

Stearn, Anne HLTH:EX

From: Brown, Stephen R HLTH:EX
Sent: Monday, January 12, 2015 1:16 PM
To: Lake, Terry HLTH:EX; Feulgen, Sabine HLTH:EX
Cc: Kislock, Lindsay M HLTH:EX
Subject: Re: CST

Hi Sabine
can you give the Minister an update. Thks

Sent from my iPhone

> On Jan 12, 2015, at 1:13 PM, Lake, Terry HLTH:EX <Terry.Lake@gov.bc.ca> wrote:

>

> Well, we are getting close to when we need to see some positive movement on the CST file. Can you provide me with any update?

>

> Thanks, T

>

> Terry Lake DVM

> Minister of Health

Stearn, Anne HLTH:EX

From: Brown, Stephen R HLTH:EX
Sent: Friday, February 13, 2015 11:09 AM
To: Shera, Deborah HLTH:EX
Cc: Feulgen, Sabine HLTH:EX
Subject: Re: CST

Thks for offer I have cc's Sabine as project chair. Steve

Sent from my iPhone

On Feb 11, 2015, at 10:00 AM, Shera, Deborah HLTH:EX <Deborah.Shera@gov.bc.ca> wrote:

If there is anything I could contribute given my background let me know –

Stearn, Anne HLTH:EX

From: Brown, Stephen R HLTH:EX
Sent: Thursday, May 14, 2015 11:45 AM
To: Obee, Sarah F HLTH:EX
Subject: FW: CST Project - Follow up meeting

From: Feulgen, Sabine HLTH:EX
Sent: Friday, November 14, 2014 6:52 PM
To: McKnight, Elaine L PSA:EX; XT:Roy, Carl EHS:IN; XT:HLTH Doyle, Dianne; XT:HLTH Ackenhusen, Mary; Stevenson, Lynn HLTH:EX; Brown, Stephen R HLTH:EX
Subject: CST Project - Follow up meeting

Invitees:

Prior to beginning the larger discussion on Monday on how to move forward on the CST project, as Chair I propose that it would be productive to spend the first 40 minutes of the meeting allowing Mary, Carl, Dianne, and Elaine each 10 minutes to provide their perspectives on:

1. the issues
2. the risks (quantified as much as possible)
3. mitigation strategies

My plan is to reach common agreement/understanding on the issues that are causing risk/concern and find resolution(s) as a team.

Thanks. I am looking forward to meeting the HA CEOs in person on Monday.

Sabine Feulgen
Associate Deputy Minister, Corporate Services
Ministry of Health

phone: 250.952-1764
email: Sabine.Feulgen@gov.bc.ca

Stearn, Anne HLTH:EX

From: Brown, Stephen R HLTH:EX
Sent: Tuesday, July 21, 2015 8:19 AM
To: Feulgen, Sabine HLTH:EX; Sidhu, Manjit HLTH:EX (Manjit.Sidhu@gov.bc.ca)
Subject: FW: Performance Audit Coverage Plan 2015/16 – 2017/18
Attachments: L Coverage Plan Project Min of Health 2018 2015 07 17.pdf

-----Original Message-----

From: Ricard, Michele [<mailto:MRicard@bcauditor.com>]
Sent: Friday, July 17, 2015 1:13 PM
To: Lake, Terry HLTH:EX
Cc: Brown, Stephen R HLTH:EX
Subject: Performance Audit Coverage Plan 2015/16 – 2017/18

Sent on behalf of Carol Bellringer, Auditor General.

As part of our commitment to encourage conversation and demonstrate greater transparency, we will public our three-year Performance Audit Coverage Plan on July 21, 2015. In advance of that, we want to make you aware of the information included in the attached letter.

Sincerely,
Carol

Michele Ricard
Administrative Services Assistant/Records Administrator Office of the Auditor General of British Columbia
623 Fort Street, Victoria, BC V8W 1G1
Phone: 250.419.6132
mricard@bcauditor.com www.bcauditor.com

Attention:

This message is intended only for the use of the individual(s) to which it is addressed and may contain confidential information. If you have received this message in error, please contact the sender immediately and delete the material from your computer.

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FACT SHEET

CST Project Update

ISSUE

The Clinical and Systems Transformation (CST) Project has completed its review and replanning process, and has launched its design phase, while also preparing for the first implementation at Lions Gate Hospital and other Vancouver Coastal “Sea to Sky” sites. The project budget remains \$842 million, with a scope that better reflects the clinical goals of the project – an outcome of the learnings realized through the re-plan work undertaken over the last year.

KEY FACTS

- The Clinical and Systems Transformation project team completed their re-planning work in April, and are now designing the clinical information system, and developing consistent clinical practices and workflows across the three organizations (Vancouver Coastal, Provincial Health Services Authority and Providence Health Care).
- As part of the replanning work, the project team identified some necessary clinical improvements to the project. These elements include:
 - Enhanced oncology for cancer care.
 - Ambulatory Care.
 - Behavioural Health – i.e., mental health and substance use services.
 - Bedside Medical Device Integration – the seamless integration of data from vital sign monitors, so that nurses do not need to manually input this data.
 - Provider documentation – the original scope envisioned that doctors would continue to document patient notes on paper, while the rest of the patient chart was electronic, a clear deficiency that would increase risk to patients.
 - Physician voice-recognition dictation.
 - Added resources for learning and training.
- Implementation is scheduled to begin spring 2017 at the first sites – Lions Gate Hospital and Sea-to-Sky facilities – building on the opening the new Regional Pharmacy Production Centre scheduled for this fall 2016.
- This will be followed by implementation at the BC Cancer Agency.
- The sequencing of implementation at sites after BC Cancer will be refined, based on the learnings from the first sites – implementation is always an iterative process of adjusting and fine-tuning.
- This is a true “enterprise” solution, designed to establish common workflows and practices for all three organizations. This clinical transformation will be an ongoing process over the next year.

Chronology

- April 2013 – CST Project begins with IBM.
- March 2015 – Health organizations and IBM agree to end contract.
- April – September 2015 – Project reset completed, with assistance of PriceWaterhouseCoopers.
- July 2015 – Cerner retained as new project partner.
- October 2015 – Replanning phase initiated with Cerner.
- February 2016 – Design and Configuration work begins.
- April 2016 – Review and replanning work completed.

Key Highlights of the Project Refresh

- A governance structure that ensures accountability, transparency and proactive risk management;

FACT SHEET

- External advisors on the Project Board with relevant industry experience to help inform decision-making;
- A shift in responsibility for project management and project delivery from a contracted service provider to the health organizations;
- A new agreement with the project's software provider Cerner;
- A new external project assurance function for formal, objective project oversight;
- An improved approach to the design of clinical workflows and configuration of the new clinical information system;
- A comprehensive review of the project scope for alignment with the CST clinical goals and clinical workflow; and
- Review, refinement and validation of the CST clinical goals and objectives and alignment of workstreams with financial objectives.

Design and Configuration Process Improvements:

- A pre-configured system – the foundation for the continuation of design work will be Cerner's pre-built "Model System," a fully functioning prototype based on global best practices from Intermountain Healthcare, one of Cerner's leading clients.
- Seeing our work as we go – building on the Model System, our design teams will be able to map our requirements from the first phase of design and make progressive, iterative improvements throughout the design and configuration process.
- A clear and robust validation process – with the ability to create prototypes of our new system, we are better able to identify and fix problems before they are set in stone – making validation an ongoing part of our process.
- New program and specialty liaison roles – these clinical informatics resources will be an important point of contact between the design teams and the clinical programs and specialty areas of our health organizations, bringing a systemic view and helping facilitate the transformation from design through to implementation.

FINANCIAL IMPLICATIONS

- Based on the original Business Case, the total cost of ownership of the CST project, including both one-time costs and regular ongoing operating costs, was estimated to be \$842 million over 10 years. This was comprised of project costs of \$480 million capital expenditure and \$77 million operating for a total of \$557 million net new project costs, plus a \$285 million base spend over the 10 year period, primarily existing IT budget for the legacy systems or replacement systems.
- Total spending to date up to the launch of the design phase in February 2016 is \$177 million.

Approved by:

Paul Shrimpton, Health IT Strategy Branch; April 29, 2016

Stearn, Anne HLTH:EX

From: Brown, Stephen R HLTH:EX
Sent: Wednesday, November 16, 2016 8:20 AM
To: Shera, Deborah HLTH:EX
Subject: RE: Meeting with Michael Long and Bill Trafford

Ok thks – I will give you access to the report if you come by my office, Steve

From: Shera, Deborah HLTH:EX
Sent: Wednesday, November 16, 2016 7:49 AM
To: Brown, Stephen R HLTH:EX
Subject: Re: Meeting with Michael Long and Bill Trafford

Ok that's fine - your office said Sabine was invited. I will clarify for Michael. Could I get a copy of the report? See u later and I will have four slides re panorama in case you have time

Sent from my iPhone

On Nov 16, 2016, at 7:37 AM, Brown, Stephen R HLTH:EX <Stephen.Brown@gov.bc.ca> wrote:

Hi Deb

Only Lynn is joining us which I thought would be helpful as she will have a key role in following up on Doug C's IHealth report. I still need a frank conversation so that I can learn and understand better the issues. Steve

From: Shera, Deborah HLTH:EX
Sent: Tuesday, November 15, 2016 5:20 PM
To: Brown, Stephen R HLTH:EX
Subject: Meeting with Michael Long and Bill Trafford

Steve we originally set this up as a one on one with you to ensure a frank conversation. I understand the meeting has been broadened to include Sabine and Lynn. As Michael reports to a project board of Carl, Mary and Sabine it would put him in an awkward position to address any questions you may want to pose re CST in this setting eg with the board chair absent the other two. So I am proposing that I open the meeting and clearly articulate that we are here to "hear about experiences from Alberta in rolling out acute care systems" and that the conversation is limited to hearing from them on that topic.

He is by the way not charging his time or his travel to come to this meeting as he did not feel he could charge it to CST and I don't have a mechanism to pay him.

Ok?

Deborah Shera
ADM, Health Sector Information Management and Information Technology
Ministry of Health

Phone – 250.952.6202
Cell – 250.415.7462

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Stearn, Anne HLTH:EX

From: Feulgen, Sabine HLTH:EX
Sent: Wednesday, January 18, 2017 7:29 AM
To: Brown, Stephen R HLTH:EX; Stevenson, Lynn HLTH:EX
Subject: Draft report for the Ministry
Attachments: 2016-12-09 Report for Ministry of Health.docx

Hi Steve, Lynn

Attached is the report out from the CST project re: interviews with other Cerner clients. No surprises – just more validation of the experience and pitfalls to manage. It is a helpful reminder.

Sabine

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COLUMBIA

NOV 05 2015

1036195 (xref 1036231)

Ms. Judy Darcy
MLA, New Westminster
Official Opposition Spokesperson for Health
737 Sixth St.
New Westminster BC V3L 3C6

Dear Ms. Darcy *Judy*

Thank you for your letter of June 15, 2015, regarding your information requests from the Ministry of Health's May 2015 Estimates Debate. I apologize for the delayed response. I am writing today in response to your questions specific to the Clinical and Systems Transformation (CST) project.

You requested information about the number of full time equivalents (FTE) working on the CST project and the amount that is budgeted for staff. As of March 31, 2015, the total number of staff working on the project was equivalent to 178.3 FTEs. This equates to \$26.26 million in staffing costs. The team size was reduced in early May, and the total number of staff working on the project as of June 2015 is 138 FTEs.

The cost for the PricewaterhouseCoopers project assurance work on the CST project is \$1.6 million to mid-June 2015.

I trust this information satisfies your earlier queries.

Sincerely,

Terry Lake
Minister

Lake, Terry HLTH:EX

From: Anderson, Kristy GCPE:EX
Sent: Monday, September 5, 2016 10:04 PM
To: Lake, Terry HLTH:EX
Cc: hlth Ministerial and Executive Assistants; Belanger, Matthew GCPE:EX; Beneteau, Nicole GCPE:EX; MacDougall, Cindy GCPE:EX; May, Stephen GCPE:EX; Peaker, Alexandra GCPE:EX; Plank, Sarah GCPE:EX; Thistle-Walker, Carlene GCPE:EX; Brown, Stephen R HLTH:EX; Feulgen, Sabine HLTH:EX
Subject: FW: CST leadership memo and IN
Attachments: 20160906_Memo_CST leadership_v2.docx; 20160902_IN_CST leadership_v1.docx

FYI on the attached Minister - The Clinical and Systems Transformation (CST) Project Board is appointing a new Chief Transformation Officer, Michael Long, to lead the project through its next phase. Their IN and memo is attached.

Kristy Anderson
Director, Media Relations
Ministry of Health
250-952-3387 (office) 778-678-5200 (mobile)
Kristy.Anderson@gov.bc.ca



Memorandum

Date: Sep. 6, 2016

To: VCH, PHC and PHSA Leaders

From: **Mary Ackenhusen**, President & CEO, Vancouver Coastal Health
Dianne Doyle, President & CEO, Providence Health Care
Carl Roy, President & CEO, Provincial Health Services Authority

Re: **CST Project leadership**

Since the completion of our project reset in April, and launch of the Design/Configure/Validate phase, the CST project team has been working hard to get ready to successfully implement at Lions Gate Hospital and Sea-to-Sky facilities.

As interim Chief Transformation Officer over the past year, Jeremy Smith has helped lead the project through this reset process and some of its most important elements. Jeremy joined us at a critical juncture, replacing Rebecca Hahn during her s.22 He has successfully guided us through the planning phase, including implementing recommendations suggested last year by PricewaterhouseCoopers (PwC), helped build a strong and talented project team, and positioned us for future success.

As Jeremy's term comes to an end and the project moves closer to implementation, it's important that our project leadership reflect that changing focus.

To that end, the CST Project Board has appointed Michael Long as acting Chief Transformation Officer, to help us prepare for implementation and ensure we have the necessary leadership experience.

Michael brings a wealth of experience in the implementation and delivery of large health IT projects on behalf of health organizations. He served for three years as CIO of Alberta Health Services, implemented and led the eHealth portfolio and strategy for the government of South Australia, and has led the successful delivery of a number of electronic medical record projects.

More recently he has served since October as Director of Enterprise Architecture and Security for our organizations' shared IMITS team, and is a member of the CST Project Steering Committee, Data Decision Group and Technical Decision Group, all of which will help ensure a timely, smooth leadership transition.

Jeremy will remain with the CST project temporarily to support a smooth and orderly transition. Details regarding a replacement for Michael at IMITS will be communicated separately to the IMITS team. Please join us in thanking Jeremy for his many contributions that have paved the way for a successful CST implementation, and Michael for agreeing to lead us through the next phase.





CONFIDENTIAL ISSUES NOTE

Sep. 2, 2016 – Appointment of new CST Project Chief Transformation Officer

The Clinical and Systems Transformation (CST) Project Board is appointing a new Chief Transformation Officer, Michael Long, to lead the project through its next phase.

Background:

- The current Chief Transformation Officer Jeremy Smith was appointed on a one-year contract, effective July 13, 2015, to replace Rebecca Hahn who is s.22 s.22
- Now that the project has completed its project reset, and in April entered the Design, Configure and Validate phase, the Project Board has decided that new leadership is required with skills and direct experience in implementing a large project of this nature.
- On Sep. 6, the Project Board will internally announced the appointment of Michael Long as acting Chief Transformation Officer, to help the board prepare for implementation and ensure it has have the necessary leadership experience.
- Michael served for three years as CIO of Alberta Health Services, and since October as PHSA's Director of Enterprise Architecture and Security and a member of the CST Project Steering Committee, all of which will help ensure a timely, smooth leadership transition.

The CST Communications Department recommends that the following key messages:

Key Messages:

- As interim Chief Transformation Officer over the past year, Jeremy Smith helped successfully lead the project through its reset and planning phase.
- As Jeremy's term comes to an end and the project moves closer to implementation next year, it's important that our project leadership reflect that changing focus.
- Implementation is a different skillset to project planning, and requires strong, rigorous project management and oversight.
- Michael Long brings a wealth of experience in the implementation and delivery of large health IT projects; having served as CIO of Alberta Health Services, implemented the eHealth portfolio and strategy for the government of South Australia, and led the delivery of a number of electronic medical record projects.
- Jeremy will remain with the CST project temporarily, to enable a smooth transition.

If Asked about IHealth project and media reports about it

- These are two different projects at different phases.
- It's important to note that the Cerner clinical information system, being implemented by Island Health, Vancouver Coastal Health, Providence Health Care, Provincial Health Services Authority and Northern Health, is used successfully every day in thousands of organizations around the world, including across Canada.

DRAFT – Confidential Advice



CLINICAL + SYSTEMS TRANSFORMATION

Our path to smarter, seamless care

- A representative from Island Health sits on the CST Project Board to share their learnings, and the CST team is in regular contact with Island Health.
- In particular, the Island Health team has underscored the importance of implementation experience on any large project of this nature, the need for strong, robust project management and clinician engagement.

Contact Information			
Contact	Name	Title	Phone
Program:	Carl Roy	CEO, PHSA	Tel: 604-675-7497 Cell: 604-788-1610
Communications	Dave Cunningham	CCO, PHSA	Tel: 604-875-7147 Cell: 604-837-5360
Spokesperson(s)	Carl Roy		
Creation & Revision History			
Sep. 1, 2016		D. Cunningham	

DRAFT

DRAFT – Confidential Advice

Lake, Terry HLTH:EX

From: Anderson, Kristy GCPE:EX
Sent: Tuesday, July 5, 2016 3:40 PM
To: Lake, Terry HLTH:EX
Cc: Feulgen, Sabine HLTH:EX; hlth Ministerial and Executive Assistants
Subject: Issues note - CST leadership
Attachments: 20160623_IN_CST leadership.docx; CST memo - P Hudson v2.docx

Hi Minister

I believe you are aware of some possible changes in the CST leadership – see attached IN.

AAAA
I have been speaking with PHSA on this today and wanted to update you on a couple of things. The current Chief Transformation Officer Jeremy Smith, has in principle agreed to stay on the project and work with new leadership. s.22 is being considered for the position and will be visiting the site next week to determine if s.22 will take the job. PHSA has drafted the attached memo about s.22 site visit. The memo only mentions that s.22 is there for a visit as an expert. Followings.22 visit s.22 will decide if s.22 wants to take on the project. They will be keeping the distribution of the memo very small. It is scheduled to go out tomorrow morning.

Please let me know if you have any questions/concerns.

Cheers,

Kristy Anderson
Manager Media Relations
Ministry of Health
250-952-3387 (office) 778-678-5200 (mobile)
Kristy.Anderson@gov.bc.ca

CONFIDENTIAL ISSUE NOTE

June 23, 2016 – Appointment of new CST Project Chief Transformation Officer

The Clinical and Systems Transformation (CST) Project Board has decided to appoint a new Chief Transformation Officer to lead the project through its next phase.

Background:

- The current Chief Transformation Officer Jeremy Smith was appointed on a one-year contract, effective July 13, 2015, to replace Rebecca Hahn who is ^{s.22}
s.22
- Now that the project has completed its project reset, and entered the Design, Configure and Validate phase, the Project Board has decided that new leadership is required with skills and direct experience in implementing a large project of this nature.
- A potential replacement has been identified but not yet appointed.

The Provincial Health Services Authority - Communications Department recommends that the following key messages be communicated publicly:

Key Messages:

- This appointment was a one-year contract, and was structured all along as an interim appointment to cover s.22
- Jeremy has done a good job in implementing recommendations suggested by PricewaterhouseCoopers (PwC), who were retained by the health authorities last year to advise on the project, and in completing the project reset.
- Now that the project has entered the next phase of "design, configure, validate" for the new Cerner clinical information system, and shared clinical processes, the project board will be appointing a project lead with direct experience in implementing a large project of this nature.
- Implementation is a different skillset to project planning, and requires strong, rigorous project management and oversight.
- We hope and expect that Jeremy will remain part of the senior leadership team of the CST project, to retain his expertise and knowledge.

If Asked about IHealth project and media reports about it

- These are two different projects at different phases.
- It's important to note that the Cerner clinical information system, being implemented by Island Health, Vancouver Coastal Health, Providence Health Care, Provincial Health Services Authority and Northern Health, is used successfully every day in thousands of organizations around the world, including across Canada.
- A representative from Island Health sits on the CST Project Board to share their learnings, and the CST team is in regular contact with Island Health.
- That said, the Island Health team has certainly reinforced to their counterparts at other health authorities the implementation risks and challenges associated with any large project like this, and the need for strong, robust project management and clinician engagement.

Contact Information			
Contact	Name	Title	Phone
Program:	Carl Roy	CEO	Tel:
Communications	Dave Cunningham	Chief Communications Officer	Tel: 604-875-7147 Cell: 604-837-5360
Spokesperson(s)	Carl Roy		
Creation & Revision History			
June 23 draft		D. Cunningham	

DRAFT



Memorandum

Date: Jul. 3, 2016

To: CST senior staff and Health Organization leaders

From: **Mary Ackenhuse**n, President & CEO, Vancouver Coastal Health
Dianne Doyle, President & CEO, Providence Health Care
Carl Roy, President & CEO, Provincial Health Services Authority
Jeremy Smith, Chief Transformation Officer

Re: **Meetings with Pamela Hudson**

Since the completion of our project reset in April, and launch of the clinical transformation and enterprise design phase, the CST project team has been doing great work getting ready to successfully implement the Cerner system at Lions Gate Hospital and Sea-to-Sky facilities.

That said, there are some critical subject matter expert vacancies in key areas that have been difficult to fill, and are challenging the team. These areas include software and system configuration, sustainment and implementation.

To assist the team we have arranged for Pamela Hudson, who is experienced with projects of a similar size and scope, to provide her perspective on the key project challenges at the current time, as well as her strategic input on the critical resources required at this stage. Pamela will be on site Monday July 11 meeting with selected project leadership and will provide her immediate feedback following her visit.

Jeremy will finalize the schedule of meetings by Wednesday. These will include, but not be limited to, meetings with:

- Dr. Eric Grafstein, VCH Chief Medical Information Officer, and Barb Lawrie, Chief Clinical Information Officer, given the priority of our Coastal Group 1 implementation;
- Peggy Ah Yong, Director CST Project Management Office;
- Oliver Gruter-Andrew, Chief Information Officer, Michael Long and Laura White;
- Cerner, and Ernst & Young, our project assurance advisor.

We would ask you to ensure you are able to provide Pam with your candid assessment of the challenges and resources required to ensure our first Group 1 implementation is a resounding success.

Lake, Terry HLTH:EX

From: Plank, Sarah GCPE:EX
Sent: Monday, May 30, 2016 1:58 PM
To: Lake, Terry HLTH:EX
Cc: hlth Ministerial and Executive Assistants; Feulgen, Sabine HLTH:EX; Shera, Deborah HLTH:EX; Anderson, Kristy GCPE:EX; Belanger, Matthew GCPE:EX; Beneteau, Nicole GCPE:EX; Frattaroli, Angela GCPE:EX; Heinze, Laura R GCPE:EX; MacDougall, Cindy GCPE:EX; May, Stephen GCPE:EX; Peaker, Alexandra GCPE:EX
Subject: RE: MEDIA REQUEST - Cindy Harnett, Times Colonist - IHealth

Okay. She has asked me directly whether the ministry/minister will be asking Island Health to pause implementation. I would like to at least let her know that we are not...

Also just flagging that Rob Shaw has now contacted us as well, looking at this from a broader perspective on IT projects, so we will be sending up that request to you shortly.

Sarah.

From: Lake, Terry HLTH:EX
Sent: Monday, May 30, 2016 1:24 PM
To: Plank, Sarah GCPE:EX
Cc: hlth Ministerial and Executive Assistants; Feulgen, Sabine HLTH:EX; Shera, Deborah HLTH:EX; Anderson, Kristy GCPE:EX; Belanger, Matthew GCPE:EX; Beneteau, Nicole GCPE:EX; Frattaroli, Angela GCPE:EX; Heinze, Laura R GCPE:EX; MacDougall, Cindy GCPE:EX; May, Stephen GCPE:EX; Peaker, Alexandra GCPE:EX
Subject: Re: MEDIA REQUEST - Cindy Harnett, Times Colonist - IHealth

I did not want a response.

Sent from my BlackBerry 10 smartphone on the TELUS network.

From: Plank, Sarah GCPE:EX
Sent: Monday, May 30, 2016 12:46 PM
To: Lake, Terry HLTH:EX
Cc: hlth Ministerial and Executive Assistants; Feulgen, Sabine HLTH:EX; Shera, Deborah HLTH:EX; Anderson, Kristy GCPE:EX; Belanger, Matthew GCPE:EX; Beneteau, Nicole GCPE:EX; Frattaroli, Angela GCPE:EX; Heinze, Laura R GCPE:EX; MacDougall, Cindy GCPE:EX; May, Stephen GCPE:EX; Peaker, Alexandra GCPE:EX
Subject: FW: MEDIA REQUEST - Cindy Harnett, Times Colonist - IHealth

Hi Minister,

As you are not able to do the interview, Cindy Harnett has asked for a statement to address whether the province will be ordering Island Health to pause implementation in light of the challenges brought forward, and the fact that the system in Nanaimo has been used as an example of success in electronic health records but it does not seem to be working well.

Would this work from your perspective?

Draft Statement:

Electronic health records are about improving the quality and safety of patient care. The new IHealth system recently introduced in Nanaimo is the first stage of implementing a full electronic health record across the Island that will allow Island Health to continually improve quality of care for their patients. The introduction of IHealth in Nanaimo is a monumental change for frontline providers, and it is not unanticipated that staff and physicians are experiencing some challenges. Island Health recognizes these challenges – particularly in high-volume and high-acuity areas such as the ER and ICU – and is providing extra in-person hands-on supports for providers at NRGH.

There is no question that implementing a system transformation of this scope is difficult. Once implementation begins and a system is actually being used in a facility, it is expected and in fact planned that modifications will be made along the way. I have been assured that dedicated IHealth staff are working with individual doctors and staff to trouble-shoot specific processes that are not working as smoothly as they could and making improvements to workflow issues based on this feedback. Island Health continues to proactively work with providers to implement modifications to address any challenges as they come up.

Island Health has investigated the concerns raised and I have been reassured that the system is working as it should, with no evidence that it is changing or deleting orders. Island Health has done both an internal independent review of the system by their Quality and Safety department, and commissioned a review by an external expert from North York Hospital – which also implemented a Cerner electronic health record system – to ensure the system is safe and operating as it should.

Thanks,
Sarah.

Sarah Plank
Communications Director | Ministry of Health
Government Communications & Public Engagement
Office: 250.952.1889 | Mobile: 250.208.9621 | Email: sarah.plank@gov.bc.ca

From: Plank, Sarah GCPE:EX
Sent: Monday, May 30, 2016 10:49 AM
To: Lake, Terry HLTH:EX
Cc: hlth Ministerial and Executive Assistants; Feulgen, Sabine HLTH:EX; Shera, Deborah HLTH:EX; Anderson, Kristy GCPE:EX; Belanger, Matthew GCPE:EX; Beneteau, Nicole GCPE:EX; Frattaroli, Angela GCPE:EX; Heinze, Laura R GCPE:EX; MacDougall, Cindy GCPE:EX; May, Stephen GCPE:EX; Peaker, Alexandra GCPE:EX
Subject: MEDIA REQUEST - Cindy Harnett, Times Colonist - IHealth
Importance: High

Hi Minister,

Are you able to call Cindy today? She would need to speak to you before 1:30pm, as she's on the early shift today. Attached is the key messaging per our discussion with Island Health on Friday, as well as the current CST messaging. I think that will address her questions, but let me know if you need anything more.

Reporter: Cindy Harnett

Media outlet: Times Colonist

Telephone #: 250.380.5348 (o) / 250.213.3603 (c)

Deadline: 1:30pm

Questions:

I'm following up on my story from Thursday on Nanaimo doctors saying the iHealth system that went live 9 weeks ago is a failure and patient safety risk, causing mistakes in medication doses and pharmaceutical discharge sheets, as well as being slow and inefficient and difficult to use.

In a phone interview I would like to ask the Minister about:

- 1. His reaction to the Nanaimo doctors complaints given the health minister pointed to Cerner's iHealth implementation in Nanaimo as an example of the success of Cerner's system and an example for the rest of the province and how it would set the right course for Vancouver Coastal Health, PHSA, and Providence Health Care after the collapse of the \$842 million IBM system.*
- 2. What if anything the province will do to stop and suspend the implementation in Nanaimo until doctors agree its useable and safe?*
- 3. How much has the province spent on EHR development and implementation in total in the last 5 and 10 years?*

Proposed Response:

- Electronic health records are about improving the quality and safety of patient care.
- The new IHealth system recently introduced in Nanaimo is the first stage of implementing a full electronic health record across the Island.
- It will provide a single record of a person's health history that will allow Island Health to continually improve quality of care for their patients.
- The introduction of IHealth in Nanaimo is a monumental change for frontline providers – it is not unexpected that staff and physicians are experiencing some challenges.
- Island Health recognizes these challenges – particularly in high-volume and high-acuity areas such as the ER and ICU – and is providing extra in-person hands-on supports in these areas.
- As part of this, dedicated IHealth staff are working with individual doctors and staff to trouble-shoot specific processes that are not working as smoothly as they could and making improvements to the system in real-time.

- Island Health has investigated the concerns raised by the physician in the article – I have been reassured that the system is working as it should, with no evidence that it is changing or deleting orders.
- Island Health commissioned a review of the system by their separate Quality and Safety department, which determined IHealth in Nanaimo is just as safe as the previous paper-based system.
- Additionally, Island Health brought in an external expert from North York Hospital – which also implemented a Cerner electronic health record system – to review the implementation in Nanaimo to ensure everything is going as expected.

CST project

- Electronic health records are about improving the quality and safety of patient care.
- Clinical and Systems Transformation is a major transformation of clinical processes and care protocols across the three health organizations, focused on achieving the safe and consistent services of an integrated health system as our patients expect.
- This is a large and complex project.
- We knew from the outset that this wasn't going to be an easy project – but we also recognized that it was important for patients in the Lower Mainland and those across the province accessing specialized provincial services.
- The CST project board committed to looking at the entire project in depth as part of the project reset that began last year - including scope, resources and implementation.
- The CST board has been doing the due diligence and planning necessary to ensure the project is done properly.
- The team is moving forward with testing and configuration to get ready for implementation of full electronic medical records at the first site in the Lower Mainland next year – Lion's Gate Hospital in Spring 2017.
- Fine-tuning and validating common workflows and practices, as well as education and training, will be ongoing over the next year in the North Shore and Sea-to-Sky region facilities.

- Learnings from the first sites implemented will be incorporated into the successive implementations at other facilities.
- In March, I went up to Nanaimo where Island Health has just started the first phase to bring their IHealth electronic record system online.
- The IHealth project has been very successful so far and will be a huge benefit to quality and safety in the entire health system on Vancouver Island.
- It has not been without challenges and course corrections along the way – as would any project of this size and magnitude.
- Island Health is now providing their expertise to the CST project to help incorporate some of their lessons learned into that project.

If asked about project reset:

- This program had challenges initially – which is why we took a step back and made the decision to reset the program.
- That reset has allowed the project team – supported by stronger governance – to reposition the project and put it on solid ground.
- The ministry has learned from our experience with other large IT projects, including the valuable review of the Panorama public health system by the Auditor General.
- We also secured PriceWaterhouseCooper last year to help identify project management and governance issues as part of the project reset.
- As a result, we made changes to the governance and planning to ensure a better program that will improve the quality and consistency of patient and caregiver experiences.
- As part of their re-planning work over the past year, the project team has also realized we needed to engage frontline clinicians which has added valuable clinical elements that will ensure the system meets the needs of our health care providers – thereby ensuring better patient care.
- Clinical input is key – user adaption is critical to the success of this program.
- The Ministry met with the Auditor General in the fall to discuss the way forward on the project and actions taken to strengthen its governance – to ensure we are on the right track.

- We will be meeting again with the Auditor General in May to provide an update and get any feedback on our approach.
- With this new model, with improved governance, project management and a better plan for change management and incorporating clinical needs – we can provide a better service.
- That includes implementing it in phases, to make adjustments on the go to improve the program, so that we have the best possible system for staff.

Sarah Plank

Communications Director | Ministry of Health

Government Communications & Public Engagement

Office: 250.952.1889 | Mobile: 250.208.9621 | Email: sarah.plank@gov.bc.ca

Key Messages – Clinical Systems Transformation

May 1, 2016

- Electronic health records are about improving the quality and safety of patient care.
- Clinical and Systems Transformation is a major transformation of clinical processes and care protocols across the three health organizations, focused on achieving the safe and consistent services of an integrated health system as our patients expect.
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- That includes implementing it in phases, to make adjustments on the go to improve the program, so that we have the best possible system for staff.

If asked about changes in scope:

- Implementation will start at Vancouver Coastal sites on the North Shore and Sea-to-Sky, called Group 1, and will be followed by the BC Cancer Agency, Group 2.
- The sequence of other sites after Group 2 will be refined, based on the learnings from those sites.
- Implementation is always an iterative process of adjusting and fine-tuning after the first sites.
- It's important to note that while implementation will begin at Vancouver Coastal sites, this true “enterprise” solution is

being designed to establish common workflows and practices for all three health organizations.

- This clinical transformation will be an ongoing process over the next year.

CST Governance:

- The Project Board was strengthened last spring to improve governance.
- It includes the three health authority CEOs, ministry leadership and the project's Chief Transformation Officer, as well as the External Advisors for the project – to provide expert, independent advice on potential risks.
- It also includes a non-voting member from Island Health to share lessons learned from their Cerner IHealth project.
- The board meets regularly to provide ongoing direction and oversight, and to review scope, scheduling and budget planning. All major financial decisions must be approved by the Project Board.

Benefits of the project:

- The CST clinical goals, or “Drivers” reflect the anticipated benefits of the project:
 - *Reduce errors and adverse events:* Up to 24,000 Canadian adults die every year because of preventable adverse events in acute care hospitals – and those are just the incidents we can measure. We can do better. That's why we are investing in a safer future today.
 - *Improve quality and consistency of care:* We are designing safe, efficient care pathways that reflect the

latest evidence and will reduce unnecessary variations in care across our facilities and healthcare organizations. We are supporting a culture of continuous learning and quality improvement.

- *Improve the healthcare experience for patients and care teams:* When care teams have the information they need at their fingertips, it means more time for patients. Transitions across health care settings will be smoother; everyone will be on the same page about the plan of care. Care teams won't have to ask the same questions over and over or repeat tests.
- *Make better information available to improve decision-making:* Fuller, richer information will give us a clearer picture of how we're doing and where we can improve. Data from today will be used to benefit the patients of tomorrow – across health disciplines and organizations.
- *Improve system reliability and sustainability:* Right now, we use over 200 systems and programs. Logging in, logging out, forgetting passwords: all this takes time away from patient care. Many of our outdated systems will be replaced with one clinical information system, which will connect with other key systems. This will reduce investment, maintenance and training costs.

Key Messages – IHealth

May 2016

- Electronic health records are about improving the quality and safety of patient care.
- The new IHealth system recently introduced in Nanaimo is the first stage of implementing a full electronic health record across the Island.
- It will provide a single record of a person's health history that will allow Island Health to continually improve quality of care for their patients.
- The introduction of IHealth in Nanaimo is a monumental change for frontline providers – it is not unexpected that staff and physicians are experiencing some challenges.
- Island Health recognizes these challenges – particularly in high-volume and high-acuity areas such as the ER and ICU – and is providing extra in-person hands-on supports in these areas.
- As part of this, dedicated IHealth staff are working with individual doctors and staff to trouble-shoot specific processes that are not working as smoothly as they could and making improvements to the system in real-time.
- Island Health has investigated the concerns raised by the physician in the article – I have been reassured that the system is working as it should, with no evidence that it is changing or deleting orders.
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- Additionally, Island Health brought in an external expert from North York Hospital – which also implemented a Cerner electronic health record system – to review the implementation in Nanaimo to ensure everything is going as expected.

Lake, Terry HLTH:EX

From: Anderson, Kristy GCPE:EX
Sent: Sunday, May 1, 2016 7:50 PM
To: Lake, Terry HLTH:EX
Cc: hlth Ministerial and Executive Assistants; Belanger, Matthew GCPE:EX; Beneteau, Nicole GCPE:EX; Heinze, Laura R GCPE:EX; Lawrie, Hannah GCPE:EX; MacDougall, Cindy GCPE:EX; May, Stephen GCPE:EX; Peaker, Alexandra GCPE:EX; Plank, Sarah GCPE:EX; Thistle-Walker, Carlene GCPE:EX
Subject: FINAL IN - CST Updated Note
Attachments: PHSA IN - CST project plan update - Apr 29.docx; IN_CST update_Apr 29_16_FINAL.DOCX

Hi Minister

As you are aware there have been some changes to the CST project – see below. We have updated our note to reflect the current status of the project. We have attached it here as well as PHSA's and we will be adding them to your binder as this one always comes up in Estimates.

- Implementation sites and schedules have been reorganized to better reflect more efficient sequencing and better use of resources. Implementation will begin with Group 1 at Lions Gate Hospital followed by Sea-to-Sky facilities (Squamish General Hospital, Pemberton Health Centre and Whistler Health Care Center) in 2017.
- Group 2 implementation will capture BC Cancer Agency sites throughout the province.
- Other sites will be added after implementation of the first two groups – and use the information learned from the previous implementations to help guide the process.

Kristy Anderson
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Ministry of Health
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Kristy.Anderson@gov.bc.ca



CONFIDENTIAL ISSUES NOTE

Apr. 29, 2016 – CST project plan update

The Clinical and Systems Transformation (CST) Project has completed its review and replanning process, and has launched its design phase, while also preparing for the first implementation at Lions Gate Hospital and other Vancouver Coastal "Sea to Sky" sites. The project budget remains \$842 million, with a scope that better reflects the clinical goals of the project – an outcome of the learnings realized through the re-plan work undertaken over the last year.

The CST Communications team recommends the following key messages.

Key Messages:

- The Clinical and Systems Transformation project team completed their re-planning work in April, and are now designing the clinical information system, and developing consistent clinical practices and workflows across the three organizations.
- Implementation is scheduled to begin next spring 2017 at the first sites – Lions Gate Hospital and Sea-to-Sky facilities – building on the opening the new Regional Pharmacy Production Centre scheduled for this fall 2016.
- As part of the replanning work, the project team identified some necessary clinical improvements to the project. These elements include:
 - Enhanced oncology for cancer care.
 - Ambulatory Care.
 - Behavioural Health – ie. mental health and substance use services.
 - Bedside Medical Device Integration – the seamless integration of data from vital sign monitors, so that nurses do not need to manually input this data.
 - Provider documentation – the original scope envisioned that doctors would continue to document patient notes on paper, while the rest of the patient chart was electronic, a clear deficiency that would increase risk to patients.
 - Physician voice-recognition dictation.
 - Added resources for learning and training.
- As part of prudent project-management, adjustments will always be made along the way.
- For example, the original plan for Island Health's new IHealth system did not include voice dictation capability for physicians – it was added to the plan later based on clinician input, and physicians using the system in the Nanaimo ER say they could not function without it.
- Likewise, the CST project did not have this functionality initially, but clinical engagement resulted in a recommendation that this element of design should be included.
- Implementation will start at Vancouver Coastal sites on the North Shore and Sea-to-Sky, called Group 1, and will be followed by the BC Cancer Agency, Group 2.

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CLINICAL + SYSTEMS TRANSFORMATION

Our path to smarter, seamless care

- The sequence of other sites after Group 2 will be refined, based on the learnings from those sites – implementation is always an iterative process of adjusting and fine-tuning after the first sites.
- It's important to note that while implementation will begin at Vancouver Coastal sites, this is a true "enterprise" solution, designed to establish common workflows and practices for all three health organizations.
- This clinical transformation will be an ongoing process over the next year.

How were the initial sites chosen

- Best practice in a project like this is to begin in a mid-sized hospital, with a wide range of clinical services, before moving on to more complex sites.
- Lions Gate Hospital has an aging technology system (shared with Sea-to-Sky facilities) that requires replacement.
- The Group 1 sites were selected based on these principles, after extensive consultation with leaders across the three organizations.

General messaging

- The Clinical and Systems Transformation project is a joint initiative of three health organizations: Vancouver Coastal Health, Provincial Health Services Authority and Providence Health Care.
- The project is designed to transform healthcare delivery systems and processes to improve the quality and consistency of the patient and caregiver experience.
- CST will support the health organizations in establishing common clinical and process standards, including work flows, order sets, clinical guidelines, integrated plans of care and a common electronic health record.
- This clinical transformation will be supported by the implementation of a clinical information system that will replace aging existing systems.
- The project will be implemented in stages across the health organizations.

Background:

Chronology:

- April 2013 – CST Project begins with IBM.
- March 2015 – Health organizations and IBM agree to end contract.
- April – September 2015 – Project reset completed, with assistance of PriceWaterhouseCoopers.
- July – Cerner retained as new project partner.
- October 2015 – Replanning phase initiated with Cerner.
- February 2016 – Design and Configuration work begins.
- April 2016 – Review and replanning work completed.

Key highlights of the project refresh:

- A governance structure that ensures accountability, transparency and proactive risk management.
- external advisors on the Project Board with relevant industry experience to help inform decision-making;

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A joint initiative of:

Vancouver
Coastal Health

Provincial Health
Services Authority
Providence Health
Care

Providence
HEALTH CARE



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- a shift in responsibility for project management and project delivery from a contracted service provider to the health organizations;
- a new agreement with the project's software provider Cerner;
- a new external project assurance function for formal, objective project oversight;
- an improved approach to the design of clinical workflows and configuration of the new clinical information system;
- several important appointments, including those of Chief Transformation Officer, Chief Clinical Information Officer (clinical lead), and Project Management Office Director;
- a comprehensive review of the project scope for alignment with the project's clinical goals and clinical workflow; and
- review, refinement and validation of the CST project clinical goals and objectives and alignment of workstreams with financial objectives.

Design and Configuration Process Improvements:

- A pre-configured system – the foundation for the continuation of design work will be Cerner's pre-built "Model System," a fully functioning prototype based on global best practices from Intermountain Healthcare, one of Cerner's leading clients.
- Seeing our work as we go – Building on the Model System, our design teams will be able to map our requirements from the first phase of design and make progressive, iterative improvements throughout the design and configuration process.
- A clear and robust validation process – With the ability to create prototypes of our new system, we are better able to identify and fix problems before they are set in stone – making validation an ongoing part of our process.
- New program/specialty liaison roles – These clinical informatics resources will be an important point of contact between the design teams and the clinical programs and specialty areas of our health organizations, bringing a systemic view and helping facilitate the transformation from design through to implementation.

Project Budget:

- Based on the original Business Case, the total cost of ownership of the CST project, including both one-time costs and regular ongoing operating costs, was estimated to be \$842 million over 10 years. This was comprised of project costs of \$480 million capital expenditure and \$77 million operating for a total of \$557 million net new project costs, plus a \$285 million base spend over the 10 year period, primarily existing IT budget for the legacy systems or replacement systems.
- Total spending to date up to the launch of the design phase in Feb. 2016 is \$177 million. Of this spend, the majority was on labour costs for health organization staff and clinicians, whose learnings and experience gained from the project's early work on clinical practices and workflows will continue to benefit the project moving forward.
- There is a contractual obligation not to make any public reference to the dispute resolution process with IBM, and to keep the settlement payment / total payment to IBM confidential.

Contact information

Contact	Name	Title	Phone

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Vancouver
CoastalHealth

A joint initiative of

Provincial Health
Services Authority
Provincial Health Services
British Columbia

Providence
Healthcare
How you make a difference



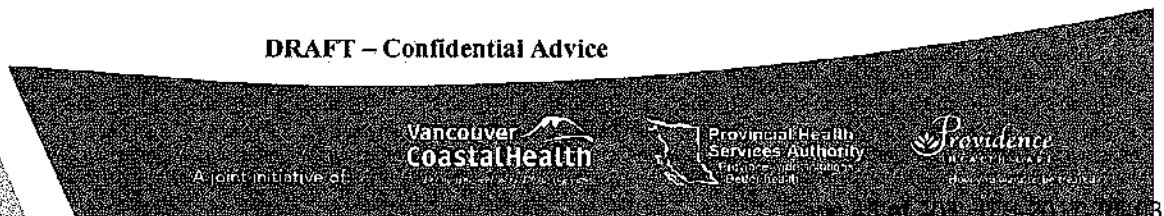
CLINICAL + SYSTEMS TRANSFORMATION

Our path to smarter, seamless care

Program	Jeremy Smith	Chief Transformation Officer, CST	604-875-4732 (o) 250-889-6720 (c)
Communications	Dave Cunningham	CCO – PHSA	604-837-5360 (c)
Creation & revision history			
Mar. 8, 2016		Issues note created	
Mar. 9		Reviewed by Sabine Feulgen	
Apr. 7		Updated draft	
Apr. 27		Reviewed by Jeremy Smith	

DRAFT

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ADVICE TO MINISTER

CONFIDENTIAL ISSUES NOTE

Ministry: Health

Date: April 29, 2016

Minister Responsible: Terry Lake

Clinical Services Transformation update

BACKGROUND REGARDING THE ISSUE:

- The CST project is a joint initiative of Vancouver Coastal Health, Provincial Health Services Authority and Providence Health Care. CST is designed to transform healthcare delivery processes and systems –through a new Cerner IT system for electronic health records – to improve the quality and consistency of the patient and caregiver experience.
- CST will support the health authorities in establishing common clinical and process standards, including work flows, order sets, clinical guidelines, integrated care plans and a common clinical information system to replace multiple aging existing systems.
- The project was originally awarded to IBM Canada, however the project board and IBM mutually agreed to part ways in early 2015.
- After Cerner was retained as the new project partner in July 2015 – the project board initiated a review of the scope, schedule and implementation of CST.
- Subsequently, implementation sites and schedules have been reorganized to better reflect more efficient sequencing and better use of resources. Implementation will begin with Group 1 at Lions Gate Hospital followed by Sea-to-Sky facilities (Squamish General Hospital, Pemberton Health Centre and Whistler Health Care Center) in 2017.
- Group 2 implementation will capture BC Cancer Agency sites throughout the province.
- Other sites will be added after implementation of the first two groups – and use the information learned from the previous implementations to help guide the process.
- Engagement has begun with health care staff at Lions Gate already, to prepare for the launch of CST in Spring 2017, as change management of this magnitude is difficult.
- The project reset work over the past year resulted in some refinements to the plan:
 - A pre-configured system - the foundation for continued design work will be Cerner's pre-built "Model System," a fully functioning prototype based on global best practices from Intermountain Healthcare, one of Cerner's leading clients.
 - Building on the Model System, design teams will be able to map requirements from the first phase of design and make progressive, iterative improvements throughout the design and configuration process.
 - A new "agile" methodology will closely involve staff on the ground, allowing changes to be shared and tested immediately with both the subject matter experts who participated and broader stakeholders, to ensure it meets their needs. The methodology helps ensure user adaption and clinical driven change.

DISCUSSION/ADVICE:

- The budget of the CST project was estimated to be \$842 million over 10 years.

- As of January 2015, expenditure to date is \$175.5 million: \$147 million in capital (more than half for health authority staff salaries) and \$28.6 million in operating spending.

ADVICE AND RECOMMENDED RESPONSE:

- **Electronic health records are about improving the quality and safety of patient care.**
- **Clinical and Systems Transformation is a major transformation of clinical processes and care protocols across the three health organizations, focused on achieving the safe and consistent services of an integrated health system as our patients expect.**
- **This is a large and complex project.**
- **We knew from the outset that this wasn't going to be an easy project – but we also recognized that it was important for patients in the Lower Mainland and those across the province accessing specialized provincial services.**
- **The CST project board committed to looking at the entire project in depth as part of the project reset that began last year - including scope, resources and implementation.**
- **The CST board has been doing the due diligence and planning necessary to ensure the project is done properly.**
- **The team is moving forward with testing and configuration to get ready for implementation of full electronic medical records at the first site in the Lower Mainland next year – Lion's Gate Hospital in Spring 2017.**
- **Fine-tuning and validating common workflows and practices, as well as education and training, will be ongoing over the next year in the North Shore and Sea-to-Sky region facilities.**
- **Learnings from the first sites implemented will be incorporated into the successive implementations at other facilities.**
- **In March, I went up to Nanaimo where Island Health has just started the first phase to bring their IHealth electronic record system online.**
- **The IHealth project has been very successful so far and will be a huge benefit to quality and safety in the entire health system on Vancouver Island.**
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- **Island Health is now providing their expertise to the CST project to help incorporate some of their lessons learned into that project.**

If asked about project reset:

- **This program had challenges initially – which is why we took a step back and made the decision to reset the program.**
- **That reset has allowed the project team – supported by stronger governance – to reposition the project and put it on solid ground.**

ADVICE TO MINISTER

- The ministry has learned from our experience with other large IT projects, including the valuable review of the Panorama public health system by the Auditor General.
- We also secured PriceWaterhouseCooper last year to help identify project management and governance issues as part of the project reset.
- As a result, we made changes to the governance and planning to ensure a better program that will improve the quality and consistency of patient and caregiver experiences.
- As part of their re-planning work over the past year, the project team has also realized we needed to engage frontline clinicians which has added valuable clinical elements that will ensure the system meets the needs of our health care providers – thereby ensuring better patient care.
- Clinical input is key – user adaption is critical to the success of this program.
- The Ministry met with the Auditor General in the fall to discuss the way forward on the project and actions taken to strengthen its governance – to ensure we are on the right track.
- We will be meeting again with the Auditor General in May to provide an update and get any feedback on our approach.
- With this new model, with improved governance, project management and a better plan for change management and incorporating clinical needs – we can provide a better service.
- That includes implementing it in phases, to make adjustments on the go to improve the program, so that we have the best possible system for staff.

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- This clinical transformation will be an ongoing process over the next year.

CST Governance:

- The Project Board was strengthened last spring to improve governance.

- It includes the three health authority CEOs, ministry leadership and the project's Chief Transformation Officer, as well as the External Advisors for the project – to provide expert, independent advice on potential risks.
- It also includes a non-voting member from Island Health to share lessons learned from their Cerner IHealth project.
- The board meets regularly to provide ongoing direction and oversight, and to review scope, scheduling and budget planning. All major financial decisions must be approved by the Project Board.

Benefits of the project:

- The CST clinical goals, or “Drivers” reflect the anticipated benefits of the project:
 - ***Reduce errors and adverse events:*** Up to 24,000 Canadian adults die every year because of preventable adverse events in acute care hospitals – and those are just the incidents we can measure. We can do better. That's why we are investing in a safer future today.
 - ***Improve quality and consistency of care:*** We are designing safe, efficient care pathways that reflect the latest evidence and will reduce unnecessary variations in care across our facilities and healthcare organizations. We are supporting a culture of continuous learning and quality improvement.
 - ***Improve the healthcare experience for patients and care teams:*** When care teams have the information they need at their fingertips, it means more time for patients. Transitions across health care settings will be smoother; everyone will be on the same page about the plan of care. Care teams won't have to ask the same questions over and over or repeat tests.
 - ***Make better information available to improve decision-making:*** Fuller, richer information will give us a clearer picture of how we're doing and where we can improve. Data from today will be used to benefit the patients of tomorrow – across health disciplines and organizations.
 - ***Improve system reliability and sustainability:*** Right now, we use over 200 systems and programs. Logging in, logging out, forgetting passwords: all this takes time away from patient care. Many of our outdated systems will be replaced with one clinical information system, which will connect with other key systems. This will reduce investment, maintenance and training costs.

Communications Contact:	Stephen May	Reviewer:
Program Area Contact:	Sabine Feulgen	
File Created:	April 26, 2016	
File Updated:	April 29, 2016	

Minister's Office	Program Area	Deputy	HLTH Communications

Lake, Terry HLTH:EX

From: Plank, Sarah GCPE:EX
Sent: Monday, March 7, 2016 11:41 AM
To: Lake, Terry HLTH:EX
Cc: hlth Ministerial and Executive Assistants; Heinze, Laura R GCPE:EX; Feulgen, Sabine HLTH:EX; Brown, Stephen R HLTH:EX
Subject: article

Hi Minister,

This didn't make it into the morning clippings, so sending it directly...

Vancouver Sun, Page A09, 04-Mar-2016

Health IT project on track, says minister Lake

By Rob Shaw

Copyright

Thx, S.

Sarah Plank

Communications Director | Ministry of Health

Government Communications & Public Engagement

Office: 250.952.1889 | Mobile: 250.208.9621 | Email: sarah.plank@gov.bc.ca

Lake, Terry HLTH:EX

From: Heinze, Laura R GCPE:EX
Sent: Tuesday, March 1, 2016 1:14 PM
To: Lake, Terry HLTH:EX
Cc: May, Stephen GCPE:EX; Belanger, Matthew GCPE:EX; MacDougall, Cindy GCPE:EX; Thistle-Walker, Carlene GCPE:EX; Shepherd, Brent GCPE:EX; Beneteau, Nicole GCPE:EX; Frattaroli, Angela GCPE:EX; Lawrie, Hannah GCPE:EX; Plank, Sarah GCPE:EX; hlth Ministerial and Executive Assistants
Subject: RE: MEDIA REQUEST: Rob Shaw -- Van Sun -- CST -- 250-893-0841

For sure -- here I have added with our other messaging around the other work to date..

- The project board has been looking at the project as a whole since the project reset last year - including scope, resources and implementation.
- That work is still underway. No decisions have been made.
- It is important that the project board do the due diligence and planning necessary to ensure the project is done properly. That is the work they are doing now, and we need to let them do that work.
- That said, throughout this process, work has continued in the last few months on the project, focusing on improving the governance structure, assessing the work already done, and updating the project plan. Achievements of this re-planning work include:
 - A governance structure that ensures accountability, transparency and proactive risk management;
 - External advisors on the Project Board with relevant industry experience to help inform decision-making;
 - A shift in responsibility for project management and project delivery from a contracted service provider to the health organizations;
 - A new agreement with our software provider Cerner;
 - A new external project assurance function for formal, objective project oversight;
 - An improved approach to the design of clinical workflows and configuration of the new clinical information system;
 - Several important appointments, including those of Chief Transformation Officer, Chief Clinical Information Officer (clinical lead), and Project Management Office Director.
 - A comprehensive review of project scope for alignment with the clinical goals and clinical workflow.
- This project remains a priority for the Health Organizations and will continue. The Clinical Systems Transformation project will have many benefits for our patients, staff, physicians and the health system as a whole.

From: Lake, Terry HLTH:EX
Sent: Tuesday, March 1, 2016 12:37 PM
To: Heinze, Laura R GCPE:EX
Cc: May, Stephen GCPE:EX; Belanger, Matthew GCPE:EX; MacDougall, Cindy GCPE:EX; Thistle-Walker, Carlene GCPE:EX; Shepherd, Brent GCPE:EX; Beneteau, Nicole GCPE:EX; Frattaroli, Angela GCPE:EX; Lawrie, Hannah GCPE:EX; Plank, Sarah GCPE:EX; Heinze, Laura R GCPE:EX; hlth Ministerial and Executive Assistants
Subject: Re: MEDIA REQUEST: Rob Shaw -- Van Sun -- CST -- 250-893-0841

Can't we add more in regarding the governance structure with MoH oversight?

Sent from my BlackBerry 10 smartphone on the TELUS network.

From: Heinze, Laura R GCPE:EX
Sent: Tuesday, March 1, 2016 12:22 PM
To: Lake, Terry HLTH:EX

Cc: May, Stephen GCPE:EX; Belanger, Matthew GCPE:EX; MacDougall, Cindy GCPE:EX; Thistle-Walker, Carlene GCPE:EX; Shepherd, Brent GCPE:EX; Beneteau, Nicole GCPE:EX; Frattaroli, Angela GCPE:EX; Lawrie, Hannah GCPE:EX; Plank, Sarah GCPE:EX; Heinze, Laura R GCPE:EX; hlth Ministerial and Executive Assistants
Subject: MEDIA REQUEST: Rob Shaw -- Van Sun -- CST -- 250-893-0841

Minister,

Rob Shaw is following up on the questions on CST today and is asking for an update on budget and timelines. Our proposed messages are below -- these have been run through PHSA and Sabine.

Thanks

Laura

Reporter: Rob Shaw

Media Outlet: Vancouver Sun

Phone Number: 250-893-0841

Email: rshaw@vancouversun.com

Deadline: ASAP

Call Time:

Topic: Interesting ndp question in QP -- is Clinical Systems Transformation project now \$200m over its \$842m budget and exceeding \$1b?

When I spoke to the project manager there for our IT project recently he said they were still on budget... so something changed? Is ministry aware?

Proposed messages:

- **The project board has been looking at the project as a whole since the project reset last year - including scope, resources and implementation.**
- **That work is still underway. No decisions have been made.**
- **It is important that the project board do the due diligence and planning necessary to ensure the project is done properly. That is the work they are doing now, and we need to let them do that work.**
- **That said, throughout this process, work has continued in the last few months on the project, focusing on improving the governance structure, assessing the work already done, and updating the project plan. Achievements of this re-planning work include:**
 - **A governance structure that ensures accountability, transparency and proactive risk management;**
 - **External advisors on the Project Board with relevant industry experience to help inform decision-making;**
 - **A shift in responsibility for project management and project delivery from a contracted service provider to the health organizations;**
 - **A new agreement with our software provider Cerner;**
 - **A new external project assurance function for formal, objective project oversight;**
 - **An improved approach to the design of clinical workflows and configuration of the new clinical information system;**

- Several important appointments, including those of Chief Transformation Officer, Chief Clinical Information Officer (clinical lead), and Project Management Office Director.
- A comprehensive review of project scope for alignment with the clinical goals and clinical workflow.
- This project remains a priority for the Health Organizations and will continue. The Clinical Systems Transformation project will have many benefits for our patients, staff, physicians and the health system as a whole.

Laura Heinze

Manager, Media Relations – Ministry of Health

(250) 952-3387

(cell) 250-208-6295

Laura.Heinze@gov.bc.ca

Lake, Terry HLTH:EX

From: Plank, Sarah GCPE:EX
Sent: Saturday, December 12, 2015 7:34 AM
To: Lake, Terry HLTH:EX
Cc: hlth Ministerial and Executive Assistants; Heinze, Laura R GCPE:EX; Thistle-Walker, Carlene GCPE:EX; May, Stephen GCPE:EX; Brown, Stephen R HLTH:EX; Shera, Deborah HLTH:EX; Feulgen, Sabine HLTH:EX; Sidhu, Manjit HLTH:EX
Subject: Heads up re: Vancouver Sun IT projects series
Attachments: IN_Vancouver Sun_IT strategy request_11Dec15_FINAL.docx

Hi Minister,

The Sun series on challenges with IT projects in the public sector started today. Below are the first of the articles. There will be several others into next week. Attached is our issues note for our pieces of this.

B.C.'s IT missteps

TODAY: Eight high-profile IT projects recently undertaken by the province are \$350 million over budget and counting.

Dec. 14: A "thoughtful reset" of troubled Health Ministry IT projects.

Dec. 15: B.C. is not alone, twothirds of complex IT projects everywhere hit snags.

Dec. 16: Solutions - Better planning is the first step.

Major IT projects go over budget or end up missing key features

Vancouver Sun

12-Dec-2015

Page A14

By Rob Shaw And Lori Culbert

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Page 058 to/à Page 060

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B.C.'s largest IT projects of the last decade

Vancouver Sun

12-Dec-2015

Page A15

By Lori Culbert and Rob Shaw

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Page 062 to/à Page 063

Withheld pursuant to/removed as

Copyright

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School software has drawn mixed reviews, at best

Vancouver Sun

12-Dec-2015

Page A15

By Lori Culbert

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Page 065

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ADVICE TO MINISTER

CONFIDENTIAL ISSUES NOTE

Ministry: Health

Date: December 10, 2015

Minister Responsible: Terry Lake

Vancouver Sun – IT strategy request

BACKGROUND REGARDING THE ISSUE:

- Rob Shaw of the Vancouver Sun is working on feature stories regarding government and government agency challenges with large Information Technology (IT) projects.
- He has done an interview with the Minister, the Deputy Minister and the government's Chief Information Officer on this topic, as well as the project manager for the Clinical Services Transformation project in the Lower Mainland.
- As part of the series he is focusing on health projects that have had challenges:
 - Panorama; and
 - Clinical Systems Transformation
- A recent report from the Auditor General was highly critical of the Panorama program and the opposition and media have expressed concerns about the Clinical Systems Transformation project after the original contract with IBM was cancelled.
- The Ministry is using the recent OAG report as an opportunity to improve management on IT projects in the health sector.
- A team of experts will review the ministry's governance, project management and contract management and make recommendations on how to improve IM/IT project management in the health sector.
- The ministry will develop a policy framework for best practices in IM/IT project management to establish a clear process for all new projects, and evaluate existing projects against the framework.
- A joint ministry/health authority standing committee on IMIT has been given more clearly articulated accountabilities.
- The Ministry will establish an external expert panel to provide expertise and advice on an ongoing basis to improve the Ministry's management and oversight of IM/IT projects.

ADVICE AND RECOMMENDED RESPONSE:

- Large Information Technology and Management projects are challenging – especially in health care.
- Dealing with complex clinical needs, as well as complex technology needs, is challenging because of different priorities and goals.
- Over the past several years, the Ministry has been working to implement a number of very large and complex electronic health systems in B.C. that provide more efficient, better information to health care workers, while protecting patient privacy.
- We are aware of the challenges that we have faced with these large IT projects –

especially the Panorama project.

- The ministry is taking lessons learned from these projects very seriously, and using them as an opportunity to improve how we manage IT projects into the future.
 - A review of current projects is underway, to confirm they are on-track.
 - The ministry has proactively engaged with the Auditor General on the largest current IT project – the Clinical Systems Transformation electronic health record project in the Lower Mainland. We will have ongoing discussions with the OAG as the project moves forward.
 - This kind of proactive approach with the OAG will also be used with future large IT projects, and we are grateful for the Auditor General's support.
 - The ministry will be developing an overarching policy framework to guide all large health IT projects.
 - The ministry will establish an external panel of experts to provide advice on large IT projects.
- Despite some challenges with IT projects, there have been a number successes in the health sector in recent years:
 - The Provincial Diagnostic Imaging Viewer project – which allows authorized users to access diagnostic images from throughout the Province via a diagnostic imaging viewer.
 - The Provincial Lab Information Solution (PLIS) – a provincial repository of diagnostic laboratory results – accessible by authorized caregivers.
 - The interoperable Electronic Health Record project – which creates the technical infrastructure to support electronic health records and secure information exchanges between health professionals.
 - Electronic Medical Record Integration – which allows physician electronic medical records to be integrated with provincial electronic health records.
 - Replaced aging and non-secure systems with advanced infrastructure, protecting the privacy and security of sensitive patient data.

Communications Contact:	Stephen May	Reviewer:
Program Area Contact:	Stephen Brown	
File Created:	December 3, 2015	
File Updated:	December 8, 2015	

Minister's Office	Program Area	Deputy	HLTH Communications

Lake, Terry HLTH:EX

From: Plank, Sarah GCPE:EX
Sent: Tuesday, May 31, 2016 3:05 PM
To: Lake, Terry HLTH:EX; Anderson, Kristy GCPE:EX
Cc: hlth Ministerial and Executive Assistants; Beneteau, Nicole GCPE:EX; Heinze, Laura R GCPE:EX; Lawrie, Hannah GCPE:EX; MacDougall, Cindy GCPE:EX; May, Stephen GCPE:EX; Peaker, Alexandra GCPE:EX; Thistle-Walker, Carlene GCPE:EX
Subject: RE: MEDIA REQUEST: Vancouver Sun - Rob Shaw - ihealth/CST

Thanks.

From: Lake, Terry HLTH:EX
Sent: Tuesday, May 31, 2016 2:55 PM
To: Plank, Sarah GCPE:EX; Anderson, Kristy GCPE:EX
Cc: hlth Ministerial and Executive Assistants; Beneteau, Nicole GCPE:EX; Heinze, Laura R GCPE:EX; Lawrie, Hannah GCPE:EX; MacDougall, Cindy GCPE:EX; May, Stephen GCPE:EX; Peaker, Alexandra GCPE:EX; Thistle-Walker, Carlene GCPE:EX
Subject: Re: MEDIA REQUEST: Vancouver Sun - Rob Shaw - ihealth/CST

I told him I thought it was irresponsible to print a letter under a pseudonym but that we are not discounting concerns of clinicians. That I was confident VIHA was putting a plan in place to overcome any challenges and that patient safety would not be at risk. I said we cannot allow these expected challenges to paralyze us from getting to a properly integrated EHR. I said if in four weeks there was a continuing problem, then I would be concerned about ramifications to the CST project.

T

Sent from my BlackBerry 10 smartphone on the TELUS network.

From: Plank, Sarah GCPE:EX
Sent: Tuesday, May 31, 2016 2:44 PM
To: Lake, Terry HLTH:EX; Anderson, Kristy GCPE:EX
Cc: hlth Ministerial and Executive Assistants; Beneteau, Nicole GCPE:EX; Heinze, Laura R GCPE:EX; Lawrie, Hannah GCPE:EX; MacDougall, Cindy GCPE:EX; May, Stephen GCPE:EX; Peaker, Alexandra GCPE:EX; Thistle-Walker, Carlene GCPE:EX
Subject: RE: MEDIA REQUEST: Vancouver Sun - Rob Shaw - ihealth/CST

Hi Minister – thanks for doing that. I'm sure Rob is much happier with an interview than a statement. Mind letting us know what you told him so we can share with VIHA and PHSA? Thanks very much! Sarah.

From: Lake, Terry HLTH:EX
Sent: Tuesday, May 31, 2016 2:42 PM
To: Anderson, Kristy GCPE:EX
Cc: hlth Ministerial and Executive Assistants; Beneteau, Nicole GCPE:EX; Heinze, Laura R GCPE:EX; Lawrie, Hannah GCPE:EX; MacDougall, Cindy GCPE:EX; May, Stephen GCPE:EX; Peaker, Alexandra GCPE:EX; Plank, Sarah GCPE:EX; Thistle-Walker, Carlene GCPE:EX
Subject: Re: MEDIA REQUEST: Vancouver Sun - Rob Shaw - ihealth/CST

I gave him a call.

Terry Lake DVM
Minister of Health

On May 31, 2016, at 1:57 PM, Anderson, Kristy GCPE:EX <Kristy.Anderson@gov.bc.ca> wrote:

Hi Minister – As Sarah mentioned on the call this morning Rob Shaw was following up on the IHealth story and trying to tie it with CST. She has done up the below response – is this fine to send to Rob?

Thanks,

Reporter: Rob Shaw
Media Outlet: Vancouver Sun
Phone Number: T: [250-953-5932](tel:250-953-5932)
C: [250-893-0841](tel:250-893-0841)
Email: rshaw@vancouversun.com
Deadline: End of day
Call Time:
Topic: ihealth/CST

From: Shaw, Rob [<mailto:rshaw@vancouversun.com>]
Sent: Monday, May 30, 2016 1:23 PM
To: Plank, Sarah GCPE:EX
Subject: minister on VIHA IT problems

Hey Sarah,

Working on a story about what the VIHA Nanaimo iHealth problems that Cindy wrote about last week might mean for other big eHealth initiatives like Clinical Systems Transformation in the Lower Mainland. Both use Cerner. CST not only uses Cerner for software but also hired Cerner for development after firing IBM.

I know the minister has spoke in the past about how VIHA's system was a success story that others could follow because it was on time, on budget and worked well. But that doesn't appear to be the case. So would like to ask him if he's concerned, what he's doing about it, if there are implications for other larger projects like CST and whether he can apply the new "lense" that Stephen Brown talked about on health IT projects (outside expert panels, etc) to fix what's happened.

Looking for him today or tomorrow for Wednesday.

Also, I will put in a request to talk to someone at CST as well.
Thanks,
Rob

Proposed Response

These two initiatives are in very different stages. The governance and oversight improvements applied to the Lower Mainland electronic health record initiative responded to significant issues that arose relatively early in the project planning and building phase. The project required provincial involvement to get it back on track. There is nothing to suggest that the IHealth project is in trouble, but rather it is going through expected and normal implementation and change management challenges that always arise with such a large-scale implementation. Island Health has provided a representative to the CST project team to help incorporate their lessons learned as the CST project moves forward.

Electronic health records are about improving the quality and safety of patient care. The new IHealth system recently introduced in Nanaimo is the first stage of implementing a full electronic health record across the island that will allow Island Health to continually improve quality of care for their patients. The introduction of IHealth in Nanaimo is a monumental change for frontline providers, and it is not unanticipated that staff and physicians are experiencing some challenges. Island Health recognizes these challenges – particularly in high-volume and high-acuity areas such as the ER and ICU – and is providing extra hands-on IHealth staff to support providers at NRGH.

Once implementation begins and a system is actually being used in a facility, it is expected that modifications are made along the way. Island Health continues to proactively work with providers to implement modifications to address issues as they come up.

Island Health has investigated the concerns raised and we understand that the system is working as it should, with no evidence that it is changing or deleting orders. Island Health has also done both an internal independent review of the system by their Quality and Safety department, and commissioned a review by an external expert from North York Hospital – which has implemented a Cerner electronic health record system – to ensure the system is safe and operating as it should.

Kristy Anderson
Manager Media Relations
Ministry of Health
250-952-3387 (office) 778-678-5200 (cell)
Kristy.Anderson@gov.bc.ca

Lake, Terry HLTH:EX

From: Plank, Sarah GCPE:EX
Sent: Tuesday, May 31, 2016 2:43 PM
To: Lake, Terry HLTH:EX
Cc: hlth Ministerial and Executive Assistants; Anderson, Kristy GCPE:EX; Feulgen, Sabine HLTH:EX; Shera, Deborah HLTH:EX; Brown, Stephen R HLTH:EX
Subject: CST statement to Vancouver sun interview

FYI that this is what was sent to Rob from PHSA...

From: Cunningham, Dave
Sent: Tuesday, May 31, 2016 2:22 PM
To: 'Shaw, Rob' <rshaw@vancouver.sun.com>
Subject: RE: CST interview

Hi Rob. As discussed, here is a statement from Jeremy Smith, Chief Transformation Officer, Clinical and Systems Transformation (CST) Project:

The Cerner clinical information system being implemented by Island Health, as well as through the CST Project, is used successfully every day in thousands of organizations around the world, including across Canada.

Island Health has had the primary components of the Cerner clinical information system in place on the Island for up to 15 years, including the module used within the pharmacy to dispense medications (the same module that will be used by the Pharmacy Regional Production Centre (RPC) in Vancouver). They have also recently successfully conducted a major island-wide upgrade of that foundation. The comments made recently by some physicians are related primarily to the addition of physician electronic prescribing, particularly in the complex settings of the Emergency Department and ICU.

The adoption of physician order entry, particularly for prescribing, is always one of the most difficult steps in the process and requires refinement and support both before and during the transition. It is a necessary hurdle to overcome in order to enable other aspects (such as closed-loop medication management) and achieve most of the benefits for safety and quality of care. We already have experience with this transition in past years through our older legacy systems within VCH and PHC in the emergency departments at St. Pauls, Mount St. Josephs, and Lion's Gate hospitals, and to a partial degree at Richmond and Vancouver General hospitals.

We are working closely with Island Health to learn from their design and implementation experiences with IHealth, and to benefit from their learnings. A representative from Island Health sits on the CST Project Board to share their learnings, and our teams are in regular contact with their counterparts at Island Health. We also connect regularly with other Canadian and international organizations who use Cerner to learn from their experiences.

From: Shaw, Rob [<mailto:rshaw@vancouver.sun.com>]
Sent: Monday, May 30, 2016 1:28 PM
To: Cunningham, Dave <Dave.Cunningham@phsa.ca>
Subject: CST interview

Hi Dave,

I was hoping to set up an interview with Jeremy or someone at CST in the next day or so.

I'm following up on a story in the Victoria Times Colonist about problems with Island Health's iHealth Cerner system rolled out in Nanaimo. Doctors have complained about serious shortcomings:

<http://www.timescolonist.com/news/local/nanaimo-doctors-say-electronic-health-record-system-unsafe-should-be-shut-down-1.2264497>

I'm wondering what if any implications there are for CST, since it also uses Cerner software and has hired Cerner to help with consulting and development. There are specific concerns raised about the digital pharmacy drug dispensing and prescription writing system that would seem to apply potentially to CST's digital pharmacy dispensing model it is hoping to roll out within months at Lions Gate.

And get an update on the project as well. Hoping to see if we can set up the interview for tomorrow.

Thanks,
Rob

ROB SHAW
LEGISLATIVE REPORTER
The Vancouver Sun | The Province
Room 360, Parliament Buildings
Victoria, B.C. V8V1X4
T: [250-953-5932](tel:250-953-5932)
C: [250-893-0841](tel:250-893-0841)
rshaw@vancouversun.com
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Lake, Terry HLTH:EX

From: Anderson, Kristy GCPE:EX
Sent: Tuesday, May 31, 2016 2:33 PM
To: Lake, Terry HLTH:EX
Cc: hlth Ministerial and Executive Assistants; Anderson, Kristy GCPE:EX; Beneteau, Nicole GCPE:EX; Heinze, Laura R GCPE:EX; Lawrie, Hannah GCPE:EX; MacDougall, Cindy GCPE:EX; May, Stephen GCPE:EX; Peaker, Alexandra GCPE:EX; Plank, Sarah GCPE:EX; Thistle-Walker, Carlene GCPE:EX
Subject: FW: MEDIA REQUEST: Vancouver Sun - Rob Shaw - ihealth/CST

Hi Minister – there were a couple tweaks to this one and Rob asked if we could send him a couple transcripts of your scrums on e-health. Let me know if you have any concerns with us sending him those (see below)

Cheers,

Thanks,

Reporter: Rob Shaw
Media Outlet: Vancouver Sun
Phone Number: T: [250-953-5932](tel:250-953-5932)
C: [250-893-0841](tel:250-893-0841)
Email: rshaw@vancouver.sun.com
Deadline: End of day
Call Time:
Topic: ihealth/CST

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To: Plank, Sarah GCPE:EX
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Scrum
Lake scrum following PM QP
18-May-2016 14:45

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Scrum
Lake prior to AM QP
19-May-2016 09:50

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Page 076

Withheld pursuant to/removed as

Copyright

Kristy Anderson
Manager Media Relations
Ministry of Health
250-952-3387 (office) 778-678-5200 (cell)
Kristy.Anderson@gov.bc.ca

Lake, Terry HLTH:EX

From: Heinze, Laura R GCPE:EX
Sent: Tuesday, March 1, 2016 12:23 PM
To: Lake, Terry HLTH:EX
Cc: May, Stephen GCPE:EX; Belanger, Matthew GCPE:EX; MacDougall, Cindy GCPE:EX; Thistle-Walker, Carlene GCPE:EX; Shepherd, Brent GCPE:EX; Beneteau, Nicole GCPE:EX; Frattaroli, Angela GCPE:EX; Lawrie, Hannah GCPE:EX; Plank, Sarah GCPE:EX; Heinze, Laura R GCPE:EX; hlth Ministerial and Executive Assistants
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Phone Number: 250-893-0841
Email: rshaw@vancouversun.com
Deadline: ASAP
Call Time:

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Laura Heinze
Manager, Media Relations – Ministry of Health

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(cell) 250-208-6295
Laura.Heinze@gov.bc.ca

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Subject: Re: CST statement to Vancouver sun interview

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Terry Lake DVM
Minister of Health

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Sent: Monday, May 30, 2016 1:28 PM
To: Cunningham, Dave <Dave.Cunningham@phsa.ca>
Subject: CST interview

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And get an update on the project as well. Hoping to see if we can set up the interview for tomorrow.

Thanks,
Rob

ROB SHAW
LEGISLATIVE REPORTER
The Vancouver Sun | The Province
Room 360, Parliament Buildings
Victoria, B.C. V8V1X4
T: [250-953-6932](tel:250-953-6932)
C: [250-893-0841](tel:250-893-0841)
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twitter.com/robshaw_vansun

<image001.png>

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Lake, Terry HLTH:EX

From: Plank, Sarah GCPE:EX
Sent: Monday, May 30, 2016 11:05 AM
To: Lake, Terry HLTH:EX
Cc: hlth Ministerial and Executive Assistants; Feulgen, Sabine HLTH:EX; Shera, Deborah HLTH:EX; Anderson, Kristy GCPE:EX; Belanger, Matthew GCPE:EX; Beneteau, Nicole GCPE:EX; Frattaroli, Angela GCPE:EX; Heinze, Laura R GCPE:EX; MacDougall, Cindy GCPE:EX; May, Stephen GCPE:EX; Peaker, Alexandra GCPE:EX
Subject: RE: MEDIA REQUEST - Cindy Harnett, Times Colonist - IHealth

In case it's helpful, Minister, Island Health has also provided their messaging for you to have handy for the interview with Cindy, if you are able to do it...

Island Health messaging:

KEY MESSAGES (for leaders that are asked about the article);

- I respect the right of individuals to express their opinion,
- It is disappointing that in the spirit of transparency this individual did not identify themselves, if in fact they are actually a physician.
- The new system is safe.
- Users will become proficient in the use of the system by working with it.
- Island Health has not abandoned the system and gone back to paper.
- This individual does not represent me or my opinions of the new IHealth system.
- This new system will improve quality and safety for patient
- Change is hard - moving to an integrate electronic system is the right thing to do. I am not aware of any harm to any person or patient as a result of moving to this new system (if that is the case)
- Island Health has provided extensive training and support for staff and physicians.
- The system is safe and is reducing and or eliminating potential harm with built-in safety mechanisms.
- The transition has had some challenges.
- Island Health has acknowledged these challenges and is working with staff and physicians to address them.

Island Health Media Lines:

- The IHealth system is doing what it is intended to do.
- Implementing a system transformation of this scope is difficult and we have always known that once implementation began we would need to make modifications along the way.

- Nanaimo has some of the top physicians in the country and we value and respect the feedback they are providing to us.
- We recognize that this change has been a challenge for some providers while other providers have had no problems adjusting to the new system.
- We have made some modifications to workflow issues based on this feedback.
- We will continue to proactively work with providers, listen to their challenges and implement modifications to address challenges.
- We acknowledge that documentation for staff doing emergency-department patient intake is a challenge, in particular, getting medication orders into the system, getting clinical staff trained and work flow and documentation.
- We have put additional resources in place including targeted education, to help providers understand and work with the system.
- We have also made some modifications to work flows based on provider input.
- While we work toward other modifications to simplify these processes, we have added additional staffing resources to speed up admissions and to assist providers to input orders into the system.
- Health providers worldwide have encountered similar problems when moving from a paper-based system to a computerized one.
- Software-system challenges when implementing a new system are not confined to the health-care sector.
- This new system is improving quality and safety. In fact, well over 400 human caused medication errors and conflicts at three sites have been caught by the system. This is a definite sign that the system is working.
- The health-care system worldwide deals with medical human errors resulting in more than 250,000 adverse drug events and more than 150,000 preventable deaths.
- The system produces a warning, for example, if the dosage is too high for a patient's weight, if the drug is not appropriate for a particular disease or if there's a drug conflict.
- Computerized health care improves health-care delivery processes because electronic records can be accessed more easily than paper reports.
- IHealth will allow for quicker diagnosis and treatment of medical problems.
- Display of all test results reduces redundant and additional testing.
- Cerner is working with Island Health staff, and they'll be here until the system is fully implemented.

S.

From: Plank, Sarah GCPE:EX

Sent: Monday, May 30, 2016 10:49 AM

To: Lake, Terry HLTH:EX

Cc: hlth Ministerial and Executive Assistants; Feulgen, Sabine HLTH:EX; Shera, Deborah HLTH:EX; Anderson, Kristy GCPE:EX; Belanger, Matthew GCPE:EX; Beneteau, Nicole GCPE:EX; Frattaroli, Angela GCPE:EX; Heinze, Laura R GCPE:EX; MacDougall, Cindy GCPE:EX; May, Stephen GCPE:EX; Peaker, Alexandra GCPE:EX

Subject: MEDIA REQUEST - Cindy Harnett, Times Colonist - IHealth

Importance: High

Hi Minister,

Are you able to call Cindy today? She would need to speak to you before 1:30pm, as she's on the early shift today. Attached is the key messaging per our discussion with Island Health on Friday, as well as the current CST messaging. I think that will address her questions, but let me know if you need anything more.

Reporter: Cindy Harnett

Media outlet: Times Colonist

Telephone #: 250.380.5348 (o) / 250.213.3603 (c)

Deadline: 1:30pm

Questions:

I'm following up on my story from Thursday on Nanaimo doctors saying the iHealth system that went live 9 weeks ago is a failure and patient safety risk, causing mistakes in medication doses and pharmaceutical discharge sheets, as well as being slow and inefficient and difficult to use.

In a phone interview I would like to ask the Minister about:

- 1. His reaction to the Nanaimo doctors complaints given the health minister pointed to Cerner's iHealth implementation in Nanaimo as an example of the success of Cerner's system and an example for the rest of the province and how it would set the right course for Vancouver Coastal Health, PHSA, and Providence Health Care after the collapse of the \$842 million IBM system.*
- 2. What if anything the province will do to stop and suspend the implementation in Nanaimo until doctors agree its useable and safe?*
- 3. How much has the province spent on EHR development and implementation in total in the last 5 and 10 years?*

Proposed Response:

- Electronic health records are about improving the quality and safety of patient care.
- The new IHealth system recently introduced in Nanaimo is the first stage of implementing a full electronic health record across the Island.
- It will provide a single record of a person's health history that will allow Island Health to continually improve quality of care for their patients.

- The introduction of IHealth in Nanaimo is a monumental change for frontline providers – it is not unexpected that staff and physicians are experiencing some challenges.
- Island Health recognizes these challenges – particularly in high-volume and high-acuity areas such as the ER and ICU – and is providing extra in-person hands-on supports in these areas.
- As part of this, dedicated IHealth staff are working with individual doctors and staff to trouble-shoot specific processes that are not working as smoothly as they could and making improvements to the system in real-time.
- Island Health has investigated the concerns raised by the physician in the article – I have been reassured that the system is working as it should, with no evidence that it is changing or deleting orders.
- Island Health commissioned a review of the system by their separate Quality and Safety department, which determined IHealth in Nanaimo is just as safe as the previous paper-based system.
- Additionally, Island Health brought in an external expert from North York Hospital – which also implemented a Cerner electronic health record system – to review the implementation in Nanaimo to ensure everything is going as expected.

CST project

- Electronic health records are about improving the quality and safety of patient care.
- Clinical and Systems Transformation is a major transformation of clinical processes and care protocols across the three health organizations, focused on achieving the safe and consistent services of an integrated health system as our patients expect.
- This is a large and complex project.
- We knew from the outset that this wasn't going to be an easy project – but we also recognized that it was important for patients in the Lower Mainland and those across the province accessing specialized provincial services.
- The CST project board committed to looking at the entire project in depth as part of the project reset that began last year - including scope, resources and implementation.

- The CST board has been doing the due diligence and planning necessary to ensure the project is done properly.
- The team is moving forward with testing and configuration to get ready for implementation of full electronic medical records at the first site in the Lower Mainland next year – Lion's Gate Hospital in Spring 2017.
- Fine-tuning and validating common workflows and practices, as well as education and training, will be ongoing over the next year in the North Shore and Sea-to-Sky region facilities.
- Learnings from the first sites implemented will be incorporated into the successive implementations at other facilities.
- In March, I went up to Nanaimo where Island Health has just started the first phase to bring their IHealth electronic record system online.
- The IHealth project has been very successful so far and will be a huge benefit to quality and safety in the entire health system on Vancouver Island.
- It has not been without challenges and course corrections along the way – as would any project of this size and magnitude.
- Island Health is now providing their expertise to the CST project to help incorporate some of their lessons learned into that project.

If asked about project reset:

- This program had challenges initially – which is why we took a step back and made the decision to reset the program.
- That reset has allowed the project team – supported by stronger governance – to reposition the project and put it on solid ground.
- The ministry has learned from our experience with other large IT projects, including the valuable review of the Panorama public health system by the Auditor General.
- We also secured PriceWaterhouseCooper last year to help identify project management and governance issues as part of the project reset.
- As a result, we made changes to the governance and planning to ensure a better program that will improve the quality and consistency of patient and caregiver experiences.

- As part of their re-planning work over the past year, the project team has also realized we needed to engage frontline clinicians which has added valuable clinical elements that will ensure the system meets the needs of our health care providers – thereby ensuring better patient care.
- Clinical input is key – user adaption is critical to the success of this program.
- The Ministry met with the Auditor General in the fall to discuss the way forward on the project and actions taken to strengthen its governance – to ensure we are on the right track.
- We will be meeting again with the Auditor General in May to provide an update and get any feedback on our approach.
- With this new model, with improved governance, project management and a better plan for change management and incorporating clinical needs – we can provide a better service.
- That includes implementing it in phases, to make adjustments on the go to improve the program, so that we have the best possible system for staff.

Sarah Plank
Communications Director | Ministry of Health
Government Communications & Public Engagement
Office: 250.952.1889 | Mobile: 250.208.9621 | Email: sarah.plank@gov.bc.ca

Lake, Terry HLTH:EX

From: Lake, Terry HLTH:EX
Sent: Wednesday, January 27, 2016 4:03 PM
To: Jukes, Shaina HLTH:EX
Cc: O'Brien, Kellie HLTH:EX
Subject: Re: Meetings/ Briefings for consideration

Yes please.

Sent from my BlackBerry 10 smartphone on the TELUS network.

From: Jukes, Shaina HLTH:EX
Sent: Wednesday, January 27, 2016 4:01 PM
To: Lake, Terry HLTH:EX
Cc: O'Brien, Kellie HLTH:EX
Subject: Meetings/ Briefings for consideration

Hi Minister, Please advise if you would like to set up the following meeting and briefing for the week of February 8th.

1. Meeting with the candidate that has been selected as the new board chair for BC Clinical and Shared Services. This would hopefully occur in the first week of session so that the new chair can be vetted by the Minister and announced.

2. Sabine would like to request a 1hour meeting with the Minister and Island Health.

Agenda:

- To brief the Minister on IH's *i-Health* project which is going live at the end of February. (this is their Clinical Systems Transformation project).

Attendees:

- Dr. Brendan Carr and 3 other members from IH.
- Steve Brown
- Sabine Feulgen
- Deb Shera

Shaina Jukes

Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca

From: James, Ben <Ben.James@leg.bc.ca>
Sent: Tuesday, August 11, 2015 7:51 AM
Subject: Issue Alert: Vancouver Sun story on the Clinical Systems and Transformation project

Issue Alert: Vancouver Sun story on the Clinical Systems and Transformation project

The Vancouver Sun has run a story on the Clinical Systems and Transformation project, an integrated electronic health records system, following the release of documents obtained through a Freedom of Information request. A new contractor, Cerner, has replaced IBM Canada the original contractor. The purpose of the project is to integrate software systems between hospitals and health facilities in Provincial Health Services Authority, Vancouver Coastal Health and Providence Health Care.

Lead: Ministry of Health

Key Messages:

- We knew from the outset that this wasn't going to be an easy project – but we also recognized that it was important for patients in the Lower Mainland.
- Work has continued in-house in the last few months on the project – focusing on improving the governance structure, updating the project plan and assessing the work already done.
- The Clinical Systems and Transformation project board is moving to a new model where the project is internally-led, and supported by the outside vendor, as opposed to led by them. This approach will mean that skills and capacity will be built within the project team, with an aim for self-sufficiency.
- As part of that, we have entered into an agreement with Cerner to assess and assist in what needs to be done, and how best to do it. That work will begin in the coming weeks.
- The project board has streamlined its governance structure to help with decision making and to focus on strong oversight and accountability of this project as it moves forward.
- A few key additions include independent technical and clinical advisory services supporting the Project Board and a Chief Clinical Information Officer supporting the Chief Transformation Officer.
- From working with other large IT projects, such as Panorama, we have learned:
 - Large IT projects are challenging and complex and the decision making structure needs to be nimble, inclusive, and allow for forward thinking
 - A change management plan is critical for success and engagement needs to start early
 - All partners need to be supportive and take responsibility for bringing all sides together
 - Business requirements and IT solutions need to be well understood by all parties to achieve the right balance
- This project remains a priority for the Health Organizations and will continue. The Clinical Systems Transformation project will have many benefits for our patients, staff, physicians and the health system as a whole.
- The work completed since the beginning of the project is highly valuable and will continue to be utilized.

Ben James
Director of Communications
BC Liberal Government Caucus
250-356-9131 (office)
250-208-7052 (mobile)

Chan-Kent, Marissa HLTH:EX

From: Anderson, Kristy GCPE:EX
Sent: Friday, November 25, 2016 5:02 PM
To: Lake, Terry HLTH:EX
Cc: hlth Ministerial and Executive Assistants; Brown, Stephen R HLTH:EX; Feulgen, Sabine HLTH:EX; Plank, Sarah GCPE:EX
Subject: FW: 20161125_IN_CST schedule change v2
Attachments: 20161125_IN_CST schedule change v2.docx; 20161124 CST Activation schedule change memo v1.docx

Importance: High

Hi Minister

Flagging for you that the CST project team would like to send out the attached memo notifying the team of a delay in implementation at the first sites as a result of a comprehensive review of the CST project plan over the last month on what will be required to activate the new Cerner clinical information system.

They were hoping to send the memo out next week. I suggested that waiting until Monday Dec 5th when you are back s.13

They have started to put together an IN on this which is also attached (it still needs work but as you are going on holidays I wanted you to have something).

I feel like their comms materials IN/QA doc need a bit of work before they will be ready. That being said the longer it is delayed the longer the team is not focused on the right work.

Do you want them to hold the memo until you are back?

Kristy Anderson

Director, Media Relations
Ministry of Health
250-952-3387 (office) 778-678-5200 (mobile)
Kristy.Anderson@gov.bc.ca



CONFIDENTIAL ISSUES NOTE

Nov. 25, 2016 – Changes to CST activation schedule

The Clinical and Systems Transformation (CST) Project Board has decided to delay implementation of the project. Implementation was scheduled to begin in spring 2017 at Lions Gate Hospital and other Vancouver Coastal "Sea to Sky" sites. The project team is now completing a review of its progress, and working with Coastal site leaders to finalize a new schedule.

The CST Communications team recommends the following key messages:

Key Messages:

- Activation of the new clinical information system at VCH-Coastal/Group 1 sites will not take place in Spring 2017 as previously planned. (Group 1 sites include Lions Gate Hospital campus and Sea-to-Sky facilities.)
- The decision to change the timing was driven by a comprehensive review of the project plan that determined more work is required to ensure a successful activation at Group 1 sites.
- CST project leaders are now working with VCH-Coastal stakeholders to put together a revised implementation schedule and expect to set a new target activation date by the end of 2016.
- The Province and the three CST project partners (VCH, PHSA and PHC) remain deeply committed to supporting the project, which is so important to improving the safety, quality and consistency of patient care.

Questions and Answers:

s.13

DRAFT – Confidential Advice



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Our path to smarter, seamless care

s.13

Background:

Chronology:

- March 2013 – CST Project contracts with a consortium led by IBM to design and implement a Cerner-based clinical information system.
- April 2013 – Planning, strategy and validation phase begins.
- January 2014 – Design, build and integrate phase begins.
- Fall 2014 – Difference of opinion between IBM and the health organizations regarding scope of project and methodology of design leads health organizations to conclude that more design, build and validation work is needed before entering testing phase.
- December 2014 – Health organizations and IBM begin negotiations on how to address the additional design, build and validation work required.
- March 2015 – Health organizations and IBM agree to end contract.
- April – September 2015 – Project reset completed, with assistance of PriceWaterhouseCoopers.

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- July – Cerner retained as new project partner.
- October 2015 – Replanning phase initiated with Cerner.
- February 2016 – Design and configuration work begins.
- April 2016 – Review and replanning work completed.
- Sep. 2016 – Michael Long appointed as new acting CTO.
- Oct. 2016 – Review initiated of progress on Design and Configure phase, and project structure.
- Nov. 2016 – Decision made to delay implementation.

Design and Configuration Process Improvements:

- A pre-configured system – the foundation for the continuation of design work will be Cerner's pre-built "Model System," a fully functioning prototype based on global best practices from Intermountain Healthcare, one of Cerner's leading clients.
- Seeing our work as we go – Building on the Model System, our design teams will be able to map our requirements from the first phase of design and make progressive, iterative improvements throughout the design and configuration process.
- A clear and robust validation process – With the ability to create prototypes of our new system, we are better able to identify and fix problems before they are set in stone – making validation an ongoing part of our process.
- New program/specialty liaison roles – These clinical informatics resources will be an important point of contact between the design teams and the clinical programs and specialty areas of our health organizations, bringing a systemic view and helping facilitate the transformation from design through to implementation.

Project Budget:

- Based on the original Business Case, the total cost of ownership of the CST project, including both one-time costs and regular ongoing operating costs, was estimated to be \$842 million over 10 years. This was comprised of project costs of \$480 million capital expenditure and \$77 million operating for a total of \$557 million net new project costs, plus a \$285 million base spend over the 10 year period, primarily existing IT budget for the legacy systems or replacement systems.
- Total spending to date is \$xxx million. Of this spend, the majority was on labour costs for health organization staff and clinicians, whose learnings and experience gained from the project's early work on clinical practices and workflows will continue to benefit the project moving forward.

Contact information			
Contact	Name	Title	Phone
Program	Michael Long	Acting Chief Transformation Officer, CST	403-617-3877 (c)
Communications	Dave Cunningham	CCO – PHSA	604-837-5360 (c)
Creation & revision history			
Nov. 25		Issues note created	
Nov. 25		Reviewed by Michael Long	

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590 West 8th Avenue
Vancouver, BC
Canada V5Z 1C5
T 604.675.2510
E info@CSTproject.ca

Memorandum

Date: Nov. 25, 2016

To: VCH, PHSA and PHC leaders

CC: VCH-Coastal staff and physicians
CST project staff

From: **Mary Ackenhuse**n, CEO, VCH
Carl Roy, CEO, PHSA
Dianne Doyle, CEO, PHC
Michael Long, Acting Chief Transformation Officer, Clinical and Systems Transformation (CST)

Re: **Update on timing of CST activation at VCH-Coastal sites**

We are writing to let you know that we have decided to revisit the original timing of the VCH Coastal/Group 1 activation. A comprehensive review of the CST project plan over the last month has given us a much clearer picture of what will be required to confidently activate the new Cerner clinical information system.

Based on that review, we concluded that moving forward with a spring activation schedule is simply not in the best interests of patients and care providers. This means that the Coastal/Group 1 sites will not go live in the spring of 2017.

Group 1 sites consist of Lions Gate Hospital campus (Lions Gate Hospital, the HOpe Centre, Evergreen House and North Shore Hospice) and Sea-to-Sky facilities (Squamish General Hospital, Hilltop House, Whistler Health Centre, Pemberton Health Centre) as well as Radiology at Sechelt Hospital, Bella Coola General Hospital and RW Large Memorial Hospital in Bella Bella.

It is not a decision we take lightly, as we recognize the need to fully realize the benefits of CST for the sake of British Columbians as soon as we can. Yet we must balance the need for change with the imperative to get it right. The recently released findings and recommendations of Dr. Doug Cochrane's *Review of the Functioning of IHealth* report also reaffirm our decision.

Next steps

Work on CST design and implementation planning continues. Now that a decision has been made to postpone the first site activations, the CST team will continue to consult with Coastal/Group 1, BCCA, C&W and other health organization stakeholders to understand all the implications of the change and revise the implementation schedule accordingly. This collaboration is critical to establishing a firm timeline for our first site activations in which we can all be confident. Establishing this timeline is our focus in December and determining the optimal sequence for sites to go-live will be the focus immediately in the New Year.



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Vancouver, BC
Canada V5Z 1C5

T 604.675.2510
E info@CSTproject.ca

The success of CST remains our top priority, and as leaders we remain deeply committed to supporting the project, which is so important to improving patient care across all three of our health organizations.

For more information about CST

Website: CSTproject.ca Email: info@CSTproject.ca	CST Executive Directors & Transformation Leads: VCH: Elizabeth Stanger, Elizabeth.Stanger@vch.ca PHSA: Vicky Crompton, Vcrompton@phsa.ca PHC: Grant McCullough, GMcCullough@providencehealth.bc.ca	Chief Medical Information Officers: VCH/PHC: Eric Grafstein, Eric.Grafstein@vch.ca PHSA: Alain Gagnon, Alain.Gagnon@phsa.ca



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Chan-Kent, Marissa HLTH:EX

From: Chan-Kent, Marissa HLTH:EX
Sent: Friday, November 25, 2016 5:22 PM
To: Anderson, Kristy GCPE:EX
Cc: O'Brien, Kellie HLTH:EX
Subject: Re: 20161125_IN_CST schedule change v2

I'm guessing he'll likely want a briefing or at least get caught up on this on the Monday he's back. If the release could be held until Tuesday that'd be helpful. But we'll see what his preference is.

On Nov 25, 2016, at 5:01 PM, Anderson, Kristy GCPE:EX <Kristy.Anderson@gov.bc.ca> wrote:

Hi Minister

Flagging for you that the CST project team would like to send out the attached memo notifying the team of a delay in implementation at the first sites as a result of a comprehensive review of the CST project plan over the last month on what will be required to activate the new Cerner clinical information system.

They were hoping to send the memo out next week. I suggested that waiting until Monday Dec 5th when you are back is.13

They have started to put together an IN on this which is also attached (it still needs work but as you are going on holidays I wanted you to have something).

I feel like their comms materials IN/QA doc need a bit of work before they will be ready. That being said the longer it is delayed the longer the team is not focused on the right work.

Do you want them to hold the memo until you are back?

Kristy Anderson

Director, Media Relations

Ministry of Health

250-952-3387 (office) 778-678-5200 (mobile)

Kristy.Anderson@gov.bc.ca

<20161125_IN_CST schedule change v2.docx>

<20161124 CST Activation schedule change memo v1.docx>

Chan-Kent, Marissa HLTH:EX

From: Anderson, Kristy GCPE:EX
Sent: Friday, November 25, 2016 6:43 PM
To: Lake, Terry HLTH:EX
Cc: hlth Ministerial and Executive Assistants; Brown, Stephen R HLTH:EX; Feulgen, Sabine HLTH:EX; Plank, Sarah GCPE:EX
Subject: Re: 20161125_IN_CST schedule change v2

Thanks. We will have them do that and get this out next week.

Kristy Anderson
778.678.5200

On Nov 25, 2016, at 6:01 PM, Lake, Terry HLTH:EX <Terry.Lake@gov.bc.ca> wrote:

I think they should release on their schedule. I do think that the appointment of a new lead should be highlighted more.

Sent on the TELUS Mobility network with BlackBerry

From: "Anderson, Kristy GCPE:EX" <Kristy.Anderson@gov.bc.ca>
Date: Sat, 26 Nov 2016 01:01:41 +0000
To: Lake, Terry HLTH:EX <Terry.Lake@gov.bc.ca>
Cc: hlth Ministerial and Executive Assistants <hlthmaea@Victorial.gov.bc.ca>; Brown, Stephen R HLTH:EX <Stephen.Brown@gov.bc.ca>; Feulgen, Sabine HLTH:EX <Sabine.Feulgen@gov.bc.ca>; Plank, Sarah GCPE:EX <Sarah.Plank@gov.bc.ca>
Subject: FW: 20161125_IN_CST schedule change v2

Hi Minister

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Kristy Anderson

Director, Media Relations

Ministry of Health

250-952-3387 (office) 778-678-5200 (mobile)

Kristy.Anderson@gov.bc.ca

Chan-Kent, Marissa HLTH:EX

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, December 13, 2016 4:19 PM
To: Will, Jordan HLTH:EX
Cc: O'Brien, Kellie HLTH:EX
Subject: RE: CST Update Briefing - Thursday

So Mary cannot be available for 10:45am?

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

From: Will, Jordan HLTH:EX
Sent: Tuesday, December 13, 2016 3:57 PM
To: Jukes, Shaina HLTH:EX
Cc: O'Brien, Kellie HLTH:EX
Subject: Re: CST Update Briefing - Thursday

Sabine s.22 unfortunately

JORDAN WILL
a/Director, Executive Operations
Office of the Deputy Minister
Ministry of Health

P: [250.952.1908](tel:250.952.1908) | Jordan.will@gov.bc.ca
Sent from my iPhone

On Dec 13, 2016, at 3:56 PM, Jukes, Shaina HLTH:EX <Shaina.Jukes@gov.bc.ca> wrote:

What about moving this to the 20th or 21st in Vancouver?

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

From: Will, Jordan HLTH:EX
Sent: Tuesday, December 13, 2016 3:37 PM
To: Jukes, Shaina HLTH:EX

Cc: O'Brien, Kellie HLTH:EX
Subject: RE: CST Update Briefing - Thursday

We have reached out to VCH and Mary is available before 11 or from 1-2 on Thursday. She is not available tomorrow.

Carl s.22 but should be able to dial in when we set the time.

As noted, Sabine is currently booked on a flight leaving Victoria at 840, arriving at PVO at 9:30 at the earliest. Ideally we could do 10:15-10:45 for this briefing, or right after TB – depending on lunch booking etc.

Let me know what you think.

tHanks

JORDAN WILL
a/Director, Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | Jordan.Will@gov.bc.ca

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, December 13, 2016 2:30 PM
To: Will, Jordan HLTH:EX
Cc: O'Brien, Kellie HLTH:EX
Subject: RE: CST Update Briefing - Thursday

If you use the PVO/Government locations or cancel whatever is happening at 1515 Blanshard.

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

From: Will, Jordan HLTH:EX
Sent: Tuesday, December 13, 2016 11:23 AM
To: Jukes, Shaina HLTH:EX
Cc: O'Brien, Kellie HLTH:EX
Subject: Re: CST Update Briefing - Thursday

Is telepresence a possibility?

JORDAN WILL
a/Director, Executive Operations
Office of the Deputy Minister
Ministry of Health

P: [250.952.1908](tel:250.952.1908) | Jordan.will@gov.bc.ca

Sent from my iPhone

On Dec 13, 2016, at 10:54 AM, Jukes, Shaina HLTH:EX <Shaina.Jukes@gov.bc.ca> wrote:

Jordan I have requested a room at PVO, let me know if the timing works.

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

From: O'Brien, Kellie HLTH:EX
Sent: Monday, December 12, 2016 7:41 PM
To: Jukes, Shaina HLTH:EX; Will, Jordan HLTH:EX
Subject: CST Update Briefing - Thursday

Hi,

As we know this was cancelled today. I'm wondering if we can add it back in for Thursday morning. I've moved it to 9:30am but will let you two sort of logistics.

Please advise.

Thanks,
Kellie

Kellie O'Brien
Chief of Staff to the Hon. Terry Lake
Minister of Health
T: [250-953-3547](tel:250-953-3547)
E: Kellie.Obrien@gov.bc.ca

Sent from my iPhone

Lake, Terry HLTH:EX

From: Anderson, Kristy GCPE:EX
Sent: Monday, October 3, 2016 3:22 PM
To: Lake, Terry HLTH:EX
Cc: hlth Ministerial and Executive Assistants; Belanger, Matthew GCPE:EX; Beneteau, Nicole GCPE:EX; Cascaden, Lori R GCPE:EX; May, Stephen GCPE:EX; Peaker, Alexandra GCPE:EX; Plank, Sarah GCPE:EX; Price, Gabrielle GCPE:EX; Thistle-Walker, Carlene GCPE:EX
Subject: CST - IBM contract released through FOI
Attachments: 20160929_IN_CST IBM contract-schedule.docx; Services Agreement (excluding Schedule DD, Appendix B, Appendix C, Sched....pdf

Hi Minister there has been a great deal of back and forth with an FOI applicant and IBM on their CST contract. It has been released to the applicant in pieces with the final piece being released last week. There has been no media coverage on this to date. PHSA's IN is attached and a summary is below. The actual contract is also attached.

Cheers,

- In November 2013, PHSA received identical FOI requests on the same day from a member of the media and a member of the Opposition, requesting copies of the contract with IBM Canada for the CST project.
- IBM requested a review with the Office of the Information and Privacy Commissioner (OIPC), due to concerns regarding the release of competitively-sensitive pricing and proprietary information.
- In April 2015, the health organization partners and IBM announced their agreement to terminate their contract, and the government publicly confirmed at that time that the company had been paid a total of \$72 million.
- In July 2015, while still awaiting a review with the OIPC, IBM changed its position and agreed to release the contract and appendices – with the exception of the pricing schedules – and these were provided to the applicants.
- The contract and appendices contained typical contract provisions, including for services, hardware, governance, personnel, security and term, and generated no media questions or follow-up in the Legislature.
- In June 2016, while once again awaiting a review with the OIPC regarding release of the pricing schedules, IBM once again changed its position and agreed to the release of the pricing schedules – with the exception of a clause pertaining to the percentage of mark-up that IBM would charge on services or costs provided to it by third parties.
- The pricing schedules released included the total contract value of \$188 million, which had already been disclosed previously, and once again generated no media questions.
- Last week, IBM once again changed its position, consenting to a third and final release, consisting of the clause dealing with mark-up costs, capped at 15%, with the result that the applicants have now been provided with the contract in its entirety.
- The Commissioner has closed its file on this request and no other releases are pending.

Kristy Anderson
Director, Media Relations
Ministry of Health
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CONFIDENTIAL ISSUES NOTE

Sep. 29, 2016 – Release of updated IBM contract-schedule

In response to a November 2013 Freedom of Information (FOI) request, PHSA has now released a final, unredacted version of a previously-released schedule to the contract with IBM Canada, for its work on the Clinical and Systems Transformation (CST) project. This recent release contains only one clause of previously unreleased information which had been withheld at IBM's request.

Background:

- In November 2013, PHSA received identical FOI requests on the same day from a member of the media and a member of the Opposition, requesting copies of the contract with IBM Canada for the CST project.
- IBM requested a review with the Office of the Information and Privacy Commissioner (OIPC), due to concerns regarding the release of competitively-sensitive pricing and proprietary information.
- In April 2015, the health organization partners and IBM announced their agreement to terminate their contract, and the government publicly confirmed at that time that the company had been paid a total of \$72 million.
- In July 2015, while still awaiting a review with the OIPC, IBM changed its position and agreed to release the contract and appendices – with the exception of the pricing schedules – and these were provided to the applicants.
- The contract and appendices contained typical contract provisions, including for services, hardware, governance, personnel, security and term, and generated no media questions or follow-up in the Legislature.
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- The pricing schedules released included the total contract value of \$188 million, which had already been disclosed previously, and once again generated no media questions.
- Last week, IBM once again changed its position, consenting to a third and final release, consisting of the clause dealing with mark-up costs, capped at 15%, with the result that the applicants have now been provided with the contract in its entirety.
- The Commissioner has closed its file on this request and no other releases are pending.

The CST Communications Department recommends that the following key messages:

Key Messages:

- The IBM contract-schedule was initially withheld at the company's request.
- IBM subsequently agreed to its release, and we provided the release to the applicants as soon as we secured IBM's permission.
- The previously released contract contained typical contract provisions, including sections defining terms for services, hardware, governance and personnel.

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CLINICAL+SYSTEMS TRANSFORMATION

Our path to smarter, seamless care

- Much of this information, including the original total contract value, has been previously reported.

Contact Information			
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Spokesperson(s)	Carl Roy		
Creation & Revision History			
Sep. 29, 2016		Created by D. Cunningham	
Sep. 29		Review by S. MacKay	

DRAFT

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A joint initiative of



SERVICES AGREEMENT

by and between

**PROVINCIAL HEALTH SERVICES AUTHORITY,
VANCOUVER COASTAL HEALTH AUTHORITY
AND PROVIDENCE HEALTH CARE SOCIETY**

AND

IBM CANADA LIMITED

March 28, 2013

CONFIDENTIAL

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SERVICES AGREEMENT

This Agreement is entered into as of the 28th day of March, 2013 (the “**Effective Date**”) by and among **Provincial Health Services Authority (“PHSA”), Vancouver Coastal Health Authority (“VCH”), Providence Health Care Society (“PHC”) and IBM Canada Limited (“Service Provider”).**

RECITALS

A. On August 8, 2011, PHSA, through its procurement division Health Shared Services British Columbia (“**HSSBC**”), issued a Request for Prequalification for Strategic Transformation for Clinical Information Systems (RFPQ # HSSBC-00432) (“**RFPQ**”) on behalf of PHSA, VCH and Providence, pursuant to which HSSBC prequalified prospective service providers to provide services described in the RFPQ;

B. On February 15, 2012, HSSBC issued a subsequent directed Request for Proposal HSSBC-00578 (“**RFP**”) for the purposes of selecting an experienced and qualified service provider to provide certain services including the Services;

C. The Service Provider submitted to HSSBC a proposal on April 10, 2012 (the “**Service Provider Proposal**”), and represented to HSSBC that it has the expertise, personnel, products, services and skills required to meet the requirements set out in the RFP;

D. In reliance on representations made by Service Provider in the Service Provider Proposal and subsequent discussions, on June 6, 2012 HSSBC selected Service Provider over other prospective service providers to provide the Health Organizations with the Services; and

E. PHSA, VCH and PHC and Service Provider want to specify the terms and conditions under which Service Provider will provide such Services to the Health Organizations.

NOW THEREFORE in consideration of the representations, warranties, promises and covenants contained herein, and other good and valuable consideration, the receipt, sufficiency and adequacy of which are hereby acknowledged, the Parties, intending to be legally bound, hereby agree as follows:

ARTICLE 1 GUIDING PRINCIPLES

1.1 Guiding Principles

The principles identified below (“**Guiding Principles**”) are intended to provide a general introduction to this Agreement by way of setting out the principles that the Parties have determined to be important to ensure the success of their relationship. The Guiding Principles are not intended to expand the scope of the Parties’ obligations hereunder or to alter the plain meaning of the terms and conditions of this Agreement. However, if any term or condition of this Agreement is ambiguous or unclear or does not address a particular circumstance, such term or condition will be interpreted and construed with a view to giving effect to the Guiding Principles.

- (1) **Enhance Capabilities and Effectiveness.** Services will be provided by Service Provider to the Health Organizations in a manner that enhances the Health Organizations’ ability to deliver high-quality, cost-effective services internally within each Health Organization and to their respective users with the bare minimum of interruptions in, and adverse impacts on, the Health Organizations’ delivery of such services. The quality of the Services and the technology utilized by Service Provider

Restricted and Confidential – Services Agreement

to provide the Services will be no less than consistent with the standards customarily observed by leading North American providers of the same or substantially similar services.

- (2) **Reduce Costs.** Cost reduction is a key objective for the Health Organizations in securing Services from Service Provider. Service Provider will advise the Health Organizations of cost reduction opportunities and will, subject to the Change Process, implement such cost reduction opportunities. Service Provider will also implement improved internal processes and methodologies in order to further reduce the overall cost of the Services to the Health Organizations and will report on same to the Health Organizations.
- (3) **Improve Services.** Service Provider will identify ways to improve the service levels and the functionality, quality, consistency, reliability, security and accuracy of the Services and will, subject to the Change Process, implement same. Service Provider will also implement improved internal processes and methodologies in order to further improve the service levels and the functionality, quality, consistency, reliability, security and accuracy of the Services and will report on same to the Health Organizations.
- (4) **Effective Relationship.** The Health Organizations and Service Provider each value the development of a close and effective working relationship between the Parties and recognize that such a relationship will better facilitate the implementation and delivery of the Services and the achievement of the objectives of this Agreement.
- (5) **Focus on Core Competencies.** By having the Services performed by the Service Provider and leveraging Service Provider's core competencies, Service Provider will enable the Health Organizations to focus more of their internal resources on strategy, providing services to their users and to improving the levels of service.
- (6) **Security and Privacy.** Service Provider will identify ways to improve and, subject to the Change Process, will implement such improvements to the control and security of the Services. Service Provider will use Canadian privacy and security industry best practices to protect the Health Organization Data and the Health Organizations' environments.
- (7) **Transition.** Transition activities, into, between and from Services are to be smooth and seamless, are to be performed in a cooperative manner (among the Health Organizations and their service providers), and to cause minimum disruptions to the Health Organizations and their users.
- (8) **Environmental Requirements.** The Service Provider acknowledges the importance of environmental leadership. The Service Provider maintains a corporate environmental policy and the Service Provider will: (a) provide available reports to the Health Organizations on the direct and indirect environmental impacts of the Services; and (b) use all commercially reasonable efforts to reduce the environmental impacts of the Services (including GHG Emissions) in a manner consistent with the practices customarily observed by leading North American providers of services the same or substantially similar to the Services (or as may otherwise be required by the Health Organizations subject to the Change Process).

ARTICLE 2 INTERPRETATION

2.1 Defined Terms

Unless the context otherwise requires, or unless otherwise defined in the particular Section or Schedule A (*Definitions*) of this Agreement, all terms with an initial capital letter used in this Agreement (including the Recitals) will be interpreted in accordance with the definitions given to such terms in Schedule A (*Definitions*) of this Agreement.

2.2 Articles, Sections and Headings

The division of this Agreement into Articles, Sections, subsections, paragraphs and Schedules, and the insertion of headings and an index are for convenience of reference only and will not affect the construction or interpretation of this Agreement. The Schedules attached to this Agreement form part of this Agreement. Unless otherwise specified herein, any reference herein to an Article, Section, subsection, paragraph or Schedule refers to the specified Article, Section, subsection or paragraph of, or Schedule to this Agreement. In this Agreement, the terms “this Agreement”, “hereof”, “herein”, “hereunder” and similar expressions refer to this Agreement and not to any particular part, Article, Section, subsection, paragraph or other provision hereof.

2.3 Number and Gender

In this Agreement, words importing the singular will include the plural and vice versa and words importing one gender will include all genders, unless the context otherwise requires.

2.4 Inclusion

Where the word “include”, “includes” or “including” is used in this Agreement, it means “include”, “includes” or “including”, in each case, “without limitation”.

2.5 Discretion

Where the words “discretion” or “option”, or such similar words are used in this Agreement with respect to the Health Organizations or the Service Provider, such words shall be deemed to mean in the case of the Service Provider such party’s sole and absolute discretion or option or in the case of the Health Organizations, their collective absolute discretion or option.

2.6 Consents and Approvals

- (1) **No Additional Obligations.** If either Party consents to or approves: (a) the content of any plan, manual or document prepared in whole or in part by the other Party; (b) the taking of any action by the other Party; or (c) any matter, in accordance with the provisions of this Agreement, the mere making or granting of such consent or approval will not, in and of itself, impose any additional obligations or liabilities upon the Party making or granting such consent or approval.
- (2) **Withholding or Delay.** Except to the extent a contrary intention is expressly set forth in this Agreement, whenever a Party is to provide its approval of or consent to an action, condition or event, such approval or consent will not be unreasonably withheld or delayed.

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2.7 Business Days

Any reference herein to “days”, that does not refer to Business Days, is a reference to days. Unless otherwise specified herein, whenever any payment to be made or action to be taken hereunder is required to be made or taken on a day other than a Business Day, such payment will be made or action taken on the next following Business Day.

2.8 Computation of Time Periods

Unless otherwise specified herein, in the computation of a period of time from a specified date to a later date, the word “from” means “from and including” and the words “to” and “until” mean “to but excluding”. Unless otherwise specified herein, all references to any time of day will refer to the time of day in British Columbia.

2.9 Time of Essence

Time will be of the essence in this Agreement.

2.10 Currency

Unless otherwise specified, all dollar amounts referred to herein are expressed in Canadian dollars.

2.11 Accounting Terms

All accounting terms not specifically defined in this Agreement will be construed in accordance with GAAP or IFRS (at such time that International Business Machines Corporation, the Service Provider’s ultimate parent, is required to adopt IFRS by Applicable Law) or any successor standard.

2.12 Priority

If there is any apparent conflict or inconsistency between the provisions set forth in the body of this Agreement and the provisions set forth in any Schedule, the provisions set forth in the body of this Agreement will prevail.

2.13 Statutory References

Any reference in this Agreement to a statute should be deemed to refer to the statute and any regulations thereunder (in force at the Effective Date), as may be subsequently amended or replaced, from time to time.

2.14 Schedules

The following Schedules are attached to and form part of this Agreement:

Schedule A	Definitions
Schedule B	Intentionally Deleted
Schedule C	Intentionally Deleted
Schedule D	Services
Schedule E	Change Process Forms
Schedule F	Intentionally Deleted
Schedule G	Intentionally Deleted

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Schedule H	Governance
Schedule I	Intentionally Deleted
Schedule J	Intentionally Deleted
Schedule K	Intentionally Deleted
Schedule L	Privacy and Security
Schedule M	Intentionally Deleted
Schedule N	Termination Fees
Schedule O	Form of Certificate of Insurance
Schedule P	Dispute Resolution Process
Schedule Q	Health Organization Policies and Procedures
Schedule R	Permitted Service Locations
Schedule S	List of Reports
Schedule T	Intentionally Deleted
Schedule U	Intentionally Deleted
Schedule V	Intentionally Deleted
Schedule W	Intentionally Deleted
Schedule X	Intentionally Deleted
Schedule Y	Intentionally Deleted
Schedule Z	Intentionally Deleted
Schedule AA	Health Organization Service Locations
Schedule BB	Service Provider Key Personnel
Schedule CC	Approved Subcontractors
Schedule DD	Fees
Schedule EE	Form of Invoice
Schedule FF	Corporate Organizational Chart
Schedule GG	Additional Remedies of Health Organizations

**ARTICLE 3
TRANSITION**

Intentionally deleted.

**ARTICLE 4
SERVICES**

4.1 Provision of Services

In consideration for the payment of the Fees by the Health Organizations to the Service Provider, the Service Provider will perform for, and provide to, the Health Organizations all of the services, functions, responsibilities or tasks provided for in this Agreement, including:

- (1) the services, as more particularly described in Schedule D (*Services*) as follows:
 - (a) Schedule D1(a)(i) – Strategy & Verification Services;
 - (b) Schedule D1(a)(ii) – Enterprise Build Services;
 - (c) Schedule D3(a) – Implementation Wave 1 Services;

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Restricted and Confidential – Services Agreement

- (d) Schedule D3(b) – Implementation Wave 2 Services;
- (e) Schedule D3(c) – Implementation Wave 3 Services;
- (f) Schedule D3(d) – Optimization Services;
- (2) the Transition Out Services set forth in Article 19; and
- (3) any additional services which are to be performed by Service Provider pursuant to the Change Process,

as such services may evolve or be supplemented, enhanced, modified or replaced from time to time in accordance with the terms of this Agreement (collectively, the “Services”).

4.2 Service Inclusions

If any services, functions, responsibilities or tasks not specifically described in this Agreement are required for the proper performance of any of the Services and are inherent in or incidental to the performance of the Services, such additional services, functions, responsibilities and tasks will be deemed to be implied by and included within the scope of the Services to the same extent and in the same manner as if specifically described in this Agreement.

4.3 Roles and Responsibilities

The specific roles and responsibilities of the Service Provider and the Health Organizations will be set out in the Services schedules attached to this Agreement.

4.4 Non-exclusivity

A Health Organization is not precluded by this Agreement from obtaining services from any other provider that may be similar or identical to the Services, and may also obtain services which are outside the scope of the Services from either Service Provider or any other provider.

4.5 Service Locations

Unless otherwise agreed by the Health Organizations, the Services will be performed by Service Provider at and from the locations set forth in Schedule R (*Permitted Service Locations*) (the “**Permitted Service Locations**”). If Service Provider recommends that any Services be performed at a location other than the Permitted Service Locations, the Service Provider will obtain the prior written approval of the Health Organizations for the performance of those Services from such other location. The Health Organizations’ approval of locations other than Permitted Service Locations will not be unreasonably withheld provided that the Health Organizations are satisfied that the Services will be performed in compliance with this Agreement, all Applicable Laws, and appropriate safeguards will otherwise meet all of the Health Organizations’ reasonable requirements.

4.6 Operations Manual

Intentionally deleted.

4.7 Extension of Agreement to Health Authorities

The Health Organizations may, at their option and upon not less than sixty (60) days written notice to Service Provider, extend the scope of this Agreement and the right to purchase Services to any of their existing or future hospitals or health care facilities or agencies or to other health authorities in British Columbia or to hospitals or health care facilities or agencies governed by or affiliated with such other health authorities that are not, as of the Effective Date purchasers of Services under this Agreement (collectively, the “**Health Facilities**”). Any such extension of the Agreement and the right to purchase Services from Service Provider will be on the same terms contained herein, including pricing as set forth in Schedule DD (*Fees*). Any such extension of the Agreement is at the discretion of the Health Organizations and such Health Facilities. For greater certainty, the Health Facilities are not required to participate in the Agreement and may elect to pursue other solutions if their specific requirements are not met by this Agreement. In the event that the Health Organizations exercise such option under this Section 4.7, the Service Provider, the Health Organizations and such Health Facilities will, within ninety (90) days of receipt of notice from the Health Organizations of the Health Organizations’ intention to exercise such option, enter into such agreements as may be reasonably required to give effect to this Section 4.7. The Health Organizations and the Health Facilities will at all times have the right to tender their requirements in order to ensure they receive optimum products, services and pricing. Any such tendering will be without prejudice to the Health Organizations’ option to extend the scope of this Agreement and the right to purchase the Service Provider’s Services to any of the Health Facilities.

ARTICLE 5 SERVICE LEVELS AND SERVICE LEVEL REPORTING

Intentionally deleted.

ARTICLE 6 HARDWARE, CONTRACTS, AND FACILITIES

6.1 Health Organization Hardware

- (1) **Health Organization Hardware.** All Health Organization Hardware will be owned or leased by the Health Organizations. During the Term, the Health Organizations will be responsible for replacing, from time to time, all Health Organization Hardware that is no longer current or in appropriate working order for its intended purpose as determined by the Health Organizations.

6.2 Service Provider Hardware

- (1) **Service Provider Hardware.** The Service Provider will own or lease all equipment used by Service Provider to provide the Services, other than Health Organization Hardware, used by the Service Provider. The Service Provider will be responsible for managing, maintaining, repairing, and replacing all Service Provider Hardware.
- (2) **Installation of Service Provider Hardware.** To the extent necessary, the Service Provider will arrange for, and will be responsible for the transportation and installation of any Service Provider Hardware that the Parties have agreed, in writing, will be located at a Health Organization Service Location. If the Health Organizations relocates any Health Organization Service Location in which any such Service Provider Hardware is installed, the Health Organizations will be responsible for the relocation costs relating to such Service Provider Hardware. If Service Provider

requests the relocation of any such Service Provider Hardware, Service Provider will be responsible for the relocation costs relating to such Service Provider Hardware.

6.3 Use of Health Organization Facilities

- (1) *Use of Health Organization Facilities.* The Health Organizations will make reasonably necessary space and furnishings (the “**Health Organization Facilities**”) available to Service Provider’s On-site Dedicated Personnel who are performing Services at Health Organization Service Locations throughout the Term and the Health Organizations will maintain Health Organization Facilities in areas and at a level similar to that which they maintains for their own employees performing similar work.
- (2) *Health Organization Facilities “AS IS”.* The Health Organization Facilities and the office space, furnishings and assets installed or operated at Health Organization Facilities and supplies allocated, are provided “AS IS, WHERE IS,” and are to be used exclusively for performance of Services for the Health Organizations. Any office supplies and furnishings (other than existing, basic office furnishings) for use of the On-site Dedicated Personnel are the exclusive responsibility of Service Provider.
- (3) *Service Provider Improvements.* Service Provider will be entitled to make improvements to any space where On-site Dedicated Personnel are performing Services on-site at a Health Organization Service Location, provided that: (i) such improvements will have been previously approved in writing by the Health Organizations (which approval may be withheld in the Health Organizations’ discretion); (ii) such improvements will be made at no cost to the Health Organizations; (iii) any Subcontractors used by Service Provider to perform such improvements will have been approved in writing by the Health Organizations; (iv) the Health Organizations will be granted, without further consideration, all rights of ownership in such improvements; and (v) such improvements are subject to the terms of Section 6.3(2).
- (4) *Other Facility-Related Obligations.* Except as expressly provided in this Agreement, Service Provider will use Health Organization Facilities for the sole and exclusive purpose of providing the Services. Use of such facilities by Service Provider does not constitute a leasehold interest in favour of Service Provider. Service Provider will use Health Organization Facilities in a reasonable and efficient manner. Service Provider, Service Provider Personnel and Subcontractors will keep Health Organization Facilities that the Service Provider uses clean and in good order, will not commit or permit waste or damage to such facilities, and will not use such facilities for any unlawful purpose or act. Service Provider will comply, and will cause its Service Provider Personnel and Subcontractors to comply, with all Applicable Laws and Health Organization Policies and Procedures relating to Health Organization Facilities (copies or relevant excerpts of which will be provided to Service Provider in hard copy or electronic form) and all Health Organization Policies and Procedures that relate to access to and/or use of the Health Organization Facilities, including procedures for the physical security of Health Organization Facilities. Service Provider will not make any improvements or changes involving structural, mechanical, or electrical alterations to Health Organization Facilities without the Health Organizations’ prior written approval. When Health Organization Facilities

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are no longer required for performance of the Services and if requested by the Health Organizations, Service Provider will return such facilities to the Health Organizations in substantially the same condition as when Service Provider began use of such facilities, subject to reasonable wear and tear. Service Provider will not cause the breach of any lease contracts governing use of Health Organization Facilities.

- (5) *Specific Provider Equipment.* Except as expressly provided herein, the Service Provider will provide and will, in all respects, be responsible for cell phones, laptop computers and peripheral devices required by its personnel in the performance of the Services at the Health Organization Facilities. The Health Organizations will provide telephones (including conference phones) and network access for Service Provider Personnel at Health Organization Facilities, similar to those which they provide for their own employees performing similar work. Service Provider will be responsible for all usage-based charges incurred by Service Provider Personnel in connection therewith. For greater clarity, in all other respects the Service Provider is responsible for providing any and all hardware, tools or other equipment required by the Service Provider Personnel in the performance of the Services.

ARTICLE 7 CHANGE PROCESS

7.1 Health Organization Initiation of Change Process.

The Health Organizations may initiate the Change Process at any time, and from time to time, during the Term and any Transition Out Period, by completing and delivering to Service Provider a request for a Change (“**Change Request**”) in the form attached as Schedule E (*Change Process Forms*). Each Change Request shall be signed by the Health Organization Contract Executive, or his or her designee.

The Health Organizations may solicit a response from the Service Provider and other prospective providers to perform services (for clarity, the price to be charged for such services not currently set forth in Schedule DD (*Fees*)). Where the Health Organizations wish to obtain a proposal for such services or otherwise requires a Change to the Services from the Service Provider under this Agreement, the Health Organizations will provide the Service Provider with a Change Request. The Health Organizations may make a Change (including increases or decreases) to the Services, including to:

- (a) the scope, content or description of the Service in this Agreement; or
- (b) other contractual obligations relating to the provision of the Services,

by following the Change Process. The Service Provider may not implement any such change without the Health Organizations’ prior written consent, which may be withheld in the Health Organizations’ discretion.

7.2 Content of Change Request.

The Change Request shall specify all of the proposed changes in sufficient detail to enable evaluation by the Service Provider.

7.3 Service Provider Initiation of Change Process & Response to Change Request.

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Within ten (10) Business Days following the date of Service Provider's receipt of a Change Request, or at Service Provider's own initiative, Service Provider shall provide the Health Organization Contract Executive, or any other Person designated by the Health Organization Contract Executive in writing from time to time, with a change proposal ("**Change Proposal**") in the form attached as Schedule E (*Change Process Forms*) that contains the following:

- (1) a description of any:
 - (a) Change to the Services;
 - (b) additional Services;
 - (c) change to the terms of the Agreement;
 - (d) work which is to be performed; or
 - (e) other Changes, in each case as requested in or required by the Change Request;
- (2) the roles and responsibilities of the Parties with respect to such Changes or work;
- (3) if applicable, the Deliverables required by or to be prepared in connection with the Change Request;
- (4) categories of personnel required to complete any additional work required by the Change Request;
- (5) if applicable, an implementation plan and the timeframe for performance with Critical Milestones;
- (6) if applicable, completion and acceptance criteria for any work or Deliverables required by the Change Request;
- (7) if applicable, the ownership and licensing terms of any software, hardware or other materials to be developed or supplied under the Change Proposal;
- (8) if applicable, the resources reasonably required to perform the requested work and any additional fees and/or costs which may reasonably be required to perform such work;
- (9) if applicable, the schedule, applicable milestones and method of payment; and
- (10) if applicable, any additional continuing Fees that would apply.

Each Change Proposal shall be signed by the Service Provider's Contract Executive or his or her designees. In respect of any proposed Change Request, Service Provider shall provide reasonable assistance to the Health Organizations with respect to the Health Organizations' assessment and approval thereof, the development of the Health Organizations' requirements and work-plans, and any re-scoping required by the Health Organizations.

7.4 Implications of Changes on Fees

The Fee implications, if any, set out in the Change Proposal shall be calculated on a net basis and shall equal the net amount of the increases and reductions in costs reasonably expected to result from the proposed Changes, taken in the aggregate. Where additional obligations are to be imposed on Service Provider, any increase to the Fees set out in the Change Proposal shall be limited to those costs reasonably required in order for Service Provider to meet such new obligations. Where Service Provider's previous obligations are to be removed or reduced, the reduced Fees set out in the Change Proposal shall reflect the costs that Service Provider is, acting diligently, reasonably able to avoid as a result of the removal and/or reductions in the obligations. If any changes to the Fees are proposed in a Change Proposal, such Change Proposal shall contain a detailed, justification of the reasonableness of the proposed increases and reductions in Fees (including, cost-based justification for all third party hardware and software costs).

7.5 Complex Change Request

In the case of a large or complex Change Request, the Health Organizations may agree that Service Provider will promptly provide to the Health Organizations a high level summary of the above information for the Health Organizations' consideration. After such consideration, the Health Organizations may request Service Provider to provide a detailed Change Proposal, which shall be prepared and delivered within ten (10) Business Days of such request.

7.6 Acceptance of Change Proposal.

In order to be effective and the services described therein to be provided and incorporated into the Services, the Change Proposal must be accepted and converted into a Change Order and signed by the Health Organization Contract Executive, or any other Person designated by the Health Organization Contract Executive in writing from time to time. The Health Organizations' acceptance or rejection of any Change Proposal shall be in their discretion. If Service Provider reasonably believes that the rejection of the Change Proposal will have an unavoidable, material negative impact on the Services, Service Provider will notify the Health Organizations of such belief and of a proposed work-around to avoid such impact.

7.7 Change Proposal Fees

Service Provider's proposed fees for performing the work described in each Change Proposal will be competitive, commercially reasonable and calculated in the manner (fixed price, time and materials, or otherwise) requested by the Health Organizations in the Change Request. The fees will, in each case, be based upon the Service Rates or such lower rates as may be offered by Service Provider to the Health Organizations to ensure the competitiveness of the services to be provided under the Change Order.

ARTICLE 8 CONTRACT MANAGEMENT

8.1 Governance

The Parties' relationship management and governance under this Agreement will be in accordance with the procedures, roles and responsibilities set out in Schedule H (*Governance*).

8.2 Management Functions

From time-to-time as agreed by the Parties and in order to administer certain functional aspects of the Parties' relationship, each Party will designate appropriate, qualified individual(s) to address various subject matter including performance and process management, architecture and technology management, finance/contract management, enterprise standards management, sourcing relationship management, quality assurance management, business unit management, and transition management, with such roles and responsibilities of these individuals as may be determined by the Parties at such time.

ARTICLE 9 PERSONNEL

9.1 Service Provider Key Personnel

- (1) **Designation of Service Provider Key Personnel.** Each of the Service Provider Key Personnel is designated on, and will have the general responsibility assigned to such person as set forth in Schedule BB (*Service Provider Key Personnel*).
- (2) **Changes to Service Provider Key Personnel.** Schedule BB (*Service Provider Key Personnel*) may be modified from time-to-time in accordance with this Agreement and will be deemed modified upon any approved replacement or substitution of a new person for any Service Provider Key Personnel.
- (3) **Health Organization Approval Right.** Prior to the assignment or designation of any person to fill the position or perform the duties provided by any Service Provider Key Personnel, the Health Organizations will have the right to interview such person and approve the selection of such person to fill the position or perform the duties provided by the Service Provider Key Personnel to be replaced.
- (4) **Knowledge Backup.** Service Provider will maintain a process for the replacement of Service Provider Key Personnel to ensure that all Service Provider Key Personnel have at least one designated individual from the account team assigned to the Services as his or her core knowledge backup. Service Provider acknowledges that cross-sharing of knowledge is critical to minimizing the potential impact to the Health Organizations if any of the Service Provider Key Personnel become unavailable for any reason.

9.2 Service Provider Personnel

The Service Provider will, at all times during the Term, employ sufficient personnel of the Service Provider (including both employees and independent contractors of the Service Provider), and the Service Provider will ensure that sufficient personnel (including both employees and independent contractors), are employed by its Subcontractors, to perform the Services in accordance with the terms and conditions of this Agreement including. No more than once per Contract Year, upon thirty (30) days prior written notice of such a request by the Health Organizations, Service Provider will provide the Health Organizations with a written list of all Principally Dedicated Service Provider Personnel, and the contents of such written list will include, the employees' titles, names, dates of placement, assignment addresses, principal duties and responsibilities. Service Provider will, upon receiving a request from the Health Organizations, make available to the Health Organizations the resume of any Principally Dedicated Service Provider Personnel.

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In addition, the Service Provider will ensure that Service Provider Personnel, who spend sixty percent (60%) or more of their time providing the Services (“**Principally Dedicated**”) do not allow the services provided for Service Provider’s other customers to detract, in any way, from such Principally Dedicated Service Provider Personnel’s performance of his/her responsibilities under the Agreement.

9.3 Removal/Replacement of Service Provider Key Personnel

All Service Provider Key Personnel will be assigned to perform the Services on such basis (for example, full time assignment or otherwise) as set opposite such Service Provider Key Personnel in Schedule BB (*Service Provider Key Personnel*) and to ensure that the Services contemplated hereunder are provided in an efficient and timely manner. The Service Provider shall not transfer, reassign or otherwise re-deploy any Service Provider Key Personnel from performance of Service Provider’s duties under this Agreement, except in the case of disability, leave of absence, resignation or termination (or similar causes beyond the Service Provider’s control), for the period set opposite such Service Provider Key Personnel’s name in Schedule BB (*Service Provider Key Personnel*). If any one of the Service Provider Key Personnel becomes incapacitated, takes a leave of absence, employment with Service Provider (or any of Service Provider’s Affiliates or is terminated or is transferred, reassigned or redeployed with the consent of the Health Organizations, Service Provider will provide the Health Organizations with as much advance notice as is feasible under the circumstances, will promptly consult with the Health Organizations with respect to an appropriate replacement and will promptly ensure that such Service Provider Key Personnel’s function is competently performed on an interim basis, to allow the Parties sufficient time to establish a longer term solution. Service Provider will promptly identify potential candidates to replace such Service Provider Key Personnel. Service Provider will replace such person with another person, approved by the Health Organizations, that possesses comparable experience and training as the Service Provider Key Personnel and has sufficient knowledge and expertise to perform the Services in accordance with this Agreement. For purposes of this Section 9.3, the movement of Service Provider Key Personnel from the employ of Service Provider to an Affiliate of Service Provider will be considered a reassignment requiring the Health Organizations’ consent and not a cessation of employment. To the extent feasible, Service Provider will provide the Health Organizations with advance notice and will consult with the Health Organizations concerning, and prior to, the replacement of Service Provider Key Personnel. Service Provider will use commercially reasonable efforts to promptly identify proposed candidates in the event of any sudden departure of any Service Provider Key Personnel.

9.4 Removal of Service Provider Personnel by Health Organizations

Notwithstanding anything contained in this Agreement to the contrary, if the Health Organizations believe in good faith that the performance or conduct of any Person employed or retained by Service Provider to perform Service Provider’s obligations under this Agreement (including Service Provider Key Personnel) is unsatisfactory for any reason and is not in compliance with the provisions of this Agreement, the Health Organizations will so notify Service Provider in writing and Service Provider will promptly address the performance or conduct of such Person, or, at the Health Organizations’ request, acting reasonably, promptly replace such Person with another Person acceptable to the Health Organizations and with sufficient knowledge and expertise to perform the Services in accordance with this Agreement. Service Provider will respond to any such request within five (5) Business Days of receiving notice from the Health Organizations, and will provide any replacement required within fifteen (15) Business Days of receiving the Health Organizations’ request to replace such Person, or such longer period of time as reasonably required to replace such Person having regard for the Person’s expertise and availability of resources with similar skills and experience, provided that any non-compliance with the provisions of this Agreement have been cured. The Health Organizations will not be responsible for any relocation

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expenses arising from any relocation activities involved in Service Provider complying with this Section 9.4 or any other term or condition of this Agreement.

9.5 Replacement Personnel

Any and all proposed replacement personnel under this Article 9 will be:

- (a) “qualified,” meaning that the proposed replacement personnel will possess comparable experience and training as the Service Provider Personnel or Service Provider Key Personnel, as the case may be, to be replaced and has sufficient knowledge and expertise to perform the Services in accordance with this Agreement; and
- (b) except in the case of disability, leave of absence, resignation or termination, the replacement personnel will work with the replaced Service Provider Key Personnel during a mutually agreed transition period, the duration of which will be determined based on the duties and responsibilities of the person to be replaced, and all costs and expenses associated with educating and training the replacement personnel will be borne by Service Provider. Without limiting the generality of the foregoing, such transition period for the Service Provider Contract Executive will be at least one (1) month in length. In addition, provided that the replaced Service Provider Key Personnel remains employed by Service Provider, such individual will continue to be available by telephone to answer any Health Organization-related questions.

9.6 In-Scope and Selected Employees

In the event that any Health Organization Personnel are being transferred to Service Provider as part of the business agreement between the Parties, such transfer will be completed in accordance with terms and conditions set out in a Master Transfer Agreement between the Parties.

9.7 Criminal Records Check

- (1) **CPIC Level 1** - All Service Provider Personnel (including for certainty, Service Provider Key Personnel) will, prior to their assignment to perform Services, be subject to security clearances by Service Provider (a criminal records check using Canadian Police Identification Centre (CPIC) Level 1 query) consistent with any applicable policies and/or practices of the Service Provider, from time to time. All costs and expenses associated with providing, equipping and retaining Service Provider Personnel are included within the Fees.

9.8 Minimum Proficiency Levels

In addition to Service Provider Key Personnel, Service Provider will provide and make available such Service Provider Personnel as are required to fully and properly perform all of Service Provider's obligations under this Agreement. Service Provider Personnel will have experience, training and expertise sufficient to perform Service Provider's obligations under this Agreement. Subject to the requirements of Section 9.4, in the event the Health Organizations believe any such person does not possess the indicated level of experience and expertise, the Health Organizations may request removal of such person.

9.9 Training

Service Provider will provide, and cause its Subcontractors to provide, all such training to the Service Provider Personnel (and for greater certainty, the Subcontractors personnel) as may be necessary for them to perform all of Service Provider's duties under this Agreement (including technical training as well as training regarding applicable administrative matters such as training regarding applicable Health Organization Policies and Procedures and the requirements relating to Personal Information).

9.10 Supervision and Conduct of Service Provider Personnel

- (1) Neither the Service Provider nor the Service Provider Personnel, Subcontractors or agents of Service Provider are or will be deemed to be employees of the Health Organizations. Service Provider or, with respect to Persons who work for a Subcontractor, the applicable Subcontractor(s), will be responsible for their own staff assigned to provide Services, and, subject to this Article 9, Service Provider (directly or through Subcontractors) will have the sole right to direct and control the management of such staff.
- (2) The Health Organizations will have no direct or indirect liability to any Service Provider Personnel or other Persons who work for Service Provider or Subcontractors under this Agreement. Without limiting the foregoing, Service Provider and its Subcontractors will, as applicable, in respect of Persons who work for Service Provider or Subcontractors:
 - (a) determine and pay all applicable wages and salaries, including applicable overtime and other premium pay;
 - (b) provide healthcare, retirement and other benefits, as it deems necessary or desirable;
 - (c) comply with Applicable Laws, including income tax and employment tax withholding laws;
 - (d) comply with all Applicable Laws governing the relationship between Service Provider or Subcontractors and their respective employees, including laws relating to accommodation of disabilities, equal pay, provision of leave (for example, jury duty, etc.), unlawful discrimination, as well as wage and hour requirements;
 - (e) comply with all workers' compensation insurance coverage as required by Applicable Laws;
 - (f) file all applicable reports with federal, provincial and local agencies and authorities as required by Applicable Law;
 - (g) maintain all required employment records, including personnel and medical files consistent with Applicable Laws and customary business practices; and
 - (h) comply with all applicable equal employment opportunity as required by Applicable Laws.

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- (3) While at or on Health Organization Facilities or otherwise at the premises of the Health Organizations, the Service Provider, the Subcontractors and the Service Provider Personnel will:
- (a) conduct themselves in a businesslike manner; and
 - (b) comply with the applicable Health Organization Policies and Procedures; and
 - (c) to the extent that notice of same is given by the Health Organizations to Service Provider, all other applicable rules and requests of the Health Organizations including those relating to safety and health and personal, professional and ethical conduct (including those contained in the Health Organizations' employee manuals and written policies and procedures) as may be required for such locations.

**ARTICLE 10
USE OF SUBCONTRACTORS**

10.1 Use of Subcontractors

The Service Provider acknowledges and agrees that it is the prime contractor for the Services under this Agreement and, notwithstanding that the Service Provider may enter into subcontracts with Subcontractors to perform certain of the Services, the Service Provider shall remain solely responsible for all of its obligations under this Agreement. The Service Provider shall be liable for any and all defaults or delays caused by any Subcontractor as though such acts, omissions, defaults or delays were caused by the Service Provider.

10.2 Approval of Key Subcontractors

Service Provider will not perform or provide the Services through Subcontractors without the prior written consent of the Health Organizations as to the selection of the Subcontractor, which consent may be withheld by the Health Organizations in their discretion. Notwithstanding the foregoing, the Health Organizations hereby consent to the use by Service Provider of the Subcontractors identified in Schedule CC (*Approved Subcontractors*). Service Provider will ensure that each Subcontractor has obtained and maintains all licenses required in connection with the Services for which such Subcontractor is responsible. Service Provider agrees that it will continue throughout the Term to retain the Subcontractors identified as "**Key Subcontractors**" in Schedule CC (*Approved Subcontractors*) and that such Persons will continue to provide the Services initially provided, unless Service Provider wishes to provide the Services itself or has obtained the Health Organizations' prior written consent to any changes, which consent may be withheld in the Health Organizations' discretion.

10.3 Subcontractor Information

Service Provider will, prior to seeking the Health Organizations' consents, pursuant to Section 10.2 provide the Health Organizations with a written notice specifying the components of the Services to be provided by the Subcontractor, the scope of the proposed subcontract, and the identity and qualifications of the proposed Subcontractor. At the Health Organizations' request, Service Provider will forward to the Health Organizations a description of the scope and material terms (other than financial) of the subcontract or proposed subcontract.

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10.4 Liability and Replacement

In no event will Service Provider be relieved of its obligations under this Agreement as a result of its use of any Subcontractor, Affiliate, employee or agent to perform the Services or such obligation. Unless expressly provided in this Agreement, or unless otherwise required by the context, Service Provider will cause its Subcontractors to comply with each obligation hereunder of Service Provider (whether or not such obligation is expressly stated hereunder to apply to Subcontractors) and Service Provider will be liable for any failure of its Subcontractors to comply with such obligations. Service Provider will supervise the activities and performance of each Subcontractor, Affiliate, employee or agent and will be liable for any act or failure to act by such Subcontractor, Affiliate, employee or agent, in the performance of the Services or otherwise under this Agreement, to the same extent as if the act or failure was committed by Service Provider. If the Health Organizations determine that the performance or conduct of any Subcontractor is unsatisfactory, the Health Organizations may notify Service Provider of such determination in writing, indicating the reasons therefor, in which event Service Provider promptly will take all necessary actions to remedy the performance or conduct of such Subcontractor and, if such Subcontractor has failed to comply with the provisions of this Agreement (subject to any cure period for such failure) and subject to the terms of Section 10.2, replace such Subcontractor by another Third Party or by Service Provider Personnel.

10.5 Direct Agreements

Upon expiration of the Term or termination of the Agreement for any reason, the Health Organizations will have the unfettered right to enter into direct Contracts with any Subcontractors. Service Provider represents, warrants, and covenants to the Health Organizations that its arrangements with such Subcontractors will not in any way prohibit or restrict such Subcontractors from entering into direct Contracts with the Health Organizations.

ARTICLE 11 BUSINESS REQUIREMENTS STRATEGY

11.1 General

The Health Organizations will retain the exclusive right and authority to set the Health Organizations' business strategies and to determine, alter, and define any or all of the Health Organizations' requirements and operational and business processes and procedures. The Health Organizations will consult with Service Provider to inform Service Provider, in advance, of material changes in the Health Organizations' requirements and business processes relating to the Services. Service Provider will actively participate in any of the foregoing as the Health Organizations request and will, if requested, provide the Health Organizations with advice, information and assistance in identifying and defining projects and future requirements to meet the Health Organizations' objectives, as agreed by the Parties.

11.2 Specific Retained Responsibilities

Without limiting the generality of Section 11.1, the Health Organizations will retain exclusive authority, discretion and rights of approval with respect to the following:

- (1) considering opportunities to reduce the costs of the Services suggested by Service Provider (and Service Provider will use commercially reasonable efforts to suggest such opportunities) and making decisions with respect to the implementation of Changes to exploit such opportunities (whether identified by Service Provider or the Health Organizations); and

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- (2) overseeing the delivery of Services; the selection of the Health Organizations' suppliers; security requirements; prioritization, and service conflict resolution among users of the Services; and general operational management guidelines;
- (3) the Health Organizations will have the right, in their discretion, to approve or deny any Change Proposals in accordance with the applicable Change Process.
- (4) the Health Organizations will retain exclusive authority, discretion and rights of approval with respect to performing validation and verification activities in relation to key Changes and the Health Organizations' operational processes.
- (5) the Health Organizations will have the right to review and accept or reject all Deliverables to be provided by Service Provider to the Health Organizations under this Agreement (including, for greater certainty, under Schedule D), in accordance with the applicable documents issued thereunder respecting work to be performed by Service Provider.

**ARTICLE 12
INTELLECTUAL PROPERTY RIGHTS AND LICENSES**

12.1 Health Organization Owned Materials

Other than Service Provider Background Materials used or created in the provision of the Services, the Health Organizations will own of all newly created copyright in the Health Organization Developed Deliverables and Derivative Works of such Health Organization Developed Deliverables unless otherwise agreed to by the Parties in a Change Order.

Nothing in this Agreement affects the Health Organizations' ownership of all rights, title and interest including, without limitation, Intellectual Property Rights in and to:

- (1) Data and Modified Data;
- (2) Health Organization Proprietary Software and all Derivative Works thereof; or
- (3) Health Organization Licensed Software

(together with the Health Organization Developed Deliverables and all Derivative Works thereof, the "Health Organization Owned Materials").

The Health Organizations make no grant to Service Provider of any ownership interests, Intellectual Property Rights or other rights in the Health Organization Owned Materials, except for the limited licenses expressly set forth herein. The Health Organizations retain all other rights in and to the Health Organization Owned Materials that are not expressly licensed or granted to Service Provider under this Agreement. Service Provider acknowledges that the Parties do not intend Service Provider to be, and in no event will Service Provider be deemed to be, a joint owner or joint author of any of the Intellectual Property Rights in any Health Organization Owned Materials.

12.2 Service Provider-Owned Software

Nothing in this Agreement affects Service Provider's ownership of all rights, title and interest, including Intellectual Property Rights, in and to any expressions of literary works or other works of authorship (such as programs, programming tools, documentation, reports and similar works) developed by Service

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Provider or its Subcontractors or Affiliates prior to this Agreement or outside the scope of this Agreement, and all Derivative Works thereof (“**Service Provider Background Materials**”).

Service Provider makes no grant to the Health Organizations of any ownership interests, Intellectual Property Rights or other rights in the Service Provider Background Materials, except for the licenses and rights in and to the Service Provider Background Materials expressly set forth herein. Service Provider retains all other rights not expressly licensed or granted to the Health Organizations under this Agreement. The Health Organizations acknowledges that the Parties do not intend the Health Organizations to be, and in no event will the Health Organizations be deemed to be, a joint owner or joint author of any of the Intellectual Property Rights in the Service Provider Background Materials.

12.3 Service Provider Perpetual Licenses to Health Organizations

Where Service Provider Background Materials are embedded or embodied in any Deliverables provided by Service Provider to the Health Organizations, Service Provider hereby grants to each Health Organization a perpetual, non-exclusive, fully-paid up, worldwide, right and license to use, copy, modify, translate and create Derivative Works of such embedded Service Provider Background Materials, as embedded or embodied in such Deliverables, for its sole benefit and internal use, and the right:

- (1) for the Health Organizations to use any Deliverables for their respective benefit and internal use, provided that such Service Provider Background Materials remain embedded or embodied in such Deliverables; and
- (2) to authorize a Replacement Service Provider to exercise any of the Health Organizations' rights with respect to the Service Provider-Background Materials embedded or embodied in any Deliverables provided that the Replacement Service Provider is obligated to use Service Provider-Background Materials only as part of such Deliverables and only for the sole purpose of providing services for or on behalf of the Health Organizations,

and provided further that the Health Organizations and Replacement Service Provider are obligated to maintain the Service Provider- Background Materials in confidence, without further disclosing copies of the Service Provider- Background Materials to any other party except its employees, subcontractors and professional advisors who require access for the purpose of providing services on behalf of the Health Organizations, and in connection therewith, the following provisions will apply:

- (3) the foregoing rights granted to the Health Organizations do not give the Health Organizations the right, and the Health Organizations are not authorized, to market any Service Provider-Background Materials or Derivative Works thereof or to authorize any other Person to market any Service Provider-Background Materials thereof (other than Replacement Service Providers who require the same for purposes of, and in connection with, the delivery of the Services to the Health Organizations) to any other Person unless authorized in writing by Service Provider in a Change Order or separate written agreement; and
- (4) the Health Organizations are not permitted to use any Service Provider-Background Materials or any Derivative Work thereof for the benefit of any other Person without the prior written consent of Service Provider, provided that the Health Organizations will have the right to authorize their Replacement Service Providers to use the Service Provider-Background Materials solely for the purpose of providing services for or on behalf of the Health Organizations.

12.4 Assignment of any Copyright in Health Organization Developed Deliverables

Subject to Section 12.3, Service Provider hereby assigns and will assign, and will cause its Subcontractors and Service Provider Personnel to assign, to the Health Organizations or their designee (as directed by the Health Organization Executive or his or her designee), immediately upon their creation, all copyright of in the following Deliverables:

- (1) the Deliverables that Service Provider or its Subcontractors or Service Provider Personnel have created, during the Term, and delivered to the Health Organizations in accordance with Schedule D1; and
- (2) the Deliverables that Service Provider or its Subcontractors or Service Provider Personnel have created, during the Term, and delivered to the Health Organizations in accordance with Schedule D3;

(together, the “**Health Organization Developed Deliverables**”)

without further consideration, free from any claims, royalties or liens. Service Provider will also obtain waivers of any author’s moral rights in such Health Organization Developed Deliverables in favour of the Health Organizations, their assignees, licensees and designees.

Service Provider will obtain similar written assignments from all Subcontractors who will perform any Services, and will require that Subcontractors obtain similar waivers of moral rights from Subcontractor Personnel, so as to ensure the Health Organizations’ ownership of the Health Organization Developed Deliverables as provided herein, and will not commence the deployment of any such Subcontractor or Service Provider Personnel until such a written assignment and waiver has been obtained from such Subcontractor or Service Provider Personnel and delivered to Service Provider.

12.5 Health Organization Licenses to Service Provider

During the Term, the Health Organizations hereby grant to Service Provider a non-exclusive, fully-paid up, non-transferable limited right and license, to use, copy, distribute, modify, translate and create Derivative Works of the Health Organization Owned Materials for the sole purpose of delivering the Services to the Health Organizations. In connection therewith, the following provisions will apply:

- (1) the foregoing rights granted to Service Provider do not give Service Provider the right, and Service Provider is not authorized, to market any Health Organization Owned Materials or Derivative Works thereto or to authorize any other Person to market or use any Health Organization Owned Materials or Derivative Works thereto (other than Subcontractors who require the same for purposes of, and in connection with, the delivery of the Services to the Health Organizations);
- (2) Service Provider will not be permitted to use any Health Organization Owned Materials or any Derivative Works thereto for the benefit of any other Person without the prior written consent of the Health Organizations, provided that Service Provider will have the right to authorize its Subcontractors to use Health Organization Owned Materials solely for the purpose of providing the Services pursuant to, and in accordance with, the terms of this Agreement; and
- (3) the foregoing rights will terminate upon the termination or expiry of this Agreement, which ever is the later.

12.6 Non-Assert

Service Provider agrees that during the Term and following its termination or expiration, not to assert against the Health Organizations any of its patent claims that are necessarily infringed by: (1) the use or procurement by the Health Organizations of the Services provided under this Agreement; (2) the use by the Health Organizations of the Deliverables; or (3) the exercise by the Health Organizations of any of the license rights granted to the Health Organizations pursuant to Section 12.3; provided that the foregoing non-assertion will only apply to Deliverables for which Service Provider has received full payment from the Health Organizations, and further provided that the foregoing non-assertion covenant will not apply: (i) to any product or service not provided by, or process not performed by (or not previously performed by), Service Provider as part of the Deliverables or Services; (ii) to any modifications made (other than by Service Provider) to the Deliverables or Services, as applicable, which causes infringement of a Service Provider patent that was not infringing in the absence of such modification; (iv) any combination of a Deliverable or Services, or any part thereof, with other product, hardware device, program, data apparatus, or method (made other than by Service Provider) which causes infringement of a Service Provider patent which was not infringed in the absence of such combination; the use of any Deliverables or Services provided by Service Provider outside of the Health Organizations, except as may be authorized by Service Provider in writing under a Change Order or separate agreement with Service Provider; or (vi) any Deliverable or Services against which a patent claim has been asserted by the Health Organizations. If any of the Health Organizations asserts any patent embedded or embodied in any of the Deliverables or used in connection with the Services against Service Provider, this covenant not to assert granted above and the license granted under Section 12.4 shall terminate immediately vis-a-vis the asserting party. Except as provided in this Section 12.6, no other covenants or rights under Service Provider patents are granted under this Agreement either directly, by implication, or otherwise.

12.7 Further Assurances and Co-operation

The Parties will co-operate with each other and execute such other documents as may be appropriate to achieve the objectives in this Article 12.

Each Party will execute and deliver, and will cause its subcontractors and employees to execute and deliver, any and all Intellectual Property Rights applications, assignments and other documents that the other Party requests for protecting the ownership rights granted or otherwise recognized under this Article 12 to the requesting Party. Each Party will have the full and sole power to prosecute such applications and to take all other action concerning such rights, and the other Party will co-operate, at the requesting Party's expense, in the preparation and prosecution of all such applications.

12.8 Disclosure and Delivery

During the Term, Service Provider will, upon request from the Health Organizations, disclose and deliver to the Health Organizations all Health Organization Owned Materials made, created, developed, procured or arising under or as a result of this Agreement, provided such Materials are no longer required for the performance of the Services, which delivery will include without limitation both source code and object code and all available user manuals and documentation then in the Service Provider's possession or otherwise required in accordance with Schedule D.

12.9 Health Organization Data

- (1) **Access to Data.** Service Provider may access Health Organization Data solely to the extent Service Provider requires access to such data to provide the Services in accordance with the terms of this Agreement. Service Provider may only access and process Health Organization Data in connection herewith or as directed by the Health

Organization Contract Executive or his or her designee in writing and may not otherwise modify Health Organization Data, merge it with other data, commercially exploit it or engage in any practice or activity that may in any manner adversely affect the integrity, security or confidentiality of such data, other than as specifically permitted herein or as directed by the Health Organizations in writing. Nothing in this Agreement affects the Health Organizations' ownership of all rights, title, and interest, including Intellectual Property Rights, in and to the Health Organization Data and in and to any Derivative Works therefrom (collectively, the "**Data and Modified Data**").

- (2) **Service Provider Assignment.** Service Provider hereby assigns and will assign, and will cause its Subcontractors and Service Provider Personnel to assign, to the Health Organizations or their designee, all of their rights, title and interest including newly created copyright in and to the Data and Modified Data, that Service Provider or its Subcontractors or Service Provider Personnel have, may have or obtain, without further consideration, free from any claim, royalties, lien for balance due, or rights of retention thereto on the part of Service Provider. Service Provider will also obtain waivers of any author's moral rights in such Data and Modified Data in favour of the Health Organizations, their assignees, licensees and designees.
- (3) **Waivers.** Service Provider will obtain similar written undertakings and waivers from all Subcontractors and Service Provider Personnel who will perform any Services, and required that Subcontractors obtain similar waivers of moral rights from Subcontractor Personnel, so as to ensure the Health Organizations' ownership of the Data and Modified Data as provided herein, and will not commence the deployment of any such Sub-contractor or Service Provider Personnel until such a written undertaking and waiver has been obtained from such Subcontractor or Service Provider Personnel and delivered to Service Provider. Service Provider acknowledges that the Parties do not intend Service Provider to be a joint owner of any Intellectual Property Rights in the Data and Modified Data and that Service Provider will in no event be deemed the joint author of any Data and Modified Data. The Parties will co-operate with each other and execute such other documents as may be appropriate to achieve the objectives in this Section 12.9.

12.10 Open Source Software

- (1) Any open source software ("**OSS**") that Service Provider may install, update, access or otherwise use under this Agreement is and will be licensed and distributed to the Health Organizations by the relevant OSS distributors or respective copyright or other right holders under their terms and conditions, subject to Subsection 12.10(2) below. Service Provider is not a licensee, licensor, or a distributor of such OSS and performs the work described in this Agreement on the Health Organization's behalf. Except as set out below in Subsection 12.10(2), notwithstanding anything else to the contrary contained in this Agreement, Service Provider makes no express or implied warranties or representations with respect to such OSS. Service Provider grants no express or implied patent or other license with respect to such OSS and provides no indemnity for such OSS. For greater certainty, the foregoing shall not relieve the Service Provider of its obligations under this Agreement, including Schedule D and the obligation to cause the Deliverables to meet the functional and other requirements

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therein set forth. Any modification or creation of derivative works of any OSS is outside the scope of this Agreement.

- (2) To the extent Service Provider incorporates, integrates or bundles OSS in or with any Health Organization Developed Deliverables, Service Provider shall ensure that such incorporation, integration or bundling does not cause any Health Organization Owned Materials to become subject to a license that requires that such Health Organization Owned Materials be (i) disclosed or distributed in source code form, (ii) licensed for the purpose of making derivative works, or (iii) redistributable at no charge.

12.11 Infringement

If either Party receives a notice of infringement, request for disclosure, subpoena, or other inquiry with respect to any matter under this Article 12, then such Party will, as soon as practical, notify the other Party in writing and the matter will be dealt with in accordance with Article 21. Neither Party will respond to such notices, requests, subpoenas or inquiries with respect to the Intellectual Property Rights of the other Party, or disclose the other Party's Confidential Information to third parties, without first so notifying the other Party in writing (to the extent possible).

12.12 Co-operation

If at any time the Health Organizations bring, or investigate the possibility of bringing, any claim against any Person for infringement of any Intellectual Property Right of the Health Organizations, including misappropriation of trade secrets and misuse of confidential information (including without limitation, Data and Modified Data), then Service Provider, upon the request and at the expense of the Health Organizations, will provide reasonable cooperation and assistance to the Health Organizations in the investigation or pursuit of such claim, subject to Service Provider's confidentiality obligations to Affiliates and Third Parties.

12.13 Use of Names and Trademarks

Neither Party will have the right to use, reproduce or display and will not use, reproduce or display, the logos, trade-marks or trade names of the other Party in any manner without the prior written consent of the other Party, which consent may be withheld in such other Party's discretion.

12.14 Freedom of Action

Service Provider may enter into similar agreements with other Persons and develop and provide hardware, software or services that are similar to or competitive with the hardware, software, and Services provided under this Agreement, except to the extent that performance by Service Provider under such other agreements result in such hardware, software or services infringing any of the Health Organizations' Intellectual Property Rights. Subject to the foregoing and to Service Provider's obligations with respect to dedication of Key Personnel as set forth in Article 9 of this Agreement, Service Provider Personnel providing Services to the Health Organizations under this Agreement may perform similar services for others and this Agreement will not prevent Service Provider from using the personnel and equipment provided to the Health Organizations under this Agreement for such purposes.

12.15 Limitation

All rights not expressly granted by a Party under this Agreement including rights in patents are reserved by such party.

**ARTICLE 13
PRIVACY, SECURITY AND CONFIDENTIALITY**

13.1 Security

Intentionally deleted.

13.2 Privacy – General

- (1) **Privacy Requirements.** The Service Provider acknowledges and agrees that neither the Service Provider nor any Subcontractor (or their respective personnel) requires access to Personal Information in the performance of the Services or otherwise under this Agreement. Subject to Section 13.2(2), any access, collection, storage, use or disclosure of Personal Information by the Service Provider or any Subcontractor (or their respective personnel) in the performance of the Services or otherwise under this Agreement, shall be deemed material breach of the Agreement and the provisions of Schedule L shall apply. For greater clarity, the Service Provider and its Subcontractors and their respective personnel, as part of performing the Services, will be in the environments where Personal Information is present. The viewing of such Personal Information is not a breach or deemed material breach of the Agreement, provided the Service Provider complies with 13.2(2)(a)(ii) below.
- (2) Notwithstanding Section 13.2(1), the Service Provider shall not be in breach or material breach of this Agreement where the Service Provider or any Subcontractor (or their respective personnel):
 - (a) inadvertently receives Personal Information from the Health Organizations or, receives Personal Information in circumstances where it did not request or intend to receive it, *provided that* the Service Provider: (i) immediately notifies the designated Privacy Representative who shall immediately notify the Health Organizations (through the Health Organization Contract Executive or his or her designee) of such access to Personal Information including details of such access known at the time, (ii) takes all steps necessary in the circumstances to prevent any further access to such Personal Information in accordance with Service Provider's established internal process, including immediate engagement of the designated Privacy Representative, and where appropriate, requiring the Health Organizations to promptly desist and remove such access; (iii) takes any and all steps necessary in the circumstances to prevent any collection, storage, use or disclosure of such Personal Information; and (iv) promptly returns such Personal Information to the Health Organizations. Any issues under this Section 13.2(2) shall promptly be escalated by either Party to the Joint Executive Committee; or
 - (b) had unaided memory of any Personal Information viewed in the performance of the Services *provided that* neither the Service Provider nor any Subcontractor (or their respective personnel) subsequently records, stores, uses or discloses such Personal Information.
- (3) **Foreign Disclosure Orders.** The Service Provider expressly acknowledges and agrees that it is subject to the laws of British Columbia and the laws of Canada applicable in British Columbia with respect to this Agreement and the performance of the Service Provider's obligations under this Agreement, and it is not subject to

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Foreign Disclosure Laws including, without limitation, any orders, directives, rulings, requirements, judgments, injunctions, awards or decrees, decisions, or other requirements issued pursuant to any Foreign Disclosure Laws, or any directions or requests from any Affiliate of the Service Provider in respect of the same (each a “**Disclosure Order**”). The Service Provider will immediately inform the Health Organizations if the Service Provider receives a Disclosure Order. Upon receipt of a Disclosure Order, the Service Provider will not disclose any Personal Information in response thereto and the Service Provider will, at all times, act in accordance with the terms and conditions of this Agreement. Any disclosure of Personal Information pursuant to this Section will be a material breach under this Agreement. The provisions of this Section represent a lawful restriction on the Service Provider, being a Person governed by the laws of British Columbia and the laws of Canada applicable in British Columbia. The Service Provider will flow through the requirements of this Section to any Subcontractors *mutatis mutandis*.

- (4) **Service Provider Corporate Structure.** As of the Effective Date, the corporate organizational chart, indicating all shareholdings to the ultimate indirect shareholder (other than the shareholdings of a public company listed on a recognized stock exchange) of the Service Provider (each a “**Corporate Organizational Chart**”), are as set forth in Schedule FF (*Corporate Organizational Chart*). Throughout the Term, the Service Provider will provide the Health Organizations with an updated Corporate Organizational Chart on a quarterly basis and upon the reasonable request by the Health Organizations. Unless agreed otherwise by the Health Organizations, for so long as the Service Provider has, or could have, disclosure or use of, or access to any Personal Information in connection with the performance of the Services under this Agreement, the Service Provider will be and remain a Canadian Entity, and any failure of the Service Provider to remain so controlled a Canadian Entity will be deemed to be a material breach under this Agreement and will give rise to the right of the Health Organizations to terminate this Agreement provided that the Health Organizations exercise such right of termination within 120 days after the date of such material breach or the date that the Health Organizations receive written notice of such material breach from the Service Provider, which ever date is the later, and in which case, the Service Provider acknowledges and agrees to remain obligated to perform the Transition Out Services hereunder until they are fulfilled.
- (5) **Canadian Controlled Entities.** Except as set forth in Schedule CC, throughout the Term, the Service Provider and the Subcontractors that are corporations, partnerships, limited partnerships, or other similar entities that are incorporated or created under the laws of Canada or under the laws of any province of Canada (each a “**Canadian Entity**”), and that the Service Provider Personnel (which includes, for clarity, Subcontractor personnel) and Subcontractors who are individuals are not Foreign Employed Individuals. Unless agreed otherwise by the Health Organizations, and for so long as any Service Provider Personnel (which includes, for clarity, Subcontractor personnel) and Subcontractors who are individuals has or could have any access to, or use or disclosure of, any Personal Information in connection with the performance of the Services under this Agreement, the Service Provider will ensure that:
 - (a) in the case of Subcontractors who are individuals, the Subcontractor are not, and do not become, a Foreign Employed Individual; and

- (b) in all other cases, the Subcontractors are and remain a Canadian Entity, and unless otherwise approved by the Health Organizations, a Canadian Entity that is Corporately Controlled by a Canadian Entity or by individuals who are not Foreign Employed Individuals.
- (6) **Trans-border Data Flows.** Service Provider will not transfer outside the Permitted Service Locations in Canada or provide access to any other Health Organization Data consisting of Personal Information from outside the Permitted Service Locations in Canada, without the Health Organizations' prior written consent.
- (7) **Service Provider.** Service Provider also undertakes to co-operate with the Health Organizations with respect to the provision of such additional documentation of Service Provider's obligations under this Agreement as may assist the Health Organizations to comply with Privacy Laws.

13.3 Information Access

- (1) Prior to performing any Services, Service Provider will ensure that all of its Service Provider Personnel and Subcontractors who may have access to the Health Organization Data and/or the Health Organization Owned Materials (and in particular, the Personal Information) have executed agreements with Service Provider under which such Service Provider Personnel and Subcontractors have agreed to protect the confidentiality, privacy and security of the confidential information of the Health Organizations in a manner which is no less rigorous than that required of Service Provider under this Agreement.
- (2) Service Provider will, upon request by the Health Organization Contract Executive or his or her designee, provide the Health Organizations with appropriate evidence (for example, copies of specimen provisions) and assurances (for example, confirmations of execution, without names) regarding compliance by Service Provider Personnel and Subcontractors with the confidentiality and security obligations set forth herein.
- (3) Except with respect to Health Organization Confidential Information, and the obligations applicable thereto which are set forth in Section **Error! Reference source not found.**, Service Provider will comply and will cause the Service Provider Personnel and Subcontractors to comply with all Health Organization Policies and Procedures that may be provided by the Health Organizations and reviewed and clarified by the Parties from time-to-time, regarding data access, privacy and security, including those prohibiting or restricting remote access to, use and disclosure of the Health Organizations systems and data. Notwithstanding anything to the contrary herein, any material changes to Health Organization Policies and Procedures that impact the services, will be implemented using the Change Process.
- (4) The Health Organizations will authorize, and Service Provider will issue, any necessary information-access mechanisms, including access IDs and passwords, and Service Provider agrees that the same will be used only by the Service Provider Personnel to whom they are issued and who have a need to access Health Organization Data. Service Provider will provide to such personnel only such level of access as is necessary to perform the tasks and functions for which such personnel are responsible.

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- (5) Service Provider will from time-to-time, upon request from the Health Organizations, but (absent exceptional circumstances) no more frequently than quarterly, provide the Health Organizations with an updated list of those Service Provider Personnel having access to the Health Organizations' systems (if any), software, and data, and the level of such access. Computer data and software, including Health Organization Data, provided by the Health Organizations or accessed (or accessible) by Service Provider Personnel (which includes, for clarity, Subcontractor personnel), will be accessed, collected and used by such personnel only to the extent required in order for Service Provider to perform its obligations hereunder, and will not otherwise be used or exploited by Service Provider or its Subcontractors in any manner whatsoever.
- (6) Without limiting any other rights or remedies available under this Agreement, at law or in equity, a material breach by Service Provider or Service Provider Personnel, agents or Subcontractors of the provisions of this Article 13 may result in the Health Organizations restricting the offending personnel from access to the Health Organizations computer systems or Health Organization Data and/or the termination of this Agreement for cause to the extent permitted in accordance with the provisions of Section 18.4. It is Service Provider's obligation and responsibility to maintain and ensure the confidentiality, privacy and security of Health Organization Data in accordance with the terms of this Agreement.

13.4 Personal Information Protection.

- (1) To the extent that a Party provides access or transfers to the other Party (including the other Party's employees, agents, Affiliates and subcontractors (including Subcontractors)) any Personal Information pursuant to this Agreement, the other Party will, and will ensure that its employees, agents, Affiliates and subcontractors, including, for the Service Provider, the Subcontractors:
 - (a) not use such Personal Information for any purpose other than fulfilling its obligations or exercising its rights under the Agreement;
 - (b) not disclose such Personal Information to any Person other than as expressly permitted by the Party providing the Personal Information or as required or permitted by Applicable Laws;
 - (c) immediately refer to the providing Party any individual who contacts the receiving Party (or any of the receiving Party's employees, agents, Affiliates or subcontractors (including Subcontractors)) seeking access or correction to or with any inquiries or complaints about their Personal Information as such Personal Information may relate to the Agreement, and immediately notify the providing Party regarding any such request, inquiry or complaint;
 - (d) immediately return to the providing Party or, at the direction of the providing Party, dispose of all Personal Information, if any, relating to the Agreement using the measures specified in this Agreement or agreed to by the Parties at that time;
 - (e) designate an individual to handle all aspects of the Agreement that relate to the handling of Personal Information;

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- (f) not subcontract, assign or delegate its obligations with respect to Personal Information under this Agreement without the express consent of the providing Party; and
- (g) to the extent that Service Provider may in fulfilling its obligations under this Agreement, collect, use or disclose Personal Information that has not been provided to it directly by the Health Organizations, Service Provider will ensure that such Personal Information is collected, used and disclosed in accordance with the Health Organization Policies and Procedures, and will otherwise comply with the obligations set forth in this Section 13.4, if any.

13.5 Background Checks

- (1) If Service Provider assigns Persons (whether employees, subcontractors (including Subcontractors) or agents) to perform work at any Health Organization site or to have access to any sensitive Health Organization Data, Service Provider will conduct a background check on all such Persons and review the results of the background check of each Person to verify that the Person meets Service Provider's standards for employment and confirm in writing to the Health Organization Contract Executive or his or her designee that such background checks have been completed before requesting that the Health Organizations grant access to any such Person to any Health Organization site or sensitive Health Organization Data.
- (2) No Person will have access to any Health Organization site or sensitive Health Organization Data prior to the completion of a background check and the Service Provider's confirmation to the Health Organization Contract Executive or his or her designee, in writing, that such Person has successfully completed such background check. The Health Organizations will be permitted, at their sole option, to refuse access of any Person to any Health Organization site or facility. Such background check will include, as required under Section 9.7, CPIC Level 1 clearance, and be in the form generally used by Service Provider in its initial hiring of employees or contracting for contractors (including Subcontractors and agents) or, as applicable.
- (3) Prior to presenting any Person to the Health Organizations, with verification of the completion of the required background checks and on an annual basis, Service Provider's Project Executive for this Agreement will certify that the background check required by this Section 13.5 has been conducted with respect to all Persons assigned by Service Provider to perform work at any Health Organization site or to access any sensitive Health Organization Data.

13.6 Other Policies

Except with respect to Health Organization Confidential Information, and the obligations applicable thereto which are set forth in Section 13.7, Service Provider will, and will cause the Service Provider Personnel (including Subcontractors) and agents to, abide by all applicable Health Organization Policies and Procedures that may be provided by the Health Organizations in writing as the same may be clarified by the Parties from time-to-time, including rules and requirements for the protection of premises, materials, equipment and personnel and patients. Notwithstanding anything to the contrary herein, any Changes to Health Organization Policies and Procedures are to be implemented using the Change Process.

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13.7 Health Organization Confidential Information – Non-Disclosure

- (1) Subject to the provisions of Article 12, all Health Organization Confidential Information will, as between the Parties, be deemed the sole property of the Health Organizations and will be used by Service Provider and the Service Provider Personnel (including Subcontractors) solely for the purposes of performing Service Provider's obligations under this Agreement, and, except as permitted under Section 13.9, is not to be collected or used except as provided for in this Agreement and is not to be published, transmitted, released or disclosed by Service Provider or its Subcontractors to any other Person without the prior written consent of the Health Organizations, which consent the Health Organizations may withhold in their discretion.
- (2) Except where this Agreement specifies that a higher standard will apply, to ensure compliance with subsection (1), above, Service Provider will use the same standard of care to prevent disclosure of the Health Organization Confidential Information as it uses to prevent disclosure of Service Provider's own information of a similar nature, but in no event less than a reasonable degree of care.

13.8 Disclosure Requests

Except as otherwise specified in this Agreement, any and all requests for copies of or access to, or disclosure of, any Health Organization Confidential Information will be promptly submitted to the Health Organizations for disposition.

13.9 Permitted Disclosures

Service Provider will require each of its Service Provider Personnel and Subcontractors providing Services hereunder or otherwise having access, in whatever form or function, to the Health Organization Confidential Information, to execute, prior to any such activity or access, an agreement in substance providing not less than the standard of protection of Health Organization Confidential Information as set out in this Agreement. Service Provider will provide the Health Organizations with appropriate evidence and assurances regarding compliance by Service Provider Personnel and Subcontractors with the confidentiality obligations set forth herein. Service Provider may disclose Health Organization Confidential Information only to those of such Service Provider Personnel and Subcontractors who have a need to know such Health Organization Confidential Information in order to perform their duties under this Agreement, and only to the extent reasonably necessary. Regardless of the form of any Contract executed with Service Provider Personnel, contractors (including Subcontractors) and agents, Service Provider will retain liability for all breaches of this Section 13.7 and for the related acts or omissions of its officers, Service Provider Personnel and Subcontractors, and the like, including the unauthorized use or disclosure of Health Organization Confidential Information, by its officers, Service Provider Personnel and Subcontractors, and the like.

13.10 Service Provider Confidential Information

The Health Organizations may disclose Service Provider Confidential Information only to their personnel who have a need to know such Service Provider Confidential Information, and only to the extent reasonably necessary. Except as otherwise specifically provided in this Agreement, the Health Organizations may not publish, transmit, release or disclose Service Provider Confidential Information to Third Parties unless they obtain the prior written consent of Service Provider. The Health Organizations will use the same care to prevent disclosure of the Service Provider Confidential Information as they use

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to prevent disclosure of their own information of a similar nature, but in no event less than a reasonable degree of care.

13.11 Legally Required Disclosures

The Receiving Party may disclose the Confidential Information of the Disclosing Party to the extent disclosure is based on the good faith written opinion of the Receiving Party's legal counsel that disclosure is required by Applicable Law or by order of a court of competent jurisdiction or governmental agency with jurisdiction; provided, however, that the Receiving Party will give advance notice of such requested disclosure and legal opinion to the Disclosing Party prior to any such disclosure and will use all commercially reasonable efforts to obtain a protective order or otherwise protect the confidentiality of the Disclosing Party's Confidential Information. Notwithstanding the foregoing, the Disclosing Party reserves the right to obtain a protective order or otherwise protect the confidentiality of such Confidential Information. For purposes of this Section 13.11, a Receiving Party's internal legal counsel may act as such party's legal counsel.

13.12 Notification and Mitigation

In the event of any impermissible disclosure, loss or destruction of Confidential Information, the Receiving Party will immediately notify the Disclosing Party and take all reasonable steps to mitigate any potential harm or further disclosure, loss or destruction of such Confidential Information.

13.13 Return of Confidential Information

- (1) **Expiration or Termination.** Upon the expiration of the Term or termination of this Agreement, and at any other time upon written request by the Disclosing Party, the Receiving Party promptly will return to the Disclosing Party all Confidential Information (and all copies thereof) of the Disclosing Party then in its possession or control. In addition, unless the Disclosing Party otherwise consents in writing, the Receiving Party also will deliver to the Disclosing Party or, if requested by the Disclosing Party, will delete or destroy, any copies, duplicates, summaries, abstracts or representations of any such Confidential Information or any part thereof, in whatever form, then in the possession or control of the Receiving Party. Service Provider's obligations under this Article 13 will survive until five (5) years after the date upon which Service Provider provides a certificate which certifies the return or destruction of all Health Organization Confidential Information received, created or stored by Service Provider under this Agreement.
- (2) **Certificate.** The certificate certifying the return or destruction of all Health Organization Confidential Information survives the termination of this Agreement without limit. The Health Organizations' obligations under this Article 13 will survive until five (5) years after the date upon which the Health Organizations provides a certificate which certifies the return or destruction of all Service Provider Confidential Information received, created or stored by the Health Organizations under this Agreement.
- (3) **Survival of Confidentiality Obligation.** To the extent that any Confidential Information in the possession or control of the Receiving Party cannot be deleted or destroyed, then the obligations of the Receiving Party under this Article 13 shall survive indefinitely, notwithstanding any other provision of this Agreement.

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13.14 Injunctive Relief

If the Receiving Party or anyone acting on its behalf or operating under its control, including employees, Subcontractors and Third Parties, publishes, transmits, releases, discloses or uses any Confidential Information of the Disclosing Party in violation of this Article 13, or if the Disclosing Party anticipates that the Receiving Party may violate or continue to violate any restriction set forth in this Article 13, then the Disclosing Party will have the right to have the provisions of this Article 13 specifically enforced by any court having equity jurisdiction, without being required to post bond or other security and without having to prove the inadequacy of available remedies at law, it being acknowledged and agreed that any such violation will, unless the other party demonstrates to the contrary, cause irreparable harm to the Disclosing Party which will not be compensable by monetary damages alone and, accordingly, the Disclosing Party will, in addition to other available legal or equitable remedies, be entitled to seek an immediate injunction or other affirmative relief restraining the violating Person from committing or continuing to commit a violation without such constituting an election of remedies. A Party may avail itself of injunctive relief in addition and without prejudice to any other remedies available to it.

13.15 Residuals Protection

Subject to compliance with all applicable intellectual property laws, neither Party will be restricted from using in its business the Residuals retained in the unaided memories of its employees who have had access to Service Provider Confidential Information or Health Organization Confidential Information (as the case may be) under this Agreement.

13.16 Intellectual Property Rights Not Affected

Nothing in this Article 13 will affect or prevent the transfer or exercise of any Intellectual Property Rights assigned or licensed pursuant to Article 12.

13.17 Permitted and Required Retention

Notwithstanding the return or destruction obligations set out in Sections 12.8, 13.13(1) and 18.7(1),

- (1) the Service Provider and its Subcontractor, Deloitte, may each retain one copy of the Deliverables provided that: (a) the copy is only retained for archival purposes and is marked as confidential; (b) the copy is maintained by the Service Provider's designated IBM Canada Global Services Client Executive or the Deloitte lead engagement partner, respectively; (c) the Service Provider and Deloitte are subject to confidentiality obligations in respect of the copy that are no less protective of the Health Organizations than those under of this Article 13, which obligations will survive indefinitely; and (d) the copy is not stored in any general database or repository of Service Provider owned or licensed materials; and
- (2) the Service Provider's Subcontractor, Deloitte, may retain copies of records, documentation and related information (excluding Personal Information and information or materials subject to Third Party rights that do not permit such retention), as required by professional standards applicable to Deloitte's delivery of services in connection with this Agreement ("**Retained Materials**") provided that: (a) the Retained Materials are only retained by Deloitte to the extent required by those professional standards and are marked as confidential; (b) Deloitte is subject to confidentiality obligations in respect of the Retained Materials that are no less protective of the Health Organizations than those under this Article 13, which

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obligations will survive indefinitely; (c) upon request, Deloitte returns promptly those Retained Materials that the Health Organizations are legally obligated to seek the return of; and (d) the Retained Materials are not stored in any general database or repository of Deloitte owned or licensed materials.

ARTICLE 14 TECHNOLOGY MANAGEMENT

Intentionally deleted.

ARTICLE 15 LEGAL COMPLIANCE

15.1 Compliance with Applicable Laws

The Service Provider and the Health Organizations will perform their respective obligations hereunder in compliance with all Applicable Laws. Service Provider will use all commercially reasonable efforts to assist the Health Organizations, as required or as requested by the Health Organizations in writing, so that the Health Organizations can comply with all Applicable Laws, including in the event of an audit initiated by a regulator or otherwise under Applicable Laws (provided that additional costs incurred by the Service Provider to assist the Health Organizations as contemplated by this Section, will be subject to the Change Process). The Health Organizations will, through the Change Process, implement any changes required by changes to Applicable Laws which relate specifically to the Health Organizations and affect the manner in which the Services are to be performed (including those laws referred to under Section 15.3). No provision of this Agreement will have any force or effect if it would cause a violation of any Applicable Laws, or would require any consent or approval (other than those which have been obtained) to prevent any such violation, but any such provision will be replaced, to the extent possible, by a provision which achieves the same business objectives in a manner which complies with Applicable Laws.

15.2 Service Provider Permits, Licenses and Assistance

Except as otherwise provided in this Agreement, Service Provider will obtain and maintain, and will cause its Subcontractors to obtain and maintain, at no cost to the Health Organizations, all Consents, permits, and forms of documentation required in order to comply with all Applicable Laws applicable to Service Provider or its Subcontractors in connection with the performance of the Services and Service Provider's obligations hereunder. The Health Organizations reserve the right to reasonably request and review all such Consents and permits prior to the commencement of any Services hereunder. If requested, the Health Organizations will co-operate with Service Provider, at Service Provider's cost and expense, to obtain any such Consents and permits. Similarly, Service Provider will provide reasonable assistance to the Health Organizations in the Health Organizations' attempt to fully comply with any Applicable Laws concerning data and privacy protection, including any obligation of the Health Organizations to certify or respond to any data protection or privacy authority regarding such matters. To the extent such assistance can be provided using dedicated resources, such assistance will be provided without additional charge or fee. The Health Organizations may request further assistance in accordance with the Change Process.

15.3 Specific Laws and Agreements

The Parties acknowledge that they have taken reasonable efforts to cause this Agreement and the Services as described herein to be compliant with the Applicable Laws (including those set forth in this Section 15.3). Without limiting Section 15.1 (*Compliance with Applicable Laws*), at all times during the Term, the Service Provider will comply with and will cause the Service Provider Personnel and Subcontractors to comply with the following in the performance of the Services:

- (1) ***Financial Administration Act and Budget Transparency and Accountability Act.*** The Health Organizations are required to comply with the requirements of the *Financial Administration Act* (British Columbia) and *Budget Transparency and Accountability Act* (British Columbia) regarding the maintenance of financial records, the reporting of financial results, and similar financial matters. The Parties shall use reasonable efforts to monitor changes to the legislation, make the other Party aware of any such changes, and work together to identify the impact of such changes on the Services. The Service Provider shall use all reasonable efforts to comply with the requirements of the *Financial Administration Act* (British Columbia) and the *Budget Transparency and Accountability Act* (British Columbia), to the extent such act would apply to the performance of the Services by the Health Organizations internally, and shall assist the Health Organizations as necessary to ensure that the Health Organizations are in compliance with the requirements of the *Financial Administration Act* (British Columbia) and the *Budget Transparency and Accountability Act* (British Columbia) with respect to the performance of the Services;
- (2) ***North American Free Trade Agreement.*** The Service Provider agrees on its own behalf, and on behalf of its Affiliates, successors and assigns, to waive any and all rights that it may have under the North American Free Trade Agreement, including, but not limited to, all rights under North American Free Trade Agreement Chapter Eleven. The Service Provider specifically acknowledges and agrees that this waiver precludes any of the Service Provider, or its Affiliates, Subcontractors and their respective successors or permitted assigns, from providing their consent to arbitration under North American Free Trade Agreement Article 1121 and from thereby commencing or assisting in any claim under Section B of North American Free Trade Agreement Chapter Eleven concerning any dispute arising out of or relating to this Agreement; and
- (3) ***e-Health Personal Health Information Access and Protection of Privacy Act.*** The Service Provider acknowledges that the Health Organizations are subject to the *e-Health Personal Health Information Access and Protection of Privacy Act* (British Columbia), and that they may from time to time be required to provide information in accordance with the requirements of such legislation. The Health Organizations will identify and make interpretations of the *e-Health Personal Health Information Access and Protection of Privacy Act* (British Columbia) as applicable to the performance or utilization of the Services. In performing its Services, the Service Provider shall comply with any applicable policies and directive issues by the Health Organizations with respect to the compliance with the *e-Health Personal Health Information Access and Protection of Privacy Act* (British Columbia) which shall be implemented in accordance with the Change Process.

15.4 Provincial and Federal Privacy Legislation

Service Provider will ensure that it, its agents, Affiliates and Subcontractors will perform the Services in compliance with the provisions of this Agreement, including the technological, organizational and physical measures for protection of Personal Information set out in the Health Organization Policies and Procedures and Schedule L (*Privacy and Security*), as applicable. The Health Organizations will ensure that such Personal Information within its control is collected, used and disclosed with the knowledge and consent of the individual to whom the Personal Information relates in accordance with Applicable Laws. If Service Provider believes that Personal Information has been subject to unauthorized access, Service Provider will provide prompt written notice to the Health Organizations (and in any event, within twenty-four (24) hours). If the Health Organizations reasonably determine that actions must be taken to comply with any Privacy Laws, Service Provider will fully co-operate with the Health Organizations to achieve such compliance and, where such actions must be taken as a result of any failure of Service Provider or any of its Service Provider Personnel, Affiliates or Subcontractors to comply with this Section 15.4, all such compliance related activities by Service Provider will be performed at Service Provider's sole cost and expense. Subject to Section 21.9, Service Provider will be liable for damages suffered by the Health Organizations as a result of such failure. Nothing contained herein will be deemed to release Service Provider from its indemnification obligations as set forth in Sections 21.3 and 21.4 of this Agreement.

Service Provider will comply with all Applicable Laws in connection with the collection, storage, use, processing and/or disclosure of Personal Information by Service Provider pursuant to its obligations under this Agreement, to the extent applicable to Service Provider in connection with this Agreement. Service Provider will oblige its Service Provider Personnel, Affiliates, and Subcontractors (if any) to comply with Privacy Laws applicable to the Service Provider and to undertake in writing only to collect, process or use any data containing Personal Information received from the Health Organizations for purposes of providing the Services and not to make data containing Personal Information received from the Health Organizations available to any Third Parties except as expressly set forth in this Agreement.

ARTICLE 16 RECORDKEEPING AND AUDIT RIGHTS

16.1 Record Keeping

In addition to any obligations that Service Provider may, apart from this Agreement, have to collect and maintain records, Service Provider will, as part of the Services, collect, maintain and retain:

- (1) utilizing generally accepted accounting principles in accordance with GAAP or IFRS (at such time that International Business Machines Corporation, the Service Provider's ultimate parent, is required to adopt IFRS by Applicable Law) or any successor standard, consistently applied, complete and accurate records and books of account with respect to this Agreement and the Services, including all records related to the Fees and Sales Taxes invoiced to the Health Organizations under this Agreement;
- (2) all records and copies of any correspondence relating to any actual or threatened claim, suit or proceeding with any third party relating to this Agreement or the Services provided that such records are not privileged communications;
- (3) all records documenting Service Provider's compliance with Health Organization Policies and Procedures applicable to the Services, and compliance with security and confidentiality obligations and operational procedures applicable to this Agreement or the Services;

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- (4) records and reports relating to changes made through the Change Process and any other changes made to the Hardware, Software or Services; and
- (5) records, measurements and reports pertaining to performance of the Services including those relating to Dispute Resolution Process (provided such records are not subject to legal privilege) and all documentation used to create such records, measurements and reports,

(all such records, measurements, reports, correspondence and documentation are herein referred to as the “**Retained Records**”). Notwithstanding the provisions of this Section 16.1, Retained Records shall not include Service Provider internal audit records, confidential information of Service Provider’s customers other than the Health Organizations and records containing Service Provider’s costs.

16.2 Retention of Records

Service Provider will retain each of the Retained Records until:

- (1) the delivery of same to the Health Organizations (or their designees); or
- (2) the later to occur of:
 - (a) the time period or time periods set forth below with respect to such Retained Records;
 - (b) any time period for which Service Provider is required to retain such Retained Records pursuant to applicable Service Provider record retention policies;
 - (c) any time period for which Service Provider is required to retain such Retained Records pursuant to Applicable Laws; and
 - (d) one (1) year following the final resolution of all audits or the full and final resolution of any dispute, litigation or threatened litigation to which such Retained Records relate.

The minimum time periods, referred to in part (a) of the preceding sentence, for which Retained Records must be retained by Service Provider for not less than seven (7) years from the date of its creation or for such longer period as may be required pursuant to applicable Service Provider record retention policies. The Retained Records referred to in this Agreement will constitute Service Provider Confidential Information. The Health Organizations will, unless otherwise required by Applicable Law, only use such information in connection with their requirements for or the performance of the Services, and will treat any pricing information that may be included in the Retained Records as Confidential Information of Service Provider. Without limiting any of the foregoing, all Retained Records and the procedures used to collect, maintain and report such Retained Records, will be in accordance with GAAP, and the Service Provider will facilitate the reconciliation of all data contained in the Retained Records on standardized platforms maintained by the Service Provider for similar information, and will comply with the confidentiality and nondisclosure provisions set forth in this Agreement.

16.3 Availability of Records

During the retention periods referred to in Section 16.2 above, the Health Organizations (and their designees) shall have the right, during normal Business Hours, to examine and to obtain from Service

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Provider copies of extracts from the Retained Records pertaining to this Agreement, the Services or the Health Organizations other than Retained Records relating to Service Provider's pricing methodologies or to the actual or budgeted costs or expenses incurred by Service Provider in providing the Services (provided that the Health Organizations will be entitled to have access to and to copy all Retained Records relating to Pass-Through Expenses). At the end of the retention periods referred to in Section 16.1, above, as requested by the Health Organizations, Service Provider will at no additional charge deliver to the Health Organizations (or their designee) in electronic form in which they are maintained, the Retained Records referred to in Sections 16.1(3) to 16.1(5) and Service Provider may, at its option, destroy the Retained Records referred to in Sections 16.1(1) and 16.1(2).

16.4 Operational Audits

Intentionally deleted.

16.5 Financial Audits

The Health Organizations and/or the Health Organizations' external auditors or representatives (who the Health Organizations acknowledges and agrees shall be engaged on a non-contingent basis) shall have the right, at any time during the Term and for twelve (12) months thereafter, upon reasonable notice to Service Provider, to perform financial audits with respect to Service Provider's performance of its obligations hereunder and in connection therewith will have the right to examine and to obtain from Service Provider copies of extracts from the Retained Records (subject to the exceptions for any pricing methodologies, or the costs and expenses referred to in Section 16.3 above) to the extent necessary to verify any amounts paid or payable hereunder. Such auditors will be provided with such access to such personnel and systems as may be reasonably required to confirm the accuracy of Service Provider's invoices, documents, and other information supporting such invoices, and any pricing adjustment computations. All such audits will be conducted during Business Hours, upon reasonable notice, and will include access to all proprietary and confidential information of Service Provider to the extent reasonably necessary to comply with the provisions of this Section 16.5 (other than Service Provider's internal audit records, confidential information of Service Provider's other customers other than the Health Organizations and records containing the Service Provider's costs or pricing methodologies). The Service Provider will promptly refund any overcharges identified as a result of a financial audit to the Health Organizations with interest at the rates and as otherwise set forth in the Interest on Overdue Accounts Payable regulation (B.C. Reg. 215/83), as amended or replaced from time to time. If any such audit reveals that Service Provider has overcharged the Health Organizations by three and one half percent (3 1/2%) or more of the Fees during the period (as determined prior to the commencement of the audit) to which the audit relates, Service Provider will reimburse the Health Organizations for the Health Organizations' Out-of-Pocket Expenses incurred in connection with such audit and any re-audit requested by the Health Organizations to validate that the specific matter identified by audit has been rectified. If any such audit reveals that Service Provider has overcharged the Health Organizations by less than three and one half percent (3 1/2%) of the Fees during the period (as determined prior to the commencement of the audit) to which the audit relates, Service Provider will reimburse the Health Organizations for the Health Organizations' Out-of-Pocket Expenses incurred in connection with any re-audit requested by the Health Organizations to validate that the specific matter identified by audit has been rectified.

16.6 Intentionally Deleted.

16.7 Audit Frequency

Absent exceptional circumstances, the Health Organizations may perform the audit referred to in Section 16.5 only once during each consecutive twelve (12) month period during the Term, but for greater

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certainly, the Health Organizations will have no obligation to perform such an audit. Exceptional circumstances which may merit an additional audit (or audits) include possible changes to Applicable Laws or regulations which contemplate such an audit, requirements to confirm that deficiencies identified in a previous audit have been rectified, or evidence of significant discrepancies in invoices or reports delivered by Service Provider or other significant discrepancies. The Health Organizations will have any audits performed pursuant to this Article 16 carried out in a manner so as to avoid auditing the performance of same functions for the same period of time more than once.

16.8 Subcontractors Records

- (1) **Approval of New Subcontractors.** The Health Organizations will, when considering the approval of a potential Subcontractor proposed by Service Provider pursuant to Section 10.1, consider the Health Organizations' reasonable requirements for such potential Subcontractor to retain records, provide the Health Organizations with access to such retained records and provide the Health Organizations with such audit rights as it may reasonably require in view of the Services to be performed by such proposed Subcontractor. The Health Organizations will require rights to audit with respect to operational, compliance and security matters which may be relevant to the Services provided by the Subcontractor and will not use its audit rights in an effort to discover Service Provider's costs (other than with respect to Pass-Through Expenses) and will not require retention, access or audit rights with respect to Subcontractors providing Services which are not material to the Health Organizations.
- (2) **Reasonable Assistance.** Service Provider will, upon request by the Health Organizations, provide reasonable assistance to the Health Organizations in the exercise of any rights that the Health Organizations may have to either access information retained by a Subcontractor or to audit such Subcontractor.

ARTICLE 17 FEES AND PAYMENT TERMS

17.1 Fees - General

As the financial consideration for all of the Services to be performed by Service Provider hereunder and for all of the tasks, services, licenses, assignments, representations, warranties and obligations of Service Provider, the Health Organizations will pay to Service Provider the amounts set forth in Schedule DD (*Fees*) this Agreement or as agreed pursuant to the Change Process (the "*Fees*"). Except as otherwise expressly stated in this Agreement or in Schedule DD, the Health Organizations will not pay Service Provider any additional fees, assessments, reimbursements or expenses for labour and general business expenses (including travel, meals, and overhead expenses) for the Services and other obligations of Service Provider hereunder.

17.2 Taxes

- (1) All Fees payable to Service Provider hereunder will be inclusive of and Service Provider will be responsible for paying all Taxes imposed by any domestic or foreign taxing authority in respect of the hardware, software and other goods or services consumed or acquired by Service Provider in the provision of the Services, any Intellectual Property Rights licenses, and assignments provided by Service Provider to the Health Organizations hereunder, including any sales, use, income, property, capital, excise, value-added, services, withholding, consumption, telecommunication, access or other taxes (collectively, the “**Service Provider Taxes**”).
- (2) The Health Organizations will be responsible for all Taxes in connection with the Health Organizations’ receipt of the Services (other than Service Provider Taxes and those for which the Health Organizations are exempt under Applicable Laws), including any sales, use, excise, value-added, services or consumption taxes.
- (3) Service Provider’s invoices will state applicable Taxes owed by the Health Organizations, if any. The Parties will also work together to segregate all payments or charges on the invoice under this Agreement into three payment streams: (1) those for taxable services; (2) those for non-taxable services; (3) Pass-Through Expenses. Service Provider and the Health Organizations agree to cooperate reasonably with the other to determine the Health Organizations’ tax liability on Service Provider’s charges.

17.3 Pass-Through Expenses

Pass-Through Expenses are to be paid by Service Provider on behalf of the Health Organizations on an out-of-pocket expenses basis. Prior to paying any Pass-Through Expenses on behalf of the Health Organizations, Service Provider will review the invoice charges to determine whether such charges are reasonable, proper and valid and should be paid and will provide the Health Organizations with a reasonable opportunity to review the invoice to confirm Service Provider’s determination. Following such review by the Parties, Service Provider will pay the amounts due. The Health Organizations will pay the Service Provider the amount of any Pass-Through Expenses in accordance with the provisions of Section 17.6.

17.4 Financial Responsibility For Own Costs

Except as may otherwise be provided for in this Agreement or agreed between the Parties, each Party will be responsible for all of the costs and expenses which it incurs and the management responsibilities that are associated with the performance by it of its obligations under this Agreement.

17.5 Right of Set-Off

The Health Organizations may set off against Fees: (1) any and all undisputed amounts agreed to be owed by Service Provider to the Health Organizations, if any; and (2) any and all undisputed third party costs to the Health Organizations arising from Service Provider’s breach of the Agreement that is not the subject of a Dispute. At the time of any such set-off, the Health Organizations will provide to Service Provider a written accounting of such set-off and a written statement of the reasons therefore.

17.6 Invoices and Payment

- (1) On the last day of each month during the Term, the Service Provider will submit its monthly invoice for Fees to the Health Organization Contract Executive or his or her designee in respect of the Services provided during the month (and reflecting any adjustments required to be made in respect of the preceding month). Each monthly invoice will be in the form attached as Schedule EE (*Form of Invoice*).
- (2) Any proposed changes to the monthly invoice format will be approved by the Health Organizations in advance of such changes. All invoices will be subject to the Health Organizations' review prior to payment.
- (3) Amounts payable by the Health Organizations under this Agreement may, at the Health Organizations' option, be paid to Service Provider by wire transfer or electronic funds transfer. Overdue invoices will be subject to interest payable at the rates and as otherwise set forth in the Interest on Overdue Accounts Payable regulation (B.C. Reg. 215/83), as amended or replaced from time to time.
- (4) Subject to Section 17.7, invoices are due and payable by the Health Organizations within thirty (30) days after receipt of such invoice, provided that the invoice complies with the requirements of this Agreement.

17.7 Disputed Amounts

Except for payments by the Health Organizations to the Service Provider for Deliverables as contemplated in Schedule D and subject to and in accordance with the provisions of this Section 17.7, the Health Organizations may withhold payment of any portion of a Service Provider invoice that the Health Organizations in good faith disputes as due or owing (including any such payment under a Service Provider invoice in respect of which the Health Organizations assert a right of set-off pursuant to Section 17.5); provided that the amount withheld by the Health Organizations under this Section 17.7: (a) with respect to any monthly invoice, will not exceed 25% of such monthly invoice amount; and (b) the aggregate amount withheld by the Health Organizations will not exceed an amount equal to the 25% withheld on each monthly invoice as set out in Section 17.7(a) for a period of three months (whether such three month period consists of consecutive months or not). In such case, the Health Organizations will pay any undisputed amounts to the Service Provider and provide to Service Provider a written explanation of the basis for the Dispute as to the disputed amounts. The failure of the Health Organizations to pay a disputed invoice, or to pay the disputed part of an invoice, will not constitute a breach or default by the Health Organizations, so long as the Health Organizations complies with the provisions of this Section 17.7. Any dispute relating to amounts owed by a Party hereunder will be considered a Dispute and may be escalated by either Party through the Expedited Dispute Resolution Process. All of Service Provider's obligations under this Agreement will continue unabated during any Dispute Resolution Process.

17.8 Pro Ration

All periodic charges payable under this Agreement will be computed on a calendar month basis and will be pro rated for any partial month.

17.9 Service Provider Travel and Living Expenses

Any and all travel and living expenses incurred by the Service Provider in connection with the Services, for which the Service Provider will seek reimbursement from the Health Organizations, must comply with the Health Organizations' travel and living expenses guidelines.

ARTICLE 18 TERM AND TERMINATION

18.1 Term

This Agreement will become effective on the Effective Date. Unless terminated earlier in accordance with Section 18.4 or Section 18.6 or otherwise under the terms of this Agreement, this Agreement will continue for a period ending on the tenth anniversary of the Effective Date (the "Term").

18.2 Annual Review

Commencing at the end of the first Contract Year and for the Term of this Agreement, the Health Organizations and Service Provider will meet no later than thirty (30) days prior to each anniversary of the Contract Year to review the status of the performance of the Agreement and to discuss any modifications to the terms of this Agreement which may be mutually agreed by the Parties. Unless the Parties agree to make any such modifications during such thirty (30) day period, the then-existing terms and conditions of this Agreement will remain unchanged and in full force and effect.

18.3 Early Termination

(1) For Convenience

The Health Organizations will have the right to terminate this Agreement or one or more Services for convenience upon thirty (30) days prior written notice to Service Provider and upon payment of the Termination Fee by the Health Organizations to the Service Provider. In the event of such termination for convenience, the Termination Fee will be payable by the Health Organizations on the effective date of the Termination as set out in the notice of termination. The Parties acknowledge and agree that the Termination Fee constitutes a reasonable pre-estimate of damages and not a penalty.

(2) Termination for Force Majeure Event

In the event of a Force Majeure Event and the Service Provider is unable to provide the Services either itself or through an alternate Service Provider within ninety (90) days following commencement of the Force Majeure Event, the Health Organizations will have the right to terminate this Agreement by delivering to Service Provider a Termination Notice specifying the Termination Date; provided, however, that Service Provider will remain obligated to perform the Transition Out Services until such obligations have been fulfilled. The Health Organizations will remain obligated to pay for Services actually provided and for Transition Out Services as are provided after the termination of this Agreement. The Health Organizations and Service Provider

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will take the other actions and the Health Organizations will make such further payments as are provided for in Section 18.7 but the Health Organizations will otherwise have no further liability or obligation to Service Provider under this Agreement. Any termination pursuant to this Section (2) will not constitute a termination for convenience nor cause, and the Health Organizations will in no event be required to pay any amount of or the entire Termination Fee to Service Provider with respect to any such termination.

18.4 Events of Default

The following events will constitute “**Events of Default**”, and the occurrence of any one (1) or more of such Events of Default will constitute a material breach of this Agreement in respect of which the Health Organizations will have the rights and remedies set forth in this Agreement:

- (1) Service Provider files a voluntary petition in bankruptcy or insolvency or will petition for reorganization under any bankruptcy or insolvency law;
- (2) an involuntary petition in bankruptcy or a receiving order is given against Service Provider under the *Bankruptcy and Insolvency Act*, as amended, or the comparable law of any other jurisdiction (and such is not dismissed within ten (10) days);
- (3) there will be entered an order, judgment or decree by a court of competent jurisdiction, upon the application of a creditor, approving a petition seeking reorganization or appointing a receiver, trustee or liquidator of all or a substantial part of Service Provider’s assets and such order, judgment or decree continues in effect for a period of thirty (30) consecutive days;
- (4) Service Provider makes an assignment of all or substantially all of its assets for the benefit of creditors, or Service Provider’s Board of Directors takes any corporate action by in furtherance of the above action;
- (5) the Service Provider ceases or threatens to cease carrying on business;
- (6) the Service Provider assigns this Agreement contrary to the provisions of Section 25.2;
- (7) if Service Provider fails to comply with the provisions of Section 13.2;
- (8) any:
 - (a) disclosure of Personal Information (other than pursuant to a Disclosure Order) contrary to the *Freedom of Information and Protection of Privacy Act* (British Columbia); or
 - (b) storing or allowing access to Personal Information outside of Canada contrary to the *Freedom of Information and Protection of Privacy Act* (British Columbia); or
 - (c) using the Personal Information contrary to the permitted use thereof as per the terms of this Agreement and the provisions of the *Freedom of Information and Protection of Privacy Act* (British Columbia);

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provided that before the Health Organizations exercises their right under this Agreement for any disclosure of Personal Information under this Subsection 18.5(11), the Health Organizations shall have regard to all of the surrounding circumstances, the nature and significance of the breach, whether such breach is an isolated occurrence and the bearing thereof on the significance of the breach;

- (9) any disclosure of Personal Information pursuant to a Disclosure Order; or
- (10) the Service Provider's material breach of the Agreement where such material breach is not cured:
 - (a) within sixty (60) days following receipt of written notice from the Health Organizations, provided that the Service Provider prepares and delivers to the Health Organizations a cure plan within ten (10) days of receipt of notice of such material breach, detailing how the Service Provider will cure such material breach; or
 - (b) if the Service Provider fails to provide a cure plan within ten (10) days of receipt of notice of such material breach, then thirty (30) days following receipt of written notice from the Health Organizations.

For greater certainty, Section 2.9 of this Agreement shall not in any way impact the right to the cure period provided in this Section 18.4(10).

18.5 Rights and Remedies of Health Organizations Upon Default of Service Provider

Upon the occurrence of an Event of Default by or with respect to Service Provider, subject to the terms of Article 21, the Health Organizations will be entitled to any or all of the following remedies:

- (1) subject to the Health Organizations' rights as set forth below in this Section 18.5, to terminate some of the Services or this Agreement, provided that for any Event of Default other than under Section 18.4(7), 18.4(8) and 18.4(9), the Health Organizations provide the Service Provider with a Termination Notice within 120 days after:
 - (a) the date of such Event of Default under Section 18.4(10), or
 - (b) the date that the Health Organizations receive written notice of such Event of Default under Section 18.4(1) - (6) from the Service Provider,

and the Service Provider acknowledges and agrees to remain obligated to perform the Transition Out Services hereunder until they are fulfilled. Notwithstanding the foregoing, with respect to Section 18(10), the Service Provider shall not be required to provide notice of such Event of Default;

- (2) seek to recover direct, provable damages from Service Provider;
- (3) if applicable, obtain the additional rights and remedies set forth in Section 24.2; or
- (4) any additional remedies that may be set forth in this Agreement, Schedule GG (*Additional Remedies of Health Organizations*) or in any Schedule or Addendum.

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For clarity, the Health Organizations will in no event be required to pay any amount of the Termination Fee to Service Provider with respect to any termination pursuant to this Section 18.5.

18.6 Health Organization Events of Default

The Health Organizations shall be in material breach of their obligations under this Agreement if the Health Organizations fails to pay, when due, the amount of any Fees that is not subject to Dispute pursuant to the Health Organizations' right of dispute under Section 17.7 and the Health Organizations fail to remedy such failure within thirty (30) days of the Health Organizations' receipt of a written notice from the Service Provider to the Health Organizations of such failure. If such invoices continue to remain unpaid for a period of thirty (30) days, then the Service Provider may, at its election, escalate such non-payment of such Fees to the appropriate level of governance, up to and including the Health Organizations' CEOs, for resolution and failing which such matter shall be settled in accordance with the Expedited Dispute provisions of Schedule P.

18.7 Effects of Termination

Upon the expiration of the Term or any termination of this Agreement:

- (1) *Return of Property.* Unless otherwise provided in this Agreement, each Party will return to the other Party, within thirty (30) days of the expiration of the Term or termination of this Agreement, all property or materials of the other Party and its clients in the possession or control of such Party or its Subcontractors that is not Confidential Information (the return of which is provided for in Section 13.13).
- (2) *Outstanding Payments.* Upon the expiration of the Term or any termination of this Agreement, the Health Organizations will, within thirty (30) days of receipt of the Service Providers final invoice, pay to Service Provider all outstanding Fees which are due and payable (and not otherwise the subject of a Dispute under Section 17.3) for Services delivered to the date of termination (including work in progress), and the Parties will use commercially reasonable efforts to promptly settle any outstanding Disputes with respect to any outstanding Fees in accordance with the Dispute Resolution Process.

18.8 Non-Exclusive Remedies

The remedies provided in this Article 18 and elsewhere in this Agreement are neither exclusive nor mutually exclusive, and subject to the limitation of liability provisions in this Agreement, the Parties will be entitled to any and all such remedies, and any and all other remedies that may be available to the Parties at law or in equity, by statute or otherwise, individually or in any combination thereof.

18.9 Survival.

Unless otherwise provided in this Agreement, the following provisions (including the obligations of the Health Organizations and the Service Provider under the Agreement) shall survive the expiration or termination of this Agreement: Section 10.1, Section 10.5, Section 25.1, Section 25.4, Section 25.6, Section 25.8, Section 25.10 - 25.13 and Article 2, Article 12, Article 13, Article 16, Article 17, Article 18, Article 19, Article 21 and Article 24.

**ARTICLE 19
TRANSITION OUT SERVICES**

19.1 General Obligations

Upon any expiration of the Term or termination of this Agreement, or termination of any Services provided hereunder, Service Provider will provide Transition Out Services. The Health Organizations or the Replacement Service Provider shall be responsible for the overall transition to the Health Organizations or the Replacement Service Provider, including the development of an overall transition plan. Without restricting the generality of the foregoing, Service Provider will:

- (1) co-operate with the Health Organizations and any Health Organization designee (collectively, the **"Replacement Service Provider"**), including promptly taking all steps required to assist the Health Organizations in effecting a complete transitioning out;
- (2) provide to the Health Organizations and the Replacement Service Provider all information (excluding Service Provider proprietary information) and professional services related to the Services as needed for effecting a complete transitioning out, including interface specifications;
- (3) provide for the prompt and orderly transition of all work (including Deliverables), as the Health Organizations may direct, including completion or partial completion of all Services including support, documentation of work in process, and measures to provide an orderly transition to the Health Organizations and the Replacement Service Provider; and
- (4) such other transition out assistance as reasonably requested by the Health Organizations.

Prior to the Termination Date, all Transition Out Services will be performed, to the maximum extent possible, as part of the Services which are included in the Fees. The Parties will work together and cooperate in good faith to redeploy the Service Provider resources, who were previously used to perform the Services, to instead provide the Transition Out Services with a view to minimizing the cost of any additional Service Provider resources and, as a result, the cost to the Health Organizations. Any additional or different Service Provider resources which are required to perform the Transition Out Services will be provided for reasonable rates which are not to exceed the Services Rates. Subject to the last paragraph of this Section 19.1, all Transition Out Services provided after the Termination date will be provided for reasonable rates which are not to exceed the Services Rates and will be provided in cooperation with Health Organization Personnel and such other personnel as the Health Organizations may specify.

Without limiting the foregoing, in the event of any early termination of this Agreement, within five (5) Business Days after the date of termination as set out in the Termination Notice, the Service Provider and the Health Organizations will prepare a transition out plan that will address, in detail, the requirements set out in this Section 19.1(a) – (4) (the **"Transition Out Plan"**). The Service Provider will provide the Service Provider Personnel, and will cause the Subcontractors to provide the Subcontractor personnel, required to carry out the Transition Services in the Transition Out Plan and the Service Provider will use commercially reasonable efforts to redeploy all other Service Provider Personnel, and will cause all Subcontractors to use such efforts to redeploy Subcontractor personnel, providing Services at the time the Health Organizations provides notice of termination.

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If the Agreement is terminated by the Health Organizations for convenience under Section 18.3(1) or for Force Majeure Event under Section 18.3(2), then to the extent that the Service Provider or any Subcontractors are not able to redeploy such personnel the Service Provider will notify the Health Organizations and provide the Health Organizations with details as to the number of personnel not redeployed (“**Available Personnel**”). The Health Organizations will be responsible for the Fees for such Available Personnel during the 30 day notice period set out in Section 18.3(1) provided that the Health Organizations may, in their discretion, require that such Available Personnel perform additional tasks for the Health Organizations during such 30 day notice period at no additional cost. For greater certainty, except as set out in this paragraph, if the Agreement is terminated for Force Majeure the Health Organizations shall not be responsible for, nor shall the Health Organizations pay to the Service Provider for, any termination fees of any kind whatsoever.

If the Agreement is terminated by the Health Organizations as a result of an Event of Default under Section 18.4, then notwithstanding the provisions of this Section 19.1, the Service Provider will be responsible for all costs associated with the Service Provider resources required to perform the Transition Out Services (and otherwise to carry out the Transition Out Plan) during the Transition Out Period. For greater certainty, the Health Organizations will not be responsible for, nor will the Health Organizations pay the Service Provider for, any Service Provider Personnel during the Transition Out Period. If the Health Organizations requires that the Service Provider complete any Deliverable that is a work-in-progress at the time the Health Organizations provides the notice of termination then the Service Provider will complete such Deliverables and the Service Provider will charge the Health Organizations and the Health Organizations will pay the Fees for such Deliverables as set forth in the Agreement.

19.2 Transition Out Period

Service Provider will provide the Transition Out Services during the period (the “**Transition Out Period**”) commencing on the earlier of:

- (1) the date designated by the Health Organizations in connection with expiration of the Term; or
- (2) the Termination Date specified in any Termination Notice provided by one Party to the other Party pursuant to Article 18 (unless the non-terminating Party in good faith disputes such termination),

and continuing until the date (the “**Expiration Date**”) that is the later of:

- (3) either
 - (a) up to one (1) months after the expiration of the Term, in the case of paragraph (1) above; or
 - (b) up to one (1) months after the date specified in paragraph (2), in the case of paragraph (2) above.

19.3 Specific Obligations

Transition Out Services will include, without limitation, the performance of the specific obligations described in this Section 19.3.

- (1) **List of Items.** Service Provider will, as soon as reasonably possible following the Transition Notice Date, but in no event more than ten (10) Business Days thereafter, provide to the Health Organizations a complete and accurate list of all items that will be subject to return to the Health Organizations or delivery to the Replacement Service Provider, as provided in Section 18.7.
- (2) **Full Co-operation, Information and Knowledge Transfer.** During the Transition Out Period, the Parties will co-operate fully with one another to facilitate a smooth transition of the Services from Service Provider and its Subcontractors to the Health Organizations and the Replacement Service Provider. During the Transition Out Period, the Service Provider will provide such co-operation, and such co-operation will include, without limitation, provision of full, complete and detailed information including: (i) all non-proprietary information then being utilized by Service Provider with respect to the Services (subject to the provisions of Section 12.3); (ii) configuration data, configuration diagrams and specifications; and (iii) knowledge transfer with respect to all such information as required for a skilled service provider to fully assume and continue without interruption, the provision of the Services. Service Provider will co-operate with the Health Organizations and all of the Health Organizations' other service providers to provide a smooth transitioning out, with no unnecessary interruption of Services, no unnecessary adverse impact on the provision of Services or the Health Organizations' activities and no unnecessary interruption of, or unnecessary adverse impact on, any services provided to the Health Organizations by Third Parties.
- (3) **Delivery of Documentation and Data.** If and as requested by the Health Organizations, Service Provider will deliver to the Health Organizations and the Replacement Service Provider all the Health Organizations documentation and data including, without limitation, Work Products, Interim Milestones, Critical Deliverables and any other Deliverables (all as defined in Schedule D) or, in the event of early termination, any work-in-progress with respect thereto.

ARTICLE 20 REPRESENTATIONS, WARRANTIES AND COVENANTS

20.1 Service Provider Representations, Warranties and Covenants

The Service Provider represents, warrants and covenants as follows to each of the Health Organizations, as of the date of this Agreement and (except as otherwise noted) throughout the Term, and acknowledges and confirms that each of the Health Organizations is relying upon such representations, warranties and covenants in entering into of this Agreement:

- (1) **Legal and Corporate Authority of Service Provider**
 - (a) it is a corporation incorporated under the laws of Canada, and is registered to transact business and in good standing, in all locations where the performance of its obligations hereunder would require such qualification;
 - (b) it has all necessary corporate power, capacity and legal authority to enter into, execute and deliver the Agreement and to perform its obligations hereunder, and the Agreement has been duly executed and delivered by the Service Provider and constitutes a legal, valid and binding obligation of the Service Provider

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enforceable against the Service Provider in accordance with its terms, subject to applicable bankruptcy, insolvency and other laws of general application limiting the enforceability of creditors' rights, and to the fact that specific performance and injunctive relief are equitable remedies available only in the discretion of the court;

- (c) the execution and performance of this Agreement by Service Provider will not violate any Applicable Laws and will not breach any Contract, court order, judgment or decree to which Service Provider is a party or by which it is bound;
- (d) it has, and promises that it will maintain in effect, all governmental licenses and permits necessary for it to provide the Services contemplated by this Agreement;
- (e) it owns or leases and promises that it will own or lease, free and clear of all liens and encumbrances, other than security interests of Service Provider's lenders, all right, title, and interest in and to the tangible property and technology and the like that Service Provider intends to use or uses to provide the Services (other than the Health Organization Hardware and Health Organization Software), and in and to the related Intellectual Property Rights, or has received appropriate licenses, leases or other rights from Third Parties to permit such use; and
- (f) this Agreement constitutes a valid, binding, and enforceable obligation of Service Provider.

(2) Intentionally Deleted

(3) Violations

Service Provider represents and warrants to each of the Health Organizations that it is not, and covenants that it will not be, in violation of any Applicable Laws to which it is subject, and has not failed, and will not fail, to obtain any licenses, permits, franchises or other governmental authorizations necessary for the ownership of its properties or the conduct of its business, which violation or failure, either individually or in the aggregate, could reasonably be expected to have a material adverse effect on its business, the consummation of the transactions contemplated by this Agreement, or the performance of its obligations hereunder.

(4) Performance of the Services

Service Provider represents and warrants to each of the Health Organizations that it has the skills, resources and expertise to provide and will provide all Services in accordance with the terms of this Agreement. Without limiting the generality of the foregoing, Service Provider represents and warrants to each of the Health Organizations that Service Provider will use all commercially reasonable efforts to reduce the environmental impacts of the Services and that all Services will be provided in a timely, professional and workmanlike manner, in each case consistent with the standards of quality and integrity customarily observed by leading North American providers of services that are the same or similar to the Services provided, however, that where this Agreement specifies a particular standard or criteria for performance, this warranty is not intended to and does not diminish that standard or criteria for performance.

(5) Viruses and Disabling Devices

Service Provider will implement and use anti-virus software on all workstations that are utilized by the Service Provider or its Subcontractors in connection with the Services to identify, screen, prevent and not introduce, any Disabling Device in hardware, software, or other information technology services utilized by Service Provider, the Health Organizations in connection with the Services. A “Disabling Device” is any virus, timer, clock, counter, time lock, time bomb, Trojan horse, worms, file infectors, boot sector infectors or limiting design, instruction or routine and surveillance software or routines or data gathering or collecting software or devices that could, if triggered, erase data or programming, have an adverse impact on the Services, cause the hardware, software or resources to become inoperable or otherwise incapable of being used in the full manner for which such hardware, software or resources were intended to be used, or that collect data or information. However, for greater certainty, Disabling Devices do not include either software keys used in industry or disabling code used to temporarily disable a section of code while a patch or fix is being applied.

(6) Loss of Data / Breach of Backup Obligation

Intentionally deleted.

(7) Conflicts of Interest

- (a) *No Financial Interest.* Service Provider represents and warrants to each of the Health Organizations that to the knowledge of the Service Provider, neither the Service Provider nor any of its Affiliates operating in the Permitted Service Locations, nor any employee of either, has, will have, or will acquire, any contractual, financial, business or other interest or advantage, direct or indirect, that would materially conflict with Service Provider’s performance of its duties and responsibilities to each of the Health Organizations under this Agreement or otherwise create an appearance of impropriety with respect to this Agreement; and Service Provider will promptly inform the Health Organizations of any such interest of which Service Provider becomes aware.
- (b) *No Abuse of Authority or Information for Financial Gain.* Service Provider represents and warrants to each of the Health Organizations that to the knowledge of the Service Provider, neither the Service Provider nor any of its Affiliates operating in the Permitted Service Locations, nor any employee of either, directly or indirectly, has used or will use the authority, or any Health Organization Confidential Information, provided or to be provided under this Agreement to improperly obtain financial gain, advantage or benefit for Service Provider, any of its Affiliates, or any of their employees, and Service Provider will promptly inform each of the Health Organizations of any such interest of which Service Provider becomes aware;
- (c) *No Influence.* Service Provider represents and warrants to each of the Health Organizations that to the knowledge of the Service Provider, neither the Service Provider nor any of its Affiliates, nor any employee of either, directly or indirectly, has offered an undisclosed inducement that would provide a financial gain, advantage or benefit to, or could otherwise be expected to influence an employee or representative of each of the Health Organizations, and Service

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Provider will promptly inform the Health Organizations of any such interest of which Service Provider becomes aware;

- (d) ***No Collusion.*** Service Provider represents and warrants to each of the Health Organizations that the prices presented in the Service Provider Proposal were arrived at independently, without consultation, communication or agreement with any other proposer for the purpose of restricting competition; the prices quoted were not knowingly disclosed by Service Provider to any other proposer; and no attempt was made by Service Provider to induce any other Person to submit or not to submit a proposal for the purpose of restricting competition.

(8) Condition

Service Provider represents and warrants to each of the Health Organizations that it now possesses, and covenants that it will maintain throughout the Term, the resources necessary to comply with the requirements of this Agreement. If Service Provider experiences a change in its condition or circumstances that could reasonably be expected to materially adversely affect its ability to perform its obligations under this Agreement, then it will promptly notify, and in any event within two (2) Business Days, the Health Organizations of such change.

(9) Litigation and Service of Process

Service Provider represents and warrants to each of the Health Organizations that as of the Effective Date there is no actual, pending or, to the knowledge of the Service Provider, anticipated claim, suit or proceeding involving Service Provider or its Affiliates that could reasonably be expected to have a material adverse effect on the ability of Service Provider or its Affiliates to perform its or their obligations under this Agreement including actions pertaining to the proprietary rights described in Article 12. Service Provider will notify the Health Organizations, within fifteen (15) days of Service Provider's knowledge of any such actual or anticipated claim, suit or proceeding. In addition, Service Provider will either notify the Health Organizations, within fifteen (15) days of Service Provider becoming aware of any actual or anticipated claim, suit or proceeding involving a subcontractor that could reasonably be expected to have a material adverse effect on the ability of such subcontractor to perform its obligations in connection with the Services or Service Provider will take appropriate action to ensure that delivery of the Services is not adversely affected by such claim, suit or proceeding. Without limiting the further terms of Section 13.11, Service Provider will notify the Health Organizations, within forty-eight (48) hours, if process is served on Service Provider in connection with this Agreement, including any subpoena or court order for Service Provider's records, and will send a written notice of the service together with a copy of the same to the Health Organizations within seventy-two (72) hours of such service.

(10) Proprietary Rights Infringement

Service Provider represents, warrants and covenants to each of the Health Organizations that:

- (a) the performance of the Services and Service Provider's obligations hereunder (except if such performance is expressly specified and directed by the Health Organizations);
- (b) the grant or provision of licenses by Service Provider herein;

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- (c) the assignment or obtaining of assignments of all copyright in the Deliverables by Service Provider herein;
- (d) the use of any services, techniques or products (except with respect to techniques or products developed by the Health Organizations or that the Health Organizations require the Service Provider to use, as contemplated in Schedule D) provided or used by the Service Provider to provide the Services,

does not and will not infringe upon, violate or misappropriate any Third Party's Intellectual Property Rights in any of the jurisdictions in which the Services are being performed. Any infringement contrary to this Section 20.1(10) will be addressed in accordance with Article 12 and Section 21.4.

(11) Information Furnished to Health Organizations

Service Provider represents and warrants to each of the Health Organizations that:

- (a) to the knowledge of the Service Provider, all information, statements and facts furnished by Service Provider to HSSBC in the Service Provider Proposal, all documents provided by Service Provider to HSSBC as supplements to the Service Provider Proposal (including the written answers by Service Provider to HSSBC in response to questions developed by HSSBC as a result of its analysis of the Service Provider Proposal) provided prior to the Effective Date and all the information made a part of this Agreement are true, accurate, and complete, and contain no untrue statement of a material fact, nor omit any material fact necessary to make such information, statements, facts, representations or warranties, not misleading; and
- (b) as of the Effective Date all representations and warranties made by Service Provider that are contained in this Agreement or that may be contained in any Schedule or other document that may comprise this Agreement, are true, accurate, and complete, and contain no untrue statement of a material fact, nor omit any material fact necessary to make such information, statements, facts, representations or warranties, not misleading and, after the Effective Date, the Service Provider will promptly inform the Health Organizations if any representation or warranty is no longer true, accurate, or complete, or if and representation or warranty contains any untrue statement of a material fact, or omits any material fact necessary to make such information, statements, facts, representations or warranties, not misleading

(12) Completeness of Due Diligence Activities

Service Provider acknowledges that it has been provided with sufficient access to Health Organization Facilities, information and personnel, and has had sufficient time in which to conduct and perform a thorough due diligence of the Health Organizations' operations and business requirements and the Health Organizations' assets currently used by the Health Organizations in currently providing such services. In light of the foregoing, Service Provider will not seek any adjustment in the Fees based on any incorrect assumptions made by Service Provider in arriving at the Fees, except to the extent that such assumptions have been expressly set out in this Agreement. In the event any such assumptions set forth in the Schedules are

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incorrect, the Health Organizations will compensate the Service Provider for additional costs, the amount of which will be confirmed through the Change Process.

20.2 Intentionally Deleted.

20.3 Warranty Disclaimer

(1) Health Organizations - No Warranty

The Health Organizations do not make any representation or warranty, express or implied, with respect to the Services or any component thereof; and all hardware, software, networks, and items made available by the Health Organizations to Service Provider under this Agreement are made available or conveyed to Service Provider **“AS IS, WHERE IS AND WITH ALL FAULTS,”** and there are no guarantees, representations, warranties or conditions of any kind express or implied, including warranties with respect to condition, capabilities, attributes, uninterrupted or error free operation, merchantability, quality or fitness for a particular purpose and those arising by statute or otherwise, or from a course of dealing or usage of trade, except the Health Organizations hereby confirm that the Hardware owned or leased by the Health Organizations and the Software owned or licensed by the Health Organizations is being used in the day-to-day business and operations of the Health Organizations.

(2) General Warranty Disclaimer

EXCEPT AS EXPRESSLY STATED IN THIS AGREEMENT, NEITHER PARTY MAKES OR GIVES ANY REPRESENTATIONS, WARRANTIES OR CONDITIONS OF ANY KIND, EXPRESS OR IMPLIED, INCLUDING WARRANTIES AS TO UNINTERRUPTED OR ERROR FREE OPERATION, MERCHANTABILITY, QUALITY OR FITNESS FOR A PARTICULAR PURPOSE AND THOSE ARISING BY STATUTE OR OTHERWISE, OR FROM A COURSE OF DEALING OR USAGE OF TRADE.

ARTICLE 21 INDEMNIFICATION AND LIMITATION OF LIABILITY

21.1 General Intent

Each Party will be liable to the other Party for any damages that may be properly and lawfully awarded against a Party in favour of the other Party under the terms of, or in connection to this Agreement. The Service Provider and the Health Organizations agree that monetary damages may not be a sufficient remedy for any breach of this Agreement, and each of the Service Provider and the Health Organizations shall be entitled to seek equitable relief, including injunctive relief and specific performance in the event of a breach of this Agreement, to the extent that such remedy is available to a Party in accordance with Applicable Laws. For greater clarification, the provisions of this Section are not intended to in any way interfere or otherwise limit the jurisdiction of any arbitrators appointed or otherwise engaged pursuant to the provisions of Article 24 (*Dispute Resolution Process*).

21.2 Indemnification by Health Organizations

A Health Organization shall indemnify and save harmless the Service Provider and its Subcontractors and their respective directors, officers, employees, advisors, agents and representatives (the **“Service Provider Indemnified Parties”**) to the fullest extent permitted by law, from and against any and all Claims suffered or incurred by any of them arising as a result of or in connection with any of the

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following (except and to the extent such Claims are suffered or incurred as a result of the comparative fault of the Service Provider Indemnified Parties):

- (1) from the death of or bodily injury to any third party or any employee of the Service Provider or its Affiliates to the extent caused by the negligent or willful misconduct of that Health Organization;
- (2) from the loss of or damage to any tangible personal property or real property of the Service Provider or property of any third party to the extent caused by the negligence or willful misconduct of that Health Organization;
- (3) the failure of that Health Organization to perform its obligations under the Assigned Contracts prior to the assignment thereof from the Health Organizations to the Service Provider;
- (4) except where prevented by Applicable Law, Claims brought directly by any Health Facilities against the Service Provider that are related directly or indirectly to the Services or this Agreement; and
- (5) for the purposes of Subsections 21.2(1) and (3), the term “**Claims**” shall be limited to:
 - (a) all damages that a court finally awards to a third party for such claim and any defence costs; or
 - (b) subject to the provisions of Section 21.6, the amount of any settlement agreed to by the Indemnified Party.

21.3 Indemnification by the Service Provider

Without duplication of any liquidated damages to be paid by the Service Provider to the Health Organizations hereunder, the Service Provider shall indemnify and save harmless the Health Organizations and their directors, officers, employees, advisors, agents and representatives (the “**Health Organization Indemnified Parties**”) to the fullest extent permitted by law, from and against any and all Claims suffered or incurred by any of them arising as a result of or in connection with any of the following (except to the extent such Claims are suffered or incurred as a result of the comparative fault of Health Organization Indemnified Parties):

- (1) any third party Claim relating to the failure of the Service Provider to perform its obligations under any license, lease or other agreement:
 - (a) between the Service Provider and a third party, including Subcontractors and landlords,
 - (b) assigned by the Service Provider to the Health Organizations or to an alternate service provider in connection with the termination of this Agreement, but only with respect to any Claims that arise from or relate to the period prior to the assignment thereof by the Service Provider to the Health Organizations or the Alternative Service Provider,

that arises as a result of the Health Organizations receiving Services under this Agreement;

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- (2) any misuse or disclosure of Personal Information by the Service Provider in breach of its obligations under Section 13.2(1) or 13.2(2) (including Schedule L (*Privacy and Security*)) if applicable) including any failure by the Service Provider to ensure that Service Provider Personnel and Subcontractors do not misuse or disclose Personal Information contrary to the provisions of Section 13.2(1) or 13.2(2) (including Schedule L (*Privacy and Security*)) if applicable);
- (3) the failure of the Service Provider to pay and discharge any Taxes for which the Service Provider is responsible pursuant to this Agreement and Applicable Laws, provided that nothing in this Agreement shall impose on the Service Provider any obligation or liability with respect to any Taxes for which its Subcontractors may be responsible at law;
- (4) the death of or bodily injury to any third party or to any employee of the Health Organizations to the extent caused by the willful misconduct or, negligence of the Service Provider, its Personnel or its Subcontractors or External Personnel in connection with the performance of the Services (for greater certainty, the indemnity under this Sections 21.3(4) is limited to injury arising from actions in the performance of the Services and not injury to patients resulting from the Health Organizations' use of the hardware, software, systems or Services in the provision of healthcare to patients;
- (5) the loss of or damage to any tangible personal property and real property of the Health Organizations or any third party, to the extent caused by the negligence or willful misconduct of the Service Provider, its Personnel or its Subcontractors or External Personnel in connection with the performance of the Services; and
- (6) any claim, proceeding or action taken or initiated by a Service Provider Affiliate in breach of Section 15.3 (*North American Free Trade Agreement*), Article 24 (*Dispute Resolution*) or Section 25.12 (*Governing Law and Venue*).

For the purposes of Subsections 21.3(1), (4) and (6), the term “**Claims**” shall be limited to:

- (7) all damages that a court finally awards to a third party for such claim and any defence costs; or
- (8) subject to the provisions of Section 21.6, the amount of any settlement agreed to by the Indemnified Party.

For greater clarification, the Service Provider shall not be required to indemnify Health Organization Indemnified Parties under this Section in respect of an event giving rise to termination by the Health Organizations for which the Parties have agreed to pay liquidated damages under the provisions of this Agreement.

21.4 Service Provider Intellectual Property Indemnification

Subject to Section 21.6, the Service Provider shall indemnify and save harmless Health Organization Indemnified Parties from and against any and all Claims suffered or incurred by any of them arising as a result of, or in connection with, any actual or alleged infringement of the patents or copyrights of a third party or the violation of the rights of a third party in respect of its trade secrets by the Deliverables, any Service Provider Background Materials (collectively, the “**Service Provider Intellectual Property**”),

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provided, used or made by the Service Provider or any of its Subcontractors or Affiliates in the course of performing the Services (collectively, the “**Service Provider Indemnified Materials**”), provided that the Service Provider shall have no liability under this Section for any Claims that arise as a result of:

- (1) any Health Organization’s combination, operation, or use of the Service Provider Indemnified Materials with products or data not provided by the Service Provider and not set forth in the relevant Specifications for such Service Provider Intellectual Property, or the use of any Software in other than their specified operating environment;
- (2) a Derivative Work made by any of the Health Organizations or their employees or Subcontractors or Affiliates to the Service Provider Indemnified Materials, except to the extent such Derivative Work was made at the instruction of or with the consent of the Service Provider or its Affiliates or Subcontractors;
- (3) the use by the Service Provider of any Health Organization Owned Material or Third Party Software provided to the Service Provider by any of the Health Organizations, except to the extent that such infringement is caused by a Derivative Work of the same made by the Service Provider (or any of its Affiliates or Subcontractors);
- (4) the compliance by the Service Provider with any Specification specified by any of the Health Organizations if the infringement or violation would not have occurred but for compliance with that Specification; or
- (5) any Claims in respect of which any of the Health Organizations are required to indemnify the Service Provider Indemnified Parties pursuant to Section 21.5.

For the purposes of this Section 21.4, the term “**Claims**” shall be limited to:

- (6) all damages that a court finally awards to a third party for such claim and any defence costs; or
- (7) subject to the provisions of Section 21.6, the amount of any settlement agreed to by the Indemnified Party.

Without limiting or otherwise restricting the Service Provider’s liability and obligations to the Health Organizations in respect of the foregoing, if the Health Organizations’ use of any Service Provider Indemnified Materials provided or otherwise made available by the Service Provider to the Health Organizations pursuant to this Agreement is found to be infringing the patents or copyrights of a third party or violating the trade secret rights of a third party or, in the Service Provider’s reasonable judgment is likely to be found to be infringing or in violation, then the Service Provider may (at its option and expense) either procure for the Health Organizations the right to continue using such Service Provider Indemnified Materials, or replace or modify such Service Provider Indemnified Materials to make its continued use non-infringing while providing substantially the same functionality.

21.5 Health Organization Intellectual Property Indemnification

Subject to Section 21.6, a Health Organization shall indemnify and save harmless the Service Provider Indemnified Parties from and against any and all Claims suffered or incurred by any of them arising as a result of, or in connection with, the actual or alleged infringement of the patents and copyrights of a third party or the violation of the rights of a third party in respect of its trade secrets by any Health

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Organization Owned Material or any Derivative Work created by that Health Organization or any of its Subcontractors to any Service Provider Intellectual Property or Health Organization Owned Materials or Third Party Software (collectively the “**Health Organization Indemnified Materials**”), provided that the Health Organization shall have no liability under this Section for any Claims that arise as a result of:

- (1) a Derivative Work made by the Service Provider or any of its Subcontractors or Affiliates to Health Organization Indemnified Materials;
- (2) the use by the Service Provider of Health Organization Indemnified Materials provided to the Service Provider by that Health Organization to the extent that such infringement is caused by a Derivative Work of the same created by the Service Provider (or any of its Subcontractors or Affiliates); or
- (3) any Claims in respect of which the Service Provider is required to indemnify Health Organization Indemnified Parties pursuant to Section 21.4.

For the purposes of this Section 21.5, the term “**Claims**” shall be limited to:

- (4) all damages that a court finally awards to a third party for such claim and any defence costs; or
- (5) subject to the provisions of Section 21.6, the amount of any settlement agreed to by the Indemnified Party.

Without limiting or otherwise restricting s Health Organizations’ liability and obligation to the Service Provider in respect of the foregoing, if use of any Health Organization Indemnified Materials provided or otherwise made available by that Health Organization to the Service Provider pursuant to this Agreement is found to be infringing the patents or copyrights of a third party or violating the trade secret rights of a third party or, in the Health Organization’ reasonable judgment it is likely to be infringing or in violation, then the Health Organization may (at its option and expense), either procure for the Service Provider the right to continue using such Health Organization Indemnified Materials, or replace or modify such Health Organization Indemnified Materials to make its continued use non-infringing while providing substantially the same functionality.

21.6 Third Party Claim Process

- (1) If the Indemnified Party intends to seek indemnification under this Article from the Indemnifying Party in respect of any third party Claims, then the Indemnified Party shall promptly give the Indemnifying Party written notice of such Claims for indemnification, such notice to be given as soon as practicable following the commencement of any action by a third party; provided, however, that the failure of an Indemnified Party to give the Indemnifying Party such prompt notice shall not relieve the Indemnifying Party of its obligations under this Agreement, except to the extent that such failure results in a material prejudice to the Indemnifying Party’s defence to such Claims;
- (2) If the Indemnifying Party receives a notice of any Claim pursuant to paragraph (a) above, then:
 - (a) where the Indemnifying Party is the Health Organizations, then the Service Provider may permit the Health Organizations to defend and control the defence

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of the Service Provider against such Claim at the Health Organizations' expense and the Health Organizations will pay such costs, damages and legal fees that a court finally awards or are included in a settlement agreed to by the Health Organizations, as are in proportion to the Health Organizations' comparative fault in causing such amounts;

- (b) where the Indemnifying Party is the Service Provider, then the Health Organizations may permit the Service Provider to defend and control the defence of the Health Organizations against such Claim at the Service Provider's expense and the Service Provider will pay such costs, damages and legal fees that a court finally awards or are included in a settlement agreed to by the Service Provider, as are in proportion to the Service Provider's comparative fault in causing such amounts;
 - (c) the Indemnified Party shall cooperate in all reasonable respects with the Indemnifying Party and its counsel in the defence, and may reasonably participate but, for greater clarification, not take control or conduct of such defence at its own expense through its separate legal counsel or otherwise; and
 - (d) if the defendants in any such action include both the Indemnified Party and the Indemnifying Party, and the Indemnified Party shall have reasonably concluded that there may be legal defences available to it which are different from or additional to those available to the Indemnifying Party, then the Indemnified Party shall have the right to select separate counsel, the cost of which shall be at the Indemnified Party's expense, to assert such legal defences or to otherwise participate in the defence of such action on behalf of the Indemnified Party; and
- (3) To the extent that the Indemnified Party has not permitted the Indemnifying Party to control its defence of the Claim pursuant to Subsection 21.9(2)(a) or 21.6(2)(b) above, then the Indemnified Party shall not settle any Claim for which it may seek indemnification from the Indemnifying Party pursuant to this Section, without consultation with the Indemnifying Party. Notwithstanding such consultation, the Indemnified Party shall have the right to settle such Claim provided, however, that if the Indemnified Party has reached a bona fide settlement agreement with the plaintiff(s) in any such action and the Indemnifying Party disputes:
- (a) the settlement amount; or
 - (b) the proportion of the Indemnifying Party's comparative fault in causing such settlement amount,

(collectively, the "**Disputed Matters**")

then, the Disputed Matters shall be resolved in accordance with the provisions of Article 24 (*Dispute Resolution Process*) of this Agreement. For greater clarification, the Disputed Matters shall not include the Indemnified Party's decision to settle any Claim. All settlements of Claims subject to indemnification under this Article 21 shall include an appropriate non-disclosure agreement with the plaintiff(s), prohibiting the disclosure of the terms of such settlement by the plaintiff(s).

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21.7 Mitigation

Each Party has a duty to mitigate the Claims that would otherwise be recoverable from the other Party pursuant to this Agreement by taking appropriate and reasonable actions to reduce or limit the amount of such Claims.

21.8 Limitation

The Parties acknowledge and agree that this Article 21 contains the Parties entire liability with respect to third party Claims. For certainty, neither the Service Provider nor the Service Provider Personnel, Subcontractors or Affiliates, or the Service Provider, Subcontractor or Affiliates respective officers, and directors have any liability under this Agreement, regardless of the basis of the claim (including breach, negligence, misrepresentation, or other contract or tort claim), for claims for damages made against the Health Organizations by third parties, except for the Service Provider's obligation to indemnify the Health Organizations pursuant to this Article 21.

21.9 Limitation of Liability

- (1) Subject to 21.9(2) and 21.9(4), neither Party nor their respective subcontractors (including, for the Service Provider, the Subcontractors), Affiliates, directors, officers, employees, or agents shall be liable for any special, incidental, punitive, indirect or consequential damages arising out of or in connection with the Services provided under this Agreement including, but not limited to, lost revenue, lost profits, replacement goods, loss of technology rights or services, loss of data, or interruption or loss of use of Software or any portion thereof, even if foreseeable or if the Service Provider or the Health Organizations have been advised of the possibility of such damages, and regardless of the basis on which the other Party is entitled to claim (including breach, negligence, misrepresentation, or other contract or tort claim).
- (2) The provisions of Sections 21.9(1) shall not exclude the following:
 - (a) consequential damages arising as a result of the wrongful disclosure of Health Organization Confidential Information as a result of the Service Provider's breach of its obligations pursuant to Section 13.6;
 - (b) consequential damages arising as a result of the wrongful disclosure of Service Provider Confidential Information as a result of the Health Organizations' breach of its obligations pursuant to Section 13.6
 - (c) the Service Provider's obligations to indemnify for third party Claims pursuant to Sections 21.3 and 21.4;
 - (d) the Health Organizations' obligations to indemnify for third party Claims pursuant to Sections 21.2 and 21.5; and
 - (e) negligence of the Service Provider or Subcontractor in connection with the performance of the Services.

Provided that a Party's entire liability for consequential damages under this Agreement shall not exceed five million dollars (\$5,000,000.00) per occurrence and in the aggregate for all claims and causes of action (collectively, the "Consequential Damage Cap").

This Consequential Damage Cap shall apply irrespective of the nature of the cause of action, demand or action including any breach of contract, negligence, tort or any other legal theory. If and when the Consequential Damage Cap is reached as a result of Claims, then the Parties may, subject to mutual agreement, increase the amount of the aggregate Consequential Damage Cap for all claims and causes of actions under this Agreement, to an amount equal to ten million dollars (\$10,000,000.00), and if the Parties are unable to so agree within sixty (60) days of a request by one Party to the other to reset the amount of the Consequential Damage Cap, then the Health Organizations shall be entitled to terminate this Agreement, in its sole discretion, without payment of a termination fee, in which case, the provisions of Article 19 (*Transition Out Services*) shall apply.

- (3) Subject to Section 21.9(2), the entire liability of the Service Provider (if any) to the Health Organizations, and that of its Subcontractors, Affiliates', employees', officers' and directors', relating to or arising from this Agreement, other than pursuant to the indemnities granted under Subsection 21.3(3) and Section 21.4 (the "**Excluded Claims**"), shall be limited to any actual, direct damages and shall not exceed twenty million dollars (\$20,000,000.00) per occurrence and in the aggregate for all such claims and causes of action (the "**Direct Damage Cap**"). This Direct Damage Cap shall apply (other than with respect to the Excluded Claims) irrespective of the nature of the cause of action, demand or action including any breach of contract, negligence, tort, misrepresentation, or any other legal theory. If and when the Direct Damage Cap is reached as a result of Claims, then the Parties may, subject to mutual agreement, increase the amount of the aggregate Direct Damage Cap for all claims and causes of actions, to an amount equal to twenty-five million dollars (\$25,000,000.00), and if the Parties are unable to so agree within sixty (60) days of a request by one Party to the other to reset the amount of the Direct Damage Cap, then the Health Organizations shall be entitled to terminate this Agreement, in its sole discretion, without payment of a termination fee, in which case, the provisions of Article 19 (*Transition Out Services*) shall apply.
- (4) Notwithstanding the provisions of Section 21.9(2), in the event of any misuse, disclosure or other misappropriation of Personal Information, by the Service Provider (including, for greater certainty, where such misuse, disclosure or other misappropriation of Personal Information arises in connection with the negligence of the Service Provider), the Service Provider's entire liability for consequential damages set forth in in Section 21.9(2) shall be increased by five million dollars (\$5,000,000.00). The limitation of liability set out in this Section 21.9(4) shall increase the Consequential Damages Cap for any misuse, disclosure or other misappropriation of Personal Information only. All damages paid by the Service Provider to the Health Organizations under Section 21.9(2) (and as increased under this Section 21.9(4) as applicable) shall reduce the amount available under those sections to satisfy subsequent Claims for consequential damages.
- (5) The provisions of Section 21.9(1) shall not apply to the Health Organizations' failure to pay any amounts owing to the Service Provider under this Agreement (including amounts owing for Services rendered or services that would have been rendered but for the Health Organizations' breach of this Agreement).
- (6) Each Party agrees that it shall not assert any Claims from the other Party until such Claims aggregate an amount equal to fifty thousand dollars (\$50,000.00), at which

Restricted and Confidential – Services Agreement

time, the Party seeking the Claims from the other (in accordance with the terms of this Agreement) shall be entitled to claim all such Claims. This Section 21.9(3) shall not apply to the indemnity granted by the Service Provider under Section 21.3(2)

- (7) Notwithstanding the foregoing paragraphs, nothing in this Section shall entitle either Party to Claims in respect of amounts already paid to that Party pursuant to this Article and Schedule N (*Termination Fees*).

21.10 Intentionally Deleted.

ARTICLE 22 FORCE MAJEURE

22.1 Force Majeure

No Party shall be in breach of this Agreement where its failure to perform or its delay in performing any obligation is due any Force Majeure Event.

22.2 Mitigation of the Force Majeure Event

Where a Party becomes aware of the occurrence of an event, condition or circumstance that could reasonably be expected to cause such Party to claim a Force Majeure Event, then that Party will use commercially reasonable efforts to prevent or avoid such event, condition or circumstance developing into a Force Majeure Event, to the extent possible. Failing prevention of the occurrence of such Force Majeure Event by the use of such efforts, the Party claiming the Force Majeure Event will, during the continuance of such Force Majeure Event, use reasonable efforts to mitigate and minimize the effect of such Force Majeure Event, to reduce and minimize any ensuing delay or interruption in the performance of its obligations under this Agreement, and to recommence performance of its obligations under this Agreement whenever and to whatever extent possible and without further delay.

22.3 Delay in Payment

A Force Majeure Event affecting the Health Organizations' payment processing systems may result in a delay in any payment owing under this Agreement being made within the timeframes required in this Agreement; however, any monies subject to a delay in payment will remain owing to the other Party together with interest thereon in accordance with Article 17. For greater certainty, an inability to pay for any other reason shall not in any way limit rights under Section 18.6 (*Health Organizations Events of Default*) of this Agreement.

22.4 Extension of Performance

Each Party shall notify the other promptly and in writing of any failure to perform or delay in performing due to a Force Majeure Event, and shall provide an estimate as soon as practicable of the time when the obligation will be performed. Subject to Section 18.3(2), the time for performing the obligation shall be extended for a period of time equal to the period of delay resulting from such a cause. Without restricting the generality of the foregoing, whenever an actual or potential labour dispute is delaying or threatens to delay the performance of Services, the Service Provider shall promptly notify the Health Organizations in writing. Such notice shall include all relevant information concerning the dispute and its background.

22.5 Health Organizations Recourse to Third Parties

During each such Force Majeure Event, the Health Organizations may, in the Health Organizations' discretion, and without incurring any liability, seek to have its requirements (which would otherwise be met hereunder) met by or through a third party or third parties.

22.6 Work Around Plans

When requested by the Health Organizations, the Service Provider shall deliver, within ten (10) Business Days of receipt of a request, a description in a form satisfactory to the Health Organizations of work-around plans including any means that the Service Provider will use to overcome a Force Majeure Event, and shall endeavour to prevent any further similar Force Majeure Event. Upon receipt of approval in writing by the Health Organizations, which shall not be unreasonably withheld, the Service Provider shall implement such work-around plans.

22.7 Costs of Work Around

The Parties, both acting reasonably, shall agree on an equitable manner of sharing:

- (1) the costs associated with the development and implementation of any work-around plans; and
- (2) any third party expenses incurred with respect to such work-around plans, prior to incurring any such third party expenses.

ARTICLE 23 INSURANCE

23.1 Insurance

The Service Provider shall procure and maintain at all times during the Term of this Agreement, at its own expense and without reimbursement from the Health Organizations, the following insurance policies which may be provided by way of an umbrella or excess policy and which shall be underwritten by insurers licensed to carry on insurance business in Canada as long as such coverage remains commercially available and reasonably viable in the market place:

- (1) **Commercial General Liability.** Commercial general liability insurance protecting against Claims of bodily injury (including death) and property damage which may arise out of the performance of the Services by the Service Provider or otherwise under this Agreement, in an amount not less than ten million dollars (\$10,000,000.00) inclusive per occurrence. The policy(s) shall include coverage for non-owned automobile liability, personal injury liability, employer's liability, blanket contractual liability coverage, broad form property damage coverage and coverage for products and completed operations. The policy(s) shall contain a cross-liability clause, and include the Health Organizations as an additional insured. In the event the Service Provider receives a notice of cancellation of coverage or a notice of material change from its insurer and such is reasonably expected to disrupt coverage required under this section, the Service Provider will provide prompt notice of such to the Health Organizations and in any event will provide such notice within seventy-two (72) hours of the receipt of such notice from its insurer; and

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- (2) **Errors & Omissions Liability.** Errors and omissions liability insurance protecting against Claims arising out of any error or omission by the Service Provider in the provision of the Services, in an amount not less than five million dollars (\$5,000,000.00). In the event the Service Provider receives a notice of cancellation of coverage or a notice of material change from its insurer and such is reasonably expected to disrupt coverage required under this section, the Service Provider will provide prompt notice of such to the Health Organizations and in any event will provide such notice within seventy-two (72) hours of the receipt of such notice from its insurer.

The Parties agree that should any change in the insurance industry materially impact Service Provider's ability to obtain the insurance and insurance coverage levels set forth in this Article 23 (*Insurance*), including where such coverage remains commercially available and reasonably viable in the market place, the Parties will assess such impact and negotiate in good faith any amendments to this Article 23 (*Insurance*) to account for such insurance industry changes.

23.2 Certificate of Insurance

The Service Provider shall provide the Health Organizations with evidence of all required insurance in the form attached as Schedule O (*Form of Certificate of Insurance*) within thirty (30) days after the Effective Date, and upon the reasonable request of the Health Organizations from time to time but not more frequently than annually.

23.3 Adequacy of Insurance

The Service Provider acknowledges that any requirement for insurance under this Agreement shall not constitute a representation by the Health Organizations that the amount or type of insurance required is adequate, and the Service Provider acknowledges and agrees that it is solely responsible for obtaining and maintaining its own policies of insurance in such amounts as the Service Provider determines to be appropriate and adequate, subject to the minimum requirements set out in this Article 23 (*Insurance*).

ARTICLE 24 DISPUTE RESOLUTION

24.1 Dispute Resolution Process

The Parties agree to endeavour to resolve any unresolved Issues or Disputes using the Dispute resolution procedures set out in Schedule P (*Dispute Resolution Process*) ("**Dispute Resolution Process**"). Notwithstanding the foregoing, any Issue or Dispute involving a third party will be resolved by the Parties, acting reasonably, in consultation and negotiations with such third party and will not, unless the third party agrees in writing to participate in and be bound by the results of such arbitration, be subject to escalation to arbitration as provided for in Schedule P (*Dispute Resolution Process*).

24.2 Equitable Relief

Notwithstanding anything contained in the Agreement to the contrary, the Parties will be entitled to seek injunctive or other equitable relief from a court of competent jurisdiction whenever the facts or circumstances would permit a Party to seek such relief.

**ARTICLE 25
MISCELLANEOUS**

25.1 Third-Party Beneficiaries

This Agreement is an agreement between the Parties and, except for the Health Organization Indemnified Parties and the Service Provider Indemnified Parties for which the Health Organizations and Service Provider can act on their behalf, confers no rights upon any of such Parties' employees, agents, or contractors, or upon any other Person.

25.2 Assignment

- (1) **Assignment by Health Organization.** Each Health Organization may assign, at any time, in its sole discretion, and without the consent of the Service Provider but upon reasonable prior written notice, this Agreement to any government, public sector or Crown entity, body or authority having responsibility for the Health Authorities.
- (2) **Assignment by Service Provider.** The Service Provider shall not assign, either directly or indirectly, this Agreement or any rights, duties, obligations or interests of the Service Provider under this Agreement, without the prior written consent of the Health Organizations, which consent may be given or withheld in the sole and absolute discretion of the Health Organizations. For the purpose of this Agreement, the following shall be deemed to be an assignment:
 - (a) the amalgamation of the Service Provider, excluding amalgamations with Service Provider Affiliates that do not result in a change in the Corporate Control of the Service Provider to which this Section 25.2 does not apply;
 - (b) an assignment by operation of law (but not including assignments by operation of law as a result of amalgamations permitted under paragraph (a) above);
 - (c) a sale of all or substantially all of the assets or undertaking of the Service Provider; or
 - (d) a change in the direct Corporate Control of the Service Provider, other than a change in the direct Corporate Control of the Service Provider where the Service Provider continues to be a Canadian Entity, and continues to be under the Corporate Control of an Affiliate of the Service Provider to which this Section 25.3 does not apply.

Notwithstanding the foregoing, the Health Organizations will not unreasonably withhold their consent to an assignment of this Agreement, in its entirety, to a Service Provider Affiliate (the "**Designated Affiliate**") provided that at the time of such assignment:

- (e) the Service Provider has, corporately assigned all of its then existing outsourcing agreements with any Person to the Designated Affiliate;
- (f) the Designated Affiliate is a Canadian Entity;
- (g) the Designated Affiliate shall be the Service Provider's entity for contracting and performing all of the Service Provider's outsourcing services in Canada;

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- (h) the Health Organizations shall be reasonably satisfied that the Designated Affiliate is of sound financial condition; and
- (i) the Designated Affiliate shall assume, in writing (in form and substance reasonably satisfactory to the Health Organizations), all of the rights and obligations of the Service Provider under this Agreement.

Notwithstanding the foregoing, in the event of any assignment of this Agreement by the Service Provider, the Service Provider shall not be released from any of its obligations or liabilities under this Agreement.

Any attempt by the Service Provider to assign this Agreement or any of the Service Provider's rights, duties, obligations or interests under this Agreement contrary to this Section, shall be null and void and without effect, and shall be deemed to be a material breach of this Agreement and constitute an Event of Default under Section 18.5(8), giving rise to the right of the Health Organizations to terminate this Agreement. For greater clarification, at no time shall the Health Organizations consent to any assignment where such assignment could in any manner expose any Personal Information to any increased risk of disclosure contrary to the terms of this Agreement.

25.3 Notices

Unless specifically provided otherwise in this Agreement, including through the Governance Process, wherever any notice, communication, demand, invoice, approval or other document is required or permitted to be given, sent or delivered by one Party to another under this Agreement, then it will be in writing and may be delivered personally, by facsimile or PDF or sent by a recognized courier service (and for greater clarification, no notice, demand or approval required or permitted to be given under this Agreement will be, or be deemed to be, effective or delivered if given by email). Any such notice, communication, demand, invoice, approval or other document so personally delivered or sent by facsimile or courier will be deemed to be given when actually received and will be addressed as follows:

To PHSA:

Provincial Health Services Authority
700-1380 Burrard Street
Vancouver, B.C. V6Z 2H3

Attn: Lynda Cranston, President and CEO

Fax: (604) 708-2700

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To VCH:

Vancouver Coastal Health Authority
11th Floor, 601 West Broadway
Vancouver, B.C. V5Z 4C2

Attn: Dr. David Ostrow, President and CEO

Fax: (604) 875-4750

To PHC:

Providence Health Care Society
11th Floor, 1190 Hornby Street
Vancouver, BC V6Z 2K5

Attn: Dianne Doyle, President and CEO

Fax: (604) 806-8811

To the Service Provider:

IBM Canada Limited
Suite 200 – 1803 Douglas Street
Victoria, British Columbia
V8T 5C3

Attn: Mark Derraugh

Fax: (250) 220-8034

Either Party may change its address or facsimile number for notices upon giving prior written notice of the change to the other Party in the manner provided above.

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25.4 Relationship Between the Parties

Neither Party (nor any employee, subcontractor (including, for the Service Provider, the Subcontractors) or agent thereof) will be deemed or otherwise considered a representative, agent, employee, partner or joint venturer of the other. Further, neither Party (nor any employee, subcontractor (including, for the Service Provider, the Subcontractors) or agent thereof) will have the authority to enter into any contract, nor to assume any liability, on behalf of the other Party, nor to bind or commit the other Party in any manner, except as expressly provided in this Agreement.

25.5 Counterparts; Faxed Signatures

This Agreement may be executed in duplicate counterparts, each of which will be deemed an original and both of which together, when delivered by facsimile, PDF or otherwise, will constitute one and the same instrument. The Parties hereby adopt as original any signatures received via facsimile or PDF.

25.6 Public Announcements

- (1) The Service Provider will not, without the prior written consent of the Health Organizations, issue any such press release or make any public announcement to a third party that include a factual description of any of the Services, information about the Services, this Agreement or relationship between the Service Provider and the Health Organizations provided, however, that the Service Provider may, without such consent, make such disclosure if the same is required by Applicable Law, any stock exchange on which any of the securities of the Service Provider are listed or posted for trading, or any securities commission or other similar regulatory authority having jurisdiction over the Service Provider, and if such disclosure is required. The Service Provider in making any such disclosure will use all commercially reasonable efforts to give prior oral or written notice to the others, and if such prior notice is not possible, to give such notice immediately following the making of such disclosure. Either Party may include the other Party's name on its employee bulletin boards, in its list of customers or service providers and in the experience section of proposals to third parties, in internal business planning documents and in its, or its Affiliate's, annual report to shareholders or annual information form and whenever otherwise required by reason of legal, accounting or regulatory requirements.
- (2) The Service Provider will consult the Health Organizations before issuing any press release or making any other public announcement with respect to this Agreement or the transactions contemplated hereby (other than any promotional or marketing material of such Party which merely identifies the Health Organizations as a customer or service provider).

25.7 Effect of Certificates

All certificates provided under this Agreement by an officer or director of a Party will be provided in that Person's capacity as an officer or director of such Party, and not in that Person's personal capacity, and no such officer or director will incur any personal liability to any Party under or as a result of such certificate.

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25.8 Expenses

Each Party will bear all expenses paid or incurred by it in connection with the planning, negotiation and consummation of this Agreement.

25.9 Entire Agreement

This Agreement sets forth the entire agreement between the Parties with respect to the matters referred to herein and supersedes all prior agreements, understandings, negotiations and discussions, whether written or oral. There are no conditions, covenants, agreements, representations, warranties or other provisions, express or implied, collateral, statutory or otherwise, relating to the subject matter contained herein other than those set forth in or referred to in this Agreement. The Agreement for Confidential Information between the Parties and signed by the Service Provider on January 23, 2012, will be terminated, superseded and replaced by this Agreement, provided that all Confidential Information provided thereunder will be deemed to be Confidential Information under this Agreement, and the Non-Disclosure and Confidentiality Agreement will survive with respect to the remedies available in respect of any breach of such agreement which occurred prior to the Effective Date.

25.10 Fully Negotiated Agreement

The Parties agree that all of the provisions of this Agreement have been fully negotiated, that neither of them will be deemed the drafter of this Agreement and that, in construing this Agreement in case of any claim that any provision hereof may be ambiguous, no such provision will be construed in favour of one Party on the ground that such provision was drafted by the other Party.

25.11 Severability

If any provision of this Agreement is determined to be invalid or unenforceable by a court of competent jurisdiction, that provision will be deemed stricken with respect to that jurisdiction and the remainder of this Agreement will continue in full force and effect insofar as it remains a workable instrument to accomplish the original intent and purposes of the Parties, and, if possible, the Parties will act in good faith to replace the severed provision with a valid and enforceable provision that reflects the intention of the Parties with respect to the severed provision.

25.12 Governing Law and Venue

This Agreement will be construed, interpreted and enforced in accordance with, and the respective rights and obligations of the Parties will be governed by, the laws of the Province of British Columbia and the federal laws of Canada applicable therein, without giving effect to conflicts of laws principles. Subject to the dispute resolution provisions in Article 24, each Party hereby irrevocably and unconditionally submits to the exclusive jurisdiction of the courts of such Province and all courts competent to hear appeals therefrom and each Party irrevocably accepts and submits to the sole and exclusive jurisdiction of such courts, generally and unconditionally with respect to any action, suit or proceeding brought by or against it by the other Party. Except as hereafter provided in this Section 25.12, neither Party will bring any legal action, suit or proceeding in any way arising out of or relating to this agreement in any other court or in any other jurisdiction and will not assert any claim, whether as an original action or as a counterclaim or otherwise, against the other in any other court or jurisdiction. Each Party irrevocably waives and agrees not to assert, by way of motion, as a defence or otherwise, any objection that it may now or hereafter have to the venue of any of the aforesaid actions, suits or proceedings in the courts referred to above, and further waives and agrees not to plead or claim in any such court that any such action or proceeding brought in any such court has been brought in an inconvenient forum, that the venue of the suit, action or

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proceeding is improper, or that this Agreement or the subject matter hereof or thereof may not be enforced in or by such court. As the only exception to the above, if a Party is entitled to seek injunctive or other equitable relief which is not available in the venue specified in this Section 25.12, this Section will not be deemed to be a bar to the Party seeking such relief if such relief is wholly non-monetary injunctive or other equitable relief. The terms of this Section 25.12 will apply regardless of the country of origin of any Dispute. Further, each of the Parties agrees that any judgment rendered by a provincial or federal court located in Canada is a valid and binding judgment, entitled to recognition and enforcement in and by any court, tribunal, judge, jury or other body exercising judicial functions located in the country of the applicable Party, including, in the case of Service Provider, the Service Provider Parent (collectively, a “Local Court”). Each Party agrees that any such judgment may be entered into evidence in any suit, action or proceeding commenced in any Local Court and hereby irrevocably waives and agrees not to assert, by way of motion, as a defence or otherwise, any objection that it may now or hereafter have relating to the validity of any such judgment and its introduction into evidence in any suit, action or proceeding in any Local Court, and further irrevocably waives and agrees not to plead or claim in any such suit, action or proceeding that the judgment may not be recognized or enforced by such Local Court. Either Party may seek interim measures of protection, including but not limited to interim injunctive relief, in a court of competent jurisdiction located in the Province of British Columbia. The Parties consent and agree to the jurisdiction of the courts mentioned in this paragraph, and waive any and all objections to such forums, including but not limited to objections based on improper venue or inconvenient forum.

25.13 Appropriation

The payment of money by the Health Organizations to the Service Provider under this Agreement is subject to:

- (1) there being sufficient monies available in an appropriation, as defined in the *Financial Administration Act* (British Columbia), to enable the Health Organizations to make that payment; and
- (2) Treasury Board, as defined in the *Financial Administration Act* (British Columbia), not having controlled or limited, under the *Financial Administration Act* (British Columbia), expenditure under any appropriation referred to in paragraph (1) above.

25.14 Amendments and Waivers

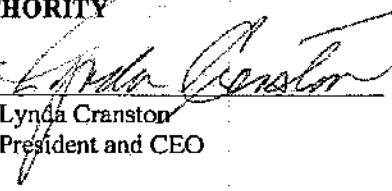
No amendment or waiver of any provision of this Agreement will be binding on any Party unless consented to in writing by such Party. Except as provided under the Change Process, Service Provider expressly agrees that all amendments to this Agreement executed by the Parties after the Effective Date must be signed by a Vice President or a higher-level officer of the Health Organizations and a representative of Service Provider in order to be effective (and all amendments so signed will be effective and binding on the Parties). No waiver of any provision of this Agreement will constitute a waiver of any other provisions, nor will any waiver constitute a continuing waiver, unless otherwise expressly provided therein.

25.15 Representative

The Health Organizations will provide Service Provider with a single point of contact to exercise on their behalf their rights and obligations under this Agreement and to receive notices in connection with this Agreement.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the Effective Date.

**PROVINCIAL HEALTH SERVICES
AUTHORITY**

By: 
Lynda Cranston
President and CEO

Date: March 28 / 13

IBM CANADA LIMITED

By: _____
Todd Lavieri
General Manager, GBS Canada

Date: _____

**VANCOUVER COASTAL HEALTH
AUTHORITY**

By: _____
Dr. David Ostrow
President and CEO

Date: _____

**PROVIDENCE HEALTH CARE
SOCIETY**

By: _____
Dianne Doyle
President and CEO

Date: _____

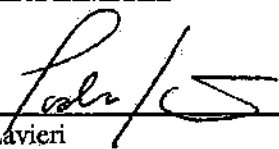
IN WITNESS WHEREOF, the Parties have executed this Agreement as of the Effective Date.

**PROVINCIAL HEALTH SERVICES
AUTHORITY**

By: _____
Lynda Cranston
President and CEO

Date: _____

IBM CANADA LIMITED

By:  _____
Todd Lavieri
General Manager, GBS Canada

Date: 3/28/13

**VANCOUVER COASTAL HEALTH
AUTHORITY**

By: _____
Dr. David Ostrow
President and CEO

Date: _____

**PROVIDENCE HEALTH CARE
SOCIETY**

By: _____
Dianne Doyle
President and CEO

Date: _____

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the Effective Date.

**PROVINCIAL HEALTH SERVICES
AUTHORITY**

By: _____
Lynda Cranston
President and CEO

Date: _____

IBM CANADA LIMITED

By: _____
Todd Lavieri
General Manager, GBS Canada

Date: _____

**VANCOUVER COASTAL HEALTH
AUTHORITY**

By: _____
Dr. David Ostrow
President and CEO

Date: March 28, 2013

**PROVIDENCE HEALTH CARE
SOCIETY**

By: _____
Dianne Doyle
President and CEO

Date: _____

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the Effective Date.

**PROVINCIAL HEALTH SERVICES
AUTHORITY**

By: _____
Lynda Cranston
President and CEO

Date: _____

IBM CANADA LIMITED

By: _____
Todd Lavieri
General Manager, GBS Canada

Date: _____

**VANCOUVER COASTAL HEALTH
AUTHORITY**

By: _____
Dr. David Ostrow
President and CEO

Date: _____

**PROVIDENCE HEALTH CARE
SOCIETY**

By: *Dianne Doyle*
Dianne Doyle
President and CEO

Date: MARCH 28/2013

**SCHEDULE A
DEFINITIONS**

"Affiliate" means, from time to time, as to any Person, any other Person that, at the relevant time, directly or indirectly controls, is controlled by, or is under common control with, such Person, whether through ownership of voting securities or otherwise. For this purpose, and without limiting the foregoing, any Person that holds, directly or indirectly, the beneficial or equitable ownership of 50% or more of the capital stock (or other ownership interests, if not a corporation) of such other Person will be deemed to control such other Person.

"Agreement" means this Services Agreement, the recitals hereto and all Schedules, attachments, appendices, addenda and other documents attached hereto or incorporated herein by reference, as amended from time-to-time in accordance with the provisions hereof.

"Applicable Laws" means all statutes, laws, by-laws, rules, binding policies, regulations, codes, ordinances, orders, restrictions and requirements of governmental, regulatory or other authorities having jurisdiction (which have the force of law), and all amendments thereto, at any time and from time to time in force including all laws and regulations relating to export of technology and the collection, storage, disclosure, dissemination, transfer and use of data, including privacy laws, and laws relating to reduction of reporting on the direct and indirect environmental impacts of the Services. In the case of Service Provider, Applicable Laws are laws that apply to Service Provider as a provider of services that are the same or similar to the Services.

"Business Day" means any day, which is not a Saturday, Sunday or statutory holiday in Vancouver, British Columbia.

"Business Hours" means 8:00 am to 6:00 pm Pacific Time on a Business Day.

"Canadian Entity" has the meaning set forth in Section 13.2(4).

"Change" means the addition, modification or removal of Services, Hardware, Software and/or documentation, under this Agreement, as approved pursuant to the Change Process.

"Change in Control" means: (a) any transaction or combination of transactions as a result of which either a Person or a group of Persons that customarily has acted in concert and that presently is in control of a Party ceases to be in control of such Party; (b) the sale, transfer, exchange or other disposition (including disposition in full or partial dissolution) of fifty percent (50%) or more of the beneficial ownership (as defined in Rule 13(d) of the *Securities Exchange Act* of 1934) of the voting power of a Party, or of the assets of such Party that constitute a substantial or material business segment of such Party; or (c) with respect to Service Provider, the unit, division or operating group of Service Provider that is responsible in providing the Services to the Health Organizations is sold, transferred or otherwise experiences a change in ownership or control.

"Change Order" means an agreed Change Proposal entered into by the Parties in accordance with this Agreement.

"Change Process" means the process for controlling Changes in a controlled manner enabling approved Changes with minimum disruption as more particularly set forth in Article 7 and Schedule E (*Change Process Forms*).

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“Change Proposal” means a Change proposal in the form set forth in Section 7.3 describing services or work that Service Provider proposes be performed.

“Change Request” means a Change request in the form set forth in Section 7.1 requesting the performance of services or work that is not being performed by Service Provider at a particular time or change to the Services, Hardware, Software and/or documentation, under this Agreement.

“Claims” means any and all claims, legal or other proceedings, suits, actions, causes of action, losses, damages, liabilities, costs and expenses (whether accrued, actual, contingent, latent or otherwise), and all reasonable legal fees suffered or incurred by a Person.

“Confidential Information” means Health Organization Confidential Information or Service Provider Confidential Information, as the case may be.

“Confidentiality Covenants” has the meaning set forth in Section 33 of Schedule L (*Privacy and Security*).

“Consents” means consents, approvals, acknowledgements, licenses, permissions and authorizations.

“Consequential Damage Cap” has the meaning set forth in Section 21.9(2).

“Contract Executive” means, as applicable the Health Organization Contract Executive or the Service Provider Contract Executive, and **“Contract Executives”** means both the Health Organization Contract Executive and the Service Provider Contract Executive.

“Contract Year” means a year during the Term that begins on the Effective Date or any anniversary thereof.

“Contracts” means any and all agreements, covenants, indentures, contracts, leases, deeds of trust, licences, options, undertakings, instruments or commitments, whether oral or written.

“Control” has the meaning set forth in Section 2 of Schedule L (*Privacy and Security*).

“Corporate Control” of a corporation or other entity is directly held by a Person where securities of the corporation or other entity to which are attached 50% or more of the votes that may be cast to elect directors or persons acting in a similar capacity of the corporation or other entity are directly held, other than by way of security only, by or for the benefit of such Person, and **“Corporately Controlled”** has corresponding meaning.

“Corporate Organizational Chart” has the meaning set forth in Section 13.2(3).

“CPIC” means Canadian Police Identification Centre.

“Critical Milestone At-Risk Amount” has the meaning set forth in Schedule D of this Agreement.

“Critical Milestones” means those milestones, activities, actions and the achievement of certain objectives under this Agreement which are identified as Critical Milestones pursuant to Schedule D of this Agreement, or elsewhere in or pursuant to this Agreement.

“Custody” means to have physical possession and immediate responsibility for the safe-keeping and preservation.

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“Data and Modified Data” has the meaning set forth in Section 12.9.

“Deliverable” means any item delivered to the Health Organizations under Schedule D of this Agreement, tangible or intangible, document, system, software or material which is produced, created, provided, delivered or made available by Service Provider to the Health Organizations and identified as a deliverable under this Agreement, including any source code or object code, specifications, technical information, data or reports.

“Derivative Works” means a work based on one or more pre-existing works, including any and all revisions, modifications, changes, translations, abridgements, compilations, condensations or expansions of the applicable underlying work or any form in which that work may be recast, transformed or adapted, together with all documentation and instructions relating to such revisions, modifications, changes, translations, abridgements, compilations, condensations or expansions, which, if prepared without authorization of the owner of the relevant Intellectual Property Rights in such pre-existing work, would constitute infringement of such Intellectual Property Rights.

“Direct Damage Cap” has the meaning set forth in Section 12.9 (3).

“Disclosing Party” means the Party that has disclosed Confidential Information to the other Party.

“Disclosure Order” has the meaning set forth in Section 13.2(2).

“Designated Affiliate” has the meaning set forth in Section 25.2.

“Dispute” means any Issue which is escalated for resolution in accordance with the Dispute Resolution Process.

“Dispute Resolution Process” has the meaning set forth in Section 24.1.

“Disputed Matters” has the meaning set forth in Section 21.6 (3).

“Effective Date” has the meaning set forth in the opening paragraph of the Agreement.

“Events of Default” means any of the events described in Section 18.4.

“Excluded Claims” has the meaning set forth in Section 12.9 (4).

“Executive Committee” has the meaning set forth in Schedule H (*Governance*).

“Expiration Date” means the close of business on the last day of the Term of this Agreement.

“External Confidentiality Covenants” has the meaning set forth in Section 34 of Schedule I (*Privacy and Security*).

“Fees” has the meaning set forth in Section 17.1.

“FOIPPA” means the *Freedom of Information and Protection of Privacy Act* (British Columbia).

“Force Majeure Event” means an act of God, act of governmental body or military authority, fire, explosion, flood, earthquake, epidemic, riot or civil disturbance, war, terrorism, sabotage, insurrections, blockades, embargoes, storms or other similar events that are beyond the reasonable control of the

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affected Party that interferes with, delays or prevents the performance by a Party of its obligations under this Agreement. Notwithstanding the foregoing, “Force Majeure Event” expressly excludes:

- (a) any event that Service Provider could have prevented if it had performed system testing required to be performed by the Service Provider pursuant to this Agreement or necessary to provide the Services;
- (b) any Service Provider strike, walkout or labour shortage; and/or
- (c) any non-performance of a Service Provider Affiliate or Subcontractor, regardless of cause (unless due to a Force Majeure Event).

“Foreign Disclosure Laws” means any laws, statutes, by-laws, treaty, directive, policy having the force of law, order, judgment, injunction, award, decree or other similar matter of any government, legislature (or similar body), court, governmental department, commission, board, bureau, agency, instrumentality, province, state, territory, association, county, municipality, city, town or other political or governmental jurisdiction, whether not or in the future constituted, outside of Canada, that may require, request, or otherwise demand access, use or disclosure of Personal Information, whether to intercept or obstruct terrorism, or for any other reason.

“Foreign Employed Individuals” means individuals who have entered into an employment agreement or other similar agreement for the provision of personal services thereunder, whether express or implied by law, with a Person that is not a Canadian Entity.

“GAAP” means Canadian Generally Accepted Accounting Principles, consistently applied.

“GHG Emissions” means green house gas emissions (calculated in terms of the CO₂ equivalent volume of the gas for non-CO₂ emissions) in tons.

“Governance Process” has the meaning set forth in Schedule H (*Governance*).

“Guiding Principles” has the meaning set forth in Section 1.1.

“Hardware” means the Health Organization Hardware and the Service Provider Hardware all other hardware that is required to provide the Services, together with all replacements therefor and all incidental and ancillary components, connecting equipment, peripherals, media, firmware and embedded software and instructions but, for greater certainty does not include equipment used to provide heating, lighting, ventilation, air conditioning or electrical power at premises owned or leased by the Health Organizations. The requirements for Hardware may be modified from time to time through the Change Process.

“Health Facilities” has the meaning set forth in Section 4.7.

“Health Organizations” means PHSA, VCH and PHC and such other health organizations in the Province of British Columbia from time to time that agree to bound by the terms and conditions of this Agreement and become a party hereto, and **“Health Organization”** means any one of them, as the context indicates, and for certainty, (a) a reference to the Health Organizations includes each applicable Health Organization and (b) where the extension of a reference to Health Organization to include one or more of the Health Organizations is otherwise reasonably implied by the context, the reference includes each applicable Health Organization.

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“Health Organization Confidential Information” means all records, data and information of the Health Organizations that is disclosed to Service Provider or any of its employees, contractors (including Subcontractors) or agents, whether in tangible, intangible or oral form, and whether in written form or readable by machine, as follows:

- (a) all Health Organization Data;
- (b) Health Organization Owned Materials;
- (c) all financial information, personnel information, business information, client information, reports, documents, correspondence, plans and specifications relating to the Health Organizations;
- (d) all technical information, materials, data, reports, programs, documentation, diagrams, developed by or for the Health Organizations;
- (e) any information that the Health Organizations or any of their user identifies to Service Provider as confidential by a stamp or other similar notice; and
- (f) all other records, data or information collected, received, stored or transmitted in any manner connected with the provision of Services hereunder which by its nature or the circumstances under which it is disclosed ought reasonably to be considered as confidential to the Health Organizations.

Health Organization Confidential Information will not include information that Service Provider can demonstrate was: (a) at the time of disclosure to Service Provider, in the public domain; (b) after disclosure to Service Provider, published or otherwise made a part of the public domain through no fault of Service Provider; (c) received, after disclosure by the Health Organizations to Service Provider, from a Third Party who had a lawful right to disclose such information to Service Provider free from any obligation of confidentiality; or (d) independently developed by Service Provider without reference to Health Organization Confidential Information or (e) disclosed by the Health Organizations to a Third Party without obligation of confidentiality. For purposes of this provision, information is in the public domain if it is generally known (through no fault of Service Provider) to Third Parties who are not subject to nondisclosure restrictions with respect to such information.

“Health Organization Contract Executive” has the meaning set forth in Schedule H (*Governance*).

“Health Organization Data” means, in or on any media or in any form: (a) all data that is in the possession of the Health Organizations, and all data concerning or indexing such data, all data relating to the operations and business of the Health Organizations and (b) all records, data, files, input materials, reports, forms and other items that may be received, computed, developed for the Health Organizations, used exclusively for the Health Organizations or stored by Service Provider or any of its employees, Subcontractors or agents from, on behalf of the Health Organizations.

“Health Organization Developed Deliverables” has the meaning set forth in Section 12.4.

“Health Organization Facilities” has the meaning set forth in Section 6.8.

“Health Organization Hardware” means all Hardware owned, leased or otherwise held by the Health Organizations that is used or required in connection with the performance of the Services, including the

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Hardware listed in Schedule U (*Health Organization Supplied Hardware*) and all replacements of and additions to such Hardware, but excluding the Service Provider Hardware.

“Health Organization Indemnified Materials” has the meaning set forth in Section 21.5.

“Health Organization Indemnified Parties” has the meaning set forth in Section 21.3.

“Health Organization Licensed Software” means the Third Party Software for which the Health Organizations have a license to use.

“Health Organization Owned Materials” has the meaning set forth in Section 12.1.

“Health Organization Personnel” means the personnel and independent contractors of the Health Organizations.

“Health Organization Policies and Procedures” means the policies and procedures set forth in Schedule Q (*Health Organization Policies and Procedures*), as such policies and procedures may be amended from time to time by the Health Organizations using the Change Process.

“Health Organization Proprietary Software” means the software owned by the Health Organizations, including object and source code versions, and any documentation and any Derivative Works or interfaces relating to the foregoing created by or on behalf of the Health Organizations from time to time, but excluding Third Party Software.

“HSSBC” has the meaning set forth in the opening paragraph of the Agreement.

“Indemnified Party” means either: (1) the Health Organizations, in the case of Claims, suits or proceedings subject to indemnification by Service Provider under Section 21.3, or (2) Service Provider, in the case of Claims, suits or proceedings subject to indemnification by the Health Organizations under Section 21.2.

“Indemnifying Party” means: (1) Service Provider, in the case of Claims, suits or proceedings subject to indemnification by Service Provider under Section 21.3, or (2) the Health Organizations, in the case of Claims, suits or proceedings subject to indemnification by the Health Organizations under Section 21.2.

“Intellectual Property Rights” means any and all copyrights, copyright registrations and applications therefore, moral rights, patents, patent applications, trade-marks, trade-mark registrations and applications thereof, industrial designs, industrial design applications, inventions, processes, trade secrets, integrated circuit topographies and integrated circuit topography applications and other industrial or intellectual property anywhere in the world, whether or not registered or registrable.

“Issue” means any issue or dispute arising under or relating to this Agreement, including those that relate to any of the following:

- (a) an alleged failure by either Party to perform its obligations under this Agreement;
- (b) a request for services or resources, where the Parties disagree whether such services or resources are within the scope of the Services (and therefore included in the Fees) or otherwise within the scope of this Agreement or the Change Process;

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- (c) adjustments to Fees or the prices proposed to be charged by Service Provider to the Health Organizations for any Services under this Agreement (including any services that the Health Organizations has requested be provided through the Change Process or the adjustments to Fees resulting from any modification or termination of any Services);
- (d) a disagreement as to the responsibilities either Party has under this Agreement;
- (e) any other disagreement or dispute related to the interpretation or construction of this Agreement; and/or
- (f) any other issue or dispute arising under this Agreement,

with the exception of the following:

- (g) any issue or dispute to the extent that it has been escalated to the Executive Committee for resolution and thereby deemed to be a Dispute; and/or
- (h) any issue or dispute to the extent that it has been resolved by injunctive or equitable relief as provided for in Section 24.2.

“IT” means information technology.

“Key Subcontractors” has the meaning set forth in Section 10.2.

“Local Court” has the meaning set forth in Section 25.12.

“maxIT” means MaxIT-VCS, an SAIC Company.

“OSS” has the meaning set forth in Section 12.10.

“On-site Dedicated Personnel” means Service Provider Personnel assigned to perform Service Provider’s obligations under this Agreement at the Health Organization Facilities.

“Out-of-Pocket Expenses” means the reasonable and actual out-of-pocket expenses incurred by a Party, but, for greater certainty, does not include such Party’s overhead cost or any administrative fee or other mark-up.

“Parties” means the Health Organizations and Service Provider, “Party” means any one of them and references to “a Party”, “other Party” or “either Party” (or similar constructions) will be deemed to refer to the Health Organizations, collectively, on the one hand, and Service Provider, on the other hand.

“Pass-Through Expenses” means Out-of-Pocket Expenses relating to reasonable travel and living expenses incurred by Service Provider Personnel in accordance with this Agreement (including, for greater certainty, the Health Organization Policies and Procedures) or as otherwise approved in writing by the Health Organizations.

“Permitted Purpose” has the meaning set forth in Schedule L (*Privacy and Security*).

“Permitted Service Locations” has the meaning set forth in Section 4.5.

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“Person” means any natural person, corporation, limited liability company, limited liability partnership, general partnership, limited partnership, trust, association, governmental organization or agency, political subdivision, body politic or other legal person or entity of any kind, legally constituted.

“Personal Information” means information about an identifiable individual as more particularly defined in FOIPPA made available by the Health Organizations to the Service Provider under this Agreement or that the Service Provider otherwise has access to as a result of the Services provided under this Agreement.

“PHSA” has the meaning set forth in the opening paragraph of the Agreement.

“Principally Dedicated” has the meaning set forth in Section 9.1(4).

“Privacy Laws” means all federal, provincial and territorial legislation, regulations, and decisions, as amended or supplemented from time to time, now in force or that may in the future come into force in Canada governing the protection of personal information in the private and public sector, and in the case of the Service Provider applicable to Service Provider or in the case of the Health Organizations applicable to the Health Organizations in relation to the Services or obligations under this Agreement, and includes the *Freedom of Information and Protection of Privacy Act* (FIPPA), *Personal Information Protection Act* (British Columbia).

“Receiving Party” means the Party that has received Confidential Information from the other Party.

“Replacement Service Provider” has the meaning set forth in Section 19.1(1).

“Residuals” means general knowledge, skill and experience, and any ideas, concepts, or know-how, of a technical nature that are within the scope of the Recipient’s information technology operations and are used, acquired, or developed in the course of providing or receiving the Services.

“Retained Records” has the meaning set forth in Section 16.1.

“RFP” has the meaning set forth in Recital B.

“RFPQ” has the meaning set forth in Recital A.

“Sales Taxes” means commodity, value-add and sales taxes applicable by law to, and payable by the Health Organizations on, the Services and any goods provided hereunder, but excludes any taxes on the income, personnel, property or other assets which are used by Service Provider in connection with the Services.

“Services” has the meaning set forth in Section 4.1.

“Service Provider” means IBM Canada Limited, and includes its successors or assigns as permitted under Section 25.2 of the Agreement.

“Service Background Materials” has the meaning set forth in Section 12.2.

“Service Provider Confidential Information” means records, data, and information that is either marked or identified as “confidential” or by its nature or the circumstances under which it is disclosed ought reasonably to be considered as confidential to Service Provider, that is obtained by the Health

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Organizations from Service Provider or its Affiliates or Subcontractors in connection with this Agreement, including, without limitation

- (a) all statistical information, personnel information, financial information, operational information and business plans relating to Service Provider;
- (b) all technical information, materials, data, reports, programs, documentation, diagrams, not developed by Service Provider specifically for the Health Organizations (for greater certainty, Deliverables are not Service Provider Confidential Information); and
- (c) Service Provider Background Materials, Service Provider-Owned Materials and Service Provider Developed Materials (other than as set forth in (b) above).

Service Provider Confidential Information will not include any Health Organization Confidential Information or information that the Health Organizations can demonstrate was: (a) at the time of disclosure to the Health Organizations, in the public domain; (b) after disclosure to the Health Organizations, published or otherwise made a part of the public domain through no fault of the Health Organizations; (c) in the possession of the Health Organizations at the time of disclosure to it and the Health Organizations was not then under an obligation of confidentiality with respect thereto; (d) received, after disclosure by Service Provider to the Health Organizations, from a Third Party who had a lawful right to disclose such information to the Health Organizations free from any obligation of confidentiality; (e) independently developed by the Health Organizations without reference to Service Provider Confidential Information or (f) disclosed by Service Provider to a Third Party without obligation of confidentiality. For purposes of this provision, information is in the public domain if it is generally known (through no fault of the Health Organizations) to Third Parties that are not subject to nondisclosure restrictions with respect to such information.

“Service Provider Contract Executive” has the meaning set forth in Schedule H (*Governance*).

“Service Provider Developed Deliverables” has the meaning set forth in Section 12.6.

“Service Provider Hardware” means any equipment owned, leased or otherwise held by Service Provider that is used by Service Provider in providing the Services, including the Hardware listed in Schedule V (*Service Provider Supplied Hardware*), but excluding the Health Organization Hardware.

“Service Provider Indemnified Materials” has the meaning set forth in Section 21.4.

“Service Provider Indemnified Parties” has the meaning set forth in Section 21.2.

“Service Provider Intellectual Property” has the meaning set forth in Section 21.4.

“Service Provider Key Personnel” means the personnel of Service Provider and its Subcontractors who are so designated in Schedule BB (*Service Provider Key Personnel*), as amended from time to time in accordance with Article 9.

“Service Provider Personnel” means Service Provider Key Personnel, and all other personnel assigned by Service Provider or its Affiliates to perform Service Provider’s obligations under this Agreement including, for greater certainty, independent contractors of the Service Provider or Affiliates. For clarification, where they Service Provider will cause Service Provider Personnel to provide Services, carry out a task or an obligation, or otherwise, as the case may be, the Subcontractor will cause its

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personnel and independent contractors to provide such Services, carry out such task or such obligation, or otherwise, as the case may be.

“Service Provider Proposal” has the meaning set forth in Recital C.

“Service Provider Service Delivery Managers” has the meaning set forth in Schedule H (*Governance*).

“Service Provider Taxes” has the meaning set forth in Section 17.2(1).

“Service Rates” means the hourly service rates set forth in Schedule DD (*Fees*) as such rates may be adjusted.

“Services” has the meaning set forth in Section 4.1.

“Software” means all of the software listed in the Schedules, and other incidental or related software used in connection therewith, as such software may be modified, supplemented or replaced through the Change Process.

“Subcontractor” means, subject to the terms of Sections 10.1 and 16.8, any Person other than Service Provider or Service Provider Personnel, including any consultant, that provides Services to the Health Organizations pursuant to a Contract with, or on behalf of, Service Provider. Reference to Subcontractor in this Agreement includes Subcontractor personnel as applicable.

“Tax(es)” means goods, services, sales, harmonized sales, commodity, use, excise, value-added, services, withholding, consumption, employment, capital, access, payroll (including other employment-related taxes and source deductions) and other taxes.

“Term” means the period of time from the Effective Date until the termination of this Agreement.

“Termination Date” means 11:59 p.m., Vancouver time on the specified date of termination, as specified in a Termination Notice.

“Termination Fee” has the meaning set forth in Schedule N (Termination Fees).

“Termination Notice” means a written notice of termination as required under this Agreement.

“Third Party” means a Person or entity other than the Parties, their Affiliates or any director, employee or agent of any of the Parties or their Affiliates.

“Third Party Software” means any software that is subject to a license from a third party Person or an Affiliate of Service Provider; for the purposes of clarity, Third Party Software excludes Health Organization Owned Materials.

“Transition Notice Date” means (a) in the case of expiry of this Agreement, the date designated by the Health Organizations in connection with expiration of the Term and, (b) in the case of termination of this Agreement, the date on which Termination Notice is received by the non-terminating Party.

“Transition Out Period” has the meaning set forth in Section 19.2.

“Transition Out Services” means the termination assistance services as more particularly described in Article 19.

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“Travel and Living Expenses Guidelines” means the document attached at the end of Schedule Q.

SCHEDULE B

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SCHEDULE C

Intentionally Deleted

SCHEDULE E
CHANGE PROCESS FORMS
to the
SERVICES AGREEMENT

Change Request Form				
Identification – Joint Project Management Office				
Change ID		Short description		
Priority	Emergency High Medium Low	Date raised	Status	Open Approved for analysis Approved for implementation Rejected / Deferred/ Closed
Raised by / Stakeholder change ID				

Change Request Assessment (Health Organizations)			
Detailed description			
Requested Response Date		Health Organizations' requirements defined	Yes / No
Privacy Related Information Associated?	Yes / No	Confidential Information Associated?	Yes / No
Assigned to		Assigned date	

Change Request Analysis – Service Provider Delivery Team			
* Impact analysis			
Solutions considered			
Effort estimate (if requirements not defined, estimate to define requirements)		Cost estimate	
Potential start date for Implementation		Potential target date	
Impact level		Resources	
Estimates validated on		Estimates validated by	
Analyzed by			
PIA Required?	Yes / No	PIA completed by	

* (if requirements still to be defined, indicate if Change Request will be used to investigate Health Organizations' requirements)

Impact on project plans, Schedules and/or Agreements – Service Provider Delivery Team			
Incorporate into Project Plan		Incorporated into Project Plan by	
Modifications to other plans (eg. roadmap)			
Schedule(s) Modified		Incorporated into Schedule(s) by	
Agreement Terms amended			
Completion criteria			
Change order ID(s)			
Change Request Commitment – Health Organization Project Executive			
Approved on		Approved by	
Closure Data – Joint Project Management Office			
Date closed		Date completed	
Change Request History			
Date	Comments		

Change Proposal Form			
Change Proposal ID			
Change order ID		Short description	
Date			
Status	Open / Investigation Purposes Only/ Proposal preparation In progress / Expired / Completed		

Associated Change Requests	
IDs	Short description

Change Proposal Description
1. Background: <i>[Insert sufficient background information to present a roadmap for the Change (in particular, the amendments below).</i> 2. Amendments to the Agreement or Schedule(s) (if any): (a) Description of the Services: <i>[Insert changes to the Services (including any additions or removal to, or modifications of the Services, Dedicated Hardware or Dedicated Software)]</i> (b) Changes to SLAs: <i>[Insert additions to, removal of, or changes to any SLAs]</i> (c) Service Provider Responsibilities: <i>[Insert detailed description of tasks and responsibilities of the Service Provider including: date of commencement of Services, term or duration of Services to be provided, any specific requirements, specifications). For new Services, categories of personnel required and associated fees if not currently set forth in Schedule DD (Fees)]</i> (d) Service Provider Deliverables: <i>[Insert Interim Milestones and Critical Deliverables (if any), specifications and acceptance criteria). The details in items (c) and (d) must be in the form attached as Appendix 1 to this Change Order Form]</i> (e) HO Dependencies: <i>[Insert specific HO Dependencies, the date that the HO Dependency is required, specific deliverables comprising the HO Dependency, HO resources, if applicable, other]</i> (f) If applicable, is the asset or third party service "Critical" to the Health Organizations as defined in the MSA: Y/N (g) Fees: <i>[Insert details of any and all Fees associated with the Change Proposal and any and all possible financial impacts on the Agreement (including any Schedules thereto)]</i> The Parties acknowledge and agree that the Fees set out in this Change Proposal shall be the only Fees payable by the Health Organizations to the Service Provider in connection with the subject matter of the Change. (h) Effective Date of the Change: <i>[Insert date that the Change will be effective.]</i> (i) Threat and Risk Assessment and Privacy Impact Assessment: <i>[Insert whether a TRA or PIA is required and if so, when it was carried out and what, if any, privacy and security related changes are contemplated in the Change]</i>

Order.]

Change Proposal Review Process			
Reviewed by	Name	Date Reviewed	Signature
Health Organizations			
	[Insert name/Title of HO Representative]		
	[Insert name/Title of Representative]		
	[Insert name/Title of Representative]		
	[Insert name/Title of Representative]		
Service Provider			
	[Insert name/Title of Representative]		
	[Insert name/Title of Representative]		
	[Insert name/Title of Representative]		

Any and all representatives required to review and approve the Change Proposal to be listed above for the Health Organizations and the Service Provider. The signature of Party's representative (above) on any Change Proposal Form does not create a binding legal obligation on the Parties. The Review Process signatures only indicate that a particular representative required to review the final Change Proposal has reviewed the Change Proposal and is in agreement with the Change Proposal. Once all applicable representatives listed above have approved the Change Proposal Form, then the Change Proposal Form may be converted into a Change Order (using the Change Order Form) for final agreement an signature by an authorized signatory of the HOs.

CHANGE PROPOSAL
APPENDIX

Work Package	Steps and Tasks	Service Provider Resources	H/O Dependencies	Completion Criteria/Accep- tance Criteria	Milestone nr	
					Deliverable/ Required Date	Milestone Deliverable Price

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Change Order Form			
Change Order ID			
Change order ID		Short description	
Date			
Status	Open / Investigation Purposes Only/ Proposal preparation In progress / Expired / Completed		

Associated Change Requests	
IDs	Short description

Change Order
1. Background: <i>[Insert sufficient background information to present a roadmap for the Change (in particular, the amendments below).</i> 2. Amendments to the Agreement or Schedule(s) (if any): (a) Description of the Services: <i>[Insert changes to the Services (including any additions or removal to, or modifications of the Services, Dedicated Hardware or Dedicated Software)]</i> (b) Changes to SLAs: <i>[Insert additions to, removal of, or changes to any SLAs]</i> (c) Service Provider Responsibilities: <i>[Insert detailed description of tasks and responsibilities of the Service Provider including, date of commencement of Services, term or duration of Services to be provided, any specific requirements, specifications). For new Services, categories of personnel required and associated fees if not currently set forth in Schedule DD (Fees)]</i> (d) Service Provider Deliverables: <i>[Insert Interim Milestones and Critical Deliverables (if any), specifications and acceptance criteria). The details in items (c) and (d) must be in the form attached as Appendix 1 to this Change Order Form]</i> (e) HO Dependencies: <i>[Insert specific HO Dependencies, the date that the HO Dependency is required, specific deliverables comprising the HO Dependency, HO resources, if applicable, other]</i> (f) If applicable, is the asset or third party service "Critical" to the Health Organizations as defined in the MSA: Y/N (g) Fees: <i>[Insert details of any and all fees associated with the Change Order and any and all possible financial impacts on the Services Agreement (including any Schedules thereto)]</i> The Parties acknowledge and agree that the Fees set out in this Change Order shall be the only Fees payable by the Health Organizations to the Service Provider in connection with the subject matter of the Change. (h) Effective Date of the Change: <i>[Insert date that the Change will be effective.]</i> (i) Threat and Risk Assessment and Privacy Impact Assessment: <i>[Insert whether a TRA or PIA is required and if so, when it was carried out and what, if any, privacy and security related changes are contemplated in the Change Order.]</i>

Approvals			
Approved by		Date approved	Signature
Health Organization			
Approved by Service Provider	[Insert name/Title of SP Representative]		

The Parties acknowledge and agree that this Change Order shall be deemed to be duly executed by the Parties on the latest signature date identified above. This Change Order may be executed in several counterparts, each of which will be deemed to be an original. Such counterparts together will constitute one and the same instrument, notwithstanding that all of the Parties are not signatories to the original or the same counterpart.

SCHEDULE F

Intentionally Deleted

SCHEDULE G

Intentionally Deleted

SCHEDULE H GOVERNANCE

to the

SERVICES AGREEMENT

SCHEDULE H
GOVERNANCE

1. GOVERNANCE AND RELATIONSHIP MANAGEMENT OVERVIEW

1.1 Governance and Relationship Management. This Schedule H sets forth the roles and responsibilities of the Parties for matters relating to governance and relationship management and, in particular, the governance and relationship management functions and activities (“**Governance and Relationship Management**”) to be undertaken by both Parties to support the effective and efficient delivery, management and oversight of the Services under the Agreement, including the continuing evolution of the Services to meet the Health Organizations’ changing requirements, technological developments and other changes, and the transition in and transition out of the Services at the outset and at the termination of the Agreement.

Communications between the Health Organizations and Service Provider shall, wherever possible and practicable, be face to face. Video or audio conferences will be the second choice of communication medium. Where video or audio conferences are not practical, e-mail will be the fall-back communication medium.

All formal meetings, whether face to face or video or audio conferences, shall:

- (a) have an agenda, prepared by the Health Organizations, that sets out clear details concerning the location and/or medium to be used for the meeting; the date and timings of the meeting; the topics to be covered and expected outcome for each topic; the owners of each topic; and any pre-work to be undertaken by topic owners or attendees prior to the meeting;
- (b) have a chairperson and note taker, who shall be specified by the Health Organizations in their sole discretion; and
- (c) be documented with meeting minutes by the note taker, and such meeting minutes shall include high-level summaries of key discussion points and future actions with timings and persons responsible for the actions.

Prior to the end of each meeting the Health Organizations shall identify the person who shall be responsible for organizing the next meeting. After the meeting the meeting minutes shall be distributed to the attendees, any missing attendees and any persons with actions to be taken.

1.2 Purpose. This Schedule H sets forth the overarching governance framework for the effective implementation of the Agreement, which will be facilitated by the Health Organizations and the Service Provider through joint direction and control and joint management through defined areas of responsibility and authority. The intent of the governance framework is to facilitate:

- (a) the adherence to the Guiding Principles;
- (b) the effective implementation of the Agreement; and
- (c) the development of productive organizational relationships, including relationship management, through processes that support “best practice” joint governance.

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1.3 Objectives of the Governance Framework. The primary objectives of the governance framework are to continually ensure that:

- (a) the value proposition derived from the Agreement is consistent with the expectations of the Health Organizations and the Service Provider;
- (b) the strategies and plans of the Health Organizations and the Service Provider, to the extent that such strategies and plans will have an impact on the Agreement, are understood by all and aligned;
- (c) effective contract and service management processes exist, including, change, problem, and crisis management, request for service and contract amendment; and
- (d) an effective relationship management process exists including communication, decision making, reporting, measurement, issue resolution and dispute resolutions processes.

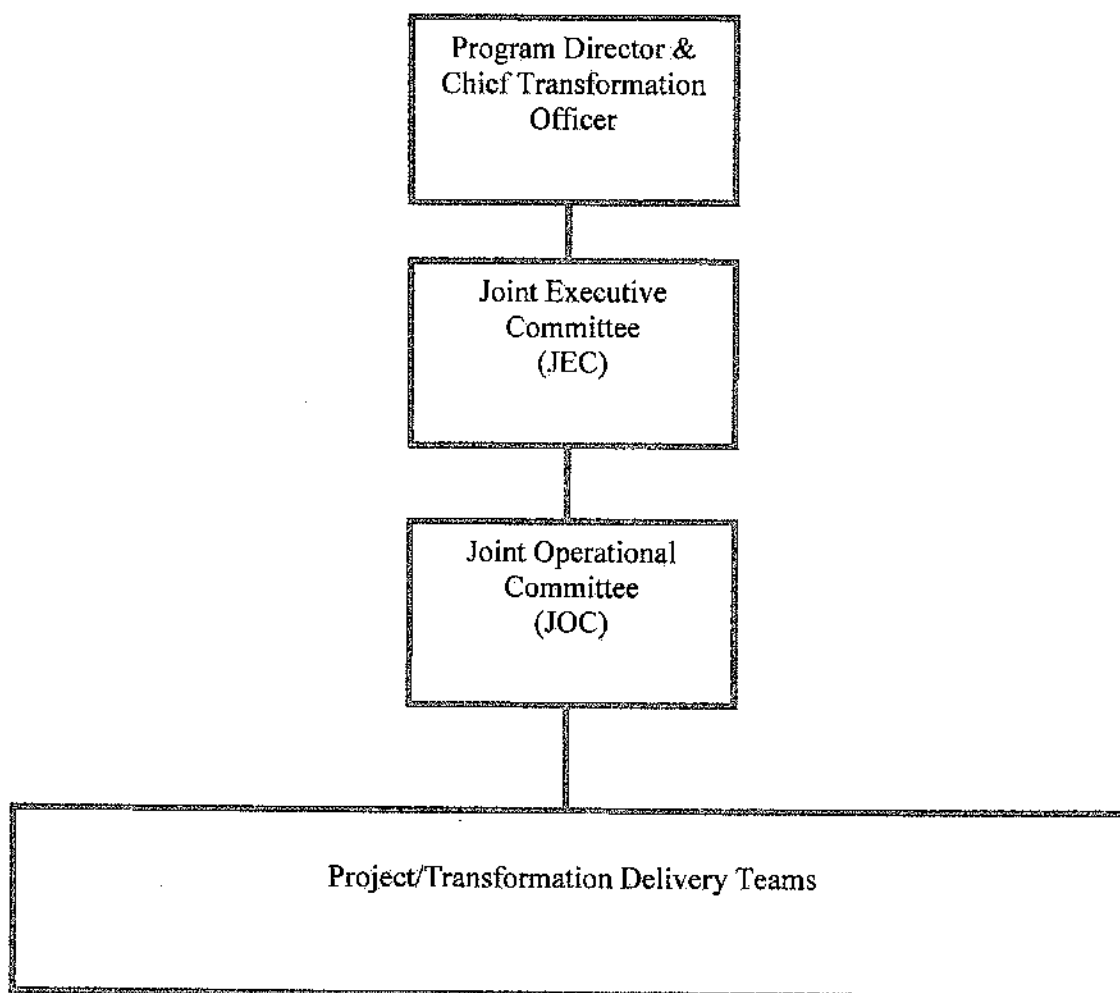
1.4 Guiding Principles. The Parties agree to adhere to the following guiding principles:

- (a) proactively identify sources of disagreement and discord and take timely action before they become matters of dispute;
- (b) endeavor to be sensitive to activities that may be of concern to the others, providing early notice that it wishes to pursue such activity and will engage in consultation about such activity;
- (c) where possible, resolve issues through a process of cooperative and amicable negotiations;
- (d) ensure that the governance framework enables the Health Organizations and Service Provider to:
 - (i) understand and execute their responsibilities and accountabilities under the Agreement;
 - (ii) subject to the specific rights of a Party set out in the Agreement, work co-operatively together over the entire Term of the Agreement;
 - (iii) subject to the specific rights of a Party set out in the Agreement, make decisions guided by what is best for the on-going management and delivery of high quality Services;
 - (iv) subject to the specific restrictions set out in the Agreement, have access to the information necessary to fulfill their obligations under the Agreement;
 - (v) subject to the specific rights of a Party set out in the Agreement, develop and maintain high quality relationships;
 - (vi) effectively identify and resolve difficult issues;
 - (vii) accommodate the lifecycle of the Agreement;

- (e) allow the Health Organizations and Service Provider to acknowledge and act in ways that are consistent with their complex and varied roles and responsibilities pursuant to the Agreements;
- (f) clarify and facilitate ongoing relationships with the Health Organizations and stakeholders;
- (g) ensure that the Health Organizations' and Service Provider's detailed knowledge about the Services is retained; and
- (h) end a relationship responsibly when appropriate.

2. GOVERNANCE STRUCTURE

The overall governance structure is depicted as follows:



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1. Project / Transformation Delivery teams will be identified as part of the Schedule Refinement process and listed in the appropriate project documentation (i.e. project charter) prior to the start of the Design and Build Phase set out in Schedule D1(a)(ii).
2. The Adoption Committee, Physician Advisory Group (PAG) and Clinician Advisory Group (CAG) will be finalized during the process set out in Schedule D1(a)(i) and prior to the start of the Design and Build Phase set out in Schedule D1(a)(ii).

2.1 Joint Executive Committee

(a) *Appointment*

The Health Organizations and Service Provider shall each designate senior executives to comprise a joint executive committee (the “**Joint Executive Committee**”). The Health Organizations and Service Provider may change their respective designees from time to time by giving written notice to the other of such change. The senior executives from the Health Organizations shall include the Executive Vice President and Chief Administrative Officer, PHSA, the Program Director and Chief Transformation Officer, VCH, PHSA and PHC, the VP of Clinical and Systems Transformation, VCH and PHC, the Chief Information Officer, VCH, PHSA and PHC and the respective HO CMIO’s. The senior executives of Service Provider shall include the senior executive with profit and loss responsibility for Service Provider’s Canadian Global Business Services operations for BC Public Sector (and to whom the Service Provider Contract Executive reports).

(b) *Decisions*

Each member of the Joint Executive Committee shall be vested by the Health Organizations and Service Provider, as applicable, with all necessary authority to act and make binding decisions in connection with all aspects of the Agreement.

(c) *Meetings*

The Joint Executive Committee shall meet as needed but no less frequently than monthly. All meetings shall be held at times and locations jointly agreed by the Health Organizations and Service Provider. In order to hold a meeting of the Joint Executive Committee, at least two members from the Health Organizations and two members from Service Provider must be present in person or by telephone.

Prior to each meeting of the Joint Executive Committee, the Health Organizations shall prepare and circulate the meeting agenda. Service Provider shall make available its senior management personnel to answer questions from the Health Organizations’ senior management personnel regarding the agenda items for such meeting. Further, either the Health Organizations or Service Provider may invite industry leaders or other relevant third parties, as approved by the Health Organizations, to participate in such meetings to facilitate information exchange and increase the value of the strategies discussed.

(d) *Roles and Responsibilities*

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The Joint Executive Committee shall discuss high level strategic and operational issues relating to the Agreement and shall have the following roles and responsibilities, in addition to any other roles and responsibilities set forth in the Agreement:

- (i) set overall direction for the relationship, based on the Guiding Principles and the Health Organizations' business and IMITS strategy;
- (ii) review and approve the Transformation Roadmap;
- (iii) review overall service performance on a quarterly basis, or more often as required in the event of unresolved Issues;
- (iv) review the relevant reports;
- (v) address relevant high level matters, strategies and directions appropriate for executive level discussion; and
- (vi) address and resolve Disputes, in accordance with Schedule P (Dispute Resolution Process) or Changes that have been escalated to the Joint Executive Committee.

In addition to the roles and responsibilities set forth above, the Joint Executive Committee shall be responsible for providing guidance to the Joint Operational Committee (defined below) on overall direction.

2.2 Joint Operational Committee

(a) *Appointment*

The Health Organizations and Service Provider shall each designate a number of personnel, including each of the respective Contract Executives, to comprise a joint operational committee (the "**Joint Operational Committee**"). The Health Organizations or Service Provider may change their designees, other than the Contract Executives from time to time by giving written notice to the other of such change. The Health Organizations and Service Provider shall assign individuals to the Joint Operational Committee who possess the appropriate skills, responsibilities and authorities to ensure the effective functioning of the committee.

(b) *Decisions*

Each member of the Joint Operational Committee shall be vested by the Health Organizations and Service Provider, as applicable, with all necessary authority to act in connection with all roles and responsibilities set out in Section 2.2(d) below.

(c) *Meetings*

The Joint Operational Committee shall meet as needed but no less frequently than monthly. All meetings shall be held at times and locations jointly agreed by the Health Organizations and Service Provider. In order to hold a meeting of the Joint Operational Committee, at least three (3) members from the Health Organizations and two (2)

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members from Service Provider must be present in person or by telephone, or as otherwise defined in its terms of reference as updated from time to time.

Prior to each meeting of the Joint Operational Committee, the Health Organizations shall prepare and circulate the meeting agenda.

(d) *Roles and Responsibilities*

The Joint Operational Committee shall have the following roles and responsibilities, in addition to any other roles and responsibilities set forth in the Agreement:

- (i) discuss Service Provider's overall compliance for all Services as set forth in the Agreement;
- (ii) address the performance of each Service Schedule and any Issues or other difficulties experienced by the Parties;
- (iii) review Health Organization satisfaction measures;
- (iv) review all financial arrangements, including any questions with respect to the invoices submitted by Service Provider;
- (v) review the Health Organizations' satisfaction with the Service Provider personnel, including the Service Provider Key Personnel;
- (vi) plan for new Services and removal of Services;
- (vii) define and recommend innovation and improvement opportunities for the Services and how such ideas and strategies would effectively impact the Services. The Health Organizations and Service Provider shall agree on whether any given opportunity is a "major" opportunity that must be referred to the Joint Executive Committee or a "minor" opportunity that the Joint Operational Committee has the authority to approve;
- (viii) address Issues, in accordance with Schedule P (Dispute Resolution Procedures), that have been escalated to the Joint Operational Committee;
- (ix) review and approve Change Requests that have been escalated to the Joint Operational Committee;
- (x) discuss status of planned initiatives and discussing initiatives that may impact Interim Milestones or Critical Deliverables;
- (xi) review and address any issues related to interdependencies across multiple service providers;
- (xii) review the relevant reports;
- (xiii) provide input into the dashboard report, prepared for the Joint Executive Committee;

- (xiv) escalate any unresolved Issues to the Joint Executive Committee for resolution; and
- (xv) address such other matters as the Health Organizations or Service Provider may bring to the other.

2.3 Project / Transformation Delivery Teams

(a) *Appointment*

There shall be a project/transformation delivery team constituted for each of the following Service Schedules:

- Schedule D1(a)(i) - Strategy & Verification
- Schedule D1(a)(ii) - Enterprise Build
- Schedule D3(a) - Implementation Wave 1
- Schedule D3(b) - Implementation Wave 2
- Schedule D3(c) - Implementation Wave 3
- Schedule D3(d) - Optimization

(each a “**Project / Transformation Delivery Team**”).

The Project/Transformation Delivery Teams shall be responsible for overseeing the specific activities and deliverables identified in each of the Service Schedules identified above. The Health Organizations and Service Provider may change its designees from time to time by giving written notice to the other of such change. The Health Organizations and Service shall assign individuals to each of the Project/Transformation Delivery Teams who possess the appropriate skills, responsibilities and authorities to ensure the effective functioning of their respective team.

Additional Health Organization personnel may attend the Project/Transformation Delivery Team meetings at the Health Organizations’ sole discretion. Additional Service Provider personnel may attend such meetings as agreed in advance by the Parties.

(b) *Decisions*

Each member of each Project/Transformation Delivery Team shall be vested by the Health Organizations and Service Provider, as applicable, with all necessary authority to act in connection with all roles and responsibilities set out in Section 2.3(d) below.

(c) *Meetings*

Each Project/Transformation Delivery Team shall meet as needed but no less frequently than weekly. All meetings shall be held at times and locations jointly agreed by the Parties. In order to hold a meeting of a Project/Transformation Delivery Team, one (1) member from the Health Organizations and one (1) member from the Service Provider must either be present in person or represented by proxy. Prior to each meeting of a

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Project/Transformation Delivery Team, the Health Organizations shall prepare and circulate the meeting agenda.

(d) *Roles and Responsibilities*

Each Project/Transformation Delivery Team shall have the following roles and responsibilities with respect to the applicable Service Schedule, in addition to any other roles and responsibilities set forth in the Agreement:

- (i) review and address Services-related incidents, problems, issues and Changes;
- (ii) review and approve root cause analysis of any previous problems or Issues;
- (iii) review Service Provider's compliance with the Services measures;
- (iv) review the relevant reports, as identified in such Service Schedule;
- (v) provide input with respect to such Service Schedule into the Transformation Roadmap;
- (vi) address such other matters as the Health Organizations and Service Provider may bring to the other;
- (vii) escalate any unresolved Issues and Disputes, as provided for in Schedule P (Dispute Resolution Procedures), to the Joint Operational Committee; and
- (viii) review and plan for future Changes.

2.4 *Committees*

(a) *Adoption Committee*

The Health Organizations and Service Provider intend to include an adoption committee (the "**Adoption Committee**") in the governance model during the Strategy and Verification Phase and prior to the commencement of Schedule D1(a)(ii)

(b) *Roles and Responsibilities*

It is intended that the Adoption Committee shall have the following responsibilities with respect to the applicable Service Schedule, in addition to any other responsibilities that may be set forth in the Agreement:

- (i) for each Critical Deliverable, review the Adoption Strategy (as up-dated or amended by agreement of the Parties in writing) and confirm the acceptance or rejection of such Critical Deliverable; and

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- (ii) if a Critical Deliverable is rejected then the Service Provider will prepare and deliver to the Health Organizations, an escalation and mitigation strategy in accordance with Section 9 of Schedule D2, which the Adoption Committee will review and approve or reject.

Notwithstanding the foregoing, nothing contained in this Section shall amend the Deliverables review and approval process set forth in Schedule D.

3. PERSONNEL AND ROLES

The operational levels of governance are set forth in the Services Schedules to the Agreement.

3.1 Contract Executives

The Health Organizations and Service Provider shall each designate an individual (for the Health Organizations, the “**Health Organization Contract Executive**”, and for Service Provider, the “**Service Provider Contract Executive**”), who shall be each Party’s primary point of contact for all matters relating to the Agreement throughout the Term. The Health Organizations may change the Health Organization Contract Executive from time to time by providing prior written notice to Service Provider of such designation. The Service Provider Contract Executive is subject to the Service Provider Key Personnel provisions under the Agreement.

The Service Provider Contract Executive shall be:

- (a) the primary relationship manager between Service Provider and the Health Organizations;
- (b) empowered by Service Provider to make commitments of resources and financial decisions to address Service Provider’s obligations to the Health Organizations under the Agreement without seeking further approvals;
- (c) knowledgeable about the Services and each of Service Provider’s and its Subcontractors’ products and services;
- (d) experienced at managing the delivery of services which are comparable in size and scope to the Services; and
- (e) otherwise acceptable to the Health Organizations in accordance with the terms of the Agreement.

The Service Provider Contract Executive shall have overall responsibility for directing all of Service Provider’s activities hereunder and shall be vested by Service Provider with all necessary authority to act for Service Provider in connection with all aspects of this Agreement. Service Provider and Subcontractor staff shall be managed in the performance of their duties by the Service Provider Contract Executive.

The Health Organizations will define, and convey to the Service Provider, the role and responsibilities to be performed by the Health Organization Contract Executive under the Agreement.

The Health Organizations and Service Provider shall agree on performance objectives for the Service Provider Contract Executive for the coming year (the “**Contract Executive Performance Objectives**”)

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and such objectives shall be reviewed and approved by the Joint Executive Committee. The Health Organizations shall annually provide a written evaluation of the Service Provider Contract Executive's performance against the Contract Executive Performance Objectives for the previous year. Service Provider shall consider the Health Organizations' written evaluation of the Service Provider Contract Executive's performance when determining the Service Provider Contract Executive's salary and variable compensation.

3.2 Contract Managers

The Health Organizations and Service Provider shall each designate an individual (for the Health Organizations, the "**Health Organization Contract Manager**", and for Service Provider, the "**Service Provider Contract Manager**") who shall be their primary point of contact for all matters relating to the contractual relationship between the Health Organizations and Service Provider.

The Service Provider Contract Manager shall be separate and independent from the Service Provider sales and delivery functions and shall:

- (a) facilitate all contract activities from the execution of the Agreement through ongoing operations;
- (b) monitor and report to the Health Organizations on Service Provider compliance with the terms and conditions of the Agreement and provide recommendations to the Parties to resolve Issues related to Service Provider's non-compliance; and
- (c) be the single point of contact with the Health Organizations for any contractual questions, discussions or Issues relating to the Agreement.

The Health Organizations will define, and convey to the Service Provider, the role and responsibilities to be performed by the Health Organization Contract Manager under the Agreement.

4. GOVERNANCE AND RELATIONSHIP MANAGEMENT PROCESSES

4.1 Service Descriptions and Roles & Responsibilities

The detailed processes underlying governance and relationship management and the underlying roles and responsibilities associated with the governance and relationship management Services shall be defined by the Health Organizations and Service Provider within six (6) weeks of the date of the commencement of Services under Schedule DI(a)(i) - Strategy & Verification, shall be based on this Schedule H and shall be documented in writing by the Parties .

4.2 Exclusions

The following items are specifically excluded from this Schedule, and shall be the responsibility of the Health Organizations:

- (a) human resources management of Health Organization staff; and
- (b) the activities listed in Section 10.2 of the Agreement.

4.3 Meeting Protocols.

The Parties acknowledge and agree that, to the extent possible, all governance meetings should follow the following standard business practices for meeting etiquette:

- (a) to the extent possible, the governance committee will establish a pre-determined schedule of meeting dates, which will be communicated to the members by the chair;
- (b) any unscheduled meeting dates, and changes to any scheduled or unscheduled meeting dates, will be communicated in writing (or by email) by the chair to the committee members at least five Business Days in advance, where possible, unless the five Business Day notice period is waived by all members of the committee, and except for unexpected or emergency situations that do not permit such five Business Days notice period to be given; meetings shall start at the stated time on the circulated agenda;
- (c) meetings shall start at the stated time on the circulated agenda;
- (d) meeting invitees will indicate their ability to attend the meeting at least 3 Business Days prior to the meeting and, if unable to attend, to send an appropriate delegate with decision-making authority;
- (e) where attendance of committee members is mandatory, meeting notices will indicate such mandatory attendance;
- (f) any member of a committee may call a meeting of such member's committee outside of regularly scheduled meetings by sending a request to the chair of such committee that the meeting be called, and stating the purpose of the meeting and the details of the matters to be considered or discussed at the meeting;
- (g) meeting agendas and meeting materials will be established by the committee chair and will be circulated by the chair to the committee members with as much prior notice as is reasonably possible, but in any event not less than 24 hours before any meeting;
- (h) unless the meeting notice indicates that attendance must be in-person, to the extent possible the meetings of committees will be held in-person, provided that the members of a committee may hold their meetings by way of video conference, telephone conference or any other communication facility where all persons participating in the meeting can hear each other and make themselves heard; and
- (i) minutes of all meetings of the committee will be taken by the chair of the committee or an individual appointed by the chair and circulated to all members of the committee as soon as practicable following the conclusion of a meeting but in any event, within five Business Days after the meeting. The members of the committee will have five Business Days to provide their comments on the minutes or object to the minutes by notifying the chair of such comments or objection, in writing. Where no comments or objection is received within the 5 business Day period, the minutes will be deemed to be accepted. The chair will circulate the final copy of all minutes of the meetings of the committee to the members on a timely basis.

SCHEDULE I

Intentionally Deleted

SCHEDULE J

Intentionally Deleted

SCHEDULE K

Intentionally Deleted

SCHEDULE L
PRIVACY AND SECURITY

to the
SERVICES AGREEMENT

1. Purpose

The purpose of this Schedule is to: (a) enable the Customer to comply with its statutory obligations under the *Act* with respect to personal information; and (b) ensure that the Service Provider is aware of and complies with its statutory obligations under the *Act* with respect to personal information.

For the purposes of Section 18.4 (*Events of Default*) of the Agreement, Service Provider acknowledges and agrees that if it fails to fulfil its obligations in this Appendix in any material respect and such failure results in a use, disclosure, access or storage (outside of Canada) of Personal Information in a manner not authorized under the Agreement no cure period will apply. Otherwise a cure period of 14 days will apply.

2. Definitions

"Act" means the *Freedom of Information and Protection of Privacy Act* (British Columbia), as amended from time to time.

"Associate" has the meaning specified in the Act.

"Authorized Site" means Service Provider's head office in British Columbia or at such other location in Canada as may be approved in writing by the Customer.

"Agreement" means the Agreement to which the Schedule is appended.

"Commissioner" means the BC Information and Commissioner appointed under the Act.

"Conflicting Foreign Order" means any order, subpoena, directive, ruling, judgement, injunction, award or decree, decision, request or other requirement issued from a foreign court, agency of a foreign state or other authority outside Canada or any foreign legislation the compliance with which would likely render the Customer or its employees in non-compliance with the Act.

"Contact Information" means information to enable an individual at a place of business to be contacted and includes the name, position name or title, business telephone number, business address, business email or business fax number of the individual.

"Customer" means the Health Organizations.

"Foreign Access Conditions" means:

- (i) the Service Provider must ensure that such access is limited to temporary access and storage for the minimum time necessary for the Permitted Purpose; and
- (ii) if such access is for the Permitted Purpose of data recovery, the Service Provider must ensure such access is limited to access and storage only after the system failure has occurred.

"Permitted Purpose" means access to Records containing Personal Information that is necessary for:

- (i) installing, implementing, maintaining, repairing, trouble-shooting or upgrading an electronic system used by the Customer or by the Service Provider to provide services to the Customer pursuant to the Agreement, or any equipment that

includes an electronic system used by the Customer or by the Service Provider to provide services to the Customer pursuant to the Agreement; or

- (ii) recovery of data (including Personal Information) undertaken following the failure of an electronic system used by the Customer or by the Service Provider to provide services to the Customer.

"Personal Information" means recorded information about an identifiable individual, other than contact information, collected or created by the Service Provider or otherwise held on behalf of the Service Provider as a result of the Agreement or any previous agreement between the Customer and the Service Provider dealing with the same subject matter as the Agreement but excluding any such information that, if this Schedule did not apply to it, would not be under the "control of a public body" within the meaning of the Act.

"Service Provider Personnel" means any employees, agents, representatives or Associates of the Service Provider who provide the Services or to whom access is made available to Personal Information for the purposes of fulfilling the Service Provider's obligations under the Agreement.

"Access Agreement" means an agreement between Service Provider Personnel and the Service Provider requiring the security of Personal Information.

"Record" includes books, documents, maps, drawings, photographs, letters, vouchers, papers and any other thing on which information, including Personal Information, is recorded or stored by graphic, electronic, mechanical or other means, but does not include a computer program or any other mechanism that produces records.

"Service Provider" means Service Provider.

"Schedule" means this Privacy Schedule, as may be amended from time to time.

3. Interpretation

In this Schedule, references to sections by number are to sections of this Schedule unless otherwise specified in this Schedule.

4. Service Provider Subject to the Act

- (a) The Service Provider must in relation to Personal Information comply with: (a) the requirements of the Act applicable to the Service Provider, including any applicable order of the Commissioner under the Act; and (b) any direction given by the Customer under this Schedule. If the Customer learns of a Commissioner order applicable to the Service Provider's services, it will notify the Service Provider.
- (b) The Service Provider acknowledges that it is familiar with the requirements of the Act governing Personal Information that are applicable to it as a service provider.

5. Collection of Personal Information

- (a) Unless the Agreement otherwise specifies or the Customer otherwise directs in writing, the Service Provider may only collect, create or hold, on behalf of the Customer, Personal Information that is necessary for the performance of the Service Provider's obligations, or the exercise of the Service Provider's rights, under the Agreement.

- (b) The Service Provider may only collect Personal Information if expressly authorized by the Agreement. Where authorized to do so, and unless the Agreement otherwise specifies or the Customer otherwise directs in writing, the Service Provider shall: (i) collect Personal Information directly from the individual the information is about; and (ii) tell an individual from whom the Service Provider collects Personal Information the purpose for collecting it; the legal authority for collecting it; and the title, business address and business telephone number of the person designated by the Customer to answer questions about the Service Provider's collection of Personal Information.

6. Accuracy of Personal Information

Where applicable to the Services provided by the Service Provider pursuant to the Agreement, the Service Provider shall make every reasonable effort to ensure the accuracy and completeness of any Personal Information that comes into their custody pursuant to this Agreement and which may be used by the Service Provider or the Customer to make a decision that directly affects the individual the information is about.

7. Receiving Requests for Access or Correction to Personal Information

If a request is received under the Act for access to, or correction of, Records that are in the custody of the Service Provider but under the control of the Customer, the Service Provider must promptly advise the person to make the request to the Customer and if the Customer has advised the Service Provider of the name or title and contact information of an official of the Customer to whom such requests are to be made, the Service Provider must also promptly provide that official's name or title and contact information to the person making the request. The Service Provider must provide the Records to the Customer for management by the Customer's Information and Privacy Officer. This shall occur within a reasonable time frame to enable the Customer to comply with the Act. If a request is permitted by the Act, the Service Provider shall be responsible for providing the Records at the Service provider's expense to the Customer. If the Service Provider is expressly authorized by the Agreement to manage the request for correction of records, the Service Provider shall do so in accordance with Section 8 of this schedule.

8. Correction of Personal Information

The Service Provider may only correct Personal Information if expressly authorized by the Agreement. Where authorized to do so, and unless the Agreement otherwise specifies or the Customer otherwise directs in writing:

- (a) Within 5 business days of receiving a written direction from the Customer to correct or annotate any Personal Information, the Service Provider must annotate or correct the information in accordance with the direction.
- (b) When issuing a written direction under paragraph (a), the Customer must advise the Service Provider of the date the correction request to which the direction relates was received by the Customer in order that the Service Provider may comply.
- (c) Within 5 business days of correcting or annotating any Personal Information, the Service Provider must provide the corrected or annotated information to any party to whom, within one year prior to the date the correction request was made to the Customer, the Service Provider disclosed the information being corrected or annotated.

9. Control of and Rights in the Record

All right, title and interest in, and control and custody of, all Records shall remain with the Customer. No interest or any right respecting the Record, other than as expressly set out herein, is granted to the Service Provider under this Schedule, by implication or otherwise. If Personal Information is collected by the Service Provider and transmitted to the Customer, such Personal Information is deemed to be under the control of the Customer.

10. Access to and Use of Personal Information

- (a) The Service Provider is hereby granted temporary access to Personal Information pursuant to the terms and conditions of this Schedule, for the sole and express purpose of fulfilling its obligations under the Agreement and for no other use or purpose except as required to comply with any Canadian statutory or other legal requirement, including an Order of a Canadian Court, although any disclosure of Personal Information remains subject to Section 12 of this Schedule. The Service Provider shall not copy or reproduce any written materials containing Personal Information without the Customer's prior written consent. Notwithstanding the foregoing, the Service Provider may access Records containing Personal Information for a Permitted Purpose. However, if Records containing Personal Information are disclosed outside of Canada or accessed from outside of Canada, the Service Provider must comply with the Foreign Access Conditions.
- (b) The Service Provider shall not take any action to obtain access of any kind to any Personal Information from any location outside of Canada except for a Permitted Purpose or as permitted by the Act and then only subject to the Foreign Access Conditions and such other processes and access controls as may be imposed by the Customer.
- (c) Except as otherwise permitted under this Schedule, the Service Provider shall not remove, physically, electronically or in other manner whatsoever from the authorized premises of the Customer, any Personal Information, without the Customer's prior written consent. Except as otherwise permitted under this Schedule, the Service Provider shall not store any Personal Information or permitted back-up copies of the Personal Information off-site unless expressly authorized by Customer. Where authorized, Service Provider must store back-up records off-site in Canada under conditions that are the same as or better than on-site storage conditions for original Records.
- (d) The Service Provider will ensure that only Service Provider Personnel who have entered into a Access Agreement may access the Personal Information. Unless approved by the Customer, the Service Provider may not enter into any form of a Personal Information sharing relationship with any other party.

11. Return or Destruction of the Record Upon Request

- (a) Unless the Agreement otherwise specifies, the Service provider must retain Personal Information until directed by the Customer in writing to dispose of it or deliver it as specified in the direction. Upon the request of the Customer for any reason whatsoever, and unless required to do otherwise in order to comply with any Canadian statutory or other legal requirement, including an Order of a Canadian Court, although any disclosure of Personal Information remains subject to Section 12 of this Schedule, the Service Provider shall deliver to the Customer or destroy promptly, according to the Customer's instructions, all documents or other Records in any form or format whatsoever in the

Service Provider's possession constituting or based upon Personal Information and shall confirm that delivery or destruction to the Customer in writing. If, for any reason, the Service Provider fails to return or destroy any Record in accordance with this Section 11, the Service Provider's obligations pursuant to this Schedule will continue in full force and effect.

- (b) In the event of destruction of electronic Personal Information by the Service Provider, the following instructions shall be adhered to:
 - (i) Personal Information erasure may be accomplished by software erasure (where feasible) or by physical destruction of the media;
 - (ii) Software erasure must be at a minimum to US DoD standard 5220.22-M (this standard is achievable through a number of products such as Norton WipeInfo);
 - (iii) Physical destruction of paper media can be done by burning, by cross-cut shredding, or by pulping;
 - (iv) Physical destruction of disc media can be done by use of tools such as hammers, band saws, or drills in order to render the device no longer useable; and
 - (v) Some media such as diskettes can be run through a degausser in order to render them no longer readable.

12. Disclosure to Third Parties

Except as specifically permitted by the Customer in writing, the Service Provider shall not disclose and shall not allow any Service Provider Personnel to disclose in any manner whatsoever any Personal Information to any person, firm or corporation without the prior written consent of the Customer. The Service Provider agrees that such consent shall only be provided if such disclosure is permitted under the Act and the third party agrees, in writing, to be bound by the Act. If the Service Provider or anyone to whom the Service Provider transmits Personal Information pursuant to a Permitted Purpose, becomes legally compelled or otherwise receives a demand to disclose Personal Information other than as permitted by the Act, including without limitation pursuant to any Conflicting Foreign Order, the Service Provider will not do so unless: (a) the Customer has been notified; (b) the parties have appeared before a Canadian Court; and (c) the Court has ordered the disclosure. Unauthorized disclosure is subject to penalties under the Act.

13. Privacy Representative

If required by the Customer, immediately upon execution of the Agreement the Service Provider shall appoint a representative to be responsible for the Service Provider's compliance with this Schedule and the Act (the "Privacy Representative"). The Service Provider shall grant its Privacy Representative sufficient authority to communicate and execute documents on behalf of the Service Provider as may be required from time to time for this purpose. The Service Provider shall promptly provide the Customer with the name of its Privacy Representative and shall promptly notify the Customer of any change of its Privacy Representative.

14. Notice of Breach

- (a) If for any reason the Service Provider does not comply, or anticipates that it will be unable to comply, with a provision in this Schedule in any respect, the Service Provider

must promptly notify the Customer of the particulars of the non-compliance or anticipated non-compliance and what steps it proposes to take to address, or prevent recurrence of the non-compliance or anticipated non-compliance.

- (b) The Service Provider shall notify the Customer immediately of the disclosure of Personal Information to any person or entity not authorized by the Agreement to have such Personal Information, including full details of such disclosure. The Service Provider shall co-operate with the Customer in preventing the recurrence of such disclosure and to the extent feasible, in recovering the disclosed Personal Information, including any copies thereof.

15. Service Provider Personnel Bound by the Act

- (a) The Service Provider and the Customer hereby further acknowledge and agree that in order to fulfill its obligations under the Agreement or in connection with a Permitted Purpose it may be necessary for the Service Provider to grant to Service Provider Personnel access to Personal Information. The Service Provider hereby agrees that:
 - (i) it shall only make Personal Information available to Service Provider Personnel to the extent it is necessary for the purpose of fulfilling the Service Provider's obligations under the Agreement and for a Permitted Purpose;
 - (ii) it shall not make Personal Information available to any Service Provider Personnel while any such persons are physically located outside of Canada, except for a Permitted Purpose under the Foreign Access Conditions or as permitted by the Act;
 - (iii) if and whenever requested by the Customer, the Service Provider shall cause each of the Service Provider Personnel providing services on behalf of the Service Provider under the Agreement to enter into an Access Agreement, in a form and substance acceptable to the Customer wherein the Service Provider Personnel agree, among other things, to comply with the requirements of all applicable laws including in particular the requirements of the Act as if that person were originally bound by the Act; and
 - (iv) the Customer is granted the right to demand that the Service Provider Personnel who breached the obligation be removed from the provision of services pursuant to the Agreement.

The Service Provider shall be required to renew and refresh any or all such agreements from time to time at the reasonable request of the Customer.

- (b) The Service Provider shall properly advise each of the Service Provider Personnel providing services under the Agreement of the requirements of the Service Provider under this Schedule and the Act. If requested by the Customer, the Service Provider shall provide and conduct specific ongoing training for all such individuals in form and substance reasonably satisfactory to the Customer. The Service Provider acknowledges its obligations and, to the extent legally permissible, will address any non-compliance with this Agreement, by their staff, at their discretion.
- (c) Intentionally Deleted.

- (d) The Service Provider shall, upon request by Customer, provide a copy of the access agreement to the Customer.

16. Subcontractors

Any reference to the Service Provider in this Schedule includes any subcontractor or agent retained by the Service Provider to perform obligations under the Agreement and the Service Provider must ensure that any such subcontractors and agents comply with this Schedule.

17. Intentionally Deleted

18. Intentionally Deleted

19. Termination

- (a) Upon the expiration or earlier termination of the Agreement, the Service Provider shall promptly return to the Customer or destroy promptly, according to the Customer's instructions, all Records in the Service Provider's possession pursuant to the Agreement, whether created by the Service Provider or by others, constituting or based upon Personal Information and shall confirm that delivery or destruction to the Customer in writing.
- (b) In the event of a change to the Act or any other applicable privacy legislation or the issuance of a directive or policy by the government of the Province of British Columbia or a finding or report by the Commissioner, such that the Customer reasonably considers that the terms and conditions of the Agreement for the protection of Personal Information are deficient, the Customer and the Service Provider will enter into good faith negotiations in an effort to cure any deficiency and agree to new or amended terms of the Agreement such that it is no longer deficient. Should such negotiations fail, the Customer may terminate all or any portion of the Agreement in accordance with the termination requirements in the Agreement, upon provision of written notice to the Service Provider or upon such other future date as the Customer may specify in writing in such notice.

20. No Withholding

The Service Provider shall not be entitled to, and hereby waives any and all right to, withhold any Personal Information from the Customer to enforce any alleged payment obligation or in connection with any dispute relating to the terms of the Agreement or any other matter between the Customer and the Service Provider.

21. Investigation

The Service Provider shall co-operate with any Customer investigation of a complaint that the Customer's Personal Information has been used contrary to the Act or this Schedule.

22. Storage and Access to Personal Information

The Service Provider shall maintain Personal Information only at an Authorized Site. Except in relation to a Permitted Purpose under Foreign Access Conditions, no services that require access to Personal Information shall be provided or performed by the Service Provider in any location outside Canada and no Personal Information may be stored, transmitted or otherwise made available in any manner or accessed from outside Canada and no person outside Canada shall have access in any manner to Personal

Information except as expressly approved by the Customer in writing. The Service Provider will notify the Customer prior to changing the Authorized Site.

23. Segregation of Data

The Service Provider shall take reasonable steps to ensure that all Personal Information is securely segregated from any information owned by the Service Provider or third parties, including access barriers, physical segregation, password authorization and public key encryption systems. The Service Provider must store Personal Information on agreed-upon media using techniques enabling access only by authorized persons, including encryption and compression of Personal Information. The Service Provider must encrypt Personal Information held on portable storage devices, including laptops.

24. Protection of Personal Information

The Service Provider must protect Personal Information by making reasonable security arrangements against such risks as unauthorized access, collection, use, disclosure or disposal, including any expressly set out in the Agreement.

25. Paramountcy

- (a) The Service Provider must comply with the provisions of this Schedule despite any conflicting provision of this Agreement or, subject to section 25 (b), the law of any jurisdiction outside Canada or any conflicting Foreign Order.
- (b) Nothing in this Schedule requires the Service Provider to contravene the law of any jurisdiction outside Canada unless such contravention is required to comply with the Act.
- (c) The Service Provider acknowledges that the Customer is subject to the Act.
- (d) The Service Provider shall immediately inform the Customer if the Service Provider or any of the Service Provider Personnel receive any Conflicting Foreign Order.

26. Survival

The obligations of the Service Provider in this Schedule will survive the termination of the Agreement.

27. Amendment

Upon enactment of any British Columbia law or regulation or amendment to such law or regulation affecting the use or disclosure of Personal Information, or the publication of any decision of a British Columbia court relating to such law or regulation, or the publication of any interpretive policy or opinion of any government agency charged with the enforcement of any such law or regulation, the Customer, by written notice to the Service Provider, may specify the amendment of this Schedule in such manner as the Customer reasonably determines necessary to comply with such law or regulation to the extent such law or regulation is directly applicable and enforceable against the Service Provider. This provision is additional to any rights of the Customer to terminate pursuant to Section 19(b) of this Schedule.

28. Inconsistency

If a provision of the Agreement (including any direction given by the Customer under this Schedule) conflicts with a requirement of the Act or an applicable order of the Commissioner under the Act, the conflicting provision of the Agreement (or direction) will be inoperative to the extent of the conflict.

Where in the Customer's reasonable opinion, there is ambiguity regarding whether a provision conflicts, the conflicting provision will be inoperative to the extent determined by the Customer. The Service Provider must comply with the provisions of this Schedule despite any conflicting provision of this Agreement or the law of any jurisdiction outside Canada.

The Parties acknowledge and agree that:

1. Notwithstanding that Schedule L to the Agreement requires that "the Service Provider shall, upon request by Customer, provide a copy of the Access Agreement to the Customer", the Parties agree that the Health Organizations may request, and the Service Provider will provide, confirmation of execution of Access Agreements, but Service Provider shall not be required to provide copies of such Access Agreements to the Health Organizations;
2. Section 15 of the Schedule L provides that "the Service Provider shall cause each of the Service Provider Personnel providing services on behalf of the Service Provider under the Agreement to enter into an Access Agreement, in a form and substance acceptable to the Customer". The Parties irrevocably acknowledge and agree that the Access Agreement will be in the form attached as Appendix 1 for Service Provider Personnel, and the Access Agreement will be in the form attached as Appendix 2 for External Personnel.
3. Section 22 of Schedule L provides that "the Service Provider shall maintain Personal Information only at an Authorized Site" and the intention is not for the Service Provider to store such Personal Information and that any Personal Information received by Service Provider shall be promptly returned or destroyed. In the event that the Service Provider receives Personal Information, hard copies shall be maintained at the Authorized Site until returned or destroyed. Notwithstanding the requirements for maintaining information at an Authorized Site, information received electronically shall be deleted on any laptop or personal computer, and any server copies may be stored at the server location provided there is no disclosure, use or access.

APPENDIX 1

CONFIDENTIALITY COVENANTS AND ACCESS AGREEMENT

BACKGROUND

Pursuant to a contract ("**Contract**") entered into among **Provincial Health Services Authority**, as well as **Vancouver Coastal Health Authority** and **Providence Health Care Society** (collectively, the "**Health Organizations**") and **IBM Canada Limited** ("**Service Provider**") for the provision of Transformation Services for their Clinical Information Systems, Service Provider will be providing services to the Health Organizations. In providing services to the Health Organizations, Service Provider Personnel will be in environments where Personal Information is present and may be viewed, including highly sensitive health personal information (the "**Health Organization Data**"), and Service Provider is obligated to ensure the privacy, and confidentiality of the Health Organization Data.

DEFINITION

"Foreign Disclosure Laws" means any laws, statutes, by-laws, treaty, directive, policy having the force of law, order, judgment, injunction, award, decree or other similar matter of any government, legislature (or similar body), court, governmental department, commission, board, bureau, agency, instrumentality, province, state, territory, association, county, municipality, city, town or other political of governmental jurisdiction, whether not or in the future constituted, outside of Canada, that may require, request, or otherwise demand access, use or disclosure of personal information, whether to intercept or obstruct terrorism, or for any other reason.

"Personal Information" means information about an identifiable individual as more particularly defined in FOIPPA made available by the Health Organizations to the Service Provider under the Contract or that the Service Provider otherwise has access to as a result of the Services provided under the Contract.

COVENANT

I, the undersigned, acknowledge that upon my employment with Service Provider it will be a condition of my access to the Health Organization Data that I maintain the confidentiality of the Health Organization Data and report any breach or suspected breach of confidentiality and any wrongdoing or suspected wrongdoing of which I am or become aware.

I, the undersigned, covenant that upon my employment with Service Provider:

1. Even though I may be in environments where Personal Information is present and may be viewed by me, I will not deliberately access, collect, store use or disclose the Health Organization Data, nor will I ask to receive Personal Information. In the event I receive Personal Information from the Health Organizations, I will immediately notify the IBM Privacy Representative and comply with the Service Provider's established internal process, including all Service Provider policies that expressly prohibit any disclosure of the Health Organization Data pursuant to Foreign Disclosure Laws (collectively, the "**Privacy Requirements**").
2. I will not disclose any Health Organization Data except as clearly permitted or provided for by the Privacy Requirements.
3. In the event that I know or suspect that Service Provider or any other person or organization has accessed or disclosed or intends to access or disclose any Health Organization Data in any manner that is not

permitted by, or that is inconsistent with, the provisions of the Privacy Requirements (a "**Breach**"), I will:

- (a) not take any action to assist Service Provider or any other person in committing the Breach or that might otherwise permit or provide for the furtherance of the Breach, even if instructed to do so by Service Provider or by any other person; and
 - (b) immediately notify the Privacy Representative for Service Provider of the Breach and cooperate with Service Provider by providing all relevant information regarding the details of the Breach.
- 4. Where I have any questions as to whether a Breach has occurred, I will call the Privacy Representative. I will be deemed to be in compliance with my obligations under this Confidentiality Covenant where I follow any direction that I receive from the Privacy Representative.
- 5. I am aware that under the *Freedom of Information and Protection of Privacy Act* (British Columbia) ("**FOIPPA**"), there are certain obligations placed on me as an employee of "service provider" and, in particular, an obligation to provide notice to the Health Organizations of any foreign demand for disclosure of personal information.
- 6. I am aware that FOIPPA also provides for "whistle blower" protection for those who report incidents relating to foreign demands for disclosure, which requires, among other things, that an employer not discipline an employee because the employee, acting in good faith and on the basis of reasonable belief, has notified the commissioner under FOIPPA of an unauthorized disclosure of personal information or has notified the minister responsible under FOIPPA of a foreign demand for disclosure.
- 7. I acknowledge and agree that my obligations to Service Provider pursuant to this Confidentiality Covenant take priority over any agreement with or commitment to any other party (including Service Provider) that is inconsistent with this Confidentiality Covenant.
- 8. I acknowledge and agree that, if I leave the employ of Service Provider, I will not disclose to any person any Health Organization Data nor take with me any Health Organization Data received during the course of my employment with Service Provider.
- 9. I will, on an annual basis or as otherwise requested by the Health Organizations or Service Provider, reconfirm my commitments in respect of the Health Organization Data.

I acknowledge that, upon my employment with Service Provider, my failure to comply with the provisions of this Confidentiality Covenant will be cause for and may result in disciplinary action up to and including, where necessary, my dismissal from Service Provider.

IN WITNESS WHEREOF I have executed this Confidentiality Covenant as of the ____ day of _____, 20____.

SIGNED, SEALED and DELIVERED by ♦ in
the presence of:

Signature

Print Name

Address

Occupation

APPENDIX 2

EXTERNAL CONFIDENTIALITY COVENANT AND ACCESS AGREEMENT

BACKGROUND

Pursuant to a contract ("**Contract**") entered into among **Provincial Health Services Authority**, as well as **Vancouver Coastal Health Authority** and **Providence Health Care Society** (collectively, the "**Health Organizations**") and **IBM Canada Limited** ("**Service Provider**") for the provision of Transformation Services for their Clinical Information Systems, Service Provider will be providing services to the Health Organizations. In providing services to the Health Organizations, Service Provider Personnel will be in environments where Personal Information is present and may be viewed, including highly sensitive health personal information (the "**Health Organization Data**"), and Service Provider is obligated to ensure the privacy and confidentiality of the Health Organization Data. I am currently employed by *[Insert name of Subcontractor]* (the "**Company**") and I have been advised that the Company will provide services to Service Provider as a subcontractor and that, in providing such services to one or more of Health Organizations, the Company will be in environments where Personal Information is present and may be viewed, including Health Organization Data.

DEFINITION

"**Foreign Disclosure Laws**" means any laws, statutes, by-laws, treaty, directive, policy having the force of law, order, judgment, injunction, award, decree or other similar matter of any government, legislature (or similar body), court, governmental department, commission, board, bureau, agency, instrumentality, province, state, territory, association, county, municipality, city, town or other political of governmental jurisdiction, whether not or in the future constituted, outside of Canada, that may require, request, or otherwise demand access, use or disclosure of personal information, whether to intercept or obstruct terrorism, or for any other reason.

"**Personal Information**" means information about an identifiable individual as more particularly defined in FOIPPA made available by the Health Organizations to the Service Provider under the Contract or that the Service Provider otherwise has access to as a result of the Services provided under the Contract.

COVENANT

I, the undersigned, acknowledge that upon my employment with the Company it will be a condition of my access to Health Organization Data that I maintain the confidentiality of Health Organization Data and report any breach or suspected breach of confidentiality and any wrongdoing or suspected wrongdoing of which I am aware.

I, the undersigned, covenant that upon my employment with the Company:

1. Even though I may be in environments where Personal Information is present and may be viewed by me, I will not deliberately access, collect, store use or disclose Health Organization Data, nor will I ask to receive Personal Information. In the event I receive Personal Information from the Health Organizations, I will immediately notify the Privacy Representative of Service Provider and comply with the Service Provider's established internal process including all Service Provider policies that expressly prohibit any disclosure of Health Organization Data pursuant to Foreign Disclosure Laws (collectively, the "**Privacy Requirements**").

2. I will not disclose any Health Organization Data except as clearly permitted or provided for by the Privacy Requirements.
3. In the event that I know or suspect that the Company or any other person or organization has accessed or disclosed or intends to access or disclose any Health Organization Data in any manner that is not permitted by, or that is inconsistent with, the provisions of the Privacy Requirements (a "Breach"), I will:
 - (a) not take any action to assist the Company or any other person in committing the Breach or that might otherwise permit or provide for the furtherance of the Breach, even if instructed to do so by the Company or by any other person; and
 - (b) immediately notify the Privacy Representative for Service Provider and cooperate with Service Provider by providing all relevant information regarding the details of the Breach.
4. Where I have any questions as to whether a Breach has occurred, I will call the Representative for Service Provider. I will be deemed to be in compliance with my obligations under this External Confidentiality Covenant where I follow any direction that I receive from the Privacy Representative.
5. I am aware that under the *Freedom of Information and Protection of Privacy Act* (British Columbia) ("FOIPPA"), there are certain obligations placed on me as an employee of a "service provider" and, in particular, an obligation to provide notice to the Health Organizations of any foreign demand for disclosure of personal information.
6. I am aware that FOIPPA also provides for "whistle blower" protection for those who report incidents relating to foreign demands for disclosure, which requires, among other things, that an employer not discipline an employee because the employee, acting in good faith and on the basis of reasonable belief, has notified the commissioner under FOIPPA of an unauthorized disclosure of personal information or has notified the minister responsible under FOIPPA of a foreign demand for disclosure.
7. I acknowledge and agree that my obligations to the Company pursuant to this External Confidentiality Covenant take priority over any agreement with or commitment to any other party (including the Company) that is inconsistent with this External Confidentiality Covenant.
8. I acknowledge and agree that, if I leave the employ of the Company, I will not disclose to any person any the Health Organization Data nor take with me any the Health Organization Data received during the course of my employment with the Company.
9. I will, on an annual basis or as otherwise requested by the Health Organizations or the Company, reconfirm my commitments in respect of the Health Organization Data.

I acknowledge that, upon my employment with the Company, my failure to comply with the provisions of this External Confidentiality Covenant will be cause for and may result in disciplinary action up to and including, where necessary, my dismissal from the Company.

IN WITNESS WHEREOF I have executed this External Confidentiality Covenant as of the ____ day of _____, 20____.

SIGNED, SEALED and DELIVERED by ♦ in	)	
the presence of:	)	
_____	)	
Signature	)	
_____	)	
Print Name	)	♦
_____	)	
Address	)	
_____	)	
_____	)	
Occupation	)	

SCHEDULE M

Intentionally Deleted

SCHEDULE N
TERMINATION FEES

to the
SERVICES AGREEMENT

SCHEDULE N
TERMINATION FEES (AND DE-SCOPING FEES)

1. As of the Effective Date, the termination fee (the “**Termination Fee**”) payable by the Health Organizations to the Service Provider as contemplated under this Agreement shall be four million dollars (\$4,000,000.00) with such Termination Fee being reduced as follows:
 - (a) on a monthly basis calculated on a straight line declining balance, starting on the Effective Date and going to zero on the 20th month after the Effective Date, being a reduction of \$200,000 per month, as more particularly set forth in Table 1 – Termination Fee below; and
 - (b) if the Termination Date should be other than the monthly anniversary of the Effective Date, then the monthly reduction of the Termination Fee will be pro-rated on a daily basis for that month.
2. After the Effective Date but before the 20th month after the Effective Date, if a Services Schedule is removed from the Services by the Health Organizations because of a failure of the Parties to agree and complete the Schedule Refinement Process be performed as contemplated in the relevant Schedule D (a “**De-Scoping**”), and the Health Organizations do not replace the de-scoped Services with new services of equivalent or greater value within sixty (60) days of the De-Scoping through the Change Process, then the De-Scoping Fee payable by the Health Organizations to the Service Provider for the De-Scoping will be calculated as follows (the “**De-scoping Fees**”):

$$\text{De-Scoping Fees} = \text{Monthly Termination Fee} \times \text{Prorated Factor}$$

Where:

Monthly Termination Fee = the applicable Termination Fee set forth in Table 1 – Termination Fee below based upon the effective date of the De-Scoping, pro-rated as provided for in paragraph (b) above (to the extent applicable)

Prorated Factor = the applicable “Percentage of Total Contract Value” allocated to the Services Schedule that is the subject of the De-Scoping, as set forth in Schedule DD – Fees, and reproduced in the Prorated Factor Table below for convenience of reference only (and should there be an inconsistency between the Prorated Factor table below and the “Percentage of Total Contract Value” set forth in Schedule DD – Fees, the “Percentage of Total Contract Value” set forth in Schedule DD – Fees will govern):

The Service Provider acknowledges and agrees to use good faith efforts to settle the terms of any Change Order contemplated in this Section (c).

Prorated Factor Table

Schedule	Percentage of Total Contract Value
Schedule D1(a)(i) - Strategy and Verification	2.5%
Schedule D1(a)(ii) - Enterprise Design Build	41.3%
Schedule D3(a) - Wave 1 Local Configuration and Implementation	26.6%
Schedule D3(b) - Wave 2 Local Configuration and Implementation	12.8%
Schedule D3(c) - Wave 3 Local Configuration and Implementation	8.0%
Schedule D3(d) - Automation and Optimization	8.8%
Total	100%

Table 1 – Termination Fee

Month	Termination Fee	
	Month Start	Month End
1	\$4,000,000	\$3,800,000
2	\$3,800,000	\$3,600,000
3	\$3,600,000	\$3,400,000
4	\$3,400,000	\$3,200,000
5	\$3,200,000	\$3,000,000
6	\$3,000,000	\$2,800,000
7	\$2,800,000	\$2,600,000
8	\$2,600,000	\$2,400,000
9	\$2,400,000	\$2,200,000
10	\$2,200,000	\$2,000,000
11	\$2,000,000	\$1,800,000
12	\$1,800,000	\$1,600,000
13	\$1,600,000	\$1,400,000
14	\$1,400,000	\$1,200,000
15	\$1,200,000	\$1,000,000
16	\$1,000,000	\$800,000
17	\$800,000	\$600,000
18	\$600,000	\$400,000
19	\$400,000	\$200,000
20	\$200,000	\$0

**SCHEDULE O
FORM OF CERTIFICATE OF
INSURANCE**

to the

SERVICES AGREEMENT

SCHEDULE O
FORM OF CERTIFICATE OF INSURANCE

(see attached)

Freedom of Information and Protection of Privacy Act
The personal information requested on this form is collected under the authority of and used for the purposes of contract review.

THIS CERTIFICATE IS REQUESTED BY and ISSUED TO (Name of office)		AGREEMENT IDENTIFICATION NO.
HEALTH CARE AGENCY CONTACT PERSON NAME & TITLE		PHONE NO () FAX NO ()
MAILING ADDRESS		POSTAL CODE
CONTRACTOR NAME		
CONTRACTOR ADDRESS		POSTAL CODE

INSURED	NAME		
	ADDRESS		POSTAL CODE
OPERATIONS INSURED	PROVIDE DETAILS		
TYPE OF INSURANCE List each separately	COMPANY NAME, POLICY NO. & BRIEF DESCRIPTION	EXPIRY DATE YYYY/MM/DD	LIMIT OF LIABILITY/AMOUNT

AGENT OR BROKER COMMENTS:

AGENT OR BROKER	ADDRESS	PHONE NO ()
SIGNED BY THE AGENT OR BROKER ON BEHALF OF THE ABOVE INSURER(S)		DATE SIGNED

SCHEDULE P
DISPUTE RESOLUTION PROCEDURES

to the

SERVICES AGREEMENT

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SCHEDULE P
DISPUTE RESOLUTION PROCESS

1. ISSUE AND DISPUTE RESOLUTION PROCEDURES

1.1 Service Delivery Managers-Level Review and Resolution

If a Dispute related to the delivery of the Services arises between the Parties, the Health Organization representatives and the Service Provider representatives shall meet and attempt to resolve the Dispute and, as appropriate, prevent its reoccurrence, in accordance with the provisions of Schedule D. Written minutes of such meetings shall be taken by the Health Organizations and agreed the Parties. If the Parties are unable to resolve the Dispute within five (5) Business Days after the initial request for a meeting, then either Party may escalate the Dispute in accordance with the dispute resolution process set forth in this Schedule P.

1.2 Informal Dispute Resolution Process

In the event of any Dispute, the Parties will use reasonable efforts to settle such Dispute internally and will consult and negotiate with each other in good faith in an effort to reach a fair and equitable solution satisfactory to the Parties. Prior to the initiation of formal dispute resolution procedures, the Parties will first attempt to informally resolve any dispute, controversy or Claim (including any failure by the Parties to reach agreement where expressly provided for in this Agreement) arising under or in connection with this Agreement as follows:

- (a) the appropriate Service Provider operational representative and the Health Organization operational representative will attempt to resolve the Dispute informally by meeting as often, for a duration and as promptly as those representatives deem necessary, to discuss the Dispute and negotiate in good faith in an attempt to resolve the Dispute;
- (b) if such persons are unable to resolve the Dispute within a reasonable period, then either one of them may refer the Dispute to the Joint Operational Committee, and the Joint Operational Committee will promptly schedule a meeting to discuss the Dispute and negotiate in good faith in an attempt to resolve the Dispute;
- (c) the Joint Operational Committee will meet as often and as promptly as the Parties deem necessary to discuss the Dispute and negotiate in good faith in an effort to resolve the Dispute;
- (d) if the Joint Operational Committee is unable to resolve the Dispute within five (5) Business Days of the Dispute being escalated to the Joint Operational Committee, then the Joint Operational Committee will promptly schedule a meeting with the Joint Executive Committee to discuss the Dispute;
- (e) the Joint Executive Committee will meet as often and as promptly as the Parties deem necessary to discuss the Dispute and negotiate in good faith in an effort to resolve the Dispute;
- (f) during the course of all discussions referred to in paragraphs (a) to (e) above, all reasonable requests made by one Party to another for non-privileged information, reasonably related to the Dispute, will be provided by the other Party so that both Parties

may be fully apprised of the other's interests in the Dispute and resulting positions and interests. The specific format for such discussions will be decided by mutual agreement of the Parties, but may include the preparation of agreed-upon statements of fact or written statements of position or interest;

- (g) if the Joint Executive Committee does not resolve the Dispute within ten (10) Business Days of the referral of the Dispute to the Joint Executive Committee (or such longer period to which the Parties may agree), then either Party may upon written notice to the other Party (the "**Mediation Notice**") elect to submit the Dispute to non-binding mediation, and if such Mediation Notice is accepted in writing within five (5) Business Days of receipt thereof, then the Parties will proceed to mediation in accordance with paragraph (i) below. For greater clarification, either Party may elect to bypass mediation, in which case, the Dispute will be settled by binding arbitration in accordance with Section 2 below;
- (h) if the Dispute is referred to non-binding mediation in accordance with paragraph (g) above, then the Parties will thereafter attempt to promptly agree upon and appoint a sole mediator. If the Parties are unable to agree upon a mediator within five (5) Business Days after the effective date of the Mediation Notice (or such longer period as the Parties may agree), then the Parties will bypass mediation and proceed to arbitration in accordance with Section 2;
- (i) if the Parties agree upon a mediator within the time required pursuant to paragraph (g) above, then the mediation will be conducted at a time, in a city in British Columbia and at a specific location as may be agreed to by the Parties with the mediator, or if the Parties cannot agree, as so designated by the mediator. The mediation will be held within five (5) Business Days after the mediator is appointed. If any Party has substantial need for information from another Party in order to prepare for the mediation, then the Parties will use reasonable efforts to agree on procedures for the formal exchange of information. Each Party will be represented in the mediation by at least an individual with authority to settle the Dispute on behalf of that Party and, if desired by that Party, by legal counsel for that Party. The Parties' representatives in the mediation will continue with the mediation as long as the mediator reasonably requests, but in no event longer than thirty (30) days from the first day that the Parties meet to commence mediation. Unless otherwise agreed to in writing by the Parties, each Party will pay one-half of the mediator's fees and expenses and will bear all of its own expenses in connection with the mediation. No Party may employ or use the mediator as a witness, consultant, expert, counsel or other similar position regarding the Dispute or any related matters and all communications during or in connection with the mediation shall be deemed "without prejudice" and such communications shall not be admissible in any arbitration or court; and
- (j) if the parties are unable to resolve the Dispute by mediation, , or if either Party elects to bypass mediation entirely, then the matter will be referred to binding arbitration in accordance with Section 2.

2. ARBITRATION

Subject to the provisions of Article 21 of the Agreement and Section 3 and Section 7 below, any Dispute that is not settled in accordance with Section 1.2, will be settled at the request of either Party by binding arbitration in Vancouver, British Columbia in accordance with the *Commercial Arbitration Act* (British Columbia) on the following terms:

Confidential – Services Agreement

- (a) all hearings will be in held and kept confidence subject to Applicable Laws;
- (b) the arbitration will be heard before a panel of three arbitrators, and each Party will select an arbitrator and those two arbitrators will together select a third arbitrator, unless otherwise agreed by the Parties as set out in Section 5 below, to form the panel;
- (c) unless the Parties agree otherwise in writing, all arbitrators (including the Designated Arbitrators) will either be:
 - (i) a lawyer in good standing with the Law Society of British Columbia or equivalent body in all jurisdictions in Canada where that lawyer is called to the bar,
 - (ii) a retired lawyer who was previously in good standing with the Law Society of British Columbia or equivalent body in all jurisdictions in Canada where that lawyer was previously called to the bar before that lawyer's retirement; or
 - (iii) a retired judge having been a member of the bench in Canada;
- (d) no individual may be appointed as a Designated Arbitrator if that individual is (but for the appointment as arbitrator in connection with a Dispute under this Agreement) or was directly involved in matters relating to this Agreement, the Dispute or the Services to be performed by the Service Provider under this Agreement or is otherwise not independent of each Party;
- (e) all Designated Arbitrators selected or otherwise appointed to hear a Dispute will have experience in complex, commercial outsourcing engagements and be skilled or knowledgeable in the subject matter of the Dispute;
- (f) if the arbitration is heard before a panel of three arbitrators, then the decision of the arbitration panel will be made by a majority vote;
- (g) judgment upon the award rendered in any such arbitration may be entered in any court having competent jurisdiction;
- (h) the Parties will direct the arbitrator (or arbitrators) to make an award of costs, which award will include the remuneration and expenses and any related administrative fees that are charged by the arbitrator (or arbitrators) in connection with the arbitration of the Dispute, and the Parties will pay all such costs in accordance with the direction of the arbitrator (or arbitrators); each Party will pay its own costs and expenses incurred in preparing for and participating in the arbitration (including the costs related to retaining legal counsel);
- (i) the Parties will instruct the arbitrator (or arbitrators) to make the final award with respect to the Dispute within 60 days after the hearings have been closed, or such other reasonable period of time, as may be agreed to in writing by the Parties before the commencement of the arbitration hearings and so notified in writing to the arbitrator (or arbitrators). Awards shall be in writing and shall, unless the parties otherwise agree, state the reasons upon which they are based;

Confidential – Services Agreement

- (j) notwithstanding anything to the contrary in the *Commercial Arbitration Act* (British Columbia):
 - (i) the same procedural requirements and rights of discovery as are available under the British Columbia Rules of Court will apply, *mutatis mutandis*, except that the arbitrator (or arbitrators) may make adjustments to the time limits contained in such Rules of Court,
 - (ii) the laws and rules of evidence applicable in the Courts of British Columbia will apply, and the arbitrator (or arbitrators) may only require the production of relevant documentary and testimonial evidence not protected by the solicitor-client privilege, and
 - (iii) the arbitrator (or arbitrators) will adjudicate the Dispute by reference to law in accordance with Section 23 of the *Commercial Arbitration Act* (British Columbia), including the precedent of other Court decisions, statutory laws, and laws of interpretation, as would be followed by a Court having competent jurisdiction, and the Parties expressly agree that the Dispute will not be decided upon the law of equity or some other similar basis;
- (k) the arbitrator (or arbitrators) will have no power or authority to grant any award or permit any other recourse that would be precluded by the terms of this Agreement, including, without limitation, an award for damages that would be in excess of any limitation of liability in the Agreement and nor will the arbitrator (or arbitrators) have the power to make any award that addresses matters outside the scope of the Dispute or grant injunctive relief; and
- (l) provided that either Party may appeal any question of law arising out of the award to the court, the Parties will be bound by any award issued by the arbitrator (or arbitrators), which award the Parties agree to be bound by and to accept as a final and binding award.

3. EXPEDITED DISPUTE RESOLUTION

Certain Disputes are expressly designated in this Agreement as being subject to expedited arbitration or as an Expedited Dispute under the terms of this Agreement, and in particular, Sections 17.7 and 18.6 which shall follow the step-by-step resolution procedures set forth below to the extent necessary to resolve the Dispute, without first having to comply with the provisions of Section 1.2 or Section 2:

- (a) the Expedited Arbitration resolution process shall be commenced by a notice from either Party to the other referring to this Section 3 of Schedule P (Dispute Resolution Process – Expedited Arbitration) and setting out the matter that is to be resolved as an Expedited Arbitration and such notice shall constitute the commencement of the Dispute Resolution Process in respect of such Expedited Arbitration;
- (b) the Dispute will be directly escalated to the Joint Executive Committee for resolution and to the extent the Dispute is not fully resolved by the Joint Executive Committee within a period of 72 hours from referral to the Joint Executive Committee then either Party may, upon written notice to the other Party, refer the Dispute to binding arbitration in accordance with Section 2 above;

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- (c) if the Dispute is referred to binding arbitration in accordance with Section 2, then the Designated Arbitrator will be the first Designated Arbitrator who is immediately available starting at the top of the list of Designated Arbitrators set out in Section 6 below;
- (d) the Expedited Arbitration shall take place in Vancouver, British Columbia in accordance with the Commercial Arbitration Act (British Columbia), in the presence of one Designated Arbitrator subject to the following:
 - (i) all submissions must be made within four (4) days of the Designated Arbitrator being appointed,
 - (ii) the Designated Arbitrator being required to render a decision within three (3) Business Days of receipt of the submissions, and
 - (iii) each Party shall pay its own costs and expenses and one-half (1/2) of the Designated Arbitrator costs, except in the event of extraordinary or extenuating circumstances where, in the judgment of the Designated Arbitrator, having regard to all of the surrounding circumstances, it would be inequitable or otherwise inappropriate to do so, in which case, the Parties shall pay the costs of the Designated Arbitrator in accordance with the final apportionment thereof by the Designated Arbitrator; and
 - (iv) either Party shall have the right to appeal the decision of the arbitrator to a panel of three arbitrators as set forth in Section 2 above.

4. CONTINUED PERFORMANCE; CURE PERIODS

Except for the duration of a valid Force Majeure Event, or in accordance with Article 22 of the Agreement, the Service Provider will continue performing its obligations under the Agreement, in good faith, while the Dispute is being resolved as provided in this Schedule P, until the Dispute is resolved or until the Agreement is terminated. The Health Organizations will continue to pay all Fees that are due and payable under the terms of the Agreement subject Section 17.9. The time frame for a Party to cure any breach of the Agreement shall not be suspended during the referral of a Dispute to resolution under the Dispute Resolution process.

5. SINGLE ARBITRATOR

The Parties may, notwithstanding Section 2(b) above, agree that the arbitration may be heard before one of the following “Designated Arbitrators”:

- (a) Henri Alvarez, Q.C.;
- (b) Leon Getz, Q.C.;
- (c) Murray Clemens, Q.C.;
- (d) Bill Berardino, Q.C.; and
- (e) Gerald Ghikas, Q.C.

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In the event none of the Designated Arbitrators are readily available, the Parties shall meet and agree on an alternate arbitrator within three (3) days of the matter being referred to arbitration.

6. CONFIDENTIALITY

The proceedings of all negotiations, mediations and arbitrations as part of the Dispute Resolution Process will at all times be privately conducted. All offers of settlement occurring in connection with any mediation, or otherwise in pursuit of settlement of any Dispute, shall, unless the parties otherwise agree in writing, be “without prejudice”, and evidence of any such offers of settlement shall not be admissible in any arbitration. The Parties agree that all statements and other communications made during the Dispute Resolution Process including, without limitation, offers of settlement, settlement terms and all documents or other materials created, produced or disclosed for the purposes of the Dispute Resolution Process:

- (a) are made on a without prejudice basis;
- (b) do not constitute an admission or waiver of rights; and
- (c) will not be offered into evidence, disclosed or used for any other purpose other than the Dispute Resolution Process.

During the Dispute Resolution Process, no Party is required to disclose to the other Party any information, documents or materials with respect to which they claim privilege; however, if as part of the Dispute Resolution Process a Party should disclose to the other Party information, documents or materials with respect to which they claim privilege or any information, documents or materials which they regard and identify as confidential or proprietary, then the other Party will maintain the confidentiality of the information, documents or materials so obtained and, to the extent permitted by law, any such disclosure will not constitute a waiver of any privilege or confidentiality. The Parties agree that any information regarding the Dispute Resolution Process, including any decisions or awards made, will not be disclosed to any third parties or used for any purpose other than the Dispute Resolution Process, unless the Parties otherwise agree; provided that nothing in this provision will prevent such disclosure as may be necessary to enforce or appealing any arbitration awards.

7. JOINDER AND CONSOLIDATION

- (a) If more than one arbitration is begun under this Agreement and any separate agreements related to this agreement including without limitation an Approved Subcontract (“Related Agreements”) and Party contends that two or more arbitrations are substantially related and that the issues should be heard in one proceeding, the arbitral tribunal appointed this Agreement shall have the power to determine whether, in the interests of justice and efficiency, the whole or part of the matters at issue should be consolidated before this arbitral tribunal upon such terms or conditions as the arbitral tribunal thinks fit.
- (b) The Parties expressly accept that any Dispute under this Agreement may accordingly be disposed of in the same arbitration proceedings as any other dispute arising under another Related Agreement, even in the presence of parties other than the Parties to this Agreement.
- (c) The arbitral tribunal appointed in respect of a Dispute may, upon the request of a Party or a party to any of the Related Agreements which itself wishes to be joined in any arbitration proceedings in relation to a Dispute, having regard to the stage of the proceedings and other relevant circumstances, join any Party or any party to any of the

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Related Agreements to arbitration proceedings in relation to that Dispute. Any party so joined to arbitration proceedings may request that one or more further Parties or parties to any of the Related Agreements be joined to such arbitration proceedings.

- (d) Each of the Parties hereby consents to be joined to arbitration proceedings in relation to any dispute at the request of a party to that dispute following the initiation of the joinder of parties or consolidation of disputes or arbitral proceedings. The Parties hereby agree that any arbitration proceedings to which any one or more of them may be joined pursuant to this clause shall continue under the same arbitration rules as those under which it was commenced and with the same arbitral tribunal.

8. EXCEPTIONS TO THE DISPUTE RESOLUTION PROCESS

The provisions of this Schedule P will not be construed to prevent a Party from:

- (a) seeking a temporary restraining order or injunctive or other equitable relief with respect to a breach (or attempted breach) of this Agreement by the other Party, to the extent such remedies are available to a Party pursuant to Applicable Law (including, without limitation, the *Crown Proceeding Act* (British Columbia));
- (b) instituting litigation or other formal proceedings to the extent necessary and available pursuant to Applicable Law:
 - (i) to enforce arbitration awards or orders for injunctive or other similar relief,
 - (ii) to avoid the expiration of any applicable limitations period, or
 - (iii) to preserve a position with respect to other creditors;
- (c) pursuing any remedy expressly set forth in this Agreement without having to first complete the informal dispute resolution procedures in Section 1.2 or the arbitration under Section 2 above; or
- (d) defending any law suits involving third parties.

**SCHEDULE Q
HEALTH ORGANIZATION POLICIES
AND PROCEDURES**

to the

SERVICES AGREEMENT

SCHEDULE Q
HEALTH ORGANIZATION POLICIES AND PROCEDURES

1. The HO Policies:

- (a) The Health Organization Information Security Policies (“**HO Policies**”) were provided to the Service Provider by email transmission between counsel on September 30, 2012 at 10:26 a.m. (Pacific). Subject to Section 1(b) below, the Service Provider will comply with the HO Policies to the extent applicable to the Services.
- (b) The Health Organizations acknowledges that the HO Policies refer, in certain respects, to specific standards that have not been provided to the Service Provider. The Service Provider will use all commercially reasonable efforts to comply with such HO Policies notwithstanding such standards have not been provided. When such standards become available they will be incorporated into the HO Policies under this Agreement through the Change Process.

2. The HSSBC/Provincial Health Services Authority Travel and Business Expense Policy as supplemented by the one page addendum (HSSBC Travel and Living Expenses Guidelines) attached, to the extent applicable.

Category: Corporate Finance Policy	
Title: Travel and Business Expense Policy	Reference Number: FIN-200
Approved by: PHSA Senior Executive Team	Last Approved: February 28, 2011 Last Reviewed: February 28, 2011

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1 Purpose and Scope

- 1.1. This policy:
 - i. Establishes the reimbursement and cash advance principles for travel, meals and entertainment and business expenses; and
 - ii. Applies to all individuals (employees, physicians and contractors) associated with the Provincial Health Services Authority and member agencies ("PHSA") who are submitting claims (collectively the "claimants") for reimbursement of expenses incurred on PHSA business relating to all funds controlled or administered by the PHSA, including those from grants and contracts.
- 1.2. Where a claimant is covered by a collective agreement, and the collective agreement has express provisions that vary from those contained in this policy, the provisions contained in the collective agreement will take precedence.
- 1.3. Where a claimant has incurred expenses in relation to a grant or contract, and such grant or contract has express provisions that vary from those contained in this policy, the provisions contained in the grant or contract will take precedence.
- 1.4. This policy does not cover the reimbursement of employee related expenses with direct benefit to PHSA such as membership fees, relocation costs, recruitment expenses, training fees, etc. Consult your human resources representative for information on reimbursement of these expenses.

2 Policy Principles

- 2.1. PHSA administers public funds and must be publicly accountable. To meet this objective, all expenses, specifically those of a discretionary nature, must be:
 - i. appropriate, in reference to the nature and context of the expense;
 - ii. reasonable, in reference to the economy of the expense amount; and
 - iii. necessary for business purposes or supporting the mission of the PHSA.
- 2.2. Claimants should not gain or lose financially at the expense or gain of PHSA as a direct result of incurring business or travel expenses.
- 2.3. It is the responsibility of the claimant to submit expense reports for expenses that are directly incurred in the fulfillment of official duties.
- 2.4. It is the responsibility of the approver to ensure that expense reports submitted by the claimant are reasonable, complete, accurate, and in compliance with this policy.
- 2.5. Any unresolved issues should be forwarded to an individual at least one administrative level higher than the approver.
- 2.6. PHSA assumes no obligation for reimbursing claimants for expenses incurred by claimants that are not in compliance with this policy.

3 General Policy

3.1. Judgment

Sound business judgment must be exercised in determining travel. The travel decision must consider the following factors:

- i. most economical cost;
- ii. the duration of the travel;
- iii. a reasonable level of comfort, convenience, and practicality;
- vi. personal safety; and
- v. the most sensible route and mode of travel consistent with the purposes and context of the trip

3.2. Preferred Travel Services Provider

PHSA's preferred travel agency UNIGLOBE Vision Travel Inc. ("Uniglobe") must be used to book travel arrangements such as airfare, vehicle rentals, hotels, etc. Uniglobe can be contacted by calling 604-688-7286, or toll-free 1-800-665-6446 to be assisted by the dedicated PHSA travel team, or by using the portal link <http://pod/transport/travel/pages/Default.aspx>.

3.3. Emergency Traveler Helpline

A 24-hour world-wide call centre is available for travel arrangements booked through Uniglobe for travelers with emergency needs (such as cancelled flights, changes, or last minute new requests). Emergency contacts are included on all Uniglobe issued travel documentation (such as invoices, e-tickets, etc).

3.4. Gratuity

Where customary, the maximum gratuity that should be given is 15% of the cost before taxes.

3.5. PHSA Corporate Credit Card

Please refer to the PHSA Corporate Credit Card Policy FIN-230 for further details.

4 Expense Reports

4.1. Expense Documentation

- 4.1.1 Original invoices, receipts or ticket stubs must be submitted with an explanation of the business purpose as supporting documentation for all individual expenses over \$5.
- 4.1.2 Credit card vouchers and statements are not adequate supporting documentation for an expense report.

4.2. Expense Report Submission

- 4.2.1 All expense claims, except those to be reimbursed through petty cash (refer the PHSA Petty Cash Policy FIN-170) must be submitted on the PHSA standard claim form (the "expense report"), which can be found on POD.
- 4.2.2 Expense reports are to be promptly completed and submitted for approval within one month of incurrence of the expenses.
- 4.2.3 Expense reports must be submitted together with the original supporting documentation and each transaction properly coded. Supporting explanations required by the policy such as business purpose, meal attendees must also be documented.
- 4.2.4 All expense reports submitted for expense reimbursement, to support a cash advance, or to support a PHSA Corporate Credit Card Account, should be signed off by the claimant to confirm the business purpose of the expenses is appropriate and the expense reports are complete and accurate.
- 4.2.5 Reimbursement of foreign currency expenditures is made in Canadian dollars at a reasonable foreign exchange rate such as the exchange rate at the date of the transaction or the Canadian dollar equivalent amount billed on a credit card statement.
- 4.2.6 Reimbursement to the claimant will be made within two weeks from the date that all approvals and documentation has been received by the Finance Department.

4.3. Third Party Charges

- 4.3.1 A third party charge is an expense that will be shared amongst one or more parties. Only the portion that PHSA is responsible for paying should be submitted for reimbursement by PHSA. The claimant must fully disclose all financial details of the third party costs that are shared or reimbursed by the other organization(s).

4.4. Expenses Incurred on Behalf of Other PHSA Employees

- 4.4.1 If the claimant needs to be reimbursed for expenses incurred on behalf of another individual, for example, on behalf of a colleague, trainee, fellow or student, the expense reports should clearly identify the individual on whose behalf the expenses have been incurred. The report should include (a) the name of the individual to whom the expense relates (b) the relationship of the individual to the claimant (c) the employee ID of the person if he/she is an employee (d) the purpose of the expense (e) receipts supporting total expenses and (f) appropriate approval of the expenses.

5 Approvals

- 5.1. All expense reports submitted must be approved and evidenced through a signature by an appropriate approver. A signature confirms that all provisions of this policy have been met, particularly noting the responsibilities outlined in Section 5.5. After signing the expense report, it should be sent to the disbursements department at 260-1770 West 7th Avenue, Vancouver, BC V6J 4Y6.
- 5.2. Please refer to Appendix 1 of the PHSA Financial Signing Authority Administration policy FIN-110 for the signing authority approval limits.

- 5.3. The approver must ensure the total amount of the expense report is within their signing authority approval limit.
- 5.4. The expense report approver must be at least one administrative level higher than the claimant.
- 5.5. The expense report approver is responsible for ensuring the following:
 - i. Expense report details are complete and accurate. This includes ensuring that expense coding is correct, advance approvals were obtained where required, and supporting documentation (original receipts) are appropriate. In instances where a receipt is not provided, or there is an unsatisfactory business purpose, a reasonable explanation should be obtained from the claimant and documented on the report prior to approval, or the expense should be denied.
 - ii. All expenses to be reimbursed to the claimant are reasonable and incurred for the purposes of carrying out official duties in compliance with this policy.
 - iii. Recouping any expenditures (such as third party recoveries or cash advances made to PHSA claimants) that are not in compliance with this policy and taking the necessary corrective action.
- 5.6. Expenses requiring advance approval by a signing authority are:
 - i. Cash advances for travel and business expenses;
 - ii. Travel outside of British Columbia;
 - iii. Prepaid travel expenses such as airfares;
 - iv. In-town meals and entertainment attended solely by claimants and contracted service providers;
 - v. Business-use car insurance for a personal motor vehicle used in conducting PHSA official business; and
 - vi. Other expenses not specifically addressed in this policy, as per section 14 of this policy.

6 Use of Personal Motor Vehicle

6.1. Motor Vehicle Expenses

- 6.1.1 Business travel is defined as all travel related to PHSA official business excluding normal travel between the claimant's residence and normal place of work (i.e. where a claimant ordinarily performs his/her duties).
- 6.1.2 Where a personal motor vehicle is used for business travel, claimants are entitled to claim costs based on the distance traveled from the shorter of home to the business destination or the normal place of work (i.e. where a claimant ordinarily performs his/her duties) to the business destination at PHSA's standard rate per kilometre as noted in the Addendum to this policy.
- 6.1.3 Where PHSA provides transportation, such as an inter-site shuttle bus service, this service should be used whenever practical. When a personal motor vehicle is used for inter-site travel, claims are reimbursed based on actual distances as per Section 6.1.2.
- 6.1.4 When a personal motor vehicle is used and there is a choice between air travel and use of a personal motor vehicle, the claimant must restrict the value of the claim to the lesser of the lowest economy airfare(s) or the mileage allowance.

- 6.1.5 The intention of sections 6.1.1 through 6.1.4 is to reimburse reasonable *incremental* motor vehicle costs related to the performance of official duties.

6.2. Other Motor Vehicle Expenses

- 6.2.1 The owner is responsible for obtaining appropriate motor vehicle insurance coverage. Business use insurance coverage must be obtained when the motor vehicle is driven for business use for greater than any portion of six days (i.e. does not include travel to and from work) in a calendar month. The business use portion of the insurance cost may be reimbursed subject to advance approval with the appropriate documentation to support the reimbursement.
- 6.2.2 When there is damage to or theft of a personal motor vehicle while being used in the course of business, PHSA at their discretion can reimburse the claimant for the lesser of any repair costs incurred or the insurance deductible amount, up to a maximum of \$500. This section covers damage relating to accidents, fire, and theft of motor vehicle or vandalism but does not cover cases of wilful or gross negligence.
- 6.2.3 Business related parking costs at locations other than the normal place of work will be reimbursed.
- 6.2.4 Traffic and/or parking fines and towing charges do not qualify for reimbursement.

7 Other Forms of Transportation

7.1. General

- 7.1.1 Business related transportation such as buses, taxis, car rentals, ferry and parking expenses are eligible for reimbursement.
- 7.1.2 Claimants are encouraged to use low cost services and public transportation whenever possible. Where such options are not reasonable or available, other reasonable alternatives may be chosen.

7.2. Car Rental

- 7.2.1 Where taxi travel is not economical, rental costs for a reasonable rental car, as well as all insurance and fuel charges will be reimbursed.
- 7.2.2 Car rentals must be arranged through the preferred travel services provider (Section 3.2) to obtain the most economical rates when possible.
- 7.2.3 The individual is responsible for possessing appropriate motor vehicle insurance coverage for each car rental through a rental agency either from coverage through their personal or PHSA corporate credit card, or by purchasing an insurance package from the rental agency. If a PHSA corporate credit card is used for the rental, the Collision Damage Waiver should be declined if all of the conditions in the auto rental collision/loss damage insurance certificate are met (refer to the Addendum to this Policy). The individual should purchase third party liability, personal accident and personal effects coverage if these are not automatically included in the rental package.

7.3. Ferry

- 7.3.1** The full cost of ferry travel will be reimbursed including the cost of the Reservation System or Assured Loading Tickets ("ALT") when necessary.

8 Telephone and Wireless

8.1. Long Distance Telephone Calls

- 8.1.1** All business related long distance telephone calls made from a personal residence are eligible for reimbursement.

8.2. Wireless devices

- 8.2.1** When PHSA provides a wireless device for business use, such as a cellular phone or blackberry, all costs associated with the operation of the wireless device with the exception of personal long distance calls will be reimbursed.
- 8.2.2** When a personal wireless device is used for business purposes, the minutes and the proportional percentage of general administrative charges incurred for business use can be reimbursed.

9 Accommodation

- 9.1.** Accommodation must be arranged through the preferred travel services provider (Section 3.2) to obtain the most economical rates when possible.
- 9.2.** Preference should be given to reasonable accommodations providing special provincial and/or federal government rates, which are ordinarily offered to claimants of publicly funded organizations. Where such accommodation is not available, other reasonable accommodation should be selected based on consideration of the lowest overall cost in conjunction with safety, security, modest level of comfort, convenience and practicality.
- 9.3.** Where a claimant has arranged accommodation with a relative/friend while traveling for business, an allowance will be paid to the claimant as outlined in the Addendum to this policy. Lodging dates and location must be provided with the claim.

10 Travel Meals and Incidentals

10.1. General

- 10.1.1** When traveling on business, the lower of the actual meal and incidental costs that are considered to be reasonable, or the per diem allowance (as outlined in sections 10.2 and 10.3), should be claimed.
- 10.1.2** Where a meal has been pre-arranged or provided, and consumed, meal allowances and/or expenses cannot be claimed.
- 10.1.3** The per diem allowance does not apply to claimants who have temporary reassignments to positions other than at their normal place of work, unless the temporary reassignment is out of town.
- 10.1.4** For travel outside of Canada on business, claimants may claim the same rates specified in this policy in the currency of the country visited. If actual costs are greater, PHSA will reimburse reasonable amounts for meal and

incidental costs incurred provided these claims are supported by appropriate documentation and reasonable explanations.

10.1.5 Maximum meal and incidental per diem allowances are outlined in the Addendum to this Policy.

10.2. Allowance for Out of Town Travel with Overnight Stays

10.2.1 A per diem allowance is provided to cover meals and incidental expenses, such as reasonable customary gratuities, laundry and personal telephone calls. Receipts are not required to support the per diem allowance claim and can be allocated in a reasonable manner as determined by the claimant.

10.3. Allowance for Out of Town Travel with No Overnight Stays

10.3.1 A per diem for each meal is provided to claimants who are not able to return home during usual meal hours when they are on out of town business travel where an overnight stay is not required. Receipts are not required to support the per diem allowance claim and can be allocated in a reasonable manner as determined by the claimant.

10.3.2 The maximum per diem can only be claimed if the claimant meets the time of departure criteria as outlined in the Addendum to this policy.

10.4. The intention of sections 10.1 to 10.3 is to compensate for reasonable incremental meal and incidental costs related to the performance of official duties.

11 Business Meals, Refreshments and Entertainment

11.1. All meals, refreshments and entertainment expense claims must include all of the following:

- i. A list of the names of all attendees;
- ii. An explanation of the business purpose of the function; and
- iii. The original itemized receipt.

11.2. Internal meetings

11.2.1 PHSA considers meals or refreshments for internal meetings to be appropriate business expenses allowable under this policy where the following criteria are met:

- If the meeting is required to be scheduled between the hours of noon and 2:00pm; or from 6:30pm and 8:30pm.
- There is an appropriate business purpose of the meeting (refer section 11.2.2 below); and
- The nature or location of the meeting does not allow participants to provide their own meals or refreshments.

11.2.2 Meal and refreshment expenses which are not considered of an appropriate business purpose include, but are not limited to, celebrations for staff birthdays, promotions, nuptials and births, and staff retirements where the expenses are in addition to the allowances provided under HR_013 *Retirement Recognition* policy.

11.3. External participant meals and entertainment expenses

- 11.3.1** PHSA covers the cost of meals and entertainment expenses incurred by members in carrying out official duties with parties external to PHSA such as guests, recruits, visitors or donors, provided the expenses are necessary, authorized, reasonable and appropriately documented.
- 11.3.2** The reasonableness of meals and entertainment considers the involvement of an appropriate number of people relative to the significance or business purpose of the event.
- 11.3.3** Any portion of meals and entertainment expenses that are attributable to spouses, other family members and/or friends are not reimbursable.

11.4. Alcohol Consumption

- 11.4.1** The consumption of alcoholic beverages with parties external to PHSA is not encouraged. However, in rare circumstances, reasonable expenses for alcoholic beverages consumed by those external parties may be expensed. Where alcoholic beverages are consumed, the portion attributable to the consumption by the external party may be expensed by the claimant if they are reasonable. Any alcohol consumed by the claimant when with external parties is not reimbursable.
- 11.4.2** The consumption of alcoholic beverages at a function attended by all internal PHSA claimants and/or contracted service providers is not reimbursable.

12 Air Travel

- 12.1.** Air travel must be arranged through the preferred travel services provider (Section 3.2) to obtain the most economical rates when possible.
- 12.2.** The most economical air fare should be chosen regardless of frequent flyer program memberships. However, if this is not permissible given schedules, air traffic conditions and the terms and conditions, a reasonable alternative can be chosen with advance approval from the expense report approver.
- 12.3.** The Chief Executive Officer and accompanying staff may elect to upgrade to business class where the travel is six hours or more.
- 12.4.** All exceptions to economy class air travel must be approved in writing in advance by the appropriate member of the Executive Leaders Council and the Chief Financial Officer.
- 12.5.** All exceptions to the economy class air travel by Executive Leaders Council members must be approved by one executive level higher.
- 12.6.** Flight cancellation insurance is recommended for non-refundable tickets over \$200 (including taxes). Where flights are cancelled and a personal credit with the airline is received, this credit must be used for business travel. Where flights are cancelled and charges are reversed on a personal credit card, reimbursement to PHSA will be required.
- 12.7.** Claimants will not be reimbursed or otherwise compensated if they elect to use mileage points to travel on business.

- 12.8. Frequent flyer points accumulated through travel on business will accrue to the traveler.
- 12.9. Prepaid airfare such as float plane or helijet tickets should be approved in advance by the approver. The approver is also responsible for the controls surrounding usage and safekeeping of the air fares.
- 12.10. Departure fees or taxes and other airport mandatory charges are reimbursable.
- 12.11. The traveler is responsible additional costs related to modification to a ticket for personal reasons.

13 Combining Business and Personal Travel

- 13.1. Travel that combines business and personal travel is reimbursed at the lesser of: i) actual transportation expenses; or ii) the expenses that would have been incurred if the personal travel had not taken place, applying reasonable estimates where necessary.
- 13.2. Where a business trip is extended for personal reasons, the claimant is responsible for all additional costs incurred. Where a claimant can demonstrate, with documentation, that airfare savings resulting from extending the trip, exceed the additional costs claimed for reimbursement, the claim for additional costs is allowable.
- 13.3. Additional costs that arise when a claimant's spouse, other family member or friend accompanies the claimant on travel are not eligible for reimbursement.

14 Other Business Expenses

- 14.1. Other staff expenses which are not considered of an appropriate business purpose and therefore not reimbursable under this policy include, but are not limited to:
 - i. Flowers and gift baskets;
 - ii. Monetary staff recognition, such as gift cards;
 - iii. Staff party supplies
- 14.2. Other expenses not specifically addressed in this policy, but are required to be incurred in carrying out official PHSA duties may also be reimbursed under this policy if approved in advance by an authorized approver. Examples of such expenses include internet and dedicated phone lines.

15 Advances

- 15.1. Cash advances can be provided to claimants if needed, at PHSA's discretion, for travel and business expenses estimated to be greater than \$500 that will be incurred in carrying out official duties.
- 15.2. All cash advances must be approved in advance by an authorized approver who is one administrative level higher.
- 15.3. Cash advances must be used within three months of the cash advance date. Where expense reports have not been provided by the end of the three month period, a chargeback against future expense report reimbursements will occur.

15.4. Original itemized receipts or invoices must be provided to support the cash advances provided. Any cash advances issued in excess of actual expenses must be repaid to PHSA. If cash advances issued in excess of actual expenses are not repaid, a chargeback against future expense reimbursement claims will occur.

15.5. Cash advances cannot be received using the Corporate Credit Card.

Policy Created on: May 21, 2004

Revision Dates:

✚ September 30, 2007

✚ February 28, 2011

✚ November 22, 2010

Approved by: PHSA Senior Executive Team
Date: February 28, 2011

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Addendum – Travel and Business Expense Policy

Reference: Section 6.1.2

Unless specified in a collective agreement, where a personal vehicle is used for business travel, the standard rate per kilometre for claimants is \$0.50.

Reference: Section 10.2

The per diem allowance for meals and incidentals for overnight stays are as follows:

	Canadian Travel (\$CDN incl tax)
Meals – Breakfast, lunch and dinner	\$45.00
Incidentals	\$5.00
Daily Maximum	\$50.00

Reference: Section 10.3

The per diem allowance for meals without overnight stays based on time of departure criteria are as follows:

	Meal Per Diem eligibility is based on the time of Departure:	Canadian Travel (\$CDN incl tax)
Breakfast	Before 7:00am	\$11.00
Lunch	Before 12:00pm	\$13.00
Dinner	Before 6:00pm	\$21.00
Daily Maximum		\$45.00

Reference: Section 9.3

Where a claimant has arranged out of town accommodation with a relative or friend while traveling for business, an allowance of \$30 per night will be paid to the claimant.

Reference: Section 7.2.3

E. COVERAGE TERMINATION

THERE IS NO COVERAGE WHEN:

1. THE RENTAL AGENCY REASSUMES CONTROL OF THE RENTAL VEHICLE;
2. THIS POLICY IS CANCELLED;
3. YOUR RENTAL PERIOD IS MORE THAN 48 CONSECUTIVE DAYS, OR YOUR RENTAL PERIOD IS EXTENDED FOR MORE THAN 48 CONSECUTIVE DAYS BY RENEWING OR TAKING OUT A NEW RENTAL AGREEMENT WITH THE SAME OR ANOTHER RENTAL AGENCY FOR THE SAME VEHICLE OR OTHER VEHICLES.
4. YOUR U.S. BANK CANADA VISA CORPORATE CARD IS CANCELLED OR CARD PRIVILEGES ARE OTHERWISE TERMINATED.

F. WHERE COVERAGE IS AVAILABLE

THIS COVERAGE IS AVAILABLE ON A 24-HOUR BASIS UNLESS PRECLUDED BY LAW OR THE COVERAGE IS IN VIOLATION OF THE TERMS OF THE RENTAL CONTRACT IN THE JURISDICTION IN WHICH IT WAS FORMED (OTHER THAN UNDER SECTION B, PART 7 (A) (B) OR (C) ABOVE).

(SEE THE SECTION ON "HELPFUL HINTS" FOR TIPS ON LOCATIONS WHERE USE OF THIS COVERAGE MAY BE CHALLENGED AND WHAT TO DO WHEN A RENTAL AGENCY MAKES THE RENTAL OR RETURN OF A VEHICLE DIFFICULT.)

G. TYPES OF VEHICLES COVERED

THE TYPES OF RENTAL VEHICLES COVERED INCLUDE:

ALL CARS, SPORT UTILITY VEHICLES, AND MINI-VANS (DEFINED AS VANS MADE BY AN AUTOMOBILE MANUFACTURER AND CLASSIFIED BY THE MANUFACTURER OR A GOVERNMENT AUTHORITY AS MINI-VANS MADE TO TRANSPORT A MAXIMUM OF EIGHT (8) PEOPLE INCLUDING THE DRIVER AND WHICH ARE USED EXCLUSIVELY FOR THE TRANSPORTATION OF PASSENGERS AND THEIR LUGGAGE) EXCEPT THOSE EXCLUDED BELOW.

THE FOLLOWING VEHICLES ARE NOT COVERED:

1. VANS, TRUCKS OR PICK-UP TRUCKS (OTHER THAN MINI-VANS AS DESCRIBED ABOVE);
2. LIMOUSINES;
3. OFF-ROAD VEHICLES - MEANING ANY VEHICLE USED ON ROADS THAT ARE NOT PUBLICLY MAINTAINED
4. ROADS UNLESS USED TO INGRESS AND EGRESS PRIVATE PROPERTY;
5. MOTORCYCLES, MOPEDS OR MOTOR BIKES;
6. TRAILERS, CAMPERS, RECREATIONAL VEHICLES OR VEHICLES NOT LICENSED FOR ROAD USE;
7. VEHICLES TOWING OR PROPELLING TRAILERS OR ANY OTHER OBJECT;
8. MINI-BUSES OR BUSES;
9. EXPENSIVE OR EXOTIC VEHICLES, MEANING VEHICLES SUCH AS ASTON MARTIN, BENTLEY, BRICKLIN, DAIMLER, DELOREAN, EXCALIBUR, FERRARI, JENSEN, LAMBORGHINI, LAND ROVER, LOTUS, MASERATI, PORSCHE, ROLLS ROYCE, ANY LIMOUSINE OR ANY VEHICLE WHICH IS EITHER WHOLLY OR IN PART HAND MADE, HAND FINISHED OR HAS A LIMITED PRODUCTION OF UNDER 2,500 VEHICLES PER YEAR;
10. ANTIQUE VEHICLES, MEANING A VEHICLE OVER TWENTY (20) YEARS OLD OR WHICH HAS NOT BEEN MANUFACTURED FOR TEN (10) YEARS OR MORE.

LUXURY VEHICLES SUCH AS BMW, CADILLAC, LINCOLN AND MERCEDES BENZ ARE COVERED AS LONG AS THEY ARE NOT LIMOUSINES OR VANS.

HSSBC TRAVEL AND LIVING EXPENSES GUIDELINES

Purchaser will reimburse Supplier upon invoice for Supplier's reasonable out-of-pocket expenses in connection with providing the services described in this Agreement. All expenses related to travel, accommodations and meals incurred by the Supplier in the course of providing the Services must be pre-approved by Purchaser, itemized at a cost and substantiated with receipts upon invoicing. All expenses are subject to the standard expense guidelines of HSSBC. Purchaser will reimburse the Supplier only for the actual cost of disbursements with no mark-ups, within 30 days of receiving the aforementioned documentation. All travel arrangements including flight, accommodations and car rental must be made by the Supplier. The Supplier is expected to use the most economical accommodations, air and ground transportation.

The following limitations apply to out-of-pocket expenses:

- **Food / Meals:**
 - Not to exceed \$50.00 CDN per day.
 - Alcohol is excluded and is not an expendable item.
- **Air Transportation:**
 - Airfare is restricted to coach class.
 - Airline tickets are valid between Supplier location and nearest airport to Purchaser.
- **Car Rental:**
 - Not to exceed a mid-size class vehicle.
 - Not to exceed \$100.00 CDN per day including mileage.
 - Use of personal vehicle is allowed and mileage is reimbursed at a rate of \$0.40 CDN per kilometre.
- **Other Transportation:**
 - Travel between Supplier locations & airport is covered via taxi or personal car whichever is more cost effective.
 - Trips between airport or hotel and Purchaser's sites via taxi are covered.
 - Limousine taxi is not covered.
- **Accommodations:**
 - Not to exceed \$130.00 CDN per night.
 - Restricted to standard room rates.
- **Parking:**
 - Parking fees are restricted to Supplier's airport, Purchaser's sites, and hotel only.
- **Entertainment:**

Personal entertainment is not included.

**SCHEDULE R
PERMITTED SERVICE LOCATIONS**

to the

SERVICES AGREEMENT

SCHEDULE R
PERMITTED SERVICE LOCATIONS

1. Schedule D1(a)(i) (Strategy and Verification) and Schedule D1(a)(ii) (Enterprise Build)

a) IBM Locations

i) IBM Primary Locations

- 609 Granville Suite 1590, Vancouver, British Columbia, V7Y 1G5
- 750 West Pender St. Suite 1750, Vancouver, British Columbia, V6C 2T8
- 4611 Canada Way, Burnaby, British Columbia, V5G 4X3
- 1803 Douglas Street 2nd floor, Victoria Centre, Victoria, British Columbia, V8T 5C3

ii) IBM Secondary Services Locations

- See Appendix A

b) Subcontractors Locations

i) Deloitte Primary Location

- 2800 - 1055 Dunsmuir Street, 4 Bentall Centre

ii) Deloitte Secondary Services Locations

- Suite 700, 850-2nd Street SW, Calgary, Alberta, T2P 0R8
- 2000 Manulife Place, 10180 - 101st Street, Edmonton, Alberta, T5J 4E4
- 30 Wellington St. W, P.O. Box 400, Toronto, Ontario, M5L 1B1
- St. Andrews Square, 737 Yates Street Suite 300, Victoria, BC, V8W 1L6
- 191 Peachtree Street NE, Suite 2000, Atlanta, GA, USA, 30303-1943
- 111 S Wacker Dr., 24th Floor, Chicago, IL, USA, 60606-4301
- 2200 Ross Ave., Ste. 1600, Dallas, TX, USA, 75201
- 200 Renaissance Center, Suite 3900, Detroit, MI, USA, 48243-1704
- 555 Mission Street, Suite 1400, San Francisco, CA, USA, 94105
- 925 4th Ave., Ste. 3300, Seattle, WA, USA, 98104-1126
- Hyderabad (Blocks A-D), Deloitte Drive, Road No. 2, Hitec City Layout, Madhapur, Hyderabad, India

iii) UPMC Primary Locations

a) Iroquois Building: 3600 Forbes Ave; Suite 308; Pittsburgh, PA 15213 USA

iv) UPMC Secondary Services Locations

- Forbes Tower, 3600 Meyran Avenue, Pittsburgh, PA, USA, 15213
- Mercy South Side Outpatient Center, 2000 Mary Street, Pittsburgh, PA, USA, 15203
- UPMC Corporate Offices, USX Tower, 600 Grant Street, Pittsburgh, PA, USA

- UPMC Melwood Bldg, 450 Melwood Street, Pittsburgh, USA, 15213
- UPMC Passavant, 9100 Babcock Blvd., Pittsburgh, PA, USA, 15237-5842
- Children's Hospital of Pittsburgh of UPMC, 4401 Penn Avenue, Pittsburgh, PA, USA
- Magee-Womens Hospital of UPMC, 300 Halket Street, Pittsburgh, PA, USA, 15213-3180
- UPMC Presbyterian-Shadyside, 200 Lothrop St., Pittsburgh, PA, USA, 15213-2582
- UPMC St. Margaret, 815 Freeport Road, Pittsburgh, PA, USA, 15215
- Western Psychiatric Institute & Clinic, 3811 O'Hara Street, Pittsburgh, PA, USA, 15213-2593
- Hillman Cancer Center, 5115 Centre Avenue, Pittsburgh, PA, USA, 15232
- UPMC East DeMarco Durzo Bldg, 2775 Mossdale Blvd., Monroeville, PA, USA, 15146
- UPMC Mercy, 1400 Locust Street, Pittsburgh, PA, USA, 15219
- UPMC Quantum One Bldg, 2 Hot Metal Street, Pittsburgh, PA, USA, 15203
- UPMC Technology Development Center, 6425 Penn Avenue, Bakery Square Pittsburgh, PA, USA, 15206

v) maxIT Primary Locations

- Health Organization Facilities
- IBM Permitted Service Locations as set out above
- Deloitte Permitted Service Locations as set out above

vi) maxIT Secondary Services Locations

- Suite 240 – 10 Research Drive, Regina, SK Canada S4S 7J7
- Suite 1516 – 60 Queen Street, Ottawa, ON Canada K1P 5Y7
- 999 West Broadway, Suite 720, Vancouver, BC V5Z 1K5

c) Such other Subcontractor locations as may be added to or substituted for the offices identified above.

d) Such other locations in Canada as Service Provider Personnel or Subcontractor personnel may deliver services on a remote basis provided that any access to the Health Organizations systems shall only be through use of a Virtual Private Network.

e) Such other locations outside Canada provided that such Service Provider Personnel or Subcontractor personnel do not have access to Personal Information in connection with the performance of Services outside Canada.

2. Schedule D3(a)(b)(c) (Implementation Services)

a) IBM Locations

i) IBM Primary Locations

- 609 Granville Suite 1590, Vancouver, British Columbia, V7Y 1G5
- 750 West Pender St. Suite 1750, Vancouver, British Columbia, V6C 2T8
- 4611 Canada Way, Burnaby, British Columbia, V5G 4X3
- 1803 Douglas Street 2nd floor, Victoria Centre, Victoria, British Columbia, V8T 5C3

ii) IBM Secondary Services Locations

- See Appendix A

b) Subcontractors Locations

i) Deloitte Primary Locations

- 2800 - 1055 Dunsmuir Street, 4 Bentall Centre

ii) Deloitte Secondary Services Locations

- Suite 700, 850-2nd Street SW, Calgary, Alberta, T2P 0R8
- 2000 ManuLife Place, 10180 - 101st Street, Edmonton, Alberta, T5J 4E4
- 30 Wellington St. W, P.O. Box 400, Toronto, Ontario, M5L 1B1
- St. Andrews Square, 737 Yates Street Suite 300, Victoria, BC, V8W 1L6
- 191 Peachtree Street NE, Suite 2000, Atlanta, GA, USA, 30303-1943
- 111 S Wacker Dr., 24th Floor, Chicago, IL, USA, 60606-4301
- 2200 Ross Ave., Ste. 1600, Dallas, TX, USA, 75201
- 200 Renaissance Center, Suite 3900, Detroit, MI, USA, 48243-1704
- 555 Mission Street, Suite 1400, San Francisco, CA, USA, 94105
- 925 4th Ave., Ste. 3300, Seattle, WA, USA, 98104-1126
- Hyderabad (Blocks A-D), Deloitte Drive, Road No. 2, Hitec City Layout, Madhapur, Hyderabad, India

iii) maxIT Primary Locations

- Health Organization Facilities
- IBM Permitted Service Locations as set out above
- Deloitte Permitted Service Locations as set out above

iv) maxIT Secondary Services Locations

- Suite 240 – 10 Research Drive, Regina, SK Canada S4S 7J7
- Suite 1516 – 60 Queen Street, Ottawa, ON Canada K1P 5Y7
- 999 West Broadway, Suite 720, Vancouver, BC V5Z 1K5

c) Such other Subcontractor locations as may be added to or substituted for the offices identified above.

d) Such other locations in Canada as Service Provider Personnel or Subcontractor Personnel may deliver services on a remote basis, provided that any access to the Health Organizations systems shall only be through use of a Virtual Private Network.

e) Such other locations outside Canada provided that such Service Provider Personnel or Subcontractor Personnel do not have access to Personal Information in connection with the performance of Services outside Canada.

3. Schedule D3(d) (Optimization Services)

a) IBM Locations

i) IBM Primary Locations

- 609 Granville Suite 1590, Vancouver, British Columbia, V7Y 1G5
- 750 West Pender St. Suite 1750, Vancouver, British Columbia, V6C 2T8
- 4611 Canada Way, Burnaby, British Columbia, V5G 4X3
- 1803 Douglas Street 2nd floor, Victoria Centre, Victoria, British Columbia, V8T 5C3

ii) IBM Secondary Services Locations

- See Appendix A

b) Such other locations in Canada as Service Provider Personnel or Subcontractor Personnel may deliver services on a remote basis, provided that any access to the Health Organizations systems shall only be through use of a Virtual Private Network.

c) Such other locations outside Canada provided that such Service Provider Personnel or Subcontractor Personnel do not have access to Personal Information in connection with the performance of Services outside Canada.

4. Tools

The Parties acknowledge and agree that the tools used in the performance of the services, may be located at any IBM location, whether or not in Canada provided that Personal Information is not stored in the tools or accessed by the tools located outside Canada.

**Appendix R1 to Schedule R -- Permitted Service Locations
IBM Secondary Locations**

227 - 11th Avenue SW, Calgary, Alberta, T2R 1R9
400 Ellice Avenue, Winnipeg, Manitoba, R3B 3M3
630 - 3 Avenue SW 2nd Floor, Calgary, Alberta, T2P 4L4
1190 Homer Street, Suite 401, Vancouver, British Columbia, V6B 2X6
1801 Hamilton Street Suite 600, Regina, Saskatchewan, S4P 4B4
4396 West Saanich Road 2nd floor, Victoria, British Columbia, V8Z 3E9
10044 - 108 Street Suite 141, Edmonton, Alberta, T5J 3S7
4 Alliance Boulevard Unit # 12, Barrie, Ontario, L4M 5J1
34 Commerce Crescent, North Bay, ON, P1A 0B4
505 Bayview Drive, Barrie, Ontario, L4N 8Y2
79 Wellington Street W. 3rd Floor, Toronto, Ontario, M5K 1B1
100 Gough Road Markham, Ontario, L3R 4B7
100 Wynford Drive 2nd floor, North York, Ontario, M3C 1K4
120 Bloor Street East Suite 104, Toronto, Ontario, M4W 1B7
151 Front Street West Suite 207, Toronto, Ontario, M2J 1R3
245 Consumers Road, North York, Ontario, M2J 1R3
740 Progress Avenue, Scarborough, Ontario, M1H 2X3
1751 Wentworth Unit 1 & 2, Whitby, Ontario, L1N 8R6
3500 Steeles Ave. East Markham, Ontario, L3R 2Z1
3600 Steeles Avenue East Markham, Ontario, L3R 9Z7
4175 - 14th Avenue, Markham, Ontario, L3R 5R5
62 Auriga Drive, Ottawa, Ontario, K2E 7W6
65 Auriga Drive, Ottawa, Ontario, K2E 7W6
340 Albert Street Suite 1610, Ottawa, Ontario,
350 Terry Fox Drive Suite 100, Ottawa, Ontario, K2K 2W5
690 Dalton Avenue Unit # 2, Kingston, Ontario, K7M 8N8
770 Palladium Drive, Kanata, Ontario, K2V 1C8
1400 St-Laurent Blvd. Suite 500, Ottawa, Ontario, K1K 4H4
3755 Riverside Drive, Ottawa, Ontario, K1G 4K9
250 York Street Suite 301, London, Ontario, N6A 6K2
410 Albert Street, Waterloo, Ontario, N2L 3V3
3375 North Service Road, Burlington, Ontario, L7N 3G2
140, Grande Allée Est 5th floor, Québec, Québec, G1R 5N6
200 Bouchard 6ème Etage, Dorval, Québec, H9S 1A8
275, avenue Viger Est Montréal, Québec, H2X 3R7
1360, boulevard René-J. Lévesque Ouest Montréal, Québec, H3G 2W6
1995 - 55e Avenue Dorval, Québec, H9P 1G9
2700, boulevard Laurier Tour Champlain - Bureau 4000 Sainte-Foy, Québec, G1V 4K5
80 Bishop Drive, Unit B, Fredericton, New Brunswick, E3C 1B2
136 Crosbie Road, St. John's, Newfoundland, A1B 3K3
400 Main Street, Saint John, New Brunswick, E2K 4N5
535 Edinburg Drive Unit 200, Moncton, New Brunswick, E1E 4E3
1969 Upper Water Street, Purdy's Wharf, Tower 2, Suite 1704, Halifax, Nova Scotia, B3J 3R7

Such other IBM locations as may be added to or substituted for the offices identified above

SCHEDULE S LIST OF REPORTS

to the

SERVICES AGREEMENT

SCHEDULE S
LIST OF REPORTS

See reports and reporting requirements in Schedules D1(a)(i), D1(a)(ii), D3(a), D3(b), D3(c) and D3(d).

SCHEDULE T

Intentionally Deleted

SCHEDULE U

Intentionally Deleted

SCHEDULE V

Intentionally Deleted

SCHEDULE W

Intentionally Deleted

SCHEDULE X

Intentionally Deleted

SCHEDULE Y

Intentionally Deleted

SCHEDULE Z

Intentionally Deleted

**SCHEDULE AA
HEALTH ORGANIZATION
SERVICE LOCATIONS**

to the

SERVICES AGREEMENT

SCHEDULE AA
HEALTH ORGANIZATION SERVICE LOCATIONS

Schedule AA provides a listing of facility locations across the three Health Organizations. Schedule AA does not expand the scope or volume of services as set out in Schedule D.

Health Authority	Organization	Facility Name	Street Address	City
PHSA	BC Cancer Agency	Vancouver Cancer Centre	600 West 10th Avenue	Vancouver
PHSA	BC Cancer Agency	Fraser Valley Centre	13750 96th Avenue	Vancouver
PHSA	BC Cancer Agency	Vancouver Island Centre	2410 Lee Avenue	Victoria
PHSA	BC Cancer Agency	Centre for the Southern Interior	399 Royal Avenue	Kelowna
PHSA	BC Cancer Agency	BC Cancer Research Centre	675 West 10th Avenue	Vancouver
PHSA	BC Cancer Agency	Abbotsford Centre	32900 Marshall Road	Abbotsford
PHSA	BC Children's Hospital	BCCH	4480 Oak Street	Vancouver
PHSA	Sunny Hill Health Centre	Sunny Hill	3644 Slocan Street	Vancouver
PHSA	BC Mental Health & Addiction Services	Forensic Psychiatric Hospital	70 Colony Farm Road	Port Coquitlam
PHSA	BC Mental Health & Addiction Services	Child and Youth Mental Health	4500 Oak Street	Vancouver
PHSA	BC Women's Hospital and Health Centre	BCWH	4500 Oak Street	Vancouver
VCHA	Providence Health Care	St. Paul's Hospital	1081 Burrard Street	Vancouver
VCHA	Providence Health Care	Mount Saint Joseph Hospital	3080 Prince Edward Street	Vancouver
VCHA	Providence Health Care	Holy Family Hospital	7801 Argyle Street	Vancouver
VCHA	VCHA - Hospital	Bella Coola General Hospital	1025 Elcho Street	Bella Coola
VCHA	VCHA - Hospital	Lions Gate Hospital	231 E 15th Street	North Vancouver
VCHA	VCHA - Hospital	Powell River General Hospital	5000 Joyce Avenue	Powell River

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Health Authority	Organization	Facility Name	Street Address	City
VCHA	VCHA - Hospital	Richmond Hospital	7000 Westminster Highway	Richmond
VCHA	VCHA - Hospital	Squamish General Hospital	38140 Behrner Drive	Squamish
VCHA	VCHA - Hospital	St. Mary's Hospital	5544 Sunshine Coast Highway	Sechelt
VCHA	VCHA - Hospital	UBC Hospital	2255 Wesbrook Mall	Vancouver
VCHA	VCHA - Hospital	Vancouver General Hospital	855 W 12th Avenue	Vancouver
VCHA	VCHA - Hospital	Whistler Health Care Centre	4380 Lorimer Road	Whistler
PHSA	BC Centre for Disease Control		655 West 12th Avenue	Vancouver
PHSA	BC Renal Agency		700-1380 Burrard Street	Vancouver
PHSA	BC Transplant		555 West 12th Avenue	Vancouver
PHSA	Cardiac Services of BC		4500 Oak Street	Vancouver
PHSA	Perinatal Services BC		555 West 12th Avenue	Vancouver
PHSA	BC Ambulance Service			Burnaby
PHSA	Provincial Blood Coordinating Office			Vancouver
PHSA	Provincial Infection Control Network of BC			Vancouver
PHSA	Provincial Emergency Services			Burnaby
PHSA	Telehealth			Vancouver
PHSA	Surgical Services			Vancouver
PHSA	Aboriginal Health Program			Vancouver
PHSA	Provincial Language Service			Vancouver
PHSA	PHSA Laboratories			Vancouver
PHSA	BC Early Hearing Program			Vancouver

BPS Services Agreement
Schedule 8 – Service Locations

Health Authority	Organization	Facility Name	Street Address	City
PHSA	Autism Assessment Network	see Sunny Hill		Vancouver
VCHA	Providence Health Care	Youville Residence	4950 Heather Street	Vancouver
VCHA	Providence Health Care	Marion Hospice	9th floor, Windermere Care Centre	Vancouver
VCHA	Providence Health Care	St. Vincent's Langara	255 West 62nd Avenue	Vancouver
VCHA	Providence Health Care	St. Vincent's Honoria Conwar-Heather	4875 Heather Street	Vancouver
VCHA	Providence Health Care	St. Vincent's Brock Fahmi	4650 Oak Street	Vancouver
VCHA	Providence Health Care	Providence Crosstown Clinic	84 West Hastings Street	Vancouver
VCHA	Providence Health Care	Community Dialysis Units – North Shore	117 – 260 W. Esplanade	North Vancouver
VCHA	Providence Health Care	Community Dialysis Units – Powell River	Powell River General Hospital Room 3004 500 Joyce Avenue	Powell River
VCHA	Providence Health Care	Community Dialysis Units – Richmond	120 – 4671 No. 3 Road	Richmond
VCHA	Providence Health Care	Community Dialysis Units – Sechelt	5544 Sunshine Coast Highway	Sechelt
VCHA	Providence Health Care	Community Dialysis Units 0 Squamish	Squamish General Hospital 38140 Behrner Drive	Squamish
VCHA	Providence Health Care	Community Dialysis Units - Vancouver	100 – 520 West 6 th Avenue	Vancouver
VCHA	Providence Health Care	Community Dialysis Units – East Vancouver	2845 Gradview Highway	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	1055 Dunsmuir Street, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	1145 Commercial Drive, Vancouver	Vancouver

BPS Services Agreement
Schedule 8 – Service Locations

Health Authority	Organization	Facility Name	Street Address	City
VCHIA	VCHA - Health Clinic	Health Clinic	115 16th Street West, North Vancouver	North Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	11666 Steveston Highway, Richmond	Richmond
VCHA	VCHA - Health Clinic	Health Clinic	11700 Cambie Road, Richmond	Richmond
VCHA	VCHA - Health Clinic	Health Clinic	1224 Marine Drive, North Vancouver	North Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	1280 Granville Street, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	1296 Pacific Boulevard, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	145 17th Street West, North Vancouver	North Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	1515 Commercial Drive, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	179 Davie Street, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	1816 West Broadway, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	1884 Marine Drive, West Vancouver	West Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	1940 Lonsdale Avenue, North Vancouver	North Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	2025 West Broadway, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	2155 Allison Road, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	2516 Commercial Drive, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	2525 Commercial Drive, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	2578 Granville Street, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	2590 Commercial Drive, Vancouver	Vancouver
VCHIA	VCHA - Health Clinic	Health Clinic	2678 West Broadway, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	2689 West Broadway, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	288 East Georgia Street, Vancouver	Vancouver

Health Authority	Organization	Facility Name	Street Address	City
VCHA	VCHA - Health Clinic	Health Clinic	333 Brooksbank Avenue, North Vancouver	North Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	333 Seymour Boulevard, North Vancouver	North Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	360 Columbia Street, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	3675 Westminster Highway, Richmond	Richmond
VCHA	VCHA - Health Clinic	Health Clinic	40147 Glenalder Place, Squamish	Squamish
VCHA	VCHA - Health Clinic	Health Clinic	4060 Cambie Street, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	4186 Dunbar Street, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	4314 Main Street, Whistler	Whistler
VCHA	VCHA - Health Clinic	Health Clinic	4359 Main Street, Whistler	Whistler
VCHA	VCHA - Health Clinic	Health Clinic	4380 No. 3 Road, Richmond	Richmond
VCHA	VCHA - Health Clinic	Health Clinic	449 East Hastings Street, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	507 West Broadway, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	5317 Headland Drive, West Vancouver	West Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	5531 Inlet Avenue, Sechelt	Sechelt
VCHA	VCHA - Health Clinic	Health Clinic	601 Broadway West, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	6020 Blundell Road, Richmond	Richmond
VCHA	VCHA - Health Clinic	Health Clinic	6176 Fraser Street, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	7031 Westminster Highway, Richmond	Richmond
VCHA	VCHA - Health Clinic	Health Clinic	8160 Cook Road, Richmond	Richmond
VCHA	VCHA - Health Clinic	Health Clinic	8171 Cook Road, Richmond	Richmond
VCHA	VCHA - Health Clinic	Health Clinic	8311 Lansdowne Road, Richmond	Richmond

BPS Services Agreement
Schedule 8 – Service Locations

Health Authority	Organization	Facility Name	Street Address	City
VCHA	VCHA - Health Clinic	IHealth Clinic	8671 No. 1 Road, Richmond	Richmond
VCHA	VCHA - Health Clinic	Health Clinic	920 Seymour Street, Vancouver	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	925 Main Street, West Vancouver	West Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	Aberdeen Centre	Richmond
VCHA	VCHA - Health Clinic	Health Clinic	Mid-Main Community Health Centre	Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	Park Royal Shopping Centre North Mall, West Vancouver	West Vancouver
VCHA	VCHA - Health Clinic	Health Clinic	Simon Fraser University - Harbour Centre Campus	Vancouver
VCHA	VCHA - Community Health Centre	1985 4th Avenue West, Vancouver		Vancouver
VCHA	VCHA - Community Health Centre	Central Community Health Centre		North Vancouver
VCHA	VCHA - Community Health Centre	Downtown Community Health Centre		Vancouver
VCHA	VCHA - Community Health Centre	Evergreen Community Health Centre		Vancouver
VCHA	VCHA - Community Health Centre	Gibsons Health Unit		Gibsons
VCHA	VCHA - Community Health Centre	Pacific Spirit Community Health Centre		Vancouver
VCHA	VCHA - Community Health Centre	Parkgate Community Health Centre		North Vancouver
VCHA	VCHA - Community Health Centre	Pemberton Health Centre		Pemberton

Health Authority	Organization	Facility Name	Street Address	City
VCHA	VCHA - Community Health Centre	Pender Community Health Centre		Vancouver
VCHA	VCHA - Community Health Centre	Pender Harbour and District Health Centre		Madeira Park
VCHA	VCHA - Community Health Centre	Powell River Community Health Centre		Powell River
VCHA	VCHA - Community Health Centre	Raven Song Community Health Centre		Vancouver
VCHA	VCHA - Community Health Centre	Richmond Health Services		Richmond
VCHA	VCHA - Community Health Centre	Robert and Lily Lee Family Community Health Centre		Vancouver
VCHA	VCHA - Community Health Centre	Sechelt Health Unit		Sechelt
VCHA	VCHA - Community Health Centre	South Community Health Centre		Vancouver
VCHA	VCHA - Community Health Centre	Squamish Community Health Centre		Squamish
VCHA	VCHA - Community Health Centre	Three Bridges Community Health Centre		Vancouver
VCHA	VCHA - Community Health Centre	West Vancouver Community Health Centre		West Vancouver
VCHA	VCHA - Assisted Living Centres	Austin Harris Residence		Richmond
VCHA	VCHA - Assisted Living Centres	Cedar Garden		North Vancouver
VCHA	VCHA - Assisted Living Centres	Christenson Village		Gibsons
VCHA	VCHA - Assisted Living Centres	Churchill House		North Vancouver

BPS Services Agreement
Schedule 8 – Service Locations

Health Authority	Organization	Facility Name	Street Address	City
VCHA	VCHA - Assisted Living Centres	Clarendon Court		Vancouver
VCHA	VCHA - Assisted Living Centres	Courtyard Gardens		Richmond
VCHA	VCHA - Assisted Living Centres	Harmony House		Vancouver
VCHA	VCHA - Assisted Living Centres	Haro Park Centre		Vancouver
VCHA	PHC - Assisted Living Centres	Honorio Conway at St. Vincent's Heather		Vancouver
VCHA	VCHA - Assisted Living Centres	Icelandic Harbour		Vancouver
VCHA	VCHA - Assisted Living Centres	Kiwanis Garden Manor		Powell River
VCHA	VCHA - Assisted Living Centres	Kiwanis Manor		West Vancouver
VCHA	VCHA - Assisted Living Centres	Millennium Tower		Vancouver
VCHA	VCHA - Assisted Living Centres	Shannon Falls Retirement Residence		Squamish
VCHA	VCHA - Assisted Living Centres	Southview Heights		Vancouver
VCHA	VCHA - Assisted Living Centres	Terraces on 7th		Vancouver
VCHA	VCHA - Assisted Living Centres	The Cedars at Bculah Gardens		Vancouver
VCHA	VCHA - Assisted Living Centres	Weinberg Residence		Vancouver
VCHA	VCHA - Hospice	319 14th Street East, North Vancouver		North Vancouver
VCHA	VCHA - Hospice	900 12th Avenue West, Vancouver		Vancouver
VCHA	VCHA - Hospice	May's Place Hospice		Vancouver
VCHA	VCHA - Hospice	Salvation Army Rotary Hospice House		Richmond
VCHA	VCHA - Hospice	St. James Cottage Hospice		Vancouver

BPS Services Agreement
Schedule 8 - Service Locations

Health Authority	Organization	Facility Name	Street Address	City
VCHA	VCHA - Residential	Adanac Park Lodge		Vancouver
VCHA	VCHA - Residential	Amherst Private Hospital		Vancouver
VCHA	VCHA - Residential	Arbutus Care Centre		Vancouver
VCHA	VCHA - Residential	Blenheim Lodge		Vancouver
VCHA	VCHA - Residential	Bradden Private Hospital		Vancouver
VCHA	VCHA - Residential	Broadway Pentecostal Lodge		Vancouver
VCHA	VCHA - Residential	Capilano Care Centre		West Vancouver
VCHA	VCHA - Residential	Cedarview Lodge		North Vancouver
VCHA	VCHA - Residential	Central City Lodge		Vancouver
VCHA	VCHA - Residential	Columbus Residence		Vancouver
VCHA	VCHA - Residential	Dogwood Lodge		Vancouver
VCHA	VCHA - Residential	Evergreen Extended Care		Powell River
VCHA	VCHA - Residential	Evergreen House		North Vancouver
VCHA	VCHA - Residential	Fair Haven		Vancouver
VCHA	VCHA - Residential	Finnish Home		Vancouver
VCHA	VCHA - Residential	Fraserview Intermediate Care Lodge		Richmond
VCHA	VCHA - Residential	George Pearson Centre		Vancouver
VCHA	VCHA - Residential	German Canadian Care Home		Vancouver
VCHA	VCHA - Residential	Haro Park Centre		Vancouver
VCHA	VCHA - Residential	Hilltop House		Squamish
VCHA	VCHA - Residential	Holy Family Hospital		Vancouver

BPS Services Agreement
Schedule 8 – Service Locations

Health Authority	Organization	Facility Name	Street Address	City
VCHA	VCHA - Residential	Inglewood Care Centre		West Vancouver
VCHA	VCHA - Residential	Kiwanis Care Centre - North Shore		North Vancouver
VCHA	VCHA - Residential	Kopernik Lodge		Vancouver
VCHA	VCHA - Residential	Lakeview Care Centre		Vancouver
VCHA	VCHA - Residential	Little Mountain Place		Vancouver
VCHA	VCHA - Residential	Minoru Residence	6111 Minoru Boulevard	Richmond
VCHA	VCHA - Residential	Olive Devaud Residence		Powell River
VCHA	VCHA - Residential	Pinegrove Place		Richmond
VCHA	VCHA - Residential	Point Grey Private Hospital		Vancouver
VCHA	VCHA - Residential	Renfrew Care Centre		Vancouver
VCHA	VCHA - Residential	Richmond Lions Manor		Richmond
VCHA	VCHA - Residential	Rosewood Manor		Richmond
VCHA	VCHA - Residential	Royal Arch Masonic Home		Vancouver
VCHA	VCHA - Residential	Royal Ascot Care Centre		Vancouver
VCHA	VCHA - Residential	Shorncliffe Intermediate Care Facility		Sechelt
VCHA	VCHA - Residential	Simon KY Lee Seniors Home		Vancouver
VCHA	VCHA - Residential	St. Jude's Anglican Home		Vancouver
VCHA	VCHA - Residential	St. Vincent's Hospital - Brock Fahrni Pavilion		Vancouver
VCHA	VCHA - Residential	The Louis Brier Home and Hospital		Vancouver
VCHA	VCHA - Residential	Three Links Care Centre		Vancouver

BPS Services Agreement
Schedule 8 -- Service Locations

Health Authority	Organization	Facility Name	Street Address	City
VCHA	VCHA - Residential	Totem Lodge		Sechelt
VCHA	VCHA - Residential	Villa Carital		Vancouver
VCHA	VCHA - Residential	Villa Cathay Care Home		Vancouver
VCHA	VCHA - Residential	West Vancouver Care Centre		West Vancouver
VCHA	VCHA - Residential	Yaletown House		Vancouver

**SCHEDULE BB
SERVICE PROVIDER KEY PERSONNEL**

to the

SERVICES AGREEMENT

SCHEDULE BB
SERVICE PROVIDER KEY PERSONNEL

Service Provider Key Personnel		2 Year Minimum Initial Period
Project Executive	TBD	<i>Full Time</i>
Chief Technology Officer	Allan Helton	<i>Full Time</i>
PartnerCST Leadership	Julia Cooney	<i>Full Time</i>
Stakeholder Engagement Executive	Mark Derraugh	<i>Full Time</i>
Clinical Implementation Lead	TBD	<i>Full Time</i>
Clinical Transformation Advisor	Dalton Truthwaite	<i>Full Time</i>

The Parties acknowledge and agree that within 2 months after the commencement of Schedule D1(a)(i): (a) the Parties will complete the TBD references in the table above; and (b) the Parties will prepare a list containing a reasonable number of additional Service Provider Key Personnel roles to be added to the table above (with the specific individuals to fill such additional Service Provider Key Personnel roles) to be provided to the Joint Executive Committee for review and approval.

SCHEDULE CC
APPROVED SUBCONTRACTORS

to the

SERVICES AGREEMENT

SCHEDULE CC
APPROVED SUBCONTRACTORS

1. Approved Subcontractors

Deloitte Inc. (“**Deloitte**”) (which may include Deloitte Consulting LLP and Deloitte Consulting India Private Limited)

maxIT Healthcare Ltd. (“**maxIT**”)

SBI Business Initiatives, LLC, an affiliate of University of Pittsburgh Medical Center (“**UPMC**”) (including, for certainty, UPMC Canada Technologies Ltd.)

2. Approved Subcontractors who are not Canadian Entities

Notwithstanding Section 13.2(4) of the Agreement, the following Approved Subcontractors are not a Canadian Entity as defined therein:

UPMC

The Health Organizations hereby agree that the provisions of Section 13.2(5) of the Agreement with respect to UPMC:

- a. being or remaining a Canadian Entity
- b. being or remaining corporately controlled by a Canadian entity, or
- c. being or remaining corporately controlled by or by individuals who are not Foreign Employed Individuals

shall not apply for the purposes of this Agreement.

3. Approved Subcontractors who are not Corporately Controlled by a Canadian Entity

Notwithstanding Section 13.2(5) of the Agreement, the following Approved Subcontractors are not Corporately Controlled by Canadian Entity as defined therein:

maxIT

Deloitte

The Health Organizations hereby agree that the provisions of Section 13.2(5) of the Agreement with respect to maxIT and Deloitte:

- a. being or remaining corporately controlled by a Canadian Entity, or
- b. being or remaining corporately controlled by or by individuals who are not Foreign Employed Individuals

shall not apply for the purposes of this Agreement.

4. Service Provider and Subcontractor Personnel

Notwithstanding Section 13.2(5) of the Agreement, Service Provider Personnel and Subcontractor Personnel used by the following Approved Subcontractors in the performance of Services may be Foreign Employed Individuals:

Deloitte

maxIT

UPMC

The Health Organizations hereby agree that the provisions of Section 13.2(5) of the Agreement with respect to Personnel (whether Service Provider Personnel or Subcontractor Personnel) shall not apply with respect to Deloitte, maxIT and UPMC.

**SCHEDULE DD
FEES**

to the

SERVICES AGREEMENT

**SCHEDULE DD
FEES**

1. INTRODUCTION

1.1 Definitions

Capitalized words used in this Schedule shall have the meanings given to such words as in the Agreement and, if any such word is not defined in the Agreement, it shall have the meaning provided in Appendix A (*Definitions*) to this Schedule unless the context requires otherwise.

1.2 Purpose of this Schedule

This Schedule sets forth the financial consideration payable by the Health Organizations to the Service Provider for all of the Services to be performed by Service Provider, and all of the tasks, services, licenses, assignments, representations, warranties and obligations of Service Provider, under the Agreement.

1.3 Principles of this Schedule

The Parties acknowledge that the Fees set forth in this Schedule are based upon the following principles, which principles apply to, and form an integral part of, this Schedule:

- (a) as of the Effective Date, the Fees payable for the Services performed under the Service Schedules consist of the following:
 - (i) fees calculated on a time and materials basis using the committed hourly labour rates set forth in the attached Appendix B (the “**Hourly Labour Rates**”) multiplied by the applicable Estimated Work Effort for such Services as set forth in the attached Appendix C (the “**Time and Materials Fees**”) and invoiced on a monthly basis based on the actual effort (in hours) incurred as reported by the Service Provider to the Health Organizations, and payable in accordance with Article 17 of the Agreement; and
 - (ii) Pass-Through Expenses in accordance with Section 2.2 below;
- (b) the total contract value for the scope of Services under the Service Schedules is \$188.32M, based upon the estimated Time and Materials Fees for each Service Schedule calculated using the applicable Hourly Labour Rates and Estimated Work Effort for each Service Schedule, as set forth below:

Schedule	Allocation of Total Contract Value	Percentage of Total Contract Value
Schedule D1(a)(i) - Strategy and Verification	\$4,703,286	2.5%
Schedule D1(a)(ii) - Enterprise Design Build	\$77,688,819	41.3%
Schedule D3(a) - Wave 1 Local Configuration and Implementation	\$50,150,763	26.6%
Schedule D3(b) - Wave 2 Local Configuration and Implementation	\$24,050,092	12.8%
Schedule D3(c) - Wave 3 Local	\$15,105,676	8.0%

Configuration and Implementation		
Schedule D3(d) – Automation and Optimization	\$16,619,132	8.8%
Total	\$188,317,768	100%

- (c) all Time and Materials Fees exclude Pass-Through Expenses, which will be paid for separately in accordance with Sections 2.2 and 2.2 below;
- (d) The Health Organizations will have the option to convert the Time and Materials Fees and the Pass-Through Expenses for the Services performed under any one or more of the Service Schedules to fixed price Fees using the applicable Fixed Price Premium, as more particularly described in Section 3 below (the “Fixed Price Fees”). If the Health Organizations elect to convert the Time and Materials Fees for a Service Schedule or specific Work Packages within a Service Schedule to Fixed Price Fees, then:
 - (iii) the Health Organizations may, but are not obligated to, also convert the Pass Through Expenses for that Service Schedule, or specific Work Packages within that Service Schedule, to Fixed T&L Fees at the same time; and
 - (iv) the Parties will cooperate with each other, acting in good faith, and will use all reasonable commercial efforts, to minimize the risks driving the Fixed Price Premium used to convert any Time and Materials Fees and the Pass Through Expenses to Fixed Price Fees and Fixed T&L Fees respectively, it being the express intention of the Parties that the lowest possible Fixed Price Premium be used under the prevailing circumstances;
- (e) the Services to be provided by the Service Provider under the Agreement, and all Schedules attached to the Agreement, are included in the Fees payable by the Health Organizations in respect of the Service Schedules as set forth in this Schedule DD – Fees, with the exception of any new fees payable under a Change Order;
- (f) all Fees payable by the Health Organizations to the Service Provider under the Agreement are subject to a specified level of transparency in favour of the Health Organizations, as more particularly described in Section 2.4 below;
- (g) the Hourly Labour Rates set forth in the attached Appendix B are two-year rates that do not include any inflationary component after Contract Year 2, and accordingly, they are subject to adjustment for inflation after Contract Year 2, as more particularly described in Section 2.6 below;
- (h) utilizing the Schedule Refinement Process described in the Services Schedules (other than Schedule D1(a)(i)), the Parties will finalize and update the Service Schedules and if they are unable to agree upon the finalized and updated Service Schedules within the Schedule Refinement Period, then the Health Organizations may either proceed with the applicable Service Schedule in the form attached to the Agreement, or they may de-scope the Services by removing the Service Schedule in question from the Services to be performed by the Service Provider, in which case, the provisions of Section 2 of Schedule N, De-Scoping Fees, will apply;

- (i) the Parties acknowledge and agree that any and all Fees associated with Schedule D3(d), as contemplated in this Schedule DD, may be reallocated by the Health Organizations, in their sole discretion, and used by the Health Organizations to pay for any other Services purchased by the Health Organizations from the Service Provider under the Agreement (including, for greater certainty, Future Potential Services contemplated in Appendix I to each of the Services Schedules). For clarity, this provision does not in any way amend, limit or affect the Health Organizations' right to De-Scoping of a Service Schedule under Schedule N to the Agreement; and
- (j) with respect to items DB45, DB46, DB47 of Appendix C, Table 2 (Schedule 1(a)(ii) of this Schedule, the Parties acknowledge and agree that the Fees for such items (items DB45, DB46, DB47 of Table 2) are based on the Health Organizations completing the necessary re-work of the RAD Net. The Parties agree that the evaluation criteria to determine whether the necessary re-work has been completed will be determined by mutual agreement of the Parties on or before July 19, 2013.

1.4 Appendices

The following Appendices are attached to and form part of this Schedule:

Appendix A	-	Definitions
Appendix B	-	Rate Tables
Appendix C	-	Service Schedule Pricing and Fees Tables
Appendix D	-	Risk Contingency Criteria

2. PRICING

2.1 Hourly Labour Rates

The Hourly Labour Rates for the Time and Materials Fees payable in respect of the Services provided under the Service Schedules, as set forth in the attached Appendix B, include all labour and other forms of resources required by the Service Provider to perform those Services, other than the following:

- (a) Pass-Through Expenses;
- (b) the Program Management Office fixed fees (the "PMO Fixed Fees"); and
- (c) inflation after Contract Year 2

2.2 Pass-Through Expenses

2.2.1 Where the Service Provider is performing the Services under a Service Schedule for Time and Materials Fees, then the Service Provider is entitled to charge the Health Organizations for the applicable Pass Through Expenses properly incurred by the Service Provider in accordance with Schedule Q of the Agreement (in particular the Travel and Business Expense Policy as amended by the one page addendum attached or as otherwise documented and agreed to by the Parties in writing), which Pass Through Expenses will be in addition to the Time and Materials Fees, invoiced monthly, payable on a monthly basis by the Health Organizations in accordance with Article 17 of the Agreement.

2.2.2 Pass-Through Expenses will be adjusted in accordance with the Schedule Refinement Process.

2.2.3 If the Health Organizations convert the Time and Materials Fees for the Services performed under a Service Schedule, or specific Work Packages within a Service Schedule, to Fixed Price Fees (in accordance with Section 3 below), then the Health Organizations may, at the same time and at their option, elect to convert the applicable Pass Through Expenses for that Service Schedule to fixed price fees calculated as the "T&L Estimate" for that Service Schedule, or specific Work Packages within a Service Schedule, as indicated in the attached Appendix C - Service Schedule Pricing and Fees Tables (and as adjusted by the Schedule Refinement Process), marked-up by a percentage equal to 15% plus the Fixed Price Premium for that Service Schedule, or specific Work Packages within a Service Schedule (the "Fixed T&L Fees").

2.3 Program Management Office Fixed Fees

2.3.1 The Service Provider will provide Program Management Office services, as described in the Services Schedule, in the delivery of the Services Schedules, and the Health Organizations will pay the Service Provider the PMO Fixed Fees monthly as set forth in Appendix C, Table 7 – Service Schedule Pricing and Fees Tables of this Schedule DD, upon completion of the Program Management Office services set forth in Section 11 of each Service Schedule and related Appendix C of each Service Schedule.

2.3.2 The PMO Fixed Fees will not be subject by the Adjustment Mechanism in section 2.6 over the Term (PMO Fixed Fees are not subject to inflation adjustments).

2.3.3 If the Health Organizations wish to convert a Service Schedule, or specific Work Packages within a Service Schedule, to Fixed Price Fees, the PMO Fixed Fees will not be subject to section 3 and therefore not subject to the Risk Premiums as set forth in Sections 3.4(b) and 3.8.

2.4 Financial Transparency

2.4.1 The Service Provider will provide the Health Organizations with financial transparency of the Fees by disclosing to the Health Organizations the unit pricing for each of the following (where unit pricing can be reasonably identified) and specific labour rates for individual resources, such as the Hourly Labour Rates in Appendix B – Rates Table.

2.4.2 If the Health Organizations elect, through the Change Process, to cause the Service Provider to perform any optional services under the Agreement, then the Service Provider will provide the Health Organizations with financial transparency on the fees for those optional services by disclosing to the Health Organizations the unit pricing associated with the optional services. For example, and by way of illustration, the unit pricing may include the unit prices for the following:

- (a) physical servers;
- (b) servers images;
- (c) Appliances;
- (d) Service Provider Tools;
- (e) Service Provider Software; and
- (f) Design & Build Accelerators.

2.4.3 If the Health Organizations request a change to a portion of the Services that are integrated into the other Services to be provided under the Service Schedules (the "**Changed Integrated Services**"), such that the Health Organizations cannot reasonably obtain the Changed Integrated Services from an alternate provider, and the Parties are unable to agree on the fees for the Changed Integrated Services, then the fees for the Changed Integrated Services will be charged based upon the following, subject to the Change Process:

- (a) the prevailing Hourly Labour Rates for the actual time spent by the applicable resources in performing the Changed Integrated Services; and
- (b) all actual third party hardware, software or maintenance costs incurred by the Service Provider, if any, in performing the Changed Integrated Services plus 15%, unless the Service Provider is restricted by its contractual agreements with the third party vendor from sharing its costs in which case the Service Provider will charge a price that includes a mark-up not to exceed 15%.

2.5 Windfall Protection

The Service Provider will notify the Health Organizations of any technological advances identified by the Service Provider which can be, or are being, used by the Service Provider to materially lower its costs of performing the Services. The Health Organizations and the Service Provider will use the Joint Executive Governance Committee to review any such significant technological advances identified, and will work cooperatively with each other, in good faith and both acting reasonably, to consider and agree upon any resulting changes to the Fees under this Schedule DD—as a result of the use of any such technological advances by the Service Provider.

2.6 Adjustment Mechanism - Hourly Labour Rates

2.6.1 Commencing in Contract Year 3, and for each subsequent Contract Year, the Hourly Labour Rates set forth in the attached Appendix B, and any Fixed Price Fees where the Health Organizations have not elected to apply the Fixed Inflation, will be subject to an inflation adjustment calculated on an annual basis, that is equal to the percentage change in the Canadian Consumer Price Index (all items) over the preceding 12 month calendar year, calculated based upon the following (the "**Adjustment Mechanism**"):

- (a) the Parties will use the annual Canadian All-items Consumer Price Index determined by Statistics Canada, CANSIM Table 326-0021 (the "**Annual CPI**") for purposes of determining any adjustments to the Hourly Labour Rates or the applicable Fixed Price Fees, as the case may be, under this provision;
- (b) the percentage change in the Annual CPI over the preceding calendar year to be applied to the Hourly Labour Rates or the applicable Fixed Price Fees, as the case may be, will be calculated as follows:

Percentage Change in CPI	=	$\frac{[(\text{CPI Current Year} - \text{Base Year Index}) / \text{Base Year Index}] * 100\%}{}$

Example Illustrations: *The following calculations are for illustrative purposes.*

Percentage Change in CPI for Contract Year 3	=	$[(\text{Annual CPI for 2014} - \text{Annual CPI for 2013}) / \text{Annual CPI for 2013}] * 100\%$
Percentage Change in CPI for Contract Year 4	=	$[(\text{Annual CPI for 2015} - \text{Annual CPI for 2014}) / \text{Annual CPI for 2014}] * 100\%$
Percentage Change in CPI for Contract Year 7	=	$[(\text{Annual CPI for 2018} - \text{Annual CPI for 2017}) / \text{Annual CPI for 2017}] * 100\%$

Where:

“**CPI Current Year**” means the Annual CPI for the calendar year immediately preceding the current Contract Year; and

“**Base Year Index**” means the Annual CPI for the calendar year that immediately precedes the calendar year applicable to the CPI Current Year.

For clarity, the PMO Fixed Fees will not be subject by the Adjustment Mechanism over the Term. (PMO Fixed Fees are not subject to inflation adjustments).

2.6.2 If the Health Organizations convert the Time and Materials Fees for the Services performed under a Service Schedule to Fixed Price Fees, then the Health Organizations may, at the same time and at their option, elect to convert the Adjustment Mechanism to be applied to the Fixed Price Fees for that Service Schedule to a fixed inflation amount (the “**Fixed Inflation**”), calculated by the Service Provider and accepted by the Health Organizations. The Fixed Inflation Amount will be incorporated into, and form part of, the Fixed Price Fees, and accordingly, there will be no further annual or other adjustments made thereto as a result of inflation.

2.6.3 Upon application of the Adjustment Mechanism, the Hourly Rates in Appendix B, and any related fees in Appendix C will be amended accordingly.

3. **FIXED PRICING APPROACH**

3.1 **Right to Convert to Fixed Price**

As part of the Schedule Refinement Process under the applicable Services Schedule and not later than three (3) weeks from commencement of the next Services Schedule, the Health Organizations will notify the Service Provider that the Health Organizations may exercise their right to convert the particular Service Schedule, or specific Work Packages within a Service Schedule, from Time and Materials Fees to Fixed Price Fees, and at the option of the Health Organizations that any one or more of the following corresponding costs be converted as follows: (i) the Pass Through Expenses related thereto be converted to Fixed T&L Fees, and/or (ii) the Adjustment Mechanism related thereto be converted to Fixed Inflation.

3.2 **Notice to Convert to Fixed Price**

If the Health Organizations wish to convert a Service Schedule, or specific Work Packages within a Service Schedule, to Fixed Price Fees, then they will notify the Service Provider of their intention during the Schedule Refinement Process not later than one (1) week before the Services are scheduled to commence thereunder. Upon receipt of the notice from the Health Organizations, the Service Provider will prepare (working in consultation with the Health Organizations, as required) and deliver to the Health Organizations within the applicable time requirements of the Review Period, a draft Fixed Price Fee quote for the Services to be performed under the Service Schedule, and where applicable, the Fixed T&L Fee quote for the applicable Pass Through Expenses.

3.3 Review Period

The Parties will agree on a fixed time period (the “**Review Period**”) to prepare and review the draft Fixed Price Fee quote for the Service Schedule, and the Review Period will include the following:

- (a) the target completion date for the initial draft of the Fixed Price Fee quote;
- (b) the target review period(s) stated in calendar days for the the Health Organizations to review and provide comments and requested changes to the Service Provider;
- (c) the target period stated in calendar days for the Service Provider to respond to the Health Organizations’ comments and requested changes;
- (d) the target date for the Service Provide to deliver to the Health Organizations a final Fixed Price Fee quote.

3.4 Fixed Price Fee Quote

The draft and final Fixed Price Fee quote for the applicable Services Schedule (Service Schedule or specific Work Packages that the Health Organizations wish to convert as contemplated in this Section 3) will include the following:

- (a) a Fixed Price Fee calculation that includes the following components:
 - (i) the Estimated Work Effort required for each resource role multiplied by the Hourly Labour Rates, as set forth in Appendix C - Service Schedule Pricing and Fees Tables;
 - (ii) a description and estimate of any relevant expenses to be incurred, including but not limited to, Pass Through Expenses;
 - (iii) the Service Provider’s assessment of the Risk Profile with supporting reasons for the determination of overall Risk Profile rating based upon the Risk Contingency Criteria set out in the attached Appendix D – Risk Contingency Criteria.
- (b) the total Fixed Price Fees will be calculated as the sum total of:
 - (i) all costs for labour identified in Section 3.4(a)(i) above, multiplied by (1 + Risk Premium Percentage), using the applicable percentage (or blend of percentages as applicable) from the table below:

Overall Risk Assessment	Low	Medium	High
Risk Premium Percentage	6%	12%	18%

- (ii) if the Health Organizations elect to convert Pass Through Expenses to fixed price, the Service Provider will calculate a Fixed Price T&L Fee quote in accordance with Section 2.2.3 of this Schedule DD and provide the same to the Health Organizations.
- (c) a delivery payment schedule that will include all Interim Milestones and Critical Deliverables and their associated payments applicable to the Fixed Price Fee quote (such that the total of all payments equals the Fixed Price Fee quote calculated in accordance with the above).

3.5 Approval of Fixed Price Fee

Prior to finalizing the draft Fixed Price Fee quote, the Health Organizations may reject the draft Fixed Price Fee quote, provide comments back to the Service Provider, or recommend acceptance of the Fixed Price Fee quote or initiate a Dispute with respect to the Risk Premium Percentage amount. Such Dispute will be an Expedited Arbitration under Schedule P – Dispute Resolution.

3.6 SP Response to Health Organization Comments

If the Health Organizations provide comments or suggested changes to the draft Fixed Price Fee quote, then the Service Provider will review and respond to the comments or changes and, as required, provide an updated draft Fixed Price Fee quote to the Health Organizations as per the timing requirements of the Review Period, or other such period as may be mutually agreed to by the Parties, acting reasonably.

3.7 Acceptance of Fixed Fee

If the Health Organizations notifies the Service Provider, in writing, that it accepts the draft Fixed Price Fee quote, then the draft Fixed Price Fee quote will be, and will be deemed to be, final and will be incorporated into the Agreement using the Change Process. Notwithstanding the provisions of Section 17.6(4) of the Agreement, invoices for the Fixed Price Fees will be delivered by the Service Provider to the Health Organizations upon the acceptance of the Interim Milestone or Critical Deliverable, as the case may be, and such invoices are due and payable within thirty days (30) days after receipt by the Health Organizations, provided that the invoice complies with the requirements of the Agreement.

3.8 Escalation

If at the conclusion of the Review Period the draft Fixed Price Fee quote is rejected by the the Health Organizations, then the Parties will escalate the issue to the Executive Governance Committee for resolution. If the matter is not resolved after being escalated to the Executive Governance Committee, then the Health Organizations may elect to either de-scope and thereby remove the Services for the applicable Service Schedule through the Change Process (and payment of the applicable Termination Fee) or elect to proceed with the applicable Service Schedule in the form attached to this Agreement, and converting the applicable Service Schedule fees set forth in Appendix C - Service Schedule Pricing and Fees Tables to Fixed Price Fees based upon:

- (a) applying the applicable Fixed Price Risk Premiums set forth in the table below to:
 - (i) the applicable Service Schedule Time and Materials Fees , and
 - (ii) where elected by the Health Organizations, to convert the applicable Service Schedule Pass Through Expenses in to Fixed T&L Fees

Schedule	Fixed Price Risk Premium %
Schedule D1(a)(i) Strategy and Verification	6%
Schedule D1(a)(ii) Enterprise Design, Build	16.5%
Schedule D3(a) - Implementation Wave 1	14%
Schedule D3(b) - Implementation Wave 2	14%
Schedule D3(c) - Implementation Wave 3	10%
Schedule D3(d) - On-Going Optimization	6%

and,

- (b) including the applicable monthly based Service Schedule PMO Fixed Fees as set forth in Appendix C table 7 – Service Schedule Pricing and Fees Tables.

**SCHEDULE DD
FEES**

**APPENDIX A
DEFINITIONS**

“Adjustment Mechanism” has the meaning set forth in Section 2.6.1 of this Schedule DD – Fees.

“Annual CPI” has the meaning set forth in Section 2.6.1(a) of this Schedule DD – Fees.

“Appliance” means a purpose-built computing device; a virtual or physical server dedicated to a single purpose or applications (e.g. a firewall appliance, a Google search appliance); hardware is optimized for the specific application and conversely, the application is highly optimized for the hardware.

“Base Year Index” has the meaning set forth in Section 2.6.1(b) of this Schedule DD – Fees.

“Changed Integrated Services” has the meaning set forth in Section 2.4.3 of this Schedule DD – Fees.

“Contract Year” means any one year period during the Term, commencing on the Effective Date or any anniversary thereof.

“Estimated Work Effort” means the hours of effort by resource role the Service Provider has estimated will be required to perform the Services as described in a Services Schedule.

“Fixed Inflation” has the meaning set forth in Section 2.6.2 of this Schedule DD – Fees.

“Fixed Price Fees” has the meaning set forth in Section 1.3(d) of this Schedule DD – Fees.

“Fixed T&L Fees” has the meaning set forth in Section 2.2.3 of this Schedule DD – Fees.

“Fixed Price Premium” means the percentage premium to be applied to certain fees or costs under this Schedule DD – Fees for purposes of converting them to a fixed fee or fixed cost, as determined pursuant to Section 3 of this Schedule DD- Fees (including, without limitation, Sections 3.1 and 3.8 thereof).

“Hourly Labour Rates” has the meaning set forth in Section 1.3(a) of this Schedule DD – Fees.

“Percentage Change in CPI” is calculated in accordance with Section 2.6.1(b) of this Schedule DD – Fees.

“PMO Fixed Fees” has the meaning set forth in Section 2.1 of this Schedule DD – Fees.

“Review Period” has the meaning set forth in Section 3.3 of this Schedule DD – Fees.

“Risk Profile” means the designation of a low, medium or high “Overall Risk Assessment” to the Services for a Service Schedule, as contemplated under Section 3.4(b) of this Schedule DD- Fees, for purposes of determining the applicable Risk Premium Percentage.

“Schedule Refinement Process” means the process that the Parties undertake to make refinements to a Service Schedule (as set forth in each Service Schedule).

“Service Provider Software” means the Service Provider’s commercially available software.

“Service Provider Tools” means the Service Provider’s commercially available software required by the Service Provider to perform the Services.

“Service Schedules” means Schedule D1(a)(i)- Strategy and Verification, Schedule D1(a)(ii) - Enterprise Design Build, Schedule D3(a) - Wave 1 Local Configuration and Implementation, Schedule D3(b) - Wave 2 Local Configuration and Implementation, Schedule D3(c) - Wave 3 Local Configuration and Implementation and Schedule D3(d) – Automation and Optimization.

“Time and Materials Fees” has the meaning set forth in Section 1.3(a) of this Schedule DD – Fees.

**SCHEDULE DD
FEES**

**APPENDIX D
RISK CONTINGENCY CRITERIA**

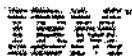
Risk Criteria	High	Medium	Low
General Criteria: <i>The following applies to each Schedule or Work Package</i>			
Clarity and Granularity of Requirements	Requirements are ambiguous or are not documented in the Work Package	Requirements are known but not documented in detail in the Work Package	Requirements are well defined in the Work Package (e.g. exist as detailed specifications or Use Cases)
Scope Quantification	Scope is not quantified for deliverables	Scope is quantified for functional deliverables	Scope is fully quantified for all material deliverables
Schedule Contingency	Highly compressed schedule; No schedule contingency	Compressed schedule with one week of schedule contingency per quarter	>1 week of schedule contingency per quarter
Roles & Responsibilities of all parties	No written roles and responsibilities	Written roles and responsibilities but without interdependency clarifications (i.e. no RACI)	Fully documented and completely clear. RACI in place and agreed to by all participants
Dependency on, and access to HO SMEs (clinical & technical)	HO SMEs are not named,	Some SMEs will be named and assigned	SMEs will be named and assigned
Dependency on 3 rd parties (e.g. Cerner)	3 rd party milestones lack clarity or we have no proven track record of 3 rd performance	3 rd party milestones are clear, past track record has been good but 3 rd party is not contractually bound to their applicable milestone	No dependence on 3 rd party for milestones or the Health Organizations has bound the 3 rd party to the applicable milestones
Work Package Duration	Long (9 months or more) with 3 or more phases	Moderate (4-8 months) and single or few phases	Short (up to 4 months) and single phase
HO Team work location	Team working in multiple locations outside of a single metro area	Team working in multiple locations in the same metro area	Team working in same physical location
Special Criteria: <i>The following only applies to Schedules or Work Packages that have Design, Configure, Build or Test components</i>			
Data Quality/Complexity	Data migration required but data design and quality not fully understood	Data migration required but data design and quality are fully understood	No data migration requirements

**SCHEDULE EE
FORM OF INVOICE**

to the

SERVICES AGREEMENT

SCHEDULE EE
FORM OF INVOICE



IBM Canada Ltd.

IBM GLOBAL BUSINESS SERVICES

Install At Health Shared Services BC
700-1380 Burrard Street
Vancouver, British Columbia, V6Z 2H3

Invoice No.: XXXXXX
Invoice Date: Month Day Year
Customer No.: XXXXXX

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P.O. Box 34030
Vancouver, B.C. V6J 4M1

Invoice To Health Shared Services BC
700-1380 Burrard Street
Vancouver, British Columbia, V6Z 2H3
ATTN: ACCOUNTS PAYABLE
VICTORIA BC

For questions about your invoice

Call: CUSTOMER SUPPORT ONLINE
1-866-880-2765
Write: 1380 RENE-LEVESQUE BLVD WEST
SUITE 400 MONTREAL QC H3G 2W6
Fax: 1-845-491-5063
Email: cso1@ca.ibm.com

Description	Quantity	Charge	Bill Amount
Install Customer #: 0000000			
P.O.# PO NUMBER HERE			
Project Number: PROJECT DESCRIPTION HERE			

FOR FIXED PRICE SERVICES & EXPENSES UNDER SCHEDULE D1(a)(ii) DURING THE MONTH OF ~~March~~ 2013

FIXED PRICE DELIVERABLES ACCEPTED

Deliverable 1		582,000.00
Deliverable 2		195,500.00
Deliverable 3		866,350.00
Harmonized Sales Tax 12% x	1,643,850.00	197,262.00

PCO SERVICES FIXED FEE

Harmonized Sales Tax 12% x	177,023.52	177,023.52
		21,242.82

EXPENSES

A Smith		11,544.00
B Jones		4,811.43
J Doe		2,315.75
Harmonized Sales Tax 12% x	18,671.18	2,240.54

SUMMARY

Total of Services and Expenses	1,839,544.70
Total of Harmonized Sales Tax	220,745.36
IBM GST REGISTRATION NUMBER 102444452 RT0001	

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e-payment options including wire transfers, electronics funds transfers
direct debit and credit card. For more information please visit
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Payable on MONTH DAY YEAR

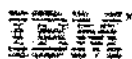
=> \$ 2,060,290.06

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Page 1 of 1



IBM Canada Ltd.

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Fax: 1-845-491-5063
Email: cso1@ca.ibm.com

Description	Quantity	Charge	Bill Amount
Install Customer #: 0000000			
P.O.# PO NUMBER HERE			
Project Number: PROJECT DESCRIPTION HERE			
FOR TIME & MATERIAL SERVICES & EXPENSES UNDER SCHEDULE D1(a) (i) DURING THE MONTH OF mm 2013			
TIME & MATERIAL SERVICES FEES			
CIS leadership Senior Project Manager	185 HRS	390.00	72,150.00
CIS Leadership Application Support	160 HRS	182.00	29,120.00
CIS leadership Technical Architect	85 HRS	162.50	13,812.50
Harmonized Sales Tax 12% x			13,809.90
EXPENSES			
A Smith			11,544.00
B Jones			4,811.43
J Doe			2,315.75
Harmonized Sales Tax 12% x			2,240.54
SUMMARY			
Total of Services and Expenses			133,753.68
Total of Harmonized Sales Tax			16,050.44
IBM GST REGISTRATION NUMBER 10244452 RT0001			

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Page 1 of 1

**SCHEDULE FF
CORPORATE ORGANIZATION CHART**

to the

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**SCHEDULE FF
CORPORATE ORGANIZATIONAL CHART**

**Organizational Structure
IBM Canada Limited as of the Effective Date**

IBM International Business Machines is a publicly traded company listed on the New York Stock Exchange

International Business Machines Corporation

International Business Machines Corporation owns 80% of the issued and outstanding shares in the capital of IBM International Group B.V.

(20% is owned by IBM World Trade Investments B.V. a wholly owned subsidiary of IBM World Trade Corp. which is, in turn, a wholly owned subsidiary of International Business Machines Corporation)

IBM International Group B.V.

IBM International Group B.V. owns 100% of the issued and outstanding shares in the capital of IBM Canada Holdings B.V.

IBM World Trade Americas Holding ULC.

IBM World Trade Americas Holding ULC owns 100% of the issued and outstanding shares in the capital of IBM Canada Limited

IBM Canada Limited

This Schedule FF constitutes commercial and financial information of Service Provider, and is supplied by Service Provider to HSSBC only as required in accordance with Section 13.2. Schedule FF constitutes Service Provider Confidential Information.

**SCHEDULE GG
ADDITIONAL REMEDIES OF
HEALTH ORGANIZATIONS**

to the

SERVICES AGREEMENT

SCHEDULE GG
ADDITIONAL REMEDIES OF HEALTH ORGANIZATIONS

Nil

Michell, Jennifer HLTH:EX

From: Long, Michael <Michael.Long@phsa.ca>
Sent: Wednesday, December 21, 2016 3:18 PM
To: Feulgen, Sabine HLTH:EX
Subject: FW: Draft report for the Ministry
Attachments: 2016-12-09 Report for Ministry of Health.docx

Categories: Printed

Sabine,

Just a quick follow-up on this report and what next steps you would like us to take.

Have a great Christmas!

Michael

From: Long, Michael
Sent: Tuesday, December 13, 2016 10:28 PM
To: 'Feulgen, Sabine'
Subject: FW: Draft report for the Ministry

Sabine,

This is the draft report we have created from interviews with other Canadian Cerner clients.

Please let me know if this meets your needs for Stephen.

Michael

Michell, Jennifer HLTH:EX

From: Anderson, Kristy GCPE:EX
Sent: Friday, November 25, 2016 11:45 AM
To: Feulgen, Sabine HLTH:EX
Subject: FW: CST Activation schedule-change memo - for your review
Attachments: 20161124 CST Activation schedule change memo v1.docx

Hi Sabine – do you have any issues with this going out? I might suggest they wait until Dec. 5th when MTL is back but that is my only suggestion.

Kristy Anderson
Director, Media Relations
Ministry of Health
250-952-3387 (office) 778-678-5200 (mobile)
Kristy.Anderson@gov.bc.ca

From: Cunningham, Dave [<mailto:Dave.Cunningham@phsa.ca>]
Sent: Thursday, November 24, 2016 2:56 PM
To: Anderson, Kristy GCPE:EX
Subject: CST Activation schedule-change memo - for your review

Hi Kristy. Further to our discussion last week with Sabine, here's the internal memo that Michael and the CEOs would like to issue as soon as you're comfortable, regarding the change of activation-schedule for CST. Grateful for feedback – can you also share with Sabine? Thx!

Dave Cunningham
Chief Communications Officer
Provincial Health Services Authority

700-1380 Burrard Street
Vancouver, BC V6X2H3
604-875-7147 Work
604-837-5360 Mobile
dave.cunningham@phsa.ca
[@davcunn](http://www.phsa.ca)

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Memorandum

Date: Nov. 17, 2016

To: VCH, PHSA, and PHC leaders and physicians

From: Michael Long, Acting Chief Transformation Officer, CST

Re: IHealth report and CST project schedule

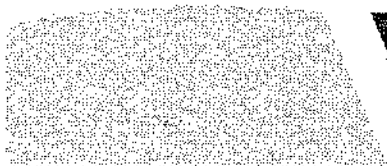
Earlier today, the Ministry of Health, in partnership with Island Health, released results of an independent review of the IHealth electronic health record system.

The review was announced in May in response to concerns raised by physicians and other clinicians regarding the impact of the system – which, like our own Clinical & Systems Transformation (CST) project, is based on the Cerner platform – on workflow and patient care. We took notice then, and we are paying close attention now. Given the obvious similarities of what we are all trying to achieve – namely the creation of an electronic patient care system that will improve safety, quality and consistency of care – it's worthwhile to pause and see what we can learn.

The report, *Review of the Functioning of IHealth*, was prepared under the leadership of Dr. Doug Cochrane, Provincial Patient Safety & Quality Officer and Chair, BC Patient Safety & Quality Council. It provides 26 recommendations.

We have taken a first look at the report. The good news is that it clearly endorses the need for and benefits of an electronic patient care system. With that, we remain confident that we are on the right track. However, the report also flags clear opportunities for us to learn, adapt and achieve the best possible outcomes with our own CST implementation:

- Prior to going live with any new system, we must have a deep understanding of current clinical work processes. Our system must support how our frontline caregivers do their work. To achieve this, it is imperative that we continue to consult with physicians and clinicians on system design – and ensure we work closely with sites to understand the impact of workflow changes prior to implementation;
- Related to this, we must strive to manage those changes in a way that reduces their impacts to clinicians and users as much as possible. A key goal of the CST project is greater consistency in our clinical workflow and practices. That said, if a particular work process needs to change, it should be done in a way that is manageable. People can only cope with so much at one time;
- We must make every effort to create a system that is as user friendly as possible. For example, the IHealth report references clinician concerns with long drop-down menus, font-size and excessive demands for data input. This reinforces the need to design our system in a way that is as relevant as possible to the tasks or work groups at hand;





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- Finally, the report serves as reminder that “training” is only part of the solution in terms of getting ready to use a new system. Our broader “adoption strategy” must include not only technical training, but also mentoring, visible on-site leadership that is responsive to concerns as they are raised, and ongoing support.

The report documents other concerns as well, such as challenges related to how the system supports medication administration and ordering, and the inability to document physician and nurse comments. Both of these challenges reinforce the point that designing clinical information systems is incredibly complex and no one person or team can anticipate everything.

We have already actively sought out Island Health’s experience and learnings, and begun incorporating these into our project planning and system design. This report will be a further help and benefit to our health organizations, and a reminder that our success depends on ensuring we have meaningful clinical oversight from as many users as possible, at every stage.

There is no doubt that even with this feedback, implementing our own CST project will be challenging – made more so by the pressure to “get it right” so that we don’t let our people down, and that we get to a place where we are providing even higher quality care than we do today.

This clear mandate – to do the right thing and to get it right the first time – is now driving our decision to delay the first implementation of CST. We were scheduled to go live at Lions Gate Hospital in spring 2017, but in recent days – ahead and independent of the IHealth report – we decided this is not the best approach. This decision is a direct result of an in-depth assessment, informed by our ongoing engagement and feedback with clinicians, and is the right thing to do.

In the weeks ahead, we will closely review and study the recommendations of the IHealth report, and continue to work with our project teams, physicians and clinicians to seek their input and feedback to ensure the project’s success. In addition to learning from Island Health, we have also increased our effort to learn from others by engaging other organizations who are ahead of us on their clinical information system journey. We will also continue to enlist the help of experienced people based on specific project needs.

For information about CST:

General Inquiries	CST Executive Directors & Transformation Leads	Chief Medical Information Officers
Website: CSTproject.ca Email: info@CSTproject.ca	VCH: Elizabeth Stanger, Elizabeth.Stanger@vch.ca PHSA: Vicky Crompton, Vcrompton@phsa.ca PHC: Grant McCullough, GMcCullough@providencehealth.bc.ca	VCH: Dr. Eric Grafstein, Eric.Grafstein@vch.ca PHSA: Dr. Alain Gagnon, Alain.Gagnon@phsa.ca

Michell, Jennifer HLTH:EX

From: Cunningham, Dave <Dave.Cunningham@phsa.ca>
Sent: Thursday, November 17, 2016 2:58 PM
To: Feulgen, Sabine HLTH:EX; XT:Roy, Carl EHS:IN
Cc: Anderson, Kristy GCPE:EX
Subject: RE: MEMO - Response to IHealth report - DRAFT v4_SF edits
Attachments: 20161117 CST response to IHealth memo - final.docx

Great, thanks Sabine. We'll just remove that section and announce delay separately next week. Kristy, final attached. Cheers, d.

-----Original Message-----

From: Feulgen, Sabine HLTH:EX [<mailto:Sabine.Feulgen@gov.bc.ca>]
Sent: Thursday, November 17, 2016 2:52 PM
To: Roy, Carl <CRoy@phsa.ca>
Cc: Cunningham, Dave <Dave.Cunningham@phsa.ca>; kristy.anderson@gov.bc.ca
Subject: FW: MEMO - Response to IHealth report - DRAFT v4_SF edits

Think it needs a few changes.

Sabine
phone: 250.952-1764
email: Sabine.Feulgen@gov.bc.ca<<mailto:Sabine.Feulgen@gov.bc.ca>>

This email is intended only for the use of the individual or organization to whom it is addressed. It may contain information that is privileged or confidential. Any distribution, disclosure, copying, or other use by anyone else is strictly prohibited. If you have received this in error, please telephone or e-mail the sender immediately and delete the message.

From: Feulgen, Sabine HLTH:EX
Sent: Thursday, November 17, 2016 2:51 PM
To: Dave Cunningham
Subject: MEMO - Response to IHealth report - DRAFT v4_SF edits

Memorandum

Date: Nov. 17, 2016

To: VCH, PHSA, and PHC leaders and physicians

From: Michael Long, Acting Chief Transformation Officer, CST

Re: IHealth report

Earlier today, the Ministry of Health, in partnership with Island Health, released results of an independent review of the IHealth electronic health record system.

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- Finally, the report serves as reminder that “training” is only part of the solution in terms of getting ready to use a new system. Our broader “adoption strategy” must include not only technical training, but also mentoring, visible on-site leadership that is responsive to concerns as they are raised, and ongoing support.

The report documents other concerns as well, such as challenges related to how the system supports medication administration and ordering, and the inability to document physician and nurse comments. Both of these challenges reinforce the point that designing clinical information systems is incredibly complex and no one person or team can anticipate everything.

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In addition to learning from Island Health, we have also increased our effort to learn from others by engaging other organizations who are ahead of us on their clinical information system journey. We will also continue to enlist the help of experienced people based on specific project needs.

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Michell, Jennifer HLTH:EX

From: Ackenhusen, Mary [CORP] <Mary.Ackenhusen@vch.ca>
Sent: Thursday, November 17, 2016 1:58 PM
To: Feulgen, Sabine HLTH:EX
Subject: FW: CST response to IHealth - staff memo
Attachments: 20161117 CST response to IHealth memo - v5.docx

Mary Ackenhusen
President and CEO
Vancouver Coastal Health
11th Floor, 601 West Broadway
Vancouver, BC V5Z 4C2
Tel: 604.875.4721
e-mail: mary.ackenhussen@vch.ca<<mailto:mary.ackenhussen@vch.ca>>
Executive Assistant: Winnie Price, winnie.price@vch.ca, 604 875-4721

From: Dave Cunningham <dave.cunningham@phsa.ca<<mailto:dave.cunningham@phsa.ca>>>
Date: Thursday, November 17, 2016 at 1:45 PM
To: Carl Roy <CRoy@phsa.ca<<mailto:CRoy@phsa.ca>>>, Mary Ackenhusen
<mary.ackenhussen@vch.ca<<mailto:mary.ackenhussen@vch.ca>>>
Subject: CST response to IHealth - staff memo

Kristy in MoH Comms would like Sabine's sign-off on this memo before approving, but Sabine is in Leadership Council with you. Any chance one of you can discuss this with her if you have a break? (In particular the highlighted section re. delaying CST implementation – Michael and I feel we need to communicate this.)

Memorandum

Date: Nov. 17, 2016
To: VCH, PHSA, and PHC leaders and physicians
From: Michael Long, Acting Chief Transformation Officer, CST
Re: IHealth report and CST project schedule

Earlier today, the Ministry of Health, in partnership with Island Health, released results of an independent review of the IHealth electronic health record system.

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- Finally, the report serves as reminder that “training” is only part of the solution in terms of getting ready to use a new system. Our broader “adoption strategy” must include not only technical training, but also mentoring, visible on-site leadership that is responsive to concerns as they are raised, and ongoing support.

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This clear mandate – to do the right thing and to get it right the first time – is now driving our decision to delay the first implementation of CST. We were scheduled to go live at Lions Gate Hospital in spring 2017, but in recent days – ahead and independent of the IHealth report – we decided this is not the best approach. This decision is a direct result of an in-depth assessment, informed by our ongoing engagement and feedback with clinicians, and is the right thing to do.

In the weeks ahead, we will closely review and study the recommendations of the IHealth report, and continue to work with our project teams, physicians and clinicians to seek their input and feedback to ensure the project’s success. In addition to learning from Island Health, we have also increased our effort to learn from others by engaging other organizations who are ahead of us on their clinical information system journey. We will also continue to enlist the help of experienced people based on specific project needs.

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For More Information

General Inquiries	CST Executive Directors & Transformation Leads	Chief Medical Information Officers
Website:	VCH: Elizabeth Stanger,	VCH: Dr. Eric Grafstein,



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Re: IHealth report and CST project schedule

Earlier today, the Ministry of Health, in partnership with Island Health, released results of an independent review of the IHealth electronic health record system.

The review was announced in May in response to concerns raised by physicians and other clinicians regarding the impact of the system – which, like our own Clinical & Systems Transformation (CST) project, is based on the Cerner platform – on workflow and patient care. We took notice then, and we are paying close attention now. Given the obvious similarities of what we are all trying to achieve – namely the creation of an electronic patient care system that will improve safety, quality and consistency of care – it's worthwhile to pause and see what we can learn.

The report, formally known as the *"Review of the Functioning of IHealth,"* was prepared under the leadership of Dr. Doug Cochrane, Provincial Patient Safety & Quality Officer and Chair, BC Patient Safety & Quality Council. It provides 26 recommendations.

We have taken a first look at the report. The good news is that it clearly endorses the need for and benefits of an electronic patient care system. With that, we remain confident that we are on the right track.

However, the report also flags clear opportunities for us to learn, adapt and achieve the best possible outcomes with our own CST implementation:

- Prior to going live with any new system, we must have a deep understanding of current clinical work processes. Our system must support how our frontline caregivers do their work and to achieve this, it is imperative that we continue to consult with physicians and clinicians on system design – and ensure we work closely with sites to understand the impact of changes in workflows prior to implementation;
- Related to this, we must strive to manage those changes in a way that reduces their impacts to clinicians and users as much as possible. A key goal of the CST project is greater consistency in our clinical workflow and practices. That said, if a particular work process needs to change, it should be done in a way that is manageable. People can only cope with so much at one time;



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Michell, Jennifer HLTH:EX

From: Matthew Watson s.22
Sent: Wednesday, June 1, 2016 7:37 AM
To: 'Smith, Jeremy'; 'CST Governance'; 'Ah Yong, Peggy'; XT:Roy, Carl EHS:IN; XT:Ackenhusen, Mary HLTH:IN; XT:HLTH Doyle, Dianne; Feulgen, Sabine HLTH:EX; Sidhu, Manjit HLTH:EX; 'Miller, Mike'; 'Rosenal, Tom'
Subject: RE: Vancouver Sun article on IHealth and CST

Thanks Jeremy. There was always going to be an article or more like this. Also, thanks for sending a link to the digital version of the article as the paper version would have been difficult for me to find and might not contain the latest edits



From: Smith, Jeremy [mailto:Jeremy.Smith@phsa.ca]
Sent: Tuesday, May 31, 2016 11:24 PM
To: CST Governance; Ah Yong, Peggy; Roy, Carl; [VCH] Ackenhusen, Mary [CORP]; [VCH] Doyle, Dianne [PH]; 'Feulgen, Sabine'; 'Manjit Sidu (manjit.sidhu@gov.bc.ca)'; 'Miller, Mike'; 'Rosenal, Tom'; 'Watson, Matthew'
Subject: Vancouver Sun article on IHealth and CST

Project Board,

FYI, below is an article appearing in the Vancouver Sun in the morning referencing CST, and below that a copy of a memo sent this morning from Island Health CEO Dr. Brendan Carr to physicians and staff in Nanaimo.

Jeremy

<http://vancouversun.com/news/local-news/b-c-health-minister-defends-maligned-ihealth-records-system>

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Page 335 to/à Page 337

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Michell, Jennifer HLTH:EX

From: Plank, Sarah GCPE:EX
Sent: Tuesday, May 31, 2016 2:51 PM
To: Shera, Deborah HLTH:EX; Feulgen, Sabine HLTH:EX
Cc: Anderson, Kristy GCPE:EX
Subject: RE: MEDIA REQUEST - Rob Shaw, Vancouver Sun - minister on VIHA IT problems

Well, the minister ended up calling the reporter anyway, so we didn't send this after all. He said he wasn't going to do an interview, so we prepped this, and then he went ahead and called him. No idea what he actually said, but trying to find out!

From: Shera, Deborah HLTH:EX
Sent: Tuesday, May 31, 2016 2:49 PM
To: Plank, Sarah GCPE:EX; Feulgen, Sabine HLTH:EX
Cc: Anderson, Kristy GCPE:EX
Subject: RE: MEDIA REQUEST - Rob Shaw, Vancouver Sun - minister on VIHA IT problems

s.13

From: Plank, Sarah GCPE:EX
Sent: Tuesday, May 31, 2016 2:42 PM
To: Shera, Deborah HLTH:EX; Brown, Stephen R HLTH:EX; Feulgen, Sabine HLTH:EX
Cc: Anderson, Kristy GCPE:EX
Subject: RE: MEDIA REQUEST - Rob Shaw, Vancouver Sun - minister on VIHA IT problems

Great minds think alike! Sabine also wanted that line out.

Here is what we have sent up to the minister for his okay (VIHA and PHSA have both reviewed and okay'd):

These two initiatives are in very different stages. The governance and oversight improvements applied to the Lower Mainland electronic health record initiative responded to significant issues that arose relatively early in the project planning and building phase. There is nothing to suggest that the IHealth project is in trouble, but rather it is going through expected and normal implementation and change management challenges that always arise with such a large-scale implementation. Island Health has representation on the CST project board, and is actively sharing their lessons learned as the CST project moves forward.

Electronic health records are about improving the quality and safety of patient care. The new IHealth system recently introduced in Nanaimo is the first stage of implementing a full electronic health record across the Island that will allow Island Health to continually improve quality of care for their patients. The introduction of IHealth in Nanaimo is a monumental change for frontline providers, and it is not unanticipated that staff and physicians are experiencing some challenges. Island Health recognizes these challenges – particularly in high-volume and high-acuity areas such as the ER and ICU – and is providing extra hands-on IHealth staff to support providers at NRGH.

Once implementation begins and a system is actually being used in a facility, it is expected that modifications are made along the way. Island Health continues to proactively work with providers to implement modifications to address issues as they come up.

Island Health has investigated the concerns raised and we understand that the system is working as it should, with no evidence that it is changing or deleting orders. Island Health has also done both an internal independent review of the system by their Quality and Safety department, and commissioned a review by an external expert from North York Hospital – which has implemented a Cerner electronic health record system – to ensure the system is safe and operating as it should.

Thanks, Sarah.

From: Shera, Deborah HLTH:EX
Sent: Tuesday, May 31, 2016 2:40 PM
To: Plank, Sarah GCPE:EX; Brown, Stephen R HLTH:EX; Feulgen, Sabine HLTH:EX
Cc: Anderson, Kristy GCPE:EX
Subject: RE: MEDIA REQUEST - Rob Shaw, Vancouver Sun - minister on VIHA IT problems

Suggested changes below otherwise looks good to me

From: Plank, Sarah GCPE:EX
Sent: Tuesday, May 31, 2016 1:15 PM
To: Shera, Deborah HLTH:EX; Brown, Stephen R HLTH:EX; Feulgen, Sabine HLTH:EX
Cc: Anderson, Kristy GCPE:EX
Subject: RE: MEDIA REQUEST - Rob Shaw, Vancouver Sun - minister on VIHA IT problems

How does this look for a statement for Rob Shaw?

These two initiatives are in very different stages. The governance and oversight improvements applied to the Lower Mainland electronic health record initiative responded to significant issues that arose relatively early in the project planning and building phase.^{s.13} There is nothing to suggest that the IHealth project is in trouble, but rather it is going through expected and normal implementation and change management challenges that always arise with such a large-scale implementation. We have had no indication that the project requires the kinds of review processes instituted for the Clinical Systems and Transformation project. Island Health has a representative provided to the CST project team to help incorporate their lessons learned as the CST project moves forward.

Electronic health records are about improving the quality and safety of patient care. The new IHealth system recently introduced in Nanaimo is the first stage of implementing a full electronic health record across the Island that will allow Island Health to continually improve quality of care for their patients. The introduction of IHealth in Nanaimo is a monumental change for frontline providers, and it is not unanticipated that staff and physicians are experiencing some challenges. Island Health recognizes these challenges – particularly in high-volume and high-acuity areas such as the ER and ICU – and is providing extra hands-on IHealth staff to support providers at NRGH.

Once implementation begins and a system is actually being used in a facility, it is expected that modifications are made along the way. Island Health continues to proactively work with providers to implement modifications to address issues as they come up.

Island Health has investigated the concerns raised and we understand that the system is working as it should, with no evidence that it is changing or deleting orders. Island Health has also done both an internal independent review of the system by their Quality and Safety department, and commissioned a review by an external expert from North York Hospital – which has implemented a Cerner electronic health record system – to ensure the system is safe and operating as it should.

From: Shera, Deborah HLTH:EX
Sent: Monday, May 30, 2016 3:00 PM
To: Plank, Sarah GCPE:EX; Brown, Stephen R HLTH:EX; Feulgen, Sabine HLTH:EX
Subject: RE: MEDIA REQUEST - Rob Shaw, Vancouver Sun - minister on VIHA IT problems

You will need to clear this with Steve/Sabine but I see these two initiatives as in very different places. CST is in the project/build phase and ran into major problems and so all the items below eg assurance were required. The messaging we are getting from Island would suggest not a project in trouble but rather expected and normal implementation/change management issues that always arise in major implementations. There is nothing we are hearing that suggests a project in trouble at this time or requirements for the review processes instituted in CST.

Should there be further developments or real issues identified then the answer to the question would change – and this response is based on the messages coming from Island

Thoughts

From: Plank, Sarah GCPE:EX
Sent: Monday, May 30, 2016 2:25 PM
To: Brown, Stephen R HLTH:EX; Feulgen, Sabine HLTH:EX; Shera, Deborah HLTH:EX
Subject: MEDIA REQUEST - Rob Shaw, Vancouver Sun - minister on VIHA IT problems

Hi all – flagging this request for you... Most of this as far as CST we can answer, but looking for some guidance as far as his question about whether we are applying our new oversight approach to IT projects to IHealth. Thanks, Sarah.

From: Shaw, Rob [<mailto:rshaw@vancouver.sun.com>]
Sent: Monday, May 30, 2016 1:23 PM
To: Plank, Sarah GCPE:EX
Subject: minister on VIHA IT problems

Hey Sarah,

Working on a story about what the VIHA Nanaimo iHealth problems that Cindy wrote about last week might mean for other big eHealth initiatives like Clinical Systems Transformation in the Lower Mainland. Both use Cerner. CST not only uses Cerner for software but also hired Cerner for development after firing IBM.

I know the minister has spoke in the past about how VIHA's system was a success story that others could follow because it was on time, on budget and worked well. But that doesn't appear to be the case. So would like to ask him if he's concerned, what he's doing about it, if there are implications for other larger projects like CST and whether he can apply the new "lense" that Stephen Brown talked about on health IT projects (outside expert panels, etc) to fix what's happened.

Looking for him today or tomorrow for Wednesday.

Also, I will put in a request to talk to someone at CST as well.

Thanks,

Rob

ROB SHAW
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Michell, Jennifer HLTH:EX

From: Feulgen, Sabine HLTH:EX
Sent: Monday, May 30, 2016 3:35 PM
To: Plank, Sarah GCPE:EX; Shera, Deborah HLTH:EX; Brown, Stephen R HLTH:EX
Subject: RE: MEDIA REQUEST - Rob Shaw, Vancouver Sun - minister on VIHA IT problems

Deborah has provided a good answer.

Sabine

phone: 250.952-1764
email: Sabine.Feulgen@gov.bc.ca

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From: Plank, Sarah GCPE:EX
Sent: Monday, May 30, 2016 3:26 PM
To: Shera, Deborah HLTH:EX; Brown, Stephen R HLTH:EX; Feulgen, Sabine HLTH:EX
Subject: RE: MEDIA REQUEST - Rob Shaw, Vancouver Sun - minister on VIHA IT problems

Thanks. That seems like a reasonable response to me – and in line with what we heard from Island on Friday when they briefed the minister. But will let Steve/Sabine weigh in...

From: Shera, Deborah HLTH:EX
Sent: Monday, May 30, 2016 3:00 PM
To: Plank, Sarah GCPE:EX; Brown, Stephen R HLTH:EX; Feulgen, Sabine HLTH:EX
Subject: RE: MEDIA REQUEST - Rob Shaw, Vancouver Sun - minister on VIHA IT problems

You will need to clear this with Steve/Sabine but I see these two initiatives as in very different places. CST is in the project/build phase and ran into major problems and so all the items below eg assurance were required. The messaging we are getting from Island would suggest not a project in trouble but rather expected and normal implementation/change management issues that always arise in major implementations. There is nothing we are hearing that suggests a project in trouble at this time or requirements for the review processes instituted in CST.

Should there be further developments or real issues identified then the answer to the question would change – and this response is based on the messages coming from Island

Thoughts

From: Plank, Sarah GCPE:EX
Sent: Monday, May 30, 2016 2:25 PM
To: Brown, Stephen R HLTH:EX; Feulgen, Sabine HLTH:EX; Shera, Deborah HLTH:EX
Subject: MEDIA REQUEST - Rob Shaw, Vancouver Sun - minister on VIHA IT problems

Hi all – flagging this request for you... Most of this as far as CST we can answer, but looking for some guidance as far as his question about whether we are applying our new oversight approach to IT projects to iHealth. Thanks, Sarah.

From: Shaw, Rob [<mailto:rshaw@vancouver.sun.com>]

Sent: Monday, May 30, 2016 1:23 PM

To: Plank, Sarah GCPE:EX

Subject: minister on VIHA IT problems

Hey Sarah,

Working on a story about what the VIHA Nanaimo iHealth problems that Cindy wrote about last week might mean for other big eHealth initiatives like Clinical Systems Transformation in the Lower Mainland. Both use Cerner. CST not only uses Cerner for software but also hired Cerner for development after firing IBM.

I know the minister has spoke in the past about how VIHA's system was a success story that others could follow because it was on time, on budget and worked well. But that doesn't appear to be the case. So would like to ask him if he's concerned, what he's doing about it, if there are implications for other larger projects like CST and whether he can apply the new "lense" that Stephen Brown talked about on health IT projects (outside expert panels, etc) to fix what's happened.

Looking for him today or tomorrow for Wednesday.

Also, I will put in a request to talk to someone at CST as well.

Thanks,

Rob

ROB SHAW

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Michell, Jennifer HLTH:EX

From: Plank, Sarah GCPE:EX
Sent: Monday, May 30, 2016 12:47 PM
To: Lake, Terry HLTH:EX
Cc: hlth Ministerial and Executive Assistants; Feulgen, Sabine HLTH:EX; Shera, Deborah HLTH:EX; Anderson, Kristy GCPE:EX; Belanger, Matthew GCPE:EX; Beneteau, Nicole GCPE:EX; Frattaroli, Angela GCPE:EX; Heinze, Laura R GCPE:EX; MacDougall, Cindy GCPE:EX; May, Stephen GCPE:EX; Peaker, Alexandra GCPE:EX
Subject: FW: MEDIA REQUEST - Cindy Harnett, Times Colonist - IHealth
Attachments: KM_IHealth_physician concerns_27May2016.doc.docx; CST_May 1_16_KM.docx
Importance: High

Hi Minister,

As you are not able to do the interview, Cindy Harnett has asked for a statement to address whether the province will be ordering Island Health to pause implementation in light of the challenges brought forward, and the fact that the system in Nanaimo has been used as an example of success in electronic health records but it does not seem to be working well.

Would this work from your perspective?

Draft Statement:

Electronic health records are about improving the quality and safety of patient care. The new IHealth system recently introduced in Nanaimo is the first stage of implementing a full electronic health record across the Island that will allow Island Health to continually improve quality of care for their patients. The introduction of IHealth in Nanaimo is a monumental change for frontline providers, and it is not unanticipated that staff and physicians are experiencing some challenges. Island Health recognizes these challenges – particularly in high-volume and high-acuity areas such as the ER and ICU – and is providing extra in-person hands-on supports for providers at NRGH.

There is no question that implementing a system transformation of this scope is difficult. Once implementation begins and a system is actually being used in a facility, it is expected and in fact planned that modifications will be made along the way. I have been assured that dedicated IHealth staff are working with individual doctors and staff to trouble-shoot specific processes that are not working as smoothly as they could and making improvements to workflow issues based on this feedback. Island Health continues to proactively work with providers to implement modifications to address any challenges as they come up.

Island Health has investigated the concerns raised and I have been reassured that the system is working as it should, with no evidence that it is changing or deleting orders. Island Health has done both an internal independent review of the system by their Quality and Safety department, and commissioned a review by an external expert from North York Hospital – which also implemented a Cerner electronic health record system – to ensure the system is safe and operating as it should.

Thanks,
Sarah.

Sarah Plank
Communications Director | Ministry of Health
Government Communications & Public Engagement
Office: 250.952.1889 | Mobile: 250.208.9621 | Email: sarah.plank@gov.bc.ca

From: Plank, Sarah GCPE:EX
Sent: Monday, May 30, 2016 10:49 AM
To: Lake, Terry HLTH:EX
Cc: hlth Ministerial and Executive Assistants; Feulgen, Sabine HLTH:EX; Shera, Deborah HLTH:EX; Anderson, Kristy GCPE:EX; Belanger, Matthew GCPE:EX; Beneteau, Nicole GCPE:EX; Frattaroli, Angela GCPE:EX; Heinze, Laura R GCPE:EX; MacDougall, Cindy GCPE:EX; May, Stephen GCPE:EX; Peaker, Alexandra GCPE:EX
Subject: MEDIA REQUEST - Cindy Harnett, Times Colonist - iHealth
Importance: High

Hi Minister,

Are you able to call Cindy today? She would need to speak to you before 1:30pm, as she's on the early shift today. Attached is the key messaging per our discussion with Island Health on Friday, as well as the current CST messaging. I think that will address her questions, but let me know if you need anything more.

Reporter: Cindy Harnett

Media outlet: Times Colonist

Telephone #: 250.380.5348 (o) / 250.213.3603 (c)

Deadline: 1:30pm

Questions:

I'm following up on my story from Thursday on Nanaimo doctors saying the iHealth system that went live 9 weeks ago is a failure and patient safety risk, causing mistakes in medication doses and pharmaceutical discharge sheets, as well as being slow and inefficient and difficult to use.

In a phone interview I would like to ask the Minister about:

- 1. His reaction to the Nanaimo doctors complaints given the health minister pointed to Cerner's iHealth implementation in Nanaimo as an example of the success of Cerner's system and an example for the rest of the province and how it would set the right course for Vancouver Coastal Health, PHSA, and Providence Health Care after the collapse of the \$842 million IBM system.*
- 2. What if anything the province will do to stop and suspend the implementation in Nanaimo until doctors agree its useable and safe?*
- 3. How much has the province spent on EHR development and implementation in total in the last 5 and 10 years?*

Proposed Response:

- Electronic health records are about improving the quality and safety of patient care.
- The new IHealth system recently introduced in Nanaimo is the first stage of implementing a full electronic health record across the Island.
- It will provide a single record of a person's health history that will allow Island Health to continually improve quality of care for their patients.
- The introduction of IHealth in Nanaimo is a monumental change for frontline providers – it is not unexpected that staff and physicians are experiencing some challenges.
- Island Health recognizes these challenges – particularly in high-volume and high-acuity areas such as the ER and ICU – and is providing extra in-person hands-on supports in these areas.
- As part of this, dedicated IHealth staff are working with individual doctors and staff to trouble-shoot specific processes that are not working as smoothly as they could and making improvements to the system in real-time.
- Island Health has investigated the concerns raised by the physician in the article – I have been reassured that the system is working as it should, with no evidence that it is changing or deleting orders.
- Island Health commissioned a review of the system by their separate Quality and Safety department, which determined IHealth in Nanaimo is just as safe as the previous paper-based system.
- Additionally, Island Health brought in an external expert from North York Hospital – which also implemented a Cerner electronic health record system – to review the implementation in Nanaimo to ensure everything is going as expected.

CST project

- Electronic health records are about improving the quality and safety of patient care.
- Clinical and Systems Transformation is a major transformation of clinical processes and care protocols across the three health organizations, focused on

achieving the safe and consistent services of an integrated health system as our patients expect.

- This is a large and complex project.
- We knew from the outset that this wasn't going to be an easy project – but we also recognized that it was important for patients in the Lower Mainland and those across the province accessing specialized provincial services.
- The CST project board committed to looking at the entire project in depth as part of the project reset that began last year - including scope, resources and implementation.
- The CST board has been doing the due diligence and planning necessary to ensure the project is done properly.
- The team is moving forward with testing and configuration to get ready for implementation of full electronic medical records at the first site in the Lower Mainland next year – Lion's Gate Hospital in Spring 2017.
- Fine-tuning and validating common workflows and practices, as well as education and training, will be ongoing over the next year in the North Shore and Sea-to-Sky region facilities.
- Learnings from the first sites implemented will be incorporated into the successive implementations at other facilities.
- In March, I went up to Nanaimo where Island Health has just started the first phase to bring their IHealth electronic record system online.
- The IHealth project has been very successful so far and will be a huge benefit to quality and safety in the entire health system on Vancouver Island.
- It has not been without challenges and course corrections along the way – as would any project of this size and magnitude.
- Island Health is now providing their expertise to the CST project to help incorporate some of their lessons learned into that project.

If asked about project reset:

- This program had challenges initially – which is why we took a step back and made the decision to reset the program.

- That reset has allowed the project team – supported by stronger governance – to reposition the project and put it on solid ground.
- The ministry has learned from our experience with other large IT projects, including the valuable review of the Panorama public health system by the Auditor General.
- We also secured PriceWaterhouseCooper last year to help identify project management and governance issues as part of the project reset.
- As a result, we made changes to the governance and planning to ensure a better program that will improve the quality and consistency of patient and caregiver experiences.
- As part of their re-planning work over the past year, the project team has also realized we needed to engage frontline clinicians which has added valuable clinical elements that will ensure the system meets the needs of our health care providers – thereby ensuring better patient care.
- Clinical input is key – user adaption is critical to the success of this program.
- The Ministry met with the Auditor General in the fall to discuss the way forward on the project and actions taken to strengthen its governance – to ensure we are on the right track.
- We will be meeting again with the Auditor General in May to provide an update and get any feedback on our approach.
- With this new model, with improved governance, project management and a better plan for change management and incorporating clinical needs – we can provide a better service.
- That includes implementing it in phases, to make adjustments on the go to improve the program, so that we have the best possible system for staff.

Sarah Plank
 Communications Director | Ministry of Health
 Government Communications & Public Engagement
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Michell, Jennifer HLTH:EX

From: Feulgen, Sabine HLTH:EX
Sent: Wednesday, November 30, 2016 12:19 PM
To: Michael Long
Subject: RE: Report for Ministry

Hi Michael

Just spoke to Steve. He would still like a short summary report of your findings at the other Cerner sites – and what learnings you might take forward into implementing CST. It may help to do a tie-in to the Cochrane report/findings where there are no doubt commonalities of experience but perhaps different paths to success? I think if other sites used the agile methodology it might be worth noting. I think you may want to consider making available internally (on the CST site) your findings as well (ie summary report). Just another way to let staff know that the CST project is paying attention and trying to avoid the missteps others have experienced and perhaps providing an avenue for clinicians outside of the project to engage? Just a thought. Thanks.

Sabine

From: Long, Michael [<mailto:Michael.Long@phsa.ca>]
Sent: November 29, 2016 10:38 PM
To: Feulgen, Sabine HLTH:EX
Subject: Report for Ministry

Sabine,

Can you confirm expectations around creating a report on experiences at other Cerner sites? Is it still required?

Any particular format? Key points we need to include?

Michael

Michell, Jennifer HLTH:EX

From: Feulgen, Sabine HLTH:EX
Sent: Friday, November 25, 2016 12:04 PM
To: Anderson, Kristy GCPE:EX
Subject: RE: CST Activation schedule-change memo - for your review

I think it is okay to go now.

Sabine

phone: 250.952-1764
email: Sabine.Feulgen@gov.bc.ca

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From: Anderson, Kristy GCPE:EX
Sent: Friday, November 25, 2016 11:45 AM
To: Feulgen, Sabine HLTH:EX
Subject: FW: CST Activation schedule-change memo - for your review

Hi Sabine – do you have any issues with this going out? I might suggest they wait until Dec. 5th when MTL is back but that is my only suggestion.

Kristy Anderson
Director, Media Relations
Ministry of Health
250-952-3387 (office) 778-678-5200 (mobile)
Kristy.Anderson@gov.bc.ca

From: Cunningham, Dave [<mailto:Dave.Cunningham@phsa.ca>]
Sent: Thursday, November 24, 2016 2:56 PM
To: Anderson, Kristy GCPE:EX
Subject: CST Activation schedule-change memo - for your review

Hi Kristy. Further to our discussion last week with Sabine, here's the internal memo that Michael and the CEOs would like to issue as soon as you're comfortable, regarding the change of activation-schedule for CST. Grateful for feedback – can you also share with Sabine? Thx!

Dave Cunningham
Chief Communications Officer
Provincial Health Services Authority

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Michell, Jennifer HLTH:EX

From: Roy, Carl <CRoy@phsa.ca>
Sent: Friday, November 18, 2016 7:29 AM
To: XT:Ackenhusen, Mary HLTH:IN
Cc: Feulgen, Sabine HLTH:EX
Subject: Re: CST response to IHealth - staff memo

Mary I call you this morning to explain.

Sent from my iPhone

On Nov 17, 2016, at 8:14 PM, [VCH] Ackenhusen, Mary [CORP] <Mary.Ackenhusen@vch.ca> wrote:

Hi

I was surprised to see the communication issued this afternoon without the delay in LGH mentioned. I assume this was what you two were working on this afternoon?

Why would we go against the recommendation of Dave and Michael?

Any reason this was not discussed with me, given this context?

Really would like to understand the process for this.

Thanks

Mary

Mary Ackenhusen

President and CEO

Vancouver Coastal Health

11th Floor, 601 West Broadway

Vancouver, BC V5Z 4C2

Tel: 604.875.4721

e-mail: mary.ackenhussen@vch.ca

Executive Assistant: Winnie Price, winnie.price@vch.ca, 604 875-4721

From: Dave Cunningham <dave.cunningham@phsa.ca>

Date: Thursday, November 17, 2016 at 1:45 PM

To: Carl Roy <CRoy@phsa.ca>, Mary Ackenhusen <mary.ackenhusen@vch.ca>
Subject: CST response to IHealth - staff memo

Kristy in MoH Comms would like Sabine's sign-off on this memo before approving, but Sabine is in Leadership Council with you. Any chance one of you can discuss this with her if you have a break? (In particular the highlighted section re. delaying CST implementation – Michael and I feel we need to communicate this.)

<20161117 CST response to IHealth memo - v5.docx>

Michell, Jennifer HLTH:EX

From: Stevenson, Lynn HLTH:EX
Sent: Thursday, November 17, 2016 9:54 PM
To: Anderson, Kristy GCPE:EX; Feulgen, Sabine HLTH:EX
Cc: Brown, Stephen R HLTH:EX
Subject: RE: For your review: CST staff-memo re. Cochrane report

Sorry missed that

From: Anderson, Kristy GCPE:EX
Sent: Thursday, November 17, 2016 9:49 PM
To: Stevenson, Lynn HLTH:EX; Feulgen, Sabine HLTH:EX
Cc: Brown, Stephen R HLTH:EX
Subject: RE: For your review: CST staff-memo re. Cochrane report

They are uncoupled now. Separate memos as per discussion Sabine had with them.

Kristy Anderson
Director, Media Relations
Ministry of Health
250-952-3387 (office) 778-678-5200 (mobile)
Kristy.Anderson@gov.bc.ca

From: Stevenson, Lynn HLTH:EX
Sent: Thursday, November 17, 2016 9:49 PM
To: Anderson, Kristy GCPE:EX; Feulgen, Sabine HLTH:EX
Cc: Brown, Stephen R HLTH:EX
Subject: RE: For your review: CST staff-memo re. Cochrane report

I had understood that there was going to be a delay regardless of ihealth so not sure tying the two together makes sense....but could be wrong...lynn

From: Anderson, Kristy GCPE:EX
Sent: Thursday, November 17, 2016 1:38 PM
To: Feulgen, Sabine HLTH:EX
Cc: Brown, Stephen R HLTH:EX; Stevenson, Lynn HLTH:EX
Subject: FW: For your review: CST staff-memo re. Cochrane report

Mary and Carl are going to talk to you about this.

I have suggested to Dave that they send out the IHealth reaction components of this memo if they want but that they should not include the delay at all. I think that if we don't want these tied together they should come out with a separate memo that speaks to the work Michael Long is doing, what he has found and their commitment to take the time to get it right.

Just my thoughts based on your direction,

Kristy Anderson
Director, Media Relations
Ministry of Health

250-952-3387 (office) 778-678-5200 (mobile)
Kristy.Anderson@gov.bc.ca

From: Cunningham, Dave [<mailto:Dave.Cunningham@phsa.ca>]
Sent: Wednesday, November 16, 2016 5:14 PM
To: Anderson, Kristy GCPE:EX
Subject: For your review: CST staff-memo re. Cochrane report

Hi Kristy – attached for your review is our DRAFT staff memo re. Cochrane report, reviewed and signed-off by our CEOs.

Re. our implementation delay, we've ensured we're taking ownership of the decision, by explicitly stating that it was NOT related to Cochrane report, so that there's no linkage - as requested.

That said, Michael and CEOs do feel that we need to at least reference the delay, as the implementation timeframe directly affects internal workflows, and we need to quickly reprioritize the team's workload in light of this schedule change – so any delay in announcing the schedule-delay could be costly in terms of labour/staff time.

Let me know of any concerns! We're also finalizing a Q&A, which we'll quickly amend to be consistent with your messaging whenever we get final materials.

cheers, d.

Michell, Jennifer HLTH:EX

From: Long, Michael <Michael.Long@phsa.ca>
Sent: Wednesday, November 2, 2016 7:46 AM
To: Feulgen, Sabine HLTH:EX
Subject: Re: Is there a planned release date for the report?

I will get on that

Original Message

From: Feulgen, Sabine HLTH:EX
Sent: Wednesday, November 2, 2016 07:40
To: Long, Michael
Subject: Re: Is there a planned release date for the report?

Sooner than later but not today as far as I know. I did receive direction for the CST project to engage with other facilities that have put in the Cerner product. The DM would like a report by the end of Nov/early Dec for release before xmas. I will call you later today to discuss further but if you can get a team ready that would be great.

Sabine Feulgen
Associate Deputy Minister, Corporate Services Ministry of Health

T: 250.952.1764
E: Sabine.Feulgen@gov.bc.ca
From: Long, Michael
Sent: Wednesday, November 2, 2016 07:09
To: Feulgen, Sabine HLTH:EX
Subject: Is there a planned release date for the report?

Michell, Jennifer HLTH:EX

From: Feulgen, Sabine HLTH:EX
Sent: Tuesday, September 13, 2016 11:24 PM
To: Matthew Watson; Sidhu, Manjit HLTH:EX
Subject: CST leadership change

FYI. Michael Long will be at helm tomorrow as Interim CTO.



0160906_Memo_Cs
leadership_v...

Michell, Jennifer HLTH:EX

From: Feulgen, Sabine HLTH:EX
Sent: Thursday, June 2, 2016 9:55 PM
To: Plank, Sarah GCPE:EX; Shrimpton, Paul HLTH:EX; Shera, Deborah HLTH:EX
Cc: May, Stephen GCPE:EX; Anderson, Kristy GCPE:EX; Stevenson, Lynn HLTH:EX
Subject: RE: MEDIA REQUEST - Cindy Harnett, Times Colonist - EHRs

For the technical approval of interoperability language – Deborah you will need to weigh in with your team.

From: Plank, Sarah GCPE:EX
Sent: June 2, 2016 3:40 PM
To: Shrimpton, Paul HLTH:EX; Feulgen, Sabine HLTH:EX; Shera, Deborah HLTH:EX
Cc: May, Stephen GCPE:EX; Anderson, Kristy GCPE:EX; Stevenson, Lynn HLTH:EX
Subject: RE: MEDIA REQUEST - Cindy Harnett, Times Colonist - EHRs

Thanks all for the info. Is this fine from your perspectives?

A fully integrated Electronic Health system would require the entire province to move to one large database – run by the same software. This would be a tremendous logistical challenge, with significant costs, risks and delays. This is the software and implementation philosophy seen in the implementations at Island Health and the Lower Mainland are true of to like systems like this around the world – they are usually consolidated to a certain level (such as across a health authority) – but they also work to ensure that some patient information can be easily shared between systems.

By adopting Cerner and ensuring consistent base configuration of the patient identification and data standards, Island Health and the health authorities using CST will be able to facilitate exchange of patient charts.

The Ministry and the Health Authorities are working together to implement standards for exchanging personal health information to support the delivery of care as patients transition from one point of the health system to another. The first area of focus is on enabling the delivery of clinical documents, such as laboratory reports, from health authorities to community practitioners. Incrementally, over time, as these standards are refined, the exchange of information can expand to include more health organizations.

Thx,
S.

From: Shrimpton, Paul HLTH:EX
Sent: Thursday, June 2, 2016 11:12 AM
To: Feulgen, Sabine HLTH:EX; Plank, Sarah GCPE:EX; Shera, Deborah HLTH:EX
Cc: May, Stephen GCPE:EX; Anderson, Kristy GCPE:EX; Stevenson, Lynn HLTH:EX
Subject: RE: MEDIA REQUEST - Cindy Harnett, Times Colonist - EHRs

As an add on... The Ministry and the Health Authorities are working together to implement standards for exchanging personal health information to support the delivery of care as patients transition from one point of the health system to another. The first area of focus is on enabling the delivery of clinical documents, such as laboratory reports, from HAs to community practitioners. Incrementally, over time, as these standards are refined, the exchange of information can expand to include more health organizations.

From: Feulgen, Sabine HLTH:EX

Sent: Thursday, June 2, 2016 10:51 AM

To: Plank, Sarah GCPE:EX; Shera, Deborah HLTH:EX; Shrimpton, Paul HLTH:EX

Cc: May, Stephen GCPE:EX; Anderson, Kristy GCPE:EX; Stevenson, Lynn HLTH:EX

Subject: RE: MEDIA REQUEST - Cindy Harnett, Times Colonist - EHRs

1. Will records be shareable between the Island and the VPP HOs?

- For completely seamless access within Cerner across all care settings, all health organizations in BC would have to move to a single instance of the same software (i.e. one large shared database), which has not been contemplated due to the significant costs, risks, and delays that would be associated.
- By adopting Cerner and ensuring consistent base configuration of the patient identification and data standards, the Island Health and the VPP health organizations can facilitate exchange of patient charts.
- There is greater patient flow between Fraser Health and the VPP HOs, and continuity is facilitated through the provincial CareConnect viewer.

And a follow-up I had.

I would have thought interfaces would provide the interoperability between the various systems. One patient, one record - will that not be the final outcome in the acute care settings of the LM and the Island.

And the answer.

If we want completely one patient record, seamlessly for the entire province (i.e. a doctor in Kelowna can instantly look at the full detailed charts with minute-by-minute vital signs from a patient's stay in an ICU in Nanaimo due to a holiday car accident), then you literally have to have every care setting in the entire province on one single system. That is almost unheard of worldwide.

Instead, most places consolidate systems to a reasonable level (e.g. within an HA, or across VPP HOs), and use interoperability to exchange data beyond that for continuity of care across geographies (e.g. HA to HA) and across care settings (e.g. hospitals to GPs).

This is generally a reasonable cost-benefit trade-off because the VAST majority of clinical needs can be met with manageable cost, complexity and risk.

Banks don't all use one system, they rely on Interac to exchange basic banking info for cash transactions, but not complex mortgage info or investment instruments.

It's a classic balance of benefit with cost and risk.

Sabine

phone: 250.952-1764

email: Sabine.Feulgen@gov.bc.ca

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From: Feulgen, Sabine HLTH:EX
Sent: Thursday, June 2, 2016 10:44 AM
To: Plank, Sarah GCPE:EX; Shera, Deborah HLTH:EX
Cc: May, Stephen GCPE:EX; Anderson, Kristy GCPE:EX; Stevenson, Lynn HLTH:EX
Subject: RE: MEDIA REQUEST - Cindy Harnett, Times Colonist - EHRs

I have asked the question of the CST team previously and have an answer I can dig up.

Sabine

phone: 250.952-1764
email: Sabine.Feulgen@gov.bc.ca

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From: Plank, Sarah GCPE:EX
Sent: Thursday, June 2, 2016 10:41 AM
To: Feulgen, Sabine HLTH:EX; Shera, Deborah HLTH:EX
Cc: May, Stephen GCPE:EX; Anderson, Kristy GCPE:EX; Stevenson, Lynn HLTH:EX
Subject: MEDIA REQUEST - Cindy Harnett, Times Colonist - EHRs

Hi there, see below re: media request. My understanding is that the answer is no. Do you have any further thoughts on a response as to the why not?

Thanks,
Sarah.

Sarah Plank
Communications Director | Ministry of Health
Government Communications & Public Engagement
Office: 250.952.1889 | Mobile: 250.208.9621 | Email: sarah.plank@gov.bc.ca

From: Harnett, Cindy (Times-Colonist) [<mailto:CHarnett@timescolonist.com>]
Sent: Thursday, June 2, 2016 10:36 AM
To: Plank, Sarah GCPE:EX
Subject:

Hi Sarah,

Can you let me know if when iHealth is completed across Island if it will be fully integrated with CST system and other health authorities?. Basically, will all systems across the province be integrated and EHR accessible from if patient is in hospital in Fort St. John or Kamloops, Vancouver, or Port Hardy... in any of five HAs.

My only other question is if this is not the case, why wasn't one company/one common system used?

Thanks! Cindy

Cindy E. Harnett
Times Colonist reporter
Health/Federal politics
250-380-5348 (direct)

250-213-3603 (cell)
ceharnett@timescolonist.com
@cindyeharnett

Michell, Jennifer HLTH:EX

From: Michell, Jennifer HLTH:EX
Sent: Thursday, May 5, 2016 1:44 PM
To: Feulgen, Sabine HLTH:EX
Subject: Questions on Notice - May 2, 2016
Attachments: Hansard Response - CST Resources - 1755.doc

Response for CST question for your review.

From: Shera, Deborah HLTH:EX
Sent: Thursday, May 5, 2016 1:40 PM
To: Michell, Jennifer HLTH:EX
Subject: FW: URGENT - MoH Estimates Debate - Questions on Notice - May 2, 2016

Below is one of the responses

From: Somner, Kurstie HLTH:EX
Sent: Thursday, May 5, 2016 1:35 PM
To: Shrimpton, Paul HLTH:EX; Shera, Deborah HLTH:EX
Subject: RE: URGENT - MoH Estimates Debate - Questions on Notice - May 2, 2016

Hi, yes see attached and pasted below. ok?

1755	Honourable Terry Lake – Afternoon Committee May 2, 2016	
Member:	Judy Darcy	Minister: Honourable Terry Lake
Assigned To: Health Sector IMIT Division		
Topic: CST Project - staffing		
Member's Request	How many staff were working on this project before IBM left the project? How many are working on it now? How many are health authority employees? How many are external contractors and consultants?	
Minister's Response	The number of people working on the project will vary, depending on what phase of the project is being implemented. The current stage that we are in is called the design-configure-validate phase. Currently, there are about 300 employees that are from our CST team and about 50 Cerner associates that are working on the project at the moment. Now, they're not going to be there the whole time, but this is a very intense phase of the project. There are about 355 to 360 people in total that are working on the project at the moment. Even before IBM departed, that number would have gone up and down, depending on the phase of the project. I can provide the member - hopefully, tomorrow - with a bit of a timeline, in terms of the ups and downs of the number of people working on the project at any sort of stage. At the moment, we've got about 350 people working on the project.	

	As of May 4, 2016, the current CST staffing is as follows:
	Staff: 241
	Staff Vacancies: 44 (80%) <i>staff including current vacancies</i>
	Contractors: 19 (5%)
Recommended Response	Cerner: 54 (15%)
	TOTAL: 358
	As of Sept 2014, the best estimate based on available data is:
	Staff: 207 (63%)
	Contractors: 11 (3%)
	IBM: 113 (34%)
	TOTAL: 324
	The IBM contract was a deliverables-based fixed price contract so individual resources were not tracked by CST in the same way they are now with Cerner, and the details on IBM resources assigned to the project are no longer available. The estimate of 113 IBM resources is based on documents retained by CST after IBM's departure.

From: Shrimpton, Paul HLTH:EX
Sent: Thursday, May 5, 2016 1:32 PM
To: Shera, Deborah HLTH:EX
Cc: Sömner, Kurstie HLTH:EX
Subject: Re: URGENT - MoH Estimates Debate - Questions on Notice - May 2, 2016

Kurstie - could you edit the response to ensure it's clear that it's 80% staff, 5% contractors etc?

On May 5, 2016, at 1:28 PM, Shrimpton, Paul HLTH:EX <Paul.Shrimpton@gov.bc.ca> wrote:

To answer your question Deb- the 80% is indeed the overall percentage of staff vs contractors.

Begin forwarded message:

From: "Smith, Jeremy" <Jeremy.Smith@phsa.ca>
Date: May 5, 2016 at 12:00:38 PM PDT
To: "Shrimpton, Paul HLTH:EX" <Paul.Shrimpton@gov.bc.ca>
Cc: "Cunningham, Dave" <Dave.Cunningham@phsa.ca>
Subject: Re: URGENT - MoH Estimates Debate - Questions on Notice - May 2, 2016

80% should appear beside the second row titled "Staff Vacancies" and is 241 staff + 44 vacancies / 358 total = 80%.

Contractors are 5% and Cerner 15% of the 358 total.

Does that match what you are seeing?

Jeremy

On May 5, 2016, at 11:51 AM, Shrimpton, Paul HLTH:EX
<Paul.Shrimpton@gov.bc.ca> wrote:

I just want to confirm that the 80% refers to the percentage of staff vs contractors
- in my version that figure appeared in the same row as 'vacancies'.

On May 4, 2016, at 6:16 PM, Smith, Jeremy
<Jeremy.Smith@phsa.ca<<mailto:Jeremy.Smith@phsa.ca>>> wrote:

Hi Paul, attached is response 2 of 2 re resources. Dave, is there any reason
resulting from the IBM separation that the count of resources is
confidential? Please see attached.

Thanks, Jeremy

From: Shrimpton, Paul HLTH:EX<<mailto:Paul.Shrimpton@gov.bc.ca>>
Sent: May 3, 2016 1:45 PM
To: Smith, Jeremy<<mailto:Jeremy.Smith@phsa.ca>>
Subject: Fwd: URGENT - MoH Estimates Debate - Questions on Notice - May 2, 2016

Another one. To your question. Turnaround is as quick as possible please?

Sent from my iPhone

Begin forwarded message:

From: "Shera, Deborah HLTH:EX"
<Deborah.Shera@gov.bc.ca<<mailto:Deborah.Shera@gov.bc.ca>><<mailto:Deborah.Shera@gov.bc.ca>>>
Date: May 3, 2016 at 1:45:43 PM PDT
To: "Shrimpton, Paul HLTH:EX"
<Paul.Shrimpton@gov.bc.ca<<mailto:Paul.Shrimpton@gov.bc.ca>><<mailto:Paul.Shrimpton@gov.bc.ca>>>
Subject: FW: URGENT - MoH Estimates Debate - Questions on Notice - May 2, 2016

Another

From: Hewlett, Cheryl A HLTH:EX
Sent: Tuesday, May 3, 2016 1:41 PM
To: Shera, Deborah HLTH:EX
Cc: Somner, Kurstic HLTH:EX; Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX; Godfrey, Debbie HLTH:EX
Subject: URGENT - MoH Estimates Debate - Questions on Notice - May 2, 2016

Importance: High

Hi Deborah,

Here is one more question on notice from yesterday's Estimates Debate for response (template attached).

Many thanks,
Cheryl

1755

CST Project/Timeline of People Involvement

J. Darcy: How many staff were working on this project before IBM left the project? How many are working on it now? How many are health authority employees? How many are external contractors and consultants?

Hon. T. Lake: The number of people working on the project will vary, depending on what phase of the project is being implemented.

The current stage that we are in is called the design-configure-validate phase.

Currently, there are about 300 employees that are from our CST team and about 50 Cerner associates that are working on the project at the moment. Now, they're not going to be there the whole time, but this is a very intense phase of the project. There are about 355 to 360 people in total that are working on the project at the moment.

Even before IBM departed, that number would have gone up and down, depending on the phase of the project. I can provide the member - hopefully, tomorrow - with a bit of a timeline, in terms of the ups and downs of the number of people working on the project at any sort of stage. At the moment, we've got about 350 people working on the project.

Cheryl Hewlett | Project Coordinator | Office of the Deputy Minister | Ministry of Health

Telephone: 250-952-3596 | 5th Floor-1515 Blanshard Street | PO Box 9639 Stn Prov Govt, Victoria BC V8W 9P1

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<Hansard Response - CST Resources.doc>

Michell, Jennifer HLTH:EX

From: Plank, Sarah GCPE:EX
Sent: Tuesday, April 19, 2016 8:35 AM
To: Feulgen, Sabine HLTH:EX
Subject: FW: memos - HO leaders, + Coastal Group 1 staff
Attachments: DRAFT CST update memo - Apr xx v5.docx; DRAFT Group 1 launch memo - Apr xx v5.docx; Issues Note - CST project plan update - Apr 8 v2.docx

Categories: Printed

Hi Sabine – here are the draft materials from PHSA. I think the memos are fine, but we need to figure out the issues note messaging together. Sarah.

From: Cunningham, Dave [<mailto:Dave.Cunningham@phsa.ca>]
Sent: Wednesday, April 13, 2016 10:01 AM
To: Plank, Sarah GCPE:EX
Cc: XT:HLTH Adams, Clay
Subject: RE: CST internal launch memos - HO leaders, + Coastal Group 1 staff

Hi Sarah,

As discussed, re-sending latest versions of our internal health authority leaders' memo re. project update, and also the all-staff memo to VCH-Coastal staff.

The real urgency is around VCH-Coastal memo – implementation work is already underway on-site at LGH, and it's becoming a real challenge for the leadership team there with their staff to not have any communication about this. I've promised Mary that we're trying to get messaging approved asap.

Also resending the latest Issue Note, which provides proposed reactive messaging in the event of media queries about facilities roadmap.

Dave

From: Cunningham, Dave
Sent: Wednesday, April 06, 2016 3:09 PM
To: 'Plank, Sarah GCPE:EX' <Sarah.Plank@gov.bc.ca>
Subject: CST internal launch memos - HO leaders, + Coastal Group 1 staff

Here are the draft memos, as discussed - plus the Mar. 9 Issues Note which I will quickly update.

The first memo is to the health organization leaders. The second is specifically for Coastal Group 1 staff, given implementation planning will begin on-site there in the coming weeks.

Dave Cunningham
Chief Communications Officer
Provincial Health Services Authority

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604-837-5360 Mobile
dave.cunningham@phsa.ca
www.phsa.ca
[@davcunn](#)

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DRAFT Memorandum

Date: Apr. xx, 2016

To: Health Organization Leaders

From: **Paul Brownrigg**, Vice President of CST and Innovation, Vancouver Coastal Health
Nick Foster, Vice President Consolidated Services, CST and Special Projects, Provincial Health Services Authority
Yoel Robens-Paradise, Vice President of CST and Lower Mainland Health Information Management, Providence Health Care
Jeremy Smith, Chief Transformation Officer, CST

Re: CST Project Update

We are pleased to confirm that the Clinical and Systems Transformation (CST) project has now completed its review and planning process, and is now formally launching its enterprise design phase and preparing for the first implementation at Coastal "Group 1" sites, comprised of Lions Gate Hospital (LGH) and Sea-to-Sky facilities.

In particular, we have made a number of important improvements to the design work now underway:

Focus on Coastal Group 1 implementation

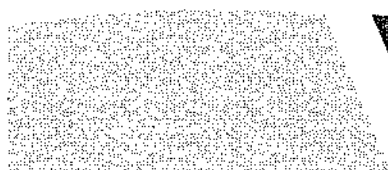
The CST enterprise design teams are now formally launching their work to design a true enterprise solution for our three organizations over the next year. Implementation is scheduled to begin next May or June at the Coastal "Group 1" sites. However, it is important to note that the clinical transformation process of designing common workflows and practices will be an ongoing process over the next year. In particular, learnings from Group 1 will be incorporated into successive implementations at other facilities.

The Coastal Group 1 Implementation Team is already on site at LGH, and will be working with Coastal senior leaders over the coming weeks to kick-off implementation planning.

There will be considerable on-site activity with Group 1 clinical leaders related to this planning work, including CST project Learning, Change Management, Device and Technology team members working with their counterparts at LGH and Squamish to conduct site readiness assessments. More details will be communicated separately to Coastal staff.

A shift to using "Agile" design methodology

Page 1





CLINICAL + SYSTEMS TRANSFORMATION

Our path to smarter, seamless care

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E info@CSTproject.ca

A common challenge in clinical transformation is the risk of designing new workflows and practices that, when implemented, fail to meet providers' and patients' needs.

To mitigate this risk, we have adopted "Agile" methodology, which consists of organizing design work in shorter, 2-week segments called "sprints." This allows for the work completed in a sprint to immediately be shared and tested with the subject matter experts who participated and broader stakeholders, to ensure it meets their needs.

In particular, all our design teams will include health organization subject matter experts.

One consequence of this approach is that it will require ongoing input from health organization stakeholders and subject matter experts. As we engage your clinical leaders in the process, we will sometimes require their prompt feedback and follow-up, and appreciate your support in this regard.

To engage our clinical leaders in this process, the CST team is scheduling a series of presentations with clinical leaders at health organization sites over the next two months, to provide an overview of our methodology. We will be reaching out to select leaders over the coming weeks to invite you to these sessions.

Scope and roadmap

s.13

About the CST Project

The Clinical and Systems Transformation project is a joint initiative of three health organizations: Vancouver Coastal Health, Provincial Health Services Authority and Providence Health Care. The project is designed to transform healthcare delivery systems and processes to improve the quality and consistency of the patient and caregiver experience. CST will support the health organizations in establishing common clinical and process standards, including work flows, order sets, clinical guidelines integrated plans of care and a common electronic health record. This clinical transformation will be supported by the implementation of a clinical information system that will replace aging existing systems. The project will be implemented in stages across the health organizations.

For More Information

Page 2

A joint initiative of:



We will continue to provide regular updates on the project to keep you informed. If you have any questions or concerns, please visit www.CSTproject.ca or contact:

General Inquiries	CST Executive Directors & Transformation Leads	Chief Medical Information Officers/Chief Nursing Officer
info@CSTproject.ca	VCH: Donna Stanton, Donna.Stanton@vch.ca PHSA: Vicky Crompton, Vcrompton@phsa.ca PHC: Grant McCullough gmcullough@providencehealth.bc.ca	VCH/PHC: Dr. Eric Grafstein, Eric.Grafstein@vch.ca PHSA: Dr. Alain Gagnon, Alain.Gagnon@phsa.ca Nursing/Allied: Barb Lawrie, Barb.Lawrie@vch.ca

Questions and Answers

s.13

Q2: When will Group 2 (BC Cancer Agency) implement CST?

Group 2 includes all six BC Cancer Agency centres (the Abbotsford Centre; the Centre for the North; the Centre for the Southern Interior; the Fraser Valley Centre; the Vancouver Island Centre; the Vancouver Centre); plus screening clinics, satellite clinics and Community Oncology Network clinics. Implementation of Group 2 is tentatively expected to begin in late 2017, with precise timing dependent on our experience and learnings in the first implementation.

Q4: Will all sites will get all the functionality that is in scope for CST?

The shared clinical practices and system that we are developing is a true “enterprise” initiative, designed to meet the needs of all facilities across our three health organizations. However, the functionality implemented will vary across sites, depending on the health services provided at the facility, and the needs of staff. These decisions will be finalized as part of the CST Design work, and for Coastal Group 1, by the Implementation Team’s on-site planning work now underway.

Q5: When and how will the rest of the sites, beyond Groups 1 and 2, implement CST; especially given the expanded scope of the project?

Page 3



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E info@CSTproject.ca

VCH, PHSA and PHC the health organizations remain absolutely committed to implementing the new CST clinical practices, workflows and system at all facilities. The experience and learnings we gain in the first two implementations will give us a much clearer understanding of the best approach to implementing at other facilities.



DRAFT Memorandum

Date: Apr. xx, 2016

To: All VCH-Coastal staff and physicians

From: **Mary Ackenhusen**, CEO, VCH
Mike Nader, Chief Operating Officer – Coastal, VCH
Paul Brownrigg, Vice President of CST and Innovation, VCH
Dr. Eric Grafstein, Chief Medical Information Officer, VCH
Barb Lawrie, Chief Clinical Information Officer, VCH

Re: CST Implementation at VCH-Coastal sites

We are pleased to confirm that the Clinical and Systems Transformation (CST) project is now formally launching its enterprise design phase, and that the first Coastal "Group 1" sites to be implemented will be Lions Gate Hospital (LGH) campus and Sea-to-Sky facilities.

These sites include HOpe Centre, Evergreen House and North Shore Hospice in North Vancouver, along with Squamish Hospital and the three health centres along the Sea-to-Sky Highway (Hilltop House, Pemberton Health Centre and Whistler Health Care Centre). The extent of the initial clinical deployment will vary from site to site based on clinical priorities and local needs.

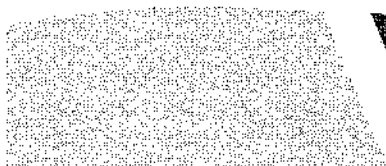
VCH-Coastal facilities in Sechelt, Powell River, Bella Bella and Bella Coola remain part of the project scope, but because of the urgency of replacing the aging, fragile clinical systems in Group 1 and Group 2 (BC Cancer Agency), these locations will be implemented as part of subsequent groups.

The Coastal implementation will build on other CST-related initiatives that include construction of our Regional Pharmacy Production Centre, which is targeted to open in the fall of 2016 at VCH, and the installation of Omnicell automated medication dispensing cabinets at LGH and other acute care facilities.

Coastal Group 1 Update

Here's what's happening on the ground at the first group of sites right now, and what to expect in the weeks and months to come:

- Members of the CST Coastal implementation team are now embedded at key locations within Coastal. After a team kickoff event on April 20th they will be rolling up their sleeves to work with site teams on detailed implementation planning.





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E info@CSTproject.ca

- The Professional Practice Group will be meeting with Coastal Professional Practice Educators, managers and Patient Care Coordinators on April 26th, led by VCH's Chief Clinical Information Officer Barb Lawrie. This key group is helping define the best-practice workflows, patient care plans and order sets that are at the heart of the clinical transformation.
- Starting next week, CST project Learning, Change Management, Device and Technology team members will be working with their local counterparts at LGH and Squamish to conduct site readiness assessments.
- By June, staff and physician involvement in the CST project will increase with a series of on-site workshops that will give participants a detailed look at how the new CST workflows and practice changes will affect various areas.

It's Good to be First

Being the first to adopt the transformative changes of the CST project has both potential risks and rewards. The first implementation is by nature the most challenging, and will take longer than subsequent groups. But being first will give our Coastal team an opportunity to provide valuable input that will lead to safer, better, more consistent care for patients at our sites, as well as at all the sites that follow us. As with all of our care facilities, the Group 1 sites will be fully supported by the CST team, which is ready to respond to immediate needs and challenges before, during and after the implementation.

As we move forward it's important to remember that CST implementation will include a process of ongoing clinical transformation over the next year, both at Coastal and across the three health organizations, as we work to develop common workflows and practices.

For More Information

We will continue to provide regular updates on the project to keep you informed. If you have any questions or concerns, please visit www.CSTproject.ca or contact:

Questions and Answers

Q1: Which VCH-Coastal sites are included in Group 1?

Group 1 includes Lions Gate Hospital, HOpe Centre, Evergreen House and North Shore Hospice in North Vancouver, along with Squamish Hospital and the three health centres along the Sea-to-Sky Highway (Hilltop House, Pemberton Health Centre and Whistler Health Care Centre). The extent of the initial clinical deployment will vary from site to site based on clinical priorities and local needs.

s.13

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DRAFT - CONFIDENTIAL ISSUES NOTE
Apr. 8, 2016 – CST project plan update

The Clinical and Systems Transformation (CST) Project Board has completed its review of scope, schedule and implementation roadmap. The project budget remains \$842 million, with a scope that better reflects the clinical goals of the project – an outcome of the learnings realized through the re-plan work undertaken over the last year.

The CST Communications team recommends the following key messages:

Key Messages:

- As part of their re-planning work, the health organizations reviewed the underlying clinical objectives of the project, and identified some necessary improvements to the scope that were not included in the original plan. These added elements include:
 - Enhanced oncology – the original system scope did not include the full functionality of the unique policies, processes and procedures required for cancer care.
 - Ambulatory Care.
 - Behavioural Health.
 - Bedside Medical Device Integration – the seamless integration of data from vital sign monitors, so that nurses do not need to manually input this data.
 - Provider documentation – the original scope envisioned that doctors would continue to document patient notes on paper, while the rest of the patient chart was electronic, a clear deficiency that would increase risk to patients.
 - Physician voice-recognition dictation.
 - Added resources for learning and training.
- Prudent project management means you need to make adjustments along the way.
- For example, the original plan for Island Health's new IHealth system did not include voice dictation capability for physicians – it was added to the plan later based on clinician input. Physicians using the system in the Nanaimo ER say they could not function without it.
- Likewise, the CST project did not have this functionality initially, but clinical engagement resulted in a recommendation that this is an element of design that is critical to service delivery.
- A consequence of these many improvements, combined with the time invested in our project refresh, is that we will not be able to implement as many facilities within the project budget.
- Budget resources are being directed towards those facilities that will derive the maximum benefit from the new clinical practices and system, and where system upgrades are most urgently needed. Other sites will be included in successive implementation groups.
- Implementation is always an iterative process of adjusting and fine-tuning after the first sites. Deferring less urgent sites will enable the project team to focus its resources on a successful implementation of the most urgent and critical facilities.
- However, the health organizations remain absolutely committed to implementing the new CST clinical practices, workflows and system at all facilities.

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Background:

- Note, both BMDI and provider-documentation were also not included in the original scope of Island Health's system, and were later identified as necessary and added.

Chronology:

- April 2013 – CST Project begins with IBM.
- March 2015 – Health organizations and IBM agree to end contract.
- April – September 2015 – Project reset completed, with assistance of PriceWaterhouseCoopers.
- July – Cerner retained as new project partner.
- October 2015 – Replanning phase initiated with Cerner.
- February 2016 – Design and Configuration work begins.
- March 2016 – Revised integrated project plan, including scope and budget.

Key highlights of the project refresh:

- A governance structure that ensures accountability, transparency and proactive risk management;
- external advisors on the Project Board with relevant industry experience to help inform decision-making;
- a shift in responsibility for project management and project delivery from a contracted service provider to the health organizations;
- a new agreement with the project's software provider Cerner;
- a new external project assurance function for formal, objective project oversight;
- an improved approach to the design of clinical workflows and configuration of the new clinical information system;
- several important appointments, including those of Chief Transformation Officer, Chief Clinical Information Officer (clinical lead), and Project Management Office Director;
- a comprehensive review of the project scope for alignment with the project's clinical goals and clinical workflow; and
- review, refinement and validation of the CST project clinical goals and objectives and alignment of workstreams with financial objectives.

Design and Configuration Process Improvements:

- A pre-configured system – the foundation for the continuation of design work will be Cerner's pre-built "Model System," a fully functioning prototype based on global best practices from Intermountain Healthcare, one of Cerner's leading clients.
- Seeing our work as we go – Building on the Model System, our design teams will be able to map our requirements from the first phase of design and make progressive, iterative improvements throughout the design and configuration process.
- A clear and robust validation process – With the ability to create prototypes of our new system, we are better able to identify and fix problems before they are set in stone – making validation an ongoing part of our process.
- New program/specialty liaison roles – These clinical informatics resources will be an important point of contact between the design teams and the clinical programs and specialty areas of our

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health organizations, bringing a systemic view and helping facilitate the transformation from design through to implementation.

Project Budget:

- Based on the original Business Case, the total cost of ownership of the CST project, including both one-time costs and regular ongoing operating costs, was estimated to be \$842 million over 10 years. This was comprised of project costs of \$480 million capital expenditure and \$77 million operating for a total of \$557 million net new project costs, plus a \$285 million base spend over the 10 year period, primarily existing IT budget for the legacy systems or replacement systems.
- As of Jan. 2016, expenditure to date on the CST project and base spend on operations (total cost of ownership) is \$175.5 million: \$147 million capital and \$28.6 million operating.

Contact Information			
Contact	Name	Title	Phone
Program	Jeremy Smith	Chief Transformation Officer, CST	604-875-4732 (o) 250-889-6720 (c)
Communications	Dave Cunningham	CCO – PHSA	604-837-5360 (c)
Creation & revision history			
Mar. 8, 2016		Issues note created	
Mar. 9		Reviewed by Sabine Feulgen	
Apr. 7		Updated draft	
Apr. 8		Review	

DRAFT – Confidential Advice

A joint initiative of:



Michell, Jennifer HLTH:EX

From: Plank, Sarah GCPE:EX
Sent: Thursday, March 10, 2016 10:36 AM
To: Feulgen, Sabine HLTH:EX
Subject: Issues note - CST
Attachments: Issues Note - CST project plan update - Mar 9.docx

Is this still current, after the meeting?

Thx, S.

Sarah Plank
Communications Director | Ministry of Health
Government Communications & Public Engagement
Office: 250.952.1889 | Mobile: 250.208.9621 | Email: sarah.plank@gov.bc.ca

CONFIDENTIAL ISSUES NOTE

Mar. 9, 2016 – CST project plan update

The CST Project Board is considering an updated project plan proposal. The proposal retains the original budget of \$842 million, with a scope that reflects the clinical goals of the project – an outcome of the learnings realized through the re-plan work undertaken over the last year.

The CST Communications team recommends the following key messages:

Key Messages:

- This is still only a proposal for discussion. A final project plan has not yet been approved and will require both Health Organization and Ministry of Health approval.
- The Clinical and Systems Transformation Project board has been looking at the entire project in depth since the project reset began last year - including scope, resources and implementation.
- Part of the work is the testing and validation of the original assumptions, with respect to what should be included in the scope of the project, and ensuring elements that provide maximum clinical benefit are included.
- Prudent project-management on projects of this scale means you need to make adjustments and course-correct along the way.
- For example, I recently was given a demonstration of Island Health's new IHealth system. The original plan for IHealth did not include voice dictation capability for physicians – it was added to the plan later based on clinician input. Physicians using the system in the Nanaimo ER say they could not function without it.
- The CST project did not have this functionality initially, but similar to Island Health's experience, clinical engagement has resulted in a recommendation that this is an element of design that is critical to service delivery.
- There are always trade-offs along the way. Enhanced functionality in one area may mean having to reduce scope in another area.
- The project board is doing that due diligence and planning to ensure the project is done properly. That is the work they are doing now, and they are getting close to completion.

Background:

- On March 9, the CST Project Board will be considering an updated project plan proposal, including budget, scope and schedule. The proposal retains the original budget of \$842 million.
- As part of its re-planning work, the team has reviewed the underlying clinical objectives of the project, and identified some necessary improvements to the scope of the project to achieve these objectives that were not included in the original plan. These added elements include:
 - Cancer care – the original system scope did not include the full functionality of the unique policies, processes and procedures required for cancer care.
 - Bedside Medical Device Integration – the seamless integration of data from vital sign monitors, so that nurses do not need to manually input this data.



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- Provider documentation – the original scope envisioned that doctors would continue to document patient notes on paper, while the rest of the patient chart was electronic, a clear deficiency that would increase risk to patients.
- Note, both BMDI and provider-documentation were also not included in the original scope of Island Health's system, and were later identified as necessary and are now being added as part of IHealth.
- While the new proposed plan expands the clinical value and scope, the implementation schedule is impacted.
- The new proposal recommends that available budget resources be directed towards those facilities that will derive the maximum benefit from the dollars available. Implementation at some sites will be thus deferred.
- Implementation is always an iterative process of adjusting and fine-tuning after the first sites. Deferring the least urgent sites will enable the project team to focus its resources on a successful implementation of the most urgent and critical facilities.
- \$175.5 million has been spent to date.

Chronology:

- April 2013 – CST Project begins with IBM.
- March 2015 – Health organizations and IBM agree to end contract.
- April – September 2015 – Project reset completed, with assistance of PriceWaterhouseCoopers.
- July – Cerner retained as new project partner.
- October 2015 – Replanning phase initiated with Cerner.
- February 2016 – Design and Configuration work begins.
- March 2016 – Revised integrated project plan, including scope and budget, being considered.

Key highlights of the project reset and replanning:

- A governance structure that ensures accountability, transparency and proactive risk management;
- external advisors on the Project Board with relevant industry experience to help inform decision-making;
- a shift in responsibility for project management and project delivery from a contracted service provider to the health organizations;
- a new agreement with the project's software provider Cerner;
- a new external project assurance function for formal, objective project oversight;
- an improved approach to the design of clinical workflows and configuration of the new clinical information system;
- several important appointments, including those of Chief Transformation Officer, Chief Clinical Information Officer (clinical lead), and Project Management Office Director;
- a comprehensive review of the project scope for alignment with the project's clinical goals and clinical workflow; and
- review, refinement and validation of the CST project clinical goals and objectives and alignment of workstreams with financial objectives.

Design and Configuration Process Improvements:

- A pre-configured system – the foundation for the continuation of design work will be Cerner's pre-built "Model System," a fully functioning prototype based on global best practices from Intermountain Healthcare, one of Cerner's leading clients.
- Seeing our work as we go – Building on the Model System, our design teams will be able to map our requirements from the first phase of design and make progressive, iterative improvements throughout the design and configuration process.
- A clear and robust validation process – With the ability to create prototypes of our new system, we are better able to identify and fix problems before they are set in stone – making validation an ongoing part of our process.
- New program/specialty liaison roles – These clinical informatics resources will be an important point of contact between the design teams and the clinical programs and specialty areas of our health organizations, bringing a systemic view and helping facilitate the transformation from design through to implementation.

Project Budget:

- Based on the original Business Case, the total cost of ownership of the CST project, including both one-time costs and regular ongoing operating costs, was estimated to be \$842 million over 10 years. This was comprised of project costs of \$480 million capital expenditure and \$77 million operating for a total of \$557 million net new project costs, plus a \$285 million base spend over the 10 year period, primarily existing IT budget for the legacy systems or replacement systems.
- As of Jan. 2016, expenditure to date on the CST project and base spend on operations (total cost of ownership) is \$175.5 million: \$147 million capital and \$28.6 million operating.

Contact information			
Contact	Name	Title	Phone
Program	Jeremy Smith	Chief Transformation Officer, CST	604-875-4732 (o) 250-889-6720 (c)
Communications	Dave Cunningham	CCO – PHSA	604-837-5360 (c)
Creation & revision history			
Mar. 8, 2016		Issues note created	
Mar. 9		Reviewed by Sabine Feulgen	

Michell, Jennifer HLTH:EX

From: Plank, Sarah GCPE:EX
Sent: Thursday, March 10, 2016 10:39 AM
To: Feulgen, Sabine HLTH:EX
Subject: RE: Issues note - CST

Yes – just wondering if it comes up in QP right now, is the note still current?

From: Feulgen, Sabine HLTH:EX
Sent: Thursday, March 10, 2016 10:37 AM
To: Plank, Sarah GCPE:EX
Subject: RE: Issues note - CST

I have asked Martyn to get me some time with MTL today. Looks like it might be 1 pm or 2:30. I asked for 2:30.

Sabine

phone: 250.952-1764
email: Sabine.Feulgen@gov.bc.ca

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From: Plank, Sarah GCPE:EX
Sent: Thursday, March 10, 2016 10:36 AM
To: Feulgen, Sabine HLTH:EX
Subject: Issues note - CST

Is this still current, after the meeting?

Thx, S.

Sarah Plank
Communications Director | Ministry of Health
Government Communications & Public Engagement
Office: 250.952.1889 | Mobile: 250.208.9621 | Email: sarah.plank@gov.bc.ca

Michell, Jennifer HLTH:EX

From: Feulgen, Sabine HLTH:EX
Sent: Tuesday, March 8, 2016 11:59 PM
To: Sarah Plank
Subject: Issues Note - CST scope update - Mar 8 - I made some changes



Issues Note - CST
scope update...



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CONFIDENTIAL ISSUES NOTE

Mar. 8, 2016 – CST project plan update

The CST Project Board is considering an updated project plan proposal. The proposal retains the original budget of \$842 million, but with a s.13 scope that better reflects the clinical goals of the project on a site specific basis; an outcome of the learnings realized through the re-plan work undertaken over the last year; and a s.13

Comment (FSF1): I don't believe the implementation schedule has ever been in the public domain.

The CST Communications team recommends the following key messages:

Key Messages:

- This is still only a proposal for discussion. A final I-project plan has not yet been approved and will require both Health Organization and Ministry of Health approval.
- The project board for Clinical Systems Transformation Project board has been looking at the entire project in depth since the project reset began last year - including scope, resources and implementation.
- Part of the work the team is doing is to undertake is the testing and validate-validation of the original assumptions, about what's with respect to what should be included in the scope of the project, and ensuring the elements that provide maximum clinical benefit are captured. This is a challenge with this project, which has a magnitude of scope (number of sites) and complexity that has not been seen in the North American Health Care Sector previously.
- Prudent project management on projects of this scale means you need to make adjustments and course-correct along the way.
- For example, I recently was given a demonstration of Island Health's new IHealth system.
- The original plan for IHealth - IHealth system did not include voice dictation capability for physicians - it was added to the plan later based on clinician input, and now Pphysicians using the system in the Nanaimo ER say they could not function without it. The CST project has had the same experience with a voice dictation pilot. The CST project de-scoped this functionality at the front end, but similar to Island Health's experience, clinical engagement has resulted in a recommendation coming forward that this is an element of design that is critical to service delivery.
- Prudent project management on projects of this scale means you need to make adjustments and course-correct along the way.
- The project board is looking at a variety of options and scenarios to achieve integrated electronic health records - as they should be, to ensure they end up with the best possible solution that improves the quality and safety of patient care.
- There are always trade-offs along the way. Enhanced functionality in one area may mean having to reduce scope in another area, or the number of facilities that can be included.
- The project board is doing that due diligence and planning to ensure the project is done properly. That is the work they are doing now, and they are getting close to completion.

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- On March 9, the CST Project Board ~~will be~~ is considering an updated project plan proposal, including budget, scope and schedule. The proposal retains the original budget of \$842 million.
- As part of its re-planning work, the team has reviewed the underlying clinical objectives of the project, and identified some necessary improvements to the scope of the project to achieve these objectives that were not included in the original plan. These added elements include:
 - Cancer care – the original system scope did not include the full functionality of the unique policies, processes and procedures required for cancer care.
 - Bedside Medical Device Integration – the seamless integration of data from vital sign monitors, so that nurses do not need to manually input this data.
 - Provider documentation – the original scope envisioned that doctors would continue to document patient notes on paper, while the rest of the patient chart was electronic, a clear deficiency that would increase risk to patients.
- Note, both BMDI and provider-documentation were also not included in the original scope of Island Health's system, and were later identified as necessary and are now being added as part of IHealth.
- While the new proposed plan expands the clinical value and scope, it also ~~includes fewer facilities than originally planned~~ the implementation schedule is impacted
- The revised ~~new~~ proposal is an effort to focus ~~recommends that available budget resources be directed towards~~ budget resources where they are needed most, and on those facilities that we know for certain will require system upgrades in the next five years ~~will derive the maximum benefit, from the investment dollars available, while deferring implementation at some sites will be thus deferred that are less urgent or where subject to clarity of requirements and the timing of funding availability~~ implementation costs are less clear.
- Implementation is always an iterative process of adjusting and fine-tuning after the first sites. Deferring the least urgent sites will enable the project team to focus its resources on a successful implementation ~~at of~~ the most urgent and critical facilities.
- \$168 million has been spent to date.

Chronology:

- April 2013 – CST Project begins with IBM.
- March 2015 – Health organizations and IBM agree to end contract.
- April – September 2015 – Project reset completed, with assistance of PriceWaterhouseCoopers.
- July – Cerner retained as new project partner.
- October – ~~November 2015~~ – Replanning phase ~~completed~~ initiated with Cerner.
- February 2016 – Design and Configuration work begins.
- March 2016 – Revised integrated project plan, including scope and budget, being considered.

Key highlights of the project reset and replanning:

- A governance structure that ensures accountability, transparency and proactive risk management;
- external advisors on the Project Board with relevant industry experience to help inform decision-making;
- a shift in responsibility for project management and project delivery from a contracted service provider to the health organizations;
- a new agreement with the project's software provider Cerner;

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- a new external project assurance function for formal, objective project oversight;
- an improved approach to the design of clinical workflows and configuration of the new clinical information system;
- several important appointments, including those of Chief Transformation Officer, Chief Clinical Information Officer (clinical lead), and Project Management Office Director;
- a comprehensive review of the project scope for alignment with the project's clinical goals and clinical workflow; and
- review, refinement and validation of the CST project clinical goals and objectives and alignment of workstreams with financial objectives.

Design and Configuration Process Improvements:

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Project Budget:

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- As of Jan. 2016, expenditure to date on the CST project and base spend on operations (total cost of ownership) is \$168.5 million: \$147 million capital and \$28.6 million operating.

Contact Information			
Contact	Name	Title	Phone
Program	Jeremy Smith	Chief Transformation Officer, CST	604-875-4732 (o) 250-889-6720 (c)
Communications	Dave Cunningham	CCO – PHSA	604-837-5360 (c)
Creation & revision history			
Mar. 8, 2016		Issues note created	

Page 3

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Michell, Jennifer HLTH:EX

From: Plank, Sarah GCPE:EX
Sent: Tuesday, March 8, 2016 10:10 PM
To: Feulgen, Sabine HLTH:EX
Subject: FW: Issues Note - CST project plan update - Mar 8
Attachments: Issues Note - CST scope update - Mar 8.docx

Hi Sabine – how does this look to you? Thx, S.

From: Plank, Sarah GCPE:EX
Sent: Tuesday, March 8, 2016 10:09 PM
To: XT:Cunningham, Dave HLTH:IN
Subject: RE: Issues Note - CST project plan update - Mar 8

Thanks Dave. This is great. I think it has the info the minister will need.

I have suggested a few revisions to the messaging.

If you are okay with it, I will run it by Sabine as well.

Thanks,
Sarah.

From: Cunningham, Dave [<mailto:Dave.Cunningham@phsa.ca>]
Sent: Tuesday, March 8, 2016 6:58 PM
To: Plank, Sarah GCPE:EX
Subject: Fwd: Issues Note - CST project plan update - Mar 8

Hi. Here's a draft. Still awaiting final feedback from Carl and Mary, but I don't anticipate any major changes.

Begin forwarded message:

From: "Cunningham, Dave" <Dave.Cunningham@phsa.ca>
Date: March 8, 2016 at 6:10:15 PM PST
To: "Roy, Carl" <CRoy@phsa.ca>, "[VCH] Ackenhusen, Mary [CORP]" <Mary.Ackenhusen@vch.ca>
Cc: "Smith, Jeremy" <Jeremy.Smith@phsa.ca>
Subject: Issues Note - CST project plan update - Mar 8

Carl, Mary – attached is a draft Issues Note for your review, to assist Minister in case he receives any questions about the revised project plan going to PB tomorrow.



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CONFIDENTIAL ISSUES NOTE

Mar. 8, 2016 – CST project plan update

The CST Project Board is considering an updated project plan proposal. The proposal retains the original budget of \$842 million, but with a revised scope to better reflect the clinical goals of the project, and a revised implementation plan.

The CST Communications team recommends the following key messages:

Key Messages:

- This is still only a proposal for discussion. A final project plan has not yet been approved.
- The project board for Clinical Systems Transformation has been looking at the entire project in depth since the project reset last year - including scope, resources and implementation.
- Part of the work the team is doing is to test and validate the original assumptions about what's included in the scope of the project.
- Prudent project management on projects of this scale means you need to make adjustments and course-correct along the way.
- For example, I recently was given a demonstration of Island Health's new IHealth system.
- The original plan for IHealth - Health system did not include voice dictation capability for physicians - it was added to the plan later based on clinician input, and now Pphysicians using the system in the Nanaimo ER say they could not function without it. The CST project has had the same experience with a voice dictation pilot.
- Prudent project management on projects of this scale means you need to make adjustments and course-correct along the way.
- The project board is looking at a variety of options and scenarios to achieve integrated electronic health records - as they should be to ensure they end up with the best possible solution that improves the quality and safety of patient care.
- There are always trade-offs along the way. Enhanced functionality in one area may mean having to reduce scope in another area, or the number of facilities that can be included.
- The project board is doing that due diligence and planning to ensure the project is done properly. That is the work they are doing now, and they are getting close to completion.

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Background:

- On March 9, the CST Project Board is considering an updated project plan proposal, including budget, scope and schedule. The proposal retains the original budget of \$842 million.
- As part of its replanning work, the team has reviewed the underlying clinical objectives of the project, and identified some necessary improvements to the scope of the project to achieve these objectives that were not included in the original plan. These added elements include:
 - Cancer care - the original system scope did not include the full functionality of the unique policies, processes and procedures required for cancer care.
 - Bedside Medical Device Integration - the seamless integration of data from vital sign monitors, so that nurses do not need to manually input this data.

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- Provider documentation – the original scope envisioned that doctors would continue to document patient notes on paper, while the rest of the patient chart was electronic, a clear deficiency that would increase risk to patients.
- Note, both BMDI and provider-documentation were also not included in the original scope of Island Health's system, and were later identified as necessary and are now being added as part of IHealth.
- While the new proposed plan expands the clinical value and scope, it also includes fewer facilities than originally planned.
- The revised proposal is an effort to focus budget resources where they are needed most, and on those facilities that we know for certain will require system upgrades in the next five years, while deferring implementation at sites that are less urgent or where implementation costs are less clear.
- Implementation is always an iterative process of adjusting and fine-tuning after the first sites. Deferring the least urgent sites will enable the project team to focus its resources on a successful implementation at the most urgent and critical facilities.
- \$168 million has been spent to date.

Chronology:

- April 2013 – CST Project begins with IBM.
- March 2015 – Health organizations and IBM agree to end contract.
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- October – November 2015 – Replanning phase completed with Cerner.
- February 2016 – Design and Configuration work begins.
- March 2016 – Revised integrated project plan, including scope and budget, being considered.

Key highlights of the project reset and replanning:

- A governance structure that ensures accountability, transparency and proactive risk management;
- external advisors on the Project Board with relevant industry experience to help inform decision-making;
- a shift in responsibility for project management and project delivery from a contracted service provider to the health organizations;
- a new agreement with the project's software provider Cerner;
- a new external project assurance function for formal, objective project oversight;
- an improved approach to the design of clinical workflows and configuration of the new clinical information system;
- several important appointments, including those of Chief Transformation Officer, Chief Clinical Information Officer (clinical lead), and Project Management Office Director;
- a comprehensive review of the project scope for alignment with the project's clinical goals and clinical workflow; and
- review, refinement and validation of the CST project clinical goals and objectives.

Design and Configuration Process Improvements:

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CLINICAL + SYSTEMS TRANSFORMATION

Our path to smarter, seamless care

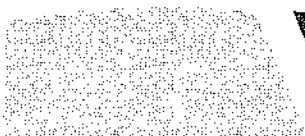
- A pre-configured system – the foundation for the continuation of design work will be Cerner's pre-built "Model System," a fully functioning prototype based on global best practices from Intermountain Healthcare, one of Cerner's leading clients.
- Seeing our work as we go – Building on the Model System, our design teams will be able to map our requirements from the first phase of design and make progressive, iterative improvements throughout the design and configuration process.
- A clear and robust validation process – With the ability to create prototypes of our new system, we are better able to identify and fix problems before they are set in stone – making validation an ongoing part of our process.
- New program/specialty liaison roles – These clinical informatics resources will be an important point of contact between the design teams and the clinical programs and specialty areas of our health organizations, bringing a systemic view and helping facilitate the transformation from design through to implementation.

Project Budget:

- Based on the original Business Case, the total cost of ownership of the CST project, including both one-time costs and regular ongoing operating costs, was estimated to be \$842 million over 10 years. This was comprised of project costs of \$480 million capital expenditure and \$77 million operating for a total of \$557 million net new project costs, plus a \$285 million base spend over the 10 year period, primarily existing IT budget for the legacy systems or replacement systems.
- As of Jan. 2016, expenditure to date on the CST project and base spend on operations (total cost of ownership) is \$168.5 million: \$147 million capital and \$28.6 million operating.

Contact information			
Contact	Name	Title	Phone
Program	Jeremy Smith	Chief Transformation Officer, CST	604-875-4732 (o) 250-889-6720 (c)
Communications	Dave Cunningham	CCO – PHSA	604-837-5360 (c)
Creation & revision history			
Mar. 8, 2016		Issues note created	

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Providence
HEALTH CARE
PROVIDENCE SOLUTIONS
PROVEN RESULTS

Michell, Jennifer HLTH:EX

From: Feulgen, Sabine HLTH:EX
Sent: Wednesday, March 2, 2016 10:31 PM
To: Sarah Plank
Subject: just read the darcy interview

We never seem to talk about the CST website which I think has done a very good job at being transparent, outlining objectives, and giving regular project updates (that would address many of the Darcy comments). Not sure if MTL would ever direct a questioner to that website – but it has loads of value in my opinion.

<http://cstproject.ca/>

From: Feulgen, Sabine HLTH:EX
Sent: Tuesday, March 1, 2016 6:07 PM
To: Mary Ackenhusen; Carl Roy; Dianne Doyle
Cc: Jeremy Smith; Sidhu, Manjit HLTH:EX
Subject: QP Transcripts - CST Item

Here is the draft transcript of the CST item raised by MLA Darcy today during Question Period. Media followed up asking for confirmation of the statement re: budget and schedule. Communications has responded – no changes to budget or schedule (from delay previously reported). Project Board undertaking the due diligence opportunity provided through the reset of the project. Potentially more questions in the House tomorrow.

HEALTH INFORMATION TECHNOLOGY PROJECT ISSUES AND COSTS

J. Darcy: Last February, we raised the latest IT failure under this Liberal government — the debacle of the clinical system's transformation project in Health. This \$840 million project had gone off the rails, and the contractor, a little company called IBM, had walked away from it.

Well, in the fine fashion of Liberal failures, this one has become even worse. Sources at Vancouver Coastal Health now tell us that the project will cost another \$250 million and go well over a billion dollars. That's billion with a "b." These are precious health care dollars that are being squandered at a time when home support for seniors is being cut.

Can the Health Minister tell us if he intends to cut care for seniors even further to pay for his government's latest computer technology failure?

Hon. T. Lake: You know, I'm almost speechless at the member's accusations in terms of....

Interjections.

Hon. T. Lake: Well, thank you.

What we have done for the people that built this province — in terms of building new residential care facilities, being the first province in Canada to have a seniors advocate, increasing home supports, focusing the energy of the Health Ministry on keeping people in their homes longer — that speaks for itself.

The clinical and systems transformation project in the Lower Mainland will modernize the health care system to ensure that there's one electronic health record for a patient to ensure seamless care throughout a complex system. That will empower patients. It will empower the whole health care system. It's the rise thing to do, and we'll make sure that we do it correctly.

J. Darcy: Every time we raise this debacle about the clinical and systems transformation project, the minister acts like everything is just fine or he completely ignores the question, as he did just now.

When IBM walked away last spring, the minister came up with a notable analogy. "This marriage didn't work out," the minister said, "but the children are beautiful." Well, it seems he was wrong on that score too. Sources now tell us that this project will be delayed to at least October 2017, that it will cost more and it will be scaled back.

So just to be clear, last May in estimates, the minister said the project would still cost \$840 million, that it would be delayed for a year but that it would go live in October of 2016. Is that what the minister is still telling this House today?

Hon. T. Lake: This is a complex project. There's no question about it. We are taking steps to ensure....

[1100]

Interjections.

Madame Speaker: Members. Members.
Please continue.

Hon. T. Lake: Thank you, hon. Speaker.

It's a complex project that will make a real difference to patients. What we've done is we've created a...

HSE - 20160301 AM 013/JAH/1100

Madame Speaker: Members. Members.
Please continue.

Hon. T. Lake: Thank you, Madame Speaker. It's a complex project that will make real difference to patients. But what we've done is we've created a...

Interjections.

Madame Speaker: Continue.

Hon. T. Lake: What we've done is create a governance structure that ensures accountability, transparency and proactive risk management. We have external advisers on the project board, with relevant industry experience, that will help in decision-making -- a shift in responsibility for project management and delivery from a contracted service provider to the health organizations. They are taking ownership of this project. I'm confident that it will be done and make a huge difference in terms of health care in the Lower Mainland.

[End of question period.]

Michell, Jennifer HLTH:EX

From: Plank, Sarah GCPE:EX
Sent: Tuesday, March 1, 2016 2:24 PM
To: XT:Cunningham, Dave HLTH:IN
Cc: Heinze, Laura R GCPE:EX; Feulgen, Sabine HLTH:EX
Subject: RE: FOR REVIEW - CST messages

Reporter is pushing back. Dave -- any concerns with saying this:

There has been no change to the budget or new timeline.

From: Cunningham, Dave [mailto:Dave.Cunningham@phsa.ca]
Sent: Tuesday, March 1, 2016 1:10 PM
To: Plank, Sarah GCPE:EX
Cc: Heinze, Laura R GCPE:EX; Feulgen, Sabine HLTH:EX
Subject: Re: FOR REVIEW - CST messages

Thanks, looks great to me too, Laura.

On Mar 1, 2016, at 12:49 PM, Plank, Sarah GCPE:EX <Sarah.Plank@gov.bc.ca> wrote:

I like it. Thanks Laura. Will let Dave and Sabine weigh in as well.

From: Heinze, Laura R GCPE:EX
Sent: Tuesday, March 1, 2016 12:49 PM
To: Feulgen, Sabine HLTH:EX; XT:Cunningham, Dave HLTH:IN
Cc: Plank, Sarah GCPE:EX
Subject: RE: FOR REVIEW - CST messages
Importance: High

Minister is looking for more on the other work -- I've combined with our previous messaging -- are we still ok with all of this?

- The project board has been looking at the project as a whole since the project reset last year - including scope, resources and implementation.
- That work is still underway. No decisions have been made.
- It is important that the project board do the due diligence and planning necessary to ensure the project is done properly. That is the work they are doing now, and we need to let them do that work.
- That said, throughout this process, work has continued in the last few months on the project, focusing on improving the governance structure, assessing the work already done, and updating the project plan. Achievements of this re-planning work include:
 - A governance structure that ensures accountability, transparency and proactive risk management;
 - External advisors on the Project Board with relevant industry experience to help inform decision-making;
 - A shift in responsibility for project management and project delivery from a contracted service provider to the health organizations;
 - A new agreement with our software provider Cerner;
 - A new external project assurance function for formal, objective project oversight;
 - An improved approach to the design of clinical workflows and configuration of the new clinical information system;

- Several important appointments, including those of Chief Transformation Officer, Chief Clinical Information Officer (clinical lead), and Project Management Office Director.
- A comprehensive review of project scope for alignment with the clinical goals and clinical workflow.
- This project remains a priority for the Health Organizations and will continue. The Clinical Systems Transformation project will have many benefits for our patients, staff, physicians and the health system as a whole.

-----Original Message-----

From: Feulgen, Sabine HLTH:EX
 Sent: Tuesday, March 1, 2016 12:07 PM
 To: XT:Cunningham, Dave HLTH:IN
 Cc: Plank, Sarah GCPE:EX; Heinze, Laura R GCPE:EX
 Subject: Re: FOR REVIEW - CST messages

Notwithstanding - it begs the second question.

Sabine Feulgen
 Associate Deputy Minister, Corporate Services Ministry of Health

T: 250.952.1764
 E: Sabine.Feulgen@gov.bc.ca
 Original Message
 From: Cunningham, Dave
 Sent: Tuesday, March 1, 2016 11:58
 To: Feulgen, Sabine HLTH:EX
 Cc: Plank, Sarah GCPE:EX; Heinze, Laura R GCPE:EX
 Subject: Re: FOR REVIEW - CST messages

I thinks it's good. It's true.

On Mar 1, 2016, at 11:52 AM, Feulgen, Sabine HLTH:EX <Sabine.Feulgen@gov.bc.ca> wrote:

Do we need the middle paragraph re: no decisions?

Sabine Feulgen
 Associate Deputy Minister, Corporate Services Ministry of Health

T: 250.952.1764
 E: Sabine.Feulgen@gov.bc.ca
 From: Plank, Sarah GCPE:EX
 Sent: Tuesday, March 1, 2016 11:47
 To: Feulgen, Sabine HLTH:EX
 Cc: Heinze, Laura R GCPE:EX; XT:Cunningham, Dave HLTH:IN
 Subject: FOR REVIEW - CST messages

Hi Sabine - I have revised it a bit from what I sent just a few minutes ago... How does this look?

The project board has been looking at the project as a whole since the project reset last year - including scope, resources and implementation.

That work is still underway. No decisions have been made at this point in time as far as project scope, facilities or costs, and that work is ongoing.

It is important that the project board do the due diligence and planning necessary to ensure the project is done properly. That is the work they are doing now, and we need to let them do that work.

Thx, S.

Michell, Jennifer HLTH:EX

From: Plank, Sarah GCPE;EX
Sent: Tuesday, March 1, 2016 11:40 AM
To: Feulgen, Sabine HLTH:EX
Subject: CST messages

Importance: High

How's this?

The project board has been looking at the project as a whole since the project reset last year - including scope, resources and implementation.

That work is still underway. No decisions have been made at this point in time.

No decisions have been finalized yet on project scope, facilities or costs, and that work is ongoing.

Michell, Jennifer HLTH:EX

From: Shera, Deborah HLTH:EX
Sent: Tuesday, March 1, 2016 11:29 AM
To: Feulgen, Sabine HLTH:EX; Shrimpton, Paul HLTH:EX
Subject: FW: HEADS UP: CST Project in QP

FYI

From: Leake, Greg HLTH:EX
Sent: Tuesday, March 1, 2016 11:03 AM
To: Shera, Deborah HLTH:EX
Cc: Somner, Kirstie HLTH:EX
Subject: HEADS UP: CST Project in QP

Deb:

MLA Darcy was just asking the minister about information from inside VCH that the project is expected to cost over \$1B by the time it is done.

We'll have the summary out shortly.

G.

Greg Leake
Executive Director
Performance and Issues Management
Ministry of Health
250-952-2326

Michell, Jennifer HLTH:EX

From: Plank, Sarah GCPE:EX
Sent: Tuesday, March 1, 2016 11:01 AM
To: Feulgen, Sabine HLTH:EX; Brown, Stephen R HLTH:EX
Cc: Heinze, Laura R GCPE:EX
Subject: URGENT - QP: clinical systems
Attachments: CST project update_Jan20_16_IN.DOCX

Importance: High

FYI – Sabine do you have any more info on this? See below.

Our IN says this:

- Based on the original Business Case, the Total Cost of Ownership (TCO) of the CST project, including both one-time project costs and regular ongoing operating costs, is estimated to be \$842 million over 10 years. This is comprised of project costs of \$480 million capital expenditure and \$77 million operating for a total of \$557 million net new project costs, plus the \$285 million base spend which is primarily existing IT budget for the legacy systems or replacement systems over the 10 year period.
- As of Dec. 2015, expenditure to date on the CST project and base spend on operations (total cost of ownership) is \$168.5 million (\$140.7 million capital and \$27.8 million operating).

Is there something new on this??

S.

From: Shaw, Rob (Vancouver Sun) [<mailto:rshaw@vancouver.sun.com>]
Sent: Tuesday, March 1, 2016 10:59 AM
To: Plank, Sarah GCPE:EX
Subject: clinical systems

Interesting ndp question in QP – is Clinical Systems Transformation project now \$200m over its \$842m budget and exceeding \$1b?

When I spoke to the project manager there for our IT project recently he said they were still on budget... so something changed? Is ministry aware?

Rob

ROB SHAW
Legislative Reporter
The Vancouver Sun
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Twitter: @robshaw_vansun

ADVICE TO MINISTER

CONFIDENTIAL ISSUES NOTE

Ministry: Health

Date: January 20, 2016

Minister Responsible: Terry Lake

CST – Project Status Update

BACKGROUND REGARDING THE ISSUE:

- The Clinical Systems Transformation (CST) project is a joint initiative of VCH, PHSA and PHC. CST is designed to transform healthcare delivery processes and systems to improve the quality and consistency of the patient and caregiver experience.
- CST will support the health organizations in establishing common clinical and process standards, including work flows, order sets, clinical guidelines, integrated plans of care and a common clinical information system that will replace multiple aging existing systems.
- VCH, PHSA and PHC are working together to design the clinical workflows and configure the system, which will be implemented in stages across the three health organizations.
- Benefits for patients will include enhanced medication safety; an integrated approach with increased consistency of care; faster access to results and medication therapies; and less time spent repeating themselves during consultations or undergoing duplicate tests.
- Work on the project started in April 2013 under an initial service agreement with IBM.
- In March 2015, the Health Organizations and IBM mutually agreed to end their contract.
- Following IBM's departure, PriceWaterhouseCoopers Canada (PwC) was engaged to assist in a project reset which occurred through September 2015. An agreement was signed with Cerner on July 25 to assist in completing the CST Project. Cerner was already the software vendor for CST and will now also provide its implementation expertise.
 - Cerner has a history of successful implementations across North America, including within VCH, PHSA, Island Health and Northern Health, and has recently been engaged on a major project for the US Department of Defense.
 - The cost of the current phases of the Cerner agreement is \$13,382,803, to be funded within the existing budget previously allocated for work with IBM.
 - This work was procured as part of the existing Master Services Agreement already in place with Cerner, through PHSA.

DISCUSSION/ADVICE:

- While media attention has focused on the technology and clinical information system portions of this project, the more significant focus and work to date is the standardization of clinical practices and processes across the three health organizations, including establishment of clinical best practices.

- As of January 18, 2016, preparations for the restart of design are nearly complete. Cerner is working with VCH, PHSA, PHC and the CST project team to finalize a new integrated project plan and restart design work in February. This phase will focus on the design of clinical workflows and the configuration of our new clinical information system.
- The clinical workflow design and system configuration phase is expected to last approximately eight months. The next step will be to test the system to ensure it meets the requirements outlined during the design process.
- Among the first major changes associated with the CST project will be the establishment of a new pharmacy Regional Production Centre (RPC) at Vancouver General Hospital, which will automate the packaging and distribution of prescription medication in unit dose format to facilitate CST's closed-loop safe medication management processes. The RPC is a foundational component for CST implementation at all other sites.
- CST site implementation will start in 2017 with a group of facilities on the North Shore including Lions Gate Hospital. Exact timing and details will be based on consultation with clinical and operations leaders.
- The final order of CST implementation may change based on site readiness and the urgency of replacing existing aging clinical systems.
- Based on the original Business Case, the Total Cost of Ownership (TCO) of the CST project, including both one-time project costs and regular ongoing operating costs, is estimated to be \$842 million over 10 years. This is comprised of project costs of \$480 million capital expenditure and \$77 million operating for a total of \$557 million net new project costs, plus the \$285 million base spend which is primarily existing IT budget for the legacy systems or replacement systems over the 10 year period.
- As of Dec. 2015, expenditure to date on the CST project and base spend on operations (total cost of ownership) is \$168.5 million (\$140.7 million capital and \$27.8 million operating).

ADVICE AND RECOMMENDED RESPONSE:

- **We knew from the outset that this wasn't going to be an easy project - but we also recognized that it was important for patients in the Lower Mainland and those across the province accessing PHSA's specialized services.**
- **Clinical Systems Transformation – or CST – is a major transformation of clinical processes and care protocols across the three health organizations, focused on achieving the safe and consistent services of an integrated health system that our patients expect.**
- **While it is still expected that the project will be on budget based on the existing scope and schedule, it would be prudent to wait for the updated plan to be completed before making that assumption.**
- **Work has continued in the last few months on the project, focusing on improving the governance structure, assessing the work already done, and updating the**

ADVICE TO MINISTER

project plan. Achievements of this re-planning work include:

- A governance structure that ensures accountability, transparency and proactive risk management;
 - External advisors on the Project Board with relevant industry experience to help inform decision-making;
 - A shift in responsibility for project management and project delivery from a contracted service provider to the health organizations;
 - A new agreement with our software provider Cerner;
 - A new external project assurance function for formal, objective project oversight;
 - An improved approach to the design of clinical workflows and configuration of the new clinical information system;
 - Several important appointments, including those of Chief Transformation Officer, Chief Clinical Information Officer (clinical lead), and Project Management Office Director.
 - A comprehensive review of project scope for alignment with the clinical goals and clinical workflow.
- This project remains a priority for the Health Organizations and will continue. The Clinical Systems Transformation project will have many benefits for our patients, staff, physicians and the health system as a whole.
 - There are many examples of success on similar projects at other organizations, and the project is actively engaging with those organizations to inform and ensure success with CST.
 - The work completed since the beginning of the project is highly valuable and will continue to be utilized.

Benefits of the project:

- The CST clinical goals, or “Drivers” reflect the anticipated benefits of the project:
 - Reduce errors and adverse events: Up to 24,000 Canadian adults die every year because of preventable adverse events in acute care hospitals – and those are just the incidents we can measure. We can do better. That’s why we are investing in a safer future today.
 - Improve quality and consistency of care: We are designing safe, efficient care pathways that reflect the latest evidence and will reduce unnecessary variations in care across our facilities and healthcare organizations. We are supporting a culture of continuous learning and quality improvement.

- **Improve the healthcare experience for patients and care teams:** When care teams have the information they need at their fingertips, it means more time for patients. Transitions across health care settings will be smoother; everyone will be on the same page about the plan of care. Care teams won't have to ask the same questions over and over or repeat tests.
- **Make better information available to improve decision-making:** Fuller, richer information will give us a clearer picture of how we're doing and where we can improve. Data from today will be used to benefit the patients of tomorrow – across health disciplines and organizations.
- **Improve system reliability and sustainability:** Right now, we use over 200 systems and programs. Logging in, logging out, forgetting passwords: all this takes time away from patient care. Many of our outdated systems will be replaced with one clinical information system, which will connect with other key systems. This will reduce investment, maintenance and training costs.

Communications Contact: Stephen May Reviewer:
 Program Area Contact: Sabine Feulgen
 File Created: August 6, 2015
 File Updated: January 20, 2016

Minister's Office	Program Area	Deputy	HLTH Communications