Information Brief

For Board of Directors

Version: 1.0 (Nov-2017)

EXECUTIVE SUMMARY

Title	Community Paramedicine Initiative (CPI) status update
Purpose	To provide the Senior Executive Team (SET) with an update on the status of the CPI in Interior Health (IH).
Top Risks	1. (Human Resources) Employees from different unions and employers will need to work in a new interprofessional care model that if not managed carefully could result in grievances or other workplace environment complaints. 2. (Patient) BCEHS and IH patient/client documentation systems are not integrated and as a result care is being recorded in two parallel clinical records which creates a patient safety risk. 3. (Patient) Community Paramedics (CP) have a specific skill set and when these BCEHS positions are vacant there is a risk that patients will experience an interruption in their clinical care.
Lead	Cheryl Whittleton, Administrator, Hospitals and Communities Integrated Services
Sponsor	Susan Brown, Vice President and Chief Operating Officer, Hospitals and Communities

RECOMMENDATION

That Board of Directors accepts this brief for information only.

BACKGROUND

The CPI is intended to provide British Columbians in rural and remote communities with better access to primary health care and a more stabilized paramedic presence for emergency response. The program is a partnership with the Ministry of Health, the regional health authorities, the Ambulance Paramedics of BC (Local 873), and the First Nations Health Authority. The program involves 76 communities in the North, Interior, Coastal, Island and Fraser Health authorities. The Regional Health Authorities were involved in community selection and Interior communities are involved in both the prototype and wider provincial roll-out.

CP's are employees of BCEHS and will work in collaboration with other community care resources including Physicians and IH employees and contractors.

The objectives of the CPI are to:

1. Contribute to the stabilization of paramedic staffing in rural and remote communities by introducing CPs with the ability to augment additional shifts in emergency response capabilities.
2. Bridge health service delivery gaps in the community, identified in collaboration with local primary care teams, consistent with the paramedics' scope of practice.

The CPI is informed by a Provincial Advisory Committee and is delivered locally by an IH led Steering Committee on behalf of Susan Brown as the VP and COO, Hospitals and Communities. Glenn McRae, Chief Nursing Officer (CNO) and Professional Practice Lead from IH is a member of the Provincial Advisory Committee as the Provincial CNO Council representative and is also the Hospitals and Communities Portfolio senior leader supporting the IH implementation. Cheryl Whittleton, Health Service Administrator from the Hospitals and Communities Portfolio is a member of the Provincial Advisory Committee as the IH representative and is also the chair of the IH steering committee.

DISCUSSION

IH has 2 of 9 CP prototype communities. These communities are Creston and Princeton. Prototype communities were chosen to help determine the supports that would be required for the province wide rollout. The CPs for Creston and Princeton were hired in the summer of 2015 and have been involved in significant work related to the development of principles of collaborative practice, and key performance measures. The Privacy Impact Assessment (PIA) was executed on March 29, 2016. It provides a comprehensive assessment of privacy, security

issues and risks related to information flow, access and disclosure, as well as record storage, policies and procedures. An addendum for use of emails and secure texting between CP's and Health Authorities is in the final signatory stages, and an additional addendum is being developed to support CPI evaluation data collection.

The CPs have been attending discharge planning meetings and working with local community health teams to develop care plans for clients. The CPs began visiting clients in their homes in May 2016. These home visits allowed forms and policies to be trialed and revised as needed prior to the province wide roll-out.

On April 26, 2016 IH received an additional 20.5 FTEs of CP funding for 29 selected communities as part of the province wide rollout (see Appendix A). Recruitment for these positions began in July 2016. The CP's started providing care in February 2017.

Phase three, final deployment, is currently pending Ministry of Health endorsement. We are expected to receive an additional 8.53 FTE in 8 communities within IH. Recruitment for these positions will begin as soon as Ministry of Health endorsement is received. BCEHS will be deploying CP's into 38 IH communities. 87% (27 of 31) round 1 and 2 selected IH communities have total LHA population of <4000.

EVALUATION

An evaluation framework was completed and endorsed by the Evaluation Advisory Committee. The evaluation is being carried out over the course of the rollout to measure outcomes and inform quality improvement. An interim evaluation report will be delivered in the fall of 2017, with a final evaluation report planned for 2018. James Coyle, Director, Health Systems Evaluation is representing IH.

Initial feedback from the pilot and round 2 communities in IH, has been very positive.

ALTERNATIVES

n/a

CONSULTATION

Position	Date Information Sent	Date Feedback Received	Type of Feedback
<business support lead>	<date>	<date>	<type>
Roger Parsonage, Director Strategic Initiative, HCIS	October 30, 2017	October 30, 2017	Consultation
Glen McRae, CNO HCIS	October 30, 2017	October 30, 2017	Consultation
Karen Bloemink, ED IH East, HCIS	October 30, 2017	October 30, 2017	Information

TIMELINES

Milestone	Lead	Date of Completion
Decision brief written	Cheryl Whittleton, Health Service Administrator	October 24, 2016
Assessment of communication requirements	Karl Hardt	November 2, 2017
Presentation to Strategy and Risk Management Council	n/a	<date>
Presentation to SET	Cheryl Whittleton, Health Services Administrator, Kootenay Boundary Nancy Kotani, BCEHS	November 14, 2017
Presentation to the Board	Cheryl Whittleton, Health Services Administrator, Kootenay Boundary Nancy Kotani, BCEHS	December 5, 2017

ENCLOSURES

Appendix A: Community Paramedicine Initiative – Provincial implementation.

Board Presentation

REFERENCES

n/a

APPROVAL OF RECOMMENDATIONS

Name for Approval / Endorsement	Signature	Date

Interior Health

April 27, 2016

To: **IH Leadership Teams**
From: **Susan Brown, VP and COO Hospitals and Communities**

Re: Community Paramedicine Initiative – provincial implementation

Today the province announced 73 rural and remote B.C. communities, including 31 within Interior Health, that will welcome community paramedicine, a program that offers residents enhanced health services from paramedics. This is great news regarding the next phase of an innovative partnership with BC Emergency Health Services (BCEHS).

Under the program BCEHS paramedics will provide basic health-care services, within their scope of practice, in partnership with local health-care providers. As part of this announcement within Interior Health 20.5 new full-time equivalent positions will support community paramedicine.

Last year community paramedic positions were posted in nine prototype communities in B.C., including one FTE in Creston and one FTE in Princeton in Interior Health. Positions were filled in the fall and these community paramedics have since been working alongside IH staff as part of a successful partnership to enhance care in those areas. For example, these paramedics have begun to regularly attend discharge meetings, and are expected to begin home visits in the coming weeks.

Services provided by community paramedics may include checking blood pressure, assisting with diabetic care, helping to identify fall hazards, medication assessment, post-injury or illness evaluation, and assisting with respiratory conditions.

A staged implementation will now begin in Northern Health, followed by Interior Health, then Island Health and Vancouver Coastal. The new community paramedics are expected to be delivering community health services in Interior Health in early 2017.

Read the full news release online. A list of Interior Health communities follows. For information please contact IH project lead Cheryl Whittleton.

Interior Health region (31 communities):
*Prototype communities announced in 2015

- Alexis Creek
- Anahim Lake
- Blue River
- Clearwater
- Clinton
- Creston*
- Edgewood
- Elkford
- Field
- Fruitvale
- Gold Bridge
- Golden
- Greenwood
- Kaslo
- Keremeos
- Lillooet
- Logan Lake
- Lumby
- Lytton
- Midway
- Nakusp
- New Denver
- Princeton*
- Revelstoke
- Riondel
- Rossland
- Salmo
- Seton Portage
- Sicamous
- Sparwood
- Winlaw

BC Community Paramedicine

Interior Health Open Board Meeting
December 5, 2017

Presented by:
Cheryl Whittleton, Health Services Administrator, IH
Nancy Kotani, Chief Transformation Officer, BCEHS

Interior Health
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Working Together

I have more time to get to know (the patients), understand their needs, and help them become more comfortable with the health care process.

They know we are local and we have the community's best interest at heart. They like the one-on-one care.

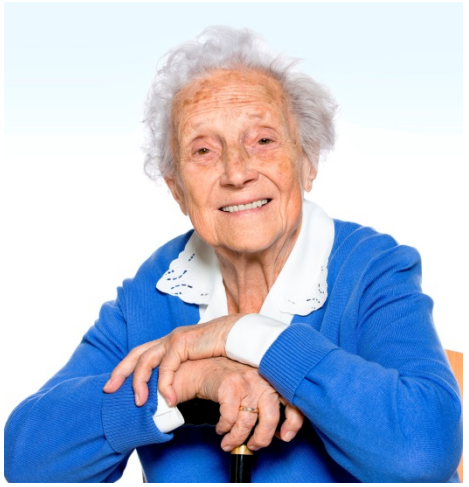
Tom Robins, Keremeos CP
@interiorhealth

We can do things we weren't able to do before . . . bringing benefits to residents and communities, and the health (system) . . .We improved discharge planning (and follow-up) . . .We think we are seeing a decline in the number of medically unnecessary 911 calls and ER visits."

Health Authority Interviewee Evaluation "Snapshot Report" March 31, 2017

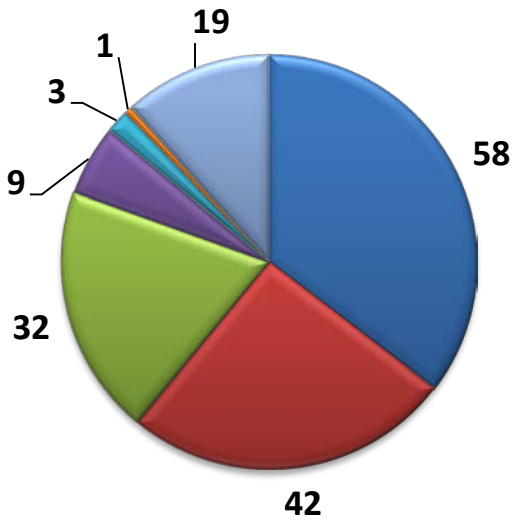
Population Profile

* Older people living on their own
* Living with chronic conditions: heart failure, chronic obstructive pulmonary disease and diabetes
* Referred by their doctor or other primary health care provider
* Service provided at no cost to the patient

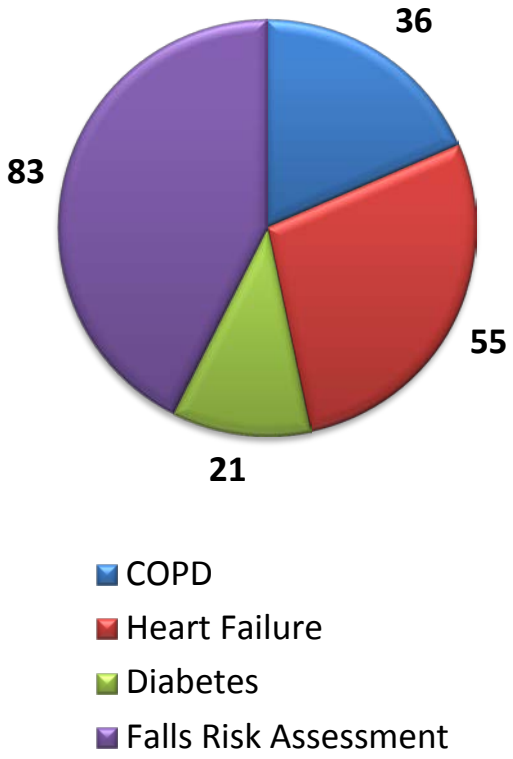


Interior Patient Profiles: Jan 2016-Sep 2017

Patient Ages



CP Referrals

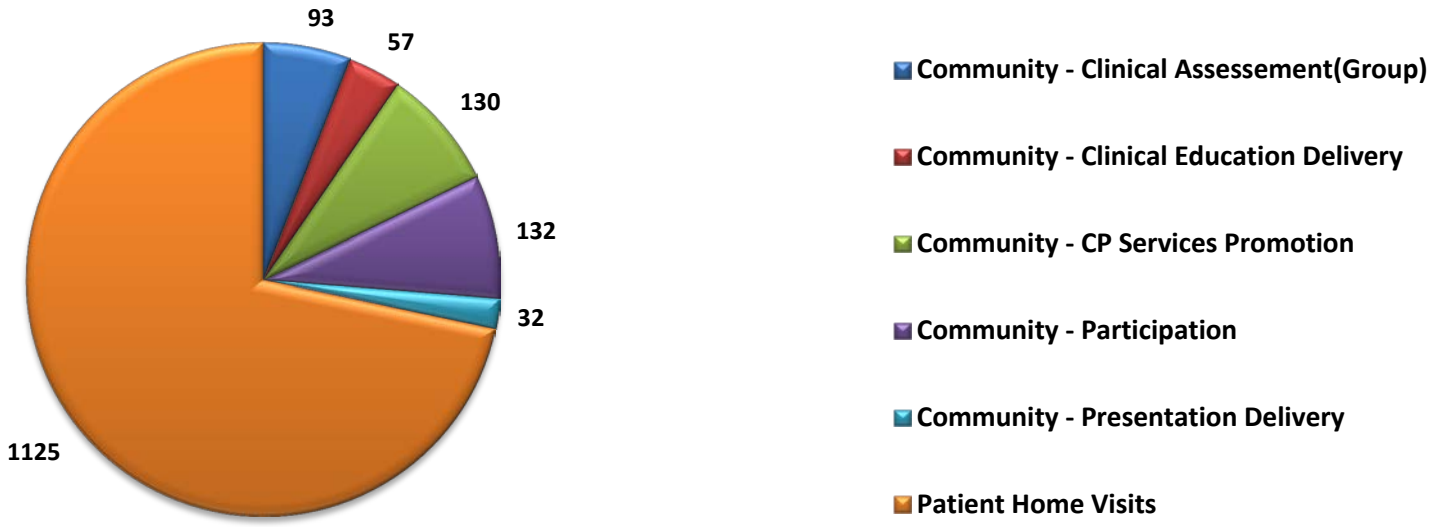


Interior CP Communities

Communities	Working in Community
Prototypes: Creston, Princeton	October 2016
Phase 1: Alexis Creek, Anahim Lake, Blue River, Edgewood, Elkford, Field, Golden, Greenwood, Kaslo, Keremeos, Midway, Nakusp, New Denver, Riondel, Salmo, Sparwood, Winlaw	May 2017
Phase 2: Clearwater, Clinton, Fruitvale, Gold Bridge, Lillooet, Logan Lake, Lumby, Lytton, Revelstoke, Rossland, Seton Portage, Sicamous	October 2017
Optimal Deployment (pending government endorsement): Ashcroft, Barriere*, Castlegar, Chase, Cranbrook**, Grand Forks, Kimberley, Merritt, Osoyoos * Part-time CP **Full-time ACP CP – also covers Kimberley	June 2018

Services Delivered – Interior

Jan 2016 – Sep 2017	
Unique patients seen by CPs	164
Total home visits	1,125



CP Impacts on 911 Events

* CPs are available to support 911 calls when appropriate (i.e. safe to leave their patient)

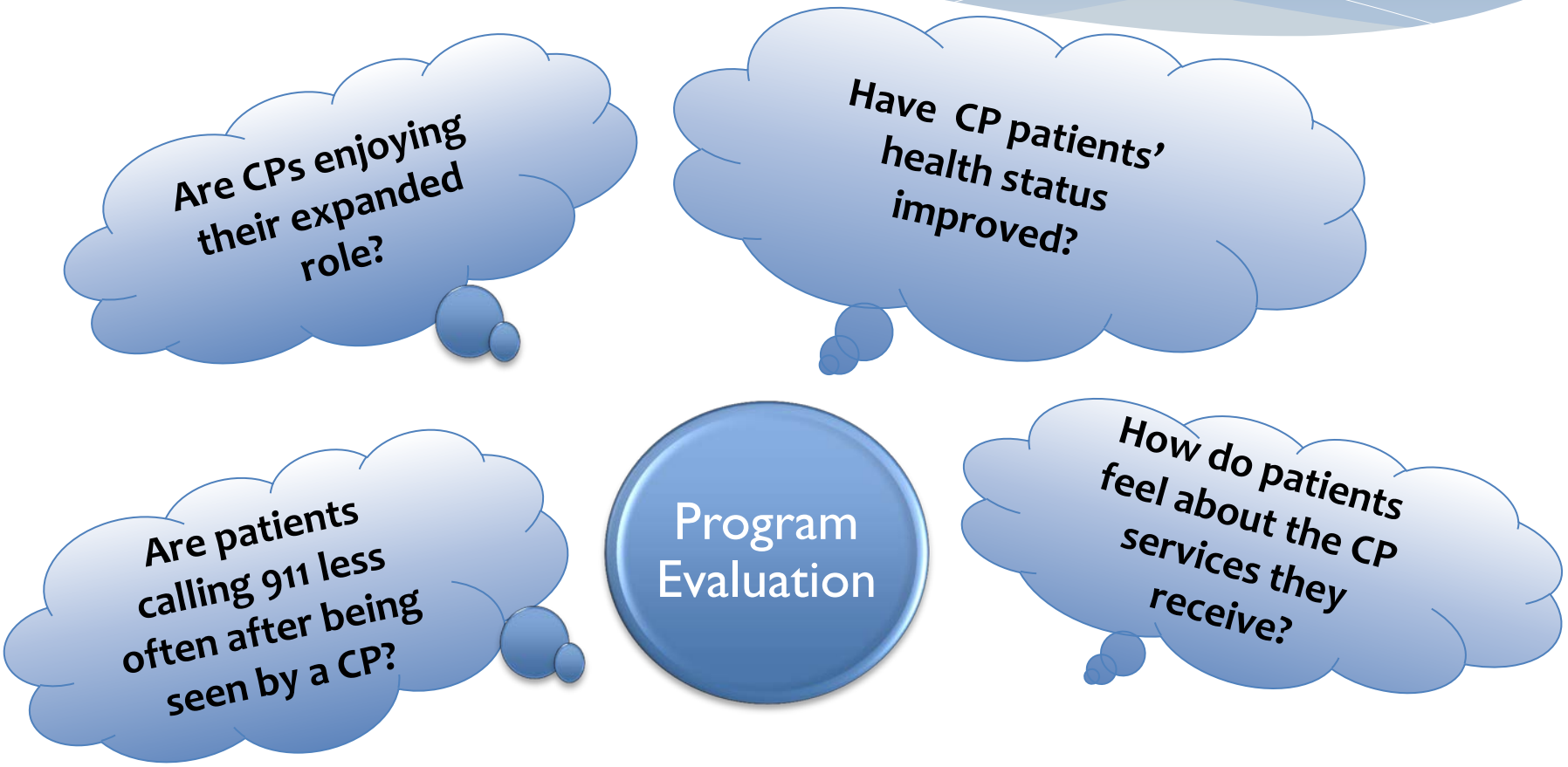
* CPs are reducing the number of 911 calls by providing early intervention to "familiar faces"

CP Home Health Monitoring

* Started enrolling patients in Princeton and Creston week of October 10th
* COPD protocol offered initially

	Communities	CPs	HHM Readiness	Patients Enrolled
Prototypes	2	3	October 10, 2017	10
Phase 1	17	16	December 4, 2017	N/A
Phase 2	12	15	Spring 2018	N/A

Evaluating Community Paramedicine



Thank You

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Information Brief

For Board of Directors

Version: 1.0 (Nov-2017)

EXECUTIVE SUMMARY

Title	Research Ethics Board Annual Report
Purpose	Provide information to the Interior Health (IH) Board of Directors on the work of the Research Ethics Board for the 2016/17 fiscal year.
Top Risks	1. (Other) Inadequate protection for persons who participate in research, if the research has not received ethical approval. 2. (Other) Possible breach of Interior Health obligations for research outlined in the Board of Directors policy 3.13 Research and Research Ethics. 3. (Other) Failure to meet nationally accepted standards for research ethics if resources are insufficient for research ethics functions.
Lead	Wendy Petillion, Chair, Interior Health Research Ethics Board Dorothy Herbert, Coordinator, Interior Health Research Ethics Board
Sponsor	Susan Brown, VP & Chief Operating Officer, Hospitals and Communities

RECOMMENDATION

That the Board accepts this brief for information only.

BACKGROUND

The Research Ethics Board is accountable to the IH Board of Directors and functions independently in decision making. The purpose of the Research Ethics Board is to:

- Provide an independent, multi-disciplinary review of all research involving human participants conducted under the auspices of IH: in IH facilities or programs; by IH staff or physicians; or with IH staff, physicians and/or patients;
- Ensure that all research aligns with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (2014) and other regulations applicable to research conducted with human participants; and
- Ensure that the ethical obligations of research are met before the research commences, thereby protecting research participants, Interior Health and affiliated parties.

DISCUSSION

This Annual Report is intended to highlight the work of the Research Ethics Board in 2016/17 for the Board of Directors.

EVALUATION

n/a

ALTERNATIVES

n/a

CONSULTATION

Position	Date Information Sent	Date Feedback Received	Type of Feedback
Jana Bradshaw, Business Consultant	May 1, 2017	May 5, 2017	Consultation
Deanne Taylor, Director, Research Department	June 7, 2017	June 22, 2017	Consultation
Yvonne Lefebvre, Scientific Director of Research	June 22, 2017	June 22, 2017	Information
Glen McRae, Chief Nursing Officer & PPL	June 22, 2017	June 23, 2017	Consultation

TIMELINES

Milestone	Lead	Date of Completion
Decision brief written	Wendy Petillion, Chair, Interior Health Research Ethics Board	June 8, 2017
Assessment of communication requirements	Wendy Petillion, Chair, Interior Health Research Ethics Board	June 8, 2017
Presentation to SET	Susan Brown, VP & COO, Hospitals and Communities	September 11, 2017
Presentation to the IH Board	Dorothy Herbert, Coordinator, Interior Health Research Ethics Board	December 5, 2017

ENCLOSURES

Interior Health Research Ethics Board Annual Report 2016/17

REFERENCES

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, December 2014.

Interior Health Board Policy 3.13 *Research and Research Ethics,* October 2015.

APPROVAL / ENDORSEMENT

n/a

Name for Approval / Endorsement	Signature	Date

Interior Health

Every person matters

RESEARCH ETHICS BOARD ANNUAL REPORT

April 1, 2016 – March 31, 2017

Wendy Petillion, Chair REB

Dorothy Herbert, Coordinator REB

RESEARCH ETHICS BOARD ANNUAL REPORT

April 1, 2016 – March 31, 2017

Table of Contents

A. Executive Summary

This report highlights the activities of the Interior Health Research Ethics Board (REB) in 2016-17 and provides some insights into the factors that influence research ethics review within Interior Health (IH).

The Research Ethics Office, in addition to supporting ethical review of research, tracks data to help the organization better understand what sort of research is occurring, where it is occurring, and who is leading it

The majority of reviews conducted by the REB are done in cooperation with one or more of the seven other partner institutions in the BC Ethics Harmonization Initiative (BCHEI). This initiative, which formally ended in 2016, aimed to make BC a more attractive environment for research. This is reflected in the upward trend of the volume of new research studies reviewed by the REB over the past few years. In an average year, the REB reviews 70 new studies, a 25% increase from just three years ago. In 2016-17, the REB received 81 new studies for review.

The majority of research initiated in IH is locally driven, with 47 of the 81 studies initiated by IH or UBCO. IH is also a generous supporter of student research, with 39 of the 81 new studies being led by students. Many of these projects are supported in-kind by IH, in return for receiving targeted information about IH's programs, services, patients or residents. In this respect, IH lives up to its commitment to the Academic Health Sciences Network, a provincial organization committed to achieving better health for British Columbians through the integration of clinical care, education and research.

In order to report on what sort of research is being conducted, the IH REB adopted the categories used by the Canadian Institutes of Health Research. This data demonstrates that IH has embraced the recommendations of the 2014 Research Strategy, particularly the recommendation to focus on Population Health and Health Services Research. These two categories comprise 73% of all research submitted to the IH REB in the past year.

The REB currently maintains oversight over 160 active research studies, a jump of 60% in the past 3 years. The majority of this work is done on behalf of the REB by the Research Ethics Office, but the REB still meets monthly to review interventional and higher-risk research studies. The membership of the board can change over time but never varies from the core commitment to provide expertise in the relevant scientific, legal, and community perspectives required for ethical review of research. Presently, the IH REB is preparing to meet the needs of the institution as interest in conducting clinical trials ramps up. The Research Ethics Board has recruited and trained additional members and has worked closely with the Research Department, providing expertise in research policy.

In addition to providing leadership and support for research ethics reviews, the Research Ethics Office (REO) provides consultation services on matters pertaining to research and ethics, provides leadership in research policy development, and provides relevant educational opportunities and resources to REB members, staff, and researchers.

B. Introduction

The Interior Health Research Ethics Board (REB) provides independent ethical review of research that involves human participants and is conducted within the jurisdiction of IH. This includes research that: occurs in any IH facility, department or program; involves an IH staff member, physician, or student as a researcher; or involves IH patients, clients, residents, staff, physicians, volunteers, students, or their information as participants. The REB commenced operations in November 2005, replacing three site-specific Research Review Committees that previously existed in IH, and making REB review accessible to every site, employee, and physician throughout the health authority.

The REB abides by the national standard for research ethics review, the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (2014)*, commonly known as the TCPS2. In addition, the work of the REB aligns with applicable Health Canada and FDA regulations, privacy legislation, and institutional policy. The REB works to provide thoughtful interpretation of these standards in order to promote the highest ethical conduct of research involving human participants.

C. Research Ethics Reviews 2016-17

1. New Research Ethics Applications

For the second consecutive year, the REB received an above-average number of research ethics applications for review. The 10-year moving average number of studies reviewed per year is now 63. Following a bubble in 2015-16 when 99 new research studies were reviewed, the REB received 81 new studies in 2016-17. A number of influences contribute to the increased interest in conducting research at IH over the past few years, and these are discussed later in this report.

The REB approved 68 research studies in the year ending March 31, 2017, with review of the remaining new studies carried forward to the new fiscal year. The REB works with the Principal Investigator (PI) throughout the review process until the study meets conditions for approval.

Nine studies were withdrawn from IH REB review prior to receiving ethical approval. In 8 of the 9 cases, it was the PI's decision to withdraw the study from ethical review because of a change in his or her capacity to conduct the research as planned. In 1 case a study was withdrawn because the infrastructure required to support the research at IH was insufficient. This case involved a clinical trial; at the time it was submitted for ethical review IH had limited capacity to support physicians with clinical trials. Since that time, the IH Research Department, with the cooperation and support of the REB, has invested in additional resources to support physicians affiliated with IH to conduct clinical trials.

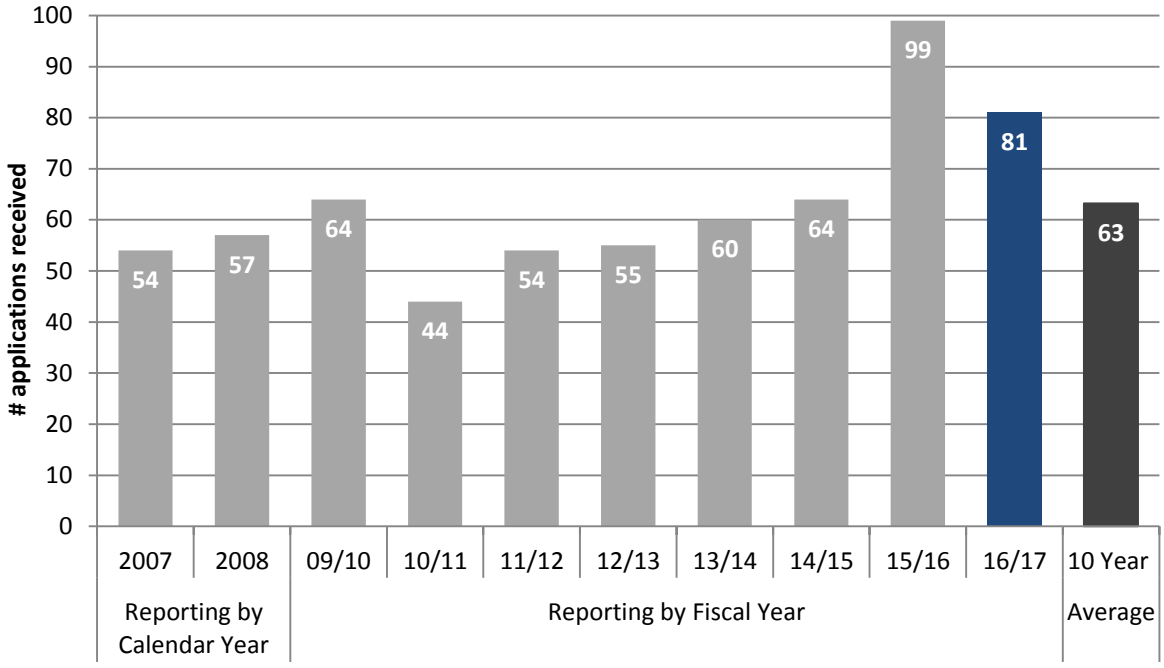

Figure 1: Number of research applications received per year by IH REB

2. Origin of Research Applications

The origin of an application for a new research study is defined as the primary institutional affiliation of the PI. For several years, UBC (Vancouver) has been the primary source of new research applications at IH, but that changed in the 2016-17 fiscal year. Two influencing factors were efforts by IH to promote internal clinicians and employees in research, and the thriving relationship between IH and UBC Okanagan. Thus 25 new studies originated with UBCO, 22 within IH, and 20 from UBC Vancouver in the past year.

IH PIs came from a diverse array of health specialties. Sixty-five percent of the IH-based researchers were physicians. Other disciplines represented include Pharmacy, Nurse Practitioner, Dietitians, Aboriginal Services, the Quality Office, and the HART Team.

The other 12 studies were initiated by researchers with a primary affiliation at other universities including 4 from Royal Roads University, 3 from the University of Victoria, 2 from Thompson Rivers University, and 1 each from A.T. Still University and McGill University. The final 3 studies originated with Fraser Health Authority, Island Health Authority, and a private clinical trial site in Kelowna. (See Figure 2).

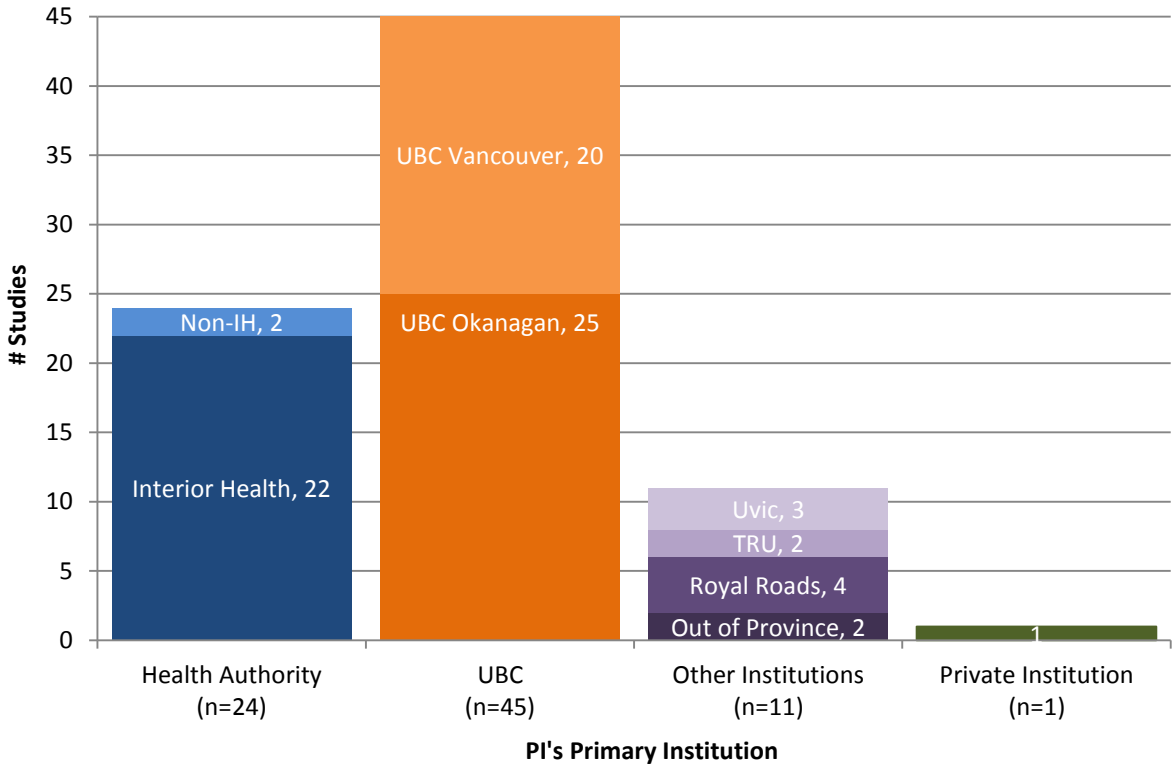

Figure 2: Origin of research by Principal Investigator's primary affiliation

3. Student Research

IH is a part of the BC Academic Health Sciences Network (AHSN), an organization formed in 2016 with a mandate to achieve better health for British Columbians through the integration of clinical care, education and research. IH exemplifies this integration with its high proportion of student-led research projects. In 2016-17, nearly half of the studies submitted to the REB, 39 of 81, were student projects. Not only do these students represent a variety of different universities and disciplines, but the research they are doing involves IH staff from a variety of occupations and in a variety of settings. Midwives, nursing student preceptors, physicians, community-based first responders, Mental Health & Substance Use staff, occupational and physical therapists, and Health Records staff were among the many occupations represented in research as study team members, participants, facilitators or preceptors. In 8 cases, the graduate student conducting the research was also an IH employee.

The workplaces represented by these IH personnel spanned the length and breadth of the health authority and included urban and rural, acute and community, residential, primary care and specialty services. The participation of IH in so many student research projects brought the benefits of research participation closer to home for IH employees and the people they serve.

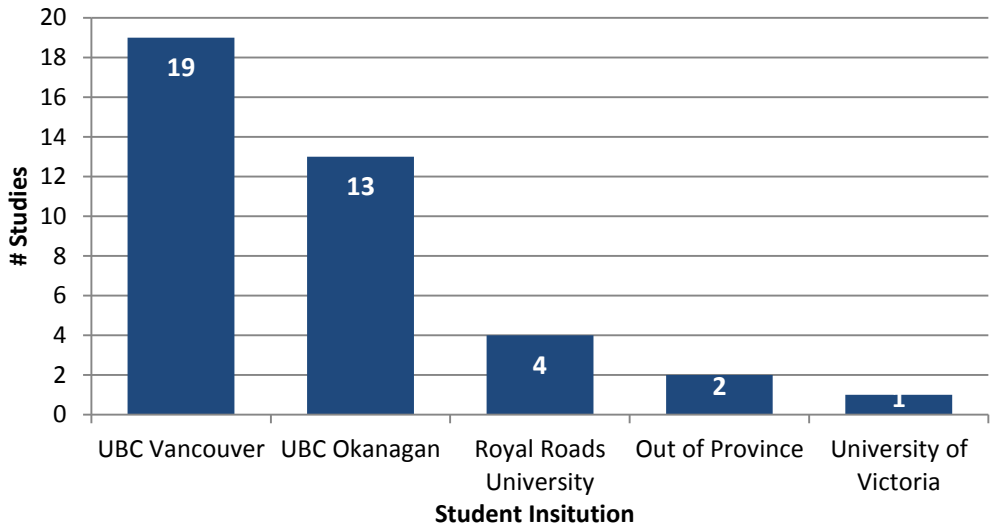

Figure 3: Number of student REB applications by student institution

4. Categories of Research

The Canadian Institutes for Health Research (CIHR) is the premier public funding agency for health research in Canada. CIHR categorizes health research into 4 broad themes, and IH models its categories of research after these themes, allowing IH to articulate where it is developing expertise. The themes are:

- Biomedical: 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.

- Clinical: 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.

- Health Services: 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.

- Social, Cultural, Environmental and Population Health: 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.

Just as research in IH has expanded across geography and across disciplines, it has grown in the past year to represent a more balanced distribution of studies across the four CIHR themes. In recent years, Health Services research dominated the landscape. In 2016/17, IH experienced increases in the proportion of Population Health (26), Clinical (19), and Biomedical Research (3) studies.

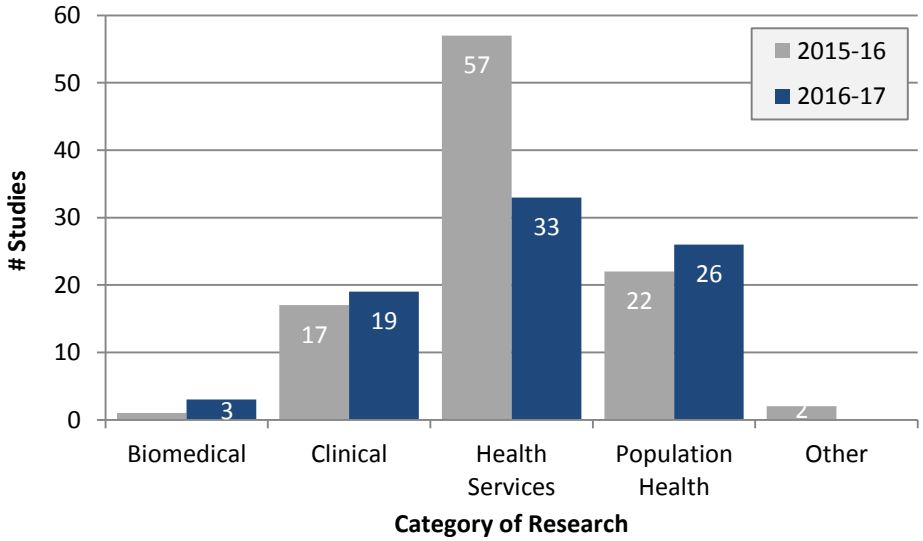

Figure 4: Number of Applications per CIHR Category of Research by year

5. Categories of Ethical Review

There are two research ethics review processes used by Canadian REBs as outlined in the TCPS2. Full board review is required for all research that is deemed to be above minimal risk, and a delegated review process is used for all research that meets the definition of minimal risk:

> *Research that poses no greater risk to the participants than they can reasonably expect to encounter in everyday life.*

In British Columbia, the eight institutional partners[1] of the BC Ethics Harmonization Initiative (BCEHI) also provide harmonized ethical review for multi-jurisdictional research using delegated and full board review processed. Harmonization of REB review has had multiple positive effects including: saving time and duplication of effort for researchers; enabling research that might have remained fairly local to spread easily throughout the province, creating more robust data and results that are more generalizable; and distributing the benefits of research more equitably around the province.

In 2016-17, the REB conducted 83% of all ethical reviews with at least one other harmonized REB partner. This is a stark contrast to 2011-12, when the early efforts of the BCEHI partners led to IH participating in three harmonized reviews for the year, two of which were completed with UBCO under a pre-existing affiliation agreement. Figure 5 shows how collaborative review of research has grown tremendously and now accounts for approximately four out of five ethical reviews conducted by the REB.

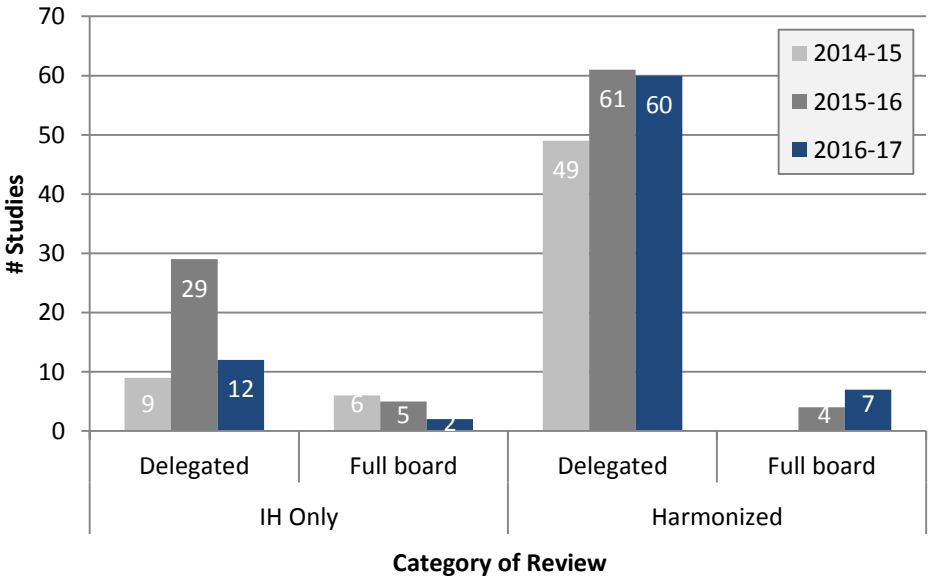

Figure 5: Number of Research Studies per Category of Review by Year

6. Continuing Review

The REB maintains oversight of all active research studies from submission to completion via review of: annual status reports submitted with renewal of ethical approval requests; amendments to research protocols; adverse events reports; safety reports; and closure reports. Each report is assessed for level of risk by REO staff. When the continuing review activity is found to pose greater than minimal risk to participants, it is reviewed by the full board; otherwise this work is done by the REO on behalf of the REB. During 2016-17, the REB maintained oversight of 160 active research studies.

[1] See Appendix 2 for BCEHI partner list

The high number of active studies resulted in a greater number of continuing review activities over the previous year, in every category. The increase in the number of safety reports is not indicative of increased risk to participant safety. Safety reports are reviewed regularly by a sub-committee of the IH REB, and most of the reports they reviewed required no further action be taken. Only one safety report out of 25 resulted in six recommendations being forwarded to the PI and shared with the UBC Clinical REB, with whom the IH REB shares ethical oversight for the research study in question.

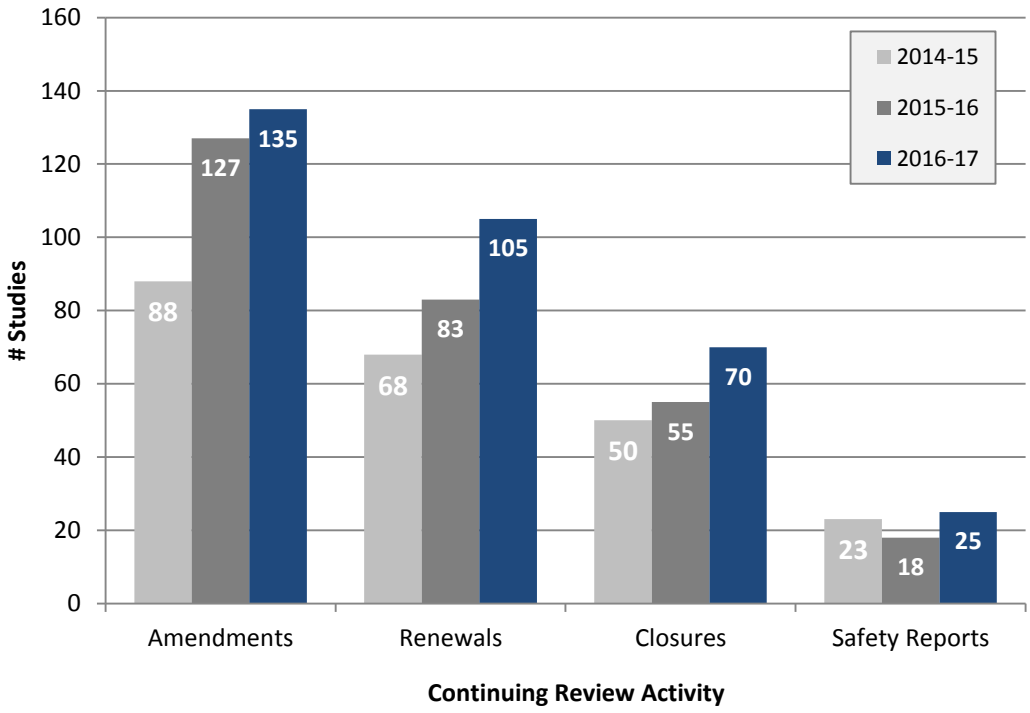

Figure 6: Number of Studies per Continuing Review Activity by Year

C. Consultations

The REO provides ethics expertise to a wide variety of stakeholders both internal and external to the health authority. Frequently, queries concern whether or not REB approval is necessary for a specific project. The REO staff can assist in determining if a project is research versus quality improvement or evaluation, as well as determining whether a given research project falls under the auspices of the REB.

This year there were a cluster of new and unique queries, often related to the intersection of research in private industry and publicly-funded health care services. Examples included: a private clinical trial participant wanting to have their research lab work done at an IH facility when the REB had not reviewed and approved the study; and determining who should sign a non-disclosure agreement for a clinical trial to be conducted in IH.

REO staff collaborates with other IH departments in order to determine the best course of action in response to these queries. We collaborated with Health Records, Laboratory Services, Privacy and Information Security, Executive Medical Directors, the Finance Department and others in order to provide the best advice and promote the high ethical standards this organization strives to achieve.

The 2016-17 fiscal year produced a record number of 65 consultations, where an average year yields 30-40 requests. This could be related to the increased profile of the REB as it enters its twelfth year of operation, and the influence of the *Ethics in Interior Health* framework in promoting an ethical culture throughout the organization.

When a research ethics related query is particularly challenging, the IH REB may consult the Interagency Advisory Panel (PRE or the Panel) on Research Ethics. This expert Panel was created by Canada's three federal research agencies to provide development, implementation and interpretation of the TCPS2.

D. Operations

1. Research Ethics Board Membership

The REB made some carefully considered additions to its membership in 2016-17 in order to meet role requirements and to address gaps left by members whose terms ended. One community member retired from the board and 2 new community members were recruited, both from rural communities. In addition to offering the perspective of REB member not affiliated with the institution, 1 of the 2 new members is affiliated with the First Nations Health Authority and brings expertise in Indigenous Studies. Another new member expressed interest in serving as a reviewer; however her expertise in epidemiology led to an invitation to join as a standing member. A long term goal to have allied health representation was realized with the recruitment of 2 health professionals from that portfolio. The growing presence of nurse practitioners in the health authority is now reflected in the REB membership with 3 recruited as substitute members. Finally, the IH REB has 2 new physician members, precipitated in part when Dr. Michael Ertel, the last founding member of the board, stepped down after 10 exemplary years of service. The current membership of the board is the most geographically diverse it has ever been, with members based in Kamloops, Kelowna, Nelson, Osoyoos, Revelstoke, Summerland, and Trail.

The focus of the REB for the 2017-18 fiscal year is to complete training and mentorship for all new members, and to anticipate and prepare for changes to the Chair role. One of the recommendations of the October 2016 *REB Current State and Recommendations Report* is that the role of Chair be filled by someone external to the IH Research Department. The current Chair's term will end November 2, 2017, and the institution will look to fill the role in a way that best suits the needs of researchers, research participants, REB members, and the institution.

2. Research Ethics Office

The Research Ethics Board is supported by the Research Ethics Office (REO). The office is staffed by a full time Regional Practice Lead, who currently also serves as the REB Chair. A half time Coordinator assists with the management of the REB and review of studies. The Coordinator was replaced with a temporary full-time coordinator for an extended leave for February and March 2017.

The REO worked with other members of the Research Department to transfer responsibility for managing operational approval of research in IH effective February 1, 2017. Though this was a necessary function of the REO staff when the Research Department was nascent and small, as it grew it became possible to cleave oversight of the operational approval process from those who are also involved in the ethical approval. This addressed a concern for potential conflict of interest, as well as clarifying requirements for researchers. The Research Ethics Leader developed policy *RD0300 Operational Approval to Conduct* Research, which was approved in November 2016.

In August 2016, the REB Coordinator developed 6 standard operating procedures outlining processes for:

- Orientation of REB members
- Archiving of REB documents
- Initial review of REB applications
- Amendments to an REB approved project
- Renewal of REB approval
- Closure of a research project.

These procedures provide guidance for REO staff in managing the increasing volume of research ethics review activities.

3. Education

The REO both provided and participated in a variety of educational opportunities in 2016-17. The REB Chair attended the premier event for REBs, the Canadian Association of Research Ethics Boards (CAREB) conference in May of 2016. The knowledge gained was shared with REB members and staff and is a daily influence in the work of the Chair.

The IH Research Department, including REO staff co-hosted the Rural Health Services Research Conference, hosted at Thompson Rivers University in April of 2016. The conference provided opportunities to focus on conversations of integrating research ethics in rural health research.

In recognition of the fact that the REB serves a population that is geographically dispersed, the REO develops resources with the goal of making information accessible, relevant, and when possible, self-guided. *A Beginner's Guide to Ethics in Human Research* was presented several times in 2016 to various student groups, REB members, and the IH Research Network. The information is also part of the orientation package for new REB members; another resource that was extensively updated in early

2017. The *IH REB Application for Ethical Review form* was redeveloped to provide learning opportunities for researchers embedded into the application process. Each section of the application now comes with extensive Guidance Notes and additional references.

Finally, to keep current in research ethics and related knowledge, REO staff took part in a number of online educational courses this year. The Regional Practice Lead and the REB Coordinator are IH gold level privacy ambassadors, and both recently obtained re-certification in TCPS2, including new modules on multi-jurisdictional research and research involving Aboriginal peoples. Further training was accessed through the Collaborative Institutional Training Initiative (CITI) at the New York University School of Medicine (formerly at the University of Miami). CITI is a recognized leader in research ethics education, training more than 1 million researchers annually. REB staff completed courses in Good Clinical Practice (GCP), which is an international ethical and scientific quality standard for the conduct of clinical trials; Social & Behavioural Research; and a specialized course in GCP for REB members.

4. Financial Report

Apart from support provided by its host institution, REBs may receive revenue through fees generated by the ethical review of research. The industry standard is that institutional REBs do not charge a fee for review of research funded by government or foundation grants, nor for research funded by unrestricted grants from the private sector. This leaves clinical trials funded by drug or device companies as the sole source of external revenue.

When the REB was new and first created a budget, it was estimated that it would review 12 clinical trials per year, at a fee of $1500, yielding expected revenue of $18,000 annually. This did not materialize, but this revenue remains as a line item.

In recent years, few clinical trials have come to IH however interest is noticeably ramping up. The REB has assessed its review fee and brought it in line with other BC REBs, raising it to $3000 for initial review and $500 for annual renewal of ethical approval effective April 1, 2016. Only one industry-sponsored clinical trial was reviewed in 2016-17, however, the Research Ethics Office is aware of growing interest and expects this to increase significantly in 2017-18.

The *REB Current State and Recommendations Report* which was presented to the Scientific Director of Research in October 2016 contained a recommendation to compensate all REB members for their service, as is common for other BC REBs. Currently, only physician members are compensated, under a contract process through Physician Compensation. Another recommendation was to recruit a Chair who is external to the Research Department and provide compensation in line with other health authority REBs. These recommendations will have an impact on the REB budget when they are adopted in the next fiscal year.

REB statement of revenues & expenses for the year ending March 31, 2017

	Actual	Budget	Variance
	Revenue		
Reading fees	(3,000)	(18,000)	(15,000)
Other Sources	(9,209)	0	9,209
	0	0	(5,791)
	Expenses		
Wage*	63,447	48,727	(14,720)
Non-wage	5,341	7,748	(2.407)
	68,788	56,475	(12,313)
	Total Surplus/(Deficit)		
	(68,788)	(56,475)	(12,313)

**excludes Wage Benefits*

Source: IH Insight Financial Statements, DPT 1002.71.1102515
Prepared: May 5, 2017, J. Bradshaw

The revenue variance is primarily due to a historical budget expectation for reading fees for reviewing clinical trials which never materialized.

The expense variance is primarily a result of an increase in staff hours which was required to meet the growing needs of the research department. This majority of this wage increase is offset by revenue from BC Ethics Harmonization Initiative (BCEHI).

E. Summary

Research in Interior Health is in a phase of rapid growth and change, and this clearly impacts both the volume and type of work that the REB performs. Evidence suggests that this trend will continue, buoyed by the influence of ethics harmonization and by the growing interest in developing a cadre of affiliated physician-investigators to conduct clinical trial research. Clinical trial research will bring with it the need for more full-board reviews. The REB has responded to this growth in a number of ways:

- additions to its membership, including nurse practitioners, allied health professionals and new community members
- a comprehensive list of recommendations derived from a detailed review of its operations
- frequent collaboration and consultation with REB partners throughout BC
- development and provision of educational resources for REB members and researchers
- continuing education for REO staff that supports the provision of high quality ethical reviews
- participation in the review of our principal national policy, the TCPS2

- development of standard operating procedures to ensure the smooth and consistent flow of operations
- substantial re-development of the orientation and training procedures for new REB members

The REB and the REO welcome the challenges and opportunities that characterize this dynamic research environment.

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5. Appendices

- REB Membership list
- BCEHI list of member institutions

6. References

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*, December 2014. Retrieved from http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/Default/.

Research Ethics Board Current State and Recommendations Report 2016

Appendix 1:

Research Ethics Board - Voting Members as at March 31, 2017						
Name	**Gender**	**Date Appointed**	**Highest Degree**	**Primary Specialty**	**Role**	**IH Affiliate**
Armstrong, Jan	F	Aug 2016	--	Community member	Community Member	No
Bernhardt, Jesse	M	Jun 2015	J.D	Law	Legal	No
Arockiasamy, Dr. Vincent	M	Mar 2017	MD	Pediatrics, Neonatal-Perinatal Medicine	Scientific	Yes
Gorman, Dr. Sean	M	Nov 2014	PhD	Pharmacy	Scientific	Yes
Kjorven, Mary	F	Dec 2012	MsN	Clinical Nurse Specialist, Geriatrics	Scientific	Yes
Manossa, Geraldine	F	Aug 2016	MA	Indigenous Studies	Community Member	No
Mori, Julie	F	Mar 2017	PhD	Epidemiology	Scientific	Yes
Ogborn, Dr. Malcolm	M	Mar 2015	MD	Pediatrics, Nephrology	Scientific	Yes
Parker, Brent	M	Mar 2015	BSc	Population & Public Health, Statistics	Scientific	Yes
Petillion, Wendy	F	Sep 2013	MHS	Nursing, Ethics	Ethics, Scientific	Yes
Purdon, Dr. Mike	M	Sep 2013	MD	Family Medicine	Scientific	No
Secord, Dr. Jon	M	Mar 2017	MD	Emergency Medicine, Rural Family Practice	Scientific	Yes
Szostak, Dr. Carolyn	F	Sep 2013	PhD	Psychology, Social Sciences, Ethics	Ethics, Scientific	No

Research Ethics Board – Substitute Members as at March 31, 2017						
Name	**Gender**	**Date Appointed**	**Highest Degree**	**Primary Specialty**	**Role**	**IH Affiliate**
Balfour, Jennifer	F	Mar 2017	MsN	Nurse Practitioner	Scientific	Yes
Klassen, Pamela	F	Mar 2017	MsN	Nurse Practitioner	Scientific	Yes
Nakano, Grace	F	Mar 2017	MN	Nurse Practitioner	Scientific	Yes
Nicol, Judy	F	Nov 2013	BSW	Ethics, Social Work	Ethics	Yes
Reiswig, Joan	F	Mar 2017	M. ED	Dental Hygiene	Scientific	Yes
Stubbings, Matthew	M	Mar 2017	RT	Respiratory Therapy	Scientific	Yes
Slavik, Dr. Richard	M	Jun 2007	PhD	Pharmacy, Clinical trials	Scientific	Yes

Research Ethics Board - Staff	
Herbert, Dorothy	Research Ethics Board Coordinator
Adderley, Coleen	Research Ethics Board Coordinator

All voting members are Canadian citizens or permanent residents of Canada.

The Research Ethics Board is organized and operates in accordance with applicable laws and regulations, including: Section 3 of the Health Canada Good Clinical Practice: Consolidated Guidelines, 1997; Part C, Division 5 of the Food and Drug Regulations, and all provincial and federal privacy legislation.

The Research Ethics Board complies with US Dept of Health and Human Services (HHS) Code of Federal Regulations Title 45, Part 46 (45 CFR 45); and the HHS Health Insurance Portability and Accountability Act (HIPAA).

The IH REB Federal wide Assurance (FWA) Number is 00010352.

Appendix 2:

The BC Ethics Harmonization Initiative (BCEHI)

BCEHI is a collaborative effort among British Columbia's regional health authorities and 4 major research universities, who collectively conduct more than 80 percent of the province's human subject ethics reviews.

Partner Organizations

Fraser Health

Interior Health

Island Health

Northern Health

Simon Fraser University

University of British Columbia* (representing multiple institutions – see below)

University of Northern British Columbia

University of Victoria

* Institutions represented by UBC

Vancouver Coastal Health

Providence Health Care

BC Cancer Agency

Children's and Women's Health Centre of BC

Research Ethics Board Annual Report 2016/17

Presentation for the IH Board of Directors

December 5, 2017

Interior Health

Every person matters

REB Mandate

* Provides independent, multi-disciplinary review for ethical acceptability of research involving humans under the auspices of IH

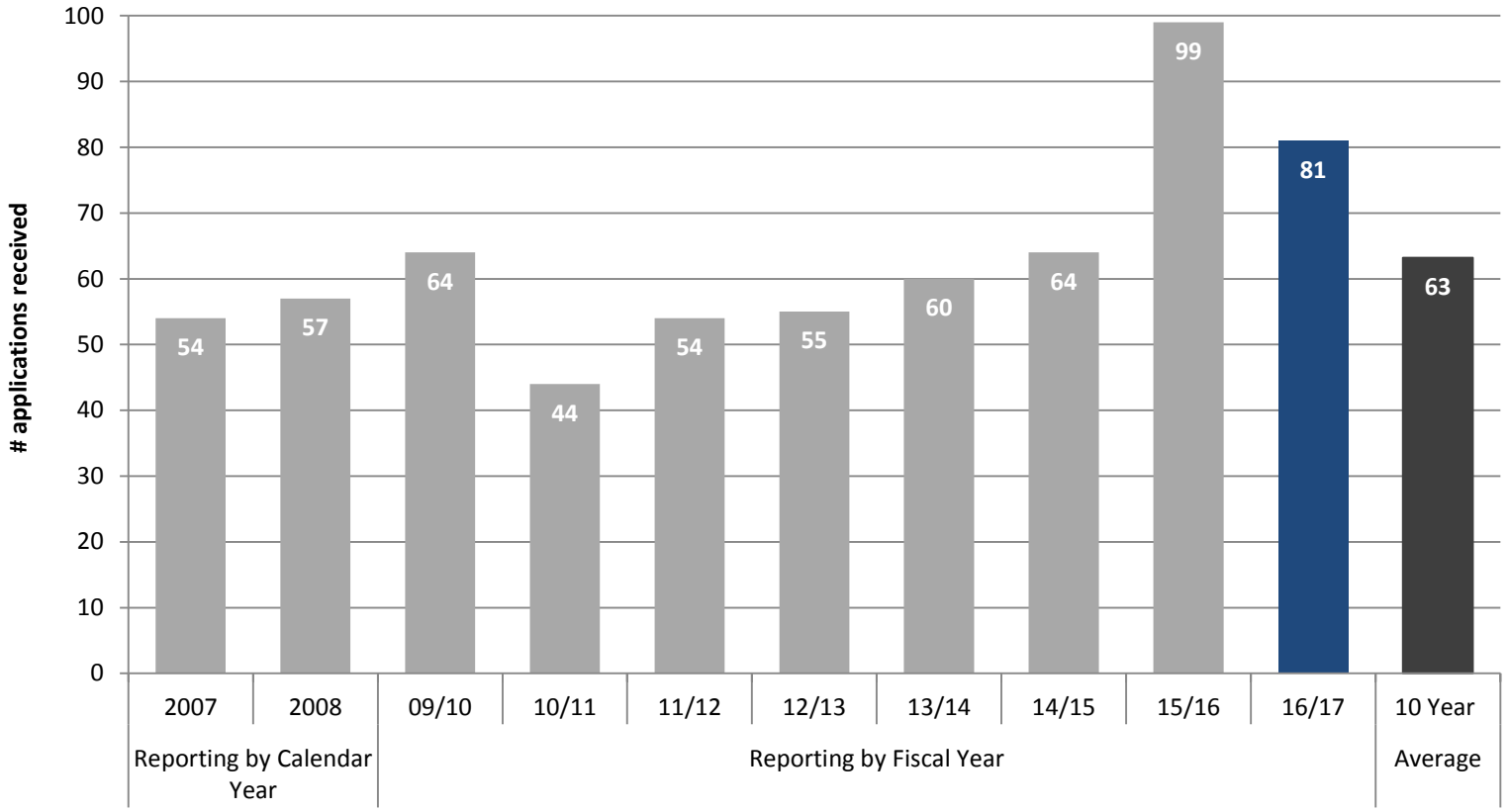
* Protects the rights and interests of research participants

* Accountable to the IH Board per policy 3.13 Research and Research Ethics

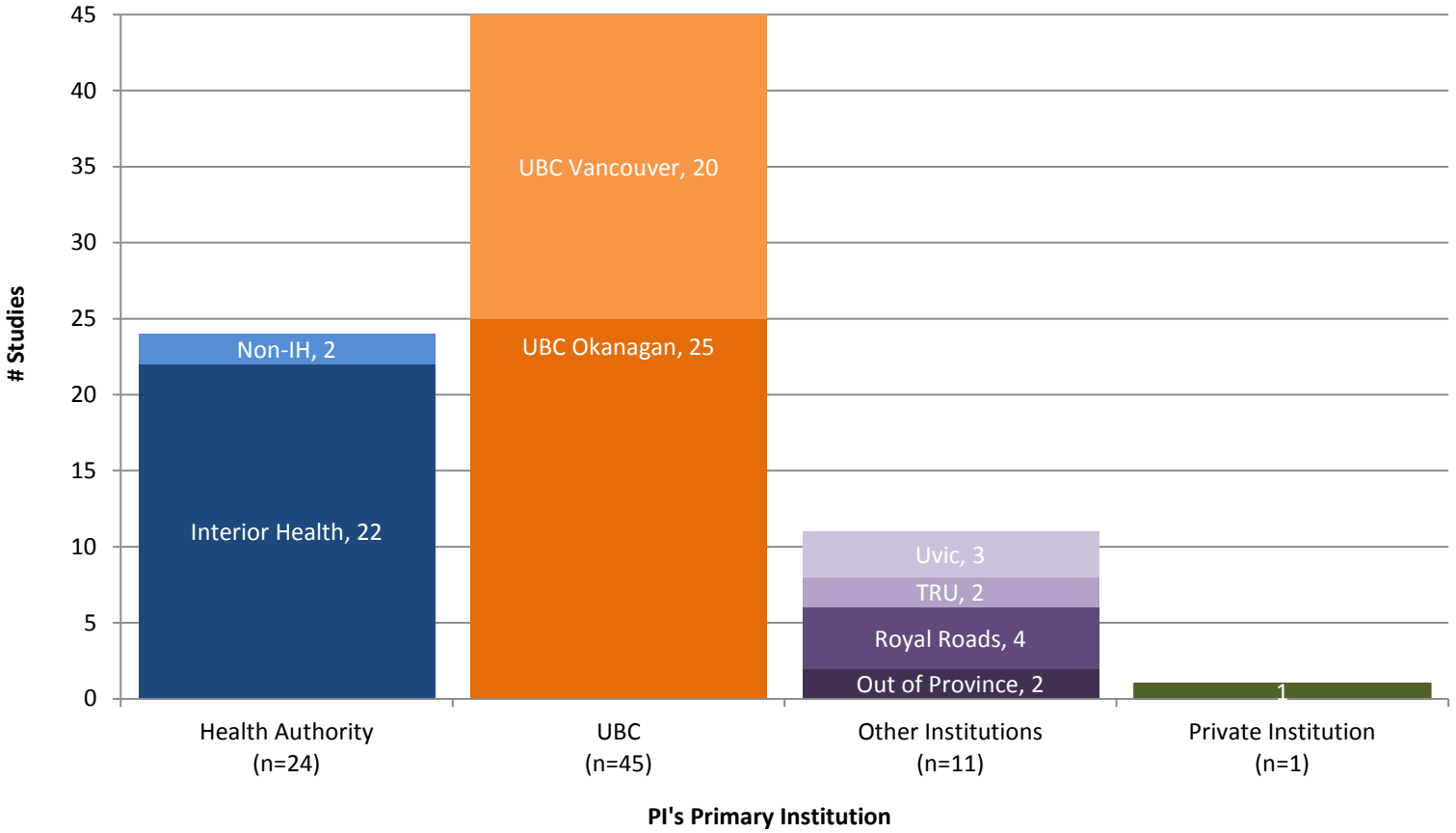
Out of Scope for REB Review

* QI projects and Evaluation
* Research not involving humans
* Research outside of Interior Health
* Research in which IH employees are acting outside of Interior Health

Number of new studies by year

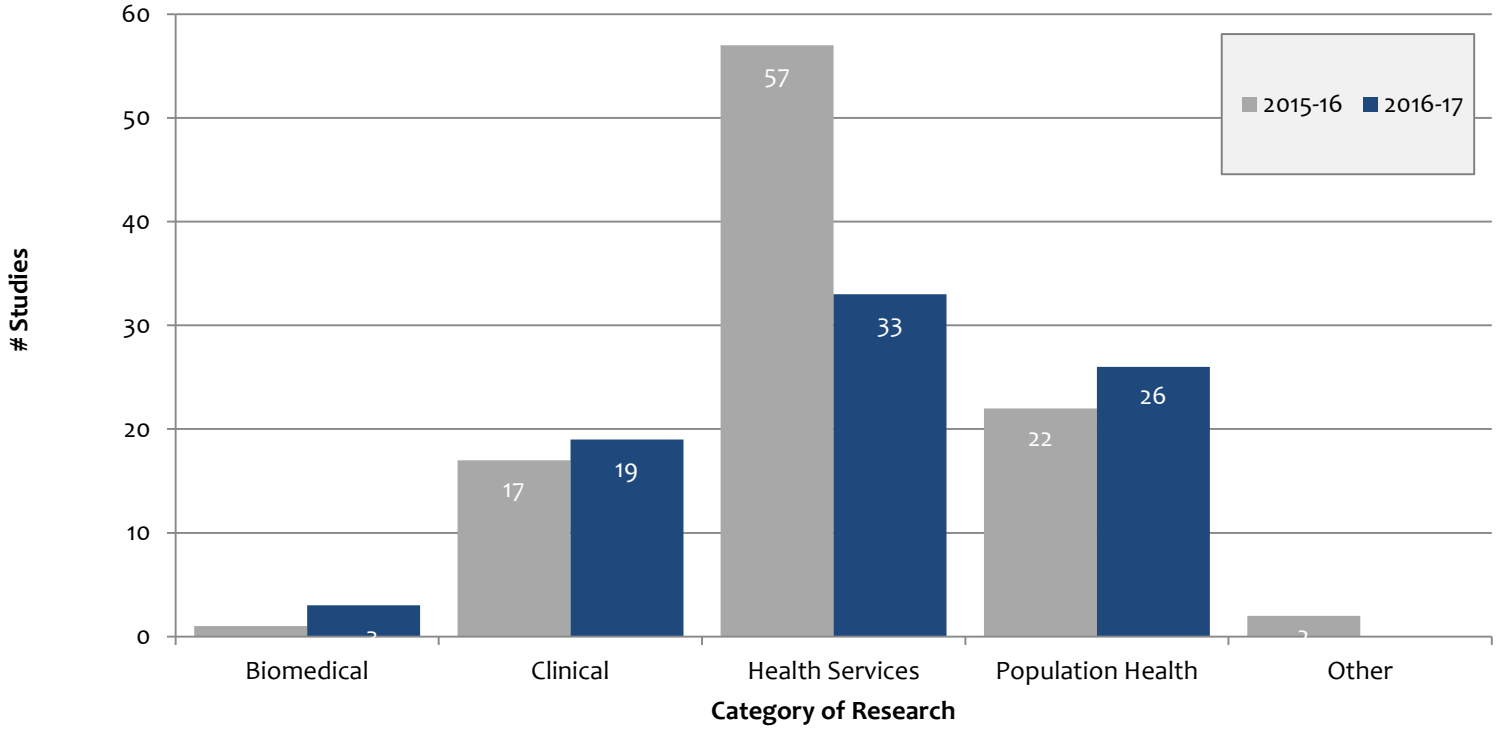


Origin of Applications

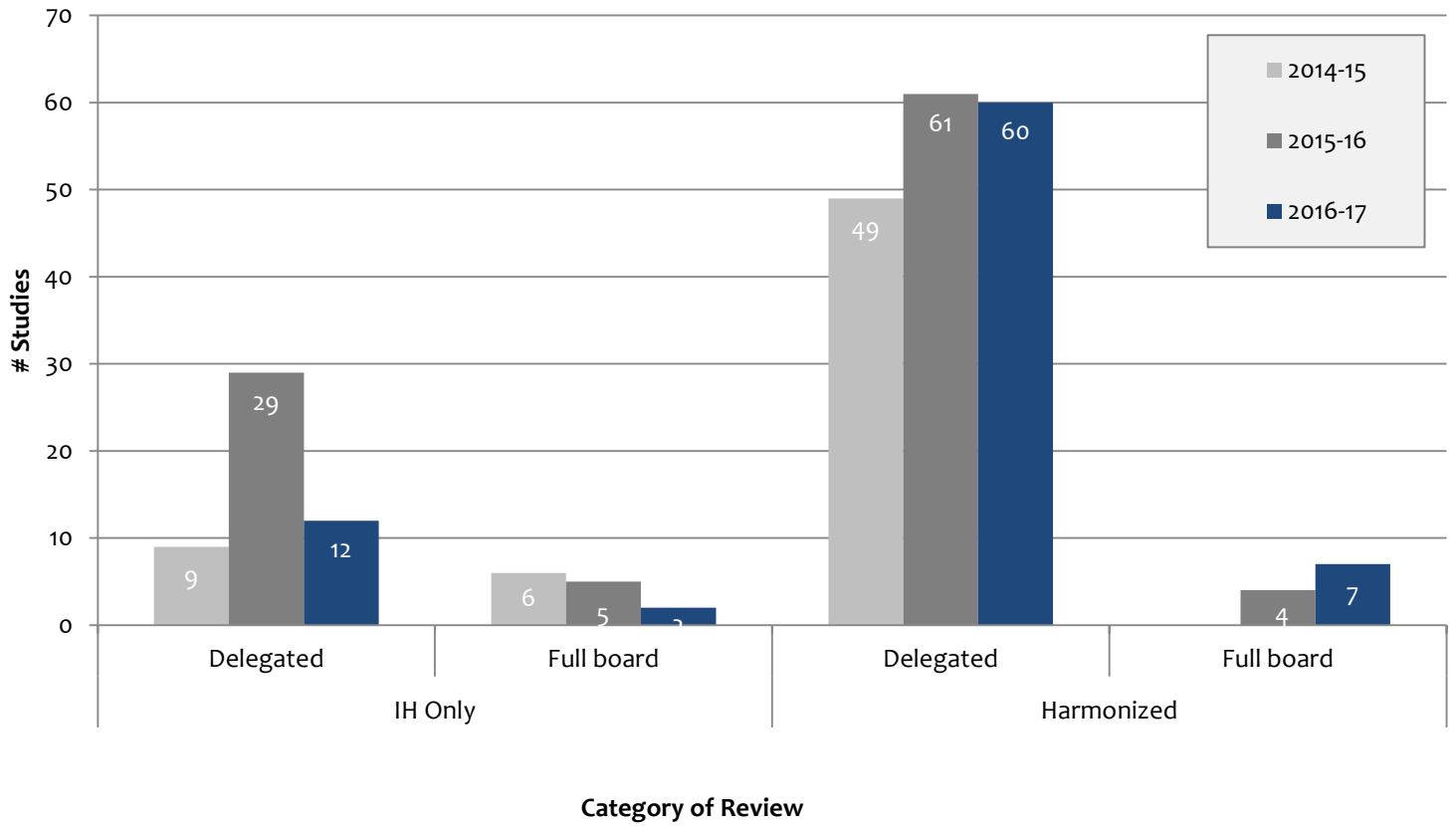


Every person matters

Categories of Research



Types of ethical review



Every person matters

Summary

* IH REB has been responsive to rapid growth and change
* Recruitment and training of REB members and reviewers
* Resources for researchers and REB members
* Looking forward

Thank you for your ongoing support of research in IH

Decision Brief

For Board of Directors

Version 1.2(Nov-2017)

EXECUTIVE SUMMARY

Title	*Board Policy 3.11 - Risk Management* Revisions
Purpose	To review revisions to Board Risk Management Policy as directed by recommendations from Internal Audit Enterprise Risk Management Maturity Assessment.
Top Risks	1. (Other) Board Risk Management policy may not reflect current practice at Interior Health.
Lead	Patty Garrett, Director Risk Management
Sponsor	Dr. Michael Ertel, VP Medicine & Quality

RECOMMENDATION

That the Board approves the revisions to *Board Policy 3.11Risk Management*

BACKGROUND

In 2015 Internal Audit completed an Enterprise Risk Management maturity assessment. The final reported included a number of recommendations. One of the recommendations directed at the Board was to:

…enhance their Risk Management Policy to further define the CEO and Senior Executive Team roles to include responsibility for:

a. providing direction and oversight to ensure key risks are addressed;
b. assigning 'owners' to each risk who will manage and monitor the risk treatment strategies; and,
c. implementing and maintaining effective ERM programs in VP portfolios.

DISCUSSION

The Board Risk Management Policy has been revised in the following ways:

1. Page 2- Removal of 3 (4) - As most activities are not discrete therefore Senior Executive Team felt that this statement was not necessary.
2. Page 5-Addition of the responsibilities of the Strategic and Risk Management Council as reflected in the Council's terms of reference.
3. Page 6-Addition of the minimum requirements of an effective ERM program.
4. Page 6- change from March to Annual and change from October to Annual to allow flexibility in completion and review of Enterprise Risk Registers and mitigation plans.
5. Document as a whole- Language was significantly revised to improve readability and comprehension but did not alter the intent of the policy.

EVALUATION

The Risk Management Department will continue to review the Board Risk Management Policy as advised by SRMC, SET or the Board.

ALTERNATIVES

The Board of Directors may wish to provide comments on the revisions.

CONSULTATION

Position	Date Information Sent	Date Feedback Received	Type of Feedback

Givonna Debruin, Corporate Director Internal Audit	May 12, 2017		Endorsed changes
Renee Wasylyk	July 25, 2017	July 25, 2017	Endorsed changes

TIMELINES

Milestone	Lead	Date of Completion
Decision brief written	Patty Garrett, Director Risk Management	May 12, 2017
Assessment of communication requirements	Patty Garrett, Director Risk Management	May 12, 2017
Presentation to Strategy and Risk Management Council	Patty Garrett, Director Risk Management	August 2, 2017
Presentation to SET	Patty Garrett, Director Risk Management	September 11, 2017
Presentation to the Board	Patty Garrett, Director Risk Management	December 5, 2017

ENCLOSURES

Board Policy 3.11 - Risk Management December 2017 Revised

REFERENCES

n/a

APPROVAL OF RECOMMENDATIONS

Name for Approval / Endorsement	Signature	Date

RISK MANAGEMENT POLICY

1. INTRODUCTION

1.1. As Interior Health (the "Authority") carries out operations to meet its Mission to "Promote healthy lifestyles and provide needed health services in a timely, caring and efficient manner, to the highest professional and quality standards", there are a number of risk factors that can cause uncertainty in achieving this.

1.2. Risk management is the coordinated activities to direct and control an organization with regard to managing the effects of these uncertainties. This means identifying, analysing, evaluating and treating risks in a timely manner so that their potential effects are reduced to acceptable levels. While structured reviews are meant to be conducted on a regular basis, any serious risks that become apparent should be reported immediately to management for review and treatment.

1.3. Other benefits sought from the Enterprise Risk Management ("ERM") program are, support for better management planning and decision making, detection of new opportunities and better usage of limited resources.

1.4. The purpose of this policy is to establish a general framework for the Authority's risk management program and its overall objectives. Responsibility for implementation of this program and its effective operation will rest with Management.

1.5. The *Terms of Reference for the Board of Directors* requires the Board of Directors (the "Board") "ensure management identifies the principal financial and non-financial risks of the Authority and implements systems and programs to manage these risks".

2. OVERALL OBJECTIVES

The objectives of the Authority's risk management program are:

a. recognize risk management as critical to the achievement of Authority goals and governance responsibilities;

b. integrate Enterprise-Wide Risk Management into the organizational culture;

c. maintain a proactive approach to the identification, analysis, evaluation and treatment of potential risks at optimal levels of assurance for stakeholders and at minimum cost to the Authority;

d. establish a risk management process that is clearly defined and documented and fully integrated with other strategic and operational processes;

e. continuously apply risk management practices and disciplines in decision-making including proper accountability, performance monitoring, and improvement of planning and practices; and

f. identify, commit and train the resources necessary to implement effective ERM practices.

3. ENTERPRISE RISK MANAGEMENT FRAMEWORK

3.1. The Enterprise Risk Management Framework (the "Framework") is based upon the International Organization for Standardization's ISO 31000 Risk Management - Principles and Guidelines, and aligns with the risk management guidelines set out by the Province of British Columbia's Risk Management Branch and Government Security Office.

3.2. The Framework is the foundation for ensuring that information derived from the risk management process is adequately reported and used as a basis for decision making and accountability at all relevant organization levels.

3.3. At an organization level the Framework consists of:

a. policies and procedures related to risk management;

b. the risk management process; and

c. supporting systems for tracking risk information, providing education and consultative services.

~~3.4 Since risk management does not work in isolation in the organization, a number of the Framework's activities may overlap or blend into other areas of the Health Authority, for example strategic planning and incident management.~~

3.5 The process flow of the Framework follows a regular cycle of:

a. reviewing the design of the Framework to ensure that it is still appropriate and effective;

b. implementing required modifications;

c. monitoring and reviewing the performance of the Framework; and

d. developing and incorporating improvements derived from monitoring of the Framework into the next redesign cycle.

RISK MANAGEMENT POLICY

4. RISK MANAGEMENT PROCESS

To guide the identification, analysis and treatment of risks, the Framework risk management process follows the cycle as outlined below.

4.1. Establishing the context

To set the scope and risk criteria for the process, the objectives, strategies, scope and parameters of the activities of the Authority, or those parts of the Authority where the risk management process is being applied, will be established.

4.2. Risk identification

Identification will include risks, whether or not their source is under the control of the Authority, and even if the risk source or cause may not be evident. Risk identification will consider scenarios where there are knock-on effects, including cascade events, or the compounded effects of multiple events.

4.3. Risk analysis

Risk analysis involves consideration of the causes and sources of risk, their positive and negative consequences, and the likelihood that those consequences can occur.

4.4. Risk evaluation

Risk evaluation assists with making decisions and setting implementation priority for risks requiring treatment, and are based on the outcomes of the risk analysis.

4.5. Risk treatment

Risk treatment involves selecting one or more options for modifying risks so that risk effects are reduced to acceptable levels.

4.6. Communicate and consultation

Communication and consultation with external and internal stakeholders will take place during all stages of the risk management process.

4.7. Monitor and Control

Monitoring and control processes encompass all aspects of the risk management process for the purposes of ensuring components are effective and efficient in both design and operation, and obtaining further information to improve the risk management process.

4.8. **Risk Management Process Cycle**

a. This Risk Management Process cycle is repeated at regular intervals (at least annually) with a frequency that is established according to the area being assessed and operational needs.

b. The annual cycle will conclude in advance of the annual Senior Executive Team Strategic Planning session.

c. An update of the ERM program, including identified risks and mitigation strategies, will be presented to the in camera Board meeting for discussion at least once per year.

4.9. **Risk Register**

Information on risks is maintained within a risk register. Risks of greatest concern are elevated to the Strategy and Risk Management Council and/or Senior Executive Team for consideration. Certain risks may also be reviewed by the Board.

5. RISK MANAGEMENT STRUCTURE & ROLES

5.1. **Risk Management Office**

The Authority's ERM program is coordinated and monitored by the Risk Management Office (RMO). The RMO will:

a. recommend specific risk management practices and methodologies;

b. assist management in the formal review of the specific risks identified;

c. maintain the enterprise risk register;

d. promote conformity in the management of risks across the organization by setting appropriate standards;

e. developing/acquire common risk management tools and event tracking databases;

f. develop or acquire measurement tools that span organizational boundaries;

g. provide guidance, training and expertise in support of the Framework;

h. monitor the operation of the ERM program and ensure reports are distributed in accordance with the accountability structure; and

i. periodically re-examine the effectiveness of the ERM program and recommend changes as appropriate.

j.

5.2 **Strategy and Risk Management Council**

The Strategy and Risk Management Council performs the Risk Committee function for the Authority's Enterprise Risk Management program, by reviewing the appropriateness of items on the enterprise risk register; monitoring the implementation of risk mitigation plans and their effectiveness; and recommending additions/deletions of risk items.

5.3 **Internal Audit**

In the course of its continuing audit of current and developing control systems, Internal Audit will:

a. gather information on all aspects of the ERM program and how it is functioning across the Authority; and

b. provide the President and Chief Executive Officer (the "CEO") and Senior Executive Team (the "SET") and the Board with an independent assessment of the strengths and weaknesses of the program and advise on where changes in either policy or process may be desirable.

5.4 **President and Chief Executive Officer and Senior Executive Team**

As part of their management responsibilities for the Authority, the CEO and SET will:

a. determine and provide the resources needed to implement and maintain an effective ERM program including at a minimum:

i. risk registers at the Corporate and Vice President leadership levels;

ii. assigned risk owners for all strategic and high scoring risks on the corporate risk register risk heat map; and

iii. effective ERM programs, which include updated risk registers, assigned risk owners and defined VP portfolio mitigation strategies.

b. define the roles of management and management committees, ensuring a clear assignment of responsibility for the effective implementation of the ERM program;

c. monitor the operation of the ERM program and provide the Board:

i. an annual update on the ERM program including identified risks and mitigation strategies; and

ii. an annual update outlining any changes to previously identified risks and mitigation strategies;

d. provide updates as required to Board Committees in respect to the categories of risk with which the Committee is directly concerned; and

e. recommend any changes in policy or process which may be needed to realize the overall objectives of the Authority's risk management program.

5.5 **Board Committees**

The Audit & Finance, Governance & Human Resources, Quality, and Strategic Priorities Committees of the Board will:

a. receive updates as required in respect to categories of risk for which the Committees are directly concerned;

b. receive from time to time independent reports of the Internal Auditor;

c. keep the Board informed of any major incident reports; and

d. recommend to the Board any need for changes in policy or process.

5.6 **Board of Directors**

The Board will:

a. Have a continuing understanding of the principal risks associated with the Authority's objectives.

RISK MANAGEMENT POLICY

b. Ensure management keeps the Board and its committees well informed of changing risks.

c. Review ERM program functioning and identify any need for changes in policy or process;

d. Receive an update from management on the ERM program including identified risks and mitigation strategies on an annual and as required basis;

e. Receive an update from management on any changes to the annual ERM program and any identified risks and mitigation strategies; and

f. Maintain a supportive stance, reinforcing the importance of effective risk management in all decision-making relevant to the achievement of the Authority's Mission and its accountability to its stakeholders.

DRAFT MINUTES OF OCTOBER 3, 2017
REGULAR BOARD MEETING
9:00 am – 10:30 am
5th Floor Boardroom – 505 Doyle Avenue

Board Members:

Dr. Doug Cochrane, Chair
Ken Burrows
Debra Cannon
Patricia Dooley (T)
Diane Jules
Dr. Selena Lawrie
Dennis Rounsville
Cindy Stewart
Tammy Tugnum

Resource Staff:

Chris Mazurkewich, President & Chief Executive Officer (Ex Officio)
Debra Brinkman, Board Resource Officer (Recorder)

Guests:

Susan Brown, VP & COO, Hospitals & Communities
Dr. Trevor Corneil, VP Population Health & Chief Medical Health Officer
Mal Griffin, VP Human Resources
Donna Lommer, VP Support Services & CFO
Norma Malanowich, VP, Clinical Support Services & Chief Information Officer
Dr. Glenn Fedor, Chair, Health Authority Medical Advisory Committee (T)
Anne-Marie Visockas, VP, Health System Planning, MHSU, Residential Services
Givonna De Bruin, Corporate Director, Internal Audit

Presenters:

Joseph Savage, Director, Standards, Quality & Practice, Mental Health Substance Use
Corinne Dolman, Practice Lead, Mental Health Substance Use
Gillian Frosst, Epidemiologist

(R) Regrets (T) Teleconference (V) Videoconference

1. CALL TO ORDER

Chair Cochrane called the meeting to order and welcomed Board Directors, staff and visitors.

1.1 Acknowledgement of the First Nations and their Territory

Chair Cochrane respectfully acknowledged that the meeting was held on the Okanagan Nation traditional territory. Director Jules offered a pray of thanks.

1.2 Approval of Agenda

Director Tugnum moved, Director Burrows seconded:

Motion: 17-22 **MOVED AND CARRIED UNANIMOUSLY THAT** the Board approve the agenda as presented.

2. PRESENTATIONS FROM THE PUBLIC

None

3. PRESENTATIONS FOR INFORMATION

3.1 Wildfire Response, Recovery and Recognition

Chris Mazurkewich provided a report on the response to the wildfire emergency that took place throughout many communities in the Cariboo and Thompson region this summer. He wished to acknowledge that Interior Health relied heavily on private businesses, community services, First Nations communities, municipalities, Thompson Rivers University, Northern Health Authority, First Nations Health Authority, Provincial Health Services Authority and the Armed Forces during the evacuation events. It was a massive collaborative effort with an amazing response. Due to outstanding leadership an outstanding response emerged however, there were lesson learned and those will be forthcoming. The Minister of Health, Adrian Dix also came to the areas affected by the wildfires and met with staff and physicians and personally thanked those who provided aid and comfort. Many heartwarming stories came out of this tragedy.

Chair Cochrane asked how the health authority will support citizens who may require assistance as they cope with the trauma of the events in their communities. Chris Mazurkewich, Anne-Marie Visockas and Norma Malanowich commented that Interior Health's Mental Health and Substance Use professionals are aware of the issues within communities and for First Nations communities and are collaborating with the First Nations Health Authority. The BC Emergency Management System (BCEMS) are also working on a coordinated approach to assist those communities who are struggling.

The Board expressed their sincere gratitude to all those who assisted in this unprecedented event.

3.2 Interior Health Community Overdose Profile for Kelowna

Dr. Trevor Corneil reported that from January 1 to June 30, 2017, a total of 122 illicit drug overdose deaths were reported in the IH region (32.5 per 100,000). Among these, 46 deaths occurred in Kelowna (73.2 per 100,000). Joseph Savage spoke about the community profile for Kelowna. Currently, the Okanagan is the most affected region in Interior Health with overdose deaths in Kelowna in 2017 projected to be almost double the number reported in 2016. Interior Health has been monitoring overdose trends in Kelowna using data provided by emergency departments, BC Emergency Health Services and the BC Coroners Service. The profile highlighted that overdoses disproportionately affect males aged 30-49 and Aboriginals. The highest risks of fatal overdoses are people using drugs alone and in private residences.

Fentanyl is detected in over 90% of fatal overdoses, however, various types of drugs and modes of consumption were reported. Over 2,500 Take Home Naloxone kits have been distributed with approximately 4,500 client visits occurring at the supervised consumptions services.

Coordinated efforts are taking place to provide follow up mental health and substance use services and harm reduction services to those who experienced an overdose.

The crisis response is now transitioning to operations. The Emergency Operations Centre has been closed. An operational steering committee was established and continues to work on proactive responses and strategies.

The Directors asked questions of the guests.

APPROVAL

4.1 Approval – Minutes

Director Tugnum moved, Director Cannon seconded:

Motion: 17-23 **MOVED AND CARRIED UNANIMOUSLY THAT** the Board approves the minutes of the August 1, 2017 Board Meeting as presented.

5. FOLLOW UP ACTIONS FROM PREVIOUS MEETING

There were no actions for review.

6. COMMITTEE REPORTS

6.1 Health Authority Medical Advisory Committee (HAMAC)

Dr. Glenn Fedor provided an overview of the Summary Report of the Health Authority Medical Advisory Committee meeting that took place on September 15, 2017.

Dr. Fedor noted that HAMAC met in Kamloops for the first time with positive feedback from the members. Presentations from the Research Ethics Board, Infection Control and Mental Health and Substance Use were well received.

6.1.1 HAMAC Recommendation(s) for Action / Discussion / Information

- There were no recommendations from HAMAC at this time.

6.2 Audit and Finance Committee

Director Rounsville requested the Boards approval for the following motion:

Director Rounsville moved, Director Cannon seconded:

Motion: 17-24 **MOVED AND CARRIED UNANIMOUSLY THAT** the Board approve the advancement of the 2018/19 IMIT Tactical Plan 'Core Infrastructure Refresh' capital project at a total project cost of $4M.

The recommended funding source is the 2018/19 >$100K allocation for the IMIT tactical plan and will be included in the IMIT corporate projects presented to the Regional Hospital Districts for funding consideration and approval. Need to acknowledge normally funding source approval confirmed prior to Board approval granted to purchase.

Director Rounsville reported:

- The Board Audit & Finance Committee will recommend to the Board Governance and Human Resources Committee the approval of the revised Terms of Reference.
- The financial summary for period 5 was reviewed. A revised Ministry funding letter has not yet been received.
- Laundry Services onboarding went very well.

6.3 Quality Committee

Director Cannon reported:

- The Board Quality Committee will recommend to the Board Governance and Human Resources Committee to approve the revised Terms of Reference.
- Diagnostic Imaging Annual Report was received. Notable details included the installation of 3 new fixed MRI machines coming in the next 18 months and an overall increase of 4% in volume from last year.

6.3 Governance & Human Resources Committee

Director Tugnum requested the Boards approval for the following motions.

Director Tugnum moved, Chair Cochrane seconded:

Motion 17-25 **MOVED AND CARRIED UNANIMOUSLY THAT** the Board approve the attached revised Governance and Human Resources Committee Terms of Reference.

Director Tugnum moved, Director Jules seconded:

Motion 17-26 **MOVED AND CARRIED UNANIMOUSLY THAT** the Board approve the attached revised *Board Policy 2.1 - Board of Directors Terms of Reference; Board Policy 2.3 - President & Chief Executive Officer Terms of Reference; and Board Policy 6.4 - Board Calendar.*

Director Tugnum reported that:

- Workplace Health and Safety Annual Report was received.

6.4 Strategic Priorities Committee

Chair Cochrane reported that:

- The Board Strategic Priorities Committee will recommend to the Board Governance and Human Resources Committee to approve the revised Terms of Reference.

6.5 Stakeholders Relations Committee Report

The Stakeholder Relations Committee Report was received as information. Chris Mazurkewich provided a brief summary of the CEO / Board Chair visits on August 22-24, 2017 to St'at'imc (Lillooet) & Nlaka'pamux (Lytton) Nation that included the following communities:

- Xaxli'p
- Ts'kw'aylaxw
- Sek'welas
- T'it'q'et
- Xwisten
- Nicomen
- Cook's Ferry
- Siska
- Kanaka Bar
- Skuppah

Director Jules relayed thanks from the communities that they visited and looks forward to future engagement.

7. REPORTS

7.3 President and CEO Report

The President & CEO Report was received as information.

Highlights included:

- Thank you to Mal Griffin for his role as acting VP Communications and Engagement while a new VP of Communications and Engagement, Jenn Goodwin was being recruited. Mal Griffin had personal thank you letters sent to individual staff and community members that went above and beyond during the wildfire crisis. Also a thank you was provided to Communication and Engagement staff who assisted in crafting the CEO Wildfire memos which were very well received by physicians and staff. In addition, individual and team thank you letters were sent to staff, physicians, private businesses, Northern Health Authority, Provincial Health Services Authority, First Nations Health Authority and others.

Chris Mazurkewich answered questions from the Directors.

7.2 Chair Report

Chair Cochrane did not have a report at this time.

8. CORRESPONDENCE

Board correspondence was received as information.

9. DISCUSSION ITEMS

None

10. INFORMATION ITEMS

None

11. NEW BUSINESS

None

12. FUTURE AGENDA ITEMS

None

13. NEXT MEETING

Tuesday, December 5, 2017 – 9:00 a.m. – Kelowna, BC

14. ADJOURNMENT

There being no further business, the meeting adjourned at 10:22 am

_____	_____
Doug Cochrane, Board Chair	Chris Mazurkewich, President & CEO

Interior Health

ACTION ITEMS
REGULAR BOARD MEETING

December 5, 2017

ITEM	ACTION	RESPONSIBLE PERSON(S)	DEADLINE
None			

Interior Health
Every person matters

SUMMARY REPORT FROM HAMAC TO THE BOARD

HAMAC Date: October 13, 2017

1. MOTIONS PASSED
None.
2. DECISIONS
None.
3. ACTIONS
None.
4. PRESENTATIONS TO HAMAC
Focus on Developing Resources to Support Leaders *M. Stuttard, D. Milat* Michelle Stuttard and Dawn Milat provided live demonstration to the TeamSite designed to support and develop IH Medical Leaders. Physician Expectation, Community MHSU *Dr. P. Dagg* Dr. Paul Dagg provided update on letter delivered to all physicians providing 6-month notice re: contract updates. Pharmacy & Therapeutics Executive Summary *K. Peters, I Petterson* P&T Executive Summary presented to HAMAC members. Infection Prevention and Control (IPAC) Report *Dr. B. Wang* IPAC report presented to HAMAC members. Annual Lab Quality Report *Dr. M. Moss, M. Woods* Annual lab quality report presented to HAMAC members. 2018 HAMAC Meeting Dates *Dr. G. Fedor* Meeting dates presented to HAMAC members. No changes requested. 2018 Medical Advisory Meeting Dates *Dr. G. Fedor* 2018 meeting dates presented for information of Local and Regional Medical Advisory Committee for HAMAC members.

HAMAC Date: November 17, 2017

1. MOTIONS PASSED
Motion: That HAMAC provide endorsement of implementing the new BC Symptom Management Guidelines for Palliative Care (2017), and removal of old guidelines – *carried unanimously*
2. DECISIONS
None.
3. ACTIONS
None.

Interior Health
Every person matters

SUMMARY REPORT FROM HAMAC TO THE BOARD

HAMAC Date: October 13, 2017

4. PRESENTATIONS TO HAMAC

Palliative Care Ask Dr. *A. Nixon, V. Kennedy*
Seeking endorsement & approval of new guidelines, and removal of old guidelines for Palliative Care Guidelines.

Early Predictions of Impact of Upcoming Influenza Season *Dr. S. Mema, G. Frosst*
Early predictions for flu season presented to HAMAC members.

Interior Health

Stakeholders Committee
REPORT TO THE BOARD
— December 2017 —

The Committee has participated in the following stakeholder relations activities in support of management led external/internal communication responsibilities and the Board's goals and objectives

September 2017

September 26, 2017	Long Term Service Awards – Penticton – Director Burrows

October 2017

October 4, 2017	JoeAnna's House Campaign Launch – Chair Cochrane
October 10, 2017	Long Term Service Awards – Kamloops – Director Tugnum
October 18, 2017	Regional Hospital District & Interior Health Fall Joint Meeting – Chair Cochrane
October 23, 2017	Long Term Service Awards – Cranbrook – Chair Cochrane & Director Rounsville
October 24-26, 2017	CEO/Board Site Tours – East & West Kootenay – Chair Cochrane & Director Rounsville
October 27, 2017	Penticton Regional Hospital Topping Off Ceremony & Site Tour – Chair Cochrane & Director Burrows
October 27, 2017	Cariboo Place Residential Care Facility Groundbreaking – Director Tugnum

November 2017

November 1, 2017	Wildfire Staff Appreciation Event – Williams Lake – Director Tugnum
November 1, 2017	East Kootenay Foundation for Health Event – Director Rounsville
November 3, 2017	East Kootenay Regional Hospital District Board Meeting – Director Rounsville
November 3, 2017	Physician Administrator Co-Leadership Meeting – Chair Cochrane & Director Lawrie
November 4, 2017	Physician Administrator Co-Leadership Meeting – Chair Cochrane
November 7, 2017	Long Term Service Awards – Vernon – Director Cannon
November 7, 2017	Interior Region Fall Caucus – Chair Cochrane & Director Jules
November 17, 2017	HAMAC Meeting – Chair Cochrane

November 21, 2017	Long Term Service Awards – Kelowna – Chair Cochrane
November 22, 2017	Partnership Accord Leadership Table – Chair Cochrane & Director Jules
November 29, 2017	The Hamlets Residential Care Project Launch Event – Director Lawrie

December 2017

December 1, 2017	Chair to Chair Meeting with Minister Dix – Chair Cochrane

President & Chief Executive Officer
Report to the Board
December, 2017

Highlights (September - November)

Interior Health and First Nations Health Authority make joint $3-million investment to enhance Elder Care

IH is contributing $2-million in 2019/20 to a partnership with the seven Nations of the Interior and the FNHA that will bring Elder Care closer to home for First Nation communities. The funding will support nursing enhancements to improve access to culturally safe, holistic and quality healthcare services for Elders. The FNHA is contributing $1 million in the first year of the partnership. *See news release*.

Overdose emergency a continued priority

The Minister for Mental Health and Substance Use, Judy Darcy, visited Kamloops on November 14 and met with clients and staff at the King Street Centre (IH community-based mental health services), the Kamloops Aboriginal Friendship Centre and the IH Supervised Consumption site.

An IH social media campaign is raising the profile of frontline staff who are responding to the overdose crisis and providing services to individuals living with addictions. Using the hashtag #STOPOVERDOSE, IH is addressing the stigma of mental health and substance use and promoting a compassionate response focused on reducing ODs.

In addition to online engagement, IH continues to work collaboratively with partners in the community. In October, IH presented at Kelowna City Council.

Celebrating local investment

IH is moving forward with investments into local health facilities, marking milestones across the region this fall. These included a beam-signing and topping off ceremony at Penticton Regional Hospital, the start of construction of the MRI space at East Kootenay Regional Hospital, the launch of construction of Cariboo Place in Williams Lake and the ground breaking for the helipad project in Revelstoke. These events reinforce IH's message that 'Every person matters,' as they are visible signs of investment in our communities, and by our communities.

Every Person Matters – Staff, physicians recognized across IH

Staff and physicians marking milestone anniversaries at IH were recognized at events across IH this fall. Feedback from those who attended was positive, and several award recipients shared stories of their

commitment to serving patients, clients and residents over the years. In addition to long service award ceremonies, IH is hosting recognition events for staff and physicians in communities in the Interior impacted by wildfires this summer.

Over 31,000 patients are accessing their IH health information online

MyHealthPortal provides patients 24-hour access to their health information via their smart phone, tablet or computer through a secure portal from the Interior Health website. To date, over 31,000 patients have enrolled.

IH Goal #1: Improve Health and Wellness

Letter of Understanding signed – Secwepemc Nation and Interior Health

A Letter of Understanding between the Secwepemc Nation and IH was re-signed at a ceremony in Kamloops on November 7. IH Board Chair Doug Cochrane and Aboriginal Health Corporate Director Brad Anderson represented Interior Health, while 16 Kukpi7s representing all the communities of the Secwepemc signed the joint document. The LoU was first signed for a three-year term in 2014 as a way for the two groups to develop an engagement process for the planning of Aboriginal services, programs and operations across the Secwepemc Territory. The overarching goal is to improve health services and health outcomes for Secwepemc people.

Public Awareness of Drinking Water Quality

Earlier this year, IH launched a new public website, drinkingwaterforeveryone.ca, to provide information on drinking water systems and safety. The website will be fully launched and promoted publicly during BC Drinking Water Week in May, 2018.

Lower Columbia Healthy Communities Plan

Trail City Council is the first local government in the Lower Columbia region to formally adopt the Lower Columbia Healthy Communities Plan. Five key stakeholders (IH, Family Action Network, Healthy Schools, Columbia Basin Alliance for Literacy and the City of Trail) initiated the project in 2016. Over the past 18 months, over 40 stakeholders from the Lower Columbia with a mandate to build healthy communities have attended three workshops to develop the final Plan. The intent is for other municipalities to adopt the Plan and become united under a shared vision to create healthy communities.

Strategic Goal #2: Deliver High Quality Care

Improved access to primary care for seniors

The implementation of an electronic medical record (EMR) at the new IH seniors' health and wellness centres in Kamloops and Kelowna. The technology, called 'Profile', provides an electronic record that is accessed by all

members of a patient's care team: whether they are part of community services or primary care. Read more in the October @IHmagazine.

'Right care, right place, right provider'

The Grand Forks/West Boundary Primary and Community Care Transformation Initiative is focused on getting residents across the Boundary the right care in the right place, from the right health-care provider when it is needed. Through partnership between IH and the Kootenay Boundary Division of Family Practice, a team of five new primary care staff are meeting local needs and serving patients in the community. *See news release*.

Community paramedicine initiative strengthens care in rural communities

Community paramedicine is being introduced across the province by BC Emergency Health Services and its program partners, including IH. The program goals are to help stabilize paramedic staffing in these communities and to bridge health service delivery gaps. The program has been in place in Creston and Princeton since 2015 and is currently being expanded to 29 additional IH communities. *See more in the October @IHmagazine*.

Strategic Goal #3: Ensure Sustainable Health Care

The future is digital: Highlights of the past year in IMIT at IH

IH's Information Management and Information Technology (IMIT) department continues to move toward its Vision 2020 strategy --- *e-enabled person services, integrated electronic health records, and information driven decision making.* Highlights of the past year include:

- The Royal Inland Hospital (Kamloops) was the first Emergency Department (ED) to incorporate advanced Clinical software enabling electronic physician ordering and documentation by doctors and nurses; additionally, BC Ambulance service can now send clinical information as well as ECGs to the ED enroute, ensuring improved patient care.
- Through the first year of the Primary Care EMR Enhancement & Implementation project, infrastructure upgrades have been completed, supporting future growth; site implementations include: Nelson Opioid Agonist Treatment Clinic, Kelowna Seniors Health and Wellness Centre, Kamloops North Shore Primary Care Services, Kamloops North Hills Care Centre
- The First Nations Remote MEDITECH Access project is rolling out to our First Nation Partners, supporting patients who are transitioning from hospital to home; First Nation clinicians now access their patients' electronic health record and can see treatment histories, medical interventions and prescription orders.
- Home Health Clinicians are transitioning to e-documentation, through an IH effort to standardize the number of clinical forms, reducing from 29 in total to 13; a shift away from paper means that clinical information is secure, follows documentation standards, and is accessible not only to Home Health clinicians, but all clinical areas with access to MEDITECH.
- Telehealth at IH expanded in cardiac care, obstetrics/gynecology, mental health and primary care.

Strategic Goal #4: Cultivate an Engaged Workforce and a Healthy Workplace

Enabling improved, real-time communication for frontline care staff and physicians

In 2016/17, IH implemented Vocera at Kelowna General Hospital, Royal Inland Hospital (Kamloops), Dr. Helmcken Memorial Hospital (Clearwater), Arrow Lakes Hospital (Nakusp), Park View Place (Enderby), Westview at Penticton Regional Hospital, and at Kimberley Special Care. Vocera is a hands-free staff communication device that is voice-activated or one-touch activated. It improves staff safety and physician safety and workplace flow.

Staying Smoke-Free

Enforcing Smoke-Free policies can be challenging. IH Population Health has begun a six-month pilot project that includes audits of IH sites, data collection (including complaints and security officer interactions with smokers), and engagement with site leaders with respect to next steps. To date, twelve audits have been conducted across the region and have been well-received by administrators.

Growing the IH workforce

A new Social Media Strategy is under development to expand IH's online recruitment presence and enable Recruitment and Communications to collaborate efforts for marketing and promotion. The strategy aims to increase the number of candidates who link to our website, grow brand awareness, and expand the recruitment team's community promotion efforts. Initially, the strategy will use Facebook, Twitter and LinkedIn in conjunction with a redesigned and content-refreshed employee recruitment website that launched on November 15.

Community Engagement

IH Board Chair Doug Cochrane, CEO Chris Mazurkewich, Board Director Dennis Rounsville and VP Jenn Goodwin visited Fernie, Cranbrook, Kimberley, Invermere, Revelstoke and Golden on a tour of IH sites through the East Kootenay October 23-26. The stops included meetings with physicians, hospital and community managers and leaders, Foundation and Auxiliary volunteers, local elected officials and First Nation leaders. Themes of discussion included the increasing opportunities to use technology to enhance local care, improving access to primary care and staff recruitment.

Health Minister Adrian Dix was in Penticton October 27 for the capping off ceremony of the Patient Care Tower (PCT) and toured South Okanagan General Hospital. Key stakeholders and staff were invited to sign a beam to be placed in the PCT.

Stakeholder Engagement by Community Liaisons:

IH West:

- Acute Health Service Director for Cariboo participated in Leaders Moving Forward meeting with mayor of Williams Lake, Cariboo Regional District Chair, Thompson Rivers University Dean, and RCMP

Community Liaison; attended wildfire appreciate events in Williams Lake and 100 Mile House, which included staff, physicians, local mayors, regional district and First Nations representatives.

- Acute Health Services Manager for Revelstoke attended City of Revelstoke Advisory Committee on Healthcare meeting October 16 where a clean air bylaw, upcoming flu clinics, radon, and options for an emergency shelter were discussed; attended a public meeting with approximately 60 people on October 17 to discuss youth mental health and receive input on a draft Pathway to Care document.

IH Central:

- Acute Health Service Administrator for South Okanagan led a tour of South Okanagan General Hospital (SOGH) in Oliver on November 15. Participants included Health Minister Adrian Dix, Oliver mayor, Osoyoos mayor, the local MLA and site leads. The purpose of the tour and meeting was to discuss the future capacity plan at SOGH.
- Acute Health Service Administrator for Kelowna General Hospital (KGH) attended Healthy City Strategy Steering Committee meeting October 19 with City of Kelowna representatives; joined Okanagan Nation Alliance and First Nations partners at a meeting on October 20 to discuss the Letter of Understanding and First Nations engagement.
- Acute and Community Health Service Administrators for North Okanagan jointly presented October 31 to the North Okanagan Columbia Shuswap Regional Hospital District to provide an update on efforts to shift to community and primary care, reduce surgical waitlists, enhance Mental Health Substance Use services, and address the overdose crisis.

IH East:

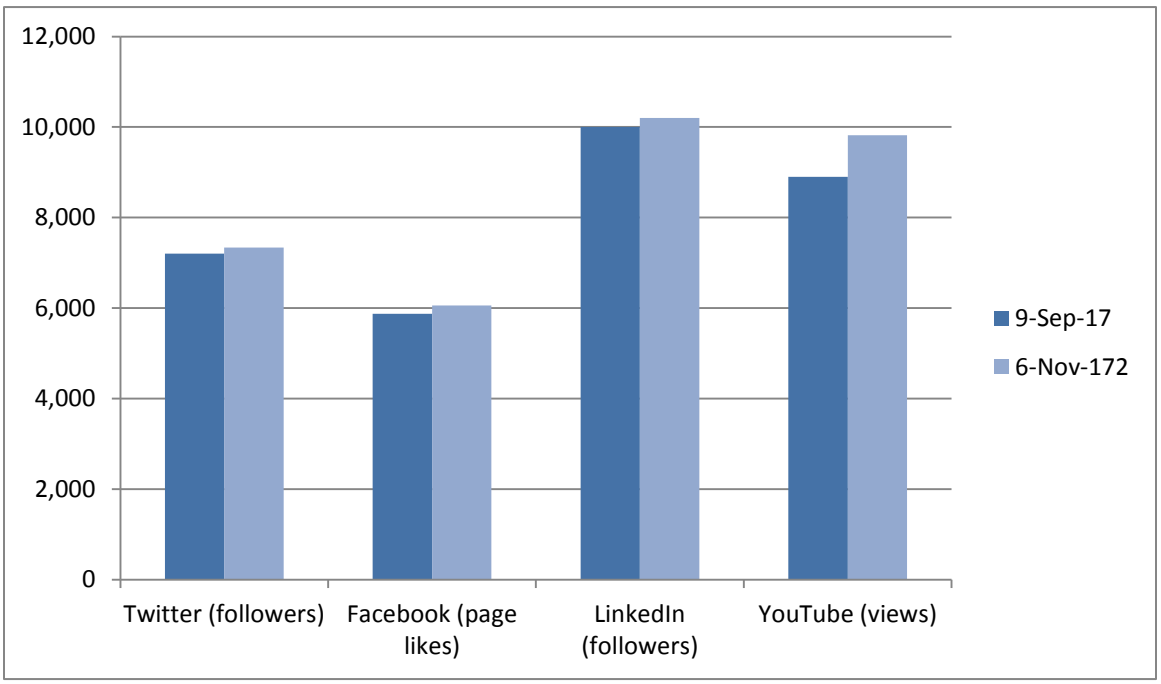
- Acute Health Service Director for Golden/Invermere joined a group of staff from chronic disease management, residential services, community nursing, and telehealth to represent Interior Health at a Seniors Health Fair in Invermere on October 26.
- Health Service Director for Creston/Fernie joined mayor, town and regional district representatives, and town physician recruiter at the Creston Valley Health Working Group meeting October 5 to discuss physician recruitment; supported City of Fernie during week of October 17 on response and at media conference following ammonia incident at local arena.
- Community Health Service Administrator for Kootenay Boundary joined local MLA, Slocan-area mayors, BC Emergency Health Services, and regional district representatives at Slocan Community Health Centre discussions on September 13 and October 17; met with KB Division of Family Practice and Okanagan Nation Alliance October 3 to discuss the Boundary proof of concept.
- Acute Health Service Director for Kootenay Boundary attended KB Divisions of Family Practice Annual General Meeting October 26 in Castlegar; attended Connected Communities meeting November 16 in Nelson.

Stakeholder Engagement by Healthy Communities team:

- October 6 – co-presentation with Trisha Davison, Director of Parks & Recreation for the City of Trail, on a panel called 'Leading Diversity' at the Royal Roads University Leadership Conference 2017 in Victoria.
- October 23: Two members from the broader Healthy Communities team co-planned and attended the Merritt Food Gathering Stakeholders Meeting facilitated by Fraser Basin Council. Attendees included local city councillors, First Nations and food producers. A working group is being established for next steps.

- October 30: Two members from the Healthy Communities team attended a meeting with City of Kamloops planners to discuss the inclusion of meaningful health indicators for the Official Community Plan's Implementation Plan (under development).
- October 31: Met with the Thompson Rivers University/United Way Knowledge Mobilization Officer to discuss partnership/collaboration opportunities to advance community wellness research within Kamloops and the surrounding rural communities.
- November 1 - Initial meeting with Splatsin and FNHA about partnering on a pilot project related to water management, in particular as it relates to the Hullcar aquifer issue.
- November 2 – co-presentation with representatives from Columbia Basin Rural Development Institute, Trail SKILLS Centre, City of Revelstoke, and City of Nelson in a Vibrant Communities Canada national webinar called 'Measuring Up To Poverty Reduction in Rural B.C.'. Over 50 people attended.

IH Social Media presence and engagement *(as of November 6)*



The IH social media reach and presence has increased across Twitter, Facebook, LinkedIn and YouTube since September.

- Tweets with the most impressions were related to #StopOverdose Heroes, Community Paramedicine, Care Aide Day, MDR Week, Flu Clinics, Change Day, and the Illicit Drug Alert.
- The Facebook post generating the most engagement with our followers was "Say Thank You to a Health Care Assistant Today" (1,469 post clicks; 719 reactions; 57 comments; and 76 shares, with a total reach of over 12,200).

BOARD CORRESPONDENCE

October 3, 2017-November 22, 2017

Board Correspondence received:

Board Mail:

University of British Columbia Board Chair Congratulatory Letter
Minister Darcy response letter re: Minister of Health & Addictions appointment
Thompson Regional Hospital District letter to Minister Dix re: Royal Inland Hospital Patient Care Tower
City of Kelowna Office of the Mayor letter re: Success of RCMP-IHA Mental Health Police and Crisis Team Car initiative.
First Nations Health Authority Board Chair Congratulatory Letter

The above correspondence items have been referred to the CEO and/or appropriate Vice-President and/or Patient Quality Care Office and have been responded to accordingly.

THE UNIVERSITY OF BRITISH COLUMBIA

OFFICE OF THE DEPUTY VICE-CHANCELLOR

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Phone 250 807 9224
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deputy.vicechancellor@ubc.ca

Professor Deborah Buszard
Deputy Vice-Chancellor and Principal

2 October, 2017

Dr. Doug Cochrane
Chair, Board of Directors
Interior Health Authority
505 Doyle Avenue
Kelowna, BC V1Y 0C5

Dear Dr. Cochrane:

On behalf of the University of British Columbia, congratulations on your appointment as Chair of the Interior Health Authority Board of Directors.

UBC is a proud partner of Interior Health. The university values collaborating with the health authority to train health professionals, nurses, and physicians at sites across the region. We are particularly proud of recent successes in growing the cohort of Aboriginal students in our health programs. For example, our School of Nursing has doubled enrolment of Aboriginal students since 2011 and boasts a 93 per cent retention rate for Aboriginal students. Moreover, last year Aboriginal students made up 18 per cent of the first year Nursing cohort (up from 6 per cent in 2011). UBC looks forward to building on our relationship over the coming years to better serve communities in our region, including rural, remote, and Indigenous populations. We also look forward to identifying additional opportunities to train health professionals in our region, including in new areas like occupational and physical therapy.

The partnership between Interior Health and UBC Okanagan also greatly benefits researchers at both organizations, including those investigating practices that have a direct impact on how care is delivered in communities in our region. For example, this past summer, clinical professors with UBC Okanagan's Southern Medical Program joined with colleagues from KGH's Interior Health Thoracic Surgery Group to demonstrate telemedicine's dramatic benefits and report on the lessons learned from years of study regarding access to quality medical care facilitated by telemedicine.

Once again, congratulations. I would welcome the opportunity to host you on campus in the months ahead to offer a first-hand look at some of the exciting work underway and to discuss new opportunities to collaborate. Until we have an opportunity to meet, please accept my best wishes.

Sincerely,

Deborah Buszard
Deputy Vice-Chancellor and Principal

cc: Gordon Binsted, Dean, Faculty of Health and Social Development
Allan Jones, Regional Associate Dean, Interior, Faculty of Medicine

OCT - 4 2017

BRITISH COLUMBIA

Mr. John O'Fee
Chair, Board of Directors
Interior Health Authority
505 Doyle Ave
Kelowna BC V1Y 0C5

Dear Mr. O'Fee:

Thank you very much for your warm letter of congratulations. Your support is greatly appreciated.

I am honoured to have been appointed Minister of Mental Health and Addictions and excited to work with so many interested stakeholders to strengthen our mental health and addiction systems and make a difference for the people and families struggling to get the support they need.

Our immediate priority is to urgently address the overdose crisis. In response to what we've heard from people on the front lines about what is most urgently required, we are taking action to save lives now. Some of the steps we are taking include: expanding overdose prevention sites; significantly increasing access to naloxone and people trained to administer it; improving access to pain management services, and to safe medications - especially prescription hydromorphone.

We have also started taking the first steps to develop a transformative mental health and addictions strategy - to improve access to treatment for those who need it, with a focus on early prevention and youth mental health. As the issues facing the mental health and addictions system are complex and inter-related, we are taking an all-of-government approach.

We work closely with the Ministries of Health, Children and Family Development, Education, Housing and Justice, as well as community service agencies, local governments, First Nations and indigenous peoples, health and addictions researchers and advocates, and the whole range of service providers. In all of this work, we are committed to developing solutions in collaboration with people with lived experience and their families. Together we will identify the most effective ways to deliver quality mental health and addiction services across BC.

...2

Ministry of Mental Health and Addictions
Office of the Minister
Mailing Address:
PO Box 9087 Stn Prov Govt
Victoria BC V8W 9E4
Location:
Parliament Buildings
Victoria

Our mental health and addictions strategy aims to build an organized, well-coordinated, and resourced system of care for mental health and addictions focused on promoting wellness, prevention, early intervention, harm reduction, treatment and recovery for people and their families. The plan will begin addressing the fragmented mental health and addictions care system so that treatment is seamless, available and effective for everyone who needs it – working toward a system where you can "ask once, and get help fast".

In the past weeks I have met with frontline providers and advocates from many areas of the province. I have been moved by their compassion and dedication to helping people, despite the many challenges in the system overall. I know that with a collaborative approach, we can build upon the efforts of those working in the field of mental health and addictions to transform supports for British Columbians and create a seamless, coordinated system of care.

Again, thank you for writing, and I look forward to working with you in the future.

Yours sincerely,

Judy Darcy
Minister

TRHD ***THOMPSON REGIONAL HOSPITAL DISTRICT***
#300 - 465 Victoria Street
Kamloops, British Columbia V2C 2A9
Telephone (250) 377-8673
Fax (250) 372-5048

October 5, 2017

Honourable Adrian Dix
Minister of Health
PO Box 9050 Stn Prov Govt
Victoria, BC V8W 9E2

Delivered via email: HLTH.health@gov.bc.ca

Dear Minister Dix:

Re: Patient Care Tower Project at the Royal Inland Hospital

Thank you for meeting with representatives from the Thompson Regional Hospital District, Thompson-Nicola Regional District, and the City of Kamloops on September 28, 2017 to discuss the Patient Care Tower project at the Royal Inland Hospital (RIH). We were very pleased to hear that you share our goal of completing this project with the same scope and budget, and in the same timeframe as was planned.

As you are aware, the Royal Inland Hospital is one of only 2 tertiary hospitals in the Interior Health Authority (IHA), and services a population of over 200,000 people. RIH is an older facility and we appreciated your recognition that it is in need of the updates that this project aims to provide. This is an important improvement for our regional hospital that has support from across our local governments. Having you add your support to the Patient Care Tower is appreciated by all of us who have been involved in its process.

Thank you again for your commitment to supporting the Patient Care Tower project. We value the positive working relationship we have with your Ministry, and look forward to working with you.

Yours truly,

R Elliott

Ronaye Elliott, Acting Chair
Thompson Regional Hospital District

p.c.: P.A. John Ranta, Chair, Thompson-Nicola Regional District
Arjun Singh, Acting Mayor, City of Kamloops
Chris Mazurkewich, CEO, Interior Health Authority
Heidi Coleman, CEO, Royal Inland Hospital Foundation
Tracey Rannie, Administrator, Royal Inland Hospital

City of Kelowna

Office of the Mayor

October 20, 2017

Dr. Doug Cochrane
Chair, Interior Health
505 Doyle Avenue
Kelowna, BC V1Y 6V8

Dear Doug,

I am writing on behalf of Kelowna City Council to express our pleasure at the success of the RCMP-IHA Mental Health PACT Car initiative and to encourage IHA to consider expanding the program in Kelowna.

As you know, this program was implemented to improve mental health patients' access to care by connecting them to services within the community, and to divert police resources from repeated mental health calls to public safety matters. Anecdotally, PACT members note that since the project commenced, they have witnessed situations where ambulance and hospital visits have been avoided. In addition, PACT has provided appropriate community referrals thus bypassing emergency visits, reducing rates of recidivism and effectively reducing workloads for both IHA and RCMP.

As a result, the Police and Crisis Team worked collaboratively, engaging in approximately 25 per cent of all mental health calls for service. Of the clients who were deemed by the PACT car as needing further immediate medical assistance, 100 per cent were certified by a physician upon arrival at the Kelowna General Hospital. This speaks to the knowledge and professionalism of the nurse and RCMP member of our PACT car.

Council and the City of Kelowna are committed to humane and compassionate approaches to assist people who find themselves in crisis. The RCMP and Interior Health joined together to bring the proven PACT model to our streets and we are all reaping the benefits of giving assistance to people who, through no fault of their own, are suffering. However, having begun this innovative service less than one year ago, we can see that the volume of work that exists has already pushed the PACT members to the limits of their capacity to help more clients. It is our hope Interior Health can find the resources to add more capacity to the program in 2018.

The PACT program is a great example of how we can mobilize as a community to make a real difference in the lives of people who need help. I know Kelowna City Council is looking forward to more collaboration on community needs in the years ahead, and we see great benefits in keeping the PACT momentum going in 2018.

Sincerely on behalf of City Council,

Colin Basran
MAYOR

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October 25, 2017

Mr. Doug Cochrane, Board Chair
Interior Health
505 Doyle Avenue
Kelowna, BC V1Y 0C5

Dear Doug:

I am writing to congratulate you on your new appointment as Board Chair for Interior Health.

As Board Chair for the First Nations Health Authority, I truly look forward to meeting with you in the near future, and working alongside you to ensure that First Nations and all British Columbians receive the best possible care within our health-care system.

I also look forward to collaborating with you to advance the work set out in the *Interior Partnership Accord* that was signed between Interior Health and Interior Region First Nations and witnessed by the FNHA in 2012. In the spirit of this partnership, our organizations can continue to work together to improve the health status of BC First Nations children, families and communities in our province.

All the best in your new leadership position!

In Wellness,

Lydia Hwitsum
FNHA Board Chair
First Nations Health Authority

STAKEHOLDER ENGAGEMENT

Report to the Board

December 2017

Background

Engaging our stakeholders – elected officials, partner agencies, clients and the public – is key to strengthening relationships and trust with external stakeholders, while increasing awareness of the health-care system and ultimately improving population health.

Stakeholder Engagement by Community Liaisons:

IH West:

- Acute Health Service Director for Cariboo participated in Leaders Moving Forward meeting with mayor of Williams Lake, Cariboo Regional District Chair, Thompson Rivers University Dean, and RCMP Community Liaison; attended wildfire appreciation events in Williams Lake and 100 Mile House, which included staff, physicians, local mayors, regional district and First Nations representatives.
- Acute Health Services Manager for Revelstoke attended City of Revelstoke Advisory Committee on Healthcare meeting Oct. 16 where a clean air bylaw, upcoming flu clinics, radon, and options for an emergency shelter were discussed; attended a public meeting with approximately 60 people on Oct. 17 to discuss youth mental health and receive input on a draft Pathway to Care document.

IH Central:

- Acute Health Service Administrator for South Okanagan led a tour of South Okanagan General Hospital (SOGH) in Oliver on Nov. 15. Participants included Oliver mayor, Osoyoos mayor, local MLA and site leads. The purpose of the tour and meeting was to discuss the future capacity plan at SOGH.
- Acute Health Service Administrator for Kelowna General Hospital (KGH) attended Healthy City Strategy Steering Committee meeting Oct. 19 with City of Kelowna representatives; joined Okanagan Nation Alliance and First Nations partners at a meeting on Oct. 20 to discuss the Letter of Understanding and First Nations engagement.
- Acute and Community Health Service Administrators for North Okanagan jointly presented Oct. 31 to the North Okanagan Columbia Shuswap Regional Hospital District to provide an update on efforts to shift to community and primary care, reduce surgical waitlists, enhance Mental Health Substance Use services, and address the overdose crisis.

IH East:

- Acute Health Service Director for Golden/Invermere joined a group of staff from chronic disease management, residential services, community nursing, and telehealth to represent Interior Health at a Seniors Health Fair in Invermere on Oct. 26.
- Health Service Director for Creston/Fernie joined mayor, town and regional district representatives, and town physician recruiter at the Creston Valley Health Working Group meeting Oct. 5 to discuss physician recruitment; supported City of Fernie during week of Oct. 17 on response and at media conference following ammonia incident at local arena.
- Community Health Service Administrator for Kootenay Boundary (KB) joined local MLA, Slocan-area mayors, B.C. Emergency Health Services, and regional district representatives at Slocan Community Health Centre discussions on Sep. 13 and Oct. 17; met with KB Division of Family Practice and Okanagan Nation Alliance Oct. 3 to discuss the Boundary proof of concept.
- Acute Health Service Director for Kootenay Boundary attended KB Divisions of Family Practice Annual General Meeting Oct. 26 in Castlegar; attended Connected Communities meeting Nov. 16 in Nelson.

Stakeholder Engagement by Healthy Communities Team:

- Oct. 6: Co-presentation with Trisha Davison, Director of Parks & Recreation for the City of Trail, on a panel called ‘Leading Diversity’ at the Royal Roads University Leadership Conference 2017 in Victoria.
- Oct. 23: Two members from the broader Healthy Communities team co-planned and attended the Merritt Food Gathering Stakeholders Meeting facilitated by Fraser Basin Council. Attendees included local city councillors, First Nations and food producers. A working group is being established for next steps.
- Oct. 30: Two members from the Healthy Communities team attended a meeting with City of Kamloops planners to discuss the inclusion of meaningful health indicators for the Official Community Plan’s Implementation Plan (under development).

- Oct. 31: Met with the Thompson Rivers University/United Way Knowledge Mobilization Officer to discuss partnership/collaboration opportunities to advance community wellness research within Kamloops and the surrounding rural communities.
- Nov. 1: Initial meeting with Splatsin and First National Health Authority about partnering on a pilot project related to water management, in particular as it relates to the Hullcar aquifer issue.
- Nov. 2: Co-presented with representatives from Columbia Basin Rural Development Institute, Trail SKILLS Centre, City of Revelstoke, and City of Nelson in a Vibrant Communities Canada national webinar called ‘Measuring Up To Poverty Reduction in Rural B.C.’. Over 50 people attended.