Meeting of the Northern Health Board
December 7, 2020

Due to COVID-19 Pandemic the Northern Health Board did not host a Public Board meeting on December 7, 2020 as originally scheduled.

The Northern Health Board met virtually to address regular Board business. Part of the meeting included a review of the material in this package.

Northern Health Board
Public Package – December 2020

BOARD BRIEFING NOTE

Date:	November 12, 2020	
Agenda item:	2020-21 Period 7 – Operating Budget Update	
Purpose:	☐ **Information**	☒ **Decision**
Prepared for:	NH Board of Directors	
Prepared by:	Mark De Croos, VP Financial & Corporate Services/CFO	

YTD October 15, 2020 (Period 7)

Year to date Period 7, Northern Health (NH) has a net operating surplus (deficit) of nil.

Excluding extra-ordinary items, revenues are unfavourable to budget by $10.2 million or 1.9% and expenses are favourable to budget by $7.9 million or 1.5%.

The unfavourable variance in revenue is primarily due to shortfall in patient and client revenues. Health Authorities are able to bill for services provided to non-residents of BC. However, with travel restrictions due to COVID-19, service utilization by non-residents severely declined resulting in a shortfall in revenue. Additionally, reduction in utilization of diagnostic and rehabilitation services due to COVID-19 resulted in a reduction in revenue from third party payers such as Medical Services Plan and WorkSafe BC.

The favourable variance in Acute Care is primarily due to actual hospital occupancy at all NH hospitals being less than budgeted volumes. The year to date average daily occupancy is 470.1 patient days, which is below the budget of 581.0 and, comparative prior year actual of 585.8.

The favourable variance in Community programs is primarily due to vacancies.

The budget overage in Long term Care is primarily due to vacancies in a number of care aide positions across the region resulting in vacant shifts filled at overtime rates.

In response to the global COVID-19 pandemic, NH has incurred $36.5 million in related extra-ordinary expenditure to the end of Period 7. The Ministry of Health has approved supplemental funding to offset pandemic related expenditure and net revenue shortfalls.

Recommendation:

The following motion is recommended:

> ***The Northern Health Board receives the 2020-21 Period 7 financial update as presented.***

NORTHERN HEALTH
Statement of Operations
Year to date ending October 15, 2020
$ thousand

	Annual Budget	YTD October 15, 2020 (Period 7) Budget	Actual	Variance	%
REVENUE					
Ministry of Health Contributions	734,289	393,606	389,766	(3,840)	-1.0%
Other revenues	243,810	130,347	124,033	(6,314)	-4.8%
TOTAL REVENUES	**978,099**	**523,953**	**513,799**	**(10,154)**	**-1.9%**
EXPENSES (BY PROGRAM)					
Acute Care	523,755	278,383	274,859	3,524	1.3%
Community Care	248,840	134,286	126,623	7,663	5.7%
Long term care	128,569	69,466	72,380	(2,914)	-4.2%
Corporate	76,935	41,818	42,241	(423)	-1.0%
TOTAL EXPENSES	**978,099**	**523,953**	**516,103**	**7,850**	**1.5%**
Net operating deficit before extraordinary items	**-**	**-**	**(2,304)**		
Extraordinary items					
COVID-19 incremental expenditures	-	-	23,554		
Pandemic pay	-		12,981		
Total extraordinary expenses	-	-	36,535		
Supplemental Ministry of Health contributions	-	-	38,839		
Net extraordinary items	-	-	2,304		
NET OPERATING SURPLUS	**-**	**-**	**-**		

northern health
the northern way of caring

BOARD BRIEFING NOTE

Date:	November 12, 2020	
Agenda item:	Capital Public Note	
Purpose:	☐ **Information**	☒ **Decision**
Prepared for:	NH 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 2020-21 capital expenditure plan in February 2020, and an amendment in August 2020. The updated plan approves total expenditures of $112.2M, with funding support from the Ministry of Health ($67.4M, 60%), Six Regional Hospital Districts ($32.4M, 29%), Foundations, Auxiliaries and Other Entities ($2.1M, 2%), and Northern Health ($10.3M, 9%).

Year to date Period 7 (October 15, 2020), $26M has been spent towards the execution of the plan as summarized below:

$ million	**YTD**	**Plan**
Major Capital Projects (> $5.0M)	13.7	61.8
Major Capital Projects (< $5.0M)	2.0	14.2
Major Capital Equipment (> $100,000)	1.2	15.7
Equipment & Projects (< $100,000)	5.5	10.3
Information Technology	3.2	10.3
	25.7	112.2

Significant capital projects currently underway and/or completed in 2020-21 are as follows:

Northern Interior Service Delivery Area (NI-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Burns Lake	BLH FM Domestic Hot Water Heaters	$0.41	Planning	MOH
Fort St. James	Stuart Lake Hospital Replacement	$116.12	Planning	SNRHD, MOH
Granisle	Granisle Health Centre Leasehold Improvements	$1.15	In Progress	SNRHD, NH
McBride	MCB Boiler Plant Upgrade	$0.40	Planning	MOH
Prince George	UHNBC BioFire File Array	$0.28	In Progress	MOH
Prince George	UHNBC Cardiac Services Department Upgrade	$3.55	Planning	FFGRHD, MOH, NH
Prince George	UHNBC DI Interventional Fluoroscopy	$2.89	Planning	FFGRHD, MOH, NH
Prince George	UHNBC CT 320 Replacement	$2.59	In Progress	FFGRHD, MOH, NH
Prince George	UHNBC GenExpert XVI	$0.12	In Progress	MOH
Prince George	UHNBC Integrated Fault Detection & Diagnostics	$0.17	Planning	FFGRHD, MOH
Prince George	UHNBC LND Washing Machine 1	$0.73	Planning	FFGRHD, MOH
Prince George	UHNBC Low Temperature Sterilizer	$0.12	Complete	FFGRHD, MOH
Prince George	UHN OR Electrical Upgrade and Lights	$0.12	Planning	MOH
Prince George	UHNBC OR Microscopes	$0.36	Planning	MOH
Prince George	UHNBC Panther Fusion	$0.64	In Progress	MOH
Prince George	UHNBC Pharmacy Fastpak Verifier	$0.17	In Progress	FFGRHD, MOH

Prince George	UHNBC Phone System Replacement Phase 1	$0.38	In Progress	FFGRHD, MOH
Prince George	UHNBC Phone System Replacement Phase 2	$0.91	Planning	FFGRHD, MOH
Prince George	UHN – New Acute Tower Business Plan	$5.00	Planning	To be Determined
Prince George	Long Term Care Business Plan	$1.40	Planning	To be Determined
Prince George	UHNBC Sterilizer – Sterizone	$0.13	In Progress	MOH
Prince George	UHN – Sterile Compounding Room Upgrade Planning	$0.29	Planning	FFGRHD, NH
Quesnel	GR Baker X-Ray Replacement	$0.90	In Progress	CCRHD, MOH
Quesnel	GRB CT Scanner Replacement	$1.92	In Progress	CCRHD, MOH
Quesnel	GR Baker ER & ICU Addition	$27.0	In Progress	CCRHD, MOH
Quesnel	GR Baker Kitchen Renovation	$5.00	In Progress	CCRHD, MOH
Quesnel	GR Baker Sterile Compounding Room Upgrade	$0.11	Complete	CCRHD, NH
Quesnel	Long Term Care Business Plan	$0.90	Planning	To be Determined
Vanderhoof	SJH Boiler Replacement	$0.84	Closing	SNRHD, MOH
Vanderhoof	SJH Heat Pumps and Coils	$0.52	Planning	SNRHD, MOH
Vanderhoof	SJH Sterile Compounding Room Upgrade	$0.67	Planning	SNRHD, NH, MOH

Northwest Health Service Delivery Area (NW-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Kitimat	KIT DI C-Arm Replacement	$0.19	In Progress	MOH
Kitimat	KIT DI Mini C-Arm Replacement	$0.10	Planning	MOH
Kitimat	LND Washing Machine Replacement	$0.39	Planning	NWRHD, MOH
Kitimat	KIT OR Anesthetic Machine Replacement	$0.17	In Progress	MOH
Terrace	MMH Hospital Replacement	$447.50	Planning	NWRHD, MOH
Terrace	MMH OR Anesthetic Machines	$0.45	Planning	MOH
Terrace	MMH OR Automated Medication Dispensing Cabinet	$0.18	Planning	MOH
Terrace	MMH OR Video System Tower 1 Replacement	$0.23	Complete	NWRHD, MOH
Terrace	MMH OR Video System Tower 2 Replacement	$0.23	In Progress	MOH
Terrace	MMH – Ultrasound (unit 3)	$0.21	Planning	DR REM Lee Foundation, MOH
Hazelton	Wrinch X-Ray	$0.91	In Progress	NWRHD, MOH
Hazelton	Long Term Care Business Plan	$0.60	Planning	To be Determined
Northern Haida Gwaii	NHG Nurse Call System	$0.16	Planning	NWRHD, MOH
Northern Haida Gwaii	NHG Observation Room	$0.99	Planning	NWRHD, NH
Prince Rupert	PRR Chemistry Analyzers Replacement	$0.59	In Procurement	NWRHD, NH
Prince Rupert	PRR MDRD Equipment Replacement and Centralization	$0.74	Planning	MOH
Prince Rupert	PRR Sterile Compounding Room Upgrade	$0.65	Planning	NWRHD, NH
Smithers	BVDH OR Anesthetic Machine	$0.10	Complete	NWRHD, MOH
Smithers	BVDH Sterile Compounding Room Upgrade	$1.24	Planning	NWRHD, MOH, NH

Smithers	Bulkley Lodge Domestic Hot Water Heaters and Tank and Repiping	$0.30	Planning	MOH
Smithers	Long Term Care Business Plan	$0.90	Planning	To be Determined
Smithers	BVDH – 2nd Ultrasound	$0.25	Planning	BVDH Hospital Foundation, MOH

Northeast Health Service Delivery Area (NE-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Chetwynd	CHT X-Ray Replacement	$0.89	In Progress	PRRHD, MOH
Dawson Creek	DCH OR Anesthetic Machine Replacement	$0.16	In Progress	MOH
Dawson Creek	DCH Automated Medication Dispensing Cabinet	$0.15	Planning	MOH
Dawson Creek	DCH Hospital Replacement	$377.86	Planning	PRRHD, MOH
Dawson Creek	DCH OR Video Towers Replacement	$0.21	In Progress	MOH
Dawson Creek	DCH Portable X-Ray Machine 1 Replacement	$0.26	Received	PRRHD, MOH
Dawson Creek	Rotary Manor Chiller Replacement	$0.29	In Progress	PRRHD, NH
Fort Nelson	FNH – Ultrasound Machine Replacement	$0.14	Planning	Fort Nelson Hospital Foundation, NH
Fort St. John	Long Term Care Business Plan	$1.20	Planning	To be Determined
Fort St. John	Spect CT	$1.76	Ordered	PRRHD, NH, MOH
Fort St. John	Medical Clinic – 3rd Pod Renovation	$2.05	Closing	PRRHD, NH
Fort St. John	FSH OR Anesthetic Machines Replacement	$0.20	Complete	PRRHD, MOH
Fort St. John	FSH Sterile Compounding Room Upgrade	$0.46	Planning	PRRHD, NH

Regional Projects

Community	Project	Project $M	Status	Funding partner (note 1)
All	Breast Imaging Electronic Reporting Solution	$0.17	Work In Progress	MOH, PHSA
All	Community Health Record (Phase 3)	$4.90	Work In Progress	MOH, CCRHD, FFGRHD, NRRHD, NWRHD, PRRHD, SNRHD
All	Clinical Interoperability	$.62	Work In Progress	NH
All	EmergCare	$4.35	Work In Progress	MOH, CCRHD, FFGRHD, NRRHD, NWRHD, PRRHD, SNRHD
All	Endoscopy System Replacement Phase 1	$0.78	Work In Progress	MOH, PRRHD, FFGRHD, CCRHD
All	Physician eScheduling and OnCall	$0.49	Work In Progress	MOH, NH
All	Home Care Redesign	$1.29	Work In Progress	MOH
All	InCare Phase 1	$4.91	Planning	MOH, CCRHD, FFGRHD, NRRHD, NWRHD, PRRHD, SNRHD
All	InTouch Virtual Care Clinic Platform	$0.14	Work In Progress	MOH
All	MOIS/Momentum Interop	$0.16	Planning	MOH
All	MySchedule – Smart Leave, Annual Vacation	$0.36	Work In Progress	NH
All	MySchedule – Partial Shifts, Prebooking	$0.18	Work In Progress	NH

All	Northern Lights – Personal Health Record and Portal	$1.20	Work In Progress	MOH, CCRHD, FFGRHD, NRRHD, NWRHD, PRRHD, SNRHD
All	Sharepoint Upgrade	$0.18	Work In Progress	NH
All	Clinical Data Repository (CeDaR)	$1.53	Work 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 2020-21, it is forecasted that NH will spend $12.96M 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 Period 7 update on the 2020-21 Capital Expenditure Plan.

BOARD BRIEFING NOTE

Date:	December 7, 2020	
Agenda item	Implementing the Idealized System of Services: Primary and Community Care and Specialized Community Services Update	
Purpose:	☒ Discussion	☐ Decision
Prepared for:	Northern Health Board of Directors	
Prepared by:	Kelly Gunn, Vice President Primary and Community Care	
Reviewed by:	Cathy Ulrich, President and CEO	

Issue & Purpose

An update on progress towards implementing Primary and Community Care and Specialized Community Services Programs according to Priority 2: Coordinated and Accessible Services as outlined in the Northern Health Strategic Plan.

Background:

This work is informed by the Ministry of Health policies for Primary Care Networks and Specialized Community Services Programs and forms the basis for achieving the Critical Initiative to enhance primary and community care services as discussed at the October 19 Board Planning session. All work has necessarily been adapted to accommodate the Pandemic Response.

In 2017 the Ministry of Health released a policy requiring all health authorities to establish Primary Care Networks. In 2018/19, targeted funding was provided to Northern Health to strengthen team based care, improve the care experience for people and families served by Primary Care Networks[i] and to ensure access to Urgent Primary Care services[ii]. The Ministry of Health, Northern Health, the First Nations Health Authority and northern Divisions of Family Practice have defined 23 Primary Care Networks in the north. Our 2018/19 investments added specific types of health professionals to the teams. These investments were made across all communities where service gaps existed and to enable us to achieve the Ministry requirements for increased service volumes in home support and the professional community services such as nursing, social work and rehabilitation services. Additional Primary Care Network funding is secured through a collaborative service planning process between Northern Health, Divisions of Family Practice and the First Nations Health Authority. The Ministry has received and reviewed submitted Service Plans for the Northern

Interior Division, the North Peace and Haida Gwaii. Funding decisions are expected before Christmas.

Key Actions, Changes & Progress:

The Primary and Community Care Initiative aim is to make primary and community health services more accessible and coordinated for people and their families and involves four projects:

- Home Support Redesign- increasing hours of service across the region
- Team Based Care- teams will work collaboratively with primary care providers to plan and coordinate care for people experiencing complex health concerns
- Childhood Immunizations- with a first focus on seasonal influenza shots for all eligible populations while maintaining routine immunizations for children ages 2 mos. to Grade 9 according to the BC Center of Disease Control immunization schedule.
- Team Based Care- In partnership with Primary Care Providers, improve care planning and coordination in service of people with complex care needs.
- Virtually enhanced access to primary and specialist care (the Virtual Strategy) – increase access to primary and community care and support rural service providers using technology.

1) Virtual Strategy – Pillar 1 (Develop a regional, virtually enabled Primary and Community Care service)

Northern Health is partnering with the Rural Coordination Centre of BC, First Nations Health Authority, Health Link BC and northern Divisions of Family Practice to draft and implement the *Enhanced Access to Primary and Specialist Care Strategy*. The strategy aim is to use virtual technology to improve equity, access and the care experience of people in rural, remote and First Nations Communities as well as to support the provider's experience of caring for people. The current COVID- 19 Clinic will expand to offer full primary care services beginning November 16th with a first focus to support our most rural and remote communities. Within a week, the service will be available to all northerners. The hours of service will be 10 am to 10 pm Monday to Friday. The service is also available on weekends and statutory holidays. Additional components of the strategy include supporting providers to use technology to improve primary care access locally and to support service integration with existing local in person services as well as virtually enabled regional and provincial services. All elements of the strategy are subject to a developmental evaluation approach to allow for short, responsive quality improvement cycles to ensure we are effectively meeting people's needs.

2) The Community Health Record (CHR) project continues to improve our use of the electronic medical record (EMR) in all non-acute health services to improve documentation and enable team access to clinical information for the purpose of providing care. Of the 101 planned implementations, 73 sites/teams have been completed. The schedule for completion of the CHR project will be completed by the end of March 2021. A CHR EMR Adoption Dashboard has been developed to support teams to monitor appropriate EMR usage for the purpose of quality

improvement. Within the last 30 days the teams have achieved a 75% compliance rate with the standard use metrics and a 50% compliance rate to the core data set. In late October a newer version of the CMOIS EMR will be implemented and better tool functionality is expected to improve the team's compliance with both the standard use and core data set metrics.

3) The Implementation of Specialized Community Service Programs for the Medically Complex/Frail and Mental Health Substance Use population continues. Priority actions by March 31, 2021 have been oriented predominantly to Mental Health and Substance Use service provision due to the opioid crisis. Work has focused on increasing access to substance use services and improved care coordination through defined care pathways to and from the Primary Care Home, Specialized Community Services and Specialists/Sub Specialist medical services offered both virtually and in person. This will minimize unnecessary transitions of care, minimize patients' need to travel, reduce admission to acute care, shorten patient length of stay in hospital and reduce hospital readmission rates. To achieve this we are:
   - Increasing access to overdose prevention services (OPS) including outdoor inhalation overdose prevention;
   - Increasing access to interdisciplinary outreach teams; and
   - Increasing nursing support for the implementation of the Risk Mitigation Guidelines to support individuals who are self- isolating and may require safer alternatives to the toxic drug supply.

Primary and Community Care and Specialized Community Services Response to COVID 19:

1) In response to required COVID-19 safety measures, the Specialized Geriatric Assessment and Consultation Team shifted to a virtually enabled service model. Since April 2020, over 200 patients requiring continuing care in community, acute care, long-term care and assisted living facilities received services virtually. This ensured care continuity and reduced unnecessary transitions of care and travel for seniors and their families. We are sustaining this model.

2) A COVID-19 Palliative Care Task Group was formed to develop clinical resources to assist clinicians in all care settings to provide palliative care for COVID-19 patients based on provincial care best practices and symptom guidelines. The Regional Palliative Care Consultative Team continues to provide on-going consultative support throughout the pandemic, both in-person and virtually.

3) In May 2020, a virtually enabled substance use assessment and treatment stream was added to the COVID-19 Virtual Clinic. The service includes care planning for follow up assessment and ongoing support.

4) In April 2020, the Northern Health Regional Vulnerable Populations Working Group was created to establish specific planning and goals as it pertains to supporting people who use substances and are disproportionally affected by the dual public health emergencies. Northern Health in partnership with BC Housing and community agencies has developed a temporary accommodation referral process for homeless or precariously housed people with or without COVID-like symptoms or people who are housed and have COVID-like symptoms. This is available in communities in each HSDA. The provision of outreach services to care for people in these settings remains a priority.

5) Clinical guidance and support to enable the provision of safe care in the context of the COVID-19 pandemic has been provided through the development and updating of Clinical Response Guidelines and Pathways. To ensure timely access to COVID-19 information, screening, assessment, and testing a number of strategies have been employed working with Primary Care Providers and local Primary Care Interprofessional Teams to support an agile and flexible response.

Risks:

We continue to work on increasing needed health human resources in a number of service areas within primary and community care and specialized community services.

Recommendation(s):

This report is submitted for information and discussion purposes.

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[i] Primary Care Networks are defined as a network of Primary Care Homes (Physician or Nurse Practitioner practices) linked with health authority Interprofessional Teams comprised of nurses and other health professionals and paraprofessionals including social workers, physiotherapists, occupational therapists, home support and life skills workers to better serve people and families within a defined geographical area. Primary Care Networks are achieved in partnership with Divisions of Family Practice and developed in close partnership with the First Nations Health Authority to ensure indigenous wellness and primary and community care services are accessible and culturally safe.

[ii] Urgent Primary Care Services are defined as care for injuries and illnesses that should be seen within 12/24 hours but do not require the level of service or expertise found in Emergency Departments. The purpose of Urgent Primary Care Services is to extend team based care service hours including weekends and statutory holidays, to enhance access to diagnostics and to support and coordinate patient attachment to achieve longitudinal care.

BOARD BRIEFING NOTE

Date:	December 7, 2020	
Agenda item	Update on Child and Youth Service Network	
Purpose:	☒ Discussion	☐ Decision
Prepared for:	Northern Health Board of Directors	
Prepared by:	Jennifer Begg, Executive Lead Child and Youth Health Dr. Matthew Burkey, Medical Lead Child and Youth Mental Health Dr. Kirsten Miller, Medical Lead Child and Youth Health	
Reviewed by:	Kelly Gunn, Vice President Primary & Community Care and Chief Nursing Executive	

Issue & Purpose:

To provide the Northern Health Board of Directors with an overview of the priority work of the Child and Youth Health Service Network.

Background:

The Child and Youth Service Network supports efforts to keep children healthy and well and improve health care services for children and youth. Our work is primarily guided by the 2017/18 Northern Health Child Health Action Plan and key initiatives from *A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia* that focus on improved wellness for children, youth and young adults.

Since the start of the pandemic, a large proportion of the Child and Youth Service Network work has focused on meeting the need for prompt reviews and contextualization of provincial Pediatric Clinical Guidance for COVID-19 produced for the BC Centre for Disease Control Centre (BCCDC) website and for our northern providers. The Service Network also assists with the dissemination of this clinical guidance to emergency departments, acute inpatient units and primary and community care settings.

The following partners support all of the Service Network's work and have also been instrumental in making needed changes to pediatric services to safely care for children, youth and families in the context of COVID-19.

- Ministry of Children and Family Development-Child and Youth Mental Health
- Child Health BC
- First Nations Health Authority
- School district partners
- Parents with lived experience
- Divisions of Family Practice and specialists
- Academic research partners

Key Actions, Changes & Progress:

1) Development of Child and Youth Mental Health and Substance Use Resources

COVID-19 has caused lower numbers of children and youth with mental health concerns to present for services in acute care and the community setting. Those experiencing neurodevelopmental diagnoses such as Autism or Fetal Alcohol Spectrum Disorders have had school based services interrupted. To ensure families and service providers are aware of available resources and how to safely access them, multiple child health and wellness resource lists have been developed and published. These include resource lists for:

- Health care providers supporting child & youth with mental health and substance use concerns
- Families and support teams caring for children and youth with neurodevelopmental diagnoses
- Parents whose children are going back to school
- 24/7 crisis support lines

Children's Healthcare Canada and BC Children's Hospital neuropsychiatry team including Compass (a provincial telephone consultation service for physicians and staff) continue to support our local care teams to treat and support children and youth with mental health and substance use concerns.

2) Identification, development and implementation of clinical practice guidelines, tools, resources and education supporting the care of children and youth.

The Service Network continues to develop evidence based clinical practice standards and order sets to ensure quality care for pediatric patients with medical, mental health and/or substance use concerns. Pediatric patients have different physiological, social and developmental needs than adults and these differences affect treatment and care protocols. Examples include the care and management of children with:

- common childhood illnesses
- a chronic disease e.g. type 1 diabetes
- mental health and substance concerns requiring treatment in an acute care setting
- family vulnerabilities that may be heightened in the context of the pandemic e.g.an increase in physical abuse and its presentation in emergency departments.

3) Supporting the Immunization Critical Priority

The Child and Youth Service Network continues to partner with Population Public Health and the Primary and Community Care Program to support completed infant and child immunization series in accordance to the immunization schedule set out by the BC Centre for Disease Control (BCCDC).

4) Sustaining Pediatric Medical Support

The Service Network is supporting efforts to stabilize pediatric services in Terrace due to service instability caused by the unexpected retirement of a pediatrician and challenges to re-recruit to the role. A group of pediatricians from BC Children's Hospital provide call coverage for one week out of four. Additionally, the provincial Real Time Virtual Pediatric Service is available to supplement call coverage as required. It's important to note that CHARLiE is available to the entire region and not just Terrace.

Risks:

We will continue to promote access to community based services and supports for children and youth to help this population group stay healthy and well and to prevent higher acuity presentations to emergency rooms.

Recommendation(s):

This Program update is provided to the Northern Health Board of Directors for information and discussion purposes.

BOARD BRIEFING NOTE

Date:	December 7, 2020	
Agenda item	Quality Program	
Purpose:	☒ Discussion	☐ Decision
Prepared for:	Northern Health Board of Directors	
Prepared by:	Vash Ebbadi-Cook, Interim Regional Director, Quality & Innovation	
Reviewed by:	Fraser Bell, VP Planning, Quality and Information Management	

Issue:

This briefing note is to update the Northern Health Board of Directors on key initiatives in the Quality Program:

1. Pandemic Response
2. Person and family-centred care (PFCC)
3. Accreditation
4. Maturing as a Learning Health System

1. Pandemic Response

Quality & Innovation, like all departments across Northern Health, has been impacted by and positioned in the response to the COVID-19 pandemic. As the pandemic has evolved, many of our department staff have been redeployed to support urgent and emergent functions in the response efforts. Within the Quality Program, multiple program functions have been disrupted, slowed, or stopped to reposition capacity and to support urgent response activities and comply with organizational measures to reduce the risks of transmission. The Quality Program has played an essential role throughout pandemic response. In April 2020, the COVID-19 Document Control Office was established, led by Linda Axen, Regional Manager for the Policy Office, and advanced our capacity to manage policies and documents in a coordinate and efficient manner to address the quickly evolving pandemic context. Additionally, the pandemic response reinforced the need for Gender-Based Analyses (GBA+) and assessments of our policies through the lenses of anti-racism and cultural safety. Specific impacts of the pandemic to the Accreditation cycle are detailed in the section below.

2. Person and Family-Centred Care (PFCC)

The PFCC Strategy and Steering Committee has developed a comprehensive strategy to enhance person and family centredness across Northern Health (NH) services. The strategy involves 21 objectives that are drawn from leading practice evidence. Over 40 NH staff and patient partners were involved in the development and early implementation of the PFCC strategy. These individuals reconvened in March 2020 to recognize and celebrate the efforts and achievements to date and to inform the next steps under the strategy. This is an important step to 'close the loop' on the development phase, particularly with our patient partners. A new Strategic Advisory Group is envisioned to form from this session to guide PFCC activity and direction including consideration of how executive priorities can impact and influence PFCC.

The Lead, Person and Community Engagement has now been in place in NH since 2019, with a mandate to support the implementation and evaluation of the PFCC strategy. This role is focused on strengthening and supporting the engagement of individuals and families in decision making, quality improvement and research. The role was developed by leveraging funding through Northern Centre of the BC SUPPORT Unit which is the research partnership between UNBC and NH under Canada's (Canadian Institutes of Health Research – CIHR) Strategy for Patient-Oriented Research (SPOR). This year, PFCC was embedded into the refreshed Strategic Plan 2021-2023 as one of the four dimensions of NH's organizational culture. Examples of work to create engagement capable environments at NH include:

- NH Stories series to acknowledge and celebrate the role of patient partners
- Cultural safety and competency in engagement practices working group
- Policy and Clinical Practice Standards Office engagement strategy development
- Honorarium Policy awareness and support with implementation
- Patient Experience working group
- Engagement Community of Practice
- Education if NH leadership in PFCC Online curriculum development.

Patient partners are involved in an increasing number of NH projects and initiatives, and are embedded in standard setting and decision-making structures such as Service Networks. NH works closely with the Patient Voices Network (PVN) to engage with patient partners who have received training through the BC Patient Safety and Quality Council. Examples of completed or ongoing engagements with Patient Partners include:

- Medical Assistance in Dying brochure review
- CareDocumentation working group member
- Hospital at Home working group member
- Clinical research engagement planning session
- Person and Family Engagement Committee, Research and Quality Conference
- Empathetic conversations during COVID-19 conversation guide review
- Substance use stigma reduction project peer review

Additionally, upcoming engagements with Patient Partners include the Person, Family, Community Engagement Reference Group - Primary and Community Care, and Re-designing NH allergy/sensitivity record review.

3. Accreditation – Primary and Community Care Services and Population Health (November 2021)

Beginning in 2018 we engaged with Accreditation Canada and the Health Standards Organization (HSO) to develop a consolidated set of standards for primary and community care services and population health to better reflect the service model we are working toward in Northern Health. The Primary and Community Care Services and Population Health manual compiles 10 separate standard sets which had been individually assessed in past Accreditation Canada surveys but reflect the traditional way of thinking about and delivering these health services.

To support planning for a Site Survey to assess this customized standard set, every Inter-professional Team (IPT) conducted a self-assessment of their adherence to standards through a community- or cluster-based group process. Physicians and leadership were included in this self-assessment process. Additionally, regional corporate-level standards were assessed through the lens of improving the health of the population, led by the Acting Chief Medical Health Officer (CMHO) and Population & Public Health (PPH) leadership team. The self-assessment process was completed between September and December 2019. Community teams were supported to improve standards implementation based on their self-assessment results, focusing on Required Organizational Practices (ROPs), then high priority criteria. Appropriate regional and operational leadership (e.g., service networks, regional programs) have undertaken improvements to refine applicability of resources to community and primary care (e.g., hand hygiene observation, MedRec, falls prevention).

From January to March, 2019, ROP Stewards held question and answer sessions and a Key Messages document was developed as a quick reference for all ROPs. The staff one-pager on the on-site survey process was updated and preliminary changes made to the Accreditation Handbook. In February 2020, 19 staff and leaders participated in Accreditation Canada Mock Surveyor Training to prepare volunteers for hosting simulated site visits to help teams prepare. Quality Improvement Leads presented at the January and March 2019 Mega-Ops forums to share updates and listen to any concerns and identify any support needs.

On March 16th 2020, in response to the progression of the COVID-19 pandemic, Accreditation Canada and Northern Health agreed to postpone the June 2020 Site Survey with a plan to monitor the pandemic and to announce rescheduled Site Visit dates. During the intervening period, we continued to work with leaders across the organization to address themes emerging from self-assessments; appropriate regional and operational leadership (e.g., service networks, senior leadership teams) and communities have undertaken local improvement work based on their self-assessment results. On August 27th, 2020 Accreditation Canada granted our request to reschedule the Site Survey to assess the Primary and Community Care Services and Population standard set to November 14-19, 2021. Communities/sites to be visited and assessed in November 2021 will be finalized in May 2021. The efforts and momentum put toward preparations for the originally scheduled June 2020 Site Visit will not be lost; the Accreditation Steering Committee and Accreditation Joint Leads/ROP Stewards monthly meeting have restarted and continue preparations for the November 2021 Site Visit.

Additionally, evidence suggests that Continuous Quality Improvement is greatly facilitated through systematized auditing and checklist processes. We continue to work with Accreditation Leads and ROP Stewards to maintain these processes and have collaboratively established an Audit & Checklist monthly schedule to support preparedness and sustainability.

New to the Accreditation Canada Site Survey process this year is the ability to attest to a subset of criteria in advance of the site-survey. The attestation process broadens our learning about the standards and streamlines the site survey process. Our team is working with IPTs and their leadership to identify attesters for all appropriate standards. Additionally, communities and teams will have the opportunity to participate in 'mock tracers', an activity that involves walking through a survey process facilitated by a NH staff person and supported by the appropriate service network/clinical program lead.

4. Maturing as a Learning Health System

To sustain Continuous Quality Improvement and a Culture of Quality across the organization, the Quality Program will foster and support the maturing of Northern Health as a Learning Health System. Our program does this by stimulating and supporting the organization toward a quality orientation.

Quality Improvement Training and Education

In 2010, Northern Health began offering an in-house training program in addition to promoting external training opportunities offered by organizations like the BC Patient Safety and Quality Council and the Institute for Healthcare Improvement. These training and education opportunities are grounded in Lean methodologies and quality improvement leading practice. The quality training numbers for 2010-2019 have been compiled into a one page infographic as part of the 2019 Quality Celebration (presented on the last page of this Briefing Note).

Due to the COVID-19 pandemic, the Quality Program has halted the Intermediate Quality Improvement training. As our team explores how best to deliver this training in our new context we will be drawing on learnings from recently developed online quality training including Quality Academy Online (QAO) deliver by the BC Patient Safety & Quality Council (BCPSQC) and the Institute for Health Improvements (IHI) Open School virtual training programs.

Additionally our program fosters continuous learning and celebration of quality work and projects to share of knowledge and learnings across the organization, northern BC, and the province. Celebration activities include a Storyboard Book, a collection of posters describing quality improvement projects in NH. Results of QI and Evaluation projects continue to be shared on OurNH; further updates to this page are planned in alignment with the SharePoint 2019 rollout across the organization in early 2021. In October 2020, The Learning Series was established as a monthly hour long knowledge sharing session to support dissemination, scaling, and spread of QI, evaluation, research, and analytics work, projects, and approaches.

Northern Health Quality Framework

Northern Health's first quality framework was developed in 2014. It is a foundational document that defines what quality is and how we undertake quality improvement, including organizational structures and priorities. In the past six years the framework has been updated modestly as the organization matures. In 2019 the "Building a Collective Picture of Quality Health Care in Northern BC" event brought together physicians, clinicians, quality improvement coaches, patient partners, NH leadership, First Nations Health Authority, UNBC, Divisions of Family Practice and Medical Staff Associations, to refresh the quality framework and broaden it to be reflective of health care quality in northern BC. Another key activity in 2019 was the BC Patient Safety and Quality Council convening a group to inform a new BC Health Quality Matrix released in March 2020. The Health Quality Matrix provides a common language and understanding about quality for all those who engage with, deliver, support, manage and govern health and wellness services.

A consultative process with partners is planned with the objective to inform a refreshed Quality Framework; these timelines have been impacted by the COVID-19 pandemic.

First Nations Health Authority (FNHA) Partnership

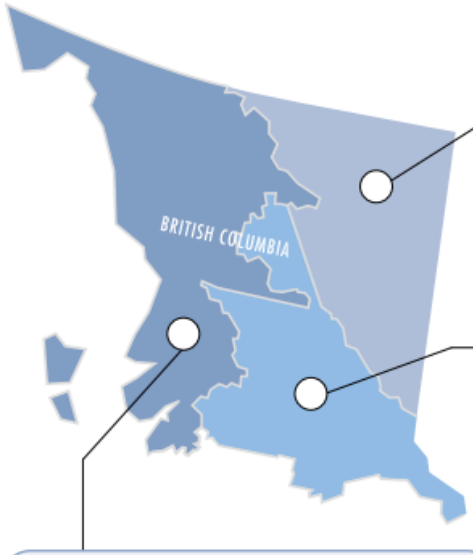
Northern Health has recently committed to partner with the FNHA on the development and operation of Service Networks and the organization's prioritization process. This partnership will enable alignment of goals, priorities, and implementation measures between NH and FNHA in a way that links directly to both NH's and FNHA's efforts to affect two-way, local-regional, communication and implementation in care sites and in communities. The partnership allows for NH to explore further opportunities to coordinate, collaborate, and improve the health system and to foster a common approach to maturing a Learning Health System in Northern BC through a lens of Person and Family Centred Care and Cultural Safety.

Recommendation(s):

This briefing note is for information.

QUALITY IMPROVEMENT TRAINING NUMBERS

Highlights from 2010 to 2019



NORTHEAST TOTALS

Intro to Quality Improvement	272
White Belt	112
Yellow Belt	60
Intermediate Quality Improvement	31
Green Belt	43
Black Belt	2
Quality Academy	2

NORTHERN INTERIOR TOTALS

Intro to Quality Improvement	774
White Belt	323
Yellow Belt	332
Intermediate Quality Improvement	58
Green Belt	55
Black Belt	4
Quality Academy	10

NORTHWEST TOTALS

Intro to Quality Improvement	344
White Belt	173
Yellow Belt	192
Intermediate Quality Improvement	34
Green Belt	36
Black Belt	1
Quality Academy	4

REGIONAL POSITIONS TOTALS

Intro to Quality Improvement	288
White Belt	27
Yellow Belt	31
Intermediate Quality Improvement	33
Green Belt	31
Black Belt	3
Quality Academy	21

TOTALS

Intro to Quality Improvement	1,678
White Belt	635
Yellow Belt	615
Intermediate Quality Improvement	156
Green Belt	165
Black Belt	10
Quality Academy	37

INTERMEDIATE QUALITY IMPROVEMENT

67 in progress

23 NH staff mentors for QI students

111 Physician-focused Principles of Quality Improvement: Level 1

QUALITY IMPROVEMENT CONFERENCES

755 Participants 2014 to 2018

196 Storyboards presented 2014 to 2018

northern health
the northern way of caring

PERFORMANCE EVALUATION PROCESS FOR THE PRESIDENT AND CHIEF EXECUTIVE OFFICER V.1

BRD 400

Introduction

The evaluation of the President & Chief Executive Officer (the "CEO") is one of the most important responsibilities of the Board of Directors of Northern Health (the "Board"). The evaluation process provides a formal opportunity for the Board and CEO to have a constructive discussion regarding the performance of Northern Health and the CEO's leadership of the organization.

Although the Board is involved in approving CEO objectives and reviewing the final evaluation, the Board works through the Governance and Management Relations Committee (the "Committee") in implementing the evaluation process.

Key Result Areas

The following constitute the key result areas against which the review takes place:

1. A written statement of the CEO's personal goals for the year under review. These goals have been agreed to by the CEO and the Board at the beginning of the year under review.
2. Northern Health's performance against the strategic, operating and capital plans
3. Board approved terms of reference for the CEO (BRD130)

The Process

1. The GMR Committee is charged with leading and implementing the CEO evaluation in accordance with the timeline set forth below
2. At the beginning of the review period the GMR Committee reviews, and the Board approves, the CEO's objectives
3. At the end of the review period the GMR Committee evaluates the CEO's performance against the agreed upon objectives of the previous year and the strategic, operating and capital plans, and the Terms of Reference for the CEO (BRD130)
4. The evaluation process, at the discretion of the Board, may include any or all of the following sections:
   a. Board Assessment

Author(s): Governance & Management Relations Committee
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b. Senior Management Staff Assessment
c. Key External Stakeholder Assessment
d. CEO Self-Assessment
e. A full 360° assessment

5. The results are collated and are viewed in a Board-only session without the CEO in a discussion led by the Chair of the GMR Committee and the Board Chair. Agreement is sought on the feedback to be provided to the CEO.
6. The Board Chair and GMR Committee Chair meet with the CEO to provide the CEO with the feedback from the evaluation process

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Timing and Responsibilities

Activity	***Who***	***When***
a) The evaluation process and timeline for the current year is established by the Governance and Management Relations (GMR) Committee	- CEO - GMR Committee - Board	January GMR meeting and February Board meeting
b) CEO self-assessment	- CEO - GMR Committee - Board	March GMR meeting and April Board meeting
c) Board Chair and Chair GMR reviews results of self-assessment and 360 (if done) with CEO	- Board Chair - Chair GMR	Within 2 weeks after the April Board meeting
d) CEO goals and objectives	- CEO - GMR Committee - Board	May GMR meeting and June Board meeting

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BOARD, COMMITTEE AND CHAIR EVALUATION PROCESS V1 BRD 410

POLICY

The Board of Directors of Northern Health (the "Board") annually assesses its own performance and the performance of:

a) Individual Directors against the Terms of Reference for a Director (BRD140)

b) Each of its committees against their respective terms of reference (BRD310, 320, ~~& 330~~, and 350)

c) The Board Chair against the Terms of Reference for the Board Chair (BRD120)

GENERAL GUIDELINES

1. Northern Health will establish processes and procedures to conduct an assessment of the Board, individual Directors, Board committees and the Board Chair that are consistent with the *Governance and Disclosure Guidelines for Governing Boards of British Columbia – Public Sector Organizations 2006*[1] and subsequent updates
2. The Governance and Management Relations Committee (the "GMR Committee") is responsible for recommending to the Board the specific tools for, and approach to, the components of this assessment process
3. The Board review process, the committee review process, the individual Director review process and the Board Chair review process will normally be conducted in the spring of each year with the results completed and reported prior to, or in conjunction with, the annual strategic planning process usually held in the fall
4. The Board Review process shall generally follow a 4-year cycle:
   a. Evaluation of the Board as a whole using a survey instrument
   b. Peer-to-peer evaluation of individual Board member performance

[1] See https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/services-policies-for-government/public-sector-management/cabro/best-practice-guidelines-boards.pdf~~https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/services-policies-for-government/public-sector-management/cabro/best-practice-guidelines-for-board-appointees-bc.pdf~~

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   c. Use of Accreditation Canada governance evaluation tools (in the year of an accreditation)
   d. Board Chair interviews with each Director and summary report to the full Board
5. Consolidation of evaluations and assessments, and relevant report preparation is the responsibility of the Chair of the GMR Committee with support from the Corporate Secretary
6. The results of the Board assessment will be reviewed with the Board Chair and reported to the Board at a Board-only session
7. The results of the individual Director assessment will be provided to the Board Chair who will discuss the results with each Director individually
8. The results of the Board Chair assessment[2] will be discussed with the Chair of the GMR Committee and the Board Chair, and will be shared with the Board at a Board-only session
9. The results of the committee assessments[3] will be discussed with the Board Chair and the Chair of the each Board Committee, and will be shared with the committee members
10. Should an opportunity to modify performance arise, the issues will be identified, agreed on and committed to in writing, and shall comprise a component of the relevant final assessment report

[2] The Board Chair is evaluated as a component of the Board evaluation and the Accreditation Governance Functioning Tool
[3] Committees are evaluated as a component of the Board evaluation and the Accreditation Governance Functioning Tool

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STRATEGIC PLANNING PROCESS V1 BRD 420

POLICY

The Board of Directors of Northern Health (the "Board") will provide strategic direction to the organization for the annual business planning cycle through a collaborative process with senior management

PROCEDURE

1. The annual strategic planning session is a dedicated 1 to 2 day session normally scheduled in October or November. Participation will include Directors of the Board of Northern Health, the President and Chief Executive Officer (the "CEO") and other members of senior management as determined by the CEO with the Board Chair's agreement. In addition, special guests, either internal or external to Northern Health, may be invited to a portion of the meeting to contribute to discussions for specific subject matter input.

   A facilitator may lead the discussion to allow Board members and management to participate fully in the deliberations.

2. Management will prepare background material for the planning process which may include but is not limited to:
   - an environmental scan that outlines the Ministry of Health's priorities for the BC health system, and the economic, political, social, labour and other relevant issues that could impact the delivery of quality health care to the region
   - a summary of outcomes and issues from community consultations
   - other government directives
   - mid-year progress against current Strategic Plan in terms of financial results and progress against agreed objectives
   - other relevant material that reflects the assumptions, risks, opportunities and strategic options for consideration
   - an annual risk management assessment
3. The Board may align the strategic planning session with the fall meeting of the northern Regional Hospital Districts (RHDs), when feasible, to enable the Board to meet with key municipal and RHD leaders, and receive their input
4. The primary outcomes from the annual strategic planning process will be to:
   a. endorse or revise the Strategic Plan
   b. review the governance structure in relation to the Strategic Plan

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c. review the results of the annual Board evaluation[1]
d. set the annual direction for Northern Health
e. ensure that Northern Health's Strategic Plan and organizational priorities are derived from the priorities of Government and the Ministry of Health's priorities for the BC health system
f. provide the basis for the development of the annual capital and operating plans.

5. Following the annual strategic planning session, management will prepare the capital and operating plans, including budgets, for the next fiscal year
6. The CEO and Board Chair will liaise during the development of the capital and operating plans to ensure alignment between the Board and management and to facilitate timely communication with the Ministry of Health and other government officials
7. The capital and operating plans for the next fiscal year will normally be presented for approval at the April meeting of the Board

[1] See BRD410: General Guidelines #3

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): December 2, 2019 (r)

BOARD SUCCESSION PLANNING AND RENEWAL PROCESS V1 BRD 430

INTRODUCTION

The Board of Directors of Northern Health (the "Board") is responsible for ensuring the effective delivery of health care across northern British Columbia. The value of the Board, in meeting its mandate, comes from the knowledge of the Directors, their cohesion as a group, their relationship with the President and Chief Executive Officer (the "CEO"), and their commitment to improving health outcomes for the people of northern British Columbia.

Directors contribute their professional knowledge and governance experience to policy formation, decision-making and oversight of Northern Health. To ensure continuity and to provide for long-term renewal, the Board requires Directors who have the ability and willingness to govern, and are prepared to:

1. Contribute their judgment
2. Invest the level of time and effort required
3. Personally commit to Northern Health's Mission, Vision and Values

While the authority of appointment rests with the Minister of Health, the Governance and Management Relations Committee (the "GMR Committee") will work closely with the Government of British Columbia's Crown Agencies and Board Resourcing Office (CABRO) to identify qualified candidates for recommendation to the Minister.

OBJECTIVE OF BOARD SUCCESSION AND RENEWAL PLAN

The objective of the Board Succession and Renewal Plan is to ensure that, collectively, the Directors have the knowledge and skills necessary to enhance the long-term performance of the organization.

The suitability of candidates for the Board is considered by examining a combination of many factors, including:

1. Personal attributes and traits
2. Community standing
3. Qualifications and expertise
4. Diversity of viewpoints

The process of recruiting Directors will be guided by a Board Selection Criteria Profile which sets out the general qualifications to be used in the identification of individual candidates as well as the key qualifications and core competencies required for the Board as a whole.

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BOARD SELECTION CRITERIA PROFILE

General Profile for Potential Directors

In the identification and evaluation of individual candidates, the following general profile will apply:

1. Personal Attributes
   a. high ethical standards and integrity in professional and personal dealings
   b. appreciation of responsibilities to the public
   c. flexibility, responsiveness and willingness to consider change
   d. ability and willingness to listen to others
   e. capability for a wide perspective on issues
   f. ability to work and contribute as a team member
   g. willingness to act on and remain accountable for boardroom decisions
   h. respectful of others
2. Informed Judgment and Independence
   a. ability to provide wise, thoughtful counsel on a broad range of issues
   b. ability and willingness to raise potentially controversial issues in a manner that encourages dialogue
   c. constructive in expressing ideas and opinions
   d. analytical problem-solving and decision-making skills
3. High Performance Standards
   a. personal history of achievements that reflect high standards for themselves and others
4. Education and Experience
   a. advanced formal education desirable but not mandatory
   b. successful record of achievement in his or her chosen field of endeavour

Key Qualifications and Core Competencies

To fulfill the Board's complex roles, the Board is strongest and most effective when key qualifications and core competencies are represented on the Board as a whole. In addition to the general profile requirements, each Director should contribute knowledge, experience and skills in at least one or two areas of expertise/critical competencies[1]:

1. Accounting/finance qualifications
2. Legal qualifications

[1] Refer to the Competencies Matrix for a Governing Board maintained by the Corporate Secretary

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3. Governance expertise **[2]
4. Understanding of government structures and processes **
5. Business management acumen
6. Knowledge of current and emerging health issues
7. Public sector knowledge
8. Labour relations and human resources
9. Financial literacy **
10. Communications or public relations
11. Technology

Commitment and Capacity to Contribute

In addition to possessing personal attributes and key qualifications required of a Board member, a Director is expected to:

1. Declare any conflict of interest **
2. Commit the time that is required to fulfil his or her responsibilities
3. Attend all scheduled Board and committee meetings, attend occasional special meetings, and be adequately prepared for all meetings
4. Travel, as required, to participate in Board and committee meetings and to occasionally represent the Board at special events, particularly in the geographic area the Board member lives in (BRD610)
5. Ensure he or she acts in compliance with the Taxpayer Accountability Principles, Northern Health's Standards of Conduct Guidelines, and Board policy BRD210 - Code of Conduct and Conflict of Interest Guidelines for Directors
6. Bring the perspective of northern residents to the affairs of Northern Health
7. Perform his or her duties consistent with the overall mandate and policies of Northern Health and the Ministry of Health
8. Sign, for public posting, the Ministry of Health mandate letter each year in order to demonstrate support of the Taxpayer Accountability Principles

Identifying Vacancies and Sourcing Qualified Candidates

1. The GMR Committee will identify the need for future appointments at least six months prior to the expiry of current Directors' terms of appointment. The Corporate Secretary will notify the CABRO of the anticipated requirements.

[2] Items marked with a double asterisk ** are considered critical

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2. A Director will be asked to continue to serve if, in the opinion of the Board Chair and in consultation with the Chair of the committee the Director serves on, the Director has performed satisfactorily during his or her term
3. Relevant factors in the consideration of satisfactory performance will be :
   a. The appointee's contribution to the strategic goals and objectives of Northern Health
   b. Participation in Board, committee work and other activities in support of the organization
4. If the person is prepared to continue as a Director the Corporate Secretary will notify the CABRO of the person's willingness to serve and the recommended duration of the re-appointment
5. When positions become vacant, the GMR Committee will develop a skills profile for the position consistent with the Board Selection Criteria Profile and the Competencies Matrix. In identifying the requirements, consideration will be given to the present membership of the Board and to the key qualifications which should be added or strengthened over time to maintain a Board which will meet the evolving needs of Northern Health. This objective will most likely be achieved by a body of Directors with an appreciation of the diverse needs and interests of the people of northern British Columbia and an understanding of the challenges of effective health care delivery in a vast and remote geographic area.
6. The GMR Committee will work with the CABRO to identify and review qualified candidates. Current Board members will be encouraged to identify potential candidates known to them through personal or community contacts. Candidates determined to have the required qualifications will be interviewed by the Board Chair and discussed with the GMR Committee. During the course of the interviews, the Board Chair will ensure that candidates have a clear understanding of the requirements of a Director and are prepared to make the necessary commitments of time, energy and expertise if appointed.
7. The GMR Committee will make its recommendations to the Board. Once the Board has approved the candidates to be nominated, the Corporate Secretary will forward its recommendations to the CABRO for consideration by the Minister of Health.
8. All recommendations to the Minister will be based on an objective assessment of the fit between the skills and qualifications of the prospective candidate or candidates and the needs of the organization. While care will be taken in identifying candidates who can effectively represent the regional, ethnic, age and gender diversity of northern British Columbia, the overriding principle is selection based on merit.

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9. To achieve a good balance between continuity of experience and injection of fresh perspectives to the Board, appointments to the Board should be staggered. Generally, appointments are not renewed beyond a maximum of six years.
10. Individuals who have been employed in the provincial health system during the past two years or individuals who are currently serving in an elected public office are not eligible as candidates for Board appointment, unless otherwise directed by the CABRO.

See also:

BRD140 – Terms of Reference - Director
BRD200 - Board Role and Governance Overview
BRD210 - Code of Conduct and Conflict of Interest Guidelines for Directors

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): December 2, 2019 (r)

PRESIDENT & CHIEF EXECUTIVE OFFICER SUCCESSION PLANNING PROCESS V1 BRD 435

INTRODUCTION

The Board of Directors of Northern Health (the "Board") has laid out a process for President and Chief Executive Officer (the "CEO") succession planning, which assigns responsibility to the CEO for preparation of a succession plan. This plan is provided to the Governance & Management Relations Committee (the "GMR Committee") for review; the responsibility for approval of the plan rests with the Board.

PROCESS

There are three components to CEO succession and coverage planning:

1. **Vacation and other short term coverage.**

   It is expected that there will be times when the CEO will be unavailable for short periods due to vacation or participation in events or conferences. During these occasions the CEO will ensure that appropriate executive level coverage is in place and communicated.

2. **Immediate coverage should the CEO become unavailable indefinitely or for an uncertain period.**

   Should the CEO not be available, Northern Health will require interim leadership until a replacement can be found, or until the incumbent is able to return. During this time, the organization's primary need is for stability of direction, stability of financial management, and effective communication between the Board, executive team, key external bodies, and the provincial government.

   Upon notification that the CEO has become unavailable, the following actions occur:

   a. The Board Chair (the "Chair") will convene a meeting to advise the Board of the situation and seek a decision by the Board that the succession plan should be implemented
   b. The Chair will consult with the Minister of Health and/or Deputy Minister regarding a proposed candidate for interim CEO
   c. The Chair will communicate to the interim CEO the need to assume acting duties for an interim period, and develop with the interim CEO an immediate communication to all staff and medical staff, Board members, and key external audiences identifying the appointment of an interim CEO

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The Board will normally designate an interim CEO from the Executive due to their familiarity and knowledge of Northern Health and of Board and Ministry of Health processes. The Chair, in consultation with the Board, will assess the needs and issues facing the organization and recommend an interim CEO to the Board who is best positioned to address these needs. The Board may choose to select an interim CEO external to the organization if circumstances are such that an external appointment will best serve the needs of Northern Health.

If the interim CEO is designated from the Executive, the Chair should provide the interim CEO with an opportunity to develop a plan to reassign their existing duties to ensure that the CEO duties will be assumed on a full time basis. Upon assignment of these duties, the Chair will confirm the appointment of the interim CEO. The interim CEO will exercise all authority resting in the CEO position subject only to such reporting and monitoring requirements as the Board may wish to adjust for the duration of the interim appointment.

3. Executive Search for a Permanent CEO

When the Chair determines a permanent replacement for the CEO is required, the Chair will convene a meeting of the Board to establish a search committee and will normally assign to the Vice President - Human Resources the task of preparing recommendations for the search process for consideration by the Board. At this meeting consideration should be given to the likely duration of the acting assignment for the interim CEO and the approach to compensation that is warranted.

There is considerable depth of knowledge and skill on the executive team of Northern Health. A number of executive team members would potentially be capable of assuming the CEO position in Northern Health or elsewhere. The development of these senior leaders is a critical component of effective long term CEO succession planning.

Therefore, the CEO will identify those executive team members with the leadership attributes and competencies necessary to perform CEO level work. The CEO will work with these leaders to ensure that ongoing developmental and learning opportunities are made available. Annually, and in accordance with the GMR Committee work plan, the CEO will prepare a succession plan. The CEO will provide the Board, in a Board-only session, with a summary report outlining those executive team members who are demonstrating CEO level competencies and leadership attributes.

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Issuing Authority: Northern Health Board
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BOARD BRIEFING NOTE

Date:	13 November 2020	
Agenda item	Legislative Compliance Review: • *Health Authorities Act*	
Purpose:	☒ **Discussion**	☐ **Decision**
Prepared for:	GMR Committee & Northern Health Board of Dierctors	
Prepared by:	K. Thomson, Regional Director, Legal Affairs, Enterprise Risk & Compliance	
Reviewed by:	C. Ulrich, CEO	

Issue & Purpose

To provide an update on the legislative compliance review process.

Background:

The *Health Authorities Act* describes how health authorities are created by the Minister of Health, how health authority boards function, how multiple boards can be amalgamated, and how health sector labour relations are managed.

The structure and activities of the board, described in Part 2 of the Act, are fully reflected in Northern Health board policies and bylaws.

This *Act* does not impose outstanding obligations or compliance issues on Northern Health.

Recommendation(s):

That the Board receives this briefing note for information.

northern health

RISK AND COMPLIANCE
LEGISLATIVE COMPLIANCE RECORD

HEALTH AUTHORITIES ACT

[RSBC 1996] Chapter 180

Date	Action
31 March 2016	Last full review
13 November 2020	GMR Review
6 December 2020	Board Review
Executive Sign-Off Received:	C. Ulrich (2020-11-05) M. De Croos (2020-10-20)
December 2025	Next full review

Summary

The *Health Authorities Act* describes the role of the Minister of Health in establishing standards for the provision of health services, including the creation of health authorities, the designation of regional health boards and the geographical areas they cover.

The Act further describes the structure and activities of the board, including its constitution, purpose, reporting requirements, powers and procedures, financial administration, staff and benefits, liability of members, and tax exemptions.

Further procedures described in the Act include: amalgamation of two or more old boards, transfer of facilities from the Provincial government, appointment of a public administrator (in lieu of a board), and health sector labour relations.

Part 3 of the Act describes health sector labour relations and includes provisions on appropriate bargaining units, certifications of trade unions, associations of bargaining units, and the development of collective agreements.

A. Review

Section	Description	Comments	Compliance[1]	Likelihood[2]	Impact[3]
4	(1) The minister, by regulation, may designate: (a) a regional health board, and (b) an area of British Columbia that constitutes the region for the board.	Other subsections describe the appointment of voting members and the chair of the board by the minister, as well as the allowance for reimbursement of board member expenses. Northern Health Authority is designated under the Regional Health Boards Regulation, and described in section 4 of that Regulation.	U	U	U
5	(1) The purposes of a board are as follows: a) to develop and implement a regional health plan b) to develop policies, set priorities, prepare and submit budgets to the minister and allocate resources for the delivery of health services, in the region, under the regional health plan c) to administer and allocate grants made by the government for the provisions of health services in the region d) to deliver regional services through its employees or to enter into agreements with the government or other public or private bodies for the delivery of those services		U	U	U

[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[1]	Likelihood[2]	Impact[3]
	f) to develop and implement regional standards for the delivery of health services in the region g) to monitor, evaluate and comply with Provincial and regional standards and ensure delivery of specified services applicable to the region h) to collaborate with BC Emergency Health Services, the Provincial Health Services Authority, for the provision of ambulance, emergency health, urgent health and ancillary health services				
7.1	A board must comply with any general or special direction made by order of the minister with respect to the exercise of the powers and the performance of the duties of the board.		H	L	H
7.2	(3) A board must comply with an order from the minister to (a) report on any matter relevant to the stewardship purpose, and (b) disclose personal information within a report made for stewardship purpose.		H	L	M
8	(2) A board may, by bylaw approved by the minister: a) determine its own procedure b) provide for the control and conduct of its meetings c) provide for the election of officers of the board, including the chair and the member to be the actin chair in the absence of the chair d) establish committees and specify the functions and duties of those committees, and e) delegate administrative or management duties to its employees	NH has minister-approved bylaws describing the procedures and conduct of the Board (BRD 600). The bylaws are further supported by a suite of Board policies that support Board activity and which are reviewed on an annual basis.	H	L	M

Section	Description	Comments	Compliance[1]	Likelihood[2]	Impact[3]
8	(4) The acquisition or disposal of real or personal property owned or administered by a board may only be done on authority of a bylaw of the board.	This specific requirement is captured in paragraph 2.2 BRD 600.	H	L	M
10	(1) Each board must establish and maintain an accounting system satisfactory to the minister	General ledger charts of accounts are maintained in accordance with Canadian Institute for Health Information MIS standards and with any supplemental requirements approved by the Ministry of Health. Annually financial statements are prepared in accordance with Public Sector Accounting Standards (PSAB) and Ministry of Finance Directives	H	L	L
	(2) All books or records of account, documents, and other financial records of a board must at all times be open for inspection by the minister	NH's trial balance is submitted to the Ministry's Healthy Authority Management Information System (MIS) at close of every period	H	L	L
	(4) The board must appoint an auditor who is authorized to be the auditor of a company under sections 205 and 206 of the Business Corporations Act to audit the accounts of the board at least once each year.	Financial statements are audited annually by qualified external independent auditor Captured in BRD 230 – Executive Limitations and BRD 315 – External Auditor Independence	H	L	L

Section	Description	Comments	Compliance[1]	Likelihood[2]	Impact[3]
	(5) After the end of its fiscal year, a board must prepare and submit to the minister (a) a report of the board on its operations for the preceding fiscal year, and (b) a financial statement showing the assets and liabilities of the board at the end of the preceding fiscal year and the income and expenditures of the board for that year and a statement of changes in financial position of the board for the fiscal year then ended	Audited financial statements for the year just ended are provided to the Ministry by June 30. The Statement of Financial Information (SOFI) for the year just ended is prepared in accordance with Ministry of Finance direction and submitted to the Ministry of Health by September 30	H	L	L
	(6) The financial statement referred to in 10(5) must be prepared in accordance with generally accepted accounting principles and with the regulations made under section 21(2)(l)	The financial statements are prepared in accordance with Canadian generally accepted accounting principles and any Ministry of Finance issued directives. The external auditor attests that the financial statements were prepared in compliance with the appropriate accounting standards and any directives.	H	L	L
14	(1) No action for damages lies or may be brought against a member, officer or employee of a board because of anything done or omitted in good faith (a) in the performance or intended performance of any duty under this Act, or (b) in the exercise or intended exercise of any power under this Act.	In addition to legislative exemption of liability, board members have liability coverage through the Health Care Protection Program. Discussed in BRD 510 – Director Liability and BRD 600 - Bylaws	U	U	U

Health Authorities Act.pdf

B. Risk Matrix

IMPACT				
	H	7.1		
	M	7.2, 8		
	L	10		
		L	M	H
		LIKELIHOOD		

C. Other Acts Referred to in this Act

Section	Description	Notes
1	*Public Health Act* *Hospital Act* *Hospital District Act* *Mental Health Act* *Financial Administration Act*	Definitions for public bodies
5	*Emergency Health Services Act*	Required collaboration between health authorities and BC Emergency Health Services
7.2	*Ministry of Health Act*	Defining stewardship purpose for the purpose of the board reporting to the minister
10	*Financial Administration Act* *Auditor General Act* *Business Corporations Act* *Financial Information Act*	Describing financial reporting requirements Describing external auditing requirements
11	*Public Services Act*	Inapplicable to a board or members

15	*Local Government Act* *Provincial Sales Tax Act*	Exemptions from property tax on property vested in a board
19.91	*Education and Health Collective Bargaining Assistance Act*	Describing collective bargaining agreements

(*) Denotes an Act previously reviewed by the Board through the legislative compliance review process

D. Certificate(s) of Compliance

I, Mark De Croos, VP Finance, 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 ***Health Authorities Act***:

Section(s)	**Compliance**	
8, 10	☒ Full, without reservation	☐ Substantial, with reservation – see notes below
	☐ Partial – see notes below	☐ Non-compliant – see notes below

Signature

OCT 20, 2020
Date

D. Certificate(s) of Compliance

I, Cathy Ulrich, Chief Executive 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 ***Health Authorities Act***:

Section(s)	**Compliance**	
4, 5, 7.1, 7.2, 14	☒ Full, without reservation	☐ Substantial, with reservation – see notes below
	☐ Partial – see notes below	☐ Non-compliant – see notes below

November 5, 2020

Signature

Date

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

HR REPORT

Workplace Health and Safety

Northern Health's Workplace Health & Safety department consists of the following portfolios:

- **Health, Safety, and Prevention** – collaborates with the organization and external agents to build an occupational health and safety management system that controls hazards and prevents workplace incidents and illnesses.
- **Disability Management** – helps support and guide injured or ill employees to recover and participate in return-to-work activities as soon as medically possible.

Health Safety and Prevention

COVID-19 Pandemic Response and Workplace Safety Plans

To date in 2020, the COVID-19 pandemic response has dominated the Health Safety and Prevention department's efforts, while work on other priority occupational health and safety initiatives has continued to the degree possible.

During the pandemic response, Health Safety and Prevention has provided guidance on personal protective equipment (PPE) decisions and allocation, including: support for PPE champions and delivering urgent fit testing to high-risk departments due to respirator model shortages. In addition, advisors developed tools, resources, and support for COVID-19 Workplace Safety Plans and facility risk assessments required to restart operations in June 2020.

Influenza Prevention Program

The Influenza Prevention Program immunizes upwards of 4500 health care workers annually within Northern Health facilities, via clinics and Peer Immunizers. New COVID-19 guidelines[1] to ensure health care workers' and community safety impact all areas of the program, most significantly the immunization service model. The mass immunization

[1] BCCDC and Health Canada guidelines.

clinic format is required to change to a localized model to align with safety and prevention measures. This season, Peer Immunizers will be the primary service model for employees to receive immunization.

Joint Occupational Health and Safety Committees

Health Safety and Prevention Advisors met with the co-chairs of all 42 Northern Health Joint Occupational Health and Safety Committees (JOHSC) to guide them through completion of their annual evaluation, a requirement of the Occupational Health and Safety Regulation. The evaluation is a self-assessment tool that allows committees to determine current state and identify areas for improvement. Health Safety and Prevention provides support to the joint committees through new member education, a quarterly newsletter, and guidance on regulatory questions.

Provincial Violence Prevention Curriculum Delivery

The Provincial Violence Prevention Curriculum (PVPC) is an education and training program for all BC health care workers. It is designed to reduce incidents related to violence in the workplace. Workplace Health and Safety continues to support the organization in sustaining this training. The curriculum consists of:

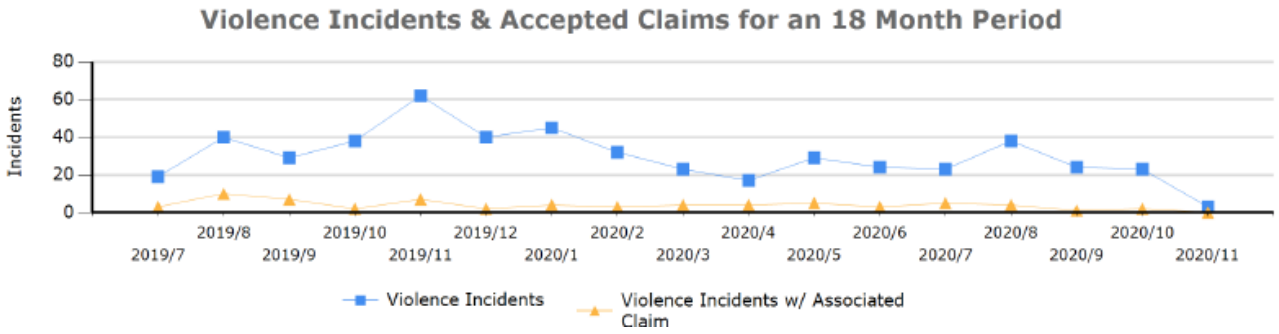
- Eight foundational online modules
- Classroom training (7.5 hours)
- Refresher training (30 minutes)

Advanced Team Response training is provided at sites that have an advanced team response to Code Whites (University Hospital of Northern BC, Mills Memorial Hospital, Dawson Creek and District Hospital, and GR Baker Memorial Hospital).

Health, Safety and Prevention partners with operations to sustain Provincial Violence Prevention Curriculum delivery. During the COVID-19 pandemic response, classroom training was put on hold; however, in-person sessions have resumed with COVID safety precautions in place. In addition, Health Safety and Prevention advisors are providing more frequent virtual PVPC classroom and refreshers.

Violent Incidents & Accepted Claims for Last 18 Months

Northern Health continues to demonstrate a positive reporting culture for violent incidents with a favorable ratio of report-only incidents (incidents that have the potential to cause an employee injury, but do not) compared to incidents that do result in an injury and a WorkSafeBC claim.



Disability Management

Occupational Injuries/Illnesses – Return to-Work Outcomes

Workers who have become ill or injured as a result of work should be offered support at work and/or return-to-work as soon as possible, as transitional work or a graduated return-to-work program can help the employee protect their quality of life while reducing the employer's WorkSafeBC claim costs, work days lost, and premiums.

From quarter four of 2019 to quarter three of 2020, Northern Health's average days lost was at 48.1 in comparison to the provincial average of 50.2 and the average claim cost was at $5,888, which is also lower than the provincial average of $6,514.

Factors that are influencing average days lost include:

- Barriers to timely access to treatment (e.g. physiotherapy), and the closure of treatment providers early on in the pandemic.
- Return-to-work plans starting past the anticipated full recovery time due to delay from general/ treatment providers (as per disability guidelines for sprains/strains), and because of the demographics of our injured workers influencing delays in recovery (ex. BMI, age at date of injury, and pre-existing conditions).
- Complex illnesses with poor prognosis for return to work by injured worker to their pre-injury occupation.

Long-Term Disability – Non-Occupational Injuries/Illnesses

Northern Health's benefits plan includes long-term disability insurance for any permanent employee who is 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 Canada Life (formally Great West Life) and Healthcare Benefit Trust, Workplace Health and Safety continues to promote early, safe return-to-work

programs, and temporary or permanent accommodation solutions to improve long-term disability performance and reduce overall claims.

For the active claims of 2020 (January to October 2020); 41% are Mental Health, 30% are Musculoskeletal and Connective Tissue, 9% are Cancer, 9% are Nervous System and Sensory Organs and 9% are other. Mental Health claims have increased provincially, especially in the age band less than 45 years of age.

Northern Health has increased the number of referrals to Early Intervention Services (i.e. claims referred during the qualification period to connect employees to services early, which positively impacts claim duration) and Canada Life has noted that claim duration for Mental Health and Musculoskeletal is on a downward trend. The common factors impacting the rise in claims include: an aging workforce, staff with chronic illnesses, mental health conditions, and staff with multiple barriers include personal, medical and workplace barriers. All of which can result in complex recovery journeys. The challenges for mental health return-to-work support are characterized by:

- Non-linear recovery (not a straightforward move to a state of well-being, occasional setbacks and waxing/waning of symptoms).
- Absence of hard/ set recovery guidelines as would occur for physical injuries.
- Lack of available accommodation opportunities within Northern Health due to the functional abilities of the worker.

Disability Management continues to focus on initiatives and support tools/resources aimed at fostering awareness and facilitating positive mental health and coping strategies for the many work and life stressors that exist.

Northern Health is committed to increasing psychological health and safety awareness in our workplaces and to reduce the stigma surrounding mental health. It is important to recognize, address and treat mental health with the same attention as physical health or any other health-related condition.

Disability Management Intake

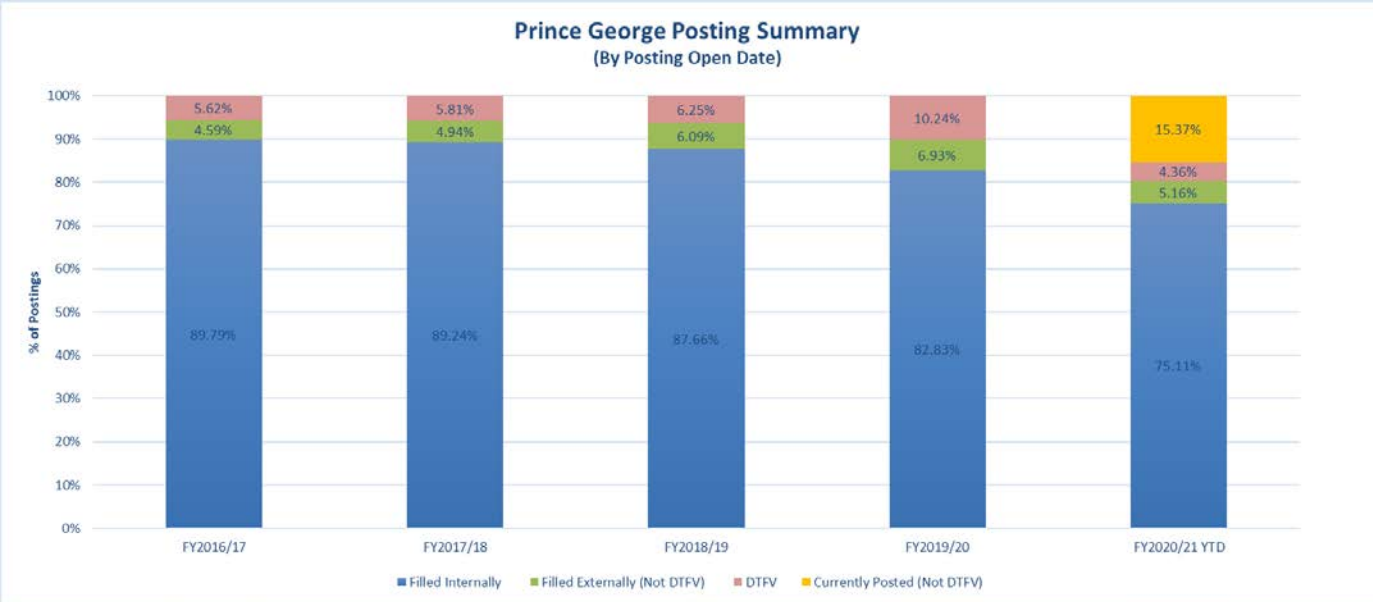
Disability Management receives referrals from a variety of sources, payroll reports, the Workplace Health Call Centre, managers, employee self-referral, the union, etc. for employees who are in need of support services. For 2020, there has been an increase in the number of employees who have been referred to Disability Management; 1944 so far in 2020 in comparison to 1721 in 2019 from quarter one to four. Of the 1944 referrals in 2020, 565 staff have been enrolled in the Enhanced Disability Management Program (prompting comprehensive case management plans), as well as another 1042 triaged with support, guidance and monitoring leading to a successful return to work within 30 days (i.e. return-to-work imminent).

This year's increase is likely due to the pandemic which prompted an increase in the number of staff going off work due to being immunocompromised, pregnant, required to self-isolate, etc. Where possible, staff have been accommodated in their own department such as working from home or alternate location, or to low-risk departments such as the virtual care clinic and transporting of lab samples.

Northern Health Recruitment Update

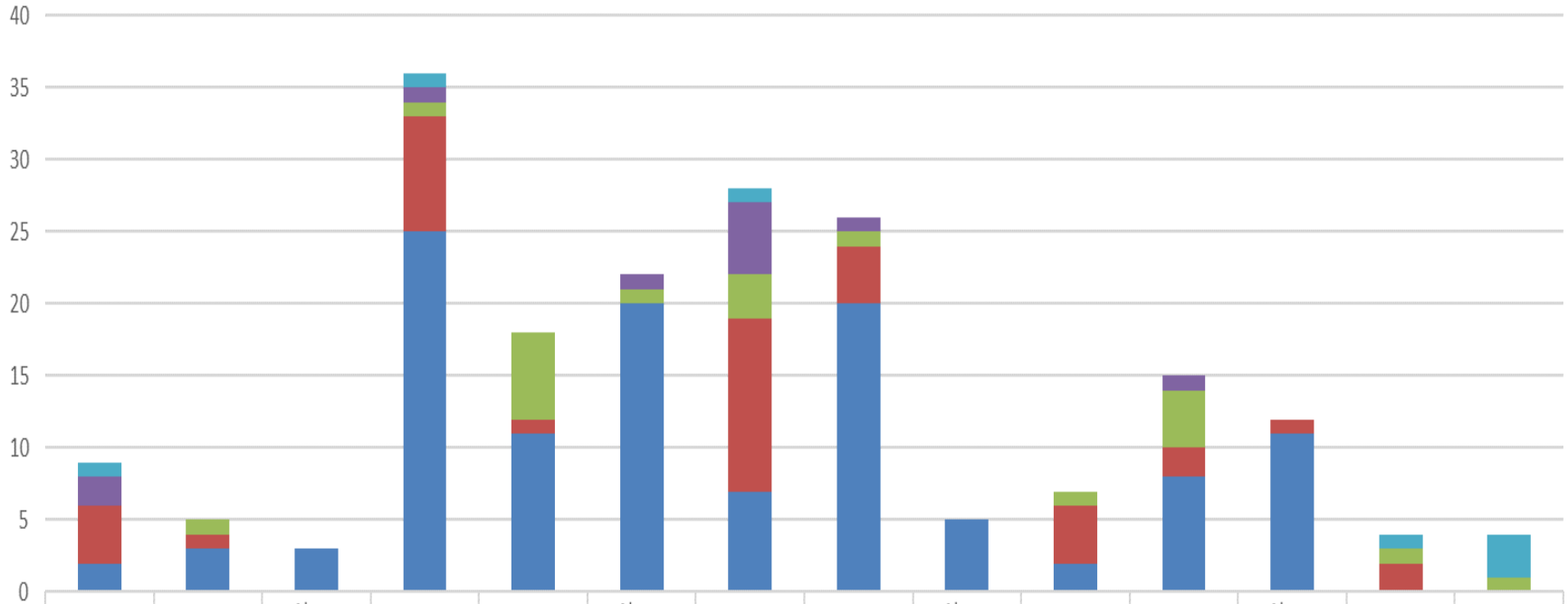
In fiscal year 2019/20, Northern Health posted 1328 non-casual positions in Prince George; 83% were filled by internal staff (existing regular and casual staff) and 7% were filled externally (qualified applicants from outside of NH) within 90 days. Positions that remain unfilled for more than 90 days become difficult-to-fill vacancies (DTFV), with approximately 10% of postings becoming DTFV in 2019/20. Some unfilled positions are currently in the competition phase.

Casual hires are not reflected in this data. On average, there are 366 casuals hired per year in Prince George, with many of these staff successfully bid into permanent, ongoing positions through our internal posting process.



Current Open Difficult-to-Fill Vacancies (DTFV) by Posting Type

As at November 13, 2020



	NI Rural			North East			North West			Prince George			Regional	
	Permanent	Relief/Term	Above Baseline	Permanent	Relief/Term	Above Baseline	Permanent	Relief/Term	Above Baseline	Permanent	Relief/Term	Above Baseline	Permanent	Relief/Term
EXCLUDED	1			1			1						1	3
COMMUNITY SUBSECTOR	2			1		1	5	1			1			
FACILITIES SUBSECTOR		1		1	6	1	3	1		1	4		1	1
HEALTH SCIENCE PROFESSIONALS	4	1		8	1		12	4		4	2	1	2	
NURSES PROVINCIAL AGREEMENT	2	3	3	25	11	20	7	20	5	2	8	11		

The Face of Northern Health

As at November 13, 2020

Summary of Employees by Status	Headcount	%	FTE
Active: Total	8,456	100%	5,193
Full-time	3,880	46%	
Part-time	1,918	23%	
Casual	2,658	31%	
Non-Active: Total	946	100%	758
Leave	555	59%	411
Long Term Disability (LTD)	391	41%	347

Active Employees by Region	Headcount	%
Active: Total	8,456	100%
North East	1,285	15%
North West	1,996	24%
Northern Interior: Prince George	2,705	32%
Northern Interior: Rural	1,185	14%
Regional	1,285	15%

Active Employees by Collective Agreement	Headcount	%
Active: Total	8,456	100%
Nurses	2,647	31%
Facilities	3,312	39%
Health Sciences	1,078	13%
Community	778	9%
Excluded	641	8%

Active Nursing	Headcount	%
Active: Total	2,647	100%
RN/RPN	1,950	74%
LPN	697	26%

Clinical vs. Support	Facilities	Community
Active: Total	3,312	777
Clinical	1,399	663
Non-Clinical	1,913	114

Count of Employees - By Status