Ministry of Municipal Affairs and Housing

PROVINCIAL RESPONSE

to the Resolutions of the 2017
Union of British Columbia Municipalities
Convention

ADDENDUM #2

APRIL 2018

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B39 REGIONAL HOSPITAL DISTRICT CAPITAL FUNDING

WHEREAS regional hospital districts were created by provincial legislation to raise a 'local share' of capital costs for hospital equipment and building through property taxation with the 'local share' historically held at 40% for regional hospital capital projects and the Province contributing 60%;

AND WHEREAS local governments have limited ways to generate funding to pay for local services and infrastructure since property taxes are the primary source of revenue and are being stretched to meet the diverse demands local governments already face which cannot sustain the increased load in meeting hospital board expenditures:

THEREFORE be it resolved that UBCM petition the provincial government to acknowledge that property tax revenue is an unsuitable avenue to fund hospital infrastructure renewal projects and prioritize the urgent review of the historic cost sharing ratio with a recommendation, in consultation with regional hospital districts, to amend current policy accordingly.

RESPONSE: Ministry of Health

Regional hospital districts (RHDs) continue to be key partners in building and maintaining local healthcare infrastructure.

The expected amount of RHDs' financial contributions towards capital projects has historically been 40 percent. The Ministry of Health is aware that some RHDs have requested a review of and amendments to the *Hospital District Act* (the Act) in order to clarify a number of issues, including funding.

The Ministry recognizes that the Act and its regulation need to be updated and aligned with current practices. If the Ministry receives direction that there is an opportunity to amend this Act, then consultations with RHDs and a review of the historic cost-sharing model for capital funding will be part of the amendment process.

B40 HEALTH SERVICES PLANNING

WHEREAS the social determinants of health include housing, transportation, and built environment, which are directly influenced by local government decision making;

AND WHEREAS there is no mandated direct process for coordination of integrated planning between health authorities and local government:

THEREFORE be it resolved that UBCM petition the provincial government to establish formal mechanisms for including local government consultation in health services planning by health authorities.

RESPONSE: Ministry of Health

Every year, the Ministry provides health authorities with their capital funding budget for the current fiscal year, as well as notional capital funding targets for the next three fiscal years.

All health authorities are expected to consult with local communities when planning new services and/or changes to services. In addition, health authorities are working to improve community engagement in the design and planning of health services.

Since 2013, health authorities have established a number of linkages with local governments. Island Health reorganized its operational and accountability structures to facilitate stronger relationships and decision making closer to the community level. Island Health continues to foster those relationships with local governments and stakeholder groups to improve engagement, consultation and to enable input on key initiatives.

Island Health continues to engage local governments with respect to many of their public health initiatives and planning including Healthy Living Strategy Plans, Health Protection and Environmental Services, and Healthy Built Environment.

Fraser Health's CEO and Chair of the Board of Directors meet bi-annually with mayors or their appointed representatives. These meetings provide a forum for exchanging health care information between municipal leaders and Fraser Health to enable discussion on issues of mutual interest that will assist Fraser Health and the municipalities in planning.

Interior Health (IH) has also created a centralized Healthy Built Environment service that works with local governments to provide a health lens to their current and long-term planning documents. This is a service that is offered to all communities.

Community Liaisons are identified IH representatives across the health authority, that serve as a primary connection with elected officials and other key stakeholders through ongoing communication and community organization. Community Liaisons are responsible for guiding discussions that foster collaboration and transparency when there is potential impact to operations in a particular community or region.

B41 NURSE PRACTITIONERS

WHEREAS the attraction and retention of sufficient medical doctors is an ongoing issue for rural BC communities;

AND WHEREAS nurse practitioners provide an excellent means of supporting doctors in meeting the needs of those seeking medical care and allowing physicians to focus on more complex and challenging patient health complaints:

THEREFORE be it resolved that UBCM request that the Province of BC provide additional funding for nurse practitioners in rural communities and support their implementation throughout the province.

RESPONSE: Ministry of Health

There are 426 practicing nurse practitioners registered with the College of Registered Nurses of BC.[1]

BC has the ability to train up to 45 nurse practitioners per year at the University of British Columbia, University of Northern BC, and University of Victoria. Each site has 15 training seats.

Nurse practitioners are central to the Ministry of Health's new integrated model of care aimed at improving access to primary care for patients across BC. New Primary Care Networks (PCNs), including patient medical homes, will provide team-based care with nurse practitioners, registered nurses, licensed practice nurses, physicians and other professions working together to provide quality, safe and patient-centred care.

Where PCNs are developed, these will provide immediate opportunities for further implementation of nurse practitioners into both existing and new Community Health Centres and/or Patient Medical Homes, thereby increasing primary care capacity and access and demonstrating the positive outcomes NPs have within the primary health care system. The Ministry has identified several existing models of compensation to enable this, including: Nurse in Practice, Population based/Value Based, and salaried funding models. Similar to general practitioners (GPs) compensation, multiple funding arrangements will be important to attract and retain nurse practitioners across community settings, including rural.

Further, the Ministry has developed a Nurse in Practice funding model in an effort to increase practice capacity and net new patient attachments as part of the General Practice Services Committee's implementation of the Patient Medical Home. The model aims to expand capacity while improving patient and provider experience through a team-based care approach where a nurse practitioner, registered nurse and/or licensed practical nurse functions in a complementary role in the family practice. A number of family physicians are currently working towards integrating a nurse into their practices.

Currently, eight family practices in the Central Okanagan and two in the Central Interior Rural divisions of family practice are moving forward with Nurse in Practice. These practices will be able to integrate a nurse or nurse practitioner into their primary care team. Team-based approaches to care will benefit patients in rural areas by increasing the capacity of family practices to improve access and attach new patients to a regular

[1] College of Registered Nurses of British Columbia. *Annual Report 2016-17*.

primary care provider. These primary care practices will also be working towards the attributes of the BC Patient Medical Home model as part of their commitment to person- and family-centred, team-based care.

B42 PROVINCIAL ASSISTANCE TO ATTRACT DOCTORS TO BC

WHEREAS British Columbians are facing a critical shortage of primary care physicians in BC communities and unable to provide vital services to residents because BC is not competitive for a number of reasons, such as trained physicians choosing to practice in other provinces where opportunities are more economically attractive, the average gross clinical payments to BC physicians being one of the lowest in Canada and almost $100,000 less than Ontario, and new graduates with substantial student debt accepting positions in other provinces, such as Alberta, where the average physician salary is the highest in the country at $366,000 from billings;

AND WHEREAS too many highly qualified undergraduates are denied admission to UBC's 288 seat four-year medical degree program where only about 15% of the applicants are accepted compared to Alberta's 332 seats for first year medical students in a province with a population 12% smaller than BC's, forcing students to look elsewhere for their medical training, compounded by BC doctors who go abroad to get their medical education and must annually compete with up to 160 graduates from foreign medical schools for the handful of international residency training spots because there is no preferential treatment for BC born applicants who want to set up practices in BC in order to be closer to family and friends:

THEREFORE be it resolved that the communities of British Columbia—a strong and flourishing province, who want BC to be the greatest province in Canada by providing the full, holistic and complete communities that our residents expect and deserve—work together to open the doors for communities to attract doctors back to BC communities;

AND be it further resolved that UBCM request that the Province of British Columbia take definitive action to put in place the necessary framework, tools, and incentives to make us competitive with the other provinces and attract physicians back into BC communities.

RESPONSE: Ministry of Health

Government has taken steps to prepare future doctors for the challenges and benefits of medical practice in a variety of communities, including rural, remote, northern and underserved communities.

Priority in physician training has reflected a preference for generalist specialties to ensure a 60/40 split between generalists and specialists. Generalists include the areas of Family Medicine, General Surgery, Internal Medicine, Obstetrics and Gynecology, Pediatrics and Psychiatry. This aligns with Ministry priorities in primary and community care. As a result of the expansion and distribution of physician training, the total number of entry-level postgraduate medical education (PGME or residency) positions has increased from 134 in 2003 to 346 in 2017.

The number of entry-level residency positions for International Medical Graduates or IMGs (physicians who have received some of their training outside of Canada) has also increased from six positions in 2003 to 58 in 2016. IMG residency positions include a Return-of-Service (ROS) agreement which requires them to work in an identified community of need in BC upon completion of residency training for two or three years depending on their speciality.

Health Authority Medical Directors and recruiters that are linked to BC's IMG Return of Service Program are connecting with Divisions of Family Practice to help identify high priority communities and practices in need of family physicians.

As of 2017, PGME is only now reaching steady state with 346 entry-level positions offered annually.[2] As residents move through their training into practice (2-7 years), we will in time begin to realize the outcomes of expansion and distribution.

BC has created a streamlined pathway to enable practicing physicians from outside of Canada to gain licensure. The Practice Ready Assessment BC (PRA-BC) program is funded by the Ministry of Health and Doctors of BC and has enabled 73 family physicians to establish practices in rural and remote communities throughout BC. PRA-BC physicians are required to commit to the community for three years.

The Joint Standing Committee on Rural Issues – a collaborative committee of the Ministry of Health and Doctors of BC – funds over $130 million in programs and incentives to attract and retain physicians to rural and remote communities throughout BC. This includes one-time incentive payments, ongoing payments to encourage doctors to provide emergency room coverage and subsidies to enable physicians to provide outreach practice to remote communities. More information can be found in the booklet *Rural Programs*: https://www.doctorsofbc.ca/sites/default/files/ruralguide.pdf

Canadian Institute for Health Information (CIHI) data does indicate that family physicians earn more in some provinces. However, British Columbia continues to be an attractive place for family physicians to practice. BC routinely attracts more family physicians than it loses; CIHI data indicates that in 2016, BC saw a net gain of 149 family physicians. BC also has the highest ratio of family physicians to population in the country: 130 family physicians per 100,000 people, well above the Canadian average of 116.

The Ministry will continue to monitor physician recruitment and retention initiatives.

[2] Canadian Resident Matching Service. 2017 *R-1 Main Residency Match Report.* Accessed September 15, 2017. http://carms.ca/wp-content/uploads/2017/05/2017-R-1-match-report-full-EN.pdf

B43 PROVINCIAL SUPPORT FOR PHYSICIAN RETENTION

WHEREAS the provincial practice ready assessment program is attracting new physicians to rural communities; And whereas rural communities, including Logan Lake, have benefitted from the program;

AND WHEREAS the doctor is encouraged to establish a private practice by securing patients, but is reluctant to do so because:

- patients have secured physician services elsewhere (given the lack of a doctor for several years in their home community) and are hesitant to sign-on with the new local doctor as they fear losing the service once the return to service program concludes;
- due to lack of staff, is hesitant to hire additional staff and begin a private practice due to a lack of patients;
- existing staff are unable to respond to the influx of calls from new patients due to workload;
- they have limited understanding/knowledge of how to run a business in the province (i.e. the current health care billing system or the sharing of patient files);

AND WHEREAS the new doctor looks forward to moving on after 3 years to establish practice elsewhere where there are more patients:

THEREFORE be it resolved that the Ministry of Health increase funding for the rural doctor program and establish a new support model for health provision for rural communities, with other possible solutions including:

- re-establishing a local advisory council or ensuring site managers attend facilities in a timely and on a more regular basis, particularly during the transitional period of the arrival of a new doctor, during staff changeover, or to provide leadership and support to existing staff, so that Interior Health is better informed about what is happening in their rural communities;
- incentivizing rural community graduates seeking health care training whereby a student obtains a specified number of years free post-secondary education in exchange for returning to their home community for a specified number of years; or
- providing additional and adequate support to rural doctors in the form of additional office staff and/or seed money to bridge establishing a private practice.

RESPONSE: Ministry of Health

The Ministry, in partnership with the Doctors of BC, has established the Practice Ready Assessment BC (PRA-BC) program to create a pathway for experienced International Medical Graduatess to gain licensure in BC.[3] The PRA-BC program works closely with the College of Physicians and Surgeons of BC to ensure family physicians meet BC's high standards for patient care, quality and safety. In its first two years of operations, PRA-BC has placed 73 family physicians in rural communities identified by the regional health authorities. The Ministry is aware that some PRA-BC candidates have had difficulty establishing their practices due to a variety of issues including social/cultural concerns, lack of experience operating a small business and a lack of familiarity with the Canadian health care system.

Ministry staff are undertaking work with the regional health authorities and partners such as the Doctors of BC, Rural and Remote Division of Family Practice and the Rural Coordination Centre of BC to identify areas of

[3] http://prabc.ca

concern for internationally educated physicians, improve integration of existing physician support and mentoring programs and, where necessary, develop new programs to ensure IMGs are successful in British Columbia. A key component of this work is identifying the role of local government and community agencies to help with community readiness for new physicians to help ensure their success.
New-to-Practice family physicians can access the Practice Support Program[4] which provides a suite of educational and on-site supports to improve physician's clinical practice as well as practice management.

The Joint Standing Committee on Rural Issues (JSC), a joint committee of Doctors of BC, Ministry of Health and Health Authorities, oversees a comprehensive set of programs to attract and retain physicians in rural BC.[5] It is the goal of the JSC to enhance the availability and stability of physician services in rural and remote areas of the Province by addressing some of the unique and challenging circumstances faced by physicians in these areas. Included in the programs supported by JSC that family physicians practicing in an eligible rural community are eligible for include the Recruitment Incentive Program (a lump sum payment upon recruitment), Recruitment Contingency Fund (which helps cover the cost of moving expenses, site visits, etc), Rural Retention Program (a generous premium on all fee-for-service claims submitted by the physician and an annual lump sum amount for physicians who reside and practice in the community), and Rural Continuing Medical Education Fund (annual allowance for ongoing education and training).

[4] http://www.gpscbc.ca/what-we-do/professional-development/psp
[5] http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/physician-compensation/rural-practice-programs

B44 REGULATION & LICENSING OF SUPPORTIVE RECOVERY HOMES

WHEREAS addictions are a health care issue and the operation of supportive recovery homes can play an important role in supporting improvements to individual and community health outcomes through recovery from drug and alcohol addictions;

AND WHEREAS under the *Community Care and Assisted Living Act*, many of the operating standards required of licensed treatment facilities—such as screening, programming, nutrition, staff competencies, and staff-to-client ratios—do not apply to supportive recovery homes, thereby reducing their effectiveness and putting at risk the safety of the vulnerable individuals they serve; facility staff; and the local community:

THEREFORE be it resolved that the Union of British Columbia Municipalities urge the provincial government to undertake licensing and more stringent regulation of supportive recovery homes to ensure effective care, support, and safety for persons seeking assistance with recovery from drug and alcohol addictions; and to provide improved oversight and accountability to the communities in which they are situated.

RESPONSE: Ministry of Health

The Ministry of Health presently regulates supportive recovery homes through the *Community Care and Assisted Living Act.* Supportive Recovery Residences are designed to provide access to substance use services and supportive housing for persons who are recovering from substance use disorders.

The Ministry of Health introduced amendments to the *Community Care and Assisted Living Act* in 2016. The amendments to the *Community Care and Assisted Living Act* provide for increased oversight by the Assisted Living Registrar such as: the ability to set registration requirements, including applicant qualifications; the ability to establish conditions upon registration; enhanced inspection authority and the ability to take summary action. Amendments to the *Community Care and Assisted Living Act* will also enable additional regulations to be developed for this sector.

A consultation process was initiated in January 2017 to obtain advice from a diverse group of mental health and substance use stakeholders and service providers regarding elements that should be included in future regulatory provisions.

A broad public consultation process using an online survey was conducted in the Spring of 2017. Through the consultation process the Ministry received feedback that existing health and safety requirements should be strengthened and clarified.

The Ministry has reviewed the feedback received and anticipates that new regulations will be developed, in collaboration with the Ministry of Mental Health and Addictions, based upon the current health and safety standards.

Recommendations for strengthened regulatory areas include:

- Definition of supportive recovery
- Ban on weapons

- Setting minimum staffing requirements and minimum employee qualifications and training required
- Requirement for role and job descriptions for Peer Mentors
- Clarity on requirements for psychosocial support program
- Requirement that meals must be nutritious and balanced according to Canada's Food Guide

B51 SOCIAL SUPPORT SERVICES FOR SENIORS

WHEREAS the demographic of those over 65 continues to increase across British Columbia;

AND WHEREAS increasing numbers of seniors experience financial, social, health and housing vulnerabilities;

AND WHEREAS services for seniors are provided by a variety of local ministries, agencies and governments:

THEREFORE be it resolved that the provincial government be requested to plan system-wide initiatives to support seniors' healthy, stable and successful aging to limit social isolation, varieties of abuse and limited access to needed housing.

RESPONSE: Ministry of Health

The Province funds the Age-friendly Communities grant program for local governments in BC to develop policies or plans or projects that enable seniors to age in place, and facilitate the creation of age-friendly communities. The province is providing $500,000 for the 2018 Age-friendly Communities Grant program, to enable local governments to work on age-friendly assessments, action plans and projects. Local governments can apply for Stream 1 planning grants (up to $25,000) or Stream 2 project grants (up to $15,000). A local government must have recently completed an assessment or action plan before it can apply for a project grant.

The BC Government announced a total of $548 million over three years to the Ministry of Health in Budget 2018 to improve care for seniors including investments in home and community care, residential care, and assisted living. Approximately 28,000 people live in residential care facilities. The Office of the Seniors Advocate indicated that 85 percent of the province's residential care facilities were operating below 3.36 direct care hours worked per resident day (HPRD). The Ministry of Health (the Ministry) has committed to ensuring that each Health Authority provides an average of 3.36 direct care hours per resident day. The additional care hours will provide for more interaction between care staff and residents, resulting in more social engagement and a better quality of life.

The Ministry, in partnership with the federal government, is investing $275 million over four years toward improving home care and home support, to enable seniors to live independently in the comfort and familiarity of their own homes, and remain connected to their communities for as long as possible.
As of April 1, 2018, the government has restored the 100 percent seniors discount on ferry fares from Monday to Thursday that will make it more affordable for seniors to remain connected to their loved ones and their communities.

Federal, provincial and territorial (FPT) governments work together through the FPT Ministers Responsible for Seniors Forum to support in meaningful ways present and future generations of older Canadians. The Ministry is a participant on the FPT Seniors Forum. The FPT Ministers Responsible for Seniors have developed the Social Isolation of Seniors Toolkit to support BC's priority to promote seniors' health and well-being, and to help seniors remain living at home in their community for as long as possible. Social isolation and exclusion is related to serious negative health effects, elder abuse, and reduced quality of life

for seniors. BC is committed to exploring opportunities for the dissemination and use of the Toolkit and Supplements.

FPT Ministers have directed officials to do further work to respond to the social inclusion needs of three specific sub-populations that may be at high risk of being socially isolated, namely: recent immigrant and refugees; LGBTQ (Lesbian, Gay, Bisexual, Transgender, Transsexual, Two-spirited, Intersex or Queer/Questioning Individuals); and Indigenous seniors. This work is expected to be completed by spring 2018. The FPT work on social inclusion of seniors complements other provincial initiatives to support seniors, such as Age-friendly BC, and Aging Well, a healthy aging resource on HealthyFamiliesBC.ca that includes promotion of staying connected.

The Province also acts to prevent seniors from becoming socially isolated by providing simple, non-medical home support services through the Better at Home program (managed by the United Way). Better at Home services help seniors remain independent in their own homes, and keep them connected to their communities for as long as possible. Better at Home services may include light housekeeping, yard work, snow shoveling, grocery shopping, minor home repairs, transportation services and friendly visiting. Services are provided by local non-profit organizations and delivered by a mix of volunteers, contractors and paid staff. Sixty-nine Better at Home program sites are operating in communities across BC; many serve more than one community; four of these communities are on First Nations Reserves. As of September 2017, Better at Home had delivered nearly 500,000 services, and more than 22,000 seniors and elders were enrolled.

The Province's approach to addressing elder abuse is one of multi-sector collaboration, awareness and engagement building, training and inspiring the public to take action to reduce elder abuse, and affect a societal change in attitudes. The Council to Reduce Elder Abuse (CREA), was established in 2013 to facilitate multi sector collaboration in addressing elder abuse, and to galvanize society to commit to taking action to prevent elder abuse.

The Ministry has undertaken a range of elder abuse prevention activities including:

- Provided $4.7 million to the BC Association of Community Response Networks (in 157 communities), including $650,000 for community-based initiatives to build awareness, enhance training, and improve response to elder abuse;
- The Provincial Health Services Authority provided $850,000 in 2012/13 to the BC Centre for Elder Advocacy and Support to expand the capacity and hours of its Seniors Abuse and Information Line (SAIL).
- In 2016/17, the Ministry provided $250,000 to Seniors First BC to support services related to the Council to Reduce Elder Abuse ($50,000), and to operate the SAIL ($200,000), a help line for victims of elder abuse and those close to them;

Beginning in 2006, proclaimed World Elder Abuse Awareness Day annually on June 15;

- Provided digital signage in **62** ServiceBC offices around the province;
- Developed and distributed 31,000 Elder Abuse Prevention Information kits in English, French, Punjabi and Traditional Chinese (digital versions available at SeniorsBC.ca);
- Expanded the elder abuse resources available on the Seniorsbc.ca website;
- Updated the Elder Abuse Prevention Series on the HealthLinkbc.ca website;
- Developed an online interactive course for caregivers and service-providers on recognizing, preventing and responding to the abuse of adults;
- Implementing consistent, province-wide procedures for consent to care facility admission.

The Ministry of Justice provides programs and services for victims of elder abuse (e.g., VictimLink BC helpline; Understanding and Responding to Elder Abuse E-Book and a webinar for support workers; information resources in multiple languages, and website); is responsible for some of the relevant legislation (e.g., Adult Guardianship Act); and, through the Public Guardian and Trustee, protects adults from legal, financial and personal care abuse. The Ministry of Advanced Education has developed publicly accessible training for practitioners in the health, legal, financial and social services.

The Shelter Aid for Elderly Renters (SAFER) program is expanding eligibility, and increasing benefits for the seniors rental support program. The Government is investing $58 million over three years to the SAFER program. Effective September 2018, on average, approximately 22,000 seniors will receive an extra $930 per year.

The Government has committed to build, directly and through partnerships, 114,000 rental, social and co-op homes over 10 years to help address the gap in suitable and affordable housing for seniors. BC Housing's Seniors' Supportive Housing Program provides housing and support services to older adults, seniors and people with disabilities. The Program assists low-income British Columbians who are 55 years of age or older, and people of any age who have a disability or diminished ability. The program's modified apartment units are designed for people who can live independently with some assistance, but who are not eligible for assisted living or a greater level of care.

B70 FUNDING FOR CHILD & YOUTH MENTAL HEALTH & SUBSTANCE USE COLLABORATIVE

WHEREAS the Child and Youth Mental Health and Substance Use Collaborative (CYMHSUC), funded and supported by Doctors of BC and the Government of British Columbia, has been working to increase timely access to integrated support and services for children, youth and families, which work contributes to improving and potentially saving the lives of children and youth struggling with mental health and substance abuse issues in British Columbia;

AND WHEREAS the CYMHSUC has grown, since 2013, to 11 provincial working groups, comprising the 64 CYMHSUC local action teams, addressing complex issues such as emergency room protocols, rural telehealth, information sharing guidelines and increased literacy for mental health and substance use in schools through training teachers and counsellors on mental health curriculum and mental health first aid;

AND WHEREAS the Government of British Columbia has not committed funding for the CYMHSUC beyond 2017:

THEREFORE be it resolved that the Government of British Columbia continue funding and support for the Child and Youth Mental Health and Substance Use Collaborative beyond 2017.

RESPONSE: Ministry of Health

The Child & Youth Mental Health & Substance Use Collaborative (CYMHSUC) is a program administered under the Shared Care Committee (SCC), a partnership between the Ministry of Health and the British Columbia Medical Association (operating as Doctors of BC) formed under the Physician Master Agreement (PMA). The PMA is between the Government of BC, Doctors of BC and the Medical Services Commission. The term of the PMA is from April 1, 2014 to March 31, 2019.

Although the SCC has committed to supporting and funding the CYMHSUC program only until March 31, 2018, the Government of BC has committed funding to SCC until March 31, 2019, the end date of the PMA. Since the SCC is a partnership between the Ministry of Health and the Doctors of BC, the Ministry will work with the Doctors of BC to continue to support the CYMHSUC program beyond current dates.

Since April 1, 2013 to March 31, 2017, through the SCC, approximately $18 million has been invested in the CYMHSUC program. For fiscal year 2017/18, an additional $3.2 million was committed towards the CYMHSUC program.

B96 REVIEW OF & AMENDMENTS TO THE *HOSPITAL DISTRICT ACT*

WHEREAS the enabling legislation of regional hospital districts in British Columbia, the *Hospital District Act*, prescribes the purpose of hospital districts which hospital district boards struggle to interpret;

AND WHEREAS in 2003 the Ministry of Health recommended that the Act be updated and in 2014 the Assistant Deputy Minister of Health stated that a review of the Act was in progress:

THEREFORE be it resolved that UBCM urge the provincial government to review and update the *Hospital District Act* expeditiously and invite input from the regional hospital districts in British Columbia in order to clarify the mandate and role of hospital districts.

RESPONSE: Ministry of Health

Regional hospital districts (RHDs) continue to be key partners in building and maintaining local healthcare infrastructure.

The *Hospital District Act* (the Act) is a legislative framework for RHDs and their roles and responsibilities. The Ministry recognizes that the Act needs to be updated and aligned with current practices.

If/when the Ministry receives direction that there is an opportunity to amend this Act, then in consultation with RHDs, health authorities and other stakeholders will be part of the amendment process.

B117 SEXUAL ASSAULT EVIDENCE COLLECTION KITS FUNDING

WHEREAS sexual assault evidence collection (SAEC) kits are currently funded through the Ministry of Health, with SAEC kits considered evidence that is from a committed crime;

AND WHEREAS survivors of sexual assault need medical forensic examinations readily available on demand and should not be expected to travel further than 50km to facilitate equitable access to justice and associated resources:

THEREFORE be it resolved that the provincial government fund comprehensive, 24/7 access to services and staffing needed (sexual assault nurse examiners) and to provide SAEC kits in communities lacking in forensic services.

RESPONSE: Ministry of Health

All patients across BC who are in need have access to Sexual Assault Forensic Evaluation (SAFE) services. These services are highly sensitive and require appropriately trained health professionals to administer and to ensure that the patient's needs and legal requirements to meet court standards of admissibility are met.

SAFE should only be performed by specially trained medical professionals. Specialized SAFE training provides examiners with instruction on how to perform SAFE in a patient-centred manner, properly prepare and store evidence, and provide expert testimony in criminal proceedings. Providing a patient with a SAFE examination may routinely take one or more hours to complete. Maintaining competencies related to SAFE requires regularly performing SAFE examinations; some areas of the province experience requests for SAFE at a volume lower than required to maintain examiner competency as well as the required equipment and physical space.

Because SAFE services (e.g. collection of biological samples, relevant patient history, and/or documentation of injuries) are highly specialized and should only be performed by specially trained medical professionals, it is not available at every individual hospital in the province. However, SAFE services can be accessed by any patient presenting at any hospital. Either transportation will be coordinated by the hospital to the nearest community that offers SAFE or a travelling team will travel to the patient.

Additionally, the Emergency Services Advisory Committee is working to standardize protocols and training, to be implemented at all hospitals across the province, to ensure that victims of sexual assault can receive immediate supports and medication regardless of where they present, while the SAFE trained medical professionals at the nearest hospital are contacted.

B133 BC AMBULANCE SERVICES

WHEREAS the BC Ambulance Service provides emergency response in rural areas to those who experience serious trauma accidents or life threatening medical emergencies;

AND WHEREAS most rural ambulance stations are staffed with paramedics trained to the emergency medical responder or primary care paramedic levels;

AND WHEREAS most of the better trained advanced care paramedics and critical care paramedics are stationed in larger urban centers whose residents benefit from tertiary care facilities within relative proximity compared to rural residents' health facilities:

THEREFORE be it resolved that the provincial government require the BC Ambulance Service to staff rural ambulance stations with much needed advanced care or critical care paramedics whose skills and training are necessary for life support where tertiary care is often hours away rather than minutes away as it is in urban centers.

RESPONSE: Ministry of Health

BC Emergency Health Services (BCEHS) recognizes that staffing can be a challenge in rural communities and acknowledges that the use of paramedics with a higher level of clinical skill could be beneficial in some non-urban settings. Currently, BCEHS is working with Northern Health Authority to explore options for using advanced care paramedics in remote practice settings.

Improving emergency response times for high acuity patients, and improving service delivery in rural and remote communities are both priorities for BCEHS and key objectives of theirs. The Ministry of Health has committed to fund up to 80 new regular full-time equivalent Community Paramedicine positions to be established between April 1, 2015 and March 31, 2019, and BCEHS continues to work towards enhancing emergency response in rural and remote communities by improving paramedic recruitment and retention.

In addition to recruitment efforts, BCEHS has recently introduced an interim four hour wage guarantee for on-call shifts at stations with low call volumes. They are also in the process of reviewing changes to the deployment model which would see the introduction of regular part-time positions in some rural communities, and help attract employees to these communities on a longer-term basis.

Through the Community Paramedicine Initiative, BCEHS is improving access to health care in select rural and remote communities by expanding the role of qualified paramedics to include providing primary care services in non-emergency settings such as in the community and patients' homes. This initiative will help stabilize staffing and introduce community paramedics with the training to deliver additional types of care.

B134 COMPARABLE STANDBY WAGES FOR BC AMBULANCE SERVICE

WHEREAS many remote and rural municipalities experience a shortage of qualified ambulance staff and this puts these municipalities in danger of not having the service when they need it the most;

AND WHEREAS many rural ambulance stations only provide on-call coverage with no guaranteed shifts for staff and the on-call rate of $2 per hour is not a sufficient rate for paramedics to make the income needed to be self-sufficient:

THEREFORE be it resolved that UBCM call on the BC government to work with the provincial bargaining body and BC Ambulance Service in the next round of provincial collective agreement bargaining to ensure that BC Ambulance Service staff have on-call rates of pay comparable with other health science professionals, e.g. lab technologists, radiation technologists, and nurses.

RESPONSE: Ministry of Health

Government is interested in supporting paramedics and the services they provide, including in rural and remote areas. Standby wages are an important issue, however, they are a collective bargaining matter and need to be discussed through that process by the employer and the union.

The Labour Relations Board notified that a standalone bargaining unit came into effect on January 18, 2018, for the Ambulance Paramedics of British Columbia (CUPE Local 873), the union representing the more than 3,600 paramedics and dispatchers in British Columbia. This will help to ensure a strong voice for paramedics and also support patient care, with a focus on key areas such as response times, rural and remote staffing, and innovative ways of treating patients with non-emergency injuries and illnesses.

The Ministry of Health is working closely with BC Emergency Health Services, health authorities, the Ambulance Paramedics of BC (CUPE Local 873), and others to successfully implement British Columbia's first Community Paramedicine Initiative. In BC, community paramedicine is intended primarily for rural and remote communities. The program objectives are to help stabilize paramedic staffing in these communities, and bridge health service delivery gaps identified in collaboration with local health care teams.

The Community Paramedicine Initiative was launched in April 2015 with three prototype community projects in Northern Health. This was followed with two in Interior Health and four in Island Health. The provincial rollout began in late April 2016 with the announcement of 76 communities.

B135 BC AMBULANCE SERVICE

WHEREAS the BC Ambulance Service is an integral part of the provincial health care system;

AND WHEREAS BC Ambulance dispatch services are not provided locally to rural communities in BC;

AND WHEREAS there are logistical challenges in rural challenges that may be best managed locally:

THEREFORE be it resolved that UBCM urge the provincial Minister of Health to require the BC Ambulance Service to amend its dispatch model to allow for local responders to determine how best to manage a response to an emergency or other calls for service.

RESPONSE: Ministry of Health

The Ministry of Health and BC Emergency Health Services (BCEHS) recognize that in remote and isolated communities transporting patients to a BCEHS ambulance for transport to higher levels of care can be challenging.

BCEHS is working with a variety communities facing the challenges of transporting patients from rural and isolated areas. However, they are limited by the fact that BCEHS is not the body that determines what actions first responders may take. The Emergency Medical Assistants Licensing Board is the licensing body responsible for determining and enforcing those regulations through provincial legislation. Each license level of emergency responders / paramedics is only able to perform very specific actions for which they have been trained. Under the Emergency Health Services Act regulations, the minimum licence level permitted to transport a patient is the Emergency Medical Responder level.

BCEHS is currently developing criteria which will help bring clarity to small communities regarding patient transport options.

This criterion will help determine the circumstances in which BCEHS would enable the transport of patients with an acceptable ambulance under its guidelines. For example: factors like remoteness, distance and time for crews to respond are all factors being considered as part of the criteria.

The criteria is being developed in consultation with fire department representatives in small and remote areas of BC, and will form the basis by which new consent agreements will be developed. These new agreements will clarify the role and scope of First Responders and EMRs in remote and isolated communities, so they can safely provide support for patients in need and their local communities until BCEHS crews can reach them.

B136 HELICOPTER EMERGENCY MEDICAL SERVICES

WHEREAS the resource sector is the corner stone of the economies of most rural communities and modern health care is crucial to attracting new investment, a workforce, and securing quality of life for rural residents;

AND WHEREAS the BC Forest Safety Ombudsman's report on Helicopter Emergency Medical Services has identified that rural communities are negatively affected by an inadequate emergency transportation system:

THEREFORE be it resolved that UBCM call on the provincial government to adopt the BC Forest Safety Ombudsman recommendations on "Helicopter Emergency Medical Services" including mandating a legislated one-hour timeline for every resident of the province to have access to Trauma 3 Level of care.

RESPONSE: Ministry of Health

BC Emergency Health Services (BCEHS) and the Ministry of Health both understand the importance of providing emergency care when and where it is needed, while keeping emergency services staff and patients safe in the delivery of that care. Although distance, weather and a number of other factors can affect emergency response, air ambulances are dispatched according to the care needs of each patient, and the level of urgency required.

In June 2017, BCEHS started utilizing a fixed-wing air ambulance based in Fort St. John to better serve north-east communities, enabling long distance emergency transports to the major trauma facilities in Kelowna and Vancouver. In August 2017, BCEHS announced that the contracted provider for 3 of its 4 dedicated helicopters will be adding night vision technology. It is expected that this technology, when installed next year, will mean at least 140 more patients a year can be transported via helicopter.

BCEHS provides excellent pre-hospital and patient transfer care by air, and has implemented training for all front-line staff on how to approach high-risk remote situations. Search and rescue (SAR) operations are the responsibility of more than 80 SAR volunteer groups across the province. These groups maintain the requisite skills, equipment, and other resources to access remote locations that BCEHS paramedics are not able to. BCEHS coordinates with SAR groups to transport patients from remote areas to care facilities. WorkSafeBC requires employers operating in remote areas, like those operating commercial enterprises in the logging, mining, fishing and ski resort sectors, to be responsible for transporting out patients injured in remote areas.

The Ministry of Health and BCEHS will continue work towards improving health care in rural and remote communities.