

Select Standing Committee on Health

Looking Forward: Improving Rural Health Care, Primary Care, and Addiction Recovery Programs



MARCH 2017



March 1, 2017

To the Honourable
Legislative Assembly of the
Province of British Columbia

Honourable Members:

I have the honour to present herewith the First Report of the Select Standing Committee on Health for the Sixth Session of the 40th Parliament.

The Report covers the work of the Committee in regard to identifying potential strategies for maintaining the sustainability and quality of British Columbia's health care system and was unanimously adopted by the Committee.

Respectfully submitted on behalf of the Committee,

Linda Larson, MLA
Chair

Table of Contents

Composition of the Committee.....	i
Terms of Reference.....	ii
Executive Summary.....	1
Consultation Process	5
Meetings Schedule.....	8
Part I – Rural Health Care and Recruitment.....	9
Part II – Interdisciplinary Teams.....	21
Part III – Addiction Recovery Programs.....	31
Summary of Recommendations.....	45
Appendix A: Presentations	51
Appendix B: Written Submissions.....	53
Appendix C: Composition of the Committee	56
Appendix D: Previous Terms of Reference.....	58
Appendix E: Meetings Schedule.....	61

Composition of the Committee

Note: Committee Membership for previous Sessions is available in Appendix C.

Members

6th Session

Linda Larson, MLA	Chair	Boundary-Similkameen
Judy Darcy, MLA	Deputy Chair	New Westminster
Dr. Doug Bing, MLA		Maple Ridge-Pitt Meadows
Marc Dalton, MLA		Maple Ridge-Mission
Sue Hammell, MLA		Surrey-Green Timbers
Dr. Darryl Plecas, MLA		Abbotsford South
Selina Robinson, MLA		Coquitlam-Maillardville
Dr. Jane Jae Kyung Shin, MLA		Burnaby-Lougheed
Sam Sullivan, MLA		Vancouver-False Creek
John Yap, MLA		Richmond-Steveston

Committee Staff

Susan Sourial, Clerk Assistant, Committees and Interparliamentary Relations

Lisa Hill, Committee Research Analyst

Karan Riarh, Committee Researcher

Terms of Reference

Note: Terms of Reference for previous Sessions is available in Appendix D.

6th Session Terms of Reference

On February 20, 2017, The Legislative Assembly agreed that the Select Standing Committee on Health be empowered to:

1. Identify potential strategies to maintain a sustainable health care system for British Columbians; and
2. Consider health capital funding options.

In addition to the powers previously conferred upon the Select Standing Committee on Health, the committee shall be empowered:

- a. to appoint of their number one or more subcommittees and to refer to such subcommittees any of the matters referred to the committee and to delegate to the subcommittee all or any of its powers except the power to report directly to the House;
- b. to sit during a period in which the House is adjourned, during the recess after prorogation until the next following Session and during any sitting of the House;
- c. to conduct consultations by any means the committee considers appropriate;
- d. to adjourn from place to place as may be convenient; and
- e. to retain such personnel as required to assist the committee;

and shall report to the House as soon as possible, or following any adjournment or at the next following Session, as the case may be; to deposit the original of its reports with the Clerk of the Legislative Assembly during a period of adjournment and upon resumption of the sittings of the House, the Chair shall present all reports to the Legislative Assembly.

Report Highlights



Strategies for ensuring the sustainability and improving the quality of B.C.'s health care system.

INQUIRY

RURAL HEALTH CARE AND RECRUITMENT

INTERDISCIPLINARY TEAMS

ADDICTION RECOVERY PROGRAMS



What we heard



NUMBER OF COMMITTEE RECOMMENDATIONS: 59



Executive Summary

Health care delivery in British Columbia must be flexible, responsive and sustainable in order to respond to the changing needs of British Columbians and our province's geographic, economic and cultural diversity. To address these challenges, the Select Standing Committee on Health (the Committee) undertook two consultations in 2014-15 and 2016 to ask British Columbians for input related to maintaining the sustainability and quality of B.C.'s health care system. On October 28, 2015, the Committee released an interim report on physician-assisted dying, and another report on improvements for end-of-life care followed on May 10, 2016. In this final report, the Committee makes 59 recommendations in regards to the following areas of inquiry:

- How can we improve health and health care services in rural British Columbia? In particular, what long-term solutions can address the challenges of recruitment and retention of health care professionals in rural British Columbia?
- How can we create a cost-effective system of primary and community care built around interdisciplinary teams?
- How can we enhance the effectiveness of addiction recovery programs?

Rural Health Care and Recruitment

British Columbia's rural population is dispersed over a vast and varied geography – a significant challenge when it comes to the delivery of health care services. Access to quality health care services in rural, remote and isolated communities was a recurring theme during the Committee's inquiry. Presenters shared that many communities are under-resourced for a number of services, and that a significant increase in the provision of resources and services is required to meet the unique needs of individual communities and to ensure positive health outcomes. How British Columbians physically access health care services, and affordable and accessible transportation and transit, are other key challenges.

Improving access also means that existing service delivery models should be regularly examined for cost-effectiveness and efficiency. Presenters brought forward numerous examples of innovative models for delivering health care in rural communities, which could be customized according to each community's unique needs. Existing funding and compensation models must also be updated to align with any changes or innovations in service delivery.

A sustainable, accessible and high-quality health care system depends on an effective and engaged workforce. Recruitment and retention of health care providers in rural communities is an ongoing challenge. Improvements in areas such as education and training, accelerating the qualifying and approval process for integration of foreign-trained health care providers,

promoting the benefits of living and working in rural B.C., and encouraging British Columbians from rural, remote and isolated communities to pursue careers in health care would help alleviate these shortages. In addition to workforce improvements, leveraging existing public infrastructure to provide co-located services, as well as investing in innovative technologies, would better support health care service delivery in these communities.

The foundation of any health care system is rooted in the overall health and wellness of its population. Numerous presenters highlighted the need to encourage and support British Columbians to adopt and maintain healthy lifestyles, with the goal of improving long-term health outcomes. The Committee would like to see improved collaboration between federal, provincial and municipal governments to provide an array of health and wellness supports in communities throughout the province. Collaboration with local stakeholders is also key to ensuring that all health care policies, programs and initiatives suit each community's particular needs.

Interdisciplinary Teams

The Committee learned about a number of successful interdisciplinary team models in which health care providers work collaboratively to deliver complementary health care services. Opportunities exist throughout the province, in both primary and community care, to implement a range of scalable and customized interdisciplinary team models.

Strong and effective interdisciplinary teams depend on the skills, experience and availability of individual team members. To strengthen workforce planning and professional development for health care providers, we need to develop and implement a comprehensive, long-term health human resources plan that includes the entire range of health care providers, as well as increase inter-professional education and interdisciplinary training. Another key to the successful implementation of interdisciplinary teams is ensuring that each team member is working to their full scope of practice. To support the implementation and expansion of different models of interdisciplinary teams, we need to look at our funding and compensation models. The Committee recognizes that current funding models may need to be adjusted to better support team-based care and service delivery.

The Committee heard how innovations in information management and technology support interdisciplinary teams by allowing health care providers to share information seamlessly within secured networks. The implementation of a province-wide singular patient health record across health authorities is one such example of how the capabilities of new technologies might be maximized. Finally, interdisciplinary teams need to be monitored and evaluated on a regular basis to ensure that they are providing high-quality, accessible, cost-effective and efficient health care for British Columbians.

Addiction Recovery Programs

Similar to other chronic illnesses, addiction is a disease that can affect individuals from many walks of life. The current opioid crisis in Canada, and the rise of fentanyl use in B.C., highlights the urgent need for responsive action from all levels of government. Input received by the Committee pointed to the need for holistic, multi-faceted and integrated approaches for addiction treatment and recovery programs, including a focus on evaluation to ensure these programs are effective in delivering expected outcomes.

Research shows that prevention and early intervention can help stop the escalation to addiction. Submissions highlighted the need for a comprehensive, province-wide suite of programs for school-aged children, and youth up to the age of 24. Another area of concern was the need for more treatment and recovery beds for youth to meet current demand. Professional development and training for those who specialize in addictions medicine, and first responders, should be expanded as well.

In addition to children and youth, the needs of adults struggling with addiction are also not being met. A significant increase in the number of detoxification, post-detoxification, treatment and recovery beds is required, as well as a substantial increase in funding to enable access to evidence-based residential and community-based services and supports. The simultaneous integration of complementary services and supports for mental health and addiction into primary health care settings can only result in significant benefits for those individuals who face the dual challenges of addiction and mental illness.

Stigma, discrimination and stereotyping can often dissuade individuals from seeking treatment for addiction. Increased public education and awareness can help diminish stigma, and promote a better understanding of addiction and those living in recovery. More inclusive and accepting communities can further help provide a vital link to those struggling with addiction or feeling isolated in recovery. Many presenters highlighted youth specifically as a group that might need more support to develop resiliency skills in order to avoid other self-destructive behaviours.

To mitigate the negative health outcomes and socioeconomic impacts of addiction, a full range of harm reduction programs, services and supports should be provided throughout the province. This includes expanding evidence-based initiatives that provide controlled access to currently illicit substances. Additionally, we must implement public awareness campaigns that highlight the value of harm reduction within the context of reducing social harms.

Consultation Process

On July 23, 2013, the Legislative Assembly tasked the all-party Select Standing Committee on Health (the Committee) to identify potential strategies for maintaining the sustainability and quality of British Columbia's health care system. To fulfill their mandate, the Committee invited British Columbians to share their ideas on how we can continue to ensure the sustainability of, and make improvements to, our health care system. In order to focus the consultation, the Committee sought submissions addressing the following questions:

- How can we improve health and health care services in rural British Columbia? In particular, what long-term solutions can address the challenges of recruitment and retention of health care professionals in rural British Columbia?
- How can we create a cost-effective system of primary and community care built around interdisciplinary teams?
- What best practices can be implemented to improve end-of-life care?
- How can we enhance the effectiveness of addiction recovery programs?

The Committee conducted two public consultations, one held in 2014-15 and a second round held in 2016, and released an interim report in October 2015, as well as a report on end-of life care in May 2016. For both consultation processes, the Committee invited a number of stakeholders and individuals to present at public hearings or to make a written, audio or video submission. To encourage participation in the consultations, the Committee issued media releases, posted information about the consultations on the Committee's website, and used social media.

As the Committee's consultations began in 2014, during the 2nd Session of the 40th Parliament, and continued into the 6th Session in 2017, there have been a number of changes to the Committee's membership. A list of Committee Members from the previous Sessions is available in Appendix C. Additionally, the Committee's Terms of Reference has been modified since the 2nd Session. The Committee's original Terms of Reference tasked the Committee with outlining strategies to mitigate the impact of cost drivers on the sustainability and improvement of the health care system. In October 2014, the Terms of Reference were expanded to include the consideration of health capital funding options. In the 5th and 6th Sessions, the Committee was asked to identifying potential strategies to maintain a sustainable health care system and to consider options for health capital funding. The Committee's Terms of Reference for the previous Sessions are available in Appendix D.

Reports

A large number of submissions received during the 2014-15 consultation process addressed the topic of physician-assisted dying, even though this topic was not included in the four areas of inquiry outlined in the Committee's questions. In March 2015, the Committee struck a subcommittee to review the submissions received on physician-assisted dying and released an interim report in October 2015.

Based on the significant number of submissions the Committee received during their 2014-15 consultation process, the Committee decided to address end-of-life care in a stand-alone report released in May 2016 entitled *Improving End-of-Life Care for British Columbians*.

This final report summarizes the information, ideas and suggestions the Committee received in relation to the Committee's three remaining areas of inquiry: rural health care and recruitment; interdisciplinary teams; and enhancing the effectiveness of addiction recovery programs.

Presentations and Written Submissions

Representatives from the Ministry of Health provided a briefing to the Committee on May 13, 2015 about current initiatives related to strengthening physician services for rural health care in B.C. Ministry officials noted that the need to recruit and retain health care providers in rural, remote and isolated communities is still a major concern. Presenters highlighted a number of strategic priorities, including the need to establish a coherent and sustainable approach to delivering rural health services, develop Community Service Plans, and promote increased use of integrated and interdisciplinary virtual and co-located care teams. The Ministry of Health, the province's regional health authorities and the Provincial Health Services Authority also made a joint written submission as the Leadership Council in July 2016 which outlined improvements to rural service delivery, the use of interdisciplinary teams for addiction recovery programs and other approaches for improving patient health outcomes and reducing hospitalizations for moderate-to-complex health conditions through effective community services.

Representatives from the Canadian Centre on Substance Abuse (CCSA) were invited to present to Committee Members on July 4, 2016 as part of an expert briefing to provide a current overview of addiction recovery from a national perspective. Rita Notarandrea, CEO of CCSA, spoke about recent findings regarding Canadian addiction recovery efforts, targeted professional development models that encompass addictions and mental health curriculums in several provinces in Canada, the enactment in the United States of the *Comprehensive Addiction and Recovery Act of 2016*, and the development of a community recovery-oriented mapping manual by Public Health England.

During their 2014-15 and 2016 consultation processes, the Committee heard from a total of 64 presenters who attended the Committee's 12 public hearings and received 211 written submissions on the topics of rural health care and recruitment, interdisciplinary teams, and enhancing the effectiveness of addiction recovery programs.

Full lists of presenters and written submissions are available in Appendices A and B.

Presentations and written submissions received by the Committee are available on the Committee's website: <https://www.leg.bc.ca/cmt/health>

Meetings Schedule

Note: Meetings schedules for the previous Sessions are available in Appendix E.

5th Session

<i>Date</i>	<i>Type</i>	<i>Location</i>
March 31, 2016	Organizational Meeting, Deliberations	Vancouver
May 2, 2016	Deliberations, Adoption of First Report	Victoria
May 11, 2016	Business Planning	Victoria
July 4, 2016	Briefing, Public Hearing	Victoria
July 5, 2016	Public Hearing	Prince George
July 6, 2016	Public Hearing	Kamloops
July 7, 2016	Public Hearing	Vancouver
July 8, 2016	Public Hearing	Vancouver
July 12, 2016	Public Hearing	Vancouver
November 28, 2016	Deliberations	Vancouver
December 9, 2016	Deliberations	Vancouver
January 17, 2017	Deliberations	Vancouver
February 10, 2017	Deliberations, Adoption of Final Report	Victoria

6th Session

<i>Date</i>	<i>Type</i>	<i>Location</i>
February 27, 2017	Organizational Meeting	Victoria

Part I – Rural Health Care and Recruitment

Introduction

Rural British Columbia's share of the overall provincial population has been steadily declining over the last several decades. According to the 2016 census, approximately 14 percent of British Columbians live in rural areas, one of the lowest proportions in Canada. In addition, 14 percent of B.C.'s Aboriginal population lives in rural areas with another 25 percent living on reserve; the Aboriginal population also tends to be considerably younger than the non-Aboriginal population.¹

Regardless of where they live, British Columbians require and deserve access to quality health care services. However, with a population dispersed over a vast and varied geography, B.C.'s health care system faces many challenges in delivering health care services to the province's rural, remote and isolated communities. This is further exacerbated by difficulties with recruiting and retaining health care providers to work in these areas, and by the increased need for health care based on B.C.'s aging demographics. Developments in technology, alternative service delivery models, and other initiatives to address these challenges hold promise; however, additional solutions and resources are required to improve health care service delivery to British Columbians in rural, remote and isolated communities.

Committee Findings

Access to Health Care Services

Access to quality health care services remains a significant issue for many British Columbians in rural, remote and isolated communities. Provision of local services in many of these communities has declined as health care services are increasingly centralized, and as the local health care workforce ages and retires with no one to take their place.

British Columbians understand that not all services, particularly specialist services, can be provided in a rural environment in the same manner as in urban centres, nor do they desire a replication of an urban health care model. However, as the Squamish-Lillooet Regional District described in their written submission, "rural and isolated communities are under-resourced for many services...significant increases in resources and service provision across the board are necessary." A number of community organizations, local governments and individuals echoed

¹ BC Stats. Aboriginal Population in British Columbia: A Study of Selected Indicators for Off-Reserve and Urban Aboriginal and Non-Aboriginal Populations. (November 2011)
Available at: www.bcstats.gov.bc.ca/Files/809bbb0f-40a1-47bf-9a53-9cc1da60803f/AboriginalPopulationinBCAStudyofSelectedIndicatorsNovember2011.pdf

this statement, and called for an increase in a range of health care services and supports including physician and hospital services, mental health, preventative care, natal care, dental care, and addiction treatment.

Several submissions also highlighted that sustainable health care depends on access to home care, as well as assisted living and residential care to enable seniors to age in place. Aging in place refers to “having the health and social supports and services you need to live safely and independently in your home or your community for as long as you wish and are able.”² Seniors in B.C.’s rural, remote and isolated communities are often forced to leave their communities because they lack access to social supports, such as meal deliveries, to continue living independently in their own homes. When requirements for care change, assisted living and residential care may be unavailable or not offered in their communities. In other situations, seniors leave to be closer to primary and acute care services that are not sufficiently provided for in rural, remote and isolated communities.

Issues with access also extend to how British Columbians physically get to health care services. Organizations such as the Nelson Area Society for Health described the patchwork of transit services that currently exist and the inconsistency across neighbouring communities. Others mentioned the significant distances some residents have to travel in order to access health care in larger centres, which can be a significant barrier in the winter and cost prohibitive if individuals have to take time off work or pay for an overnight stay. The barriers are all the more acute for seniors and persons with disabilities. As Ed Staples of the B.C. Health Coalition and Support Our Health Care Society noted in his presentation to the Committee, “For people living in rural communities, access to health care services requires access to transportation. As our population ages, this requirement means a greater dependency on transportation provided by others. Public transportation service is limited, and for many elderly residents needing specialist care, an all-day trip to a regional hospital is a daunting proposition, not to mention the out-of-pocket costs that may be a significant hardship for some seniors.” Targeted investment in these areas could reduce burdens on the health care system.

Dr. Trina Larsen Soles, Co-Chair of the Advancing Rural Medicine Canadian Collaborative Task Force, and Transport Lead for the Rural Coordinating Centre of B.C., described how transportation issues also present challenges for health care providers trying to refer or transfer a patient to other health care services, particularly for higher levels of care. In these situations, time is often a critical factor for successful outcomes, and challenges with patient transport frustrate health care providers trying to deliver timely, appropriate care.

² Government of Canada, Federal/Provincial/Territorial Ministers Responsible for Seniors Forum. Thinking about aging in place. (2012) Available at: <https://www.canada.ca/content/dam/esdc-edsc/documents/corporate/seniors/forum/place.pdf>

Key to improving health and health care services in rural British Columbia is facilitating access to these services through affordable and accessible transportation or transit services. Committee Members expressed concerns about the loss of core health care services and recognized the need to increase the provision of these services, as well as other health care supports, in rural, remote and isolated communities. The Committee further acknowledged that a lack of sufficient transportation services can result in inequities in access to health care services, and view improving transportation as critical to improving access.

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

1. Expand access to health care in rural, remote and isolated areas with a full suite of health care services, including, but not limited to: acute care; home supports; respite care; mental health and addictions services; counselling; specialists; testing or imaging; preventative and rehabilitative care; and cardiac, surgical, maternity and pediatric care.
 2. Expand or provide transportation options that are accessible, affordable and readily-available to enable access to health care, including ground, air and water transportation, as well as public transit and shuttle bus options.
 3. Support aging in place through increased home supports, and assisted living and residential care spaces.
-

Rural Health Care Models, Funding and Compensation

Improving access not only requires a targeted increase in resources and services, it also requires examining the delivery of these resources and services to ensure they are cost-effective and efficient. Many submissions detailed the unique characteristics of rural communities, and how these characteristics necessitate the development and implementation of specific service delivery models to better meet the needs of rural residents.

Innovative models for delivering health care in rural, remote and isolated areas do exist, however additional provincial support is required to implement them. Examples brought forward to the Committee include:

- Mobile health units: individual health care providers or teams of providers travel or rotate through communities to provide specialist services, accessible diagnostic and screening clinics, pharmacy services and more.
- Community paramedics or expanded emergency medical services: paramedics provide a broader range of community-based, non-emergency care in the home and the community.
- Inter-/multi-disciplinary teams: a range of health care providers (e.g. physicians, nurses, allied health professionals, health care aides, etc.) work together to provide primary and community care.
- Nurse practitioner (NP) models: NPs provide some of the primary or residential care delivered by physicians in their own stand-alone, independent NP practice, or as a complementary aspect of a physician's practice.
- Telehealth and telemedicine: telephone and internet-based technologies can be used to link residents and health care providers in rural, remote and isolated communities to specialist and other health care services and expertise in larger centres.
- Rehabilitative or convalescent spaces: intermediate support for individuals following a stay in hospital or treatment before they transition back into their homes and communities.

Rural, remote and isolated communities may need any one or a combination of health care delivery models to facilitate better access to health care services. To support and enable these alternative models, the health system's funding and compensation models also need to change. This could include the use of population-based, salary-based or blended funding models, changes to the billing system to account for services provided via technology, and the development of payment systems specific for NPs.

Many submissions and presentations drew particular attention to the potential for filling gaps in services with NPs and the challenges with realizing that potential. The Association of Registered Nurses of British Columbia (ARNBC) explained that a number of impediments prevent the full utilization of NPs, stating that, "Most British Columbians cannot access a nurse practitioner, who are most frequently hired by [regional] health authorities to work with marginalized populations and cannot take on patients outside of that base. Because funding mechanisms are not in place, and legislation that would enable NPs to work to full scope is not in place, British Columbia is unable to take advantage of the competent care these well-educated individuals can provide."

Health care service delivery in rural, remote and isolated areas of the province needs to be more flexible to better meet specific local demands. No single model or solution is going to improve health care services in rural B.C. Rather, regional health authorities, the First Nations Health Authority, and communities require a range of solutions and actions to implement health care models suited to the unique needs of each community's population. Committee Members recognized that the province's funding and compensation systems currently limit flexibility to facilitate the adoption of alternative models.

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

4. Increase the use of alternative models of health care delivery, including interdisciplinary teams, fully-accessible travelling diagnostic and screening clinics, mobile health units, and expanded use of nurse practitioners, nurses and midwives.
 5. Expand Emergency Medical Services (EMS) and community paramedic programs to enable paramedics to provide other health services, in addition to emergency services, in remote, rural and isolated communities.
 6. Establish rehabilitative or convalescent spaces to support individuals transitioning back into their communities.
 7. Implement alternative compensation models, including salary, population-based funding or other blended funding models, to support new ways of delivering health care, such as the increased use of interdisciplinary co-located teams.
 8. Increase flexibility in physician billing to support different models of health care delivery, including in-person, telephone or videoconferencing options.
-

Workforce and Education

A sustainable, accessible and high-quality health care system depends on an effective and engaged workforce. Rural areas tend to experience a shortage of health care workers due to challenges in recruitment and retention, and gaps in the supply of health care providers.

One trend that has contributed to this shortage is increasing specialization within the medical field and the loss of generalist practice. The Committee heard from a number of presenters, including Dr. Stefan Grzybowski from the Centre for Rural Health Research at the University of British Columbia, that a generalist practice, with linkages to specialist services via technology,

is key to providing appropriate care in rural communities. While the linkages to specialist services can be arranged with infrastructure and technology investments, educational institutions also need to better incorporate rural placements into generalist practice and medical curriculums.

Shortages in several provider groups leave rural residents without access to much-needed services, particularly for rehabilitative or preventative care and primary care. These shortages could be addressed by greater collaboration with educational institutions to ensure an adequate supply of health care providers in rural areas, as well as by streamlining the qualifying and approvals process for integration of foreign-trained health care providers, and incenting these groups of health care providers to work in rural B.C.

The Committee also received a number of suggestions aimed at encouraging health care providers to work in rural, remote and isolated communities, such as promoting the lifestyle and professional benefits of working in these communities. They also heard about some of the drawbacks to certain inducements, such as financial compensation in exchange for years of service, where the incentives only provide temporary solutions as health care providers often leave once the service agreement has been fulfilled.

Many submissions advocated encouraging rural British Columbians to pursue careers in the health care field, and that distribution of medical education across the province might be a way to encourage entry into this field. Proponents pointed to research which demonstrates that individuals who are from rural, remote and isolated communities and are trained in the health care field are much more likely to return to their communities. The Committee heard about a number of initiatives undertaken by educational institutions and regional health authorities to expose young people living in rural B.C. to the health care field. One example was a health care travelling road show in the north organized by the University of Northern British Columbia and University of British Columbia Northern Medical Program. As Dr. Sean Maurice described to the Committee, the road show consists of a team of health care students from a range of fields (medicine, nursing, physiotherapy, midwifery, dentistry and others) travelling to communities to deliver short presentations and host small group interactive sessions about their respective professions. Not only does this program expose youth in the communities to the health care field as a potential career choice, it also provides the health care students with exposure to rural environments. Tours of local facilities and informal get-togethers with local leaders are also part of the experience.

The First Nations Health Council and the First Nations Health Authority also identified recruiting health care providers from First Nation communities as a long-term solution to ensuring an adequate health care workforce within First Nations communities. They explained that, "First Nations health professionals are more likely to have a desire to work with First Nations peoples, and also have a historical, cultural and lived understanding of being a First

Nation person.” The First Nations Health Council, the First Nations Health Authority, and other organizations and individuals, further emphasized the importance of cultural understanding through the inclusion of holistic health care approaches and cultural competencies in the training and education of all health care providers.

In addition to developing capacity from within rural, remote and isolated communities, existing health care providers in rural areas need to be better supported. The Committee heard how improved employee engagement through mentorship and professional development are key drivers of job satisfaction and competency development. Work hours and scheduling practices must also be re-examined as younger professionals, particularly physicians, place a greater emphasis on work-life balance, and do not desire to work the long hours that have been typical of the profession. Other providers seek more stable schedules and full-time work with several submissions sharing anecdotes about the challenges and unsustainability associated with casual or part-time work assignments, which are common to health care positions in rural areas.

Another means to recruit and retain health care providers in rural, remote and isolated communities is to better share the professional and lifestyle benefits of being in smaller communities, as well as provide these workers with better support and integration into their new communities. Many submissions highlighted that health care workers in rural areas have the opportunity to work to their full scope of practice as they may be one of only a few health care providers, or the only health care provider, in the area. In terms of lifestyle, health care providers in rural areas can become part of small, tight-knit communities and have access to recreational opportunities in some of the province’s most beautiful natural environments.

Workforce challenges are clearly complex and require action in multiple areas involving educational institutions, communities, health authorities and the provincial government. Committee Members recognized the efforts of communities to address these challenges, and expressed appreciation for the numerous suggestions and examples brought forward to develop and expand the health care workforce in rural, remote and isolated communities. More needs to be done to expose health care students to rural medicine and practice, as well as to attract prospective health care workers from rural areas. Opportunities also exist to better recognize equivalencies and streamline the qualifying and approval process for foreign-trained health care providers, provided that the province and educational institutions continue to ensure foreign-trained health care providers have the appropriate training and education required. Making adjustments to schedules or positions, and improving employee engagement through professional development, may assist in attracting health care providers to work in rural areas. Committee Members also felt that that the province, communities, and health authorities should draw on intrinsic motivations to recruit and retain health care providers by highlighting the many positives of developing a career and living in these rural,

remote and isolated communities, such as lifestyle benefits and opportunities for a more diverse professional experience.

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

9. Incorporate rural practice and generalist models of care in education and training curriculums, and work with post-secondary institutions to increase the overall provision of education for doctors, nurses, allied health and other health care providers across the province, including increased seats in programs where shortages have been identified.
 10. Encourage British Columbians from rural, remote and isolated communities to pursue health-related careers, and provide increased support for professional development for existing rural health care providers.
 11. Work with communities to promote the professional and personal benefits of living and working in rural B.C., and improve scheduling and work assignments to create a stable health care workforce in rural, remote and isolated areas of the province.
 12. Accelerate the qualifying and approval process for integrating foreign-trained health care providers to work in British Columbia.
-

Infrastructure and Technology

Health care services and providers rely on an array of infrastructure and technology. Health infrastructure is typically associated with the physical facilities that British Columbians use to access health care services. These facilities, including hospitals, clinics and residential care homes, often symbolize the heart of a community, especially in smaller communities. The Committee received several submissions which noted that rural health care facilities need to have the appropriate resources, equipment and machinery to provide quality care.

In addition, some submissions and presentations discussed opportunities to use existing health and other public infrastructure more creatively. For example, clinics could be housed in schools or child care services could be provided in residential care homes. In doing so, multiple needs could be met, while maximizing the efficiency of existing and sometimes underutilized infrastructure.

Similarly, technology offers innovative solutions for access to health care services and the management of health information. However, high speed internet infrastructure is lacking or inadequate in many rural, remote and isolated communities, making the use of initiatives such as telehealth difficult or impossible to implement. In addition, information management and electronic medical records systems typically lack compatibility across information technology systems and health authorities. Technology initiatives sometimes do a poor job of incorporating end-user (typically the health care provider) needs and requirements into new systems, and appropriate end-user training may not always be delivered.

The Committee acknowledged the importance of health care facilities in the provision of care and discussed the advantages of using public infrastructure to its fullest potential. Committee Members shared the optimism expressed by participants for technology's ability to improve access and information management, and noted the challenges and issues associated with the adoption of any new technology. Committee Members were pleased to hear about the December, 2016 ruling from the Canadian Radio-television and Telecommunications Commission (CRTC) which declared high-speed internet a basic telecommunications service and welcomed the federal and provincial governments' anticipated targeted investments to expand broadband services in remote regions of the country.

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

13. Leverage existing public infrastructure, such as hospitals, schools and residential care facilities, to provide co-located health and social services.
14. Improve virtual connectivity with health services, and partner with relevant stakeholders to implement innovative health technologies in rural, remote and isolated communities.

Health and Wellness

The foundation of any health care system is rooted in the overall health and wellness of its population. A functioning and sustainable health care system can also help prevent or mitigate the need for ongoing health care services in some cases.

A common sentiment in a number of submissions was the need to encourage and support British Columbians to adopt and maintain healthy lifestyles. Suggestions for promoting health

and wellness included access to nutrition workshops, incorporating health programs in the K-12 curriculum, and partnering with municipal governments and local communities on wellness initiatives. One submission mentioned building more recreation infrastructure to specifically support younger British Columbians. Dr. Richard Mathias, from the University of British Columbia's School of Population and Public Health, shared a study on improved health outcomes resulting from lifestyle interventions in rural B.C., including dietary or nutrition-based changes and increased physical activity.

Supporting health and wellness is an essential component of improving health care and long-term health outcomes for British Columbians. Committee Members discussed the vital role of local communities in promoting and maintaining a healthy lifestyle, and the initiatives many communities have undertaken in partnership with municipal governments to improve general health and wellness among citizens. Committee Members shared concerns about a lack of physical activity, particularly among youth, and agreed that if British Columbians adopt and maintain healthy practices from the time they are young and have access to wellness supports as they mature and age, some of the future pressures on our health care system could be mitigated.

Recommendation

The Committee recommends to the Legislative Assembly that the provincial government:

15. Provide increased access to health and wellness supports, such as nutrition workshops, fitness and recreation facilities and prescriptions for exercise, in collaboration with federal and municipal governments and local communities, in order to promote and encourage healthy living and self-care.

Community Input

A common theme throughout the submissions received from rural residents was that decision-making processes did not account for their voices and perspectives.

In his presentation to the Committee, Ron Hood of the Ashcroft and Area Community Resources Society stated that "The problem...began with the creation of the super regions. There are lots of compelling reasons for that super region, of course, but what happened as a result of them is they took the rural communities completely out of the picture. All of the decision-making and planning was centralized into a few small or a few urban centres." As a result, rural residents feel that health care service delivery in their communities lacks a clear

understanding of local issues. Echoing this perspective, other rural organizations and residents called for mechanisms to allow for ongoing local input so as to inform discussions and decisions on health care services to reflect the concerns and needs of local communities.

Committee Members agreed that decision-making processes and policy development should be improved to include more community input, including the opportunity for communities to identify their local needs or concerns and collaboratively develop solutions. Residents are appropriately positioned to provide regular input, feedback and perspectives on the experiences and needs of their communities, and the value of this information should not be overlooked.

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

16. Broaden opportunities for communities to collaborate with health authorities to identify local needs and concerns and develop solutions through mechanisms such as community advisory committees.
17. Promote the wider application of a rural lens in the development of all health care policies, programs and initiatives.

Part II – Interdisciplinary Teams

Introduction

British Columbia's health care system is comprised of thousands of health care providers, as well as non-clinical staff, administrators and informal caregivers, working across a range of disciplines to deliver high quality health care. In addition to physicians, British Columbians may interact with registered nurses, nurse practitioners, physiotherapists, pharmacists, health care aides, midwives and many other health care providers during the course of their lifetime.

Within primary and community care, the benefits of collaborative approaches to health care delivery are becoming increasingly recognized. This coordinated approach to health care contributes to the sustainability of the health care system through the provision of quality care, improved access and patient outcomes, and integrated and efficient service delivery. While several models of collaborative care or interdisciplinary teams currently exist in B.C., barriers to wider implementation within primary and community care persist. Further measures need to be taken to facilitate the adoption of interdisciplinary teams, particularly in relation to the health care workforce, scopes of practice, funding and compensation, information management and technology, and ongoing quality improvement.

Committee Findings

Primary and Community Care Models

Interdisciplinary teams can include any number and combination of health care providers working collaboratively to deliver complementary health care services. Providers could be working together within a physical setting, such as a clinic, or coordinating across a network of physical or virtual settings, or any combination thereof.

Many submissions outlined the advantages of interdisciplinary teams in primary and community care settings. Interdisciplinary teams increase the capacity of existing providers by allowing care to be shared or distributed amongst several providers. Collaborating across disciplines also allows for a more holistic and complementary approach to care as providers work toward common goals while adhering to coordinated patient care plans. Patients therefore receive more appropriate care as they are referred to additional health care providers who are better suited to help address their individual health care needs. Interdisciplinary teams also improve access as patients are able to connect to a team of providers where the primary connection does not always need to be a physician.

In their submission, the Hospital Employees' Union described the importance of team-based care in both community care and residential care settings, and the importance of including all health care providers within the team. They noted that the majority of direct care nursing in residential long-term care is provided by care aides; however, the organizational culture in residential care settings prevents care aides from being a formal part of health care teams. Given their regular interaction with residents in assisting with daily activities, care aides, as well as dietary workers, housekeepers and other staff are well-positioned to be included as valued members of the health care team.

Organizations such as the Professional Association of Residents of British Columbia (PARBC) also identified interdisciplinary teams as a model to support the management of chronic, complex diseases. As they explained, "[a] significant proportion of health care expenditures in Canada is directed towards management of chronic disease. Provision of appropriate, timely and accessible care continues to be a challenge... Evidence demonstrates that developing inter-disciplinary community based teams and programs to support patients with chronic diseases in caring for their health leads to improved health outcomes". They also stated that the "comprehensive scope of inter-disciplinary teams in caring for patients with chronic disease helps to ensure a holistic approach to health care."

One common interdisciplinary team model in B.C. is the community health centre (CHC). The British Columbia Federation of Community Health Centres (BCFCHC) describe CHCs as "comprehensive, integrated primary health care organizations that bring health care providers like family physicians, nurse practitioners, nurses, dietitians, therapists and others out of isolation to work together in collaborative, interdisciplinary teams." Moreover, "CHCs integrate interdisciplinary care teams with health promotion programs, social supports and community programs that emphasize illness-prevention, wellbeing and local socio-economic development." The BCFCHC shared that CHCs in B.C. suffer from a lack of coordinated planning and funding, and opportunities exist to implement more CHCs in communities across the province.

The Committee also heard from Dr. Danièle Behn Smith from the Ts'ewulhtun Health Centre's Slhexun sun'ts'a clinic. The clinic uses a "teamlet" model, "comprised of a range of health care providers, to provide functional medicine care based on Hul'qumi'num teachings." According to Dr. Smith, "functional medicine is a personalized, systems-oriented model that empowers patients and practitioners to achieve the highest expression of health by working in collaboration to address the underlying causes of disease" and "promotes culture safety and humility in practice." Dr. Smith noted that in the teamlet model, each patient is assigned a "health coach", typically a licensed practical nurse (LPN), who acts in a navigator-like role to provide assistance or support, monitoring and follow-up for the patient as they journey through the health care system. Health care providers in the clinic use a holistic, client-centered approach to understand a patient's history and develop a care plan suited to the

patient's needs. Moreover, the clinic provides ongoing follow-up and support to promote continuity of care and efficiency. Dr. Smith encouraged the Committee to take a closer look at the teamlet model, and consider its replication to provide similar benefits in other communities.

In addition to the many examples of models of interdisciplinary teams, the Committee also heard that government should be working towards the provision of 24/7 access to primary, home and community-based care. Whether connected to an individual primary care physician or a team of providers, British Columbians often only have access to those providers during scheduled office hours, and may need to resort to emergency rooms for care outside of office hours. In her written submission, Marijke Henkemans referenced a model in the Netherlands that provides after-hours medical care. The submission outlined how general practitioners in the Netherlands work together in call-groups, and patients in need of after-hours medical care are directed to an on-call physician or clinic.

Committee Members discussed the benefits of interdisciplinary teams in primary and community care, particularly as it relates to improved health outcomes. Different communities have different needs as evidenced by the variety of successful team models the Committee heard about. Committee Members agreed with many of the submissions and presentations regarding the importance of allowing for a range of models, so that team structures and composition can be customized to meet the needs of patients and communities. The Committee also discussed including social service providers in interdisciplinary teams, given the existing linkages between health care and social services.

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

18. Implement a range of team-based, scalable and customizable interdisciplinary primary and community care models based on communities' needs, including the integration of health and social services, where appropriate.
19. Implement a community health centre model of care, comprised of co-located interdisciplinary teams, including a physician or nurse practitioner, and other health care providers.
20. Set clear targets to ensure 24/7 access to primary, home and community-based care as a standard of practice.

21. Improve health care coordination across interdisciplinary teams to treat common chronic conditions, expand preventative care, and to motivate patients to proactively manage their own health and wellness.
-

Professional Development and Workforce Planning

While a range of interdisciplinary models of primary and community care exist, developing and implementing them depends on the provision of health human resources. Many different types of health care providers have the potential and ability to be integral parts of interdisciplinary teams, and to offer the care and services required by British Columbians.

The Physiotherapy Association of British Columbia and the Canadian Association of Occupational Therapists – B.C. Chapter illustrated the value their respective professions bring to patients and how their practice can complement and enhance a team-based model of care. The demand for physiotherapy and occupational therapy has grown, however supply has not kept pace with demand and it was noted that shortages are particularly problematic outside of the Lower Mainland.

To facilitate the successful implementation of interdisciplinary team care models, health care providers need to be supported and encouraged to engage in these models. The Committee heard from many health care provider organizations who supported the use of interdisciplinary teams and the involvement of their provider groups within these teams. These organizations identified a lack of training on collaborative care, and a lack of awareness of the roles and scope of practice of health care providers as key barriers to team-based care.

Addressing these barriers begins with integrating collaborative care into training curriculums, and providing students with experiences in alternative team structures and models during their training. Dr. Louise Nasmith, Associate Provost Health at the University of British Columbia (UBC) emphasized this point in her presentation to the Committee, and shared some of the ways in which UBC is incorporating inter-professional education within its medical programs. Dr. Nasmith explained that education in collaborative care also extends to practicing health care providers and helping them learn to work together. Several other submissions similarly discussed the importance of team members to develop a shared culture of collaboration based on common principles of patient-centered care, respect, teamwork, flexibility and autonomy.

The Committee was pleased to learn that many health care provider groups are interested in being part of interdisciplinary teams, and discussed the use of physician assistants alongside other health care providers within interdisciplinary teams. Committee Members

acknowledged the challenges of building an appropriate interdisciplinary health care workforce and felt that health human resource planning needs to better incorporate the full range of health care providers in the province, especially if primary and community care is going to further integrate team-based models of care. Committee Members also discussed the importance of training and education to facilitating team-based care, and the need to encourage health care teams to adopt mutually agreed-upon principles of collaboration.

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

22. Develop and implement a comprehensive, long-term health human resources plan that includes the entire range of health care providers to address current and future health care needs.
 23. In developing any health human resources plans, consult with a broad range of stakeholders including professional associations, academic institutions, unions, and licensing authorities that represent regulated and non-regulated health care providers.
 24. Support and fund inter-professional education and interdisciplinary training, including cultural competencies, for all health care providers in order to promote collaborative, team-based care and alternative leadership structures.
-

Scope of Practice

According to the BC Ministry of Health, “scope of practice statements are the concise descriptions, in broad, non-exclusive terms, of each regulated profession's activities and areas of professional practice. These statements describe in general what each profession does and how it does it. They are not exhaustive lists of every service the profession may provide, nor do they exclude other regulated professions or unregulated persons from providing services that fall within a particular profession’s scope of practice.”

Many submissions described the underutilization of the skills and competencies of health care providers such as nurses, midwives, pharmacists and care aides. These submissions suggested that health care providers be permitted to work to their full scope of practice so interdisciplinary teams can be efficient and effective, and able to perform to their maximum potential. In some cases, existing policy, regulations and legislation do not permit some health

care providers to provide specific services even though their training and education may support it.

Health care providers should be able to work to their full scope of practice and where appropriate, changes should be made to support providers to maximize their knowledge, skills and experience. Conversely, Committee Members expressed concerns about expanding the scope of practice of any health care provider and recognized the corresponding funding implications. The Committee cautioned that expansions must be rooted in training and evidence, and most importantly, be beneficial to patients in attaining positive health outcomes.

Recommendation

The Committee recommends to the Legislative Assembly that the provincial government:

25. Amend policy, regulations and/or legislation to ensure that the skills of all health care providers are utilized to the fullest extent possible, and allow funding flexibility to support expanded scopes of practice.

Funding and Compensation

Part of supporting health care providers to adopt interdisciplinary care team models is re-examining how the health care system funds and compensates providers in the delivery of health care services. The present system, and particularly the fee-for-service model for physicians, is viewed by many as a significant barrier.

Several submissions suggested making adjustments to existing funding and compensation models to facilitate team-based care. For example, permitting physicians to delegate certain tasks and authorities to other health care providers, and accounting for this in the compensation model, would allow other health care providers to take a role in a physician-based practice, freeing physicians to focus on the most critical priorities.

Other organizations and individuals questioned how funding is distributed and allocated, and advocated for more fundamental changes. The Committee heard that B.C.'s funding and compensation systems need to be more flexible in order to encourage creativity and innovation in incorporating team-based care in primary and community care service delivery models, while ensuring that health care providers working in teams are appropriately remunerated. Submissions described several alternative funding and compensation models

such as alternate payment plans, population-based funding, enhanced fee-for-service, block funding and others that may better suit interdisciplinary team models.

In support of this, Doctors of BC suggested that long-term funding and resources be dedicated to interdisciplinary care including “the removal of financial and administrative barriers to incorporating allied health care providers within physician offices.” They further state that funding models must be “flexible enough to accommodate variations in population health needs.” The British Columbia Nurse Practitioner Association (BCNPA) identified the lack of a sustainable funding model for nurse practitioners as a significant barrier to their integration in the B.C. health care system. The BCNPA, along with other presenters, drew attention to the significant role nurse practitioners could play as either interdisciplinary team members or leaders, and the need for flexible funding models to support the increased use of nurse practitioners in our health care system.

On a separate funding note, the Committee also received requests for capital funding for community health centres. Submissions outlined the demonstrated positive outcomes of community health centres, such as the ease of access to interdisciplinary teams, centralization of interrelated services, and the cost savings of sharing a facility and administrative supports. Increased capital funding for this purpose could improve interdisciplinary care for British Columbians.

The province’s funding and compensation systems need to better facilitate the development of interdisciplinary team health care models. In recognition of the impending pressures on the health care system as B.C.’s population ages, the Committee expressed their view that primary and community care, and the development of interdisciplinary teams within those two settings, are critical to reforming the health care system and ensuring British Columbians receive ongoing quality care. Committee Members discussed the February, 2014 report by B.C.’s Office of the Auditor General called “Oversight of Physician Services” which outlined six recommendations aimed at improving the oversight of physician services, including rebuilding the compensation model to align with the delivery of high-quality, cost-effective physician services.

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

26. Develop and implement alternative flexible funding and compensation structures for health care providers, including nurse practitioners, in order to encourage the adoption of innovative primary and community care models.

27. Provide adequate operational and capital funding for new and existing community health centres throughout the province.
 28. Provide consistent evaluation of health care outcomes to increase accountability and ensure the sustainable delivery of high-quality, cost-effective services, and value optimization in relation to health care funding.
-

Information Management and Technology

Another essential component to supporting interdisciplinary teams is information management and technology. The ability to share information seamlessly across platforms and networks enables efficient communication between team members, as well as improved continuity of care for patients. It also helps address a common complaint voiced by patients when they are asked to repeatedly relay their health history, information and issues to each health care provider they may interact with.

Many submissions and presentations asserted that health care providers should have access to a common electronic medical record (EMR) where each patient has one record, and EMRs should be compatible across health authorities with the ability for patients to access their own records. Moreover, as the College of Pharmacists of British Columbia explained, "If all health care providers on a team were documenting in a common system, outcomes could also be easily evaluated since all relevant information would be recorded and accessible. As a medium for electronic information sharing, a common EMR could save a lot of time and effort than the current system, where duplicate efforts are spent on acquiring information."

Additionally, many submissions highlighted the role of innovative technologies in fostering interdisciplinary teams, particularly as it relates to virtual teams. While it may be difficult to house a group of health care providers representing many disciplines in one physical setting, they can still be connected to each other and patients using a variety of internet and telephone-based technologies. The Rural Shuswap Health Services Network noted that creating and better utilizing virtual health care teams is especially helpful for rural, remote and isolated communities. While implementation of these technologies is hindered by inequitable connectivity across the province, they hold significant promise for facilitating improved team-based care for patients, their families and caregivers.

EMRs are a central tool for enabling interdisciplinary teams to work effectively and efficiently, and ideally these records should be made available through a common system. At the same time, appropriate considerations and safeguards for privacy concerns need to be in place. The

Committee was interested to learn how new and innovative technologies are improving access to health care services.

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

29. Implement a province-wide electronic “one patient, one health record” model, and mandate compatibility across health authorities and related IT systems.
 30. Ensure a central role for end users of electronic medical records and health IT systems during the design, development, implementation and ongoing evaluation phases.
 31. Provide patients with secure access to their own medical records (electronic and hard copy) without charge.
 32. Accelerate the adoption of innovative health technologies to facilitate patient-centered, team-based care, and to enable secure access to health care services and information.
-

Quality Improvement and Reporting

To ensure interdisciplinary team models are working as intended, evaluating and reporting on outcomes is critical to help identify best practices and models suited for specific contexts so that successful innovations can be scaled up and deployed in other areas of the province.

Representatives from the College of Physicians and Surgeons of BC advocated for a provincial approach to managing and measuring primary care outcomes pointing out that it is “hard to improve things without measuring them.” In their submission to the Committee, Dr. Margaret McGregor and Dr. Sue Turgeon similarly encouraged ongoing comparative research and evaluation of primary care.

Existing and new models of primary and community care need to be monitored and evaluated on an ongoing basis. The Committee noted that Ontario has a robust system of measuring outcomes in their community health centres, and other areas of primary care, which allows government policy-makers to understand which models work best in different settings. The Committee agreed that evaluation and evidence-based decision-making are key to making sure that British Columbians receive quality health care while also ensuring that primary and community care models are accessible, cost-efficient and effective.

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

33. Monitor, formally evaluate, and report out on models of interdisciplinary, team-based care to identify and improve best practices, the overall quality of care and health outcomes.
 34. Mandate knowledge exchange within and between institutions, regional health authorities, and the First Nations Health Authority, to enhance the continuous cycle of assessment and improvement, and scale up effective service innovations.
-

Part III – Addiction Recovery Programs

Introduction

Addiction can affect British Columbians from all walks of life and it can have a significant impact on health, and impose economic and social costs on individuals, families and communities. According to the Canadian Centre on Substance Abuse, approximately 4.4 percent of Canadians meet the criteria for a substance abuse disorder and substance abuse costs the Canadian economy \$24.3 billion a year in lost productivity. In B.C., hospitalizations related to alcohol and drug addictions have increased steadily since 2010³.

Recent advances in scientific research show that addiction is a chronic disease of the brain that requires ongoing monitoring, support, and sometimes repeated intervention and treatment. Public opinion is slowly shifting to view addiction as an illness, and those who struggle with addiction as having a substance use disorder.

To yield positive, long-term outcomes for individuals living with addiction and their communities, provide supports for harm reduction, and to promote ongoing recovery, B.C.'s health care system needs to implement a holistic, multi-faceted and integrated approach to addiction recovery programs, aligned with evidence-based best practices. Part of this includes the need to continuously assess and improve the quality, accessibility and effectiveness of addiction treatment and recovery programs

Current Context

The current opioid crisis in Canada, and the rise of fentanyl use in British Columbia, continues to serve as a reminder of the potentially deadly consequences of addiction, and highlights the urgent need for responsive and coordinated action from all levels of government. The BC Coroners Service revealed that 914 people died of illicit drug overdoses in B.C. in 2016, which represents a 79 percent increase in overdose deaths compared to 2015. Chief Coroner Lisa Lapointe noted that "This is an illicit drug dependency crisis and it is not likely to be resolved anytime soon." In addition to the significant increase in the number of overdose deaths, other negative health impacts of increased illicit drug consumption continue to place prolonged and significant pressures on B.C.'s health care system. The newly-established British Columbia Centre on Substance Use will help address some of these issues as their work will focus on developing and strengthening the provincial system of care for people dealing with substance use disorder. While the Committee's consultations on health care sustainability began before the provincial opioid crisis reached its current level, Committee Members agreed that their

³ University of Victoria, Centre for Addictions Research of BC. Available at: www.uvic.ca/research/centres/carbc/stats/hospitalizations-and-deaths/index.php

deliberations and recommendations need to reflect the current context, as well as the submissions received during their consultations.

Committee Findings

Prevention and Early Intervention

Research shows that many adults with addictions first developed problems with addictive substances and behaviours in adolescence or young adulthood. The opportunity exists to offer education, information and awareness of the risk factors of substance use early in life, delivered through established school curriculums. Prioritizing increased general public awareness would ensure that everyone receives information about substance use throughout the course of their lifetime.

There are many underlying causes that can lead to addiction, including economic, physical and mental factors and other social determinants. Several presenters suggested the need for a provincial addictions strategy, and more funding to deliver cohesive and relevant prevention and early intervention information to British Columbians.

The Rural Shuswap Health Services Network highlighted the importance of promoting health and wellness, including age-appropriate information about the risks associated with substance use and dependence, to children in grades K-12. The Mental Health Commission of Canada noted that the implementation of good practices in prevention and early intervention during the early childhood development years could be scaled up. The British Columbia Council for Recovery Excellence echoed this sentiment and suggested an increased focus on early interventions for youth.

Reckitt Benckiser Pharmaceuticals (Canada) felt that careful monitoring and follow-up are critical when opioids, and other narcotics, are prescribed in the course of medical treatment for pain management. Committee Members also heard that there needs to be more public awareness regarding the dependencies that can develop in relation to pain medications.

Committee Members voiced their concerns about the risks associated with seniors developing addictions to prescription medications. According to the 2015 report by the Office of the Seniors Advocate (BC), "Placement, Drugs and Therapy... We Can Do Better", the inappropriate use of antipsychotic drugs for the 27,000 B.C. seniors living in nursing homes has decreased, but the use of antidepressants among such seniors remains high in B.C., compared to other provinces. The Committee discussed the need to ensure that overmedication of seniors does not occur, which in some cases, can lead to potential addiction issues. While the Committee chose not to make a specific recommendation related to their concerns, Committee Members would like to see further action taken to monitor this issue.

The Committee discussed the need to ensure that all health care providers are aware of the unintended consequences related to the over-prescription or prolonged use of medications for pain management, including opioids. Health care providers should also keep up to date on the programs, services and supports available for controlled withdrawal, detoxification and addiction treatments. While Committee Members acknowledged that those suffering with chronic or acute pain require appropriate treatment for pain management, they agreed that there needs to be much greater public awareness of the dangers of over-reliance on prescription medications for pain management. Committee Members expressed similar concerns about the over-prescription of antipsychotics or medications for mental illnesses, such as depression, and how, in some cases, this may lead to addiction. The Committee considered expanding or replicating existing education and awareness programs in community-based settings.

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

35. Develop and implement a cohesive provincial strategy for addictions to address the underlying causes and factors that can impede recovery.
 36. As part of the K-12 health and wellness programming, provide age-appropriate information to children and youth regarding the health risks associated with substance abuse and dependence.
 37. Increase public awareness and education for health care providers regarding the use of prescription medications for pain management, and provide appropriate supports for those who become addicted to pain medication prescribed in the course of medical treatment.
-

Funding and Access

While government budgets represent finite resources, how funding is applied to various programs, services and supports needs to be regularly examined to ensure that the health care system is working well to meet the diverse needs of B.C.'s citizens. One way to monitor the performance of the health care system and to ensure evidence-based decision-making is through ongoing data collection, analysis and reporting. Adjustments can then be made as required to ensure optimal performance and positive health outcomes for British Columbians.

The Committee heard about a wide range of addiction recovery programs, both secular and non-secular in nature. Submissions from the Campbell River North Citizens for Quality Health Care and Peace River Regional District, among others, noted the benefits of having a variety of treatment options available so that each individual can create an individualized program that best suits their needs as part of a holistic patient-centered approach to care. Several submissions noted that a health care system that can respond to the varying degrees of severity associated with harms related to substance use is needed.

Presenters noted the importance of ensuring a continuum of care for addiction by ensuring quick and easy entry into a recovery program once someone has completed the detoxification process. The use of peer mentors – many of whom are living in recovery themselves – as a support mechanism in the recovery process is a successful model that could be expanded.

Committee Members stressed the importance of a robust provincial infrastructure to provide for the collection, analysis and reporting of data to ensure that prevention, treatment and recovery programs are operated and maintained to a high standard while adhering to established best practices. A seamless continuum of care related to addiction recovery must be in place so that individuals can move through the phases of detoxification, treatment, and recovery as they are ready to do so. The process of treatment and recovery can look very different for each individual, in terms of timelines and specific needs. A “one size fits all” approach will not work to provide positive and sustained outcomes, and the Committee discussed their desire to see increased funding for a variety of programs, services and supports that have demonstrated, evidence-based, long-term outcomes.

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

38. Increase funding for evidence-based addiction prevention and early intervention programs, including community and school-based programs.
39. Increase the number of available addiction recovery and treatment programs that have proven to be effective and that have demonstrated positive long-term outcomes.
40. Provide dedicated funding to facilitate ongoing community care for addiction, including the involvement of health care and social service providers, as well as peer counsellors and volunteers.

Professional Development and Training

British Columbians rely on health care professionals and providers to deliver services and supports to a diverse population with a wide range of needs dispersed over a varied geography. Ongoing training and professional development, particularly related to addictions medicine, is an important key to ensuring good health care for B.C.'s citizens. The use of interdisciplinary teams to deliver services and supports for those with addictions is an increasingly popular model. The "teamlet" model described on page 22 of this report that was created by the Ts'ewulhtun Health Centre's Slhexun sun'ts'a clinic, is one example of this.

Health care providers should receive specific training in addictions medicine and updated information about prevention, harm reduction, treatment and recovery programs. The Professional Association of Residents of British Columbians suggested promoting education in addictions medicine through mechanisms such as trainee scholarships and research grants in order to ensure there are more primary care health providers who specialize in addictions medicine to meet current and future demands. The First Nations Health Authority and First Nations Health Council outlined opportunities to strengthen and expand cultural competency training given to health care providers, including specific practices related to interactions with those from the LGBTQ+ community, newcomers and refugees, and people living with disabilities.

Committee Members recognized the unique challenges faced by health care providers who choose to specialize in addiction treatment and recovery. Committee Members discussed the importance of continuing to professionalize the roles of those that provide care in treatment and recovery programs. This can be done by ensuring that professional development and training opportunities are made available at educational institutions in diagnosing, treating and providing follow-through care for addiction. The Committee also discussed the need to ensure that health care providers are equipped with the necessary skills and knowledge to perform to the fullest range of their abilities within their scope of practice. Committee Members acknowledged the important work being done by emergency responders and health care providers who are working to provide care during the current opioid crisis and want to ensure that appropriate additional human resources, training, and support are provided for those working on the front lines.

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

41. Expand training in addictions medicine for all health care providers, particularly in the areas of: risk factors; prevention and early intervention; diagnosis; treatment and the

continuum of recovery options; harm reduction; cultural competencies; and trauma-informed practice.

42. Ensure that the full range of health care providers and first responders have the additional human resources, training, tools and supports that they require to respond effectively in addiction and overdose scenarios.
 43. Strengthen evidence-based guidelines, best practices, standards and accountability practices or measures for staff working in addiction treatment and recovery programs.
-

Services and Supports

The provision of services and supports play a key role in the continuum of care relating to addiction, regardless of where an individual may be in that process. Addiction is a complex specialty within the medical discipline, and treatment and recovery may take many forms. From prevention and early intervention, to detoxification and controlled withdrawal, treatment and recovery, or harm reduction, there are many paths available for those living with addiction.

Organizations such as The Last Door Addiction Treatment Centre, Support Our Health Care (SOHC) Society of Princeton, and the Centre for Addictions Research of BC, University of Victoria, emphasized the value of community-based programs, and noted that the long-term success of residential inpatient treatment depends on effective follow-up. Many of the most effective treatment and recovery programs rely on a holistic, integrated and patient-centered approach that provides individualized care delivered by an interdisciplinary team. Programs like this may include assistance with housing, income and employment, social and legal issues. Some individuals may also require specific care to address underlying vulnerabilities such as mental health issues or a history of trauma. Within a fully-integrated system, a person can access options according to their needs, strengths, and preferences.

The Centre for Addictions Research of BC, University of Victoria, noted that inpatient treatment is not the only option available to manage withdrawal symptoms, but that home-based detoxification programs may also be an option for some patients and a cost-effective one for the health care system. Several presenters noted the value of family or peer involvement as a means of support for those in treatment and addiction recovery programs, based on an individual's customized recovery plan, and particular home environment.

The cost of travelling long distances to access treatment in an urban centre can be prohibitive for many in rural, remote and isolated communities. Waiting to access withdrawal services can be a roadblock for those wanting to address their addiction. As noted by the Centre for

Addictions Research of BC, University of Victoria, “services need to be available when a person is ready.” The Committee heard about the financial barriers that can exist for some people to access both residential and community-based treatment and recovery programs, as well as how this can be particularly challenging for those who live in remote, rural or isolated communities where these services may not be available.

The Committee discussed the fundamental concept of addiction as an illness or chronic disease or condition that requires ongoing treatment, services and monitoring, as well as long-term support or follow up, much as any other illness or disease. Committee Members recognized the value of a system which provides a range of options through a seamless continuum of care model for those seeking to address their addiction, including detoxification programs, primary care, community addiction treatment programs, specialized mental health services, peer and volunteer supports, as well as related social services. Financial and geographic barriers need to be addressed so that all British Columbians can access services and supports regardless of their particular circumstances or where they live.

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

44. Significantly increase the number of detoxification, post-detoxification, treatment and recovery program beds to meet current needs, and allow clients to remain in these programs as required by their individualized recovery plans.
45. Significantly increase access to evidence-based residential and community-based services and supports to meet current needs as part of a seamless continuum of care model from detoxification to treatment through to ongoing recovery and long-term support programs.
46. Eliminate financial barriers that limit access to treatment and recovery programs and accommodate parental, family or caregiver support within these programs as appropriate.
47. Eliminate financial and geographic barriers for those living in remote, rural and isolated communities to access residential and community-based treatment, post-detoxification and recovery programs with assistance for travel costs.
48. Implement a holistic and multi-faceted approach to addiction recovery that includes integrated and individualized health care, as well as access to affordable housing and other community-based services and supports.

Mental Health

The Mental Health Commission of Canada notes that in any given year, one in five Canadians will experience a mental health problem or illness. Only one in three people who experience a mental health problem or illness — and as few as one in four children or youth⁴ — report that they have sought and received services and treatment. While these issues may not always present together, substance abuse, addiction and mental health issues can often be interrelated or co-existing for many individuals. A variety of treatment options within the continuum of care for those with multiple challenges needs to be available in order to achieve positive health outcomes for individuals.

Diagnosis of mental health issues can often occur in the teenage years or early adulthood. According to the Canadian Mental Health Association, BC Division's website, "About one in seven young people in B.C. (14%) will experience a mental illness at some point" and that between 50 to 70 percent of mental illnesses will begin to appear before the age of 18. Having services available to provide treatment and support for children or youth at this early point in their lives can make a significant difference in that individual's current and future quality of life.

In their presentation to the Committee, the College of Physicians and Surgeons of British Columbia stated that mental health and counselling services should be included as part of addiction care. The Union of BC Municipalities noted that mental health and addiction services should be multi-faceted and provided concurrently, in both rural and urban settings.

Interdisciplinary teams are an opportunity to offer a unified approach to those who require mental health and addiction services and supports concurrently, potentially in primary health care settings. The Committee discussed wait times for those requiring mental health and addiction recovery services and suggested the implementation of provincial standards, similar to other provincial wait time benchmarks already in place for hip replacement or cancer surgery. Committee Members agreed that provincial and federal governments should work together to increase targeted investments in mental health.

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

49. Work with federal counterparts to increase targeted investments in mental health.

⁴ For the purpose of this report, children and youth up to the age of 24 are referred to collectively as "children and youth".

50. Provide concurrent integration of mental health and addiction recovery programs and services in primary health care settings.
 51. Establish and work towards meeting acceptable standard provincial wait times for access to community mental health and addiction recovery services.
-

Public Education and Awareness

For those with a desire to seek treatment for their addiction, stigma, discrimination and stereotyping can be deterrents. Increased public education and awareness can help dispel misconceptions about addiction and recovery, and provide information about how addiction can affect people from many walks of life. The concept of recovery can take various forms and many individuals can have full and meaningful lives while living in recovery.

The Committee was interested to learn about the first annual Recovery Day Street Festival that took place in New Westminster in September, 2016 and how this event served to provide public education and awareness, and to celebrate those living in recovery. In their written submission to the Committee, the Professional Association of Residents of British Columbia highlighted opportunities to “support public education and promote awareness campaigns aimed at the de-stigmatization of addiction.” Similar suggestions were put forth by the First Nations Health Council and Peace River Regional District.

Public education is crucial to provide a better understanding of addiction and lessen negative biases. The Committee discussed how an increased public education awareness campaign could help promote a more positive perception of those living in recovery by shifting the focus to view addiction as a chronic illness.

Recommendation

The Committee recommends to the Legislative Assembly that the provincial government:

52. Provide more public education and awareness regarding addiction as a chronic illness to help diminish stigma and negative preconceptions about addiction and those living in recovery.
-

Youth

According to a 2013 B.C. Adolescent Health Survey administered by the McCreary Centre Society, 17 percent of youth have tried at least one substance other than alcohol or marijuana. With the availability of opioids increasing at a dramatic rate provincially, the need to provide age-appropriate education and information to children and youth takes on an urgent focus.

As an alternative to other possibly self-destructive coping mechanisms, youth require the skills and knowledge to help them develop resiliency to deal with the stresses that life may bring. Presenters from the First Nations Health Authority suggested the development of child and youth specific programming and prevention strategies, as well as options for treatment. Early intervention and education can help stop the escalation to addiction, mental and physical illness and social dysfunction that youth can face in their formative years. The Canadian Centre on Substance Abuse and the British Columbia Council for Recovery Excellence both noted that increased early interventions and more improvements to services and supports are needed for youth. Services need to be increased in remote, rural and isolated communities so that children and youth don't have to travel long distances to access treatment or recovery programs, often far away from family and their communities, which can, in some cases, impede the recovery process.

There are some good substance abuse education and awareness programs for children and youth already available, such as the "iMinds" program developed at the University of Victoria which is used to deliver drug and gambling literacy-related curriculums to students from grades 4-12. The Committee discussed the benefits of age-appropriate education and awareness campaigns for children in earlier grades and the benefits of ensuring that children and youth are equipped with age-appropriate self-regulation skills. These include emotional, cognitive, social and moral attributes, such as impulse control, sustained attention and an understanding of socially-desirable behaviours. Committee Members discussed the potential linkages that can exist between youth mental health issues and experimentation with illicit substances as a coping mechanism and the age discrepancies that exist in relation to what delineates a youth from an adult to access programs, services and supports. This issue could create gaps in service for youth, and in particular at-risk youth, or force youth to be placed in programs or to access services better suited to adults.

With the Agreements with a Young Adult (AYA), B.C. recently broadened the definition of youth to include those under the age of 26, with a view towards ensuring better support for youth transitioning out of government care. British Columbia's *Representative for Children and Youth Act* and the *Child, Family, and Community Service Act* both define "youth" as a person aged 16 – 19 years and "child" as a person under 19 years of age. Committee Members felt that these definitions may cause confusion and would like to see a broader definition of youth uniformly implemented to include anyone under the age of 24, and clearer definitions for

“child” and “youth” in relation to accessing services and supports. The Committee wants to see increased services, programming, and awareness or outreach campaigns for children and youth in relation to mental health, substance use and addiction, particularly for high-risk youth who are “aging out” of government care.

Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

53. Develop and implement a comprehensive, province-wide suite of programs for children and youth up to age 24, including awareness and education, prevention and early intervention, and significantly increase the number of treatment and recovery beds to meet current youth needs.
 54. Increase self-regulation skills in school programming to promote positive mental health for children and youth, and to mitigate against the development of mental health problems that can lead to mental or physical illness and potentially to addiction.
 55. Increase supports and services for high-risk youth, such as those “aging out” of government care.
-

Harm Reduction

According to the BC Centre for Disease Control, “harm reduction involves a range of support services and strategies to enhance the knowledge, skills, resources, and supports for individuals, families and communities to be safer and healthier.” A range of services can be provided to prevent harm from substance use, including: overdose prevention and response; supervised consumption facilities; impaired driving prevention campaigns; substitution injection treatment and therapies; needle distribution programs; and peer support and outreach services. Harm reduction is another area where flexibility and a diversity of offerings are fundamental to positive outcomes, which can mean different things to different people.

The Centre for Addictions Research for BC, University of Victoria suggested that “a full range of harm reduction programs and non-abstinence services to complement existing abstinence-based services should be established.” Echoing this, in their joint submission, the First Nations Health Authority and First Nations Health Council indicated that increased training in harm reduction techniques should be provided to those working in the support recovery sector, and

that the Assisted Living Registry should be updated to include information regarding which staff have completed harm reduction training.

At times, harm reduction can take on a more urgent focus. The College of Physicians and Surgeons of British Columbia and the British Columbia Pharmacy Association highlighted the need for an increased supply of, and wider access to, naloxone and other narcotic or opioid overdose treatments which can serve as a vital tool to save lives. The Committee also learned about the challenges faced by first responders and health care providers who attend to an individual in crisis or overdosing. They often do not have a range of options available for a more sustained approach to treatment and, if requested, are not able to offer entry into a detoxification program in a timely manner. An effective approach highlighted by a number of presenters is a model in which a variety of services are offered within a single facility. For instance, those that frequent Vancouver's Insite facility are able to access information about related health care services, including local treatment and recovery programs. Some presenters noted the positive health outcomes of managed alcohol programs as an alternative to abstinence-focused treatment and recovery programs.

Abstinence may not be a desirable or achievable final outcome for some who face challenges with addiction. Committee Members acknowledged the complexity of the topic of harm reduction, from legislative, political, and clinical standpoints, among others. Initiatives are underway whereby currently illicit substances or drugs are provided in a controlled environment and, within the context of social harm reduction, this may benefit not only individuals with addictions, but communities as well. The Committee recognized that the true costs of addiction are not limited to the health care system, but also extend into other areas such as the justice system, social services, housing and the economy, through lost productivity. New initiatives or programs need to be expanded, pending further study based on data collection and fulsome evidence that they are performing as intended. The Committee highlighted the need for a full range of harm reduction programs, services and supports throughout B.C.

Recommendations

56. Provide a full range of harm reduction programs, supports and services throughout B.C., including an increased supply of naloxone and opioid or other narcotic overdose treatments, safe injection or consumption sites, and needle exchanges.
57. Ensure those accessing harm reduction programs or seeking addiction services and supports can get into treatment and recovery programs in a timely manner.

58. Develop a public education and awareness campaign that highlights the importance of harm reduction within the context of social harm reduction.
 59. Support and expand evidence-based initiatives or programs for safe and controlled access to currently illicit substances.
-

Summary of Recommendations

The Committee recommends to the Legislative Assembly that the provincial government:

Rural Health Care and Recruitment

1. Expand access to health care in rural, remote and isolated areas with a full suite of health care services, including, but not limited to: acute care; home supports; respite care; mental health and addictions services; counselling; specialists; testing or imaging; preventative and rehabilitative care; and cardiac, surgical, maternity and pediatric care.
2. Expand or provide transportation options that are accessible, affordable and readily-available to enable access to health care, including ground, air and water transportation, as well as public transit and shuttle bus options.
3. Support aging in place through increased home supports, and assisted living and residential care spaces.
4. Increase the use of alternative models of health care delivery, including interdisciplinary teams, fully-accessible travelling diagnostic and screening clinics, mobile health units, and expanded use of nurse practitioners, nurses and midwives.
5. Expand Emergency Medical Services (EMS) and community paramedic programs to enable paramedics to provide other health services, in addition to emergency services, in remote, rural and isolated communities.
6. Establish rehabilitative or convalescent spaces to support individuals transitioning back into their communities.
7. Implement alternative compensation models, including salary, population-based funding or other blended funding models, to support new ways of delivering health care, such as the increased use of interdisciplinary co-located teams.
8. Increase flexibility in physician billing to support different models of health care delivery, including in-person, telephone or videoconferencing options.
9. Incorporate rural practice and generalist models of care in education and training curriculums, and work with post-secondary institutions to increase the overall provision of education for doctors, nurses, allied health and other health care providers across the province, including increased seats in programs where shortages have been identified.

10. Encourage British Columbians from rural, remote and isolated communities to pursue health-related careers, and provide increased support for professional development for existing rural health care providers.
11. Work with communities to promote the professional and personal benefits of living and working in rural B.C., and improve scheduling and work assignments to create a stable health care workforce in rural, remote and isolated areas of the province.
12. Accelerate the qualifying and approval process for integrating foreign-trained health care providers to work in British Columbia.
13. Leverage existing public infrastructure, such as hospitals, schools and residential care facilities, to provide co-located health and social services.
14. Improve virtual connectivity with health services, and partner with relevant stakeholders to implement innovative health technologies in rural, remote and isolated communities.
15. Provide increased access to health and wellness supports, such as nutrition workshops, fitness and recreation facilities and prescriptions for exercise, in collaboration with federal and municipal governments and local communities, in order to promote and encourage healthy living and self-care.
16. Broaden opportunities for communities to collaborate with health authorities to identify local needs and concerns and develop solutions through mechanisms such as community advisory committees.
17. Promote the wider application of a rural lens in the development of all health care policies, programs and initiatives.

Interdisciplinary Teams

18. Implement a range of team-based, scalable and customizable interdisciplinary primary and community care models based on communities' needs, including the integration of health and social services, where appropriate.
19. Implement a community health centre model of care, comprised of co-located interdisciplinary teams, including a physician or nurse practitioner, and other health care providers.
20. Set clear targets to ensure 24/7 access to primary, home and community-based care as a standard of practice.
21. Improve health care coordination across interdisciplinary teams to treat common chronic conditions, expand preventative care, and to motivate patients to proactively manage their own health and wellness.

22. Develop and implement a comprehensive, long-term health human resources plan that includes the entire range of health care providers to address current and future health care needs.
23. In developing any health human resources plans, consult with a broad range of stakeholders including professional associations, academic institutions, unions, and licensing authorities that represent regulated and non-regulated health care providers.
24. Support and fund inter-professional education and interdisciplinary training, including cultural competencies, for all health care providers in order to promote collaborative, team-based care and alternative leadership structures.
25. Amend policy, regulations and/or legislation to ensure that the skills of all health care providers are utilized to the fullest extent possible, and allow funding flexibility to support expanded scopes of practice.
26. Develop and implement alternative flexible funding and compensation structures for health care providers, including nurse practitioners, in order to encourage the adoption of innovative primary and community care models.
27. Provide adequate operational and capital funding for new and existing community health centres throughout the province.
28. Provide consistent evaluation of health care outcomes to increase accountability and ensure the sustainable delivery of high-quality, cost-effective services, and value optimization in relation to health care funding.
29. Implement a province-wide electronic “one patient, one health record” model, and mandate compatibility across health authorities and related IT systems.
30. Ensure a central role for end users of electronic medical records and health IT systems during the design, development, implementation and ongoing evaluation phases.
31. Provide patients with secure access to their own medical records (electronic and hard copy) without charge.
32. Accelerate the adoption of innovative health technologies to facilitate patient-centered, team-based care, and to enable secure access to health care services and information.
33. Monitor, formally evaluate, and report out on models of interdisciplinary, team-based care to identify and improve best practices, the overall quality of care and health outcomes.

34. Mandate knowledge exchange within and between institutions, regional health authorities, and the First Nations Health Authority, to enhance the continuous cycle of assessment and improvement, and scale up effective service innovations.

Addiction Recovery Programs

35. Develop and implement a cohesive provincial strategy for addictions to address the underlying causes and factors that can impede recovery.
36. As part of the K-12 health and wellness programming, provide age-appropriate information to children and youth regarding the health risks associated with substance abuse and dependence.
37. Increase public awareness and education for health care providers regarding the use of prescription medications for pain management, and provide appropriate supports for those who become addicted to pain medication prescribed in the course of medical treatment.
38. Increase funding for evidence-based addiction prevention and early intervention programs, including community and school-based programs.
39. Increase the number of available addiction recovery and treatment programs that have proven to be effective and that have demonstrated positive long-term outcomes.
40. Provide dedicated funding to facilitate ongoing community care for addiction, including the involvement of health care and social service providers, as well as peer counsellors and volunteers.
41. Expand training in addictions medicine for all health care providers, particularly in the areas of: risk factors; prevention and early intervention; diagnosis; treatment and the continuum of recovery options; harm reduction; cultural competencies; and trauma-informed practice.
42. Ensure that the full range of health care providers and first responders have the additional human resources, training, tools and supports that they require to respond effectively in addiction and overdose scenarios.
43. Strengthen evidence-based guidelines, best practices, standards and accountability practices or measures for staff working in addiction treatment and recovery programs.
44. Significantly increase the number of detoxification, post-detoxification, treatment and recovery program beds to meet current needs, and allow clients to remain in these programs as required by their individualized recovery plans.
45. Significantly increase access to evidence-based residential and community-based services and supports to meet current needs as part of a seamless continuum of care

model from detoxification to treatment through to ongoing recovery and long-term support programs.

46. Eliminate financial barriers that limit access to treatment and recovery programs and accommodate parental, family or caregiver support within these programs as appropriate.
47. Eliminate financial and geographic barriers for those living in remote, rural and isolated communities to access residential and community-based treatment, post-detoxification and recovery programs with assistance for travel costs.
48. Implement a holistic and multi-faceted approach to addiction recovery that includes integrated and individualized health care, as well as access to affordable housing and other community-based services and supports.
49. Work with federal counterparts to increase targeted investments in mental health.
50. Provide concurrent integration of mental health and addiction recovery programs and services in primary health care settings.
51. Establish and work towards meeting acceptable standard provincial wait times for access to community mental health and addiction recovery services.
52. Provide more public education and awareness regarding addiction as a chronic illness to help diminish stigma and negative preconceptions about addiction and those living in recovery.
53. Develop and implement a comprehensive, province-wide suite of programs for children and youth up to age 24, including awareness and education, prevention and early intervention, and significantly increase the number of treatment and recovery beds to meet current youth needs.
54. Increase self-regulation skills in school programming to promote positive mental health for children and youth, and to mitigate against the development of mental health problems that can lead to mental or physical illness and potentially to addiction.
55. Increase supports and services for high-risk youth, such as those “aging out” of government care.
56. Provide a full range of harm reduction programs, supports and services throughout B.C., including an increased supply of naloxone and opioid or other narcotic overdose treatments, safe injection or consumption sites, and needle exchanges.
57. Ensure those accessing harm reduction programs or seeking addiction services and supports can get into treatment and recovery programs in a timely manner.

58. Develop a public education and awareness campaign that highlights the importance of harm reduction within the context of social harm reduction.
 59. Support and expand evidence-based initiatives or programs for safe and controlled access to currently illicit substances.
-

Appendix A: Presentations

- Ambulance Paramedics of British Columbia, Bronwyn Barter, Cameron Eby and Maureen Evashkevich (7-Jul-16, Vancouver)
- Apotex, Heather West (12-Jul-16, Vancouver)
- Association of Registered Nurses of British Columbia, Andrea Burton, Joy Peacock and Patrick Chiu (7-Jul-16, Vancouver)
- Dr. Ray Baker (12-Jul-16, Vancouver)
- BC Care Providers Association, Michael Kary and Daniel Fontaine (8-Jul-16, Vancouver)
- BC College of Family Physicians, Dr. Christie Newton and Toby Kirshin (7-Jul-16, Vancouver)
- BC Council for Recovery Excellence, Marshall Smith (4-Jul-16, Victoria)
- BC Doctors of Optometry, Dr. Gurpreet Leekha (12-Jul-16, Vancouver)
- BC Humanist Association, Ian Bushfield and David Byron Wood (12-Jul-16, Vancouver)
- BC Integrated Youth Services Initiative, Dr. Steve Mathias and Pamela Liversidge (8-Jul-16, Vancouver)
- BC Patient Safety and Quality Council, Dr. Douglas Cochrane and Christina Krause (8-Jul-16, Vancouver)
- BC Transport Nurses Network, Scott Lamont and Michael Sandler (6-Jul-16, Kamloops)
- British Columbia Association of TCM and Acupuncture Practitioners, Joseph Ranallo (12-Jul-16, Vancouver)
- British Columbia Chiropractic Association, Dr. Jay Robinson and Lisa Kallstrom (7-Jul-16, Vancouver)
- Canadian Association of Occupational Therapists - BC Chapter, Giovanna Boniface and Dr. Susan Farwell (7-Jul-16, Vancouver)
- Canadian Centre for Policy Alternatives - BC Office, Marcy Cohen and Igljka Ivanova (14-Sep-15, Vancouver)
- Canadian Centre on Substance Abuse, Rita Notarandrea (4-Jul-16, Victoria)
- Canadian Mental Health Association - BC Division, Bev Gutray, Barb Keith and Jonny Morris (12-Jul-16, Vancouver)
- Central Interior Native Health Society, Murry Krause (5-Jul-16, Prince George)
- Centre for Rural Health Research, University of British Columbia, Dr. Stefan Grzybowski (4-Jul-16, Victoria)
- Centre on Aging, University of Victoria, Dr. Neena Chappell and Dr. Marcus Hollander (14-Sep-15, Vancouver)
- College of Physicians and Surgeons of British Columbia, Dr. Heidi Oetter and Dr. Gerrard Vaughan (7-Jul-16, Vancouver)
- Cool Aid Community Health Centre, Grey Showler (4-Jul-16, Victoria)
- Dr. Jel Coward (8-Jul-16, Vancouver)
- Cridge Centre for the Family, Geoff Sing (4-Jul-16, Victoria)
- Department of Family Medicine, Faculty of Medicine, University of British Columbia Dr. Margaret McGregor and Susan Troesch (8-Jul-16, Vancouver)
- Dieticians of Canada - BC Region, Sonya Kupka, Courtenay Hopson and Marianne Bloudoff (5-Jul-16, Prince George)
- Digniti Home-Hospital Research Project, Rees Moerman and Deanna Cross (6-Jul-16, Kamloops)
- Division of Rheumatology, Faculty of Medicine, University of British Columbia, Dr. Kam Shojanian (8-Jul-16, Vancouver)
- Doctors of BC, Dr. Alan Ruddiman (8-Jul-16, Vancouver)
- Drug Prevention Network of Canada, David Berner and Chuck Doucette (12-Jul-16, Vancouver)
- Edgewood Addiction Treatment Centre, Lorne Hildebrand (12-Jul-16, Vancouver)

Faculty of Medicine, University of British Columbia, Dr. Roger Wong (7-Jul-16, Vancouver)

Dr. Paul Farnan (12-Jul-16, Vancouver)

First Nations Health Authority, Richard Jock and Jason Calla (7-Jul-16, Vancouver)

First Nations Health Council, Grand Chief Doug Kelly (4-Jul-16, Victoria)

Dr. Mark Fromberg (6-Jul-16, Kamloops)

Healthy Homes IAQ, Craig Hostland (6-Jul-16, Kamloops)

Indivior Canada Ltd, Cameron Bishop (12-Jul-16, Vancouver)

Kamloops Health Coalition, Fawn Knox (6-Jul-16, Kamloops)

Christine Kozakowski (6-Jul-16, Kamloops)

Last Door Recovery Society, Giuseppe Ganci, Jessica Cooksey, Daniel Marks and Tyler Dovey (12-Jul-16, Vancouver)

Dr. Denise Mcleod (5-Jul-16, Prince George)

Northern B.C. First Nations HIV/AIDS Coalition, Emma Palmantier (5-Jul-16, Prince George)

Northern Medical Program, University of Northern British Columbia & University of British Columbia, Dr. Sean Maurice (5-Jul-16, Prince George)

Office of the Vice-Provost Health, University of British Columbia, Dr. Louise Nasmith and Dr. Bill Miller (7-Jul-16, Vancouver)

Pacifica Housing, Dean Fortin (4-Jul-16, Victoria)

Parkinson Society British Columbia, Jean Blake, Paddi Wood and Brian Wood (4-Jul-16, Victoria)

Patients and Supporters of Mid-Main Community Health Centre, Greg Kozak (7-Jul-16, Vancouver)

Physiotherapy Association of British Columbia, Kevin Evans, Hilary Crowley and Jenny Hogan (5-Jul-16, Prince George)

Connie Redknap (6-Jul-16, Kamloops)

Registered Massage Therapists' Association of British Columbia, Brenda Locke, Gordon MacDonald and Bodhi Haraldsson (7-Jul-16, Vancouver)

School of Health Sciences, University of Northern British Columbia, Dr. Martha MacLeod (5-Jul-16, Prince George)

School of Nursing, University of Northern British Columbia, Dr. Martha MacLeod (5-Jul-16, Prince George)

School of Population and Public Health, University of British Columbia, Dr. Richard Mathias (7-Jul-16, Vancouver)

Aaron Sihota and Robson Liu (7-Jul-16, Vancouver)

Society for Canadians Studying Medicine Abroad, Rosemary Pawliuk and Praveen Vohora (12-Jul-16, Vancouver)

Support Our Health Care Society of Princeton, Edward Staples (4-Jul-16, Victoria)

Gabrielle Trépanier (8-Jul-16, Vancouver)

Ts'ewulhtun Health Centre, Danièle Behn Smith, Jennifer Jones and Derek Thompson (4-Jul-16, Victoria)

Rick Turner (6-Jul-16, Kamloops)

Union of British Columbia Municipalities, Al Richmond (12-Jul-16, Vancouver)

Vancouver Citizens Health Initiative, Kyle Pearce (7-Jul-16, Vancouver)

Wellness & Health Action Coalition, Ashcroft & Area Community Resources Society, Ron Hood, Pam Webster, Chellie Dickson, David Durksen and Marilyn Bueckert (6-Jul-16, Kamloops)

Appendix B: Written Submissions

*Provided two written submissions, one during each consultation process (2014/15 and 2016).

Action Committee for People with Disabilities, Philip He	BC Nurses' Union, Gayle Duteil*	Burnaby Seniors Outreach Services Society, Danelle Laidlaw
Advancing Rural Family Medicine: The Canadian Collaborative Task Force, Dr. Trina Larsen Soles	BC Schizophrenia Society Pentiction Branch, Sharon Evans	Campbell River North Citizens for Quality Health Care, Lois Jarvis
Keith Ahamad	BC Transport Nurses Network Scott Lamont	Sheila Campbell
Alzheimer Society of B.C., Rebecca Morris	BCMA Section of Dermatology, Evert Tuyp	Canadian Agency for Drugs and Technologies in Health (CADTH), Brian O'Rourke
Ambulance Paramedics of British Columbia, Bronwyn Barter	Myron Bedford	Canadian Association of Occupational Therapists - BC Chapter, Giovanna Boniface
Dr. Karen Andres	Behavioural Health Consultation Program, Vancouver Coastal Health, Dr. Joachim Sehrbrock	Canadian Blood Services, Dr. Graham D. Sher
Association of Registered Nurses of British Columbia, Julie Fraser	Alex Berland	Canadian Cancer Society, BC and Yukon, Kathryn Seely
Karen Back	Chris Bibby	Canadian Centre for Policy Alternatives - BC Office, Marcy Cohen
Phil Barker	Dr. Barbara Bienkowska	Canadian Diabetes Association, Serge Corbeil
Jennie Barron	Diane Bond	Canadian Independent Medical Clinics Association, Dr. Brian Day
Kenneth Barry	Sheila Branscombe	Canadian Mental Health Association - BC Division, Jonathan Morris
BC Association of Community Response Networks, Sherry Baker	Charles Brasfield	Arlene Carsten
BC Association of Kinesiologists, Daryl Reynolds	British Columbia Association of TCM & Acupuncture Practitioners, Joseph Ranallo	Centre for Addictions Research of BC, University of Victoria, Dr. Karen Urbanoski
BC Coalition of Nursing Associations, Andrea Burton	British Columbia Chiropractic Association, Rick Nickelchok	Centre for Clinical Epidemiology and Evaluation, Dr. Margaret McGregor
BC College of Family Physicians, Toby Kirshin	British Columbia Dental Association, Jocelyn Johnston and Ina Hunt*	Centre for Rural Health Research, University of British
BC Doctors of Optometry, Sherman Tung	British Columbia Federation of Community Health Centres, Scott Wolfe	
BC Government and Service Employees' Union, Simon Kelly and Carol Wood*	British Columbia Naturopathic Association, Dr. Victor Chan	
BC Health Coalition, Rick Turner	British Columbia Pharmacy Association, Geraldine Vance*	
BC Nurse Practitioner Association, Kathleen Fyvie	Gary Bro	

Columbia, Dr. Stefan	Chris Dixon	Nicholas Lamm
Grzybowski and Dr. Jude	Doctors of BC, Dr. Bill Cavers	Dr. Selena Lawrie
Kornelsen	Irmgard I. Dommel	Leadership Council (Ministry of
Centre on Aging, University of	Drug Prevention Network of	Health, Regional Health
Victoria, Dr. Neena Chappell	Canada, David Berner	Authorities, Provincial Health
Jonathan Chapnick	Alice and David Durksen	Services Authority), Stephen
Child Health BC, Maureen	Pat Elliott	Brown
O'Donnell	Jordan Evans	Robert Lehman
City of Chilliwack, Karen	Sharon Evans	Licensed Practical Nurses
Stanton	Faculty of Pharmaceutical	Association of BC, Anita
College of Health Disciplines,	Sciences, University of British	Dickson
University of British	Columbia, Peter Zed*	Margaret Little
Columbia, Martin Dawes	Stephen Fawcett	Logan Lake Health Care
College of Midwives of British	Federation of Oceanside	Advisory Committee, Elaine
Columbia, Louise Aerts	Residents' Associations,	Pennoyer
College of Pharmacists of	James Dimmick*	Joan Lyons
British Columbia, Bob	First Nations Health Authority	DeAnna MacArthur
Nakagawa	and First Nations Health	Jack Mackenzie
Don Collicutt	Council, Avril Ullett	Karen Mason
Community Resources Society,	Peter Gallie	Cecilia Mavrow*
Ashcroft & District Health	Joan Garcia	McCreary Centre Society,
Care Auxiliary and Thompson	Darren Gregory	Colleen Poon
View Manor Society, Barbara	June Halter	Grant McDonald
Pesut	Claire Hawrys	Dr. Margaret McGregor and Dr.
Concerned Citizens for Health	Peter Heap	Sue Turgeon
Care, Brad Brain	Wenche Hemphill	Dianne McKay
Corporation of the Village of	Marijke Henkemans	McKesson Canada, Anthony
Pouce Coupe, Gordon Howie	Hospital Employees' Union,	Leong*
Council of Senior Citizens'	Jennifer Whiteside	Carol Mclean
Organizations of BC, Art Kube	Dr. Kelly Hyslop	John Mclean
Cranbrook Kimberley Hospice	Robert Ingram	Mental Health Commission of
Society, Donald L. Davidson	InspireHealth Supportive	Canada, Stephanie Machel
Lynda Cronin	Oncology Centre, Hal Gunn	and Jennifer Vornbrock*
Jay Cross	Interior Health and Kamloops	Merck Canada Inc., Bonnie
Denominational Health	Aboriginal Friendship	Swan
Association, Susan House	Society, Chris Philips	Ralph Meyer
Desert Valley Hospice Society,	Lois Jarvis	Mid-Main Community Health
Dr. David Shaw	Christine and Melville Johnston	Centre Society, Irene
Koert Dieterman	Don Jones	Clarence
Dietitians of Canada, Sonya	Kamloops and District Elizabeth	Midwives Association of British
Kupka	Fry Society, Parents Support	Columbia, Alixandra Bacon
Digniti Home-Hospital	Group, Penny Douglass	Andrew Mitchell
Research Project, Rees	Heather Kauer	Harry Moore
Moerman	Ronnie Korol	Kirsten Morgan

Ken Murray	Public Health Association of BC,	Squamish-Lillooet Regional
Shelley Myatovic	John Millar	District, Jack Crompton
Nelson Area Society for Health,	Reckitt Benckiser	Carol Stanley
Pegasis McGauley	Pharmaceuticals (Canada),	Carol Stein
Nelson CARES Society, Health	Carlene Variyan	Kristina Stevens
Services Strategy Group,	Joanne Redies	Support Our Health Care
Corrine Younie	Connie Redknapp	Society of Princeton, Edward
NexJ Systems Inc., Eric	Resident Doctors of BC, Dr.	Staples
Gombrich	Goldis Mitra	Lori Swanson
Oceanside Coalition for Strong	Richmond Poverty Response	The Arthritis Society, BC &
Communities, John Olsen	Committee, Lynda Brummitt	Yukon Division, Joan Vyner
Office of the Seniors Advocate,	Ridge Meadows Seniors	The BC Association of
Isobel Mackenzie	Society, Sheila Pratt	Speech/Language
Louanne Ohlhauser	John Robertson	Pathologists & Audiologists,
David Olsen	Rural Coordination Centre of	Julia Hodder
Michael O'Malley	British Columbia, Robert	The Canada Sweden
Karen Omelchuk	Woollard	International Institute for
Maureen Palmer	Rural Shuswap Health Services	Sustainable Regional
Patients and Supporters of Mid-	Network, Sue McCrae*	Economies, Kell Petersen*
Main Community Health	Salt Spring Health	The College of Physicians and
Centre, Greg Kozak	Advancement Coalition, Barb	Surgeons of British Columbia,
Peace River Regional District,	Aust	William Walton
Brad Sperling	Heather Sapergia	think: act consulting, Kyle
Melissa Peet	Kristin Saunders	Pearce
Christopher Pengilly	Save Our Northern Seniors,	Patricia Thomson
Penticton & District Hospice	Jean Leahy and Margaret	Neil Thomson*
Society, Kelly Phipps	Little*	Kathy Turnbull
Perinatal Services BC, Leanne	School of Population and	Union of British Columbia
Yeates	Public Health, University of	Municipalities, Marylyn
Physiotherapy Association of	British Columbia, Dr. Richard	Chiang
British Columbia, Kevin Evans	Mathias	Vancouver Division of Family
Positive Living Society of BC,	Diane Shepherd	Practice, Cheryl Hogg
Romari Undi	Cindy Shipley	Karla Wagner
Sheila Pratt	Kieran Shoker	Allan Warner
Professional Association of	Aaron Sihota	Angela Wilson
Residents of British	Society for Canadians Studying	Susanna Wong
Columbia, Kate Milne	Medicine Abroad, Rosemary	Byron Wood
Psychosocial Rehabilitation BC,	Pawliuk Society for	Evan Wood
John Higenbottam	Protection and Care of	Ruth Zenger
	Seniors, Janice Androsoff	

Appendix C: Composition of the Committee

Members

2nd Session (February 11, 2014 to October 6, 2014)

Linda Larson, MLA	Chair	Boundary-Similkameen
Judy Darcy, MLA	Deputy Chair	New Westminster
Donna Barnett, MLA		Cariboo-Chilcotin
Dr. Doug Bing, MLA		Maple Ridge-Pitt Meadows
Katrine Conroy, MLA		Kootenay West
Sue Hammell, MLA		Surrey-Green Timbers
Richard T. Lee, MLA		Burnaby North
Hon. Norm Letnick, MLA <i>(to April 30, 2014)</i>		Kelowna-Lake Country
Dr. Jane Jae Kyung Shin, MLA		Burnaby-Lougheed
Hon. Michelle Stilwell, MLA		Parksville-Qualicum
Dr. Moira Stilwell, MLA <i>(from April 30, 2014)</i>		Vancouver-Langara

3rd Session (October 6, 2014 to February 10, 2015)

Linda Larson, MLA	Chair	Boundary-Similkameen
Judy Darcy, MLA	Deputy Chair	New Westminster
Donna Barnett, MLA		Cariboo-Chilcotin
Dr. Doug Bing, MLA		Maple Ridge-Pitt Meadows
Sue Hammell, MLA		Surrey-Green Timbers
Richard T. Lee, MLA		Burnaby North
Jennifer Rice, MLA		North Coast
Bill Routley, MLA		Cowichan Valley
Hon. Michelle Stilwell, MLA		Parksville-Qualicum
Dr. Moira Stilwell, MLA		Vancouver-Langara

4th Session (February 10, 2015 to February 9, 2016)

Linda Larson, MLA	Chair	Boundary-Similkameen
Judy Darcy, MLA	Deputy Chair	New Westminster
Donna Barnett, MLA		Cariboo-Chilcotin
Dr. Doug Bing, MLA		Maple Ridge-Pitt Meadows
Marc Dalton, MLA <i>(from October 20, 2015)</i>		Maple Ridge-Mission
Sue Hammell, MLA		Surrey-Green Timbers
Richard T. Lee, MLA <i>(to October 20, 2015)</i>		Burnaby North
Dr. Darryl Plecas, MLA		Abbotsford South
Jennifer Rice, MLA <i>(to September 8, 2015)</i>		North Coast
Bill Routley, MLA		Cowichan Valley
Dr. Jane Jae Kyung Shin, MLA <i>(from September 8, 2015)</i>		Burnaby-Lougheed
Dr. Moira Stilwell, MLA		Vancouver-Langara

5th Session (February 9, 2016 to February 14, 2017)

Linda Larson, MLA	Chair	Boundary-Similkameen
Judy Darcy, MLA	Deputy Chair	New Westminster
Hon. Donna Barnett, MLA <i>(to November 1, 2016)</i>		Cariboo-Chilcotin
Dr. Doug Bing, MLA		Maple Ridge-Pitt Meadows
Marc Dalton, MLA		Maple Ridge-Mission
Sue Hammell, MLA		Surrey-Green Timbers
Dr. Darryl Plecas, MLA		Abbotsford South
Selina Robinson, MLA		Coquitlam-Maillardville
Dr. Jane Jae Kyung Shin, MLA		Burnaby-Lougheed
Sam Sullivan, MLA		Vancouver-False Creek
John Yap, MLA <i>(from November 1, 2016)</i>		Richmond-Steveston

Appendix D: Previous Terms of Reference

2nd Session Terms of Reference

On February 25, 2014, the Legislative Assembly agreed that the Select Standing Committee on Health be empowered to:

1. Consider the conclusions contained in the *Interim Report*, October 2012, of the Select Standing Committee on Health of the 39th Parliament; as such, the *Interim Report* of the Select Standing Committee on Health, and any submissions and evidence received during the 39th Parliament, are referred to the Committee;
2. Outline potential alternative strategies to mitigate the impact of the significant cost drivers identified in the Report on the sustainability and improvement of the provincial health care system; and
3. Identify current public levels of acceptance toward the potential alternative strategies.

In addition to the powers previously conferred upon the Select Standing Committee on Health, the Committee shall be empowered:

- a. to appoint of their number, one or more subcommittees and to refer to such subcommittees any of the matters referred to the Committee;
- b. to sit during a period in which the House is adjourned, during the recess after prorogation until the next following Session and during any sitting of the House;
- c. to conduct consultations by any means the committee considers appropriate;
- d. to adjourn from place to place as may be convenient; and
- e. to retain such personnel as required to assist the Committee;

And shall report to the House as soon as possible, or following any adjournment or at the next following Session, as the case may be; to deposit the original of its reports with the Clerk of the Legislative Assembly during a period of adjournment and upon resumption of the sittings of the House, the Chair shall present all reports to the Legislative Assembly.

3rd and 4th Session Terms of Reference

On October 9, 2014 and February 25, 2015, the Legislative Assembly agreed that the Select Standing Committee on Health be empowered to:

1. Consider the conclusions contained in the Interim Report, October 2012, of the Select Standing Committee on Health of the 39th Parliament; as such, the Interim Report of

the Select Standing Committee on Health, and any submissions and evidence received during the 39th Parliament, are referred to the Committee;

2. Outline potential alternative strategies to mitigate the impact of the significant cost drivers identified in the Report on the sustainability and improvement of the provincial health care system; and
3. Identify current public levels of acceptance toward the potential alternative strategies; and,
4. Consider health capital funding options.

In addition to the powers previously conferred upon the Select Standing Committee on Health, the Committee shall be empowered:

- a. to appoint of their number, one or more subcommittees and to refer to such subcommittees any of the matters referred to the Committee;
- b. to sit during a period in which the House is adjourned, during the recess after prorogation until the next following Session and during any sitting of the House;
- c. to conduct consultations by any means the committee considers appropriate;
- d. to adjourn from place to place as may be convenient; and
- e. to retain such personnel as required to assist the Committee;

and shall report to the House as soon as possible, or following any adjournment or at the next following Session, as the case may be; to deposit the original of its reports with the Clerk of the Legislative Assembly during a period of adjournment and upon resumption of the sittings of the House, the Chair shall present all reports to the Legislative Assembly.

5th Session Terms of Reference

On March 1, 2016, The Legislative Assembly agreed that the Select Standing Committee on Health be empowered to:

3. Identify potential strategies to maintain a sustainable health care system for British Columbians; and
4. Consider health capital funding options.

In addition to the powers previously conferred upon the Select Standing Committee on Health, the committee shall be empowered:

- f. to appoint of their number one or more subcommittees and to refer to such subcommittees any of the matters referred to the committee and to delegate to the

subcommittee all or any of its powers except the power to report directly to the House;

- g. to sit during a period in which the House is adjourned, during the recess after prorogation until the next following Session and during any sitting of the House;
- h. to conduct consultations by any means the committee considers appropriate;
- i. to adjourn from place to place as may be convenient; and
- j. to retain such personnel as required to assist the committee;

and shall report to the House as soon as possible, or following any adjournment or at the next following Session, as the case may be; to deposit the original of its reports with the Clerk of the Legislative Assembly during a period of adjournment and upon resumption of the sittings of the House, the Chair shall present all reports to the Legislative Assembly.

Appendix E: Meetings Schedule

2nd Session

<i>Date</i>	<i>Type</i>	<i>Location</i>
March 26, 2014	Organizational Meeting, Briefings	Victoria
April 9, 2014	Business Planning	Victoria
May 27, 2014	Organizational Meeting	Victoria
September 11, 2014	Business Planning	Vancouver

3rd Session

October 9, 2014	Organizational Meeting	Victoria
-----------------	------------------------	----------

4th Session

March 5, 2015	Organizational Meeting	Victoria
March 26, 2015	Business Planning	Victoria
April 15, 2015	Presentations	Victoria
April 22, 2015	Business Planning	Victoria
April 29, 2015	Presentations	Victoria
May 13, 2015	Briefing, Presentations	Victoria
May 15, 2015	Presentations	Vancouver
July 15, 2015	Presentations	Victoria
September 14, 2015	Presentations	Vancouver
October 15, 2015	Sub-Committee Meeting	Vancouver
October 21, 2015	Deliberations, Adoption of Interim Report	Victoria
October 28, 2015	Deliberations	Victoria
December 15, 2015	Deliberations	Vancouver

