)	$252,916	$23,547	$20,183	$49,890	$346,536	$356,738	$205,636
Pollock, Sue	Chief Medical Health Officer	$279,238	$26,899	$22,428	$12,592	$341,157	$377,414	$0
Lommer, Donna	VP, Clinical & Corporate Services	$267,338	$26,055	$26,772	$13,947	$334,112	$325,810	$315,039
Letwin, Shallen	VP Clinical Operations, IH South	$265,772	$25,491	$26,196	$9,255	$326,714	$315,644	$310,048
Ertel, Mike	VP, Medicine & Quality (last day: November 30, 2022)	$196,324	$19,328	$14,115	$41,308	$271,075	$350,519	$343,379
Northern Health								
Ulrich, Cathy	President & CEO	$355,448	$23,559	$15,905	$4,929	$399,841	$406,906	$390,771
Chapman, Dr. Ronald	VP, Medicine	$309,660	$28,829	$15,827	$79	$354,395	$355,608	$342,788
Kim, Dr. Jong Woan	Chief Medical Health Officer	$299,150	$27,851	$13,462	$0	$340,463	$348,674	$320,919
Anguish, Penny	Chief Operating Officer, NI HSDA	$255,996	$23,833	$16,631	$0	$296,460	$297,748	$286,008
De Croos, Mark	VP, Financial & Corporate Services/CFO	$234,839	$22,787	$16,644	$0	$274,270	$273,940	$263,340
Providence Health Care								
Dalton, Fiona	President & CEO	$348,004	$32,399	$15,405	$0	$395,808	$381,548	$393,132
Simmers, Brian	CFO & VP, Health Informatics & Corporate Development	$303,105	$28,219	$17,865	$6,298	$355,487	$338,146	$313,649
Ingram, David	VP, Major Capital Projects	$294,828	$27,448	$17,602	$7,135	$347,013	$328,874	$0
Carere, Ron	VP, Medical Affairs	$235,082	$0	$0	$0	$235,082	$262,500	$262,500
Peters, Norman	Chief Operating Officer (effective June 20th, 2022)	$189,540	$17,646	$20,240	$6,170	$233,596	$0	$0
Provincial Health Services								
Byres, David	President & CEO	$369,200	$34,372	$16,087	$10,293	$429,952	$221,011	$47,431
Wong, Jason	Interim Executive Medical Director, BC Centre for Disease Control (effective September 3rd, 2022)	$293,829	$27,356	$14,179	$21,723	$357,087	$0	$0
Heppell, Leanne	Executive VP, BC Emergency Health Services and Chief Ambulance Officer (effective January 17th 2022)	$300,519	$0	$41,168	$6,667	$348,354	$0	$0
MacNair, Scott	Executive VP, Business Operations	$296,400	$27,595	$17,167	$953	$342,115	$340,851	$132,588
Wannamaker, Susan	Executive VP, Clinical Service Delivery, PHSA	$310,432	$0	$15,911	$0	$326,343	$342,209	$313,292
Malovec, Shannon	Executive VP, Digital Health, Information Services and Innovation (effective July 13th 2022)	$278,384	$24,984	$17,037	$0	$320,405	$0	$0
Gustafson, Reka	VP, Public Health & Deputy Officer (last day: September 10th 2022)	$179,926	$12,877	$4,712	$0	$197,515	$463,870	$0
Vancouver Coastal Health								
Eliopoulos, Vivian	President & CEO	$381,344	$0	$13,845	$22,599	$417,788	$391,031	$337,242
Daly, Patricia	VP, Public Health and Chief Medical Health Officer	$306,264	$28,508	$16,977	$31,948	$383,697	$387,493	$356,056
Pica, Fernando	CFO & Vice President, Strategic Business Services	$326,439	$30,386	$17,794	$3,600	$378,219	$376,732	$360,075
Chittock, Dean	VP, Medicine, and Quality and Safety	$344,931	$0	$0	$0	$344,931	$283,041	$183,750
Sparks, Brett	VP, People (last day: July 18, 2022)	$178,997	$16,583	$10,763	$98,958	$305,301	$294,382	$293,500
Blashin, Wayne	Interim VP, People (effective August 5, 2022)	$231,214	$24,091	$16,075	$2,945	$274,325	$241,873	$0
Vancouver Island Health								
MacNeil, Kathryn E	President & CEO	$358,425	$33,369	$21,550	$9,659	$423,003	$403,791	$405,088
Williams, Dr. Ben	VP Medicine and Quality & Chief Medical Executive	$281,163	$26,176	$22,838	$52,360	$382,537	$334,257	$321,497
Kerrone, Kim	VP & CFO	$283,578	$26,401	$16,991	$26,112	$353,082	$334,085	$321,700
Bjarnason, Lilja Elin	VP, Clinical Operations (last day: October 9, 2022)	$263,560	$24,537	$22,905	$33,710	$344,712	$306,190	$304,706
Hanson, James	VP, Clinical Operations	$252,347	$23,493	$21,649	$7,309	$304,798	$305,354	$0
Stanwick, Dr. Richard	VP, Population Health & Public Health & Chief MHO (last day: August 8, 2022)	$113,907	$0	$840	$153,791	$268,538	$376,227	$0
Gustafson, Dr. Reka	VP Island Health (effective September 12, 2022)	$150,275	$14,033	$19,821	$3,231	$187,360	$0	$0

LEGISLATIVE SESSION – ESTIMATES NOTE

C-06

KEY BACKGROUND

- As part of the BC government's economic recovery plan, the Minister of Finance determined that employers subject to compensation plans under the *Public Sector Employers Act* will be required to amend their Compensation Reference Plans (CRPs) to indicate that there will be no performance increases or adjustments paid to executive-level employees for the 2020/21 performance year.
- In 2016, under Phase 2 of the *BC Public Sector Compensation Review*, employers received approval to adjust executive and excluded management compensation within approved ranges.
- In 2015, under Phase 1 of the *BC Public Sector Compensation Review*, compensation reference plans and benchmarking were revised to ensure alignment with a common public sector compensation philosophy.
- In 2014, under the *BC Public Sector Compensation Review*, Government adopted a common public sector compensation philosophy, implemented new taxpayer accountability principles, and revised disclosure guidelines to further clarify and enhance transparency.
- In 2007/2008, the *Public Sector Employers Act* was amended requiring the disclosure of the salaries of public sector CEOs and the next 4 highest-ranking executives earning $125,000 or more in base pay.
- In 2002, the *Public Sector Employers Act* (Bill 66) was introduced, which required Ministerial approval of compensation plans, strengthened standards for severance payments, accumulated sick leave and vacation payouts.
- The *Public Sector Employers Act* requires that current contracts of senior executives be filed with the PSEC and available to the public.

LAST UPDATED

The content of this estimates note is current as of February 6, 2024.

APPROVALS

2024 02 06 – Peter Klotz, Regional Grants and Decision Support
2024 02 06 – Rob Byers, Finance and Corporate Services Division

C-07

LEGISLATIVE SESSION – ESTIMATES NOTE

Fraser Health Authority

Topic: The Fraser Health Authority (FHA) is 1 of 6 health authorities created in 2001. The Ministry of Health provides annual operating funding directly to the FHA via the annual Regional Services funding allocation.

Key Messaging and Recommended Response:

- **It is the Ministry's policy that health authorities (HAs) operate within balanced budgets.**
- **FHA had a surplus of $7.436 million in its 2022/23 Audited Financial Statements excluding affiliates. (Revenues of $5,486.904 million less expenditures of $5,479.468 million).**
- **As at Quarter 3 of fiscal year 2023/24, the Ministry has committed to providing FHA $5.169 billion in Regional Services funding.**

CURRENT SITUATION

- FHA had a surplus of $7.436 million in its 2022/23 Audited Financial Statements excluding affiliates, creating a surplus of $6.698 million with Menno Hospital and St. Michael's Centre included.
- As at Quarter 3 of fiscal year 2023/24, the Ministry has committed to providing FHA $5.169 billion in Regional Services funding.

FINANCIAL IMPLICATIONS

2022/23 Audited Financial Statements of FHA (excluding Menno and St. Michael's)

Total Revenues	$5,486.904 million
Total Expenses	$5,479.468 million
Surplus (Deficit)	$ 7.436 million

2022/23 Breakdown of Total Revenues by Major Funding Source
Year Ended March 31, 2023
($ Millions)

	Budget 2022/23	Actuals 2022/23	Actuals 2021/22
Revenues			
Ministry of Health Contributions	4019.600	4620.214	4357.893
Medical Services Plan	232.500	265.777	255.674
Recoveries from other health authorities and BC government reporting entities	142.700	134.401	125.189
Patients, clients and residents	98.829	127.860	109.112
Amortization of deferred capital contributions	101.100	109.743	101.840
Other contributions	91.500	97.192	93.660
Other	43.189	111.500	89.693
Interest income	2.782	20.217	2.886
	4732.200	**5486.904**	**5135.947**

Note: Amounts as per 2022/23 audited financial statements

LEGISLATIVE SESSION – ESTIMATES NOTE

Regional Services Funding Allocation (to FHA from Ministry)

2019/20 - $3.416 billion (per 2019/20 Final Funding Letter)
2020/21 - $4.051 billion (per 2020/21 Post Final Funding Letter)
2021/22 - $4.509 billion (per 2021/22 Post Final Funding Letter)
2022/23 - $4.628 billion (per 2022/23 Post Final Funding Letter)
2023/24 - $5.169 billion (per 2023/24 Funding Letter Update #3)

Estimated Full-Time Equivalents (FTEs)

According to Health Sector Compensation Information System 2022 data (2023 data is expected in April 2024), the estimated number of – excluding Menno Hospital, St. Michael's, and Other Contracted Agencies – is as follows:

Union – 20,875
Non-Union/Management – 2,417

Central Deposit Program

- FHA participates in the Ministry of Finance/Provincial Treasury Central Deposit Program (see Health Authority Cash Management and Central Deposit Program Fact Sheet). The Central Deposit Program was created by the Provincial Treasury in response to a recommendation by the Office of the Auditor General to better manage cash holdings by health authorities.
- At Quarter 3, FHA forecasts its 2023/24 year-end position will reflect the following:
    - Cash Balance in Central Deposit Program - $472.166 million
    - Cash and Cash Equivalents on Hand (Unrestricted and Restricted) - $52.066 million
    - Portfolio Investment on Hand - $0

FHA Population

- According to BC Stats, the FHA's population forecast and rate of growth is as follows:
    - 2023/24 – 2.173 million, 3.35% growth
    - 2024/25 – 2.221 million, 2.19% growth
    - 2025/26 – 2.268 million, 2.15% growth
- As of December 2023, approximately 17.04% of FHA's population is age 65 and over.

KEY BACKGROUND

- This Ministry's Regional Services funding represents the vast majority of the FHA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan, the Provincial Health Services Authority, and fees paid by patients and other health insurers (e.g., fees for services provided to non-residents of Canada, parking, and preferred accommodation).
- Working in co-operation with the FHA to provide health services within the FHA region are 2 denominational affiliates or hospital societies established per the *Hospital Act* (i.e., Menno Hospital and St. Michael's Centre). These denominational affiliates are separate legal entities, and each has its own board of directors and issues its own audited financial statements.
- The Ministry does not provide operating funding directly to the denominational affiliates; the FHA is responsible for allocating operating funding to the denominational affiliates. The financial results of the FHA and the denominational affiliates are consolidated in the Government Reporting Entity.

LAST UPDATED

The content of this estimates note is current as of February 8, 2024, as confirmed by Peter Klotz, Executive Director, Regional Grants and Decision Support.

APPROVALS

2024 02 20 - Peter Klotz, Finance and Corporate Services Division
2024 02 20 - Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

C-07

First Nations Health Authority

Topic: In 2011, the First Nations Health Society, federal government, and provincial government finalized the *British Columbia Tripartite Framework Agreement on First Nation Health Governance* (the Framework Agreement). The First Nations Health Authority (FNHA) receives funding from the Ministry of Health through various agreements and targeted funding.

Key Messaging and Recommended Response:

- **The Ministry provides annual funding to FNHA to support healthcare services to First Nations across the province.**
- **FNHA identified a budget of $840.487[1] million in its 2023/24 Service Plan.**

CURRENT SITUATION

- FNHA identified a budget of $840.487 million in its 2023/24 Service Plan.
- FNHA's 2022/23 Audited Financial Statements identified expenditures of $791.220 million2.
- The Ministry continues to provide funding to support FNHA.

FINANCIAL IMPLICATIONS

The Ministry provided FNHA with funding of $64.482[3] million in 2021/22 and $124.208[4] million in 2022/23.

Framework Agreement

- The framework agreement ended in 2019/20. At the end of fiscal year 2019/20, the Ministry had provided $100 million[5] to the FNHA to support the Framework Agreement . The funding schedule up to 2019/20 is provided in the table below:

Fiscal Year	Amount ($ millions)
2006/07 to 2014/15	$45.00
2015/16	$11.00
2016/17	$11.00
2017/18	$11.00
2018/19	$11.00
2019/20	$11.00
Funds Provided from 2006/07 to 2019/20	**$100.00**
Total Commitment	**$100.00**

- Although the Ministry has provided the full amount of funding related to this commitment, in 2019/20 the Ministry provided an additional $22.0 million (not reflected in the table above) to further support the FNHA.

Other Funding

- To support Joint Project Board projects, the Ministry provided:
  - $5.51 million in 2016/17;
  - $7.88 million in 2017/18;
  - $10.27 million in 2018/19;

[1] Paddling Together: FirstNations health Authority Health and Wellness Plan. 2023/24 FNHA Service Plan. FNHA-Summary-Service-Plan-2023-2024.pdf pg.58. Accessed February 6, 2024.
[2] FNHA Annual Report 2022/23. FNHA-Annual-Report-2022-2023.pdf Pgs. 92-93. Accessed February 6, 2024
[3] MoH 2021/22 Post Final Funding Letter Updates
[4] MoH 2022/23 Post Final Funding Letter Updates
[5] Internal FCS approved Table for Fact Sheet -FNHA Agreement Funding 2020.06.04

  - $13.17 million in 2019/20;
  - $13.88 million in 2020/21; and
  - $15.33 million as ongoing annual base funding in 2021/22.
- Other Ministry 2023/24 funding includes base funding of $42.18 million6 (excluding base funding of $15.33 million for the JPB projects), composed of:
  - $10.750 million to support Indigenous Treatment and Land-Based Healing Services
  - $10.313 million to support Primary Care Strategy
  - $8 million to support Indigenous Health and Culturally Appropriate Services
  - $7.730 million to support Mental Health and Addictions Services
  - $1.902 million to support Primary Care Networks
  - $1 million to support Traditional Healing and Wellness Strategy
  - $0.720 million to support Health Authority Liaison
  - $0.595 million to support Cultural Safety & Humility
  - $0.473 million to support Primary Care
  - $0.250 million to support Aboriginal Land-based Substance Use
  - $0.250 million to support Aboriginal Suicide & Critical Incident Response Team Expansion
  - $0.196 million to support Health Human Resources Strategy the following one-time funding:
    - $0.740 million to support Mental Health and Addictions Services
  - $0.239 million to support Primary Care Strategy and other funding from Medical Services Plan:
    - $7.893 million to support Midwifery Service Contracts 2022/23
    - $2.552 million to support Virtual Physician Services
    - $0.139 million to support Midwifery Service Contracts

KEY BACKGROUND

Framework Agreement

- In 2011, the FNHA, federal government, and provincial government finalized the Framework Agreement, which includes provisions for the transfer of the planning, design, management, and delivery of First Nations health programs from the federal government to a new FNHA.
- On October 1, 2013, the transition of programs and services designed for First Nations and managed by Health Canada were transferred to the FHNA.
- The Canada Funding Agreement provides funding to the FHNA to support the planning, design, management, delivery and funding of health programs by the FNHA.
- The total funding under the Canada Funding Agreement was $4.7 billion over 10 years (beginning July 2, 2013, and expiring March 31, 2023).
- The Ministry provided $100 million in funding to FNHA from 2006/07 to 2019/20 for Framework Agreement implementation and other commitments in the Transformative Change Accord: *First Nations Health Plan and the Tripartite First Nations Health Plan.*

MSP Agreement

- Prior to the Framework Agreement, Health Canada provided MSP payments to the Ministry on behalf of BC First Nations as per a Memorandum of Understanding between the federal government and Province. As of July 2, 2013, the FNHA assumed financial and administrative responsibility for First Nation clients whose MSP premiums were previously covered by the federal government.
- As part of an MSP Agreement, the FNHA agreed to provide 75% of annual financial contribution commitment directly to the Ministry of Finance and set aside the remaining 25% to support MSP primary care related initiatives. These primary care initiatives do not include MSP funded services, but broader initiatives such as e-health to improve health delivery services to First Nations.
- An FNHA and Ministry Joint Project Board identifies priority projects for this funding. As part of the MSP Agreement, the FNHA funds the initial start-up costs and first year of the project's operations

[6] MoH 2023/24 Funding Letter Update #3

and the Ministry commits to sustaining the project thereafter. The MSP Agreement was extended to March 2020 and, although expired, the commitment to maintain the funding continues.

LAST UPDATED

The content of this estimates note is current as of February 9, 2024.

APPROVALS

2024 02 09 - Peter Klotz, Finance and Corporate Services Division
2024 02 20 – Rob Byers, Finance and Corporate Services Division

C-07

LEGISLATIVE SESSION - ESTIMATES NOTE

Interior Health Authority

Topic: The Interior Health Authority (IHA) is 1 of 6 health authorities created in 2001. The Ministry of Health provides annual operating funding directly to the IHA via the annual Regional Services funding allocation.

Key Messaging and Recommended Response:

- **It is the Ministry's policy that health authorities (HAs) operate within balanced budgets.**
- **IHA had a surplus of $2.293 million in its 2022/23 Audited Financial Statements. (Revenues of $3,355.533 million less expenditures of $3,353.240 million).**
- **At Quarter 3 of fiscal year 2023/24, the Ministry has committed to providing $3.150 billion to IHA in Regional Services funding.**

CURRENT SITUATION

- IHA had a surplus of $2.293 million in its 2022/23 Audited Financial Statements.
- At Quarter 3 of fiscal year 2023/24, the Ministry has committed to providing $3.150 billion to IHA in Regional Services funding.

FINANCIAL IMPLICATIONS

2022/23 Audited Financial Statements of IHA

Total Revenues	$3,355.533 million
Total Expenses	$3,353.240 million
Surplus (Deficit)	$ 2.293 million

2022/23 Breakdown of Total Revenues by Major Funding Source

Year ended March 31, 2023 ($ Millions)

	Budget 2022/23	Actuals 2022/23	Actuals 2021/22
Revenues			
Ministry of Health contributions	2,547.623	2,739.831	2,528.365
Medical Services Plan	205.217	221.651	214.229
Patients, clients and residents	117.778	123.905	107.314
Amortization of deferred capital contributions	94.061	100.593	99.639
Recoveries from other health authorities and BC government reporting entities	60.561	69.250	65.550
Other contributions	42.833	46.814	45.303
Other revenues	40.658	43.650	35.181
Investment income	1.866	9.839	1.765
	3,110.597	3,355.533	3,097.346

Note: Amounts as per the 2022/23 audited financial statements.

LEGISLATIVE SESSION - ESTIMATES NOTE

Regional Services Funding Allocation (To IHA from Ministry)

2018/19 - $1.859 billion (per 2018/19 Final Funding Letter)
2019/20 - $2.028 billion (per 2019/20 Final Funding Letter)
2020/21 - $2.383 billion (per 2020/21 Post-Final Funding Letter)
2021/22 - $2.586 billion (per 2021/22 Post-Final Funding Letter)
2022/23 - $2.781 billion (per 2022/23 Post-final Funding Letter)
2023/24 - $3.150 billion (per 2023/24 Funding Letter Update #3)

Estimated Full-Time Equivalents (FTEs)

- According to Health Sector Compensation Information System 2022 data (2023 data is expected in April 2024), the estimated number of FTEs is as follows:
    - Unionized – 14,784
    - Non-unionized/Management – 1,456

Central Deposit Program

- The IHA participates in the Ministry of Finance/Provincial Treasury Central Deposit Program (see Health Authority Cash Management and Central Deposit Program Fact Sheet). The Central Deposit Program was created by the Provincial Treasury in response to a recommendation by the Office of the Auditor General to better manage cash holdings by health authorities.
- At Quarter 3, IHA forecasts its 2023/24 year-end position will reflect the following:
    - Cash Balance in the Central Deposit Program – $142.206 million
    - Cash and Cash Equivalents on Hand (Unrestricted) – ($151.130) million
    - Cash and Cash Equivalents on Hand (Restricted) – $198.419 million
    - Portfolio Investment on Hand - $0

IHA Population

- According to BC Stats, IHA's population forecast, and rate of growth is as follows:
    - 2023/24 – 0.896 million, 2.93% growth
    - 2024/25 – 0.912 million, 1.74% growth
    - 2025/26 – 0.927 million, 1.63% growth

KEY BACKGROUND

- The Ministery's Regional Services funding represents the vast majority of the IHA's annual operating revenues.
- Other significant sources of operating revenues include funding from the Medical Services Plan, Provincial Health Services Authority, and fees paid by patients and other health insurers (e.g., fees for services provided to non-residents of Canada, parking and preferred accommodation).

LAST UPDATED

The content of this estimates note is current as of February 7, 2024 as confirmed by Peter Klotz, Executive Director, Regional Grants and Decision Support.

APPROVALS

2024 02 20- Peter Klotz, Finance and Corporate Services Division
2024 02 20 - Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

C-07

Northern Health Authority

Topic: The Northern Health Authority (NHA) is 1 of 6 health authorities created in 2001. The Ministry of Health provides annual operating funding directly to the NHA via the annual Regional Services funding allocation.

Key Messaging and Recommended Response:

- **It is the Ministry's policy that health authorities (HAs) operate within balanced budgets.**
- **NHA had a surplus of $0.842 million in its 2022/23 Audited Financial Statements (Revenues of $1.220.906 million less expenditures of $1,220.064 million).**
- **At quarter 3 of fiscal year 2023/24, the Ministry has committed to providing $1,113.485 million to NHA in Regional Services funding.**

CURRENT SITUATION

- NHA had a surplus of $0.842 million in its 2022/23 Audited Financial Statements.
- At quarter 3 of fiscal year 2023/24, the Ministry has committed to providing $1,113.485 million to NHA in Regional Services funding.

FINANCIAL IMPLICATIONS

2022/23 Audited Financial Statements of NHA

Total Revenues	$1,220.906 million
Total Expenses	$1,220.064 million
Surplus/(Deficit)	$ 0.842 million

2022/23 Breakdown of Total Revenues by Major Funding Source

Year ended March 31, 2023

($ Millions)

	Budget 2022/23	Actuals 2022/23	Actuals 2021/22
Revenues			
Ministry of Health contributions	976.400	956.002	870.414
Medical Services Plan	121.800	112.679	113.642
Amortization of deferred capital contributions	47.200	46.950	45.478
Patients, clients and residents	47.200	47.771	44.036
Other contributions	18.000	16.402	19.566
Recoveries from other health authorities and BC government reporting entities	18.300	16.163	16.963
Investment income	1.400	6.249	0.917
Other revenues	13.100	18.690	14.803
	1243.400	1220.906	1125.819

Note: Amounts as per 2022/23 audited financial statements.

Regional Services Funding Allocation

2018/19 - $652.177 million (per 2018/19 Final Funding Letter)
2019/20 - $712.074 million (per 2019/20 Final Funding Letter)
2020/21 - $822.884 million (per 2020/21 Post-Final Funding Letter)
2021/22 - $910.126 million (per 2021/22 Post-final Funding Letter)
2022/23 - $952.553 million (per 2022/23 Post-final Funding Letter)
2023/24 - $1,113.485 million (per 2023/24 Funding Letter Update #3)

Estimated Full-Time Equivalents (FTEs)

- According to Health Sector Compensation Information System 2022 data (2023 data is expected in April 2024), the estimated number of FTEs is as follows:
  - Union – 5,291
  - Non-Union/Management – 662

Central Deposit Program

- The NHA participates in the Ministry of Finance/Provincial Treasury Central Deposit Program (see Health Authority Cash Management and Central Deposit Program Fact Sheet). The Central Deposit Program was created by the Provincial Treasury in response to a recommendation by the Office of the Auditor General to better manage cash holdings by health authorities.
- At Quarter 3, NHA forecast its 2023/24 year-end position will reflect the following:
  - Cash Balance in the Central Deposit Program – $111.416 million
  - Cash and Cash Equivalents on Hand (Unrestricted) – $90.068 million
  - Cash and Cash Equivalents on Hand (Restricted) – $27.621 million
  - Portfolio Investment on Hand – $0

NHA Population

- According to BC Stats, the NHA's population forecast, and rate of growth is as follows:
  - 2023/24 – 0.313 million, 1.76% growth
  - 2024/25 – 0.315 million, 0.63% growth
  - 2025/26 – 0.317 million, 0.54% growth
- As of December 2023, approximately 16.8% of NHA's population is age 65 and over.

KEY BACKGROUND

- This Ministry's Regional Services funding represents the vast majority of the NHA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan, the Provincial Health Services Authority, and fees paid by patients and other health insurers (fees for services provided to non-residents of Canada, parking, preferred accommodation, etc.).
- Wrinch Memorial Hospital in Hazelton became part of the NHA on April 1, 2016 and was included in the NHA's audited financial statements in 2016/17. Wrinch Memorial Hospital was previously a denominational affiliate. Denominational affiliates are separate legal entities, and each has its own board of directors and issues its own audited financial statements. The Ministry does not provide Regional Services operating funding directly to the denominational affiliate; the NHA is responsible for allocating operating funding to the denominational affiliate. The financial results of the NHA and the denominational affiliates are consolidated in the Government Reporting Entity.

LAST UPDATED

The content of this estimates note is current as of February 9, 2024 as confirmed by Peter Klotz.

APPROVALS

2024 02 20 – Rob Byers, Finance and Corporate Services Division
2024 02 20 - Peter Klotz, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

C-07

Provincial Health Services Authority

Topic: The Provincial Health Services Authority (PHSA) is 1 of 6 health authorities created in 2001. The Ministry of Health provides annual operating funding directly to the PHSA via the annual Regional Services funding allocation.

Key Messaging and Recommended Response:

- **It is the Ministry's policy that health authorities (HAs) operate within balanced budgets.**
- **PHSA had a deficit of $218.8 million in its 2022/23 Audited Financial Statements. (Revenues of $5,004.788 million less expenditures of $5,223.587 million).**
- **At Quarter 3 of fiscal year 2023/24, the Ministry has committed to providing $4.003 billion to PHSA in Regional Services funding.**

CURRENT SITUATION

- PHSA had a deficit of $218.8 million in its 2022/23 Audited Financial Statements which is mainly due to the write-down on Personal Protective Equipment (PPE).
- At Quarter 3 of fiscal year 2023/24, the Ministry has committed to providing $4.003 billion to PHSA in Regional Services funding.

FINANCIAL IMPLICATIONS

2022/23 Audited Financial Statements of PHSA

Total Revenues	$5,004.788 million
Total Expenses	$5,223.587 million
Deficit	$ (218.799) million

2022/23 Breakdown of Total Revenues by Major Funding Source

Year ended March 31, 2023 ($ Millions)

	Budget 2022/23	Actuals 2022/23	Actuals 2021/22
Revenues			
Ministry of Health contributions	3,181.287	3,510.480	3,192.503
Recoveries from other health authorities and BC Government reporting entities	691.332	775.830	754.150
Medical Services Plan	251.702	274.805	253.990
Other contributions	109.142	118.620	117.223
Amortization of deferred capital contributions	112.476	125.927	102.634
Research and designated contributions	98.432	116.179	100.507
Other revenues	37.775	41.355	39.249
Patients, clients and residents	13.590	24.635	19.604
Pharmacare	5.550	4.082	4.460
Investment income	2.238	12.875	3.053
	4,503.524	5,004.788	4,587.373

Note: Amounts as per 2022/23 audited financial statements, and do not include Operating Summary (revenues and expenses) for PHSA Agencies.

Regional Services Funding Allocation

2018/19 - $2.429 billion (per 2018/19 Post Final Funding Letter Update #2)
2019/20 - $2.555 billion (per 2019/20 Final Funding Letter)
2020/21 - $3.198 billion (per 2020/21 Post Final Funding Letter)
2021/22 - $3.192 billion (per 2021/22 Post Final Funding Letter)
2022/23 - $3.456 billion (per 2022/23 Post Final Funding Letter)
2023/24 - $4.003 billion (per 2023/24 Funding Letter Update #3)

Estimated Full-Time Equivalents (FTEs)

- According to Health Sector Compensation Information System 2022 data, (2023 data is expected in April 2024), the estimated number of FTEs is as follows:
    - Union – 12,501
    - Non-Union/Management – 4,474

Central Deposit Program

- PHSA participates in the Ministry of Finance/Provincial Treasury Central Deposit Program (see Health Authority Cash Management and Central Deposit Program Fact Sheet). The Central Deposit Program was created by the Provincial Treasury in response to a recommendation by the Office of the Auditor General to better manage cash holdings by health authorities.
- At Quarter 3, PHSA forecasts its 2023/24 year-end position will reflect the following:
    - Cash Balance in Central Deposit Program – $0.007 million
    - Cash and Cash Equivalents on Hand (Unrestricted) – $49.891 million
    - Cash and Cash Equivalents on Hand (Restricted) – $283.920 million
    - Portfolio Investment on Hand – $0

KEY BACKGROUND

- The Regional Services funding represents the vast majority of the PHSA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan, other health authorities, foundations, and fees paid by patients and other health insurers (e.g., fees for services provided to non-residents of Canada, parking and preferred accommodation).
- The PHSA is responsible for:
    - Planning in conjunction with regional health authorities, and in some cases providing direct funding, for specialized services, including cardiac services and programs; thoracic surgery; trauma services; Centre for Excellence in HIV/AIDS; and BC Autism Assessment Network.
    - Providing leadership and coordination, in conjunction with the Ministry on several system improvements in emergency care, surgical services, and specialized neonatal care.
    - Corporate governance and management for provincial agencies and services, including BC Cancer; BC Centre for Disease Control; BC Renal; BC Transplant; BC Mental Health and Substance Use; BC Women's Hospital and Health Centre; BC Children's Hospital and Health Centre; BC Children's Hospital and Sunny Hill Health Centre; and PHSA Cardiac Services BC.

LAST UPDATED

The content of this estimates note is current as of February 21, 2024, as confirmed by Peter Klotz, Executive Director, Regional Grants and Decision Support.

APPROVALS

2024-02-21 – Peter Klotz, Finance and Corporate Services Division
2024-02-21 – Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

C-07

Vancouver Coastal Health Authority

Topic: The Vancouver Coastal Health Authority (VCHA) is one of six health authorities created in 2001. The Ministry of Health provides annual operating funding directly to VCHA via the annual Regional Services funding allocation.

Key Messaging and Recommended Response:

- **It is the Ministry's Policy that health authorities (HAs) operate within balanced budgets.**
- **VCHA had a surplus of $1.721 million in its 2022/23 Audited Financial Statements excluding PHC and Louis Brier. (Revenues of $5,302.655 million less expenditures of $5,300.934 million).**
- **As at Quarter 3 of fiscal year 2023/24, the Ministry has committed to providing $4.635 billion to VCHA in Regional Services funding.**

CURRENT SITUATION

- VCHA reported a $1.721 million surplus in its 2022/23 Audited Financial Statements excluding affiliates, creating a surplus of $1.755 million with Providence Health Care (PHC) and Louis Brier Hospital included. Affiliate organizations receive funding from VCHA.
- PHC reported a 2022/23 surplus of $0.059 million (revenues of $1,243.778 million, less expenditures of $1,243.719 million). $792.960 million of the revenue was provided by VCHA.
- Louis Brier Hospital reported a 2022/23 loss of $0.025 million (revenues of $26.022 million less expenditures of $26.047 million). $18.706 million of the revenue was provided by VCHA.

FINANCIAL IMPLICATIONS

2022/23 Audited Financial Statements of VCHA (excluding PHC and Louis Brier)

Total Revenues	$5,302.655 million
Total Expenses	$5,300.934 million
Surplus (Deficit)	$1.721 million

2022/23 Breakdown of Total Revenues by Major Funding Source

Year ended March 31, 2023 ($ Millions)

	2023 Budget	2023 Actual	2022 Restated
Revenues			
Ministry of Health contributions	3,672.544	4,164.789	3,859.579
Medical Services Plan	339.010	345.413	333.052
Revenue from other health authorities and BC government reporting entities	199.918	236.902	202.088
Other contributions	182.905	190.973	186.333
Patients, clients and residents	151.629	156.041	118.484
Amortization of deferred capital contributions	103.404	129.490	101.488
Other	30.787	45.243	38.727
Research and designated revenue	20.000	18.024	16.529
Investment income	1.660	9.275	2.352
PharmaCare	5.502	6.505	6.268
	4,707.359	**5,302.655**	**4,864.900**

Note: Amounts as per 2022/23 audited financial statements.

Regional Services Funding Allocation (to VCHA from Ministry)

2018/19 - $2.842 billion (per 2018/19 Final Funding Letter)
2019/20 - $3.075 billion (per 2019/20 Final Funding Letter)
2020/21 - $3.706 billion (per 2020/21 Post Final Funding Letter)
2021/22 - $3.918 billion (per 2021/22 Post Final Funding Letter)
2022/23 - $4.174 billion (per 2022/23 Post Final Funding Letter)
2023/24 - $4.635 billion (per 2023/24 Funding Letter Update#3)

Estimated Full-Time Equivalents (FTEs)

- According to Health Sector Compensation Information System 2022 Quarter 4 data, the estimated number of FTEs, including PHC, but excluding other denominational affiliates and contracted agencies, is as follows:
    - Union – 21,395
    - Non-Union/Management – 2,929

Central Deposit Program

- VCHA participates in the Ministry of Finance/Provincial Treasury Central Deposit Program (see Health Authority Cash Management and Central Deposit Program Fact Sheet). The Central Deposit Program was created by the Provincial Treasury in response to a recommendation by the Office of the Auditor General to better manage cash holdings by health authorities.
- At Quarter 3, VCHA forecasts its 2023/24 year end position will reflect the following:
    - Cash Balance in the Central Deposit Program - $549.807 million
    - Cash and Cash Equivalents on Hand (Unrestricted) – $93.030 million
    - Cash and Cash Equivalents on Hand (Restricted) - $11.976 million
    - Portfolio Investment on Hand - $0

VCHA Population

- According to BC Stats, VCHA's population forecast and rate of growth is as follows:
    - 2023/24 – 1.327 million, 2.29% growth
    - 2024/25 – 1.343 million, 1.20% growth
    - 2025/26 – 1.359 million, 1.19% growth
- As of December 2023, approximately 18.26% of VCHA's population is age 65 and over.

KEY BACKGROUND

- This Ministry's Regional Services funding represents the vast majority of the VCHA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan

Provincial Health Services Authority, and fees paid by patients and other health insurers (e.g., fees for services provided to non residents of Canada, parking, preferred accommodation, etc.).

- Working in co-operation with the VCHA to provide health services within the VCHA region are two denominational affiliates or hospital societies established per the Hospital Act, namely PHC and Louis Brier Hospital in Vancouver. These denominational affiliates are separate legal entities, and each has its own board of directors and issues its own audited financial statements (two former denominational affiliates or hospital societies, R. W. Large Memorial Hospital in Bella Bella and Bella Coola General Hospital were absorbed by VCHA as of April 1, 2014).
- The Ministry does not provide Regional Services operating funding directly to the denominational affiliates; the VCHA is responsible for allocating operating funding to its denominational affiliates. The financial results of the VCHA and the denominational affiliates are consolidated in the Government Reporting Entity.

LAST UPDATED

The content of this estimates note is current as of February 6, 2024, as confirmed by Peter Klotz, Executive Director, Regional Grants and Decision Support.

APPROVALS

2024 02 20 - Peter Klotz, Finance and Corporate Services Division
2024 02 20 - Rob Byers, Finance and Corporate Services Division

C-07

LEGISLATIVE SESSION – ESTIMATES NOTE

Vancouver Island Health Authority

Topic: The Vancouver Island Health Authority (VIHA) is 1 of 6 health authorities created in 2001. The Ministry of Health provides annual operating funding directly to the VIHA via the annual Regional Services funding allocation.

Key Messaging and Recommended Response:

- **It is the Ministry's policy that health authorities operate within balanced budgets.**
- **VIHA reported a surplus of $5.478 million in its 2022/23 Audited Financial Statements excluding affiliates. (Revenues of $3,714.239 million less expenditures of $3,708.761 million).**
- **As at Quarter 3 of fiscal year 2023/24, the Ministry has committed to providing VIHA with $3.412 billion in Regional Services funding.**

CURRENT SITUATION

- VIHA had a surplus of $5.478 million in its 2022/23 Audited Financial Statements excluding affiliates, creating a surplus of $5.197 million with Mount St. Mary Hospital.
- As at Quarter 3 of fiscal year 2023/24, the Ministry has committed to providing VIHA with $3.412 billion in Regional Services funding.

FINANCIAL IMPLICATIONS

2022/23 Audited Financial Statements of VIHA (Excluding Mount St. Mary Hospital)

Total Revenues	$3,714.239 million
Total Expenses	$3,708.761 million
Surplus (deficit)	$5.478 million

2022/23 Breakdown of Total Revenues By Major Funding Source

Year Ended March 31, 2023 ($ Millions)

	Budget 2022/23	Actuals 2022/23	Actuals 2021/22
Revenues			
Ministry of Health contributions	2,912.671	3,085.944	2,821.924
Medical Services Plan	202.156	238.505	225.712
Patients, clients and residents	69.279	83.965	72.667
Amortization of deferred capital contributions	93.194	88.091	87.601
Recoveries from other health authorities and BC government reporting entities	138.424	148.510	138.062
Other contributions	4.815	3.801	4.269
Other revenues	36.299	61.769	46.013
Investment income	1.536	3.654	0.715
	3,458.374	3,714.239	3,396.963

Note: Amounts as per 2022/2023 audited financial statement.

Regional Services Funding Allocation (to VIHA from Ministry)

2019/20 - $2.256 billion (per 2019/20 Final Funding Letter)

2020/21 - $2.648 billion (per 2020/21 Post Final Funding Letter)

2021/22 - $2.905 billion (per 2021/22 Post Final Funding Letter)
2022/23 - $3.097 billion (per 2022/23 Post Final Funding Letter)
2023/24 - $3.412 billion (per 2023/24 Funding Letter Update #3)

Estimated Full-Time Equivalents (FTEs)

- According to Health Sector Compensation Information System 2022 data (2023 data is expected in April 2024), the estimated number of FTEs – excluding Mount St. Mary Hospital, St. Joseph's General Hospital and other contracted agencies – is as follows:
    - Union – 16,263
    - Non-Union/Management – 1,809

Central Deposit Program

- VIHA participates in the Ministry of Finance/Provincial Treasury Central Deposit Program (see Health Authority Cash Management and Central Deposit Program Fact Sheet). The Central Deposit Program was created by the Provincial Treasury in response to a recommendation by the Office of the Auditor General to better manage cash holdings by health authorities.
- At Quarter 3, VIHA forecasts its 2023/24 year-end position will reflect the following:
    - Cash Balance in the Central Deposit Program – $145.230 million
    - Cash and Cash Equivalents on Hand (Unrestricted) – $21.817 million
    - Cash and Cash Equivalents on Hand (Restricted) – $30.966 million
    - Portfolio Investment on Hand – $0

VIHA Population

- According to BC Stats, VIHA's population forecast and rate of growth is as follows:
    - 2023/24 – 0.938 million, 2.90% growth
    - 2024/25 – 0.954 million, 1.70% growth
    - 2025/26 – 0.969 million, 1.59% growth
- As of December 2023, approximately 25.6% of VIHA's population is age 65 and over.

KEY BACKGROUND

- This Ministry's Regional Services funding represents the vast majority of the VIHA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan, the Provincial Health Services Authority, and fees paid by patients and other health insurers (fees for services provided to non-residents- of Canada, parking, and preferred accommodation, etc.).
- Working in cooperation with the VIHA to provide health services within the VIHA region are 2 denominational affiliates or hospital societies established per the *Hospital Act*, namely Mount St. Mary Hospital in Victoria and St. Joseph's General Hospital in Comox. These denominational affiliates are separate legal entities, and each has its own board of directors and issues its own audited financial statements.
- St. Joseph's General Hospital transferred its acute care services to the VIHA on October 1, 2017, through the North Island Hospital, Comox Valley, Courtenay. St. Joseph's General Hospital continues to operate 117 residential care beds and 4 hospice beds at its Comox site. St. Joseph's General Hospital reached an agreement with Providence Residential and Community Care Services Society (PRCC) to transfer ownership and operation of St. Joseph's General Hospital to PRCC effective April 1, 2019, at which time was superseded by PRCC as an affiliate of the VIHA.
- The Ministry does not provide Regional Services operating funding directly to the denominational affiliates; the VIHA is responsible for allocating operating funding to its denominational affiliates. The financial results of the VIHA and the denominational affiliates are consolidated in the Government Reporting Entity.

LAST UPDATE

The content of this estimates note is current as of February 20, 2024, as confirmed by Peter Klotz, Executive Director, Regional Grants and Decision Support.

LEGISLATIVE SESSION – ESTIMATES NOTE

C-07

APPROVALS

2024 02 20 - Peter Klotz, Finance and Corporate Services Division
2024 02 20 - Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

D-01

Capital Budget 2024/25 to 2026/27

Topic: Ministry of Health funding for health authority (HA) capital projects under the current 3-year budget and fiscal plan.

Key Messaging and Recommended Response:

- **Government continues to make historic investments in the expansion and upgrading of health facilities across BC.**
- **By investing in new and existing public health-care facilities, people will have even better access to care. These projects also create jobs and stimulate economic activity.**
- **Capital spending on infrastructure in the health sector will total $13.0 billion over the next three years – a record level of investment.**
- **These investments support new major construction projects and upgrading of health facilities, medical and diagnostic equipment, and IM/IT systems. Examples include:**
  - **New St. Paul's Hospital**
  - **Royal Columbian Hospital Redevelopment**
  - **Richmond Hospital Redevelopment**
  - **New Surrey Hospital and BC Cancer Centre**
  - **Burnaby Hospital Redevelopment Phases 1, 2, and BC Cancer Centre**
  - **Mills Memorial Hospital Replacement**
  - **Dawson Creek & District Hospital Replacement**
  - **Stuart Lake Hospital Replacement**
  - **Cariboo Memorial Hospital Redevelopment**
  - **Cowichan District Hospital Replacement**
  - **Eight Long-Term Care facility redevelopment or replacement projects**
  - **New cancer centres in Kamloops and Nanaimo**

- **These investments over the next three years are supported by funding from the Province (84% of the total) as well as other sources (16% of the total), such as Regional Hospital Districts and Hospital Foundations.**

CURRENT SITUATION

The current 3-year budget and fiscal plan has a total of $10,878 million in Restricted Capital Grant (RCG) funding for HAs. Other sector funding of $2,130 million brings the total 3-year capital budget to $13,008 million.

FINANCIAL IMPLICATIONS

- The Ministry provides HAs with RCG for major construction, equipment, IMIT, and upgrading of existing health facilities over $100,000. This funding is provided through the Health Facilities sub vote of the Capital Funding Vote in Other Appropriations.
- Under the current 3-year budget and fiscal plan, the Ministry's capital budget for HAs is:

Health Sector Capital Spending Budgets	Forecast	Budget 2024			Total 2024/25 to 2026/27	% of Total 2024/25 to 2026/27
$ Millions	2023/24	2024/25	2025/26	2026/27		
Government Financial Information						

- The split of Restricted Capital grant funding between Priority Investment projects and annual Routine Capital Investment spend is:

Restricted Capital Grants $ Millions	2023/24	2024/25	2025/26	2026/27	Total 2024/25 to 2026/27	% of Total 2024/25 to 2026/27
Government Financial Information						

Sources:

- Ministry Capital – 2023/24 – amounts as per Q3 22/23 capital submission to Ministry of Finance (FIN).
- Ministry Capital – 2024/25 to 2026/27 – amounts per Q3 23/24 capital submission to FIN.

KEY BACKGROUND

HAs obtain additional capital funding from own-source revenues, Regional Hospital Districts, Foundations, and Auxiliaries.

RCG Funding

- The current 3-year budget and fiscal plan includes funding for:
  - Hospital redevelopment and replacement projects.
  - Investments in new and replacement medical and diagnostic equipment, such as MRI and CT machines.
  - Investments in information management and technology.
  - Investments in projects to reduce energy costs, demonstrate clean energy, and lower carbon emissions as part of the Carbon Neutral Capital Program.
  - Investments to address asset rehabilitation, upgrades, and renovations at various facilities across BC.

  - Investments to support and improve cancer care
  - Renewal and expansion of long-term care facilities, and
  - Primary care networks and Urgent and Primary Care Centres (UPCCs).
- All major capital projects with a total capital cost of $50 million or more and an approved business plan are summarized in the "Over $50 million Table" in the quarterly financial reports released by the Ministry of Finance. Currently, there are 33 health capital projects included in the $50 million table contained in the Budget and Fiscal Plan 2024/25 – 2026/27, reflecting costs to December 31, 2023. As capital projects span multiple fiscal years, not all the funding for these projects is included in the current 3-year budget and fiscal plan period.

Public Private Partnerships (P3)

There is currently $440 thousand of trailing costs remaining on the Royal Inland Hospital Patient Care Tower project that will be paid by fiscal 2024/25. There are no other P3 projects active nor future projects planned at this time.

Non-RCG Capital Funding and Maintenance Allocation (for items <$100k)

The Ministry also provides funding from the operating budget to be used for minor construction, equipment, and capital upgrading costing less than $100,000, as well as capital maintenance. This funding is approximately $77 million per annum with some additional one-off funding provided for renal projects and faculty of medicine expenditure allocated each year.

LAST UPDATED

The content of this estimates note is current as of February 8, 2024, as confirmed by Mark Bell, Executive Director, Capital Services Branch, Financial and Corporate Services Division.

APPROVALS

2024 02 08 – Mark Bell, Capital Services Branch, Finance and Corporate Services
2024-02-20 - Rob Byers, Financial and Corporate Services Division

D-02

LEGISLATIVE SESSION – ESTIMATES NOTE

Capital Funding for Long-Term Care Renewal and Expansion

Topic: Status update on Long-term Care (LTC) renewal and expansion.

Key Messaging and Recommended Response:

- **Investment in the renewal and expansion of health authority LTC facilities is a priority for the capital plan.**
- **The overriding objective is to replace outdated facilities and eliminate multi-bed rooms, while also adding to the supply of health authority-owned beds to help meet growing demand.**
- **To date, eight (8) project business plans have been approved and publicly announced as part of the LTC renewal and expansion initiative.**
- **All projects are currently in the procurement and design stage with construction expected to start in 2025.**
- **The eight projects will provide 1,691 beds in single occupancy rooms built to current standards in modern facilities and over 1,100 of those will be net new beds.**
- **All the LTC projects include childcare spaces and older adult day program spaces**

CURRENT SITUATION

- Cabinet Confidences; Government Financial Information

LEGISLATIVE SESSION – ESTIMATES NOTE

Table 1 – Approved LTC Projects

Project Name	Location	# LTC Beds	# Beds Replaced	# Net New Beds	Gov't Approved	Announced	Total Project Cost $000	Provincial Funding $000
St. Vincent's Heather Care Home	Vancouver	240	225	15	Jul-22	Mar-22-23	206,754	206,754
Western Communities LTC home	Colwood	306		306	Sep-22	Mar-16-23	223,694	156,585
Cottage-Worthington Replacement	Abbotsford	200	109	91	Apr-23	Jun-23-23	210,914	157,469
Richmond Lions Manor Replacement	Richmond	158	86	72	Apr-23	Jun-22-23	177,653	177,653
Nanaimo (Lantzville) LTC	Nanaimo	286		286	Apr-23	Oct-19-23	285,762	171,457
Mountain View Manor Replacement	Delta	200	92	108	Apr-23	Jun-08-23	179,702	161,452
Campbell River LTC	Campbell R.	153		153	Apr-23	Jul-19-23	134,074	80,444
FW Green Replacement	Cranbrook	148	60	88	Jul-23	Sep-18-23	156,494	93,896
Subtotal Approved/Announced Projects		**1,691**	**572**	**1,119**			**1,575,047**	**1,205,710**

Cabinet Confidences; Government Financial Information

FINANCIAL IMPLICATIONS

- Cabinet Confidences; Government Financial Information
-
- The capital cost and funding sources of each project will be confirmed in the project business plans and announced after the Business Plans are approved.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

CONFIDENTIAL INFORMATION – NOT PUBLICLY DISCLOSED

Advice/Recommentations; Cabinet Confidences

Advice/Recommentations; Cabinet Confidences bringing the total amount of funding to just over $2 billion.

Advice/Recommentations; Cabinet Confidences

LAST UPDATED

The content of this estimates note is current as of February 28, 2024, as confirmed by Mark Bell, Acting Executive Director, Capital Services Branch.

APPROVALS

2024 02 07 – Rob Byers, Finance and Corporate Services Division
2024 02 28 – Mark Bell, Capital Services Branch, Finance and Corporate Services Division

D-03

LEGISLATIVE SESSION – ESTIMATES NOTE

COVID-19 Capital Expenditures

Topic: Status update on capital expenditures to support the COVID-19 pandemic response.

Key Messaging and Recommended Response:

- **On March 18, 2020, the Province declared a Provincial State of Emergency in response to the COVID-19 pandemic.**
- **In September 2020, Treasury Board approved $149.25 million in additional capital expenditures for the Ministry of Health to help with the response to the COVID-19 pandemic.**
- **Of that amount, $133.95 million was allocated to health authorities for a variety of initiatives focusing on renovations and equipment needed for the pandemic response.**
- **This includes enhancing surge capacity in COVID-19 designated hospitals, supporting the Province's surgical strategy, and acquiring additional medical resources such as physical beds and stretchers, ventilators, patient monitors, and defibrillators.**
- **The funds also contribute to additional IM/IT infrastructure to support increasing data needs, virtual care, and contact tracing, as well as providing lab testing equipment, upgrading warehouse facilities, and improving medical imaging capabilities.**
- **Furthermore, the funding supports additional BCEHS capacity, including refurbishment or replacement of ambulances to participate appropriately in the Rural Remote and Indigenous Framework and to be prepared for additional surge capacity in the event of a COVID-19 resurgence in the fall/winter.**
- **The remaining $15.3 million was for Ministry IM/IT projects and funded from the Consolidated Revenue Fund (CRF).**

CURRENT SITUATION

- In September 2020, Treasury Board approved $149.25 million in additional capital expenditures for the Ministry of Health to help with the response to the COVID-19 pandemic.
- $133.95 million was allocated to health authorities for the initiatives summarized in Table 1.
- The remaining $15.3 million was for Ministry IM/IT projects. Expenses incurred for these projects in 2020/21 were funded from the Consolidated Revenue Fund (CRF) capital contingencies vote.

LEGISLATIVE SESSION – ESTIMATES NOTE

Table 1: Allocation of COVID-19 Capital Funding

COVID 19 Capital		Approved Funding As per Letters						
	Initiative	FHA	IHA	NHA	PHSA	VCHA	VIHA	Total
1	Surgical Renewal	$ 5,000,000	$ 5,558,000	$ 4,100,000	$ -	$ 1,530,871	$ 5,600,000	$ 21,788,871
2	HAU, ICU Renovations	$ -	$ -	$ -	$ -	$ -	$ 9,832,527	$ 9,832,527
3	Beds & Stretchers	$ -	$ 5,819	$ 315,000	$ 8,182,998	$ 3,103,856	$ 689,744	$ 12,297,416
4	Ventilators	$ -	$ 604,500	$ 795,474	$ 7,041,149	$ 1,664,989	$ 224,049	$ 10,330,161
5	Monitors/Defibrillators	$ -	$ 77,537	$ 13,641	$ 9,365,666	$ 1,384,898	$ 327,540	$ 11,169,282
6	IM/IT Infrastructure (HA Capital)	$ 3,694,683	$ 900,000	$ 233,690	$ 10,442,188	$ 15,680	$ 3,262,534	$ 18,548,775
7	Lab Testing Equipment	$ 3,985,809	$ 3,775,008	$ 1,770,222	$ 12,447,879	$ 2,450,698	$ 591,653	$ 25,021,269
8	BCCDC Vaccine Warehouse Upgrades	$ -	$ -	$ -	$ 4,250,000	$ -		$ 4,250,000
9	Medical Imaging	$ 762,552	$ 350,000	$ -	$ -	$ 264,252	$ 635,268	$ 2,012,072
10	Ambulances	$ -	$ -	$ -	$ 12,426,709	$ -		$ 12,426,709
11	Other Equipment	$ 1,651,050	$ 1,102,631	$ 83,042	$ 1,621,720	$ 528,632	$ 1,286,713	$ 6,273,788
	HA Total	**$ 15,094,094**	**$ 12,373,495**	**$ 7,311,069**	**$ 65,778,309**	**$ 10,943,876**	**$ 22,450,028**	**$ 133,950,871**

FINANCIAL IMPLICATIONS

- Provincial capital funding totalling $119.6 million has been spent to date with $13.0 million forecasted to be spent by the end of fiscal 2024/25. There is currently projected to be $1.4 million in savings from the original approved allocations. See Table 2 for greater detail.

Table 2: Current and Forecasted COVID-19 Capital Spending

Health Authority	Approved Funding	Historic Spending			Forecasted Spending		Total	Projected Savings
		2020/2021	2021/2022	2022/2023	2023/2024	2024/2025		
FHA	**$ 15,094,094**	$ 7,239,202	$ 3,186,995	$ 2,284,565	$ 1,818,739	$ -	**$ 14,529,501**	**$ 564,593**
IHA	**$ 12,373,495**	$ 9,537,039	$ 1,884,159	-$ 2,343	$ 162,109	$ -	**$ 11,580,964**	**$ 792,531**
NHA	**$ 7,311,069**	$ 5,128,956	$ 721,865	$ 1,460,248	$ -	$ -	**$ 7,311,069**	**$ -**
PHSA	**$ 65,778,309**	$ 37,800,679	$ 13,414,888	$ 3,581,288	$ 9,631,454	$ 1,350,000	**$ 65,778,309**	**$ -**
VCHA	**$ 10,943,876**	$ 8,271,949	$ 2,480,153	$ 191,698	$ -	$ -	**$ 10,943,800**	**$ 76**
VIHA	**$ 22,450,028**	$ 20,160,847	$ 2,289,181	$ -	$ -	$ -	**$ 22,450,028**	**$ -**
Total	**$ 133,950,871**	**$ 88,138,672**	**$ 23,977,241**	**$ 7,515,456**	**$ 11,612,302**	**$ 1,350,000**	**$ 132,593,671**	**$ 1,357,200**

- The Ministry spent $8.4 million in 2020/21 for five Ministry IM/IT projects as part of its response to the COVID-19 pandemic and a further $3.8m in 2021/22 for COVID-19 Ministry IM/IT projects. Funding came from the CRF.

KEY BACKGROUND

- On March 18, 2020, BC declared a Provincial State of Emergency to support the province-wide response to the COVID-19 pandemic - one day after the Provincial Health Officer declared a Public Health Emergency on March 17, 2020.
- From the outset, BC responded with clear guidance, transparency, and an evidence-based approach to fight against COVID-19.
- Health authorities, including the regional health authorities and the Provincial Health Services Authority and agencies, have responded to the pandemic in part by identifying required equipment and renovations to prepare for surges in demand for testing and patient care, and by supporting increased infection control requirements.
- The capital funding is mostly for renovations and equipment needed for the pandemic response, including:
  - Renovations to enable surge capacity in COVID-19 designated hospitals;
  - Equipment and renovations to support the Province's surgical strategy;
  - More physical beds and stretchers, ventilators, patient monitors, and defibrillators to address anticipated surges in bed requirements, provide acute capacity overflow, support critically ill patients, stock BC Emergency Health Services (BCEHS) vehicles, support remote monitoring, and enable enhanced infection control and limit transmission between patients;

- Additional IM/IT infrastructure to support increasing data needs, virtual care, and support for contact tracing;
- Lab testing equipment for BC Centre for Disease Control (BCCDC) and health authorities;
- BCCDC warehouse upgrades and increased fridge capacity;
- Additional medical imaging and imaging systems equipment, including portable and mobile equipment and systems to enable remote viewing; and
- Additional BCEHS capacity, including refurbishment/replacement of up to 55 ambulances to participate appropriately in the Rural Remote Framework, and to also be prepared for additional surge capacity in the event of a COVID-19 resurgence in the fall/winter.

LAST UPDATED

The content of this estimates note is current as of February 9, 2024, as confirmed by Mark Bell, A/Executive Director, Capital Services Branch

APPROVALS

2024 02 09 – Mark Bell, Capital Services Branch, Finance and Corporate Services Division
2024 02 20 - Rob Byers, Finance and Corporate Services Division

LEGISLATION SESSION - ESTIMATES NOTE

D-04

New Regional Cancer Centres in Nanaimo and Kamloops

Topic: Status of planning for new regional cancer centres in Nanaimo and Kamloops.

Key Messaging and Recommended Response:

- **People are one step closer to accessing enhanced health services as the government approved the business plan for the new BC Cancer centre at Royal Inland Hospital in Kamloops and procurement is underway with the release of RFQ.**
- **Approval of the business plan is a critical milestone for this crucial project.**
- **This state-of-the-art cancer centre will benefit patients in Kamloops and the surrounding area by offering the confidence from knowing that we're building treatment capacity for now and the future.**
- **Construction will start in 2025.**
- **We expect news soon on the business plan for the Nanaimo Cancer Centre.**

CURRENT SITUATION

- The cancer centres will be located on the campuses of the Nanaimo Regional General Hospital (NRGH) and the Royal Inland Hospital (RIH) in Kamloops.
- Planning for the Cancer Centres was led by the Provincial Health Services Authority (PHSA) and BC Cancer, in collaboration with Interior Health Authority (IHA), Vancouver Island Health Authority (VIHA) and the Ministry of Health.
- Concept plans were approved by Treasury Board and announced in May 2023.
- The Kamloops Cancer Centre business plan was approved by Treasury Board on January 30, 2024, and announced on February 8, 2024.
- The Design Build Request for Qualifications (RFQ) was issued on February 16, 2024.
- The Nanaimo Cancer Centre business plan was presented to Treasury Board at the end of February 2024.
- Cabinet Confidences

- The table below summarizes the scope of each project and the estimated total capital cost.

Project	Preliminary Scope	Total Project Cost
Kamloops Cancer Centre	**The new building** will provide space for: • Patient arrival and check-in. • Radiation treatment, including three shielded treatment rooms ("bunkers") for high energy radiation treatment Linear Accelerators (LINACS), which is planned to meet demand to 2041. • Radiation therapy planning, including a CT Simulator. • An outpatient ambulatory care unit, including 10 exam rooms and 2 consult rooms. • Staff support, including offices and workstations. • A net new MRI suite with change rooms, intravenous preparation space and scanner.	$359.04M The RHD is finalizing tl contribution Cabinet Confidences; Government Financial Information

Project	Preliminary Scope	Total Project Cost
	• Approximately 470 parking stalls (including 48 electric vehicle and 12 accessible stalls) as a part of an attached parkade. **Host hospital upgrades** include: • Renovation and relocation of the existing CON clinic to improve functionality/design and to update treatment spaces to current standards and ensure the space is more appropriately sized. The systemic treatment spaces remain at 17 and ambulatory care exam rooms expand from 7 to 10. • Renovations to the existing Pharmacy, moving administrative functions out of the pharmacy space to accommodate growth. Subsequently, a renovation within the existing Pharmacy will be conducted to improve flow of materials, increased security measures, improved function for receiving and decanting of product, improved dispensing and automated dispensing cabinet replenishing area, and storage. • Renovations to make space available for the displaced administrative offices from the Pharmacy expansion. In total, approximately 1,000 to 2,000 m^2 of renovation and 19,000 to 20,000 m^2 of new construction is anticipated (4,000 m^2 dedicated to the cancer centre and the rest making up the parkade).	
Nanaimo Cancer Centre Cabinet Confidences	**The new building** will provide space for: • Patient arrival and check-in. • Radiation treatment, including four shielded treatment rooms ("bunkers") for high energy radiation treatment Linear Accelerators (LINACS), which is planned to meet demand to 2041. • Radiation therapy planning, including a CT Simulator. • An outpatient ambulatory care unit, including 12 exam rooms and 4 consult rooms. • Staff support, including offices and workstations. • A net new PET/CT machine. **Host hospital expansion and upgrades** include: • Renovations to the existing Ambulatory Care Building as well as a new single-story addition of approximately 1,303 square meters will enable the expansion of the CON and the Pharmacy. • The CON will include 16 treatment bays, 2 private treatment rooms, 5 exam/consult rooms, 6 physician offices, a medication room, a sterile utility room, a soiled utility room, a nutrition station, staff and patient washrooms, and service space. • The Pharmacy will be NAPRA compliant and include shipping/receiving, unpack and storage, outpatient pharmacy, a compounding room, staff change/washrooms, service space. • Renovations to make space available for an additional six inpatient beds. • A 90 stall parkade adjacent to the Ambulatory Care Building and the Cancer Centre that will nearly replace 91 stalls lost due to construction as well as 165 new surface parking stalls (164 total net new parking stalls). In total, approximately 1,300 BGSM of renovation and 5,885 BGSM of new constr is anticipated.	$288.76M Cabinet Confidences; Government Financial Information

FINANCIAL IMPLICATIONS

- The total project cost of the Kamloops Cancer Centre is estimated to be $359.04M Cabinet Confidences; Cabinet Confidences; Government Financial Information

- The TRHD has expressed support towards funding the parkade, MRI, Community Oncology Clinic and Pharmacy upgrades. Government Financial Information

  Government Financial Information
- The total project cost of the Nanaimo Cancer Centre is estimated to be $288.76M.

  Cabinet Confidences; Government Financial Information

KEY BACKGROUND

Government Commitments

- The NDP Platform released on October 6, 2020, commits to establishing a 10-year cancer care plan.
- At a campaign stop on October 7, 2020, in Vancouver, Premier Horgan committed to a 10-year cancer plan that includes new cancer centres at Nanaimo and Kamloops.
- An NDP Press Release on October 17, 2020, noted the NDP's commitment to deliver a new cancer centre in Kamloops as part of the 10-year cancer plan.
- On May 25, 2023, the province announced approval of the concept plan for the Kamloops Cancer Centre. Although the news release did not contain cost or schedule information, the Minister did say "he expects the building to be ready to see patients in 2027 and that cancer centres typically cost between $200 and $300 million".
- On May 26, 2023, the province announced approval of the concept plan for the Nanaimo Cancer Centre. Although the news release did not contain cost or schedule information, the Minister did say "the intention is to have the centre open in 2027 and that cancer centres of this scope typically cost $200-300 million".
- On February 8, 2024, the province announced approval of the business plan for the Kamloops Cancer Centre. The project budget is approximately $359 million, shared between the provincial government, Interior Health, and Thompson Regional Hospital District. The procurement process is underway with the release of the RFQ on February 15, 2024. Construction is expected to begin in 2025 and be completed in 2028.

LAST UPDATED

The content of this fact sheet is current as of March 11, 2024, as confirmed by Mark Bell, A/Executive Director, Capital Services Branch

APPROVALS

2024 03 11 – Mark Bell, Capital Services Branch
2024 03 11 – Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

D-05

New Surrey Hospital and BC Cancer Centre

Topic: Status and scope of the New Surrey Hospital and BC Cancer Centre project.

Key Messaging and Recommended Response:

- **The New Surrey Hospital and BC Cancer Centre project is currently in construction and estimated to open to patients in 2030.**
- **Activity currently includes detailed design and site construction activity, including completed site stripping and construction of a guide wall.**
- **The project will increase capacity to improve access to services and help meet the needs of a growing and aging population, while reducing congestion and overflow pressures at Surrey Memorial Hospital and the Jim Pattison Outpatient Care & Surgery Centre, and providing a new BC Cancer Centre for the residents of Surrey.**

CURRENT SITUATION

- The New Surrey Hospital and BC Cancer Centre (NSHBCCC) project is currently in construction and estimated to open to patients in 2030.
- Fraser Health Authority (FHA) executed a Design Build Agreement and Enhanced Inclusion Development Agreement with with EllisDon Design Build Inc. (EllisDon) in September 2023.
- A ground breaking ceremony was held on September 12, 2023, including representation from the the Kwantlen, Katzie and Semiahmoo (KKS) First Nations.

Intergovernmental Communications

- EllisDon will be responsible to complete the design and construct the new facility. Current activity includes design development and site construction including completed site stripping and excavation and construction of a guide wall to support the perimeter diaphragm wall.
- Upcoming construction activity includes start of diaphragm (retaining) walls in February 2024, start of piles installation in February 2024, and start of benching and tie backs in July 2024.
- The NSHBCCC project, including scope of services, was planned through the detailed concept and business planning process, led by FHA in partnership with BC Cancer and Provincial Health Services Authority (PHSA).
- The NSHBCCC project will increase capacity to improve access services and help meet the needs of a growing and aging population, while reducing congestion and overflow pressures at Surrey Memorial Hospital, Jim Pattison Outpatient Care & Surgery Centre and at BC Cancer - Surrey.
- The new state-of-the-art smart hospital will be digitally equipped and technologically advanced. It will be a fully electric hospital, one of the first in Canada.
- The approved scope of the NSHBCCC project is an integrated community hospital and cancer centre of approximately 70,000 m^2 in size that includes:
    - Inpatient services with 168 acuity adaptable inpatient beds;
    - Virtual care throughout all clinical service areas;

  - Surgical/perioperative suite with 4 operating rooms, 4 procedure rooms and a brachytherapy suite;
  - Emergency department with 55 treatment spaces;
  - Outpatient ambulatory care with 27 exam rooms/chairs;
  - Medical imaging department, including 3 CT scanners, 2 MRI machines, 6 general radiology rooms, 1 bone density room, 5 mammography rooms, 4 echocardiogram rooms, and 6 ultrasound rooms;
  - Pharmacy, laboratory, academic spaces, and facility and clinical support services;
  - Dedicated area for spiritual care and family gatherings that support cultural diversity and spiritual practices;
  - New BC Cancer Centre with an oncology ambulatory care unit with 50 exam rooms; 54 chemotherapy treatment spaces; room for 6 linear accelerators for radiation therapy (5 equipped at opening); functional imaging, including 2 PET/CT machines and a new Cyclotron for production of radioisotopes; clinical trials unit, oncology pharmacy, and administrative space;
  - Parking of approximately 730 stalls, including surface and underground parking; and
  - 49 space Childcare Centre.
- The NSHBCCC project will support Government policy objectives, including: climate resilience and energy conservation measures; childcare spaces; and, labour objectives, including promoting apprentices in construction, representation of underrepresented groups in construction and design, and Indigenous cultural and business opportunities.

FINANCIAL IMPLICATIONS

The total estimated capital cost of the Project is $2.88 billion, with $2.82 billion funded by the Province and the remaining $60 million by the BC Cancer and Surrey Hospitals Foundations.

- Increased costs since business plan are attributable to: increased land acquisition cost, higher than expected design and construction costs since business plan due to market volatility, plus proportional increases in risk reserves and soft costs, related to anticipated change in BC Building code, larger design solution with deeper excavation and more extensive geotechnical and soil conditions treatment, longer proponent schedule, continued shortages in skilled trades, material and consultants, and negotiated labour rate increases.

KEY BACKGROUND

- Expansion of health services in Surrey is needed to meet a rapidly growing and aging population and to help alleviate capacity constraints at existing facilities in Surrey.
- On December 18, 2017, the planning for a new hospital was announced in Surrey.
- On May 29, 2019, FHA submitted a Concept Plan for a New Surrey Hospital (the NSH) to the Ministry of Health.
- In July 2019, Treasury Board approved the Concept Plan for the NSH, and for FHA to proceed to business planning for a preferred site beside Kwantlen Polytechnic University (KPU) at 5500 180 Street in Cloverdale. This approval was announced on December 9, 2019 in Surrey.
- On June 17, 2020, Treasury Board approved the addition of an integrated cancer centre and rightsizing of the host hospital to the project scope.
- On November 30, 2020, the FHA submitted the NSHBCCC Business Plan to the Ministry of Health and to the FHA Capital Project Board, which provided oversight for the development of the Business Plan and will continue to oversee the project through to completion.
- Government approved the NSHBCCC business plan in March 2021.
- Government announced the issuing of a Release for Qualifications (RFQ) for the Project in November 2021. Two proponents were shortlisted in the RFQ process, which ended on March 17, 2022. The two proponents were EllisDon Design Build Inc. and PCL Construction Ltd.

- The Request for Proposals (RFP) was issued on June 30, 2022 to the two proponents. At the time, the announcement indicated that the construction was expected to start in summer 2023, with facility scheduled to be ready for patients in 2027.
- The Preferred Proponent approval occurred July 2023 and early works agreement in August 2023. The DBA execution was September 2023. A traditional Design Build procurement provides a fixed price, fixed schedule result so the final construction schedule is set by the builder, in this case EllisDon Inc. Construction is now expected to be complete in late 2029 with opening to patients anticipated in early 2030. The primary reasons for the longer construction are likely due to EllisDon's larger than expected design and soil and geotechnical solution.
- Formal First Nations Consultation with the KKS on the land transfer for NSHBCCC from KPU to FHA took place between December 2019 and May 2022, when a final consultation close-out letter was issued to the KKS. Following approval of the land transfer by Ministry of Post-Secondary Education and Future Skills (PSFS) on June 24, 2022, KPU and FHA executed the purchase and sale agreement on January 9, 2023, with subject removal and closing competed in August 2023.

LAST UPDATED

The content of this estimates note is current as of February 7, 2023, as confirmed by Mark Bell, Acting Executive Director, Capital Services.

APPROVALS

2024 02 20 – Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

E-01

Measure of Attachment to a Primary Care Provider

Topic: "Attachment" describes an ongoing care relationship between a primary care provider and a patient. The relative size of the unattached population is an indicator of the need for primary care resources.

Key Messaging and Recommended Response:

- **Since announcing the expansion of the Health Connect Registry (HCR) in July 2023, the Province has built out remaining elements of the Provincial Attachment System, which includes a Clinic and Provider Registry and a Patient Panel Registry.**
- **Together, these will enable us to streamline and improve connections between patients and providers available for attachment in communities throughout BC.**
- **As of February 7, 2024, more than 50,000 people have been connected to primary care through the HCR.**
- **There are now more than 230 new family physicians committed to providing longitudinal primary care under the program since we launched the New to Practice Incentives Program for Family Physicians in September 2022.**
- **There are also more than 230 nurse practitioners working in longitudinal primary care under service contracts.**
- **More than 243,000 patients have been attached through this program, with an estimated 222,500 future attachments remaining before they reach the end of their contracts.**
- **There has been unprecedented growth in demand for health-care services over the past 5 years with Family Physicians delivering nearly 2.7M more services in 2022/23 than in 2017/18.**

CURRENT SITUATION

- The Ministry of Health has historically relied on two measures to estimate patient attachment:
  - The Ministry's attachment algorithm (provincial and community level estimates).
  - Canadian Community Health Survey data (Statistics Canada survey).
- Additional measures are being used to estimate need and track the progress of the Ministry's Primary Care Strategy.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

Current/Historical Attachment Measures

The Attachment Algorithm

- The algorithm is derived from Medical Services Plan (MSP) data on patterns of primary care use. It has the advantage of using administrative data to generate a full-system view of how patients access primary care.
- The algorithm does not provide any information on how patients and providers view their care relationship.
- Patients may be categorized as attached, unattached, or unknown.
    - A patient is categorized as **attached** if: The majority of a minimum of 5 primary care visits in (up to) the last 10 years were made to the same primary care provider or group practice, or a patient does not have 5 visits but has 3 visits to the same practice/provider.
    - A patient is categorized as **unattached** if the patient has the minimum 5 visits in up to 10 years but does not have a majority with a primary care practice/provider.
    - A patient is categorized as **unknown** if the patient does not have the minimum 5 visits in up to 10 years and does not have 3 visits to the same practice.
- Attachment to an individual provider is also calculated, although attachment to a group/solo practice is the measure most commonly used because it better reflects the reality of primary care delivery; a patient may have a primary care provider but may not see the same provider each time they visit the practice.
- The unattached grouping is the population of focus; these are patients who use primary care, but who do not seem to have a longitudinal relationship with a provider.
- The unknown population uses very little primary care and is similar in magnitude to the percent of BC residents who say they are not looking for a provider in the Canadian Community Health Survey.
- Compared to the over all population, the unattached population tends to be:
    - More male: 53.9%, compared to 47.0% of the attached and 49.5% of the total populations.
    - Younger: average age of the unattached is 35, compared to 47 in the attached and 43 overall.

Table 2. Attachment Algorithm Patient Attachment Status for Last 5 Fiscal Years[1]

	Attached		Unattached		Unknown	
Fiscal Year	Residents	Percent	Residents	Percent	Residents	Percent
2022/23	4,270,911	75.5%	692,373	12.2%	691,864	12.2%
2021/22	4,219,425	77.2%	663,305	12.1%	584,326	10.7%
2020/21	4,111,389	77.3%	686,514	12.9%	519,631	9.8%
2019/20	3,960,990	75.4%	774,372	14.7%	515,128	9.8%
2018/19	3,866,618	75.3%	799,115	15.6%	467,287	9.1%

Statistics Canada's Annual Canadian Community Health Survey (CCHS)

- The CCHS provides a patient (aged 12+) perspective on attachment that is unavailable in the attachment algorithm calculation and been frequently used in Ministry communications.
- Estimates at the provincial level are comparable across jusrisdictions. Results in 2022 estimated 83.4% of British Columbians aged 12+ reported having a regular primary care provider, compared with 86% for Canada. BC was 7th of 10 provinces, Ontario was first with 90.2%.
- The CCHS does not have sufficient sample to enable BC to compare rates over time. Recognizing this, the 2023 CCHS has a significantly larger sample. Provincial results for 2023 will be available in July 2024.

Table 1. Canadian Community Health Survey, 2022. Estimate of those with and without a regular healthcare provider

Year	Percent with regular provider	Percent with no regular provider	BC population	Estimated number without provider
2022	83.4%	16.6%	5,319,324	883,008
2021	83.0%	17.0%	5,202,378	884,404

[1] Ministry of Health, Health Sector Information, Analysis, & Reporting Division, Client Roster Database, Extracted February 13, 2023.

Provincial Attachment System (PAS)

- Planning and performance monitoring requires current numbers and rates of attached and unattached people geographically and demographically. The Ministry is developing the PAS for this purpose.
- Longitudinal family physicians and nurse practitioners are currently uploading their patient panels to the PAS.
- Once panels have been uploaded, a data quality exercise and clarification of the Most Responsible Provider for patients who appear on multiple panels will take place.
- Once complete, the Ministry and its partners will have a comprehensive view of how many people have a primary care provider and where additional providers and care are most required.

On-Going Monitoring of Attachment

- Attachment progress towards a PCN community's target is tracked via a $0 fee item which practitioners enter into the MSP system when they meet with and agree to take on a patient.
- As of January 5, 2024, 408,926 people have been attached through Primary Care Strategy initiatives since implementation began in fiscal year 2018/2019.

LAST UPDATED

The content of this estimates note is current as of February 20, 2024, as confirmed by Eric Larson.

APPROVALS

2023 03 01 – Martin Wright, Health Sector Information, Analysis & Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE

E-02

Physician Supply Numbers

Topic: An overview of BC's current complement of physicians, recent trends, and comparison with other Canadian jurisdictions.

Key Messaging and Recommended Response:

- **Compared to other provinces, BC has a good supply of physicians, and supply growth continues to outpace population growth.**
- **According to the Canadian Institute for Health Information (CIHI) 2022 data, BC has 270 physicians per 100,000, higher than the national average of 247 and ahead or equal to all other provinces.**
- **BC is making record investments and regulatory changes to improve physician supply by:**
  - **expanding the University of BC's medical school intake by adding 40 first-year undergraduate and 142 residency intake seats by 2028 from funding provided through the Health Human Resources (HHR) Strategy.**
  - **expanding the Practice Ready Assessment (PRA-BC) program, a pathway for internationally educated family doctors from 32 seats to 96 seats by March 2024.**
  - **growing the international medical graduate (IMG-BC) residency program from 6 annual entry positions in 2003 to 58 today.**
  - **recruiting doctors internationally, specifically targeting the UK since the College process for foreign credential recognition and transferring credentials is more compatible compared to other jurisdictions.**
  - **launching a new second medical school in BC at a Simon Fraser University location based in Surrey, with the aim to accept its first students by 2026.**

CURRENT SITUATION

- Compared to other provinces, BC has a good supply of physicians, and supply growth continues to outpace population growth; over the last 5 fiscal years (2018/19 – 2022/23), the number of physicians providing MSP services grew by 13.8%[1], while the BC population grew by 6.2%[2].

[1] Health Workforce Analytics, Primary & Acute Care and Sector Workforce, Health Sector Information Analysis & Reporting Division, Ministry of Health. Data from VT4, as of February 2024

[2] Health Workforce Analytics, Primary & Acute Care and Sector Workforce, Health Sector Information Analysis & Reporting Division, Ministry of Health. Data from PEOPLE_LHA, as of February 2024

- In 2022/23, the Ministry counted 14,410 physicians under all payment sources.[3] Physicians receive payments through fee-for-service, alternative payments, capitation, or a combination of modalities.
    - In February 2023, BC implemented the Longitudinal Family Physician (LFP) payment model and as of February 21, 2024, 4,010 Family Physicians registered for the model (excludes physicians in transition).
    - Out of all family physicians who previously practiced longitudinal primary care (2021/2022), 72% have registered for the LFP model.[4]
- The College of Physicians and Surgeons of BC reported 15,502 registrants in 2022/23. This count differs from the Ministry's as there is a subset of practicing physicians in the province who are not compensated through the public health system.[5]
- The Canadian Institute for Health Information (CIHI) estimates that BC has 270 physicians per 100,000 population (2022).
    - 141 Family Medicine physicians per 100,000; and,
    - 128 Specialists per 100,000.
- BC's figures are higher than the Canadian rate of 247 per 100,000 and ahead or equal to all other provinces.[6]
- BC is increasing self-sufficiency in physician training while remaining an attractive destination for physicians relocating from other jurisdictions (total net migration of 112 in 2022[7]).
- As outlined in the Ministry's Provincial HHR Strategy, BC's Practice Ready Assessment (PRA-BC) program for internationally educated family physicians will increase intake from 32 to 96 annual seats by March 2024. PRA-BC program participants complete a 3-year return of service (ROS) in a health authority-identified underserved community upon successful completion of the assessment. By April 2024, 243 participants will have been placed into 68 communities in BC[8].

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

Challenges

- Discussion of physician shortage is not only related to the total number of physicians needed, but also related to changes in physician working preferences and distribution.
- In 2022/23 the average physician age in BC was 49 years compared to 50 years 5 years prior in 2018/19. In 2018/19, there were 1,653 physicians aged 65 or older and in 2022/23 there were 1,806. Therefore, despite the decrease in average physician age, the absolute number of retirees may still rise in the future due to the aging population of physicians. [9]

Training

- Advice/Recommentations

- In 2024, BC will have a total intake of up to 591 residents, including 204 family medicine, 210 first-year specialty, and 177 subspecialty intake positions. This is a 30% increase since 2017 (i.e., 454).
- Advice/Recommentations

- The Ministry continues to support the Ministry of Post Secondary Education and Future Skills to establish a second medical school at Simon Fraser University's Surrey campus.

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[3] Health Workforce Analytics, Primary & Acute Care and Sector Workforce, Health Sector Information Analysis & Reporting Division, Ministry of Health. Data from HSPP: Physician Compensation Dashboard, as of February 2024

[4] Health Sector Information Analysis & Reporting Division, Ministry of Health. Longitudinal Family Physician (LFP) Payment Model Uptake Report, as of February 2024

[5] Annual Report 2022/23, British Columbia College of Physicians and Surgeons, https://www.cpsbc.ca/about-us/annual-report - Verified by HSIAR

[6] Canadian Institute for Health Information (CIHI). Supply, Migration, and Distribution of Physicians in Canada, 2022: Data Tables. Retrieved February 2024 from: https://secure.cihi.ca/estore/productSeries.htm?pc=PCC34– Verified per HSIAR

[7] *Ibid*, 6 – Verified per HSIAR

[8] Physician Services Return of Service Participant Data, March 22, 2024

[9] *Ibid*, 1 – Verified per HSIAR

- Residents selected into IMG-BC positions are required to complete a ROS in a health authority-identified underserved community upon finishing their residency program.
    - 52 of the 58 entry-level IMG-BC positions are in family medicine; the other 6 intake positions are in priority specialties that include psychiatry, internal medicine, and pediatrics.
    - An IMG-BC resident completing Family Medicine is required to complete a 2-year ROS; and a 3-year ROS if practicing in a Royal College specialty.
    - Inclusive of upcoming 2024 confirmed placements, 524 family physicians and 77 specialists have been placed in 98 communities, since the program started in 2006[10].

LAST UPDATED

The content of this fact sheet is current as of February 29, 2023, as confirmed by Eric Larson.

APPROVALS

2024 03 26 – Martin Wright, Health Sector Information Analysis & Reporting Division

[10] Physician Services, Return of Service Participant Data, February 13, 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE

E-03

Summary of Family Physician Supply in BC

Topic: An overview of family physicians (FPs) supply in BC, including programs to educate, recruit and retain FPs.

Key Messaging and Recommended Response:

- **Retaining, recruiting and training more family doctors in BC is a top priority for our Government.**
- **That is why we have significantly expanded pathways for international medical graduates (IMGs) to practice in BC, such as tripling the Practice Ready Assessment BC (PRA-BC) Program from 32 to 96 seats by March 2024.**
    - **As of April 15, 2024, 243 physicians have successfully completed the PRA-BC Program and have been placed in 68 Return of Service communities across BC.**
- **We have made significant expansions in post-secondary medical education at University of BC's (UBC) School of Medicine, most recently through our record investment of $995M in BC's Health Human Resources Strategy announced in the fall of 2022.**

Advice/Recommentations

- **Not only are we recruiting and training more family doctors, we are changing their payment structures to retain existing doctors and attract more to practice in BC by ratifying a physician master agreement and introducing a Longitudinal Family Physician Payment Model that moves away from fee-for-service.**
    - **As of February 21, 2024, 4,010 family physicians have signed on to the new model.** [1]
- **We are also engaging in international recruitment, and specifically targeting the UK since the College process for foreign credential recognition and transferring credentials is more compatible compared to other jurisdictions.**

[1] Longitudinal Family Physician (LFP) Payment Model Uptake Report – February 21, 2024.

- **We're committed to supporting health-care workers so they remain in their profession, are inspired by their work, and grow their skills and expertise.**

CURRENT SITUATION

- In the 2022/23 fiscal year, 7,305 FPs (50% of all physicians) received payment from the Ministry for providing patient care services.[2] This corresponds closely to the number of FPs registered through College of Physicians and Surgeons of BC during the same period.[3]
- In most years, BC's number of FPs grows faster than the population: Between 2018/19 and 2022/23, the number of FPs grew by 12.1%, while BC's population grew by 6.7%[4].
- BC compares favourably with other Canadian provinces in per population supply of FPs: according to the Canadian Institute for Health Information (CIHI), in 2022, BC had 141 FPs per 100,000 population, behind only the Yukon and well above the Canadian rate of 124 per 100,000[5].
- That ratio for BC grew from 134 per 100,000 in 2018 to 141 per 100,000 in 2022[6].
- BC continues to train and qualify more FPs to practice:
    - Advice/Recommentations
    - BC's Practice Ready Assessment (PRA-BC) program for internationally educated family physicians will also increase from 32 (current) to 96 annual seats by March 2024.
- Table 1 illustrates the distribution of FPs providing patient care services across payment models over the last 5 fiscal years for which there is complete data. FP remuneration is trending away from fee-for-service as the exclusive payment modality to other models, e.g., such as service contracts, salary, sessional or capitation.

Table 1. Family Physician Headcounts that Provided Patient Care Services by Payment Modality[7]

Modality	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Fee-for-Service Only (FFS)	4,170	4,086	3,652	3,496	3,717
Mixed FFS/Other Payments	2,007	2,229	2,703	3,158	3,002
Other Payments Only	340	348	470	621	586
Total	**6,517**	**6,663**	**6,825**	**7,275**	**7,305**

- Table 2 provides detail on the number of FPs working under various payment arrangements, as of February 2024. FPs are counted in each payment model under which they worked, but only once in the total.

Table 2. Family Physician Headcounts by Payment Modality, Detail, 2022/2023[8]

Modality	Family Physicians
Fee-for-Service	6,792
Longitudinal Family Practice	2,558
Alternative Payments Program	2,216
Group Contract	119
Northern Model (capitation)	30
New-to-practice Contracts	214
Population-Based Funding (capitation)	132
Primary Care Strategy Funded APP	52
Total	**7,343**

[2] Health Workforce Analytics, Primary & Acute Care and Sector Workforce, Health Sector Information Analysis & Reporting Division, Ministry of Health. Data from VT4, as of February 2024.
[3] CPSBC, 2022/23 Annual Report. Retrieved on February 7, 2023, from https://www.cpsbc.ca/files/pdf/2022-23-Annual-Report.pdf
[4] From July 1, 2018 to July 1, 2022. PEOPLE 2023. BC Stats Population Estimates and Projections; updated February 22, 2024.
[5] Canadian Institute for Health Information. Supply, Distribution and Migration of Physicians in Canada, 2022 — Historical Data. Ottawa, ON: CIHI; 2023.
[6] *Ibid 3.*
[7] *Ibid* 2.
[8] Health Workforce Analytics, Primary & Acute Care and Sector Workforce, Health Sector Information Analysis & Reporting Division, Ministry of Health. Data from HSPP: Physician Compensation Dashboard; VT4; and SCRUBS, as of February 2024.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

Postgraduate Medical Education (PGME)

- Family medicine residency positions continue to be expanded:
  - Aligned with Ministry's key priorities and BC's workforce needs, UBC continues to maintain a strong focus on training family medicine physicians to help support increased access to primary care.
  - Advice/Recommentations
  - As new family medicine residents move through their residency training programs, BC will continue to realize the benefits of the Ministry's significant investment into PGME training.
- UBC's family medicine PGME program is distributed at 24 regionally based training sites across BC to:
  - Expose and prepare medical residents for the challenges and benefits of practicing in rural, remote, and other underserved communities.
  - Enhance health care service capacity across the province; note that medical residents also provide direct patient care while they train.
  - Upon completion of PGME, encourage these newly licensed physicians to establish a practice within the communities where they have been educated and trained.
- Residents selected into BC's IMG-BC family medicine positions are required to complete a 2-year return of service (ROS), in a health authority-identified underserved community upon finishing their residency program.
  - 52 of the 58 entry-level IMG-BC positions are in family medicine; the other 6 intake positions are in priority specialties that include psychiatry, internal medicine, and pediatrics.
  - ROS placements in rural, remote, and other underserved communities support equitable access to patient care across BC.
  - By Fall 2024, 524 family physicians and 77 specialists will have been placed in 98 communities since 2006, when the program was established [9].

PRA-BC Program

- The PRA-BC program offers a pathway to licensure in BC for internationally educated FPs who have completed residencies outside of Canada.
- PRA-BC is funded by both the Ministry and the Joint Standing Committee on Rural Issues - a joint partnership between the Ministry and Doctors of BC.
- PRA-BC supports improved access to FPs by requiring successful applicants to provide a 3-year ROS in a health authority-identified community of need.
- As of April 15, 2024, 243 PRA-BC FPs will have been placed in 68 communities in BC.[10]

LAST UPDATED

The content of this estimates note is current as of February 29, 2023, as confirmed by Eric Larson.

APPROVALS

2024 03 26 – Martin Wright, Health Sector Information, Analysis, and Reporting Division

[9] Physician Services Branch, Health Sector Workforce and Beneficiary Services Division, Ministry of Health. IMG-BC Community Placements. Data as of February 13, 2024.

[10] Physician Services; Health Sector Workforce and Beneficiary Services Division. PRA Participant Placements Data. Data as of March 21, 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE

E-04

Virtual Care – Physician Payment Growth

Topic: Virtual care provided by physicians paid under fee--for--service models.

Key Messaging and Recommended Response:

- **Virtual care played a critical role in providing access to health care for people in BC during the COVID-19 pandemic.**
- **Episodic care continues to be a necessary and important aspect of primary care service delivery.**
- **Many health-care professionals are offering their attached patients' appointments virtually in addition to in-person.**
- **The province is working closely with the Doctors of BC and physicians to ensure the right balance between in-person and virtual care with the focus being delivery of high-quality public health care to all people in BC.**
- **BC's new physician master agreement includes provisions for the creation of an independent Virtual Care Clinical Reference Group, which will provide detailed guidance on clinical practice and the appropriate balance between virtual and in-person care.**

CURRENT SITUATION

- Virtual care has played a critical role in facilitating access to care during the COVID-19 pandemic. In 2020/21, Virtual Care visits rose by 691.8% over the previous year.
- Since then, utilization and expenditures of virtual care have decreased[1]:
  - Total virtual care expenditures in 2022/23 were $689.9M, a decrease of 14.9% ($120.5M) from 2021/2022 ($810.4M).
  - Total virtual care services in 2022/23 were 14M, a decrease of 15.0% from 2021/22.
- In the first 3-quarters of 2023/24[2]:
  - Virtual care fee item visits and consultations, as a proportion of all visits and consultations, decreased from 47.3% to 41.9%.
  - Virtual care visits and consultation services decreased from 9.4M to 8.4M
  - Total in-person visits and consultations increased by 11.2%; family practitioner in-person visits and consultations increased from 6.0M to 6.7M.
  - Among family practitioner virtual care services:
    - Services decreased by 12.0%, from 7.8M to 6.9M.
    - The number of patients decreased by 2.2%, from 2.7M to 2.6M.
    - The number of participating physicians grew by 3.7%, from 5,851 to 5,918.

[1] Ministry of Health Data are for fiscal years 2018/2019 to 2021/2022 inclusive, with the paid date as of the following September 30th for each fiscal year, the fiscal year 2022/2023 MSP data is with the paid data as of August 31, 2023.
[2] Ministry of Health System Information, Analysis and Reporting Division Integrated Analytics: Primary & Acute Care and Workforce Branch, Medical Services Plan Database, updated February 6, 2023.

Virtual Care Fee Items Expenditures and Services Totals by Fiscal Year for 5 Fiscal Years[3] [4] [5]

Metric	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Expenditure ($M)	43.32	83.28	896.69	810.43	689.9
% change		92.2%	976.7%	-9.6%	-14.9%
Services (M)	1.45	2.34	18.53	17.11	14.55
% change		61.5%	691.8%	-7.7%	-15.0%

Virtual and In-Person Patient Visits and Consultations

Specialty	Care Type	2019/2020	2020/2021	2021/2022	2022/2023
Family Practice	Virtual Care	700,827	13,897,629	12,494,227	10,366,746
	In-Person Care	17,165,518	5,634,626	7,009,922	8,205,275
	Total	**17,866,345**	**19,532,255**	**19,504,149**	**18,572,021**
	% Virtual care	**3.92%**	**71.15%**	**64.06%**	**55.82%**
Specialists	Virtual Care	187,132	2,837,866	2,496,734	2,103,600
	In-Person Care	7,036,792	4,880,121	5,631,688	6,083,891
	Total	**7,223,924**	**7,717,987**	**8,128,422**	**8,187,491**
	% Virtual care	**2.59%**	**36.77%**	**30.72%**	**25.69%**

FINANCIAL IMPLICATIONS

Total virtual care expenditures in 2022/23 were $689.9M.

KEY BACKGROUND

- "Telehealth Service" is a specifically defined term in the Medical Services Commission (MSC) Payment Schedule: "a medical practitioner delivered health service provided to a patient via live image transmission of those images to a receiving medical practitioner at another approved site, using video technology."
- In response to the pandemic, the General Preamble has been changed temporarily to include telephone calls in the definition of telehealth and where there is no telehealth fee for consultations, office visits, and non-procedural interventions, to allow a virtual care service to be claimed under the face-to-face fee, with a claim note record that the service was provided via telehealth.
- Initially, the delivery of telehealth services payable under the MSC Payment Schedule was restricted to a health authority facility. To support physicians and patients that were not physically close to a health authority facility, that requirement was removed in 2011.
- Since then, the Ministry of Health has seen significant increases in utilization across all specialties, but particularly in Family Physician telehealth fees.
- Prior to the pandemic, most physician virtual care visits were delivered through use of private, internet-based providers.
- Currently there are 259 Virtual Care fees[6] for medical specialties in the MSC Payment Schedule[7]. These include Telehealth (206 fees) and services using other platforms (i.e., telephone, e-mail, text, fax).
- 10 fees originally established under the General Practice Services Committee (GPSC) and 8[8] fees originally established under the Specialist Services Committee (SSC) transferred to the MSC Payment Schedule April 1, 2020, per the Physician Master Agreement.
- 25 new Virtual Care fees were temporarily approved to support access to healthcare during the pandemic and 6 virtual care fees temporarily deleted.

[3] Ministry of Health Data are for fiscal years 2018/2019 to 2022/2023 inclusive, with the paid date as of the following September 30th for each fiscal year. (RMS 3533).
[4] Data are for medical, nurse practitioner and midwives claims only.
[5] Fees originally established by GPSC and SSC were transferred to the general MSC Payment Schedule effective April 1, 2020.
[6] Include temporary fees to support access to healthcare during COVID-19 pandemic.
[7] Ministry of Health. Healthideas fee item database
[8] Ministry of Health. Healthideas fee item database.

LEGISLATIVE SESSION – ESTIMATES NOTE

E-04

LAST UPDATED

The content of this estimates note is current as of February 16, 2024, as confirmed by Eric Larson.

APPROVALS

2024 02 16 - Martin Wright, Health Sector Information Analysis & Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE

F-01

Health Gateway

Topic: Health Gateway is the provincial patient portal that gives BC residents secure online access to their health information and services from anywhere in the province. It is accessible by computer, laptop, tablet and as a downloadable app for mobile devices.

Key Messaging and Recommended Response:

- **British Columbians no longer have to wait to see their doctors or primary care providers to access certain types of personal health information such as lab and imaging results, medication, and immunization history. Instead, they can access it online at their own convenience on the Health Gateway platform.**
- **This portal empowers people in BC to be active participants in their journey through the health system with secure access to their personal health information.**
- **New improvements include access to diagnostic imaging reports (as of November 2023), which were previously only available upon request (paper copy) or through health authority online portals.**
- **As of February 6, 2024, BC Cancer Cervical Screening test results and recalls (reminders) are also available in Health Gateway.**
- **Health Gateway will move to a new, more robust platform for online and virtual services in Spring 2024. Additional online services are planned for the future.**
- **Health Gateway currently has more than 1.5 million registered users.**
- **Health Gateway continues to be a reference example of digital transformation in government and responsive to Digital Plan 2023 priorities for British Columbians.**

CURRENT SITUATION

- As of February 6, 2024, the Health Gateway has 1,518,281 registered users.
- Health Gateway enables secure login and registration using the BC Services Card.
- The portal gives users access to their personal health information and online services, including:
  - Prescription history.
  - Lab result history.
  - Immunization history and forecast (including COVID-19).
  - BC Cancer Cervical Screening test results and recalls.
  - Special authority drug request status.
  - Hospital visits.
  - Healthcare visits billed to the Medical Services Plan.
  - Organ donor registration status.
  - Diagnostic imaging reports.

  - The ability for users to capture information about their own health care experiences with notes and comments.
- More clinical documents and online services are planned for patients to access using the Health Gateway (e.g., notifications, appointment reminders, secure messaging, tracking referrals).
- The province works closely with patients, families, health care providers, HealthLink BC and health authorities to ensure that the information available in the Health Gateway supports patients to better manage their health through safe and equitable access to their personal information and relevant services.
- The Health Gateway team is working with health sector partners to align patient portals across to province, creating a more unified and connected patient experience for British Columbians.
- The Health Gateway is moving to a new technology platform that will support the province to deliver more online and virtual services starting in Spring 2024.

FINANCIAL IMPLICATIONS

- In 2021/22 the Ministry received capital funding of $2.475 million from the Office of the Chief information Officer (OCIO) for the Health Gateway through the Health Information Exchange (HIE) funding request.
- In 2022/23 the Ministry received capital funding of $1.667 million from the OCIO through the HIE funding request, and a further $2.200 million from OCIO through the Health Gateway 2.0 funding request.
- In 2023/24 the Ministry received capital funding of $2.681 million from OCIO through the Health Gateway 2.0 funding request.

KEY BACKGROUND

- In 2019, the Health Gateway project was approved as a cross-sector initiative led by the Ministry of Health in partnership with the Office of the CIO and Government Digital Experience. Both organizations are within the Ministry of Citizens' Services.
- Health Gateway launched as a web-based application in December 2019 and has continued to evolve to meet the needs of British Columbians, with emphasis on access to COVID-19 health information during the height of the pandemic.
- In Summer 2022, the Provincial Deputy Ministers' Committee on Digital and Data further endorsed Health Gateway with an additional 3-year funding commitment to continue to expand to meet the needs of British Columbians.
- Health Gateway, as a provincial service, continues to be a reference example of digital transformation in government and responsive to Digital Plan 2023 priorities for British Columbians.
- Health Gateway continues to support BC residents in accessing their COVID-19 information by providing access to:
  - The BC Vaccine Card for showing proof of vaccination where required.
  - The Federal Vaccine Proof to show proof of vaccination to travel outside of Canada and/or to access events, businesses, and services across Canada where required.
  - A mechanism for Service BC to support BC residents needing printing/mailout of their BC Vaccine Card and/or Federal Vaccine Proof.
  - COVID-19 vaccination records.
  - COVID-19 PCR test results.

LAST UPDATED

The content of this estimates note is current as of February 6, 2024 as confirmed by Heidi Giesbrecht.

APPROVALS

2024 02 13 - Heidi Giesbrecht, Health IT Strategy Branch, Health Sector IM/IT Division
2024 02 20 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2024 02 21 - Jeff Aitken, Health Sector IM/IT Division

LEGISLATIVE SESSION – ESTIMATES NOTE

G-01

Agency Nurses

Topic: Health authority (HA) usage of temporary agency services to address health system nursing workforce demands.

Key Messaging and Recommended Response:

- **Like many other jurisdictions, agency staffing costs in BC increased during he COVID-19 pandemic (from $20.45M in 2018/19 to $163.7M in 2022/23):**
  - **By expanding utilization of agency nurses, health authorities (HAs) minimized impacts to existing services and teams during the pandemic.**
  - **In 2022/23, agency nurses provided less than 3% of all nursing hours worked in BC.**
- **To address increased agency staffing utilization, BC issued a moratorium on new agency contracts in November 2022 and began working on a strategic provincial approach, including:**
  - **Creating standard provincial agency staffing contract for HAs to improve financial transparency and prioritize patient safety.**
  - **Investing through BC's Health Human Resources (HHR) Strategy in GoHealth BC - the provincial travel pool staffed by HA-employed nurses who are deployed to rural and remote communities where agency utilization is highest.**
  - **Attracting agency nurses back to the public sector through generational investments in the nursing workforce including wage and premium increases under the 2022-2025 Nurse Bargaining Association (NBA) collective agreement, minimum Nurse to Patient Ratios (mNPR), recruitment, retention, and training incentives announced March 1, 2024.**

CURRENT SITUATION

- In November 2022, the Ministry of Health placed a moratorium on new agency contracts for HAs and began work on a strategic provincial approach to agency staffing.
- Since then, several Key actions have been initiated to manage the province's approach to nursing agencies and supporting nurses to work in the public health system. They include:

1. The Ministry is aligning HAs around a provincial approach with standard contract requirements to ensure agencies are providing safe, quality, culturally safe care.
   - The Provincial Health Services Authority has created an inventory of agencies and has standardized agreements to pay the same hourly amount to the agency being utilized.

- As of March 2024, a new nursing agency provincial contract template has been developed. The agreement will be available to private/affiliate employers so that there is a single approach to how agency nursing is contracted in the province.

2. **GoHealth BC** is the Government's innovative response to the proliferation of private nursing agencies, supporting short-term nurse deployments to high-needs rural and remote communities.
   - GoHealth is currently deploying 211 nurses to 25 communities across Northern, Island, and Interior Health, and has planned expansion to rural and remote communities across the province and to other health occupations.
   - GoHealth nurses have provided over 250,000 hours of nursing support since the program was launched as the Northern Prototype Travel Pool in 2018.
3. The **2022-2025 NBA collective agreement**, ratified April 27, 2023, includes general wage increases, improved on call rates, responsibility pay, premiums, and expanded mentorship positions that will support the recruitment and retention of nurses.
4. BC is the first jurisdiction in Canada to implement **mNPRs**, anchoring the delivery of patient care to a standard formula, which is expected to improve BC's recruitment and retention of nurses to the public sector from private staffing agencies.
5. On March 1, 2024, the Minister of Health announced[1] a suite of **incentives** to support the provincial nursing workforce, including signing bonuses for nurses new to BC's public health sector that join GoHealth BC, move to rural and remote communities, or fill difficult to fill vacant positions.
   - The Provincial Rural Retention Incentive is also being expanded to include additional rural and remote communities, where agency nursing utilization is highest.

FINANCIAL IMPLICATIONS

- Through the HHR Strategy, $113.7M over 3 years (2023/24 – 2025/26) is available to expand GoHealth BC.
- Through mNPRs, $237 M in 2023/24 will support initiatives to retain, encourage the return of, and recruit new nurses into the health-care system – reducing our reliance on staffing agencies.[2]

KEY BACKGROUND

- During COVID-19 pandemic, HAs employed agency nurses and travel nurses extensively to staff vaccination clinics, testing centres, and contact tracing centres.
  - The spending increase is due to a combination of factors beyond increased utilization.
  - Inflation and increased cost of travel and accommodation expenses are among the reasons why the rate of expenditure growth has exceeded the rate of utilization growth.
- Agency nurses in BC:
  - Agency nurses are required to be registered with the BC College of Nurses and Midwives (BCCNM) and practice in alignment with BCCNM's Bylaws and Standards of Practice and employer policies.
  - Agency nurses have higher hourly pay; however, they do not have access to the same benefits, employer supports, union protections, and professional development opportunities as regular staff.
  - Agency nurses are not covered by the NBA Collective Agreement.

LAST UPDATED

The content of this estimates note is current as of March 13, 2024 as confirmed Zachary Matieschyn, ED NPS and Lynn Hancock, Director SPRR.

APPROVALS

2024 03 11 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 04 03 –Mark Armitage, Health Sector Workforce and Beneficiary Services Division

[1] https://news.gov.bc.ca/30389
[2] https://news.gov.bc.ca/30389

LEGISLATIVE SESSION – ESTIMATES NOTE

G-02

Alternative Payment Program Budget for BC Cancer Physician Resources

Topic: The Alternative Payments Program (APP) funds health authorities and other agencies to engage physicians on a service contract, salary, or sessional basis in situations where the fee-for-service payment modality would be ineffective in attracting and maintaining adequate physician services. BC Cancer is primarily funded through APP service contract and salary arrangements due to patient complexity, scope of care and a multidisciplinary team approach. This is an overview of the current and incremental funding available to BC Cancer through APP.

Key Messaging and Recommended Response:

- **BC has launched a 10-year cancer action plan covering the full continuum of care that will transform service delivery to meet growing demand in the province.**
- **As a result of Ministry funding commitments since 2019/20, BC Cancer has recruited 89.05FTE net new physician resources which have been implemented across six provincial centers.**
- **We will continue our work to require physicians to find appropriate ways to fund their vital work to ensure the best cancer care.**

CURRENT SITUATION

- As of January 2024, BC Cancer currently has 279.06 implemented physician FTEs, which is $ 113.9M[1] in approved APP funding[2]. An additional $24.4M in APP funding is committed for BC Cancer physician compensation in 2023/24 to fund rate increases and excess hours of physician work. In addition, BC Cancer has $9.55M[1] in available funding for hiring net new physician FTEs.
- A total of 89.05 net new physician FTEs have been hired by BC Cancer since 2019/20, 44.6 FTE[3] of which were APP-funded positions. Additional FTEs have been awarded to BC Cancer through the BC Cancer Plan commitments (outside of APP budget).
- BC Cancer was awarded 22.60 FTEs through the 2019 Physician Master Agreement (PMA) Workload Funding process (19% of the total FTEs distributed across the province), of which 19.60 have been implemented to date. The remaining 3.00 FTEs are awaiting implementation due to recruitment delays and overarching contract negotiations[1].
- Through 2023/24 Workload Funding process from the 2022 PMA, BC Cancer has been awarded an additional 19.0 FTEs of APP-funded physician resources with a net new budget of $8.3M[1].
- In July 2021, BC Cancer was approved for funding for 25 physician FTEs (Advanced Recruitment Plan) while the 10-year Provincial Cancer Plan was under review. As of August 2023, all 25 APP FTEs have been hired and have been added into BC Cancer's APP budget ($10.26M[1] in APP funding). An additional round of Workload Funding applications is under review for 2024/2025.
- While recruitment was underway, the Advanced Recruitment Plan funding supported two temporary BCCA compensation initiatives in 2021/22 and 2022/23 to assist with retaining existing BC Cancer physicians and compensating them with additional pay to further reduce wait times:

[1] "A:\APP\APP LAN TEST\Contracts\PHSA\05 - Contract Development\BC Cancer\2024 Fact Sheet\BC Cancer Supporting Data_v7.xlsx"
[2] Based on current interim rates for 2023/2024 APSA which are subject to PMA increases.
[3] 25FTE from Advanced recruitment plan + 19.6FTE from WLF

  - A retroactive one-time payment paid a lump-sum of up to $30,000 to eligible Medical and Radiation Oncologists. $6.26M[1] in funding was provided to 231 eligible physicians in 2022 to recognize extraordinary levels of service provision between July 2021 to May 2022.
  - Temporary prospective payments to full-time physicians in the Medical and Radiation Oncology programs for providing additional consultations and follow-up visits to reduce waitlists. In 2022/23, funding of $3.97M was provided from APP budget which permitted physicians to work an additional 20,052.95 hours[4] (equivalent to approximately 12 FTEs) across six BC Cancer sites.
- In 2023/24, the Ministry continues to enable additional workload above 1.0 FTE to be taken on by the existing physician workforce. Beginning May 1, 2023, through the Excess Workload initiative, additional payments above 1.0 FTE will allow eligible Salaried and Service Contracted physicians to work beyond their regularly scheduled hours and be paid for every incremental hour of service provided, up to 1.4 FTE. The authorization to provide up to an additional 40% of paid hours by eligible physicians will enable expanded service provision and support further reduction in wait times for a broader scope of oncology services including weekend and evening radiation and chemotherapy clinics and inpatient services. This is estimated to cost an additional $17.2M in APP funding in 2023/24.
- In 2024, BC Cancer will expand the hours of Radiation Therapy and Systemic Therapy clinics. Physicians who have agreed to take on these expanded hours (evenings/weekends) and added services to address patient waitlists will be authorized to work beyond the 1.2 FTE limit to a maximum of 1.4 FTE and will receive an additional stipend to incentivize this expansion.
- While the above temporary initiatives were approved to help address immediate compensation concerns among existing BC Cancer physicians, HEABC also completed a jurisdictional scan to review the competitiveness of BC's oncologist rate compared with Canadian and some international jurisdictions.
- Based on the jurisdictional scan's findings, the Ministry will provide $6.8M in funding to BCCA to compensate contracted and salaried medical and radiation and hematology oncologists an additional $28,000 annually per FTE[3]. This exceptional rate increase will be offered as of April 1, 2023 to eligible physicians (currently 241.65 FTEs) in addition to the 2022 PMA contract compensation lifts[5] and will make BC's oncologist workforce one of the highest compensated in Canada.
- In addition, the Ministry will provide increased funding of $367,605[6] to ensure all General Practitioner Oncologists (GPO) are paid at the maximum range for their APSA practice category.

FINANCIAL IMPLICATIONS

- The current approved APP funding based on currently implemented physician resources is 279.06 FTEs at a value of $113.9M[7].
- The remaining 22.0 FTEs of APP funding ($9.59M) from Workload Funding awards is available to support additional service delivery upon recruitment and/or conclusion of contract negotiations.
- APP budget has committed funding of an additional $7.2M in Oncologist and GPO rate increases beginning April 1, 2023 and an estimated $17.2M in additional funding to support the Excess Workload physician hours in 2023/2024.
- The total APP funding available to BC Cancer is $147.9M in 2023/24.

KEY BACKGROUND

- BC is launching a 10-year cancer action plan covering the full continuum of care that will transform service delivery to meet growing demand in the province.
- As patients are living longer and better, cancer care is changing due to personalized treatments. This new treatment method has had an impact on service delivery, and as a result, physicians' resourcing demand has increased.

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[4] Based on the final utilization submission for 22/23.

[5] PMA income increases are partially negotiated by PMA-mandated committees, so the final rates will result from those discussions and cannot be pre-determined.

[6] APSA Practice Category for GPOs is GP Defined Scope A (GPDSA) offering a maximum of $312,098 based on 23/24 interim rates and may be subject to further PMA increases.

[7]"\ "A:\APP\APP LAN TEST\Contracts\PHSA\05 - Contract Development\BC Cancer\2024 Fact Sheet\BC Cancer Supporting Data_v7.xlsx"

- As a result of Ministry funding commitments since 2019/20, BC Cancer has recruited 89.05FTE net new physician resources which have been implemented across six provincial centers. Additional funding commitments are being approved through Workload Funding and the BC Cancer Plan.

LAST UPDATED

The content of this estimates note is current as of February 9, 2024, as confirmed by Marie Ty, Executive Director, Compensation Policy and Programs Branch.

APPROVALS

2024 02 26 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2024 02 28 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

G-03

Associate Physicians

Topic: BC's implementation of the Associate Physician role.

Key Messaging and Recommended Response:

- **BC has recently introduced Associate Physicians into the healthcare system. As physician extenders, associate physicians work under the direction and supervision of an attending physician to increase healthcare capacity and improve the efficiency of service delivery in team-based care settings.**
- **The Associate Physician classification supports international medical graduates, who are not otherwise eligible for licensure as independent practitioners, to find meaningful employment opportunities that help meet priority health system needs across BC.**
- **Health authorities are rapidly implementing the Associate Physician role in a wide range of service settings.**
- **To date, 69 Associate Physicians have been offered employment subject to meeting all licensing and employment requirements.**
- **Associate physicians are one more way we are creating pathways to allow more medical professionals to meet the human resources needs of BC's healthcare system.**

CURRENT SITUATION

- Expansion of Associate Physician (AP) deployment is included as action 23 in BC's Health Human Resources (HHR) Strategy, and the Ministry of Health has committed direct funding for salary, benefits, and other costs to accelerate AP program development and hiring across the province.
    - The AP program is providing opportunities for internationally trained physicians who would not otherwise be able to contribute to patient care in BC.
- Health authorities have responded with the launch of 50 AP programs accredited by the College of Physicians and Surgeons of BC (CPSBC).
    - A further 59 are in the planning or accreditation phases.
- Provincially, there are 151 open job opportunities, 34 completed hires, and a further 35 offers extended pending acceptance and licensure by the CPSBC.
- The AP role is active in or planned for a wide variety range of clinical settings. Current accredited programs target Inpatient Care, Surgery, Perinatal, Medical Oncology, General Internal Medicine, Critical Care, Obstetrics and Gynecology, and many other areas.
- Health Match BC (HMBC) is actively supporting candidates to find employment and become licensed. Of the 640 individuals who have expressed interest to HMBC:
    - Approximately 90 appear to meet CPSBC requirements and are already authorized to work in Canada.
    - Other candidates require English language testing, completion of the Medical Council of Canada (MCC) Qualifying Exam, or demonstration of clinical currency.

- Except for a small pilot project in Northern Health, AP deployment has been limited to acute care settings. The Ministry is working with health authorities to explore options for broader AP deployment in health authority owned and operated primary care settings in 2024/25.

FINANCIAL IMPLICATIONS

Budget 2023 provided $995 million over three years to support 70 actions in the HHR Strategy, which includes several of the initiatives above.

KEY BACKGROUND

- APs are physician extenders who work under an associate physician class of licensure available to qualified International Medical Graduates (IMGs) who are unable to meet the requirements for full or provisional licensure through the CPSBC.
- APs work as health authority employees in team-based settings under physician direction and supervision to increase health care quality, access, and the patient experience.
- CPSBC maintains two distinct AP classes of registration – *AP Acute Care* and *AP Community Primary Care*. *AP Acute Care* is open to medical or surgical specialists who have a minimum of two years of post-graduate training whereas *AP Community Primary Care* is available to general practitioners with at least one year of post-graduate training.
- To become licensed as an AP in BC, an IMG must have:
    - completed a medical degree outside of Canada at a school listed in the World Directory of Medical Schools;
    - undertaken at least one year of post-graduate training for work in community primary care and two years for work in acute care settings;
    - passed Part 1 of the MCC Qualifying Exam and be a licentiate of MCC (or CPSBC-defined equivalent);
    - maintained clinical currency to the satisfaction of CPSBC by working at least 24 months in the prior three years; and
    - obtained an offer of employment and sponsorship by a health authority.
- Prospective APs must also demonstrate they meet the general English language proficiency requirements of CPSBC. They can do this by showing that the primary language of their medical education and prior patient care was English or by taking a standardized proficiency test (IELTS Academic, OET Medicine, or CELPIP General).
- Health authorities that employ APs must do so within a program that has been accredited by CPSBC to ensure program quality, provide an objective means of assessment, and enable CPSBC to provide guidance as programs are developed.
    - Specific accreditation requirements include defined oversight and supervision models, a comprehensive job description, a performance evaluation system, and continuing professional development monitoring and support processes.
- CPSBC first amended their bylaws to create a registration category for APs on May 29, 2020. Since then, the Ministry has worked collaboratively with CPSBC, health authorities and other partners to develop the policies, process and structures needed to integrate AP within acute and community primary care settings.
- HMBC maintains a pool of candidates who have expressed interest in becoming an AP, profiles all vacancies, provides pre-screening for prospective applicants, works with eligible candidates to apply for open positions, and assists those who are successful to submit a registration package to CPSBC.

LAST UPDATED

The content of this estimates note is current as of April 8, 2024, as confirmed Kevin Brown, Executive Director.

APPROVALS

2024 02 20, Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 04 09 - Mark Armitage, Health Sector Workforce and Beneficiary Services

LEGISLATIVE SESSION – ESTIMATES NOTE

G-04

GoHealth BC

Topic: The status of the GoHealth BC program – an innovative response to the proliferation of private nursing agencies in rural and remote communities.

Key Messaging and Recommended Response:

- **GoHealth BC is Government's innovative response to the proliferation of private nursing agencies. It is action 34 in BC's Health Human Resources Strategy providing a creative and flexible approach to serving rural and remote communities in the province.**
- **GoHealth BC:**
    - **supports short-term deployments to high-needs areas in response to urgent and endemic staffing shortages, replacing agency staffing.**
    - **schedules nursing supports in communities that need it up to three months ahead of time, contributing to workforce stability in those areas.**
- **Go Health BC is underway with deployments in place in 25 communities across Northern Health, Interior Health and Island Health.**
- **GoHealth BC allows service delivery in rural and remote communities to continue and provides a mechanism for nurses who may have an interest in rural and remote medicine but do not live in a rural community to practice.**
- **Since the program launched in 2018, GoHealth BC nurses have provided over 250,000 hours of travel nursing service in 25 rural and remote communities across BC.**
- **There are now over 200 nurses employed by GoHealth, alleviating workforce pressures and reducing our reliance on agency nursing.**
- **Starting April 1, 2024, nurses may be eligible to receive up to $15,000 in signing bonuses if they choose to take a position with GoHealth BC – we are focusing on nurses new to the BC health system and those returning to the public health system.**

CURRENT SITUATION

- GoHealth BC nurses are employed by Northern Health Authority (NHA) and provide planned travel nursing services in the place of third-party agencies to rural and remote communities in NHA, Interior Health (IHA), and Island Health (VIHA).

- Deployments are arranged several months in advance in collaboration between NHA and the receiving HA. These deployments contribute to workforce stability and reduce HA reliance on agencies.
- GoHealth currently employs 200 nurses, including registered nurses, registered psychiatric nurses and licensed practical nurses (RNs, RPNs, and LPNs).[1]
    - Nurses have been deployed across 25 rural and remote communities and have provided over 250,000 hours of total nursing service since the program began in 2018.[1]
    - 88 (44%) of GoHealth BC nurses were recruited from outside of BC or are otherwise net new to BC's healthcare system.[1]
    - The GoHealth workforce has grown by 94% in the past year, with funding support through the Strategy (Action 34).[1]
- With Strategy funding in 2024, GoHealth will begin expanding to:
    - Advice/Recommendations
    -
    -
- Recruitment incentives for nurses joining GoHealth were announced March 1, 2024. Eligibility for incentives will focus on nurses who are new to BC's workforce or returning to BC's public workforce (e.g. from third party staffing agencies).

FINANCIAL IMPLICATIONS

Budget 2023 provided $995 million over three years for the Strategy of which $113.7 million is allocated for GoHealth BC.

KEY BACKGROUND

- Agency nurse usage has been increasing across the health sector as a response to ongoing and episodic difficult-to-fill vacancies.
- Northern Health's Travel Resource Pool (TRP) began in 2018 as a response to this proliferation of agency nursing usage in Northern rural and remote communities.
    - The TRP was initially limited to specific rural and remote communities in the North.
    - The program successfully provided travel nursing services and ensured continued healthcare delivery by nurses employed by the public sector.
- Action 34 in the Strategy committed the Ministry to expanding the TRP to rural and remote communities across the province over 3 years, starting in 2023.
    - The program rebranded to GoHealth BC in 2023 to support the planned provincial expansion.
    - Throughout 2023, the program expanded to support additional communities in Northern Health, and to communities in Interior and Island Health.

LAST UPDATED

The content of this estimates note is current as of February 20, 2024, as confirmed by Executive Director, Meghann Brinoni, Health Workforce Planning & Implementation Branch.

APPROVALS

2024 02 22 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 04 - Miranda Mason, Health Sector Workforce and Beneficiary Services Division

[1] GoHealth Workforce Data – January 2024. Provided to HWPSI February 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE

G-05

Health Care Assistants

Topic: The Ministry of Health (MoH) actively and financially supports the development and sustainability of the Health Care Assistant (HCA) workforce in BC.

Key Messaging and Recommended Response:

- **The BC Care Aide and community Health Worker Registry provides oversight to Health Care Assistants (HCA). To be eligible to work as an HCA in any publicly funded health care setting in BC, applicants must have registered with the Registry. As of December 31, 2023, 52,060 HCAs are registered with active status.**
- **We've made significant investments in HCA education, recruitment and retention which will help build the workforce and decrease pressure on current staff:**
- **We provided $585 million over three years to support the Health Career Access Program, which aims to train, recruit and employ up to 3,000 entry-level health care workers each year (Budget 2021).**
- **Growing these programs and increasing BC's supply of highly skilled graduates will ensure the province has the right health professionals in the right places so that British Columbians can access the health services they need now and in the future.**

CURRENT SITUATION

- The Health Care Assistant (HCA) occupation is unregulated in BC. Oversight is provided by the BC Care Aide & Community Health Worker Registry and employers. HEABC is contracted by the MoH Health to manage Registry operations. HEABC also includes Health Match BC (HMBC), Locums for Rural BC, and Practice Ready Assessment BC.
- The Registry's mandate is to protect vulnerable clients and patients under the care of HCAs, as well as to ensure minimum standards of education and skill among HCAs.Health employers receiving public funding, including private employers under public contract, are required to employ HCAs who are active registrants of the Registry. They must report to the Registry every suspension or termination of an HCA for alleged client and patient abuse. Private employers who receive no public funds are not required to hire registered HCAs, but HCAs working for these employers who meet the Registry's eligibility requirements are permitted to register.
- As of December 31, 2023, 52,060 HCAs are registered with active status.[1]
- The HCA Curriculum Guide was updated in June 2023 and minor changes were made to the HCA Core Competency Profile. This is a collaboration between the MoH and the Ministry of Post Secondary Education and Future Skills (PSFS). A review of the HCA Curriculum and Competency Profile takes place every five

[1] BC Care Aide & Community Health Worker Registry 2023 Year-End Update Report (confidential), January 23, 2024

years. It was updated in June 2023 to include enhanced sections on mental health, medication assistance, nail care, and indigenous reconciliation.

- MoH has received several requests over the years from stakeholders, including employers and seniors' advocates, to expand the HCA role. The MoH did not expand the HCA role with the 2023 curriculum and competency review. If any formal activity is initiated to change or expand the role of HCAs, the MoH will engage all necessary and appropriate stakeholders.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- HCAs are direct care providers that work in acute care, long term care and assisted living, group homes, and community care. Working as part of a health care team and receiving direction and supervision from regulated health professionals, HCAs are trained to provide personal care assistance and supports to older adults, people living with disabilities and/or chronic illnesses, and clients receiving palliative care. Duties include providing personal care and support with some activities of daily living.
- The Registry recognizes both public and private HCA educational and training programs.[2] Currently, there are 33 recognized programs offered at 75 approved locations across BC (16 private colleges 17 public colleges).[3]

HCA Education

- HCA programs are typically 8 months (with an additional 12 weeks for programs offering an HCA ESL variation). On average, BC HCA programs offer two student intakes per year.[4]
- The Health Careers Access Program (HCAP) was developed in 2020 as a work-integrated learning pathway that introduces the role of health care support worker (HCSW) and leads to full HCA certification. HCAP follows established Provincial standards and applicants who are accepted into the program receive a comprehensive 2-week, provincially standardized orientation. The HCAP Partnership Pathway (HCAP-PP) program offers 2 model frameworks to HCSWs enrolled in the program: part-time modular model - students split weekly time between work and education; and block modular model-students undertake alternating work/education program modules. (see *Health Career Access Program* Estimates Note)

HCA Strategies

- In 2019 the MoH implemented the Provincial Marketing and Recruitment Strategy in collaboration with HEABC, BC College of Nurses and Midwives and HMBC to generate an estimated 200 net new HCAs in 3 years. The Choose2Care campaign was launched by HMBC through this strategy, which included the development of a website as well as print, transit, community media, digital/social media to drive visitors to the website.[5] The purpose of Choose2Care is to increase public awareness of the HCA profession and to provide potential HCAs with the information they need to train, register, and become employed.
- In 2020, COVID-19 increased the need for HCAs in long-term care and assisted living settings across BC. HCAP was implemented to provide a path for applicants with no health care experience to get hired as HCSWs and receive paid employer sponsored health care assistant training as part of their employment (See "Health Career Access Program Fact Sheet" for more information).

LAST UPDATED

The content of this estimates note is current as of February 13, 2024 as confirmed by Zachary Matieschyn

APPROVALS

2024 02 20 – Miranda Mason, Health Sector Workforce and Beneficiary Services Division

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[2] BC Care Aide & CHW Registry, https://www.cachwr.bc.ca/About-the-Registry/List-of-HCA-programs-in-BC.aspx.
[3] Data received from PSFS September 1, 2022
[5] Information confirmed by PSFS January 31, 2023
[5] Cliff# 1115957 BN, Advancing HCAs Education, Recruitment and Retention, Signed by the DM on Sept 18, 2018.

LEGISLATIVE SESSION – ESTIMATES NOTE

G-06

Health Career Access Program

Topic: Government announced the Health Career Access Program (HCAP) on September 9, 2020[1] to recruit over 3,000 entry-level health care workers annually for long-term care homes, assisted living facilities, and various health services across the province.

Key Messaging and Recommended Response:

- **Government is taking action to recruit over 3,000 entry level health-care workers annually into the health sector.**
- **Budget 2021 provided $585 million over three years to support the Health Care Access Program.**
- **The Health Career Access Program provides a flexible pathway to a rewarding career in health care.**
- **This program is part of the Province's Health Human Resources Strategy which works to strengthen BC's health workforce through recruitment, retention and training, as well as redesigning the health-care system.**
- **The Health Career Access Program allows participants to begin working as health care support workers while upgrading their skills to become licensed health care assistants, which helps remove financial barriers to furthering their education.**
- **Since the program was announced on September 9, 2020, 7,528 positions in the Health Career Access Program have been filled.**
- **The program is supported by over $117 million as part of Budget 2023.**

CURRENT SITUATION

- On September 9, 2020, Government announced the hiring of 7,000 individuals into the health sector over three initiatives including creating 3,000 net new HCSW FTEs.[2]
- As of February 8, 2024, a total of 7,528 HCAP positions have been filled[2]:
  - 5,844 for HCAP in health authority, private, and affiliate LTC/AL settings
  - 1,481 for HCAP in health authority home health settings
  - 203 for HCAP in acute care settings
- As of February 8, 2024, 5,020 HCAP participants have started their training at a post secondary institution, with 3,267 having graduated from their HCA education program. [3]

[1] BC Government News Release Sept.9, 2020: https://news.gov.bc.ca/releases/2020PREM0050-001694

[2] On September 9, 2020, Government announced the hiring of 7,000 individuals into the health sector over three initiatives including: (1) 3,000 net new Health Care Support Worker (HCSW) FTEs (2) 2,000 net new FTEs to support visitation in long-term care and assisted living and (3) 2,000 existing vacancies filled through the Provincial Recruitment campaign. As of February 8, 2024, 7,528 positions have been filled across three initiatives.

[3] Health Career Access Program (HCAP) Portal, April 18, 2023.

Table 1 HCAP Hiring Activity as of February 8, 2024

Site Type	Allocation	Total Hires
LTC/AL Sites	**5,720**	**5,844**
Health Authority Sites	*2,040*	*2,339*
Private/Affiliate	*3,680*	*3,505*
Home Support	**1,453**	**1,481**
Acute Care	**408**	**203**
Total	**7,581**	**7,528**

- An expansion into acute care, supporting a new team-based care model in Emergency Departments, was prototyped across all health authorities starting April 1, 2023. There have since been 203 hired participants across the province into an acute setting.
- The first prototype expanding HCAP into Indigenous communities initiated in May 2022. Several First Nations communities from various regions expressed their interest in participating, and currently approximately 6% of all participants self-identify as indigenous.
- The expansion into the Mental Health and Substance Use (MHSU) softly launched on November 30, 2023, in collaboration with the Ministry of Mental Health and Addictions and a $43.260 million budget. The MHSU pilot program aims to recruit up to 500 participants over 3 years with Northern Health, Island Health, and Interior Health being early adopters. A formal announcement, including system wide launch is expected Spring 2024. [see MMHA-HCAP-MHSU Estimates Note]

FINANCIAL IMPLICATIONS

- Budget 2021 provided $585 million over three years to continue support of the HCAP program.
- In 2022/23, $117 million was provided to the health authorities for wage and benefit supports and $900,000 for administrative supports while individuals train as health-care workers in long-term care homes and assisted-living facilities throughout BC.
- An additional $3 million was provided in 2020/21, $4.2 million in 2021/22, and $4.7 million in 2022/23 to the Ministry of Post-Secondary Education and Future Skills (PSFS) to support direct program funding to post-secondary institutions.

KEY BACKGROUND

- HCAP offers publicly funded training for aspiring HCAs, enabling participants to start as Health Care Support Workers (HCSWs) and alternate between work and formal study. After program completion, participants qualify as HCAs, eligible for registration with the BC Care Aide and Community Health Worker Registry. HCSWs, supervised by regulated health professionals, focus on non-clinical tasks. The program aims to boost the provincial HCA supply, stabilize staffing in healthcare facilities, and aid labor market transitions, covering all education and employment costs.
- The recruitment, allocation, matching, and hiring processes for the HCAP are employer-driven. Employers select candidates from a provincial pool or other channels if needed. HCSWs undergo a standardized two-week orientation and onboarding program, followed by formal HCA education at approved post-secondary institutions. Successful completion earns participants a recognized credential for registry registration. Formal HCAP participation concludes, with participants often fulfilling a 12-month return-of-service commitment as registered HCAs.

LAST UPDATED

The content of this estimates note is current as of February 13, 2024, as confirmed by Zachary Matieschyn.

APPROVALS

2024 02 20 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 02 23 - Miranda Mason, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

G-07

Health Education Expansion

Topic: To outline the comprehensive investments in health education expansion.

Key Messaging and Recommended Response:

- **Expanding health education seats remains a priority in BC and is fundamental to ensuring we have the health workforce required so that everyone in BC has access to the care they need**.
- **Since 2017, Government has invested in education expansions for more than 20 different health occupations, including:**
    - **Midwives and nursing occupations including nurses, practical nurses, and nurse practitioners.**
    - **Allied health occupations including physiotherapists, social workers, medical lab technologists, and others.**
    - **Family and specialist physicians**
- **In 2023, the province made significant investments towards seats expansions and programs that remove financial barriers for various occupation streams including nursing, allied health, and physicians.**

CURRENT SITUATION

Nursing and Midwives:

- BC has significantly expanded nurse training since 2021 with 602 new nursing seats – adding to the approximate 2,000 existing nursing seats in the province. This includes:
    - 362 registered nursing seats, 40 registered psychiatric nursing seats, 20 nurse practitioner seats and 180 licensed practical nurse seats at 17 public post-secondary institutions.
    - 35 seats for nurses re-entering practice at Kwantlen Polytechnic University.
    - Up to 1000 new specialty nursing training seats (offering additional training to nurses in areas such as acute care, critical care, and peri and post-operative surgical care).
- This represents a doubling of the nurse practitioner seats, a 46% increase in practical nursing seats and 22% increase in registered nursing seats.
- We have 20 seats to UBC's midwifery program, bringing the total annual intake to 48.
- Government provided $1.1 million in funding to launch the first nursing degree program in the Northeast region of BC in Fort St. John.
- BC is also investing in actions to reduce financial barriers and increase uptake of training opportunities including through bursaries of up to $10,000 available to:
    - IENs and nurses re-entering practice to complete remedial education
    - HCAs training as LPNs through Access to Practical Nursing programs

Allied Health

- In July 2022, the government announced the expansion of up to 322 new allied health seats for multiple programs at post-secondary institutions across the province.

- 238 of the up to 322 seat expansions had been implemented.
  - Programs which have completed their implementation of seats: pharmacy technicians (41), respiratory therapists (40), medical laboratory technologists (28), social workers (25), medical laboratory assistants (24), rehabilitation assistants (20), occupational therapists (16), magnetic resonance imaging (MRI) technologists (12), dietitians (12), anesthesia assistants (10), radiation therapists (8), and genetic counsellors (2).
  - Advice/Recommentations
  -

- Physical Therapy has also seen a $24.9 million investment made to purchase and renovate the new program space in Surrey. This allowed the University of British Columbia to implement 20 new seats into its Master of Physical Therapy program.

Health Care Assistants (HCAP)

- The Health Care Assistant Partnership Pathway (HCA-PP) is the Health Care Assistant (HCA) education component of the Health Career Access Program (HCAP).
- Over 1800 HCA-PP seats have been filled in 2023/24 with another 548 seats to start next fiscal year. PSFS is currently working with PSIs to schedule additional HCA-PP cohorts for FY 2024/25.

Physicians

- Between 2017 and 2022, HLTH funded the addition of 60 new annual residency positions in key areas including anesthesiology, family medicine, geriatrics, emergency medicine, palliative care, pediatrics, psychiatry and addictions, maternity, and cancer care.
- In 2023, the province began supporting further expansion of UBC's medical school and its postgraduate medical residency training programs to deliver new seats annually.
  - 40 total additional undergraduate medical school seats will be phased-in over 2023/24 and 2024/25, to a total of 328 per year - a 14% increase since the previous 288 intake.
  - Advice/Recommentations
    - Since 2022, 30 additional family medicine positions were added (12 in 2023, 18 in 2024).
- HLTH continues to support the Ministry of PSFS's mandate to launch a new Simon Fraser University medical program based in Surrey, with the aim to accept its first students by September 2026.

FINANCIAL IMPLICATIONS

- Budget 2021 provided $96 million over 3 years for health sector education.
- Budget 2023 provides nearly $1 billion over three years to support BC's Health Human Resources Strategy, including $324 million in training to create accessible career pathways.

KEY BACKGROUND

- The Ministry of Post-Secondary Education and Future Skills (PSFS) works collaborates with the Ministry of Health (HLTH) and Post-Secondary Institutions (PSIs) to make sure the supply of seats aligns with demand.
- Training is one of the four cornerstones of BC's Health Human Resources Strategy.

LAST UPDATED

The content of this estimates note is current as of February 16, 2024, as confirmed by Meghann Brinoni, ED, Health Workforce Planning and Implementation Branch.

APPROVALS

2024 03 01 – Miranda Mason, Health Sector Workforce and Beneficiary Services Division
2024 03 01 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

G-08

Health Human Resources Strategy

Topic: An update on progress against BC's Health Human Resources (HHR) Strategy.

Key Messaging and Recommended Response:

- **BC's HHR Strategy was announced on September 29, 2022.**
- **The strategy supports patients by ensuring they get the health services they need and are cared for by a healthy workforce.**
- **Starting with Budget 2023, the Government has provided funding of nearly $1 billion over three years to implement 70 key actions to recruit, train and retain health-care workers, while redesigning the health-care system to foster workplace satisfaction and innovation.**
- **On December 5, 2023 we released our year-one update[1], highlighting 47 actions that are complete or underway, and 23 that are in planning.**
- **In Year One of implementation we had four areas of focus:**
  - **Responding to urgent pressures by building sustainable programs, enhancing and expanding scopes of practice, and incentivizing regular work.**
  - **Expanding and modernizing priority education and training to keep pace with population growth and aging.**
  - **Adding more workplace supports for healthcare workers across all four cornerstones of the strategy: retain, redesign, recruit, and train.**
  - **Improving credential recognition, training, and registration processes to get internationally educated healthcare workers onto the frontlines by eliminating financial and other barriers to practice.**

CURRENT SITUATION

- **2 actions are complete:** Wage levelling in affiliate long-term care and assisted living (Action 9) and changes to the provincial nominee program (PNP) to prioritize healthcare workers (Action 38).
- **45 actions are in implementation**. Some key highlights of our achievements to date include:
  - 320 relational security officers hired to provide culturally informed security services at high-risk sites across BC (Action 3).
  - 150 new nurse clinical mentor positions created (funded through a $108.6M policy agreement with the Nurse Bargaining Association that builds on the Strategy) to provide clinical leadership and support to frontline nurses (Action 8).

[1] https://news.gov.bc.ca/files/HealthHumanResourcesStrategyOneyearUpdate-December2023.pdf

  - The introduction of the Minor Ailments and Contraception Service so people in BC can seek contraception and treatment for 21 ailments directly from a pharmacist (Action 26).
  - The provincial expansion of Go Health BC which now provides travel nursing service in 25 rural and remote communities and has delivered 250,000 hours since launching in 2018 as the northern health prototype travel program (Action 34).
  - 1,774 Internationally Educated Nurses (IEN) who have received a registration decision from the BC College of Nurses and Midwives (BCCNM), including 806 who have received full registration under the IEN support program, up from 288 in 2022 (Action 36).
  - Over 7,500 participants hired by the Health Career Access Program (HCAP) since it launched in September 2020, adding much needed capacity in long term care, assisted living, home health, Indigenous home health, and – most recently – mental health and substance use settings across BC HCAP participants are hired into non-clinical care roles and receive employer-sponsored training for an entry level clinical role (Action 52).
  - Seat expansions across all profession groups including 602 nursing seats, up to 322 allied health seats, 20 midwifery seats, and 60 physician residencies added between 2017 and 2022 and – with the Strategy and Budget 2023, an additional 40 undergraduate physician seats and up to 122 physician residencies will be added.
- **23 actions are in planning** with implementation dates in Fiscal Year 2024/25 and 2025/26.
  - Many of these include input from health system partners and other ministries including PSFS, MMHA, MUNI, EDUC, and HOUS.

FINANCIAL IMPLICATIONS

The HHR Strategy is supported with three year funding of $995M starting with Budget 2023. Funding ramps up: $273.6 million in FY2023/24, $349.6 million in FY2024/25, and $372.7 million in FY2025/26.

KEY BACKGROUND

- The Provincial Health Human Resources Coordination Centre (PHHRCC) provides governance and oversight to the Strategy and includes leadership from the Ministry of Health, regional health authorities (HAs), the Provincial Health Services Authority, the Health Employers Association of British Columbia (HEABC), Providence Health Care, and the First Nations Health Authority.
- We have made significant investments in the health sector workforce since 2017, resulting in an increase of over 40,000 employees since 2017[2]; however, continued workforce growth is required to meet current and future needs for health services.
  - The number of people over the age of 75 in BC has increased by 24% between 2017 and 2023 and BC's net migration reached over 166,000 people annually in 2023.3
  - Labour shortages, rising demand, and increased competition (provincially, nationally, and internationally) have created a tight labour market – particularly in rural communities.
  - Work BC estimates that by 2031 there will be 166,300 job openings in BC's health sector.4
  - Health services must also keep pace with economic growth to ensure that new entrants to the labour force and employers have access to a strong, responsive healthcare system.
- The Strategy includes actions needed to help address today's challenges while building out for the longer-term needs of the health system.
- The Strategy also advances Government's commitment to Indigenous Health and Reconciliation by prioritizing actions to improve health outcomes for Indigenous Peoples, break cycles of systemic racism, and support Indigenous health sector workers to improve representation and equity.

[2] Public Sector Employers Council. (2023, 2022, 2021, 2019, 2018). Public Sector Annual Compensation Forecast.
[3] PEOPLE 2023. BC Stats Population Estimates and Projections; updated on February 22, 2024.
[4] Work BC. (2023). 2023 Labour Market Outlook.

LEGISLATIVE SESSION – ESTIMATES NOTE

G-08

LAST UPDATED

The content of this estimates note is current as of March 5, 2024 as confirmed by Lynn Hancock.

APPROVALS

2024 02 26 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 05 - Miranda Mason, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

G-09

Health Professional License Fees

Topic: Overview of professional license fees for regulated health professionals in BC

Key Messaging and Recommended Response:

- **Health profession regulatory colleges have been delegated authority under provincial legislation to govern the practice of their registrants in the public interest.**
- **Health profession regulatory colleges are self-funded through fees collected from registrants.**
- **Fees are utilized to fund college operations required to fulfill public safety mandates under the *Health Professions Act*.**
- **The Ministry of Health does not have a role in setting college fees.**

CURRENT SITUATION

- Under the *Health Professions Act* (HPA), health profession regulatory colleges are responsible for establishing fees payable to the college by registrants.
- Regulatory colleges are self-funded through registrant fees. These fees cover college costs, including administrative and public protection operations, including registration, quality assurance, investigations, and discipline.
- The Ministry of Health (the Ministry) does not have a role in establishing college fees.
- Under the HPA, fee changes are established in college bylaws and are filed with the Minister and subject to a 60-day administrative filing period that may be shortened by the Minister. The Minister also has an ability to disallow bylaw amendments in extraordinary circumstances. Ministry staff are aware of no instance in which a Minister of Health has exercised this power.
- Each year colleges review their fee schedules based on budgeted costs for the year and if necessary, raise fees to ensure they can maintain operational functions.
- In recent years, some colleges have raised fees by larger amounts (of up to 15 percent) due to increased costs associated with factors such as inflation, restricted supply chains, labour shortages, cost-of-living increases, increased investigation costs, COVID-19 pandemic costs, and previous budget deficits/debt.
- The two most significant fee increases in the past two years involve the British Columbia College of Nurses and Midwives (BCCNM) and the College of Pharmacists of British Columbia (CPhBC).
- BCCNM raised its annual full registrant renewal fees by 15 percent in 2023 and will be increasing these fees by a further 12 percent in 2024. The college has cited reasons for the increase as: Busi ness Business Information the cost of implementing cultural safety and humility standards and resources, increased complaints and investigations, and continuing costs relating to the amalgamation of the four former nursing and midwifery colleges.
- CPhBC raised its annual full registrant renewal fees by 15 percent in 2023 and will be increasing them by a further 15 percent in 2024. The College has cited reasons for the increases, include inflation, supply chain restrictions, labour shortages, and implementation of new regulatory programs to improve patient safety and culturally safe care, and establish new standards and requirements for the implementation of newly introduced pharmacist prescribing powers.

- Currently, registrants of regulated health professions who are employed in Health Authorities (HA), and required by the HA to be a registrant, have their annual college registration fees paid by the HA.

FINANCIAL IMPLICATIONS

Colleges are self-funded through fees collected from registrants.

KEY BACKGROUND

- As colleges do not follow the same financial reporting periods and registrant renewal cycles, some colleges have not yet submitted fee changes for 2024 registration fees. For fields marked n/a, the Ministry has not yet received notice of fees for 2024.
- The following table illustrates annual full registrant renewal fees, to date, for registrants of BC's 15 health profession regulatory colleges.

College	Fees 2017	Fees 2018	Fees 2019	Fees 2020	Fees 2021	Fees 2022	Fees 2023	Fees 2024	Increase 2022-23	Increase 2023-24
College of Chiropractors of BC[1]	$1,550	$1,550	$1,550	$1,550	$1,550	$1,550	$1,550	n/a	0%	n/a
College of Dietitians of BC[2]	$580	$592	$600	$600	$615	$615	$630	n/a	2%	n/a
College of Massage Therapists of BC[3]	$550	$575	$600	$600	$600	$750	$750	n/a	0%	n/a
College of Naturopathic Physicians of BC[4]	$1,810	$1,810	$1,810	$1,810	$1,900	$2,090	$2,090	n/a	0%	n/a
BC College of Nurses and Midwives (Licensed Practical Nurse) [5][6]	$350	$350	$397.85	$497.25	$514.80	$521.95	$600.24	$671.60	15%	12%
BC College of Nurses and Midwives (Registered Psychiatric Nurse) [7][8]	$460	$460	$448.95	$500.05	$558.36	$521.95	$600.24	$671.60	15%	12%
BC College of Nurses and Midwives (Registered Nurse) [9][10]	$350.40	$448.95	$448.95	$500.05	$558.36	$521.95	$600.24	$671.60	15%	12%
BC College of Nurses and Midwives (Nurse Practitioner)[11][12]	$551.15	$649.70	$649.70	$719.05	$803.88	$751.90	$867.42	$967.25	15%	12%
BC College of Nurses and Midwives (Midwife)[13][14]	$2,250	$2,250	$2,250	$2,435.52	$740.95	$751.90	$867.42	$967.25	15%	12%
College of Occupational Therapists of BC[15]	$525	$525	$525	$525	$525	$525	$525	n/a	0%	n/a
College of Opticians of BC[16]	$460	$490	$590	$625	$650	$675	$675	n/a	0%	n/a

[1]College of Chiropractors of BC (2024). Retrieved February 7, 2024 from Bylaws of the College of Chiropractors of B.C. under the Health Professions Act https://www.chirobc.com/wp-content/uploads/2023/07/CCBC-Bylaws.pdf.

[2] College of Dietitians of BC (2024). Retrieved February 7, 2024, from Schedule B Fees. https://collegeofdietitiansofbc.org/wp-content/uploads/2022/03/211101_Sch_B_Fees.pdf.

[3] College of Massage Therapists of BC (2024). Retrieved February 7, 2024, from Schedule "B" – Fees https://www.cmtbc.ca/law-standards/cmtbc-bylaws/.

[4] College of Naturopathic Physicians of BC. Retrieved February 7, 2024, from the College of Naturopathic Physicians of British Columbia Bylaws under the Health Professions Act https://cnpbc.bc.ca/wp-content/uploads/CNPBC-Bylaws.pdf.

[5] BC College of Nurses and Midwives (2024). Retrieved February 7, 2024 from the Bylaws of the British Columbia College of Nurses and Midwives https://www.bccnm.ca/Documents/regulation/bylaws/BCCNM_bylaws_consol_10.pdf.

[6] Prior to 2020, Licensed Practical Nurses were regulated by the BC College of Nursing Professionals. Prior to 2019, they were regulated by the College of Licensed Practical Nurses of BC.

[7] BC College of Nurses and Midwives (2024). Retrieved February 7, 2024 from the Bylaws of the British Columbia College of Nurses and Midwives https://www.bccnm.ca/Documents/regulation/bylaws/BCCNM_bylaws_consol_10.pdf.

[8] Prior to 2020, Registered Psychiatric Nurses were regulated by the BC College of Nursing Professionals. Prior to 2019, they were regulated by the College of Registered Psychiatric Nurses of BC.

[9] BC College of Nurses and Midwives (2024). Retrieved February 7, 2024 from the Bylaws of the British Columbia College of Nurses and Midwives https://www.bccnm.ca/Documents/regulation/bylaws/BCCNM_bylaws_consol_10.pdf.

[10] Prior to 2020, Registered Nurses were regulated by the BC College of Nursing Professionals. Prior to 2019, they were regulated by the College of Registered Nurses of BC.

[11] BC College of Nurses and Midwives (2024). Retrieved February 7, 2024 from the Bylaws of the British Columbia College of Nurses and Midwives https://www.bccnm.ca/Documents/regulation/bylaws/BCCNM_bylaws_consol_10.pdf.

[12] Prior to 2020, Nurse Practitioners were regulated by the BC College of Nursing Professionals. Prior to 2019, they were regulated by the College of Registered Nurses of BC.

[13] BC College of Nurses and Midwives (2024). Retrieved February 7, 2024 from the Bylaws of the British Columbia College of Nurses and Midwives https://www.bccnm.ca/Documents/regulation/bylaws/BCCNM_bylaws_consol_10.pdf.

[14] Prior to 2020, Midwives were regulated by the BC College of Midwives.

[15] College of Occupational Therapists of BC (2024). Retrieved February 7, 2024, from Fees and Insurance https://cotbc.org/registration/fees-insurance/.

[16] College of Opticians of BC (2024). Retrieved February 7, 2024 from the College of Opticians of British Columbia College Bylaws https://cobc.ca/wp-content/uploads/2023/08/College-of-Opticians-of-BC-Bylaws-as-of-August-29-2023.pdf.

College	Fees 2017	Fees 2018	Fees 2019	Fees 2020	Fees 2021	Fees 2022	Fees 2023	Fees 2024	Increase 2022-23	Increase 2023-24
College of Optometrists of BC[17]	$1,390	$1,390	$1,390	$1,390	$1,390	$1,390	$1,390	n/a	0%	n/a
BC College of Oral Health Practitioners (Dental Hygienist)[18][19]	$495	$505	$515	$515	$515	$515	$515	n/a	0%	n/a
BC College of Oral Health Practitioners (Dentist)[20][21]	$1,478	$1,598	$1,633	$1,633	$1,633	$1,633	$1,633	n/a	0%	n/a
BC College of Oral Health Practitioners (Dental Technician)[22][23]	$775	$775	$775	$775	$775	$775	$775	n/a	0%	n/a
BC College of Oral Health Practitioners (Denturist)[24][25]	$1,249	$1,500	$1,600	$1,600	$1,600	$1,600	$1,600	n/a	0%	n/a
College of Pharmacists of BC[26]	$699	$724	$739	$778	$809	$846	$973	$1,220	15%	15%
College of Psychologists of BC[27]	$1,200	$1,200	$1,200	$1,200	$1,200	$1,200	$1,200	n/a	0%	n/a
College of Physical Therapists of BC[28]	$500	$500	$500	$500	$500	$500	$500	n/a	0%	n/a
College of Physicians and Surgeons of BC[29]	$1,685	$1,700	$1,715	$1,715	$1,725	$1,725	$1,795	$1,875	4%	4%
College of Speech and Hearing Health Professionals of BC[30]	$500	$500	$750	$750	$860	$860	$950	$950	10%	0%
College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC[31]	$850	$850	$850	$850	$850	$850	$850	n/a	0%	n/a

Figures in red represent fees charged by pre-amalgamation legacy colleges (see footnotes).

LAST UPDATED

The content of this estimates note is current as of February 8, 2024, as confirmed by Executive Director, Mark MacKinnon, Profession Regulation and Oversight Branch.

APPROVALS

2024 02 20 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 02 23 - Mark Armitage, Health Sector Workforce and Beneficiary Services

[17] College of Optometrists of BC (2024). Retrieved February 7, 2024 from the College of Optometrists of British Columbia Bylaws https://optometrybc.com/wp-content/uploads/2024/01/Bylaws_DEC_11_2023.pdf.
[18] BC College of Oral Health Practitioners (2024). Retrieved February 7, 2024 from Bylaws of the British Columbia College of Oral Health Professionals https://oralhealthbc.ca/wp-content/uploads/2022/08/BCCOHP-Bylaws-September-1-2022.pdf.
[19] Prior to 2022, Dental Hygienists were regulated by the College of Dental Hygienists of BC.
[20] BC College of Oral Health Practitioners (2024). Retrieved February 7, 2024 from Bylaws of the British Columbia College of Oral Health Professionals https://oralhealthbc.ca/wp-content/uploads/2022/08/BCCOHP-Bylaws-September-1-2022.pdf.
[21] Prior to 2022, Dentists were regulated by the College of Dental Surgeons of BC.
[22] BC College of Oral Health Practitioners (2024). Retrieved February 7, 2024 from Bylaws of the British Columbia College of Oral Health Professionals https://oralhealthbc.ca/wp-content/uploads/2022/08/BCCOHP-Bylaws-September-1-2022.pdf.
[23] Prior to 2022, Dental Technicians were regulated by the College of Dental Technicians of BC.
[24] BC College of Oral Health Practitioners (2024). Retrieved February 7, 2024 from Bylaws of the British Columbia College of Oral Health Professionals https://oralhealthbc.ca/wp-content/uploads/2022/08/BCCOHP-Bylaws-September-1-2022.pdf.
[25] Prior to 2022, Denturists were regulated by the College of Denturists of BC.
[26] College of Pharmacists of BC (2024). Retrieved February 7, 2024 from College of Pharmacists of B.C. Fee Schedule HPA Bylaws "Schedule D" https://library.bcpharmacists.org/6_Resources/6-1_Provincial_Legislation/1026-CPBC_Fee_Schedule_HPA.pdf.
[27] College of Psychologists of BC (2024). Retrieved February 7, 2024, from Schedule C Schedule of Fees https://collegeofpsychologists.bc.ca/docs/Schedule-C.pdf
[28] College of Physical Therapists of BC (2024). Retrieved February 7, 2024 from College of Physical Therapists of British Columbia Bylaws https://cptbc.org/wp-content/uploads/2023/07/CPTBC_Bylaw_Amendments_July6_2023.pdf.
[29] College of Physicians and Surgeons of BC (2024). Retrieved February 7, 2024, from College of Physicians and Surgeons of British Columbia Bylaws https://www.cpsbc.ca/files/pdf/HPA-Bylaws.pdf.
[30] College of Speech and Hearing Health Professionals of BC (2024). Retrieved February 7, 2024, from College of Speech and Hearing Health Professionals of BC Bylaws https://cshbc.ca/standards-legislation/bylaws/.
[31] College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC (2024). Retrieved February 7, 2024 from College of Traditional Chinese Medicine Practitioners and Acupuncturists of British Columbia Bylaws https://www.ctcma.bc.ca/wp-content/uploads/2023/07/ctcma-bylaws-and-schedules.pdf.

LEGISLATIVE SESSION – ESTIMATES NOTE

G-10

Health Professions and Occupations Act

Topic: New legislation called the *Health Professions and Occupations Act* received royal assent on November 24, 2022, and work is underway to prepare for the legislation coming into force through regulation at a future date.

Key Messaging and Recommended Response:

- **The *Health Professions and Occupations Act* (HPOA) is not yet in force. It will come into force by regulation of the Lieutenant Governor in Council at a future date.**
- **This legislation is about ensuring patients are kept safe from harm and discrimination. That's always been the role of regulatory colleges and this legislation creates a framework to do this even better.**
- **The HPOA does a number of significant things, including the following:**
  - **Commits to cultural safety and humility by taking a proactive approach to discrimination in BC's healthcare system.**
  - **Improves governance of regulatory colleges, moving to a merit and competency-based appointment process for board members.**
  - **Strengthens oversight of regulatory colleges by creating the Office of the Superintendent of Health Profession and Occupation Oversight to ensure regulatory colleges are laser-focused on patient safety and the public interest.**
  - **Creates safer complaints system with a new independent disciplinary hearing process.**
  - **Improves information sharing and transparency for enhanced patient safety.**
- Extensive consultation pre-dates the passing of this legislation.
- The Ministry of Health continues to meet with regulators, associations, employers and health professional groups to clarify how the legislation works and how it can be implemented.

LEGISLATIVE SESSION – ESTIMATES NOTE

G-10

CURRENT SITUATION

- The HPOA received royal assent on November 24, 2022.
- Work is underway to prepare for implementation of the legislation, which will come into force through regulation at a future date.
- Advice/Recommentations
  Advice/Recommentations it is not anticipated the legislation can come into force before 2025.

FINANCIAL IMPLICATIONS

The Ministry provided the BC Health Regulators (BCHR) with $4.5 million in 2023/24 to support the regulatory colleges in preparation for implementation of the HPOA.

KEY BACKGROUND

Cayton Report

- On April 11, 2019, the Minister released the report: *An Inquiry into the performance of the College of Dental Surgeons of British Columbia and the Health Professions Act* (the Cayton Report).
- A multi-party steering committee developed a consultation paper, based on significant public consultation, with proposed changes to health profession regulation.
- Public consultation on the consultation paper was held between November 27, 2019, and January 10, 2020. A total of 4,018 surveys and 1,480 written submissions were received.
- On August 27, 2020, the steering committee released its final recommendations based in part on public consultation, key recommendations from the Cayton report, as well as expert advice.

Implementation

- On October 18, 2023, parts of the HPOA were brought into force to stand up the Superintendent's Office.
- A merit-based process is ongoing to finalize who the Superintendent and Director of Discipline will be.
- Appointments for the Superintendent (appointed by Cabinet) and Director of Discipline (appointed by the Minister) are anticipated to take place in the spring of 2024.
- Once appointed, the Superintendent's Office will begin consultation to build out policy which will inform its oversight activities and tribunal processes. They will also begin staffing the Office and Tribunal.

Public response and communication

- Since the legislation received royal assent, there has been negative media coverage, most of which includes misinterpretation of what the HPOA does. Intergovernmental Communications
  Intergovernmental Communications
- Ministry staff have met with BC Health Regulators, Boards of Regulatory Colleges, various Health Profession Associations, Health Authorities, regulatory colleges, and other stakeholders, to dispel misinformation, educate on the legislation, and address concerns surrounding full appointment of regulatory college boards, alleged lack of consultation, and fears of erosion of freedom of speech among other things.
- In response to public concerns a "Q&A" section was added to the Professional Regulation and Oversight public webpage.
- This addition is intended to enhance clarity around what the HPOA does, clearly demonstrate the extent of consultation, and debunk some of the more common misinformation.
- A newsletter was sent out to key stakeholders on December 20, 2023, which provided an update on modernization initiatives including implementation progress on the HPOA. The newsletter is publicly available on the Professional Regulation website.

LEGISLATIVE SESSION – ESTIMATES NOTE

G-10

LAST UPDATED

The content of this estimates note is current as of as of February 8, 2024, as confirmed by Mark MacKinnon, Executive Director, Professional Regulation and Oversight Branch.

APPROVALS

2024 02 19 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 02 23 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

G-11

Health Sector Sick Leave

Topic: An overview of short-term sick leave rates in the BC health sector and Government actions to support workers needing sick leave.

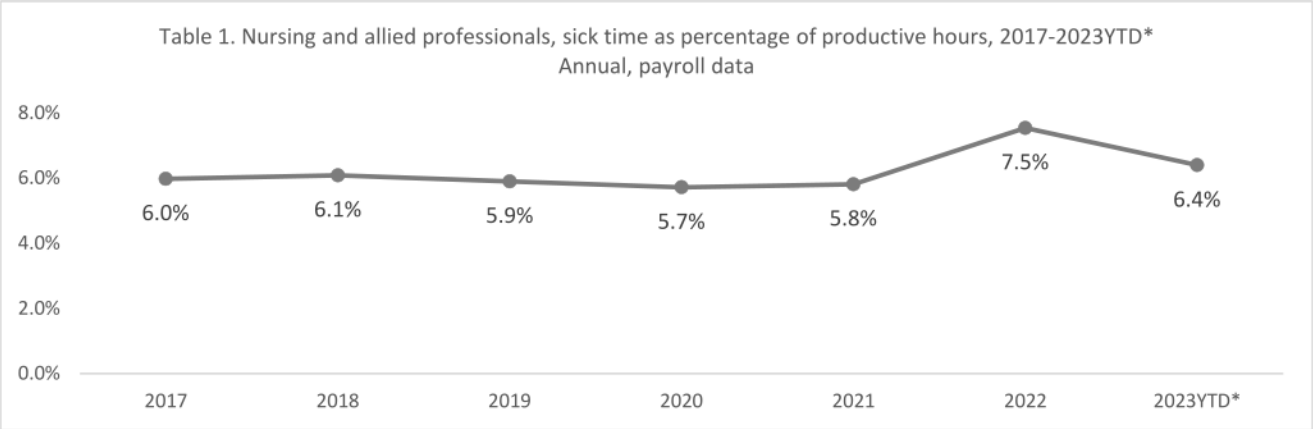
Key Messaging and Recommended Response:

- **The COVID-19 pandemic and respiratory viruses causing illness highlight just how important it is for workers to be able to stay home if they are sick.**
- **No one should have to choose between going to work sick or losing wages. That's why, as of January 1, 2022, BC became the first province in Canada to implement a minimum standard of five days of employer-paid sick leave every year.**
- **Now, employees in BC are able to take a sick day when they need it. This decision came after extensive and wide-ranging consultations.**
- **Paid sick leave applies to all employees covered by BC's Employment Standards Act (ESA), including temporary or casual employees.**
- **Paid sick leave is an important way we can support workers and help prevent the transmission of disease.**
- **We know staff absences in the health workforce can have impacts on service delivery and that staffing resources are critical for providing the care that British Columbians deserve.**
- **That is why Our Health Human Resources Strategy, announced in fall 2022, has 70 concrete actions focused on training, recruitment, and retention of health care workers.**
- **These actions address staffing capacity issues throughout the health-care system and will help alleviate the burden on our health-care workers.**

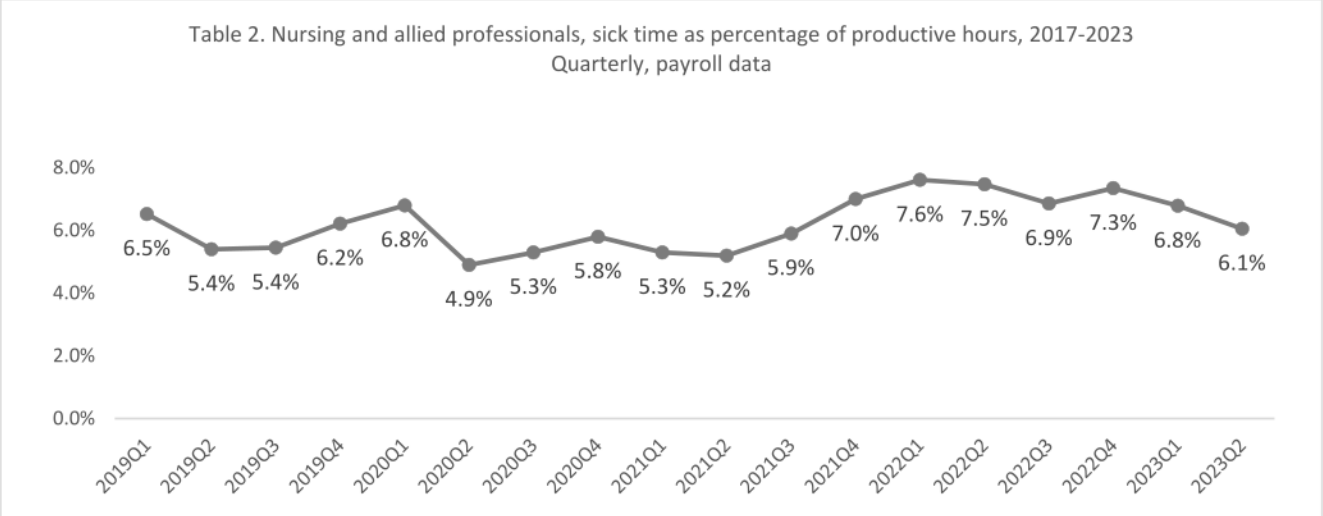
CURRENT SITUATION

From 2017 to 2021 sick time in the health sector has been steady from an average of 6.0% of productive hours in 2017 to 5.8% in 2021.[1] However, sick time has been significantly higher at 7.5% of productive hours in 2022 while it decreased to 6.4% through the first two quarters of 2023.

[1] Health Sector Compensation Information System, Health Employers Association of BC



* 2023 YTD includes quarter 1 and 2 of 2023



FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

Employment Standards Act (5-day paid leave)

- Effective January 1, 2022, Section 49.1 of the *Employment Standards Act* (ESA) was amended to include a general entitlement to paid sick leave for personal illness or injury after 90 consecutive days of employment.
    - On November 24, 2021, the Government passed a regulation designating the entitlement at five days of paid sick leave in each employment year.
    - Effective January 1, 2022, employees covered by collective agreements with guaranteed sick leave that "meets or exceeds" 5 days receive sick leave in accordance with their collective agreement, not the ESA. Based on this test, ESA paid sick leave was not applied to casual employees.
    - Effective March 31, 2022, the ESA was further amended to remove the "meet or exceed" test. This means that the five days of sick leave must be granted to all employees, including casual employees.
    - Casual employee entitlements took effect March 31, 2022 and are not retroactive.
    - In addition, this ESA amendment included a change from the annual entitlement applying to the individual's employment year calculated from their date of hire to the calendar year.
- As of March 31, 2022:
    - All employees, including casual, are eligible for paid sick leave after 90 continuous days of employment.

  - Section 49.1(3) indicates that employees must be paid no less than an average day of pay for each sick day.
    - Average Day = (amount paid in previous 30 days excluding overtime) divided by (number of days worked in the last 30 days)
- Public health sector employees are eligible to benefit from these new changes, and employers have implemented paid sick leave.

Reporting

Health Authorities collect absenteeism data through a variety of different sources.

- Vancouver Island and Northern Health Authorities use scheduling systems whereas Vancouver Coastal, Fraser Health, Interior Health, Providence Health, and the Provincial Health Services Authority use a 24-7 phone-in employee absence reporting line (EARL).
- Neither of these sources is able to fully capture the duration of a leave but payroll systems include a roughly 3-week lag (2 weeks to the end of the pay period and 1 week for data validation and cleanup).

LAST UPDATED

The content of this estimates note is current as of February 7, 2024, as per Ryan Murray, Executive Director, Labour and Agreements Branch.

APPROVALS

2024 03 01 – Heather Richards obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 03 03 – Mark Armitage, Health Sector Workforce and Beneficiary Services

LEGISLATIVE SESSION – ESTIMATES NOTE

G-12

Human Capital Management System

Topic: Status of the project to procure and implement a new provincial health sector Human Capital Management System in alignment with Action 30 of BC's Health Human Resources (HHR) Strategy.

Key Messaging and Recommended Response:

- **Action 30 of BC's HHR Strategy commits to replacing aging and at-risk HR, talent management and payroll systems for all Health Authorities (HAs) and Providence Health Care (PHC).**
- **On February 2, 2024, the Ministry of Health (HLTH) and Provincial Health Services Authority (PHSA) announced, on BC Bid, a 10-year contract awarded to Workday Canada to replace existing Human Capital Management System (HCMS) applications with a single, modern, integrated solution inclusive of:**
  - **Core HR: employee and employment records, self-service, job architecture, labour relations, benefits, absences, seniority, etc.**
  - **Talent: talent acquisition, onboarding, learning, etc.**
  - **Payroll: time tracking, employee pay, deductions, tax reporting, etc.**
- **Development and deployment of the new HCMS will take approximately 4-years:**
  - **In 2024 (Phase 0), teams will focus on harmonizing current processes, policies, data, and other functions to support a common HCMS core design to be shared by all HAs and PHC.**
  - **From late-2024 to late-2027, teams will configure and test the system and deploy it across all HAs and PHC in waves.**

CURRENT SITUATION

- Project governance reports to Leadership Council and includes an Executive Steering Committee of HLTH and HA/PHC executives, and a Centre of Excellence with leaders from HLTH and the HAs/PHC.
- The PHSA will lead the central program delivery team with a Chief Project Officer and a Transformation Program Office (TPO) providing project management support to the Executive Steering Committee, Centre of Excellence, and other teams.
- Phase 0 is now underway with governance structures being finalized, HAs/PHC identifying key subject matter experts (SMEs) to sit on provincial design teams, and current state data and process maps being collected and shared with Workday and its partners (KPMG and Deloitte).

FINANCIAL IMPLICATIONS

- Budget 2023 invested $995 million over three-years for the HHR Strategy. The Ministry has allocated $36.3 million of the $995 million to cover costs associated with HCMS change management and system integration.
- To streamline the procurement and reduce confusion over shared versus individual HA/PHC costs, HLTH has also committed to paying HCMS Enterprise cloud application subscription fees at a flat annual rate for the 10-year contract (Government Financial Information starting in 2023/24.

KEY BACKGROUND

- HAs/PHC are facing human resource challenges and the existing systems to support the staffing processes – from recruitment to retirement – are no longer fit for purpose.
- The COVID-19 pandemic highlighted the degree of the issue as HAs/PHC struggled to provide real-time reporting to answer seemingly simple questions such as number of full-time equivalents (FTEs), their work locations, and their vaccine status.
- HCMS supports end-to-end human resource management such as recruitment, employee onboarding, payroll, workforce modeling, and reporting.
- In September 2022, HLTH released BC's Health Human Resources Strategy with 70 actions organized around four cornerstones: retain, redesign, recruit, and train.
    - Action 30 of the HHR Strategy (in the Redesign cornerstone) commits HLTH and HAs/PHC to procuring and implementing a new provincial HCMS to replace aging and legacy systems.
- Starting in October 2022, HAs/PHC came together to build requirements, review proposals, and launch a negotiated request for proposals (NRFP) through BC Bid.
    - The NRFP went live on BC Bid on April 17, 2023, and lead evaluators were selected for HLTH and HAs/PHC. More than 100 SMEs were trained across HAs/PHC and HLTH.
    - Written proposals were evaluated, and proponents were shortlisted (June 12 to July 12, 2023).
    - Presentations and demonstrations were conducted (July 18 – August 11, 2023) across 9 topics: Core HR, Payroll, Talent, Finance, Supply Chain, Pricing, Architecture, Technical, Experience/ Corporate/ Governance/ Master Data Management).
    - Evaluation and scoring was completed (July 18 – August 29).
    - Contract negotiations began with the lead proponent on September 1, 2023.
    - HLTH and PHSA announced on BC Bid that a 10-year contract had been awarded to Canada Workday LLC (Workday) on February 2, 2024.

LAST UPDATED

The content of this estimates note is current as of February 14, 2024, as confirmed by Michael Cleghorn obo Executive Director, Meghann Brinoni.

APPROVALS

2024 02 22 – Peter Klotz obo Rob Byers, Finance and Corporate Services
2024 02 26 - Miranda Mason, Health Sector Workforce and Beneficiary Services

LEGISLATIVE SESSION – ESTIMATES NOTE

G-13

International Medical Graduate-BC Return of Service Program

Topic: There are a designated number of postgraduate medical education (PGME) positions for International Medical Graduates (IMGs) in exchange for a practice commitment (known as a return of service (ROS)) in a health authority-identified community of need.

Key Messaging and Recommended Response:

- **Ensuring everyone living in BC has access to a primary care provider is one of our top priorities. That is why this government funds programs like the Postgraduate Medical Education (PGME) International Medical Graduate (IMG) Program.**
- **PGME-IMG provides international medical graduates with an opportunity to train and qualify as a practicing physician in BC. After completing residency, family medicine participants complete a two-year return of service (ROS), and specialist participants complete a three-year ROS in an identified community of need, often in rural or remote areas.**
- **We fund UBC residency positions that are protected for international medical graduates:**
    - **The IMG-BC program at UBC has expanded substantially from six annual entry positions in 2003 to 58 today.**
    - **These 58 positions are specially protected for IMGs and include 52 in family medicine, an area of great need for British Columbians.**
    - **PGME-IMG residency positions are funded in family medicine, internal medicine, pediatrics, and psychiatry.**
    - **From 2017 to 2023, 333 family physicians and 44 specialists started their ROS, through the IMG-BC program with a further 49 family physicians and 9 specialists are expected to start ROS in 2024. From 2017-2024, 87 communities will have received physician ROS placements.**

KEY MESSAGING AND RECOMMENDED RESPONSE

- The IMG-BC Program at the University of BC (UBC) provides IMGs with an opportunity to train and qualify as a practicing physician in BC.
- The program has expanded substantially from six annual positions in 2003 to 58 today.
- IMG residency positions are funded in family medicine, internal medicine, pediatrics, and psychiatry.
- 52 of the 58 positions are in family medicine, an area of great need for British Columbians.
- After completing residency, family medicine participants complete a 2-year ROS, and specialist participants complete a 3-year ROS in a health authority-identified community of need.

CURRENT SITUATION

- The province funds a designated number of PGME seats for IMGs in exchange for a ROS within a BC community of need as identified by the health authority after the IMG completes their residency.
- In 2023, 50 IMG physicians (48 Family Medicine and 2 Specialty) started their ROS and in 2024, it is expected that 58 IMG physicians (49 Family Medicine and 9 Specialty) will start their ROS.[1]
- By Fall 2024, 524 family physicians and 77 specialists on a ROS will have been placed in 98 communities since 2006, when the program was established.[2]
- New in 2023 is a Medical Residency (Competitive) Stream that provides opportunities for IMGs to apply to 20 UBC residency specialist medicine seats alongside CMGs colleagues in a variety of specialty medicine areas. These seats come with a 3-year ROS commitment to BC.
- There are a number of other recent initiatives launched to support IMGs licensure (see Pathways to Practice for Internationally Educated Physicians estimates note).

FINANCIAL IMPLICATIONS

- In 2022/23, the Ministry provided a total of $171.5M to the UBC Faculty of Medicine to support PGME residency training, up from $135M in 2017/18.[3]
- In 2022/23, the Ministry provided $17.7M to UBC Faculty of Medicine to support IMGs through their PGME training in Family Medicine, Psychiatry, General Pediatrics, and Internal Medicine.[4]

KEY BACKGROUND

Return of Service

- Family Medicine participants are required to complete a 2-year ROS and specialist participants complete a 3-year ROS practicing medicine in a health authority identified community of need after completing training.
- This Ministry of Health provides governance for ROS programs and the contractual agreement is between the Ministry and the physician participating in the UBC IMG stream with an ROS.

Medical Education and Residency

- IMGs are a diverse group of Canadian citizens or permanent residents who complete their medical education outside of Canada or the United States as listed in the World Directory of Medical Schools.
- Medical education varies among IMGs due to the different evaluation and credentialing processes at international schools. As a result, IMGs must pass a series of examinations that test knowledge, skills, and aptitude to assess their readiness for entrance into a Canadian residency program including the:
    - Medical Council of Canada's Qualifying Examination Part 1[5] – a summative examination assessing critical medical knowledge and clinical decision-making ability.
    - National Assessment Collaboration Examination – an objective structured clinical exam which is a series of mock clinical situations with standardized patients in designated stations.[6]
- IMGs applying to PGME positions in BC through the Canadian Resident Matching Service (CaRMS) participate in UBC's one-day Clinical Assessment Program. The program assesses candidates' clinical experience, potential for success in residency and suitability for working in BC.[7]
- To attain an IMG residency position through CaRMS, IMGs must also meet the basic eligibility criteria and have no prior PGME training in Canada or the United States. This does not preclude individuals with PGME training from non-approved jurisdictions from applying (approved jurisdictions are determined by the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada and

[1] Physician Services Branch, Health Sector Workforce and Beneficiary Services Division, Ministry of Health, Return of Service Data_Data as of Feb 12, 2024
[2] Ibid.
[3] Physician Services Branch, Health Sector Workforce and Beneficiary Services Division, Ministry of Health. Cost per FTE 2023_24_FINAL. Data as of February 12, 2024
[4] Ibid.
[5] Medical Council of Canada (2024). https://mcc.ca/examinations/mccqe-part-i/ Last accessed February 12, 2024.
[6] Medical Council of Canada (2024). https://mcc.ca/examinations/nac-overview/ Last accessed February 12, 2024.
[7] UBC Faculty of Medicine (2024). https://imgbc.med.ubc.ca/clinical-assessment/ Last accessed February 12, 2024.

have been assessed against the national college's standards).
- IMGs compete for entry-level (1st year) dedicated IMG residency positions in the first iteration of CaRMS and for unfilled IMG and Canadian Medical Graduate positions in the second iteration of the match.
- In 2023, 1,562 IMGs applied for 370 IMG-dedicated residency positions in Canada through CaRMS.[8]

Reducing Barriers to PGME
- IMG entry-level PGME positions at UBC increased from 6 in 2003 to 58 (52 Family Medicine and 6 specialty) by 2019, including 40 new positions since 2011[9]. Priority is given to Family Medicine, Internal Medicine, Pediatrics and Psychiatry.
- IMGs who obtain a residency position at UBC take part in an orientation on the Canadian medical system and are introduced to tools and resources to help them succeed in residency.
- Students from international medical schools can apply to UBC's Visiting Electives Program in their final year of study if their school has a "Canada" designation on the World Directory of Medical Schools. Clinical electives provide IMGs with an opportunity to gain practical experience in BC's heath care system and demonstrate their clinical skills.[10]

LAST UPDATED

The content of this estimates note is current as of February 14, 2024 as confirmed by Kevin Brown, Executive Director, Physician Services Branch.

APPROVALS

2024 02 22 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 02 23 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division

[8] CaRMS (2023). R-1 Match Reports Tables 1 and 14. http://www.carms.ca/data-reports/r1-data-reports/. Last accessed February 8, 2024.
[9] Physician Services Branch, Health Sector Workforce and Beneficiary Services Division, Ministry of Health. (2024). Master Tracker. Data as of February 8, 2024.
[10] AFMC Student Portal (2022). https://afmcstudentportal.ca/ . Last accessed February 12, 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE

G-14

Internationally Educated Allied Health Professionals Bursary Program

Topic: Bursary programs to assist Internationally Educated Allied Health Professionals (IEAHPs) with the costs associated with becoming licensed/certified to work in BC.

Key Messaging and Recommended Response:

- **This government is taking actions to recruit, train, and retain allied health professionals to ensure that people living in BC can access the care they need through our health-care system.**
- **We've also heard from internationally educated allied health professionals (IEAHP) about the challenges they face when entering the workforce in the province. We are working to address these challenges.**
- **Action 37 in our Health Human Resources (HHR) Strategy includes the implementation of an IEAHP assessment support program to facilitate access to public-sector careers in allied health. In July 2022, we announced $4.5 million in bursaries that support this strategy.**
- **There are currently 3 bursary programs to support Internationally Educated Physiotherapists (IEPTs), Occupational Therapists (IEOTs), and Medical Laboratory Technologists (IEMLTs), with ongoing funding provided through Action 37 of BC's HHR Strategy.**
    - **Bursaries assist with costs associated with credential assessment, language proficiency testing and supplementary education.**
    - **To be eligible, applicants must commit to a Return of Service with a publicly funded health employer within BC for one or two years.**
- **Ultimately these actions mean more allied health care professionals to relieve pressures and reduce staff shortages in the health-care system in BC.**

CURRENT SITUATION

- On July 19, 2022, the Ministry of Health announced education, recruitment, and retention initiatives to help meet the increasing demand for allied health care workers in BC.[1] This included $4.5 million for bursaries to support priority IEAHPs.
- Building on these efforts, on September 29, 2022, the Ministry released *B.C.'s Health Human Resources Strategy* (the Strategy), which outlines 70 actions that will help build and support a healthy and productive workforce. Action 37 – Internationally Educated Allied Health Providers Assessment Support Program

[1] British Columbia Ministry of Health. (2022, July 19). *British Columbia trains, recruits more allied health professionals*. [Press release]. Retrieved from https://news.gov.bc.ca/releases/2022HLTH0047-001138

bolsters provincial recruitment efforts through the offering of bursaries to cover the costs associated with professional registration and certification of IEAHPs.

- Administered through Health Match BC (HMBC), the bursary program provides financial support to assist with costs associated with credential assessment, English language proficiency testing, and supplementary education.
- To be eligible, IEAHPs must commit to a Return of Service (ROS) with a publicly funded health employer within BC for one or two years, depending on the FTE of their employment.
- The internationally educated physiotherapist (IEPT) bursary program was launched June 12, 2023. This bursary includes an upfront fee-waiving option in partnership with the Canadian Alliance of Physiotherapy Regulators.
- The internationally educated medical laboratory technologist (IEMLT) and occupational therapist (IEOT) bursaries were launched in conjunction with the Allied Health Jobs BC website on January 15, 2024. As of February 26, 2024, there have been 195 IEMLT applicants with 9 signed IEMLT ROS agreements and 9 IEOT applicants with 1 signed IEOT ROS agreement.
- As of February 26, 2024, there have been 180 IEPT bursary program applicants, and 122 IEPT signed ROS agreements.

Advice/Recommendations

- Additional priority occupations will be added to the IEAHP Bursary Program in a phased approach over the coming years.

FINANCIAL IMPLICATIONS

- On July 19, 2022, the Province announced $4.5 million in funding to support IEAHPs from high priority occupations that want to work in BC's public health system.[2]
- Budget 2023 provided $995 million over three years to support BC's HHR Strategy. $11.3 million of the $995 million is allocated for Action 37.

KEY BACKGROUND

- Each allied health occupation has its own specific qualifying process, including credential evaluation, supplementary education (including bridging, gap-filling and/or exam preparation), and often followed by certification or licensing examinations. Additionally, IEAHPs who were educated in a language other than English will need to complete an English language assessment.
- Assessment pathways for IEAHPs can cost thousands of dollars and prevent IEAHPs from seeking a credential assessment to practice in BC; bursaries will help reduce these barriers.
- The IEAHP bursary program is expected to increase the supply of high-priority allied health professionals in the public health-care system.
- The Allied Health Policy Secretariat (AHPS) reviewed the full range of allied health occupations to select initial occupations that could benefit from bursaries, using the following criteria:
  - Occupations utilized within the Ministry's priority service areas.
  - Occupations that have known high vacancy rates.
  - Occupations with clear credential assessment pathways and which have substantial credential assessment costs.

[2] https://news.gov.bc.ca/releases/2022HLTH0047-001138

- IEAHPs are currently supported with the credentialing, job finding, and immigration processes by several other BC government programs:
  - BC Health Careers, through the Allied Health Jobs BC, currently provides job search and immigration support to internationally educated physiotherapists, occupational therapists, clinical/hospital pharmacists, medical laboratory technologists, diagnostic medical sonographers, and medical radiation technologists.[3]
  - Through the Career Paths for Skilled Immigrants program, IEAHPs can access financial support for language and skills upgrading, career planning and coaching, and other supports that assist with pathways to BC employment.[4]
  - IEAHPs who meet the applicable requirements for licensure and/or certification, and have a formal job offer in BC may be eligible for immigration support with the BC Provincial Nominee Program (health care occupation category).[5]

LAST UPDATED

The content of this estimates note is current as of February 26, 2024, as confirmed by Lorrie Cramb, Executive Director, Allied Health Policy Secretariat.

APPROVALS

2024 02 22 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 02 26 - Miranda Mason, Health Sector Workforce and Beneficiary Services

[3] Allied Health Jobs BC. Home - Allied Health Jobs BC Accessed 7 February 2024
[4] Province of British Columbia. Career Paths for Skilled Immigrants. https://www.welcomebc.ca/Work-in-B-C/Career-Paths-for-Skilled-Immigrants. Accessed 7 February 2024
[5] Province of British Columbia. About the Provincial Nominee Program. https://www.welcomebc.ca/Immigrate-to-B-C/About-The-BC-PNP. Accessed 7 February 2024

LEGISLATIVE SESSION – ESTIMATES NOTE

G-15

Internationally Educated Nurse and Nurse Re-entry Support Program

Topic: Reducing barriers for Internationally Educated Nurses to enter BC's health workforce and supporting nurses to re-enter practice will help meet growing labour demand.

Key Messaging and Recommended Response:

- **The province is making it easier for internationally educated nurses (IENs) to work in BC's health-care system with new financial supports and a faster more efficient assessment pathway.**
- **The Ministry of Health worked closely with the BC College of Nurses and Midwives (BCCNM) to develop a more efficient process that simultaneously assesses IENs for the Health Care Assistant (HCA), Licensed Practical Nurse (LPN), & Registered Nurse (RN) designations.**
    - **This new process helps determine where IENs best fit in BC's health workforce and allows them to start work sooner as an HCA or LPN while upgrading their training to work as a Registered Nurse.**
- **On January 9, 2023, we announced more financial supports for IENs including directly covering the $3,700 application, assessment fees for IEN's, a new pathway through BCCNM, and Inspire Global Assessments (IGA) - (formerly known as the Nursing Community Assessment Service/NCAS). The new pathway will reduce registration wait-time; down from 3 years to 4-9 months.**
- **The Government has also invested in financial supports to help nurses that want to return to practice after a period of absence.**
    - **This includes covering the $300 BCCNM application fee, over $4,000 in new supports to cover assessments and eligible travel costs, and up to $10,000 in bursaries for any additional education required for nurses returning to practice.**
- **Additional action was taken to expedite IENs in the application and registration pathway with registrations from the US, Australia, New Zealand, and the United Kingdom, as these countries have education and training aligned with BC.**

CURRENT SITUATION

- On April 19, 2022, the Ministry announced the Internationally Educated Nurse Bursary Program to help offset Internationally Educated Nurses (IENs') costs for assessments, applications, and educational bridging costs required to practice in BC's health system. Eligibility criteria apply and bursaries are subject to IENs signing a Return of Service (ROS) with a publicly funded health employer within BC for one or two years, depending on the FTE of their employment.
- On January 9, 2023, the Ministry further expanded these efforts with funding through *BC's Health Human Resources Strategy* (the Strategy) and introduced the following process improvements:
    - Instead of paying for Inspire Global Assessments (previously known as Nursing Community Assessment Service) upfront, IENs can now sign a ROS and then have access to the BC Health Careers (previously Health Match BC) navigation supports and a free NCAS assessment pathway funded directly by the Ministry.
    - IENs may now use services other than NNAS for curriculum review, which took up to two years to complete. There are now four more agencies who can provide credential assessments.[1]
    - Streamlined IEN application and registration pathway which will reduce the time it takes from initial application to registration decision to 4-9 months from approximately 1-3 years. Registrants may still need to take additional bridging education following a registration decision from BCCNM.
- Additional refinements were subsequently made to expedite applications from countries with education and training aligned with the requirements in BC (i.e., United States (US), Australia (AUS), New Zealand (NZ), and the United Kingdom (UK).
- The funding for IEN bursaries has also been extended to provide supports to nurses who previously held a practicing nursing license in Canada and want to return to practice.
- From January 2023 (when the program launched) to January 31, 2024, 1,774 IENs received a registration decision from BCCNM:
    - 806 IENs have received full registration as a registered nurse (RN) or licensed practical nurse (LPN), up from only 288 in 2022.
    - 828 IENs have been referred to additional education for which they can access bursaries and grants.
    - 140 IENs have registered as health care assistants.

FINANCIAL IMPLICATIONS

- In April, 2022, the Ministry announced $12 million in funding to support the development and hiring of nurse navigators and for IEN application, assessment, and educational bursaries.
- Budget 2023 invested $995 million over three years in the Strategy, of which $28.08 million has been allocated for Action 36 – Internationally Educated Nurse Assessment and Nurse Re-Entry Support Program.

KEY BACKGROUND

- Registering as a nurse or HCA in BC as an IEN is complicated and lengthy, costing approximately $6,000 if a competency assessment is required. This excludes language test costs (if required)[2], document translation fees, travel, license fees and national exam fees. IENs who require remedial education also must pay an additional $500 to $10,000.
- Historically, it had taken IENs approximately 2-6 years to obtain nursing registration in BC.[3] [4]
- A business case to reduce IEN barriers to entry into the healthcare system was developed in 2021, in collaboration with health partners, which led to:
    - The development of a single assessment intake and fee for IENs seeking multiple registrations (i.e., RN, LPN and/or HCA – known as 'Triple Track').

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[1] Approved credential assessment agencies include: NNAS, The Canadian branch of World Education Service (WES), Comparative Education Service (CES), International Credential Assessment Service (ICAS) International Credential Evaluation Service (ICES).

[2] BCCNM (2021). English proficiency. https://www.bccnm.ca/RN/applications_registration/Pages/English_proficiency.aspx. Accessed September 10, 2021.

[3] NNAS (2020). Frequently Asked Questions, The Advisory Report – How long does it take to get an Advisory Report and how long does the application process take? https://www.nnas.ca/faqs/ Accessed on October 8, 2020.

[4] BCCNM (2021). Applying to BCCNM. https://www.bccnm.ca/RN/applications_registration/how_to_apply/InternationalEN/Pages/Applying.aspx. Accessed on September 10, 2021.

  - The creation of IEN nursing system navigators to support IENs through the registration process.
  - An expedited process for IENs from countries with education and training aligned with the requirements in BC (I.e., US., Australia, New Zealand, and the UK).
  - Process improvements reducing time to receive a registration decision to 4-9 months.
- The January 9, 2023, announcement extended the IEN bursaries to provide the same supports to eligible Return to Practice nurses when they are required to re-instate their registration and/or take an unpaid Supervised Practice Experience (SPE)[5] or an IGA assessment and additional education prior to being able to reinstate their practice license if required.

LAST UPDATED

The content of this estimates note is current as of February 15, 2024, as confirmed by Zachary Matieschyn.

APPROVALS

2024 02 21 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 02 26 - Miranda Mason, Health Sector Workforce and Beneficiary Services Division

[5] SPEs must be approved by a health employer and accepted by BCCNM.

LEGISLATIVE SESSION – ESTIMATES NOTE

G-16

IVF Coverage

Topic: In vitro fertilization treatment coverage.

Key Messaging and Recommended Response:

- **Starting April 1, 2025, a new publicly funded in vitro fertilization (IVF) program will fund both treatment and medication for a single cycle of IVF treatment. Program details will be developed over the next year.**
- **In 2024, an expert clinical group will be constituted to assist in the creation of publicly funding IVF services including age consideration, service delivery options, and care pathways to access the service throughout BC. Starting April 1, 2025, BC will launch the new publicly funded IVF program to help with the costs of treatment and medication for a single cycle of treatment. The total funding set aside in *Budget 2024* for these measures in $68 million.**
- **In the interim, under BC's Medical Services Plan (MSP) many costs related to infertility assessments and investigations are covered so that people can get the answers they're looking for and make plans to start their families.**
- **MSP covers costs related to infertility assessments and investigations, which includes detailed gynecological investigations, lab tests to measure hormones related to ovulation, and seminal examination to determine the presence or absence of sperm.**
- **MSP also covers artificial insemination performed in a doctor's office. In 2022/23, MSP covered more than 3,900 procedures[1].**

CURRENT SITUATION

- As announced in the *Budget 2024*, starting April 1, 2025, a new publicly funded IVF program will fund both treatment and medication for a single cycle of IVF treatment.
- In the interim, under MSP, there is coverage for infertility investigations, such as detailed gynaecological investigations to determine the cause of female infertility, lab tests to measure hormones related to ovulation, seminal examination to determine the presence or absence of sperm in the case of suspected male infertility, and artificial insemination performed in a doctor's office.

FINANCIAL IMPLICATIONS

Budget 2024 allocated a total of $68 million from contingency funding ($34 million in 2025/26 and $34 million in 2026/27).

[1] Medical Services Plan. MSP Fee-For-Service Payment Analysis 2018/2019-2022/2023 fee item 4545, https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/msp_ffs_4_fee_item_detail.pdf, cutoff as of September 30, 2023.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- MSP is governed by the *Medicare Protection Act and Regulations*. This legislation stipulates that only those services considered medically necessary may be a benefit of MSP to eligible and enrolled BC residents.
- IVF is not covered under MSP.
- In recent years, years, other provinces in Canada, along with other countries have started supporting IVF treatment through either direct funding or tax credits.
- While many provinces provide support for IVF though tax credit and subsidy programs, only Ontario and Quebec fully fund IVF.

LAST UPDATED

The content of this estimates note is current as of February 25, 2024 as confirmed by Marie Ty, Compensation Policy and Programs Branch.

APPROVALS

2024 02 27 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division
2024 02 08 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE

G-17

Laboratory Health Human Resources

Topic: Addressing high vacancy rates, recruitment, and retention of Medical Laboratory Assistants and Medical Laboratory Technologists across the province to meet health system demands.

Key Messaging and Recommended Response:

- **The Ministry recognizes the critical roles that Medical Laboratory Assistants (MLAs) and Medical Laboratory Technologists (MLTs) play in the healthcare system, particularly in the diagnosis, treatment, monitoring, and prevention of diseases.**
- **We acknowledge the significant challenges facing both health authorities (HAs) and publicly funded community laboratories in meeting the staffing requirements for MLAs and MLTs, which was exacerbated by the COVID-19 pandemic.**
- **The government has taken several actions, in alignment with the StrongerBC: *B.C's Health Human Resources Strategy* and the *Allied Health Strategic Plan*, to optimize the health system, expand training, and further improve the recruitment and retention of qualified laboratory professionals.**
- **These actions include developing bursary programs, expanding education seats, international recruitment and optimizing workloads and care models.**
- **We're committed to addressing the challenges facing MLA and MLT staffing to ensure that our healthcare system has the necessary capacity to provide quality care for the people living in British Columbia.**

CURRENT SITUATION

- Over the next 5 years, laboratory services will be expanded throughout the province. This expansion requires the growth and development of the laboratory workforce to meet the increasing demand. Furthermore, there is an opportunity to address the high level of current Health Human Resources (HHR) vacancies across the province, especially in rural and remote locations.
- On September 29, 2022, the Ministry released *B.C's Health Human Resources Strategy*[1] to optimize the health system, expand training, and further improve recruitment and retention. To date, the Ministry has taken the following actions in alignment with the Strategy to support the laboratory workforce:
  - Launched the Internationally Educated MLT Bursary program, offering financial assistance to alleviate expenses related to the credential evaluation and pathway to certification. (Action #37)
  - Led the development of an employer-sponsored 'Earn-and-Learn program', sponsoring 36 Facilities Bargaining Association members with paid tuition and training to become MLAs. (Action #53)

[1] https://news.gov.bc.ca/releases/2022HLTH0059-001464

  - Implemented student recruitment and retention bursaries for MLA and MLT students, with the goal of attracting and retaining students enrolled in priority education programs offered at public post-secondary institutions in BC. (Action #57)
- On July 19, 2022, the Ministry announced the expansion of MLT programs in BC, adding 16 seats at the BC Institute of Technology, starting in September 2022, and 12 seats at the College of New Caledonia (CNC), beginning in January 2023. Students from these program expansions will soon enter the MLT workforce, offering a promising opportunity to strengthen and expand the field of MLTs.
- Expanded MLA training capacity by introducing an additional 24 seats to the Vancouver Community College (VCC) MLA program starting in May 2022, with additional one-time funding to support an extra 12 MLAs in both the May 2023 and September 2023 cohorts at VCC.
- The BC Centre for Disease Control leveraged Bachelor of Science (BSc) graduates specializing in microbiology to deliver essential molecular testing for COVID-19 and address other service gaps, made possible through a variance with the Diagnostic Accreditation Program (DAP), run by the College of Physicians and Surgeons of BC.
- The Ministry of Health maintains ongoing collaboration with health sector partners, engaging in regular consultations to strategize, share information, identify challenges, and proactively address priority matters concerning the laboratory workforce.

FINANCIAL IMPLICATIONS

On July 19, 2022: the Ministry announced $1.5 million in funding to support 36 Facilities Bargaining Association (FBA) employees to become MLAs to help support critical staffing shortages; $3 million in professional development funding to the Health Science Professional Bargaining Association to support the training and upgrading of health-science professional development in occupations such as MLTs; and $4.5 million in bursaries for internationally educated high-priority allied health professionals that want to work in BC.[2]

KEY BACKGROUND

- Challenges with MLA and MLT staffing had been present prior to the COVID-19 pandemic, but increased testing pressures associated with COVID-19, and high turnover and retirements exacerbated the situation.
- Health authorities reported the following challenges for MLAs and MLTs:
  - MLAs
    - Some MLAs have chosen to resign from permanent positions to work in non-direct patient care areas or take casual status due to burn out.
    - Some MLA training programs are undersubscribed, resulting in fewer graduates.
    - Shortages of MLAs have resulted in temporary and permanent closures of some laboratories.
  - MLTs
    - The increased workload on MLTs due to the demands of COVID-19 testing has led to greater shortages of staff for regular patient services.
    - The previous supply of MLT graduates has not been able to keep up with system demand.
    - Many MLTs have retired or are expecting to retire within the next few years, and some chose to leave the workforce early altogether.
- The Ministry is working with the health authorities (HAs) and the Provincial Laboratory Medicine Services (PLMS) at the Provincial Health Services Authority via a provincial forum (the Laboratory HHR Advisory Committee) to identify laboratory workforce challenges and develop strategies for short- and long-term staffing solutions for laboratories across BC.
- The Ministry is also working closely with the Ministry of Post-Secondary Education and Future Skills (PSFS), PLMS, laboratory managers/directors from each regional HA, and a representative each from LifeLabs and Dynacare Valley Medical Laboratories to find solutions to address the recruitment and retention of laboratory personnel at the Joint MLA/MLT Working Group, established in Winter 2022.

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[2] BC trains, recruits more allied health professionals. Retrieved September 15, 2022 at British Columbia trains, recruits more allied health professionals | BC Gov News

[2] Stronger BC: BC's Health Human Resources Strategy: https://news.gov.bc.ca/files/BCHealthHumanResourcesStrategy-Sept2022.pdf

Education and Training

- In September 2022, BCIT implemented changes to their MLT program to improve student retention, satisfaction, and practice-readiness. This work is expected to increase the number of BC MLT graduates.
- The MLA program is a certificate-level program that is 6-10 months in length. There are currently 10 post-secondary institutions in BC that are approved by the BC Society of Laboratory Science (BCSLS) to offer this program, 3 of which are public.[3] Programs vary between part-time, self-paced, and full-time depending on the institution; however, an in-person practicum is mandatory. Certification with BCSLS is not legally required to practice as an MLA, though most employers require it.
- The MLT program is a diploma-level program that is 2.5 years in length, offered at BCIT and the CNC. BCIT requires a 35-week clinical practicum, and CNC requires a 39-week clinical practicum. BCIT has a 96-seat student cohort annually, and CNC has a 36-seat cohort annually. Employers require that MLT graduates pass the certification examination with the CSMLS in order to practice.

LAST UPDATED

The content of this estimates note is current as of February7, 2024 as confirmed by Lorrie Cramb, Executive Director, Allied Health Policy Secretariat.

APPROVALS

2024 02 12 – Lintao Liu obo Rob Byers, Finance and Corporate Services Division
2024 02 26 – Miranda Mason, Health Sector Workforce and Beneficiary Services

LEGISLATIVE SESSION – ESTIMATES NOTE

G-18

Longitudinal Family Physician (LFP) Payment Model

Topic: Overview of the new Longitudinal Family Physician (LFP) Payment Model

Key Messaging and Recommended Response:

- **We are encouraged by the strong support for the LFP payment model among family doctors since its introduction in February 2023.**
- **The model provides an alternative to the traditional fee-for-service payment model and increases payment, streamlines, and simplifies the administrative burden on physicians.**
- **The LFP Payment Model has three payment streams and compensates doctors for time, including time spent managing and coordinating their patients' care, which we know may involve much more than the visit with a patient.**
- **The redesigned payment model was developed in collaboration with the Doctors of BC and was in direct response to concerns we've heard from physicians who felt dissuaded from family medicine.**
- **The LFP Payment Model is one of a number of initiatives in the province's action plan to strengthen primary care and better connect people to primary-care providers.**
- **As of February 1, 2024, 3,991 physicians have registered for the LFP Payment Model, 71.8% were longitudinal family physicians in BC in FY 2021/22. This is a tremendous uptake, and we are confident this new compensation model is helping to attract more family physicians to the province and retaining more physicians within the province.**
- **The Ministry of Health anticipates the LFP Payment Model will be expanded to facility-based maternity care, long-term care, and inpatient care settings by June 10, 2024.**

CURRENT SITUATION

- In 2022, almost one million British Columbians did not have a family physician. To address this issue, the Ministry of Health in partnership with Doctors of BC (DOBC) and BC Family Doctors (BCFD) developed the Longitudinal Family Physician Payment model, implemented on February 1, 2023.
- The LFP Payment Model covers almost all clinic-based primary care services. The primary exceptions are ICBC, WorkSafe, out-of-province patients, and minor surgical procedures.
- There are three payment components: time, patient interactions, and a panel payment tied to the number and complexity of attached patients.

- To be eligible, a longitudinal family physician must meet the eligibility criteria, including provide timely, accessible, comprehensive, and relationship-based care to patients; have a panel of at least 250 patients; and upload their panel to the Patient Attachment System (PAS).
- Most locum physicians providing care on behalf of a longitudinal physician are eligible to enroll as an LFP locum.
- Physicians enrolled in the LFP model cannot provide more than 30% of their services to patients not on their panel or the panel of another physician at their clinic. This limit extends to locums providing care on their behalf.
    - Maternity and complex contraceptive care are exempt from this limit.
    - As well, until March 31, 2024 physicians actively transitioning their practice to meet this requirement and rural communities receiving the Northern Isolation Allowance premiums as of December 12, 2002, are also exempt.
- As of February 1, 2024, of the 3,991 physicians are enrolled in the LFP Payment Model, 72% were longitudinal family physicians in BC in FY 2021/22. Of those who have enrolled:
    - 225 had not previously identified themselves as longitudinal physicians
    - 493 are new to practice or MSP
    - 311 are enrolled as LFP locum physicians
- The Ministry, in partnership with DOBC and BCFD to expand the LFP Payment Model to facility-based maternity care, long-term care, and inpatient care settings. The anticipated implementation for this expansion is June 2024.
- The expanded payment model will provide payment for time and interactions, with overall daytime pay equitable to that of clinic-based care. Travel time will be eligible for payment and additional compensation will be provided for after-hours care.
- Payment for on-call availability will be provided under separate mechanisms (Medical On-call Availability Program for maternity services and the Family Practice Services Committee for long-term care and inpatient care).

FINANCIAL IMPLICATIONS

- The financial implications will depend on the number of physicians transitioning to the LFP Payment Model and new physicians establishing family practice.
- As of February 1, 2024, 72.0% of existing longitudinal family physicians and 52.2% of existing longitudinal family physician locums have enrolled in LFP as longitudinal providers, locums in longitudinal practices, or both. These figures are based on existing longitudinal family physicians and family physician locums in BC in FY 2021/22.

KEY BACKGROUND

- The LFP Payment Model was developed in collaboration with DOBC and BCFD in response to family physician concerns with the fee-for-service model. Launched on February 1, 2023, it is expected to improve recruitment of and retention of family physicians and increase patient access and attachment.
- To be eligible, a longitudinal family physician must meet the eligibility criteria, including: provide timely, accessible, comprehensive and relationship-based care to patients; contribute to the rent, lease, or ownership costs, and other operating costs of their longitudinal clinic; have a panel of at least 250 patients; work at least one day per week; provide at least 70% of their services to longitudinal patients; and upload their panel to the Patient Attachment System (PAS).
- A physician who works 1680 hours, with a panel of 1250 patients of average complexity, and engages in 5000 patient interactions per year is expected to earn $425,000 under the LFP Payment Model, (up from $385K in 2022 due to negotiated PMA increases).
- There are three time codes (direct patient care, indirect patient care, and clinical administrative) all valued at $130 per hour, and eight patient interaction codes ranging from $10 – 110.

- Panel payments vary depending on panel size and complexity but are paid at approximately $53.52 per patient of average complexity per year. A physician with a panel of 1250 active patients of average complexity will receive an annual amount of approximately $66,900.
- The methodology for the panel payment is being developed collaboratively with DOBC and BCFD. In the interim, the methodology used by the Family Practice Services Committee to make annual panel payments to longitudinal family physicians is being used to calculate LFP panel payments.
- The LFP Payment Model is subject to Plan-Do-Study-Act (PDSA) cycles with DOBC and BCFD.
- The Ministry of Health, Doctors of BC, and BCFD are working to improve and adapt the LFP Payment Model on an ongoing basis.

LAST UPDATED

The content of this estimates note is current as of February 21, 2024, as confirmed by Executive Director, Marie Ty, Compensation Policy and Programs Branch.

APPROVALS

2024 02 14 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 15 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2024 02 23 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

G-19

Midwives

Topic: To support improved integration of midwives into the health system and access to maternity care, the Ministry is exploring more inclusive policy and compensation models.

Key Messaging and Recommended Response:

- **Midwives play an important role in the delivery of primary health care to pregnant people and their newborn babies from early pregnancy through labour and birth, and up to 12 weeks postpartum.**
- **Currently, there are 584 registered midwives in BC.**
- **In FY 2022/23, 11,264 or 27% of total live births in BC were assisted by midwives.**
- **Midwifery is an important part of providing culturally safe maternity care and supporting traditional birth practices for Indigenous people.**
- **In February 2023, the Province expanded the midwifery program at the University of BC by 20 seats, which is an increase of over 70%.**
- **The Province is working with the BC College of Nurses and Midwives and the Midwives Association of BC on policy to strengthen the role of midwives and better integrate them in the primary care and health system.**

CURRENT SITUATION

- In BC, registered midwives (RMs) are autonomous, regulated health professionals who offer primary health care to healthy pregnant people and their newborn babies, from early pregnancy through labour and birth, and up to 12 weeks postpartum.
- In FY 2022/23, in BC there were 11,264 live births assisted by midwives (27% of live births in the province) and in FY 2023/2024 (incomplete), 9,712 live births (28.4% of live births) have been assisted by midwives.[1]
- Midwives experience barriers to practicing to full scope: challenges with hospital privileging, regulatory barriers, interprofessional misconceptions about midwifery care, and limited system integration.[2]
- As part of the provincial effort to address challenges facing maternity care, the Ministry is leading policy work to strengthen midwifery alignment into primary care networks and the health system.
- Indigenous midwifery is a key area of focus with demand increasing for resources and processes to enable Indigenous midwives to practice traditional Indigenous midwifery and reclaim Indigenous birth practices in community. The Ministry is collaborating with Perinatal Services BC and First Nations Health Authority to work towards a coordinated approach to support Indigenous midwifery and traditional birth practices.
- The Ministry has committed up to $2.5 million in ongoing funding to support programs to support Indigenous midwives and communities which includes supporting reclamation of Indigenous midwifery.[3]

[1] Email from Priority Projects and Joint Collaborative Committees, HSIAR to Nursing Policy Secretariat (NPS), February 15, 2024.
[2] Health Sector Workforce: Priority Health Sector Occupation Profiles, Health Workforce Planning and Implementation Branch, October 2021.
[3] Letter from Assoc. DM Mark Armitage to MABC, June 12, 2023.

FINANCIAL IMPLICATIONS

In 2022/23, midwifery services cost approximately $44.2 million in fees, $7.1 million in the Midwives Association of BC (MABC) payments, and $0.85 million in midwifery contracts. The midwifery services budget for 2022/23 is approximately $48.9 million.in fees, $7.1 million in the Midwives Association of BC (MABC) payments, and $0.85 million in midwifery contracts. The midwifery services budget for 2022/23 is approximately $48.9 million.

KEY BACKGROUND

- Midwifery is a designated profession under the *Health Professions Act*. The first midwives were registered to practice in BC on January 1, 1998.
- In BC, midwives offer primary health care to healthy pregnant women and their newborn babies, from early pregnancy through labour and birth, and up to 12 weeks postpartum.
- Midwifery services are a benefit under the BC Midwifery Program for eligible BC residents enrolled with the Medical Services Plan funded by the Ministry. MSP only covers services up to six weeks post partum.
- The BC College of Nurses and Midwives (BCCNM) is the regulatory body for the midwifery profession in BC Midwives practicing midwifery in BC must be registered with BCCNM.
- As of August 19, 2021, the Jurisprudence exam is no longer a registration requirement for RMs.[4]
- As of January 31, 2024, BCCNM had a total of 584 midwife registrants (400 practicing; 90 non-practicing, 2 provisional, 92 student midwives)).[5]
- To practice as a midwife in BC, the minimum educational requirement is a Bachelor in Midwifery (BMw).
- The University of BC (UBC) has offeredhttp://www.bcmidwives.com/ubcprogram.htm a 4-year BMw program since September 2002.[6]
- UBC has offered an Internationally Educated Midwifery Bridging Program (IEMBP) since January 2016.[7] The IEMBP helps internationally trained midwives become registered for practice within BC.[8]
- Midwifery seat expansion: the Province added 20 seats to UBC's midwifery program, bringing the total annual intake to 48:
    - 12 seats were added to the BMW program, bringing the total annual intake from 20 to 32. (Four seats added in September 2022; eight seats added in September 2023.)
    - 8 seats were added (in January 2022) to the IEMBP bringing total annual intake from eight to 16. [9]
- UBC has developed an Advanced Placement Plan for Registered Nurses (RN) interested in becoming midwives which enables RN applicants to reduce the 143 credit BMw program by 27 credit hours.[10]
- Beginning in 2020, 10 service contracts (2.0 FTEs per community) for midwives were implemented in 5 rural communities (formerly referred to as "1A contracts") to help stabilize service in those communities. Recently, the Ministry approved the addition of a third FTE in each of the 5 communities.

Arbitration/Negotiations

- Compensation to registered midwives is governed by a Midwifery Main Agreement (MMA) between the Medical Services Commission, the Ministry, and the MABC.
- In 2019 and 2020 the Ministry and MABC attempted to negotiate an agreement for 2019-2022 mandate period. They were unable to reach a tentative agreement and the matter was referred to binding arbitration.
- During the spring/summer of 2021, the Ministry and MABC participated in binding arbitration hearings. Submissions, witness testimony, and closing arguments were completed on July 20, 2021.
- On December 20, 2021, the arbitrator submitted a decision on the terms of the agreement under dispute.

[4] Ibid., https://www.bccnm.ca/BCCNM/Announcements/Pages/Announcement.aspx?AnnouncementID=283.
[5] BCCNM email, Feb. 15, 2024.
[6] Email confirmation from the Ministry of Post-Secondary Education and Future Skills (PSFS) to NPS, February 1, 2023.
[7] Ibid.
[8] University of British Columbia, https://iembp.midwifery.ubc.ca/.
[9] Email communication from PSFS to NPS, January 31, 2023.
[10] University of British Columbia https://midwifery.ubc.ca/program/requirements/rn-advanced-placement-plan/.

- The Ministry has implemented the terms of the decision and proposed negotiation terms that were not under dispute throughout the 2022 calendar year.
- The Ministry began the 2022 round of negotiations with the MABC on April 4, 2022: a tentative agreement was reached between the parties on June 13, 2023, and the Agreement was ratified on July 31, 2023. Advic

Advice/Recommendations

LAST UPDATED

The content of this estimates note is current as of February 20, 2024, as confirmed by Zachary Matieschyn, Executive Director, Nursing Policy Secretariat Branch.

APPROVALS

2024 02 26 - Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 28 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 02 29 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

G-20

Minimum Nurse-to-Patient Ratio

Topic: Update on the progress of minimum Nurse-to-Patient Ratio (mNPRs) implementation in BC.

Key Messaging and Recommended Response:

- **Together with the BCNU, the Ministry of Health is establishing minimum nurse-to patient-ratios, the first in Canadian history, which will begin in spring 2024.**
- **Announced alongside the tentative agreement with the Nurses' Bargaining Association (NBA) in April 2023, the Ministry and NBA signed a $750 million memorandum of understanding to implement Minimum Nurse-to-Patient ratios (mNPRs) as part of a larger nursing strategy developed to support nurse well-being, facilitate quality patient outcomes, and increase capacity and efficiency of the healthcare system in BC.**
- **mNPR implementation is a long-term commitment and, from our learning from other jurisdictions including California and Australia, is anticipated to:**
  - **improve nurse retention and recruitment, quality of patient care, simplicity in staffing procedures and job satisfaction.**
  - **decrease the number of vacancies and burnout of nursing staff.**
  - **lead to a more efficient health-care system based on a predictable funding model.**
- **mNPRs will be implemented in hospitals, long-term care and assisted living, and health authority community and non-hospital care settings.**
- **The first 6 ratios were announced on Mar 1st with a commitment from the province to provide an update on the remainder by June 2024.**
- **mNPRs are supported by a $750 million investment over three years ($200 million in 2023/2024, $250 million in 2024/2025 and $300 million in 2025/2026).**

CURRENT SITUATION

- The Ministry of Health's policy direction on adult medical surgical units is near final.
- The Ministry and BC Nurses Union (BCNU) Senior Executives held a joint public announcement on Mar 1st, 2024 in Vancouver, BC.
- The announcement focused on the implementation of the first 6 mNPRs in acute care covering 365 days a year:
  - Adult medical and surgical units operating 24/7 (excluding surgical daycare): one nurse to four patients (1:4). NOTE: Adult medical-surgical units make up the majority of acute care across the province.

  - Palliative care units: one nurse to three patients 24/7 (1:3).
  - Rehabilitation units: one nurse to five patients on day/evening shifts; one nurse to seven patients on night shifts (1:5 days/evenings, 1:7 nights)
  - Focused (Special) Care units (Adult Care): one nurse to three patients 24/7 (1:3).
  - High Acuity/Step Down units: one nurse to two patients 24/7 (1:2)
  - Intensive Care (Adult/Child) units: one nurse to one patient 24/7(1:1)
- The first 6 ratios are for licensed practical nurses (LPN), registered psychiatric nurses (RPN), and registered nurses (RN), working in adult medical-surgical units.
- A bed-based and staffing gap analysis is underway, together with an implementation plan and budget template for health authorities to submit to the Ministry for approval.
- The target date for implementation is late Spring, early Summer of 2024.
- The Ministry and BCNU are working together to implement additional ratios which include the remaining hospital-based ratios, non-hospital (including health authority community care) settings and long-term care and assisted living settings and will provide an update on these settings by June 2024

FINANCIAL IMPLICATIONS

- Funding to implement mNPR included $200 million in 2023/2024, $250 million in 2024/2025 and $300 million in 2025/2026 – for a three–year total of $750 million.
- To support the implementation of minimum nurse-to-patient ratios, the Province announced that it is investing $237 million in initiatives that will retain, encourage the return of, and recruit new nurses into the health-care system, such as:
  - $169.5 million in one-time funding for the expansion of provincewide rural-retention incentives, GoHealth BC signing bonuses, recruitment signing bonuses for rural and remote communities, signing bonuses for difficult-to-fill urban and metro vacancies, and consistent with the agreement reached with the NBA in April of 2023, additional funding to support nurses in the areas of recruitment, retention and/or mental wellness.
  - $68.1 million in one-time funding for training and licensing investments, which will go toward expanding the internationally educated nurse (IEN) bridging program, implementing a licensed practical nurse (LPN) to registered nurse (RN) bridging pilot program at Kwantlen Polytechnic University, a nursing student tuition credit, an Indigenous nursing student tuition credit and new graduate transition program bursaries.

KEY BACKGROUND

- A Memorandum of Understanding (MoU) was signed between the Ministry and the Nurses' Bargaining Association (NBA) to implement mNPRs alongside the Provincial NBA Collective Agreement as part of the Shared Recovery Mandate on April 4, 2023.
- A provincial executive steering committee, comprised of members of the Ministry, BCNU, NBA, Health Employers Association of BC (HEABC) and health authority leaders was established in 2023 to facilitate the introduction of the new staffing model.
- In September 2022, the province released B.C.'s Health Human Resources (HHR) Strategy that addresses the underlying nursing workforce challenges across all four cornerstones (retain, redesign, recruit, and train). There are 42 actions focused on supporting nurses in the HHR strategy.

LAST UPDATED

The content of this estimates note is current as of February 13, 2024, as confirmed by Zachary Matieschyn, Executive Director, Nursing Policy Secretariat Branch.

APPROVALS

2024 02 20 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 11 - Miranda Mason, Health Sector Workforce and Beneficiary Services Division
2024 03 11 - Mark Armitage, Health sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

G-21

MSC - Public Healthcare System in BC

Topic: Efforts taken to defend the public healthcare system in BC.

Key Messaging and Recommended Response:

- **The responsibilities of the Medical Services Commission (MSC) are two-fold: to ensure all BC residents have reasonable access to medical care; and to manage the provision and payment of medical services in an effective and cost-efficient manner.**
- **In 2018, we strengthened the *Medicare Protection Act* (MPA) to include new protections for patients to prevent extra billing, clarify the rules for medical practitioners and establish consequences for those who break the rules.**
- **In September 2020, we saw a successful outcome in the landmark Cambie Surgeries Corporation litigation. The appeal was heard in June 2021, and a decision was rendered by the BC Court of Appeal in July 2022 upholding that of the BC Supreme Court, in favour of the province. On April 6, 2023, the Supreme Court of Canada denied Cambie's application for leave to appeal, bringing this ongoing proceeding to a successful conclusion.**
- **In December 2022, the MSC filed an injunction against TELUS Health for contravening the MPA. In April 2023, TELUS Health demonstrated to the Commission's satisfaction it would make the necessary changes to the LifePlus program to come into compliance.**
- **Similarly in February 2023, the MSC filed an injunction application against Harrison Healthcare, alleging contraventions of the MPA. Discussions between Harrison Healthcare and the MSC remain ongoing.**
- **We continue to demonstrate our commitment to upholding the principles of public healthcare in accordance with the *Canada Health Act* and the MPA. Our focus remains on building and investing in the public system including bringing more private clinics under public control.**

CURRENT SITUATION

- BC demonstrates rigorous commitment to defending public healthcare.
- In September 2020, BC saw a successful outcome in the landmark Cambie Surgeries Corporation (Cambie) litigation. The appeal was heard in June 2021, and a decision was rendered by the BC Court of Appeal on July 15, 2022. The decision upheld that of the BC Supreme Court, in favour of the province. On

April 6, 2023, the Supreme Court of Canada denied Cambie's application for leave to appeal, bringing this ongoing proceeding to a successful conclusion.

- Operational processes are in place to protect patients from extra billing. The BC Ministry of Health and the Medical Services Commission (MSC) process patient complaints and investigate allegations of extra billing to determine whether extra billing has taken place.
- Since 2017, the Ministry has completed twelve audits of private surgical clinics, including Cambie Surgeries Corporation. The results of these audits were shared with Health Canada.
- BC has seen success in curbing extra billing through government contracts with private clinics. As a requirement of these contracts, clinics and physicians are required to sign compliance statements acknowledging that they will not engage in extra billing.
    - In 2021/22, there were 8 facilities which the Health Authorities contracted with, to perform surgeries.
    - By negotiating contracts with private clinics to publicly insured services instead of private-pay services, BC continues to act to prevent extra-billing.
- Additionally, in April 2022 BC announced its purchase of View Royal Surgical Centre and Seafield Surgical Centre. These purchases resulted in an additional 2,300 surgeries and 2,300 endoscopies per year in the Island Health Authority. Through this strategy BC demonstrates its continued commitment to addressing patient extra-billing.
- On December 1, 2022, the MSC filed an injunction against TELUS Health, alleging TELUS' LifePlus Program contravened the MPA. In April 2023, TELUS Health demonstrated to the Commission's satisfaction that it would make the necessary changes to the LifePlus program to come into compliance with the MPA.
- On February 1, 2023, the Commission filed an injunction application against Harrison Healthcare, alleging contraventions of the MPA. Discussions between Harrison Healthcare and the MSC remain ongoing.
- The Commission has contacted nearly 20 entities that it is aware are offering bundled services (similar to the services offered by TELUS LifePlus and Harrison Healthcare) and continues to contact new entities brought to its attention. These include corporations, bricks and mortar health care clinics, and independent practitioners. Efforts to stop those services continue.

FINANCIAL IMPLICATIONS

- In last year's report for 2020/21, the amount of extra billing and user charges reported by BC to Health Canada was $23,110,530.54. BC's March 2023 Canada Health Transfer (CHT) payment was reduced by this amount.
- In this year's report for 2021/22, the amount of extra billing and user charges reported by BC to Health Canada was $18,118,720.87, a reduction of nearly $5 million in comparison to the 2020/21 report.
    - The report included a total of $11,270,216 in extra billing related to diagnostic services.
- In March 2023, under Health Canada's Reimbursement Policy, a $22,405,749[1] reimbursement was applied to BC's March 2024 CHT payments, which represents a partial reimbursement of BC's March 2022, March 2023, and March 2024 CHT deductions.

KEY BACKGROUND

- The purpose of the MPA is to preserve a publicly managed insurance plan and a fiscally sustainable health care system in which access to necessary medical care is based on need and not an individual's ability to pay.
- The MSC pays for insured medical services (benefits) provided to eligible residents of BC under the Medical Services Plan (MSP) in accordance with the MPA. The MPA establishes rules regarding billing for services provided by physicians who are enrolled with MSP. In general, patients (or their representatives) must not be charged for benefits. The MPA also prohibits anyone from charging patients for *"materials, consultations, procedures, use of an office, clinic, or other place, or for any other matters that relate to the rendering of a benefit",* unless specifically permitted by the Commission.

[1] March 5, 2023, email from Jocelyne Voisin (Health Canada) to Mark Armitage (B.C. Ministry of Health).

- In 2018, the Government brought into force outstanding provisions of the Act, which enhanced the Commission's authority around extra billing (Bill 92).
- Private companies are attracting physicians and other primary healthcare practitioners away from the public health care system compounding existing, underlying systemic challenges with primary care.

LAST UPDATED

The content of this estimates note is current as of March 12, 2024, as confirmed by Executive Director, Stephanie Power.

APPROVALS

2024 02 26 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2024 03 14 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

G-22

Northern Health Workforce Supports

TOPIC: Progress on Ministry-funded programs that support service delivery and improve rural recruitment and retention in Northern Health Authority.

Key Messaging and Recommended Response:

- **In September 2021, the Ministry of Health announced funding to Northern Health Authority to support programs that address health workforce challenges in rural and remote communities.**
- **These include a prototype rural retention incentive, a travel resource pool, childcare and housing supports, as well as clinical management supports to bolster the workforce and address challenges faced in rural communities.**
- **Many of these initiatives are being expanded through BC's Health Human Resources (HHR) Strategy to include rural and remote areas across the province:**
  - **The Prototype Rural Retention Incentive is being expanded to 72 rural and remote communities across the province as the Provincial Rural Retention Incentive;**
  - **The Travel Resource Pool has expanded (as GoHealth BC) to additional communities in Northern Health and select rural communities in Island and Interior Health;**
  - **The Childcare and Housing supports pilot programs are slated to expand through the HHR Strategy; and**
  - **Clinical management supports are being developed through the HHR Strategy (Actions 14 and 15). Health authorities are recruiting additional managers and management extenders and are assessing the workload of current clinical managers.**
- **Through Nurse-to-Patient Ratios (NPR) (announced March 1, 2024), incentives for nurses joining rural and remote communities, taking difficult to fill vacancies in urban and metro communities, and joining GoHealth BC.**

CURRENT SITUATION

- **The Prototype Rural Retention Incentive (PRRI)**[1] – up to $2,000 per quarter for high needs communities and occupations.

[1] Prototype Rural Retention Incentive Data. HA submission to HWPI, September 2023.

  - An average of 1,038 employees per quarter have received this incentive in the Northern Health Authority (NHA).
  - Between Q4 of FY2022/23 and Q1 of FY2023/24 an additional 24 employees started receiving PRRI payments- a 1.5% increase between quarters.
  - PRRI has since been extended to Grand Forks (Interior Health) and Mt Waddington (Island Health).
  - An expansion of the PRRI (as the Provincial Rural Retention Incentive) to an additional 56 communities across the province (increasing the number of communities supported in NHA by 16, to 28) was announced March 1, 2024, through BC's Health Human Resources Strategy and the minimum Nurse to Patient ratios.
- **The Travel Resource Pool (TRP/GoHealth BC)**[2] - a pool of health care workers who travel to high-needs communities in response to urgent staffing shortages. The TRP expanded in 2023 to provide deployments to rural and remote communities in Interior and Island Health, as 'GoHealth BC'.
  - Provincial expansion and expansion to additional occupations is planned for 2024.
  - GoHealth currently employs 200 RNs and LPNs, 44% of which have joined from addresses outside BC and are net new to the provincial system.
  - Announced on March 1, 2024 , some nurses will be eligible to receive up to $15,000 in signing bonuses if they choose to take a regular position with GoHealth BC.
- **Recruitment Incentives –** as of April 1, 2024, to support the unique needs and challenges of working in remote communities, the province will provide as much as $30,000 to eligible nurses who fill identified high needs vacancies in northern rural and remote communities.
- **Housing Supports**[3] – a prototype to fund the procurement of housing units in communities where suitable market housing is a barrier to permanent staffing and short-term deployments.
  - NHA has obtained 1 property in Dawson Creek, 3 units in Fort St. John, 1 property in Kitimat, 3 units in Prince Rupert, 1 unit in Chetwynd, and 1 unit in Valemount. Renovations to existing units are nearing completion in Hazelton and a furniture upgrade has been completed for an on-site residence in Vanderhoof.
  - Partnership with Valemount Regional District to support their purchasing of a multi-unit house in the Village of Valemount.
  - Standard Operating Procedures and Policies for housing operations are now in place and there are designated housing coordinators in Dawson Creek/Chetwynd, Fort St. John, Hazelton, and Prince Rupert.
  - A provincial health sector housing strategy is being developed through the HHR Strategy.
- **Childcare Support**[4] – a prototype to support expanded net new childcare seats and expanded hours of operation to meet the needs of health care workers.
  - Expansion from 33 spaces in January 2023 to 113 spaces in January 2024.
  - Underway in 4 communities (Chetwynd, Fort St. John, Kitimat, and Prince George).
  - 36 spaces live in Fort St. John, 24 of which are extended hours childcare spaces.
  - 21 spaces secured in Terrace and 32 spaces secured in Prince George.
  - 12 additional spots targeted in Chetwynd.
  - 24 spaces prioritized for NHA in School District 52's Before and After School program in Prince Rupert.
  - A provincial health sector childcare strategy is being developed through the HHR Strategy.
- **Clinical Management Supports**[5] – prototype to increase clinical program management capacity to ensure workload and workforce sustainability.
  - 12 positions created in Prince Rupert and the Northeast: clinical nurse educators, patient care coordinators, operations assistants, recruitment ambassadors, and HR assistants.

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[2] GoHealth BC Data. HA Submission to HWPI. January 2024.
[3] HHR Summary Report to Ministry for Estimates Debate. HA Submission to HWPI. February 2024.
[4] Ibid
[5] Discussion Document Ministry Funded Immediate Actions Costings 23-24. HA Submission to HWPI. February 2022.

- A provincial clinical management support framework and program expansion is being developed through the HHR Strategy and is currently in implementation stages.

- **Terrace Obstetrical Care Services**[6] – one-time community fund to support appropriate care levels.
  - Recruited new members and retained the existing members resulting in service stabilization.

FINANCIAL IMPLICATIONS

- Budget 2023 invests $995 million over three years to support 70 actions in the HHR Strategy, which includes several of the initiatives above.
- The Nurse-to-Patient Ratios initiative is investing $51.5M in FY2024/25 in recruitment and retention incentives (the Provincial Rural Retention Incentive, Rural and Remote Recruitment Incentive, Difficult to Fill Vacancy Recruitment Incentive, and GoHealth BC Signing Bonus) for nurses in BC.

KEY BACKGROUND

- Rural and remote communities in NHA have consistently had trouble with healthcare worker recruitment and retention.
- The COVID-19 pandemic increased strain on the workforce and exacerbated health workforce challenges in NHA.
- Starting in 2021/22,[7] the Ministry of Health (HLTH) has provided over $6.3M to NHA for programs and incentives to stabilize services, attract new health care workers, and retain existing workers.
- In FY2023/24,[8], HLTH provided the following funding to continue, and expand, support programs:
  - Prototype Rural Retention Incentive (PRRI): HLTH has provided NHA with approximately $8.5M to fund financial incentives for priority health-care workers.
    - The incentive was implemented in January 2022, retroactive to October 2021. In 2023, PRRI was expanded to include Haida Gwaii.
  - GoHealth BC: HLTH has provided $27.7 million to continue and expand the NHA Travel Resource Pool, which directly contributes to service stability in rural and remote regions of the health authority. This includes an expansion in FTEs and communities served.
  - NHA Housing Pilot: HLTH has provided $2.1 million in funding so NHA can develop a pilot housing program in communities where suitable market housing is barrier to both permanent staffing and short-term deployments, as well as work with ministry staff to develop a provincial health housing strategy.
  - Northern Health Childcare Pilot: HLTH has provided $860,000 in funding so that NHA can develop a pilot childcare program to meet the needs of health-care workers (especially those working 12-hour shifts) in addition to supporting the creation of a new provincial health childcare strategy.
  - Clinical Management Supports: HLTH has provided $1.6 million in funding to NHA to create clinical management supports for Prince Rupert and the northeastern region, as well as to support development of a provincial program expansion.
- Actions supported by the Provincial Health Human Resources Strategy that build on this work include:
  - Action 06 - Targeted Provincial Retention Incentive
  - Action 07 - Health Childcare Strategy and Childcare Pilot Expansion
  - Action 14 - Clinical Management Capacity Building
  - Action 34 - Provincial Travel Resource Pool
  - Action 42 - Provincial Health Sector Housing Strategy

LAST UPDATED

The content of this estimates note is current as of February 28, 2024 as confirmed by Executive Director, Meghann Brinoni, Health Workforce Planning and Implementation.

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[6] Discussion Document Ministry Funded Immediate Actions Costings 23-24. HA Submission to HWPI. February 2022.
[7] Ibid
[8] Ibid

APPROVALS

2024 03 08 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 20– Miranda Mason, Health Sector Workforce and Beneficiary Services Division.

LEGISLATIVE SESSION – ESTIMATES NOTE

G-23

Number of Health Professional Registrants by College or Registry

Topic: Update on the current number of health professional registrants in BC.

Key Messaging and Recommended Response:

- **BC's Health Human Resources Strategy, announced fall 2022, has 70 concrete actions focused on training, recruitment, and retention of health care workers.**
  - **These actions address staffing capacity issues throughout the health care system and will help alleviate the burden on health care workers in BC.**
- **Since 2017 we have added 40,000 health care workers to our public health care system in BC.**[1]
- **Many health sector workers are required to register with their professional regulatory college or a register.**
- **The following numbers are the health professional registrants for the 2022/23 reporting cycle.**

CURRENT SITUATION

Health Professions		Reporting Cycle	Practicing Only	Total (incl. non-practicing)
Chiropractors[2]		2022/23	1,427	1,487
Dental Hygienists[3]		2022/23	4,358	4,747
Dental Surgeons[2]	Dentists	2022/23	4008	4144
	Certified Dental Assistants	2022/23	6176	6672
Dental Technicians[2]		2022/23	295	298
Denturists[2]		2022/23	242	252
Dietitians[4]		2022/23	1,500	1,551
Licensed Practical Nurse[5]		2022	15,609	16,047
Massage Therapists[6]		2022	6,087	6,314
Midwives[4]	Midwives	2022	363	459
	Employed student midwife	2022	80	80
Naturopathic Physicians[7]		2022	731	874
Occupational Therapists[8]		2021/22	2,922	3,022
Opticians[9]		2021/22	911	993
Optometrists[10]		2022	938	940
	Pharmacists	2022/23	-	6,731

[1] PSEC Annual Compensation Forecast, 2023 vs. 2018
[2] College of Chiropractors of BC 2022-23 Annual Report.
[3] British Columbia College of Oral Health Professionals 2022-23 Annual Report.
[4] College of Dietitians of BC 2022-23 Annual Report.
[5] BC College of Nurses and Midwives 2022 Annual Report.
[6] College of Massage Therapists of BC 2022 Annual Report.
[7] College of Naturopathic Physicians of BC 2022 Annual Report. Excludes Student Registrants.
[8] College of Occupational Therapists of BC 2021-22 Annual Report.
[9] College of Opticians of BC 2021-22 Annual Report.
[10] College of Optometrists of BC 2022 Annual Report.

Health Professions		Reporting Cycle	Practicing Only	Total (incl. non-practicing)
Pharmacists[11]	Technicians	2022/23	-	1725
Physical Therapists[12]		2022/23	-	4960
Physicians and Surgeons[13]	Family practitioners	2022/23	7,393	15,502[14]
	Specialists	2022/23	7,257	
Podiatric Surgeons[15]		2022/23	73	See above.
Psychologists[16]		2022	1,353	1,453
Registered Nurses[4]	Registered Nurses	2022	46,102	47,463
	Employed student nurses	2022	1,101	1,101
Registered Psychiatric Nurses[4]	Registered Psychiatric Nurses	2022	3,388	3498
	Employed student psychiatric nurses	2022	30	30
Speech and Hearing Health Professionals[17]	Audiologists	2022	-	319
	Hearing Instrument Practitioners	2022	-	566
	Speech Language Pathologists	2022	-	1,486
	Total	2022	-	2,371
Traditional Chinese Medicine Practitioners and Acupuncturists[18]		2022/23	2,906	3,005
Emergency Medical Assistants[19]	Paramedics	January 3, 2024	-	8,845
	First Responders	January 3, 2024	-	7,301
Health Care Assistants[20]		January 29, 2024	N/A	52,060

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

N/A

LAST UPDATED

The content of this estimates note is current as of February 21, 2024, as confirmed by Mark MacKinnon, ED PRO.

APPROVALS

2024 02 28 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division

[11] College of Pharmacists of BC 2022-23 Annual Report.
[12] College of Physical Therapists of BC 2022-2023 Annual Report.
[13] College of Physicians and Surgeons of BC 2021-22 Annual Report.
[14] This number includes a small number of podiatric surgeons as the total number of registrants outlined in the college's annual report includes both physicians and podiatric surgeons.
[15] College of Physicians and Surgeons of BC 2022/23 Annual Report.
[16] College of Psychologists of BC 2022 Annual Report.
[17] College of Speech and Hearing Health Professionals of BC 2022 Annual Report. This total is less than the combined number for each profession as many registrants are registered in two or three professions.
[18] College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC 2022/23 Annual Report.
[19] Emergency Medical Assistants Licensing Board (2024).
[20] BC Care Aide & Community Health Worker Registry 2023 Year-End Update Report to MOH (confidential), January 29, 2024

LEGISLATIVE SESSION – ESTIMATES NOTE

G-24

Nurse Practitioners

Topic: Demand for Nurse Practitioners (NPs) has remained high since their introduction in 2005. As of December 31, 2023, there are 1,075 NPs registered in the Province.[1]

Key Messaging and Recommended Response:

- **We are dedicated to actions that grow, retain, and support NPs.**
  - **Under this government, the number of NP education seats at post-secondary institutions in BC has more than doubled, to 100 seats.**
  - **As part of the Provincial HHR Strategy, this government is further expanding NP education to 165 seats by September 2024; almost quadrupling NP seats since 2017.**
- **These actions to grow the NP workforce are making a difference to people living in BC:**
  - **The NP workforce in BC has more than doubled under the current government, from 418 NPs in 2017 to 1,075 NPs registered in BC across all classes including 1,029 practicing, 26 non-practicing, and 20 provisional as of December 31, 2023.**
  - **In 2020, three NP primary care clinics (NPPCCs) were opened in Nanaimo, Surrey, and Victoria. These clinics have attached over 14,000 previously unattached patients and are expected to ultimately attach 21,000 patients.**
  - **Independent research conducted by the University of Victoria has shown patients experience dramatic improvements in access to care, as well as improvements in their health, after attaching to an NP at an NPPCC.**
- **Increasing NP training seats and investing in NPPCCs are just some of the ways we are taking action to increase health system capacity and service delivery in the province, ensuring that the people in BC receive the care that they need.**

CURRENT SITUATION

- NPs are an integral part of the new model of team based primary health care.[2]
- NPs have a background as registered nurses. Once they have gained a minimum of 2 years of clinical experience they then complete a clinically focused master's degree which allows them to serve as autonomous practitioners in both primary and acute care.

[1] Provider and Location Registry data extract, January 11, 2024. NPs with status code "terminated" or "suspended" are filtered out.
[2] For more information on MoH primary care policy, see the Primary Care Networks fact sheet.

- NPs have a broad scope of practice (SOP) that includes:
  - Attaching, managing, and treating patients;
  - Conducting health assessments;
  - Ordering and interpreting diagnostic tests;
  - Managing acute and chronic illnesses or injuries;
  - Prescribing medication and other interventions; and
  - Referring patients to specialists and other care providers if needed.
- Full-time primary care NPs are generally expected to carry a panel of 1,000 patients. Reductions to this target may occur if the NP serves rural/remote or priority populations.
- In addition to longitudinal primary care, NPs also provide a variety of acute and specialty care. For example, this includes post-surgical cardiac care, oncology, NICU, etc.
- Standards, limits, and conditions for BC NPs are set by the BC College of Nurses and Midwives (BCCNM). These are found in the Scope of Practice for Nurse Practitioners section of the BCCNM website.[3]
- The vast majority of NPs work in publicly funded positions. NPs are paid a salary or hourly wage and do not submit fee-for-service claims like most physicians in BC. However, they must still submit encounter codes to the Ministry of Health (MoH) documenting their activities.
- Demand for NPs has remained high since their introduction in 2005. As of December 31, 2023, there are 1,075 NPs registered in the Province.[4]
- NPs in BC currently have two main compensation options: working as employees of health authorities (HAs) or, since 2018, as independent contractors on PCN service contracts. The latter is designed for providing longitudinal primary care and offers greater independence and remuneration in place of the extended benefits, leave, and coverage offered by HAs.
- The majority of NPs are employed by HAs, with 236 currently working as contractors.
- HA employed NPs receive practice supports from their employer, generally including personal and professional support, internal learning opportunities, and funding for continued education.
- PCN contracted NPs receive practice support through the Nurses and Nurse Practitioners of BC (NNPBC) professional association. These are: clinical coaching; advice, mentorship, and advocacy; quality improvement and assurance; funding for continuing professional development; and reimbursement for time spend participating in PCN committees, MoH working groups, and QI activities.
- NPs in BC are educated at one of the Province's four NP programs (UVic, UBC, UNBC, TRU) or arrive with equivalent credentials. BC NP programs currently graduate 100 students each year, with an additional 65 seats starting in September 2024.
- The Nursing Policy Secretariat (NPS) was founded in 2017 to support the work of NPs and other nursing designations. This includes identifying and addressing legislative barriers to NP's SOP, such as amending the *Human Tissue Gift Act* so NPs can declare death for organ donors for the purpose of transplantation.
- In 2020, 3 NPPCCs were opened in Nanaimo, Surrey, and Victoria, communities where a significant percentage of the population lacks access to an MRP. They are expected to collectively attach more than 21,000 previously unattached patients.[5]
- In December 2022, Personal Information commenced an action in the BC Supreme Court against Interior Health and the Province, alleging compensation inequity compared to general practitioner physicians. The plaintiffs still have not served the claim on the Province and it seems they may not intend to pursue it.

FINANCIAL IMPLICATIONS

- From 2005/06 to 2023/24, the Province has provided approximately $473 million in funding for NP positions and supports.

[3] *Scope of Practice for Nurse Practitioners* (BCCNM, September 2018). Retrieved January 14, 2021 from: https://www.bccnm.ca/NP/ScopePractice/Pages/Default.aspx

[4] Provider and Location Registry data extract, January 11, 2024. NPs with status code "terminated" or "suspended" are filtered out.

[5] For more information about NP PCCs, please see the NPs in Primary Care Estimates Note and NPPCC Supplemental.

- The MoH has made several large-scale investments to train, deploy, and support NPs, including:
  - Since 2012/13, the NP4BC program provided HAs with approximately $53.4 million to hire 135 primary care NPs.
  - In 2018, Government announced funding of approximately $115 million over three years for 200 (later increased to over 400) FTE NPs on PCN contracts.[6]
  - From March 2019 to February 2024, the MoH has provided $10.05 million in funding to the NNPBC to develop and deliver practice support programs for PCN contracted NPs and others who lack access to practice supports[7].

KEY BACKGROUND

The MoH has continually worked with BC's NP programs and PSFS to increase the number of student seats.

- In 2004, the first 30 placements were funded at UVic and UBC (15 each).
- In 2006, 15 additional seats were created with the founding of UNBC's NP program, making the total 45.
- The number of student seats remained static until being increased to 70 in 2019.[8]
- 10 additional student seats were added to the UVic program over 2020-2021.
- In 2023, 5 further seats were added to the UVic program, and 15 additional seats created as part of the launch of TRU's NP program.[9] This brought the total to 100 seats.
- As a result of the Provincial HHR Strategy, in September 2024 an additional 65 seats will be created, bringing the total to 165.

The MoH has also reduced the legislative/regulatory barriers that prevent NP's from exercising their full SOP.

- In 2011, *Bill 10* amended 12 acts and brought 11 others into force – all increased NP's SOP.
- In 2012, the *Hospital* and *Hospital Insurance Acts* were amended to permit NPs to admit/discharge.
- In 2014, *Bill 17* amended 9 additional acts to again increase NP's SOP.
- From 2015-2019, NPs became able to prescribe controlled drugs and opioid agonists, order diagnostic tests like MRIs, serve as medical assistance in dying assessors and prescribers, and affirm disabilities.
- As of February 1, 2023, sections of *Bill 10* were brought into force to amend the *Mental Health Act* to permit NPs to issue involuntary 48 hour holds for those whose mental health crises pose a serious risk to themselves or others.

LAST UPDATED

The content of this estimates note is current as of February 15, 2024 as confirmed by Zachary Matieschyn, Executive Director, Nursing Policy Secretariat.

APPROVALS

2024 02 20 - Eric Larson obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2024 02 22 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 02 27 - Miranda Mason, Health Sector Workforce and Beneficiary Services Division

[6] Creating new opportunities for nurse practitioners as part of team-based care system. May 23, 2018. Retrieved January 14, 2021 from https://news.gov.bc.ca/releases/2018HLTH0034-000995
[7] GL detail report – Payments to NNPBC from beginning of contract to February 21, 2024. Source: NNPBC - GL Details (Payments).xls
[8] https://news.gov.bc.ca/releases/2018HLTH0034-000995.
[9] https://news.gov.bc.ca/releases/2022HLTH0004-000250.

LEGISLATIVE SESSION – ESTIMATES NOTE

G-25

Nursing Supply Numbers

Topic: An overview of nursing workforce data.

Key Messaging and Recommended Response:

- **Nurses play an essential role in our health care system and the province is dedicated to actions that grow, retain, and support nurses.**
- **42 of the 70 actions of BC's Health Human Resources (HHR) strategy address issues affecting nurses.**
- **These actions include:**
  - **Funding 602 new seats in nursing programs at public post-secondary institutions across BC.**
  - **Doubled the number of nurse practitioner seats at UNBC School of Nursing from 20 to 40 seats. The first cohort will be starting in September 2024.**
  - **Added financial support and career navigators to help internationally educated nurses (IENs) through the assessment and licensing processes. This means helping IENs enter the workforce more quickly so they can help care for patients in BC as soon as possible.**
  - **Providing bursaries to support health care assistants interested in training to become licensed practical nurses – this helps grow and retain our healthcare workforce.**
  - **Implementing minimum nurse-to-patient ratios across the health system over the coming years.**
- **Despite the challenges that we've been facing, between 2017 and 2023, we've seen a 19.8% increase in the number of nurses registered in BC.**

CURRENT SITUATION

- As of December 31,2024, there are 70,163 nurses registered with the BC College of Nurses and Midwives across all categories (practicing, non-practicing, provisional, employed student), including registered nurses (RNs), registered psychiatric nurses (RPNs), licensed practical nurses (LPNs), employed student nurses, and nurse practitioners (NPs). These numbers do not include Temporary Emergency Registrations.
  - This is a net increase of 10,674 (17.9%) since 2018.
  - 6,567 nurses were newly registered in BC in 2023 (January 1 to December 31) – these are new to BC's healthcare system but does not take outflows (retirements, departures) into consideration.

- According to the most recent CIHI data, from 2021 to 2022:[1]
  - BC was third among the provinces in growth in the number of RNs (+1.4%) compared with 1.4% growth in Ontario and 0.04% growth in Alberta.
  - BC was fourth among the provinces in growth in LPNs (+1.6%) compared with 2.9% growth in Ontario and 4.6% growth in Alberta.
  - From 2021 to 2022, BC was third among the provinces in growth in all nurses (RNs, LPNs, RPNs, and NPs) (+1.7%) compared with 2.0% growth in Ontario and 1.5% growth in Alberta.
- According to the most recent CIHI data, from 2017 to 2022:[2]
  - BC was third among the provinces in growth in the number of RNs (+9.5%) compared with only 6.0% growth in Ontario and 2.4% growth in Alberta.
  - BC was third among the provinces in growth in LPNs (+13.7%) compared with 17.8% growth in Ontario and 23.6% growth in Alberta.
  - From 2017 to 2022 BC was third the provinces in growth in all nurses (RNs, LPNs, RPNs, and NPs) (+11.5%) compared with 10.3% growth in Ontario and 8.6% growth in Alberta.
- Since the Internationally Educated Nurse (IEN) Assessment and Nurse Re-Entry Support Program (Action 36 of BC's HHR Strategy) launched in January 2023, 1,774 IENs received a registration decision from BCCNM (as of February 29, 2024):
  - 871 IENs have received full registration as an RN, RPN, or LPN, up from only 288 in 2022.
  - 942 IENs have been referred to additional education for which they can access bursaries.
  - 150 IENs have registered as health care assistants.
- Health Authorities(HAs)/Providence Health Care (PHC) hired an estimated 6500 nurses in 2023.[3]
- Nurses in BC worked an estimated 33,508 full-time equivalents (FTEs) in 2023.[4]
  - The average FTE to headcount ratio was 0.68 for RNs/RPNs and 0.64 for LPNs.
- In the HA workforce, RNs/RPNs headcount increased from 36,841 in 2017 to 40,852 in 2022 (11%).[5]
- LPN headcount increased from 9,702 in 2017 to 11,264 in 2022 (16%).[6]
- Characteristics of the BC Nursing Workforce in 2022:[7]
  - 46% of RNs and 49% of LPNs are under the age of 40.
  - 90% of RNs and LPNs are female.
  - 14% of RNs were internationally educated, while 85% of LPNs were Canadian educated.
  - 94% of RNs and 92% of LPNs work in urban areas.
  - 91% of RNs and 93% of LPNs work in Direct Care.
  - 67% of RNs work in hospitals, 19% in community settings, and 6% in nursing homes/long term care.
  - 38% of LPNs work in hospitals, 15% in community settings, and 40% in nursing homes/long term care.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

Education and Training[8]

- Most nurse graduates from BC remain in BC (92% of LPNs, 76% of RPNs, 76% of RNs).[9]

[1] CIHI. Nursing in Canada, 2022 — Data Tables. Ottawa, ON: CIHI; 2023.I https://secure.cihi.ca/estore/productSeries.htm?locale=en&pc=PCC449
[2] *Ibid* 6.
[3] Hiring data and number of distinct employees as provided to the ministry by HAs/PHC in February 2024.
[4] 2023 FTEs were estimated using historical trends by the Finance and Corporate Services Division.
[5] Health Sector Compensation Information System (HSCIS) v. 20230306, MOH-HHR Occupations FTE EE Count by Geographic Region-20230320 data as of March 6, 2023.
[6] Ibid 4.
[7] Ibid 6.
[8] Health Sector Priority Occupation Profiles and Workforce Data, Strategic Priorities Recruitment and Reporting, Health Sector Workforce and Beneficiary Services Division May 2022
[9] *Ibid* 6.

- The BC College of Nurses and Midwives (BCCNM) recognizes 13 Bachelor of Science in Nursing (BSN) degree granting programs (9 universities, 3 colleges, and British Columbia Institute of Technology) and 7 recognized colleges that partner with a university BSN program.
- BCCNM recognizes educational institutions in 34 communities throughout BC that offer a practical nursing program.
- Budget 2021 included $96 million for seat expansions to add 602 new nursing seats across BC and 1000 new specialty nursing training opportunities. Total enrollment in nursing programs has increased 19% since the 2019/20 school year.
- In 2024/25, BC post-secondary institutes expect to graduate approximately:
  - 1,500 RNs
  - 120 RPNs
  - 500 LPNs
- Nursing education takes up to 4 years. As a result, the effects of seat expansions announced in Budget 2021 have yet to be realized in the number of annual RN graduations.

Nursing Seats per Year	2019/20	2020/21	2021/22	2022/23	2023/24
Nursing	**3096**	**3096**	**3144**	**3499**	**3675**
Licensed Practical Nurse	450	450	450	540	630
Registered Nurse	1526	1526	1574	1799	1885
Registered Psychiatric Nurse	120	120	120	160	160
Specialty Nurse	1000	1000	1000	1000	1000

LAST UPDATED

The content of this estimates note is current as of February 21, 2024, as confirmed by Executive Director, Meghann Brinoni, Health Workforce Planning and Strategic Implementation Branch.

APPROVALS

2024 02 29 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 04 11 – Miranda Mason, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

G-26

Pathways to Practice for Internationally Educated Physicians

Topic: Internationally educated physicians or International Medical Graduates (IMGs) who received their medical training outside of Canada have several pathways to licensure in BC.

Key Messaging and Recommended Response:

- **Physicians who have completed their medical training outside of Canada contribute significantly to the province's health workforce and play a vital role in achieving positive health outcomes for people living in BC.**
- **The Ministry is actively supporting and implementing strategies to help International Medical Graduates (IMGs) start practicing in BC.**
    - **The Practice-Ready Assessment BC (PRA-BC) program for internationally licensed family physicians expanded from 32 to 96 seats annually in 2024 supporting improved access to medical care across the province.**
- **The introduction of Associate Physicians (APs) has created over 100 open job opportunities for IMGs who would not otherwise be able to contribute to patient care in BC.**
    - **APs are now working in health authorities across BC under the supervision of a fully licensed physician providing safe, quality patient care and improving access to health services across the province.**
- **The Ministry-funded recruitment service, Health Match BC (MyHealthCareers), conducts the initial screening of the credentials of IMGs wishing to practice medicine in BC. This service supports IMGs through the various options for licensure and registration process; as well as provide information and guidance on immigrating to Canada.**
- **793 IMGs were registered between January 1, 2023 – February 28, 2024.**

CURRENT SITUATION

- **PRA-BC** - IMGs who completed their residency and practiced independently abroad as a family practitioner can apply to complete the PRA-BC program. PRA-BC program expanded intake from 32 to 96 seats annually in 2024, with communities across BC receiving Return of Service (ROS) placements. (See PRA-BC Estimates Note)
- **Residency Training** - IMGs who have not completed postgraduate training or who have completed postgraduate training outside of Canada and are willing to retrain may apply to UBC's IMG stream or new Competitive stream residency program through Canadian Residency Matching Service (CaRMS). These programs come with an attached ROS to benefit many communities across BC, while also providing a route to full licensure in BC. (See IMG-BC Estimates Note)

- **Associate Physicians** – Health authorities are rapidly implementing the associate physician role in a wide range of service settings. (See Associate Physicians Fact Sheet)
- **USA Certified** – In January 2023, the CPSBC added the 'USA certified' class of licensure for American Board of Medical Specialties (ABMS) certified physicians with three years of specialty training in Emergency Medicine, Internal Medicine, and Pediatrics who wish to practice medicine in BC and who are not otherwise eligible for registration in the full or provisional licensure classes.
- **American Osteopathic Board of Family Physicians** – In October 2023, the College of Physicians and Surgeons of BC (CPSBC) has introduced a route to provisional licensure in the family medicine class for physicians who have obtained certification with the American Osteopathic Board of Family Physicians.
- **Alternatives to national certification exams** – In October 2023, the CPSBC amended their bylaws to provide new alternatives to the College of Family Physicians of Canada (CFPC) and Royal College of Physicians and Surgeons (RCPSC) national certification exams.
    - Summative assessment – physicians in the provisional class of registration can transfer to the full class after successfully completing an assessment of competency.
    - Restricted licensure (Family & Specialty) – physicians in the provisional class who have not obtained the CFPC or RCPSC certification exam but have completed 5 years of practice in BC can move to a new class of restricted licensure (with health authority sponsorship).

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- Medical education varies widely among IMGs due, in part, to the varied selection, evaluation and credentialing processes in place at different international medical schools.
- Physicians wanting to practice medicine in BC must be registered and licensed with the CPSBC as the provincial medical regulatory authority. The role of the CPSBC is to ensure physicians meet expected standards of practice and conduct and the over-riding interest is protection and safety of patients.
- The CPSBC relies on the national regulatory bodies, the CFPC and the RCPSC, to determine if IMGs meet the appropriate national standards for certification.
- In BC, there are a variety of licensure categories available for IMGs depending on their educational background and clinical experience:
    - **Provisional (Family & Specialty)** - Permits a registrant to practice medicine with limits and conditions granted by the CPSBC. An IMG granted a provisional license must have a sponsoring organization (i.e., health authority) and a supervisor approved by the CPSBC.
    - **Clinical observer**– For IMGs seeking to enter a postgraduate (residency) training program in BC. Clinical observers are not authorized to practice independently and function at the level of a fourth-year medical student.
    - **Assessment** – For qualified internationally trained family physicians selected to participate in the PRA-BC Program.
    - **Associate Physician (Acute and Community Primary Care)–** For IMGs, who do not meet the requirements for any other class of licensure, to practice under the supervision of a fully licensed physician in accredited structured team-based care settings.
    - **USA Certified** – In January 2023, the CPSBC added the 'USA certified' class of licensure for American Board of Medical Specialties (ABMS) certified physicians with three years of specialty training in Emergency Medicine, Internal Medicine, and Pediatrics who wish to practice medicine in BC and who are not otherwise eligible for registration in the full or provisional licensure classes. The USA Certified class is an independent class of licensure that is restricted to a physician's scope of practice.
    - **American Osteopaths** - allows US trained physicians with certification from the American Osteopathic Board of Family Medicine to become provisional registrants. The CFPC has recognized these physicians through the practice eligibility route, and they have the ability to sit the CCFP certification examination after two years of practice in a Canadian jurisdiction.

LEGISLATIVE SESSION – ESTIMATES NOTE

G-26

LAST UPDATED

The content of this estimates note is current as of March 26, 2024, as confirmed by Executive Director, Kevin Brown.

APPROVALS

2024 04 03 - Mark Armitage, Health Sector Workforce and Beneficiary Services

LEGISLATIVE SESSION – ESTIMATES NOTE

G-27

Pharmacist Scope of Practice

Topic: The province recently optimized and expanded pharmacists' scope of practice in relation to their authority to renew and adapt prescriptions, administer injections, and prescribe for minor ailments and contraception.

Key Messaging and Recommended Response:

- **BC's Health Human Resources Strategy commits to optimizing and expanding pharmacy services to support primary care. Actions and progress made in relation to this commitment include:**
  - **As of October 14, 2022, the province optimized pharmacist scope of practice so that pharmacists can adapt and renew prescriptions for a wider range of drugs and conditions, and are able to administer, further to a prescription, a wider range of drugs by injection or intranasally.**
  - **As of June 1, 2023, the province expanded pharmacist scope of practice to allow pharmacists to prescribe for minor ailments and contraception.**

CURRENT SITUATION

- As of October 14, 2022, BC pharmacists are authorized to:
  - Renew and adapt existing prescriptions for a wider range of medication types and conditions, including chronic diseases.
  - Renew prescriptions for narcotics, controlled drugs and targeted substances, for the same duration as originally prescribed (as permitted by a Health Canada temporary exemption to the federal *Controlled Drugs and Substances Act*).
  - Administer a wider range of prescribed drugs by injection and intranasal route.
- As of June 1, 2023, BC residents can seek treatment for 21 minor ailments (such as uncomplicated urinary tract infection, acne, dermatitis) and contraception directly from a pharmacist through the Minor Ailments and Contraception Service (MACS).

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- The practice of pharmacy is a designated health profession under the *Health Profession Act* and is regulated by the College of Pharmacists of British Columbia (CPhBC) in accordance with the Act, the Pharmacists Regulation, and the bylaws of the CPhBC.
- On September 29, 2022, Minister Dix announced a new health workforce strategy for BC, which included actions related to the optimization and expansion of pharmacy services to improve healthcare access for British Columbians.
- In October 2022, the CPhBC made changes to professional practice policy to optimize pharmacists' scope of practice in relation to renewing and adapting prescriptions and administering prescribed drugs by injection and intranasal route.
- At that time, the valid period for prescriptions was extended to two years, instead of one year.

- In 2023, the Ministry worked with the CPhBC to develop and implement regulatory changes to the Pharmacists Regulation that authorizes pharmacists to prescribe for 21 minor ailments and forms of contraception.
    - This expansion in pharmacist scope of practice aligned BC with what is enabled in other provinces (i.e., all provinces authorize pharmacists to prescribe for a defined list of minor ailments, and some authorize pharmacists to prescribe contraception).

LAST UPDATED

The content of this estimates note is current as of February 20, 2024, as confirmed by Mark MacKinnon, Executive Director, Professional Regulation and Oversight Branch.

APPROVALS

2024 02 20 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

G-28

Physician Assistants

Topic: Provide an overview of integrating physician assistants into the BC healthcare system.

Key Messaging and Recommended Response:

- **The College of Physicians and Surgeons of BC, in consultation with the Ministry of Health, have amended their bylaws to introduce a framework for licensing and regulating Physician Assistants (PAs) to practice in emergency departments under the direction and supervision of physicians.**
- **PAs are healthcare professionals that work under the direction and supervision of licensed physicians to provide a broad range of health services. They act as 'physician extenders' that complement existing health services and are not autonomous practitioners.**
- **PAs are currently only permitted to practice in emergency departments within health authorities. Emergency department stabilization is a critical issue and PAs are part of the response to mitigate this issue.**
- Business Information; Personal Information
- Advice/Recommentations; Cabinet Confidences
- **Expanding the scope of health-care professionals is part of BC's Health Human Resources Strategy which works to retain, recruit, and train health-care workers while redesigning the health-care system to foster workplace satisfaction and innovation.**

CURRENT SITUATION

- The Saanich Peninsula Hospital emergency department (SPH ED) has been identified as the first site to implement PAs into the BC health workforce. Cabinet Confidences
  Cabinet Confidences
- Advice/Recommentations; Cabinet Confidences

- The Health Employers Association of BC (HEABC) and the Public Sector Employers' Council Secretariat have approved a compensation framework for PAs, which considered the core principles and policy objectives of the Compensation Reference Plan (CRP), the BC Public Sector Guide to Accountable Compensation, and approved compensation frameworks for other healthcare providers.

- PA compensation is aligned to salary range 8 of the April 1, 2023, CRP Reference Salary Range Schedule for the Management Professional Technical Group.
- A Reference Group has been established and meets weekly, with membership representing physicians and other clinicians, all health authorities, HEABC, CPSBC, Emergency Care BC, and the Ministry's Health Human Resources division.
- There are roughly 127 annual new graduates across four established PA training programs in Canada.
- BC does not currently have a PA training program. There are four established PA training programs in Canada: 1) University of Manitoba 2) McMaster University 3) The Consortium of PA Education (University of Toronto in collaboration with the Northern Ontario School of Medicine and the Michener Institute at University Health Network) 4) Dalhousie University. There are two training programs in development: 1) University of Calgary and 2) University of Saskatchewan.
- The PA training program extends over a 24-month period and students are provided with a comprehensive curriculum that directly addresses and assesses preparation for clinical practice, patient navigation, and resource application.
- Graduates of an accredited Canadian PA program are eligible to write the PA entry to practice examination administered by the Physician Assistant Certification Council of Canada. Individuals who successfully pass the exam are awarded the Canadian Certified Physician Assistant (CCPA) designation.
- There are approximately 960 active PAs in Canada with every province except Quebec allowing PAs to practice.
- Intergovernmental Communications

- The PA's supervising physician must sign off that the PA is competent to perform all the duties outlined in their employment contract and contract of supervision. A physician who is supervising a PA must be personally competent to perform the medical procedure that is being designated to a PA to perform.
- The Canadian Association of Physician Assistants is the professional association representing PAs nationally.
- PAs are not currently designated a health profession in BC under the *Health Professions Act*. This means that PAs do not have a scope of practice or title protection and all work is to be assigned, supervised, or delegated by the supervising physician(s). Under the existing legislation, all delegation of restricted activities from a physician must be set out in the CPSBC Bylaws.
- The CPSBC Bylaws permits PAs to provide a broad range of health services within emergency departments including conducting patient interviews and obtaining medical histories, performing patient exams, ordering laboratory and diagnostic tests, prescribing medications, and advising patients on assessment findings and/or diagnoses.

FINANCIAL IMPLICATIONS

To be determined.

KEY BACKGROUND

- In 2009, a PA Steering Committee recommended that the Ministry consider introducing PAs in hospitalist programs to support general medical and surgical units.
- In 2010, at the Ministry's request, CPSBC developed a draft regulatory framework for PAs and submitted a cost estimate for implementation if/when the Ministry was to proceed.
- Advice/Recommentations

- In January 2014, the Minister of Health directed Ministry staff to explore the practical considerations for introducing PAs in BC. A draft concept paper identified and discussed considerations, including practice settings and overlapping roles, an appropriate legislative and regulatory framework, a funding model, employment and labour relations implications, and education and training.
- At the request of the Ministry, the CPSBC began development of a licensing and regulatory framework to enable appropriately qualified PAs to work under the delegation and supervision of physicians in emergency departments in BC.
- In September 2023, the CPSBC posted their proposed bylaw changes online and members of the public had seven days to provide input.
- The bylaw changes were approved in October 2023, allowing PAs to practice under the delegated authority of a supervising physician. The bylaws also require PAs to become “certified non-registrants” of the CPSBC.
- PA education programs are focused on preparing a medical generalist that can adapt to any clinical environment, including primary care, specialty practice, or hospital-based roles. In these roles, the PA develops specific competencies and knowledge relating to their primary practice area, thus mirroring their physicians' scope of practice. A PA will develop an increased knowledge of a medical or surgical specialty over time and may practice in more than one specialty throughout their career.
- PAs are a relatively new health profession in Canada, although their introduction to Canada began in the Canadian Armed Forces in the 1950’s.
- In Canada, most PAs are remunerated via salary ranging from $70,000 to $130,000 (or more) depending on the PA’s education, experience, scope of practice, hours of work, and the employer.
- The way PAs practice and how they are recognized and/or regulated varies across Canada. In other Canadian jurisdictions, a PA’s degree of autonomy will also depend on the regulations of the provincial jurisdiction where they practice.

LAST UPDATED

The content of this estimates note is current as of February 22, 2024 as confirmed by Ryan Murray, Executive Director, Labour and Agreements.

APPROVALS

2024 02 23 - Mark Armitage, Health Human Resources and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

G-29

Postgraduate Medical Education

Topic: Postgraduate (PGME or 'residency') and undergraduate medical education (UGME or 'medical school') programs are expanding across BC.

Key Messaging and Recommended Response:

- **Training more health care workings, including doctors, to deliver services for people living in BC is one of our top priorities. Our investments in recruitment, retention, and resident training are making a difference. The number of physicians in BC continues to grow.**
- Advice/Recommentations

- **In 2024, BC will have a total intake of up to 591 new residents, including 204 family medicine, 210 first-year specialty, and 177 subspecialty intake positions. This is a 30% increase since 2017; there were 454 intake positions in 2017.**
- **There are currently over 1,400 medical residents across all academic years of their PGME programs providing care as they train throughout BC.**

CURRENT SITUATION[1]

- UBC has the single largest family medicine intake in Canada and has **filled all allocated family medicine positions** (100%) for the past ten consecutive years (2014 to 2023).
- In 2024, the Ministry of Health (HLTH) introduced a new pilot '**competitive PGME stream' offering 20 entry-level positions** available to graduates from both Canadian and international medical schools.
    - Successful 2024 applicants to the competitive stream will be required to make a **return of service commitment** to stay and practice in B.C. for three years upon completion of their training.
- As part of the **provincial HHR Strategy**, medical education has expanded significantly since 2022.

<u>UBC UGME (leading to an MD degree)</u>

- **40 new UGME seats** have been added over two years: 18 in 2023 and 22 in 2024.
- In total, UBC's distributed UGME program will increase from **288 seats to 328**, a 14% increase.

	2022	2023		2024	
University - City	Total Intake #	Incremental Expansion #	Total Intake #	Incremental Expansion #	Total Intake #
University of BC - Vancouver	192	6	198	10	208
University of Northern BC - Prince George	32	4	36	4	40
University of Victoria - Victoria	32	4	36	4	40
University of BC Okanagan - Kelowna	32	4	36	4	40
TOTAL	**288**	**18**	**306**	**22**	**328**

[1] Data monitored internally within Physician Services Branch

UBC PGME (leading to full practice)

- **142 PGME positions** will be added by 2028.

	Actual Filled*			Planned**			
	2022	2023		2024		2028	
PGME Training Programs	Total Intake	Incremental Increase	Total Intake	Incremental Increase	Total Intake	Incremental Increase	Total Intake
UBC Family Medicine	174	12	186	18	204	24	228
UBC Enhanced Skills	65	-1	64	9	73	0	73
UBC Specialty	260	18	278	28	306	24	330
UBC Re-entry into PGME	0	7	7	1	8	2	10
TOTAL	**499**	**36**	**535**	**56**	**591**	**50**	**641**
Cumulative Increase		**36**		**92**		**142**	

* Positions filled by residents.

** Figures represent planned positions. Actual filled positions may vary subject to resident applicant demand.

  - **30 positions in family medicine** were allocated across the province in 2023 (12) and 2024 (18):
    - Expansion sites: Coastal (Lions Gate/Sunshine Coast), St. Paul's Hospital, Surrey South Fraser, Vancouver Fraser, Victoria, Abbotsford-Mission, Chilliwack, Kamloops, Kelowna Regional, Kootenay Boundary, Vancouver Island (Indigenous population focus), Vancouver (Indigenous population focus).
    - In 2024, new sites were established in Cowichan, Vernon, and rural North communities.
  - **62 specialty positions** were allocated across the province in 2023 (36) and 2024 (56), including eight 'Re-entry in PGME' positions for licensed physicians seeking to retrain in high-priority specialty areas.
  - **50 additional PGME positions** will be added by 2028: 24 family medicine, 24 specialties, 2 'Re-entry.'

Second Medical School

- HLTH continues to support the Ministry of Post-Secondary Education and Future Skills' (PSFS) mandate **to launch a new medical school in BC** at Simon Fraser University's (SFU) Surrey campus.
- SFU submitted a business case to HLTH and PSFS on August 31, 2023, planning for an inaugural UGME intake in 2026. Work is ongoing to confirm the implementation timeline for PGME positions at SFU.

FINANCIAL IMPLICATIONS[2]

- HLTH funds PGME residency training, and PSFS funds UGME medical school education.
- HLTH allocated $201.6 million to support PGME training in 2023/24, up from $135 million in 2017/18.
- To date, HLTH has provided $4 million to SFU and PSFS to support planning and start-up costs associated with the new medical school at SFU; $1.5 million in 2021/22 and $2.5 million in 2022/23.

KEY BACKGROUND

- UGME is four years in duration and is followed by either a family medicine residency requiring two additional years of PGME or a specialty residency requiring four to seven more years of PGME.
- UGME graduates must compete for PGME positions across Canada as part of a fair, transparent, and equitable national matching process through the Canadian Resident Matching Service (CaRMS).
- **Over 1400 resident physicians** provide health care as they train within various settings across BC:
  - Distributed training enables trainees to experience urban, rural, and remote clinical settings and helps build relationships and connections that influence future practice location.
  - Table shows the number of resident rotations (4-week training placements) by health authority.[3]

[2] Data monitored internally within Physician Services Branch

[3] University of BC. Faculty of Medicine Long-Term Outcomes Evaluation Annual Data Source Workbook. (2023). Sankey. Data as of October 2023

PGME Resident Rotations	FHA	IHA	NHA	VCH	VIHA
Family medicine	115	103	55	165	105
Specialist	988	297	141	1688	458

  - 92% of trainees completing both UGME and PGME at UBC choose to stay in BC to practice[4].
- In 2024, **58 International medical graduate (IMG)** first-year positions were allocated in BC:
  - 52 positions in family medicine and 6 in psychiatry, internal medicine, and pediatrics.
  - CaRMS distinguishes IMGs based on whether the applicant has graduated from a medical school accredited by a North American accreditation body, not on national origin.
  - CaRMS does not differentiate between Canadians Studying Abroad (CSAs) and naturalized Canadian IMGs because this would constitute a breach of the Canadian Charter of Rights and Freedoms in addition to other human rights legislation.

LAST UPDATED

The content of this estimates note is current as of February 14, 2024 as confirmed by Kevin Brown, Executive Director, Physician Services Branch.

APPROVALS

2024 02 21 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2024 02 23 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division

[4] University of BC. Faculty of Medicine Long-Term Outcomes Evaluation Annual Data Source Workbook. (2023). Sankey. Data as of October 2023

LEGISLATIVE SESSION – ESTIMATES NOTE

G-30

Practice Ready Assessment-BC for Family Physicians

Topic: Practice Ready Assessment-BC (PRA-BC) program provides a pathway to licensure for internationally trained family physicians (FPs) in exchange for a practice commitment in a BC community.

Key Messaging and Recommended Response:

- **This government prioritizes reducing barriers for international medical graduates (IMGs) while ensuring all physicians practicing in the province provide the high-quality of care that people living in BC deserve.**
- **Physicians who have completed their medical training outside of Canada contribute significantly to the province's health workforce and play a vital role in achieving positive health outcomes for British Columbians.**
- **International Medicine Graduates (IMGs) who are licensed, practicing family physicians in other countries, are often unable to qualify for a license to practice medicine in Canada. The PRA-BC program provides a pathway to licensure for these IMGs.**
- **PRA-BC expanded from 32 to 96 seats in 2024 supporting improved access to medical care across the province.**
- **As of April 15, 2024, 243 PRA-BC IMGs will have been placed in 68 communities in BC since the program was established in 2015.**
- **This is just one of the many ways in which we are taking action to ensure that people in BC have access to the care they need.**

CURRENT SITUATION

- PRA-BC program provides a pathway to licensure for internationally trained Family Physicians in exchange for a three-year return of service (ROS) commitment within an identified community of need as identified by a health authority.
- The PRA-BC program expanded intake from 32 to 96 seats annually starting in 2024.
- An additional 58 participants will begin their assessment in 2024, and if successful, will equal a total of 301 participants in 81 distinct placement communities.
- As of April 15, 2024, 243 PRA-BC FPs will have been placed in 68 communities in BC since the program was established in 2015.[1]
- Since 2017, 204 PRA-BC participants have an ROS in a community of need in BC[2].
- PRA BC is on track to achieve the expanded seat intake of 96 in 2024, with the first of the two cohorts' participants confirmed.

[1] Physician Workforce Development, Health Sector Workforce and Beneficiary Services Division. PRA-BC community placements 2024-03-21
[2] ibid

- Spring cohort (April) 2024, 44 participants are confirmed to begin the three-month Clinical Field Assessment (CFA).
- Fall cohort (October) 2024, 14 participants have been confirmed (pre-selected). ROS communities and CFA assessors/clinics for the remaining seats are currently being identified (through March 2024). Candidate interviews will follow, with community/participant match results to be confirmed in June, 2024 for the remaining Fall 2024 cohort participants and pre-selections for Spring 2025 cohort.
- The Fall 2023 partially expanded cohort of 21 participants successfully recently completed the CFA and will start in their ROS communities in March/April 2024.
- Annual Allocation:
    - Joint Standing Committee on Rural Allocation 16 across two cohorts - seats for rural communities are allocated in relation to rurality and other physician return of service allocations (IMG-BC)
    - Primary Care Network Allocation 80 across two cohorts as an equal seat allocation to HAs (2024; may be adjusted)

PRA-BC Expansion			
Annual Allocations by Health Authority			
HA	**JSC**	**PCN**	**Total**
Northern Health	6	16	22
Interior Health	4	16	20
Island Health	4	16	20
Vancouver Coastal	1	16	17
Fraser Health	1	16	17
TOTAL	**16**	**80**	**96**

FINANCIAL IMPLICATIONS

- PRA-BC program is jointly funded by the Ministry and the Joint Standing Committee on Rural Issues, a joint committee between the Ministry and Doctors of BC.
- In 2023/24, the Ministry provided $4.01 million to support PRA-BC program; $1.15 million of this funding is provided by the Joint Standing Committee on Rural Issues (JSC).[3]

KEY BACKGROUND

PRA-BC Program

- FPs licensed in countries that are not recognized and approved by the College of Family Physicians of Canada (CFPC) can apply to the PRA-BC program. Approved jurisdictions are: US, UK, Ireland, and Australia.
- The program has a Spring and Fall intake. Participants participate in a 2-week orientation followed by a 12-week CFA under the supervision of a fully licensed FP.
- Following successful completion of the CFA the participant may be eligible for provisional licensure with the College of Physicians and Surgeons of BC (CPSBC) to practice medicine in BC.
- Successful participants are then required to complete a 3-year ROS practicing in community family practice setting in a health authority-identified community of need.
- Of the 96 seats, 16 seats are allocated to rural communities (as funded by the JSC) and 80 seats to Primary Care Networks, which may be in urban, semi-urban or rural communities.
- A number of new PRA programs have been established across Canada in 2023, with provinces actively competing for the same IMG resources.
- PRA-BC program is administered by Health Employers Association of BC, on behalf of the Ministry.

[3] 2023/24 Funding Letter Update #2. Funding through both Ministry and the Joint Standing Committee on Rural Issues; a collaborative committee of the Ministry and Doctors of BC

PRA Background

- PRA-BC follows a standardized format approved by the Medical Council of Canada's National Assessment Collaboration (NAC). The format meets the medical regulatory authorities' provisional licensure requirements across Canada, aligned with the Agreement on Internal Trade which enables interprovincial labour mobility. Organizations participating in NAC include federal and provincial health ministries, faculties of medicine, medical regulatory authorities, and regional IMG assessment programs.
- Due to changes to the Agreement on Internal Trade in 2009, the CFPC began work on pathway 1: enabling licensure of FPs from the US, Australia, UK, and Ireland, and NAC began work on pathway 2: a practice assessment for FPs.
- In 2013, NAC finalized the PRA for internationally trained FPs. A pathway for internationally trained specialists has not yet been established.

LAST UPDATED

The content of this estimates note is current as of March 21, 2024, as confirmed by Kevin Brown, Executive Director, Physician Services Branch.

APPROVALS

2024 02 21 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 21 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

G-31

Psychological Health and Safety in the Health Care Workplace

Topic: *BC's Health Human Resources Strategy (2022)* outlines the actions and investments committed to by the Ministry of Health to foster healthy, safe, and inspired workplaces that support the mental health and psychological well-being of healthcare workers in the province through the adoption and implementation of the Canadian Standards Association (CSA) National Standard for Psychological Health and Safety in the Workplace (the Standard).

Key Messaging and Recommended Response:

- **The psychological health and safety of healthcare workers is an important priority for the Government of BC.**
- **In partnership with Health Organizations (HOs), health sector unions, SWITCH BC, SafeCare BC, and Doctors of BC, the Ministry of Health continues to work towards improving the psychological well-being of healthcare workers.**
- **The Ministry of Health is supporting HOs in implementing the National Standard for Psychological Health and Safety in the Workplace through actions and investments made in BC's Health Human Resources Strategy.**
- **SWITCH BC, an organization focused on the health, safety, and well-being of everyone working in healthcare in BC, is supporting the Ministry of Health in the provincial work to advance implementation of the National Standard for Psychological Health and Safety in the Workplace.**

CURRENT SITUATION

CSA National Standard for Psychological Health and Safety in the Workplace

- The health organizations[1] (HOs) are at various stages of implementing the Standard.
- Implementation activities at some of the HOs include:
  - Review of the thirteen psychosocial factors that have been identified to universally impact psychological health and safety, as well as the two additional factors specific to the healthcare sector (protection from moral distress and support for psychological self-care).
  - Assessment of existing programs and services in their organization (e.g., Employee and Family Assistance Programs) to determine effectiveness and alignment with the Standard.
  - Development of promotional awareness campaigns regarding mental health and wellness.
- As of January 2023, the Ministry of Health's *Implementation of the National Standard on Psychological Health and Safety in the Workplace* policy directive (2017) is undergoing review.
  - A refreshed policy directive is planned for 2024 to reflect the current state, ensure alignment with the ongoing provincial and regional efforts to implement the Standard, and meet the obligations committed to in the last round of health sector collective bargaining.

[1] In this note, health organizations include regional health authorities and Providence Health Care (PHC)

- In collaboration with the Ministry of Health, HOs, health sector unions, SafeCare BC, Doctors of BC, and WorkSafeBC, SWITCH BC is supporting provincial activities to advance implementation of the Standard, including the creation of a Psychological Health and Safety Community of Practice to facilitate networking and information sharing across the health sector organizations.

Total Count of Psychological Incident Time-Loss Claims Submitted to WorkSafeBC, by HO, from January 2018-December 2023[2]

HO	2018	2019	2020	2021	2022	2023	% Change from 2018-2023
FHA	58	91	100	144	125	107	84.48
IHA	63	88	72	111	122	83	31.75
NHA	17	28	16	40	40	35	105.88
PHC	13	22	22	34	44	34	161.54
PHSA	24	32	27	28	35	43	79.17
VCH	42	52	84	80	77	75	78.57
VIHA	74	94	106	151	187	93	25.68
Grand total	**424**	**601**	**637**	**871**	**858**	**613**	**44.58**

Total Rate of Psychological Incident Time-Loss Claims Submitted to WorkSafeBC (per 100 FTE), by HO, from January 2018-December 2023[3]

HO	2018	2019	2020	2021	2022	2023	% Change from 2018-2023
FHA	0.29	0.45	0.45	0.58	0.50	0.39	33.41
IHA	0.42	0.56	0.46	0.66	0.74	0.47	12.04
NHA	0.29	0.46	0.25	0.61	0.61	0.51	75.20
PHC	0.24	0.40	0.38	0.56	0.71	0.50	107.53
PHSA	0.20	0.25	0.21	0.20	0.24	0.27	33.93
VCH	0.26	0.32	0.47	0.40	0.38	0.33	26.15
VIHA	0.49	0.59	0.60	0.79	0.96	0.45	-7.45
Grand total	**0.46**	**0.63**	**0.62**	**0.79**	**0.76**	**0.50**	**9.3**

Total Cost of Psychological Incident Time-Loss Claims Submitted to WorkSafeBC, by HO, from January 2018-December 2023[4]

HO	2018	2019	2020	2021	2022	2023	% Change from 2018-2023
FHA	2,007,020	2,805,492	3,108,539	6,057,681	3,026,709	1,317,744	-35.28
IHA	2,231,029	3,725,610	2,498,149	4,516,094	2,659,491	1,198,050	-49.03
NHA	738,935	959,445	295,564	1,552,969	976,514	486,214	-34.24
PHC	379,556	1,883,049	1,922,334	1,077,461	824,430	568,611	49.63
PHSA	858,912	2,586,335	1,446,293	1,174,046	760,371	558,113	-35.04
VCH	1,101,867	1,968,540	2,906,154	2,287,194	1,674,633	1,091,087	-1.91
VIHA	3,195,248	4,545,505	4,914,366	7,285,101	5,486,242	1,558,666	-52.14
Grand total	**18,742,055**	**34,447,773**	**28,158,361**	**36,617,588**	**22,667,584**	**9,463,295**	**-51.11**

[2] Data provided by OHS Solutions, February 6, 2024
[3] Data provided by OHS Solutions, February 6, 2024
[4] Data provided by OHS Solutions, February 6, 2024

Total Days Lost of Psychological Incident Time-Loss Claims Submitted to WorkSafeBC, by HO, from January 2018-December 2023[5]

HO	2018	2019	2020	2021	2022	2023	% Change from 2018-2023
FHA	5,250	10,954	10,695	24,575	13,677	6,041	14.26
IHA	7,701	11,319	7,315	18,880	12,492	6,268	-18.92
NHA	2,192	1,982	1,728	6,902	4,460	2,105	-3.97
PHC	830	5,089	5,540	4,178	3,879	2,816	239.28
PHSA	2,728	5,945	4,599	5,091	3,888	3,056	12.01
VCH	4,431	6,655	11,073	10,245	7,642	5,424	22.41
VIHA	10,414	13,000	16,236	30,752	25,000	7,312	-30.95
Grand total	**53,850**	**89,617**	**85,193**	**139,869**	**97,260**	**44,144**	**-18.74**

FINANCIAL IMPLICATIONS

- The Ministry of Health provided total funding of $8.5 million to support the establishment of SWITCH BC.
- Occupational and psychological health and safety and wellness is also supported by 17 actions under the "Retain: Build Healthy, Safe, and Inspired Workplaces" cornerstone of BC's Health Human Resources Strategy. Funding of $253.39 million is available for this cornerstone over three years starting with Budget 2023.

KEY BACKGROUND

Mental Disorder Claims under the *Workers Compensation Act*

- Under the *Mental Health Disorder Presumption Regulation,* eligible workers who are diagnosed with a mental disorder such as post-traumatic stress disorder do not have to prove their condition resulted from their employment.
- The regulation lists the following health sector occupations as eligible under the presumptive clause: emergency medical assistants (e.g., paramedics), emergency dispatchers[6], nurses regulated by the BC College of Nursing Professionals, and health care assistants registered with the BC Care Aide and Community Health Worker Registry and employed in a publicly funded organization or setting.[7]

LAST UPDATED

The content of this estimates note is current as of February 22, 2024, as confirmed by Ryan Murray, Executive Director, Labour and Agreements.

APPROVALS

2024 02 14 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 04 03 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division

[5] Data provided by OHS Solutions, February 6, 2024
[6] Whose duties include receiving 911 calls from the public, and/or dispatching firefighters, police, and ambulance services.
[7] The presumptive clause for the listed occupations came into effect on April 16, 2019.

LEGISLATIVE SESSION – ESTIMATES NOTE

G-32

Regulation of Clinical Counsellors and D&T Occupations

Topic: Counselling therapists and diagnostic and therapeutic health occupations seeking to become regulated health professions under the *Health Professions Act* (HPA).

Key Messaging and Recommended Response:

- **Health professionals in BC are regulated to ensure safe delivery of health care services. We are committed to ensuring ethical, professional, and competent Diagnostic and Therapeutic (D&T) professions throughout BC.**
- **4 D&T professions: respiratory therapists, radiation therapists, clinical perfusionists, and medical laboratory technologists were designated as health professions by Cabinet in 2017.**
    - **The Ministry of Health is working with partners to develop the 4 D&T profession-specific regulations.**
    - **These regulations will come into force following the implementation of the *Health Professions and Occupations Act (HPOA).***
    - **These D&T professions will be regulated by a future amalgamated college, as recommended in a Steering Committee report on modernizing the province's health regulatory framework.**
- **Counsellors are not currently regulated in BC.**
    - **Counsellors in the province may choose to be members of associations such as the BC Association of Clinical Counselors (BCACC) and the Federation of Associations for Counselling Therapists in BC (FACTBC).**
- **The Ministry is conducting a designation assessment under the HPA to inform a decision by Cabinet about whether or not to regulate counselling disciplines as health professions.**
    - **Designation assessments must be conducted in accordance with the Public Interest Criteria within the Health Professions Designation and Amalgamation Regulation.**
    - **This includes conducting analysis into the extent to which the practice of counselling may involve a risk of physical, mental, or emotional harm to**

the well-being of the public and determining if all types of counselling occupations warrant regulation under the HPA.

- **Ministry staff are working to complete the designation assessment and have engaged key stakeholders including BCACC and FACTBC.**

CURRENT SITUATION

- 4 D&T professions have been designated under the HPA and will be regulated by a future college.
- During committee stage of the HPOA, the Minister of Health stated interest in regulating counsellors.
- Work is underway to gather the information necessary to inform a decision whether to designate counselling occupations as a regulated health profession.
- The Ministry's current focus is implementing the HPOA, which requires the amalgamation of 11 existing colleges into 2, creation of the Office of the Superintendent of Health Profession and Occupation Oversight, and supporting the existing colleges to prepare for the new requirements of the HPOA.
- Advice/Recommentations

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

D&T

- 4 D&T occupations (respiratory therapists, radiation therapists, clinical perfusionists and medical laboratory technologists) were designated by Cabinet as health professions in 2017.
- The 4 designated D&T professions were previously slated to be regulated under their own regulatory college however, this work was paused as the Ministry focused on the Cayton Report, the resulting work of the Steering Committee, and the development of the HPOA.
- Work is underway to develop the D&T profession-specific regulations, which will come into force following implementation of the HPOA.

Clinical Counsellors

- Counselling occupations are not currently designated or regulated health professionals in BC.
- Counsellors include a wide variety of occupations with different areas of practice, including health, education, spiritual, and cultural mandates.
- The 2 largest associations representing counselling occupations in the province are BCACC and FACTBC.
- BCACC is a professional association that represents Registered Clinical Counsellors and psychotherapists who meet the association's defined educational and competency requirements.
- FACTBC is a society which represents 11 counselling associations including those for art therapy, music therapy, family counselling, hypnotherapy, spiritual therapy, Christian counselling, cooperative counselling, and psychotherapy.
- The Professional Regulation and Oversight branch has begun a designation assessment to inform a decision whether to designate counselling occupations as a regulated health profession.
- Designation of a new health profession under the HPA would require a 3-month public consultation period and a decision by Cabinet to move forward.
- Before the newly designated health profession can be regulated, the HPA requires a new college to be created to regulate them. This does not align with Ministry initiatives to reduce the overall number of colleges and could delay implementation of the HPOA.
- Once brought into force, the HPOA will not automatically result in the designation or regulation of any new health professions.

- Regulatory colleges will be focused on implementing and aligning with the HPOA in the short term, and taking on the regulation of a new profession concurrently could lead to a regulator not being able to meet their public protection mandate.

LAST UPDATED

The content of this estimates note is current as of March 25, 2024, as confirmed by Mark MacKinnon.

APPROVALS

2024 04 03 - Mark Armitage, Health Sector Workforce and Beneficiary Services

LEGISLATIVE SESSION – ESTIMATES NOTE

G-33

Relational Security Initiative

Topic: The Ministry of Health's Health Sector Health and Safety Unit (HSHS) implemented the Relational Security Initiative (RSI), an in-house relational security model, at 26 designated health care settings across the province. The initiative imbedded trauma-informed care into health facilities through the hiring, onboarding, and training of 320 Relational Security Officers (RSOs) and 14 Violence Prevention (VP) Leads.

Key Messaging and Recommended Response:

- **Workplace violence is a serious issue and is more common in healthcare than in other industries. Ensuring our health care facilities are free of violence is a priority for the province.**
- **That is why government is taking action to build safer workplaces for health care workers by introducing a new security model that was implemented in 26 sites across all health authorities.**
- **The new relational security model includes training for all protection-services personnel in workplace violence prevention and mental health. They also receive trauma-informed practice training to apply a trauma-informed perspective to interactions with patients, families, clients, and colleagues. Indigenous cultural safety is a key component of training.**
- **As of October 1, 2023, the new relational security officers (RSOs) were operational at all 26 designated health care settings within a team-based care approach.**
- **This new security model will help ensure health care facilities are free of violence and help support, recruit, and retain health care workers in their vital roles in the health care system.**

CURRENT SITUATION

- The goal of this initiative is to support the retention and retainment of health sector workforce through the reduction of workplace violence and psychological injury by integrating trauma informed protection services within a team-based care approach.
- Health Organizations have hired, trained, and onboarded all 320 RSOs.
- To ensure adequate operational and training support for the implementation of the relational security model, 14 permanent VP Lead have been hired. The RSI also included the hiring of additional management and educators to support the initiative.
- All RSOs receive standardized training and onboarding, including additional customized Trauma Informed Practice (TIP) Training.
- TIP will equip RSOs with the necessary skills, language, and knowledge to be able to apply an appropriate and trauma informed lens to interactions with patients, clients, and colleagues.

- The Ministry has worked in collaboration with the Provincial Health Authority (PHSA) to ensure the sustainability of TIP training for RSOs by establishing a TIP Facilitator Community of Practice and by offering more facilitator training sessions which support program growth and attrition. As of February 5th, 2024, 30 individuals have been trained as RSO educators and 39 have completed TIP facilitator training.
- The 26 sites for implementation of the relational security model were selected in consultation with the BCNU and health authorities. Sites identified include:

Fraser Health	Providence Health	Vancouver Coastal Health	Provincial Health Services Authority	Island Health	Interior Health	Northern Health
• Abbotsford Regional • Burnaby Hospital • Chilliwack General • Delta Hospital • Langley Memorial • Peace Arch • Royal Columbian • Surrey Memorial	• Mount Saint Joseph • St. Paul's Hospital	• Lion's Gate Hospital • Richmond Hospital • Vancouver General Hospital	• BC Women's and Children's Hospital	• Cowichan Lodge • Saanich Peninsula Hospital	• Cariboo Memorial • East Kootenay Regional • Kelowna General • Kootenay Boundary Regional • Penticton Regional • Royal Inland • Vernon Jubilee	• Mills Memorial • Prince Rupert Regional • University Hospital

- To measure the effect of implementation of the relational security model, an evaluation framework has been co-created with SWITCH BC, in consultation with health organization representatives.

FINANCIAL IMPLICATIONS

- Through the BC's Health Human Resources Strategy, the Ministry has committed $63.2 million over three-years to support the RSI (approximately $23.5 million annually ongoing).
- The Ministry has committed additional funding to health authorities/Providence Health Care for leadership and other operational supports for the RSI ($27.3 million over three years and approximately $8.1 million annually ongoing).
- In 2023/24, the Ministry provided $75,700 to PHSA to build the TIP curriculum, including the training of facilitators, development of a community of practice, and implementing curriculum improvements.

KEY BACKGROUND

- The Marchbank Report prioritized the collaboration between the Ministry and health authorities to develop, plan and implement the expansion of a provincial integrated security model, with enhanced security functions as part of the broader care team in high-risk units.
- In addition, in 2021, the BC Nurses' Union (BCNU) reiterated workplace health and safety concerns, specifically requesting that Protection Service Officers (PSOs) be staffed 24/7 at sites deemed high-risk for violence.
- This initiative is one of five actions under BC's 2022 Health Human Resources Strategy retention cornerstone, reiterating a commitment to retaining the current health care workforce by ensuring physically and psychologically safe workplaces.
- Since 2002, most provincial health care protection services positions have been privately contracted, except for the Vancouver Island Health Authority (VIHA). VIHA's successful in-house Protection Services Officer (PSO) model integrates PSOs into team-based care planning. The RSI was modeled after VIHA's successful PSO program.

- RSOs will be direct health authority employees, and unionized Hospital Employees' Union positions under the Facilities' Bargaining Association collective agreement. PSOs at VIHA are currently a Grid 19.
- Implementation of a new protection services model provides an opportunity to create and plan phased implementation of a provincial healthcare protection services framework that incorporates best practices into team-based care and achieves further benefits for workers under continued repatriation of privatized health sector support services, under Bill 47.

LAST UPDATED

The content of this estimates note is current as of February 9, 2024 as confirmed by Ryan Murray, Executive Director, Labour and Agreements Branch.

APPROVALS

2024 02 22 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 02 23 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

G-34

Rural Retention Incentives

Topic: Financial incentives to support healthcare worker retention in rural communities.

Key Messaging and Recommended Response:

- **We've taken actions to deliver healthcare services when and where people need them, including in rural and remote areas of BC.**
- **The Prototype Rural Retention Incentives (PRRI) are currently supporting communities in Northern Health Authority, Mount Waddington in Vancouver Island Health Authority, and Grand Forks in Interior Health Authority.**
    - **The PRRI is a program that provides health care workers with an incentive for high needs communities and occupations.**
- **A provincial expansion of the PRRI is being implemented through BC's Health Human Resources Strategy – announced March 1, 2024.**
- **The new Provincial Rural Retention Incentives (PRRI) will prioritize health care workers in 63 rural and remote communities and includes a policy and framework refresh of the incentive program.**
- **This expansion will prioritize BC's high needs communities and ensure that the health sector workforce in rural and remote areas are supported to care for patients and clients.**
- **Eligible nurses who fill identified high needs vacancies in rural and remote communities will be eligible for recruitment incentives starting April 1, 2024.**
    - **New Provincial Signing Bonuses – announced for nurses on March 1, 2024, and in development for allied health occupations.**
    - **The GoHealth BC Signing Bonus – up to $15,000 for nurses who are new to BC's health system (new graduates, new entrants, and former agency staff).**
    - **The Northern Signing Bonus – up to $30,000 for nurses who accept regular roles in rural and remote communities in Northern Health.**
    - **The Rural Signing Bonus – up to $20,000 for nurses who accept regular roles in rural and remote communities outside of Northern Health**

- **The Urban and Metro Signing Bonus - Up to $15,000 for nurses who fill regular difficult-to-fill (vacant more than 90 days) and high-needs vacancies in urban and metro communities.**

CURRENT SITUATION

- The **Prototype Rural Retention Incentive (PRRI)** supports high needs communities and occupations in Northern Health (NHA), Interior Health (IHA), and Island Health (VIHA) through a financial retention incentive.
- The PRRI was piloted in NHA in 2021[1] and expanded to include Grand Forks in Interior Health[2] in 2022, and Mount Waddington in Island Health[3] in 2023.
  - An average of 1038 employees per quarter have received this incentive in NHA, and between Q4 of FY2022/23 and Q1 of FY2023/2024, an additional 24 employees started receiving PRRI payments – a 1.5% increase between quarters.[4]
  - 517 payouts have been made to employees in Grand Forks, an average of 172 payments per quarter.[4]
  - 453 payouts have been made to employees in Mount Waddington, to 243 unique employees[4].
- An expansion to PRRI is being implemented through BC's Health Human Resources Strategy (the Strategy) that encompasses a new framework and a provincial scope.
- The new **Provincial Rural Retention Incentive (PRRI)** will prioritise healthcare workers in BC's rural and remote communities while mitigating risk for intra-health authority competition.
  - PRRI expansion was announced March 1, 2024 to support an additional 48 communities (total of 63).
- PRRI policy creation has been conducted with support from health authorities and Providence Health Care through the Provincial Health Human Resources Coordination Centre (PHHRCC) to ensure that all healthcare workers and regions in the province are represented.
- The new PRRI incorporates monitoring, reporting, and evaluation criteria, allowing government to conduct a full program review – an approach that has not yet been taken in other jurisdictions to assess the effectiveness of retention incentives.
- Announced March 1, 2024, BC will provide up to $30,000 for eligible nurses who fill identified high needs vacancies in rural and remote communities starting April 1, 2024, with a two-year return-of-service agreement.
  - Up to $30,000 in the North.
  - Up to $20,000 in other rural and remote areas.

FINANCIAL IMPLICATIONS

The Strategy is funded for nearly $1 billion over 3 years starting with Budget 2023.

KEY BACKGROUND

- Rural and remote communities have faced significant and long-standing recruitment and retention challenges with impacts for service delivery including emergency room diversions, reduced hours of service, and increased utilization of agency nursing.
- The COVID-19 pandemic has increased the strain on the workforce and exacerbated challenges faced in rural and remote communities across the province.
- In 2021, the Ministry of Health piloted the PRRI in NHA to support healthcare workers in rural and remote communities in the Northeast, Hazelton, and Prince Rupert.
- The PRRI is prorated for up to $2000 per quarter for regular health authority staff who work in eligible rural and remote communities.

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[1] Boosting support, hiring to enhance services in Northern Health. News Release. September 2021.
[2] New financial incentives launched for health-care staff in Grand Forks. Interior Health Authority. November 2022.
[3] Province takes action to stabilize northern Vancouver Island health-care services. Government news release. January 2023.
[4] Prototype Rural Retention Incentive Data. HA submission to HWPI, September 2023.

- In 2022, PHHRCC placed a moratorium on new health authority and Providence Health Care (HAs/PHC) incentives, as the forum determined that the incentives developed were causing regressive interprovincial competition and staffing churn.
    - The moratorium was placed with the understanding that PHHRCC and the Ministry would develop provincial retention and recruitment incentives.

LAST UPDATED

The content of this estimates note is current as of February 21, 2024, as confirmed by Executive Director, Meghann Brinoni, Health Workforce Planning and Strategic Implementation Branch.

APPROVALS

2024 02 22 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 01 - Miranda Mason, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

G-35

Second Medical School

Topic: Progress on the development of a new medical school at Simon Fraser University (SFU).

Key Messaging and Recommended Response:

- **The Ministry of Health is working in partnership with the Ministry of Post-Secondary Education and Future Skills to support the development of a second medical school for BC at Simon Fraser University (SFU).**
- **This is a key part of the Government's comprehensive strategy to improve patient care and address a critical need for more physicians across the province.**
- **SFU is on track to meet the critical milestones in the planning and accreditation process and anticipates being able to welcome 48 medical school students by summer 2026 and grow to 120 seats by 2036.**

Advice/Recommendations

- **This new medical school is one of the key actions in BC's Health Human Resources Strategy that works to optimize the health system by expanding training, further improving recruitment, and retention of health care workers in the province.**
- **The School of Medicine at SFU will be the first new medical school in Western Canada in over 55 years.**

CURRENT SITUATION

- Since the second medical school project was announced, the Ministry of Health (HLTH) and the Ministry of Post-Secondary Education and Future Skills (PSFS) have collaborated closely to ensure strong oversight and alignment with health system needs.
- Cabinet Confidences; Government Financial Information

- PSFS was invited through *Budget 2024* to submit a proposal for capital and operational expenses to support the development of the School of Medicine at SFU.
- The capital and ongoing operating funding committed by Government in *Budget 2024* will enable SFU to secure space on or near its existing Surrey campus while continuing curriculum development, hiring staff and faculty, obtaining necessary program approvals through its Senate and Board of Governors, and further building out its partnership with Fraser Health and First Nations Health Authority.
- The medical school's Founding Dean is anticipated to be announced in late Spring 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE

FINANCIAL IMPLICATIONS

- HTLH has provided $4.0 million to SFU and PSFS to support planning and start-up costs associated with the new medical school:
    - 2021/22: $1.5 million planning grant was awarded directly by HLTH to SFU.
    - 2022/23: $2.5 million was transferred from HLTH to PSFS to cover SFU start-up costs.
- Cabinet Confidences; Government Financial Information
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KEY BACKGROUND

- BC's second medical school at SFU was announced in November 2022 and is part of the comprehensive Provincial HHR Strategy to improve patient care and address the critical shortage of physicians and other healthcare workers in BC.
- The new Fraser-based medical school will complement UBC's Vancouver-Fraser, Island (Victoria), Northern (Prince George) and Southern (Kelowna) undergraduate medical education (UGME) program sites.
- SFU is in the process of planning for the medical school accreditation requirements set by the Committee on Accreditation of Canadian Medical Schools.
- SFU is also in the process of planning for the PGME program accreditation, which is set by the Canadian Residency Accreditation Consortium. Each PGME specialty will require accreditation in addition to the overall institutional PGME accreditation.
- The medical school at SFU intends to integrate interprofessional education as part of the clinical training curriculum throughout both medical school and residency with a dedicated focus on immersing and training students and residents within team-based care practices.
- To facilitate interprofessional education, the medical school at SFU plans to explore opportunities to develop collaborative relationships with institutions offering allied health professional training to provide clinical instruction in team-based settings.
- The medical school at SFU has proposed a *community primary care clinic* in the Fraser Health Authority that would integrate different medical professions and provide SFUMS students with hands-on training and the opportunity to treat patients early in their education.
- Physicians graduating from the medical school at SFU will have the skills and commitment to provide team-based community-level health care in various communities across BC.

LAST UPDATED

The content of this estimates note is current as of April 9, 2024, as confirmed by Kevin Brown, Physician Services Branch.

APPROVALS

2024 04 09 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 04 10 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

G-36

Training Bursaries

Topic: Bursaries to increase access to post-secondary training for priority health careers.

Key Messaging and Recommended Response:

- **Bursaries attract students to priority health education programs, reduce financial barriers to training, and ultimately fill key workforce gaps.**
- **In August 2022, we announced the Access to Practical Nursing Bursary with $3M in funding to support Health Care Assistants (HCAs) to advance their careers and develop new skills by training to become Licensed Practical Nurses (LPNs).**
    - **Participants sign a 12-month full-time or 24-month part-time return of service agreement, to be fulfilled in the public sector upon graduation.**
- **Additional bursary programs have been launched through the Health Human Resources Strategy (HHR) Action 57 – Priority Program Bursaries:**
    - **A Student Recruitment and Retention Bursary of $2,000 per program year.**
    - **An Indigenous Student Recruitment Bursary of $5,000 per program year.**
- **On March 1, 2024 – as part of our announcement of minimum Nurse to Patient Ratios (mNPR) we expanded these two bursary programs to include all registered nursing (RN), registered psychiatric nursing (RPN), and LPN students at eligible public post post-secondary institutions.**
- **These bursaries are administrated by eligible post-secondary institutions and deducted directly from tuition fees.**
- **The Ministry is finalizing plans for a Public Sector Recruitment Bursary of $10,000 offered in the final program year in exchange for a return of service (ROS) in the public health sector.**

CURRENT SITUATION

- Action 57 of the HHR Strategy supports the development of new priority program bursaries (PPB) that attract students to key programs and public health occupations over three streams:
    - **Student Recruitment and Retention Bursary** ($2,000 per program year): Medical Lab Assistant, Medical Lab Tech, Medical Radiography Technician, Medical Resonance Imaging Technician – First Discipline, Nuclear Medicine, Respiratory Therapy, Environmental Health, and Radiation Therapy.
    - **Indigenous Student Recruitment Bursary** ($5,000/program year): Dietitian, Midwifery, Nurse Practitioner, Occupational Therapy, Physical Therapy, Practical Nursing, Psychiatric Nursing, and Speech Language Pathology.

  - **Public Sector Recruitment Bursary** ($10,000 in the final program year with a 1–2-year return of service agreement): to become operational in 2024.
- Programs were initially selected based on enrollment (supply) and workforce (demand) data.
- On March 1, 2024 – in support of Government's announcement of mNPR we announced nursing student tuition credits that expand the Student Recruitment and Retention Bursary ($2000 per program year) and Indigenous Student Recruitment Bursary to nursing students in RN, RPN, and LPN programs at eligible public post-secondary institutions.
  - The nursing student bursaries will be retroactively available to students enrolled in nursing programs in public post-secondary institutions from September 2023 to August 2026.
- As of January 2024, 362 students have been provided funding through the Student Recruitment and Retention Bursary and 50 students through the Indigenous Student Recruitment Bursary[1].
- On August 23, 2023, the Ministry launched **Access to Practical Nursing (APN) bursaries** worth up to $10,000 per student to offset tuition and other fees for HCAs enrolled in an APN program at a public post-secondary institution.
  - The APN program is intended to reduce financial and other barriers for HCAs and improve the supply and geographic mix of new LPNs in BC with a special focus on rural communities.
  - The APN program is administered by the Health Employers Association of BC and paid in equal installments to students each semester.
- Eligible bursary applicants include new students registered in an APN program between September 1, 2022, and May 31, 2024. As of February 2024, 154 APN students have benefitted from the bursary:
  - 59 recipients have graduated as LPNs.
  - 29 graduated LPNs have begun their ROS with a qualifying employer[2].

FINANCIAL IMPLICATIONS

- In August 2022 the Ministry of Health announced one-time funding of $3 million for APN bursaries.[3]
- BC's HHR Strategy has three-year funding of nearly $1 billion, starting with Budget 2023.[4]
- Bursaries for nurses are also supported by $750 million over three years for minimum Nurse to Patient Ratios.

KEY BACKGROUND

- The HHR Strategy highlights the importance of post-secondary training as a primary source of healthcare workers in BC.
- Tuition support is a key focus area within the Strategy, removing barriers to education and addressing the increased demand for health care workers in BC.[5]
- Most PPB and APN programs are offered only at select public post-secondary institutions.

LAST UPDATED

The content of this estimates note is current as of March 5, 2024.

APPROVALS

2024 02 28 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 05 – Miranda Mason, Health Sector Workforce and Beneficiary Services Division

[1] As reported to the Ministry of Health by the Ministry of Post-Secondary Education and Future Skills by email, on January 4, 2024.
[2] HealthMatch BC: APN Education Incentive Bursary Cumulative Data August 23, 2022 - February 1, 2024; and ROS Tracker maintained by Health Workforce Programs and Operations team as of February 14, 2024.
[3] News Release, APN Bursaries: https://news.gov.bc.ca/releases/2022HLTH0053-001272
[4] https://news.gov.bc.ca/releases/2023HLTH0150-001930
[5] BC Ministry of Health. September 2022. BC's Health Human Resources Strategy. Pg. 39.

LEGISLATIVE SESSION – ESTIMATES NOTE

G-37

Workplace Violence in Health Care

Topic: The Ministry of Health is working with the Health Employers Association of BC (HEABC), health authorities, health sector unions, Doctors of BC, WorkSafeBC, SWITCH BC and SafeCare BC, to reduce and prevent violence in the health care system.

Key Messaging and Recommended Response:

- **Workplace violence is a serious issue, and we know it is more common in healthcare than in other industries.**
- **Ensuring our health-care facilities are free of violence is a priority for the province.**
- **That is why the government is taking action to build safer workplaces for healthcare workers by implementing a new relational security model in 26 sites across all heath authorities.**
- **This new model ensures security personnel have an acute awareness of patients and their surroundings, as well as how to anticipate, de-escalate and ultimately prevent aggression. It is based on trauma-informed practice, which integrates knowledge of how people are affected by trauma into procedures, practices, and services.**
- **This new security model will help ensure health-care facilities are free of violence and help support, recruit, and retain health-care workers in their vital roles in the health care system.**

CURRENT SITUATION

- Workplace injuries due to violence are on the rise in the health care and social service sector. The industry is seeing a steady increase in the number of incidents year over year.
- In 2023, there were 5,315 reported incidents of violence in BC's health authorities (up 645 year-on-year), and 742 associated WorkSafe BC time loss claims.[1] BC Emergency Health Services has the highest incident rate of violence with 9.99 incidents per 100 FTE.[2]

Provincial Framework and Policy Directive on Workplace Violence Prevention

- In 2017, the Ministry issued a Provincial Violence Prevention Policy Framework and a Policy Directive (WVP Directive) to improve injury reporting systems, provide more effective violence prevention training, and ensure greater accountability for policies and practices among all public and private health employers.
- The Workplace Violence Prevention Policy Directive is currently being refreshed, following the analysis of feedback received about the WVP Directive from partners and stakeholders.

[1] Data from OHS Solutions, February 5th, 2024.
[2] Data from OHS Solutions, February 5th, 2024.

Provincial Violence Prevention Curriculum (PVPC)

- As of February 6, 2024, 83% of health authority staff who work in high-risk programs (including mental health and substance use, emergency, and residential care) have completed PVPC core curriculum training.[3]
- A Physician Violence Prevention curriculum was implemented in June 2019 with 350 medical residents completing the 1.5 hours online and 3.5 hours classroom in the first year. Physicians receive continuing medical education credits upon completion.
- A 3-year project to refresh the content of the PVPC is currently underway, led by SWITCH BC. The refreshed PVPC content is expected to launch in Fall of 2024 and is intended to incorporate a trauma-informed and cultural safety lens to the curriculum. (Please refer to the SWITCH BC's fact sheet for additional details.)

Review of Protection Services in Health Care Settings

- On October 24, 2022[4], the Minister announced the implementation of a new initiative, the Relational Security Initiative (RSI) across all health authorities.
- The RSI established an in-house relational security model at 26 designated health care settings across the province, through the hiring of 320 Relational Security Officers (RSOs) and 14 Violence Prevention Leads, in addition to a standardized onboarding and training curriculum to embed trauma-informed care principles. Please refer to the Relational Security Initiative fact sheet for additional details.
- The October 24, 2022, announcement also included expanding funding for SWITCH BC, an organization focused on workplace safety.

Priority Sites

- In 2015, the Ministry and the Nurses' Bargaining Association (NBA) committed to safety improvements at four facilities deemed high risk for violence: Forensic Psychiatric Hospital, Hillside Centre, Seven Oaks, Tertiary Mental Health, and Abbotsford Regional Hospital. Violence prevention actions implemented included environmental modifications, increased staffing levels, upgraded communications systems, and added security.
- In 2016, the Ministry and the NBA expanded these efforts to six additional sites: Mills Memorial Hospital, Royal Columbian Hospital, Royal Jubilee Hospital, East Kootenay Regional Hospital, Powell River General Hospital, and Downtown Eastside Community Health Centre.
- Implementation of the recommendations, and the utilization of the six sites funds was extended to December 31, 2023.
- Except for Royal Jubilee Hospital, which was approved for a further extension for the use of funds until March 31, 2024, all sites are completed.
- Advice/Recommendations

FINANCIAL IMPLICATIONS

- In 2015/16, the Ministry and the NBA each committed $1.0 million[5] (total $2 million) to implement violence prevention measures at four high-priority sites (noted above).
- In 2016, the Ministry committed $2.0 million[6] through the NBA agreement, to be matched by the NBA, for the purposes of taking targeted action at six high priority sites (noted above).
- The Ministry has provided $8.5 million to support the establishment of SWITCH BC.[7] In October 2022, the Ministry announced an additional $2 million in funding to SWITCH BC to address workplace safety[8].

[3] Data from OHS Solutions, February 5th, 2024.
[4] News Release: 320 protection services officers will support safer workplaces for health-care workers
[5] BC Nurses Union Website: https://www.bcnu.org/news-and-events/update-magazine/oct2015-mental-health
[6] BC Nurses Union Website: https://www.bcnu.org/news-and-events/update-magazine/oct2015-mental-health
[7] News Release: Reducing injuries for health-care workers focus of new safety organization
[8] News Release: 320 protection services officers will support safer workplaces for health-care workers

KEY BACKGROUND

- A Therapeutic Relational Security model was implemented at the Forensic Psychiatric Hospital in Coquitlam in 2018 and was very successful in reducing patient aggression and violence.
- In 2018, Michael Marchbank was commissioned by the Ministry to conduct a review on violence in the health sector. The completed report and recommendations were accepted in early 2019.
- As recommended in Marchbank's report, the Ministry established a new Health Sector Health and Safety Unit in 2019 to work with key partners and stakeholders to lead, monitor, and report on the progress towards reducing violence in the health sector.

LAST UPDATED

The content of this estimates note is current as of as February 21, 2024 confirmed by Ryan Murray, Executive Director, Labour and Agreements Branch.

APPROVALS

2024 02 15– Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 02 23– Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

H-01

Abortion Services Access

Topic: The government of BC is committed to providing safe, effective, and accessible abortion services to the residents of the province, regardless of their income level.

Key Messaging and Recommended Response:

- **The government of BC supports the rights of people who are pregnant to make decisions about their bodies.**
- **Abortion is a fundamental part of health care in the province.**
- **Both medical abortions (i.e., use of a medication, such as Mifegymiso, to end a pregnancy) and surgical abortions (surgical procedures provided in clinics or hospitals) are available in the province; various factors determine which is more suitable for a patient, including patient preference.**
    - **In BC, people can access abortion services through abortion clinics and some general practitioners, nurse practitioners, gynecologists, and hospitals.**
    - **Mifegymiso® is available by prescription through primary care providers, community clinics (including public health clinics, walk-ins, urgent and primary care centres) and by telehealth and is dispensed by community pharmacies throughout the province. It is fully paid for, for any BC resident with a prescription, under BC PharmaCare's Plan Z.**
- **The government of BC is committed to continuing to provide access to safe abortion services to all British Columbians who need them.**
- **Anyone who must travel for abortion services may be eligible for the Ministry of Health's Travel Assistance Program, which helps alleviate the costs of travelling for health care.**

CURRENT SITUATION

- Abortion is an insured service when determined by a physician that it is medically required for a specific patient on a case-by-case basis. Abortion services are available at many facilities in BC.
- Both medical abortions (i.e., use of a medication, such as Mifegymiso, to end a pregnancy) and surgical abortions (surgical procedures provided in clinics or hospitals) are available in the province; various factors determine which is more suitable for a patient, including patient preference. Until the past few years, medical abortions made up a very small proportion of total abortions in BC, but since 2020/21 there have been more medical abortions than surgical abortions in the province.
- Regional health authorities are responsible for planning, managing, and delivering publicly funded health care services in their jurisdictions, and are expected to provide reasonable access to abortion services. Like

any service, the provision of abortion services may be impacted by operational circumstances (e.g., limited availability of health human resources can create an access challenge).

- Government will continue to work with the health authorities to provide, and expand where appropriate, access to abortion services in BC, while prioritizing the protection of people's privacy.

Impact of Mifegymiso on Access to Abortion Services

- Mifegymiso (combination of the drugs mifepristone and misoprostol) can be used to terminate pregnancies up to 9 weeks gestation. Since 2018, when Mifegymiso became available to all British Columbians at no cost, its uptake appears to indicate improved access and choice for patients.
- Between January 15, 2018, and March 31, 2023, 1,740 prescribers (physicians, Advice/ and pharmacists) prescribed Mifegymiso, and 801 pharmacies dispensed it to over 34,200 patients.[1] Data for 2016/17 - 2022/23 (Table 1) shows that the number of medical abortions increased, and the number of surgical abortions decreased, since full coverage of Mifegymiso by Pharmacare began.
- Mifegymiso provides significant advantages over a surgical option – it can be provided through telemedicine, dispensed in community pharmacies, taken at home, and is more cost effective.
- By avoiding unnecessary surgery, universal coverage of Mifegymiso has resulted in safer, more accessible abortion services. Removing the cost barrier helps ensure that individuals can access this safe and legal option if they choose. It is important, however, that patients are still able to access surgical abortion services, as medical abortion is not always preferable or medically appropriate.

Table 1: Number of Mifegymiso Dispenses and Surgical Abortions in BC, by Fiscal Year[1,2,3]

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Mifegymiso Dispenses	91	1,844	4,922	6,327	8,205	8,440	9,960
Surgical Abortions	10,086	9,424	8,281	7,593	5,916	5,892	6,092
Total	10,177	11,268	13,203	13,920	14,121	14,332	16,052

Health Authority Access Issues

- Service gaps in surgical abortion access in Kitimat and Quesnel have been brought to the attention of the Ministry of Health. Northern Health Authority (NHA) continues to work to fill any vacancies and anticipates that recruitment efforts will lead to improvements in access to reproductive health care. Surgical abortion access is available in nearby communities. Medical abortion continues to be available.
- Fraser Health Authority (FHA) is in the process of developing surgical abortion services within the region; patients can access abortion services at Vancouver clinics, if appropriate for their needs. Medical abortions are available in FHA.

US Citizens - Access to Abortion Services in BC

- Since 2022, access to abortion services has been restricted or banned in several U.S states.
- People from outside BC can access abortion services in the province but individuals not covered by the BC Medical Services Plan (MSP), or another federal/provincial/territorial medical services plan must pay for the healthcare services they receive in BC. New BC residents who are in the MSP wait period can receive coverage for Mifegymiso.

Protest Activities in BC

- Currently, the main abortion-related protests in the province are held twice per year by an organization called "40 Days for Life", which promotes anti-abortion campaigns world-wide.
- The next protest period by the "40 Days for Life" group is scheduled for February 14–March 24, 2024, with "vigils" in BC planned for Victoria (Victoria General Hospital) and Vancouver (BC Women's Hospital).

[1] PharmaNet, HealthIdeas, Health Sector Information, Analysis and Reporting, February 20, 2024.
[2] PharmaNet, HealthIdeas, Health Sector Information, Analysis and Reporting, February 20, 2024.
[3] MSP. MSP Fee-For-Service Payment Analysis 2016/2017-2021/2022 fee items 4110, 4111, and 4114, https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/msp_ffs_4_fee_item_detail.pdf., as of September 30, 2022.

FINANCIAL IMPLICATIONS

There are no known direct financial implications of abortion access zones for the Ministry.

KEY BACKGROUND

Related Legislation and Regulations to Ensure Access and Safety

- Abortion is an insured service under the Provincial *Medicare Protection Act*, and the Provincial Hospital Insurance Act Regulations.
- The *Access to Abortion Services Act* states all people who use the BC health care system, and who provide services for it, should be treated with courtesy and with respect for their dignity and privacy. The Act provides for the establishment of access zones around facilities, doctors' offices, and the homes of doctors and service providers, to ensure the safety of staff and patients. Harassment (such as protest, interference, and intimidation) is prohibited within access zones.
- In addition to those under the Act, access zones have been established by regulation at 5 facilities.

LAST UPDATED

The content of this estimates note is current as of February 14, 2024, as confirmed by Manpreet Khaira.

APPROVALS

2024 02 22 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 27 – Kristy Anderson, Hospital & Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

H-02

Alberta Health Care Services Access

Topic: BC patients' access to health services in Alberta.

Key Messaging and Recommended Response:

- **The Ministry of Health continues to work collaboratively with the Alberta Ministry of Health to ensure people living on the eastern border of BC can access the critical care they need when they need it.**
- **The Ministries continue to work together to formalize the referral and transfer processes for time sensitive life limb threatened organ (LLTO) emergency patients in both BC and Alberta.**
- **While that agreement is being formalized, patients in the East Kootenay and Northeast Health Service Delivery Areas continue to be transported to Alberta hospitals.**
- **BC will continue to monitor access concerns and ensure collaboration between health-care systems in BC and Alberta align with existing policy and legislation.**

CURRENT SITUATION

- The Ministry of Health continues work begun prior to and delayed by COVID-19 with the Alberta Ministry of Health (AMoH) to address health care access issues along the eastern border of BC.
- Restrictions to Out-of-Province (OOP) non-urgent/elective surgeries have been in place since January 2021, and will remain in place until Alberta is caught up on its COVID-19 surgical backlog.
- In February 2022, following discussions between BC and Alberta Ministry and Alberta Health Services (AHS) representatives, AHS agreed to continue to provide health services for time-sensitive/Life, Limb and Threatened Organ (LLTO) emergency patients along the BC and Alberta corridor and therefore replaced a previous directive with new guidance and criteria regarding OOP Intensive Care Unit (ICU) transfers.
- The BC and Alberta Ministries resumed bimonthly meetings in April 2023 to formalize the referral and transfer of Red or LLTO emergency patients.
    - There was a short pause during their recent provincial election but meetings have resumed.
    - Meetings have happened in December and January 2023/24 to continue to update and refine the MOU.
    - Timelines for completion of this work is dependent on AHS's review and feedback on the draft MOU.
- Northern Health Authority, Interior Health Authority and BC Emergency Health Services have been engaged in the MOU development and are parties of the MOU.
- Consistent with the *Canada Health Act*, publicly insured individuals can receive publicly funded healthcare services in any Canadian jurisdiction.
- There is no obligation for a province to provide elective procedural care to patients from other provinces and it is widely accepted that provinces are to strive for self-sufficiency in their ability to meet the healthcare needs of their populations.
- The Ministry continues to monitor access concerns and ensure collaboration between healthcare systems in Alberta and BC aligns with existing policy and legislation.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- Prior to COVID-19, congestion in Calgary hospitals resulted in some BC patients being denied access to health care in Alberta hospitals.
- There is no obligation for a province to provide elective procedural care to patients from other provinces and it is widely accepted that provinces are to strive for self-sufficiency in their ability to meet the healthcare needs of their populations.
- Between 2018/19 and 2022/23 there were 1979 more acute care inpatient cases of Alberta patients treated in BC than cases of BC patients receiving care in Alberta. The annual average for this five-year period is 396.[1]

Table 1. Acute Inpatient Flow between BC and Alberta by Fiscal Year (excluding day surgeries)[2]

	2018/19	2019/20	2020/21	2021/22	2022/23
Inpatients with BC HCN at AB Hospitals	2938	2738	1651	1767	2065
Alberta inpatients cared for in BC Hospitals	2772	2774	2487	2611	2484
Percent more AB Inpatients served in BC	-6%	1%	51%	48%	20%

<u>Alberta Health Services Memorandum – OOP ICU Patients to Alberta</u>

- In September 2021, AHS senior leadership issued a memorandum to zone officers and medical directors outlining a 4-stage approach in response to planning for a worst-case scenario where Alberta's health system reaches maximum capacity. AHS enacted Stage 1 and ceased ICU transfers from BC.
    - Stage 1 - From regions with their own ICU and specialty services, stop intake of ICU patients and those likely to utilize ICU/specialty ICU beds (CCU, Neuro ICU -stroke, neurotrauma and neurovascular, trauma).
- BC met with the Alberta Ministry and AHS representatives in February 2022, and came to an agreement on a revised directive that Alberta would continue to provide health services for time-sensitive/LLTO emergency patients.
- Patients requiring time dependent emergent interventions unable to be performed within the therapeutic window as listed below may be accepted:
    - Acute neuro interventional stroke;
    - Cardiac interventional procedures;
    - Critically ill trauma patients requiring time dependent referral to Level 1 or 2 Trauma Centres; and
    - High risk patients who require time dependent tertiary maternal fetal medicine care/neonatal ICU.
- In January 2023, AHS senior leadership issued a memorandum to zone officers and medical directors lifting the OOP ICU restrictions laid out in the February 2022 memorandum.
- Alberta physicians may again accept adult ICU patients in accordance with pre-pandemic/historical criteria and referral patterns with the condition that the sending site will repatriate the patient once the patient no longer requires ICU care and is safe for transport.
- Given current high occupancy in pediatric ICUs, pediatric transfers should be limited to those where AHS is western Canadian referral centre. Neonatal intensive care referral patterns remain unchanged.
- AHS will continue to monitor capacity pressures and may need to restrict OOP ICU transfers for adult patients in the future if capacity becomes further challenged.

[1] Data source: DAD, Health Sector Information, Analysis and Reporting (HSIAR) Division, Ministry of Health. PAS # 3000.1249 updated September 20, 2023: "Sep 2023 Factsheet update_Cross-Border Health Services (BC-AB) 2018-2022".

[2] Previously, this table included day surgeries and small counts of non-acute inpatient cases (psychiatric, rehab, extended care). Data for BC patients who received day surgery in Alberta is not available, and reporting standards for non-acute cases varies across provinces. This table is updated with only inpatient cases to ensure comparisons are made for similar groups of services.

Non-Urgent/Elective Surgeries

- In January 2021, AHS directed Alberta physicians to decline incoming non-urgent OOP patient referrals and that new non-urgent OOP patients would not be accepted on the AHS scheduled surgery waitlist.
- Alberta physicians were to assist waitlisted patients to find a provider to complete their non-urgent elective surgery within their home province.
- Due to East Kootenay's geographic location patients often sought non-emergency specialized medical services at Alberta hospitals as travel to and convalescing locally is much easier and historical referral patterns existed. Previously, issues of access to ophthalmology surgery in Alberta for East Kootenay residents were raised.
- In March 2021, an escalation process to address critical ophthalmology cases involving intraocular gas and support access on a case-by-case basis was established with Alberta with at least 4 East Kootenay residents receiving timely access to ophthalmology surgery.
- In January 2023, AHS confirmed the continued restriction on provision of scheduled elective non urgent surgeries for OOP patients as that province continues to focus on reducing surgical wait times for Albertans.

LAST UPDATED

The content of this estimates note is current as of February 21, 2024, as confirmed by Manpreet Khaira.

APPROVALS

2024 02 26 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 28 – Kristy Anderson, Hospital & Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

H-03

Alternate Level of Care

Topic: Active management of Alternate Level of Care rates plays an important role in ensuring patients receive health care services in the most appropriate setting and helps to reduce hospital congestion.

Key Messaging and Recommended Response:

- **Active management of Alternate Level of Care (ALC) patient days plays an important role in ensuring both ALC and new patients receive the care they need, in the most appropriate setting.**
- **ALC rates vary by health authority (HA) and by facility. The provincial rate was 14.4% in 2022/23, lower than the pre-pandemic level of 15.2% in 2019/20.**
- **We continue to work with HAs to focus on strategies to reduce the ALC rate and ensure all patients receive the care they need, in the most appropriate location.**
- **The Provincial Access and Flow Committee is developing provincial hospital access and flow standards to ensure timely discharge planning occurs with all patients. These standards will be implemented across all our hospitals in the coming months.**
- **The Ministry of Health has supported the regional HAs to implement strategies to create capacity in home health and reduce the number of ALC patients during the fall/winter surge, including the implementation of rapid response teams in the community and provision of 24/7 home support where appropriate.**
- **These initiatives aim to shorten hospital stays for both acute and alternate level of care patients.**

CURRENT SITUATION

- ALC is a clinical designation applied to a patient who is occupying a bed in a hospital and does not require the intensity of resources/services provided in the acute care setting.
- In preparation for Fall/Winter surge season 2023/24, health authorities (HAs) implemented home and community care strategies to help reduce the need for ALC beds - increasing hospital capacity and providing additional supports that help meet care needs in community.
- These initiatives include:
    - Long-term Care (LTC) Strategies:
        - Work with operators to re-open closed LTC beds, and/or purchase additional publicly funded LTC beds.
        - Offer patients choices and incentives to support individuals who accept accommodation temporarily in LTC facilities outside of their home community.

- Home Health Strategies: To support timely discharge home from acute care and mitigate risk of re-admission/emergency department visits, HAs draw from the following strategies:
  - Rapid response teams and enhanced supports (i.e., stabilization and activation after discharge from acute care, including overnight care, where required, for complex clients who can be supported at home).
  - Expanded use of home support, adult day programs and respite to support higher needs clients and their caregivers.
  - Expedited access to equipment to support acute care discharge.
- Acute Care Strategies:
  - Seven day a week access and flow leadership structures in place at large hospitals to ensure timely escalation support with discharge planning.
  - HAs are implementing a variety of options to expand support to teams to connect patients with resources in the community (seniors and mental health).
  - The provincial access and flow committee has been established and a provincial capacity surge response plan has been developed for all health authorities to adopt and this plan outlines standard ALC mitigation tactics that should be applied.
- Results of the above strategies indicate that the provincial ALC rate (total ALC patient days/total patient days) was 14.4% in 2022/23 (see Table 1), slightly lower than pre-pandemic levels. Year to date (April to August) for 2023/24 is 14.3% compared to 13.7% the same time last year, and 15.2% for 2019.
- In 2022/23 the ALC rate for seniors was 19.2%, compared to 7.2% for adults 19-64, and 0.8% for those age 0-18.

FINANCIAL IMPLICATIONS

- *Budget 2024* provides $354 million over three years to support seniors to age comfortably and safely in their own homes and maximize their quality of life, including:
  - $227 million over three years to improve the quality and responsiveness of home health services, including care management services delivered by community-based professionals (e.g., registered nurses, social workers, occupational and physical therapists) and home support services delivered by community health workers.
  - $127 million over three years to stabilize and expand community-based seniors' services that provide seniors with non-medical support, including assistance with day-to-day tasks, and deliver programs that help keep seniors physically active, socially engaged, and connected to their communities.
- The government has invested approximately $2 billion over the last 5 years to improve care for seniors, including investments in primary care, home health, LTC, and Assisted Living.
- This funding includes $145 million to expand respite care and adult day programs.
- BC has invested $1.65 billion in capital funding in long-term care since 2017.

KEY BACKGROUND

- A patient who no longer requires acute care but cannot be discharged, is designated as ALC if they meet specific clinical criteria. Many factors can delay discharge of a patient from hospital, including:
  - Waiting for transition to another type of facility (LTC, convalescent care, etc.)
  - Waiting for clinical assessment to determine needs[1]
  - Waiting for arrangements with community service/helping agency (e.g., to set up equipment)
  - Home modifications are being made (e.g., putting in a ramp)
  - Housing, economic, or social reasons (e.g., homelessness, financial resources)
- ALC patients may face increased risk of adverse events in hospital (falls, infection, functional decline, etc.). The services that these patients require may be offered more appropriately and cost-effectively via transitional care services (convalescent care, home health services, community-based programs or LTC).

[1] Clinical assessment of inpatients for appropriateness for admission to a LTC home should, whenever possible, take place after discharge from hospital and occur in a community setting.

- ALC rates are closely monitored by HAs and the Ministry of Health. While ALC rates are not expected to be zero since it can take time to arrange a service, alternative facility, or family member to provide care for the patient, hospitals should make every effort to minimize these rates.

Table 1: ALC Days as Percentage of Inpatient Days, by Fiscal Year, by Health Authority

Health Authority	2017/18	2018/19	2019/20	2020/21[2]	2021/22	2022/23	2023/24[3]
Interior Health Authority	16.4%	18.1%	19.0%	15.1%	16.8%	19.7%	16.8%
Fraser Health Authority	14.1%	14.4%	16.0%	12.9%	12.2%	13.6%	12.8%
Vancouver Coastal Health Authority	6.6%	7.7%	8.0%	7.5%	7.4%	9.2%	10.4%
Vancouver Island Health Authority	14.1%	16.0%	15.9%	14.1%	13.7%	14.6%	17.1%
Northern Health Authority	19.3%	22.1%	29.2%	22.8%	23.5%	27.1%	25.0%
Provincial Health Services Authority	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
British Columbia	**12.6%**	**13.9%**	**15.2%**	**12.6%**	**12.6%**	**14.4%**	**14.3%**

LAST UPDATED

The content of this estimates note is current as of March 1, 2024, as confirmed by Manpreet Khaira.

APPROVALS

2024 02 27 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 29 – Peter Klotz obo Rob Byers, Finance & Corporate Services Division
2024 03 02 – Kristy Anderson, Hospital & Provincial Health Services Division

[2] ALC rates in most health authorities were lower in 2020/21 than in the previous year due to significant decanting efforts as a result of the COVID-19 pandemic and reduced emergency department visits as a result of concerns regarding COVID-19.
[3] This data is for April-August 2023. Results cannot be directly compared to prior columns with full years due to seasonality in ALC rates.

LEGISLATIVE SESSION – ESTIMATES NOTE

H-04

BC Emergency Health Services - General

Topic: BC Emergency Health Services is part of the Provincial Health Services Authority and coordinates emergency health services to more than 5 million[1] British Columbians across the province and governs emergency health services provided by first responders to British Columbians.

Key Messaging and Recommended Response:

- **Since 2021, the government has made significant investments to improve BC Emergency Health Services' (BCEHS') organizational governance and strengthen ambulance services throughout the province.**
- **In 2023, BCEHS paramedics responded to over 580,000 medical emergency 9-1-1 events and transferred more than 69,000 patients between facilities.**
- **Since 2017, BCEHS has added more than 1,500 new full time and part time permanent paramedic positions and emergency medical responder positions, with 700 of these paramedics working in rural and remote communities throughout the province.**

CURRENT SITUATION

- BCEHS paramedics respond to more than half a million medical emergency 9-1-1 events a year and transfer more than 67,000 patients a year between facilities (usually hospitals).
- In 2023, BCEHS responded to 586,625 medical emergencies (9-1-1 events). This represents an increase of 40,618 (7.43%) calls compared from 2022 to 2023. In 2022, BCEHS responded to 546,007 medical emergencies (9-1-1 events).
- In 2023, BCEHS completed 69,591 inter-facility transfer events. This represents an increase of 1,833 (2.7%) transfer events from 2022 to 2023. In 2022, BCEHS completed 67,758 inter-facility transfer events.
- Since 2017, BCEHS has added more than 1,500 new full time and part time permanent paramedics and Emergency Medical Responder (EMR) positions, with 700 of these paramedics working in rural and remote communities throughout the province. Note: 2023 was the only year that BCEHS specifically added EMR positions since 2017.
- Specifics around the hiring related to these more than 1,500 positions are:
    - Between 2017 and 2019, BCEHS added more than 135 full-time regular positions, this includes 115 paramedic positions and 20 dispatchers. 104 regular part-time Community Paramedic positions were also added.
    - In 2020, BCEHS added 22 net new full-time regular positions and 8 net new regular part-time positions.
    - In 2021, BCEHS added 652 permanent new full-time positions. This includes 539 permanent regular full-time paramedic positions, 71 permanent irregular full-time positions (irregular positions cover for leaves, vacations, illness, etc.), and 42 full-time dispatch positions. Also in 2021, BCEHS added 190 permanent new regular part-time positions in rural and remote communities around the province.

[1] B.C. government population estimates 2022.

  - In 2022, BCEHS added 281[2] permanent new full-time regular paramedic positions. This includes 226 regular full-time positions and 52 irregular full-time positions (irregular positions cover for leaves, vacations, illness, etc.).
  - In April 2023, BCEHS added 190 permanent full-time Primary Care Paramedic (PCP) and EMR positions (60 regular full-time paramedic positions, 15 irregular full-time paramedic positions, 92 regular full-time EMR positions, and 23 irregular EMR positions)
- Out of 2,868 total permanent regular part-time and full-time paramedic positions, 2,256 of these positions were filled (79%) as of February 2, 2024. For comparison, on February 3, 2023, BCEHS had a total of 2,643 positions and of those 1,975 were filled (75%).
- In March 2022, the Provincial Health Services Authority supported the creation of a dedicated talent acquisition team within BCEHS.
  - The team has increased from 8.8 permanent positions to 32 permanent positions, as well as adding temporary support positions to assist with recruitment and posting.
  - BCEHS have also created a Proactive Recruitment team that consists of Indigenous (5 positions) and non-Indigenous (6 Positions) Recruiters.
  - The BCEHS Youth pathway program initiates EMR training in High Schools with the goal of creating a pathway for youth to work with BCEHS.
- Since 2020, BCEHS has added 77 ground ambulances and 5 air ambulances. 55 new ground ambulances and 5 air ambulances were added as part of the Rural, Remote, First Nations and Indigenous COVID-19 Response Framework. 22 new ambulances announced in 2021, were deployed over 2021/22 to support patient care. Two temporary air resources have also been added and are in place until October 2024.
- A 3-year agreement (April 1, 2022, to March 31, 2025) between the Ambulance Paramedics and Ambulance Dispatchers Bargaining Association and the Health Employers Association of BC was reached on January 6, 2023, with ratification announced on February 15, 2023. The ratified agreement includes general wage increases:
  - Year 1 - a flat increase of $0.25 per hour, which provides a greater percentage increase for lower-paid employees, plus a wage increase of 3.24%
  - Year 2 - 5.5% plus a potential cost-of-living adjustment to a maximum of 6.75%
  - Year 3 - 2% plus a potential cost-of-living adjustment to a maximum of 3%

<u>Scheduled On Call</u>

- The new Ambulance Paramedics and Ambulance Dispatchers Bargaining Association of BC (APADBA) Collective Agreement (CA) provides for the phase out of the SOC model in the existing 60 communities to another model by March 31, 2024.
- On November 9, 2023, the Province announced that they had accepted the new staffing model recommendations for the 60 communities: <u>More ambulance services coming soon to rural and remote communities across B.C. (bcehs.ca)</u>.
- The new models are:
  - 22 communities to an “Alpha” model, which will provide reliable 24/7 emergency response service as staff are in station and on duty 24/7. Note – was 21 before Rossland was changed to the Alpha 24/7 model.
    - Communities moving to this model will have paramedics in the station on-duty three times more than with the SOC model.
    - Alpha stations will have 8 full-time equivalent (FTE) positions, plus an additional 2 for backfill.
  - 25 communities to a “Mix Shift” model, which will provide staff with more flexibility and better work/life balance than the SOC model.
    - Communities moving to this model will have staff on duty in the station twice as often as they do with the SOC model, with 16 hours in station on duty and 8 hours on call (pager) at night.
    - Mix-Shift stations will have 8, 0.75 FTE positions, plus the potential for backfill as needed.

[2] The number 278 refers to all of 2022. While most positions were added in November, there were a handful (e.g.: Central Saanich) that were added prior to November 2022.

  - 13 communities to a "Kilo" model with a full-time permanent unit chief and staff on call (pager). Compared to the SOC model, the Kilo model will offer more flexible staffing options to maximize local recruitment. Note – was 14 before Sointula was changed to the Mix Shift model.
    - Staffing allocation at Kilo stations is determined based on historic staffing knowledge and the requirement to ensure enough staff are hired to fill the shifts. As such, staffing numbers for these stations can vary by community.
- Following the November 9, 2023, announcement the models for Sointula and Rossland were reconsidered and adjusted as follows:
  - Sointula was originally designated a "Kilo" model. As of December 15, 2023, the community was notified that it would be a "Mix Shift" model.
  - Rossland was originally designated a "Mix Shift" model. As of December 15, 2023, it was changed to an "Alpha" 24/7 model.
- As part of the SOC Phase Out:
  - BCEHS will be available to support routine transfers in the late afternoon and evenings as needed.
  - Paramedics will no longer need to work for 72 straight hours, as required in the SOC model.
  - Paramedics will have a better work/life balance, which means that BCEHS will be better able to ensure all communities are covered, especially in the evenings.
- As of April 1, 2024, due to the SOC phase-out, there will be an additional 55.2 FTE stand-alone Community Paramedics (CP) that will provide dedicated community-based care and community outreach. These positions were posted in mid-December 2023 and are waiting to be filled with a target start-date in May 2024.
- This is a change from the current SOC model as they will no longer be coupled with a 911 response paramedic. However, CPs will respond to high-acuity 911 calls in the event they are the closest, appropriate unit. See Appendix B for more detail on Community Paramedic locations.
- This transition of CP positions was done in consultation with a Community Paramedic Working Group composed of members from APBCBCEHS leadership and Heath Employers Association of BC. This Working Group was established in 2023 and will meet through 2024 to conclude the work.
- The Collective Agreement also includes at least 22.5 FTE standalone CP positions, with employer discretion as to the full-time employment of each CP position. These positions are currently posted and are waiting to be filled.

<u>System Performance/Impacts</u>

- BCEHS meets its provincial median target of under 9 minutes to respond to the most life-threatening category of calls (Purple calls) in metro and urban communities.
- In 2023, BCEHS responded to an average of 1,600 9-1-1 events per day. Of these, 34% were lower acuity (e.g., require care for cuts, wounds, sprains, muscle strains, mild illness, or skin conditions). Some of these patients do not require a trip to an emergency department, but they require some form of connection to care. In 2022, BCEHS responded to an average of 1,500 9-1-1 events per day. Of these, 36% were lower acuity.
- Secondary triage primary care paramedics were added in early 2022, to manage less-urgent calls to help reserve ambulances for emergencies. The secondary triage desk is supported by paramedic specialists, senior dispatchers and a patient navigator for patients who may not need transport to hospital.
- In 2021, BCEHS improved its contingency/escalation process (Clinical Safety Plan) to maintain patient and staff safety through spikes in demand. The Clinical Safety Plan helps reduce turnaround times at hospitals, delays non-urgent transfers and increases secondary triage/alternate care and transport options, so ambulances are available for life-threatening 9-1-1 calls.
- In 2021, BCEHS introduced alternate transport methods that provides "low-acuity response units" to transport patients with non-urgent conditions to health care centres. The program was launched with 11 units in 2021 and, as of summer 2023, was expanded to 14 units – 6 units are in Fraser Health Authority, 3 are in Interior Health Authority, and 5 are in Vancouver Coastal Health Authority. An additional unit can be deployed as staffing availability allows.

FINANCIAL IMPLICATIONS

- Since fiscal year 2016/17, BCEHS' annual spending has increased from $424.254 million to $766.175 million in 2022/23 – nearly a 80.59% increase.
- Budget 2023 provides $130 million over 3 years to support an increase to the on-call rate for paramedics that will expand ambulance coverage throughout BC.
- On February 2, 2023, the government announced $2 million to expand paramedic training programs in communities around the province.

KEY BACKGROUND

- Since 2021, the HLTH has provided BCEHS with significant investment funding for increased paramedic/dispatch staffing to improve ambulance service and includes converting on-call/casual positions to regularly scheduled full- and part-time positions.
- In July 2021, the Minister announced 22 rural community ambulance stations (since increased to 24) would transition to 24/7 Alpha shift models and the hiring of an additional 177 full time paramedic positions. This was complete in October 2021.
- In September 2022, regulations to expand the range of services paramedics and first responders can provide were finalized. This means that when appropriate training and licensing are in place, paramedics and first responders will be able to better assist and treat patients on scene.
- Once the appropriate training and licensing is in place, paramedics and first responders will be able to better assist and treat patients on scene.
- In November 2023, the Minister of Health announced that the Scheduled on Call (SOC) staffing model currently in 60 rural and remote communities across the province would be phased out to another model by March 31, 2024.
    - The 3 new staffing models are the "Alpha" model, which has staff in station and on duty 24/7, the "Mix-Shift" model which has staff on duty in station for 16 hours and on call (pager) 8 hours at night and the "Kilo" model which has a full-time permanent unit chief and staff on call (pager).
- With these new models in place and the addition of 278 full time paramedic positions, these communities will benefit from improved 9-1-1 responsiveness. In addition, 55.2 full time equivalent Community Paramedic positions added as part of the SOC phase out will provide dedicated community-based care and community outreach.

LAST UPDATED

The content of this estimates note[3] is current as of March 12, 2024, as confirmed by Eugene Johnson.

APPROVALS

2024 02 29 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 13 – Kristy Anderson, Hospital and Provincial Health Services Division

[3] BCEHS Contact: Vincent Poirier, BCEHS, Data Governance Lead, Strategy and Transformation, Email : vincent.poirier@bcehs.ca

LEGISLATIVE SESSION – ESTIMATES NOTE

H-05

BC's 10-Year Cancer Action Plan

Topic: Achievements and Progress on BC's 10-Year Cancer Action Plan

Key Messaging and Recommended Response:

- **Through Budget 2024, the government has announced $270 million more over the next three years to support BC's 10-Year Cancer Action Plan.**
- **In 2023/24, the province invested nearly a half-a-billion dollars ($440 million) in the 10-Year Cancer Action Plan to support immediate steps to better prevent, detect and treat cancers.**
- **$150 million of the funding was provided to the BC Cancer Foundation to advance research, recruit cancer talent, and enhance patient access to treatments.**
- **A further $20 million went to the Canadian Cancer Society and Hope Air to expand travel programs that support cancer patients.**
- **This built on over $1 billion in investments and efforts undertaken since 2017 to support the creation of a strong and sustainable cancer system in BC.**

CURRENT SITUATION

Achievements and progress on BC's 10-Year Cancer Action Plan include:

<u>Cervical Cancer Prevention (HPV Immunization)</u>

- The HPV vaccination information campaign is underway, targeting youth ages 14-18 and parents of children ages 9-18 to increase the vaccination rate and improve awareness of HPV and the efficacy, safety, and importance of vaccine. The multi-media strategy will also target parents who speak Mandarin, Cantonese, or Punjabi. HealthLinkBC provides additional details.
- Anyone who missed getting the HPV vaccine at school can contact their local health unit, community health centre or pharmacy to make an appointment to get vaccinated. Males (born in 2005 or later) and females (born in 1997 or later) remain eligible to receive the HPV vaccine for free if they get their first dose before they turn 19 and get their last dose before they turn 26.
- HPV vaccination eligibility was extended to males born between January-June 2005 (announced January 15, 2024) until June 30, 2024.

<u>Cervical Cancer Screening</u>

- Human papillomavirus (HPV) testing including province-wide self-screening for cervical cancer was launched January 29, 2024 (announced January 9, 2024). Since the launch, 17,406 self-collect kits have been distributed province-wide (to February 29, 2024, P12).
- The option to self-collect removes obstacles such as cultural barriers, history of trauma, the need for transportation, childcare and booking time off from work for traditional testing.
- A province-wide public education campaign encouraging screening and the self-screening option was launched the week of February 12, 2024.

- HPV is now known to be the primary cause of cervical cancer so testing for it early, potentially before pre-cancerous cells develop, makes it a more sensitive test than the Pap test which looks for pre-cancerous or cancerous cells.

Specialized Cancer Treatments – Delivering CAR-T in BC

- CAR-T is Health Canada approved as a standard of care for the treatment of refractory or relapsed large B-cell lymphoma in adults and acute lymphocytic leukemia in pediatric and young adults.
- As part of the Plan, the province is launching the delivery of CAR-T (Chimeric Antigen Receptor T-Cell) therapy at Vancouver General Hospital and BC Children's Hospital.
- The program is initially expected to provide treatment to up to 25 patients per year (20 adult and 5 children/youth).

New Cancer Centres and Technologies

- BC's 4 new cancer centres are moving forward:
    - Surrey: construction on the second cancer centre Surrey started in 2023 and is expected to be complete in 2030.
    - Burnaby: Construction is expected to start on the new cancer centre in 2025 and the project is expected to be complete in 2030.
    - Kamloops: the business plan for a new cancer centre in Kamloops is approved (announced February 8, 2024). Construction will start in 2025 with an expected opening date in 2028.
    - Nanaimo: the concept plan is approved (announced May 26, 2023) and business plan complete. The targeted opening date is expected in 2028.
- Construction is underway for a new cyclotron and radiopharmacy laboratory in Vancouver that will serve cancer centres with Positron Emission Tomography-Computed Tomography (PET/CT) scanning in Kelowna and Victoria as well. The radioisotopes produced are key for cancer diagnostics and advanced imaging and this new facility will expand capacity and access to PET/CT scans and innovative cancer treatments across the province. For patients this means a more personalized treatment plan and better outcomes. The facility is expected to be operational in 2026 (announced January 30, 2024).

Team-Based Care and Investments in Cancer Workforce

- Recent investments in the cancer workforce have facilitated the implementation of team-based care and added treatment capacity.
- BC Cancer has activated 69 teams at all BC Cancer regional centres made up of oncologists, nurses, pharmacists, patient care aides and unit clerks. The next phase of team-based care is to add supportive care (e.g., physiotherapy, occupational therapy, social work, nutritionists) resources.
- Since 2021/22, approximately 750 new full-time equivalent (FTE) roles have been added to the cancer workforce with approximately 510 supporting team-based care (oncologists, nurses, pharmacists, patient care aides, unit clerks). The remaining 240 new FTE cancer care staff added were to support the Hereditary Cancer Screening Program, Indigenous patient navigators, molecular imaging and therapy including medical physicists, radiation therapy including radiation therapists, radiation service technicians and medical physicists, data and analytics, supportive care including counsellors, dieticians and speech language pathologists, and administrative staff including unit clerks, secretaries, and receptionists.[1]
- Targeted recruitment efforts are underway given the global health human resource (HHR) crisis.
- To attract and retain in demand cancer care professionals, pay structures were revised to make BC more attractive and competitive, including:
    - Increased compensation for oncologists as of April 1, 2023 (approximately $473,000 per FTE).
    - Increased compensation for radiation therapists as of April 1, 2023.
- These revised pay structures have supported the hiring of:

[1] BC Cancer Estimates Information, February 29, 2024

- 55.3 new physician FTEs (a 16.2% increase) between April 1, 2023, and February 29, 2024 (P12). By headcount, 92 new physicians have been hired since April 1, 2024, including 71 oncologists (only oncologists and hematologists are eligible for increased compensation).30 FTE radiation therapists hired between April 1, 2023 and February 29, 2024 (P12).
- To support culturally safe care, a total of 8 Indigenous patient navigators (1 at each Abbotsford, Prince George, Surrey, Victoria, 2 in Kelowna, 2 in Vancouver) are now in place.

Increased Treatment Capacity

- The volume of patients receiving treatment or consults has increased in comparison to the same period of 2022/23.
    - The number of new patient consults has seen an 8% increase for Medical Oncology and 9.9% for Radiation Oncology.
    - The number of follow up visits has increased 12.9% for Medical Oncology and 12.2% for Radiation Oncology.
- Additional capacity has been added to the provincial system through the expansion of PET/CT operating hours in Victoria and Kelowna. As of Period 11 (February 1, 2024), a total of 17,077 PET/CT exams have been conducted, marking an increase of 8.0% compared to the same period in 2022/23, during which 15,817 exams were completed.[2]
- Launched a temporary 2-year initiative – the Across Borders Radiation Treatment Commitment - in May 2023 offering eligible patients radiation treatment in Bellingham, Washington for up to 50 patients each week. As of March 1, 2024, 2,182 patients have been referred to receive radiation treatment, 620 patients have received a consult, 566 have started treatment, 42 are actively receiving treatment, and 524 (401 breast cancer; 123 prostate cancer) have completed radiation therapy in the U.S.[3]

New Travel Supports for Cancer Patients

- The Canadian Cancer Society (CCS) and Hope Air each received $10 million in grant funding to expand their travel support programs for cancer patients.
- Both organizations reported a significant increase in the number of people applying for their travel programs.
- Between October to December 2023, CCS:
    - supported 568 patients through the Travel Treatment Fund. During the same period in 2022, CCS supported 32 patients (1,675% increase).
    - provided 5,833 lodge nights at no cost (used to be $55 per night).
    - CCS supported 1,337 one-way trips by volunteer drivers from October to December 2023.
    - supported 59 patients who travelled to Vancouver for bone marrow transplants to cover their travel for treatment expenses with a grant of $4,000 and expenses covered for air and ground transportation. Last year this program did not exist, and patients would have paid out-of-pocket for the costs of staying in Vancouver for up to 4 months.
- Hope Air individual travel arrangements (air, ground, accommodation, meals) for cancer patients increased from 573 to 2095 or 266% year over year from September to December 2022 to 2023.
    - Year over year the number of patients served increased from 115 to 263 (129% increase) and the number of caregivers served increased from 67 to 111 (66% increase).
    - The number of flights increased from 347 to 560, a 61% increase over the same period last year.
    - The number of accommodation nights provided increased from 167 to 926 or 454%.
    - The number of meals increased from 39 to 419, an increase of 974% from the same period last year.

[2] BC Cancer Performance Report Fiscal Period 11, February 23, 2024
[3] BC Cancer Estimates Information, March 25, 2024

Investing in Research and Recruitment

- A one-time $150 million grant was provided to the BC Cancer Foundation in 2022/23 to support advancement of the Plan through improved patient access to clinical trials and the recruitment and retention of cancer scientists and clinicians. From April 1, 2023, to February 16, 2024, BC Cancer has:
  - Hired 15 new FTEs to support clinical trials.
  - Funded 23 radiation oncology clinical trials.
  - Awarded 13 clinical researcher start up grants. This includes research on diverse topics such as equity-oriented cancer care, survivorship, AI models, population-based outcomes, and male breast cancer.
  - Awarded 14 Rising Star (MSc/PhD) scholarships, 5 Rising Stars post-doctoral scholarships and 1 Canadian College of Medical Geneticists Fellowship.
  - Funded numerous clinical and multidisciplinary research projects e.g., the BC Generations Project, the Northern Biobank Initiative, and Real World Evidence Data Collection and Analysis.

Cancer Plan Governance

To support achievement of the Plan, a new governance structure has been put in place. This includes an Executive Provincial Steering Committee with representation from the Provincial Health Services Authority, BC Cancer, and the Ministry of Health. Several working groups reporting to the Steering Committee have been formed to take action on the Plan. An Expert Advisory Panel comprised of leading international experts on cancer care helps inform on best practices.

FINANCIAL IMPLICATIONS

- BC Cancer annual expenditures have risen from $812.4 million in 2018/19 to $1,060.3 million in 2022/23. In addition, the BC Cancer drug expenditures (net of rebates) rose from $310.1 million in 2018/19 to $404.6 million in 2022/23.
- To support implementation of the Plan and immediately improve services, government initially invested $440 million including:
  - $270 million of operating funding over 3 years to BC Cancer ($90 million each year starting 2023/24).
  - $150 million grant to the BC Cancer Foundation to support cancer research.
  - $20 million grant to Canadian Cancer Society and Hope Air to expand their cancer travel and accommodation programs.
- On February 22, 2024, the government announced an additional $270 million over 3 years to support further implementation of the Plan.

KEY BACKGROUND

- The number of people in BC who receive a cancer diagnosis annually is expected to rise from approximately 30,000 in 2021 to 45,000 by 2035, representing a 50% increase.[4]
- In Canada in 2023, prostate cancer is expected to be the most diagnosed cancer in males, accounting for about 1 in 5 (21%) new cases. It is followed by lung cancer (12%), colorectal cancer (11%), bladder cancer (8%) and non-Hodgkin lymphoma (5%). In females, breast cancer is expected to be the most diagnosed cancer, accounting for about 1 in 4 (26%) new cases. It is followed by lung cancer (14%), colorectal cancer (9%), uterine cancer (7%) and non-Hodgkin lymphoma (4%).[5]
- The Plan was launched in the spring of 2023 with an initial $440 million investment to expand cancer-care teams and service hours, introduce revised pay structures to ensure BC is attractive and competitive for oncologists and cancer-care professionals, improve cancer screening programs, support cancer research, increase Indigenous patient support positions, and support patients who must travel for care from rural communities.

[4] Cancer Statistics Online Dashboard (bccancer.bc.ca)
[5] Cancer Statistics Online Dashboard (bccancer.bc.ca)

- The Plan responds to increasing demand for cancer care due to a growing population and the population living to an older age when the risk of cancer increases. Because of advances in diagnosis, technology and treatment, more people with cancer are surviving and those surviving are living longer.
- The $270 million in operating funding over 3 years ($90 million per year starting in 2023/24) will support foundational work including Expanded cancer-care teams at all 6 cancer centres; Revised pay structures to ensure BC is attractive and competitive for oncologists and cancer-care professionals; Expanded access to systemic (chemo) and radiation therapy; Improved cancer screening programs, including diagnosis and breast imaging times; Increased Indigenous patient support positions; and Innovative treatment in BC.
- New funding of $270 million ($90 million per year starting in 2024/25) announced in Budget 2024 will support the Plan with prevention and screening services such as HPV vaccines and cervical cancer screenings, hereditary cancer screening, and medical imaging strategies. New funding will also support improved collaboration, partnership, and capacity for the cancer care workforce.
- Timely access to cancer treatments will also be improved by expanding specialized cancer services, such as malignant hematology, immunotherapy, theranostics, and pediatric oncology services. This will deliver treatments that are difficult to access or currently unavailable in the province.

LAST UPDATED

The content of this estimates note is current as of April 22, 2024, as confirmed by Tracy Martell.

APPROVALS

2024 02 28 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 04 22 – Kristy Anderson, Hospital and Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

H-06

Diagnostic Imaging Strategy

Topic: Update on the diagnostic imaging strategy focused on access and wait times for Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) exams.

Key Messaging and Recommended Response:

- **Since 2016/17, the Province has increased the total number of Magnetic Resonance Imaging (MRI) units to 43 from 25, and total number of Computed Tomography (CT) units to 72 from 63.**
- **Nine net-new CT units and 18 net-new MRI units have been added around BC to both increase capacity and improve geographic access to diagnostic imaging services.**
- **Additionally, since 2016/17, health authorities have significantly increased exams, and in 2023/24 are expected to provide:**
    - **314,832 MRI exams, 79% or 139,125 more compared to 2016/17.**
    - **983,526 CT exams, 41% or 288,278 more compared to 2016/17.**
- **For MRI wait times in the 90th percentile, we went from third in the country in 2019 to first in 2022, according to last year's Canadian Institute for Health Information (CIHI) report.**
- **We have made tremendous progress on improving capacity for services and reducing wait times, and we recognize we couldn't achieve such success without everyone involved in delivering medical imaging services.**
- **That's why we developed a new direct-entry MRI technologist training program at BC Institute of Technology (BCIT) to bolster the workforce.**
- **The program no longer requires an existing medical imaging certification, so recruitment of high school graduates can replace recruitment of other medical imaging staff.**
- **And in Spring 2022, we invested $2.5 million in the MRI Technologist Bursary Program which provides tuition and stipend funding to BCIT students who are health authority employees.**
- **Since it was first offered in Spring 2022, 59 students have taken advantage of the bursary funding.**

CURRENT SITUATION

- Enhanced access to MRI and CT exams is supported by 4 key strategies: 1) building further capacity; 2) increasing essential personnel; 3) optimizing business processes; and 4) improving waitlist management and reporting.
- Shortages of technologists continue to impact maintenance and limit additional operating hours for MRI and CT services. Initiatives to increase staffing include:
    - New direct-entry MRI technologist 2-year training program at BC Institute of Technology (BCIT) ensuring a steadier supply of graduates. This diploma program does not require an existing medical imaging certification (as the 2nd discipline certificate program does), so recruitment of high school graduates can reduce the recruitment of other medical imaging staff with roles in X-ray, nuclear medicine, radiation therapy, or sonography. Began in January 2023 with 12 students; the next annual intake in January 2024 was for 14 students as they aim to increase cohort size.
    - Launch of the MRI Technologist Bursary Program in Spring 2022 providing tuition and stipend funding to BCIT students who are health authority employees. The government provided $2.5million in funding for this bursary, which was designed to support students to complete the part-time, self-paced program at BCIT in an accelerated timeframe. Since the bursary program was first offered, 59 students have taken advantage of the bursary funding. Throughout the 6 terms since the bursary became available, those students have received funding to complete 66 individual courses, including 73 theory courses and 48 clinical placements.
- Work is underway to modernize MRI and CT requisitions with electronic tools that will reduce wait times by reducing delays caused by rejected requisitions, manual entry into systems, and provide patients and referring practitioners with transparent waitlist information to inform site selection.

FINANCIAL IMPLICATIONS

- In both 2021/22 and 2022/23 the Ministry of Health allocated $42.16 million to address medical imaging activities wait times in the health authorities.
- In 2023/24, the Ministry allocated $46.9 million.

KEY BACKGROUND

NOTE: All 2023/24 data is based on Period 10 submissions and are subject to change post-audit. Year-end Projections have been provided by the health authorities.

Magnetic Resonance Imaging (MRI)

Volumes[1]

In 2023/24, health authorities are expecting to exceed their target of 302,254 by over 12,500 exams this fiscal year, a 79% increase in exams provided over 2016/17 fiscal year.

MRI	2016/17	2017/18	2018/19	2019/20	2020/21*	2021/22	2022/23	2023/24** P10 YTD	2023/24*** Projections
Volumes	175,707	189,520	233,368	252,527	247,106	296,408	299,061	241,723	314,832

** For the first 6 weeks of 2020/21, non-urgent MRI exams were postponed due to the COVID-19 pandemic.*
***2023/24 Period 10 Medical Imaging report*
****Based on Year End Estimations/Projections. Final numbers may differ.*

Equipment Inventory:

- Since 2017, the number of MRI scanners in BC has increased from 25 to 43, an increase of 18 MRI scanners or an increase 72%.
- This equates to 7.8 MRI units per 1,000,000 population, compared to the national rate of 10.0.

[1] Health Sector Information, Analysis and Reporting (HSIAR) Division. HAMIS data.

Computed Tomography (CT)

Volumes[2]

In 2023/24, health authorities are expecting to exceed their target of 924,951 by over 58,500 exams this fiscal year, a 41% increase in exams over 2016/17 fiscal year.

CT	2016/17	2017/18	2018/19	2019/20	2020/21*	2021/22	2022/23	2023/24 P10 YTD**	2023/24*** Projections
Volumes	695,248	733,787	788,439	805,584	812,212	901,296	923,989	753,113	983,526

**For the first 6 weeks of 2020/21, non-urgent MRI exams were postponed due to the COVID-19 pandemic.*
***2023/24 Period 10 Medical Imaging report*
****Based on Year End Estimations/Projections. Final number may differ.*

Equipment Inventory:

- Since 2017, the number of CT scanners in BC has increased from 63 to 72 an increase of 9 scanners or an increase of 14%.
- This equates to 13.1 CT units per 1,000,000 population, compared to the national rate of 14.5.

LAST UPDATED

The content of this estimates note is current as of March 13, 2024, as confirmed by Shana Ooms.

APPROVALS

2024 02 26 – Eric Larson obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2024 02 27 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 01 – Kristy Anderson, Hospital and Provincial Health Services Division

[2] Health Sector Information, Analysis and Reporting (HSIAR) Division. HAMIS data.

LEGISLATIVE SESSION – ESTIMATES NOTE

H-07

Eating Disorders

Topic: An overview of eating disorder care in BC.

Key Messaging and Recommended Response:

- **We recognize the importance of eating disorder services and the unique needs some eating disorder clients have.**
- **The Ministry of Health is committed to providing access to eating disorder services and these services are an important component of the overall mental health continuum of care.**
- **Services and supports for people living with eating disorders are delivered through clinics administered by the Ministry of Children and Family Development, health authorities, and contracted service providers.**
- **The province has established practice guidelines to assist clinicians in assessing an individual's needs and determining whether they can be appropriately supported through community services, or if they require admission to hospital.**
- **People may also be referred to tertiary level eating disorder care with the Provincial Adult Tertiary Specialized Eating Disorders Program (St Paul's Hospital) or Looking Glass Residence residential program on the mainland if they require more intensive treatment.**

CURRENT SITUATION

- Ministry of Children and Family Development (MCFD) currently holds responsibility for and facilitates the South Island Eating Disorder Program (SIEDP) for children, youth, and adults , and 2 other eating disorder (ED) clinics in Fraser Health Authority (FHA) serving children and youth only.
- The SIEDP has served adults, children, youth, and families since 1997, when child and youth mental health services transferred from the Ministry of Health (HLTH) to MCFD.
- The SIEDP is the only ED program in the province where adult services are provided by MCFD and not by a regional health authority (RHA).
- SIEDP provides all community ED services, and Island Health Authority (VIHA) provides acute primary care and emergency ED services in the South Island region.
- SIEDP is staffed by 2 dieticians, 6 clinicians, 1 Psychologist and a Team Leader and 1 administrative assistant.
- The current waitlist is approximately: 41 adults and 65 youth.

Table 1. Referrals for SIEDP

	New Referrals Rates		New Referrals – Rejected Rates	
	2023	2022	2023	2022
Youth:	138	126	26	22
Adult	163	124	65	64
Total:	**301**	**250**	**91**	**86**

- Government also supports organizations providing ED counselling for certain regions (e.g., Foundry North Shore has a Youth ED Program; Looking Glass Foundation Bridge The Gap Program).
- Non-government and non-profit organizations provide some ED services (e.g., Looking Glass Foundation, Kelty Eating Disorders, Jessie's Legacy);
- There are also private treatment options.

FINANCIAL IMPLICATIONS

From 2020/21 to 2023/24 the province has allocated $0.617 million to Looking Glass Foundation to support ED services.

KEY BACKGROUND

- EDs are mental health conditions characterized by atypical eating behaviours that affect quality of life. Symptoms of general eating pathology (e.g., skipping meals, binge eating) increased from 15.3% to 23.3% during COVID-19, which was greater than symptoms of depression and anxiety.
- Primary care providers are often the first point of contact for persons with ED, but these providers may have limited knowledge to identify/treat ED and typically refer to ED programs with specialist care. Some ED programs can have team-based care providing access to dietitians and psychiatrists.
- Specialist ED services in BC are delivered by various sources. Admission criteria and wait times vary across regions and depend on specific programs within these sources:
    - HLTH funds RHAs to provide adult outpatient and emergency care, and Provincial Health Service Authority (PHSA) and Providence Health Care provide tertiary care.
        - RHAs provide 45 community and tertiary care beds for youth and adults.
        - PHSA's BC Children's Hospital (BCCH) provides assessments, recommendations, and treatment for children, youth, and young adults with EDs while supporting families and caregivers in their Specialized Eating Disorders Program and The Looking Glass Residence.
        - BCCH chairs the BC Provincial Eating Disorders Network (the Network), which meets quarterly with the goal of knowledge exchange and relationship building related to the prevention and treatment of ED across pediatric and adult populations in BC. The Ministry of Mental Health and Addictions (MMHA) currently participates on behalf of MMHA and HLTH.
    - MCFD funds Child Youth and Mental Health (CYMH) teams to provide outpatient care to children and youth, but specialized programs vary between communities. Some communities provide ED care through CYMH only; some have a collaboration between CYMH and adult mental health through RHAs, and some contract the work out.

LAST UPDATED

The content of this estimates note is current as of March 1, 2024, as confirmed by Eugene Johnson.

APPROVALS

2024 02 22 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 02 – Kristy Anderson, Hospital and Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

H-08

Emergency Department Access

Topic: Access to timely acute care emergency services is important to both patients and health care providers.

Key Messaging and Recommended Response:

- **As is the case at hospitals across BC and Canada, generally we are seeing higher emergency department (ED) visits and higher acuity patients in hospital.**
- **Healthcare worker shortages throughout BC, nationally and internationally, has resulted in temporary ED diversions.**
- **The decision to divert patients to a nearby hospital is never made lightly and is only done as a last resort. Health authorities look at all options prior to implementing diversions. This includes looking to move staff between sites as able/needed.**
- **Staffing pressures are often amplified at rural sites where staffing pools are typically smaller.**
- **When a hospital or department is under diversion, patients are sent to other available sites within the region. Every effort is made to divert patients to the closest hospital.**
- **Through the Province's Health Human Resources Strategy, launched in the fall of 2022, BC has made significant progress to better support the public health-care system by adding more doctors and other healthcare professionals, new education and training seats, and taking actions to improve healthcare worker retention, and optimize the health care system to ensure patients in BC get the care they need when they need it.**
- **Recruitment efforts, particularly in rural and remote communities, include incentives such as relocation assistance, rural retention grant and BC loan forgiveness.**
- **A new Provincial Emergency Physician Locum Pool has prevented more than 56 ED diversions and continues to support many communities in need of physician staffing with the 186 emergency room physicians from across the province who are willing to provide emergency locum coverage.**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- As we emerge from the pandemic, emergency departments (EDs) are faced with an increasing volume of patients, staffing shortages and staff burnout.
- While ED visits dropped significantly in 2020/21 with the onset of the COVID-19 pandemic and public health orders, during the current fiscal year the number of ED visits has returned to its pre-pandemic growth trend.
- Current ED wait times are impacted by increased ED visits, increased overall hospital occupancy rates, more hospital beds occupied by patients with an Alternate Level of Care (i.e., patients who do not require the intensity of services provided in that care setting) and staffing challenges across the entire acute care and community health sector.
- Staffing challenges and extraordinary climate events have meant some EDs have had to go on diversion to ensure safe care.

KEY BACKGROUND

Emergency Department Visit Volumes

- Between 2016/17 and 2019/20, the average annual growth rate for provincial ED visits was 1.6%.
- In 2020/21, ED visits dropped significantly. Province-wide, the number of ED visits decreased by 15.9% compared to 2019/20.
- During the last fiscal year, 2022/23, the number of ED visits has returned to pre-pandemic growth trend (higher in many cases), with the provincial daily average number of ED visits increasing by 5.2% compared to 2019/20.

	Daily Average ED Visits 2018/19 to 2023/24						ED Visits Percentage Change from Pre-COVID Year 2019/2020			
HA	Pre-COVID		During COVID		Post COVID		During COVID		Post COVID	
	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Change in 2020/21 from 2019/20	Change in 2021/22 from 2019/20	Change in 2022/23 from 2019/20	Change in 2023/24 (Up to Period 10) from 2019/20
IHA	1,364	1,374	1,175	1,325	1,429	1,471	-14.5%	-3.6%	4.0%	7.1%
FHA	1,925	1,919	1,606	1,897	1,998	2,020	-16.3%	-1.1%	4.1%	5.3%
VCHA	1,192	1,178	986	1,195	1,248	1,279	-16.3%	1.5%	6.0%	8.5%
VIHA	1,129	1,144	1,011	1,191	1,264	1,256	-11.6%	4.2%	10.5%	9.8%
NHA	747	744	593	670	738	739	-20.3%	-10.0%	-0.8%	-0.7%
PHSA	131	126	83	121	146	140	-34.4%	-4.1%	15.6%	11.5%
BC	**6,487**	**6,484**	**5,453**	**6,399**	**6,823**	**6,906**	**-15.9%**	**-1.3%**	**5.2%**	**6.5%**

Data Source: Calculated value, based on HSIAR/HAMIS ED Report, File Name 2023_24 - Period 10 - ED Visits

Emergency Department Diversions

- Temporary diversions occur when there is a gap in service at one facility that can be filled using BC's extensive network of hospitals and health care services.
- BC's health care system has experienced extreme strain from COVID-19 and other factors, and this has created particular staffing challenges, which at times may result in a diversion. These pressures are often amplified at rural sites where staffing pools are typically smaller.
- While diversions are never ideal, they are sometimes necessary to ensure the best and safest care is provided to patients temporarily. Diversions can occur in many departments. When a hospital is under diversion, patients are sent to other available sites within the region. Every effort is made to divert a patient to the closest hospital.
- Health care worker shortages, intensified by the ongoing pandemic, have contributed to staffing issues throughout BC and nationally. These can be a result of:

  - Higher than normal sick call rates among existing staff, Challenges with recruitment of full-time positions, Challenges with retaining staff, and National nursing and physician shortages.
- At times, adverse weather events have impacted EDs (forest fires, flooding, freezing weather) which have also resulted in diversions.
- Health authorities look at all options prior to implementing diversions. This includes looking to move staff between sites as able/needed.
- Health authorities take steps to prepare for diversions, including advising BC Emergency Health Services as diversions may impact demand for ambulances in the area experiencing a diversion. Additionally, communities are advised via public service announcements which include information on how to safely access care.

Mitigation Strategies

- Created Emergency Care BC (ECBC), a Health Improvement Network of provincial partners to drive improvement across the BC health care system and optimize health outcomes by:
  - Hosting reference groups of ED physicians and nurses who meet on a monthly basis – through this type of collaboration, front line staff are engaged and bringing forward solutions to providing quality emergency services and addressing system barriers. Specifically, these groups have given input on the physician locum program, hybrid models of care, community partnerships with primary and community care, and ED clinical service planning which improve the quality and coordination of services.
  - Defining EDs clinical and workforce requirements such scope optimization of LPNs which will help broaden the ED workforce and support team-based care. ECBC is also participating in the physician assistant pilot in Island Health and will help take learnings to implement provincially.
  - Identifying the necessary resources and/or clinical services required onsite to support hybrid models of care in emergency departments where virtual care could be delivered and help optimize physician capacity in that community.
  - ECBC is operating the new Provincial Emergency Physician Locum Pool which has prevented more than 56 ED diversions and continues to support many communities in need of physician staffing with the 186 emergency room physicians from across the province who are willing to provide emergency locum coverage.
- The Ministry of Health developed the Health Human Resources Strategy, which has 70 concrete actions that are being implemented now. These actions address staffing capacity issues throughout the health-care system and will help alleviate the burden on our health-care workers.
- GoHealth B.C. now employs 200 nurses delivering services in 25 rural and remote communities in Northern Health (NHA), Interior Health (IHA), and Island Health (VIHA) Authorities.
  - GoHealth B.C. is the provincial travel resource pool funded by the Ministry.
  - GoHealth B.C. nurses have delivered over 250,000 hours of travel nursing since the program was launched in 2019 as the Northern Health Prototype Travel Pool, alleviating workforce pressures and reducing our reliance on agency nursing.
- Health authorities continuously work to recruit across all their vacancies, particularly in rural and remote communities, where a very small number of vacancies, annual leave or sick time can significantly disrupt the delivery of services. Recruitment efforts include incentives such as relocation assistance, rural retention grant and BC loan forgiveness.
- IHA has worked to create new rotations where feasible, to support weekend coverage and stronger recruitment (such as in Ashcroft and Clearwater). Local tables have also been set up in some communities, made up of a variety of key stakeholders, to look at ways to support the delivery of health services in these rural communities.
- To stabilize and support staffing on northern Vancouver Island, VIHA has enhanced staff recruitment and retention incentives for eligible staff with travel-wage increases, upgraded accommodations for travelling staff and increased protection-service officers to improve safety and site support.

- The Ministry in partnership with VIHA, BC College of Nurses & Midwives, College of Physicians and Surgeons of BC and others have begun planning for introducing a pilot of Physician Assistants at Saanich Peninsula Hospital.

LAST UPDATED

Content of this estimates note is current as of February 15, 2024, as confirmed by Razvan Diacu, A/ED.

APPROVALS

2024 02 26 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 28 – Kristy Anderson, Hospital & Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

H-09

Hospital Capacity

Topic: To ensure patients have timely access to emergency and acute care services maintaining hospital capacity is imperative, especially during periods of increased demand with seasonal variation season combined with shortages in health human resources.

Key Messaging and Recommended Response:

- **As is the case at hospitals across BC and Canada, generally we are seeing higher emergency department volumes (more people visiting EDs) and higher acuity patients in hospital. This is typically exacerbated during the respiratory illness season.**
- **The Ministry of Health closely monitors hospital capacity and performance, and works with the health authorities to address risk, barriers, and supports required to manage hospital surges, increased congestion, and escalate delays in accessing care through the Daily Provincial Coordination call.**
- **In the event of increased demand, like the respiratory season for example, there are plans and processes in place at hospitals and within hospital networks to add beds and expediate patient flow as needed.**
- **The province will continue to work in partnership with the health authorities to advance initiatives to manage hospital capacity and will launch provincial task groups to continue our work collectively to standardize best practices across the healthcare system.**
- **This past fall/winter for example, a standard provincial seasonal surge response plan was developed based on the learnings of the past 3 seasons, in partnership with Health Emergency Management BC and the health authorities. In November 2023, the number of provincially funded base acute care beds increased from 9,202 to 9,929 beds, an increase of 7.9% in the funded bed base. This includes mostly medicine/surgical beds, but also critical care and other specialty beds.**
- **This past fall/winter, health authorities had an additional 1,500 surge beds that could be activated, if needed.**

CURRENT SITUATION

- Each health authority (HA) has hospital surge plans in place to address the increasing demand seen in our winter surge months. Key mitigation strategies involve:
  - Standard access and flow leadership structures are in place or being developed for all HAs to enable provincial access and flow with identified regional leadership within large hospitals 7 days a week.
  - Critical Care BC and Emergency Care BC have been established to focus on supporting these priority services.
  - Provincial access & flow coordination calls are occurring daily with HA, Ministry of Health (Ministry), and BC Emergency Health Services (BCEHS) to ensure timely movement of patients as well as provide any support to removing barriers as needed.
  - HAs continue to build out enhanced Urgent and Primary Care Centre capacity for urgent access.
  - HAs are implementing a variety of options to expand support to teams to connect patients with resources in the community (seniors and mental health).
- Occupancy decreased at Christmas (reduced admissions and increased discharges) and peaked the Wednesday of the first full work week post-holiday season with full resumption of service:
  - Monday, December 19 occupancy 10,040 inpatients.[1]
  - Monday, December 25 occupancy decreased to 9,036 (-10%).
  - Wednesday, January 10 occupancy peaked at 10,435 inpatients (+15.5%).
- Occupancy has decreased to 9,921 inpatients as of February 12 through coordinated efforts.
  - 4.9% decrease from January 10 and below December 19.
  - 3.3% increase in inpatients over the same date last year (2023).
  - Alternate Level of Care patient volume is 1,502 patients; 260 patients over last year.

FINANCIAL IMPLICATIONS

The Ministry continues to work with the health authorities to monitor expenditures related to acute care and sustain service delivery.

KEY BACKGROUND

Acute Care Beds

- In anticipation of the fall/winter seasonal surge new bed definitions were developed in partnership with HAs which allowed a more complete inventory of base and overcapacity beds.
- The Ministry invested in some of these additional acute care beds in November 2023. The provincial funded base acute care beds increased from 9,202 to 9,929 beds, an increase of 7.9% in the funded bed base.
- The following were the beds added by each HA: Fraser Health Authority (FHA) 207; Interior Health Authority (IHA) 111; Northern Health Authority (NHA) 77; Provincial Health Services Authority (PHSA) 14; Vancouver Coastal Health Authority/Providence Health Care (VCH/PHC) 225; Island Health Authority (VIHA) 93.

Hospital Surge Preparedness

- In partnership with Health Emergency Management BC and HAs, a standard provincial seasonal surge response plan has been developed based on the learnings over the past 3 seasons.
  - This 4-phase plan escalates from the unit level to the site, HA and finally activation of a provincial response which can be activated by the Ministry or on request of an HA.
- A Provincial Access and Flow Committee has been established with representatives from all HAs. This committee is currently focusing on developing access and flow standards related to: patient transition leadership structures, hospital capacity management and surge response protocols, enhancing flow through inpatient beds, a hospital performance monitoring framework, and the development of a provincial and regional hospital coordination office.

[1] Ministry of Health. Health System Performance Portal. Daily Monitoring of Hospital Capacity: Snapshot.

Hospital Data

- The volume of inpatients (number of unique patients cared for as inpatients in the fiscal year) has been stable (0% change) when comparing 2018/19 to 2022/23 with some health authorities experiencing volume increases between 1 and 3 %. The largest decrease in PHSA (-10%).

Inpatient cases	2018/19	2019/20	2020/21	2021/22	2022/23	% change in 2022/23 from 2018/19
IHA	84,375	84,855	80,987	83,909	85,024	1%
FHA	144,284	143,545	137,176	146,566	146,965	2%
VCHA	91,327	91,365	82,306	86,759	88,702	-3%
VIHA	84,847	87,225	81,583	85,708	87,740	3%
NHA	29,597	29,377	27,228	28,325	28,209	-5%
PHSA	23,370	23,301	21,279	22,145	21,014	-10%
BC	**457,800**	**459,668**	**430,559**	**453,412**	**457,654**	0%
British Columbia Hospitals: Inpatient Overview Discharge Abstract Database (DAD),Health Authority Management Information System (HAMIS)						

- Inpatient days have increased by 8% between 2018/19 and 2022/23. No change in inpatient volumes means the driver for the increase in inpatients was length of stay. Patient complexity, an aging population, and staffing shortages have led to increased care planning needs for patients.

Inpatient days	2018/19	2019/20	2020/21	2021/22	2022/23	% change in 2022/23 from 2018/19
IHA	537,401	557,348	475,125	551,169	600,463	12%
FHA	1,049,482	1,076,459	960,315	1,086,504	1,139,057	9%
VCHA	744,824	756,864	671,007	763,565	801,074	8%
VIHA	668,720	690,250	603,768	675,043	710,599	6%
NHA	212,639	229,333	186,390	205,852	228,761	8%
PHSA	111,662	109,365	96,908	100,748	100,907	-10%
BC	**3,324,728**	**3,419,619**	**2,993,513**	**3,382,881**	**3,580,861**	**8%**
British Columbia Hospitals: Inpatient Overview Discharge Abstract Database (DAD),Health Authority Management Information System (HAMIS)						

LAST UPDATED

The content of this estimates note is current as of February 25, 2024, as confirmed by Manpreet Khaira.

APPROVALS

2024 02 22 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 26 – Kristy Anderson, Hospital & Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

H-10

Hospital at Home

Topic: Progress on implementing Government's commitment to provide a new Hospital at Home program that delivers safe, effective care to patients in the comfort of their own homes, while also increasing hospital capacity.

Key Messaging and Recommended Response:

- **The Hospital at Home (HaH) program provides patients with the choice to receive short-term acute care in the comfort of their own home.**
- **Eligible patients are admitted to hospital but receive care at home from a multidisciplinary team led by a most responsible practitioner with hospital admitting privileges, so they can be transferred directly back to the hospital if needed.**
- **Patients receive daily in-person care supplemented by virtual care and monitoring, with 24/7 access to care. It is a safe, respectful and effective alternative to traditional in-patient treatment. Patients and caregivers have reported highly positive experiences with this type of patient-centred care.**
- **The HaH program reduces pressure on inpatient hospital beds, decreases hospital congestion by optimizing patient flow, and improves overall system capacity.**
- **Over 3,100 patients have received care at home via HaH instead of in hospital since the program launch.**
- **HaH prototype programs currently run in the Fraser Health Authority, Vancouver Island Health Authority, Northern Health Authority, Vancouver Coastal Health Authority, and Providence Health Care.**
- **Interior Health Authority, Fraser Health Authority, and Vancouver Island Health Authority will launch additional HaH programs in the coming months.**

CURRENT SITUATION

- Five HaH programs are in place in the Vancouver Island Health Authority (VIHA), Fraser Health Authority (FHA), Northern Health Authority (NHA), Vancouver Coastal Health Authority (VCHA), and Providence Health Care (PHC).
- Combined, the programs offer 55 HaH acute care beds to patients who meet eligibility criteria.
- 3,175 patients have been admitted into HaH prototype programs as of February 6, 2024, since program launch in 2020.[1]

[1] VIHA HaH Update Feb. 6, 2024, FHA Update Feb.5, 2024, and NHA HaH Update Feb.5, 2024 and email from PHC and VCHA on Feb.9, 2024.

VIHA - 2,115 patients admitted into HaH as of February 6, 2024.[2]

- 20 HaH acute care beds.
- Victoria General Hospital - launched in November 2020 - has 10 beds.
- Royal Jubilee Hospital - launched in March 2021 has 10 beds.
- Most responsible provider (MRP) services are provided by hospital-based physicians working exclusively on HaH for the duration of their shift.
- In April 2022, VIHA's HaH program won a national award for *Excellence in Patient Experience* from the Canadian College of Health Leaders. The award honours organizations and individuals who have set in place innovations that improve the human experience in healthcare.

NHA - 793 patients admitted into HaH as of February 1, 2024.[3]

- 8 HaH acute care beds at the University Hospital of Northern BC.
- Phase 1 (March 2021 to mid-May 2021) relied on community-based family physicians with hospital-admitting privileges who provided HaH as part of their family practice; however, there were challenges with the physician compensation model for Prince George community-based family practitioners.
- Phase 2 (current) prototypes an approach focused on caring for patients after surgery, using surgeons as MRP.

VCH – 5 patients admitted in HaH as of February 9, 2024[4]

- 5 HaH acute care beds at Vancouver General Hospital (prototype program launched January 22, 2024)
- MRP services are provided by hospital-based physicians working exclusively on HaH for the duration of their shift.

PHC - 18 patients admitted in HaH as of February 9, 2024

- 6 HaH acute care beds at St. Paul's Hospital (prototype program launched December 18, 2023) [5]
- MRP services are provided by hospital-based physicians working exclusively on HaH for the duration of their shift.

FHA Virtual Psychiatric Unit (VPU) – 244 patients admitted as of January 31, 2024.[6]

- 16 HaH acute psychiatric beds (prototype program launched September 20, 2022)
- MRP services are provided by a Fraser Health Psychiatrist with supported medical management. The Addiction Medicine Team provides specialized substance use services.
- The VPU is operated under a 'hub and spoke' model, where the majority of health care providers are based out of a 'hub' in Central City, the FHA corporate office and additional nurses work out of 'spoke' locations based in Royal Columbian Hospital and complete home visits with HaH patients.

FINANCIAL IMPLICATIONS

Since 2020/21 the Ministry of Health has provided health authorities with over $22 million to support HaH.

KEY BACKGROUND

- Government first committed to implementing a provincial HaH program in May 2020 as a COVID-19 response strategy to reduce pressure on hospital medical beds.
- 2 HaH prototype programs have been operational for nearly 3 years: 1 in VIHA and the other in NHA.
- FHA introduced a virtual psychiatric unit in 2022 that demonstrated the ability to provide HaH service to a new patient population safely.
- Budget 2022 referred to the need for HaH to become a permanent program.[7]

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[2] Island Health HaH Update February 6, 2024.
[3] Northern Health HaH Update February 1, 2024.
[4] Vancouver Coastal Health Update February 9, 2024
[5] Providence Health Update February 9, 2024
[6] Fraser Health VPU Update February 5, 2024
[7] "Stronger Together: Budget and Fiscal Plan 2022/23–2024/25." p. 44 & p. 130. https://www.bcbudget.gov.bc.ca/2022/pdf/2022_Budget_and_Fiscal_Plan.pdf.

- In 2023/24, the Ministry worked with health authorities to expand HaH to include Vancouver General Hospital and St Paul's Hospital.

Program Description

- HaH allows a subset of acutely ill, clinically stable patients who require hospital care to choose an alternative to traditional in-patient treatment that is still safe, respectful and effective.
- Patients receive daily in-person care supplemented by virtual care and monitoring, with 24/7 access to care.
- Patients are admitted to hospital but receive care at home from an interdisciplinary team led by a MRP (currently physicians but could also be Nurse Practitioners in future) with hospital admitting privileges.
    - The team consists of nurses, occupational therapists and/or physiotherapists, rehabilitation assistants, pharmacists, peer support workers, and others.
- HaH patients are considered hospital inpatients, therefore they can be transferred directly back to hospital, if needed, without going through the emergency department. Access to medically necessary general hospital services/resources (diagnostics, medications) is available in the same timely way as in a traditional hospital at no cost to the patient.
- Participation is entirely voluntary, and patients/caregivers can decline to participate or choose to return to hospital at any time.

BC HaH Patient Experience and Profile

- Patients and family caregivers report their experience of BC HaH care has been highly positive.[8]
- Common patient diagnoses have included: heart failure without coronary angiogram, lower urinary tract infection, cellulitis, viral/unspecified pneumonia, and chronic obstructive pulmonary disease.[9]
- While the BC HaH patient population is primarily older, patients have ranged from age 17 to 107.[10]

Benefits of HaH for Patients

Several Cochrane reviews, which represent the highest standard in meta-analysis, report the HaH model has fewer complications compared to traditional hospitalization such as fewer instances of delirium, blood clots, infection and functional decline.[11,12] Other benefits may include lower readmission rates, high satisfaction among patients/caregivers, and potentially fewer admissions to long-term care. This also allows for local hospitals to build capacity for patients that require acute inpatient care within hospital building.

LAST UPDATED

The content of this estimates note is current as of March 12, 2024, as confirmed by Manpreet Khaira.

APPROVALS

2024 02 22 – Eric Larson obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2024 02 27 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 13 – Kristy Anderson, Hospital and Provincial Health Services Division

[8] Island Health HaH patient experience data November 2020 to November 2021.
[9] Island Health HaH Patient Profile, October 2021.
[10] Island Health HaH Update January 3, 2023.
[11] Gonçalves-Bradley DC, Iliffe S, Doll HA, Broad J, Gladman J, Langhorne P, Richards SH, Shepperd S. Early discharge hospital at home. Cochrane Database of Systematic Reviews 2017, Issue 6. Art. No.: CD000356. DOI: 10.1002/14651858.CD000356.pub4.
[12] Shepperd S, Iliffe S, Doll HA, Clarke MJ, Kalra L, Wilson AD, Gonçalves-Bradley D. Admission avoidance hospital at home. Cochrane Database of Systematic Reviews 2016, Issue 9. Art. No.: CD007491. DOI: 10.1002/14651858.CD007491.pub2

LEGISLATIVE SESSION – ESTIMATES NOTE

H-11

MAiD Access and Faith-Based Organizations

Topic: Faith-based organizations are exempt from the provincial requirement that medical assistance in dying (MAiD) be made reasonably available in settings where end-of-life services are normally offered; as a result, patients in facilities operated by faith-based organizations must be transferred to another facility for MAiD provision to take place.

Key Messaging and Recommended Response:

- **Medical assistance in dying (MAiD) is a legal end-of-life choice, and this government is committed to providing MAiD in a manner that is respectful and supportive of patients, families, and providers.**
- **Ministry of Health policy requires that each health authority has a MAiD Care Coordination service in place to support individuals requesting MAiD to understand available services and to navigate access.**
- **Faith-based organizations may choose to opt out of the provision of MAiD at their facilities regardless of the amount of bed funding they receive from a health authority; however, they must ensure that patient-centered pathways are in place to support an effective connection with another health care provider or organization willing to explore a request for information, transfer of care, or physical transfer of the patient, as required.**
- **When it comes to St. Paul's Hospital, I have directed Vancouver Coastal Health Authority to establish and operate a clinical space adjacent to St. Paul's where patients can access compassionate and dignified MAiD services, without the need for these patients to be transported to another facility.**
    - **It is expected this building will be completed in August 2024.**

CURRENT SITUATION

- Personal Information

- Since St. Paul's Hospital is operated by Providence Health Care (PHC), a Catholic group opposed to MAiD, the provision of MAiD is not permitted on site.Personal Information
  Personal Information

- On November 29, 2023, Minister Adrian Dix announced that a new clinical space where MAiD can be provided will be established next to St. Paul's Hospital.
- The clinical space will be staffed by Vancouver Coastal Health Authority (VCHA) healthcare professionals and will be connected by a corridor to St. Paul's Hospital. Patients from St. Paul's Hospital accessing MAiD will be discharged by PHC and transferred to the care of VCHA in this new clinical space, which is expected to be completed in August 2024.

- In the meantime, the Ministry of Health has directed PHC and VCHA to implement a patient-centred approach for patients at St. Paul's Hospital who wish to access MAiD.
  - This includes arranging transport for MAiD patients if required and overseeing care and communication with families throughout the process.
  - PHC and VCHA will collaborate to make the transfer process and the patient's subsequent care as seamless and comfortable as possible.
- There were 52 transfers for the provision of MAiD due to the originating facility's policy on MAiD in 2023, representing less than 2% of MAiD provisions that year. Of these transfers, 41 were within the geographic boundaries of the VCHA, representing 7.4% of the 553 cases that occurred within the health authority. St. Paul's Hospital was the originating facility Person of these transfers, St. John Hospice Perso and May's Place Hospice Perso (see "MAiD Access at St. John Hospice and May's Place Hospice" section for additional information about MAiD transfers at these sites).

FINANCIAL IMPLICATIONS

The estimated capital cost of establishing the new clinical space next to St. Paul's Hospital is $1.7 million and is being funded by VCHA.

KEY BACKGROUND

MAiD Access and Care Coordination Policy

- Access to MAiD is prescribed by the Ministry's *Medical Assistance in Dying: Access and Care Coordination* policy (the MAiD policy). The MAiD policy requires that MAiD be reasonably available where end-of-life services are normally offered, in all health authority owned/operated facilities as well as facilities run by contracted organizations that receive more than 50% of their bed funding from a health authority.
- Faith-based organizations are not required to allow access to MAiD in their facilities, regardless of the level of public funding they receive. The policy defines a faith-based organization as "an organization that is party to the Master Agreement with the Denominational Health Care Facilities Association, or otherwise in its constitution declares itself as being an organization based on religion or spirituality."
- The exemption for faith-based organizations respects the 1995 Master Agreement, which states that members of the Denominational Health Association (formerly called the Denominational Health Care Facilities Association) are "not required to provide those services which are inconsistent with [their] mission and values."
- The Master Agreement obligates faith-based facilities to plan and deliver health care services in collaboration with other health bodies, including health authorities. This relationship ensures the availability of an appropriate range of health services within each health region.
- The Denominational Health Association provides more than 7,800 beds and suites across BC, including over 5000 long-term care beds, over 1100 assisted living suites, and over 500 acute care beds.

MAiD Access at St. John Hospice and May's Place Hospice

- In addition to the new clinical space being established at St. Paul's Hospital, there are 2 other facilities operated by PHC where patients can access MAiD.
- St. John Hospice, located on the University of British Columbia Endowment Lands, and May's Place Hospice, located on Vancouver's Downtown Eastside, are operated by PHC but owned by the Order of St. John and the Bloom Group, respectively.
- Advice/Recommendations

- Advice/Recommentations

LAST UPDATED

The content of this estimates note is current as of February 14, 2024, as confirmed by Manpreet Khaira.

APPROVALS

2024 02 20 – Mark J. Bell obo Rob Byers, Finance and Corporate Services Division
2024 02 23 – Kristy Anderson, Hospital and Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

H-12

Medical Assistance in Dying (MAiD) – General

Topic: An overview of the provision of Medical Assistance in Dying (MAiD) in BC and its associated monitoring, reporting, and oversight structures.

Key Messaging and Recommended Response:

- **MAiD is a legal end-of-life choice, and the Ministry of Health is committed to providing MAiD in a manner that is respectful and supportive of patients, families, and providers.**
- **To ensure MAiD is provided in a safe and appropriate manner, a system of safeguards is in place to protect vulnerable people and support all people in making informed decisions.**
- **Doctors and nurse practitioners in BC follow the federal legislation for medical assistance in dying only when specific eligibility criteria are met and safeguards are followed.**
- **Oversight of MAiD is provided by the MAiD Oversight Unit in the Ministry, which reviews every MAiD case in BC for compliance with the eligibility criteria, federal safeguards, federal regulations, provincial safeguards, and professional regulatory college practice standards for MAiD.**
- **Patients have the right to choose MAiD if they are eligible and that is their wish, and our medical system must provide patients with access to that choice.**

CURRENT SITUATION

- Between January 1 and December 31, 2023, there were 2,767 medically assisted deaths in BC. Of these, 97.1% (2,688) were individuals who were facing a reasonably foreseeable natural death (i.e. who had a terminal condition), whereas 2.9% (79) were not[1].
- There were 52 transfers for the provision of MAiD due to the originating facility's policy on MAiD in 2023, representing less than 2% of MAiD provisions that year. Of these transfers, Personal Information Personal Information

- All MAiD provisions in BC must be reported to the MAiD Oversight Unit, within the Ministry of Health (Ministry), for the purposes of monitoring, reporting, and oversight.
- Federal reporting and monitoring regulations set out the information that must be collected as part of the MAiD process, including information about the individual requesting MAiD and their eligibility as well as information from the doctors or nurse practitioners involved, including that the safeguards were followed. In BC, this information is collected by the MAiD Oversight Unit and reported to the federal government quarterly.

[1] Numbers are not finalized and are subject to change.

  - The federal regulations were updated on January 1, 2023, expanding mandatory data collection to include additional demographic information such as gender identity, race, Indigenous identity, and disability information about individuals seeking MAiD (with their consent) to create a broader picture of MAiD recipients in Canada.
- As of December 2023, quarterly and annual MAiD statistics for BC, including MAiD provisions by health authority, sex, age, and underlying illness, disease, or disability, are now publicly posted to the Ministry's MAiD website. This promotes transparency and allows faster access to a wider range of statistics for researchers, healthcare professionals, and the public compared to Health Canada's annual report on MAiD.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- The *Criminal Code* sets out the eligibility criteria and safeguards for MAiD:
  - To be eligible, the individual (1) must be eligible for health services funded by a government in Canada, (2) must be at least 18 years of age and capable of making decisions about their health care, (3) must have a grievous and irremediable condition, (4) must be making a voluntary request for MAiD, and (5) must give informed consent for MAiD after having been informed of other means of alleviating their suffering.
  - Safeguards for MAiD include that (1) the request must be made in writing and signed before an independent witness, (2) at least 2 doctors or nurse practitioners must find the individual eligible, (3) the individual must be informed that they can withdraw their request at any time, and (4) they must give express consent immediately prior to receiving MAiD (unless a waiver of final consent is used).
  - On March 17, 2021, the *Criminal Code* was amended to expand eligibility for MAiD to patients whose natural death is not reasonably foreseeable (i.e. who do not have a terminal condition). These cases are subject to additional safeguards, which include (1) 1 of the 2 doctors or nurse practitioners assessing the individual must have expertise in the condition causing the individual's suffering (or a third doctor or nurse practitioner with such expertise must be consulted), (2) at least 90 days must elapse between the start of the first assessment and when MAiD is provided, and that (3) the individual must give serious consideration to other means of alleviating their suffering before MAiD is provided.
- Patients whose sole underlying medical condition is mental disorder are currently not eligible for MAiD services. The *Criminal Code* includes a sunset clause that removes this exclusion on March 17, 2024. However, a Parliamentary Bill (C-62) has been submitted seeking to delay implementation of mental disorder as their sole underlying medical condition (MD-SUMC) until March 17, 2027. As of February 23, 2024, the bill was at Second Reading in the Senate.
- Oversight of MAiD in BC is provided by the Ministry's MAiD Oversight Unit:
  - Doctors and nurse practitioners who provide MAiD in BC must submit all required documentation to the MAiD Oversight Unit within 72 hours of a MAiD provision.
  - This includes documentation of the patient's request for MAiD, the doctor or nurse practitioner's own assessment of the patient's eligibility, the assessment of a second doctor or nurse practitioner, and a medication administration record.
  - All documentation is reviewed by the MAiD Oversight Unit for compliance with the eligibility criteria, federal safeguards, federal regulations, provincial safeguards and professional regulatory college practice standards for MAiD.
  - If concerns are identified, the MAiD Oversight Unit may provide education, make a referral to the applicable professional college, or make a referral to law enforcement, as required.
- The *Medical Assistance in Dying: Access and Care Coordination* policy (the MAiD policy) outlines the Ministry's expectations of HAs regarding the delivery of MAiD. HAs are responsible for ensuring that MAiD is reasonably available in a manner like other end-of-life services.

- In addition to HA owned/operated facilities, the MAiD policy delivery expectations extend to contracted organizations (e.g., long-term care facilities, hospices, assisted living residences and other settings) that receive more than 50% of their bed funding from HAs.
- Contracted organizations that have 50% or less of their beds funded by HAs may decline to allow the provision of MAiD, but if they do so, they must inform individuals of their policy prior to consent to admission and clearly post their policy related to MAiD on their website.
- Faith-based organizations, defined as an organization that is a party to the Master Agreement with the Denominational Health Care Facilities Association or otherwise in its constitution declares itself as being an organization based on religion or spirituality, are exempt from the requirement to allow access to MAiD, regardless of the level of funding received.

LAST UPDATED

The content of this estimates note is current as of February 14, 2024, as confirmed by Manpreet Khaira.

APPROVALS

2024 02 23 – Kristy Anderson, Hospital and Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

H-13

MAiD – Mental Disorder as the Sole Underlying Medical Condition

Topic: Individuals with a mental disorder as their sole underlying medical condition (MD-SUMC) are currently excluded from eligibility for medical assistance in dying (MAiD); however, this is expected to change in 2027.

Key Messaging and Recommended Response:

- **Parliament has passed legislation delaying the expansion of eligibility for Medical Assistance in Dying (MAiD) to include people with mental illness as their sole underlying medical condition until March 2027.**
- **We welcome Parliament's decision.**
- **It is essential any expansion of the eligibility criteria for MAiD be done right to fully consider and protect the well-being and rights of all individuals, particularly those living with mental illnesses or disorders.**
- **Additional safeguards are required to ensure the safe and appropriate delivery of MAiD for this population, and it is important that all jurisdictions, health authorities, regulators and MAiD practitioners have the required time to implement these safeguards.**
- **The Government of BC remains committed to continuing to support practitioners in meeting their legislative requirements and responsibilities, and to enact appropriate guidance and practices in accordance with the MAiD legislative framework.**

CURRENT SITUATION

- The federal *Criminal Code of Canada*, which governs MAiD, currently excludes mental illness from eligibility for MAiD. This exclusion was set to expire March 2024, as the result of a sunset clause.
- However, on February 29, 2024, Parliament passed Bill C-62, *An Act to amend An Act to amend the Criminal Code (medical assistance in dying), No. 2*, which will extend the exclusion for mental illness until March 17, 2027.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- The *Criminal Code of Canada* provisions for MAiD were amended on March 17, 2021, and eligibility for MAiD was extended to include persons whose natural deaths are not reasonably foreseeable (i.e. who do not have a terminal condition).
- However, individuals with MD-SUMC were temporarily excluded from eligibility for a period of 2 years, until March 2023. This exclusion was later extended to March 2024, and federal Bill C-62 has now extended the exclusion by an additional 3 years, to March 2027.

  - The federal government has stated this extension would provide more time for provinces and territories to prepare their health care systems, including the development of policies, standards, guidance, and additional resources to assess and provide MAiD for MD-SUMC. It would also provide practitioners with more time to participate in training and become familiar with available supports, guidelines, and standards.
  - This delay in implementation aligns with the recommendations of the parliamentary Special Joint Committee on MAiD (AMAD) in its report *MAiD and Mental Disorders: The Road Ahead*, which was tabled on January 29, 2024.
  - Bill C-62 also requires that a joint parliamentary committee undertake a comprehensive review relating to the eligibility for MAiD of persons with MD-SUMC within 2 years after the bill receives royal assent.
- In preparation for the proposed legislative change which would have allowed individuals with MD-SUMC to become eligible for MAiD, a provincial Subcommittee on MAiD and Mental Health was formed in August 2022 to advise on any new provincial safeguards required for this population, as well as resources and guidance required by MAiD assessors and providers in BC.
- The Subcommittee includes members with both clinical and operational expertise in mental health and MAiD, as well as representation from the Ministry of Health, Ministry of Mental Health and Addictions, and Ministry of Social Development and Poverty Reduction.
- The Subcommittee has finalized its recommendations for new provincial safeguards for MAiD for mental disorders, and these recommendations have been endorsed by the provincial MAiD Oversight Advisory Committee. However, as the exclusion of eligibility for MD-SUMC will extended by an additional 3 years, these provincial safeguards have not yet been implemented.
- Provincial safeguards for MAiD in BC are embedded within the practice standards of BC's regulatory colleges.

LAST UPDATED

The content of this estimates note is current as of March 12, 2024, as confirmed by Manpreet Khaira.

APPROVALS

2024 03 13 – Kristy Anderson, Hospital and Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

H-14

Nursing Support Services

Topic: Nursing Support Services (NSS) is a provincial program operated by the Provincial Health Services Authority (PHSA) through the BC Children's Hospital (BCCH). NSS provides support to children and youth (0-19) with chronic, complex health conditions for whom aspects of their community care needs require the knowledge, judgement, and skill of a licensed nurse in the absence of parents/guardians.

Key Messaging and Recommended Response:

- **We know children with complex medical needs, and their families, face unique challenges. The Ministry of Health is committed to ensuring they receive the support they need, when and where they need it.**
- **Nursing Support Services (NSS) provides support to children and youth whose medical care needs in community settings require additional assistance in the absence of their parents/guardians. This support is currently provided through 2 streams of care: In-School Delegated Nursing Care/Seizure Rescue Intervention Training and In-Home Nursing Respite Care.**
- **NSS, in partnership with Ministries of Health, and Education and Child Care are implementing changes to school-based supports and are making enhancements to programming to better align with best practices and standards.**
- **In addition to the evolution of the NSS program, BC Children's Hospital will open a first-of-its-kind dedicated facility for children and families with health complexity in Vancouver in 2028.**
- **The goal of NSS is to enable children living with medical complexity, and their families, to live the highest quality of life possible in their home communities.**

CURRENT SITUATION

- In Summer 2023, the PHSA and BCCH initiated worked to inform future NSS programming and services to better meet the current and future needs of children and their families. The work includes in-home respite, school-based services, and childcare and involves significant consultation with families, advocacy groups, provincial and regional partners to understand their perspectives and needs. PHSA and BCCH plan to bring forward their findings in Spring/Summer2024.
- NSS does not have a wait list and accepts children as they are eligible.
- Currently, NSS delivers services through 2 distinct streams of care: Delegated Nursing Care/Seizure Rescue Intervention Training and In-Home Nursing Respite Care.
- Delegated Nursing Care/Seizure Rescue Intervention Training is currently only available in the K-12 school system.
- Childcare settings are out of scope for the program at this time.
- As of February 13, 2024, 689 children are receiving NSS Delegated Nursing Care while at school.

- During the 2022/23 school year, NSS received 309 requests provincially for seizure rescue intervention training in schools.
- In late Spring 2022, it was determined that delegating the administration of seizure rescue medication to non-medical school staff falls outside the scope of care a registered nurse is allowed to delegate per BC College of Nurses and Midwives (BCCNM) practice standards.
- A working group was established in late Spring 2022 to examine issues related to NSS delegated care and seizure rescue medication administration in the school setting with representation from NSS, the Ministry of Education and Child Care (ECC), the Ministry of Health (HLTH) including the Nursing Policy Secretariat, Pharmacy, Professional Regulation, and BCCH Division of Neurology. The working group recommended the transition to a training model which was implemented in September 2022.
- NSS seizure rescue training ensures children who may require the administration of seizure rescue intervention (including medication) while at school can receive it. Training provides general information and skills education to school staff about aspects of care. Nurses do not hold overall accountability and responsibility for ongoing monitoring or supervision and the school employee performing the task is no longer providing care under the nurses' professional license.
- School districts and families were directly notified of the change on September 9, 2022, by joint communication from NSS and HLTH. Information and resources are also available on the NSS website.
- A working group with membership from HLTH, NSS, and ECC continues to meet to develop long-term solutions for challenges associated with NSS school-based care and the delivery of care for medically complex children in the school setting more broadly.
- As of February 13, 2024, 205 children and youth are receiving In-Home Nursing Respite Care, with 69 of those children and youth eligible for In School Support (ISS) hours.
- In-Home Nursing Respite Care has been affected by staffing shortages. Staffing remains a focus in all areas, however rural and remote areas are the most impacted. Nursing agencies are continuing recruitment efforts.
- In response to the COVID-19 pandemic and family concerns about children attending school in-person, starting in the 2020/21 school year, NSS allowed an exemption for families to use ISS hours in the home as additional respite during the time that children would have normally been attending school. This temporary exemption has continued into the 2023/24 school year in light of unprecedented respiratory illnesses that have significantly affected the pediatric population. NSS is aiming to ensure that these hours are in alignment with their intended purpose to support a child's attendance for in-person instruction at school.

FINANCIAL IMPLICATIONS

- The budget for NSS in 2023/24 is $30.51 million.
- 2022/23 actual expenditures were $26.39 million.

KEY BACKGROUND

- The NSS program was initiated in 1997, with governance and oversight provided by the PHSA since April 2015 when the program transitioned from the Ministry of Children and Family Development (MCFD) to HLTH.
- NSS provides respite care for children and youth whose care needs require the scope of practice of a licensed nurse for some aspects of their care due to the child/youth's medically complex and fragile health needs.
- Prior to 2015, NSS provided delegated care in childcare settings as a program under MCFD.
- Delegated Nursing Care Provides training/ongoing monitoring of unregulated caregivers (educational assistants) in school settings to provide specific aspects of a child's care, such as gastronomy tube meals, blood glucose monitoring and insulin administration, clean intermittent catheterization, and oral suctioning.
- Delegation of care is in accordance with BCCNM practice standard Delegation to Unregulated Care Providers.

- The decision to delegate is nurse and client specific, the delegating nurse holds ultimate accountability for the decision to delegate under their practicing license.
- Delegation to unregulated care providers requires that the client has a stable condition with a predictable and expected response to the medical tasks that are provided. To be safely delegated, a task must be routine, predictable, and have predictable outcomes. Other important factors for a nurse to consider when deciding to delegate care activities are client health and consent; the type of activity to be delegated, including risks and complexity; the care environment; the knowledge, skills, ability, and judgment of the unregulated care provider; and the level of supervision required.
- A nurse may decline to delegate care if they have concerns about their ability to manage expectations for delegation as described in the BCCNM practice standard.
- NSS In-Home Nursing Respite Care provides parents/guardians with scheduled, intermittent periods of respite up to a maximum of 56 hours per week. Families may be eligible for an additional 10 hours/week of home hours if the child/youth has extraordinary care needs and no secondary form of respite (e.g., school/preschool/other funding, extended family) is available. The current program average is 40 hours per week.
- As a respite service, it is an expectation that families are prepared, capable and able to provide all aspects of their child's care in the absence of nursing. NSS is not an emergency response service nor does the program provide interventional care such as home IV or post-operative care (e.g., dressing changes).
- All children eligible for In-Home Nursing Respite Care are required to have, at minimum, an annual comprehensive nursing assessment to determine their current medical/nursing care needs. Allocation of nursing respite hours reflect a child's care needs that require the scope of a licensed nurse.
- Families eligible for In-Home Nursing Respite Care may also receive ISS hours to enable eligible children to attend in-person, classroom instruction at school. NSS determines eligibility for ISS hours based on required care that can only be provided by parent and/or specially trained adult during the time the child is at school. ISS hours are subject to change in response to a child's attendance at school—these hours may increase as a child's attendance increases (to a maximum of 30 hours/week, consistent with a typical school day) or they may decrease if families choose not to send their child to school.
- In early 2022, government approved the PHSA's business plan for a new first of its kind children's complex care transition centre (Slocan Site Redevelopment Project) in Vancouver that will house a range of services for children and youth living with health complexity, including the NSS program. The center is planned to open to the public in 2028.

LAST UPDATED

The content of this estimates note is current as of February 16, 2024, as confirmed by Eugene Johnson.

APPROVALS

2024 02 22 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 02 25 – Kristy Anderson, Hospital and Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

H-15

Out of Country Radiation Treatment

Topic: Status update on the out of country radiation treatment program.

Key Messaging and Recommended Response:

- **Between May 29, 2023, and March 1, 2024, 2,182 breast and prostate cancer patients have been referred to receive radiation therapy at 1 of 2 facilities in Bellingham, Washington.**
- **524 of these patients have completed their treatment in the US.**
- **BC Cancer is working to address radiation wait times through recruitment of oncologists and radiation therapists, implementing team-based care, and beginning in spring 2024, extending hours of operation at sites.**
- **The goal of the out of country radiation treatment program is to get cancer patients the treatment they need, sooner. It also frees up space and capacity for more patients to get their treatment in BC.**
- **This program is just one tool in our toolbox to improve cancer care in the province, which is outlined in the 10-year Cancer Care Action Plan and includes an initial investment of $440 million to support immediate steps to better prevent, detect and treat cancers, deliver improved care for people while preparing for the growing needs of the future.**
- **Budget 2024 announced a further $270 million to support the implementation of the cancer plan.**

CURRENT SITUATION

- As of March 1, 2024, 2,182 patients (1,470 breast cancer; 712 prostate cancer) have been referred to receive radiation treatment, 620 patients have received a consult, 566 have started treatment, and 524 (401 breast cancer; 123 prostate cancer) have completed radiation therapy in the US.
- A change in how patients are referred to the Out of Country program occurred in late August 2023. Since fall 2023 an average of 70 patients per week have been referred and an average of 51 unique patients per week have received treatment in the US.
- The majority of patients (70%) who have received treatment in the US were referred from the Fraser Health Authority (276 patients with breast cancer and 92 patients with prostate cancer).

Patients completed treatment by health authority (as of February 1, 2024)

Health Authority	Breast	Prostate
Fraser	276	92
Interior	9	0
Island	56	26
North	21	3
Vancouver Coastal	39	2
TOTAL	**401**	**123**

FINANCIAL IMPLICATIONS

For fiscal year 2024/25, the costs are estimated to be $35 million, including $30 million in US facilities contracts, $3.7 million in patient travel, and $1.4 million for the implementation of BC Cancer's Across Borders Cancer Radiation Treatment commitment patient travel program to support patients travelling to receive care in Washington State. As of January 2024, 2023/24, year to date expenditures are $11.22 million.

Breakdown of Spending to Date:

Category	Amount	Number of Patients	Average per Patient
Amount spent on patient travel and supports	$1,661,153	449	$3,700
Amount provided to each of the two Bellingham clinics to pay for treatment	$9,253,239	449	$20,609
Program administration	$306,795		
TOTAL	**$11,221,187**	**898**	**$12,496**
Centre Breakdown of $9.25 million			
North Cascades	*$3,575,129*	*251*	*$14,244*
Peace Health	*$5,678,110*	*198*	*$28,677*

- Note: This is based on 566 patients though 524 patients completed treatment by March 1, 2024, due to a lag in reconciling expenses.
- The average travel is based on total cost/number of patients. There is a range of between 5-20 days for the most common treatments. But there have been cases where patients stay for longer (up to 6 weeks).
- PeaceHealth more frequently sees cases with a higher number of treatments so the average cost per patient shown below is higher.
- Program administration is BC Cancer staff providing concierge service for travel.

KEY BACKGROUND

- On May 29, 2023, BC Cancer began offering eligible breast and prostate cancer patients the opportunity to receive radiation treatment at 1 of 2 partner clinics in Bellingham, Washington that can support up to 50 patients each week.
- The goal of the Across Borders Cancer Radiation Treatment commitment is to help address immediate challenges with wait times while BC Cancer expands its capacity to deliver radiation therapy services by recruiting additional oncologists and radiation therapists, continues to implement team-based care at all 6 cancer centres, and expands hours of operation.
- The option to receive treatment in Washington State is provided at no cost to patients and each patient has comprehensive access to a BC Cancer support team to arrange appointments, coordinate and facilitate travel plans, and support them upon their return to care at BC Cancer.
- This solution was previously used in the early and mid-90s when BC Cancer patients were sent to Bellingham for radiation therapy.
- BC Cancer reports that expanded hours of operation for radiation treatment in BC planned for early 2024 will further increase radiation therapy capacity to improve performance and keep up with growing demand.

LAST UPDATED

The content of this estimates note is current as of March 11, 2024, as confirmed by Tracy Martell.

APPROVALS

2024 02 22 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 06 – Kristy Anderson, Hospital and Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

H-16

Post-COVID-19 Interdisciplinary Clinical Care Networks

Topic: The Post-COVID-19 Interdisciplinary Clinical Care Network (PC-ICCN) aims to support the best possible outcomes for people experiencing symptoms that are impacting their day-to-day lives three months or more after their initial COVID-19 infection. The Network, a partnership between the provincial Ministry of Health (HLTH), Provincial Health Services Authority (PHSA), Providence Health Care, BC's regional health authorities, patients, and research organizations, provides this support through education, clinical care, and research.

Key Messaging and Recommended Response:

- **We know that COVID-19 can leave people with symptoms long after they've recovered. The government is supporting and caring for every person who gets COVID-19, including people experiencing longer-term symptoms.**
- **People living in British Columbia who experience lingering symptoms 3 months or more after their initial COVID-19 infection are able to access services and care, when they need it, through the Post-COVID-19 Interdisciplinary Care Clinic Network (PC-ICCN).**
- **The PC-ICCN is a partnership between the provincial Ministry of Health, Provincial Health Services Authority, Providence Health Care (which manages the provincial virtual clinic), BC's regional health authorities, patients and research organizations across the province and offers education, care, and research opportunities to support patients experiencing post-COVID symptoms and their health-care providers.**
- **The PC-ICCN model of care takes an education-first approach. It offers online education resources, including the MyGuide Long COVID online tool to help patients support their recovery at any time.**
- **Data collected in BC and elsewhere indicates that the majority of people living with long COVID benefit most from self-management tools and strategies versus hospital-based care.**
- **In March 2023, PC-ICCN evolved its model of care to better reflect current demands and the specific needs of people living with long COVID. The 4 physical Post-COVID Recovery Clinics in BC consolidated into one province-wide virtual clinic, managed, and staffed by Providence Health Care in partnership with PC-ICCN.**
    - **After consulting with patients and clinicians, PC-ICCN followed the recommendation that services could optimally be delivered virtually. The majority of patients were already accessing clinical care virtually through PC-**

ICCN, and the Network recorded a decrease in the number of patients being referred.

- **Patients referred to this virtual clinic have province-wide access to care, including group education sessions and rehabilitation support from a multidisciplinary health-care team. Access to physician specialists is timely, when required.**
- **Content and curriculum continue to evolve and grow based on identified needs and feedback.**

- **The number of patients referred to the Network continues to decrease over time.**

CURRENT SITUATION

- The PC-ICCN is a partnership between the provincial HLTH, PHSA, Providence Health Care (which manages the provincial virtual clinic), BC's regional health authorities, patients, and research organizations.
- The PC-ICCN supports people living in British Columbia who experience lingering symptoms 3 months or more after their initial COVID-19 infection, through 3 main streams of work: Education, Clinical Care (Post-Covid Clinics), and Research.
- **EDUCATION:** PC-ICCN's model of care takes an evidence-based, education-first approach as data collected from network and patient continues to indicate that the majority of people living with long COVID benefit most from self-management tools and strategies versus hospital-based care.
  - The PC-ICCN offers online education resources, including the MyGuide Long COVID tool (launched in August 2023) to help patients support their recovery.
  - PC-ICCN partnered with patients to develop its MyGuide Long COVID online tool based on their identified needs, specifically tailoring the approach to improve the experience of accessing resources at challenging times in their recovery.
  - PC-ICCN also provides clinical and educational resources for physicians and other health-care providers to help them support their patients living with long COVID.
- **CLINICAL CARE (Post-Covid Clinics):** The total number of referrals to for clinical care peaked at 382 in June 2021. Since that time, referrals to the PC-ICCN consistently decreased prompting the PC-ICCN to shift from a 5-regional in-person clinics to a province-wide virtual Post-COVID Recovery Clinic serving people throughout BC. The virtual Post-COVID Recovery Clinic, operated by Providence Health Care, opened on April 1, 2023. Since then, the PC-ICCN still reports a decrease in referrals with only 39 referrals were recorded in January 2024.
  - As of January 31, 2024, since 2020 the PC-ICCN has received 8,226 referrals for clinical care services.
  - Provided 12,100 clinic visits (both in-person and virtual).
  - Successfully transitioned 2,817 patients (approximately 64% of patients) out of the clinical care services.[1] Of these:
    - 1,433 showed improved symptoms following a visit to the recovery clinics and were discharged.
    - 956 patients successfully completed an 18-month treatment pathway.
    - Remaining patients were provided with education and resources offered by the PC-ICCN.
- **RESEARCH:** BC is the only province in Canada that has an interdisciplinary provincial network of this kind that coordinates clinical care, research and education for the post-COVID-19 condition. PC-ICCN is committed to supporting evidence-based treatments through research and is working with local and national research partners to enable patient access to clinical trials.

[1] Source: PROMIS Database. February 9, 2024

- PC-ICCN has partnered with the national Long COVID Web to ensure that BC's collaborative approaches for research and care are consistent with those being implemented across Canada.
- PC-ICCN is reaching out to patients who have attended and are currently attending the Post COVID Recovery Clinic to recruit participants for clinical trials led by PC-ICCN-funded researchers.
- PC-ICCN is conducting several studies to understand the impact of long COVID on the employment and functioning of adults aged 18-64, including the long-term prognosis, the economic impacts, and the return-to-work experience. These studies will inform the clinical and social services required to support patients.
- PC-ICCN is supporting a study that explores primary care knowledge and comfort in caring for patients with long COVID. Results will inform modifications to existing materials or the development of new tools.

FINANCIAL IMPLICATIONS

- The PC-ICCN is supported by ongoing funding from HLTH which provides $5 million annual funding.
  - $2.2 million is allocated to support PC-ICCN central infrastructure and $2.8 million is allocated to support the provincial virtual clinic.
- In 2021/22, one time funding of $1.5 million was provided to the St Paul's Foundation from the HLTH Research, Evaluation, and Knowledge Management Fund (REKMF) for research, evaluation, and knowledge translation initiatives to support work that helps family practitioners in building knowledge and capacity. The funds must be used by 2025.

KEY BACKGROUND

- PC-ICCN launched in 2020, as evidence of long-term symptoms was emerging. The original model of care, which has since evolved over time to an education-first approach, included in-person clinics, online educational resources for people living with long COVID and health-care providers, and research.
- In October 2022, PC-ICCN shifted to an education-first approach to patient care, only prioritizing patients for clinic visits if they did not see any improvement after completing the education program. This model of care is evidence-based, using data gathered over 2½ years of operations and a survey of patients and Network partners in September 2022.
- Five physical Post-COVID Recovery Clinics (PCRCs) clinics were established: Vancouver General Hospital, St. Paul's Hospital, Jim Pattison Outpatient Care and Surgery Centre, Abbotsford Regional Hospital and Royal Jubilee Hospital in Victoria. Northern Health Authority and Interior Health Authority opted for a community navigation model.
- After consulting with patients and clinicians, PC-ICCN followed the recommendation that services could be optimally delivered virtually as the majority of patients were already accessing clinical care virtually due to COVID-19 precautions. Patients receiving care at this virtual clinic have province-wide access to care, including group education sessions and rehabilitation support from a multidisciplinary health-care team. Access to physician specialists is timely, when required.
- The Network's current approach offers online education resources, including the MyGuide Long COVID tool (launched in August 2023) to help patients support their recovery. Content and curriculum continue to evolve and grow based on identified needs and feedback. Education sessions include information on upcoming research studies, and an introductory session familiarizes patients with physicians and the entire interdisciplinary team.

LAST UPDATED

The content of this estimates note is current as of March 1, 2024, as confirmed by Eugene Johnson.

APPROVALS

2024 02 23 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 02 – Kristy Anderson, Hospital and Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

H-17

Private Surgical Centres

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

Key Messaging and Recommended Response:

- **Contracting private facilities for day care procedures provides short-term relief for capacity pressures in public hospitals, allowing them to focus on more urgent and complex cases, such as cardiac surgeries. This was a critical way to maintain service during the COVID-19 pandemic.**
- **We use private facilities to expand capacity, and to leverage efficiencies already within our system.**
- **There were 13,021 surgical cases completed at contracted sites across the province in 2022/23 (3.7% of the total surgeries completed). As of P10 2023/24, 8,181 cases have been completed at contracted private sites.**
- **The $23.8 million spent on private clinics for acute care services in 2022/23 represented only 0.18% of the total $13.6 billion acute care spending.**
- **The number of surgeries done in private facilities - and spending on them - is small compared to the total number of surgeries we complete across the province each year.**
- **Our focus remains on building and investing in the public system.**
- **This includes increasing operating room time and capacity, increasing training opportunities and bringing more private clinics under public control.**
- **For example, in 2022/23, the Island Health Authority purchased Seafield Surgical Centre (now Centre Island Surgical Centre) and View Royal Surgical Centre (now South Island Surgical Centre) for $11.5 million. In May 2023, Northern Health Authority purchased Prince George Surgery Centre.**
- **Health care services delivered through contracts with private clinics are fully funded by government, as required by the *Canada Health Act.* Under these arrangements, clinics are prohibited from charging patients any additional fees for insured services – also known as "extra billing."**

CURRENT SITUATION

- In 2023/24, health authorities (HAs) have continued to contract out day care procedures to provide short-term relief for capacity pressures. In 2023/24, there are 7 private surgical clinics (9 contracts) that HAs contracted with in compliance with the *Canada Health Act* to perform surgeries.
  - Kamloops Surgical Centre - Interior Health Authority (IHA),
  - Okanagan Health Surgical Centre - IHA,
  - False Creek Healthcare Centre - Fraser Health Authority (FHA) and Vancouver Coastal Health Authority (VCHA),
  - New Westminster Surgery Centre - FHA and VCHA,
  - Valley Surgery Centre - FHA,
  - LASIK MD Vancouver Hornby - VCHA, and,
  - Anesthesia For Dentistry Clinic - Provincial Health Services Authority (PHSA).
- In 2022/23, the Vancouver Island Health Authority purchased Seafield Surgical Centre (now Centre Island Surgical Centre) and View Royal Surgical Centre (now South Island Surgical Centre) for $11.5 million. In May 2023, Northern Health Authority (NHA) purchased Prince George Surgery Centre.
- Additional private surgical clinics no longer contracted by HAs include Fraser Valley Cataract and Laser Center (FHA) which ended in 2020/21 and Vancouver Ambulatory Surgery Center (VCHA) which ended in 2022/23.

FINANCIAL IMPLICATIONS

The total amount paid by HAs in 2022/23 to private clinics for acute care services was $23.8 million; 0.18% of the $13.6 billion HAs reported spending in acute care in the same time period (source: 2022/23 audited HA financial statements). The Ministry of Health (Ministry) provided funding of $12.1 million to the HAs to support contracts with private sites in 2023/24.

KEY BACKGROUND

- Since 2002, Ministry policy[1] has allowed HAs to purchase outpatient clinical services from private diagnostic and medical/surgical clinics, in addition to providing these services directly, if 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 Medical Services Plan (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 (CPSBC), 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.
- The types of surgeries contracted out to private surgical centres include cataracts, dentistry, ear, nose and throat procedures, neurosurgery, plastic surgery, ophthalmology, orthopedics, and many others. These are all considered day care procedures, and the patient length of stay at the facility may be no more than 24 hours following a procedure.
  - 2016/17: 9,948 contracted surgical cases[3] (3.2%) out of 315,203 total surgical cases[4].
  - 2017/18: 9,355 contracted surgical cases[3] (2.9%) out of 319,143 total surgical cases[4].
  - 2018/19: 11,607 contracted surgical cases[3] (3.5%) out of 331,159 total surgical cases[4].
  - 2019/20: 12,336 contracted surgical cases[3] (3.7%) out of 330,405 total surgical cases[4].
  - 2020/21: 13,862 contracted surgical cases[3] (4.4%) out of 316,275 total surgical cases[4].

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

[2] *Canada Health Act https://laws-lois.justice.gc.ca/eng/acts/C-6/ last amended on 2017-12-12*

[3] Contracted surgical cases: health authorities' submissions, Total surgical cases: Health Sector Information Analytics, and Reporting, Ministry of Health, Surgical Wait Times Database (Site ID 297)

[4] Total surgical cases: Surgical Wait Times (SWTP) Site ID 285, Reporting exclusions are not applied.

[5] Total surgical cases: Health Sector Information Analytics, and Reporting, Surgical Wait Times Database (Site ID 399)

  - 2021/22: 16,777 contracted surgical cases[3] (5.0%) out of 337,560 total surgical cases[4].
  - 2022/23: 13,021 contracted surgical cases[3] (3.7%) out of 350,844 total surgical cases[5].
  - 2023/24 P10 YTD: 8,181 contracted surgical cases[3*] (3.0%) out of 269,123 total surgical cases[5].
- WorkSafe BC (WSBC) also procures surgical services from private for-profit providers across the province. Procedures include (but are not limited to) knee, ankle, foot, hand, shoulder, spine surgeries; hernia repair; hardware removal; etc.
- The *Health Professions Act* requires that the CPSBC establish, maintain, and enforce bylaws that regulate non-hospital medical and surgical facilities. The Non-Hospital Medical and Surgical Facilities Accreditation Program (NHMSFAP), managed by the CPSBC, is responsible for all accreditation decisions.
- As per NHMSFAP, the patient length of stay at the facility may be no more than 24 hours following a procedure. Only non-hospital facilities accredited as a general anesthesia facility may provide overnight stay services.
- Private clinics must also be approved by the Medical Services Commission (MSC) to bill the MSP for publicly funded surgeries.
- The *Medicare Protection Act* along with the *Canada Health Act* prevents physicians in private clinics from charging MSP-insurable patients (residents of BC) for MSP-billable services. It is illegal for private clinics to charge any additional fees for services that are insured benefits of MSP or hospital services under the *Hospital Insurance Act*. To allow such extra billing of patients is a violation of the legislation.
- On April 6, 2023, the Supreme Court of Canada announced that it would not hear the case of Cambie vs BC.

LAST UPDATED

The content of this estimates note is current as of March 1, 2024, as confirmed by Shana Ooms.

APPROVALS

2024 02 22 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2024 02 28 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 01 – Kristy Anderson, Hospital and Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

H-18

Scope of Practice

Topic: The province has expanded the care Emergency Medical Assistants (EMAs) including First Responders (primarily firefighters) can provide to British Columbians in emergency situations.

Key Messaging and Recommended Response:

- **To improve patient care and safety, in 2022, the province expanded services paramedics and first responders can provide.**
- **These changes are a result of a series of recommendations made by the Emergency Medical Assistants Licensing Board that increase paramedic's scope of practice to include new or expanded services.**
- **BC Emergency Health Services (BCEHS) is upskilling their approximately 935 Emergency Medical Responders and 117 Critical Care Paramedics.**
- **Upskill training for the approximately 3,519 BCEHS Primary Care Paramedics and the 372 BCEHS Advanced Care Paramedics will get underway in April 2024.**
- **Upskilling for all levels of paramedics is expected to be complete by Spring 2025, with Critical Care Paramedic training expected to be complete by Spring 2024.**

CURRENT SITUATION

- To improve patient care and overall patient safety, amendments were made to the Emergency Medical Assistants (EMA) Regulation which came into effect September 23, 2022, by way of Ministerial Order No. M292.
- As of November 2023, BCEHS is currently working to upskill their approximately 935 Emergency Medical Responders and 117 Critical Care Paramedics.
- Upskill training for the approximately 3,519 BCEHS Primary Care Paramedics (PCPs) and the 372 BCEHS Advanced Care Paramedics (ACPs) will get underway in April 2024.
- Upskilling for all levels of paramedics is expected to be complete by Spring 2025, except for Critical Care Paramedics with training expected to be complete by Spring 2024.
- As these changes are implemented, paramedics and first responders will increasingly be able to better help patients on scene. For paramedics, this means the ability to provide more life-saving interventions, which at various licensing levels can include:
    - improved access to a range of analgesic (pain medications) options, including opiates;
    - enhanced airway management approaches;
    - providing life supporting or sustaining medications during transport; and
    - needle decompression for major chest traumas to support breathing (Note: this applies to a small patient population and PCPs would only use in the case of traumatic cardiac arrest).
- These changes are further supported by increases to the care that EMA First Responders can provide including:
    - additional diagnostic testing including blood pressure and blood glucose that can better inform paramedics about the next steps in patient care;
    - administering epinephrine for a life-threatening allergic reaction; and
    - supporting the preparation or packaging of patients for transport by paramedics.

- The Ministerial Order has a transition period of September 2024.
- Due to curriculum development for some of the license levels required in-depth and collaborative discussions prior to building the curriculum and the need for BC Emergency Health Services (BCEHS) to ensure that training requirements are balanced with operational requirements, it is unlikely training will be fully complete by the transition date.
- The Ministry of Health (HLTH) is currently assessing options surrounding the transition date to allow BCEHS the required time to train their paramedics.

Training Statistics:

Table 1: EMA Upskilling Achievements (Source: BCEHS). Data as of March 13, 2024.

BCEHS EMAs			
License Level	Total Employees	BCEHS Graduates from upskilling	Updated Licensees
Emergency Medical Responder (EMR)	1,000	378 = 37.8%	264 = 25.4% (percentage of Total employees who have had EMALB licenses updated).
Primary Care Paramedic (PCP)	3,519	0	0
Advanced Care Paramedic (ACP)	372	0	0
Critical Care Paramedic (CCP)	108	57 = 52.7%	0

Notes:

- *Numbers are based on the license EMA is currently holding. For example, some PCP licensed employees choose to work EMR transfer fleet.*
- *As of November 2023, BCEHS is currently working to upskill their approximately 935 Emergency Medical Responders and 117 Critical Care Paramedics.*
- *Upskill training for the approximately 3,519 BCEHS Primary Care Paramedics and the 372 BCEHS Advanced Care Paramedics will get underway in April 2024.*
- *Upskilling for all levels of paramedics is expected to be complete by March 2025, except for Critical Care Paramedics with training expected to be complete by March 2024.*

Table 2: EMA Restriction Removal Licensing Data by Schedule* (Source: EMALB – data as of February March 12, 2024).

Note: The EMA Regulation defines 6 categories of licenses of EMAs in BC.

EMA Licensing Stats – March 12, 2024			
License Category	**Total Licensees**	**Total Schedule 1 Restrictions Removed**	**Percent Removed**
EMA FR	7,298	651	8.92%
EMR	3,385	544	16.07%
PCP	4,658	9	0.19%
ACP	789	6	0.76%
CCP	138	41	29.71%
ITT	20	0	0.00%
Total	**16,288**	**1,251**	**7.68%**

FINANCIAL IMPLICATIONS

- In 2022/23, HLTH provided $750,000 for BCEHS to support the scope of practice expansion.
- For 2023/24, HLTH provided $10 million for BCEHS to continue the scope of practice changes.
- For 2024/25, HLTH has allocated $10 million for BCEHS to continue the scope of practice changes.
- In 2022/23, Ministry of Post-secondary Education and Future Skills (PSFS) confirmed funding to Justice Institute of BC (JIBC) in the amounts of $1,233,823 to support curriculum development and $144,223 to support minor capital purchases.

KEY BACKGROUND

- A steering committee was established and is meeting consistently to support collaborative practice for this project. The steering committee is comprised of HLTH and PSFS, in partnership with BCEHS and JIBC.
- In the latter part of March 2023, PSFS provided funding to JIBC, a publicly funded training institution, to lead the development of upskilling the curriculum based on the specifications of BCEHS' OSP.
- The changes to the regulations stem from recommendations made by the Emergency Medical Assistants Licensing Board (EMALB) to provide better outcomes for patients needing emergency health services.
- The recommendations were made following the EMALB's consultation with stakeholders, including BCEHS, Ambulance Paramedics of BC (CUPE 873), BC Professional Fire Fighters Association, Fire Chiefs Association of BC, EMA recognized training program representatives, and paramedics in industry.
- EMALB is responsible for examining, registering, and licensing all EMAs in BC, including First Responders.
- Services for each licence category are set out in Schedule 1 of the Regulation, with each license building on the previous license. Optional endorsements are set out in Schedule 2 of the Regulation.
- Schedule 1 is viewed as the minimum level to which an EMA should be trained but enabling both Schedules 1 and 2 as the legal scope of practice provides the widest set of parameters for EMA practice at any given license level.
- Under BCEHS' authority, EMA employers can restrict parameters into an operational scope of practice that can be a subset or comprise the entire legal scope of practice for a license category.
- The BCEHS Scope of Practice Expansion Project operationalizes full Schedule 1 and select Schedule 2 skills from the updated EMA Regulations for the BC Ambulance Service.
- In the future BCEHS may elect to operationalize additional Schedule 2 skills which are not currently being implemented at the PCP and ACP levels.
- As the proposed changes are implemented, EMAs will increasingly be able to provide improved care for patients on scene.
- These amendments align with the February 27, 2019, Office of the Auditor General report Access to Emergency Health Services.

LAST UPDATED

The content of this estimates note is current as of March 14, 2024, as confirmed[1][2] by Eugene Johnson, Provincial Services Branch, and Wendy Vowles, Emergency Medical Assistants Licensing Branch, HSWBS.

APPROVALS

2024 03 06 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 07 – Kristy Anderson, Hospital and Provincial Health Services Division

[1] Ryan Ackerman, Learning and Professional Practice, BCEHS, Ryan.Ackerman@bcehs.ca
[2] Shell Lau, Strategy and Transformation, BCEHS, Shell.Lau@bcehs.ca

LEGISLATIVE SESSION – ESTIMATES NOTE

H-19

Surgical Renewal

Topic: Update on the May 7, 2020, Minister of Health announcement regarding the Commitment to Surgical Renewal; a $250 million plan to increase surgical capacity to address postponed non-urgent scheduled surgeries due to the COVID-19 pandemic, meet growing demand for surgery, and change the way surgeries are delivered in BC[1].

Key Messaging and Recommended Response:

- **In May 2020, we made our commitment to Surgical Renewal, to catch up on surgeries postponed due to the COVID-19 pandemic and keep up with the rising demand for surgical services.**
- **More importantly, we made a commitment to patients in BC to ensure they receive the care services they need.**
- **Despite 2 crises in the pandemic and the toxic drug supply, as well as numerous extreme weather events, we delivered on our commitment.**
- **All 24,485 postponed surgeries have now been completed.**
- **Our continued progress on transforming our surgical system shows the resilience of our health-care workers and health-care system.**
- **During Year 3 of Surgical Renewal (April 1, 2022, to March 31, 2023), we completed 350,844 surgeries[2]. This is the highest number of surgeries ever performed in a year in BC.**
- **In addition – this past summer we delivered a record number of surgeries - 4,661 more surgeries were performed during the weeks of June 28 and August 27 than the same period in 2019.**
- **In January 2024 we delivered the highest number of surgeries ever in one week - 7,927.**
- **I am grateful to the surgical teams and health authorities (HAs) for working together to change the way deliver surgeries in BC[3].**
- **As noted in Canadian Institute for Health Information (CIHI's) 2023 report, BC ranked first nationally for the percent of patients meeting clinical benchmarks for cataract surgeries.**

[1] BC Gov News. (May 7, 2020). Province Launches Renewal Plan for Surgeries. Retrieved from: https://news.gov.bc.ca/releases/2020HLTH0026-000830
[2] Source: Health Sector Information Analysis and Reporting, For Spring Estimate Master Workbook, Site 399. Exclusions not applied; Data restated.
[3] BC Gov News (Sept 2023) Retrieved from: B.C. surgical renewal breaks records bringing more patients surgeries they need | BC Gov News

- **BC ranks second nationally for the percent of patients meeting clinical benchmarks for both hip and knee replacements.**
- **This incredible progress would not be possible without investments in our public health-care system and increasing operating room time and capacity in the health authorities. We have been working hard to have all the HAs running above pre-COVID surgical capacity as part of our overall goal to ensure patients have access to surgeries.**
- **We are focused on building on existing achievements, continuing to overcome challenges, and finding new ways to deliver the surgeries patients need.**

CURRENT SITUATION

- All 24,485 surgeries postponed throughout the COVID-19 pandemic were completed or scheduled, as of Q2/P06 2023/24[4]. HAs accommodated a small number of patients who delayed booking their surgeries due to their own scheduling considerations and preferences.
- As a result of the extreme heat, wildfires, floods, the shortage of health human resources (HHR) and multiple and sustained COVID-19 impacts, Advice/Recommentations

Advice/Recommentations

- Other surgical renewal achievements in FY 2023/24 include[5]:
  - Between April 1, 2023, to January 4, 2024 (P10 YTD):
    - Delivery of 269,123[6] scheduled and unscheduled surgeries – 9,202 surgeries or 3.5% more compared to the same timeframe as 2019.
    - Delivery of 25,410 urgent scheduled surgeries completed within four weeks – 3.2% more compared to the same timeframe as 2019.
    - Delivery of 22,004 non-urgent scheduled surgeries completed for patients waiting longer than 2 times their target wait – 9.0% more compared to the same timeframe in 2019.
    - Expansion of OR hours by 37,749 to 478,111 hours – 8.6% more compared to the same timeframe as 2019.
    - Addition of 21 new initiatives in HAs to increase OR time and capacity.
  - Since April 2020:
    - 1,278 nurses have completed surgical specialty training throughout BC, with 316 completions this FY as of P09.
    - BC has added additional (net) healthcare staff to surgical services across the province, including 199 surgeons, 151 anesthesiologists, 249 perioperative nurses, 11 general practitioner anesthetists, and 41 medical device reprocessing technicians.[7]
- The Ministry of Health continues to work with HAs to find ways to increase HHR for surgery while balancing other strategic priorities that draw nursing staff including primary and acute care.
- On July 13, 2021, the Ministry issued a refreshed Waitlist Management Policy that all 6 HAs have implemented as of Q3/P09 2022/23. Policy implementation will support improved accuracy of reported wait times through enhanced sharing of patient unavailable time, improved BC Diagnosis Code selection by

[4] Surgical Renewal Progress Report 21
[5] Source: Health Sector Information Analysis and Reporting 2023_24 P10 Surgical Standard Report Site 399, restated data
[6] Source: Health Sector Information Analysis and Reporting, For Spring 2024 Estimates Master Workbook, Site 399, Exclusions not applied, restated data
[7] Source: FY23 Q3 – Surgical Workforce Report- FINAL

surgeons, and routine waitlist audits by HAs and surgeons. In addition, improved patient communication has resulted through Patient Notification letters and phone calls.

FINANCIAL IMPLICATIONS

In addition to the initial $250 million investment, on September 9, 2020, the Government announced the Ministry received approval to access operating funding of up to $1.6 billion and capital funding of $150 million in 2020/21 to respond to the health-care requirements related to the COVID-19 pandemic response[8]. Of this amount, approximately $187.5 million was allocated to support enhanced surgical capacity, including additional nursing staff and operating room costs.

KEY BACKGROUND

- On March 16, 2020, non-urgent scheduled surgeries were postponed because of COVID-19, and on May18, 2020, non-urgent scheduled surgeries resumed.
- The Commitment to Surgical Renewal launched May 7, 2020, and outlines 5 steps: 1) increasing surgeries; 2) increasing essential personnel; 3) focusing on patients; 4) adding more resources; and 5) reporting on progress.
- The plan prioritizes urgent surgeries; patients who had their surgery postponed and have been waiting over twice their clinical benchmark; day surgeries; and maximizing surgeries that can be performed outside of operating rooms.
- During the initial COVID-19 response, surgeries were taking approximately 26% longer to complete due to a necessary increase in infection prevention controls. By the June 26 to July 23, 2020, reporting period, surgical efficiency returned to approximately pre-COVID-19 levels[9].
- HAs originally planned to add 16% more surgical capacity (OR hours) from June 15, 2020, to March 3, 2021, annualizing to a 24% gain in 2021/22[10]. Based on those plans, all HAs were projected to catch-up to postponed surgeries by the end of 2021. These plans were impacted by the subsequent waves of COVID-19.
- For Fiscal Year 2020/21 (Year 1 of Surgical Renewal)[4]:
    - Total surgical volumes were 316,440[5], a decrease of 4.2% since 2019/20 and an increase of 0.4% since 2016/17 levels, despite significant impacts of the pandemic in 2020.
- For Fiscal Year 2021/22 (Year 2 of Surgical Renewal)[4]:
    - Total surgical volumes were 338,171[5], an increase of 2.3% since 2019/20 and an increase of 7.3% since 2016/17 levels.
    - In August 2021, HAs met their goal of providing 400 additional surgical specialty nurse training seats.
    - The Ministry and HAs also met their goal of training 100 medical device reprocessing technicians and continue to ramp up training.
- For Fiscal Year 2022/23 (Year 3 of Surgical Renewal)[4] :
    - Total surgical volumes were 350,844[5,11] an increase in 6.2% since 2019/20 and an increase of 11.3% since 2016/17 levels.

LAST UPDATED

The content of this estimates note is current as of March 15, 2024, as confirmed by Shana Ooms.

APPROVALS

2024 02 29 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2024 03 01 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 03 – Kristy Anderson, Hospital and Provincial Health Services Division

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[8] BC Gov News. (September 9, 2020). Investment brings new support to those most vulnerable to COVID-19 and communities where they live. Retrieved from: https://news.gov.bc.ca/releases/2020PREM0050-001694

[9] BC Gov News. (September 1, 2020). B.C progresses on surgical renewal plan. Retrieved from: https://news.gov.bc.ca/releases/2020HLTH0049-001627 Progress Report 2 https://news.gov.bc.ca/files/2020_surgical-renewal-commitment-progress-report-June-July-2020.pdf

[10] BC Gov News. (January 6, 2021). Adding surgeries for patients: Catching up from COVID-19. Retrieved from: http://news.gov.bc.ca/releases/2021HLTH0003-000011 Progress Report #3 https://news.gov.bc.ca/files/SurgicalRenewalReport3.pdf

[11] Note – volume previously reported was 350,866. Data has since been restated as part of routine data integrity processes.

2024 ESTIMATES NOTES – Table of Contents

LEGISLATIVE SESSION – ESTIMATES NOTE

J-01

Access to New Drugs in BC Compared to Other Jurisdictions

Topic: Access to new drugs in BC compared to other jurisdictions.

Key Messaging and Recommended Response:

- **Pharmaceuticals are not included in the *Canada Health Act*. Therefore, which drugs are covered, and the extent of the coverage provided can vary from province to province.**
- **While there are cases in which other provinces cover a drug not included in BC's PharmaCare's benefit list, there are also cases in which PharmaCare covers a drug that other provinces do not.**
- **Overall, among the provinces, there is a relatively high degree of consistency in terms of which drugs are covered. In cases where a particular drug is not covered, the province may in fact cover a clinically equivalent alternative drug within the same drug class.**
- **In terms of the extent of coverage, BC provides one of the most generous drug coverage programs in Canada with many plans providing 100% coverage and Fair PharmaCare, providing universal income-based coverage.**
- **Between January 1, 2015, and December 31, 2023, BC completed 479 drug reviews. Innovative Medicines Canada (IMC) has stated that, during this time, 39 of BC's coverage decisions during this time were inconsistent with other provinces. This means that, in more than 90% of cases, BC's coverage decisions aligned with other Canadian jurisdictions during the specified time period.**
- **The pharmaceutical industry has used comparisons to other provinces as a means to lobby for increased drug expenditure in BC for at least a decade.**
- **BC is often held up as a model for the rest of Canada in terms of pharmaceutical policy and health outcomes, and these positive health outcomes are achieved at a lower cost than other provinces.**
- **BC has the lowest debt-to-GDP ratio in the country. This puts BC in a stronger position to continue to invest in people, not in drugs without proven cost-effectiveness.**

LEGISLATIVE SESSION – ESTIMATES NOTE

J-01

CURRENT SITUATION

- IMC is a lobby group that represents Canada's innovative pharmaceutical industry. They, along with their network of patient groups such as the Gastrointestinal Society assert the following:
  - BC covers the fewest drugs of all provinces, e.g., between 2018 and 2023, BC refused to cover 31 newly recommended medications when Ontario declined coverage for only 2 and Alberta for 3.
  - BC underfunds its drug program and spends only $257 per person on medications, compared to the Canadian average of $442.
  - While these low spending figures might be touted by government as good fiscal management, what it really means is that patients can't get the medications they need.[1]

FINANCIAL IMPLICATIONS

Drugs that have not demonstrated value for money when reviewed by PharmaCare's rigorous and transparent process are not added for coverage. A formal budget impact analysis has not been completed for all 39 drugs identified by the IMC. Advice/Recommentations

KEY BACKGROUND

- IMC represents 47 of the largest pharmaceutical companies in the world including Eli Lilly, Novo Nordisk, Johnson & Johnson, Merck, Roche, AstraZeneca, AbbVie and Pfizer. There is a financial interest for IMC to advocate for increased drug expenditure in BC.
- In the summer of 2023, IMC presented BC PharmaCare with its latest analysis that there are drugs used to treat 39 indications that since 2015, BC has not covered even though there is a positive recommendation from Canada's Drug and Health Technology Agency (CADTH) as well as a pan-Canadian Pharmaceutical Alliance (pCPA) negotiated price.
- The drugs identified are 5-fluorouracil 0.5% and salicylic Acid 10% (Actikerall™), riociguat (Adempas®), lixisenatide (Adlyxine™), tazarotene (Arazlo™), halobetasol propionate (Bryhali™), cysteamine ophthalmic solution (Cystadrops®), halobetasol propionate and tazarotene (Duobrii™), dupilumab (Dupixent®), PEG-filgrastim (Fulphila™), PEG-filgrastim (Lapelga™), tildrakizumab (Ilumya™), eplerenone (Inspra®), travoprost ophthalmic solution (Izba™), ofatumumab (Kesimpta®), edoxaban (Lixiana®), mesalazine (Mezera™), propiverine hydrochloride (Mictoryl®), mirabegron (Myrbetriq™), ocrelizumab (Ocrevus®), baricitinib (Olumiant™), peginterferon beta-1a (Plegridy™), buprenorphine hydrochloride (Probuphine™), cysteamine bitartrate (Procysbi®), levofloxacin (Quinsair®), interferon beta 1-a (Rebif®), teduglutide (Revestive®), upadacitinib (Rinvoq®), brodalumab (Siliq™), (Simponi®), insulin glargine and lixisenatide (Soliqua™), insulin degludec (Tresiba®), triamcinolone hexacetonide, sucroferric oxyhydroxide (Velphoro), cyclosporine ocular (Verkazia™), dapagliflozin-metformin hydrochloride (XigDuo®), and omalizumab (Xolair).
- All drugs on the list have either therapeutic alternatives listed on the BC formulary that provide better value for money, or the confidential negotiated price by the pCPA did not reach the cost-effective price determined by the CADTH and therefore would not be an efficient allocation of resources
- Overall, BC provides one of the most generous drug coverage programs in Canada. BC, Saskatchewan and Manitoba are the only provinces that offer income-based universal drug coverage programs.

LAST UPDATED

The content of this estimates note is current as of February 14, 2024, as confirmed by Tijana Fazlagic.

APPROVALS

2024 02 15 – Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division
2024 02 16 – Christine Voggenreiter obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 22 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

[1] BC-Medication-Coverage-Report-2024-FINAL.pdf (badgut.org)

LEGISLATIVE SESSION – ESTIMATES NOTE

J-02

Cabenuva Drug Coverage for HIV

Topic: Coverage of Cabenuva, an injectable antiretroviral therapy for people living with HIV.

Key Messaging and Recommended Response:

- **BC provides drug treatments for HIV-AIDS through the BC Centre for Excellence in HIV/AIDS.**
- **The BC Centre for Excellence in HIV/AIDS (BC-CfE) is the largest HIV/AIDS research and treatment facility in Canada.**
- **The BC-CfE is responsible for reviewing drugs for treatment of HIV/AIDS, establishing treatment guidelines, and providing coverage for eligible drugs.**
- **Cabenuva (cabotegravir 200mg/mL and rilpivirine 300mg/mL) is an extended-release injectable therapy to treat HIV-1 infection in people 12 years and older. It is a relatively new injectable treatment for HIV patients that is administered monthly or bi-monthly and can be used by some patients as an alternative to daily oral medications.**
- **Cabenuva has been reviewed by the BC-CfE and is currently available to people in BC through the BC-CfE.**
- **Patients must meet certain criteria to be eligible for provincial funding of Cabenuva. Because of the particulars of the drug, this is recommended in very specific clinical circumstances, consistent with the product's regulatory approval.**
- **Healthcare providers experienced in the management of HIV can request Cabenuva for eligible patients by making an application to the BC-CfE, which reviews such applications on a case-by-case basis.**

CURRENT SITUATION

- The BC Centre for Excellence in HIV/AIDS (BC-CfE) leads HIV/AIDS research and treatment in the province and develops guidance and patient eligibility requirements for the drugs used to treat HIV/AIDS.
- As is the case for all drugs funded by the Ministry of Health (the Ministry), the funding criteria for HIV/AIDS treatments were developed based on expert input and clinical evidence.
- The Ministry supports the BC-CfE's decisions about the drug treatments it oversees.
- Certain criteria must be met for patients to receive funding for Cabenuva therapy; one of the requirements is that they are unable to take the oral alternatives.
- Patients who have a prescription for HIV/AIDS drugs can opt to fill their prescription at any pharmacy, if they don't qualify for or choose not to receive them through the BC-CfE.

FINANCIAL IMPLICATIONS

- For fiscal year 2023/24, the Ministry committed to provide up to $110M in funding to the BC-CfE
- Based on transparent pricing, the cost of one year of Cabenuva treatment is approximately $14,500. The cost of comparable oral treatments ranges from $9,907 to $19,769 annually based on transparent pricing.
- HIV/AIDS treatments provided by the BC-CfE are 100% covered for qualifying patients.

KEY BACKGROUND

- The BC-CfE applies rigorous, evidence-based processes when making decisions and is considered a Canadian and world leader in HIV/AIDS research and treatment.
- The BC-CfE is the primary source of provincial government-funded antiretroviral therapy for treatment of individuals living with HIV in BC. There are several small programs that operate in the province under federal auspices (i.e.: IFH, NIHB, RCMP, Military).
- Cabenuva is a combination therapy made up of cabotegravir (200mg/mL) and rilpivirine (300mg/mL) injections. It is an extended-release injectable treatment used to treat HIV infection in people who are 12 and older.
- In contrast to currently available oral ARV therapies, there are a range of additional clinical, logistical, and administrative considerations in determining whether this treatment is right for the patient.
- The key difference between Cabenuva and conventional oral therapies is that Cabenuva must be injected by a healthcare professional every month (or, in some cases, every two months), while oral therapies (one to three pills) are taken at home every day.
- The potential failure to ensure clinical appropriateness for this 2-drug therapy, or the inability to support on-time injections, include possible treatment failure and acquired drug resistance to key HIV drug classes. This has potential serious implications in limiting future treatment options for an individual and warrants thoughtful consideration for eligibility.
- Of note, there have been cases of treatment failure despite on-time injections. This remains a concern as these treatment failures remain unexplained.
- Cabenuva is available in BC through the BC-CfE's Drug Treatment Program, with eligibility criteria consistent with the product's regulatory approval.
- Physicians can request Cabenuva on behalf of patients; requests are reviewed for suitability and criteria by the BC-CfE on a case-by-case basis.
- Cabenuva has requirements to ensure its safe and effective handling, storage, scheduling and administration; these requirements must be met in order for the drug to be funded and provided to HIV patients in BC.

BC-CfE SUMMARY of Requests for Cabotegravir and Rilpivirine Injections (as of March 27, 2024)

- Total requests received (62)
- Withdrawn by prescriber/ cancelled (7)
- Approved requests (27)
- Dispensed (21)
    - Continuing (18)
    - Discontinued (3)
        - Post-injection pain (1)
        - Concern about side effects (1)
        - Prefers oral (1)
- Pending start (6)
- Not approved (20)
    - NNRTI (Rilpivirine) and/or integrase inhibitor resistance (5)
    - Adverse reactions to integrase inhibitors (2)
    - Detectable pVL (1)
    - Caution elevated BMI (3)
    - Clinical eligibility not met (9)

- Pending additional information (8)

LAST UPDATED

The content of this estimates note is current as of February 2, 2024, as confirmed by Tijana Fazlagic.

APPROVALS

2024 02 07 – Lenore Ogilvy obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 08 – Brenda Rafter, obo Rob Byers, Finance and Corporate Services Division
2024 04 02 – Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

J-03

Canadian Blood Services Plasma Collection Contract

Topic:

- Canadian Blood Services (CBS) has signed a contract with Grifols, a global healthcare company, to increase Canada's domestic self-sufficiency of plasma derived products and improve the security of supply for Canadian patients.
- The deal involves the establishment of collection centres by Grifols where donors would be financially remunerated for their plasma.

Key Messaging and Recommended Response:

- **On behalf of the provinces and territories, CBS is responsible for ensuring Canadian patients who rely on immunoglobulin (Ig) have a secure supply of this lifesaving product derived from human plasma.**
- **BC has been working with CBS and other provinces and territories to increase Canada's self-sufficiency of Ig, as well as plasma collection. At the same time, the Province also remains committed to protecting and enhancing the voluntary plasma donations system, through enforcement of the *Voluntary Blood Donations Act (*the Act*)*, which came into effect in 2018.**
- **The Act prohibits organizations from paying donors for blood and plasma donations.**
- **It was brought into force to: protect the public blood system from encroachment by the private sector; ensure that plasma collected from British Columbians was used to treat patients in Canada, and, to prevent private entities from exploiting an essential resource and generous donors.**
- **The Act provides exemptions for select organizations and prescribed classes in the event remuneration of donors is necessary. It was not intended to allow a private entity to establish collection sites in BC with a donor remuneration model.**
- **Our voluntary blood donation system is an integral resource that patients rely on.**
- **To fulfill its contractual obligations to CBS, Grifols announced its acquisition of Canadian Plasma Resources and will also open five locations in Ontario, which have been pre-approved by CBS. No paid plasma donation centres are anticipated to open in BC.**

- **In addition to their agreement with Grifols, CBS is increasing their own plasma collection through the establishment and operation of 11 CBS plasma donor centres, funded by federal, provincial (P), and territorial (T) governments.**
- **The Ministry of Health is extremely pleased that two CBS plasma collection centres are open in BC; one in Kelowna and one in Abbotsford.**

CURRENT SITUATION

- Grifols has no current plans or need to open any plasma collection centres in BC. However, Grifols has locations in Alberta, Saskatchewan, Manitoba, New Brunswick and Nova Scotia, and plans to open five in Ontario.

Plasma and Ig

- Ig is a life-saving treatment for over 50% of the patients who rely on this product.[1]
- Currently, only 26.9% of the Ig that is used to treat Canadian patients is manufactured from plasma that is collected in Canada.[2] The remaining required Ig is purchased by CBS on the global market, and comes primarily from the United States, where donors are financially compensated.
- In recent years, the global supply of plasma to manufacture into Ig has been disrupted and constrained due to factors such as the COVID-19 pandemic and inflation, highlighting the importance of a domestic supply of plasma.
- To increase domestic plasma self-sufficiency for fractionation, CBS, with the backing of PT governments, established a plan to develop 11 collection centres dedicated to plasma.
- So far, nine sites have opened across Canada with another two planned. CBS has two dedicated plasma collection centres in BC: one in Kelowna, which opened in June 2021; and the other located in Abbotsford, which opened in April 2023.
- CBS' plasma collections currently provide 19.3% of the Ig Canada uses.[2] Once established, these sites and increasing collections in CBS' existing centres are expected to provide 25% domestic plasma sufficiency.

Grifols Contract

- In 2022, CBS repeated the Risk Based Decision Making framework created by the Association of Blood Operators (previously completed in 2016). The evidence-based review resulted in a recommendation to increase the self-sufficiency target from 50% to a range of 50-60% and to leverage the expertise of the commercial plasma collection industry.
- A request for proposals was conducted by CBS to assess potential commercial providers and Grifols was selected as the viable commercial partner.
- On September 7, 2022, CBS publicly announced that it was entering a 15-year contract with Grifols to establish an end-to-end supply chain where plasma is both collected and fractionated in Canada.
- The agreement ensures none of the plasma collected in Canada or the Ig manufactured from that plasma by Grifols can be sold or shipped offshore. The contract will provide CBS with the additional capacity it needs to reach the 50% target for plasma self-sufficiency through an approach that is considered cost competitive to purchasing Ig from the global market. Grifols currently contributes 7.6% towards the target.[2]
- A key feature of the proposal is that Grifols would pay donors for their plasma, which contrasts with CBS' voluntary donation model.
- As the national blood operator for Canada, CBS has been entrusted with the operational authority to establish and implement this new contractual agreement.

[1] Plasma and Immunoglobulin Security of Supply: Risk-Based Decision Making Analysis (June 2022) p 11.
[2] Canadian Blood Services Performance Report to Members (Q4 2023-24), June 28, 2024, p3.

Voluntary Blood Donations Act

- In May 2018, BC passed the *Voluntary Blood Donations Act* (The Act) that prohibits organizations from paying donors for blood and plasma.
- The Act was brought into force to: protect the public blood system from encroachment by the private sector; ensure that plasma collected from British Columbians is used to treat patients in Canada; and prevent private entities from exploiting an essential resource and the individuals who generously donate blood.
- The Act provides exemptions for CBS, its agents and successors, and prescribed classes if remuneration of donors is necessary in special circumstances.

Other Jurisdictions

- Ontario and Quebec are the only other jurisdictions with legislation prohibiting remuneration for blood and plasma donation. Alberta passed legislation in 2017, which was then repealed in 2020. Ontario will allow Grifols to operate as an agent of CBS under their legislation.
- Grifols currently has 11 plasma collection centres in Canada (in Alberta, Saskatchewan, Manitoba, New Brunswick and Nova Scotia). Some of these centres are from Grifols' acquisition of Canadian Plasma Resources, which was announced in June 2023. Canadian Plasma Resources had centres in multiple provinces that financially compensated donors.
- Grifols plans to open five locations in Ontario, which have been pre-approved by CBS.

FINANCIAL IMPLICATIONS

For 2023/24, CBS' total national expenditures were $1.49 billion with BC's portion of this at $251 million. Of the total expenditures, the amount for plasma operations totaled $35 million nationally, and $5.96 million for BC.[3]

KEY BACKGROUND

- CBS is a national not-for-profit organization established in 1998, by a Federal/PT Memorandum of Understanding to supply blood, blood products and their alternatives to PT health systems (except Québec, which has its own blood system).
- CBS was established following the *Royal Commission of Inquiry on the Blood System in Canada* (the Krever Inquiry) and replaced the Canadian Red Cross Society as the national blood system operator.
- PT Ministers of Health (except Quebec's) are the Corporate Members of CBS and are responsible for the mission, mandate, and funding of CBS; approving a rolling 3-year corporate plan and annual budget; electing directors to the CBS Board; and overall expenditure of public funds by CBS.
- CBS operates at arm's-length from governments and is responsible for providing a safe, secure, and affordable supply of blood, blood products and their alternatives. PT Ministers of Health do not direct operational decisions of the CBS Board of Directors or its staff.

LAST UPDATED

The content of this estimates note is current as of [2024-08-01], as confirmed by [Pouya Sadeghi Pour] acting on behalf of Mariana Diacu Executive Director of the Laboratory and Blood Services Branch.

APPROVALS

2024 [2024-08-02] - Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division
2024 [2024-08-01] - Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

[3] Canadian Blood Services 2023-24 Non-Consolidated Financial Statements, Schedule 3

LEGISLATIVE SESSION – ESTIMATES NOTE

J-04

COVID-19 Antiviral Treatments

Topic: Update on access to antivirals, nirmatrelvir/ritonavir (Paxlovid™) and remdesivir (Veklury™) for the treatment of mild to moderate COVID-19

Key Messaging and Recommended Response:

- **Two antivirals, nirmatrelvir/ritonavir (Paxlovid™) given orally and remdesivir (Veklury™) are approved for treatment of mild to moderate COVID-19 in patients at high risk for progression to severe disease. Both medications have been procured and supplied by the Public Health Agency of Canada (PHAC) since January 2022 and federal procurement will end on March 31, 2024. There is limited public supply of Paxlovid in BC, with most expiring by March 31, 2024, and some expiring by May 31, 2024. Communications to pharmacists have been distributed to prioritize limited stock based on expiry and preserve Paxlovid until PharmaCare completes its review.**
- **In BC, patients may get a prescription for Paxlovid through their primary care provider, or through a centralized intake system by contacting Service BC. Since March 1, 2022, all community pharmacies in BC have the ability to order and dispense Paxlovid.**
- **PharmaCare is in the process of reviewing Paxlovid for provincial coverage while Canada's Drug and Health Technology Agency (CADTH)'s reimbursement review is underway. Pricing negotiation with the manufacturer (Pfizer) is underway through the pan-Canadian Pharmaceutical Alliance (pCPA). Provincial eligibility criteria for coverage is to be determined and will consider clinical recommendations by the COVID-19 Therapeutics Committee (CTC) and the COVID-19 Treatment Review and Advisory Group (CTRAWG).**
- **A real-world effectiveness study in BC has shown that Paxlovid moderately reduces the risk of hospitalization or death (an absolute risk reduction of 2.5%, 95% CI, -4.8% to -0.2%) amongst those who are severely and moderately immunosuppressed. Given the high vaccination rate and most patients having experienced at least one COVID-19 infection, the overall risk of hospitalization or death in severely immunosuppressed patients is now low (approximately 3%), even without treatment with Paxlovid.**

- **CTC and CTRAWG recommend Veklury be used as the first-line alternative IV treatment if Paxlovid cannot be prescribed.**
- **Provincial coverage for Veklury will be reviewed in 2024 pending CADTH reimbursement recommendation. Currently, there is adequate supply of federally procured Veklury in BC to meet the projected demand until end of 2024.**

CURRENT SITUATION

- Paxlovid is an oral antiviral medication indicated for individuals with mild to moderate COVID-19 who are at high risk of developing serious illness.
- Veklury is an antiviral administered intravenously with a similar indication as Paxlovid, and is generally used when an individual cannot take Paxlovid due to drug-drug interaction or contraindications. Veklury is also approved for hospitalized COVID-19 patients requiring supplemental oxygen.
- Since January 31, 2022, PHAC procured and allocated Paxlovid and Veklury to provinces and territories (P/Ts). The federal supply will end by March 31, 2024. Most Paxlovid supply will expire before May 31, 2024. The supply of federally procured Veklury is expected to last through December 2024.
- There is limited public supply of Paxlovid after most of the regular formulation (standard dosing) expires on March 31, 2024. From April 1, 2024, pharmacies will continue to order remaining stock of renal-impairment formulation with expiry date of May 31, 2024. Pharmacists and wholesalers have been made aware of the limited stock in BC, and have been instructed to preserve supply by prioritizing Paxlovid dispense with short expiry.
- Federally procured Paxlovid was provided to patients through PharmaCare Plan Z. From January 31, 2022 to December 31, 2023, over 37,000 Paxlovid treatment packs were dispensed to more than 34,500 patients in BC[1].
- CADTH is conducting a reimbursement review for Paxlovid and P/Ts are currently reviewing the drug for provincial coverage. Pricing negotiation with the manufacturer (Pfizer) is underway through the pCPA.
- The price of Paxlovid was increased in the United States from $530 to $1,390 USD for a 5-day treatment course shortly before Pfizer submitted to CADTH for its reimbursement review. In Canada, the manufacturer's list price is $1,288.88 per 5-day treatment course. CADTH has determined that a price reduction of 62% is required to be cost-effectiveness. However, there will still be a significant budget impact.
- A real-world evaluation by the Therapeutics Initiative using BC data showed that clinically extremely vulnerable 1 (CEV1) patients that received Paxlovid were associated with a 2.5% absolute risk reduction in hospitalization and mortality compared to similar patients without Paxlovid.[2] There was a 1.7% risk reduction in CEV2 patients and no benefit was observed in the CEV3 and non-CEV patients. This study largely informed CADTH's draft recommendations for reimbursement conditions of Paxlovid which include treatment of patients who are moderately or severely immunosuppressed.
- CADTH reimbursement review for Veklury is expected to be completed in the fall of 2024.

FINANCIAL IMPLICATIONS

- Since January 2022, PHAC procured COVID-19 therapies were provided to P/Ts through the federal budget. PharmaCare was responsible for the dispensing fees for Paxlovid, which was approximately $328,000, up to December 31, 2023[1].

[1] PharmaNet, Health Sector Information, Analysis and Reporting, February 16, 2024

[2] Dormuth CR, Kim JD, Fisher A, et al. Nirmatrelvir-Ritonavir and COVID-19 mortality and hospitalization among patients with vulnerability to COVID-19 complications *JAMA Network Open.* 2023;6(10):e2336678. doi:10.1001/jamanetworkopen.2023.36678.

- Provincial coverage of Paxlovid is estimated at $24 million per year based on transparent pricing and current utilization.
- According to Pfizer's submission to PharmaCare, they estimate BC's annual budget impact to be Government per year with less restrictive coverage criteria.

KEY BACKGROUND

- CTC and CTRAWG review clinical evidence for drugs proposed for treatment of COVID-19 and provide recommendations and decisions on their use in BC.
- In the pre-Omicron wave, Paxlovid and Veklury reduced the risk of COVID-19 related hospitalizations and deaths in mild to moderately ill outpatients from about 6% to about 1%.[2] Real-world evidence conducted during Omicron suggested that Paxlovid reduce the risk of hospitalization in those with high risk factors from about 3% to under 1%.[3] Age, vaccination status and comorbid conditions are associated with a higher risk of hospitalization from COVID-19 and a greater likelihood of benefit.
- A real-world evaluation by the Therapeutics Initiative using BC data showed that clinically extremely vulnerable 1 (CEV1) patients that received Paxlovid were associated with a 2.5% absolute risk reduction in hospitalization and mortality compared to similar patients without Paxlovid.[4] There was a 1.7% absolute risk reduction in CEV2 patients and no statistically significant benefit was observed in the CEV3 and non-CEV patients. This study largely informed CADTH's draft recommendations for reimbursement conditions of Paxlovid which include treatment of patients who are moderately or severely immunosuppressed.
- Evidence to date shows that Paxlovid has no impact on days to symptom alleviation and is not effective for post-exposure prophylaxis. Literature examining the effect of Paxlovid on post-COVID condition, or long COVID remains inconclusive.
- Paxlovid is associated with significant drug-drug interactions and contraindications, therefore pharmacists are involved in patient medication reviews either prior to prescription being provided by a prescriber or at the time of dispensing.
- In BC, patients may get a prescription for Paxlovid through their primary care provider, or through a centralized intake system by contacting Service BC. Since March 1, 2022, all community pharmacies in BC have the ability to order and dispense Paxlovid.
- CTC and CTRAWG recommend Veklury be used as the first-line alternative IV treatment if Paxlovid cannot be prescribed.
- Veklury was also studied in severely ill COVID-19 patients and was authorized by Health Canada in July 2020 for the treatment of hospitalized patients with pneumonia requiring supplemental oxygen. However, due to lack of clinical benefit in survival, disease progression of length of hospital stay, the CTC does not recommend routine use of Veklury in severely ill patients.

LAST UPDATED

The content of this estimates note is current as of March 25, 2024, as confirmed by Tijana Fazlagic.

APPROVALS

2024 02 22 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 23 - Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2024 03 25 – Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division

[3]Clinical Practice Guide for Therapeutics in Patients with Mild-Moderate COVID-19: September 2023. ClinicalPracticeGuide_Therapeutics_MildModerateCOVID.pdf (bccdc.ca)

[4] Dormuth CR, Kim JD, Fisher A, et al. Nirmatrelvir-Ritonavir and COVID-19 mortality and hospitalization among patients with vulnerability to COVID-19 complications *JAMA Network Open.* 2023;6(10):e2336678. doi:10.1001/jamanetworkopen.2023.36678.

LEGISLATIVE SESSION – ESTIMATES NOTE

J-05

Drug Shortages

Topic: The Ministry of Health continues to manage impactful and high-profile shortages, including the recent semaglutide (Ozempic) and other GLP-1 agonists shortages.

Key Messaging and Recommended Response:

- **Since fall 2023, Semaglutide (Ozempic) and other GLP-1 agonists have been experiencing significant supply constraints due to high global demand and overall supply constraints.**
    - **The manufacturer updated their shortage report for the 1mg pen on January 17, 2024, to indicate the shortage has been resolved.**
    - **However, ordering restrictions remain in place for pharmacies, meaning there may still be challenges getting enough supply to meet demand.**
    - **The manufacturer launched a new format of the 0.25mg/0.5mg pen as an effort to increase overall supply of this dosage format. This pen also has ordering restrictions in place. The shortage for this dosage form is anticipated to resolve March 31, 2024.**
- **The Ministry of Health remains committed to ensuring diabetes patients in BC have access to the medication they need.**
- **We released temporary coverage of the drug Trulicity, which is similar to Ozempic, on September 30th.**
    - **To switch prescriptions to Trulicity, patients can visit their local pharmacist. Pharmacists in BC can now adapt most prescriptions.**
- **The Ministry works collaboratively with Health Canada and other provinces and territories, as well as drug manufacturers and health care practitioners, to respond to drug shortage issues as they occur.**

CURRENT SITUATION

As of January 26, 2024, there are 1,854 actual shortages reported in Canada. Out of these, 29 are currently considered critical and 650 are impacting PharmaCare benefits in BC.

Ozempic and other GLP-1 agonist shortages:

- In spring 2023, the Ministry promptly responded to BC internet pharmacies supplying Ozempic to US residents through a new Drug Schedules (Limits on Sale) Regulation under the *Pharmacy Operations and Drug Scheduling Act* on April 19, 2023. This regulation was implemented to enforce specific conditions on the sale of semaglutide by pharmacies in BC.

- In late August 2023, shortage of the 1mg format of Ozempic was reported due to an increased global demand and limited production capacities from the manufacturer.
- PharmaCare released temporary coverage of dulaglutide (Trulicity) on September 30, 2023. Coverage will be removed February 13, 2024. Tirzepatide (Mounjaro), a GIP and GLP-1 receptor agonist, was launched in November 2023 which has not yet had a listing decision by PharmaCare.
- Both alternatives are expecting shortages throughout early 2024 due to high global demand.
- PharmaCare did not release full coverage for the lower strength pen as there was not enough supply of the lower dose pen to accommodate patients on the 1mg pen.
- The manufacturer updated their shortage reports on October 30, 2023, to indicate that both Ozempic pens will experience intermittent supply delays until March 31, 2024.
- Recommendations while Ozempic and other GLP-1 agonists are in shortage were published on Health Canada's (HC) website on December 6. Key recommendations for prescribers include do not start new patients, unless there are no suitable alternatives and there's a clinical reason to do so, consider prescribing an alternative drug, and conserve existing supply for patients who are stabilized and have no other treatment options. There were no recommendations specifically addressing using for weight loss off-label.
- The Canadian Pharmacists Association in collaboration with medSask, developed resources to provide guidance for managing this shortage. Supply information has been posted on Health Canada's website for the public. Updates were posted on the BC drug shortages webpage.
- The manufacturer resolved their 1mg pen shortage on January 17, 2024. The manufacturer launched a new format of the 0.25mg/0.5mg dose pen in January 2024 to increase supply.
- HC is actively monitoring the shortages and engaging manufacturers around future supplies.

FINANCIAL IMPLICATIONS

Between September 30 to December 31, 2023, PharmaCare has spent over $928,000 on dulaglutide since releasing coverage.[1]

KEY BACKGROUND

- Shortages occur when a drug manufacturer is not able to supply enough of a drug to meet all of its orders on time.
- Drug manufacturers are required to publicly report actual and anticipated drug shortages and discontinuations on www.drugshortagescanada.ca.

Provincial Work

- The Ministry coordinates actions and information flow between stakeholders during a shortage.
- The Ministry maintains a drug shortages webpage which provides up-to-date information about drugs covered by PharmaCare that are in short supply at BC community pharmacies, including any temporary replacement or alternate products that PharmaCare covers during the shortage. However, the list does not include shortages of drugs PharmaCare does not cover nor hospital drugs. Health Insurance BC manages the web page for the Ministry.
- BC participates in drug shortages task groups/committees to identify and develop strategies to manage drug shortages. The different task groups/committees include:
    - The Federal/Provincial/Territorial (FPT) ADM Drug Shortages Table and the FPT Drug Shortages Task Force were created April 2020 to address COVID-19 drug supply issues.
    - As of April 2021, BC began a two-year term as the chair of Provincial/Territorial Drug Shortages Task Team (PT DSTT) and as the co-chair of the Multi-Stakeholder Steering Committee on Drug Shortages (MSSC). There is work underway to establish a permanent unit for BC to continue in these roles.
        - The MSSC addresses drug shortages at the national level by providing a forum to discuss shortages of concern, shortage mitigation and prevention measures, and overarching

[1] PharmaNet, Healthideas, Health Sector Information, Analysis and Reporting, February 12, 2024

policy issues related to shortages. Membership includes industry associations, FPT governments, health professional associations and patients.
    - The PT DSTT helps identify, prevent, alleviate, and resolve drug shortage situations that have a significant effect on public health and impact on patients. The chair engages with HC's Drug Shortages Unit to discuss shortages that require active case management.
  - The BC Pharmaceutical Supply Chain Subcommittee is responsible for developing and maintaining a single BC Health Authority drug formulary. Meetings include discussion of backorders of concern and allocations of drugs in shortage in BC hospitals.

At the Federal Level

- During a drug shortage, HC works with drug supply chain stakeholders to determine the details of the shortage, coordinate information sharing, and identify collaborative mitigation strategies.
- HC has tools and strategies available to mitigate shortages, including:
  - working with manufacturers to review alternate suppliers, changes or expedition in manufacturing processes;
  - allowing good manufacturing practice flexibilities, like shelf-life extension;
  - allowing exceptional importation of foreign authorized product;
  - regulations prohibiting the bulk export of drugs if they will cause or worsen a shortage in Canada;
  - providing priority access to non-marketed alternatives on an emergency basis via the Special Access Program.

LAST UPDATED

The content of this estimates note is current as of February 5, 2024, as confirmed by Susan Bouma.

APPROVALS

2024 02 05 – Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division
2024 02 09 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2024 02 12 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE

J-06

Drugs for Rare Diseases

Topic: Overview of PharmaCare's Expensive Drugs for Rare Diseases process, and BC's involvement in implementing a national strategy aimed at addressing the accessibility, evidentiary and sustainability challenges associated these therapies.

Key Messaging and Recommended Response:

- **Our government recognizes the importance of ensuring that British Columbians have access to the medications they need to manage rare conditions.**
- **The BC Expensive Drugs for Rare Diseases (EDRD) process is an important step in improving access to high-cost drugs that treat rare conditions for those who need them most.**
- **EDRDs are considered non-benefits, but some drugs and patients may be eligible for coverage on a case-by-case basis for eligible patients who meet specific criteria.**
- **EDRDs are generally associated with limited clinical information about both the disease and treatment. Because of this, therapies must be carefully reviewed to ensure that the medication is effective for each person being treated.**
- **This means that patients can have confidence that they are receiving treatments that have been thoroughly evaluated and deemed safe and effective.**
- **EDRDs are drugs that cost more than $100,000 per patient per year to treat diseases that have an incidence rate of less than 1.65 per 100,000 population.**
- **Drug manufacturers are increasingly setting very high prices for drugs that treat more prevalent conditions, with incidence rates as high as 25 per 100,000.**
- **Before an EDRD can be considered for exceptional funding on a case-by-case basis, it must undergo the same thorough review as other PharmaCare drugs, but with an additional EDRD patient review process.**
    - **The BC-level review ensures that the PharmaCare program remains fair, effective and sustainable. At the end of the review, the Ministry decides which eligible drugs and indications are to be considered for case-by-case funding.**
- **Following the March 2023 announcement of the National Strategy for Drugs for Rare Diseases, BC, along with federal, provincial, and territorial partners, are**

continuing to advance the development of bilateral funding agreements that will improve patient access to drugs for rare diseases across Canada.

CURRENT SITUATION

- The Ministry's Expensive Drugs for Rare Diseases (EDRD) process has approximately 500 active beneficiaries, each receiving funding of between $100,000 and $1 million annually. At list price, EDRD expenditures in 2023/24 are projected to be approximately $180 million, an 80 percent increase from the year prior.
- Notable cost drivers include:
  - More EDRDs being considered for funding under the process (32 drugs are currently covered, an increase from 24 drugs the year prior)
  - Growing uptake of high patient-volume EDRDs
    - Trikafta: 215 people with cystic fibrosis receive Ministry coverage for Trikafta; Trikafta costs about $300,000 per patient per year
    - Tafamidis (brand names Vyndaqel, Vyndamax): as of January 23, 2024, 112 EDRD patients are funded for tafamidis (up from 70 at the end of FY 22/23)
  - Routine provincewide newborn screening for spinal muscular atrophy (SMA), introduced in fall 2022, resulting in more SMA diagnoses and eligibility for the one-time $2.9-million treatment, Zolgensma.
- The Ministry is active in discussions with its federal, provincial, and territorial (FPT) counterparts in developing a National Strategy for Drugs for Rare Diseases (NSDRD) since it was announced by the federal government in March 2023.

FINANCIAL IMPLICATIONS

- EDRD expenditures were $100 million in 2022/23[1] and are on track to be approximately $180 million in 2023/24[2].
- Expenditures in the previous three fiscal years were $46.6M, $36.2M and $32.1M. [3]
- These costs do not reflect any confidential pricing agreements between the Ministry and drug manufacturers, which can result in lower costs for certain drugs.

KEY BACKGROUND

EDRD

- EDRDs are drugs that cost more than $100,000 per patient per year to treat diseases that have an incidence rate of less than 1.65 per 100,000 population.
- Drug manufacturers are increasingly setting very high prices for drugs that treat more prevalent conditions, with incidence rates as high as 25 per 100,000.
- The EDRD process and the decisions it makes have ethical, clinical, and financial implications, particularly considering disease rarity (a relatively small number of BC residents directly benefit from funding), often-limited clinical evidence in support of available therapies, and high per-patient costs.
- The list of Ministry-funded EDRDs continues to grow, and 5 drugs were added in FY 2023/24: tafamidis (Vyndamax), givosiran (Givlaari), triheptanoin (Dojolvi), sebelipase alfa (Kanuma) and mecasermin (Increlex). In addition, criteria for Trikafta expanded to include children 2 years of age and older.
- In making case-by-case EDRD funding decisions, the Ministry considers advice from the arm's-length EDRD advisory committee and its 8 subcommittees:
  - The advisory committee is composed of expert clinicians in pediatrics, critical care and pharmacy, as well as professionals in health economics and ethics. The Provincial Health Services Authority (PHSA) provides administrative oversight

[1] PHSA EDRD expenditure invoices
[2] MoH EDRD financial forecasting
[3] PHSA EDRD expenditure invoices

  - The subcommittees and/or advisory committee evaluate funding requests and makes funding recommendations to the Ministry
  - The committees' evaluation considers factors such as: coverage criteria, natural disease history, clinical evidence, drug efficacy, alternative treatment options, patient history and disease details, expected treatment outcome, consequences of withdrawing or not providing funding, pharmacoeconomic factors, cost, clinical guidelines and ethics
- Since April 2016, the Ministry has partnered with the PHSA to administer the EDRD process.

NSDRD

- In March 2023, the federal government announced the NSDRD and committed to investing up to $1.5 billion over 3 years to improve access to drugs, screening, and early diagnosis for rare diseases across the country.
- This funding will help provinces and territories improve access to new and emerging drugs for Canadians with rare diseases, as well as support enhanced access to existing drugs, early diagnosis and screening for rare diseases.
- In addition, the federal government is also investing $68 million for various initiatives to support collaborative governance, data infrastructure, and research for drugs for rare diseases, which will help improve consistency of access to drugs for rare diseases across the country.
- Currently, Heath Canada and PTs are working to identify a set of new and emerging EDRDs that will be cost-shared and covered in a consistent way across the country.
- BC supports the NSDRD and its aim of achieving Canada-wide consistency in access to drugs for rare diseases.

LAST UPDATED

The content of this estimates note is current as of February 9, 2024, as confirmed by Tijana Fazlagic.

APPROVALS

2023 02 13 – Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division
2024 02 14 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 15 – Brenda Rafter obo Rob Byers. Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

J-07

Free Prescription Contraception Coverage

Topic: In recognition of the right of BC residents to make and implement informed choices about their sexual and reproductive health, effective April 1, 2023, contraception is free for all BC residents with active MSP coverage.

Key Messaging and Recommended Response:

- **Everyone should be able to make their own choices about their reproductive health without being limited or burdened by cost.**
- **That is why, effective April 1, 2023, more than 60 commonly used birth-control methods, including oral contraceptives, copper and hormonal intrauterine devices (IUDs), hormonal injections and the morning-after pill are free to people in BC.**
- **To further improve access to contraceptives, pharmacists can also prescribe for contraception as of June 1, 2023.**
- **Between April 1, 2023, and January 31, 2024, more than 208,000 people received free contraceptives[2].**
- **BC is the first and only province in Canada to provide universal free contraceptives to all residents.**

CURRENT SITUATION

- Since April 1, 2023, contraception is free for all BC residents with active MSP coverage.
- As of June 1, 2023, pharmacists in BC can prescribe for contraception.
- The Ministry transitioned all current prescription contraceptive products listed on PharmaCare formularies, including oral contraceptives, hormonal IUDs, an injection, an implant, and emergency oral contraceptives ('morning after pill'), to Plan Z (Assurance), which provides 100% coverage to BC residents. At the same time, PharmaCare added copper IUDs as a new benefit under Plan Z.
- Effective June 26, 2023, PharmaCare provides three months of exceptional Plan Z coverage for contraception to BC residents who have completed MSP two-step enrolment and are in the wait period for active MSP coverage.
- On August 3, 2023, Haloette, a vaginal ring, was added to the Plan Z formulary.
- To access 100% contraceptive coverage, residents need to obtain their contraceptives from a pharmacy. They can present their prescription at a pharmacy along with their BC Services Card. The pharmacist will bill PharmaCare directly and cannot charge patients for dispensing, assessment or any other action associated with filling the prescription.
- However, if a prescription is for a brand name product, it may not be fully covered. If a patient is taking a brand name contraceptive and PharmaCare covers the generic alternative, then PharmaCare will cover 100% of the cost of the generic alternative and the patient will be responsible for the difference. For 100% coverage, the patient can request that the prescriber or pharmacists change their prescription to the generic alternative. Covered generics are as effective and safe as their brand name counterparts.

- The Ministry is working with clinics that provide sexual health testing, such as Options for Sexual Health and Foundry, to support their clients to access free contraceptives. In the meantime, the public can access free contraceptives through a community pharmacy.

FINANCIAL IMPLICATIONS

- In FY 2022/23, PharmaCare paid $3.36 million in drug cost and dispensing fees for contraceptives (including $2.04 million on hormonal contraceptives[1] and $1.14 million on IUDs)[2].
- Government Financial Information

- Budget 2023 dedicated $119 million over three years making contraceptives free[4].
- The forecast spending for FY 2023/24 is $36.2 million[5].

KEY BACKGROUND

- Offering free prescription contraception to all BC residents supports a range of population health benefits.
- Cost has been identified as the main barrier to accessing prescription contraception in BC.
- Effective April 1, 2023, the Ministry transitioned all current prescription contraceptive products listed on PharmaCare formularies to Plan Z, which provides 100% coverage to BC residents.
- In December 2021, the Nexplanon contraceptive implant was added as a regular benefit under PharmaCare.
- Any product available through PharmaCare is reviewed for safety and efficacy; review of an expanded range of contraceptive products may take longer than other implementation activities.
- Planning is underway within the Ministry to strengthen equitable access to contraception-related health services, to align the provision of free prescription contraception with the Minister's Mandate Letter on addressing systemic racism in the health care system, and to align with the principles of anti-racism set out in the Ministry of Health's 2022/23 to 2024/25 and 2023/24 to 2025/26 Service Plans.

LAST UPDATED

The content of this estimates note is current as of February 28, 2024, as confirmed by John Capelli.

APPROVALS

2024 02 15 – Brenda rafter obo Rob Byers, Finance and Corporate Services Division
2024 02 16 – Meaghan Thumath, Strategy, Planning and Evaluation Branch, Population and Public Health Division
2024 02 16 – Maryna Korchagina, Population and Public Health Division
2024 03 01 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 03 01 - Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division

1 This includes hormonal pills and injections.
[2] PharmaNet database. Health Sector Information, Analysis and Reporting. Extracted February 13, 2024.
[3] PharmaNet database. Health Sector Information, Analysis and Reporting. Extracted February 12, 2024.
[4] Budget 2023 takes action on issues that matter most | BC Gov News
[5] PharmaNet database. Health Sector Information, Analysis and Reporting. Extracted February 28, 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE

J-08

Minor Ailments

Topic: Updates on pharmacists assessing and prescribing for minor ailments and contraception.

Key Messaging and Recommended Response:

- **On June 1, 2023, the Province expanded the scope of practice for pharmacists, enabling them to prescribe for 21 minor ailments and for contraception, while simultaneously launching the Minor Ailments and Contraception Service (MACS) to support the expanded scope.**
- **Between June 1, 2023 and January 31, 2024, more than 210,000 people in BC have used the new service.**
- **Enabling pharmacists to prescribe for minor ailments and for contraception is expected to reduce patient volumes at emergency departments and primary care clinics, as these patients can now get the care they need faster and easier by visiting their local pharmacy.**
- **The top 5 reasons people are seeing a pharmacist are for uncomplicated urinary tract infections, contraception, pink eye (conjunctivitis), herpes labialis (cold sores) and allergic rhinitis.**
- **As of January 31, 2024, 90% of community pharmacies and 73% of active pharmacists in BC are providing the new minor ailments and contraception service.**

CURRENT SITUATION

- Rapid and positive uptake of Pharmacists Prescribing for Minor Ailments and Contraception (PPMAC) was seen with more than 210,000 patients accessing the service between June 1, 2023 and January 31, 2024. 90% of community pharmacies and 73% of active pharmacists in BC have participated in providing the service.[1]
- The top 5 conditions for PPMAC have remained broadly consistent since launch. As of January 31, 2024, the most common conditions were 1) uncomplicated urinary tract infections, 2) contraception, 3) conjunctivitis, 4) herpes labialis (cold sores), and 5) allergic rhinitis.[2]
- Between June 29, 2023 and January 31, 2024, 19,891 appointments have been made on the provincial booking system.[3]
- Sharing of clinical documentation between pharmacists, physicians, other healthcare professionals, and PharmaCare remains a challenge, and feasibility of options such as CareConnect is being explored.

[1] PharmaNet, Health Sector Information, Analysis, and Reporting Division, April 12, 2024.
[2] PharmaNet, Health Sector Information, Analysis, and Reporting Division, April 12, 2024.
[3] BC Pharmacy Association, April 12, 2024.

- Program evaluation activities are underway to assess the impact of PPMAC and ensure quality of care by pharmacists. This includes a patient survey that will launch by June 2024 to better understand patients' experiences in accessing PPMAC, and a pharmacist survey to identify ongoing barriers when providing care.

FINANCIAL IMPLICATIONS

- Between June 1, 2023 and January 31, 2024, over 263,000 eligible MACS claims were submitted, resulting in an estimated $5.27 million PharmaCare-paid fees.[4]
- The Ministry of Health contracted the BC Pharmacy Association and the University of BC's Continuing Pharmacy Professional Development to provide supporting educational resources at no cost to pharmacists. This resulted in funding of $765,000 to BCPhA over 4 years (2022/23 to 2025/26) and $605,500 to UBC over 3 years (2022/23 to 2024/25).
- Cost for evaluation to date include an estimated $170,000 in funding to BC Stats over 2 years (2023/24 to 2024/25) to implement a patient survey.

KEY BACKGROUND

- In June 2023, the Ministry worked with the College of Pharmacists of BC to enable pharmacists prescribing for 21 minor ailments and contraception. Amendments to the *Pharmacists Regulation* outline the expanded scope and specify the drug categories pharmacists are authorized to prescribe for each listed ailment. The College of Pharmacists of BC set out standards, limits, and conditions for making a diagnosis and prescribing under the bylaws of *Health Professions Act*.
- The 21 minor ailments included are: acne, allergic rhinitis, conjunctivitis, dermatitis, dysmenorrhea, dyspepsia, fungal infections, gastroesophageal reflux disease, headache, hemorrhoids, herpes labialis, impetigo, musculoskeletal pain, nicotine dependence, oral ulcers, oropharyngeal candidiasis, shingles, threadworms or pinworms, uncomplicated urinary tract infection, urticaria and vaginal candidiasis.
- The implementation team held broad stakeholder engagement sessions with pharmacy operators, independent pharmacy owners, patients, patient advocacy groups, the First Nations Health Authority, regulatory bodies of health professionals, professional associations, and others.
- PharmaCare pays pharmacies $20 for each MACS provided to eligible patients. The MACS fee is included in the $78 PharmaCare maximum daily limit. PharmaCare does not reimburse a medication review service claim and a MACS claim for the same patient if both are conducted on the same day. PharmaCare does not reimburse pharmacies for dispensing fees when they prescribe medications for daily and/or frequent dispensing.

LAST UPDATED

The content of this estimates note is current as of April 15, 2024, as confirmed by Susan Bouma.

APPROVALS

2024 04 12 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 04 16 – Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division
2024 04 17 - Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

[4] PharmaNet, Health Sector Information, Analysis, and Reporting Division, April 12, 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE

J-09

Out-of-Country Sale of Drugs

Topic: The Patented Medicines Price Review Board protects Canadians by ensuring that the prices of patented medicines sold in Canada are not excessive. On the other hand, the United States (US) does not have the measures to regulate drug prices and is turning to Canada for access to cheaper drugs.

Key Messaging and Recommended Response:

- **The US is turning to Canada for cheaper drugs. Unlike the US, Canada has measures in place to regulate drug prices.**
- **Allowing drugs that were intended for Canadians to be exported to the US could have major consequences on patients here with shortages of drugs that are used to treat conditions such as HIV/AIDS, diabetes, Hepatitis C, and mental illness, to name a few.**
- **We know that Canadian drug manufacturers want to safeguard our drug supply. Health Canada is closely monitoring the situation, but we need the federal government to send a strong message to the US that they are going to protect Canadian drugs.**
- **The Ministry of Health is committed to ensuring that drug supply is protected for British Columbians.**
- **An example of our steadfast commitment is the action we took on the diabetes drug semaglutide (Ozempic) last spring.**
- **We enacted new regulations to curb the sale of semaglutide to non-Canadians after we saw a concerningly high percentage of medication dispenses being purchased by US patients from pharmacies located in BC.**
- **Through the Drug Schedules (Limits on Sale) Regulation which came into effect on April 19, 2023, BC residents and other Canadian citizens and permanent residents can buy semaglutide drugs (Ozempic, Rybelsus and Wegovy) through BC pharmacies, in-person and online. Others can only purchase the drug in-person at a pharmacy.**
- **Prior to the new regulation coming into force, the monthly number of semaglutide (Ozempic) dispenses to people with US addresses increased from 378 in January 2021 to 12,753 in March 2023.**

- **Since the regulation was enacted, the monthly average has been 27, constituting a reduction of 99.8% from March 2023.**

CURRENT SITUATION

- Canada has measures in place to regulate drug prices with the Patented Medicines Price Review Board, which protects Canadians by ensuring that the prices of patented medicines sold in Canada are not excessive.
- The US is turning to Canada for access to cheaper drugs as they don't have measures to regulate drug prices. The US drug market is nearly 10 times bigger than the Canadian market.
- On January 5, 2024, the US Food and Drug Administration (FDA) announced its approval of Florida's Agency for Health Care Administration's drug importation program, a pathway facilitating Florida's importation of certain prescription drugs from Canada.
- The program's purpose is to address high drug prices in the US. It is estimated that the program could save taxpayers up to $150 million annually once fully implemented. Several other states have importation program proposals seeking FDA approval.
- Canada's Food and Drug Regulations prohibit Drug Establishment Licence holders (i.e., drug manufacturers, wholesalers and distributors), from distributing Canadian drugs for consumption or use outside Canada if there are reasonable grounds to believe that doing so could cause or worsen a drug shortage.
- Following the FDA announcement, Health Canada issued a reminder to Drug Establishment Licence holders of their obligations under the Food and Drug Regulations. Health Canada is actively monitoring the Canadian drug supply and continues to ensure that Canadians have access to the drugs that they need.[1]
- Ozempic® is an injectable prescription drug designed to treat type 2 diabetes mellitus. In BC, from January 1 to April 18, 2023, 15% of Ozempic dispenses were sold to people with addresses in the US, whereas the average of dispenses of other drugs sold to people with addresses in the US is 0.4%.[2]
- An analysis of dispenses of Ozempic from BC pharmacies to patients located in the US from January 1 to April 18, 2023, shows that 95% were prescribed by one or more prescribers licensed by the College of Physicians and Surgeons of Nova Scotia[3].
- From January 1 to April 18, 2023, only 1% of dispenses were prescribed by prescribers licensed by the College of Physicians and Surgeons of BC, with the remaining dispenses prescribed by prescribers from other licensing bodies within Canada.[3]
- On April 19, 2023, the new Drug Schedules (Limits on Sale) Regulation under the *Pharmacy Operations and Drug Scheduling Act* was enacted to impose conditions on the sale of semaglutide by pharmacies in BC. Through this new regulation, BC residents and other Canadian citizens and permanent residents can buy Ozempic through BC pharmacies, in-person and online. Others can only purchase the drug in-person at a pharmacy.
- Currently, the new regulation only includes semaglutide drugs (i.e., Ozempic, Rybelsus, and Wegovy), but other drugs can be added if there are supply issues.
- Prior to the new regulation coming into force, the monthly number of semaglutide (Ozempic) dispenses to people with US addresses increased from 378 in January 2021 to 12,753 in March 2023; since the regulation was enacted, the monthly average has been 27, constituting a reduction of 99.8% from March 2023.[4]
- On August 18, 2023, NovoNordisk published a national drug shortage report for Ozempic 1 mg[5]. This is due to a temporary delay in shipments and delivery, global supply constraints and increased demand for the product. The shortage has been resolved on January 17, 2024.

[1] Statement from Health Canada on FDA decision on Florida bulk drug importation plan - Canada.ca
[2] PharmaNet, Health Sector Information, Analysis and Reporting Division, February 16, 2024
[3] PharmaNet, Health Sector Information, Analysis and Reporting Division, February 16, 2024
[4] PharmaNet, Health Sector Information, Analysis and Reporting Division, February 16, 2024
[5] Drug Shortage Report for OZEMPIC (drugshortagescanada.ca)

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- Semaglutide is an injectable prescription drug designed to treat type 2 diabetes mellitus. Under the brand name Ozempic, semaglutide has been approved by Health Canada for the treatment of type 2 diabetes mellitus in adults.
- Semaglutide under the brand name Wegovy® has been approved by Health Canada for chronic weight management in adult patients.
- One of the side effects of Ozempic is weight loss; it has gained popularity as a weight loss medication due to extensive social media coverage. As a result of the social media coverage and heavy marketing, demand for Ozempic has driven shortages of the drug in the US.[6]
- PharmaCare currently provides Limited Coverage for Ozempic for the treatment of type 2 diabetes mellitus through Special Authority.
- Under existing provincial and federal legislation, BC pharmacies are legally permitted to fill prescriptions for patients written by US doctors if they are co-signed or re-written by a Canadian practitioner.
- On March 18, 2023, Drug Shortages Canada posted a notice of a short-term supply shortage of Ozempic 1 mg.[7] A shortage was not reported in BC at that time.
- On March 28, 2023, the Minister of Health ordered the following immediate actions to prevent an Ozempic shortage in BC:
    - Expedite the amendment of the current regulation to limit the sale or dispense of Ozempic to non-Canadian residents;
    - For the College of Pharmacists of BC to ensure that pharmacies dispensing Ozempic are complying with all clinical dispensing practices;
    - For the College of Physicians and Surgeons of BC to ensure physicians prescribing Ozempic are complying with the approved indication of the drug and that they meet all clinical practice requirements for prescribing.
    - The Minister also requested that the College of Physicians and Surgeons of Nova Scotia initiate an investigation into the exceptionally high number of out-of-province prescriptions for Ozempic emanating from Nova Scotia practitioners for dispense in BC and take action to address this issue. The license of the physician identified as having written thousands of Ozempic prescriptions dispensed in BC has been temporarily suspended.
    - The Minister also requested that then-federal Minister of Health, the Honourable Jean-Yves Duclos, review the Food and Drug Regulation under the *Food and Drug Act* in collaboration with provincial health ministers to address the concerning number of Ozempic prescriptions emanating from practitioners in one province.

LAST UPDATED

The content of this estimates note is current as of February 12, 2024, as confirmed by John Capelli

APPROVALS

2024 02 15 – Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division
2024 02 16 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division

[6] Ozempic shortage: Diabetes drug is being used for weight loss | CTV News
[7] Drug Shortage Report for OZEMPIC (drugshortagescanada.ca)

LEGISLATIVE SESSION – ESTIMATES NOTE

J-10

PharmaCare's Response to the Opioid Overdose Crisis

Topic: Rising number of unintended overdose deaths due to the toxic street opioid supply.

Key Messaging and Recommended Response:

- **We know one of the most important ways to save lives during this ongoing public health emergency is to separate people from the toxic illicit drug supply.**
- **Opioid Agonist Treatment (OAT) is recognized as a first-line evidence-based treatment for opioid use disorder (OUD).**
- **Increasing the number of people with OUD who are engaged and retained in OAT is a key priority in the provincial response to the toxic drug crisis.**
- **We expanded coverage for existing OAT benefit drugs including methadone, buprenorphine/naloxone, Sublocade® (extended-release injectable buprenorphine) and slow-release oral morphine by including them into Plan Z (Assurance) for all BC residents.**
- **In March 2020, at the start of the COVID-19 public health emergency, the province implemented prescribed safer supply in BC and expanded it in July 2021, the first province in Canada to do this.**
- **Prescribed alternatives to the toxic supply are a critical part of the broader continuum of care and the treatment of addiction as a health issue.**

CURRENT SITUATION

- Unintended overdose deaths due to the toxic street opioid supply have reached historical levels, with 7.2 people dying daily according to the BC Coroner's latest statistics as of December 2023, mainly because of street opioids being laced with the extremely potent opioid fentanyl and its analogues.[1] This increase began in 2016 and has risen to unprecedented levels over the past couple of years.
- The Pharmaceutical, Laboratory and Blood Services Division (PLBSD) has expanded coverage for existing OAT benefit drugs including methadone, buprenorphine/naloxone, extended-release injectable buprenorphine and slow-release oral morphine by including them in Plan Z (Assurance) for all BC residents as of June 6, 2023. Plan Z is a no deductible, 100% coverage plan and improves access to OUD treatment as it reduces the cost of treatment for individuals not already part of a 100% coverage plan such as Plan C (Income Assistance) or Plan G (Psychiatric Medications). All residents of BC with active Medical Services Plan (MSP) coverage are eligible for Plan Z. Exceptional Plan Z coverage is available to bridge coverage gaps for people living in BC not yet enrolled or in the wait period for MSP.
- PLBSD has improved access to evidence-supported OAT treatment extended-release injectable buprenorphine (Sublocade®) by expanding coverage from Limited Coverage to regular benefit, meaning Special Authority is no longer required as of March 14, 2023.

[1] Unregulated Drug Deaths in BC, posted January 24, 2024; accessed February 13, 2024
https://www2.gov.bc.ca/gov/content/life-events/death/coroners-service/statistical-reports

- PLBSD has also responded by actively assisting with access to prescribed alternatives to the toxic supply (PA) that support people who use street drugs, to separate them from the toxic supply in an effort to reduce overdose deaths. Coverage has been expanded for PA as part of the Prescribed Safer Supply (PSS) policy.
- In August 2021, fentanyl patch and buccal tablets were added as Limited Coverage with criteria of reducing risk of harm from the toxic street drug supply. Both fentanyl products and sufentanil became available for coverage under Plan G to recognize substance use disorder as a mental health condition. Sufentanil is an injectable fentanyl-type PA. Protocols for PSS Sufentanil and Fentora were published by the BC Centre on Substance Use (BCCSU) in August 2023, after review by PLBSD.
- Coverage has expanded for drugs outlined in the BCCSU's Risk Mitigation in the Context of Dual Public Health Emergencies (RMG); the opioid option hydromorphone 8mg tablets were added to the Plan G (Psychiatric Medications) formulary to allow for substance use coverage.
- PLBSD has been pivotal in encouraging a Canadian pharmaceutical manufacturer to develop a domestic supply of injectable diacetylmorphine (DAM). Health Canada approved this product in February 2022, and the Supply Agreement with Provincial Health Services Authority and Pharmascience was signed August 2022. This agreement has since been terminated and a new Supply Agreement between the Ministry of Health and Pharmascience was signed November 2023. This will expand access to DAM as an evidence-based treatment for substance use disorder.
- PLBSD pharmacists work closely with members of the Overdose Emergency Response Centre in Ministry of Mental Health and Addictions to proactively respond to emerging needs of those at risk of harm from the street supply.
    - Current active work involves facilitating access to a compounded smokeable opioid option, e.g. fentanyl compounded capsules, as 78% of those that reported fentanyl use prefer smoking to injecting their drug.[2]
- PLBSD pharmacists are actively involved in planning the implementation and monitoring/evaluation of PA. PLBSD pharmacists have assisted Health Sector Information, Analysis & Reporting Division in updating the OAT and PA reporting algorithm.
- PLBSD pharmacists are monitoring the national supply of opioids used for PA to ensure supply is available as patient numbers increase and opioid options expand.
- PLBSD pharmacists are working with clinicians, people who use drugs, other government groups, and the regulatory Colleges as needed to lower or remove barriers to access PA for patients.

FINANCIAL IMPLICATIONS

- PharmaCare spend on OAT products for opioids in 2022/23 was $86.45M for over 27,000 beneficiaries.[3]
- PharmaCare spend on PA products, including opioids, stimulants and benzodiazepines in 2022/23 was $14.22M for over 7,600 beneficiaries.[3]
- The two-year agreement between Pharmascience and Ministry of Health costs $12.49M over two years.

KEY BACKGROUND

- Fentanyl or one of its more potent analogues such as carfentanil was detected in 83% of illicit drug toxicity deaths in 2023.[1] The high potency of fentanyl and analogues makes small amounts lethal if the user is not tolerant to that level due to prolonged use.
- OAT is recognized as a first-line evidence-based treatment for OUD. The BCCSU updated the Guideline for the Clinical Management of OUD in November 2023.
- In March 2020, the BCCSU published RMG, which outlined ways to support people who used the street drug supply to mitigate their risks during COVID-19. The guidance included the provision of prescription

[2] 2021 BC Harm Reduction Client Survey, Accessed February 13, 2024
http://www.bccdc.ca/resource-gallery/Documents/Statistics%20and%20Research/Statistics%20and%20Reports/Overdose/2021%20-%20BC_Overall_HR%20Survey%20%28Apr%2020%29.pdf

[3] PharmaNet, HealthIdeas, Health Sector Information, Analysis and Reporting Division. Extracted March 20, 2024.

opioids e.g. hydromorphone 8mg tablets to opioid users so that they did not have seek out a street supply during times of self-isolation/quarantine.

- While there was some success with the use of hydromorphone tablets, it was identified that for many people other opioid options needed to be made available to help separate them from the toxic street supply. As a result, PSS was developed with the support of BC Provincial Health Officer Dr. Bonnie Henry.
- In July 2021, BC's PSS policy went into effect, opening the door to the provision of medical-grade opioid products to people who used street drugs. Fentanyl products were the first to be offered due to the high level of fentanyl in the street supply.
- On February 1, 2024, the Office of the Provincial Health Officer released A Review of Prescribed Safer Supply Programs Across British Columbia: Recommendations for Future Action. Some key recommendations are to retire the RMG, maintain tablet hydromorphone as a PA option, continue with the PSS Policy and to better operationalize access to PA by looking at smokeable formulations and supporting the medication supply chain.
- Research shows that 64% of people who use drugs prefer to smoke or inhale their drug versus inject it.[2] Very few commercial opioid products can be used in this fashion; therefore, compounded options are being sought. Compounded, pre-measured, pharmaceutical-grade fentanyl or DAM powder in capsules that can be opened is one innovative option being tried to assist with the need for smokeable products.

LAST UPDATED

The content of this estimates note is current as of March 18, 2024, as confirmed by Susan Bouma.

APPROVALS

2024 02 23 - Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2024 03 18 – Susan Bouma, Clinical Services and Evaluation Branch
2024 03 18 – Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division
2024 03 20 – Nathalie Darmon obo Christine Voggenreiter, Health Sector Information, Analysis & Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE

J-11

Provincial Retinal Diseases Treatment Program

Topic: The Provincial Retinal Diseases Treatment Program (PRDTP) operates in collaboration with the Provincial Health Services Authority (PHSA) and registered BC retinal specialists.

Key Messaging and Recommended Response:

- **The Provincial Retinal Diseases Program (PRDTP) provides treatment for approximately 25,000 BC residents annually who have irreversible, degenerative retinal diseases.**
- **The program fully reimburses multiple retinal therapies for patients eligible for treatment.**
- **33 retinal specialists participate in the program, a subspecialty of the province's approximately 240 licensed ophthalmologists.**
- **The program's retinal specialists are required to track the safety and efficacy of the treatments they administer. The PHSA uses this data to monitor drug access, safety, and efficacy and make adjustments to the program as needed.**
- **The Ministry and the PHSA continue to monitor and optimize the safety and efficacy of therapy provided through the program.**

CURRENT SITUATION

- On January 15, 2024, PRDTP retinal specialists issued the Ministry of Health and the PHSA a notice of termination of their participation in the program, effective March 31, 2024.
- The Ministry and PHSA are working to develop an interim solution to ensure uninterrupted coverage and care for PRDTP patients when the program ends. The post-interim model of coverage is actively being developed.
- The balance of this estimates note covers aspects of the program in its current (pre-April 1) state.

Potentially Contentious Issues

Retinal Specialists' Remuneration

- The retinal specialists are remunerated through both the PRDTP's program management fee (PMF) and a Medical Services Plan fee.
- The PMF compensates specialists for performing administrative activities, such as database submissions, program quality initiatives, safety and effectiveness monitoring, clinical practice guideline development (including drug utilization ratio guidance), and drug budget co-management.
- The remuneration of PRDTP retinal specialists is higher than that of any other physician group in BC, including surgical specialties and other ophthalmology subspecialties[1].

[1] BC Ministry of Health - Medical Services Commission: Financial Statement For the Fiscal Year Ended March 31, 2022. https://www2.gov.bc.ca/assets/download/016FE4A1C78A4D01B9B5165F49E50E78, PRDTP fact sheet: http://www.phsa.ca/surgical-services-site/Documents/PHSA_PRDTP_FactSheet_April2023.pdf

Glaucoma Risk

- Based on a quality review by the Ministry and the PHSA published May 2021, the benefits of the retinal treatments provided through the PRDTP outweigh the potential risks. The treatments are clinically proven to be safe, and without them, affected patients would be at a much higher risk of vision deterioration and/or blindness.

Patient Access to Specialists

- PRDTP retinal specialists are predominantly located in urban centres. The PHSA monitors geographical accessibility and patient demand and adds new retinal specialists to the program where possible to help meet demand.
- An estimated 91% of patients with the retinal diseases treated under the program are able to receive funded treatment through the PRDTP[2]. The remainder pay out of pocket or use third-party insurance to cover the treatment.

FINANCIAL IMPLICATIONS

The PRDTP treated 24,550 patients in FY 2022/23 with an expenditure of $22.6 million (of which $7.6 million was the PMF paid to program specialists). This includes drug costs, administrative work by the PHSA, and the PMF.[3]

KEY BACKGROUND

- Established in 2009, the PRDTP provides 100% coverage for bevacizumab (Avastin), ranibizumab (Lucentis), and aflibercept (Eylea) to treat 3 retinal diseases: wet age-related macular degeneration (wAMD), diabetic macular edema, and retinal vein occlusion. The program also covers verteporfin (Visudyne) with photodynamic therapy for wAMD.
- Coverage is provided only when the drugs are prescribed and administered by retinal specialists who have signed an agreement with the PHSA to participate in the program.
- The program's retinal specialists are required to track the safety and efficacy of the treatments they administer. The PHSA uses this data to monitor drug access, safety, and efficacy and make adjustments to the program as needed.
- The Ministry and the PHSA continue to monitor and optimize the safety and efficacy of therapy provided through the program. More information is available at: http://www.phsa.ca/our-services/programs-services/provincial-retinal-disease-treatment#Quality--Improvement

LAST UPDATED

The content of this estimates note is current as of February 9, 2024, as confirmed by Tijana Fazlagic.

APPROVALS

2024 02 13 – Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division
2024 02 14 – Lenore Ogilvy obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 16– Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

[2] PHSA database and PRDTP-queried MSP data
[3] Provincial Health Services Authority. Provincial Retinal Disease Treatment Program: Final Report (April 1 2022 to March 31, 2023). May 11, 2023 (unpublished)

LEGISLATIVE SESSION – ESTIMATES NOTE

J-12

Sale of Zonnic

Topic: Zonnic is a buccal nicotine pouch authorized for sale in Canada as a nicotine replacement therapy (NRT). To ensure NRTs are used for their intended purpose of aiding individuals in quitting smoking, effective February 7, 2024, the Drug Schedules Regulation was amended to reschedule buccal nicotine pouches as Schedule 2 drugs.

Key Messaging and Recommended Response:

- **Nicotine is highly addictive, and children and youth are more likely to develop nicotine dependence.**
- **Nicotine affects memory and concentration, and can alter brain development, reduce impulse control, and cause cognitive and behavioural issues in children and youth. Nicotine dependence can result in withdrawal and cause symptoms such as headaches, shakes, dizziness and feelings of anxiety or depression.**
- **Through an amendment to the Drug Schedules Regulation, buccal nicotine pouches have been regulated as Schedule 2 drugs. This means they can only be sold by pharmacies from behind the counter.**
- **Our government is committed to protecting the health and well-being of young people from the harms of nicotine addiction.**
- **Buccal nicotine pouches are taken orally and contain up to 4 milligrams of nicotine, which is equivalent to the amount of nicotine absorbed from 3 to 4 cigarettes.**
- **When used as intended, buccal nicotine pouches can be used as a nicotine-replacement therapy product to help people reduce nicotine dependency. However, public health experts have identified the concerning trend of youth using nicotine-cessation products recreationally.**
- **BC will continue to work with other provinces, territories and the federal government to ensure that nicotine-cessation products are appropriately distributed to those who need them.**

CURRENT SITUATION

- In Canada, tobacco-free nicotine health products are regulated under the *Food and Drugs Act* (FDA).
- Buccal nicotine pouches for NRT are classified as a drug-medical device combination product and are regulated as natural health products under the FDA.
- There is currently no mechanism through Health Canada's approval process to ensure NRTs are used for their intended purpose of aiding individuals in quitting smoking.

- Zonnic, produced by Imperial Tobacco Canada, is the first buccal nicotine pouch approved for sale in Canada. Health Canada's Natural and Non-Prescription Health Products Directorate authorized the sale of Zonnic as an NRT.
- Canada's Drug and Health Product Register requires tobacco-free products containing nicotine to be prescribed, but NRTs in the form of gum, lozenges, buccal pouches and inhalers containing 4 mg or less of nicotine and patches with a delivery rate of 22 mg or less of nicotine per day are exempt. This allows nicotine pouches to be sold in Canada without a prescription.
- Nicotine can cause changes in the brains of young people.[1] Furthermore, national health organizations such as the Canadian Cancer Society and Canadian Lung Association have expressed their concerns about Zonnic, and how it is being deliberately marketed to youth.[2]
- To prevent new nicotine dependency, the Drug Schedules Regulation has been amended through a Ministerial Order to reschedule tobacco-free nicotine pouches as Schedule 2 drugs.[3] As of February 7, 2024, buccal nicotine pouches (Zonnic), as well as sprays and inhalers (e.g., Nicorette® QuickMist® and Inhaler®) are sold by pharmacies only and as behind-the-counter products.
- Advice/Recommentations; Business Information

- Advice/Recommendations

- The Convenience Industry Council of Canada and Imperial Tobacco Canada have also expressed their concerns regarding the decision to limit the sale of Zonnic to pharmacies.
- The Ministry continues to consult with Health Canada for further modifications to the nicotine listing in the drug schedules.
- The rescheduling of buccal nicotine pouches will be reevaluated in 12 months, or if the federal government decides to restrict the sales of these products.
- Prior to the regulation amendment, there were no restrictions on the sale of Zonnic in BC.
- In November 2023, the federal Minister of Health, Mark Holland, said that Health Canada's processes for approving nicotine products will be rigorously reviewed.[4]

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- Nicotine is highly addictive, and children and youth are more likely to develop nicotine dependence.[5]
- Nicotine affects memory and concentration, can alter brain development, reduce impulse control, and cause cognitive and behavioural issues in children and youth.[6]
- Buccal nicotine pouches are taken orally and contain up to 4 milligrams of nicotine, which is equivalent to the amount of nicotine absorbed from 3 to 4 cigarettes.[7]
- Health Canada's recommended dose for Zonnic is 1 per day, for adults 18 years or older.
- As part of providing the Minor Ailments and Contraception Service, BC pharmacists can assess and prescribe for nicotine dependence.

[1] B.C. moves flavoured nicotine pouches behind pharmacy counters to protect youth | CBC News
[2] National health groups call on Ottawa to prevent sales of nicotine pouches to children | CBC News
[3] https://www.bclaws.gov.bc.ca/civix/content/mo/mo/1926185331/?xsl=/templates/browse.xsl
[4] 'We were duped': Health minister vows to close 'loophole' on flavoured nicotine pouches | CBC News
[5] Province takes action to prevent sale of nicotine products to youth | BC Gov News
[6] Province takes action to prevent sale of nicotine products to youth | BC Gov News
[7] Province takes action to prevent sale of nicotine products to youth | BC Gov News

- The BC Smoking Cessation Program helps BC residents of any age to stop using tobacco products.

LAST UPDATED

The content of this estimates note is current as of March 20, 2024, as confirmed by John Capelli.

APPROVALS

2024 02 22 - Maryna Korchagina, Population and Public Health Division
2024 03 21 - Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

J-13

Semaglutide for Diabetes and Weight Loss

Topic: PharmaCare coverage of Semaglutide (Ozempic) for diabetes and semaglutide (Wegovy) for weight loss

Key Messaging and Recommended Response:

- **Semaglutide (Ozempic and Wegovy) is a blockbuster drug for the Denmark based company Novo Nordisk. Total Ozempic sales in BC in 2023 was more than $239M.**
- **PharmaCare covers semaglutide (Ozempic) 1.34 mg/mL (4 mg/pen) as a Limited Coverage drug for the treatment of Type 2 diabetes (T2DM) to improve glycemic control since December 15, 2020.**
- **Ozempic has experienced worldwide shortages since 2023 because of high demand, partly due to its popularity as a treatment for weight loss.**
- **Effective February 6, 2024, PharmaCare added coverage for another Ozempic product, 0.68 mg/mL (2 mg/pen), which improves availability of product for the starting doses of Ozempic (0.25 to 0.5 mg weekly) for the treatment of T2DM.**
- **PharmaCare is currently reviewing a new Ozempic dose, 2.68 mg/mL (8 mg/pen), which allows for increasing the weekly dose to a maximum of 2 mg for control of HbA1c (the previous maximum approved dose was 1 mg per week).**
- **Ozempic is not approved by Health Canada for weight loss.**
- **Semaglutide under the brand name Wegovy has been approved by Health Canada for chronic weight management in adult patients.**
- **The Canada's Drug and Health Technology Agency (CADTH) recommended that provincial and territorial drug plans not provide coverage for Wegovy as the treatment did not evaluate improvements in or the prevention of weigh-related comorbidities such as major adverse cardiovascular events (MACE), osteoarthritis, and obstructive sleep apnea.**
- **As a result, PharmaCare does not cover Wegovy. However, on December 14, 2023, the SELECT study was published which demonstrated a 20% relative risk reduction in MACE (8% to 6.5% compared to placebo). Therefore, the coverage of Wegovy will need to be re-evaluated in the future.**

- **Wegovy is currently not available on the Canadian market due to shortage.**
- **The Ministry of Health remains committed to ensuring diabetes patients in BC have access to the medication they need.**
- **We released temporary coverage of the drug Trulicity, which is similar to Ozempic, on September 30, 2023.**
- **The Ministry works collaboratively with Health Canada and other provinces and territories, as well as drug manufacturers and health care practitioners, to respond to drug shortage issues as they occur.**
- **When we found out about the shortage of the Ozempic pens, our government took swift action.**
- **Just like we took action last spring to limit the sale of semaglutide drugs to BC residents to help protect supply for diabetes patients in our province.**

If asked about plans to get Mounjaro covered under PharmaCare:

- **Although Health Canada has approved Mounjaro for use in Canada, BC, like all public drug plans in Canada, has a rigorous and transparent drug review process to determine whether a drug should be covered through its public formulary.**

CURRENT SITUATION

- PharmaCare currently covers two semaglutide (Ozempic) products, the 0.68 mg/mL (2 mg/pen) and 1.34 mg/mL (4 mg/pen), as Limited Coverage benefits for treatment of T2DM.
- PharmaCare is currently reviewing another Ozempic product, the 2.68 mg/mL (8 mg/pen).
- PharmaCare does not cover oral semaglutide (Rybelsus), which is approved for T2DM since it has not demonstrated a reduction in reduction in cardiovascular disease (CVD) events (unlike the injectable version Ozempic).
- PharmaCare does not cover semaglutide (Wegovy), which is approved for weight loss.
- The Drug Schedules (Limits on Sale) Regulation under the *Pharmacy Operations and Drug Scheduling Act* was enacted to limit impose conditions on the sale of semaglutide by pharmacies in BC.
- Out-of-province sales of Ozempic within BC have been reduced to normal levels but there is currently a worldwide shortage of Ozempic, especially the 1.34 mg/mL (4 mg/pen) dose.

FINANCIAL IMPLICATIONS

Between January 1, 2023, and December 31, 2023, more than $239M of Ozempic was sold in BC, with a total PharmaCare expenditure of more than $39M[1]. Of note:

- The Ministry has a product listing agreement resulting in a significant discount.
- There were supply constraints in late 2023 that reduce overall semaglutide sales.

[1] PharmaNet, HealthIdeas, Health Sector Information, Analysis and Reporting Division, February 21, 2024

KEY BACKGROUND

- One of the side effects of Ozempic is weight loss. As a result of the social media coverage and heavy marketing, demand for Ozempic has driven shortages of the drug.
- PharmaCare provides coverage for Ozempic for the treatment of T2DM as a Limited Coverage benefit.
    - Currently the only glucagon-like peptide 1 (GLP1) based therapies available in Canada that have demonstrated a reduction in CVD events when used for the treatment of T2DM are semaglutide (Ozempic), liraglutide (Victoza) and dulaglutide (Trulicity).
    - Only semaglutide reached a letter of intent with the pan-Canadian Pharmaceutical Alliance.
- Under existing provincial and federal legislation, BC pharmacies are legally permitted to fill prescriptions for patients written by US doctors if they are co-signed or re-written by a Canadian practitioner.
- A Ministry of Health analysis of dispenses of Ozempic from BC pharmacies to patients located in the US from January 1 to April 18, 2023, showed that 95% were prescribed by one or more prescribers licensed by the College of Physicians and Surgeons of Nova Scotia (CPSNS).[2]
- From January 1 to April 18, 2023, only 1% of dispenses were prescribed by prescribers licensed by the College of Physicians and Surgeons of BC, with the remaining dispenses prescribed by prescribers from other licensing bodies within Canada[2].
- On March 28, 2023, the Minister of Health ordered the following immediate actions to prevent an Ozempic shortage in BC:
    - Expedite the amendment of the current regulation to limit the sale or dispense of Ozempic to non-Canadian residents;
    - For the College of Pharmacists of BC to ensure that pharmacies dispensing Ozempic are complying with all clinical dispensing practices;
    - For the College of Physicians and Surgeons of BC to ensure physicians prescribing Ozempic are complying with the approved indication of the drug and that they meet all clinical practice requirements for prescribing.
- The Minister also requested the CPSNS initiate an investigation into the exceptionally high number of out-of-province prescriptions for Ozempic written by Nova Scotia practitioners for dispense in BC. The license of the Nova Scotia physician identified as having written thousands of Ozempic prescriptions dispensed in BC has been temporarily suspended.
- The Minister also requested that then-federal Minister of Health, the Honourable Jean-Yves Duclos, review the Food and Drug Regulation under the *Food and Drug Act* in collaboration with provincial health ministers to address the concerning number of Ozempic prescriptions emanating from practitioners in one province.
- As of April 19, 2023, the new Drug Schedules (Limits on Sale) Regulation under the *Pharmacy Operations and Drug Scheduling Act* was enacted to impose conditions on the sale of semaglutide by pharmacies in BC. Through this new regulation, BC residents and other Canadian citizens and permanent residents can buy Ozempic through BC pharmacies, in-person and online. Others can only purchase the drug in-person at a pharmacy.
- Currently, the new regulation only includes semaglutide drugs (i.e., Ozempic, Rybelsus, and Wegovy), but other drugs can be added if there are supply issues.
- Prior to the new regulation coming into force, the monthly number of semaglutide (Ozempic) dispenses to people with US addresses increased from 378 in January 2021 to 12,753 in March 2023; since the regulation was enacted, the monthly average has been 27, constituting a reduction of 99.8% from March 2023[3].
- Semaglutide under the brand name Wegovy has been approved by Health Canada for chronic weight management in adult patients.
- CADTH recommended that participating drug plans not provide coverage for Wegovy because, although the drug demonstrated effectiveness in weight loss in combination with a reduced calorie diet and increased physical activity, it was not clear from the clinical trials that Wegovy treatment resulted in a

[2] PharmaNet, HealthIdeas, Health Sector Information, Analysis and Reporting Division, February 21, 2024
[3] PharmaNet, HealthIdeas, Health Sector Information, Analysis and Reporting Division, February 21, 2024

reduction in weight-related comorbidities (such as MACE, osteoarthritis, and obstructive sleep apnea) or improvement in health-related quality of life.

- As a result, PharmaCare decided not to list Wegovy. However, on December 14, 2023, the SELECT study was published which demonstrated a 20% reduction in MACE (8% to 6.5% compared to placebo). Therefore, the coverage of Wegovy will need to be re-evaluated in the future.
- Novo Nordisk has significant future plans for semaglutide, including combining it with insulin or Amylin, obtaining an indication for the treatment of metabolic dysfunction-associated steatohepatitis and Alzheimer's disease, and launching extended-release versions (weekly oral product and monthly injectable product).
- Semaglutide's closest competitor tirzepatide (Mounjaro), which is made by Eli Lilly has not yet been submitted to CADTH for review despite obtaining a Notice of Compliance for the treatment of T2DM in November 2022. However, tirzepatide is undergoing phase 3 trials for heart failure, obstructive sleep apnea, morbidity and mortality in obesity, and cardiovascular outcomes in T2DM. If Lilly's research program is successful, tirzepatide may out compete semaglutide in the coming years.

LAST UPDATED

The content of this estimates note is current as of February 14, 2024, as confirmed by Tijana Fazlagic.

APPROVALS

2024 02 20 - Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division
2024 02 22 – Christine Voggenreiter obo Martin Wright Health Sector Information, Analysis & Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE

J-14

Special Authority

Topic: The PharmaCare Special Authority (SA) program grants full benefit status to drugs, medical supplies or medical devices that otherwise would not be covered or would be only partially covered.

Key Messaging and Recommended Response:

- **Our government is committed to ensuring patients have access to the medical treatment they need through the PharmaCare Special Authority (SA) program.**
- **The SA program is designed to provide full or partial coverage to a drug or device that otherwise would not be covered or only covered partially. Coverage is provided to patients in specific medical circumstances.**
- **SA requests are made by a prescriber. Coverage is approved for patients who meet the published criteria. In exceptional circumstances, SA coverage may be provided when patients don't meet the criteria or for non-benefit items.**
- **Prescribers can submit SA requests online quicker via eForms or by fax.**
- **SA approval must be in place before a patient pays for a prescription. Coverage is not retroactive.**
- **The SA program took action to reduce the request wait-times backlog which included hiring temporary help, adding more drugs for auto-adjudication when possible, enrolling practitioners onto the eForms platform, and implementing overtime for current staff.**
- **Due to these actions, the wait-time for regular-status medication coverage requests was reduced to approximately 6 weeks as of January 2024 – it was previously 11 weeks in 2021. Urgent requests continue to be completed within 1 to 2 business days.**

CURRENT SITUATION

- The SA program currently receives up to 1,500 requests a day by eForm, fax, and phone submissions.
- As of January 30, 2024, 70% of submissions are faxed, 26% are eForms and 4% are received by phone/voice mail. Target turnaround times for urgent requests is 24 hours (1 business day), and 2 weeks for regular priority requests. The average wait time for the urgent SA phone line is 30 seconds. **Note:** Only phone calls received through the prescriber line for urgent SA requests are answered.
- Approval rate is 63% (faxes 55.3%; eForms 77.8%), with 7% (8.6% fax; eForms 4%) returning to the prescriber as Not Approved, 8% (11% fax; eForms 3%) requiring more information, and 16% (17.7% fax; eForm 12.7%) are for patients with coverage already in place for the requested medication. Coverage entry into PharmaNet by SA staff is 95+% accurate.

- The Special Authority Transformation (SAT) project began in March 2020, to improve service delivery through digitization. This has resulted in more accurate submissions from eForms with only a 3.2% return rate, and positive feedback from providers for the ease of use and improved turnaround rates.
- There were more requests received (375,311) than processed (369,488), in 2023.
- The total number of SA requests sitting in the queue is reflected in the following stats:
    - at the beginning of 2023 there were 16,946;
    - at the end of 2023 there were 18,677; and
    - as of January 31, 2024, the SAs waiting for review was at 12,968.

SAT project: eForms Platform and SalesForce Case Management System

- In collaboration with the Provincial Health Services Authority (PHSA), SA eForms were introduced on the Provincial eForms Solution platform in 2021; therefore, prescribers can submit requests online.
- eForms are far more efficient than fax and phone submissions: some fields are automatically filled (once a prescriber is enrolled); inputs are always legible; there is less room for error in inputs.
- All eligible SA medications/devices are available for request through the eForms submission system and can be adjudicated in the SalesForce case management system. Certain drugs (currently 37 medications) are automatically adjudicated, resulting in shorter wait times for patient coverage.
- As of January 30, 2024, PharmaCare has received nearly 147,000 eForm submissions from prescribers and pharmacists in both the community and health authority settings. PharmaCare has also processed over 900,000 SA drug coverage requests through the new SalesForce Case Management system. **Note:** This total includes phone, fax, and eForm submissions.
- SA requests that were processed through SalesForce since May 2021 are now records that patients can access through the Health Gateway portal, rather than contacting their prescriber or pharmacist.
- Phase 4 of the SAT project is anticipated to begin in spring 2024, to further improve this system.
- The Ministry of Health, Doctors of BC, and Health Quality BC are committed to working together to review current requirements to support accessible, high-quality care. One of the identified areas of focus is SA forms and processes. eMR integration with the eForm platform is a key priority for the project team.
- As part of this commitment and as a result of the 2022 Physician Master Agreement, in an effort to improve work efficiencies for prescribers and SA staff, the Administrative Burdens Working Group was formed with the goal of creating a number of recommendations to maximize physician resources by reducing time spent on administrative tasks.

Adjudication Timelines

- The wait time for regular-status medication coverage requests was 11 weeks in 2021, which is now reduced to approximately 6 weeks as of January 2024. Urgent requests continue to be completed within 1 to 2 business days. SA has managed the workload by:
    - hiring temporary help;
    - implementing strategies to increase productivity such as: auto-faxing confirmations to prescribers (Auto IT); using SalesForce to make workflow more efficient; and removing unnecessary steps;
    - adding more drugs for auto-adjudication when possible;
    - enrolling practitioners onto the eForms platform; and
    - implementing overtime for current staff.

FINANCIAL IMPLICATIONS

- Limited Coverage drug (LCD) expenditures for 2022/23 were $687.44 million of the total PharmaCare drug (ingredients) spend of $1.03 billion.[1]
- 67% of PharmaCare drug expenditures for 2022/23 were attributed to SA submissions.
- In 2022/2023, some more commonly prescribed medications with PharmaCare accepted claims for at least 10,000 patients (e.g. gliclazide, zopiclone and rabeprazole) ranged in price from $30 to $50 per patient excluding dispensing fees.[1]

- The top 3 most costly medications excluding dispensing fees with accepted claims for at least 10 patients are detailed below. In 2022/2023, the cost for edaravone, for amyotrophic lateral sclerosis (ALS), was $71,000 per patient; whereas the annual cost per patient of carbidopa/levodopa gel, for Parkinson's was approximately $80,000 and treprostinil, for pulmonary arterial hypertension, was approximately $88,000 per patient.[1]

KEY BACKGROUND

- If a patient is granted SA approval, PharmaCare covers the drug or device up to their plan rules. The patient must also be registered with the Medical Services Plan and a plan such as Fair PharmaCare for coverage.
- There are 312 Limited Coverage Drugs on the PharmaCare formulary.
- In 2023, 23 out of 26 new listings to the PharmaCare formulary are Limited Coverage drugs (88.46%); Since 2013, there have been 236 Limited Coverage drug listings (74.68%) out of 316 total listings, which include Limited Coverage and Regular benefit drugs.
- SA coverage may be for a limited time (i.e. 6 months to one year or indefinitely), depending on the specific drug and condition being treated.
- Currently, when a coverage decision is reached, SA informs the prescriber by fax. The patient is also updated through the Health Gateway.
- SA coverage is valid from the date approval is entered into a patient's record on PharmaNet (BC's electronic network linking the province's community pharmacies) up until the coverage expiry date. SA approval must be in place before the drug is purchased, as no retroactive coverage is permitted.
- The task of completing a SA request is considered part of a prescriber office visit. Prescribers should not be charging patients for completing SA forms**,** based on the Medical Services Commission as stated in the *Medicare Protection Act*, which is current as of March 29, 2023. (*Medicare Protection Act* (gov.bc.ca)) - General limits on direct or extra billing 17[2].

LAST UPDATED

The content of this estimates note is current as of February 9, 2024, as confirmed by Susan Bouma.

APPROVALS

2024 02 09 - Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2024 02 12 - Mitch Moneo, Pharmaceutical, Laboratory, and Blood Services Division
2024 02 14 - Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis and Reporting Division

[1] PharmaNet, Health Sector Information, Analysis and Reporting Division , February 13, 2024. Expenditures exclude Trikafta, an expensive drug for rare diseases.
[2] Ibid

LEGISLATIVE SESSION – ESTIMATES NOTE

K-01

COVID-19 Immunization Program

Topic: BC's provincial COVID-19 immunization program.

Key Messaging and Recommended Response:

- **Vaccination continues to be a key measure for protecting ourselves, our loved ones, and our communities against COVID-19.**
- **Canada's National Advisory Committee on Immunization (NACI) strongly recommends people aged 65 years and older, residents of long-term care homes and congregate living settings, Indigenous people, pregnant people, and people with underlying medical conditions receive a dose of the XBB.1.5-containing COVID-19 vaccine this viral respiratory illness season.**
- **Beginning October 10, 2023, COVID-19 vaccines became available for anyone 6 months of age and older in BC, as long as it is given 6 months after their last dose.**
- **As of March 17, 2024, 1,422,468 doses of COVID-19 vaccine have been administered during the 2023/24 (most recent) respiratory illness season, representing 55.1% of the population 65 years and older.**
- **As of March 17, 2024, 63.2% of influenza vaccine doses have been co-administered with COVID-19 vaccines this season.**
- **For spring 2024, NACI recommends that people who are at an increased risk of severe illness from COVID-19 may get an additional vaccine dose. This includes adults aged 65 years and older, residents of long-term care and other congregate living settings, and people 6 months and older who are moderately or severely immunocompromised.**

CURRENT SITUATION

- Beginning October 10, 2023, British Columbians 6 months of age or older were eligible to receive the updated formulation of the COVID-19 vaccine, which is designed to protect against the XBB.1.5 variant, if it has been 6 months since the previous dose or known SARS-CoV-2 infection (whichever is later).[1]
- For those who have never been vaccinated against COVID-19, one dose of the XBB.1.5-containing formulation of the vaccine is recommended for those 5 years or older and is sufficient to be considered fully vaccinated. For those 6 months to 4 years of age who have never been vaccinated against COVID-19, two doses spaced 8 weeks apart are recommended.
- The fall COVID-19 and Influenza immunization campaign started on October 10, 2023, for the general public. Immunization of LTC/AL residents began prior to that date.

[1] Government of BC. COVID-19 Immunization. Retrieved January 29, 2024, from https://www2.gov.bc.ca/gov/content/covid-19/vaccine/register.

- In line with NACI recommendations, BC's priority populations for receiving a dose of XBB.1.5-containing COVID-19 vaccine were people 65 years of age or older, residents of long-term care homes and other congregate living settings, Indigenous people, pregnant people, people with underlying medical health conditions placing them at increased risk, members of racialized or other equity-deserving communities, and people who provide essential community services.[2]
- For the fall immunization campaign, BC ordered 2.8 million doses of Pfizer and Moderna XBB.1.5-containing COVID-19 vaccines. For those who cannot or do not want to receive an mRNA vaccine, the non-MRNA vaccine Novavax, also updated to contain the XBB.1.5 formulation, became available later in the fall.[3]
- As of March 17, 2024:[4]
  - 1,422,468 doses of COVID-19 vaccine have been administered during the 2023/24 respiratory illness season.
  - Over 24,000 doses of COVID-19 vaccine have been administered to residents in long term care (LTC) during the 2023/24 respiratory illness season. This is an approximation as LTC residents are vaccinated as they enter a facility or when an outbreak is declared over, and the vaccine can be given.
  - 63.2% of doses of influenza vaccine have been co-administered with COVID-19 doses during the 2023/24 respiratory illness season.
  - 91% of people 12 years of age or older have had at least 2 doses of a COVID-19 vaccine.
  - 43% of people 5 to 11 years of age have had at least 2 doses of a COVID-19 vaccine.
  - 19% of people 6 months to 4 years of age have had 2 doses of a COVID-19 vaccine. Three or more vaccine doses are not currently recommended for this age group, unless they are severely or moderately immunocompromised.
- The table below provides the total COVID-19 vaccinations administered by calendar year, as of February 28, 2024:

Calendar Year	COVID-19 Vaccinations Administered (All Vaccine Products; as per Daily PIR report as of February 28, 2024)
2020 (Dec 14 – Dec 31)	20,437
2021	9,220,481
2022	4,549,452
2023	2,048,533
2024 (Jan 1 – Feb 28)	69,563
Total Administered to Date	**15,908,466**

- On January 12, 2024, NACI released guidance for an additional dose of COVID-19 vaccine for the spring 2024. NACI states that the following individuals who are at an increased risk of severe illness from COVID-19 may get an additional dose: adults 65 years of age or older, residents of long-term care and other congregate living settings, and individuals 6 months of age or older who are moderately and severely immunocompromised.[5]

FINANCIAL IMPLICATIONS

The cost of purchasing COVID-19 vaccines is currently covered by the Government of Canada.

[2] Government of Canada. Guidance on the use of COVID-19 vaccines in the fall of 2023. Retrieved January 29, 2023, from https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-guidance-use-covid-19-vaccines-fall-2023.html#_Recommendations

[3] BC Vaccine Operations Centre. Status Update, September 12, 2023; http://www.bccdc.ca/health-info/diseases-conditions/covid-19/covid-19-vaccine/vaccines-for-covid-19

[4] Personal Communication with Lori Smart COVID and Influenza Doses as of Mar 21, 2024

[5] Government of Canada. Summary of NACI statement of January 12, 2024: Guidance on an additional dose of COVID-19 vaccines in the spring of 2024 for individuals at high risk of severe illness due to COVID-19. Retrieved January 29, 2024, from https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-summary-guidance-additional-dose-covid-19-vaccines-spring-2024-individuals-high-risk-severe-illness-due-covid-19.html.

KEY BACKGROUND

- COVID-19 is an infectious respiratory disease that is caused by the virus SARS-CoV-2.[6] Some people, including older adults and people with underlying health conditions, have a higher risk of infection and/or a higher risk of experiencing serious COVID-19 symptoms and complications than others.
- There are several COVID-19 vaccines approved by Health Canada and available for use in BC (see Table 1 below for details). In accordance with NACI guidance, BC recommends vaccination with an mRNA COVID-19 vaccine to ensure the most effective protection against COVID-19.[7]
- In the fall of 2023, individuals could once again use the provincial Get Vaccinated system to book their seasonal influenza vaccination at the same appointment as their COVID-19 vaccination.
- Children can get the COVID-19 vaccine at the same time as their routine childhood vaccines, including the influenza vaccine. COVID-19 vaccines approved for use in children are listed in Table 1. Children need a smaller dose of the vaccine to achieve the same protection from COVID-19 as adults.

Table 1: Authorized COVID-19 Vaccines Available in BC.[8]

Vaccine	Age Group	Vaccine Type	Comments
Fall 2023 Vaccines			
Pfizer-BioNTech Comirnaty **XBB.1.5**	6 months+	mRNA	This vaccine targets the Omicron strain XBB.1.5. but still provides good protection against other strains.
Moderna Spikevax **XBB.1.5**	6 months+	mRNA	This vaccine targets the Omicron strain XBB.1.5 but still provides good protection against other strains.
Novavax Nuvaxoid **XBB.1.5**	12+	Authorized protein sub-unit	This vaccine targets the Omicron strain XBB.1.5 but still provides good protection against other strains.

LAST UPDATED

The content of this estimates note is current as of March , 2024, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch.

APPROVALS

2024 02 15 - Dr. Martin Lavoie, Office of the Provincial Health Officer
2024 02 22 - Martin Wright, Health Sector Information, Analysis, and Reporting Division
2024 03 25 - Brian Sagar, Communicable Disease Prevention and Control Branch
2024 03 25 – Brian Sagar obo Maryna Korchagina, Population and Public Health Division

[6] ImmunizeBC. COVID-19 vaccines. January 12, 2023: https://immunizebc.ca/covid-19.
[7] COVID-19 mRNA vaccines. HealthLinkBC. October 20, 2023. https://www.healthlinkbc.ca/healthlinkbc-files/covid-19-mrna-vaccines#:~:text=The%20COVID%2D19%20mRNA%20vaccines%20provide%20better%20protection%20than%20other%20COVID%2D19%20vaccines
[8] BCCDC. BC Immunization Manual: Part 4: Biological Products. http://www.bccdc.ca/health-professionals/clinical-resources/communicable-disease-control-manual/immunization/biological-products . Accessed February 09, 2023.

LEGISLATIVE SESSION – ESTIMATES NOTE

K-02

COVID-19 Infection Prevention and Control Guidance in Health Care

Topic: Provincial guidance for the prevention and control of COVID-19 and other viral respiratory illnesses in health care settings.

Key Messaging and Recommended Response:

- **BC's approach to preventing and controlling the transmission of viral respiratory and gastrointestinal illnesses in health care settings is grounded in a comprehensive hierarchy of infection and exposure control measures that includes health measures (e.g., Orders from the Office of the Provincial Health Officer, contact tracing, guidance on testing and self-monitoring); environmental measures (e.g., ventilation, cleaning, disinfection); administrative measures (e.g., symptom screening, signage, sick leave policies, training); personal measures (e.g., hand hygiene, staying home when sick, ensuring immunizations are up-to-date); and personal protective equipment (use of medical masks, eye protection, gloves, and respirators when indicated).**
- **In collaboration with the Provincial Health Officer, the Ministry of Health continues to update and maintain over 40 evidence-based infection control guidelines and resources for reducing the spread of infectious diseases – including COVID-19 – in health care settings.**
- **Updates to BC's provincial infection control guidelines reflect emerging scientific data, the evolving epidemiology of SARS-CoV-2 and other viruses, and international, national and provincial expert recommendations.**
- **To protect patients and health care workers during the 2023/2024 viral respiratory illness season, the Ministry of Health and the Provincial Health Officer reinstated enhanced infection prevention and control measures in health care facilities, including universal medical masking by all health care workers, volunteers, contractors, and visitors; positioning of ambassadors at facility entrances; continued emphasis on rigorous hand hygiene; and continued enhanced cleaning and disinfection procedures in patient rooms, treatment rooms, and at high-touch points.**[1]

[1] BC Ministry of Health. "Actions protect people, B.C. communities this respiratory illness season". September 28, 2023. https://news.gov.bc.ca/releases/2023HLTH0121-001523.

CURRENT SITUATION

- In collaboration with the Provincial Health Officer (PHO), the Ministry of Health continues to update and maintain over 40 evidence-based infection control guidelines and resources to reduce the spread of infectious disease in health care settings.
- Updates to guidelines are made in accordance with emerging scientific data, the evolving epidemiology of SARS-CoV-2 and other viruses, and international, national and provincial expert recommendations. Updates are made in partnership with health authorities, the Provincial Infection Control Network of BC (PICNet), the BC Centre for Disease Control, the Office of the Provincial Health Officer, the First Nations Health Authority, and other health system partners.
- Ongoing surveillance of viral respiratory illness trends and variants of concern informs this work and identify required changes to infection control measures.
- On October 13, 2023, the Ministry of Health released *Policy Communiqué 2023*-04, *Infection Prevention and Control Measure for Viral Respiratory Illness Season*, in preparation for the 2023/24 VRI season.[2] The Communique outlines provincial expectations for the implementation of enhanced infection control measures, including medical mask wearing by all health-care workers, volunteers, contractors, and visitors in patient care areas; positioning of ambassadors at facility entrances; continuing emphasis on rigorous hand hygiene; and continued enhanced cleaning and disinfection procedures in patient rooms, treatment rooms, and at high-touch points, in all health authority facilities, programs, and services, including outpatient clinics and ambulatory care settings.

FINANCIAL IMPLICATIONS

Budget 2023 provided $875 million in contingency funding for ongoing COVID-19 health response measures.

KEY BACKGROUND

- BC's approach to preventing and controlling the transmission of viral respiratory and gastrointestinal illnesses in health care settings is grounded in a comprehensive hierarchy of measures including health measures (e.g., Orders from the Office of the Provincial Health Officer, contact tracing, guidance on testing and self-monitoring); environmental measures (e.g., ventilation, cleaning, disinfection); administrative measures (e.g., symptom screening, signage, sick leave policies, training); personal measures (e.g., hand hygiene, staying home when sick, ensuring immunizations are up-to-date); and personal protective equipment (use of medical masks, eye protection, gloves, and respirators when indicated).[3]
- On March 20, 2020, the Ministry of Health and the Provincial Health Officer (PHO) issued *Policy Communique 2020-01: Infection Prevention and Control for COVID-19* to health authorities which included requirements to implement IPC guidance in acute care, long-term care (LTC) and assisted living (AL) settings. The Policy Communique was subsequently updated on May 19, 2020 and September 1, 2021[4] with additional, revised content.

LAST UPDATED

The content of this estimates note is current as of February 23, 2024, as confirmed by Brian Sagar.

APPROVALS

2024 02 20 - Dr. Bonnie Henry, Office of the Provincial Health Officer
2024 02 21 - Lenore Ogilvy obo Martin Wright, Finance and Corporate Services Division
2024 02 22 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 02 28 - Maryna Korchagina, Population and Public Health Division

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[2] Ministry of Health. Policy Communiqué #2023-04. Infection Prevention and Control Measures for Viral Respiratory Illness. October 13, 2023. Retrieved January 29, 2024, from http://www.bccdc.ca/Health-Professionals-Site/Documents/Respiratory/Policy_Communique_Infection_Prevention_Control_Measures_Respiratory_Illness.pdf.

[3] BCCDC. Hierarchy for Infection Prevention and Exposure Control Measures for Communicable Diseases. June 29, 2022. Accessed September 13, 2023 at http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID-guidance/Hierarchy_Infection_Prevention_Controls.pdf.

[4] Both the May 19, 2020 and the September 1, 2021 versions of Policy Communique #2020-01 can be accessed through the Infection Prevention and Control Team at the Ministry of Health.

LEGISLATIVE SESSION – ESTIMATES NOTE

K-03

COVID-19 - Post-COVID-19 Conditions

Topic: Symptoms, risk factors, prevalence, and health system supports for people experiencing post-COVID-19 conditions (aka “Long COVID").

Key Messaging and Recommended Response:

- **We know COVID-19 can leave people with symptoms long after they’ve recovered. The government is supporting and caring for every person who gets COVID-19, including people experiencing longer-term symptoms.**
- **Most people with acute COVID-19 fully recover a few days to a few weeks after infection. Post-COVID Condition (also known as “Long COVID”) is the persistence of COVID-19 symptoms or the onset of new symptoms for more than 12 weeks after an initial COVID-19 infection.**
- **Post-COVID Conditions can manifest through over one hundred different symptoms of varying severity. These include fatigue, trouble sleeping, shortness of breath, general pain and discomfort, cognitive problems (e.g., difficulty concentrating), and mental health symptoms (e.g., depression).**
- **The biological cause of the complex symptoms and conditions seen in Post-COVID Condition remains unknown. There are currently no specific diagnostic tests or treatments available for Post-COVID Condition.**
- **In July 2020, BC established the Post-COVID-19 Interdisciplinary Clinical Care Network (the Network) offering clinical care, education, and research supporting patients with Post-COVID Condition and their health care providers.**
- **A 2023 evaluation of the Network found that 40% of patients showed improvement in their health-related quality of life, and 36% had stability.**
- **In its first two years, the Post-COVID-19 Interdisciplinary Clinical Care Network had 6,439 referrals, of which 4,014 (62.3%) were accepted.**

CURRENT SITUATION

- Most people with acute COVID-19 fully recover a few days to a few weeks after infection.[1,2] Post-COVID Condition (also known as "Long COVID") is the persistence of COVID-19 symptoms or the onset of new symptoms for more than 12 weeks after an initial COVID-19 infection.[3]
- Post-COVID Conditions can manifest through over one hundred different symptoms of varying severity, including fatigue, trouble sleeping, shortness of breath, general pain and discomfort, cognitive problems (e.g., difficulty concentrating), and mental health symptoms (e.g., depression) in adults.[4,5]
- In a study of BC's Post-COVID Recovery Clinics, 892 patients presented three months after their COVID-19 infection with the following most common symptoms based on standardized testing: shortness of breath (85.9%), fatigue (75.7%), weakness (56.1%), memory problems (47.3%), and myalgia (45.6%), with a variability in severity and burden of symptoms.[6]
- In July 2020, BC established the Post-COVID-19 Interdisciplinary Clinical Care Network (the Network) that offers clinical care, education, and research supporting patients with Post-COVID Condition and their health care providers. Eligible patients can be referred to the province-wide virtual Post-COVID Recovery Clinic by their primary care provider if they are experiencing symptoms that limit their daily activities for at least three months following their presumed or confirmed COVID-19 illness.
- Once accepted, the patient is assessed by a specialist nurse, using a standardized panel of blood work and questionnaires containing patient-reported outcome measure (PROM) instruments.[7] Based on symptoms, the patient receives immediate access to self-management supports and group learning opportunities. Where the assessment identifies the need for a physician consultation, clinic staff facilitate referrals to general medicine or sub-specialists.
- In the first two years, the Network had 6,439 referrals, of which 4,014 (62.3%) were accepted. A 2023 evaluation of the Network found that 40% of patients referred between July 2020 and June 2022 showed improvements in their health-related quality of life and 36% had stability.
- PHSA continues to maintain public websites with information and resources for BC residents living with Post-COVID Condition symptoms,[8] as well as information for health care providers.[9]

FINANCIAL IMPLICATIONS

$5 million annually to support the Post-COVID-19 Interdisciplinary Clinical Care Network central infrastructure and consolidated provincial clinic.

KEY BACKGROUND

- The biological cause of the complex symptoms and conditions seen in Post-COVID Condition remains unknown. It is hypothesized that some populations may have an increased susceptibility due to underlying

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[1] Government of Canada. Post-COVID-19 Condition in Canada: What we know, what we don't know, and a framework for action. Last updated February 8, 2024. Accessed February 9, 2024 at https://science.gc.ca/site/science/en/office-chief-science-advisor/initiatives-covid-19/post-covid-19-condition-canada-what-we-know-what-we-dont-know-and-framework-action.

[2] US Centers for Disease Control and Prevention. Long COVID or Post-COVID Conditions. Last updated July 20, 2023. Accessed February 9, 2024 at https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html.

[3] Government of Canada. Post COVID-19 condition (long COVID). Last updated March 9, 2023. Accessed February 9, 2024 at https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/symptoms/post-covid-19-condition.html.

[4] Ibid.

[5] Government of Canada. Post COVID-19 condition (long COVID). Last updated March 9, 2023. Accessed February 9, 2024 at https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/symptoms/post-covid-19-condition.html.

[6] Tran, Karen, Alyson Wong, Zachary Schwartz, Jesse Greiner, Peter Birks, Sharry Kahlon, Christopher Carlsten, et al. 'Post-COVID-19 Condition Characterizing the Burden of Symptoms Using Standardized Assessment'. Canadian Journal of General Internal Medicine. University of Toronto Press Inc. (UTPress), 8 June 2023. Accessed February 9, 2024 at : https://www.researchgate.net/publication/371884996_Post-COVID-19_Condition_Characterizing_the_Burden_of_Symptoms_Using_Standardized_Assessment_A_Prospective_Observational_Cohort_British_Columbia_Canada.

[7] World Health Organization. Clinical management of COVID-19: living guideline, January 13, 2023. Accessed February 9, 2024 at https://www.who.int/publications/i/item/WHO-2019-nCoV-clinical-2023.2.

[8] Provincial Health Services Authority, "Living with Post-COVID Symptoms – Clinical Care", no date, accessed February 9, 2024 at http://www.phsa.ca/health-info/post-covid-19-care-recovery#Self-care--info.

[9] PHSA. Post-COVID Recovery Care. No date [cited February 9, 2024]. Available from: http://www.phsa.ca/health-professionals/clinical-resources/post-covid-19-care.

chronic conditions, lack of COVID-19 vaccination, or severe COVID-19 illness requiring hospitalization or critical care.[10]

- There are currently no specific diagnostic tests or treatments available for Post-COVID Condition.

LAST UPDATED

The content of this estimates note is current as of March 1, 2024, as confirmed by Bethany McMullen obo Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch.

APPROVALS

2024 02 13 - Dr. Bonnie Henry, Office of the Provincial Health Officer
2024 02 26 - Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 27 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 01 - Maryna Korchagina, Population and Public Health Division

[10] US Centers for Disease Control and Prevention, "Long COVID or Post-COVID Conditions", last updated July 20, 2023, accessed February 9, 2024 at https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html.

LEGISLATIVE SESSION – ESTIMATES NOTE

K-04

COVID-19 Mode of Transmission and Mask Policy

Topic: The mode of transmission of viral respiratory illnesses, including COVID-19, and provincial mask requirements for patients, residents, visitors and health care workers.

Key Messaging and Recommended Response:

- **COVID-19 and other viral respiratory illnesses are primarily spread by liquid droplets that come out of the mouth and nose when a person infected with the virus breathes, coughs, sneezes, talks, or sings.**
- **Droplets come in a wide range of sizes that behave differently depending on their size.**
- **The Ministry of Health's mask policy specifies that additional Personal Protective Equipment (PPE), including respirators (e.g., N95s), will be provided whenever a health care worker determines there is an elevated risk of viral transmission based on a point-of-care risk assessment.**
- **This policy language accounts for and is inclusive of higher risk scenarios in health care settings where, for example, smaller droplets may collect in enclosed or poorly ventilated spaces, resulting in accumulation, and creating the conditions that may lead to viral transmission.**
- **BC continues to use a multi-layered approach to protect BC's health care workers in the workplace.**
- **In October 2023, additional infection prevention and control measures were reintroduced in health care settings for the 2023/24 viral respiratory season, including universal masking in all patient care areas and the repositioning of ambassadors at all facility entrances.**

CURRENT SITUATION

- Viral respiratory illnesses, such as influenza, COVID-19, and respiratory syncytial virus (RSV), are mainly spread by liquid droplets that come out of the mouth and nose when a person infected with the virus breathes, coughs, sneezes, talks, or sings.[1, 2, 3]

[1] Government of Canada. "COVID-19: Main modes of transmission". June 29, 2021. Retrieved January 29, 2024 from www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/main-modes-transmission.html.
[2] Government of Canada. "Evidence of the risk of COVID-19 transmission in flight: update 3". November 2021. Retrieved February 12, 2024 from https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/canadas-reponse/summaries-recent-evidence/evidence-risk-covid-19-transmission-flight-update-3.html.
[3] Provincial Infection Control Network of British Columbia (PICNet). "COVID-19: Risk of SARS-CoV-2 Aerosol Transmission in Health-Care Settings". September 27, 2023. Retrieved February 11, 2024 from https://picnet.ca/wp-content/uploads/Archived-Aerosol-Transmission-HC-Settings-SARSCoV2_27Sep2023.pdf.

- Droplets come in a wide range of sizes that behave differently depending on their size: Larger droplets are heavier and usually fall quickly to the ground; and smaller droplets (i.e., aerosols) are lighter and can float in the air for longer periods. Smaller droplets can collect in enclosed spaces especially those without fresh air circulation.[4]
- Viruses naturally mutate over time, leading to new versions or variants. Omicron variants have a large number of mutations in the spike region of the virus which affect their ability to transmit and how they respond to vaccination.[5] International data shows that Omicron transmits differently than previous wild type variants: they preferentially infect the upper airway; have an increased ability to overcome neutralizing antibodies; evade immunity from prior infection; have an enhanced capacity to bind to the receptive surfaces of human cells; have a shorter incubation period and faster onset of illness; and have an increased ability to spread to others even if they have been vaccinated.[6, 7]
- Among people who have received at least 2 doses of a COVID-19 vaccine, Omicron variants of SARS-CoV-2 cause less serious health outcomes and lower rates of hospitalization than other COVID-19 variants as they are less efficient at infiltrating the lungs.
- Currently, there are no COVID-19 variants of concern in Canada. In March 2023, Omicron was moved to the "de-escalation" category by the Federal SARS-CoV-2 Variant Surveillance Group.[8]

FINANCIAL IMPLICATIONS

N/A.

KEY BACKGROUND

Ministry of Health *Policy Communiqué 2023-04* directs health authorities to implement a range of infection control measures for health care workers, visitors, and patients, regardless of their immunization status:

- Health care workers must wear a mask while working in all patient care areas. Additional personal protective equipment (PPE) must be provided when a health care worker determines there is an elevated risk of VRI transmission after conducting a point-of-care risk assessment.
- Patients must wear a medical mask in emergency departments and in waiting rooms for their protection (if tolerated); when instructed by a health care worker; and based on personal choice.[9]
- Visitors must wear a medical mask in all patient/resident care areas in health care facilities, including communal areas and when participating in indoor group events, celebrations, gatherings and activities in Long-Term Care and Seniors' Assisted Living residences, except when eating and/or drinking.

LAST UPDATED

The content of this estimates note is current as of February 12, 2024, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch.

[4] BC Centre for Disease Control. "COVID-19: Risk of SARS-CoV-2 Aerosol Transmission in Health-Care Settings." August 29, 2022. Retrieved February 6, 2024 from https://medicalstaff.islandhealth.ca/sites/default/files/covid-19/latest-communications/bccdc/aerosol-transmission.pdf.
[5] Government of Canada. Statement from the Chief Public Health Officer of Canada on April 1, 2022. Retrieved February 6, 2024 from https://www.canada.ca/en/public-health/news/2022/04/statement-from-the-chief-public-health-officer-of-canada-on-april-1-2022.html.
[6] World Health Organization. Enhancing readiness for Omicron (B.1.1.529): Technical brief and priority actions for Member States. Dated December 23, 2021. Retrieved February 6, 2024 from www.who.int/docs/default-source/coronaviruse/2021-12-23-global-technical-brief-and-priority-action-on-omicron.pdf?sfvrsn=d0e9fb6c_8.
[7] World Health Organization. Statement on the Fourteenth meeting of the International Health Regulations (2005) Emergency Committee regarding the coronavirus disease (COVID-19) pandemic. January 30, 2023. Retrieved February 6, 2024 from https://www.who.int/news/item/30-01-2023-statement-on-the-fourteenth-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-coronavirus-disease-(covid-19)-pandemic.
[8] Government of Canada, Testing and Variants. Retrieved February 6, 2024. https://health-infobase.canada.ca/covid-19/testing-variants.html#vocChart.
[9] BC Ministry of Health. Policy Communiqué 2023-04 "Infection Prevention and Control Measures for Viral Respiratory Illness Season". October 13, 2023. Retrieved February 12, 2024 from http://www.bccdc.ca/Health-Professionals-Site/Documents/Respiratory/Policy_Communique_Infection_Prevention_Control_Measures_Respiratory_Illness.pdf.

APPROVALS

2024 02 12 - Brian Sagar, Communicable Disease Prevention and Control Branch
2024 02 13 - Dr. Bonnie Henry, Provincial Health Officer, Office of the Provincial Health Officer
2024 02 14 - Eric Larson obo Martin Wright, Health Sector Information Analysis and Reporting Division
2024 02 22 - Maryna Korchagina, Population and Public Health Division

LEGISLATIVE SESSION – ESTIMATES NOTE

K-05

CSA Infection Prevention and Control Standards for LTC

Topic: The Canadian Standards Association's (CSA) Z8004:22 guidance document "Long-Term Care Home Operations and Infection Prevention and Control."[1]

Key Messaging and Recommended Response:

- **Effective infection prevention and control measures in long-term care and seniors' assisted living settings are vital to keeping residents, visitors, and staff safe from COVID-19 and other infections.**
- **Released in December 2022, CSA Z8004:22 (the CSA document) provides guidance on resident care and supports, building design, facility operating practices, and infection prevention and control measures for normal, day-to-day circumstances and for catastrophic events (e.g., outbreaks, epidemics, pandemics, fires, earthquakes, and loss of power).**
- **The CSA document also addresses a range of important topics that are not directly related to infection control, such as patient rights, sexual expression and intimacy, resident nutrition, music programming, and the availability of recreational spaces.**
- **The CSA document covers topics that are already addressed by existing provincial legislation, regulation and/or policies, including the Community Care and *Assisted Living Act*, the Patient Bill of Rights, the *Public Health Act*, WorkSafe BC's Occupational Health and Safety Regulation, and Ministry of Health policies for hand hygiene, medical device reprocessing, and environmental cleaning.**
- **Given this duplication, the CSA document is currently voluntary in BC and is not enforced by provincial bodies as a standard of practice to be met for implementation.**

CURRENT SITUATION

- Released in December 2022, the CSA Standard Z8004:22 ("the CSA document") provides guidance on resident care and supports, building design, facility operating practices, and infection prevention and control measures in Long Term Care (LTC) homes for normal, day-to-day circumstances and for catastrophic events (e.g., outbreaks, epidemics, pandemics, fires, earthquakes, and loss of power).[2]

[1] Canadian Standards Association. CSA Z8004:22 Long-term care home operations and infection prevention and control. 2022. Accessed January 31, 2024 at https://www.csagroup.org/store/product/CSA%20Z8004%3A22/.
[2] Ibid.

- The CSA document addresses a range of infection control issues, measures, and practices in LTC homes, including hand hygiene, personal protective equipment (PPE), cleaning and disinfection, laundry, new and emerging technologies, antimicrobial stewardship, practice auditing, outbreak management, and pandemic readiness.
- The CSA document also addresses a range of important topics that are not directly related to infection control, such as patient rights, sexual expression and intimacy, resident nutrition, music programming, and the availability of recreational spaces.
- The CSA document is currently voluntary in BC and is not enforced by provincial bodies as a standard of practice to be met for implementation.
- The CSA document addresses topics that are already addressed by existing provincial legislation, regulation and/or policies (e.g., the *Community Care and Assisted Living Act*, the Patient Bill of Rights, the *Public Health Act*, WorkSafe BC's Occupational Health and Safety Regulation, and Ministry of Health policies for hand hygiene, medical device reprocessing, and environmental cleaning).
- Adopting the CSA document in BC would require the unnecessary implementation of multiple sets of differing standards stemming from multiple sources of authority.

FINANCIAL IMPLICATIONS

The mandatory implementation of CSA Z8004:22 would have significant financial implications. At this time, an estimate of costs has not been completed.

KEY BACKGROUND

- In response to the federal government's commitment in 2020 to improve the provision of LTC across Canada, the Standards Council of Canada (SCC), the CSA Group, and Health Standards Organization (HSO) developed two new national standards for LTC services in Canada.
- The CSA-led document focuses on the design, operation, and infection control practices in LTC homes, while the HSO-led document addresses the delivery of LTC services.

LAST UPDATED

The content of this estimates note is current as of February 8, 2024, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch.

APPROVALS

2024 02 10 - Dr. Bonnie Henry, Provincial Health Officer, Office of the Provincial Health Officer
2024 02 12 - Jennifer Brooke obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 21 - Maryna Korchagina, Population and Public Health Division

LEGISLATIVE SESSION – ESTIMATES NOTE

K-06

Human Papillomavirus - Testing and Immunization

Topic: Provincial human papillomavirus vaccination and testing programs to prevent cervical cancer.

Key Messaging and Recommended Response:

- **BC has been a world leader in cervical cancer prevention and is continuing along that path by increasing opportunities for Human Papillomavirus (or HPV) vaccination and testing for HPV to prevent cervical cancer.**
- **HPV infections can cause different types of cancers in both females and males, and genital warts.**
- **The province continues to provide a publicly funded HPV immunization program and last summer, it extended eligibility to include males born in 2005.**
- **HPV vaccine is routinely offered for free to all students in grade 6 in BC through school-based immunization clinics. The vaccine is also offered in schools to students in Grade 7, Grade 8, and Grade 9, who may have missed the HPV vaccine in Grade 6, providing an additional opportunity to get vaccinated.**
- **Children who missed getting the HPV vaccine at school can contact their local health unit, community health centre, or pharmacy to make an appointment to get vaccinated.**
- **Health authorities are working to provide additional school-based clinics to increase HPV vaccine uptake in their school-based immunization programs to align with the BC Cancer Action Plan goals.**
- **On January 29, 2024, BC was the first province in Canada to launch self-screening for the Human Papillomavirus that can cause cervical cancer.**
- **The province is transitioning from cytology (also known as a Pap test) to HPV testing as the primary screening method. HPV testing detects the virus before it can cause cancer and is more accurate and widely accessible.**
- **The province is dedicated to reducing barriers to HPV screening and cancer prevention, as well as reducing the health human resource demands at the laboratory and for primary care providers.**
- **This program allows people to enter the screening program and access a self-collect kit for HPV testing without a primary care provider.**

CURRENT SITUATION

- Announced on February 24, 2023,[1] BC's 10-year Cancer Action Plan commits to achieving the following goals in support of the World Health Organization (WHO) goal of eliminating cervical cancer:[2]
    - Increase the uptake of the HPV vaccine to achieve the national target of 90% HPV vaccination coverage (two or more doses) among adolescents by 17 years of age.
    - Complete the transition from cytology testing (cervical pre-cancer and cancer screening) to HPV infection screening, including through self-sampled screening.

HPV Vaccination

- The HPV9 vaccine, publicly funded in BC, protects against 9 types of HPV, two types of which cause 70% of cervical cancers and 80% of anal cancers. The HPV9 vaccine also protects against five additional types of HPV that cause 15% of cervical cancers, 11% of anal cancers in females and 4% in males[3] and that can cause cancers of the mouth and throat, penis, vagina, vulva, and genital warts.[4]
- The HPV9 vaccine is routinely offered for free to all students in grade 6 in BC through school-based immunization clinics. The vaccine is also offered in schools to students in Grades 7, Grade 8, and Grade 9, who may have missed the HPV vaccine in grade 6, providing an additional opportunity to get vaccinated.
- Children who missed getting the HPV vaccine at school can contact their local health unit, community health centre, or pharmacy to make an appointment to get vaccinated.
- Health authorities are working to increase HPV vaccine uptake in their school-based immunization program by providing additional school-based clinics to align with the BC Cancer Action Plan goals.
- Males (born in 2005 or later) and females (born in 1997 or later) remain eligible to receive the HPV vaccine for free if they get their first dose before they turn 19 and get their last dose before they turn 26.
- An operational grace period is offered until June 30, 2024, to males born in 2005 who became eligible to receive the publicly funded HPV vaccine as of November 28, 2023.[5]
- To maximize immunization awareness and opportunities, the Get Vaccinated System was used to notify males born in 2005 of their new eligibility to receive publicly funded HPV vaccine.[6]
- In BC, uptake of the HPV vaccine for grade 6 females in 2021, 2022 and 2023was 13.2%, 60.6% and 60.0%, respectively, and 12.7%, 59.0% and 57.7% among grade 6 males, respectively.[7]
- Despite the success of the in-school vaccination program, HPV vaccine rates in schools decreased during the pandemic , the public messaging shifting towards COVID vaccination and redistribution of public health resources to support the pandemic response. BC continue to work on improving the HPV vaccine uptake rates in the province to align with the BC Cancer Action Plan goals.

HPV Testing

- It is important to note vaccination against HPV is highly effective at protecting against several types of HPV but not every type. Accordingly, it is still important to be monitored and screened for cervical cancer routinely regardless of HPV immunization.
- Cervical screening with conventional cytology/pap testing has reduced the incidence and mortality of cervical cancer by over 70% in BC.[8]
- Cervical screening is recommended for anyone with a cervix, including women and TTGD (Two-Spirit, transgender, and gender diverse) people between the ages of 25 and 69.[9]

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[1] BC Gov News. B.C. launches action plan to better detect, treat, prevent cancers. Retrieved February 9, 2024, from https://news.gov.bc.ca/releases/2023HLTH0012-000229

[2] Government of BC. 10-Year Cancer Action Plan. Retrieved January 30, 2024, from https://news.gov.bc.ca/files/CancerPlan2023.pdf.

[3] BCCDC. Vaccines in BC – Human Papillomavirus (HPV) Vaccine. Retrieved February 23, 2024, from http://www.bccdc.ca/health-professionals/clinical-resources/vaccines-in-bc.

[4] ImmunizeBC. HPV Vaccine. Retrieved January 30, 2024, from https://immunizebc.ca/vaccines-by-disease/hpv

[5] Administrative Circular 2023:31. BCCDC. November 28, 2023. Update to Communicable Disease Control Manual, Chapter 2: Immunization, Part 1 – Immunization Schedules & Part 4 – Biological Products

[6] Ibid.

[7] Email from 2024 Western Canada Immunization Forum. February 29, 2024.

[8] Cervix Screening Program Overview. BC Cancer. January 23, 2024. http://www.bccancer.bc.ca/screening/Documents/Cervix-Program-Overview.pdf

[9] HealthLInk BC. Cervical Cancer Screening. Retrieved February 9, 2024, from https://www.healthlinkbc.ca/illnesses-conditions/cancer/cervical-cancer-screening

- Unlike pap testing which detects changes to the cells of the cervix that have been caused by HPV, HPV testing can detect the presence of high-risk types of HPV before cell changes have occurred.
- Given the higher sensitivity (capacity to detect) and higher negative predictive value (fewer false negatives) of testing for HPV compared to a pap test, the interval after a negative screening can be safely extended from 3 years to 5 years.[10]
- On January 29, 2024, BC was the first province in Canada to launch self-screening for the Human Papillomavirus that can cause cervical cancer.[11]
- Sample collection for HPV testing can be performed by a provider (vaginal or cervical collection) or by the participants themselves (vaginal collection).
- People who are eligible for cervical cancer screening can contact BC Cancer's Screening Program directly and request a screening kit be mailed to their home. People can also access screening through their primary care provider. In the event of an abnormal HPV test result, the Cervix Screening Program will connect the individual to follow-up care.
- This program reduces barriers to screening and improves equity for individuals with a history of trauma and cultural sensitivities or who are having difficulty accessing a primary care provider.

FINANCIAL IMPLICATIONS

Government Financial Information

The cost of transition to the HPV screening program is $12.5M annually.

KEY BACKGROUND

- HPV is a common sexually transmitted infection that most adults have in their lifetime. The body usually clears HPV without treatment; however, the abnormal cells caused by HPV can remain in the body and over time. These abnormal cells can evolve into cervical, oral, penile, anal, and other cancers.[14]
- In BC, 1 in 170 unvaccinated females is expected to develop cervical cancer during their lifetime and 1 in 530 females are expected to die of cervical cancer.[15]
- The most effective way to help prevent cervical cancer is to get vaccinated against HPV and have regular testing for HPV.
- In BC, the HPV9 vaccine was first publicly funded in 2009 for females in grade 6 and 9. By 2017, the program had expanded to include males in grades 6 and 9.
- Currently, a complete HPV vaccine series includes two doses for individuals aged 9 to 14 years and three doses for ages 15 and older, as well as those who are immunocompromised.
- BC has been the pioneer in population-based cervical cancer screening since the launch of its Cervix Screening Program in 1955 – the first such program in the world.
- HPV testing can be done with either a provider-collected cervical sample (obtained using a speculum exam) or a patient-collected vaginal sample.

LAST UPDATED

The immunization content of this estimates note is current as of February 28, 2024, as confirmed by Bethany McMullen, obo Brian Sagar, Communicable Disease Prevention and Control Branch.

[10] Transitioning from Cytology (Pap Test) to HPV Primary Screening. BC Cancer. Retrieved February 9, 2024 from http://www.bccancer.bc.ca/screening/Documents/Cervix-UpdateBulletin-Oct2023.pdf

[11] BC Gov News. New self-screening program will help detect cervical cancer sooner. Retrieved February 9, 2024, from https://news.gov.bc.ca/releases/2024HLTH0001-000015

[12] Personal communication with Zaahira Lalani, BCCDC. October 5, 2023.

[13] Personal communication with Lori Smart, BCCDC. August 9, 2023.

[14] BC Cancer Agency. Cervical Cancer. Retrieved April 13, 2023, from http://www.bccancer.bc.ca/health-info/types-of-cancer/pelvic-area/cervix.

[15] BC Cancer Agency. Statistics by Cancer Type - Cervix. January 17, 2021. http://www.bccancer.bc.ca/statistics-and-reports-site/Documents/Cancer_Type_Cervix_2018_20210305.pdf.

APPROVALS

2024 02 20 - Dr. Martin Lavoie, Office of the Provincial Health Officer
2024 02 23 - Lenore Ogilvy obo Martin Wright, Health Sector Information, Analysis & Reporting
2024 02 27 - Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2024 03 25 – Brian Sagar obo Maryna Korchagina, Population and Public Health Division

LEGISLATIVE SESSION – ESTIMATES NOTE

K-07

Immunization - Enhanced Influenza Vaccine for Seniors

Topic: Enhanced influenza vaccines for all BC seniors (65+).

Key Messaging and Recommended Response:

- **Immunization is the best way to protect against influenza. When you get immunized, you are also helping protect others by reducing the spread of the influenza virus.[1]**
- **Enhanced influenza vaccines, such as Fluzone High Dose and Fluad, are formulated to create a stronger immune response and compensate for the natural weakening of the immune system that occurs with age.**
- **In accordance with guidance from Canada's National Advisory Committee on Immunization (NACI), all adults in BC aged 65 and older are offered 'enhanced' influenza vaccines during viral respiratory illness season.**
- **For the 2023/24 season, BC purchased 699,000 doses of Fluad vaccine for community-based seniors (65+) and the Government of Canada purchased 49,250 doses of Fluzone High Dose for BC seniors (65+) living in LTC/AL facilities; a portion of these doses BC is offering to Indigenous elders (65+) living in community.**
- **It's worth noting there is no evidence to support using any of the enhanced vaccines for seniors over the other (high dose vs adjuvanted, Fluad vs Fluzone), and that either provides superior protection to standard dose.**
- **As of March 17, 2024, 484,207 doses of enhanced influenza vaccine have been administered during the 2023/24 (most recent) respiratory illness season, including over 37,600 doses to residents in Long Term Care and seniors' Assisted Living facilities, and to Indigenous seniors over 65 years of age.**
- **As of February March 17, 2024, 274,000 doses of enhanced influenza vaccine have been co-administered with COVID-19 vaccines this season.**

CURRENT SITUATION

- For the 2023/24 viral respiratory illness season, BC seniors (65+) were offered 'enhanced' influenza vaccines that provide additional protections against influenza-related illness. Fluzone High Dose vaccine was offered to seniors (65+) in Long Term Care (LTC) homes, seniors' Assisted Living (AL) facilities, and to

[1] ImmunizeBC. "Influenza (flu) vaccine". November 28, 2023. https://immunizebc.ca/vaccines-by-disease/influenza

Indigenous seniors living in community. Adjuvanted Fluad vaccine was offered to all other BC seniors (65+).

- For the 2023/24 season, the province purchased 2.33 million doses of influenza vaccine, including 699,000 doses of Fluad vaccine for community-based seniors (65+)[2] In addition, the Government of Canada purchased 49,250 doses of Fluzone High Dose for BC seniors (65+) living in LTC/AL facilities and BC is offering a portion of these doses to Indigenous elders (65+) living in community.[3]
- All eligible people in BC can receive their influenza and COVID-19 vaccine doses at the same appointment (i.e., "co-administration").

FINANCIAL IMPLICATIONS

For the 2023/24 (most recent) respiratory illness season, the province invested $27.635 million to purchase influenza vaccine. Of this amount, $9.114 million was for purchasing enhanced influenza vaccines for seniors.[4]

KEY BACKGROUND

- Influenza is an acute respiratory illness caused by the Influenza A or B virus.[5]
- Those at the greatest risk of influenza-related complications include residents of nursing homes, Indigenous peoples, and adults 65 years of age and older.
- BC's enhanced influenza vaccine program for Indigenous elders and seniors in LTC/AL started with the 2020/21 influenza season. The enhanced influenza vaccine program was expanded to include all other seniors (65+) in community settings as of the 2022/23 influenza season.
- Enhanced influenza vaccines are formulated to create a stronger immune response and compensate for the natural weakening of the immune system that occurs with age.[6] Fluzone High Dose vaccine contains 4 times more antigen than a 'standard' influenza vaccine. Fluad contains an additional ingredient (or 'adjuvant') that stimulates a greater immune response in the body.
- Evidence shows that both Fluad and Fluzone High Dose are effective at protecting seniors against influenza-related illness, complications, and hospitalization. There is limited evidence, however, indicating that one of the vaccines is superior to the other.
- Canada's National Advisory Committee on Immunization (NACI) strongly recommends that all adults aged 65 years and older should be offered enhanced influenza vaccines.[7,8] However, if no enhanced influenza vaccine for adults 65 years and older is available, NACI recommends that a 'standard' dose of influenza vaccine should be used.[9]

Calendar Year	COVID-19 Vaccinations Administered (All Vaccine Products; as per Daily PIR report as of February 28, 2024 at 11:59 PM)
2020 (Dec 14 – Dec 31)	20,437
2021	9,220,481
2022	4,549,452
2023	2,048,533
2024 (Jan 1 – Feb 28)	69,563

LAST UPDATED

The content of this estimates note is current as of February 22, 2024, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control.

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[2] Email correspondence with Lori Smart, BCCDC. February 16, 2023.
[3] Ibid.
[4] Ibid.
[5] HealthLink BC. "Facts about influenza". https://www.healthlinkbc.ca/healthlinkbc-files/facts-about-influenza-flu. Accessed February 6, 2024.
[6] Ibid.
[7] Note: NACI specifically states that IIV-HD (Fluzone High Dose), IIV-Adj (Fluad) and RIV (Recombinant influenza vaccine) over other influenza vaccines for seniors. See footnote 12.
[8] Government of Canada. An Advisory Committee Statement (ACS) National Advisory Committee on Immunization (NACI): Supplemental guidance on influenza vaccination in adults 65 years of age and older. Personal communication from the Canadian Immunization Committee received Dec 19. 2023.
[9] Government of Canada. Statement on Seasonal Influenza Vaccine for 2023-24. https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-statement-seasonal-influenza-vaccine-2023-2024.html#a5.3

APPROVALS

2024 02 13 - Dr. Brian Emerson, Office of the Provincial Health Officer
2024 02 13 - Lenore Ogilvy obo Martin Wright, Health Sector Information Analysis and Reporting Division
2024 02 21 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 25 – Brian Sagar obo Maryna Korchagina, Population and Public Health Division

LEGISLATIVE SESSION – ESTIMATES NOTE

K-08

Immunization - Influenza Seasonal Vaccination Program

Topic: BC's publicly funded seasonal influenza immunization program.

Key Messaging and Recommended Response:

- **Immunization is the best way to protect against influenza. When you or your child get immunized, you are also helping protect others by reducing the spread of the influenza virus.[1]**
- **Everyone in BC aged 6 months and older is eligible to receive an influenza vaccine free of charge each fall.**
- **In addition to universal eligibility, all BC seniors (65+) are offered 'enhanced' influenza vaccines that are formulated to provide better protection against influenza-related illness in older adults.**
- **All eligible people in BC can receive their influenza and COVID-19 vaccine doses at the same appointment.**
- **As of March 17, 2024, over 1.55 million doses of influenza vaccine have been administered during the 2023/24 (most recent) respiratory illness season, including 484,207 doses of enhanced vaccines for seniors.**
- **As of March 17, 2024, 63.2% of influenza vaccine doses have been co-administered with COVID-19 doses this season.**

CURRENT SITUATION

- During the 2023/24 (most recent) respiratory illness season, influenza vaccines were publicly funded for everyone in BC aged 6 months or older.
- In addition to universal eligibility, BC seniors (65+) were offered 'enhanced' influenza vaccines that provide better protection against influenza-related illness. Fluzone High Dose vaccine was offered to seniors (65+) in Long Term Care (LTC) homes, seniors' Assisted Living (AL) facilities, and to Indigenous seniors living in community. Adjuvanted Fluad vaccine was offered to all other BC seniors (65+).
- For the 2023/24 season, BC purchased a total of 2.33 million doses of influenza vaccine, including 699,000 doses of Fluad vaccine for community-based seniors (65+).[2] In addition, the Government of Canada purchased 49,250 doses of Fluzone High Dose for BC seniors (65+) living in LTC/AL facilities, and BC is offering a portion of these doses to Indigenous elders (65+) living in community.
- All eligible people in BC can receive their influenza and COVID-19 vaccine doses at the same appointment (i.e., "co-administration").

[1] ImmunizeBC. "Influenza (flu) vaccine". November 28, 2023. https://immunizebc.ca/vaccines-by-disease/influenza

[2] Personal communication with Lori Smart, BCCDC. February 16, 2023.

- To date, the province has administered over 1.55 million doses of influenza vaccines during the 2023/24 respiratory illness season. Of these, 80.6% were administered in pharmacies, and 19.4% in health authority clinics. Over 225,000 doses of influenza vaccine have been distributed to primary care.[3]
- To date, 63.2% of influenza vaccine doses have been co-administered with COVID-19 doses during the 2023/24 respiratory illness season.[4]

FINANCIAL IMPLICATIONS

For the 2023/24 respiratory illness season, the province invested $27.635 million to purchase influenza vaccine. Of this amount, $9.114 million was for purchasing enhanced influenza vaccines for seniors.[5]

KEY BACKGROUND

- Influenza is an acute respiratory illness caused by the Influenza A or B virus.[6]
- Those at the greatest risk of severe disease and influenza-related complications include residents of nursing homes, Indigenous peoples, and adults 65 years of age and older.
- As of October 19, 2021, the Province has adopted universal eligibility criteria for publicly funded influenza vaccines. This includes all BC residents aged 6 months or older.

Enhanced Influenza Vaccine Program

- Fluzone High Dose and Fluad are 'enhanced' influenza vaccines for adults aged 65 years and older.
- Enhanced influenza vaccines have been formulated to create a stronger immune response to compensate for the natural weakening of the immune system that occurs with age.
- BC's enhanced influenza vaccine program for Indigenous elders and seniors in LTC/AL started with the 2020/21 influenza season. The enhanced influenza vaccine program was expanded to include all other seniors (65+) in community settings as of the 2022/23 influenza season.

LAST UPDATED

The content of this estimates note is current as of March 25, 2024, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control.

APPROVALS

2024 02 15 - Dr. Martin Lavoie, Office of the Provincial Health Officer
2023 02 16 – Lenore Ogilvy obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2024 02 27 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 25 – Brian Sagar obo Maryna Korchagina, Population and Public Health Division

[3] 20240320 Weekly Influenza Report (as of March 17 2024). Invictus.
[4] Ibid.
[5] Email correspondence with Lori Smart, BCCDC. February 16, 2023.
[6] HealthLink BC. "Facts about influenza". https://www.healthlinkbc.ca/healthlinkbc-files/facts-about-influenza-flu. Accessed February 6, 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE

K-09

Immunization – Measles Immunization Program and Response

Topic: BC's publicly funded measles immunization program and response to a confirmed case of measles in BC in March 2024.

Key Messaging and Recommended Response:[1]

- **With measles outbreaks being reported nationally and internationally, we join our public health officials in reminding people in BC to check their children's and their own vaccination records to ensure they are protected against this highly contagious virus.**
- **One case of measles was reported in BC in early March of 2024.**
- **As of March 9, 26 cases of measles have also been reported in Canada in 2024.**
- **To date, most of the measles cases involve people who were not immunized or not fully immunized against measles, and people who travelled to countries where measles is spreading.**
- **The people most at risk from measles are those who are completely unvaccinated against the disease and have not had measles.**
- **That is why getting your immunizations up to date is so crucially important.**
- **In BC measles vaccine is given as a series of two doses. The first dose is given as the measles, mumps, and rubella (MMR) vaccine on a child's first birthday and the second dose is given around the time of starting school as the measles, mumps, rubella, and varicella (MMRV) vaccine.**
- **Babies as young as six months should get vaccinated against measles before travelling to countries where measles is spreading. Children between one and four years can also get their second dose before travelling internationally.**
- **Adults may already have protection from childhood vaccination or from having measles. Measles vaccines are typically not needed for those born before 1970 as most people in that age group have immunity to measles from a prior infection, before vaccination was widely available. However, before international travel, adults should ensure they have received two doses of a measles-containing vaccine if they were born in 1970 or later.**

[1] Health Issues, Key Messages on Measles Immunizations, March 3 2024

- **To support British Columbians during this time of increased measles activity and risk of spread, we are recommending and offering a number of things:**
  - **we are offering young children who are planning to travel internationally an opportunity to receive a first dose of measles-containing vaccine earlier;**
  - **for those who are 12 months or older and who have not yet received their first dose, they should consider getting it as soon as possible; and**
  - **for those who have had their first vaccine dose, we are offering the opportunity to receive their second dose sooner.**
- **Vaccine appointments can be booked through local public health units, community health centres, nursing stations, and some pharmacies.**
- **Some primary-care providers and travel clinics also offer measles vaccinations. Children four years or older, as well as adults, can also be vaccinated by a pharmacist.**

CURRENT SITUATION

- One measles case was reported in BC, the weekend of March 3-4, 2024. This is the first measles case reported in BC since the 31 cases reported during the measles outbreak in 2019.[2]
- As of March 9, 26 cases of measles have been reported in Canada in 2024.[3] Overall, Canada is seeing increased measles activity in 2024 compared to 2023.
- The case of measles occurred within Vancouver Coastal Health's Richmond Health Service Delivery Area, which has the highest measles vaccination coverage rates in BC; it involved someone who had recently travelled abroad. Vaccination coverage rates for seven-year-olds in Richmond have been above 90% since 2013.[4]
- The measles vaccine is very highly effective. The first dose usually provides good protection, but two doses of measles-containing vaccine are recommended to ensure the best protection possible.
- In BC, measles-containing vaccines are given at 12 months of age and at school entry (age 4-6 years).[5]
- BC has enough supply of vaccine to meet routine and additional demand for both the measles, mumps, and rubella (MMR) and measles, mumps, rubella and varicella (MMRV) vaccines. In 2022, approximately 83% of two-year-olds were up-to-date (received one dose) and 77% of seven-year-olds were up-to-date (received two doses) with measles vaccination in BC.[6]
- As a special consideration, babies as young as six months should get vaccinated against measles before travelling to countries where measles is spreading. Children between one and four years can also get their second dose of measles-containing vaccine before travelling internationally.
- Parents and caregivers are reminded to ensure their child's immunization records are up to date in the Provincial Immunization Registry and submit any missing immunization records to the registry. Viewing immunization records and submitting any missing records can be done via Health Gateway, for all

[2] BC Ministry of Health. "People advised to check immunization records before spring break travel". March 4, 2024. People advised to check immunization records before spring break travel | BC Gov News

[3] Measles & Rubella Weekly Monitoring Reports. Accessed on March 22, 2024. https://www.canada.ca/en/public-health/services/diseases/measles/surveillance-measles/measles-rubella-weekly-monitoring-reports.html

[4] Personal Communication with Monika Naus, Medical Director from BCCDC. March 4 2024.

[5] BCCDC. "Measles vaccine". Accessed on March 8, 2024. http://www.bccdc.ca/health-professionals/clinical-resources/vaccines-in-bc

[6] Personal Communication with Monika Naus, Medical Director from BCCDC. March 4 2024.

immunizations administered by BC public health clinics or pharmacies since 2009, or by connecting with a local public health unit or your primary care provider.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

Measles Infection

Measles is a highly contagious disease caused by the measles virus. Complications, such as encephalitis (inflammation of the brain), seizures, deafness, brain damage and pneumonia, and death can result from a measles infection, most commonly in infants less than 12 months old and in adults.[7]

Measles Immunization – Eligibility and History of the Program in BC

- In BC, two doses of measles vaccine are provided free of charge as part of routine childhood immunizations. It is also provided free of charge to:
  - Infants aged 6 to 11 months who will be travelling to countries where there is measles or are known to have been in contact with someone with measles.
  - Women of childbearing age who are not immune to rubella (the vaccine protects against measles, mumps, and rubella).
  - Older children and adults who have not been immunized or do not have evidence of immunity to measles, mumps, and rubella[8]
- In 1996, all Canadian provinces implemented a measles elimination strategy. In BC, the elimination strategy included:[9]
  - Offering measles-containing vaccine to all children province-wide 19 months and older, including those in kindergarten through grade 12, and post-secondary students.
  - Changing the immunization schedule to include a routine 2nd dose of measles-containing vaccine for children.
- Individuals born before 1970, when measles was still circulating, are assumed to have immunity due to prior infection. In BC, the cohort of those born in 1979 and later have will have been offered two-doses of measles containing vaccine as part of the measles elimination strategy. Newcomers to BC born prior to 1996 may not have received a second dose of measles containing vaccine.

Measles Outbreaks in BC and 2019 Response

- Measles outbreaks have occurred periodically in BC:
  - In 2010, during the Winter Olympic Games held in Vancouver.
  - In 2014, when 342 cases of measles were reported, the majority in members of a religious community in the Fraser Valley.
  - In 2018, when nine cases of measles were reported in BC.
  - In 2019, when 31 cases of measles were reported in BC.[10]
- After the 2019 measles outbreak, the Ministry committed to a two-phase response:[11]
  - Phase one of the plan included a rapid three-month childhood immunization catch-up period:
    - In those three months, health authorities and pharmacists administered over 28,000 additional doses of measles vaccine for K-12 students, and health authorities reviewed over 590,000 immunization records, adding over 10,000 children to the immunization registry.

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[7] BCCDC. "Measles". Accessed on March 8, 2024. http://www.bccdc.ca/health-info/diseases-conditions/measles

[8] HealthLink BC. "MMR vaccine". Accessed on March 8 2024. https://www.healthlinkbc.ca/healthlinkbc-files/measles-mumps-rubella-mmr-vaccine

[9] BCCDC. "History of Immunization in BC". Pp. 16-17. http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%202%20-%20Imms/HistoryImmunization.pdf

[10] BCCDC. "Measles Epidemiological Summary, British Columbia 2019 year to date – July 26th". https://www.canada.ca/en/public-health/services/publications/diseases-conditions/measles-rubella-surveillance/2024/week-8.html

[11] BC Ministry of Health. Measles Immunization Catch-up Program. July 25, 2019.

- In this three-month time period, the number of children fully immunized against measles rose by almost 38,000.

- Phase two of this plan, was to improve reporting of vaccine status.
  - On July 1, 2019, BC implemented Vaccination Status Reporting Regulation (VSRR) under the *Public Health Act* which requires that school-age children have a current and complete immunization status record on file with Public Health.
- Gathering all immunization status records in the provincial immunization registry increases public health's ability to respond effectively during an outbreak, as it allows officials to quickly identify those who are under-immunized and unimmunized, and implement timely, appropriate, and effective control measures.

LAST UPDATED

The content of this estimates note is current as of March 11, 2024, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control.

APPROVALS

2024 03 11 - Dr. Martin Lavoie, Office of the Provincial Health Officer
2024 03 11 - Lenore Ogilvy obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 03 12 – Andy Watson, Government Communications & Public Engagement (OPHO)
2024 03 25 – Brian Sagar obo Maryna Korchagina, Population and Public Health Division

LEGISLATIVE SESSION – ESTIMATES NOTE

K-10

Immunization - Respiratory Syncytial Virus (RSV) Vaccination

Topic: New Respiratory Syncytial Virus (RSV) vaccines approved for use in Canada.

Key Messaging and Recommended Response:

- **GlaxoSmithKline's "Arexvy" vaccine and Pfizer's "Abrysvo" vaccine were approved for use by Health Canada on August 4, 2023, and December 21, 2023, respectively.**
- **Arexvy and Abrysvo are the first vaccines ever authorized in Canada to protect against RSV infections.**
- **While Arexvy and Abrysvo are approved for use in Canada, the new vaccines have not been reviewed to identify recommendations for vaccine administration, priority populations, vaccine schedules, and other standard pieces of guidance required by immunizers.**
- **Canada's National Advisory Committee on Immunization (NACI) is reviewing the new RSV vaccines now.**
- **Once NACI releases their recommendations, our provincial immunization and public health experts will review the NACI guidance in the context of the BC health system, ultimately leading to recommendations that the Ministry of Health will consider amid other health system priorities.**

If asked if seniors can purchase the RSV vaccine in BC, why is it available in Ontario?

- **We understand that some RSV vaccine may be available in BC for purchase by seniors.**
- **In Ontario, it is only available on a limited basis for vulnerable seniors (e.g. seniors in long-term care homes).**
- **It is still available for purchase in BC until we have enough evidence to make an informed decision for BC.**

If pressed

- Advice/Recommentations

CURRENT SITUATION

- On August 4, 2023, Health Canada approved GlaxoSmithKline's "Arexvy" vaccine for use in adults 60 years of age and older.[1] On December 21, 2023, Health Canada subsequently approved Pfizer's "Abrysvo" vaccine for use in adults 60 years of age and older and for pregnant individuals.[2]
- RSV vaccines are not publicly funded in BC at this time.
- In BC, publicly funded vaccine programs are reviewed, approved, and funded in the context of guidance from Canada's National Advisory Committee on Immunization (NACI), and recommendations from our provincial immunization and public health experts.
- While Health Canada has authorized Arexvy and Abrysvo for use in Canada, the new vaccines have not been reviewed to identify recommendations for vaccine administration, priority populations, vaccine schedules, and other standard pieces of guidance required by immunization programs.
- NACI's review of the new RSV vaccines is a prioritized project on NACI's 2022-2024 workplan.[3]
- Arexvy is currently available in select pharmacies and travel clinics in BC. The timeline for Abrysvo becoming available in Canada is still to be determined.

FINANCIAL IMPLICATIONS

If an RSV vaccination program were to be considered for BC, pricing of the new RSV vaccines would be determined through a federal collective purchasing agreement. Advice/Recommentations

Advice/Recommentations This pricing does not include vaccine distribution, clinician administration fees or other related costs.

KEY BACKGROUND

RSV Illness

- RSV is a common respiratory virus that typically causes a mild illness with cold-like symptoms. RSV has a greater likelihood of developing into more severe illness, including bronchiolitis and lower respiratory tract infections, in very young children and older adults.[5]
- In Canada, the RSV season typically begins in October or November and lasts until April or May.[6]
- In BC, RSV activity peaked in late December 2023 and has continued to decrease in January and February 2024.[7]

RSV Vaccines

- Arexvy and Abrysvo are single dose vaccines.
- Data from randomized clinical trials indicate that Arexvy is 82.6% effective at preventing lower respiratory tract disease caused by RSV in adults 60 years of age and older, compared to those who received a placebo.[8]
- Data from randomized clinical trials indicate that Abrysvo is 85.7% effective at preventing lower respiratory tract disease caused by RSV in adults 60 years of age and older, compared to those who received a placebo.[9]

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[1] CBC News. "Health Canada approves 1st RSV vaccine for people 60 and older". Retrieved August 8, 2023, from https://www.cbc.ca/news/health/rsv-health-canada-vaccine-1.6928175.

2 Pfizer Canada. "Product Monograph Including Patient Medication Information – ABRYSVO". December 21, 2023. https://pdf.hres.ca/dpd_pm/00073900.PDF

[3] National Advisory Committee on Immunization. "Workplan 2022-2024". Retrieved September 14, 2023 from https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci/workplan.html#a2.

[4] Public Service and Procurement Canada. Communication to BCCDC. August 18, 2023.

[5] Government of Canada. "Respiratory Syncytial Virus (RSV): Symptoms and Treatment". Retrieved August 8, 2023, from https://www.canada.ca/en/public-health/services/diseases/respiratory-syncytial-virus-rsv.html.

[6] Ibid.

[7] BC Centre for Disease Control. "Respiratory Epidemiological Summary" February 8, 2024. http://www.bccdc.ca/Health-Info-Site/Documents/Respiratory_data/respiratory_epidemiological_summary_2024-02-08.pdf

[8] GlaxoSmithKline. "GSK's Arexy, the first respiratory syntyical virus (RSV) vaccine for older adults approved in Canada". Retrieved September 20, 2023 from https://ca.gsk.com/en-ca/media/press-releases/gsk-s-AREXVY-the-first-respiratory-syncytial-virus-rsv-vaccine-for-older-adults-approved-in-canada/.

[9] Pfizer Canada. "Product Monograph Including Patient Medication Information – ABRYSVO". December 21, 2023. https://pdf.hres.ca/dpd_pm/00073900.PDF

- Data from randomized clinical trials indicate that Abrysvo (when given to a pregnant person) is 69.4% effective at reducing severe lower respiratory tract disease caused by RSV in infants 180 days after birth, compared to a placebo.[10]

RSV Vaccination Programs - Canada

- Ontario is the only Canadian jurisdiction with a publicly funded RSV program at this time.
- Ontario is offering publicly funded Arexvy vaccine to high-risk adults aged 60 years and older, including residents of long-term care and assisted living facilities, immunocompromised individuals, people experiencing homelessness, and people who identify as First Nations, Inuit, or Métis.[11]
- In all other provinces and territories, RSV vaccine is available for private purchase in community pharmacies.

LAST UPDATED

The content of this estimates note is current as of February 9, 2024, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch.

APPROVALS

2024 02 12 - Jennifer Brooke obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 14 - Brenda Rafter, obo Rob Byers, Finance and Corporate Services Division
2024 02 22 - Brian Sagar, Communicable Disease Prevention and Control Branch
2024 02 22 - Maryna Korchagina, Population and Public Health Division

[10] Ibid.
[11] Respiratory Syncytial Virus https://www.ontario.ca/page/respiratory-syncytial-virus

LEGISLATIVE SESSION – ESTIMATES NOTE

K-11

Pandemic Readiness Planning

Topic: Preparing BC for a future pandemic.

Key Messaging and Recommended Response:

- **BC has a pathogen-specific Pandemic Influenza Response Plan and a non-pathogen specific Pandemic Provincial Coordination Plan.**
- **The Response Plan describes how BC's health care system will respond to a pandemic by setting out a comprehensive province-wide approach for health sector preparedness and response planning in critical areas such as public health measures, disease surveillance, and human resources.**
- **The Coordination Plan supports an all-of-government response to a pandemic by outlining the province's strategy for cross-ministry coordination, internal and external communications, and provincial government business continuity.**
- **The Ministry of Health is continuing to work closely with the Provincial Health Officer to ensure that coordinated provincial pandemic response and readiness plans are in place to effectively prepare the health system for a future pandemic.**
- **Central to this work is the development of a 'Pandemic Preparedness Playbook' that will serve as a living document to build on COVID-19 pandemic learnings, support ongoing health system resilience, and guide the management and response to future pandemics.**

CURRENT SITUATION

- BC has a pathogen-specific *Pandemic Influenza Response Plan* (the *Response Plan*, 2012)[1] and a non-pathogen specific *Pandemic Provincial Coordination Plan* (the *Coordination Plan*, 2020).[2] In 2020, the Response Plan provided the basis for the health sector's COVID-19 Response Plan.[3]
- BC's *Response Plan* describes how BC's health care system will respond to a pandemic by setting out a comprehensive province-wide approach for health sector preparedness and response planning in critical areas such as public health measures, disease surveillance, and human resources. The *Response Plan* is intended to be reviewed and revised every three years and would be tailored to an emerging pathogen and newly declared pandemic. The *Response Plan* was used to guide and inform BC's response to the COVID-19 pandemic.

[1] Province of British Columbia. "BC Pandemic Influenza Response Plan. September, 2012. https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/bc-pandemic-influenza-plan-2012.pdf.
[2] Province of British Columbia. "BC Pandemic Provincial Coordination Plan". February 2020. https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/pandemic-provincial-coordination-plan.pdf.
[3] Correspondence from Dr. Bonnie Henry, Provincial Health Officer. February 16, 2024.

- Most recently updated in February 2020, the *Coordination Plan* supports an all-of-government response to a pandemic by outlining the province's strategy for cross-ministry coordination, internal and external communications, and provincial government business continuity.
- The Minister of Health's mandate letter includes "[continued] work with the Provincial Health Officer to control the spread of COVID-19 in BC and prepare our province for any future pandemic…" as a Ministerial priority.[4]
- The Ministry of Health and the Provincial Health Officer have continued their work to ensure that coordinated provincial pandemic response and readiness plans are in place to effectively prepare the health system for a future pandemic. Central to this work is the development of a draft 'Pandemic Preparedness Playbook' that will serve as a living document to build on COVID-19 pandemic learnings, support ongoing health system resilience, and guide the management and response to future pandemics.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- The *Emergency Program Management Regulation* identifies the Ministry of Health as the body responsible for coordinating the government's response to threats caused by human diseases.[5]
- At the national level, BC is participating in the Federal/Provincial/Territorial process to develop a comprehensive Pandemic Preparedness Plan as part of the Pandemic Preparedness Task Group.
- At the global level, the WHO has two initiatives for pandemic preparedness and response which inform BC's planning:
    - an international, legally binding agreement on pandemic preparedness and response for member states which is under development; and,
    - a technical platform that follows an integrated mode of transmission response.
- In the first phase of its initiative, the WHO is supporting countries to develop pandemic plans for respiratory pathogens, focusing on emergency coordination; access to countermeasures; clinical care; surveillance; and community protection.[6]

LAST UPDATED

The content of this estimates note is current as of February 16, 2024, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch.

APPROVALS

2024 02 16 - Brian Sagar, Communicable Disease Prevention and Control Branch
2024 02 16 - Dr. Bonnie Henry, Office of the Provincial Health Officer
2024 02 19 – Lenore Ogilvy obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 28 - Maryna Korchagina, Population and Public Health Division

[4] Premier David Eby. "Ministerial Mandate Letter – Health." January 15, 2024. Pg. 4. Retrieved January 29, 2024 from https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/premier-cabinet-mlas/minister-letter/hlth_-_dix.pdf.
[5] Province of British Columbia. "Emergency Program Management Regulation." Schedule 1. December 16, 1994. Retrieved January 28, 2024 from https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/477_94.
[6] World Health Organization. "Preparedness and Resilience for Emerging Threats Module 1: Planning for respiratory pathogen pandemics Version 1.0 (draft)". March 2, 2023. Retrieved January 29, 2024 from https://www.who.int/publications/m/item/preparedness-and-resilience-for-emerging-threats-module-1-planning-for-respiratory-pathogen-pandemics-version-1.

LEGISLATIVE SESSION – ESTIMATES NOTE

K-12

Vaping

Topic: To address the rise in youth vaping, the Ministry of Health introduced a 10-Point Provincial Vaping Action Plan.

Key Messaging and Recommended Response:

- **Vaping is highly addictive, especially for young people.**
- **The Canadian Tobacco and Nicotine Survey (CTNS) 2022 data shows that 13% of youth in Canada vaped in the last 30 days. In BC, the vaping rates are higher with 16.1% of youth, aged 15 – 19, having vaped in the past 30 days.**
- **The 10-Point Provincial Vaping Action Plan focuses on regulatory, financial, and education and awareness measures to protect youth from the harms of vaping and nicotine dependence.**
- **BC has some of the strongest vaping regulations in Canada, restricting advertising, display, sale and use, and requiring mandatory reporting from vapour product retailers. It is illegal to use, sell, or give any vapour products to someone under the age of 19.**
- **BC will continue to evaluate the prevalence of vaping, work with the federal government, and assess actions needed to strengthen its response.**

CURRENT SITUATION

- In BC, 4.7% of the total population and 16.1% of youth ages 15 to 19, have vaped in the past 30 days.[1]
  - BC has the lowest total population vaping rate in the country.
  - BC's vaping rate among youth ages 15 to 19 is above the national average which is 13.6%.
- On November 14, 2019, the Action Plan was launched to address the rise in youth vaping in BC and focused on regulatory, financial, and education and awareness measures to protect youth from the harms of vaping.[2]
- All 10 of the actions from the Action Plan are now complete.
- On February 7, 2024, the Premier announced an amendment to the Drug Schedules Regulation under the *Pharmacy Operations and Drug Scheduling Act* to restrict the sale of buccal nicotine-pouch products to behind the counter at pharmacies on a non-prescription basis. This action is to ensure nicotine cessation products are used for their intended purpose and to prevent misuse, especially among youth and non-smokers.

Regulation and enforcement:

- On July 20, 2020, as part of the Action Plan, the following provincial regulations came into force:
  - E-Substances Regulation (ESR) under the *Public Health Act*;
  - amendments to the Health Hazards Regulation under the *Public Health Act*; and

[1] Canadian Tobacco and Nicotine Survey: https://www.canada.ca/en/health-canada/services/canadian-tobacco-nicotine-survey/2022-summary/2022-detailed-tables.html#tbl6

[2] BC Gov News, https://news.gov.bc.ca/releases/2019HLTH0118-002192

  - amendments to the Tobacco and Vapour Products Control Regulation (TVPCR) under the *Tobacco and Vapour Products Control Act* (TVPCA).
- Tobacco and Vapour Enforcement Officers with the regional health authorities are responsible for the compliance and enforcement of the ESR and other tobacco and vaping related legislation.
- The ESR requires vapour product retailers to submit an annual sales report for the period between October 1 to September 30 of the following year, on or before January 15 using the BC E-Substances Reporting (BCER) application. By January 15 of each year, retailers are also required to renew their notice of intent to sell products for the coming year. Retailers also submit product and manufacturing information through the BCER.
- On June 21, 2023, the federal government enacted the Vaping Products Reporting Regulations, which requires manufacturers to provide Health Canada with sales and ingredient reports of all vapour products sold in Canada.

Prevention, Reduction and Cessation:

- Starting in 2020, the province launched vaping marketing campaigns that have reached over 4 million British Columbians. Two campaign streams target different audiences: *Evapourate* and *A-Z of Vaping* for youth and *Clear the Air* for adult influencers of youth.
- As of August 2021, the vaping prevention toolkit, funded by the Ministry and created by the BC Lung Foundation, is available for use in BC. Since its original publication, the toolkit has been translated into seven additional languages, had printed versions distributed to all K-12 schools, and an additional resource has been created for Grade 8 to Grade10.
- In October 2023, QuitNow launched a dedicated website and resources tailored for youth wanting to quit vaping. QuitNow also provides cessation support to youth and adults who are seeking support to quit vaping.
- The Canadian Cancer Society was contracted to evaluate the Action Plan and provided the Ministry with a final report in December 2023, which is currently under review.

FINANCIAL IMPLICATIONS

- The Ministry provides $2.325 million in annual funding to the regional health authorities to support tobacco and vaping enforcement as follows:
  - Fraser Health Authority: $0.568 million
  - Interior Health Authority: $0.508 million
  - Northern Health Authority: $0.246 million
  - Vancouver Coastal Health Authority: $0.586 million
  - Vancouver Island Health Authority: $0.417 million
- The Ministry spent $187,000 in 2019/20 and $362,356 in 2020/21 on developing and implementing a social marketing campaign known as 'Evapourate.'
- The Ministry spent $511,608 in 2022/23 and $86,200 in 2023/24 (as of February 2024) on developing and implementing a social marketing campaign known as 'the A-Z of Vaping.'
- In 2019/20, the Ministry provided $38,000 to the McCreary Centre Society to support an enhanced survey module for youth on vaping.
- In 2019/20, the Ministry provided $77,000 to the BC Lung Foundation to deliver an education and awareness campaign.
- In 2022/23, the Ministry invested $142,000 for user and design enhancements to the BC E-Substances Reporting (BCER) database. The Ministry previously invested:
  - $413,471 in 2020/2021 to design and develop the BCER.
  - $ 424,190 in 2021/2022 to add reporting functionality and user and design enhancements.
- The Ministry provided $187,500 to the Canadian Cancer Society over 2020/21 and 2022/23 to evaluate the Action Plan.

KEY BACKGROUND

- On January 1, 2020, a 20% provincial sales tax increase on all vaping products and accessories was brought into force and is administered by the Ministry of Finance.
- As part of the Action Plan, regulations were introduced in July 2020, including:
  - Prescribing new health hazards via the Health Hazards Regulation under the *Public Health Act* to prescribe non-therapeutic nicotine as a health hazard.
  - The enactment of the E-Substance Regulation, which requires:
    - limiting e-substance volume and nicotine concentration;
    - restricting the sale of flavored E-Substances;
    - provincial labelling and packaging requirements; and
    - mandatory notice of intent to sell vapour products and, product sales and manufacturing reporting.
  - Amending the TVPCR to restrict the locations where vapour products can be advertised.
- TVPCA and TVPCR also set standards and requirements for vapour product use, including restrictions on where you can vape, retailer signage, and minimum age of purchase of 19.
- In 2021, the Minister launched a provincial youth advisory council (YAC). The YAC has helped inform the development of many youth vaping prevention resources including: the BC Lung Foundation's vaping prevention toolkit[3], the 'Evapourate' and 'A-Z of Vaping' social media campaigns against youth vaping, anti-vaping resources for schools, QuitNow's dedicated vaping mini-site, the evaluation of the Action Plan, conducted in partnership with the Canadian Cancer Society, and a video about the risks associated with vaping that was endorsed by the Minister of Health.

LAST UPDATED

The content of this estimates note is current as of February 6, 2024, as confirmed by Geneen Russo, Executive Director, Health Protection Branch and Jonathan Robinson, Executive Director, Prevention and Health Promotion Branch.

APPROVALS

2024 02 15 - Lenore Ogilvy obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2024 02 21 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 02 22 - Geneen Russo, Health Protection Branch, Population Public Health Division
2024 02 26 - Maryna Korchagina, Population Public Health Division

[3] BC Lung Foundation, Vaping Health Education Toolkit for Parents and Teachers: Vaping Health Education Toolkits for Parents & Teachers | BC Lung Foundation

LEGISLATIVE SESSION – ESTIMATES NOTE

K-13

Respiratory Illness Outbreak Management

Topic: Outbreak management in acute care, long-term care and seniors' assisted living settings for COVID-19 and other viral respiratory illnesses.

Key Messaging and Recommended Response:

- **The official declaration of an outbreak in a health care facility is made by a Medical Health Officer or their official designate.**
- **Declaring an outbreak coincides with the implementation of additional infection prevention and control measures over and above those that are normally in place. These additional measures could include closing an affected unit to new admissions or transfers, or temporarily restricting non-essential visits.**
- **BC has two COVID-19-specific outbreak protocols; one for acute care settings and one for Long Term Care/Seniors' Assisted Living settings.**
- **The outbreak protocols include criteria and considerations for declaring an outbreak, for managing an outbreak, and for declaring an outbreak over, as wells as clinical forms to support symptom screening and tracking in patients, clients, residents, and staff.**
- **BC's outbreak protocols are being updated to include guidance for managing outbreaks of all viral respiratory illnesses, not just COVID-19, and to further clarify the criteria for declaring outbreaks.**
- **Updated weekly reporting of outbreaks in Long Term Care/Seniors' Assisted Living settings and acute care settings is available to the public on the BC Centre for Disease Control's website.[1]**
- **From January 28, 2023, to March 23, 2024, there were 13 influenza outbreaks reported in Long Term Care facilities and 5 influenza outbreaks reported in acute care facilities.[2]**
- **During this same period, there were 4 COVID-19 outbreak reported in Long Term Care facilities and 0 (zero) COVID-19 outbreaks reported in acute care facilities.[3]**

[1] BCCDC. "Respiratory virus data". http://www.bccdc.ca/health-professionals/data-reports/respiratory-virus-data#Dashboards
[2] BCCDC. "Acute care and long-term care outbreaks". March 28, 2024. https://bccdc.shinyapps.io/respiratory_aggregate_outbreaks/
[3] Ibid.

CURRENT SITUATION

- The official declaration of an outbreak in a health care facility is made by a Medical Health Officer (MHO) or their official designate. Declaring an outbreak coincides with the implementation of additional infection prevention and control measures, over and above those that would be routinely implemented. These measures could include closing the affected unit to new admissions or transfers, or temporarily restricting non-essential visits.
- BC has 2 COVID-19-specific outbreak protocols that include actions to prepare for an outbreak in acute care or Long Term Care (LTC)/Seniors' Assisted Living (AL) settings: criteria and considerations for declaring an outbreak; managing an outbreak; identifying when enhanced monitoring is required; declaring it over and actions to take; and clinical forms to support screening and tracking of symptoms in patients, clients, residents, staff, and health care workers.
- BC's current COVID-19 outbreak definitions for these settings are as follows:
    - *Acute Care:*[4] The occurrence or suspicion of epidemiologically linked cases of confirmed health care associated COVID-19 within a 10-day period; an investigation indicates that transmission most likely occurred within the same unit or facility, from another patient, visitor, or staff, rather than prior to admission or from community exposure, and the number of cases or the severity of illness is beyond what is normal or expected based on circulating virus.
    - *LTC and Seniors' AL Facility:*[5] A COVID-19 outbreak in LTC is declared when the following criteria are met: an unexpected increase in COVID-19 cases or case severity among residents which may involve a rapid increase in cases amongst residents with no known contact with other identified cases; which is not responding or expected to respond to usual infection prevention and control measures; and/or resident susceptibility to severe illness has been deemed to be particularly high; and the application of additional control measures are considered to have a higher overall benefit than risk.
- The COVID-19 acute care outbreak protocol and the Long-Term Care (LTC)/Seniors' Assisted Living (AL) protocol are being updated to include measures for managing outbreaks of all viral respiratory illnesses, including COVID-19, influenza, and respiratory syncytial virus (RSV), and to further clarify the criteria for declaring an outbreak.
- Weekly reports of outbreaks in LTC/AL and acute care settings are available to the public on the BC Centre for Disease Control's (BCCDC) website.[6]

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- On March 4, 2021, BC issued a standardized provincial outbreak management protocol (the Outbreak Protocol) to provide guidance and best practices to prepare for, detect and respond to outbreaks of COVID-19 in acute care, long-term care (LTC) and seniors' assisted living (AL) settings.
- Due to the differences between these settings, the Outbreak Protocol was later separated into two documents for guiding the management of COVID-19 outbreaks in acute care and LTC/seniors' AL settings, respectively. These updated documents were publicly posted on February 2, 2022, and revised on August 22, 2022.[7, 8]

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[4] BC Centre for Disease Control. COVID-19: Outbreak Management Protocol for Acute Care Settings. August 22, 2022. Pg. 7. Retrieved February 05, 2024 from http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID-19_Acute_Care_Outbreak_Management_Protocol.pdf.

[5] BC Centre for Disease Control. Interim Guidance: Public Health Management of COVID-19 in the Community. Pg. 10. Dated November 17, 2022. Retrieved February 05, 2024 from http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%201%20-%20CDC/COVID-19%20Public%20Health%20Guidance%20Nov_17_2022.pdf.

[6] BC Centre for Disease Control. Respiratory Diseases Data Platform. Retrieved February 05, 2024 from http://www.bccdc.ca/health-professionals/data-reports/respiratory-diseases.

[7] BC Centre for Disease Control. COVID-19 Outbreak Management Protocol for Long-Term Care and Connected Seniors' Assisted Living Settings. Dated August 22, 2022. Retrieved February 05, 2024 from http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID-19_Provincial_Outbreak_Management_Protocol_LTC.pdf.

[8] BC Centre for Disease Control. COVID-19: Outbreak Management Protocol for Acute Care Settings. Dated August 22, 2022. Retrieved February 05, 2024 from http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID-19_Acute_Care_Outbreak_Management_Protocol.pdf.

- Enhanced monitoring and implementation of additional IPC measures occurs in circumstances where the COVID-19 cases at a health care unit or facility do not meet the threshold for an outbreak, but still require increased attention to prevent transmission. This can include increased active symptom screening and precautionary initiation of droplet and contact precautions for some patients, clients, or residents. Enhanced IPC measures are applied and adjusted as necessary based on assessed risks and in discussion between the MHO, the facility, and the IPC team.

LAST UPDATED

The content of this estimates note is current as of April 3, 2024, as confirmed by Brian Sagar, Executive Director, Communicable Disease Prevention and Control Branch.

APPROVALS

2024 03 22 - Dr. Bonnie Henry, Provincial Health Officer, Office of the Provincial Health Officer
2024 03 22 - Martin Wright Assistant Deputy Minister, Health Sector Information, Analysis & Reporting Division
2024 04 03 - Brian Sagar obo Maryna Korchagina, Population and Public Health Division

LEGISLATIVE SESSION – ESTIMATES NOTE

L-01

Community Health Centres

Topic: Community Health Centres (CHCs) provide comprehensive person- and-community-centered longitudinal and episodic primary health care typically to priority populations and often provide access to other supports to address the social determinants of health using an interdisciplinary team-based care approach.

Key Messaging and Recommended Response:

- **Community Health Centres (CHCs) are one of several clinic models the Ministry is funding to support team-based primary care through its provincial primary care strategy.**
- **There are nine new or significantly expanded CHCs funded through the province's primary care strategy. These include:**
  - **Fraser Health (3): Umbrella Multicultural Health Co-op,** Cabinet Confidences
    Cabinet Confidences
  - **Vancouver Coastal Health (2): RISE CHC and Bowen Island CHC**
  - **Island Health (3): Island Sexual Health, Westshore CHC, and Luther Court CHC**
  - **Interior Health (1): Rutland CHC**
- **The province has committed over $27M in annual funding to support 9 CHCs currently in implementation.**
- **There are five additional CHCs currently in planning:**
  - Cabinet Confidences; Intergovernmental Communications
  -
- **CHCs funded through the primary care strategy have hired 86.4 full-time equivalents (FTEs).**
- **There are also many other CHCs operating in communities throughout the province. Since 2018, the Ministry has also provided grant funding ($12.54M) to**

the BC Association of Community Health Centres (BCACHC) to distribute to other CHCs in the province to support primary care services.

CURRENT SITUATION

- As of January 2024, there are nine Primary Care Strategy (PCS)-funded CHCs with five additional CHCs in various stages of planning.
  - The total attachment to Strategy-funded CHCs to date is 10,108.
- The Ministry partners with the BCACHC, who acts as a key intermediary between the Ministry and the broader CHC sector.
  - As of January 2024, there are 44 registered BCACHC members (including all the Ministry's Strategy-funded CHCs as well as several non-Strategy-funded CHCs). 29 of these members represent operational CHCs providing longitudinal primary care, while 15 represent "emerging CHCs" (community not-for-profits working towards becoming a CHC).
  - The Ministry has provided emergency sustainment funding (in the form of grants and, most recently, a Shared Cost Arrangement [SCA]) to support the continued delivery of critical primary care services for BCACHC members.
  - 17 BCACHC CHCs (non-Strategy funded) received grant funding in FY 23/24, and these CHCs have 34,266 attached patients.[1]
- As of January 2024, there are an estimated 135 "other" community health centres in the province (not Strategy-funded, and not BCACHC members, some are health authority owned) providing a range of health and non-clinical services, often including primary care. A comprehensive inventory has been developed listing all community health centres in the province.

FINANCIAL IMPLICATIONS

- As of January 2024, the Ministry has committed to fund $27.55M in annual operating costs for the nine Strategy-funded CHCs currently in implementation, $4.07M in capital, $8.65M in one-time start-up costs and $0.51M in Change Management Costs.
- The Ministry has also invested a total of $12.54M in emergency sustainment funding to non-Strategy funded CHCs since 2018 ($2.13M in 2017/18; $1M in 2019/20; $2.13M in 2020/21; $3.78M in 2021/22; 3.5M in 2023/24) and plans to continue with these investments for FY 24/25 (to ensure non-disruption to critical primary care services in the province).
- The Ministry's budget includes $538.32M in 2024/25 to support the continued implementation of Primary Care Strategy initiatives (including Primary Care Networks, Urgent and Primary Care Centres, CHCs, and Family Physician- and Nurse Practitioner-led clinics). This is an increase of $76.40M over the projected 2023/24 Primary Care Strategy expenditure of $461.92M.

KEY BACKGROUND

- CHCs are community-led and governed (by not-for-profit societies) and offer both primary care as well as access to social services for priority populations.
  - Goals of the CHC model include increasing attachment to primary care, decreasing access barriers, and offering services that improve health equity.
- Key partners include CHCs, regional health authorities (who partner for funding flow-through), BCACHC, and Primary Care Networks.
- Other service arrangements may be supported by health authorities or CHCs may be funded through Fee-for-Service. CHCs may also receive partial or ongoing funding from other provincial ministries (e.g., Ministry of Children and Family Development). Many existing CHCs were built and paid for by local community members who still finance major portions of the health and social services delivered.

[1] Retrieved from the BC Association of Community Health Centres Shared Cost Agreement Contract's Culminative Report of Primary Care Sustainment-Funded CHC members. January 2024.

- Beyond the Ministry's Primary Care Division, community health centres may also be funded through several other mechanisms such as: service arrangements supported by health authorities; partial or ongoing funding from other provincial ministries (e.g., Ministry of Children and Family Development); local community members (many CHCs were built and paid for by community members who still finance major portions of the health and social services); etc.

LAST UPDATED

The content of this estimates note is current as of April 11, 2024 as confirmed by Kelly McQuillen.

APPROVALS

2024 02 20 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 23 – Leighanne Tripp obo Rob Byers, Finance and Corporate Services Division
2024 04 12 – Ted Patterson, Primary Care Division

LEGISLATIVE SESSION – ESTIMATES NOTE

L-02

Family Practice Services Committee

Topic: Dedicated to strengthening longitudinal family practice as the foundation of an integrated system of care, the Family Practice Services Committee (FPSC) is involved in, or oversees, key primary care transformation strategies in BC in partnership with the Ministry of Health.

Key Messaging and Recommended Response:

- **The Ministry of Health and Doctors of BC are leaders in Canada as a result of the collaborative partnership of the Family Practice Services Committee (FPSC).**
- **Since its formation in 2002, a key focus of the FPSC has been to improve the quality and sustainability of primary care in BC. Most recently this has included:**
  - **Providing $38.4M in 2023/24 and an additional $33.8M in 2024/25 to stabilize facility-based care and maintain service delivery, specifically in-patient, maternity, and long-term care.**
  - **Collaborating on the launch (Feb. 2023) and now (ongoing) expansion of the Longitudinal Family Physician Payment Model.**
  - **Supporting the new Provincial Attachment System, which is connecting patients throughout BC with providers in their communities.**
  - **Announcing a refreshed approach to Primary Care Networks.**
  - **Launching and expanding (Jan. 2024) the After-Hours Care pilot program.**
  - **Supporting the launch of a new Nurse in Practice program (Feb. 2024)**
  - **Implementing and evaluating the Urban Locum Pilot Program in Victoria and South Island, which supports family physicians in receiving practice coverage for up to 10 days annually.**

CURRENT SITUATION

Chaired by Primary Care Division's Assistant Deputy Minister Ted Patterson, and Doctors of BC's Dr. Sari Cooper, the FPSC meets weekly to discuss primary care goals and objectives, as well as consider innovative approaches to increase both access and attachment to primary care for those seeking a family physician (FP) or a nurse practitioner.

FINANCIAL IMPLICATIONS

Per the 2022 Physician Master Agreement, the 2023/24 annual funding is $192.3M.[1,2] FPSC's annual funding for 2024/25 is $193.3M.[3,4]

KEY BACKGROUND

- In 2023/24, FPSC provided $6.3M in quarterly $5000 grants to support FPs to maintain maternity services in hospital until March 31, 2024.[5]
- The new Longitudinal Family Physician (LFP) Payment Model, announced in February 2023, has seen 4000 FPs enrolled as of February 2024.[6]
- For Nurse in Practice information, please see the Nurse in Practice Program Estimates Note.
- The FPSC will continue to provide approximately $20.8M to support longitudinal care provided by FPs working under fee-for-service or other payment models as part of the 2023 Community Longitudinal Family Physician (CLFP) Payment.[7]
- Team-Based Care Grants provide up to $15,000 to eligible family practices to address the costs of recruiting and onboarding team-based professionals into practice. In 2023/24 (as of Feb 9, 2024), $121,350 has been paid to 22 family practices for an initial claim, $143,400 has been paid to 32 family practices for their second installment, and $148,500 has been paid to 25 family practices for final payment.[8]
- Long-term Care Initiative: Since 2015, the FPSC has made available $12.1M in annual funding for the provincial Long-term Care Initiative, a provincial quality improvement initiative to increase the implementation of five best practices to help ensure patients living in long-term care facilities have FP care.[9] In 2023/24, the FPSC has provided an additional $15.4M in quarterly $5000 grants to support FPs to sustain their services in long-term care homes.[10]
- In 2023/24, the FPSC extended In-patient Care bridge funding to provide $14M to 48 hospital locations to support FPs providing inpatient care. The FPSC is providing $10.2M in funding to 48 hospital locations to further stabilize inpatient care services, in addition to the $14.8M that FPSC provides annually for Medical Services Plan (MSP) fee items supporting inpatient care networks and other inpatient care services. In 2023/24, FPSC aims to provide $53.2M supporting inpatient care by FPs in BC. [11]
- A total of $8.8M is budgeted annually to compensate physicians for participating in two FPSC programs (Practice Support Program and Doctors Technology Office) which provide comprehensive services to FPs (e.g., developing proactive care processes, using data to inform improvement).[12]
- In 2023/24, $43.33M was available to fund 35 Divisions of Family Practice (DoFP) as they engage physicians and support change management in the primary care system; $2.75M was provided to support and enhance recruitment & retention efforts; and $2.7M was provided to support primary care transformation, including regional engagement and Primary Care Network (PCN)/Patient Medical Home and team-based care implementation across the province. $3.9M in Attachment Mechanism Funding has been distributed among 35 DoFPs to hire Attachment Coordinators and develop patient attachment mechanisms aligned with the Health Connect Registry.[13]

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[1] 2022 Physician Master Agreement. https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/ministries/health/consolidated_physician_master_agreement.pdf
[2] FPSC Work Plan and Budget 2023-24.
[3] 2022 Physician Master Agreement. https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/ministries/health/consolidated_physician_master_agreement.pdf
[4] FPSC Work Plan and Budget 2024-25 DRAFT.
[5] Based on FPSC payment expenditure information.
[6] Doctors of BC Announcement: https://www.doctorsofbc.ca/news/celebrating-one-year-anniversary-longitudinal-family-physician-payment-model
[7] Based on FPSC payment expenditure estimates.
[8] Based on FPSC payment expenditure estimates.
[9] FPSC Work Plan and Budget 2023-24.
[10] Based on FPSC payment expenditure estimates
[11] Based on FPSC payment expenditure estimates
[12] FPSC Work Plan and Budget 2023-24.
[13] FPSC Work Plan and Budget 2023-24.

- The FPSC continues to co-lead the PCN refresh, including changes to the PCN Steering Committee composition and leadership (Physician Convenor/Chair model) and strengthening engagement with Indigenous, community and patient partners.

LAST UPDATED

The content of this estimates note is current as of February 9, 2024 as confirmed by Jennifer Gough.

APPROVALS

2024 02 11 – Ted Patterson, Primary Care Division
2024 02 16 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

L-03

HealthLink BC Core Services

Topic: HealthLink BC (HLBC) delivers high quality, multidisciplinary virtual and digital health services across the continuum of care to people living in BC.

Key Messaging and Recommended Response:

- **HealthLink BC provides trusted, virtual and digital health information and advice to people living in BC any time of the day or night. Nurses, dietitians, pharmacists, exercise professionals and physicians are available to British Columbians free of charge at 8-1-1.**
- **HealthLink BC helps patients understand the health services available in their community and, through the Health Connect Registry, supports the registration for and attachment to a primary care provider.**
- **HealthLink BC 8-1-1 provides virtual health supports to 1,500 callers a day and healthlinkbc.ca digital health services to 20,000 visitors a day.**
- **The role and mandate of HealthLink BC will continue to evolve and expand to support the Ministry's strategic priorities, such as primary care, to better meet the needs of British Columbians.**

CURRENT SITUATION

- HealthLinkBC (HLBC) 8-1-1 virtual health services provide support to people anywhere in BC to manage their symptoms, answer health related questions, identify when and where to access health services, and support registration for longitudinal attachment. The virtual health team includes patient navigators, nurses, dietitians, exercise professionals, pharmacist and physicians. At approximately 1,500 calls/day, the virtual health team supports 550,000 calls/year.
- In additional to general health services, the virtual health team also provides:
  - Virtual Physician Services. Since launch on April 6, 2020, to December 31, 2023, physicians have provided 160,498 patient consults. For continuity of care, the medical consult is shared with community providers via CareConnect.[1]
  - Provincial COVID-19 Treatment Program. Since launch on February 19, 2022 to December 31, 2023, the service has received 14,283 patient referrals. Of the patients seen, 7,498 patients (52%) were provided with treatment options (7,059 Paxlovid prescription and 439 IV therapy referral).
  - Provincial Prescription Renewal Support Service. Since launch on January 24, to December 31, 2023, the service has received 843 patient referrals. Of patients seen, 550 (65%) received a prescription renewal, 174 (21%) required laboratory testing, and 95 (11%) required referral to in-person care in community for physical assessment.[2]
  - After-Hours Care Program. In partnership with the Family Practice Services Committee (FPSC), the Program provides physician supports to attachment patients when community family practice clinics

[1] KDR Data Mart, *HEiDi_Summary_2023*, 2023, HealthLink BC
[2] KDR Data Mart, *HEiDi_Summary_2023*, 2023, HealthLink BC

are closed. The pilot was successful in 5 regions in BC and will be expanded provincially in early 2024. Refer to After-Hours Care Program supplemental.

- HLBC digital health services at healthlinkbc.ca provide access to trusted health information and interactive tools on over 5,000 health topics and a searchable database of over 6,500 health and health related services throughout BC. The HLBC website receives up to 20,000 visits/day.[3]
- In addition to general digital health services, the digital team also provides:
  - Health Connect Registry. Provides people living in BC the opportunity to register themselves, their family or a person in their care for a primary care provider. Registrants unable to do so online or who require translation can call 8-1-1. Refer to Provincial Attachment System (PAS) Estimates Note.
  - Primary Care Online. Patient-focused content on healthlinkbc.ca aimed at increasing awareness of the province's primary care model by helping citizens understand what primary care services are available in their community, and how to access them. Refer to Primary Care Online supplemental.

FINANCIAL IMPLICATIONS

HLBC's expenditures were $29.3M in 2019/20, $35.9M in 2020/21, $36.3M in 2021/22, and $39.1Min 2022/23. For 2023/24, HLBC budget is approximately $38.6M.

KEY BACKGROUND

- HLBC has seen an increase in demand for all services since 2016/17 and markedly so during the province's response to COVID-19. Prior to the pandemic, 8-1-1 service demand averaged 1,250 calls/day in early 2020. During the peaks of the COVID-19 pandemic (Wave 1 in March 2020, and the Omicron Variant in November 2021), 8-1-1 received over 6,700 calls/day. Online healthlinkbc.ca experienced a 400% increase in demand with up to 60,000 or more visits/day in 2021.[4]
- HealthLink BC 8-1-1 virtual health service calls received / encounters with patients:

	2022[5]		2023[6]	
	Annual	Daily Average	Annual	Daily Average
Navigators	689,610	1,889	543,518	1,489
Nurses	304,242	834	319,291	875
Dietitians	9,474	36	9,603	38
Exercise Professionals	1,221	5	1,694	7
Pharmacists	23,337	64	22,741	62
Physicians	43,937	120	50,825	139

- Of the nurse encounters, 9% of clients recommended to call 9-1-1, 33% recommended to visit the emergency department or health care provider within the hour, 27% recommended to visit their physician or clinic within 12 hours, 4% recommended to make an appointment with their primary care provider within 1-2 weeks, and 28% provided self-management support and health education.
- Of the physician consultations, 23% of patients recommended to visit the emergency department, 10% recommended to seek care with a primary care provider, 26% recommended to schedule an appointment with physician within 1–2 weeks, and 41% provided self-management support and health education. Physicians have diverted 62% of calls where a HLBC nurse had initially referred the patient to an emergency department or Urgent and Primary Care Centre.

[3] Symmetrics NVISION Data Mart, *BIU21_ NAV_ Org*, 2022, HealthLink BC

[4] Symmetrics NVISION Data Mart, *BIU21_ NAV_ Org*, 2021, HealthLink BC; KDR Data Mart, *Project BIU21_NS_Org, Project BIU21_DS_Org, Project BIU21_PAS_Org, Project BIU21_PS_Org, HEiDi_Summary_2021*, 2021, HealthLink BC

[5] Symmetrics NVISION Data Mart, *BIU21_ NAV_ Org*, 2022, HealthLink BC; KDR Data Mart, *Project BIU21_NS_Org, Project BIU21_DS_Org, Project BIU21_PAS_Org, Project BIU21_PS_Org, HEiDi_Summary_2021*, 2022, HealthLink BC

[6] Symmetrics NVISION Data Mart, *BIU23_ NAV_ Org*, 2023, HealthLink BC; KDR Data Mart, *Project BIU23_NS_Org, Project BIU23_DS_Org, Project BIU23_PAS_Org, Project BIU23_PS_Org, HEiDi_Summary_2023*, 2023, HealthLink BC

LEGISLATIVE SESSION – ESTIMATES NOTE

L-03

LAST UPDATED

The content of this estimates note is current as of February 9, 2024 as confirmed by Sandra Sundhu.

APPROVALS

2024 02 11 - Ted Patterson, Primary Care Division
2024 02 20 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

L-04

Indigenous Primary Care Initiatives

Topic: Enhancing access to culturally safe primary care for Indigenous people is a key focus of the Ministry of Health's primary care strategy in BC.

Key Messaging and Recommended Response:

- **The Province's primary care strategy provides funding for Indigenous people to access culturally safe care through a number of different models of care including Primary Care Networks (PCNs), Community Health Centres (CHCs), and First Nations-led Primary Care Centres (FNPCCs).**
- **As of January 2024, 38.8 full time equivalent (FTE) elders and traditional wellness supports have been hired in PCNs (including CHCs, FNPCCs and NPPCCs) for Indigenous communities supporting culturally safe team-based primary care delivery.**
- **Three FNPCCs are in operation (Lu'ma Medical Centre, All Nations Healing House and Éyameth Health Centre). One FNPCC is approved but not yet in operation (Fraser West) and three additional FNPCCs are in planning for phased openings (Gitxsan & Wet'suwet'en, Dakelh, and Saulteau & West Moberly).**
- **Across these seven FNPCCs, these FTEs aim for an attachment target of approximately 14,950 new patients.**
- **As of January 2024, 25.1 FTE of the total approved 38.5 FTE (65%) for the three FNPCCs in operation (Lu'ma Medical Centre, All Nations Healing House and Éyameth Health Centre) have been recruited.**

CURRENT SITUATION

Primary Care Networks (PCNs)

- Local community PCNs are engaging with First Nations and Indigenous health organizations in service plan development and implementation. Representatives from each are members of PCN Planning and Steering Committees, are active in PCN governance, and in some, are serving as PCN co-chairs.
- As of January 2024, through the Primary and Community Care Governance Refresh, governance pathways with Indigenous partners and the Métis Nations to enhance, support and evolve authentic engagement in PCN development and delivery towards culturally safe services for their people are being explored.

First Nations-led Primary Care Centres (FNPCCs)

- Five additional FNPCCs are in active service planning: Lil'wat and Southern Stl'atl'imx (Pemberton); Nuu-chah-nulth (Tofino); Nuxalk (Bella Coola), Coast Salish (S Vancouver Island), and Kwakwaka'wakw (N Vancouver Island). Three more sites are planned, with locations to be determined.

Provincial Partnerships

- The Joint Project/Priorities Board (JPB) is a First Nations Health Authority (FNHA) and Ministry partnership supporting 27 primary and community care projects.
- In Plain Sight (IPS) recommendations are actioned in part through the jointly co-chaired Ministry and FNHA Indigenous Cultural Safety and Humility (ICSH) in Primary and Community Care Provincial Working Group. Established in 2021, the group includes Ministry and FNHA representatives with Métis Nation BC, health authorities, Doctors of BC, Colleges, and health system stakeholders.
- The ICSH Working Group's initial focus is to design an ICSH Engagement and Learning Pathway for community-based physicians and primary care teams. The pathway will leverage existing ICSH materials and partnerships to improve relational and culturally safe practice(s) with Indigenous Peoples.

FINANCIAL IMPLICATIONS

The following funding was provided by the Ministry to support Indigenous Primary Care Initiatives in 2023/24:

- $15.33M to FNHA to support the JPB primary and provincial community care projects.[1]
- $21.18M in funding (including $0.79M in change management costs and $1.85M in one-time costs) to FNHA to support FNPCCs in implementation (Lu'ma Medical Centre, All Nations Healing House, Gitxsan & Wet'suwet'en FNPCC, Dakelh FNPCC, Éyameth Health Centre , Fraser West FNPCC, Nuu-Chah-nulth and Saulteau & West Moberly FNPCC).[2]
- As of January 2024, the Ministry has committed approximately $7.30M in annualized funding towards traditional wellness supports for Indigenous communities (including the salaries of supports working in FNPCCs) through the team based care models of PCNs, Community Health Centres, and FNPCCs.
- $377,640 in funding to FNHA to support First Nations Primary Care Initiative (FNPCI) project managers to develop service plans for future FNPCIs in various stages of active planning.[3]
- $6.99M in funding to FNHA and Northern Health Authority to support First Nations Virtual Doctor of the Day (FNvDOD) and First Nations Virtual Substance Use and Psychiatry Service (FNvSUPs).[4]
- *Budget 2022* allocated $45M over three years (2022/23 to 2024/25) to implement PCNs and bring additional Traditional Wellness Providers closer to Indigenous communities.

KEY BACKGROUND

The Ministry is committed to enhancing the health and wellbeing of Indigenous peoples, as identified through the United Nations Declaration on the Rights of Indigenous Peoples, the Truth and Reconciliation Commission, and the *In Plain Sight (IPS): Addressing Indigenous Specific Racism in BC Health Care* Report recommendations that are being actioned through First Nations health plans and agreements, as is mental health and wellness and substance use, Indigenous recruitment, anti-racism, cultural humility, and trauma-informed training.

LAST UPDATED

The content of this estimates note is current as of April 11, 2024 as confirmed by Kelly McQuillen.

APPROVALS

2024 02 14 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 22 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 04 12 – Ted Patterson, Primary Care Division

[1] Data retrieved from 2022/23 Ministry of Health – FNHA Letter of Mutual Accountability
[2] Data retrieved from PCD FNHA 23-24 budget
[3] Data retrieved from FNHA Project Manager funding letter issued April 11, 2023
[4] Data retrieved from NHA and FNHA 23-24 Funding Letters for Real Time Virtual Supports

LEGISLATIVE SESSION – ESTIMATES NOTE

Maternity Services Strategy – Primary Care Maternity Services

Topic: Government response to address maternity services challenges in BC.

Key Messaging and Recommended Response:

- **The Ministry of Health, Provincial Health Services Authority (PHSA), and Perinatal Services BC (PSBC) developed a three-year roadmap to improve access and quality of care for maternity services across the province.**
- **Key actions of the roadmap include promoting culturally safe care, enhancing supports for rural and remote care, promoting team-based maternity care services, and attracting and retaining skilled providers.**
- **The Ministry has taken concrete steps to stabilize the workforce by expanding the Longitudinal Family Physician payment model to include maternity (December 1, 2023) and by adding twenty midwifery seats to the UBC Midwifery Program (announced February 2023) to attract and retain maternity providers.**
- **The Ministry is taking steps to strengthen system-wide planning and coordination, focusing on sustainable transport delivery models aligned with Maternal/Fetal and Neonatal Tiers of Service.**

CURRENT SITUATION

- Addressing compensation is a key pre-requisite for improving recruitment and retention of family physicians to provide maternity care services. As such, the Ministry and Doctors of BC (DoBC) have taken a number of steps to stabilize and support maternity services provided by longitudinal family physicians.
- In December 2023, the Ministry and DoBC agreed to expand the Longitudinal Family Physician (LFP) Payment Model to include hospital-based services delivered by family physicians. The new model will be available for billing by these physicians by June 2024.
- As of December 1, 2023, family physicians (FPs) enrolled in the LFP payment model who provide care at maternity clinics separate from their LFP clinic can bill under the LFP payment model.
- Similarly, as of December 1, 2023, FPs providing maternity call coverage (inclusive of labor and birth care in hospital) are now eligible to receive on-call availability payments through the Medical On-Call Availability Program (MOCAP).
- In June 2023, FPs providing maternity care in hospitals received a one-time grant of $10,000 from the Family Practice Services Committee (FPSC) if they committed to maintaining services until December 31, 2023. FPSC has agreed to extend this funding into the next year, at a rate of $5,000 quarterly per physician pending further expansion of the LFP Payment Model for services in these areas. FPs will be able to bill facility-based care through the model in the near future (announcement pending).
- Alternative Payment Program (APP) service contracts have been put in place in the past year to stabilize facility-based FP maternity services provided by family physicians for patients in Kamloops, Kelowna, and Victoria. APP is anticipating the implementation of similar APP contracts in at least three additional communities in the province – all are in early discussions.

- Service contracts put in place to support the continued delivery of midwifery maternity services in Hazelton, Haida Gwaii, Invermere, Salt Spring Island, Port Hardy and Powell River have been increased from 2 to 3 full-time equivalents (FTEs) in each community to ensure adequate cross coverage and to prevent burnout.
- The province is also taking steps to support the important role that midwives play in delivering maternity services. A new three-year agreement was ratified between the Province and the Midwives Association of British Columbia. The agreement is effective retroactively from April 2022 until March 2025.
- Under the agreement the Ministry commits to developing both a service contract compensation model and a new payment model for midwives similar to the LFP payment model for FPs. Work on these models is currently underway.
- The Ministry is also currently exploring new strategies to increase maternity care capacity, care coordination and mitigate community crises through Primary Care Networks (PCNs).
    - As of January 2024, 18 PCNs are using Ministry-approved funding to hire maternity providers or increase the number of providers who include maternity within their practices.[1]
    - The Ministry is developing policy to guide PCN partners on expectations around delivery of maternity services in a PCN.
- Though not primary care, the Ministry has also been meeting with Obstetrics/Gynecology specialists, who work alongside family physicians and midwives in hospital settings, to understand their concerns around current compensation models for specialists.

FINANCIAL IMPLICATIONS

- Advice/Recommentations

- The Ministry's budget includes $538.32M in 2024/25 to support the continued implementation of Primary Care Strategy initiatives (including PCNs, Urgent and Primary Care Centres, Community Health Centres, and FP- and Nurse Practitioner-led clinics). This is an increase of $76.40M over the projected 2023/24 Primary Care Strategy expenditure of $461.92M.

KEY BACKGROUND

- Since 2021, the number of births in BC has steadily been trending downward with 44,079 births reported in 2021, 41,928 births in 2022, and 41,354 births in 2023.[2]
- Recruitment and retention of primary care maternity service providers is a significant challenge:
    - Since 2010, the number of FPs providing birth delivery (intrapartum) services dropped 34.5% (852 in 2010/11 vs 558 in 2022/23), due to a reluctance to work non-standard hours and a recognition that fee-for-service and LFP payment models do not incentivize on-call intrapartum care.[3,4]
    - Of the 492 midwives registered to practice in the province, 400 are actively practicing.[5]
- Since 2003, over 20 rural maternity sites closed due to provider attrition. Key factors included the incompatibility of fee-for-service compensation in low-volume birth settings, low nursing and physician confidence, under-developed networks for maternity care providers and the 24-hour nature of the service.[6]
- Low-risk maternity care is part of the comprehensive basket of services PCNs are expected to provide to their local populations. This includes sexual health promotion, preconception counselling, and health promotion services through all stages of the perinatal period, as well as access to contraception, abortion services and post-abortion care.

[1] Maternity Services Scan of Primary Care Initiatives (PCIs). Primary Care Division. As of January 2024.
[2] HSIAR Vital Events: birth event data extracted February 23, 2024. Data for 2023 is subject to change as some births may not be registered..
[3] Data as of February 2024. Extracted February 20, 2024, from MSP using claim specialty codes 00, 50, 76 and fee items for induction of labour, labour management and delivery by HSIAR.
[4] Ibid.
[5] Received from the BC College of Nurses and Midwives January 31, 2024.
[6] Centre for Rural Health Research: https://med-fom-crhr.sites.olt.ubc.ca/files/2018/11/Working-Together-for-Sustainability-Proceedings.pdf. 01/26/22.

LEGISLATIVE SESSION – ESTIMATES NOTE

- Since 2020, the Ministry has provided funding support to the Maternity and Baby Advice Line (MaBAL), which offers rural, remote, and Indigenous primary care providers with 24/7 virtual access to FPs with expertise in maternal/newborn care. From August 2020 to January 2024, MaBAL received 3,782 calls.[7]

LAST UPDAT

The content of this estimates note is current as of February 9, 2024, as confirmed by Jeremy McLay.

APPROVALS

2024 02 11 – Ted Patterson, Primary Care Division
2024 02 22 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 26 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

[7] Data received from the Rural Coordination Centre of BC for calls up to January 14, 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE

L-06

Mental Health and Substance Use in Primary Care

Topic: Access to quality, culturally safe, person and family-centred mental health and substance use (MHSU) primary care services.

Key Messaging and Recommended Response:

- **A key attribute and expectation of Primary Care Networks (PCNs) is they are working to provide *comprehensive* primary care services under a team-based care model.**
- **This includes Mental Health and Substance Use (MHSU) services such as screening, assessment, and management of mild to moderate conditions, as well as ensuring effective transitions of care to the nearest specialized community services program when more specialized care is needed.**
- **Within PCNs, MHSU services may be provided by a range of health care providers including family physicians, nurse practitioners, Indigenous health providers, psychologists, counsellors, and social workers. Providers work together to understand patients' needs and to provide the most appropriate and timely care services.**
- **As part of the Primary Care Strategy, as of January 2024, 77 PCNs have been implemented with 75 (97%) recruiting staff with MHSU specific classifications.[1]**
- **As of January 2024, 318.7 full-time equivalents (FTEs) have been hired in PCNs to directly support the mental health and wellness of patients in BC communities.**
- **The Ministry is also working with the BC Psychologists Association on a pilot project to incorporate more psychologists in primary care through PCNs.**
- **Outside of PCNs, there are also virtual MHSU supports provided by health authorities and other partners, for example the First Nations Virtual Substance Use and Psychiatry Service delivered by First Nations Health Authority.**

CURRENT SITUATION

- The majority of Primary Care Networks (PCNs) (97%) offer some level of focused MHSU services. For example, MHSU specific primary care supports in **Vancouver Coastal Health** region include RISE Community Health Centre (CHC), Lu'ma Medical Centre (First Nations-led Primary Care Centre), and Foundry Centres. In **Fraser Health** region, the Fraser Northwest PCN has a Rapid Access Mental Health

[1] See Table 1 Page 2

Program. In **Interior Health**, three PCN communities (Cranbrook, Kelowna, and Penticton) have Foundry Centres. In **Island Health**, focused MHSU primary care resources are available in all PCN communities apart from the Port Alberni PCN. For example, the Island Sexual Health CHC in Victoria provides MHSU services, Foundry is partnering with Victoria PCN and Campbell River and District PCN, and the Nanaimo Urgent and Primary Care Centre (UPCC) provides opioid agonist therapy (OAT). In **Northern Health** region, interprofessional teams offer primary care mental health supports in community settings in all PCN communities apart from the Nisga'a PCN. The Carrier Sekani Family Services Foundry is partnering in the Northern Interior Rural PCN.

- As of January 2024, 97% of PCNs in implementation have successfully recruited staff with MHSU specific classifications.
- Of 1,800 full-time equivalents (FTEs) recruited under the broader primary care strategy, 318.7 FTEs are delivering dedicated MHSU services (see Table 1), with more expected as the number of PCNs and associated clinics continue to grow and recruit clinical staff. [2]
- Cabinet Confidences

Table 1: Hired clinical staff with MHSU classifications (as of January 2024).

Resource	CHC	FNPCC	NPPCC	PCN	UPCC
Counsellor	0.4	-	3.0	49.1	6.7
Community Health Worker	13.3	-	-	5.0	1.0
Life Skills Worker	-	-	-	1.0	-
Mental Health Professional (Indigenous)	-	1.0	-	1.0	-
Mental Health and Substance Use worker	-	-	-	34.0	16.4
Outreach and Prevention Worker	-	-	-	1.2	0.5
Psychologist	-	-	-	0.0	-
Registered Psychiatric Nurse	0.0	-	-	0.0	-
Social Worker & Disciplines Allied to Social Work	8.7	2.0	4.8	99.7	65.3
Social Worker/Navigator (Indigenous)	-	2.0	-	2.0	0.5
Totals	**22.5**	**5.0**	**7.8**	**193.0**	**90.4**

FINANCIAL IMPLICATIONS

The Ministry's budget includes $538.32M in 2024/25 to support the continued implementation of Primary Care Strategy initiatives (including PCNs, UPCCs, CHCs, and Family Practitioner- and Nurse Practitioner-led clinics). This is an increase of $76.40M over the projected 2023/24 Primary Care Strategy expenditure of $461.92M.

KEY BACKGROUND

- In September 2021, the Ministry began work with the Ministry of Mental Health and Addictions (MMHA) to support MMHA's Mandate Letter, focused on building a comprehensive system of mental health and addictions care, including by implementing *A Pathway to Hope*. The intersection of the Ministry's primary care strategy with MMHA's *A Pathway to Hope* has led both Ministries to collaborate on MMHA's deliverable of expanding access to counselling services**.**
- The Ministry's PCN policy outlines a requirement to provide comprehensive primary care services, which includes MHSU services, as well as ensuring effective transitions of care to health authority specialized community services programs when more specialized care is needed.
- PCNs offer comprehensive primary care services, which may include care for mental health and substance use, including screening, counselling, pharmacological treatment and medication monitoring, rapid access to crisis intervention services, harm reduction resources, and OAT services.

[2] Gitxsan, Sts'ailes and Dak'elh FNPCCs not included in FY 2023/24 P10 Workforce Hiring Report, Results Management Office, Primary Care Division.

LEGISLATIVE SESSION – ESTIMATES NOTE

L-06

LAST UPDATED

The content of this estimates note is current as of April 11, 2024, as confirmed by Jeremy McLay.

APPROVALS

2024 02 13 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 22 – Leighanne Tripp obo Rob Byers, Finance and Corporate Services Division
2024 04 12 – Ted Patterson, Primary Care Division

LEGISLATIVE SESSION – ESTIMATES NOTE

L-07

Nurse in Practice Program

Topic: The Nurse in Practice program supports primary care access and patient attachment by integrating Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) into focused and longitudinal primary care clinics.

Key Messaging and Recommended Response:

- **The Ministry of Health expanded the Nurse in Practice program in February 2024, which provides eligible family practices funding to hire registered nurses (RNs) and Licensed Practical Nurses (LPNs).**
- **The program initially launched in 2017 on a very small scale in several Interior Region clinics.**
- **It will now be available province-wide to family practices and focused primary care clinics serving priority populations.**
- **Adding RNs and LPNs in a team-based primary care clinic allows the clinic to increase capacity to serve patients, facilitate more timely access to care, reduce wait times for patients seeking care, help family physicians and nurse practitioners work to their full scope of practice, and ultimately improve patient outcomes.**
- **Eligible family practices include independent and not-for-profit clinics providing focused primary care to priority populations or longitudinal primary care to a full panel of patients.**

CURRENT SITUATION

- Applications for funding will be reviewed quarterly beginning with a first intake deadline of April 1, 2024.
- Funding to hire RNs and LPNs will be made available to eligible family practices providing focused primary care to priority populations (e.g., Indigenous Persons, maternity care, sexual health and/or gender affirming care) or longitudinal primary care to a full panel of patients.
- Eligible practices must be independently operated by family physicians (FPs) or nurse practitioners (NPs) or operated by a not-for-profit society.
- Clinics who already employ their own RN/LPN can also apply for funding to sustain employment of the RN/LPN.
- Clinics who already have a Primary Care Network (PCN) funded/Health Authority RN/LPN are not permitted to terminate their nurse in order to hire a clinic-employed nurse.
- The primary objective of the program is to deliver more timely access to primary care services. The secondary objective is to increase attachment in practice settings where possible.
    - It is expected the addition of an RN/LPN will enable practices to better respond to urgent clinical needs of patients, increasing same-day access to primary care.
    - A RN or LPN may screen concerns, conduct assessments, facilitate care by the FP/NP, and fulfill key clinical functions including health promotion and disease/injury prevention, and care coordination.

  - One full-time RN/LPN funded through the program is expected to add 4,400 nursing encounters to a family practice clinic per year. At least 70% direct clinical care time is expected and added clinic capacity for same day access. Participating clinics are expected to provide after-hours care.
  - RNs and LPNs support attachment to FPs and NPs rather than attaching their own patients.
  - A full-time RN/LPN is expected to increase the number of patients attached to a longitudinal family practice clinic by 300-500 in an urban setting and 200-400 in a rural setting. For focused practices serving priority populations, and clinics with panel sizes that exceed PCN requirements, the addition of a RN/LPN is not expected to increase panel sizes but will support improved access.
- It is expected FPs/NPs and RNs/LPNs will work autonomously within their optimal scopes of practice to improve patient access to primary care services.
- Participating clinics will fully participate in the Provincial Attachment System.

FINANCIAL IMPLICATIONS

- The expanded Nurse in Practice program was launched in February 2024. Therefore, as of January 2024, no expenditures have been incurred. Additionally, there are no anticipated expenditures for the remainder of the current fiscal year.
- The Ministry's budget includes $538.32M in 2024/25 to support the continued implementation of Primary Care Strategy initiatives (including PCNs, Urgent and Primary Care Centres, Community Health Centres, and FP- and NP-led clinics). This is an increase of $76.40M over the projected 2023/24 Primary Care Strategy expenditure of $461.92M.

KEY BACKGROUND

- Team-based primary care:
  - improves continuity of care,
  - strengthens relationships between patients and their primary care providers and members of the health care team,
  - provides more timely patient access to continuous, comprehensive care and appropriate supports to support their health needs,
  - increases efficiency of practices and streamlined processes to maximize time and capacity to attach new patients, and
  - fosters all members of primary care teams to work to their strengths, and support and rely on each other to give patients the best care.
- The provincial Nurse in Practice Program builds on a pilot program launched in Kelowna in 2017 that provided funding to integrate RNs, LPNs, or NPs into physician family practices. An evaluation of the pilot program demonstrated the importance of allowing clinics to hire nurses based on optimal fit for their own clinical team to support effective team functioning, scope optimization, and consistency for providers.
- The program also aligns with the PCN Governance refresh and the commitment to strengthening team-based care in family practices by hiring RNs and LPNs directly to their practices, building on the 2017 pilot program.

LAST UPDATED

The content of this estimates note is current as of February 13, 2024, as confirmed by Jeremy McLay.

APPROVALS

2023 02 13 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 22 – Leighanne Tripp obo Rob Byers, Finance and Corporate Services Division
2024 03 22 – Ted Patterson, Primary Care Division

LEGISLATIVE SESSION – ESTIMATES NOTE

L-08

Nurse Practitioners in Primary Care

Topic: Integration of Nurse Practitioners (NPs) into Primary Care Networks (PCNs).

Key Messaging and Recommended Response:

- **Nurse Practitioners (NPs) are important longitudinal and episodic primary care providers and are a key partner in the Ministry's primary care strategy.**
- **They provide high quality, comprehensive primary care services to patients, acting as the 'most responsible' primary care provider. They also work in urgent/episodic primary care settings as well as in focused practice setting serving priority populations.**
- **432 primary care NPs have been hired to date and have attached more than 123,994 patients who previously lacked access to a consistent primary care provider.**
- **This total includes 303.2 full time equivalent (FTE) NPs hired across all initiatives in the primary care strategy.**
- **There are three Ministry-funded Nurse Practitioner Primary Care Centres (NPPCCs) in implementation today, in the communities of Nanaimo, Surrey, and Victoria.**

CURRENT SITUATION

- As of December 31, 2023, there are 432 NPs working in primary care who have attached 123,994 patients since January 2019.[1]
- As of January 2024, 303.2 FTE NPs having been recruited, either using a PCN NP Contract or as health authority salaried staff.[2]
- Above and beyond this level, the Ministry of Health provides NP4BC funding to HAs to hire NPs.
  - As of February 2024, NP4BC funded 115 HA NP positions, totaling 93.9 FTE.
  - NP4BC is the largest source of funds for HA-employed NPs other than HA global operating funds, funding 19% of all HA-employed NP FTEs.
  - NP4BC, which pre-dates the primary care strategy, covers the cost of NP salaries, but not overhead costs.
  - NP4BC funded positions can be found in all HAs (other than FNHA).
  - NP4BC funds go mainly to longitudinal primary care (72%), with the remaining 28% going to non-longitudinal care such as cardiac care, cancer care, MHSU, obstetrics/gynecology, geriatric medicine, and other areas.
- Where they are working in longitudinal primary care, The 20.1 FTE NPs at Nurse Practitioner Primary Care Centres (NPPCCs) have reported attaching 14,650 patients as of January 2024.[3,4]

[1] Ministry of Health, HSIAR, $0 Attachment code reporting
[2] Ministry of Health, Results Management Office, Workforce Report, FY2023/24, P10 to January 4, 2024.
[3] Ministry of Health, Results Management Office, Primary Care Division, FY2023/24 P10, January 4, 2024.
[4] Ministry of Health, Nursing Policy Secretariat, Clinic self-reported attachments (sent directly to the Ministry). December 2024.

- Effective August 23, 2023, PCNs were able to add NP contracts beyond those approved in their PCN service plan if they have opportunity or need to recruit an additional NP. The PCN NP Contract is a mechanism to integrate NPs into primary care as independent practitioners and requires practitioners to agree to become part of the PCN in their community and to adopt the attributes of the Patient Medical Home (PMH).[5]
- As of January 2024, the three approved NPPCCs are fully operational with 31.8 FTEs hired including 20.1 FTE NPs, 6.9 FTE Registered Nurses (RNs), and 4.8 FTE Allied Health Professionals (AHP).[6]
- Research conducted by the University of Victoria School of Nursing indicates that patients attached to NPs in NPPCCs experience significantly improved access to primary care and improved health.[7] The research also shows that these clinics have comparable cost-effectiveness to physician clinics.[8]
- The Nurse and Nurse Practitioner Association of BC (NNPBC) has been a strong partner in the development of the Provincial Attachment System. To date (Feb 15, 2024) 296 NPs have uploaded their panels to the system and 113 have signalled their willingness to attach new patients.

FINANCIAL IMPLICATIONS

- As of January 2024, the Ministry has committed to fund $6.27M in annual operating costs (including NP, RN, AHP salaries and overhead) for 3 NPPCCs currently in implementation, $1.70M in one-time start-up costs and $0.54M in change management costs.
- As of January 2024, the Ministry has committed a total of $74.18M towards NPs in Primary Care (including the salaries of NP's working in NPPCCs), through all of BC's team-based care models currently in implementation.
- In addition, we have provided support to Nurse and Nurse Practitioner Association of BC through the Provincial Initiatives Program $3.66M in 2021/22, $4.34M in 2022/23, and $5.34M in 2023/24.

KEY BACKGROUND

- A unique service model under the primary care strategy, NPPCCs are developed by NPs who work within a collaborative, team-based environment and as part of local PCNs.
- Each NPPCC is funded to provide longitudinal, team-based primary care services delivered by a team comprised of (on average):
    - 6.7 FTE NPs;
    - 0.4 FTE NP Clinical Director;
    - 2.3 FTE RNs, including relief;
    - 1.0 FTE Social Worker; and
    - 1.0 FTE Mental Health Worker.
- The Ministry has been working collaboratively with local Divisions of Family Practice and health authorities to support integration of the NPPCCs in PCN planning at the community level.
- To support provincial consistency of performance monitoring, reporting requirements for NPPCCs will follow the same evaluative criteria as PMHs and Urgent and Primary Care Centres.

LAST UPDATED

The content of this estimates note is current as of April 11, 2024, as confirmed by Jeremy McLay.

APPROVALS

2024 02 22 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 27 – Kerri Harrison obo Rob Byers, Finance and Corporate Services Division
2024 04 12 – Ted Patterson, Primary Care Division

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[5] Patient Medical Home in BC http://www.gpscbc.ca/sites/default/files/PMH%20graphic%20%2020160920.pdf
[6] Ministry of Health, Results Management Office, Primary Care Workforce Report, FY2023/24 P10, to January 4, 2024.
[7] Contandriopoulos D, Bertoni K, Duhoux A, Randhawa GK. Pre-post analysis of the impact of British Columbia nurse practitioner primary care clinics on patient health and care experience. BMJ Open. 2023 Oct 19;13(10).
[8] Contandriopoulos D, Bertoni K, McCracken R, Hedden L, Lavergne R, Randhawa GK. Evaluating the cost of NP-led vs GP-led primary care in British Columbia. Healthcare Management Forum. 2024;0(0).

LEGISLATIVE SESSION – ESTIMATES NOTE

L-09

Primary Care Networks

Topic: Primary Care Networks (PCNs) are geographically based, locally planned, and coordinated systems of primary care where family practices, Urgent and Primary Care Centres, Community Health Centres, First Nations-led Primary Health Care Centres, Foundry Clinics and Nurse Practitioner Primary Care Centres are networked to provide people with access to comprehensive longitudinal and episodic primary care services.

Key Messaging and Recommended Response:

- **Primary Care Networks (PCNs) are a key element of the province's primary care strategy. Through PCNs, family practices and other types of clinics and health organizations work together to meet the primary care needs of their community.**
- **Through services plans, PCNs access Ministry funding for additional team-based care resources to support their efforts.**
- **PCNs are led by family physicians, supported by Divisions of Family Practice, and are governed by a collaborative PCN Steering Committee that includes health authorities, First Nations and various types of primary care providers and patient and community representatives.**
- **PCN Steering Committees organize primary care in community; PCNs' Collaborative Services Committees are the points of integration and collaboration between primary care and the broader health system within that geographic region.**
- **As of February 2024, 77 PCNs are in implementation, covering 84% of all provincial Community Health Service Areas (CHSAs) and 90% of the provincial population.**
- **The province has committed $332M in annual funding to support the 77 PCNs currently in implementation.**
- **As of January 2024, a total of 1,800 full-time equivalents (FTEs) have been hired across the 77 PCN communities, across all models of care.**
- **Work is underway to establish approximately 100 PCNs in communities throughout the province by 2025.**

CURRENT SITUATION

- The total Community Health Service Areas (CHSAs) covered by PCN communities is 84% of all CHSAs, equating to 90% of the provincial population.[1]
- PCN CHSA coverage is highest in Vancouver Coastal, with approximately 96% of their population and 89% of CHSAs in their region. Vancouver Island covers 95% of their population and 86% of their region's CHSAs are covered by PCNs in implementation. Interior covers 80% of their population and 81% of the region's CHSAs currently have a PCN in implementation. Fraser covers 89% of their population and 89% of the region's CHSAs, and Northern covers 79% of their population and 76% of the region's CHSAs.[2]
- As of January 2024, 1,800 FTE have been hired into the 77 PCN communities[3], across all models of care.
- 1,178.8 FTEs have been hired for the networks: 573.8 FTEs have been hired across 23 steady state[4] PCNs (9 communities); 374.3 FTEs have been hired across 17 PCNs in Year 4 (11 communities); 108.5 FTEs have been hired across 14 PCNs in Year 3 (4 communities); 69.0 FTEs have been hired across 9 PCNs in Year 2 (3 communities) and 53.2 FTEs have been hired across 14 PCNs in Year 1 (8 communities).[5]

FINANCIAL IMPLICATIONS

- The Ministry's budget includes $538.32M in 2024/25 to support the continued implementation of Primary Care Strategy initiatives (including PCNs, Urgent and Primary Care Centres, Community Health Centres, and Family Physician- and Nurse Practitioner-led clinics). This is an increase of $76.40M over the projected 2023/24 Primary Care Strategy expenditure of $461.92M.
- As of January 2024, the Ministry has committed to fund $332M in annual operating costs for the 77 PCNs currently in implementation once fully implemented, $56M in capital, $7M in one-time start-up costs and $42M in change management costs.

Table 1: PCN Annual Funding for PCNs In Implementation[6]

Community	PCNs	Annual Operating Funding
Burnaby	4	$16M
Comox Valley	1	$6M
Fraser Northwest	4	$18M
Kootenay Boundary	1	$9M
Prince George	1	$4M
Richmond	3	$17M
Ridge Meadows	2	$9M
South Okanagan Similkameen (SOS)	1	$7M
Vancouver	6	$39M
Total – Year 5 PCNs	***23***	***$125M***
Central Interior Rural Division (CIRD)	1	$5M
Central Okanagan	3	$11M
Chilliwack & Fraser Health Rural	3	$14M
Cowichan Valley	1	$9M
East Kootenay	1	$10M
Mission	1	$5M
North Shore (North Vancouver)	3	$14M
Oceanside	1	$6M
Saanich Peninsula	1	$10M

[1] Results Management Office CHSA Tracker, January 2024
[2] Results Management Office CHSA Tracker, January 2024
[3] Ministry of Health, RMO Primary Workforce Report, FY2023/24 Period 10, January, 2024.
[4] Steady state is defined as in year 5 or more of implementation, as per Service Plan template and Funding Letter renewals, schedule 2.
[5] Ministry of Health, RMO Primary Workforce Report, FY2023/24 Period 10, January, 2024.
[6] From individual approved PCN Service Plans and 2023/24 Funding Letter renewals; incorporating approved Change Requests and tracked on the Ministry's Attachment Tracker, as at January 2024

LEGISLATIVE SESSION – ESTIMATES NOTE

Community	PCNs	Annual Operating Funding
Western Communities	1	$11M
White Rock South Surrey (WRSS)	1	$6M
Total – Year 4 PCNs	***17***	***$101M***
Nanaimo	2	$9M
North Peace	1	$2M
Northern Interior Rural (NIRD)	7	$4M
Victoria	4	$18M
Total – Year 3 PCNs	***14***	***$33M***
Bulkley Valley-Witset	2	$3M
Campbell River	1	$6M
Surrey-North Delta	6	$24M
Total – Year 2 PCNs	***9***	***$33M***
Coast Mountain	3	$6M
Haida Gwaii	2	$1M
Langley	3	$11M
Nisga'a	1	$1M
Port Alberni	1	$1M
qathet	1	$3M
Shuswap North Okanagan	2	$13M
Sunshine Coast	1	$4M
Total – Year 1 PCNs	***14***	***$40M***
GRAND TOTAL	**77**	**$332M**

KEY BACKGROUND

- PCNs are supported through a collaborative governance model and a local PCN Steering Committee, which reflect and prioritize community primary care needs. Community partners work together to create and adjust service plans, outline current primary care gaps, and identify resources required to fill the gaps through access to interdisciplinary team-based care.
- This strategy was developed in response to challenges including increasing numbers of people in BC without a regular primary care provider.

LAST UPDATED

The content of this estimates note is current as of April 11, 2024, as confirmed by Jennifer Gough and Kelly McQuillen.

APPROVALS

2024 02 23 – Leighanne Tripp obo Rob Byers, Finance and Corporate Services Division
2024 02 26 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 04 12 – Ted Patterson, Primary Care Division

LEGISLATIVE SESSION – ESTIMATES NOTE

L-10

Primary Care Patient Attachment (Data)

Topic: Overview of the current status of primary care patient attachment in BC.

Key Messaging and Recommended Response:

- **408,926 people have been attached to a primary care provider in BC since 2018/19, when the primary care strategy launched.[1]**
- **52,270 patients have been attached to a family physician (FP) or a nurse practitioner (NP) through the Health Connect Registry and a further 10,010 are in the process of becoming attached, for a total of 62,280 Health Connect Registry patients attached or pending as of February 14, 2024.[2]**
- **The new capacity created within BC's primary care system will support the 279,000 people who are now registered with the Health Connect Registry to attach to primary care.[3]**
- **Actions taken to increase primary care patient attachment include:**
  - **Expanding the Health Connect Registry.**
  - **A new Longitudinal Family Physician compensation model to attract and retain FPs that, as of February 2024, has 4,004 physicians registered.**
  - **Launching the New-to-Practice Incentives Program for FPs in summer 2022, with more than 230 new FPs committed to providing longitudinal primary care under the program, and also more than 230 NPs working in longitudinal primary care under service contracts. Through this program, providers have attached more than 243,000 patients.**
  - **A new provincial Panel registry for individual FPs and NPs.**
  - **A new Clinic and Provider Registry for medical directors and staff to provide information about their clinics. To date, more than 1,400 clinics have registered.**

CURRENT SITUATION

- The Provincial Attachment System (PAS) launched in July 2023 and since that time significant work has been spent on user acceptance testing, training, support materials, working through technical issues and ongoing communication.

[1] $0 Attachment Code Utilization Report, HSIAR, February 2024
[2] Ibid
[3] PAS Weekly Program Report – Feb 14, 2024

- The Provider elements of the PAS (the Panel Registry and Clinic and Provider Registry) formally launched for user adoption on September 20, 2023. Clinic Medical Directors, family physicians (FPs) and nurse practitioners (NPs) have started registering themselves to start using these two registries and updating their information.
- FPs and NPs began to upload patient panels at the end of 2023 and that work continues. Uploads started with FPs working on the Longitudinal Family Physician (LFP) Payment Model and a subset of NPs.
- As of February 15, 2024, more than 4,230 FPs and NPs had uploaded their panel data, including more than 95% of FPs on the LFP payment model, covering more than 3.8 million unique attached patients. Once panel uploads are complete, the Ministry will work with providers and patients to resolve panel conflicts.[4]
- As of February 14, 2024, 3,678 FPs and NPs had signed on and used the panel registry to update their practice information. Of these, 640 providers have indicated they can accept new patients for a collective maximum total of 129,408 new patients.[5]

Health Connect Registry, Patients Seeing Attachment, Feb 14, 2024

Health Authority	Registrant Status			Total Attached + Pending
	Active	Attached	Pending	
FHA	74,094	6,313	2,570	8,883
IHA	60,095	14,104	1,867	15,971
NHA	8,533	3,259	462	3,721
VCHA	32,476	3,366	1,969	5,335
VIHA	103,985	25,228	3,142	28,370
Grand Total	**279,183**	**52,270**	**10,010**	**62,280**

FINANCIAL IMPLICATIONS

- In 2018/19, $264,000 in capital funding went into the initial development of the Health Connect Registry (HCR) proof of concept. In 2019/20 through 2022/23, maintenance of the HCR was funded through the Primary Care Division, HealthLink BC annual operational web maintenance budget.
- The province has invested $37.63M in operating funding for 2023/24 to support the Primary Care Digital Enablers (including the Attachment Management System, Patient Information Sharing initiatives, and HealthLink BC digital refresh). In addition, the province has invested $26.60M in capital funding (including capital allocated to Provincial Health Services Authority).

KEY BACKGROUND

- Since 2017, more than 38,000 health care providers have been added to the health system.
- Since the 2018-19 implementation of the primary care strategy a total of 408,926 attachments have been made by new-to-practice family physicians, nurse practitioners and other providers.

LAST UPDATED

The content of this estimates note is current as of April 11, 2024 as confirmed by Eric Bringsli.

APPROVALS

2024 02 22 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 27 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2024 04 12 – Ted Patterson, Primary Care Division

[4] PAS Panel Submission Report – February 15, 2024
[5] PAS Weekly Program Report – February 12, 2024

LEGISLATIVE SESSION – ESTIMATES NOTE

L-11

Primary Care Strategy Overview and Refresh

Topic: BC's primary care strategy launched in 2018/19 to support new team-based primary care throughout BC.

Key Messaging and Recommended Response:

- **Through the Primary Care Strategy, the Province has committed over $512M in annual funding to support the initiatives currently in implementation, once fully implemented. The Province has also invested an additional $267M, which includes capital expenditures.**
- **These investments support new team-based primary care in family practice clinics, Urgent and Primary Care Centres (UPCCs), Community Health Centres (CHCs), Nurse Practitioner Primary Care Centres (NPPCCs) and First Nations-led Primary Care Centres (FNPCCs).**
- **There are also 77 Primary Care Networks (PCNs) currently in implementation and work is underway to establish approximately 100 PCNs in communities throughout the province by 2025.**
- **As of January 2024, 1,800 full time equivalent health care workers are recruited, including: Family Physicians (FPs), Nurse Practitioners, Registered Nurses, Allied Health Professionals, Pharmacists and Indigenous Providers.**
- **There are 32 UPCCs in implementation, with plans to reach 50 by 2025. Between April 2023 and January 2024, UPCCs provided 545,009 patient visits. Since the first UPCC opened in 2018, all UPCCs have provided a total of 2,368,655 patient visits.**
- **Three NPPCCs, three FNPCCs and nine CHCs are in implementation as of January 2024.**
- **The Provincial Attachment System through the Health Connect Registry connects people looking for a family physician or nurse practitioner with a provider. As of February 14, 2024, 640 providers have signalled capacity and more than 52,000 people have been attached.**
- **The new Longitudinal Family Physician payment model has more than 4,000[1] physicians registered as of February 15, 2024 (3,936 as of December 31, 2023).**
- **In the first nine months of 2023/24, there were 708 more physicians providing longitudinal primary care in the province than in the same period in 2022/23.[2]**

[1] LFP Adoption Report – February 15, 2024
[2] Monthly Primary Care Providers Report, February 2024

- **The Ministry and Doctors of BC announced $118M in short-term stabilization funding in August 2022 to help ensure patients continued to receive access to family practice and walk-in primary care services while a new sustainable longitudinal family physician payment model was developed.**
- **Announced in June 2022, the New-to-Practice Incentives Program for early career or 'new to BC' family physicians who choose to work in longitudinal family practice have signed on more than 230[3] FPs as of January 2024.**

CURRENT SITUATION

Primary Care Strategy Implementation as of January 2024:

- The Strategy is in its fifth year of implementation.
- The Ministry has 77 Primary Care Networks (PCNs), 32 Urgent and Primary Care Centres (UPCCs), 9 Community Health Centres (CHCs), 3 First Nations-led Primary Care Centres (FNPCCs), and 3 Nurse Practitioner Primary Care Centres (NPPCCs) in implementation.[4]
- A key priority of the refreshed Strategy is to meet projected demand for primary care services by delivering 27 million to 29 million patient visits each year over the next three years.[5]
- To achieve this goal, major compensation and incentives initiatives were introduced to increase recruitment and retention of family physicians (FPs) in longitudinal primary care, including:
  - Longitudinal Family Physician (LFP) Payment Model (launched February 2023, expanded in 2024),
  - New-to-Practice Incentives Program (announced in June and launched in August 2022), and
  - 60+ Retention Incentives Program (under development).
- Another major element of the Strategy is the implementation of the Provincial Attachment System (PAS) to help match patients with FPs and nurse practitioners (NPs) (see: Provincial Attachment System Overview Note).
- The Strategy also aims to improve access to urgent (non-life-threatening) and episodic primary care by, for example, expanding the scope of practice for BC pharmacists to renew prescriptions and issue prescriptions for minor ailments and contraceptives (launched June 2023).[6]
- As of January 2024, 1,800 full-time equivalents (FTEs) have been hired to support over 350 clinics and 77 PCNs throughout the province, including: 381.4 FTE FPs, 303.2 FTE NPs, 479.8 FTE Registered Nurses, 418.4 FTE Allied Health Professionals, 38.8 FTE Indigenous providers, 50.0 FTE clinical pharmacists, and 128.7 FTE program administrators.[7]

FINANCIAL IMPLICATIONS

- As of January 2024, the Ministry has committed $512.27M in annual operating costs once fully implemented, $175.72M in capital, $47.63M in one-time start-up costs and $44.12M in change management costs.
- The Ministry's budget includes $538.32M in 2024/25 to support the continued implementation of Primary Care Strategy initiatives (including PCNs, UPCCs, CHCs, and FN- and NP-led clinics). This is an increase of $76.40M over the projected 2023/24 Primary Care Strategy expenditure of $461.92M.

[3] New-to-Practice Incentives Program Report January 31, 2024
[4] Ministry of Health, Results Management Office, Data retrieved from P10 Program Report Data Tables as at January 4, 2024
[5] Ministry of Health 2023/24-2025/26 Service Plan, pg. 11, retrieved September 2023
[6] BC Gov News, Provincial booking system for appointments with pharmacists going live, https://news.gov.bc.ca/releases/2023PREM0038-001055.
[7] Ministry of Health, Results Management Office, P10 Workforce Report, as at January 4, 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- The Strategy continues to focus on culturally safe, team-based care deployed through a range of different clinical models (family practices, UPCCs, CHCs, NPPCCs, FNPCCs, and more).
- In August 2022, the Ministry and Doctors of BC announced $118M in short-term stabilization funding, to help ensure patients continued to receive access to primary care services in family practice clinics and walk-in clinics, while the LFP payment model was developed (Family Practice Services Committee provided $43M of this funding).

LAST UPDATED

The content of this estimates note is current as of April 11, 2024, as confirmed by Jeremy McLay.

APPROVALS

2024 02 20 – Eric Larson. Health Sector Information, Analysis & Reporting Division
2024 02 23 – Leighanne Tripp obo Rob Byers, Finance and Corporate Services Division
2024 04 12 – Ted Patterson, Primary Care Division

LEGISLATIVE SESSION – ESTIMATES NOTE

L-12

Primary Care Strategy Recruitment

Topic: Status of recruitment across all initiatives funded through BC's primary care strategy.

Key Messaging and Recommended Response:

- **As of December 2023, there were approximately 5,000 FPs working in longitudinal primary care; an increase of 708, or 16.5%, from December 2022.**
- **In addition, there were 590 NPs working in primary care; an increase of 60 or 11.3% since December 2022 to December 2023.**
- **A year since its launch, the new Longitudinal Family Physician payment model has seen more than 4000 physicians registered to date. This is a tremendous uptake and proof this new compensation model is helping to attract more family physicians to the province.**
- **As of January 2024, 1,800 new full-time equivalent health care workers has been committed to support team-based primary care and have been recruited into approximately 350 clinics and regional hubs.**
- **Since launching the New-to-Practice Incentives Program for FPs in summer 2022, there are now more than 230 new FPs committed to providing longitudinal primary care under the program, and also more than 230 NPs working in longitudinal primary care under service contracts.**
- **The Ministry tripled the number of seats in the Practice Ready Assessment BC program, from 32 seats to 96 by March 2024. Half of all graduates will practice in priority PCNs after receiving licensure. Since 2015, PRA-BC has assessed 222 family physicians and placed them in 63 BC communities.**
- **The province has made significant investments in the health workforce, resulting in an increase of over 38,000 employees since 2017.**
- **The Ministry of Health is committed to supporting primary care providers, so they remain in their profession, are inspired by their work, and grow their skills and expertise.**
- **We also want to attract the next generation of care providers so we can meet the health care needs of BC's growing and aging population.**

- **BC is not alone in seeing health care recruitment and retention challenges, but it is a complex issue that we are tackling together with partners.**

CURRENT SITUATION

- As of January 2024, 1,800 approved full-time equivalent (FTE) resources[1] have been recruited into approximately 350 clinics and regional hubs across all primary care initiatives to support team-based care:
  - 573.8 FTEs hired across 23 steady-state[2] Primary Care Networks (PCNs) (covering 9 communities)
  - 374.3 FTEs hired across 17 PCNs in Year 4 of implementation (covering 11 communities)
  - 108.5 FTEs hired across 14 PCNs in Year 3 of implementation (covering 4 communities)
  - 69.0 FTEs hired across 9 PCNs in Year 2 of implementation (covering 3 communities)
  - 53.2 FTEs hired across 14 PCNs in Year 1 of implementation (covering 8 communities)
  - 477.2 FTEs hired in 32 Urgent and Primary Care Centres (UPCCs)
  - 31.8 FTEs hired in 3 Nurse Practitioner Primary Care Centres
  - 86.4 FTEs hired in 9 Community Health Centres (CHCs)
  - 25.1 FTEs hired in 3 First Nations-led Primary Care Centres[3]
- By profession, recruitment to date (episodic and longitudinal) includes:
  - 381.4 FTEs of Family Physicians (FPs) (of 453.3 FTEs approved)
  - 303.2 FTEs of Nurse Practitioners (NPs) (of 467.1 FTEs approved)
  - 479.8 FTEs of Nursing Resources (of 722.6 FTEs approved)
  - 418.4 FTEs of Allied Health Professionals (of 691.2 FTEs approved)
  - 50.0 FTEs of Clinical Pharmacists (of 72.1 FTEs approved)
  - 128.7 of 157.1 FTEs of Administrative Staff, including PCN Managers, Admin staff
  - 38.8 FTEs of Indigenous Health Resources, including Elders, Traditional Healers, and Health Coordinators (of 77.6 FTEs approved)

FINANCIAL IMPLICATIONS

- As of January 2024, the Ministry has committed $512.27M in annual operating costs once fully implemented, $175.72M in capital, $47.63M in one-time start-up costs and $44.12M in change management costs.
- The Ministry's budget includes $538.32M in 2024/25 to support the continued implementation of Primary Care Strategy initiatives (including PCNs, UPCCs, CHCs, and FP- and NP-led clinics). This is an increase of $76.40M over the projected 2023/24 Primary Care Strategy expenditure of $461.92M.

KEY BACKGROUND

- The Ministry tripled the number of seats in the Practice Ready Assessment BC program, from 32 seats to 96 by March 2024. Half of all graduates will practice in priority PCNs after receiving licensure.
- Funding has been committed to support team-based primary care, with approximately 1,800 FTEs having been recruited as of January 2024. This includes FPs; NPs; registered nurses; pharmacists; social workers and other mental-health workers; dietitians, physiotherapists, and other allied health workers; Elders, traditional healers and cultural supports; and administrative support workers.
- The Health Human Resources Strategy announced in September 2022 helps ensure people get the health services they need and are cared for by a healthy workforce. The strategy focuses on 70 actions to recruit, train and retain health care workers, while redesigning the health care system to foster workplace satisfaction and innovation.
- Furthermore, in November 2023, the Ministry implemented major reforms to increase the number of International Medical Graduates serving in BC, specifically to work in PCNs.

[1] Ministry of Health, RMO Primary Workforce Report, FY2023/24 Period 10, January, 2024.
[2] Steady state is defined as in year 5 or more of implementation.
[3] Excludes Fraser West FNPCC which has been approved and is in implementation, but is not yet operational, with a 1.0 hired FTE.

- Working with the College of Physicians and Surgeons of BC to prepare bylaw changes to allow doctors trained in the US for three years to practice medicine in community settings, such as UPCCs, community clinics, and family practices.

LAST UPDATED

The content of this estimates note is current as of April 11, 2024 as confirmed by Jennifer Gough.

APPROVALS

2024 02 20 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 22 – Leighanne Tripp obo Rob Byers, Finance and Corporate Services Division
2024 04 12 – Ted Patterson, Primary Care Division

LEGISLATIVE SESSION – ESTIMATES NOTE

L-13

Provincial Attachment System Overview

Topic: The Ministry of Health created the Provincial Attachment System (PAS) to better connect people to primary care providers who have the capacity to take on new patients and to measure and manage attachment more effectively in the province.

Key Messaging and Recommended Response:

- **Strengthening the health care system to ensure everyone in the province who needs a primary care provider gets one is a top priority.**
- **The Provincial Attachment System (PAS) is designed to provide a coordinated and seamless approach to connecting patients with a family doctor (FP) or nurse practitioner (NP) in their community.**
- **The PAS consists of three elements: the Health Connect Registry (HCR) for patients; and the Patient Panel Registry (PPR) and Clinic and Provider Registry (CPR) for primary care providers and clinics.**
- **The HCR is now available province-wide for anyone to register their interest in attachment to a primary care provider and receive information on where to access care in the interim.**
- **Since announcing the expansion of the HCR in July 2023, the Province has been working with Doctors of BC and Nurses and Nurse Practitioners of BC on building out the PPR and CPR, which launched in September 2023.**
- **The CPR collects clinic and staff information for all family practices and other types of primary care clinics throughout the province.**
- **The PPR supports individual family physicians and nurse practitioners to upload their panel data and identify when they are accepting patients.**
- **Together, these three elements of PAS will enable us to streamline and improve connections between patients and providers available for attachment in communities throughout BC.**
- **As of February 14, 2024, more than 52,000 people have been connected to primary care through the HCR. There are approx. 289,000 people actively registered on the HCR. More than 80% of FPs and NPs have uploaded their panels to the PAS, and 640 FPs and NPs have told us they are available for attachment.**

CURRENT SITUATION

- As part of the Provincial Attachment System (PAS), on July 1, 2023, in partnership with the Doctors of BC (DoBC) and Nurses and Nurse Practitioners of BC (NNPBC), the Province:
  - expanded the Health Connect Registry (HCR), hosted by HealthLink BC (HLBC) and available in early-adopter communities since 2019, to all communities throughout BC to help people find a primary care provider close to where they live;
  - introduced a new Clinic and Provider Registry for medical directors and staff to provide information about their clinics so the Ministry can better support practitioner needs;
  - introduced a new Patient Panel Registry for individual family doctors and nurse practitioners to upload and manage their patient panel information and identify whether they can accept new patients and how many;
  - expanded activities to increase the number of attachment coordination resources across BC that, through PAS, match HCR registrants to accepting primary care providers;
  - added additional capacity to HLBC to facilitate the attachment process and support patients with registration and services in the interim of attachment.
- The Ministry, DoBC and NNPBC are working to further streamline the approach to the registries to ensure it involves as little administrative effort as possible for primary care providers, and the attachment process is as streamlined as possible for the patient. The opportunity to establish provincial workflows and further digitize the solution will increase attachment rates.

FINANCIAL IMPLICATIONS

- In 2018/19, $264,000 in capital funding went into the initial development of the HCR proof of concept. In 2019/20 through 2022/23, maintenance of the HCR was funded through the Primary Care Division, HLBC annual operational web maintenance budget.
- The Province has invested $37.63M in operating funding for 2023/24 to support the Primary Care Digital Enablers (including the Attachment Management System, Patient Information Sharing initiatives, and HLBC digital refresh). In addition, the Province has invested $26.60M in capital funding (including capital allocated to Provincial Health Services Authority).

KEY BACKGROUND

Patient-Facing Solution (Health Connect Registry)

- HCR proof of concept was launched in 2019 with 30 early adopter communities by HLBC.
- Expanded in 2023, anyone in BC can register themselves, their family or a person in their care for a primary care provider online at healthlinkbc.ca/hcr. Information about community health and 8-1-1 services are made available at the time of registration.
- Those unable to register online can do so by calling 8-1-1. Registration support is available in over 130 languages, by 7-1-1 for the deaf and hard of hearing, and Video Relay Service (VRS) for sign language interpretation.
- HLBC is actively working with all communities across BC to close and transition all local waitlists to the HCR. New registrants and those transferred from community lists will receive an email confirmation they are on the HCR. Registrants will retain their original registration date, on the HCR or from their community waitlist. All communities should be merged in Summer 2024.

Provider Focused Registries (Clinic and Provider Registry and Patient Panel Registry)

- Family Physicians (FPs) on the Longitudinal Family Physician (LFP) payment model had until October 31, 2023; and non-LFP physicians had until January 31, 2024 (or within three months of signing on to the LFP model, whichever is greater) to upload their panels on the Patient Panel Registry.
- Since Fall 2023, the Ministry, DoBC and NNPBC are providing learning opportunities including specialized informational webinars and training sessions to providers so they can learn more about PAS, upload their panels and start using the registries.

- All longitudinal providers regardless of payment model are incentivized to upload and be on PAS as well as all clinics that provide any form of primary care.
- Starting Fall 2023, and continuing quarterly, the Province will publicly report on progress to add more family doctors and nurse practitioners, and on connecting more patients from HCR to an available primary care provider.

LAST UPDATED

The content of this estimates note is current as of February 9, 2024, as confirmed by Eric Bringsli.

APPROVALS

2024 02 11 – Ted Patterson, Primary Care Division
2024 02 20 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 27 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

L-14

Urgent and Primary Care Centres

Topic: Urgent and Primary Care Centres (UPCCs) provide access to same day urgent, non-emergency primary care, increase existing primary care capacity, enable new patient attachment, and reduce pressures on emergency departments.

Key Messaging and Recommended Response:

- **Urgent and Primary Care Centres (UPCCs) are one of a number of clinic models the Ministry is investing in to support expansion of team-based primary care.**
- **UPCCs typically focus on urgent episodic primary care, but many also provide longitudinal primary care services.**
- **There are now 32 UPCCs in implementation.**
- **Through the first three quarters of 2023/24, UPCCs provided 545,009 patient visits (to January 2024).**
- **Since the first UPCC opened in 2018, UPCCs have provided more than 2.37 million (to January 2024) patient visits.**
- **The Province has committed $123.33M in annual operating funding to support 32 UPCCs currently in implementation.**
- **UPCCs typically facilitate attachment in the broader Primary Care Network community, or they may attach patients directly at the UPCC. 21,920 patients are attached to UPCCs, which increased by 2,344 patients in 2023/24.**

CURRENT SITUATION

- Currently, 32 UPCCs are in implementation[5].
- As of January 2024, UPCCs have collectively provided 2,368,655 patient visits and have attached 21,920 patients.[1,2]
- As of January 2024, UPCCs have hired 477.2 full-time equivalents (FTEs), including 101.2 FTE Family Physicians (FPs), 60.4 FTE Nurse Practitioners (NPs), 218.3 FTE Nursing, 82.2 FTE allied health professionals (AHPs), and 6.0 FTE Clinical Pharmacists.[3]

FINANCIAL IMPLICATIONS

- As of January 2024, the Ministry has committed to fund $123.33M in annual operating costs for the 32 UPCCs currently in implementation once fully implemented, $115.66M in capital, $12.90M in one-time start-up costs and $0.15M in change management costs.
- Across all UPCCs, 29 have required capital funding, consisting of $86.46M from the Ministry, $9.50M from health authority internal sources, $11.83M from Regional Hospital Districts, and $7.87M from landlords.

[1] UPCC self reported volume and visits data P10 FY2023/24, Results Management Office. As of January 4, 2024.
[2] Primary Care Quality, Primary Care Division. UPCC Attachment Summary (extracted from UPCC period reports). As of January 4, 2024.
[3] Results Management Office, Primary Care Division. Primary Care Workforce Report P10 FY2023/24 P10. As of January 4, 2024.

- The Ministry's budget includes $538.32M in 2024/25 to support the continued implementation of Primary Care Strategy initiatives (including PCNs, UPCCs, Community Health Centres, and FP- and NP-led clinics). This is an increase of $76.40M over the projected 2023/24 Primary Care Strategy expenditure of $461.92M.

KEY BACKGROUND

- The first 11 UPCCs were developed under an initial policy direction focused primarily on non-emergency, urgent situations that can be treated by a primary care provider within 12-24 hours, access for unattached patients, and extended hours. Starting in 2019, the revised UPCC policy included on-site attachment and additional emphasis on longitudinal care (LC).
- Lower attachment totals in some UPCCs may be due to adjustments in LC resources in response to shifting patient access needs and/or to gradual scale up of LC services as care teams are established (e.g., VCHA shows zero attachment as they have not implemented LC due to space constraints and a dedicated focus on increasing access for urgent, episodic care in response to population need).
- All UPCCs include some mental health and substance use (MHSU) access and/or services and can coordinate rapid access to MHSU crisis intervention services. Some UPCCs emphasize care for underserved populations and have more extensive MHSU services (e.g., Vernon UPCC focuses on providing specialized services and support to those experiencing MHSU challenges and Nanaimo provides timely access for patients looking for Opioid Agonist Therapy).
- As of January 2024, by UPCC initiative, visits and attachments are as follows: [4,5,6]

UPCC Name by Health Authority	Date Opened[7]	Number of Patient Visits	Number of Attachments
Fraser			
Surrey Whalley	November 8, 2018	137,070	1,659
Edmonds	September 23, 2019	71,992	0
Ridge Meadows	October 1, 2019	63,310	0
Abbotsford	April 17, 2020	63,529	990
Surrey Newton	May 25, 2020	66,580	1,772
Port Moody	February 22, 2021	74,135	862
Metrotown	November 1, 2022	40,497	784
Interior			
Kamloops South Shore	June 12, 2018	153,402	1,503
Vernon	October 1, 2019	89,819	2,486
Kelowna	December 30, 2019	171,072	525
Castlegar	April 6, 2020	19,672	0
West Kelowna	October 5, 2020	70,607	1,293
Penticton	March 31, 2021	50,211	1,301
Cranbrook	December 12, 2021	39,044	0
Ashcroft	September 27, 2022	8,354	0
Rutland	November 21, 2023	1,903	0
Northern			
Quesnel	October 31, 2018	34,165	0
Prince George	June 5, 2019	154,047	0
Cabinet Confidences			
Vancouver Coastal			
Vancouver City Centre	November 26, 2018	153,506	0
North Vancouver	November 4, 2019	112,130	0
REACH	November 4, 2019	77,499	0

[4] "0 attached patients" does not yet reflect facilitation to the PCN.
[5] Results Management Office, Primary Care Division. UPCC Services Report; self reported data submitted by the UPCCs; not independently verified with zero fee-based codes. As of January 4, 2024. Excludes facilitated attachment to a PCN.
[6] Primary Care Quality, Primary Care Division. UPCC Attachment Summary (extracted from UPCC period reports). As of January 4, 2024.
[7] Results Management Office, Primary Care Division. UPCC Status Tracker. As of January 4, 2024.

UPCC Name by Health Authority	Date Opened[7]	Number of Patient Visits	Number of Attachments
Northeast	February 16, 2021	61,841	0
Richmond City Centre	April 1, 2021	71,168	0
Southeast	March 29, 2022	41,429	0
Vancouver Island			
Westshore	November 5, 2018	120,080	640
Nanaimo	June 3, 2019	131,735	0
North Quadra	November 30, 2019	54,052	172
James Bay	April 28, 2020	69,507	1,869
Downtown Victoria	July 19, 2021	109,852	4,559
Esquimalt	December 6, 2021	34,494	333
Gorge Road	September 21, 2022	20,028	1,172

- Lower attachment totals in some UPCCs may be due to adjustments in LC resources in response to shifting patient access needs and/or to gradual scale up of LC services as care teams are established (e.g., VCHA shows zero attachment as they have not implemented LC due to space constraints and a dedicated focus on increasing access for urgent, episodic care in response to population need).
- All UPCCs include some mental health and substance use (MHSU) access and/or services and can coordinate rapid access to MHSU crisis intervention services. Some UPCCs emphasize care for underserved populations and have more extensive MHSU services (e.g., Vernon UPCC focuses on providing specialized services and support to those experiencing MHSU challenges and Nanaimo provides timely access for patients looking for Opioid Agonist Therapy).
- As of January 2024, by UPCC initiative, visits and attachments are as follows: [8,9,10]

LAST UPDATED

The content of this estimates note is current as of April 11, 2024 as confirmed by Kelly McQuillen.

APPROVALS

2024 02 20 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 23 – Leighanne Tripp obo Rob Byers, Finance and Corporate Services Division
2024 04 12 – Ted Patterson, Primary Care Division

[8] "0 attached patients" does not yet reflect facilitation to the PCN.
[9] Results Management Office, Primary Care Division. UPCC Services Report; self reported data submitted by the UPCCs; not independently verified with zero fee-based codes. As of January 4, 2024. Excludes facilitated attachment to a PCN.
[10] Primary Care Quality, Primary Care Division. UPCC Attachment Summary (extracted from UPCC period reports). As of January 4, 2024.

LEGISLATIVE SESSION – ESTIMATES NOTE

M-01

Access and Admission to Long-Term Care

Topic:

- On July 15, 2019, the policy regarding access to long-term care (LTC) in the Home and Community Care (HCC) Policy Manual was revised to provide greater choice for individuals and their families through a more client-centered, consistent, transparent, and clear LTC access process.
- The LTC Access Policy complies with Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act* (HCCCFAA), which came into force November 4, 2019.
- Both the policy and the legislation address recommendations made in the Ombudsperson's 2012 seniors' care report and promote a more client-centered approach to how seniors enter LTC homes.
- The new LTC Access Policy also addresses recommendations made by the Seniors Advocate in her 2015 housing report and enhances the transparency, consistency, and clarity of the access process.

Key Messaging and Recommended Response:

- **In 2019, following requests from many seniors, and recommendations from the Ombudsperson and the Seniors Advocate, we changed the policy regarding access to long-term care to allow for more choice for people requiring care.**
- **The Ministry of Health and health authorities meet monthly to review the current situation and address any issues that may arise.**
- **In the past five years, the senior population of BC has grown by 17%. Seniors now represent 20% of the BC population.**
- **To address the increasing demand, our government established a capital funding envelope for LTC renewal and expansion in 2018 and $1.3 billion in provincial funding was approved. In 2023, the budget increased to over $2 billion.**
- **To better retain health-care workers in long-term care, we have put in place a standardized approach to wages for workers in LTC and have moved forward with funding temporary wage increases while work is underway on a standardized LTC Funding Model.**

CURRENT SITUATION

LTC Access Policy

- The Ministry of Health and health authority leads meet on a monthly basis and continue to review the impact of the policy changes and address any issues that arise.
- The Ministry is monitoring the impact of the revised LTC Access Policy over time through collection of data and information from health authorities. At Q3 2023/24[1]:

[1] Ministry of Health. Long-Term Care Access Monitoring Indicators Summary Report (2023/24 Q3).

- In BC, clients admitted to LTC from acute care waited, on average, 50 days, if their wait started in hospital, and 148 days, if their wait started in community prior to acute care admission.
- Clients admitted to LTC directly from community waited, on average, 5 months (160 days).
- When looking at both admissions from community and from acute care in Q3, 35% of clients were admitted directly to a Preferred Care Home (PCH). Broken down, 28% of LTC admissions from acute care were to a PCH and 41% of LTC admissions from community were to a PCH. At the provincial level, admissions directly to a PCH have decreased since the policy was implemented, from 43% in Q3 2019/20 to an average of 35% (ranging between 33-37%) over the last four quarters (as of Q3 2022/23).
- Clients admitted to an Interim Care Home (ICH) and transferred to a PCH in Q3 waited an average of 8 months (240 days) for transfer to a PCH.
- The Q2 2023/24 provincial proportion of alternative level of care (ALC) patients waiting for LTC was 17% (844 clients).
- Initial concerns that the average provincial length of stay (LOS) of ALC patients in acute care would be negatively impacted by the policy change did not materialize. Although the average LOS increased slightly during the implementation phase of the new LTC access policy (43-46 days in 2019/20), the average LOS decreased to a low of 30 days in 2020/21 Q2 before increasing gradually back to to 19/20 levels, and is currently at 48 days (Q2 2023/24).

- It should be noted data from 2020/21 and 2021/22 are not directly comparable to 2019/20 data due to the impact of COVID-19 and the policy adjustments, restrictions, and suspensions implemented to mitigate the risk of introduction and transmission of COVID-19 in LTC homes and to support acute care capacity. However the following provides some observed trends.[2]
  - Average quarterly wait times for admissions directly from the community have increased since 2019/20. (80-89 days until Q1 2020/21, compared with 89-160 days from Q2 2020/21 onwards.)
  - Average quarterly wait times for admissions directly from acute care remained mostly unchanged from Q3 2019/20 (38 days) to Q1 2023/24 (36 days), but increased in the last two quarters (48-50 days).
  - Average quarterly wait times for transfers from an ICH to a PCH have increased since 2019/20. (131-180 days from 2019/20 Q3 to 2020/21 Q1, compared with 226-240 days since 2023/24 Q1 onwards).
  - Average quarterly LOS for ALC patients waiting for LTC decreased from 2019/20 to 2021/22 (43-46 days in 2019/20, compared with 27-35 days in 2021/22). Average quarterly LOS has increased gradually since 2021/22 and is currently at 48 days (Q2 2023/24).

Part 3 of HCCCFAA

- In the fall of 2019, the Ministry delivered sessions across the Province to provide information to and answer questions from health authority staff and facility operators about the legislative changes.
- Health authorities and facility operators are able to access resources created by the Ministry such as the Practice Guidelines for Seeking Consent to Care Facility Admission and an e-learning course.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

LTC Access Policy

- HCC Policy Manual, Chapter 2.D, Client Access, Assessments, and Chapter 6, LTC Services, provide the regional health authorities with direction for planning and delivering publicly subsidized LTC services.
- The LTC Access Policy ensures compliance with Part 3 of the HCCCFAA, by removing any elements in the previous admission criteria that could be construed as coercive, such as the requirement that a client accept the first appropriate bed to be eligible for LTC.

[2] Ibid

- The LTC Access Policy meets recommendations from the Ombudsperson to be more client-centered, consistent, transparent, and clear, including:
    - ensuring clients and/or their substitute decision makers receive comprehensive, clear, and consistent information about options for care homes that meet the clients' needs, the admission process to an LTC home, and the process for transfers from an ICH to a PCH;
    - increasing the number of PCHs that a client can choose, to 3, where possible;
    - allowing more time to accept or decline a move into an ICH;
    - informing clients who are waiting for an offer of an ICH or a PCH of their options to wait at home with publicly funded and/or private-pay home support or choose to reside in a private-pay care home;
    - allowing a client to maintain their position on the waitlist for a PCH whether they decline an offer of an ICH or move into an ICH (one wait list approach); and
    - for those clients in hospital waitlisted for LTC services and unable to return home prior to being admitted to a care home:
        - the expectation is they will agree to move to an appropriate ICH while waiting for one of their PCHs (or they may choose to move to a private-pay care home); and
        - if they decline an ICH/PCH offer and elect to remain in hospital, then client charges will be based on provincial acute care policy (updated in December 2019 to align with LTC Access Policy changes).

<u>Part 3 of HCCCFAA</u>

- Part 3 of the HCCCFAA legally requires consent to be obtained for an adult's admission into a care facility, including LTC homes and licensed mental health and substance use facilities.
- This consent is given by the adult to be admitted, unless they have been determined to be incapable of giving or refusing consent to care facility admission, through an assessment conducted according to the requirements of the HCCCFAA and Health Care Consent Regulation.
- An incapability assessment can be conducted by a registered nurse, registered psychiatric nurse, nurse practitioner, psychologist, occupational therapist, social worker, or a medical practitioner.
- If the adult is determined to be incapable of giving or refusing consent, consent must be obtained from a substitute, according to the ranked list set out in legislation. In the event there is no appropriate substitute available, the Public Guardian and Trustee can make the care facility decision on behalf of an incapable adult.
- If a person is found incapable of giving or refusing consent, they have the right to a second assessment. Second assessments must be conducted by a medical practitioner or nurse practitioner if the first assessment was not done by one of these professions.

LAST UPDATED

The content of this estimates note is current as of February 11, 2024, as confirmed by Danielle Prpich.

APPROVALS

2024 02 26 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 02 26 – Ross Hayward, Seniors' Services Division

LEGISLATIVE SESSION - ESTIMATES NOTE

M-02

Affordability for Seniors

Topic: BC's Office of the Seniors Advocate released a report titled *BC Seniors: Falling Further Behind* on September 22, 2022, offering a systemic review of affordability issues for seniors across BC. The report's 10 recommendations span initiatives and projects within multiple BC Ministries, including Housing, Social Development and Poverty Reduction, Transportation, and Health.

Key Messaging and Recommended Response:

- **Every senior in BC should have access to the support and services they need to live a healthy and happy life.**
- **The government has invested approximately $2 billion over the last 5 years to improve care for seniors, including investments in primary care, home health, long-term care, assisted living and respite services.**
- **These historic investments in seniors care include making the first-ever increase to the senior's supplement, nearly doubling rental payment amounts under the SAFER program, and supporting seniors to ensure they can live independently in their own homes for as long as safely possible and, if needed, provide the best possible living options.**
- **This included $145 million over the last 5 years to expand respite and adult day programs (ADPs).**
- **Funding also expanded training for health-care assistants to address critical staffing shortages in the long-term care, assisted living and home care sectors with $25 million in 2022-23.**
- **In 2018, the Ministry of Housing expanded eligibility and increased monthly rental payment amounts by approximately 42% under SAFER.**
- **Even with these changes, we recognize that the SAFER rent ceilings have not kept up with market rents, and with the increased living costs that many low-income seniors are struggling with in the current rental market.**
- **BC Housing and the Ministry of Housing have completed a review of the Rental Assistance Program (RAP) and SAFER to help us better understand the challenges and how to improve the programs.**
- **We are working through the recommendations from the review, reviewing options to improve uptake and impact of RAP and SAFER, simplify the**

application process, as well as improve accessibility of the programs for seniors and families.

CURRENT SITUATION

- The report contains three recommendations related to Ministry of Health (MoH) programs and services:
  - #6: Eliminate the daily rate for publicly funded home support (HS) services.
  - #7: Provide an extended health benefit for seniors that includes eyeglasses, hearing aids, mobility aids and necessary medical equipment. The cost of the plan could be covered by premiums based on income, ensuring it is an affordable option for all BC seniors.
  - #10: Develop a comprehensive plan to build the capacity of seniors' centers across BC to better support social engagement and help support older people access the support and services they need to continue to live independently.
- The table below outlines government initiatives and planned actions related to the recommendations:

Recommendation	Current Government Initiatives and Planned Actions

#6: Eliminate the daily rate for publicly funded home support services.	• In 2024, 67% of long-term HS clients (16,001 clients) were assessed a $0 rate (i.e., no co-payment/daily rate).[1]
	• Clients do not pay a client rate for HS services if they receive:
	  ○ Income benefits, including Guaranteed Income Supplement (GIS), Income or Disability Assistance, War Veteran's Allowance.
	  ○ Time-limited acute home health services, i.e., two weeks after acute discharge.
	  ○ BC's Palliative Care Benefits and eligible for the health authority palliative program, including approved medical supplies and equipment.
	• In 2024, 13% of assessed long-term HS clients (3,034 clients) had their rate capped at $300 per month.
	• In 2024, 20% of assessed long-term HS clients (5,573 clients) were not eligible for $0 rate or $300 cap. The average rate for the group was $58.97, median $45.12, with a range of $0.10 – $1,063.42.
	• In 2024, 0.4% of long-term HS clients (84 clients) were assessed a rate exceeding $300. The average rate by the group was $815.91, median $606.25, with a range of $301.67 – $11,697.05.
	• If a client or their family experiences serious financial hardship by paying the assessed client rate, the client may apply for a waiver of all, or a portion, of the client rate for up to one year.
	Advice/Recommendations

#7: Provide an extended health benefit for seniors that includes eyeglasses, hearing aids, mobility aids and necessary medical equipment. The cost of the plan could be covered by premiums based on income, ensuring it is an affordable option for all BC seniors.	

[1] Summary Notes 2024 Client Rates for Home Support; HSIAR

Recommendation	Current Government Initiatives and Planned Actions
#10: Develop a comprehensive plan to build the capacity of seniors' centres across BC to better support social engagement and help support older people access the supports and services they need to continue to live independently.	• MoH has prioritized investments in the community-based seniors' services (CBSS) sector by funding programs delivered through a variety of municipal and non-profit agencies including, but not limited to, seniors centers. • Provincially funded CBSS programming has included Better at Home (BH), Higher Needs Grants (HNG) demonstration projects, and the Safe Seniors, Strong Communities program, which supported seniors during the COVID-19 pandemic. Advice/Recommentations

FINANCIAL IMPLICATIONS

- All 10 report recommendations have potential financial implications across government programs.
- Advice/Recommentations

- Re #10: Since 2011/12, the MoH and the Provincial Health Services Authority invested $183 million into BC's CBSS sector, through United Way British Columbia (UWBC). Additional ad hoc funding has been delivered directly to CBSS agencies.; and, in 2022/23, the Ministry provided $70 million over two years to support continued Better at Home and Higher Needs Grant programs and ongoing sector expansion, as outlined above.
- *Budget 2024* provides $354 million over three years to support seniors to age comfortably and safely in their own homes and maximize their quality of life, including:
    - $227 million over three years to improve the quality and responsiveness of home health services, including care management services delivered by community-based professionals (e.g., registered nurses, social workers, occupational and physical therapists) and home support services delivered by community health workers.
    - $127 million over three years to stabilize and expand community-based seniors' services that provide seniors with non-medical support, including assistance with day-to-day tasks, and deliver programs that help keep seniors physically active, socially engaged, and connected to their communities.

KEY BACKGROUND

The stated intention of the report was to understand the impact of rising costs on seniors. A range of government support, services and subsidies were reviewed to determine their effectiveness, using data from a 2022 survey of low-income seniors and consultation with 82 community agencies. The 10 report recommendations include:

1. Index the BC Seniors Supplement to inflation consistent with other income supports such as GIS/Old Age Security (OAS) and Canadian Pension Plan (CPP).
2. Redesign the Shelter Aid for Elderly Renters (SAFER) program to reflect the current reality of the BC rental market and ensure yearly rent increases are recognized.
3. Increase the number of Seniors Subsidized Housing Units with a particular focus on rural BC where the overall supply of rental accommodation for seniors is most challenging.
4. Increase awareness of the Property Tax Deferral Program and examine an expansion of the program for low- and modest-income seniors to defer other costs such as strata fees, hydro costs, and other municipal charges. Examine how seniors living in co-operative housing might be able to take advantage of the program.
5. Develop a program to assist low- and modest-income seniors with major home repairs.
6. Eliminate the daily rate for publicly funded home support services.

7. Provide an extended health benefit for seniors that includes eyeglasses, hearing aids, mobility aids and necessary medical equipment. The cost of the plan could be covered by premiums based on income, ensuring it is an affordable option for all BC seniors.
8. Work with the federal government to ensure dental coverage for seniors with co-payments and deductibles based on income or include in an overall extended benefit plan.
9. Provide an annual province-wide bus pass for all seniors that includes HandyDART. The fee for the pass could be based on a sliding scale matched to income.
10. Develop a comprehensive plan to build the capacity of seniors' centers across BC to better support social engagement and help support older people access the supports and services they need to continue to live independently.

LAST UPDATED

The content of this estimates note is current as of February 12, 2024, as confirmed by Alix Adams, Executive Director, Seniors' Services Division

APPROVALS

2024 02 21 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2024 03 01 – Danielle Prpich obo Ross Hayward, Seniors' Services Division
2024 03 01 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

M-03

Aging with Dignity - Federal Funding Agreement

Topic: Aging with Dignity

Key Messaging and Recommended Response:

- **As BC's seniors' population grows at an unprecedented rate, so does the demand for health-care services.**
- **The new bilateral funding agreement bolsters BC's investments to meet the health needs of older adults in BC in the short and long term by improving access to high-quality, safe, dignified home and community care, palliative and end-of-life care as well as long-term care services for seniors and their families.**
- **This funding will help strengthen access to high-quality, safe, and dignified home and community care and long-term care in communities around BC, so more seniors in BC can age comfortably, near their loved ones.**

CURRENT SITUATION

- On February 12, 2024, Honourable Mark Holland, Canada's Minister of Health and the Honourable Adrian Dix, Minister of Health of BC announced a bilateral agreement to invest $733 million over the next five years.
- This funding builds on the $1.2 billion bilateral agreement that was announced with the province in October of 2023.Initiatives supported by federal funds.

Home and Community Care

1. Expanding and integrating home and community care services for seniors with complex medical conditions and frailty to better meet their needs and help reduce pressures on hospitals and emergency departments.
2. Increase access to palliative and end of life care for people outside hospital settings, enabling them to have these supports in their home, hospice, or community settings.

Long-term Care

1. Improve the quality of dementia care, palliative, and end-of-life care in Long Term Care through implementation of evidence-based practice knowledge, standardized education, and monitoring tools.
2. Strengthen the appropriateness, safety, and quality of LTC by enabling consistent, appropriate standards of care and oversight of LTC services.
3. Continue to stabilize and support the LTC workforce.

LEGISLATIVE SESSION – ESTIMATES NOTE

M-03

FINANCIAL IMPLICATIONS

Initiative	Incremental Investments					
	2023-24	2024-25	2025-26	2026-27	2027-28	Total
Total available Funding	**163**	**163**	**163**	**163**	**81**	**733**
Home and Community Care (HCC)						
Home and Community Care Services	**61**	**77**	**69**	**69**	**N/A**	**276**
Palliative/End of Life Care	**13**	**13**	**13**	**13**	**N/A**	**52**
HCC planned expenditure	**74**	**90**	**82**	**82**	**N/A**	**328**
Long-Term Care (LTC)						
Improve the quality of dementia care	**0**	**3**	**3**	**4**	**0**	**10**
Strengthen the appropriateness, safety, and quality of LTC by enabling consistent, appropriate standards of care and oversight of LTC services						
InterRai	**0**	**10**	**10**	**0**	**0**	**20**
Long Term Care at Home	**0**	**3**	**10**	**17**	**17**	**47**
Resources for Licensing and Quality Improvement	**0**	**10**	**10**	**10**	**10**	**40**
Continue to stabilize and support the LTC workforce	**0**	**50**	**75**	**80**	**83**	**288**
LTC planned expenditure	**0**	**76**	**108**	**111**	**110**	**405**
Total planned carry forward into next fiscal year	**89**	**86**	**59**	**29**	**0**	**-**

KEY BACKGROUND

- Since 2019, and the onset of Federal Funding, the number of clients receiving home support has increased by 9% to 54,700 – this includes assistance with activities of daily living (i.e., personal care, mobilization), as well as delegated nursing and rehabilitation tasks.
- Community Based Professional Services, such as client assessment, care planning, care coordination, and health care provision, have seen a 13% increase in the number of clients seen rising from 124,286 to 139,385.

LAST UPDATED

The content of this estimates note is current as of February 21, 2024, as confirmed by Danielle Prpich.

APPROVALS

2024-02-21 – Danielle Prpich, Seniors' Services Division.
2024 02 22 – Ross Hayward, Seniors Services Division.

LEGISLATIVE SESSION – ESTIMATES NOTE

M-04

Antipsychotic Use in Long-Term Care

Topic: Antipsychotic medications are commonly prescribed to manage behavioral and psychological symptoms of dementia (BPSD) and are associated with an increased risk of serious side effects.

Key Messaging and Recommended Response:

- **Our government remains committed to delivering the best quality of care to patients around the province, and a part of that is ensuring people receive appropriate care.**
- **At a national level, the use of antipsychotic medication in long-term care increased in 2020/21 to 2022/23 during the pandemic, including in BC.**
- **Prior to the pandemic, the performance measure was holding steady in BC (25.4% in 2017/18, 24.7% in 2018/19 and 24.7% in 2019/20).**
- **As a part of the ongoing commitment to quality of care, the government is actively working with health authorities and key quality partners to reduce the use of antipsychotics in long-term care.**
- **That is why the Ministry established a Provincial Advisory Working Group to actively engage with key partners, clinicians, and dementia care experts to inform and support the antipsychotic initiatives underway.**
- **As a part of our action plan, the Ministry is working to strengthen the monitoring and oversight of the use of antipsychotic medications in the long-term care settings through the development of provincial policy and the implementation of a LTC Quality Framework.**
- **A Provincial Advisory Working Group has been established comprised of key partners, clinicians, and dementia care experts to inform and support the antipsychotic initiatives underway.**
- **The Ministry is actively working to strengthen the monitoring and oversight of the use of antipsychotic medications in the long-term care settings through the development of provincial policy and the implementation of a LTC Quality Framework.**

CURRENT SITUATION

- The Canadian Institute for Health Information (CIHI) indicator *Potentially Inappropriate Use of Antipsychotics in Long-Term Care* is identified as a system performance measure in the Ministry of Health Service Plan.
  The 2024/25 – 2026/27 Ministry of Health Service Plan[1] sets targets to reduce the percentage of potentially inappropriate use of antipsychotics in LTC over 2024/25 to 2026/27:

2017/18 Baseline	2023/24 Forecast[1]	2024/25 Target	2025/26 Target	2026/27 Target
25.4%	**30.1%**	**21.0%**	**18.0%**	**18.0%**

[1] Forecast based on historical data from 2016/17 to 2022/23, generated as of Q4 2022/23.

- The baseline year of 2017/18 remains the same since the performance measure was introduced into the service plan in 2019/20. The targets have been retained from those published in the previous service plan. The target for 2026/27 aims to maintain the 18.0 percent target set for 2025/26. The national rate for this measure was 24.5 percent in 2022/23. Targets used in this plan aim to improve performance over time from current levels. The forecast for 2023/24 was modelled using historical data up to and including Q4 2022/23.
- The data shows that prior to the pandemic, the performance measure was holding steady across BC.[2]
- Ongoing challenges including the impact of COVID-19 in Long-Term Care (LTC), and widespread health human resources have negatively impacted this metric.

Potentially inappropriate use of antipsychotics by health authority[2]								
	2017/18 (Baseline) [3]	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	
							Q1	**Q2**
Fraser Health	22.8%	21.4%	21.4%	23.6%	26.4%	26.9%	27.3%	27.7%
Interior Health	25.8%	26.0%	24.9%	26.3%	25.7%	29.1%	29.7%	30.0%
Northern Health	32.2%	32.3%	36.3%	39.8%	35.3%	35.7%	34.8%	33.2%
Vancouver Coastal Health	26.9%	26.6%	26.4%	27.8%	31.0%	32.3%	32.5%	32.7%
Island Health	26.5%	25.7%	25.6%	27.7%	27.4%	27.3%	27.5%	27.1%
BC	**25.4%**	**24.7%**	**24.7%**	**26.5%**	**27.9%**	**29.0%**	**29.3%**	**29.4%**

- The following table provides data for Canadian jurisdictions for which data is available. The Canada rates includes participation from approximately 65% of long-term care facilities across the country.
- Compared to other jurisdictions, BC performance on this measure has been consistently poor.
- At a national level, the use of antipsychotic medication in long-term care increased in 2020/21 to 2022/23 during the pandemic, including in BC.

Potentially Inappropriate Use of Antipsychotics by Province[4]					
	2018/19	**2019/20**	**2020/21**	**2021/22**	**2022/23**
Canada	20.7%	20.2%	21.1%	23.9%	24.5%
British Columbia	24.7%	24.7%	26.5%	27.9%	29.0%
Alberta	17.2%	18.1%	19.9%	21.9%	22.3%
New Brunswick			30.4%	32.4%	33.1%
Newfoundland and Labrador	28.2%	23.1%	22.3%	26.4%	29.4%
Ontario	19.0%	18.3%	19.3%	21.1%	21.2%
Saskatchewan	27.5%		30.5%	33.1%	34.3%
Yukon	27.3%	28.6%	36.9%	36.2%	41.3%

[1] Ministry of Health Service Plan 2024/25 - 2026/27 (February 2024). https://www.bcbudget.gov.bc.ca/2024/sp/pdf/ministry/hlth.pdf
[2] CIHI eReporting Extracted 2024-01-24
[3] CIHI, eReporting Extracted 2022-07-20
[4] CIHI eReporting Extracted 2024-02-27

- Nationally, or internationally, there is no clear optimal target for the current performance measure due to evolving resident complexity and rising rates of dementia.
- As we continue to review this target, quality improvement actions are being implemented including increased oversight, accountability, and resources to support the appropriate use of antipsychotics and other medications in long-term care settings.
- The Ministry is actively working with health authorities on actions to reduce the use of antipsychotics in LTC in the following key areas:
    - Increase the scope and scale of the PIECES Learning and Development Program by facilitating certification for new PIECES educators in all regional health authorities.
        - Increased PIECES[5] education in the province, and by March 2025, there will be up to 140 newly trained PIECES Educators throughout British Columbia. These educators will provide clinical education for LTC staff on appropriate non-pharmacological approaches to managing behavioral symptoms of dementia.
        - In April 2023, the PIECES program expanded to include all five regional health authorities with the addition of new Educators in the Northern Health Authority.
        - Between September 2022 and December 2023, the PIECES Educators delivered 23 PIECES Learning and Development Program sessions across the province, attended by 383 learners who are primarily nurses and clinical nurse educators.
    - A Provincial Advisory Working Group has been established comprised of key partners, clinicians, and dementia care experts to inform and support the antipsychotic initiatives underway.
    - The Ministry is actively working to strengthen the monitoring and oversight of the use of antipsychotic medications in the long-term care settings through the development of provincial policy and the implementation of a LTC Quality Framework.
    - The Ministry is providing additional resources to support enhanced dementia care education for front-line health care staff in long-term care.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- This performance measure captures use of antipsychotic medications that may be appropriate in improving quality of life and reducing distress experienced by some long-term care residents who do not have a diagnosis for psychosis and who otherwise do not respond to non-pharmacological strategies for relief of behavioral symptoms such as severe agitation.
- Adverse effects of antipsychotic medications can include sedation, and increased risk of falls, stroke, and death in older persons.
- The Canadian Institute for Health Information (CIHI) reports publicly on the potentially inappropriate use of antipsychotics as a quality indicator. CIHI also directly compares the provincial/territorial and national averages as an assessment of health service performance.
- The Office of the Seniors Advocate's 2022 Monitoring Seniors Services Report highlighted the potentially inappropriate use of antipsychotics is at its highest level in the past five years.[4]
- At a national level, the use of antipsychotic medication in LTC increased in 2020/21 and 2021/22 over pandemic period, including in BC.[6] The increase is likely impacted by health system and health care challenges as a result of the pandemic and response measures, such as limited in-person visits for residents, increased stress and workload due to pandemic protocols for residents and staff.
- Provincial regulation governs the use of physical and chemical restraints in LTC settings.

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[5] PIECES Learning and Development Program™ (PIECES Program), a Ministry of Health funded education program for health care practitioners focused on assessment and management of behavioural and psychological symptoms of dementia aimed at enhancing quality care for older adults and improving staff experience.

[6] CIHI, Your Health System in Depth. Retrieved from: https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en#/indicator/008/2/C9001/. Provincial state of emergency: March 18, 2020 to June 30, 2021

- The PIECES Learning and Development Program™, which is an evidence-based approach for the care of people with dementia that health care providers apply in LTC settings. This program has been funded in BC since 2013, and funding has been extended until 2025.
- The CLeAR (Call for Less Antipsychotics in Residential Care) initiative, led by Health Quality BC (HQBC, formerly BC Patient Safety and Quality Council), was a quality improvement initiative aimed at LTC homes with high levels of potentially inappropriate antipsychotic use.
    - The HQBC website includes evaluation, lessons-learned, and resources related to CLeAR.
    - HQBC publishes practical resources, such as care plan templates, evidence-based advice on prescription appropriateness, and resident assessment tools to support physicians and the care teams to assess options for non-pharmacological interventions and to help determine when antipsychotic use is appropriate.

LAST UPDATED

The content of this estimates note is current as of February 9, 2024, as confirmed by Karen Neilson, ED, SSD.

APPROVALS

2024 02 28– Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 03-01 – Danielle Prpich obo Ross Hayward, Seniors' Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

M-05

Assisted Living - Seniors

Topic: Under the authority of the *Community Care and Assisted Living Act* and the Assisted Living Regulation, the Assisted Living Registry registers assisted living residences, conducts site inspections, and responds to complaints.

Key Messaging and Recommended Response:

- **The Ministry of Health's Assisted Living Registry is responsible for the oversight of registered supportive recovery residences. It is the Registrar's role to take action, if needed, in circumstances where the registrant is not protecting health and safety of residents.**
- **If a home is found to be in contravention of the *Community Care and Assisted Living Act* and/or the Assisted Living Regulation, the Assisted Living Registry would work with the operator to provide education and resources, as many contraventions can be resolved in that way.**
- **All operators of registered assisted living residences and licensed services must comply with the relevant regulations: Assisted Living Regulation or Residential Care Regulation. Complaints can be filed with the Assisted Living Registry if there is a concern for a person being provided services at a registered assisted living residence.**
- **The Registry continues to administer its operational requirements under the *Community Care and Assisted Living Act*.**

CURRENT SITUATION

- Over the last few years, the Assisted Living Registry (ALR) has experienced ongoing staffing and database challenges and has been struggling to respond to and address registration applications and public complaints in a timely manner.
- The ALR has been unable to implement proactive ongoing regulatory education and operator compliance inspections due to staffing vacancies.
- The ALR has reorganized the staffing structure to create two population focused portfolios. One for seniors and persons with disabilities and the second for supportive recovery and mental health assisted living residences. Staffing has also been enhanced within the portfolios, with the creation of a director, practice lead and senior investigator positions. Work is currently underway to fill the new practice lead and senior investigator positions. As well as continued recruitment to achieve a full complement of investigative staff.
- With the new structure and staffing increase, it is anticipated that the ALR will be better positioned to carry out the legislative duties under the *Community Care and Assisted Living Act* (CCALA).
- In September, the ALR began the design and development work on a new data system. The new data system includes the existing database functionality and new features for improved reporting and workload management as well as secure and stable operations. The new system is nearing completion of the first

phase of development with initial implementation anticipated in March. A second phase of design and development work is expected to begin in April, which will bring further enhancements and automation features for public reporting.

- Renewal of each registration is an annual requirement under CCALA. Registrations expire annually on March 31.
- The renewal process includes a review of each residence to confirm or update the number of registered units, update any changes to business operations and staffing, as well as confirmation of the services being offered to residents.
- An initial registration process typically takes between 3 – 6 months for each new applicant to complete. This includes time for the applicant to complete all the required components (such as municipal approvals and business licensing) as well as for the applicant to submit the required policies to the ALR. The ALR then reviews all the documents and policies to ensure that they meet regulatory requirements. Once this process is completed a registration can then be issued.

New Registrations, Applications, and Renewals - April 1, 2023 to February 2, 2024

- Two applications to open Senior's residences were received:
  - 1 is currently under review
  - 1 has been approved
- No existing registrations were cancelled.

Incident Reports - April 1, 2023 to February 2, 2024

- 591 incident reports were received, reviewed and closed.
- The Assisted Living Regulation (Regulation) requires incident reports to be submitted by the operator within 24 hours of an incident occurrence. Operators must report on specific incident types as required by the Regulation such as missing/wandering residents, falls and disease outbreak.
- Registry staff review and follow up with the operator on incidents they report. Some incident reports require multiple follow ups and further assessment for compliance with the legislation and to ensure the operator is protecting the health and safety of their residents.

Site Inspections - April 1, 2023 to February 2, 2024

- 46 Seniors residence site inspections were conducted by the Registry.
- Site inspections included complaint follow up, new registrations and education.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- Assisted Living (AL) is congregate housing that provides 1 or more AL services (i.e., assistance with activities of daily living, assistance with medication management, assistance with safekeeping money and personal property, assistance with managing therapeutic diets, assistance with behaviour management, and psychosocial supports) and 5 hospitality services (meals, housekeeping, laundry, recreation, emergency response system).
- AL residences for seniors' support adults who require support but can make decisions on their own behalf that are necessary to live safely in a semi-independent environment.
- The ALR registers AL residences and responds to complaints or other information that indicates residences are being operated in a way that does not ensure the health and safety of the residents, or that an unregistered AL residence is being operated. Anyone with a concern can make a complaint to the ALR. ALR staff conduct investigations that are remedial in nature.
- Residences which meet the definition of AL are required to be registered with the provincial Registry, regardless of whether they are publicly subsidized or private pay.

LEGISLATIVE SESSION – ESTIMATES NOTE

M-05

LAST UPDATED

The content of this estimates note is current as of February 7, 2024, as confirmed by Dawn Williams. Data sourced from the Assisted Living Registry database.

APPROVALS

2024 02 07 - Dawn Williams obo Sue Bedford
2024 02 14 - Ross Hayward, Seniors Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

M-06

Better at Home Program

Topic: Better at Home (BH) is a community-based program funded by the provincial government and managed by United Way BC (UWBC) that provides seniors with access to simple, non-medical home support services (light housekeeping, light yard work, snow shoveling, grocery shopping, minor home repairs, transportation to appointments and friendly visiting) to help them stay independent in their own homes and connected to their communities.

Key Messaging and Recommended Response:

- **There are 93 Better at Home (BH) programs in B.C., including two new programs this year:**
  - **Vancouver Coastal Health – 16**
  - **Fraser Health – 15**
  - **Interior Health – 27 (1 new, Lillooet)**
  - **Island Health – 19**
  - **Northern Health – 16 (1 new, Fort Nelson)**
- **BH programs are community driven, and local circumstances determine the exact services available in each community.**
- **Eligible seniors with low-income receive services at no cost.** Business Information

  Business Information
- **Effective April 1, 2024, the BH basket of services is expanding with an even greater emphasis on social connection. New services are being added and will include support with referral and system navigation, peer support, expanded group activities, social meals, and more flexible transportation options.**
- **Budget 2024 provides $127 million over three years to stabilize and expand community-based seniors' services that provide seniors with non-medical support, including assistance with day-to-day tasks, and deliver programs that help keep seniors physically active, socially engaged, and connected to their communities.**

CURRENT SITUATION

- 93 core BH programs operate across BC, serving over 260 communities, including First Nations communities (Cowichan Elders, Gitxsan First Nation, Stó:lo Territory, and Squamish-Tsleil-Waututh Nation).[1]

[1] United Way British Columbia email correspondence, February 6, 2024.

- As BH extends its reach across the province, new program expansion is beginning to slow, and we are seeing expansion through existing programs serving new communities.
- BH services are provided by local non-profit organizations and delivered by a mix of volunteers, contractors, and staff.
- From April 1, 2022, to March 31, 2023, BH delivered 283,027 services to 13,917 seniors and Elders.[2] This represents a 11.0% increase in services delivered, and a 8.0% increase in number of seniors and Elders served compared to 2021/22 (255,082 services and 12,888 seniors).
- Effective April 1, 2024, BH is expanding its basket of services to put social connection more directly at the core of service delivery. New services include support with referral and system navigation, peer support, expanded group activities, social meals, and more flexible transportation options. BH agencies will be able to apply for additional funding streams to support these changes in response to community needs and priorities. (See FS Healthy Aging – Community Based Seniors Services.)

FINANCIAL IMPLICATIONS

Since 2011/12, the Ministry and the Provincial Health Services Authority provided $183 million to the UWBC to expand and operate the BH program: $15 million in 2011/12; $5 million in 2012/13; $2 million in 2013/14; $4 million in 2014/15; $5 million in 2015/16; $10 million in 2016/17; $10 million in 2017/18; $6.6 million in 2018/19; $55.4 million in 2019/20 ($50 million and $5.4 million)[3]; and $70 million in 2022/23[4].

KEY BACKGROUND

- Program sites are selected based on criteria (i.e., proportion of seniors, number of seniors likely to require BH services) and guidance from seniors' organizations and local and regional experts.
- Better at Home programs are community driven. Local circumstances determine the exact services available and the sliding-scale fee structure. Eligible seniors with low-income receive services at no cost. Cabinet Confidences
- BH expansion in progress: Bella Bella, Hudson's Hope, Lasqueti Island, Thetis Island, Haida Gwaii, Kimberley, and Rosswood. Lytton, Usk, and Dease Lake, announced for expansion in May 2023[6], Cabinet Confidences Cabinet Confidences
- The current programs are (entries in **bold** represent new programs added in 2023/24):

No.	Program Name	Program location	No.	Program Name	Program location
Fraser Health Region (15 programs)					
1	Abbotsford BH	Abbotsford	9	New Westminster BH	New Westminster
2	Burnaby BH	Burnaby	10	South Surrey/White Rock BH	Surrey
3	Chilliwack BH	Chilliwack	11	Stó:lo Territory BH	Agassiz
4	Delta BH	Delta	12	Surrey-Newton BH	Surrey
5	Hope/Fraser Canyon BH	Hope	13	Surrey-Whalley BH	Surrey
6	Langley BH	Langley	14	Tri-cities BH	Port Moody
7	Maple Ridge/Pitt Meadows BH	Maple Ridge	15	Agassiz-Harrison BH	Agassiz
8	Mission BH	Mission			
Interior Health Region (27 programs, including 1 new program)					
1	Arrow Lakes BH	Nakusp	13	Nelson BH	Nelson
2	Ashcroft/Cache Creek BH	Kamloops	14	North Okanagan BH	Vernon
3	Boundary BH	Grand Forks	15	North Thompson BH	Clearwater
4	Castlegar BH	Castlegar	16	Penticton BH	Penticton

[2] United Way British Columbia email correspondence August 22, 2023.
[3] The $5.4 million was provided as a "top-up" to the $5.6 million provided in 2018/19 to fulfill a commitment to provide up to $11.0 million in 2018/19. The Ministry had to split the payment into two amounts to comply with Treasury Board approvals.
[4] The $70 million was publicly announced in May 9 and June 5, 2023 News Releases. The $34.378 million is Better at Home's allocation from the $70 million agreement with UWBC for continued operation and expansion of Better at Home, as well as supports for bc211 and other community-based projects for seniors who need extra help accessing programs and services.
[5] United Way British Columbia email correspondence, September 8, 2023.
[6] Expanded supports help seniors to continue living independently | BC Gov News

LEGISLATIVE SESSION – ESTIMATES NOTE

No.	Program Name	Program location	No.	Program Name	Program location
5	Central Okanagan BH	Kelowna	17	Shuswap Region BH	Sicamous
		West Kelowna	18	South Okanagan BH	Oliver & Osoyoos
		Lake Country	19	Williams Lake BH	Williams Lake
6	Columbia Valley BH	Invermere	20	Peachland BH	Peachland
7	Cranbrook BH	Cranbrook	21	Golden BH	Golden
8	Creston Valley BH	Creston	22	Princeton BH	Princeton
		Crawford Bay	23	Nicola Valley BH	Merritt
9	Kamloops BH	Kamloops	24	Revelstoke BH	Revelstoke
10	Logan Lake BH	Logan Lake	25	Elk Valley BH	Invermere
11	Southern Cariboo BH	100 Mile House	26	Slocan Valley BH	Slocan
12	Lower Columbia BH	Trail	**27**	**Lillooet BH**	**Lillooet**
Northern Health Region (16 programs, including 1 new program)					
1	Dawson Creek BH	Dawson Creek	9	Prince Rupert BH	Prince Rupert
2	Fort St. John BH	Fort St. John	10	Quesnel BH	Quesnel
3	Gitxsan BH	New Hazelton	11	Robson Valley BH	Fort St. James
4	Granisle BH	Granisle	12	Terrace BH	Terrace
5	Kitimat BH	Kitimat	13	Houston BH	Houston
6	North Central BC BH	Fraser Lake	14	Burns Lake BH	Burns Lake
7	Chetwynd BH	Chetwynd	15	Mackenzie BH	Mackenzie
		Tumbler Ridge			
8	Prince George BH	Prince George	**16**	**Fort Nelson BH**	**Fort Nelson**
Vancouver Coastal Health Region (16 programs)					
1	Hastings-Sunrise BH	Vancouver	9	Richmond BH	Richmond
2	Kitsilano BH	Vancouver	10	Sea to Sky BH	Squamish
3	KOMDS BH	Vancouver	11	Vancouver Inner City BH	Vancouver
4	Mount Pleasant BH	Vancouver	12	Sunshine Coast BH	Sechelt
5	Wavefront Centre BH	Vancouver	13	Squamish Nation-Tsleil-Waututh Nation BH	Squamish
6	Powell River BH	Powell River	14	Vancouver South BH	Vancouver
7	Renfrew-Collingwood BH	Vancouver	15	West End & Coal Harbour BH	Vancouver
8	North Shore BH	North Vancouver	16	Pender Harbour BH	Madeira Park
Vancouver Island Health Region (19 programs)					
1	Campbell River BH	Campbell River	11	Oceanside BH	Parksville
2	Comox Valley BH	Hornby Island	12	Port Alberni BH	Port Alberni
3	Cowichan Region BH	Duncan	13	Saanich BH	Saanich
4	Cowichan Elders BH	Duncan	14	Cortes Island BH	Cortes Island
5	Esquimalt BH	Victoria	15	Sooke BH	Sooke
6	Galiano BH	Galiano Island	16	Southern Gulf Islands BH	Pender Island
7	Nanaimo BH	Nanaimo	17	Victoria and Oak Bay BH	Victoria
8	North Island BH	Port Hardy	18	West Shore BH	Victoria
9	Quadra Island BH	Quadra Island	19	Pacific Rim BH	Tofino
10	Salt Spring Island BH	Salt Spring Island			

LAST UPDATED

The content of this estimates note is current as of February 27, 2024, as confirmed by Alix Adams.

APPROVALS

2024 02 14 – Ross Hayward, Seniors' Service Division
2024 02 22 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 02 27 – Alix Adams obo Ross Hayward, Seniors' Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

M-07

Caregiver Support

Topic: Caregiver support provides relief from the emotional and physical demands of caregiving and includes in-facility (overnight) respite, adult day services, and in-home respite visits.

Key Messaging and Recommended Response:

- **Family and friend caregivers are an important part of the care team and support seniors to age at home longer.**
- **Adult day services capacity is recovering from pandemic service suspensions with a 22% increase in clients served between YTD 2022/23 and YTD 2023/24[1].**
- **In 2023/24 YTD, 196,807 days of adult day program service have been delivered, which represents a 40% increase over the same period in 2022/23.**
- **The Ministry doubled funding for Family Caregivers of BC providing approximately $1 million in 2020/21, helping support both caregivers and seniors as part of BC's emergency COVID-19 response plan.**

CURRENT SITUATION

- The Office of the Seniors Advocate report, *We Must Do Better*, released in February 2023, recommended respite care for home support clients be increased to meet the needs of family caregivers.
- The Ministry is exploring options to enhance support for caregivers, including examining utilization of current services with an eye to modernization to meet client and caregiver needs.

Adult Day Services (ADS)[2,3]

- As of January 2024 (P10), approximately 6,000 clients received 196,807 days of ADS service in 30,183 available ADS spaces, representing a 40% increase in service days, a 22% increase in clients and 11% increase in spaces from P10 2022/23[5].

Table 1. Adult Day Services by Health Authority, Year-to-Date, Period 10 2023/24 [4,5]

HA	2022/23 YTD			2023/24 YTD			% Change Year to Date		
	ADS Spaces	ADS Days	ADS Clients	ADS Spaces	ADS Days	ADS Clients	ADS Spaces	ADS Days	ADS clients
IHA	5,504	27,553	1,161	6,899	38,583	1,384	25%	40%	19%
FHA	6,785	33,864	1,502	7,651	59,555	1,933	13%	76%	29%
VCHA	6,454	39,782	1,019	6,956	50,871	1,362	8%	28%	34%
VIHA	7,195	38,644	1,288	7,221	45,592	1,319	0.4%	18%	2%
NHA	1,295	989	-	1,456	2,206	88	12%	123%	-
.BC	27,233	140,832	4,900[5]	30,183	196,807	6,000	11%	40%	22%

[1] Ministry of Health. Report ID: RMS 2391. Home and Community Care Services Report. Retrieved from: https://hspp.hlth.gov.bc.ca. Last accessed on: February 14, 2024

[2] HSIAR, Home and Community Care Progress Report, 2023/24 Period 10, last accessed February 13, 2024.

[3] ADS spaces are reported as the average number of spaces reported by HAs by reporting period; YTD is averaged over 10 periods and annual values are averaged over 13 periods.

[4] HCC Manual Submissions, 2023/24 Period 10, data as of January 4, 2024.

[5] NHA was unable provide 2022/23 annual and YTD client counts for ADS and Respite. Due to this the B.C. total does not include NHA data. To allow for an accurate comparison of clients, NHA data was excluded from the % change calculation for ADS and respite clients.

Table 2. Adult Day Services Provincial Annual Comparisons[2,Error! Bookmark not defined.]

Metrics	2018/19	2019/20	2020/21	2021/22	2022/23	% Change 2022/23 vs. 2018/19
ADS Spaces	28,121	31,078	365	15,116	27,995	-0.4%
ADS Days	254,348	288,308	12,910	91,046	193,110	-24%
ADS Client Counts (approx.)	6,700	7,200	900	3,600	5,900	-12%

- ADS was suspended for the majority of 2020/21 during the COVID-19 pandemic, resulting in a 96% decrease in service days and 88% decrease in clients served compared to pre-pandemic (2019/20).
- Health authorities (HA) have been actively working to return ADS to pre-pandemic service levels, however, uptake and utilization of ADS is impacted by changing attitudes of clients who prefer 1:1 care in their homes vs. group settings.
- At the end of FY 2022/23, ADS service days have returned to 67% of pre-pandemic volumes, serving 82% of pre-pandemic clients.**Error! Bookmark not defined.** Service days and client counts are anticipated to be higher for the complete 2023/24 year, as YTD, HAs have achieved 40% increase in service days and 22% increase in clients served.[2]

Overnight/In-Facility Respite

- In-facility respite capacity is recovering from pandemic service suspensions. By the end of 2022/23, approximately 2,900 British Columbians (17% below 2019/20; 12% below the 2018/19 baseline) received a total of 76,169 days of services (16% below 2019/20; 23% below 2018/19 baseline)[2,**Error! Bookmark not defined.**.
- HAs report workforce shortages, long-term care admissions, and prioritization of beds to support alternate level of care (ALC)/acute patients, are impacting service delivery to clients admitted from home settings.
- At the end of FY 2022/23, in-facility respite days have returned to 84% of pre-pandemic (2019/20) volumes, serving 83% of pre-pandemic clients**Error! Bookmark not defined.**. Service days and client counts are anticipated to be higher for the complete 2023/24 year, as YTD, HAs have achieved 3% increase in service days and 24% increase in clients served.[2]

FINANCIAL IMPLICATIONS

- Budget 2024 provides targeted supports of $354 million over three years in home and community care for seniors.
- Budget 2021 provided $68 million over the three years ($22.5 million annually) to increase support for home care services, including increasing care aides and community providers.
- The Ministry invested $145 million over the last five years to expand respite care and adult day services, helping both seniors and their loved ones.
- The Ministry doubled funding for Family Caregivers of BC providing approximately $1.0 million in 2020/21, helping support both caregivers and seniors as part of BC's emergency COVID-19 response plan.
- In 2023/24 BC and Canada entered into the Aging with Dignity bilateral agreement which provides BC with $733 million over five years to help British Columbians age with dignity, closer to home, through improved access to home and community care and long-term care. This includes funding for respite support which offers respite beds within facilities on a predictable, regular model, for one week per month to a subset of seniors with more complex needs. Fundamentally, this will relieve caregiver pressures and burnout, while supporting a health check-in while the senior is in the facility.

KEY BACKGROUND

- Caregiver support provides relief from the emotional and physical demands of caregiving. Services are designed to provide caregivers with a break from caregiving duties while supporting clients to receive safe professional care.

- ADS are a group of programs provided in a community setting. Clients receive a range of personal care, health care, and therapeutic social/recreational activities and caregivers receive a break from caregiving duties.
- In-facility respite provides short-term care for clients in a licensed long-term care home. This supports caregivers by enabling time away from caregiving while clients receive safe, professional care.
- A 2017 Seniors Advocate's report, *Caregivers in Distress: A Growing Problem*, recommended increasing access to caregiver support including ADS and in-home and overnight respite.
- This was echoed in a February 2023 Senior's Advocate's report, *We Must Do Better*, with a recommended increase in respite care.
- Both ADS and in-facility respite caregiver supports are recovering from pandemic service suspensions and seeing an increase in capacity and utilization

Seniors' Guide

- The BC Seniors' Guide (the Guide) is an invaluable resource for seniors and caregivers, providing information about services and support available throughout the province.
- Since 2016/17, the Guide has been translated into five additional languages (Farsi, Korean, Vietnamese, Hindi, and Tagalog).
- The 11th Edition was reviewed and updated in 2020/21 with the 12th Edition released in May 2020.
- The 12th and current Edition is available (print and electronic) in nine languages and contains contemporary information regarding digital literacy, cultural safety, LGBTQ2S+ support, medical assistance in dying, housing, transportation, finances, safety, and more.

Family Caregivers of BC

Family Caregivers of BC is a non-profit organization dedicated to supporting informal and unpaid caregivers. They assist with navigating the health care system, offer education and information, facilitate emotional support groups, and operate a toll-free caregiver support line.

LAST UPDATED

The content of this estimates note is current as of February 12, 2024, as confirmed by Alix Adams, Executive Director, Seniors' Services Branch.

APPROVALS

2024 03 01 - Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 03 01 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2023 04 03 - Ross Hayward, Seniors Services' Division

LEGISLATIVE SESSION – ESTIMATES NOTE

M-08

Home and Community Care (HCC) Seniors Funding

Topic: The Ministry of Health invests significant funding in programs and services to support seniors and individuals with complex medical conditions or frailty.

Key Messaging and Recommended Response:

- **The province has invested approximately $2 billion over the last 5 years to improve care for seniors, including investments in primary care, home health, long-term care, assisted living and respite services.**
- **Funding also expanded training for health-care assistants to address critical staffing shortages in the long-term care, assisted living and home care sectors with $25 million in 2022-23.**
- **Budget 2024 provides $354 million over three years for home and community care for seniors.**
- **The recently announced Aging with Dignity Funding through the federal government will help strengthen access to high-quality, safe and dignified home and community care and LTC in communities, stabilize and support the LTC workforce. This includes $81 million in new funding for LTC.**
- **In addition, we've invested $145 million over the last five years to expand respite care and adult day programs to help seniors and their loved ones. Adult day programs are community-based care programs for clients to receive a range of personal care, health care, and therapeutic social/recreational activities.**
- **The Ministry also doubled funding for Family Caregivers of BC providing approximately $1 million in 2020/21, helping support both caregivers and seniors as part of BC's emergency COVID-19 response plan.**
- **All of these steps are crucial to ensure our growing senior's population is supported to age in place, in their home communities, and for their loved ones and caregivers to feel supported as well.**

CURRENT SITUATION

Home and Community Care

- Health authorities reported spending on services that primarily support the seniors' population has increased by more than $1.8 billion since 2018/19 (see **Table 2**).

Table 2 - Community and Long-Term Care Expenditures (2016/17 to 2022/23)

	Health Authority Expenditures ($M)							2018/19 - 2022/23	
	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	$ Change	% Change
Community Care	1,157	1,228	1,316	1,490	1,729	1,940	2,163		
Long-Term Care	1,905	1,985	2,074	2,230	2,643	2,871	3,078		
Total	**3,062**	**3,213**	**3,390**	**3,719**	**4,372**	**4,811**	**5,240**	**1,850**	**54.6%**
% increase year-over-year	**N/A**	**4.9%**	**5.5%**	**9.7%**	**17.5%**	**10.0%**	**8.9%**		

- Some of this funding growth is attributed to annual increases in response to population growth, negotiated wage increases established through collective bargaining, and investments government implemented in response to the the COVID-19 pandemic (wage leveling, supplies, overtime, visitor screening, and stabilization funding).
- Much of the investments target improved access and services for publicly subsidized home support, assisted living, and long term care for seniors and others who experience complex medical conditions and / or frailty. Examples include:

Community Based Seniors Services

- The Ministry also provides grants to non-profit organizations to support seniors, i.e. United Way of BC, to provide seniors with non medical supports they need to age well at home (including investments in response to the COVID-19 pandemic). Table 3 summarizes how funding for these grants has evolved since 2016.

Table 3 – Seniors' Grant Funding (2016/17 to 2022/23)

	Grant Funding ($M)						
	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Total	26.76	19.60	13.13	72.92	7.76	26.77	99.72

- In 2022/23, the Minisry provided United Way BC (UWBC) $70 million for continued operation and expansion of Better at Home, continued delivery of the Higher Needs Grants demonstration projects, as well as supports for bc211 and other community-based projects for seniors who need extra help accessing programs and services.

- In 2021/22, the Ministry provided $8 million and $14 million in 2022/23 (Not Yet Announced) to the BC Care Providers Association (BCCPA) to continue supporting publicly-funded LTC and AL residence operators to respond to the COVID-19 pandemic and improve infection prevention and extreme weather events in the sector.
- In 2019/20, the Ministry provided $55.4 million ($50 million announced, $5.4 million not announced) to the United Way of the Lower Mainland (UWLM, now UWBC) to deliver Better at Home; expand the Higher Needs Grants demonstration projects; and deliver the Safe Seniors, Strong Communities program that provided non-medical services to seniors whose regular support network was disrupted by the COVID-19 pandemic, or whose need for support increased due to self-isolation.
- In 2019/20, the Ministry provided $10 million to the BCCPA to support and expand the EquipCare BC program; a component of which was used to create an Infection Control Enhancement Program to support publicly funded and private LTC and AL operators to respond to the COVID-19 pandemic and improve infection prevention.
- In 2018/19, the Ministry provided Government Financial to the UWLM to administer the Higher Needs grant program and $435,000 to conduct research on community-identified and community-based programs. (Not announced.)

HCC Targeted Budgets

- The above funding has been supported, in part, through Provincial budget increases including:
  - Budget 2021 provided $68 million over three years ($22.5 million annually) to increase support for home care services.
  - Budget 2018 provided $548 million over three years ($250 million annually by 2020/21) to improve services for seniors across the continuum, including investments in primary care, home and community care, residential care, and assisted living.
- In addition to operating funding, BC has invested $1.65 billion in capital funding in long-term care since 2017.
- Budget 2024 provides $354 million over three years for home and community care for seniors.

Government of Canada Agreements/Contributions - Home and Community Care

- On February 12, 2024, BC and Canada announced a bilateral agreement over the next five years to help British Columbians age with dignity, closer to home, through improved access to home and community care and long-term care (LTC), which includes funding of $82 million (included in above targeted health authority funding) to sustain previous home and community care investments (2023/24 – 2026/27) and new funding of $81 million for long-term care (2023/24 – 2027/28).
- In 2021/22, the bilateral agreement was amended committing $134.9 million in funding for BC for the Safe Long-Term Care Fund to support increase infection prevention and control in long-term care facilities.
- In 2018, BC entered into an agreement with the Government of Canada that provided $394 million over five years to increase support for home and community care, as well as palliative and end-of-life care. (Included in above health authority targeted funding)

Health Career Access Program

- Budget 2021 provided $585 million over three years to the Health Career Access Program, which supports training and recruitment of the home health workforce.

Office of the Seniors Advocate

- Funding for the Office of the Seniors Advocate (OSA), an independent office of the BC provincial government is also provided through the Ministry of Health.
- In 2023/24, the Ministry provided $3.21 million for the OSA to undertake work related to monitoring and analyzing senior services and issues in BC and making recommendations to government and service providers to address systemic issues.

FINANCIAL IMPLICATIONS

- We have invested approximately $2 billion over the last five years to improve care for seniors, including investments in primary care, home health, long-term care and assisted living.
- Budget 2024 provides $354 million over three years to support seniors to age comfortably and safely in their own homes and maximize their quality of life, including:
    - $227 million over three years to improve the quality and responsiveness of home health services, including care management services delivered by community-based professionals (e.g., registered nurses, social workers, occupational and physical therapists) and home support services delivered by community health workers.
    - $127 million over three years to stabilize and expand community-based seniors' services that provide seniors with non-medical support, including assistance with day-to-day tasks, and deliver programs that help keep seniors physically active, socially engaged, and connected to their communities.

KEY BACKGROUND

- Funding is provided through health authorities to deliver home and community care services, including home support, community professional services (e.g., nursing, rehab, social work), respite (e.g., adult day programs), assisted living, long term care and palliative care.
- Additionally, the Ministry provides funding through non profit community-based seniors serving organizations to support seniors with non-medical supports they need to age well in the community.

LAST UPDATED

The content of this etimates note is current as of February 14, 2024 as confirmed by Alix Adams, SSD.

APPROVALS

2024 02 29 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 01 - Danielle Prpich obo Ross Hayward, Seniors' Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

M-09

Home Health

Topic: BC has a comprehensive range of home health (HH) services that support seniors, as well as people experiencing short- or long-term disability, to manage their health care needs and remain living at home in their community.

Key Messaging and Recommended Response:

- **Home health services help seniors to age at home and that is why our focus has been on expanding these services.**
- **YTD 2023/24 (period 10), approximately 9,232,000 hours of home support were delivered, which is a 7% increase over the same period last year and a 10% increase over the past five years (versus P10 2018/19).**
- **Budget 2024 provides $354 over three years in targeted support for home and community care for seniors, including $227 million for home health services.**
- **Policy development is underway to achieve the mandate commitment, including proposed changes to improve the responsiveness and coordination of services to clients (hours of coverage, response times, client to most responsible clinician ratio); more flexibility of services offered; review of the client rate structure and alternative funding models.**
- **In addition, our government continues to invest in adult day programs and support for caregivers.**
- **The Ministry doubled funding for Family Caregivers of BC providing approximately $1 million in 2020/21, helping support both caregivers and seniors as part of BC's emergency COVID-19 response plan.**

CURRENT SITUATION

- Premier Eby's January 2024, mandate letter to Minister Dix calls to: *'expand publicly funded home care'* and policy development is underway to achieve the mandate commitment, including: proposed changes to improve the responsiveness and quality of services to clients (hours of coverage, response times, care coordination, client to community based professional services ratios); more flexibility of services offered; increasing the number of community health workers; review of the client rate structure and alternative funding models.
- A key component of the Ministry's approach to HH will be implementation of Specialized Community Service Programs in regional health authorities (HA), designed to improve the coordination of services and integration of HH with other primary care and community-based services.
- Budget 2024 provides $227 million over three years to improve the quality and responsiveness of home health services, including care management services delivered by community-based professionals (e.g.,

registered nurses, social workers, occupational and physical therapists) and home support services delivered by community health workers. Improvements will include:
  - Providing more robust care management and care coordination so clients have more contact and support with the person overseeing their care plan.
  - Expanding hours of service availability so coverage is more comprehensive and timely.
  - Increasing the flexibility and coverage of home support services.
- The following data shows the client and service volumes for 2023/24, up until January 4, 2024[1]:

Table 1. Home Support Client Counts and Service Hours by Fiscal Year [2]

	Fiscal Year	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24 YTD (P10)
Client Counts	Clients	50,500	52,300	50,900	53,900	54,700	50,100
	Year over Year % Change	-	4%	-3%	6%	1%	13%
	Cumulative % Change	-	4%	1%	7%	8%	12%
Service Hours	Service Hours	10,788,500	11,285,754	11,126,264	11,537,268	11,337,726	9,232,152
	Year over Year % Change	-	5%	-1%	4%	-2%	7%
	Cumulative % Change	-	5%	3%	7%	5%	10%

- YTD 2023/24, home support client counts, and service hours have increased by 13% and 7%, respectively, compared to the previous year.
- In the past five years, since 2018/19, home support client counts and service hours have increased by 12% and 10%, respectively.
- Service volumes decreased by 2% from 2021/22 to 2022/23, while clients served expanded by 1%. Provincial level data is influenced by decreases observed in regions predominantly rural/remote, where home support service delivery is strongly influenced by geography (i.e., increased costs due to longer travel distances and associated time between visits), and workforce factors (i.e., recruitment/retention challenges and slower workforce growth is experienced in rural regions).
- Despite the small drop in 2022/23, HAs are projected to deliver ~12 million service hours for the complete FY 2023/24, representing a ~6% increase from 2022/23, ~4% increase from all-time highs achieved in 2021/22, and ~11% increase from the baseline year of 2018/19.[3]

Table 2. Community Based Professional Services Client Counts and Visits by Fiscal Year[4]

	Fiscal Year	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24 YTD (P10)
Client Counts	Distinct Clients	124,200	130,000	133,500	140,000	141,000	121,000
	Year over Year % Change	-	5%	3%	5%	1%	14%
	Cumulative % Change	-	5%	7%	13%	14%	14%
CBPS Visits	Number of Visits	1,497,189	1,614,874	1,725,149	1,713,914	1,690,748	1,291,608
	Year over Year % Change	-	8%	7%	-1%	-1%	1%
	Cumulative % Change	-	8%	15%	14%	13%	11%

- YTD 2023/24, community based professional services (CBPS) client counts and visits have increased by 14% and 1%, respectively, compared to the previous year.
- In the past five years, since 2018/19, CBPS client counts and visits have both increased by 14% and 11%, respectively.

[1] Ministry of Health. Report ID: RMS 2391. Home and Community Care Services Report. Retrieved from: https://hspp.hlth.gov.bc.ca. Period 10 data is up to January 4, 2024.

[2] Home support data reported by MoH differs from that of the Office of the Seniors Advocate. Both include short-term and long-term home support, but MoH also includes home support provided in assisted living, whereas OSA includes CSIL. NHA could not provide YTD P10 client counts for 2022/23, therefore NHA data is excluded from the year-over-year 2023/24 P10 growth rate calculation.

[3] Projection based on a monthly average of hours delivered as of P10, multiplied by 13 reporting periods.

[4] Community Based Professional Services includes Community Nursing, Community Rehab, Clinical Social Work and Case Management services. NHA could not provide YTD P10 client counts for 2022/23, therefore NHA data is excluded from the year-over-year 2023/24 P10 growth rate calculation.

- As of February 7, 2024, 1,470 Health Care Support Workers were hired by the regional HA, since September 2020, to work in HH settings (i.e., home support) through the Health Career Access Program (HCAP)[5]. This represents a 28.7% increase since September 2023, and a 63% increase since April 2023.
- HA implement strategies to create capacity in home health and reduce the number of Alternate Level of Care (ALC) patients during the fall/winter surge, including the implementation of rapid response teams in the community.
- On February 23, 2023, the OSA released a report on HS services and recommended: elimination of the financial barrier to home support access; increase respite care; standardize and set targets for all aspects of service delivery; modernize care plans; measure, monitor and report performance. These recommendations align with work underway to increase access and coordination of HH services to help people remain living well at home longer.

FINANCIAL IMPLICATIONS

- Budget 2024 provides $227 million over three years to improve the quality and responsiveness of home health services, including care management services delivered by community-based professionals (e.g., registered nurses, social workers, occupational and physical therapists) and home support services delivered by community health workers.
- Budget 2021 provided:
    - $68 million over three years ($22.5 million annually) to increase support for home care services, including increasing care aides and community providers.
    - $12 million over three years for the Home Health Monitoring Initiative which supports patients to self-manage their health from the comfort of their homes.
    - $585 million over three years to support the HCAP.
- In 2022/23, HAs reported spending more than $2.1 billion on community care services, including adult day services, professional services (nursing and rehabilitation), home support, case management and assisted living services.
- The Ministry invested $145 million over the last five years to expand respite care and adult day services, helping both seniors and their loved ones.
- In 2023/24 BC and Canada entered into the Aging with Dignity bilateral agreement which provides BC with $733 million over five years to help British Columbians age with dignity, closer to home, through improved access to home and community care and long-term care (LTC).

KEY BACKGROUND

Community Based Professional Services (CBPS)

CBPS are provided by regulated health care professionals and include nursing, rehabilitation (occupational and physical therapy), and social work. CBPS include assessment, care planning, care provision, and care coordination, with emphasis on early intervention, post hospital discharge and prevention of readmission through linkages with primary care, community-based seniors services, and other specialized services.

Caregiver Support (CS) Services[6]

- CS provides relief from the emotional and physical demands of caregiving. Services are designed to provide caregivers with a break from caregiving duties while supporting clients to receive safe professional care.
- CS includes in-facility (overnight) respite (short-term care for clients in a licensed long-term care facility); adult day services (group programs provided in a community setting that involve therapeutic social/recreational activities amongst other activities); and in-home respite visits.
- The Office of the Seniors Advocate report, We Must Do Better, released in February 2023, recommended that respite care for home support clients be prioritized to meet the needs of family caregivers; and the Ministry is exploring options to enhance support for caregivers.

[5] Report on HCAP Home Health hires compared to other settings, February 7, 2024, HSWBS. For further information see HCAP Estimates Note.
[6] For further information see Caregiver Supports Estimates Note

Home Support (HS) Services

- HS services are provided by unregulated care providers (Health Care Assistants [HCAs] / Community Health Workers [CHWs]) to clients who require assistance with activities of daily living (e.g., personal care, mobilization). Services may also include safety maintenance activities (e.g., cleaning spills or laundering), delegated nursing and rehabilitation tasks as required, and in-home respite.
- HA are working to increase service hours for long-term HS clients to enable independent living for as long as possible, and for short-term home support clients (i.e., following hospital discharge).
- The HCAP, announced in September 2020, is a work integrated learning program designed to increase the supply of HCAs and provide opportunities for British Columbians to access careers in the health sector. Participants are hired into a non-direct care role and funded for the education to become a registered HCA by program end.
- Service redesign in some geographic areas is underway to improve continuity of care within communities through:
    - The implementation of neighborhood models of care, where teams of healthcare providers collaborate within set geographic areas to support clients throughout the day.
    - Enhancing scheduling strategies, including geographic and fixed shift scheduling, to support retention of CHWs by focusing on consistency of shifts, and increasing capacity to ensure responsive, client-focused care.
- Some eligible HS clients receive support through the Choice in Supports for Independent Living (CSIL) program[7], a self-directed option for clients with high-intensity care needs.

LAST UPDATED

The content of this estimates note is current as of February 12, 2024, as confirmed by Alix Adams, Executive Director, Seniors' Services Division.

APPROVALS

2024 02 29 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2024 03 01 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 04 08 – Ross Hayward, Seniors' Services Division

[7] For further information see Choice in Supports for Independent Living (CSIL) Program Estimates Note

LEGISLATIVE SESSION – ESTIMATES NOTE

M-10

Licensed Community Care Facilities - Child Care

Topic: Community care facilities are regulated under the *Community Care and Assisted Living Act* (CCALA) and are licensed through regional health authorities (HAs).

Key Messaging and Recommended Response:

- **Our health-care system includes a robust network of private and subsidized community care facilities that are regulated under the CCALA and licensed through the HAs.**
- **There are several different types of licensed care under the CCALA, including child day care, child and youth residential care and care for specialized populations including Acquired Brain Injury, Community Living, Hospice, Long Term Care, Mental Health and Substance Use.**
- **There are 7,860 child care facilities throughout BC that provide licensed child care services.**
- **The Ministry of Education and Child Care will have information regarding waitlists or the number of new child care spaces.**

CURRENT SITUATION

- Licensed community care facilities include both publicly subsidized and private pay models.
- In May 2021, the government created two new licensed categories of care: School Age Care on School Grounds and Recreation Care. The school age category has been well-received with its streamlined requirements and a substantial uptake of 137 licenses issued since Dec 31, 2022.

December 31, 2023	FHA	IHA	VIHA	NHA	VCHA	BC
Facility Service Type						
Group Child Care < 36 months	532	166	193	55	311	**1,257**
Group Child Care > 30 months	726	275	368	90	443	**1,902**
Group Child Care School Age[1]	208	253	200	89	248	**998**
Preschool	347	186	143	86	167	**929**
Family Child Care	285	179	255	147	190	**1,056**
Occasional Child Care[2]	5	5	9	3	19	**41**
In-Home Multi Age Child Care	181	64	83	39	78	**445**
Multi Age Child Care	394	153	122	67	88	**824**
Child-minding	11	0	2	2	4	**19**

1 HA data indicates 198 less Group Child Care School-Age facilities. However, this fluctuation can be attributed to operators shifting to School Age Care on School Ground category which reflects an increase of 137 School Age Care on School Grounds.

[2] Dec 31, 2022 FHA and IHA Occasional Care totals are wrong. Suspected due to final formatting/accepting track changes. Aug 2022 FHA were 4 changed to 3 not 43 and IHA were 3 changed to 6 not 36. This error attributes to a significant decrease from Dec 2022 that is not accurate. Numbers are likely to have remained steady.

December 31, 2023	FHA	IHA	VIHA	NHA	VCHA	BC
School Age Care on School Grounds	176	32	81	34	52	**375**
Recreational Care	7	1	0	0	6	**14**
Total	2,872	1,316	1,456	612	1,606	**7,860**

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

December 31, 2022	FHA	IHA	VIHA	NHA	VCHA	BC
Facility Service Type						
Group Child Care < 36 months	471	151	173	56	292	**1,143**
Group Child Care > 30 months	650	255	336	87	413	**1,741**
Group Child Care School Age*	428	244	208	56	260	**1,196**
Preschool	369	169	158	71	178	**945**
Family Child Care	299	177	261	144	207	**1,088**
Occasional Child Care	43	36	10	1	24	**74**
In-Home Multi Age Child Care	171	57	84	33	68	**413**
Multi Age Child Care	363	147	115	66	88	**779**
Child-minding	12	2	2	1	3	**20**
School Age Care on School Grounds	114	15	58	24	27	**238**
Recreational Care	3	1	2	0	0	**6**
Total	2,883	1,254	1,407	539	1,560	**7,643**

* HA data reported less Group Child Care School-Age facilities; however, this fluctuation is thought to be from operators shifting to School Age Care on School Ground.

LAST UPDATED

The content of this estimates note is current as of February 9, 2024, as confirmed by Dawn Williams.

APPROVALS

2024 02 09 - Dawn Williams, Assisted Living Registry and Community Care Licensing
2023 02 14 - Ross Hayward, Seniors' Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

M-11

Licensed Community Care Facilities – Residential Care (All Categories)

Topic: Community care facilities are regulated under the *Community Care and Assisted Living Act* (CCALA) and are licensed through the regional health authorities (HAs).

Key Messaging and Recommended Response:

- **Our health-care system includes a robust network of private and subsidized community care facilities that are regulated under the *Community Care and Assisted Living Act* and licensed through the regional authorities.**
- **There are several different types of licensed care under *the Community Care and Assisted Living Act*, including child day care, child and youth residential care and care for specialized populations including Acquired Brain Injury, Community Living, Hospice, Long Term Care, Mental Health and Substance Use.**
- **There are 1,232 facilities throughout BC that provide licensed care services.**

CURRENT SITUATION

- HAs provide quarterly data to the Community Care Facility Licensing branch of the Ministry of Health. The data consists of the number of facilities under each service type, as described in the CCALA Residential Care Regulation.
- Licensed community care facilities include both publicly subsidized and private pay models.

[1]December 31, 2023	FHA[2]	IHA	Island[3]	NHA	VCHA	BC
Facility Service Type						
Acquired Injury	12	6	2	1	13	**34**
Child and Youth Residential	17	7	15	17	19	**75**
Community Living	152	95	118	27	87	**479**
Hospice	7	4	2	1	6	**20**
Long Term Care	92	84	84	25	69	**354**
Mental Health	33	10	13	3	46	**105**
Substance Use	19	11	8	1	19	**58**
Hospital Act	27	19	30	10	21	**107**
[4]	0	0	0	0	0	**0**
Total	***359***	***236***	***272***	***85***	***280***	***1,232***

FINANCIAL IMPLICATIONS

N/A

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[1] Data is current to December 31, 2023. Source: HCC Long-Term Care & Assisted Living Summary Report, as of December 2023(for Acquired Injury, Hospice, and Long-Term Care), and HA Community Care Facility Licensing programs (for the remaining 5 service types)

[2] Fraser Health reports each service type separately, therefore the sum of facilities by service types is more than the number of individual facilities.

[3] Island Health reports by primary service type. Some facilities will have more than one service type at a premise, but only the dominant service type is counted.

[4] Category Mental Health and Substance Use is now reported out separately by HAs.

KEY BACKGROUND

There are several different types of licensed care under the CCALA, including child day care, child and youth residential care, and care for specialized populations including Acquired Brain Injury, Community Living, Hospice, Long Term Care, Mental Health, and Substance Use. The tables below provide facility counts by type and HAs.

[5]December 31, 2022	FHA[6]	IHA	Island[7]	NHA	VCHA	BC
Facility Service Type						
Acquired Injury	12	5	2	1	12	**32**
Child and Youth Residential	14	4	11	18	20	**67**
Community Living	157	92	123	30	87	**489**
Hospice	7	4	2	1	6	**20**
Long Term Care	92	85	83	24	68	**352**
Mental Health	33	9	14	3	45	**104**
Substance Use	16	10	7	0	17	**50**
Hospital Act	24	16	30	12	17	**99**
Mental Health and Substance Use	0	8	0	4	1	**13**
Total	***355***	***233***	***272***	***93***	***273***	***1,226***

LAST UPDATED

The content of this estimates note is current as of February 9, 2024, as confirmed by Dawn Williams obo Sue Bedford, ALRCCL, Seniors Services Division.

APPROVALS

2024 02 09 - Dawn Williams, Assisted Living Registry and Community Care Licensing, Seniors' Services Division
2024 02 22 - Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 04 03 - Ross Hayward, Seniors' Services Division

[5] Data is current to December 31, 2022Source: HCC Long-Term Care & Assisted Living Summary Report, as of December 2022(for Acquired Injury, Hospice, and Long-Term Care), and HA Community Care Facility Licensing programs (for the remaining 5 service types)
[6] Fraser Health reports each service type separately, therefore the sum of facilities by service types is more than the number of individual facilities.
[7] Island Health reports by primary service type. Some facilities will have more than one service type at a premise, but only the dominant service type is counted.

LEGISLATIVE SESSION – ESTIMATES NOTE

M-12

Long-Term Care Staffing (3.36 HPRD)

Topic: Summary of the impact of *Budget 2018* allocation of $240 million over 3 years to increase direct care hours in Long-Term Care (LTC) facilities.

Key Messaging and Recommended Response:

- **Our government remains committed to providing the highest quality care in Long-Term Care (LTC).**
- **In 2017, the government released the *Residential Care Staffing Review Report* which examined the state of LTC service delivery with a focus on staffing levels and staffing mix. The report concluded that a minimum of 3.36 Hours per Resident Day (HPRD), on average, across each health authority (HA) is required for safe, quality care.**
- **Budget 2018 allocated $240 million over three years (2018/19 - $50 million; 2019/20 - $80 million; 2020/21 $110 million) to increase direct care hours in LTC facilities to ensure each HA reached the target of 3.36 Hours HPRD, on average, across all facilities by 2021.**
- **This target was met. In fiscal 2020/21, all 5 HAs were funded to meet or exceed th target of 3.36 HPRD, on average, across all facilities; and all 5 HAs met or exceede the target in 2020/21 for the first time and have done so since then.**
- **Further, as of April 1, 2022, the province made additional investments to bring any remaining publicly funded LTC facilities up to a minimum, of 3.36 HPRD (i.e., those that remained below 3.36 HPRD even though the HA average of 3.36 HPRD was met). In 2016/17, only 15% of facilities were funded to meet or exceed the 3.36 HPRD (44 of 293).**
- **In 2023/24, the provincial average funded HPRD is 3.43, an increase of 0.32 HPRD from the 2016/17 baseline provincial average HPRD of 3.11.**
- **As of Q3 in 2023/24, all 5 HAs are forecasting to meet or exceed the HPRD target based on resident days (i.e., actual bed occupancy) resulting in forecast average BC level HPRD of 3.57.**

CURRENT SITUATION

- Budget 2018 allocated $240 million over 3 years (2018/19 - $50 million; 2019/20 - $80 million; 2020/21 - $110 million) to increase direct care hours in LTC facilities to ensure each health authority reached the target of 3.36 Hours per Resident Day (HPRD), on average, across all facilities by 2021.

- This target was met, as of fiscal 2020/21, all 5 regional health authorities were funded to meet or exceed the target of 3.36 HPRD, on average, across all facilities; and all 5 met or exceeded this target in 2020/21 for the first time.
- In 2021/22, a decision was made to expand the target to fund all LTC facilities at 3.36 HPRD (i.e., bring 59 facilities that remained below 3.36 as of April 1, 2021, up to the target). Implementation occurred part-way through fiscal year 2021/22, and therefore, as of April 1, 2022, all 295 publicly funded LTC facilities across the province were funded to meet, at a minimum, the standard of 3.36 HPRD and continue to be funded at this rate.
- In 2023/24, the provincial average funded HPRD is 3.43, an increase of 0.32 HPRD from the 2016/17 baseline provincial average HPRD of 3.11. Further, in 2016/17, 15% of facilities met or exceeded 3.36 HPRD (44 of 293), and in 2023/24 100% of facilities were funded to meet or exceed 3.36 HPRD.

FINANCIAL IMPLICATIONS

In 2023/24, the total annual incremental HPRD investment is $113.6 million, and all 296 facilities continue to be funded to meet a minimum of 3.36 HPRD.

KEY BACKGROUND

- In 2017, the Ministry of Health released the Residential Care Staffing Review Report which examined the state of LTC service delivery with a focus on staffing levels and staffing mix. The report concluded a minimum of 3.36 HPRD, on average, across each health authority is required for safe, quality care. The target of 3.36 comprises 3.0 hours of direct nursing care (including health care assistants) and 0.36 hours of direct allied health care.
- Funding to health authorities for direct care staffing to achieve HPRD targets is calculated based on 100% bed occupancy (i.e., bed days), thereby ensuring sufficient funding is allocated so the HPRD target can be met when the facility is fully occupied. This is the funded HPRD.
- Actual HPRD, however, considers the direct care provided, based on the beds that are occupied (i.e., resident days). When occupancy levels fall below 100%, residents receive a higher number of care hours. HPRD based on resident days (rather than 100% occupancy) is a more accurate reflection of direct care provided to residents.
- As of Q3 in 2023/24 all five health authorities are forecasting to exceed the HPRD target, on average, in 2023/24 based on resident days (i.e., actual bed occupancy) for the fourth year in a row, with a forecast provincial average HPRD of 3.57. Details shown in Table 1.

Table 1:

HPRD Summary by HA														
HA	2016/17 Baseline	2018/19 Budget	2018/19 Q4	2019/20 Budget	2019/20 Q4	2020/21 Budget	2020/21 Q4*	2021/22 Budget	2021/22 Rev. Budget	2021/22 Q4*	2022/23 Budget	2022/23 Q4*	2023/24 Budget	2023/24 Q3*
FHA	3.05	3.24	3.24	3.25	3.28	3.38	3.56	3.38	3.41	3.57	3.41	3.53	3.41	3.55
VCHA	3.03	3.19	3.20	3.22	3.26	3.37	3.64	3.43	3.47	3.64	3.47	3.62	3.48	3.56
VIHA	3.13	3.23	3.21	3.28	3.27	3.36	3.55	3.38	3.39	3.51	3.41	3.51	3.42	3.57
IHA	3.23	3.31	3.29	3.35	3.36	3.36	3.54	3.37	3.38	3.57	3.39	3.62	3.39	3.57
NHA	3.39	3.47	3.42	3.45	3.47	3.45	3.64	3.45	3.45	3.56	3.45	3.66	3.48	3.75
Total	3.11	3.25	3.24	3.28	3.30	3.37	3.58	3.39	3.41	3.57	3.42	3.57	3.43	3.57

* HPRD is based on resident days (i.e., actual bed occupancy)

- Since April 1, 2022, all facilities have been funded to meet, as a minimum, the 3.36 HPRD target. As of Q3 in 2023/24, 237 facilities or 80% are forecasting to meet the 3.36 minimum target, with 59 facilities forecasting to not achieve the target. Details provided in Table 2.

Table 2:

# of facilities > = 3.36 by HA														
HA	2016/17 Baseline	2018/19 Budget	2018/19 Q4	2019/20 Budget	2019/20 Q4	2020/21 Budget	2020/21 Q4*	2021/22 Budget	2021/22 Rev. Budget	2021/22 Q4*	2022/23 Budget	2022/23 Q4*	2023/24 Budget**	2023/24 Q3*
FHA	9	32	32	39	39	67	62	68	68	72	79	74	79	68
VCHA	9	11	15	25	23	44	46	47	50	50	56	51	56	47
VIHA	4	6	6	21	14	51	47	50	51	43	58	44	58	44
IHA	11	18	20	43	31	60	69	60	68	61	79	60	79	56
NHA	11	24	15	24	18	24	23	24	24	23	24	24	24	22
Total	44	91	88	152	125	246	247	249	261	249	296	253	296	237
% of total # of sites	15%	31%	30%	51%	42%	82%	83%	84%	88%	84%		85%		80%

- In January 2023 the Health Standards Organization released Federal Long-term Care Standards. The HSO standards reference 4.10 Hours Per Resident Day (HPRD) as a recommendation from researchers. The Ministry of Health is reviewing this recommendation, and to date no decision has been made to adjust 3.36 HPRD as the standard in BC.
- In 2020, the Royal Society Report *Restoring Trust: Covid-19 and the Future of Long-Term Care"* made a recommendation for provinces to adopt 4.1 HPRD as the standard in LTC.
- In January 2024, the Royal Society Report *Repair and Recovery in Long-Term Care: Restoring Trust in the Aftermath of Covid-19 (2020 – 2023)* made recommendation for provinces to adopt 4.5 HPRD as the standard in LTC.
- Across Canada funding commitments toward increasing HPRD have been made by[1];
  - Nova Scotia to move to 4.10 HPRD.
  - Ontario to continue progress on reaching 4.00 of average direct care per resident per day by March 31, 2025.[2]
  - In 2023 Manitoba announced an increase to 3.80 HPRD.
  - Alberta government has not committed to recommendations to increase from 3.40 HPRD, with staffing shortages part of the challenge.

LAST UPDATED

The content of this estimates note is current as of March 26, 2024, as confirmed by Danielle Prpich, ED SSD Long Term Care & Assisted Living Strategy & Policy.

APPROVALS

2024 02 15 - Danielle Prpich, Seniors Services Division
2024 03 26- Kerri Harrison, obo Rob Byers, Finance and Corporate Services Division
2024 04 03 - Ross Hayward, Seniors' Services Division

[1] Seniors' Services Division, Ministry of Health. (2023). Estimates 2023, ED ADM Binders, supplementation document 02A18 Environmental Scan – 4.10 HPRD. April 2023.
[2] Ontario Ministry of Long-Term Care. (2023). Expenditure Estimates for the Ministry of Long-Term Care (2023-2024). April 2023. https://www.ontario.ca/page/expenditure-estimates-ministry-long-term-care-2023-24

LEGISLATIVE SESSION – ESTIMATES NOTE

M-13

Long-Term Care Quality Framework

Topic: BC Long-Term Care (LTC) Quality Framework Implementation 2024

Key Messaging and Recommended Response:

- **As part of BC's strategy to improve care for seniors, the Ministry of Health has developed an evidence-based Quality Framework and Policy Directive for LTC that enables and formalizes comprehensive provincial-level reporting, monitoring and evaluation that supports continuous quality improvement within the LTC sector.**
- **The Policy Directive requires health authorities to:**
  - **report on, monitor, and evaluate the quality of LTC services in their region using 16 indicators identified in the Framework;**
  - **establish regional quality improvement initiatives that are consistent with the Framework; and**
  - **establish regional quality improvement leadership structures that monitor quality, collaboratively participate in continuous quality improvement with their LTC providers.**
- **The Ministry will develop a baseline LTC quality report in late 2024, that reports on outcomes of quality indicators for the 2023/24 fiscal year, quality improvement initiatives and investments made both in the Ministry, and across health authorities to support quality improvement and improve person-centered outcomes for people in LTC.**
- **Annual updates to the indicators will involve ongoing collaboration with health authorities, sector partners and residents and their family members.**
- **This work will support additional actions taken to support seniors' care, including the recently announced Aging with Dignity Funding through the federal government will help strengthen access to high-quality, safe, and dignified home and community care and LTC in communities, stabilize and support the LTC workforce.**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- The Framework sets expectations for quality, improves government oversight of the sector, and is in alignment with key initiatives to improve LTC services, including:
  - the development of a standardized LTC funding model;
  - the implementation of the LTC financial reporting tool;
  - strengthening of Resident and Family Councils;
  - expansion of LTC capacity;
  - quality initiatives led by BC Health Quality and health authorities (HAs) within their regional jurisdictions; and
  - strategic priorities and goals outlined in the Ministry Plan and the Ministry of Health 2023/24 – 2025/26 Service Plan.
- The Framework contributes to the Strategic Repositioning Initiatives - Objective D: Strengthen access to Assisted Living and LTC services to provide more people-centered, dignified, and culturally safe care.
- The Framework is based on approaches to assess and understand quality according to three Domains of Care (quality of care, quality of service and quality of life) and seven Dimensions of Quality (respect, safety, accessibility, appropriateness, effectiveness, efficiency, and equity).
- The Dimensions of Quality and Domains of Care are underpinned by three key principles: Person Centered Care, Cultural Safety and Humility, and Continuous Quality Improvement.
- The Ministry will develop a baseline LTC quality report in late 2024, that reports on outcomes of quality indicators for the 2023/24 fiscal year, quality improvement initiatives and investments made both in the Ministry, and across health authorities (HAs) to support quality improvement and improve person-centered outcomes for people in LTC.
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FINANCIAL IMPLICATIONS

- Baseline reporting utilizes existing, evidence informed indicators already in use across the Ministry and HAs and has no immediate financial implications.
- Funding may be required to establish quality improvement leadership structures across all HAs.
- There is an anticipated potential financial implication in the development of future indicators and to support HAs resourcing toward Framework's monitoring and reporting as the Framework evolves further.

KEY BACKGROUND

- Ministry staff from the Seniors Services Division, developed the Framework in consultation with stakeholders and key partners in the LTC sector, comprising of representatives from the HAs, First Nations Health Authority, Health Quality BC, Office of the Seniors Advocate, contracted LTC service providers, advocacy groups, residents, and family members.
- Within the Framework are situated an initial series of 16 quality indicators which are informed by the Canadian Quality & Patient Safety Framework and the BC Health Quality Matrix dimensions of quality.
- The 16 indicators were selected from data resources currently collected in BC and commonly analyzed within HAs as indicators of quality and/or indicators of areas where improvement is required. The indicators are intended to provide comparable and actionable information about priority topics within LTC and health system performance.
- The implementation of the Framework supports foundational principles and service outcomes identified in the HSO Long-Term Care Service National Standard. The reporting and analysis enabled by the Framework will inform and monitor actions identified in the request for Aging with Dignity federal funds by enabling identification of issues and impact of initiatives intended to enhance quality of LTC services in the province.

LAST UPDATED

The content of this estimates note is current as of February 20, 2024, as confirmed by Danielle Prpich.

APPROVALS

2024 02 20 – Danielle Prpich, Seniors' Services Division
2024 02 22 – Ross Hayward, Seniors' Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

M-14

Multi-Bed Rooms

Topic: The Ministry of Health has a mandate commitment to reduce the number of multi-bed rooms in health-authority operated Long-term Care (LTC) facilities

Key Messaging and Recommended Response:

- **The standard for health, safety and dignity set out in the Residential Care Regulation, requires a minimum of 95% of 95 % residents in a LTC home to be accommodated in single occupancy rooms:[1]**
- **The Ministry of Health has a mandate commitment to reduce the number of multi-bed rooms in LTC facilities.**
- **2023/24 reporting of publicly subsidized facilities (health authority owned and operated and contracted facilities) shows 91% of all resident rooms are single occupancy, with 78% of residents occupying these rooms.**
- **As of December 2023, 79% of residents are in a private room based on Ministry of Health data (publicly subsidized facilities), a 7% improvement since 2017/18.**
- **Of the 28 announced LTC developments in BC, 14 (or 50%) included replacement beds, will replace 1,622 beds in outdated facilities, many of which are multi-bed rooms. By 2027 when all announced projects are completed, there will be an additional 2,939 net new beds.**

CURRENT SITUATION

- There are 354 total LTC homes as of December 2023 (including Acquired Brain Injury homes (ABI), 377)[2],and 31,288 total regular LTC beds for BC (including ABI 31,459)[3].
- There are 305 (including ABI 325)[4] LTC homes across BC that are publicly subsidized serving seniors with 27,831 beds (including ABI 27,964).[5]
- Since 2018 the Office of the Seniors Advocate's Long-Term Care Directory has reported data on single occupancy, double occupancy, and multi-bed rooms in publicly funded LTC homes.
- The Ministry began collecting data on single, double, and multi-bed occupancy rooms as part of the quarterly Bed Inventory Survey for LTC homes, starting March 2022. The data on bed configuration differs from the Office of the Seniors Advocate due to the definition of LTC home used to collect data.
- Monitoring the number of multi-bed rooms in LTC measures the impact of initiatives over time to reduce multi-bed rooms in aging facilities.

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[1] Residential Care Regulation (gov.bc.ca)

[2] Ministry of Health. Report ID: RMS 1228. Home & Community Care Bed/Facility Inventory. Retrieved from: https://hspp.hlth.gov.bc.ca/framework/service-delivery/specialized-community-services/home-and-community-care-bedfacility-inventory-report. Last accessed on: 2/8/2024 12:53:03 AM

[3] Ibid.

[4] Ibid.

[5] Ibid.

- In 2022/23, 77% of residents were in a private room, a 5% improvement since the initial data collection in 2017/18 (5% improvement over 5 years).
- As of December 2023, 79% of residents are in a private room based on Ministry of Health data (publicly subsidized facilities)[6], a 7% improvement since 2017/18.
- The following tables provide current (December 2023 – Q3 2023/24) and previous year's (December 2022 – Q3 2022/23) status of LTC multi-bed rooms by Health Authority[7]:
- Note that every HA has increased their percentage of single LTC rooms and reduced multi-bed occupancy between 2022 and 2023.

December 2023

LTC Type	Single LTC Rooms		Double LTC Rooms		3-Bed LTC Rooms		4-Bed LTC Rooms		> 4 Bed LTC Rooms		Total	
Health Authority	Count	% of Total	Count	% of Total	Count	% of Total	Count	% of Total	Count	% of Total	Count	% of Total
1 Interior	4,882	93.88%	193	3.71%	8	0.15%	117	2.25%	0	0.00%	5,200	100.00%
2 Fraser	6,809	89.63%	642	8.45%	23	0.30%	123	1.62%	0	0.00%	7,597	100.00%
3 Vancouver Coastal	4,663	85.78%	535	9.84%	58	1.07%	180	3.31%	0	0.00%	5,436	100.00%
4 Vancouver Island	4,543	92.00%	215	4.35%	30	0.61%	150	3.04%	0	0.00%	4,938	100.00%
5 Northern	997	95.13%	37	3.53%	0	0.00%	14	1.34%	0	0.00%	1,048	100.00%
Total	**21,894**	**90.40%**	**1,622**	**6.70%**	**119**	**0.49%**	**584**	**2.41%**	**0**	**0.00%**	**24,219**	**100.00%**

December 2022

LTC Type	Single LTC Rooms		Double LTC Rooms		3-Bed LTC Rooms		4-Bed LTC Rooms		> 4 Bed LTC Rooms		Total	
Health Authority	Count	% of Total	Count	% of Total	Count	% of Total	Count	% of Total	Count	% of Total	Count	% of Total
1 Interior	4,877	93.90%	193	3.72%	8	0.15%	116	2.23%	0	0.00%	5,194	100.00%
2 Fraser	6,521	89.13%	613	8.38%	26	0.36%	154	2.10%	2	0.03%	7,316	100.00%
3 Vancouver Coastal	4,465	84.60%	549	10.40%	61	1.16%	203	3.85%	0	0.00%	5,278	100.00%
4 Vancouver Island	4,497	91.93%	215	4.39%	30	0.61%	150	3.07%	0	0.00%	4,892	100.00%
5 Northern	993	94.93%	39	3.73%	0	0.00%	14	1.34%	0	0.00%	1,046	100.00%
Total	**21,353**	**90.00%**	**1,609**	**6.78%**	**125**	**0.53%**	**637**	**2.68%**	**2**	**0.01%**	**23,726**	**100.00%**

- From the Office of the Seniors Advocate's report Long-*Term Care and Assisted Living Directory 2023* the below table presents their collection of bed-type information from 2018-19 to 2022/23:

LONG-TERM CARE FACILITY DEMOGRAPHICS, 2018/19-2022/23

INDICATOR	2018/19	2019/20	2020/21	2021/22	2022/23
NUMBER OF FACILITIES	293	296	297	294	297
NUMBER OF PUBLICLY SUBSIDIZED BEDS	27,214	27,505	27,931	27,702	28,064
% SINGLE OCCUPANCY ROOMS	88%	89%	90%	90%	91%
% DOUBLE OCCUPANCY ROOMS	8%	7%	7%	7%	6%
% MULTI-BED ROOMS	4%	4%	4%	3%	3%
% OF RESIDENTS IN SINGLE OCCUPANCY ROOMS	73%	76%	77%	77%	77%

- Cabinet Confidences

[6] Calculation based on information from the Ministry of Health. Report ID: RMS 1228. Home & Community Care Bed/Facility Inventory. Retrieved from: https://hspp.hlth.gov.bc.ca/framework/service-delivery/specialized-community-services/home-and-community-care-bedfacility-inventory-report. Last accessed on: 2/7/2024 11:38:25 PM

[7] Ministry of Health. Report ID: RMS 1228. Home & Community Care Bed/Facility Inventory. Retrieved from: https://hspp.hlth.gov.bc.ca/framework/service-delivery/specialized-community-services/home-and-community-care-bedfacility-inventory-report. Last accessed on: 2/7/2024 11:38:25 PM

Community	Replacement Beds	Net New Beds	Total Beds in Scope of Project	Expected Completion Date
Cabinet Confidences				
Vernon	0	90	90	Cabinet Confidences
Cabinet Confidences				
Nanaimo / Lantzville	0	306	306	2027
Campbell River	0	153	153	2027
Colwood	0	306	306	2027

FINANCIAL IMPLICATIONS

Monitoring numbers of multi-bed rooms in publicly funded LTC homes carries no financial implications.

KEY BACKGROUND

- On October 6, 2021, the Office of the Seniors Advocate released the report: *Review of COVID-19 Outbreaks in Care Homes in British Columbia*. The review made recommendations, including the *elimination of shared rooms* to limit the spread of COVID-19.
- The Ministry of Health has a mandate commitment to reduce the number of multi-bed rooms in LTC facilities. This commitment is referenced in the 2020 mandate letters for both the Minister of Health and the Parliamentary Secretary for Seniors: "*…working toward eliminating multi-bed rooms in health authority-owned long-term care facilities, giving seniors more dignity.*"[8]

LAST UPDATED

The content of this estimates note is current as of April 3, 2024, as confirmed by Danielle Prpich, ED, Long Term Care & Assisted Living Strategy & Policy.

APPROVALS

2024 02 22 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 04 03 - Ross Hayward, Seniors' Services Division

[8] Minister of Health mandate letter. November 2020. https://news.gov.bc.ca/files/HLTH-Dix-mandate.pdf

LEGISLATIVE SESSION – ESTIMATES NOTE

M-15

OSA Billions More Reasons to Care Report

Topic: Office of the Seniors Advocate Report – *Billions More Reasons to Care: Contracted Long-Term Care Funding Review Update" (September 2023)*

Key Messaging and Recommended Response:

- **We thank the seniors advocate for this report and will review the recommendations.**
- **Our government has invested $2 billion over the last five years to improve care for seniors, including investments in primary care, community-based services, home health, long-term care, assisted living and respite services.**
- **We want to ensure that the money we invest in improving seniors care is put to good use and is used for that purpose.**
- **To meet government's goal of improving care standards and expanding options for seniors, we continue to focus on:**
  - **Increasing staffing levels in the long-term care homes and community care sectors**
  - **Increasing direct care hours in long-term care**
  - **Actively working with health authorities on the development of a LTC Funding Model**
  - **Wage leveling**
- **As identified in the OSA report, there has been a trend where for-profit LTC operators deliver fewer direct care hours (DCHs) than what they are funded to deliver.**
- **As part of the 3.36 hours per resident day initiative the Ministry through the health authorities (as contract holders) monitors actual direct care hours delivered in publicly funded beds against the funding allocated. If incremental direct care hours are not achieved, or if incremental funding is not spent on direct care staffing, funding may be recovered.**
- **Consistent with Mandate Letter direction, the Ministry is working to support the delivery of better care to seniors by holding LTC operators more accountable for the public funding they receive, including:**

- **Development and implementation of a web based LTC reporting tool to standardize reporting of direct care hours and financial information across all LTC homes in the province has occurred; with the expectation the final year-end report will be audited (targeting Q4 2024/25).**

CURRENT SITUATION

- On September 25, 2023, the Office of the Seniors Advocate (OSA) released a second report on Long-Term Care (LTC) funding, "*Billions More Reasons to Care* (BMRC).
- The BMRC report is in follow up to a February 4, 2020, report "*A Billion Reasons to Care: A Funding Review of Contracted Long-Term Care in BC".*
- The BMRC report is based on a review of the financial reporting from contracted LTC operators to HAs, covering the five-year period 2017/18 to 2021/22 quarterly reporting to HAs.
- The OSA BMRC report is based on a review of the Quarterly Reports of each contracted (for profit and not for profit) LTC home in Fraser Health, Vancouver Coastal, Island Health, and to a more limited degree Interior Health. Northern Health was excluded as its contracted sector consists of 2 contracted LTC homes. Due to a financial reporting change, Interior Health's data set for fiscal 2021/22 is limited.
- The BMRC report draws attention to trends in the time between the initial Billion Reason report and the BMRC report.
- The BMRC report focuses on the funding and delivery of Direct Care Hours (DCH) and reports a significant gap in the for-profit sector of non-delivered DCH.
- In addition, the BMRC notes the following trends:
    - A 13% decrease in LTC beds/1000 age 75+.
        - This is because of a growing aging population.
    - A 48% increase in wait times from 2018 for placement into LTC.[1]
    - A 45% increase in total spent by HAs on LTC in the last 5 years.
        - Of this, 65% ($1.9B) was for the NFP and FP sector, noting this as "one of the largest annual transfers of public funds to the private sector across government".
            - Increased funding in response to COVID-19 initiatives in LTC, wage levelling, visitation.
        - A 23% increase in the last 5 years in the base per diem.
            - This is attributable to increased funding for 3.36 HPRD, wage levelling, and other COVID-19 initiatives in LTC.
        - Cost per hour worked increased by 22% in the FP group, and 15% in the NFP sector.
            - Wage levelling, overtime, and agency staffing costs all impact the cost per hour worked across the sector, regardless of ownership type.
        - Cost per hour worked in the NFP sector is 17% higher than FP.
            - The higher cost per hour of work in NFP is attributable to the costs of benefits in the NFP sector.
    - A 32% increase over 5 years in HA base funding.
        - Reflecting increased care hours, pandemic funding, and a reduction in the proportion of revenue from resident co-payments.
    - A 7% increase over 5 years in resident co-payment fees.
        - The relatively smaller increase in resident co-payments will shift more of the cost for LTC to HAs who will require increased base funding.
    - A 21% increase in private-pay bed revenue.
    - A 281% increase in revenue from other sources.
    - A 400% increase in "other" revenue.

[1] Please see Estimates Note: Access and Admission to LTC

        - This represents additional funding provided to respond to COVID 19.
    - FO spent 15% of revenue on building expenses, with NFP spending 9%. Overall FP spent 66% more per bed on building costs than NFP.
    - 113% increase in profit/surplus over the 5-year period.
        - The actual profit/surplus increased from 3% in Billions of Reasons to Care to 4% in BMRC.
- A comparison of the BMRC report and the previous "*A Billion Reasons to Care*" report is provided below:

A Billion Reasons to Care (data: 2017/18)	**A Billion More Reasons to Care (data: 2021/22)**
• 174 contracted facilities	• 181 contracted facilities – 93% of contracted homes
• $1.4 billion in revenue	• $1.89 billion in revenue and expenses – 35% increase
• 72% was spent on labour costs. • 53% was spent on direct care. • 19% was spent on non-direct care. • 10% spent on supplies/administration/other. • 15% spent on buildings/properties. • 3% profit (surplus)	• 70% was spent on labour costs. • 33% increase in direct care compensation, which can largely be attributed to wage levelling. • 33% increase in non-direct care compensation, which can be largely attributed to wage leveling. • 12% was spent on supplies, administration, and other – overall 61% increase. • 12% spent on building costs - 18% increase in capital building costs. • 61% increase in supply, admin, other costs, which can largely be attributed to the pandemic. • 4% profit – 113% increase
• NFP spent 24% more per resident on direct care	• NFP spent 25% more per resident on direct care, which is an increase over the 24% noted previously
• FP spent 155% more on building/property costs	• FP spent 42% more per bed on capital build costs
• 68% of facilities generated a profit	• 74% of contracted facilities generated a profit
• 18 care homes with an annual profit more than $1M • 66% of total LTC homes generate a profit, 92% of these are FP facilities	• 80% of total profit/surplus is concentrated in 20% of facilities, and 82% of these are FP facilities
• FPs report 12X more in profit than NFPs ($34.4M versus $2.8M)	• FPs report 7X more profit per bed than NFPs, which is expected given the mandates of those ownership models.
• NFP delivered 80,000 hours more care than they were funded to deliver	• NFPs delivered 93,000 hours more care than they were funded, an increase from the previous report
• FP delivered 207,000 fewer care hours than they were funded to delivery	• FPs delivered 500,000 hours fewer than they were funded to deliver. MoH is unable to validate this figure, however, the Ministry does recover targeted direct care funding from operators who fail to deliver incremental direct care hours. See info in Table 1 for details.
• variation in funding by HAs	• variation in funding between HAs continues.
Recommendations: 1. Funding for direct care must be spent on direct care. 2. Monitoring for compliance with funded care hours must be more accurate. 3. Define which aspects of LTC home operation can make profits. 4. Standardize reporting for all care homes throughout BC. 5. Make revenues and expenditures for publicly funded care homes available to the public.	Recommendations: 1. Funding for care must be spent on care. 2. Make revenues and expenditures for publicly funded care homes available to the public. 3. Improve accuracy and transparency of monitoring and reporting for compliance with funded care hours. 4. Define profit.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- In 2020, the OSA published the report "*A Billion Reasons to Care"* which was the first provincial review of the $1.4 billion-dollar contracted long-term care sector in British Columbia.
- The 2020 report examined 174 contracted LTC homes' 2016/17 and 2017/18 financial statements and expense reports submitted to health authorities by LTC home operators.
- The OSA report "*A Billion Reasons to Care"* noted in 2017/18: "For-profit care homes failed to deliver 207,000 hours of funded direct care hours while not-for-profit care homes over-delivered by providing an additional 80,000 hours of direct care beyond what they were funded to deliver."
- The OSA report "*Billion More Reasons to Care: Contracted Long-term Care funding Review Update*" noted in 2021/22."Not-for-Profit (NFP) facilities delivered 93,000 more care hours than they were funded to deliver, while for-profit (FP) facilities delivered 500,000 less hours than they were funded to deliver".
- Advice/Recommentations

- The OSA Report identified several discrepancies and inequities between for-profit and non-profit homes when comparing indicators such as spending on direct care hours, building costs, overall profits and surplus, employee wage costs, and financial transparency.

LAST UPDATED

The content of this estimates note is current as of February 12, 2024 as confirmed by Danielle Prpich

APPROVALS

2024 02 12 – Danielle Prpich, ED, Seniors Services Division
2024 02 21 – Leighanne Tripp obo Rob Byers, Finance and Corporate Services Division
2024 04 03 – Ross Hayward, Seniors Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

M-16

Palliative Care

Topic: Palliative and end-of-life care services are provided across the continuum of care, from home care and community hospice care to long-term and acute care, with the goal of improving the quality of life for people living with life limiting illnesses and supporting family caregivers.

Key Messaging and Recommended Response:

- **End of life and palliative care services are provided throughout the health care system, with the goal of supporting caregivers and improving the quality of life for those going through this most challenging of times.**
- **The current Ministry Service Plan outlines our commitment to improve access and coordination of care for seniors with complex medical conditions and/or frailty including community based professional services, home support, caregiver supports, and palliative care with a focus on integration of services to enable individuals to remain living at home longer.**

CURRENT SITUATION

- In 2023/24 BC and Canada entered into the Aging with Dignity bilateral agreement which provides BC with $733 million over five years to help British Columbians age with dignity, closer to home, through improved access to home and community care and long-term care (LTC). $52 million of the $733 million is targeted for palliative care.
- Impact of the COVID-19 pandemic on palliative care in home and community care settings includes a trend toward later identification of clients, reflecting delay in some people seeking diagnosis and treatment.
- Throughout the pandemic, palliative care providers have shared clinical experience and resources related to end of life care, serious illness conversation, grief, and bereavement.

Palliative Care and Hospice Beds

- There are currently 506 palliative/hospice beds in BC, including 342 community hospice beds (capturing both dedicated and designated community hospice beds) and 164 acute beds.[1,2] This represents an increase of 127 beds, or 34%, from March 2017.
- Currently, the provincial palliative care bed to population ratio is 11 hospice beds per 100,000 adults. International best practice is 8-10 beds per 100,000.[3] A higher ratio may reflect strategies to increase access to palliative care closer to home in rural communities, and/or regional variation in population characteristics such as age and complex chronic conditions/frailty.

Provincial Services/Initiatives

- The After-Hours Palliative Nursing Service (AHPNS) is a provincial telephone service that provides palliative nursing support to eligible clients living at home, and their caregivers, available in four regional health authorities (Interior Health Authority [IHA], Island Health Authority [VIHA], Northern Health Authority [NHA], and Fraser Health Authority [FHA]). Vancouver Coastal Health Authority (VCHA) maintains its own

[1] HCC Long-Term Care & Assisted Living Summary Report, as of December 2023, HSIAR, BC Ministry of Health. **Dedicated end-of-life beds:* beds reserved for end-of-life care (and may not be used for anything else). *Designated end-of-life beds:* beds allocated for end-of-life care as of the survey date but may at other times be allocated to different bed category.

[2] Acute Care Beds Report, as of2023/2024, P10, HSIAR, BC Ministry of Health.

[3] European Association for Palliative Care (2010). White Paper on standards and norms for hospice and palliative care in Europe: part 2. European Journal of Palliative Care, 17(1): 22-32.

telephone-based service to support palliative clients and their caregivers. In 2022/23, the AHPNS managed 584 calls, and forwarded 98 calls to the Palliative Response Nurse upon being assessed for more specialized support.[4]

- BC Palliative Care Benefits (PCB) support BC residents of any age who have reached the end stage of a life-threatening illness to receive palliative care at home. Benefits include coverage for eligible palliative care medications, medical supplies, and equipment. Since its inception in 2001 to December 31, 2023, over 171,000 clients have received PCB[5]. In 2022/23, $21.3 million was spent on PCB medications and pharmacy services.[5]
- *My Voice: Expressing My Wishes for the Future Health Care Treatment* (My Voice) is the BC Government's resource to assist the public with advance care planning. The online My Voice guide has been translated into *a total of eleven* languages including English, French, Chinese, Punjabi, Korean, Farsi, Hindi, Vietnamese, Tagalog, Spanish and German.[6]

FINANCIAL IMPLICATIONS

- In 2023/24 BC and Canada entered into the Aging with Dignity bilateral agreement which provides BC with $733 million over five years to help British Columbians age with dignity, closer to home, through improved access to home and community care and long-term care (LTC). $52 million of the $733 million is targeted for palliative care.
- Government provided $9.1 million to the Institute for Health System Transformation and Sustainability (IHSTS) between 2013-2015 to establish and support the BC Centre for Palliative Care (the Centre), of which $2.1 million was allocated to advance best practices in palliative care service delivery. Between 2018/19 and 2021/22 the Ministry provided $6 million to IHSTS in support of the Centre, to continue to improve access to palliative care, support implementation of provincial palliative care policy and partnership initiatives, education, and local community-based initiatives.
- Cabinet Confidences; Government Financial Information

  Cabinet to promote leading practice, capacity building and delivery of high-quality hospice palliative care provided through BC hospice organizations.

KEY BACKGROUND

- The 2023/24 to 2025/26 Ministry of Health Service Plan outlines government's commitment to improve access and coordination of care for seniors with complex medical conditions and/or frailty including professional services, home support, caregiver supports, and palliative care with a focus on affordability and integration of services to enable individuals to remain living at home longer.[7]
- The Province has had a palliative care action plan in place since 2013.[8]
- The Province is also focused on linking a person-centred system of regional and provincial specialized services delivered by providers such as the Provincial Health Services Authority and BC Cancer, to support the full spectrum of cancer care including prevention, screening, diagnosis and treatment, research and education, as well as palliative care.[7]
- The Ministry supports palliative and end-of-life care services for people in the care setting that best meets their needs; and a comprehensive and coordinated system of care that prioritizes the provision of palliative care at home and in community settings (hospice, assisted living, long-term care, and ambulatory care) where appropriate.

[4] Based on draft AHPNS Year End 2022/2023 report; numbers to be validated.
[5] PharmaNet, Healthideas, Health Sector Information, Analysis and Reporting Division, Ministry of Health. February 20, 2024.
[6] Contract Issue Note, My Voice Translation, December 31, 2021, Seniors Services, BC Ministry of Health
[7] Ministry of Health (February 2023). *2023/24-2025/26 Service Plan*. Retrieved from: https://www.bcbudget.gov.bc.ca/2023/sp/pdf/ministry/hlth.pdf
[8] The Provincial End-of-Life Care Action Plan for British Columbia. BC Ministry of Health. March 2013. Available at: Provincial End-of-Life Care Action Plan for British Columbia (gov.bc.ca)

- Work underway in BC aligns with the 2019 Federal Action Plan on Palliative Care which lays out Health Canada's 5-year plan for palliative care in Canada and complements support provided to the provinces and territories under the Common Statement of Principles on Shared Health Priorities.[9,10]
- BC Centre for Palliative Care (the Centre) is a provincial hub to advance the practice of palliative and end-of-life care for people living with and dying from serious illness.
- A palliative care incentive payment of $100.62 (PG14063) compensates family physicians to take time needed to create a care plan to support the best possible quality of life for patients who are in the last six months of life expectancy.[11]

LAST UPDATED

The content of this estimates note is current as of February 12, 2024, as confirmed by Alix Adams, Executive Director, Seniors' Services Branch.

APPROVALS

2024 02 21 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2024 03 01 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2024 03 01 – Danielle Prpich obo Ross Hayward, Seniors Services Division

[9] Government of Canada. (2019). *Action Plan on Palliative Care.* Retrieved from https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/palliative-care/action-plan-palliative-care.html
[10] Government of Canada. (2023). *The Framework on Palliative Care in Canada – Five Years Later: A Report on the State of Palliative Care in Canada.* Retrieved from https://www.canada.ca/en/health-canada/services/publications/health-system-services/framework-palliative-care-five-years-later.html
[11] GPSC Palliative Care Billing Guide (February 4, 2022). Retrieved from https://fpscbc.ca/sites/default/files/GPSC-Palliative-Billing-Guide.pdf

LEGISLATIVE SESSION – ESTIMATES NOTE

M-17

Resident and Family Councils

Topic: Resident and Family Councils are an opportunity to ensure greater voices for residents and their families in decisions that affect them and their loved ones in Long-Term Care.

Key Messaging and Recommended Response:

- **Long-term care residences are people's homes and it's important that residents and family members have a place to share concerns and ideas when it comes to decisions about how the homes are operating.**
- **Resident and Family Councils ensure a greater voice for residents and their families, and strengthen the partnerships between residents, families, Long-Term Care home operators, health authorities and the Ministry of Health.**
- **In September 2022, the Residential Care Regulation (RCR) requirements were amended to enhance the role of Resident and Family Councils.**
- **In order to promote the intent of Resident and Family Councils to be independent and member driven, Long-Term Care (LTC) home operators only attend Resident and Family Council meetings by invitation from Council members.**
- **While the level of (LTC) home operator involvement is determined by Council members, the RCR requires LTC home operators to provide administrative support for Resident and Family Councils, such as providing a room for meeting and equipment to allow members to participate virtually.**
- **The RCR requires LTC home operators to, at least twice a year, provide the opportunity for Resident and Family Councils to meet with the LTC home operator for the purpose of promoting the collective interests of residents and involve them in decision making that affects resident's day-to-day experiences.**
- **The new RCR also requires LTC home operators to respond in writing to recommendations made by Resident and Family Councils.**
- **Two Provincial Forum meetings have happened over the past year and the Regional Resident and Family Councils are meeting regularly, which ensures the voices of residents and families in the local councils are being heard at all levels.**

CURRENT SITUATION

- The Ministry of Health has taken steps to increase support for Resident and Family Councils (RFCs) in all licensed LTC homes, as announced by the Minister on November 3, 2022.
- As of November 2023, out of 303 publicly subsidized LTC homes, 288 (95%) had either a resident or family council (or a combination of both). 15 (5%) were found to have no resident or family council.[1,2]
- All health authorities held three regional RFC meetings in 2023 and one in 2024, except for Interior Health who has not held a meeting in 2024 (as of February 20th, 2024).
- Each health authority has established a Regional Resident Family Councils which meet at least twice annually. These meetings provide an ongoing opportunity for RFC representatives to discuss successes, common issues of concern, share experiences and information to improve quality of life for residents of LTC homes.
- On June 20, 2023, the Ministry hosted the first Provincial Forum for RFCs-meeting to discuss systemic issues, promote best practices and advance quality of life for residents of LTC homes. The Provincial Forum included resident and family representatives from Regional Councils, was attended by Minister Dix and co-chaired by Parliamentary Secretary for Seniors Services and Long-Term Care, Harwinder Sandhu, and Assistant Deputy Minister Ross Hayward.
- A second Provincial Forum was held on December 6, 2023, with the same co-hosts and engagement from regional council's members, including several residents. The Ministry's Human Resources team presented on the Human Resources Strategy Framework, which intends to address issues raised regarding recruitment and retention of staff. Participants felt at ease to communicate issues, share successful practices in their regions, and make suggestions for Ministry's consideration.
- Issues discussed at the Provincial Forums included food quality, staffing concerns, services provided, structure of RFC system and complaints processes.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- In September 2022, the Residential Care Regulation (RCR) was amended to enhance the requirements related to RFCs in LTC homes, ensuring a greater voice for residents and their families, and strengthening the partnerships between residents, families, LTC home operators, health authorities and the Ministry.
- The Guidelines for RFCs, *Developing, Supporting and Maintaining Resident Councils and Resident and Family Councils*, previously published in 2011, were updated and published based on the new requirements in 2022. Booklet language, as well as Policy 6.H in the Home and Community Care Policy Manual are currently under review to integrate feedback received from Regional RFCs and RFC Provincial Forum andto ensure cultural sensitivity and inclusivity with the diverse population of BC.
- RFCs are independent and member driven.
- The RCR requires LTC home operators to provide administrative support for RFCs, such as providing a room for meetings and equipment to allow members to participate virtually.
- The RCR requires LTC home operators to, at least twice a year, provide the opportunity for RFCs to meet with the LTC home operator for the purpose of promoting the collective interests of residents and involve them in decision making that affects resident's day-to-day experiences.
- The new RCR also requires LTC home operators to respond in writing to recommendations made by RFCs.

LAST UPDATED

The content of this estimates note is current as of April 3, 2024, as confirmed by Danielle Prpich, ED, SSD, Long Term Care & Assisted Living Strategy & Policy.

[1] HCC LTC & AL Summary Report, as of November 2023. Excludes standalone ABI, standalone short-stay, and fully private sites.
[2] BC LTC & AL Directory 2023 – Office of the Senior's Advocate.

APPROVALS

2024 02 14 – Christine Voggenreiter obo Martin Wright, HSIAR
2024 04 03 – Ross Hayward ADM, Seniors' Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

N-01

2024/25 – 2026/27 Ministry of Health Service Plan Overview

Topic: The Ministry of Health 2024/25 – 2026/27 Service Plan makes public the Ministry's goals, objectives, and performance targets for the three-year period, and includes the Ministry's financial information as required under the *Budget Transparency and Accountability Act*.

Key Messaging and Recommended Response:

- **In BC, and around the world, health needs are increasing and becoming more complex, which is putting more pressures on the health system.**
- **This is a result of a growing and aging population as well as the impacts from health emergencies like the highly toxic illicit drug supply, extreme weather events, and the long-term impacts of the COVID-19 pandemic.**
- **We are supporting a strong workforce to respond to ongoing and new challenges and support complexities within the system.**
- **We are also strengthening population health, as well as ensuring community supports and services are accessible, timely, and meet the needs of the regional population in urban/metro, rural and remote communities.**
- **Together with our partners, we are improving health outcomes for Indigenous Peoples and breaking the cycles of systemic racism throughout the health system.**
- **In 2024/25, we will remain focused on providing the services and infrastructure that people depend on to live their healthiest lives.**
- **It means we will continue to deliver results that matter to people in the province including providing quality, safe, and comprehensive health care services closer to home.**

CURRENT SITUATION

The 2024/25 Ministry Service Plan was tabled on Budget Day, February 22, 2024.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- The Ministry Service Plan is intended to provide the public a high-level overview of the Ministry's purpose, strategic direction, key priorities, and the results it expects to achieve with the use of its financial resources.

- The 2024/25 Service Plan reflects government's strategic direction, and the Ministry's top priorities as outlined in the Minister's Mandate Letter of January 15, 2024, and the Parliamentary Secretary for Seniors' Services and Long-Term Care Mandate Letter (December 7, 2022).

This years' Service Plan contains the same three goals, and nine objectives:

Goal 1: Primary and community care services are integrated, accessible, and well-coordinated within the health system

- Objective 1.1: Timely access to team-based, culturally safe, and comprehensive primary care services
- Objective 1.2: Increase access to community-based care, including specialized services for adults with complex care needs and/or frailty
- Objective 1.3: Expand with key partners an accessible system of care for mental health and substance use

Goal 2: Regional and provincial health care services meet the diverse needs of all in BC

- Objective 2.1: Provide timely access to ambulance services to meet the needs of all in BC
- Objective 2.2: Timely access to hospital, surgical and diagnostic services throughout the province
- Objective 2.3: Improve access to cancer care services across the entire continuum of cancer care

Goal 3: A high quality sustainable health care system supported by a skilled and diverse workforce, and effective and efficient systems and structures

- Objective 3.1: A sustainable, skilled and diverse health sector workforce supported by a healthy, safe and engaging health care setting
- Objective 3.2: Enable sustainable health sector innovation for quality population and patient health care
- Objective 3.3: Modernize digital care services and tools to provide a connected, safe, and trusted system

The Service Plan key strategies continue to reflect efforts on significant health care priorities, and all content throughout is focused on the commitment to reconciliation, addressing systemic racism in the health system, recognizing the diverse needs of all in BC, and ensuring an equity lens has been applied to support cultural safety and inclusion using GBA+ analysis.

The 8 performance measures stated below exactly as presented in the 2024/25–2026/27 Ministry of Health Service Plan

Performance Measure	Baseline[1]	2023/24 Forecast	2024/25 Target	2025/26 Target	2026/27 Target
[1a] Access to Primary Care Services – Number of Visits	N/A	27,000,000	28,000,000	29,000,000	30,000,000
[1b] Number of people admitted to hospital for a chronic disease per 100,000 people aged 75 years and older	3,360 (2016/17)	2,050	<2,650	<2,650	<2,650
[1c] Potentially inappropriate use of antipsychotics in long-term care	25.4% (2017/18)	30.1%	21.0%	18.0%	18.0%
[1d] Percentage of people admitted for mental illness or substance use who are readmitted within 30 days	N/A	15.3%	13.7%	13.6%	13.6%
[2a] Ambulance In-Service hours	N/A	2,600,000	2,700,000	2,800,000	2,800,000

Performance Measure	Baseline[1]	2023/24 Forecast	2024/25 Target	2025/26 Target	2026/27 Target
[2b] Total Operating Room Hours	545,419 (2016/17)	618,100	689,600	696,700	703,900
[3a] Nursing and allied health professionals' overtime hours as a percent of productive hours	N/A	8.9%[2]	5.7%[2]	4.6%[2]	4.6%[2]
[3b] Percentage of population who access the provincial patient portal	N/A	35%	60%	75%	80%

[1] Baseline values were not used this year for measures where baselines were not informing target setting.

[2] The indicator *Nursing and allied health professionals' overtime hours as a percent of productive hours* is a calendar year indicator: 2023 Forecast, 2024 Target, 2025 Target, and 2026 Target respectively.

LAST UPDATED

The content of this estimates note is current as of February 7, 2024, as confirmed by Alexis Tanner.

APPROVALS

2024 02 26 - Kelly Uyeno, Strategy Management and People Office
2024 02 27 - Martin Wright, Health Sector Information, Analysis & Reporting Division