Meeting of the Northern Health Authority
Board of Directors
Public Session

Prince George, British Columbia

325 Brunswick Street

Brunswick Boardroom

Wednesday October 21, 2015

northern health

the northern way of caring

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Public Session

AGENDA

October 21, 2015
Brunswick Boardroom
Prince George, BC

AGENDA ITEMS	Responsibility of…	Expected Outcome	Time (Approx.)	Page
1. Call to Order of Open Board Session	Chairman Jago		**1:15pm**	
2. Opening Remarks	Chairman Jago			
3. Conflict of Interest Declaration	Chairman Jago	Discussion		
4. Approval of Agenda	Chairman Jago	Motion		**1**
5. Approval of Previous Minutes: June 15, 2015	Chairman Jago	Motion		**3**
6. Business Arising from Previous Minutes	Chairman Jago			**-**
7. CEO Report	C Ulrich	Information		**8**
7.1 Human Resources Report	D Williams	Information		**11**
8. Audit & Finance Committee				
8.1 Financial Statements (YTD Period 5)	M De Croos	Motion		**21**
8.2 Reappointment of External Auditor (2015-16)	M De Croos	Motion		**23**
8.3 Major Capital Projects Summary (Period 5)	M De Croos	Information		**24**
9. Performance, Planning & Priorities Committee				
9.1 Strategic Priorities: A Focus on Our People				
9.1.1. Occupational Health	D Williams	Information		**26**
9.2 Strategic Priorities: High Quality Services				
9.2.1. Healthy Aging in the North: Action Plan	K Gunn	Information		**35**
Guest presenters: Stacey Patchett, Executive Lead, Elder Program; Dr. Nicole Ebert, Medical Lead, Elder Program				
10. Presentation: Regional Dysphagia Management Team **Guest Presenter**: Susanne Watson, Professional Practice Lead, Home Care	P Anguish	Information		**63**
11. Governance & Management Relations Committee	C Jago			
11.1 Policy Manual BRD 300 Series	C Ulrich	Motion		**77**
11.2 Community Consultation Strategy: Child Health	S Raper	Discussion		**104**
ADJOURN			**3:00pm**	

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Public Motions *Meeting Date:* ***October 21, 2015***				
Agenda Item		**Motion**	**Approved**	**Not Approved**
3.	Conflict of Interest Declaration	Does any Director present have a conflict of interest they wish to declare regarding any business before the Northern Health Board at this meeting?	☐	☐
4.	Approval of Agenda	The Northern Health Board approves the public agenda as presented		
5.	Approval of Minutes	The Northern Health Board approves the June 15, 2015 public minutes as presented	☐	☐
8.1	Financial Statement (YTD Period 5)	The Northern Health Board approves Northern Health's Period 5 financial statement, as presented	☐	☐
8.2	Reappointment of External Auditor (2015-16)	The Northern Health Board approves the reappointment of KPMG LLP as external auditor to Northern Health for the fiscal year ending March 31, 2016, representing Year Four of a five-year term of engagement.	☐	☐
11.1	Policy Manual BRD 300 Series	The Northern Health Board approves the revised Policy Manual BRD 300 Series	☐	☐

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Board Meeting

Date: June 15, 2015

Location: CNC – Room 007

Chair: Dr. Charles Jago

Recorder: Desa Chipman

Board:
- Sharon Hartwell
- Gary Townsend
- Ben Sander
- Maurice Squires
- Edward Stanford
- Rosemary Landry
- Gaurav Parmar
- Stephanie Killam

Executive:
- Cathy Ulrich
- Kelly Gunn
- Mark De Croos
- Michael McMillan
- Dr. Sandra Allison
- Steve Raper
- Dr. Jaco Fourie

Public Minutes

1. Call to Order Public Session

The Open Board session was called to order at 1:19pm.

2. Opening Remarks

Chairman Jago expressed pleasure at being back in Burns Lake and shared that the Board members are looking forward to touring the new hospital.

3. Conflict of Interest Declaration

Chairman Jago asked if any Director present had a conflict of interest they wish to declare regarding any business before the Northern Health Board at this meeting.

- Ben Sander expressed a conflict of Interest to item 10.3.
- There were no other conflict of interest declarations made related to the June 15, 2015 Public agenda.

4. Approval of Agenda

Moved by S Hartwell seconded by S Killam
The Northern Health Board approves the June 15, 2015 public agenda as presented.

5. Approval of Board Minutes

Moved by M Squires seconded by E Stanford
The Northern Health Board approves the April 20, 2015 public minutes as presented.

6. Business Arising from previous minutes

There was no business arising from the previous minutes.

7. CEO Report

C Ulrich provided an overview of the CEO report and highlighted the following:

- On May 25, 2015 Chairman Jago received an honorary Doctorate of Law degree and provided the convocation speech at the UNBC Graduation Ceremony.
- Northern Health was recognized by the Canadian Public Relations Society on June 2, 2015 with a 2015 Gold Award in the Best Special Events category for its preparation work for the 2015 Canada Winter Games. The award is part of the CPRS Awards of Excellence program that recognizes outstanding projects in public relations and communications.
- North Central Local Government Association
  - On May 6th, 2015, Dr Charles Jago and Cathy Ulrich attended the North Central Local Government Association conference where meetings where held with local government representatives from 16 different communities.
  - Northern Health had the opportunity to organize a panel discussion which focused on population health topics:
    - Impacts of natural resource development
    - Partnering for Healthier Communities
    - NH First Nations Health: Partnership between Northern Health and the First Nations Health Authority
- The grand opening of the Learning & Development Centre, located at UHNBC took place on Monday, June 8, 2015. This capital project is the final component of the infrastructure development to support the Northern Medical Program. The building includes meeting and educational rooms, patient simulation and library space. This new space will support Northern Health's partnership in education and research with post-secondary institutions including the University of Northern B.C., the UBC Faculty of Medicine, the College of New Caledonia and other partners in the region.

7.1. Human Resources Report

An overview of the Human Resources Report was presented with the following areas highlighted:

- A gap analysis of the Violence Prevention Program was recently completed and an action plan developed to address identified gaps and support a sustainable approach which includes identifying roles and responsibilities of all workplace parties.
- With the establishment of the Duty to Accommodate Team in 2013 Northern Health has been able to focus on improved collaboration, due diligence and standardization in working with the Human Resources Team and Operations Managers. This project has been announced as the winner of the 2015 BC Excellence in Healthcare Award of Merit in the category of Workplace Innovation.
- As of May 13th, there are 111 vacancies which represent a reduction in the vacancy rates to 2.10% from 2.31% in April 2015. Since December 2014, the new hires overall is trending upwards with 106 new hires reported in April 2015.
- Currently the difficult-to-fill professions include Nurse Practitioners (13) and Physiotherapists (4). As of May 26th, a Physiotherapist position has been filled in Dawson Creek. Strategies to recruit for this difficult-to-fill profession include attending the UBC Rehab Program Career event on June 1, 2015 and the Canadian Physiotherapy Association Conference on June 18th.
- Recruitment is actively working with Secondary Students and hosting "Grow Our Own" events where Recruitment staff facilitate interactive presentations to Grades 10, 11, and 12 Students showcasing 25 diverse health care careers. Northern Health Professionals are invited to each presentation and provide a first-hand account of their career paths including sharing how they become interested in their career, why they love their work and what keeps them engaged.

8. Audit and Finance Committee

8.1. Public Comments Fiscal Y/E 2014-15

- Northern Health ended fiscal year 2014-15 on March 31, 2015. The year-end financial statements are currently being audited by KPMG. Northern Health awaits the outcome of the audit, but is confident that it will end the year in a surplus position.

8.2. Major Capital Projects Summary (Period 13)

- M De Croos provided a high level overview of the Period 13 Major Capital Projects Summary Report and advised that the majority of the capital projects are on schedule. Details were provided on those projects that are behind schedule.

9. Performance Planning and Priorities Committee

9.1. Annual School Medical Health Officer Appointments

- The School Act requires the Northern Health Board of Directors to designate a School Medical Officer for each school district within its region.

Moved by S Hartwell seconded by S Killam
The Northern Health Board approves the appointment of Drs. Sandra Allison, Charl Badenhorst, and Raina Fumerton as School Medical Officers as per Section 89 of the *School Act* for the school districts within the geography of Northern Health.

9.2. Seniors' Advocate Report and Actions

- The Office of the Seniors Advocate released a paper 'Seniors' Housing: Affordable, Appropriate, Available' to the public at the end of May 2015. The Board is provided with an overview of the key recommendations of the report as they relate to the public consultation on seniors wellness and Northern Health's Seniors' Strategy. The Executive Summary of the Seniors' Advocate's report and recommendations are appended for information.
- The Seniors Advocate's recommendations are consistent with the views and perspectives gained from the 2013 Northern Health's public consultation Let's Talk about Healthy Aging and Seniors' Wellness and Northern Health Seniors Strategy.
- The details of the Seniors Advocate's Key Recommendations were included in the package for review, discussion and information.

10. Governance and Management Relations Committee

10.1. Northern Health Violence Strategy

- M McMillan provided a presentation on the Northern Health Violence Strategy.
- **The commitment from the executive team is** as follows:
  - Northern Health leaders are committed to a safe and healthy workplace for all NH staff and physicians. In NH our people are our most valuable asset. Our goal is to have each and every staff member and physician leave work in the same condition that they arrived – safe and healthy.
- **Violence Prevention Program 2015/16**
  - Action Plan Developed that outlines roles and responsibilities of:
    - Site/Frontline, Regional and Senior Leadership
    - Workplace Health and Safety Staff
    - Joint Occupational Health and Safety Committees
    - Professional Practice/Medical Affairs
    - All staff
    - Health Care Unions

- **Going Forward**
  - Northern Health will establish a working group to foster a collaborative approach to develop and implement a Violence Prevention awareness campaign, in collaboration with external partners (e.g. unions, WSBC, RCMP, Protection Services, security contractors and BC Ambulance Service)

10.2. Policy Manual BRD 200 Series

- The policy manual BRD 200 Series was provided to the Board with the suggested edits highlighted for approval.

Moved by R Landry seconded by M Squires
The Northern Health Board approves the revised BRD 200 series.

10.3. Policy Manual BRD 315 External Auditor Independence

- Ben Sander departed the meeting due to a conflict of interest with this topic and abstained from voting.
- The policy manual BRD 315 External Auditor Independence policy was provided to the Board with the suggested changes highlighted for approval.

Moved by G Townsend seconded by S Hartwell
The Northern Health Board approves the revised BRD 315 policy.

10.4. 2016 Board Meeting Calendar

- After discussion the Board agreed that the Board will meet in Quesnel in February and Fort St John in April. April dates could change to the 18th & 19th, management will confirm availability of all Board members before confirming the final dates.
- The Community of Mackenzie will be considered in 2017.

Moved by R Landry seconded by G Parmar
The Northern Health Board approves the proposed 2016 Board Calendar as revised.

10.5. Community Consultation Strategy

- The next formal Board Community Consultation is expected to begin in the fall of 2016 however this will be confirmed following the October Board Planning Session.
- Management is seeking endorsement from the Board on the topic of Child Health as the recommendation for the next formal consultation.

Moved by R Landy seconded by M Squires
The Northern Health Board approves the recommendation that the 2016 Consultation focus on Child Health.

10.6. Carbon Neutral Action Report

- Northern Health has submitted the 2014 Carbon Action Neutral Program Results and once again has been able to reap the rewards of previous years' work as Northern Health has further reduced natural gas consumption year over year. In addition electricity consumption was reduced in 2014 by more than 2% from the previous year, a slight increase over electrical consumption in 2009.
- The increase in electricity consumption since the baseline year of 2009 is attributed to a 15% increase in floor area including additional electrical load related to new

diagnostic/clinical equipment. These accomplishments resulted in an overall cost avoidance of $3.9M over 4 years in energy consumption (electricity, natural gas and propane).

- The highlights by key actions taken to reduce greenhouse gas emissions over this past year was included in the report along with a description of future plans.

10.7. Regulatory Framework – Legislative Compliance

10.7.1. Financial Administration Act

10.7.2. Financial Information Act

10.7.3. Public Sector Employers Act

- Management provided the Northern Health Board with an update on the legislative compliance review that occurred of the Financial Administration Act, the Financial Information Act and the Public Sector Employers Act. Northern Health is in compliance with all three Acts.

The public session was adjourned at 2:35pm

Dr Charles Jago, Chair

Desa Chipman, Recording Secretary

Northern Health Regional Office
600-299 Victoria Street,
Prince George, BC V2L 5B8

CEO REPORT

Meeting:	Northern Health Board Meeting	Date:	October 21, 2015
Agenda Item:	CEO Report		
Purpose:	Information		
Prepared by:	Cathy Ulrich		

Union of BC Municipalities 2015

On September 22nd & 23rd, 2015 Dr Charles Jago and I attended the Union of BC Municipalities conference where we had the opportunity to meet with local government representatives from 23 communities and Regional Hospital Districts to discuss issues of concern to the communities. Follow up letters

The themes from these discussions were:

1. Physician Recruitment and Retention
2. Capital Projects
3. Industrial Development and Health Impacts including environmental impacts
4. Primary and Community Care
5. Mental Health and Substance Use

Regional Hospital District and Northern Health Board Annual Planning meeting

The six Northern Regional Hospital Districts met with Northern Health on October 19, 2015 in Prince George at the recently opened Learning & Development Centre. The annual planning meeting provided an opportunity for Northern Health and Regional Hospital District members to discuss several topics including:

1. Northern Health 2015/16 Capital Plan Projects
2. Physician Recruitment updates
3. Follow up planning resulting from the Northern Health Board's 2014 Consultation process, *Let's Talk About Health Aging in the North*

In addition Regional Hospital District members were provided with an overview of the development of the 2016-2021 Northern Health Strategic Plan.

Primary and Community Care Follow-up Forum - Ministry of Health

In follow up to the June 2015 primary and community care forum on seniors services, teams from around the province attended a second forum on October 14th & 15th to present actions that have been undertaken since June 2015. In attendance from Northern Health were two teams of community service providers, Northern Health managers, physicians and staff from the Divisions of Family Practice in Vanderhoof and Prince George.

Canadian HR Awards 2015

Northern Health was nominated in partnership with Interior Health as a finalist in the 2015 Canadian HR Awards in the category "***The Winds of Change Award for Best Health & Wellness Strategy***". There were nine finalists in this category. This award recognizes excellence in the area of corporate health and well-being, with clear evidence of a positive impact on the workforce, including reductions in absence levels, injury levels and/or improvements in staff engagement and performance.

Being nominated was a significant achievement and while Interior Health & Northern Health did not win the award it shows that both health authorities have done considerable work in this area to improve the health and wellness of staff and physicians.

HEABC Golden Apple Award

In June, the Health Employers Association of BC hosted the annual Health Care Gold Apple award luncheon in Vancouver. Northern Health was the recipient of two awards, one in collaboration with Interior Health:

Heather Floris – Head Nurse, St John Hospital in Vanderhoof, was awarded the Health Care Hero gold apple for Northern Health. Heather was profiled as follows at this event:

> "*Drawn to nursing for the opportunity to help people at their most vulnerable, Heather Floris exemplifies selfless dedication in service to others including her family, community, staff and colleagues. Covering a busy rural emergency room requires skill, knowledge and an enormous capacity for flexibility. Universally cherished, Heather has been seen driving discharged patients home when no ride is available, picking up medications for those unable to do it themselves, leading the hospital response to emergency situations such as a fire at the local mill, and for simply "getting things done". She was once witnessed pushing an unoccupied patient bed up a hill in front of the hospital to the attached residential care facility when it wouldn't fit inside the elevator. With more than 15 testimonials accompanying her nomination – from the Mayor to the RCMP commander to her colleagues at the hospital – it's clear the significant impact Heather has had on hospital care and the broader community in Vanderhoof."*

Northern Health and Interior Health were also nominated for an award of merit for the *Duty-to-Accommodate Pilot Project: A Collaboration with HR Operations & Disability Management.* The team includes Darlene Doricic, Disability Management Program Leader and team members Kara Hannigan, Jasvinder Heer, Joan Meidl. The project was described as follows at the event:

> *Interior Health and Northern Health collaborated on a pilot project to create a duty-to-accommodate team focused entirely on the assessment, support and placement of employees with permanent disabling limitations. The overall goals of the project were to retain skilled workers, reduce the duration of sick leaves/ long-term disability and WorkSafeBC claims, and adhere to a standardized process when dealing with disabled employees. The implementation of the dedicated duty-to-accommodate team created focused resources, standardized procedures and early intervention. The pilot has been a great success. At Interior Health, 48 per cent of cases were resolved within 30 days and at Northern Health, 57 per cent of cases were resolved within 30 days – a significant improvement over past practice. In 2013/14, WorkSafeBC short-term claim duration for both Interior Health and Northern Health improved by 19 per cent, and there was a long-term disability cost avoidance of six million dollars for the organizations.*

Human Resources Board Report

October 2015

Workplace Health and Safety

Strategic Directions

Current State Assessment Process – Violence Prevention
At the request of Northern Health's (NH) Executive Team, a Current State Assessment Process, including a reporting tool, has been developed for the Violence Prevention Program (VPP) at all 2015 high risk sites (as outlined below). The Current State Assessment is based on all WorkSafeBC requirements for VPP, with particular attention being paid to the internal responsibility system (IRS) as required by the Ministry of Health (July 2015). The IRS is the underlying philosophy of the occupational health and safety legislation; that states that the employer, workers and others, who are in a position to affect the occupational health and safety (OHS) of workers, share that responsibility to the extent of each party's authority and ability to do so. The information collected from the current state assessment process will be used to develop site-specific action plans to address any identified gaps in implementation and to support the ongoing sustainability of the VPP.

The WorkSafeBC 2015 High Risk Strategy Focus Locations for NH are:

Employer ID: Northern Health 687546		
Classification Unit (CU): Acute Care 766001		
Location Code	**Location Name**	**Location**
001	UHNBC	Prince George
049	GR Baker Memorial Hospital	Quesnel
005	Dawson Creek & District Hospital	Dawson Creek
045	Fort St. John Hospital	Fort St. John
004	Bulkley Valley District Hospital	Smithers
Classification Unit (CU): Long Term Care 766011		
Location Code	**Location Name**	**Location**
022	Bulkley Valley Lodge	Smithers
030	Terraceview Lodge	Terrace
073	Gateway Lodge	Prince George
Classification Unit (CU): Community Health Support Services 766006		
Location Code	**Location Name**	**Location**
082	Mental Health & Addictions 201-1705 Third Avenue, Prince George	Prince George

Operational Reports
NH is working with the other health authorities to identify a user-friendly "one stop" operational reporting system for existing key lagging indicators, (e.g. time loss, medical aid/report only incident rates, and claim duration) that could be generated from the system which would provide capacity to store site/department specific occupational health and safety documentation as well as pulling data from other existing system such as the WHITE database. Sample reports identifying above will be shared with operational leaders when available.

"Leading" Indicators
Work is also underway to begin identifying key "leading" indicators (e.g. immunizations, education and training, workplace inspections and risk assessments) that would assist operational leaders in proactively measuring safety compliance and climate. Traditional lagging OHS indicators such as lost time incidents, incident duration and frequency indicators

represent the outcomes of an OHS program. While lagging indicators are still important to identify trends in past performance, they may not allow the organization to react to unsafe or unhealthy conditions until after a negative outcome occurs. Leading indicators measure the actions that are occurring to proactively manage health and safety.

A well-functioning health and safety system will promote increased reporting of all incidents, each of which will be followed by a high-quality investigation. This means that the investigation focuses on systemic contributing factors and corrective measures, instead of focusing on person-specific factors and measures. Also, it is imperative that the investigation meets WorkSafeBC's timelines and criteria for completion, involving worker representatives, etc.) The Strategic Directions team is currently gathering all data related to a high-quality investigation and plans to share this valuable information with leaders when it is available.

Partnership Documentation
It has been five years since WHS embarked on a voluntary journey to deliver joint workplace health and safety services to both NH and Interior Health. This decision was made to support the B.C. Rural Collaborative Partnership Agreement, through which efficiencies would be realized by jointly delivering services to most of B.C.'s rural and remote communities. WHS is now in the process of documenting this journey, including gathering feedback from various internal and external stakeholders to illustrate the impact of this collaboration.

Health, Safety and Prevention

Influenza Program
Historically, less than 25% of all new hires consistently report their immunization status upon hire. On April 1, 2015 an immunization reporting project was launched to encourage reporting of immunization status for all newly hired employees. Since the initiation of the project an average of 70% of all new hires are now reporting their immunization status upon hire. This reporting provides the organization with the necessary information about who is safe to work during an outbreak situation based on immunity.

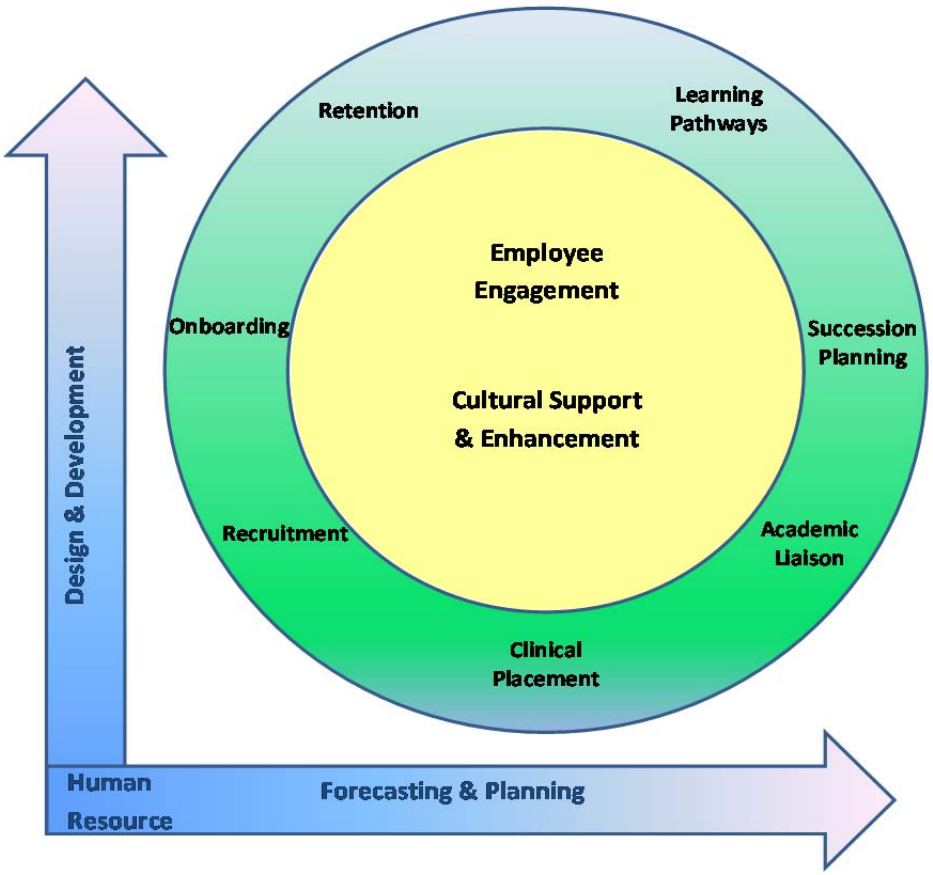
Influenza season is quickly approaching and three new flu program nurses have been hired to assist and support the delivery of the influenza program. Influenza clinics will be offered to staff, physicians and volunteers across NH at various facilities for a period of three weeks from October 26 to November 13

WorkSafe BC
On May 14, the Workers Compensation Amendment Act (Bill 9) received Royal Assent and contained a number of changes. These included expanded stop work order powers, changes to employer incident investigations, expanded injunction powers and changes to penalty due diligence. As a result of the specific changes to employer incident investigations the electronic tool used to complete these investigations has become a focus for all health authorities and provincial solutions are being developed. It is anticipated that a new tool will be available for all Health Authorities to utilize in the Spring of 2016. In the interim a preliminary investigation process has been communicated (for those incidents requiring an investigation).

Human Resources Planning & Design, Education & Training

In July 2015, NH created a new portfolio combining education and training with human resources planning and design. This new portfolio combined the areas of: clinical placement; recruitment and retention; education - inclusive of the learning management system, learning pathways, and continuing medical education; organization development; and human resources planning and design.

This new configuration of services is intended to support the lifecycle of NH's employees from our engagement with them as students, to their flourishing to their highest potential with NH. This lifecycle is shaped by human resources planning and design and contextualized in Northern Health's culture of engagement and learning. The following figure represents this conceptualization of services:



The following initiatives are focuses of this portfolio:

Engagement
At the provincial level, a review is being undertaken to determine the potential of a province-wide employee engagement strategy, which goes beyond administration of a survey every two years.

Cultural Enhancement

- *Above and Beyond Awards* is a program that demonstrates NH appreciation of the excellent work performed by staff members. This year, we are reviewing this program to better align with the new NH values and to create a celebratory event for award reception. Communication and implementation will start in the fall.

- *Team interventions*, developed at the request of a leader who wishes to improve team performance or through a Labour Relations investigation into allegations of harassment, bullying etc., have been executed and more are planned. Nine workshops have been conducted, three have been scheduled and will be completed in September, and three other teams have expressed an interest and are awaiting finalization and scheduling.

- *Emotional Intelligence workshops* (2) were provided to mental health and addictions teams at their request.

- *Respectful Workplace Workshops and Conflict Resolution Workshops* have been delivered in multiple locations.

Change Management

Three NH employees will be supported to be designated Master Trainers in the Prosci® Change Management Program. This training aligns with the Ministry of Health's direction to support change management in a more purposive manner, as well as with the provincial partners' endorsement of the Prosci® Change Management Program as a training tool. Primary Care teams have been supported in their changes in work and roles. Change management principles and tools will be imbedded in the Learning Management System.

Clinical Placement

This fall, the Health Sciences Placement Network (HSPnet) was implemented in NH. HSPnet is a comprehensive, web-enabled Practice Education Management system for the health sciences, which addresses the challenges of discipline-specific and interprofessional student placements. HSPnet will assist NH to place, track, and manage student placements across the health authority.

Implementation activities include: supporting staff and students by creating and updating student policy and guidelines, managing affiliation agreements with post-secondary institutions, and supporting staff and students by fostering a positive learning environment through facilitation preceptor education.

Onboarding

Work is underway to refresh NH's organizational orientation (onboarding). Leading practices are being gathered and a framework for this activity will be presented to Senior Leadership in the fall.

Leadership Development

- *LINX Programs* - Three levels of the LINX program are offered to support NH leadership. *Core LINX* is designed to support new and developing managers, and will be offered this fall. *Experience LINX* is designed for emerging or new Directors, and will be offered to 14 NH leaders this fall. *Transformation LINX* is designed for new or emerging executive staff, and was attended by five NH leaders over the summer. For leaders who have completed

Core or Experience LINX, *Mentoring LINX* is an individualized online system designed to support a network of learning, sharing, and growth amongst leaders.

- *Face-to-Face Training* – Several coaching workshops have been offered, and one-on-one coaching has been provided to assist leaders with the challenges they experience. This fall, we are planning a Management Forum to support a community practice forum for front line managers.

Learning Pathways

A learning pathway is one where we take all the competencies in a clinical or service area and determine what a person needs in the first few weeks of working in that area; what they would subsequently might need for the first few months of working in that area and so on up to their mastery of the area. This way we match education to the way human beings learn, and also can help staff where they may wish to change their area of care and service.
Learning Pathways work commenced this fall with the initiation of three clinical pathways (primary care, critical care in a rural context, and surgery).Completion is expected in the New Year. Organizational pathways include primary care assistant, and two more to be determined at a later date.

LearningHub

The LearningHub is a computer platform for education delivery. NH and PHSA (the LearningHub administration group) are working toward a November 2015 launch for targeted users before a full-scale launch in early 2016. In preparation for this, a communication plan and resource materials are being prepared for all stakeholders. Course managers will be trained to utilize this system over the fall.

Academic Liaison

Meaningful connections with our academic partners afford opportunities for NH to shape the academic preparation of potential staff to our health human resource needs. To assist in this work, members of the Education team sit on academic advisory councils, and we invite academic partners to sit on our NH Education and Training Council (starting this fall). Through these connections we learn what disciplines are being prepared and how, and can inform the academy what new roles we might need to serve our patients and families. For example, this summer, work is moving forward to create a physiotherapist assistant role, and educational preparation to augment our need for greater depth of allied staff in this area is underway.

Human Resources Planning & Design

Beginning with meetings this fall, the Ministry of Health (MOH) is embarking on work in this area. Preparing for a greater focus on this activity, NH has hired a Human Resource Planning and Design Manager and Advisor to work with the MOH to bring together our forecasting data and allow NH to better understand who we need to hire to attain the high-quality care that we aspire to provide.

Succession Planning

With better understanding of our workforce needs and structural designs for our human resources, NH will begin a more clearly articulated plan for succession at all levels of the organization. This work will follow our HR planning and design efforts and understandings.

Performance Management
This area of work will be reviewed over the next six months with recommendations to be made to Senior Leadership in the spring

These efforts, taken together, will transform NH into a learning, growing organization that will attract people interested in excellence and innovation in clinical care and service, and allow them to flourish with us.

Recruitment & Retention
In addition to the day-to-day recruitment efforts that NH Recruiters are tasked with, several initiatives are underway to recruit and retain the best for NH:

- **Grow Our Own**
  Recruiters work with academic institutions to proactively forecast difficult to fill professions, then visit high schools and post-secondary institutions to showcase health care careers.

- **Engage Others**
  Employee referral incentive program; support and train hiring managers to reduce post-to-hire times and hire for fit.

- **Trending Data**
  Examine trends in professions - e.g. increased retirement or increase in a younger cohort; interpreting data to determine foci for efforts (see appendix).

- **Hire for Fit**
  Conducting surveys and workshops to help understand and promote best practices in this activity, which will lead recruitment practices with a high retention aim.

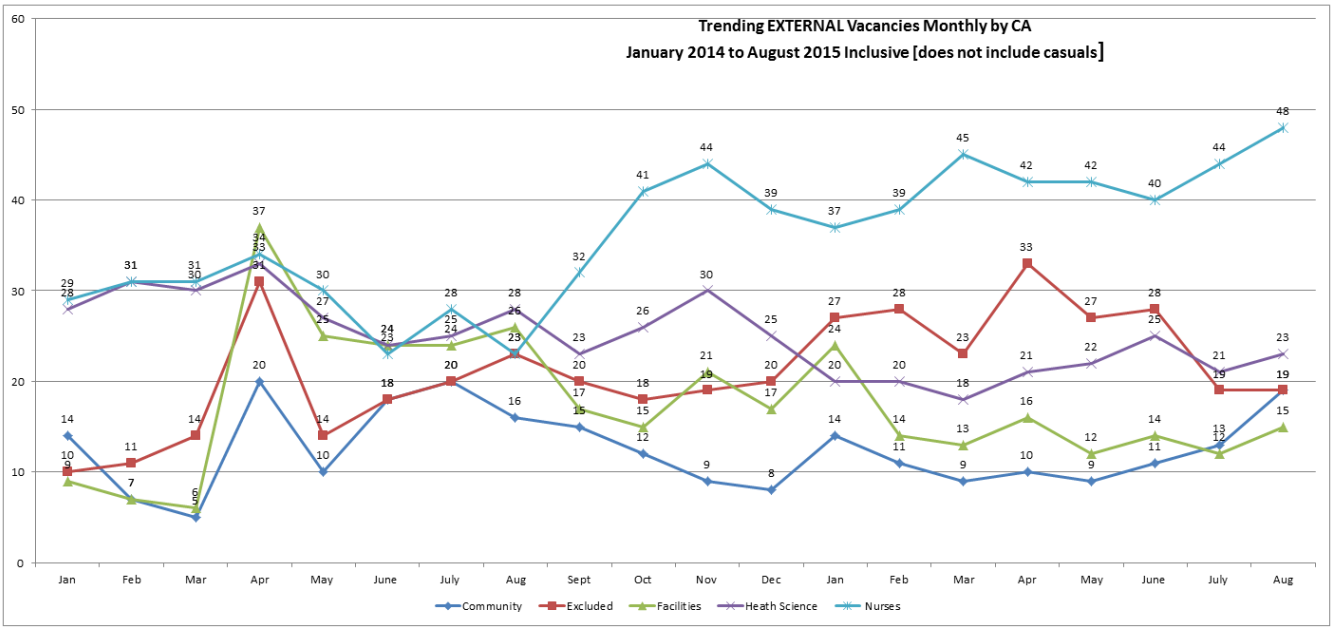
- **Family Recruitment**
  Looking at spousal opportunities in recruiting communities by partnering with major businesses and industry.

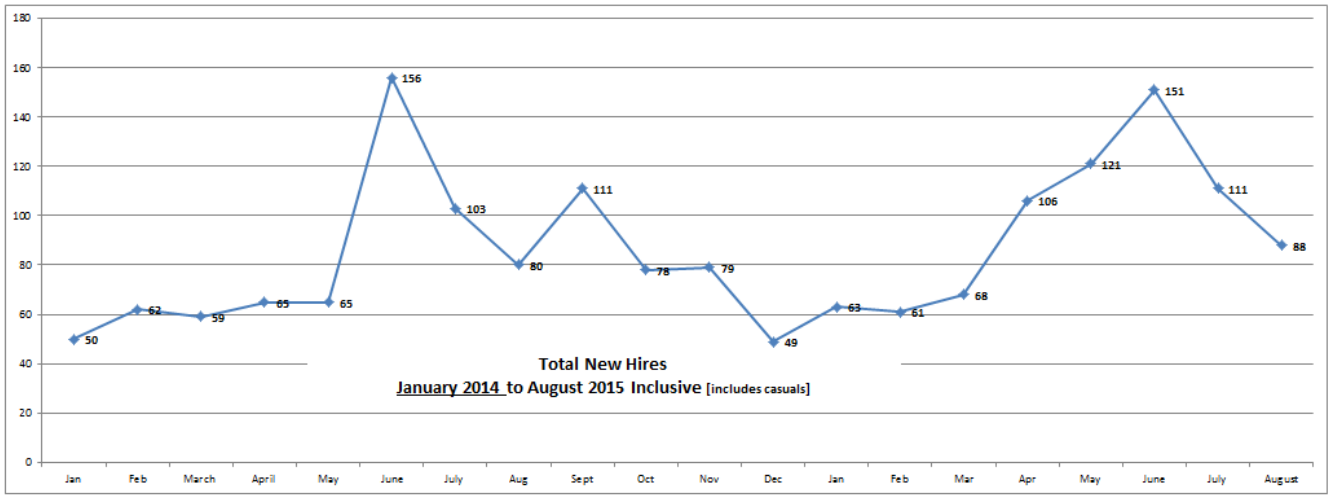
- **Candidate Relationship Management**
  Creatively connecting and staying connected with over 15,000 NH qualified applicants.

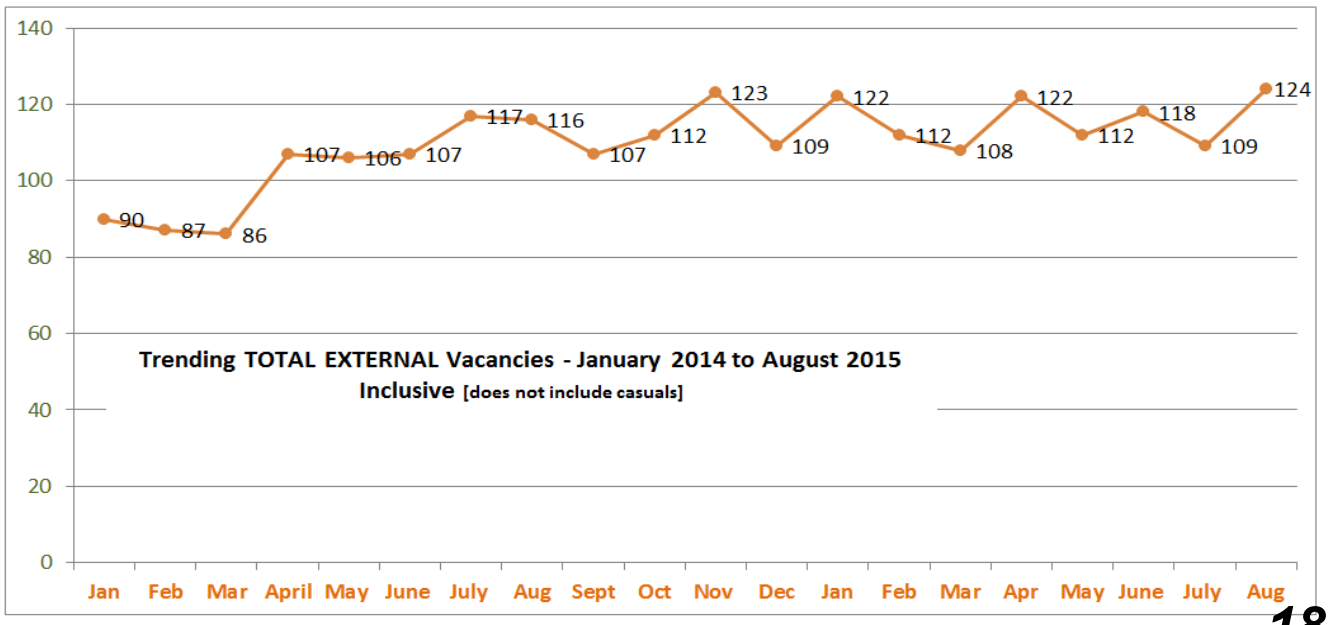
- **Marketing**
  Using social and traditional media to strategically showcase NH as the best place to work.

- **Upcoming Career Fairs/Recruitment Conferences**
  The recruitment team is keeping busy this fall, attending community events and career specific conferences:
    - UNBC Nurse Practitioner Classroom visit- Prince George (Sept. 14)
    - Canadian Association of Advanced Practice Nurses Conference (Sept. 23-25)
    - IMSS Career Fair- Prince George (Sept. 24)
    - Canadian Association of Critical Care Nurses Conference – Winnipeg (Sept. 27-29)
    - UNBC Fall Fair – UNBC Prince George (Oct. 6)
    - BC Health Leaders Conference – Vancouver (Oct. 20-21)
    - National Conference of Mental Health Nurses- Niagara Falls (Oct. 21-23)

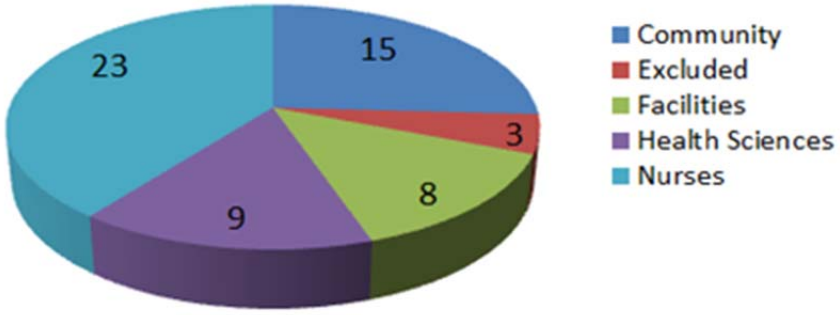
Data and Trending



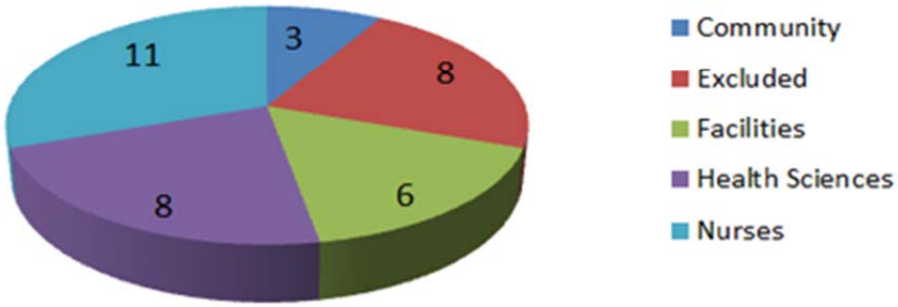




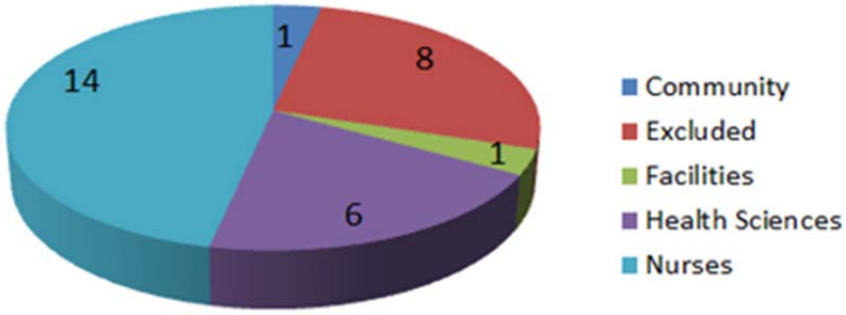
(58) External Vacancies - NORTHEAST
August 2015 [*does not include casuals*]



(36) - External Vacancies - NORTHWEST
August 2015[*does not include casuals*]



(30) External Vacancies - NORTHERN INTERIOR
August 2015 [*does not include casuals*]

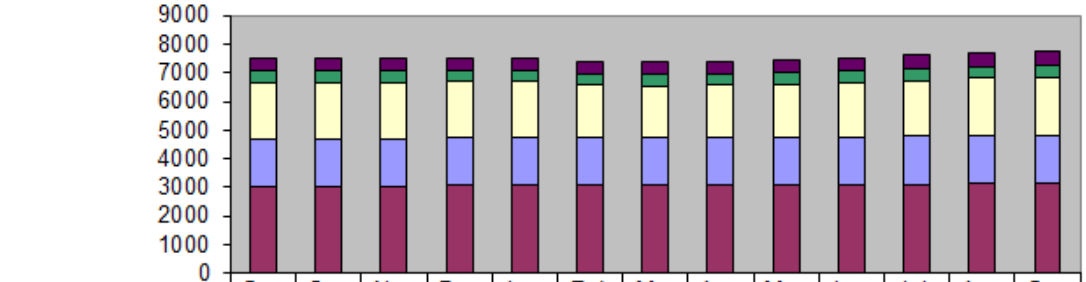


HRIS/Staffing

Employee and FTE Counts

Northern Health Employee Counts by Month

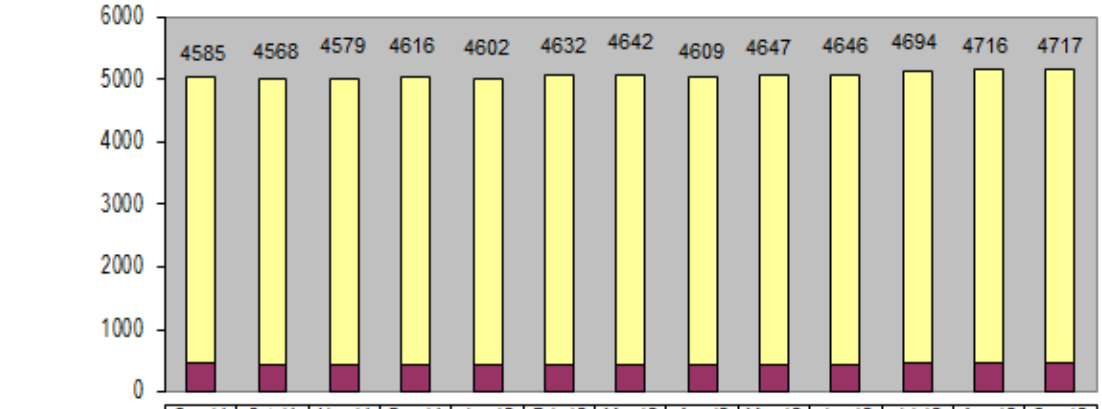
Displays the total # of employees, regardless of their status. Employee is based on unique SIN.



	Sep -14	Oct-14	Nov -14	Dec -14	Jan-15	Feb -15	Mar -15	Apr-15	May -15	Jun-15	Jul-15	Aug -15	Sep -15
Short Term Leave*	449	430	440	430	424	426	443	443	432	426	453	447	461
Multiple ID's**	426	433	444	384	397	391	393	405	421	446	414	422	433
Casual**	1960	1986	1972	1985	1950	1814	1779	1803	1792	1887	1935	1979	2018
Part time	1640	1636	1634	1655	1666	1677	1676	1663	1655	1656	1679	1675	1663
Full time	3043	3044	3040	3075	3068	3086	3081	3094	3114	3110	3117	3146	3142
Total	7453	7518	7529	7530	7529	7505	7394	7372	7408	7414	7525	7598	7669

Northern Health FTE counts by Month

Displays the total # of FTEs across the organization, not including casual employees.



	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Full FTE	4585	4568	4579	4616	4602	4632	4642	4609	4647	4646	4694	4716	4717
Short term leave*	449	430	440	430	424	426	443	443	432	426	453	447	461

Chart notes:

*Short Term Leave – Regular employees (part time or full time) that will be absent from 2 to 24 months. Reasons include, but not limited to; maternity, sick, education, LTD, WCB. These employees and their relief are included in the total FTE count.

**Multiple ID's – Employees who work in more than one facility or certification have an ID for each area worked and receive a separate pay cheque for each employee ID.

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BOARD BRIEFING NOTE

Date:	September 9, 2015	
Agenda item:	Period 5 Comments and Financial Statement	
Purpose:	☐ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☒ **Decision**
Prepared for:	Audit & Finance Committee – NH Board of Directors	
Prepared by:	Mark De Croos, VP Financial & Corporate Services/CFO	

August 13, 2015

Year to date Period 5, revenues exceeded expenses by $795,000.

Revenues are unfavourable to budget by $2.1 million or 0.7%. Expenses are favourable to budget by $2.9 million or 1.0%.

Delays in approval of targeted funding for a few budgeted programs have resulted in a delay in program expenditures and recognition of related funding. It was budgeted that $1.9M of targeted funding and matching expenditure would have been realized to the end of Period 5. As a result, revenues are showing an unfavourable variance to budget, while expenditures are showing a corresponding favourable variance to budget.

Forecast Yearend 2015-15

At this time, Northern Health is forecasting to be in a balanced position at yearend.

Recommendation:

The Northern Health Board approves Northern Health's Period 5 financial statement, as presented.

NORTHERN HEALTH

Statement of Operations

Year to date ending August 13, 2015 (Period 5)

$ thousand

	Annual Budget	YTD August 13, 2015 (Period 5)			
		Budget	Actual	Variance	%
REVENUE					
Ministry of Health Contributions	571,348	207,744	207,413	(331)	-0.2%
Other revenues	209,287	75,467	73,719	(1,748)	-2.3%
TOTAL REVENUES	**780,635**	**283,211**	**281,132**	**(2,079)**	**-0.7%**
EXPENSES (BY PROGRAM)					
Acute Care	435,389	157,216	158,509	(1,293)	-0.8%
Residential Care	102,627	38,008	38,118	(110)	-0.3%
Community Care	85,413	31,036	28,800	2,236	7.2%
Mental Health & Substance Use	56,152	20,339	18,701	1,638	8.1%
Population Health & Wellness	36,774	13,843	13,294	549	4.0%
Corporate	64,280	22,769	22,915	(146)	-0.6%
TOTAL EXPENSES	**780,635**	**283,211**	**280,337**	**2,874**	**1.0%**
EXCESS OF REVENUES OVER EXPENSES	**-**	**-**	**795**		

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BOARD BRIEFING NOTE

Date:	September 29, 2015	
Agenda item:	Reappointment of External Auditor – 2015-16	
Purpose:	☐ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☒ **Decision**
Prepared for:	Board of Directors	
Prepared by:	Beverly Little, Director, Finance & Controller	
Reviewed by:	Mark De Croos, VP Financial & Corporate Services/CFO	

Issue:

Board approval is required for the reappointment of KPMG LLP as Northern Health's external auditor for the fiscal year ending March 31, 2016.

Background:

In October 2012 the Board approved a five-year service contract with KPMG LLP for the provision of external audit services (representing fiscal years 2012-13 – 2016-17 inclusive.) Board approval is required each year to reappoint the external auditor for the next fiscal year-end audit.

Recommendation:

The Northern Health Board approves the reappointment of KPMG LLP as external auditor to Northern Health for the fiscal year ending March 31, 2016, representing Year Four of a five-year term of engagement.

northern health

PROJECT SUMMARY REPORT
PERIOD 05 CAPITAL PROJECTS

Fiscal Period End Date **13-Aug-15**

Northern Health Major Projects Summary

	Project	*Meeting Scope *Yes/No*	**Scope Date Change	*On Schedule: *Yes/No*	**Schedule Date Change	*On Budget: *Yes/No*	**Budget Date Change
1	NE - FNH Morgue Renovation	Y		Y	19-Dec-14	Y	19-Dec-14
2	NE - FNH Roof Replacement II	Y		Y		Y	
3	NE - FNH Tub Room Renovation	Y		Y	19-Dec-14	Y	19-Dec-14
4	NE - FSH Landing Pad, Mobile MRI	Y		Y		Y	
5	NE - FSH Planning - Old Fort St John Hospital Asset Retirement	Y		Y		Y	
6	NI - BLH Lakes District Hospital & Health Centre Replacement	Y		Y		Y	12-Sep-13
7	NI - DPL Energy Conservation Measures CNCP	Y		Y		Y	
8	NI - GRB QUESST Renovation	Y		Y		Y	
9	NI - GRB Switchgear Replacement	Y		Y		Y	
10	NI - STH Stuart Lake Hospital Sprinkler System	Y		N	1-Dec-14	Y	9-Jul-14
11	NI - UHN Learning & Development Commons	Y		Y	10-Oct-13	Y	10-Oct-13
12	NW - ACM Acropolis Manor/ Summit Residence Floor Elevation Moveme	Y		Y		Y	
13	NW - BVH Boiler and Controls CNCP	Y		Y		Y	
14	NW - MAH Roof Condensation Issue	Y		Y		N	4-Mar-15
15	NW - MMH Landing Pad, Mobile MRI	Y		Y		Y	
16	NW - MMH Nurse Call System	Y		Y		Y	
17	NW - MMH Outpatient Clinic Renovaton	Y		Y	29-Oct-14	Y	29-Oct-14
18	NW - PRR Building Automation System DDC Upgrade	Y		Y		Y	
19	NW - PRR Electrical Power System	Y		Y		Y	
20	NW - QCI Hospital Replacement	Y		N	15-Oct-14	N	12-Sep-13
21	NW - STC Energy Conservation Measures CNCP	Y		Y		Y	
22	NW - STE Ventilation Isolation CNCP	Y		Y		Y	
23	NW - WRI Sprinkler System Install	Y		N	1-Dec-14	Y	9-Jul-14
24	IT - NHR Data Centre Transition (STMS)	N	2-Jul-13	N	3-Jan-13	Y	
25	IT - NHR Enterprise Master Person Index (EMPI) Active Integration	N	2-Jan-14	N	22-May-14	Y	31-Mar-14
26	IT - NHR Regional Nutrition Systems Project (CBORD)	Y	7-Mar-14	N	14-Aug-14	N	7-Mar-14
27	IT - NHR Voice Recognition Electronic Documentation	Y		Y	15-Jan-15	Y	
28	IT - NHR ICCIS	Y		Y		Y	

*** Yes denotes green health indicator**
*** No denotes yellow/red health indicator**
*** Comments related to health indicators are noted below**

**** If there is a date in these columns, it indicates the date of the latest status change to no**
**** If there is no date in these columns, the yes/no status has never changed and represents original**

10	Project is now behind schedule due to issues related to unknown water connection; additional engineering was required to establish water requirements which delayed finalizing design
14	Tender closed, price very over budget. Currently reviewing cost and scope. Approval received from Board April 20th to award.
20	Contractor submitted delay claims are currently under review
23	Project schedule has been impacted due to a delay in being able to start civil work; the interior work has commenced within the facility, however the civil work has to be pushed out until frost is gone which will delay the schedule by a few months
24	Delays on infrastructure preparation
25	Schedule at risk due to Cerner delivery of enhancement to VIHA and NH and due to the integration software coming from CGI (MOH Tech Support)
26	Network and printing issues have impacted CBORD implementation. Focused effort to resolve the issues is underway

Please note that individual Project Status Reports on the above identified projects are received and reviewed in detail by Audit & Finance Committee. Detailed Project Status Reports are available upon request from the Regional Director, Capital Planning & Support Services.

When reviewing detailed dashboards, please note a system issue between fiscal and calendar reporting in the Budget to Date vs Actual to Date

Where significant updates are available this summary dashboard reflects current information up to: 2-Sep-15

COMPLETED PROJECT SUMMARY REPORT (Note 1)

Fiscal Period End Date **13-Aug-15**

Projects completed during period P05

Project	*Scope *Yes/No*	*Schedule On Time: *Yes/No*	*Budget On Budget: *Yes/No*	File No.

Construction completed - Projects under financial review (Note 2)

Project	*Scope *Yes/No*	*Schedule On Time: *Yes/No*	*Budget On Budget: *Yes/No*	File No.
NE - DCH Control System Upgrade CNCP	Y	Y	Y	N651530008
NI - GTW 3rd Floor Conversion	Y	Y	Y	
NE - FNH DDC System Upgrade CNCP	Y	Y	Y	N651530009
NW - BVH Nurse Call System Replacement	Y	Y	Y	N671540004

Projects completed during Fiscal Year 15/16

Project	*Scope *Yes/No*	*Schedule On Time: *Yes/No*	*Budget On Budget: *Yes/No*	File No.

***Comments Field: (required if "NO" selected)**

Note 1

Please note that individual Project Status Reports on the above identified projects have been received and reviewed in detail by Audit & Finance Committee. Detailed Project Status Reports are available upon request from the Regional Director, Capital Planning & Support Services.

Note 2

Financial Review is underway to assess final financial project closure related to expenses and funding sources in order to enable amortization of the asset according to generally accepted accounting principles.

Human Resources
700-299 Victoria Street,
Prince George BC
V2L 5B8

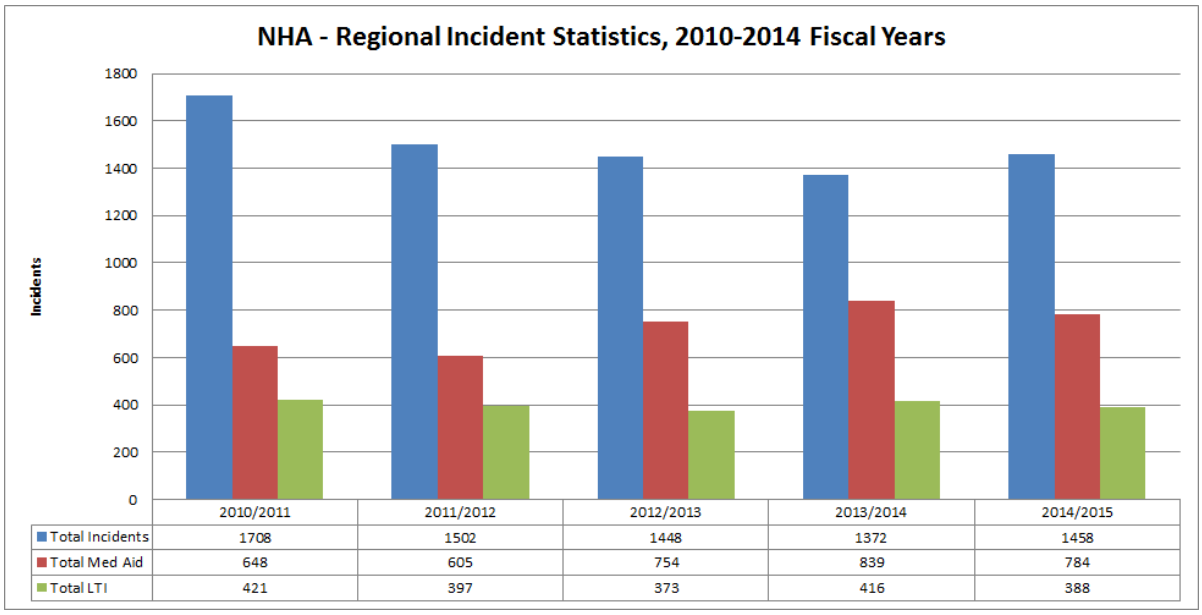
BRIEFING NOTE

Date:	**October 2, 2015**	
Agenda item	**Occupational Health and Safety Annual Update 2014-2015**	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**3P Board Committee &** **Northern Health Board of Directors**	
Prepared by:	**Frank Talarico, Director Workplace Health & Safety**	
Reviewed by:	**David Williams, Vice President Human Resources**	

Issue:
To provide an update to the Northern Health Board of Directors on Occupational Health and Safety for 2014- 2015.

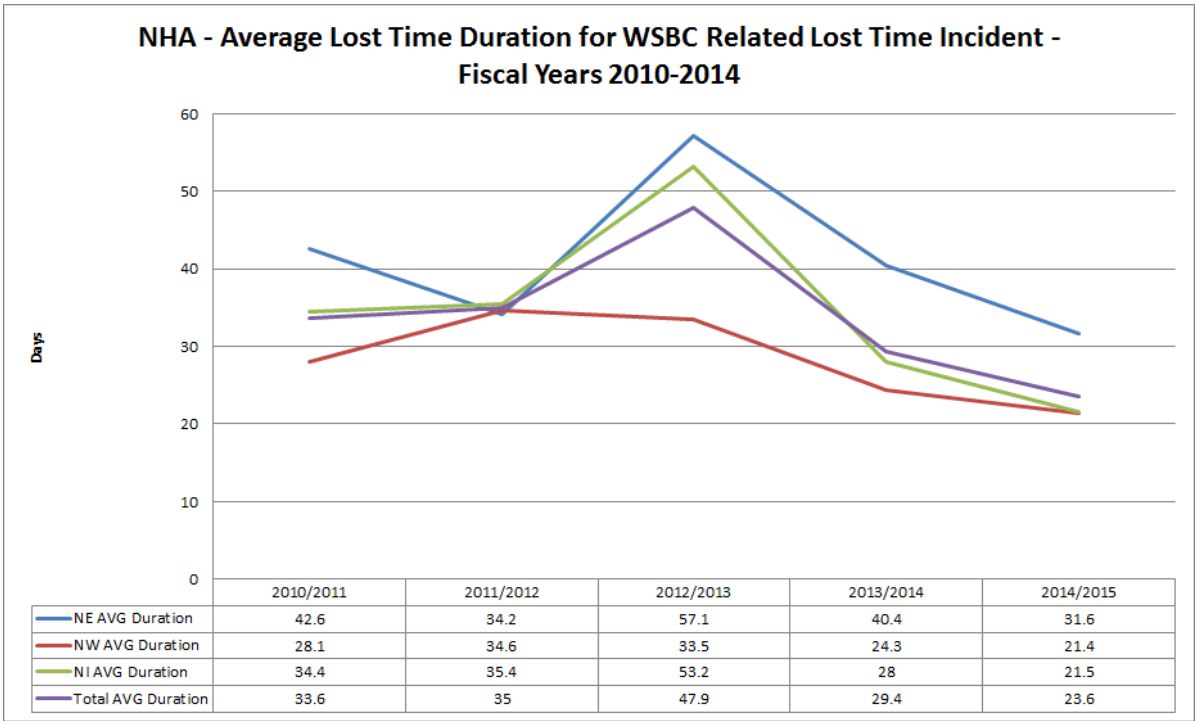
Background:
Health and Safety performance outcomes are shown below in the following charts.

Note: These charts are generated from WHITE.net using each fiscal year period only. It will differ from WorkSafeBC data as WHITE.net does not consider the WorkSafeBC Experience Rating formula.



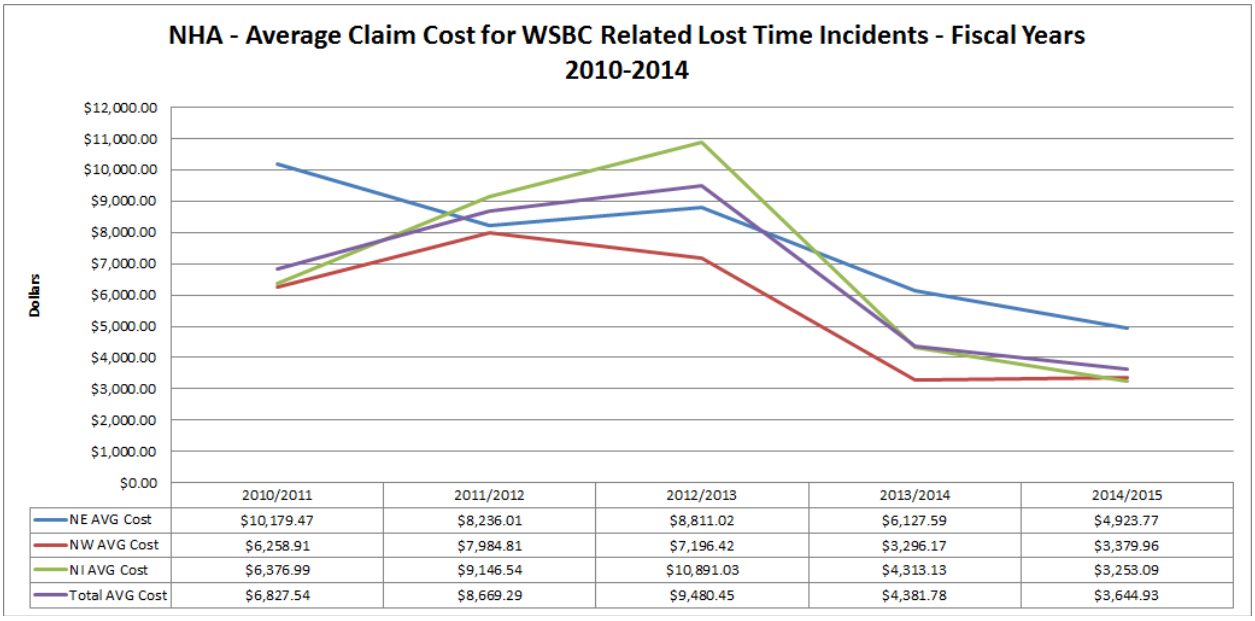
	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015
Total Incidents	1708	1502	1448	1372	1458
Total Med Aid	648	605	754	839	784
Total LTI	421	397	373	416	388

The overall number of incidents has been decreasing, medical aid increasing and lost time relatively stable. This shows that our injury prevention methods are being sustained and the Stay at Work Program is effective.



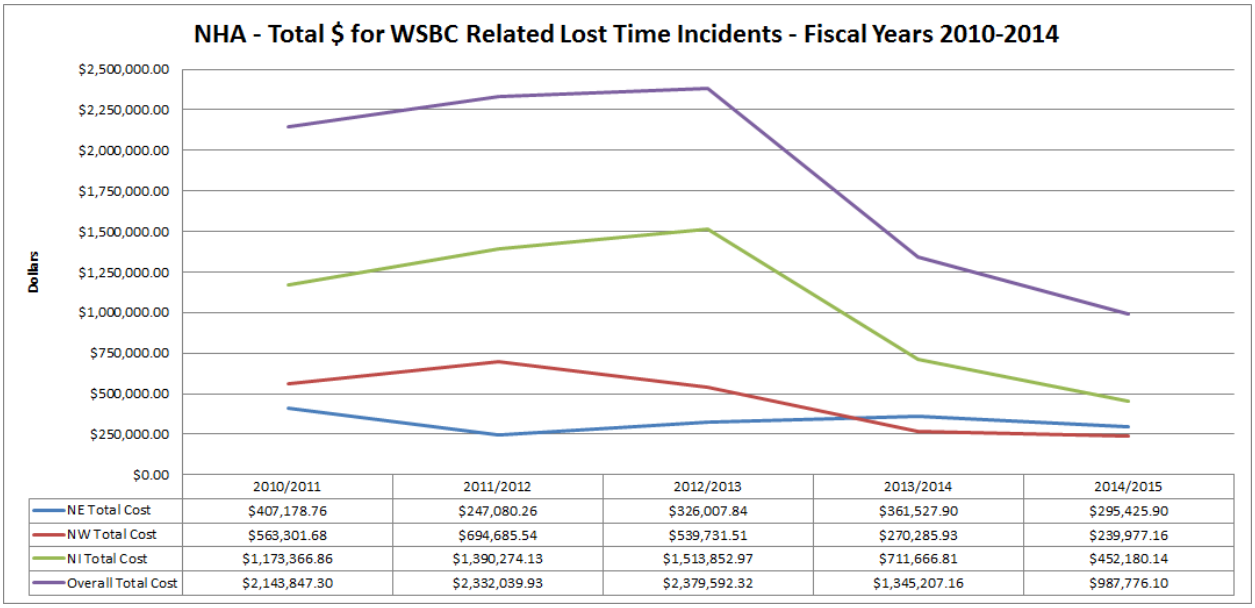
	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015
NE AVG Duration	42.6	34.2	57.1	40.4	31.6
NW AVG Duration	28.1	34.6	33.5	24.3	21.4
NI AVG Duration	34.4	35.4	53.2	28	21.5
Total AVG Duration	33.6	35	47.9	29.4	23.6

As demonstrated in the graph above, our incident duration continues to trend downwards. This has resulted in large part from designating specific disability management professionals to focus on managing our long term and complex claims. In October of 2012, we joined the provincial call centre. You can see, as illustrated above, that we experienced a short-term increase in duration following this transition. Since spring of 2013, we have experienced continuous improvement and are now at our lowest duration historically.



	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015
NE AVG Cost	$10,179.47	$8,236.01	$8,811.02	$6,127.59	$4,923.77
NW AVG Cost	$6,258.91	$7,984.81	$7,196.42	$3,296.17	$3,379.96
NI AVG Cost	$6,376.99	$9,146.54	$10,891.03	$4,313.13	$3,253.09
Total AVG Cost	$6,827.54	$8,669.29	$9,480.45	$4,381.78	$3,644.93

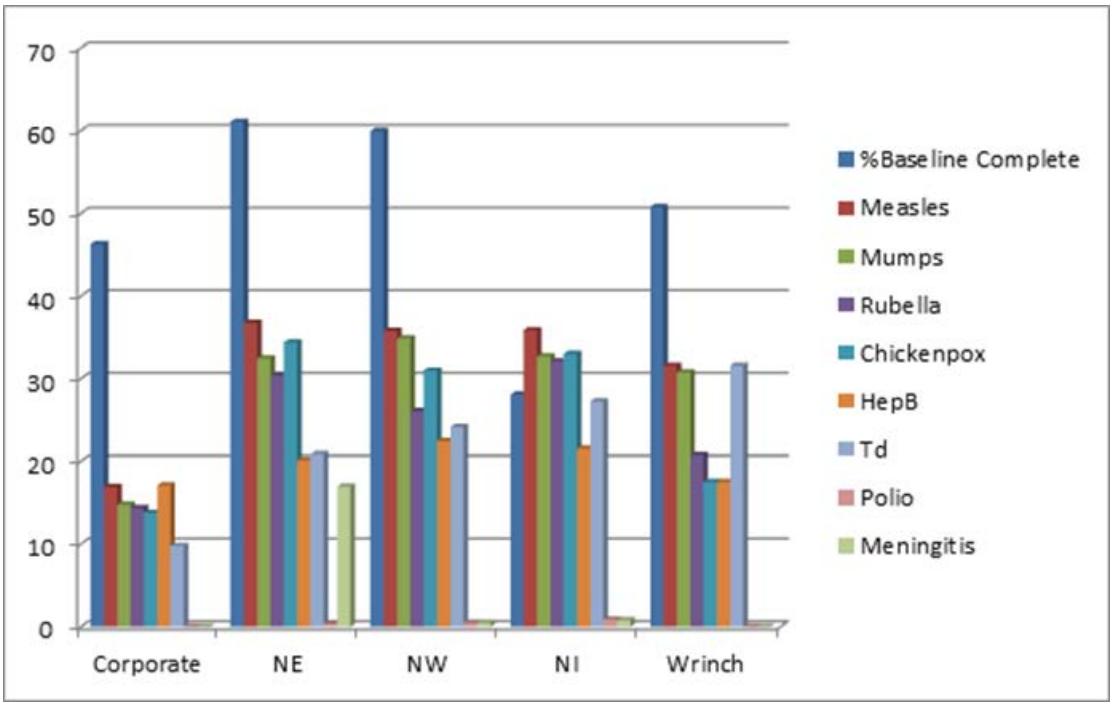
The downward trend in average claim cost demonstrates that the organization is effectively managing prevention and WorkSafeBC claims. This is effectively decreasing overall costs to the organization and improving our experience rating.



	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015
NE Total Cost	$407,178.76	$247,080.26	$326,007.84	$361,527.90	$295,425.90
NW Total Cost	$563,301.68	$694,685.54	$539,731.51	$270,285.93	$239,977.16
NI Total Cost	$1,173,366.86	$1,390,274.13	$1,513,852.97	$711,666.81	$452,180.14
Overall Total Cost	$2,143,847.30	$2,332,039.93	$2,379,592.32	$1,345,207.16	$987,776.10

The same downward trend is evident in this graph representing overall claim dollars. Since 2010, and directly related to WSBC claims payments, the organization has realized a cost avoidance in excess of $1.1 million.

Baseline Immunization 2014/15



The above graph represents the percentage of baseline immunization status screenings that have been completed. In addition to the immunization screenings that have been completed the percentage of staff that have been vaccinated against the respective diseases is also

shown. For example in the NI just over 30% have been vaccinated against measles, mumps and rubella. Should an outbreak of measles, mumps or rubella occur in the NI, according to the records on file, just over 30% of the staff in that area would be available to safely work.

Highlights:

Violence Prevention Program and WorkSafeBC High Risk Strategy

In January 2015 WorkSafeBC announced their High Risk Strategy. This strategy focuses primarily on violence prevention in the workplace and the role of the supervisor. Several activities were in place to address this strategy and a number of additional activities have been initiated to enhance and support violence prevention in the workplace. Highlights of the activities are as follows:

Executive Commitment;
An audit of Violence Prevention Program Elements was completed and submitted at the request of the Ministry of Health. This audit was coordinated by the Occupational Health and Safety (OHS) Directors and included information on; current education platforms, training statistics, hazard risk assessment tools, policies and reporting practices currently available at the Health Authorities.

This audit provided the basis for enhanced conversations with Senior Executive who is supporting the development of a violence prevention program current state assessment to determine existing program implementation at WSBC designated high risk sites. This information will be used to develop site and HSDA specific action plans to support sustainability of the violence prevention program.

Health Safety in Action (HSIA) Phase 2;
This initiative focuses on providing violence prevention training to all staff in the WSBC high risk areas of emergency and mental health over a 3-year period. The objective of this term specific project is to augment the health authorities' current training capacity to ensure all employees working in these areas are appropriately trained and processes are developed to sustain these training efforts.

WorkSafeBC 2015 High Risk Strategy;
This strategy is designed to reduce injuries to front-line caregivers and to also reduce violence-related injuries in health care. The focus of the high risk strategy is on specific prevention initiatives and risk-reduction tactics in areas identified as high risk with a goal to apply resources and effort where they will be most effective. Inspections will concentrate on worker-patient interactions, the internal responsibility system, and the management of violence prevention program elements in the workplace.

Violence Prevention Training April 2014-March 2015 (NH)

- Personal Safety classes offered: 35 sessions
    - 425 staff trained in Personal Safety
- Code White New Member classes offered: 10 sessions
    - 111 staff trained
- Code White Recertification classes offered: 10 sessions
    - 51 staff trained

Workplace Health & Safety Orientation for New Hires and Managers/Leaders

Understanding our Workplace Health and Safety program is critical for new managers and supervisors, as well as new employees joining our teams. This includes requirements organization-wide and within specific sites/jobs, as well as the supports and resources available to help meet those requirements. To make this information more easily accessible, WH&S developed two orientation checklists; one specific for new managers and one specific for employees. These checklists outline all Occupational Health and Safety Training available to staff (with links embedded) and is available for managers to use in the development of department specific orientation for their staff.

Workplace Health & Safety Inspection Guidelines

Effective workplace inspections are integral to ensuring the safety of our staff by managing the risk of incidents and injuries in the workplace. Regular inspections highlight best practices, identify opportunities for improvement, and are a requirement under BC Occupational Health and Safety Regulation. WH&S has developed a new Guide to Workplace Inspections to support sites and departments in conducting regular workplace inspections.

Working Alone or In Isolation Provincial Request for Proposals (RFP)

A multi-ministry Request for Proposal to establish a "working alone check-in service" was completed. The successful applicant was Tsunami Solutions Ltd Safety Line a cloud based safety monitoring of staff which includes check-in monitoring and emergency notification. This system is now available to Northern Health departments/facilities that require a working alone solution for their staff.

Occupational Health & Safety (OHS) Leaders eLearning Module

The WorkSafeBC eBook "Managing Safety in Health Care: A Guide for Leaders" content has been converted to an e-learning module and has been included in the provincial healthcare management education program. This program provides the foundational OHS information needed for leaders in healthcare.

Safe Patient Handling (SPH) Peer Leader Training

The Safe Patient Handling program recently added a new eLearning resource series. This series is a building block to the education being offered in the SPH peer champion program. WH&S continues to support peer champions via quarterly teleconferences/videoconferences and through the use of a Team Site.

SPH Peer Champion Training April 2014-March 2015

- 16 sessions offered; (one cancelled due to inclement weather/driving conditions)
    - 111 Peer Champions trained

Employee Absence Reporting Line (EARL)

EARL is a telephonic absence reporting system that permits employees to place a single call to report their absence: including general (3) reasons why an employee is absent. This system provides notification to their manager or designate for payroll and staffing purposes and, when appropriate, to a Disability Management professional for immediate follow up. Staffing offices are notified by email when staff has called in absences, this triggers them to follow up with filling that position to ensure consistent patient care. EARL is implemented

100% at both Interior Health and Northern Health authorities. Contingency plans for both health authorities are almost complete with report discussions being the next priority. Incorporating EARL into manager/employee orientation is next on the agenda.

Influenza Protection Program

This was the third year of mandatory influenza protection for HCWs. Northern Health had an overall participation rate of 75%, which is an increase of 3% over last season. These rates can be broken down as follows; Administration 64%, Community Care 80%, Residential 71% and Acute Care 75%. Many facilities achieved 100% and our goal for the 2015/2016 campaign is to continue to increase these numbers. The Steering Committee who has previously overseen the program will be ad Hoc this year due to a successful program which is gaining acceptance of employees to the Influenza Control Program Policy.

Immunization Status Reporting project

In response to low reporting rates of immunizations, Workplace Health & Safety implemented an Immunization Status Reporting Project which launched April 1, 2015 focusing on new hires to the Health Authority. The objective of the project is to ensure that optimal vaccination rates are achieved for direct NH employees. It is anticipated that through increased knowledge and reporting of vaccination history, workers will be better protected against vaccine preventable diseases, in turn protecting the patients that they interact with daily. In addition, should an outbreak situation occur, information will be easily accessible to those that require it to ensure worker and patient safety.

The project elements include development of Northern Health policies; **Immunization Reporting Status** and **Prevention and Management Of Occupational Exposure to Communicable Diseases**, which outlines employee responsibility with the reporting of their Immunization Status. The value of having a new hire complete the immunity status assessment is significant; in the event of an employee exposure to a communicable disease, the immune status of the employee will be known and the appropriate follow-up can be completed in a timely manner. To support this the new hire employee package was revised to include Immunization reporting requirements in the employee offer letter, and an Immunization Status reporting memo outlining the requirements and process for reporting. Furthermore, new employees and their managers are receiving automated reminder emails at 5 and 10 day post hire, for employees that have not yet reported. The immunization status of the HA will continue to be evaluated further over the course of the project to determine the effectiveness of these efforts.

WH&S also began providing full services immunization clinics in many facilities of Northern Health, further increasing employee access to recommended immunization. In addition, strong partnerships between WH&S and Public Health continue, as employees are referred to public health, vaccination clinics continue to be offered jointly in order to effectively reach those within our extensive geography.

Executive Core Requirements Assessment

The Core Requirements Assessment was conducted with the NH Executive Team in February 2015. The Health and Safety Management System (HSMS) electronic application and HSMS dashboard are completed to support the HSMS Core Requirements implementation when initiated.

Enhanced Disability Management Program (EDMP)

The Enhanced Disability Management Program (EDMP) continues to operate fully within all the Bargaining Associations (NBA, HSPA, FBA and CBA).

EDMP Benefits:

- Support of union representation in coordinating early safe return to work which mitigates costs associated with Sick-Leave, WorkSafeBC and Long-Term-Disability claims.

EDMP Challenges:

- No interpretation manual available so multiple interpretations of the EDMP policy/procedures between the union and the employer creating barriers in best practice and delays in Disability Management (DM) services.
- EDMP Representatives/stewards take on an advocacy approach, often escalating disability management issues into the labour forum by involving union Labour Relations Officers.
- Role creep/confusion between the Disability Management Professional role and the EDMP Steward/Representative role creating significant delays in DM processes.

Duty-to-Accommodate (DTA) Pilot Project

Northern & Interior Health Collaboration with Human Resources Operations and Disability Management:

- Winners of the 2015 BC Excellence in Healthcare Award of Merit in the category of Workplace Innovation
- 2015 Canadian HR Awards Finalist in the category of Best Health & Wellness Strategy.

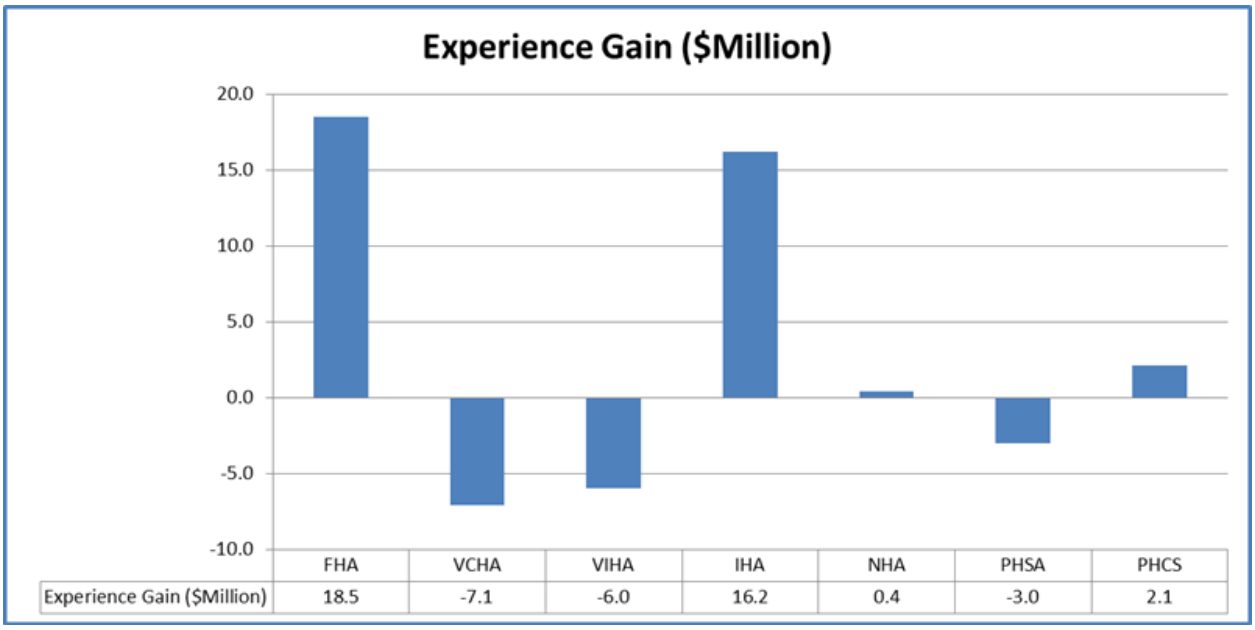
The implementation of a Duty to Accommodate (DTA) team involving Disability Management and HR partnering together to develop a small and focused team of professionals who were 100% dedicated to the DTA program for the entire health authority. The team established focused resources, standardized procedures and early intervention processes in returning disabled employees back into the workplace. The DTA team retained employees in their occupation eliminating indirect costs such as staff replacement, orientation/training and overtime with the next best practice being placement in a position that matches the employee's functional capabilities and training. The DTA Team's efforts resulted in significant value being recognized to the organizations in both financial and human worth. Disabled employees are accommodated into positions in a more stream-lined, faster, and efficient model of practice than ever due to the DTA team's efforts.

Disability Management Team 2014 Canadian HR Awards Finalist in the category of Best Health & Wellness Strategy

Northern and Interior Health's Disability Management team were selected as finalist in the 2014 Canadian HR Awards national competition for the category of Best Health & Wellness Strategy. The overall objective of the Disability Management Program is to promote employee health and well-being through use of a multi-disciplinary team approach, active medical case management and providing timely and safe return-to-work opportunities.

Long Term Disability

In 2014, Northern Health had a cost avoidance total of four hundred thousand dollars for Long Term Disability. LTD premiums are based on a 5 year experience rate.



Experience gains or losses are not an accurate reflection of the current year performance; rather they are a smoothing of the previous 5 years. An Experience Gain is a cost avoidance, an Experience Loss is a cost increase. In 2014 we experienced a marginal gain as 1 of our better years, 2009 dropped off of the 5 year history. Interior Health and Fraser Health are showing larger gains as they have their best 5 years showing at present, Coastal and Island having 5 consecutively poor years.

WorkSafeBC Short-Term Duration

In 2014, WorkSafeBC Short Term Duration (WSBC STD) improved by 14% for Northern Health (i.e. in June 2014, NH was at 50 days STD duration, and July 2015 NH was at 43 STD duration). When injured employees are able to return to modified duties as soon as medically approved, WSBC STD duration outcomes and claims costs decrease for the organization.

NH/IH WH&S Partnership:

We are now five years into the Workplace Health and Safety integration with Interior Health. We continue to experience significant gains/cost avoidance of LTD and WSBC benefits.

The WHS portfolios were realigned in January 2015 to bring Communicable Disease Management and OHS Prevention together under one Manager, and to create a new Strategic Directions portfolio.

Strategic Direction 2015/16:

We are now beginning the fourth year of our comprehensive Five Year Plan which is aligned with both Interior Health and Northern Health's organizational strategic plans, and will to continue to be revised annually to support the Vice Presidents of Human Resources and People and Clinical Services' annual plans.

Workplace Health and Safety continues to promote a comprehensive systems approach supporting a culture of health and safety across Interior Health and Northern Health. A

primary focus continues to be supporting increased capacity at all levels to incorporate health and safety into operational practices, policies, procedures and decision-making.

Recommendation:

This is provided to the Northern Health Board of Directors for information only.

Healthy Aging in the North: Action Plan
(2015/16 - 2020/21)

DRAFT – September 1, 2015

northern health
the northern way of caring

Introduction

Northern Health provides a full range of health care services for the approximately 287,729 residents[1] of northern British Columbia. This includes acute care services available in hospital, residential care services and a range of community services and family supports focused on prevention, health protection, chronic disease management and supporting seniors to stay healthy and at home.

Responding to an Aging Population

The seniors' population (age 65 or older) in northern BC is proportionally growing more rapidly in comparison to the rest of the province. This growth is expected to continue at an accelerated pace over the next 15 years (see Table A in Appendix C). The increasing number of older adults in northern B.C. can be attributed to two different processes: more youth moving away from the north and older adults choosing to remain in the north as they age instead of retiring elsewhere. This is a relatively recent phenomenon for northern B.C., a region that has historically been characterized by a younger population.[2] For rural and remote areas, this has profound implications for the delivery of health services. To best support older adults within Northern Health's resources, there will be a focus on health promotion, prevention, and community support for healthy aging[3] in order to reduce premature and unnecessary acute care visits, as well as inappropriate and premature admissions to facility based care.

According to Health Canada (2002) healthy aging is "a lifelong process of optimizing opportunities for improving and preserving health and physical, social and mental wellness, independence, quality of life and enhancing successful life-course transitions."

Developing a Healthy Aging in the North: Action Plan

The Healthy Aging in the North: Action Plan provides a framework for the delivery of seniors' health services in northern BC spanning the next 5 years. It is a broad framework intended to be flexible and responsive to a particular community's context, needs, health services, and other related resources.

In 2013, Northern Health engaged in extensive consultations with seniors and seniors' groups throughout northern communities. During these consultations, Northern Health gleaned insights into what healthy aging and wellness mean to seniors in the north, what is working for them in terms of meeting their health needs, as well as what could be improved upon[4]. The Healthy Aging in the North: Action Plan is designed to "take the lead" from the results of these conversations and put them into action.

[1] BC Stats Population Estimates by Health Authority- August 2015
http://www.bcstats.gov.bc.ca/StatisticsBySubject/Demography/PopulationEstimates.aspx
[2] Hanlon, N. & Halseth, G. (2005). *The Greying of Resource Communities in Northern BC: Implications for Health Care Delivery in Already Under-Serviced Communities.* The Canadian Geographer: 49(1), 1-24.
[3] Healthy Aging and Wellness Working Group of the Federal/Provincial/Territorial (F/P/T) Committee of Officials (Seniors). (2006, p. 3). *Healthy Aging in Canada: A New Vision, A Vital Investment From Evidence to Action: A Background Paper Prepared for the Federal, Provincial and Territorial Committee of Officials (Seniors).* Retrieved September 25, 2012 from http://www.health.gov.nl.ca/health/publications/vision_rpt_e.pdf.
[4] Northern Health. (2013). *Let's Talk About Health Aging and Seniors' Wellness. Northern Health 2013 Community Consultation.* Prince George, BC: Northern Health.

This action plan was presented to other key community stakeholders and Northern Health decision-makers. Input and feedback from these consultations is integrated into the final action plan. Consultations were held with:

- Regional Hospital Districts
- Northern Health Medical Directors
- The Northern Health Medical Advisory Committee
- The First Nations Health Authority
- The North Peace Division of Family Practice
- The Prince George Division of Family Practice
- Community Groups (e.g. Smithers Health Committee)
- Northern Health Staff

Elements of the Action Plan

The action plan is embedded within the context of Northern Health's Idealized System of Services (Appendix B). The principal aim is to assist seniors to live well, retain their independence, and where possible, to avoid or minimize the duration of hospital stays. Ultimately, the goal is to support seniors to continue to be active and vibrant in their communities and to age healthily and gracefully at home. If hospital or facility care is required, the action plan guides the best quality experience possible for the elderly.

The Healthy Aging in the North: Action Plan is underpinned by care planning processes that are constructed in the Primary Care Home in collaboration with the person and their family. Of significant importance is a focus on anticipating the wishes and needs of seniors well before a health crisis. Finally, this action plan contemplates dementia care and a palliative approach to care for individuals with chronic disease(s) or other life limiting conditions as being integral to this five year plan. For clarity, and to enable a depth of focus, both dementia and palliative care plans will be developed separately but will be closely related to the senior action plan.

The following principles guide the action plan:

- A Population Health Approach
- Supporting Community and Family Capacity
- Primary Care Homes and Integrated Services
- Person and Family Centered Care
- Care in the Right Place
- A Rehabilitative Approach in Northern Health Care Settings
- Recognizing Diversity and Choice

Defining Population Health
"A population health approach aims to elevate the health of the entire population and to reduce health inequities among population groups. It simply means that we look at the health of groups of people rather than at the health of one person at a time."
(Northern Health, Population Health)

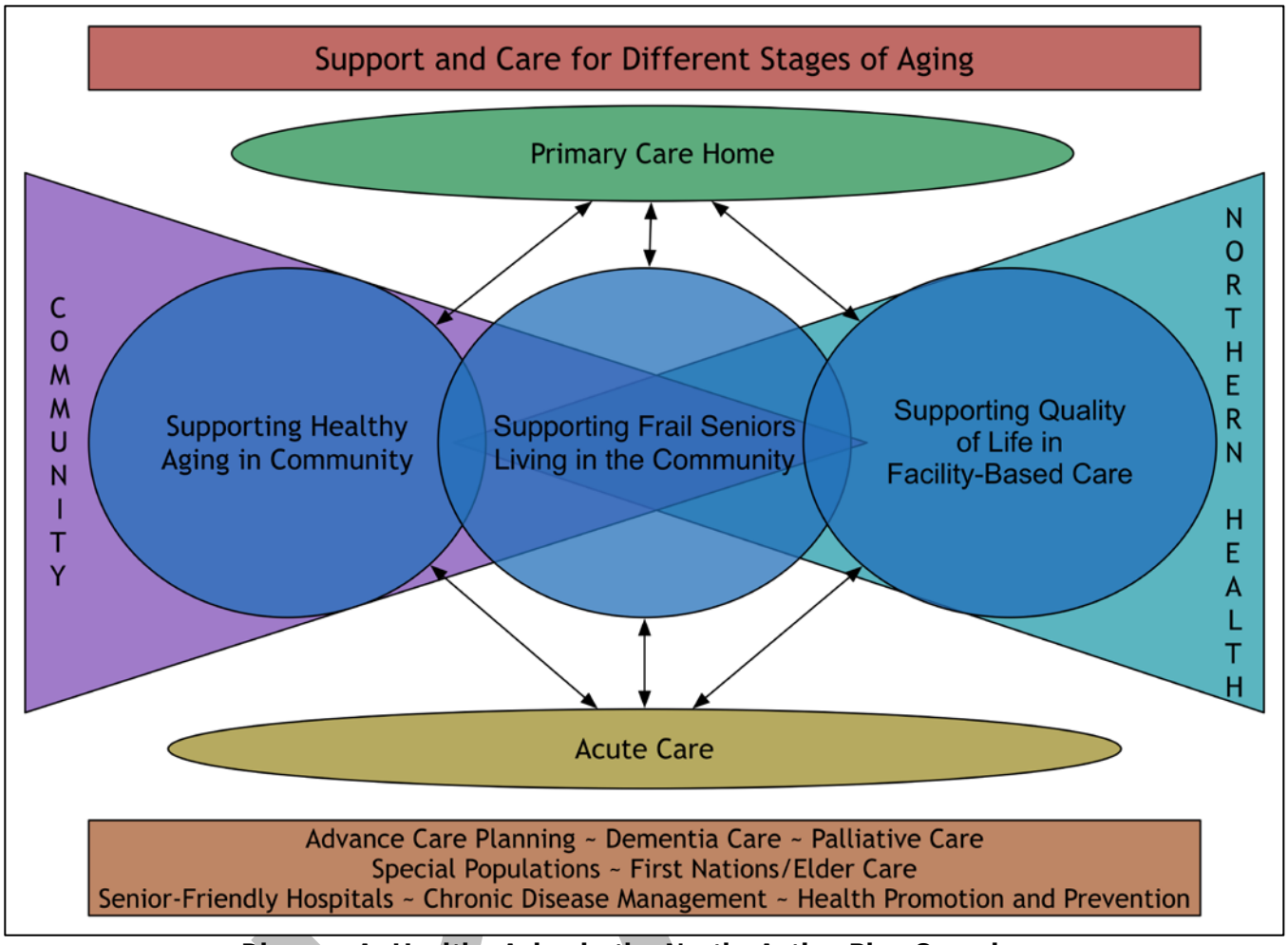


Diagram A: Healthy Aging in the North: Action Plan Overview

This action plan is divided into three focus areas that encompass the pathway of support and care as seniors' transition through the stages from healthy, active aging to end of life. The services provided through the Primary Care Home including advance care planning play the most critical role in supporting smooth transitions within the system as health needs change, and to facilitate crisis prevention.

The focus areas that guide this work are:

1. Healthy Aging in Community
2. Frail Seniors Living in Community
3. Quality of Life in Facility-Based Care

Focus Area 1: Supporting Healthy Aging in Community

Over 90% of older Canadians live independently in the community and wish to remain there[5]. This is certainly reflective of what Northern Health heard throughout the 2013 Seniors' Consultation[6]. Therefore, the first focus of this action plan is to engage and work with communities and volunteer agencies to promote and establish age-friendly communities.

Age-friendly communities are characterized by appropriate, accessible and affordable transportation, housing and support services. Seniors are able to take part in inter-generational, religious, social and recreational events of importance to them. A supportive community fosters lifelong learning and allows seniors meaningful opportunity to be involved in community life. By acting as a resource, Northern Health can assist communities in recognizing barriers for seniors and developing strategies to address them.

Target Population

The target population for supports and services at this stage of aging are seniors who can manage at home on their own with little or no assistance. They are[7]:

- ✓ Physically active/mobile
- ✓ Generally well with no active disease or who may have treated, stable comorbid disease(s).

*The United Way's **Better Care At Home** integration project identifies better ways to integrate with existing medical and non-medical support services for seniors and is an example of community partnership developing an age-friendly community.*

Key Elements

Community focused elements include:

- o Affordable, accessible transportation and housing options
- o Housing with appropriate adaptations to meet changing needs
- o Partnering with volunteer and not for profit organizations (e.g. Better Care At Home)
- o Providing a variety of opportunities to stay active and involved in community life
- o Health promotion including education and advanced care planning

Northern Health focused elements include:

- o Acting as a resource to communities for ideas on leveraging resources, health promotion and partnerships with available community supports across the region (e.g. Tobacco Reduction Program, providing grant money for health initiatives, partnering with organizations such as the Red Cross and United Way)
- o Providing communities with health information and Northern Health's influence (voice) to assist their efforts to advocate for investment in community resources and services for seniors
- o Communicating with seniors and their families in a variety of ways to ensure they are aware of services and how to access them.
- o Recognizing the transitioning needs of seniors and ensuring timely access to primary care

[5] Healthy Aging and Wellness Working Group of the Federal/Provincial/Territorial (F/P/T) Committee of Officials (Seniors). (2006, p. 3). *Healthy Aging in Canada: A New Vision, A Vital Investment From Evidence to Action: A Background Paper Prepared for the Federal, Provincial and Territorial Committee of Officials (Seniors).* Retrieved September 25, 2012 from http://www.health.gov.nl.ca/health/publications/vision_rpt_e.pdf.

[6] Northern Health. (2013). *Let's Talk About Health Aging and Seniors' Wellness. Northern Health 2013 Community Consultation.* Prince George, BC: Northern Health.

[7] BC Ministry of Health. (2008). *Frailty in Older Adults – Early Identification and Management*. BC Guidelines & Protocols Advisory Committee. Link: http://www.bcguidelines.ca/guideline_frailty.html.

Focus Area 2: Supporting Frail Seniors Living in Community

Pressure on the acute care system coupled with seniors' desire to stay in their homes requires Northern Health to re-imagine supports for seniors across the health continuum with an emphasis on strengthening community based services and supports for seniors' and their families to prevent or delay the need for higher levels of care.

Target Population

Seniors experiencing frailty are vulnerable and have complex needs involving both community-based services and service provided by Northern Health. This strategic area of focus addresses the needs of seniors who are:

- ✓ Experiencing increased burden of symptoms
- ✓ Medically complex and highly vulnerable to adverse health outcomes
- ✓ Require assistance in order remain at home

> *"Frailty develops as a consequence of age related decline in multiple body systems, which results in vulnerability to sudden health status changes triggered by minor stress or events such as infection or a fall at home. People with frailty have a substantially increased risk of falls, disability, long-term care and death."*
> *(NHS England, 2014)*

The goal is to enable seniors with early signs of increasing frailty, to maintain relative independence and prevent or delay functional decline. The emphasis is on the provision of person and family-centered primary care and supports that are timely, accessible, coordinated, and delivered through the efforts of our physicians, nurse practitioners and the other members of the inter-professional team. Recognition, support and prevention of burnout of caregivers are essential to this focus area as is providing flexible supports and respite care with a rehabilitative focus.

Key Elements

Key elements of the action plan for frail seniors living in the community include:

- o Providing support for chronic disease management, advanced care planning, and establishing strong relationships through the Primary Care Home in advance of medical crises
- o Developing the care plan with the senior and the family
- o
- o Using the Electronic Medical Record to enable care planning and service pathways, including timely and seamless transitions to and from specialised services
- o Rapid and flexible information sharing/communication amongst all members of the Interprofessional Team
- o Geriatric focused education for all members of the Interprofessional team
- o Assessment and early recognition of frailty risk factors and focus on preserving or improving function
- o Rapid, flexible mobilization of resources (including the Interprofessional Team; Home and Community Care, volunteer organizations)
- o Seamless transitions to specialized community supports and/or age-friendly, rehabilitative care in hospital when hospitalization is required.
- o Recognition and support of caregiver's needs including provision of respite and convalescent care (in home and in facility as appropriate).

Focus Area 3: Quality of Life in Residential Care

At some point, despite best efforts, a certain percentage of seniors will need to be cared for in a residential care or alternative housing environment. It is important that Northern Health project the need for residential care and alternative housing into the future in order to plan services for this percentage of people in northern BC (Table E Appendix C). Focusing on care in the right place means having housing and facility options that prevent inappropriate admissions to hospital and long term care facilities and ensuring these options are flexible enough to meet the variable care needs of seniors as they age.

Target Population

Residential care options are designed for seniors who have significant health and mobility restrictions/challenges such that they are no longer able to manage in their own homes, even with support. This may include:

- ✓ Those with extensive functional deficits and complex needs who require 24 hour nursing care
- ✓ Seniors who require a supportive, supervised living arrangement but are physically well (e.g. seniors living with dementia, mental health and addictions, etc.)
- ✓ Seniors who are cognitively intact but have extensive physical deficits (e.g. seniors living with Parkinson's or ALS (Amyotrophic Lateral Sclerosis –Lou Gehrig's Disease)
- ✓ Seniors who are no longer able to stay at home but can maintain relative independence in an assisted living type arrangement.

Key Elements

The focus at this stage is on improving and/or maintaining health and optimizing residents' quality of life in residential care. Key aspects include:

- o Increased options for facility-based care (e.g. seniors living in special supervised care homes, assisted living, residential care).
- o Education for nurses and other staff to ensure care is delivered in ways that promote respectful and gentle interactions and provide positive outcomes for the senior
- o Living environments that are tailored to the needs of people with dementia who are otherwise physically well.
- o Culturally safe care for Elders
- o Medication reviews and a falls prevention program
- o Education capacity for staff to care for people with special considerations (for example – mental health and addictions, developmental disabilities, Huntington's disease)
- o End of life care that respects the wishes of the person and their family.

*The **Residential Care Initiative** through the General Practices Services Committee supports physicians to provide 'best practice' care for people living in residential care environments. An incentive fee is available to enable, among other things, call availability to the care home, meaningful medical reviews and other supportive medical care. The incentive funding is available through divisions of family practice (or where no division exists, a self-organized group of General Practitioners).*

Healthy Aging in the North: Action Plan: Areas of Special Consideration

Acute Care

Although this action plan describes a continuum of care that appears linear and progressive towards admission to residential care, this is not the case. The continuum simplifies a dynamic set of circumstances that affect how care strategies are deployed to address what is often a changing set of health issues and needs. For example, while not desirable, older adults will likely require admission to hospital to address acute health care issues. The admission of a senior to hospital should trigger an immediate, coordinated intervention with a rehabilitative focus, and attention to appropriate discharge planning with necessary community supports in place. This is particularly important when supporting seniors living with frailty. The care seniors receive in an acute care facility has a significant impact on the trajectory of their recovery and how long they will be able to remain in their homes after the acute care visit. The goal is to facilitate a return home for a senior as rapidly possible, with appropriate supports in place to restore function to the previous baseline where possible and to minimize decline as a result of the adverse health event that precipitated the hospital admission.

Improvements to current hospital based care practices and approaches to care in community will need to occur in order to achieve the above. Staff competency in geriatric friendly approaches to care provision is critical for seniors' recovery. Senior Friendly Hospitals including targeted education in gerontology and a rehabilitative approach are essential for the senior population to be provided the highest quality care. As well, improved awareness and communication of care plans between Primary Care Homes and acute care is important.

System Level Outcomes

This Healthy Aging in the North: Action Plan is designed to improve services for the seniors population but also to impact system level outcomes, including:

- reduction in emergency room visits,
- Reduction in length of stay in acute care
- Reduction in waitlist times for residential care beds (see Table D in Appendix C)
- Reduction in Alternate Level of Care (ALC) inpatient days in acute care settings. (Inpatient days are considered ALC if the patient no longer requires acute care and is waiting to be discharged and/ or placed in other types of care, e.g., residential care, mental health facilities, assisted living).

On average, 22 percent of all Northern Health inpatient days are considered ALC, which accounts for 39,120 inpatient days (Table C in Appendix C). ALC is a very complex issue and a substantial number of ALC patients are comprised of individuals awaiting residential care placement, alternate housing solutions, further rehabilitation and those requiring palliative and sub-acute/ convalescent levels of care.

Aboriginal Health and Caring for Other Cultures

Canada's population is not only aging but it is also culturally diverse. Culture is a determinant of health influencing perceptions of health and illness, health practices, behaviours and decisions to seek health care.

Aboriginal populations are not uniformly distributed across the north. The highest overall proportion of Aboriginal peoples (mostly First Nation) is found in the Northwest HSDA. The highest proportion of Metis peoples are found in the Northern Interior and Northeast HSDAs. As well, more than two-thirds (68 per cent) of Aboriginal persons in northern BC choose to live off reserve.[1] These distributions are important considerations as we strive to provide culturally safe services for Aboriginal peoples.
(See Tables F & G in Appendix C)

While the health status of Aboriginal people has improved in several respects over the past few decades, the Aboriginal population in British Columbia continues to experience poorer health and a disproportionate rate of chronic diseases and injuries compared to other British Columbia residents. [8] [9]
Northern Health continues to work with the First Nations Health Authority, Aboriginal people and communities on approaches that better address their health needs and to provide services in a culturally safe manner. During the census in 2006, approximately 48,050 persons identified themselves as being Aboriginal: either status First Nations; Metis; or Inuit. Aboriginal people represent approximately 17% of the northern BC population: the highest of all British Columbia Health regions. Northern Health is working alongside the First Nations Health Authority to understand what supports and resources exist in the First Nations communities that will allow aging in place and to facilitate supported and smooth transitions from hospital back to their communities. [10]

In 2001, visible minorities made up 12.3 percent and immigrants made up 36 percent of the total senior population in BC.[11] In northern British Columbia there are approximately 12,660 visible minorities or about 4.6 percent of the North's population.[12]

Seniors services needs to be culturally safe with respect for all cultural diversity. Services will enable maximum family and patient participation and involvement in all care settings and will adopt philosophies of care that honor and promote cultural safety. Age related programs and policies will recognize that the seniors' population is not a homogenous group.

Dementia Care

Dementia is a condition where cognitive ability declines in a manner beyond that associated with normal aging. Individuals with dementia often need a variety of supports to keep them safe and also to prevent burnout of their caregiver(s). Wandering and agitation are challenging behaviors that can be associated with various stages of dementia and require special attention. Dementia care is a special area of focus within the broader action plan as some seniors are physically well despite having dementia and require different approaches to care and support to optimize safety and quality of life. The focus of Northern Health's

Northern Health anticipates 50% increase in the number of individuals who are frail and/or experience dementia over the next 10 years. This increase threatens to place a significant burden on primary, acute and long-term care health services unless new ways of managing dementia and/or serving individuals with dementia can be found.
(See Table H in Appendix C.)

8 The Crisis of Chronic Disease Among Aboriginal Peoples: CAHR; University of Victoria http://www.cahr.uvic.ca/docs/ChronicDisease%20Final.pdf
9 Pathways to Health and Healing: 2nd report on the Health and Wellbeing of Aboriginal Peop
BC Provincial Health Officer's Annual Report 2007. http://www.hls.gov.bc.ca/pho/annual.h
10 Geographic Profile of Aboriginal Peoples. BC Stats. http://www.bcstats.gov.bc.ca/data/cen01/abor/HA5.pdf
11 BC Ministry of Health Services (2004). A profile of Seniors in British Columbia. Victoria, BC: BC Ministry of Health Services
12 National Household Survey 2011 Census of Canada https://www12.statcan.gc.ca/nhs-enm/2011/rt-td/index-eng.cfm#tabs2

Dementia Care will be to increase the individual's, community's and health service's capacity to provide early, appropriate and effective care and support to assist people with dementia to remain at home and in their communities to the greatest extent possible. Education for the public and health care staff is the cornerstone of dementia care including early recognition and available supports. Northern Health will concentrate efforts on education through evidence based programs and initiatives (Appendix F). The other key focus will be on educating and supporting caregivers through a variety of means (home support, respite, education etc.). A companion document is being developed to guide Northern Health's approach to Dementia Care.

Palliative and End of Life Care in the North

The Northern Health Hospice Palliative Care Action Plan provides the framework for all services in the region offering palliative care. This is to ensure standardized evidence-informed guidelines are followed when providing palliative care services in any setting (community, acute and residential care). The Northern Health Palliative Care Program is a regional consultative service delivered by family physicians and other health professionals with palliative care expertise. The Palliative Care Program supports and mentors primary care providers in communities across the health authority.

Northern Health has developed a five year Palliative Care Action Plan which is guided by:

- A Population Health Approach
- A Person and Family Centered approach,
- Palliative Care in the location of the patient/family's choosing
- Service delivery within a rural and remote context
- Within the context of Primary Care Homes, supported by Interprofessional Teams, a Palliative Approach to Care (care in the right place, at the right time and by the right provider when a person is diagnosed with a condition that will ultimately end their life)

The Palliative Care Action Plan goals are to:

- Improve access to hospice palliative care
- Standardize the quality of hospice palliative care
- Promote the integration and coordination of care throughout Northern Health.

Interventions will focus on:

- Provision of palliative care information, education, tool and resources
- Supporting quality palliative care in communities
- Strengthen health system accountability and efficiency and
- Designating palliative care beds.

Summary

Healthy Aging in the North: Action Plan outlines three areas of focus designed to support the health needs of an aging population in northern BC. The action plan is meant to provide a guiding framework that is flexible and responsive to the specific context of communities throughout the region. The specific role for Northern Health and related priority actions and commitments over the next 5 years are outlined in Appendix A. Northern Health's Elder Program will develop goals informed by these priorities. For example:

- Resources will be provided to every community for advanced care planning
- An 'early identification frail elderly tool' will be provided to Primary Care Homes with 100% of Primary Care homes using the identified tool
- Quality of life surveys will be performed at every residential care facility in northern British Columbia. Goals will be established to improve quality of life in residential care.

Alignment with Other Initiatives & Guidelines

Northern Health is not working in isolation to address the changing needs of an aging population. This 5-year action plan is informed by and aligns with other local, provincial and federal senior and age-friendly initiatives and guidelines. Specific details with respect to these key initiatives and guidelines will be outlined in a forthcoming operational plan and include:

- Government of Canada Guide for Age-Friendly Rural and Remote Communities
- Office of the Seniors' Advocate Report
- Northern Health Position Statements: Healthy Aging & Healthy Communities
- Provincial Dementia Strategy Refresh Advisory Committee
- Collaborative anti-psychotic medication reduction project (residential care)

Next Steps

Following the endorsement of this action, a summary will be developed for distribution to Northern Health communities, residents and our partners in service delivery. A more detailed operational plan will follow, along with sub-strategies addressing aspects of palliative and dementia care.

Appendices

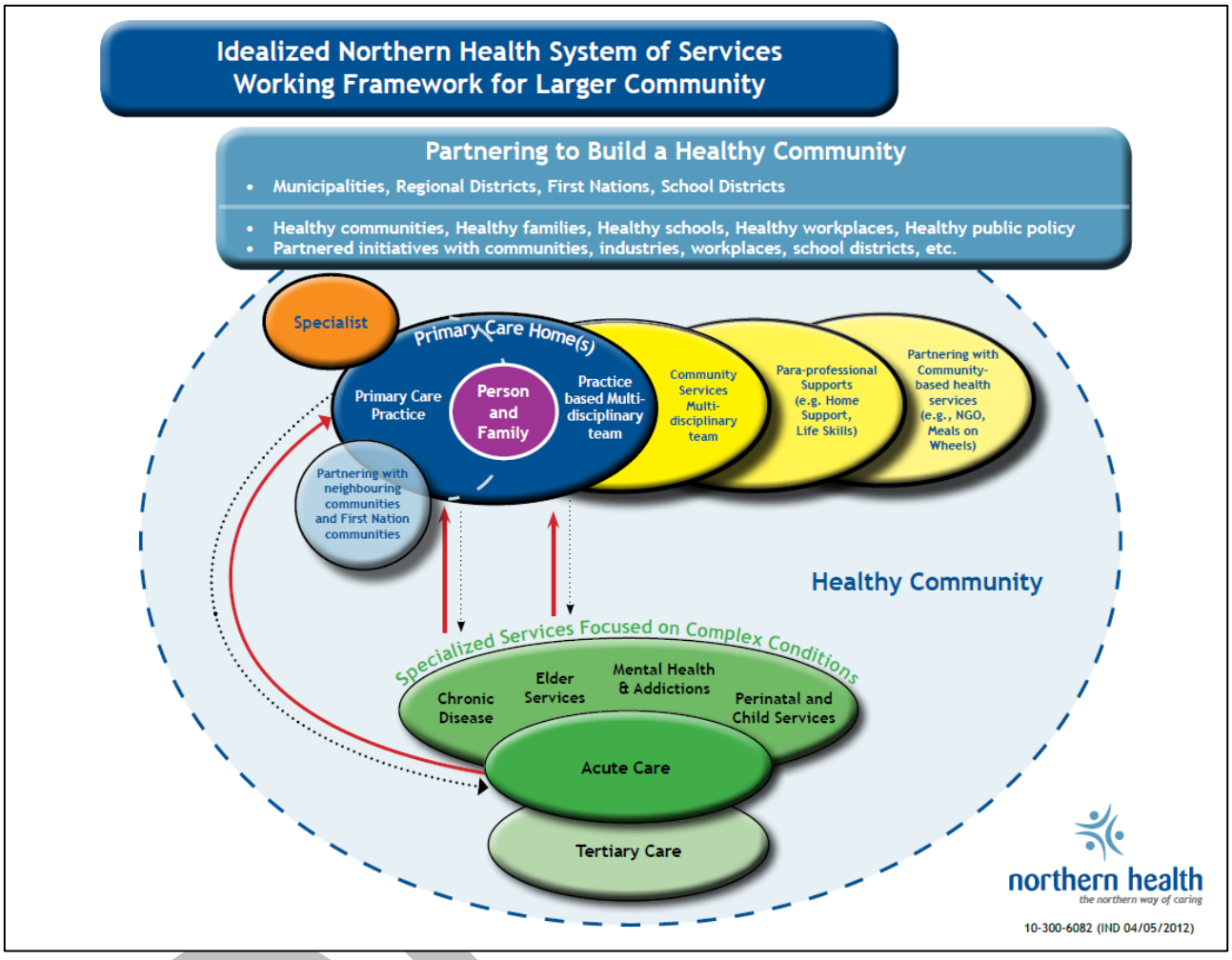
Appendix A: The Role of Northern Health & Priority Actions **IN DEVELOPMENT – Priorities to be determined through consultation with HSDA Operational Leaders.**

The Role of Northern Health	Priority Actions		
Priority #1: Supporting Healthy Aging in Community	**Year 1**	**Year 1-3**	**Year 3-5**
Work with communities to create and partner with age-friendly initiatives	* provide data to communities (both community groups and municipalities) to support and advocate in designing and promoting community efforts to plan and invest in age friendly initiatives (i.e. – transportation, housing, exercise programs). (Appendix E). *will lend Northern Health influence and voice to help build age friendly initiatives and infrastructure	* work with communities to link and leverage grant money to age friendly community initiatives * coordinate primary care with community-based supports. (i.e. work with United Way's Better at Home program to expand program to more communities)	*review age friendly initiatives and plan for further support and sustainability of current initiatives *leverage existing initiatives into new opportunities *explore new opportunities with communities *Northern Health will continue to provide data and a voice or influence for communities seeking opportunities to increase age friendly initiatives
Advanced Care Planning	*participate in provincial work around advanced care planning (this will include evaluation of 'My Voice' Document', testing "Speak Up BC' resource, inventory of advanced care planning tools and resources)	*pilot protocols for Advanced Care Planning *evaluation of pilot *implement and educate health care staff on Advanced Care Planning resources *promote Advanced Care Planning to the public (including a calendar of public awareness and education activities for the communities)	*monitor the progress and uptake of advanced care planning documents and re-evaluate activities if necessary *continue promotion of advanced care planning
Priority #2: Frail Seniors Living in Community	**Year 1**	**Year 1-3**	**Year 3-5**
Promote and implement care plans and implement a Frail Elder care pathway.	*engage primary care providers around standardize care planning for frail elderly, include person and family in this process * improve the gerontology knowledge base of all care providers through education opportunities such as Gentle Persuasive Approach Training and the Gerontology Certification	* Set the standard for care plans for frail elderly and support the implementation and sustainment with primary care homes and interprofessional teams	*review care planning including % of seniors with care plan in hospital, community and residential care. Review to inform next steps
Falls Prevention	*review best practices and incorporate any new best practices into existing policy and	*monitor falls incidents in acute care, residential care and community *continue to provide	*promote falls prevention activities that will decrease the number of falls

	guidelines *review current acute care falls prevention strategy and identify any gaps in the strategy and make appropriate adjustments to strategy (including education to accompany changes) * create and implement community and residential care falls prevention strategy *adopt and implement a screening tool for early identification of frail elderly	support to help sustain Falls Prevention as a practice change (this will include education and review of resources) *Falls Prevention Public Campaign to the public including a falls prevention exercise program *support communities to implement Strategies and Actions for Independent Living (SAIL) programs (falls prevention program focused on staying active)	*continuous review of the falls prevention strategy to further inform next steps (i.e. – identifying hospitals, communities or residential care sites with high number of falls and provide support to decrease number of falls through education and activities)
Review home support.	*review best practices *perform environmental scan (including reviewing current policies and current practice) *review human resource impact	*develop standardized home support service model for Northern Health *support community teams to implement and sustain home support services including the rapid mobilization of resources to help keep people at home or return to home	*evaluate and modify program as needed
Senior friendly hospitals	*literature and best practice review *focus groups with seniors on what they would like to see in a senior friendly hospital (partnership with Patient Voices Network)	*identify pilot hospitals to implement *evaluate initiatives (including focus groups and satisfaction surveys) and make necessary changes	*implement initiative through remaining hospitals
Palliative Care – see companion document			
Dementia Care – companion document in development	*development and recruitment of a Dementia and Geriatric Lead		
Priority #3: Support Quality of Life in Facility-Based Care	**Year 1**	**Year 1-3**	**Year 3-5**
Physician Support for Residential Care	*promotion of General Practice Services Committee (GPSC) Residential Care Initiative to provide more physician support in residential care	*Northern Health to enter into Memorandum of Understanding with Divisions of Family Practice for GPSC Residential Care services *education opportunities for physicians and health care staff to promote quality residential care * Quality of Life Surveys administered in all NH owned Residential Care Facilities	*respond to areas of concern identified in survey results. * re-survey and measure improvement in quality care every eighteen to twenty four months.
Determine the projected future needs for facility-based care in Northern Health.	*review residential care bed modeling scenarios including application of Residential Assessment	*investigate and identify opportunities and barriers for options for alternate facilities and	*trial a group home for people with dementia that are able to perform their

	Instrument (RAI) data to ensure only persons who meet residential criteria are in residential care. When residential care is identified as not appropriate will work with residents and families to return the resident to a more appropriate level of care (assisted living, group home, own home with supports).	levels of care (i.e. group homes for people living with dementia, development of Dementia Cottages)	activities of daily living but need supervision for safety reasons (wandering, forgetting to turn off the stove etc.)
Risk Aversion	*identify staff, resident and family perception of risk in facility care *develop a working group to identify best practices that will ensure a balance between quality of life and risk	*implementation of guidelines of risk across facilities *monitor number of safety incidents residents are involved in due to perceived risky behaviors (i.e. falls occurring when residents are walking in the outdoor spaces)	*evaluation of guidelines impact on facility care and quality of life *review number of safety issues and update guidelines where appropriate

Appendix B: Idealized Northern Health System of Services



Appendix C: Background Information and Tables

Responding to an Aging Population

Table A: Northern Health Population Projection 2010-2030

Northern Health: Population Projection						Population Change 2015 - 2030	
Broad Age Groups	**2010**	**2015**	**2020**	**2025**	**2030**	number	%
<20	75,268	71,885	71,342	71,101	70,041	-1,844	-2.6
20-44	97,586	100,448	101,010	100,879	100,990	542	0.5
45-64	83,861	85,850	83,683	78,959	76,528	-9,322	-10.9
65+	31,968	40,646	51,604	62,982	72,454	31,808	78.3
Total Population	288,683	298,829	307,639	313,921	320,013	21,184	7.1
Focus on Seniors	**2010**	**2015**	**2020**	**2025**	**2030**	number	%
65+	31,968	40,646	51,604	62,982	72,454	31,808	78.3
75+	12,577	15,419	19,670	25,543	32,470	17,051	110.6
85+	3,035	4,333	5,840	7,010	8,923	4,590	105.9
90+	1,034	1,630	2,417	3,120	3,650	2,020	123.9

BC Stats: Population Projections: PEOPLE 2013: Published August 2013

Pressure on Inpatient Beds

The following table (Table B) provides Northern Health's current staffed and in operation acute bed complement contrasted with beds required to meet current needs and those projected over the next 15 years (2025). The projection assumes occupancy rates no greater than 95 per cent and 90 per cent.

Table B: Northern Health Acute Care Bed Needs

	Current 2012		Modeled 2012			Modeled 2017			Modeled 2022			Modeled 2027		
HSDA	Beds	Occupancy	Beds	Occupancy	Variance from 2012	Beds	Occupancy	Variance from 2012	Beds	Occupancy	Variance from 2012	Beds	Occupancy	Variance from 2012
Northeast	108	86.9%	109	88.9%	1	127	90.0%	19	151	90.0%	43	179	90.0%	71
Northern Interior	273	99.6%	316	93.1%	43	359	93.3%	86	403	93.3%	130	450	93.3%	177
Northwest	124	94.6%	121	88.1%	-3	137	89.6%	13	156	90.0%	32	174	90.0%	50
Northern Health	**505**	**95.6%**	**546**	**91.2%**	**41**	**624**	**91.8%**	**119**	**710**	**91.9%**	**205**	**804**	**91.8%**	**299**

To meet targeted occupancy rates, Northern Health would need an additional 41 acute beds. As the population ages, this pressure increases significantly – to the point where an additional 299 beds would be needed by 2027.Clearly, the aging of the population (near doubling of the 65+ and 75+ subpopulations in the next ten years) will exert a dramatic pressure on Northern Health's acute inpatient services. Indeed nearly the entire 299 bed pressure which represents an increase of

approximately 104,000 inpatient days can be attributed to increases in the seniors/elderly population.

Alternative Levels of Care (ALC)

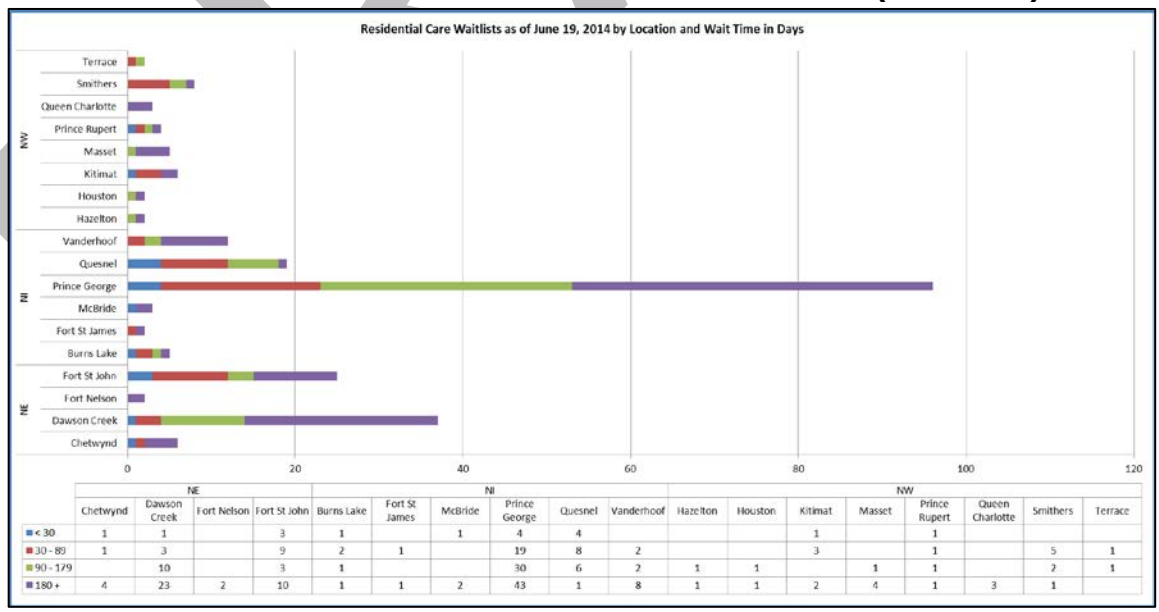
Table C: Northern Health ALC Inpatient Days

Alternative Level of Care 2013/14					
HSDA	**Facility**	**Total Inpatient Days (Acute + ALC)**	**Acute Inpatient Days**	**ALC Days**	**ALC Days as a % of Inpatient Days**
NE	Chetwynd	1,748	1,370	378	22%
	Dawson Creek	15,939	11,686	4,253	27%
	Fort Nelson	2,947	1,880	1,067	36%
	Fort St. John	15,049	8,423	6,626	44%
NE Total		35,683	23,359	12,324	35%
NI	GR Baker Memorial	13,541	10,201	3,340	25%
	Lakes District	3,591	2,829	762	21%
	MacKenzie	1,035	1,035	-	0%
	McBride	1,063	956	107	10%
	St John	6,615	3,693	2,922	44%
	Stuart Lake	1,727	1,700	27	2%
	UHNBC	76,720	63,907	12,813	17%
NI Total		104,292	84,321	19,971	19%
NW	Bulkley Valley	4,968	4,390	578	12%
	Kitimat General	5,326	5,027	299	6%
	Mills Memorial	15,068	12,936	2,132	14%
	N. Haida Gwaii	838	545	293	35%
	Prince Rupert	9,261	7,188	2,073	22%
	QCIGH	1,533	1,245	288	19%
	Wrinch Memorial	3,104	1,942	1,162	37%
NW Total		40,098	33,273	6,825	17%
Northern Health Total		180,073	140,953	39,120	22%

Source: NH MIS data, June 2014

Residential Care Wait Times & Bed Pressures

Table D: Northern Health Residential Care Wait Times (June 2014)



	NE				NI						NW							
	Chetwynd	Dawson Creek	Fort Nelson	Fort St John	Burns Lake	Fort St James	McBride	Prince George	Quesnel	Vanderhoof	Hazelton	Houston	Kitimat	Masset	Prince Rupert	Queen Charlotte	Smithers	Terrace
< 30	1	1		3	1		1	4	4				1		1			
30 - 89	1	3		9	2	1		19	8	2			3		1		5	1
90 - 179		10		3	1			30	6	2	1	1		1	1		2	1
180 +	4	23	2	10	1	1	2	43	1	8	1	1	2	4	1	3	1	

Source: Procura Information System. 27/6/2014

Table E: Northern Health Residential Care Bed Projections - 2012, 2017 & 2022

	2012 Current	2012 Projections*		2017 Projections*		2022 Projections*	
HSDA	Beds Actual	Beds Projected	Variance from 2012 Actual	Beds Projected	Variance from 2012 Actual	Beds Projected	Variance from 2012 Actual
Northeast	245	335	90	377	132	420	175
Northern Interior	580	662	82	721	141	777	197
Northwest	267	315	48	343	76	368	101
Northern Health	**1092**	**1312**	**220**	**1441**	**349**	**1565**	**473**

*projections model required bed capacity to meet 90% in 90 days placement target

Aboriginal Health

***Both graphs: Statistical Profile of Aboriginal Peoples by Health Authority; 2006. BC Stats April 2009. http://www.bcstats.gov.bc.ca/StatisticsBySubject/AboriginalPeoples.aspx*

Table F: 2006 Aboriginal Population Information

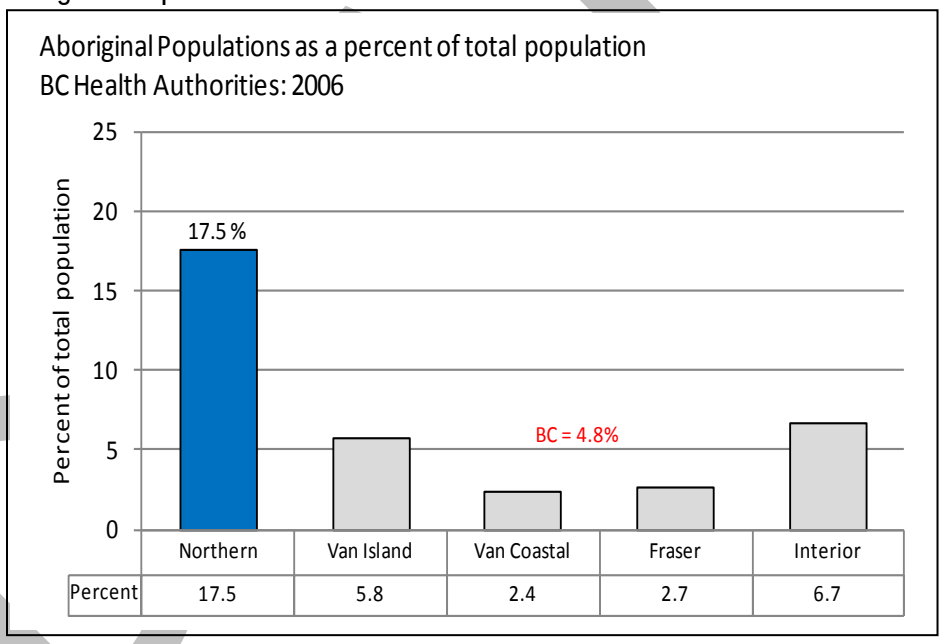
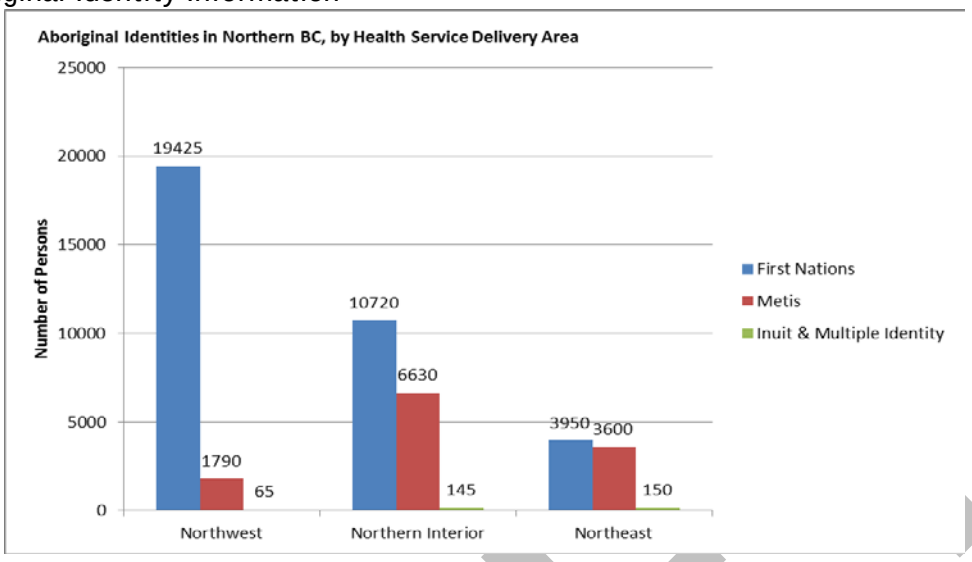


Table G: Aboriginal Identity Information



Dementia Care

Table H: Northern Health Population 75+: 2013 & 2023

Year	Population 75+	Frailty		CPS 2: Mild		CPS 3-4: Moderate		CPS 5-6: Severe	
	P.E.O.P.L.E. 2012	#	% of Pop	#	% of Pop	#	% of Pop	#	% of Pop
2013	14,307	1430	10.0%	440	3.1%	606	4.2%	300	2.1%
2023	23,317	2331	10.0%	717	3.1%	988	4.2%	489	2.1%

Sources: Northern Health HCC 2014, MOHS Health System Matrix 5.0

Note: -This is a straight line projection

-The frailty figure (from the Health System Matrix 5.0) does not capture all those whom we have identified as having dementia. Likewise, it does not count individuals who may be case managed, but choose to purchase their own services (the community segment captures "People who are living in publicly funded Assisted Living units or living in their own homes receiving publicly funded home support.")

Appendix D: Definitions (Facilities, Services, Terms)

TYPES OF FACILITIES[13]

Adult Day Centers

- Adult day centers provide an organized program of personal care, health care and therapeutic social and recreational activities in a group setting that meets client health care needs and/or caregiver needs for respite.

Home Care

- Home Care is health services provided in clients' homes. The services may be provided by a number of professionals including: nursing, physical therapist or occupational therapist, and dietician. All services are for clients who may require acute, chronic, palliative or rehabilitative support.

Home Support

- Home Support services are direct care services provided by unregulated care providers to clients who require personal assistance with activities of daily living, such as mobilization, nutrition, lifts and transfers, bathing, grooming and toileting. There is also the provision for services to include delegated tasks from professionals – an example is medication management.

Assisted Living

- Assisted Living services are provided in a supportive accommodation environment for clients with physical and functional health challenges who can no longer reside at home but are able to make decisions on their own behalf. Each unit incorporates all of the following: private housing unit with a lockable door; personal care services; and hospitality services that include: meals, housekeeping, laundry, social and recreational opportunities and a 24-hr response system.

Residential Care

- Residential care services provide a secure, supervised physical environment, accommodation, and care to clients who cannot have their care needs met at home or in an assisted living residence. Some residential care facilities offer Special Care Units; short term services such as: Respite; Convalescent Care; and hospice palliative care. Other residential care facilities provide long term services only, termed Complex Care.

Special Care Units

- Within residential care services, some facilities provide specialized supports and constant supervision for medically stable, mobile seniors living with dementia.

Residential Care Short Term Services:

- Respite
  - Residential respite care is intended to allow the client's principle caregiver a period of relief, or to provide the client with a period of supported care to increase independence.
- Convalescent
  - Residential convalescent care is provided to clients with defined and stable care needs who require a supervised environment for reactivation or recuperation usually prior to discharge home, most commonly following an acute episode of care.

[13] Definitions from Home and Community Care iportal Page: https://iportal.northernhealth.ca/clinicalresources/hcc/Pages/default.aspx.

- Hospice palliative care
    - Residential hospice palliative care is provided to clients who require support with comfort, dignity and quality of life in the final days or weeks of their lives and is distinct from end-of-life care provided to residential care clients who become palliative.

Residential Care Long Term Services:

- Complex Care
    - Residential complex care is provided for clients who are assessed as needing 24-hour professional nursing supervision and care needs that cannot be met in the client's home; or the degree of risk is not manageable within available community resources/services; the client has an urgent need; the client has been investigated and treated for medical causes and the need continues; the client may also have a caregiver who is living with unacceptable risk or there is no caregiver.

Primary Care Home

- A primary care home is "a place where people establish a long-term relationship with a multidisciplinary team and, through this team, receive health care and are supported in managing their own health."[14] The primary care home consists of physicians, the infrastructure that supports their practices, and a multidisciplinary team. Care can be provided in a shared location or virtually. The multidisciplinary team helps the frail elderly, perinatal and other specialized populations, such as people with complex conditions like chronic disease or mental health/addictions issues.

[14] Northern Health. (2012). *Northern Health's Idealized System of Services: Working Framework*. Prince George, BC: Northern Health.

Appendix E: Regional Inventory of Related Services by Community

				Northern Health Community Based Services										
HSDA	LHA	LHA Name	Community	HCC Case Management	*ADC / ADP	HS	HCN	HOP	Community Rehab	Meals On Wheels	CSIL	Community Nutrition	Social Work	HSCL
Northwest	50	Queen Charlottes	Masset	Yes	Yes	Yes	Yes	Yes	OT	Yes	No	No	No	No
Northwest	50	Queen Charlottes	QCC Village	Yes	Yes	Yes	Yes	Yes	OT	No	No	No	No	No
Northwest	50	Queen Charlottes	Skidegate	Yes	Yes	Yes	Yes	Yes	OT	No	No	Yes	No	No
Northwest	51	Snow Country	Stewart	Yes	No	Yes	Yes	Yes	No	No	No	No	No	No
Northwest	52	Prince Rupert	Prince Rupert	Yes	Yes	Yes	Yes	Yes	OT	MOW3	No	Yes	No	No
Northwest	53	Upper Skeena	Hazeltons	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No
Northwest	54	Smithers	Smithers	Yes	Bulkey Lodge	Yes	Yes	Yes	OT / PT	MOW2	No	No	No	No
Northwest	54	Smithers	Houston	Yes	Yes	Yes	No	Yes	No		No	No	No	No
Northwest	80	Kitimat	Kitimat	Yes	Yes	Yes	Yes	Yes	No	MOW3	Yes	No	No	No
Northwest	87	Stikine	Atlin	Yes	No	Yes	Yes	Yes	No			No	No	No
Northwest	88	Terrace	Terrace	Yes	Terrace View	Yes	Yes	Yes	OT / PT	MOW3	Yes	No	No	Yes
Northern Interior	55	Burns Lake	Burns Lake	Yes	Pines	Yes	Yes	Yes	OT / PT	MOW2	Yes	No	No	No
Northern Interior	55	Burns Lake	Southside	Yes	No	Yes	No	Yes	OT	No		No	No	No
Northern Interior	56	Nechako	Vanderhoof	Yes	StrtNchko Mnr	Yes	Yes	Yes	OT	No	Yes	No	No	No
Northern Interior	56	Nechako	Fort St James	Yes	No	Yes	Yes	Yes	No	No		No	No	No
Northern Interior	56	Nechako	Fraser Lake	Yes	No	Yes	Yes	Yes	No	No		No	No	No
Northern Interior	57	Prince George	Prince George	Yes	Rainbow	Yes	Yes	Yes	OT / PT	MOW1	Yes	No	Yes	Yes
Northern Interior	58	Prince George	Mackenzie	Yes	No	Yes	Yes	Yes	No	MOW1	No	No	No	No
Northern Interior	57	Prince George	Valemount	Yes	No	Yes	Yes	Yes	No	No	No	No	No	No
Northern Interior	57	Prince George	McBride	Yes	No	Yes	Yes	Yes	No	No	No	No	No	No
Northern Interior	28	Quesnel	Quesnel	Yes	Dunrovin	Yes	Yes	Yes	OT / PT	MOW1	Yes	No	Yes	Yes
Northeast	59	Peace South	Dawson Creek	Yes	Rotary	Yes	Yes	Yes	OT / PT	No	Yes	Yes	Yes	Yes
Northeast	59	Peace South	Tumbler Ridge	Yes	No	Yes	Yes	Yes	No	No	No	No	No	No
Northeast	59	Peace South	Chetwynd	Yes	Yes	Yes	Yes	Yes	OT / PT	No	No	Yes	No	No
Northeast	60	Peace North	Ft. St John	Yes	Peace Villa	Yes	Yes	Yes	OT / PT	MOW3	Yes	Yes	Yes	Yes
Northeast	60	Peace North	Hudsons Hope	Yes	No	Yes	Yes	Yes	No	No	No	No	No	No
Northeast	81	Fort Nelson	Fort Nelson	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No

Definitions & Notes

ADC / ADP: Adult Day Centre / Programs (ADC / ADP) - many of the ADC / ADP are physically delivered in our Acute care / residential facilities. ADC / ADP assist seniors and adults with disabilities to continue to live in their own homes by providing supportive group programs and health services that assist with daily activities of living and give clients a chance to be more involved in their community.

Case Management: Case Managers act as coordinators to help eligible clients obtain Home and Community Care services. They determine the nature, intensity and duration of services that would best meet clients' needs and arrange their services

Community Nutrition: Community Dieticians assist clients with education and choices around healthy eating and may provide instruction and techniques for feeding clients with developmental challenges.

Community Rehabilitation: Community Rehab (OT/PT) is a professional service, delivered to eligible clients in the community by rehabilitation therapists who provide assessment and treatment to ensure a client's home is suitably arranged for their needs and safety. The availability of staff strongly influences our ability to provide OT /PT services. Consequently there can be quite a bit of variability in the levels of service provision.

CSIL: Choices in Supports for Community Living (CSIL) is an alternative option for eligible home support clients. CSIL was developed to give British Columbians with disabilities and high-intensity care needs more flexibility in managing their home support services. CSIL is a "self-managed model of care." Clients receive funds directly for the purchase of home support services. They assume full

responsibility for the management, coordination and financial accountability of their services, including recruiting, hiring, training, scheduling and supervising home support workers.

HCN: Home Care Nursing (HCN), or Community Nursing, is professional services, delivered to eligible clients in the community by registered nurses. Nursing care is available on a non-emergency basis for British Columbians requiring acute, chronic, palliative or rehabilitative support.

HOP: Home Oxygen Program (HOP) is regionally coordinated by Northern Health. Participation requires an application from a physician. Clients, often seniors, may have such conditions as Emphysema or COPD. Presently there are more than 600 clients participating in the HOP across northern BC

HPC: The Hospice Palliative Care program (HPC) is a core service provided to all patients and their families. Registration of the patient with the HPC program is required in order to access identified services and ensure timely access to HPC. Registration requires written confirmation, by a physician, that the patient meets the palliative care status criteria as outlined in the program. Northern Health also offers access to publicly subsidized hospice palliative care beds in a number of our residential care facilities.

HS: Home Support (HS) services are designed to help eligible clients remain independent and in their own home as long as possible. Home Support provides personal assistance with daily activities, such as bathing, dressing and grooming. Home Support services complement and supplement, but do not replace the efforts of individuals to care for themselves with the assistance of family

HSCL: Health Services for Community Living (HSCL) program provides non-emergency nursing, rehabilitation, dietary and dental hygiene services to adults who live in the community and have a developmental disability and are eligible for services under Community Living British Columbia (CLBC).

Meals on Wheels: Meals on Wheels (MOW) is a program that prepares and delivers meals for clients to help ensure they can remain healthy, well-nourished and independent in their living circumstances:
There are 3 MOW Delivery models
MOW 1: Northern Health contracts for food preparation and distribution: Prince George (Laurier Manor A/L) and Quesnel and Mackenzie
MOW2: Northern Health prepares the meals at hospital facilities; Contractor takes care of distribution: Burns Lake and Smithers
MOW3: Northern Health prepares the meals and provides distribution: Haida Gwaii (Queen Charlottes), Kitimat, Terrace, Fort St John and Prince Rupert

Social Work: Social Workers help clients to navigate, coordinate and schedule services as well as address psycho-social needs of the clients.

Other Definitions

HSDA: Health Service Delivery Area (HSDA) is a geographic area used for health service governance as well as health services planning, delivery and analysis.

LHA: Local Health Area (LHA) is a geographic area that we use for health services planning and analysis - similar in size to school districts

Service Definitions: Northern Health
http://www.northernhealth.ca/YourHealth/HomeandCommunityCare/HomeandCommunityCareServices.aspx
Service Definitions: BC Ministry of Health
http://www2.gov.bc.ca/gov/topic.page?id=95C3022D0E3A422BBBE3F99B03F035C4

Appendix F: Dementia Related Education and Initiatives

Northern Health is involved in two provincial and one local initiative that collectively build on each other to develop a continuum of assessment, intervention and action within the concept of a person centered model of care.

PIECES (Physical, Intellectual, Emotional Health, Center or Focus in Care, Environment individual interacts within, Social Self and Support Network) is an acronym used to describe a best practice learning and development initiative that provides an approach to understanding and enhancing care for individuals with complex physical and cognitive/mental health needs and behavior changes. PIECES is a holistic, person and care partner-directed model which enhances capacity at the individual, TEAM, organization and system levels to support the care of the older individual living with complex chronic disorders, including cognitive and/or mental health needs and associated responsive behaviors. PIECES provide a practical framework for assessment and supportive care strategies using a comprehensive interprofessional person-directed approach. This framework complements and integrates other strategies, approaches and relevant bodies of knowledge. A common set of values, a common language for communicating across the system and a common yet comprehensive approach to collaborative care are embedded within the model and supports a shared accountability for person and care partner-directed care across the system of care focused on health promotion, prevention and chronic disease management.[15] (PIECES Consult Group, 2009)

[15] (PIECES Consult Group, 2009)

Gentle Persuasive Approach (GPA) in an innovative dementia care curriculum based on a person centered approach. Designed for interdisciplinary point of care staff across a variety of sectors. The education session is evidence-based, interactive and practical. The information assists care providers to fully understand responsive behaviors in order to be able to respond effectively and appropriately to the needs of a person with dementia. Reducing Antipsychotics in Residential Care is a work focused on the appropriate use of antipsychotic medications in residential care. One in three long term care (LTC) residents in Canada is on antipsychotic medication without a diagnosis of psychosis from a doctor. There is also significant variation between rates in different long term care homes, pointing to the potentially inappropriate use of these medications. Research has shown that antipsychotic practices are, at best, only minimally effective in managing behavioural issues and have serious risks associated with them, especially in the elderly.[16] Research shows that 33% of residents in British Columbian residential care homes may have their quality of life affected because they are taking potentially inappropriate antipsychotic medications.[17]

Canada is taking steps to make quality improvements in this area. New accreditation standards, that will mandate LTC facilities to assess the appropriateness of antipsychotic use and use this information to improve services, will be in effect in 2015. Northern Health will aim to provide a person centred non-pharma logical approach to managing behaviors associated with dementia. Support for this work has occurred by partnering with the Canadian Foundation for Healthcare Improvement and BC Patient Safety and Quality Council to implement initiatives in Residential Care facilities in Northern Health, this work will continue through education and support of staff until it is an embedded best practice.

[16] taken from http://www.cfhi-fcass.ca/Elearning/spreading-healthcare-innovations-initiative/reducing-antipsychotic-medication-use-in-long-term-care June 2015

[17] Canadian Institute for Health Information. (2014). Your Health System. (Retrieved 2015, from http://yourhealthsystem.cihi.ca/hsp/indepth?lang=en#/indicator/008/2/C9001/)

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Dysphagia Management

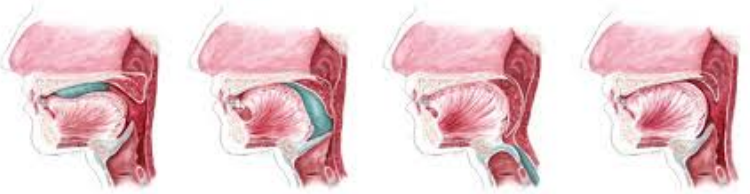
northern health

the northern way of caring

What is dysphagia?

Dysphagia is a term used to describe difficulty swallowing. Dysphagia refers to difficulty, discomfort and disorders of swallowing. Swallowing involves 50 pairs of muscles and many nerves in order to receive food, prepare it in the mouth and move it to the stomach. Dysphagia can occur at any stage of the swallow including oral (in the mouth), pharyngeal (in the throat) and/or esophageal (in the esophagus) stage.

Dysphagia ranges in severity. Some individuals may have difficulty safely swallowing various consistencies of foods and/or liquids. Others may be completely unable to swallow anything, including saliva.



Some common signs and symptoms of dysphagia

- Poor management of saliva
- Recurrent episodes of pneumonia
- Slow rate of eating or excessive chewing
- Negative reaction to food or drink, pulls away from cup, refusal
- Recent unexplained weight loss
- Multiple swallows during a single bite or sip
- Choking or gagging during or after eating or drinking
- Coughing during or after eating or drinking
- Bringing food back up or regurgitation from the mouth or nose

- Pain when swallowing
- Frequent throat clearing during or after eating or drinking
- Intake of less than 75% of meal
- Loss of food from the mouth
- Loss of appetite
- Frequent low grade fever
- Secretions from nose or watery eyes at meal times
- Wet or gurgly vocal quality during or after eating or drinking
- Food remaining in mouth after swallowing (pocketing)

What are the causes of dysphagia?

Swallowing difficulties occur due to problems with the control and function of the muscles and structures involved in any part of the swallowing process. Some common diagnoses related to dysphagia in adults are:

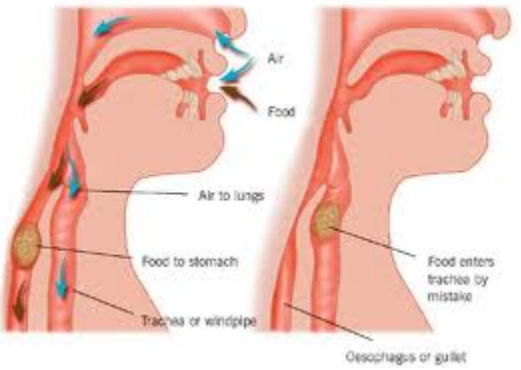
- Neurological disorders (MS, ALS, Huntington's, Parkinson's)
- Cardiovascular accidents (Stroke)
- Acquired brain injuries
- Dementia (Alzheimer's)
- Muscular conditions (Bell's palsy, Cerebral Palsy, Myasthenia Gravis)
- Head/neck cancers
- Airway obstructions/conditions (COPD)
- Gastro-intestinal issues (GERD)
- Xerostomia (Dry mouth)
- Spinal cord injuries

Problems associated with dysphagia

If swallowing difficulties do not receive proper attention and treatment it can result in one or more of the following: **dehydration, malnutrition, reduced enjoyment in eating/ drinking, embarrassment, isolation, airway obstruction, aspiration pneumonia/respiratory infections, urinary tract infections, reduced quality of life and/or death.**

What is aspiration?

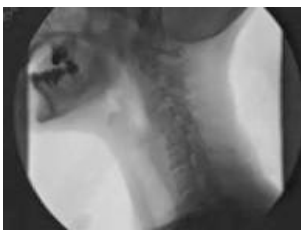
Aspiration is when foods or liquids enter into the airway instead of going into the esophagus and into the stomach. Typically, the body's natural response to aspiration is to cough and try to remove the substance from the airway. However, not all individuals have the ability or sensation to do this. In these cases, the individuals are at risk of developing aspiration pneumonia. Aspiration pneumonia is caused by foreign substances entering into the lungs, which can cause an infection. This infection can be life threatening, especially in those individuals who already have a compromised immune system.



How is dysphagia diagnosed?

A careful review of the signs and symptoms is required in order to assess for the presence of dysphagia. Often there are many professionals involved including Physicians, nursing staff, occupational therapists, registered dietitians and speech-language pathologists. This team works together in order to complete a comprehensive physical and functional assessment. This may include the following:

- A careful review of the individual's history, medical conditions and symptoms
- Oral motor status examination (examining strength, movement and coordination of oral muscles involved in swallowing)
- Observation of the individual eating/drinking (observing posture, behaviour, oral movements and symptoms during eating and drinking)
- Utilizing a stethoscope to listen to the individual's respirations and throat before, during, and after the swallow (known as cervical auscultation)
- Possible instrumental examinations such as modified barium swallow/video fluoroscopic swallow study (involves a moving x-ray of the individual swallowing different consistencies of foods and/or drinks mixed with barium, in order to identify areas of difficulty)
- Possible endoscopic assessment (a lighted scope is inserted through the individual's nose, and then the swallow can be viewed on a screen)



Management of dysphagia

Treatment of dysphagia is specific to the individual and is based on the specific difficulties the individual is experiencing. After a comprehensive assessment, your dysphagia practitioner will determine the most appropriate treatment plan. Treatment may include but is not limited to:

- Postural changes (modification of body position during and after meals)
- Food/drink consistency changes (identifying the safest food and liquid consistencies to consume)
- Swallowing techniques (strategies to improve effectiveness of swallow such as repeat swallows, chin tuck position etc.)
- Swallowing exercises (to improve muscle strength, range of motion and/or coordination of swallowing and facial muscles)
- Rate/volume adaptations (adapting the rate, volume and amount of food eaten at a meal)
- Use of adaptive materials (such as weighted or angled utensils, scoop plates etc.)
- Environmental set up (creating an environment that is free from distractions and noise)

These treatments may help reduce the risks for complications associated with dysphagia; they do not "cure" the problems experienced. Rate and degree of improvement depend on a number of factors such as age, severity of the problem, cause of the problem, co-existing

medical conditions and commitment of the individual and their caregivers. In severe cases of eating and swallowing disorders, non-oral, such as tube feeding, may need to be considered.

Texture Modified Diets

When an individual has dysphagia, it makes eating and drinking difficult and they may not be able to take in enough to meet their daily nutritional needs. This can lead to dehydration and malnutrition. Therefore an individual with dysphagia may be prescribed a specific texture of food or thickness of fluid that is easier and safer for them to swallow. It is important for family and/or care givers to understand that the modified food or drink consistencies can be very helpful for an individual with dysphagia. If the prescribed diet is not followed it causes a significant health risk. The following are some of the modified consistencies used for individuals with dysphagia in Northern Health.

Dental soft foods are easy to chew and swallow. Examples include thinly sliced and moist meat, bread and butter, bananas and canned fruits, soft cooked vegetables.

Cut Up foods are easy to swallow and are easy to pick up on a fork. They are typically cut into a 2x2 cm piece. Examples include: soft meats cut into small pieces, bread and butter, bananas and cut up fruit, cooked vegetables and salad.

Minced foods are foods that require minimal chewing and are finely cut. Examples include moist, minced meats, soft minced vegetables and fruits, smooth soups.

Minced and pureed foods require minimal or no chewing. Examples include pureed (smooth consistency such as hummus) vegetables, fruits, bread and grain products, soups, minced meats and casseroles.

Pureed foods are a smooth consistency and do not require chewing. Examples include smooth texture meats, vegetables, fruits and grain products.

Thickened fluids comes in three different levels of thickness, this includes drinks and also food that are liquids such as soups.

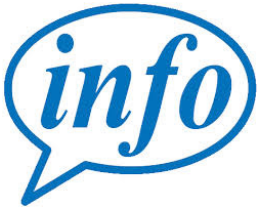
- *Nectar thick fluids* – fluids can to be sipped from a cup or through a straw and will slowly drip off a spoon that is tipped, leaving a thin coating on the spoon. (e.g. – tomato juice, eggnog, commercially prepared nectar thick juice, milk, etc.)
- *Honey thick fluids* – fluids that can be eaten with a spoon but do not hold their shape on a spoon. Can be sipped from a cup but are too thick to be sipped through a straw. (e.g. – Yogurt, tomato sauce, commercially prepared honey thick juice, etc.)
- *Pudding thick fluids* - fluids that are very thick and pudding-like and must be eaten with a spoon. Fluids hold their shape on a spoon and are too thick to be sipped from a cup. (e.g. – applesauce, soups thickened to pudding thick, commercially thickened fluids, juice, etc.)

Tips for safe eating and drinking

- Eat and drink only when fully awake
- Sit up straight in a chair if possible
- Inform staff if you notice any signs or symptoms indicating that someone may have swallowing difficulties
- Ensure clients are wearing their dentures, hearing aids and glasses during meals

- Ensure dentures fit properly
- Attend routine dental appointments
- Follow an oral hygiene routine before and after meals
- Encourage small bites/sips
- Be sure the first bite/sip is swallowed before giving the next bite/sip
- Encourage a slow rate of eating/drinking
- Remain sitting upright for 30 minutes after eating or drinking
- Encourage the individual to swallow twice per mouthful
- Watch for signs/symptoms of aspiration (coughing, wet vocal quality, choking, lung congestion)
- Check for foods remaining in the mouth and cheeks after meals
- Provide verbal cues to swallow as necessary
- Provide smaller utensils in order to limit the amount of food presented per mouthful
- Encourage the individual to chew food well
- Encourage the individual to take a drink every few bites

** Some level of risk will remain so that vigilance and adaptation during everyday meals will be required, and may change over time. Caregivers are encouraged to contact the dysphagia practitioner at their site, or the physician responsible, if the ability to eat and swallow safely and enjoyably changes. Additional training can be provided, as requested by the Regional Dysphagia Management Team by contacting them at RDMT@Northernhealth.ca



Where can I go to get more information?

For more information and or assistance with swallowing or feeding concerns please contact the dysphagia practitioner at your site:

Or speak with your family doctor. The Regional Dysphagia Management Team is a resource that can be contacted in order to obtain guidance and clarity around the management of dysphagia as well as where to find general information on the topic. Please contact the team with any questions, concerns or for further information, at the following email address: RDMT@Northernhealth.ca

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The information is a product of The Regional Dysphagia Management Team on behalf of Northern Health, 2014.

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10-500-6047 (IND 03/14)

Regional Dysphagia Management Team

This team was established as a regional resource to build local capacity for managing eating, drinking and swallowing problems for our senior population in residential care

Tysen LeBlond,
Occupational Therapist
Terrace

Shelley Doerksen,
Speech Language Pathologist
(Term ending June, 2016)
Quesnel

Kate Cooke,
Administrative Assistant
Prince George

Susanne Watson,
Team Manager &
Professional Practice Lead, Rehab
Smithers

Amy Horrock,
Registered Dietitian
Prince George

Julie Lidstone,
Speech Language
Pathologist (on maternity
leave until June 2016)
Prince George

The team can be reached at **rdmt@northernhealth.ca** or individually

WHAT WE DO

Mentorship & Consultation:

- Working across Northern Health with dysphagia practitioners such as SLPs, RDs and OTs
- Working collaboratively on challenging cases to develop inter-professional plans of care
- Providing support to the care team either in person, by phone, by e-mail or telehealth

Education and Training:

- Educating nursing staff, care aides and rec staff on the dysphagia screening checklist and other related topics
- Host an annual conference for dysphagia practitioners

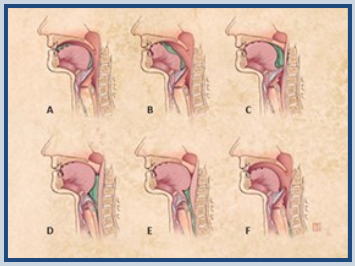
237 Phone / Email Consultations

197 Site Visits

Survey Findings
Practitioners report confidence ↑ 4.9 to 6.2

Other work we do:

- Establishing processes that improve standards of care
- Collecting data that informs and supports our work
- Provide resources for family or staff education

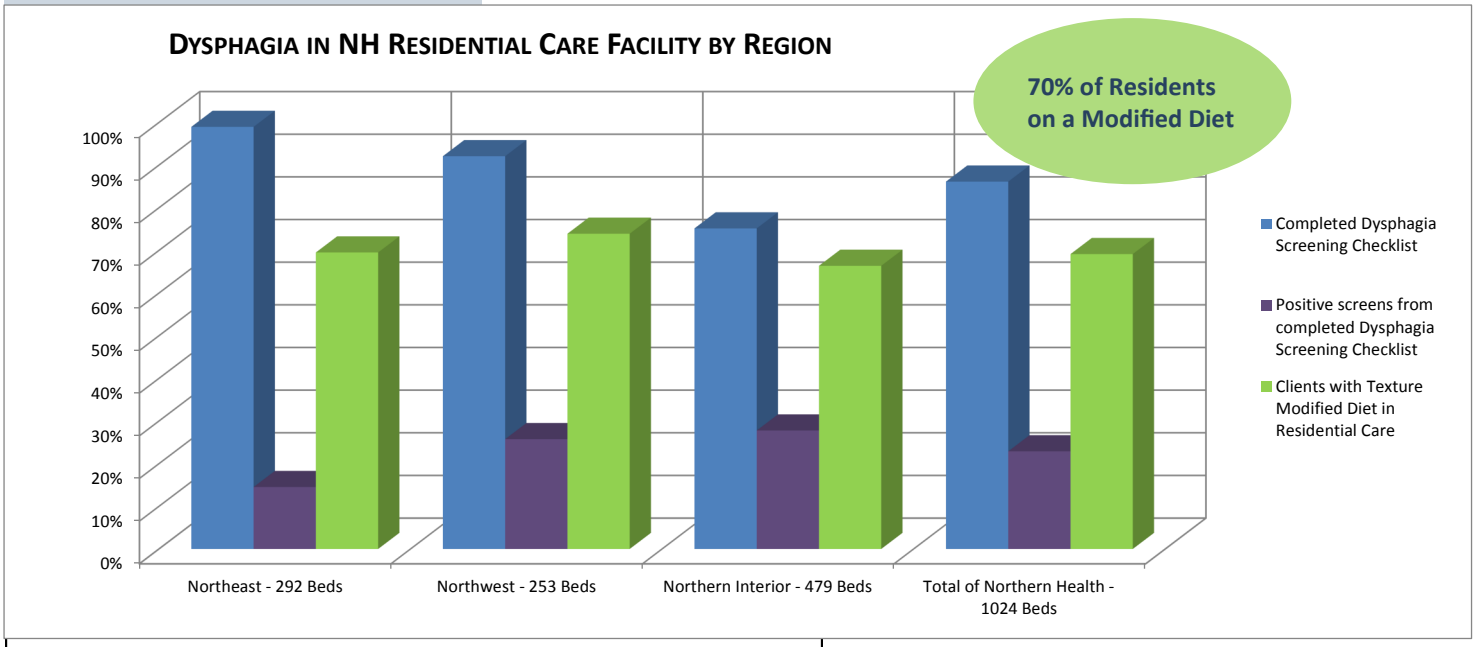


AIM Statement

- We will build the confidence and capacity for dysphagia practitioners to work to the appropriate level of competency within a interprofessional framework.
- We will improve the QoL and ensure the safety of all residents at risk for, and experiencing dysphagia by establishing best practices for Meal Time Management.

Regional Dysphagia Management Team

This team was established as a regional resource to build local capacity for managing eating, drinking and swallowing problems for our senior population in residential care



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Dysphagia Screening Checklist Page 1 of 2 PATIENT LABEL

Mealtime observation
Training mandatory for use of the screening checklist

Meal observed: ☐ Breakfast ☐ Lunch ☐ Dinner
Meal consisted of: _____
Current diet texture: _____ Current fluid consistency: _____
Length of time taken to complete meal: ☐ Less than 30 minutes ☐ 30 - 60 minutes ☐ 60 minutes or more
Does the resident feed themselves? ☐ Yes ☐ No ☐ Sometimes
If sometimes, please describe what assistance is needed (cueing, set-up, hand over hand, etc.): _____

1.	Does the resident or caregiver report having difficulty or pain during swallowing during the last 7 days?	☐ Yes ☐ No
2.	Has the resident reported food getting "stuck" in their throat within the last 7 days?	☐ Yes ☐ No
3.	Does the resident have difficulty swallowing medication as it is currently given?	☐ Yes ☐ No
4.	Does the resident have decreased alertness/level of consciousness on a regular basis when eating?	☐ Yes ☐ No
5.	Has the resident experienced a choking incident in the past 7 days? If so, describe: _____	☐ Yes ☐ No
6.	Does the resident have history of recurrent pneumonia or respiratory infections (not COPD, CHF or oxygen therapy related)?	☐ Yes ☐ No
7.	Does the resident have a persistant cough during or after meals?	☐ Yes ☐ No
8.	Does the resident show a lack of insight during meals which makes them unsafe while eating or drinking (eating too quickly, taking huge bites)?	☐ Yes ☐ No
9.	Does the resident have a wet, gurgly or hoarse sounding voice after eating/drinking?	☐ Yes ☐ No
10.	Does the resident clear their throat regularly during/after meals?	☐ Yes ☐ No
11.	Does the resident have difficulty breaking down food (spitting out food, removing bits from mouth)?	☐ Yes ☐ No
12.	Does the resident finish less than 75% of their meal and you suspect that it is directly related to their chewing or swallowing ability?	☐ Yes ☐ No

Comment/difficulties observed: _____

Name: _____ Signature: _____ Title: _____ Date: _____

If you answered "yes" to any of the questions, complete a referral to the dysphagia clinician at your facility.
See reverse for swallowing assessment referral instructions/information.
Referred to dysphagia clinician: ☐ Yes ☐ No

10-500-5029 (LC - Rev. - 01/15)

The Dysphagia Screening Checklist

Captures residents with unmanaged dysphagia

Staff trained on Dysphagia Screening Tool

517 Staff trained In-Person

300 trained by Webinar

In Northern Heath since 2011

- 48 aspiration pneumonias resulting in an acute care transfer
- 18 separate choking incidences reported in PSLS

• RDMT@northernhealth.ca • fax (250) 563-4377

BOARD COMMITTEES V.1 BRD 300

PURPOSE

1. Board committees are a mechanism that permits deeper examination of major areas for which the Board of Directors of Northern Health (the "Board") has governance responsibilities, both continuing and emergent, and supports the Board in handling its responsibilities.
2. Only Directors may serve as voting members on Board Committees.
3. Board committees and their respective mandates are established by the Board, and the Board may vary the committee structure from time to time to meet its governance needs. The current Board committees are:
    - Audit and Finance Committee
    - Governance and Management Relations Committee
    - Performance, Planning and Priorities Committee
4. From time to time the Board may assign exceptional tasks to a committee not captured by the committee's terms of reference.
5. The Board may delegate, by Board motion, specific areas of business to a committee to act on behalf of the Board between Board meetings and the committee must report thereon at the Board meeting immediately following.
6. Board committees are not established to assume functions or responsibilities that properly rest with management.

GENERAL GUIDELINES FOR COMMITTEES

1. Each committee reviews its mandate and terms of reference annually. These are submitted to the Governance and Management Relations Committee (GMR) for review in terms of alignment to policy standards, and then submitted by GMR to the Board for approval.

2. Each year the Board Chair is responsible for proposing to the Board the leadership and membership of each committee to be appointed. This will occur in accordance with the Board and Committee work plans or as needed to fill vacancies during the year.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): February 16 2015 (R)

3. In preparing recommendations for committee membership and leadership, the Board Chair will consult with the President and Chief Executive Officer (the "CEO") and take into account the preferences, skills and experience of each Director. Periodic rotation in committee membership and leadership is to be considered in a way that recognizes and balances the need for new ideas, continuity, and maintenance of functional expertise.

4. The Board Chair will be an ex-officio and voting member of all committees on which the Board Chair is not a formal member.

5. The CEO shall be an ex-officio and non-voting member of all committees.

6. A committee member may be removed or replaced at any time by the Board and will cease to be a member upon ceasing to be a Director of the Board.

7. The number of members and composition of each committee is indicated in each committee's terms of reference.

8. Each committee will normally meet before each Board meeting or more frequently as deemed necessary by the committee. Generally, meetings will be scheduled each year in advance.

9. Business conducted by committees of the Board will not be open to the public (BRD220).

10. Each committee shall have a committee timetable and work plan that outlines when the committee will address each of its duties and responsibilities during the course of the year. The timetable and work plan shall be referenced in the committee's terms of reference, but does not form part of the terms of reference. Changes to the terms of reference require~~s~~ Board approval; changes to the timetable and work plan are the domain of the committee, can be made at any time, and must be recorded in the minutes of the committee. If, in the view of the committee, a work plan change is substantive, the terms of reference and work plan should be referred back to the Board for approval.

11. Notice of the time and place of every committee meeting shall be given in writing or by facsimile or email communication to each regular and ex

officio member of the committee at least 48 hours prior to the time fixed for such meeting provided, however, that a member may in any manner waive notice of a meeting; and attendance at a meeting is a waiver of notice of the meeting, except where a member attends a meeting for the express purpose of objecting to the transaction of any business on the grounds that the meeting was not lawfully called.

12. The Chair of a committee or any two members of a committee may call a meeting of the committee.

13. If a committee Chair is unable to attend or is not present at any meeting of a committee within thirty minutes after the time that the meeting is scheduled to commence, one of the other members of the committee present at the meeting shall be chosen by the committee to preside at the meeting.

14. A committee member may participate in a committee meeting by means of such telephonic, electronic or other communication facilities that permit all persons participating in the meeting to communicate adequately with each other. A member participating in such a meeting by any such means is deemed to be present at the meeting.

15. A quorum for the transaction of business at a committee meeting will be a majority of the voting members, which includes the Board Chair if in attendance as an ex officio member as per #4 above. Questions arising at a meeting will be determined by a majority of votes of the members present. Note: 50% is the majority for a quorum; more than 50% is a majority for the purpose of voting.

16. The committee shall designate a Recording Secretary who will ensure that the minutes of each committee meeting are prepared and given in a timely fashion to each committee member and to the Corporate Secretary. A complete meeting record will be maintained electronically by the Recording Secretary and the Corporate Secretary and shall be made available to Directors and the CEO.

17. A committee may invite such Director or, in consultation with the CEO, such Northern Health employees or consultants as may be considered desirable

to attend meetings and assist in the discussion and consideration of the business of the committee.

18. A committee may, from time to time, require the expertise of outside resources. No outside resource will be retained without the approval of the Board or Board Chair, generally in consultation with the CEO.

19. Committees will provide written reports to the Board through minutes as outlined in #16 above, and will report to the Board at each Board meeting with respect to specific recommendations or advice consistent with its mandate or other responsibilities as assigned by the Board. The Board will take whatever action it deems appropriate.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): February 16 2015 (R)

TERMS OF REFERENCE FOR THE AUDIT AND FINANCE COMMITTEE [PROPOSED REVISIONS AS AT MAY 14,2015] BRD 310

Purpose

The primary function of the Audit and Finance Committee (the "Committee") is to advise the Board of Directors of Northern Health (the "Board) in fulfilling its oversight responsibilities by reviewing financial planning and performance related to the operating and capital budgets, including:

a. The provision of financial information to the Government and other stakeholders
b. The systems of internal controls
c. Compliance with legal and regulatory requirements related to financial planning and performance
d. All audit processes conducted through the office of the Internal Auditor
e. All other external financial audits
f. Financial risk management
g. Oversight of investment management activities

This Committee is not intended to act on behalf of the Board unless specific delegated authorities have been given to it.

Composition and Operations

The Committee shall be composed of not fewer than three directors and not more than five directors. (see Membership section for complete Committee membership details).

The Committee shall operate in a manner that is consistent with the General Guidelines for Committees (BRD 300).

All Committee members shall be both independent and "financially literate" and at least one member shall have "accounting or related financial expertise"[1].

[1] The Board has defined "financial literacy" as the ability to read and understand standard financial reporting. Where there is a requirement for a Director to have "accounting or financial expertise", this

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): February 16 2015 (R)

Northern Health's external auditors and the BC Office of the Auditor General (OAG) shall be advised of the names of the Committee members. The Committee shall meet with the external auditor and the OAG as it deems appropriate to consider any matter that the Committee, auditors or the OAG determine should be brought to the attention of the Board.

Duties and Responsibilities

Subject to the powers and duties of the Board, the Committee will perform the following duties:

A. Financial Performance

The Committee shall:

1. Review and recommend for approval to the Board, financial information that will be forwarded to the Government or made publicly available, including:
   a. The financial content of Northern Health's annual report and other significant reports required by government or regulatory authorities (to the extent such reports discuss the financial position or operating results) for consistency of disclosure with the financial statements themselves
2. Review and approve Northern Health's annual "Statement of Financial Information (SOFI)" (also referred to as "Public Bodies Report)[2]
3. Review normal periodic financial information provided to the Board, including:
   a. Periodic financial statements
   b. Capital budget reports that provide information on both a project and expenditure basis
   c. Annual audited financial statements
4. Request and review various other financial and operational information as needed to fulfill the Committee's oversight responsibilities.

means the Director shall have the ability to analyze and understand a full set of financial statements, including the notes attached thereto in accordance with Canadian GAAP.

[2] In accordance with BRD 300 as a delegated authority from the Board (Oct 19, 2010: Motion Public/10-18)

Author(s): Governance & Management Relations Committee
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4.5. Ensure that:

a. The Board receives timely, meaningful reports that keep it properly informed of Northern Health's financial situation and that provide the information needed for decision-making
b. All reports to the Board clearly display the financial results of each principal area of activity and include cash flow for the period and year-to-date
c. The Board receives, at each meeting, an up-to-date forecast of year-end results, which reflects events to date and known factors which may materially influence either revenue or expense components

5.6. Review and discuss:

a. The appropriateness of accounting policies and financial reporting practices used by Northern Health
b. Any significant proposed changes in financial reporting and accounting policies and practices to be adopted by Northern Health
c. Any new or pending developments in accounting and reporting standards that may affect Northern Health

B. Budget Development

The Committee will, with the assistance of the Chief Financial Officer, make an examination of the budget development process, including:

1. The methodology used to establish the operating budget such as revenue estimates, base assumptions for expense projections, financial risk factors, inflation allowances
2. Planned capital expenditure by category and the projections for expenditures justified by a priority scoring method endorsed by the Committee, including rate of return
3. Alignment/correlation of planned operating and capital budget decisions to the strategic direction of Northern Health

The Committee will review the planned management summary presentation to the Board to ensure that it will provide the Directors with a clear, concise picture of the financial implications of the operating plan and the associated financial risks.

C. Financial Risk Management, Internal Control and Information Systems

The Committee will review and obtain reasonable assurance that financial risk management, internal control and information systems are operating effectively to produce accurate, appropriate and timely financial information.

This includes:

1. Reviewing ~~of~~ Northern Health's financial risk management controls and processes relating to financial planning and performance
2. Reviewing ~~of~~ management steps to implement and maintain appropriate internal control procedures
3. Obtaining reasonable assurance that the information systems are reliable and the systems of internal controls are properly designed and effectively implemented through discussions with and reports from management, the internal auditor and the external auditor
4. Reviewing ~~of~~ the adequacy of security of information, information systems and recovery plans and annually receiving~~e~~ affirmation of security and integrity
5. Monitoring compliance with statutory and regulatory obligations relating to financial planning and performance

Level of Spending Authority

The Committee shall:

6. Develop with management a comprehensive statement of authorities for operating and capital expenditures, in compliance with Northern Health's executive limitations policy, and present these authorities to the Board for approval
7. Monitor compliance with the approved signing authority policy[3] through the internal audit process and recommend to the Board any changes which may be necessary from time to time

D. Internal Audit

The Committee will oversee Northern Health's internal audit function and the

[3] DST 4-4-02-030-P: Finance>Accounts Payable>Signing Authority

internal audit relationship with the external auditor and with management.

This includes:

1. Reviewing ~~of~~ the objectivity and independence of the internal auditor
2. Reviewing ~~of~~ goals, resources and work plans
3. Reviewing ~~of~~ any restrictions or issues
4. Reviewing ~~of~~ significant recommendations and management responses
5. Meeting periodically and at least twice per year, with the Regional Director of Internal Audit without management present
6. Reviewing ~~of~~ proposed changes in the internal audit function

E. External Audit

The Committee will review the planning and results of audit activities and the ongoing relationship with the auditor.

This includes:

1. Assessing the performance of, and recommending to the Board for approval, engagement of the auditor
2. Reviewing ~~of~~ the annual audit plan, including but not limited to the following:
   a. engagement letter
   b. objectives and scope of the external audit work
   c. materiality limit
   d. areas of audit risk
   e. staffing
   f. timetable
   g. proposed fees
3. Meeting with the external auditor to discuss Northern Health's annual financial statements and the auditor's report including the appropriateness of accounting policies and underlying estimates
4. Reviewing and advising the Board with respect to the planning, conduct and reporting of the annual audit, including but not limited to:
   a. Any difficulties encountered, or restrictions imposed by management, during the annual audit
   b. Any significant accounting or financial reporting issue

c. The auditor's review of Northern Health's system of internal controls, procedures and documentation
d. The post audit or management letter containing any findings or recommendations of the external auditor, including management's response thereto and the subsequent follow-up to any identified internal control weaknesses
e. Any other matters the auditor brings to the Committee's attention

5. Reviewing any disagreements between management and the auditor regarding financial reporting
6. Reviewing and receiving assurances on the independence of the auditor
7. Reviewing the internal audit services and non-audit services to be provided by the auditor's firm or its affiliates (including estimated fees), and consider the impact on the independence of the audit
8. Meeting periodically, and at least annually, with the auditor without management present

F. Banking and Investment Management Activity

The Committee shall:

1. Annually review the banking policy and recommend any needed revisions to the Board.
2. Receive, at minimum, an annual report of all bank accounts, including their purposes and signing officers.
3. Annually review the investment policy for those handling Northern Health's funds and recommend any needed revisions to the Board
4. Receive, at minimum, semi-annual reports from the Chief Financial Officer on Northern Health's investment portfolio
5. Where appropriate, recommend the appointment, renewal or replacement of fund managers
6. Regularly review the performance of fund managers, if any, against the investment policy

G. Other

The Committee shall:

1. Oversee the organizational and Board processes that foster a productive relationship with the Regional Hospital Districts (RHDs) for the purpose of accomplishing the Capital Plan, including renewal of any Memorandum of Understanding (MoU)s with RHDs
2. Oversee the organizational and Board processes that foster a productive relationship with the Foundations, Auxiliaries and Societies involved in fundraising for the benefit of Northern Health, including the renewal of MoU(s) with Foundation(s)
3. Review annually a Business Development report detailing progress on goals and objectives set out for the prior and current fiscal years
4. Review insurance coverage of significant risks and uncertainties
5. Review material litigation and its impact on financial reporting
6. Institute and oversee special examinations or investigations as needed
7. Receive reports regarding Ministry of Health funding models
8. Review the Committee work plan annually and the Committee terms of reference as part of the regular Board Policy Review cycle
9. Confirm annually that all responsibilities outlined in the work plan attached to these terms of reference have been carried out

Accountability

The Committee is accountable to the Board and will maintain minutes of its meetings and will bring forward advice and recommendations for Board deliberation and decision-making at the next Board meeting.

Membership

- Committee Chair (Board member)
- Minimum two additional Board members (to a maximum of four)

Ex Officio:

- Northern Health Board Chair (voting)
- President and Chief Executive Officer (non-voting)

Executive and Management Support:

- Vice President, Financial & Corporate Services/Chief Financial Officer

- Regional Director, Internal Audit
- Regional Director, Capital Planning and Support Services

Recording Secretary:

- Executive Assistant to Vice President, Financial & Corporate Services/Chief Financial Officer

Ad Hoc:

Presenters to the Committee will be called upon from time to time, at the request of the Committee Chair, including:

- Chief Information Officer
- Director, Business Development

COMMITTEE WORK PLAN

The Recording Secretary shall maintain the Committee's annual work plan and will:

1. Ensure that changes to the Committee's terms of reference are reflected in the work plan, and
2. In accordance with G.(9), ~~A~~annually provide to the Committee a report that:
   a. Indicates all elements of the work plan were undertaken in the previous year.
   b. Notes any exceptions and provides an explanation,
   c. Affirms that the work contemplated in the Terms of Reference is reflected in the Committee work plan.

Author(s): Governance & Management Relations Committee
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EXTERNAL AUDITOR INDEPENDENCE V. 1 BRD 315

PURPOSE

Policy BRD 310, *Terms of Reference for the Audit & Finance Committee* (the "Committee"), assigns to the Committee the responsibility of reviewing the planning and results of external audit activities, and for overseeing the ongoing relationship with the external auditor.

The Committee recommends engagement of the external auditor to the Board of Directors of Northern Health (the "Board"). As specified in the section entitled "External Audit", it is also required to:

- *review and receive assurances on the independence of the external auditor; and*
- *review the non-audit services to be provided by the external auditor's firm or its affiliates (including estimated fees) and consider the impact on the independence of the external audit*

The objectivity and integrity of the external auditor is fundamental to the public confidence in the reliability of the external auditor's report and hence the public accountability of Northern Health.

Since the external auditor is required to have a relationship with the client, absolute independence is not possible. The significance of economic, financial and other relationships must therefore be evaluated in the light of what a reasonable and informed third party would conclude as acceptable.

The purpose of this policy is to establish principles and controls designed to provide reasonable assurance that the external auditor maintains an adequate degree of independence to ensure objectivity and integrity.

The principles and controls set out below concern the engagement of the external auditor, the justification of non-audit services, and the hiring of audit staff.

ENGAGEMENT OF THE EXTERNAL AUDITOR

1. The external auditor's independence can be influenced by a number of threats including, but not limited to:
   a. Self-review threats that occur when an external auditor provides assurance on his or her own work

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b. Self-interest threats that occur when an external auditor could benefit from a financial interest in a client or when there is an undue dependence on an assurance[1] client
c. Advocacy threats that occur when an external auditor promotes a client's position or opinion
d. Familiarity threats which occur when an external auditor becomes too sympathetic to a client's interests
e. Intimidation threats which occur when an external auditor is deterred from acting objectively by actual or perceived threats from a client

2. It is expected that the external auditor will maintain a quality control system which recognizes these and other threats and provides reasonable assurance that his or her independence is not impaired.
3. The external auditor is required to give the Committee annual assurances concerning independence.
4. The external auditor is expected to adhere to a rotation policy that provides a balance between effectiveness, efficiency and independence. This rotation must be at intervals of no more than seven years for the lead partner responsible for the audit.

   An exemption on an annual basis from these requirements can be granted by the Committee if circumstances require such an exemption. Where there is only one partner engaged, the Committee may request that a partner from another location of the same firm be utilized in at least one year.
5. The external auditor should not hire and involve any of the following individuals to participate in the audit within twelve months of the cessation of their employment with Northern Health:
   a. Individuals who were previously employed as senior management of Northern Health, or
   b. Individuals who were previously employed as participants in processes or areas subject to external audit procedures.
6. Once the Committee is satisfied that the external auditor recognizes and accepts these principles and responsibilities it will authorize the Board Chair and the President and Chief Executive Officer (the "CEO) to jointly co-sign the letter of engagement.
7. The Committee will annually provide the Board with a summary of any internal audit and non-audit services undertaken by the external auditor and the associated fees.

[1] An 'assurance client' is a client who is receiving external audit services

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INTERNAL AUDIT SERVICES

1. Internal audit services encompass assurance and consulting activities undertaken by the Internal Audit department of Northern Health. Internal Audit may, during the course of the year, seek assistance on projects through contract relationships with qualified individuals or firms.
2. The Institute of Chartered Accountants of British Columbia (ICABC) Rules of Professional Conduct[2] specifically prohibit performance of an external audit engagement if:

   "... during either the period covered by the financial statements subject to audit or the engagement period, …the licensed firm… provides an internal audit service to the client or a related entity, that relates to the client's, or the related entity's, internal accounting controls, financial systems or financial statements unless it is reasonable to conclude that the results of that service will not be subject to audit procedures during the audit of the financial statements. In determining whether such a conclusion is reasonable, there is a rebuttable presumption that the results of the internal audit service will be subject to audit procedures."
3. The external auditor should not provide internal audit services where the services comprise a significant portion of the internal audit activities.
4. Certain internal audit activities may impair the independence of the external auditor and should not be undertaken by the external auditor:
   a. Performing ongoing monitoring or quality control activities that relate to the execution, accounting for, or approval of transactions
   b. Determining which, if any, recommendations for improving the internal control system should be implemented
   c. Reporting to the Board or the Committee on behalf of management or Internal Audit
   d. Approving or being responsible for the overall internal audit work plan, including the determination of the internal audit risk and scope, project priorities, and frequency of performance of audit procedures
5. The licensed firm is required to identify threats to its independence and either apply safeguards to reduce the threats to an acceptable level or refuse to accept the external audit engagement.[3]

[2] *Rules of Professional Conduct*. Institute of Chartered Accountants of British Columbia: s.204.4 (27) – Mar/2012.
[3] Ibid, 204.2.

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6. A proposal by Internal Audit to engage the external auditor for any internal audit services must be approved in advance by the Committee. The proposal will provide an estimate of fees and a description of safeguards to ensure independence of the external auditor is maintained. The proposal must be accompanied by a statement by the external auditor that such services:
   a. Will not be provided by external audit staff members participating in an external audit of Northern Health within twelve months of the provision of internal audit services
   b. Will be supervised and reviewed by an external audit partner other than that responsible for the provision of external audit services
   c. Will exclude audit items covered in the annual external audit
   d. Will exclude activities outlined in #4 above
7. The total fees incurred in the provision of internal audit services by the external auditor will not exceed 25% of the regular external audit fee for the year as approved by the Board.

NON-AUDIT SERVICES

1. External audit services are those related to the formulation of an opinion on financial statements prepared by management and include advice on accounting policies. Non-audit services are those services other than external or internal audit services.
2. Non-audit services undertaken by the external auditor create actual and/or perceived self-review, self-interest or advocacy threats to the independence of the external auditor. The degree of the threat depends on the nature, scale and scope of the non-audit services.
3. In relation to the provision of non-audit services, the term external auditor shall be interpreted as meaning the external auditor and any of its affiliates. The term affiliates will be interpreted by reference to the substance of a relationship with the audit firm but will generally include any entity controlled by the audit firm or under common control, ownership or management.
4. The external auditor may be engaged to provide non-audit services where there are good reasons and the services to be provided do not create a material threat to the independence of the external auditor. Good reasons for the external auditor to be appointed to perform non-audit services include:

a. It is economical in terms of skill and effort for the external auditor to provide such services as a result of his or her intimate and specialised knowledge of the business
b. The information required is a by-product of the audit process
c. The services are required by legislation or regulation

5. Certain categories of non-audit services are considered to be potentially incompatible with the independence of the external auditor and should normally be avoided. These categories include:
   a. Performance of management functions or making management decisions
   b. Financial statement preparation services and bookkeeping services
   c. Valuation services
   d. Actuarial services
   e. Designing or implementing a hardware or software system
   f. Designing or implementing internal controls over financial reporting
   g. Legal services
   h. Recruiting services
   i. Certain corporate finance activities that create an unacceptable advocacy or self-review threat including making investment decisions or having custody of assets such as securities
6. A proposal by Northern Health management to engage the external auditor for any services in the categories set-out in #5 above must be approved in advance by the Committee. In the review of such proposals the Committee will, where further detailed guidance is considered necessary, refer to standards and guidelines issued by the Canadian Institute of Chartered Accountants and the Institute of Chartered Accountants of British Columbia.
7. Except for those services set out in #5 above, management may arrange the provision of non-audit services by the external auditor provided that:
   a. A formal procurement is followed in accordance with NH procurement policies
   b. The costs of such services do not exceed an amount equal to 25% of the regular external audit fee for the year as approved by the Board
   c. The costs of the service to be provided, combined with the cost of any other non-audit or internal audit services provided by the external auditor in the same year do not exceed an amount equal to 50% of the regular audit fee
   d. All such services are reported to the Committee at the next scheduled meeting along with the reasons therefore

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e. Any proposal to engage the external auditor for the provision of non-audit services, the costs of which will exceed the limits set out in 7(b) and (c), must have the prior approval of the Committee. Where the need for such services is time sensitive, the CFO may request the Chair of the Committee to convene a special meeting of the Committee.

8. Taxation services comprise a broad range of services, including compliance, planning, provision of formal taxation opinions and assistance in the resolution of tax disputes. Such assignments are generally not seen to create threats to external auditor independence.

HIRING OF EXTERNAL AUDIT STAFF

1. Any individual that was employed by the external audit firm and participated in the external audit within the last three months will not be hired to a position at the Regional Director level or above.

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TERMS OF REFERENCE FOR THE GOVERNANCE & MANAGEMENT RELATIONS COMMITTEE V. 1 BRD 320

PURPOSE

The primary function of the Governance and Management Relations Committee ("GMR" or the "Committee") is to assist the Board of Directors of Northern Health (the "Board") in fulfilling its oversight responsibilities by providing advice to the Board in the following areas of responsibility:

- Overseeing the development of Board meeting agendas to address the critical issues emerging from the deliberations of Board Committees and elsewhere in the organization
- Assessing and making recommendations regarding Board effectiveness, providing direction in relation to ongoing Director development and leading the process for recommending Director criteria to the government for consideration when appointing Directors, and setting and reviewing Board policies and procedures
- Providing guidance to the Board Chair and to the President & Chief Executive Officer (the "CEO") regarding the development and management of government relations
- Developing~~ment of~~ the agreement between Northern Health and the Government of British Columbia as set out in the mandate letter
- Assisting the Board in fulfilling its obligations related to management compensation policy and overseeing plans for the continuity and development of senior management

This committee is not intended to act on behalf of the Board unless specific delegated authorities have been given.

COMPOSITION AND OPERATIONS

The Committee shall be composed of the Chair of the Audit and Finance Committee, the Chair of the Performance, Planning and Priorities Committee, the Board Chair, and one or two Directors, one of whom will serve as Committee Chair. (See Membership section for complete committee membership details).

The Committee shall operate in a manner that is consistent with committee guidelines outlined in policy BRD 300 of the Board policy manual.

DUTIES AND RESPONSIBILITIES

The duties and responsibilities of the Committee will include:

A. Governance

The Committee shall:

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1. Develop Board meeting agendas with a focus on the strategic and critical issues emerging from Board Committee deliberations.
2. Establish the key internal and external communication messages arising from the Board meeting agenda and initiate the development of Board communication releases based on these messages.
3. Oversee the creation and distribution of the annual report.
4. Recommend to the Board the plan for Northern Health's community consultation strategy and oversee the implementation of this strategy.
5. Oversee the development and monitoring of Northern Health's enterprise-wide Integrated Risk Management Framework.
6. Review and advise the Board with respect to risk management issues including major incident/negligence summaries, and issues involving litigation.
7. Review and advise the Board with respect to Privacy and the Patient Care Quality Office (PCQO).
8. Develop, and annually update, a long-term plan for Board composition that takes into consideration the current strengths, skills and experience on the Board, retirement dates and the strategic direction of Northern Health.
9. Develop recommendations regarding the essential and desired experiences and skills for potential Directors, taking into consideration the Board's short-term needs and long-term succession plans.
10. In consultation with the Board Chair and the CEO, recommend to the Board for subsequent recommendation to government, criteria and potential candidates for consideration when they are appointing Directors.
11. Review, monitor and make recommendations regarding Director orientation and ongoing development.
12. Recommend to the Board, and annually implement, the appropriate evaluation process for the Board.
13. Review annually, for Board approval, a board manual outlining the policies and procedures by which the Board will operate including, but not limited to, the terms of reference for the Board, the Board Chair, the CEO, individual Directors and Board committees.
14. Ensure there is a system that enables a committee or Director to engage separate independent counsel in appropriate circumstances, at Northern Health's expense, and be responsible for the ongoing administration of such a system.
15. Review annually, for Board approval, all Board Enduring Motions to ensure that they are still current and relevant.
16. Monitor compliance with laws and regulations and ensure that procedures have been established to receive and address reports and complaints regarding non-compliance.
17. Recommend to the Board any reports on governance that may be required or considered advisable.

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18. Oversee the development, revision and renewal of the Memorandum of Understanding between Northern Health and the University of Northern British Columbia including the Innovation and Development Commons (IDC)
19. Oversee the development, revision and renewal of the Northern Partnership Accord between the First Nations Health Council: Northern Regional Caucus, Northern Health, and the First Nations Health Authority
20. At the request of the Board Chair or the Board, undertake such other governance initiatives as may be necessary or desirable to contribute to the success of Northern Health.
21. Provide direction for content of the annual Board planning session and build items arising from this planning into the Board's work plan.
22. Review the existence and application of the corporate conduct policy on an annual basis (BRD 260).

B. Management Relations

The Committee shall:

1. Recommend a performance planning and review process for the CEO and, when approved, lead the implementation of the process.
2. Review and recommend the CEO's compensation to the Board for approval, subject to the legislative guidelines.
3. Review policy and procedures related to the review and approval of the CEO's expenses.
4. Review the CEO's analysis of the senior management team structure, processes, and performance.
5. Review with the CEO the succession planning strategy across all management levels and ensure that comprehensive succession plans are in place for all senior executive positions.
6. Review and recommend Northern Health's compensation philosophy and guidelines and ensure compliance with any applicable guidelines established by Health Employers' Association of BC (HEABC) and the Public Sector Employers Council (PSEC).
7. Review and recommend to the Board the ratification of collective agreements. Only the Board has the authority to ratify collective agreements.
8. Review with the CEO any significant outside commitments the CEO is considering before the commitment is made. This includes commitments to act as a Director or Trustee of for-profit and not-for-profit organizations.

C. Government Relations

The Committee shall:

1. Provide advice to the Board Chair and CEO in relation to regular interactions with government through such forums as the Board Chairs/CEO meeting,

Northern Caucus, meetings with the Minister of Health Services, and other ministries and government bodies.

2. Create an environment that fosters productive relationships with the North Central Local Government Association (NCLGA), Regional Hospital Districts (RHD), and MLAs through regular communication, management of issues, and opportunities for interaction with the Board during regular Board meetings.
3. Receive reports and provide advice regarding Board Chair and CEO meetings with local government at the NCLGA and Union of British Columbia Municipalities (UBCM) meetings.
4. Organize opportunities for the Board to interact with the Minister and Ministry of Health leadership, as relevant to Northern Health priorities and issues.
5. Oversee the communications processes between Northern Health, Government Communications & Public Engagement (GCPE), the Ministry of Health and other government organizations and bodies.
6. Oversee the performance of the Health Shared Services BC (HSSBC) and determine if it is meeting the needs of Northern Health.
7. Oversee the relationship between Northern Health and the Provincial Health Services Authority (PHSA), HEABC and Healthcare Benefit Trust (HBT).
8. Annually review Northern Health's (a) Energy and Sustainability Policy, and (b) Carbon Neutral Action Report.

ACCOUNTABILITY

The Committee is accountable to the Board and will maintain minutes of its meetings and will bring forward advice and recommendations for Board deliberation and decision making at the next Board meeting.

MEMBERSHIP

- Northern Heath Board Chair
- Chairs of the Standing Committees (Audit & Finance; Performance, Planning~~,~~ and Priorities)
- 1 or 2 other Board Members one of whom will serve as the Committee Chair

Ex Officio:

- President and Chief Executive Officer (non-voting)

Executive and Management Support:

- Regional Director, Risk Management & Compliance
- Executive Assistant, Northern Health Board & President/CEO

Recording Secretary:

- Executive Assistant, Vice President Human Resources

Ad Hoc:

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- Presenters to the Committee will be called upon from time to time, at the request of the Committee Chair

COMMITTEE WORK PLAN

The Recording Secretary shall maintain the Committee's annual work plan and will:

1. Ensure that changes to the Committee's terms of reference are reflected in the work plan, and
2. Annually provide to the Committee a report that:
    a. Indicates all elements of the work plan were undertaken in the previous year.
    b. Notes any exceptions and provides an explanation,
    c. Affirms that the work contemplated in the Terms of Reference is reflected in the Committee work plan.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
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TERMS OF REFERENCE FOR THE PERFORMANCE, PLANNING AND PRIORITIES COMMITTEE V.1 (WITH EDITS FROM 3P MAY) BRD 330

PURPOSE

The purpose of the Performance, Planning and Priorities Committee ("3P" or the "Committee") is to assist the Board of Directors of Northern Health (the "Board") in fulfilling its oversight responsibilities by providing advice to the Board in the following areas of responsibility:

- Oversight of quality and patient safety review processes for the purpose of improving the quality of health care or practice within Northern Health
- Development and review of the Strategic Plan
- Setting of strategic priorities designed to enable the organization to meet the goals set out in the Strategic Plan
- Monitoring performance of the organization in achieving the goals set out in the Strategic Plan and the performance expectations set forth by the Ministry of Health
- Ensuring a Communications Strategy is developed, implemented and monitored

This Committee is not intended to act on behalf of the Board unless specific delegated authorities have been given.

COMPOSITION AND OPERATIONS

The Committee shall be composed of not fewer than three Directors and not more than five Directors. (See Membership section for complete Committee membership details).

- The Committee shall operate in a manner that is consistent with the Committee Guidelines outlined in Policy BRD300 of the Board Manual
- Each committee meeting will focus on one (or two) strategic priorities with the understanding that there may be the need to include additional agenda items that are time sensitive
- Each Committee meeting will include a review of the scorecard indicators for the strategic priority being reviewed

DUTIES AND RESPONSIBILITIES

The duties and responsibilities of the Committee shall include the following:

1. Overseeing the development and implementation of the quality improvement framework including the policies, standards, structures and processes necessary to support quality improvement and patient safety

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2. Receivinges reports arising from quality review committees properly constituted within the provisions of Section 51 of the *Evidence Act [RSBC 1996] Chapter 124*[1]
3. Reviewing high level work of clinical programs to ensure establishment of quality improvement goals at the program level and to oversee quality monitoring
4. Reviewing and advisinge the Board with respect to an Annual Quality Review
5. Overseeing the development and review of the Strategic Plan
6. Overseeing the development, monitoring, and evaluation of the annual Service Plan
7. Measuringe performance and management's success in achieving the goals and targets as set out in the Strategic Plan, annual Service Plan and Ministry of Health performance expectations
8. Providinge guidance in setting the strategic priorities and directions required to achieve the expected outcomes
9. Overseeing the development, review, revision and approval process for the Medical Staff Bylaws and Rules
10. Reviewing Northern Health's policies, structures and processes for:
    a. the credentialing, privileging, appointment and reappointment of the Medical Staff in compliance with the Medical Staff Bylaws and Rules
    b. the development of the Medical Staff structure
    c. the development of the Physician Human Resource Plan
11. Reviewing and advisinge the Board with respect to region-wide, coordinated emergency preparedness planning
12. Overseeing the development, monitoring and evaluation of the Human Resource Plan including recruitment, retention, employee engagement, labour relations, leadership development, education framework and plan, workplace health and safety and physician relations
13. Overseeing the development, implementation, and evaluation of the Communications Strategy including:
    a. Internal communications
    b. External communications
    c. Media relations
14. Reviewing an annual overview of the Information Management and Information Technology Plan and progress to the plan
15. Overseeing the development and review of the Integrated Ethics Framework
16. Providinge advice to the Board Chair and President and Chief Executive Officer (the "CEO") regarding emerging communication issues involving the Board
17. Review and advise the Board with respect to annual school medical officer appointments.

[1] The 3P Committee does not itself conduct quality reviews under Section 51 of the Evidence Act.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): February 16 2015 (R)

ACCOUNTABILITY

The Committee is accountable to the Northern Health Board and will maintain minutes of its meetings and will bring forward advice and recommendations for Board deliberation and decision making at the next Board meeting.

Membership

- Committee Chair (Director – not the Board Chair)
- Two to four additional Directors

Ex Officio:

- Board Chair (voting)
- CEO (non-voting)

Executive & Management Support:

- Vice President, Planning, Quality and Information Management
- Regional Director, Internal Audit

Recording Secretary:

- Executive Assistant, VP Planning, Quality and Information Management

Ad Hoc:

- Presenters to the Committee will be called upon from time to time, at the request of the Committee Chair.

COMMITTEE WORK PLAN

The Recording Secretary shall maintain the Committee's annual work plan and will:

1. Ensure that changes to the Committee's terms of reference are reflected in the work plan, and
2. Annually provide to the Committee a report that:
    a. Indicates all elements of the work plan were undertaken in the previous year.
    b. Notes any exceptions and provides an explanation,
    c. Affirms that the work contemplated in the Terms of Reference is reflected in the Committee work plan.

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TASK FORCES V.1 BRD 340

A task force is a committee of the Board of Directors of Northern Health (the "Board") established for a defined period of time, normally not longer than six months, to undertake a specific task, and is then disbanded.

Guidelines for Task Forces

1. A task force operates according to a Board approved mandate, which outlines its duties and responsibilities.
2. Each task force must have terms of reference with the following headings:
    - Purpose
    - Composition
    - Duties and Responsibilities
    - Completion Date
3. A task force must get an extension approved to go beyond the time limit specified in its terms of reference. The Guidelines for Committees (Policy BRD 300) also apply to task forces established by the Board.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): October 22, 2014 (R)

BRIEFING NOTE

Date:	**September 6, 2015**	
Agenda item	**Community Consultation: Child Health**	
Purpose:	☒ **Information**	☒ **Discussion**
	☒ **Seeking direction**	☒ **Decision**
Prepared for:	**GMR Board Committee & Northern Health Board of Directors**	
Prepared by:	**Steve Raper, Director of Communications**	
Reviewed by:	**Dr. Sandra Allison, Chief Medical Health Office** **Cathy Ulrich, CEO**	

Issue:

To discuss the proposed topic and timelines for the NH Board public consultation.

Background:

The planning has begun to determine the topic and timelines for the NH Board's Public Consultation.

In December, 2015, at the NH Board meeting, Dr Allison will be presenting her child health status report focused on pre-natal to children up to 5 years of age. With the release of this heatlh status report later in 2015, it is proposed that the NH Boards' Community Consultation process in 2016 focus on Child Health.

The MHO report that the NH Board will receive provides a platform from which to gather community perspectives on growing up healthy in the communities of northern BC. The proposed consultation will seek to gain a wide range of input from our community stakeholders on the status of child health from pre-natal to the age of 17. This proposed consultation could be entitled, "Growing Up Healthy in Northern BC", and would occur in the spring 2016.

The proposed time table is as follows:

- December 2015 - Board receives Dr Allison's child health status report
- January/February 2016 – Board publicly releases the child health status report and announces public consultation topic
- March 2016 – Board announces public consultation plan and timelines
- April /June 2016 –Public consultation takes place in communities across the North
- December 2016 – Consultation report received by board
- Spring 2017 – Consultation report released publicly

Recommendation:

To seek feedback from the NH Board that will provide direction for the next steps in planning the community consultation topic and timelines.