Meeting of the Northern Health Board
Public Meeting
Monday – April 16, 2018

Best Western Terrace Inn
Skeena Room
(4553 Greig Avenue)
Terrace, BC

northern health
the northern way of caring

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Public Session

AGENDA

April 16, 2018
Best Western Terrace Inn
Skeena Meeting Room
4553 Greig Avenue, Terrace BC

AGENDA ITEMS	Responsibility of…	Expected Outcome	Time (Approx.)	Page
1. Call to Order of Open Board Session	Chair Nyce		**11:15am**	
2. Opening Remarks	Chair Nyce			
3. Conflict of Interest Declaration	Chair Nyce	Discussion		
4. Approval of Agenda	Chair Nyce	Motion		
5. Approval of Previous Minutes: February 19, 2018	Chair Nyce	Motion		**3**
6. Business Arising from Previous Minutes	Chair Nyce			
7. CEO Report	C Ulrich	Information		**8**
7.1 Human Resources Report	D Williams	Information		**12**
8. Audit & Finance Committee				
8.1 Period 12 Comments & Financial Statement	M De Croos	Motion		**24**
8.2 Major Capital Expenditure Plan Update (Period 12)	M De Croos	Motion		**26**
9. Performance, Planning & Priorities Committee				
9.1 Strategic Priority: Coordinated and Accessible Services				
9.1.1. Northern First Nations Health and Wellness Plan	M Greenwood	Information		**31**
9.2 Strategic Priority: Quality				
9.2.1. Annual Review – Integrated Ethics Framework	K Thomson	Information		**39**
10. Presentation: Specialized Mental Health and Substance Use Services: Improvements in the Terrace and Kitimat corridor that are supporting the whole North West **Presenters:** 1. Clare Cooper, Director, Specialized Services, NW Integrated Health Services 2. Jennifer Hass, Team Lead ICMT 3. Briana Emery, Team Lead Inpatient Psychiatry	C Panessa	Information		**-**
11. Governance & Management Relations Committee				
11.1 Policy Manual BRD 100 Series	K Thomson	Motion		**43**
11.2 Code of Conduct Signing (BRD 210)	K Thomson	Motion		**66**
11.3 Overview of Research Partnerships	F Bell	Information		**75**
11.4 Designation of Medical School Officer for NE	K Thomson	Motion		**93**
11.5 Regulatory Framework – Legislative Compliance: Residential Tenancy Act	K Thomson	Information		**95**
Adjourned			**12:40pm**	

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Public Motions *Meeting Date: April 16, 2018*				
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 April 16, 2018 public agenda as presented.		
5.	Approval of Minutes	The Northern Health Board approves the February 19, 2018 public minutes as presented.	☐	☐
8.1	Period 12 Comments & Financial Statements	The Northern Health Board receives the 2017-18 Period 12 financial update as presented.	☐	☐
8.2	Major Capital Expenditure Plan update (Period 12)	The Northern Health Board receives the 2017-18 Period 12 capital expenditure plan update, as presented.	☐	☐
11.1	Policy Manual BRD 100 Series	The Northern Health Board approves the revised BRD 100 series.	☐	☐
11.2	Code of Conduct Signing and revised Policy BRD 210	The Northern Health Board approves the revised BRD 210 Policy.	☐	☐
11.4	Designation of Medical School Officer for North East	The Northern Health Board designates Dr. Jong Kim as the school medical officer for the school districts as described in the table provided.	☐	☐

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Board Meeting

Date: February 19, 2018

Location: Vanderhoof BC

Chair: Colleen Nyce

Recorder: Desa Chipman

Board:
- Ben Sander
- Frank Everitt
- Maurice Squires
- Brian Fehr
- Edward Stanford
- Rosemary Landry
- Gaurav Parmar
- Stephanie Killam

Executive:
- Cathy Ulrich
- Fraser Bell
- Kelly Gunn
- Mark De Croos
- Steve Raper
- David Williams
- Dr. Ronald Chapman
- Penny Anguish
- Dr. Sandra Allison
- Dr. Helene Smith

Public Minutes

1. Call to Order Public Session

The Open Board session was called to order at 9:35am.

2. Opening Remarks

Chair Nyce welcomed members of the public to the meeting and expressed pleasure at being in Vanderhoof and meeting in Stuart Nechako Manor.

3. Conflict of Interest Declaration

Chair Nyce 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 were no conflict of interest declarations made related to the February 19, 2018 Public agenda.

4. Approval of Agenda

Moved by S Killam seconded by G Parmar
The Northern Health Board approves the February 19, 2018 public agenda as presented

5. Approval of Previous Minutes

Moved by G Parmar seconded by F Everitt
The Northern Health Board approves the December 4, 2017 public minutes as presented

6. Business Arising from Previous Minutes

There was no business arising from previous minutes.

7. CEO Report

An overview of the CEO Report was provided with the following topics being highlighted:

- **St John Hospital Flooding** – an update was provided on the recent flooding event that occurred on February 10, 2019. It has been discovered that the likely cause was a hot water heater that had a frozen coil. Due to the maintenance area being on the second floor there was damage to the operating room area on the floor below. The Board will have the opportunity to tour the site following the public meeting. Due to the quick action of management, physicians and staff who were working at the time, the damage was not as severe as it could have been and everyone is to be commended for their quick action. The Board and Executive members will have the opportunity to tour the facility.
- Capital restoration has completed their investigation and the scope of the project has been provided. The contract has been given to Napp Enterprises. The abatement will take approximately 3 weeks and during the initial part a better understanding will be provided for the overall construction process. Some services from the OR will continue as scheduled having been referred out / perinatal – physicians will individually assess the patient to determine if they can still deliver in Vanderhoof (lower risk) – there is an emergency operating centre set up in the trauma area so that there is a space if an urgent issue arose.
- **Celebration of Life**: On Friday January 26, 2018 a Celebration of Life was held for Dr. Bert Kelly who passed away on December 12, 2017. Dr. Kelly had a vision for health care in northern BC. This vision was strategic and comprehensive. And maybe more importantly his vision was situated in what he knew about life in northern BC and what he knew about the experience of people in northern BC and he was patient but relentless in his pursuit of that vision. He cared passionately about his chosen profession. He was an expert clinician who recognized how critical education in the north for the north is to the sustainability of health services. He not only advocated for this education but lived out this commitment in his practice as he supported the education of many students. The North is a better place and we have a better health care system as a result of his life and dedication to his profession.
- **Project Health:** Once a year, St John Hospital hosts local high school students interested in health care professions for a full day. Students are able to have hands on experiences throughout the day. These experiences include such opportunities as observing how x-ray equipment works, using an ultrasound machine, visiting the acute, oncology and emergency departments, having hands on experiences with OT and PT professionals, suturing pig's feet, and visiting the residents of Stuart Nechako Manor. These hands on experiences are an excellent way to encourage students to consider health care professions as a career choice.
- **Opioid Response in the Omineca area:** There is a Local Improvement Team in Vanderhoof focused on substance use issues with representation including the Mayor, Council, a physician, community services staff, RCMP, and the high school Principal. This is an active and engaged team who are focused on prevention and education for youth struggling with mental health and substance use issues. Some of the family practice physicians are also providing a regular medical clinic in the local high school to increase access to services.
- **In Fort St. James**, the primary and community care space planning is progressing well. This project will co-locate physician and nurse practitioner practices with the community services interprofessional team. This redeveloped space will enhance service delivery and access to services in the community and will provide improved space for primary care providers and staff.

7.1. Human Resources Report

An overview of the Human Resources Report was provided for information and discussion with the following topics being highlighted:

- Human Resources is continuously researching and implementing innovative and collaborative workforce planning, recruitment, and retention solutions to meet the goals

of the Our People priority, assisting the organization in achieving its vision of leading the way in promoting health and providing health services for Northern and rural populations.

- Currently, Human Resources is realigning components of its existing Health Human Resources Planning, Recruitment, and Retention strategies and supports to ensure a cohesive strategy that addresses the unique challenges faced by Northern Health and an ever-changing health care environment. This strategy will consist of clear objectives, associated actions, which will be submitted for Northern Health Board approval by September/October 2018.
- Northern Health's development of an Integrated Health Human Resources (HHR) Plan, which is occurring in partnership with the Ministry of Health, is well underway. This plan includes forecasts on key professions identified by the province (i.e. nursing and allied health). Over the course of 2017-18, Human Resources Planning and Design, the department responsible for Northern Health's HHR planning, has been refining analysis tools and improving metrics in order to support the organization in more effective workforce planning. Workforce planning will continue at the community level over 2018, and result in a Northern Health-specific HHR plan by the 2018/19 fiscal year end.
- To ensure a highly-inclusive and collaborative relationship with all of Northern Health's First Nations partners, the Recruitment department has begun initial conversations with the First Nations Health Authority. This collaboration will be a crucial foundational component to Northern Health's recruitment strategy (see below: Recruitment) and its success. Specifically, the Recruitment team is collaborating to:
  - Determine which strategies will resonate with specific communities and their community members
  - Connect directly with members of communities to recruit local talent
  - Ensure Northern Health is becoming more reflective of the communities it serves
- A multi-disciplinary team of HR professionals is working to refresh Northern Health's Onboarding Program. The new program will be hosted on our e-learning platform, and all new hires will be required to complete the program before their start date. After this program has launched, Northern Health's attention will shift to supporting operations in their review of site-specific orientation programs.
- To date in fiscal year 2017/18, Northern Health has posted 2135 positions, 83% have been filled by internal staff (existing regular and casual staff) and 8% have been filed externally (qualified applicants from outside of Northern Health). Some unfilled positions are currently in the competition phase. Positions that remain unfilled for more than 90 days become difficult-to-fill vacancies (DTFV). On average, only 5% of approximately 2,100 positions go to DTFV.
  - Casual hires are not reflected in this data. On average, NH hires 1,000 casuals per year, many of these staff successfully bid into permanent, ongoing positions through our internal posting process.
- To date in fiscal year 2017/18, Northern Health has posted 545 RN positions. 83% have been filled by internal staff and 4% have been filled externally. On average, 8% of RN postings become DTFV.
- The Board acknowledged the challenge in recruiting to rural and remote communities and commends the Human Resources team for the continued focus in this area.

8. Audit and Finance Committee

8.1. Period 9 Comments & Financial Statements

- Year to date Period 9, Northern Health's (NH) expenses exceeded revenues by $448,000.
- On base operations, revenues are favourable to budget by $1.5 million or 0.3% and expenses are unfavourable to budget by $1.9 million or 0.4%. Budget overage in Acute Care is primarily due to higher than expected patient volumes in a number of acute care facilities. Budget

overage in Long Term Care is primarily due to higher than expected employee sick time and resulting overtime to replace sick staff.
- At this time, Northern Health is forecasting to be in a balanced position on base operations at yearend.

Moved by G Parmar seconded by E Stanford
The Northern Health Board receives the 2017-18 Period 9 financial update as presented.

8.2. Period 9 Capital Expenditure Plan update
- The Northern Health Board approved the 2017-18 capital expenditure plan in February 2017, and amendments in July and December 2017. The updated plan approves total expenditures of $49.4M, with funding support from the Ministry of Health ($19M, 39%), Six Regional Hospital Districts ($18M, 37%), Foundations, Auxiliaries and Other Entities ($3.5M, 7%), and Northern Health ($8.5M, 17%).
- The details on the year to date Period 9 (November 30, 2017), $20.7M that has been spent towards the executive of the plan was outlined in the briefing note.
- In addition to 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 2017-18, it is forecasted that NH will spend $8.3M on such items.

Moved by B Sander seconded by G Parmar
The Northern Health Board receives the 2017-18 Period 9 capital expenditure plan update, as presented.

9. Performance, Planning & Priorities Committee

9.1. Clinical Program Quality Update: Surgical, Critical Care and Emergency Trauma
- Northern Health has established a number of clinical programs to stimulate and steward planning and quality improvement across the region for the services under their auspices.
- A summary update on the progress and the identified next steps of the Surgical, Critical Care, and Emergency/Trauma Programs' progress in achieving their goals and initiatives was provided. The priorities were highlighted as follows:
- The Surgical Services Program has identified a number of priorities for the 2017/18 fiscal year.
  - Continue to implement recommendations arising from the three-year Surgical Services Program Action Plan.
  - Facilitate continuous quality improvement in prioritized areas:
    - Surgical safety checklist
    - Prevention of Venous Thromboembolism (VTE)
    - Ensure timeliness of hip fracture fixation
    - Reduce percentage of patients waiting 26 weeks or more for elective surgery
  - Plan and steward regional implementation of the Ministry of Health's Accelerated Surgical Services Initiative.
- The Critical Care Services Program has four key priorities for 2017/18:
  - Sepsis management. Improve and maintain the use of the Sepsis Protocol in all Emergency Departments and across facility.
  - Improve Care for Patients experiencing pain, agitation and delirium (PAD) in Intensive Care Units through the development and implementation of leading practice protocols
  - Sustainability Goal: Transfer of Care Documentation. Ensure continued compliance with required documentation to ensure safe and effective transfers of patients between services (within and beyond NH).

- Develop a critical care network as a means to collaborate and share information across the region.

- The Emergency and Trauma Services program has established four broad priorities:
  - Preparation for trauma accreditation through the Accreditation Canada, Trauma Distinction Program in the fall, 2018.
  - Development of an enhanced network of support for rural emergency departments
  - Strengthened relationship between Emergency Services, Primary Care, and Community services.
  - Support improvements in high and low acuity patient transfers in partnership with BC Emergency Health Services.

9.2. Presentation: Transitions in Care through Acute, Community and Primary Care Homes.
Raquel Miles, Community Services Manager, Heather Goretzky, Practice Support Coach, and Dr. Suzanne Campbell, Family Physician in Vanderhoof joined the meeting to provide a presentation on the Transitions in Care through Acute, Community and Primary Care Homes.

- Patient stories were shared to showcase examples of how a team based approach is key in the transitions in care. An overview of the ongoing education and cross training was also provided.
- The Board members appreciated hearing the stories and the details around the work that has transpired and the work that will continue. Chair Nyce acknowledged the effectiveness of the team based approach and thanked the presenters for making themselves available to share this information with the Board.

10. Governance and Management Relations Committee

10.1. Policy Manual BRD 500 Series
The revised policy manual BRD 500 Series was presented to the Board for review and approval.

Moved by G Parmar seconded by R Landry
The Northern Health Board of Directors approves the revised BRD 500 series

10.2. Policy Manual BRD 600 Series
The revised policy manual BRD 600 Series was presented to the Board for review and approval.

Moved by G Parmar seconded by S Killam
The Northern Health Board of Directors approves revised BRD 600 series.

11. Men's Shed Collaboration

A presentation on the Men's Shed Collaboration was provided with Northern Health Life Skills Wroker, John Allen along with representatives from the Vanderhoof Men's Shed Executive Board, Gene Mitran, John Aldeliesten, Cliff Irving and John Dunn. The presentation shared the various aspects of the Men's Shed and the role it plays in the community. Appreciation was expressed by the guests to Northern Health for the partnership that has developed.

- The Northern Health Board members commended the work the Men's Shed undertakes within a community and were pleased to see the established partnership with Northern Health staff.

The Board meeting was adjourned at 11:44am
Moved by M Squires

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

CEO REPORT

Meeting:	Northern Health Board Meeting	Date:	April 5, 2018
Agenda Item:	CEO Report		
Purpose:	Information		
Prepared by:	Cathy Ulrich		

Access to Primary Care in Terrace:

Throughout 2017/18, there has been a growing number of people who are unattached to a primary care practice. This has occurred as physicians and their families have chosen to leave the community of Terrace. Primary Care physicians work in independent private practice businesses in the community and are compensated directly through a fee-for-service mechanism with the Ministry of Health. Northern Health works in partnership with the primary care physician practices in the community to recruit physicians to both the practice they undertake within the hospital environment (Northern Health's responsibility) and to the private practice in the community (physician responsibility). Currently, we are working in partnership to put in place strategies to address the significant and growing concern regarding physician recruitment and retention. These strategies include:

- Targeted recruitment and retention initiatives including the rural incentives and programs available through the provincial Rural Subsidiary Agreement and additional supports being established between physician practices and Northern Health.
- Collaborative recruitment and retention committee between physicians, Northern Health, the North West Regional Hospital District and the City of Terrace. The focus of this committee will be on recruitment and retention of physicians and their families to a particular community, which is a third important aspect of recruitment and retention.
- Establishing an unattached patient clinic in the community until the number of primary care physicians in the community increases and stabilizes.
- Addressing the sustainability of services in the Emergency Department at Mills Memorial Hospital to enable a better work-life balance for physicians recruited to the community.
- Providing access to an interprofessional team of health professionals such as nurses, social workers, mental health clinicians to support a team based approach to primary and community care.

We will be continuing this work with the community and the physicians in Terrace to support them as they recruit to their practices. Further detail regarding these strategies will be provided during the Northern Health Board meeting.

Mills Memorial Hospital Replacement Planning Process

On February 9, 2018, the Minister of Health announced that Northern Health would be moving forward with developing a business plan for the replacement of Mills Memorial Hospital. This is an important and exciting opportunity for the community of Terrace and the North West region and will enable an improved physical infrastructure for the provision of care to patients and their families and for physicians and staff as they provide services in the hospital environment. Partnerships BC is working with Northern Health on the development of the Business Plan. Currently, we are working on the procurement of the consultants in the area of engineering, architecture, legal, and cost consulting among others. We expect to complete the business plan by the late fall. There will be ongoing opportunity for consultation and engagement throughout this process.

The Dr. R.E.M. Lee Hospital Foundation – Terrace

Northern Health is very grateful for the partnership we have with the Dr. R.E.M. Lee Hospital Foundation. The Foundation collaborates with Northern Health managers to support investments that improve the quality of services that we provide to the residents in the Terrace area.

- As the result of a bequest to the Dr. R.E.M. Lee Hospital Foundation, Northern Health has been able to procure the following medical equipment for Mills Memorial Hospital:
  - $49,000 OPMI Pico Microscope for Ear, Nose, Throat specialists
  - $50,000 Colposcopy for cervical cancer screening
  - $48,000 Panda Warming Unit for the maternity unit
  - $21,000 Ultrasound unit software upgrade
- The Foundation is undertaking two campaigns this year to raise $509,000. To date they have raised $328,570 towards this goal.
- The Foundation is contributing funding to the following equipment:
  - $242,000 for a c-arm surgical unit, which completes phase II of the urology suite upgrade.
  - An ophthalmic surgical microscope for MMH. The current microscope is 15 years-old and is currently supporting 24-36 surgeries a week. With three surgeons, and an increased case load, a second instrument is required to support this expanding service.

On behalf of Northern Health, we thank both the Dr. R.E.M. Lee Hospital Foundation and those who faithfully support the foundation through volunteerism and philanthropy. The difference these efforts makes is 'the difference that makes a difference'.

Capital Projects completed in the Terrace area:

Several major capital projects were completed in the Terrace area this last year including:

- An upgrade to the MMH phone system - $350,000
- An upgrade to the Terrace View Lodge nurse call system - $461,000
- Replacement of a MMH Boiler - $341,000

In addition, approximately $457,000 was invested in medical and patient care equipment in the OR, lab, medical imaging, inpatient units and for community services at MMH, Terrace View Lodge and the community services interprofessional teams.

Second Annual Dr. Charles Jago Awards – 2018 Winners:

On March 7, 2018, Northern Health Board Chair, Colleen Nyce and I were privileged to recognize the winners and nominees of the Second Annual Dr. Charles Jago Awards at the March Northern Health Leadership Forum.

Named to honour Northern Health's former Board Chair, Dr. Charles Jago, these awards acknowledge and celebrate individuals and teams who have made outstanding contributions to achieving NH's vision and mission and reflecting our values – Empathy, Respect, Collaboration, and Innovation – in the process. We would like to recognize and congratulate the 26 nominees for their daily work and efforts to live Northern Health's values.

The winners for 2018 are as follows:

- **Empathy:** *Dr. Amor Kloppers* – Dr. Kloppers frequently goes above and beyond what is expected from a family physician. He is always availing himself to those who need medical attention in his wide scope of family practice and in the community. Dr. Kloppers works in his family practice, the maternity clinic, operating room, emergency room, and is on the Prince Rupert community harm reduction committee. He is approachable, compassionate, and, most importantly, understanding and empathetic.

- **Respect:** *Eryn Collins* – Eryn lives all of NH's values, and anyone who has the pleasure of working with her – often regarding challenging issues and topics – can certainly attest to those values. Eryn's role as Communications Officer requires strong collaboration with leaders across the organization, and she does that in a manner that is seen as essential, helpful, and executed with care. In Eryn's position, no problem is ever the same and often there is no roadmap to solutions. Anyone who has worked with her knows she brings an empathetic approach and innovative spirit to solving these challenges. On top of these values, she brings respect for our people, our systems, and the public to work every day.

- **Collaboration:** *ITS Custom Application Development/Reporting Team (including Claire Schultz, Erin Gable, Martin Stentrop, Mani Samani, Emery Berg, and Jim Condon)* – When faced with challenges, this team asks questions and thoughtfully presents options that match health care-specific requests. With eContracts, the team was tasked with producing an intuitive product that any user could navigate. Through this development, the team persevered to provide Finance with an end-product that is user-friendly and provides a high level of reporting. This invaluable and knowledgeable team came up with innovative ways to make the system work smarter and find efficiencies for users in the application.

- **Innovation:** *The Terrace Leadership Team (including: Chris Simms, Shirley Nichol, Brad Leier, Mitch Griffith, and Justin DeMedeiros)* – This team is made of leaders who not only embrace innovative ways of bringing a culture of safety and quality, but lead by example. At department head meetings, they are always asking the team: "How can we make the system better and can we improve the patient experience?" Without imposing their own ideals and thoughts, they guided their teams to think about quality improvement in small ways instead of large, sometimes intimidating ways. The NOD/WOW initiative was a collaborative effort by their teams to help improve the patient experience. By being the champions of this project and leading with positive encouragement and consistent follow up, this project was a success. They are constantly re-enforcing quality improvement through ideas like these and others, such as departmental quality walls that highlight safety, communication and infection control memos, and daily departmental huddles.

Human Resources Board Report:
Focus on Workplace Health & Safety

April 2018

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Workplace Health & Safety

Northern Health's Workplace Health & Safety department consists of the Disability Management; Health, Safety, and Prevention; and Psychological Health and Safety in the Workplace programs. The Disability Management program provides support and guidance to help injured or ill employees recover and return-to-work activities, as soon as medically possible. The Health, Safety, and Prevention portfolio partners with the organization and external agents to build an occupational health and safety management system to control hazards and prevent workplace incidents and illnesses. The Psychological Health and Safety in the Workplace program involves a documented and systematic approach to developing and sustaining a psychologically healthy and safe workplace. This helps to remove stigma surrounding mental health within the organization.

Workplace Health & Safety Key Deliverables for 2017/18

Throughout 2017 and the beginning of 2018, Workplace Health & Safety has focused on the following key deliverables, many of which involved multiple stakeholders and provincial collaboration.

Provincial Violence Prevention Curriculum Delivery

The Provincial Violence Prevention Curriculum is an education and training program for all BC health care workers designed to reduce incidents related to violence in the workplace. It incorporates accepted best practices and was developed through a consultative process that included all BC health authorities, BC's health care unions, and WorkSafeBC. The curriculum includes eight e-learning modules and a classroom component. The classroom component is facilitated by qualified Provincial Violence Prevention Curriculum facilitators.

The majority of Northern Health staff have now completed the Provincial Violence Prevention Curriculum. Sustainability plans are in place to ensure that all employees who have not yet completed the training will do so as soon as possible, and that all new employees complete the curriculum as part of orientation. Seventeen additional Provincial Violence Prevention Curriculum facilitators were trained in November 2017, ensuring that all areas of Northern Health have access to local facilitators to provide the classroom sessions.

Implementation of the annual Provincial Violence Prevention Curriculum Refresher training is underway for all employees working in high-risk areas (Emergency, Mental Health and Psychiatry, Residential Care, Neurology Units, Interprofessional Teams, and Home Support) to maintain skills and further reduce incidents of violence in the workplace.

Joint Occupational Health and Safety Committees

A Joint Occupational Health and Safety Committee is an advisory group consisting of employers and employees working together to improve occupational health and safety in their workplace. In November and December 2017, two provincially-developed education sessions for new Joint Occupational Health and Safety Committee members were piloted using a distance format. This education is required under the Occupational Health and Safety Regulation changes, which were brought into effect in April 2017. It covers roles and responsibilities and must be completed within the first six months of joining a Joint Occupational Health and Safety Committee. Regularly scheduled sessions will be held throughout 2018 and on an ongoing basis moving forwards.

Another new requirement of the Occupational Health and Safety Regulation is Joint Occupational Health and Safety Committee evaluation. A provincially developed evaluation tool has been finalized by the health authorities. Northern Health Joint Occupational Health and Safety Committees will begin using this tool in early 2018.

Safety/Survival Kits

In northern and isolated areas where employees are required to travel for work, Northern Health is required to provide and maintain safety and survival equipment for fleet and personal vehicles. Workplace Health & Safety, in consultation with Northern Health Joint Occupational Health and Safety Committees, has determined the contents of the safety and survival kits and drafted a policy and procedure for determining who needs the kits, how to purchase the kits, and how to sustain the use of the kits where required. Workplace Health & Safety, in partnership with operations leaders, will support implementation plans for this initiative.

Duty to Accommodate

Northern Health strives to accommodate all employees whose medical condition results in a permanent medical disability. This means that the employee can no longer return to their pre-disability occupation. The accommodation process is intended to be timely and transparent, with every effort to find suitable accommodation for employees who would not pose undue hardship for Northern Health.

The Duty to Accommodate program was revised in 2016/17, resulting in reduced time spent awaiting placement for employees who require alternate work and enhanced tracking, demonstrating due diligence in accommodation efforts.

Additional Workplace Health & Safety Priorities for 2017/18

Influenza Prevention

Workplace Health & Safety continues to work with the Infection Prevention and Control and Public Health departments to minimize the spread of influenza through immunization, education, and monitoring.

WorkSafeBC High Risk Strategy for Health Care

WorkSafeBC's High Risk Strategy identifies and targets industries with high risk of serious workplace injury. Care interactions between heath care workers and patients pose the greatest risk of injury to health care workers, and put workers at risk for various injuries including serious injuries due to acts of violence. WorkSafeBC's High Risk Strategy for Health Care goals are to:

- Decrease the risk of workplace violence and related injuries
- Decrease the risk of overexertion or musculoskeletal injuries, primarily due to patient lifting and mobility activities

Onboarding Program

To satisfy compliance with WorkSafeBC regulation, all new and young workers require a general and site/job-specific orientation, including a comprehensive onboarding program. Onboarding helps new employees acclimate smoothly and become engaged members of Northern Health's workforce. A long-term process, onboarding starts before the employee begins and typically lasts through the first year of employment.

A new and revised onboarding program, set to launch in April 2018, will replace the previous, out-of-date content that was hosted by a third-party provider. The new program will be available to all new employees through an e-learning system. Managers will receive automatically-generated reports that identify completion rates for their new hires, as well as reminder emails for non-completion.

Short-Term Disability

Short-Term Disability Duration is the average number of days an employee is off for a work-related injury/illness. When injured employees are able to return to modified duties as soon as medically approved, WorksafeBC Short-Term Disability Duration outcomes and claims costs decrease for the organization.

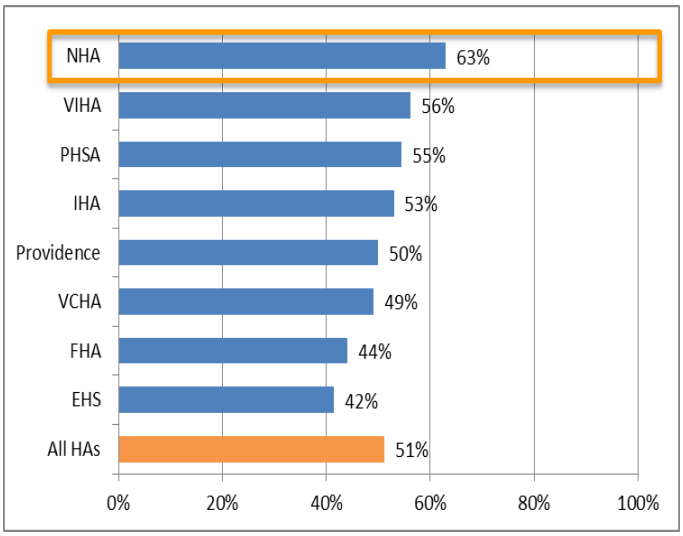
Strategies to reduce short-term disability duration include:

- Dedicated disability claims coordinator establishing contact day one of illness/injury to promote recovery at work and return to work efforts
- Supporting departments in proactively developing transitional, modified duty lists for staff

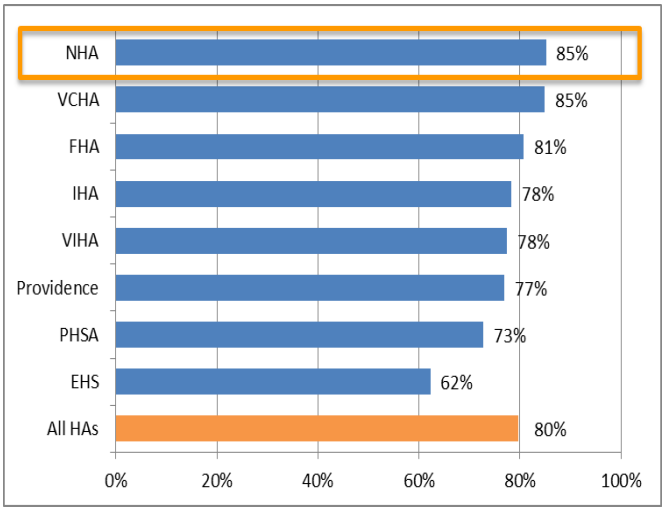
- Collaborating with insurer to connect injured employees with early intervention initiatives

The following graphs identify the percent of successful return to work with regards to time-loss claims

Return to Work at 4 Weeks



Return to Work at 12 weeks



NH's Short-Term Disability Duration is currently at 58 days which is within industry target. Short-term disability duration fluctuates on a monthly basis due to variability in claims that are returned to work at 4 and 12 weeks, as well as those extending beyond 12 weeks.

Long-Term Disability

Northern Health's benefits plan includes long-term disability insurance for permanent employees who are unable to work for a prolonged period of time due to an illness or injury. The qualification period ranges from four to five months off work, depending on the employee's collective agreement.

In partnership with other health authorities, Great West Life, and Healthcare Benefit Trust, Workplace Health & Safety continues to implement strategies such as promotion of early, safe return-to-work programs and temporary or permanent accommodation solutions in order to improve long-term disability performance and reduce overall claims

The chart below highlights long-term disability claims activity by quarter since January 2017 (source: Healthcare Benefit Trust). The reporting period highlights a decrease of 16 claims from January 2017 to end of period December 2017 (364 to 348 claims overall); however, this is not representative of long-term disability claim activity in its entirety due to the introduction of multiple joint benefit trusts in 2017. For a comprehensive total of long term disability active claims, the introduction of the joint benefit trusts must also be considered.

Joint Benefit Trusts

Joint Benefit Trusts are not-for profit health and welfare benefits collaborations in which unions and employers are equal partners in providing certain employee benefits, as well as services related to those benefits. Under this innovative model, both parties will be contributors in operating an efficient and sustainable benefit plan. On April 1, 2017, three health sector joint benefit trusts were created to assume responsibility for administering employee benefits to staff in the following bargaining associations:

1. Health Science Professionals Bargaining Association
2. Facilities Bargaining Association
3. Community Bargaining Association

2016-2017 Long-Term Disability Claims by Quarter (Health Benefit Trust/Joint Benefit Trusts)

Quarterly Reporting 2016-2017	Jan - Mar 2016	April-June 2016	Jul - Sep 2016	Oct - Dec 2016	Jan - Mar 2017	Apr - Jun 2017	July - Sep 2017	Oct - Dec 2017
Open Claims at Beginning of Period (Healthcare Benefit Trust)	365	377	359	359	355	364	346	353
New claims	25	15	22	23	31	17	25	9
Reopened claims	8	2	6	4	9	6	8	10
Terminated claims	21	35	28	32	31	41	26	24
Joint Benefit Trusts (open at End of Period)	0	0	0	0	0	0	0	13
Open at End of Period	377	359	359	354	364	346	353	361

Definitions:

- Open Claims at Beginning of Period: Claims open the month before the start of the current reporting period
- New claims: Claims opened for the first time within the reporting period
- Reopened claims: Claims reinstated within the reporting period
- Terminated claims: Claims terminated within the reporting period
- Open at End of Period: Claims open at the end of the reporting period

Support at Work

In 2016, numerous initiatives were implemented to identify and enroll employees who are struggling at work into the Enhanced Disability Management Program. The Enhanced Disability Management Program's ultimate goal is providing ill/injured employees early and timely support and services while maintaining their connection with the workplace and further preventing sick leave absences.

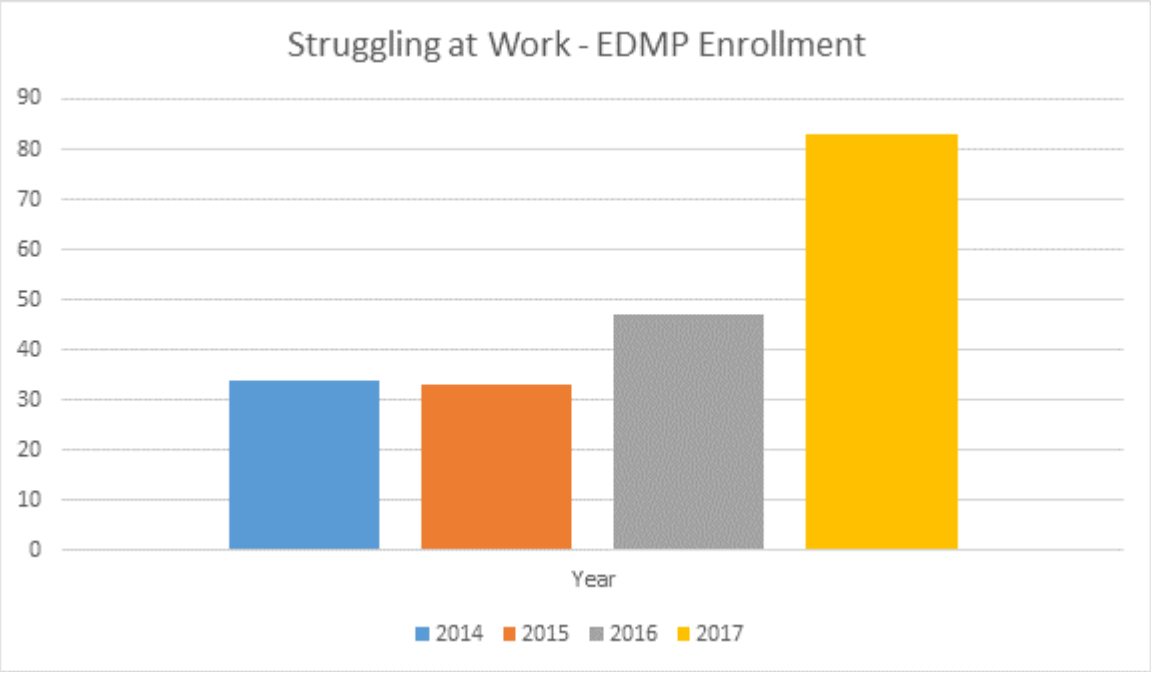
Current support-at-work initiatives include:

- Broadening promotion of the Enhanced Disability Management Program to reach employees who are struggling at work, opposed to only those who are automatically referred after missing five consecutive days off work (as outlined

in collective agreement language).

- Supporting and encouraging alternate Enhanced Disability Management Program referral channels (other than the payroll or the Employee Absence Reporting Line reports) such as:
    - Manager referrals
    - Employee self-referrals
    - Union referrals
    - Attendance Support Program referrals
- Implementing comprehensive support-at-work solutions, such as transitional work and flexible work hours, to mitigate sick leaves and remove barriers for employees staying in the workplace.
- The introduction of predefined modified work for employees to remain in the workplace. This involves keeping an open and productive dialogue between operational leaders and the Disability Management department to create an inventory of available project work that may be suitable for ill/injured workers.

The graph below, Struggling at Work – Enhanced Disability Management Program (EDMP) Enrollment, highlights the yearly increase of employee enrollment for those who are struggling, but still at work. This data captures enrollments from 2014 to November 2017. As depicted, enrollment has significantly increased.



The initiatives listed above have aided the Disability Management department in enhancing a supportive approach for those struggling at work. Initiatives listed above will continue into 2018.

Employee and Family Assistance Program

Northern Health provides all employees and their families with an Employee and Family Assistance Program (EFAP) through Morneau-Shepell. EFAP offers services that can be accessed via telephone, video, e-counselling, or in person. EFAP includes numerous services to help employees deal with personal and emotional issues, including:

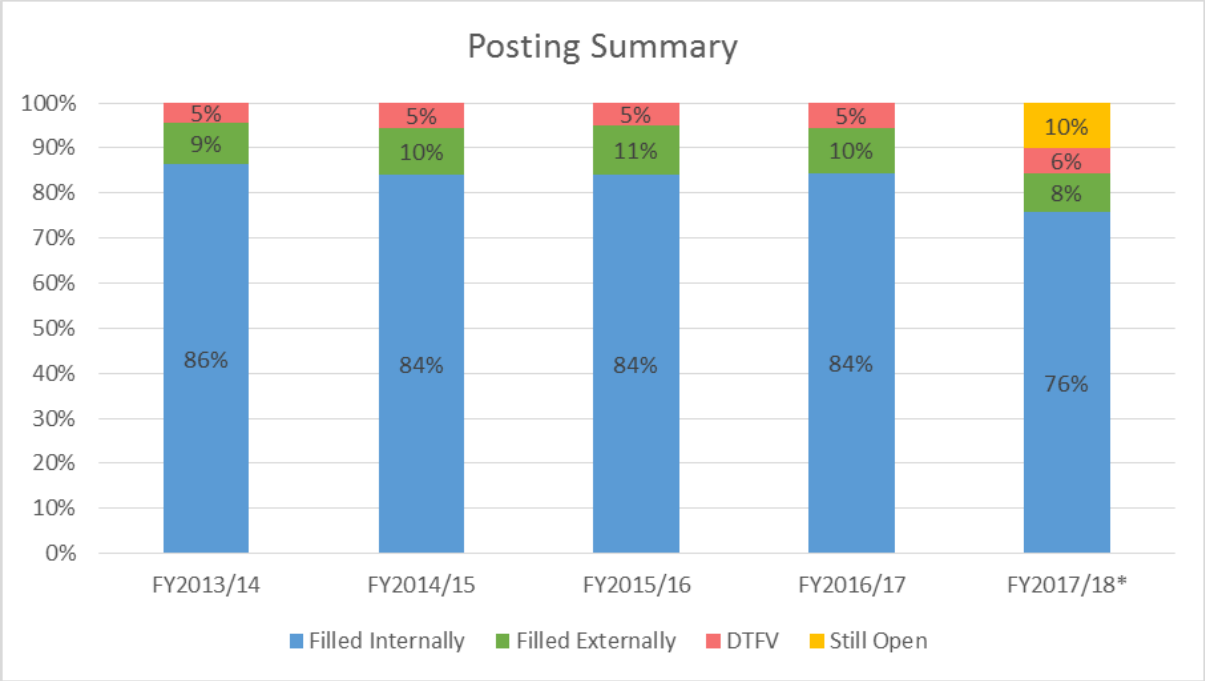
- Urgent mental-health issues
- Critical incident supports, assessment, counselling, coaching, and information
- Training to employees and families

Appendix: Supporting Information & Data

1.) Posting Summary

To date in fiscal year 2017/18, Northern Health has posted 3037 positions, 76% have been filled by internal staff (existing regular and casual staff) and 8% have been filled externally (qualified applicants from outside of Northern Health). Some unfilled positions are currently in the competition phase. Positions that remain unfilled for more than 90 days become difficult-to-fill vacancies (DTFV). On average, only 6% of approximately 3000 positions go to DTFV.

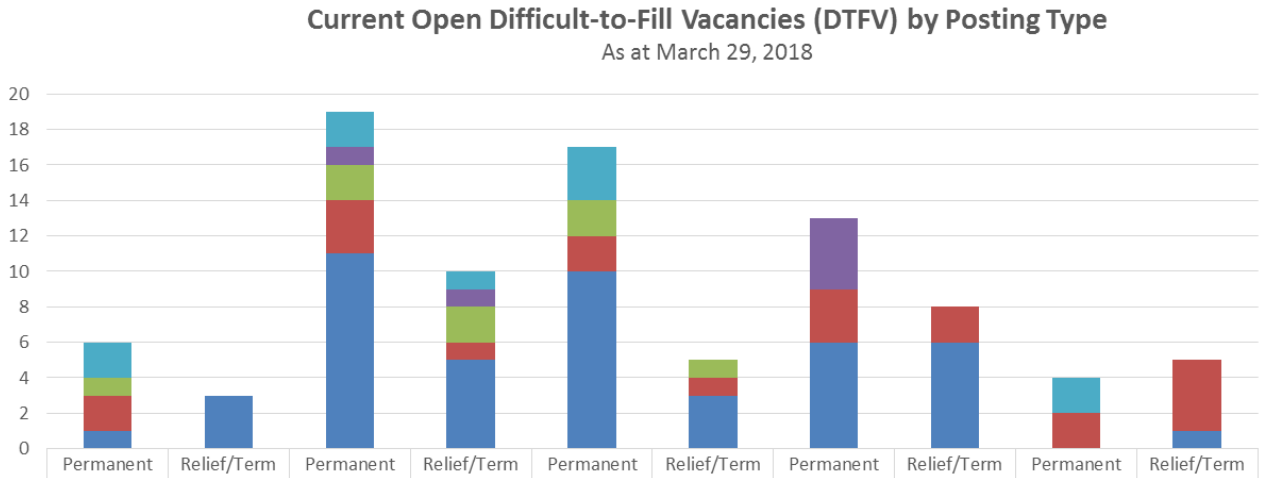
Casual hires are not reflected in this data. On average, NH hires 1,000 casuals per year, many of these staff successfully bid into permanent, ongoing positions through our internal posting process.



2.) Difficult-to-Fill Vacancies by Posting Type

Northern Health recruitment continues to focus on a variety of strategies to address DTFV. There has been a focus on profession based strategies including Nurse Practitioners, Nursing, Physiotherapy and Speech Language Pathologists.

- Northern Health collaborated with Six Sigma Productions on the creation of a Nurse Practitioner recruitment video. This resource will allow greater reach in our multi-media marketing plan. In addition, the video identifies collaboration between Nurse Practitioners and Physicians which will support the transition of recruitment of Nurse Practitioners to Medical Affairs.
- Recruitment is coordinating monthly meetings with the Chief Operating Officer's in each HSDA to review all current postings and be proactive in forecasting future needs for each geographic area.
- Recruitment has partnered with HealthMatch BC to attend conferences to target qualified nurses in the United States. Additionally recruitment has expanded efforts to attend conferences and post-secondary student events to address shortages in areas including Nursing, Physiotherapists and Speech Language Pathologists.



	NI Rural		North East		North West		Prince George		Regional	
	Permanent	Relief/Term	Permanent	Relief/Term	Permanent	Relief/Term	Permanent	Relief/Term	Permanent	Relief/Term
EXCLUDED	2		2	1	3				2	
COMMUNITY SUBSECTOR			1	1			4			
FACILITIES SUBSECTOR	1		2	2	2	1				
HEALTH SCIENCE PROFESSIONALS	2		3	1	2	1	3	2	2	4
NURSES PROVINCIAL AGREEMENT	1	3	11	5	10	3	6	6		1

The Face of Northern Health

As at March 29, 2018

Summary of Employees by Status	Headcount	%	FTE
Active: Total	7,733	100%	4,772
Full-time	3,504	45%	
Part-time	1,875	24%	
Casual	2,354	30%	
Non-Active: Total	804	100%	620
Leave	432	54%	291
Long Term Disability (LTD)	372	46%	328

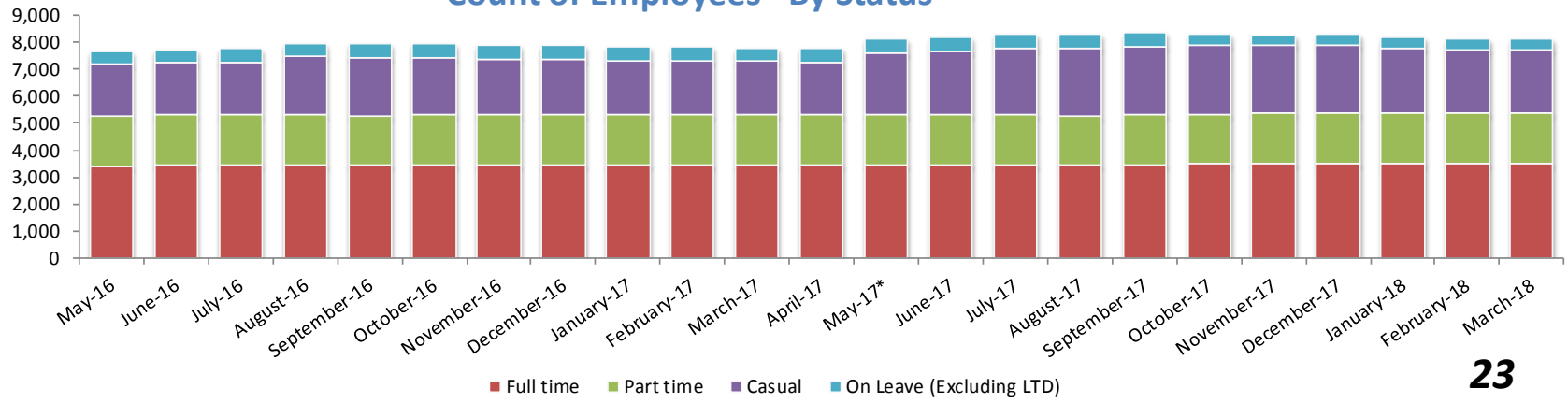
Active Employees by Region	Headcount	%
Active: Total	7,733	100%
North East	1,178	15%
North West	1,851	24%
Northern Interior: Prince George	2,373	31%
Northern Interior: Rural	1,127	15%
Regional	1,204	16%

Active Employees by Collective Agreement	Headcount	%
Active: Total	7,733	100%
Nurses	2,469	32%
Facilities	3,033	39%
Health Sciences	992	13%
Community	683	9%
Excluded	556	7%

Active Nursing	Headcount	%
Active: Total	2,469	100%
RN/RPN	1,804	73%
LPN	665	27%

Clinical vs. Support	Facilities	Community
Active: Total	3,033	683
Clinical	1,302	406
Non-Clinical	1,731	277

Count of Employees - By Status



BOARD BRIEFING NOTE

Date:	March 20, 2018	
Agenda item:	2017-18 Period 12 – Operating Budget Update	
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	

February 22, 2018 (Period 12)

Year to date Period 12, Northern Health's (NH) expenses exceeded revenues by $478,000.

On base operations, revenues are favourable to budget by $2.3 million or 0.3% and expenses are unfavourable to budget by $2.8 million or 0.4%. Budget overage in Acute Care is primarily due to higher than expected patient volumes in a number of acute care facilities. Budget overage in Long Term Care is primarily due to higher than expected employee sick time and resulting overtime to replace sick staff.

Forecast Yearend 2017-18

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

Recommendation(s):

The following motion is recommended:

> The Northern Health Board receives the 2017-18 Period 12 financial update as presented.

NORTHERN HEALTH
Statement of Operations
Year to date ending February 22, 2018 (Period 12)
$ thousand

	Annual Budget	YTD February 22, 2018 (Period 12) Budget	Actual	Variance	%
REVENUE					
Ministry of Health Contributions	612,924	547,436	547,515	79	0.0%
Other revenues	220,250	197,141	199,405	2,264	1.1%
TOTAL REVENUES	**833,174**	**744,577**	**746,920**	**2,343**	**0.3%**
EXPENSES (BY PROGRAM)					
Acute Care	449,376	404,383	413,608	(9,225)	-2.3%
Community Care	202,424	178,143	172,510	5,633	3.2%
Long term care	111,285	99,840	102,175	(2,335)	-2.3%
Corporate	70,089	62,211	59,105	3,106	5.0%
TOTAL EXPENSES	**833,174**	**744,577**	**747,398**	**(2,821)**	**-0.4%**
Net operating deficit before extraordinary items		**-**	**(478)**		
Cost of wildfire response		-	4,032		
Less anticipated supplemental funding from Ministry of Health		-	(4,032)		
Net extraordinary items		-	-		
Net operating deficit	**-**	**-**	**(478)**		

northern health
the northern way of caring

BOARD BRIEFING NOTE

Date:	March 14, 2018	
Agenda item:	Capital Public Note (Period 12)	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	Board of Directors	
Prepared by:	Deb Taylor, Regional Manager Capital Accounting	
Reviewed by:	Mark De Croos, VP Finance & Chief Financial Officer	

The Northern Health Board approved the 2017-18 capital expenditure plan in February 2017, and amendments in July and December 2017, and January 2018. The updated plan approves total expenditures of $49.4M, with funding support from the Ministry of Health ($19M, 39%), Six Regional Hospital Districts ($18M, 37%), Foundations, Auxiliaries and Other Entities ($3.5M, 7%), and Northern Health ($8.5M, 17%).

Year to date Period 12 (February 22, 2018), $26.5M has been spent towards the execution of the plan as summarized below:

$ million	YTD	Plan
Major Capital Projects (> $5.0M)	0.5	2.4
Major Capital Projects (< $5.0M)	4.1	13.3
Major Capital Equipment (> $100,000)	11.9	15.0
Equipment & Projects (< $100,000)	6.1	9.3
Information Technology	3.8	9.3
	26.5	49.4

Significant capital projects currently underway and completed in 2017-18 are as follows:

Northwest Health Service Delivery Area (NW-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Terrace	MMH Boiler #3 Replacement	$0.34	Closing	MOH, NWRHD
Terrace	MMH C-Arm	$0.22	Approved	Dr. REM Lee Foundation
Terrace	MMH Echocardiography Machine	$0.19	Complete	Dr. REM Lee Foundation, MOH
Terrace	MMH Magnetic Resonance Imaging Machine	$2.92	Closing	MOH, NWRHD
Terrace	MMH Phone System	$0.44	In Progress	NWRHD, NH
Terrace	MMH SPECT Scanner	$1.55	Complete	MOH, NWRHD, NH
Terrace	Terraceview Lodge Nurse Call System	$0.46	In Progress	MOH, NWRHD
Smithers	BVDH Digital Mammography	$0.95	Ordered	MOH
Smithers	BVDH Maternity Modernization Project	$0.21	Complete	MOH, Bulkley Valley Healthcare & Hospital Foundation
Smithers	BVDH Radiology Room #1	$0.90	In Progress	NWRHD, NH
Smithers	BVDH Ultrasound Machine	$0.21	Ordered	MOH, NH
Stewart	X-Ray Room	$0.27	Closing	NWRHD, NH
Prince Rupert	Fluoroscopy Unit	$1.35	Closing	MOH, NWRHD
Prince Rupert	C-Arm	$0.15	In Progress	MOH, NH
Queen Charlotte	Haida Gwaii Hospital replacement	$50.00	Closing	MOH, NWRHD

Northern Interior Service Delivery Area (NI-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Vanderhoof	SJH Patient Monitoring Systems	$0.33	Complete	SNRHD, NH
Vanderhoof/Southside	Phone Systems	$0.26	In Progress	SNRHD, NH
Prince George	UHNBC Digital Mammography	$2.58	Complete	MOH, Spirit of the North
Prince George	UHNBC Electrical Supply Upgrade	$4.50	In Progress	MOH, FFGRHD, NH
Prince George	UHNBC Energy Conservation Project	$0.94	In Progress	MOH, FFGRHD
Prince George	UHNBC Inpatient Bed Capacity Project	$8.00	In Progress	MOH, FFGRHD, NH
Prince George	UHNBC Magnetic Resonance Imaging	$2.69	Complete	MOH, FFGRHD
Prince George	UHNBC Mass Spectrometer	$0.30	Closing	Spirit of the North, MOH
Prince George	UHNBC Patient Monitoring Systems	$1.20	In Progress	FFGRHD, NH, Spirit of the North
Prince George	UHNBC Security Camera System	$0.44	In Progress	FFGRHD, NH
Prince George	UHNBC Bone Densitometer	$0.13	Ordered	NH
Mackenzie	Integrated Care Space Development	$0.70	Complete	FFGRHD, NH
McBride	Ventilation System	$1.43	In Progress	FFGRHD, NH
Quesnel	Dunrovin Park Lodge Elevator Replacement	$0.33	Complete	MOH, CCRHD
Quesnel	GRB Anesthesia System	$0.16	Ordered	MOH, CCRHD
Quesnel	GRB C-Arm	$0.25	Ordered	MOH, CCRHD, NH
Quesnel	GRB Emergency Generator Replacement	$1.21	Closing	MOH, CCRHD

Northeast Health Service Delivery Area (NE-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Chetwynd	Automated Medication Dispensing Cabinet	$0.16	Ordered	MOH, PRRHD
Dawson Creek	Fluoroscopy Room Renovation	$0.18	Complete	PRRHD, NH
Dawson Creek	Medical Device Reprocessing Renovation	$2.08	In Progress	PRRHD, NH
Fort Nelson	Automated Medication Dispensing Cabinet	$0.15	On hold	NRRHD, NH
Fort St. John	Magnetic Resonance Imaging Machine	$2.71	Closing	MOH, PRRHD, FSJ Hospital Foundation, FSJ Hospital Auxiliary
Fort St. John	X-Ray Rad Rex Room #1	$0.64	Ordered	PRRHD, NH

Regional Projects

Community	Project	Project $M	Status	Funding partner (note 1)
All	Health Link North: Cerner Upgrade	$4.5	In Progress	MOH, CCRHD, FFGRHD, NRRHD, NWRHD, PRRHD, SNRHD
All	Community Health Record (Phase 2)	$3.16	In Progress	MOH, CCRHD, FFGRHD, NRRHD, NWRHD, PRRHD, SNRHD
All	Clinical Interoperability	$1.0	In Progress	NH
All	PACS and Cardiology Information System	$3.27	In Progress	CCRHD, FFGRHD, NRRHD, NWRHD,

				PRRHD, SNRHD, NH
All	MySchedule Enhancements	$0.16	In Progress	NH
All	Secure Texting	$0.79	In Progress	NH

In addition to the 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 2017-18, it is forecasted that NH will spend $8.3M on such items.

Note 1: Abbreviations used:

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

Recommendation:

It is recommended that the Audit & Finance Committee recommend the following motion to the Board:

> The Northern Health Board receives the 2017-18 Period 12 capital expenditure plan update, as presented.

Indigenous Health, Corporate Office
600 – 299 Victoria Street
Prince George, BC V2L 5B8

BOARD BRIEFING NOTE

Date:	**April 16, 2018**	
Item:	**Indigenous Health Update**	
Purpose:	☒ **Information**	☒ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**Northern Health Board of Directors**	
Prepared by:	**Margo Greenwood, VP Aboriginal Health**	
Reviewed by:	**Cathy Ulrich, CEO**	

Indigenous Health continues to partner and support departments within NH and collaborate in meaningful partnerships with the First Nations Health Authority, northern First Nations and other Indigenous groups. Several examples of partnership initiatives and activities are presented in this briefing note along with updates of those that are ongoing.

1. Implementation of the Northern First Nations Health and Wellness Plan
Implementation of the Northern First Nations Health and Wellness Plan continues to be guided by the Northern First Nations Health Partnership Committee through working groups in five specific topic areas: primary health, population and public health, mental wellness and substance use, cultural safety and maternal child health. Initiatives funded by the Joint Project Board supports the work of the Mental Wellness and Primary Care Working Groups, these are discussed in more detail below

As the work of the partnership has become more operational in nature it is apparent that an "NH/FNHA Operational Committee" comprised of senior leadership from NH and FNHA is necessary steer the more operational initiatives. The Terms of Reference attached outline the goals and responsibilities of this group. The first meeting of this group will be the end of March, 2018.

There are also discussions underway to co-host a NH/FNHA Health Gathering, (a commitment in the Northern First Nations NH Partnership Agreement) in the regions beginning with the northwest later this year.

2. Joint Project Board (JPB) Initiatives
The Joint Project Board (JPB) initiatives (including the Mental Wellness Mobile Support Teams (MSTs), Nurse Practitioner (NP) supports and mobile Primary Care (mPCT) team in the northwest) continue to take shape through planning, collaboration and operationalization.

Mobile Support Teams (MSTs)

- Phase I Mental Wellness MSTs have been established in Quesnel, Fort St. John and Dease Lake. These teams are guided by Project Advisory Committees (PACs), which are comprised of NH, FNHA, and First Nation community representatives. Each team has a PAC guiding planning and implementation, as well as interfacing with other services (NH, FNHA, or otherwise). A decision has been made by the Tahltan communities to host the Dease Lake team. Funding transfers are underway.
- All Phase II MSTs (Terrace, Haida Gwaii, Hazelton, Burns Lake, Fort St. James, Prince George, and Fort Nelson) now have active PACs with meetings at least once a month. Decisions regarding actual service delivery is decided by these groups.
- Active recruitment is underway for Quesnel, Fort St. James, and Ft. St. John, which continue to be teams hosted by NH. At times there is a tension between hiring requirements resulting from necessary professional qualifications and the 'fit' with community.

Nurse Practitioner (NP) Supports

- Supports for NPs have been undertaken in some areas although not all positions are filled at this time.
- NP recruitment for some isolated First Nation communities continues to be a significant challenge. Coupled with this are ensuring the requisite EMR interfaces are in place. In several cases, internet bandwidth availability continues to pose challenges. Telehealth options are also being worked on between all organizations.

Mobile Primary Care Team (Coast Tsimshian)

- Considerable planning and collaboration has gone into the mobile primary care team. Postings for an Occupational Therapist, Mental Health clinician, Primary Care Assistant, and second NP are all currently active. Discussions continue with potential physicians for this team.
- Planning and collaboration continues to ensure the four isolated First Nation communities to be served have the necessary accommodation, clinical space, EMRs, and travel arrangements – as well as links between future clinicians and existing community services.

3. Northern Health/First Nations Health Authority – Partnered Activities

Northern Indigenous Community Wellness Funding Awards

In 2015, Indigenous Health, NH and the First Nations Health Authority partnered to offer Northern Indigenous Community Wellness Funding Awards for First Nations and Indigenous communities across the north. These annual awards provide a maximum of $5,000 to support Indigenous communities and organizations working to improve health and wellness in northern BC. Projects support community-based initiatives that focus on holistic health and wellness. In 2016/17 32 community based projects were funded across the north. Awards for 2017/18 are to be announced shortly.

Post-Secondary Student Awards

The Northern First Nations Health Partnership Committee initiated a post-secondary student award opportunity for Indigenous students studying in health-related disciplines in northern BC. Through these awards the donors: Indigenous Health – Northern Health and the First Nations Health Authority show their commitment to supporting First Nations and Indigenous students in the areas of health and well-being. These awards are offered through northern BC universities

and colleges: including: Northwest Community College, Northern Lights College, College of New Caledonia, and University of Northern BC. Individual student awards range from $500 to $2000 each.

First Nations Community –based Learning Program
Northern Health, the Northern Medical Program, the Health Arts Research Centre, and the First Nations Health Authority are partnering to offer undergraduate medical students the opportunity to visit northern First Nations communities for a weekend of cultural exchange and sharing of holistic health and wellness teachings. Since 2012, more than 40 undergraduate medical students have learned in northern First Nations communities including: Burns Lake, Old Masset, Nak'azdli, Gitlaxt'aamiks, Kispiox, Nisga'a communities and Fort Babine to name a few.

These same organizations are currently in discussion to design and deliver a science camp for northern Indigenous youth.

4. Aboriginal Health Improvement Committees (AHICs)
The AHICs continue to meet across the north. For the past four years they have been focused on the development of local cultural resources designed to respond to the question: "If I was a new health practitioner coming into your community what would you like me to know about you and your community?" To date, more than 50 resources have been developed. A resource booklet summarizing these resources may be found at https://indigenoushealthnh.ca/sites/default/files/2017-01/Cultural_Resources_Booklet-web.pdf.

The AHICs also gather annually in Prince George to share information, resources and educational opportunities. Most recently, they met on May 16-17, 2017 to exchange ideas and to showcase their work. Guest presenter, Rose Lemay a member of the Tahltan Nation led the learning opportunity that focused on Indigenous social political history, racism and cultural safety. As part of her presentation she acknowledged the work of NH particularly the cultural resource work that the AHICs have been undertaking.

One recent example of AHIC work was the unveiling of their "Community Hearts" Welcome Sign project in the foyer of UNHBC on February 23, 2018. This project began in 2015 and represents an incredible partnership between NH and the Lheidli T'enneh.

In the future we will be engaging with the AHICs more directly in the specific planning and hosting of the all AHIC gathering so that there is opportunity for AHICs to host in the regions should they wish to do so.

5. Cultural Safety
With the signing of the Declaration of Commitment to Cultural Safety and Cultural Humility in 2015 our emphasis is on cultural safety in health service delivery. In response the NH Indigenous Health team created a 5-minute animated cultural safety video along with supporting booklets and posters. This video is on our new Indigenous Health website, and has been profiled locally, provincially, nationally and internationally including: *The Fourth National Forum on Indigenous Determinants of Health, Population Mental Health and Wellness Promotion: Clarifying the Roles of Public Health, and Commission on Equity and Health Inequalities in the Americas, Health Inequalities and Ethnicity in North America Meeting*

This video is also a foundational component of training and curriculum that Indigenous Health has been developing and piloting in various forums.

Extending the First Nations Health Authority's campaign on cultural safety and humility, the Indigenous Health team has promoted this campaign within Northern Health with staff and leadership. The executive committee made pledges in February of last year role modelling for the organization the importance of this commitment.

In addition over the past year, Indigenous Health has been developing and piloting a training curriculum focused on cultural safety and cultural humility. This has included delivering shorter one hour through to three hour workshops with internal NH staff, facilities, and departments; as well as delivering three hour workshops with second year nursing students at the College of New Caledonia. This curriculum includes information and training on trauma informed practice, the Truth and Reconciliation Commission (TRC) *Calls to Action*, and the importance of local community participation in cultural safety initiatives (e.g. development of local cultural resources).

6. Resource and Website Development

Indigenous Health area has a new website: www.indigenoushealthnh.ca. Of important note is the renaming from the term Aboriginal to Indigenous. The IH website has been very well received and is serving as a template for several other NH department websites. In addition, the popular *Patient Complaints* booklet was recently updated and updates are underway for the *Sacred Spaces and Gathering Spaces* booklet. In another venue, the Indigenous Health team has continued publishing in academic venues including a recent article in the prestigious medical journal The Lancet, entitled: *Challenges in health equity for Indigenous peoples in Canada*.

7. Evaluation

<u>Aboriginal Patient Liaison Evaluation</u>

Over the past 10 months, an external evaluator has been conducting an evaluation of the APL program. This evaluation has included an extensive literature review, online surveys, multiple interviews, and a review of a range of documents. A couple of NH interviews remain to be conducted. A draft preliminary final report is currently under review. The final report will be available and distributed in coming months.

<u>Partnership Accord Evaluation</u>

NH and FNHA northern region are actively involved in evaluation activities including the development of indicators that will guide the assessment of regional Partnership Agreements and associated activities.

NORTHERN OPERATIONAL COMMITTEE
DRAFT 01 - TERMS OF REFERENCE
January 22, 2018

Background:
Northern Health, the Northern Regional Health Caucus and First Nations Health Authority signed a Northern Partnership Accord on May 11, 2012 outlining how Northern Health, the Northern Regional Health Caucus and the First Nations Health Authority will collaborate in planning and monitoring health services that impact First Nations communities in the North Region. One of the commitments flowing from the Partnership Accord was the development of the Northern First Nations Health Partnership Committee to oversee the development and implementation of a Northern First Nations Health and Wellness Plan. Now, several years into the implementation of priority areas, there is a need to address operational issues that arise from implementation of the Northern First Nations Health and Wellness Plan along with issues arising in existing health service delivery.

The Northern First Nations Health Partnership Committee (NFNHPC) adopted the following
'7 Directives', governance standards as provided by the collective BC Chiefs, to guide the work of the NFNHPC in implementing the Northern First Nations Health and Wellness Plan, therefore also apply to all work undertaken by the Operational Table. All decisions that have an impact on the health and wellness of First Nations populations are required to meet as many of the 7 Directives as possible:

Directive #1: Community Driven, Nation-Based
Directive #2: Increase First Nations Decision-Making
Directive#3: Improve Services
Directive #4: Foster Meaningful Collaboration & Partnership
Directive #5: Develop Human and Economic Capacity
Directive #6: Be without Prejudice to First Nations Interests
Directive #7: Function at a High Operational Standard

Purpose:
The purpose of the Northern Operational Committee is to create a forum between Northern Health and the First Nations Health Authority to work out the operationalization of health programs and services for First Nations people in the Northern region that require collaborative and partnered leadership between the two organizations. This Operational Committee will work together to address challenges impeding the delivery of culturally safe and appropriate health programs and services for First Nations peoples of the Northern Region.

Operational Table activities may include but are not limited to:

1. Reviewing and revising a Terms of Reference for the Committee on an annual basis.
2. Addressing policy and strategy development necessary to support the partnership.
3. Identifying potential facilitators and barriers to implementation of the Northern First Nations Health and Wellness Plan, leverage the facilitators, and address the barriers and issues.
4. Addressing health service delivery issues and/or challenges identified by northern First Nations communities, FNHA and or NH.

5. Developing a collaborative approach to implementation including sorting through organizational differences in process and approach.
6. Monitoring and assessing the impact of interventions taken to address challenges and barriers.

Principles:
The following principles are intended to guide the work of the Operational Table. They include maintaining:

1. A collaborative problem-solving approach to addressing issues and challenges;
2. A culturally safe population health approach;
3. Positive, constructive approaches in creating solutions;
4. Respect for organizational processes in each organization;
5. Reciprocal accountability between the organizations.

Membership:
While there will be a specific membership for the Operational Table content matter experts will be invited to attend as specific issues arise.

Northern Health:
Chief Operating Officer, Northwest: Ciro Panessa
Vice President, Primary & Community Care and Clinical Programs: Kelly Gunn
Regional Director, Medical Affairs: Greg Marr
Chief Medical Health Officer, NH: Dr. Sandra Allison
Vice President, Human Resources: David Williams
Vice President, Indigenous Health: Dr. Margo Greenwood
Chief Communications and External Relations: Steve Raper

First Nations Health Authority:
Chief Operating Officer: Richard Jock
Executive Director, Policy Planning and Transformation: Harmony Johnson
Vice President, Programs, Services, Research & Knowledge Exchange: Sonia Isaac-Maan
Northern Regional Director, FNHA, Nicole Cross
Executive Director, Michelle Adkins

Secretariat Support
- **Executive Assistant Indigenous Health – Northern Health**
- **Senior Administrative Assistant– FNHA North Region**

Frequency of Meetings:
The Committee will meet five times per year: January, March, May, September and November and at the call of the co-chairs for any additional meetings.

Scheduling NFNHPC Operational Table Meetings:
Co-chairs will convene meetings.

Term:
The respective member organizations/bodies will determine the length of term of their respective representatives.

Decision Making:
Decisions will be made by consensus where there is agreement reached by a group as a whole. The membership will determine the communication plan for decisions made.

Quorum:
A minimum of two representatives from each member organization.

Roles and Responsibilities:

Co-Chairs:
The Co-Chairs of this committee will be FNHA COO (Richard Jock) and NH COO Northwest (Ciro Panessa). The responsibility of the Co-Chairs is to plan the agenda and chair the meetings. The Co-Chairs may also call additional meetings as required. Once per year, the Co-Chairs will meet with the Chair of the Northern Regional Caucus and the CEOs of the First Nations Health Authority and Northern Health to review progress in achieving the goals and objectives of the Operational Table. The Co-chairs will make clear the relationship between the Operational Table and the NFNHPC.

Committee Members:
The Committee members agree to:

1. Acknowledge that the parties have jurisdictional, legal and fiduciary responsibilities and operate under specific mandates;
2. Support each other in a positive and constructive manner in addressing northern health care program and service delivery issues and challenges;
3. Gain knowledge, share and inform one another about each, other's service delivery processes, fiscal restraints, opportunities for solutions;
4. Collaborate on operationalizing solutions by contributing information, ideas, guidance, and expertise to collaborative and common projects and population health initiatives; and
5. Advocate for First Nations perspectives and inclusion in regional solutions to local challenges.

Accountability:

The Operational Committee reports to the Executive Leadership of NH and FNHA through the co-chairs in order to:
1. Ensure that decisions made by the Operational Committee are operationalized by each organization including the development of enabling policy, procedures, and processes
2. Enable decisions to be communicated to the appropriate leadership in each organization
3. Seek input and feedback from each organization that will support the Operational Committee to make effective decisions

The Operational Committee has a direct relationship with the Northern First Nations Health Partnership Committee and Working Groups established by the NFNHPC or the Operational Committee.

1. The Operational Committee provides regular reports and activity updates to the NFNHPC and seeks advice and input on current and future operational priorities.
2. Working Groups work closely with and report to the Operational Table, taking direction and operationalizing those directions into the delivery of effective culturally safe health services.
3. Working Groups identify operational challenges and potential facilitators of effective service delivery to the Operational Committee.

The membership agrees to hold each other accountable in the spirit of reciprocal accountability for the commitments within the Northern Partnership Accord.

Board & Administration Services
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BOARD BRIEFING NOTE

Date:	**April 16, 2018**	
Agenda item	**Integrated Ethics Framework**	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**Northern Health Board of Directors**	
Prepared by:	**K. Thomson**	
Reviewed by:	**C. Ulrich**	

Issue:

To update the Board on the activities related to the Integrated Ethics Framework within Northern Health.

Background:

In October 2014, the Integrated Ethics Framework ("the Framework") was formally adopted by Northern Health. The Framework outlines the Northern Health integrated ethics approach[1] to addressing ethical concerns, conflicts of interest and decision-making by providing an overview of:

- The NH Standards of Conduct
- Guidelines, policies, principles, resources and value statements that direct ethical behaviour and decision-making.

The Framework highlights three ethical domains: Clinical Ethics/Bioethics, Organizational & Business Ethics, and Research Ethics. It also addresses the Accreditation Canada priority placed on Ethics as it relates to Governance.

[1] Fox, E. et al. 2010. Integrated ethics: An innovative program to improve ethics quality in health care. *The Innovation Journal: The Public Sector Innovation Journal*, Vol. 15(2), article 8. http://www.innovation.cc/scholarly-style/fox_integrated8ethics_8_final.pdf

1. Organizational & Business Ethics

The specific standard from the Accreditation Canada Governance Standards is:

1.3 The governing body approves, adopts, and follows the ethics framework used by the organization.

Guidelines

An ethics framework provides a standardized approach to working through ethical issues, addressing conflicts of interest, and making decisions. The framework can include codes of conduct, guidelines, processes, and values to help guide decision-making.

The organization's leaders develop the ethics framework for the organization, but may receive input from the governing body.

The governing body's minutes reflect that the ethics framework is used as part of its regular activities.

Additionally, section 2.6 asks that Directors sign a statement which includes compliance with the organization's ethics framework. The Code of Conduct and Conflict of Interest Guidelines for Directors (BRD 210) as well as the annually signed Director Declaration Form are being reviewed to consider specific reference to the Northern Health Integrated Ethics Framework.

As we prepare for the 2018 Accreditation Canada Survey, the NH Ethics Committee has been actively working with NH Communications to update the Ethics Communication Plan, to ensure that all possible opportunities to promote the Integrated Ethics Framework and ethics committee structure are realized.

2. Clinical Ethics

Northern Health has 3 HSDA Ethics Committees which receive and advise on clinical consultations with specific ethical concerns. Consultations are most often received from health care providers, but may also come from patients or their families.

The most common theme among the ethical consultation requests received by all three HSDA Ethics Committees is the right of an individual to accept risk in their lifestyle choices. Often, the consideration of right to accept risk is countered by capacity concerns, and concern as to whether the individual truly appreciates the consequence of the risk they are choosing. Northern Health is undertaking the implementation of a standardized patient assessment process and has begun work on care planning across settings. Patient assessment and care planning is helpful to care providers working with individuals who may be choosing to live at risk.

In the past year, the number of consultations involving end-of-life interventions increased. These consultations generally were referrals from health care providers looking for support in decision making around the levels of interventions to be

offered to critically ill patients, where the clinical advice of the practitioner was at odds with the desires of the patient or representatives. Support for this type of ethical challenge has recently been provided to practitioners with the publishing of the Compassionate Withdrawal of Mechanical Support After Brain Death clinical practice standard, developed as a collaboration between the Critical Care program and Risk Management.

The volume and subjects of clinical ethical consultation in NH in the past year can be broken down as follows:

HSDA	Date	Theme
NE	October 17, 2017	Patient autonomy/mature minor
	January 12, 2018	Right to live at risk/diet choice
NW	April 20, 2017	Use of restraints
	May 13, 2017	Stewardship of resources/Workplace Health and Safety
	January 25, 2018	Patient autonomy; use of Mental Health Act
	February 20, 2018	End of life intervention; role of substitute decision makers
NI	March 14, 2017	End of life intervention
	March 17, 2017	Capacity to consent/right to live at risk
	March 28, 2017	End of life intervention
	May 5, 2017	End of life intervention
	May 13, 2017	Stewardship of resources/end of life intervention
	May 23, 2017	Right to live at risk
	May 25, 2017	Stewardship of resources/appropriate placement
	June 6, 2017	Right to live at risk
	December 21, 2017	Right to live at risk
	January 3, 2018	Right to live at risk; Public health and safety
	January 8, 2018	Provider disagreement on appropriate diet
	January 29, 2018	End of life intervention
	February 2, 2018	Stewardship of resources
	February 28, 2018	Right to live at risk
	March 1, 2018	Right to live at risk; use of Mental Health Act

3. Research Ethics

To ensure research is conducted safely and appropriately, Northern Health has policy and procedures, as well as a formal body, the Research Review Committee, that govern any research that may involve Northern Health clients, staff, or facilities. The Research Review Committee reviews research proposals to provide both an ethical approval and an operational or feasibility approval.

Northern Health also actively participates with other health authorities and educational institutions in a Harmonized Ethics approval process, whereby an application that involves multiple institutions can submit one application for review by all institutions involved. This process has simplified ethics approval applications, allowing researchers to submit one application for approval. In 2017, the Research Review Committee saw 85% of ethics approval applications come through as harmonized ethics reviews, compared to 83% in 2016, and 40% in 2015. The applications that were not part of the harmonized process were either from BC institutions not yet incorporated into the harmonized process, or from institutions outside of BC.

In 2017, the Research Review Committee has seen a growing interest in researchers wishing to conduct clinical research in northern BC, compared to the more evaluative and/or retrospective reviews that have traditionally made up the majority of the studies approved through the committee. The clinical research studies are typically being investigated through the University of British Columbia and are applying to Northern Health through the harmonized review process. The Research Review Committee generally defers to the expertise of our partners in the governance of clinical research ethics, though we are currently exploring opportunities to develop this expertise in the north, partnering with the University of Northern British Columbia, as the interest in clinical research continues to grow in the north.

Recommendation(s):

That the NH Board of Directors receives this briefing note for information.

MISSION, VISION, VALUES, AND PRIORITIES V.1 BRD 100

INTRODUCTION

The Board of Directors of Northern Health (the "Board) establishes the mission, vision, values, and priorities statements that guide the delivery of care and services in Northern Health.

SLOGAN

"The Northern way of caring"

MISSION

Through the efforts of dedicated staff and physicians, in partnership with communities and organizations, we provide exceptional health services for Northerners

VISION

Northern Health leads the way in promoting health and providing health services for northern and rural populations

VALUES

Value statements guide decisions and actions.

We will succeed in our work through:

Empathy
Seeking to understand each individual's experience.

Respect
Accepting each person as a unique individual.

Collaboration
Working together to build partnerships.

Innovation
Seeking creative and practical solutions.

STRATEGIC PRIORITIES

Health People in Healthy Communities
Northern Health will partner with communities to support people to live well and to prevent disease and injury.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): April 24th 2017 (r)

Coordinated and Accessible Services
Northern Health will provide services based in a Primary Care Home and linked to a range of specialized services which support each person and their family over the course of their lives, from staying healthy, to addressing disease and injury, to end-of-life care.

Quality
Northern Health will ensure a culture of continuous quality improvement in all areas.

ENABLING PRIORITIES

Our People
Northern Health provides services through its people and will work to have those people in place and to help them flourish in their work.

Communications, Technology, and Infrastructure
Northern Health will implement effective communications systems, and sustain a network of facilities and infrastructure that enables service delivery.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): April 24th 2017 (r)

BOARD CALENDAR BRD 110

The following items are brought forward to the Board for decision throughout the calendar year. Refer to committee work plans for additional detail (BRD 310, 320 & 330).

	LEAD	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
A. Strategies, Plans and Performance													
i) Review Mission, Vision and Values	Board Chair & CEO										X		
ii) Preliminary review of Strategic Plan	Board Chair & CEO												X
iii) Review and approval of Strategic Plan	Board Chair & CEO		X										
iii) Review and approval of Service Plan	Board Chair & CEO				X								
iv) Review and approval of Annual Budget Management Plan.	Chair Audit & Finance Committee & CFO				X								
iv) Review and approval of Annual Capital Plan.	Chair Audit & Finance Committee & CFO		X										
v) Performance Reporting against Strategic and Service Plan	CEO Board Committees	ONGOING OR AS REQUIRED											
vi) CEO's Report	CEO	ONGOING OR AS REQUIRED											

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): April 24th 2017 (r)

	LEAD	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
B. Financial Control													
i) Appoint External Auditors	Chair Audit & Finance Committee & CFO										X		
ii) Set Audit Fees	Chair Audit & Finance Committee & CFO										X		
iii) Approve Annual Statements	Chair Audit & Finance Committee & CFO						X						
iv) Review Operating and Financial Performance	CFO	ONGOING OR AS REQUIRED											
C. Governance & Management Relations													
i) Approve CEO Annual Objectives	Chair GMR Committee						X						
ii) CEO Performance Evaluation	Chair GMR Committee				X		X						
iii) Approve CEO Compensation	Chair GMR Committee						X						
iv) Review Management Succession and Development Plans	VP HR										X		
v) Compensation Policy Review	VP HR		X										
vi) Review Board Profile and Director Criteria	Chair GMR Committee	ONGOING OR AS REQUIRED											

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): April 24th 2017 (r)

	LEAD	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
vii) Recommend potential candidates to the Government	Chair GMR Committee & Board Chair	ONGOING OR AS REQUIRED											
viii) Appoint Committee Chairs and Members (Deputy Chair elected by Board - BRD150)	Board Chair						**X**						
ix) Board/Board Chair/Committee Evaluation/Individual Director Evaluation	Chair GMR Committee										X		
x) Bylaw review	Chair GMR Committee	ONGOING OR AS REQUIRED											
xi) Annual Report	Chair GMR Committee & Director Communications						X						
xii) Community Consultation (major initiative every second year)	Chair GMR Committee & Director Communications						X				X		

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): April 24th 2017 (r)

	LEAD	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
D. Medical Advisory Committee													
i) Medical Advisory Committee Report	Chair 3P Committee & VP Medicine	ONGOING OR AS REQUIRED											
ii) Medical Staff Annual Reappointment Process	Chair 3P Committee & VP Medicine												X
iii) New Medical Staff appointments	Chair 3P Committee & VP Medicine	ONGOING OR AS REQUIRED											
vi) Physician HR Planning	Chair 3P Committee & VP Medicine										X		
E. Government/Board Interface													
i) Meet with the Minister/Deputy Minister	Board Chair / CEO	ONGOING OR AS REQUIRED											
ii) Review annual Mandate Letter from the Minister of Health	Board Chair/CEO	ONGOING OR AS REQUIRED											

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): April 18 2016 (r)

TERMS OF REFERENCE FOR THE BOARD CHAIR V.1 BRD 120

INTRODUCTION

1. The Board Chair is appointed by the BC Minister of Health.

2. The Board Chair's primary role is to act as the presiding Director at Board meetings and to manage the affairs of the Board of Directors of Northern Health (the "Board"). This includes ensuring that the Board is properly organized, functions effectively, and meets its obligations and responsibilities.

3. The Board Chair builds and maintains a sound working relationship with the President and Chief Executive Officer (the "CEO") and ensures an effective relationship between the Minister of Health, other government representatives and key stakeholders.

4. The Board Chair is an ex-officio member of Board committees where he/she is not appointed as a full member, including the Northern Health Medical Advisory Committee.

DUTIES AND RESPONSIBILITIES

Working with Management

The Board Chair:

1. Acts as a sounding board, counsellor and confidante for the CEO and assists in the review of strategy, definition of issues, maintenance of accountability, and building of relationships.

2. In conjunction with the CEO, represents Northern Health as required.

3. Ensures the CEO is aware of concerns of Government, the Board and other stakeholders.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
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4. Leads the Board in monitoring and evaluating the performance of the CEO, ensures the accountability of the CEO, and ensures implementation of the management succession and development plans by the CEO.

5. Works closely with the CEO to ensure management strategies, plans and performance are appropriately represented to the Board.

6. In conjunction with the CEO, fosters a constructive and harmonious relationship between the Board and the senior management group.

Managing the Board

The Board Chair:

1. Acts as the primary spokesperson for the Board.

2. Ensures the Board is alert to its obligations to Northern Health, the Government and other stakeholders.

3. Chairs Board meetings and ensures that the appropriate issues are addressed.

4. Establishes the frequency of Board meetings and reviews such frequency from time to time as considered appropriate, or as requested, by the Board.

5. Assists the Governance & Management Relations Committee in developing Director criteria and in identifying potential candidates to be recommended to the Government for appointment as Directors, and communicates with the Government regarding the criteria and names of candidates.

6. Recommends committee membership and committee Chair appointments to the Board for approval. Reviews and reports to the Board the need for, and the performance and suitability of, Board committees.

7. Liaises and communicates with all Directors and committee Chairs to coordinate input from Directors, and optimizes the effectiveness of the Board and its committees.

8. Ensures the coordination of the agenda, information packages and related events for Board meetings in conjunction with the CEO and the Corporate Secretary.

Author(s): Governance & Management Relations Committee
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9. Ensures major initiatives have proper and timely Board understanding, consideration, oversight and approval.

10. Ensures the Board receives adequate and regular updates from the CEO on all issues important to the welfare and future of Northern Health.

11. Builds consensus and develops teamwork within the Board.

12. Reviews Director conflict of interest issues as they arise.

13. In collaboration with the CEO, ensures information requested by Directors or committees of the Board is provided and meets their needs.

14. Ensures regular evaluations are conducted of the Board, Board Chair, Directors and Board committees.

15. Engages independent counsel or advisors, as considered necessary, and provides approval to Board committees seeking to engage independent counsel or advisors, as appropriate.

Relations with the Government and other Stakeholders

In consultation with the Board, the Board Chair has the responsibility to establish regular interactions and relationships with individuals, groups, organizations and at meetings such as:

- Board Chair/CEO meetings
- Chair to Chair meetings
- Local & municipal governments
- Minister of Health
- MLAs
- NGOs (Alzheimer Society, Canadian Cancer Society, Canadian Red Cross etc.)
- North Central Local Government Association (NCLGA) & Union of British Columbia Municipalities (UBCM)
- Other provincial Ministries and government bodies
- Regional Districts (RD) & Regional Hospital Districts (RHD)

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): April 24th 2017 (R)

TERMS OF REFERENCE FOR THE PRESIDENT AND CHIEF EXECUTIVE OFFICER V.1

BRD 130

INTRODUCTION

The President and Chief Executive Officer (the "CEO") reports to the Northern Health Board of Directors (the "Board") and maintains open communication with the Board Chair. The CEO is not a member of the Board.

The CEO is responsible for:

1. Providing leadership, management and control of the operations of Northern Health on a day-to-day basis in accordance with the strategies, plans and policies approved by the Board

2. Providing leadership and management to ensure strategic and annual plans are effectively developed and implemented, the results are monitored and reported to the Board, and financial and operational objectives are attained

DUTIES AND RESPONSIBILITIES

General

1. Leads and manages the organization within parameters established by the Board, as informed by Ministry of Health directives, and within Executive Limitations (BRD 230)

2. Ensures the safe and efficient operation of the organization

3. Ensures compliance with applicable laws and regulations, and with Board and Administration policies and practices

4. Fosters a corporate culture that promotes ethical practices, respect in the workplace, individual integrity, and social responsibility

5. Obtains Board approval prior to acceptance of significant public service commitments and/or outside Board appointments

Communication and Counsel to the Board

Information and advice to the Board shall be timely, complete, and accurate. Accordingly, the CEO shall:

1. Ensure the Board is aware of relevant trends, material risks, and significant internal and external organizational changes and anticipated adverse media coverage

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2. Inform the Board of any contract that, in the judgement of the CEO, may be of special interest to the Board. These include contracts that could materially affect the standard of care, represent unusual risk, or have significant community impact.

3. Submit the appropriate information in a timely, accurate and understandable fashion to allow for fully informed Board decisions

4. Provide appropriate mechanisms for official Board communications

5. Normally deal with the Board as a whole, while recognizing that periodic interaction with individual members, officers and Board committees is necessary to perform the CEO's responsibilities

6. Report to the Board non-compliance with any Board policy

7. Keep the Board fully informed of all significant operational, financial and other matters relevant to the organization. This includes external items emanating from Governments and stakeholders

8. Co-sign with the Board Chair the quarterly & annual financial statements and the annual auditor engagement letter

9. Manage and oversee the required interfaces between Northern Health, Government and stakeholders, and acts as the principal spokesperson for Northern Health

10. Ensure effective communications with the general public and stakeholders and shall foster and maintain relationships with agencies, educational institutions, Government, health delivery organizations, other key stakeholders, professional regulatory bodies and special interest groups to encourage understanding and cooperation in the development, implementation and evaluation of operational and strategic plans

11. The CEO may speak on the Chair's behalf if the Board Chair is unavailable[1].

STRATEGIC PLANNING

1. The CEO shall develop and recommend processes to the Board regarding:

[1] See also BRD220

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): April 24th 2017 (r)

a. The development, evaluation, and revision of NH's Strategic Plan including the mission, vision, values, and strategic directions
b. Ensuring alignment of NH's Strategic Plan with NH's commitment to government through the Mandate Letter

2. The CEO shall establish organizational processes that enable the development of operational, financial, and capital plans that position NH to achieve the Strategic Plan

3. The CEO shall successfully implement the Board approved annual service, budget management, and capital plans

4. The CEO shall establish accountability processes (e.g. scorecard) for the Board regarding the performance of the organization in achieving the goals and targets set out in the operational plan

QUALITY

1. The CEO shall ensure the development and implementation of a quality improvement framework including:
   a. The policies, standards, structures and processes necessary to support quality improvement and patient safety
   b. Delegation of authority to individuals or positions to conduct quality reviews under Section 51 of the *Evidence Act*

WORKING ENVIRONMENT

Northern Health acknowledges that the staff is its most important resource and that there is both an obligation of, and the benefit to, the organization in maintaining a positive working environment. Accordingly the CEO shall:

1. Ensure that working conditions are respectful and safe, and in compliance with negotiated agreements or legislated employment standards

2. Develop and maintain a sound, effective organization structure

3. Ensure progressive employee training and development programs exist

4. Ensure that all members of the organization have their responsibilities and authorities clearly established

Author(s): Governance & Management Relations Committee
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5. Establish and maintain a Board approved plan for senior management development and succession that is reviewed on an annual basis

6. Provide the Board, at Board and committee meetings, with exposure to key management personnel

FINANCIAL AND CAPITAL PLANNING

1. The CEO shall facilitate financial and capital planning which:
    a. Is consistent with established Board priorities
    b. Is fiscally prudent
    c. Is reflective of a generally acceptable level of foresight
    d. Plans the expenditure of funds in any fiscal year that are projected to be available in that period and if a shortfall is predicted, articulates the strategy to address the funding shortfall
    e. Allocates resources among competing budgetary need.
    f. Is consistent with long-term organizational planning
    g. Addresses fiscal contingencies

2. The CEO will implement financial and capital reporting processes that contain sufficient information to enable:
    a. Accurate projections of revenues and expenses
    b. Separation of capital and operational items
    c. Cash flow analysis
    d. Subsequent audit trails
    e. Disclosure of planning assumptions
    f. Accurate projections of any significant changes in the financial position

Asset Protection

The CEO shall ensure Northern Health's assets are protected, adequately maintained and not put at unreasonable or unnecessary risk. Accordingly, the CEO shall:

1. Identify the principal risks of the organization's business, and implement appropriate systems to manage these risks

2. Ensure that appropriate steps are taken to reasonably protect Northern Health, its Board and staff from claims of liability

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3. Maintain adequate levels of insurance against:
   a. Theft, fire and casualty losses
   b. Liability losses to Directors, staff and individuals engaged in activities on behalf of Northern Health
   c. Losses due to errors and omissions on the part of Directors and staff

4. Receive, process, or disburse funds under controls developed in consultation with Internal Audit that are sufficient for the Board appointed external auditor to rely upon when expressing their opinion on the financial statements[2]

5. Invest or hold operating capital consistent with the approved Investment Policy[3]

6. Establish effective control and co-ordination mechanisms for all operations and activities. Ensure the integrity of internal control, management, and clinical systems.

Compensation and Benefits

With respect to employment, compensation and benefits to employees, consultants, contract workers and volunteers, the CEO shall not allow the fiscal integrity or the public image of Northern Health to be jeopardized. Accordingly, and as per BRD 230 - Executive Limitations, the CEO shall not change his/her own compensation or benefits

[2] See DST 4-4-2-030: Finance>Accounts Payable>Signing Authority
[3] See DST 4-4-6-~~050~~040: Finance>General Accounting>Banking and Investment

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): April 24th 2017 (r)

TERMS OF REFERENCE FOR A DIRECTOR V.1 **BRD 140**

INTRODUCTION

A Director of the Board of Northern Health (the "Board") has the following fundamental obligations.

FIDUCIARY RESPONSIBILITIES

Honesty and Good Faith

Common law requires a Director to act honestly and in good faith with a view towards the best interests of the organization. The key elements of this standard of behaviour are:

1. A Director must act in the best interests of the organization and not in his or her self-interest. This also means a Director should not be acting in the best interests of some special interest group or constituency.

2. A Director must not take personal advantage of opportunities that come before him/her in the course of performing his/her Director duties

3. A Director must disclose to the Board any personal interests that he/she holds that may conflict with the interests of the organization

4. A Director must respect the confidentiality requirements of the Board's Code of Conduct and Conflict of Interest Guidelines (BRD210)

Skillful Management

A Director shall exercise the degree of care, diligence and skill that a reasonably prudent person would exercise in similar circumstances. This means:

1. Directors are expected to bring their expertise to bear upon matters under consideration

2. The Director must be proactive in the performance of his or her duties by:

    a. showing diligence by examination of reports, discussion with other Directors, and otherwise being sufficiently familiar with the organization's activities

Author(s): Governance & Management Relations
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b. participating in a meaningful way

c. being vigilant to ensure the organization is being properly managed and is complying with laws affecting the organization

d. participating in the annual Board evaluation and the evaluation of individual Directors

STANDARDS OF BEHAVIOUR ESTABLISHED BY THE BOARD

The Board has established the following standards of behaviour for Directors.

General

As a member of the Board, each Director will:

1. Demonstrate a solid understanding of the role, responsibilities and legal duties of a Director and the governance structure of the organization as outlined in the Board manual

2. Demonstrate high ethical standards in personal and professional dealings

3. Understand the difference between governing and managing, and not encroach on management's area of responsibility

Strategies and Plan

As a member of the Board, each Director will:

1. Demonstrate an understanding of the organization's strategic direction

2. Contribute and add value to discussions regarding the organization's strategic direction

3. Provide strategic advice and support to the President and Chief Executive Officer (the "CEO")

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4. Participate in monitoring and evaluating the success of the organization and the CEO in achieving established goals and objectives, including participation in the annual CEO performance planning and review process

Preparation, Attendance and Availability

As a member of the Board, each Director will:

1. Prepare for Board and committee meetings by reading reports and background materials distributed in advance

2. Maintain an excellent Board and committee meeting attendance record. The target is 100% attendance. Anything less than 80%, without extenuating circumstances, would create difficulties for the Board. Where a Board member anticipates an inability to meet the attendance requirements, he or she will discuss the circumstances with the Board Chair to determine an appropriate course of action. This may include an unpaid leave of absence or potential resignation from the Board.

3. Attend the entire Board or committee meeting, not just parts of meetings

4. Participate in committees and contribute to their purpose

5. Participate in Board meetings in person particularly those where the Board members are meeting members of the public. Some exceptions can be made in extenuating circumstances.

Communication and Interaction

As a member of the Board, each Director will:

1. Demonstrate good judgment

2. Interact appropriately with the leadership and management of the organization

3. Participate fully and frankly in the deliberations and discussions of the Board

4. Be a positive and constructive force within the Board

Author(s): Governance & Management Relations
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5. Demonstrate openness to other opinions and the willingness to listen

6. Have the confidence and will to make tough decisions, including the strength to challenge the majority view

7. Maintain collaborative and congenial relationships with colleagues on the Board.

8. Advise the CEO and the Chair in advance when introducing significant and/or previously unknown information or material at a Board or Board Committee meeting

9. Once a decision has been made, support the decision

10. While the Board Chair is the primary spokesperson for the Board (BRD120), individual Directors may be called upon to speak on behalf of the Board in instances where the Board Chair is not available (e.g. opening of a new facility). See BRD220.

Health Authority Knowledge

Each Director will:

1. Become generally knowledgeable about the organization's operation, health care issues, and how the organization fits into the provincial health care system

2. Participate in Director orientation and development programs developed by the organization from time to time

3. Maintain an understanding of the regulatory, legislative, social and political environments within which the organization operates

4. Become acquainted with the organization's senior managers

5. Be an effective ambassador and representative of Northern Health

Author(s): Governance & Management Relations
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): April 24th 2017 (r)

TERMS OF REFERENCE FOR THE DEPUTY CHAIR V.1 BRD 150

INTRODUCTION

1. The selection of the Deputy Chair lies with the Board of Directors of Northern Health (the "Board"), through a nomination process.

2. The Deputy Chair shall be elected annually from among the Board members at the June Board meeting. The election will be held by secret ballot.

3. In order to develop additional leadership strength, the role of Deputy Chair will provide a developmental opportunity for Directors.

4. The Board may, at any time, end the term of a Deputy Chair.

ROLE OF THE DEPUTY CHAIR

1. The Deputy Chair will perform the duties of the Board Chair when the Board Chair is unavailable or unable to act.

2. In the event of the Board Chair resigning, the Deputy Chair will perform the duties of the Board Chair, at the pleasure of Government, until a new Board Chair is appointed.

3. If both the Board Chair and Deputy Chair are unavailable or unable to act, the Board may elect from among its members an Acting Chair to conduct a meeting or for such other purposes as the Board may determine.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): April 24th 2017 (r)

TERMS OF REFERENCE FOR THE CORPORATE SECRETARY V.1 BRD 160

GENERAL

The Corporate Secretary of Northern Health is the President & Chief Executive Officer (the "CEO") who has overall responsibility for the secretariat function and duties as outlined herein. The CEO may delegate certain aspects of these duties while maintaining overall oversight and accountability.

SPECIFIC RESPONSIBILITIES

1. Attends all meetings of the Board of Directors of Northern Health (the "Board") and Board Committees, including Board-only sessions, unless otherwise directed by the Board Chair

2. Organizes and ensures the proper recording of the activities of the Board and committee meetings

3. Ensures that Northern Health complies with its governing legislation and Organization and Procedure Bylaws (BRD600)

4. Reviews Organization and Procedure Bylaws to ensure their continued adequacy and relevance, and provides recommendations to the Governance and Management Relations Committee on necessary revisions

5. Keeps the corporate records

6. Maintains custody of the corporate seal

7. Reviews and keeps up-to-date on developments in corporate governance and promotes strong corporate governance practices

8. Advises and assists Directors with respect to their duties and responsibilities

9. Serves as the main source of governance expertise to the Board in relation to:

    a. Current developments in governance practice
    b. Effective relationships between Board and Executive

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c. Policy and legislative compliance

10. Facilitates the orientation and on-going education of Directors, with direction from the Board

11. Acts as a channel of communication and information for Directors

12. Administers the Code of Conduct and Conflict of Interest Guidelines for Directors (BRD 210)

13. Verifies, authorizes and processes payment of:

    a. Board and Committee meeting fees
    b. Board Director expense and travel claims (BRD 610)

14. Monitors Board member terms and liaises with the Board Chair and the Board Resourcing and Development Office (BRDO) to ensure the timely processing of documentation for Board appointments and reappointments for Board continuity

15. Carries out any other appropriate duties and responsibilities as may be assigned by the Board Chair

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
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TERMS OF REFERENCE FOR THE CHAIR OF THE NORTHERN HEALTH MEDICAL ADVISORY COMMITTEE AT BOARD MEETINGS V.1 **BRD 170**

INTRODUCTION

The Board of the Directors of Northern Health (the "Board") shall appoint a Northern Health Medical Advisory Committee (NHMAC)[1]

The Chair of the Northern Health Medical Advisory Committee ("NHMAC Chair") is appointed by the Board after consideration of the recommendation of the NHMAC[2]

The NHMAC Chair provides advice to the President and Chief Executive Officer of Northern Health (the "CEO") and to the Board on:

1. The processes in place to manage the appointment of Northern Health Medical Staff, including credentialing and privileging.
2. The deliberations and recommendations of the NHMAC regarding appointments to the Northern Health Medical Staff.
3. The provision of medical care within the facilities and programs operated by Northern Health
4. The monitoring of the quality and effectiveness of medical care provided within the facilities and programs operated by Northern Health
5. The adequacy of medical staff resources
6. The continuing education of the members of the medical staff
7. Planning goals for meeting the medical care needs of the population served by Northern Health

The Chair or Vice Chair of NHMAC shall provide a report to the Board and to the CEO on a regular basis

THE ROLE OF THE NHMAC CHAIR AT THE BOARD

The role of the NHMAC Chair at Board meetings is to provide a report on the deliberations, motions, recommendations and decisions of the NHMAC. The NHMAC Chair will also inform the Board of any items of discussion from NHMAC meetings that are not included in the minutes as necessary to contribute to the Board discussion.

The Board will be provided with copies of the 'draft' minutes of the NHMAC meetings in order that the Board may independently review the issues discussed by NHMAC and to ensure that they are familiar with the NHMAC's deliberations.

[1] NH Medical Staff Bylaws Article 8.1.1
[2] NH Medical Staff Bylaws Article 8.2.2

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In addition, the NHMAC Chair may participate in Board discussions. The perspective of a practicing physician will be helpful to the Board when discussing certain issues. Because of the size and diversity of the region and the opinion of the various medical communities, it is important that the NHMAC Chair is explicit when he/she is reflecting the opinion of the NHMAC and when the he/she is reflecting his/her own personal or professional opinion.

The NHMAC Chair will be encouraged to contribute to the Board agenda items that are related to quality of care and service delivery issues and items that are identified in the Medical Staff Bylaws.

The NHMAC Chair may request, or be requested, to attend meetings of Board committees to provide specific NHMAC advice and perspective to quality of care and service delivery issues being considered by Board committees. However, the NHMAC Chair is not expected nor entitled to attend Board committee meetings other than by specific invitation.

The Board recognizes and differentiates between advocacy for the interests of medical practitioners and the provision of professional advice regarding quality of care and service delivery issues of importance to patients. Advocacy for the former is a function of the Medical Staff Association, a companion to the medical staff organization. The NHMAC Chair is expected to differentiate between these perspectives and to restrict his/her function as NHMAC Chair to the provision of professional advice regarding quality of care and service delivery issues.

The NHMAC Chair will be excused from 'in camera' portions of Board meetings dealing with agenda items for which, in the opinion of the Board Chair, or of the Chairs of Board committees, the presence of the NHMAC Chair would create a conflict of interest for the NHMAC Chair, or which may prejudice the relationship between the Board and the NHMAC, medical staff or NHMAC Chair if the NHMAC Chair is present during discussions.

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CODE OF CONDUCT AND CONFLICT OF INTEREST GUIDELINES FOR DIRECTORS V.1 BRD 210

Introduction

The Board of Directors of Northern Health (the "Board") is committed to developing and maintaining a reputation for Northern Health as an ethical organization.

The fundamental relationship between each Director and Northern Health must be one of trust; essential to trust is a commitment to honesty and integrity. Ethical conduct within this relationship imposes certain obligations.

1. Directors are expected to use their best efforts to ensure that consideration is given to legal and/or statutory components of any decision taken by the Board. If in doubt, Directors are expected to ask for clarification.
2. No Director shall commit or condone an unethical or illegal act or instruct another Director, employee, or supplier to do so.
3. Directors have a responsibility to have some familiarity with the regulatory regime in which Northern Health operates. They are expected to recognize potential liabilities and to know when to seek legal advice. If in doubt, Directors are expected to ask for clarification[1].

Northern Health is continually under public scrutiny. Therefore, Directors must not only comply fully with the law, but must also avoid any situation which could be perceived as improper or indicate a casual attitude towards compliance. Directors must be familiar and compliant with the Integrated Ethics Framework[2], including using the ethical framework to guide Board decision-making.

Conflicts Of Interest

1. In general, a conflict of interest[3] exists for Directors who use their positions on the Board to:
    a. Benefit themselves, friends, relatives[4], or business associates, or
    b. Benefit other corporations, societies[5], suppliers, unions or partnerships in which they have an interest or hold a position, or

[1] Throughout this policy, when Directors are requested to seek clarification or make a declaration, unless specific direction is otherwise given, Directors shall consult with either the Board Chair, the CEO, or the Corporate Secretary.
[2] Northern Health Integrated Ethics Framework
[3] *Conflict of interest* can be real or apparent; direct or indirect.
[4] *Relatives* generally means a spouse, child, parent or sibling of a Director and can include other relatives, direct or through marriage.
[5] Refer to *Schlenker v. Torgrimson 2013 BCCA 9*

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c. Benefit the interests of a person to whom the Director owes an obligation.

The above are hereafter collectively referred to as "Related Persons[6]".

2. A Director must not take personal advantage of an opportunity available to Northern Health unless the Board or management has clearly and irrevocably decided against pursuing the opportunity, and the opportunity is also available to other Directors or the public.
3. A Director must not use his or her position with Northern Health to solicit clients for the Director's business or Related Persons.
4. Every Director must avoid any situation in which there is, or may appear to be, potential conflict which could appear[7] to interfere with the Director's judgment in making decisions in Northern Health's best interest.
5. There are several situations that could give rise to a conflict of interest. The most common are accepting gifts, favours or kickbacks, or the passing on of confidential information and using privileged information inappropriately.

Disclosure

Northern Health requires full disclosure of all circumstances that could conceivably be construed as conflict of interest.

1. Full disclosure enables Directors to resolve unclear situations before any difficulty can arise.
2. At the beginning of each meeting of the Board, or of one of its Committees or Task Forces, there shall be a standing agenda item requiring each Director present to declare any conflict of interest he/she may have with any item of business on the agenda.
3. Outside of meetings, a Director must, immediately upon becoming aware of a potential conflict of interest situation, disclose the conflict in writing to the Board Chair. This requirement exists even if the Director does not become aware of the conflict until after a transaction is completed.
4. If a Director is in doubt whether a situation involves a conflict, the Director must immediately seek the advice of the Board Chair or the Chair of the Governance and Management Relations Committee (GMR). It may also be appropriate to seek legal advice.

[6] Not an exhaustive list, merely representative.

[7] *Apparent conflict of interest* means any situation where it would appear to a reasonable person that the Director is in a conflict of interest situation.

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5. Unless a Director is otherwise directed by the Board Chair, a Director must immediately take steps to resolve the conflict or remove the suspicion that it exists.
6. If a Director is concerned that another Director is in a conflict of interest situation, the Director must immediately bring his or her concern to the other Director's attention and request that the conflict be declared. If the other Director refuses to declare the conflict, the Director must immediately bring his or her concern to the attention of the Board Chair. If there is a concern with the Board Chair, the issue should be referred to the Chair of GMR.
7. A Director is required to disclose the nature and extent of any conflict at the first meeting of the Board after which the facts leading to the conflict have come to that Director's attention. After disclosing the conflict, the Director:
   a. must not take part in the discussion of the matter or vote on any questions in respect of the matter. However, the Director may be counted in the quorum present at the Board meeting.
   b. may, if the meeting is open to the public, remain in the room, but shall not take part in that portion of the meeting during which the matter giving rise to the conflict is under discussion, and shall leave the room prior to any vote on the matter giving rise to the conflict.
   c. must, if the meeting is not open to the public, immediately leave the meeting and not return until all discussion and voting with respect to the matter giving rise to the conflict is completed.
   d. must not attempt, in any way or at any time, to influence the discussion or the voting of the Board on any question relating to the matter giving rise to the conflict.

Outside Business Interests

1. Directors must declare possible conflicting outside business activities at the time of appointment. Notwithstanding any outside activities, Directors are required to act in the best interest of Northern Health.
2. No Director may hold a significant financial interest, either directly or through a Related Person, or hold or accept a position as an officer or Director in an organization in a relationship with Northern Health, where by virtue of his or her position on the Board, the Director could in any way benefit the other organization by influencing the purchasing, selling or other decisions of Northern Health, unless that interest has been fully disclosed in writing to the Board Chair. A “significant financial interest” in this context is any interest substantial enough that decisions of Northern Health could result in a personal gain for the Director.

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3. These restrictions apply equally to interests in companies that may compete with Northern Health in any of its areas of activity.

Confidential Information

1. Confidential information includes personal, proprietary, technical, business, financial, legal, or Director information, which the Board or management treats as confidential.
2. Directors may not disclose such information to any outside person unless authorized.
3. Similarly, Directors may never disclose or use confidential information gained by virtue of their association with Northern Health for personal gain, or to benefit Related Persons.

Directors are advised to seek guidance from the Board Chair or the President & Chief Executive Officer (the "CEO") with respect to what is considered confidential.

Investment Activity

Directors may not, either directly or through Related Persons, acquire or dispose of any interest, including publicly traded shares, in any company while having undisclosed confidential information obtained in the course of work on the Board, which could reasonably affect the value of such securities.

Outside Employment or Association

A Director, who accepts a position with any organization that could lead to a conflict of interest or situation prejudicial to Northern Health's interests, shall discuss the implications of accepting such a position with the Board Chair, recognizing that acceptance of such a position may require the Director's resignation from the Board.

Public Office

1. No one who holds public elected office[8] is eligible to be a Director of Northern Health unless otherwise directed by the Crown Agency Board Resourcing Office (CABRO).
2. A Director may run for public office while a member of the Board, and shall while campaigning:
    a. Take a paid leave of absence from the Board, or

[8] Public elected office includes: Municipal Council, Band Council, School Board, Regional District/Regional Hospital District, Member of the Legislative Assembly of BC, Member of Parliament.

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b. Attend Board and Board Committee meetings with the proviso that:
    i. At the start of each meeting the Director's candidacy for elected office is declared and minuted, and
    ii. The Director excuses[9] themselves from any discussion/vote that could be viewed as partisan, and
c. Not speak on behalf of Northern Health, and
d. Not refer to their work on the Board other than a factual declaration of Board membership in their biography.

3. If elected, the Director must resign immediately unless otherwise directed by the Board Resourcing Office.

Entertainment, Gifts and Favours

1. It is essential to efficient business practices that all those who associate with Northern Health, as suppliers, contractors or Directors, have access to Northern Health on equal terms.
2. Directors and Related Persons shall not accept entertainment, gifts or favours that create or appear to create a favoured position for doing business with Northern Health. Any firm offering such inducement shall be asked to cease doing so. A sustained business relationship will be conditional on compliance with this code.
    a. Inappropriate gifts received by a Director shall be returned to the donor and will be accompanied by a copy of this code with full and immediate disclosure to the Board Chair.

~~2.~~3. Similarly, no Director may offer or solicit gifts or favours in order to secure preferential treatment for themselves, Related Persons or Northern Health.

~~3.~~4. Under no circumstances may Directors offer or receive cash, preferred loans, securities, or secret commissions in exchange for preferential treatment. Any Director experiencing or witnessing such an offer must report the incident to the Board Chair immediately.

~~4.1. Inappropriate gifts received by a Director shall be returned to the donor and will be accompanied by a copy of this code with full and immediate disclosure to the Board Chair.~~

[9] When a Director excuses themselves from discussion in an in camera meeting they shall leave the room. The Director may remain in the room if during the public session. The minutes of the meeting shall note the Director's actions to excuse themselves from discussion.

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Use of the Authority's Property

1. A Director requires Northern Health's approval to use property owned by Northern Health for personal purposes, or to purchase property from Northern Health unless the purchase is made through the usual channels also available to the public.
2. Even then, a Director must not purchase property owned by Northern Health if that Director is involved in an official capacity in some aspect of the sale or purchase.
3. Directors may be entrusted with the care, management and cost-effective use of Northern Health's property and shall not make significant use of these resources for their own personal benefit or purposes. Clarification on this issue should be sought from the Board Chair.
4. Directors shall ensure all Northern Health property which may be assigned to them is maintained in good condition and shall be able to account for such property.
5. Directors may not dispose of Northern Health property except in accordance with the guidelines established by Northern Health.

Responsibility

1. Each Director must adhere to the standards described in this Code of Conduct, and to the standards set out in applicable policies, guidelines or legislation.
2. Integrity, honesty, and trust are essential elements of Northern Health's success. Any Director who knows or suspects a breach of this Code of Conduct and Conflict of Interest Guidelines has a responsibility to report it to the Board Chair.
3. To demonstrate determination and commitment, Northern Health requires each Director to review and sign the Code annually. The willingness and ability to sign the Code is a requirement of all Directors.

Breach of Code

A Director found to have breached his/her duty by violating the Code of Conduct will be liable to Board censure or a recommendation for dismissal to the Government.

Where to Seek Clarification

The Board Chair or the Chair of GMR will provide guidance on any item in this Code of Conduct and Conflict of Interest Guidelines. The Board Chair may at

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his/her discretion, or at the request of a Director, seek the advice of outside legal counsel.

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DIRECTOR DECLARATION FORM

I ACKNOWLEDGE that I have read, considered and understood the *Code of Conduct and Conflict of Interest Guidelines for Directors* of Northern Health (BRD210) and the Northern Health Integrated Ethics Framework.

A perceived direct or indirect conflict with my duty as a Director of Northern Health may arise because:

a. I hold the following offices or sit on the following Boards (appointed or elected):

☐ None

_____

_____

_____

_____

b. I receive financial remuneration (either for services performed by me, as an owner or part owner, Trustee, Director, employee or otherwise) from the following sources:

☐ None

_____

_____

_____

_____

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Do you have relationships or interests with any of Northern Health's vendors as listed in the annual Statement of Financial Information (SOFI)?

☐ Yes ☐ No

Describe:

_____

_____

_____

_____

Other than disclosed above, do you have any relationships or interests that could compromise, either directly or indirectly, or be perceived to compromise, your ability to exercise judgement with a view to the best interests of Northern Health?

☐ Yes ☐ No

Describe:

_____

_____

_____

_____

I agree to conduct myself in accordance with the Code of Conduct and affirm, to the best of my knowledge, that I have no undeclared Conflict of Interest.

_____
Signature

_____ _____
Print Name Date

_____ _____
Corporate Secretary Date

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Regional Office
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BOARD BRIEFING NOTE

Date:	**March 12, 2018**	
Agenda item	**Overview of Research Partnerships**	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**GMR Committee & Northern Health Board of Directors**	
Prepared by:	**Tanis Hampe, Regional Director, Quality and Innovation** **Tammy Hoefer, Regional Manager, Innovation and Development Commons/Northern Clinical Simulation/Co-Lead BC SUPPORT Unit Northern Centre**	
Reviewed by:	**Fraser Bell, VP Planning, Quality and Information Management** **Cathy Ulrich, CEO**	

Issue:

Northern Health's (NH) strategic plan commits us to *engage in research, education and quality improvement partnerships with academic organizations to create a learning environment throughout NH*. A critical success factor to achieve a culture of quality improvement and safety in NH is that we will *partner to continue to align research, education/training and service delivery.*

Northern Health (NH) supports research activity and the use of research findings for innovation and evidence-informed practice. We use knowledge generated from research, evaluation and quality improvement to improve the quality and safety of services we provide and as a vehicle for innovation in our region to provide exceptional health services for Northerners.

This briefing note is intended to update the Board on key research activities:

- Research in Northern Health – presentation of 2017 Research Review Committee Annual Report
- Research Partnerships – overview

Research in Northern Health

The NH Research Review Committee (RRC) facilitates the ethical conduct of health research. It is mandated by NH policy to approve, reject, propose modifications to or terminate any proposed or ongoing research involving humans that is conducted: in NH facilities/programs; by NH staff or physicians; or with NH staff, physicians and/or patients.

The RRC's function is to ensure that ethical principles and standards respecting the personal welfare and rights of research participants have been recognized and accommodated. The RRC is also directed to consider the impact of the research on the NH organization. A study requires both research ethics approval and NH operational approval before it can proceed.

Research ethics is a domain in NH's Integrated Ethics Framework, alongside clinical and organizational ethics.

The NH RRC was established in January 2007. To date, 465 research applications have been reviewed by the Committee.

Highlights from the 2017 Annual Report (attached) include:

- 45 applications were received and reviewed in 2017. The average number of applications received over the last five years is 46.

- The majority of principal researchers (71%) were affiliated with the University of Northern British Columbia (UNBC) and the University of British Columbia (UBC) (including Northern Medical Program faculty and students, and clinical program residents practicing in the north).

- 23% of 2017 applications involved a UNBC Principal Investigator or Co-investigator which is lower than the average for the past five years (28%).

- Student and Clinical Resident research comprised 54% of the applications. This is slightly higher than in previous years.

- The primary topics of research projects were population and public health, chronic diseases, health human resources, critical care, acute care and cancer. There were declines in the previously prominent categories of primary healthcare and mental health and addictions research. In 2017, research about health technologies (e.g., personal health records, telehealth, mobile technology) started to emerge as a popular category.

- Eighty-four percent (84%) of applications received by NH in 2017 were reviewed together with other BC Health Authorities and Universities using the harmonized research ethics model (up from 83% in 2016 and 41% in 2015).

In January 2018 the BC Ethics Harmonization Initiative was brought under the BC Academic Health Sciences Network (AHSN) and funded to continue operations and the development of a single research ethics application platform for the province.

Research Partnerships

A Vision to Continue Strengthening Research in Northern BC

Senior leadership and key research support staff from NH, UNBC and the Northern Medical Program (NMP) have drafted a collective vision for research that includes:

- A core coalition of the three partners surrounded by a network of organizations involved and interested in research in northern BC,
- Administrative and medical co-leadership with a secretariat, and
- Four areas for focused development:
    - Data support (for research, quality improvement and decision support)
    - Clinical research unit
    - Research capacity and support
    - Knowledge mobilization

This vision will be flushed out into a plan with identification of resourcing (which will include consolidating existing resources and seeking new funding). The group is in conversation with the Michael Smith Foundation for Health Research to explore partnership and funding opportunities.

Clinical Research

One element of the vision to strengthen research in northern BC is a clinical research unit. Activity in the area of clinical research development in 2017-18 included:

- A working group representing interests and research supports from UNBC, the NMP, BC Cancer Agency Centre for the North and NH began work on a northern BC model for clinical research in partnership. The group:
    - Collected information and learnings from other organizations in BC and across Canada
    - Shared perspectives from northern BC researchers and operations
    - Identified facilitators and barriers to achieving a clinical research environment in northern BC
    - Explored human resources opportunities to add capacity to the system for clinical research and endeavoured to map out research processes
    - Identified clinical research studies in this partnership that were trying to get started in the north and began problem solving how to operationalize these studies in our environment. Acknowledging that there was significant development required to advance clinical research, the conversation was moved to senior leadership.

- The Northern Biobank Initiative, led by Dr. Nadine Caron, is in the advanced planning stage. In 2017 a NH-UNBC steering committee was formed with an initial focus on the implementation of a retrospective breast cancer biobank (2004-2014) at UHNBC. This project is resulting in significant learning about

clinical infrastructure development in the north. The retrospective biobank is in the final stages of research ethics approval. Pathologists, lab staff and space have been identified, and standard operating procedures drafted. The biobank is expected to begin to be populated in the spring of 2018. This will establish the foundation for a future prospective biobank involving our northern patients.

- UHNBC's purpose and identity as an academic hospital has been intentionally explored through the UHNBC Clinical Leadership Review. An element of an academic hospital is an active research environment.

BC Academic Health Sciences Network – Northern Node

On June 1, 2017, stakeholders came together to consider opportunities for the northern research and academic landscape presented by the potential BC AHSN Northern Node. The purpose of the meeting was to develop a concept for the Northern Node (NN) that would reflect a natural, living relationship amongst the partners, one that could evolve in future as information became available about BC AHSN's plans for node development. Over the course of the summer/fall, representatives from the group continued to meet and develop a draft proposal for regional stakeholder consideration. The proposal includes a draft value proposition, vision and mission statements, operating principles and preliminary options for participation and governance. While these continue to be refined, there is agreement on the strategic business objectives for the node, which include:

1. Advocating for the remote and rural point of view
2. Convening, catalyzing and facilitating
3. Ensuring northern relevance
4. Providing research support services
5. Promoting implementation science
6. Data capacity building
7. Developing critical mass
8. Ensuring education aligns with northern priorities

BC SUPPORT Unit Northern Centre

The Northern Centre is one of four regional centres of the BC SUPPORT Unit. It's the go-to resource for patient-oriented research within the geographic area served by Northern Health. The Centre serves the communities of Northern British Columbia from Quesnel north to the Yukon border, and Haida Gwaii east to the Alberta border and operates as a partnership between Northern Health and the University of Northern British Columbia through the Innovation and Development Commons.

Recently the Northern Centre launched its "Developing Northern Research Collaboration" seed grant program. The Northern Centre received ten applications with these five successful proposals receiving the highest scores from the adjudication committee. Each successful project was awarded $10,000 which is to be spent March 1, 2018 – February 28, 2019.

- Envisioning Health with Nadleh Whut'En - Dr. Sara de Leeuw

- Improving health outcomes for persons in long-term care facilities in northern British Columbia: Development of an intervention study aimed to improve quality of life by enhancing accessibility to the natural environment and horticulture therapy - Dr. Shannon Freeman
- Access to Care for Women with Complex Pregnancies in Northern BC: Patient Partner Capacity-Building - Dr. Sheona Mitchell-Foster
- Industry and Health in Northern BC Communities - Dr. Margot Parkes
- Building a Patient-Oriented Physical Activity Research Framework for Northern BC - Dr. Chelsea Pelletier

The Northern Centre is also proud to be hosting a three-day training session in June on the CIHR Foundations in Patient Oriented Research. This course is designed to equip patients, researchers and others (including research assistants, trainees, care providers and system decision-makers) with the knowledge, skills and attitudes to work in partnership doing patient-oriented research. Currently there are 23 people registered including patient partners, NH staff and researchers from BC Cancer Agency and UNBC.

UNBC-NH Collaboration on Health Promotion Course & "Applied Health Promotion Projects" (HHSC473/606)

The HHSC473/606 Course has been taught in collaboration with Northern Health since 2009. The students are generally in the 4th year of Bachelor in Health Sciences and Masters students tend to be in 2nd year with variable knowledge of the BC Health context. This semester's cohort includes 7 undergraduates and 1 PhD student. Students were partnered with Northern Health staff to work on an applied health promotion project focused on an applied issue or question related to health promotion at Northern Health. The topics include:

- Enhancing orientation materials for new Childcare providers
- Tobacco and vapour free environments bylaw development
- Measuring success in healthy community development
- Mental wellness and prevention of substance harms communications plan and messaging
- Physical activity interventions – determining best practice for clinical settings
- Increasing STI testing in young adults

Collaboration for Health Research in Northern BC Seed Grant Competition

The Provincial Health Services Authority (PHSA), NH and UNBC have been collaborating on the seed grant program since 2015. The goal of this program is to enable researchers and knowledge users at PHSA, NH and UNBC to work in partnership and initiate new research projects that focus on improving the quality of health services and improving population health in northern BC. Since the last Board update in March 2017, 7 additional grants were awarded to successful applicants bringing the total since 2015 to 18. The topics for the new grants include:

- Mapping of pregnancy care for women living with HIV in Northern BC
- Mental health service users' and carers' experience of cancer care

- A recall system to improve vaccine coverage in Northern BC: A pilot community intervention trial
- Understanding how nurse practitioners engage in primary health care practices in Northern BC
- SmartParent: A texting program for the first year of parenting
- Veriscan in mammary epithelial invasion
- Feasibility of implementing leg cycle ergometers in an independent dialysis unit in a northern BC setting

Knowledge Mobilization

In addition to generating new knowledge through research, we focus on the importance of creating opportunities to implement knowledge into policy and practice. In northern BC we regularly host a Brown Bag Lunch series and other events through the Innovation and Development Commons and the UNBC Health Research Institute. When NH is a true partner in the research endeavor, the implementation of the research results happens fluidly and effectively. Examples of partnered research are the Northern Biobank Initiative, research on health impacts of resource development (Dr. Margot Parkes, Canada Research Chair in Health, Ecosystems and Society, UNBC with Dr. Sandra Allison, Chief Medical Health Officer, NH) and the research projects with Dr. Martha MacLeod highlighted below.

Demonstrating the value of knowledge mobilization, UNBC and NH created a Knowledge Mobilization Chair role, held by Dr. Martha MacLeod, Professor in the Schools of Nursing and Health Sciences, and Co-Lead of the UNBC Health Research Institute. She is currently leading the following research projects in collaboration with NH:

- *Partnering for Change II* – Continues the study of process through which NH is changing primary health care services in collaboration with physicians and communities
- *Leading Implementation* – Explores how front line leaders and middle managers go about leading implementation of primary health care service change in NH
- *A Hermeneutic Approach to Advancing Implementation Science* – Studies how practitioners, other research users, and researchers work together to create knowledge and use it to improve clinical practices or policies in rural/remote settings
- *Contextualizing Evidence for Change* – Working with Newfoundland and northern Ontario, examines how to contextualize evidence about preventing and managing agitation and aggression in persons with dementia, for implementation in long term care facilities in NH.
- *Nursing Practice in Rural and Remote Canada II* – A nation-wide study, with Penny Anguish as the Lead Knowledge User is examining what will contribute to the recruitment and retention of nurses in rural and remote communities.

Dr. Dave Snadden was appointed the founding Rural Doctors' UBC Chair in Rural Health for a five year term beginning in late 2016. The focus of this position is improving rural health care and Dr. Snadden's research approach with communities and exploration of real-world solutions to challenges faced by rural health professionals and their patients both embodies and facilitates knowledge mobilization.

Northern Health Research and Quality Conference: November 6-8, 2018, Prince George

Two important vehicles for sharing and celebrating knowledge development in northern BC are the biennial Research Days and the annual Quality Conference. In 2018, these two conferences are blending into a single event, acknowledgeing the complementarity of our research and quality improvement activities and the value of a single knowledge sharing event for staff, physicians and our academic and community partners.

Recommendation(s):

Accept this briefing note for information.

Attachments:

- Research Review Committee Annual Report 2017

Research Review Committee
Annual Report 2017

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northern health

the northern way of caring

Introduction and Background

All research conducted within or for Northern Health (NH) must be reviewed and approved by the NH Research Review Committee (RRC).

The RRC is mandated by NH policy to approve, reject, propose modifications to or terminate any proposed or ongoing research involving humans that is conducted: in NH facilities/programs; by NH staff or physicians; or with NH staff, physicians and/or patients.

The RRC's function is to ensure that ethical principles and standards respecting the personal welfare and rights of research participants have been recognized and accommodated. The RRC is also directed to consider the impact of the research on the NH organization. A study requires both research ethics approval and NH operational approval before it can proceed.

The Committee follows NH Research Policy and Principles, the Freedom of Information and Protection of Privacy Act (FIPPA) and the (TCPS-2) Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans.

The RRC is accountable to the Governance and Management Relations Committee of the NH Board of Directors.

2017 Membership

- Dr. Sandra Allison, Chief Medical Health Officer, NH
- Linda Axen, Regional Manager Policies and Clinical Practice Standards, NH
- Jim Campbell, Executive Lead, Mental Health and Addictions Program, NH
- Tamara Checkley, Lead, Research & Evaluation, NH
- Damen DeLeenheer, Clinical Educator, NI Rural Communities, Mental Health and Addictions, NH
- Dr. Andrew Gray, Medical Health Officer, NI, NH
- Tanis Hampe, Regional Director, Quality and Innovation, NH
- Kerensa Medhurst, Research Facilitator, BC Cancer Agency Centre for the North
- Sam Milligan, Integrated Care Coordinator, Carrier-Sekani Family Services
- Robert Pammett, Research and Development Pharmacist – Primary Care, NH/UBC
- Graeme Richardson, Adult Mental Health and Addictions Case Manager, NH
- Kirsten Thomson, Regional Director, Risk and Compliance, NH
- Debra Woods, Regional Manager, Strategic Initiatives and Project Support, NH

Associate members:
Associate members were introduced in 2016. They complete reviews of research applications in the areas of their expertise. They do not participate on the Committee as regular members (i.e., attend meetings, hold a committee vote).

- Scott Christie, Environmental Health Officer
- Tysen LeBlond, Occupational Therapist
- Joanna Paterson, Project Lead, Chronic Pain
- Dr. Ann Syme, Director, HR Planning & Design and Education & Training

Ad hoc member: Traci de Pape, Regional Manager, Privacy Office is included in the review process when Section 35 of FIPPA applies to a research application or consulted on other relevant privacy concerns or legislation.

Committee Chair: Tamara Checkley, Lead, Research & Evaluation, NH

Administrative support: Administrative Assistant, Planning, Quality & Information Management (Jaclyn Sawtell January-July 2017; Janet Rockwell August – December 2017)

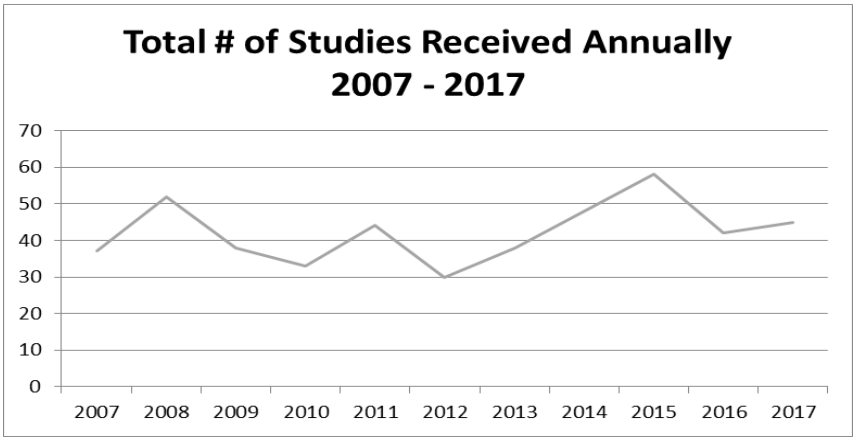
Outgoing Members:
Northern Health would like to thank the outgoing members of the Research Review Committee for their contributions and service:

- Dr. Sandra Allison, Chief Medical Health Officer, NH
- Jim Campbell, Executive Lead, Mental Health and Addictions Program, NH
- Graeme Richardson, Adult Mental Health and Addictions Case Manager, NH
- Dr. Ann Syme, Director, HR Planning & Design and Education & Training

Research Reviewed

Forty-five (45) studies were received by the Research Review Committee in 2017. Six (6) were subsequently withdrawn by the researchers because the study was placed on hold, decided not to proceed at NH sites, or determined to be outside of NH RRC jurisdiction (e.g., research in a family practice office).

This is a slight increase in applications from 2016. The average number of applications received over the last five years is 46.



The development and implementation of a model of harmonized research ethics review among BC Universities and Health Authorities beginning in 2012 resulted in an opening up of NH and other Health Authorities for researchers and is reflected in the increase in volume of applications received, which is now levelling off.

In 2017, 84% of the studies reviewed by NH were completed through the BC ethics harmonization initiative (BCEHI). Almost every application to the NH RRC had a Principal Investigator from a BC University that is a BCEHI partner institution. This continued growth in the proportion of harmonized reviews conducted in NH (see the blue box to the right) is due to the maturation of the BC ethics harmonization process and partnerships.

Northern Health Participation in BC Harmonized Reviews
2014: 10 (21% of total studies)
2015: 24 (41%)
2016: 35 (83%)
2017: 38 (84%)

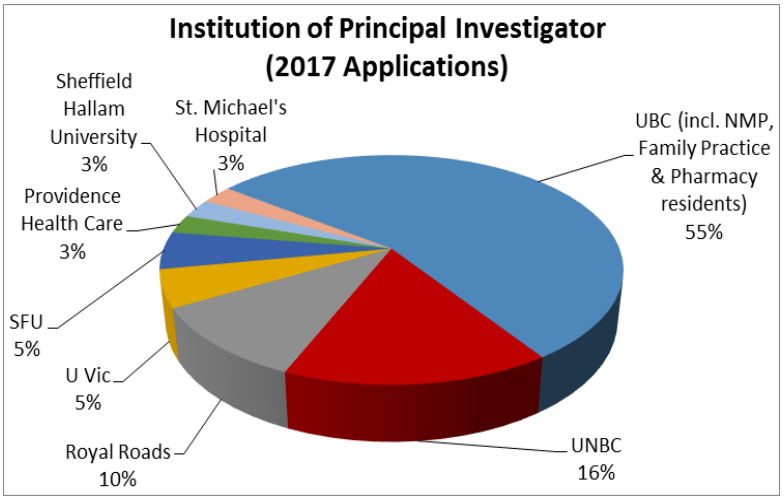
Status of applications received in 2017 (as of February 28, 2018):

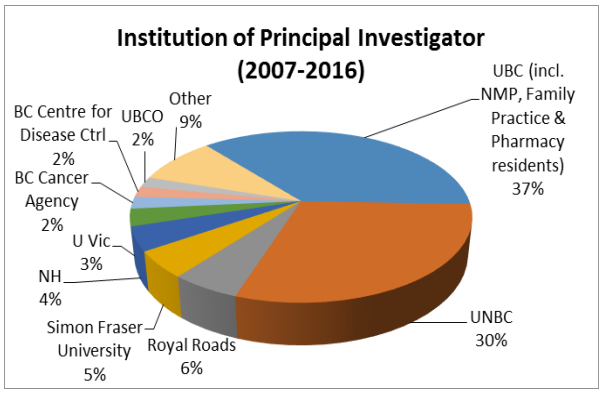
33 – Approved
3 – Waiting for response from researcher (e.g., full application, revisions required)
2 – Ethics approval granted; need to complete operational approvals
1 – Currently under review

Appendix A contains a list of the research applications approved by the RRC in 2017.

Principal Investigators

As in previous years, the majority of applications to the NH RRC were received from UBC and UNBC Principal Investigators (PI) (55% and 16% respectively). Proportionally there has been an increase in the applications from UBC researchers (resulting in a proportional decrease in PIs from UNBC and other institutions), with the maturity of the Northern Medical Program, UBC clinical residency programs based in the north and the implementation of the BCEHI in which the majority of PIs are affiliated with UBC.



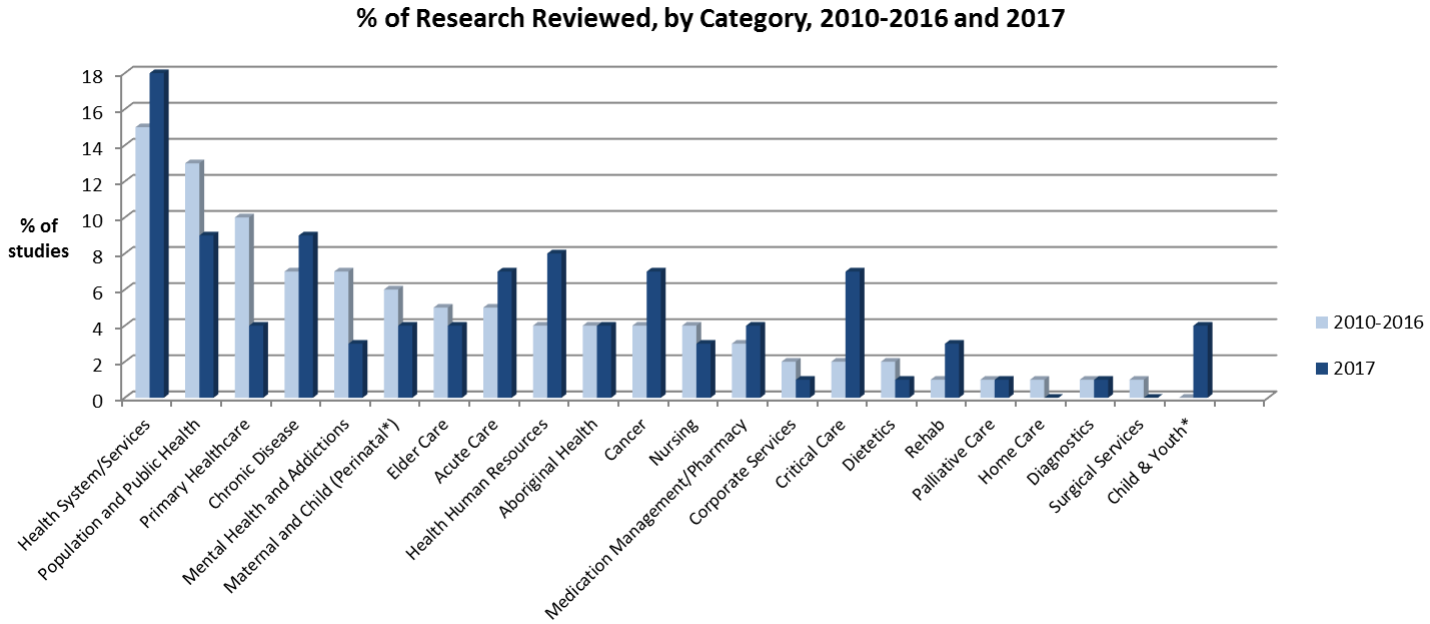


Twenty-three percent (23%) of 2017 applications involved a **UNBC PI and/or Co-Investigator** (compared with 33% in 2016, 26% in 2015 and 21% in 2014).

Student and clinical resident research comprised 54% of the applications which is up slightly from previous years (48% in 2016, 46% in 2015 and 53% in 2014).

Category of Research

Starting in 2010, researchers were invited to select the most suitable categories for their study. Researchers identified up to three categories per study.

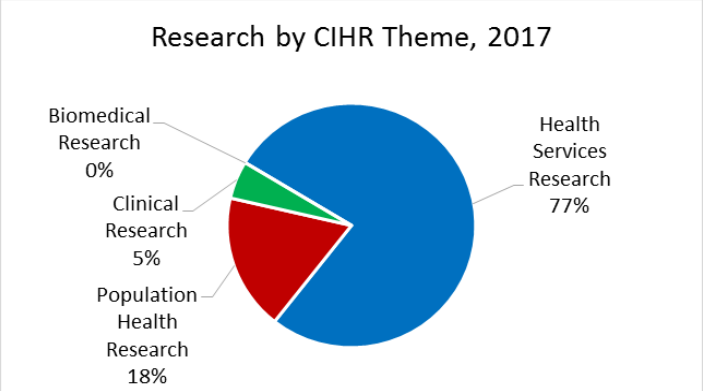


Health system/services, population and public health, and chronic disease remain popular categories of research in NH. Researchers often select health services/systems in addition to categories that identify a specific care area or population. There was an increase in acute care, health human resources, cancer, critical care, rehabilitation and child/youth. There was a decline in primary healthcare and mental health and addictions research, which have been 'top' categories in previous years.

Not reflected in these categories is an increase in the number of studies investigating and/or trialing health technology in the delivery of care or engagement of people in their care (e.g., electronic personal health records, telehealth, mobile technology). These are generally captured in the "health services/systems" category.

The Canadian Institutes for Health Research (CIHR) categorize research into four 'themes'. Appendix A contains definitions of the four themes of health research.

The most significant proportion of research in northern BC falls into the health services research theme, with some population health research. This has not changed since the establishment of the RRC.



There was an influx of clinical research in 2016 (12% of applications). It has taken considerable time to determine how to operationalize many of these studies in the organization and some are not yet able to proceed at NH sites. The recognition that we are in development phase for clinical research has led to a decrease in applications for clinical research in 2017. This is an area of focus for development with research partners in northern BC (NH, UNBC, UBC and BC Cancer Agency Centre for the North).

2017 Administrative Activity and Developments

- The committee met nine times in 2017 (every month except July, August and December). Delegated reviews were carried out in months when the Committee did not meet.

- Northern Health continued as a partner in the BC Ethics Harmonization Initiative (BCEHI). The aim of the BCEHI is to create efficient, coordinated, and high-quality processes that support and encourage multi-jurisdictional human health research in BC. It is a collaboration among the health authorities and BC's four major research universities, who collectively conduct more than 80 percent of the province's human subject ethics reviews. The initiative is currently funded by the Michael Smith Foundation for Health Research. In 2017 work began to design, test and implement a provincial platform for harmonized ethical review and approval. Information about the initiative is at https://bcethics.ca.

- Through the BC Academic Health Sciences Network and the BC SUPPORT (Support for People and Patient-Oriented Research and Trials) Unit[1], a province-wide membership agreement was signed that provides NH with access to N2 Network of Networks[2] resources. NH RRC members were introduced to online training opportunities available through this membership (e.g., good clinical practice, social and behavioural research ethics, and responsible conduct of research).

- The Committee developed a site on the NH Sharepoint platform to consolidate committee documents, increase access for committee members external to NH, and reduce email correspondence.

[1] For information about the BC Academic Health Sciences Network and BC SUPPORT Unit visit: http://bcahsn.ca/ and http://bcsupportunit.ca/
[2] http://n2canada.ca/

Conclusion

In 2017, health research was reviewed and approved by the RRC on a wide range of topics including population and public health, chronic disease, acute care, health human resources, and the use of technology in patient engagement and care. The volume of applications remained around the average for the past five years (45). Student and clinical resident research projects comprised more than half of the applications received. Almost three quarters of the studies involving northern communities and NH sites, patients and staff were led by researchers affiliated with UNBC and UBC. The proportion of reviews done in partnership with Universities and Health Authorities through the BC Ethics Harmonization process continued to increase in 2017, to 84%, as the harmonized research ethics model matured.

Research is an important contributor to the high quality services in Northern Health and in 2018 the organization will continue its commitment in the strategic plan to *engage in research, education and quality improvement partnerships with academic organizations to create a learning environment throughout Northern Health.*

Appendix A: 2017 Research Projects (Received in 2017; Approved to Feb 28, 2017)
Including Canadian Institute for Health Research Themes (http://www.cihr-irsc.gc.ca/e/48801.html)

Theme 1: Biomedical Research (B)

Biomedical research is research with the goal of understanding normal and abnormal human functioning, at the molecular, cellular, organ system and whole body levels, including development of tools and techniques to be applied for this purpose; developing new therapies or devices that improve health or the quality of life of individuals, up to the point where they are tested on human subjects. Biomedical research may also include studies on human subjects that do not have a diagnostic or therapeutic orientation.

Theme 2: Clinical Research (C)

Clinical research is research with the goal of improving the diagnosis, and treatment (including rehabilitation and palliation), of disease and injury; improving the health and quality of life of individuals as they pass through normal life stages. Clinical research usually encompasses research on, or for the treatment of, patients.

Theme 3: Health Services Research (H)

Health services research includes research with the goal of improving the efficiency and effectiveness of health professionals and the health care system, through changes to practice and policy. Health services research is a multidisciplinary field of scientific investigation that studies how social factors, financing systems, organizational structures and processes, health technologies, and personal behaviours affect access to health care, the quality and cost of health care, and, ultimately, Canadians' health and well-being.

Theme 4: Social, Cultural, Environmental, and Population Health Research (P)

Population and public health research comprises research with the goal of improving the health of the Canadian population, or of defined sub-populations, through a better understanding of the ways in which social, cultural, environmental, occupational and economic factors determine health status.

Title of Research	Principal Investigator (PI)	PI Institution & Department	NH Operational Approval		CIHR Research Theme
Received and Approved by Research Review Committee					
A Provincial Perspective of New Manager Training Across British Columbia Health Authorities	Farzana Himani	University of Victoria, Public Administration	Ann Syme	Regional Director, HR Planning & Design, Education & Training	H
Addressing a wicked service problem to create a sustainable rural oncology clinic	Johnathan Cooper	Sheffield Hallam University, Nursing	Pamela Dawkins;	Manager, Acute Care Services, Kitimat;	H

Title of Research	Principal Investigator (PI)	PI Institution & Department	NH Operational Approval		CIHR Research Theme
			Ciro Panessa; Tanis Hampe	Chief Operating Officer, NW; Regional Director, Quality & Innovation	
Assessing the knowledge, attitudes, and beliefs of Kidney Care Clinic staff about kidney transplantation before and after a multi-pronged education program	Ruth Elaine McCarrell	Providence Health Care, Renal Transplant	Sherri Leon Torres	Regional Manager, Chronic Disease Clinical Services	H
Clinical Texting and Teledermatology in British Columbia	Dr. Clifford Neil Kitson. Med student Nicole Hong	UBC Medicine	n/a	n/a	H
Culturally Safe Perinatal Housing for Women Struggling with Substance use	Sheona Mitchell	UBC Obstetrics & Gynaecology	Kelsey Nelson	Health Information Management	P
Decreasing Barriers to Engaging in Colposcopy for Women Living in Northern British Columbia through Mobile Technology	Sheona Mitchell	UBC Obstetrics & Gynaecology	Shelley Barwise	Program Lead, Ambulatory Services, UHNBC	H
Determining the accessibility to take home naloxone and harm reduction services in Northern Health	Robert Pammett	UBC Pharmaceutical Sciences	Dana Cole	Director of Pharmacy Services	H
Evaluating the frequency of intravenous antibiotic conversion to oral administration in adult inpatients at a university teaching hospital in Northern BC - Pharmacy Resident Project	Alicia Rahier (Kyle Costa -Resident)	UBC Pharmaceutical Sciences	Julie Gagnon, Melanie Baker	Pharmacy Manager; Health Information Management	H
Feasibility of Implementing Leg Cycle Ergometers in an Independent Dialysis Unit in a Northern BC Setting	Robin Roots	Northern Medical Program	Sherri Yeast	Regional Manager, Chronic Diseases - Specialized Services	C
HEARTSMAP Implementation Evaluation	Quynh Doan	UBC Paediatrics	Deb Nielsen	Regional Manager, Analytics & Reporting	H
Improving Communication among Physicians and	Michelle	Royal Roads	Anne	HSA, Prince George	H

Title of Research	Principal Investigator (PI)	PI Institution & Department	NH Operational Approval		CIHR Research Theme
Interprofessional Teams	Lawrence	Leadership	Chisholm		
Indigenous Families Stories and Journeys with Early Intervention Therapies in Northern British Columbia: A Critical Qualitative Inquiry	Dr. Alison Gerlach	UNBC National Collaborating Centre for Aboriginal Health	Jennifer Begg	Executive Lead, Child and Youth Health Program	p
Integrating self-collected HPV testing at community-based primary care clinics: Decreasing barriers to screening for Indigenous and marginalized women	Sheona Mitchell	UBC Obstetrics & Gynaecology	n/a	n/a	C
Longitudinal Observation of Ultrasound Equipment Gross Contamination in a Medium Sized British Columbia Emergency Department	Dr. Floyd Besserer	UBC Medicine	Rita Sweeney	Manager, Emergency Department, UHNBC	H
Mental Health Service Users' and Carers' Experiences of Cancer Care	Candida Graham	UNBC Psychiatry	Site managers		H
Narrative Influences on Northern BC Womens Experiences of Caring for Spouse with Dementia	Karen Koning	UNBC Social Work	Jason Jaswal	Director Residential Services	P
Outpatient management of Pulmonary Embolism: A retrospective assessment of patient eligibility for outpatient treatment	Floyd Besserer	UBC Emergency Medicine	Nona Gatchalian	Manager, Health Information Management, NI	H
Physician-Nurse Collaboration in the Emergency Department at University Hospital of Northern BC	April Price	Royal Roads Leadership	Rita Sweeney	UHNBC Emergency Department	H
Primary Care Providers Perception of Standardized Electronic Medication Monitoring Plans - Pharmacy Residency Project	Benjamin Wou	UBC Pharmaceutical Sciences	Dana Cole	Regional Director, Pharmacy Services	H
Promoting Health Equity for Indigenous and non-Indigenous People in Emergency Rooms ("EQUIP Emergency Research Phase 1 (Observation)")	Colleen Varcoe	UBC School of Nursing	Anne Chisholm	HSA, Prince George	H
Promoting Health Equity for Indigenous and non-Indigenous People in Emergency Rooms ("EQUIP Emergency Research Phase 2 (Surveys)	Colleen Varcoe	UBC School of Nursing	Anne Chisholm	HSA, Prince George	H

Title of Research	Principal Investigator (PI)	PI Institution & Department	NH Operational Approval		CIHR Research Theme
Retrospective Evaluation of Clostridium Difficile Infection Risk Factors and Management at a University Teaching Hospital in Northern BC ("C. difficile at UHNBC")	Bellefeuille; Alicia Ridgewell	UBC Pharmaceutical Sciences	Melanie Baker	Health Information Management	H
Self-managed upper-body surveillance and rehabilitation: A qualitative exploration of the perspective of breast cancer survivors and physiotherapists	Kirstin Campbell	UBC Physical Therapy	Gail Booker	Physiotherapist, UHNBC	H
Stories of Palliative Care Providers in Northern BC: A Narrative Medicine Inquiry	Sarah MacVicar	UBC Medicine	Stacey Joyce	Lead, Regional Palliative Care Consultation Team	H
Testing new formats for the presentation of systematic review evidence to health care managers and policy makers	Dr. Sharon Straus	Knowledge Translation Program	Tanis Hampe	Director, Quality & Innovation	H
The ECHO Network (Environment, Community, Health Observatory): Strengthening intersectoral capacity to understand and respond to health impacts of resource development (Phase 1)	Margot Parkes	School of Health Sciences	Cathy Ulrich	CEO	P
The Impact of Meaningful Discourse between Indigenous and Northern Health Healthcare Leads in Improving Culturally Safe Care	Victoria Carter	Leadership	Heidi Johns; Angela Szabo; Jacquie Hakes; Margo Greenwood	HSA Prince Rupert & Haida Gwaii; Director of Acute Care Services, Prince Rupert & Haida Gwaii; Community Services Manager; VP Indigenous Health	H
The role of context in food retail environment interventions	Rebecca Hasdell	School of Public Health	Flo Sheppard	Team Lead/Chief Dietician	P
Two-Way text-messaging supported Chronic Disease Care on Haida Gwaii, BC	Tracy Morton	Medicine	Michael Melia	HSA Prince Rupert & Haida Gwaii	H

Title of Research	Principal Investigator (PI)	PI Institution & Department	NH Operational Approval		CIHR Research Theme
UBC Family Practice Resident Research Project: Dating Ultrasound	Ian Schokking (Nicole Touhey & Ashley Bowden Residents)	Medicine	Kelsy Nelson	Health Information Management	H
UBC Family Practice Resident Research Project: Effect of Implementing Candian Best Practice Recommendations for Stroke Care at University Hospital of Northern BC	Ian Schokking (Reena Yu Resident)	Medicine	Kelsy Nelson	Health Information Management	C
Using Personal Health Record Technology for Shared Decision Making as a Routine Practice for Diabetic Youth	Selena Davis	Health Information Science	Mitch Griffith	Community Services Manager, Terrace	H

Regional Office
600 – 299 Victoria Street
Prince George BC V2L 5B8

BOARD BRIEFING NOTE

Date:	2018 March 5	
Agenda item	**Designation of School Medical Officer**	
Purpose:	☐ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☒ **Decision**
Prepared for:	**GMR Committee &** **Northern Health Board of Directors**	
Prepared by:	**K. Thomson**	
Reviewed by:	**C. Ulrich**	

Issue:

School Medical Officers under the *School Act* require designation by the Board of Directors of Northern Health. Dr. Jong Kim is nominated to fulfil the role of School Medical Officer for the North East Health Service Delivery Area.

Background:

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

> ***School Act***
> **87.1 "school medical officer"** means a medical health officer under the *Public Health Act* who is designated as a school medical officer under section 89 (1) of this Act.
> **89** (1) Each regional health board under the *Health Authorities Act* must designate a school medical officer for each school district.

Recommendation(s):

It is recommended that the following motion be passed by the Board at its April meeting:

BE IT RESOLVED THAT:

Pursuant to section 89(1) of the *School Act*, RSBC 1996, c 412, the Northern Health Board of Directors designates Dr. Jong Kim as the school medical officer for the school districts as described in the following table:

HSDA	SCHOOL DISTRICT	School Medical Officer/ Contact Info
NE	**#59 – Peace River South**	**Dr. Jong Kim** **O: 250-261-7235** **C: 250-262-4011** **(First alternate: Dr. Sandra Allison)** **O: 250-565-7424** **C: 250-612-2582**
	#60 – Peace River North	
	81 – Peace River Fort Nelson	

This designation is effective from the date of this resolution until the earlier of:

(a) The date that designation as a Medical Health Officer is rescinded; and

(b) The date that the Medical Health Officer ceases to be employed as a Medical Health Officer within Northern Health.

Northern Health Regional Office
#600-299 Victoria Street, Prince George, BC V2L 5B8
T: (250) 565-2649, F: (250) 565-2640, www.northernhealth.ca

BOARD BRIEFING NOTE

Date:	**2018 March 19**	
Agenda item	**Regulatory Framework – Legislative Compliance** • ***Residential Tenancy Act***	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**GMR Committee &** **Northern Health Board of Directors**	
Prepared by:	**K. Thomson**	
Reviewed by:	**C. Ulrich**	

Issue:

To provide an update on the legislative compliance review process.

Background:

1. Current Review

The *Residential Tenancy Act* describes both the duties and rights of landlords and tenants engaged in rental, tenancy and lease agreements. It includes provisions on how to create tenancy agreements, as well as requirements and prohibitions on certain provisions, such as security deposits, rent increases, and short term/fixed term rentals.

Northern Health is engaged as a landlord with respect to a number of seniors' housing facilities in Prince George; in these tenancy agreements, Northern Health bears the responsibilities laid out in the Act, as the service is not a health care service, unlike placement agreements in long term care or assisted living facilities, which are covered under the *Community Care and Assisted Living Act*, or the *Hospital Act*.

Northern Health employs a Seniors Housing Coordinator who manages all tenancy agreements; she is very familiar with the requirements of the Act, and ensures that Northern Health meets its obligations as a landlord.
Northern Health is compliant with the requirements of the Act; there are no outstanding obligations or compliance issues.

2. Completed Reviews

The running list of completed reviews is maintained in a separate spreadsheet stored in the GMR Committee folder on the network drive.

3. Next Review
TBD

Recommendation(s):

That the Board receives this briefing note for information.

northern health

RISK AND COMPLIANCE
LEGISLATIVE COMPLIANCE RECORD

RESIDENTIAL TENANCY ACT

[SBC 2002] Chapter 78

Date	Action
2018 March 5	Document Created
2018 March 29	GMR Review
2018 April	Board Review
Executive Sign-Off Received:	M. De Croos (2018-03-20)
2023 March	Next full review

Summary

The *Residential Tenancy Act* describes both the duties and rights of landlords and tenants engaged in rental, tenancy and lease agreements. It includes provisions on how to create tenancy agreements, as well as requirements and prohibitions on certain provisions, such as security deposits, rent increases, and short term/fixed term rentals.

The *Residential Tenancy Regulation* further supports the direction in the Act, and a recent Order in Council from December 2017 has made changes to the regulation, specifically of interest being the prescribed circumstances in which a landlord may require a tenant to vacate a rental unit following a fixed term tenancy agreement.

This Act is of interest to Northern Health because we maintain several seniors housing properties for which we are the landlord, and for which all the requirements of the Act apply.

A. Review

Section	Description	Comments	Compliance[1]	Likelihood[2]	Impact[3]
13	(1) A landlord must prepare in writing every tenancy agreement entered into on or after January 1, 2004. (2) A tenancy agreement must comply with any requirements prescribed in the regulations and must set out all of the following: a. The standard terms b. The correct legal names of the landlord and tenant c. The address of the rental unit d. The date the tenancy agreement is entered into e. The address for service and telephone number of the landlord or the landlord's agent f. The agreed terms in respect of the following: i. The date on which the tenancy starts; ii. If the tenancy is a periodic	Note subsection (2)(f)(iv) – By Order in Council issued December 2017, Northern Health does not qualify as a landlord who can require tenants to vacate at the end of a fixed term tenancy. Section 44(3) of the Act describes the process for continuing a fixed term tenancy – either by way of new agreement between tenant and landlord; or, in absence of a new agreement, the existing agreement is deemed to be renewed on a monthly basis on the same terms The Schedule to the Regulation to the Act provides more detail on the standard terms of a tenancy agreement, and what the landlord may or may not require of tenants. The standard tenancy agreement used by Northern Health for seniors housing is	H	L	M

[1] Compliance = degree to which NH currently complies with this requirement. Key: H= High; M = Medium; L = Low; U = Unranked
[2] Likelihood = residual risk in light of processes already in place
[3] Impact = impact on operations, sustainability or reputation if NH were to inadvertently fail to meet this requirement

Section	Description	Comments	Compliance	Likelihood[2]	Impact[3]
	tenancy, whether it is on a weekly, monthly or other periodic basis; iii. If the tenancy is a fixed term tenancy, the date on which the term ends; iv. If the tenancy is a fixed term tenancy in circumstances prescribed under section 97(2)(a.1), that the tenant must vacate the rental unit at the end of the term; v. The amount of rent payable for a specified period, and, if the rent varies with the number of occupants, the amount by which it varies; vi. The day in the month, or in the other period on which the tenancy is based, on which the rent is due; vii. Which services and facilities are included in the rent; viii. The amount of any security deposit or pet damage deposit was or must be paid	compliant with these terms.			

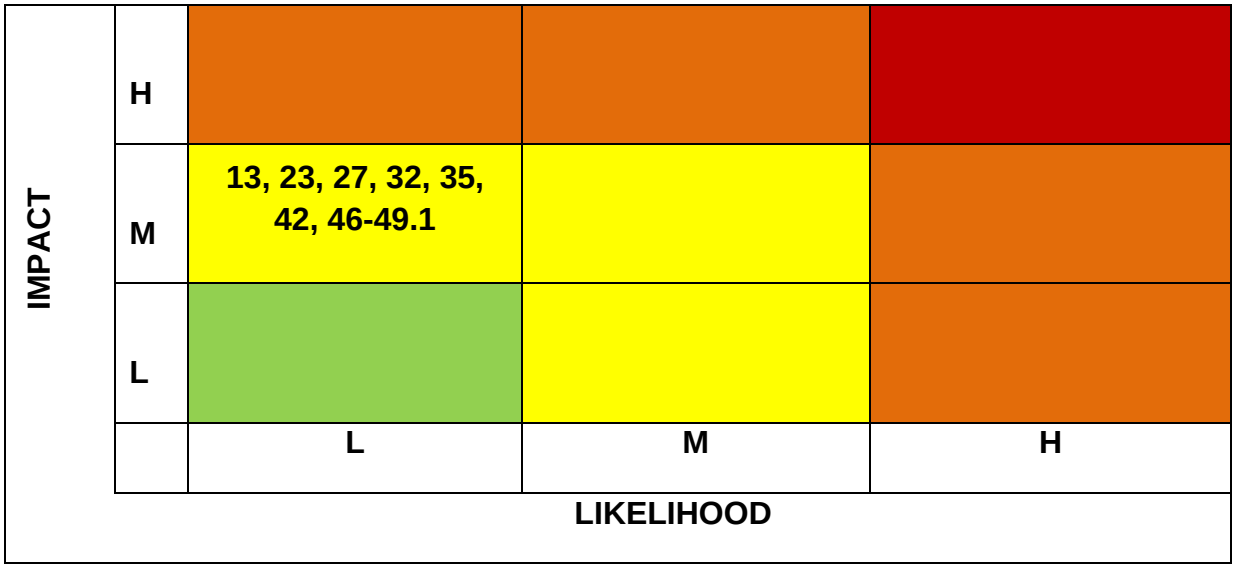
Section	Description	Comments	Compliance	Likelihood[2]	Impact[3]
	(3) Within 21 days after a landlord and tenant enter into a tenancy agreement, the landlord must give the tenant a copy of the agreement				
23	(1) The landlord and tenant together must inspect the condition of the rental unit on the day the tenant is entitled to possession of the rental unit or on another mutually agreed day.		H	L	M
27	(1) A landlord must not terminate or restrict a service or facility if a. The service or facility is essential to the tenant's use of the rental unit as living accommodation, or b. Providing the service or facility is a material term of the tenancy agreement		H	L	M
32	(1) A landlord must provide and maintain residential property in a state of decoration and repair that a. Complies with the health, safety and housing standards required by law, and b. Having regard to the age, character and location of the rental unit, makes it suitable for occupation by a tenant.		H	L	M

Section	Description	Comments	Compliance	Likelihood[2]	Impact[3]
35	(1) The landlord and tenant together must inspect the condition of the rental unit before a new tenant begins to occupy the rental unit a. On or after the day the tenant ceases to occupy the rental unit, or b. On another mutually agreed day.		H	L	M
42	(1) A landlord must not impose a rent increase for at least 12 months after whichever of the following applies: a. If the tenant's rent has not previously been increased, the date on which the tenant's rent was first payable for the rental unit; b. If the tenant's rent has previously been increased, the effective date of the last rent increase made in accordance with this Act.	Subsequent provisions describe how to give notice for rent increases. s. 43 describes how much by which rent may be increased.	H	L	M
46-49.1	These sections describe how a landlord may end a tenancy: 46 – Landlord's notice: non-payment of rent 47 – Landlord's notice: cause 48 – Landlord's notice: end of employment with the landlord 49 – Landlord's notice: landlord's use of property 49.1 – Landlord's notice: tenant ceases to qualify		H	L	M

Section	Description	Comments	Compliance	Likelihood[2]	Impact[3]
	for rental unit				

Residential Tenancy Act.pdf

B. Risk Matrix



C. Certificate(s) of Compliance

I, Mark De Croos, VP Finance and Chief Financial Officer, in my capacity as the Northern Health staff person with executive lead responsibility, do hereby certify Northern Health's compliance with the above reviewed sections of the ***Residential Tenancy Act***:

Section(s)	**Compliance**	
All	☑ Full, without reservation	☐ Substantial, with reservation – see notes below
	☐ Partial – see notes below	☐ Non-compliant – see notes below

Signature

March 20/18
Date

northern health

PUBLIC PRESENTATION

April 16, 2018
Best Western Terrace Inn
Skeena Meeting Room
4553 Greig Avenue, Terrace BC

AGENDA ITEMS	Responsibility of…	Expected Outcome	Time (Approx.)	Page
1. Call to Order of Public Presentation	Chair Nyce		**12:45pm**	
2. Opening Remarks	Chair Nyce			
3. Mr. Moe Naguib	Chair Nyce	Information	**12:50pm**	**2**
4. Terrace Hospice Society Presenter: Sue Skeates, Board Chair	Chair Nyce	Information	**1:00pm**	**3**
Adjourned			**1:10pm**	

northern health
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Request to Address the Board

Date of Request: Tuesday, March 27, 2018

Date of Board Meeting You Wish to Present at: April 16, 2018

Group/Organization/Delegation Being Represented:

Name(s) of Presenter: Moe Naguib

Key Contact

Name: Moe Naguib **Title:**

Address: 4707 Walsh ave. Terrace, British Columbia

Phone: 250-635-4753 **Fax:**

Topic: Doctorless Patience

Brief Summary (please provide a brief overview of your topic)

Since Late last fall a new system was instituted for the Doctorless of Terrace, they are now forbidden from Phoning Park Avenue Medical and seeking appointments, we must wait outside in whatever weather there is in the hope of being granted an appointment from the Satellite clinic Park Avenue Medical on Lazelle avenue operated by Park Avenue Medical.

Preference for giving presentation

☑ In Person ☐ Videoconference *(may not be available at all sites)*

Audiovisual Requirements

☐ Laptop ☐ Proxima ☐ Overhead Projector

Other:

Please submit all requests to:

Desa Chipman, Executive Assistant
#600-299 Victoria St.
Prince George, BC V2L 5B8
Phone: (250) 565-2922 Fax: (250) 564-7196
Email: desa.chipman@northernhealth.ca

****** Requests must be received at least 10 business days in advance of the meeting date. ******

northern health
the northern way of caring

Request to Address the Board

Date of Request: March 27, 2018

Date of Board Meeting You Wish to Present at: April 16, 2018

Group/Organization/Delegation Being Represented: Terrace Hospice Society

Name(s) of Presenter: Board Chair: Sue Skeates

Key Contact

Name: Sue Skeates **Title:** Board Chair

Address: #207 4650 Lazelle Avenue

Phone: 250-635-4811 **Fax:** 250-635-4817

Topic: Hospice House

Brief Summary (please provide a brief overview of your topic)

Terrace Hospice Society (THS) is a non-profit organization that aims to improve the quality of life for those living with a terminal illness and their families. We provide emotional and spiritual support through volunteers, both at home and in institutional settings. We are in the earliest stages of negotiating for building and furnishing funds for a hospice palliative care area of up to 6 beds that will include a dining and meeting space. THS proposes we partner with the Hospital Board to provide a state of the art Palliative Care Resource Center in Terrace where qualified volunteers and health care professionals can provide compassionate care for those facing the challenges of end-of-life.

Preference for giving presentation

☑ In Person ☐ Videoconference *(may not be available at all sites)*

Audiovisual Requirements

☐ Laptop ☐ Proxima ☐ Overhead Projector

Other: None

Please submit all requests to:

Desa Chipman, Executive Assistant
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Prince George, BC V2L 5B8
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Email: desa.chipman@northernhealth.ca

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