AMBULANCE PARAMEDICS AND
EMERGENCY DISPATCHERS OF BC
CUPE LOCAL 873

CONVENTION 2020

Provincial Vice-President's & Chief Grievance Officer Report Attachments

Appendix Package

FORUM 10

Ottawa-Gatineau 2019

PROGRAMME

CIMVHR
Canadian Institute for Military and Veteran Health Research

ICRSMV
L'Institut canadien de recherche sur la santé des militaires et des vétérans

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CIMVHR
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A DECADE OF SERVING THOSE WHO SERVE US

From the very beginning, our role at CIMVHR has been to create a network through which experts actively collaborate in addressing the health needs of our military, Veterans and their families, as well as other related populations. For the last decade, the annual CIMVHR Forum has been the preeminent research event at which these types of collaborations begin, grow and mature. We feel deep gratitude that over 700 of you, our largest delegation to-date, have come together this year for the 10th Annual Forum

With the expert guidance of Drs. Heidi Cramm and Nicholas Carleton, Co-Chairs of the CIMVHR Forum Scientific Committee, the agenda is a high quality and diverse representation of research happening right now across Canada. In just three days, you will have the opportunity to hear over 250 research presentations, which will show us all how far we have come, and more importantly, where we need to focus next to continue advancing health research for these unique populations.

Whether this is your first Forum, or your tenth, we thank you. Thank you for coming to our 10th Annual CIMVHR Forum, and for *serving those who serve us*.

David Pedlar, PhD, Scientific Director, CIMVHR

Stéphanie Bélanger, CD, PhD, Associate Scientific Director, CIMVHR

UNE DÉCENNIE AU SERVICE DES HOMMES ET DES FEMMES QUI SERVENT FIÈREMENT

Nous avons dès le début, à l'ICRSMV, eu pour rôle de mettre sur pied un réseau par l'entremise duquel les expert(e)s collaborent activement concernant les besoins en matière de santé de nos militaires, de nos vétéran(e)s et de leurs proches ainsi que de ceux de groupes connexes. Au cours de la dernière décennie, le Forum annuel de l'ICRSMV a été la principale activité relative aux recherches dans le domaine dans lequel ces types de collaborations commencent, croissent et mûrissent. Nous sommes très heureux que plus de 700 d'entre vous, qui formez notre délégation la plus nombreuse à ce jour, soyez réunis cette année en vue du dixième Forum annuel.

Sous la direction éclairée des co-président(e)s du comité scientifique du Forum de l'ICRSMV, Heidi Cramm, PhD, et Nicholas Carleton, PhD, le programme constitue une représentation de grande qualité sur ce qui se passe en ce moment même dans le domaine de la recherche à la grandeur du Canada. En seulement trois jours, vous aurez l'occasion d'entendre plus de 250 présentations sur des recherches, qui vont, à nous tous, nous faire découvrir les progrès que nous avons faits et, ce qui est plus important, les points sur lesquels nous devons à compter de maintenant nous concentrer pour continuer à faire progresser les recherches en matière de santé pour ces groupes particuliers.

Que le présent Forum soit votre premier, ou votre dixième, nous vous remercions. Merci d'assister au présent Forum annuel de l'ICRSMV, qui est notre dixième, et d'être au service des hommes et des femmes qui servent fièrement.

M. David Pedlar, PhD, Directeur scientifique, ICRSMV

Mme Stéphanie Bélanger, CD, PhD, Directrice scientifique associée, ICRSMV

AGENDA 2019

2017

2016

2016


2015

MONDAY, OCTOBER 21 / LUNDI 21 OCTOBRE

7:30AM
7h30

REGISTRATION OPENS / LES INSCRIPTIONS SONT OUVERTES

8:00-9:30
8h00 à 9h30

TRADESHOW AND POSTER SET UP / MISE EN PLACE DES AFFICHES ET DU SALON DES EXPOSANTS

8:30-10:00
8h30 à 10h00

BREAKFAST / DÉJEUNER

10:00-11:00
10h00 à 11h00

OPENING PLENARY / SÉANCE D'OUVERTURE

INVESTING IN IMPACT: THE ROLE OF RESEARCH IN THE LIVES OF MILITARY MEMBERS, VETERANS AND THEIR FAMILIES

Moderator:

Nora Spinks, CEO, The Vanier Institute of the Family

Panelists:

Jitender Sareen, MD, Professor and Head, Department of Psychiatry, University of Manitoba; Medical Director, WRHA Mental Health Program; CIMVHR Fellow

Sanela Dursun, PhD, Director, Research Personnel and Family Support, Defence Research and Development Canada

Lacey Cranston, Managing Editor, Journal of Military, Veteran and Family Health, Canadian Institute for Military and Veteran Health Reasearch

11:00-11:30
11h00 à 11h30

NETWORKING BREAK AND TRADESHOW / PAUSE RÉSEAUTAGE ET SALON D'EXPOSITION

11:30-12:30
11h30 à 12h30

MORNING PLENARY / SÉANCE PLÉNIÈRE MATINALE

Vice-Admiral H.C. Edmundson, OMM, MSM, CD, Commander, Military Personnel Command

Major-General A.M.T. Downes, OMM, CD, QHP, MD, Surgeon General and Commander of Canadian Forces Health Service Group

BANTING AWARD PRESENTATION

Robert Hawes, MSc, PhD/GDip (Cand.), Senior Epidemiologist, Directorate of Force Health Protection, Canadian Forces Health Services Group, Department of National Defence, Government of Canada

12:30-1:00
12h30 à 13h00

LUNCH / REPAS DU MIDI

1:00-2:20
13h00 à 14h20

SCIENTIFIC SHOWCASE AND NETWORKING SESSION / PRÉSENTATIONS SCIENTIFIQUES PAR AFFICHE ET SÉANCE RÉSEAUTAGE

Following the Forum agenda is the list of poster presenters and their presentation times.

Vous trouverez la liste des présentations par affiches et leurs heures de présentation à la suite de l'agenda du Forum.

Room / Salle de réunion : Julien / Gagnon / Walker

2:20-2:30
14h20 à 14h30

TRANSITION TIME / PÉRIODE DE TRANSITION

2:30-4:15 / 14h30 à 16h15 — CONCURRENT SESSION 1 / SÉANCES PARALLÈLES 1

Session / Séance	1A	1B	1C	1D	1E
	Serving Members / Membres en service	Serving Members / Membres en service	Veterans / Vétéran(e)s	Families / Familles	Public Safety Personnel / Personnel de la sécurité publique
Room / Salle de réunion	Chopin	Mozart	Delfosse	Suzor-Côté	Beethoven
Title / Titre	**SYMPOSIUM** **Dynamics of Resilience among Canadian Special Operations Forces Members and Families / Les dynamiques de la résilience chez les membres du Commandement des Forces d'opérations spéciales et leurs proches**	**SYMPOSIUM** **Alcohol Misuse in Military and Veteran Populations: Prevalence, Comorbidity and Intervention / L'abus d'alcool dans la population militaire et vétérane : la prévalence, la comorbidité et l'intervention**	**SYMPOSIUM** **Highlights from the Canadian Armed Forces Transition and Well-being Survey Program of Research / Les points saillants du Sondage des anciens combattants canadiens en transition**	**Mental Health and Families / La santé mentale et les familles**	**SYMPOSIUM** **The Royal Canadian Mounted Police Post-traumatic Stress Disorder Study / L'étude sur l'État de stress post-traumatique et la Gendarmerie royale du Canada**
2:30-2:50 / 14h30 à 14h50	**Isabelle Richer**, PhD 1A01 Facing Adversity from the Perspective of Canadian Special Operations Forces Members (1 of 5)	**Cherie Armour**, PhD 1B01 Examining the Co-morbidity between Alcohol use and Post-traumatic Stress Disorder using Network Analysis (1 of 5)	**Heather McCuaig Edge**, PhD 1C01 Identifying Correlates of Challenges Associated with Military to Civilian Transition among Veterans (1 of 5)	**Heather Stuart**, PhD 1D01 Promoting Mental Wellness in Military Populations: The #Here4U™ e-solution	**R. Nicholas Carleton**, PhD 1E01 The Royal Canadian Mounted Police Longitudinal Post-traumatic Stress Disorder Study: Overview, design, description and progress update (1 of 5)
2:50-3:10 / 14h50 à 15h10	**Christine Frank**, PhD 1A02 A Social-ecological Approach to Resilience (2 of 5)	**Laura Palmer**, MSc 1B02 Drinking Motives and Perceptions of Dependence in United Kingdom Veterans Misusing Alcohol (2 of 5)	**Jennifer Lee**, PhD 1C02 Health and Loss of Military Identity during the Transition to Civilian Life among Canadian Armed Forces Veterans (2 of 5)	**Candice Monson**, PhD 1D02 Couple HOPES: Development of a Guided, Internet-delivered Version of Cognitive-behavioral Conjoint Therapy for Post-traumatic Stress Disorder	**Ron Martin**, PhD 1E02 Adapting the Unified Protocol to the Policing (Royal Canadian Mounted Police) Context (2 of 5)
3:10-3:30 / 15h10 à 15h30	**Christine Frank**, PhD 1A03 The Process of Resilience across Deployments (3 of 5)	**Rachael Gribble**, PhD 1B03 Recognition and Help-seeking for Alcohol Problems among Serving and Ex-serving United Kingdom Military Personnel (3 of 5)	**Alla Skomorovsky**, PhD 1C03 Military to Civilian Transition Challenges and Well-being of Spouses of Newly Released Veterans (3 of 5)	**Heidi Cramm**, PhD 1D03 Intra-provincial Variation in Mental Health Services use among Military Families in Ontario	**Ronald Camp II**, PhD 1E03 Leadership Development for Team Psychological Safety in the Royal Canadian Mounted Police (3 of 5)

3:30-3:50 **15h30 à 15h50**	**Isabelle Richer**, PhD **1A04** Well-being, Adjustment, and Support Needs of Canadian Special Operations Forces Families (4 of 5)	**Laura Goodwin**, PhD **1B04** Usability and Acceptability of a Tailored Alcohol App for Ex-serving Military Personnel (4 of 5)	**Robert Morrow**, MA **1C04** Satisfaction with Transition Services among Injured Canadian Armed Forces Members from Military to Civilian Transition (4 of 5)	**Christine Basnett**, MSW and **Polliann Maher** **1D04** Year Two: Development and implications of a workshop for family members of Canadian Armed Forces personnel and Veterans with operational stress injuries	**Gregory Kratzig**, PhD **1E04** Education and Training to Improve Mental Health and to Reduce Stigma (4 of 5)
3:50-4:10 **15h50 à 16h10**	**Shannon King**, MDS **1A05** Discussant: Dynamics of Resilience among Canadian Special Operations Forces Members and Families (5 of 5)	**Nicola Fear,** PhD **1B05** Discussant: Alcohol Misuse in Military and Veteran Populations: Prevalence, Comorbidity and Intervention (5 of 5)	**Sanela Dursun**, PhD **1C05** Discussant: Highlights from the Canadian Armed Forces Transition and Well-being Survey Program of Research (5 of 5)	**Kelly Schwartz**, PhD **1D05** Resiliency and Development in Military-connected Families with an Operational Stress Injury	**Tracie Afifi**, PhD **1E05** Discussant: The Royal Canadian Mounted Police Post-traumatic Stress Disorder Study (5 of 5)
4:15-4:45 **16h15 à 16h45**	**NETWORKING BREAK AND TRADESHOW / PAUSE RÉSEAUTAGE ET SALON D'EXPOSITION**				
4:45-6:30 **16h45 à 18h30**	**CONCURRENT SESSION 2 / SÉANCES PARALLÈLES 2**				
Session/Séance	**2A** Serving Members / Membres en service	**2B** Serving Members / Membres en service	**2C** Veterans / Vétéran(e)s	**2D** Families / Familles	**2E** Public Safety Personnel / Personnel de la sécurité publique
Room / Salle de réunion	Chopin	Mozart	Delfosse	Suzor-Côté	Beethoven
Title / Titre	**Combat and Emergency Trauma / Les traumatismes dans les domaines de combat et des soins d'urgence**	**Sexual Trauma, Ethics and Moral Injury / Les traumatismes sexuels, l'éthique et les blessures morales**	**Veteran Suicide / Le suicide chez les vétérans**	**Relationships and Resilience / Les relations et la résilience**	**Interventions and Supports / Les interventions et le soutien**
4:45-5:05 **16h45 à 17h05**	**Leilani Doyle**, MD **2A01** The Creation of the Canadian Medical Emergency Response Team: Nascent concept to deployed reality	**Allan English**, PhD **2B01** Overcoming Systemic Barriers to Comprehensive Culture Change in the Canadian Armed Forces: An assessment of Operation HONOUR after four years	**J. Don Richardson**, MD **2C01** Suicidal Ideation in Treatment-seeking Canadian Armed Forces Veterans: The use of advanced analytics	**Valerie Wood**, PhD **2D01** Reunited, but He's Not Meeting My Needs: Spouses' attachment anxiety and conflict post-deployment	**Simon Hatcher**, MD **2E01** Why do only Some People get Mental Injuries after Trauma and why doesn't Everyone Recover? A model

5:05-5:25 **17h05 à 17h25**	**Luisa Valbuena**, MPH **2A02** Disease and Injury Burden during Combat, Training and Humanitarian Missions Using the Canadian Armed Forces Disease and Injury Surveillance System	**Claire Cookson-Hills**, PhD **2B02** A Canadian Perspective on Military Sexual Trauma	K**arl Hamner**, PhD **2C02** Understanding the Ecological Context of Veteran Suicide: A narrative literature review	**Rachel Linsner**, MS **2D02** Predictors of Stress and Resilience in Military Spouses	**Ruth Lanius**, MD, PhD **2E02** Alpha Neurofeedback as an Adjunct Treatment for Post-traumatic Stress Disorder: A randomized controlled trial
5:25-5:45 **17h25 à 17h45**	**Gerard Slobogean**, MD **2A03** Effect of Antibiotic Duration in Treatment of Open Fractures Differs by Level of Contamination	**Marc Imbeault**, PhD **2B03** Enjeux éthiques des missions médicales à court termes et éthique professionnelle militaire	**Alyson Mahar**, PhD **2C03** Self-harm and Suicide in Canadian Veterans Living in Ontario	**Lynda Manser**, MMgt **2D03** Resilience: The journey to a comprehensive military family plan	**Danielle Maltais**, PhD **2E03** Les retombées de l´intervention psychosociale chez les intervenants de deuxième ligne
5:45-6:05 **17h45 à 18h05**	**Jean Philip Dawe**, MD **2A04** Tele-mentored Damage-control and Emergency Trauma Surgery: A feasibility study using live tissue models	**Daniel Perkins**, PhD **2B04** Childhood Trauma, War Exposure and Moral Injury: Mental health predictors among post-9/11 United States Veterans	**Deniz Fikretoglu**, PhD **2C04** How do Depressive Symptoms and Suicidal Ideation Change during the Civilian to Military Transition?	**Linna Tam-Seto**, PhD **2D04** Innovation to Impact: Improving military family health care with culturally appropriate tools	**Margaret McKinnon**, PhD and **Alina Protopopescu**, PhD (Cand) **2E04** The Effects of Goal Management Training on Cognition in Military Personnel, Veterans, and Public Safety Personnel
6:05-6:25 **18h05 à 18h25**	**Richard Hilsden**, MD **2A05** Junctional Tourniquet use in the Modern Combat Environment	**DISCUSSION**	**Linda VanTil**, MSc **2C05** 2018 Veteran Suicide Mortality Study: When are they at greatest risk?	**DISCUSSION**	**Robin Campbell**, MRM **2E05** After the Alarm: Navigating community assets to cope with occupational stress

6:30PM
18h30

FORUM DAY 1 ENDS / FIN DU JOUR 1

6:30-8:30
18h30 à 20h30

STUDENT AND POST-DOCTORAL ENGAGEMENT COMMITTEE NETWORKING EVENT

SPONSORED BY WOUNDED WARRIORS CANADA

This event will provide an opportunity for students and post-docs, participating in Forum 2019, to get to know one another, learn about the various student activities ongoing at CIMVHR and create connections with colleagues in their field. Those who have a research interest in military, Veteran and family health and well-being, including other related populations, should plan to attend.

MOBILISATION DES ÉTUDIANT(E)S ET DES CHERCHEUR(E)S POST-DOCTORAUX(ALES)

COMMANDITÉ PAR WOUNDED WARRIORS CANADA

Cet événement offrira la chance aux étudiant(e)s participant au Forum 2019 de se rencontrer et d'en apprendre plus sur les autres activités dédiées aux étudiant(e)s et aux chercheur(e)s post-doctoraux(ales) lors de la conférence. Tou(te)s les étudiant(e)s et chercheur(e)s avec un intérêt pour la recherche sur la santé et le bien-être des militaires, des vétérans et de leurs proches, incluant d'autres populations similaires, sont encouragé(e)s à participer à cet événement.

Room / Salle de réunion : Salon du Jardin

TUESDAY, OCTOBER 22 / MARDI 22 OCTOBRE

7:00AM
7h00

REGISTRATION OPENS / LES INSCRIPTIONS SONT OUVERTES

7:30-8:45
7h30 à 8h45

WORKSHOP 1 / ATELIER 1

OUT OF THE SHADOWS: LIVING WITH CHRONIC PAIN / DE L'OMBRE À LA LUMIÈRE : VIVRE AVEC LA DOULEUR CHRONIQUE

Room / Salle de réunion : Salon du Jardin

7:30-8:45
7h30 à 8h45

WORKSHOP 2 / ATELIER 2

FAMILIES IN TRANSITION: INTEGRATING RESEARCH, THEORY, AND POLICY / LES FAMILLES EN TRANSITION : INTÉGRATION DE LA RECHERCHE, DE LA THÉORIE ET DES POLITIQUES

Room / Salle de réunion : Krieghoff

7:30-8:45
7h30 à 8h45

WORKSHOP 3 / ATELIER 3

UNRAVELING CHALLENGES IN MENTAL HEALTH RESEARCH USING BIG DATA / MIEUX COMPRENDRE LES PROBLÈMES ASSOCIÉS À LA RECHERCHE EN SANTÉ MENTALE EN UTILISANT DES DONNÉES MASSIVES

Room / Salle de réunion : Salon Royal

8:00
8h00

BREAKFAST / DÉJEUNER

9:00-10:00
9h00 à 10h00

MORNING PLENARY / SÉANCE PLÉNIÈRE MATINALE

General (Retd) Walt Natynczuk, CMM, CD, MSc , Deputy Minister, Veterans Affairs Canada

INTEGRATED COMPREHENSIVE PAIN MANAGEMENT IN THE US MILITARY AND VA

Eric B. Schoomaker, MD, PhD

Lieutenant General, U.S. Army (Retired);

42nd U.S. Army Surgeon General and Former Commanding General of the U.S. Army Medical Command;

Emeritus Professor, Department of Military and Emergency Medicine, F. Edward Hebert School of Medicine,Uniformed Services University of the Health Sciences, Bethesda, MD

10:00-10:30 **10h00 à 10h30**	**NETWORKING BREAK AND TRADESHOW / PAUSE RÉSEAUTAGE ET SALON D'EXPOSITION**				
10:30-12:30 **10h30 à 12h30**	**CONCURRENT SESSION 3 / SÉANCES PARALLÈLES 3**				
Session / Séance	**3A** Serving Members / Membres en service	**3B** Serving Members / Membres en service	**3C** Serving Members / Membres en service	**3D** Veterans / Vétéran(e)s	**3E** Public Safety Personnel / Personnel de la sécurité publique
Room / Salle de réunion	Chopin	Mozart	Delfosse	Suzor-Côté	Beethoven
Title / Titre	**SYMPOSIUM** **Sexual Misconduct in the Canadian Armed Forces / L'inconduite sexuelle dans les Forces armées canadiennes**	**SYMPOSIUM** **Measuring Performance in Mental Health Care / Comment mesurer la performance du système des soins de la santé mentale**	**SYMPOSIUM** **Results from the 2018 Canadian Armed Forces Members and Veterans Mental Health Follow-up Survey / Les résultats du sondage de suivi 2018 sur la santé mentale des membres des Forces armés canadiennes et des vétérans**	**Life After Release / La vie après la libération**	**Populations and Prevalence / La prevalence des populations**
10:30-10:50 **10h30 à 10h50**	**Sanela Dursun**, PhD **3A01** The Prevalence of Sexual Misconduct in the Military (1 of 6)	**Bryan Garber**, MD **3B01** Introduction to a Performance Measurement Framework for Clinical Mental Health Care (1 of 6)	**Jitender Sareen**, MD **3C01** Deployment-related Traumas and Mental Disorders in Military Personnel (1 of 6)	**Mary Beth MacLean**, MA **3D01** Financial Security Among Veterans in Canada	**Rosemary Ricciardelli**, PhD **3E01** Understanding the Prevalence of Mental Health Disorders among Provincial Correctional Staff
10:50-11:10 **10h50 à 11h10**	**Manon LeBlanc**, PhD **3A02** Sexual Misconduct in the Canadian Armed Forces Training Environment (2 of 6)	**Corneliu Rusu**, MD **3B02** Experienced Wait Times and Completeness of Suicide Risk Assessment in Canadian Forces Mental Health Services (2 of 6)	**Tracie Afifi**, PhD **3C02** Child Maltreatment, Exposure Deployment-related Traumatic Events and Mental Disorders (2 of 6)	**Shree Nadkarni**, BSc **3D02** Veteran Employment and Health Status have Variable effects on Domains of Participation	**Sharon Stevelink**, PhD **3E02** Mental Health and Blood Pressure in United Kingdom Police Officers
11:10-11:30 **11h10 à 11h30**	**Amanda Bullock**, PhD **3A03** Canadian Armed Forces Members' Perceptions about the Military's Climate towards Operation HONOUR (3 of 6)	**Corneliu Rusu**, MD **3B03** Factors Associated with Completion of an Antidepressant Medication for New Episodes of Depression (3 of 6)	**Natalie Mota**, PhD **3C03** Course and Predictors of Post-traumatic Stress Disorder in the Canadian Armed Forces (3 of 6)	**Joel Watson**, MA (Cand) **3D03** Re-establishment to Meaningful Career, Home and Community: Power of networks	**Keltie Pratt**, MA **3E03** A Longitudinal Study of Federal Correctional Service Officer Candidates: Pre-service mental health

11:30-11:50 **11h30 à 11h50**	**Karen D. Davis**, PhD **3A04** Influences on Healthy and Inclusive Military Culture: Qualitative insights (4 of 6)	**Corneliu Rusu**, MD **3B04** Implementation of the Client-reported Outcome Management Information System in the Canadian Forces Mental Health System: A progress report (4 of 6)	**Murray Enns**, MD **3C04** Course and Predictors of Depression in Regular Force Members of the Canadian Armed Forces (4 of 6)	**Cheryl Forchuk**, PhD **3D04** Housing First Workshops for Homeless Veterans: Facilitating collaboration to address homelessness	**Sharon Stevelink**, PhD **3E04** The Mental Health of First Responders in the United Kingdom Biobank
11:50-12:10 **11h50 à 12h10**	**Max Hlywa**, MA **3A05** Performance Measurement for the Sexual Misconduct Response Centre (5 of 6)	**Eva Guérin**, PhD **3B05** Organizational Readiness for Change: Are we ready for measurement-based care through the Client-Reported Outcomes Monitoring Information System? (5 of 6)	**Shay-Lee Bolton**, PhD **3C05** A Long-term Follow-up of Suicidal Behavior in the Canadian Armed Forces (5 of 6)	**Stephanie Felder**, PhD **3D05** The Life Course of Homeless Female Veterans: A Qualitative Study	**Renee MacPhee**, PhD **3E05** Substance use and Mental Health in Paramedics
12:10-12:30 **12h10 à 12h30**	**Sanela Dursun**, PhD **3A06** Discussant: Sexual Misconduct in the Canadian Armed Forces (6 of 6)	**Bryan Garber**, MD **3B06** Discussant: Measuring Performance in Mental Health Care (6 of 6)	**Rakesh Jetly**, MD **3C06** Discussant: Results from the 2018 Canadian Armed Forces Members and Veterans Mental Health Follow-up Survey (6 of 6)	**Ashley Williams**, MSc **3D06** From Canadian Forces Health Services to Provincial Primary Care During Transition to Civilian Life	**Dianne Groll**, PhD **3E06** Previous Military Experience and Mental Health Disorders in Public Safety Personnel in Canada
12:30-1:00 **12h30 à 13h00**	**LUNCH / REPAS DU MIDI**				
1:00-2:20 **13h00 à 14h20**	**SCIENTIFIC SHOWCASE AND NETWORKING SESSION / PRÉSENTATIONS SCIENTIFIQUES PAR AFFICHE ET SÉANCE RÉSEAUTAGE** Following the Forum agenda is the list of poster presenters and their presentation times. Vous trouverez la liste des présentations par affiche et les heures de présentation à la suite de l'agenda du Forum. Room / Salle de réunion : Julien / Gagnon / Walker				
2:20-2:30 **14h20 à 14h30**	**TRANSITION TIME / PÉRIODE DE TRANSITION**				

2:30-4:10
14h30 à 16h10

CONCURRENT SESSION 4 / SÉANCES PARALLÈLES 4

Session / Séance	**4A**	**4B**	**4C**	**4D**	**4E**
	Serving Members / Membres en service	Serving Members / Membres en service	Serving Members and Veterans / Membres en service et Vétéran(e)s	Veterans / Vétéran(e)s	Public Safety Personnel / Personnel de la sécurité publique
Room / Salle de réunion	Chopin	Mozart	Delfosse	Suzor-Côté	Beethoven
Title / Titre	**Rehabilitation / La réadaptation**	**Resilience and Post-traumatic Stress Disorder / La résilience et l'état de stress post-traumatique**	**Supporting Mental Health / Le soutien de la santé mentale**	**Factors Impacting Health and Well-being / Les facteurs qui impactent la santé et le bien-être**	**Organizations and Innovations / Les organisations et les innovations**
2:30-2:50 **14h30 à 14h50**	**Lucie Pelland**, PhD **4A01** A Plausible Role of the Central Nervous System in the Pathway of Neck Pain	**Shannon Gottschall**, PhD **4B01** Organizational, Interpersonal and Intrapersonal Resilience Factors for Royal Canadian Navy Members	**Marla Buchanan**, PhD **4C01** Using Interpersonal Process Recall Method with Australian Veterans	**J. Don Richardson**, MD **4D01** Predictors of Recovery from Military-related Post-traumatic Stress Disorder in Treatment-seeking Veterans	**Robert Stewart**, BA **4E01** Engaging Public Communications Officials in Research: Development of a national registry
2:50-3:10 **14h50 à 15h10**	**Juan Forero**, PhD **4A02** Quantifying high-level Balance Abilities in Normative and Impaired Participants with the Computer-Assisted Rehabilitation Environment	**Michelle Todd**, PhD **4B02** Group Prolonged Exposure Therapy for Post-traumatic Stress Disorder - Pilot program	**Linna Tam-Seto**, PhD **4C02** Mental Health Apps for Military Members and Veterans: A scoping review	**Tanya Oakley**, MSW **4D02** Gender Differences in Clinical Presentation among Treatment-seeking Veterans and Canadian Armed Forces Personnel	**Stephen Czarnuch**, PhD **4E02** Internet Cognitive Behaviour Therapy: Informing a national platform for public safety personnel
3:10-3:30 **15h10 à 15h30**	**Eva Guérin**, PhD **4A03** Correlates of Acute Injuries and Repetitive Strain Injuries among Canadian Armed Forces Personnel	**Laura Palmer**, MSc **4B03** The TRIAD Study: Traumatic exposures and the development of Post-traumatic Stress Disroder symptoms in the United Kingdom Armed Forces	**Marnin Heisel**, PhD **4C03** Meaning-centered Men's Groups: Findings of a Novel Intervention to Reduce Suicide Vulnerability	**Shay-Lee Bolton**, PhD **4D03** Transition from Service and Mental and Physical Well-being in Canadian Forces Veterans	**Cheryl Drewitz**, MPH **4E03** Workplace Communication and Emotional Expression between Paramedics following Emergency Calls
3:30-3:50 **15h30 à 15h50**	**Markus Besemann**, MD **4A04** ReMAP: Effectively Integrating Physiatry and Decreasing Wait Times in Canadian Armed Forces Health Services Centres	**Jacob Cohen**, BSc **4B04** Low Frequency Magnetic Stimulation to Treat Post-traumatic Stress Disorder	**Sonia Dussault**, MA **4C04** What's Next: An environmental scan of programs during military to civilian transition for women	**Cherie Armour**, PhD **4D04** Identifying Service-related Predictors of Poor Community Reintegration in Northern Irish Veterans	**Paula Di Nota**, PhD **4E04** Police Stress and Memory: Implications for policy and practice

3:50-4:10 **15h50 à 16h10**	**Patrick Lebel**, CPO (Cand) 4A05 Improving Outcomes following Lower Extremity Trauma with a Dynamic Unloading Ankle-foot Orthosis	**DISCUSSION**	**Renee Hunt**, PhD 4C05 Understanding Functional Quality of life in Veterans Diagnosed with Post-traumatic Stress Disorder in Recovery	**David McBride**, PhD 4D05 The Psychological and Physical Health and Well-being of New Zealand Veterans	**Renee MacPhee**, PhD 4E05 Why are Paramedics Leaving the Profession?
4:10-4:40 **16h10 à 16h40**	**NETWORKING BREAK AND TRADESHOW / PAUSE RÉSEAUTAGE ET SALON D'EXPOSITION**				
4:40-6:00 **16h40 à 18h00**	**CONCURRENT SESSION 5 / SÉANCES PARALLÈLES 5**				
Session / Séance	**5A** Serving Members / Membres en service	**5B** Serving Members / Membres en service	**5C** Serving Members and Veterans / Membres en service et Vétéran(e)s	**5D** Families / Familles	**5E** Public Safety Personnel / Personnel de la sécurité publique
Room / Salle de réunion	Chopin	Mozart	Delfosse	Suzor-Côté	Beethoven
Title / Titre	**Screening and Resiliency Skills / Les compétences de dépistage et de résilience**	**Physical Health and Fitness / La santé et la forme physique**	**Biological Interventions / Les interventions biologiques**	**Children in Military Families / Les enfants des familles militaires**	**Technology and Measurement / La technologie et les mesures**
4:40-5:00 **16h40 à 17h00**	**Bryan Garber**, PhD **5A01** A Description of the Canadian Armed Forces Post-deployment Screening Program	**Heather McCuaig Edge**, PhD **5B01** The Canadian Armed Forces Recruit Health Questionnaire: How collecting baseline health data informs later well-being	**Maya Roth**, PhD **5C01** Use of Pharmacogenetics to Enhance Personalized Medicine for Canadian Armed Forces Members and Veterans: A pilot study	**Alyson Mahar**, PhD **5D01** Reasons for Mental Health Physician Visits in Children and Youth in Canadian Armed Forces Families and Civilians	**Stephen Czarnuch**, PhD **5E01** Next Generation 911: Supporting emergency telecommunicators using artificial intelligence
5:00-5:20 **17h00 à 17h20**	**Kerry Sudom**, PhD **5A02** Validation of a Shortened AUDIT Questionnaire for High Risk Drinking Behaviour	**Michael Spivock**, PhD **5B02** BALANCE - The Canadian Armed Forces´ Physical Performance Strategy	**Edouard Auger**, MD **5C02** Pharmacotherapy of Post-traumatic Stress Disorder: Going beyond the guidelines	**Deborah Norris**, PhD **5D02** Exploring the Experiences of Adult Children of Canadian Armed Forces Veterans: Implications for policy development	**Andrew Nicholson**, PhD **5E02** Predicting Intrinsic Connectivity Network Dynamics in Post-traumatic Stress Disorder with Machine Learning
5:20-5:40 **17h20 à 17h40**	**Josh Granek**, PhD **5A03** Impact of Tactical Breathing and Biofeedback on Marksmanship Performance as Part of Road to Mental Readiness Training	**Celina Shirazipour**, PhD **5B03** Examining the Impact of Sport Recovery Programming on Competitors of the Toronto 2017 Invictus Games	**Mélanie Bérubé**, PhD **5C03** Feasibility of a Tapering Opioids Prescription Program for High Risk Trauma Patients	**Amanda Bullock**, PhD **5D03** Impact of Occupational Stressors on Children's Maladjustment from Military Single Parent Families	**Michael Williams-Bell**, PhD **5E03** Heart Rate Responses of Pre-service Firefighters during Simulated Cold Environment Activities

5:40-6:00 **17h40 à 18h00**	**Deniz Fikretoglu**, PhD **5A04** What is the Relationship between the Big 4 skills of the Road to Mental Readiness Program and Psychological Outcomes?	**Sean Lafontaine**, BAS **5B04** Canadian Armed Forces Environmental Neighborhood Evaluation: Initial base results	**DISCUSSION**	**Shannon Hill**, Med **5D04** Supporting the School Transitions of Military-connected Adolescents in Ontario	**Joy MacDermid**, PhD **5E04** Development and Measurement Properties of a Firefighter-specific Work Limitations Scale

6:00PM
18h00

SESSIONS END / FIN DES SÉANCES

6:30PM – 9:30PM
18h30 à 21h30

NETWORKING RECEPTION / RÉCEPTION RÉSEAUTAGE

Room / Salle de réunion : Convention Foyer

WEDNESDAY, OCTOBER 23 / MERCREDI 23 OCTOBRE

7:30AM
7h30

REGISTRATION OPENS / LES INSCRIPTIONS SONT OUVERTES

7:30-8:45
7h30 à 8h45

WORKSHOP 4 / ATELIER 4

WORK AS WELLNESS; PURPOSE AS POLICY / TRAVAILLER POUR LE BIEN-ÊTRE; OBJECTIFS EN TANT QUE POLITIQUE

Room / Salle de réunion : Krieghoff

7:30-8:45
7h30 à 8h45

WORKSHOP 5 / ATELIER 5

PSYCHOLOGICAL CONSEQUENCES OF EXPOSURE TO SEXUAL TRAUMA DURING MILITARY SERVICE IN FEMALE-IDENTIFYING CANADIAN MILITARY MEMBERS AND VETERANS / LES CONSÉQUENCES PSYCHOLOGIQUES DUES AUX TRAUMATISMES SEXUELS LIÉS AU SERVICE MILITAIRE CHEZ DES MEMBRES DES FORCES ARMÉES CANADIENNES ET ANCIENS COMBATTANTS S'ÉTANT IDENTIFIÉ COMME FEMME

Room / Salle de réunion : Salon du Jardin

8:00
8h00

BREAKFAST / DÉJEUNER

9:00-9:45
9h00 à 9h45

MORNING PLENARY / SÉANCE PLÉNIÈRE MATINALE

FROM FAR FORWARD TO FAR OUT: SPECIAL OPERATIONS AND DEEP SPACE HEALTH CARE

Rob Riddell, MD

Flight Surgeon, Operational Space Medicine Group, Canadian Space Agency

9:45-10:15
9h45 à 10h15

NETWORKING BREAK AND TRADESHOW / PAUSE RÉSEAUTAGE ET SALON D'EXPOSITION

10:15-11:55 / 10h15 à 11h55 — CONCURRENT SESSION 6 / SÉANCES PARALLÈLES 6

Session / Séance	6A	6B	6C	6D	6E
	Serving Members / Membres en service	Serving Members / Membres en service	Veterans / Vétéran(e)s	Families / Familles	Public Safety Personnel / Personnel de la sécurité publique
Room / Salle de réunion	Chopin	Mozart	Delfosse	Suzor-Côté	Beethoven
Title / Titre	**Blood and Dental / Le sang et les dents**	**Traumatic Brain Injury, Cancer and Environmental Exposure / Les traumatismes crâniens, le cancer et les expositions environnementales**	**Life after Release, Psychological Health and Sexual Trauma / La vie après la libération des Forces, les traumatismes sexuels et la santé psychologique**	**Symposium Round Table / Colloque sur la Famille: table ronde**	**Programs and Professional Development / Les programmes et le développement professionnel**
10:15-10:35 **10h15 à 10h35**	**Marcus Moore**, MD **6A01** The Development of Canadian Freeze Dried Plasma	**Markus Besemann**, MD **6B01** Traumatic Brain Injury in the Canadian Armed Forces: Epidemiology, Rehabilitation and Management	**Amy Palmer**, PhD **6C01** Finding your Purpose after Release from the Military: An evaluation of the Shaping Purpose program	**LCol (Retd) Russell Mann**, Senior Advisor Vanier Institute of the Family From Information and Insights to Ideas and Impact	**Timothy Black**, PhD **6E01** Shame and Post-traumatic Stress Disorder in the Wounded Warriors Canada Trauma Resiliency Program: Preliminary data analysis
10:35-10:55 **10h35 à 10h55**	**Christian Kastrup**, PhD **6A02** Self-dispersing Bioabsorbable Hemostatic Powder Non-invasively Addresses Truncal Hemorrhage in Swine	**Ashirbani Saha**, PhD **6B02** Convolutional Neural Network-based Representation of Diffusion Tensor Imaging to Classify Concussion Patients	**Maya Eichler**, PhD **6C02** The Experiences of Military Sexual Trauma Survivors with the Veterans Review and Appeal Board		**Andrea Stelnicki**, PhD and **Vivien Lee**, PhD **6E02** Boots on the Ground: Supporting the supporters
10:55-11:15 **10h55 à 11h15**	**Massimo Cau**, BSc **6A03** Hemostatic Powder Sprayed through Tubing Halts Severe Bleeds: Towards wearable hemostatic protection	**Carolyn McGregor**, PhD **6B03** Extreme Climate Pre-deployment Acclimation Resilience Assessment using Climate Chambers and Big Data	**Walter Callaghan**, MA **6C03** Allyship, Willful Blindness and Toxic Masculinity: Veteran responses to #MeToo and Operation HONOUR		**Megan McElheran**, PsyD **6E03** Psychological Resiliency in Public Safety Personnel: A description of the Before Operational Stress program
11:15-11:35 **11h15 à 11h35**	**Randal Boyes**, PhD (Cand) **6A04** The Effect of Water Fluoridation on the Dental Health of Recruits in the Canadian Armed Forces	**Lydia Hamer**, BAS **6B04** Background Exposures to Environmental Toxicity in Conflict Zones: A literature review	**DISCUSSION**		**Valerie Testa**, MSc (Cand) **6E04** Implementation of a First Responder Operational Stress Injury Clinic Using Theoretical Domains Framework and Consolidated Framework for Implementation Research

11:35-11:55 **11h35 à 11h55**	**Constantine Batsos**, MSc **6A05** Development and Validation of a Predictive Model for Dental Emergencies in the Canadian Armed Forces	**DISCUSSION**	**DISCUSSION**		**Aman Hussain**, PhD **6E05** Perspectives of Municipal First Responders on Learning and Professional Development
12:15 **12h15**	**AWARDS CEREMONY / REMISE DES PRIX**				
1:00 **13h00**	**LUNCH / REPAS DU MIDI**				
2:00PM **14h00**	**FORUM 2019 ENDS / FIN DU FORUM 2019**				

POSTER SESSION / PRÉSENTATIONS SCIENTIFIQUES PAR AFFICHE


2014


2017

2015

2011

Name	Designation/ Degree	Affiliation(s)	Presentation Title	Poster ID
Angehrn, Andreanne	BA	University of Regina	Gender Differences in the Mental Health of Canadian Police: The role of stress and social support	PM105
Armour, Chérie	PhD	Ulster University	Prevalence and Concordance of Screening for Diagnostic and Statistical Manual-5 and International Classification of Diseases-11 Post-traumatic Stress Disorder Diagnoses	PM147
Bailliu, Anne	MSW	The Royal Ottawa Health Care Group	Dissemination of Prolonged Exposure Therapy in Canada	PM125
Bennett, Brittany	BA	Memorial University	"Then you´re in the wrong profession" Perceptions of Officer Fitness from Correctional Trainees	PM103
Bergman, Beverly	PhD	University of Glasgow	The Scottish Veterans Health Study: Insights into long-term health	PM142
Boland, Hamid	MEng	Department of National Defence	A Reward-based Approach to Improve Workplace Well-being Awareness and Behaviours	PM124
Boulos, David	MSc	Department of National Defence	A Study of Compliance with Screening Policy	PM112
Bourassa, Stephane	PhD (Student)	Université de Montréal; Canadian Armed Forces; Laval University	Methods to Reduce Oxygen Consumption in a Pre-hospital Transportation or Military Setting	PM135
Boyle, Alistair	PhD	Carleton University	Machine Learning for the Prediction of Autonomic Nervous System Response during Virtual Reality Treatment using Biometric Data	PM117
Bremault-Phillips, Suzette	PhD	University of Alberta	Veteran-friendly Campuses in Alberta: Supporting Veteran Military to Civilian Transition	PM143
Buchanan, Marla	PhD	University of British Columbia	Veterans´ Experiences of Participating in a Natural Horsemanship Program	PM148
Burtch, Andrew	PhD	Carleton University	Accounting for Suicide Cases among Canada´s Korean War Dead, 1950-1956	PM149
Carlucci, Samantha	BA	Department of National Defence	Moderating Effect of Age on the Relationship between Personality and Mental Health in Canadian Armed Forces Recruits	PM134

Carrese, Pasqualina	DPs (Cand)	University of Sherbrooke, Faculté des Lettres et Sciences humainesVeterans Affairs Canada, Directorate of Mental Health	Process of Post-traumatic Growth in Canadian Veterans Diagnosed with Post-traumatic Stress Disorder who became Peer Helpers	**PM155**
Cassidy, Clifford	PhD	University of Ottawa	Investigating the Function of the Noradrenergic System in Post-traumatic Stress Disorder using Neuromelanin-sensitive Magnetic Resonance Imaging	**PM150**
Cheema, Sheraz	HBSc	University of Toronto	Pharmacogenetic Testing for the Treatment of Post-traumatic Stress Disorder Patients	**PM126**
Cousineau-Short, Yvon Daniel	MPH	Carleton University; University of Waterloo; Department of National Defence	Study on Pre-enrolment Risk Factors for Suicide in the Canadian Armed Forces: Selection of cases and controls	**PM127**
Daoust, Jean-Philippe	PhD	University of Ottawa	Groupe de gestion de la colère pour vétérans de combat ayant un Trouble Stress Post Traumatique - Description et estimation de son efficacité et de son efficience	**PM151**
Deschênes, Shana	MSc (Cand)	Université du Québec à Chicoutimi	Activité physique et prise en charge des traumatismes liés au stress opérationnel chez les vétérans	**PM144**
Easterbrook, Bethany	PhD (Student)	McMaster University	Trauma-exposure in Military Members and Public Safety Personnel: A qualitative investigation	**PM106**
Edgelow, Megan	MSc	Queen's University	The Impact of Sleep on the Health of Canadian Firefighters	**PM104**
Fikretoglu, Deniz	PhD	Department of National Defence	National Trends in Mental Health Service Use Intensity in Canadian Military and Civilians, 2002-2013	**PM128**
Forsyth, Ashleigh	PhD (Student)	Queen's University	Efficacy of Methylenedioxymethamphetamine-assisted Psychotherapy for Post-traumatic Stress Disorder: A systematic review and meta-analysis	**PM152**
Fredette, Anny	MSc	Université Laval	Lower Limb Running-related Injuries and Running Parameters Among Military Members	**PM113**
Geck, Celia	MA	The Royal Ottawa Health Care Group	Operational Stress Injury Clinic Services for the Royal Canadian Mounted Police Members: A 10-year review	**PM107**
Godsell, Pauline	BSc	Department of National Defence	What Gets Measured Gets Managed - Traumatic Brain Injury Persistent Motor Control Deficits	**PM136**

Hawkey, Kyle	MEd	Pennsylvania State University; US Air Force	Implementing and Evaluating a Zero Suicide Approach Within the U.S. Air Force	**PM129**
Holly, Janet	MSc	The Ottawa Hospital	Use of Computer Assisted Rehabilitation Environment Optokinetic Stimulation for Pseudo-neglect in Complex Regional Pain Syndrome	**PM118**
Honey, Jonathan	DC	Canadian Armed Forces	Summary of Indoor Air Quality Assessments Aboard Royal Canadian Navy Frigates	**PM114**
Houle-Johnson, Stephanie	PhD (Student)	University of Ottawa	Impact of Potentially Morally Injurious Experiences in the Canadian Forces: A multi-method analysis	**PM130**
Jones, Chelsea	PhD (Student)	University of Alberta; Department of National Defense	Technology Acceptance and Usability of a Virtual Reality Based intervention for Post-traumatic Stress Disorder via the Computer Assisted Rehabilitation Environment	**PM122**
Jones, Chelsea	PhD (Student)	University of Alberta; Department of National Defense	Pre/Post Analysis of an Occupational Therapy Tinnitus Management Intervention for Canadian Armed Forces Members	**PM123**
Lu, Diane	MD, PhD	Department of National Defence	The Canadian Armed Forces Health Survey: Collection experience	**PM137**
Major, Robin	MA	Canadian Armed Forces	Self-compassion Training for Compasssion Fatigue, Spiritual Fitness and Psychological Flexibility	**PM131**
Manser, Lynda	MMgt	Department of National Defence	Parents of Military Members	**PM101**
Manser, Lynda	MMgt	Department of National Defence	The Military Family Experience with Posting-related Relocations	**PM102**
Martin, Krystle	PhD	Ontario Shores Centre for Mental Health Sciences	Civilian Law Enforcement Personnel and Mental Health	**PM111**
McPherson, Carson	Doc.SocSci	Cedars at Cobble Hill	Impact of Social Support for Military Members Initiating and Maintaining Recovery from Addiction	**PM132**
Moll, Sandra	PhD	McMaster University	Co-designing a Mobile App to Prevent Post-traumatic Stress Injury in Public Safety Personnel	**PM108**
O'Neil, Jennifer	MHSc	University of Ottawa, Faculty of Health Sciences, School of Rehabilitation SciencesBruyère Research Institute	Remotely Supervised Home Exercise Interventions in Survivors of Moderate or Severe Traumatic Brain Injury: A protocol	**PM156**
O'Toole, Kaitlin	MSc (Student)	University of Alberta	Evaluating the Quality of Resilience Apps for Military Members and First Responders	**PM119**

Pajuluoma, Gordon	MSPH	Canadian Armed Forces	Determination of Asbestos Containing Materials Within the Skrunda-1 Training Facility in Latvia	**PM138**
Poirier, Alain	OCAD	Veterans Affairs Canada	Risk Screening at Veterans Affairs Canada: Development of a questionnaire	**PM145**
Pound, Teresa	BSc	Veterans Affairs Canada	Female and Male Veterans and Canadians: A sex-disaggregated comparison of well-being	**PM146**
Romero-Sanchiz, Pablo	PhD	Dalhousie University	Craving and Emotional Responses to Tailored Cues in Cannabis users with Military and Civil Trauma	**PM153**
Shields, Duncan	PhD	University of British Columbia	Police Officers Experience of Occupational Stress and Well-being	**PM109**
Shimmons, Kristina	MA	Statistics Canada	Canadian Armed Forces and Veteran data available at Statistics Canada	**PM120**
Slobogean, Gerard	MD	University of Maryland	'T-clamp' Provides Rapid Pelvic Ring Stabilization in a Resource Limited Environment	**PM139**
Smith, Andrew	PhD	Carleton University; The Ottawa Hospital; Department of National Defence	A Mobile App For Annotating Symptoms of Polytrauma Involving Traumatic Brain Injury, Post-traumatic Stress Disorder, and Complex Pain	**PM121**
Smith, Shane	MD	Western University	The Effectiveness of Junctional Tourniquets: A systematic review and meta-analysis	**PM140**
Stelnicki, Andrea	PhD	University of Regina	Evaluating the Effectiveness of the Before Operational Stress Program	**PM110**
Stevelink, Sharon	PhD PhD	King's College London	Identifying Military Veterans in a Clinical Research Database: Evaluation of two methods	**PM141**
Tam-Seto, Linna	PhD	Queen's University	“The Dragon” and “The Dark Spot”: The language of post-traumatic stress disorder according to the Canadian military community	**PM133**
Thierbach, Sylvi	MD	German Armed Forces	Use of C-MAC® Videolaryngoscope for Endotracheal Intubation in Patients with Out-of-hospital Cardiac Arrest	**PM115**
Wood, Valerie	PhD	Queen's University	Characteristics of the Canadian Armed Forces Help-seekers, Non-help seekers, and No Need Groups	**PM116**
Zafari, Hasan	PhD	Queen's University	Weakly Supervised Text Classification for Assisting Patient Data Processing	**PM154**

Name	Designation/ Degree	Affiliation(s)	Presentation Title	Poster ID
Armour, Chérie	PhD	Ulster University	Confirmatory Factor Analysis of the International Trauma Questionnaire among Northern Ireland Veterans	PT245
Arsenault, Evan	BASc	Queen's University	Meet our #Here4U AI Chatbot Prototype, Supporting the Mental Health of the Military Community	PT225
Bauermann, Tonya	PhD	The Royal Ottawa Health Care Group	Efficacy of a Two-part Cognitive-behavioural Therapy Protocol for Insomnia, Nightmares and Post-traumatic Stress Disorder	PT233
Boulos, David	MSc	Department of National Defence	Impact of Screening on Delay to Care for Deployment Related Mental Disorder	PT226
Bridgewater, Courtney	MSc	The Ottawa Hospital	Clinical and Virtual Reality Assessment of Patients with Mild Traumatic Brain Injury Requiring Prism Glasses: Symptomology	PT234
Carroll, Brooke	BA	University of Ottawa	Evaluating the Efficacy of PEER to Inform the Pharmacotherapy for Military Personnel with Depression	PT219
Cousineau-Short, Yvon Daniel	MPH	Carleton University; University of Waterloo; Department of National Defence	Sleep Problems in the Military and Public Health Interventions to Address them: A scoping review	PT220
Drummelsmith, Jennifer	MA	The Chicago School of Professional Psychology	Mental Health Needs and Perceptions of Incarcerated Canadian Veterans	PT246
Edgelow, Megan	MSc	Queen's University	The Occupational Therapy Trauma Intervention Framework: A program evaluation	PT205
Fletcher, Kari	PhD	University of St. Thomas	Global Implications for Civic Engagement among US Student Veterans	PT241
Franz, Anja	MSc	Department of National Defence	Differential Diagnosis using Directional Preference in Canadian Armed Forces Members Suffering from Low Back Pain	PT235
Geck, Celia	MA	The Royal Ottawa Health Care Group	Dialectical Behaviour Therapy for Military and Law Enforcement with Operational Stress Injuries	PT228
Gillis, Alasdair	MSW	The Royal Ottawa Health Care Group	Collaborative Decision Making in Post-traumatic Stress Disorder Treatment: A survey of client and clinician perspectives	PT215
Godfrey, Kelli	LMSW	University of Alabama	Mental Health of Women Veterans can have Consequences on Future Employment	PT247

Granek, Josh	PhD	Department of National Defence	Optimizing Mental Health and Resilience by Leveraging Technology in Training for Canadian Armed Forces Personnel	**PT229**
Holly, Janet	MSc	The Ottawa Hospital	Developing the Hierarchical Domains of Sympathetic Activation of the Autonomic Nervous System	**PT224**
House, Cody	PsyD	Alberta Health Services	Lessons Learned in Group Programming: Responding to the needs of Veterans	**PT248**
Hussain, Aman	PhD	University of Winnipeg	Preliminary Findings with a Municipal Fire Department's Ongoing Professional Development	**PT206**
Jones, Chelsea	PhD (Student)	University of Alberta; Department of National Defense	Edmonton Police Services Workplace Reintegration Program: Analysis of a trainer training initiative	**PT208**
Kelly, Laura	PhD	Office of the Veterans Ombudsman	Spouses Supporting Transition	**PT203**
Ketcheson, Felicia	MSc	St. Joseph's Health Care	Association between Post-traumatic Stress Disorder and Major Depressive Disorder and Severity of Somatic Symptoms in Treatment-seeking Veterans	**PT230**
Killip, Shannon	MSc	McMaster University	Differences in Disability Management Outcomes in First Responders Compared to other Occupations	**PT204**
Lam, Andrea	MPH	Canadian Armed Forces	An Evaluation of the Maritime Forces Pacific Health and Wellness Strategy	**PT222**
Lam, Jason	MA (Student)	Queen's University	Identifying Patients with Post-traumatic Stress Disorder using Deep Learning	**PT249**
MacLean, Mary Beth	MA	Veterans Affairs Canada, Research Directorate	Health Services Utilization among Canadian Armed Forces Veterans	**PT244**
Mailloux, Olivier	MD	Université Laval; Canadian Armed Forces	Bariatric Surgery in Active Duty Military Personnel: A literature reveiw	**PT236**
Major, Robin	MA	Department of National Defence	The Effect of a Cognitive Behaviour Therapy Program for Insomnia on Patients´ Psychological and Daytime Functioning	**PT231**
Manser, Lynda	MMgt	Department of National Defence, Military Family Services	Enhancing Military Family Resilience	**PT201**
Mausz, Justin	PhD (Cand)	McMaster University	Unpacking the Sociocultural Characteristics of Paramedic Mental Health: A grounded theory study	**PT209**
Mavor, Matthew	MSc	University of Ottawa	Lifting Strategies in Male and Female Soldiers following a Loaded March at Varying Temperatures	**PT237**

Mccomber, Teri	PhD (Cand)	Veterans Affairs Canada	Identifying the Demographics of Veterans Affairs Canada´s clients who access the Veterans Emergency Fund Program	**PT240**
McIntyre, Kelli	PT	Canadian Armed Forces	Evidence-based Conservative Rehabilitation for Posterior Glenohumeral Instability: Systematic review	**PT238**
McWilliams, Brenna	MSc (Cand)	Memorial University of Newfoundland	Anxiety and Learning to Prepare Hauling Systems for Rope Rescue at Height	**PT210**
Morin, Jean-Sébastien	MA	University of Ottawa; Canadian Armed Forces	Addressing Moral Injury: A current state analysis of the contributions of Mental Health Chaplains	**PT227**
Naicker, Kiyuri	PhD	Department of National Defense	Analysis of Sick Leave, Excused Duty, and Medical Employment Limitations in the Canadian Armed Forces (2017/18)	**PT216**
Nazari, Goris	PhD (Cand)	Western University	Prevalence of Musculoskeletal Disorders In Canadian Firefighters. A systematic review-meta-analysis	**PT213**
Novick, Jason	MA	Carewest Operational Stress Injury Clinic	Evaluating Clients' Perceptions of Care with Treatment Received for Operational Stress Injuries	**PT232**
Oakley, Tanya	MSW	St. Joseph's Healthcare	The Relationship between Deployment, Gender and Mental Health in Treatment-seeking Veterans	**PT250**
Palmer, Laura	MSc	King's College London	Public and Employer Perceptions of Veterans in Canada	**PT251**
Paquet, Emilie	PCP	Department of National Defence	Patient Reported Outcomes and Functional Measures in Canadian Forces with Chronic Pain Conditions	**PT223**
Park, Rosemary	MSc	Servicewomen's Salute	Creating a Servicewomen´s Salute Online Portal for Transitioning and Veteran Canadian Armed Forces Servicewomen	**PT252**
Poirier, Alain	OCAD	Veterans Affairs Canada	Risk Screening at Veterans Affairs Canada: Pilot testing of the tool	**PT242**
Reilly, Tara	PhD	Canadian Armed Forces	Generating Resilience to Injuries through Training: A study protocol	**PT239**
Retell, James	PhD	Queen's University	Development and Validation of a Mental Health Screening Tool for Public Safety Professionals	**PT207**
Ritchie, Kimberly	PhD (Cand)	Queen's University	A Multiple Case Study Exploring Post-traumatic Stress Disorder in Veterans with Dementia Living in Long-term Care	**PT253**

Salter, Blair	BSc	Canadian Armed Forces	Adherence to Revised Policy on Malaria Chemoprophylaxis in the Canadian Armed Forces	**PT214**
Seagram, Belinda	PhD	Landing Strong	Harnessing the potential of virtual community as a method of engaging Injured Veterans and First Responders	**PT254**
Shields, Robyn	BA	University of Regina	Stigma, Mental Health Dnowledge, and Mental Health Service use in Canadian Paramedics	**PT211**
Stelnicki, Andrea	PhD	University of Regina	Tracking the Mental Health of Canadian Firefighter Peer Supporters	**PT212**
Theriault, Francois	MSc	Department of National Defence	Case Management in the Canadian Armed Forces: Epidemiological surveillance of a national program	**PT217**
Thierbach, Sylvi	MD	German Armed Forces	Necessity to Depict Variable Neck Anatomy for Training of Cricothyroidotomy	**PT218**
VanTil, Linda	MSc	Veterans Affairs Canada	Census 2021	**PT243**
Williams, Ashley	MSc	Queen's University, Faculty of Health Sciences, Department of Occupational Therapy, School of Rehabilitation Therapy	Healthcare Access Pathways for Military-connected Children with Autism Spectrum Disorder	**PT202**

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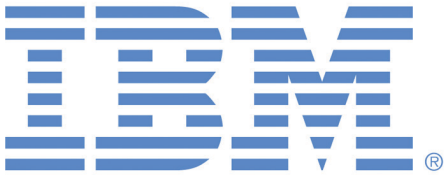

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UNCLOUDING MENTAL WELLNESS...

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As part of the National Research Consortium, CIPSRT serves as the Knowledge Exchange Hub for knowledge synthesis, translation, and exchange that relies upon the best contemporary research evidence supporting an overall mission to help current and former public safety personnel, their leaders, and their families to maintain and improve their mental health and well-being.

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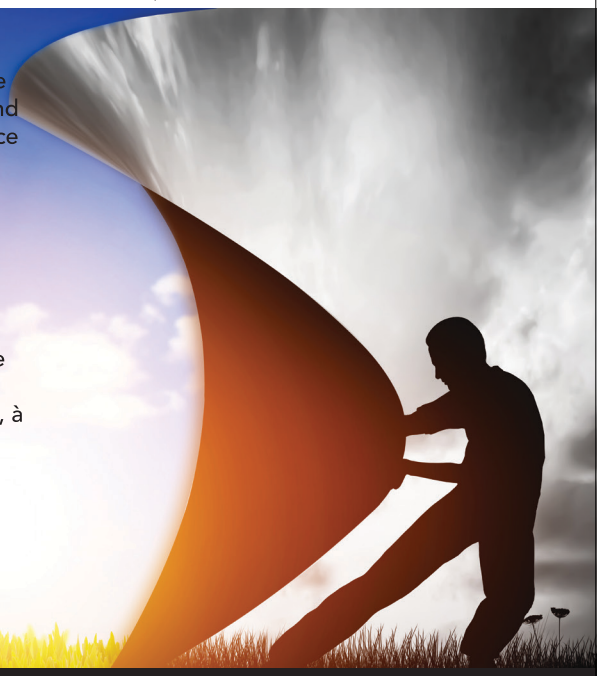
https://www.cipsrt-icrtsp.ca

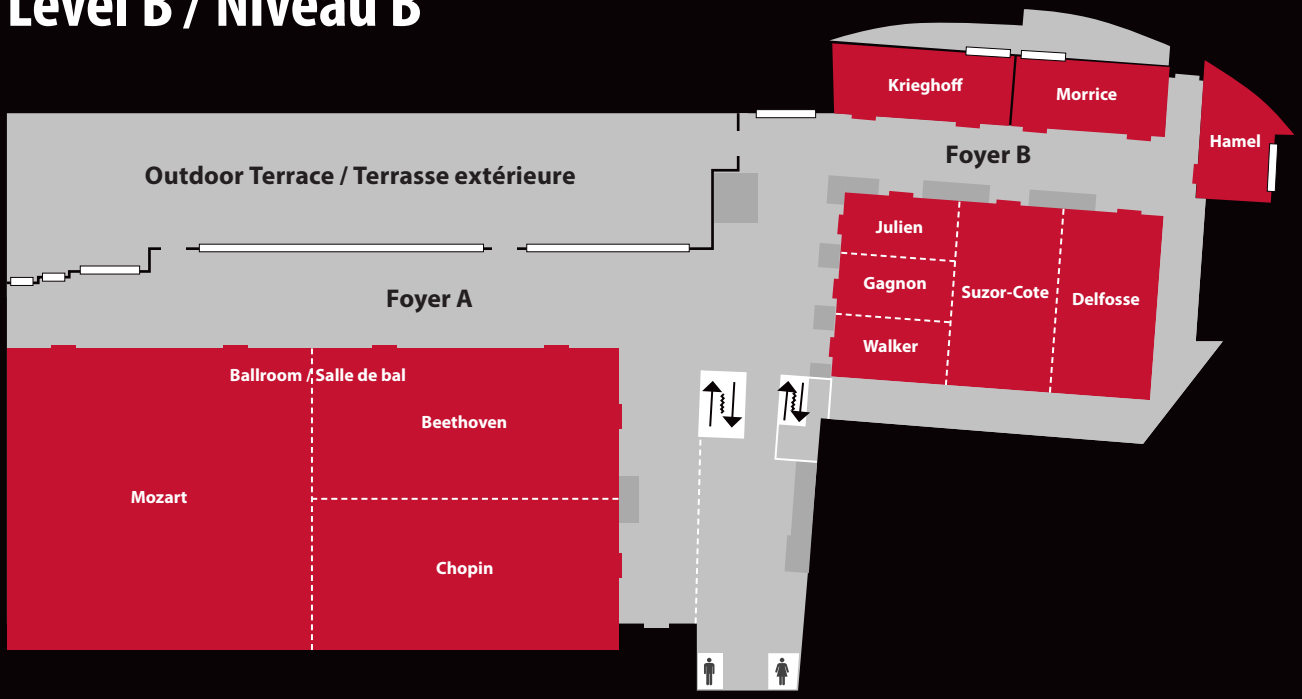
RESEARCH THAT HAS IMPACT...



University of Regina. 3737 Wascana Parkway, Regina, SK Canada S4S 0A2. CIPSRT@cipsrt-icrtsp.ca Tel: +1-306-337-2287

FLOORPLAN / PLAN DES SALLES

Level B / Niveau B



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FORUM 10

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Kingston ON Canada

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L'Institut canadien de recherche sur la santé des militaires et des vétérans

Ambulance Paramedics
of British Columbia - CUPE 873

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105 - 21900 Westminster Hwy., Richmond, BC V6V 0A8
info@apbc.ca | www.apbc.ca

November 21, 2019

Ms. Patricia Lane, Chair
Emergency Medical Assistants Licensing Board
EMA Licensing Branch
Ministry of Health
PO Box 9625 Stn Prov Govt
Victoria BC V8W 9P1

Via Email and Canada Post

Dear Ms. Lane;

Re: Recent British Columbia Emergency Health Services (BCEHS) Direction to Practitioners

I write to you today on behalf of the over four thousand, three hundred (4,300) licensed BCEHS Emergency Medical Responders (EMR'S) and Paramedics for whom we represent. As you are aware, the Ambulance Paramedics & Emergency Dispatchers of BC (APBC) is both the labour union and processional advocate for the profession in this Province.

We have become aware of some recent direction from BCEHS to practitioners that we believe will: 1) impact patient safety and treatment negatively, and 2) puts license holders in a potential moral, ethical and legal dilemma.

Specifically, we point to two (2) recent directions from BCEHS:

1) On October 1st, 2019, BCEHS published its regular "Op's Update" on the BCEHS intranet. In that update, under Clinical and Professional Practice update, under bulletin 1.3, the employer is directing BCAS license holders who are riding third on "observation" shifts to not provide direct patient care, other than providing CPR or holding C-Spine at the direction of the crew. We have attached the PDF version of the update for your reference.

2) On, or around November 11th, 2019, BCEHS, through Clinical and Professional Practice, have directed licensed Advanced Care Paramedics (ACP's) who have not completed an employer sanctioned education session (Airway Interventions in Medical Emergencies (AIME) - 3) to not engage in the provision of endotracheal intubation (ET). We have attached the email correspondence between BCEHS CPP and the APBC for your reference.

It should be noted, that in both situations noted above, the equipment to provide a license holders full scope of practice and/or services are available to the license holder. In addition, we have become aware that BCEHS may have refused to send a paramedic unit to a call because of their clinical direction.

As you can imagine, this puts our members into a significantly difficult position of undue stress during already stressful events.

Under the Emergency Medical Assistants Regulations, under Section 11 – Condition of License, it states: "*It is a condition of every license that the EMA must comply with the Act and the regulations, including without limitation the Code of Ethics set out in Schedule 3.*"

Further, under Schedule 3 of the regulations – code of ethics, it is clear and unambiguous in relation to treating patients in relation to this letter at subsections (a), (b), (e), and (g).

Finally, in the fall newsletter from the EMALB, Dr. Yoon provides expert clarity on these issues with his statement, under the "Duty to advocate" section:

"When present for a 911 scene response or an interfacility transfer, every EMA is expected to use their knowledge and skills as a professional. Even when working in a role as a driver or learner, the EMA cannot simply be a bystander or observer. The EMALB expects every EMA, regardless of role, seniority or qualifications, to interact with fellow crew members to serve the best interests of the patient."

For its part, BCEHS claims one of the reasons for the restriction on intubation as ***"In addition, we are responsible for ensuring that paramedics demonstrate competence in high acuity, low occurrence (HALO) procedures such as intubation***;" and that ***"As I am sure you fully understand and can appreciate, having untrained paramedics performing these types of interventions poses its own risks to patient safety, which is why we made the decision to restrict practice."*** Concerning to the Union is that not only are these ACP's trained in intubation, but the BCAS has not restricted other HALO procedures such as needle decompression in tension pneumothorax cases or front of neck access (FONA) which, arguably, are even less frequent then the skill of intubation.

It has always been the understanding of the APBC that, employers have the right to restrict practice of license holders, but in doing so, must not place a license holder in a position of moral, ethical or legal dilemmas. For example, if the employer does not want non-AIME 3 ACP's to provide intubation, they could remove that equipment from the ACP's workplace. We are unsure how the employer would be able to accomplish that for license holders on observations shifts.

All the above in consideration, we believe that the BCEHS, through its restrictions noted above, is placing patient safety in jeopardy in addition to providing direction contrary to the statues, regulations and expectations of the EMALB.

We respectfully ask that the board investigate our concerns in addition to providing the board's position on how employers can restrict a license holders practice in compliance with the boards regulations, policy and expectations.

If we can provide any further information, please feel free to contact the undersigned.

Thank you for your attention to this serious matter.

Sincerely,

Dave Deines
Provincial Vice President
Ambulance Paramedics & Emergency Dispatchers of British Columbia
CUPE Local 873

Cc: Provincial Executive Board, Local 873

DD/sd/MoveUp

OPS Update

BCEHS | BC Emergency Health Services
Provincial Health Services Authority

Issue 13 | October 2019

In this issue...

CLINICAL UPDATE

Clinical and professional practice update for October 2019

1. Practice updates

1.1. Removal of sternal rub for assessing level of consciousness

In the past, BCEHS paramedics have used the sternal rub as a painful stimulus in assessing the level of consciousness in an unconscious patient. This practice is **no longer supported**. While examining literature on the subject, it is clear that the sternal rub actually causes patient harm. It is for these reasons that sternal rubs for assessing level of consciousness are no longer supported by BCEHS and are in fact now considered **dangerous practice**.

1.2 DimenhyDRINATE - Indications

The indication for DimenhyDRINATE administration for use as a mild sedative prior to a patient being moved has been removed from practice and the changes are reflected in the BCEHS Treatment Guidelines.

1.3 Riding third/observation - Paramedic practice

Clinical and Medical Programs is aware of employees who have been practicing under their license during unpaid voluntary observation “riding third” shifts. Going forward, any employee who voluntarily rides third outside of a student placement, clinical orientation, or approved education experience is not to provide direct patient care or undertake treatment interventions, other than performing CPR and holding c-spine under the advice of the crew. If you have any questions about this change, please email ClinicalPractice@bcehs.ca.

2. Practice reminders

2.1 Ringers Lactate in transfers

To clarify the ability for paramedics to undertake transfers of patients who are being administered Ringers Lactate solution: While this is not part of the BCEHS Treatment Guidelines for administration, it is an approved intervention for interfacility transfers and is also covered under your legal scope of license.

2.2 Controlled and targeted substances - Fentanyl and ketamine roll-out

The roll-out of the new controlled and targeted substances policy, procedures and medication registers on **October 8** will be followed by the provincial roll-out for ketamine and fentanyl in all remaining hospital and station safes on **October 16**.

A reminder that all staff utilizing and/or accounting for controlled and targeted substances should familiarize themselves with the new policy, procedures and training updates on the Learning Hub, along with the **AIME 3 refresher podcast** to review key principles and the new medications prior to October 16.

2.3 Hanging pre-prepared IV bags

The practice of hanging pre-prepared IV bags at the start of a shift is not an endorsed practice by Clinical and Medical Programs. It introduces many risks and is wasteful. Instead, IVs and solutions should only be prepared when indicated for patient care in line with the BCEHS Treatment Guidelines.

3.0 Paramedic research and education

3.1 Congratulations to Adam Greene

To fulfill our vision of being an international leader in the provision of pre-hospital care, research plays a vital role in determining best practice standards and provides sound evidence for the care we provide across the province.

BCEHS research goals

1. Ensure research capacity and awareness within BCEHS
2. Align BCEHS research with organizational and PHSA strategic objectives
3. Ensure that the pre-hospital practice of care is based on best practice and the best available evidence
4. Improve the quantity and quality of BCEHS participation in clinical research activities that BCEHS leads or is a partner in
5. Improve the accessibility and usability of research resources for staff

Congratulations to Adam Greene and his team for their tremendous achievement in the recent publication of their work: "*Systematic review of scores and predictors to trigger activation of massive transfusion protocols*". This work is published in the Journal of Trauma and Acute Care Surgery, a well-respected and monthly peer-reviewed journal. The link to the full article is here.

3.2 Palliative clinical pathway: Questionnaire

There have been many responses to the questionnaire on palliative care. A common theme in the responses so far is the challenge of navigating a patient's previously stated wishes that are in contrast to the family dynamics and requests. We are working on finding approaches and strategies to support paramedics in these situations.

The palliative initiative, which aligns with the BCEHS Assess, See, Treat and Refer approach, is intended to:

- support quality of life for palliative/end-of-life (EOL) patients
- educate paramedics to better respond to palliative patients in crisis situations
- bridge the gaps in service until their regular care team is available, thereby avoiding unnecessary transport to hospital when possible.

To gain a better understanding of the current paramedic clinical practice relating to caring for palliative/EOL patients, please consider taking this questionnaire if you haven't already. To answer a question, please choose the answer that is closest to the way you feel about your interaction with palliative/EOL care calls.

Get involved and share your thoughts and experience. Access the questionnaire here.

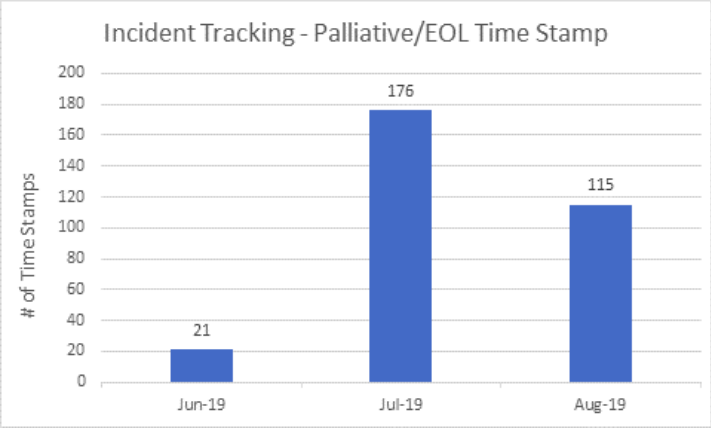
3.3 Palliative care clinical pathway

"Track-Event" Update

The Paramedics & Palliative Care Project supports paramedics in delivering palliative, symptom- management care to patients who have accessed 911 when their usual care team is not available, or when crisis situations occur. The goal is for paramedics to use the palliative clinical pathway to support patients in their desire to stay at home, rather than being transported to hospital, when possible.

When a patient/family member calls 911 during a symptom crisis and self-identifies as palliative/EOL, the call-taker follows their usual dispatch procedures, and additionally, the call-taker is now using the "Palliative/EOL" timestamp, which results in a notification to the CliniCall desk for secondary triage and call-back purposes. Early data indicates increased support of patient wishes when a paramedic specialist is involved in the clinical support for paramedic crews treating palliative patients.

Thanks to the BCEHS call-takers, dispatchers and paramedic specialists for their continued and critical involvement in the early identification of palliative patients.



Paramedic specialists and the palliative clinical pathway

Paramedics specialists working on the street may attend palliative/EOL calls alongside you. These patients present with both acute and/or chronic presentations, and don't necessarily appear to require traditional "ALS" care.

The paramedic specialists will assist with patient management as required, but more importantly, they can help support patient's wishes and evaluate the patient for potential inclusion in the palliative clinical pathway with non-conveyance to a hospital.

If a paramedic specialist is enroute to a palliative/EOL event, and you are unsure if they should keep coming, consult with CliniCall to determine the best course of action.

It is recognized that this new approach to patient-centered care, with potential non-conveyance to emergency departments through pre-determined clinical pathways, represents a significant change in practice for paramedics. Please continue to read these updates to stay up-to-date with the roll-out of the palliative clinical pathway, familiarize yourself with the palliative/EOL clinical practice guidelines and proactively share your thoughts and suggestions.

3.4 Paramedic mini-CAT (critically appraised topic)-Nitrous Oxide/Entonox for pain

Critically appraised topics (CATs) are one-to-two page evidence-based, clinical appraisals on current paramedic care, intended to present the evidence to support such practice. Clinical and Medical Programs has started a monthly mini CAT bank, where these learning resources are available for all BCEHS paramedics.

You can check out the latest CAT that investigates the evidence base for "Nitrous Oxide/Entonox for pain in the pre-hospital setting", here.

If you'd like to contribute to the creation of a paramedic mini-CAT please email clinicalpractice@bcehs.ca.

3.5 Extracorporeal cardio-pulmonary resuscitation simulation

St Paul's Hospital out-of-hospital cardiac arrest (OHCA) extracorporeal cardio-pulmonary resuscitation (ECPR) program simulation will occur on the fourth Monday of each month. Two emergency physicians and nursing staff will be at each simulation. Ideally representatives from perfusion, cardiovascular surgery, and interventional cardiology will also attend.

Simulation schedule:

- 0745: prehospital protocol activation by paramedics, ED preparation begins
- 0800: patient arrival at hospital
- 0815: Non-ED team members arrive at resuscitation bay

This excellent training is open to all paramedics and is particularly relevant to those paramedics who work at stations involved in the extracorporeal membrane oxygenation (ECMO) trial (Vancouver and North Vancouver).

4.0 EMALB - Paramedic regulator

4.1 Reminder for continuing competency

During 2018/19, the EMALB sent out 330 hearing letters to license holders in shortfall for the 2017/18 reporting period. Of the 330, 24 responded to the letter, 111 were suspended, 131 who had previously suspended licenses had their licenses revoked, and 64 relinquished their license.

For the 2018/19 reporting period, 603 license holders were in shortfall, which is a 20 per cent increase over the 2017/18 reporting period. This is the first time since the 2014/15 reporting period that there was an increase in license holders in shortfall. During 2019/20, the branch will determine if additional education or policy change is required to reduce the number of license holders in continuing competence shortfall.

of policy change is required to reduce the number of license holders in continuing competence shortfall.

To ensure you are not in shortfall, the continuing competence requirements consist of: 20 patient contacts and 20 CME credits. You can use additional CME credits if you are short of patient contacts, but not the other way around. Read more, here.

5.0 Questions and Answers

5.1 Q: Will there be clearer guidance on the practice of vulnerable adults and children as part of the Clinical Practice Guideline (CPG) Project?

5.1 A: Yes, the CPG team has included the development of these areas of practice as part of the project, as well as guidance on sexual assault and domestic abuse. For more information email ClinicalPractice@bcehs.ca.

The Clinical and Professional Practice team will provide a monthly update with a special section answering your questions. If you have any questions, comments, or feedback about clinical and professional practice, treatment guidelines, EMA regulation, or other practice issues, please email us at: ClinicalPractice@bcehs.ca. We will do our best to get back to you within 10 days and/or publish your questions in a future update.

OPERATIONS UPDATE

The Universal Response Matrix goes live October 7, 2019

Universal Layering Matrix

May 2019

Clinical Response Model Indicator	Ideal Response	Unit Response Mode	Additional Considerations
PURPLE	ACP or CCP + PCP or EMR	Respond Code 3	Community Paramedic
RED	ACP or CCP + PCP or EMR	Respond Code 3	Community Paramedic
ORANGE	PCP or EMR	Respond Code 3	ACP if significantly closest & layer PCP/EMR unit routine to assist if they are within 30 minutes of the scene
YELLOW	PCP or EMR	Respond Code 2	If a PCP or EMR unit is not readily available or significantly delayed, consider other resources (ALS, FR, etc) with Paramedic Specialist and Supervisor approval.
GREEN	TBD	TBD	
BLUE	TBD	TBD	

What's New?

The Universal Response Matrix (previously the ALS Layering Matrix) is used by dispatchers to determine how crews should be deployed to events in conjunction with the Clinical Response Model. The new matrix brings together the multiple versions of deployment matrices across the province to convey consistent guidance to dispatchers.

Why?

This new Universal Response Matrix provides dispatchers with a consistent approach when assigning the various qualifications of paramedics across the province to a variety of scenarios. It now takes all BCEHS' deployable resources into consideration when there are multiple qualifications to choose from.

How does this affect my Practice?

Paramedics are expected to be in full compliance with the matrix, as shown above.

Emergency medical dispatchers now have additional resources to consider when dispatching yellow, orange, red and purple events.

Enhancements include additional considerations such as the paramedic specialist Tango unit, community paramedics and advanced care paramedic units to orange and yellow events.
The intention is to utilize the additional consideration(s) when the ideal response is difficult to achieve based on the location of units.

Where can I get more information?

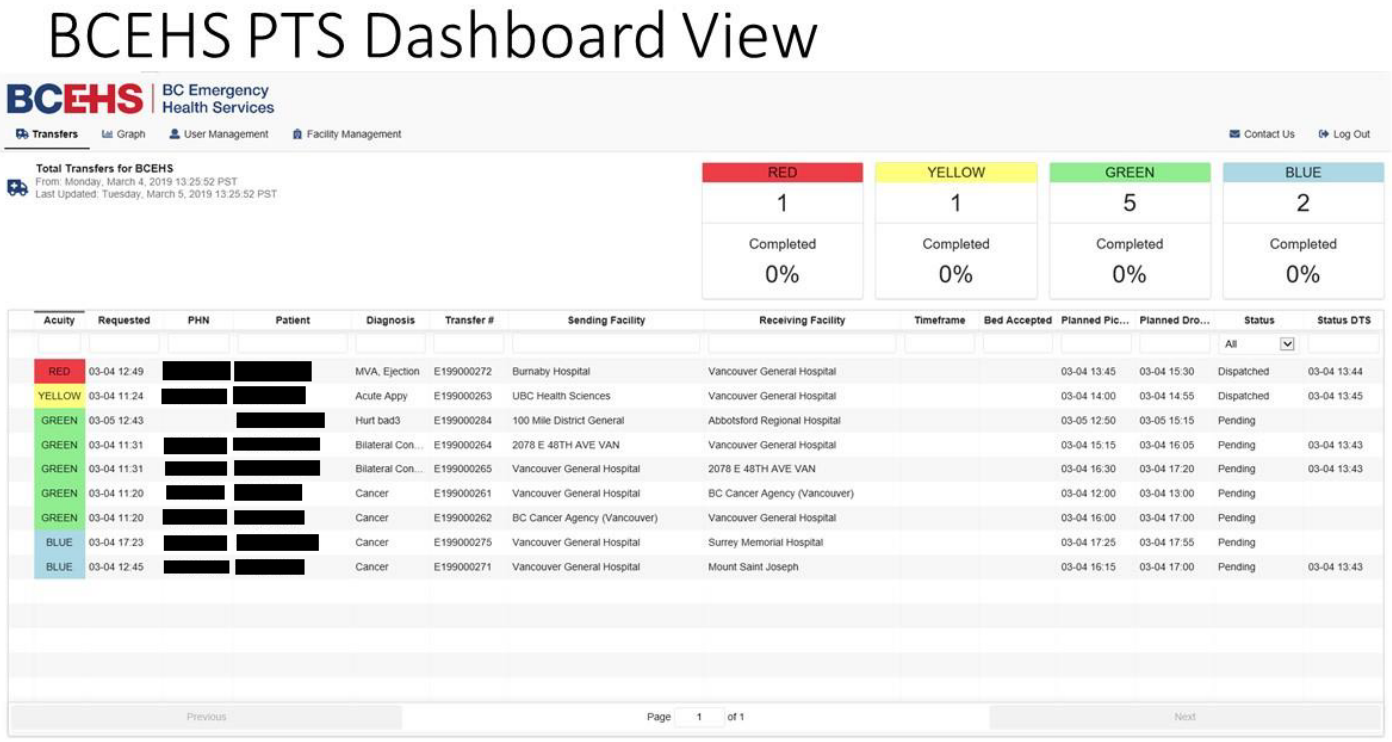
Please refer to the Universal Response Matrix (above)

Who do I contact if I have questions?

Please contact your supervisor or manager.

OPERATIONS UPDATE

Improvements to Patient Transfer system



BCEHS Provincial Patient Transfer Services has just launched a new tool to enhance the communication and transparency of our patient transfers. This new online dashboard provides up-to-the-minute information on patient transfers. This means our health care partners will be able to log into a secure online site to track and prepare for outbound or incoming patients. Read more about it in this recent all-staff memo.

OPERATIONS UPDATE

ICBC changes: what you need to know

The Insurance Corporation of BC (ICBC) is moving to an insurance model that is more driver-based which means crashes will now follow the driver. Starting January 1, 2020 if an employee has had an at-fault crash while driving a fleet vehicle that crashes, the fault may now follow them.

However, accidents involving an ambulance will be excluded from the personal driving record of paramedics and should not impact their personal insurance rates. ICBC, *"recognizing the public safety and service that emergency responders provide to the province"* will exclude the accident from an emergency vehicle driver's personal claim payment record. The personal driving record exemption will apply to all BCEHS ambulances. This exclusion will also apply to a non-

ambulance vehicle if it meets the definition of an emergency vehicle according to the Motor Vehicle Act at the time of incident.

"*Emergency vehicle*" means any of the following: *(a) a motor vehicle, or cycle as defined in Part 3, carrying rescue or first aid equipment if there is an urgent emergency justifying a rate of speed in excess of any maximum rate of speed provided for in this Act;*

As an example, the exclusion would cover a community paramedicine vehicle dispatched to an emergency event.

BCEHS Fleet will update its accident reporting procedures to help ensure exemptions are made for staff, where appropriate.

EQUIPMENT UPDATE

How clean is your stethoscope?

A recent report in the American Journal of Infection Control highlighted that stethoscopes are used several times throughout a shift and can become contaminated with micro-organisms. There is evidence that contamination of stethoscopes can occur after a single physical examination.

Links: https://apic.org/news/failures-in-stethoscope-hygiene-can-lead-to-patient-infections/
https://www.mayoclinicproceedings.org/article/S0025-6196(13)01084-7/abstract

Failing to clean and disinfect the stethoscope between each patient use is a patient safety issue. So how clean is your stethoscope?

Recently several BCEHS stethoscopes were swabbed using an ATP machine. Adenosine Triphosphate (ATP) is an organic module that is used by living cells as a main source of energy; animals, plant, bacteria, yeast and mold cells produce ATP.

The presence of ATP on a surface indicates the surface has not been adequately cleaned and disinfected, potentially harbouring micro-organisms and aiding bacterial growth.

The BCEHS Logistics team use readings between 31-60 as a caution and 61+ to identify an item as unclean. The readings above clearly indicate that we need further discussion on the importance of cleaning and disinfecting our stethoscopes between use. Discuss the importance of cleaning and disinfection of stethoscopes (and any other equipment used on a patient) between patient use with your colleagues. Accel Prevention wipes and liquid are a 'two in one' product. This means that by wiping (with friction), we are cleaning but they need **3-minute wet contact time** for the disinfecting properties to work.

Friction and wet contact time are key to effective cleaning and disinfection.

Hand Hygiene is also important to ensure micro-organisms aren't transferred between patients and equipment or vice versa. Review this video: https://www.youtube.com/watch?v=l9NKpj1EW-s#action=share

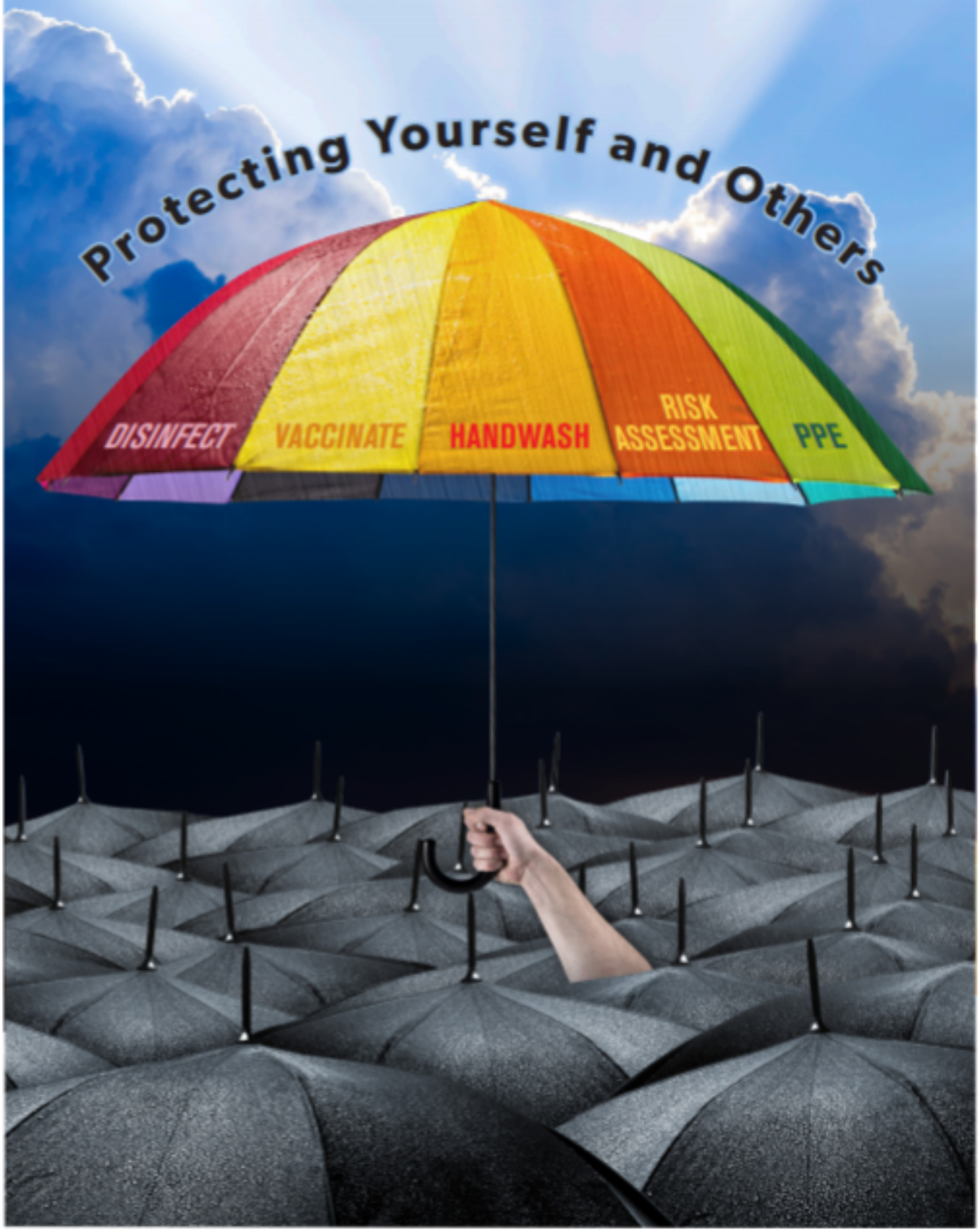
Please refer to the Cleaning and Disinfection toolkit and Post transport (In-between patient cleans).

Please contact BCEHS Infection Prevention for further details: Janie.Nichols@BCEHS.ca

OPERATIONS UPDATE

Infection Prevention and Control (IPAC) week: October 14 - 18, 2019

The third week in October is designated as National Infection Control Week (NICW) in Canada and the U.S.



In Canada, IPAC week is used to highlight infection prevention efforts in Canadian pre-hospital care, acute and long-term care facilities and in the community.

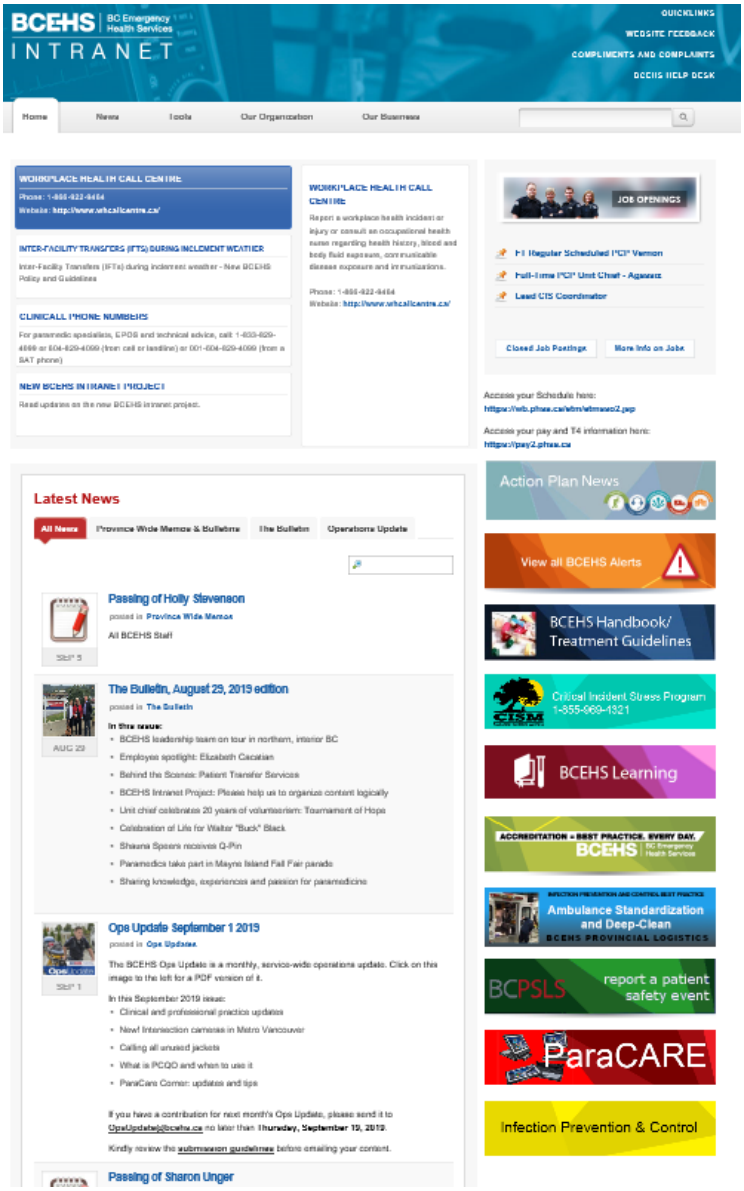
The 2019 IPAC week theme is **Infection Prevention and Control in Every Season**.

The 'spokes' of the umbrella pictured above refer to infection prevention principals. BCEHS has several links to information that refers to these points.

- **Cleaning and Disinfection**
  - BCEHS has a Cleaning and Disinfection toolkit which includes standard operating guidelines for:

        - Routine post-transport cleaning of ambulance and equipment (in between ALL patients
        - Routine cleaning of the ambulance at each shift
        - Routine deep cleaning
        - General blood and/or body fluid spill clean-up
    - This information is also on the BCEHS Handbook. Type '*cleaning*' into the search box and select '*Cleaning and Disinfection of equipment*'.
- **Vaccination**
    - WPH have information on vaccinations recommended for BCEHS staff. https://intranet.bcas.ca/areas/osh/whcc/ http://www.phsa.ca/staff-resources/staff-influenza-resources
    - WPH call centre webpage pages: http://www.whcallcentre.ca/
    - If you have been a BCEHS employee for more than three months, contact: OccupationalHealthNursing@phsa.ca for immunization information.
- **Hand Hygiene**
    - The IPAC pages, have lots of information regarding hand hygiene and posters for the station.
    - Click on ***Hand Hygiene*** for information on how to clean your hands and the BCEHS on-line module.
    - Click on ***Audit results*** for the up-to-date information regarding hand hygiene for BCEHS
    - **NOTE:** Keep your eyes open for a hand hygiene survey coming out this October. The purpose of the survey is to measure hand hygiene compliance across the province. The information will be used to develop hand hygiene education, improve practices and meet accreditation standards for measuring hand hygiene. More, soon!
- **Risk Assessment**
    - The Exposure Control Plan (ECP) has information regarding point-of-care risk assessments for IPAC (p.71)
    - This information is also on the BCEHS Handbook. Type '*exposure con*' into the search box and select part 2 of the ECP.
- **Personal Protective Equipment (PPE)**
    - Refer to the ECP plan (p.71)
    - This information is also on the BCEHS Handbook. Type 'exposure co' into the search box and select either PPE required by precaution type or part 2 of the IPAC ECP.

General IPAC information is found on the IPAC resource page or click on the yellow button from the BCEHS intranet home page. This page contains all the information discussed above.



If you have any suggestions regarding content or have any questions, please contact Janie.Nichols@BCEHS.ca

SAFETY UPDATE

Time for high-visibility apparel

Fall is upon us and with this new season comes longer hours of dusk and darkness, frequent weather changes, rain, fog, and slippery conditions.

Motorists are not always paying attention or ready for this time of year and there is a greater risk of motor vehicle and pedestrian incidents. Many pedestrians are wearing dark garments and are hard to see. Frequently these incidents occur in parking lots, side streets and unlit areas. As an emergency vehicle operator, it's important to be constantly on guard and watching for pedestrians.

BCEHS and your OSH Safety Committee would like to remind everyone of the importance of wearing high visibility apparel when exiting the ambulance, especially in areas such as airport tarmacs, roads, highways, parking areas, industrial sites and anywhere there are moving vehicles, machinery, or heavy equipment in operation.

Being seen reduces risk and enhances safety. Help others see you. Look after yourself and your partner by wearing high visibility apparel.

EQUIPMENT UPDATE

ParaCare Corner

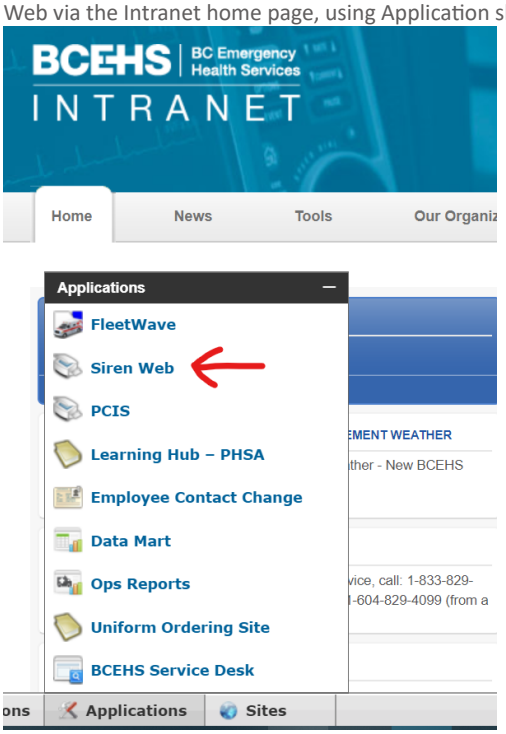
Each month in the Ops Update, ParaCare Corner highlights tips, tricks and Siren related news. Also visit the BCEHS Handbook to get up-to-date instructions, procedures and other great info. Look for 'Siren Reference' under Operations.

- The next update to Siren is just around the corner. Some of the new features include care plans for patient refusals, an updated Provider's Impression list and additions to past medical history

and additions to past medical history.

- If you're an ACP paramedic, you have the ability to import all your patient data from the LP15's directly into the PCR. This includes 12 leads, drugs and any other data captured during the call. Once the reports are imported to the PCR you can select which reports to attach to the PCR. This allows facilities using Siren Notification Board to print the LP15 reports as well as your PCR. If you're unsure of the process, please refer to the BCEHS Handbook.
- Password resets still account for most of the calls to BCEHS help desk each day. To reset your password, go to the Siren Web page, and login using your Siren user name to setup two security questions. By doing this, if you've forgotten your password, you can go back and reset your password. Access Siren

Web via the Intranet home page, using Application shortcuts at the bottom.



We regularly receive feedback and suggestions from paramedics across the province on how we can improve the user experience in Siren. This information is really helpful, and all input is carefully analyzed during our regular planning meetings. If you have an idea, send it to paracare@bcehs.ca

Watch for our next issue on November 1, 2019

Deadline for submissions: October 24

Hi Anne Marie,

Thanks for your email.

I believe this is all a matter of perspective. As you outline in your email, we would fully agree with you, that this is all about patient safety. As I am sure you are aware, BCEHS is obligated by our commitment to patient safety and risk management to ensure that our paramedics demonstrate competence in the use of new medications and procedures.

In addition, we are responsible for ensuring that paramedics demonstrate competence in high acuity, low occurrence (HALO) procedures such as intubation; that is the reason why AIME3 was designated as required education. As I am sure you fully understand and can appreciate, having untrained paramedics performing these types of interventions poses its own risks to patient safety, which is why we made the decision to restrict practice. Until our BCEHS ACPs complete the full AIME3 course they are restricted from using the new medications: fentanyl, ketamine and phenylephrine. In addition, because BCEHS Clinical Governance has changed the approach to airway management and intubation, the ACPs who have not done AIME3 are also restricted from intubating all patients, not only those patients where ketamine and/or fentanyl are used.

PCD, Learning and CMP are currently finalizing a plan to support the remaining ACPs who have not completed the education so they can meet the minimum standards set to deliver safe, effective patient care.

Please let us know if you have any further questions,

Kind Regards,

Leon Baranowski, MSc, MEd, DipHE, FHEA, MCPARA, ACP
Paramedic Practice Leader | Clinical & Professional Practice
BC Emergency Health Services, Clinical and Medical Programs
150 ? 2955 Virtual Way, Vancouver BC V5M 4X6
Office: 778-617-2503 | Cell: 604-968-5839 | Email: Leon.baranowski@bcehs.ca | Twitter: @leonbaranowski

● Respect People ● Be Compassionate ● Dare to Innovate ● Cultivate Partnerships ● Serve with Purpose

-----Original Message-----
From: Annemarie Byers [mailto:annemarie.byers@apbc.ca]
Sent: Monday, November 11, 2019 1:11 PM
To: Mcilhargey, Allen R EHS:EX
Subject: ACP restrictions.

Al.
We have two grievances filled in regards to the ACP restrictions.
We respectfully ask that you help facilitate a way for the recently restricted ACP members, to resolve the problem, ASAP.
These members contribute a great source of support in the region and to the PCP crews.
For the safety of our patients we ask that this is resolved quickly.

Thank you

Annemarie Byers
2E RVP
APBC CUPE 873/873-02
annemarie.byers@apbc.ca

February 14, 2020

Mr. Dave Deines
Provincial Vice President
Ambulance Paramedics & Emergency Dispatchers of British Columbia
CUPE Local 873
105 – 21900 Westminster Hwy
Richmond, BC
V6V 0A8

RE: Concerns with BCEHS directives

Dear Mr. Deines,

Thank you for your letter dated November 21, 2019. I apologize for the delay in responding. We recently had a significant change in our Board composition, and this has impacted our ability to respond to inquiries in a timely manner.

In relation to your request for the Board to initiate an investigation of the directives of any particular employer, including BCEHS, I would respectfully indicate that such an action is outside our legislated mandate. The Board has statutory authorization to investigate complaints relating to the conduct of individual EMAs, but not organizations.

Having said that, the Board can provide some comments about your concerns.

Observer status on ridealongs – The Board has discussed the BCEHS communication indicating that those employees that choose to undergo unpaid, voluntary ride-along shifts must not provide direct patient care or undertake treatment interventions during such shifts. In its previous communications with BCEHS representatives, the Board understands that the corporation provides liability and insurance coverage for those employees that partake in ridealongs that are authorized as part of a learning or practice improvement program and are paid to do so. However, we have been informed that BCEHS is not prepared to extend liability/insurance coverage to those paramedics who arrange ridealongs on an individual ad hoc and unpaid basis. The Board also understands that the practice restriction in such a setting is not absolute. In the rare circumstance where a paramedic doing a voluntary unpaid ridealong happens to be the only person on a scene to save a patient's life by performing his/her regular licensed duties, then that person can call into CliniCall and will expectedly receive authorization from either a Paramedic Specialist or an EPOS physician at that point to intervene to treat a patient.

Intubation practice restriction – BCEHS asserts to the Board that this practice restriction is being imposed on those ACPs who have been directed to take the AIME3 (Airway Interventions & Management in Emergencies) course but have failed or refused to do so. The assertion is that this restriction only came into place after BCEHS Learning repeatedly directed these ACPs to take the course but these individuals had yet to do

... /2

so. New intubation medications have been provided to the paramedics (i.e. ketamine and fentanyl) and the AIME3 course specifically addresses these new drugs. BCEHS argues that it is appropriate for them to restrict practice when employees fail to undergo employer-mandated training.

The corporation further argues that such paramedics may be in contravention of sections G, H, and I of the Code of Ethics. In this situation, it is incumbent upon the corporation to demonstrate reasonable diligence in providing adequate access to focused or rolling educational sessions in order capture all affected employees.

Again, BCEHS informs us that this practice restriction is not absolute. If an ACP is in a situation where he/she is the only one on a scene that can intervene to save a life, then a call can be made to CliniCall to receive authorization to lift the practice restriction.

In the EMALB's Fall 2019 Newsletter, the article addressing the duty to advocate addresses the responsibility for EMAs to resolve conflicts in a professional manner: "Good leadership and a responsive team-based environment require respectful open communications and a cooperative approach to conflict resolution." Indeed, the article goes on to state "conflict resolution skills and humility are key determinants of a successful outcome to challenging situations."

In this light, the Board strongly encourages the APBC Executive to engage with BCEHS in a direct, open, honest and collaborative forum to resolve these disagreements. The Board is not currently in a position to act as a mediator between the two organizations. Our expectation and hope are that APBC and BCEHS representatives continue the dialogue on these matters and arrive at a mutually satisfactory resolution through clear, constructive and respectful communication with a focus on the best interests of the patient.

If you have any further questions or concerns about the above, please feel free to contact me.

Sincerely,

Philip Yoon, MD, MBA, CCFP(EM), FCFP
Acting Chair
Emergency Medical Assistants Licensing Board

BCEHS | BC Emergency Health Services
Provincial Health Services Authority

STANDARD OPERATING GUIDELINES

Article 13.00 Selection - Lateral [Post Shuffle] Guidelines – FT & RPT

SOG #: **0.1.0**

STAKEHOLDERS: Talent Acquisition, WFMS, BCEHS Operations, APADBA, BCEHS/PHSA Finance and BCEHS Systems Implementation Project Team

TITLE: 13.00 Selection – Lateral [Post Shuffle] Guidelines – FT & RPT

PURPOSE: Document the post shuffle guidelines for greater clarity and consistency

BACKGROUND: The bargained collective agreement language has established Post Shuffle Committee to document the post shuffle process, noting the differences between Vancouver Post and the rest of the province. The below outlines the key steps for the operating procedures for BCEHS and system partners to follow during the recruitment and selection process.

PROCESS: GENERAL PRINCIPLES – LATERAL [POST SHUFFLE] PROCESS – ALL POSTS

ID #	DESCRIPTION	NOTES
0.1.1	A post shuffle may not occur unless there is a vacancy and/or new position(s) created	
0.1.2	Incumbents may not be displaced from an existing position by a post shuffle	
0.1.3	Employees may not lateral between employee status (ISE to FT Reg, RPT to RFT) or classifications/qualifications in a post shuffle.	This includes changes in license level, supervisory/ specialized classifications.
0.1.4	There shall be separate postings for each position status (FT, ISE, RPT) and classification/qualification (PCPIV, EMD, UC, Charge)	
0.1.5	Each posting will also include a summary of positions in the post at the applicable status and qualification/classification. This informs applicants of all the possible vacancies that may become available through the process	The summary will include any new positions created if applicable
0.1.6	All employees who wish to lateral, including in-post employees must apply following the instructions in the posting which includes: 1) Apply to the posting	

ID #	DESCRIPTION	NOTES
	2) Complete and submit the appropriate post shuffle preference form	
0.1.7	Only those applicants who have completed both steps will be deemed to have completed the application process and will be considered in the recruitment/shuffle process.	
0.1.8	The post shuffle preference forms will not be used for subsequent postings. Each posting requires a new shuffle preference form.	
0.1.9	In-post applicants who have submitted a post shuffle preference form will not be permitted to rescind their application or decline the new position after the close of the posting.	
0.1.10	The employer will assign each vacancy in order of seniority, by classification and qualification, to employees based on their preference form. This process is repeated until all vacancies are filled.	*Applicants who select “any” or do not specify their preference on their form have relinquished their right to select from the vacancies and will be assigned by the employer
0.1.11	Once the initial post shuffle process is completed and employees have been formally notified of their new position, employees are not required to accept a subsequent vacancy – even if it is higher on their preference form. The employee(s) will be contacted and offered any vacancy that occurs, if higher on their preference form.	
0.1.12	This process will be applied to both existing and new positions within the post.	
0.1.13	The appropriate clauses in the collective agreement will be followed in relation to provincial/local hiring,	
0.1.14	Applicants will not be contacted if the vacancy available is not listed on their preference form.	
0.1.14	This process does not apply to the on-call lateral process or temporary positions/vacancies.	

ID #	DESCRIPTION	NOTES
0.1.15	Temporary vacancies and/or positions will be filled in accordance with the MOU – Temporary Vacancies & Positions.	

PROCESS: PROVINCIAL LATERAL [POST SHUFFLE] GUIDELINES – [EXCLUDES VANCOUVER POST]

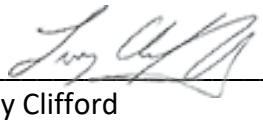
ID #	DESCRIPTION	NOTES
0.2.1	A vacancy or new position occurs and requires a posting under Article 13.00	
0.2.2	A provincial posting is created which identifies the status, qualification/classification, and number of positions available.	
0.2.3	At the close of the posting, an applicant list is generated which includes all qualified applicants in order of seniority. Eligibility is determined once the list is formed.	Both in-post and out-of-post employees are blended on the same list
0.2.4	The successful applicant to the original vacancy is the senior employee from the applicant list and has the vacancy listed on their preference.	See 0.1.5 for reference.
0.2.5	If the senior applicant is an out-of-post employee, with the preference listed, selection is complete.	
0.2.6	If the senior applicant is an in-post employee that has indicated the vacancy as a preference, they are awarded the position. The subsequent vacancies will be continued to be filled in seniority order, the applicant list and preference forms.	
0.2.7	Each time a new vacancy is created, the process is restarted at the top of the applicant list, by seniority and preference. The paper exercise will occur until the vacancy is filled to ensure employees receive the position with the highest preference based on vacancies and seiority.	
0.2.8	In-post applicants receiving a new position will be notified of their resulting position and transition date(s) and the out-of-post employee(s) will be provided an offer letter with 24 hours to accept or decline the position.	If the position is declined the selection process continues under 0.2.8
0.2.9	This process will be repeated until all vacancies in the posting are filled at the applicable status and qualification/classification.	

PROCESS: VANCOUVER POST LATERAL [POST SHUFFLE] PROCESS

ID #	DESCRIPTION	NOTES
0.3.1	A vacancy or new position occurs and requires a posting under Article 13.00	
0.3.2	Provincial postings are created for each category of position type. Posting details including the status and qualification/classification.	
0.3.3	Lateral postings are also created for each category of position type. Posting details include the status and qualification/classification.	
0.3.4	Employees must apply for each posting, following the posting instructions, including submitting any required documents identified.	
0.3.5	The Vancouver Post Shuffle Process will occur on established calendar dates, rather than intermittent dates. With notice to employees, additional post shuffle dates may be added.	Currently January, April, and September
0.3.6	The employer will first assign the vacancies through the lateral postings and applicant lists by seniority and shuffle preference form to Vancouver in-post employees. Employees will only be assigned to positions in the same status, classification/qualification in this step.	
0.3.7	Once the Vancouver Post Shuffle Process is completed, the employer will offer each vacancy in order of seniority, by classification/qualification and preference form. This process is repeated until all vacancies are filled.	

REFERENCE DOCUMENTS:
APADBA Collective Agreement 2019-2022
HEABC Summary of Changes 2019-2022

Joint Implementation Committee Representatives:



Troy Clifford
Provincial President
Ambulance Paramedics of BC
Emergency Dispatchers of BC
CUPE Local 873

Paul Vallely
Senior Provincial Executive Director
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BC Emergency Health Services

Carmen Hamilton
Director, Negotiations and Implementation
Health Employers Association of BC

Signed July 20, 2020

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January 20, 2020

B.C. MINISTRY OF HEALTH
Room 337, Parliament Buildings
Victoria, BC, V8V 1X4

Attn: The Honourable Adrian Dix, M.L.A., Minister of Health

and

STEERING COMMITTEE ON MODERNIZATION OF HEALTH PROFESSION REGULATION
c/o PROREGADMIN@gov.bc.ca

Attn: Steering Committee on Modernization of Health Profession Regulation

Dear Minister Dix and Members of Steering Committee:

Re: Application of Ambulance Paramedics & Emergency Dispatchers of British Columbia, CUPE Local 873 for designation as a health profession pursuant to section 7(1) of the *Health Professions Act*, RSBC 1996, c. 183; and
Feedback –Regulating Health Professionals

I. Introduction

The Ambulance Paramedics and Emergency Dispatchers of British Columbia ("APBC"), a key stakeholder in health care, is the professional organization that represents over 4,500 paramedics including primary, advanced and critical care paramedics and emergency medical responders, and emergency dispatchers employed by the British Columbia Emergency Health Services ("BCEHS")[1] and by Emergency Communications for B.C. Incorporated ("Ecomm")[2]. Paramedics provide emergency, urgent, routine and

[1] BCEHS is the primary employer of paramedics in B.C. and is part of the provincial government responsible for the delivery, co-ordination and governance of all pre-hospital emergency health services, emergent, urgent, routine and ancillary health services including call intake and dispatch

[2] E-Comm is a multi-municipality agency that provides emergency communications operations for British Columbia. The company coordinates 9-1-1 service for police, fire, and ambulance service, providing call-taking and dispatch services for multiple agencies (other than for ambulance) across B.C.

ancillary health services[3] to British Columbians at the scene, en route by ambulance to hospital, and during patient transfers between hospitals, as well as primary health care through community paramedic programs.

On behalf of the APBC, please accept the within application to designate paramedicine as a health profession pursuant to section 7 of the *Health Professions Act* ("HPA") and the *Health Professions Designation and Amalgamation Regulation* ("Designation Regulations"). (The prescribed fee pursuant to the Designation Regulations will follow by registered mail).

Also included is the APBC's response to various issues raised by the Steering Committee on Modernization of Health Professional Regulation in *Modernizing the provincial health profession regulatory framework: a paper for consultation*, November 2019 ("Consultation Paper").

We appreciate your consideration of our submissions in the context of proposed legislative and regulatory changes currently under consideration for improving the regulation of health professionals in B.C.

II. Paramedic Association of Canada support for paramedic self-regulation in British Columbia

The Paramedic Association of Canada ("PAC") is a national voluntary organization of over 20,000 paramedic practitioners, comprised of eleven chapters from nine provinces, Paramedic Educators and the Canadian Forces. APBC is one of the founding chapters of PAC and is PAC's British Columbia chapter.

PAC considers paramedicine to be a distinct health profession, with a distinct body of knowledge and supports self-regulation for paramedics across Canada, including in B.C. At present, paramedics in five provinces are self-regulated (Alberta, Saskatchewan, Manitoba, New Brunswick and Nova Scotia), with Quebec and P.E.I currently in the process of review for self-regulation.

PAC has reviewed the within submissions and supports the APBC's application for designation under the HPA, as well as the establishment of a stand-alone college of paramedics (to include all Emergency Medical Assistants) in British Columbia.

III. Current framework

Paramedics and first responders[4] are considered Emergency Medical Assistants ("EMAs") under the *Emergency Health Services Act* ("EHSA") and, although governed by different levels of government (provincial and municipal), are regulated by a single government-appointed body, the Emergency Medical Assistants Licensing Board ("EMALB"), under the *Emergency Medical Assistants Regulation* ("EMA Regulation").

The EMA Regulation spells out in detail the duties of the EMALB, various levels of qualification for an EMA, licensure application, maintenance, conditions and terms for those individuals providing care as an EMA.

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[3] "Emergency health services" means first aid or other health care that is provided outside of a health facility, without delay, to save lives or prevent or alleviate serious harm or pain; see EHSA, section 1 -definitions

[4] First responders are employed by municipal governments and provide basic life-saving interventions at the scene as part of a coordinated response and play an essential role in supporting BCEHS to provide the quickest possible response to patients requiring time-critical care. Further to section 5 of the EHSA, first responders are permitted to perform emergency medical first response to the extent consented or agreed to by the Minister or BCEHS

Skills performed at any level of EMA is restricted to those outlined in the respective schedule or, where endorsed, to the level of endorsement. An EMA is permitted to hold a licence in only one of the following categories at a time: Emergency Medical Assistant First Responder ("EMA FR"); Emergency Medical Responder ("EMR"); Primary Care Paramedic ("PCP"); Advanced Care Paramedic ("ACP"), Critical Care Paramedic ("CCP") and Infant Transport Team ("ITT"). (As addressed below, Community Paramedics and Paramedic Specialists are not licenced categories for EMAs).

The EMALB is composed of three members[5], one of whom must be an EMA[6], another of whom must be a medical practitioner and the third is a member of the public. The EMALB oversees 15,000[7] registrants and governs entry into practice, scope of practice and maintenance of licensure in B.C. of EMAs, and responds to complaints (investigates and conducts hearings) as necessary.

As the submissions below establish, there are various challenges with the current regulatory framework for EMAs.

IV. Overview

Paramedicine[8] does not currently fall under a college based self-governance model in B.C. and out of the 26 regulated health professions in the province, is the only one not regulated by the HPA. This needs to change. As the Cayton Report[9] and Consultation Paper recognize, consistent regulation across health professions is needed. This objective is not met by leaving the regulation of paramedicine outside the college self-governing framework.

As well, there are significant problems with the existing structure and approach to regulating EMAs under the EHSA and EMA Regulation. Although EMAs enjoy a high degree of public confidence and respect[10], an updated model for oversight of EMAs is imperative to enhance protection of patients and the public, and to ensure the interests of the public in the future are protected.

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[5] EHSA, section 6

[6] The EMA appointed to the EMALB is selected by the bargaining agent: *Emergency Medical Assistants Licensing Board Regulation*

[7] EMALB 2018/19 Annual Report

[8] "Paramedicine" is emergency medical care provided outside of hospitals in pre- and inter-hospital settings, although it is not limited to emergency care

[9] Harry Cayton, *An Inquiry into the performance of the College of Dental Surgeons of British Columbia and the Health Professions Act*, December 21, 2018 ("Cayton Report")

[10] Surveys of public prepared for PAC: **Appendix "A"**: Abacus Data, *Assessing the Profession, Community Paramedicine and other Issues* (October 2012), page 3, Executive Summary; **Appendix "B"**: Abacus Data, *Probing perceptions and attitudes to paramedics* (November 2014), page 3, Key Findings; **Appendix "C"**: Abacus Data, *Public attitudes towards paramedics and paramedicine in British Columbia,* (Summer 2016), page 11 re rating service, page 23 re respect for profession and page 28 re importance of role in healthcare; and **Appendix "D"**: Abacus Data, *Public attitudes towards paramedics and paramedicine in British Columbia,* (November 2018), page 3 re Executive Summary and page 22 re importance in public safety (altogether "Public Surveys")

APBC seizes this opportunity to advocate for a college based self-governance model for EMAs under the HPA. We believe professional self-regulation for those currently regulated by the EMALB is in the best interests of patients, the public and the profession.

Accordingly, the parties herein apply to the Minister of Health at this time to have paramedicine designated as a health profession under the HPA and submit that a stand-alone college for EMAs is justified, and moreover mandated, considering the criteria for designation as a health profession under the HPA and the Designation Regulation, and the paramount goals of safety of patients and the protection of the public, as well as other important objectives highlighted in the Cayton Report.[11] Indeed, Cayton and the Steering Committee implicitly accept that professional self-governance, despite its challenges, is the best model to achieve these objectives. We agree.

As interested parties, APBC also supports modernizing the provincial health profession regulatory framework and proposed overhaul of the HPA. In that regard, we respond below to the Steering Committee's call for submissions.

Any structural reform under the HPA or through the introduction of new legislation[12], however, must include governance of EMAs under the self-regulatory model. For the reasons identified herein, this is most appropriately achieved by establishing a stand-alone 'College of Paramedics' for EMAs.

Alternatively, the APBC supports including EMAs in the proposed single-umbrella 'College of Health and Care Professions' and respectfully ask that EMAs be prioritized for consideration for self-governance under the HPA before other professions not currently regulated under the HPA[13]. A college for EMAs (stand-alone or multi-profession) will protect the safety of patients, ensure public confidence in paramedicine continues and will meet the objectives of improved efficiency and effectiveness.

V. Timely reform is imperative

As the Minister is aware, the APBC has made numerous submissions to government over the years, most recently in July 2018, and is committed to working with government to advance the regulation of paramedicine in the province.

Respectfully, the time has come for government to take action.

Not only is a government review currently underway for the regulation of health professionals and challenges for EMA regulation under the present statutory framework ongoing, the EMALB currently has no public oversight. As recently announced, the former Chair of the EMALB, Patricia Lane, originally appointed to the board in 2017 has not been re-appointed. There is no indication from government when or if a new chair appointment will be made. Meanwhile, we query the current and ongoing ability of the EMALB to operate effectively in the absence of a board chair and submit it is all the more imperative that government move

[11] Cayton Report, paragraph 10.5
[12] Cayton Report, paragraph 10.1
[13] Further to *Modernizing the provincial health profession regulatory framework consultation paper*, pages 14-15, "Existing professions not regulated under the Health Professions Act"

forward with inclusion of EMAs within the contemplated regulatory restructuring of health professionals in B.C. at this time.

VI. Current challenges under the EHSA and EMA Regulations

EMAs are committed, respected health professionals who provide the highest possible level of care to the citizens of British Columbia. However, the legal framework that governs the practice of paramedicine in B.C. is not adequate. There are numerous deficiencies.

The APBC submits that the various challenges can be addressed, and improvements to regulation achieved, by brining EMAs within the self-governance, college model of regulation under the HPA and establishing a stand-alone 'College of Paramedics'.

A. Current model not sufficiently responsive to evolving, evidence-based paramedicine

To begin, the legislation regulating EMAs is outdated and does not allow paramedicine to keep pace with evolving standards of practice or to respond adequately to new risks and opportunities as they arise. This poses a potential risk of harm to patients. For EMAs to provide the best possible care to patients, clinical practices and standards need to be kept current and evolve in a timely manner in response to evidence-based developments in the field of paramedicine. The statutory framework governing EMAs does not adequately allow for this.

The specific skills of EMAs and the services they are authorized to provide are outlined in schedules to the EMA Regulation. The EMA Regulation is extremely specific, more so than any other health regulation. As such, changes to clinical practice standards must be made through amendments to the EMA Regulations. This means that if a new procedure or medication is proven to have a demonstrated benefit to patient care, despite being recommended by the EMALB, EMAs have to await government action (or inaction, as determined by government). This is inefficient. The result is that paramedicine is slow to adapt and respond to changing medical evidence.[14]

Of 26 regulated health professions in BC, 25 of them set their own professional practice standards and guidelines, not requiring an act of government to amend. Fundamental to the self-governance model is a recognition that health professionals are best situated as subject-matter experts to determine the standards of practice and licensure associated with their field and to judge adherence to those standards. Despite this, it is the government that imposes requirements on those practicing the profession of paramedicine under the current framework.

Like other regulated health professions in B.C., EMAs are in the best position to set standards for their profession and to evaluate whether they have been met. EMAs have developed a specialized distinct body of knowledge over time and have expertize in up-to-date paramedicine (knowledge, skills, practice environment,

[14] We acknowledge there is room for improvement in the current framework under the HPA as well. See Cayton Report, paragraphs 9.26 and 10.19 respecting the need for colleges to be given greater freedom to change their own rules and bylaws to enable them to better respond to change.

etc.). Making EMAs themselves responsible and accountable for their standards of practice, rather than government, would therefore improve the safety of patients and public protection.

The college model of self-regulation would also ensure EMAs are able to make scope of practices changes to better serve the public in an appropriate and timely way. Professionals regulated under a college scheme are generally able to respond to changes in medical standards in a timely, flexible way, thereby providing the most up to date, clinically relevant care available to British Columbians which is clearly in the public interest.

B. EMALB's obligations – a patient safety focus is not expressly mandated

Also a critical issue, the principle of patient safety is not expressed as central to the legislation governing EMAs.

The Cayton Report emphasizes that professional regulation should include a "relentless focus" on the safety of patients, directing that a clear legislative mandate under the HPA in this regard is required. Regulators should be focused primarily on safety, on standards of clinical care and on the health needs of patients, he says.[15] There is no such express duty on the EMALB under the EHSA. A well-defined legislative direction to prioritize patient safety is absent.

The duty of regulatory colleges under the current HPA, although vague[16], is to serve and protect the public[17]. On the other hand, the EMALB's legal obligations (mainly expressed in terms of its powers and authority) are directed at its functions rather than focused on protecting the public or patient safety.[18] Again, this poses risk to the public. Including paramedicine within an updated health legislative framework, one that includes Cayton's recommendations to prioritize patient safety in the regulator's legislative mandate, would address this concern.

C. EMA Regulations - Code of Ethics

Clayton also indicates colleges should be directed to prioritize the ethical conduct of registrants[19]. Although the EMA Regulation includes a Code of Ethics, it is embedded at *Schedule 3*, demonstrating that the safety of patients is not satisfactorily prioritized in the regulation. Also the principles of ethical conduct (which include the obligation of EMAs to protect patient safety), are expressed differently than those applicable to health professionals regulated by the HPA[20]. Mr. Cayton recommends a single, uniform code of ethics and conduct for all health professions[21]. Should this recommendation be adopted, bringing EMAs under the college framework assures those practicing paramedicine are held to a consistent ethical standard of conduct applicable to other regulated health professionals.

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[15] Cayton Report, paragraph 9.17
[16] Cayton Report, paragraph 9.16
[17] HPA, section 16
[18] EHSA, sections 6(5); see also sections 7 and 8
[19] Cayton Report, paragraph 19.17
[20] See, for example, guiding ethical principles for registrants of College of Physicians and Surgeons of BC: *CMA Code of Ethics and Professionalism*
[21] Cayton Report, paragraph 10.8

Additionally, the objects of a regulatory college under the HPA include, to establish a patient relations programme to seek to prevent professional misconduct of a sexual nature.[22] In contrast, the EHSA does not impose a similar duty on the EMALB.[23] This is another concern with the existing legislation regulating EMAs—one that calls for bringing regulation into the modern age.

D. Complex and confusing complaint, investigation and resolution process

The EMALB sets its own rules governing complaint, investigation and hearing procedures. The procedures established are complicated and cumbersome.[24] Processing complaints often involves significant delays by the EMALB.[25]

A significant issue is that contrary to principles of natural justice and fairness, there is a requirement for a respondent to admit culpability in order to access the alternative dispute resolution process. This is particularly problematic when a complainant chooses to sue an EMA civilly respecting the same conduct. This issue also demonstrates the lack of transparency in the EMALB's rules and processes as this requirement is not found in the board's rules or related materials.[26]

Another problem is that the only avenue of appeal from decisions of the EMALB is to the B.C. Supreme Court.[27] This raises access to justice issues.

Adding further challenges with the complaints and resolution process under the EMALB, the EMALB website is confusing and provides incomplete information respecting timelines and other matters in some respects.[28]

E. EMALB – composition, size and term of members

The Cayton Report recognizes that the "most effective size for a board is generally agreed to be between eight and 12 people", specifying that "this aids engagement and discussion and promotes corporate decision-making".[29] In contrast, the EMALB is a 3 member board - smaller than any other health profession regulator's board n B.C. The EHSA also only allows for one practitioner appointee. This is not the standard on boards/ councils of colleges of paramedics across the country[30]. Nor does such a limited number of

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[22] EHSA, section 16(2)(f)
[23] See further concerns raised by Steering Committee respecting establishing consistency across regulatory colleges in relation to how they address sexual abuse and sexual misconduct: Consultation Paper, page 20
[24] **Appendix "E"**: EMALB Complaints Process (flow chart); **Appendix "F"**: EMALB Complaint, Investigation and Hearing Procedure Rules and Part 2, Rules of the EMALB- Summary Procedures for Failure to Complete Assessment Process; and **Appendix "G"**: EMA Patient Care Complaint Process Flow Diagram
[25] 2018/19 EMALB Annual Report, page 14, referring to efforts to reduce complaint processing times
[26] See **Appendices "E", "F" and "G"**
[27] EHSA, sections 8 and 9
[28] See for example, **Appendix "E"**: EMALB Complaints Process (flow chart) which contains incomplete references to steps (eg. "The Board conducts this step in one day but it can take up to one month for a" [ends. Remainder of information is missing]), confusing colour coding, etc.
[29] Cayton Report, para. 9.23

[30] Current composition of boards/ councils of colleges of paramedics (as reflected on respective websites, accessed January 19, 2020):
AB 2 Public 6 Practitioners

board members allow for desirable diversity (ethnic, gender, etc.) in the same way as a larger board can facilitate.

Among the most critical concerns with the EMALB's composition is that a single physician, a single EMA and a single member of the public together can decide and recommend to government what treatment EMAs should provide to patients. This does not serve the best interests of the public. At a minimum the board should include a larger representation of all levels of practitioners who would bring different perspectives and varied expertise and experiences to the board.

As well, the term of board appointments to the EMALB is two years. As Cayton identified, a three year term of office for board appointees, renewable for a further three years, provides for greater continuity and the expertise which comes with experience than shorter appointments.[31]

Again, bringing EMAs within an updated common regulatory framework would remedy this.

F. EMALB lacks transparency

The EMALB lacks transparency in various ways, including, for example with respect to:

- how (criteria applied, process followed) the EMALB sets practice standards that it recommends to government for regulatory changes;
- the criteria applied by a "Board Officer" when determining the appropriateness of a complaint "for the Board"; and
- providing sufficient and up to date information on the board's website. For example, the website contains no information respecting when the current chair vacancy may be filled.[32]

G. Undesirable conflicts

When special interest groups lobby government, changes to the licensure or scope of practice of an EMA category may result from political motivation rather than objective, empirical data/ scientific metrics. The self-regulatory model on the other hand helps to insulate government from such conflicts as political considerations do not exist to the same extent under a college model of regulation.

SK	3 public	6 Practitioners
MB	4 Public	11 Practitioners
NB	2 public	13 Practitioners
NS	5 public	8 Practitioners

[31] Cayton Report, paragraph 9.24

[32] EMALB website: https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/colleges-boards-and-commissions/emergency-medical-assistants-licensing-board (accessed January 19, 2020)

Another unintended conflict can arise from the fact that government may be constrained by the budgetary considerations (eg. the cost of adding a new medication or equipment to the 500 ambulances[33] in the province), more so than college boards which are squarely mandated to protect the public.

H. Title 'paramedic' is not recognized under the EHSA or EMA Regulations

Regulatory colleges play an important role in ensuring public confidence by protecting the professional titles associated with various health professions in order to help the public recognize qualified professionals who have demonstrated the requirements to practice safely.

Currently under the EHSA and EMA Regulations, although the title of "emergency medical assistant" is protected[34], use of the title "paramedic" is not restricted. Simply put, a self-proclaimed "paramedic" may not be a registrant of the EMALB authorized to practice paramedicine. This poses an obvious risk to the public.

The HPA sets out that the Minister of Health can prescribe protected titles which only registrants may use. A 'College of Paramedics' which identifies EMAs in accordance with the nomenclature of "paramedic" would assist in the protection of the public.

[33] Auditor General of British Columbia: *Access to Emergency Health Services* (February 2019), at page 15
[34] EHSA, section 12

I. Identifying EMAs and verifying credentials

The Cayton Report recommends that a single registry of all regulated health professionals be established and maintained, recognizing it will better serve and protect the public by making it easier to identify individual health professionals as may be required and to verify their credentials.[35]

Currently, if a member of the public wants to verify an EMA's credentials, they must contact the EMALB during business hours by telephone. This is antiquated and inconvenient and lacks transparency. There is currently no registry of EMAs available to the public on-line; nor is an on-line registry mandated currently by the EHSA. By bringing EMAs under the same legislation as other health professions and mandating they become part of the proposed single registry, this issue would be remedied.

J. Regulatory challenges respecting community paramedicine and paramedic specialist

Self-regulation for EMAs would also increase public safety by ensuring the practice of paramedicine in environments beyond pre-hospital settings is fully regulated.

Currently 'community paramedics' ("CPs"), under the BCEHS's community paramedicine program,[36] provide community health care (community outreach and awareness, services to older patients with chronic conditions, fall prevention assessments, home visits, etc.)[37] despite not being statutorily regulated under the EMA Regulations: "community paramedic" does not appear in the regulation. The gap in the regulations (term, scope and standards for CPs) poses challenges for enforcement. The result is that although CPs are regulated by the EMALB as EMAs, they are performing unregulated services set by the employer, BCEHS.[38] Additionally, there is nothing legislative that the public or allied health professionals can look to or rely upon to verify credentials of CPs or inform themselves about the scope of services CPs provide.

Furthermore, this again highlights how the current regulatory framework for EMAs is slow to respond to evolving public health care requirements. Self-governance, on the other hand, can be more responsive to the demand for community paramedicine and other changing public health care demands and expectations by ensuring measures and standards of practice to govern CPs are established as the need arises.

Similarly, 'paramedic specialists' ("PSs") are not referred to the EMA Regulations. This raises similar issues. Both CPs and PSs are currently practicing paramedicine in a 'grey area' under the current regulations. Again, self-regulation would increase public safety by ensuring the regulation of paramedicine keeps pace and is flexible to respond to evolving public needs and employer requirements.

K. Dual role: health and public safety not recognized by current legislation

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[35] Cayton Report, paragraphs 10.13-10.15

[36] In November 2015, the Minister of Health approved a ministerial order to establish the program aimed at enhancing the number of full and part time paramedics in rural and remote communities and also provide additional health human resources in support of primary care

[37] **Appendix "H":** BCEHS First Responders and Paramedic Credentials in BC (September 2018)

[38] This raises issues akin to those identified by government as problematic following the decision in *Emergency Health Service Commission and Ambulance Employees' Union, CUPE Local 873,* December 8, 1987 (Kelleher), unreported, which pre-empted the creation of the EMALB.

Practitioners of paramedicine are the only regulated health service providers that play a dual role in society, spanning both the public safety and health care domains. This means every fire department EMA is considered a 'public safety' responder, while every paramedic EMA provides services in both health care (eg. licensed paramedics employed by hospitals, CPs, etc.) and public safety environments (working for search and rescue organizations, attached to a police unit conducting crowd control,[39] etc.). Nonetheless, the current legislation and regulations governing EMAs fail to recognize this dual role, instead focusing (to the extent it does) on only public safety.

The implication is that when the EMALB reviews and recommends regulatory changes to the Minister of Health or liaises with other emergency care bodies, they are not statutorily required to consider the issues through a lenses specific to public safety *or* public health. For example, the EMA Regulations does not address how a paramedic is an advocate for patients, nor does it address how an EMA uses social determinants of health to provide patient care.

L. Conclusions respecting challenges with current regulatory framework

Unquestionably, EMAs provide care and services to patients to high ethical standards. Paramedics continue to be highly respected, a sentiment that has been relatively unchanged since 2012.[40]

Nonetheless, many of the varied challenges identified above associated with the current regulatory structure and legislation applicable to EMAs could be remedied by designating paramedicine as a health profession under the HPA. Furthermore, the APBC submits there is a clear public interest and benefit to ensuring the regulation of paramedics is brought into line with the other 25 regulated health professions in British Columbia.

VII. Designation as a heath profession – further support for self-regulation and a stand-alone college

The APBC submits that the profession of paramedicine in B.C. meets the public interest criteria set out at Part 3 of the Designation Regulations for designating a health profession under the HPA. The extent to which the profession is practiced and the nature of the services provided, the risk profile associated with practicing paramedicine, among other factors canvassed below, we say justifies designating paramedicine as a health profession under the HPA.

[39] While this function is not currently required by BCEHS, paramedics are trained to provide this service and have done so in the past

[40] See **Appendices "A" to "D"**, *supra*, Public Surveys

A. The extent to which the profession of paramedicine is practiced

Considering first the extent to which the profession is practiced, EMAs are a significant stakeholder in the provision of health care in British Columbia. Paramedicine is the second largest health profession in the province, comprised of approximately 15,085 EMAs[41]- outnumbering physicians and coming second only to nurses in number of registrants[42].

EMAs provide a vast number of controlled medical acts to the BC public on a daily basis which if performed in error have serious potential for harm or death. In 2018, paramedics in B.C. responded to over 756,000 [43]pre-hospital events and completed over 90,000[44] inter-hospital transfers (with 7,195 transported by air ambulance).

B. High risk nature of the services provided and unique aspects and responsibilities of practicing paramedicine

The nature of paramedicine services, and the environment and circumstances in which services are provided, presents a high risk of harm to the public and therefore supports designation.

Although the services provided and the diagnostic and treatment modalities EMAs perform are shared by a number of other health professions, including physicians, nurses, respiratory therapists and midwives, EMAs differ because they use these modalities in an out-of-hospital environment which is often uncontrolled (poorly lit, confined spaces, varied weather, hazardous, etc.). And EMAs regularly apply their skills and perform their duties while in transit (in all weather and road conditions).

Further to this, EMAs are one of the only health professionals that operate in every environment on land, air and sea and under conditions uncommon to all other health providers. EMAs may be on the ocean on a hovercraft or at the scene of a vehicle accident one hour, and then conducting an inter-facility transfer by air or on stand-by for a high-risk police event or warrant execution the next.

EMAs are also presented on a regular basis with tremendous emotional stressors associated with emergency scenes (unsafe, chaotic, unfriendly, unfamiliar, loud, etc.). And most often provide care under severe time pressures.

There are times in the provision of service (remote and other environments) when human and medical resources are limited as well. Even when available, EMAs may have no ability (time) to consult other health professions or obtain (access) additional medical resources.

Additionally, an EMA uses the skill sets of multiple other health professions within in one setting. The profession has evolved such that EMAs are now routinely performing medical acts that have been historically performed by and reserved for emergency and intensive care physicians in a hospital or other medical facility.

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[41] EMALB 2018/19 Annual Report
[42] **Appendix "I"**: Comparison Chart of Health Professions in British Columbia
[43] BCEHS.com (website, as at January 11, 2020), FAQ Facts Sheet
[44] Auditor General of British Columbia: *Access to Emergency Health Services* (February 2019), at page 5

And we are performing services that are normally performed by *multiple* health professionals in controlled settings, in a coordinated fashion.

In these respects, EMAs take on a far greater level of responsibility in the provision of health care than many other providers. Having to perform services (make instantaneous life and death decisions, administer treatment, with limited resources, etc.) in a complex, dynamic, high-intensity environment presents a high potential risk of harm to the health and safety of patients. These factors present practice and treatment challenges exclusive to EMAs and, in the APBC's submission, support designation of paramedicine as a health profession and the creation of a stand-alone college for EMAs.

C. Government acknowledgement that the profession of paramedicine is unique

The exceptional nature of practicing paramedicine has in fact been recognized by both the provincial and federal governments. The federal government has designated EMAs as a public safety occupation ("PSO"), allowing EMAs to retire early with un-penalized pension and benefits under the *Income Tax Act*. Out of 26 health professions in B.C., EMAs are the only ones who have the PSO designation.

On the provincial side, the government has recognized EMAs and Emergency Dispatchers as having presumptive legislation for mental health injury and illness under the *Workers Compensation Act* ("WCA"). This means, again unlike the other 25 regulated health professions in the province, that if an EMA submits a claim under the WCA for compensation arising from post-traumatic stress disorder for example, the illness is presumptively considered to be caused by the EMA's work. Government has clearly accepted that the health services provided by EMAs are different than all other health professions.

In addition to considering paramedicine to be PSO, the Minister of Health has recently again acknowledged the unique nature of paramedicine by finding a stand-alone bargaining unit for APBC's paramedics and dispatchers is appropriate, determining that to do so would improve patient care.[45]

Certainly the fact that EMAs are currently regulated as a distinct group from other regulated health professions demonstrates that government considers regulation of paramedicine essential and appropriate. However, given the challenges with the current regulatory model and, in particular with the EMALB, as well as with the EHSA and EMA Regulations, there is no justification for maintaining the current regulatory model and moreover, sound reasons to bring paramedicine fully into alignment with the model of regulation applicable to the other 25 regulated health professions in B.C. The balance needed which accounts for the unique nature of paramedicine, but also addresses the ongoing challenges under the current regulatory framework is found in a stand-alone college for EMAs.

[45] **Appendix "J":** Ministry of Health press release: "New bargaining unit for paramedics and dispatchers to improve patient care": https://news.gov.bc.ca/15694 (October 24, 2017)

D. Distinct body of knowledge

Paramedicine has a distinct body of knowledge that forms the basis of the standards of practice for EMAs. This is a hallmark of self-regulating professions. As described above, practitioners of paramedicine have developed a specialized body of knowledge over time specific to their field, making them experts in their subject matter. They are therefore best placed to determine and monitor standards of practice respecting the paramedicine profession – again calling for designation as a health profession.

E. Post-secondary education

Another criteria that may be considered by the Minister of Health when designating a health profession is whether practitioners are awarded a certificate or degree from a post-secondary educational institution. Putting aside the current, already distinct certification requirements for EMAs, the profession of paramedicine is moving towards a paramedicine baccalaureate entry into practice across the country by 2025. With increased education and greater responsibility, there is a concomitant need for self-regulation as exists in other degreed health professions.

F. Public recognition and respect for the profession

PAC has engaged Abacus Data Inc., a professional survey company, on various occasions to survey the public about their views of paramedics and, indirectly, first responders. Survey results, most recently in 2016 and 2018, reflect that among the key findings, paramedics and first responders continue to be viewed among the most respected and recognized health professions in Canada, ranking together with doctors and nurses[46].

Notably, the survey data also reflects that the public supports self-regulation for paramedics.[47]

G. Additional criteria supporting designation as a health profession

The practice of paramedicine has several other distinguishing features when compared to other health professions which make it suitable for self-regulation and support establishing a stand-alone 'College of Paramedics'.

Firstly, the dual role of paramedics in both the safety and public health realms, discussed above, creates unique responsibilities[48] for the profession.

Secondly, the practice of paramedicine involves a higher risk of harm to patients when compared to other regulated professions, a criteria set out under Part 3 of the Designation Regulations, arising from the fact that EMAs (other than CCPs) cannot accept delegated authority when providing services within their scope of practice.[49] Stated generally, an EMA's scope of practice includes autonomous decision making around the emergency care of patients. In this regard, our scope of practice is defined differently than the other regulated health professions. In stark contrast to the nursing model of health care for example in which

[46] See **Appendices "A" to "D"**, *supra*, Public Surveys
[47] See **Appendix "C"**, supra, Public Survey Summer 2016, page 40
[48] Consultation Paper, page 9 re justifications for maintaining identified stand-alone colleges
[49] EMA Regulations, section 8(2)

nurses are under the supervision of a physician, an EMA (other than a CCP) may not accept direction to perform a medical act from another person who is qualified to practice as a member of a different health profession (or from any other person).

Thirdly, unlike most other regulated health professions, EMAs have a lock-step progression for licensure. As referenced above, the services provided by EMAs are delivered according to the standards and competencies of the EMA's level of training and credentials – those associated with their category of licence[50]. EMA licensure recognizes that each level of licence is independent but also that each level is required to perform the services specified in the category below.[51] For example, an ACP under the EMA Regulation is expected to provide all of the services[52] of an EMA FR, an EMR and PCP in addition to the skills and services within their own scope. This is generally unique to the health professions and again supports designation as well as the establishment of a stand-alone college.

H. Improved opportunity to collaborate and consistency across regulators

The Cayton Report also highlights the modern inter-professional, team-based model of health care delivery.[53] Paramedicine has evolved dramatically since the EMA Regulations were first enacted. By bringing EMAs within the college framework, the regulator will be better situated to exchange information and collaborate with other professional regulators to enhance health care and standards. This is particularly relevant for EMAs as paramedics' body of knowledge overlaps with that of several regulated health professions, including nurses, midwives, respiratory therapists and physicians.

The college regulatory model for EMAs will also bring EMAs in line with the way other health professions are regulated, meeting the objective of consistency in regulation across heath care professions.[54]

I. A stand-alone 'College of Paramedics' is practicable

Another criteria the Minister of Health may consider when deciding to designate a health profession is the likelihood that a college established under the HPA would be capable of carrying out the duties under the HPA. The ABPC submits that not only is self-regulation through a stand-alone 'College of Paramedics' in the public interest, it is also practicable.

As noted above, the EMALB has a registrant base of over 15,000 EMAs. As such it is of sufficient size and registrant base to establish a stand-alone college. And in fact, it exceeds the registrant base of the College of Physicians and Surgeons (13,724 registrants) by approximately 1,300 and has almost double registrants as those governed by the College of Pharmacists (6,769 registrants). Indeed a stand-alone EMA regulation exists now.

The viability of a stand-alone 'College of Paramedics' in B.C. is demonstrated by the experience in other provinces. As noted above, stand-alone colleges for paramedics are currently established in five provinces:

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[50] **Appendix "H"**, *supra,* BCEHS First Responders and Paramedic Credentials in BC (September 2018)
[51] EMA Regulations, Schedule 1
[52] See **Appendix "H"**, *supra*
[53] Cayton Report, paragraphs 10.2, 11.3
[54] Consultation Paper, page 9

Alberta, Saskatchewan, Manitoba, New Brunswick and Nova Scotia. Quebec and Prince Edward Island are currently in the process of moving to self-regulation. (Ontario and Newfoundland and Labrador are government regulated; the Territories are not regulated). The numbers of registrants for each are as follows:

AB	9,081
SK	2,070
MB	2,500
NB	1,304
NS	1,392

Clearly, with over 15,000 registrants, EMAs in B.C. are the largest paramedic group in Canada. This lends further support for designation and the establishment of a stand-alone 'College of Paramedics'.

VIII. Alternative – regulation of EMAs within a multi-profession college

In relation to Cayton's recommendation to reduce the existing number of colleges, the Steering Committee points to the creation of a 'College of Health and Care Professions' to regulate a diverse range of professions and bring together numerous existing colleges.[55]

The APBC submits that although inclusion in a multi-profession college is preferable to the current regulatory scheme for EMAs, a stand-alone college is the best alternative for several reasons.

As outlined above, there are several aspects of paramedicine that make it unique and distinguish it from all other health professions including, among other factors:

- the size and registrant base;
- extent to which the profession is practiced;
- the distinct nature of the services provided;
- the high-risk profile of practicing paramedicine;
- its distinct body of knowledge;
- its dual role in safety and in health care;
- unique scope of practice – cannot accept delegation (other than CCPs);
- unique licensure;

[55] Consultation Paper, page 10

- the recognition as a PSO; and
- the high public regard for EMAs.

Where such unique jurisdiction and responsibilities are present in other professions (oral health, physicians, nurses and pharmacists), Cayton and the Steering Committee have concluded that stand-alone colleges are justified and advisable.[56] The same reasoning applies to the creation of a 'College of Paramedics'. Like these other stand-alone colleges, EMAs also have unique jurisdiction and responsibilities.

Moreover, with 15,000 registrants, EMAs far outnumber the majority of health professions that will become part of the new multi-profession regulatory college: The registrants of smaller colleges may indirectly take on added costs arising from the far greater number of EMAs (eg. number of complaints, etc.). Also, although in a multiple college system, economies of scale may be realized, that has not always proven to be the case.[57]

Furthermore, grouping EMAs together with health colleges that provide completely unrelated services does not have the common sense justification applicable to groupings of colleges around particular services such as oral health or nursing. The EMAs interests and subject-matter and other concerns are not aligned. With respect, the concerns of massage or speech therapists are simply not aligned with the concerns (responsibilities, etc.) of EMAs.

Additionally, as referenced above, the Steering Committee's interest in establishing more consistent standards across professions are largely achieved by bringing EMAs under a common legislative and regulatory framework with other regulated health professions. It is not necessary to place EMAs in a multi-profession college to achieve this desired outcome, particularly in light of the functions and role contemplated for the proposed oversight body.

On the whole, given these and other considerations canvassed herein, a stand-alone 'College of Paramedics' will best serve the public interests and protect patients.

IX. Answers issues raised in *Modernizing the provincial health profession regulatory framework: a paper for consultation*

The Steering Committee's consultation paper provides for proposed changes to the HPA and the current regulation of health profession colleges in terms of four broad categories:

(1) Improving governance (concerning the elimination of board elections and introduction of a more transparent, competency-based appointment process, etc.);

(2) Creating an independent oversight body (to increase accountability and consistency of health regulatory colleges);

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[56] Consultation Paper, page 9

[57] For example, when two additional groups (College of Licensed Practical Nurses and the College of Registered Psychiatric Nurses) were amalgamated on September 4, 2018 with the College of Registered Nurses, and became the College of Nursing Professionals, the registrant fee increased: https://www.bccnp.ca/Registration/fees/Pages/Default.aspx (accessed January 19, 2020)

(3) Simplifying and improving the complaints and discipline processes;

(4) Reducing the number of regulatory colleges from twenty to five (to be comprised of: Nurses and Midwives; Physicians and Podiatric Surgeons; Oral health professionals; Pharmacists; and the remaining colleges under a single umbrella, "Health and Care Professions")

Many of these topics have been touched upon in our submissions above. We provide further feedback as follows.

A. Improving governance

The Cayton Report recommends the elimination of elected board members in favour of competency based appointment and fully appointed boards comprised of equal parts health professionals and members of the public.[58]

While the APBC supports increased accountability through competency based appointments (based on specified criteria, etc. and considers diversity) to college boards, as well as adequate compensation for all board members and extension of terms to three years, we do not favour equal professional-public composition. In our view, the profession-specific perspective and expertise is required in larger proportion to public members in order to have relevant, effective governance. Although inclusion of the public on regulatory boards is important, college registrants – those with technical and practical expertise and experience in their field – should have a majority say in setting standards and competencies, and making other decisions directly impacting the practice of their profession. This is a fundamental aspect of professional self-governance.

Again, we acknowledge that professional regulation needs to be shared between the profession and the public in the interests of society as a whole; however, for similar reasons as just described, we oppose fully appointed boards for colleges. Elections for registrant appointees should be maintained.

[58] Cayton Report, paragraph 9.20

Other jurisdictions which have colleges of paramedics have similar board/ council composition to what the APBC advocates for (again, for ease of reference):

AB	2 Public	6 Practitioners[59]
SK	3 public	6 Practitioners
MB	4 Public	11 Practitioners
NB	2 public	13 Practitioners
NS	5 public	8 Practitioners

Indeed, Question Q2e of the consultation paper acknowledges the importance of and continued reliance on profession-specific clinical expertize as an important element of effective regulation; for example, in the development of professional standards. We submit this aspect of effective regulation is best served by having a majority of board members be elected college registrants.

B. Independent oversight body

One of Cayton's recommendations is to strengthen the oversight of regulatory colleges. Among other recommendations, he proposes various functions of a new oversight body (reviewing determinations, review registration appeals, publication of performance data, oversight of appointments process, approval of by-law changes, risk assessment of occupations and investigations and reviews). [60]

In general terms the APBC is supportive of these changes as picked up on by the steering committee. In particular, as highlighted above, the need for professional regulators to be more flexible and better able to respond to changing public health care demands and expectations, and to evolving medical knowledge and health care practices, is required. The proposals for shared standards for ethics and conduct, a single registry for registrants, and for an oversight body to advise, but not direct, colleges and the Minister on shared improvements to regulatory practice affecting all health professions, are clearly functions beneficial to all health professions and the public. Accordingly, we support an oversight body carrying out such functions.

C. Improving the complaints and discipline process

Cayton says that significant revision is needed in the complaints process of colleges, noting among other things, separating the complaints and discipline processes and the adoption of a shared policy on the consideration of past conduct history of a registrant in complaint dispositions, are needed.[61]

APBC supports the increase in fairness, transparency, consistency and efficiency that are sure to result from such changes.

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[59] See, for example, current members of the Alberta College of Paramedics council: https://abparamedics.com/council/ (Accessed January 18, 2020)
[60] Cayton Report, paragraph 10.19 and see Table at page 90
[61] Cayton Report, paragraph 9.47

D. Reduction in the number of regulatory colleges

Cayton does not recommend a reduction in the current number of regulated professions (as highlighted by the Steering Committee[62]) but rather in the number of colleges, while suggesting a moratorium on the creation of any new colleges.[63]

On the latter point, the APBC emphasizes that Cayton did not undertake an inquiry into the administration and operation of the EMALB; he was not authorized to review or make recommendations respecting changes to the EHSA or EMA Regulations.[64] He reaches no conclusions in that regard. Such an inquiry has yet to occur. We ask that it be undertaken now.

The APBC submits that such a review is called for at this time in light of:

- the current ongoing review process of regulated health professions in B.C. and contemplated overhaul of the HPA;
- the proposed oversight body for colleges and its functions - which is contemplated to include assessing and recommending whether the public interest could be better served if certain existing regulated professions were to be regulated under the HPA[65];
- the Steering Committee's comments that there is opportunity to consider improvements respecting how EMAs are regulated[66];
- the recognition of the Steering Committee that more consistent standards across professions is desirable and will support the current health delivering model of integrated care for patients[67];
- the many challenges with the governance model, legislation and regulations currently regulated EMAs;
- the investigation into an application for the designation of a health profession contemplated under the Designation Regulation; and
- the within application of APBC to be designated as a health profession under the HPA.

APBC recognizes the need to transition to fewer regulatory colleges in B.C. where there is a clear benefit to doing so (eg. groupings of colleges around services such as dentistry) in order to improve performance, efficiency and effectiveness of the regulatory framework. However, for the reasons details above, the APBC

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[62] Consultation Paper, page 11
[63] Cayton Report, paragraph 10.21
[64] Cayton Report, Annex 1 Terms of Reference
[65] Cayton Report, paragraphs 2.4 and 10.21-10.23; and Consultation Paper, pages 11 and 14-15
[66] Consultation Paper, page 15
[67] Consultation Paper, page 9

submits that a stand-alone college for EMAs will better serve the interests of the public and the profession than inclusion in the proposed 'College of Health and Care Professions'.

X. Conclusions

The paramount concern of the APBC is that EMAs be included in any new structure that may be implemented to regulate health professions in B.C. The need for consistent model of regulation for all health professions is required. In that regard, the APBC believes that many of the current challenges with the regulation of EMAs could be remedied by designating paramedicine as a health profession under the HPA and the introduction of a self-governance model of regulation for EMAs. Doing so is clearly aligned with the overall objectives of reform of health professional regulation identified by Cayton[68]. In our submission, this is best achieved by establishing a stand-alone 'College of Paramedics'; or alternatively, through inclusion within the single umbrella college of "Health and Care Professions".

For the reasons outlined herein we respectfully ask, further to the Designation Regulations, that at this time an investigation into the regulation of EMAs be carried out on a priority basis as part of the ongoing review of the regulation of health professions in B.C. We look forward to consulting with the Minister of Health further in this regard.

In closing, we reiterate our commitment to working with government on moving the issues canvassed herein forward in the best interests of the public, the patients we serve, our practitioners and allied professionals in public safety and health.

ALL OF WHICH IS RESPECTFULLY SUBMITTED.

Enclosures

AMBULANCE PARAMEDICS AND EMERGENCY DISPATCHERS OF BRITISH COLUMBIA

TROY CLIFFORD, President, Ambulance Paramedics and Emergency Dispatchers of British Columbia, CUPE Local 873

[68] Cayton Report, paragraph 9.14

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August 27, 2020

APBC POSITION STATEMENT ON MENTAL HEALTH CONSIDERATIONS OF PARAMEDICS DURING COVID-19

In March 2020, the World Health Organization (WHO) declared the outbreak of a new coronavirus disease, Covid-19, a global pandemic.[1] As countries, governmental agencies, and health authorities act to contain the virus, this time of crisis is generating widespread psychological concerns. At particular psychological risk during this pandemic are our healthcare professionals, including our paramedic practitioners. We are issuing this position statement to highlight what the existing literature tells us about the mental health effects of previous pandemics on frontline healthcare staff. It is also critical to acknowledge how Covid-19 has already, at this relatively early stage, impacted the working environment for healthcare professionals, our members included. And perhaps most importantly, we want to advocate for the psychological support of the profession.

According to previous studies from SARS, H1N1, MERS, and Ebola epidemics, the psychological burden that healthcare professionals experience during these crises is significant.[2] Both their physical and mental well-being has been shown to be compromised by a myriad of factors including increased workload, physical exhaustion, insufficient personal protective equipment, and the potential distress of making ethically difficult decisions regarding the rationing of care.[3] Furthermore, the resiliency of these healthcare professionals can be further compromised by isolation and loss of support, risk of or infections of family and friends, as well as often unsettling changes in medical protocols and workplace procedures.[3]

Studies have indicated that healthcare professionals are vulnerable to specific mental health concerns both during and after pandemics. In a study of 1800 hospital practitioners in Hong Kong after the 2015 MERS outbreak, it was found that medical staff who performed MERS-related tasks showed the highest risk for posttraumatic stress disorder symptoms.[4] Surveys from over 10,000 healthcare workers in Singapore after SARS found that staff in daily contact with SARS or staff from SARS-affected institutions expressed significantly higher levels of an anxiety.[5] In addition, more than half reported increased work stress and workload. And here in Canada, the *Impact of SARS Study* found that one to two years after the outbreak, professional burnout and symptoms of traumatic stress, anxiety, and depression remained elevated among Toronto hospital workers compared with colleagues in settings that did not treat SARS patients.[6]

Research has already started to emerge regarding the psychological implications of Covid-19 on front-line healthcare providers. Systematic reviews conducted of these studies indicated that healthcare workers are encountering a considerable degree of stress, anxiety, depression, and insomnia.[3,7] For example, a survey of 1257 healthcare workers in China found that a considerable portion reported symptoms of general distress (71.5%), anxiety (44.6%), depression (50.4%), and insomnia (34%).[8] Another observational study of 180 healthcare workers found substantial levels of anxiety and stress that negatively impacted sleep quality and feelings of self-efficacy.[9]

Our position is that the Covid-19 pandemic will impact the psychological health of paramedics and dispatchers. The workload and burden has already increased, as the BCEHS CISM team was activated on 232 occasions in April 2020 as opposed to 130 activations in April 2019.

It is imperative that we learn from previous pandemics and the aforementioned research. It should help us predict future mental health needs, and act and prepare accordingly. We are also aware that in the absence of a pandemic, our profession is already at higher risk for stress disorders than most other occupations.[10] Therefore, we feel strongly that the profession should be psychologically supported both during this time and on an ongoing basis. It is true that healthcare providers who feel well supported and trained experience better mental health over the long term.[11] Organizational provision of psychological services, support for staff in isolation/quarantine, peer support, as well as communication, empowerment, and humanity from leaders have been identified as considerations for supporting healthcare providers during this pandemic.[12] We feel strongly that paramedics and dispatchers deserve to have access to these kinds of supports for their mental health.

(Writing and recommendations by Dr. Kathy Keating, Registered Psychologist (CPBC #2169), Commissioned by the Ambulance Paramedics & Emergency Dispatchers of BC)

Provincial Executive Board
Ambulance Paramedics & Emergency Dispatchers of BC
CUPE Local 873

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[1] World Health Organization (2020, March 18). *Mental health and psychosocial considerations during the Covid-19 outbreak.* WHO/2019-nCoV/Mental Health/2020.1

[2] Liu, X., Kakade, M., Fuller, C., Fan, B., Fang, Y., Kong, J., Guan, Z., & Wu, P. (2012). Depression after exposure to stressful events: Lessons learned from the severe acute respiratory syndrome epidemic. *Comprehensive Psychiatry 53*(1), 15-23. https://doi.org/10.1016/j.comppsych.2011.02.003

[3] Pappa, S., Ntella, V., Giannakas, T., Giannakoulis, V. G., Papoutsi, E., Katsaounou. (2020). Prevalence of depression, anxiety, and insomnia among healthcare workers during the COVID-19 pandemic: A systematic review and meta-analysis. *Brain, Behavior, and Immunity.* https://doi.org/10.1016/j.bbi.2020.05.026

[4] Lee, S. M., Kang, W. S., Cho, A. Kim, T, & Park, J. K. (2018). Psychological impact for the 2015 MERS outbreak on hospital workers and quarantined hemodialysis patients. (2018). *Comprehensive Psychiatry, 87*, 123-127. https://doi.org/10.1016/j.comppsych.2018.10.003

[5] Koh, D., Lim, M., Chia, S., Ko, S., Qian, F., Ng, V., Tan, B., Wong, K., Chew, W., Tang, H., Ng, W., Muttakin, Z., Emmanuel, S., Fong, N., Koh, G., Kwa, C., Tan, B., Fones, C. (2005). Risk perception and impact of severe acute respoiratory symdrome (SARS) on work and personal lives of healthcare workers in Singapore: What can we learn? *Medical Care,43*(7), *676-682.* doi: 10.1097/01.mlr.0000167181.36730.cc

[6] Maunder, R. G., Lancee, W. J., Balderson, K. E., Bennett, J. P., Borgundvaag, B., Evans, S., Fernandes, C. M. B., Goldbloom, D. S., Gupta, M., Hunter, J. J., McGillis Hall, L., Nagle, L. M., Pain, C., Pecseniuk, S. S., Raymond, G., Read, N., Rourke, S. B., Steinbery, R. J., Stewart, T. E., VanDeVelde-Coke, S., Veldhorst, G. G., Wasylenki, D. A., (2006). Long-term psychological and occupational effects of providing hospital healthcare during SARS outbreak. *Emerging Infectious Disease, 12*(12), 1924-1932. doi: 10.3201/eid1212.060584

[7] Spoorthy, M. S., Pratapa, S. K., Mahant, S. (2020). Mental health problems faced by healthcare workers due to the COVID-19 pandemic-a review. *Asian Journal of Psychiatry, 51*. https://doi.org/10.1016/j.ajp.2020.102119

[8] Lai, J., Ma, S., Wang, Y., Cai, Z., Hu, J., Wei, N., Wu, J., Du, H., Chen, T., Li, R., Tan, H., Kang, L., Yao, L., Huang, M., Wang, H., Wang, G., Liu, Z., & Hu, S. (2020). Factors associated with mental health outcomes among health care workers exposed to

coronavirus disease 2019. *Journal of the American Medical Association Network Open, 3*(3). https://dx.doi.org/10.1001%2Fjamanetworkopen.2020.3976

[9] Xiao, H., Zhang, Y., Kong, D., Li, S., & Yang, N. (2020). The effects of social support on sleep quality of medical staff treating patients with coronavirus disease 2019 (COVID-19) in January and February in China. *Medical Science Monitor, 26.* https://dx.doi.org/10.12659%2FMSM.923549

[10] Haugen, P., Evces, M. & Weiss, D. (2012). Treating posttraumatic stress disorder in first responders: A systematic review. *Clinical Psychology Review, 32*, 370-380. https://doi.org/10.1016/j.cpr.2012.04.001

[11] Lancee, W. J., Maunder, R. G., Goldbloom, D. S. (2008). Prevalance of psychiatric disorders among Toronto hospital workers one to two years after the SARS outbreak. *Psychiatric Services, 59*(1), 91-95. https://dx.doi.org/10.1176%2Fps.2008.59.1.91

[12] Walton, M., Murray, E., Christian, M. D. (2020). Mental health care for medical staff and affiliated healthcare workers during the COVID-19 pandemic. *European Heart Journal: Acute Cardiovascular Care*. https://doi.org/10.1177%2F2048872620922795

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Attention: **Troy Clifford, President**

Dear Sirs / Mesdames:

Re: **2019 amendments to the *Employment Standards Act***

You have requested our opinion regarding the following question.

QUESTION

To what extent do the provisions of the recently amended *Employment Standards Act* (the "ESA") apply to workers covered by a collective agreement?

ANSWER

When considering the application of ESA provisions to workers covered by a collective agreement, there are two broad categories of substantive ESA provisions.

The first category are those ESA provisions that apply generally to both non-union workers and unionized workers. These include, most significantly, the following:

(a) Part 3 – Wages, Special Clothing, Records, and Gratuities (other than sections 25(1) and (2) dealing with special clothing); and

(b) Part 6 – Leaves and Jury Duty.

(c) Certain provisions of Part 8 – Termination of Employment, dealing with group terminations (**not** individual terminations).

The second category are those ESA provisions that apply generally to non-union workers, but apply to unionized workers **only** if a particular basket of collective agreement provisions **does not** "meet or exceed" a comparable basket of ESA provisions. If a particular basket of collective agreement provisions **does** "meet or exceed" the comparable basket of ESA provisions, the basket of collective agreement provisions replaces the requirements of the comparable basket of ESA provisions.

The baskets of provisions to be compared are as follows:

Collective agreement	ESA
Special Clothing	Section 25(1) or (2)
Hours of work or overtime	Part 4
Statutory Holidays	Part 5
Annual Vacation or vacation pay	Part 7
Seniority retention, recall, termination of employment or layoff	Section 63

Consequently, it is possible for a collective agreement to contain individual provisions that are inferior to the minimum standards set out in the ESA for non-union workers, provided that the overall basket of provisions under the collective agreement meets or exceeds the comparable basket of ESA provisions.

If the basket of collective agreement provisions **does not** "meet or exceed" the comparable basket of ESA provisions, those ESA provisions are incorporated in the collective agreement. The incorporated ESA provisions also likely replace the basket of collective agreement provisions (with the consequence that any superior collective agreement provisions in the basket would be lost).

FACTS

The facts upon which this opinion is based are as follows. Please advise if there are any errors or omissions in the facts, as any difference in the facts may affect our opinion.

REASONS

Introduction

1. We will begin by describing the historical evolution of the ESA provisions regarding the ability of trade unions to effectively contract out of minimum standards contained in the ESA. We will then consider the current ESA provisions in this regard.

Historical evolution of the ESA

Introduction

2. The ESA has gone through significant changes over recent decades in regard to the ability of trade unions to contract out of minimum standards contained in the ESA. The various statutory schemes can be summarized as follows:

- Prior to 1983 — No contracting out
- 1983 to 1993 — The first "any provision" test
- 1993 to 1995 — The first "meet or exceed" test
- 1995 to 2002 — The second "meet or exceed" test
- 2002 to 2019 — The second "any provision" test
- 2019 to present — The third "meet or exceed" test

3. We will address each of these statutory schemes in turn.

Prior to 1983 – No contracting out

4. Prior to 1983, there was generally no ability for unions to contract out of the minimum standards contained in the ESA by negotiating inferior provisions in their collective agreements.[1] The minimum standards contained in the ESA applied to all workers, whether covered by a collective agreement or not. Inferior collective agreement provisions were effectively superseded by superior ESA provisions.

1983 to 1993 – The First "Any Provision" Test

5. However, in 1983 the ESA was amended under the Social Credit government to allow unions to contract out of the ESA if their collective agreement contained **any** provisions regarding the same subject matter as various baskets of ESA provisions. Section 2 of the amended ESA provided in part:

> (1) Subject to subsection (2), a requirement of or made under this Act is a minimum requirement, and an agreement to waive such a requirement, not being an agreement referred to in subsection (2), is void.
>
> (2) Where a collective agreement contains any provision respecting a matter set out in Column 1 of the following table, the Part of this Act set out opposite that matter in Column 2 does not apply in respect of employment pursuant to that collective agreement:

[1] Subject to certain very limited exceptions.

Column 1 Matter	Column 2 Part
Hours of work or overtime	Part 3
Annual vacation or vacation pay	Part 4
Termination of employment or layoff	Part 5
Maternity and parental leave	Part 7

(3) Where a collective agreement contains no provision respecting a matter set out in Column 1 of the table to subsection (2), the Part of this Act set out opposite the matter in Column 2 shall be deemed to be incorporated in the collective agreement as part of its terms.

6. Under this first "any provision" test, a union could agree to a basket of collective agreement provisions that was entirely inferior to the comparable basket of ESA provisions, and the superior ESA provisions would have no application to the workers covered by the collective agreement.

1993 to 1995 – The first "meet or exceed" test

7. The situation changed when the NDP government amended the ESA in 1993 to provide for the first "meet or exceed" test. Section 2 of the ESA after the 1993 amendments provided in part:

> (2) where a collective agreement contains any provisions respecting a matter set out in column 1 of the following table, the sections of the Part of this Act or the regulations set out opposite the matter in Column 2 do not apply in respect of employment covered by the collective agreement if the provisions of the collective agreement respecting the matter, when considered together, meet or exceed the minimum requirements established by the sections of the applicable Part or regulations, when considered together:

Column 1	Column 2
Hours of work and overtime	Part 3
Annual Vacation and Vacation Pay	Part 4
Termination of employment or layoff	Part 5
General holidays	Regulations made under Section 105(2)(c)(i), (ii), (iv) and (v)

> (3) Where the provisions of a collective agreement respecting a matter referred to in Column 1 of subsection (2) do not, when considered together, meet or exceed the minimum requirements established by the sections of the applicable Part or regulations referred to in Column 2 of subsection (2), when considered together,
>
> a) the sections of the applicable Part or regulations are deemed to be incorporated in the collective agreement and to replace the provisions of the collective agreement respecting the matter....

8. While this first "meet or exceed" test might appear to require a comparison between the entirety of the basket of identified collective agreement provisions and the entirety of the basket of comparable ESA provisions, it was interpreted somewhat differently by arbitrator Munroe in *Crestbrook Forest Industries Ltd. v. Industrial Wood and Allied Workers of Canada, Local 1-405*, [1995] B.C.C.A.A.A. No. 127 ("*Crestbrook*"). In *Crestbrook*, arbitrator Munroe described the proper approach under this first "meet or exceed" test as follows:

> First, one identifies and considers together those sections of the applicable Part of the Act having a rational and meaningful connection with the nominal subject matter of the inquiry. Then, one identifies and considers together those provisions of the collective agreement having a rational and meaningful connection with the nominal subject matter of the inquiry. And finally, one judges whether the relevant contractual provisions, viewed as a package, are at least equal to the relevant statutory provisions, viewed as a package -- i.e., for employment standards purposes..." (at para 23, emphasis added).

9. At issue in *Crestbrook* were eating periods (i.e. meal breaks), found in Part 3 of the ESA dealing with hours of work and overtime. Arbitrator Munroe rejected an approach which would require a comparison of **all** provisions of a collective agreement dealing with hours of work and overtime with **all** sections of Part 3 of the Act. He also rejected an approach where the comparison between the ESA and collective agreement was solely about the precise provision at issue (e.g. eating periods). Instead, he took the middle ground of comparing only those parts of the two baskets having a "rational and meaningful connection with the subject matter of the inquiry."[2]

1995 to 2002 – The second "meet or exceed" test

10. In 1995 the ESA was further amended. Under the amended ESA, there were multiple "meet or exceed" provisions specific to certain parts of the ESA. For example, in Part 4 – Hours of Work and Overtime, section 43 provided:

> (1) If the hours of work, overtime and special clothing provisions of a collective agreement, when considered together, meet or exceed the requirements of this Part and Section 25 when considered together, those provisions replace the requirements of this Part and section 25 for the employees covered by the collective agreement.
>
> (2) If the hours of work, overtime and special clothing provisions of a collective agreement, when considered together, do not meet or exceed the requirements of this Part and section 25 when considered together,
>
> (a) the requirements of this Part and section 25 are deemed to form part of the collective agreement and to replace these provisions, and
>
> (b) the grievance provisions of the collective agreement apply for resolving any dispute about the application or interpretation of those requirements.

[2] A subset of the baskets that may be difficult to identify in practice.

11. Similar language was also found in Part 5 – Statutory Holidays (section 49), and in Part 7 – Annual Vacation (section 61).

12. Initial decisions after these 1995 amendments endorsed Arbitrator Munroe's *Crestbrook* approach of comparing subsets of the applicable baskets.[3]

13. However, in *Community Social Services Employers' Assn.*, BCLRB No. B551/98 ("*Community Social Services*") the Labour Relations Board rejected the approach taken by arbitrator Munroe in *Crestbrook* under the previous version of the statute. The Labour Relations Board found that the **entirety** of the baskets must be compared under the second "meet or exceed" test, rather than some subset of those baskets as arbitrator Munroe had found under the first "meet or exceed" test:

> The "meet or exceed" test in the Employment Standards Act requires arbitrators to consider together the collective agreement provisions for all employees covered by the agreement, and to compare them to the corresponding requirements of the Act, as also considered together for all of the employees. In carrying out this exercise, arbitrators must have regard to the aggregate of the collective agreement provisions which correspond to the aggregate of the statutory requirements in the particular part of the Act. (para 86) [4]

14. The Labour Relations Board went on to describe the consequences of not meeting the "meet or exceed" test:

> Where collective agreement provisions do not "meet or exceed" the requirements of the Act, the latter are deemed to form part of the collective agreement and replace its provisions for all employees in the bargaining unit, regardless of the particular form of the determination made by an arbitrator. (para 86)

15. Therefore, under this second "meet or exceed" test, where the meet or exceed threshold has not been met, the entire basket of collective agreement provisions is replaced by the entire corresponding basket of ESA provisions. There is no room to "cherry-pick" individual ESA provisions, as the statutory language contemplates a wholesale replacement of the basket of collective agreement provisions with the corresponding basket of ESA provisions.[5]

---

[3] See *Overwaitea Food Group*, BCLRB No. B420/97 and *Vancouver Island Haven Society*, BCLRB No. B359/97

[4] Though note that in *Communications, Energy and Paperworkers Union v National Representatives Union (Hodgson Grievance)*, [1999] BCCAAA No. 431, Arbitrator Munroe continued to use the *Crestbrook* approach with respect to the second "meet or exceed" test, without any apparent consideration of the *Community Social Services* decision.

[5] See also *British Columbia*, BCLRB No. B32/99.

16. In addition, under this second "meet or exceed" test, the Labour Relations Board determined that the comparison of baskets had to be considered from the vantage point of employees as a whole, not certain sub-groups of employees.[6] Similarly, the comparison of baskets had to be considered over the long term, rather than over some short period of time.[7]

2002 – 2019 - The second "any provision" test

17. In 2002, the ESA was further amended under the Liberals to once again provide for an "any provision" test:

> 3(2) If a collective agreement contains any provision respecting a matter set out in Column 1 of the following table, the Part or provision of this Act specified opposite that matter in Column 2 does not apply in respect of employees covered by the collective agreement:

Column 1 Matter	Column 2 Part or Provision
Hours of work or overtime	Part 4
Statutory Holidays	Part 5
Annual Vacation or vacation pay	Part 7
Seniority retention, recall, termination of employment or layoff	Section 63

> (3) If a collective agreement contains no provision respecting a matter set out in Column 1 of the following table, the Part or provision of this Act specified opposite that matter in Column 2 is deemed to be incorporated in the collective agreement as part of its terms:

Column 1 Matter	Column 2 Part or Provision
Hours of work or overtime	Part 4, except section 37
Statutory Holidays	Part 5
Annual Vacation or vacation pay	Part 7
Seniority retention, recall, termination of employment or layoff	Section 63

[6] *Community Social Services*, BCLRB No. B551/98.

[7] *Community Social Services*, BCLRB No. B551/98.

18. In addition, the amended ESA provided in section 3(6):

> If a collective agreement contains any provision respecting a matter set out in one of the following specified provisions of this Act, that specified provision of this Act does not apply in respect of employees covered by the collective agreement:
>
> section 17 *[paydays]*;
> section 18 (1) *[payment of wages when employer terminates]*;
> section 18 (2) *[payment of wages when employee terminates]*;
> section 20 *[how wages are paid]*;
> section 22 *[assignment of wages]*;
> section 23 *[employer's duty to make assigned payments]*;
> section 24 *[how an assignment is cancelled]*;
> section 25 (1) or (2) *[special clothing]*;
> section 26 *[payments by employer to funds, insurers or others]*;
> section 27 *[wage statements]*;
> section 28 (1) *[content of payroll records]*;
> section 28 (2) *[payroll record requirements]*.

19. Under this second "any provision" test, a union could again agree to provisions that were entirely inferior to the specified ESA provisions.

2019 to present – The third "meet or exceed" test

20. The ESA was then further amended on May 30, 2019. This current version of the ESA again contains a "meet or exceed" test. However, the wording is different than either of the prior "meet or exceed" tests. Section 3 of the current ESA provides in part as follows:

> (2) If a collective agreement contains any provisions respecting a matter set out in column 1 of the following table, and the provisions, when considered together, meet or exceed the requirements, when considered together, of the Part or section of this Act specified opposite the matter in column 2 of the table, those provisions of the collective agreement replace the requirements of that Part or section of the Act in respect of employees covered by the collective agreement:

Column 1 Matter	Column 2 Part or Section
Special Clothing	Section 25(1) or (2)
Hours of work or overtime	Part 4
Statutory Holidays	Part 5
Annual Vacation or vacation pay	Part 7
Seniority retention, recall, termination of employment or layoff	Section 63

(3) If a collective agreement contains no provisions respecting a matter set out in column 1 of the following table, or contains any provisions respecting a matter set out in column 1 that, when considered together, do not meet or exceed the requirements, when considered together, of the part or section of this Act specified opposite the matter in column 2 of the table, that Part or section of the Act is deemed to be incorporated in the collective agreement as part of its terms:

Column 1 Matter	Column 2 Part or Section
Special Clothing	Section 25(1) or (2)
Hours of work or overtime	Part 4, except section 37
Statutory Holidays	Part 5
Annual Vacation or Vacation Pay	Part 7
Seniority Retention, recall, termination of employment or layoff	Section 63

(emphasis added)

21. In addition, the May 30, 2019 amendments changed section 3(6) so that the various other sections of the ESA referred to in section 3(6) now apply generally to workers covered by a collective agreement (although enforcement of those provisions is a matter for arbitration rather than proceedings under the ESA):

> Parts 10, 11 and 13 of this Act do not apply in relation to the enforcement of the following provisions of this Act in respect of an employee covered by a collective agreement:
>
> section 3 (2) *[when provisions of collective agreement replace requirements of this Act]*;
> section 3 (3) *[when requirements of this Act are deemed incorporated into collective agreement]*;
> section 9 *[hiring children]*;
> section 10 *[no charge for hiring or providing information]*;
> section 16 *[employers required to pay minimum wage]*;
> section 17 *[paydays]*;
> section 18 (1) *[payment of wages when employer terminates]*;
> section 18 (2) *[payment of wages when employee terminates]*;
> section 20 *[how wages are paid]*;
> section 21 *[deductions]*;
> section 22 *[assignment of wages]*;
> section 23 *[employer's duty to make assigned payments]*;
> section 24 *[how an assignment is cancelled]*;
> section 26 *[payments by employer to funds, insurers or others]*;
> section 27 *[wage statements]*;
> section 28 (1) *[content of payroll records]*;
> section 28 (2) *[payroll record requirements]*;

section 30.3 *[gratuities]*;
section 30.4 *[redistribution of gratuities]*;
Part 6 *[leaves and jury duty]*;
section 64 *[group terminations]*;
section 65 *[exceptions to section 64]*;
section 67 *[rules about notice of termination]*;
section 68 *[rules about payments on termination]*.

(emphasis added)

22. The amendments to section 3 apply to collective agreements made or renewed after the date that the amendments came into force.[8]

23. We are unaware of any decisions that have interpreted these recent amendments, and consequently there is significant uncertainty as to precisely how this third "meet or exceed" test will be interpreted. However, based on the wording of the present statute[9], in our opinion this third "meet or exceed" test very likely requires a comparison of the **entirety** of the baskets of provisions set out in sections 3(2) and 3(3), not some subset of those baskets as concluded by arbitrator Munroe under the first "meet or exceed" test in *Crestbrook*.

24. Similarly, where a basket of collective agreement provisions **does** "meet or exceed" the comparable basket of ESA provisions, in our opinion it is very likely that the entirety of the collective agreement basket replaces the entirety of the corresponding part or section of the ESA set out in section 3(2).

25. However, where a basket of collective agreement provisions **does not** meet or exceed the comparable basket of ESA provisions, an interesting issue arises. This is because the consequence set out in section 3(3) is that the corresponding part or section of the ESA is "deemed to be incorporated in the collective agreement". There is no express mention of the ESA provisions serving to "replace" the collective agreement provisions, unlike both the first and second "meet or exceed" tests. Consequently there is a possibility that, where a basket of collective agreement provisions does **not** meet or exceed the comparable basket of ESA provisions, the basket of collective agreement provisions are not replaced in their entirety by the comparable basket of ESA provisions and instead workers covered by the collective agreement get the benefit of both baskets – effectively

[8] See the transitional provisions in the *Employment Standards Amendment Act*, section 39.

[9] Including in particular the words that we have emphasized in the excerpt from section 3 in paragraph 20 above.

permitting the type of cherry-picking that was not permitted under the second "meet or exceed" test. However, while there is significant uncertainty in this regard, in our opinion such an interpretation of section 3(3) is unlikely to be adopted, particularly because of its inconsistency with the results under section 3(2) where similar cherry-picking is very unlikely to be permitted. It is instead likely that, where a basket of collective agreement provisions does not meet or exceed the comparable basket of ESA provisions, the basket of collective agreement provisions will effectively be replaced in their entirety by the comparable basket of ESA provisions, just like under the second "meet or exceed" test. This has very important consequences in circumstances where the collective agreement basket contains both superior and inferior provisions: any superior collective agreement provisions in the basket would likely be lost if the collective agreement basket as a whole did not meet or exceed the comparable basket of ESA provisions.[10]

26. Finally, in our opinion, it is likely that the comparison of baskets under this third "meet or exceed" test will be considered from the vantage point of employees as a whole rather than sub-groups of employees, and over the long term rather than over some shorter period of time.[11]

We trust this opinion will be of assistance to you. As discussed, once you have had an opportunity to review the general background provided in this opinion, we would be pleased to consider the interaction between the ESA and particular provisions of your collective agreement.

If you have any questions or require any further assistance, please do not hesitate to contact us.

Yours truly,

Patrick Dickie
pdickie@dickielaw.ca

[10] However, we again stress that there is significant uncertainty in this regard.

[11] As the Labour Relations Board concluded under the second "meet or exceed" test discussed above.

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APBC Position Statement on the Application of the Pandemic Pay

Background:

On May 19th, 2020, BC Finance Minister Carol James announced a temporary pandemic pay "top up" for front line health workers. This top up was intended to support health, social services and corrections employees working during COVID-19 who were not able, through their occupations, to maintain the public health recommended social distancing.

The lump sum pay-out amounts to $4 per hour for a period of straight time worked hours between March 15th, 2020 and July 15th, 2020. On a standard 35-hour work week, this equals a lump sum of $2,240.

Because of the multiple different shift patterns and length of "work weeks" this lump sum total will vary between BCEHS full-time members. For example, an employee on Alpha works a levelled work week of 42 hours, which would result in a lump sum pay-out of $2,688.

Due to the unpredictable remuneration of on-call staff, this will also greatly affect the total pay-out for those categories of employees.

On the government of British Columbia's webpage information section on Pandemic pay, it states the following in relation to eligibility for pay:

"Casual, on-call, and part-time workers who have worked straight-time hours during this period are also eligible"

The above guideline raised concerns with APBC as the application of "casual" and "on-call" employee categories are much different in the BCEHS workforce then other health care environments. This prompted the Union to inquire with HEABC on the applicability of the pay-out for employees providing Fox and Kilo Paramedic coverage.

On June 17th, HEABC confirmed that the pay-out would not apply to the on-call hours or kilo guarantee hours for members providing Kilo coverage. HEABC did confirm that stand-by hours for the Foxtrot units *would* be applied in the calculation for the pandemic pay top-up.

Potential Impacts:

The APBC is concerned that this position will a create further feeling of disparity and unfairness among the on-call (Kilo) staff. It should be noted that the kilo guarantee was just eliminated in 39 stations as a result of collective bargaining but was seen by some as an "attack" on members providing Kilo coverage.

By not including on-call hours in the calculation for the pandemic top up, this in effect, means every category of work (FT, RPT, and Fox) except kilo is included, creating a perception of unfairness. This will be compounded even further with the dramatic reduction in call volume (earning potential of straight time hours) for these members due to COVID-19. Other significant potential impacts would also include the fact that full-

time members who will receive the top up on their regular full-time hours may also receive a lift on the hours that they provided kilo coverage (as these are reported as straight time.)

Reasons for Inclusion:

As noted above, the nomenclature used to describe eligibility for the pandemic top up appear to be taken as universal for "health care" workers. As we know, the APADBA Collective Agreement is unique from the other five (5) Health Bargaining Associations and their respective collective agreements. While the correct terminology for our members providing fox and kilo coverage is "On-call", they are often compared to casual employees in other health jurisdictions. This is problematic as, unlike health care casuals, our on-call employees agree to maintain the service of the employer but are not remunerated unless a request for service is generated. This would be akin to a casual registered nurse being asked to make sure they are ready to respond to patients in an emergency department, bit only getting paid if they provided a treatment. In the vast majority of circumstances, on-call employees are also physically at the employer's work premise as they do not live in the community they work and provide multiple shifts of coverage during a work block. Although not captured in an employer policy, it is the employer's expectation that these on-call employees are also within a reasonable response time of the station.

It should be noted that, there are also many communities in British Columbia that have on-call (kilo) as the only deployment model. The opportunity for these members to work any other shift does not exist and therefore places a further inequity on them.

In addition to the above and as previously stated, the APADBA also differs from the rest of health in that full-time employees can provide on-call kilo coverage and be activated, working paid hours, for straight time rates. This is outside of their FTE and may be calculated as straight time hours in the pandemic pay out.

Recommendation:

All on-call (Fox and Kilo) hours, including stand-by, on-call and paid paramedic straight time be included in the calculation for the temporary pandemic COVID-19 top up.

SETTLEMENT AGREEMENT

BETWEEN:

BC EMERGENCY HEALTH SERVICES

(the "Employer")

AND:

AMBULANCE PARAMEDICS OF BC, CUPE LOCAL 873

(the "Union")

(ACP External Hires – Policy Grievance)

WHEREAS:

A. Between March 2017 and January 2019 the Employer posted a number of job postings for Irregularly Scheduled Advanced Care Paramedics ("ACP") in the Vancouver area (the "Postings");

B. The Employer was not able to fill all of the vacancies in the Postings with qualified applicants (both internal and external);

C. The Union filed a policy grievance – Grievance No. 18120014 in relation to the Postings and the Employer's hiring of unqualified external applicants;

D. The Parties have agreed to resolve the Grievance on the terms set out in this Settlement Agreement.

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, the Parties agree as follows:

1. The Employer will post for eight (8) ACP training course opportunities in September 2020 (the "Training Opportunities"). The Training Opportunities will be posted in the Vancouver post only and will be filled from applicants within the Vancouver post as per Article 13.05.

2. In order to be eligible for the Training Opportunities, applicants must have completed, and received the requisite grade for, at least six (6) of the courses required by the Justice Institute of British Columbia (the "JIBC") for admission into its ACP Training Program (the "ACP Program") by the closing date of the posting. Applicants are required to provide proof of completion with their application. Applicants who have applied to the JIBC for a course equivalency review are required to provide a letter from the JIBC confirming that the applicant has six (6) courses that meet the admission

requirements for the ACP program. Applicants are required to provide this letter with their application.

3. The Employer will select eligible applicants for the Training Opportunities in accordance with Article 13.05 of the Collective Agreement. In accordance with Article 13.05(b)(iii) and (iv), the written and oral exams (the "Exams") will be based upon a bank of questions mutually agreed to by the Employer and the Union.

4. All successful applicants for the Training Opportunities must apply for admission to the ACP Program by February 2021. A successful applicant that is not accepted into the September 2021 cohort in New Westminster or Kelowna must re-apply for admission to the ACP Program by February 2022. The Employer will support a successful applicant by providing the JIBC with a letter confirming that the applicant participated and was successful in the selection training process outlined in Article 13.05(b).

5. The Parties agree that no more than four (4) successful applicants may undertake the ACP Program commencing in September 2021 and no more than four (4) successful applicants may undertake the ACP Program commencing in September 2022 pursuant to this Settlement Agreement. The Union will determine which successful applicants will commence the ACP Program in 2021 and which applicants will commence the Program in 2022. The Union will advise the Employer and the successful applicants of its decision by no later than February 26, 2021.

6. A successful applicant must complete all of the ACP Program Specific Requirements (the "Prerequisites") on their own time and at their own cost. All successful applicants must complete all of the Prerequisites by no later than December 31, 2020 to be eligible for entry into the 2021 ACP Training Program, or by no later than December 31, 2021 for entry into the 2022 ACP Training Program. Absent exceptional circumstances, an applicant who does not complete the Prerequisites by December 31, 2021 will be removed from the Training Opportunity and will forfeit this opportunity for paid ACP training. All successful applicants must provide proof of completion of the Prerequisites to the Employer by no later than December 31, 2021.

7. The Employer will grant a leave of absence ("LOA") for the successful applicants to complete the ACP Program and will continue to pay the wages of their current position by way of salary maintenance (excluding overtime rates) as per Article 23.02 and in accordance with paragraph 8 below.

8. A successful applicant must complete the ACP Program within 24 months of commencement of the Program. The Employer will pay for 20 months of the ACP Program on a salary maintenance basis (excluding overtime rates). If a successful applicant requires longer than 20 months to complete the ACP Program, the Employer will extend their LOA for up to four (4) additional months. This additional four (4) month LOA will be unpaid. Any additional fees incurred as a result of taking longer than 20 months to complete the ACP Program will be paid for by the successful applicant.

9. A successful applicant must apply for the EMA Education Fund Award (the "Award"), which is administered by the JIBC, to cover the cost of the expenses associated with

the ACP Program, including, but not limited, to tuition, textbooks and uniforms (the "Expenses"). The Parties understand that every employee who applies for the Award will receive the full amount of the Award. The Parties agree that a successful applicant who does not qualify for the entire amount of the Award because he/she has previously received the Award will be required to incur the cost of the Expenses. However, and in recognition of the fact that the Award may not be available to applicants of the ACP Program in two years' time, the Employer agrees that it will pay up to $22,000 to successful applicants who are admitted into the September 2022 cohort and who do not receive some or all of the Award (or its successor or equivalent) through no fault of their own. For greater clarity, if a successful applicant previously received a partial amount of the Award, he/she will receive the difference between the partial amount and $22,000. By way of example, if an applicant previously received an Award of $10,000, the Employer will pay the applicant $12,000 to cover the cost of the Expenses.

10. The Parties agree that a Training Opportunity that is accepted but not realised because the applicant did not pass the Prerequisites or the ACP Program (including withdraw with or without approval from the Employer) will be forfeited. In other words, a Training Opportunity that is accepted but not realised does not give rise to a further training opportunity or vacancy. The Parties further agree that in the event there are no or insufficient qualified applicants for the Training Opportunities, the Employer will not re-post the Training Opportunities.

11. If a successful applicant does not pass, withdraws (without approval from the Employer), or is required to withdraw from the ACP Program, they will be prohibited from applying for future ACP training opportunities for a period of three (3) years [currently Article 13.05(i)].

12. Following the successful completion of the ACP Program, successful applicants will return to their previous position and work station and will need to post into an ACP vacancy in accordance with the Collective Agreement.

13. Employees who successfully complete the ACP Program and are subsequently appointed to a full-time ACP position pursuant to Article 13.01(d)(i), may not bid out of such an appointment for at least three (3) years. However, such employees may apply for a promotion or a lateral transfer within the three-year period provided they have completed their probationary period (the "Training Commitment") [currently Article 13.01(d)(iii)].

14. On a go-forward basis, the Employer agrees that it will:

    (a) post internal and external job postings simultaneously and these postings will close on the same date;

    (b) fill postings in accordance with the Collective Agreement;

    (c) provide the actual number of vacancies it intends to fill on its postings, subject to *bona fide* operational requirements; and

(d) identify external applicants on the applicants list and the successful applicants list it sends to the Union and posts on the employee intranet. External applicants may be identified by number so long as they are clearly identified as external applicants.

15. The Employer agrees that Article 13.01 of the Collective Agreement requires it to offer ACP training opportunities to internal applicants before it hires unqualified external applicants and fill the total number of ACP vacancies identified on each posting pursuant to the Collective Agreement. In other words, the Employer must offer ACP training opportunities to internal applicants in the event it does not receive a sufficient number of applications from qualified internal or external applicants. The Parties agree that this provision does not do away with the Employer's management right to properly cancel or vary a posting. The Parties agree that the Employer may not cancel or vary a posting to avoid offering paid ACP Training Opportunities.

16. The Parties agree that applicants to all future ACP training opportunities must have completed all of the prerequisite courses required by the JIBC for admission into its ACP Program by the closing date of the posting. Applicants are required to provide proof of completion with their application. Applicants who have applied to the JIBC for a course equivalency review are required to provide a letter from the JIBC confirming that the applicant has all of the courses that meet the admission requirements for the ACP program. This letter must be provided with their application. The Parties further agree that the Employer will pay for future ACP training opportunities on a salary maintenance basis (excluding overtime rates) as per Article 23.02 of the Collective Agreement.

17. The Union agrees to withdraw the Grievance and any other grievances relating to the interpretation and/or application of Article 13.01(d)(ii) and (iii) that exist up to the effective date of this Agreement, including, but not limited to, Grievance 19050020.

18. The Employer will withdraw the current job posting for the Abbotsford ACP position, and will award the position to Jonathan Rasmussen. Mr. Rasmussen will commence the Abbotsford ACP position following successful completion of his ACP probationary period. In consideration of this transfer, the Union agrees to withdraw grievances 19040022 and 19050010, which relate to posting numbers 19:029; 19:103 and 19:164 (the "Abbotsford Grievance") and grievance 19060006 (Lockwood) and agrees not to file any future grievance on behalf of any members affected by the Abbotsford Grievance.

19. The Parties expressly agree that the terms of this Settlement Agreement, with the exception of paragraphs 14 to 16 above, do not establish any practice or precedent in respect of any other matter other than the specific facts and issues addressed herein.

20. The Parties represent and warrant to each other that they are duly authorised and entitled to sign this Settlement Agreement.

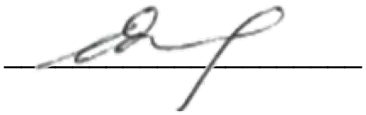
21. Arbitrator Chris Sullivan remains seized with any issues arising out of the implementation of this Agreement.

22. This Settlement Agreement may be executed in counterparts.

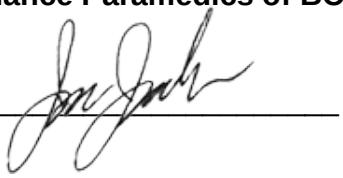
IN WITNESS WHEREOF the Parties have entered into this Settlement Agreement.

Dated this 20 day of June, 2019 in the City of Vancouver in the province of British Columbia.

BC Emergency Health Services

Per: 

Ambulance Paramedics of BC, CUPE Local 873

Per: 

Ambulance Paramedics
of British Columbia - CUPE 873

Tel: 604-273-5722 | **Fax:** 604-273-5762 | **Toll Free:** 1-866-273-5766 | **Toll Free Fax:** 1-866-273-5762
105 - 21900 Westminster Hwy., Richmond, BC V6V 0A8
info@apbc.ca | www.apbc.ca

February 27, 2020

Mr. Paul Vallely
Executive Director, Patient Care Delivery
British Columbia Emergency Heath Survives

Dear Paul;

Re: COVID-19 Staff Procedures

With the ongoing COVID-19 outbreak and given the recent developments, the Union writes to seek the Employer's clarification on specific procedures and protections for our members. Specifically, we are looking for the Employer's response to the following urgent questions:

- To date, how many Ambulance Paramedics of BC (APBC) members have been exposed to potential and confirmed cases of COVID-19?
- Is the Employer reporting these cases through the DOSH and POSH processes?
- When members have a potential or confirmed exposure, they have been directed to "self-isolate" by the Employer. What, EXACTLY, does this mean?
- If they are to isolate themselves in their residences, what information, protection and ***support*** is available to other individuals that may be in that residence (family, roommates, etc.)?
- What is the direction to employee's that commute to their place of work? For example, an employee who works in the Lower Mainland who commutes from the Island. Are they to travel on public transit (buses, Skytrain, the BC Ferries) to get back to their place of residence when there is a potential exposure?
- What if the employee shares accommodation with other employees while commuting?
- Should an employee be directed to self-isolate, what medical, psychological and social supports are in place by BCEHS? For example, how will employees accomplish simple tasks like getting groceries, doing personal administrative tasks or have their psychological well-being addressed?
- Are all potential and confirmed exposures sentinel events for the Critical Incident Management Team? If not, why?

- If an employee has a potential or confirmed exposure, what is the Employer's position on processing a Work Safe BC (WSBC) claim?

- What if an employee does not have access to STIIP or CTO, how will BCEHS assist in mitigating a financial loss?

- What is the current status of the Infectious Disease Care Team (IDCT), their training and equipment?

- What is the current status if the stockpile, Provincially, for personal protective equipment?

- What is the plan should in an increase in COVID-19 cases and/or specific procedures (ie – donning/doffing, mass self-isolation cases) impact the ability to deliver care?

As you can imagine, there are many, many more questions surrounding this outbreak, but the above represents an urgent requirement for information for our members.

While it is important to remain diligent around the most up-to-date information and not propagate non-factual statements or fear, we can only do this with enhanced and frequent communication, engagement and information from the Employer. The Union remains available to assist the Employer.

Sincerely,

Troy Clifford
President
Ambulance Paramedics &
Emergency Dispatchers of BC
CUPE Local 873

CC: PEB
Darlene MacKinnon

TC/km/MoveUp

WITHOUT PREJUDICE OFFER

MEMORANDUM OF SETTLEMENT

BETWEEN:

BRITISH COLUMBIA EMERGENCY HEALTH SERVICES

("Employer")

AND:

AMBULANCE PARAMEDICS OF BRITISH COLUMBIA, CUPE LOCAL 873

("Union")

(Collectively the "Parties")

(Re: On Call and Regular Part Time to Full Time UHR Rate Policy Grievance #19060017)

WHEREAS:

A. The Parties implemented the Universal Hourly Rate ("UHR") Pay Scale (the "Wage Grid"),as of April 2017 and agreed to Letter of Understanding #66 regarding the application of the UHR Pay Scale on April 12, 2017 (revisions June 2, 2017), which was appended to the 2014 Collective Agreement;

B. In December 2018, the Parties agreed where on-call and/or regular part-time employees moved to full-time status, they would be credited with one-year of work for purposes of placement on the Wage Grid if they had accumulated 975 hours or more since their last wage increase based on 1950 hours per year and part-time adjusted date of hire. (the "December 2018 Agreement");

C. In March 2019, the Union discovered that the Employer had failed in some cases to retroactively (to April 7, 2017) credit on-call and/or regular part-time employees moving to full-time status with their one-year of work for purposes of placement on the Wage Grid even though those employees had accumulated 975 hours or more of work since their last wage increase based on 1950 hours per year and part-time adjusted date of hire.;

D. The Union also discovered that the Employer was calculating the wage increments under the Wage Grid from the first day an employee worked as a full-time employee, rather than the seniority date;

E. The Union further discovered that the Employer was calculating vacation accrual from the first shift an employee worked as a full-time employee, rather than the seniority date;

F. As a result, the Union filed a policy grievance (the "Grievance") alleging that the Employer breached the 2014 Collective Agreement and Letter of Understanding #66;

G. The Parties then entered into the 2019 Collective Agreement and incorporated the December 2018 Agreement and Letter of Understanding #66 into Article A1.03 of Schedule A.

H. The Employer and the Union wish to resolve the Grievance on a without prejudice basis.

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, the Parties agree on a without prejudice basis as follows:

1. The Employer agrees that Article A1.03(g) of Schedule A in the 2019 Collective Agreement accurately reflects the Parties' agreement as to the practice retroactively applied to April 7, 2017.

2. The Employer agrees to place affected employees who have moved from on-call and/or regular part-time status to full-time status and have not received credit for 975 or more accumulated hours on the correct UHR Pay Scale, as per A1.03(g) of the Collective Agreement, and pay any monies owed to such employees by December 31, 2020.

3. The Parties agree that the seniority date and start date for full-time employees is calculated from the first day an employee commences full-time employment for individual hires. For group hires on a posting with multiple start dates, the seniority date is based on the first day worked by the first employee on that posting, not necessarily the date an individual employee worked their first shift.

4. Subject to the provisions that follow, the Parties agree that the Employer can calculate vacation accrual and wage increments from the date the employee worked their first day as a full-time employee.

5. Notwithstanding paragraph 4 and for clarity, as per Article A1.03 (a), (b), (d), (g) and Article 22.04of the 2019 Collective Agreement, wage increments are initially calculated from part-time adjusted date of hire and employees who move from on-call and/or regular part-time status to full-time status retain all increments, and receive all credits, previously earned in their on-call and/or part-time positions subject to A1.01(g). However, after moving into a full-time position, all subsequent increases in the wage increments will be based on paragraph 4.

6. The Parties agree that the difference between the first and last start dates specified by the Employer within a group hire should not exceed 10 days. Where the start date specified by the Employer for an employee is more than 10 days after the start date of the first employee in the group hire, the date established for wage Increments and vacation accrual will be set at the date that is 10 days after the start date of the first employee in the group hire.

7. Where the Employer determines start dates will be significantly different, the Employer will post the positions separately and will not utilize Article 13.01 (g) of the 2019 Collective Agreement.

8. Notwithstanding paragraph 6 above, an employee's probation period does not begin, nor is an employee entitled to any leave provisions or other full-time benefits, including Leaves under Article 20 (Sick Leave) or 21 (Leave of Absence) until after their first day worked as a full-time employee or such other time specified in the Collective Agreement or the Benefits Booklet.

9. For employees unable to start work on the date specified by the Employer, their seniority date and start date shall normally be their first day worked as a full-time employee. For such employees, the Parties agree that this is the date that is used for vacation accrual and wage increments.

10. The posted start dates in a group hire posting will not span two calendar years. For clarity, the Employer agrees not to post in the end of a calendar year for start dates that are split over December of the current calendar year and January of the following calendar year. Individual start dates may, however, span two calendar years where individual circumstances so require.

11. The Parties agree that for the purposes of Article 12.01(e) of the 2019 Collective Agreement, an employee returning to full-time status from on-call/regular part-time status, or a regular part-time employee moving to full-time status, who is credited with earned seniority from prior service as a full-time or regular part-time employee, shall receive the annual vacation entitlement under Article 19 in accordance with the years of seniority credited.

12. The Parties agree that this Memorandum of Settlement is a settlement of the Grievance and a temporary without prejudice interpretive aid and the Parties will address the issues herein during the next round of Collective Bargaining. Accordingly, the Parties agree that this Memorandum of Settlement shall expire upon conclusion of a renewal collective agreement and shall be of no force or effect going forward.

13. The Parties agree to meet and seek a mutually acceptable resolution if either Party discovers any unintended consequence arising from the Memorandum of Settlement that were not previously considered and/or discussed.

14. The Parties agree that nothing in this Memorandum of Settlement amends or changes the 2019 Collective Agreement, and that this Memorandum of Settlement is entered into without prejudice to any of the parties' positions in the Grievance.

15. In the event the Parties do not address the issues herein further to 12 above, the Union will not be estopped from, and the Employer will not object to, the advancement of a fresh grievance on the issues herein following the conclusion of a renewal collective agreement. The Employer further agrees it will not object to the union seeking to expedite such a grievance.

16. The Parties agree Arbitrator Ken Saunders will remain seized of the matter, including the interpretation, application, administration and/or alleged violation of this Agreement.

17. This Agreement constitutes full and final resolution of the Grievance.

IN WITNESS THEREOF the Parties have entered into this Memorandum of Settlement.

Dated this 14 day of September 2020 in the City of Vancouver in the province of British Columbia.

BC Emergency Health Services

Per: _____
Signature

Darlene MacMillan
Name (Please Print)

For HEABC

_____ Sept 15 / 2020

Ryan Goldvine

For the Union

_____

Jason Jackson
Name

SETTLEMENT AGREEMENT

Between:

BC Emergency Health Services
(the "Employer")

And:
Ambulance Paramedics of BC - Canadian Union of Public Employees, Local 873
(the "Union")

Re: An application under S.104 of the Labour Relations Code (Case No. 2020-000184)

The parties agree to the following:

Policy Grievance #20010012 – OCUC platoon shuffle

1. The Employer will notify the affected Unit Chiefs that were moved and provide them with fourteen (14) days within which to select their preferred platoon. Their platoon will then be assigned in order of seniority in their current area.

Policy Grievance #20010002 – SNBO/NNBO Assignments

2. The direction given regarding the assignment of short notice and no notice book off shifts at station 150 will be rescinded and communicated to management.

Policy Grievance #20010009 – PS CCP pay rate

3. The direction given to certain CCP-licensed Paramedic Specialists and Paramedic Practice Educators to expand their scope of practice to the CCP license level is hereby rescinded. The Employer shall communicate to all affected employees that they are only to work to the ACP license level in the role of Paramedic Specialist or Paramedic Practice Educator.

Paramedic Specialists directed to work to the CCP license level on a car so-equipped shall receive the pay differential to the CCP level retroactive to October 1, 2019.

4. The Union withdraws the three above noted grievances and any and all related individual grievances.

5. This agreement is made on a without prejudice basis, is for settlement purposes only and has no precedent setting value, nor is it to be considered an interpretation of the Collective Agreement.

Signed this 9th day of March 2020.

Signed on behalf of the Employer

Signed on behalf of the Union