Meeting of the Northern Health Authority Board of Directors

Monday, February 15, 2016

Sandman Inn – Meeting Room A

Quesnel, BC

northern health

the northern way of caring

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Public Session

AGENDA

February 15, 2016
Sandman Inn – Meeting Room A
940 Chew Road
Quesnel, BC

AGENDA ITEMS	Responsibility of…	Expected Outcome	Time (Approx.)	Page
1. Call to Order of Open Board Session	Chairman Jago		**10:00am**	
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: December 7, 2015	Chairman Jago	Motion		**3**
6. Business Arising from Previous Minutes	Chairman Jago			**-**
7. CEO Report **7.1** Human Resources Report	C Ulrich D Williams	Information Information		**8** **10**
8. Audit & Finance Committee **8.1** Financial Statement & Comments (Period 9) **8.2** Major Capital Projects Summary (Period 9)	**B Sander** M De Croos M De Croos	 Motion Information		 **20** **22**
9. Performance Planning & Priorities **9.1 Strategic Priority: Integrated Accessible Health Services** **9.1.1.** Primary Health Care	 K Gunn	 Information		 **25**
10. A Community Partnership: Primary Care Clinic Development and Physician Recruitment **Presenters:** • Debbie Strang, Health Service Administrator • Dr. Dietrich Furstenburg, Chief of Staff	M McMillan	Information		**28**
11. Governance & Management Relations Committee **11.1** Policy Manual BRD 500 & 600 Series	G Parmar C Ulrich	 Motion		 **42**
Adjourned			**11:30am**	

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Public Motions

Meeting Date: February 15, 2016

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 February 15, 2016 Public agenda as presented	☐	☐
5.	Approval of Minutes	The Northern Health Board approves the December 7, 2015 public minutes as presented	☐	☐
8.1	Financial Statements & Comments - Period 9	The Northern Health Board of Directors approves the Northern Health's Period 9 finance statement, as presented	☐	☐
11.1	Policy Manual BRD 500 & 600 Series	The Northern Health Board approves the revised BRD 500 & 600 series.	☐	☐

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Board Meeting

Date: December 7, 2015
Location: Brunswick Board Room
Prince George, BC

Chair: Dr. Charles Jago

Recorder: Desa Chipman

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

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

Public Minutes

1. Call to Order Public Session

The Open Board session was called to order at 1:18pm

2. Opening Remarks

Chairman Jago welcomed all guest observers and presenters to the meeting.

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.

- There was no conflict of interest declarations made related to the February 16, 2015 Public agenda.

4. Approval of Agenda

Moved by M Squires seconded by G Parmar
The Northern Health Board approves the public December 7, 2015 agenda as presented

5. Approval of Board Minutes

Moved by G Parmar seconded by C Nyce
The Northern Health Board approves the October 21, 2015 public minutes as presented

6. Business Arising from Previous Minutes

There was no business arising from the October 21, 2015 minutes.

7. CEO Report

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

- Presented an overview of Northern Health to the northern Credit Union's Board and management in October.
- Presented an overview of Northern Health's research partnership with UNBC to the UNBC Senate and highlighted the importance of the research and education partnership with UNBC to Northern Health's ability to recruit and retain staff.
- At the November provincial Tripartite Steering Committee on First Nations Health meeting, the partnered work underway to implement the First Nations Health and Wellness Plans each health authority has established with First Nations communities and the First Nations Health Authority was discussed. The meeting focused on how to collaborate to improve the cultural safety of health services in the province.
- Over the last two months, a number of Northern Health staff and physicians have received awards in recognition of their exemplary service. Northern Health would like to recognize these staff and physicians and thank each of them for their commitment and dedication to serving the people who live in Northern BC.
- Dr. Anthon Meyer, family physician in Fort St. James is the recipient of the **Reg L. Perkin award** as one of Canada's top physicians. This award is granted to physicians who demonstrate the four principles of family medicine - skilled clinician, community-based, serve as a resource for those in their community, value the patient-doctor relationship.
- **The Healthier You Awards** recognize those who have made an outstanding contribution towards health and wellness in the North. Northern Health and partner award winners are:
  - Seniors Initiative of the Year Award – Geriatric Assessment and Treatment Unit
  - Technology In Health Care Award – Northern Health Kidney Care Team
  - Health & Wellness Education of the Year Award – Population Health Injury Prevention Team
  - Healthy Workplace Award – collaboration between the Canadian Cancer Society, Northern Health, BC Cancer Agency, UBC and Athabasca University.
  - Mental Health in the Workplace Award – partnership between RCMP and Northern Health
  - Health & Wellness Innovator of the Year Award – Dr. Haidar Hadi and Dr. Dan Horvat: The Northern Race Line
  - Health & Wellness Provider of the Year Award – Dr. Ian Schokking - the committee lead for continuing medical education for physicians in the region and oversees the residency program for physicians.
  - Research Award – Dr Shannon Freeman, a post-doctoral fellow in the School of Health Sciences at UNBC, whose research interest focuses on the health and well-being of vulnerable populations in the areas of aging and hospice palliative care. Dr. Freeman is working collaboratively with Northern Health staff in these areas of research.
- **Nursing Excellence Awards** recognize nurses for their nursing practice contributions. Two Northern Health nurses were recognized for their contributions:
  - Karen Desormeau, a registered nurse at McBride Hospital, received the Excellence in Nursing Practice Award.
  - Miranda Fehr, a registered nurse at Fort St John Hospital, received the Rising Star award in recognition of her contributions as a newly graduated nurse.

7.1. Human Resources Report

- David Williams, VP Human Resources provided an overview of the December Human Resources as follows:
  - For the second year in a row, the Disability Management team was selected as finalists for the Canadian HR Awards' "Best Health & Wellness Strategy Award".

- The CEO memo for influenza was communicated on October 23, 2015. This memo launches the annual influenza campaign for all NH employees. Influenza Program clinics commenced on October 26th, and a total of 64 clinics staffed by 25 flu clinic nurses will be held. In addition to these clinics, Peer Nurse Immunizers are available to immunize staff, physicians, and volunteers during the influenza campaign.
- Following a serious injury at another health authority in August, WorkSafeBC (WSBC) increased its focus on laundry areas through the Province.
- A Workplace Health and Safety (WHS) Trainer Boot Camp was held in September to support the continued mentorship of site and WHS trainers. Northern Health now has an additional seven staff that meet the competencies to be considered independent trainers, increasing the capacity to offer Violence Prevention training to sites throughout the region. In addition, individual site trainers continue to be mentored, further increasing capacity for specific sites to arrange and offer their own Violence Prevention sessions (independent of the WHS scheduled training sessions).
- A Learning pathway is a "road map" that outlines the sequence of learning activities, practice, and experience required to become proficient in a function or task. The development of learning pathways will contribute to a culture of standardized orientation, the use of evidence based competencies, timely and targeted education, and ongoing staff recruitment, retention and career growth.

8. Audit and Finance Committee

8.1. Financial Statements (YTD Period 7)

- Year to date Period 7, revenues exceeded expenses by $442,000.
- Revenues are unfavourable to budget by $4.0 million or 1.0%. Expenses are favourable to budget by $4.4 million or 1.1%.
- 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 $2.6M of targeted funding and matching expenditure would have been realized to the end of Period 7. As a result, revenues are showing an unfavourable variance to budget, while expenditures are showing a corresponding favourable variance to budget.

Moved by B Sander seconded by G Parmar
The Northern Health Board approves Northern Health's Period 7 financial statement, as presented.

8.2. Major Capital Projects Summary (period 7)

- An overview of the major capital projects summary for Period 7 was provided for information with additional details provided on projects that are experiencing a delay which are as follows:
  - Project 11 - Stuart Lake Hospital Sprinkler System
  - Project 15 - has been completed since the date of this report and completed within the amended budget for that project
  - Project 21 - the contractor has filed delay claims that are being worked through. Construction on the project is continuing.

9. Performance Planning and Priorities Committee

9.1. Aboriginal Health Presentation

- Kendra Mitchell-Foster, Lead, Community Engagement & Development, Aboriginal Health, Northern Health and Renata Meconse, Regional Health Liaison, North Central/East Regional Teams, First Nations Health Authority joined the meeting to provide a presentation on the

Innovative Partnerships in First Nations Health: Implementing New Relationships. The presentation included information on the following;

- First Nations Governance Structures and Engagement Pathways
- Northern First Nations and Northern Health Formal Relationships
- Northern First Nations Health Partnership Committee
- Keys to Success
- Northern First Nations Health & Wellness Plan
- Implementing the Northern First Nations Health and Wellness Plan: The Four Priorities and More
- Cultural Competency
- Patient and Process Mapping Cultural Resources
- Progress between July 2014 and July 2015
- Cultural Competency Learning Opportunity

- The Board members thanked the guests for the presentation and found the content to be very informative.

9.2. Canada Winter Games & Follow up Action Presentation

- Kelsey Yarmish, Regional Director Population Health Programs, Population and Public Health and Mandy Levesque, Team Lead, Population Health joined the meeting to share information on the various health legacy aspects, wellness and health promotion initiatives leveraged by the 2015 Canada Winter Games.
- Details on the Key Health Legacy pieces shared are as follows:
  - Partnerships
  - Regional Strategy for Torch Relay events in Northern BC
  - Health Promotion Venue Blitzes during 2 weeks of Games
  - IMAGINE Grants awarded to 34 communities throughout the region
  - Smoke-Free/Tobacco-Free Games Declaration
  - Community Health Stars Initiative
  - Growing for Gold Initiative
  - Northern Safe Sport Tour Collaboration & NH Concussion Matters! Campaign
  - 'Spirit the Caribou' and other promotional items
    - The story written by Isabel Stratton which inspired the creation of Spirit the Caribou' mascot was shared.
  - Northern Health's Health Legacy Document/Report
- Chairman Jago thanked the presenters for the presentation and acknowledged the hard work that has transpired. The commitment to have a legacy right from the start and to promote the health and wellbeing of northern people is greatly appreciated.

10. BC Patient Safety & Quality Council – 2016 Quality Award Recipients

- The Quality Awards are presented annually by the BC Patient Safety & Quality Council (BCPSQC). The Four Excellence in Quality categories recognize initiatives that address the continuum of care: prevention, treatment of acute illness/injury, living with chronic illness, and end of life. Three categories recognize the work of exceptional individuals: a Leader in Quality, a Quality Culture Trailblazer, and an Everyday Champion who is chosen by online voting.
- This year Northern Health submitted nominations in four categories and two staff were selected as winners in the following categories: Renee Logan, Leader in Quality, and Tammy Rizmayer, Everyday Champion.
- Chairman Jago presented both Tammy Rizmayer and Renee Logan with a small token of recognition and congratulated them both on their achievements.

11. Governance and Management Relations Committee

11.1. Policy Manual BRD 400 Series

- The Policy Manual BRD 400 series was provided to the board with suggested changes highlighted for feedback and approval.

Moved by R Landry seconded by G Parmar
The Northern Health Board approves the revised BRD 400 series

11.2. Foundation & Fundraising Societies

- Trevor Lutes, Chair, Spirit of the North Foundation, addressed the Northern Health Board to express appreciation for the support and partnership. The Spirit of the North Foundation and Northern Health are working towards a new vision which will be exciting for both organizations.
- S Raper, Chief, Communications & External Relations, provided the board with a presentation on the Hospital & Health Care Foundations Contributions to Enhance Health Services. The presentation included information on the foundations established in the north along with a showcase of the gifts and donations received through the foundations.
- Northern Health and Foundations continue to be intentional and purpose driven with respect to the partnership. This partnership is built on trust and respect with a focus on philanthropic engagement across the region.
- Chairman Jago made mention of the many Hospital Auxiliaries partnerships that also provide support to Northern Health and are also greatly appreciated.

The public Session was adjourned at 3:08pm
Moved by S Killam

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:	February 15, 2016
Agenda Item:	CEO Report		
Purpose:	Information		
Prepared by:	Cathy Ulrich		

ERAS - Enhanced Recover After Surgery

Late in 2014, Mills Memorial Hospital (MMH) was selected as the Northern Health facility to take part in the provincial Enhanced Recovery after Surgery (ERAS) Collaborative. The aim of the collaborative was to provide optimal care for patients undergoing elective colorectal surgery in BC through the application of the ERAS pathway. The ERAS pathway is comprised of a set of perioperative protocols that when adhered to have shown reductions in complication rates and length of hospital stay (LOS), without adverse effects on readmission rates and overall resulting in better outcomes for patient and cost savings to the health system.

On January 12th, the MMH Team presented their results at the Collaborative Outcomes Congress and received recognition for the consistent outcomes achieved that aligned well with those in other sites across the province. At the Outcomes Congress there was clear recognition that many of the changed protocols apply well to most surgical procedures - something that was clear to the MMH team from the beginning. The next steps will include the spread of these protocol changes both across sites, but also to other surgical pathways.

Northern Health would like to thank this team of people who participated in this collaborative for their efforts over the last two years. The learnings will be helpful to the rest of Northern Health as we work to improve the quality of services we provide.

Quesnel Highlights

1. Collaboration with First Nations Communities:

Northern Health entered into a Partnership Accord with the First Nations Health Council: Northern Regional Health Caucus and the First Nations Health Authority (FNHA) in 2012. In the North, the Northern First Nations Health Partnership Committee, consisting of representatives from the Northern Regional Health Caucus, First Nations Health Authority, and Northern Health, oversees the implementation of health and wellness priorities for First Nations communities. One of these priorities is focused on Mental Health and Substance Use.

In the Quesnel area, Northern Health, the First Nations Health Authority (FNHA) and local First Nations communities are collaborating to create a new team who will provide a continuum of mental health and substance use services. The services will include consisting of prevention and health promotion activities, crisis response, assessment, intervention, and referral to other services, and capacity building within the community through education and support. The team

will consist of one social worker and two clinicians. This team will travel to the communities of Lhtako Dene, Nazko, and Khoosk'uz Dene.

Northern Health, the FNHA and local communities of Nazko and Khoosk'uz Dene (Kluskus) are also implementing a new telehealth initiative. Telehealth sites have been established in each community in order to provide chronic disease management, primary care and mental health and addictions services through virtual visits using telehealth. This service will begin with chronic disease management with an initial focus on diabetes.

2. Collaboration with the Village of Wells

Northern Health is working with Village of Wells to develop plans to provide a health clinic in the community. A local Nurse Practitioner is interested in working with Village of Wells to establish such an outreach clinic to this community.

3. *Physician Recruitment and Primary Care Services*

Since June 2015, 11 physicians have been recruited to Quesnel. This includes two specialists and nine family practice physicians.

- 5 candidates who are completing the Practice Ready Assessment BC program:
  - 2 physicians will arrive in February/March 2016 upon successful completion
  - 3 physicians will arrive in November/December 2016 upon successful completion
- 3 candidates from the International Medical Graduate Program at St. Paul's Hospital in Vancouver:
  - 2 physicians will arrive in September 2016 upon successful completion
  - 1 physician will arrive in January 2017 upon successful completion
- In addition, three family practice physicians have been recruited. One arrived in 2015 and two will be arriving over Feb and March 2016.
- One psychiatrist was recruited in 2015.

Further recruitment is underway for three additional family practice physicians and one locum position.

The Northern Health operated primary care clinic is operating out of interim space until the tenant improvements are completed in their new facilities. This work is expected to be completed in April 2016. Currently, two part time Nurse Practitioners and 1 part time Physician are working in this clinic. Once the clinic is relocated to the renovated space, the clinic will be able to expand the number of primary care providers available in the clinic and the number of patients who can be served by this clinic.

Northern Health is very grateful for the community collaboration and support in the recruitment of physicians, nurse practitioners, and other health professionals to the community of Quesnel.

Human Resources Board Report

January 2016

Workplace Health and Safety

Strategic Directions

Introduced in May 2015, the Workers Compensation Amendment Act, 2015 (Bill 9) has since brought about changes that have strengthened Work Safe BC's (WSBC) ability to enforce all aspects of Occupational Health & Safety (OHS) compliance in workplaces. Several changes have direct implications for Northern Health (NH), including timelines for completion of incident investigations and changes to the penalty process. The amendment now places the onus of due diligence on the employer and WSBC will request a submission that demonstrates all reasonable steps were taken to comply with the Workers Compensation Act. Due diligence is defined as taking all reasonable care to protect the well-being of employees or co-workers. We are currently preparing to launch the web Investigation Incident Tool (IIT) to support managers in completion of their investigations under the new requirement.

Disability Management

Currently, it takes an employee an average of 5.24 days from the time of an incident to report the incident to the Workplace Health Call Center (WHCC). NH's incident-to-notification timeliness rate was at 5.8 days in December 2014 compared to 5.24 days in November 2015. The goal is to have all employees report their incident to the Call Centre and their direct report immediately. Timeliness of reporting an injury/illness directly correlates to WSBC Short Term Disability (STD) Duration rates (the time it takes an employee to return to the workplace after an injury). WSBC STD Duration has remained steady over the last six months between 42 and 44 days. The average STD Duration for all BC Health Authorities is currently at 52 days. Shorter durations lead to more positive health and wellness outcomes for injured employees, and a decrease to WSBC claims costs.

Influenza Campaign 2015-2016 Program

Workplace Health and Safety (WHS) provided 73 immunization clinics across NH, staffed by 26 Flu Clinic Nurses, 3 Flu Program nurses, and one Occupational Health Nurse. In addition, 97 Peer Nurse Immunizers provided immunization to coworkers during their regular shifts from October 28 to December 1.

As of December 31, 2015 – our immunization rate for employees who had worked in the previous 30 days was 70%.

Violence Prevention (VP)

In the summer of 2015, a commitment was made by NH's CEO to engage leaders in reducing the frequency of violent incidents in the workplace and protecting our employees. WHS continues to support Health Service Administrators who have actively engaged in the first steps of the current state assessment process. In addition to the current state assessment, WHS continues to support the baseline education training calendar for Personal Safety and Code White training. To increase training capacity, WHS has developed a "train the trainer" program to support sites by training interested individuals who are supported by the organization to become site trainers. This does not take away from the training that WHS

continues to offer; however, it does allow the site increased flexibility in extending Personal Safety Training to specific high-risk sites.

WSBC High Risk Strategy (HRS) 2015-2016

Over the past year, WHS has been supporting the organization with its compliance in responding to WSBC's 2015 Healthcare HRS yearly strategy. This strategy is designed to reduce injuries to front-line caregivers and to reduce violence-related injuries in health care.

HRS is focused 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.

A primary goal of the 2015 inspections was the prevention of violence-related injuries. Inspections concentrated on worker-patient interactions, the Internal Responsibility System (IRS), and the management of violence prevention program elements in the workplace. WSBC was interested in verifying that equipment, procedures, and training were implemented and maintained by supervisors and staff in relation to worker-patient interactions.

The IRS is a structure of accountability and responsibility whereby everyone in the organization is personally and directly responsible for health and safety to the extent of their authority and ability to do so. An effective IRS is when everyone is duly diligent in their health and safety responsibilities. The IRS is often evaluated by reviewing the following: Joint Occupational Health and Safety (JOHS) committee meeting minutes/activities, incident investigations and corrective actions, supervision, inspections, OHS policies and procedures, education and training, and how unsafe conditions are reported and managed.

Specifically, WHS provided: recorded webinars and distance and onsite support with violence prevention risk assessments; ongoing violence prevention training, including the development of a train the trainer program; safe patient handling training; and resources for specific OHS training, which is required by supervisors and new employees.

WSBC will communicate the 2016 High Risk Strategy in the coming month. It is anticipated that a similar strategy will exist with increased emphasis on supervisor roles and responsibilities. WHS will communicate the new strategy and support it accordingly once it has been released.

Human Resources Planning & Design, Education & Training

HR Planning and Design is in the preliminary phases of building a HR Planning Toolkit which will assist managers in planning for their short-term needs. Over the next few months, the team will be meeting with the major stakeholders to ensure it is a consultative process and that the Toolkit meets the needs of the end users. Additionally, an aggregated analysis of NH's workforce is being completed for the 10 priority professions as set by the Ministry of Health. The 10 professions are:

1. Registered Nurse – Specialty
    - RN in Emergency Room (ER)
    - RN in Intensive Care Unit (ICU) and Critical Care
    - RN in Operating room and Post Anesthetic Recovery room (OR/PARR)
    - RN in Mental Health
    - Medical/Surgical RN
2. Physiotherapist
3. Registered Nurse
4. Nurse Practitioner
5. Occupational Therapist
6. Diagnostic Medical Sonographer
7. Medical Laboratory Technician
8. Licensed Practical Nurse (LPN)
9. Respiratory Therapist
10. Care Aides/Health Care Assistants (HCA)

This will not only meet the needs of the Ministry, but also give us a better understanding of our priorities over the next three years. This work is scheduled to conclude in April.

Leadership Development

Experience LINX develops capacity for individuals to self-lead, engage others and transform systems. The most recent cohort of Experience LINX graduated in December 2015. The majority of Regional Directors, Executive Leads, and HSAs have now attended this program and the program is now being offered to Directors of Care and other frontline managers. Another cohort of Experience LINX will be offered in the fall of 2016. The curriculum for a blended version of Core LINX is still being created and should be complete by the beginning of April 2016. Education Services will offer a pilot program at that time. The curriculum will increase ease of access by reducing travel time and costs for learners and facilitators alike. Two sessions of Coaching LINX are tentatively scheduled to begin in March, 2016. Coaching LINX and Core LINX form the basis of the training for frontline leaders throughout the province.

Clinical Placement

As of January 2016, HSPnet, a web-enabled clinical placing system, will be used for clinical placement requests in NH. This includes acute, community, and residential sites and is for students in the nursing disciplines of Registered Nurse, Registered Psychiatric Nurse, Licensed Practical Nurse and Registered Care Aide.

The development of a multi-disciplinary preceptor program is in progress. It will include online education via the LearningHub, an online platform for education delivery, communities of practice support for staff, integration into learning pathways, and a toolkit for staff and managers. Learning pathways are “road maps” that outline the sequence of learning activities, practice, and experience required to become proficient in a function or task.

Recruitment & Retention

Update on initiatives, which are underway to recruit and retain the best for NH:

Grow Our Own – with the objective of soliciting feedback from key stakeholders regarding a meaningful program design, world café events are scheduled as follows:

- Fort St. John –North Peace Secondary School: February 23, 2016
- Prince George – College Heights Senior Secondary: March 2, 2016
- Terrace – Caledonia Senior Secondary: March 7, 2016

Engage Others - employee referral incentive program; support & 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.

Hire for Fit - conducting surveys and workshops to help understand and promote best practices in this activity, including leading 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 media and other means and strategies to showcase NH as the best place to work.

Onboarding - A draft framework has been designed based on a literature review and reviews of leading organizations such as Disney, TELUS, First Baptist Health (US), and Covenant Health (AB). The framework will be revised to include key topics identified in the Organizational Orientation Topics Survey, which was conducted from December 7 to December 22, 2015.

Career Fairs/Recruitment Conferences:

- Northern Lights College Campus Visit - January 21, 2016
- University of Ottawa- Nursing and Rehabilitation Reception - January 19, 2016
- NorthWorks (CNC and UNBC Career Fair) - March 1 and 2, 2016

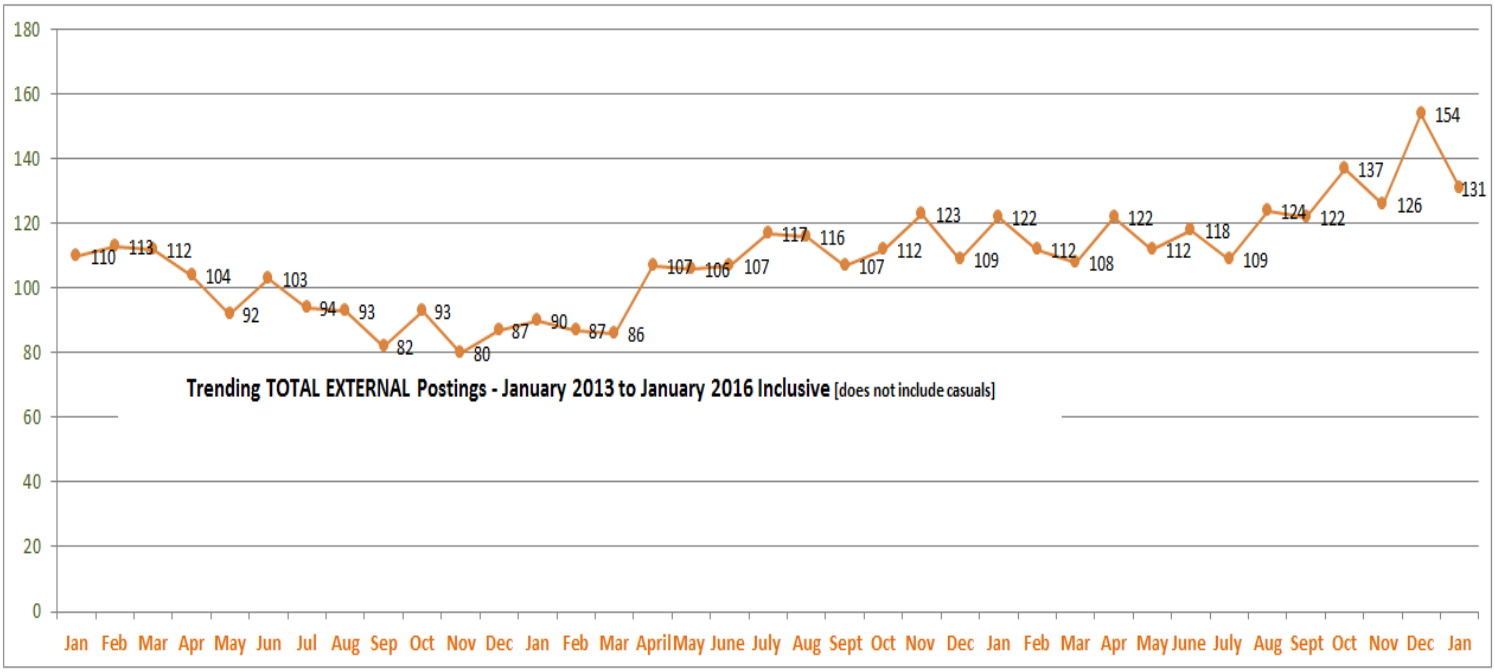
New Nursing Positions

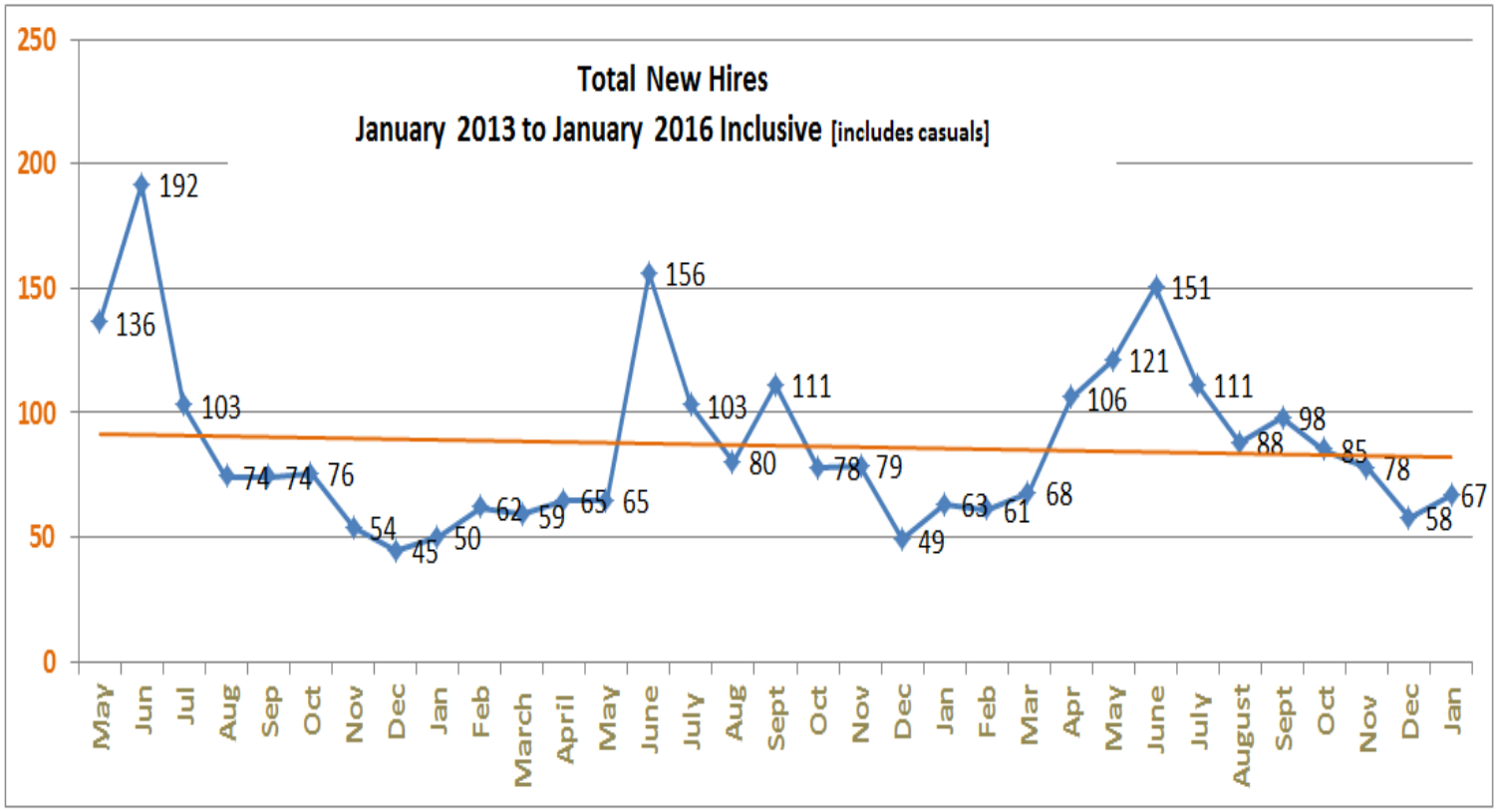
NH is pleased to collaborate with the Ministry of Health and British Columbia Nurses Union (BCNU) in the recently announced approach to recruiting nurses to our region. We have posted regular positions in a number of areas across Northern Health. A number of these positions are in difficult to fill areas including speciality nursing. We continue to work on strategies to fill these vacancies, including:

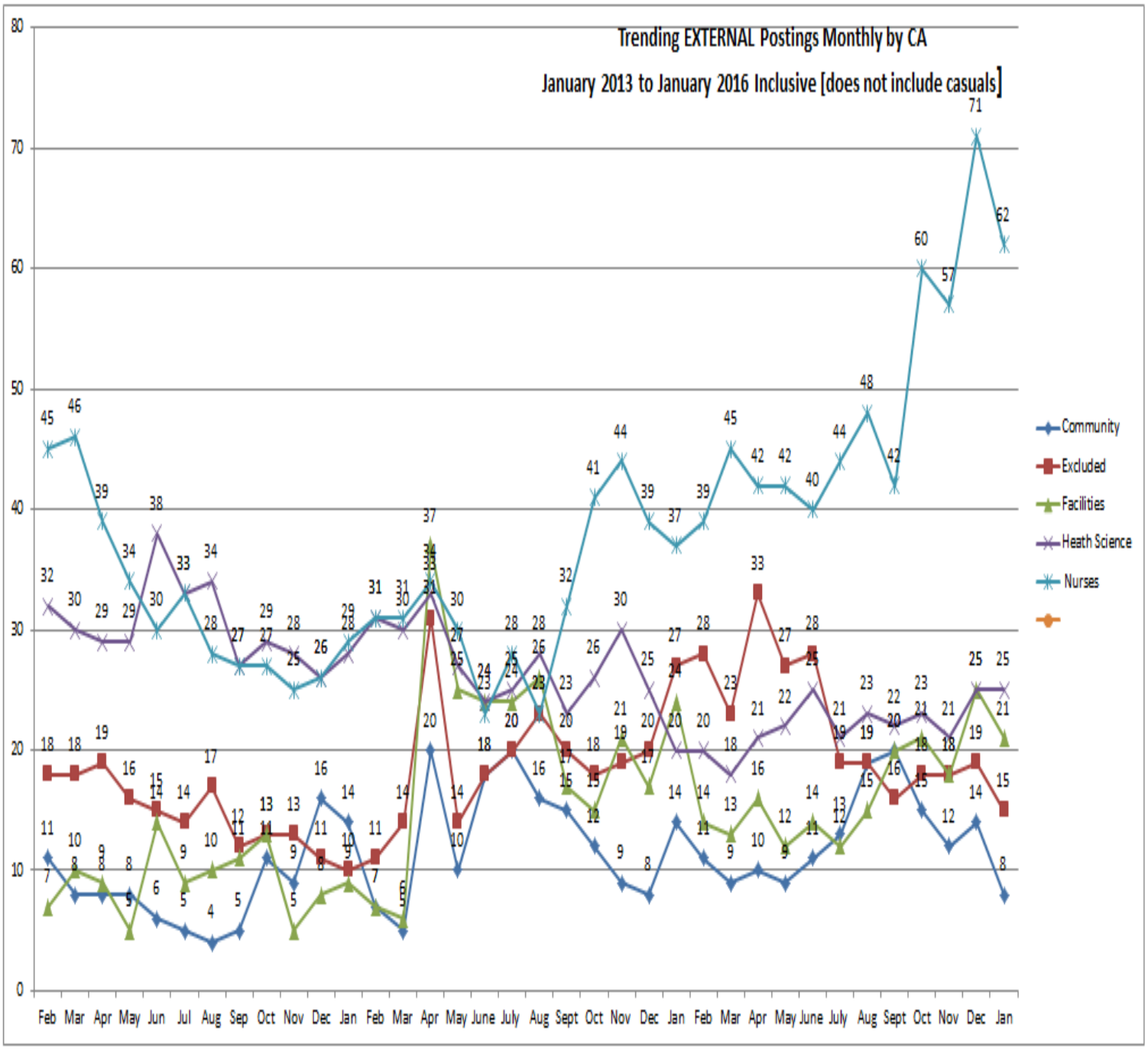
- Advance hiring of new grads to allow current staff to undergo training in speciality areas.

- Incentive programs for return in service agreements in rural and remote communities.
- Continuing to work with post-secondary institutions to recruit graduates to stay in the north.
- Collaborating with BCNU on recruitment activities including their “Hire a Nurse” campaign, designed to encourage casual nurses to explore regular position opportunities.

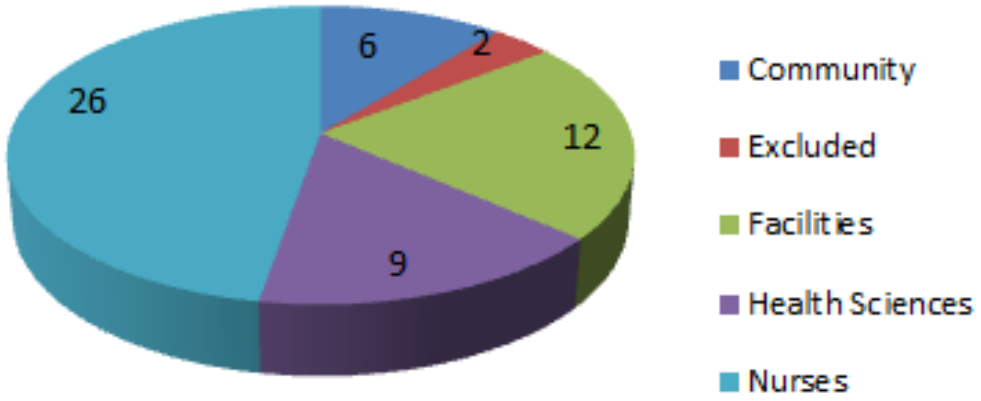
Data and Trending



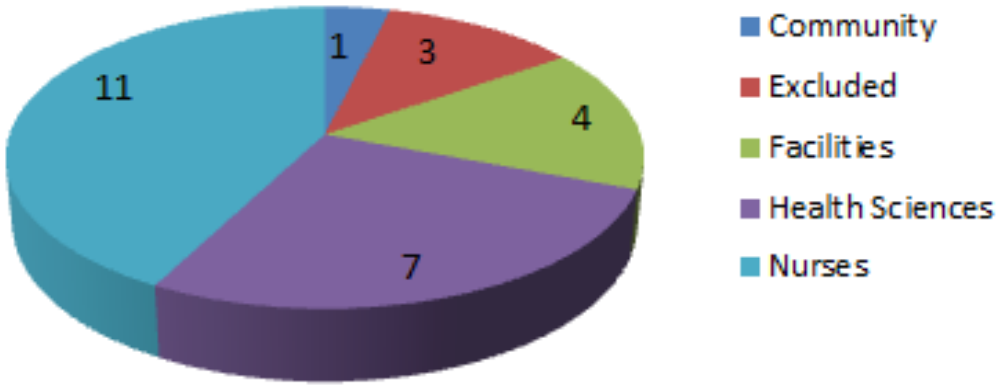



Trending EXTERNAL Postings Monthly by CA
January 2013 to January 2016 Inclusive [does not include casuals]
Community
Excluded
Facilities
Heath Science
Nurses
0
10
20
30
40
50
60
70
80
Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec Jan

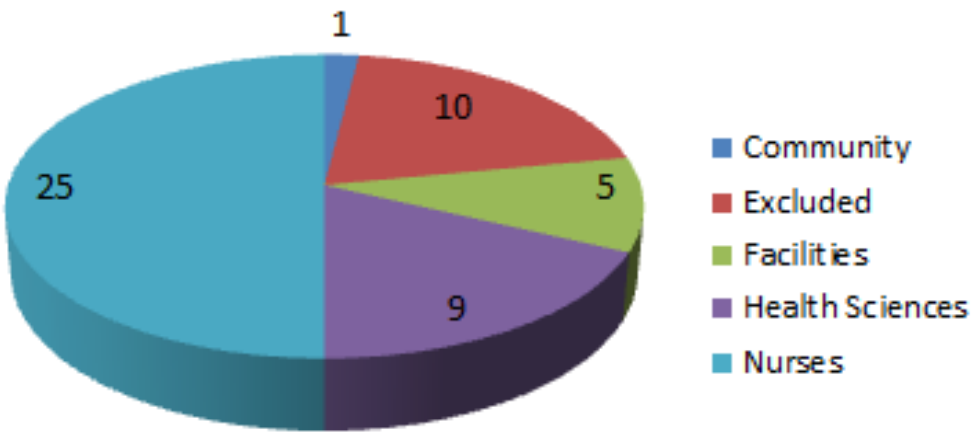
(55) External Postings - NORTHEAST
January 31, 2016 [*does not include casuals*]



(26) - External Postings - NORTHWEST
January 31, 2016 (*not include casuals*]



(50) External Postings- NORTHERN INTERIOR
January 31, 2016 [*does not include casuals*]



The Face of Northern Health

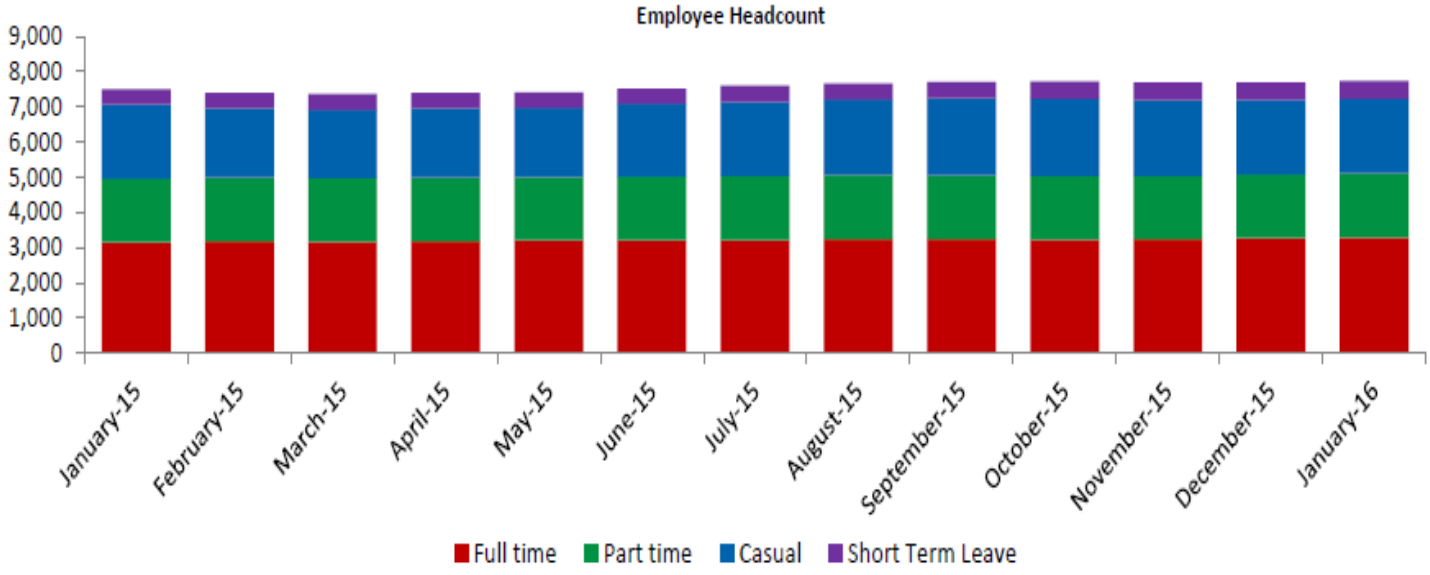
As of January 31, 2016

	Headcount	FTE
Total FTE for Active Employees		4,527
o Short Term Leaves	495	333
o Long Term Leaves (LTD)	377	331

Status		
o Full-time	3,325	(46%)
o Part-time	1,818	(26%)
o Casual	2,022	(28%)

Employees by Headcount per HSDA		
o NE	1,266	(18%)
o NI	3,735	(52%)
o NW	1,819	(25%)
o CORP	345	(5%)

Employees By Headcount			7,165
o Average Tenure (Yrs)			8.1
Employees by Collective Agreement			
o Health Sciences		874	(12%)
o Excluded		527	(7%)
o Nurses		2,245	(32%)
Registered Nurses	1,623		
Registered Psychiatric Nurses	40		
Licensed Practical Nurses	582		
o Facilities		2,894	(40%)
**Clinical	1,216		
**Support	1,678		
o Community		625	(9%)
**Clinical	406		
**Support	219		



*Graph depicts total employee headcount over a one year period. Employees with multiple ID's have been included in the group ing where they hold the highest FTE.

**COMM/FAC Clinical #'s include: Care Aides, Home Support, Activity Workers, Nursing Assistants, Lab Assistance, Pharmacy Technicians, etc.

Non-Clinical #'s include: Admin Support, Schedulers, Housekeepers, Clerks, Laundry Workers, Food Service Workers, etc.

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BOARD BRIEFING NOTE

Date:	January 13, 2016	
Agenda item:	Period 9 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	

December 3, 2015

Year to date Period 9, revenues exceeded expenses by $693,000.

Revenues are unfavourable to budget by $3.4 million or 0.7%. Expenses are favourable to budget by $4.1 million or 0.8%.

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 $3.3M of targeted funding and matching expenditure would have been realized to the end of Period 9. As a result, revenues are showing an unfavourable variance to budget, while expenditures are showing a corresponding favourable variance to budget.

Forecast Yearend 2015-16

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 9 financial statement, as presented.

NORTHERN HEALTH

Statement of Operations

Year to date ending December 3, 2015 (Period 9)

$ thousand

	Annual Budget	YTD December 3, 2015 (Period 9)			
		Budget	Actual	Variance	%
REVENUE					
Ministry of Health Contributions	571,348	380,001	379,348	(653)	-0.2%
Other revenues	209,287	141,818	139,073	(2,745)	-1.9%
TOTAL REVENUES	**780,635**	**521,819**	**518,421**	**(3,398)**	**-0.7%**
EXPENSES (BY PROGRAM)					
Acute Care	435,231	289,916	293,515	(3,599)	-1.2%
Residential Care	102,666	69,747	69,509	238	0.3%
Community Care	85,413	56,628	54,507	2,121	3.7%
Mental Health & Substance Use	56,224	37,769	33,945	3,824	10.1%
Population Health & Wellness	36,775	24,904	24,018	886	3.6%
Corporate	64,326	42,855	42,234	621	1.4%
TOTAL EXPENSES	**780,635**	**521,819**	**517,728**	**4,091**	**0.8%**
EXCESS OF REVENUES OVER EXPENSES	**-**	**-**	**693**		

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BOARD BRIEFING NOTE

Date:	January 21, 2016	
Agenda item:	Northern Health Capital Projects Update (Period 9)	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	NH Board of Directors	
Prepared by:	Mark De Croos, VP Finance & Chief Financial Officer	

The Northern Health Board approved the 2015-16 Capital Expenditure Plan in February 2015, with minor amendments over the year. The Capital Plan approves total expenditures of $54.2M, with funding support from the Ministry of Health ($32.1M, 60%), six Regional Hospital Districts ($17.0M, 31%), Foundations and Auxiliaries ($1.6M, 3%), and Northern Health ($3.5M, 6%).

Year to date Period 9 (December 3, 2015), $33.2M has been spent towards the execution of the plan as summarized below:

$ million	YTD	Plan
Major capital projects (>$5.0M)	18.2	32.4
Major capital projects (<$5.0M)	3.5	2.8
Major capital equipment (>$100,000)	1.8	3.1
Equipment & projects (<$100,000)	6.7	10.9
Information Technology	3.0	5.0
	33.2	54.2

Summary of significant capital projects currently underway or completed in 2015-16 are shown on the following page. Abbreviations used in the table are as follows:

MOH	Ministry of Health
FFGRHD	Fraser Fort George Regional Hospital District
SNRHD	Stuart Nechako Regional Hospital District
NWRHD	Northwest Regional Hospital District
CCRHD	Cariboo Chilcotin Regional Hospital District
PRRHD	Peace River Regional Hospital District
NRRHD	Northern Rockies Regional Hospital District
NH	Northern Health

Northern Interior Service Delivery Area (NI-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Burns Lake	Hospital replacement	$55.00	Complete	MOH, SNRHD
Burns Lake	Hospital Landscaping	$0.18	In Progress	SNRHD, Village of Burns Lake, Burns Lake Auxiliary
Burns Lake	The Pines generator relocation and electrical upgrade	$0.62	In Progress	NH
Prince George	Learning & Development Centre	$10.50	Complete	MOH, NH
Prince George	Gateway 3rd floor renovations	$1.16	Complete	FFGRHD, NH
Prince George	UHNBC – CT Scan Upgrade	$0.19	Complete	Spirit of the North
Prince George	UHNBC – Drug Packaging Machinery	$0.27	Ordered	MOH, FFGRHD
Prince George	UHNBC - ER Telemetry	$0.60	Ordered	MOH, FFGRHD, NH
Prince George	UHNBC MRI	$2.43	Planning	MOH, FFGRHD
Prince George	UHNBC – Sterile Processing – Cart Washer	$0.30	Ordered	MOH, FFGRHD
Prince George	UHNBC – Waste handling system	$0.85	Ordered	MOH, FFGRHD
Prince George	UHNBC – patient monitoring systems	$0.83	Ordered	FFGRHD, NH
Fort St James	Sprinkler system upgrade	$0.85	In Progress	MOH, SNRHD, NH
Quesnel	Dunrovin – Energy Conservation Measures	$0.32	In Progress	MOH, CCRHD
Quesnel	GRB - Switchgear	$0.17	In Progress	MOH, CCRHD
Quesnel	GRB – QUESST renovation	$0.33	Planning	MOH, CCRHD
Quesnel	GRB – patient monitoring systems	$0.41	Ordered	MOH, CCRHD

Northeast Health Service Delivery Area (NE-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Dawson Creek	Medication dispensing cabinet	$0.11	Ordered	MOH, PRRHD
Dawson Creek	CT Console Upgrade	$0.22	Complete	Dawson Creek Foundation
Fort Nelson	Morgue room renovation	$0.78	Complete	MOH, NRRHD, NH
Fort Nelson	Tub room renovation	$0.30	Complete	MOH, NRRHD, NH
Fort St. John	CT Console Upgrade	$0.20	Complete	FSJ Hospital Foundation
Fort St John	Medical office building	$4.75	In progress	NH

Northwest Health Service Delivery Area (NW-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Terrace	MMH – DR Room 1	$0.46	Ordered	MOH, NWRHD, NH
Terrace	MMH Nurse Call System	$0.35	In Progress	MOH, NWRHD
Smithers	BVDH Boiler and Controls	$0.27	In Progress	MOH, NWRHD, Energy Grants
Prince Rupert	Electrical power system upgrade	$1.65	Complete	MOH, NWRHD, NH
Hazelton	Wrinch Sprinkler System	$1.42	Complete	NWRHD, NH
Stewart	Ventilation Isolation	$0.28	In Progress	MOH, NWRHD, Energy Grants
Stikine	Energy Conservation Measures	$0.29	In Progress	MOH, NWRHD, Energy Grants
Queen Charlotte	Hospital replacement	$50.00	In progress	MOH, NWRHD

Regional Projects

Community	Project	Project $M	Status	Funding partner (note 1)
All	Community Health Record (Phase 1)	$2.63	In Progress	MOH, CCRHD, FFGRHD, NRRHD, NWRHD, PRRHD, SNRHD

In addition to above major capital projects, NH receives funding from the Ministry of Health, Regional Hospital Districts, Foundations, and Auxiliaries for minor equipment and projects (less than $100,000). For 2015-16, it is forecasted that NH will spend $8.7M on such items.

Recommendation:

Information only.

Primary Care Program
600 - 299 Victoria Street
Prince George, BC V2L 5B8
Phone: (250) 649-4876

BRIEFING NOTE

Date:	**January 18, 2016**	
Agenda item	**Primary Health Care Update**	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**Performance, Planning and Priorities Committee**	
Prepared by:	**Kelly Gunn, Vice President Primary and Community Care and Clinical Programs**	
Reviewed by:	**Cathy Ulrich, CEO**	

Issue:

To provide an overview of the Primary Care priorities and work in progress under the leadership of the Primary Care Program.

Background:

The Idealized Northern Health System of Services is built upon a foundation of primary care, where individuals have access to primary care providers and coordinated health services including interprofessional care, specialized community services, and higher levels of care.

The work of the Primary Care Program falls under three themes:

1. Provincial partnerships and participation;
2. Primary Care Provider engagement and partnerships; and
3. Primary Care practice and clinic level support.

Primary Care Program Update:

1. Provincial Partnerships and Participation

The General Practice Services Committee (GPSC) is a partnership of the Government of BC and the Doctors of BC. The GPSC's aim is to work on behalf of doctors to strengthen full-service family practice and patient care in BC. One role of the GPSC is to sponsor the Divisions of Family Practice[i] whose purpose is to:

- Bring community based family physicians together to work on common health care goals;
- Develop incentive payments to help family physicians deal with increasing demands of family medicine; and

- Offer practice support coaching and resources to improve primary care practice quality and efficiency through the Provincial Practice Support Program.

Northern Health's Executive Lead, Primary Care, serves as our Committee representative to advise and provide a northern and rural perspective on the implementation of GPSC initiatives. The Executive and Medical Leads for Primary Care also play a critical role in engaging Northern Divisions of Family Practice in our integration work.

2. Primary Care Provider Engagement and Partnerships

Northern Health's partnership with the Divisions of Family Practice is integral to our efforts to build collaborative relationships with northern Family Practitioners. In Northern Health there are currently five active Divisions:

- The Pacific Northwest Division;
- The Prince George Division;
- The Northern Interior Rural Division,
- The North Peace Division; and
- The Rural and Remote Division (Hazleton Chapter).

Through the Divisions of Family Practice structure, priority GPSC initiatives[ii] are advanced and as mentioned above, the Divisions play a critical role in Northern Health's efforts to support Primary Care Homes to provide person and family centered care, supported by Interprofessional Teams.

It is important to note that the Primary Care program also works to engage Family Practitioners in communities that are not currently part of a Division, namely Quesnel, Fort Nelson, and the South Peace region of the North East (Dawson Creek, Chetwynd, and Tumbler Ridge). The Executive Lead Primary Care and the Medical Lead, Dr. Paul Murray, work to engage with communities in each Health Service Delivery Area (HSDA) through community based primary care provider discussions about how we can partner effectively to strengthen primary care service delivery. In November 2015, community sessions were hosted in the northwest communities of Prince Rupert, Kitimat, Terrace, and Smithers. Similar discussions were held in the first week of January, 2016 in the northeast communities of Fort Nelson, Fort St John, Chetwynd, Dawson Creek, and Tumbler Ridge. These consultative discussions allow primary care providers opportunity to shape the implementation of interprofessional teams and delivering team based care.

Nurse Practitioner (NP) Integration

Seven new Nurse Practitioners have been recruited to Northern Health over the last year bringing our staff total to 28 positions. We are actively recruiting to an additional nine vacancies. Nurse Practitioner positions are continually evaluated to determine where to deploy these positions regionally to first stabilize primary care systems in vulnerable communities and to augment and strengthen primary care services for specific populations.

Nurse Practitioners (NPs) provide primary care services in many communities throughout the north in a number of practice settings that include Northern Health owned and operated primary care clinics, private primary care practices and community outreach and service locations that include academic institutions. For example, Nurse Practitioners have added primary care capacity in the following areas:

- Northeast - Chetwynd, Fort St John, and Hudson's Hope
- Northern Interior – The College of New Caledonia/the University of Northern British Columbia, Burns Lake/Lakes District and Quesnel
- Northwest – Kitwanga and Hazelton

In partnership with the First Nations Health Authority, additional NP support will be offered in the communities of Kitselaas, Kitsumkalum and Haisla.

3. Primary Care Practice and Clinic Support

The Primary Care Program provides primary care practice and clinic support through a number of approaches including assisting primary care providers with the meaningful use of Electronic Medical Records and implementing primary care quality improvement processes. An example of a quality improvement initiative is the use of a scheduling process to improve patient access by ensuring that every third appointment time is left open to allow people with emergent health needs to be seen on the same day.

EMR Support and Optimization

Northern Health uses the Medical Office Information System (MOIS) Electronic Medical Record (EMR)[iii]. The EMR is a key enabler to integrated coordinated care. Working with Information Technology Services (ITS), the Primary Care Program supports the delivery of EMR training for Primary Care Providers in the Primary Care environment and is developing EMR training for Interprofessional Teams.

Primary Care Quality Improvement and Coaching

Primary Care quality improvement and Practice Support coaching is provided through the delivery of the provincial Practice Support Program (PSP). The PSP is an initiative of the General Practices Services Committee (GPSC) and supports physicians in their practice through learning modules, small group learning sessions and one-to-one coaching to support quality and process improvement work. There are 20 Practice Support Coaches in the north led by a Regional Coordinator position. Traditionally, the PSP coaching focus has been exclusive to physicians. The current focus of the Primary Care Program is to work with the GPSC and the PSP to expand the mandate of the Practice Support Coaches to include support for the Interprofessional Teams.

Primary Care Homes (New Clinic Development)

In an effort to stabilize vulnerable primary care systems in some northern communities, Northern Health has established Primary Care Clinics in Fort St. John and Chetwynd. Plans are underway for a Primary Care Clinic in Quesnel and to transition Health Clinics in Houston and Tumbler Ridge to Primary Care Homes supported by Interprofessional Teams.

Primary Care Operational Support and Standardization

The Primary Care Program has established the 'Primary Care Network'; a forum for operational leaders to identify and address priority work necessary to effectively support Primary Care Homes and develop processes to appropriately involve Interprofessional Teams in the care of people and families. The Primary Care Network has been useful for operational leaders (Health Services Administrators, Team Leaders, etc.) to innovate, share knowledge across the region, problem solve and identify staff training and support needs. This Network has met twice since its inception and early feedback from participants has been positive.

Recommendation(s):

This report is provided to the Performance, Planning and Priorities Committee for information and discussion.

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[i] There are 35 Divisions in the Province and 5 Divisions in Northern Health

[ii] Incentives to increase patient attachment to primary care, provide in-patient care, maternity care, and support for Residential Care, etc.

[iii] There are other EMRs in use across the Health Authority e.g. WOLF, Osler, Med Access.

A Community Partnership: Primary Care Clinic Development and Physician Recruitment

NH Board Meeting

February 15, 2016

Debbie Strang, Health Service Administrator
Dr. Dietrich Furstenburg, Chief of Staff

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Collaboration

The work and activity of a number of persons who individually contribute toward the efficiency of the whole.

Merriam-Webster Online Dictionary 2014

The Challenge

- 17 General Practice Physicians in the Community
- Projecting 9 Physician vacancies in 2015-2016
  - Two existing vacancies
  - Four leaving in 2015, three in 2016
- Recruiting for ER, GPO and GPA's

First Steps

- April 1, 2015 – community meeting held and hosted by NH Medical Administration
- Physicians, Community Leaders, MLA, NH Clinical Managers
- Identified critical issues and potential solutions
- Table discussions with small working groups

Four Topic Areas

- Short term mitigation
- Recruitment
- Retention
- Community support

Action Plan

- Communication – Jonathon Dyck
- Oversight Committee – Debbie Strang
- Recruitment Committee – Margie Wiebe
- Project Team – Margie Wiebe, Dori Pears

Communication

- Communication strategy developed
- Article on Specialty Services
- Article introducing 2 new Physicians and 1 Nurse Practitioner
- Recruitment video with local Physician
  - Recruiting Video
- Article on appropriate use of ER
- Media event May 1st

Oversight Committee

- Mayor, MLA, CCRHD, Chief of Staff, Health Service Administrator
- Sourced location of new clinic
- Approached community partners for incentives i.e. vehicle usage and accommodation
- Physician mentorship program
- Ownership and governance of new clinic
- Review recruitment opportunities

Recruitment Committee

- Practice Support Coach, Economic Development, Northern Health Physician Recruitment, Chief of Staff, Quesnel Health Service Administrative Assistant
- Meet regularly to review status and updates
- Red carpet events
- Car rentals, housing options

Project Team

- Project Lead, Primary Care Lead, NH Leasing Manager, 2 Physicians, 2 NPs, Regional Manager Primary Clinics, Quesnel Community Manager, IT
- Developed layout of clinic
- Planned for IT requirements
- Reviewed equipment needs
- Planned for operating structure

New Primary Care Clinic Model

- Will start with 2 Physicians and 2 Nurse Practitioners
- Located in temporary space Feb 1/16
- 1 Interprofessional Team – under development
- 3 clinic staff
- Advanced access component
- Video conferencing capabilities
- Group medical visits
- Will maintain list of people waiting for a physician

Current State

- Recruitment of 10 Physicians have been confirmed
- Will have complete complement January 2017
- Recruited second Nurse Practitioner
- City pays accommodation rental for new recruits and provides vehicle for a maximum of 3 months
- Clinic planning complete, ready for operationalizing
- Clinic Coordinator and 3 PCAs hired
- City grant through NDIT for façade improvements
- Clinic Operations Oversight Committee created

Next steps

- Temporary location sourced and will begin transitioning to primary care model February 1 2016
- Construction beginning February 2016
- Continued development of the Interprofessional Team
- COOC to continue developing evaluation components and operational processes
- Develop orientation and training schedule for clinic staff and Interprofessional Team
- Tentative opening date April/May 2016
- Continue to operationalize the clinic - i.e. order equipment, post jobs, set rotations etc.

Questions

DIRECTOR LIABILITY V.1 **BRD 510**

Members of the Board of Directors of Northern Health (the "Board") act both as agents of Northern Health and as directors of Northern Health's assets. Directors[1] are responsible to act only within the authority given to them by governing legislation, regulations and policy, and Northern Health's by-laws. Directors are expected to exercise the care, diligence and honesty expected of a reasonable person, in similar circumstances.

If a director *knowingly* acts outside this authority, those actions may be invalid (doctrine of *ultra vires*[2]) and in some instances a Director may be held personally liable for the adverse consequences resulting to Northern Health.

Individually and as a group, Directors are exposed to actions under common law, civil law and, in some cases, criminal law. To reduce the risk of litigation for Directors, protection is provided by legislation, the *Health Authorities Act* and the Health Care Protection Plan's (HCPP) Directors' and Officers' Liability and Corporate Reimbursement Agreement.

The *Health Authorities Act* provides protection under Section 14 as follows:

> Liability of members
>
> **14** (1) No action for damages lies or may be brought against a member, officer or employee of a board because of anything done or omitted in good faith
>
> (a) in the performance or intended performance of any duty under this Act, or
>
> (b) in the exercise or intended exercise of any power under this Act.

The Directors' and Officers' Liability and Corporate Reimbursement Agreement is provided by the Health Care Protection Program (HCPP) through the Risk Management Branch, Ministry of Finance. Covered parties include Directors of Northern Health.

Coverage is provided for a Director for all loss resulting from a claim for a wrongful act arising solely out of their duties. Examples of exclusions to this coverage include: any act, error or omission resulting from a Director failing to act honestly and in good faith

[1] A Director is defined as: any person, who was, now is or shall become a duly elected or appointed Director of Northern Health, while acting within the scope of his/her duties as a Director of Northern Health.

[2] Ultra vires is a Latin phrase meaning literally "beyond the powers". If an act requires legal authority and it is done with such authority, it is characterised in law as intra vires (literally "within the powers"). If it is done without such authority, it is ultra vires. Acts that are intra vires may equivalently be termed "valid" and those that are ultra vires "invalid".

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

in the best interest of Northern Health; any act, error or admission outside the course of the Director's duties with Northern Health; or any loss arising out of a dishonest, fraudulent, criminal or illegal act or omission of a Director. However, for the purposes of this exclusion, knowledge possessed by any one Director shall not be imputed to any other.

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

BRD 530

PROCESS FOR DIRECTORS TO RAISE PUBLIC CONCERNS V.1

Introduction

The purpose of this policy is to ensure that a clear process exists by which Directors of the Board of Northern Health (the "Board") may direct concerns or complaints received by them from members of the public, or concerns of their own, to the office of the President and Chief Executive Officer (the "CEO") for investigation, and to be assured of a timely and appropriate response. There is a distinction between administrative complaints and complaints involving clinical or patient care issues.

Process

A. Administrative Concerns & Complaints

a) From the Public

The Director shall forward concerns or complaints of an administrative policy or process nature requiring investigation to the Executive Assistant to the CEO/Board with a copy of the correspondence, *or* by providing a brief description of the complaint if received verbally. The Director shall ensure that contact information for the complainant is provided in order to ensure a prompt response.

Where it is unlikely that the concern/complaint can be resolved within one week, the CEO or designate will forward a written acknowledgment to the individual making the complaint, indicating that the concern/complaint is under review and will be responded to as soon as possible. A copy of this acknowledgment will also be provided to the Board Chair and to the entire Board at the next Board meeting.

b) From Directors

A Director may have occasion to raise concerns, whether in their role as a member of the Board or as a member of the public.

If the Director has concerns about a fellow Director or the CEO he/she shall first have a discussion with the Board Chair. If the concern is about the Board Chair the Director shall first have a discussion with the Board Vice-Chair and the CEO.

If the concern is about a Northern Health staff member or service, a physician, or any other matter dealing with the operation or management of Northern Health, the Director shall first raise their concern directly with the CEO either verbally or in writing. The same timely process for response as delineated under 'From the Public' shall be followed.

Directors should not raise issues of this nature at Committee or Board meetings until there has been appropriate opportunity for proper advance investigation or preparation by the CEO and management that could lead to timely resolution.

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

B. Clinical or Patient Care/Safety Concerns & Complaints

Some complaints or incidents may involve legal risks related to standards of care or injury/harm resulting from the activities of Northern Health. Communications on these issues will be managed by the CEO through staff responsible for risk management to ensure compliance with the adverse event reporting procedures and to meet the reporting requirements of the Health Care Protection Program (HCPP), Northern Health's insurer.[1]

Complaints from patients are governed by the *Patient Care Quality Review Board ~~(PCQRB)~~ Act* (PCQRB Act) and follow provincial processes for response outlined in Ministerial Directives. These complaints are handled through the Northern Health Patient Care Quality Office (PCQO).

Directors receiving complaints from patients or patient representatives shall forward such complaints to the Executive Assistant to the CEO/Board with a copy of the correspondence, or by providing a brief description of the complaint if received verbally. The Director shall ensure that contact information for the complainant is provided in order to ensure a prompt response.

Communications on these issues will be managed by the CEO through staff responsible for the PCQO to ensure compliance with legislation and provincial process and to liaise with risk management if needed.

Reporting to the Board will depend on the nature of the complaint. Reports may be made through the CEO Report, as a separate Board or Board Committee agenda item, as a Section 51 follow-up through the 3P Committee, or as determined by the CEO.

[1] DST 4-2-1-030-P Health Care Protection Program (HCPP): Reportable Incidents
https://ournh.northernhealth.ca/PoliciesProcedures/DST%20Published%20Policies/4-2-1-030.pdf~~https://iportal.northernhealth.ca/CorporateResources/policies/NH%20DSTs/4-Corporate%20Admin/4-2-0-Risk%20Management/4-2-1-Claims%20Management/4-2-1-030-P.pdf~~

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

ORGANIZATION AND PROCEDURE BYLAWS V.1 BRD 600

DEFINITIONS

1.1 In these bylaws

a. "Act" means *Health Authorities Act*, and the regulations made there under.

b. "Board" means Northern Health Authority as designated pursuant to the Act and, as the context requires, also refers to the full board of Members for the Northern Health Authority (the "Board").

c. "Bylaws" means the bylaws of the Board.

d. "Chief Executive Officer" means the President and Chief Executive Officer engaged by the Board to manage its affairs (the "CEO").

e. "Health Facility" means the facilities, agencies or organizations by or through which the regional services (as defined in the Act) are provided for the Region.

f. "Health Services" means those services which the Board has agreed to manage or undertake through an agreement with the Province of British Columbia, and includes Housing Services.

g. "Housing Services" means the acquisition, construction, holding, owning, supplying, operating, managing and maintaining of housing accommodation and incidental facilities.

h. "Member" means a person appointed to the Board, by the Minister, pursuant to Act and in accordance with Ministry policy from time to time.

i. "Minister" means the Minister of Health of the Province of British Columbia.

j. "Other Acts" means all other statutes which pertain to the management and operation of the Health Services for which the Board has been delegated authority by the Minister and the regulations made there under.

k. "Ordinary Resolution" means a resolution passed by a simple majority of the persons entitled to vote who are present in person, by telephone or by videoconference at a meeting of the Members.

l. "Special Resolution" means a resolution passed by a majority of 2/3 or more of the persons entitled to vote as are present in person, by telephone or by videoconference at a meeting of the Members of which notice specifying the intention to propose the resolution as a Special Resolution has been duly given.

m. "Region" means the region designated for the Health Authority as determined pursuant to the Act.

1.2 The definitions in the Act on the date these bylaws become effective apply to these bylaws.

Author(s): Ministry of Health Services; Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): November 14, 2014 (R)

1.3 In these bylaws, words importing the singular include the plural and vice versa.

ARTICLE 2 - NORTHERN HEALTH AUTHORITY

2.1 **General** - The Board shall have the powers and purposes as are set out in the Act and as defined in these bylaws and in the Other Acts, and the property and affairs of the Board shall be managed by the Board in which shall be vested full control of the assets, liabilities, revenues and expenditures of the Board.

2.2 **Contracts and Agreements** - The Board may by Ordinary Resolution designate that orders and other contracts which exceed a stated monetary limit may only be entered into on written authority of the Board. Additionally all contracts for the acquisition or disposal of real property shall be authorized by Ordinary Resolution. In respect of orders or contracts not involving real property or which cost or involve sums less than the amounts specified or limited by the Board, the CEO and other senior staff designated by the CEO shall have the power to make such orders and contracts on behalf of the Board.

2.3 **Banking** - The banking business of the Board shall be transacted with such banks, trust companies, or other firms or bodies corporate as the Board may designate, appoint or authorize from time to time and all such banking business, or any part thereof, shall be transacted on the Board's behalf by such one or more Officers or other persons as the Board may designate, direct or authorize from time to time and to the extent thereby provided.

2.4 **Board to Govern Operations** -The Board may make rules and regulations governing its operations and the operations of the Health Facilities, which are not inconsistent with the Act, the Other Acts, or the provisions of these bylaws.

ARTICLE 3 - MEMBERS

3.1 **Appointment of Members** - Each Member will be appointed by the Minister to the Board in accordance with the Act.

3.2 **Vacancy on Board** - The Board will advise the Minister if a vacancy occurs on the Board for any reason.

3.3 **Nominations for Board** - The Board may provide the Minister with recommendations for new Members of the Board.

3.4 **Remuneration for Members** - Members shall be entitled to such remuneration as the Minister shall determine but in no event shall Members be entitled to receive remuneration in connection with duties related to Housing Services. Members shall be entitled to be paid reasonable expenses in connection with the performance of their duties. No part of the income of the Authority shall be otherwise available for the personal benefit of any Member. The latter provision is unalterable.

Author(s): Ministry of Health Services; Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): November 14, 2014 (R)

ARTICLE 4 - OFFICERS

4.1 **Chair** - The Minister will designate the Chair of the Board.

4.2 **Other Officers** - The Board may elect such other Officers for such other terms of office as the Board may determine and may fill vacancies in such offices as the Board shall determine.

4.3 **Secretary** - The CEO shall be the Secretary to the Board unless the Board otherwise determines. The appointment of the CEO to hold office does not entitle the CEO to be a Member, nor to vote at meetings of the Board or any of its committees.

4.4 **Officers** - The Board may decide what functions and duties each Officer will perform and may entrust to and confer upon such Officer any of the powers exercisable by the Board upon such terms and conditions as they think fit and may from time to time revoke, withdraw, alter or vary any of such functions, duties and powers.

ARTICLE 5 - COMMITTEES OF THE BOARD

5.1 **Committees** - The Members may appoint one or more committees consisting of such Member or Members of the Board as they think fit and may delegate[1] to any such committee any powers of the Board; except, the power to fill vacancies in the Board, the power to change the membership of or fill vacancies in any committee of the Board, and the power to appoint or remove Officers appointed by the Board.

5.2 **Procedures of Committees** - All committees may meet and adjourn as they think fit. A quorum for any Board Committee meeting will consist of two or more Members of the Board. All committees will keep minutes of their actions and will cause them to be recorded in books kept for that purpose and will report the same to the Board at such times as the Board requires. The Board will also have power at any time to revoke or override any authority given to, or acts to be done by, any such committees except as to acts done before such revocation or overriding, and to terminate the appointment or change the membership of a committee and to fill vacancies in it. Committees may make rules for the conduct of their business[2]. The CEO will act as official secretary for all Board Committees and through consultation with the Chair of the Committee, delegate this task as appropriate.

[1] It is the practice of the Northern Health Board not to delegate powers of the Board to a Committee except in rare and well defined circumstances.
[2] It is the practice of the Northern Health Board that Terms of Reference and Work Plans of Committees must be approved by the Board.

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ARTICLE 6 – MEETINGS OF THE BOARD

6.1 **Proceedings** - The Board shall meet at such times and as frequently as the Board shall determine. At the discretion of the Board, part or all of the proceedings of the Board at a Board meeting may be open to the public, but the Board shall exclude the public from a meeting or portion of a meeting if the Board considers that, in order to protect the interests of a person or the public interest, the desirability of avoiding disclosure of information to be presented outweighs the desirability of public disclosure of that information.

6.2 **Quorum** - The quorum for any meeting of the Board shall be a majority of the Members of the Board[3].

6.3 **Participation by Telephone and Other Means** - A Member may participate in a Board meeting or committee meeting by telephone call or videoconference and is not required to be physically present to be counted as part of the quorum.

6.4 **Notice** - Notice of each meeting of the Board shall be given to each Member in writing or by fax or email delivery. Notice of committee meetings shall be reasonable notice in the circumstances.

6.5 **Right to Vote** - Each Member is entitled to vote at all meetings of the Board.

6.6 **Number of Votes** - Each Member, including the Chair, is entitled to one vote.

6.7 **Method of Voting** - Voting in a committee meeting or a Board meeting is by a show of hands unless determined otherwise by the Board for a particular resolution or to accommodate a Member participating by telephone call or video conference.

6.8 **Adjourned Meeting for Lack of Quorum** - In the event a meeting of the Board cannot be held due to a lack of quorum such meeting shall have been deemed to be adjourned to a future date set by the Members present at the meeting. The date of adjourned meeting shall allow sufficient time for notice of adjournment to be given to all Members. There shall be no quorum requirements for the holding of an adjourned meeting.

6.9 **Rules of Procedure** - Except where otherwise provided by the Board or these bylaws all matters of procedure at any meetings of the Board shall be decided in accordance with the most recently revised edition of Roberts Rules of Order.

6.10 **Appoint Chair** - The Chair or in his or her absence, the Deputy Chair, shall preside as Chair at every meeting of the Board.

6.11 **Consent Resolutions** - A resolution in writing signed by all Members shall be valid and effectual as if it had been passed at a meeting of the Members duly called and constituted. Consent resolutions may be validly passed by execution by Members, delivered in counterparts and by facsimile.

6.12 **Ordinary Motions** - All ordinary motions will be approved by a simple majority of Members present and eligible to vote.

[3] 50% is a majority for the purpose of quorum.

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ARTICLE 7 – LIABILITY AND OBLIGATION OF MEMBERS/OFFICERS

7.1 **No Action** - No action for damages lies or may be brought against a Member or Officer because of anything done or omitted in good faith:

a. in the performance or intended performance of any duty under the Act or Other Acts; or

b. in the exercise or intended exercise of any power under the Act or Other Acts.

7.2 **Disclosure of Interest** - A Member or Officer who is, directly or indirectly, interested in a proposed contract or transaction with the Board shall disclose fully and promptly the nature and extent of his or her interest to each Member and have such disclosure recorded in the minutes of the next meeting of the Board.

7.3 **Indemnity** - Subject to the provisions of the *Society Act* (BC), which is applicable pursuant to Order in Council #1236 under the Act, a Member of the Board of Directors of the Northern Health Authority and his or her heirs, executors, administrators and assigns may be indemnified against all costs, charges and expenses including any amount paid to settle an action or satisfy a judgment, actually and reasonably incurred by an indemnity in a civil, criminal or administrative action or proceeding to which such a Member is made a party by reason of being or having been a Member of the Board, including any action brought by the Board if:

a. the Member acted honestly and in good faith with a view to the best interests of the Board; and

b. in the case of a criminal or administrative action or proceeding, the Member had reasonable grounds to believe his or her conduct was lawful.

ARTICLE 8 - CORPORATE ADDRESS

8.1 **Corporate Address** -The Board will maintain one corporate address where all communications and notices are to be sent or delivered, and will advise the Minister of any change of corporate address.

ARTICLE 9 - EXECUTION OF DOCUMENTS

9.1 **Authority to Execute** - All documents and contracts of the Board may be executed on behalf of the Board by the CEO or senior executives of the Board who are authorized by the CEO, provided that, in those instances in which the written authority of the Board to such document or contract is required under the terms of bylaw 2.2, the Chair or another Member designated by the Chair shall also execute the document or otherwise signify in writing the express consent of the Board to the execution of the document or contract on behalf of the Board.

9.2 **Routine Correspondence and Appointments** - In the absence of the Board Chair the CEO shall be empowered to execute on behalf of the Board routine correspondence and medical staff applications and appointments.

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ARTICLE 10 - GENERAL

10.1 Certificates of Incapability - The Board authorizes the CEO to designate persons as having authority to issue certificates of incapability under section 32 of the *Adult Guardianship Act*.

ARTICLE 11 - ADOPTION OF BYLAWS AND AMENDMENTS

11.1 **Special Resolution Required** - The bylaws may only be amended by Special Resolution.

11.2 **Ministerial Approval** - Bylaws and amendments to the bylaws are subject to the Minister's approval.

11.3 **Members to have Copy** - Every Member shall receive a copy of every bylaw of the Board upon request.

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DIRECTOR COMPENSATION AND EXPENSE GUIDELINES V.1 **BRD 610**

BOARD REMUNERATION

Introduction

The purpose of this policy is to ensure that there is a clear description of the amounts payable to members of the Board of Directors of Northern Health (the "Board") for their time while discharging their duties on behalf of Northern Health[1]. The policy also addresses reimbursement of expenses.

Annual Retainers

The annual retainer portion of Board remuneration is meant to compensate Directors for their time and expertise outside of Board and Board Committee meetings, including but not limited to attendance at Northern Health related meetings and functions other than Board or Board Committee meetings, reading in preparation for Board and Board Committee meetings, and the first two hours of travel to or from Board or Board Committee meetings etc.

- Chair $15,000
- Director $ 7,500
- Audit & Finance Committee Chair $ 5,000
- Other Committee Chairs $ 3,000

Note: Committee Chair retainers are in addition to Directors' retainers.

Payment for Attendance at Board and Committee Meetings

Directors attending Board or Board Committee meetings will be compensated as follows:

- For meetings in excess of 4 hours duration $500
- For meetings of 4 hours or less duration $250

No distinction will be made between participation in person, by videoconference or by teleconference or such other mode that permits an appointee to hear, and be heard by, all other participants.

Travel Time Compensation

Travel time to and from Board and Board Committee meetings is reimbursed at the rate of $62.50 per hour, or part thereof, but not including the first two hours of travel in each direction.

[1] This document conforms to Treasury Board Directive 3/11 dated December 16, 2010.

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Travel time shall be calculated from the Director's normal place of residence. Exceptions will be handled on a case by case basis in consultation with the Corporate Secretary and/or Board Chair.

Maximum Daily Compensation
Compensation for Board and Board Committee meetings and associated travel time will not exceed $500 in total in a 24-hour day.

Annual Compensation Limits[2]

- Chair $45,000
- Director $22,500
- Audit & Finance committee chair $27,500
- Other board committee chairs $25,500

Expense Reimbursement
Expenses are reimbursed to Directors for out of pocket expenses paid by Directors while conducting Board business. Expense reimbursement is not included within the annual compensation limits.

Directors are reimbursed for transportation, accommodation, per-diem meal and out-of-pocket expenses incurred in the course of their duties in accordance with Treasury Board directives[3]. Expense claims, other than per-diem allowances, must be supported by receipts.

Transportation and accommodation arrangements should be based on overall economy and efficiency, balancing the travel costs with the director's time commitments and travel safety. All air travel is to be booked utilizing economy class airfares and, wherever possible, arrangements should be made to obtain early booking discounts. If a Board member chooses ground transportation over air travel, the mileage compensation claimed should be less than or equal to the cost of an economy class air fare.

Preferred government rates should be used for accommodation and car rentals whenever possible.

Subject to prior approval by the Board Chair, a director attending a conference or professional development activity will be reimbursed for the registration fee and expenses on the same basis as other travel on Northern Health business.

[2] The sum of retainer plus meeting fees and travel time
[3] Board members are reimbursed using the same rates payable to Northern Health non-contract staff, which is also consistent with Treasury Board guidelines.

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Payment

Payment of Board and Board Committee meeting fees, and travel time, will be processed by the Corporate Secretary based on attendance confirmed in Board and Committee meeting minutes.

Reimbursement of expenses will be made to Directors upon submission of approved Board Member Expense Claim Forms. All claim forms are to be submitted to the Corporate Secretary for processing[4].

The annual retainer is pro-rated and paid on a monthly basis. All payments to Directors are made through the Northern Health payroll system by direct deposit.

The annual retainer, meeting fees, and compensation for travel time are subject to statutory deductions and are taxable as employment income. Expense reimbursement is not subject to statutory deductions.

[4] Claims must be submitted on a timely basis after expenses are incurred. Directors are further requested to take note of the March 31st fiscal year-end. Claims will be processed for payment within 7 days of receipt.

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