The Le Royal Mental Health - Care & Research Santé mentale - Soins et recherche	**NOTICE OF MEETING** **ROYAL OTTAWA HEALTH CARE GROUP** **BOARD OF TRUSTEES** **February 20, 2020 at 4:30 p.m.** *(a light meal will be available at 5 p.m.)* **Royal Ottawa Mental Health Centre** **Room 1424, 1145 Carling Avenue** ***Teleconference Dial-In: 1-888-875-1833 Passcode: 926707277#***	○ Oral presentation ● Paper enclosed ●● Paper to follow ●●● Paper at meeting **IN** Information **DEC** Decision required ** Guidance required

BOARD VISION	**TO BE THE CATALYST FOR IMPROVING MENTAL HEALTH CARE SYSTEM-WIDE THROUGH BOARD EXCELLENCE** This vision will be accomplished by the Board of Trustees focusing on five key areas that will define the Board's value and contribution to The Royal: • Culture, Stakeholder Engagement and Focus, Innovation, Board Processes and Stewardship

MINI-SERIES

	4:30 p.m. – Women's Mental Health - S. Farrell, R. Pow, Ann-Marie O'Brien 5:10 p.m. – Women for Mental Health – C. Little *(During dinner)*

CLIENT PRESENTATION

CLIENT PRESENTATION	5:30 p.m. – Alexis Milne

Susan Farrell, PhD, C.Psych, CHE

Brief Biography

Dr. Susan Farrell is the Vice President of Patient Care Services and Community Mental Health at The Royal. For the previous decade she was the inaugural Clinical Director of the Community Mental Health Program at the Royal. Susan is a licensed Clinical Psychologist in Ontario and Nunavut. For almost two decades, she has been a Clinical Psychologist and her work is focused on persons with mental illness and supporting them in community-based models of care. Susan is an Associate Professor in the Faculty of Medicine and a Clinical Professor in the School of Psychology at the University of Ottawa. She is an active researcher in community-based research and evaluation of community and hospital services for persons with mental illness. In 2018 she was awarded the Excellence in Training award from the Canadian Council of Professional Psychology Programs for her community-based training models for Psychology Residents and was made a Fellow of the Canadian Psychological Association for her national contributions to Psychology and society.

Robin Pow is the Director of Patient Care Services for The Community Mental Health Program at The Royal. Robin began her career working as a front-line social worker with the homeless population in both Toronto and Ottawa. For the past 16 years she has managed a variety of community based teams at The Royal and The Ottawa Hospital including Assertive Community Treatment Teams, Mobile Crisis, Community Safe Beds, Community Treatment Order Coordination, Step Down from ACTT, Psychiatric Outreach, Homes for Special Care and Dual Diagnosis Services. Robin coordinates ACTT Central Intake in Ottawa. She sits on the Technical Advisory Committee and is on the Executive of the Ontario Association of ACTT and FACT Teams. Robin has been an advocate for further expansion of the ACTT model of service in Ontario.

Ann-Marie began her career at the Brockville Psychiatric Hospital in 1985. Since that time she has held a range of clinical, administrative and academic roles. For the last 10 years she has been the lead for women's mental health. She has held leadership positions with the Ontario College of Social Workers and Social Service Workers and the Ontario Association of Social Workers.

Alexis Milne (editor of The Client's Voice)

Alexis Milne is a volunteer in the Women's Resource Centre where she co-facilitates Journaling and WRAP (Wellness Recovery Action Plan). She is a member of the Client Advisory Council and attends various committees as a voice for the clients. Alexis is the proud editor of The Client's Voice, a newsletter for clients to share their stories of recovery and their fantastic artistic abilities. She believes this newsletter is a tool to open the conversation and shed some light on the stigma of mental illness. The clients have a voice.

The Royal Mental Health - Care & Research Santé mentale - Soins et recherche	**NOTICE OF MEETING** **ROYAL OTTAWA HEALTH CARE GROUP** **BOARD OF TRUSTEES** **February 20, 2020 at 4:30 p.m.** *(a light meal will be available at 5 p.m.)* **Royal Ottawa Mental Health Centre** **Room 1424, 1145 Carling Avenue** ***Teleconference Dial-In: 1-888-875-1833 Passcode: 926707277#***	○ Oral presentation ● Paper enclosed ●● Paper to follow ●●● Paper at meeting **IN** Information **DEC** Decision required ** Guidance required

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Time (min)	Pg.	#	ITEM	REFERENCE	RESPONSIBILITY	STATUS	
02		**1.**	**CALL TO ORDER**	- *The Royal's Ethics Framework for Decision Making (page 382)* - *Conflict of Interest Policy (page 384)* - *Public, Non-Public and Restricted Meetings (page 388)*	A. Graham	○	IN
01	10	**2.**	**AGENDA AND MINUTES**	**a. Acceptance of Agenda – September 26, 2019**	All	●	DEC
01	11			**b. Approval of Minutes – June 20, 2019**	All	●	DEC
10		**3.**	**REPORTS AND UPDATES**	**a. Chair and President & CEO's Oral Report**	A. Graham J. Bezzubetz	○	IN
10	29			**b. Volunteers at The Royal Annual Report**	L. Colas	○●	IN
05				**c. IMHR Report**	F. Dzierszinski	○	IN
10	35			**d. Strategic Plan Update**	J. Lambley	○●	IN

10				**e. Update on Foundation Campaign**	M. Bellman	○	IN
05	43			**f. Presentation on what a Research Ethics Board (REB) is and how it works**	T. Beaudoin	○●	IN
05				**g. Brockville Re-development Committee Update**	S. McLean	○	IN
10	50	**4.**	**DECISION/ INFORMATION ITEMS**	**a. Quality Committee Report** - DRAFT Minutes from February 4, 2020	L. Leikin	○●	IN
	60			i. Integrated Risk Management Framework		●	DEC
	69			ii. Corporate Patient Safety Report		●	IN
05	79 88			**b. Medical Advisory Committee Report** - Minutes from November 21, 2019 - Minutes from December 12, 2019	R. Bhatla	○●	IN
	92			i. Medical Staff Privileges		●	DEC
15	93			**c. Finance Committee Report** - DRAFT Minutes from January 30, 2020 - Interim Financial Statements (with Executive Summary)	J. Gallant *Posted on Board website only*	○●	IN
				i. Integrated Risk Management Framework		○	IN
	101			ii. Capital and Operating Budgets		●	DEC
	180			a. IMHR Budget		●	DEC
	187			iii. M-SAA and H-SAA Amending Agreements		○●	DEC
				iv. EHR Update		○	IN
				v. PET/MRI Update		○	IN
10	272			**d. Audit Committee Report** - DRAFT Minutes from January 30, 2020	J. Gallant	○●	IN
	277			i. Statutory Obligations Letter		●	IN

	280			ii. Annual Audit Plan		●	DEC
15	307			**e. Governance Committee Report** - DRAFT Minutes from January 23, 2020	C. Coulter	○●	IN
	322			i. Research Ethics Board Terms of Reference		●	DEC
	329			ii. University of Ottawa ex-officio position on Board – Dr. Nyman		●	DEC
	332			iii. Past Chair Role		●	DEC
				iv. Committee Terms of Reference			
	333			- Quality Committee		●	DEC
	338			- Innovation Committee		●	DEC
				v. Board Vacancy Update		○	IN
				vi. Board Chair Assessment		○	IN
	342			vii. 2020 - 2021 Board and Committee Meeting Schedule		●	IN
05				**f. Innovation Committee Report** - Next meeting March 3, 2020	N. Bhargava	○	IN
05				**g. Compensation & Succession Planning Report** - Next meeting April 2020	A. Graham	○	IN
01				**h. Policy**	*None*		
05			**INNOVATION SPEAKER:**	***What is happening in your work environment or in your community activities of which The Royal should be aware?***	J. MacRae	○	IN
05	343	**5.**	**CONSENT AGENDA**	**a. Approval of the Consent Agenda**	A. Graham	●	DEC
	344			i. President & CEO's Report	J. Bezzubetz	●	IN
	354			ii. Research Ethics Board Report	D. Bourget	●	IN

	358			iii. The Royal Ottawa Foundation for Mental Health Report	M. Bellman	●	IN
	370			iv. Strategic Plan Performance Scorecard	J. Lambley	●	IN
	379			v. Mental Health Addictions and Quality Initiative (Peer Comparators)	M. Webb	●	IN
	381			vi. Centre of Excellence Report	P. Smith	●	IN
01		**6.**	**NEW BUSINESS** *(if any)*				
01		**7.**	**REPORT ON THE ETHICS FRAMEWORK FOR DECISION MAKING**				
01		**8.**	**NEXT MEETING**	**March 26, 2020 at 4:30 p.m.**			
01		**9.**	**ADJOURNMENT**				DEC
		10.	**EXCLUDED SESSIONS**	**RESTRICTED** (Independent Board Members, CEO and PIC/COS)			
				IN CAMERA (Independent Board Members only)			

Joanne Bezzubetz, Secretary, ROHCG Board of Trustees **RSVP to patricia.robb@theroyal.ca**

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 29	**Priority:** Routine

DATE: February 20, 2020

COMMITTEE:

PRESENTER:

SUBJECT: Acceptance of the Agenda

BACKGROUND INFORMATION:

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT the February 20, 2020 agenda be accepted, as presented.

CARRIED

Moved by:

Seconded by:

Motion approved:

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 30	**Priority:** Routine

DATE: February 20, 2020

COMMITTEE:

PRESENTER:

SUBJECT: Approval of the Previous Minutes

BACKGROUND INFORMATION:

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT, the December 12, 2019 minutes be approved, as presented.

CARRIED

Moved by:

Seconded by:

Motion approved:

The Royal Mental Health - Care & Research Santé mentale - Soins et recherche	**MINUTES** **ROYAL OTTAWA HEALTH CARE GROUP** **BOARD OF TRUSTEES** **December 12, 2019 at 5:30 p.m.** *(4:30 for Mini-Series; 5 p.m. Indigenous themed meal (and other food items))* **Royal Ottawa Mental Health Centre** **Room 1424, 1145 Carling Avenue** ***Teleconference Dial-In: 1-888-875-1833 Passcode: 926707277#***	○ Oral presentation ● Paper enclosed ●● Paper to follow ●●● Paper at meeting **IN** Information **DEC** Decision required ** Guidance required

MEMBERS		**STAFF**		**GUESTS**
Present	**Regrets**	**Present**	**Regrets**	
A. Graham, Chair I. Levy, Vice Chair *(by phone)* C. Coulter, Vice Chair N. Bhargava J. Gallant R. Anderson S. Squire L. Leikin D. Somppi S. McLean, Past Chair *Ex-officio members:* J. Bezzubetz R. Bhatla E. Millar	L. Gillen J. MacRae J. Charette *Ex-officio member:* T. Lau	C. Crocker M. Bellman K. Monaghan F. Dzierszinski S. Gulati P. Sedge J. Lambley S. Farrell		P. Smith, President & CEO, Centre of Excellence G. O'Hara, Chair, Client Advisory Council M. Langlois, Chair, Family Advisory Council J. Desrochers, Manager Client & Family Relations J. Hayes P. Johnston, Family Council Member C. Clark, Past Chair Family Advisory Council A. Shayanpour, Client presenting **REGRETS:** G. Cudney, Chair, Foundation Board S. West, Chair, IMHR Board
				SCRIBE
				P. Robb

#	ITEM	REFERENCE	ACTION ITEMS
1.	**CALL TO ORDER**	A. Graham, Chair, called the meeting to order at 5:32 p.m. and declared it to have been regularly called and properly constituted for the transaction of business. The meeting was opened by acknowledging that the land on which we gather is the traditional and unceded territory of the Algonquin nation. Welcome remarks were provided and special guests acknowledged. A. Shayanpour, a client representative and volunteer at The Royal, was introduced and presented about his mental health journey. He wanted Trustees to think about the importance of people with lived experience to be part of the system at all levels. The one area he thought we could do better is to provide more peer support. Discussion and questions followed the presentation.	

		The Chair thanked him on behalf of the Board for sharing about this personal journey.	
2.	**AGENDA & MINUTES**	**a. Acceptance of Agenda – December 12, 2019**	
		Moved by S. Squire and seconded by C. Coulter **BE IT RESOLVED THAT** the December 12, 2019 agenda be accepted, as presented. **CARRIED**	
		b. Approval of Minutes – September 26, 2019	
		Moved by D. Somppi and seconded by L. Leikin **BE IT RESOLVED THAT** the minutes of the September 26, 2019 Board meeting be approved, as amended. **CARRIED**	
3.	**REPORTS & UPDATES**	**a. Chair and President & CEO's Oral Report – A. Graham, J. Bezzubetz**	
		The Chair's theme for the meeting was collaboration, with examples given such as the external review for IMHR and the search for a candidate to fill the Vice President position. Some of the Chair's activities were as follows: o OHA conference o Tour of wet lab with Dr. P. Blier o ICD designation short course on strategic plan oversight o Leader's breakfast, which was a success o 125th anniversary in Brockville o Interviews with Board candidates o Awards ceremony (quality and education) o Women in Mind Conference, chaired by S. Farrell The President & CEO then gave her report as follows: - On December 11, 2019 there was a full-day retreat with the new senior management team. The purpose was to talk about organizational transformation for an organization of the future, and the culture change that is required. - Strategic planning is well underway and we continue to have consultations - Concluded the external review for IMHR. It is hoped that the final report will be ready by next week. Recommendations have been tabled with the external review Committee and will be shared accordingly - Search for the IMHR Vice President is underway with the posting going up on January 2, 2020 - There was a meeting with the CEO of the new LHIN, who indicated hospitals should plan for a zero increase and organizations should adopt a global concept. The Ontario Government currently has 1,300 transfer agencies and wants to get it down to less than 100 funding arrangements for the province. Many have applied in our region and some have been invited to submit final applications - OHTs are rolling out throughout the province. There will be more than anticipated On January 16, 2020, Karen Glass, Assistant Deputy Minister of Mental Health & Addictions, is attending at The Royal and will tour	

		the Robert Smart Centre. Community partners will also be joining us to meet with her.	
		b. Foundation Campaign Update – S. Farrell, F. Dzierszinski, M. Bellman	
		The purpose of the brief overview and presentation was to seek agreement to proceed with the further development of the synergistic proposals that were put forward. This was introduced by the two briefing notes included in the meeting package. Hardcopies of the briefing notes were also circulated around the boardroom table for convenience. These proposals were informed by partners and members of the community and it was heard clearly that access is a key theme to be addressed. Once the case is further developed, one of the next steps will be to test the proposals and reach out to the philanthropic community and connect with them for support. A question was raised whether The Royal had guidelines when donors want to support research conducted on specific topics (especially pharmaceutical companies) or on how money is spent. In a future presentation, the Board would like to know how this is being dealt with. After discussion, the Board gave agreement to proceed with the development of the proposals presented. *G. O'Hara attended the meeting at 6:22 p.m.*	M. Bellman
		c. IMHR Report – F. Dzierszinski - **Research Ethics Board (REB) Matters** - **QARE Report and Work Plan**	
		There have been a number of initiatives undertaken in the Research Ethics Board portfolio in the past year to ensure both compliance and clinical research development, and in line with Quality initiatives. Overall, while several processes needed to be remodeled to meet compliance requirements, our work plan shows that risk has been mitigated, and that the review will be completed early 2020. Educational sessions for researchers, SOPs and audits are taking place. Following the report, there were questions about the ethics process and which Board is responsible and whether they have a role to play in following up on audit and open items for continuous improvement. The Board also wanted to know if tri-council guidelines are followed and if researchers are trained in the areas they need to be. In answer to some of these questions, it was noted that as in all institutions, the REB directly reports to the ROHCG Board of Trustees as the highest governance body. It does not report to the IMHR Board as part of the processes in order to ensure arms' length decision making. The Board requested an educational session on what an REB is and how it works, in order to learn more about the questions they need to be asking. The governance of the REB will be discussed at the next Governance Committee meeting. The agenda will include discussion around the	F. Dzierszinski

		appointment of the REB Chair and the revision of the terms of reference. It was noted that the REB reports will look different in the future, including metrics for clients involved in clinical research studies, and a report on the QARE (Quality Assurance for Research Excellence) program, as attached to the agenda package.	
		d. Centre of Excellence (CoE) Report – P. Smith	
		The name for the Centre of Excellence may change at some future date. There is support for the need for a Centre of Excellence and locally there is enthusiasm for the hospital without walls philosophy, but there is also interest and support across the country. The Centre is building to align with this philosophy. P. Smith has been invited to co-lead the Veterans forum in Halifax next year to bring the lens of veterans and families. There is research that specially trained workers who are family members is important. Another area the Centre is leading in is moral injury. This leads to one of the reasons why it is located at The Royal so it can leverage the strength of the Brain Imaging Centre (BIC). The Centre is excited about taking the lead in developing the scale to measure moral injury. It is the third week for the first team members at the Centre. The following staff has recently come on board and other positions are also being posted: - Vice President, Research and Policy - Vice President, Strategic Partnership and Knowledge Mobilization - National Manager of Digital Marketing and Media Production - National Manager of Operations Most of the research that is being invested in will be in collaboration with those already doing the work. The Centre is collaborating with peer organizations across Canada. In general, half of the focus will be on generating new knowledge and aggressive support of uptake.	
		e. Brockville Re-development Committee – S. McLean	
		There is an urgent need for a new FTU facility in Brockville. E. Millar is Chair of the ad hoc Committee to start a new discussion on what we can and cannot do. The point of the Committee is to investigate ways to move the agenda forward. A meeting occurred a few years ago with S. Clark, who is now an MPP and Minister. Our purpose was to encourage him to understand that this is a good project to get behind. There is great support for a new facility in Brockville. The next step will be to get approval from the Board to set up another meeting with S. Clark to identify to him the concerns we have and the urgent need. This item will be on the Board agenda at every meeting and is now on the risk register. We want to take this notion to the Minister and	

		start talking to him with renewed concept and context. The Minister needs to understand that as the landlord, the province is responsible for the conditions. The Board supported S. McLean and the ad hoc Committee to proceed. They are to come back to the next meeting to report on the meeting with S. Clark. It was noted that at some point this will need to go to the Finance Committee.	S. McLean
		f. Strategic Plan Update and Mission Vision Discussion – J. Lambley	
		The purpose of the presentation was for an update on the Strategic Plan discussions at the Board Development Days and next steps. A plan should be in place in May of next year. What has been done so far was shared. There have been some excellent sessions and good connections with varying viewpoints. Other meetings are also planned in the New Year. The Terms of Reference for the Joint Oversight Committee – Strategic Planning *(now known as the Joint Oversight/Liaison Committee)* was included in the meeting package. It was also sent to the IMHR and Foundation Boards for their review and approval. The Committee is meant to represent the Board and have representation from all three Boards so good feedback can be obtained about the work we do. It is not to discourage feedback, but in order to be efficient. Discussions and questions ensued about the role of the Committee. J. Bezzubetz and J. Lambley are to meet to look at how to effectively work with all three Boards (it is important to do that after they talk with the University). They will then come up with a schedule of when that might occur and schedule a special workshop. When the time is right, feedback will be provided to the Board. Moved by D. Somppi and seconded by C. Coulter **BE IT RESOLVED THAT** the Terms of Reference of the Joint Oversight Committee – Strategic Planning be approved, as presented. **CARRIED**	J. Lambley J. Bezzubetz
4.	**DECISION/ INFORMATION ITEMS**	**a. Quality Committee Report – L. Leikin**	
		L. Leikin highlighted some issues for consideration and feedback: - The membership of the Committee has been adjusted. The Chairs of the Family and Client Advisory Councils are now non-voting members and are seen as important and essential members of the Committee. The Terms of Reference indicating this change will be brought to the February Board meeting for final approval. - The Patient Safety Report has a new look thanks to D. Simpson and R. Bhatla. The new format reports data using control charts. The Committee will examine the limits or acceptable ranges for safety indicators as part of its monitoring. Data from similar client populations and peer	

		hospitals will be examined in order to assess tolerance levels and norms for safety indicators in examining Royal patient safety. - The 2020 Quality Improvement Plan (QIP) is in development using a new methodology. Historically, the QIP has been low on the radar for the front lines, even though it is a Ministry legislated requirement and an important marker for the Royal's performance. This iteration of the QIP will engage staff at the front line, as well as clients and family, in order to be more meaningful. Staff and client participation in the QIP marks a shift towards a greater commitment to quality framework for the hospital. Indicators that are clinically meaningful to staff and clients that are rigorous and evidence based will be examined. The post accreditation teams have been maintained and are renamed as quality teams. These teams will inform the new QIP. - Five themes reported in the Strategic Plan document will form the basis of the new QIP. Input from the Committee and the Board in an open fulsome discussion was solicited, with a strong endorsement to date. The Committee wants to ensure that the themes of the QIP are consistent with the vision of the emerging strategic plan, and that indicators are meaningful. The Integrated Risk Management Framework (IRMF) is co-owned by the Finance and Quality Committees. Work is in progress on how risks come on and off the register. At the last Committee meeting, there was discussion about the risk associated with suicide. A number of differences in perspectives were highlighted. The current framework put the risk of suicide as medium, which the Committee believed was not consistent with its impact or severity. While The Royal may prevent more suicides than occur, the nature of the client population and the risk impact is considered high. The Committee recommended adjustment of the risk impact to high. This will be reviewed in the next iteration of the IRMF.	
		b. Medical Advisory Committee (MAC) Report – R. Bhatla	
		R. Bhatla provided the following report: - There are challenges in psychiatry resources across the region - IMHR's *Emerging Research* Innovators in *Mental Health* (e-RIMh) scientists presented to MAC and it was helpful in terms of giving them an opportunity to informally report on their interests and research. It has also been important for MAC to know who they are serving on the ground. Another round is being considered in the future - The annual review process will be finished by the end of December. In the New Year the reappointment process begins - Physicians are adapting to the new EHR, but there have been some challenges - Mood & Anxiety physicians have been on-boarded nicely. There are some new recruits in the various programs - The program funded by the AFP innovation fund, which are funds from the Ministry to the physician group, will be given	

		to regional psychosis, unless something is overturned by the Ministry. This will flow into next year - At the next MAC meeting there will be a session on the QIP for feedback and suggestions. In January there will be a case for support from the Foundation	
		i. Medical Staff Privileges	

		As per the ROHCG Board By-laws (3.4.1), the Board is to make any appointment or reappointments or approve any request for a change in privileges as recommended by the Medical Advisory Committee.
		
		Moved by D. Somppi and seconded by C. Coulter
		
		BE IT RESOLVED THAT in accordance with the criteria and credentialing process outlined in the ROHCG Appointment and Re-appointment Schedules, the Medical Advisory Committee recommends to the Board of Trustees the following candidates for Medical Staff Privileges:
		
		- Dr. Shehan Katuwapitiya, Psychiatrist, from Temporary to Probationary Full-Time Privileges, Mood & Anxiety Program, effective immediately.
		- Dr. Imran Jamil, Psychiatrist, Probationary Full-Time Privileges, Integrated Forensics Program, effective immediately.
		- Dr. Marie-Helene Rivard, Psychiatrist, Probationary Full-Time Privileges, Geriatrics Program, effective immediately.
		- Dr. Chrys Ezeoke, Psychiatrist, from Probationary to Primary Full-Time Privileges, Mood & Anxiety Program, effective immediately.
		- Dr. Rishi Kapur, Psychiatrist, Courtesy On-Call Privileges, Youth Program, effective immediately.
		- Dr. Erinna Brown, Psychiatrist, Courtesy On-Call Privileges, Youth Program, effective immediately.
		- Dr. David Bakish, Psychiatrist, Locum Privileges extension to October 24, 2020, Consult Clinic, effective immediately.
		- The following TOH Radiologists, Courtesy Privileges, MRI services, effective immediately:
		  - Dr. Frank Lee
		  - Dr. Matthew Quon
		  - Dr. David Hammond
		  - Dr. Robert Ritchie
		  - Dr. Karl Smyth
		  - Dr. David MacDonald
		
		CARRIED	

		c. Finance Committee Repot – J. Gallant	
		i. Report on Consultant Contracts and Sole Source Purchases	
		The Committee received the report on consultant contracts and sole source purchases from management and noted that they were all made in accordance with policy and there were no issues.	
		ii. ROP Options	

		The ROP is a long-term facility which is licensed separately by MOHLTC. There are 71 clients on the wait list and some have been waiting for 14 years. The Finance Committee received an excellent presentation on options available for consideration, such as: 1) Designation as a specialized facility. In this scenario, we may be able to get an additional $100 per day per bed for each patient. Currently there is a deficit situation at ROP so this would remedy the problem 2) Addition of 30 new beds, but this would need infrastructure changes 3) Partner with Bruyère to develop a new facility with more beds. This would free up the current ROP so the real estate could be used for another purpose. This would be a longer term plan to make a more effective use of the complex The Committee is looking at these options with management for the longer term. For the short term, there is excitement about getting additional funding. Management is pursuing this right now with the Ministry as it can take up to a year to receive a designation. Management will be following up with Bruyère as well.	
		iii. Integrated Risk Management Framework (IRMF)	
		The IRMF is jointly owned by the Finance and Quality Committees, but both Committees can come to the Board and make changes. At their last meeting, the Finance Committee requested that reputational risk be added to the register, which has been done. More detail about financial risks will also be added to the back of the report. The Committee recommended the following motion for approval, with any additions made to the next version of the report. Moved by J. Gallant and seconded by R. Anderson **BE IT RESOLVED THAT** the Integrated Risk Management Framework be approved, as presented by the Finance and Quality Committees. **CARRIED**	
		iv. Investment Policy Changes (FRIPP Advisory Group – CIBC Wood Gundy)	
		The Royal went to market through an RFP process for investment management services. This resulted in the selection of CIBC Wood Gundy/Fripp Advisory Group as our new investment manager. As part of this process, the investment policy was updated as we are moving to a new concept of using a manager of money managers approach. In a recent meeting, options were presented by Fripp Advisory Group to better suit the new structure of investments, but the Committee was critical of it as they wanted to stay within our tolerance and what the Committee felt comfortable with. A question was raised regarding the benchmarks and it was noted that the benchmarks will be reported before and after. Moved by J. Gallant and seconded by S. Squire	

		BE IT RESOLVED THAT as recommended by the Finance Committee, the Board of Trustees approve the revised Investment Policy 140-2. **CARRIED**	
		v. Dissolution and Distribution of Proceeds for OHFA Resale of HFS	
		As part of the dissolution process, the Board of Trustees of each hospital is required to approve the resolution and authorize its nominee to execute any written resolution to that effect. To finalize this work, the motion below is to approve the resolutions of the OHFA members and nominate C. Crocker to execute payments. Moved by J. Gallant and seconded by L. Leikin **BE IT RESOLVED THAT** as recommended by the Finance Committee, the Board of Trustees approve the following: **WHEREAS:** A. The Hospital is a member of the Ottawa Hospitals Food Association (**"OHFA"**); B. The Hospital's director nominee on the board of directors of OHFA (the **"Nominee"**) is Calvin Crocker; and C. The resolutions set out in Exhibit 1 hereto are proposed to be passed by the members of OHFA (the **"OHFA Member Resolutions")**; **RESOLVED that:** 1. the Hospital, in its capacity as a member of OHFA, approves the OHFA Member Resolutions, substantially in the form attached hereto as Exhibit 1, subject only to any amendments as may be approved by the Nominee; and 2. the Nominee is hereby authorized and directed to vote on behalf of the Hospital at any meeting of members of OHFA and to execute any written resolution or other document on behalf of the Hospital in its capacity as a member of OHFA as the Nominee considers necessary or desirable to give effect the above resolution **CARRIED**	
		vi. Proposal EllisDon to sell equity in Project Co (THICC) to Fiera Infrastructure	
		External counsel has had ongoing discussions and reviews of draft contracts related to the equity purchase. Confirmation has been received from Martin St-Onge, Perley-Robertson, Hill and McDougall LLP, that they have completed their due diligence and see no increased risk in relation to the proposed assignment. The letter from Perley-Robertson was included in the meeting package. It was agreed that any delivery of documents from or on behalf of The Royal in relation to the transaction must be held in trust by the party to whom they are delivered, pending and conditional upon Ministry consent to the transaction.	

		Moved by J. Gallant and seconded by R. Anderson **BE IT RESOLVED THAT** as recommended by the Finance Committee, the Board of Trustees approve the following: **WHEREAS** Management has completed their due diligence related to the detailed contracts and consents related the assignment of several project and operations agreements (the "Project Agreements") ROHCG has with THICC, to a "New Project Co", such assignment being related to the sale of equity (90%) in THICC from Ellis Don to Fiera Infrastructure; and **WHEREAS** the Finance Committee is satisfied with the outcome of this due diligence **BE IT RESOLVED THAT** the following motions be recommended to the Board of Trustees for approval: **BE IT RESOLVED THAT** the Board of Trustees consent to the assignment of the Project Agreements from THICC to New Project Co and the execution of certain ancillary and related agreements and consents, that relate to the sale of equity in THICC (90%) from EllisDon to Fiera Infrastructure **BE IT RESOLVED THAT** the Board of Trustees authorize, subject to there being no material changes, ROHCG Management to complete the final negotiations of the various agreements, as well as any other closing documents which are part of the mechanical process of implementing the proposal assignments **BE IT RESOLVED THAT** the Board of Trustees authorize the President and CEO and the Chief Operating Officer and CFO to sign the necessary consents, contracts, ancillary and related agreements related to this transaction. **CARRIED** Financial statements were uploaded to the Board portal and were reported to be on track.	
		d. Governance Committee Report – C. Coulter	
		It was noted that if any Trustees attend board training through OHA etc., a report needs to be provided to the Governance Committee. The Committee is in the midst of interviewing candidates for the current board vacancy with five candidates identified. Results will be discussed at the January Governance meeting and will be brought to the February Board meeting with recommendations. Discussion ensued about process and the Governance Committee will take a further look at the Terms of Reference to see whether language should be included around a more formal process to report to the Board about vacancies before interviews with candidates begin. A meeting is set in January for Governance Chairs from the three Boards to meet and C. Coulter will be attending.	

		There was 100% participation in the OHA self-assessment exercise. The Governance Committee will look at the results and report back to the Board in February. There was good engagement from all Boards at the Board Development Days. Results from the survey following the retreat have been received and will also be brought to the Governance Committee meeting and reported back to the Board in February.	
		i. Committee Terms of Reference	
		- **Governance Committee Terms of Reference**	
		Trustees wanted to better understand what the Governance Committee is looking for in new board members. Discussion ensued and the current skills matrix that the Board uses was noted. The Governance Committee will be taking a further look at the Terms of Reference to see whether we should include language around a more formal process to report to the Board about vacancies before we begin interviewing candidates. This will be looked at in January and reported back to the Board at the February meeting. Moved by C. Coulter and seconded by N. Bhargava **BE IT RESOLVED THAT** the Governance Committee Terms of Reference be approved, as presented. **CARRIED**	
		ii. Committee Membership	
		N. Bhargava was asked to leave the room for this vote. *N. Bhargava departed the meeting at 8:22 p.m. Quorum was maintained.* Moved by C. Coulter and seconded by D. Somppi **BE IT RESOLVED THAT** as recommended by the Governance Committee, N. Bhargava be appointed as a member of the Compensation & Succession Planning Committee. **CARRIED** *Following the vote, N. Bhargava returned to the meeting at 8:23 p.m.*	
		iii. Extension of the Board Chair's Term	
		This item was moved to the in-camera portion of the meeting.	
		iv. Annual Board Work Plan	
		The Governance Committee took on the task of integrating all the work plans into one document. The work plan, which was included in the meeting package, was approved at the October Governance Committee meeting and is being recommended for approval. Moved by C. Coulter and seconded by S. Squire **BE IT RESOLVED THAT** as recommended by the Governance Committee, the Annual Board Work Plan be approved, as presented. **CARRIED**	
		e. Innovation Committee Report – N. Bhargava	

		N. Bhargava provided the following report: - In the governance session of the meeting, there were some dry runs for reviewing innovations: Brain Imaging Centre (BIC) and es-Ketamine. In these discussions, the goal was achieved of putting rigour on process. There was good dialogue on what the business case should include. In the case of the BIC, it was a good example of a Foundation led activity. The Committee recommended this also be looked at by the Finance Committee. We need a process and governance structure to recommend to the Board to approve innovations - There was also a dry run of the governance framework. The governance framework will be looked at later in the agenda for a motion to approve as recommended by the Innovation Committee - The definition of innovation in the Committee Terms of Reference was reviewed. Currently it is: Implementing new or better ways of doing valued things. There was a discussion whether to adjust this to be new *and* better ways, but it was agreed to leave it as is, recognizing that it is up to senior management to decide what comes to the Committee - There was a good discussion about the dashboard, which was included in the meeting package. It was the first chance to really understand how innovation is happening at The Royal. 55 ideas were submitted, with 22 coming from the Quality Committee and others from the IMHR. It will be left to management to update the dashboard to have visibility at future meetings - There was a lively ideation session about ideas that can be brought forward such as the Shark Tank initiative, which will be implemented in 2020 - The Upside Foundation was tabled as a way of reaching the tech sector. It is an initiative where entrepreneurs can donate equity to charities. The Hospital for SickKids has galvanized the tech sector to donate this way N. Bhargava has made a pro bono offer to The Royal about using NuEnergy, which is a tech company that does governance of AI and data. He disclosed to the Board that he is associated with NuEnergy. He will be providing a draft agreement for management to look at.	
		v. Governance Framework – R. Anderson	
		The governance framework document was included in the meeting package. Its purpose is to govern how the Committee works and reports back to the Board. It was noted that as we work through it, this will change and will need to come back for further modification. This was recommended for approval by the Innovation Committee. Moved by N. Bhargava and seconded by R. Anderson **BE IT RESOLVED THAT** as recommended by the Innovation Committee, the Governance Framework be approved, as presented. **CARRIED**	

		f. Compensation & Succession Planning Report – A. Graham	
		This item will be reported in the in-camera session.	
		g. Policy	
		There were no policies for review.	
	INNOVATION SPEAKER	This item was deferred to the February meeting with J. MacRae as speaker.	P. Robb
5.	**CONSENT AGENDA**	**a. Approval of the Consent Agenda – A. Graham**	
		Further to the Board Development Days, suggestions were made such as: having a timekeeper at the meetings to keep the meetings on time, minutes be sent out earlier and to move the Consent Agenda to the end of the agenda to allow time for more discussion on other important items. These have all been implemented at this meeting. Moved by D. Somppi and seconded by S. Squire **BE IT RESOLVED THAT** the Consent Agenda be approved, including any motions contained therein. **CARRIED** i. President & CEO's Report ii. Research Ethics Board Report iii. The Royal Ottawa Foundation for Mental Health Report iv. Strategic Plan Performance Scorecard v. Mental Health Addictions and Quality Initiative (Peer Comparators) vi. Accreditation Update	
6.	**NEW BUSINESS** *(if any)*	M. Bellman provided details about the raffle for the Foundation, which is an important fundraiser. Trustees were encouraged to either buy or sell tickets.	
7.	**REPORT ON THE ETHICS FRAMEWORK FOR DECISION MAKING**	L. Leikin, the meeting Ethics monitor, reported that decisions were fair, equitable and that business was conducted in a transparent manner. Decisions were fact based. Members were recused if necessary. The meeting was collaborative and met requirements and our accountability for reasonableness.	
8.	**NEXT MEETING**	The next meeting will be on February 20, 2020 at 4:30 p.m.	
9.	**ADJOURNMENT**	*I. Levy departed the meeting at 8:40 p.m. Quorum was maintained.* F. Dzierszinski was thanked for her work as interim COO, IMHR. The regular meeting adjourned at 8:46 p.m. and a Restricted and In-Camera session was then held. All guests and ex-officio members departed the meeting.	
10	**EXCLUDED SESSIONS**	1. **RESTRICTED** – Independent Board Members and CEO & COS/PIC	
		2. **IN CAMERA** – Independent Board Members only	
		A. Graham departed the meeting at 8:46 p.m. and C. Coulter assumed the Chair. Moved by C. Coulter and seconded by N. Bhargava	

		BE IT RESOLVED THAT as recommended by the Governance Committee**,** A. Graham's term as Chair be extended for an additional two years (2020-2022). **CARRIED** *Following the vote, A. Graham returned to the meeting at 8:50 p.m. and resumed the Chair.* The process document for the President & CEO and Chief of Staff/Psychiatrist-in-Chief's Performance Evaluation was reviewed. It was agreed that the document needs to return to the Governance Committee at their next meeting to discuss the following: i. Moving dates/processes back closer to the start of the fiscal year so that the Board is not left approving the objectives 2-3 months into the fiscal year; and ii. Adding language so that new objectives can be inserted mid-year if they are material. Moved by C. Coulter and seconded by D. Somppi **BE IT RESOLVED THAT** as recommended by the Governance Committee, the process for the President & CEO and Chief of Staff/Psychiatrist-in-Chief's Performance Evaluation be approved, and brought to the next Governance Committee for further review as noted above. **BE IT RESOLVED THAT** as recommended by the Governance Committee, the Compensation & Succession Planning Committee Terms of Reference be approved, as presented. **CARRIED**	Governance Committee

_____ _____

A. Graham
Acting Chair, Board of Trustees

J. Bezzubetz
Secretary, Board of Trustees

Board Meeting Action Items

Item	Individual Responsible	Status
December 12, 2019		
Strategic Plan Update ***(Standing item)***	J. Lambley	February 20, 2020
To schedule a future presentation on guidelines used for Foundation donors. *The agenda item is to be named 'Foundation Campaign planning' as per M. Bellman.*	M. Bellman	March 26, 2020
The Board requested an educational session on what an REB is and how it works, in order to learn more about the questions they need to be asking.	F. Dzierszinski	February 20, 2020
Joint Oversight/Liaison Committee: To meet to look at how to effectively work with all three Boards (it is important to do that after they talk with the University). They will then come up with a schedule of when that might occur and schedule a special workshop. When the time is right, feedback will be provided to the Board.	J. Lambley J. Bezzubetz	IN PROGRESS
S. McLean to come back to the next meeting to report on the meeting with S. Clark. It was noted that at some point this will need to go to the Finance Committee.	S. McLean	February 20, 2020
The process document for the President & CEO and Chief of Staff/Psychiatrist-in-Chief's Performance Evaluation needs to return to the Governance Committee at their next meeting on January 23, 2020 for further discussion.	Governance Committee	COMPLETED January 23, 2020 Governance Committee February 20, 2020 Board In-camera
September 26, 2019		
S. McLean requested a standing agenda item regarding the redevelopment of the Brockville site. It was agreed he could have five minutes at each meeting. ***(Standing item)***	P. Robb to add to future agendas	ONGOING ~~December 12, 2019~~ February 20, 2020
The Board was asked what they needed to carry on today's key conversations (Communications Advocacy). Following the meeting a survey will be sent to Trustees by P. Robb and all are encouraged to respond.	P. Robb K. Monaghan	COMPLETED IN PROGRESS

Item	Individual Responsible	Status
Trustees requested that some key messages be drafted on what would be helpful for them to communicate to their circles.		
To send P. Blier's two-page report to Trustees	P. Robb	COMPLETED
June 20, 2019		
Accreditation to be added to September 26, 2019 agenda	K. Lepinskie P. Robb	COMPLETED September 26, 2019
A copy of J. Charette's follow up report on off-line discussions will be sent out and is to be discussed at a future restricted meeting	P. Robb	COMPLETED
To send typo change on Harassment-Free Policy to S. Sibbit for correction	P. Robb	COMPLETED
To set up a Board meeting for a presentation by S. McLean regarding the President & CEO and Chief of Staff's performance review process.	S. McLean P. Robb	COMPLETED August 8, 2019
March 28, 2019		
To send the Skills Matrix to all Trustees to be updated as needed.	P. Robb	COMPLETED
To send an updated meeting request for the 2019 Board Development days to show the end time of 3:30 p.m. instead of 1:30 p.m.	P. Robb	COMPLETED
Once a final date and time are known for governance discussion with one of the accreditors, an updated meeting request will be sent to all Trustees.	P. Robb K. Lepinskie	COMPLETED [Meeting scheduled on October 7]
Add indigenous training to the list of required training for Trustees.	P. Robb	COMPLETED October 31, 2019 COMPLETED Add a catered meal on December 12, 2019 (include vegetarian option)
Add J. MacRae to next meeting as Innovation speaker.	P. Robb	COMPLETED ~~June 20, 2019~~ deferred ~~September 26, 2019~~ deferred ~~December 12, 2019~~ deferred

Item	Individual Responsible	Status
		February 20, 2020
To hold an education session with HIROC so Board members understand the risks.	P. Robb	COMPLETED September 26, 2019
Add to agenda a regular update on the Foundation Campaign.	P. Robb	ONGOING ~~December 12, 2019~~ February 20, 2019

Volunteers at the Royal Board of Trustees update

Feb 20, 2020

Presented by: Lindsay Colas, President

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2019/2020 President's Message

- 422 volunteers have shown a dedication to the Mental Health field
  - Contributed to 36,046 volunteer hours
  - Raised over $497,500 gross revenue

- Allocated approximately $131,300 this year across 17 program groups at the Royal
- Three new board members - Total of ten board members
  - Wide range of opinions, skills, experiences and backgrounds that encourage innovation
- Common goal of improving the comfort and care of clients within the Royal and making a difference where we can

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2019/2020 Key Metrics

Client Program Allocations

- Over $215,000 allocation requests this year
  - recurring
  - new recurring
  - one-time requests
- *Implementation of a new approach for Program Allocations

Bursary Program

- Targeted to clients, volunteers and staff in mental health
- $ 4,500 has been approved
- Announcing the awards' call for applicants along with The Royal Awards announcement this year in order to streamline organizational programs

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Key 2019/2020 in review

Christmas Tree Sales (Dec 2019)

- Gross revenue $ 51,103
- Net Profit was $ 29,000 this season

- Great Public Awareness thanks to Karen and her team who went above and beyond through social media campaign
- Community support surpassed previous years with numerous shifts being filled thanks to assistance from the Foundation

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Key 2019/2020 in review

Catering

Very successful!

- Increase in catering has mostly offset decreasing coffee shop sales which we attribute to challenges earlier in the fiscal year relating to changes in nutritional standards and sourcing of inventory

Fundraising

- New Board member solely dedicated to fundraising
  - Opportunities for discussion with the Foundation in the coming month or two

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Look ahead

- Fundraising is ROVA's main priority
  - Increased in allocation requests

- Welcome the opportunity to better collaborate with the Hospital as well as the Foundation
  - Special projects

- Open to suggestions and new ideas to broaden our reach and have a greater impact

Strategic Planning Update:
Summary and Next Steps

February 20, 2020
Prepared by the Integrated Strategic Planning Working Group

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Strategic Plan Timelines

February, 2020

Strategic Plan Planning Process

with Board feedback & approval

Completed – Summer to Oct. 2019

Stakeholder Feedback & Information gathering

January – April 2020

Finalize Vision/Mission with Board feedback end March

Engage Consultant

Analyze Feedback and Develop Strategic Directions

Additional feedback from the Boards needed with approval

Expected:

End May 2020

Build out Draft Strategic Objectives & Key Performance Indicators with input from Boards & Approval

Expected: June –September 2020

Finalize Strategic Plan with Deliverables: Engagement & Communication Plan Approval of Boards

Expected: September 2020

Strategic Plan Implementation

October 2020 – April 2023

Note timelines may change slightly with engagement of Consultant in March

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Next Steps

- Continue stakeholder consultations and result analysis
  - Formalize the schedule for meetings with the consultant

- Select the consultant with participation of Board members, and client / family representatives

- Work with SMT to define key questions and the strategic approach for recommendations to the Boards

- Finalize Vision / Mission / Values with board member input and final approval from the Boards

- Complete work plan including timelines and deliverables
  - with the selected consultants

Consultant Selection Process

Step	Timeline
12 Completed RFPs were returned by deadline	January 28, 2PM
Reviewed by cross-functional team based on: Corporate profile and experience Methodology Budget (done separately)	February 6
Three vendors short listed: Optimus SRB, MacPhie, Potential Group One hour presentations scheduled to complete selection of the consultant.	February 18 – 4 to 8 pm
Final Selection ** Selection committee has members from SMT, ROHCG, IMHR, the Foundation. A Board member from each and Client/Family representatives are also part of the group that will hear final presentations and make the decision.	February 21

Emerging Themes

Aspirations

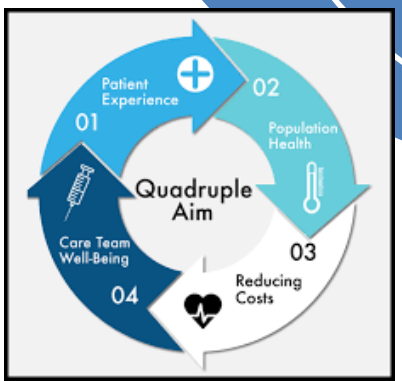
- Improve access – capacity
- Leader in Innovation
- Clinical / Research Integration
- Improved transitions
- Client Family Centred Care – every time
- One Royal
- Advocacy / Prevention
- Policy Influencer

Opportunities

- Improved access to care
- Enhanced programming (evenings and weekends)
- System navigator
- Technology
  - *(BIC)*
  - *Horizontal integration*
- Client & Family-centric care
- Research Integration
- System transformation – Ontario Health Teams

Strengths

- People
- Leader
- Royal Brand
- World Class Research
- Education
- Quality of Care Provided
- Collaboration



Government Key Concepts:
Quality, Access, Navigation

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Appendix

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Feedback Sessions

The Integrated Strategic Planning Working Group meeting with a variety of internal and external stakeholders:

Sessions to Date	
WRAP Group Client Advisory Council	Ottawa Public Health
Family Advisory Council Patient Advisory Council - Brockville	Addictions and Mental Health Network (AMHN)
IMHR Researchers Group & Individual	Psychiatric Survivors of Ottawa (PSO)
Directors of Patient Care Services Managers of PCS	Medical Advisory Committee
Town Hall – Royal & IMHR Board	Carleton University
Volunteers	STU Physicians
Quality Committee of the Board	Telfer – PhD Director
Centre of Excellence – PTSD	University of Ottawa – Faculty of Medicine, Brain & Mind Centre, plus others ongoing
SMT – Group & Small teams	Canadian Mental Health Association - Pending
CHEO / Bruyere / QCH / Waypoint Strategic Leads	177 Surveys Returned (50% staff)

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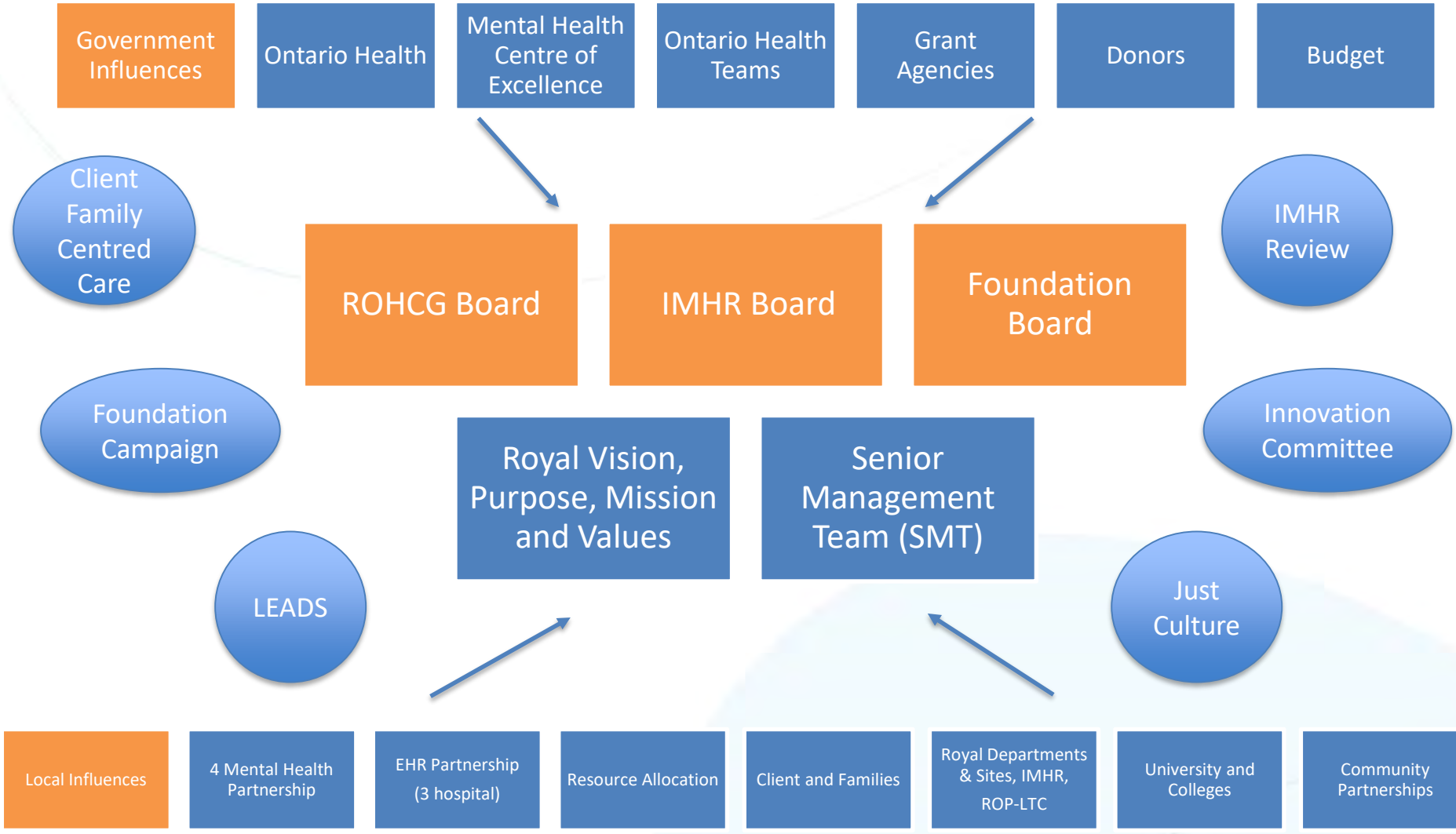
The Royal Context – Strategic Plan



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Research Ethics Boards: Authority, Mandate, Accountability & Responsibility

ROHCG Board of Trustees Meeting – February 20, 2020

Prepared & Presented by: Tammy Beaudoin, Clinical Research Support Manager

The Royal's
Institute of Mental Health Research
affiliated with the University of Ottawa

Institut de recherche en santé mentale du Royal
affilié avec l'Université d'Ottawa

What is an REB?

- An independent committee comprised of individuals possessing a variety of backgrounds and expertise who are responsible for reviewing the ***ethical acceptability*** of all research involving humans (human participants and/or substances of human origin)

Mandate and Authority

- Mandate *to review the ethical acceptability of research on behalf of the institution, including approving, rejecting, proposing modifications to or terminating any proposed or ongoing research.*
- Authority *to review the acceptability of research through its normal process of governance. An institution may not override an REB decision to reject a research proposal.*

Ethics Regulations

Canadian Institute of Health Research (CIHR)

Natural Sciences & Engineering Research Council of Canada (NSERC)

Social Sciences & Humanities Research Council of Canada (SSHRC)

TCPS2 – Three Core Guiding Principles

Respect for Persons – *understand the intrinsic value of human beings and the respect and consideration that they are due.*

Concern for Welfare – *the impact on individuals of factors such as their physical, mental & spiritual health, as well as their physical, economic and social circumstances.*

Justice – *the obligation to treat people fairly and equitably. Benefits and burdens of research must be distributed equally so that no part of the population is unduly burdened by the harms of research or denied the benefits of the knowledge generated from it.*

REB Responsibilities

Oversight of:

- New study/trial application (level of review is risk based), consent forms, participant hand-outs, compensation, etc.
- Annual review
- Study Amendments
- Safety Reports
- Adverse Event Reports

**Must adhere to TCPS2, N2 CAREB Standard Operating Procedures and ICH-GCP as well as applicable regulations (e.g. Health Canada)*

Accountability

- Regular reporting to The Board of Trustees via quarterly and annual reports
- REB Administrative Office reports to IMHR leadership and accountable to the REB Chair
- The REB is autonomous and decisions by the REB cannot be overturned by an institution or individual

Questions?

The Le Royal Mental Health - Care & Research Santé mentale - Soins et recherche	**MINUTES** **ROYAL OTTAWA HEALTH CARE GROUP** **QUALITY COMMITTEE** **February 4, 2020, at 4:30 p.m.** **Executive Boardrooms 2426-1,2&3**	○ Oral presentation ● Paper enclosed ●● Paper to follow ●●● Paper at meeting **IN** Information **DEC** Decision required ** Guidance required *** Discussion
Teleconference:	***Dial-In: 1-888-875-1833***	***Passcode: 926707277#***

MEMBERS		STAFF		GUESTS
Present	**Regrets**	**Present**	**Regrets**	
L. Leikin, Chair D. Somppi, Vice Chair J. MacRae I. Levy M. Langlois *Ex-officio members:* A. Graham, Chair of Board J. Bezzubetz, President & CEO R. Bhatla, Chief of Staff/Psychiatrist in Chief E. Millar, Chief Nursing Executive A. Khan, Vice-President Medical Staff E. Deacon, not a physician or a nurse	J. Gallant, Chair, Finance Committee G. O'Hara	C. Crocker D. Simpson S. Farrell J. Lambley		P. Sedge, Observer Presenters: B. Merkley J. Gray G. Tremblay A. McCaffrey

#	ITEM	REFERENCE	ACTION REQUIRED
1.	**CALL TO ORDER**	L. Leikin, Chair, called the meeting to order at 4:30 p.m. and declared it to have been regularly called and properly constituted for the transaction of business. The meeting was opened by acknowledging that the land on which we gather is the traditional and unceded territory of the Algonquin nation.	
2.	**WELCOME & INTRODUCTIONS**	The Chair welcomed everyone to the meeting.	
3.	**AGENDA AND PREVIOUS MINUTES**	**a) Acceptance of Agenda for February 4, 2020**	
		Moved by J. MacRae and seconded by I. Levy **BE IT RESOLVED THAT** the agenda of February 4, 2020 be accepted as presented. **CARRIED**	
		b) Approval of Previous Minutes **- Minutes of December 2, 2019**	
		Moved by I. Levy and seconded by J. MacRae	

		BE IT RESOLVED THAT the minutes of December 2, 2019 be approved as presented. **CARRIED**	
4.	**DECISION/ INFORMATION ITEMS**	**a) Corporate Patient Safety Quarterly Report – R. Bhatla** - Recommendations from Quality of Care Reviews	
		D. Simpson reported on the Corporate Patient Safety Report. A copy of the Report was included in the meeting package. She noted that a much more detailed report is sent to the programs and is continuing to be well received. The floor was opened for comments and/or questions about the report. The Committee requested follow up on the Royal suicide strategy and partnership developments in response to the suicide from the previous quarter. Dr. Bhatla will present at the next Committee meeting on the corporate suicide strategy. With respect to quality reviews following critical incidents, the review committee invites the client, the substitute decision maker, or estate trustee for an interview, and provides recommendations that come out of the reviews to clients and families. Following the specific incident from last quarter, the family was contacted, and they indicated they were satisfied with the care received in relation to the suicide. They had some suggestions for improvements at the program level, which are being addressed by the program. . The Committee remains interested in identifying patient safety trends, as well as tolerance levels for safety indicators. It was agreed that patient safety monitoring has been satisfactory, but further attention is required to develop standards and tolerance levels with indicators. Comparisons of the Royal's patient safety data with relevant population norms and other hospitals, and program specific examination of safety data, is necessary in order to fully assess Royal patient safety and to create thresholds for tolerance. This exercise will be scheduled after the Quality Improvement Plan has been completed. Moved by I. Levy and seconded by A. Graham **BE IT RESOLVED THAT** the *Corporate Patient Safety Quarterly Report* be accepted as presented and brought forward to the next Board of Trustees meeting for information. **CARRIED**	R. Bhatla D. Simpson
		b) Update on 2020-2021 Quality Improvement Plan (QIP) – L. Leikin; D. Simpson	
		D. Simpson provided an overview on this item. The committee, including client and family representation, undertook a brainstorming exercise in November to identify	

		QIP indicator priorities. Five themes were identified. Consultation with various partners and stakeholder groups in the hospital, including front-line staff and operational leaders, was undertaken to identify priority quality indicators and associated targets and behavioral measures. The 2020 QIP themes that emerged from this exercise are included in the meeting package, and were discussed as follows: <u>Specialized Individualized Transitions in Care</u> E. Deacon provided an overview of this indicator, which will use the Recovery Plan of Care tool. This is measured within the EHR where the client and care team can input readily accessible information. The client is able to contribute to their goals, along with various clinical team members who are part of the care team, and who monitor and assess goal attainment. The tool is useful as part of the transition planning, and to communication with community care partners at discharge. The client and family groups were credited with having brought this forward. The issue that this and other indicator measures were developmental process measures was discussed. The Committee recognizes that development of improved transition care planning will occur in iterations, one improvement at a time, in order take evidence-based steps toward change. E. Deacon noted that Ontario Shores and Waypoint are also incorporating the same measure in client goal attainment and transition planning in their Quality program and that efforts to share information and resources are underway in order to evaluate impact. Audits are also being performed to see how programs are using the measurement tool. It was noted that this and other Quality data is stored in the database and will be available for future analytics. The indicator identifies that a transition plan is to be completed within 28 days of discharge, which created some concern about timeliness. This timeframe represents the outer limit of acceptance. The purpose of the 28-day timeframe is to ensure that the clinical assessment protocols are being regularly reviewed and updated to reflect client progress and goal attainment in recovery. The recovery and transition tool is completed as a routine part of care with the clinician and patient and the Committee emphasized the importance of timely updates with a view that the tool gets populated as soon as the RAI is submitted. <u>Clinical Outcomes</u> This is a high priority theme and for this iteration of the QIP two indicators are under review. Medication reconciliation in out-patient clinics is a carry over indicator from previous	

		QIP's and targets have not been met to date. It is recommended that it is kept as an indicator in this QIP given its importance to achieve target levels. Clinical outcome measurement is of great interest in this QIP. The recommendation from staff was to target the number of programs who have implemented clinical outcome measurement. The Committee recommended that this indicator capture that outcome measures are clinically meaningful and evidence based and requested language to that effect. The Committee recognizes the variability with The Royal programs, that some already have sophisticated clinical outcome measurement systems, while others are in their infancy. The Committee acknowledges that each program will need to define what is appropriate for their population and that a level of rigour will be required in order to assess outcome measurement. The Committee was pleased to see this important issue incorporated into the QIP and the quality improvement process across the organization. <u>Access to Research</u> The indicator of measuring the number of programs providing access to clinical research was proposed. The Committee agreed that additional rigour is needed in the quality of research that Royal clients have access to and recommended that the clinical research indicator should be defined as research approved by the REB. The matter of assessing improved patient access to clinical research was raised. A recommendation that the indicator measure the percentage of patients (of total Royal population) instead of measuring the number of projects, makes for a more direct and meaningful examination of improved access to research for Royal patients. While examining the number of clinical research projects is of interest to the IMHR scope, the more pressing matter is improving the actual number of Royal patients able to directly access and benefit from research. The proposed indicator measures the scope of clinical to overall research, rather than the number of patients involved in research. Dr. S. Farrell was asked to re-visit this issue for clarification in order to capture the original intent of the research access issue <u>Workplace Violence</u> Workplace violence is a mandatory indicator required by Health Quality Ontario (HQO). <u>LTC</u> The recommendation is to add an indicator assessing palliative care planning and training in order to ensure excellence in care for the needs of clients at the ROP.	S. Farrell

		The Committee will hold a special teleconference meeting on March 5, 2020 to finalize the language, targets and narrative for the 2020 QIP. A progress report will also be included, which is required by HQO. The QIP will be finalized and presented to the Board at its March meeting for approval in order to satisfy the HQO April submission deadline. The team was thanked for their presentation.	D. Simpson
		c) Update on Strategic Plan Progress – J. Lambley	
		The purpose of the presentation was to update the Committee on the progress to date on the Strategic Plan. A copy of the presentation was included in the meeting package. It was noted that an update has been provided to the Foundation Board and next week will be made to the IMHR Board. The timeline has changed since the last update and has been moved to the fall. A consultant will be brought in following an RFP in the next few weeks. A common theme from family and client consultation is hope and recovery. Staff feedback has focussed around care. Next steps will be to continue consultations, analyze results and choose the consultant. A meeting is to be scheduled with the Senior Management Team around key questions and to finalize the Vision/Mission/Values and complete the work plan, which includes timing and deliverables. Implications for the Quality Committee were addressed. Once the broad themes are established, further input from the Committee will be requested. J. Lambley was thanked for the update.	
		d) Integrated Risk Management Framework (Quarterly) - J. Lambley	
		A copy of the IRMF was included in the meeting package. The Finance Committee did not review the IRMF at their last meeting, so the IRMF will go to the February Board meeting with this Committee review only. At the last Committee meeting it was noted that the IRMF process for risk inclusion, exclusion and assessment was to be brought to the Senior Management Team in January to be formalized. This was deferred as more training was needed on the portal. This item will be reported on at the next meeting. The impact for suicide was adjusted as high as recommended at the last meeting.	J. Lambley

		As the risk register continues to develop, controls along with the action plans and data alignment will develop. The access risk indicator was discussed, its current rating as medium, and whether that status created any unintended consequences. This indicator has been tied specifically to the Mood wait time, which had been high, but has now dropped down to medium. The issue of re-evaluating and broadening the parameters for defining access and its risk were discussed. Moved by J. MacRae and seconded by I. Levy **BE IT RESOLVED THAT** the *Integrated Risk Management Framework* be accepted as presented and brought forward to the next Board of Trustees meeting for approval. **CARRIED** *D. Somppi departed the meeting at 6:15 p.m. Quorum was maintained.*	
		e) Corporate Policies	
		None	
5.	**PRESENTATIONS**	**a) Integrated Forensics (Brockville) – B. Merkley; G. Tremblay; A. McCaffrey, J. Gray**	
		Introductions were made. The initiative was a team effort that was well supported by leadership. A copy of the presentation was included in the meeting package. The opportunity presented was on a functional prescription tool. A working group was set up to address a problem that comes from institutionalization. Patients can get so used to structure in the hospital that they do not gain skills to help them transition to the community and therefore require assistance to develop functional and adaptive skills. The tool developed to assist clients with improved functional living skills has been individualized for each client and developed in collaboration between client and staff. Daily and weekly tasks regarding activities, description and goals for each day of the week were identified. Clients complete the checklist to see their progress. Names of the team members involved in the client's care with their contact information was provided to promote compliance. Clients are reportedly enthusiastic about the use of the tool and want to be involved. There was some initial skepticism from nursing, but after a couple of months of implementing it, they found charting was easier and more accurate. This initiative has improved communication between the team and nursing staff.	

		The issue of moving to an electronic format was raised, but at this time the team wants to use paper in order to maintain the momentum of creating something positive and the spirit of the program. This will be considered in the future. This tool helps keep clients accountable to team members and is also a method to keep staff accountable to the client. It has inspired everyone to work for the client. There are currently 23 clients participating in the program, with the goal of having all clients on the Transition unit on a functional prescription. The challenge of the dual diagnosis client using this tool was discussed. Some challenges identified was engaging with lower functioning clients and those with a dual diagnosis. They have been able to make adaptations to the tool, but some issues still need to be worked out. Another challenge noted was continuing to get buy in from staff. In October 2019, the REB approved a formal program evaluation. The team is hoping to get 30 clients so they have a number of statistical significance. The team was thanked for their presentation. The Committee was excited to hear about the application of mental health principles in the justice population. The team were encouraged to keep doing this and in particular evaluating the impact.	
6.	**CONSENT AGENDA**	Moved by I. Levy and seconded by A. Graham **BE IT RESOLVED THAT** the Consent Agenda, including the items outlined therein, be accepted, as presented. **CARRIED** - Strategic Plan – Quality Indicators - Mental Health & Addictions Quality Initiative Comparison Scorecard - Quarterly QIP - Occupational Health & Safety Report	
7.	**ADJOURNMENT**	**Next meeting:** March 5, 2020 Special Teleconference Meeting to finalize Quality Improvement Plan. There being no further business, the meeting was adjourned at 6:17 p.m.	

L. Leikin
Chair

J. Bezzubetz
Secretary, Board of Trustees

Quality Meeting Action Items

Item #	Action Item	Individual Responsible	Status
	February 4, 2020		
1.	To present at the next Committee meeting on the corporate suicide strategy.	R. Bhatla	June 1, 2020
2.	The Committee remains interested in identifying patient safety trends, as well as tolerance levels for safety indicators. It was agreed that patient safety monitoring has been satisfactory, but further attention is required to develop standards and tolerance levels with indicators. Comparisons of the Royal's patient safety data with relevant population norms and other hospitals, and program specific examination of safety data, is necessary in order to fully assess Royal patient safety and to create thresholds for tolerance. This exercise will be scheduled after the Quality Improvement Plan has been completed.	D. Simpson	
3.	The matter of assessing improved patient access to clinical research was raised. A recommendation that the indicator measure the percentage of patients (of total Royal population) instead of measuring the number of projects, makes for a more direct and meaningful examination of improved access to research for Royal patients. While examining the number of clinical research projects is of interest to the IMHR scope, the more pressing matter is improving the actual number of Royal patients able to directly access and benefit from research. The proposed indicator measures the scope of clinical to overall research, rather than the number of patients involved in research. Dr. S. Farrell was asked to re-visit this issue for clarification in order to capture the original intent of the research access issue	S. Farrell	
4.	To revise language in QIP to review at special teleconference meeting on March 5, 2020. The QIP will be finalized and presented to the Board at its March meeting for approval in order to satisfy the HQO April submission deadline.	D. Simpson D. Simpson	March 5, 2020 Board of Trustees on March 26, 2020
5.	At the last Committee meeting it was noted that the IRMF process for risk inclusion, exclusion and assessment was to be brought to the Senior Management Team in January to be formalized. This was deferred as more training was needed on the portal. This item will be reported on at the next meeting.	J. Lambley	June 1, 2020

	December 2, 2019		
6.	Corporate Patient Safety Report - The Committee expressed interest in better understanding the Royal's role and communication pathways of shared care and inter-agency coordination with its high risk patients, and requested a briefing on any follow up with partners on this issue.	D. Simpson R. Bhatla	COMPLETED February 4, 2020
7.	Quality Improvement Plan - The Committee agreed that in order to meet the reporting and filing deadline with HQO, the QIP will need to be approved at the next meeting in early February. In order to review it before that time and to vote, it was agreed to hold a special teleconference to be scheduled in mid to late January, for final discussion. Committee members will be contacted to canvass for dates and schedule the call.	P. Robb	IN PROGRESS COMPLETED Review at February 4, 2020 meeting Special teleconference in March 2020 to approve Annual QIP
8.	The IRMF process for risk inclusion, exclusion and assessment will be brought to SMT in January to formalize. It was requested that once formalized, the process should come back to this Committee for consideration and to close the feedback loop.	J. Lambley	COMPLETED February 4, 2020
9.	The Committee agreed to the motion accepting the IRMF, with the recommendation that the impact for suicide be adjusted as high.	J. Lambley	COMPLETED February 4, 2020 The recommended change will be made in the next iteration of the report
10.	The importance of moving the organization's suicide strategy will be put on the next meeting agenda as a presentation.	L. Leikin R. Bhatla P. Robb	June 1, 2020
	November 4, 2019		
11.	The Quality Committee Terms of Reference will be sent back to the Governance Committee to bring to the Board of Trustees in February for final approval.	P. Robb	COMPLETED January 23, 2020 Governance Committee February 20, 2020 Board of Trustees meeting
12.	The full comments by Committee members on the generative discussions on the QIP were captured by K. Lepinskie and will be provided to D. Simpson and her team, who will translate them into themes and determine how they can be measured. There will be a report back to the Committee on the progress of this process at the December Committee meeting by D. Simpson and a verbal report to the Board as part of the Quality Committee report.	K. Lepinskie D. Simpson P. Robb	COMPLETED December 2, 2019 Quality Committee meeting COMPLETED December 12, 2019 Board of Trustees meeting

	September 9, 2019		
13.	To add item on Assessing Individual Board Member Performance to the Governance Committee agenda	P. Robb	COMPLETED
14.	Questions relating to the Quality Committee Terms of Reference will be added to the next Governance Committee agenda	P. Robb	COMPLETED
15.	To bring the matter of the IRMF at both the Quality and Finance Committees to the Governance Committee for clarification	P. Robb	COMPLETED
16.	To put forward a proposal about increased meeting frequency for review by members	L. Leikin	COMPLETED

H CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 31	**Priority:** Important

DATE: February 20, 2020

COMMITTEE: Quality Committee

PRESENTER: L. Lewis, Chair, Quality Committee

SUBJECT: Integrated Risk Management Framework

BACKGROUND INFORMATION:

Historically, the Integrated Risk Management Framework was about financial risk, but in the last few years the Quality Committee has reviewed it as well. The Finance and Quality Committees are empowered to recommend changes to this document and to ensure it makes it to the Board at the earliest opportunity.

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT as recommended by the Quality Committee, the *Integrated Risk Management Framework* be approved, as presented.

CARRIED

Moved by:

Seconded by:

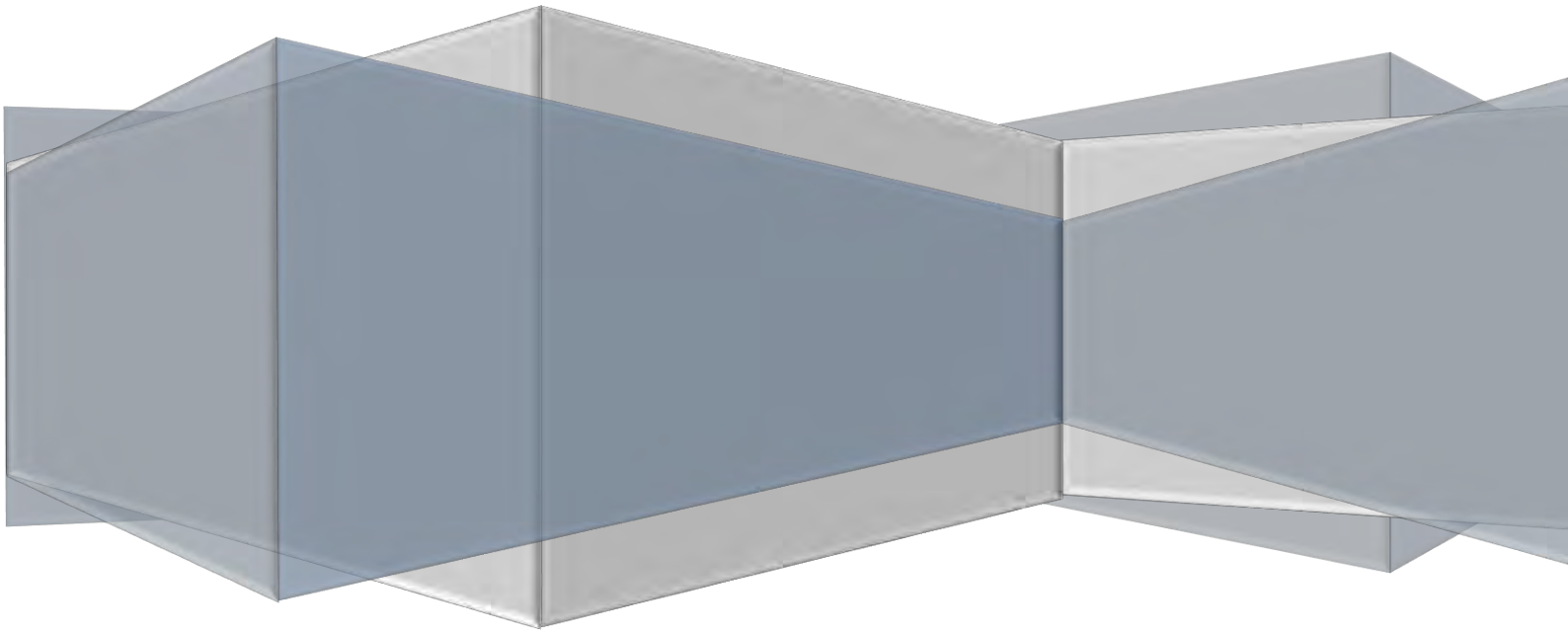
The Le Royal

Mental Health - Care & Research
Santé mentale - Soins et recherche

Integrated Risk Management (IRM) Framework

Royal Ottawa Health Care Group – January 2020 Update

Jim Lambley, Director, Strategic Planning



Executive Summary – Integrated Risk Management Framework (IRMF)

The IRMF is a “living document” and represents continual reflection leading to updates and action plans for high risk items.

In this quarterly review the document has been further refined using the online version through the HIROC portal. Senior management staff and their delegates are able to view risks and associated action plans through summary reports. All senior leads and their delegates now have access to the HIROC portal. For each very high or high risk there is an associated action plan that is updated quarterly by the lead.

There are six risks in the very high or high category, with the addition of the Suicide prevention risk.

Next Steps:

1. Review with Finance Committee of the Board
2. Review with Quality Committee of the Board
3. Bring forward to the Board of Trustees at the discretion of the Finance and Quality Committees of the Board, with risk mitigation strategies for high risk items.
4. Executive leads to engage stakeholders and continue risk mitigation action plans.
5. Continue to align the IRMF to the quality improvement plan, strategic plan document and other important metrics through the portal.

Appendix 1: HIROC Risk Sample Risk Assessment Scale

Potential Impact Scale

Dimension	Very Low	Low	Medium	High	Very High
Physical/ psychological harm	• Minimal harm, no/minimal intervention or treatment • No time off work	• Minor harm or illness, minor intervention • Time off work for <3 days • Increase in LOS by 1-3 days	• Moderate harm, professional intervention • Time off work for 4-14 days • Increase in LOS by 4-15 days • Small number of patients	• Major harm leading to long-term incapacity disability • Time off work for >14 days • Increase in LOS by >15 days • Mismanagement of patient care with long-term effects	• Incident may lead to death • Multiple permanent instances of harm, irreversible health effects • Large number of patients
Disengaged staff/ physicians	• Low level of internal grievances	• Grievances occurring but not in large numbers	• Grievances show an increasing pattern • Low staff morale	• Grievances are increasing and more pervasive • Very low staff morale	• Grievances preoccupy the organization, arbitration and external review • Loss of several key staff
Financial loss	• Small loss	• 1% of budget	• 1-2% of budget	• 2-5% of budget	• >5% of budget
Reputation with stakeholders (including: community, donor, media, gov't, public, partners)	• Rumours • Potential stakeholder concern	• Local media coverage (short term) • Elements of stakeholder expectation not being met	• Local media coverage (sustained) • Short-term reduction in stakeholder confidence	• National media coverage (short-term) • Potential for political involvement • Longer-term reduction in stakeholder confidence	• National media coverage (sustained) • Political intervention • Sr. leader termination • Long-term reduction in stakeholder confidence
Service/ business interruption	• Interruption of >1 hour	• Interruption of >8 hours	• Interruption of >1 day	• Interruption of >1 week	• Permanent loss of service or facility
Compliance	• Minor non-compliance statutory duty	• Single failure to meet external standards or follow protocol • Recommendations to comply with external agency	• Repeated failures to meet external standards • Orders issued, report required by external agency	• Multiple statutory breeches /non-compliance with external standards • Prolonged inspection, significant findings • Prosecution initiated for non-compliance	• Gross failure to meet standards • Maximum fines • Criminal code violation • Impact on affiliation agreements
Business objectives/ projects	• Insignificant schedule delay	• Minor schedule delay • Small number of objectives not met	• Moderate schedule delay • Some objectives not met	• Significant schedule delay • Key objectives not met	• Initiative not implemented • Key objectives not met

Likelihood Scale

Category	Very low	Low	Medium	High	Very high
Broad descriptors	• Will probably never occur/recur	• Do not expect it to happen/recur but it is possible	• Might happen or recur occasionally	• Will probably happen/recur	• Will undoubtedly happen/recur, possibly frequently
Time-frame	• Not expected to occur for years	• Expected to occur at least annually	• Expected to occur at least monthly	• Expected to occur at least weekly	• Expect to occur at least daily
Probability	• <0.1%	• 0.1-1%	• 1-10%	• 10-50%	• >50%

Adapted from NPSA, 2008

Appendix 2: Integrated Risk Management Document (Very High and High)

REF #	Risk category	Risk name	Senior Lead	Lead	Committee	Key strategy	Impact (current)	Likelihood (current)	Risk level (current)
2019-6	Financial	Funding Shortfall	Crocker, Cal	Kealey, Kim		Resources: Support Best Practices in Sustainability and Efficiency	High	Very High	Very High
2019-17	Care	Adverse events including Suicide	Bhatla, Dr. Raj	Gulati, Sanjiv	BOT (Board Of Trustees)	Care: Demonstrate Positive Outcomes and Experiences	High	Very High	Very High
2019-18	Facilities	Infrastructure at the Brockville campus	Crocker, Cal	Millar, Esther	BOT (Board Of Trustees)	Care: Ensure a Safe Care Environment	High	High	High
2019-13	Information Management/Technology	Privacy and cyber-security	Crocker, Cal	Webb, Melissa		Resources: Leverage Technology for Best Outcomes	High	Medium	High
2019-15	Leadership	Requirement for Innovation	Bhatla, Dr. Raj	Bhatla, Dr. Raj	BOT (Board Of Trustees)	Discovery: Integrate Clinical Care and Research	Medium	High	High
2019-4	Human Resources	Occupational health, staff injury	Crocker, Cal	Addo, Nicholas	BOT (Board Of Trustees)	Care: Ensure a Safe Care Environment	Medium	High	High

Appendix 3: Action Plans

REF #	Risk name	Description	Senior Lead	Key strategy	Controls in place	Risk level (current)
2019-17	Adverse events including Suicide	Deaths by suicide continue to occur in both in-patient and out-patient clientele, despite our best clinical efforts. The clients we treat at The Royal experience medical co-morbidities that may put the clients at risk	Bhatla, Dr. Raj	Care: Demonstrate Positive Outcomes and Experiences	Review audit of deaths by suicide of patient's of the Royal. Attempt to obtain comparable data from similar organizations. Review suicide strategy/processes at QCB. Obtain feedback regarding Royal's role in community suicide prevention as well as prevention for patient's of the Royal	Very High
2019-6	Funding Shortfall	There are funding pressures created by: i. No confirmed global funding announcement to date but direction to assume 0% increase ii. Loss of drug rebate representing $1.5M/year iii. Inflation pressures at 2%	Crocker, Cal	Resources: Support Best Practices in Sustainability and Efficiency	i. Board approved balanced budget for fiscal 2019/20 and we are projecting there will be a small surplus at year-end as required to cover capital loans. ii. Draft balanced budget for 2020/21 to be presented to the Finance Committee on January 30, 2020, based on a 0% global increase iii. Additional revenue sources under review iv. Ensure we maintain benchmark of 70/30 re: Clinical to admin, as set out in the 2016 Auditor General report v. 3 year budget projection completed for 2021/22 – 2023/24 vi. All major contract expenditures publicly tendered vii. Member of HealthPro, a National group purchasing organization allowing us to take advantage of national purchasing power volume discounts viii. Ongoing review of staffing & operational efficiencies	Very High

REF #	Risk name	Description	Senior Lead	Key strategy	Controls in place	Risk level (current)
2019-18	Infrastructure at the Brockville campus	Current FTU building inappropriate for providing leading patient care services. Units are institutional and lack of space for programming activities/personal. The current building was retrofitted in 2000 but for correctional use.	Crocker, Cal	Care: Ensure a Safe Care Environment	1. Brockville redevelopment Task Group set-up with membership including: Scott McLean, Past Chair Board ROHCG, Ester Millar, VP Professional Practice & CNE, Cal Crocker, COO & CFO, - Presented at December Board meeting and support to move forward with a discussion with Minister Clarke on new build	High
2019-4	Occupational health, staff injury	Hospitals must take “every precaution reasonable in the circumstances” for the protection of staff from violence. Efforts must be ongoing to ensure minimal violence/disruptive behaviour to prevent staff injury and negative impact on patient care. Without this, we may be subject to litigation, Ontario Labour Relations Board (OLRB) reviews, labour challenges and increased reputational risk.	Crocker, Cal	Care: Ensure a Safe Care Environment	Ongoing initiatives such as • Unit risk assessments • Mandatory training re: NCI and sharps • Orientation for new staff • Ongoing training on emergency codes • Workplace Violence Prevention Committee reviewing incident and recommending change(s) • New electronic reporting system (Datix) • Personal safety devices • Joint Health and Safety committee at ROMHC, BMHC, ROP and Carlingwood • Union and management members work together to review safety incidents on a monthly basis and recommend a process for all incidents and other suggestions they deem important • Violence in the Workplace Committee with management and union membership	High

REF #	Risk name	Description	Senior Lead	Key strategy	Controls in place	Risk level (current)
2019-13	Privacy and cyber-security	Negative consequences arising from a breach in privacy can be far-reaching and include lawsuits, reputational damage, and cyber-attacks.	Crocker, Cal	Resources: Leverage Technology for Best Outcomes	Organization: i. Added encryption on all portable devices within the organization (Completed) ii. Implementation of 2 factor authentication iii. Secure remote desktop solution for all users who will have access to the EHR (Meditech software located at Waypoint data centre) – (June2019 EHR) Partnership: i. Ensure compliance with eHealth security standards as we are using their networks for electronic traffic flow ii. Implementation of SIM (Security Information and Event Management) This software looks at patterns of data for potential threats that have not been picked up by our standard anti-virus or intrusion detection software iii. Patient Privacy Monitory System (Iatrics) This privacy software allows us to audit the EHR data access by users to ensure appropriate authorization iv. Cyber Security Assessment External consultants review covering the three partners going to market in February 2020.	High
2019-15	Requirement for Innovation	Without a sustainable infrastructure to integrate research and clinical practice, The Royal may miss the opportunity to implement newly emerging technologies and treatment approaches in our care. This may impact recruitment and retention in clinical and research areas. May leave The Royal lagging behind our peers/competitors making the organization vulnerable	Bhatla, Dr. Raj	Discovery: Integrate Clinical Care and Research	Consider research infrastructure in flagship Programs Inventory current state at The Royal and consider the role of program evaluation Focus on funding sustainability for IMHR and clinical uptake of emerging best practice	High

Appendix 4: Integrated Risk Management Document (Medium and Low)

2019-19	External Relations	Reputation Risk	Bezzubetz, Joanne	Crocker, Cal	BOT (Board Of Trustees)	Partnerships: Advocate with Partners for System Improvement	Medium	Medium	Medium
2019-2	Care	Patient Flow	Bezzubetz, Joanne	Bhatla, Dr. Raj	QCB (Quality Committee of the Board)	Partnerships: Improve Flow Throughout the System	High	Low	Medium
2019-5	Human Resources	Staff and Physician Engagement	Crocker, Cal	Gulati, Sanjiv	BOT (Board Of Trustees)	Engagement: Engage Our Staff in the Success of Our Strategic Plan	Low	Medium	Medium
2019-7	Leadership	Evolving to a Just Culture & Learning Culture	Bezzubetz, Joanne	Bhatla, Dr. Raj	QCB (Quality Committee of the Board)	Engagement: Ensure a Safe and Positive Work Environment	Medium	Medium	Medium
2019-10	Leadership	Alignment of strategic plan objectives of The Royal, Foundation and IMHR	Bezzubetz, Joanne	Dzierszinski, Florence	BOT (Board Of Trustees)	Resources: Support Best Practices in Sustainability and Efficiency	Medium	Low	Medium
2019-11	External Relations	Strategic Partnerships	Bezzubetz, Joanne	Monaghan, Karen	BOT (Board Of Trustees)	Partnerships: Advocate with Partners for System Improvement	Medium	Medium	Medium
2019-12	Information Management/Technology	Clinical Transformation	Crocker, Cal	Millar, Esther	BOT (Board Of Trustees)	Resources: Leverage Technology for Best Outcomes	High	Low	Medium
2019-3	Human Resources	Overpayment of salary/benefits	Crocker, Cal	Lashley, Rosanna	BOT (Board Of Trustees)	Engagement: Ensure a Safe and Positive Work Environment	Very Low	Low	Low
2019-16	Human Resources	Physician Recruitment & Retention	Bhatla, Dr. Raj	Gulati, Sanjiv	BOT (Board Of Trustees)	Resources: Support Best Practices in Sustainability and Efficiency	High	Very low	Low

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Mental Health - Care & Research
Santé mentale - Soins et recherche

Corporate Patient Safety Quarterly Report

Period: October 1 – December 31, 2019 (Q3)

Prepared By:
Luba Shumsky, Manager, Patient Safety & Clinical Risk Management
Royal Ottawa Health Care Group
January 14, 2020

Executive Summary

This *Quarterly Report* summarizes the incidents reported through the Client Staff Incident and Feedback (CSIF) system. In a culture of safety, everyone is encouraged to report patient safety incidents in order to identify patterns or trends, learn from the incident and make improvements. This report displays the incident data reported across The Royal in the third quarter of this fiscal year in control charts with upper and lower control limits. *Control Chart Tip Sheet* is provided on the next page as a reference on interpreting the data. The control charts allow The Royal to know when changes in the data are normal or expected, or unique and something to investigate further (special cause variation). Special cause variation is depicted in orange data points to help make it easier for the reader to see it.

Timeline:
October 1 to December 31, 2019.

General

- 591 patient incidents were reported; this is an increase of 33 incidents from the previous quarter.
- Overall incidents remained stable with no special cause variation.
- 77% of all reported incidents came from three main categories (as per the last 3 fiscal years): *Threats/Assault/Aggression, Patient Accident,* and *Medication*.
- Although the quarterly corporate report focuses on the top three incident categories plus Self-Harm, The Royal is tracking incidents in all categories (this includes Absconding/Missing Patient, Smoking & Substance Use, Exploitation, Privacy, Food & Nutrition, and Miscellaneous). Should any of these categories begin to experience special cause variation, they will be included in the report.
- 90% of *Patient Accident* incidents in this quarter were as a result of a fall.
- In 93% of all fall-related incidents in this quarter, the patient sustained no or mild injury.
- Two patients while on the Geriatric in-patient unit sustained a hip fracture after a fall; one patient was treated surgically while the other was treated conservatively (without surgical intervention)

Critical Incidents including deaths

- There was one out-patient death by suicide this quarter. A corporate-level quality of care review was held; no system or process issues were identified. Broader care review improvements, not related to the incident, will be addressed at the program level.
- There were seven other reported deaths in Q3, all of apparent natural causes. Each death was reviewed by the Quality of Care Committee.

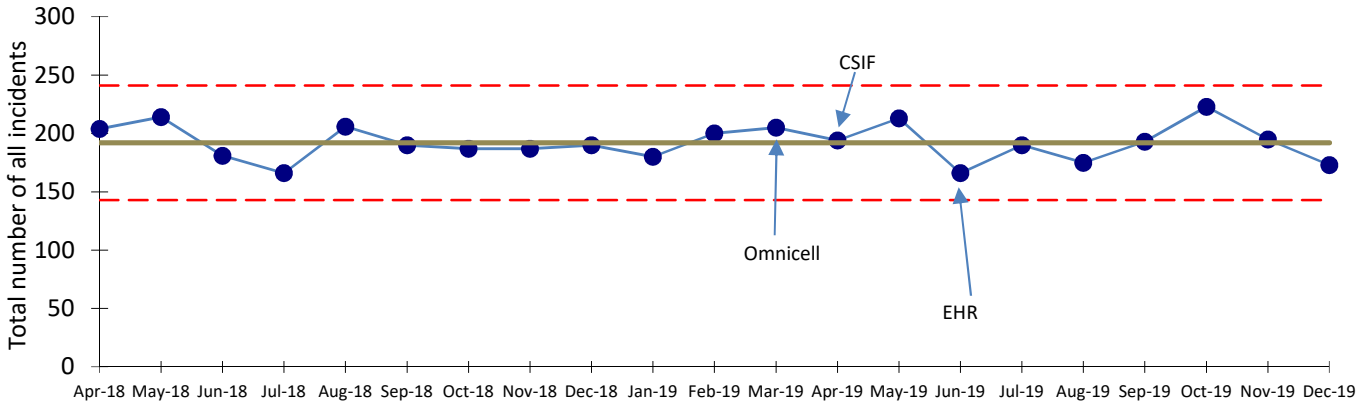
Quality Improvement

- Four patient safety leadership walkabouts took place in Q3. The issues are recorded and managed by the unit's leadership. The issues raised typically support other work being done across The Royal to improve patient safety and quality.

Key Corporate Patient Safety Metrics

Total number of incidents at The Royal have remained stable since April 2018.

Data source: Total number of incidents (April 2018-Present)

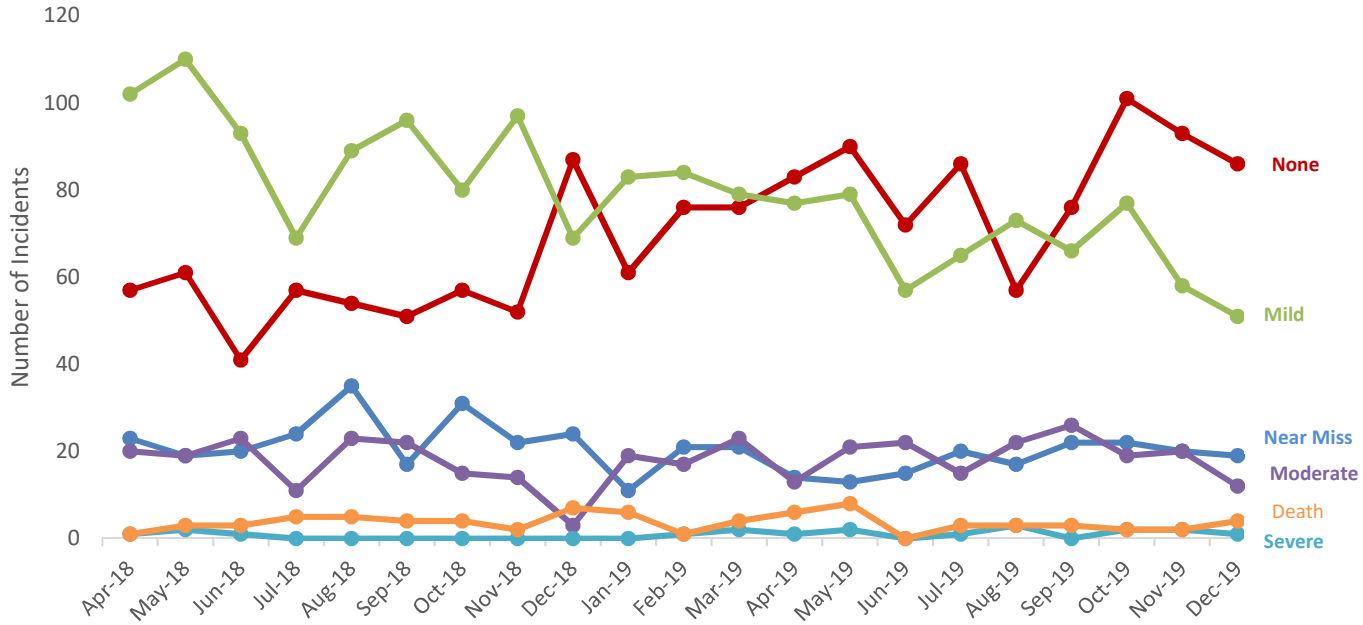


The mean number of incidents per month is 192. The three new systems - Omnicell (medication dispensing system), CSIF (Client Staff Incident and Feedback system), and EHR (Electronic Health Record) – that were implemented in the spring of 2019 are annotated on the graph to assess for impact on patient safety.

Special cause variation: None

The majority of incidents have consistently resulted in no or mild injury.

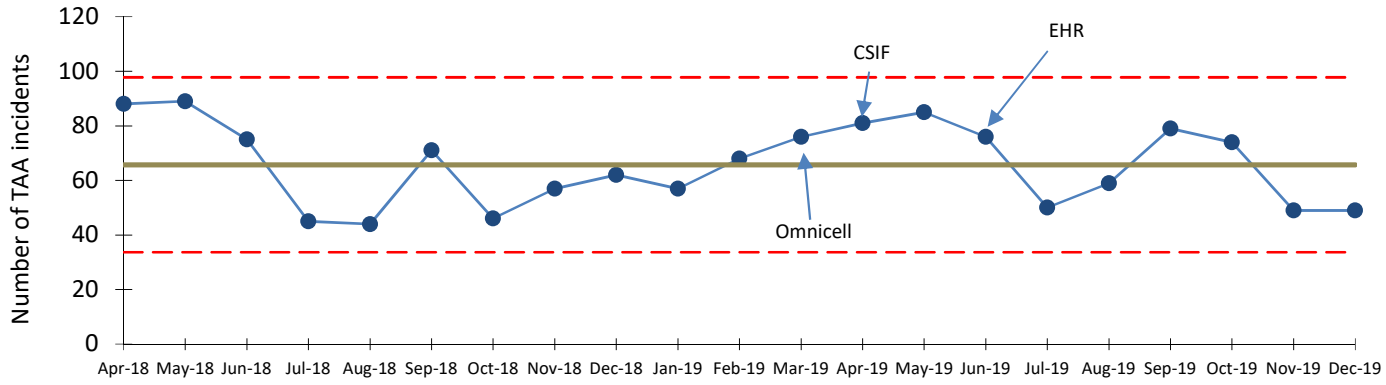
Date source: Level of severity (April 2018-Present)



Threats/Assault/Aggression (TAA)

The number of Threats/Assault/Aggression (TAA) incidents remains stable.

Data source: Total number of TAA incidents (April 2018-Present)



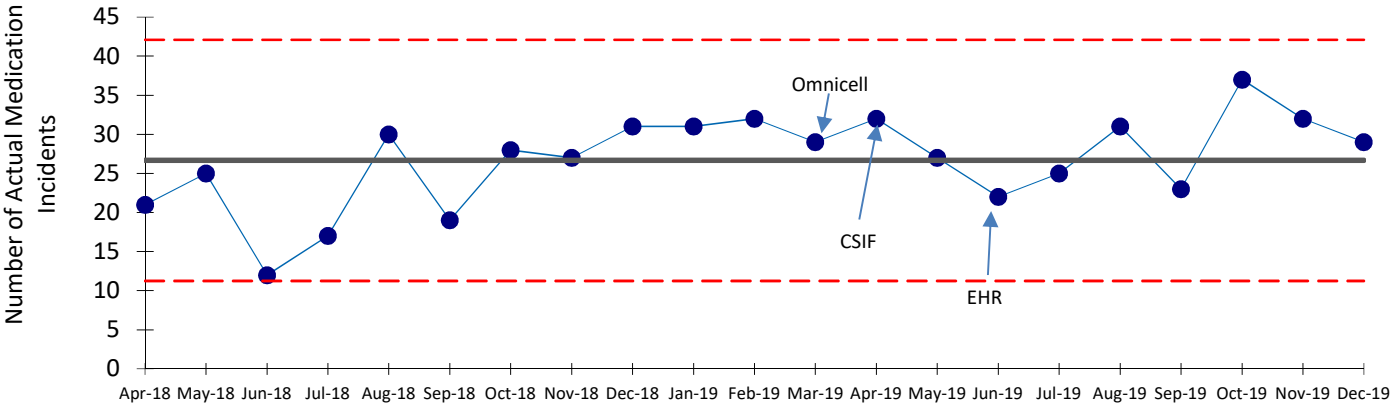
The mean or average number of TAA incidents per month is 65.71. In this quarter, seventy-eight percent of incidents involved a physical altercation between patients and/or patient-to-staff; in 87% of TAA incidents, there was no or mild harm.

Special cause variation: None

Medication

Medication incidents that reached the patient (actual) remain stable this quarter and continue to show common cause variation.

Data source: Total number of Medication incidents (April 2018-Present)

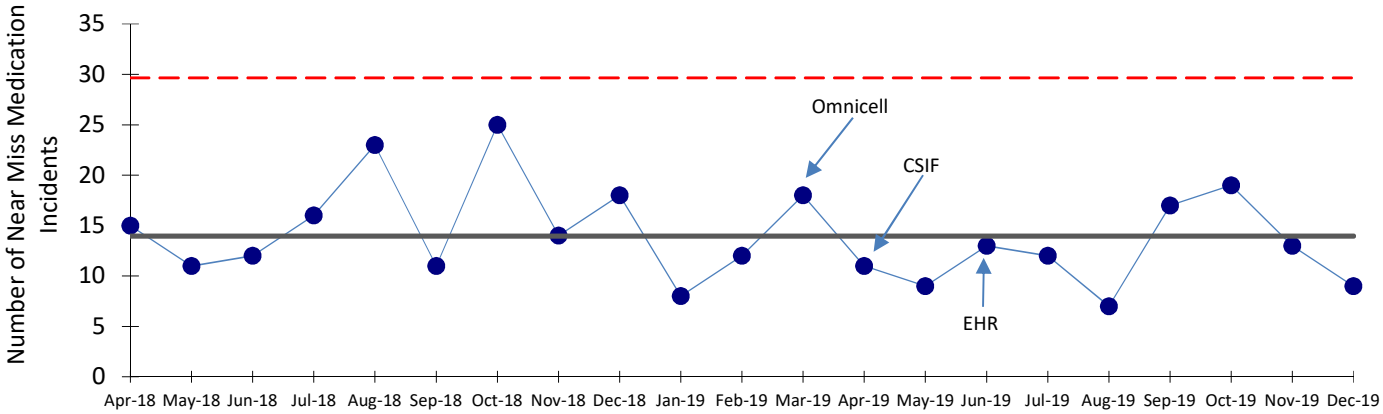


The mean or average number of medication incidents that reached the patient is 26.66 per month.

Special cause variation: None

Near Miss Medication incidents have remained stable since April 2018 with a mean or average of 13.95 incidents per month.

Data source: Total number of Medication Incidents (April 2018-Present)

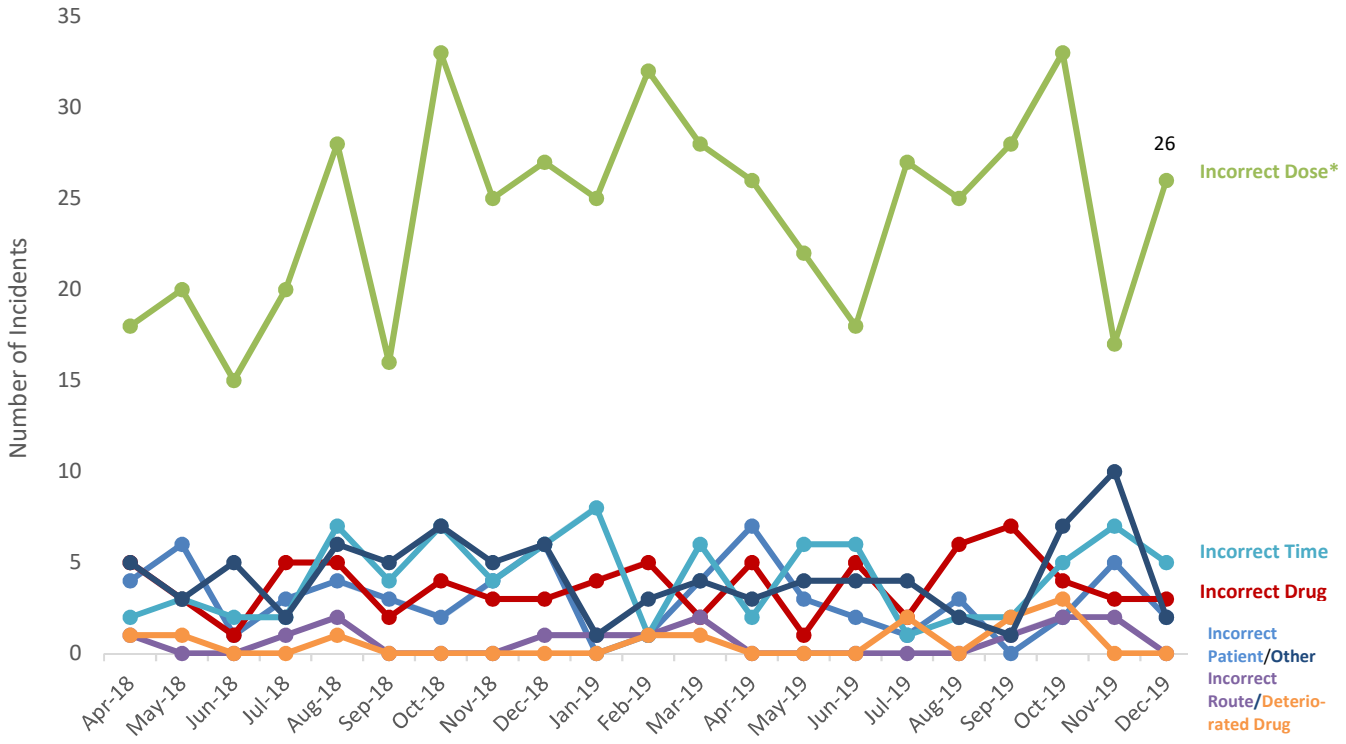


The Royal continues to encourage the reporting of all near miss events, as they provide a rich opportunity to learn how we can prevent future safety incidents from occurring.

Special cause variation: None

Incorrect Dose incidents have consistently been the most frequently occurring type of medication incident since April 2018.

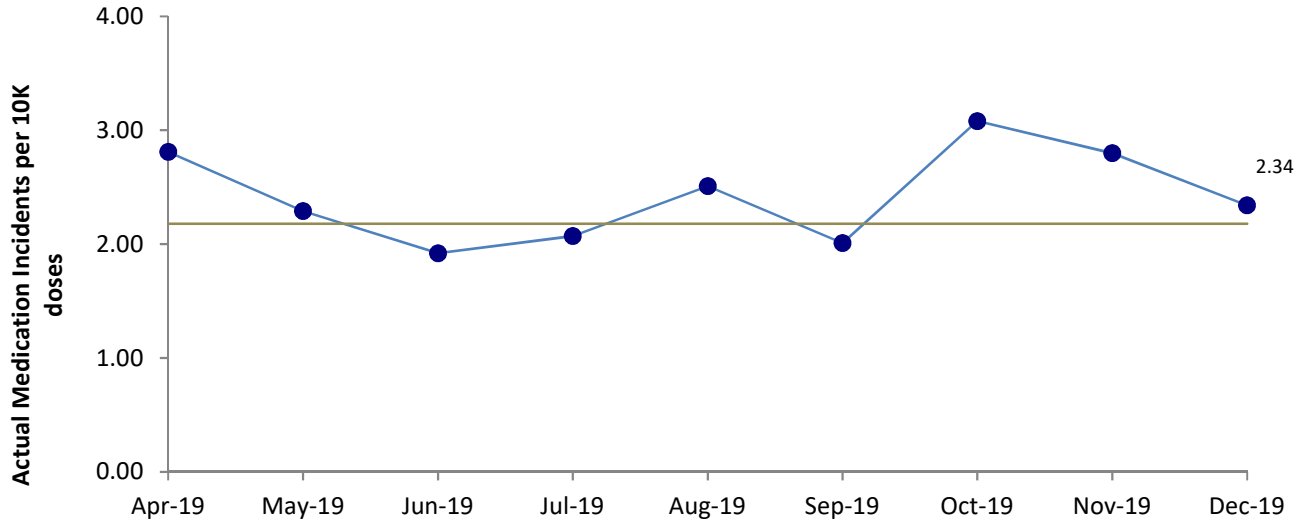
Data Source: Type of medication incident (April 2018-Present)



*Incorrect Dose incidents includes dose omission, extra dose, incorrect dosage form, incorrect frequency and incorrect duration.

Mean or average number of actual Medication incidents, when calculated by 10,000 administered doses, is 2.18 per month.

Data Source: Doses administered from the Omnicell (April 2019-Present)

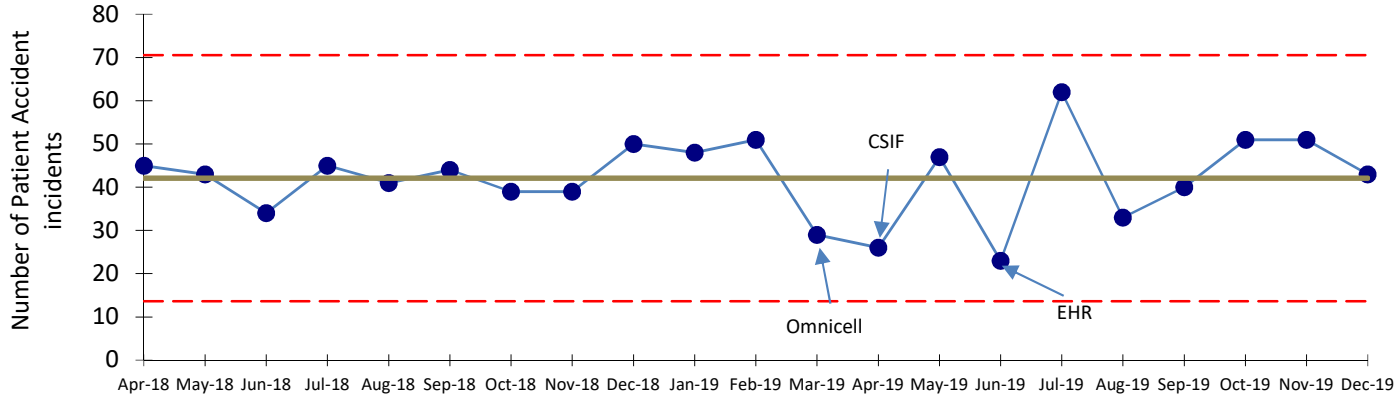


With the implementation of the new medication dispensing unit (Omnicell) mid- March 2019, actual Medication incidents (that reached the patient) can only be calculated by 10,000 doses administered since April 2019. As the data points increase, this graph will be converted to a control chart which will depict any special cause variation.

Patient Accidents

Patient Accident incidents continue to show common cause variability with a mean number of 42 incidents per month.

Data Source: Total number of Incidents (April 2018-Present)

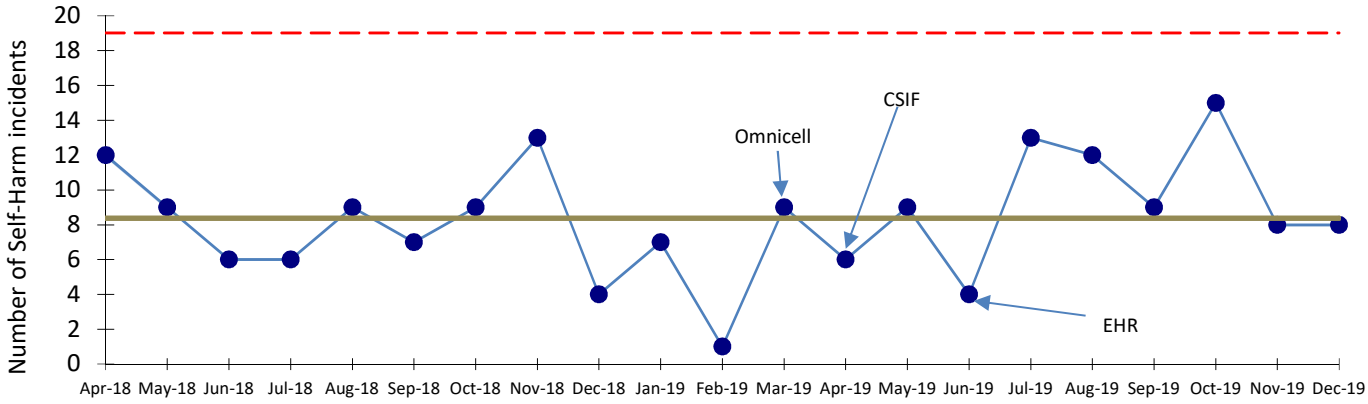


Special cause variation: None

Self-Harm

The number of Self-Harm incidents continue to show common cause variation.

Data Source: Total number of incidents (April 2018-Present)



Special cause variation: None

Critical Incidents

There were eight deaths this quarter, one of which was by suicide in the Schizophrenia Out-Patient program.

Table 1: Deaths

Program	Cause	Response
Integrated Forensics Out-Patient (Brockville)	1. Unknown (autopsy is pending)	Reviewed at Quality of Care Committee. Program-level quality of care review was conducted. No system/process issues were identified. The client was aware of how to seek out support and assistance if so required. He was additionally seen by FTU FITT staff 2-3 times per month and daily by the group home staff.
Integrated Forensics Out-Patient (Ottawa)	2. Medical 3. Medical	Reviewed at Quality of Care Committee. Program-level quality of care reviews were conducted. No system/process issues were identified.
Geriatrics (In-Patient/Outreach)	4. Palliative 5. Palliative	Reviewed at Quality of Care Committee. Program-level quality of care reviews were conducted. No system/process issues were identified; however, recommendations specific to improving the management of palliative patients are being managed locally.
Schizophrenia Out-Patient	6. Unknown 7. Cardiac-related 8. Suicide (overdose)	Reviewed at Quality of Care Committee. Program-level quality of care reviews were conducted for two of the deaths. A corporate-level review was held related to the death by suicide; no system/process issues were identified. Broader care review improvements, not related to the incident, will be addressed at the program level.

Table 2: Q3 – Corporate-level Quality of Care Review Recommendations and Status

#	Program	Incident Summary	Recommendation(s)	Implementation Timeline	Status
1	Youth OP	16yo died by suicide	**Service animals:** Obtain more information around the different legalities regarding service animals (therapy vs service vs Canadian National Institute for the Blind (CNIB) dogs) • Legal aspects around public access, particularly in a school • Educational aspects about the therapeutic benefits of a service animal Revise the current policy, as appropriate, around service animals to ensure it supports patient-centred treatment and decision-making	October 31, 2019	Complete
			Examine and/or develop a mechanism to collaborate more effectively with our partners (CHEO, Youth Service Bureau (YSB), etc) when a patient with high risk factors is in crisis and in shared-care.	December 31, 2019	In progress
			Share the recommendations from The Royal's quality of care review, with CHEO.	October 31, 2019	Complete
			Key considerations at team discussions related to patient flow and triage should be documented, as appropriate,	At the next appropriate CD/DPCS meetings	In progress
2	Recovery	Voluntary patient on approved leave, absconded	Establish a formalized process to undertake a case review for patients/clients who have been in the care of The Royal for extended periods and/or have been identified as having a treatment resistant illness. This may involve a range of specified time points and should progress from program level to external review as necessary. The primary goal of a periodic review would be to provide assistance/support to the treating team. Secondary goals would include: • Assist with prospective problem solving • Ensure that clinical care is resourced/maximized Manage patient and family expectations and ensure appropriate feedback and support to families	December 31, 2019	In progress

#	Program	Incident Summary	Recommendation(s)	Implementation Timeline	Status
			Conduct a full debrief of the incident with night and evening staff	November 30, 2019	Complete
3	Mood & Anxiety	Apparent suicide attempt by overdose while on approved leave of absence	Clarify the method with which the After Hours Manager, Physician on call, and Admin on call are notified and available to support staff following a critical incident	January 31, 2020	Not due
			Clarify the health information custodian and who can share health information between hospitals	January 31, 2020	Not due
			Clarify the role of Central Intake in the flow of information between hospitals	January 31, 2020	Not due
			Provide education to staff on the process of updating family contact information in the client's health record	January 31, 2020	Not due
			Ensure all programs make staff aware of all the debriefing and support options available to them following a critical incident	January 31, 2020	Not due
			Share the recommendations from the review with the client	December 23, 2019	Complete
4	Mood & Anxiety	Patient diagnosed with Neuroleptic Malignant syndrome (NMS)	Review and amend the process in the EHR whereby a second or subsequent order (for lab work, ECT, etc.) cancels out both/all orders for that intervention.		Not due
			Define the timeframe in which the physical assessment of a newly admitted patient must occur, with consideration to medical acuity.		Not due
			Review the process by which a medical consult is submitted in EHR, with the goal of permitting a medical physician or nurse practitioner to become aware of the consult and subsequently complete the physical assessment as early as possible, with consideration to medical acuity.		Not due
			Share the recommendations from the review with the client/family/SDM		Not due

Appendix 1 Definitions: Levels of Severity

Type	Definition
Near Miss	An incident that has potential for harm but is intercepted prior to reaching the patient
None	Incident reached the patient but patient is not harmed; no symptoms are detected and no treatment is required
Mild	Minimal symptoms/harm; no or minimal intervention is required i.e. basic first aid, increased level of observation
Moderate	Patient is symptomatic resulting in minor permanent, long-term harm or loss of function. Police/EMS/Cell Extraction Team intervention required and/or transfer to an acute care hospital for treatment. **Absconding/Missing Patient category only**: report the incident as "Moderate" if patient is certified under MHA (Form 1, 3, 4); in-custody or direct supervision status (Forensic patients only); if patient has been identified within the last 90 days as having a history of violence/self harm
Severe	Life-saving intervention or major permanent or long-term harm or loss of function. **Absconding/Missing Patient category only**: report the incidents as " Severe" if patient has recent homicidal or suicidal ideation with plan of intent and/or recent attempt of homicide/suicide
Death	Where death was caused by the incident

A patient safety incident is defined by the *Canadian Patient Safety Institute (2011)* as "an event or circumstance which could have resulted, or did result, in unnecessary harm to a patient", directly associated with the care or services provided. A near miss is a patient safety incident that did not reach the patient. A critical incident, as defined in the *Public Hospitals Act*, is any unintended event that occurs when a patient receives treatment in the hospital, and that results in death, or serious disability, injury or harm to the patient, and does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing the treatment. At The Royal, a patient incident involves harm to the patient or others.

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ROYAL OTTAWA HEALTH CARE GROUP
MINUTES
MEDICAL ADVISORY COMMITTEE MEETING HELD
November 21, 2019 – 8:30 to 10:30 a.m.
ROYAL OTTAWA MENTAL HEALTH CENTRE
Boardroom 2426-1, 2&3 (Brockville via videoconference in FTU Room B2-313)

MEMBERS		STAFF		GUESTS
Present	**Regrets**	**Present**	**Regrets**	
R. Bhatla, Chair P. Sedge S. Gulati T. Lau L. McMurray D. Attwood G. Motayne M. Willows M. Tremblay K. Huntington J. Shlik J. Gray *Ex-officio Members:* J. Bezzubetz S. Farrell E. Millar A. Winter D. Simpson T. Burta	A. Khan G. Beck	F. Dzierszinski D. Munroe	C. Crocker	C. Gemmell L. Tuominen J. Lambley K. Lepinskie
				SCRIBE
				S. Holierhoek

	AGENDA ITEMS		ACTION REQUIRED
1.	**CALL TO ORDER**	The meeting was convened at 8:37 a.m. K. Lepinskie agreed to monitor the meeting discussion based on the Royal's Ethics Framework for Decision Making.	
2.	**OPENING REMARKS**	<u>Corporate Scan</u> • The Chair welcomed Dr Paul Sedge, the new Associate Chief – Ottawa, to the MAC.	

		• The Service Awards ceremony was recently held and the Chair noted that two physicians, Dr. Kunjukrishnan and Dr. Braithwaite, celebrated 40 years of service. It was announced that Dr. Kunjukrishnan will be retiring at the end of January 2020. • The EHR has a Patient Portal functionality. One of the features of the Portal allows clients access to view their health records. Ontario Shores has been utilizing this feature since 2014 and The Royal anticipates activating the Patient Portal in a controlled, stepped approach. From a change management perspective, it is important to begin conversations around how best to proceed with the roll out of this feature and its multiple functionalities. • Following the Accreditation Canada survey, The Royal was awarded the status of "Accredited with Exemplary Standing". The Chair thanked D. Simpson and K. Lepinskie for their work with the various programs and teams and asked that leaders extend thanks to front line staff for their commitment to this endeavor. Accreditation Canada is expected to announce an amendment to their survey process which will include institution visits throughout the year. These visits may only be to one program or service of an institution. Programs and teams at The Royal will continue quality improvement work throughout the year and there is a group working to determine what our "continuous readiness state" should look like. The Chair announced that the Directors of Patient Care will be invited to attend the December MAC meeting as it will be a quality focussed meeting. • Beginning this meeting and going forward, the minutes of the Joint Delegated Medical Advisory Group (JDMAG) meetings will be included in the Consent Agenda. These minutes will assist in bringing clarity and understanding to the relationship between the three partner organizations. The Chair welcomed Dr. Lauri Tuominen, a neuroscientist at The Royal's Institute of Mental Health Research (IMHR), affiliated with the University of Ottawa, to speak about his research. During his research career, Dr. Tuominen has investigated the neurobiology of various aspects of psychopathology and developed a unique expertise in combining positron emission tomography (PET) and magnetic resonance imaging (MRI). More recently, Dr. Tuominen has been interested in	

		investigating the role of stress and trauma in mental health disorders. Dr. Tuominen's current research focuses on understanding the neurobiological basis of post-traumatic stress disorder and schizophrenia using the IMHR's new combined PET and MRI imaging capability, at The Royal's Brain Imaging Centre. His hope is that his research will lead to the development of new treatments for these mental illnesses.	
3.	**PRESENTATION**	a. Vanessa's Law D. Simpson and T. Burta presented on the *Protecting Canadians from Unsafe Drugs Act*, also known as *Vanessa's Law*, which introduces the requirement for mandatory reporting of serious adverse drug reactions and medical device incidents by hospitals. The requirement by Health Canada comes into effect on December 16, 2019. Any such incidents must be reported via the electronic Client Safety Incident Feedback (CSIF) system. Once a report of this nature has been entered into the system, the Pharmacy and Quality teams will work with the person/program reporting the incident to identify the information that requires reporting to Health Canada. Pharmacy and Quality staff members will be visiting teams and programs to conduct education sessions on how to report, and what types of information to report in these incidents. A copy of the presentation was included in the meeting package.	
		b. Integrated Strategic Planning: Process Overview and Stakeholder Feedback using SOAR J. Lambley spoke about the collaboration of the Royal Ottawa Healthcare Group, Institute of Mental Health Research and the Foundation to develop its first Integrated Strategic Plan for the period 2020 to 2023. The Integrated Strategic Planning Working Group is collecting feedback from stakeholders and community partners to assist in developing a Vision Statement and to determine the steps necessary to work towards achievement of the plan's goals and objectives. In this regard, MAC was asked to consider possible ways in which the Working Group could approach physicians and front line staff to encourage their engagement in the feedback process and active participation in attaining the plan's targets, goals and objectives. J. Lambley is available to meet to discuss ideas.	

		A copy of the presentation was included in the meeting package.	
4.	**CONSENT AGENDA**	**BE IT RESOLVED THAT the consent agenda, including the items outlined therein, be accepted as presented.** **Moved: D. Attwood** **Seconded: C. Ripley** **CARRIED** The following motions were included in the Consent Agenda: i. Acceptance of agenda of November 21, 2019 meeting ii. Approval of minutes of September 19, 2019 meeting iii. ECT Physician Safety Committee – Quarterly Report iv. Joint Delegated Medical Advisory Group (JDMAG) Agenda & Minutes of October 17, 2019 *(Draft)*	
	ITEMS MOVED FROM THE CONSENT AGENDA	No items were removed from the Consent Agenda.	
5.	**ACTION ITEMS**	The Action Registry was reviewed and updated.	
6.	**NEW BUSINESS**	a. None	
7.	**STANDING REPORTS**	**ADVISORY COMMITTEE REPORTS**	
		a. Credentials Committee – G. Motayne	
		G. Motayne reported for this Committee. The October 1, 2019 minutes were included in the meeting package.	
		i. Appointments to Medical Staff & Privileges Applications	
		BE IT RESOLVED THAT as recommended by the Credentials Committee, to recommend approval of the Appointments to Medical Staff & Privileges Applications for: - Dr. Shehan Katuwapitiya, Psychiatrist, from Temporary to Probationary Full-Time Privileges, Mood & Anxiety Program, effective immediately. - Dr. Imran Jamil, Psychiatrist, Probationary Full-Time Privileges, Integrated Forensics Program, effective immediately. - Dr. Marie-Helene Rivard, Psychiatrist, Probationary Full-Time Privileges, Geriatrics Program, effective immediately. - Dr. Chrys Ezeoke, Psychiatrist, from Probationary to Primary Full-Time Privileges, Mood & Anxiety	

		Program, effective immediately. - Dr. Sharon Levine, Psychiatrist, Consulting with Admitting and Discharge Privileges, Geriatrics Program, effective immediately. **(Defer to December 19, 2019 MAC meeting)** - Dr. Rishi Kapur, Psychiatrist, Courtesy On-Call Privileges, Youth Program, effective immediately. - Dr. Erinna Brown, Psychiatrist, Courtesy On-Call Privileges, Youth Program, effective immediately. - The following TOH Radiologists, Courtesy Privileges, MRI services, effective immediately: - Dr. Frank Lee - Dr. Matthew Quon - Dr. David Hammond - Dr. Robert Ritchie - Dr. Karl Smyth - Dr. David MacDonald - Dr. David Bakish, Psychiatrist, Locum Privileges extension to October 24, 2020, Consult Clinic, effective immediately. **Moved: C. Ripley** **Seconded: T. Lau** **CARRIED**	
		b. Integrated Ethics Committee – D. Simpson, N. Lukich	
		D. Simpson reported for this Committee. - No report.	
		c. Medical Services Committee – A. Winter, B. Pryer	
		A. Winter reported for this Committee. - The community Flu Clinic held at The Royal had good attendance. 236 people from the community were immunized. Staff and inpatient immunization is progressing well and we hope to increase participation numbers from last year. There is no nasal spray vaccine this year and OPH has run out of the geriatric version of the vaccine. In the near future extraction of data on the number of inpatients who received the flu injection will be available via the EHR. - HLS Therapeutics Inc. has a new point-of-care blood monitoring system called CSPAN Pronto, to help simplify routine bloodwork for patients on Clozapine. The Royal will be 1 of 6 sites across Canada piloting the use of this product over a 3 month period. Though	

		the cost is twice that of venipuncture, it could promote improved compliance. - J. Bezzubetz asked that the recommendations made following the pilot phase of this product be reported to the Innovation Committee. The September 10, 2019 and October 22, 2019 minutes were included in the meeting package.	
		d. Pharmacy & Therapeutics Committee – M. Tremblay, T. Burta	
		T. Burta reported for this Committee. - The Committee is in the process of collecting information from stakeholders to develop a Cannabis policy. A final policy will come to MAC once all stakeholders have had an opportunity to review the policy and provide feedback. The June 18, 2019 and September 17, 2019 minutes were included in the meeting package.	
		INCIDENTS REPORTS	
		e. Critical and Severe Incidents Report – D. Simpson	
		October; 4 deaths; program level reviews were conducted for each; all deaths were determined to be from natural causes November; 1 death; program level review conducted and no system or process issues were identified; 2 severe incidents occurred - 1 corporate level reviews has taken place and one is upcoming in the next few weeks for these incidents.	
		OTHER REPORTS	
		f. Electronic Health Records (EHR) – D. Attwood	
		The Community Mental Health Program went live with Meditech 6.1 this week. The roll out went smoothly and D. Attwood thanked C. Ripley, T. Moran and R. Pow for their support in advance of and during the roll out. Upgrading preparations for Meditech Expanse will begin in March 2020. The performance pack should be received by September 2020 and go live is targeted for March 2021. Dr. I. Fischler, Psychiatrist-in-Chief, is leaving Ontario Shores (OS) at the end of March. His absence will leave a large void but there is a strong team in place at OS. Before he leaves, Dr. Fischler has agreed to speak about OS's experience instituting use of the Patient Portal. A Privileges Policy Working Group meeting was held November 20, 2019. A policy review process will follow.	

		g. Accreditation – D. Simpson	
		K. Lepinskie thanked MAC for their leadership during the Accreditation process. Staff were forthcoming about identifying procedures that were not yet operating at 100% and provided the survey team with information on what was being done to rectify any shortcomings. The survey team was very complimentary to all programs and services in their report and were appreciative of the open and honest conversations held, especially with front line staff. Clients, families and community partners spoke highly of The Royal to the surveyors. The surveyors identified that having front line staff live and breathe "Ethics" as an area that has room for improvement. The Integrated Ethics Committee will be asked to provide some ethical work to front line staff. It was noted that our EHR not only audits for completeness, but also for quality and accuracy in reporting. Everyone is encouraged to contact K. Lepinskie with suggestions for improvements or changes that could be worked on in advance of the next accreditation survey.	
		POLICIES AND PROCEDURES	
		h. CORP VIII-I – 170 Inpatient Methadone: Prescriber Authorization, Pharmacy Profiling, Preparation, Dispensing and Dosing (Rev. Sept 30, 2019) – T. Burta	
		To approve CORP VIII-I – 170 Inpatient Methadone: Prescriber Authorization, Pharmacy Profiling, Preparation, Dispensing and Dosing (Rev. Sept 30, 2019) as presented. **Moved: M. Tremblay** **Seconded: D. Attwood** **CARRIED**	
		EXECUTIVE REPORTS	
		i. Psychiatrist-in-Chief and Chief of Staff – R. Bhatla	
		See above.	
		j. President and CEO – J. Bezzubetz	
		The Provincial government is moving ahead with the dissolution of the LHINS by early December. Five new geographic regions will replace the LHINS and there will be an interim leader for the new regions. This interim leader is coming to Ottawa in December and will host a meeting that J. Bezzubetz will attend. J. Bezzubetz will extend an invitation to the interim leader to visit The Royal.	

		Queen's Park is hosting a full day meeting for healthcare providers on November 25. J. Bezzubetz and our partner organizations will be meeting with government officials to discuss The Royal's role in supporting OHTs. All local OHTs put forward for consideration have received in person visits from MOHLTC officials. An announcement of which OHTs have been selected to move ahead with implementation is expected in the near future. There will be a second call for OHT submissions in January. The recruitment for the next IMHR President and Vice President is underway. A consulting firm and selection panel are in place. It could be next summer before the successful candidate is in place. An external review of IMHR research is being conducted by a neutral party who will make recommendations as to the way forward with respect to conducting IMHR business.	
		k. President of Medical Staff – T. Lau	
		No report.	
		l. Interim Chief Operating Officer, IMHR – F. Dzierszinski	
		The review of the UMRF competition program is progressing well and is coordinated with the executives of the Associates in Psychiatry. Once the call is in its penultimate phase, consultations will be made with the community to obtain feedback. We are anticipating that the competition will be launched in the spring of 2020. The second competition that we are planning is entitled TRIC – Translating Research Into Care. The call will be made for teams to be composed of scientists, clinicians, and administrators to propose innovative solutions. These programs correspond to a direct benefit of the strategic integrated plan exercise.	
8.	**NEXT MEETING**	**December 19, 2019 at 8:30 – 10:30 a.m.** at the ROMHC 2426-1,2&3 *(Brockville via videoconference in FTU Room B2-313)*	
9.	**THE ROYAL'S ETHICS FRAMEWORK FOR DECISION MAKING**	K. Lepinskie confirmed that the meeting discussions were in keeping with The Royal's Ethics Framework for Decision Making. L. Tuominen's presentation demonstrated collaboration between The Royal and IMHR. Honest and respectful discussion took place around the Integrated Strategic Plan presentation and subsequent conversations remained respectful.	
10.	**ADJOURNMENT**	There being no further business, the meeting was adjourned at 10:30 a.m.	

11.	**IN-CAMERA SESSION**		

R. Bhatla, Chairperson **S. Holierhoek, Secretary**

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Santé mentale - Soins et recherche

ROYAL OTTAWA HEALTH CARE GROUP
MINUTES
MEDICAL ADVISORY COMMITTEE MEETING HELD
December 19, 2019 – 8:30 to 10:30 a.m.
ROYAL OTTAWA MENTAL HEALTH CENTRE
Boardroom 2426-1, 2&3 (Brockville via videoconference in FTU Room B2-313)

MEMBERS		STAFF		GUESTS
Present	**Regrets**	**Present**	**Regrets**	
R. Bhatla, Chair P. Sedge S. Gulati T. Lau L. McMurray G. Beck D. Attwood G. Motayne M. Tremblay M. Willows J. Gray K. Huntington *Ex-officio Members:* S. Farrell A. Winter D. Simpson	A. Khan C. Ripley J. Shlik J. Bezzubetz E. Millar T. Burta	D. Munroe	F. Dzierszinski C. Crocker	J. Desrochers J. Haynes P. Johnston C. Gemmell K. Lepinskie B. Pryer (Regrets) E. Deacon B. Merkley C.A. Cumming C. Slepanki D. Pilon (Regrets) T. Stufko (for J. Garrow) K. Daley P. Jackson R. Pow (Regrets) S. Hale J. Ash (Regrets) J. Lambley
				SCRIBE
				S. Holierhoek

	AGENDA ITEMS		ACTION REQUIRED
1.	**CALL TO ORDER**	The meeting was convened at 8:37 a.m. S Gulati agreed to monitor the meeting discussion based on the Royal's Ethics Framework for Decision Making.	
2.	**OPENING REMARKS**	The Chair announced that this MAC meeting will be a focussed discussion on meaningful ways to enhance and incorporate client and family centred care into the organization and to identify Program's priority indicators with respect to the preparation of the 2020-2021 Quality Improvement Plan.	

		In this regard, the Directors of Patient Care Services were welcomed to the meeting and a roundtable of introductions was conducted.	
3.	**PRESENTATION**	a. Caring For You Like Family (CFCC Framework) J. Desrochers, J. Haynes and P. Johnston presented. J. Desrochers spoke about the importance of having a Client and Family Centred Care Framework and how it will align with Senior Management's vision and strategic direction for the organization. A discussion took place about what barriers may exist in delivering client and family centred care and what may be needed to facilitate this initiative. Further feedback can be sent to J. Desrochers. Physicians interested in becoming a member of the Family Advisory Committee would be welcome and can contact J. Desrochers in this regard. P. Johnston, a member of the Family Advisory Committee, spoke about her family's experience with trying to navigate the health system in order to get her teenage son mental health services. While ultimately receiving good care at The Royal, there were many difficult challenges in obtaining those services. P. Johnston would like to see a dedicated resource(s) for families to help navigate the health system both inside and outside The Royal. A copy of the presentation and the CFCC framework was included in the meeting package.	
4.	**CONSENT AGENDA**	**BE IT RESOLVED THAT the consent agenda, including the items outlined therein, be accepted as presented.** **Moved: G. Motayne** **Seconded: T. Lau** **CARRIED** The following motions were included in the Consent Agenda: i. Acceptance of agenda of December 19, 2019 meeting ii. Approval of minutes of November 21, 2019 meeting iii. Joint Delegated Medical Advisory Group (JDMAG) Agenda & Minutes of November 21, 2019 *(Draft)* iv. Corporate Patient Safety Quarterly Report v. Quality Improvement Plan Quarterly Update vi. Quality Improvement Plan Updates – Briefing Note	
	ITEMS MOVED FROM THE CONSENT AGENDA	No items were removed from the Consent Agenda.	

5.	**NEW BUSINESS**	a. Planning for the Quality Improvement Plan 2020-2021 – Identified Themes	
		D. Simpson introduced the five themes identified by the Quality Committee of the Board as priorities that they would like to see the organization work on. This information was contained in the meeting package. D. Simpson asked the group to consider the themes in the context of planning for the Quality Improvement Plan 2020-2021. Using the Poll Everywhere software the group was surveyed to: (a) identify which of the QCB identified themes is of greatest priority for their program; (b) identify any additional high priority themes they would like to see included in the QIP; and (c) suggest activities or indicators would be meaningful measurements at the program level. Based on poll results, the following three priority themes for the programs were identified: 1. Clinical outcomes 2. Accessible as a community partner 3. Supportive individualized transitions in care	
		b. FY 2019/2020 Quality of Care Reviews, Recommendations, and Status	
		Recommendations from Quality Care Reviews were shared by the group. The recommendations were included in the meeting package.	
		c. Client/Estate Trustee/SDM Involvement in Corporate Level Quality of Care Reviews – Briefing Note	
		The group was asked to ensure they review the briefing note which was included in the meeting package. Any questions on the matter should be brought to their managers' attention.	
6.	**NEXT MEETING**	**January 16, 2020 at 8:30 – 10:30 a.m.** at the ROMHC 2426-1,2&3 *(Brockville via videoconference in FTU Room B2-313)*	
7.	**THE ROYAL'S ETHICS FRAMEWORK FOR DECISION MAKING**	S. Gulati confirmed that the meeting discussions were in keeping with The Royal's Ethics Framework for Decision Making. The CFCC presentation was informative. The quality themes and indicators discussion was collaborative and interactive. Respectful discussions took place.	
8.	**ADJOURNMENT**	There being no further business, the meeting was adjourned at **10:30 a.m.**	

9.	**IN-CAMERA SESSION**		

R. Bhatla, Chairperson **S. Holierhoek, Secretary**

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019 – 2020 – 32	**Priority:** Important

DATE: February 20, 2020

COMMITTEE: Medical Advisory Committee

PRESENTER: R. Bhatla, Chief of Staff/Psychiatrist-in-Chief

SUBJECT: Medical Staff Privileges

BACKGROUND INFORMATION:

By-laws #3.4.1. The Board, in determining whether to make any appointment or reappointment or approve any request for a change in privileges shall take into account the recommendation of the Medical Advisory Committee and such other considerations it, in its discretion, considers relevant including, but not limited to, the Hospital Human Resources Plan, Impact Analysis, strategic plan and the Hospital's ability to operate within its resources.

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT in accordance with the criteria and credentialing process outlined in the ROHCG Appointment and Re-appointment Schedules, the Medical Advisory Committee recommends the approval of the appointment to Medical Staff & Privileges application for Dr. Sharon Levine, Psychiatrist, Primary Part-Time, Geriatrics Program, effective December 18, 2019.

CARRIED

Moved by:
Seconded by:
Motion approved:

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ROYAL OTTAWA HEALTH CARE GROUP BOARD
FINANCE COMMITTEE MINUTES
January 30, 2020 8:15 HRS
ROYAL OTTAWA MENTAL HEALTH CENTRE

Trustees	Present	Regrets	Trustees	Present	Regrets
J. Gallant, Chair	X		S. Squire		X
R. Anderson	X		J. MacRae	X	
L. Gillen	X (phone)		A. Graham	X (phone)	
L. Leikin	X		A. Khan	X	
C. Coulter	X				
Management Staff					
K. Kealey			J. Bezzubetz		
C. Crocker					
D. Bilodeau					
Guests					
C. St. Germain	X				

AGENDA ITEMS		ACTION REQUIRED
Call to Order	J. Gallant, Chair, called the meeting to order at 8:14 am and declared the meeting to have been regularly called and properly constituted for the transaction of business. The Chair welcomed Dr. Asif Khan to the meeting, being her first meeting; the committee was introduced by roundtable. The Chair welcomed Craig St. Germain, Manager Budget and Reporting. Note: Meeting agenda Q&A's were circulated amongst members via email prior to the meeting for review/response and information purposes.	
Meeting Agenda	**Moved by S. Squire, seconded by J. MacRae, BE IT RESOLVED THAT the meeting agenda, be accepted as presented** **CARRIED**	
2. Consent Agenda	**Moved by C. Coulter, and seconded by R. Anderson BE IT RESOLVED THAT** the consent agenda, including the actions outlined therein, be accepted	

AGENDA ITEMS		ACTION REQUIRED
	CARRIED • Minutes of November 22, 2019 • Draft 2019/20 Work plan • Financial Domain of the Balanced Scorecard • Update Legal Case – B. Clarke	
3. Review Interim Financial Statements	C. Crocker provided an overview of the Financial Statements for the 9 months ended December 31, 2019 noting the following highlights Balance Sheet: • There are no significant changes – reporting is consistent with previous quarter Income Statement • $486K surplus as at end of December 2019 • We remain on track to a balanced budget for fiscal year ended March 31, 2020 • Other Revenue – Sale of HFS not yet recognized – will be used as one time revenue for 20/21 as we have one time revenue of approximately $1.8M due to realized gains on investments, as investments were sold in transfer from TD to CIBC in January 2020 Sick Hours Reporting • Total number of sick hours is trending above our benchmark of 3.00% (3.35%) but the overall cost is being appropriately managed. In response to questions the following was noted: • Organizationally we are dealing with the Coronavirus alert through infection control protocols in place • Additional masks have been placed at the front entrance of the building • Communications have been placed at the front entrance of the building related to dealing with infection control measures • All students coming to the hospital are advised of infection control measures • OHA is hosting a number of sessions on the virus and are inviting those responsible for infection control to join in • We have a supply of masks and other supplies in inventory	
Budget – 2020/21: • **Operating** • **Capital** • **3-yr Forecast**	C. Crocker gave members an overview of the Draft 2020/21 Operating Budget based on detailed documents included in the package. **a. Operating Budget:** **Highlights:** **Current State (2020/21):** We are projecting a $1M surplus for the fiscal year ending March 31, 2020. Projected revenue $194,157,082 and projected expenses of $193,107,082	

AGENDA ITEMS		ACTION REQUIRED
	New base funding in 2019/20: • Global base funding projected increase of $1M (1%) • Community Mental Health and Addictions $329K CDU Day Hospital • Community Mental Health and Addictions one time Co-ordinated Access Funding $155K • Youth Program $50K Core Community Based Services • Successful in Nunavut RFP process (5 year term) **Union Agreements:** • CUPE 1.65% (expires Sept 29, 2021) • ONA 1.75% (expires Mar 31, 2020) • OPSEU BMHC 1.75% (expired Mar 31, 2022) – in negotiation • OPSEU ROMHC 1.75% (expires March 31, 2022) **Accountability Agreements:** • We will meet all H-SAA, M-SAA and L-SAA accountability agreement commitments for 2019-20 **General:** • HealthPro rebate for outpatient clozapine ended May 2019. Negative Impact on the 2019/20 budget of $1.3M **Assumptions/Risks (2020/21):** • Global Funding based on 0% increase – not confirmed • Community Programs based on 0% increase • Nunavut and Yukon contracts remain at current level $1.9M • Cost of Living Allowance based on collective agreements, non-Union based on 1% • Slow hire savings of $1.6M • Benefits Increase 2% • Med/Surg Supplies: 2% increase over forecasted actual • ROP will require $1.6M from global budget • IMHR will require $1.8M from global budget • PET/MRI will balance in 2020/21 through use of Foundation funding • No major redistribution of budgets until 21/22 with completion of new Strategic Plan • The $1M surplus covers the unfunded capital loan payments related to ROP, ROMHC and Co-Gen • Will not impact our H-SAA, M-SAA and L-SAA accountabilities • Does not impact/jeopardize any future strategic directions • Meets the legislated requirement to present a balanced budget position	

AGENDA ITEMS		ACTION REQUIRED
	b. Capital Budget: • The capital budget allocation for 20/21 is $2,105,624 with the total covered from depreciation and other sources • The EHR costs are projected at $1,074,969 for fiscal 20/21 of which $250,000 is funded and the balance of $824,969 being covered by working capital. ROMHC: • P3 contract and building renovations and major equipment such as elevator, mechanical and electrical covered by a Life Cycle Fund • Current balance (November 2019) in Life Cycle Fund is $12.3M ROP: • On site at ROMHC but not part of P3 contract • Centre was built with borrowed funds and all capital renovations and building operations are the responsibility of ROHCG • Current (November 2019) outstanding loan balance is $3.7M BMHC: • Buildings on site are leased from Infrastructure Ontario STU: • Owned by Infrastructure Ontario and leased to Corrections • ROHCG provide clinical care only under contract with the Ministry of the Solicitor General • FTU Building, Government Services Building, Centennial Hall and Maintenance Building: • Under lease from Infrastructure Canada Carlingwood Shopping Centre – Community Teams • This space is leased Other Locations (Kingston, Arnprior) • These spaces are leased In response to questions on the operating budet, the following was noted: • There is a medium risk related to ONA COLA due to Government changes to contract negotiations that may affect the employer for extra costs. ONA is the first of our contracts to come under the 1% legislated salary increases • Under the new HealthPro contract and Clozapine supplier, there is no rebate for outpatients, but in terms of inpatient use, there will be a $200K rebate. This reduced figure has been incorporated into the budget	

AGENDA ITEMS		ACTION REQUIRED
	• Fiscal 2020/21 will be the last year of the current Strategic Plan. New Strategic Plan should be completed September/October 2020 which will fall in line with 2021/22 budget planning • Sale of HFS: proceeds increased after final audits were completed in terms of procurement and final sale value of $1.802 to $2.084M • ROP specialty designation may include one time capital funding which can be used to offset costs of HVAC system • Capital items have been allocated to specific years but timing would be reviewed for 2021/22 and beyond based on available funding options **c. 3 Year Forecast – Operating (based on funding of 0%, 1%, 2%)** **Assumptions:** Salary based on union agreements – expiring as follows: • CUPE 1.65% (expires Sept 29, 2021) • ONA 1% (expires March 31, 2020) • OPSEU BMHC 1.75% (expires March 31, 2022) • OPSEU ROMHC 1.75% (expires March 31, 2022) • Non-Union 1% • Salary increase of 1% reflected in 2022/23 for all union groups • Benefit increase 2% per year • Med/Surg expense 2% per year • Drugs 2.0% per year • Other Operating Expense 1% per year • Other Fund Types and Ministry of Health Other Votes excluding Long Term Care and Youth break even • Improving Access to Structures Psychotherapy $5M permanent funding assumed **Risks** • Unknown re: future government funding • Long Term Care $1.6M deficit • IMHR $1.8 million annualized funding contribution • PET/MRI deficits beginning in 21/22 • Vacancy factor of $1.5M **Major Contracts** • Secure Treatment Unit - November 2018 to October 2023 • Operational Stress Injury Clinic - current agreement expires March 31, 2022 • Nunavut – Successful in new RFP **Moved by J. MacRae, seconded by C. Coulter,** **THAT the draft Operating and Capital budgets, for 2020/21 be recommended to the Board of Trustees for approval** **CARRIED**	

AGENDA ITEMS		ACTION REQUIRED
5. Integrated Risk Management (IRM) Framework	This item is deferred until March 19, 2020 meeting	**D. Bilodeau**
6. Review Internal Controls (Lean in Process)	Taken as read	
7. Cyber Security Update	Taken as read	
8. Investment Update	Taken as read	
9. Update: PET/MRI	Taken as read	
10. Update Excess Property/Altus Report	This item is deferred until March 19, 2020 meeting	**D. Bilodeau**
11. IMHR Budget – 2020/21	C. Crocker gave members an overview of the Draft 2020/21 IMHR Budget based on detailed documents included in the package **Highlights:** • Legal entity in breakeven position • Funding for President's position is moved to ROHCG managed by UofO IMHR • Budget excludes grant revenue and expenses as per process approved by IMHR Board due to unpredictability of timing of research activity • Recognized research revenue is approximately $5M per year • Budget is balanced – consistent with sustainability work completed in 2019/20 In response to questions the following was noted: • Research is not budgeted but recognized as expenses incurred • Hospital global component total allocation is consistent with budget allocation amount noted in the Royal draft budget • IMHR is within parameters laid out in sustainability documents approved in 2019/20 • Approval of ROHCG budget includes the IMHR global component • Documents provided to the committee are included to show the detail of how funds have been used • Additional approval is for the legal entity portion of $387K • A review across CAHO indicates this is the normal way research institutes operate – another schedule is brought forward to IMHR Finance and Audit Committee showing grant activity – this document is to be brought forward to next Finance Committee meeting • Salaries in document should have names removed – switch out document on board portal	**D. Bilodeau** **D. Bilodeau**

AGENDA ITEMS		ACTION REQUIRED
	Moved by R. Anderson, seconded by L. Leikin, **THAT the IMHR Non-Research Activity Budget for 2020/21 be recommended to the Board of Trustees for approval** **CARRIED** Cal to clarify to the IMHR Finance and Audit Committee that the hospital's commitment from global funds is based on received at worst, a 0% funding increase from government for 2020/21	**C. Crocker**
Adjournment	**The meeting adjourned at 9:35 am** **Moved by R. Anderson, seconded by C. Coulter**	
Next Meeting	March 19, 2020 IMHR Conference Room 5437	

J. Gallant Chair, Finance Committee	J. Bezzubetz Secretary of the Board	Date

Finance Meeting Action Items

Action Item	Individual Responsible	Status
Ongoing updates HFS	C. Crocker	Standing item until completed
Updates re: concepts PET/MRI Revenue Generation	C. Crocker	Standing item until completed
Update Altus Report – Market Value Carling Site Excess Property – Bring to November 2019 Meeting (ii) ROP and (iii) Land Value for Carp property to be presented in November 2019	C. Crocker	March 2020
IMHR Finance and Audit Committee Grant Activity Report to be brought forward to March 2020	D. Bilodeau	March 2020
Integrated Risk Management Framework report to be brought forward to March 2020	D. Bilodeau	March 2020

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 33	**Priority:** Important

DATE: February 20, 2020

COMMITTEE: Finance Committee

PRESENTER: J. Gallant

SUBJECT: Capital and Operating Budget

BACKGROUND INFORMATION:

Oversight of financial conditions and resources is one of the Board's responsibilities. This involves ensuring the ongoing viability and sustainability of the corporation including the provision of funds and resources needed to carry out its mission and protecting its assets from risks.

The Finance Committee recommends that the Board approve both the capital and operating budget for 2020-2021 as outlined in the attached documents.

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT as recommended by the Finance Committee, the 2020-2021 Capital and Operating Budget be approved, as presented.

CARRIED

Moved by:

Seconded by:

Motion approved:


DRAFT
The Royal
2020/2021 Budget
CONFIDENTIAL
January 30, 2020
The Royal Ottawa Mental Health Centre
University of Ottawa Institute of Mental Health Research
The Royal Ottawa Foundation for Mental Health
Brockville Mental Health Centre
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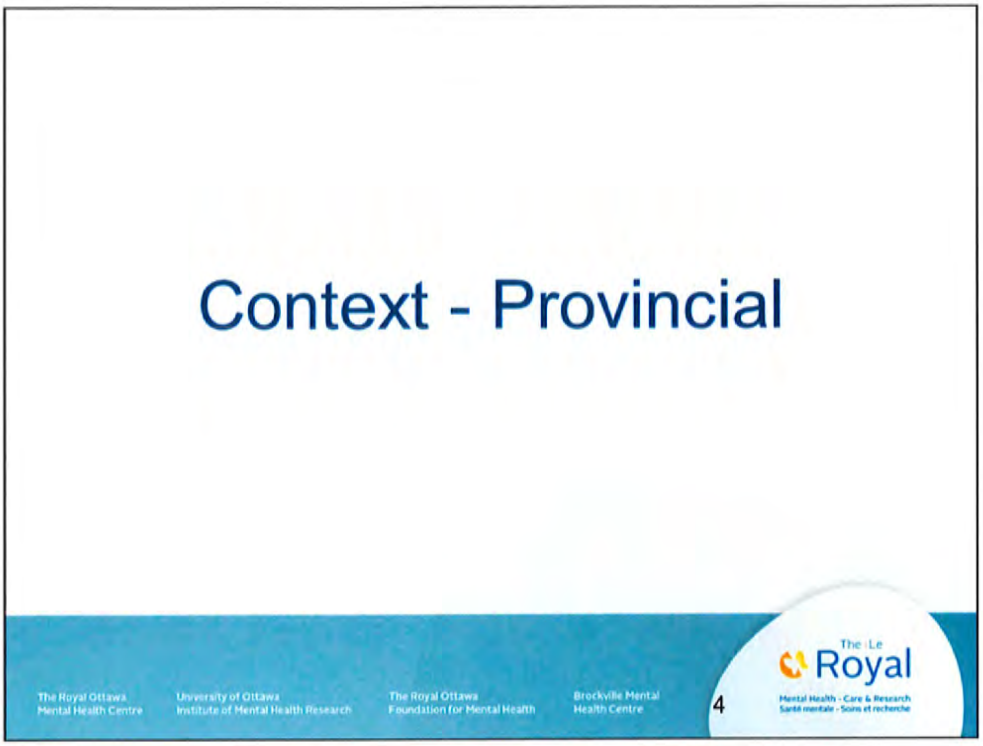
Context - Provincial
The Royal Ottawa Mental Health Centre
University of Ottawa Institute of Mental Health Research
The Royal Ottawa Foundation for Mental Health
Brockville Mental Health Centre
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Context - Provincial

- Per OHA between 2012 and 2019, funding in Ontario hospitals has increased by 5.4% per capita (all other provinces combined 12.9%)
- OHA is requesting a 4.85% funding increases for hospitals for 2020/21
- There has been no funding announcement from the government to date for fiscal 2020/21


Context - Royal
The Royal Ottawa Mental Health Centre
University of Ottawa Institute of Mental Health Research
The Royal Ottawa Foundation for Mental Health
Brockville Mental Health Centre
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Context – The Royal

- The Royal, as are all hospitals in Ontario, is required by legislation to provide a balanced budget annually
- The Royal's budget increase since 2010/11

2010/11	1.33%	2015/16	0%
2011/12	1.25%	2016/17	2%
2012/13	0%	2017/16	2%
2013/14	0%	2018/19	2%
2014/15	0%	2019/20	1%

- Comparing the increase to inflation over the same period, sees the Royal's base budget having a shortfall of approximately $6.8M
- Over the years we have managed to remain in a balanced budget position through initiatives such as:
  - Major restructuring and reduction of services and staff in Brockville
  - Skill mix review and new master schedules for all inpatient services based on peer comparators (mainly replacement of RN's with RPN's and changes in Allied Health re: psychology, social work and occupational therapy based on review of patient care needs)

Context – The Royal

- Member of HealthPro, a national group purchasing organization, ensuring competitive procurement based on national volumes
- Partnership with Waypoint and Ontario Shores for the implementation of EHR. This is allowing standardization of clinical processes, shared data centre, and shared clinical informatics

- Areas where a proxy of efficiency are used by management include:
  - Utilization reports that detail occupancy by inpatient services, new patients and discharges. Our occupancy is approximately 96%
  - Workload Measurement by discipline for nursing (outpatient and community) and Allied Health (social work, occupational therapy, recreational therapy, etc). Our productivity is at 89% (Activity / Total worked hours)

Context – The Royal

- Based on the Auditor General review in 2016, we meet the benchmark for administration/support to clinical services at a 30/70 split which we continue to meet
- Monthly program/department budget reporting to all managers/directors accountable for budgets and variance analysis for overspending that flows to the accountable VP and SMT
- We are submitting an application to the Ministry of Health for specialty bed designation for Royal Ottawa Place which if successful will eliminate / reduce the deficit of $1.6M
- Under the Mental Health and Addictions Quality Initiative (MHAQI) we rank #1 or #2 compared to our peers in listed comparator areas (document reported regularly to the Board of Trustees)

Context – The Royal

- Successful in revenue generating re:
  - IASP funding (permanent 20/21) ($5.0M/yr)
  - Yukon ($1.0M/yr)
  - Nunavut contract (2019 – 5yr) ($0.9M/yr)
  - STU contract (expires Oct 2023) ($17.0M/yr)
- We have met all LHIN H-SAA, M-SAA and L-SAA commitments since 2010/11
- We have been successful in remaining in a breakeven/small surplus position since 2010/11
- We, as are other health care organizations, are dependent on government funding (92%) and operate in a union environment (approximately 95% of all employees)


Current State
2019/20
The Royal Ottawa
Mental Health Centre
University of Ottawa
Institute of Mental Health Research
The Royal Ottawa
Foundation for Mental Health
Brockville Mental
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Current State

- We are projecting a $1M surplus for fiscal year ending March 31, 2020
- Successes in receiving new funding in 2019/20
  - Global base funding increase of $1 million (1%)
  - Community Mental Health and Addictions $329 thousand CDU Day Hospital
  - Community Mental Health and Addictions one time Co-ordinated Access Funding $155 thousand
  - Youth Program $50 thousand core community based services
  - Successful in Nunavut RFP process (5 yr term)

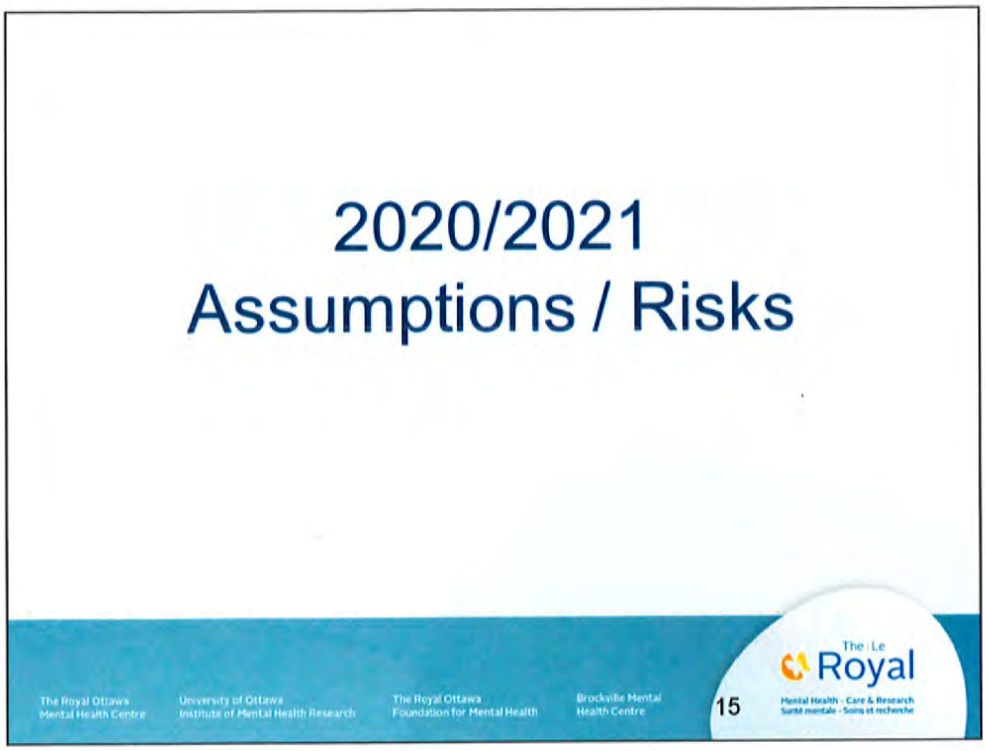
Current State

- Union Agreements
  - CUPE 1.65% (expires Sept 29/21)
  - ONA 1.75% (expires Mar 31/20)
  - OPSEU BMHC 1.75% (expires Mar 31/22)
  - OPSEU ROMHC 1.75% (expires Mar 31/22)

- Healthpro rebate for outpatient clozapine ended May 2019. Impact on 2019/20 budget $1.3 million.

Current State

- We are projected to meet our H-SAA (Hospital) commitments for 2019-20 re:
  - Current ration .87:1
  - Margin >.48%
  - Inpatient Volumes >88,628
  - Community / Outpatient Volumes >66,685
  - Other non volume commitments
- We are projected to meet all M-SAA (Community) commitments for 2019-20
- We are projected to meet all L-SAA (Long Term Care) commitments for 2019-20
  - Occupancy >97%


2020/2021
Assumptions / Risks
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University of Ottawa Institute of Mental Health Research
The Royal Ottawa Foundation for Mental Health
Brockville Mental Health Centre
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Assumptions / Risks

Assumption	Risk
Global funding based on 0% increase	Low
Community funding based on 0% increase	Low
Nunavut and Yukon contracts remain at current level $1.9M	Low
Includes one time HFS revenue related to sale	Low
Cost of Living Allowance based on current collective agreements	
CUPE 1.65% (expires Sept 29/21)	Low
ONA 1% (expires Mar 31/20)	Medium
OPSEU BMHC 1.75% (expires Mar 31/22)	Low
OPSEU ROMHC 1.75% (expires Mar 31/22)	Low
Non Union 1%	Low

Non-Union and ONA budgeted at 1% as a result of bill 124 Protecting A Sustainable Public Sector For Future Generations ACT.

ONA budgeted 1% vs 1.75% included in prior year cash flow – savings of $237,637

Non-union budgeted 1% vs 1.75% included in prior year cash flow – savings of $190,439

Assumptions / Risks cont'd

Assumption	Risk
Slow hire savings of $1.6M	Low
Benefits 2%	Low
Med/Surg Supplies 2% over forecasted actaul	Low
Drugs 2% over forecasted actual	Low
Royal Ottawa Place will require $1.6M from global budget	Low
IMHR will require $1.8M from global budget	Low
PET/MRI will balance in 20/21 (deficits expected in future years of >$500k)	Low

Assumptions / Risks cont'd

Assumption	Risk
No major redistribution of budgets until 21/22 with completion of strategic plan	Low
Covers the unfunded capital loan payments related to ROP, ROMHC and Co-Gen	Low
Will not impact our H-SAA, M-SAA and L-SAA accountabilities	Low
Does not impact / jeopardize any future strategic directions	Low
Meets the legislative requirement to present a balanced budget	Low


2020/2021
Budget Summary
The Royal Ottawa Mental Health Centre
University of Ottawa Institute of Mental Health Research
The Royal Ottawa Foundation for Mental Health
Brockville Mental Health Centre
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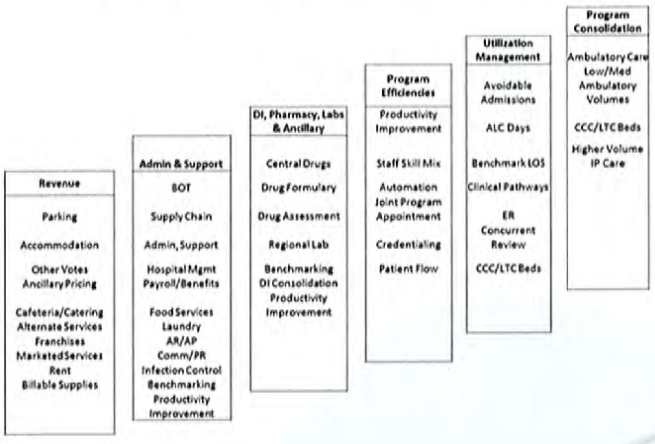
Budget Summary

	19/20 Budget	20/21 Initial Budget	$ Variance	% Variance
Funding	**$192,408,528**	**$191,565,257**	**($843,271)**	**-0.44%**
Compensation	$136,979,871	$137,938,681	($958,810)	0.70%
Supplies & Services	$45,567,346	$46,016,697	($449,351)	0.98%
Depreciation	$8,861,663	$9,888,450	($1,026,787)	11.59%
	$191,408,880	$193,843,828	($2,434,948)	1.27%
Net Surplus / (Deficit)	**$999,648**	**($2,278,571)**	**($3,278,219)**	

LHIN Prioritization Framework



Savings Initiatives

	FTE	Annualized Savings
Sale of HFS - One Time		$2,045,000
ROFMH - PET/MRI Funding		$346,825
Clozapine Inpatient Rebate		$200,000
Contingency		$330,574
IMHR Communications Specialist	0.50	$46,692
Project Manager	1.00	$144,965
Secretary	1.00	$88,997
Allied Health	1.00	$125,518
	3.50	**$3,328,571**

Budget Summary

	20/21 Budget Excluding Budget Savings Initiatives	Budget Savings Initiatives	20/21 Budget Including Budget Savings Initiatives
Funding	**$191,565,257**	**$2,591,825**	**$194,157,082**
Compensation	$137,938,681	($406,172)	$137,532,509
Supplies & Services	$46,016,697	($330,574)	$45,686,123
Depreciation	$9,888,450	$0	$9,888,450
	$193,843,828	($736,746)	$193,107,082
Net Surplus / (Deficit)	**($2,278,571)**	**$3,328,571**	**$1,050,000**

Budget Summary

	19/20 Budget	20/21 Budget	$ Variance	% Variance
Funding	**$192,408,528**	**$194,157,082**	**$1,748,554**	**0.91%**
Compensation	$136,979,871	$137,532,509	$552,638	0.40%
Supplies & Services	$45,567,346	$45,686,123	$118,777	0.26%
Depreciation	$8,861,663	$9,888,450	$1,026,787	11.59%
	$191,408,880	$193,107,082	$1,698,202	0.89%
Net Surplus / (Deficit)	**$999,648**	**$1,050,000**	**$50,352**	

*Based on known revenue sources and contract/inflationary increases


2020/2021
Funding
The Royal Ottawa Mental Health Centre
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Funding

	19/20 Budget	20/21 Budget	$ Variance	% Variance
Provincial Plan	$156,421,112	$156,693,846	$272,734	0.17%
Patient Revenue	$13,236,925	$13,302,214	$65,289	0.49%
Room Accommodation	$237,496	$137,496	($100,000)	-42.11%
Other Revenue	$15,305,999	$16,240,700	$934,701	6.11%
Grant Revenue	$7,206,996	$7,782,826	$575,830	7.99%
Total	**$192,408,528**	**$194,157,082**	**$1,748,554**	**0.91%**

Patient Revenue

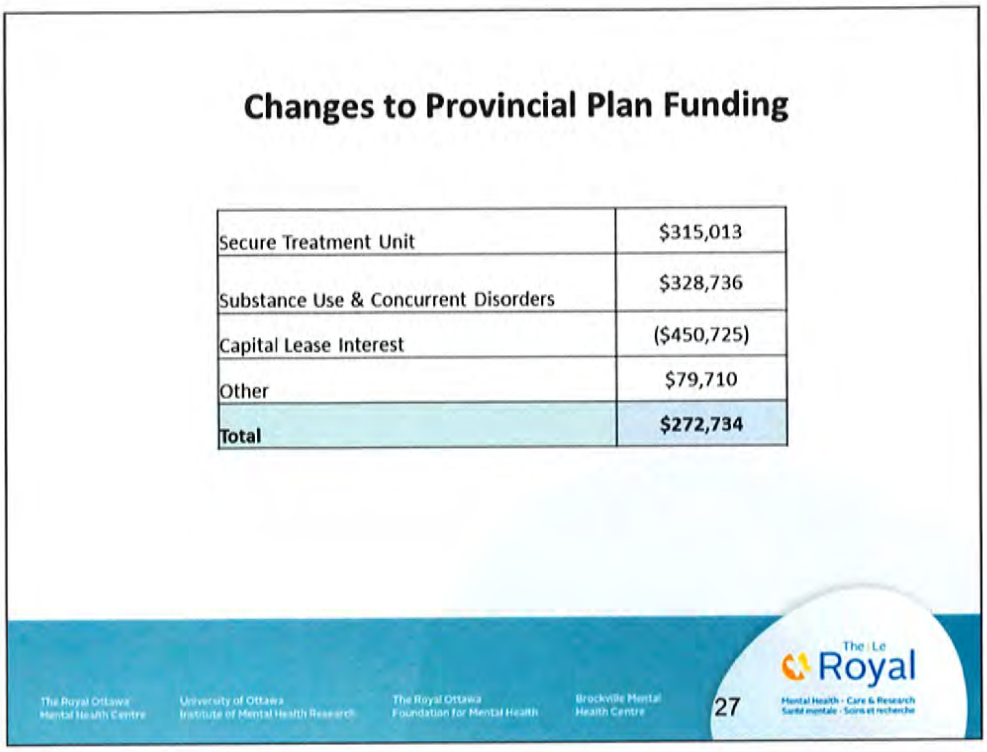
Nunavut	$100,000
OSI	($34,711)
Total	$65,289

Room Accommodation

Reduction in ROMHC room accommodation fees – based on current year forecast

Grant Revenue

Foundation funding for EHR



Changes to Provincial Plan Funding

Secure Treatment Unit	$315,013
Substance Use & Concurrent Disorders	$328,736
Capital Lease Interest	($450,725)
Other	$79,710
Total	**$272,734**

Substance Use and Concurrent Disorders – New Concurrent Disorders Day Treatment program

Changes to Other Revenue

CBT	$113,940
Clozapine Rebate	$200,000
Overhead Revenue	$132,360
HFS Sale	$282,000
IMHR	$78,388
Interest Income	$150,000
PET/MRI	($64,274)
Other	$42,287
Total	**$934,701**

Clozapine rebate for inpatient purchases only

Interest income based on current rates


2020/21
Compensation
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Compensation

	19/20 Budget	20/21 Budget	$ Variance	% Variance
Management & Operations	$21,008,540	$19,521,137	($1,487,403)	-7.08%
Unit Producing	$103,115,407	$105,250,617	$2,135,210	2.07%
Total MO & UP	$124,123,947	$124,771,754	$647,807	0.52%
Medical Staff	$12,855,924	$12,760,755	($95,169)	-0.74%
Total Compensation	**$136,979,871**	**$137,532,509**	**$552,638**	**0.40%**

Management and Operational/Unit Producing

COLA	1,124,462
Savings Initiatives (Prior year)	(801,232)
Savings Initiatives (Current year)	(406,172)
Health Records correction	(258,604)
Digital Media Coordinator	54,210
Secure Treatment Unit Contract	279,598
Division Admin Secretary	(63,902)
Director of Data Analytics	153,720
Modified Work	118,583
CDU Day Treatment	263,527
Diagnostic Services Secretary	75,408
IMHR Communications Coordinator	(47,393)
IMHR President/VP Research	300,000
IMHR Chief Operating Officer	(144,398)
Total	**647,807**

Medical Staff

OSI	($29,927)
Family Court Clinic - YOA	$52,995
Community Mental Health	($116,083)
Other	($2,154)
Total	**($95,169)**


2020/2021
Supplies & Services
The Royal Ottawa Mental Health Centre
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Supplies & Services

	19/20 Budget	20/21 Budget	$ Variance	% Variance
Med/Surg Supplies	$500,180	$533,652	$33,472	6.69%
MRI Supplies	$121,311	$104,135	($17,176)	-14.16%
Drugs	$1,781,639	$1,875,194	$93,555	5.25%
Utilities	$237,297	$237,297	$0	0.00%
Food/Hskping/Laundry	$1,186,110	$1,183,555	($2,555)	-0.22%
Maintenance of Building & Equipment	$3,106,544	$3,076,592	($29,952)	-0.96%
Insurance	$822,707	$723,292	($99,415)	-12.08%
Leases	$867,570	$876,401	$8,831	1.02%
Property Rental	$3,118,697	$3,139,697	$21,000	0.67%
Subtotal	$11,742,055	$11,749,815	$7,760	0.07%

Med/Surg Supplies – 2% above forecasted actual

Drugs – 2% above forecasted actual

Maintenance – reduction in PET/MRI equipment maintenance fees (Siemens scanner service contract)

Insurance – 5% above forecasted actual

Property rental – Community Mental Health

Supplies & Services (con't)

Subtotal from previous page	$11,742,055	$11,749,815	$7,760	0.07%
Contracted Out	$15,998,178	$15,918,510	($79,668)	-0.50%
Travel & Education	$1,502,021	$1,613,258	$111,237	7.41%
Professional Fees	$4,431,646	$4,921,771	$490,125	11.06%
Stationary/Photocopying/Printing	$683,360	$675,013	($8,347)	-1.22%
Software Licenses/Data Communication	$2,140,527	$2,228,094	$87,567	4.09%
Interest on Capital Lease	$5,782,482	$5,304,394	($478,088)	-8.27%
Other	$3,287,077	$3,275,268	($11,809)	-0.36%
Total	**$45,567,346**	**$45,686,123**	**$118,777**	**0.26%**

Contracted Out

Parking Management Fees	($59,407)
Facility Services	($5,485)
PET/MRI	($14,776)
Total	($79,668)

Travel and Education

FTU Ottawa	$ 31,877
Clinical Infomatics	$ 31,000
Data Analytics	$ 29,000
Strategic Planning	$ 12,000
Other	$ 7,360
Total	$111,237

Professional Fees

Shared Data Centre	$300,250
PET/MRI	$ 30,000

CDU Day Treatment	$ 64,508
STU	$ 21,753
IMHR	$ 12,000
LTC	$ 16,000
Other	$ 45,614
Total	$490,125

Software Licences	
Shared Data Centre	$70,125
Data Analytics	$ 9,500
Other	$ 7,942
Total	$87,567

Breakdown of Other Expense Budget

	19/20 Budget	20/21 Budget	$ Variance	% Variance
Association / Subscription Fees	$474,745	$477,413	$2,668	0.56%
Bank Charges/Interest	$45,953	$53,038	$7,085	15.42%
Board Funds	$20,200	$14,200	($6,000)	-29.70%
Communtiy	$25,053	$24,553	($500)	-2.00%
Contingency	$572,119	$378,721	($193,398)	-33.80%
Educational Supplies	$89,294	$64,620	($24,674)	-27.63%
French Language Training	$9,500	$9,500	$0	0.00%
Advertising / Communications	$171,032	$181,042	$10,010	5.85%
Minor Assets	$220,000	$225,112	$5,112	2.32%
Miscellaneous	$819,378	$982,788	$163,410	19.94%
Off Site Storage	$44,680	$69,690	$25,010	55.98%
Patient Supplies	$178,581	$178,391	($190)	-0.11%
Postage/Delivery	$55,903	$56,370	$467	0.84%
Taxes	$560,639	$559,830	($809)	-0.14%
Total	**$3,287,077**	**$3,275,268**	**($11,809)**	**-0.36%**

Miscellaneous

Shared Data Centre	$123,000
FTU Ottawa	$ 46,364
Other	($ 5,954)
Total	$163,410


2020/2021
Depreciation
The Royal Ottawa Mental Health Centre
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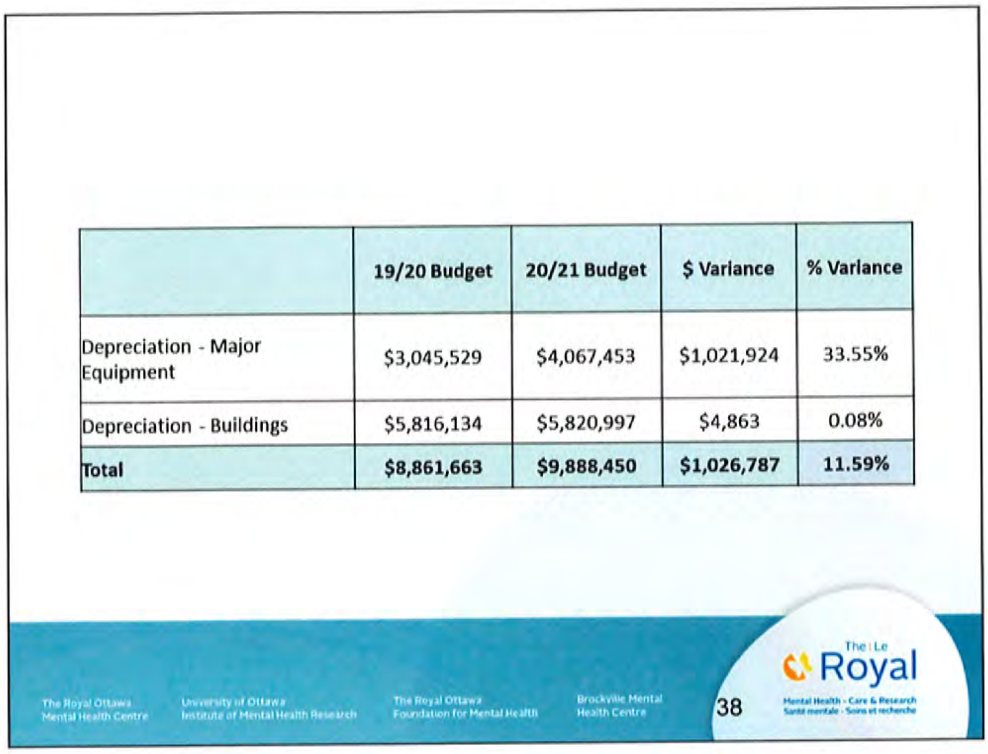

	19/20 Budget	20/21 Budget	$ Variance	% Variance
Depreciation - Major Equipment	$3,045,529	$4,067,453	$1,021,924	33.55%
Depreciation - Buildings	$5,816,134	$5,820,997	$4,863	0.08%
Total	**$8,861,663**	**$9,888,450**	**$1,026,787**	**11.59%**

EHR	$1,051,403
Other	($ 29,479)
Total	$1,021,924


20/2021
H-SAA, M-SAA & L-SAA Targets
The Royal Ottawa Mental Health Centre
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H-SAA, M-SAA & L-SAA Targets

	2019/20	2020/21	Variance
H-SAA			
Current ratio	0.93	n/a	0
Margin	0.31%	n/a	0
Patient Days	88,628	88,628	0
Weighted Patient Days	107,788	107,788	0
Outpatient Volumes	27,950	27,950	0
Community Volumes	38,735	38,735	0
M-SAA			
Visits	35,038	36,538	1,500
Not Uniquely Identified	6,250	6,250	0
Resident Days	3,135	3,000	-135
Individuals Served	3,599	3,699	100
Group Sessions	705	589	-116
Group Participants	3,100	3,100	0
Mental Health Sessional	1,060	1,060	0
L-SAA			
Occupancy	>97%	>97%	0


2020/2021
Lead Team Budgets
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Lead Team Budgets

	19/20 Budget	20/21 Budget	$ Variance	% Variance
President & Chief Executive Officer				
Cognitive Behaviour Therapy	$4,972,230	$5,086,170	$113,940	2.29%
CEO	$598,708	$602,009	$3,301	0.55%
Communications	$738,526	$843,531	$105,005	14.22%
Corp Client Relations	$146,243	$163,075	$16,832	11.51%
Strategic Planning	$270,654	$260,654	($10,000)	-3.69%
Total	**$6,726,361**	**$6,955,439**	**$229,078**	

Communications

0.5 Digital Media Coordinator

0.5 IMHR Communications Specialist

CBT offset by revenue

Corp Client Relations

Coordinator to Manager role change

Lead Team Budgets

	19/20 Budget	20/21 Budget	$ Variance	% Variance
Vice President - Patient Care Services, Professional Practice & Chief Nursing Executive				
Clinical Informatics	$508,461	$586,021	$77,560	15.25%
FTU - Ottawa	$12,413,616	$12,692,763	$279,147	2.25%
FTU - Brockville	$13,519,210	$13,333,380	($185,830)	-1.37%
LTC	$4,241,839	$4,208,712	($33,127)	-0.78%
Nursing Admin	$1,785,551	$1,865,175	$79,624	4.46%
Professional Practice	$955,512	$982,568	$27,056	2.83%
STU	$13,740,252	$14,014,323	$274,071	1.99%
VP Pt Care, Prof Practice & CNE	$380,695	$343,231	($37,464)	-9.84%
Total	**$47,545,136**	**$48,026,173**	**$481,037**	

Clinical Informatics

$43,900 Operating Costs

FTU Brockville

Elimination of team leads

Nursing Admin

Nurse Practitioner lead $12,500

Lead Team Budgets

	19/20 Budget	20/21 Budget	$ Variance	% Variance
Chief Operating Officer & Chief Financial Officer				
Board Funds	$117,622	$119,762	$2,140	1.82%
Depreciation	$5,883,670	$5,882,890	($780)	-0.01%
Diagnostic & Central Services	$1,661,312	$1,728,304	$66,992	4.03%
Division Admin	$10,084,811	$9,281,884	($802,927)	-7.96%
Division Admin – Legal	$704,610	$707,774	$3,164	0.45%
Facilities	$18,554,332	$18,460,191	($94,141)	-0.51%
Finance	$2,387,196	$2,541,933	$154,737	6.48%
Health Records & Admitting	$2,204,495	$1,965,891	($238,604)	-10.82%
Human Resources	$2,368,896	$2,415,457	$46,561	1.97%
Information Management	$6,148,281	$7,595,625	$1,447,344	23.54%
Learning & Development	$1,289,557	$1,334,876	$45,319	3.51%
Subtotal	$51,404,782	$52,034,587	$629,805	

Diagnostic & Central Services
Secretary position missing in 2019/20 budget

Division Admin
Mortgage Interest ($450,725)
Contingency ($193,398)
Insurance ($84,586)
Secretary 0.5 ($63,902)
Other ($10,316)

Finance
Analyst transferred from IMHR

Health Records & Admitting
Correcting of 2019/20 budget

Information Management

Shared Data Centre $542,125
EMR Depreciation $1,072,130

Learning & Development
Organization development position

Lead Team Budgets

	19/20 Budget	20/21 Budget	$ Variance	% Variance
Chief Operating Officer & Chief Financial Officer				
Subtotal from previous page	$51,404,782	$52,034,587	$629,805	
Municipal Taxes	$28,425	$28,425	$0	0.00%
PET/MRI	$2,659,535	$2,590,380	($69,155)	-2.60%
Pharmacy	$2,842,226	$2,979,693	$137,467	4.84%
Supply Chain	$870,465	$855,440	($15,025)	-1.73%
Volunteer Services	$212,916	$217,047	$4,131	1.94%
Workplace Safety	$1,163,391	$1,326,409	$163,018	14.01%
Data Analytics	$336,544	$547,848	$211,304	62.79%
Total	**$59,518,284**	**$60,579,829**	**$1,061,545**	**1.78%**

Pharmacy

Omnicell depreciation (funded)

Workplace Safety

Modified Work $118,583 (Budget to cover return to work)

Depreciation of software licenses $36,714 (funded)

Data Analytics

Director $153,720

Operating expenses $47,000

Lead Team Budgets

	19/20 Budget	20/21 Budget	$ Variance	% Variance
Vice President - Patient Care Services & Community Mental Health				
Central Intake	$595,441	$543,527	($51,914)	-8.72%
Community	$11,450,375	$11,511,166	$60,791	0.53%
ECT	$459,858	$499,639	$39,781	8.65%
Geriatric	$15,380,512	$15,153,709	($226,803)	-1.47%
Mood & Anxiety	$5,514,008	$5,774,657	$260,649	4.73%
OSI	$7,323,182	$7,308,214	($14,968)	-0.20%
Patient Flow	$372,825	$187,849	($184,976)	-49.61%
Project Mgmt & Pathways	$539,719	$391,552	($148,167)	-27.45%
Recovery	$2,751,168	$2,769,548	$18,380	0.67%
Schizophrenia	$8,733,591	$8,815,942	$82,351	0.94%
Subtotal	$53,120,679	$52,955,803	($164,876)	

Central Intake

0.5 Secretary

ECT

Med Surgical Supplies $8,000

0.36 RN $43,000

Mood & Anxiety

0.5 Director (prior year shared with Youth)

0.5 Manager (transfer from Patient Flow)

Patient Flow

0.5 Manager (transfer to Mood & Anxiety)

Project Mgmt & Pathways

1.0 Director (Position eliminated)

Lead Team Budgets

	19/20 Budget	20/21 Budget	$ Variance	% Variance
Vice President - Patient Care Services & Community Mental Health				
Subtotal from previous page	$53,120,679	$52,955,803	($164,876)	
Sleep Lab	$875,184	$906,329	$31,145	3.56%
SUCD	$5,350,117	$5,664,331	$314,214	5.87%
Telemedicine	$340,973	$342,236	$1,263	0.37%
VP Patient Care	$319,871	$295,707	($24,164)	-7.55%
Youth	$3,471,062	$3,538,902	$67,840	1.95%
CMHA Family Navigation	$354,960	$354,960	$0	0.00%
Total	**$63,832,846**	**$64,058,268**	**$225,422**	**0.35%**

SUCD

Meadowcreek Day Hosptial

VP Patient Care

(0.5) Secretary

Youth

1.0 FTE Director in 2020/21 vs 0.5 in 2019/20

Lead Team Budgets

Psychiatrist-in-Chief / Chief of Staff				
Clinical Teaching	$651,194	$658,044	$6,850	1.05%
Medical Administration	$10,205,139	$10,090,570	($114,569)	-1.12%
Institutional Ethics Committee	$4,968	$4,968	$0	0.00%
Risk and Patient Safety	$784,963	$805,490	$20,527	2.62%
Total	**$11,646,264**	**$11,559,072**	**($87,192)**	
IMHR	$2,139,989	$1,928,301	($211,688)	-9.89%
Grand Total	**$191,408,880**	**$193,107,082**	**$1,698,202**	**0.89%**

Risk and Patient Safety

Correction of 2019/20 budget

IMHR

President – IMHR/VP –Research - Royal $300,000 (Shared position IMHR/ROHCG)

Chief Operating Officer ($144,398) (Position eliminated)

Finance & Grants Officer ($102,732) (Position moved to finance)

Research Communications Specialist ($93,384) (Position moved to Communications)

HR Coordinator ($87,193) (Position moved to HR)

COLA and Step $18,830

Total ROHCG support $1,819,739

Expenses of $1,928,301 offset by revenue transferred from IMHR legal entity of $108,560


2020/2021 Budget
Revenue by Source
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Revenue by Source

Provincial Plan		
Ministry of Health and Long-Term Care		
Global Budget		115,785,202
Other Votes (unspent funds returned)		
Community Mental Health & Addictions	12,015,536	
Psychogeriatric Resource Consultants (Nurses)	1,348,193	
Clinical Teaching	531,936	
Psychiatric Stipend	245,353	
Municipal Taxes	28,425	
Youth Program	1,814,310	
Total Other Votes		15,983,753
Long Term Care (unspent funds returned)		
Royal Ottawa Place	3,520,267	
Behavioural Support Ontario	2,247,624	
Total Long Term Care		5,767,891
Subtotal		137,536,846

Revenue by Source (Cont'd)

Provincial Plan (Cont'd) Subtotal from previous page		137,536,846
Provincial Ministry of Children and Youth Services		
Family Court Clinic (unspent funds returned)	361,594	
Early Intervention (unspent funds returned)	85,761	
Provincial Ministry of Children and Youth Services (Total)		447,355
Provincial Ministry of Children and Youth Services – Justice Branch		
Family Court Clinic Young Offenders Assessments (unspent funds returned)		313,740
Provincial Ministry of Community Safety and Correctional Services		
Secure Treatment Unit (unspent funds returned)	17,389,984	
Psychiatric Sessionals (unspent funds returned)	339,914	
Telemedicine (unspent funds returns)	89,451	
Provincial Ministry of Community Safety and Correctional Services (Total)		17,819,349
Provincial Ministry of Community and Social Services		
FACT (unspent funds returned)		576,556
Provincial Plan (Total)		**156,693,846**

Revenue by Source (Cont'd)

Patient Revenue		
Federal Ministry of Veteran Affairs		
Operational Stress Injury Clinic (unspent funds returned)		9,453,855
Patient		
Yukon	1,000,000	
Quebec	512,534	
Nunavut	900,000	
OHIP (Diagnostic Services)	383,953	
ROP Residents	1,051,872	
Patient (Total)		3,848,359
Patient Revenue (Total)		**13,302,214**
Room Accommodation		
ROP		137,436
Room Accommodation (Total)		**137,436**

Revenue by Source (Cont'd)

Other Revenue		
ROMHC/BMHC	9,108,427	
Cognitive Behaviour Therapy (Received from CAMH)	5,086,170	
ROP	10,500	
Clinical Teaching Unit	118,064	
Youth	106,868	
IMHR (offset expenses incurred)	108,560	
PET/MRI (offset expenses incurred)	1,303,176	
Psychogeriatric Resource Consultants	17,493	
Telemedicine (offset expenses incurred)	153,199	
Women's Mental Health Resource Centre (offset expenses incurred)	228,243	
Other Revenue (Total)		**16,240,700**

Revenue by Source (Cont'd)

Grant Amortization		
ROMHC/BMHC (Building and Equipment)	7,636,276	
ROP (Building and Equipment)	146,550	
Grant Amortization (Total)		**7,782,826**
Total Revenue		**194,157,082**


2020/2021 Budget
% Summary
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2020/21 Budget % Summary

	19/20 Budget	19/20%	20/21 Budget	20/21%
Provincial/Federal Government	$180,628,905	93.88%	$179,016,698	92.20%
Non-Government	$11,779,623	6.12%	$15,140,384	7.80%
Total Revenue	$192,408,528	100.00%	$194,157,082	100.00%
Salaries & Benefits	$124,123,947	64.85%	$124,771,754	64.61%
Medical Staff	$12,855,924	6.72%	$12,760,755	6.61%
Medical & Surgical	$621,491	0.32%	$637,787	0.33%
Drugs	$1,781,639	0.93%	$1,875,194	0.97%
Utilities	$237,297	0.12%	$237,297	0.12%
Food Service / Housekeeping & Laundry	$1,186,110	0.62%	$1,183,555	0.61%
Maintenance of Building & Equipment	$3,106,544	1.62%	$3,076,592	1.59%
Insurance	$822,707	0.43%	$723,292	0.37%
Leases	$867,570	0.45%	$876,401	0.45%
Property Rental	$3,118,697	1.63%	$3,139,697	1.63%

2020/21 Budget % Summary cont'd

	19/20 Budget	19/20%	20/21 Budget	20/21%
Contracted Out	$15,998,178	8.36%	$15,918,510	8.24%
Travel & Education	$1,502,021	0.78%	$1,613,258	0.84%
Professional & Management Fees	$4,431,646	2.32%	$4,921,771	2.55%
Stationary/Photo/Printing	$683,360	0.36%	$675,013	0.35%
Software Lic/Data Comm/Long Distance	$2,140,527	1.12%	$2,228,094	1.15%
Interest on Capital Lease	$5,782,482	3.02%	$5,304,394	2.75%
Other	$3,287,077	1.72%	$3,275,268	1.70%
Depreciation	$8,861,663	4.63%	$9,888,450	5.12%
	$191,408,880	100.00%	$193,107,082	100.00%
Net Surplus / (Deficit)	**$999,648**		**$1,050,000**	


2020/2021
Capital Budget
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Site Overview

Royal Ottawa Mental Health Centre (ROMHC)

- P3 contract and building renovations and major equipment such as elevator, mechanical & electrical covered by a Life Cycle Fund.
- Current Balance (Nov 2019) in Life Cycle Fund is $12.3 Million

Royal Ottawa Place – ROP

- On site at ROMHC but was not part of the P3 contract
- The centre was built with borrowed funds & all capital renovations & building operations are the responsibility of ROHCG
- Current (Nov 2019) outstanding loan balance is $3.7 Million

Site Overview (Continued)

Brockville Mental Health Centre (BMHC)

- Buildings on this site are leased from Infrastructure Ontario

Secure Treatment Unit (STU)

- Owned by Infrastructure Ontario and leased to Corrections
- We provide clinical care only under contract with the Ministry of the Solicitor General

Forensic Treatment Unit Building, Government Services Building, Centennial Hall, and Maintenance Building

- Under lease from Infrastructure Ontario

Site Overview (Continued)

Carlingwood Shopping Centre (Community Teams)

- This space is leased

Other locations (Kingston, Arnprior)

- These spaces are leased

EHR and Joint Projects

Project Name - EHR	Estimated Total Budget	Projected to Y/E	Shared Projects 2020/21	Projected Balance
EHR – Other	490,000	65,988		
EHR – Standardization	565,557	221,734		
EHR – Infrastructure	2,033,000	743,609		
EHR – Software	2,255,218	1,668,267		
EHR – Implementation	4,754,173	4,100,402		
Infrastructure Refresh			456,000	
Expanse/Web Ambulatory			458,989	
Shared BI Tool Implementation			159,980	
Subtotal	10,097,948	6,800,000	1,074,969	2,222,979

Capital Equipment / Projects

Project Name - Capital Equipment Projects	Location	Estimated Total Budget	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	After 5 Years
Lower roof	ROP-LTC	200,000			200,000			
Elevators replacement	ROP-LTC	800,000						800,000
Hot Water tanks	ROP-LTC	125,000			125,000			
Roof Top HVAC units	ROP-LTC	800,000	800,000					
Hallway floors replacement	ROP-LTC	125,000					125,000	
Exterior doors	ROP-LTC	75,000			75,000			
HVAC in dining rooms	ROP-LTC	150,000		150,000				
Exterior lot and entrance lighting - LED	ROP-LTC	10,000		10,000				
Interior hallway light replacement to LED	ROP-LTC	35,000		35,000				
Subtotal		2,320,000	800,000	195,000	400,000	-	125,000	800,000

Capital Equipment / Projects (Continued)

Project Name - Capital Equipment Projects	Location	Estimated Total Budget	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	After 5 Years
Subtotal from previous page		2,320,000	800,000	195,000	400,000	-	125,000	800,000
Ceiling Lift Tracks	ROP-LTC	30,000	30,000					
Conference room door replacement	ROP-LTC	18,000		18,000				
Bathroom counter replacement	ROP-LTC	80,000		80,000				
Arjo lift track system	ROP-LTC	150,000		150,000				
Nurse call system upgrade	ROP-LTC	160,000		160,000				
Backflow preventer	ROP-LTC	35,000		35,000				
Convert one shower room into a bath and shower	BMHC	15,000	15,000					
Equipment storage space	Geriatric	15,000		15,000				
Call bell system	SUCD	80,000		80,000				
Subtotal		2,903,000	845,000	733,000	400,000	-	125,000	800,000

Capital Equipment / Projects (Continued)

Project Name - Capital Equipment Projects	Location	Estimated Total Budget	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	After 5 Years
Subtotal from previous page		2,903,000	845,000	733,000	400,000	-	125,000	800,000
Create new office space	FTU Ottawa	27,000		27,000				
Main staff parking lot (Repaving)	ROMHC Lands	700,000				700,000		
Renovation to expand # of beds in special care environment of Geriatric south	Geriatrics	80,000	80,000					
Total		**3,710,000**	**925,000**	**760,000**	**400,000**	**700,000**	**125,000**	**800,000**

Technology Projects

Project Name - Technology	Location	Estimated Total Budget	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	After 5 Years
Electronic Requisition (Software)	Supply Chain	155,000			155,000			
ESP Enhancement - Check In Kiosk (Software)	HR	595,000			595,000			
Finance and Payroll Upgrade	Corporate	500,000	234,830	265,170				
Aptean (Ross Archiving)	Corporate	45,000	45,000					
Process and Forms Automation - Scanning	Clinical Records	150,000			150,000			
Workload Measurement Replacement	Prof Practice	300,000				300,000		
Community Wide Scheduling	Clinical	225,000	225,000					
MH HIS Meditech Patient Portal	Corporate	300,000	300,000					
IT Projects – Infrastructure Support (servers / network equipment)	Corporate	100,000	100,000					
Subtotal		2,370,000	904,830	265,170	900,000	300,000	-	-

Technology Projects (Continued)

Project Name – Technology (Continued)	Location	Estimated Total Budget	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	After 5 Years
Subtotal from previous page		2,370,000	904,830	265,170	900,000	300,000	-	-
Data Quality & Analytics Framework and Development (Partnership)	Corporate	100,000		100,000				
Auto Fax	Corp	100,000	100,000					
Call Pilot Voicemail Replacement	Corp	150,000			150,000			
Corporate Server Refresh**inc Blade Capacity	IT	175,000					175,000	
Disaster Recovery	Corporate	150,000		150,000				
Hardware, Operating System and Office Upgrade	Corporate	2,800,000						2,800,000
PBX (Phone) Upgrade - Cloud Based	Corporate	300,000			300,000			
SAN Replacement Requirements	IT	75,000	50,000				25,000	
Dictation System Upgrade	Clinical Records	25,000				25,000		
Subtotal		6,245,000	1,054,830	515,170	1,350,000	325,000	200,000	2,800,000

Technology Projects (Continued)

Project Name – Technology (Continued)	Location	Estimated Total Budget	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	After 5 Years
Subtotal from previous page		6,245,000	1,054,830	515,170	1,350,000	325,000	200,000	2,800,000
Signalling Servers Replacement	IT	35,000					35,000	
UPS Battery Back Up Replacement	IT	50,000					50,000	
Active Directory Upgrade	Corporate	150,000					150,000	
MS Exchange Upgrade (email)	Corporate	200,000					200,000	
TMG Replacement	Corporate	15,000		15,000				
Network Switch Refresh	Corporate	500,000		150,000	100,000	100,000	150,000	
Remote Wireless Upgrade (Aruba Sites)	Corporate	250,000						250,000
Enterprise SQL Replacement	Corporate	175,000					175,000	
eLearning Development	Learn & Dev	75,000		75,000				
Clear PASS Securtiy Software	Corporate	175,000		175,000				
Security Awareness Software	Corporate	120,000			120,000			
SIEM Security Software	Corporate	120,000			120,000			
Break/Fix Devices (not project, but capital)	Corporate	300,000		75,000	75,000	75,000	75,000	
Total		**8,410,000**	**1,054,830**	**1,005,170**	**1,765,000**	**500,000**	**1,035,000**	**3,050,000**

Equipment

Equipment	Location	Estimated Total Budget	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	After 5 Years
Bed replacement	ROMHC/BMHC	500,000					500,000	
Unit furniture	ROMHC/BMHC	200,000					200,000	
Furniture/Equipment	ROMHC/BMHC	400,000			100,000	100,000	100,000	100,000
Pasteurmatic Mchine for Medical Devis Reprocssing	ROMHC/BMHC	50,000	50,000					
Blood Pressure Machines	SUCD	6,800	6,800					
Furniture	Geriatric	4,000	4,000					
Network Accessible Storage System	IMHR	6,500	6,500					
Digital Radiography	Central Services	100,000		100,000				
PACS monitors	Central Services	22,000		22,000				
MacPro Computer	Communications	7,500	7,500					
11 8TB Server and 4 Axis Cameras	FTU – Ottawa	22,650	22,650					
Subtotal		1,319,450	97,450	122,000	100,000	100,000	800,000	100,000

Equipment (Continued)

Equipment	Location	Estimated Total Budget	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	After 5 Years
Subtotal from previous page		1,319,450	97,450	122,000	100,000	100,000	800,000	100,000
Portable basketball setup	Gym	5,676	5,676					
Wipeable walls for cubicles	Diagnostics	4,668	4,668					
Bath lifts	ROP	20,000						20,000
Nustep recumbent cross trainer	ROP	6,500		6,500				
Air mattress for paliative care	ROP	8,000		8,000				
Blinds	ROP	20,000		20,000				
Vertical autoclave	Infection Control	37,585		37,585				
True Reach In Freezer	Nutrition and Food	5,000		5,000				
Rational Combi Oven	BMHC Dietary	18,000	18,000					
Fitness equipment	Recreation	60,000		30,000	30,000			
Total		**1,504,879**	**125,794**	**229,085**	**130,000**	**100,000**	**800,000**	**120,000**

Capital Budget Summary

	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
Requests:					
Capital Projects	925,000	760,000	400,000	700,000	125,000
Technology Projects	1,054,830	1,005,170	1,765,000	500,000	1,035,000
Equipment	125,794	229,085	130,000	100,000	800,000
Total	2,105,624	1,994,255	2,295,000	1,300,000	1,960,000
Funding:					
Net Depreciation	2,105,624	2,589,443	2,563,010	2,712,347	2,776,575
Royal Ottawa Foundation					
Other – One time					
Total	2,105,624	2,589,443	2,563,010	2,712,347	2,776,575
Working Capital Impact (excluding EHR)	-	595,188	268,010	1,412,347	816,575
EHR Cost	1,074,969				
EHR Funding	250,000	250,000	250,000	250,000	250,000
Working Capital Impact - EHR	(824,969)	250,000	250,000	250,000	250,000
Working Capital Impact (including EHR)	(824,969)	845,188	518,010	1,662,347	1,066,575

The Royal Ottawa Mental Health Centre | University of Ottawa Institute of Mental Health Research | The Royal Ottawa Foundation for Mental Health | Brockville Mental Health Centre | 71 | The Royal Mental Health - Care & Research

$7,782,825 of Depreciation funded through Grant revenue

$2,105,624 of Depreciation funded through Global funding

ROP Specialty designated may include one time capital funding which could be used to offset the cost of the HVAC system.

We have allocated capital items to specific years but would review timing of items in 2021/22 and beyond based on available funding option.


3 Year Forecast – Operating
(Based on Funding of 0%, 1%, 2%)
The Royal Ottawa Mental Health Centre
University of Ottawa Institute of Mental Health Research
The Royal Ottawa Foundation for Mental Health
Brockville Mental Health Centre
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3 Year Forecast

$ in 000's	2019/20	2020/21			2021/22			2022/23		
	Final Balance	0%	1%	2%	0%	1%	2%	0%	1%	2%
Provincial Revenue - Global	108.76	108.70	109.79	110.88	108.70	110.89	113.09	108.70	112.00	115.36
Provincial Revenue - Non Global	44.11	44.47	44.47	44.47	44.03	44.03	44.03	43.58	43.58	43.58
Other Revenue	31.95	33.42	33.42	33.42	30.44	30.44	30.44	29.99	29.99	29.99
Total Revenue	**184.83**	**186.59**	**187.68**	**188.77**	**183.17**	**185.36**	**187.56**	**182.28**	**185.57**	**188.93**
Compensation	129.52	130.44	130.44	130.44	131.92	131.92	131.92	133.21	133.21	133.21
Other Expenses	50.59	51.78	51.73	51.73	50.78	50.78	50.78	49.83	49.83	49.83
Total Expenses	**180.11**	**182.22**	**182.17**	**182.17**	**182.70**	**182.70**	**182.70**	**183.05**	**183.05**	**183.05**
Surplus / (Deficit) from operations excl ROP & IMHR	**4.72**	**4.37**	**5.50**	**6.59**	**0.47**	**2.66**	**4.86**	**(0.77)**	**2.53**	**5.89**
Long Term Care Deficit	(1.61)	(1.51)	(1.51)	(1.51)	(1.63)	(1.63)	(1.63)	(1.67)	(1.67)	(1.67)
IMHR Deficit	(2.11)	(1.82)	(1.82)	(1.82)	(1.82)	(1.82)	(1.82)	(1.82)	(1.82)	(1.82)
Surplus / (Deficit) from Operations	1.00	1.05	2.13	3.22	(2.98)	(0.79)	1.42	(4.26)	(0.96)	2.40
PET/MRI	0.00	0.00	0.00	0.00	(0.55)	(0.55)	(0.55)	(0.66)	(0.66)	(0.66)
Surplus / (Deficit)	**1.00**	**1.05**	**2.13**	**3.22**	**(3.53)**	**(1.34)**	**0.86**	**(4.92)**	**(1.62)**	**1.74**
Capital Contirbution	1.00	1.05	1.05	1.05	0.75	0.75	0.75	0.60	0.60	0.60
Total Shortfall	**0.00**	**0.00**	**1.08**	**2.17**	**(4.28)**	**(2.09)**	**0.11**	**(5.51)**	**(2.22)**	**1.14**

Assumptions:

- Salary based on union agreements – expiring as follows
- CUPE 1.65% (expires Sept 29, 2021)
- ONA 1% (expires March 31, 2020)
- OPSEU BMHC 1.75% (expires March 31, 2022)
- OPSEU ROMHC 1.75% (expires March 31, 2022)
- Non-Union 1%
- Salary increase of 1% reflected in 2022/23 for all union groups

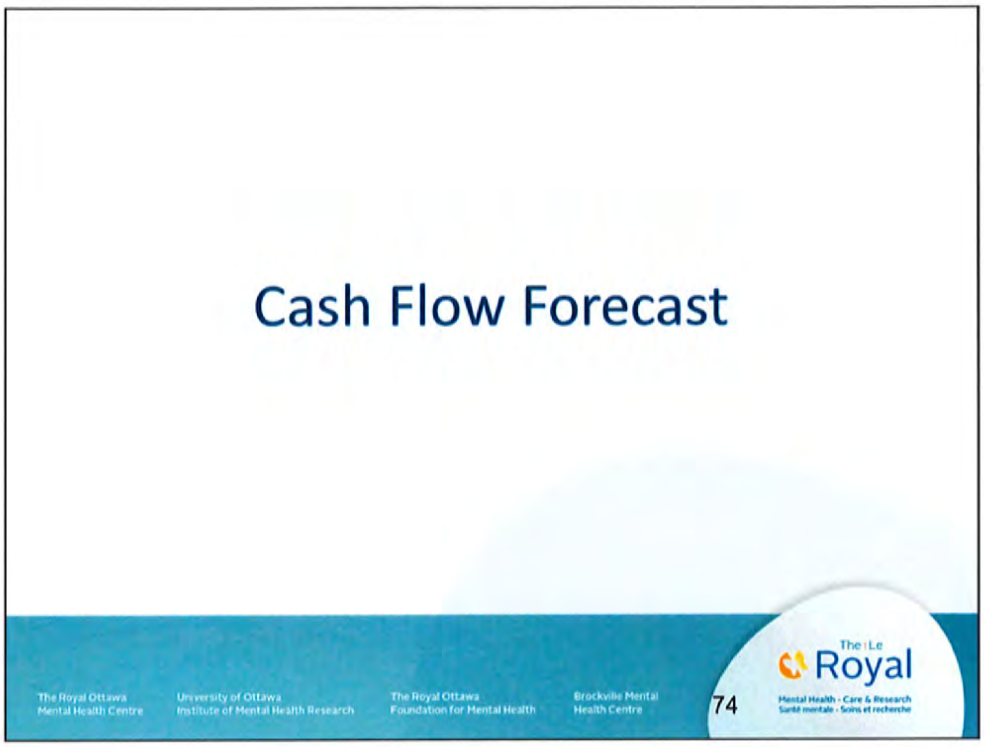
- Benefit increase 2% per year
- Med/Surg expense 2% per year
- Drugs 2.0% per year
- Other Operating Expense 1% per year
- Other Fund Types and Ministry of Health Other Votes excluding Long Term Care and Youth break even
- Improving Access to Structures Psychotherapy $5 million permanent funding assumed

Risks

- Unknown re: future government funding
- Long Term Care $1.6 million deficit
- IMHR $1.8 million annualized funding contribution
- PET/MRI deficits beginning in 21/22
- Vacancy factor of $1.5 million

Major Contracts

- Secure Treatment Unit - November 2018 to October 2023
- Operational Stress Injury Clinic - current agreement expires March 31, 2022
- Nunavut – Successful in new RFP


Cash Flow Forecast
The Royal Ottawa Mental Health Centre
University of Ottawa Institute of Mental Health Research
The Royal Ottawa Foundation for Mental Health
Brockville Mental Health Centre
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ROHGC Budgeted Cash Flow	2019-20	2020-21	
Operating activities			
Excess of revenue over expenses	999,649	1,050,000	
Items not affecting cash:			
Amortization of deferred capital asset contributions	(7,422,572)	(7,782,826)	Note 2
Amortization of capital assets	8,860,667	9,888,450	Note 2
Loss (gain) on disposal of capital assets	-	-	Note 1
Decrease in due to external parties – vested benefits	(61,215)	(61,215)	
Increase in employee future benefits	275,760	275,760	
Change in non-cash working capital items	4,743,221	138,681	Note 8
Change in operating activities	7,395,510	3,508,850	
Increase in deferred capital asset contributions	9,595,783	9,005,285	Note 3
Purchase of capital assets	(5,116,642)	(3,180,593)	Note 2
Proceeds on sale of capital assets	-	-	Note 1
Change in capital activities	4,479,141	5,824,692	
Increase in long term debt	-	-	Note 4
Increase in deferred revenue	1,468,621	1,574,980	Note 7
Principle repayments on long term debt	(9,309,631)	(9,909,101)	
Change in financing activities	(7,841,010)	(8,334,121)	
Net change in short term investments	(1,860,146)	(775,000)	Note 5
Net change in long term investments	145,000	145,000	Note 6
Change in investing activities	(1,715,146)	(630,000)	
Increase (decrease) in cash	2,318,495	369,421	

1. No capital assets of significant value to be disposed of.
2. Agrees to capital budget summary
3. Includes deferred contributions to offset capital purchases as well as Ministry of Health contributions for the ROMHC and ROP buildings
4. Assumes no additional long term debt required
5. Assumes interest income will be reinvested, assumes investments will be sold to cover cash shortfalls
6. Assumes interest income will be reinvested offset by life cycle spending
7. Equivalent to MOHLTC funding for deferred portion of life cycle reserve
8. 19/20 based on November balance sheet, following years assumes AP and AR remain constant

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 34	**Priority:** Important

DATE: February 20, 2020

COMMITTEE: Finance Committee

PRESENTER: J. Gallant

SUBJECT: IMHR Budget

BACKGROUND INFORMATION:

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT as recommended by the Finance Committee, the IMHR Non-Research Activity Budget for 2020-2021 be approved, as presented

CARRIED

Moved by:

Seconded by:

Motion approved:

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IMHR
Budget 2020/21
Global

University of Ottawa IMHR
ROHCG Budget Managed by the UofO IMHR
(Not included in Legal Entity)
2020/21 Budget

	2019/2020 Total Year Budget (in Thousand $)	2020/2021 Total Year Budget (in Thousand $)	Variance (in Thousand $)
Sources of Funding			
ROHCF	0	0	0
Gov't. Fed. CIHR	0	0	0
Gov't. Fed. Other (CRC)	0	0	0
Gov't Prov	0	0	0
UMRF & UofO Chair in Mood	0	0	0
Non-Gov't Organizations	0	0	0
International - peer reviewed	0	0	0
Other (Fed.Ind O/H Program)	30	108	78
ROHCG Support	2,110	1,820	(290)
Photocopy recovery/Salary Recovery	0	0	0
Loss on disposal of assets	0	0	0
Amortization of Deferred Revenue	0	0	0
Total Sources of Funding	2,140	1,928	(212)
Expenses			
Research Expenses			
Salary & Benefits	944	873	(71)
Operating Expenses	18	17	(1)
Sub Total - Research Expenses	962	890	(72)
Non-Research Expenses			
Salary & Benefits	1,035	894	(141)
Operating Expenses	143	144	1
Sub total operating expenses	1,178	1,038	(140)
Total Operating Expenses	2,140	1,928	(212)
Surplus (Deficit) before depreciation	0	0	0
Depreciation Expense			0
Net Surplus (Deficit)	0	0	0

Budget Assumptions

ROHCG Global Funding to IMHR will decrease by 13.75%, from $2.110M to $1.820M (results in decrease of $290,078 to IMH

$108,560 from Legal Entity Federal Indirect Overheads to balance deficit

1.0 fte Finance and Grants Officer, 1.0 fte HR Administrator and .50 fte Communcations Officer moved to the ROHCG's administrative departments

Cost of Living Allowance (COLA) increase 1.0%

Research Salary and Benefits	873
Non-Research Salary and Benefits	894
Total Salaries & Benefits	1,767

April 1st start date for President and Youth Research Unit Director

President positon budgeted from ROHCG budget managed by U of O IMHR. Offset by COO positon remvoed from the budge

Operating Expenses remain the same as previous year

Research Salary and Benefits	17
Non-Research Salary and Benefits	144
Total Operating Expenses	161

Budget balanced - consistent with sustainability work

Salaries & Benefits

Position	FTE	Cost Centre (Short Code)	2019/2020	2020/2021
Chief Operating Officer	1.00	A1109100	192,386	
President	1.00	A1109100		300,001
Administrative Assistant	0.20	A1109100	17,458	18,101
Executive Assistant	1.00	A1109100	95,199	98,601
HR Coordinator	1.00	A1109100	87,193	
Finance & Grants Administrative Officer	1.00	A1109100	102,732	
Research Lab Manager	1.00	A1109100	111,707	115,708
Research Communications Specialist	1.00	A1109100	93,384	
			10,000	7,500
Project Director	1.00	A1109100	135,749	161,719
		A1109100 Total	**$ 845,808**	**$ 701,630**
REB Secretary III	0.80	A3069000	58,906	60,326
Clinical Research Support Manager	1.00	A3069000	130,056	132,386
		A3069000 Total	**188,962**	**192,713**
Youth - Research Unit Director	1.00	A3069050	254,990	
Youth - Research Unit Director				257,005
		A3069050 Total	**$ 254,990**	**$ 257,005**
Sleep & Neuro	0.00	A4759000	50,000	
Sleep & Neuro	0.00	A4759000	6,667	
		A4759000 Total	**56,667**	**-**
Mood- Secretary VII	0.34	A4759002	25,679	26,296
		A4759002 Total	**$ 25,679**	**$ 26,296**
Forensics - Research Unit Director			110,000	120,000
		A4759028 Total	**110,000**	**120,000**
Research - Secretary VII	0.33	A7109000	24,924	25,523
Scientist	1.00	A7109000	-	123,300
Research Technician	1.00	A7109000	52,510	
		A7109000 Total	**$ 77,434**	**$ 148,823**
Scientist	0.50	A7109200	73,556	
Research - Secretary 2	0.33		24,924	-
		A7109200 Total	**98,480**	**-**
Brain Imaging - Research Unit Director	1.00	A7109100	75,000	75,000
		A7109100 Total	**75,000**	**75,000**
Research Unit Director	1.00	A7109500	216,751	220,636
Research - Secretary 2	0.33	A7109500		25,523
			216,751	**246,159**
		Total	**$ 1,949,770**	**$ 1,767,626**
		COLA	**$ 29,546**	
		Grand Total	**$ 1,979,316**	**$ 1,767,626**

Total Research	944,546	873,284
Total Non Research	1,034,770	894,342
	1,979,316	1,767,626

IMHR Global Budget
For 2020/2021

Operating Expenses

Short Code	Program/Unit	Sub-Account	Description	2019/2020 Budget	2020/2021 Budget
A1109100	IMHR Admin	74951000	General operating & supplies	$3,000	$8,000
		74100000	Printing, stationery, off sup	$4,500	$4,500
A1109100	IMHR Admin	74952010	Off Site Record Storage	$750	$750
A1109100	IMHR Admin	76101500	Delivery/Courier	$1,000	$1,000
A1109100	IMHR Admin	76103010	Staff Development	$5,900	$5,900
A1109100	IMHR Admin	76240010	Travel & Business expenses	$15,117	$15,117
A1109100	IMHR Admin	76504020	Legal Fees	$10,000	$15,000
		76509000	Professional Fees - other	$13,000	$20,000
A1109100	IMHR Admin	76700020	Advertising & Recruitment	$500	$500
A1109100	IMHR Admin	76950095	Catering	$6,000	$6,000
A1109100	IMHR Admin	77600010	IT/Telecomm Services & equipmer	$2,500	$2,500
A1109100	IMHR Admin	77600025	Cell Phone	$2,500	$2,500
A1109100	IMHR Admin	77600030	Equipment Leases	$22,000	$22,000
A1109100	IMHR Admin	76950085	photocopying charges	$16,000	
A1109100 Total				**$102,767**	**$103,767**
		74100000	Printing, stationery, off sup	$2,500	$2,500
A1109002	Communications	76102000	Long distance and telegrams	$2,500	$2,500
A1109002	Communications	76509000	Professional fees - other	$35,000	$35,000
A1109002 Total				**$40,000**	**$40,000**
A3069000	Ethics	74951000	General operating & supplies	$0	$0
A3069000	Ethics	76950095	Catering	$0	$0
A3069000 Total				**$0**	**$0**
A7109003	Stress & Anxiety	74951000	General operating & supplies	$1,206	$1,206
A7109003 Total				**$1,206**	**$1,206**
A7109200	Translational Neuroscience Unit	74951000	General operating & supplies	$500	
A7109200	Translational Neuroscience Unit	77600025	cell phones	$500	
A7109200 Total				**$1,000**	**$0**
A3069050	Youth Unit	74951000	General operating & supplies	$1,000	$1,000
A3069050 Total				**$1,000**	**$1,000**
A4759002	Mood Unit	74951000	General operating & supplies	$200	$200
A4759002	Mood Unit	74606000	medical and surgical supplies	$500	$500
A4759002	Mood Unit	76101500	Delivery/Courier	$200	$200
A4759002	Mood Unit	74100000	printing, stationery, off sup	$0	$0
A4759002	Mood Unit	74101030	Administrative Forms	$100	$100
A4759002 Total				**$1,000**	**$1,000**
A4759028	Forensic Unit	74951000	General operating & supplies	$1,000	$1,000
A4759028 Total				**$1,000**	**$1,000**
A7109000	IMHR Research		lab inspection fees	$2,500	$2,500
A7109000	IMHR Research	76509000	Professional Fees - Other	$7,200	$7,200
A7109000	IMHR Research	74951000	General operating & supplies	$1,000	$1,000
A7109000 Total				**$10,700**	**$10,700**
A7109100	Brain Imaging	76402000	Data communication charges	$1,000	$1,000
A7109100 Total				**$1,000**	**$1,000**
A7109400	Suicide Prevention	74951000	General operating & supplies	$1,000	$1,000
A7109400	Suicide Prevention			**$1,000**	**$1,000**
Grand Total				**$160,673**	**$160,673**

Research Opeating Supplies	17,906	16,906
Non-Research Operating Supplies	142,767	143,767
	$160,673	$160,673

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Mental Health - Care & Research
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IMHR
Budget 2020/21
Legal Entity

University of Ottawa IMHR
University of Ottawa Institute of Mental Health Research
Legal Entity Board Restricted Funds Budget
2020/21

	Annual (in Thousands $)
Sources of Funding	
Administration - Interest Income	225
Administration -Other Income	162
Total Sources of Funding	**387**
Non-Research Expenses	
Operating Expenses	387
Sub total Non-Research Expenses	**387**
Net Surplus (Deficit)	**0**

Note:

1 Variable Costs

Website enhancement, support and translation	12
Other operating expenses	130
Total	**142**

Fixed Costs

Support to Chair in Suicide Prevention	32
Support to eRIMH scientists	213
	245

2 Funding for Presient's positon moved to ROHCG manged by UofO IMHR

3 Excludes grant revenue and expenses as per process approved by IMHR Board due to unpredictability of timing of research activity. Recognized research revenue is approximately $5 million per year.

4 Budget balanced - consistent with sustainability work

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 35	**Priority:** Important

DATE: February 20, 2020

COMMITTEE: Finance Committee

PRESENTER: J. Gallant

SUBJECT: H-SAA and M-SAA Accountability Agreements

BACKGROUND INFORMATION:

Accountability Agreements:

- Hospital Service Accountability Agreement (H-SAA)
- Multi-Sector Accountability Agreement (M-SAA).

The H-SAA and M-SAA agreements were sent by the Champlain LHIN with a time sensitivity to have them signed and received back by March 15, 2020. The purpose of the amending agreements is to extend the current agreements for an additional three months to June 30, 2020.

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT the Board of Trustees authorizes the Board Chair and President & CEO to sign the H-SAA amending agreement to extend the current agreements for an additional three months to June 30, 2020.

BE IT ALSO RESOLVED THAT the Board of Trustees authorizes the Board Chair and President & CEO to sign the M-SAA amending agreement to extend the current agreements for an additional three months to June 30, 2020.

CARRIED

Moved by:

Seconded by:

Motion approved:

Champlain LHIN | RLISS de Champlain

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Ottawa, ON K1J 1A3
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February 6, 2020

Dr. Joanne Bezzubetz
President & Chief Executive Officer
Royal Ottawa Health Care Group
1145 Carling Avenue
Ottawa, ON K1Z 7K4

Dear Dr. Bezzubetz,

As the Interim Chief Executive Officer of Ontario Health indicated on November 14, 2019, it is expected that your 2020/21 Hospital Service Accountability Agreement (HSAA) will be with Ontario Health. This letter provides further information on the process, timeline and plan going forward.

Attached please find a Notice of Amendment and an Amending Agreement with respect to your HSAA to extend it to June 30, 2020 with minimal amendments to reflect legislative changes and to simplify the anticipated transition of the HSAA to Ontario Health from your LHIN. You are asked to have the Amending Agreement duly signed on behalf of your hospital and returned to Elizabeth Woodbury, Director, Health System Accountability at ch.accountabilityteam@lhins.on.ca no later than March 15, 2020. While your HSAA will remain with the LHIN, as of March 31, 2020, it is our expectation that your HSAA will be transferred to Ontario Health by Minister's transfer order. The three-month extension will help to enable changes to the HSAA that will address the Ministry of Health and Ontario Health priorities.

Ontario Health and the LHINs are working closely to effect a smooth transition process and have consulted with the Ontario Hospital Association. Until you are notified otherwise, the Champlain LHIN and your usual LHIN contact will be responsible for the administration of your HSAA. Please continue to direct all communications to that person.

Yours sincerely,

Renato Discenza
Chief Executive Officer

cc. Matthew Anderson, CEO, Ontario Health

Attach (2): (1) Notice of Amendment and (2) HSAA Amending Agreement

Ontario

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February 6, 2020

DELIVERED BY EMAIL to: joanne.bezzubetz@theroyal.ca

Dr. Joanne Bezzubetz
President & Chief Executive Officer
Royal Ottawa Health Care Group
1145 Carling Avenue
Ottawa, ON K1Z 7K4

Dear Dr. Bezzubetz,

LHSIA S.20 NOTICE

The *Local Health System Integration Act, 2006* requires the Champlain Local Health Integration Network (the "LHIN") to notify a health service provider when the LHIN proposes to enter into, or amend, a service accountability agreement with that health service provider.

The LHIN hereby gives notice that it proposes to amend one or more existing service accountability agreements currently in effect between the LHIN and your organization, on or before March 31, 2020.

Should you have any questions, please contact your LHIN Senior Accountability Specialist.

Sincerely yours,

Renato Discenza
Chief Executive Officer

Cc: Anne Graham, Chair of the Board, Royal Ottawa Health Care Group
James Fahey, Interim Vice President, Integration, Accountability, Communications and Engagement

Ontario

HSAA AMENDING AGREEMENT

THIS AMENDING AGREEMENT (this "Agreement") is made as of the 31st day of March, 2020.

B E T W E E N:

CHAMPLAIN LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

AND

ROYAL OTTAWA HEALTH CARE GROUP (the "Hospital")

WHEREAS the LHIN and the Hospital (together the "Parties") entered into a hospital service accountability agreement that took effect April 1, 2018 (the "HSAA");

AND WHEREAS the Parties wish to amend the HSAA in the manner set out in this Agreement;

NOW THEREFORE in consideration of mutual promises and agreements contained in this Agreement and other good and valuable consideration, the Parties agree as follows:

1.0 Definitions. Except as otherwise defined in this Agreement, all terms shall have the meaning ascribed to them in the HSAA. References in this Agreement to the HSAA mean the HSAA as amended.

2.0 Amendments.

2.1 Agreed Amendments. The HSAA is amended as follows.

a) All references to "LHIN" are deleted and replaced with "Funder", with the exception of the defined term "LHIN" as a party to the agreement, and section 7.1.1 "will be aligned with the LHIN's current integrated health service plan" which remain unamended.

b) The first four paragraphs of the part of the HSAA entitled "Background" are deleted and replaced with the following.

"This service accountability agreement is entered into pursuant to the *Local Health System Integration Act, 2006*, with the expectation that it will be transferred by means of a transfer order issued by the Minister of Health under the *Connecting Care Act, 2019* (the "CCA"), from the LHIN as funder to Ontario Health, which is a Crown agency which, pursuant to the CCA, has the power to provide funding to health service providers and integrated care delivery systems in respect of health services.

The Hospital and the Funder are committed to working together, and with others, to achieve evolving provincial priorities including building a connected and sustainable health care system centred around the needs of patients, their families and their caregivers.

In this context, the Hospital and the Funder agree that the Funder will provide funding to the Hospital on the terms and conditions set out in this Agreement to enable the provision of services to the health system by the Hospital."

c) All references to "LHSIA" are deleted and replaced with "the Enabling Legislation", with the exception of the defined term "LHSIA" in section 1.1, and section 7.1.1 in reference to the integrated health service plan as defined in LHSIA which remains unamended.

d) The defined term "MOHLTC" and its definition are deleted and replaced with the following.

"***Ministry*** means, as the context requires, the Minister or the Ministry of Health and Long-Term Care or such other ministry as may be designated in accordance with Applicable Law as the ministry responsible in relation to the relevant matter or the Minister of that ministry, as the context requires;".

e) All references to "MOHLTC" are deleted and replaced with "Ministry".

In addition to the foregoing, the HSAA is further amended as follows.

f) In section 1.1, the definition of "Accountability Agreement" is amended by deleting ", currently referred to as the "Ministry LHIN Accountability Agreement"".

g) In section 1.1, the definition of “Applicable Policy” is amended by deleting “Local Health Integration Network” and replacing it with “local health integration networks”.

h) In section 1.1, the definition of “Digital Health” is deleted and replaced with:

“***Digital Health*** means the coordinated use of digital technologies to electronically integrate points of care and transform the way care is delivered, in order to improve the quality, access, productivity and sustainability of the healthcare system;”.

i) In section 1.1, the definition of “Digital Health Board (DBH)” is deleted.

j) In section 1.1, the definition of “Indemnified Parties” is amended by deleting “her Majesty the Queen in Right of Ontario and her Ministers,” and replacing it with “Her Majesty the Queen in right of Ontario and Her Ministers,”.

k) The following definitions are added to section 1.1:

“***CCA*** means the *Connecting Care Act, 2019*, and the regulations under it, as it and they may be amended from time to time;”

Article 1. “***Enabling Legislation*** before the date a Transfer Order takes effect means LHSIA, and after the date a Transfer Order takes effect means the CCA;”

“***Funder*** before the date a Transfer Order takes effect means the LHIN, and after the date a Transfer Order takes effect means Ontario Health;”

“***Minister*** means such minister of the Crown as may be designated as the responsible minister in relation to this Agreement or in relation to any subject matter under this Agreement, as the case may be, in accordance with the *Executive Council Act*, as amended;”

“***Ontario Health*** means the corporation without share capital under the name Ontario Health as continued under the CCA;”

Article 2. “***Transfer Order*** means a transfer order issued pursuant to subsection 40(1) of the CCA transferring this

Agreement from the LHIN to Ontario Health;".

l) In section 2.1, "section 20(1) of" is deleted.

m) In section 2.2, "March 31, 2020" is deleted and replaced with "June 30, 2020".

n) In section 3.5, "Guide to Requirements and Obligations Pertaining to French Language Services" is deleted and replaced with "Guide to Requirements and Obligations Relating to French Language Services".

o) In section 3.7(a), "annual" is deleted.

p) In section 3.7, the last paragraph is deleted and replaced with:

"Despite Article 9 of this Agreement, to the extent that the Hospital is unable to comply, or anticipates it will be unable to comply with the foregoing without adversely impacting its ability to perform its other obligations under this Agreement, the Hospital, in consultation with the Funder, may refer the matter to the Ministry for resolution."

q) In section 5.1.3 and section 5.3, all references to "section 7.2.7" are deleted and replaced with "section 7.2.6":

r) The first sentence of the last paragraph of section 7.1.1 is deleted and replaced with:

"The Hospital's Planning Submission will be aligned with the LHIN's current integrated health service plan, as defined in LHSIA, if applicable, and will reflect the Funder's priorities and initiatives."

s) In section 7.2, "and 8.9" is deleted, "," after "8.7" is deleted, and "and" is added before the number "8.8".

t) In section 7.2.1 "whether within or outside of the geographic area of the LHIN" is deleted and replaced with "anywhere".

u) In sections 7.2.2, and 8.4.1 , "local" is deleted.

v) In sections 7.2.4, 7.2.5, 7.2.7(d) and 7.3.2, the words "section 27 of" are deleted.

w) In section 7.2.4, "section 25 or section 26 of" is deleted.

x) In section 7.2.4(b), “or the Minister” is added before the words “will not issue”.

y) In section 7.2.5, “or the Minister, as applicable” is added before the words “with notice of integration”.

z) Section 7.2.6 is deleted.

aa) In section 7.2.7(a) (now section 7.2.6(a)), “, or integrated care delivery systems (“Other Providers”)” is added after “health service providers”.

bb) In section 7.2.7 (b) and (c) (now section 7.2.6(b) and (c)) “health service provider or providers, as the case may be, has or” is deleted and replaced with “Other Providers”.

cc) In section 7.2.7(c) (now section 7.2.6(c)) “other health service providers” is deleted and replaced with “of the Other Providers”.

dd) In section 7.3.2, “or Minister” is added before the word “under”.

ee) In section 8.1, “its local” is deleted and replaced with “the”.

ff) Section 8.9 is deleted.

gg) In section 11.3, “his or her” is deleted and replaced with “their”.

hh) In section 11.4, “sections 21 and 22 of” is deleted.

ii) In section 15.1.1(a), “Local Health Integration Network” is deleted twice.

jj) In section 16.4, “of the Local Health Integration Networks or to the MOHLTC” is deleted and replaced with “agencies or ministries of Her Majesty the Queen in right of Ontario and as otherwise directed by the Ministry.”

kk) In section 16.7, “8.9 (LHIN Public Meetings),” is deleted.

ll) In section 16.7, “8.10” is deleted and replaced with “8.9” and “8.11” is deleted and replaced with “8.10”.

mm) The titles LHIN “Chair” and LHIN “CEO” are removed on the signature page.

2.2 Term. This Agreement and the HSAA will expire on June 30, 2020.

2.3 Schedules. The Schedules in effect on March 31, 2020 shall remain in effect until June 30, 2020, or until such other time as may be agreed to by Parties.

3.0 Effective Date. The amendments set out in Article 2 shall take effect on March 31, 2020. All other terms of the HSAA shall remain in full force and effect.

4.0 Appendix 1. Appendix 1 is the HSAA, incorporating all of the amendments set out in section 2.1 above, that is effective March 31, 2020.

5.0 Entire Agreement. This Agreement constitutes the entire agreement between the Parties with respect to the subject matter contained in this Agreement and supersedes all prior oral or written representations and agreements.

-SIGNATURE PAGE FOLLOWS -

IN WITNESS WHEREOF the Parties have executed this Agreement on the dates set out below.

CHAMPLAIN LOCAL HEALTH INTEGRATION NETWORK

By:

_____ _____

James Fahey, Interim VP, Integration, Accountability, Communications and Engagement — Date

And by:

_____ _____

Renato Discenza, CEO — Date

ROYAL OTTAWA HEALTH CARE GROUP

By:

_____ _____

Anne Graham, Chair — Date

I sign as a representative of the Hospital, not in my personal capacity, and I represent that I have authority to bind the Hospital.

And by:

_____ _____

Joanne Bezzubetz, CEO — Date

I sign as a representative of the Hospital, not in my personal capacity, and I represent that I have authority to bind the Hospital.

APPENDIX 1

Attached to and forming part of the Amending Agreement between the LHIN and the Hospital effective as of March 31, 2020.

CHAMPLAIN LOCAL HEALTH INTEGRATION NETWORK

(the "LHIN")

and

ROYAL OTTAWA HEALTH CARE GROUP

(the "Hospital")

Hospital Service Accountability Agreement for 2018 - 20

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SCHEDULES

BACKGROUND

This service accountability agreement is entered into pursuant to the *Local Health System Integration Act, 2006*, with the expectation that it will be transferred by means of a transfer order issued by the Minister of Health under the *Connecting Care Act, 2019* (the "CCA"), from the LHIN as funder to Ontario Health, which is a Crown agency which, pursuant to the CCA, has the power to provide funding to health service providers and integrated care delivery systems in respect of health services.

The Hospital and the Funder are committed to working together, and with others, to achieve evolving provincial priorities including building a connected and sustainable health care system centred around the needs of patients, their families and their caregivers.

In this context, the Hospital and the Funder agree that the Funder will provide funding to the Hospital on the terms and conditions set out in this Agreement to enable the provision of services to the health system by the Hospital.

In consideration of their respective agreements set out below, the Funder and the Hospital covenant and agree as follows:

Article 1. DEFINITIONS AND INTERPRETATION

1.1 **Definitions**. The following definitions are applicable to terms used in this Agreement:

Accountability Agreement means the accountability agreement, as that term is defined in the Enabling Legislation, in place between the Funder and the Ministry during a Funding Year;

Agreement means this agreement and includes the Schedules, as amended from time to time;

Annual Balanced Operating Budget means that in each Funding Year of the term of this Agreement, the total expenses of the Hospital are less than or equal to the total revenue, from all sources, of the Hospital when using the consolidated corporate income statements (all fund types and sector codes). Total Hospital revenues exclude interdepartmental recoveries and facility-related deferred revenues, while total Hospital expenses exclude interdepartmental expenses, facility-related amortization expenses and facility-related interest on long-term liabilities;

Applicable Law means all federal, provincial or municipal laws, regulations, common law, any orders, rules, or by-laws that are applicable to the parties, the

Hospital Services, this Agreement and the parties' obligations under this Agreement during the term of this Agreement;

Applicable Policy means any rules, policies, directives, or standards of practice issued or adopted by the Ministry or other ministries or agencies of the Province of Ontario that are applicable to the Hospital, the Hospital Services, this Agreement and the parties' obligations under this Agreement during the term of this Agreement and that are available to the Hospital on a website of a ministry or agency of the Province of Ontario or that the Hospital has received from the Funder, the Ministry, an agency of the Province or otherwise. (For certainty, Applicable Policy does not include any rules, policies, directives, or standards of practice issued or adopted unilaterally by one or more local health integration networks.);

Board means board of directors;

CCA means the *Connecting Care Act, 2019*, and the regulations under it, as it and they may be amended from time to time;

CEO means chief executive officer;

Chair means the chair of the Board;

Confidential Information means information disclosed or made available by one party to the other that is marked or otherwise identified as confidential by the disclosing party at the time of disclosure and all other information that would be understood by the parties, exercising reasonable judgment, to be confidential. Confidential Information does not include information that: (i) is or becomes available in the public domain through no act of the receiving party; (ii) is received by the receiving party from another person who has no obligation of confidence to the disclosing party; or (iii) was developed independently by the receiving party without any reliance on the disclosing party's Confidential Information;

Days means calendar days;

Digital Health means the coordinated use of digital technologies to electronically integrate points of care and transform the way care is delivered, in order to improve the quality, access, productivity and sustainability of the healthcare system;

Effective Date means April 1, 2018;

Enabling Legislation before the date a Transfer Order takes effect means LHSIA, and after the date a Transfer Order takes effect means the CCA;

Explanatory Indicator means a measure of the Hospital's performance for which no Performance Target is set. Technical specifications of specific Explanatory Indicators can be found in the HSAA Indicator Technical Specifications;

Factors Beyond the Hospital's Control include occurrences that are, in whole or in part, caused by persons or entities or events beyond the Hospital's control. Examples may include, but are not limited to, the following:

(a) significant costs associated with complying with new or amended Government of Ontario technical standards or guidelines, Applicable Law or Applicable Policy;

(b) the availability of health care in the community (long-term care, home care, and primary care);

(c) the availability of health human resources;

(d) arbitration decisions that affect Hospital employee compensation packages, including wage, benefit and pension compensation, which exceed reasonable Hospital planned compensation settlement increases and in certain cases non-monetary arbitration awards that significantly impact upon Hospital operational flexibility; and

(e) catastrophic events, such as natural disasters and infectious disease outbreaks;

FIPPA means the *Freedom of Information and Protection of Privacy Act*, Ontario and the regulations made under it, as it and they may be amended from time to time;

Funder before the date a Transfer Order takes effect means the LHIN, and after the date a Transfer Order takes effect means Ontario Health;

Funding Year means, in the case of the first Funding Year, the period commencing on the Effective Date and ending on the following March 31, and in the case of Funding Years subsequent to the first Funding Year, the period of 12 consecutive months beginning on April 1 following the end of the previous Funding Year and ending on the following March 31;

Funding means the funding provided by the Funder to the Hospital in each Funding Year under this Agreement;

GAAP means generally accepted accounting principles;

Health System Funding Reform has the meaning ascribed to it in the Accountability Agreement, and is a funding strategy that features quality-based funding to facilitate fiscal sustainability through high quality, evidence-based and patient-centred care;

Hospital's Personnel and Volunteers means the directors, officers, employees, agents, volunteers and other representatives of the Hospital. In addition to the foregoing, Hospital's Personnel and Volunteers include the contractors and subcontractors and their respective shareholders, directors, officers, employees, agents, volunteers or other representatives;

Hospital Services means the clinical services provided by the Hospital and the operational activities that support those clinical services, that are funded in whole or in part by the Funder, and includes the type, volume, frequency and availability of Hospital Services;

HSAA Indicator Technical Specifications means the document entitled "HSAA Indicator Technical Specifications" as it may be amended or replaced from time to time;

Indemnified Parties means the Funder and its officers, employees, directors, independent contractors, subcontractors, agents, successors and assigns and Her Majesty the Queen in right of Ontario and Her Ministers, appointees and employees, independent contractors, subcontractors, agents and assigns. Indemnified Parties also includes any person participating in a Review conducted under this Agreement, by or on behalf of the Funder;

Improvement Plan means a plan that the Hospital may be required to develop under Article 9 of this Agreement;

Interest Income means interest earned on Funding that has been provided subject to recovery;

LHSIA means the *Local Health System Integration Act, 2006* and the regulations made under it, as it and they may be amended from time to time;

Mandate Letter has the meaning ascribed to it in the Memorandum of Understanding and means a letter from the Ministry to the Funder establishing priorities in accordance with the Premier of Ontario's mandate letter to the Ministry.

Memorandum of Understanding means the memorandum of understanding between the Funder and the Ministry in effect from time to time in accordance with the Management Board of Cabinet "Agencies and Appointments Directive".

Minister means such minister of the Crown as may be designated as the responsible minister in relation to this Agreement or in relation to any subject matter under this Agreement, as the case may be, in accordance with the *Executive Council Act*, as amended;

Ministry means, as the context requires, the Minister or the Ministry of Health and Long-Term Care or such other ministry as may be designated in accordance with Applicable Law as the ministry responsible in relation to the relevant matter or the Minister of that ministry, as the context requires;

Notice means any notice or other communication required to be provided pursuant to this Agreement or the Enabling Legislation;

Ontario Health means the corporation without share capital under the name Ontario Health as continued under the CCA;

Performance Corridor means the acceptable range of results around a Performance Target;

Performance Factor means any matter that could or will significantly affect a party's ability to fulfill its obligations under this Agreement;

Performance Indicator means a measure of Hospital performance for which a Performance Target is set;

Performance Standard means the acceptable range of performance for a Performance Indicator or Service Volume that results when a Performance Corridor is applied to a Performance Target (as described in the Schedules and the HSAA Indicator Technical Specifications);

Performance Target means the planned level of performance expected of the Hospital in respect of Performance Indicators or Service Volumes;

person or entity includes any individual and any corporation, partnership, firm, joint venture or other single or collective form of organization under which business may be conducted;

Planning Submission means the Hospital Board-approved planning document submitted by the Hospital to the Funder. The form, content and scheduling of the Planning Submission will be identified by the Funder;

Post-Construction Operating Plan (PCOP) Funding and ***PCOP Funding*** means any annualized operating funding provided under this Agreement, whether by a funding letter or other amendment, to support service expansions and other costs occurring in conjunction with completion of an approved capital project, as may be set out in ***Schedule A*** and further detailed in ***Schedule C.4***;

Program Parameter means, in respect of a program, any one or more of the provincial standards (such as operational, financial or service standards and policies, operating manuals and program eligibility), directives, guidelines and expectations and requirements for that program that are established or required by the Ministry; and that the Hospital has been made aware of or ought reasonably to have been aware of; and that are available to the Hospital on a website of a ministry or agency of the Province of Ontario or that the Hospital

has received from the Funder, the Ministry, an agency of the Province or otherwise;

Reports means the reports described in ***Schedule B*** as well as any other reports or information required to be provided under the Enabling Legislation or this Agreement;

Review means a financial or operational audit, investigation, inspection or other form of review requested or required by the Funder under the terms of the Enabling Legislation or this Agreement, but does not include the annual audit of the Hospital's financial statements;

Schedule means any one of, and ***"Schedules"*** mean any two or more, as the context requires, of the Schedules appended to this Agreement, including the following:

Schedule A:	Funding Allocation
Schedule B:	Reporting Requirements
Schedule C:	Indicators and Volumes
Schedule C.1:	Performance Indicators
Schedule C.2:	Service Volumes
Schedule C.3:	Funder Indicators and Volumes
Schedule C.4:	PCOP Targeted Funding & Volumes

Service Volume means a measure of Hospital Services for which a Performance Target has been set.

Transfer Order means a transfer order issued pursuant to subsection 40(1) of the CCA transferring this Agreement from the LHIN to Ontario Health;

2008-18 H-SAA means the Hospital Service Accountability Agreement for 2008-10 as amended and extended to March 31, 2018.

1.2 **Interpretation**. Words in the singular include the plural and vice-versa. Words in one gender include all genders. The words "including" and "includes" are not intended to be limiting and mean "including without limitation" or "includes without limitation", as the case may. The headings do not form part of this Agreement. They are for convenience of reference only and do not affect the interpretation of this Agreement. Terms used in the Schedules have the meanings set out in this Agreement unless separately and specifically defined in a Schedule in which case the definition in the Schedule governs for the purposes of that Schedule.

1.3 **HSAA Indicator Technical Specification**. This Agreement will be interpreted with reference to the HSAA Indicator Technical Specifications.

1.4 **Denominational Hospitals**. For the purpose of interpreting this Agreement, nothing in this Agreement is intended to, and this Agreement will not be interpreted to, unjustifiably, as determined under section 1 of the *Canadian Charter of Rights and Freedoms*, require a Hospital with a denominational mission to provide a service or to perform a service in a manner that is contrary to the denominational mission of the Hospital.

Article 2. APPLICATION AND TERM OF AGREEMENT

2.1 **A Service Accountability Agreement**. This Agreement is a service accountability agreement for the purposes of the Enabling Legislation.

2.2 **Term**. The term of this Agreement will commence on the Effective Date and will expire on June 30, 2020, unless extended pursuant to its terms.

Article 3. OBLIGATIONS OF THE PARTIES

3.1 **The Funder**. The Funder will fulfill its obligations under this Agreement in accordance with the terms of this Agreement, Applicable Law and Applicable Policy.

3.2 **The Hospital**.

3.2.1 The Hospital will provide the Hospital Services and otherwise fulfill its obligations under this Agreement in accordance with the terms of this Agreement, Applicable Law, Applicable Policy and Program Parameters. Without limiting the foregoing, the Hospital acknowledges:

(a) that all Funding will be provided in accordance with the requirements of the Enabling Legislation, including the terms and conditions of the Accountability Agreement;

(b) that it is prohibited from using Funding for compensation increases prohibited by Applicable Law;

(c) its obligation to follow the Broader Public Sector Procurement Directive issued by the Management Board of Cabinet as the same may be replaced or amended from time to time; and

(d) its obligation to post a copy of this Agreement in a conspicuous public place at its sites of operations to which this Agreement applies, and on its public website if the Hospital operates a public website.

3.2.2 When providing the Hospital Services, the Hospital will meet all of the Performance Standards and other terms and conditions applicable to the Hospital Services that have been mutually agreed to by the parties.

3.2.3 The Funder will receive a Mandate Letter from the Ministry annually. Each Mandate Letter articulates areas of focus for the Funder, and the Ministry's expectation that the Funder and the health service providers it funds will collaborate to advance these areas of focus. To assist the Hospital in its collaborative efforts with the Funder, the Funder will share each relevant Mandate Letter with the Hospital.

3.3 **Subcontracting for the Provision of Hospital Services**.

3.3.1 Subject to the provisions of the Enabling Legislation, the Hospital may subcontract the provision of some or all of the Hospital Services. For the purposes of this Agreement, actions taken or not taken by the subcontractor and Hospital Services provided by the subcontractor will be deemed actions taken or not taken by the Hospital and Hospital Services provided by the Hospital.

3.3.2 The terms of any subcontract entered into by the Hospital will:

(a) enable the Hospital to meet its obligations under this Agreement; and

(b) not limit or restrict the ability of the Funder to conduct any audit or Review of the Hospital necessary to enable the Funder to confirm that the Hospital has complied with the terms of this Agreement.

3.4 **Conflict of Interest**. The Hospital has adopted (or will adopt, within 60 Days of the Effective Date) and will maintain, in writing, for the term of this Agreement, a conflict of interest policy that includes requirements for disclosure and effective management of perceived, actual and potential conflict of interest and a code of conduct, for directors, officers, employees, professional staff members and volunteers. The Hospital will provide the Funder with a copy of its conflict of interest policy upon request at any time and from time to time.

3.5 **French Language Services**. The Hospital shall comply with the requirements and obligations set out in the "Guide to Requirements and Obligations Relating to French Language Health Services". This obligation does not limit or otherwise prevent the Funder and the Hospital from negotiating specific local obligations relating to French language services, that do not conflict with the guide.

3.6 **Designated Psychiatric Facilities**. If the Hospital is designated as a psychiatric facility under the *Mental Health Act,* it will provide the essential mental health services in accordance with the specific designation for each designated site of the Hospital, and discuss any material changes to the service delivery models or service levels with the Ministry.

3.7 **Digital Health.** The Hospital shall make best efforts to:

(a) assist the Funder to prepare its Funder Digital Health plan that aligns with provincial Digital Health priorities;

(b) assist the Funder to implement the Funder Digital Health plan and include, in its annual Planning Submission, its plans for achieving the agreed upon Digital Health initiatives;

(c) track the Hospital's Digital Health performance against the Funder Digital Health plan; and

(d) comply with any clinical, technical, and information management standards, including those related to data, architecture, technology, privacy and security, set for the Hospital by the Ministry within the timeframes set by the Ministry.

Despite Article 9 of this Agreement, to the extent that the Hospital is unable to comply, or anticipates it will be unable to comply with the foregoing without adversely impacting its ability to perform its other obligations under this Agreement, the Hospital, in consultation with the Funder, may refer the matter to the Ministry for resolution.

Article 4. FUNDING

4.1 **Annual Funding**. Subject to the terms of this Agreement, the Funder:

4.1.1 will provide the Funding identified in ***Schedule A*** to the Hospital for the purpose of providing or ensuring the provision of the Hospital Services; and

4.1.2 will deposit the Funding in equal installments, twice monthly, over the term of this Agreement, into an account designated by the Hospital provided that the account resides at a Canadian financial institution and is in the name of the Hospital.

4.2 **Funding Limited**. The Funder is not responsible for any commitment or expenditure by the Hospital in excess of the Funding that the Hospital makes in order to meet its commitments under this Agreement, nor does this Agreement commit the Funder to provide additional funds during or beyond the term of this Agreement.

4.3 **Limitation on Payment of Funding**. Despite section 4.1, the Funder will not provide any Funding to the Hospital in respect of a Funding Year until the agreement for that Funding Year has been duly signed on behalf of the Hospital, whether by amendment to this Agreement or otherwise. Despite the foregoing, if:

4.3.1 the Hospital is unable to obtain necessary approval of its Board prior to the beginning of a Funding Year; and

4.3.2 the Hospital notifies the Funder:

(a) that it requires this Agreement to be extended to enable the Hospital to obtain the necessary approval of its Board; and,

(b) of the date by which the Hospital Board's approval will be obtained,

then, with the written approval of the Funder, this Agreement and Funding for the then-current Funding Year will continue into the following Funding Year for a period of time specified by the Funder.

4.4 **Rebates, Credits, Refunds and Interest Income**. The Hospital will incorporate all rebates, credits, refunds and Interest Income that it receives from the use of the Funding into its budget, in accordance with GAAP. The Hospital will use reasonable estimates of anticipated rebates, credits and refunds in its budgeting process. The Hospital will use any rebates, credits, refunds and Interest Income that it receives from the use of the Funding to provide Hospital Services unless otherwise agreed to by the Funder.

4.5 **Conditions on Funding**.

4.5.1 The Hospital will:

(a) use the Funding only for the purpose of providing the Hospital Services in accordance with the terms of this Agreement and any amendments to this Agreement, whether by funding letter or otherwise;

(b) not use in-year Funding for major building renovations or construction, or for direct expenses relating to research projects; and,

(c) plan for and maintain an Annual Balanced Operating Budget.

A. **Facilitating an Annual Balanced Operating Budget**. The parties will work together to identify budgetary flexibility and manage in-year risks and pressures to facilitate the achievement of an Annual Balanced Operating Budget for the Hospital.

B. **Waiver**. Upon written request of the Hospital, the Funder may, in its discretion, waive the obligation to achieve an Annual Balanced Operating Budget on such terms and conditions as the Funder may deem appropriate. Where such a waiver is granted, it and the conditions attached to it will form part of this Agreement.

4.5.2 All Funding is subject to all Applicable Law and Applicable Policy, including Health System Funding Reform, as it may evolve or be replaced over the term of this Agreement.

4.6 **PCOP**. The Hospital acknowledges and agrees that, despite any other provision of this Agreement, unless expressly agreed otherwise in writing, all PCOP Funding is subject to all of the terms and conditions of the funding letter or letters pursuant to which it was initially provided and all of the terms and conditions of this Agreement. For certainty, those funding letters are attached as ***Schedule C.4***.

4.7 **Estimated Funding Allocations**.

4.7.1 The Hospital's receipt of any "Estimated Funding Allocation" in ***Schedule A*** is subject to section 4.8 below and subsequent written confirmation from the Funder.

4.7.2 In the event the Funding confirmed by the Funder is less than the Estimated Funding Allocation, the Funder will have no obligation to adjust any related performance requirements unless and until the Hospital demonstrates to the Funder's satisfaction that the Hospital is unable to achieve the expected performance requirements with the confirmed Funding. In such circumstances the gap between the Estimated Funding and the confirmed Funding will be deemed to be material.

4.7.3 In the event of a material gap in Funding, the Funder and the Hospital will adjust the related performance requirements.

4.8 **Appropriation**. Funding under this Agreement is conditional upon an appropriation of moneys by the Legislature of Ontario to the Ministry and funding of the Funder by the Ministry pursuant to the Enabling Legislation. If the Funder does not receive its anticipated funding, the Funder will not be obligated to make the payments required by this Agreement.

4.9 **Funding Increases**. Before the Funder can make an allocation of additional funds to the Hospital, the parties will: (1) agree on the amount of the increase; (2) agree on any terms and conditions that will apply to the increase; and (3) execute an amendment to this Agreement that reflects the agreement reached.

Article 5. REPAYMENT AND RECOVERY OF FUNDING

5.1 **Funding Recovery**. Recovery of Funding may occur for the following reasons:

5.1.1 the Funder makes an overpayment to the Hospital that results in the Hospital receiving more Funding than specified in this Agreement and any funding letters;

5.1.2 a financial reduction under section 13.1 is assessed;

5.1.3 as a result of a system planning process under section 7.2.6;

5.1.4 as a result of an integration decision made under the Enabling Legislation by the Funder; or

5.1.5 to temporarily reallocate Funding to cover incremental costs of another provider where the Hospital has reduced Hospital Services outside of the applicable Performance Corridor without agreement of the Funder and the services are provided by another provider; and

5.1.6 with respect only to Funding that has been provided expressly subject to recovery,

(a) contractual conditions for recovery of such Funding are met; and

(b) if in the Hospital's reasonable opinion or in the Funder's reasonable opinion after consulting with the Hospital, the Hospital will not be able to use the Funding in accordance with the terms and conditions on which it was provided.

5.2 **Process for Recovery of Funding Generally**.

5.2.1 Generally, if the Funder, acting reasonably, determines that a recovery of Funding under section 5.1 is appropriate, then the Funder will give 30 Days' Notice to the Hospital.

5.2.2 The Notice will describe:

(a) the amount of the proposed recovery;

(b) the term of the recovery, if not permanent;

(c) the proposed timing of the recovery;

(d) the reasons for the recovery; and

(e) the amendments, if any, that the Funder proposes be made to the Hospital's obligations under this Agreement.

5.2.3 Where a Hospital disputes any matter set out in the Notice, the parties will discuss the circumstances that resulted in the Notice and the Hospital may make representations to the Funder about the matters set out in the Notice within 14 Days of receiving the Notice.

5.2.4 The Funder will consider the representations made by the Hospital and will advise the Hospital of its decision. Funding recoveries, if any, will occur in accordance with the timing set out in the Funder's decision. No recovery of Funding will be implemented earlier than 30 Days after the delivery of the Notice.

5.3 **Process for Recovery of Funding as a Result of System Planning or Integration**. If Hospital Services are reduced as a result of a system planning process under section 7.2.6 or an integration decision made under the Enabling Legislation, the Funder may recover Funding as agreed in the process in section 7.2.6 or as set out in the decision, and the process set out in section 5.2 will apply.

5.4 **Full Consideration**. In making a determination under section 5.2, the Funder will act reasonably and will consider the impact, if any, that a recovery of Funding will have on the Hospital's ability to meet its obligations under this Agreement.

5.5 **Consideration of Weighted Cases**. Where a settlement and recovery is primarily based on volumes of cases performed by the Hospital, the Funder may consider the Hospital's actual total weighted cases.

5.6 **Hospital's Retention of Operating Surplus**. In accordance with the Ministry's 1982 (revised 1999) Business Oriented New Development Policy (BOND), the Hospital will retain any net income or operating surplus of income over expenses earned in a Funding Year, subject to any in-year or year-end adjustments to Funding in accordance with Article 5*.* Any net income or operating surplus retained by the Hospital under the BOND policy must be used in accordance with the BOND policy. If using operating surplus to start or expand the provision of clinical services, the Hospital will comply with section 7.2.1.

5.7 **Funder Discretion Regarding Case Load Volumes**. The Funder may consider, where appropriate, accepting case load volumes that are less than a Service Volume or Performance Standard, and the Funder may decide not to settle and recover from the Hospital if such variations in volumes are: (1) only a small percentage of volumes; or (2) due to a fluctuation in demand for the services.

5.8 **Settlement and Recovery of Funding for Prior Years**.

5.8.1 The Hospital acknowledges that settlement and recovery of Funding can occur up to seven years after the provision of Funding.

5.8.2 The Hospital agrees that if the parties are directed in writing to do so by the Ministry, the Funder will settle and recover funding provided by the Ministry to the Hospital prior to the transition of the funding for the services or program to the Funder, provided that such settlement and recovery occurs within seven years of the provision of the funding by the Ministry. All such settlements and recoveries will be subject to the terms applicable to the original provision of funding.

5.9 **Debt Due**.

5.9.1 If the Funder requires the re-payment by the Hospital of any Funding in accordance with this Agreement, the amount required will be deemed to be a debt owing to the Crown by the Hospital. The Funder may adjust future Funding instalments to recover the amounts owed or may, at its discretion, direct the Hospital to pay the amount owing to the Crown. The Hospital will comply with any such direction.

5.9.2 All amounts owing to the Crown will be paid by cheque payable to the "Ontario Minister of Finance" and mailed to the Funder at the address provided in section 14.1.

5.9.3 The Funder may charge the Hospital interest on any amount owing by the Hospital at the then current interest rate charged by the Province of Ontario on accounts receivable.

Article 6. HOSPITAL SERVICES

6.1 **Hospital Services**. The Hospital will:

6.1.1 achieve the Performance Standards described in the Schedules and the HSAA Indicator Technical Specifications;

6.1.2 not reduce, stop, start, expand, cease to provide or transfer the provision of Hospital Services to another hospital or to another site of the Hospital if such action would result in the Hospital being unable to achieve the Performance Standards described in the Schedules and the HSAA Indicator Technical Specifications; and

6.1.3 not restrict or refuse the provision of Hospital Services that are funded by the Funder to an individual, directly or indirectly, based on the geographic area in which the person resides in Ontario, and will establish a policy prohibiting any health care professional providing services at the Hospital, including physicians, from doing the same.

Article 7. PLANNING AND INTEGRATION

7.1 **Planning for Future Years**.

7.1.1 **Multi-Year Planning**. The Planning Submission will be submitted to the Funder at the time and in the format required by the Funder and may require the Hospital to incorporate:

(a) prudent multi-year financial forecasts;

(b) plans for the achievement of Performance Targets; and

(c) realistic risk management strategies in respect of (a) and (b).

The Hospital's Planning Submission will be aligned with the LHIN's current integrated health service plan, as defined in LHSIA, if applicable, and will reflect the Funder's priorities and initiatives. If the Funder has provided multi-year planning targets for the Hospital, the Planning Submissions will reflect the planning targets.

7.1.2 **Multi-Year Planning Targets**. ***Schedule A*** may reflect an allocation for the first Funding Year of this Agreement as well as planning targets for up to two additional years, consistent with the term of this Agreement. In such an event:

(a) the Hospital acknowledges that if it is provided with planning targets, these targets are:

A. targets only;
B. provided solely for the purposes of planning;
C. subject to confirmation; and
D. may be changed at the discretion of the Funder in consultation with the Hospital. The Hospital will proactively manage the risks associated with multi-year planning and the potential changes to the planning targets; and

(b) the Funder agrees that it will communicate any material changes to the planning targets as soon as reasonably possible.

7.2 **System Planning**.

"Pre-proposal" means a notice from the Hospital to the Funder that informs the Funder of a potential integration for the health system in sufficient detail to enable the Funder to assess how the integration would impact the Hospital Services, Funding and the health system, including access to, and quality and cost of, services.

The parties acknowledge that sections 8.7, and 8.8 may apply to a confidential pre-proposal.

7.2.1 **General**. As required by the Enabling Legislation, the parties will separately and in conjunction with each other identify opportunities to integrate the services of the local health system to provide appropriate, co-ordinated, effective and efficient services. The Hospital acknowledges the importance of advance notice for system planning purposes. If the Hospital is planning to significantly reduce, stop, start, expand or cease to provide clinical services and operational activities that support those clinical services or to transfer any such services to another site of the Hospital, anywhere , and such action does not result in the Hospital being unable to achieve the Performance Standards described in the Schedules and the HSAA Indicator Technical Specification, then the Hospital will inform the Funder of such change with a view to providing the Funder with time to mitigate adverse impacts.

7.2.2 **Pre-proposal**. The Hospital may inform the Funder, by means of a pre-proposal, of integration opportunities in the health system. The Hospital will inform the Funder by means of a pre-proposal if the Hospital is considering an integration of its services with those of another person or entity.

7.2.3 **Further Consideration of Pre-proposal**. Following the Funder's review and evaluation of the pre-proposal and subject to section 7.2.5, the Funder may invite the Hospital to submit a detailed proposal and business case for further analysis. The Funder will provide the Hospital with guidelines for the development of a detailed proposal and business case.

7.2.4 **Funder Evaluation of the Pre-proposal not Consent**. A pre-proposal will not constitute a notice of an integration under the Enabling Legislation. The Funder's assent to develop the concept outlined in a pre-proposal does not: (a) constitute the Funder's approval to proceed with an integration; (b) presume the Funder or the Minister will not issue a decision ordering the Hospital not to proceed with the integration under the Enabling Legislation; or (c) preclude the Funder from exercising its powers under the Enabling Legislation.

7.2.5 **Act Prevails**. Nothing in this section prevents the Hospital from providing the Funder or the Minister, as applicable, with notice of integration at any time in accordance with the Enabling Legislation.

7.2.6 **Process for System Planning**. If:

(a) the Hospital has identified an opportunity to integrate its Hospital Services with that of one or more other health service providers, or integrated care delivery systems ("Other Providers");

(b) the Other Providers have agreed to the proposed integration with the Hospital;

(c) the Hospital and the Other Providers have agreed on the amount of funds needed to be transferred from the Hospital to one or more of the Other Providers to effect the integration as planned between them and the Hospital has notified the Funder of this amount;

(d) the Hospital has complied with its obligations under the Enabling Legislation, the integration proceeds or will proceed as planned in accordance with the Enabling Legislation;

(e) then the Funder may recover from the Hospital, Funding specified in ***Schedule A*** and agreed by the Hospital as needed to facilitate the integration.

7.3 **Reviews and Approvals**.

7.3.1 **Timely Response**. Subject to section 7.3.2, and except as expressly provided by the terms of this Agreement, the Funder will respond to Hospital submissions requiring a response from the Funder in a timely manner and in any event, within any time period set out in ***Schedule B***. If the Funder has not responded to the Hospital within the time period set out in ***Schedule B***, following consultation with the Hospital, the Funder will provide the Hospital with written Notice of the reasons for the delay and a new expected date of response. If a delayed response from the Funder could reasonably be expected to have a prejudicial effect on the Hospital, the Hospital may refer the matter for issue resolution under Article 11.

7.3.2 **Exceptions**. Section 7.3.1 does not apply to: (i) any notice provided to the Funder or Minister under the Enabling Legislation, which will be subject to the timelines of the Enabling Legislation; and (ii) any report required to be submitted to the Ministry by the Funder for which the Ministry response is required before the Funder can respond.

Article 8. REPORTING

8.1 **Generally**. The Funder's ability to enable the health system to provide appropriate, co-ordinated, effective and efficient services, as contemplated by the Enabling Legislation, is dependent on the timely collection and analysis of accurate information.

8.2 **General Reporting Obligations**. The Hospital will provide to the Funder, or to such other person or entity as the parties may reasonably agree, in the form and within the time specified by the Funder, the Reports, other than personal health information as defined in the Enabling Legislation, that the Funder requires for the purposes of exercising its powers and duties under this Agreement, the Enabling Legislation or for the purposes that are prescribed under any Applicable Law. For certainty, nothing in this section 8.2 or in this Agreement restricts or otherwise limits the Funder's right to access or to require access to personal health information as defined in the Enabling Legislation, in accordance with Applicable Law.

8.3 **Certain Specific Reporting Obligations**. Without limiting the foregoing, the Hospital will fulfill the specific reporting requirements set out in ***Schedule B***. The Hospital will ensure that all Reports are in a form satisfactory to the Funder, are complete, accurate and signed on behalf of the Hospital by an authorized signing officer, and are provided to the Funder in a timely manner.

8.4 **Additional Reporting Obligations**.

8.4.1 ***French Language Services***. If the Hospital is required to provide services to the public in French under the provisions of the *French Language Services Act*, the Hospital will submit a French language services report to the Funder annually. If the Hospital is not required to provide services to the public in French under the provisions of the *French Language Service Act*, the Hospital will provide a report to the Funder annually that outlines how the Hospital addresses the needs of its Francophone community.

8.4.2 **Community Engagement and Integration**. The Hospital will report annually on its community engagement and integration activities and at such other times as the Funder may request from time to time, using any templates provided by the Funder.

8.4.3 **Reporting to Certain Third Parties**. The Hospital will submit all such data and information to the Ministry, Canadian Institute for Health Information or to any other third party, as may be required by any health data reporting requirements or standards communicated by the Ministry to the Hospital. To the extent that the Hospital is unable to comply with the foregoing without adversely impacting its ability to perform its other obligations under this Agreement, the Hospital may notify the Funder and the parties will escalate the matter to their respective CEOs and Board Chairs, if so requested by either party.

8.5 **System Impacts**. Throughout the term of this Agreement, the Hospital will promptly inform the Funder of any matter that the Hospital becomes aware of that materially impacts or is likely to materially impact the health system, or could otherwise be reasonably expected to concern the Funder.

8.6 **Hospital Board Reports**.

8.6.1 **Hospital Board to be Informed**. Periodically throughout the Funding Year and at least quarterly, the Hospital's Board will receive from the Hospital's Board committees, CEO and other appropriate officers, such reports as are necessary to keep the Board, as the governing body of the Hospital, appropriately informed of the performance by the Hospital of its obligations under this Agreement, including the degree to which the Hospital has met, and will continue throughout the Funding Year to meet, its Performance Targets and its obligation to plan for and achieve an Annual Balanced Operating Budget.

8.6.2 **Hospital Board to Report to Funder**. The Hospital will provide to the Funder, annually, and quarterly upon request of the Funder, a declaration of the Hospital's Board, signed by the Chair, declaring that the Board has received the reports referred to in this Section.

8.7 **Confidential Information**. The receiving party will treat Confidential Information of the disclosing party as confidential and will not disclose Confidential Information except:

8.7.1 with the prior consent of the disclosing party; or

8.7.2 as required by law or by a court or other lawful authority, including the Enabling Legislation and FIPPA.

8.8 **Required Disclosure**. If the receiving party is required, by law or by a court or by other lawful authority, to disclose Confidential Information of the disclosing party, the receiving party will: promptly notify the disclosing party before making any such disclosure, if such notice is not prohibited by law, the court or other lawful authority; cooperate with the disclosing party on the proposed form and nature of the disclosure; and, ensure that any disclosure is made in accordance with the requirements of Applicable Law and within the parameters of the specific requirements of the court or other lawful authority.

8.9 **Document Retention and Record Maintenance**. The Hospital will:

8.9.1 retain all records (as that term is defined in FIPPA) related to the Hospital's performance of its obligations under this Agreement for seven years after this Agreement ceases to be in effect, whether due to expiry or otherwise. The Hospital's obligations under this section will survive if this Agreement ceases to be in effect, whether due to expiry or otherwise;

8.9.2 keep all financial records, invoices and other financially-related documents relating to the Funding or otherwise to the Hospital Services in a manner consistent with international financial reporting standards as advised by the Hospital's auditor; and

8.9.3 keep all non-financial documents and records relating to the Funding or otherwise to the Hospital Services in a manner consistent with all Applicable Law.

8.10 **Final Reports**. If this Agreement ceases to be in effect, whether due to expiry or otherwise, the Hospital will provide to the Funder all such reports as the Funder may reasonably request relating to, or as a result of, this Agreement ceasing to be in effect.

Article 9. PERFORMANCE MANAGEMENT, IMPROVEMENT AND REMEDIATION

9.1 **General Approach**. The parties will strive to achieve on-going performance improvement. They will follow a proactive, collaborative and responsive approach to performance management and improvement. Either party may request a meeting at any time. The parties will use their best efforts to meet as soon as possible following a request.

9.2 **Notice of a Performance Factor**. Each party will notify the other party, as soon as reasonably possible, of any Performance Factor. The Notice will:

9.2.1 describe the Performance Factor and its actual or anticipated impact;

9.2.2 include a description of any action the party is undertaking, or plans to undertake, to remedy or mitigate the Performance Factor;

9.2.3 indicate whether the party is requesting a meeting to discuss the Performance Factor; and

9.2.4 address any other issue or matter the party wishes to raise with the other party, including whether the Performance Factor may be a Factor Beyond the Hospital's Control.

9.2.5 The recipient party will acknowledge in writing receipt of the Notice within seven Days of the date on which the Notice was received ("Date of the Notice").

9.3 **Performance Meetings**. Where a meeting has been requested under section 9.2.3, the parties will meet to discuss the Performance Factor within 14 Days of the Date of the Notice. The Funder can require a meeting to discuss the Hospital's performance of its obligations under this Agreement, including a result for a Performance Indicator or a Service Volume that falls outside the applicable Performance Standard.

9.4 **Performance Meeting Purpose**. During a performance meeting, the parties will:

9.4.1 discuss the causes of the Performance Factor;

9.4.2 discuss the impact of the Performance Factor on the local health system and the risk resulting from non-performance; and

9.4.3 determine the steps to be taken to remedy or mitigate the impact of the Performance Factor (the "Performance Improvement Process").

9.5 **Performance Improvement Process**.

9.5.1 The purpose of the Performance Improvement Process is to remedy or mitigate the impact of a Performance Factor. The Performance Improvement Process may include:

(a) a requirement that the Hospital develop an Improvement Plan; or

(b) an amendment of the Hospital's obligations as mutually agreed by the parties.

9.5.2 Any Performance Improvement Process begun under a prior agreement will continue under this Agreement. Any performance improvement required by a Funder under a prior agreement will be deemed to be a requirement of this Agreement until fulfilled.

9.6 **Factors Beyond the Hospital's Control**. If the Funder, acting reasonably, determines that the Performance Factor is, in whole or in part, a Factor Beyond the Hospital's Control:

9.6.1 the Funder will collaborate with the Hospital to develop and implement a mutually agreed upon joint response plan which may include an amendment of the Hospital's obligations under this Agreement;

9.6.2 the Funder will not require the Hospital to prepare an Improvement Plan; and

9.6.3 the failure to meet an obligation under this Agreement will not be considered a breach of this Agreement to the extent that failure is caused by a Factor Beyond the Hospital's Control.

9.7 **Hospital Improvement Plan**.

9.7.1 **Development of an Improvement Plan**. If, as part of a Performance Improvement Process, the Funder requires the Hospital to develop an Improvement Plan, the process for the development and management of the Improvement Plan is as follows:

(a) The Hospital will submit the Improvement Plan to the Funder within 30 Days of receiving the Funder's request. In the Improvement Plan, the Hospital will identify remedial actions and milestones for monitoring performance improvement and the date by which the Hospital expects to meet its obligations.

(b) Within 15 business Days of its receipt of the Improvement Plan, the Funder will advise the Hospital which, if any, remedial actions the Hospital should implement immediately. If the Funder is unable to approve the Improvement Plan as presented by the Hospital, subsequent approvals will be provided as the Improvement Plan is revised to the satisfaction of the Funder.

(c) The Hospital will implement all aspects of the Improvement Plan for which it has received written approval from the Funder, upon receipt of such approval.

(d) The Hospital will report quarterly on progress under the Improvement Plan, unless the Funder advises the Hospital to report on a more frequent basis. If Hospital performance under the Improvement Plan does not improve by the timelines in the Improvement Plan, the Funder may agree to revisions to the Improvement Plan.

The Funder may require, and the Hospital will permit and assist the Funder in conducting, a Review of the Hospital to assist the Funder in its consideration and approval of the Improvement Plan. The Hospital will pay the costs of this Review.

9.7.2 **Peer/Funder Review of Improvement Plan**. If Hospital performance under the Improvement Plan does not improve in accordance with the Improvement Plan, or if the Hospital is unable to develop an Improvement Plan satisfactory to the Funder, the Funder may appoint an independent team to assist the Hospital to develop an Improvement Plan or revise an existing Improvement Plan. The independent team will include a representative from another hospital selected with input from the Ontario Hospital Association. The independent team will work closely with the representatives from the Hospital and the Funder. The Hospital will submit a new Improvement Plan or revisions to an existing Improvement Plan within 60 Days of the appointment of the independent team or within such other time as may be agreed to by the parties.

Article 10. REPRESENTATIONS, WARRANTIES AND COVENANTS

10.1 **General**. The Hospital represents, warrants and covenants that:

10.1.1 it is, and will continue for the term of this Agreement to be, a validly existing legal entity with full power to fulfill its obligations under this Agreement;

10.1.2 subject to Applicable Law, it has made reasonable efforts to ensure that the Hospital Services are and will continue to be provided by persons with the experience, expertise, professional qualifications, licensing and skills necessary to complete their respective tasks;

10.1.3 it holds all permits, licences, consents, intellectual property rights and authorities necessary to perform its obligations under this Agreement;

10.1.4 all information (including information relating to any eligibility requirements for Funding) that the Hospital provided to the Funder in support of its request for Funding was true and complete at the time the Hospital provided it, and will, subject to the provision of Notice otherwise, continue to be materially true and complete for the term of this Agreement; and

10.1.5 it does and will continue to operate for the term of this Agreement, in compliance with Applicable Law and Applicable Policy.

10.2 **Execution of Agreement**. The Hospital represents and warrants that:

10.2.1 it has the full power and authority to enter into this Agreement; and

10.2.2 it has taken all necessary actions to authorize the execution of this Agreement.

10.3 **Governance**. The Hospital represents, warrants and covenants that it will follow good governance practices comparable to those set out in the Ontario Hospital Association's Governance Centre of Excellence's "Guide to Good Governance" as it may be amended; will undertake an accreditation process which will include a review of its governance practices; and will promptly remedy any deficiencies that are identified during that accreditation process.

10.4 **Supporting Documentation**. The Hospital acknowledges that the Funder may, pursuant to the Enabling Legislation, require proof of the matters referred to in this Article 10.

Article 11. ISSUE RESOLUTION

11.1 **Principles to be Applied**. The parties acknowledge that it is desirable to use reasonable efforts to resolve issues and disputes in a collaborative manner. This includes avoiding disputes by clearly articulating expectations, establishing clear lines of communication, and respecting each party's interests.

11.2 **Informal Resolution**. The parties acknowledge that it is desirable to use reasonable efforts to resolve all issues and disputes through informal discussion and resolution. To facilitate and encourage this informal resolution process, the parties may jointly develop a written issues statement. Such an issues statement may:

11.2.1 describe the facts and events leading to the issue or dispute;

11.2.2 consider:

(a) the severity of the issue or dispute, including risk, likelihood of harm, likelihood of the situation worsening with time, scope and magnitude of the impact, likely impact with and without prompt action taken;

(b) whether the issue or dispute is isolated or part of a pattern;

(c) the likelihood of the issue or dispute recurring and if recurring, the length of time between occurrences;

(d) whether or not the issue or dispute is long-standing; and

(e) whether previous mitigation strategies have been ignored; and

11.2.3 list potential options for its resolution, which may include:

(a) performance management, in accordance with sections 9.4 through 9.7;

(b) a Review of the Hospital or a facilitated resolution, which may involve the assistance of external supports, such a peers, coaches, mentors and facilitators ("Facilitation").

11.3 **Escalation**. If the issue or dispute cannot be resolved at the level at which it first arose, either party may refer it to the senior staff member of the Funder who is responsible for this Agreement and to their counterpart in the senior management of the Hospital. If the dispute cannot be resolved at this level of senior management, either party may refer it to its respective CEO. The CEOs may meet within 14 Days of this referral and attempt to resolve the issue or dispute. If the issue or dispute remains unresolved 30 Days after the first meeting of the CEOs, then either party may refer it to their respective Board Chairs (or Board member designate) who may attempt to resolve the issue or dispute.

11.4 **Reviews and Facilitations**. The Hospital will cooperate in every Review and Facilitation. The Hospital acknowledges that for the purposes of any Review, the Funder may exercise its powers under the Enabling Legislation.

11.5 **Funder Resolution**. Nothing in this Agreement prevents the Funder from exercising any statutory or other legal right or power, or from pursuing the appointment of a supervisor of the Hospital with the Ministry, at any time.

Article 12. INSURANCE AND INDEMNITY

12.1 **Limitation of Liability**. The Indemnified Parties will not be liable to the Hospital or any of the Hospital's Personnel and Volunteers for costs, losses, claims, liabilities and damages howsoever caused arising out of or in any way related to the Hospital Services or otherwise in connection with this Agreement, unless caused by the negligence or wilful misconduct of the Indemnified Parties.

12.2 **Same**. For greater certainty and without limiting section 12.1, the Funder is not liable for how the Hospital and the Hospital's Personnel and Volunteers carry out the Hospital Services and is therefore not responsible to the Hospital for such Hospital Services; moreover the Funder is not contracting with, or employing, any of the Hospital's Personnel and Volunteers to carry out the terms of this Agreement. As such, the Funder is not liable for contracting with, employing or terminating a contract or the employment of, any of the Hospital's Personnel and Volunteers required to carry out this Agreement, nor for the withholding, collection or payment of any taxes, premiums, contributions or any other remittances due to government for the Hospital's Personnel and Volunteers required by the Hospital to perform its obligations under this Agreement.

12.3 **Indemnification**. The Hospital will indemnify and hold harmless the Indemnified Parties from and against any and all costs, expenses, losses, liabilities, damages and expenses (including legal, expert and consultant fees), causes of action, actions, claims, demands, lawsuits or other proceedings (collectively "Claims") by whomever made, sustained, brought or prosecuted (including for third party bodily injury (including death), personal injury and property damage) in any way based upon, occasioned by or attributable to anything done or omitted to be done by the Hospital or the Hospital's Personnel and Volunteers in the course of performance of the Hospital's obligations under, or otherwise in connection with, this Agreement, unless caused by the negligence or wilful misconduct of an Indemnified Party.

12.4 **Insurance**.

12.4.1 **Required Insurance**. The Hospital will put into effect and maintain, for the term of this Agreement, at its own expense, with insurers having a secure A.M. Best rating of B+ or greater, or the equivalent, all the necessary and appropriate insurance that a prudent person in the business of the Hospital would maintain including the following.

(a) **Commercial General Liability Insurance**. Commercial general liability insurance, for third-party bodily injury, personal injury and property damage to an inclusive limit of not less than five million dollars per occurrence and not less than two million dollars for products and completed operations in the aggregate. The policy will include the following clauses:

A. The Indemnified Parties as additional insureds;
B. Contractual Liability;
C. Cross Liability;
D. Products and Completed Operations Liability;
E. Employers Liability and Voluntary Compensation unless the Hospital can provide proof of *Workplace Safety and Insurance Act, 1997* ("WSIA") coverage as described in section 12.4.2(b);
F. Non-Owned automobile coverage with blanket contractual and physical damage coverage for hired automobiles, except that such coverage may nevertheless exclude liability assumed by any person insured by the policy voluntarily under any contract or agreement other than directors, officers, employees and volunteers of the Hospital pertaining only to the liability arising out of the use or operation of their automobiles while on the business of the Hospital; and
G. A thirty-day written notice of cancellation, termination or material change.

(b) **All-Risk Property Insurance**. All-risk property insurance on property of every description providing coverage to a limit of not less than the full replacement cost, including earthquake and flood. Such insurance will be written to include replacement cost value. All reasonable deductibles and/or self-insured retentions are the responsibility of the Hospital.

(c) **Boiler and Machinery Insurance**. Boiler and machinery insurance (including pressure objects, machinery objects and service supply objects) on a comprehensive basis. Such insurance will be written to include repair and replacement value. All reasonable deductibles and/or self-insured retentions are the responsibility of the Hospital.

(d) **Professional Liability Insurance**. Professional liability insurance to an inclusive limit of not less than five million dollars per occurrence for each claim of negligence resulting in bodily injury, death or property damage, arising directly or indirectly from the professional services rendered by the Hospital, its officers, agents or employees.

(e) **Directors and Officers Liability Insurance**. Directors and officers liability insurance to an inclusive limit of not less than two million dollars per claim, with an annual aggregate of not less than four million dollars, responding to claims of wrongful acts of the Hospital's directors, officers and board committee members and of the Hospital's volunteer association and auxiliary in the discharge of their duties on behalf of the Hospital or the volunteer association or auxiliary, as applicable.

12.4.2 **Proof of Insurance**. As requested by the Funder from time to time, the Hospital will provide the Funder with proof of the insurance required by this Agreement in the form of any one or more of:

(a) a valid certificate of insurance that references this Agreement and confirms the required coverage;

(b) a valid WSIA Clearance Certificate or a letter of good standing, as applicable, unless the Hospital has in effect Employers Liability and Voluntary Compensation as described above; and

(c) copy of each insurance policy.

12.4.3 **Subcontractors**. The Hospital will ensure that each of its subcontractors obtains all the necessary and appropriate insurance that a prudent person in the business of the subcontractor would maintain.

Article 13. REMEDIES FOR NON-COMPLIANCE

13.1 **Planning Cycle**. The success of the planning cycle depends on the timely performance of each party. To ensure delays do not have a material adverse effect on Hospital Services or Funder operations, the following provisions apply:

13.1.1 If the Funder fails to meet an obligation or due date in ***Schedule B***, the Funder may do one or all of the following:

(a) adjust funding for the Funding Year to offset a material adverse effect on Hospital Services resulting from the delay; and/or

(b) work with the Hospital in developing a plan to offset any material adverse effect on Hospital Services resulting from the delay, including providing Funder approvals for any necessary changes in Hospital Services.

13.1.2 At the discretion of the Funder, the Hospital may be subject to a financial reduction if the Hospital's:

(a) Planning Submission is received by the Funder after the due date in ***Schedule B*** without prior Funder approval of such delay;

(b) Planning Submission is incomplete;

(c) quarterly performance reports are not provided when due; or

(d) financial and/or clinical data requirements are late, incomplete or inaccurate.

If assessed, the financial reduction will be as follows:

A. if received within seven Days after the due date, incomplete or inaccurate, the financial penalty will be the greater of: (i) a reduction of 0.03% of the Hospital's total Funding; or (ii) $2,000; and
B. for every full or partial week of non-compliance thereafter, the rate will be one half of the initial financial reduction.

Article 14. NOTICE

14.1 **Notice**. A Notice will be in writing; delivered personally, by pre-paid courier, by any form of mail where evidence of receipt is provided by the post office, or by facsimile with confirmation of receipt, or by email where no delivery failure notification has been received. For certainty, delivery failure notification includes an automated 'out of office' notification. A Notice will be addressed to the other party as provided below or as either party will later designate to the other in writing:

To the Funder:

Champlain LHIN
1900 City Park Drive, Suite 204
Ottawa, ON K1J 1A3

Attn: Elizabeth Woodbury
Director, Health System Accountability

Fax: 613-745-1928

Email: ch.accountabilityteam@lhins.on.ca

To the Hospital:

Royal Ottawa Health Care Group
1145 Carling Avenue
Ottawa, ON K1Z 7K4

Attn: Joanne Bezzubetz
President & Chief Executive Officer

Fax: 613-722-7686

Email: joanne.bezzubetz@theroyal.ca

14.2 **Notices Effective From**. A Notice will be deemed to have been duly given one business day after delivery if the Notice is delivered personally, by pre-paid courier or by mail. A Notice that is delivered by facsimile with confirmation of receipt or by email where no delivery failure notification has been received will be deemed to have been duly given one business day after the facsimile or email was sent.

Article 15. ACKNOWLEDGEMENT OF FUNDER SUPPORT

15.1 **Publication**. For the purposes of this Article 15, the term "*Publication"* means: an annual report; a strategic plan; a material publication on a consultation about a possible integration; a material publication on community engagement; and, a material report to the community that the Hospital develops and makes available to the public in electronic or hard copy.

15.1.1 **Acknowledgment of Funding Support**.

(a) The following statement will be included on the Hospital's website, on all Publications and, upon request of the Funder, on any other publication of the Hospital relating to a Hospital initiative:

"The [Insert name of Hospital] receives funding from [Insert name of Funder]. The opinions expressed in this publication do not necessarily represent the views of [Insert name of Funder]."

(b) Upon request of the Funder, the Hospital will include a statement in a form acceptable to the Funder, acknowledging the support of the Province.

15.2 **Insignia and Logo**. Neither party may use any insignia or logo of the other party without the prior written permission of the other party. For the Hospital, this includes the insignia and logo of Her Majesty the Queen in right of Ontario.

Article 16. ADDITIONAL PROVISIONS

16.1 **Interpretation**. In the event of a conflict or inconsistency in any provision of this Agreement, the main body of this Agreement will prevail over the Schedules.

16.2 **Amendment of Agreement**. This Agreement may only be amended by a written agreement duly executed by the parties.

16.3 **Invalidity or Unenforceability of Any Provision**. The invalidity or unenforceability of any provision of this Agreement will not affect the validity or enforceability of any other provision of this Agreement and any invalid or unenforceable provision will be deemed to be severed.

16.4 **No Assignment**. The Hospital will not assign this Agreement or the Funding in whole or in part, directly or indirectly, without the prior written consent of the Funder. The Funder may assign this Agreement or any of its rights and obligations under this Agreement to any one or more agencies or ministries of Her Majesty the Queen in right of Ontario and as otherwise directed by the Ministry.

16.5 **Funder is an Agent of the Crown**. The parties acknowledge that the Funder is an agent of the Crown and may only act as an agent of the Crown in accordance with the provisions of the Enabling Legislation. Notwithstanding anything else in this Agreement, any express or implied reference to the Funder providing an indemnity or any other form of indebtedness or contingent liability that would directly or indirectly increase the indebtedness or contingent liabilities of the Funder or Ontario, whether at the time of execution of this Agreement or at any time during the term of this Agreement, will be void and of no legal effect.

16.6 **Parties Independent**. The parties are and will at all times remain independent of each other and are not and will not represent themselves to be the agent, joint venturer, partner or employee of the other. No representations will be made or acts taken by either party which could establish or imply any apparent relationship of agency, joint venture, partnership or employment and neither party will be bound in any manner whatsoever by any agreements, warranties or representations made by the other party to any other person or entity, nor with respect to any other action of the other party.

16.7 **Survival**. The provisions in Articles 1 (Definitions and Interpretation) and 5 (Repayment and Recovery of Funding), sections 8.7 (Confidential Information), 8.8 (Required Disclosure), 8.9 (Document Retention and Record Maintenance), 8.10 (Final Reports), and Articles 12 (Insurance and Indemnity), 14 (Notices) and 16 (Additional Provisions) will continue in full force and effect for a period of seven years from the date this Agreement ceases to be in effect, whether due to expiry or otherwise.

16.8 **Waiver**. A party may only rely on a waiver of the party's failure to comply with any term of this Agreement if the other party has provided a written and signed Notice of waiver. Any waiver must refer to a specific failure to comply and will not have the effect of waiving any subsequent failures to comply.

16.9 **Counterparts**. This Agreement may be executed in any number of counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument.

16.10 **Further Assurances**. The parties agree to do or cause to be done all acts or things necessary to implement and carry into effect this Agreement to its full extent.

16.11 **Governing Law.** This Agreement and the rights, obligations and relations of the parties hereto will be governed by and construed in accordance with the laws of the Province of Ontario and the federal laws of Canada applicable therein. Any litigation or arbitration arising in connection with this Agreement will be conducted in Ontario unless the parties agree in writing otherwise.

16.12 **Entire Agreement.** This Agreement forms the entire Agreement between the parties and supersedes all prior oral or written representations and agreements, except that where the Funder has provided Funding to the Hospital pursuant to an amendment to the 2008-18 H-SAA or to this Agreement, whether by funding letter or otherwise, and an amount of Funding for the same purpose is set out in ***Schedule A***, that Funding is subject to all of the terms and conditions on which funding for that purpose was initially provided, unless those terms and conditions have been superseded by any terms or conditions of this Agreement or by the HSAA Indicator Technical Specifications, or unless they conflict with Applicable Law or Applicable Policy.

-SIGNATURE PAGE FOLLOWS -

IN WITNESS WHEREOF the parties have executed this Agreement made effective as of

ROYAL OTTAWA HEALTH CARE GROUP

By:

Anne Graham, Chair — Date

I sign as a representative of the Hospital, not in my personal capacity, and I represent that I have authority to bind the Hospital.

And By:

Joanne Bezzubetz, CEO — Date

I sign as a representative of the Hospital, not in my personal capacity, and I represent that I have authority to bind the Hospital.

CHAMPLAIN LOCAL HEALTH INTEGRATION NETWORK

By:

James Fahey, Interim VP, Integration, Accountability, Communications and Engagement — Date

And By:

Renato Discenza, CEO — Date

Champlain LHIN | RLISS de Champlain

1900 City Park Drive, Suite 204
Ottawa, ON K1J 1A3
Tel 613.747.6784 • Fax 613.745.1928
Toll Free 1.866.902.5446
www.champlainlhin.on.ca

1900, promenade City Park, bureau 204
Ottawa, ON K1J 1A3
Téléphone : 613 747-6784 • Télécopieur : 613 745-1928
Sans frais : 1 866 902-5446
www.rlisschamplain.on.ca

February 11, 2020

Dr. Joanne Bezzubetz
President & Chief Executive Officer
Royal Ottawa Health Care Group
1145 Carling Avenue
Ottawa, ON K1Z 7K4

Dear Dr. Bezzubetz,

As the Interim Chief Executive Officer of Ontario Health indicated on November 14, 2019, it is expected that your 2020/21 Multi- Service Accountability Agreement (MSAA) will be with Ontario Health. This letter provides further information on the process, timeline and plan going forward.

Attached please find a Notice of Amendment and an Amending Agreement with respect to your MSAA to extend it to June 30, 2020 with minimal amendments to reflect legislative changes and to simplify the anticipated transition of the MSAA to Ontario Health from your LHIN. You are asked to have the Amending Agreement duly signed on behalf of your organization and returned to Elizabeth Woodbury, Director, Health System Accountability at ch.accountabilityteam@lhins.on.ca no later than **March 15, 2020.** While the MSAA will remain with the LHIN, as of March 31, 2020, it is our expectation that your MSAA will be transferred to Ontario Health by Minister's transfer order. The three-month extension will help to enable changes to the MSAA that will address the Ministry of Health and Ontario Health priorities.

Ontario Health and the LHINs are working closely to effect a smooth transition process. Until you are notified otherwise, the Champlain LHIN and your usual LHIN contact will be responsible for the administration of your MSAA. Please continue to direct all communications to that person.

Yours sincerely,

Renato Discenza
Chief Executive Officer

cc. Matthew Anderson, CEO, Ontario Health

Attach (2): (1) Notice of Amendment and (2) MSAA Amending Agreement

Ontario

Champlain LHIN | RLISS de Champlain

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Sans frais : 1 866 902-5446
www.rlisschamplain.on.ca

February 11, 2020

DELIVERED BY EMAIL to: joanne.bezzubetz@theroyal.ca

Dr. Joanne Bezzubetz
President & Chief Executive Officer
Royal Ottawa Health Care Group
1145 Carling Avenue
Ottawa, ON K1Z 7K4

Dear Dr. Bezzubetz,

LHSIA S.20 NOTICE

The *Local Health System Integration Act, 2006* requires the Champlain Local Health Integration (the "LHIN") to notify a health service provider when the LHIN proposes to enter into, or amend, a service accountability agreement with that health service provider.

The LHIN hereby gives notice that it proposes to amend one or more existing service accountability agreements currently in effect between the LHIN and your organization, on or before March 31, 2020.

Should you have any questions, please contact your LHIN Senior Accountability Specialist.

Sincerely yours,

Renato Discenza
Chief Executive Officer

Cc: Anne Graham, Chair of the Board, Royal Ottawa Health Care Group
James Fahey, Interim Vice President, Integration, Accountability, Communications and Engagement

Ontario

MSAA AMENDING AGREEMENT

THIS AMENDING AGREEMENT (the "Agreement") is made as of the 31st day of March, 2020

B E T W E E N:

CHAMPLAIN LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

AND

ROYAL OTTAWA HEALTH CARE GROUP (the "HSP")

WHEREAS the LHIN and the HSP (together the "Parties") entered into a multi-sector service accountability agreement that took effect April 1, 2019 (the "MSAA");

AND WHEREAS the Parties wish to amend the MSAA in the manner set out in this Agreement;

NOW THEREFORE in consideration of mutual promises and agreements contained in this Agreement and other good and valuable consideration, the Parties agree as follows:

1.0 Definitions. Except as otherwise defined in this Agreement, all terms shall have the meaning ascribed to them in the MSAA. References in this Agreement to the MSAA mean the MSAA as amended.

2.0 Amendments.

2.1 Agreed Amendments. The MSAA is amended as follows.

a) All references to "LHIN" are deleted and replaced with "Funder", with the exceptions of the defined term "LHIN" as a party to the agreement, and section 6.1(b) only in reference to the integrated health service plan which remain unamended.

b) The first four paragraphs of the part of the MSAA entitled "Background" are deleted and replaced with the following.

"This service accountability agreement is entered into pursuant to the *Local Health System Integration Act, 2006*, with the expectation that it will be transferred by means of a transfer order issued by the Minister of Health under the *Connecting Care Act, 2019* (the "CCA"), from the LHIN as funder to Ontario Health, which is a Crown agency which, pursuant to the CCA, has the power to provide funding to health service providers and integrated care delivery systems in respect of health services .

The HSP and the Funder are committed to working together, and with others, to achieve evolving provincial priorities including building a connected and sustainable health care system centred around the needs of patients, their families and their caregivers.

In this context, the HSP and the Funder agree that the Funder will provide funding to the HSP on the terms and conditions set out in this Agreement to enable the provision of services to the health system by the HSP."

c) All references to "LHSIA" are deleted and replaced with "the Enabling Legislation", with the exceptions of the defined term "LHSIA" in section 1.1, and section 6.1(b) and section 8.1(b) in reference to LHSIA sections 5(m.1) and (m.2)" which remain unamended.

d) The defined term "MOHLTC" and its definition are deleted and replaced with the following.

""**Ministry**" means, as the context requires, the Minister or the Ministry of Health and Long-Term Care or such other ministry as may be designated in accordance with Applicable Law as the ministry responsible in relation to the relevant matter or the Minister of that ministry, as the context requires;".

e) All references to "MOHLTC" are deleted and replaced with "Ministry".

In addition to the foregoing, the MSAA is further amended as follows.

f) In section 1.1, the definition of "Accountability Agreement" is amended by deleting ", currently referred to as the Ministry LHIN Accountability Agreement".

g) In section 1.1, the definition of "Confidential Information" is amended by deleting: ": (1)", and by deleting "; and (2) eligible for exclusion from disclosure at a public board meeting in accordance with section 9 of LHSIA".

h) In section 1.1, the definition of "Digital Health" is amended by deleting "has the meaning ascribed to it in the Accountability Agreement and".

i) In section 1.1, the definition of "LHIN Cluster" is deleted.

j) In section 1.1, the definition of "Mandate Letter" is amended by adding "the" before "Ministry" three times.

k) In section 1.1, the definition of "Minister" is deleted and replaced with:

""**Minister**" means such minister of the Crown as may be designated as the responsible minister in relation to this Agreement or in relation to any

subject matter under this Agreement, as the case may be, in accordance with the *Executive Council Act*, as amended;".

l) The following definitions are added to section 1.1:

""**CCA**" means the *Connecting Care Act, 2019*, and the regulations under it, as it and they may be amended from time to time;"

""**Enabling Legislation**" before the date a Transfer Order takes effect means LHSIA, and after the date a Transfer Order takes effect means the CCA;"

""**Funder**" before the date a Transfer Order takes effect means the LHIN, and after the date a Transfer Order takes effect means Ontario Health;"

""**Ontario Health**" means the corporation without share capital under the name Ontario Health as continued under the CCA;"

""**Transfer Order**" means a transfer order issued pursuant to subsection 40(1) of the CCA transferring this Agreement from the LHIN to Ontario Health;".

m) In section 2.2, "section 20(1) of" is deleted.

n) Section 3.4(a) is deleted and replaced with "assist the Funder to implement Digital Health priorities of the Funder;".

o) In section 3.4(b). "the" is added after "providers by" and again after "set by".

p) In section 3.4(c), "in the LHIN Digital Health plan" is deleted and replaced with "by the Funder".

q) In section 3.4(d), "the LHIN Cluster Digital Health plan" is deleted and replaced with "the Funder's Digital Health priorities".

r) In section 3.5.1, "Guide to Requirements and Obligations of LHIN French Language Services" is deleted and replaced with "Guide to Requirements and Obligations Relating to French Language Services".

s) The first sentence of the last paragraph of section 6.1(b) is deleted and replaced with:

"If applicable, it will be aligned with the LHIN's then current integrated health service plan required by LHSIA and will reflect the Funder's priorities and initiatives."

t) In section 6.2(a), "its local" is deleted and replaced with "the".

u) Section 6.2(b) is deleted and replaced with:

"Integration. The HSP will, separately and in conjunction with the Funder, other health service providers, if applicable, and integrated care delivery systems, if applicable, identify opportunities to integrate the services of the local health system to provide appropriate, coordinated, effective and efficient services."

v) In section 6.3(a)(2), "whether within or outside of the LHIN" is deleted twice and replaced both times with "anywhere".

w) In section 6.3(b), "section 27 of" and "sections 25 or 27 of" are deleted.

x) Section 6.5 is deleted.

y) In section 8.1(a), "its local" is deleted and replaced with "the".

z) In section 8.1(a), "as contemplated by LHSIA," is deleted.

aa) In the last paragraph of section 8.1(b), ", if applicable," is added before the words "to provide certain services" and "of LHSIA" is added after the words "with section 5(m.2)".

bb) In section 14.7 "of the LHINs or to the MOHLTC" is deleted and replaced with "agencies or ministries of Her Majesty the Queen in right of Ontario and as otherwise directed by the Ministry."

cc) The titles LHIN "Chair" and LHIN "CEO" are deleted on the signature page.

2.2 Schedules. The Schedules in effect on March 31, 2020 shall remain in effect until June 30, 2020, or until such other time as may be agreed to by the Parties.

3.0 Effective Date. The amendments set out in Article 2 shall take effect on March 31, 2020. All other terms of the MSAA shall remain in full force and effect.

4.0 Appendix 1. Appendix 1 is the MSAA, incorporating all of the amendments set out in section 2.1 above, that is effective March 31, 2020.

5.0 Entire Agreement. This Agreement constitutes the entire agreement between the Parties with respect to the subject matter contained in this Agreement and supersedes all prior oral or written representations and agreements.

-SIGNATURE PAGE FOLLOWS-

IN WITNESS WHEREOF the Parties have executed this Agreement on the dates set out below.

CHAMPLAIN LOCAL HEALTH INTEGRATION NETWORK

By:

_____	_____
James Fahey, Interim VP, Integration, Accountability, Communications and Engagement	Date

And by:

_____	_____
Renato Discenza, CEO	Date

ROYAL OTTAWA HEALTH CARE GROUP

By:

_____	_____
Anne Graham, Chair	Date

And by:

_____	_____
Dr. Joanne Bezzubetz President and Chief Executive Officer	Date

I/We have authority to bind the HSP.

APPENDIX 1

Attached to and forming part of the Amending Agreement between the LHIN and the HSP effective as of March 31, 2020.

MULTI-SECTOR SERVICE ACCOUNTABILITY AGREEMENT
April 1, 2019 to March 31, 2022

SERVICE ACCOUNTABILITY AGREEMENT

with

ROYAL OTTAWA HEALTH CARE GROUP

Effective Date: April 1, 2019

Index to Agreement

Schedules

THIS AGREEMENT effective as of the 1st day of April, 2019

B E T W E E N :

CHAMPLAIN LOCAL HEALTH INTEGRATION NETWORK (the "**LHIN**")

- and -

ROYAL OTTAWA HEALTH CARE GROUP (the "**HSP**")

Background:

This service accountability agreement is entered into pursuant to the *Local Health System Integration Act, 2006*, with the expectation that it will be transferred by means of a transfer order issued by the Minister of Health under the *Connecting Care Act, 2019* (the "CCA"), from the LHIN as funder to Ontario Health, which is a Crown agency which, pursuant to the CCA, has the power to provide funding to health service providers and integrated care delivery systems in respect of health services.

The HSP and the Funder are committed to working together, and with others, to achieve evolving provincial priorities including building a connected and sustainable health care system centred around the needs of patients, their families and their caregivers.

In this context, the HSP and the Funder agree that the Funder will provide funding to the HSP on the terms and conditions set out in this Agreement to enable the provision of services to the health system by the HSP.

In consideration of their respective agreements set out below, the Funder and the HSP covenant and agree as follows:

ARTICLE 1.0 - DEFINITIONS & INTERPRETATION

1.1 Definitions. In this Agreement the following terms will have the following meanings:

"**Accountability Agreement**" means the accountability agreement, as that term is defined in the Enabling Legislation, in place between the Funder and the Ministry during a Funding Year;

"**Active Offer**" means the clear and proactive offer of service in French to individuals, from the first point of contact, without placing the responsibility of requesting services in French on the individual;

"**Agreement**" means this agreement and includes the Schedules and any instrument amending this agreement or the Schedules;

"**Annual Balanced Budget**" means that, in each Funding Year of the term of this Agreement, the total revenues of the HSP are greater than or equal to the total expenses, from all sources, of the HSP;

"**Applicable Law**" means all federal, provincial or municipal laws, regulations, common law, orders, rules or by-laws that are applicable to the HSP, the Services, this Agreement and the parties' obligations under this Agreement during the term of this Agreement;

"**Applicable Policy**" means any rules, policies, directives, standards of practice or Program Parameters issued or adopted by the Funder, the Ministry or other ministries or agencies of the province of Ontario that are applicable to the HSP, the Services, this Agreement and the parties' obligations under this Agreement during the term of this Agreement. Without limiting the generality of the foregoing, Applicable Policy includes the other documents identified in Schedule C;

"**Board**" means:

(a) in respect of an HSP that does not have a Long-Term Care Home Service Accountability Agreement with the Funder and is:

(1) a corporation, the board of directors;

(2) a First Nation, the band council; and

(3) a municipality, the municipal council;

and,

(b) in respect of an HSP that has a Long-Term Care Home Service Accountability Agreement with the Funder and may be:

(1) a corporation, the board of directors;

(2) a First Nation, the band council;

(3) a municipality, the committee of management;

(4) a board of management established by one or more municipalities or by one or more First Nations' band councils, the members of the board of management;

"**BPSAA**" means the *Broader Public Sector Accountability Act, 2010* and regulations made under it, as it and they may be amended from time to time;

"**Budget**" means the budget approved by the Funder and appended to this Agreement in Schedule A;

"**CCA**" means the *Connecting Care Act, 2019*, and the regulations under it, as it and they may be amended from time to time;

"**CEO**" means the individual accountable to the Board for the provision of the Services in accordance with the terms of this Agreement;

"**Chair**" means, if the HSP is:

(a) a corporation, the Chair of the Board;

(b) a First Nation, the Chief; and

(c) a municipality, the Mayor,

or such other person properly authorized by the Board or under Applicable Law;

"**Compliance Declaration**" means a compliance declaration substantially in the form set out in Schedule F;

"**Confidential Information**" means information that is marked or otherwise identified as confidential by the disclosing party at the time the information is provided to the receiving party. Confidential Information does not include information that: (a) was known to the receiving party prior to receiving the information from the disclosing party; (b) has become publicly known through no wrongful act of the receiving party; or (c) is required to be disclosed by law, provided that the receiving party provides Notice in a timely manner of such requirement to the disclosing party, consults with the disclosing party on the proposed form and nature of the disclosure, and ensures that any disclosure is made in strict accordance with Applicable Law;

"**Conflict of Interest**" in respect of an HSP, includes any situation or circumstance where: in relation to the performance of its obligations under this Agreement:

(a) the HSP;

(b) a member of the HSP's Board; or

(c) any person employed by the HSP who has the capacity to influence the HSP's decision,

has other commitments, relationships or financial interests that:

(a) could or could be seen to interfere with the HSP's objective, unbiased and impartial exercise of its judgement; or

(b) could or could be seen to compromise, impair or be incompatible with the effective performance of its obligations under this Agreement;

"**Controlling Shareholder**" of a corporation means a shareholder who or which holds (or another person who or which holds for the benefit of such shareholder), other than by way of security only, voting securities of such corporation carrying more than 50% of the votes for the election of directors, provided that the votes

carried by such securities are sufficient, if exercised, to elect a majority of the board of directors of such corporation;

"**Days**" means calendar days;

"**Designated**" means designated as a public service agency under the FLSA;

"**Digital Health**" means the coordinated and integrated use of electronic systems, information and communication technologies to facilitate the collection, exchange and management of personal health information in order to improve the quality, access, productivity and sustainability of the healthcare system;

"**Effective Date"** means April 1, 2019;

"**Enabling Legislation**" before the date a Transfer Order takes effect means LHSIA, and after the date a Transfer Order takes effect means the CCA;

"**Explanatory Indicator**" means a measure that is connected to and helps to explain performance in a Performance Indicator or a Monitoring Indicator. An Explanatory Indicator may or may not be a measure of the HSP's performance. No Performance Target is set for an Explanatory Indicator;

"**Factors Beyond the HSP's Control**" include occurrences that are, in whole or in part, caused by persons, entities or events beyond the HSP's control. Examples may include, but are not limited to, the following:

(a) significant costs associated with complying with new or amended Government of Ontario technical standards, guidelines, policies or legislation;
(b) the availability of health care in the community (hospital care, long-term care, home care, and primary care);
(c) the availability of health human resources; arbitration decisions that affect HSP employee compensation packages, including wage, benefit and pension compensation, which exceed reasonable HSP planned compensation settlement increases and in certain cases non-monetary arbitration awards that significantly impact upon HSP operational flexibility; and
(d) catastrophic events, such as natural disasters and infectious disease outbreaks;

"**FIPPA**" means the *Freedom of Information and Protection of Privacy Act* (Ontario) and the regulations made under it as it and they may be amended from time to time;

"**FLSA**" means the *French Language Services Act* and the regulations made under it as it and they may be amended from time to time;

"**Funder**" before the date a Transfer Order takes effect means the LHIN, and after the date a Transfer Order takes effect means Ontario Health;

"**Funding**" means the amounts of money provided by the Funder to the HSP in each Funding Year of this Agreement;

"**Funding Year**" means in the case of the first Funding Year, the period commencing on the Effective Date and ending on the following March 31, and in the case of Funding Years subsequent to the first Funding Year, the period commencing on the date that is April 1 following the end of the previous Funding Year and ending on the following March 31;

"Health System Funding Reform" has the meaning ascribed to it in the Accountability Agreement, and is a funding strategy that features quality-based funding to facilitate fiscal sustainability through high quality, evidence-based and patient-centred care;

"**HSP's Personnel and Volunteers**" means the Controlling Shareholders (if any), directors, officers, employees, agents, volunteers and other representatives of the HSP. In addition to the foregoing, HSP's Personnel and Volunteers shall include the contractors and subcontractors and their respective shareholders, directors, officers, employees, agents, volunteers or other representatives;

"**Identified**" means identified by the Funder or the Ministry to provide French language services;

"**Indemnified Parties**" means the Funder and its officers, employees, directors, independent contractors, subcontractors, agents, successors and assigns and Her Majesty the Queen in right of Ontario and Her Ministers, appointees and employees, independent contractors, subcontractors, agents and assigns. Indemnified Parties also includes any person participating on behalf of the Funder in a Review;

"**Interest Income**" means interest earned on the Funding;

"**LHSIA**" means the *Local Health System Integration Act, 2006*, and the regulations made under it, as it and they may be amended from time to time;

"**Mandate Letter**" has the meaning ascribed to it in the Memorandum of Understanding between the Ministry and the Funder, and means a letter from the Ministry to the Funder establishing priorities in accordance with the Premier's mandate letter to the Ministry;

"**Minister**" means such minister of the Crown as may be designated as the responsible minister in relation to this Agreement or in relation to any subject matter under this Agreement, as the case may be, in accordance with the *Executive Council Act*, as amended;

"**Ministry**" means, as the context requires, the Minister or the Ministry of Health and Long-Term Care or such other ministry as may be designated in accordance

with Applicable Law as the ministry responsible in relation to the relevant matter or the Minister of that ministry, as the context requires;

"**Monitoring Indicator**" means a measure of HSP performance that may be monitored against provincial results or provincial targets, but for which no Performance Target is set;

"**MSAA Indicator Technical Specifications document**" means, as the context requires, either or both of the document entitled "Multi-Sector Service Accountability Agreement (MSAA) 2019-20 Indicator Technical Specifications November 5, 2018 Version 1.3" and the document entitled "Multi-Sector Service Accountability Agreement (MSAA) 2019-20 Target and Corridor-Setting Guidelines" as they may be amended or replaced from time to time;

"**Notice**" means any notice or other communication required to be provided pursuant to this Agreement or the Enabling Legislation;

"**Ontario Health**" means the corporation without share capital under the name Ontario Health as continued under the CCA;

"**Performance Agreement**" means an agreement between an HSP and its CEO that requires the CEO to perform in a manner that enables the HSP to achieve the terms of this Agreement and any additional performance improvement targets set out in the HSP's annual quality improvement plan under the *Excellent Care for All Act, 2010*;

"**Performance Corridor**" means the acceptable range of results around a Performance Target;

"**Performance Factor**" means any matter that could or will significantly affect a party's ability to fulfill its obligations under this Agreement;

"**Performance Indicator**" means a measure of HSP performance for which a Performance Target is set; technical specifications of specific Performance Indicators can be found in the MSAA Indicator Technical Specifications document;

"**Performance Standard**" means the acceptable range of performance for a Performance Indicator or a Service Volume that results when a Performance Corridor is applied to a Performance Target;

"**Performance Target**" means the level of performance expected of the HSP in respect of a Performance Indicator or a Service Volume;

"**person or entity**" includes any individual and any corporation, partnership, firm, joint venture or other single or collective form of organization under which business may be conducted;

"**Planning Submission**" or "**CAPS**" or "**Community Accountability Planning Submission**" means the HSP Board approved planning document submitted by the HSP to the Funder. The form, content and scheduling of the Planning Submission will be identified by the Funder;

"**Program Parameter**" means, in respect of a program, the provincial standards (such as operational, financial or service standards and policies, operating manuals and program eligibility), directives, guidelines and expectations and requirements for that program;

"**Project Funding Agreement**" means an agreement in the form of Schedule D that incorporates the terms of this Agreement and enables the Funder to provide one-time or short term funding for a specific project or service that is not already described in the Schedules;

"**Reports**" means the reports described in Schedule B as well as any other reports or information required to be provided under the Enabling Legislation or this Agreement;

"**Review**" means a financial or operational audit, investigation, inspection or other form of review requested or required by the Funder under the terms of the Enabling Legislation or this Agreement, but does not include the annual audit of the HSP's financial statements;

"**Schedule**" means any one, and "Schedules" mean any two or more, as the context requires, of the schedules appended to this Agreement including the following:

Schedule A: Total Funder Funding;

Schedule B: Reports;

Schedule C: Directives, Guidelines and Policies;

Schedule D: Performance;

Schedule E: Project Funding Agreement Template; and

Schedule F: Declaration of Compliance.

"**Service Plan**" means the Operating Plan and Budget appended as Schedules A and D2a of Schedule D;

"**Services**" means the care, programs, goods and other services described by reference to the Ontario Healthcare Reporting Standards functional centres in Schedule D2a of Schedule D, and in any Project Funding Agreement executed pursuant to this Agreement, and includes the type, volume, frequency and availability of the care, programs, goods and other services;

"**Service Volume**" means a measure of Services for which a Performance Target is set;

"**Transfer Order**" means a transfer order issued pursuant to subsection 40(1) of the CCA transferring this Agreement from the LHIN to Ontario Health;

"**Transition Plan**" means a transition plan, acceptable to the Funder that indicates how the needs of the HSP's clients will be met following the termination of this Agreement and how the transition of the clients to new service providers will be effected in a timely manner; and

"**2014-18 MSAA**" means the Multi-Sector Service Accountability Agreement April 1, 2014 to March 31, 2018.

1.2 Interpretation. Words in the singular include the plural and vice-versa. Words in one gender include all genders. The words "including" and "includes" are not intended to be limiting and shall mean "including without limitation" or "includes without limitation", as the case may be. The headings do not form part of this Agreement. They are for convenience of reference only and will not affect the interpretation of this Agreement. Terms used in the Schedules shall have the meanings set out in this Agreement unless separately and specifically defined in a Schedule in which case the definition in the Schedule shall govern for the purposes of that Schedule.

1.3 MSAA Indicator Technical Specification Document. This Agreement shall be interpreted with reference to the MSAA Indicator Technical Specifications document.

ARTICLE 2.0 - TERM AND NATURE OF THIS AGREEMENT

2.1 Term. The term of this Agreement will commence on the Effective Date and will expire on March 31, 2022 unless terminated earlier or extended pursuant to its terms.

ARTICLE 3.0A SERVICE ACCOUNTABILITY AGREEMENT. THIS AGREEMENT IS A SERVICE ACCOUNTABILITY AGREEMENT FOR THE PURPOSES OF THE ENABLING LEGISLATION.

ARTICLE 3.0 - PROVISION OF SERVICES

3.1 Provision of Services.

(a) The HSP will provide the Services in accordance with, and otherwise comply with:

(1) the terms of this Agreement, including the Service Plan;

(2) Applicable Law; and

(3) Applicable Policy.

(b) When providing the Services, the HSP will meet the Performance Standards and conditions identified in Schedule D and any applicable Project Funding Agreements.

(c) Unless otherwise provided in this Agreement, the HSP will not reduce, stop, start, expand, cease to provide or transfer the provision of the Services or change its Service Plan except with Notice to the Funder, and if required by Applicable Law or Applicable Policy, the prior written consent of the Funder.

(d) The HSP will not restrict or refuse the provision of Services to an individual, directly or indirectly, based on the geographic area in which the person resides in Ontario.

(e) The HSP will not withdraw any Services from a patient with complex needs who continues to require those Services, unless prior to discharging that patient from the Services, the HSP has made alternate arrangements for equivalent services to be delivered to that patient.

3.2 Subcontracting for the Provision of Services.

(a) The parties acknowledge that, subject to the provisions of the Enabling Legislation, the HSP may subcontract the provision of some or all of the Services. For the purposes of this Agreement, actions taken or not taken by the subcontractor, and Services provided by the subcontractor, will be deemed actions taken or not taken by the HSP, and Services provided by the HSP.

(b) When entering into a subcontract the HSP agrees that the terms of the subcontract will enable the HSP to meet its obligations under this Agreement. Without limiting the foregoing, the HSP will include a provision that permits the Funder or its authorized representatives, to audit the subcontractor in respect of the subcontract if the Funder or its authorized representatives determines that such an audit would be necessary to confirm that the HSP has complied with the terms of this Agreement.

(c) Nothing contained in this Agreement or a subcontract will create a contractual relationship between any subcontractor or its directors, officers, employees, agents, partners, affiliates or volunteers and the Funder.

(d) When entering into a subcontract, the HSP agrees that the terms of the subcontract will enable the HSP to meet its obligations under the FLSA.

3.3 Conflict of Interest. The HSP will use the Funding, provide the Services and otherwise fulfil its obligations under this Agreement, without an actual, potential or perceived Conflict of Interest. The HSP will disclose to the Funder without

delay any situation that a reasonable person would interpret as an actual, potential or perceived Conflict of Interest and comply with any requirements prescribed by the Funder to resolve any Conflict of Interest.

3.4 Digital Health. The HSP agrees to:

(a) assist the Funder to implement Digital Health priorities of the Funder;

(b) comply with any technical and information management standards, including those related to data, architecture, technology, privacy and security set for health service providers by the Ministry or the Funder within the timeframes set by the Ministry or the Funder as the case may be;

(c) implement and use the approved provincial Digital Health solutions identified by the Funder;

(d) implement technology solutions that are compatible or interoperable with the provincial blueprint and with the Funder's Digital Health priorities; and

(e) include in its annual Planning Submissions, plans for achieving Digital Health priority initiatives.

3.5 French Language Services.

3.5.1 The Funder will provide the Ministry "Guide to Requirements and Obligations Relating to French Language Services" to the HSP and the HSP will fulfill its roles, responsibilities and other obligations set out therein.

3.5.2 If Not Identified or Designated. If the HSP has not been Designated or Identified it will:

(a) develop and implement a plan to address the needs of the local Francophone community, including the provision of information on services available in French;

(b) work towards applying the principles of Active Offer in the provision of services;

(c) provide a report to the Funder that outlines how the HSP addresses the needs of its local Francophone community; and

(d) collect and submit to the Funder as requested by the Funder from time to time, French language service data.

3.5.3 If Identified. If the HSP is Identified it will:

(a) work towards applying the principles of Active Offer in the provision of services;
(b) provide services to the public in French in accordance with its existing French language services capacity;

(c) develop, and provide to the Funder upon request from time to time, a plan to become Designated by the date agreed to by the HSP and the Funder;
(d) continuously work towards improving its capacity to provide services in French and toward becoming Designated within the time frame agreed to by the parties;
(e) provide a report to the Funder that outlines progress in its capacity to provide services in French and toward becoming Designated;
(f) annually, provide a report to the Funder that outlines how it addresses the needs of its local Francophone community; and
(g) collect and submit to the Funder, as requested by the Funder from time to time, French language services data.

3.5.4 If Designated. If the HSP is Designated it will:

(a) apply the principles of Active Offer in the provision of services;
(b) continue to provide services to the public in French in accordance with the provisions of the FLSA;
(c) maintain its French language services capacity;
(d) submit a French language implementation report to the Funder on the date specified by the Funder, and thereafter, on each anniversary of that date, or on such other dates as the Funder may, by Notice, require; and
(e) collect and submit to the Funder as requested by the Funder from time to time, French language services data.

3.6 Mandate Letter language. The Funder will receive a Mandate Letter from the Ministry annually. Each Mandate Letter articulates areas of focus for the Funder, and the Ministry's expectation that the Funder and health service providers it funds will collaborate to advance these areas of focus. To assist the HSP in its collaborative efforts with the Funder, the Funder will share each relevant Mandate Letter with the HSP. The Funder may also add local obligations to Schedule D as appropriate to further advance any priorities set put in a Mandate Letter.

3.7 Policies, Guidelines, Directives and Standards. Either the Funder or the Ministry will give the HSP Notice of any amendments to the manuals, guidelines or policies identified in Schedule C. An amendment will be effective in accordance with the terms of the amendment. By signing a copy of this

Agreement the HSP acknowledges that it has a copy of the documents identified in Schedule C.

ARTICLE 4.0 - FUNDING

4.1 Funding. Subject to the terms of this Agreement, and in accordance with the applicable provisions of the Accountability Agreement, the Funder:

(a) will provide the funds identified in Schedule A to the HSP for the purpose of providing or ensuring the provision of the Services; and

(b) will deposit the funds in regular instalments, once or twice monthly, over the term of this Agreement, into an account designated by the HSP provided that the account resides at a Canadian financial institution and is in the name of the HSP.

4.2 Limitation on Payment of Funding. Despite section 4.1, the Funder:

(a) will not provide any funds to the HSP until this Agreement is fully executed;

(b) may pro-rate the funds identified in Schedule A to the date on which this Agreement is signed, if that date is after April 1;

(c) will not provide any funds to the HSP until the HSP meets the insurance requirements described in section 11.4;

(d) will not be required to continue to provide funds in the event the HSP breaches any of its obligations under this Agreement, until the breach is remedied to the Funder's satisfaction; and

(e) upon Notice to the HSP, may adjust the amount of funds it provides to the HSP in any Funding Year based upon the Funder's assessment of the information contained in the Reports.

4.3 Appropriation. Funding under this Agreement is conditional upon an appropriation of moneys by the Legislature of Ontario to the Ministry and funding of the Funder by the Ministry pursuant to the Enabling Legislation. If the Funder does not receive its anticipated funding the Funder will not be obligated to make the payments required by this Agreement.

4.4 Additional Funding.

(a) Unless the Funder has agreed to do so in writing, the Funder is not required to provide additional funds to the HSP for providing additional Services or for exceeding the requirements of Schedule D.

(b) The HSP may request additional funding by submitting a proposal to amend its Service Plan. The HSP will abide by all decisions of the Funder with respect to a proposal to amend the Service Plan and will make

whatever changes are requested or approved by the Funder. The Service Plan will be amended to include any approved additional funding.

(c) **Funding Increases**. Before the Funder can make an allocation of additional funds to the HSP, the parties will:

(1) agree on the amount of the increase;

(2) agree on any terms and conditions that will apply to the increase; and

(3) execute an amendment to this Agreement that reflects the agreement reached.

4.5 Conditions of Funding.

(a) The HSP will:

(1) fulfill all obligations in this Agreement;

(2) use the Funding only for the purpose of providing the Services in accordance with Applicable Law, Applicable Policy and the terms of this Agreement;

(3) spend the Funding only in accordance with the Service Plan; and

(4) plan for and achieve an Annual Balanced Budget.

(b) The Funder may add such additional terms or conditions on the use of the Funding which it considers appropriate for the proper expenditure and management of the Funding.

(c) All Funding is subject to all Applicable Law and Applicable Policy, including Health System Funding Reform, as it may evolve or be replaced over the term of this Agreement.

4.6 Interest.

(a) If the Funder provides the Funding to the HSP prior to the HSP's immediate need for the Funding, the HSP shall place the Funding in an interest bearing account in the name of the HSP at a Canadian financial institution.

(b) Interest Income must be used, within the fiscal year in which it is received, to provide the Services.

(c) Interest Income will be reported to the Funder and is subject to year-end reconciliation. In the event that some or all of the Interest Income is not used to provide the Services, the Funder may take one or more of the following actions:

(1) the Funder may deduct the amount equal to the unused Interest Income from any further Funding instalments under this or any other agreement with the HSP;

(2) the Funder may require the HSP to pay an amount equal to the unused Interest Income to the Ministry of Finance.

4.7 Rebates, Credits and Refunds. The HSP:

(a) acknowledges that rebates, credits and refunds it anticipates receiving from the use of the Funding have been incorporated in its Budget;

(b) agrees that it will advise the Funder if it receives any unanticipated rebates, credits and refunds from the use of the Funding, or from the use of funding received from either the Funder or the Ministry in years prior to this Agreement that was not recorded in the year of the related expenditure; and

(c) agrees that all rebates, credits and refunds referred to in (b) will be considered Funding in the year that the rebates, credits and refunds are received, regardless of the year to which the rebates, credits and refunds relate.

4.8 Procurement of Goods and Services.

(a) If the HSP is subject to the procurement provisions of the BPSAA, the HSP will abide by all directives and guidelines issued by the Management Board of Cabinet that are applicable to the HSP pursuant to the BPSAA.

(b) If the HSP is not subject to the procurement provisions of the BPSAA, the HSP will have a procurement policy in place that requires the acquisition of supplies, equipment or services valued at over $25,000 through a competitive process that ensures the best value for funds expended. If the HSP acquires supplies, equipment or services with the Funding it will do so through a process that is consistent with this policy.

4.9 Disposition. The HSP will not, without the Funder's prior written consent, sell, lease or otherwise dispose of any assets purchased with Funding, the cost of which exceeded $25,000 at the time of purchase.

ARTICLE 5.0 - REPAYMENT AND RECOVERY OF FUNDING

5.1 Repayment and Recovery.

(a) **At the End of a Funding Year**. If, in any Funding Year, the HSP has not spent all of the Funding the Funder will require the repayment of the unspent Funding.

(b) **On Termination or Expiration of this Agreement**. Upon termination or expiry of this Agreement and subject to section 12.4, the Funder will require the repayment of any Funding remaining in the possession or under the control of the HSP and the payment of an amount equal to any Funding the HSP used for purposes not permitted by this Agreement. The

Funder will act reasonably and will consider the impact, if any, that a recovery of Funding will have on the HSP's ability to meet its obligations under this Agreement.

(c) **On Reconciliation and Settlement**. If the year-end reconciliation and settlement process demonstrates that the HSP received Funding in excess of its confirmed funds, the Funder will require the repayment of the excess Funding.

(d) **As a Result of Performance Management or System Planning**. If Services are adjusted, as a result of the performance management or system planning processes, the Funder may take one or more of the following actions:

(1) adjust the Funding to be paid under Schedule A,

(2) require the repayment of excess Funding;

(3) adjust the amount of any future funding installments accordingly.

(e) **In the Event of Forecasted Surpluses**. If the HSP is forecasting a surplus, the Funder may take one or more of the following actions:

(1) adjust the amount of Funding to be paid under Schedule A,

(2) require the repayment of excess Funding;

(3) adjust the amount of any future funding installments accordingly.

(f) **On the Request of the Funder**. The HSP will, at the request of the Funder, repay the whole or any part of the Funding, or an amount equal thereto if the HSP:

(1) has provided false information to the Funder knowing it to be false;

(2) breaches a term or condition of this Agreement and does not, within 30 Days after receiving Notice from the Funder take reasonable steps to remedy the breach; or

(3) breaches any Applicable Law that directly relates to the provision of, or ensuring the provision of, the Services.

(g) Sections 5.1(c) and (d) do not apply to Funding already expended properly in accordance with this Agreement. The Funder will, at its sole discretion, and without liability or penalty, determine whether the Funding has been expended properly in accordance with this Agreement.

5.2 Provision for the Recovery of Funding. The HSP will make reasonable and prudent provision for the recovery by the Funder of any Funding for which the conditions of Funding set out in section 4.5 are not met and will hold this Funding in accordance with the provisions of section 4.6 until such time as reconciliation

and settlement has occurred with the Funder. Interest earned on Funding will be reported and recovered in accordance with section 4.6.

5.3 Process for Recovery of Funding. If the Funder, acting reasonably, determines that a recovery of Funding under section 5.1 is appropriate, then the Funder will give 30 Days' Notice to the HSP.

The Notice will describe:

(a) the amount of the proposed recovery;

(b) the term of the recovery, if not permanent;

(c) the proposed timing of the recovery;

(d) the reasons for the recovery; and

(e) the amendments, if any, that the Funder proposes be made to the HSP's obligations under this Agreement.

Where the HSP disputes any matter set out in the Notice, the parties will discuss the circumstances that resulted in the Notice and the HSP may make representations to the Funder about the matters set out in the Notice within 14 Days of receiving the Notice.

The Funder will consider the representations made by the HSP and will advise the HSP of its decision. Funding recoveries, if any, will occur in accordance with the timing set out in the Funder's decision. No recovery of Funding will be implemented earlier than 30 Days after the delivery of the Notice.

(a) **Settlement and Recovery of Funding for Prior Years**.

(a) The HSP acknowledges that settlement and recovery of Funding can occur up to 7 years after the provision of Funding.

(b) Recognizing the transition of responsibilities from the Ministry to the Funder, the HSP agrees that if the parties are directed in writing to do so by the Ministry, the Funder will settle and recover funding provided by the Ministry to the HSP prior to the transition of the Funding for the Services to the Funder, provided that such settlement and recovery occurs within 7 years of the provision of the funding by the Ministry. All such settlements and recoveries will be subject to the terms applicable to the original provision of Funding.

5.4 Debt Due.

(a) If the Funder requires the re-payment by the HSP of any Funding, the amount required will be deemed to be a debt owing to the Crown by the HSP. The Funder may adjust future funding instalments to recover the amounts owed or may, at its discretion direct the HSP to pay the amount owing to the Crown and the HSP shall comply immediately with any such direction.

(b) All amounts repayable to the Crown will be paid by cheque payable to the "Ontario Minister of Finance" and mailed or delivered to the Funder at the address provided in section 13.1.

5.5 Interest Rate. The Funder may charge the HSP interest on any amount owing by the HSP at the then current interest rate charged by the Province of Ontario on accounts receivable.

ARTICLE 6.0 - PLANNING & INTEGRATION

6.1 Planning for Future Years.

(a) **Advance Notice**. The Funder will give at least 60 Days' Notice to the HSP of the date by which a CAPS must be submitted to the Funder.

(b) **Multi-Year Planning**. The CAPS will be in a form acceptable to the Funder and may be required to incorporate:

(1) prudent multi-year financial forecasts;

(2) plans for the achievement of Performance Targets; and

(3) realistic risk management strategies.

If applicable, it will be aligned with the LHIN's then current integrated health service plan required by LHSIA and will reflect the Funder's priorities and initiatives. If the Funder has provided multi-year planning targets for the HSP, the CAPS will reflect the planning targets.

(c) **Multi-year Planning Targets**. Schedule A may reflect an allocation for the first Funding Year of this Agreement as well as planning targets for up to two additional years, consistent with the term of this Agreement. In such an event,

(1) the HSP acknowledges that if it is provided with planning targets, these targets:

a. are targets only,

b. are provided solely for the purposes of planning,

c. are subject to confirmation, and

d. may be changed at the discretion of the Funder in consultation with the HSP.

The HSP will proactively manage the risks associated with multi-year planning and the potential changes to the planning targets; and

(2) the Funder agrees that it will communicate any changes to the planning targets as soon as reasonably possible.

(d) **Service Accountability Agreements**. The HSP acknowledges that if the Funder and the HSP enter into negotiations for a subsequent service accountability agreement, subsequent funding may be interrupted if the next service accountability agreement is not executed on or before the expiration date of this Agreement.

6.2 Community Engagement & Integration Activities.

(a) **Community Engagement**. The HSP will engage the community of diverse persons and entities in the area where it provides health services when setting priorities for the delivery of health services and when developing plans for submission to the Funder including but not limited to CAPS and integration proposals. As part of its community engagement activities, the HSPs will have in place and utilize effective mechanisms for engaging families, caregivers, clients, residents, patients and other individuals who use the services of the HSP, to help inform the HSP plans, including the HSP's contribution to the establishment and implementation by the Funder of geographic sub-regions in the health system.

(b) **Integration**. The HSP will, separately and in conjunction with the Funder, other health service providers, if applicable, and integrated care delivery systems, if applicable, identify opportunities to integrate the services of the local health system to provide appropriate, coordinated, effective and efficient services.

(c) **Reporting**. The HSP will report on its community engagement and integration activities, using any templates provided by the Funder, as requested by the Funder and in any event, in its year-end report to the Funder.

6.3 Planning and Integration Activity Pre-proposals.

(a) **General**. A pre-proposal process has been developed to: (A) reduce the costs incurred by an HSP when proposing operational or service changes; (B) assist the HSP to carry out its statutory obligations; and (C) enable an effective and efficient response by the Funder. Subject to specific direction from the Funder, this pre-proposal process will be used in the following instances:

(1) the HSP is considering an integration or an integration of services, as defined in the Enabling Legislation between the HSP and another person or entity;

(2) the HSP is proposing to reduce, stop, start, expand or transfer the location of services, which for certainty includes: the transfer of services from the HSP to another person or entity anywhere; and the relocation or transfer of services from one of the HSP's sites to another of the HSP's sites anywhere;

(3) to identify opportunities to integrate the services of the local health system, other than those identified in (A) or (B) above; or

(4) if requested by the Funder.

(b) **Funder Evaluation of the Pre-proposal**. Use of the pre-proposal process is not formal Notice of a proposed integration under the Enabling Legislation. Funder consent to develop the project concept outlined in a pre-proposal does not constitute approval to proceed with the project. Nor does the Funder consent to develop a project concept presume the issuance of a favourable decision, should such a decision be required by the Enabling Legislation. Following the Funder's review and evaluation, the HSP may be invited to submit a detailed proposal and a business plan for further analysis. Guidelines for the development of a detailed proposal and business case will be provided by the Funder.

6.4 **Proposing Integration Activities in the Planning Submission**. No integration activity described in section 6.3 may be proposed in a CAPS unless the Funder has consented, in writing, to its inclusion pursuant to the process set out in section 6.3(b).

6.5

ARTICLE 7.0 - PERFORMANCE

7.1 **Performance**. The parties will strive to achieve on-going performance improvement. They will address performance improvement in a proactive, collaborative and responsive manner.

7.2 **Performance Factors.**

(a) Each party will notify the other party of the existence of a Performance Factor, as soon as reasonably possible after the party becomes aware of the Performance Factor. The Notice will:

(1) describe the Performance Factor and its actual or anticipated impact;

(2) include a description of any action the party is undertaking, or plans to undertake, to remedy or mitigate the Performance Factor;

(3) indicate whether the party is requesting a meeting to discuss the Performance Factor; and

(4) address any other issue or matter the party wishes to raise with the other party.

(b) The recipient party will provide a written acknowledgment of receipt of the Notice within 7 Days of the date on which the Notice was received ("Date of the Notice").

(c) Where a meeting has been requested under paragraph 7.2(a)(3), the parties agree to meet and discuss the Performance Factors within 14 Days of the Date of the Notice, in accordance with the provisions of section 7.3.

7.3 Performance Meetings. During a meeting on performance, the parties will:

(a) discuss the causes of a Performance Factor;

(b) discuss the impact of a Performance Factor on the local health system and the risk resulting from non-performance; and

(c) determine the steps to be taken to remedy or mitigate the impact of the Performance Factor (the "Performance Improvement Process").

7.4 The Performance Improvement Process.

(a) The Performance Improvement Process will focus on the risks of non-performance and problem-solving. It may include one or more of the following actions:

(1) a requirement that the HSP develop and implement an improvement plan that is acceptable to the Funder;

(2) the conduct of a Review;

(3) an amendment of the HSP's obligations;

(4) an in-year, or year-end, adjustment to the Funding,

among other possible means of responding to the Performance Factor or improving performance.

(b) Any performance improvement process begun under a prior service accountability agreement that was not completed under the prior agreement will continue under this Agreement. Any performance improvement required by a Funder under a prior service accountability agreement will be deemed to be a requirement of this Agreement until fulfilled or waived by the Funder.

7.5 Factors Beyond the HSP's Control. Despite the foregoing, if the Funder, acting reasonably, determines that the Performance Factor is, in whole or in part, a Factor Beyond the HSP's Control:

(a) the Funder will collaborate with the HSP to develop and implement a mutually agreed upon joint response plan which may include an amendment of the HSP's obligations under this Agreement;

(b) the Funder will not require the HSP to prepare an Improvement Plan; and

(c) the failure to meet an obligation under this Agreement will not be considered a breach of this Agreement to the extent that failure is caused by a Factor Beyond the HSP's Control.

ARTICLE 8.0 - REPORTING, ACCOUNTING AND REVIEW

8.1 Reporting.

(a) **Generally.** The Funder's ability to enable the health system to provide appropriate, co-ordinated, effective and efficient health services, is heavily dependent on the timely collection and analysis of accurate information. The HSP acknowledges that the timely provision of accurate information related to the HSP, and its performance of its obligations under this Agreement, is under the HSP's control.

(b) **Specific Obligations**. The HSP:

(1) will provide to the Funder, or to such other entity as the Funder may direct, in the form and within the time specified by the Funder, the Reports, other than personal health information as defined in the Enabling Legislation, that the Funder requires for the purposes of exercising its powers and duties under this Agreement, the Accountability Agreement, the Enabling Legislation or for the purposes that are prescribed under any Applicable Law;

(2) will fulfil the specific reporting requirements set out in Schedule B;

(3) will ensure that every Report is complete, accurate, signed on behalf of the HSP by an authorized signing officer where required and provided in a timely manner and in a form satisfactory to the Funder; and

(4) agrees that every Report submitted to the Funder by or on behalf of the HSP, will be deemed to have been authorized by the HSP for submission.

For certainty, nothing in this section 8.1 or in this Agreement restricts or otherwise limits the Funder's right to access or to require access to personal health information as defined in the Enabling Legislation, in accordance with Applicable Law for purposes of carrying out the Funder's statutory objects to achieve the purposes of the Enabling Legislation, including, if applicable, to provide certain services, supplies and equipment in accordance with section 5(m.1) of LHSIA and to manage placement of persons in accordance with section 5(m.2) of LHSIA.

(c) **French Language Services**. If the HSP is required to provide services to the public in French under the provisions of the FLSA, the HSP will be required to submit a French language services report to the Funder. If the HSP is not required to provide services to the public in French under the provisions of the FLSA, it will be required to provide a report to the Funder that outlines how the HSP addresses the needs of its local Francophone community.

(d) **Declaration of Compliance**. Within 90 Days of the HSP's fiscal year-end, the Board will issue a Compliance Declaration declaring that the HSP

has complied with the terms of this Agreement. The form of the declaration is set out in Schedule F and may be amended by the Funder from time to time through the term of this Agreement.

(e) **Financial Reductions**. Notwithstanding any other provision of this Agreement, and at the discretion of the Funder, the HSP may be subject to a financial reduction in any of the following circumstances:

(1) its CAPS is received after the due date;

(2) its CAPS is incomplete;

(3) the quarterly performance reports are not provided when due; or

(4) financial or clinical data requirements are late, incomplete or inaccurate,

where the errors or delay were not as a result of Funder actions or inaction or the actions or inactions of persons acting on behalf of the Funder. If assessed, the financial reduction will be as follows:

(1) if received within 7 Days after the due date, incomplete or inaccurate, the financial penalty will be the greater of (1) a reduction of 0.02 percent (0.02%) of the Funding; or (2) two hundred and fifty dollars ($250.00); and

(2) for every full or partial week of non-compliance thereafter, the rate will be one half of the initial reduction.

8.2 Reviews.

(a) During the term of this Agreement and for 7 years after the term of this Agreement, the HSP agrees that the Funder or its authorized representatives may conduct a Review of the HSP to confirm the HSP's fulfillment of its obligations under this Agreement. For these purposes the Funder or its authorized representatives may, upon 24 hours' Notice to the HSP and during normal business hours enter the HSP's premises to:

(1) inspect and copy any financial records, invoices and other finance-related documents, other than personal health information as defined in the Enabling Legislation, in the possession or under the control of the HSP which relate to the Funding or otherwise to the Services; and

(2) inspect and copy non-financial records, other than personal health information as defined in the Enabling Legislation, in the possession or under the control of the HSP which relate to the Funding, the Services or otherwise to the performance of the HSP under this Agreement.

(b) The cost of any Review will be borne by the HSP if the Review: (1) was made necessary because the HSP did not comply with a requirement under the Enabling Legislation or this Agreement; or (2) indicates that the

HSP has not fulfilled its obligations under this Agreement, including its obligations under Applicable Law and Applicable Policy.

(c) To assist in respect of the rights set out in (a) above, the HSP shall disclose any information requested by the Funder or its authorized representatives, and shall do so in a form requested by the Funder or its authorized representatives.

(d) The HSP may not commence a proceeding for damages or otherwise against any person with respect to any act done or omitted to be done, any conclusion reached or report submitted that is done in good faith in respect of a Review.

8.3 Document Retention and Record Maintenance. The HSP will

(a) retain all records (as that term is defined in FIPPA) related to the HSP's performance of its obligations under this Agreement for 7 years after the termination or expiration of the term of this Agreement;

(b) keep all financial records, invoices and other finance-related documents relating to the Funding or otherwise to the Services in a manner consistent with either generally accepted accounting principles or international financial reporting standards as advised by the HSP's auditor; and

(c) keep all non-financial documents and records relating to the Funding or otherwise to the Services in a manner consistent with all Applicable Law.

8.4 Disclosure of Information.

(a) **FIPPA**. The HSP acknowledges that the Funder is bound by FIPPA and that any information provided to the Funder in connection with this Agreement may be subject to disclosure in accordance with FIPPA.

(b) **Confidential Information**. The parties will treat Confidential Information as confidential and will not disclose Confidential Information except with the consent of the disclosing party or as permitted or required under FIPPA or the *Personal Health Information Protection Act, 2004*, the Enabling Legislation, court order, subpoena or other Applicable Law. Notwithstanding the foregoing, the Funder may disclose information that it collects under this Agreement in accordance with the Enabling Legislation.

8.5 Transparency. The HSP will post a copy of this Agreement and each Compliance Declaration submitted to the Funder during the term of this Agreement in a conspicuous and easily accessible public place at its sites of

operations to which this Agreement applies and on its public website, if the HSP operates a public website.

8.6 Auditor General. For greater certainty the Funder's rights under this article are in addition to any rights provided to the Auditor General under the *Auditor General Act* (Ontario).

ARTICLE 9.0 - ACKNOWLEDGEMENT OF FUNDER SUPPORT

9.1 Publication. For the purposes of this Article 9, the term "publication" means any material on or concerning the Services that the HSP makes available to the public, regardless of whether the material is provided electronically or in hard copy. Examples include a website, an advertisement, a brochure, promotional documents and a report. Materials that are prepared by the HSP in order to fulfil its reporting obligations under this Agreement are not included in the term "publication".

9.2 Acknowledgment of Funding Support.

(a) The HSP agrees all publications will include

(1) an acknowledgment of the Funding provided by the Funder and the Government of Ontario. Prior to including an acknowledgement in any publication, the HSP will obtain the Funder's approval of the form of acknowledgement. The Funder may, at its discretion, decide that an acknowledgement is not necessary; and

(2) a statement indicating that the views expressed in the publication are the views of the HSP and do not necessarily reflect those of the Funder or the Government of Ontario.

(b) The HSP shall not use any insignia or logo of Her Majesty the Queen in right of Ontario, including those of the Funder, unless it has received the prior written permission of the Funder to do so.

ARTICLE 10.0 - REPRESENTATIONS, WARRANTIES AND COVENANTS

10.1 General. The HSP represents, warrants and covenants that:

(a) it is, and will continue for the term of this Agreement to be, a validly existing legal entity with full power to fulfill its obligations under this Agreement;

(b) it has the experience and expertise necessary to carry out the Services;

(c) it holds all permits, licences, consents, intellectual property rights and authorities necessary to perform its obligations under this Agreement;

(d) all information (including information relating to any eligibility requirements for Funding) that the HSP provided to the Funder in support of its request for Funding was true and complete at the time the HSP provided it, and will, subject to the provision of Notice otherwise, continue to be true and complete for the term of this Agreement; and

(e) it does, and will continue for the term of this Agreement to, operate in compliance with all Applicable Law and Applicable Policy, including observing where applicable, the requirements of the *Corporations Act* or successor legislation and the HSP's by-laws in respect of, but not limited to, the holding of board meetings, the requirements of quorum for decision-making, the maintenance of minutes for all board and committee meetings and the holding of members' meetings.

10.2 Execution of Agreement. The HSP represents and warrants that:

(a) it has the full power and authority to enter into this Agreement; and

(b) it has taken all necessary actions to authorize the execution of this Agreement.

10.3 Governance.

(a) The HSP represents, warrants and covenants that it has established, and will maintain for the period during which this Agreement is in effect, policies and procedures:

(1) that set out a code of conduct for, and that identify the ethical responsibilities for all persons at all levels of the HSP's organization;

(2) to ensure the ongoing effective functioning of the HSP;

(3) for effective and appropriate decision-making;

(4) for effective and prudent risk-management, including the identification and management of potential, actual and perceived conflicts of interest;

(5) for the prudent and effective management of the Funding;

(6) to monitor and ensure the accurate and timely fulfillment of the HSP's obligations under this Agreement and compliance with the Enabling Legislation;

(7) to enable the preparation, approval and delivery of all Reports;

(8) to address complaints about the provision of Services, the management or governance of the HSP; and

(9) to deal with such other matters as the HSP considers necessary to ensure that the HSP carries out its obligations under this Agreement.

(b) The HSP represents and warrants that:

(1) it has, or will have within 60 Days of the execution of this Agreement, a Performance Agreement with its CEO that ties a reasonable portion of the CEO's compensation plan to the CEO's performance;

(2) it will take all reasonable care to ensure that its CEO complies with the Performance Agreement;

(3) it will enforce the HSP's rights under the Performance Agreement; and

(4) a reasonable portion of any compensation award provided to the CEO during the term of this Agreement will be pursuant to an evaluation of the CEO's performance under the Performance Agreement and the CEO's achievement of performance goals and performance improvement targets and in compliance with Applicable Law.

"compensation award", for the purposes of Section 10.3(b)(4) above, means all forms of payment, benefits and perquisites paid or provided, directly or indirectly, to or for the benefit of a CEO who performs duties and functions that entitle him or her to be paid.

10.4 Funding, Services and Reporting. The HSP represents warrants and covenants that

(a) the Funding is, and will continue to be, used only to provide the Services in accordance with the terms of this Agreement;

(b) the Services are and will continue to be provided:

(1) by persons with the expertise, professional qualifications, licensing and skills necessary to complete their respective tasks; and

(2) in compliance with Applicable Law and Applicable Policy; and

(c) every Report is accurate and in full compliance with the provisions of this Agreement, including any particular requirements applicable to the Report and any material change to a Report will be communicated to the Funder immediately.

10.5 Supporting Documentation. Upon request, the HSP will provide the Funder with proof of the matters referred to in this Article.

ARTICLE 11.0 - LIMITATION OF LIABILITY, INDEMNITY & INSURANCE

11.1 Limitation of Liability. The Indemnified Parties will not be liable to the HSP or any of the HSP's Personnel and Volunteers for costs, losses, claims, liabilities and damages howsoever caused arising out of or in any way related to the Services or otherwise in connection with this Agreement, unless caused by the negligence or wilful act of any of the Indemnified Parties.

11.2 Ibid. For greater certainty and without limiting section 11.1, the Funder is not liable for how the HSP and the HSP's Personnel and Volunteers carry out the Services and is therefore not responsible to the HSP for such Services. Moreover, the Funder is not contracting with or employing any HSP's Personnel and Volunteers to carry out the terms of this Agreement. As such, it is not liable for contracting with, employing or terminating a contract with or the employment of any HSP's Personnel and Volunteers required to carry out this Agreement, nor for the withholding, collection or payment of any taxes, premiums, contributions or any other remittances due to government for the HSP's Personnel and Volunteers required by the HSP to carry out this Agreement.

11.3 Indemnification. The HSP hereby agrees to indemnify and hold harmless the Indemnified Parties from and against any and all liability, loss, costs, damages and expenses (including legal, expert and consultant costs), causes of action, actions, claims, demands, lawsuits or other proceedings (collectively, the "Claims"), by whomever made, sustained, brought or prosecuted (including for third party bodily injury (including death), personal injury and property damage), in any way based upon, occasioned by or attributable to anything done or omitted to be done by the HSP or the HSP's Personnel and Volunteers, in the course of the performance of the HSP's obligations under, or otherwise in connection with, this Agreement, unless caused by the negligence or wilful misconduct of any Indemnified Parties.

11.4 Insurance.

(a) **Generally**. The HSP shall protect itself from and against all Claims that might arise from anything done or omitted to be done by the HSP and the HSP's Personnel and Volunteers under this Agreement and more specifically all Claims that might arise from anything done or omitted to be done under this Agreement where bodily injury (including personal injury), death or property damage, including loss of use of property is caused.

(b) **Required Insurance**. The HSP will put into effect and maintain, with insurers having a secure A.M. Best rating of B+ or greater, or the equivalent, all necessary and appropriate insurance that a prudent person in the business of the HSP would maintain, including, but not limited to, the following at its own expense:

(1) Commercial General Liability Insurance, for third party bodily injury, personal injury and property damage to an inclusive limit of not less

than 2 million dollars per occurrence and not less than 2 million dollars products and completed operations aggregate. The policy will include the following clauses:

a. The Indemnified Parties as additional insureds;
b. Contractual Liability;
c. Cross-Liability;
d. Products and Completed Operations Liability;
e. Employers Liability and Voluntary Compensation unless the HSP complies with the Section below entitled “Proof of WSIA Coverage”;
f. Tenants Legal Liability; (for premises/building leases only);
g. Non-Owned automobile coverage with blanket contractual coverage for hired automobiles; and
h. A 30-Day written notice of cancellation, termination or material change.

(2) **Proof of WSIA Coverage**. Unless the HSP puts into effect and maintains Employers Liability and Voluntary Compensation as set out above, the HSP will provide the Funder with a valid *Workplace Safety and Insurance Act, 1997* (“WSIA”) Clearance Certificate and any renewal replacements, and will pay all amounts required to be paid to maintain a valid WSIA Clearance Certificate throughout the term of this Agreement.

(3) All Risk Property Insurance on property of every description, for the term, providing coverage to a limit of not less than the full replacement cost, including earthquake and flood. All reasonable deductibles and self-insured retentions are the responsibility of the HSP.

(4) Comprehensive Crime insurance, Disappearance, Destruction and Dishonest coverage.

(5) Errors and Omissions Liability Insurance insuring liability for errors and omissions in the provision of any professional services as part of the Services or failure to perform any such professional services, in the amount of not less than two million dollars per claim and in the annual aggregate.

(c) **Certificates of Insurance**. The HSP will provide the Funder with proof of the insurance required by this Agreement in the form of a valid certificate of insurance that references this Agreement and confirms the required coverage, on or before the commencement of this Agreement, and renewal replacements on or before the expiry of any such insurance. Upon the request of the Funder, a copy of each insurance policy shall be made available to it. The HSP shall ensure that each of its subcontractors obtains all the necessary and appropriate insurance that a prudent person in the business of the subcontractor would maintain and that the Indemnified Parties are named as additional insureds with respect to any

liability arising in the course of performance of the subcontractor's obligations under the subcontract.

ARTICLE 12.0 - TERMINATION AND EXPIRY OF AGREEMENT

12.1 Termination by the Funder.

(a) **Without Cause**. The Funder may terminate this Agreement at any time, for any reason, upon giving at least 60 Days' Notice to the HSP.

(b) **Where No Appropriation**. If, as provided for in section 4.3, the Funder does not receive the necessary funding from the Ministry, the Funder may terminate this Agreement immediately by giving Notice to the HSP.

(c) **For Cause**. The Funder may terminate all or part of this Agreement immediately upon giving Notice to the HSP if:

(1) in the opinion of the Funder:

a. the HSP has knowingly provided false or misleading information regarding its funding request or in any other communication with the Funder;
b. the HSP breaches any material provision of this Agreement;
c. the HSP is unable to provide or has discontinued all or part of the Services; or
d. it is not reasonable for the HSP to continue to provide all or part of the Services;

(2) the nature of the HSP's business, or its corporate status, changes so that it no longer meets the applicable eligibility requirements of the program under which the Funder provides the Funding;

(3) the HSP makes an assignment, proposal, compromise, or arrangement for the benefit of creditors, or is petitioned into bankruptcy, or files for the appointment of a receiver; or

(4) the HSP ceases to carry on business.

(d) **Material Breach**. A breach of a material provision of this Agreement includes, but is not limited to:

(1) misuse of Funding;

(2) a failure or inability to provide the Services as set out in the Service Plan;

(3) a failure to provide the Compliance Declaration;

(4) a failure to implement, or follow, a Performance Agreement, one or more material requirements of a Performance Improvement Process or of a Transition Plan;

(5) a failure to respond to Funder requests in a timely manner;

(6) a failure to: A) advise the Funder of actual, potential or perceived Conflict of Interest; or B) comply with any requirements prescribed by the Funder to resolve a Conflict of Interest; and

(7) a Conflict of Interest that cannot be resolved.

(e) **Transition Plan**. In the event of termination by the Funder pursuant to this section, the Funder and the HSP will develop a Transition Plan. The HSP agrees that it will take all actions, and provide all information, required by the Funder to facilitate the transition of the HSP's clients.

12.2 Termination by the HSP.

(a) The HSP may terminate this Agreement at any time, for any reason, upon giving 6 months' Notice (or such shorter period as may be agreed by the HSP and the Funder) to the Funder provided that the Notice is accompanied by:

(1) satisfactory evidence that the HSP has taken all necessary actions to authorize the termination of this Agreement; and

(2) a Transition Plan, acceptable to the Funder, that indicates how the needs of the HSP's clients will be met following the termination and how the transition of the clients to new service providers will be effected within the six-month Notice period.

(b) In the event that the HSP fails to provide an acceptable Transition Plan, the Funder may reduce Funding payable to the HSP prior to termination of this Agreement to compensate the Funder for transition costs.

12.3 Opportunity to Remedy.

(a) **Opportunity to Remedy**. If the Funder considers that it is appropriate to allow the HSP an opportunity to remedy a breach of this Agreement, the Funder may give the HSP an opportunity to remedy the breach by giving the HSP Notice of the particulars of the breach and of the period of time within which the HSP is required to remedy the breach. The Notice will also advise the HSP that the Funder may terminate this Agreement:

(1) at the end of the Notice period provided for in the Notice if the HSP fails to remedy the breach within the time specified in the Notice; or

(2) prior to the end of the Notice period provided for in the Notice if it becomes apparent to the Funder that the HSP cannot completely remedy the breach within that time or such further period of time as the Funder considers reasonable, or the HSP is not proceeding to remedy the breach in a way that is satisfactory to the Funder.

(b) **Failure to Remedy**. If the Funder has provided the HSP with an opportunity to remedy the breach, and:

(1) the HSP does not remedy the breach within the time period specified in the Notice;

(2) it becomes apparent to the Funder that the HSP cannot completely remedy the breach within the time specified in the Notice or such further period of time as the Funder considers reasonable; or

(3) the HSP is not proceeding to remedy the breach in a way that is satisfactory to the Funder,

then the Funder may immediately terminate this Agreement by giving Notice of termination to the HSP.

12.4 Consequences of Termination. If this Agreement is terminated pursuant to this Article, the Funder may:

(a) cancel all further Funding instalments;

(b) demand the repayment of any Funding remaining in the possession or under the control of the HSP;

(c) through consultation with the HSP, determine the HSP's reasonable costs to wind down the Services; and

(d) permit the HSP to offset the costs determined pursuant to section (c), against the amount owing pursuant to section (b).

12.5 Effective Date. Termination under this Article will take effect as set out in the Notice.

12.6 Corrective Action. Despite its right to terminate this Agreement pursuant to this Article, the Funder may choose not to terminate this Agreement and may take whatever corrective action it considers necessary and appropriate, including suspending Funding for such period as the Funder determines, to ensure the successful completion of the Services in accordance with the terms of this Agreement.

12.7 Expiry of Agreement. If the HSP intends to allow this Agreement to expire at the end of its term, the HSP will provide 6 months' Notice (or such shorter period as may be agreed by the HSP and the Funder) to the Funder, along with a Transition Plan, acceptable to the Funder, that indicates how the needs of the HSP's clients will be met following the expiry and how the transition of the clients to new service providers will be effected within the 6-month Notice period.

12.8 Failure to Provide Notice of Expiry. If the HSP fails to provide the required 6 months' Notice that it intends to allow this Agreement to expire, or fails to provide a Transition Plan along with any such Notice, this Agreement shall automatically be extended and the HSP will continue to provide the Services under this

Agreement for so long as the Funder may reasonably require to enable all clients of the HSP to transition to new service providers.

ARTICLE 13.0 - NOTICE

13.1 Notice. A Notice will be in writing; delivered personally, by pre-paid courier, by any form of mail where evidence of receipt is provided by the post office, or by facsimile with confirmation of receipt, or by email where no delivery failure notification has been received. For certainty, delivery failure notification includes an automated 'out of office' notification. A Notice will be addressed to the other party as provided below or as either party will later designate to the other in writing:

To the Funder:

Champlain LHIN
1900 City Park Drive, Suite 204
Ottawa, ON K1J 1A3

Attn: Elizabeth Woodbury
Director, Health System Accountability
Fax: 613-745-1928
Email: ch.accountabilityteam@lhins.on.ca

To the HSP:

Royal Ottawa Health Care Group
1145 Carling Avenue
Ottawa, ON K1Z 7K4

Attn: President & Chief Executive Officer
Fax: 613-722-7686
Email: joanne.bezzubetz@theroyal.ca

13.2 Notices Effective From. A Notice will be deemed to have been duly given 1 business day after delivery if the Notice is delivered personally, by pre-paid courier or by mail. A Notice that is delivered by facsimile with confirmation of receipt or by email where no delivery failure notification has been received will be

deemed to have been duly given 1 business day after the facsimile or email was sent.

ARTICLE 14.0 - ADDITIONAL PROVISIONS

14.1 Interpretation. In the event of a conflict or inconsistency in any provision of this Agreement, the main body of this Agreement will prevail over the Schedules.

14.2 Invalidity or Unenforceability of Any Provision. The invalidity or unenforceability of any provision of this Agreement will not affect the validity or enforceability of any other provision of this Agreement and any invalid or unenforceable provision will be deemed to be severed.

14.3 Waiver. A party may only rely on a waiver of the party's failure to comply with any term of this Agreement if the other party has provided a written and signed Notice of waiver. Any waiver must refer to a specific failure to comply and will not have the effect of waiving any subsequent failures to comply.

14.4 Parties Independent. The parties are and will at all times remain independent of each other and are not and will not represent themselves to be the agent, joint venturer, partner or employee of the other. No representations will be made or acts taken by either party which could establish or imply any apparent relationship of agency, joint venture, partnership or employment and neither party will be bound in any manner whatsoever by any agreements, warranties or representations made by the other party to any other person or entity, nor with respect to any other action of the other party.

14.5 Funder is an Agent of the Crown. The parties acknowledge that the Funder is an agent of the Crown and may only act as an agent of the Crown in accordance with the provisions of the Enabling Legislation. Notwithstanding anything else in this Agreement, any express or implied reference to the Funder providing an indemnity or any other form of indebtedness or contingent liability that would directly or indirectly increase the indebtedness or contingent liabilities of the Funder or of Ontario, whether at the time of execution of this Agreement or at any time during the term of this Agreement, will be void and of no legal effect.

14.6 Express Rights and Remedies Not Limited. The express rights and remedies of the Funder are in addition to and will not limit any other rights and remedies available to the Funder at law or in equity. For further certainty, the Funder has not waived any provision of any applicable statute, including the Enabling Legislation, nor the right to exercise its rights under these statutes at any time.

14.7 No Assignment. The HSP will not assign this Agreement or the Funding in whole or in part, directly or indirectly, without the prior written consent of the Funder. No assignment or subcontract shall relieve the HSP from its obligations under this Agreement or impose any liability upon the Funder to any assignee or subcontractor. The Funder may assign this Agreement or any of its rights and

obligations under this Agreement to any one or more agencies or ministries of Her Majesty the Queen in right of Ontario and as otherwise directed by the Ministry.

14.8 Governing Law. This Agreement and the rights, obligations and relations of the parties hereto will be governed by and construed in accordance with the laws of the Province of Ontario and the federal laws of Canada applicable therein. Any litigation arising in connection with this Agreement will be conducted in Ontario unless the parties agree in writing otherwise.

14.9 Survival. The provisions in Articles 1.0, 5.0, 8.0, 10.5, 11.0, 13.0, 14.0 and 15.0 will continue in full force and effect for a period of seven years from the date of expiry or termination of this Agreement.

14.10 Further Assurances. The parties agree to do or cause to be done all acts or things necessary to implement and carry into effect this Agreement to its full extent.

14.11 Amendment of Agreement. This Agreement may only be amended by a written agreement duly executed by the parties.

14.12 Counterparts. This Agreement may be executed in any number of counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument.

ARTICLE 15.0 - ENTIRE AGREEMENT

15.1 Entire Agreement. This Agreement forms the entire Agreement between the parties and supersedes all prior oral or written representations and agreements, except that where the Funder has provided Funding to the HSP pursuant to an amendment to the 2014-2018 MSAA, the 2018 Multi-Sector Accountability Agreement, or to this Agreement, whether by Project Funding Agreement or otherwise, and an amount of Funding for the same purpose is set out in the Schedules, that Funding is subject to all of the terms and conditions on which funding for that purpose was initially provided, unless those terms and conditions have been superseded by any terms or conditions of this Agreement or by the MSAA Indicator Technical Specifications document, or unless they conflict with Applicable Law or Applicable Policy.

-SIGNATURE PAGE FOLLOWS-

The parties have executed this Agreement on the dates set out below.

CHAMPLAIN LOCAL HEALTH INTEGRATION NETWORK

By:

_____ _____
James Fahey, Interim VP, Integration, Accountability, Communications and Engagement — Date

And by:

_____ _____
Renato Discenza, CEO — Date

ROYAL OTTAWA HEALTH CARE GROUP

By:

_____ _____
Anne Graham, Chair
I have authority to bind the HSP — Date

And by:

_____ _____
Dr. Joanne Bezzubetz
President & Chief Executive Officer
I have authority to bind the HSP — Date

The Le Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

ROYAL OTTAWA HEALTH CARE GROUP BOARD
AUDIT COMMITTEE MINUTES OF THE MEETING HELD
January 30, 2020 7:30 HRS
ROYAL OTTAWA MENTAL HEALTH CENTRE

Trustees	Present	Regrets	Trustees	Present	Regrets
J. Gallant, Chair	X		S. Squire		X
R. Anderson	X		J. MacRae	X	
L. Gillen	X (phone)		A. Graham	X (phone)	
L. Leikin		X			
C. Coulter	X				
Management Staff					
K. Kealey			J. Bezzubetz		
C. Crocker					
D. Bilodeau					
Guests					
A. Newman, KPMG	X				
A. Singherayor, KPMG	X				

AGENDA ITEMS		ACTION REQUIRED
Call to Order	J. Gallant, the Chair, called the meeting to order at 7:31 am and declared the meeting to have been regularly called and properly constituted for the transaction of business. The Chair welcomed guests from KPMG.	
Meeting Agenda	**Moved by R. Anderson , seconded by J. MacRae,** **BE IT RESOLVED THAT the meeting agenda, be accepted as presented** **CARRIED**	
Consent Agenda	**Moved by R. Anderson , seconded by J. MacRae,** **BE IT RESOLVED THAT the consent agenda, including the actions outlined therein, be accepted as presented.** **CARRIED** a. Minutes – May 23, 2019 b. Workplan - Draft c. Statutory Obligations Letter d. Update – Whistleblower Policy	

AGENDA ITEMS		ACTION REQUIRED
Items Moved from the Consent Agenda	No items were removed from the Consent Agenda.	
3a Terms of Reference	C. Crocker reported that there are no changes to the Terms of Reference, these are brought to the Committee as part of annual reporting per work plan **Moved by R. Anderson, seconded by C. Coulter** **BE IT RESOLVED THAT the Terms of Reference be accepted as presented** **CARRIED**	
3b Review of Financial Risk Register	The Financial Risk Register was presented by C. Crocker In response to questions, the following was noted: • The financial risk register concept was developed from review of other organizations and what they were capturing at that time • Finance committee members decided to continue with the risk register as a separate process from the Integrated Risk Management Framework (IRMF) but to remain tied in to the broader register • A. Newman advised KPMG uses the risk register for information when reviewing audit risks • The impact scales and when appropriate, the risk, will be noted consistently with the IRMF **Action Items:** • Remove "Ad hoc Finance subcommittee established to look at long term sustainability" pg.4 • The document will be reviewed for consistency using one set of metrics and alignment with the IRMF	**C Crocker/K. Kealey C Crocker/K. Kealey**
3c Review impact of changes – reporting requirements and accounting treatment of new transactions	C. Crocker reported that there are no new reporting requirements or accounting treatments for fiscal 20/21	
3d Review recommendations – Executive	C. Crocker reported that there are no recommendations from the Executive Committee related to the Risk Management Report.	

AGENDA ITEMS		ACTION REQUIRED
Committee relating to the Risk Management Report		
3e Update status of issues identified in Management Letter from previous fiscal year	C. Crocker reported that there were no issues identified by KPMG related to the 2019/20 management letter	
3f Review Audit Planning Report, KPMG	Andrew Newman, KPMG provided an overview of the precirculated Audit Plan providing information regarding the audit approach and audit team assigned to oversee the ROHCG audit process. It was noted that the Audit Plan document refers to the term donation, which was built in to the document in error, it was noted that this error does not affect the document as a whole – this will be corrected and a final Audit Plan will be provided to submit to the Board of Trustees Ann Singherayor, KPMG Audit Manager provided a detailed overview of the Audit Plan The following was noted: • The Audit plan reporting is consistent with prior years • Benchmark materiality of 2.1% a small increase but is consistent with prior year, which was reported at 2.0% • $3.8 million materiality, which is an increase from the prior year. Materiality for the prior year was $3.5million • Performance materiality (used 75% of materiality) is $2,850,000, which is an increase from the prior year. Performance materiality for the prior year was $2,625,000 • Posting threshold is $190,000 compared to $175,000 the prior year • No significant financial reporting risk identified • No significant change in GAAP for the 2019/20 fiscal year • Data & Analytics (D&A) procedures to be integrated into the planned audit approach allowing analysis of greater quantities of data. Planned D&A areas of focus will be Journal Entry Testing and Expenses • The sale of HFS was noted as an audit risk as it is a significant unusual transaction of the ROHCG and has material impact on the financial statements – including related disclosures in the hospital and foundation financial statements • Disposition of all investments to CIBC was noted as an audit risk as investments are a material financial statement line item for ROHCG and as all the investments were disposed of there is an increased reporting surrounding the accounting for gain and	

AGENDA ITEMS		ACTION REQUIRED
	loss on disposition as well as accounting for purchase of new investments • Additional audit related work to support audit opinion on the financial statements would include sale of HFS and disposition and purchase of investments. A. Newman noted that additional fees will apply for this work but are not expected to exceed $5K • Appendix 3 – included information related to Lean In Audit. K. Kealey has provided a document to cover the Lean In process that was completed for Payroll and Accounts Payable/Procurement in the Finance Committee meeting agenda package. It was noted that no internal control weaknesses were found however the team did develop several efficiency projects for implementation • Lean In Audit provides thorough and concise reporting of procedures and identifies areas of improvement to streamline and make processes more efficient and effective. • Appendix 5 – Draft Audit Quality Indicators for NPOs was included as a follow up from the previous meeting for KPMG to include an explanation of how audit quality is addressed in their reporting • Any questions and/or comments regarding information related to Appendix 5 can be submitted directly to A. Newman • The Chair thanked KPMG for their efforts with this tool noting it will be utilized for the upcoming audit and assessed for effectiveness **<u>Action Items:</u>** • Audit Planning Report is to be amended and provided as a final document to go to the Board of Trustees • C. Crocker will clarify process of how information related to additional fees for extra work is to be identified in the APR to assure the Board of Trustees has been made aware **Moved by J. MacRae, Seconded by C. Coulter** **BE IT RESOLVED THAT the amended Audit Planning Report be recommended to the Board of Trustees for approval**	**KPMG** **C. Crocker**
Next Meeting	May 21, 2020, IMHR Conference Room 5437 7:30 am	
Adjournment	**Moved by C. Coulter, Seconded by R. Anderson** **THAT THE MEETING BE ADJOURNED AT 8:03 am** **CARRIED**	

J. Gallant,
Chair, Finance Committee

J. Bezzubetz
Secretary, Board of Trustees

Date

Audit Meeting Action Items

Action Item	Individual Responsible	Status
Risk Register - Ensure that the terminology aligns with the IRMF re: impact and likelihood	K. Kealey/C. Crocker	May 2020
Discussion regarding reporting frequency of Risk Register i.e. Bi-Annually vs Quarterly	J. Gallant/A. Graham	May 2020

Services de santé
RoyalOttawa
Health Care Group

Centre de santé mentale
Royal Ottawa
Mental Health Centre

Centre de santé mentale
Brockville
Mental Health Centre

Place
Royal Ottawa
Place

Fondation de santé mentale
Royal Ottawa
Foundation for Mental Health

University of Ottawa
Institute of Mental
Health Research

Institut de recherche
en santé mentale
de l'Université d'Ottawa

January 30, 2020

Audit Committee of the Board
Royal Ottawa Health Care Group (ROHCG)
1145 Carling Avenue
Ottawa, ON
K1Z 7K4

Re: Statutory Obligations

In the course of normal business operations, ROHCG is required by Law and Regulations, to make remittances and file reports to various authorities. Management is reporting to the Audit Committee of the Board of Trustees on the status of these obligations as of December 31, 2018.

Remittances:

Payroll

- All salary and wages to employees have been paid as required
- All employee and employer benefit contributions have been remitted to the underwriters as required.
- All employee source deductions have been remitted as required.
- All employer contributions to Canada Pension Plan, Employment Insurance, Employer Health Tax, Workplace Safety Insurance Board and Pension Plans have been disbursed as scheduled.

HST:

- All HST collected has been remitted on schedule

Filing Obligations

Hospital Annual Planning Submission (HAPS):

- The 2019/20 Hospital Annual Planning Submission was submitted on
  Preliminary November 19, 2018
  Final January 22, 2019

Community Annual Planning Submission (CAPS):

- The 2019/20 Community Annual Planning Submission was submitted on
  Preliminary Nov 16, 2018
  Final January 31, 2019

Accountability Agreements (H-SAA, M-SAA, L-SAA)

- The Hospital Service Accountability Agreement (H-SAA) was extended to March 31, 2020. (*Signed by the LHIN* and ROHCG and is effective April 1, 2017)
- The Multi-sector Service Accountability Agreement (M-SAA) was signed by the LHIN and ROHCG and is in effect from Apr 1, 2019 – March 31, 2022
- The Long Term Care Service Accountability Agreement (L-SAA) is in effect until March 31, 2020

MOHLTC Submissions

- All mandatory electronic submissions have been filed on schedule

Canada Revenue Agency

- The Charity Return documents for 2018/19 was completed on September 16, 2019

Other Obligations:

Applicable Legislation:
We are in compliance with all applicable legislation, of which we are aware, including, but not limited to:

- Corporations Act
- Public Hospitals Act
- Mental Health Act
- Nursing Homes Act
- Commitment to the Future of Medicare Act
- Local Health System Integration Act
- Personal Health Information Protection Act
- Quality of Care Information Protection Act
- Health Protection and Promotion Act
- Accessibility for Ontarians with Disabilities Act
- Occupational Health and Safety Act
- Workplace Safety and Insurance Act
- Insurance Act
- Environment Protection Act (Canada and Ontario)
- Ontario Water Resources Act
- Charities Accounting Act
- Trustee Act
- Income Tax Act
- Pension Benefits Act
- Employment Insurance Act
- Labour Relations Act
- Employer Health Tax Act
- Excise Tax Act
- Retail Sales Tax Act
- Bill 46 – Excellent Care for All Act
- Bill 168 – Occupational Health & Safety Amendment Act
- Bill 16- Creating the Foundation for Jobs & Growth Act
- Bill 22 – Employment Standards Amendment Act (Greater Protection for Interns and Vulnerable Workers), 2014
- Critical Incident Reporting Amendment to Reg 965 of Public Hospitals Act
- Ontario Human Rights Code
- Regulated Health Professionals Act
- Pay Equity Act
- Bill 122 – An act to increase the financial accountability of organizations in the Broader Public Sector
- Broader Public Sector Business Documents Directive
- Hospital Parking Directive
- Bill 210: Patients First Act, 2016

- Legislative Amendments to the *Provincial Advocate for Children and Youth Act, 2007* Bill 117
- Bill 148 Fair Workplaces, Better Jobs Act, 2017
- Bill 160 – An Act to amend, repeal and enact various Acts in the interest of strengthening quality an accountability for patients
- Long Term Care Homes Act, 2007 Amending O. Reg. 79/10
- Bill 74 -Peoples Health Care Act 2019
- Bill 124 – Protecting a Sustainable Public Sector for Future Generations Act

J. Bezzubetz
President and CEO
ROHCG

Dr. R. Bhatla
Psychiatrist-in-Chief
ROHCG

C. Crocker
Chief Operating Officer/CFO
ROHCG

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 36	**Priority:** Important

DATE: February 20, 2020

COMMITTEE: Audit Committee

PRESENTER: J. Gallant

SUBJECT: Annual Audit Plan

BACKGROUND INFORMATION:

The Audit Committee reviews annually and discusses the external auditor's written report and addresses all factors that might impact on the auditor's independence. This was reviewed at the January 30, 2020 Audit Committee meeting and is recommended to the Board of Trustees for approval.

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT as recommended by the Audit Committee, the Annual Audit Plan be approved, as presented.

CARRIED

Moved by:

Seconded by:

Motion approved:

Royal Ottawa Health Care Group ("ROHCG")

Audit Planning Report
for the year ending March 31, 2020

KPMG LLP

Prepared on January 16, 2020 for the Audit Committee meeting on January 31, 2020

kpmg.ca/audit

KPMG

Table of contents

The contacts at KPMG in connection with this report are:

Andrew C. Newman, FCPA, FCA
Lead Audit Engagement Partner
Tel: (613) 212-2877
andrewnewman@kpmg.ca

Ann Singherayor, CPA, CA
Audit Manager
Tel: (613) 212-3644
asingherayor@kpmg.ca

Executive summary

Audit and business risks

Our audit is risk-focused. In planning our audit we have taken into account key areas of focus for financial reporting.

Audit materiality

Materiality has been determined based on prior year total revenues. We have determined materiality to be $3,800,000.

Independence and Quality Control

We are independent and have extensive quality control and conflict checking processes in place. We provide complete transparency on all services and follow Audit Committee approved protocols.

Proposed Fess

Proposed professional fees for the annual audit are $65,200, including a number of required contribution audits as detailed in the Fees section below.

Current developments and Audit Trends

There are no new relevant accounting or auditing changes to be brought to your attention at this time. As requested by the Audit Committee, we are pleased to provide Common Audit Quality Indicators for Not-for-Profit Organizations in Appendix 5, which we have developed specifically for NPOs.

This Audit Planning Report should not be used for any other purpose or by anyone other than the Audit Committee. KPMG shall have no responsibility or liability for loss or damages or claims, if any, to or by any third party as this Audit Planning Report has not been prepared for, and is not intended for, and should not be used by, any third party or for any other purpose.

Key Management Team Members

Team member	Background / experience	Discussion of role
 **Andrew C. Newman, FCPA, FCA** Lead Audit Engagement Partner Tel: (613) 212-2877 andrewnewman@kpmg.ca	– Andrew has over 25 years of experience serving not-for-profit organizations. Andrew is KPMG Canada's National Leader, Education, and leads Ottawa's Public Sector practice. – This is Andrew's 6th year serving the ROHCG. – Andrew is also Vice-Chair of the Public Sector Accounting Board of Canada.	– Andrew will be responsible for the quality and timeliness of our work and the conclusions reached by the engagement team. – Andrew will provide the overall direction for audit and related services, and will have regular and direct contact with ROHCG management. – Andrew will help ensure the ROHCG receives the full benefit of our audit and specialist resources on a timely and effective basis.
 **Ann Singherayor, CPA, CA** Audit Manager Tel: (613) 212-3644 asingherayor@kpmg.ca	– Ann has over six years of experience serving not-for-profit organizations. Ann is a key member of KPMG's public sector audit practice group in Ottawa. – This is Ann's second year serving the ROHCG .	– Ann will be responsible for the direct supervision and management of the audit of the ROHCG, and will be your primary contact person. – Ann will be on site regularly during the audit period and will be your main point of contact throughout the year.

Key Royal Ottawa Health Care Group Team Members

Key Team Member	Key Responsibilities in Support of the Audit	Significant Account
Cal Crocker, Chief Operating Officer and CFO	– Cal Crocker is responsible for financial oversight of the ROHCG. He is responsible for the financial close process and will attend debrief meetings with the KPMG Partner and Senior Manager.	– Financial reporting oversight
Kim Kealey, Director of Finance	– Kim Kealey is responsible for the review of the financial statements and related note disclosures. She is the main contact to obtain required documents for the completion of the ROHCG audit.	– Financial statement review and raiser's edge report
Craig St. Germain, Manager, Budgeting and Reporting	– Craig St. Germain is responsible for the assembly of the financial statements and all related sections. For the audit, he is the main contact for all audit sections.	– All Sections
Guy Capelle, Director of IT	– Guy Capelle is responsible for information technology at ROHCG. Guy is our main contact for discussions on any changes to current ROHCG information systems.	– Information Technology
Joanne Bezzubetz, President and CEO	– Joanne Bezzubetz provides general oversight of the financial close process of the ROHCG and will attend debrief meetings with the KPMG Partner and Senior Manager.	– Financial reporting oversight
José Gallant, Audit Committee Chair	– José Gallant is responsible for providing leadership to the Audit Committee and for collaborating with Management and KPMG on audit matters.	– Financial reporting oversight

Materiality

Materiality determination	Comments	Amount
Materiality	Determined to plan and perform the audit and to evaluate the effects of identified misstatements on the audit and of any uncorrected misstatements on the financial statements. The corresponding amount for the prior year's audit was $3,500,000.	$3,800,000
Benchmark	Based on total prior year end revenues. This benchmark is consistent with the prior year. The benchmark and materiality will be re-assessed during the audit period to adjust for any new normalization or adjustment in activities.	$179,871,350
% of Benchmark	The corresponding percentage for the prior year's audit was 2.0%.	2.1%
Performance materiality	Used 75% of materiality, and used primarily to determine the nature, timing and extent of audit procedures. The corresponding amount for the previous year's audit was $2,625,000.	$2,850,000
Audit Misstatement Posting Threshold (AMPT)	Threshold used to accumulate misstatements identified during the audit. The corresponding amount for the previous year's audit was $175,000 Different threshold used to accumulated reclassification misstatements.	$190,000

Materiality is used to scope the audit, identify risks of material misstatements and evaluate the level at which we think misstatements will reasonably influence users of the financial statements. It considers both quantitative and qualitative factors.

To respond to aggregation risk, we design our procedures to detect misstatements at a lower level of materiality.

We will report to the Audit Committee both:

- Corrected audit misstatements
- Uncorrected audit misstatements

Audit approach

Areas of Audit Focus

The following accounts have been identified as significant accounts, and our audit work will be focused on these items that represent the majority of assets, liabilities, revenues and expenses for ROHCG.

Significant account / Area of Audit Focus	Comments
Cash and investments	Cash and investments have material balances. KPMG will perform substantive tests of details, including confirmations.
Accounts payable and accrued liabilities	These accounts are material and there is an underlying risk that accounts payable balances are not complete and amounts owed are not included. KPMG will perform substantive tests of details, including examining supporting documents and verification of subsequent payment of invoices.
Ministry Funding and related Receivables, Def. Revenue & AP	Ministry funding and related receivables, deferred revenue and payables all have material balances. KPMG will perform substantive tests of detail and analytical procedures including sending confirmations to the funding entities.
Accrued Benefit Liability	The accrued benefit liability contains significant accounting estimates and management relies on the valuation of the actuary when reporting the balances. We will obtain ROHCG's actuarial valuation report for the year ended March 31, 2019 and will agree the details to the provision and applicable note disclosure.
Long-Term Debt	Long-term debt pertains to the bank loans, the capital lease obligation and the interest rate swap. KPMG will perform substantive tests of details, including confirmation of these balances.
Salaries and benefits expense	Salary and benefits expense is the largest expense type recorded by ROHCG. We plan to perform tests of design and operational effectiveness on select internal controls of the payroll process. KPMG will also perform substantive analytical procedures including performing expectation testing on salaries.
Non-salary expenses	Non-salary expenses represent all operational expenses other than salaries and benefits. The amounts are material to the financial statements. KPMG will perform substantive tests of detail including vouching a sample of transactions to supporting documentation.
Related Party Disclosures	KPMG will verify that the related party disclosures are accurate and consistent with the disclosures in the financial statements of the other entities.
Information technology	Over the next few years, the audit approach is expected to evolve to include more data & analytics audit procedures which will require reliance on information technology general controls ("GITCs") to be effective. Therefore, in the current year we plan to perform a preliminary evaluation of the appropriateness and effectiveness of the ROHCG's information technology general controls, to assess the potential for reliance on these controls in future years. This work will focus on the general IT environment as it relates to change management and user accesses.

These areas of audit focus may be revised because of new transactions or events at ROHCG, or changes in systems, people or structure, and/or the results of our audit procedures. We will communicate any changes to the Audit Committee in our Audit Findings Report.

Audit risks

Significant financial reporting risks	Why is it significant?
Sale of Hospital Food Services (HFS)	The sale of HFS is a significant unusual transaction for the Royal Ottawa Health Care Group, and has a material impact on the financial statements, including related disclosures.
Disposition of all investments to CIBC	Investments are a material financial statement line item for the Royal Ottawa Health Care Group. As all the investments were disposed of there is an increased risk around the accounting for the gain and loss on disposition as well as the accounting for the purchase of new investments.

Our audit approach

KPMG will perform the following substantive audit procedures related to the sale:

- KPMG will review the sale agreement related to the transaction
- KPMG will verify proof of cash receipt through review of bank statements
- KPMG will assess the appropriateness of the disclosures made related to the sale

KPMG will perform the following substantive audit procedures related to the disposition of the investments:

- KPMG will review all agreements related to the disposition and purchase of new investments in the year
- KPMG will assess the gain and loss recorded related to the disposition of the investments through recalculation
- KPMG will confirm the investment balance as at the date of disposition
- KPMG will confirm the year end investment balances from the custodian to ensure the proper accounting of the new investments

Audit risks

Significant financial reporting risks	Why is it significant?
Fraud risk from revenue recognition	This is a presumed, but rebuttable fraud risk. Generally, this is a presumed fraud risk if there are pressures or incentives on management to commit fraudulent financial reporting through inappropriate revenue recognition when performance is measured in terms of year-over-year revenue growth or profit. The ROHCG is not subject to external or market expectations on its revenue. Therefore, we have rebutted this fraud risk.
Fraud risk from management override of controls.	This is a presumed fraud risk. We have not identified any specific additional risks of management override relating to this audit / We have identified the following risks of management override that are specific to this audit.

Our audit approach

The ROHCG receives most of its revenue through donations and does not sell goods or services as a main line of business. The ROHCG's revenue streams are non-complex and do not involve significant estimates, which diminishes the opportunity for fraud related to revenue. The risk related to adjustments made to financial statement amounts at year end are addressed in the risk identified below and as part of our audit approach.

As this fraud risk is not rebuttable, our audit methodology incorporates the required procedures in professional standards to address this risk. These procedures include testing of journal entries and other adjustments, performing a retrospective review of estimates and evaluating the business rationale of significant unusual transactions.

We also make enquiries of upper management and the Audit Committee related to their awareness of fraud risk factors of the organization and whether the organization is currently dealing with any suspected, alleged or known fraudulent activity.

Audit risks

Other areas of focus	Why are we focusing here?
Contribution Agreement audits	KPMG will complete the audit of each of the programs listed below during May and June 2020: — Community Mental Health and Addictions Program (CMHA) — Youth Program — St. Lawrence Valley Correctional and Treatment Centre (STU) — Flexible Assertive Community Treatment Program (FACT) Should any other contribution agreement audits be required, we will inform the Audit Committee in our Audit Findings Report.
Royal Ottawa Place	KPMG will complete the audit of the Long-Term Annual Report and Trust Accounts for the Royal Ottawa Place in August/September 2020.

Additional audit-related work

KPMG will perform the following services in addition to the audit of the financial statements of the ROHCG, either as a required deliverable per the engagement letter, or per request from the Audit Committee.

Additional audit work required to support our audit opinion on the financial statements	
Sale of Hospital Food Services	In the year, the founding members of HFS, including the ROHCG, sold HFS with the transaction closing in the current fiscal year. As such, KPMG is required to audit the sale including the reporting of the gain and receipts/receivables.
Disposition and Purchase of Investments	In the year, the ROHCG changed investment managers which required the sale of all investments held at one manager and then purchasing new investments for the new portfolio. KPMG is required to perform audit work on these unusual sales and purchases of investments.

Other audits	
Contribution Agreement audits	KPMG will complete the audit of each of the programs listed below during May and June 2019: — Community Mental Health and Addictions Program (CMHA) — Youth Program — St. Lawrence Valley Correctional and Treatment Centre (STU) — Flexible Assertive Community Treatment Program (FACT) Should any other contribution agreement audits be required, we will inform the Audit Committee in our Audit Findings Report.
Royal Ottawa Place	KPMG will complete the audit of the Long-Term Care Annual Report and Trust Accounts for the Royal Ottawa Place in August/September 2019.

Additional requested audit-related work	
Management and the Audit Committee have not asked KPMG to provide any additional audit-related work.	Not applicable

Key deliverables and milestones

The following table details the detailed audit timetable for the year, outlining specific dates that KPMG will deliver on, as well as deadlines for audit requirements of management. The following planned dates have been agreed-upon by KPMG and management, and delays from this timeline may impact the achievement of this audit plan. KPMG will work with management to achieve this planned timeline and will communicate significant changes in our Audit findings report to the Audit Committee on May 21, 2020. We note that the following table compares the planned milestone date to the actual delivery date from the prior year, where applicable, and we developed the following milestone dates based on the actual delivery dates from the prior year.

Audit work and deliverable description	Date delivered or performed for FY 2018-19 Audit	Planned Milestone Date for FY 2019-20 Audit
Presentation of Audit Plan to the Audit Committee	January 31, 2019	January 31, 2020
KPMG to provide PBC list to management	Week of March 25, 2019	Week of March 16, 2020
Meeting with the President of the ROHCG to discuss the fiscal year's activities	Week of April 22, 2019	Week of April 20, 2020
Year-end audit fieldwork to be performed by KPMG	April 22 –May 10, 2019	April 20 –May 25, 2020
ROHCG audit file (PBC documents) provided to KPMG	April 22, 2019	April 30, 2020
Draft financial statements provided to KPMG	May 3, 2019	May 4, 2020
Draft Audit findings report and other communications (as needed) submitted to management for review	Week of May 13, 2019	Week of May 11, 2020
Mail-out of the Audit Findings Report to the Audit Committee	Week of May 13, 2019	Week of May 11, 2020
Presentation of the Audit Findings Report to the Audit Committee	May 23, 2019	May 21, 2020
Approval of the financial statements by Board of Directors	May 20, 2019	May 21, 2020
Annual General Meeting (AGM)	June 20, 2019	June 18, 2020

Proposed fees

In determining the fees for our services, we have considered the nature, extent and timing of our planned audit procedures as described above. Our fee analysis has been reviewed with and agreed upon by management.

Our fees are estimated as follows:

	Current period (budget)	Prior period (actual)
Audit of the financial statements	$44,200	$44,200
Contribution Agreement audits of the following programs: — Community Mental Health and Addictions Program ($4,800) — Youth Programs ($6,000) — St. Lawrence Valley Correctional and Treatment Centre (STU) ($3,500)	$14,300	$14,300
Audit of the Long-term Care Health Annual Report and Trust Accounts for the Royal Ottawa Place	$3,500	$3,500
Flexible Assertive Community Treatment Program	$3,200	$3,200
Additional fee related to disposition of investments and sale of HFS	$5,000	-

Matters that could impact our fee

As described above, additional audit work is required relating to the sale of HFS and the sale and purchase of investments, which will result in an additional professional fee. We will track our professional time separately for this work, and agree to a fee with management based on the level of effort.

The proposed fees outlined above are based on the assumptions described in the engagement letter dated January 23, 2019. The critical assumptions, and factors that cause a change in our fees, include:

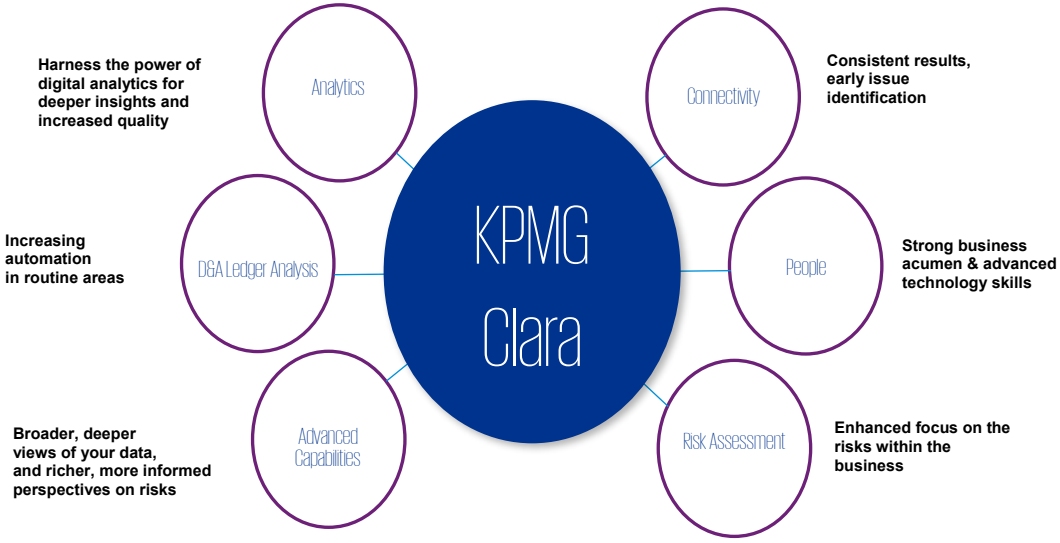
- Audit readiness, including delays in the receipt of requested working papers, audit samples, inquiries and financial statements information from the agreed upon timelines, and the books and records being properly closed at the start of our year-end audit work
- The availability, participation and responsiveness of key ROHCG's team members during the audit;
- Identification of control deficiencies during our audit, resulting in additional audit effort;
- Significant changes in the nature or size of the operations of ROHCG beyond those contemplated in our planning processes;
- Changes in professional standards or requirements arising as a result of changes in professional standards or the interpretation thereof;
- Significant one-time transactions entered into by the ROHCG;

– Attendance at more than three meetings of the Audit Committee or Board of Directors annually.

The audit of today, tomorrow & the future

As part of KPMG's technology leadership, our audit practice has developed technologies and alliances to continuously enhance our capabilities and deliver an exceptional audit experience.

Technology empowers us with the ability to perform deep analysis over your financial information, focusing our effort and interactions on the areas of greatest risk and minimizing disruption to your business.



Technology we use today

Tool	Benefit to audit
Journal Entry Analysis	Our journal entry tool assists in the performance of detailed journal entry testing based on engagement-specific risk identification and circumstances. Our tool provides auto-generated journal entry population statistics and focusses our audit effort on journal entries that are riskier in nature.
Data & Analytics Routines	Focuses manual audit effort on key exceptions and identified risk areas. Also allows for automated testing of 100% of a population.

Appendices

Appendix 1: Audit quality and risk management

KPMG maintains a system of quality control designed to reflect our drive and determination to deliver independent, unbiased advice and opinions, and also meet the requirements of Canadian professional standards. Quality control is fundamental to our business and is the responsibility of every partner and employee. The following diagram summarises the six key elements of our quality control systems. Visit our Audit Quality Resources page for more information including access to our most recent Audit Quality and Transparency Report.

We conduct regular reviews of engagements and partners. Review teams are independent and the work of every audit partner is reviewed at least once every three years.

We have policies and guidance to ensure that work performed by engagement personnel meets applicable professional standards, regulatory requirements and the firm's standards of quality. We do not offer services that would impair our independence.

All KPMG partners and staff are required to act with integrity and objectivity and comply with applicable laws, regulations and professional standards at all times.

The processes we employ to help retain and develop people include:

- Assignment based on skills and experience
- Rotation of partners
- Performance evaluation
- Development and training
- Appropriate supervision and coaching

We have policies and procedures for deciding whether to accept or continue a client relationship or to perform a specific engagement for that client.

Existing audit relationships are reviewed annually and evaluated to identify instances where we should discontinue our professional association with the client.

Other controls include:

- Before the firm issues its audit report, Engagement Quality Control
- Reviewer reviews the appropriateness of key elements of publicly listed client audits
- Technical department and specialist resources provide real-time support to audit teams in the field

Current audit trends

Our past discussions with the Audit Committee and what KPMG is seeing in the marketplace—both from an audit and industry perspective—indicate the following is information that may be of general interest to you. We would, of course, be happy to further discuss this information with you at your convenience.

Thought Leadership	Overview	Links
Accelerate	Accelerate is a KPMG audit trends report and video series that includes the perspective of subject matter leaders from across KPMG in Canada on seven key issues impacting organizations today that are disrupting the audit committee mandate.	Link to report
The Blockchain shift will be seismic	Blockchain technology is a focused disruptor of the very foundations of external and internal audit: financial recordkeeping and reporting. This Audit Point of View article offers insight on how blockchain technology is impacting business and what audit committees should be thinking about to prepare for certain risks.	Link to report
Audit Quality and Transparency Report	Learn about KPMG's ongoing commitment to continuous audit quality improvement. We are investing in new innovative technologies and building strategic alliances with leading technology companies that will have a transformative impact on the auditing process and profession. How do we seek to make an impact on society through the work that we do?	Link to report

Please visit KPMG's Audit Committee Institute (ACI) / Current Developments page for current developments in IFRS, Canadian securities matters, Canadian auditing other professional standards and US accounting, auditing and regulatory matters.

(Note: if the above hyperlinks do not work, you can find these and other insights on our website at www.kpmg.ca.)

Appendix 2: KPMG's audit approach and methodology

This year we will expand our use of technology in our audit through our new smart audit platform, KPMG Clara.

Collaboration in the audit

A dedicated KPMG Audit home page gives you real-time access to information, insights and alerts from your engagement team

Issue identification

Continuous updates on audit progress, risks and findings before issues become events

Data-driven risk assessment

Automated identification of transactions with unexpected or unusual account combinations – helping focus on higher risk transactions and outliers

Deep industry insights

Bringing intelligence and clarity to complex issues, regulations and standards

Analysis of complete populations

Powerful analysis to quickly screen, sort and filter 100% of your journal entries based on high-risk attributes

Reporting

nteractive reporting of unusual patterns and trends with the ability to drill down to ndividual transactions

Appendix 3: Lean in Audit™

An innovative approach leading to enhanced value and quality

Our innovative audit approach, Lean in Audit, further improves audit value and productivity to help deliver real insight to you. Lean in Audit is process oriented, directly engaging organizational stakeholders and employing hands-on tools, such as walkthroughs and flowcharts of actual financial processes.

By embedding Lean techniques into our core audit delivery process, our teams are able to enhance their understanding of the business processes and control environment within your organization – allowing us to provide actionable quality and productivity improvement observations.

Any insights gathered through the course of the audit will be available to both engagement teams and management. For example, we may identify control gaps and potential process improvement areas, while management has the opportunity to apply such insights to streamline processes, inform business decisions, improve compliance, lower costs, increase productivity, strengthen customer service and satisfaction and drive overall performance.

How it works

Lean in Audit employs three key Lean techniques:

1. **Lean training**

Provide basic Lean training and equip our teams with a new Lean mindset to improve quality, value and productivity.

2. **Interactive workshops**

Perform interactive workshops to conduct walkthroughs of selected financial processes providing end-to-end transparency and understanding of process and control quality and effectiveness.

3. **Insight reporting**

Quick and pragmatic insight report including immediate quick win actions and prioritized opportunities to realize benefit.

Appendix 4: Required communications

In accordance with professional standards, there are a number of communications that are required during the course of and upon completion of our audit. These include:

Engagement letter

The objectives of the audit, our responsibilities in carrying out our audit, as well as management's responsibilities, are set out in the engagement letter and any subsequent amendment letters as provided by management.

Audit planning report

This report.

Required inquiries

Professional standards require that during the planning of our audit we obtain your views on risk of fraud and other matters. We make similar inquiries of management as part of our planning process; responses to these will assist us in planning our overall audit strategy and audit approach accordingly.

Management representation letter

We will obtain from management certain representations at the completion of the annual audit. In accordance with professional standards, copies of the representation letter will be provided to the Audit Committee.

Audit findings report

At the completion of our audit, we will provide our audit findings to the Audit Committee.

Annual independence letter

At the completion of our audit, we will provide our independence letter to the Audit Committee of the ROHCG. We will confirm our independence to the ROHCG in the Audit Findings Report.

Appendix 5: Draft Audit Quality Indicators for NPOs

Audit Committees are more frequently using Audit Quality Indicators to assess the execution and results of the financial statement audit and to identify areas of improvement for the subsequent year, as well as to assess the performance in the audit of the external audit team, management and the Audit Committee as each have important roles to play. For not-for-profit organizations, Audit Quality Indicators need to be tailored to the unique characteristics of their industry and their specific operations and risks. Therefore, the following are suggested Audit Quality Indicators for consideration by Not-for-Profit Organizations.

Overall Financial Statement Audit Process Indicators

Overall FS Audit Process Indicator	Definition	Ranking (Exemplary, Satisfactory, Needs Improvement, Unsatisfactory)	Comments
1) Audit executed and completed as planned and agreed between auditor, management and audit committee, and documented in the Audit Plan	• Timelines in Audit Plan met • Level of audit effort consistent with plan • No new significant risks or events /transactions identified during the audit period		
2) Management and auditor deliverables provided to Audit Committee with sufficient time for review	• Timelines in Audit Plan met • Audit Committee and Board schedules provide for sufficient time for financial reporting close process and audit to be completed		
3) Accounting and auditing issues are resolved on a timely basis by management and auditor	• Accounting and auditing issues for new events, transactions and standard changes are resolved throughout the year in advance of audit period		

Management Indicators

Management Indicator	Definition	Ranking (Exemplary, Satisfactory, Needs Improvement, Unsatisfactory)	Comments
1) Management's financial close process operates on time and with minimal errors.	• Trial Balance and General Ledger provided to Auditor at beginning of year-end audit with minimal unexpected subsequent adjustments • Number and significance of entries in the Summary of Audit Differences		
2) Management takes responsibility for the general purpose financial statements, including selection of accounting policies and analysis of accounting issues.	• Management prepares draft of general-purpose financial statements including notes • Management presents the general-purpose financial statements to the Audit Committee		
3) Management participates fully and openly in the audit process	• Audit requirements are well-prepared on a timely basis • All management (including non-financial such as IT, HR, Legal) and their teams respond to audit queries on a timely basis		
4) Management remediates significant control weaknesses identified during the audit	• Management provides a written response to the auditor's management letter, as well as on-going updates on progress • The Auditor provides update to Audit Committee on progress in remediating the control weakness, on at least an annual basis		

Independent Auditor Indicators

Independent Auditor Indicator	Definition	Ranking (Exemplary, Satisfactory, Needs Improvement, Unsatisfactory)	Comments
1) Audit Team is experienced in the not-for-profit industry and organization	• Number of years of experience of key members (Partner, Manager, Senior Auditor) in not-for-profits generally, the specific industry (i.e. education) and with the organization itself • Audit-related and industry-specific training provided to Audit Team Members • Partner and Manager provide insight into trends in not-for-profit industry to management and Audit Committee, including in non-accounting specific areas		
2) Audit Partner and Manager are actively involved in the Audit	• Presence of Partner and Manager out on client site • Availability of Partner and Manager to CFO and Director of Finance • Attendance at Audit Committees		
3) Audit Approach is consistent with professional standards, is appropriate to the organization and continually evolves.	• Audit approach is compliant with the firm's global/national audit methodology • Audit approach is consistent with approach used for other organizations in the same NPO industry (i.e. education, healthcare, membership etc.) • Audit approach is tailored to unique operations and new events/transactions of the organization		
4) Auditor uses technology and other innovative techniques to continually improve the audit	• Auditor provides information to Audit Committee on use of new technology and other tools and how they provide value and improve the audit		
5) Auditor utilizes specialists (i.e. IT, Actuarial) in the performance of the audit, as needed	• Use of specialists in included in the Audit Plan and the Audit Findings Report for discussion with Audit Committee		

Independent Auditor Indicator	Definition	Ranking (Exemplary, Satisfactory, Needs Improvement, Unsatisfactory)	Comments
6) Auditor is independent from the organization	• Auditor has internal procedures for the approval of non-audit services provided to the organizations • Auditor reports on independence to the Audit Committee on an annual basis		
7) Auditor communicates effectively with management and audit committee	• Significant items with respect to financial statements are discussed in advance of completion of audit and audit committee ("no surprises") • Partner discusses issues of importance such as regulatory changes, new accounting standards or industry trends with the Audit Committee and management		

Audit Committee Indicators

Audit Committee Indicator	Definition	Ranking (Exemplary, Satisfactory, Needs Improvement, Unsatisfactory)	Comments
1) Sufficient time is allocated to discussions related to the annual Financial Statement Audit during the year	• Number of Meetings per year • Length of time on the Agenda • In Camera Meetings with Independent Auditor and Management		
2) Members are able to discuss the plan and results of financial statement audit with management and auditor.	• Experience and Credentials of Audit Committee members • Attendance of members at AC meetings with Independent Auditor		
3) Members have sufficient understanding of significant audit risks, new events/transactions and other areas of focus	• Significant risks and new events/transactions which have impact on the financial statements are discussed at Audit Committee meetings • Audit Committee requests of the independent auditor to put additional focus and effort on specific areas, as appropriate.		

Audit Committee Indicator	Definition	Ranking (Exemplary, Satisfactory, Needs Improvement, Unsatisfactory)	Comments
4) Appropriate emphasis placed on overall Audit Quality by Audit Committee	• Audit committee ensures that management and independent auditors have appropriate resources and capacity to enable a quality audit process		

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Board size

The Le Roya
Mental Health - Care & Researc
Santé mentale - Soins et recherch

MINUTES
ROYAL OTTAWA HEALTH CARE GROUP
GOVERNANCE COMMITTEE
January 23, 2020 at 4:30 p.m.
Royal Ottawa Mental Health Centre
Executive Boardroom 2426-1
Teleconference Dial-In: 1-888-875-1833 Passcode: 926707277#

○ Oral presentation
● Paper enclosed
●● Paper to follow
●●● Paper at meeting
IN Information
DEC Decision required
** Guidance required

Trustees	Present	Regrets	Trustees	Present	Regrets
C. Coulter, Chair	X		J. Charette	X	
S. Squire, Vice Chair	X		I. Levy	X	
D. Somppi		X	A. Graham	X	
			S. McLean		X
Management Staff					
J. Bezzubetz	X		P. Robb	X	
F. Dziersinski	X				

#	ITEM	REFERENCE	ACTION
1.	**CALL TO ORDER**	C. Coulter, Governance Committee Chair, called the meeting to order at 4:39 p.m. and declared the meeting to have been regularly called and properly constituted for the transaction of business. Committee members were welcomed. J. Charette was also welcomed as this was her first in-person Committee meeting since she moved to the UK. The meeting was opened by acknowledging that the land on which we gather is the traditional and unceded territory of the Algonquin nation.	
2.	**ACCEPTANCE OF AGENDA**	Acceptance of Agenda of January 23, 2020. Moved by S. Squire and seconded by J. Charette **BE IT RESOLVED THAT** the Agenda for January 23, 2020 be accepted, as presented. **CARRIED**	
	APPROVAL OF PREVIOUS MINUTES	Approval of October 2, 2019 Minutes Moved by J. Charette and seconded by I. Levy **BE IT RESOLVED THAT** the minutes of October 2, 2019 be approved, as presented. **CARRIED**	
3.	**BUSINESS ARISING FROM**	The action items were reviewed and updated.	

	PREVIOUS MINUTES		
4.	**DECISION/ INFORMATION ITEMS**	**a) Committee Terms of Reference**	
		The Terms of Reference of the Quality and Innovation Committees were reviewed at the last Governance Committee meeting and some suggested changes were sent back to each of the Committees. The Quality and Innovation Committees reviewed the changes and made further revisions and are recommending the Terms of Reference for approval. A small typo was noted on the Innovation Committee Terms of Reference and was corrected. The Terms of Reference for the Quality and Innovation Committees will now be forwarded to the Board of Trustees for final approval. Moved by I. Levy and seconded by S. Squire **BE IT RESOLVED THAT** the Quality Committee Terms of Reference be approved as presented and brought forward to the Board of Trustees for final approval. **CARRIED** Moved by J. Charette and seconded by A. Graham **BE IT RESOLVED THAT** the Innovation Committee Terms of Reference be approved as amended and brought forward to the Board of Trustees for approval. **CARRIED**	
		b) Research Ethics Board (REB) – J. Bezzubetz, F. Dziersinski	
		J. Bezzubetz provided a background on this item. She noted that there will be an upcoming discussion regarding the Chair of the REB, but for this meeting we are only looking at the Terms of Reference. A lot of work has been done in reviewing REBs at other institutions so a comparison could be made with ours. The briefing note that was included in the meeting package was revised and handed out at the meeting. The changes were highlighted in the Terms of Reference and F. Dziersinski provided a summary of the main changes. A copy is attached to these minutes. Discussion ensued and a question was raised about how many times the chair and members can be renewed. F. Dziersinski and J. Bezzubetz will look at what other	J. Bezzubetz F. Dziersinski J. Bezzubetz

		institutions are doing and incorporate that change to the Terms of Reference for consideration. Other suggested changes were as follows: - To add language about French language. P. Robb will send language to F. Dziersinski that is used in the ROHCG Board Committee Terms of Reference - To add language about meeting electronically so the Board is not restricted to face-to-face meetings only. P. Robb will send language to F. Dziersinski from the ROHCG By-laws - To add language about ongoing oversight and conduct and include language about audit activities. - A minor grammatical change was made to indicate that meetings will be held on a monthly basis **and additionally** at the call of the Chair F. Dziersinski is to incorporate these changes into a revised Terms of Reference. At this time it was agreed that it was premature to vote until the requested additional changes were made. Once changes have been made, the Terms of Reference are to come back to this Committee for an e-vote with the intention of approving it before the February 2020 Board meeting. A Committee member requested that guidelines for e-votes be added to a future Committee agenda.	P. Robb P. Robb F. Dziersinski F. Dziersinski P. Robb P. Robb
		c) Past Chair Role	
		At the last Committee meeting, the issue of the current role of the Past Chair was tabled as there was some confusion about it. Portions of the By-laws relating to the role of the Past Chair were included in the meeting package for background information. A concern was raised whether removing the Past Chair as a voting member of the Governance Committee would affect quorum. After discussion, it was agreed to leave the Past Chair's role as is for now. The matter of whether it would affect quorum will be looked into, but the Committee agreed that the Past Chair adds value in terms of history and from time to time is needed in terms of a vote. Moved by I. Levy and seconded by A. Graham **BE IT RESOLVED THAT** the role of the Past Chair remain as is in the By-laws (no vote at Board meetings) and in the Governance Committee Terms of Reference (a vote is allowed at Governance Committee meetings).	P. Robb

		CARRIED	
		d) Board and Committee Positions – C. Coulter	
		i. Skills Matrix Review	
		A Skills Matrix document with proposed changes was included in the meeting package for the review of the Committee. The proposed changes were reviewed along with a document describing the changes. It was noted that some of the items listed on the document are very operational and others strategic. This item will be reviewed again at the next meeting.	P. Robb
		ii. Process for Board Membership Across the Three Organizations – C. Coulter	
		A meeting was organized last week involving the three Board Governance Chairs regarding recruitment. There is a process in place where the three Governance chairs meet for this purpose twice a year, but the Committee decided that once a year would be sufficient. Unfortunately, the IMHR Board was not represented at this meeting due to a last-minute conflict. A request was made to the Governance Committee to interview G. Brimacombe, who sent in an application and CV after our current interview process was over. This item will be considered later in the agenda under New Board Trustee Recommendation.	
		iii. Committee Membership	
		The purpose of this item was to discuss whether it would be beneficial to appoint potential candidates to Committees prior to approving them as Board members. This was seen as an opportunity to gain experience, know The Royal better and for the Board to know them. After discussion, it was agreed that all new Board members are to be appointed for a one-year term in their first year as a probationary period. This change is to be added to the next By-law revision. A copy of the current Board Committee membership was included in the meeting package.	P. Robb
		iv. University of Ottawa Vacant Position – Dr. Nyman – C. Coulter	
		An excerpt from the By-laws regarding the current status of the University of Ottawa position was included in the meeting package along with an environmental scan of CAHO members showing what their practices are in regards to a University position on their Boards. Dr. Nyman's bio was also included.	

		The previous incumbent had indicated that she found it was a conflict serving the Board and the University and felt this should be a non-voting position and the By-laws were adjusted a few years ago to reflect this. In the meantime, a meeting was set up with Dr. Nyman who was seen as a great fit for the Board, but she requested this be a voting position and felt she could handle wearing two hats. The Chair noted that S. McLean relayed a caution to pass onto the Committee that the decision should not be made based on an individual, but rather on the position. This advice was taken into consideration. After discussion, the Committee agreed that as long as it is made clear what the expectations are with a voting position, the recommendation would be that Dr. Nyman be appointed to the University of Ottawa position on the Board of Trustees and that the By-laws be changed to make this a voting position. In the meantime, P. Robb will check the By-laws to see what it says about the timing to appoint members, but the intention will be that this be brought to the February 2020 Board meeting for approval. The Board Chair will advise Dr. Nyman of this outcome. Dr. Nyman is to be invited to attend the February meeting, but will be asked to leave for the vote on this matter. Moved by C. Coulter and seconded by J. Charette **BE IT RESOLVED THAT** Dr. Nyman be recommended for appointment to the Board as the University ex-officio representative as of February 2020. **CARRIED** **BE IT RESOLVED THAT** the By-laws be amended to show that the University ex-officio Board member position is a voting member. **CARRIED**	A. Graham P. Robb P. Robb
		v. New Board Trustee Recommendation – C. Coulter	
		The Application and CVs of the five candidates who were interviewed over the past two months were included in the meeting package. The candidate qualifications were reviewed with the Committee and although all the candidates had excellent qualifications, two stood out and were noted to be of interest. In the meantime, a further application was received and a request was made from the three Governance Chairs' meeting that this Committee interview him before a final decision is made.	

		There was a brief discussion about Board size. The current by-laws indicate that the Board is composed of 13 members, but the by-laws could be changed if there was a decision to have a larger Board. A. Graham also indicated that she will be having discussions with present Trustees to see who is interested in continuing on the Board next year. The size of the Board will depend on everyone's intentions. In this round of interviews it was made clear to the candidates that a decision would not be made before the June AGM so there was time for the Committee to consider all these matters. Discussion ensued and it was agreed that an interview should be set up with G. Brimacombe and once that interview is finalized, a meeting will be set up with C. Coulter, I. Levy and A. Graham to review all the candidate applications and come up with a recommendation for the March meeting.	P. Robb C. Coulter A. Graham I. Levy
		e) Board Self-Assessment Results - C. Coulter	
		A copy of the Self-Assessment Board Report was included in the meeting package. Also included was a Summary Report and Governance Action Plan Handbook. It was noted that there was 100% participation by Board members. Discussion ensued. The results will be shared at the Board meeting in February and C. Coulter or A. Graham will speak to it and open it up for conversation. This item will be put on the February 20, 2020 Board Restricted Session agenda to allow for open discussion.	C. Coulter or A. Graham P. Robb
		i. Board Chair Assessment	
		The Chair assessment will begin in April 2020. A copy of the survey questions from last year's survey were included in the meeting package and after considering them it was agreed that the same questions would be used.	P. Robb
		f) President & CEO and Chief of Staff's Performance Evaluation Process Document – C. Coulter	
		The President & CEO and Chief of Staff's Performance Evaluation Process document was included in the meeting package. This document was reviewed at an in-camera session of the December 12, 2019 Board of Trustees' meeting. The Board requested that the document be returned to this Committee to discuss moving dates/processes back closer to the start of the fiscal year so that the Board is not left approving the objectives two to three months into the fiscal year. The	

		Board also wanted the Committee to consider adding language so that any new objectives could be inserted mid-year if they were material. After discussion, the Committee decided to leave the timing of the meetings as is since dates had already been added for an earlier Compensation & Succession Planning Committee and a special Board meeting in early June for this purpose. As for the matter of the objectives, the Committee recommended that the objectives only be reviewed annually, so this change was not made. It was also noted that the Compensation & Succession Planning Committee minutes are now included in the in-camera Board package for transparency purposes and to provide a background on how the decisions were made. It was felt that this should alleviate any concerns the Board may have about the process.	
		g) Committee Size – C. Coulter	
		This item was brought forward by L. Leikin for a discussion about optimal Committee size and whether members should be on multiple Committees and, if so, how many would constitute a maximum number, including staff. This arose out of a concern that the Quality Committee was quite large. It was noted that a number of spots on the Quality Committee are ex-officio members and are required under legislation, or a staff member is needed to provide full information to the Committee to make decisions. After discussion, the Committee agreed to request L. Leikin to put forth a recommendation for the Quality Committee specifically as the other Committees were an appropriate size. A copy of the Committee membership from each of the Terms of References was included in the meeting package.	C. Coulter
		h) Board Membership Terms - C. Coulter	
		The Board Membership Terms document was updated to show that A. Graham's term as Chair has been extended and was included in the meeting package.	
		i. Process for Board Vacancies	
		At the December 12, 2019 Board of Trustees' meeting, the Board asked the Governance Committee to take a further look at the Governance Committee Terms of Reference to see whether language should be included around a more formal process to report to the Board about vacancies before candidate interviews begin. Following this request, an email was sent to the Board reminding them that an email had been sent after the	

		May 14, 2019 Governance Committee meeting, which identified that there would be a vacant position once S. McLean ended his term, and requesting Trustees to use their networks to see if there were any potential candidates they were aware of who might align with the Board's skills matrix, which was attached to the email. Two Trustees forwarded names for consideration and both of these candidates were included in the interviews. A. Graham indicated that when she calls Trustees about their interest on the Board, she will bring this up in the conversations to see if there are any other concerns, but in the meantime, the Committee felt this matter had been resolved and no further language was required on the Governance Committee Terms of Reference. A copy of the Governance Committee Terms of Reference was included in the meeting package.	
		ii. Disclosing Potential Board Candidate Names in the Minutes	
		An issue was raised through email by D. Somppi about whether the names of interested candidates for vacant Board positions should be included in the Governance Committee minutes. It was agreed that this should come back to the Governance Committee for review. The Committee discussed the matter, but it was agreed that since the minutes are not available outside of the Board and Senior Management Team, it would be left as is because it is important to document the steps taken about who was interviewed. For good practice, however, a box will be added to the application form regarding consent to identify candidates publicly by name.	P. Robb
		i) Board Development Days Survey Results - C. Coulter	
		A copy of the survey results from the 2019 Board Development Days was included in the meeting package. A. Graham provided a summary as follows: - One of the themes noted was that the Boards wanted more time to spend getting to know each other (networking opportunity) - The indigenous ceremony was an overwhelming success - There was some repetition on the governance presentation, but the discussions were worthwhile - The general feeling for next years' Board Development Days was a desire to have more input to the strategic plan - The date for the next Board Development days has been changed and will not fall on Hallowe'en as in previous years	

		All these suggestions will be taken into consideration when planning for next years' event. Board members who are interested will be asked to help plan the agenda. A suggestion made for a future agenda was to have a blue sky exercise on the strategic plan where Board members have an opportunity to provide input on what they would like to see The Royal doing. This item will be put on the February 20, 2020 Board Restricted Session agenda to allow for open discussion.	A. Graham J. Bezzubetz P. Robb
		j) Role of Client and Family Representatives Attending Board Meetings and Receiving Full Board Packages– C. Coulter	
		This item was deferred from the October 2, 2019 Committee meeting. This discussion arose following a question at the September Board meeting about the role of the Chairs of the Client and Family Advisory Councils at the Board table. An environmental scan of a few local hospitals, including the Ottawa Hospital, was included in the meeting package and showed there were no Client and Family Advisory Council representatives on their Boards. Discussion ensued. It was agreed that since there is no control over who the representatives are on the Family and Client Advisory Councils, and because they do not go through the same vetting process the Board does and the Board does not have any say over who is appointed, that they will be welcomed at the Board table as contributors, but a change will not be made to the By-laws to add them as members. The current practice of providing them with a copy of the agenda and not the full Board package will also continue as is as per policy. A copy of the Corporate policy for Board meetings was also included in the meeting package, which indicated that agenda packages are to be distributed to Board members and the Senior Management Team members only.	P. Robb
		k) Board Communication - C. Coulter	
		Dr. T. Lau, an ex-officio member of the Board of Trustees, has asked if he can have access to email the Board directly. The Royal currently has restrictions on who can communicate directly with the Board of Trustees, with only the President & CEO, Chief of Staff (since he now reports directly to the Board), and the admin support to the Board having access. This is an internal restriction put on by the IT Department and is common practice in many organizations in order to give the CEO more control over what is sent to the Board. There was discussion and it was determined that since this is an operational question, J. Bezzubetz is to discuss it with the executive team and make a decision. The	J. Bezzubetz

		Committee did indicate, however, that the Board does not want to signal that they are inaccessible.	
		l) 2020 - 2021 Board and Committee meeting dates – C. Coulter	
		A copy of a proposed Board and Committee meeting schedule for 2020-2021 was included in the meeting package for review and approval by the Committee. On review, the dates looked fine, but this will now be brought to the February 2020 Board meeting for their review and approval so no religious holidays or other potential conflicts are missed. Meeting requests will then be sent to secure the dates in the Trustees' calendars. Once confirmed, the schedule will also be sent to the IMHR and Foundation Boards for their information.	P. Robb P. Robb
5.	**NEW BUSINESS**	J. Bezzubetz introduced the idea of adding corporate counsel as a participant at the Board meetings. She thought it would add a degree of confidence to all Board members and wanted to move ahead and introduce this to the Board. After discussion, the Committee agreed that a corporate counsel could be a support to the Board, but it might raise questions since the Board has not identified any problems. J. Bezzubetz is to prepare a rationale for the Board to explain why this is being introduced.	J. Bezzubetz
6.	**ADJOURNMENT**	**Next Meeting: March 10, 2020** There being no further business, the meeting was adjourned at 6:52 p.m.	

_____ _____

C. Coulter
Chair

J. Bezzubetz
Secretary, Board of Trustees

Governance Meeting Action Items

Action Item	Individual Responsible	Status
January 23, 2020		
To add a discussion to the next agenda regarding the Chair of the REB. To look at what other institutions are doing in regards to how many times the chair and members can be renewed and incorporate suggested changes to the Terms of Reference for consideration. To incorporate these changes into a revised Terms of Reference and once they are amended, to come back to this Committee for an e-vote with the intention of approving it before the February 2020 Board meeting. To draft guidelines for e-votes and add to a future Committee agenda.	J. Bezzubetz F. Dziersinski F. Dziersinski P. Robb P. Robb	March 10, 2020 For Approval before February 20, 2020 Board meeting March 10, 2020
To check the By-laws to see if the Past Chair counts for quorum and let the Chair know.	P. Robb	
The Skills Matrix document to be reviewed again at the next meeting.	P. Robb	March 10, 2020
All new Board members are to be appointed for a one-year term in their first year as a probationary period. This change is to be added to the next By-law revision.	P. Robb	March 10, 2020
To contact Dr. Nyman to advise her of the decision to recommend her for appointment to the University of Ottawa position on the Board, the recommendation to make it a voting member position and to make clear what the expectations are with a voting position. She is also to invite her to attend the February 2020 Board meeting where this will be brought for approval, but she will be asked to leave for the vote on this matter.	A. Graham P. Robb	February 20, 2020
To set up an interview for the vacant Board position with G. Brimacombe. Once that interview is finalized, a meeting will be set up with C. Coulter, I. Levy and A. Graham to review all the candidate applications and come up with a recommendation for the March meeting.	P. Robb P. Robb C. Coulter I. Levy A. Graham	 March 10, 2020 March 26, 2020 Board meeting
The results of the Board assessment is to be shared at the Board meeting in February and C. Coulter or A. Graham will speak to it and open it up for conversation. This item will be put on the February 20, 2020 Board Restricted Session agenda to allow for open discussion.	C. Coulter or A. Graham P. Robb	February 20, 2020
The Chair assessment survey will begin in April 2020. The same survey questions from last year are to be used.	P. Robb	April 2020

To ask L. Leikin to put forth a recommendation regarding the size of the Quality Committee.	C. Coulter	
To add a box to the Board of Trustees' application form regarding consent to identify candidates publicly by name.	P. Robb	
2020 Board Development Days: Board members who are interested will be asked to help plan the agenda. A suggestion made for a future agenda is to have a blue sky exercise on the strategic plan where Board members have an opportunity to provide input on what they would like to see The Royal doing. This item will be put on the February 20, 2020 Board Restricted Session agenda to allow for open discussion.	A. Graham J. Bezzubetz P. Robb	February 20, 2020
To continue with the practice of providing the Family and Client Advisory Council members with a copy of the agenda and not the full Board package.	P. Robb	ONGOING
To discuss the matter of Board Communication with the executive team and make a decision.	J. Bezzubetz	
To add the DRAFT 2020-2021 Board schedule to the February Board agenda for review and approval so no religious holidays or other potential conflicts are missed. Meeting requests will then be sent to secure the dates in the Trustees' calendars. Once confirmed, the schedule will also be sent to the IMHR and Foundation Boards for their information.	P. Robb P. Robb	February 20, 2020 February 20, 2020
To provide a rationale for the Board about why we are introducing a corporate counsel role to the Board.	J. Bezzubetz	February 20, 2020
October 2, 2019		
To add the issue of the role of the Past Chair on the next agenda for a fuller discussion and a decision.	P. Robb	January 23, 2020
To add acknowledgement that this is unceded Algonquin territory to Board meeting agendas.	P. Robb	COMPLETED and ONGOING
The Board Development Days agenda is to be sent to Trustees to highlight that it is two full days of meetings unlike previous years. The agenda will also be sent to the IMHR and Foundation Boards. Trustees will be encouraged to dress comfortably.	P. Robb	COMPLETED P. Robb Also sent to J. Scully and M. Prince to pass along to their respective Boards
C. Coulter will communicate to Board members before Tuesday's Accreditation meeting regarding individual board member performances and about the OHA self-assessments tool. To proceed with OHA self assessment tool.	C. Coulter C. Coulter J. Bezzubetz P. Robb	COMPLETED C. Coulter sent email to Board COMPLETED Report back January 23, 2020
To reiterate process for Committee Membership and Officer selections.	A. Graham	In-camera December 12, 2019 Board meeting
To check with the Ottawa Hospital about why their University of Ottawa candidate is non-voting and	J. Bezzubetz	COMPLETED

then circle back to the Governance Committee for a decision. Also, reach out to CAMH and CAHO to see what their practices are. Pending discovery of some compelling reason, the Committee deferred to the Chair and CEO to make a provisional recommendation to make the by-law change so we can proceed with a decision. To reach out to Dr. Nyman to provide a status.	 A. Graham	Report back January 23, 2020 COMPLETED
Interviews for the vacant Board position will be set up by P. Robb for all three candidates. They will meet for an informal breakfast or lunch based on their availability. The meeting will be with C. Coulter, A. Graham, I. Levy and J. Bezzubetz. A. Graham will not attend the meeting with S. Devlin due to her working relationship with her.	P. Robb	~~Recommendation to be made on January 23, 2020~~ See action from January 23, 2020 meeting above
Client and Family Representatives Attending Board Meetings and Receiving Full Board Package	P. Robb	COMPLETED January 23, 2020 Policy regarding Board packages to be included in meeting package
Skills Matrix Review	P. Robb	COMPLETED January 23, 2020
The Compensation & Succession Planning Committee Terms of Reference were also included in the meeting package. There was a discrepancy noted in Responsibility #5 as it only refers to the President & CEO in regard to acting as the Search and Selection Committee. This will be returned to the Compensation & Succession Planning Committee to consider whether the Chief of Staff/Psychiatrist-in-Chief should be added. In the meantime, J. Bezzubetz and P. Robb will check into the ROHCG by-laws and *Public Hospitals Act* to see if there is guidance about this.	J. Bezzubetz P. Robb P. Robb	COMPLETED ROHCG By-laws and *Public Hospitals Act* check To add to Compensation & Succession Planning Committee meeting on November 20, 2019
The process for the performance appraisal of the President & Chief Executive Officer and Chief of Staff was reviewed and was agreed to with a small change in language, and under June the order of 2 and 3 will be switched.	P. Robb	COMPLETED November 20, 2019
The Governance Committee concurred with the changes to the Innovation Committee Terms of Reference, but noted a small grammar change in the Role section. This will be track changed and sent back to the Committee for information.	P. Robb	COMPLETED Sent to N. Bhargava for information. Will add to next Innovation Committee agenda for information and to December 12, 2019 Board meeting for approval.

The Finance Committee will be informed that their change from French-speaking to francophone was discussed and it was agreed for consistency with the ROHCG By-laws that it should remain as French-speaking.	C. Coulter	COMPLETED C. Coulter emailed J. Gallant and advised her P. Robb emailed C. Crocker and D. Bilodeau
A question arose at the last Board meeting about the the Chairs of the Client Advisory Council and the Family Advisory Council being non-voting members of the Quality Committee. There was discussion whether they should automatically be appointed as non-voting members. J. Bezzubetz will look at how other organizations handle this and report back to the Committee. The Quality Committee will then consider the matter and if it chooses to make a change to their Terms of Reference, it will then come back to the Governance Committee and then to the full Board for approval. This information will be passed back to the Quality Committee.	J. Bezzubetz P. Robb C. Coulter	COMPLETED J. Bezzubetz/P. Robb checked with other organizations and sent findings to C. Coulter and S. Squire COMPLETED C. Coulter advised L. Leikin To put on agenda for information at December 2, 2019 Quality Committee meeting
It was recommended that a statement be made that both the Quality and Finance Committees are empowered to recommend changes to the Integrated Risk Management Framework and that each Committee ensures it makes it to the Board at the earliest opportunity. This will be reported back to the Quality Committee and they can bring to the Board in December that this is where we ended up on this issue.	C. Coulter	COMPLETED December 2, 2019 Quality Committee meeting and then to December 12, 2019 Board meeting for information
To check the by-laws for the reference about the Chair of the Board of Trustees' attendance at Committee meetings and about the Chair of the Committees voting at Committee meetings and report back to this Committee.	P. Robb	COMPLETED Email sent to Governance Committee following meeting
To prepare language about extending Board membership in certain circumstances. In particular, J. Charette's term will be considered. This will be brought back to this Committee with appropriate language to discuss and then determine if it needs to be brought to the full Board.	S. McLean	IN PROGRESS ~~January 23, 2020~~ Deferred to March 10, 2020
The requirement for a report from Trustees following attendance at any Board sponsored events will be brought to the Board's attention at their December 2019 meeting	A. Graham	COMPLETED December 12, 2019 Board meeting
May 14, 2019		
To add a follow up item regarding off-line conversations to the June 20, 2019, Board of Trustees' agenda for their consideration regarding capturing the information flow and staff section that	P. Robb	COMPLETED

was covered in J. Charette's document as a norm or rule.		
To appoint a new Board member by the AGM meeting in June 2019. This will require identifying candidates, setting up the interviews and recommending potential candidates to the Board for approval.	P. Robb	~~October 2, 2019~~ ~~January 23, 2020~~ See action from January 23, 2020 meeting above
To arrange Educational Session on Indigenous Training at October 31/November 1, 2019 Board Development Days and arrange an Indigenous meal at the December 12, 2019 Board of Trustees' meeting.	P. Robb	COMPLETED September 26, 2019 – HIROC October 31, 2019 – Board Development Days – Indigenous Blanket Ceremony COMPLETED December 12, 2019 Board meeting – Indigenous menu

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 37	**Priority:** Important

DATE: February 20, 2020

COMMITTEE: Governance Committee

PRESENTER: C. Coulter

SUBJECT: Research Ethics Board (REB) Terms of Reference

BACKGROUND INFORMATION:

The REB Terms of Reference were reviewed at the January 23, 2020 Governance Committee meeting and are recommended to the Board of Trustees for approval.

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT as recommended by the Governance Committee, the Research Ethics Board Terms of Reference be approved, as presented.

CARRIED

Moved by:

Seconded by:

Motion approved:

The Royal's
Institute of Mental Health Research
affiliated with the University of Ottawa

Research Ethics Board – Terms of Reference - Final Draft for Review and Approval

[highlighted areas (yellow) correspond to edits and additions compared to current (2013) terms of reference (attached)]

[Areas in track changes correspond to edits and additions as per ROHCG Governance committee, January 23, 2020]

1.0 POLICY

1.1 The Board of Trustees of the Royal Ottawa Health Care Group (ROHCG) delegates to the Royal's Research Ethics Board (REB) responsibility for the review and ethics oversight of all research involving human participants at The Royal Ottawa Mental Health Centre (ROMHC)~~The Royal~~, The Institute of Mental Health Research (IMHR)~~, and~~ The Royal~~'s~~ Brockville Mental Health Centre (BMHC), the Community Mental Health Program (Carlingwood), and the Centre of Excellence on Post-Traumatic Stress & Related Mental Health Conditions (CoE). This delegation may extend to other institutions such as for applications submitted by members of the University of Ottawa (UO) and Carleton University (CU) who are involved in partnerships with the ROHCG.

1.2 The ROHCG Board of Trustees, through this policy, establish a structure to provide the REB with the mandate, autonomy, jurisdiction and authority to provide research ethics oversight of research investigations, and take reasonable measures to ensure that the roles and responsibilities of the REB are defined, resources are available and processes are in place to ensure compliance with relevant guidelines and applicable regulatory requirements. The ROHCG Board of Trustees, in collaboration with the ROHCG President/CEO, IMHR President/ROHCG ~~Vice~~ Vice-President Research, ROHCG Psychiatrist-in-Chief/Chief of Staff, ~~Psychiatrist in Chief~~ and ~~the~~ Centre of Excellence President ~~and~~/CEO will refer candidates for the position of REB Chair to the ROHCG Governance Committee, who in turn will provide the final recommendation to the ROHCG Board of Trustees.

1.3 The ROHCG Board of Trustees will receive quarterly updates on activities/issues of the REB from the REB Chair or his/her delegate at regular meetings.

1.4 The REB will deliver a written report of its operations and the ensuing issues and mitigation strategies quarterly and annually to the ~~Board of~~ROHCG Board of Trustees to ensure continuing accountability of its mandate.

1.5 ~~There~~ Given the specific institutional eligibility requirements to administer grants funds (e.g. Canadian federal funding agencies (Tri-Council CIHR, NSERC, SSHRC * see section 2.0), and in line with the institutional policies on Responsible Conduct of Research (ROHCG CORP III – 140, UO Policy 115), there is an indirect ad hoc reporting arrangement in which the ROHCG REB and the University (UO) agree to inform each other, via the IMHR, of any issues arising relating to University research of which they become aware, including those relating to ethics, participant safety or scientific integrity. The reporting line is expressed in a MOU Authorization Agreement (2008) with regard to the University's recognition of ethical approvals granted by the ROHCG REB, which involves research grant funding ~~(e.g. CIHR)~~ flowing from/to the University in which research is conducted by University of Ottawa-affiliated employees, academic staff, trainees, postdoctoral fellows and students at the ROHCG.

1.6 The REB is responsible to ensure that research involving human participants meets current scientific and ethical research standards for the protection of human research participants.

1.7 The IMHR will provide staff and resources to support the administrative tasks of the REB office functions.

2.0 DEFINITIONS

REB – Research Ethics Board
IMHR – Institute of Mental Health Research
ROHCG – Royal Ottawa Health Care Group
ROMHC - Royal Ottawa Mental Health Centre
BMHC~~G~~ – Brockville Mental Health ~~Care Group~~Centre
CoE - Centre of Excellence on Post-Traumatic Stress & Related Mental Health Conditions
UO – University of Ottawa
CU – Carleton University
CIHR - Canadian Institutes of Health Research
NSERC - Natural Sciences and Engineering Research Council of Canada
SSHRC - Social Sciences and Humanities Research Council
FDA – United States Food and Drug Administration
HC – Health Canada
OHRP – Office for Human Research Protections
ICH-GCP~~GCP~~ – International Conference on Harmonisation-Good Clinical Practice~~Good Clinical Practice Guidelines~~
TCPS2 – Tri-Council Policy Statement "Ethical Conduct for Research Involving Humans"
QARE – Quality Assurance for Research Excellence
SOP – Standard Operating Procedure
PHIPA – Personal Health Information Protection Act

3.0 GOVERNANCE AND JURISDICTION

Through ongoing oversight and reporting activities, the REB is responsible for ensuring that research involving human participants meets current scientific and ethical research standards for the protection of human research participants. The IMHR and the ROHCG will rely on the service of the REB to ensure scholarly review by ensuring compliance with the Scientific Review policies and scholarly standards of research proposals submitted to it and conducted within or by members of the professional staff of the IMHR, ROHCG, BMHCG, CU and the UO. All research involving human participants requires REB review and approval before the research can begin.

3.1 The purpose of the REB is to determine the ethical acceptability of all research involving human participants at the ROHCG or by the investigators/personnel of the institution. The REB will assume responsibility for the review of applications from members of CU and UO in accordance with agreements held with these universities. Scientific and scholarly assessment will be provided by the REB, or if there is insufficient expertise, by experts not involved in the study within either the institution, or elsewhere. The REB has a responsibility to focus on the ethical implications of a proposed study rather than issues related to study content or scientific design. Unless there is a significant concern that impacts ethical acceptability, REB members must avoid critiquing the studies under review.

3.2 The REB will meet at the ROMHC, or at locations external to the involved institutions at the call of the Chair and/or Vice Chair as deemed suitable to facilitate the work of the REB. Meetings may be held via teleconferencing during publicly declared emergencies.

3.3 The IMHR will provide administrative staff support for the activities of the REB including management of the application and review process for all submitted research projects. Administrative staff will work directly with the REB Chair/Vice-Chair and will report administratively to the ~~IMHR Chief Operating Officer or equivalent~~IMHR President/ROHCG Vice-President Research via their delegate.

3.4 The REB has the mandate to approve, reject, propose modifications to, renew, or terminate any proposed or ongoing research involving human participants that is conducted within, or by members of the ROHCG.

3.5 The REB will be responsible for the following tasks: reviewing all proposed research from scientific and ethical perspectives before the research is started; reviewing adverse event reports; conducting continuing annual review; and reviewing amendments before amendments are implemented.

3.6 The REB may suspend research deemed not to meet the standards established by the regulations and/or guidelines and/or legislation listed in section 9.

3.7 The REB is guided by the following core principles as defined in Article 1.1 of TCPS2 – Tri-Council Policy Statement "Ethical Conduct for Research Involving Humans" **~~the Tri-Council Policy Statement "Ethical Conduct for Research Involving Humans"~~: 1) Respect for persons; 2) Concern for Welfare; 3) Justice.

3.8 The REB and the IMHR shall monitor the activities of research involving human participants on an ongoing basis (including breaches of privacy, disclosures of conflict of interest or of perceived conflicts of interest related to human research). The REB fulfills this responsibility through continuing review of the research and review of unanticipated issues/problems. IMHR fulfills this responsibility through the conduct of internal audits (Quality Assurance for Research Excellence (QARE) Program).

3.9 The REB reports to the highest body of the institutions, the ROHCG Board of Trustees.

3.10 Any policies and SOPs for the REB will be written in compliance with Health Canada regulations, and adhere to existing guidelines (ICH-GCP), TCPS2, Personal health Information Protection Act (PHIPA). The REB will comply with American (FDA, OHRP) requirements, where applicable.

** TCPS2 current version: Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans – TCPS 2 (2018) https://ethics.gc.ca/eng/policy-politique_tcps2-eptc2_2018.html

4.0 MANAGEMENT OF THE REB

4.1 **REB Chair and Vice-Chair(s)**

The REB Chair/Vice-Chair should be experienced and respected REB members with at least two years of~~'~~ experience serving on an REB, and shall have a broad and deep knowledge of research ethics, literature and debates, national and international guidelines, regulations, policies and their application to the human participant research undertaken within the jurisdiction of the REB.

4.2 **Responsibilities of the REB Chair**

- Leads convened meetings
- Performs delegated review, or delegates authority to perform delegated review to an appropriate REB member when appropriate.

- Is empowered, pending REB review, to suspend the conduct of research if he/she determines that an investigator is not following the REB's policies or procedures or if there is evidence that the investigator is non-compliant with the regulations and/or guidelines and or legislation listed in section 9.
- Monitors the REB's decisions for consistency and ensures these decisions are recorded accurately, and communicated clearly to the researchers in writing as soon as possible.
- May delegate any of his/her responsibilities to other suitably qualified individual(s) as appropriate. Such delegation must be in writing.
- Convenes administrative meetings with the Vice-Chair(s), IMHR Clinical Research Support Manager, IMHR ~~Chief Operating Officer or equivalent, and~~President/ROHCG Vice-President Research or designate on a quarterly basis and notifies them of any major events.
- Guides the IMHR Clinical Research Support Manager and the REB Office Coordinator(s) on correspondence to investigators.

4.3 **Responsibilities of the Vice-Chair**

- Undertake the responsibilities of the Chair when the Chair is unable to do so.
- Carry out the responsibilities assigned to them by the Chair.
- Chair the REB meeting as required.
- Assist in the overall operation of the REB.
- Monitor the REB's decisions for consistency and ensure that the decisions are recorded accurately and communicated clearly to the researchers in writing as soon as possible.
- Guide the Clinical Research Support Manager and REB Coordinator(s) on correspondence to investigators.

4.4 **Selection, Term and Evaluation**

- ~~The~~ Following a call for nominations, the candidate(s) will be referred by the ROHCG President/CEO, IMHR President/ROHCG Vice-President Research, ROHCG Psychiatrist-in-Chief/Chief of Staff, and CoE President/CEO~~ROHCG President/CEO, Chief Psychiatrist and , VP Research and CoE President/CEO~~ to the ROHCG Governance Committee, who in turn will provide the final recommendation to the ROHCG Board of Trustees.
- The REB Chair and/or Vice-Chair(s) will undergo regular performance evaluations by the IMHR President/ROHCG Vice-President Research~~VP Research~~. Performance criteria will include the ability to fulfill the role, attendance at the REB meetings, compliance with REB SOPs, guidelines and regulations.
- The REB Chair and/or Vice-Chairs will serve a term of up to ~~five~~ three years, renewable~~,~~ for up to a maximum of three terms. Suitability for renewal will be determined by the IMHR President/ROHCG Vice-President Research~~VP Research IMHR~~, in consultation with their designate and with the Clinical Research Support Manager.
- REB ~~Members~~ members will serve a term of 3 years. ~~By~~ At the request of the Chair of the REB, and by mutual agreement between the REB member and the Chair of the REB, the REB member's term may be renewed, for up to a maximum of three consecutive terms.

5.0 BOARD COMPOSITION

5.1 The membership of the REB will be in compliance with Health Canada, current Tri-Council Policy Statement (TCPS) on Ethical Conduct for Research Involving Humans (Article 6.4), the International Council for Harmonisation Good Clinical Practice Guidelines (ICH-GCP 3.2.1), the Ontario Personal Health Information Protection Act (PHIPA) (s.15), U.S. Food and Drug Administration Code of Federal Regulations (US FDA CFR 56.107), and the Office for Human Research Protections (OHRP) (46.107).

5.2 Standard Operating Procedures (SOPs) detailing Board composition, appointment, resignation and removal process, duties, term, training requirements, provisions for ad hoc advisory process, quorum requirements, signing authority, application/submission procedures, review criteria, conflict management, and confidentiality. These SOPs have been subject to agreement and approval by ~~the~~ the IMHR President/ROHCG Vice-President Research ~~IMHR~~ or delegate ~~Chief Operating Officer or equivalent~~, REB Chair, and the IMHR Clinical Research Support Manager.

5.3 Individual members of the REB must be qualified through training, experience, and expertise to assess the acceptability of proposed research in terms of ethical principles and applicable regulations, guidelines and standards related to human participants or human materials protection.

5.4 Quorum shall consist of one-half of REB members (except REB Chair) plus one.

5.5 All members shall be without conflict of interest in the review/approval process and shall disclose actual, perceived or potential conflicts of interest at the outset of the meeting. Only those REB members who are independent of the investigator and the sponsor of a trial should participate in the initial or continuing review of any protocol or provide an opinion on a protocol-related mater, expect to provide information requested by the REB.

5.6. There shall be French-speaking representation on the REB

6.0 MEETING FREQUENCY AND ATTENDANCE

6.1 Meetings will be held on a monthly basis, and additionally ~~or~~ at the call of the Chair.

6.2 REB members are expected to attend every REB meetings as well as scheduled educational events/opportunities. Failure to attend a minimum of 66% of the meetings without explanation may be grounds for membership termination from the REB.

7.0 RECONSIDERATION AND APPEALS

Where a researcher does not receive ethics approval, or receive approval conditional on revisions that they find compromise the feasibility or integrity of the proposed research, they are entitled to re-consideration by the REB on substantive or procedural grounds. If that is not successful, they may appeal using the established mechanism in accordance with the institution's procedures, as described in 7.1 - 7.5.

7.1 The researcher and the REB should make every effort to resolve disagreements through deliberation, consultation or advice.

7.2 The REB must have an established procedure in place for handling appeals promptly.

7.3 The researcher and the REB must have fully exhausted the reconsideration process and the REB must have issued a final decision before the researcher initiates an appeal.

7.4 Once an appeal is initiated, ~~T~~the ROHCG Board of Trustees must appoint an ad hoc appeal committee that reflects a range of expertise, but does not include the REB members who originally reviewed the research.

7.5 The appeal committee shall have the authority to review negative decisions, approve, reject or request modifications to the research proposal. Its decision on behalf of the institution will be final.

8.0 REB REVIEW DURING PUBLICLY DECLARED EMERGENCIES

8.1 Research ethics review during publicly declared emergencies may follow modified procedures and practices, but must be particularly vigilant, enhance ethics oversight, and exercise special diligence in respecting ethical principles, standard operating procedures and the law. It is recognized that outbreaks may provide particular need for research, particular opportunity for research and particular vulnerability of research participants.

8.2 Procedures will be developed by the REB to detail how reviews will be conducted during an emergency. The following will be taken into account: a) what research is "essential" research during an emergency, b) the initial ethics review process of new research projects arising from the emergency; c) continuing ethics review of research undertaken prior to the occurrence of the emergency; and d) the ethics review process for changes to approved research that may require action very rapidly during emergencies.

8.3 The REB and researchers should ensure that the risks and potential benefits posed by any proposed research during an emergency are appropriately evaluated.

9.0 RELATED POLICIES AND/OR LEGISLATION

- Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS Current Version)
- The International Council for Harmonisation Guidelines for Good Clinical Practice, Section 3;
- Health Canada [Division 5, Part C.05 of the Food and Drug Act (clinical drug trials), Division 3 (PET tracers), Medical Device Regulations, and the Natural and Non-Prescription Health Product Regulations];
- Ontario Personal health Information Protection Act (PHIPA)
- US Food and Drug Administration code of Federal Regulations, Title 21, Part 56.107;
- US FDA Information Sheets, Guidance for Institutional Review Boards and Clinical Investigators
- US office for Human Research Protections 45 Code of Federal Regulations title 46.107;
- Canadian Association of Research Ethics Boards Guidance on Reporting Unanticipated Problems including Adverse Vents to Research Ethics Boards in Canada;
- US FDA Guidance for Industry and Investigators Safety Reporting Requirements for INDs and BA/BE Studies (2010);

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 38a	**Priority:** Important

DATE: February 20, 2020

COMMITTEE: Governance Committee

PRESENTER: C. Coulter

SUBJECT: University *ex-officio* position on Board of Trustees

BACKGROUND INFORMATION:

A meeting was arranged with Dr. Nyman and the Chair, Vice-Chair and President & CEO in regards to the vacant University of Ottawa position on the Board of Trustees. Dr. Nyman was considered to be a great fit for the Board and after review at the January 23, 2020 Governance Committee meeting is being recommended to the Board of Trustees for appointment to the University *ex-officio* position.

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT as recommended by the Governance Committee, Dr. Nyman be appointed as the University *ex-officio* representative as of February 2020.

CARRIED

Moved by:

Seconded by:

Motion approved:

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 38b	**Priority:** Important

DATE: February 20, 2020

COMMITTEE: Governance Committee

PRESENTER: C. Coulter

SUBJECT: Status of University *ex-officio* position on Board of Trustees

BACKGROUND INFORMATION:

The status of the University *ex-officio* position was reviewed at the January 23, 2020 Governance Committee. After consideration by the Committee, this position is being recommended for approval as a voting *ex-officio* member on the Board of Trustees.

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT as recommended by the Governance Committee, the ROHCG By-laws be amended to show or confirm, as the case may be, that the University of Ottawa ex-officio Board member position is a voting member.

CARRIED

Moved by:

Seconded by:

Motion approved:

Biography:

Dr. Jacline Nyman has been appointed Vice-President, External Relations, for a five-year term beginning August 13, 2018.

As vice-president, External Relations, Jacline is responsible for the activities of the Development Office, the Alumni Relations Office, the Communications Directorate, Language Services and Advancement Services, ensuring they are consistent with the University's mission.

Prior to joining the University of Ottawa, Jacline was the president and CEO of United Way Centraide Canada, where she led a national movement for social change. She engaged with stakeholders through donor, government and media relations, participating in public policy development and driving the United Way mission forward. Jacline was at the forefront of a bold transformation of one of Canada's oldest and most trusted brands.

Immediately prior to assuming this leadership role, Jacline worked with the Smith School of Business (Queen's University) as executive director of development and alumni relations, serving as principal gifts strategist and chief development officer. She personally negotiated many significant philanthropic gifts and business partnerships, working with stakeholders around the globe. Prior to that, she worked as vice-president of fundraising and donor relations at the York University Foundation and director of development and external relations at the University of Calgary's Haskayne School of Business.

As a non-profit sector leader, Jacline engages frequently in public speaking on a wide range of topics, including organizational leadership, philanthropy and fundraising, transformational change and modernization. Most recently, she spoke on the topic of "The Future of Generosity, Philanthropy and Artificial Intelligence" and on "The Future of Corporate Philanthropy and New Technologies" at the Economic Club of Canada. In 2015, she spoke to Canada 2020 about "5 Big Ideas for the Future of Canada." She currently volunteers on a number of advisory boards, and actively mentors young professionals as they navigate their careers.

Jacline received an adjunct professor appointment at the Telfer School of Management, University of Ottawa in 2012 and upon her appointment as vice-president becomes associate professor. Formerly, as an assistant professor at Queen's School of Business (Queen's University), Jacline taught marketing, marketing ethics and social responsibility. She has ongoing research interests in marketing, corporate social responsibility, and philanthropy. In 2011, Jacline concluded a major research project entitled "Transformational philanthropy and networks of co-created value in Canada." In 2016, she co-authored a paper, entitled "Identifying the roles of the university's fundraiser in securing transformational gifts: Lessons from Canada", published in *Studies in Higher Education* (SRHE).

Jacline holds a Bachelor of Administration (University of Ottawa), an MBA (University of Calgary) and a doctorate in Business Administration — Marketing (Cranfield University, U.K.). She lives in Ottawa with her family.

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 39	**Priority:** Important

DATE: February 20, 2020

COMMITTEE: Governance Committee

PRESENTER: C. Coulter

SUBJECT: Role of the Past Chair

BACKGROUND INFORMATION:

The role of the Past Chair was reviewed at the January 23, 2020 Governance Committee meeting. The Committee agreed that the Past Chair adds value in terms of history, but should not have a vote on the Board of Trustees, but will continue to have a vote on the Governance Committee. The Governance Committee is recommending this to the Board of Trustees for approval.

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT as recommended by the Governance Committee, the ROHCG By-laws be amended to show or confirm, as the case may be, that the Past Chair will have no vote at Board meetings, but will have a vote at the Governance Committee.

CARRIED

Moved by:

Seconded by:

Motion approved:

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 40	**Priority:** Important

DATE: February 20, 2020

COMMITTEE: Governance Committee

PRESENTER: C. Coulter

SUBJECT: Quality Committee Terms of Reference

BACKGROUND INFORMATION:

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT as recommended by the Governance Committee, the Quality Committee Terms of Reference be approved as presented.

CARRIED

Moved by:

Seconded by:

Motion approved:

The Royal Mental Health - Care & Research Santé mentale - Soins et recherche	**QUALITY** **Committee Terms of Reference**

TITLE: ROHCG BOARD COMMITTEES		
SECTION: Quality Committee Terms of Reference		**NO: ROHCG Schedules Section 6.1.1**
Issued and Approved By:	**ROHCG Board of Trustees**	**APPROVAL DATE : September 24, 2015**
		Date Initially Issued: 18/06/08
		Date Reviewed: 2019-~~09-09~~09-09 2018-09-17 2017-09-05
		Date Revised: 2019-~~11-04~~02-20 2018-09-17 2017-09-05

Role	The Committee's role is to make recommendations to the Board of Trustees on matters relating to the overall quality of patient care and the safety of our patients, staff, volunteers and visitors at The Royal.
Responsibilities	1. To monitor and report to the Board of Trustees on the quality of care provided by The Royal and to ensure there is an internal system for continuous quality improvement that incorporates innovation, evidence, and patient **and family** centred care~~.~~ 2. To make recommendations to the Board of Trustees about quality improvement policies. 3. To ensure the preparation of the annual Quality Improvement Plan that adheres to all requirements in the *Excellent Quality Care for All Act*. 4. To ensure that the process for preparing the annual Quality Improvement Plan engages patients and their caregivers and that the Plan, as well as the process for engagement, is made publically available. 5. To review critical incident aggregate trends compiled based on disclosures pursuant to regulations made under the *Public Hospitals Act*. ~~5.~~

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The Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

QUALITY
Committee Terms of Reference

	6. To ensure there are reliable processes for a) investigating critical incidents and concerning trends/spikes in other patient incidents; b) developing recommendations to limit likelihood of recurrence; and c) implementing these recommendations in a timely manner. 7. To ensure The Royal's compliance with Accreditation Canada standards. 8. To monitor and report annually to the Board of Trustees on the provision of French Language Services within the ROHCG and to recommend changes as required. 9. To review the Terms of Reference annually to ensure its relevancy and make the appropriate recommendations to the Board of Trustees and 10. To Monitor The Royal's Integrated Risk Management Plan. 11. To review the Occupational Health and Safety Report
Standing Reports	Each of the following reports will be provided with an executive summary to support the work of the Committee: 1. Strategic Plan 2. Comparison Mental Health and Addictions Quality Indicator (MHAQI) Scorecard* 3. Quality Improvement Plan 4. Corporate Patient Safety Quarterly Report 5. Ontario Perception of Care (OPOC) Tool for Mental Health & Addictions 6. Client and Family Feedback System Report 7. Staff Engagement Survey 8. Occupational Health and Safety Report 9. Accreditation Compliance Report 10. Integrated Risk Management Report * 11. French Language Report Notes: *Entire reports will be available to the members of the Quality Committee, however, only the indicators relevant to this Committee will be included in the agenda package.
Membership & Voting *Note: At least <u>one third</u> of the members of the Quality Committee must be*	<u>Voting Members of Committee</u> a) A minimum of three (3) Trustees, one of whom shall be the Chair and one of whom shall be the Vice Chair b) One (1) member of The Royal's Medical Advisory Committee c) The Royal's Chief Nursing Executive within the meaning of Regulation 965 under the *Public Hospitals Act*

The Royal Mental Health - Care & Research Santé mentale - Soins et recherche	**QUALITY** **Committee Terms of Reference**

voting members of The Royal's Board of Trustees.	d) One person who works in the hospital who is not a physician or a nurse e) The Royal's Chief Executive Officer f) The Chair, Finance Committee g) ~~Secretary~~Executive of~~,~~ Medical Staff (President, Vice-President or Secretary) Except for the Medical Advisory Committee, the Chair shall be an *ex officio* voting member of all Committees. NOTES: Any member of the Quality Committee who is an *ex officio* Trustee or who is an employee or a Medical Staff or Dental Staff member shall have a vote on advisory matters but shall not have a vote on matters delegated for final disposition to such Committee by the Board. There shall be French-speaking representation on the Committee.~~Membership shall provide for Francophone representation proportionate to the community served.~~
	Non-Voting Members of Committee ~~Such other persons as appointed by The Royal's Board of Trustees on recommendation of the Committee, including, but not limited to:~~ - Chair, Client Advisory Council - Chairs, Family Advisory Council (The Royal and Royal Ottawa Place)
Chair	The Board of Trustees shall appoint a voting member of the Board of Trustees to be chair of the Quality Committee.
Appointment of delegates	Members of the Quality Committee mentioned in b), c), d) or e) above may, with the approval of the Board of Trustees, appoint a delegate to sit as a member of the Quality Committee in his or her stead.
Frequency of Meetings	The Committee shall meet at least four times a year and additionally at the call of the Chair.
Structure of Meetings	The Chair, in cooperation with the President & Chief Executive Officer, will invite leadership teams from The Royal's Clinical Programs to present to the Committee on discrete quality improvement initiatives that demonstrate in a practical way that the Committee is adhering to its responsibilities.

The Royal Mental Health - Care & Research Santé mentale - Soins et recherche	**QUALITY** **Committee Terms of Reference**

Quorum	The quorum for meetings of the Committee shall be a majority (51%) of its voting members provided one third of those present are voting members of The Royal's Board of Trustees.
Resources	The Royal's Chief Executive Officer will identify staff member(s) to act as resources to Board Committees. The Royal's Chief ~~Nursing Executive~~of Staff/Psychiatrist-in-Chief will fulfil the role of the Committee Secretary.
Reporting	The Quality Committee shall report to The Royal's Board of Trustees.

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 41	**Priority:** Important

DATE: February 20, 2020

COMMITTEE: Governance Committee

PRESENTER: C. Coulter

SUBJECT: Innovation Committee Terms of Reference

BACKGROUND INFORMATION:

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT as recommended by the Governance Committee, the Innovation Committee Terms of Reference be approved as presented.

CARRIED

Moved by:

Seconded by:

Motion approved:

The Royal Mental Health - Care & Research Santé mentale - Soins et recherche	

TITLE: ROHCG BOARD COMMITTEES		
SECTION: INNOVATION Committee Terms of Reference		**NO: ROHCG Schedules Section 6.1.1**
Issued and Approved By:	**ROHCG Board of Trustees**	**APPROVAL DATE : February 21, 2019**
		Date Initially Issued: 2019-02-21
		Date Reviewed:
		Date Revised:

Role	The Innovation Committee's role is to encourage a culture of innovation and to advise the Board on matters relating to innovation at the Royal. This is to ~~advise the Board and~~ provide better quality of care for patients and is not limited to clinical care – it includes all aspects of the organization, including corporate services.~~encourage a culture of Innovation on matters relating to Innovation at The Royal in order to provide better quality of care for patients~~(lyin). Definition of Innovation – New or better ways of doing valued things.
Responsibilities	1. To encourage a culture for Innovation in keeping with the Vision and Strategy to improve the patient quality of care; 2. To dialogue with senior management on Innovation initiatives that are new Innovation initiatives outside the scope of approved budgets or board approved strategies. 3. To determine what matters within the scope of the Innovation Committee will be required to be submitted to the Board for its approval along with consulting with other relevant Board Committees as appropriate; 4. To review and report to the Board the ROHCG's approach and activities, (and also review the Board's approach), to Innovation and its measurement; 5. To facilitate learning on Innovation topics including external contacts, experiences and Ideation Sessions. Innovation Ideation Sessions may include the full Board and additional staff members of the ROHCG and be informal in nature; 6. To review and assess *significant* Innovations as recommended by senior management; 7. To recommend to the Board significant strategic Innovations as recommended by senior management and, if approved, monitor their

	implementation; and 8. To review the Terms of Reference annually to ensure its relevancy and make the appropriate recommendations to the Board.
Membership & Voting	Voting Members of Committee The Innovation Committee shall be composed of the following voting members: • Three to five trustees who are independent of the ROHCG, the ROFMH and The Royal's IMHR [The intention is to have representation from each ROHCG Board Committee on the Innovation Committee] • the Chief of Staff and the Psychiatrist-in-Chief (ex- officio); • the ROHCG President and Chief Executive Officer (ex-officio) and • A representative of IMHR Board (ex-officio) • A representative of the Foundation Board (ex-officio) NOTE: Any member of the Innovation Committee who is an *ex officio* Trustee or who is an employee or a Medical Staff or Dental Staff member shall have a vote on advisory matters but shall not have a vote on matters delegated for final disposition to such Committee by the Board.
	There shall be French-speaking representation on the Committee.
Chair	The Chair shall be an independent ROHCG trustee.
Appointment of delegates	The ROHCG President and Chief Executive Officer may appoint up to three non-voting delegates to the group.
Frequency of Meetings	The Innovation Committee shall meet at least four (4) times per year and has a goal of four additional Innovation Ideation Sessions a year.
Quorum	The quorum shall be 51% of the voting members provided a majority of those present are independent trustees.

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The Le Royal Mental Health - Care & Research Santé mentale - Soins et recherche	

Resources	The ROHCG Chief Executive Officer will identify staff member(s) to act as resources to Board Committees. One staff member will be identified as the Committee Secretary.
Reporting	The Innovation Committee shall report to the ROHCG Board of Trustees on a regular basis.

ROYAL OTTAWA HEALTH CARE GROUP BOARD AND COMMITTEE MEETING SCHEDULE FOR 2020 - 2021

	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021
BOARD MEETINGS Thursdays Room 1424		Sept **24** **Mini Series**		Development Days (2 full days) **Oct 22 to 23**	Dec **17** 5:30 PM **Mini Series**		Feb **18** 5:30 PM **Mini Series**	Mar **25** 5:30 PM		May **27** **Board Community Event Gen Disc**	June **3** **Special Board Meeting IN CAMERA** Jun **24** 3:30 PM **& AGM**
		PS 1st Q			PS 2nd Q			PS 3rd Q			PS 4th Q
Board Portal Website Posting		Sep 17			Dec 10		Feb 11	Mar 18			Jun 17
Due to Patricia		**Sep 15**			**Dec 8**		**Feb 9**	**Mar 16**			**Jun 15**
Committees											
Audit Thursdays 7:30 AM						Jan **21**				May **20**	
Compensation & Succession Planning Wednesdays 4:30 PM				Nov **25***					April **7***		
Executive	At the call of the Chair										
Finance Thursdays 7:30 AM		Sept **10**		Nov **19**		Jan **21**		Mar **11**		May **20**	
Governance Tuesdays 4:30 PM ***Invite Chair of Board to prep meetings*			Oct **13****			Jan **26****		Mar **9****		May **25****	
Innovation Tuesdays 4:30 PM ****Schedule prep meetings two weeks prior*		Sept **1*****			Dec **1*****			Mar **23*****		May **11*****	
Quality Mondays 4:30 PM		Sept **14**		Nov **2** Special meeting re QIP	Dec **7**		Feb **8**	Mar **1** Special meeting re QIP			June **7**

Board Orientation – TBD
Long Service Awards – October 6, 2020 BMHC Centennial Hall 1:00 to 3:30 PM and October 8, 2019 ROMHC Gymnasium from 1:00 to 3:00 PM

MAC @ 8:30 AM	Aug 15	Sep 19	Oct 17	Nov 21	Dec 19	Jan 16	Feb 20	Mar 19	Apr 16	May 21	Jun 18

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 42	**Priority:** Important

DATE: February 20, 2020

COMMITTEE:

PRESENTER: A. Graham

SUBJECT: Consent Agenda

BACKGROUND INFORMATION:

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT the Consent Agenda be approved, including any motions contained therein.

CARRIED

Moved by:

Seconded by:

Motion approved:

The Le Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

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President & CEO
REPORT TO THE BOARD OF TRUSTEES
February 20, 2020

The function of the President and CEO's report to the Board of Trustees, as outlined in the ROHCG Bylaws, is to report on any matters about which the Board should have knowledge and that may not be on the Board agenda.

ENVIRONMENTAL SCAN – January to March 2020

PROVINCIAL

KAREN GLASS VISIT TO THE ROYAL

On January 15th Karen Glass, Ontario's Assistant Deputy Minister of Mental Health and Addictions, visited The Royal. Our goal during this visit was to bring attention to some of our innovative and collaborative service delivery models as well as to discuss the role of specialized mental health service providers in Ontario's Healthcare transformation.

Ms. Glass' visit included tours of the Rapid Access Addiction Medicine Clinic and the Forensic Program in Ottawa. We also had discussions about the growing reach and impact of our Telemedicine Program (delivering services locally and across the province) and The Royal's innovative delivery of the Ontario Structured Psychotherapy program for our region (formerly called 'Increasing Access to Structured Psychotherapy').

In addition, we facilitated a meeting with the Mental Health Alliance, a group of local partners who are organizing to better coordinate and enhance services for individuals in the greater Ottawa area. This collaboration is vitally important in order to support and contribute to Ontario's health care system transformation, including the implementation of the Ontario Health Teams.

In follow up to this meeting, we have invited Ms. Glass to visit the Brockville Mental Health Centre as well as our Community Mental Health Program at Carlingwood. We are also working to organize additional conversations between our Mental Health Alliance and leaders in the Mental Health and Addictions Centre of Excellence as suggested by Ms. Glass.

MERRILEE FULLERTON AND SPECIAL DESIGNATION FOR ROYAL OTTAWA PLACE

On January 29, 2020 (Bell Let's Talk Day) Merrilee Fullerton, Ontario's Minister of Long-Term Care, visited The Royal. This visit provided the opportunity to showcase the specialized mental health support that we provide to residents of Royal Ottawa Place (ROP) and build upon previous conversations with Minister Fullerton to advocate for a special mental health designation that would provide more funding for ROP, and would serve a population of residents we are suited to serve.

During the visit, Minister Fullerton met with residents, family members, staff and volunteers at ROP. She indicated understanding of the need for the special mental health designation and an

eagerness to support our proposal. Following the visit, on February 7, 2020 we submitted the formal proposal to the LHIN and have shared it with Minister Fullerton. (The proposal is titled: Designation of Long Term Care Beds for Individuals with Severe Mental Illness and Responsive Behaviours Unable to be served by Other Housing Options.)

BROCKVILLE REDEVELOPMENT

On January 29, several members of our Senior Leadership Team met with colleagues at Brockville General Hospital (BGH) to discuss the potential redevelopment of the Brockville Mental Health Centre. BGH is supportive of this idea. A meeting with Brockville MPP and Minister of Housing, Steve Clark had been scheduled for February 7, 2020, but was delayed due to weather conditions. The meeting is now scheduled for February 14, 2020.

LOCAL

BELL LET'S TALK

January 29, 2020 was Bell Let's Talk Day, an initiative that encourages conversations about mental health and raises funds to support various projects across Canada. Many members of The Royal family took time to share their expertise and advice with the Ottawa community (and beyond!) as part of Bell Let's Talk Day.

Our communications team asked some of our staff, volunteers, clients and families to share their thoughts on why it is important to talk about mental health. Their responses were filmed and various clips were posted on The Royal's Twitter, Instagram and Facebook accounts on January 29, 2020, as well as on our YouTube channel. We also created separate versions of the video starring our teams in Brockville and Carlingwood and shared them with local audiences.

The Royal was also featured in various media focused on Bell Let's Talk Day including live interviews from the Royal Ottawa Mental Health Centre featuring researchers Natalia Jaworska and Zachary Kaminsky. Here are the media clips:

- Men's mental health, with Dr. Raj Bhatla (CTV Ottawa Morning Live)
- The importance of speaking up, with Anita Manley (at the 1:41 mark) (CTV Ottawa Morning Live)
- Mental health and exercise, with Natalia Jaworska (CTV Ottawa Morning Live)
- Suicide prevention, with Dr. Zachary Kaminsky (CTV Morning Live)
- DIFD and youth mental health, with Dr. Gail Beck (CTV Morning Live)
- Men's mental health with Dr. Raj Bhatla (at the 29:30 mark) (TSN 1200 Radio)

Finally, on Bell Let's Talk Day The Royal also hosted a special event called Let's Talk About Stigma. The event featured author and mental health advocate, Sharon Johnston and explored mental illness and the stigma that is frequently associated with it. Also featured were authors Susan Doherty (whose book Ghost Garden follows the journey of a client of The Royal's Schizophrenia

Program) and Jason Finucan, as well as Dr. Nicola Wright who provided insight into evidence-based recovery-oriented approaches to working with those who experience psychosis. This event was a fundraiser for The Royal and Salus.

COLLECTIVE IMPACT INITIATIVE TO REDUCE STIGMA RELATED TO SUBSTANCE USE

Recognizing that stigma is a significant barrier to people seeking and receiving treatment for substance use disorders, Ottawa Public Health, The Royal, the Community Addiction Peer Support Association (CAPSA), and the Canadian Centre on Substance Use and Addiction (CCSA) are working together to mobilize a variety of stakeholders from across Ottawa to address the issue.

Together we aim to increase wellness and reduce stigma and discrimination for those who use substances by driving change in policies, practices and attitudes amongst organizations in Ottawa.

We launched this collective impact initiative on January 31, 2020 with a stakeholder engagement. The session featured education and collaborative work to identify potential actions.

This initiative supports priorities identified in Ottawa's Community Action Plan on mental health and substance use.

ROYAL NAMED NATIONAL CAPITAL REGION TOP EMPLOYER

The Royal has once again been named among the National Capital Region's Top Employers. The National Capital Region's Top Employers is an annual competition organized by the editors of Canada's Top 100 Employers, and this is the fifth time The Royal has received this honour.

This special designation recognizes employers in Ottawa-Gatineau that lead their industries in offering exceptional places to work. Evaluation is based on various criteria including: physical workplace; health, financial and family benefits; work atmosphere; training and skills development; and community involvement. The announcement was made on January 29, 2020 with the recipients published ONLINE and in the Ottawa Citizen.

QUEENSWAY CARLETON HOSPITAL PRESENTATION

On January 29, 2020 Joanne Bezzubetz and Susan Farrell delivered a presentation to the Board of the Queensway Carleton Hospital (QCH). The presentation focused on The Royal's work to improve the accessibility of mental health care through integrated, community-based care delivered in collaboration with partners throughout our region. We highlighted initiatives like Coordinated Access for Mental Health and Addictions, Ontario Structures Psychotherapy and the Prompt Collaborative Care Clinic. The presentation was very well received and we look forward to building on our already strong relationship with QCH.

COVID-19 (CORONAVIRUS)

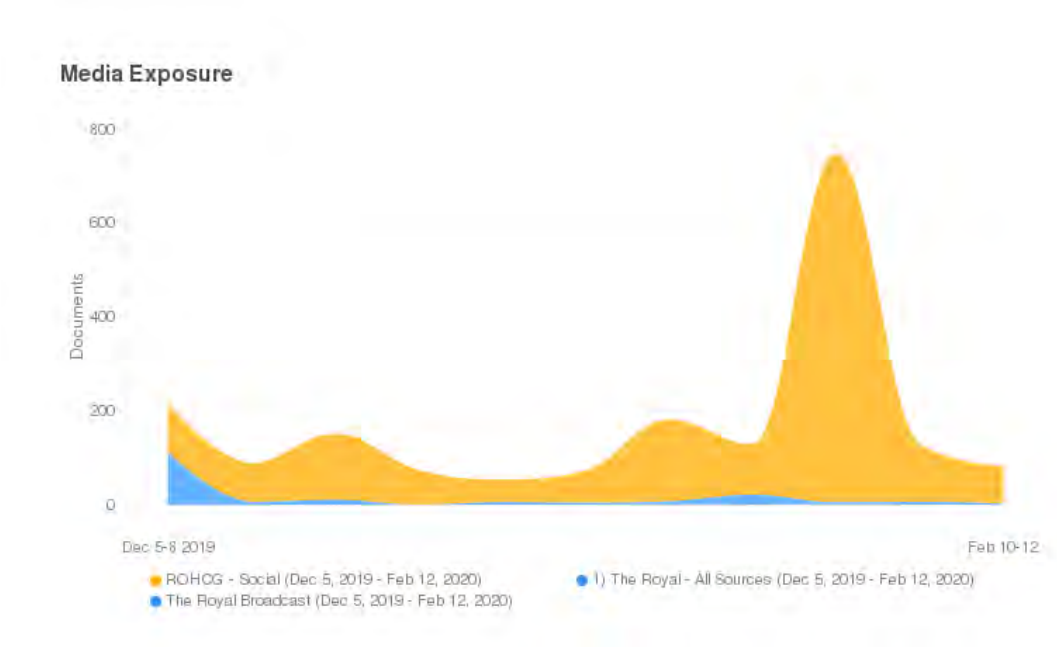
The Royal is monitoring the situation related to COVID-19 in collaboration with our local hospital partners. While the risk in our region is low, we have put appropriate infection prevention and

control measures in place, including a screening protocol at admission and signage for all who enter our facility. We have also POSTED INFORMATION ON OUR WEBSITE and will continue to update staff, clients and families.

MEDIA EXPOSURE

DECEMBER 5, 2019 TO FEBRUARY 12, 2020

Total media mentions: 1927



Media Highlights

- New mobile clinic brings physical, mental health care to at-risk Ottawans, Global News, January 14
- Ottawa Inner City Health Mobile Clinic, CTV Ottawa, January 14
- Blue Monday, Defeating the Blahs of Winter – CTV Morning Live, January 20
- Bell Let's Talk Day media as listed above

SOCIAL MEDIA

Total engagements: 7,291
Total impressions: 212,371

- Twitter Followers: 8,773 (2.2% increase)
- Facebook Followers: 4,777 (39 new, 0.82% increase)
- Instagram Followers: 1,073 (63 new, 6.2% increase)
- Twitter Retweets: 380

TELUS HEALTH FOR GOOD – MOBILE MENTAL HEALTH FOR THE UNDERSERVED

As noted in past CEO reports to the Board, TELUS has developed a stream of funding entitled Health for Good through which agencies and organizations can bid for 3-5 years of funding targeted at “bringing primary health care to underserved Canadians with complex care needs through innovative mobile outreach clinics”. To date they have funded Vancouver Coastal Health’s Women’s Mobile Health Clinic and the Victoria Doctors of the World Mobile Health Clinic.

The Royal, Ottawa Inner City Health, Sandy Hill Community Health Centre, Somerset West Community Health Centre and Ottawa Public Health, have come together to partner with TELUS for a Health for Good mobile van for Ottawa, that includes mobile mental health services for the first time in Canada. The Ottawa mobile clinic model provides physical and mental health care services focused on persons who use the safe consumption sites within the city as this vulnerable group of citizens would not normally access traditional services. These citizens are particularly vulnerable because they are homeless or marginally housed with physical and mental health care needs and concurrent substance use disorders. Their substance use often contributes to their physical and mental health problems, but prevents them from accessing existing services, even those considered “low barrier (or accessible) services”. As a result, they have the poorest health outcomes of all citizens and receive no or less health care than required. The TELUS van services include engagement, assessment and developing an integrated plan of care (including linking to other community resources) leading to improved physical and mental health outcomes. This innovation also embodies The Royal’s vision of a Hospital without Walls by offering improved access to coordinated care in an innovative service delivery model within the TELUS van.

The van has been in operation for a month and its official launch was at Ottawa City Hall on Tuesday, January 14, with media attention and subsequent evening news interviews representing The Royal and its partners. In its first month, the van has been fully used at all operational hours with high client satisfaction reported.

Media coverage of the launch:

- Your Health, CTV Ottawa
- New mobile clinic brings physical, mental health care to at-risk Ottawans, Global News
- Photos and comments from the launch on The Royal's Twitter feed

Executive Lead: Dr. Susan Farrell, Vice President Patient Care Services and Community Mental Health

TELEMEDICINE

Based on the success of the partnership between the Telemedicine program at The Royal and Algonquin College (launched during mental health week in October), a new partnership has now been formed with the Student Support Services at the University of Ottawa (UOttawa). The three-year partnership will provide specialized psychiatric services from The Royal to students selected by UOttawa counsellors. It will also provide training and capacity building for UOttawa counsellors. The design will give faster access to specialized care for UOttawa students while allowing them to remain on campus, which prevents missing class or other educational opportunities due to traditional travelling for care. It will also increase overall access to care to this specific population within The Royal's strategy of a Hospital without Walls. The first year of the partnership is funded by recent philanthropy for the Telemedicine program through The Royal's Foundation and the second and third year are funded by the University. An evaluation will help us determine the feasibility of providing these services on an ongoing basis and expanding to other educational institutions.

With respect to philanthropy, through The Royal's Foundation, in late November the Telemedicine program at The Royal received a $9,000 donation from the Calian Employees philanthropy drive. This is an event, organized by Calian employees, to invite select programs to present to all employees and then decide how to target their charitable giving. Telemedicine was selected by Calian for expansion of specialized psychiatric services to rural and underserved areas. Also, in December, the Telemedicine program received a $15,000 donation from Excel HR. Excel was celebrating their 30th anniversary and divided a $30,000 donation between our Telemedicine program and the education program at CAMH, representing their Ottawa and Toronto offices.

Partnership Development: Sarah Joynt (Telemedicine) with Executive Lead for Telemedicine, Dr. Susan Farrell, VP Patient Care Services and Community Mental Health and support from the Foundation.

REGIONAL HOSPITAL OVER-CAPACITY

For many months, most hospital inpatient units in the region have been at or over capacity. While it is usual for units to be full, this current state of over-capacity (often called surge) is significant as it is both prolonged and affected by additional factors including psychiatrist shortages at partner sites such as The Ottawa Hospital (TOH) that became most over-capacity in January 2020.

The Royal does not have an Emergency Department, but supports the flow of patients within the region in a number of ways. Pathways to Better Care, a program of The Royal that supports planning across the region, implemented and manages the Daily Flow Management Call (DFMC) that facilitates a daily review of hospital capacity and possible transfers across the Ottawa Hospital (Civic and General campuses), Montfort, Queensway Carleton, Pembroke Regional and Cornwall

hospitals. This review facilitates transfer and informs the provincial dashboard (Criticall) that assists smaller (non-schedule 1) hospitals with directing transfer patients as required.

The Royal also occasionally operates “surge beds” (beds without additional funding) that can open in special system circumstances to receive patients in the Schizophrenia and Geriatrics inpatient units. In January, The Royal approved funding to open two additional “surge beds” in Schizophrenia to support patient flow across the region. This was met with appreciation by TOH, and our regional partners. Pathways also supports the development of regional surge protocols and will oversee a review of recent increased efforts to address surge to determine their effectiveness and sustainability. The Royal is also committed to re-examining our internal practices to ensure we optimize patient flow.

Executive Lead for Pathways, Dr. Susan Farrell, VP Patient Care Services and Community Mental Health. Internal surge capacity planning and patient flow optimization also supported by Dr. Paul Sedge, Associate Chief (Ottawa) and members of the Senior Management Team.

COMMUNITY MENTAL HEALTH PROGRAM – 10TH ANNIVERSARY

The Community Mental Health Program (CMHP) celebrated its 10th Anniversary on February 1. CMHP is comprised of 10 teams/services that support people living in the community with severe and persistent mental illness, concurrent disorders and dual diagnosis. The inaugural Directors of CMHP are Robin Pow and Dr. Susan Farrell. The leadership and program size has expanded with the introduction of Women’s Mental Health and the Flexible Assertive Community Treatment Team for Persons with a Dual Diagnosis. Although the main office of CMHP is on the 2nd Floor of Carlingwood Shopping Centre, which contributes to the vision of a Hospital without Walls by ensuring access and decreased stigma through community integration, most clinical services are delivered in the community in people’s homes, and in partner community agency sites. Additional CMHP teams are located in Brockville, Pembroke and Cornwall.

PARTNERSHIP – UPSTREAM OTTAWA GALA

On October 24, 2019 Upstream Ottawa (a community-based agency partner of The Royal) held their Gala at the Hunt Club Golf and Country Club. The theme of the event was “Shining a Light on Community Mental Health Services” and Dr. Susan Farrell, VP Patient Care Services and

Community Mental Health was the keynote speaker. The Gala was their most successful fundraising event in history and will support their innovative programming in the areas of case management support, supported housing, peer wellness events and school and work readiness programs.

The Royal Calendar of Events
2019/20 (February 7, 2020)

Date/Time	Event/Activity/Location	Audience	Board Representation
February 2020			
Date: February 20, 2020 Time: 4:30 PM Where: Conference Room 1424	The Royal Board of Trustees meeting		All
Date: February 27 2020 Time: 6 to 7:30 PM Where: Auditorium, The Royal	Conversations at The Royal Topic: Family and caregivers With: Juliet Haynes		On a volunteer basis
March 2020			
Date: March 6 2020 Time: 6 to 9:30 PM Where: Infinity Conference Centre	**The Royal's Inspiration Awards** Gala		On a volunteer basis
Date: March 19 2020 Time: 7 to 8:30 PM Where: Auditorium, The Royal	Conversations at The Royal Topic: Everything you wanted to know about sexual interest(s), but there afraid to ask" With: Dr. Paul Fedoroff, Sexual Behaviours Clinic		On a volunteer basis
Date: March 26, 2020 Time: 4:30 PM Where: Conference Room 1424	The Royal Board of Trustees meeting		All
April 2020			
Date: April 23 2020 Time: 7 to 8:30 PM Where: Auditorium, The Royal	Conversations at The Royal Topic: tbd With: Client Advisory Committee		On a volunteer basis
May 2020			
Date: May 21 2020 Time: 6 to 7:30 PM	Conversations at The Royal		On a volunteer basis

Where: Auditorium, The Royal	Topic: Making Sense of Suffering. Beyond pleasure and pain With: Dr. Tim Lau		
Date: May 28, 2020 Time: tbd Where: tbd	The Royal Board of Trustees meeting Community event		All
June 2020			
Date: June 18, 2020 Time: 4:30 PM Where: Conference Room 1424	The Royal Board of Trustees meeting and AGM		All
Date: June 25, 2020 Time: 7 to 8:30 PM Where: Auditorium, The Royal	Conversations at The Royal Topic: Dementia and behaviours With: Sherri Cannon		On a volunteer basis

The Royal's
Institute of Mental Health Research
affiliated with the University of Ottawa

The Royal Ottawa Health Care Group
Research Ethics Board Quarterly Report
Q3 – October 1, 2019 to December 31, 2019

Overview: The Royal Ottawa Health Care Group (ROHCG) Research Ethics Board mandated, through the ROHCG Board of Trustees, to review all research activities involving human participants conducted within or on behalf of the ROHCG and its affiliates. The REB is responsible for ensuring research activities meet scientific, regulatory, and ethical standards for the protection of human research participants while conforming to applicable ROHCG corporate research policies and procedures.

The REB Administration Office

The REB Administration Office is responsible for managing the day-to-day activities related to research ethics oversight including new submissions, amendments, annual renewals, safety reports, terminations and adverse event review, while providing ongoing support to ROHCG researchers, scientists and staff.

The Research Ethics Board

The REB meets once a month to review clinical research applications. The Board is a multidisciplinary team consisting of 17 members, two of whom are community representatives. Specialties of the members include but are not limited to clinical psychiatry, psychology, imaging, pharmacy and law.

QUARTERLY ACTIVITY

The REB received 7 new study applications between October 1, 2019 and December 31, 2019

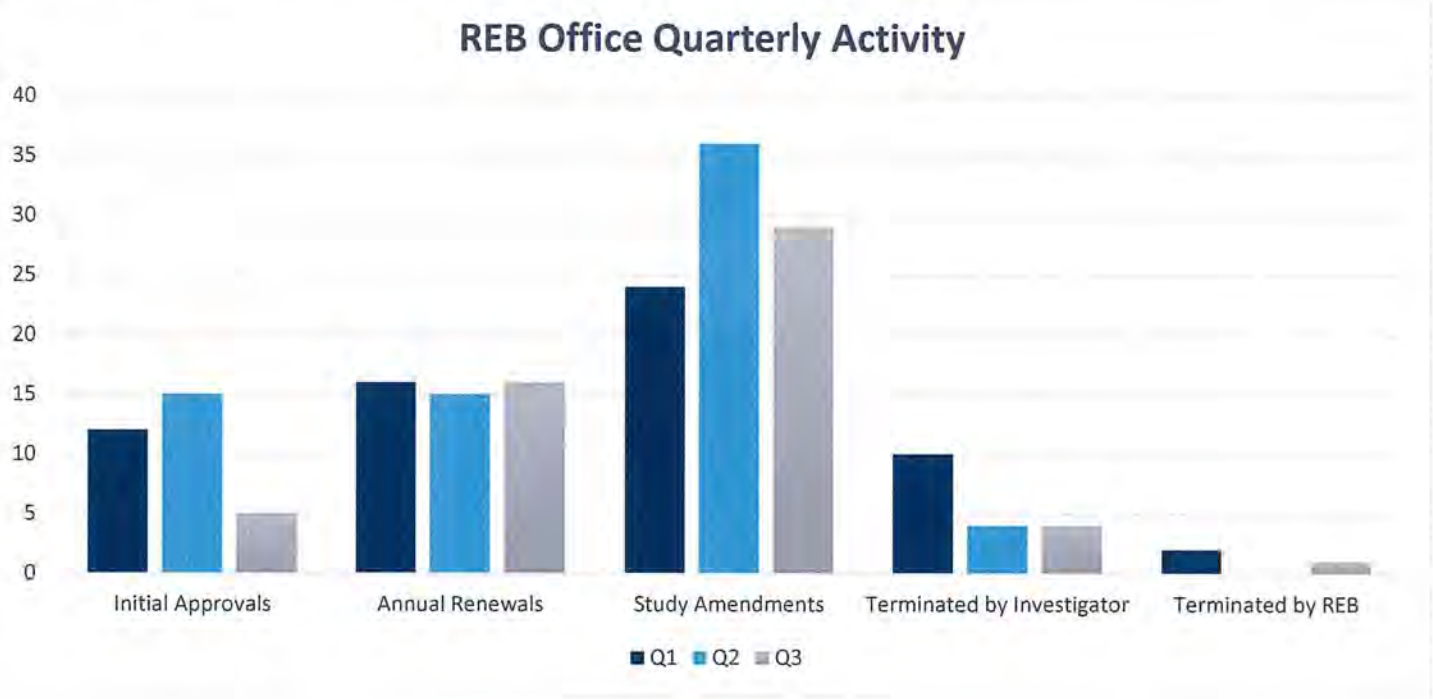
REB #	Date Submitted	Study Title	Investigator	Program
2019032	October 7, 2019	Investigating the relationship between the antipsychotic response and non-invasive proxies of neurochemistry in schizophrenia	Lauri Tuominen	Schizophrenia
2019033	October 7, 2019	Social cognition in youth who have a first degree relative with schizophrenia	Synthia Guimond	Schizophrenia
2019034	October 4, 2019	Utility of Amisulpride as an augmentation strategy to clozapine in Canadian patients with schizophrenia - a retrospective chart review	Roisin Osborne	Schizophrenia
2019035	November 8, 2019	The Role of NeurOptimal for clients of the Forensic Department with emotional regulation needs and substance use/alcohol addictions	Grytsje Schurer	Forensics
2019036	November 14, 2019	Cannabis Use, Mental Health, and Social Media	Kim Hellemans	Neuroscience Carleton
2019037	December 3, 2019	A Multidimensional Assessment of PTSD Subtypes (MAPS)	Zach Kaminsky	Suicide Prevention Sleep
2019038	December 3, 2019	Core Outcomes for Opioid Use Disorder: engagement of individuals with lived experience.	SUCD	Kim Corace

Other REB Activity

The chart below illustrates the REB Office quarterly review activities. In Q1, there were a significant number of terminations by the Investigator as the REB worked to address numerous study approvals that had expired over the years. There was also a significant increase in the number of annual renewals processed as the office was working to bring studies into compliance with REB regulations. Through the development of REB forms and ongoing education related to REB regulations and compliance, we have seen an increase in adherence to the renewal, amendment and termination processes. REB approval is in effect for all active studies, and since the implementation of these tools, there have been no lapses in REB approval. The REB terminated one study as the PI is no longer with the institution. Ethical oversight of the study was transferred to the University of Ottawa.

Clinical Research Study Approval on Hold

The REB placed one study on hold (Q2) due to concerns related to multiple amendments and unclear consent documentation. The study was reviewed in its entirety by the Full Board and an ad hoc meeting was held to determine the ethical acceptability of the study. Corrective actions were recommended by the Board and put in place by the Investigator. The REB hold was lifted in December and the study has recommenced.



Quality Improvement and Program Evaluation Projects

In some cases, it can be difficult to determine if a project is an actual research study or if it is a quality improvement project. The ROHCG REB reviews all submissions proposed to be QI or Program Evaluation to ensure that proper oversight is given and that these projects are accurately classified.

The REB office reviewed 4 program evaluation (PE) and/or quality improvement (QI) initiatives in Q3, including:

- Investigating the gap between the prevalence and recognition of ADHD in a tertiary care sample (S. Paterniti)
- Mood and Anxiety Program Evaluation (K. Nikolitch)
- Program Evaluation – Concurrent Disorder unit – Amendment (K. Corace)

ACTIVE RESEARCH STUDIES AND RECRUITMENT UPDATES

Recruitment numbers are obtained from the annual reports submitted to the REB by each research team. The recruitment numbers include only those studies where consent is obtained from participants and does not reflect chart review, database research and/or secondary use of information.

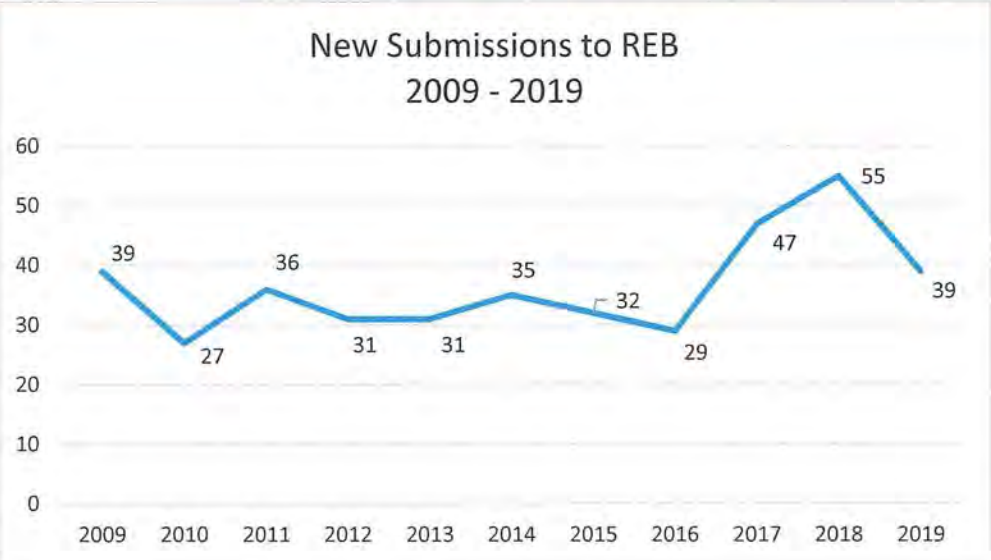
Active Studies and Recruitment Metrics –December 31, 2019

Approved Active Studies	Total Patients Enrolled (N=71)	Total Non-Patients Enrolled (N=71)
127	1909	9082

**37 studies have not yet reached the one-year renewal point and therefore recruitment numbers for these studies are not available and not reported in the totals above.*

N = studies that are approved, recruiting and have renewed approval and provided recruitment numbers in 2019.

INCREASED RESEARCH ACTIVITY REQUIRING REB OVERSIGHT



This graph illustrates the number of new projects submitted to the REB each year.

There was a significant increase in 2018 when the eRIMh scientists joined the Royal.

A slight decline is noted in 2019 which is likely attributed to the researchers focusing on current studies and not submitting new projects. It is also possible that the decreased UMRF flow has impacted the ability to start new studies.

REB Office Submission Review				
	Submissions	Amendments	Renewals	Total Processed by REB Office
2014	35	56	37	128
2015	32	89	34	155
2016	29	66	32	127
2017	47	72	24	143
2018	55	27	45	127
2019	39	116	93	248
Five Year Total	273	426	265	928

While there is a slight reduction in the number of new studies submitted for review in 2019, there is a marked increase in the number of amendments submitted for and the number of annual renewals submitted, between 2018 and 2019. This is reflective of the processes put in place to ensure compliance with regulatory requirements. The REB office is closely monitoring research activities for compliance.

IMPORTANT HIGHLIGHTS

- Efforts continue to bring the REB office into compliance with regulatory requirements and to improve the timeliness of reviews and increase efficiencies for the REB members and the applicants.
- Dr. Dominique Bourget has been fulfilling the role of Acting Chair of the REB while Dr. Blier acted as the interim IMHR CEO. Dr. Bourget will remain in her role pending the Board's decision regarding the nomination of the next Chair (process initiated).
- The REB Terms of Reference are outdated and an updated draft is pending (process initiated).
- The "Permission to Contact for Research" initiative should be activated by the end of January. This will provide researchers with access to a list of clients/patients who are interested in participating in research activities.
- The REB will be circulating a list of active studies on a monthly basis in an effort to increase the visibility of research for clinicians. The list will be circulated to the ROHCG distribution list with the goal of bridging the gap between research and clinical care for the benefit of our patients/clients.
- The Canadian Association of Research Ethics Boards (CAREB) has released the most recent standard operating procedures (SOPs). These have been adopted by The Royal and have been approved by the Clinical Research Support Manager. They will be reviewed and approved by the REB Chair and training of all REB members will follow.

Dr. Dominque Bourget
Acting Chair, The Royal's Research Ethics Board

Tammy Beaudoin
Clinical Research Support Manager, IMHR

Foundation President and CEO Report to The Royal's Board of Trustees – February 2020

Operations

We are pleased to welcome Raliat Momoh who started a four-month unpaid internship on January 6 to assist the Communications team with some defined projects. This is the Foundation's fifth intern to join the team, which speaks to the strong brand reputation of the Royal Ottawa Foundation. Raliat is in the graduating semester of the Algonquin College Public Relations Program and brings a high level of energy and passion to The Royal.

When the opportunity presents itself, the Foundation would appreciate it if board members would consider extending an invitation/complimentary ticket(s) to the Foundation for events they are either attending or cannot attend due to other commitments. Extending these invitations to occasions – such as galas or fundraising events, provides the Foundation team with the opportunity to network with community leaders, donors and potential donors.

Communications

External audience - further developing our brand and illustrating outcomes

Media External

- Royal Ottawa Foundation was mentioned in the top events photographed in 2019 in the Ottawa Citizen.

Community Engagement & Donor Recognition

- The Foundation Winter Donations at Work, eight-page, bilingual newsletter was disseminated to donors who have made a $150+ donation in the last year. This equates to just over 4,000 donors. Blowing-in a coupon soliciting donations was trialed. Donations from this pilot are beginning to come in.
- A new Royal Ottawa Foundation brochure was designed and disseminated to the community via VIP tours, community engagement opportunities and placed within the hospital.

Digital / Web Development

- Leveraging the successful #first40 event, the communications team created a graphic card for each award recipient to further highlight their contribution to the Foundation.
- The Royal Ottawa corporate video is being shared broadly.
- Videos are being produced and shared which highlight local organizations who purchased the Mental Health First Aid course at the 2019 Inspiration Awards.
- Royal Ottawa Foundation created a video celebrating the holiday party with our colleagues and residents of Royal Ottawa Place.

Internal engagement- bringing more ambassadors on board

- Donations at Work newsletter was disseminated throughout the Hospital to staff and placed in high traffic areas to increase knowledge of how the Foundation responsibly spends donor dollars.
- Royal Ottawa Foundation hosted a Christmas party for the residents of Royal Ottawa Place.

Royal Ottawa Foundation Social Media Growth

	Facebook *Likes*	*Followers*	**Twitter** *Followers*	**Instagram** *Followers*	**YouTube** *Subscribers*	**LinkedIn** *Followers*
2019 January	615	632	504	261	821	N/A
2020 January	760	923	810	641	1,654	199
Difference	⬆ 145	⬆ 291	⬆ 306	⬆ 380	⬆ 833	⬆ 192

Fundraising

Recent Donations

- $100K designated to two e-RIMH Drs. Sara Tremblay and Synthia Guimond. The funds will be equally divided.
- A $30K donation was designated to Schizophrenia.

Direct Mail Update

The Holiday Matching Gift appeal mailed on October 10 and has exceeded the projected gross revenue target of $40K ($51,550 to date and donations continue to come in).

- The letter is signed by Cynthia Clarke, the mother of a long-time client (schizophrenia program).
- Matching funds of $10K were secured from an anonymous donor and match was effective Oct 10 to Dec 15. This matching gift promo was a huge success and definitely something we would like to offer in future years, with an opportunity to increase match closer to $25K.

For the first time, the Winter newsletter included a generic reply device and prepaid return envelope, providing an opportunity for donors/public to donate to The Royal.

- $3,025 received to date.
- We would like to include a reply device as part of our biannual newsletter production moving forward.

For the first time this year we also included a series of two email messages to all donors with an email address on file, in an effort to reengage and renew donor support before the end of the calendar year.

- Both messages were signed by Mitchell Bellman; the first message was deployed on December 25 and the second on December 31.
- $8,137 received to date, which is much better than we had anticipated for our first year-end digital fundraising effort.

The Year-end appeal mailed November 25 and to date has generated 81% of projected gross revenue target of $22K.

- The letter is signed by Debbie Pilon, Director of Operations at Royal Ottawa Place.
- Results will continue to come in until March 31, 2020 and we anticipate meeting our gross revenue goal.

January Renewal appeal is signed by Mitchell Bellman and mailed the week of January 13.

- Our goal is to renew support from donors for 2020 including lapsed 2018 Breakfast donors.
- This mailing includes a donor survey that will enable us to collect information from donors including why they support The Royal, why they may have stopped giving, etc.
- Gross revenue target is $18K and we anticipate meeting at least 60% of this goal by March 31, 2020.

The March Renewal mailing – the final mailing of the current fiscal will mail the week of March 9.

- This will serve as a follow up to the January renewal mailing to those donors who have not yet renewed their support for 2020.
- The letter will be signed by Nancy Lesiuk, Manager, Patient Care Services, Outreach (Geriatrics).
- Gross revenue target is $10K though given the mail date, most of this will only be realized after the end of the current fiscal.

Women for Mental Health

- We continue to recruit new members and renew existing members to The Royal's Women for Mental Health.
- New collateral has been developed to support the upcoming campaign initiatives.
- Our new Chair, Katherine Cooligan, is actively recruiting new members.
- We will be announcing upcoming events and networking opportunities later this month.

Young Professionals Network

- The Foundation is working with our Young Professionals Network (YPN) Co-Chairs to recruit executive members.
- Our goal is to have the executive members in place and officially launch the YPN program in early 2020.

Review of Donor recognition and Donor Wall opportunities

As part of our cultivation of current donors and future campaign supporters, we have started the process of updating our donor recognition walls and plaques. We are reaching out to other hospital foundations across Canada to get a sense of their best practices.

This includes:

- Reviewing alternative and unique ways of recognizing major donors.
- Reaching out to sign companies who service Ottawa and the availability of digital opportunities vs static.
- A cost review and feasibility.

Ongoing:

- Contacting donors to seek permission and recognition information.
- Providing donors an opportunity to make a donation to move them up to the next level of recognition.
- Exploring new naming opportunities for the Access Campaign.

Events

Signature Core Events

Leaders for Mental Health Breakfast – October 2, 2019

- $729,919 raised to date.
- 2020 event booked for Wednesday, October 7, 2020 at the EY Centre.

Inspiration Awards – Friday March 6, 2020 at the Infinity Convention Centre

Request for your assistance:

- Consider sponsorship (includes table of 8) – $5,000 to $20,000.
- Solicit a couple of fabulous auction items. Online auction to go live on February 21, 2020.
- Join the Raffle ticket sales team – sell 10+ $100 tickets. Prizes include:
    1. $5,000 Canadian Tire Gift Card
    2. Two tickets anywhere Air Canada flies
    3. $1,000 MacEwen Gas Gift Card

    Early Bird: Two 100 level Sens tickets vs Edmonton Oilers on March 18, 2020
- Promote the Youth Video Contest to your networks. Deadline for submissions is February 16, 2020.

Community Led Events

Fiscal Year to date – (Apr. 1, 2019 – Jan 10, 2020) 45 events complete; 3 upcoming in FY20 (FY19 = 45 events)

Highlights

- Ottawa Monopoly Sales – $35,000 was raised for The Royal & DIFD through the sale of Ottawa Monopoly games this fall.
- Epicure Sales – a Royal supporter (Jennifer James) sold Epicure to help raise $800 for The Royal.
- December 5 – 7 – itSMF Annual Holiday Breakfast raised $3,695 for The Royal.
- December 18 – the SIBS Social Committee at the RCMP raised $900 through a jean day.
- PURE Kitchen Community Smoothie Campaign – $1.00 from every Community Smoothie sold at each PURE location in January was donated to The Royal.
- January 29 – Mental Illness: Let's Talk! Stop the Stigma – A speaker series exploring mental illness, stigma and the families it affects.

SHOPPERS LOVE.YOU. Run / Walk for Women – Saturday June 13, 2020

- Help us reach our 2020 Goals – i.e. 5,000 participants and raise $500,000.
- RFW 2020 committee, co-chaired by Leigh Harris and Liza Mrak is underway, with 15 members recruited to date.
- **We need team captains** – our goal is to recruit 225 team captains. Being a Captain is easy. You create a team. You tell all your family and friends about it and recruit 5+ people between now and June. Everyone gets a $100 Shoppers Drug Mart swag bag. If you cannot become a 2020 Captain, it would be so appreciated if you could introduce us to prospective captains.
- The public service is one of the top priorities of groups to engage in 2020 (goal 25 teams). Please connect us to anyone you know who works in PS.
- Please contact tracey.welsh@theroyal.ca for further details.

DIFD

Fiscal Year to Date – (Apr. 1, 2019 – Jan. 10, 2020) 60 events completed, 6 upcoming in FY20)

Highlights

- December 9 – Liquid Impact Tattoo Fundraiser donated $500 in support of DIFD.
- December 10 – Stephanie Richardson and two DIFD supporters participated in WE Day in Ottawa.
- December 13 – A DIFD Day was held at John McRae Secondary School.
- December 15 –The 9th Annual Lady Sens Tournament took place raising $9,500 for DIFD.

- January 2 – The Ottawa 67s vs Kingston DIFD game was held at TD Place Arena raising $750.
- January 27 – The Montreal Canadiens hosted a Mental Health Awareness game and highlighted DIFD.

February Events

- February 1-3, 8-9 – The NGHA hosted their 4th Annual DIFD Hockey Tournament.
- February 6 – DIFD Ottawa Senators Game vs Colorado Avalanche took place at the Canadian Tire Centre.
- February 8 – 3rd Annual Ottawa U Law Classic in support of DIFD was held.
- February 21-23 – KMHA Bantam Charity Tournament in support of DIFD will take place.

Event Start Date	Event Day	DIFD	Royal	W4MH	Awareness	Event Name	# of Yrs
April-June 2019	3 months		1			'This Table Cares' at Golden Palace Restaurant	1st
April		1				AY Jackson	1st
April		1				Merivale High School	1st
April		1				Sacred Heart Catholic H.S. Grade7/8 Drama Club	1st
April		1				Ray of Light	1st
1-Apr-2019	Monday	1				The Wellington Stuntman Burger	1st
1-30-Apr-19	Month Long	1				Exhalo Spa Buddha-Ful Box	1st
4-Apr-2019	Thursday	1			1	Bell High School Mental Health Week	1st
6-Apr-2019	Saturday	1				Goodwill Hockey Game for Special Olympics	1st
13-Apr-2019	Saturday		1			SDM Trivia Night	3rd
14-Apr-2019	Sunday		1			The Abundance Tribe	1st
15-Apr-2019	Monday				1	RFW Capt Rally #2	Internal
15-Apr-2019	Monday		1			Treat Yo Self	1st
17-Apr-2019	Wednesday	1				School fundraising and awareness booth	1st
24-Apr-2019	Wednesday				1	Bank Street Running Room	3rd
26-Apr-2019	Fri-Sat	1				FUG Cup	3rd
26-Apr-2019	Friday	1				Cal Bellamy Memorial Chili Cook Off	1st
27-28 April 2019	Sat-Sun				1	Women's Show RFW Promo	2nd
28-Apr-2019	Sunday				1	Slater Street Running Room	3rd
29-Apr-2019	Monday				1	Carleton Healthy Workplace "Mental Health Fair"	1st
May		1				Off-ice Board Games	2nd
May		1				Glen Cairn Public School Volleyball Fundraisor	1st
May		1				Hot stone restorative workshops	1st
May		1				Eva and Mackenzie Mother's day Cupcake sale	1st
1-May-2019	Wednesday	1				Weights for Wellness	2nd
1-May-2019	Wednesday	1				Liquid Impact Tattoo Fundraiser	3rd

Event Start Date	Event Day	DIFD	Royal	W4MH	Awareness	Event Name	# of Yrs
3-May-2019	Friday	1	1			Mental Health Gala	3rd
4-May-2019	Saturday		1			Shoppers LOVE.YOU. Beauty Gala	3rd
4-May-2019	Saturday	1				Morning Owl Manotick Opening	1st
6-11-May-2019	Mon-Sat	1				Cause for Paws	2nd
8-May-2019	Wednesday				1	NRCAN mental wellness fair	1st
8-May-2019	Wednesday				1	Canada Post/CRA Occupational Safety & Health week	1st
8-May-2019	Wednesday				1	RFW Capt Rally #3	Internal
9-May-2019	Thursday	1				Students held a bake sale during mental health fair	1st
10-May-2019	Friday	1				All Saints Bake Sale	1st
10 May to 14 June	Month Long				1	Run/MOVE/Walk with President	1st
May 11-12	Sat-Sun		1			Live the Smart Way Expo	3rd
12-May-2019	Sunday		1			Lexington RFW Fundraiser with Westboro BIA etc	1st
15-May-2019	Wednesday				1	Westboro Running Room	1st
17-May-2019	Friday		1			CanGames	1st
19-May-2019	Sunday	1				GCPS Volleyball Fundraiser	5th
21-May-2019	Tuesday		1			Knights of Columbus Golf Tournament	12th
24-May-2019	Friday		1			Bumble & Yogatown Sweat it out for Mental Health	1st
24-May-2019	Friday	1				Royal Oak Day	9th
26-May-2019	Sunday		1			Tamarack Race Weekend	5th
26-May-2019	Sunday		1			Tamarack Race Weekend - Jessica Crawford	1st
26-May-2019	Sunday		1			Somewhere out There	1st
27-May-2019	Monday				1	EDC lunch & learn with Juliet	2nd
28-May-2019	Tuesday				1	RFW WMH pres at BDO	1st
May 31-June 2, 2019	Fri-Sun	1				9th Annual DIFD 3 - Pitch Tournament	9th
1-Jun-2019	Saturday		1			City of OM	2nd
2-Jun-2019	Sunday				1	Child Services Expo	1st

Event Start Date	Event Day	DIFD	Royal	W4MH	Awareness	Event Name	# of Yrs
7-Jun-2019	Friday	1				I'll B OK	4th
9-Jun-2019	Sunday	1				Sonatas for Springtime	3rd
10-Jun-2019	**Monday**	**1**	**Core**			**The Open - 29th Annual Golf Tournament**	**29th**
14-Jun-2019	Friday		1			CMHC Golf Tournament	4th
15-Jun-2019	Saturday		1			Shoppers LOVE.YOU. Run for Women	7th
18-Jun-2019	Tuesday				1	Third party appreciation	Internal
19-Jun-2019	Wednesday				1	L4MH BF Captain Camp	Internal
20-Jun-2019	Thursday		1			EllisDon Ottawa Golf Tournament	1st
26-Jun-2019	Wednesday				1	RFW Capt Appreciation	Internal
26-Jun-2019	Wednesday	1				Westwind Public School Student Fundraiser	1st
27-Jun-2019	Thursday	1				Sacred Heart Lemonade Stand for DIFD	1st
		1				Rockdance	2nd
July		1				Longfields-Davidson “Mental Health Movement”	
6-Jul-2019	Saturday	1				J5L Golf Tournament	5th
13-Jul-2019	Saturday	1				Mike Lalande Golf Tournament	1st
20-Jul-2019	Saturday		1			Soccer Tournament	1st
20-Jul-2019	Saturday	1				Bench The Barriers	
23-Jul-2019	Tuesday	1			1	DIFD Presentation	1st
10-Aug-2019	Saturday	1				DIFD Games	1st
15-Aug-2019	Thursday	1				Landscape Ontario	
24-Aug-2019	Saturday		1			March Employee Networks Golf and 50/50 fundraiser	1st
24-Aug-2019	Saturday		1			Canada Pakistan Association of Ottawa – EID Dinner	1st
27-Aug-2019	Tuesday				1	Leaders for Mental Health Breakfast Training Camp	Internal
28-Aug-2019	Wednesday	1				Linkden Ottawa Network	1st
28-Aug-2019	Wednesday		1			National Bank Charity Raffle	1st

Event Start Date	Event Day	DIFD	Royal	W4MH	Awareness	Event Name	# of Yrs
29-Aug-2019	Thursday		1			WCMHA Golf Tournament	1st
3-Sept-2019	Ongoing		1			Boost for Mental Health	1st
5-Sept-2019	Thursday			1		ForePlay for Charity Ottawa Women's Networking Golf Tournament	5th
7-Sept-2019	Saturday	1				REDBLACKS DIFD Game	1st
10-Sept-2019	Tuesday				1	Gala Gratitude & Launch	Internal
13-Sept-2019	Friday				1	Recovery Day	
16-Sept-2019	Monday		1			Inspirational Golf Classic	2nd
19-Sept-2019	Monday		1			Treat Yo Self	2nd
20-Sept-2019	Friday	1				E.H. Price	3rd
21-Sept-2019	Saturday	1				9 & Dine Golf Outing	1st
21-Sept-2019	Saturday	1				Canada Post Colonnade Depot Family Fundraiser Walk for DIFD	2nd
27-Sept-2019	Friday		1			Double Up for Mental Health	1st
1-Oct-2019	Tuesday	1	1			Monopoly for charity	1st
2-Oct-2019	**Wednesday**		**Core**			**12th Annual Leaders for Mental Health Breakfast**	**12th**
3-Oct-2019	Thursday				1	NRCan Mental Health Day	1st
10-Oct-2019	Thursday				1	Algonquin College - Mental Illness Awareness Day	1st
10-Oct-2019	Thursday		1			Rocking Awareness	5th
11-Oct-2019	Friday		1			Michelle Obama Online Auction	1st
11-Oct-2019	Friday		1			ICC (Infinity CC) Ball	1st
18-Oct-2019	Friday		1			4th Biannual Laser Quest Extravaganza	1st
19-Oct-2019	Saturday		1			Rocktoberfest	1st
19-Oct-2019	Saturday		1			4C's Fundraising Event – Cool Cars, Coffee & Charity!	1st
24-Oct-2019	Thursday				1	EDC Wellness Fair	2nd
25-Oct-2019	Friday	1				Chalk One Up For DIFD	8th
November	Month-long		1			Jennifer James Epicure Fundraiser	1st

Event Start Date	Event Day	DIFD	Royal	W4MH	Awareness	Event Name	# of Yrs
2-Nov-2019	Saturday	1				Stacey Santaguida 50th Birthday Party	1st
6-Nov-2019	Wednesday	1				Algonquin College Community Development Class Bake Sale	1st
8-Nov-2019	Friday		1			Indo-Canada Ottawa Business Chamber (ICOBC) Annual Gala	1st
9-Nov-2019	Saturday	1				Tight and Bright Pledge Pub	1st
9-Nov-2019	Saturday	1				Knights of Columbus Ukrainian Harvest Dinner & Dance	1st
11-Nov-2019	Monday	1				OTHS Panther Prowl	2nd
13-Nov-2019	Wednesday		1			Treat Yo Self	3rd
15-Nov-2019	Friday	1				Gloucester North Lions Club Activites	1st
19-Nov-2019	Tuesday		1			Barres & Wheels Community Ride	1st
21-Nov-2019	Thursday		1			Bust your Asana	2nd
21-Nov-2019	Thursday		1			Barres & Wheels: Strong Mind – Lean Body Book Launch with Tony Greco	1st
26-Nov-2019	Tuesday		1			Barres & Wheels Community Ride	2nd
27-Nov-2019	Wednesday		1			Mo'fessionals Tailgate Lunch Party	1st
December	All month	1				Off-Ice Games - Board Game Sales	2nd
5-Dec-2019	Thursday		1			Conkuer Apparel	1st
5-Dec-2019	Thursday		1			itSMF Holiday Breakfast	7th
9-Dec-2019	Year-Long	1				Liquid Impact Tattoo Fundraiser	4th
13-Dec-2019	Friday	1				DIFD at John McCrae Secondary School	1st
15-Dec-2019	Sunday	1				8th Annual Lady Senators Tournament	8th
18-Dec-2019	Wednesday		1			SIBS Social Committee Jean Day	1st
31-Dec-2019	Tuesday	1				Carlton University Men’s Hockey NYE Party	2nd
January	Month-long		1			PURE Kitchen Community Smoothie Campaign	2nd
2-Jan-2020	Thursday	1				DIFD Student Fundraiser	1st

Event Start Date	Event Day	DIFD	Royal	W4MH	Awareness	Event Name	# of Yrs
2-Jan-2020	Thursday	1				67s DIFD game	9th
11-Jan-2020	Saturday		1			Rinaldo Hair Designers and Spa "Look Good, Feel Good" Event	1st
27-Jan-2020	Monday				1	Shoppers Run Captain Rally	Internal
29-Jan-2020	Wednesday				1	Bell Let's Talk Coffee Pot	Internal
29-Jan-2020	Wednesday		1			Mental Illness: Let's Talk! Stop the Stigma	1st
29-Jan-2020	Wednesday				1	Ottawa Hydro Lunch & Learn	
29-Jan-2020	Wednesday	1				Bell Let's Talk Happy Place	
1-Feb-2020	Saturday	1				DIFD at Laurier	
Feb 1-3, 8-9	Fri-Sun	1				NHGA Hockey Tournament	4th
6-Feb-2020	Thursday	1				DIFD Ottawa Senators Game vs Colorado Avalanche	9th
8-Feb-2020	Saturday	1				Ottawa U Law Classic	3rd
Feb 21-23, 2020	Fri-Sun	1				KMHA Bantam Charity Tournament	1st
6-Mar-2020	**Friday**		**Core**			**Inspiration Awards Gala**	**17th**
TOTALS		**64**	**47**	**1**	**27**		

The Le Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

TO: **ROHCG Board of Trustees Board Members**

FROM: **Joanne Bezzubetz**
President & CEO, ROHCG

DATE: **February 20, 2020**

SUBJECT: **2015-2020 Strategic Plan Update (DRAFT)**

Dear Board Members, the following is a status summary of the 2015-20 Strategic Plan.

2019-2020 Performance Scorecard:

As it stands, some of our scorecard performance indicators are aligned with our Quality Improvement Plan and with our Mental Health and Addictions Quality Initiative peer scorecard. We are increasing the alignment of our various performance indicators.

Q3 Highlights:
Of the 13 quarterly indicators reported, we are on target for 69%.

The use of Physical/Mechanical Restraint rose by 1.5% over last quarter; however, program level review of patient data indicates this is due to individual patients requiring restraint within the first 72 hours of admission to the Crisis and Forensic Programs.

The wait time for the Mood/Anxiety Outpatient Program has continued to decline and is now at 27 days, which is a reduction of 28 days over Q2. The Program continues to closely monitor referrals and processes. Data integrity and accuracy continues to be a focus for the indicators.

A technical issue with the Emerald workload software has affected the Q3 productivity result. IT is aware of the situation and testing solutions for an end of March implementation.

We look forward to your review of our Q3 2019-20 Performance Scorecard and welcome your feedback.

Joanne Bezzubetz,
President & CEO

Royal Ottawa Health Care Group Strategic Plan 2015-2020

Our Vision...
Mental Health Care Transformed
Through Partnerships, Innovation, and Discovery

Our Mission...
Delivering excellence in specialized mental health care, advocacy, research and education

Our Values…
We are guided by innovation and a passionate commitment to collaboration, honesty, integrity and respect

ROHCG Board of Trustees Performance Scorecard
Q3 2019-2020

The Royal's 2015 – 2020 Strategic Plan

BOARD OF TRUSTEES DASHBOARD

Q3 2019-2020

OBJECTIVES

- Enhance Our Culture of Recovery
- Ensure a Safe Care Environment
- Demonstrate Positive Outcomes and Experiences

OBJECTIVES

- Integrate Clinical Care and Research
- Drive Leading Edge Research
- Promote Inter-Professional and Community Knowledge Exchange

OBJECTIVES

- Improve Flow Throughout the System
- Advocate with Partners for System Improvement

OBJECTIVES

- Ensure a Safe and Positive Work Environment
- Enhance Staff Recognition
- Engage Our Staff in the Success of Our Strategic Plan

OBJECTIVES

- Support Best Practices in Sustainability and Efficiency
- Leverage Technology for Best Outcomes
- Create New Funding Opportunities

INDICATORS	Q3	INDICATORS	Q3	INDICATORS	Q3	INDICATORS	Q3	INDICATORS	Q3
Client Experience/Recovery (A)		REB Approved Projects (SA)		LOCUS Scores (Q)		Workplace Incidents (Q)		Productivity (Q)	
Med Rec Inpt- Admission (Q)		Grant Funding Awarded (SA)		Wait Times (Q)		Lost Time Frequency Index (Q)		Absenteeism (Q)	
Med Rec Outpt- Discharge (Q)		Publications/ (A)		Signed Transition Plans (A)		Performance Appraisals (A) Management		OTN Consults/Treatment (SA)	
Med Rec Outpt – Admisison (Q)		Journal Impact Factor (A)		ALC Days (Q)		Union/Non-Union Physicians		New IT Applications (SA)	
Acute Control Medication (Q)		Students Trained (SA)		30-Day Readmissions (Q)		Employee Supervisor Feedback (BA)		Non-MoHLTC Revenue (SA)	
Physical/Mechanical Restraint (Q)		Staff Trained (SA)		Partner Satisfaction (BA)	BA	Physician Environment (BA)		Philanthropic Funds (SA)	
Overall Client Experience (A)		Community Education (SA)				Employee Overall Engagement (BA)			
Family/Personal Support Experience (A)						Physician Overall Engagement (BA)			
Clinical Outcomes DSI (SA)		Q –Quarterly SA – Semi-annual A – Annual BA – Bi-annual				Employee Team Experience (BA)			
Clinical Outcomes PSS (SA)		+/- 2.99% of Target +/- 3 to 5.99% of Target				Physician Team Experience (BA)			
Clinical Outcomes SCI (SA)		+/- 6% of Target Target TBD							

CARE - Delivering Person and Family Centered Care, Quality & Safety Objective: Ensure a Safe Care Environment				Q3 2019-2020
Indicator: Medication Reconciliation	**Executive:** **R. Bhatla/ S. Farrell/ E. Millar**	**Data Contact:** **T. Burta**	**STATUS**	**Quarterly**

Summary

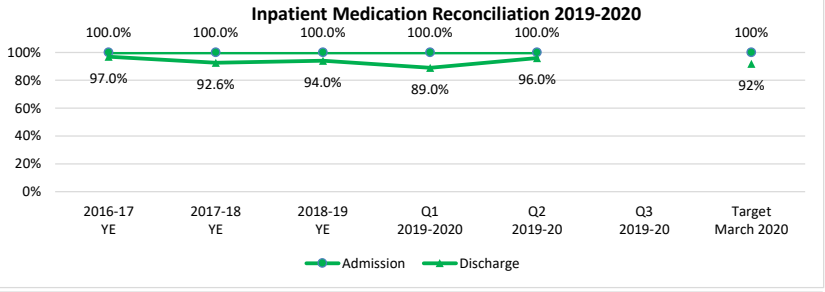
Significance Medication Reconciliation is a formalized safety process to ensure correct medication orders are provided by the hospital at admission and discharge, as well as at admission for outpatients.
Definition: % formal medication reconciliation on admission, at discharge and at admission as an outpatient.
Formula (Inpatient): Total number of inpatients reconciled at admission/ total admissions x 100; Total number of discharge reconciliations/ total discharges x 100.
Formula (Outpatient): Total number of Patients with confirmed medication list/# of Active patients in each clinic
Data Source: Manual audits.

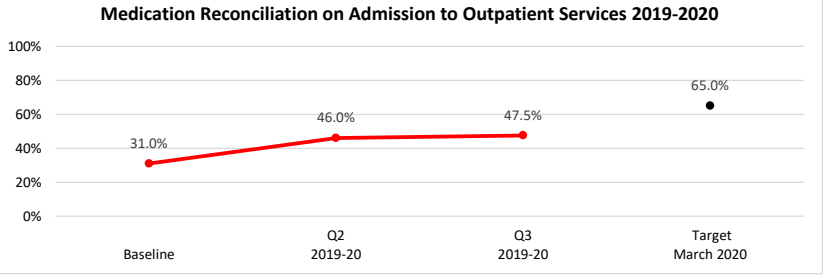
Initiatives & Mitigation Strategies

1. Medication Reconciliation Working Group has been formed to collaboratively support medication reconciliation, review audits for completion and accuracy of patient profiles, and to assist in the development of initiatives to continuously improve the quality of medication reconciliation. This interdisciplinary working group includes patient and/or family representation and will report on a monthly basis to the Pharmacy and Therapeutics Committee.
2. Medication Reconciliation in outpatient areas has been initiated in all 18 clinics, services, and programs previously identified. Electronic medication reconciliation within Meditech has been implemented in 13 of 18 clinics. The 5 remaining clinics will remain on paper until November 19, 2019 Community Mental Health go-live.
3. Medication Reconciliation eLearning modules on PALMS are updated to reflect new documentation workflow within the EHR. Nursing participation in eLearning will be measured by % of required staff completing modules. Physician education support for the EHR remains ongoing on an individual or departmental request.
4. Electronic audits for medication reconciliation completion are in development with our partner sites. Current audits will be conducted manually by the pharmacy department until electronic version is available.

Results

Medication Reconciliation at Admission to Outpatient Services: Three audits have been conducted since June 11th go-live. Each participating program, clinic, or service selected 10 random patient charts of outpatients admitted and seen within one week of the audit request. A registered pharmacy technician reviewed the charts for completion of home medication list and completion of medication reconciliation. Charts that did not meet Medication Reconciliation Policy requirements were excluded (example: if patient seen as consult only). Data obtained from the November 30, 2019 audit shows 47.5 % have Medication Reconciliation complete, which is a 1.6 % increase compared to the second audit. This audit identified Home Medication Lists were entered in 98 % of the charts reviewed, a 13.9% increase since the second audit. Only 2.0 % of charts contained no documentation of home medications, an improvement of 11.9%
Medication Reconciliation at Discharge: Consistent with our peers, the Royal includes all discharged patients in the denominator for calculating the percentage of patients with a completed medication reconciliation at discharge. However, it should be emphasized that not all patients are available at the time of discharge to engage in medication reconciliation. In Q3, there were 4 clients who were discharged against medical advice.





CARE - Delivering Person and Family Centered Care, Quality & Safety Objective: Ensure a Safe Care Environment				Q2 2019-2020
Indicator: Acute Control Intervention	**Executive:** **R. Bhatla/ S. Farrell/ E. Millar**	**Data Contact:** **R. Eagle**	**STATUS**	**Quarterly**

SUMMARY

Significance: In rare instances restraint use has resulted in harm to the patient. The Royal supports a 'least restraint' approach to care, meaning that restraint should only be used in emergency situations. Factors, such as client presentation, safety, staffing and environmental factors may determine the use of acute physical, medication and seclusion interventions.
Definition: Percentage of patients whose RAI-MH admission assessment reported use of acute physical control procedures (includes physical/mechanical) or acute control medication in the last 3 days.
Formula: Calculated by CIHI.
Data Source: OMHRS Admission Report (RAI-MH).

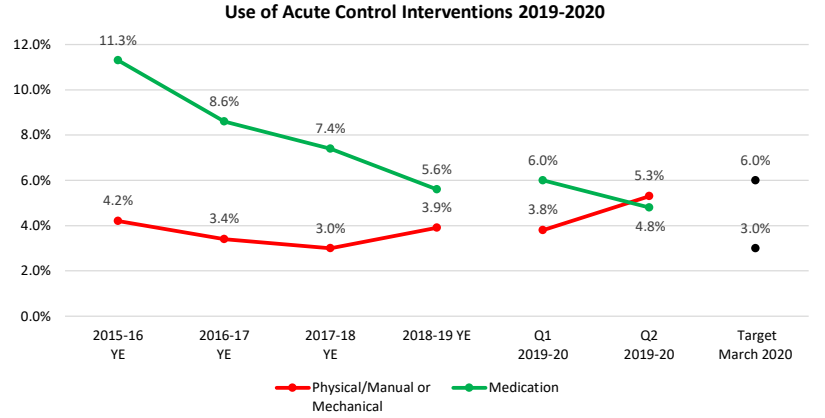
Initiatives and Mitigation Strategies

1. Review of all restraint use (with full details of clinical circumstances) with the care teams through the Recovery Plan of Care.

RESULTS

Note that the results are one quarter behind due to the Canadian Institute for Health Information (CIHI) reporting schedule.

All programs have reviewed this data and in each program found that each instance of restraint use was a different patient and a single application of restraint, within 72 hours of admission, indicating it is not a continuous practice in the provision of care.



ENGAGEMENT - Fostering a Culture of Collaboration Objective: Ensure a Safe & Positive Work Environment				Q3 2019-2020
Indicator: All Types of Employee Workplace Incidents	**Executive:** **C. Crocker**	**Data Contact:** **N. Addo**	**Status**	**Quarterly**

SUMMARY

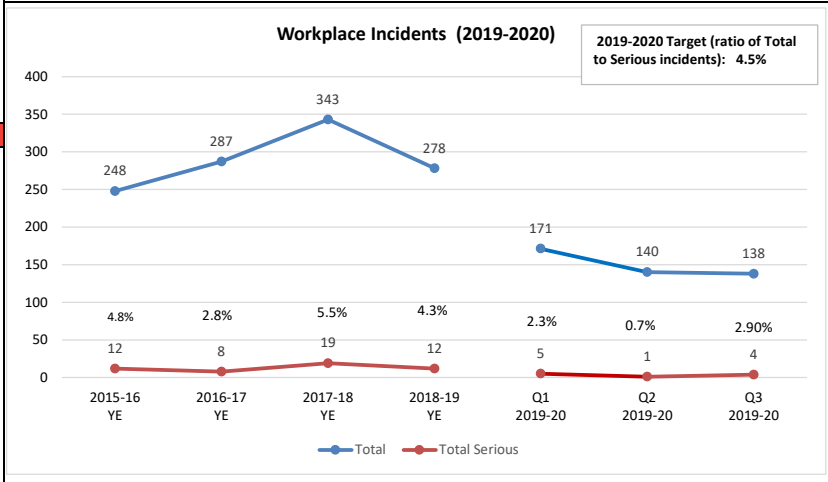
Significance: Staff working in mental health facilities require specialized training and programs to be in place to ensure their safety and to minimize workplace incidents.
Definition: All types of workplace incidents reported by staff and all serious incidents (incidents resulting in lost time).
Formula: Total # of serious incidents and total # workplace incidents reported in the period.
Data Source: Employee Incident Reporting System (EIRS).

It is important for our staff to report all incidents, including minor events and near misses, which provide opportunities for learning and for improving safety. Our target of <4.5% is based on a ratio of serious incidents relative to the overall number of incidents. The current Q3 ratio is **2.9%** **where there were 4 lost time claims this quarter.**

NOTE: This indicator reflects the number of claims submitted and not the number of claims subsequently approved by the WSIB. We are reviewing whether or not this is a valid reportable indicator as it is not something we can compare to our peers and our rate changes significantly based on the WSIB approval process. In addition, our culture of non-blame encourages the reporting of "near misses" as valuable learning opportunities and hence, our number of total incidents is expected to rise over time.
NOTE: The 2019-2020 Quality Improvement Plan tracks workplace incidents related to violence. The Performance Scorecard tracks all types of workplace incidents.

Initiatives and Mitigation Strategies

1. Violence in the Workplace Committee project to encourage reporting, thus will see total reports increased (incidents and near misses).
2. Use of risk assessment tool to identify root cause of accident and recommendations for changes.
3. Increased safety training for staff in high risk areas when incidents are occurring.
4. Benchmarking with peer hospital for implementation of leading practices.
5. Implementation of Ministry of Labour voluntary OHS Management System to ensure compliance with all regulatory and legal requirements.



ENGAGEMENT - Fostering a Culture of Collaboration Objective: Ensure a Safe & Positive Work Environment				Q3 2019-2020
Indicator: Lost Time Frequency Index	**Executive:** **C. Crocker**	**Data Contact:** **N. Addo/K. Kealey**	**Status**	**Quarterly**

SUMMARY

Significance: Hospitals have a number of quality and safety programs in place to enhance the health and safety of staff, patients and community. Workplace Safety and Insurance Board (WSIB) claims provide an indication of how safe/positive The Royal's working environment is for staff.
Definition: Tracks the number of all types of **non-approved** WSIB claims resulting from injuries/health issues that occur on, or as a result of, the job.
Formula: # of all types of Workplace Safety & Insurance Board (WSIB) lost time claims started in the reporting period, divided by total earned hours x expected hours for 100 FTE's annually (1950 x 100). NOTE:as of March, 2018, the target is based on this new calculation.
Data Source: Occupational Health and Finance. Reporting is adjusted retroactively based on the number of **actual approved claims**

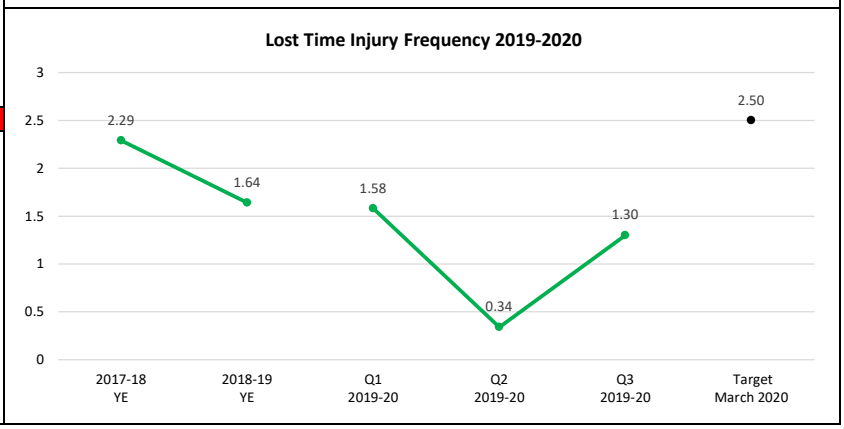
RESULTS

The Lost Time Frequency Index (LTFI) is reported on the Mental Health and Addictions Quality Initiative (MHAQI) Scorecard as well as the Royal's Performance Scorecard. In 2017-18, the MHAQI adopted a new process to calculate this indicator which brings us in line with Workplace Safety Insurance Board (WSIB) reports.

NOTE: As a revised process includes all claims, not only those approved, the four peer hospitals are reporting much higher numbers.

Initiatives and Mitigation Strategies

1. Use of risk assessment tool to identify root cause of accident and recommendations for changes.
2. Increased safety training for staff in high risk areas when incidents are occurring.
3. Benchmarking with peer hospital for implementation of leading practices.
4. Implementation of Ministry of Labour voluntary OHS Management System to ensure compliance with all regulatory and legal requirements.



PARTNERSHIPS - Working Together to Increase Capacity in our Region Objective: Improve Flow Throughout the System				Q3 2019-2020
Indicator: LOCUS Scores	**Executive:** **R. Bhatla/ S. Gulati/S. Farrell**	**Data Contact:** **Kim Breen**	**Status**	**Quarterly**

SUMMARY

Significance: The Level of Care Utilization System (LOCUS) helps match service intensity to client needs, based on their Risk of Harm; Functional Status; Co-Morbidity; Recovery Environment; Treatment/Recovery History; and Engagement. Inpatient services are typically appropriate for persons with a score of 5 or 6.
Definition: % inpatients with a LOCUS score at admission of 5 or above.
Formula: Number of inpatients with a LOCUS score of 5 or 6/ total number of inpatients assessed x 100.
Data Source: Manually collected.

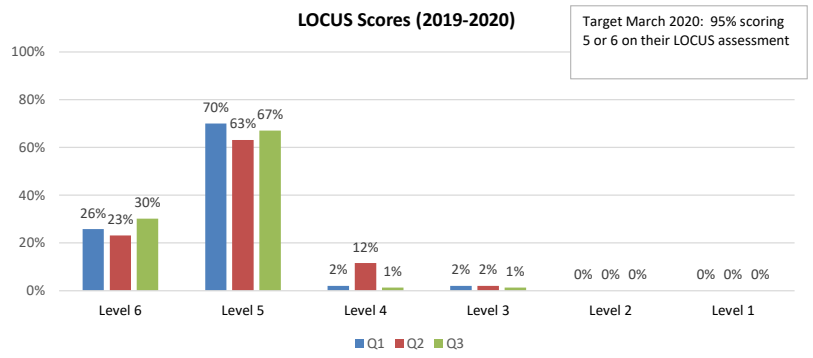
RESULTS

The description of LOCUS levels shows that clients rated at levels 5 and 6 are most appropriate for our intensive inpatient services. The Q3 2019-2020 results show that **97%** of our inpatients scored 5 or 6 on their LOCUS assessments, which within the correct target range for the Royal.

Level 1= Recovery Maintenance Health Maintenance
Level 2= Low Intensity Community Based Services
Level 3= High Intensity Community Based Services
Level 4=Medically Monitored Non-Residential Services
Level 5= Medically Monitored Residential Services
Level 6= Medically Managed Residential Services

Initiatives and Mitigation Strategies

1. Preposal that we put a note stating that the recommendation is not to focus on this indicator for future strategic planning indicators.



PARTNERSHIPS - Working Together to Increase Capacity in our Region Objective: Improve Flow Throughout the System				Q3 2019-2020
Indicator: Wait Times	**Executive:** **R. Bhatla/ S. Farrell/ E. Millar**	**Data Contact:** **H. Hussain**	**Status**	**Quarterly**

SUMMARY

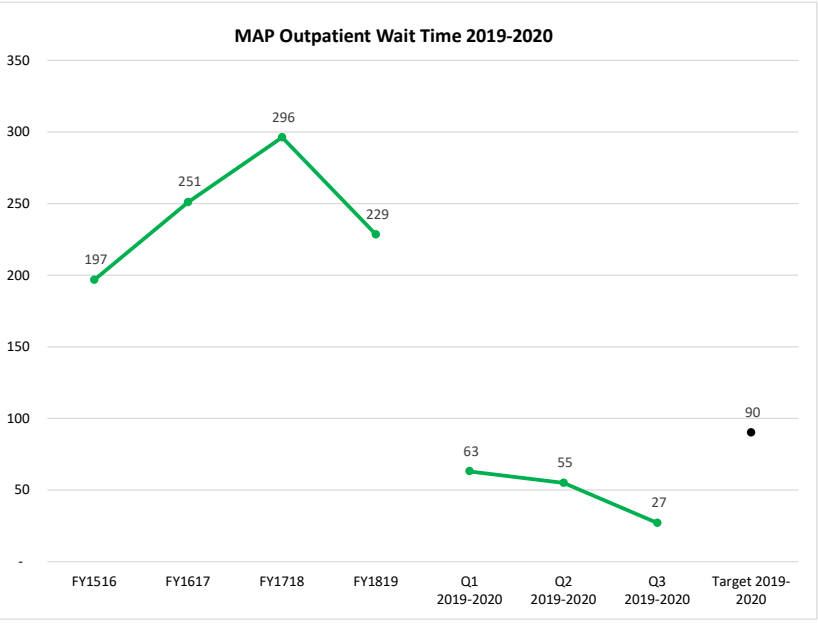
Significance:: Reducing wait times for inpatient and outpatient treatment is essential to ensuring our clients receive the services they need when they need them.
Definition: Using an approximation of acute setting definitions - Wait Times Information System (WTIS): Period of time from the date completed referral is received to date patient/client is seen by a clinician (inpatient and outpatient waits reported separately).
Formula: Total number of days between date completed referral received and date seen/ total number of patients.
Data Source: Electronic Health Record

RESULTS

The wait time for the Mood & Anxiety Outpatient Service has continued to remain under target this quarter with strategies we have in place. No new updates at this tiime.

Initiatives and Mitigation Strategies

1. Program stakeholders continue to identify a range of contributory actions to reduce and maintain wait times. This includes monitoring and increasing clarity of criteria for the program.
2. Increase in Physicain resources to 2.4 FTE's.



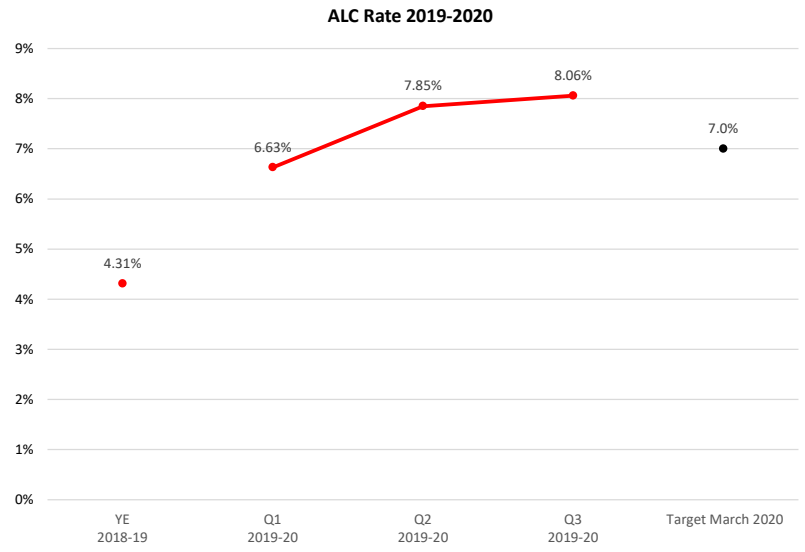
PARTNERSHIPS - Working Together to Increase Capacity in our Region Objective: Advocate with Partners for System Improvement				Q3 2019-2020
Indicator: ALC Days	**Executive:** **R. Bhatla/ S. Farrell/ E. Millar**	**Data Contact:** **Kim Kealey**	**Status**	**Quarterly**

SUMMARY

Significance: The majority of ALC patients are not able to leave the hospital until a suitable community placement is available. In addition to improving patient outcomes, pursuing and initiating partnerships with housing and other service providers is critical to improving system flow.
Definition: When patients occupy hospital beds but do not require inpatient services, they are designated as Alternate Level of Care.
Formula: # of Alternate Level of Care days during period/ # Mental Health patient days in period x 100.
Data Source: Finance

RESULTS

The results that have been provided by Cancer Care Ontario have been found to be inconsistent with our internally calculated data. After discussion with the Directors of Flow and Finance, it was agreed that the data for this indicator be derived from Finance for this fiscal year.



Initiatives and Mitigation Strategies

1. Continue to monitor with a focus on data quality.
2. The issue of ALC days is a province wide issue that is linked directly to the capacity of the community system to provide appropriate care for those people who have finished their acute phase of care. The government has recognized this and although pledging significant LTC beds, this new capacity has not been realized to any degree. This is further compounded by the lack of LTC care beds designated to care for the unique and complex needs of individuals with a significant mental illness who remain in hospital awaiting appropriate placement. This is not a metric that can be moved without systemic change from the government. All actions Royal can take will achieve impact outside the annual cycle. There are no further short term actions that can be taken. Royal will continue their actions to increase the capacity and designation of beds however these actions will not move this metric in the next 6 months.

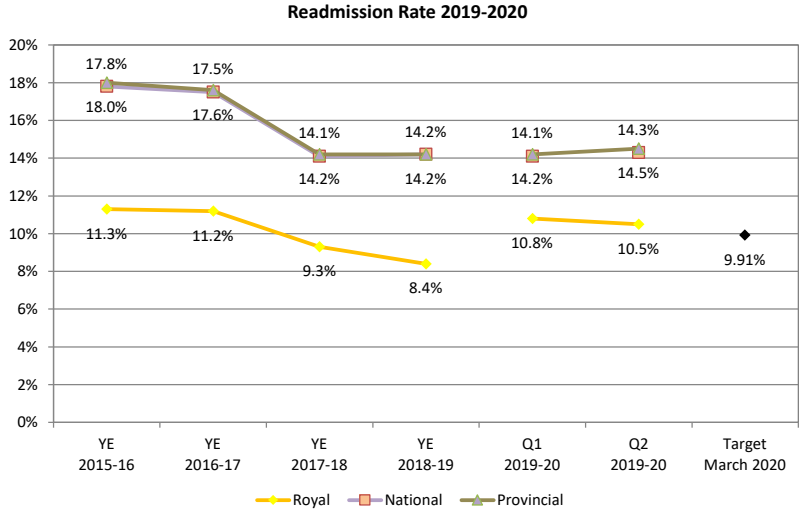
PARTNERSHIPS - Working Together to Increase Capacity in our Region Objective: Advocate with Partners for System Improvement				Q2 2019-2020
Indicator: 30 Day Readmissions	**Executive:** **R. Bhatla/ S. Farrell/ E. Millar**	**Data Contact:** **R. Eagle**	**Status**	**Quarterly**

SUMMARY

Significance: High readmission rates may mean that patients were discharged too early, or that necessary supports for clients to remain in the community were not available (e.g., housing, significant others, services, etc.).
Definition: Percentage of patients readmitted to any facility for mental health treatment within 30 days of a previous discharge. NOTE excludes same day admissions and discharges.
Formula: Calculated by CIHI.
Data Source: CIHI

RESULTS

Our results are behind by one quarter due to the CIHI reporting schedule.



Initiatives and Mitigation Strategies

With the new E.H.R., we will begin to look at strategies to be able to impact this indicator at the program level and to link to additional community support options upon discharge.

RESOURCES - Effective Use of Resources to Support Quality Care Objective: Support Best Practices in Sustainability & Efficiency				Q3 2019-2020
Indicator: Productivity	**Executive:** **C. Crocker/ S. Farrell/ E. Millar**	**Data Contact:** **K. Kealey**	**Status**	**Quarterly**

SUMMARY

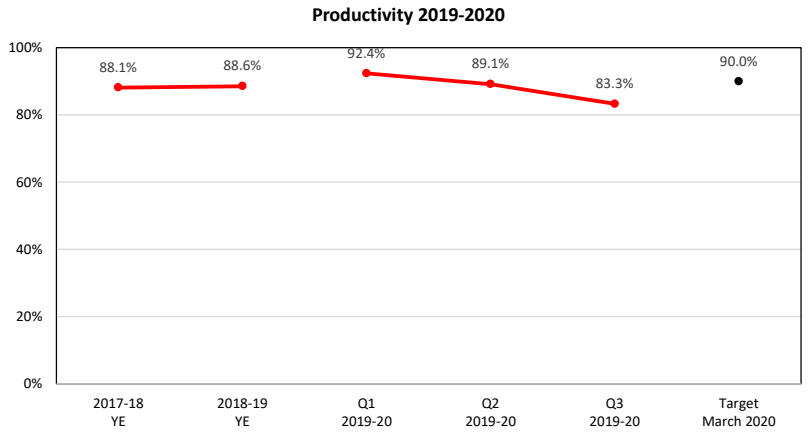
Significance: Improving our productivity means that each of us is making a full and positive contribution and those under-staffed areas can be properly resourced within our means. Workload measurement is also a requirement of the Ministry of Health and Long-term Care that may impact our funding in the future as part of the Ministry's initiative towards patient-based funding.
Definition: % of clinical worked hours spent providing service to the organization as either direct patient care or non patient care.
Formula: # workload hours reported by unit producing diagnostic and therapeutic personnel / total actual worked hours x 100.
Data Source: Workload Measurement System.

RESULTS

The organization uses the Emerald Workload Measurement system to track specific clinical employee hours. Reports are produced on a monthly basis and reviewed by Program and Professional Practice Leadership. Results for Q3 are impacted by a technical issue with the Emerald workload measurement software. IT is aware of the issue and working with the vendor to correct the problem.

Initiatives and Mitigation Strategies

1. Ensure new system is working effectively.



RESOURCES - Effective Use of Resources to Support Quality Care Objective: Support Best Practices in Sustainability & Efficiency				Q3 2019-2020
Indicator: Absenteeism	**Executive:** **C. Crocker**	**Data Contact:** **K. Kealey**	**Status**	**Quarterly**

SUMMARY

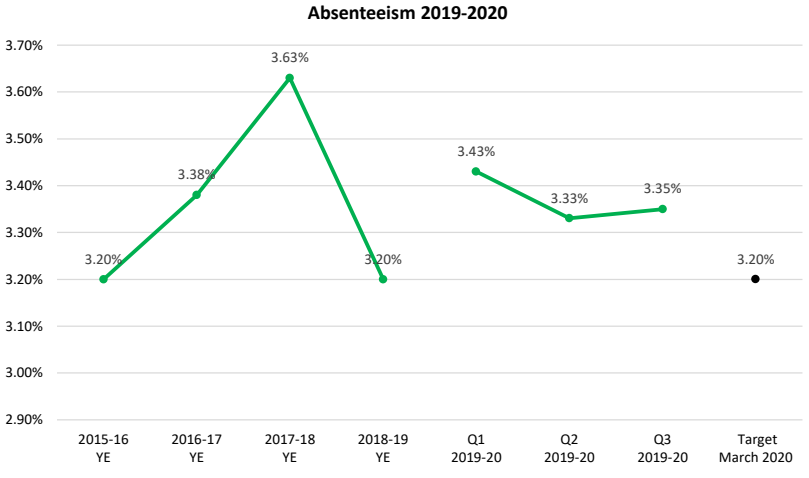
Significance: The health and well-being of every staff member is critical to the quality and continuity of care for our patients and for maintaining a positive work environment.
Definition: # of hours employees are off due to illness (entitled to paid sick leave)/total paid hours.
Formula: Total paid sick hours/total paid hours x 100.
Data Source: Finance.

RESULTS

Absenteeism data is collected and reported to Leadership on a monthly basis. It is also reported on the Peer Report Card. Our results are consistent with Provincial averages, below our peers (Waypoint and Ontario Shores) and above CAMH.

Initiatives and Mitigation Strategies

1. Develop and implement a Chronic Illness Absenteeism process in late Q2/early Q3.
2. Attendance Support Program in place.



RESOURCES - APPENDIX - HSAA Indicators (quarterly reported)

Hospital Service Accountability Agreement (HSAA)

Total Margin

The % by which total revenues exceed or fall short of total expenses, excluding the impact of facility amortization, in a given year

Comment:

2016-2017 YE	2017-2018 YE	2018-2019 YE	2019-2020 Q1	2019-2020 Q2	2019-2020 Q3	2019-2020 YE	Proposed Target
0.56%	1.05%	0.93%	0.69%	0.82%	0.76%		0.48%

Current Ratio

The number of times the ROHCG's short –term obligations can be paid using short term assets.

2016-2017 YE	2017-2018 YE	2018-2019 YE	2019-2020 Q1	2019-2020 Q2	2019-2020 Q3	2019-2020 YE	Proposed Target
0.95:1	.96:1	.91:1	.93:1	.93:1	.92:1		.87:1

Inpatient Days

Days during which services are provided to an inpatient in a globally funded bed between the census taking hours on successive days Day of admission is counted as an inpatient day, but day of separation is not an inpatient day. When service recipient is separated (discharged or die) on the same day, one inpatient day is counted.

2016-2017 YE	2017-2018 YE	2018-2019 YE	2019-2020 Q1	2019-2020 Q2	2019-2020 Q3	2019-2020 YE	Proposed Target
92,714	92,819	91,515	23,406	20,743	20,744		88,628

Ambulatory Care Visits

The number of times face-face or by videoconference services are provided to individuals by ROHCG's employees in a globally funded outpatient or community care cost center.

Comment:

2016-2017 YE	2017-2018 YE	2018-2019 YE	2019-2020 Q1	2019-2020 Q2	2019-2020 Q3	2019-2020 YE	Proposed Target
62,870	66,112	62,512	*	32,639			66,685

RESOURCES - APPENDIX - M-SAA Indicators

Multi-Sector Service Accountability Agreement (M-SAA)

Visits

The number of occasions that services are provided face to face, via videoconferencing or telephone to individuals. This includes service to the service recipient and/or significant other(s) on behalf of the service recipient. The interaction must be documented in the client file. This excludes face-to face interactions with service recipients not uniquely identified

Comment:

2016-2017 YE	2017-2018 YE	2018-2019 YE	2019-2020 Q1	2019-2020 Q2	2019-2020 Q3	2019-2020 YE	Proposed Target
45,409	39,702	42,763	*	21,423			35,038

Not Uniquely Identified Service Recipient Interactions

Number of face to face interactions when client anonymity is desired or unknown

Comment:

2016-2017 YE	2017-2018 YE	2018-2019 YE	2019-2020 Q1	2019-2020 Q2	2019-2020 Q3	2019-2020 YE	Proposed Target
11,729	10,516	10,358	*	4,354			6,250

Resident Days

The number of calendar-days a community mental health and addictions residential care client is served. The day of admission is counted and the day of separation or discharge is not counted. When the client is admitted and separated on the same day, one service recipient day is counted.

Comment:

2016-2017 YE	2017-2018 YE	2018-2019 YE	2019-2020 Q1	2019-2020 Q2	2019-2020 Q3	2019-2020 YE	Proposed Target
3,197	3,135	2,988	878	1,510	2,234		3,135

Individual Served

A year-to-date count of the number of unique individuals served in a reporting period, identified by a unique identifier (e.g. OHIP number), that received services in a functional centre. An individual is counted only once per fiscal year for each functional centre where they received service. The same individual may be counted in more than one functional centre if they are receiving services from more than one functional centre.

Comment:

2016-2017 YE	2017-2018 YE	2018-2019 YE	2019-2020 Q1	2019-2020 Q2	2019-2020 Q3	2019-2020 YE	Proposed Target
3,975	4,076	4,770	*	3,198			3,599

Group Sessions

The number of formal group sessions held of material length and planned and delivered by one or more service providers/staff to two or more service recipients at the same time. A group may consist of non-registered individuals and/or registered clients (e.g. includes information sessions with clients and/or their family members.

Comment:

2016-2017 YE	2017-2018 YE	2018-2019 YE	2019-2020 Q1	2019-2020 Q2	2019-2020 Q3	2019-2020 YE	Proposed Target
845	1,121	1,298	*	595			705

Group Participants

The number of individuals receiving services in a group.

Comment: New reporting template structure from the LHIN for all functional centres, target only for Consumer Initiatives (PLEO)

2016-2017 YE	2017-2018 YE	2018-2019 YE	2019-2020 Q1	2019-2020 Q2	2019-2020 Q3	2019-2020 YE	Proposed Target
7,035	5,646	5,575	*	2,495			3,100

Mental Health Sessions

The number of full sessions provided using psychiatric sessional fees. A full session is the intention to pay for services provided during a time period of three hours

2016-2017 YE	2017-2018 YE	2018-2019 YE	2019-2020 Q1	2019-2020 Q2	2018-2019 Q3	2019-2020 YE	Proposed Target
871	617	862	*	359			1,060

*Not reported for Q1 as per LHIN process

The Le Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

ROHCG Board of Trustees Quality Committee

Executive Summary Q2 2019-2020 Mental Health and Addictions Quality Initiative

DATE: February 4, 2020

In 2010, four specialty Ontario provincial psychiatric hospitals (CAMH, The Royal, Waypoint Centre and Ontario Shores) embarked on a mental health and addictions quality initiative (MHAQI) to standardize the collection and reporting of quality-related performance indicators. In addition to the ongoing advocacy and system transformation work of the four peer hospitals, the MHAQI supports a separate membership group of hospitals, including facilities in Quebec, Newfoundland, New Brunswick and Manitoba that compare results on a quarterly basis and engage in quality improvement discussions and activities.

Peer Report – Q2 2019-2020

It should be noted that the MHAQI Peer Ranked Report is behind by one reporting period due to the timing of results released by the Ontario Mental Health Reporting System – CIHI. The Report compares results among our four peer institutions, and provides National and Provincial benchmarks for some indicators. The full Scorecard is published on each of our external websites and, according to the Canadian Institute for Health Information, represents the only public reporting of comparative mental health indicators in Canada, if not further afield. Rank ordering of the Q2 2019-2020 results appears on this version of the report for your consideration but does not appear on our website.

Report Highlights

A table with peer rankings, as well as the Provincial and National results is presented. Q2 2019-2020 results show The Royal has performed well, ranking first or second among its peers on 67% of the indicators. Based on these results, we are admitting less complex patients than our Peers, however, results for client outcome indicators show that on discharge, they have improved clinical status as demonstrated by the Self Care Index and Overall Change in Care Needs indicators.

The Royal has consistently ranked first amongst our Peers for Non-use of Acute Control Interventions. In Q2, although the rate of medication incidents per 1000 patient days far exceeded that of our Peers, this speaks to the culture of reporting all incidents where staff are encouraged to report all patient safety incidents in order to identify patterns or trends, learn from incidents and make improvements. The Royal's first place ranking on the Lost Time Injury Frequency indicator tracks staff safety, where in Q2, there was only one lost time claim reported.

Melissa Webb,
Director, Decision Analytics

MHAQI Q2 2019-2020 PEER RANKING	1	2	3	4	PROV	N'TL
% of clients admitted with more than one reason for admission	OS 99.5%	CAMH 91.7%	WYPT 69.2%	ROYAL 62.1%	66.5%	66.5%
% of clients with more than one **psychiatric** diagnosis at discharge	ROYAL 58.2%	CAMH 58.2%	WYPT 58.2%	OS 45.1%	42.2%	42.1%
% of clients with more than one **medical** diagnosis at discharge	OS 56.4%	CAMH 29.9%	ROYAL 28.3%	WYPT 17.7%	14.9%	14.9%
% of clients with an improvement in the self care index score from admission to discharge	CAMH 62.1%	ROYAL 50.8%	OS 39.0%	WYPT 38.1%	60.3%	59.5%
% of clients reporting improvement or marked improvement at discharge (overall change in care needs)	CAMH 90.9%	OS 81.2%	ROYAL 77.3%	WYPT 70.6%	81.5%	81.0%
% of clients re-admitted to **any** facility within 30 days of discharge (reported one quarter behind)	WYPT 8.5%	ROYAL 10.5%	OS 13.4%	CAMH 15.2%	14.5%	14.3%
% Positive responses to client Inpatient survey question relating to overall rating of care	Annual Reporting					
% Positive responses to client Outpatient survey question relating to overall rating of care	Annual Reporting					
% Prevalence of acute control medication use reported in last 3 days	ROYAL 4.8%	OS 16.0%	CAMH 27.1%	WYPT smcell	16.1%	16.1%
% Prevalence of physical/manual, or mechanical restraint use in last 3 days	WYPT 3.0%	ROYAL 5.3%	CAMH 7.2%	OS smcell	6.7%	6.6%
% Prevalence of non-use of control interventions in last 3 days	ROYAL 91.8%	OS 82.5%	WYPT 79.9%	CAMH 69.9%	78.6%	78.6%
% of Unauthorized Leaves of Absences in the period	WYPT 0.00%	OS 0.07%	ROYAL 0.20%	CAMH 1.38%		
All Medication Incidents per 1000 patient days reported during the period.	OS 0.85	WYPT 2.60	CAMH 2.88	ROYAL 5.59%		
% of In-patient Medication Reconciliations completed on Admission during the period.	ROYAL 100%	OS 100%	WYPT 100%	CAMH 95%		
% of Alternative Level of Care days reported during period	WYPT 10.8%	ROYAL 11.3%	OS 15.9%	CAMH 21.9%		
Lost time injury frequency based on # of WSIB lost time claims started in the reporting period	ROYAL 0.34	OS 0.74	CAMH 2.31	WYPT 3.66		
% of paid sick hours for employees in the period.	CAMH 1.99%	ROYAL 3.22%	OS 4.50%	WYPT 4.90%		

Update from Centre of Excellence – PTSD and Related Mental Health Conditions

Dr. Patrick Smith

President &CEO

To

ROHCG – Board of Trustees: February 20, 2020

We reported that there were four new hires for The Centre of Excellence – PTSD brought on shortly before the December 12th Board meeting. There were postings in both official languages for an additional 6 new staff and interviews are currently being conducted to finalize these recruitments, bringing our new team total to 11 staff by fiscal year end March 31st.

Over the past two months since that time, staff have been actively engaged in facilitating partnerships and engaging with stakeholders across Canada. The team has been in active discussions with the Mental Health Directorate for Veterans Affairs Canada (VAC) in Montreal as well as the new Centre of Excellence (COE) on Chronic Pain at McMaster University in Hamilton, Ontario. The Canadian Institute for Military and Veterans Health Research (CIMVHR) at Queens University in Kingston has also facilitated stakeholder workshops to assist the two new COE's to engage appropriately with Veterans, family members, researchers, and clinicians.

Having been involved in guiding the development of CIHR's consultation workshop, we also attended the CIHR Post Traumatic Stress Knowledge Gaps Consensus Workshop in Ottawa on January 23rd and 24th. As reported earlier, the CIHR is developing a comprehensive funding initiative for PTSD research and knowledge exchange with 7 target populations – one of which is Veterans. We were pleased with the emphasis placed on including the voices of people with lived experience of PTSD in the workshop and expect to remain actively engaged as CIHR finalizes their plans for this initiative.

As CEO, I also had the opportunity to present an update to the Royal's Foundation Board on January 30th and will be scheduling a similar update for the Board of the IMHR. In the meantime, we have also been meeting with Florence Dzierszinski from the IMHR to review all internal research involving Veterans and PTSD at the Royal and look forward to facilitating discussions regarding how we might further support this work.

A special "shout out" and thank you to Karen Monaghan and her team who helped us develop our interim logo below to use until we have more confirmation of name/direction.

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Royal Ottawa Health Care Group

The Royal's Ethics Framework for Decision Making

ACCOUNTABILITY FOR REASONABLENESS (A4R)

A4R encourages decision-makers to reflect upon the reasons for their decisions, and to guide organizations towards fair and ethical priority setting. The framework now embodies five principles**:**

1. **Relevance:** decisions are made in a way that "fair-minded people can agree are relevant to meeting the diverse health needs" given resource constraints.
2. **Transparency:** rationales for decisions should be made publicly accessible.
3. **Revision:** opportunities should be provided to revisit and revise decisions in a timely manner if further information becomes evident. Decisions can also be challenged by fair-minded people.
4. **Compliance:** there must be either a voluntary or involuntary process of ensuring compliance with all principles.
5. **Empowerment:** there should be efforts to optimize real opportunities for participation and engagement in priority setting, and to minimize power imbalances in decision-making.

I-D-E-A FRAMEWORK

1. **Identify** the facts: medical indications, client preferences, quality of life, and contextual features
2. **Determine** the ethical principals in conflict: list the principles & explain the issue
3. **Explore** the options: discuss the options and the strengths and weaknesses of each
4. **Act** on the decision and evaluate: develop and evaluate an action plan, self-evaluation / feedback

Adapted from Gibson, Martin & Singer. (2005) Evidence, Economics and Ethics. Healthcare Quarterly, Vol. 8, No. 2. and Daniels, N. & Sabin, J. (2002) Setting Limits Fairly: Can we Learn to Share Medical Resources? Oxford: Oxford University Press.

WHY A COPORATE ETHICS FRAMEWORK?

A **Corporate Ethics Framework** is essential to ensure the decision making process is fair, equitable, transparent, and reflects the values of the organization. In a tertiary care Mental Health facility, organizational ethics encompasses multiple settings for decision making. There are **Clinical Decisions** which clinicians make on a daily basis to assist and treat their patients. They need to be governed under the guidelines or framework of a clinical ethics decision making tool. We have **Operational Decisions** that are founded on the prioritization of resources and selection of programs for service delivery. These are operational decisions which need to reflect an operational decision making process. The third area of decision making comes out of the commitment to **Research** and the ethical practices which govern the use of research protocols and client involvement in the studies.

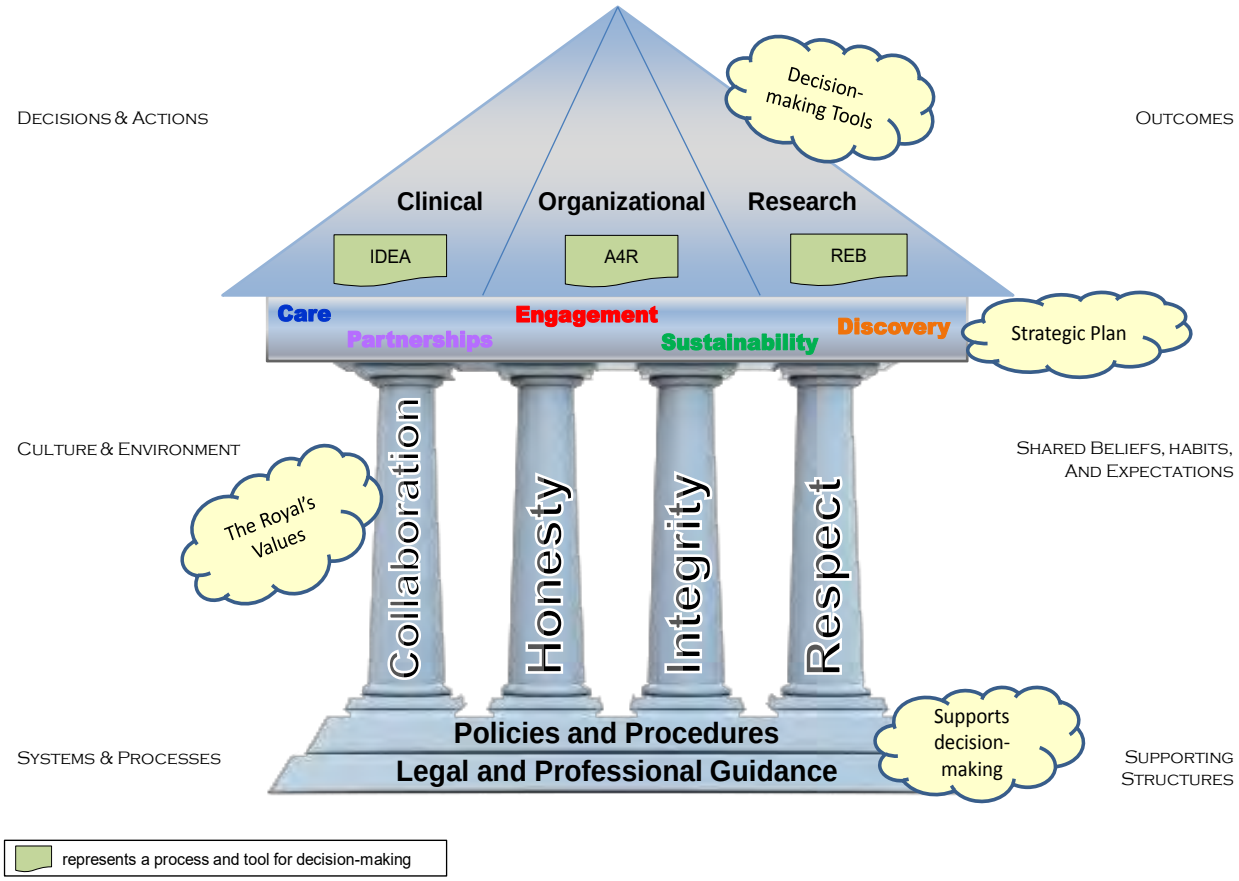
WHICH TOOLS FOR WHICH DECISIONS?

Each of these areas of decision making will use unique ethical tools to guide the thought process, selection of options, and ultimately outcome of these decisions. Clinical decisions will follow the **IDEAS framework** for ethical decision making. Operational decisions will utilize the **Accountability for Reasonableness framework (A4R)** for resource prioritization and allocation. Research decisions will follow the **Research Ethics Board** process and protocols for research project application and implementation.

ALIGNING WITH THE ORGANIZATION

The Corporate Ethics Framework itself must reflect the mission of delivering excellence in specialized mental health care, advocacy, research and education. It must also reflect and fundamentally support the values of the organization including **collaboration, honesty, integrity and respect**. The framework includes the four values which act as pillars to uphold each of the ethical tools for use in decision making.

CORPORATE ETHICS FRAMEWORK



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CONFLICT OF INTEREST: *BOARD OF TRUSTEES*			
SECTION: III ETHICS, RIGHTS & RESPONSIBILITIES		**NO: 111**	
Issued By:	Governance Committee of The Board of Trustees	**APPROVAL DATES :**	
Approved by:	Board of Trustees	**Date Initially Approved:** 21/06/2018	
		Date Reviewed:	
		Date Revised:	
		Date Implemented: 21/06/2018	
Key Words:	Board Conflict of Interest, Trustees Conflict of Interest, COI, Board of Trustees COI, Board of Trustees decision Making	**Cross Reference(s)**	CORP II- i 110 Regulatory Transparency, CORP II-i 170 Board Of Trustees: Public, Non-Public & Excluded Meetings, CORP III-110 Conflict of Interest

1. PURPOSE:

To ensure the highest business and ethical standards and the protection of the decision-making integrity of the Board of Trustees of the Royal Ottawa Health Care Group (ROHCG) and to guide Trustees, with a real, potential or perceived conflict of interest, on how to declare their conflict and the process for dealing with conflict situations.

2. POLICY STATEMENT:

It is the policy of the ROHCG that all Trustees have a duty to ensure that the trust and confidence of the public in the integrity of the decision-making processes of the Board are maintained by ensuring that they and other members of the board are free from conflict or potential conflict in their decision–making. It is inherent in a Trustee's fiduciary duty that conflicts of interest be avoided. It is important that all Trustees understand their obligations when a conflict of interest or potential conflicting interest arises.

3. SCOPE:

This policy applies to all Trustees, including ex-officio Trustees, and all non-Board members of all Board committees of the ROHCG.

4. GUIDING PRINCIPLES:

All Trustees and non-Board committee members will avoid situations in which they may be in a position of conflict of interest or perceived conflict of interest. The by-laws contain provisions with respect to conflict of interest that must be strictly adhered to. In addition to the by-laws, the process set out in this policy will be followed when a conflict or potential conflict arises. All Trustees must understand their duties when a conflict of interest arises.

5. DEFINITIONS:

Conflict of Interest: The situations in which potential conflict of interest may arise cannot be exhaustively set out. Conflicts of interest generally arise in the following circumstances:

1. When a Trustee is directly or indirectly interested in a contract or proposed contract with the Corporation. For example: Trustees are bidding on or doing contract work for the Corporation.
2. When a Trustee acts in self-interest or for a collateral purpose. When a Trustee diverts to his or her own personal benefit an opportunity in which the Corporation has an interest.
3. When a Trustee has a conflict of "duty and duty". This might arise when:
   - the Trustee serves as a board member of another corporation that is related to; has contractual relationship with; has the ability to influence the Corporation policy; or has any dealings whatsoever with the Corporation
   - the Trustee is also a Trustee of another corporation, related or otherwise, and possesses confidential information received in one boardroom that is of importance to a decision being made in the other boardroom. The Trustee cannot discharge the duty to maintain such information in confidence as a Trustee of one corporation while at the same time discharging the duty to make disclosure as a Trustee of the other corporation
4. When a Trustee uses for personal gain information (for example related to human resources financial aspects of the corporation, or related to patient care) received in confidence only for the Corporation's purposes.
5. When a Trustee and his or her family will gain or be affected by the decision of the Board.

6. PROCEDURE:

6.1 Special Considerations for the Corporation: The Corporation's unique governance structure creates automatic potential conflicts. These structural conflicts need not be a bar to participation in most aspects of the Board's deliberations. In these circumstances, the Trustees are aware of the potential for conflict of interest and as a practical matter it should not be necessary to make note of the potential conflict in regular Board proceedings. Where the potential for conflict might not be obvious, the potential conflict of interest should be declared and recorded in the minutes so that all Trustees are aware of the situation. This places an extra burden on Trustees to be acutely aware of when their actions and/or other responsibilities might create a conflict and follow the procedures in this policy to protect themselves and the best interests of the Corporation.

6.2 Disclosure of Conflicts: A Trustee who is in a position of conflict or potential conflict will immediately disclose such conflict to the board by notification to the chair or vice chair of the board. Where the chair has a conflict, notice shall be given to the vice-chair. The disclosure will be sufficient to disclose the nature and extent of the Trustee's interest. Disclosure will be made at the earliest possible time and prior to any discussion and vote on the matter. When (i) a Trustee is not present at a meeting in which a matter that is a conflict of interest for him/her is first discussed and/or noted upon or (ii) a conflict arises for a Trustee after a matter has been discussed but does not get voted

upon by the board, or, (iii) a Trustee becomes conflicted after a matter has been approved, the Trustee will make the declaration of the conflict to the chair or vice-chair as soon as possible and at the next meeting of the board. If an officer becomes interested in a contract or transaction after it is made or entered into, the disclosure shall be made as soon as possible after the officer becomes so interested. A Trustee may make a general declaration of the Trustee's relationships and interests in entities or persons that give rise to conflicts.

6.3 Abstain from Discussions: The Trustee who has declared a conflict will not be present during the discussion of the matter in which he or she has a conflict and will not attempt in any way to influence the voting.

6.4 Process for Resolution of Conflicts and Addressing Breaches of Duty: All Trustees will comply with the requirements of the by-laws and this policy. It is acknowledged that not all conflicts or potential conflicts may be satisfactorily resolved by strict compliance with the by-laws. There may be cases where the perception of a conflict of interest or breach of duty may be harmful to the corporation notwithstanding that there has been compliance with the by-laws. A Trustee should be referred to the process outlined below in any of the following circumstances:

6.4.1 Circumstances for Referral: Where any Trustee believes that he /she personally or another Trustee:

a. has breached his or her duties to the corporation;
b. is in a position where there is a potential breach of duty to the corporation;
c. is in a situation of actual or potential conflict of interest; or
d. has behaved or is likely to behave in a manner that is not consistent with the highest standards of public trust and integrity and such behaviour may have an adverse impact on the corporation

6.4.2 Process for Resolution - The actual, potential or perceived conflict will be referred to the following process for resolution:

a. the Trustee must declare to the Board or Committee the nature and extent of the interest as soon as possible and not later than the meeting at which the matter is to be considered. If a declaration is made at a Committee meeting, it must be repeated at the next Board meeting to assure disclosure to the full Board.
b. provided that the declared interest is not a financial interest, the Board member may participate in the discussion and may vote on the matter, unless two-thirds of the Board members who have not declared such an interest then decide otherwise.
c. if the declared interest is a financial interest:
    i. the Trustee may remain present at the meeting for the purpose of answering questions prior to discussion and the vote. If present at the meeting, the Trustee will be counted in the quorum for the meeting
    ii. after making the disclosure and answering questions, the Trustee who has declared a conflict must not vote or in any way attempt to influence the discussion of, or voting on, the decision at issue and must withdraw from the meeting when the matter is being discussed
d. where the matter of the conflict is unclear, the Trustee shall refer the matter to the chair of the Governance Committee or where the issue may involve the chair of the

Governance Committee, to a member of the Governance Committee who is not in conflict, with notice to the CEO.

e. the chair of the Governance Committee (or member of the Governance Committee who is not in conflict as the case may be) will either: (1) resolve the matter informally or (2) refer the matter to an ad hoc sub-committee of the Board established by the chair of the Governance Committee, which sub-committee shall report to the Board.
f. if the matter cannot be resolved in accordance with (e) above to the satisfaction of the chair of the Governance Committee (or member of the Governance Committee who is not in conflict as the case may be), ad hoc subcommittee and/or the referring Trustee and the Trustee involved, the matter will be referred to the full Board for review.
g. if the matter cannot be resolved to the satisfaction of the Board, the chair of the Governance Committee (or member of the Governance Committee who is not in conflict as the case may be) shall forward it to dispute resolution.

6.4.3 Dispute Resolution Mechanism - if the matter cannot be resolved following the Process for Resolution, the Board may appoint an acceptable non-Board member to independently review (and call on such resources as necessary to review) the matter in question and make a recommendation to the Board.

6.5 Perceived Conflicts: It is acknowledged that not all conflicts or potential conflicts may be satisfactorily resolved by strict compliance with the by-laws. There may be cases where the perception of a conflict of interest or breach of duty (even where no conflict exists or breach has occurred) may be harmful to the corporation notwithstanding that there has been compliance with the by-laws. In such circumstances, the process set out in this policy for addressing conflicts and breaches of duty shall be followed. It is recognized that the perception of conflict or breach of duty may be harmful to the corporation even where no conflict exists or breach has occurred and it may be in the best interests of the corporation that the Trustee be asked to resign.

6.6 Failure to Disclose: if a Trustee knowingly fails to disclose a conflict of interest as required by this Policy, the Trustee may be asked to resign or may be subject to removal from office pursuant to the by-laws and the *Corporations Act*. A Trustee's failure to comply with this policy does not, in or of itself, invalidate any decision made by the Board.

7. RELATED PRACTICES AND/OR LEGISLATIONS:
Corporations Act, R.S.O. 1990, c. C38 (version 2018)

8. REFERENCES:
Board Conflict of Interest Policy, Waypoint Centre for Mental Health (2017)
Board Conflict of Interest Policy, Southlake Regional Health Centre (2017)
Conflict of Interest Policy, St. Joseph's Healthcare-Hamilton (2015)
General Principles Regarding Conflict of Interest – OHA Governance Manual (2016)

9. APPENDICES: N/A

BOARD OF TRUSTEES: *Public, Non-Public & Excluded Meetings*			
SECTION: II-i ADMINISTRATION - *Leadership*		**NO: 170**	
Issued By:	Governance Committee - Board of Trustees	**APPROVAL DATES :**	
Approved by:	Board of Trustees	**Date Initially Issued:** 10/04/2011	
		Date Reviewed: 19/12/2012,	
		Date Revised: 19/12/2012, 23/05/2018	
		Date Implemented: 10/04/2011, 21/02/2013, 26/02/2015, 21/06/2018	
Key Words:	Open Meetings, Public Meetings, Closed Meetings, media access, in-camera, non-public, Board Meetings, Board of Trustee Meetings	**Cross Reference(s)**	CORP II-i 110 Regulatory Transparency

1. PURPOSE:

To provide parameters as to the attendees at public, non-public and excluded meetings of the Royal Ottawa Health Care Group (ROHCG) Board of Trustees (Board).

2. POLICY STATEMENT:

Since the ROHCG Board represents a publicly-funded entity, the Board strives to be as open and transparent in its deliberations as possible. Therefore, in the interest of good governance meetings of the Board shall be open to the public, as appropriate. In addition, there will be times, due to the nature of the issues at hand, when the Board will determine that it is in the public's best interest for meetings to be non-public and/or excluded sessions. As public meetings generate trust, openness and accountability, the general public and staff are welcome to observe any open portion of a Board meeting to in order to facilitate the conduct of the Board's business in an open and transparent manner.

3. SCOPE:

This policy applies to the ROHCG Board and associated Board Committees. The practice of Committees of the Board in relation to excluded sessions will be guided by this Policy.

4. GUIDING PRINCIPLES:

As a broad principle, meetings of the Board shall be open to all who choose to attend unless disclosures made in the presence of individuals who are not Board Trustees are reasonably likely to prejudice the interests of either the organization or some other party to whom the organization has an obligation to protect.

5. DEFINITIONS:

Excluded Sessions of the Board of Trustees: Excluded sessions may, at the direction of the Chair, be conducted at the beginning of the formal business of the meeting or at the end of the formal business of the meeting. These will be either **"**restricted session" or as an "in-camera session".

Restricted session of the Board of Trustees: is a meeting of those persons who are Trustees and the CEO of the organization. During each meeting of the Board, there will be an opportunity for independent board members only to meet in a restricted session with the President & CEO.

In-camera session of the Board is a meeting of only those persons who are Trustees and any staff who the Trustees, by agreement, authorize to be present.

Non-public meeting of the Board is not open to the general public or the media, but is open to ROHCG staff.

Public meeting of the Board is open to the general public including the media.

6. PROCEDURE:

Members of the public are able attend the public meetings of the Board of Trustees in accordance with the following:

6.1 Notice of Meeting: A schedule of the date, location and time of the Board's regularly scheduled public meetings will be available on the ROHCG's external website. Any changes to the schedule will be posted on the website.

6.2 Public Attendance at Board Meetings: Any person wishing to attend public meetings of the ROHCG Board in the capacity of an observer is entitled to do so. Because of space limitations, seating is available at the meeting on a first come first served basis and to comply with fire and other regulations, attendance may be restricted to a maximum number.

6.3 Conduct During the Meeting: Members of the public may be asked to identify themselves. Recording devices, videotaping and photography are prohibited. The Chair may require anyone who displays disruptive conduct to leave.

6.4 Agendas and Board Materials: Agendas will be distributed at any Board meeting and may be obtained from the Board secretary prior to the meeting. Supporting materials will be distributed to the Board members and Senior Management Team. The Chair of the Board shall ensure that an agenda is prepared in advance of each regular board meeting.

6.5 Excluded Sessions of the Board of Trustees: It is at the discretion of the Board Chair to determine whether or not a portion of the meeting should be identified as an excluded session. These will be either **"**restricted session" or as an "in-camera session". In recognition of the fact that members of the press and other interested persons may wish to be present at Board meetings, the excluded portion of such meetings shall, wherever practical, be held at the end of the public part of the meeting. If a Trustee believes that it is not appropriate for a matter to be discussed in an excluded session,

he/she shall discuss this matter with the Board in the excluded session and the Board shall make a decision on whether the matter should be held in the public part of the meeting. A separate agenda may be prepared for excluded sessions and the circulation restricted to the participants of the excluded session. These will be maintained in strict confidentiality. Upon the conclusion of an excluded session occurring at the beginning of the formal business of a meeting, the Chair will announce the continuation of the meeting. Upon the conclusion of an excluded session occurring at the end of the formal business of a meeting, the Chair will announce the continuation of the meeting and in the absence of any other business entertain a motion to adjourn the meeting.

6.5.1 ***Restricted Session with the President & CEO:*** During each meeting of the Board, there will be an opportunity for independent board members only to meet in a restricted session with the President & CEO. Matters that may be dealt with in a restricted session may include:

- Human resources issues, including senior management compensation and performance
- Financial, personnel, contractual and/or matters for which a decision must be made in which premature disclosure would be prejudicial
- Matters of a sensitive third party nature including matters related to civil or criminal proceedings
- Matters related to sensitive internal Board governance
- Matters related to an individual (board member or staff)
- Discussions dealing with stakeholders where the information being discussed may compromise the relationship
- Issues that arise during a Board meeting which, in the opinion of the Chair, may cause sensitivity in the open forum
- Sensitive issues involving a Board member
- Issues which in the opinion of the Chair some Board members may be reluctant or reticent to speak on in an open forum
- Confidential access to the Board by the Executive Vice-President & CFO and/or external auditors of the Board

During a restricted session, all staff will be excluded from the meeting unless invited to participate in the discussion. The Secretary of the Board (President & CEO) will record decisions, resolutions and motions. The Board will confirm when/if motions will be brought into the open forum, in consideration of the legal, privacy, human resource or other implications noted above.

6.5.2 ***In-Camera Session in the absence of the President & CEO:*** During each meeting of the Board, there will be an opportunity for independent Board members only to meet in-camera without the President & CEO. Matters that may be dealt with in an in-camera session may include:

- President & CEO Annual Performance Review
- Recruitment and compensation of the President & CEO
- Financial, human resources, contractual, legal matters dealing with the President & CEO for which a decision must be made
- Sensitive issues involving a Board member
- Board governance matters and self-assessment by independent members

The Chair will designate a board member to record decisions, resolutions and motions. The Chair will provide the Executive Vice President & CFO with any directions arising from the meeting requiring administrative follow-up. The Chair will brief the President & CEO following the meeting. All motions carried in-camera will be recorded in minutes by the board chair or designate. The Board will confirm when/if motions will be brought into the open forum in consideration of the legal, privacy and human resource implications.

6.6 Minutes: Minutes of public/non-public meetings shall be presented for approval at the next subsequent public/non-public meeting respectively.

6.6.1 Approved minutes of public Board meetings shall be made available to members of the ROHCG and members of the public on request.

6.6.2 Minutes from non-public meetings may be distributed as appropriate. Those persons to whom such minutes are distributed are required to keep them confidential.

6.6.3 Minutes of closed sessions of the board shall be recorded by the secretary or delegate, or if the secretary or delegate is not present, by a Trustee designated by the chair of the board. All minutes of closed sessions of the board shall be marked confidential and shall be handled in a secure manner. All minutes of meetings of committees and task forces of the board shall be marked confidential and shall be handled in a secure manner.

7. RELATED PRACTICES AND / OR LEGISLATIONS:

Bill 31- Personal Health Information Protection Act, S.O. 2004, *(Schedules A and B)*
Health Services Restructuring Commission, Section 1 (13/08/1997)
Public Hospitals Act
Mental Health Act (2001).
Bill 68 – Brian's Law, 2000
Health Care Consent Act, 1996
Regulated Health Professions Act, 1991,
Criminal Code of Canada. (R.S., 1985, c. C-46).
Bill 171- Health System Improvements Act, 2007, S.O., c 10
Bill 152 – Balanced Budgets for Brighter Futures Act,2000, S.O.200, c. 42
Bill 197 – Budget Measures Act, 2005, S.O. 2005, c.28
Bill 45 – Responsible Choices for Growth and Accountability Act, 2001, S.O. 2001, c. 8
Bill 36 – Local Health System Integration Act, 2006, S.O. 2006, c.4
Bill 46 - Excellent Care for All Act

8. REFERENCES:

Policy for Open Board Meetings - Grand River Hospital (2008)
Policy for Incamera Meetings - Grand River Hospital (2008)
Policy Statement - Niagara Health System (2007)
Board Policy - The Ottawa Hospital (2007)

9. APPENDICES: N/A