The Le Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

NOTICE OF MEETING
ROYAL OTTAWA HEALTH CARE GROUP
BOARD OF TRUSTEES
March 26, 2020 at 5:30 p.m.
Royal Ottawa Mental Health Centre
Via Zoom (details to be provided)

○ 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

Time (min)	Pg.	#	ITEM	REFERENCE	RESPONSIBILITY	STATUS	
05		**1.**	**CALL TO ORDER**	- *The Royal's Ethics Framework for Decision Making (217)* - *Conflict of Interest Policy (219)* - *Public, Non-Public and Restricted Meetings (223)*	A. Graham	○	IN
01	3	**2.**	**AGENDA AND MINUTES**	**a. Acceptance of Agenda**	All	●	DEC
02	4			**b. Approval of Minutes**	All	●	DEC
10		**3.**	**REPORTS AND UPDATES**	**a. Chair and President & CEO's Oral Report**	A. Graham J. Bezzubetz	○	IN
30	23			**b. Annual Report from the Chief of Staff/Psychiatrist-in-Chief**	R. Bhatla	○●	IN
10	71			**c. Strategic Plan Update**	J. Bezzubetz	○●	IN
15	83			**d. Foundation Campaign Case**	M. Bellman	○●	DEC
05				**e. Brockville Re-development Committee Update**	C. Crocker S. McLean	○	IN
05	108	**4.**	**DECISION/ INFORMATION ITEMS**	**a. Quality Committee Report** - DRAFT Minutes of March 5, 2020	L. Leikin	○●	IN
	114			i. Annual Quality Improvement Plan (QIP)		○●	DEC
06	130			**b. Medical Advisory Committee Report** - Minutes of January 16, 2020	R. Bhatla	○●	IN

	136			i. Medical Staff Privileges		●	DEC
10				**c. Finance Committee Report** - DRAFT Minutes of March 19, 2020 *(to be sent separately)* - Interim Financial Statements (with Executive Summary)	J. Gallant *Posted on Board website only for information*	○	IN
	137			i. Sinking Fund Investment		●	DEC
	142			ii. Corporate Procurement Policy		●	DEC
10	156			**d. Governance Committee Report** - DRAFT Minutes of March 10, 2020	C. Coulter	○●	IN
				i. Professional Development Reports		○●	IN
	166			- S. Squire		●	
	170			- A. Graham		●	
07	171			**e. Innovation Committee Report** - DRAFT Minutes of March 3, 2020	N. Bhargava	○●	IN
	180			i. Integrated Care		○●	IN
01		**5.**	**NEW BUSINESS** *(if any)*				
01	217	**6.**	**REPORT ON THE ETHICS FRAMEWORK FOR DECISION MAKING**				
01		**7.**	**NEXT MEETING**	- Special Meeting on June 3, 2020 at 4:30 p.m. - AGM, Regular meeting and New Officers' meeting on June 18, 2020 at 3:30 p.m.			
01		**8.**	**ADJOURNMENT**				DEC
		9.	**EXCLUDED SESSIONS** -	**RESTRICTED** (Independent Board Members, CEO and COS/PIC)			
				IN CAMERA (Independent Board Members only)			

OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 43	**Priority:** Routine

DATE: March 26, 2020

COMMITTEE:

PRESENTER:

SUBJECT: **Acceptance of the Agenda**

BACKGROUND INFORMATION:

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT the March 26, 2020 agenda be accepted, as presented.

CARRIED

Moved by:
Seconded by:
Motion approved:

OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 44	**Priority:** Routine

DATE: March 26, 2020

COMMITTEE:

PRESENTER:

SUBJECT: **Approval of the Previous Minutes**

BACKGROUND INFORMATION:

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT the February 20, 2020 minutes be approved, as presented.

CARRIED

Moved by:
Seconded by:
Motion approved:

MINUTES
ROYAL OTTAWA HEALTH CARE GROUP
BOARD OF TRUSTEES
February 20, 2020 at 4:30 p.m.
Royal Ottawa Mental Health Centre
Room 1424, 1145 Carling Avenue
Teleconference Dial-In: 1-888-875-1833 Passcode: 926707277#

MEMBERS		STAFF		GUESTS
Present	**Regrets**	**Present**	**Regrets**	
I. Levy, Acting Chair C. Coulter, Vice Chair N. Bhargava J. Gallant R. Anderson *(by phone)* S. Squire L. Leikin D. Somppi J. MacRae *Ex-officio members:* J. Bezzubetz, President & CEO R. Bhatla, Chief of Staff/Psychiatrist in Chie E. Millar, Chief Nursing Executive T. Lau, President Medical Staff S. McLean, Past Chair *(by phone for Brockville Re-development item only)*	A. Graham L. Gillen J. Charette	C. Crocker M. Bellman K. Monaghan F. Dzierszinski S. Gulati P. Sedge J. Lambley S. Farrell C. Little	J. Dagher	L. Colas, President, Volunteer Association *(by phone)* S. West, Chair, IMHR Board *(by phone)* G. O'Hara, Chair, Client Advisory Council M. Langlois, Chair, Family Advisory Council R. Pow, Mini-Series presenter A. O'Brien, Mini-Series presenter T. Beaudoin, Presenter A. Milne, Client presenting J. Nyman, University of Ottawa representative **REGRETS:** P. Smith, President & CEO, Centre of Excellence G. Cudney, Chair, Foundation Board
				SCRIBE
				P. Robb

#	ITEM	REFERENCE	ACTION ITEMS
1.	**CALL TO ORDER**	I. Levy, Acting Chair, called the meeting to order at 5:30 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. Welcome remarks were then provided and special guests acknowledged. A. Milne, a client representative, was introduced and then presented about her mental health journey. She also displayed many of the photographs she had taken through a PowerPoint presentation, which was appreciated by Trustees. Discussion and questions followed the presentation. The Chair noted how impressed he was with the optimism shown by A. Milne in her inspiring story. P. Sedge volunteered to be the meeting timekeeper and J. MacRae was thanked for acting as the Ethics monitor for the meeting with a request that he report on the quality of decision making at the end of the meeting. A copy of the Royal's Ethics Framework for Decision Making was included in	

		the meeting package. Also enclosed was the Conflict of Interest Policy and the Policy on Public, Non-Public and Restricted Meetings.	
2.	**AGENDA AND MINUTES**	**a. Acceptance of Agenda – February 20, 2020**	
		Moved by N. Bhargava and seconded by S. Squire **BE IT RESOLVED THAT** the February 20, 2020 agenda be accepted, as presented. **CARRIED**	
		b. Approval of Minutes – December 12, 2019	
		Moved by D. Somppi and seconded by C. Coulter **BE IT RESOLVED THAT** the minutes of the December 12, 2019 Board meeting be approved, as presented. **CARRIED**	
3.	**REPORTS AND UPDATES**	**a. Chair and President & CEO's Oral Report**	
		I. Levy reported on behalf of A. Graham, who sent her regrets to the meeting. She has been meeting with potential candidates to fill the current Board vacancy. She has also been attending all the Committee meetings. Next, J. Bezzubetz made her report and noted that 'A hospital without walls' has been resonating within and outside of our community. Senior management, directors and front-line staff are proud of work and are glad to see it taking traction. She recently attended the Client and Family Advisory Council meeting and was pleased with the engagement of family and client members. She noted that to be more client and family centered requires a culture change and a culture change is about attitude in the words we use and in our interactions. Our attitude makes a big difference. She is excited that we have acknowledged we have work to do and are moving the agenda forward. She thanked G. O'Hara and M. Langlois for their continued support. The amending agreements for the M-SAA and H-SAA are included in the meeting package and require a motion. C. Crocker will speak more about that under the Finance Committee report later in the agenda. At the last meeting, the Board heard a presentation from S. Farrell and F. Dzierszinski on a basket of services. Tonight, we will hear from M. Bellman on important milestones coming up in the Foundation Campaign. A more fulsome report will be provided at the March meeting. J. Bezzubetz was thanked for her report.	
		b. Volunteers at The Royal Annual Report – L. Colas	

		L. Colas, President of The Royal Volunteers Association, joined the meeting by telephone to give an annual report to the Board. She provided an overview of how the year has been going as well as upcoming activities and events. The Volunteer Association is made up of dedicated volunteers and its main priority is fundraising. There are currently 10 board members, including three new board members. One of the new board members is solely dedicated to fundraising. There are plans for discussion with the Foundation in the coming months. The Volunteer Association launched a call for allocation requests in the fall and received over $215,000 in allocation requests. A different approach will be used next year with more flexibility in how to spend allocation dollars based on a needs assessment. There is continued support for the Bursary Program. A call has been launched and applications are being received. It is a rewarding event because it supports further education for staff, clients, and volunteers. Thanks in large part to the support of the Communications team, the Christmas tree sales were a success. The catering business also continues to be very successful. The Foundation was thanked for allowing the Volunteer Association to be part of the silent auction this year. The Chair expressed gratitude for the time the volunteers put in and for their fundraising efforts. L. Colas was asked to share with her colleagues thanks from the Board and senior management. The work of the volunteers is seen as very valuable. A copy of the presentation was included in the meeting package.	
		c. IMHR Report – F. Dzierszinski	
		F. Dzierszinski reported on new initiatives that have been developed in support of the translation of research into care (TRIC) portfolio and access to novel treatment or diagnostic approaches through research for client and families. - A call for innovative proposals has been launched (TRIC). Deadline for registration is March 2 and full applications are due March 30. Winners will be announced during research week. - As of today, will be sharing the list of research studies approved by the REB. This will be disseminated monthly to clinicians and others who will be able to refer clients to active research studies directly. - The Permission to Contact registry is also being launched; this is a collaboration with Central Intake, IT and the office of the Chief Privacy Officer - Consultations have started to better understand the types of program evaluations being carried out at The Royal - Report of activities between IMHR and the Centre of Excellence in PTSD - to find synergies between the organizations. That includes discussion around the DND-funded ($1M contract) multi-dimensional study of PTSD to better detect and diagnose the dissociative subtype - Next Monday, Feb. 24, 2020 J. Bezzubetz will be attending a luncheon with parliamentarians, organized by HealthCareCAN. There will be discussions with Dr. Mona	

		Nemer, Canada's Chief Science Advisor, and with Dr. Kim McGrail, Scientific Director, SPOR Canadian Data Platform - Vision statement: The vision of the Strategy for Patient-Oriented Research (SPOR) is that Canada will demonstrably improve health outcomes and enhance the health care experience for patients through the integration of evidence at all levels of the health care system | CIHR Request for Proposals for SPOR National Data Platform, 2017 F. Dzierszinski was thanked for her report and the floor was opened for questions. She was congratulated on a CIHR SPOR grant received on framework for caregivers engagement.	
		d. Strategic Plan Update – J. Lambley	
		The purpose of the presentation was to provide an update on the Strategic Planning process. A copy of the presentation was included in the meeting package. It was noted that once we move forward with the consultant, more will happen. There were 12 responses to the request for proposal and three vendors were shortlisted. After the final interviews, there was consensus on a choice. The interview committee was impressed with the approach of the consultant, their experience and background. They can also start the work right away. They will work with the Senior Management Team to define some key questions. A March kick-off meeting is scheduled with the consultant. There will be a draft plan in June and a more fulsome plan to finalize and approve the plan by September (only after the process will these be developed). We will be requesting a first meeting with consultants for next week with any executives who are available. The role of the consultant will be to come in and take a lead role from a consulting point of view. They will take the information already developed and can incorporate it quite easily. Meetings will be set up with external partners and with the three boards. The Joint Liaison Committee may become redundant once the consultant begins. We will wait to hear from board members if they feel engaged enough. J. Bezzubetz noted that one of the challenges of the Strategic Plan is that there needs to be attention paid to internal change and there needs to be some strategic thinking about direction, future staffing and how to promote and foster innovation. Some internal work still needs to be done to become one Royal. It is also about relationships with the community and donors. It is a big change management exercise and we are trying to pay attention to all of it. Discussion ensued. There was excitement about what is coming forward. A concern was raised whether there was enough time between finalization of the plan and development of the next 2022 budget so we can start operationalizing this. This will need to be taken into consideration. J. Lambley was thanked for his presentation.	
		e. Update on Foundation Campaign - M. Bellman	

		At the last meeting a basket of items in research and clinical care was presented by S. Farrell and F. Dzierszinski. Next, a presentation will be made by the Foundation in March and April to put into context what the campaign might look like. At that time, endorsement will be sought from the three Boards. When the document is approved, it will be considered the Foundation's marching orders. A professional case writer will be engaged and it will need to be tested with donors. If there is ambivalence about the proposed campaign, it will need to come back to the Board with some modifications. It is important that it aligns with strategic priorities because donors will be the first to identify if we are not aligned. There will be an opportunity for a fulsome discussion at the next meeting. A question was raised about the timing of the launch of the quiet phase. The timeline and an overall understanding on how it is being developed will be included in the presentation at the March meeting, but once the three Boards approve and there is alignment, it looks like a June timeline from the quiet phase. There was also a comment about whether $35 million is enough and this will be covered in the March report to the Board. The issue of access and whether The Royal is accessible was also raised. The Campaign will promote access to clinical care and research and it will be framed in that context. The hook of improved access will be in the campaign and will be included in the presentation in March. Our vision is to deal with people more efficiently by moving services to the community and with partnerships with the community. The Inspiration Awards Gala is on March 6, 2020 and is almost sold out, but individual tickets are still available. The silent auction will be going live next week. R. Anderson reminded Trustees about the breakfast in October. There is a call for Committee members. It would be encouraging to see enthusiastic participation from all Boards to help identify people as table captains, or to be one. This is a major public relations and fundraising effort to support the organization. If anyone is interested, they are to contact R. Anderson.	M. Bellman
		f. Presentation on what a Research Ethics Board (REB) is and how it works – T. Beaudoin	
		This is a follow up item from the last meeting. A copy of the presentation was included in the meeting package. The REB is responsible for looking at research and the ethics around that. Members have a variety of backgrounds. The REB operates autonomously though an appeals process is in place should investigators wish to appeal a decision made by the REB. All research studies involving human participants are reviewed by the REB, regardless of whether the research has been funded. Quality improvement and program evaluation initiatives are reviewed by the REB office to ensure they are not veering into research. All of the REB activity is governed my multiple regulations. T. Beaudoin was thanked for her presentation and a brief discussion followed. A question was asked whether we are compliant. It was noted	

		that we are now, but were not compliant before. Some strict controls have been put in place to ensure people are following regulations. REB Board qualifications also have guidelines such as having a lawyer, youth and community members as part of the membership. A good background of expertise is needed. It is a volunteer board, but the Chair should be compensated. The REB Terms of Reference were included in the board package and is for approval under the Governance Committee Report.	
		g. Brockville Re-development Committee Update –S. McLean	
		S. McLean joined the meeting by phone for this item. J. Bezzubetz provided the report. There was a meeting with Minister Clark last Friday to again reinvigorate his interest in the concept of the redevelopment of the forensic treatment unit in Brockville and to hear from him in assisting our advocacy. A small group from The Royal attended and were able to impress on the Minister the Board's concerns about safety issues. They also spent time talking to him about risks. The report back was that the government is interested in continuing redevelopment of these facilities across Ontario and although we are a priority, we are not the only one. Nothing conclusive was decided from the meeting, but we were invited to provide a concept of what we envision and which will be submitted tomorrow in a letter format back to the Minister. S. McLean stressed that this is still in an exploratory stage. The clear impression was that we have to stay in the game. We were there to renew an expression of interest with the Minister. The next modest step is continuing to stay close to the Minister. There was a brief discussion and a comment that the approach may be too singular in focus on the local Minister and we might want to do outreach to relevant ministries such as Health/Corrections/the new Ontario Board and possibly to our own local MP as well. *S. McLean departed the meeting following the report.*	
4.	**DECISION/ INFORMATION ITEMS**	**a. Quality Committee Report – L. Leikin**	
		The minutes from the February 4, 2020 meeting were included in the meeting package. L. Leikin reported, and reminded the Board, that there is a new method of reporting in the patient safety report using control charts. These are based on statistical levels of tolerance that have been set. All indicators have been tracked nicely and there is no real concern or anything out of the ordinary. The Committee was not clear, however, whether the way of monitoring patient safety is meaningful to the program or the hospital. We want to get to a point to compare our data with other norms that might be available to know if it is normative.	

		Next, he reported on the Quality Improvement Plan, which is mandated by the Ministry and in the past has not been particularly well aligned with the strategic plan or of great meaning to patients, clients, families and staff. The Committee took a more rigourous approach and there is now a process of consultation with clients, families and staff to ensure that indicators are meaningful. The indicators have been narrowed down to six, with one of those mandated by the province, and the other five out of discussion, which staff, client, families, community and the Board believed to be good indicators for a culture of change and excellent care. Want to ensure there is a good transition plan in place, that programs monitor their outcomes and patients have access to research. Given the aging population at the Royal Ottawa Place, they are making sure staff are well trained in palliative issues.	
		i. Integrated Risk Management Framework (IRMF)	
		The IRMF is owned by the Quality and Finance Committees. Items come on and off it through the Senior Management Team and are reviewed by each of these Committees and levels of risk are established based on feedback. At their January meeting, the Finance Committee deferred this item so there is no input from them. As a result of discussion at the last Quality Committee meeting, the risk level was raised for suicide because of the impact. Also, R. Bhatla will be presenting to the Committee on suicide in June. It is a controversial topic, but there is a lot of good literature on what to do and not to do. Moved by L. Leikin and seconded by J. MacRae **BE IT RESOLVED THAT** as recommended by the Quality Committee, the *Integrated Risk Management Framework* be approved, as amended to change the language in Appendix 3: Action Plans to 'actions in place', rather than 'controls in place'. **CARRIED**	J. Lambley
		ii. Corporate Patient Safety Report	
		A copy of the Corporate Patient Safety Report was included in the meeting package for the information of the Board.	
		b. Medical Advisory Committee Report (MAC)	
		The minutes from the November 21 and December 19, 2019 meeting were included in the meeting package. R. Bhatla reported as follows: - The regional challenge has been access to beds - There was a good discussion at a recent MAC meeting regarding client portals. We have to pay more attention to how we make sure we are connecting well with primary care family doctors and Nurse Practitioners. Confidentiality can be an issue however, but the greater risk is not communicating. Looking to have more of a default to circle of care that may include families and what we can do to modernize the way we communicate.	

		- The first new hospital quality committee was held today. Flow and accreditation are on the radar. This committee will report up to MAC and to the Senior Management Team There was discussion following the report. It was suggested that in our messaging, we should communicate how our psychiatrists are involved in emergency room coverage at other hospitals. The issue of circle of care and privacy and how that shortage of information is difficult to have proper care was also raised.	
		i. Medical Staff Privileges	
		Moved by I. Levy and seconded by L. Leikin **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**	
		c. Finance Committee Report – J. Gallant	
		The minutes from the January 30, 2020 meeting were included in the meeting package. The majority of the Finance Committee meeting was spent reviewing the budget for 2020-2021. C. Crocker and the management team were thanked for putting together the comprehensive materials. As of the date of the meeting, we have not heard from the LHIN on any funding increase so the default is to assume we are not getting an increase. The budget presented in the meeting package assumes 0% funding increase. There are no changes to Programs and no reallocation of resources. This will be addressed as part of the strategic planning. The Assumptions/Risks are mostly low, except for one that was set at medium. It is a balanced budget. The capital budget looked reasonable to the Committee and the ongoing work that needs to be done to keep our budget balanced was recognized. The Committee is also keeping an eye on the sustainability of the PET/MRI. January statements were run today and with everything we are seeing, we will end with a million dollar surplus which is necessary to balance. We are in good shape for March 2020, but the big challenge is funding. To be safe, the budget was calculated using 0%, but if we get 1%, it will support us this year and next. The HFS money will also be used to balance the budget for 2020/21. The worry/ask was to try and grapple in some reasonable way for the Board (Finance Committee/management or both) in giving us a sense of what the discretionary leeway might be that we can put to the strategy. This will be helpful when we discuss what we want to prioritize. The	

		Finance Committee has started talking about the issues that need to be considered. There is a schedule in the budget where the income statement/statement of operations for the organization is shown. When looking at percentages, outside of wages, there is very little flex in the organization. The flex will be as we have vacancies can we hold them and can we transition to new roles. J. Gallant was thanked for her detailed report.	
		i. Integrated Risk Management Framework	
		This item was deferred at the last Finance Committee meeting.	
		ii. Capital and Operating Budgets	
		Moved by J. Gallant and seconded by J. MacRae **BE IT RESOLVED THAT** as recommended by the Finance Committee, the 2020-2021 Capital and Operating Budget be approved, as presented. **CARRIED**	
		a. IMHR Budget	
		IMHR's budget is covered by global funding. Overall expenses were reduced and we are working toward alleviation to cost of IMHR. The Board needs to approve the legal entity budget. Moved by J. Gallant and seconded by J. MacRae **BE IT RESOLVED THAT** as recommended by the Finance Committee, the IMHR Non-Research Activity Budget for 2020-2021 be approved, as presented. **CARRIED**	
		iii. H-SAA and M-SAA Amending Agreements – C. Crocker	
		C. Crocker reported on this item as it did not go to the Finance Committee as it was sent by the LHIN after the meeting. The LHIN is extending these agreements for three months and then Ontario Health will take over and presumably send us renewed agreements. There is no change in funding or accountabilities. The only change is a three-month extension to allow Ontario Health to get their systems running. A copy of the M-SAA and H-SAA Amending Agreements were included in the meeting package. Moved by J. Gallant and seconded by D. Somppi **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.	

		***BE IT ALSO RESOLVED** THAT the Board of Trustees authorizes the Board Chair and President & CEO to sign the L-SAA amending agreement to extend the current agreements for an additional three months to June 30, 2020. **CARRIED** **A subsequent electronic vote was taken regarding the L-SAA agreement received following this meeting and is reflected in the updated motion above.*	
		iv. EHR Update	
		J. Bezzubetz advised that there was a discussion at MAC about the EHR. This is currently reported to the Finance Committee because of the investment, but it is also a clinical matter. She wondered if it should be part of the Quality Committee so transformation can be supported by the Committee. It could also come through MAC because it is a joint accountability at this point in time. After discussion, it was decided that this matter should be left with R. Bhatla and L. Leikin to consider how this should be reported in the future.	R. Bhatla L. Leikin
		v. PET/MRI Update	
		A memo was received from management about the continued effort to look for funding to make the PET/MRI more sustainable. The most promising proposal to date is entering into a relationship with The Ottawa Hospital (TOH) regarding WSIB. This would require a clinical license. TOH resources would be needed to do the reading. They know the system and are willing to support us. They are positive it can happen, but are checking to see if the machine can be used for clinical purposes. The MRI would then be able to be used in partnership with TOH. It would also open up other opportunities for The Royal once we have the clinical license.	
		d. Audit Committee Report – J. Gallant	
		The minutes from January 30, 2020 were included in the meeting package.	
		i. Statutory Obligations Letter	
		The Statutory Obligations Letters was included in the meeting package. This letter was received as representation from management that it is compliant with legislation for the hospital.	
		ii. Annual Audit Plan	
		The Annual Audit Plan was included in the meeting package. There were some small changes: KPMG is going to pay particular attention to unusual transactions i.e. HFS and disposition of investment as part of the transfer of the portfolio to CIBC/Fripp. These things require more attention because they are out of the norm. There will be an extra $5,000 (maximum) in fees.	

		The appendix to the plan to assess the quality of the audit is going to be a good tool for the Committee while working with management and receiving quality services from auditor. Moved by J. Gallant and seconded by S. Squire **BE IT RESOLVED THAT** as recommended by the Audit Committee, the Annual Audit Plan be approved, as presented. **CARRIED**	
		e. Governance Committee Report – C. Coulter	
		The minutes from the January 23, 2020 meeting were included in the meeting package. Some items from the Governance Committee meeting will be dealt with in the Restricted Session to allow for open discussion. C. Coulter participated in the three-Board Governance Chairs' meeting in January. They will be meeting once a year and the purpose is to look at recruitment for the three Boards. As an update to the ROHCG Board vacancy, five candidates have been interviewed to date. One more candidate remains to be interviewed and then a decision will be made at the June Board meeting to fill the vacancy on the Board. The Committee is also reviewing the skills matrix, which will come back to the Board at a future date. On the Membership Terms, there was discussion about appointing new Trustees for a one-year term for their first term as a probationary period. This will be added as a by-law revision and will require the Board's approval.	
		i. Research Ethics Board (REB) Terms of Reference	
		The Terms of Reference for the Research Ethics Board were revised extensively. A copy of a marked-up version was included in the meeting package. The changes were made looking at best practices with other REBs, hospitals and institutions. In summary, among other things, an appeals process was added, there was more specification added for members and the Chair of the REB and the Board terms were clarified. Discussion ensued. It was noted that the REB reports to The Royal's Board and the Chair is appointed on the recommendation of senior management to the Governance Committee and then it goes to the Board for final approval. After discussion, the Board had a number of questions such as: - By which mechanism should this come to the Board (i.e. MAC or	

		Governance Committee)? - Should there be regular REB Updates at Board meetings to ensure regular reporting? - Questions about the terms of REB members and REB Board Chair It was agreed that the motion would be moved as presented, but that it should go back to the Governance Committee for a further review of the Terms of Reference based on the Board's discussions. Moved by C. Coulter and seconded by L. Leikin BE IT RESOLVED THAT as recommended by the Governance Committee, the Research Ethics Board Terms of Reference be approved, as presented. **CARRIED**	Governance Committee
		ii. University of Ottawa ex-officio position on Board: Dr. Nyman	
		J. Nyman departed the meeting for the vote. C. Coulter provided a background on this item. A letter was sent to the University asking for a candidate and they recommended J. Nyman for the position. An interview process was held and she was seen as a good fit. There was discussion and the Governance Committee was asked to take a further look at how University appointments are made. In particular, whether there is a limit to the term served or is it until a new person is appointed by the University. It was noted that an *ex-officio* remains until a successor is appointed, but the Governance Committee will review further. Moved by D. Somppi and seconded by S. Squire **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 C. Coulter and seconded by D. Somppi **BE IT RESOLVED THAT** as recommended by the Governance Committee, that 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** *J. Nyman returned to the meeting following the vote.* J. Nyman was congratulated on her new role as a voting *ex-officio* member of the Board.	Governance Committee P. Robb
		iii. Past Chair Role	

		At the January Governance Committee meeting, there was discussion, and it was agreed, that the Past Chair would be non-voting at Board meetings so as not to encumber the current chair, but would remain voting at the Governance Committee for corporate knowledge and for an additional voting member. Moved by C. Coulter and seconded by S. Squire **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 role of Past Chair will have no vote at Board meetings, but will have a vote at the Governance Committee. **CARRIED**	P. Robb
		iv. Committee Terms of Reference	
		- Quality Committee	
		Moved by C. Coulter and seconded by J. MacRae **BE IT RESOLVED THAT** as recommended by the Governance Committee, the Quality Committee Terms of Reference be approved as presented. **CARRIED**	
		- Innovation Committee	
		Moved by C. Coulter and seconded by N. Bhargava **BE IT RESOLVED THAT** as recommended by the Governance Committee, the Innovation Committee Terms of Reference be approved as presented. **CARRIED**	
		v. Board Vacancy Update	
		An update on the Board vacancy was reported on earlier in the agenda. Following a final interview, a motion to approve a new member will be put forward at the June meeting. Discussion ensued and there was a request to consider the possibility of representation on the Board by a client and not just a Client Advisory Committee member. This will be taken to the next Governance Committee meeting for consideration.	Governance Committee
		vi. Board Chair Assessment	
		The Board Chair assessment will begin in April 2020. Trustees were strongly encouraged to participate.	All P. Robb
		vii. 2020 - 2021 Board and Committee Meeting Schedule	
		A proposed meeting schedule for 2020-2021 was included in the meeting package. Trustees were asked to look at the proposed schedule and if there were any conflicts or other concerns, to let P. Robb know so it can be finalized and confirmed in calendars.	All P. Robb
		f. Innovation Committee Report – N. Bhargava	

		The next Innovation Committee meeting will be held on March 3, 2020. The Committee appreciates the encouragement of the Board on the topic of innovation. The membership on this Committee now includes representation from all three Boards. N. Bhargava met with C. Crocker and J. Bezzubetz and they advised him that the Senior Management Team has developed an innovation council to help vet items on the governance side of the Committee. The hope is that as soon as the P/VP IMHR is in place, that individual will be able to chair the council. The ideation side of the meeting will include elements of the IMHR Review. There also is a Foundation idea in review – the Upside Foundation. At ideation, ideas are brainstormed and Trustees take off their Board hat. It anyone has ideas to present for the Ideation agenda, they should feel free to bring these forward.	
		g. Compensation & Succession Planning Report – I. Levy	
		A compensation item from the previous Compensation & Succession Planning Committee meeting will be dealt with in the In-Camera session.	
		h. Policy	
		There were no policies for review.	
5.	**CONSENT AGENDA**	**a. Approval of the Consent Agenda**	
		Moved by R. Anderson and seconded by J. MacRae **BE IT RESOLVED THAT** the Consent Agenda be approved, including any motions contained therein. **CARRIED** - President & CEO's Report - Research Ethics Board Report - The Royal Ottawa Foundation for Mental Health Report - Strategic Plan Performance Scorecard - Mental Health Addictions and Quality Initiative (Peer Comparators) - Centre of Excellence Report	
		There was a brief discussion on the Consent Agenda. The strategic plan and measurements seem to be deep in the Consent Agenda. After discussion, a question was put to the Committee Chairs about whether or not this is getting sufficient attention at Committee meetings.	
6.	**NEW BUSINESS** *(if any)*		
7.	**REPORT ON THE ETHICS FRAMEWORK FOR DECISION MAKING**	J. MacRae, 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 March 26, 2020.	
9.	**ADJOURNMENT**	Moved by N. Bhargava seconded by D. Somppi There being no further business, the meeting was adjourned at 9:07 p.m. **CARRIED**	
10.	**EXCLUDED SESSIONS**	**RESTRICTED** (Independent Board Members, CEO and PIC/COS)	
		IN CAMERA (Independent Board Members only)	
		See separate minutes.	

_____ _____

I. Levy
Acting Chair, Board of Trustees

J. Bezzubetz
Secretary, Board of Trustees

Board Meeting Action Items

Item	Individual Responsible	Status
February 20, 2020		
To send meeting requests for 2020-2021 Board and Committee meetings.	P. Robb	June 18, 2020
The Board Chair assessment to begin in April 2020.	P. Robb	Begin in April 2020
To update By-laws with new Quality and Innovation Committee Terms of Reference.	P. Robb	June 18, 2020
To make a presentation to put into context what the campaign might look like. At that time, endorsement will be sought from the three Boards.	M. Bellman	March 26, 2020
There was a request to consider the possibility of representation on the Board by a patient. This will be taken to the next Governance Committee meeting for consideration.	Governance Committee	COMPLETED March 10, 2020 Governance Committee meeting March 26, 2020
To make necessary admin changes to show Past Chair is non-voting member.	P. Robb	COMPLETED
To prepare welcome package for J. Nyman as new *ex-officio* voting member.	P. Robb	COMPLETED
The Governance Committee was asked to take a further look at how University appointments are made. In particular, whether there is a limit to the term served or is it until a new person is appointed by the University.	Governance Committee	COMPLETED March 10, 2020 Governance Committee meeting March 26, 2020
The REB Terms of Reference to go back to the Governance Committee for a further review based on the Board's discussions	Governance Committee	~~March 10, 2020~~ May 21, 2020 Governance Committee meeting June 18, 2020
To look at By-law review to change first year for new Board members to be a 1-year term as a probationary period.	C. Coulter	June 18, 2020
Skills Matrix Review	C. Coulter	May 21, 2020 Governance Committee meeting June 18, 2020
Governance Committee to recommend appointment of New Board member	C. Coulter	June 18, 2020
The matter of the EHR report to be left with R. Bhatla and L. Leikin to consider how this should be reported in the future (MAC/Quality Committee).	R. Bhatla L. Leikin	
To change the language in Appendix 3: Action Plans of the Integrated Risk Management Framework to 'actions in place', rather than 'controls in place'.	J. Lambley	COMPLETED
December 12, 2019		
Strategic Plan Update ***(Standing item)***	~~J. Lambley~~ J. Bezzubetz	ONGOING March 26, 2020
To schedule a future presentation on guidelines used for Foundation donors.	M. Bellman	COMPLETED March 26, 2020 See above

Item	Individual Responsible	Status
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	COMPLETED 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	COMPLETED C. Crocker reported 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 meeting
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 March 26, 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. Trustees requested that some key messages be drafted on what would be helpful for them to communicate to their circles.	P. Robb K. Monaghan	COMPLETED IN PROGRESS
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

Item	Individual Responsible	Status
		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 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 June 18, 2020

ROHCG Board Update

Raj Bhatla MD, FRCPC, DABPN
Psychiatrist-in-Chief & Chief of Staff, ROHCG
Associate Professor, University of Ottawa
Presentation to the Board of Trustees
March 26, 2020

The Le Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

Outline

- Quality
- Physician
  - HR
  - Culture
- Annual Performance Reviews/Plans
  - Front Line
  - Clinical Director

Quality and Patient Safety Team Accomplishments 2019-2020

Accreditation

- Led the organization through Accreditation. Received Accredited with Exemplary Status with a score of 99.9%

- Developed a continuous readiness model to ensure The Royal remains ready for Accreditation. (*Being reviewed for adopted by the Quality Committee in April 2020)*

Patient Safety

- Revamped the Corporate Patient Safety Report to include the use of control charts. Also, now providing monthly data to programs on their incidents.

- Proactively promoted a patient safety culture with the introduction of the High Five Awards for good hand hygiene compliance, and the Good Catch Award related to near miss incident reporting

Patient Safety Cont'd

- Implemented the Client Staff Incident and Feedback system, allowing for all client and staff incidents, complaints, and compliments to all be logged through one system

- Increased inpatient flu vaccine rates compared to the last two years

- Provided ongoing Covid-19 and outbreak support to the organization

Quality Structure

- Created an organization wide Quality Committee to review quality for the entire organization

- Revised protocols and function of the Incident Review Committee

- Created program level quality improvement teams in each program (formerly had been our Accreditation preparation teams)

- Drafted a quality framework which will be reviewed by the Quality Committee in April 2020

Physicians – who are we?

- Undergraduate degree
- Medical school - 4 years
- Residency - 4 years
- Fellowships/sub-specialization

- At The Royal:

PHYSICIAN STATISTICS

Primary Physicians - Full-time, Primary Part-time, Probationary – 87

- 39 Female (45%)
- 48 Male (55%)

PHYSICIAN STATISTICS

Non-Forensics Primary Physicians – 65

- 32 Female (49%)
- 33 Male (51%)

PHYSICIAN STATISTICS

2019-2020

Physicians who **left** The Royal: 8

- 3 retirements
- 5 change in career path

Physicians who **joined** The Royal: 9

- 3 in Mood and Anxiety
- 1 in Community
- 1 in OSI
- 2 in Geriatrics
- 1 in Schizophrenia
- 1 in Youth

PHYSICIAN LANGUAGE

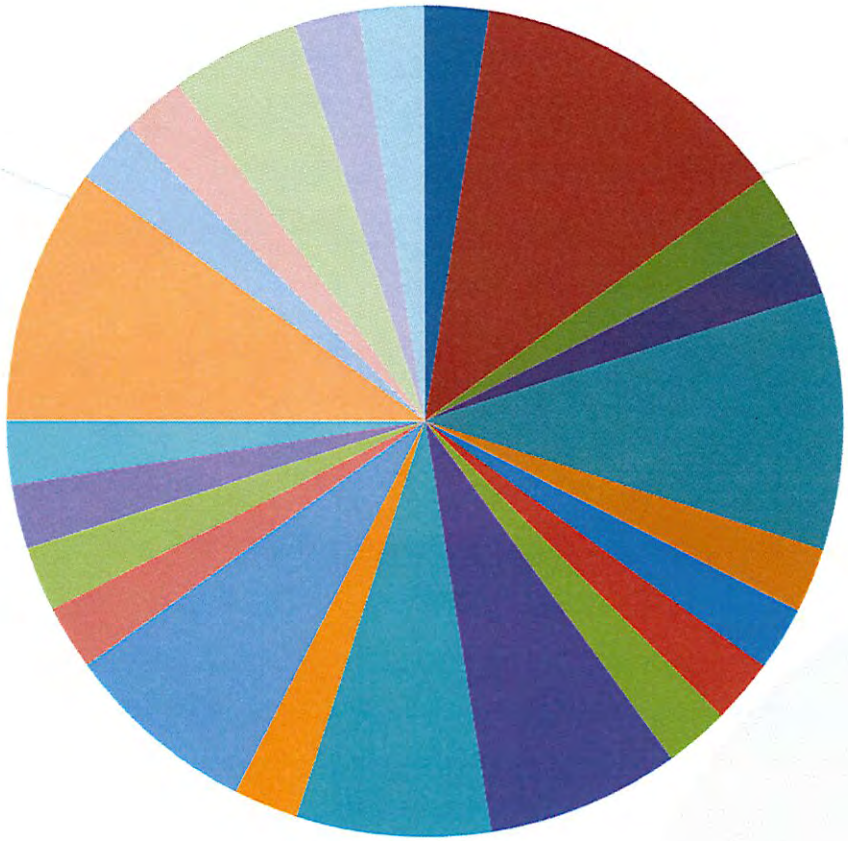
34 Physicians are bilingual

- English & French
- (40% of Primary Physicians)

PHYSICIANS:
OTHER LANGUAGES SPOKEN

2 Czechoslovakian
4 Russian
1 Bulgarian
1 Serbian
8 Spanish
1 Italian
1 Arabic
2 Farsi
1 Croatian
1 Telugu
2 Tamil
1 Sinhalese
1 Estonian
3 Polish
1 Malayalam
2 German
1 Dutch
4 Punjabi
3 Urdu
1 Creole
5 Hindi
1 Hebrew
1 Filipino

PHYSICIANS:
OTHER LANGUAGES SPOKEN



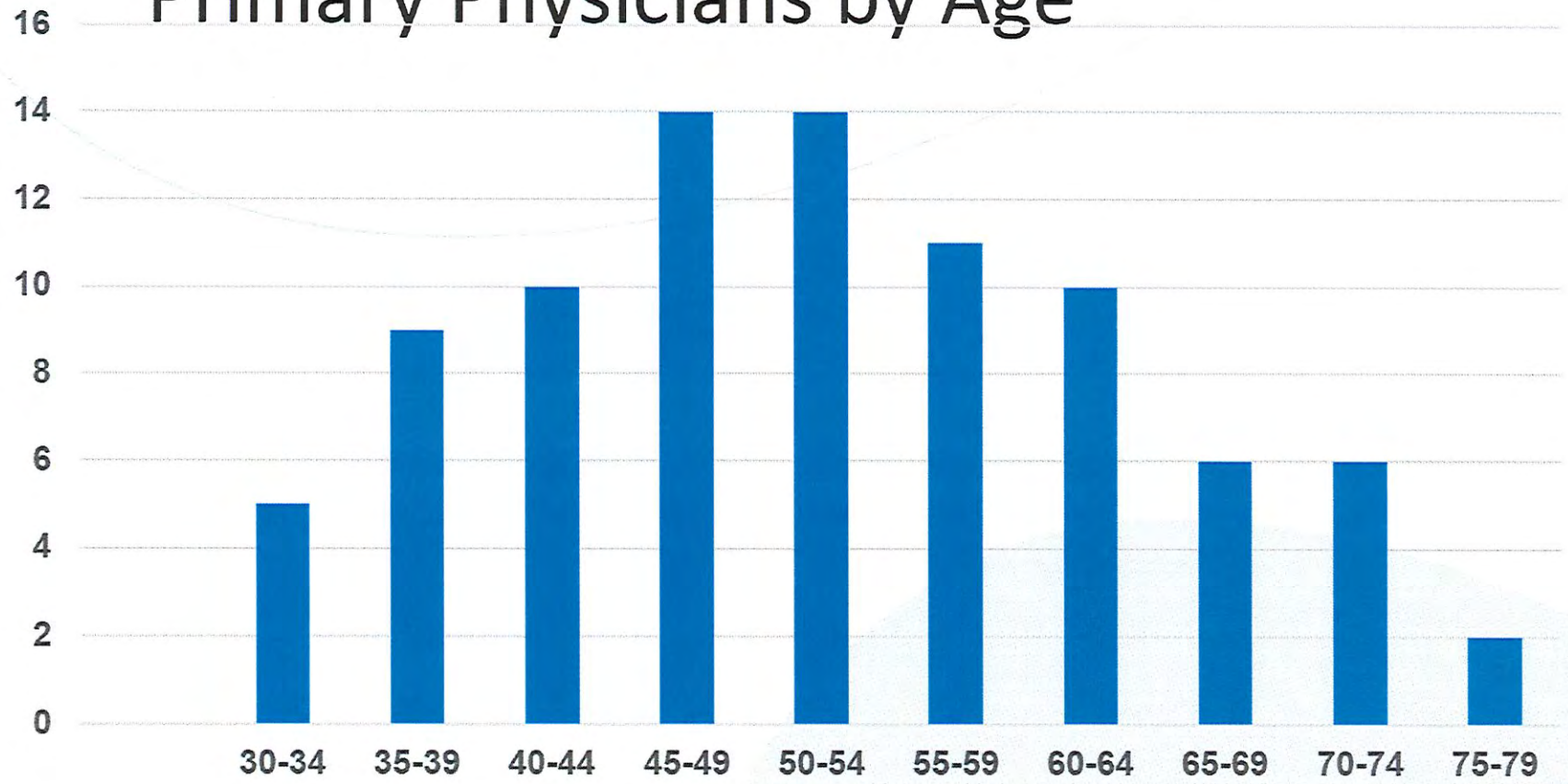
- Czech
- Russian
- Bulgarian
- Serbian
- Spanish
- Italian
- Arabic
- Farsi
- Filipino
- Hindi
- Urdu
- Dutch
- Punjabi
- Creole
- Hebrew
- German
- Malayalam
- Polish
- Estonian
- Sinhalese
- Tamil
- Telugu
- Croatian

PHYSICIAN AGE BY PROGRAM

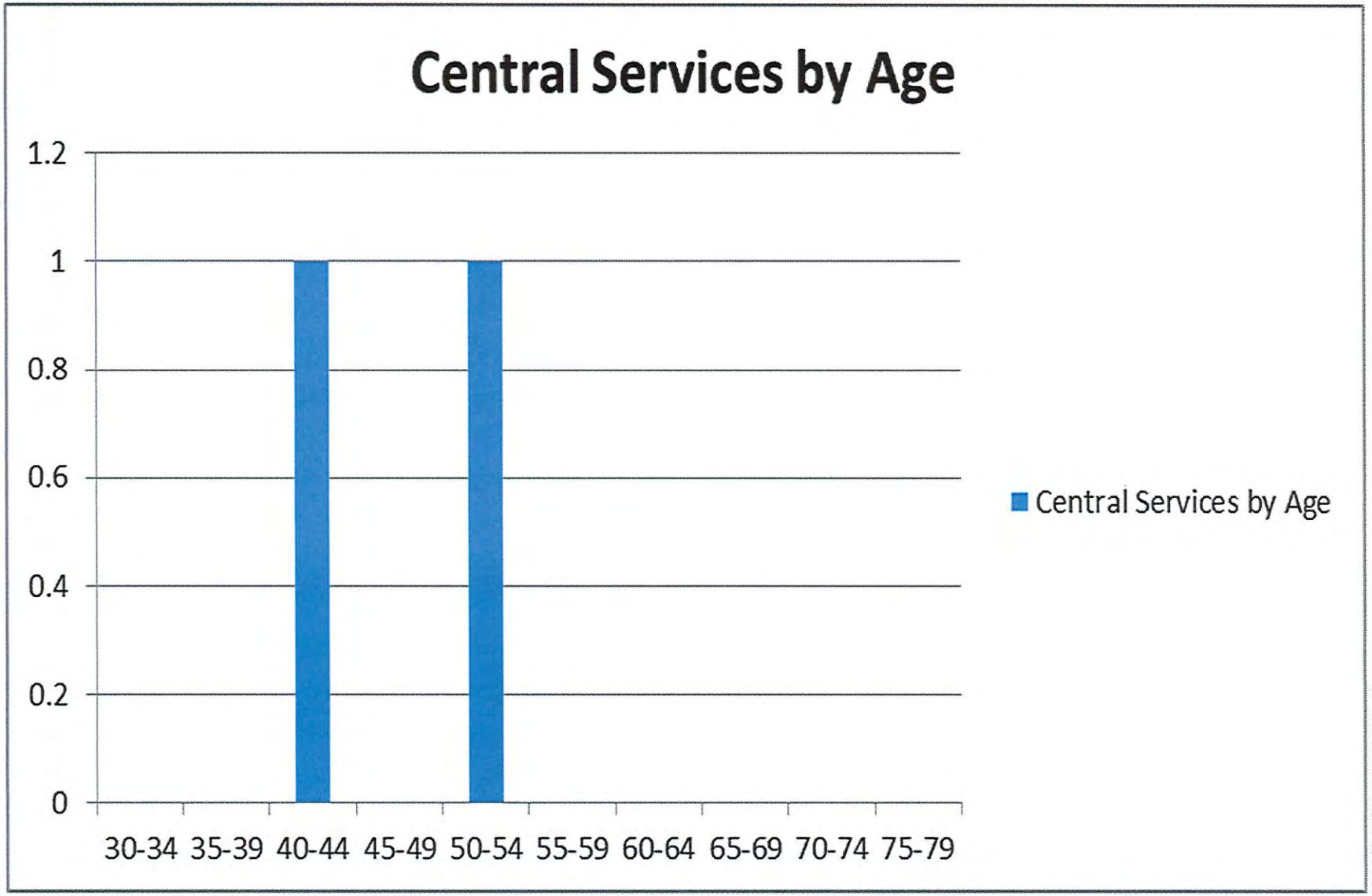
Age	Central Services	CMHP	Geriatrics	Forensics	MAP (& Sleep)	SUCD	OSI	Schizophrenia	Youth	Total
30-34						2	2	1		5
35-39			2	3	2	1			1	9
40-44	1		4	2		2		1		10
45-49		2	2	5	2			3		14
50-54	1	2	2	5			1	1	2	14
55-59		2	3	4			2			11
60-64		1	1	2	3			1	2	10
65-69			1	1	2			1	1	6
70-74		1		2	1	1		1		6
75-79				1	1					2
Total	2	8	15	25	11	6	5	9	6	87

The Le Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

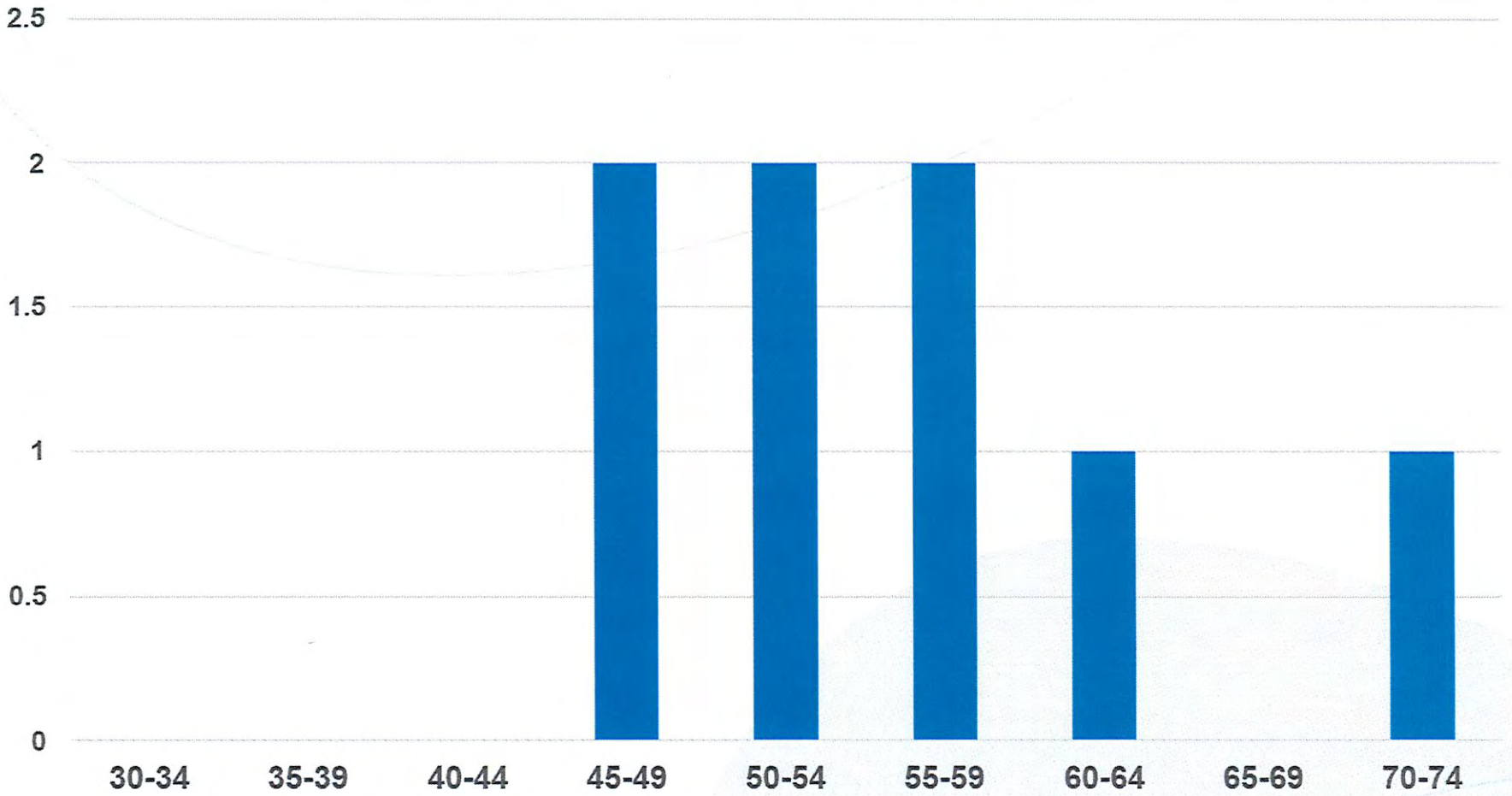
Primary Physicians by Age



The Le Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche


Central Services by Age
1.2
1
0.8
0.6
0.4
0.2
0
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75-79
Central Services by Age

Community by Age



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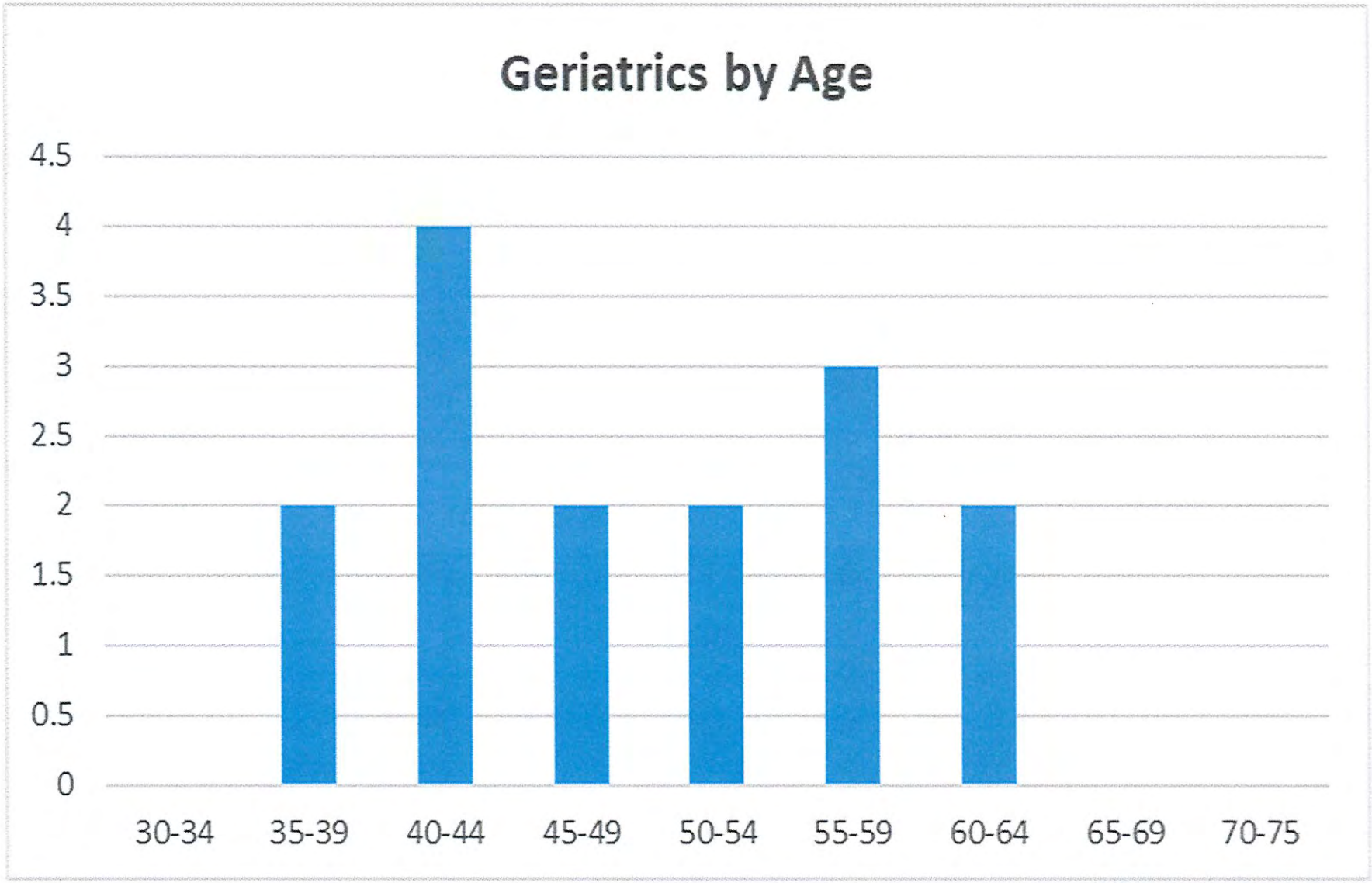
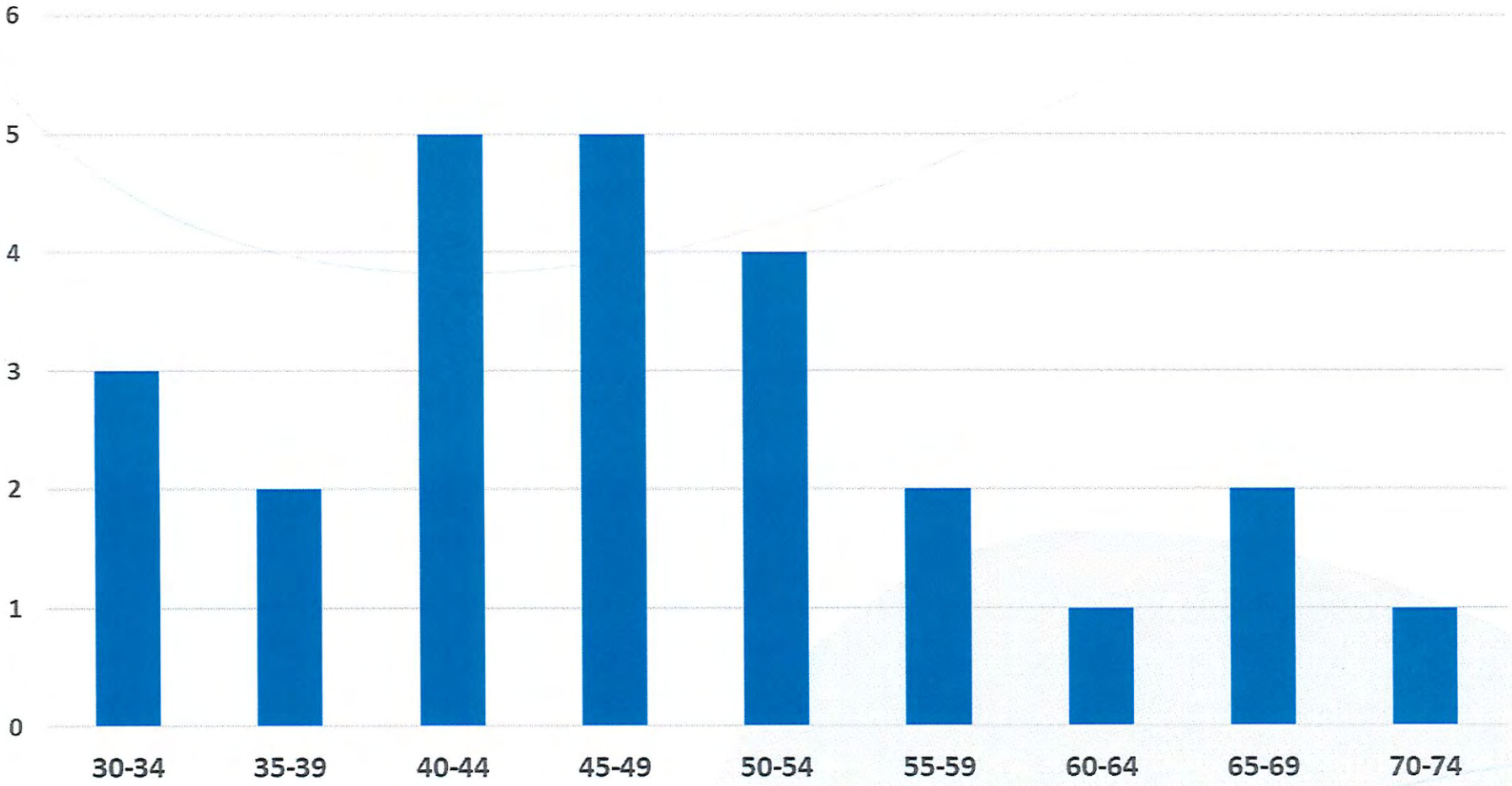
Santé mentale - Soins et recherche


Geriatrics by Age
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-75

Forensics by Age



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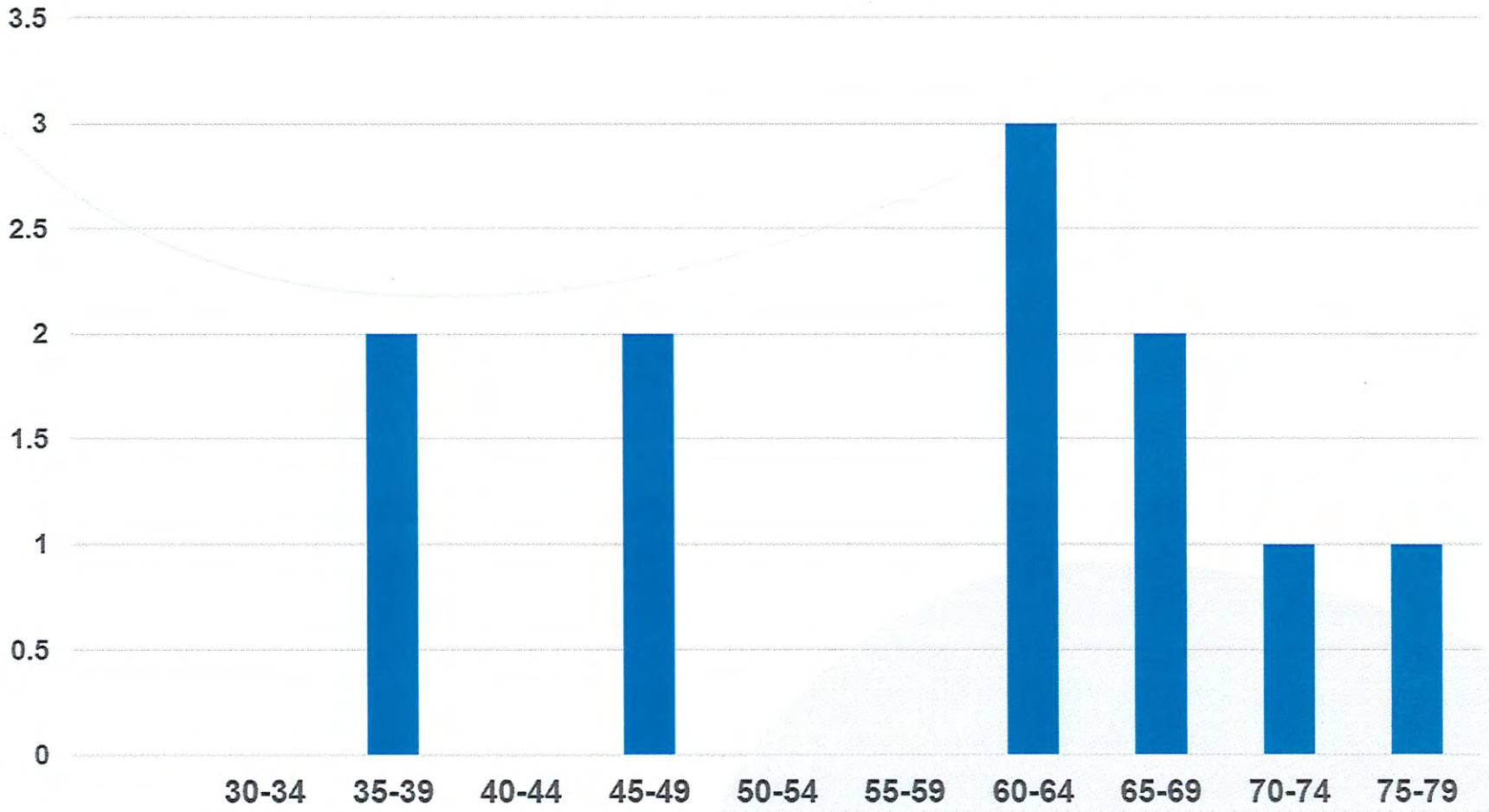
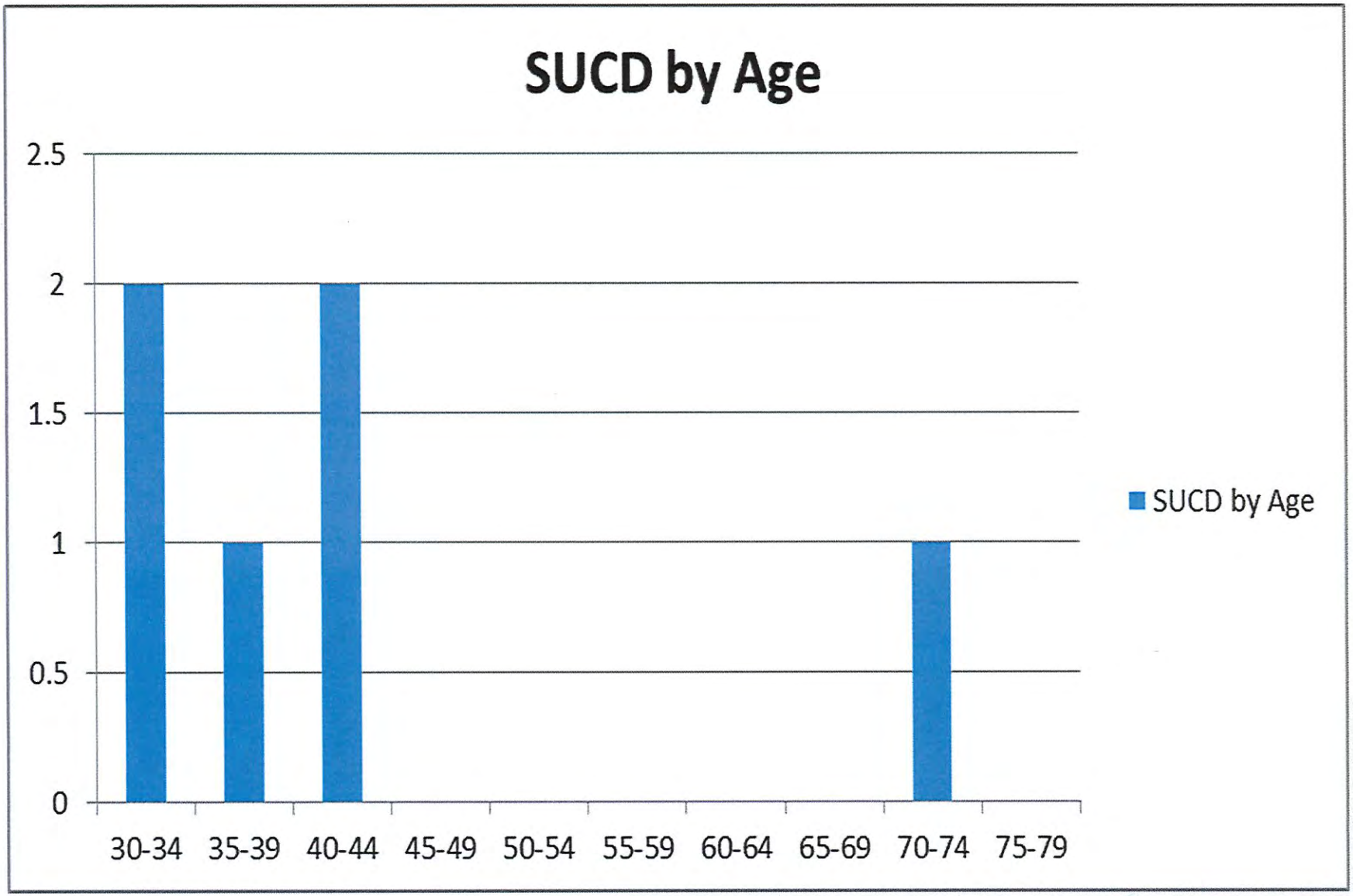
Mental Health - Care & Research
Santé mentale - Soins et recherche

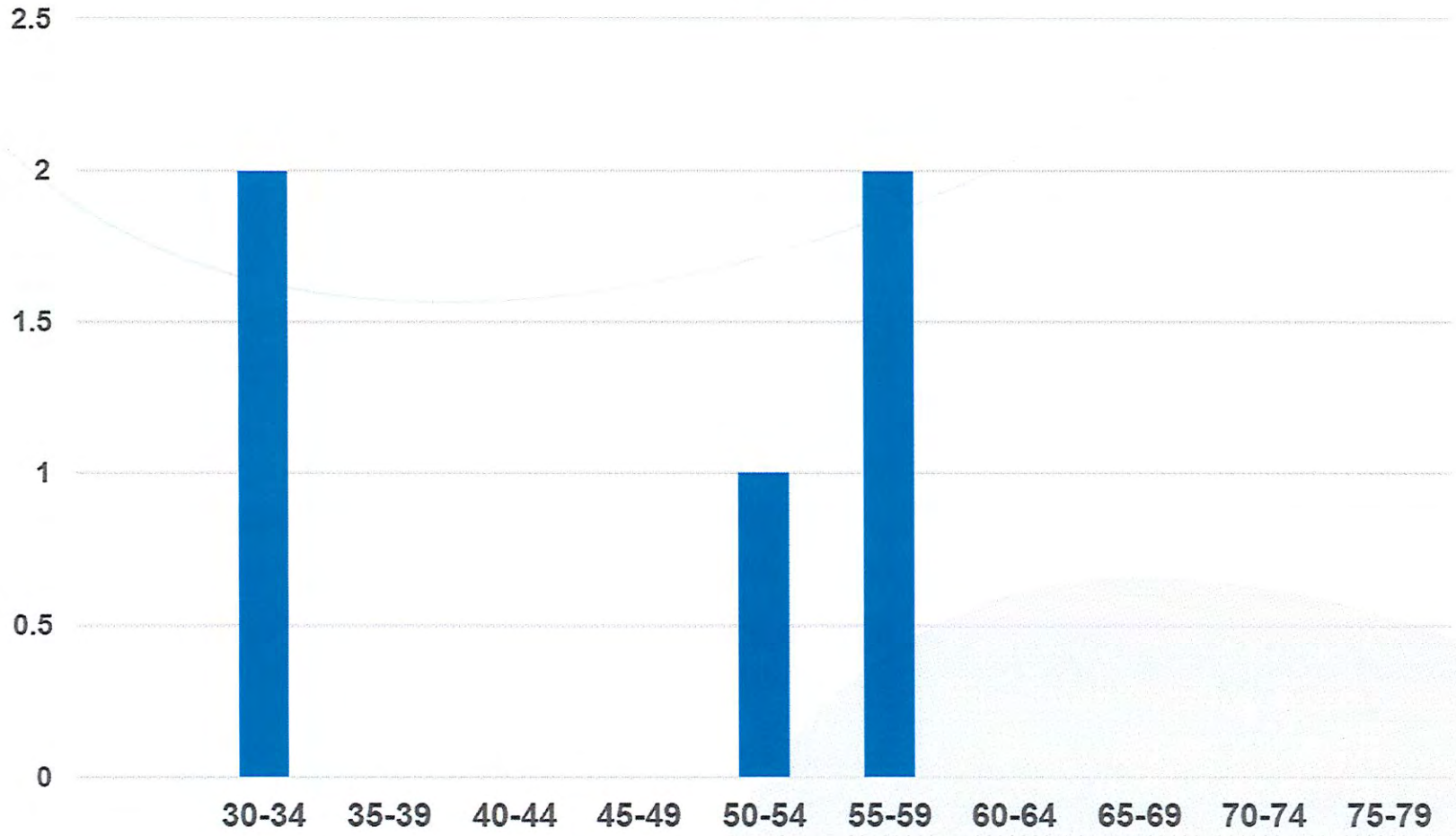
Mood (& Sleep) by Age



The Le Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche


SUCD by Age
2.5
2
1.5
1
0.5
0
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75-79
SUCD by Age

OSI by Age



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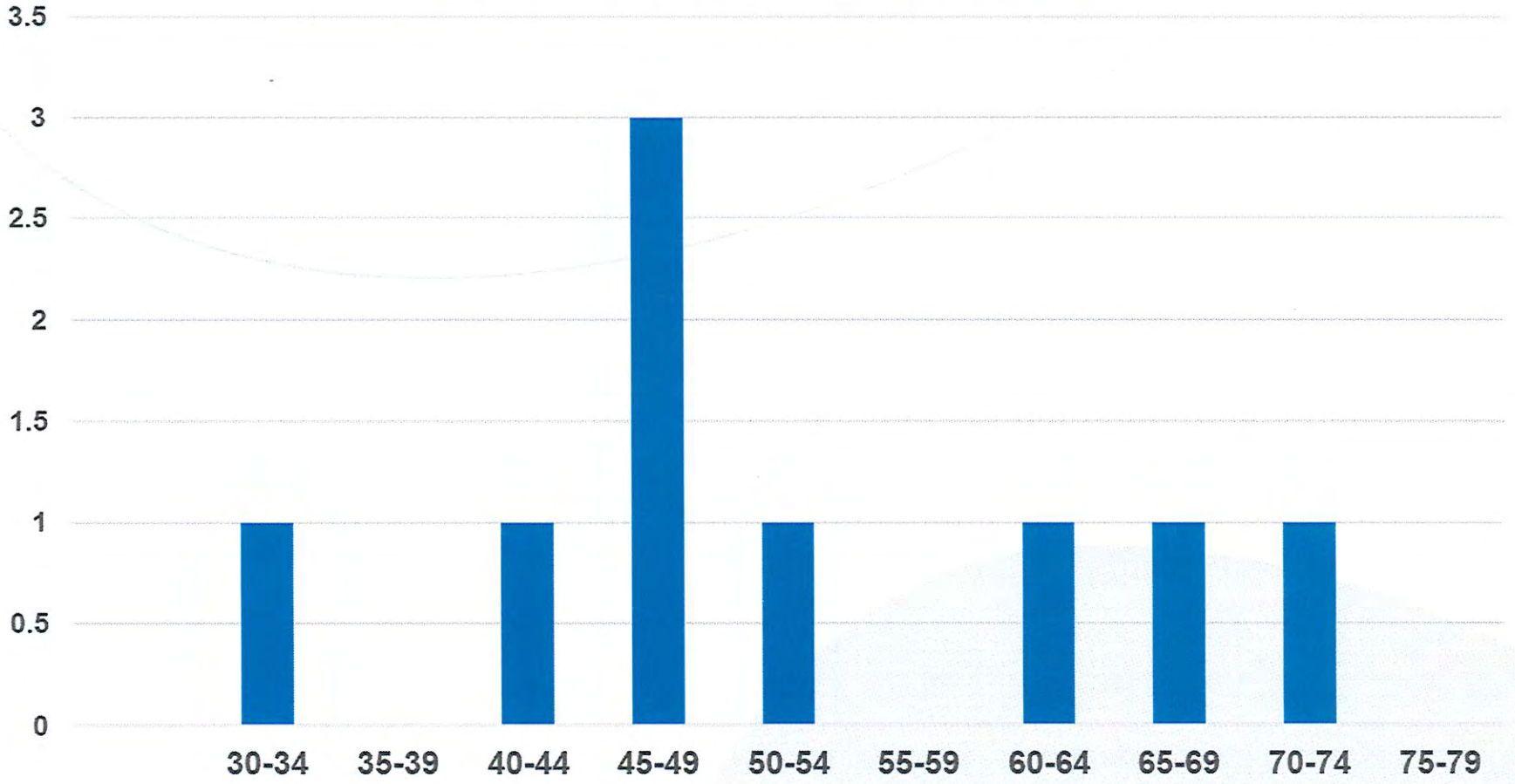
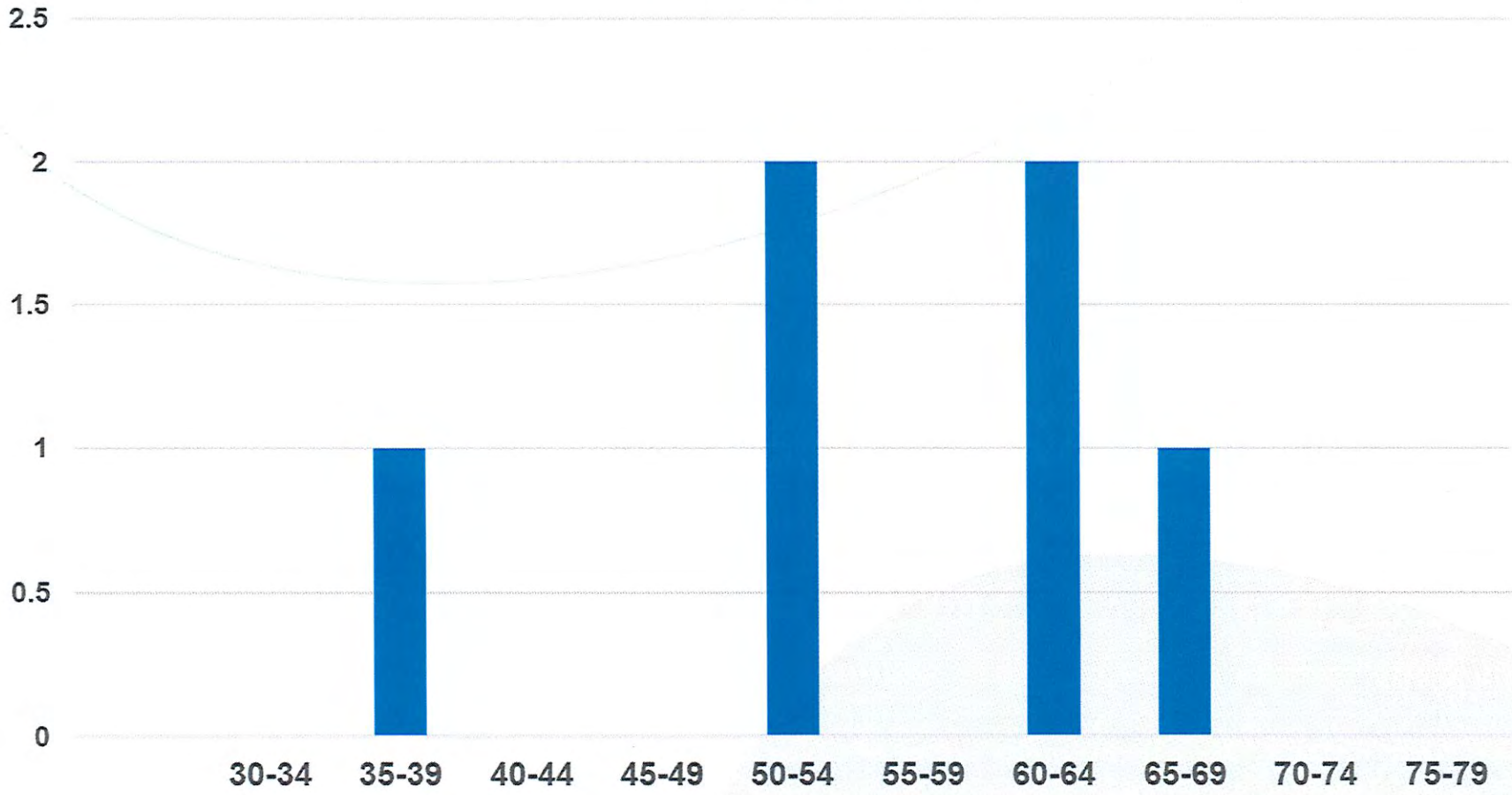
Santé mentale - Soins et recherche

Schizophrenia by Age



The Le Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

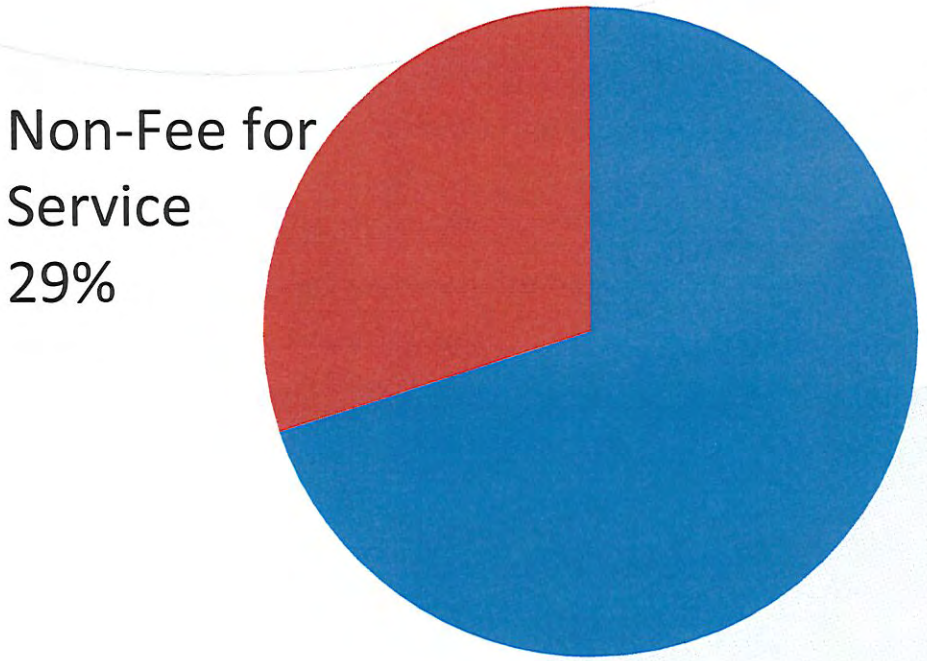
Youth by Age



Physician Culture

- Faculty at the University of Ottawa
- IMHR scientists
- Local/Regional/Provincial/National leaders
- Overnight on call responsibilities at The Royal and TOH
- Primarily OHIP (fee-for-service) funded

Total Psychiatric Remuneration - Ontario



Source: OMA Department of Economics

Physician Culture

- Cover for each other across inpatient and outpatient services and across Programs
- 100% donate ~ $500-600K per year to research
- Donate $1M over to Foundation over 5 years (again)
- Only physician group to donate to the organization in this way

Physician Culture: Academic Mandate

- Important to our Staff
- Reflected in our activities and donations
- Training the new generations
- Learning from our learners
- Maintenance of knowledge and skills
- Important in recruitment and retention

uOttawa

Faculté de médecine
Faculty of Medicine

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Culture – Engaging Others

The Le Royal

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Santé mentale - Soins et recherche

PHYSICIAN
ANNUAL PERFORMANCE ASSESSMENT FORM

Instructions on how to complete this form may be found by visiting: PALMS: Performance Appraisals & Learning Management System

PHYSICIAN INFORMATION

Physician Name:

Clinical Program:

FTE:

Academic Division:

Academic Rank:

	Confirmation		
Competency	Y	N	Please include comments below in textbox
University of Ottawa Memorandum of Agreement (MOA) Reviewed:	○	○	

Attach Feedback

	Confirmation		
Competency	Y	N	If Yes, select Areas of Focus
Intent to Apply for Academic Promotion: for info on promotion and tenure click the following link: uofO Guidelines for Academic Promotion of Clinical Faculty	○	○	---

Attach Feedback

SECTION 1: QUALITY OF CARE AND CLINICAL WORK

Response:

Inpatients: # of Beds

Outpatients: # of open

New Assessments/Consults: # per month

Other

Other

Description of clinical work:

Comments: (mandatory)

Overall Quality of Care & Clinical Rating:

Overall Rating
Overall Quality of Care & Clinical Rating:

- ○ Meets Expectations
- ○ Needs Improvement

Comments: (mandatory)

Attach Feedback

Development Plan:

Quality of Care and Clinical Work Previous Year's Goals and Objectives:

Goals	Comments:(mandatory)

Select a Rating:
- ○ **Attained**
- ○ **In Progress**
- ○ **Not Attained**

Attach Feedback

Add Past Goal

Quality of Care and Clinical Work New Goals & Objectives

Objectives

Attach Feedback
Add New Goal

SECTION 2: LEADERSHIP AND ADMINISTRATION

2.1 Committee Work:

Name of Committee	# of Meetings Held Annually	# of Meetings Attended

Overall Contributions to Committee Involvement Rating:

Ratings Scale

M - Meets Expectations
N - Needs Improvement

	Ratings Scale		
Competency	M	N	Comments: (mandatory)
Overall Contributions to Committee Involvement	○	○	

Attach Feedback

Committee Work Previous Year's Goals and Objectives:

Goals	Comments: (mandatory)

Select a Rating:
- ○ **Attained**
- ○ **In Progress**
- ○ **Not Attained**

Attach Feedback

Add Past Goal

Committee Work New Goals & Objectives

Objectives

Attach Feedback

Attach Feedback

Add New Goal

2.2 Leadership Roles

	Role	Description
1.		
2.		
3.		
4.		
5.		

Leadership Roles Previous Year's Goals and Objectives:

Goals	Comments: (mandatory)

Select a Rating:
- ○ **Attained**
- ○ **In Progress**
- ○ **Not Attained**

Attach Feedback

Add Past Goal

Leadership Roles New Goals & Objectives

Objectives

Attach Feedback

Attach Feedback

Add New Goal

SECTION 3: PROFESSIONALISM

	Confirmation		
Competency	Y	N	If No, provide comment:
I have completed the annual review of the ROHCG's Code of Conduct: (click here to view policy: Corp Policy Respectful Workplace	○	○	
Royal College Maintenance of Certification (MOC) Program:	○	○	

Attach Feedback

Overall Professionalism and Collegiality Rating:

Ratings Scale

M - Meets Expectations
N - Needs Improvement

	Ratings Scale		
Competency	M	N	If No, provide comment:
Overall Professionalism and Collegiality Rating:	○	○	

Attach Feedback

Professionalism Previous Year's Goals and Objectives:

Goals	Comments (mandatory)

Select a Rating:
- ○ **Attained**
- ○ **In Progress**
- ○ **Not Attained**

Attach Feedback

Add Past Goal

Professionalism New Goals & Objectives

Objectives

Attach Feedback

Attach Feedback

Add New Goal

SECTION 4: ACADEMIC
(this section's data to be shared with Division Head and/or Chair)

Competency	Comments: (mandatory)

4.1 Clinical Teaching Description: As a measure of clinical supervision of trainees, please indicate the number of weeks on service and the number of clinics in the past year with Medical Students or Residents.	
4.2 UNDERGRADUATE TEACHING HOURS Description: How many hours of Undergraduate Teaching did you do in the past year (lectures, workshops, CBL, etc)?	
4.3 POSTGRADUATE TEACHING HOURS Description: How many hours of Post-graduate teaching did you do in the past year (not bedside or rounds, include academic half days)?	
4.4 GRADUATE TEACHING Description: How many hours of graduate teaching did you provide in the past year?	
4.5 MENTORING Description: Please list any trainees or faculty that you have mentored over the past year. Please also indicate who your mentor is.	
4.6 INVITED PRESENTATIONS Description: How many invited presentations have you given over the past year (include Rounds and invited conference presentations)?	
4.7 PEER-REVIEWED PUBLICATIONS Description: Please list all peer-reviewed publications over the past year.	
4.8 OTHER PUBLICATIONS Description: Please list all non-peer reviewed publications over the past year.	
4.9 ABSTRACTS Description: How many scientific abstracts have you presented in the past year?	

4.10 RESEARCH PROJECT SUPERVISION Description: Please list the Medical Students/Residents/Fellows/Graduate and Post-doctoral Students whose research projects you have supervised in the past year.	
4.11 GRANTS Description: Please list any research grants received over the past year, along with the amount ($). For each grant, indicate if you were the Principal of Co-Investigator.	

Attach Feedback

Physician Final Comments

Physicians to add final comments ONLY prior to signing off on their performance assessment

Clinical Director Comments

Clinical Director to add any comments

Psychiatrist-in-Chief Comments

Psychiatrist-in-Chief to add any comments ONLY prior to accepting performance assessment

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CLINICAL DIRECTOR
ANNUAL PERFORMANCE ASSESSMENT FORM

Instructions on how to complete this form may be found by visiting: PALMS: Performance Appraisals & Learning Management System

PHYSICIAN INFORMATION

Physician Name:
Clinical Program:
FTE:
Academic Division:
Academic Rank:

	Confirmation		
Competency	Y	N	Please provide comment(s) below in textbox
University of Ottawa Memorandum of Agreement (MOA) Reviewed:	○	○	

Attach Feedback

	Confirmation		
Competency	Y	N	If Yes, select Areas of Focus
Intent to Apply for Academic Promotion: (for info on promotion and tenure click the following link: uofO Guidelines for Academic Promotion of Clinical Faculty	○	○	--------

Attach Feedback

SECTION 1: QUALITY OF CARE AND CLINICAL WORK

Response:

Inpatients: # of Beds

Outpatients: # of open

New Assessments/Consults: # per month	
Other	
Other	
Description of clinical work:	
Comments: (mandatory)	

Overall Quality of Care & Clinical Rating:

Overall Rating
Overall Quality of Care & Clinical Rating:

- ◯ Meets Expectations
- ◯ Needs Improvement

Comments: (mandatory)	

Attach Feedback

Development Plan:

Quality of Care and Clinical Work Previous Year's Goals and Objectives:

Goals	Comments:(mandatory)

Select a Rating:
- ◯ **Attained**
- ◯ **In Progress**
- ◯ **Not Attained**

Attach Feedback

Add Past Goal

Quality of Care and Clinical Work New Goals & Objectives

Objectives

Attach Feedback
Add New Goal

SECTION 2: LEADERSHIP AND ADMINISTRATION

2.1 Committee Work:

Name of Committee	# of Meetings Held Annually	# of Meetings Attended

Overall Contributions to Committee Involvement Rating:

Ratings Scale

M - Meets Expectations
N - Needs Improvement

	Ratings Scale		
Competency	M	N	Comments: (mandatory)
Overall Contributions to Committee Involvement	○	○	

Attach Feedback

Committee Work Previous Year's Goals and Objectives:

Goals	Comments: (mandatory)

Select a Rating:
- ○ **Attained**
- ○ **In Progress**
- ○ **Not Attained**

Attach Feedback

Add Past Goal

Committee Work New Goals & Objectives

Objectives

Attach Feedback

Attach Feedback

Add New Goal

2.2 Leadership Roles

	Role	Description
1.		
2.		
3.		
4.		
5.		

Leadership Roles Previous Year's Goals and Objectives:

Goals	Comments: (mandatory)

Select a Rating:
- ○ **Attained**
- ○ **In Progress**
- ○ **Not Attained**

Attach Feedback

Add Past Goal

Leadership Roles New Goals & Objectives

Objectives

Attach Feedback

Attach Feedback

Add New Goal

SECTION 3: PROFESSIONALISM

	Confirmation		
Competency	Y	N	If No, provide a comment:
I have completed the annual review of the ROHCG's Code of Conduct: (click here to view policy: Corp Policy Respectful Workplace	○	○	
Royal College Maintenance of Certification (MOC) Program:	○	○	

Attach Feedback

Overall Professionalism and Collegiality Rating:

Ratings Scale

M - Meets Expectations
N - Needs Improvement

	Ratings Scale		
Competency	M	N	If No, provide a comment:
Overall Professionalism and Collegiality Rating:	○	○	

Attach Feedback

Professionalism Previous Year's Goals and Objectives:

Goals	Comments (mandatory)

Select a Rating:
- ○ **Attained**
- ○ **In Progress**
- ○ **Not Attained**

Attach Feedback

Add Past Goal

Professionalism New Goals & Objectives

Objectives

Attach Feedback

Attach Feedback

Add New Goal

SECTION 4: KEY MANAGEMENT PERFORMANCE

	Confirmation		
Competency	Y	N	Comments: (mandatory)

4.1 (a) Planning: With the Director of Patient Care Services, plan program/service directions based on the ROHCG Mission and Mandate, and outcomes of program evaluation.	○	○	
4.1 (b) Planning: Attend regularly scheduled ROHCG Management Meetings.	○	○	
4.2 Partnerships: Foster and participate in relevant partnerships throughout the Region in collaboration with the Associate Chief and or Psychiatrist-in-Chief/Chief of Staff.	○	○	
4.3 (a) Program Objectives: Ensure that the Clinical Care is determined by Evidence Based Approaches	○	○	
4.3 (b) Program Objectives: Ensure that the Clinical Care is determined by Best Practices.	○	○	
4.3 (c) Program Objectives: Ensure that the Clinical Care is determined by Clinical Practice Guidelines.	○	○	
4.3 (d) Program Objectives: Ensure that the Clinical Care is determined by Outcome and Service Evaluations	○	○	
4.4 (a) Medical Human Resources Management:: Develop and assess the program's medical service requirements for input into the hospital's overall medical HR plan	○	○	
4.4 (b) Medical Human Resources Management: Ensure job descriptions are developed and kept up-to-date for each physician within the program	○	○	
4.4 (c) Medical Human Resources Management: Monitor medical staff clinical performance and provide feedback as necessary. Complete annual performance reviews on each physician in the program	○	○	
4.4 (d) Medical Human Resources Management: Assist the Psychiatrist-in-Chief with physician recruitment to meet the medical staffing plan.	○	○	

4.5 (a) Budget Planning/ Allocation & Control:: Actively participate in resource allocation decisions in the Program through the annual budget planning process.	○	○		
4.5 (b) Budget Planning/Allocation & Control: With the Director of Patient Care Services, ensure a mechanism is in place to regularly monitor resource allocation and utilization and determine corrective action, when required	○	○		
4.6 (a) Clinical Care Issues and Performance Appraisal: With the Director of Patient Care Services, ensure a mechanism to monitor clinical care delivered in program.	○	○		
4.6 (b) Clinical Care Issues and Performance Appraisal: Provide program clinical leadership and develop clinical programming	○	○		
4.6 (c) Clinical Care Issues and Performance Appraisal: Participate in identifying the priorities for clinical staff development	○	○		
4.6 (d) Clinical Care Issues and Performance Appraisal: Ensure job descriptions for all staff are up-to-date	○	○		
4.6 (e) Clinical Care Issues and Performance Appraisal: Ensure the regular monitoring of clinical competence performance for all staff	○	○		
4.6 (f) Clinical Care Issues and Performance Appraisal: Coordinate clinical and research activities with the program in collaboration with IMHR and Research Unit Directors	○	○		
4.7 (a) Staff Selection:: With the Director of Patient Care Services, determine Staffing requirements, based on program objectives and approved budget, including appropriate staff mix.	○	○		
4.7 (b) Staff Selection: With the Director of Patient Care Services, be responsible for hiring appropriate staff	○	○		

4.8 (a) Disciplinary Action/Clinical Disputes/Investigations into Critical Incidences:: With the Director of Patient Care Services, ensure that a process is in place for disciplinary action as necessary	○	○	
4.8 (b) Disciplinary Action/Clinical Disputes/Investigations into Critical Incidences: Follow up on physician complaints and ensure appropriate action and resolution as appropriate	○	○	

Attach Feedback

Overall Key Management Performance Rating:

Ratings Scale

M - Meets Expectations
N - Needs Improvement

	Ratings Scale		
Competency	**M**	**N**	**Comments: (mandatory)**
Overall Key Management Performance Rating:	○	○	

Attach Feedback

Key Management Performance Previous Year's Goals and Objectives:

Goals	Comments

Select a Rating:
○ **Attained**
○ **In Progress**
○ **Not Attained**

Attach Feedback

Add Past Goal

Key Management Performance New Goals & Objectives

Objectives

Attach Feedback

Attach Feedback

Add New Goal

SECTION 5: ACADEMIC

Competency	Comments:
5.1 Clinical Teaching Description: As a measure of clinical supervision of trainees, please indicate the number of weeks on service and the number of clinics in the past year with Medical Students or Residents.	
5.2 UNDERGRADUATE TEACHING HOURS Description: How many hours of Undergraduate Teaching did you do in the past year (lectures, workshops, CBL, etc)?	
5.3 POSTGRADUATE TEACHING HOURS Description: How many hours of Post-graduate teaching did you do in the past year (not bedside or rounds, include academic half days)?	
5.4 GRADUATE TEACHING Description: How many hours of graduate teaching did you provide in the past year?	
5.5 MENTORING Description: Please list any trainees or faculty that you have mentored over the past year. Please also indicate who your mentor is.	
5.6 INVITED PRESENTATIONS Description: How many invited presentations have you given over the past year (include Rounds and invited conference presentations)?	

5.7 PEER-REVIEWED PUBLICATIONS Description: Please list all peer-reviewed publications over the past year.	
5.8 OTHER PUBLICATIONS Description: Please list all non-peer reviewed publications over the past year.	
5.9 ABSTRACTS Description: How many scientific abstracts have you presented in the past year?	
5.10 RESEARCH PROJECT SUPERVISION Description: Please list the Medical Students/Residents/Fellows/Graduate and Post-doctoral Students whose research projects you have supervised in the past year.	
5.11 GRANTS Description: Please list any research grants received over the past year, along with the amount ($). For each grant, indicate if you were the Principal of Co-Investigator.	

Attach Feedback

Clinical Director Comments

Clinical Director to add final comments ONLY before final sign-off step

Associate Chief, Comments

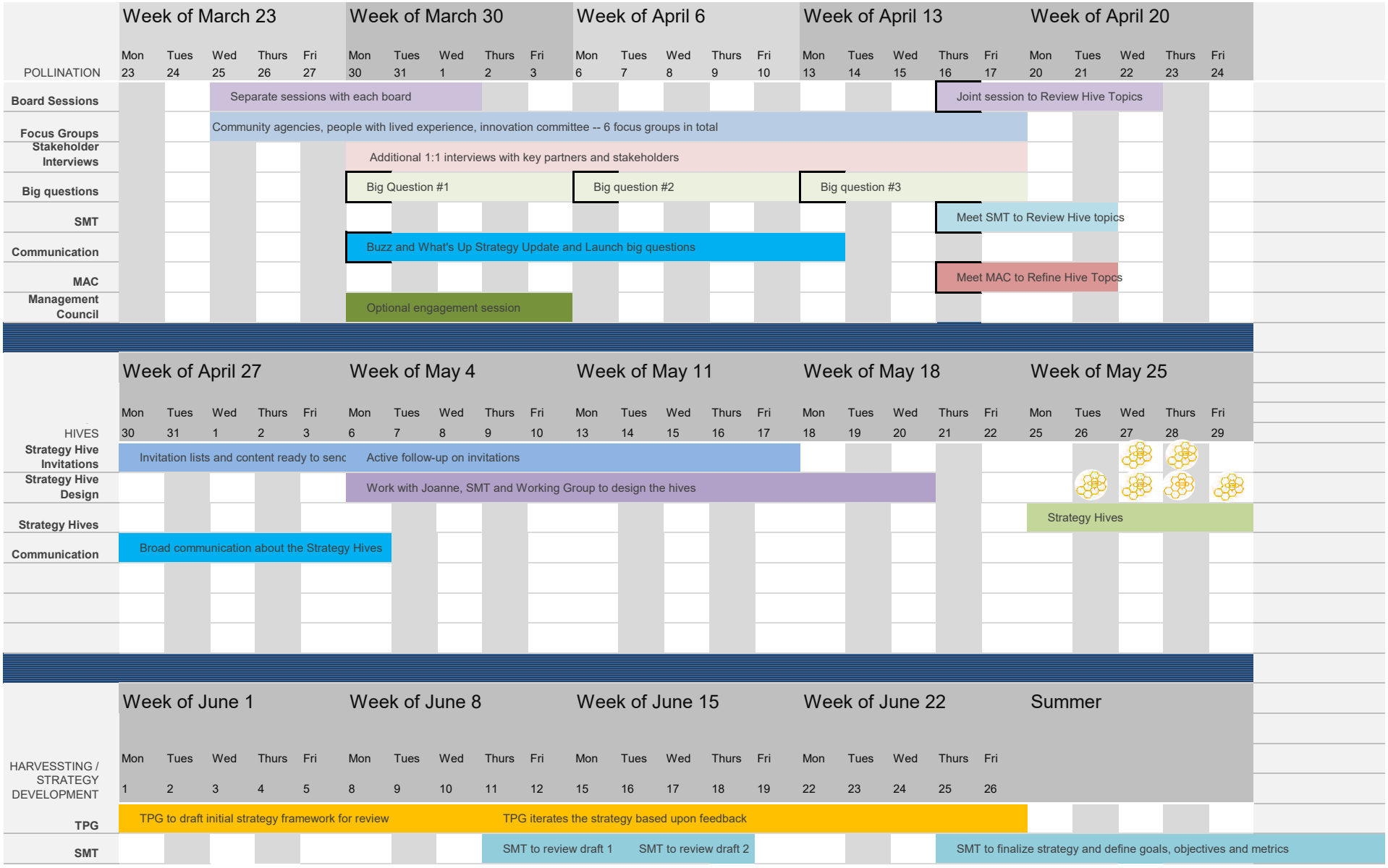
Associate Chief, to add comments ONLY prior to accepting contents of performance assessment

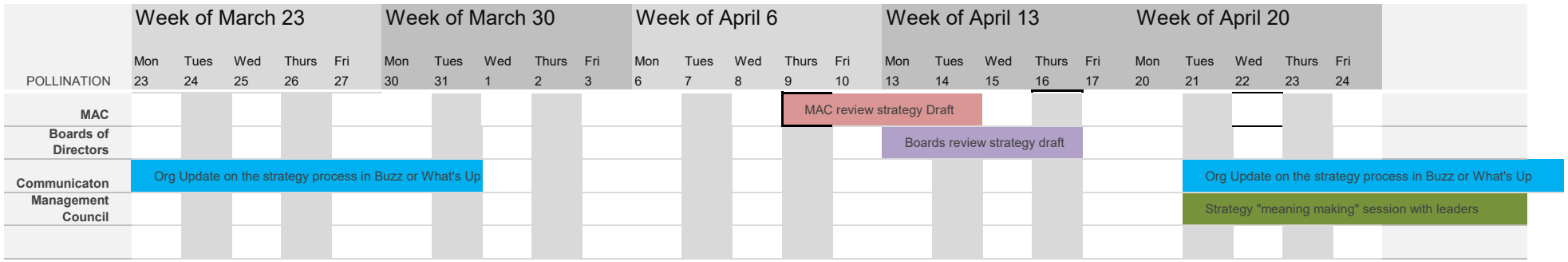
Psychiatrist-in-Chief Comments

Psychiatrist-in-Chief to add any comments ONLY prior to accepting performance assessment

Project Timeline: Strategic Planning, Royal Ottawa Healthcare Group

Start Date 2020-03-20

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MAC
Boards of Directors
Communicaton
Management Council
MAC review strategy Draft
Boards review strategy draft
Org Update on the strategy process in Buzz or What's Up
Org Update on the strategy process in Buzz or What's Up
Strategy "meaning making" session with leaders

Ontario's Plan
Our Plan
Our Campaign

Strategic Considerations

Joanne Bezzubetz, President and CEO
March 26, 2020

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Strategic Considerations for The Royal

- Our community expects us to connect the dots between the provincial government's mental health and addictions plan, what The Royal believes it can accomplish and what citizens in the community want.

- The strategic plan offers a pivotal opportunity for clients, families, stakeholders and members of the public and private sector in having a voice on defining the future design of The Royal and mental health care.

- The release of the provincial government's plan "Roadmap to Wellness" provides a foundation by which The Royal can demonstrate leadership in modelling mental health care locally, provincially and nationally. The Royal's next campaign can built upon.

Strategic Considerations for The Royal cont'd

- The Royal needs to be 'Top of mind' and the trusted voice on mental health. There is tremendous value for The Royal to be seen 'in action' and responsive to the community in remodelling mental health care.

- Unique opportunity to describe the model of mental health care that supports a hospital without walls.

Informed Approach to Launch The Royal's Next Campaign

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System Challenges – Roadmap to Wellness

- Long wait times
- Little understanding of what services are available and where to find them
- Uneven service quality between providers and regions
- Fragmentation and poor coordination

System Challenges – Roadmap to Wellness cont'd

- Lack of evidence-based funding; and
- Absence of data, which limits effective oversight and accountability
- Services are disconnected and fragmented with significant barriers to access
- Confusion and difficulty navigating mental health and addiction services

Phase I of our Strategic Plan Process

Strengths

- People
- Leader
- Royal brand
- World class research
- Education
- Quality of care provided
- Collaboration

Opportunities

Improved access to care

- Enhanced programming (evenings and weekends)
- System navigator
- Technology
  - *(BIC)*
  - *Horizontal integration*
- Client and family-centric care
- Research integration
- System transformation – Ontario Health Teams

Aspirations

Improve access – capacity

- Leader in innovation
- Clinical/research integration
- Improved transitions
- Client family-centred care - every time
- One Royal
- Advocacy/prevention
- Policy influencer

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Provincial Government's Mental Health and Addictions Plan: Roadmap to Wellness

PILLAR 1
Improving Quality: enhancing services across Ontario

- Core services based on mental health and addiction needs (complex to low level)
- Populations: emergency and inpatient psychiatry; forensic; psychotherapy; withdrawal management; peer support; and family support
- Standards to be defined

PILLAR 2
Expanding Services in Priority Areas

- Child and youth mental health
- Justice and mental health
- Mental health supports – police & correctional and first responders
- Supportive housing
- Services and co-developing programs for indigenous people and communities
- Services to Francophones

PILLAR 3
Innovative Solutions

- Mindability (lifelong skills for mental wellness)
- CBT – children and youth 10+
- Adults and seniors and social assistance and Mindability
- Integration of autism and mental health care at local level (ASD)
- Expansion of addiction services: RAAM clinics, Consumption Treatment Services, and youth wellness hubs

PILLAR 4
Improving Access

- Coordinated access to mental health and addiction core services and navigation
- Ontario Health Teams (clinical and fiscal accountability) to deliver coordinated continuum of care to defined geographic populations
- Integration of mental health and additions supports
- Measuring success: Mental Health and Addictions Centre of Excellence

TIMELINE

- **Winter 2020** – mental health plan announced
- **Spring 2020** – more services and support
- **Fall 2020** – better planning and access
- **Spring 2021** – more services and supports

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Hospital Without Walls
Elements of The Royal's Next Campaign

BUCKET 1
Improving Access

- Prompt Care Clinic (Community Mental Health Program)
- Building capacity to improve access
- Serving the underserved

BUCKET 2
Strengthening our Community

- Building skills for concurrent disorders
- Regional Psychosis Program
- Clinical Research Healthy Aging Chair

BUCKET 3
Innovative Care

- Esketamine Clinic to treat depression
- Increasing mental health expertise (or Mind Health Education)
- rTMS Clinic (youth and geriatric)
- Clinical Biomarker Discovery
- Whole Body Approaches

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Alignment: Roadmap to Wellness, Strategic Plan and Elements of The Royal's Next Campaign

	PILLAR 1 Improving Quality	PILLAR 2 Expanding Services	PILLAR 3 Innovative Solutions	PILLAR 4 Improving access
Roadmap to Wellness	• Core services for various populations ranging from complex to low need	• Child & youth mental health • Justice and mental health • Mental health (MH) supports – police & correctional and first responders • Supportive housing • Indigenous people, Francophones and communities	• Mindability CBT and social assistance • Autism and mental health • RAAM clinics • Consumption Treatment Services • Youth wellness hubs	• Coordinated Access and navigation • Ontario Health Teams • Integration of mental health and additions supports in continuum of care

A HOSPITAL WITHOUT WALLS: VIRTUAL AND CONNECTED CARE

Elements of The Royal's Campaign & Strategic Plan	• Building Skills for Concurrent Disorders • Clinical and Research outcomes • Gender and Mental Health model research	• Regional Psychosis Program • Clinical Research Chair in Healthy Aging	• Esketamine Clinic for depression • rTMS Clinic (incl. youth & geriatric) • Clinical Biomarker Discovery • Whole Body Approaches	• Prompt Access Clinic • Increasing MH expertise in areas of high need: post-residency/fellowship clinicians • Walk-in clinic (gender, health, sexuality) • Virtual and connected care

OTTAWA HEALTH CARE
GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 45	**Priority:** Important

DATE: March 26, 2020
COMMITTEE:
PRESENTER: M. Bellman

SUBJECT: **Foundation Campaign Case**

BACKGROUND INFORMATION:

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT the Case for Support be approved as presented, and the Foundation and IMHR Boards are requested to approve the case so all three Boards of The Royal are in agreement.

Moved by:
Seconded by:
Motion approved:

ROYAL OTTAWA FOUNDATION

HOSPITAL WITHOUT WALLS:

MATERIALS FOR REVIEW AND CONSIDERATION

March 19, 2020

TABLE OF CONTENTS

HOSPITAL WITHOUT WALLS

Our philosophy for The Royal is a **hospital without walls**. We want to create a future in which mental health care meets people where they are, working in partnership with clients, families and our community. We will do this by **improving access to care**, **strengthening our community** and **providing innovative care**.

Community-based care is integrated with other aspects of a person's life and with other services that support a person's wellness. While inpatient care will remain an important and necessary part of the mental health and addictions (MH&A) system – particularly for those with severe mental illness – a system of integrated community care will help people get the right care in the right place and closer to home, while helping to relieve pressure on hospitals, in particular emergency rooms.

In many cases, people living with mental illness can be cared for very effectively in the community with care that meets them where they are. As another benefit of doing so, hospital space opens to those patients requiring immediate and long-term, higher levels of care. Above all, getting MH&A services in the community allows people to maintain or develop other aspects of their lives that support their wellbeing while still having all their care needs met.

At present, one of the largest public concerns relating to MH&A care is **access**. The success of de-stigmatization initiatives such as our "You Know Who I Am" campaign have led to increased numbers of people seeking help. While this is an incredibly positive step, too often, people experience barriers to access at the time when they most need help.
The question of access is complex and involves many stakeholders in the health care system. While the government is in the process of addressing the problem of access at the provincial level, **we can start addressing many of the needs in our region *now*, contributing to the overall ecosystem**. To do this, we can raise funds to support initiatives and programs that can help our patients, their families, and our community partners - **by improving access to care**, **strengthening our community** and **providing innovative care**.

- **Improving Access:** In the spirit of our values of innovation and collaboration, The Royal will make elements of its critical mental health services more readily accessible throughout our community. This means improving and enhancing the various methods of how in which people access our traditional services.

- **Strengthening our Community:** Expanding and strengthening our community partnerships will allow us to increase training and knowledge transfer, enhance communication and provide additional resources. Collaboration and technology will be key to this.

- **Innovative Care:** Following the "nothing about me without me" principle, we are collaborating with clients and families on care and research. Clinicians and researchers at The Royal are encouraged to respond innovatively to care delivery models and embrace innovation to improve access to care. Clients and families have the opportunity

to participate in potentially life-changing research studies and become co-designers of innovative research projects.

To support this future, The Royal has developed a compelling Case for Support that builds on integrated strengths in care and research, with our clients, families, and partners. The proposed projects have been co-designed by innovators who lead on the full spectrum of care and research - within The Royal and beyond, in our communities.

IMPROVING ACCESS

Prompt Access Clinic **$10 million**

Brief Description

At present, patients with urgent Mental Health (MH) care needs face lengthy wait lists for hospital-based outpatient clinics or they crowd the emergency department (ED) seeking a crisis consultation. The number of individuals visiting EDs for mental health and addictions (MH&A) issues grew 46% in Ottawa in the last decade although many of those visits were for urgent, not emergent, care (Ottawa Public Health, 2017). Primary care providers report limited access to community mental health care services and too many barriers and delays associated with referrals to hospital-based services (Rush et al. 2019). Primary Care Providers and Hospital Psychiatric Emergency Services have provided clear and consistent feedback to The Royal and The Ottawa Hospital that this gap in services must be addressed to improve patient care and reduce hallway medicine.

In response, the Prompt Access Clinic (PAC) has been planned as an innovative, community-based, multidisciplinary MH&A assessment and treatment clinic that would provide quick access for clients/patients with urgent MH care needs. The Prompt Access Clinic (PAC) will be located in the community, provide day and evening access, and work collaboratively with Primary Care Providers in the region. Staffed with a compliment of Mental Health Nurses, Social Workers, Psychologists and Psychiatrists, the treating team will have the capacity to provide comprehensive assessments, initiate treatment (medications, addictions counselling, and/or brief psychotherapy) and coordinate access to further care services (addictions, specialized community or hospital based) as needed. In simplest terms, the Prompt Access Clinic will work with Primary Care Providers to ensure that community members with MH&A needs receive access to comprehensive care that meets their needs in a timely fashion.

The PAC will incorporate innovative strategies to maximize access and reach including:

- Bringing together a multidisciplinary team of MH providers to provide a comprehensive range of services that are not currently available on a timely and free of charge basis directly in the community
- Offering assessment, consultation and brief psychotherapy treatment models such as Cognitive Behavioural Therapy, emotion regulation, and coping skills training
- Providing psychoeducation to clients and their support networks
- Building capacity of Primary Care Providers in managing MH&A in community clients
- Incorporating telemedicine technologies to provide virtual care to patients where they are with potential for expansion outside the region
- Leveraging the partnership between The Royal and The Ottawa Hospital to improve access to resources and specialized services when needed

Clinical Outcomes

The Prompt Access Clinic will demonstrate clinical outcomes at the client and system level.

Client:

- Increased access to community-based comprehensive MH&A care in a timely fashion
- Improved coordination of care between primary care and secondary MH&A care
- Improved clinical outcomes
- Improved well-being
- Increased satisfaction with MH&A services

System:

- Increased partnerships with Primary Care Providers
- Improved knowledge of MH&A care in Primary Care Providers
- Increased satisfaction with primary and MH&A services
- Decreased use of ED for MH&A care

Research Outcomes

A range of research topics emerge within a partnership with IMHR and The University of Ottawa. Foci for clinical and system-based research include:

- Patient Profiling – examining who is best served in the model of care and the impact of services on MH&A outcomes (to allow for future expansion)
- Effectiveness- reviewing the impact of the innovative clinic model and services provided
- Efficiency – reviewing the use of resources to meet client and provider needs, including costing efficiency evaluation and reduction of use of other services, including ED

Future Impact

The PAC is a new community-based service, in partnership with The Ottawa Hospital that will offer timely access to consultation, education and short-term MH treatment. The clinic will provide a new model of care within the community while building capacity through partnership with primary care providers and community partners.

Building capacity to improve access **$1.5 million**

Brief Description

The Royal will recruit post-residency/fellowship clinicians (specialized training following successful completion of residency in psychiatry) and enable them to develop expertise in areas of mental health with high need. This is specialized training following successful completion of residency in psychiatry. These fellowships will build capacity to help improve access for clients coming to The Royal. The aim of acquiring endorsement in a subspecialty is to become an expert in the specific area of mental health. Increasing the number of spots available for training and specialization will help build capacity that in turn allows for improved access for clients requiring specialized mental health care resulting in shorter wait times.

Post fellowships, the increase in manpower at the hospital helps to drive innovation and to develop more specialized clinics within the program.

Clinical Outcomes

The plan will be to direct these fellowships toward specific areas of psychiatry, addictions medicine, increasing psychology HR and possibly other allied health disciplines.

Future Impact

The benefits noted above are multiple and the ultimate goal is to improve research capabilities within departments, provide better access to care and assessments by highly trained medical experts in the field of mental health.

Supporting the Underserved **$3 million**

Brief Description

In response to the need of improving access to mental health care and services for many people who are limited in accessing care, our plan is to develop a store-front, walk-in Resource Centre focusing on gender, health and sexuality for vulnerable populations.

We will build upon the peer support model that we use in our Women's Mental Health initiative and the Shirley E. Greenberg Resource Centre by drawing on past experience, knowledge and program evaluation to expand our reach to more people in our community. The focus would be on Gender and Mental Health (women and men) and would include a resource centre, peer support and specialized support for high needs populations. Many people in our community have diverse needs that are under-recognized, under-served and have specialized mental health requirements for which traditional mental health services would not be appropriate or be a sufficiently sensitive match. This demographic would include, but is not limited to, the LGBTQ2S+ population and their families, newcomers to Canada and the indigenous population who may be living in northern and remote areas with limited access to mental health care (First Nations, Inuit, Métis).

We will create a storefront model to provide service navigation, support groups, consultation, telemedicine outreach/care for vulnerable populations not accessing care due to sexuality issues including LGBTQ2S+ populations and families.

We will provide co-delivered (clinician and peer) support with a range of community partners. The storefront access would have extended range of hours and range of languages of service.

Clinical Outcomes

- A "storefront" concept where clients can walk-in off the street to access our services with or without a referral. This will be a safe space in a public location to help reduce stigma, and that is easily accessible via public transportation and walking distance.
- The centre will offer education and navigation to a range of underserved populations who do not access traditional office-based models of mental health care. Often underserved populations do not receive care until they are in a mental health crisis and present to the ED.
- Co-delivered peer support – clinician and peer support with a range of community partners. There is a strong evidence base for this model to promote wellness (WRAP = wellness recovery action planning) for underserved populations who do not traditionally access mental health services.
- Mental health care providers who can offer services in the five most common languages currently spoken in our community.
- Availability to be open for longer hours than typical 9-5pm, including weekends.
- A telemedicine suite for people unable to attend in person or who live in rural/remote areas.

- Specialized consultation to community agencies and system navigators inside the centre.

Research Outcomes

- Range of populations and service model research projects embedded; evaluation of innovative model will also be conducted.

Future Impact

- Improved awareness of mental health issues and services for range of under-served persons in the community and their supports.
- Provision of a unique model of care with the availability of services for these under-served (and often vulnerable) populations.
- Improved access to selected types of WRAP, consultation, navigation, telemedicine links for increased rural and remote access.
- Provide education on mental health to persons who would not access traditional models of care or information.

STRENTHENING OUR COMMUNITY

Building Skills for Concurrent Disorders $2 million

Brief Description

The Royal's Substance Use and Concurrent Disorders (SUCD) program serves those with moderate-severe substance use, mental health, and physical health disorders. It offers a range of inpatient and outpatient services for concurrent disorders.

Most individuals struggling with substance use problems have concurrent mental health problems, and most individuals struggling with mental health problems have concurrent substance use problems. The prevalence of substance use disorders is greater amongst those with severe mental health disorders, which is the population The Royal serves.

Integrated treatment for concurrent disorders is key for success; yet mental health and addiction services are often fragmented and compartmentalized. Substance use disorders are often exclusionary criteria for receiving services at mental health programs, yet the demand for concurrent disorders care far exceeds the supply. In order to address the service gap in our region, the SUCD program proposes to create a dedicated system resource team to build capacity in partnership with community and hospital providers to better care for patients with concurrent disorders. The system resource team is comprised of an addiction medicine physician, clinical psychologist, psychiatrist, social worker, nurse, residents/trainees, and a coordinator. This team will build capacity in the region, enhance the knowledge of community providers, increase access, improve care and serve more patients with concurrent disorders.

Given the gaps noted above, it is imperative that our system of providers and services has the capacity to treat substance use disorders and concurrent mental health disorders in an integrated manner in order to optimize treatment outcomes. We need a system that is equipped to work with patients with concurrent disorders (i.e., concurrent disorders capable).

Clinical Outcomes

We will assess multiple outcomes, including: training outcomes (e.g., number of agencies trained, number of providers trained), client outcomes (e.g., changes in symptoms, client satisfaction), and system outcomes (e.g., number of new agencies equipped to work with patients with concurrent disorders, number of agencies connected with each other).

- Training outcomes – Providing education and training (e.g., mentorship, clinical supervision, and training on-site or via OTN) to providers and agencies translates into serving more patients with concurrent disorders.
- Client outcomes – Increased access to evidence-based concurrent disorders care will result in better outcomes and higher likelihood of recovery.

- System outcomes – Providing networking opportunities to build connections amongst agencies will lead to improve shared care with community partners and reduce the burden placed on any given agency (i.e., increased network density).

Research Outcomes

We will conduct an environmental scan to identify agencies that provide services for individuals with mental health or substance use difficulties. We will then conduct a needs assessment to determine barriers and facilitators to providing concurrent disorders care. We will develop strategies and target education/training to eliminate barriers and leverage existing strengths to build capacity. Both provider competence and the agency's concurrent disorders capability will be assessed before and after training, to ensure that capacity has been built in the community. The resource team will be implemented in a phased approach. That is, the team will be piloted in a few agencies, outcomes will be evaluated, and adjustments will be made prior to expanding to other agencies.

- Results of the environmental scan and needs assessment will identify the partner agencies, barriers, and facilitators.
- Training outcomes: Increased provider competence, comfort, and abilities in serving clients with concurrent disorders; provider satisfaction with training
- Client outcomes: Improved mental health and substance use outcomes, quality of life, and client satisfaction
- System outcomes: Increased concurrent disorders capability across the system, reduction in wait times for services, more clients served in the community, more services available to clients with concurrent disorders

Future Impact

Many people have concurrent mental health and substance use difficulties, but few community agencies are equipped to work with such individuals.

A dedicated system resource team will:

1) build capacity in the community for other agencies to provide care

2) open new doors to treatment and services for clients who were previously denied

3) improve client outcomes and satisfaction

4) serve as a model in Ontario for others to follow provincially, nationally, and internationally.

Regional Psychosis Program $4 million

Brief Description

Schizophrenia is a mental disorder that can be characterized as a devastating cluster of symptoms that include hallucinations, delusions, disorganized thinking and bizarre behavior. Perhaps most debilitating is that those who suffer from schizophrenia often cannot recognize that that they even have an illness. For many of those affected, these symptoms begin in their late teens and early twenties, in the prime of their lives. The harsh reality is that this disorder is relatively common, often chronic, and has a tremendous impact on both patients and their families.

Treatment of schizophrenia poses another range of challenges. We know that 90% of those who seek treatment will achieve symptom remission within 1 year. Yet, we have learned that within 5 years, 85% will have experienced at least one relapse and only 14% will meet criteria for recovery. Across a patient's lifetime, only 20% remain employed and only 30% live independently. The societal cost of schizophrenia is greater than that of all types of cancers combined.

Even with our current treatment efforts, patients with schizophrenia will live 15-20 years less than the general population. This is largely secondary to otherwise treatable medical conditions, rather than their mental illness. Death from a treatable medical condition is often attributable to a pattern of disconnect between Primary Care Clinicians (PCCs) and this vulnerable population. PCCs often perceive schizophrenia as a complicated illness, better cared for by a specialist. Many will acknowledge that they are uncomfortable providing ongoing care. As a result, necessary physical and psychiatric care are not delivered together, or not at all. As can be appreciated, taking the PCC out of the circle of care has a significant deleterious impact on the well-being of individuals, contributing to their negative health outcomes.

To address the importance of delivering high quality physical and psychiatric care to this vulnerable population, The Royal is proposing the development of a Regional Psychosis Program, located in the community with far-reaching access across the region. This innovative Program will offer a multi-faceted link between a range of Primary Care Provider sites (from Community Health Centres to individual providers) and psychiatric expertise offered through The Royal. The program will provide education and training on schizophrenia and its treatments to Primary Care Providers while simultaneously educating clients and families. In addition new pathways of shared care between primary and psychiatric (specialty, tertiary) care will be offered to ensure linked care. This means that as individuals' symptoms improve, they can reduce their need for specialty care, knowing they can return when their symptoms relapse – without gaps in care.

The Regional Psychosis Program will encompass both in-person and virtual care. The in-person care will be delivered within the community and will facilitate access to complex or novel treatments that have been difficult for PCC to access. In sum, all aspects of their physical care and well-being can be seamlessly coordinated with their psychiatric care by offering access to a broad range of pharmacological and psychological treatments. Importantly, services will be

offered both in person and via virtual care to support barrier-free services for clients, family and providers across the region. The Regional Psychosis Program will link with community partners to ensure other aspects of clients' lives such as supportive housing, access to volunteer and paid work and education are coordinated with their physical and psychiatric care.

Clinical Outcomes

The primary concept of the Regional Psychosis Program is the creation of a model of care that is patient and family centered, barrier free, and promotes full spectrum health care for this vulnerable population. It will include an expanded primary care role with training and system wide support; promote interdisciplinary collaboration with various providers; enhance integration across care settings; and empower patient/caregivers to participate in the decision-making process. It is expected that comprehensive care for patients with Schizophrenia will reduce hospitalizations and involuntary treatments, promote opportunities for independent living, better vocational prospects, and decrease morbidity and mortality.

Anticipated Clinical Outcomes**:**

- Increase integration of physical and psychiatric care to support well-being
- Enhance access to a range of coordinated treatment types (pharmacological, individual and family therapy)
- Decrease use of higher intensity services such as Emergency Department and Inpatient Units to address care needs
- Decrease overall morbidity and mortality
- Improved potential for Recovery, including attaining educational and vocational goals, improved family relationships, increased community integration and improved quality of life
- Enhance client, Family, caregiver/provider satisfaction,
- Enhance Primary Care Provider knowledge, skill and satisfaction in delivering care to clients with Schizophrenia
- Establish a comprehensive care model with the potential for implementation in other regions

Research Outcomes

- Evaluate the efficiency and effectiveness of coordinated care within the Regional Psychosis Program, including key elements of care for clients, families and Primary Care Providers.
- Evaluate the cost effectiveness of coordinated care and its economic impact on client and family well-being
- Evaluate the economic impact of coordinated care within the Regional Psychosis Program

- Establish, with regional psychiatric provider partners, a collaborative registry of persons with schizophrenia to contribute to the epidemiological understanding of schizophrenia and how to meet their coordinated care needs.

Future Impact

Coordinated care to enhance the physical and mental health and well-being of persons with schizophrenia has been a request of clients, families and providers for decades. This innovative Regional Psychosis Program model will recognize these important links in care for persons living across the region.

Living well to 100: The Royal's Clinical Research Chair in Healthy Aging

***$2 million**

Brief Description

Healthy aging is both a personal and public health issue of great importance to individuals and communities. Given our demographics, research on mental health and aging is a global priority. Indeed, technological, medical and social advances are extending lives of our citizens, including those with health problems.

More than 432,000 Canadians 65 years and older live with diagnosed dementia; about two-thirds of them are women. With a growing and aging population, we expect the number of Canadians with dementia to increase.

In 2015, dementia affected 47 million people worldwide (or roughly 5% of the world's elderly population), a figure that is predicted to increase to 75 million in 2030 and 132 million by 2050. Recent reviews estimate that globally nearly 9.9 million people develop dementia each year; this figure translates into one new case every three seconds.

This is an identified niche area for The Royal, which builds on excellence in the Geriatrics clinical program, provides needed capacity, and presents great potential for development and partnerships (University of Ottawa, Bruyere and the Bruyere Research Institute, the Ottawa Hospital and the Ottawa Hospital Research Institute). The Chair in Healthy Aging will support The Royal's mission to lead in the generation and transfer of knowledge in this area.

Research Outcomes

- Practice-changing research / Research designs informed by care
- Implementing new or better ways to address mental health care and services
- The Chair would be expected to create a centre of excellence and attract additional investments

Future Impact

It is anticipated that The Royal's Clinical Research Chair in Healthy Aging will generate and transfer knowledge that will contribute to the well-being of elderly patients in Geriatrics clinical programs at The Royal and beyond. While the focus of the Chair will be determined by a number of factors, work may address behavioral changes in dementia.

*Funding will be leveraged through partnerships and matching funds (Ottawa University, Faculties, affiliated research institutes) to generate a 10 year senior chair and capacity, which would include a team (Clinical Scientist, fellowships, operations).

INNOVATIVE CARE

Esketamine Clinic – A Novel Treatment for Depression $3 million

Brief Description

The World Health Organization estimates that by the year 2030, depression will have the largest global burden of disease. One in four Canadians are diagnosed with depression at some point in their lives and up to one third of them will not respond to existing treatments. Factors that may contribute to the occurrence of a mood disorder include traumatic events during early development and life stressors; genetic predisposition; and biochemical changes.

Depression that does not respond to at least two different antidepressant strategies is considered treatment-resistant. For people with treatment-resistant depression (TRD) who have tried different medications but have not found anything that helps, ketamine has proven to be a life-changing (even life-saving) intervention. In fact, ketamine has been hailed as **the biggest breakthrough in the field of depression in the past 50 years**.

Clinical research has found that small doses of ketamine can lower depressive symptoms and reduce suicidal ideation very rapidly – within hours of the first intravenous infusion. Ground-breaking new research from The Royal's Mood Disorders Research Unit, led by Dr. Pierre Blier, has demonstrated that the effects of ketamine are not only fast – but can be long-lasting.

Esketamine – a more specific, easier to administer form of ketamine – has received FDA approval in the form of a nasal spray, and is used together with an oral antidepressant for patients with TRD.

As a leader in the use of ketamine in Canada, The Royal would like to open an Esketamine Clinic for patients with TRD. These patients would receive access to this new treatment option on a weekly to monthly basis, under close medical supervision.

Clinical Outcomes:

- Esketamine can lead to a therapeutic response and/or remission even in patients who have failed to respond to other commonly prescribed medications
- Esketamine elicits rapid therapeutic effects (within a few hours of the first treatment)
- Rapid (within hours) reduction of suicidal ideation independent of effects on mood
- Non-invasive and easy administration (nasal spray)
- Improved access to a new model of care for The Royal and the region
- Access to a new, innovative, evidence-based therapy for treatment-resistant depress

Research Outcomes:

We will conduct research and evaluation of the impact of the clinic on patients. Esketamine is a novel, innovative treatment with a mechanism of action that differs significantly from existing therapies for depression. While research has shown esketamine to be safe and effective, there remains much to be learned about how it elicits such rapid beneficial effects and how best to maintain them long-term.

- Innovative and bi-directional translational research built-in (synergy for outcomes)
- Identification of biomarkers associated with positive response to treatment
- Identification of mechanisms of action fueling future insights in innovative treatment methods

Future Impact

By evaluating patients as they undergo esketamine treatment, we will continue to lead the field in reporting clinical outcomes, devising strategies to maintain therapeutic effects, and identifying patients most likely to respond to treatment.

Repetitive Transcranial Magnetic Stimulation (rTMS) Clinic $1 million

Brief Description

In contrast to medications that act on particular chemicals in the brain to alleviate symptoms of depression, rTMS *directly stimulates the specific brain circuits*, by delivering a brief magnetic field via a coil placed against the scalp.

This non-invasive, non-drug therapy has repeatedly shown very positive outcomes in patients with hard to treat depression, and has been approved by Health Canada since 2002 as a safe and effective recommended treatment option for patients who have not responded to typical antidepressants. However, rTMS remains out of reach for many Canadians.

Currently, rTMS is only publicly funded in three provinces—Saskatchewan, Quebec and Yukon. Those who live in large urban centres with private clinics can pay out of pocket for treatment, but for many, the only other way to access rTMS is through research. At present, there are currently no rTMS clinics in the region.

This access barrier is why our IMHR scientists are hard at work developing a clinical-research platform for rTMS. This platform will be the first of its kind in the Ottawa region, and will help to make rTMS treatment more accessible to individuals with major depression.

Our scientists envision this platform as an in-demand, no-cost treatment option for individuals in the community—the only caveat being that the data gathered would be used for research purposes, to help better predict and refine rTMS treatment on a continuous basis.

In addition to offering much-needed treatment alternatives to individuals in the community, the hope is that the clinical research platform will also help inform the development of different “depression profiles”.

This could assist in increasing the effectiveness of treatment in the future, by predicting who might respond best to rTMS, ECT, ketamine or other treatments, and helping to avoid the common trial and error approach that happens now.

Clinical Outcomes

- An rTMS clinic would provide fast, free, safe and effective methods to help treat chronic and treatment-resistant depression.
- Approximately 30% of patients with depression do not respond to antidepressants. But with rTMS, about 50% see a significant reduction in their symptoms – which includes 30% who achieve complete remission.
- Unlike vagus nerve stimulation or deep brain stimulation, rTMS does not require surgery or implantation of electrodes. In addition, unlike electroconvulsive therapy (ECT), rTMS does not cause seizures or require sedation with anesthesia.
- Our options are quite limited when treating youth with depression. Youth who take antidepressant drugs may experience behavioural, emotional and physical changes that

may put them at an increased risk of self-harm or harm to others. rTMS as an alternative to drug interventions would be very useful for our youth patients.

- Many elderly patients are limited in their use of antidepressant drugs because of poor kidney or liver function. rTMS as an alternative to drug interventions would be very useful for our elderly patients.

Future Impact

- Improved access to specialized services that are safe, non-pharmacological, non-invasive and Health Canada approved
- Improved access to innovative treatment option
- Capacity building to manage mental health in local environments
- Leadership in innovative care
- Innovative and bi-directional translational research built-in (synergy for outcomes)

Clinical Biomarker Discovery $4 million

Brief Description

Mental health research can make a difference in people's lives, but we still have a lot to do, as our field is not yet as advanced as others (e.g. cancer or cardiovascular diseases). Just as cancer may manifest itself in different ways from one person to the next and just as a treatment for one person may not be the right treatment for someone else, people with depression – and other mental illnesses – respond differently to different treatments. We do not yet understand enough about all of the causes of mental health problems, how we might prevent them, and how and why treatments and interventions work.

Unlike other diseases, there are no approved clinical tests (ex. blood and pathology) for mental health disorders beyond self-reporting and evaluation. People living with mental illness often have to try multiple treatments to find one that works, often through a time-consuming and difficult process. There is a clear need and urgency for accurate and rapid treatment options. To do this, we must identify objective measures that can reflect how someone will benefit from a specific treatment.

These objective measures - called "biomarkers" – are biological and measurable indicators that reflect the severity or presence of a disease. In other words, biomarkers are physical indicators that can help in the diagnosis of particular mental illnesses and in treatment selection, as clinicians become able to quickly and reliably identify the right therapy for the right patient.

This approach has led to breakthroughs in are for cardiovascular diseases, cancer, or infectious diseases – as mental illnesses are physical diseases of the brain, impact of biomarker discovery in mental health care should be no exception.

Integration of Care and Research

Leveraging The Royal's Brain Imaging Center, through advanced neuroimaging and clinical measures, researchers are able to physically examine and research the brain to identify biomarkers, which are they tested and validated for a specific condition and through clinical trials. These studies are linked with a number of clinical programs, including: Schizophrenia, Operational Stress Injury, Geriatrics, and Mood and Anxiety.

For instance, Dr. Clifford Cassidy is collaborating with the Schizophrenia clinical program on his groundbreaking discovery of a clinical biomarker in schizophrenia. Indeed, leveraging brain imaging, he and his team have identified a compound that is an indicator of psychotic symptom severity in people with schizophrenia. We have now an opportunity to expand on this vital biomarker research in schizophrenia as well as into other mental health disorders such as treatment resistant depression, attention deficit hyperactivity disorder, addiction, post-traumatic stress disorder, dementia, and Alzheimer's to name a few.

As another example, a translational team led by Dr. Jennifer Phillips, with Dr. Zachary Kaminsky and Dr. Katherina Nikolitch (Mood and Anxiety Program), investigate the use of magnetic resonance imaging (MRI) to characterize suicidal thoughts and behaviours in the brain and examine clinical and psychosocial determinants to identify gender-specific risk factors for suicidal behaviours.

Some examples of projects may include:

- Clinical Research Chair in Schizophrenia: research chairs create, mobilize and translate knowledge. As leaders in their fields, Research Chairs play a critical role in growing our knowledge base and capacity. The Chair in Schizophrenia would be expected to create a centre of excellence and attract additional investments, including for The Royal's Brain Imaging Centre.
- Research in NM-MRI: A type of magnetic resonance imaging called neuromelanin-sensitive MRI (NM-MRI) has previously been effective in showing neurodegeneration (loss of function of neurons) in patients with Parkinson's disease, but its utility has never been demonstrated in individuals without neurodegenerative illnesses, including mental illnesses — *until now*. A team of researchers, led by The Royal's Dr. Clifford Cassidy, has discovered that NM-MRI can, in fact, serve as an effective biomarker of dopamine function in individuals with psychosis. This technique could be revolutionary for the diagnosis and treatment of schizophrenia and other mental illnesses. In collaboration with the Schizophrenia clinical program, our Institute of Mental Health Research would now like to expand research using NM-MRI as a noninvasive proxy measure of dopamine function in the human brain. This research initiative will also branch out to research and care in healthy aging and in Parkinson's disease (link with Geriatrics).
- Rapid and effective antidepressants / pharmacological therapies for treatment resistant depression. This translational research investigates how current antidepressants act on brain chemicals so that they can be used more effectively in combination with other medications, as is the case for the standard dual or triple therapy approach to asthma or HIV.

Future Impact:

There is a clear need and urgency for accurate and rapid treatment options. Objective measures will help in the diagnosis of particular mental illnesses and in treatment selection, as clinicians become able to quickly and reliably identify the right therapy for the right patient.

Holistic / Whole Body Approaches **$3 million**

Brief Description

Mental illnesses are complex conditions and co-morbidities are frequent. Therefore, it is imperative to consider conditions holistically, rather than examining illness determinants in silos. Holistic approaches – also called 'whole body approaches' - provide an opportunity to address mental health conditions in a person as a whole, integrating the many aspects of the condition.

In addition, through broad clinical data collection powered by predictive analytics/AI, we know that illness profiles can be generated with the ultimate goal to create effective and individualized treatments.

Altogether, our goal is to collect and integrate various data sources, including clinical and demographics data through electronic health records, social determinants, and biological determinants (through imaging, genetic and epigenetic measures / biomarkers) for better diagnosis and treatment options. This integration will leverage IT technologies, data mining and AI/machine learning will generate advanced predictive tools for improving mental health care access and outcomes.

Integration of Care and Research

A suite of projects are envisioned in co-design with clinical programs, including Mood and Anxiety, Schizophrenia, Operational Stress Injury, and can be expanded to all programs.

Examples include:

- Improving clinical outcomes for inpatients. This project is to develop, validate and implement algorithms to predict clinical outcomes for individuals admitted to inpatient psychiatric units in tertiary care centres. Pairing population health data with electronic medical record data collected during inpatient stays at the Royal, we will be able to examine clinical and psychosocial factors affecting outcomes, rates and pathways to readmission and post-discharge suicide risk. A particular focus will be paid to identifying gender-based risk factors and barriers to accessing care.

- Preventing recurrence of mood and anxiety disorders. This project focuses on developing and implementing risk predictive tools for recurrence of mood and anxiety disorders. Mood and anxiety disorders are the most prevalent mental health problems in the community. The tools will enable clinicians to estimate the client's probability of recurrence in the future, and thereby facilitate clinical decisions on:

    1) the timing of discharge

    2) need for intensive follow-up treatment

    3) communication with health professionals in the community for collaborative care.

With better management informed by the tools, recurrence can be reduced, which will have a direct positive impact on wait-time to care. To develop the tools, we plan to follow a cohort of 3,000 patients for 3 years.

- **Novel suicide surveillance and prevention system.** This project focuses on using advanced machine learning technique to:

  1) monitor suicide risk in the community and pairing hot spots of risk with increased gate keeper training through efforts at Suicide Prevention Ottawa

  2) triage and prioritize potential high risk clients to care

  3) using social media data, to monitor periods of elevated risk post discharge in clients at The Royal and youth in CHEO's inpatient psychiatry.

The ultimate goal of these efforts will be to translate novel analytics into decision support tools to be used by front line clinicians to augment decision making.

- **Multidimensional Assessment of PTSD subtypes.** The OSI clinic and the IMHR have partnered to create an efficient multimodal diagnostic classification model based on an extensive range of objective measures to identify dissociative post-traumatic stress disorder (PTSD). Indeed, trauma-exposed Canadian Armed Forces (CAF) members and veterans may experience operational stress injuries; but disentangling PTSD from other mental disorders can be challenging. Proper identification is critical to optimized interventions, which is further complicated by the recently defined dissociative PTSD subtype. There is an urgent need for reliable objective biomarkers that are PTSD-specific and sensitive to identifying this new dissociative subtype in order to: rapidly and efficiently identify affected individuals, better characterize functional impairment levels, and orient appropriate management strategies.

Future Impact:

This suite of projects will produce predictive tools to aid clinical decision making and communication, to increase client recovery speed, to promote tailored follow-up care, and to reduce the likelihood of relapse and re-admission. It is clear that faster recovery and reduced recurrence and readmission can contribute to better prognosis, better access to care, and more cost savings.

This line of projects also builds on the partnership established between The Royal, Ontario Shores and Waypoint in the context of the Electronic Health Record platform.

The Royal has identified ten initiatives that will be our priorities for our Campaign for Access:

Priorities	Total
Improving Access	
Prompt Access Clinic	*$10M*
Building Capacity to Improve Access	*$1.5M*
Supporting the Underserved	*$3M*
	$14.5M
Strengthening our Community	
Building Skills for Concurrent Disorders	*$2M*
Regional Psychosis Program	*$4M*
Living well to 100…	*$2M*
	$8M
Innovative Care	
Esketamine Clinic – A Novel Treatment for Depression	*$3M*
rTMS Clinic	*$1M*
Clinical Biomarker Discovery	*$4M*
Holistic/Whole Body Approaches	*$3M*
	$11M
Campaign Expenses	**$5M**
TOTAL COST	**$38.5M**

This is The Royal's ambitious plan to improve access to mental health and addictions care for our patients, their families, and our community partners by **improving access** to care, **strengthening our community** and providing **innovative care**.

The Royal Mental Health - Care & Research Santé mentale - Soins et recherche	**MINUTES** **NOTICE OF MEETING** **ROYAL OTTAWA HEALTH CARE GROUP** **QUALITY COMMITTEE** **March 5, 2020, at 4:30 p.m.** **By teleconference:** ***Dial-In: 1-888-875-1833;*** ***Passcode: 926707277#*** ***For those on site:*** **Executive Boardrooms 2426-1,2&3**	○ Oral presentation ● Paper enclosed ●● Paper to follow ●●● Paper at meeting **IN** Information **DEC** Decision required ** Guidance required *** Discussion

Present	Regrets	Present	Regrets	
L. Leikin, Chair I. Levy phone J. Gallant phone J. MacRae phone G. O'Hara M. Langlois *Ex-officio members:* A. Graham, Chair of Board phone J. Bezzubetz E. Millar phone T. Lau	D. Somppi, Vice Chair R. Bhatla E. Deacon	C. Crocker phone D. Simpson S. Farrell F. Dzierszinski		P. Sedge, Observer P. Robb, Scribe

#	ITEM	REFERENCE	ACTION REQUIRED
1.	**CALL TO ORDER**	L. Leikin, Chair, called the meeting to order at 4:32 p.m. and declared it to have been regularly called and properly constituted for the transaction of business.	
2.	**WELCOME & INTRODUCTIONS**	The Chair welcomed everyone to the meeting and introduced those who were at the table for the benefit of the members who joined by teleconference.	
3.	**AGENDA AND PREVIOUS MINUTES**	a) Acceptance of Agenda	
		Moved by A. Graham and seconded by J. Gallant **BE IT RESOLVED THAT** the March 5, 2020 agenda be accepted as presented. **CARRIED**	
		b) Approval of Previous Minutes	
		Moved by A. Graham and seconded by J. MacRae **BE IT RESOLVED THAT** the previous minutes of	

		February 4, 2020 be approved as amended. **CARRIED**	
4.	**DECISION/ INFORMATION ITEMS**	To Review 2020-2021 Quality Improvement Plan (QIP)	
		The indicators were reviewed one by one with an opportunity for comments and questions from the room and form those who joined by teleconference. Indicator #1 regarding clinical research projects involving clients and family: F. Dzierszinski provided a background on this item. After discussion and input from the Committee, D. Simpson and F. Dzierszinski will work on the language for a process indicator that would help to identify additional processes that will help enable further research. Indicator #2 regarding the incorporation of palliative training for ROP: Committee members agreed the rationale was quite clear and the indicators in process improvement are evident. D. Simpson mentioned that the baseline is currently zero, however, due to the limitations in how data can be inputted into the HQO online system, it reads as CB = Collecting Baseline. Indicator #3 regarding the Medication Reconciliation indicators: P. Sedge spoke to this item. Medication reconciliation in the ambulatory care setting has been on the QIP before in different ways. It was seen as being important enough at the staff and medical level for us to continue to focus on its implementation. There was robust discussion on this item. The Committee agreed to leave it to staff to implement the best measurement to make it impactful, but a question was raised whether the target of 90% was achievable. The team was comfortable they could now meet the target with two new pharmacy techs in place. D. Simpson noted that the baseline number came from manual audits from programs last year, however, this year a report from the E.H.R. will be built. This will increase the denominator significantly and may provide new data that may be different than our current performance. Indicator #4: The number of programs who have implemented clinical outcome measurement: S. Farrell spoke to this item. A timeline of 'by March 31, 2021' should be added to the process measure column. The Committee members agreed that adding this specificity was helpful. They also wondered if as part of this we can identify that each program has a mechanism to assist with the implementation of this indicator. This could be identified in some of the process comments throughout the year. A current inventory of program	D. Simpson F. Dzierszinski D. Simpson D. Simpson

		evaluation resources in the organization is underway and will then help senior leaders have a conversation about resourcing for this initiative. Language will also be added to identify strategies that will sustain this indicator. Indicator #5 regarding the percentage of inpatients with a Clinical Assessment Protocol: Our Decision Support department is working in collaboration with partner sites (Waypoint/Ontario Shores) on the report for this indicator. D. Simpson hoped to be able to have baseline data available by the end of next week, and will add it to the QIP if received in time. Indicator #6 regarding workplace violence. C. Crocker noted that this is an area where all mandatory training is in place and there is an automated system that tracks all workplace violence incidents. The Ministry of Labour pays a lot of attention to workplace violence. There is a cooperative environment with management and the union making sure we are doing the right thing. The QIP Narrative was then looked at and it was agreed no changes were required. D. Simpson advised the Committee that HQO have redesigned the template and going forward it will be in a new format with a larger font. The same information will be used that was approved today, but it will look different. The team was thanked for their willingness to approach this differently than in years past. The experience has been more collaborative, open and more informed. Moved by A. Graham and seconded by I. Levy **BE IT RESOLVED THAT** the **2020-2021** *Annual Quality Improvement Plan* be accepted as amended and brought forward to the next Board of Trustees meeting for approval. **CARRIED**	D. Simpson
5.	**ADJOURNMENT**	Next meeting: June 1, 2020	

L. Leikin
Chair

J. Bezzubetz
Secretary, Board of Trustees

Quality Meeting Action Items

Item #	Action Item	Individual Responsible	Status
	March 5, 2020		
	To update language on the 2020-2021 Quality Improvement Work Plan as amended in minutes above.	D. Simpson F. Dzierszinski (for indicator #1)	Before end of March 2020
	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 COMPLETED 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	K. Lepinskie D. Simpson P. Robb	COMPLETED December 2, 2019 Quality

	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.		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

OTTAWA HEALTH CARE
GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 46	**Priority:** Important

DATE: March 26, 2020
COMMITTEE: Quality Committee
PRESENTER: L. Leikin
SUBJECT: **2020-2021 Annual Quality Improvement Plan**

BACKGROUND INFORMATION:
The Quality Committee reviewed the 2020-2021 Annual Quality Improvement Plan for The Royal Ottawa Health Care Group, including Royal Ottawa Place. The Plan is in the new HQO formatting, but the content is the same as approved. The due date was April 1, 2020, but HQO has given an extension to May 1, 2020.

The Committee recommends approval of these plans

.

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT as recommended by the Quality Committee**,** the **2020-2021** *Annual Quality Improvement Plan* be approved as presented.

Moved by:
Seconded by:
Motion approved:

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 11, 2020

The Le Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

OVERVIEW

The Royal Ottawa Health Care Group ("The Royal") is made up of The Royal Ottawa Mental Health Centre, the Brockville Mental Health Centre, Royal Ottawa Place (long-term care), The Royal's Institute of Mental Health Research and the Royal Ottawa Foundation for Mental Health.
For the purposes of Quality Improvement Plan (QIP) submissions to Health Quality Ontario (HQO), we report for The Royal's mental health services (referred to in this narrative as The Royal) and our long-term care facility, Royal Ottawa Place (referred to herein as ROP). These two entities are governed by a single Board of Trustees. However, indicators and quality improvement projects for The Royal and ROP are reported separately within one QIP document to ensure clear and appropriate oversight of work undertaken.

Our Quality Improvement Plans are driven by our mission to deliver excellence in specialized mental health care, advocacy, research and education. Our 2015-2020 Strategic Plan includes five strategic domains: care, discovery, partnerships, engagement, and resources. Under each domain is a set of objectives and indicators that show how we are progressing in our mission. Everything we do is guided by the strategic plan and supportive of the objectives set out within.

https://qipnavigator.hqontario.ca/images/NarrativeImages/61217_202021413521_1.jpg

The Royal's 2020-2021 QIP indicators incorporate opportunities for improvement that were identified through a data driven review of the Client Experience Survey, the Family Satisfaction Survey, our Staff/Physician Engagement Survey, accreditation standards and aggregated (critical) incident data.

The 2020-2021 QIP was developed by reviewing the indicators from last year's QIP and identifying progress towards the established targets and with consultation across stakeholders. The Royal's peer hospital scorecard along with discussions amongst quality leaders were used to ensure common comparable indicators and benchmarks where available. Our peer organizations include Waypoint Centre for Mental Health Care, Ontario Shores Centre for Mental Health Sciences and the Centre for Addiction and Mental Health (CAMH).

DESCRIBE YOUR ORGANIZATION'S GREATEST

QI ACHIEVEMENT FROM THE PAST YEAR

This year was a transformational year at The Royal with the completion of the Transforming Care at The Royal project, which implemented the Mental Health Information System (MHIS) with our mental health partner sites, Waypoint and Ontario Shores. The new electronic health record allows The Royal to track our improvements through data in ways that were not possible in previous versions of the record, or with paper charting. Furthermore, The Royal now shares its electronic health record with two other mental health hospitals in Ontario, which helps to ensure that mental health clients are receiving the same quality of care across the three partnered sites.

The Royal is also particularly proud of achieving Exemplary Status from Accreditation Canada this year, by achieving 99.9% of their criteria. In order to prepare for Accreditation, program level teams were established to help review the Accreditation standards and criteria. This led to tremendous engagement from the program teams and numerous initiatives were undertaken to improve the quality of care at the program level. The program level Accreditation teams have now transitioned to be Quality Improvement teams, which helps to further embed The Royal's commitment to quality improvement in each and every program.

Finally, the Mood and Anxiety Outpatient program had a wait time of one year in the first quarter of 2018-2019. Over the last two years, the program has made large improvements in reducing its wait times by refining its admission criteria, recruiting more psychiatrists, and partnering with community programs such as Bounceback and Big White Wall for eligible referrals. As of the third quarter of 2019-2020, the wait time is now one and a half months, which is a significant improvement compared to the wait time of two years ago.

COLLABORATION AND INTEGRATION

All programs at The Royal work collaboratively with our partners in the Champlain region, provincially, and nationally. As the region's provider of specialized mental health services, The Royal has placed considerable focus on building capacity within our primary and community health care partners to ensure that our clients' mental health needs are adequately met. These efforts have resulted in many clients of The Royal receiving excellent care in the community rather than readmission into our facility.

The Royal is also a partner in the Champlain Pathways to Better Care initiative. Pathways works with others to implement coordinated changes to the Champlain mental health and addictions system, leading to improvements for those with lived experience and their families. Initiatives include psychiatry recruitment, wait time analysis, primary care partnerships, collaborative care planning and regional psychosis care.

The introduction of Ontario Health Teams (OHT) will allow for further collaboration across sectors. The Royal is a collaborating partner on many OHT applications, including one that has already received funding to move forward.

PATIENT/CLIENT/RESIDENT PARTNERING AND RELATIONS

The Royal continues to work at engaging clients throughout the hospital in our quality improvement initiatives. Client representation has been embraced in our quality of care culture with active client membership on our Accreditation and Quality Improvement teams. - For example, the Brockville Forensic Treatment Unit listened to clients, families and staff who wanted fencing, barbed and electrical wire removed from the outside of their facility to make it more welcoming and resemble the kind of therapeutic care and treatment provided within its walls. The Brockville site continues to work with The Royal's Foundation, and client and family advisors to renovate space that will serve as an inviting client and family meeting room, positioned at the front entrance of the facility.

At the Ottawa site, client and family advisors engaged with the Institute for Mental Health Research in a day of learning and sharing of ideas about how to improve client engagement in the co-design of research. Client advisors have since been engaged in the co-design of a project on the treatment of opioid use disorders. Family advisors were also keen to engage in and share in the direction of research that would impact families.

Client and family advisors continue to engage on committees at the corporate level and feature most importantly on the Client and Family Centred Care Committee along with staff representing various program and voices from the Senior Management Team. Additionally, the Chairs of the Client Advisory Council and the Family Advisory Council now have a formal guest seat on The Royal's Board of Trustees.

WORKPLACE VIOLENCE PREVENTION

Workplace violence prevention is a strategic priority at The Royal. With the support of the Violence in the Workplace Prevention Committee and the Joint Health and Safety Committees, The Royal has implemented and adopted new programs, updated policies and is providing additional mandatory training for staff to ensure that they recognize and respond to escalating behaviours and physical aggression appropriately. The Royal continues to benchmark itself against peer hospitals to ensure best practices and innovative programs are implemented, monitored and evaluated in addition to fully meeting the legal requirements of Section 32 of the Occupational Health and Safety Act. At the Royal, Patient and Employee safety remain a top priority. With the implementation of our a new incident reporting system (CSIF), we have seen an increase in incident reporting which has provided us with information to identify various risks and close identified gaps. Patient Safety and Employee Safety key performance indicators that are reported quarterly to the Senior Management Team, the Quality Committee of the Board and the Board of Trustees, in addition to being posted on the Royal's intranet which is available to all staff. The following strategies have been implemented to improve performance outcomes:

- Departmental Violence Risk Assessment and development of safety and security plans for staff
- Routine gap analysis on current policies and programs using PSHSA documents as benchmarks to identify areas for improvement
- Implementation of the 23 recommendations from the provincial Leadership Table for WVP
- New training tools are continually being explored.
- New Respectful Workplace/WVP signage through the WVP Committee.
- Post-incident investigations to identify root causes and action plans to avert recurrence.
- Provision of radios as a safety device
- Community programs adopting risk assessments such as the AIS scale to help identify escalating behaviour in community patients.
- Red Phones installed at Carlingwood site
- Safety and Security Plan Templates created

VIRTUAL CARE

The Royal has invested in virtual care through virtual visits, online scheduling, training and e-consultations, . Our telemedicine program has been providing virtual mental health services for over 10 years and is now offered to 186 primary care providers in 15 communities in the Champlain Region. Telemedicine creates access and allows The Royal to provide specialized mental health care to individuals in their own community, reducing wait times and travel to care. With a wait time of no more than four weeks to see a virtual community psychiatrist, patients are able to see a psychiatrist in their home, community centre, doctor's office or location of choice. The program also offers capacity building and educational sessions for primary care. In 2018-2019, the program reached over 7,066 patients, with patient's' and provider's rating their satisfaction with the virtual care experience at over 95%

The Northern Ontario Francophone Psychiatry Program provides psychiatric care to designated francophone communities in Northern Ontario. Our French speaking psychiatrists maintain ongoing liaison with the community they serve, providing clinical support to patients either on site or via telepsychiatry. They also provide health care practitioners working in underserviced areas with readily available consultation by phone for challenging cases, and education and training to local medical practitioners and other mental health professionals.

The Increasing Access to Structured Psychotherapy (IASP) program provides training in cognitive behaviour therapy protocols to 10 partner sites and consultations with our IASP trained Psychologists. The Royal, as the training hub, provides all training and supervision virtually. An online scheduling system connects all clinicians and is able to book directly into the calendars of al 30 therapists in the community. The program regularly offers therapy to clients via telemedicine. An online documentation tool to share information and track our outcome measures is used, and allows clients to track their progress and submit self-rated tools through their computer or phone. All referrals to the program can be completed online allowing primary care providers to use their electronic health records versus faxing paper referrals. This online referral platform permits communication between The Royal and primary care providers, ensuring that there is timely communication between providers.

EXECUTIVE COMPENSATION

The Royal has a performance-based compensation plan in place for the Senior Management Team which includes: the Chief Executive Officer; Chief of Staff and Psychiatrist-in-Chief; Chief Operating Officer and Chief Financial Officer; Vice President, Professional Practice and Chief Nursing Executive; Vice President, Patient Care Services and Community Mental Health.

Accountability for the execution of both the annual QIP and the Strategic plan are delegated to the Chief Executive Officer from the Board of Trustees. The plans are reviewed, approved and monitored by the Board of Trustees through performance evaluations of the Chief Executive Officer which is cascaded to the parties listed above. It is the sum of all objectives in these plans that determine the performance pay component of The Royal's Executives. As per Regulation 304/6 of the Broader Public Sector Executive Compensation Act, 2014 (BPSECA), The Royal developed an Executive Compensation Framework.

The Royal has allocated 25% of the performance-based pay to the Quality Improvement Plan, with allocation to all 8 initiatives developed under the quality dimensions of QIP for The Royal and Royal Ottawa Place. Specifically, 25% is allocated to each of the indicators as outlined below:

	Indicator	Allocation
1	% of inpatients with a Clinical Assessment Protocol (CAPS) from the Recovery Plan of Care tool updated within 28 days	3.57%
2	% of medication reconciliation completed in ambulatory care where medication is a large component of treatment (Schizophrenia/Mood & Anxiety/Geriatric Psychiatry) as a measured by the % of BPHM completed by a pharmacy technician or nurse on all new referrals to the program	3.57%
3	% of medication reconciliation completed in ambulatory care where medication is a large component of treatment (Schizophrenia/Mood & Anxiety/Geriatric Psychiatry) as measured by the % of BPHM confirmed by the attending physician	3.57%
4	Number of clinical programs who have implemented clinical outcome measurement that is both clinically appropriate to the client population and evidence based that is reviewed on a quarterly basis to drive service improvement	3.57%
5	% of clinical research projects involving clients and families at The Royal	3.57%
6	% of documented assessment of palliative care needs among residents identified to benefit from palliative care	3.57%
7	Number of workplace violence incidents (overall)	3.57%
Total		**25%**

CONTACT INFORMATION

Danielle Simpson
Director, Quality and Patient Safety
danielle.simpson@theroyal.ca

SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on _____

_____
Board Chair

_____
Board Quality Committee Chair

_____
Chief Executive Officer

_____
Other leadership as appropriate

_____

Theme II: Service Excellence

Dimension: Patient-centred

Measure

Indicator #1	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of clinical research projects involving clients and families at The Royal	C	%	In house data collection / April 2020-March 2021	51.00	61.00	Aiming to increase the involvement by 10% over the course of the year is realistic.	

Change Ideas

Change Idea #1 1) Launch the Permission to contact database to allow researchers larger access to clients who are willing to be involved in research. 2)Launch the Ask Me campaign to help clients know more about research taking place at The Royal and make research more visible at The Royal. 3)Regularly disseminate the active studies list that are currently recruiting clients at The Royal to increase research participation 4)Promote the online portal as a means to participate in research

Methods	Process measures	Target for process measure	Comments
The coordination of these activities will be handled through the Institute for Mental Health Research	Number of recruited and trained research ambassadors. % of clients who give permission to be contacted. Number of website registrations	40% of clients saying yes to the permission to contact (national average is 40%). 100% of programs have an identified research ambassador for the Ask Me campaign	This is a new indicator and reflects the ongoing efforts to integrate The Royal's research with clinical care.

Theme III: Safe and Effective Care

Dimension: Effective

Measure

Indicator #2	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
The proportion of residents with a progressive, life-limiting illness, that are identified to benefit from palliative care, who subsequently have their palliative care needs assessed using a comprehensive and holistic assessment. (Royal Ottawa Place)	P	Proportion	Local data collection / Most recent 6 month period	CB	1.00	It is the expectation that all residents have a palliative care conference. This is a change in practice which is why the baseline is currently at 0%. We have identified that our residents are aging and experiencing a need for palliative services, as traditionally our population has been quite young given their diagnosis of mental health.	

Change Ideas

Change Idea #1 Add the Palliative Performance Scale into Point Click Care. Perform education sessions for registered staff regarding completing the Palliative Performance Scale

Methods	Process measures	Target for process measure	Comments
Utilize PALMS and in-person training to ensure this is complete. Engaged the interdisciplinary working group in the implementation of all activities.	Percentage of staff trained on using the Palliative Performance Scale	100% of registered staff will have completed training on the Palliative Performance Scale by the end of 2020.	

Change Idea #2 Adapt our current care conference template to incorporate palliative services for the residents and families

Methods	Process measures	Target for process measure	Comments
Work with the interdiscplinary working group to ensure this is complete.	% of residents that have a palliative performance scale completed	100% of residents have a palliative performance scale completed on admission, quarterly and annually	

Change Idea #3 Training of registered staff on end of life medications. Training of PCAs on providing comfort care.

Methods	Process measures	Target for process measure	Comments

Utilize PALMS and in-person training to ensure this is complete.	% of staff who have completed this training	100% of registered staff will have completed training on end of life medication by the end of 2020. 100% of PCAs will have received training on providing comfort care by the end of 2020.	

Change Idea #4 Partner with volunteer resources to provide more comfort care

Methods	Process measures	Target for process measure	Comments
Reach out to volunteer resources to identify people who are available to provide comfort care	Number of volunteer resources partnered with us	Two volunteer resources have partnered with us to provide more comfort care by the end of 2020.	

Measure

Indicator #3	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of inpatients with a Clinical Assessment Protocol (CAPS) from the Recovery Plan of Care tool updated within 28 days	C	%	In house data collection / 2020-2021	CB	CB	The target will be set once the report is ready in the electronic health record.	

Change Ideas

Change Idea #1 1) Scan the current utilization and uptake of the tool 2) Support teams in using the tool at the Kardex meetings 3) Relaunch the tool with wide scale education 4)Build E.H.R. reports that allow us to pull process and outcome measures on the tool

Methods	Process measures	Target for process measure	Comments
Professional Practice will lead an inter-program working group to operationalize the planned improvement initiatives. Decision Support will work closely with this group to ensure that data is available to guide the work.	1)% of programs who have Professional Practice attend their program meeting to educate about the tool 2) % of programs who have Professional Practice come to educate on on how to use the tool in Kardex meetings	100% of programs will have Professional Practice attend their program meetings to educate about the tool and learn about how to use in Kardex meetings	This indicator will help ensure that the CAPS are updated at least once during each 28 day period.

Measure

Indicator #4	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of medication reconciliation completed in ambulatory care where medication is a large component of treatment (Schizophrenia/Mood & Anxiety/Geriatric Psychiatry) as measured by the % of BPHM completed by pharmacy tech on all new referrals to program	C	%	In house data collection / April 2020-March 2021	CB	90.00	The report for the E.H.R. for this indicator is being developed therefore baseline is unavailable. The target is in alignment with the efforts from the 2019-2020 year on medication reconciliation	

Change Ideas

Change Idea #1 1) Establish a pharmacy technician role in central intake 2)Pharmacy technician providing services to each program on designated days to assist with reconciliation

Methods	Process measures	Target for process measure	Comments
Working with an interdisciplinary working group, the group will ensure the implementation of the change initiatives.	% of patients who have a Best Possible Home Medication list completed at their initial appointment	90% of ambulatory care initial appointments will have a Best Possible Home Medication list completed	This remains a continued focus for the organization as a similar indicator was on our QIP last year.

Measure

Indicator #5	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of medication reconciliation completed in ambulatory care where medication is a large component of treatment (Schizophrenia/Mood & Anxiety/Geriatric Psychiatry) as measured by the % of Best Possible Home Medication list confirmed by attending physician	C	%	In house data collection / April 2020-March 2021	48.00	90.00	This target is in alignment with the ongoing work and improvement that occurred in 2019-2020 on medication reconciliation.	

Change Ideas

Change Idea #1 1)Identify and educate clinicians or programs with a pattern of low reconciliation rates 2) Review and update the ROH Policy on Med Re to identify ambulatory programs where medication is a major component of treatment and to outline the frequency of medication reconciliation

Methods	Process measures	Target for process measure	Comments
Working with an interdisciplinary working group, the group will ensure the implementation of the change initiatives.	Number of physician education sessions on the importance of confirming the BPMH as part of the med rec process.	Target will be set as a result of identified physician education needs	Med rec in the ambulatory care setting continues to be a priority for the organization

Measure

Indicator #6	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of programs who have implemented clinical outcome measurement that is both clinically appropriate to the client population and evidence based that is reviewed on a quarterly basis to drive service improvement	C	Number	In house data collection / April 2020-March 2021	CB	11.00	It is the expectation that all programs will review their data on a quarterly basis to drive service improvement	

Change Ideas

Change Idea #1	1) Develop an understanding of measures that are already being collected but not analyzed 2)Work with Decision Support to identify clinically appropriate and evidence based measurement available in the electronic health record 3) Conduct education and training with staff to ensure they are aware of which scales in the E.H.R need to be completed 4) Develop a mechanism to consistently analyzed and share the outcome measurement data 5)Complete a review of the resources necessary to sustain the work

Methods	Process measures	Target for process measure	Comments
Quality Team will be working with each program on a monthly basis to help implement and utilize the outcome measurement data.	Number of programs who have identified an outcome measurement for their client population	All programs should have identified an outcome measurement for their client population by March 31, 2021.	

Measure

Indicator #7	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	M	Count	Local data collection / Jan - Dec 2019	772.00	792.00	The current performance is based on in-house staff and patient safety incident reporting systems within a 12 month period. The new Client Staff Incident Feedback System (CSIFS) was introduced in April 2019, and it captures staff and patient incidents at the same time unlike the two previous systems that were not talking to one another. The new system is also easier to use, hence we did see a consistent increase in incident reporting throughout 2019 as compared to 2018. This trend is expected to continue and as such a new target of 792 is being forcasted for 2020 - a 2.5% increase. Though, we want to encourage reporting, we at the same time want to control critical injuries and significant events.	

Change Ideas

Change Idea #1	1) Encourage new-hires, students, volunteers and ROHCG staff to report all incidents including near misses. 2. Zero Tolerance Signs posted at main entrances and other vantaged areas to communicate values of The Royal. 3. In addition to NCI, specialized and advanced training modules such as Sharp-Edge Weapons Defence, Applied Physical Training, Supervisor Competency Training and Safewards are provided for staff at high risk in-patient units 4. OHSS to continue its departmental risk assessment and to develop action plans to control identified hazards/risk. 5. Benchmark with other mental health institutions to adopt and implement innovative programs. 6. Perform Gap Analysis and implement 23 recommendations from Health Care Workplace Violence Prevention Leadership Table 7. Encourage and promote safety huddles in all in-patient units 8. Promote the use of Violence Aggression & Assessment Checklist (VAAC) when admitting new clients 9. Identify root-cause of all incidents and develop action plans to avert recurrence. 10. Promote peer-support and psychological health and safety 11. Encourage reporting by instituting the Ellis-Don -"Don't Walk-By Program" or "The Good Catch" that reward incident and hazard reporting.12. Institute Internal Responsibility System (IRS) & Safety Culture

Methods	Process measures	Target for process measure	Comments

Engage the following stakeholders to work together and to implement recommended initiatives to increase reporting and to reduce incidents of violence in the hospital: JHSC, WVPC, SMT, Managers/Directors	(1) Percentage of Threat, Assault, Agression Incident reports (broken down by actual and near miss reporting) (2) # of Good Catch- Award receipients (2) Number of inspections, assessments, audits completed vs. planned. (4). # of Safety meetings and training conducted vs. planned (5). Percentage of incidents, reports investigated (6). Percentage of unit risk assessment completed (7) Percentage of corrective actions remediated on time (8) Percentage of Health Care Workplace Violence Prevention Leadership Table Recommendations implemented (9) Percentage of reported incidents followed up and closed-off	100% of staff have completed their mandatory safety training, including new-hires, contractors, volunteers, and students.	FTE=976 Continue to work on the reporting culture while focusing additional strategies to decrease critical incidents. We expect this will keep the total number of events stable year over year.

The Le Royal
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ROYAL OTTAWA HEALTH CARE GROUP
MINUTES
MEDICAL ADVISORY COMMITTEE MEETING HELD
January 16, 2020 – 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**	
S. Gulati, Chair P. Sedge T. Lau L. McMurray D. Attwood G. Motayne M. Willows M. Tremblay J. Gray *Ex-officio Members:* E. Millar A. Winter D. Simpson T. Burta	R. Bhatla A. Khan G. Beck C. Ripley J. Shlik K. Huntington J. Bezzubetz S. Farrell	F. Dzierszinski C. Crocker	D. Munroe	C. Gemmell D. Klym **SCRIBE** S. Holierhoek

	AGENDA ITEMS		ACTION REQUIRED
1.	**CALL TO ORDER**	The meeting was convened at 9:30 am. E. Millar agreed to monitor the meeting discussion based on the Royal's Ethics Framework for Decision Making.	
2.	**OPENING REMARKS**	S. Gulati chaired the meeting in R. Bhatla's absence. Due to inclement weather, the meeting start time was delayed to 9:30 am. Every effort will be made to cover the agenda during this abbreviated meeting.	
3.	**PRESENTATION**	a. Occupational Health & Safety – Mandatory Physician Training for 2020 D. Klym reviewed the amendments to the continuing education and mandatory training for 2020 for current and	

		new physicians. Their were no major changes to the training content and as such these training modules will be posted on OREO for completion in 2020. A copy of the presentation material was included in the meeting package.	
		BE IT RESOLVED THAT the proposed Mandatory Physician Training for 2020 be accepted as presented. **Moved: P. Sedge** **Seconded: M. Willows** **CARRIED**	
		b. Capital Campaign – Case for Support C. Crocker reviewed the Foundation Capital Campaign proposed project list which was distributed to members via email at the meeting. The purpose of the overview was to seek agreement to proceed with the projects presented. Discussion ensued. There were no objections to the project list. The project list document emailed to MAC members will be distributed with the meeting minutes.	
4.	**CONSENT AGENDA**	**BE IT RESOLVED THAT the consent agenda, including the items outlined therein, be accepted as presented.** **Moved: M. Willows** **Seconded: M. Tremblay** **CARRIED** The following motions were included in the Consent Agenda: i. Acceptance of agenda of January 16, 2020 meeting ii. Approval of minutes of December 19, 2019 meeting iii. Joint Delegated Medical Advisory Group (JDMAG) Agenda & Minutes of December 19, 2019 – Draft iv. Corporate Protocol – ROHCG: Anaphylaxis – Guidelines for Management (Rev. Nov 28, 2019)	
	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. QIP Indicators for 2020 & 2021	
		Deferred.	
7.	**STANDING REPORTS**	**ADVISORY COMMITTEE REPORTS**	
		a. Credentials Committee – G. Motayne	
		G. Motayne reported for this Committee.	

		The November 29, 2019 minutes were included in the meeting package.	
		i. Appointments & Privileges Applications to Medical Staff	
		BE IT RESOLVED THAT as recommended by the Credentials Committee, to recommend the approval of the Appointment to Medical Staff & Privileges Application for: - Dr. Sharon Levine, Psychiatrist, Primary Part-Time, Geriatrics Program, effective December 18, 2019. **Moved: D. Attwood** **Seconded: T. Lau** **CARRIED**	
		b. Integrated Ethics Committee – D. Simpson, N. Lukich	
		D. Simpson reported for this Committee. - Feedback from the accreditation audit suggested The Royal should include ethics discussions for frontline staff. The Committee is working to develop a series of case examples that could be discussed by the programs. - It was suggested that these conversations could be integrated into program rounds. The September 16, 2019 minutes were included in the meeting package.	
		c. Medical Services Committee – A. Winter, B. Pryer	
		A. Winter reported for this Committee. - Flu outbreaks are occurring in various facilities throughout the city, particularly in the geriatric population. Staff are encouraged to use masks and practice good hand hygiene when dealing with patients who present with flu symptoms and to work with Infection Control on containment with respect to inpatient units. - The organization continues to encourage staff to get the flu vaccine. Ottawa Public Health reports that the influenza vaccine covers 60% of influenza strains identified this year. - D. Simpson reported that work is being done to raise the organization's influenza vaccine compliance rates and a survey will be launched to help understand why some staff choose not to get or are unable to get the flu vaccine. The compliance rate for staff is currently at 50%, with a target of 58%. The compliance rate for inpatients is 50%, and we are currently 85% of the	

		way to meeting this target. It is expected we will meet the inpatient target for this flu season. - Prescribers at MAC discussed the need for dose reduction for Tamiflu for patients with renal impairment. T. Burta will submit a request to the Antimicrobial Stewardship Committee to create a guiding document to support prescribing during a flu outbreak. The November 12, 2019 minutes were included in the meeting package.	
		d. Pharmacy & Therapeutics Committee – M. Tremblay, T. Burta	
		T. Burta reported for this Committee. - Deferred The October 15, 2019 and November 19, 2019 minutes were included in the meeting package.	
		INCIDENTS REPORTS	
		e. Critical and Severe Incidents Report – D. Simpson	
		There were 4 deaths since the last MAC meeting. 1 death in Schizophrenia where a corporate level review was conducted with no recommendations forthcoming. Program level reviews were conducted for the remaining 3 deaths, all of which were due to natural causes.	
		OTHER REPORTS	
		f. Electronic Health Records (EHR) – D. Attwood	
		- Psychologists will be given access to enter the DSM-5 diagnosis into the EHR. In Ontario, clinical psychologists are permitted to perform the controlled act of making a diagnosis under the Psychology Act. S. Gulati will circulate to members the email received from Professional Practice on the matter for review and comment before sending to the physician group. - The EHR Change Request process is being modified and will result in a single manner in which to request changes to the EHR via a fillable PDF form that can be accessed on OREO. The form should be available in February or March. The new process will also allow staff to view the change requests that have been submitted which should help to reduce multiple submissions of the same request. - PCM optimization is being conducted. The 3 Mental Health Partner organizations will be integrating the clinical informatics processes in order to ensure standardization of templates and patient care across the 3 organizations.	

		- The EHR has functionality to operate a patient portal to allow patients and families access to clinical information. In the near future, conversations about what The Royal is going to allow patients and their families access to in the EHR patient portal and what changes in clinical charting practices may be necessary in this regard, is required. Dr Ilan Fischler will be at The Royal on March 3rd to speak about Ontario Shores' experience during the last five years with instituting and using the EHR's patient portal. Staff are encouraged to attend. - The MH HIS Cluster responsible for clinical informatics will now have a shared Manager who will be responsible for managing the team's people from all 3 sites. This will allow for a more cohesive work environment for the team and with the integration and standardization of documents in our shared EHR.	
		POLICIES AND PROCEDURES	
		g. CORP X-iv – 101 Levels of Activity, Authorized Leave of Absence & Unauthorized Leave (Rev. Dec 3, 2019) – S. Gulati / P. Sedge	
		To approve CORP X-iv – 101 Levels of Activity, Authorized Leave of Absence & Unauthorized Leave (Rev. Dec 3, 2019) as presented. **Moved: D. Attwood** **Seconded: T. Lau** **CARRIED**	
		EXECUTIVE REPORTS	
		h. Psychiatrist-in-Chief and Chief of Staff – R. Bhatla	
		S. Gulati updated the members on TOH's psychiatry services and bed shortages situation and The Royal's efforts to assist with the situation including opening additional surge beds until the fiscal year end. As such, The Royal's surge beds are currently full. Physicians are requested to first contact TOH before sending a patient to the ER.	
		i. President and CEO – J. Bezzubetz	
		C. Crocker provided the following updates: - With respect to the recruitment of the IMHR President and Vice President, the consulting firm, Boyden, has prepared documentation and the posting will go up next week. - The Royal's CEO and the University of Ottawa's Dean, Faculty of Medicine have received the IMHR External Review Committee's preliminary report and will meet to discuss the report. Information will be	

		shared at a later date. - As the MOH has yet to provide budget information for 2020/2021, The Royal has produced a balanced budget based on 0% funding with minimal impact on employee positions.	
		j. President of Medical Staff – T. Lau	
		The nurses have concerns with the physicians using the nurse shift report documents in the EHR. T. Lau and E. Millar will address the matter. T. Lau reiterated the importance and necessity of reviewing clinical charting practices in advance of operationalizing the EHR patient portal.	
		k. Interim Chief Operating Officer & Director, Research Development & Partnerships, IMHR – F. Dzierszinski	
		The UMRF review is progressing well. Preliminary report information will be shared in the near future.	
8.	**NEXT MEETING**	**February 20, 2020 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**	E. Millar confirmed that the meeting discussions were in keeping with The Royal's Ethics Framework for Decision Making. The Committee adhered to the ethics framework. Open discussions were held, respect was shown and others' expertise was recognized.	
10.	**ADJOURNMENT**	There being no further business, the meeting was adjourned at 10:30 a.m.	
11.	**IN-CAMERA SESSION**		

S. Gulati, Chairperson **S. Holierhoek, Secretary**

OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019 – 2020 – 47	**Priority:** Important

DATE: March 26, 2020

COMMITTEE: Medical Advisory Committee

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

SUBJECT: **Medical Staff Privileges**

BACKGROUND INFORMATION:

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 to the Board of Trustees the following candidates for Medical Staff Privileges:

- Dr. Jeewanjit Gill, GP, from Temporary to Probationary Part-Time, Royal Ottawa Place, effective immediately
- Dr. Kelly Mascioli, Psychiatrist, from Temporary to Probationary Full-Time, Youth Program, effective immediately
- Dr. Elena Paraskevopoulos, Family Physician, Locum Privileges, Central Services, effective immediately
- The following TOH Neurologists, Courtesy Privileges, EEG Services, effective immediately:
  - Dr. Rajendra Kale
  - Christopher Skinner
  - Tad Fantaneanu
  - Arezoo Rezazadeh
  - Lucian Sitwell
- Dr. Rasveg S. Grewal, Courtesy Privileges, Cardiology Services, effective immediately

Moved by:
Seconded by:
Motion approved:

OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 48	**Priority:** Important

DATE: March 26, 2020
COMMITTEE: Finance Committee
PRESENTER: J. Gallant
SUBJECT: Sinking Fund Account

BACKGROUND INFORMATION:

On March 19, 2020, the Finance Committee reviewed and voted on a motion to recommend Board approval as outlined below. This transfer will bring the sinking fund account into balance with the P3 schedule.

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT as recommended by the Finance Committee, the Board of Trustees approves the transfer of $575,572 from the Sinking Fund Account to the General Fund Investment Account.

Moved by:
Seconded by:
Motion approved:

ROHCG
P3 Sinking Fund
March 2020

- The "Sinking Fund" was set up as part of the P3 contract as a Ministry requirement to ensure The Royal had sufficient funds to cover the "local share" of the ongoing mortgage payments.

- The account was initially funded from

o Land lease payment from the Ministry	$1.3m
o Transfer from Capital Campaign	$1.8m
o Transfer from ROHCG funds	$3.3m
o Interest	$0.2m
	$6.6m

- Contribution to local share of annual payment of $1.2m.

o Land Lease payments (Government funded)	$852
o Parking	
o Retail (0)	$348
o Cafeteria (deficit)	
o 7th Floor lease of space	

- To date we have transferred $4,597,027 to bring the account into balance with the schedule and advised that we would do this annually in the future

The transfer for 2020 will be $575,572

Balance in Account (Oct 31, 2019)	$3,688,572
Required balance per P3 schedule (Year 13)	3,113,000
Transfer	$ 575,572

- We will work with CIBC to ensure a smooth transfer of funds from "Sinking Fund Investment Account" to the "General Fund Investment Account"

  The investment policy allocation is the same for both these investments.

- The only impact will be positive impact on current ratio as the Sinking Fund Investment is in long term assets and General Fund Investment in current.

- Letter attached from Perley Robertson confirming our ability to withdraw funds from the "Sinking Fund Investment Account.

PERLEY-ROBERTSON, HILL & McDOUGALL LLP/s.r.l.

Lawyers / Patent & Trade-Mark Agents
Avocats / Agents de brevets et de marques de commerce

Reply to/Communiquez avec:
Gregory J. Sim
613.566.2803 gsim@perlaw.ca

BY EMAIL

September 9, 2014

Royal Ottawa Health Care Group
1145 Carling Avenue
Ottawa, ON
K1Z 7K4
Email: Cal.Crocker@rohcg.on.ca

Attention: Mr. Cal Crocker, VP Corporate Services and Chief Financial Officer

Dear Cal:

Re: P3 - Sinking Fund
Our Reference: RYLO066

Further to your letter of April 9, 2010, please be advised that we have reviewed the particular sections of the Funding Agreement that you provided to us. In addition, we reviewed a lengthy series of emails, letters, numerous discussions with the Ministry of Health and Long Term Care representatives, their lawyers and notes of our own internal discussions with ROHCG's executives at the time and its financial advisors and project management team.

As a result of this extensive review we can confirm that ROHCG can withdraw the funds as set out in your April 9, 2010 letter.

We wish to point out the following:

(a) the Funding Agreement dated August 12, 2003 was amended by a document entitled "Amending Agreement No. 1 to Funding Agreement" which amendment itself was dated December 15, 2004. Enclosed is a copy of that signed Amending Agreement for your files.

(b) The Funding Agreement contemplates that ROHCG may need to "top-up" the Sinking Fund if it becomes aware of a shortfall in the balances set out in Schedule 11.4. Schedule 11.4 is a projection based on a number of things including the Commitment Schedule attached as Schedule 6.5. So, for example, if ROHCG becomes aware that the ancillary revenues (for parking, retail, net cafeteria, 7th floor lease) will not meet the projections,

then the balances in the Sinking Fund may be insufficient and the ROHCG may have to "top-up" the Sinking Fund as required under Section 11.4 of the Funding Agreement.

If you have any questions, please do not hesitate to contact me.

Yours very truly,

Gregory J. Sim
150:jc
Encl.

Schedule 11.4 – Post Financial Close VFMP -- ROHCG Sept 8th 2006 Final VFMC

Royal Ottawa Health Care Group Local Share Costs

Total All-in Costs	($ Millions)		
Construction Costs			
	Design-build contract		121.77
	Pre-operating costs		10.09
	Working Capital		
	MMEX reserve account		
	Senior debt interest		13.17
	Senior debt commitment fee		
	Land (Ground) Lease Cost		12.01
Total Capital Project Costs			156.63
Lifecycle Costs (also referred to as Capital Reserve Rent)			26.40
Financing Costs			126.02
Total Project Costs (including IMHR)			321.02
less IMHR Capital Portion			12.03
less IMHR Interest Portion			10.71
less IMHR Land (Ground) Lease Cost			1.50
less IMHR Portion of Capital Reserve Rent			2.42
less non-shareable IT Capital Portion			-
less non-shareable IT Interest Portion			-
less non-shareable F & E Capital Portion			-
less non-shareable F & E Interest Portion			-
Revised Project Costs			296.26
Local Share not including IMHR Capital & Financing Costs, IT and F & E		5%	14.81
Local Share of IMHR costs		100%	27.57
Local Share of non-shareable IT Capital & Financing Costs			-
Local Share of non-shareable F & E Capital & Financing Costs			-
Total Local Share			42.38
Value Adjustment Credit @ 0%			3.00
nd Lease Credit (ROHCG receives mkt. rate for ground lease)			-
Recipient Hospital's Local Share			39.48
ilable Financing Credit - Maximum			13.15
Minimum Local Share Contribution			$ 25.33

References to Financial Model Final 17-Dec 2014 New June 12

Figure 0.10 Financial Model (FM) cell G14
Summary Sheet Cell G9

Figure 0.10 FM Cell D30

Financial Old Template Cell G29

Financial Old Template Cell H60
Debt and Equity Amortization cells I124 to R130 + F40 to F200

MOH Formula
Figure 0.10 cell G10 plus MOH formula (or share of fixed costs that are financed
MOH Formula - IMHR Interest = (Fin. Costs Financed Capital Project Costs) * IMHR (Capi
MOH Formula IMHR Land Lease = (Fin. Costs Financed Capital Project Costs) * IMHR (C
MOH Formula Figure 0.10 FM used to pro-rate share of Capital Reserve Rent

MOH Formula

MOH Formula
MOH Formula

	VFMC	$ 272.59	Number provided
	THCC Cost	$ 268.49	Number provided
Mch Formula		$ 4.10	$ 3.90
05% of savings over form			

MOH Formula
MOH Formula
MOH Formula for Unrelated Cap Costs x 5% + Lev Stu of (IMHR, IT and F & E) - Fin.Cost

Sinking Fund Cash Flow

Year	Capital Contributions from Foundation	Contributions to Sinking Fund from Revenues	Opening Cash Balance	Interest @ 6% pa	Fund Payment	Fund Balance	ROHCG payment to partially reimburse of Sinking Fund		ROHCG yearly Financing Credit	Potential Financing Credit
-3		1.39	1.3	0.08	-	1.38	-		-	-
-2		-	1.4	0.08	-	1.47	-		-	-
-1		-	1.5	0.09	-	1.55	-		0.83	
1	5.12	1.14	7.6	0.47	(1.63)	6.46	-		0.83	
2	-	1.15	7.0	0.40	(1.63)	0.21	-		0.83	
3	-	1.16	7.4	0.44	(1.63)	0.07	-		0.83	
4	-	1.17	7.1	0.43	(1.63)	6.72	-		0.83	
5	-	1.17	6.8	0.41	(1.63)	6.47	-		0.83	
6	-	1.18	6.6	0.40	(1.63)	6.21	-		0.83	
7	-	1.19	6.4	0.38	(1.63)	5.94	-		0.83	
8	-	1.19	6.1	0.37	(1.63)	4.80	bond 2013		0.83	
9	-	1.20	5.8	0.35	(1.63)	4.51	bond 2014		0.83	
10	-	1.21	5.6	0.33	(1.63)	4.07	bond 2015		0.83	
11	-	1.22	5.3	0.32	(1.63)	3.77	-		0.83	
12	-	1.23	5.0	0.30	(1.63)	3.46	-		0.83	
13	-	1.24	4.7	0.28	(1.63)	3.13	-		0.83	
14	-	1.25	4.4	0.26	(1.63)	2.80	-		0.83	
15	-	1.26	4.0	0.24	(1.63)	2.45	-		0.83	
16	-	1.26	3.7	0.22	(1.63)	2.10	-		0.83	
17	-	1.27	3.4	0.20	(1.63)	1.73	-		0.83	
18	-	1.28	3.0	0.18	(1.63)	1.30	-		0.83	
19	-	1.29	2.6	0.16	(1.63)	0.97	-		0.83	
20	-	1.30	2.3	0.14	(1.63)	0.66	-		0.83	
21	-	1.15	1.7	0.10	(1.63)	0.00	-		0.83	

Term 1 Do 2.6.

OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 49	**Priority:** Important

DATE: March 26, 2020
COMMITTEE: Finance Committee
PRESENTER: J. Gallant
SUBJECT: Corporate Procurement Policy

BACKGROUND INFORMATION:

The Procurement Policy, which requires Board approval, is updated on a three year cycle as per our policy process. There have been no changes to this policy and it is submitted for approval as presented

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT, as recommended by the Finance Committee, the Board of Trustees approve the Corporate Procurement Policy as presented.

CARRIED

Moved by:
Seconded by:
Motion approved:

CORPORATE POLICY & PROCEDURE
PROCUREMENT
ROHCG
CORP II-ii 130

PROCUREMENT			
SECTION: II-ii Administration – *Finance*		**NO: 130**	
Issued By:	Senior Management Team	**APPROVAL DATES :**	
Approved by:	Board of Trustees - ROHCG Board of Directors – IMHR	**Date Initially Issued:** 26/06/2002	
		Date Reviewed: 08/02/2006, 8/02/2008, 20/10/2010, 04/03/201103/25/15	
		Date Revised: 8/02/2008, 20/10/2010, 04/03/2011,25/03/2015, 25/01/2016, 17/03/2016, 27/01/2017, 21/03/2019	
		Date Implemented: 8/02/2008, 09/12/2010, 25/03/2015, 30/03/2017,	
Key Words:	Purchasing, contracts	**Cross Reference(s)**	CORP II-i 110 Regulatory Transparency, CORP II-ii 110 Signing Authority, CORP II-ii 111 Signing Authority–Revenue, CORP II-ii 190 Contract Administration, CORP III 110 Conflict of Interest, CORP III 111 Conflict of Interest; Board of Trustees, CORP IV-ii 120 Space Allocation

1. PURPOSE:

To provide the procurement and contracting processes, leading practices and procedures that are adhered to by the Royal Ottawa Health Care Group (ROHCG).

2. POLICY STATEMENT:

The ROHCG, the Royal Ottawa Foundation for Mental Health (ROFMH), the Royal Ottawa Volunteer Association (ROVA) and the University of Ottawa Institute of Mental Health Research (IMHR) prescribe to four key procurement principles: best value; accessibility and opportunity to compete; fairness and transparency; and prudence and probity. The ROHCG, ROFMH, ROVA and the IMHR support and comply with the *Ontario Management Board of Cabinet, Broader Public Sector (BPS) Directives (2011)* and the *Accessibility for Ontarians with Disabilities Act (AODA), Accessibility Standard for Customer Service (ASCS)* and the *Integrated Accessibility Standards Regulation (IASR)* requirements.

Since the ROHCG complies with AODA, it is expected that any quoting supplier will accommodate this requirement. The ROHCG has developed a plan which is continuously reviewed and revised in order to ensure adherence to the applicable standards from AODA, (2005) across the ROHCG. The aim of the plan is to identify and facilitate the removal of barriers to equal access among persons with disabilities, including patients, their families, visitors and staff of the ROHCG.

Supply Chain Management (SCM) is responsible to monitor, control and process all acquisition and procurement activities for goods, services and consulting on behalf of the ROHCG, ROFMH, ROVA and the IMHR except for specified decentralized areas of responsibility. The Presidents and Chief Executive Officers of the ROHCG and the IMHR, respectively, the Chief Financial Officer (CFO) of the ROHCG, the Director-SCM and the respective Purchasing personnel at all sites are the only individuals who can commit the ROHCG, ROFMH, ROVA and the IMHR to any acquisition or return of goods or services. All inventory, non-inventory and service requests shall be forwarded to SCM which is responsible for processing these requests. SCM will determine, in consultation with the requisitioner, the appropriate procurement process and the ultimate supplier. Managers of each department are responsible and accountable for ensuring that purchases authorized through their department conform to this policy.

In some circumstances, the supply of goods and services is decentralized and is carried out by decentralized buyers who acquire specific goods and services related to their respective departments operating in compliance with ROHCG policy. The decentralized areas are:

- The Pharmacists at the Royal Ottawa Mental Health Centre (ROMHC) and the Brockville Mental Health Centre (BMHC) are responsible for purchasing drugs and medications (as they have the required licenses).
- Royal Ottawa Place (ROP) staff is responsible for arranging for the purchase of some drugs and medications.
- The Ministry of Community Safety and Correctional Services is responsible for some purchasing for the Secure Treatment Unit (STU)

To ensure that all parties receive best value for purchases SCM solicits competitive bids based on the *CORP II-ii 130 Procurement*. ROHCG competitive solicitations are not considered “Public Tenders” which means that the bidders are not invited to the opening. SCM personnel concerned and one witness will authenticate the documents and process by initialing each submission, ensuring all documents have been electronically time stamped in the SCM department.

3. SCOPE:

This policy applies to all ROHCG, ROFMH, ROVA and IMHR staff and Board Members. For certain purchases, the IMHR follows the procurement policies of the University of Ottawa.

4. GUIDING PRINCIPLES:

No individual outlined above, may authorize a transaction and/or participate in a competitive acquisition process, from which they or a relative may personally benefit. Any conflict of interest must be declared as per the *CORP III 110 Conflict of Interest* and *CORP III 111 Conflict of Interest; Board of Trustees*.

5. DEFINITIONS:

***Accessibility and Opportunity to Compete*:** Accessibility means structuring the procurement process in a manner that will attract and allow the greatest possible number of interested parties to compete for a particular opportunity. The opportunity to compete

must be provided to individuals or firms who have the technical, financial and managerial skills and competence to discharge the contract.

Best Value: A key objective of the *ROHCG Procurement Policy* is to secure the best value for money in meeting the planned results and other program objectives as they are determined. Best value signifies achieving the optimal combination of quality, time, and total life-cycle costs, including the cost of capital, where applicable. Best value does not mean relying solely on initial or basic cost. Competitive bidding is the underlying principle to obtain the best value for the ROHCG and the IMHR. In order to facilitate this process, the requirements of the work must be defined in terms that accommodate the competitive process. There must be a reasonable and representative number of qualified individuals or firms who are invited to bid.

Consultant: A person or entity that under an agreement, other than an employment agreement, provides expert or strategic advice and related services for consideration and decision-making. .

Consulting Services: The provision of expertise or strategic advice that is presented for consideration and decision-making.

Contract: An obligation, such as an accepted offer, between competent parties upon a legal consideration, to do or abstain from doing some act. It is essential to the creation of a contract that the parties intend that their agreement shall have legal consequences and be legally enforceable. The essential elements of a contract are an offer and an acceptance of that offer; the capacity of the parties to contract; consideration to support the contract; a mutual identity of consent or consensus ad idem; legality of purpose; and sufficient certainty of terms.

Contract Amendment: A change made to the original contract, e.g. addition to, deletion from, correction of, or modification.

Contract Performance: The certification that the work has been performed, the goods supplied at the agreed price or the services rendered, or, in the case of other payments, the payee is entitled to or eligible for the payment.

Contracting Authority: The person who has the authority to sign the contract and subsequent amendments between the ROHCG, ROFMH, ROVA, IMHR and the supplier.

***Electronically Published RFQ/RFP*:** The Agreement on Internal Trade (AIT) affects the procurement of equipment, goods and services valued at $100,000 or more, including multi-year contracts with a cumulative value of $100,000 or more. SCM is responsible to ensure these purchases are in compliance with the terms of the ITA and the solicitations are advertised electronically for a period of fifteen calendar days.

Fairness and Transparency: The ROHCG Procurement Policy promotes fairness in the entire contracting process. This can be achieved by using a competitive process, advertising openly for a qualified contractor and demonstrating no favouritism to any supplier. Transparency also means making public all contracting rules.

Independent Contractor: An independent contractor is a natural person, business, or corporation that provides goods or services to another entity under terms specified in a contract or within a verbal agreement

Prudence and Probity: Prudence means managing public funds with care and integrity when carrying out the contracting function. It means engaging in a contracting process that maximizes accessibility and competition, and achieves best value for money. Probity means to follow the rules. Managers are expected to know and follow policy and best business practices, and use sound judgment in all situations.

Purchase Order (PO): means a written offer made by a purchaser to a supplier formally stating the terms and conditions of a proposed transaction.
Request for Information (RFI): A process used to solicit information from suppliers to confirm the availability of specific goods or services such as new technology, and also used to assist managers in the preparation of Specifications or Statements of Requirements for an eventual RFQ or RFP. An RFI is not considered a competitive process and does not result in the awarding of a contract.
Request for Proposal (RFP): A competitive process used to solicit bids from a reasonable and representative number of bidders (minimum of three bidders, where feasible) to provide goods or services where the supplier is to be chosen on the basis of the performance offered rather than on price alone.
Request for Quotation (RFQ): A competitive process used to request quotations from a minimum of three suppliers (where feasible) for very specific goods or well-defined services where the supplier is chosen on the basis of cost alone.
Services: Intangible products that do not have a physical presence. No transfer of possession or ownership takes place when services are sold, and they (1) cannot be stored or transported, (2) are instantly perishable, and (3) come into existence at the time they are bought and consumed.
Spending Authority: The person who is responsible for the budget that will pay for the product contracted.
Verbal Quotations: Prices solicited by telephone or in person and recorded on the requisition.
Written Quotations: Written quotations received that are attached to the requisition.

6. PROCEDURE:

6.1 Competitive Thresholds: The following dollar thresholds (before sales taxes) have been established for the competitive acquisition of goods and services excluding consulting contracts which are outlined separately. SCM may elect to follow a more formal competitive process for the purchase of goods or services below for these thresholds.

GOODS AND SERVICES	
PROCUREMENT VALUE (before sales taxes)	**PROCUREMENT METHOD**
< $2,000	**Non-competitive possible**
$2,000 to $5,000	**Invitational Competitive Minimum two verbal quotes**
$5,001 to $10,000	**Invitational Competitive Minimum three verbal quotes**
>$10,000	**Invitational Competitive Minimum three written RFQ/RFP**
$100,000 or more	**Open Competitive Electronically published RFQ/RFP**

CONSULTING SERVICES	
PROCUREMENT METHOD	**PROCUREMENT VALUE (before sales taxes)**
Invitational Competitive	**ROHCG: $0 up to but not including $100,000** **IMHR: $0 up to but not including $10,000**
Open Competitive	**ROHCG: Mandatory for a value of $100,000 or above. May be used for any value** **IMHR: Mandatory for a value of $10,000 or above. May be used for any value**

All non-competitive procurement for consulting services must be approved by the President and CEO of the ROHCG or the IMHR and all non-competitive procurement for consulting services for the ROHCG of $250,000 or above and for the IMHR of $50,000 or above must be approved by the Board of Trustees or Board of Directors, respectively.

6.2 Procurement Process: SCM is responsible for the co-ordination of all procurement activities plus ensuring the integrity of the procurement process and compliance with applicable policies, legal requirements and directives. The total dollar value of the requested goods or services on the requisition will determine which procurement process is utilized to obtain competitive quotes. Splitting of contracts to reduce value is prohibited. The process includes the following steps:

- ***Preparation:*** This is initiated by the submission of a correctly completed purchase requisition. The requisitioner, with assistance and guidance from SCM, will develop specifications and/or scope of work. SCM, in consultation with the requisitioner, will determine the procurement strategy, identify potential bidders, and prepare the appropriate documentation.
- ***Pre-qualification:*** This process is designed to select responsible and responsive bidders based on their qualifications, resources and capabilities.
- ***Bidding conference (when required):*** This is a meeting between bidders and ROHCG staff to provide additional information and address any concerns or questions regarding the solicitation during the competitive process.
- ***Bid opening:*** This includes opening of bids received by the stipulated deadline, checking submissions for completeness and rejection of incomplete submissions. Bids received after the deadlines are returned to the bidder unopened.
- ***Evaluation:*** The evaluation of proposals by SCM and the other members of an Evaluation Team, against predetermined criteria including quality, compatibility, performance, timing , delivery, service, installation, total costs and other relevant criteria. All evaluation information must be documented and retained by SCM to support the selection decision.
- ***Selection:*** Selecting the compliant submission that scored highest against the evaluation criteria established that meets the needs and requirements of the ROHCG, ROFMH, ROVA and the IMHR and which represents the best value.
- ***Award:*** Notification to all bidders of the outcome of the competitive process.

- ***Documentation:*** SCM will ensure that the competitive process documentation is properly retained on file within SCM, and that a purchase order is issued to the supplier or that a contract is properly executed, distributed and filed.

6.3 Spending Authority: All authorized Spending Authorities (requisitioners) have the budgetary responsibility and the mandate to request equipment, supplies and services for their respective cost centres. SCM will check signatures on requisitions against the signature cards for each cost centre. Any requisition for goods having a value of $2,000.00 or more per item (including taxes, transportation costs, installation and initial training) is "Capital" and must be forwarded to the Executive V.P. & CFO for approval and signature if it is not included in the approved "Capital Budget" before it can be ordered**.**

6.4 Contracting Authority: The Contracting Authority is the person who has the authority to sign contracts (buy) between the ROHCG, ROFMH, ROVA, IMHR and the supplier. Establishing risk-based contracting authorities follows leading practices that recognize higher performance, legal and reputation risks inherent in sole source and service contracts as compared to contracts for the supply of tangible goods. The following table minimizes contracting risks while streamlining the contract signature process. All contracts for $10,000 or greater for the IMHR must be co-signed by the IMHR President & CEO.

POSITION	GOODS		SERVICES	
	COMPETITIVE	NON COMPETITIVE	COMPETITIVE	NON COMPETITIVE
Director-SCM & Director Finance (2 Signatures)	$75K	$25K	$50K	$25K
Chief Operating Officer.& Chief Financial Officer	$250K	$150K	$150K	$100K
Chief Executive Officer (ROHCG)	$1,000K	$500K	$500K	$250K
President & CEO (IMHR)	$100K	$50K	$100K	$50K
Board of Trustees (ROHCG)	>$1,000K	>$500K	>$500K	>$250K
Board of Directors (IMHR) *	>$100K	>$100K	>$100K	>$50K

* ***The ROHCG Board of Trustees approves contracts above the limits established for the ROHCG CEO and all construction contracts above $500K. The IMHR Board of Directors approves contracts above the limits established for the IMHR President & CEO and all capital contracts above $100K.***

6.5 Contract Amendments: From time to time some contracts may need to be amended when the scope or requirements change. In order to minimize risks and streamline the amendment process the Director-SCM and Director-Finance may sign agreement amendments up to a cumulative amount that is 25% of the original value of a contract up to the maximum of their contract signing limit. Any amendment that would exceed this threshold must be signed by the original Contracting Authority.

6.6 Purchasing Procedures: For multiple item contracts, capital equipment, capital projects and renovations and supplies/services, SCM solicits bids according to the established competitive thresholds. The RFP/RFQ documents contain standard terms and conditions and all clinical and/or technical specifications of the requisitioner as well as specific requirements such as approval labeling from the Canadian Standards Association and/or Ontario Hydro for the purchase of electrical and/or electronic equipment. Any bid received after the closing date is automatically rejected. Templates are updated periodically by SCM to ensure terms and conditions reflect appropriate insurance coverage, changes to taxes, government regulations and so on.

Any department requesting goods or services will complete a purchase requisition ensuring the cost centre, account number and the correct authorizing signature is on the requisition before forwarding it to SCM. SCM receives and dates the requisition and checks the authorizing signature against signature cards. It is then assigned to the appropriate Purchasing staff that is responsible for processing all required paperwork.

The requisitioner, with assistance and guidance from SCM, will develop specifications and/or scope of work. SCM, in consultation with the requisitioner, will determine the procurement strategy, identify potential bidders and prepare the appropriate documentation. A written procurement plan for all procurements estimated to be $20,000 or greater will be prepared and approved by the Evaluation Review Committee (*The Evaluation Review Committee is composed of senior representation from the client/user group and senior representation from Finance. It approves the procurement plan, carries out a management review function, performs quality assurance of documents before their release and reviews and approves the evaluation report and recommendation for the contract award*) before the release of an RFQ or RFP. The procurement plan for professional services or consultants will contain a business plan or justification as why the work cannot be done by existing ROHCG resources. All information technology related requests are forwarded to Information Technology (IT) for approval to confirm compatibility with IT infrastructure and standards. Equipment requirements are forwarded to plant operations for approval to confirm physical infrastructure requirements exist for the equipment. SCM will review terms and conditions, taxes, price and, in consultation with the requisitioner, will negotiate any discrepancies.

In some cases the value of purchases is not sufficient to generate the most aggressive pricing from bidders so where practical and beneficial to the ROHCG, ROFMH, ROVA and IMHR requirements are submitted to group purchasing initiatives. Group purchasing agreements will be considered “competitive” and be deemed compliant with this policy.

Products that are obtained as loaners or for evaluation also require a purchase requisition and a purchase order. All goods are to be received through SCM. Capital assets are entered in the Fixed Assets sub ledger for tracking purposes and tagged with an asset tag upon receipt prior to distribution to end users.

In no circumstances can hospitality, incidental or food expenses be considered allowable expenses for consultants and contractors or in any contract between an organization and a consultant or contractor. Contract administration procedures and considerations are contained in *CORP II-ii 190 Contract Administration*.

6.7 Exceptions: The exceptions to this Policy are:

- When only one source or acceptable source of supply exists;
- Where an unforeseen situation of urgency or emergency exists;
- When the required item(s) is covered by an existing contract, price agreement or is a continuation of an award from a competitive bid process;
- When the required item(s) must meet a predetermined standard or match existing equipment;
- When externally imposed restrictions around the timing for ordering or receipt of goods prohibit the Procurement Policy from being followed (ex: year-end funding announcements requiring receipt of goods prior to the end of the fiscal year).
- Contracts with a public body or a non-profit organization;
- The procurement of goods, services and construction that is financed primarily from donations that are subject to conditions that are inconsistent with the *Agreement on Internal Trade*;
- The procurement of services in Ontario that may, by legislation or regulation, be provided only by any of the following licensed professionals: medical doctors, dentists, nurses, pharmacists, veterinarians, engineers, land surveyors, architects, accountants, lawyers and notaries;
- The procurement of services of financial analysts or the management of investments by organizations who have such functions as a primary purpose;
- The procurement of financial services respecting the management of financial assets and liabilities (i.e. treasury operations), including ancillary advisory and information services, whether or not delivered by a financial institution; and
- Where an exemption, exception, or non-application clause exists under the *Agreement on Internal Trade* (AIT) or other trade agreement.

When there is an exception the reason will be clearly documented by the Spending Authority. Exceptions must be approved by the Director-SCM and by the CFO. If the Spending Authority is the CFO then the exception must be approved by the CEO. If the Spending Authority is the CEO then the exception must be approved by the Chair of the Finance Committee. In every case effort will be made to achieve competitive pricing and value for money.

6.8 Liability: Suppliers are given the address and location at the ROHCG where shipments are to be delivered and signed for. The ROHCG, ROFMH, ROVA and the IMHR do not assume responsibility or liability for any order not delivered to SCM's Receiving or

an order delivered directly to a department or individual without a purchase order or prior approval from SCM. All orders delivered and or invoiced without a purchase order will not be processed until the paperwork is complete.

6.9 Non Solicitation: The following clause will be incorporated in Requests for Proposals for services where there will be a significant and/or long standing relationship with the ROHCG, (i.e. security, facility management, capital projects, etc.):

> *"The supplier shall not solicit any existing staff member of the ROHCG, ROFMH, ROVA and the IMHR as a result of the contract during the currency of the contract and for one year following the term of the contract. In the event of such employment contrary to this term, the supplier shall be responsible for all losses and damages incurred by the ROHCG, ROFMH, ROVA and IMHR as a result of the loss of such staff."*

6.10 Return Of Equipment Or Goods: If goods have to be returned the requisitioner will contact SCM and give them the pertinent information. The Purchasing staff will contact the supplier to obtain a Returned Goods Authorization (RGA) and confirm whether re-stocking and shipping charges are applicable to the order. Any charges that would be applicable will be communicated to the requisitioner to ensure they want to proceed with the return as they are responsible for these charges. The item(s) being returned would be sent to SCM Shipping who will prepare and ship the package.

6.11 Reporting: Contracts awarded to consultants will be reported to the ROHCG Board of Trustees or the IMHR Board of Directors on a quarterly basis.

7. RELATED PRACTICES AND/OR LEGISLATION:
The Ontario Management Board of Cabinet, Broader Public Service (BPS) Procurement Directive
http://www.fin.gov.on.ca/en/bpssupplychain/documents/bps_procurement_directive.html

8. REFERENCES:
Agreement on Internal Trade (AIT) –Annex 502.4

9. APPENDICES:
Appendix 1- *The Ontario Management Board of Cabinet, Broader Public Service (BPS) Procurement Directive Mandatory Requirements*

Appendix 1 - *The Ontario Management Board of Cabinet, Broader Public Service (BPS) Procurement most recent Directive apply to the ROHCG for all competitive processes.*

Mandatory Requirement #1: Segregation of Duties
Organizations must segregate at least three of the five functional procurement roles: Requisition, Budgeting, Commitment, Receipt and Payment. Responsibilities for these roles must lie with different departments or, at a minimum, with different individuals.

Mandatory Requirement #2: Approval Authority
Organizations must establish an approval authority schedule (AAS) for procurement of goods, non-consulting and consulting services. The AAS must identify authorities that are allowed to approve procurements for different dollar thresholds. The AAS must be approved by the board of directors of the Organization or its equivalent.

Prior to commencement, any procurement of goods and non-consulting services must be approved by an appropriate authority in accordance with the AAS of the Organization.
Prior to commencement, any non-competitive procurement of goods or non-consulting services must be approved by an authority one level higher than the AAS requirements for competitive. Organizations must not reduce the overall value of procurement (e.g., dividing a single procurement into multiple procurements) in order to circumvent the approval requirements of the organizational AAS or the Procurement AAS for Consulting Services.

Mandatory Requirement #3: Competitive Procurement Thresholds
Organizations must conduct an open competitive procurement process where the estimated value of procurement of goods or services is $100,000 or more. The exemptions must be in accordance with the applicable trade agreements. Organizations must competitively procure consulting services irrespective of value. The exemptions must be in accordance with the applicable trade agreements.

Mandatory Requirement #4: Information Gathering
Where results of informal supplier or product research are insufficient, formal processes such as a Request for Information (RFI) or Request for Expression of Interest (RFEI) may be used if warranted, taking into consideration the time and effort required to conduct them. A response to RFI or RFEI must not be used to pre-qualify a potential supplier and must not influence the chances of the participating suppliers from becoming the successful proponent in any subsequent opportunity.

Mandatory Requirement #5: Supplier Pre-Qualification
The Request for Supplier Qualification (RFSQ) enables Organizations to gather information about supplier capabilities and qualifications in order to pre-qualify suppliers for an immediate product or service need or to identify qualified candidates in advance of expected future competitions. Terms and conditions of the RFSQ document must contain language that disclaims any obligation of the Organization to call on any supplier to provide goods or services as a result of pre-qualification.

Mandatory Requirement #6: Posting Competitive Procurement Documents
Calls for open competitive procurements must be made through an electronic tendering system that is readily accessible by all Canadian suppliers.

Mandatory Requirement #7: Timelines for Posting Competitive Procurements
Organizations must provide suppliers a minimum response time of 15 calendar days for procurement of goods and services valued at $100,000 or more. Organizations must consider

providing suppliers a minimum response time of 30 calendar days for procurements of high complexity, risk, and/or dollar value.

Mandatory Requirement #8: Bid Receipt
Bid submission date and closing time must be clearly stated in competitive procurement documents. Organizations must set the closing date of a competitive procurement process on a normal working day (Monday to Friday, excluding provincial and national holidays). Submissions that are delivered after the closing time must be returned unopened.

Mandatory Requirement #9: Evaluation Criteria
Evaluation criteria must be developed, reviewed and approved by an appropriate authority prior to commencement of the competitive procurement process. Competitive procurement documents must clearly outline mandatory, rated, and other criteria that will be used to evaluate submissions, including weight of each criterion. Mandatory criteria (e.g., technical standards) should be kept to a minimum to ensure that no bid is unnecessarily disqualified. Maximum justifiable weighting must be allocated to the price/cost component of the evaluation criteria. All criteria must comply with the Non-discrimination section of the Directive. The evaluation criteria are to be altered only by means of addendum to the competitive procurement documents. Organizations may request suppliers to provide alternative strategies or solutions as a part of their submission. Organizations must establish criteria to evaluate alternative strategies or solutions prior to commencement of the competitive procurement process. Alternative strategies or solutions must not be considered unless they are explicitly requested in the competitive procurement documents.

Mandatory Requirement #10: Evaluation Process Disclosure
Competitive procurement documents must fully disclose the evaluation methodology and process to be used in assessing submissions, including the method of resolving tie scores. Competitive procurement documents must state that submissions that do not meet the mandatory criteria will be disqualified.

Mandatory Requirement #11: Evaluation Team
Competitive procurement processes require an evaluation team responsible for reviewing and rating the compliant bids. Evaluation team members must be made aware of the restrictions related to utilization and distribution of confidential and commercially sensitive information collected through the competitive procurement process and refrain from engaging in activities that may create or appear to create a conflict of interest. Evaluation team members must sign a conflict-of-interest declaration and non-disclosure of confidential information agreement.

Mandatory Requirement #12: Evaluation Matrix
Each evaluation team member must complete an evaluation matrix, rating each of the submissions. Records of evaluation scores must be retained for audit purposes.
Evaluators must ensure that everything they say or write about submissions is fair, factual, and fully defensible.

Mandatory Requirement #13: Winning Bid
The submission that receives the highest evaluation score and meets all mandatory requirements set out in the competitive procurement document must be declared the winning bid.

Mandatory Requirement #14: Non-Discrimination
Organizations must not discriminate or exercise preferential treatment in awarding a contract to a supplier as a result of a competitive procurement process.

Mandatory Requirement #15: Executing the Contract
The agreement between the Organization and the successful supplier must be formally defined in a signed written contract before the provision of supplying goods or services commences. Where an immediate need exists for goods or services, and the Organization and the supplier are unable to finalize the contract as described above, an interim purchase order may be used. The justification of such decision must be documented and approved by the appropriate authority.

Mandatory Requirement #16: Establishing the Contract
The contract must be finalized using the form of agreement that was released with the procurement documents. In circumstances where an alternative procurement strategy has been used (i.e., a form of agreement was not released with the procurement document), the agreement between the Organization and the successful supplier must be defined formally in a signed written contract before the provision of supplying goods or services commences.

Mandatory Requirement #17: Termination Clauses
All contracts must include appropriate cancellation or termination clauses. Organizations should seek legal advice on the development of such clauses. When conducting complex procurements, organizations should consider, as appropriate, the use of contract clauses that permit cancellation or termination at critical project life-cycle stages.

Mandatory Requirement #18: Term of Agreement Modifications
The term of the agreement and any options to extend the agreement must be set out in the competitive procurement documents. An approval by an appropriate authority must be obtained before executing any modifications to the term of agreement.

Extending the term of agreement beyond that set out in the competitive procurement document amounts to non-competitive procurement where the extension affects the value and/or stated deliverables of procurement.

Mandatory Requirement #19: Contract Award Notification
For procurements valued at $100,000 or more, Organizations must post, in the same manner as the procurement documents were posted, contract award notification. The notification must be posted after the agreement between the successful supplier and the Organization was executed. Contract award notification must list the name of the successful supplier, agreement start and end dates, and any extension options.

Mandatory Requirement #20: Supplier Debriefing
For procurements valued at $100,000 or more, Organizations must inform all unsuccessful suppliers about their entitlement to a debriefing. Organizations must allow unsuccessful suppliers 60 calendar days following the date of the contract award notification to request a debriefing.

Mandatory Requirement #21: Non-Competitive Procurement
Organizations should employ a competitive procurement process to achieve optimum value for money. It is recognized, however, that special circumstances may require Organizations to use non-competitive procurement. Organization may utilize non-competitive procurement only in situations outlined in the exemption, exception, or non-application clauses of the AIT or other trade agreements.
Prior to commencement of non-competitive procurement, supporting documentation must be completed and approved by an appropriate authority within the Organization.

Mandatory Requirement #22: Contract Management
Procurements and the resulting contracts must be managed responsibly and effectively.

Payments must be made in accordance with provisions of the contract. All invoices must contain detailed information sufficient to warrant payment. Any overpayments must be recovered in a timely manner. Assignments must be properly documented. Supplier performance must be managed and documented, and any performance issues must be addressed. To manage disputes with suppliers throughout the life of the contract, Organizations should include a dispute resolution process in their contracts.

For services, organizations must:

- Establish clear terms of reference for the assignment. The terms should include objectives, background, scope, constraints, staff responsibilities, tangible deliverables, timing, progress reporting, approval requirements, and knowledge transfer requirements.
- Establish expense claim and reimbursement rules compliant with the Broader Public Sector Expenses Directive1 and ensure all expenses are claimed and reimbursed in accordance with these rules.
- Ensure that expenses are claimed and reimbursed only where the contract explicitly provides for reimbursement of expenses.

Mandatory Requirement #23: Procurement Records Retention

For reporting and auditing purposes, all procurement documentation, as well as any other pertinent information must be retained in a recoverable form for a period of seven years. Organizations must have a written policy for handling, storing and maintaining the suppliers' confidential and commercially sensitive information.

Mandatory Requirement #24: Conflict of Interest

Organizations must monitor any conflict of interest that may arise as a result of the Members' of the Organization, advisors', external consultants', or suppliers' involvement with the Supply Chain Activities. Individuals involved with the Supply Chain Activities must declare actual or as set out in the *Broader Public Sector Accountability Act, 2010* (s.10) potential conflicts of interest. Where a conflict of interest arises, it must be evaluated and an appropriate mitigating action must be taken.

Mandatory Requirement #25: Bid Dispute Resolution

Competitive procurement documents must outline bid dispute resolution procedures to ensure that any dispute is handled in an ethical, fair, reasonable, and timely fashion. Bid dispute resolution procedures must comply with bid protest or dispute resolution procedures set out in the applicable trade agreements.

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

MINUTES
ROYAL OTTAWA HEALTH CARE GROUP
GOVERNANCE COMMITTEE
March 10, 2020 at 4:30 p.m.
Royal Ottawa Mental Health Centre
Executive Boardroom 2426-1
Teleconference Dial-In: 1-888-875-1833 Passcode: 926707277#

Trustees	Present	Regrets	Trustees	Present	Regrets
C. Coulter, Chair	X		J. Charette		X
S. Squire, Vice Chair	X		I. Levy	X phone	
D. Somppi	X phone		A. Graham	X	
			S. McLean	X	
Management Staff					
J. Bezzubetz	X		P. Robb	X	
F. Dzierszinski	X				

#	ITEM	REFERENCE	ACTION REQUIRED
1.	**CALL TO ORDER**	C. Coulter, Governance Committee Chair, called the meeting to order at 4:34 p.m. and declared the meeting to have been regularly called and properly constituted for the transaction of business. Committee members were welcomed. 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**	**a) Acceptance of Agenda** Moved by S. Squire and seconded by A. Graham **BE IT RESOLVED THAT** the Agenda for March 10, 2020 be accepted as presented. **CARRIED**	
	APPROVAL OF PREVIOUS MINUTES	**b) Approval of Previous Minutes** Moved by A. Graham and seconded by S. Squire **BE IT RESOLVED THAT** the minutes of January 23, 2020 be approved as presented. **CARRIED**	
3.	**BUSINESS ARISING FROM PREVIOUS MINUTES**	**Review of Action Items** - P. Robb's outstanding actions will be dealt with at a later date	
4.	**DECISION/ INFORMATION ITEMS**	**a) Research Ethics Board (REB) Terms of Reference – J. Bezzubetz, F. Dzierszinski**	
		A briefing note was included in the meeting package along with the REB Terms of Reference that were approved at the February 20, 2020 Board meeting. This is a follow up item from the February 20, 2020 Board of Trustees' meeting. The Board had some questions and asked the Governance Committee to look at them and report back.	

		One of the questions raised was about the mechanism used for this to come to the Board. Various options were discussed. There was agreement that it should come through a Board Committee so the Board can be assured discussions were had at the Committee level. After a robust discussion, it was agreed to add it to the Quality Committee and review it after a year to see if it fits or whether it should go to another Committee. Another question raised was regarding the performance evaluation of the REB Board Chair. F. Dzierszinski noted that there had not been a performance evaluation in nine years, but it is going to be introduced as a new feature after a year in the position. Discussion ensued and it was agreed that J. Bezzubetz and F. Dzierszinski are to work on the objectives that the evaluation will be measured against and bring it back to this Committee. The objectives will be based on the Terms of Reference. The next question was regarding the terms of the members and of the REB Chair. J. Bezzubetz provided a brief background noting that the previous chair was in the role for 9 years, took a leave of absence to act as CEO of the IMHR and now has an interest in returning. There was discussion and various ideas were noted as follows: - The Chair term could be the same as the member term - Interest in having a bit of turnover periodically. Having some structure and fairness is important to the up and comer. The senior person can then provide mentorship - If have built in notion that people will have role for awhile, you create capacity - Not uncommon for the Chief of Staff in a small hospital to take on role for a time, then stop and later return and take on the role again. This provides institutional learning because several people can perform in the role. It could be the same for this position Based on the Committee's comments, J. Bezzubetz and F. Dzierszinski are to do more work on this and come back to the Board with some recommendations.	C. Coulter to advise L. Lewis J. Bezzubetz F. Dzierszinski J. Bezzubetz F. Dzierszinski
		b) IMHR By-laws – J. Bezzubetz	
		The IMHR By-laws were included in the meeting package. A meeting is being planned for the two Governance Committees (ROHCG/IMHR) for a facilitated session to answer questions and to have dialogue about the modernized working relationship. J. Bezzubetz provided some background. This came up at an IMHR Governance Committee meeting because they were due to make amendments and modernize their by-laws. The ROHCG's legal counsel was asked to look at the by-laws with an eye that the reporting relationship is changing, the new leadership will be a President/Vice President, and with the integration of clinical and research. The questions from M. Jolicoeur were also included in the meeting package. It was seen as a great opportunity to have the two Governance Committees join together in a discussion to arrive at the answers. This was previously raised with S. West and A. Graham and they have indicated their agreement. This will be done before April 30 and well before June when the approval of the by-laws takes place. Discussion ensued. This was seen as a positive proposal. A question was raised around the administrative structure and whether it needed to be voted on. It was noted that the job description has been vetted by many	

		parties and the only recommendation was a change in the title, which the search team agreed was better.	
		c) Board Membership and Committees of the Board	
		i. Board and Committee Membership Status Report – A. Graham	
		A. Graham reported that all Board members have been contacted and expressions of interest received to stay on with the Board. Board members also provided ideas on what they want to do in the future with regards to Committee membership. A lunch meeting is to be arranged with the Chair, Vice Chairs and the Past Chair to have a discussion to finalize Committee placements. This will happen in the next two to three weeks with a recommendation to the Board for final approval at the June AGM. S. McLean indicated that he will not be continuing in the Past Chair role after his term is up in June. He noted that it was fundamentally important that the Chair of the Board have his or her term without the encumbrance of having the Past Chair on the Board as well. The by-laws will need to be amended to note that the term of the Past Chair is for one year as it is not clearly stated right now. S. McLean also provided a brief background on why the Chair of the Governance Committee was changed to be one of the Vice Chairs of the Board rather than the Past Chair. The rationale was that it would be an opportunity for the Vice Chair to grow into the Chair role	P. Robb P. Robb
		ii. Extension of Board Membership – S. McLean	
		The intention of this recommendation was to give the Board special authority to extend membership terms in extraordinary circumstances. A briefing note was included in the meeting package providing more information. After discussion, it was agreed that this should go forward to the Board for approval as long as there are no legal issues. J. Bezzubetz is to bring this to The Royal's external legal counsel for review before it goes in the Board package. A question was raised regarding the term of the extension, and that is to be left to the discretion of the Board depending on the circumstances. This resolution will also not be tied to any one Board member. *D. Somppi and I. Levy dropped off the call. Quorum was lost.* *I. Levy and D. Somppi called back in and quorum was reached.*	J. Bezzubetz
		iii. Term of *ex-officio* University of Ottawa Position – C. Coulter	
		This item was a follow up item from the February 20, 2020 Board of Trustees' meeting. A briefing note was included in the meeting package. A question was raised whether the *ex-officio* University of Ottawa position should have a limited term. After discussion, it was agreed that the by-laws should be amended to allow for a change after 9 years.	P. Robb
		iv. Board Recruitment Update – C. Coulter	
		One final interview will be held on April 15, 2020. After that interview a meeting will be held with A. Graham, I. Levy, and C. Coulter to make a final recommendation to the Board. P. Robb will set up the meeting. It was noted that there is one opening on the ROHCG Board and there may be other openings on the IMHR Board.	P. Robb

		v. Patient Representation on the Board – C. Coulter	
		This item was also a follow up from the February 20, 2020 Board of Trustees' meeting. A briefing note was included in the meeting package. A question was posed by a Board member as to whether we should consider representation on the Board by a client and not only from the Client and Family Advisory Committees. Discussion ensued and it was agreed that lived experience will be added to the Skills Matrix as a competency, but it was important that this not be the sole reason for bringing someone on the Board.	P. Robb
		d) Skills Matrix Review – C. Coulter	
		A proposed Skills Matrix document was included in the meeting package. Also included were C. Coulter's thoughts behind the changes. This item was deferred from the last meeting. There was discussion and the following comments were made: - The matrix needs to be clearer with definitions added to make it easier to fill in - Some categories are yes/no answers and not a rating (such as the LLB or Accounting designation categories) - AI/Cyber is to be added to the Information Technology category and Innovation is to be removed - Instead of the Project Management category, Operational Experience is to be added. It is good to have operational knowledge/expertise at the Board table, but when sitting on the Board the member needs to leverage an oversight role - What are real competencies and skill sets needed? This is an opportunity to fill in some of the gaps with the hospital without walls vision A. Graham and J. Bezzubetz agreed to work on this offline and bring their recommendations back to this Committee. The goal will be to ensure we have a team with a rounded set of attributes.	J. Bezzubetz A. Graham
		e) Board Development Days Planning – C. Coulter, A. Graham, J. Bezzubetz	
		A. Graham reported on this item. Great feedback was received from the Board and that will be useful moving forward. J. Bezzubetz will have staff support to work collectively with the three Boards to put the agenda together for next Board Development Days. It was noted that the date for the next Board Development Days is October 22/23, 2020.	
		f) Mini- Series Presentations to the Board – J. Bezzubetz, A. Graham	
		The mini-series presentations have been very instructive and well attended. P. Robb is to canvass the Board and ask what topics might be relevant and of interest to them going forward to ensure we are hitting the mark for the next year.	P. Robb
		a) Professional Development Reports	
		This item was added to the agenda to promote reporting after attendance at Board sponsored events. A copy of both of these professional development reports will be included in the Board meeting package under the Governance report.	
		- S. Squire, Let's talk Cyber Issues and the Audit Committee Perspective, February 13, 2020	

		A copy of materials from the Let's talk Cyber Issues and the Audit Committee Perspective event S. Squire attended was included in the meeting package and a further report was added and sent to the Committee by email. S. Squire provided a verbal report and a good discussion ensued about the relevance of this topic for the Board and for healthcare.	
		- A. Graham, Board Oversight Strategy, September 30, 2019	
		A copy of the professional development report regarding a session on Board Oversight Strategy that A. Graham attended in September 2019 was circulated at the meeting. A copy of the report is attached to these minutes.	
5.	**NEW BUSINESS**	There was no new business. .	
6.	**ADJOURNMENT**	The next meeting will be on May 21, 2020. There being no further business, the meeting was adjourned at 6:17 p.m.	

_____ _____

C. Coulter
Chair

J. Bezzubetz
Secretary, Board of Trustees

Governance Meeting Action Items

Action Item	Individual Responsible	Status
March 10, 2020		
The REB matters will go through the Quality Committee and then will be reported to the Board. This will be reviewed after a year to see if it fits or whether it should go to another Committee.	C. Coulter to advise L. Lewis	March 26, 2020 For review on March 9, 2021
To do more work regarding the REB Board and Chair terms and come back to the Board with some recommendations.	J. Bezzubetz F. Dzierszinski	March 26, 2020
To work on the objectives that the REB Chair performance evaluation will be measured against and bring back to this Committee. The objectives will be based on the Terms of Reference.	J. Bezzubetz F. Dzierszinski	May 21, 2020
By-law changes: - The by-laws will need to be amended to note that the term of the Past Chair is for one year - To amend the by-laws to indicate that a change can be made to the University of Ottawa *ex-officio* position incumbent after 9 years	P. Robb	May 21, 2020
A lunch meeting is to be arranged with the Chair, Vice Chairs and the Past Chair to have a discussion to finalize Board Committee placements. This will happen in the next two to three weeks with a recommendation to the Board for final approval at the June AGM.	P. Robb	May 21, 2020 June 18, 2020
To bring the proposed resolution regarding extending membership terms to The Royal's external legal counsel for review to ensure there are no legal issues before it goes in the Board package.	J. Bezzubetz	Before March 26, 2020
After the final interview on April 15, 2020, to set up a meeting with A. Graham, I. Levy, and C. Coulter to make a final recommendation to the Board for a new Board member.	P. Robb	April 16, 2020
Skills Matrix changes: - To add 'Lived Experience' to the categories - To bring recommended changes to the Skills Matrix back to the Governance Committee to ensure we have a team with a rounded set of attributes.	P. Robb J. Bezzubetz A. Graham	May 21, 2020 May 21, 2020
To canvass the Board and ask what topics might be relevant and of interest to them for next year's mini-series presentations.	P. Robb	March 26, 2020
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	COMPLETED March 10, 2020 COMPLETED For Approval before February 20, 2020 Board meeting

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	COMPLETED March 10, 2020
Proposed that all new Board members be appointed for a one-year term in their first year as a probationary period. This suggested change is to be added to the next By-law revision.	P. Robb	
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	COMPLETED 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	IN PROGRESS
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	COMPLETED 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	COMPLETED
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	COMPLETED 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	COMPLETED
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	COMPLETED February 20, 2020 COMPLETED February 20, 2020
To take into consideration whether we need a new position for corporate counsel.	J. Bezzubetz	
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 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.	J. Bezzubetz A. Graham	COMPLETED 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	COMPLETED 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	COMPLETED ~~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 was covered in J. Charette's document as a norm or rule.	P. Robb	COMPLETED

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

The Royal Mental Health - Care & Research Santé mentale - Soins et recherche	**Board of Trustees** **Professional Development** **Summary Report**
Name:	**Sharon Squire**
Event Name:	**Audit Committee Perspective on Cyber Issues – Women Get on Boards**
Date:	**Feb 13, 2020**
Summary:	I attended a 30-minute information session on Audit Committee Perspectives on Cyber Issues, given by Daren Jones of KPMG, as part of the Women Get on Boards learning series. While this organization focuses more on corporate boards, the findings are relevant for us. He recommended that companies should **review their cyber risk at each Audit Committee** meeting given the continuous need to leverage new technologies, AI and mobility among others with could result in new risks. As well, attackers are innovating faster than most businesses can improve their defenses. Finally trust and reputation damage is high for a breach, particularly in the field of work of the Royal. It was also suggested that: • cyber be a key part of our Risk Register and that all the Board should be briefed regularly and what are the measures (detection/containment)? • do we have the right set of skills on our team to keep our organization safe (are new skill sets needed)? • are we spending enough on cyber and in the right places? Suggested 10% of IT spend. He suggested, that cyber strategy should consider: • Governance and Operating Model o Do you have a policy for ransomware attacks (is it principles based or strict protocol)? Are partners regularly updated? What is the limit for financial risk/demands? Have scenarios been considered? Is the Audit Committee clear on what

	impact could be of a data breach, lost treatment time, regulatory authority impacts? What is our plan to resume operations? • Protection of Critical Systems and Data Approach o What are the new cyber threats and risks and how could they affect our organization? o Are we prepared for a security event and to minimize impact? o Consider an incident response and business reliance (table top exercise) linked to ransomware scenario (management) • Internal Threat Protection (e.g. biz email compromise/fraud) • Industry Collaboration o Do we have standards for 3rd party breach notification? How do we monitor their plans? Finally he cited 6 pillars of a cyber maturity assessment: • Leadership and governance, human factors, information risk management, business continuity, operations and technology and legal/compliance. How prepared are we on these 6 elements? A list of questions for Boards and for Senior Managers is attached (KPMG – Cyber in the Boardroom)and is definitely worth a read. There is also a report (Accelerate) below 1. Accelerate: Perspective on the key issues driving the Audit Committee agenda 2. KPMG: Cyber in the Boardroom

KPMG

Boardroom Questions

Cyber security – what does it mean for the Board?

Why cyber security risk is an everyday business consideration

Companies are under increasing pressure to **adopt** and **deploy new technology** in order to remain **competitive** within their markets, with technology opening opportunities to **differentiate customer experience**, reduce **operational costs**, and increase **competitive advantage**.

At the same time, **investors, governments** and **regulators** are increasingly challenging Board members to **actively demonstrate diligence** in this area. Regulators expect **personal information to be protected** and **systems to be resilient** to both **accidents** and **deliberate attacks**.

Organizations cannot afford to be held back by cyber risks. They need to make bold decisions and feel confident that their **cyber strategy, defenses and recovery capabilities** will **protect their business** and **support their growth strategies**

Business pressures: why companies should consider reviewing their cyber strategy

Pressure to find **new customers** and compete with existing and **disrupting competitors** means many companies are **leveraging digital technology** such as Robotics, Artificial Intelligence, mobility and introducing new systems **exposing the company to data risks**

A mutating threat landscape where an increasing range of highly professional **attackers are innovating faster than many businesses can improve their defenses**

Restoring trust and minimizing **reputation damage** is key for many industries – a data breach could affect **trust, reputation** and **share price**

Potential impact and possible implications for Boards

Intellectual property losses including patented and trademarked material, client lists and commercially sensitive data

Penalties, which may be legal or regulatory fines for data privacy breaches and customer and contractual compensation, for delays

Property losses of stock or information leading to delays or failure to deliver

Reputational losses causing the market value to decline; loss of goodwill and confidence by customers and suppliers

Time, lost due to investigating the losses, keeping shareholders advised and supporting regulatory authorities (financial, fiscal and legal)

Administrative resource to correct the impact such as restoring client confidence, communications to authorities, replacing property and restoring the organization to its previous levels

Boardroom Questions

Board level awareness of emerging cyber threats and direct involvement in **determining the response** is critical. Threat intelligence can help organizations become more **proactive, focused and preventative** to take control of cyber risk in a unique and positive way.

1. What are the **new cyber security threats** and risks, how do they affect our organization?
2. Is our organization's **cyber security program ready** to meet the challenges of today's and tomorrow's cyber threat landscape?
3. Do we fully understand our **current vulnerabilities** and what **processes** do we have in place to deal with vulnerabilities?
4. Are we meeting our regulatory and compliance requirements?
5. What are our competitors doing to prevent similar threats that we face ?
6. Do we have the right set of skills to keep our organization safe?
7. If we were to experience a breach, would we know, and would we be in a position to respond?
8. Are we spending enough on Cyber, and is it in the right areas?

Questions for senior management

1. How are we **demonstrating** due diligence, ownership, and **effective management of risk**?
2. To what level have we created a **security culture** across the organization that **empowers and ensures** the right people, skills, culture and knowledge to enable cyber security?
3. How effective is our approach to achieve comprehensive and **effective risk management** of information **throughout the organization** and its delivery and **supply partners?**
4. Are we **prepared** for a security event? How do we **prevent or minimize the impact** through crisis management and stakeholder management?
5. What **control measures** do we have to address identified risks, and **how effective** are these to prevent or minimize the impact of compromise?
6. Do we have a clear **understanding of the legal and regulatory environment** within which we operate? How do we effectively **demonstrate our compliance** to our supply chain, customers and business partners?

What actions could the Board consider?

Consider developing a strategy that is more than just security through combining people, privacy, information governance and business resilience. The questions above will help to identify gaps in your current cyber security strategy.

KPMG's Cyber Maturity Assessment (CMA) provides an in depth review of an organization's ability to protect its information assets and its preparedness against cyber-crime, looking at:

- Leadership and governance
- Human factors
- Information risk management
- Business continuity
- Operations and technology
- Legal and compliance.

Contact us

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Click here
for more information
www.kpmg.com/cybersecurity

The Royal Mental Health - Care & Research Santé mentale - Soins et recherche	**Board of Trustees Professional Development Summary Report**
Name:	**Anne Graham**
Event Name:	**Board Oversight of Strategy**
Date:	**Monday, September 30, 2019**
Summary:	Developed in partnership by the Institute of Corporate Directors and CPA Canada and based on CPA Canada's Overseeing Strategy: A Framework for Board of Directors, this course is designed to help directors successfully engage in the strategic oversight process. Participants will learn how to apply the four-phase framework, when to get involved and how to effectively participate in board oversight activities in different situations and business environments. The course consisted of on-site instruction and interaction along with: **Case Studies:** The course will focus in large part on applying the Framework to the four case studies found in this package. It is important that all participants read these cases and complete the accompanying worksheet before arriving in class. This prework assignment took about 3-5 hours in total. **Framework:** CPA Canada's Overseeing Strategy: A Framework for Boards of Directors is included as a reference. **Faculty** Lead Instructor: Annalisa King Director-in-Residence: Ray Ivany **Location: Homewood Suites, Halifax, Nova Scotia**

The Royal Mental Health - Care & Research Santé mentale - Soins et recherche	**MINUTES** **ROYAL OTTAWA HEALTH CARE GROUP** **INNOVATION COMMITTEE** ***(GOVERNANCE)*** **March 3 at 4:30 p.m.** **Room 1423** ***Teleconference Dial-In: 1-888-875-1833*** ***Passcode: 926707277#***	

MANDATE ***Definition of Innovation***	To advise the Board and encourage a culture of Innovation at The Royal in order to provide better quality of care for patients ***Implementing new or better ways of doing valued things***

Members	**Present**	**Regrets**	**Members**	**Present**	**Regrets**
N. Bhargava, Chair	X		J. MacRae		X
R. Anderson, Vice Chair	X		S. Squire	X	
D. Somppi		X	L. Leikin	X	
A. Graham		X			
Ex-officio					
A. Milne, Foundation	X		Mike Mount, IMHR	X	
J. Bezzubetz	X		R. Bhatla		X
Management Staff					
S. Hale	X phone		K. Monaghan	X	
C. Crocker	X		P. Robb, Recorder	X	
Observers					
F. Dzierszinski	X		M. Bellman	X	

	ITEM	**REFERENCE**	**ACTION REQUIRED**
1.	**CALL TO ORDER**	The meeting was called to order at 4:33 p.m. Welcome remarks and introductions were made. There was no quorum at the start of the meeting, but the meeting proceeded with the non-voting items. The meeting was opened by acknowledging that the land on which we gather is the traditional and unceded territory of the Algonquin nation. S. Squire arrived at 4.40 p.m. and quorum was reached.	
2.	**APPROVALS AND UPDATES**	a) Approval of Agenda Moved by R. Anderson and seconded by L. Lewis	

		BE IT RESOLVED THAT the agenda for the March 3, 2020 Innovation Committee meeting be accepted, as presented. **CARRIED**	
		b) Approval of Previous Minutes Moved by L. Lewis and seconded by R. Anderson **BE IT RESOLVED THAT** the minutes from the December 3, 2019 Innovation Committee meeting be approved, as presented. **CARRIED**	
		c) Updates from Chair – N. Bhargava	
		N. Bhargava provided a brief background on the Innovation Committee and the governance structure. M. Mount and A. Milne were welcomed as new ex-officio members of the Committee. They are attending as representatives of the IMHR and Foundation Boards. They will be providing some remarks later in the agenda. The Chair proposed the letter for the meeting be the letter "I". "I" not just for Innovation, but for Impact. He encouraged that all our discussions be considered with the lens of Impact.	
		d) Updates from CEO – J. Bezzubetz	
		J. Bezzubetz then gave her report. She has spent some time thinking about how management will vet and receive innovation from our organization and how that will be sent to this Committee. C. Crocker was asked to work on a process for what we are calling an Innovation Council that will represent the organization broadly. Membership still needs to be discussed. It will be a management council that will have discussions around innovation and will ask the tough questions regarding sustainability, funding, timing and to distinguish between innovation and operation. The goal will be to prepare projects and initiatives for this Committee, but the first step will be to go to the Innovation Council, then to the Senior Management Team (SMT) for approval in order to prepare what will be brought to this Committee. Since the Royal is not a large organization, there are only so many resources when it comes to initiatives, operational change and quality. Management needs to be sure about what we are asking our staff to invest	

		time in. We need to pause to see what is realistic in what we need to pursue. Having the Innovation Council will help us understand what is going on in the organization and to manage ourselves. Following her report there was discussion. L. Leikin raised a question about whether the quality teams could be linked to this process. It was noted that this was also discussed at SMT because there are links to both. He was invited to raise this question again later in the agenda.	
3.	**INNOVATION GOVERNANCE**	a) Update on Inventory document and Innovation Scorecard – C. Crocker, J. Bezzubetz	
		C. Crocker reported on this item. A copy of the inventory document and scorecard was included in the meeting package. This process started when a scorecard was created with the view that management could change it. When looking at the activities on it, it needs to align with the terms of reference and goals and there needs to be a good way of displaying it. A data analytics department has been created under M. Webb. She is working with Ontario Shores and they are working in terms of standardizing some dashboards and reports. She has been asked to take a look at this process and come up with a draft dashboard to bring back to this Committee to get sign off and that fits the Committees' needs. It is important to see that we are making progress. F. Dzierszinski was asked to give a report on any progress with the Brain Imaging Centre (BIC) (and perhaps the esketamine clinic) that were reported on at the last meeting. She reported that, building on the existing partnership with the Heart Institute (HI), a meeting with Dr. Peter Liu, VP Research of the HI, took place earlier this week to discuss the joint development of PET tracers for usage at the BIC. The conversations are happening about joining forces because there is a need for partnership, but it is very early stages. Timelines also need to be put on it. It is part of enabling the BIC to move to the next phase. We need to attract new business for sustainability. They are taking a look at the PET side of things for new projects. By diversifying with the PET side, this will bring in new business and new research projects.	

		It was noted that these items will skip the Innovation Council stage because it has already been brought to the Innovation Committee and will be kept on the dashboard. An action for the next meeting will be to bring back a new scorecard that aligns with our goals and Terms of Reference. Discussion ensued and a comment was made that with the BIC we are trying to solve financial sustainability, which doesn't seem like innovation so does it belong on this Committee. Since J. Bezzubetz makes the decision on what is material to bring to the Committee, she will bring that decision back to the next meeting. There was a question raised about the data analytics function and the innovation implications of the data analytics team, and whether there will be an opportunity or mechanism to link in researchers to drive innovation and change. There is an office being developed on the 7th floor and the concept will be working with leaders in the organization and the IMHR in terms of looking at the availability of data and what we can do with it in the organization. The intention is to drive change, not just create a dashboard. These teams will be the ones to understand the technology and how to access it. What comes to the innovation ideation side of the meeting is also a vehicle for a flow chart to be considered. It will be a great opportunity in terms of discussion. L. Leikin was welcomed to bring his quality innovation question noted above to this meeting.	C. Crocker J. Bezzubetz
		b) Innovation Council – C. Crocker	
		This was discussed under the President & CEO's Report.	
		c) AI Governance Framework Process and Stakeholders – C. Crocker	
		N. Bhargava abstained from these discussions because his company is doing pro bono work on this. C. Crocker reported on this item, which is about creating a governance process around AI. They will be using Dr. Zachary Kaminsky's report as an example. This process will include two workshops with the first tentatively in March or April in looking at AI questions and a second workshop in May or June dealing with the measurements of those. The goal will be to put an	

		initial AI Governance process in place. There is currently a statement of work and a draft contract under review right now. Once these are in place, the workshops will be set up. An outstanding question for the Committee was who the attendees should be for the workshops. The Committee agreed that the full Board should be canvassed for participation in the workshops. Details still need to be finalized as to how many will be in the workshops and once those details are known, C. Crocker is to follow up with J. Bezzubetz about getting attendees for the workshops.	C. Crocker J. Bezzubetz
		d) Review State of the Culture of Innovation – J. Bezzubetz	
		In terms of enthusiasm, staff would say they are innovative. They want to do things, but are sometimes restricted because of safety (the hospital is highly legislated), and there are some built in parameters that might prevent innovation. Whether we have a culture of innovation may be something we will discover through the strategic planning process. This is something we can ask consultants to zero in on: Do we have one? If not, what needs to change? They will be talking to staff, client/family members and all three Boards. How will we know that we are innovative? What are the success indicators? How will we know we cross that threshold? Because the consultants have a hive and pollination process, they are able to collect that data. This will be with minimum effort and maximum benefit.	
		e) Representation Comments from IMHR and Foundation Boards – N. Bhargava, M. Mount, A. Milne	
		Comments were provided by the IMHR and Foundation Board representatives, M. Mount and A. Milne. M. Mount thanked the Committee for inviting him to this meeting and for having the IMHR Board as a member. He welcomed the opportunity to provide input. It is important to keep open communication on important items. On a personal level, research does not necessarily mean innovation and innovation does not happen organically, so if there is no effort from the leadership it will not happen. The goal to create a culture of innovation is in the organization. When an organization	

		has an innovative culture, people are willing to work in different ways and implement new methods. A. Milne then provided comments and noted that it is important for the Foundation Board to be at this Committee, because some of these innovative ideas can become priorities for funding. It is also important to have more communication and collaboration between the three Boards. If the Innovation Committee can be innovative and create that communication path, then that is good. Any opportunity to get the three Boards together will have positive outcomes. M. Mount and A. Milne were thanked for their comments.	
4.	**INNOVATION COMMITTEE QUESTIONS & REPORT TO THE BOARD**	A document was circulated around the table by N. Bhargava with some proposed questions for the Board on innovation at The Royal. A copy is attached to these minutes. The questions were reviewed with the Committee and there was discussion. The following comments were made: - Are we are asking the right questions, or can we ask the Board if they want to guide us on questions about what the priority questions should be to management to get clarity? - How will we know when an item is moved off of innovation and is operationalized? - Is there a critical time when we have to make that decision? - Is there a question about a go/no go? It was noted that management was taking care of this as mentioned under the President & CEO's Report - What we have in the governance framework is a gate process, from idea to pilot to operationalize. At what point does the monitoring change from the Innovation Committee? If we are doing it the right way, we should always be able to answer these questions. Once we get to gate 3, it is not an innovation topic any longer. The process under the Innovation Council is that we will accept all innovations, but once it requires resources, a business case will need to be made with a	C. Crocker J. Bezzubetz

		recommendation on implementation to bring these projects to the Committee. We will also want a timeline for implementation. This will all depend on funding and the capital campaign. It is up to this Committee to bring forward projects, timelines and how to implement them. The gating process will likely have to adjust from the management side. C. Crocker and J. Bezzubetz are to come back with some recommended changes at the next meeting.	
5.	**OTHER BUSINESS** *(if any)*	No other business.	
6.	**ADJOURNMENT**	Next Meeting May 19, 2020, 2020 at 4:30 p.m. Moved by S. Squire and seconded by R. Anderson There being no further business, the meeting adjourned at 5:34 p.m.	
7.	**IDEATION SESSION TOPICS**	Below are the agenda topics discussed at the Ideation Session: - Upside Foundation - Innovation Incubation - Integrated Care - IMHR External Review	

_____ _____

N. Bhargava
Chair

J. Bezzubetz, *Secretary*

Innovation Committee Meeting Action Items

Action Item	Individual Responsible	Status
March 3, 2020 GOVERNANCE		
To bring back a new inventory document/innovation scorecard that aligns with our goals and Terms of Reference.	C. Crocker	
To make a decision whether BIC belongs to this Committee and bring decision back to the next meeting.	J. Bezzubetz	May 19, 2020
Re governance process around AI. Once details are finalized as to how many will be in the workshops, C. Crocker will follow up with J. Bezzubetz about getting attendees for the workshops.	C. Crocker J. Bezzubetz	

C. Crocker and J. Bezzubetz are to look at the proposed questions on innovation to the Board and are to come back with some recommended changes at the next meeting.	C. Crocker J. Bezzubetz	
March 3, 2020 IDEATION		
The Integrated Care document that R. Anderson presented to the Ideation session will be shared with the Senior Management Team. J. Bezzubetz is to follow up with SMT to see if the information can be used to support any of the asks that management is making. This will also be added as part of the Innovation report to the Board on March 26 and will be included in the meeting package.	J. Bezzubetz P. Robb	COMPLETED P. Robb sent to J. Bezzubetz to add to SMT agenda COMPLETED Added to March 26, 2020 Board agenda
IMHR External Review: A future ideation topic on new types of partnerships with industry. How does mainstream partner with other providers that are for profit? There a potential to have partnerships. Think about it generically. If we have a model we have thought about it might be clearer what kinds of companies we want to form partnerships with.	N. Bhargava	May 19, 2020
To look into arranging a joint session with Innovation Committee and Scientific Advisory Board at their annual meeting. Possibly facilitated by a third party.	F. Dzierszinski	
Grant Competition: Translation of research into care. Can Innovation Committee be involved in any way? F. Dzierszinski will have some sort of summary for Committee on what they are.	F. Dzierszinski	May 19, 2020
December 3, 2019 GOVERNANCE		
The scorecard dashboard format will be updated to take into account the timing feedback as well as how to make it more aligned with the Senior Management Team practices.	J. Lambley	COMPLETED March 3, 2020
The Board will need to be informed of the discussions about the BIC and then the Finance Committee will be asked to look at it.	N. Bhargava	COMPLETED P. Robb sent email to R. Anderson to ask her to facilitate putting this on the Finance Committee agenda
The President & CEO is to come back to the Innovation Committee to report on how the Senior Management Team proposes to bring business cases to the Innovation Committee.	J. Bezzubetz	COMPLETED March 3, 2020
December 3, 2019 IDEATION		
To set up meeting with J. Bezzubetz, N. Bhargava and M. Bellman regarding the Upside Foundation.	P. Robb	COMPLETED February 11, 2020
September 10, 2019 GOVERNANCE		

To propose the staff member to collect the initial Innovation inventory and use that to propose initial categories, using the draft dashboard and governance framework as a guide.	J. Bezzubetz/SMT	COMPLETED By end of September
To update Dashboard for December meeting.	J. Bezzubetz/designate	COMPLETED December 3, 2019
To add approval of Framework to December meeting.	P. Robb	COMPLETED December 3, 2019
September 10, 2019 IDEATION		
To provide an update on Federic and the Shark Tank at the December meeting.	F. Dzierszinski	COMPLETED December 3, 2019
To provide information on data governance practices.	N. Bhargava	COMPLETED December 3, 2019

International Foundation for Integrated Care

Integrated Care Academy©

Creating the conditions for sustainable change: building blocks and building competencies for integrated care

Dr Viktoria Stein, Director of Education and Training
VON Board Retreat and Workshop
Toronto, Canada, 24 January 2020

IFIC's mission

"The International Foundation for Integrated Care (IFIC) is a network that crosses organisational and professional boundaries to bring people together to advance the science, knowledge and adoption of integrated care policy and practice. The Foundation seeks to achieve this through the development and exchange of ideas among academics, researchers, managers, clinicians, policy makers and users and carers of services throughout the World."

www.integratedcarefoundation.org

www.ijic.org

Quotes from two centuries

"Apprehension, uncertainty, waiting, expectation, fear of surprise, do a patient more harm than any exertion."

Notes on Nursing, Florence Nightingale, 1859

"Primary care requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate."

Alma-Alta Declaration, WHO 1978

"…there is a need to re-shape healthcare systems to better address new public health challenges, particularly the needs of older people. To face these challenges changing our mind-set from the current health care conceptual framework, to a new one is mandatory. It should be oriented to function instead of to disease, to prevent instead of to react, to care instead of to cure, and to provide continued and integrated care instead of episodic and fragmented care."

Advantage JA, Managing Frailty, 2018

Our health is determined by much more than the health services we receive

Peace

Shelter

Education

Food

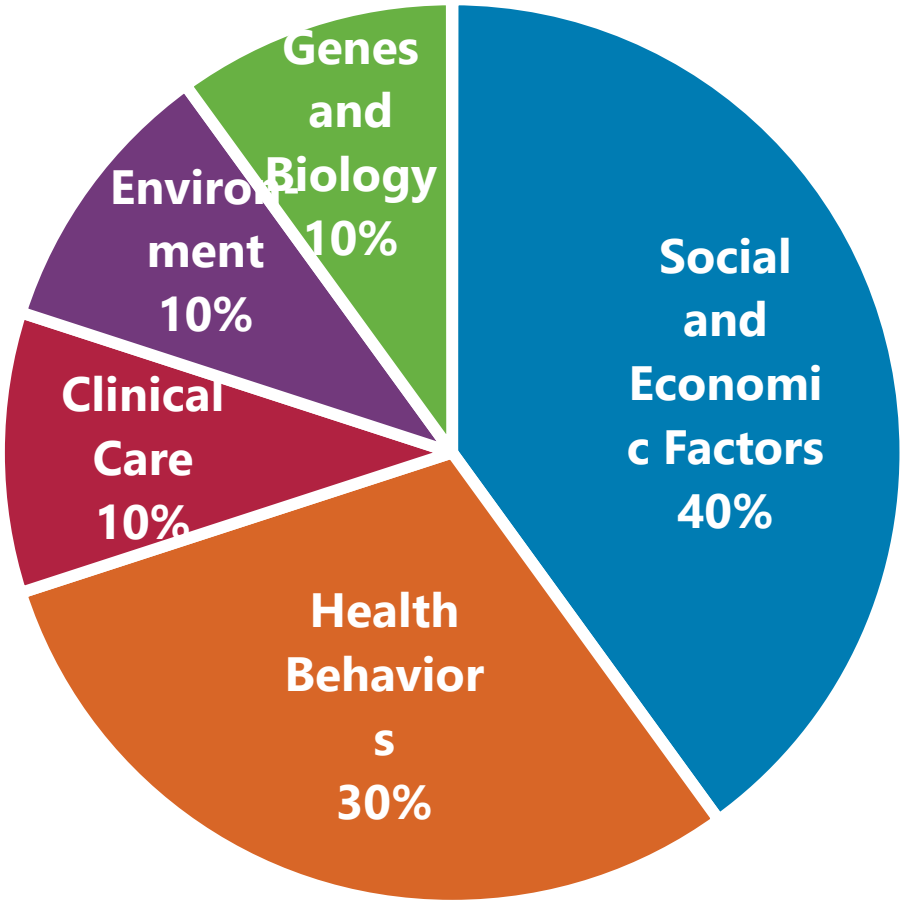
Income

Stable eco-system

Sustainable resources

Mobility

Social justice and equity



World Health Organization. Ottawa charter for health promotion. International Conference on Health Promotion: The Move Towards a New Public Health, November 17-21, 1986 Ottawa, Ontario, Canada, 1986. Accessed July 12, 2002 at <http://www.who.int/hpr/archive/docs/ottawa.html>.

Determinants of Health Model based on frameworks developed by: Tarlov AR. *Ann N Y Acad Sci* 1999; 896: 281-93; and Kindig D, Asada Y, Booske B. *JAMA* 2008; 299(17): 2081-2083.

The reality of care settings makes supported self-care an imperative

Hours with professional / NHS = 3 in a year

Health system

- People engagement is not optional, it's essential

Secondary care
Hospital
Inpatient ward
Outpatient clinic
Day surgery
Treatment center

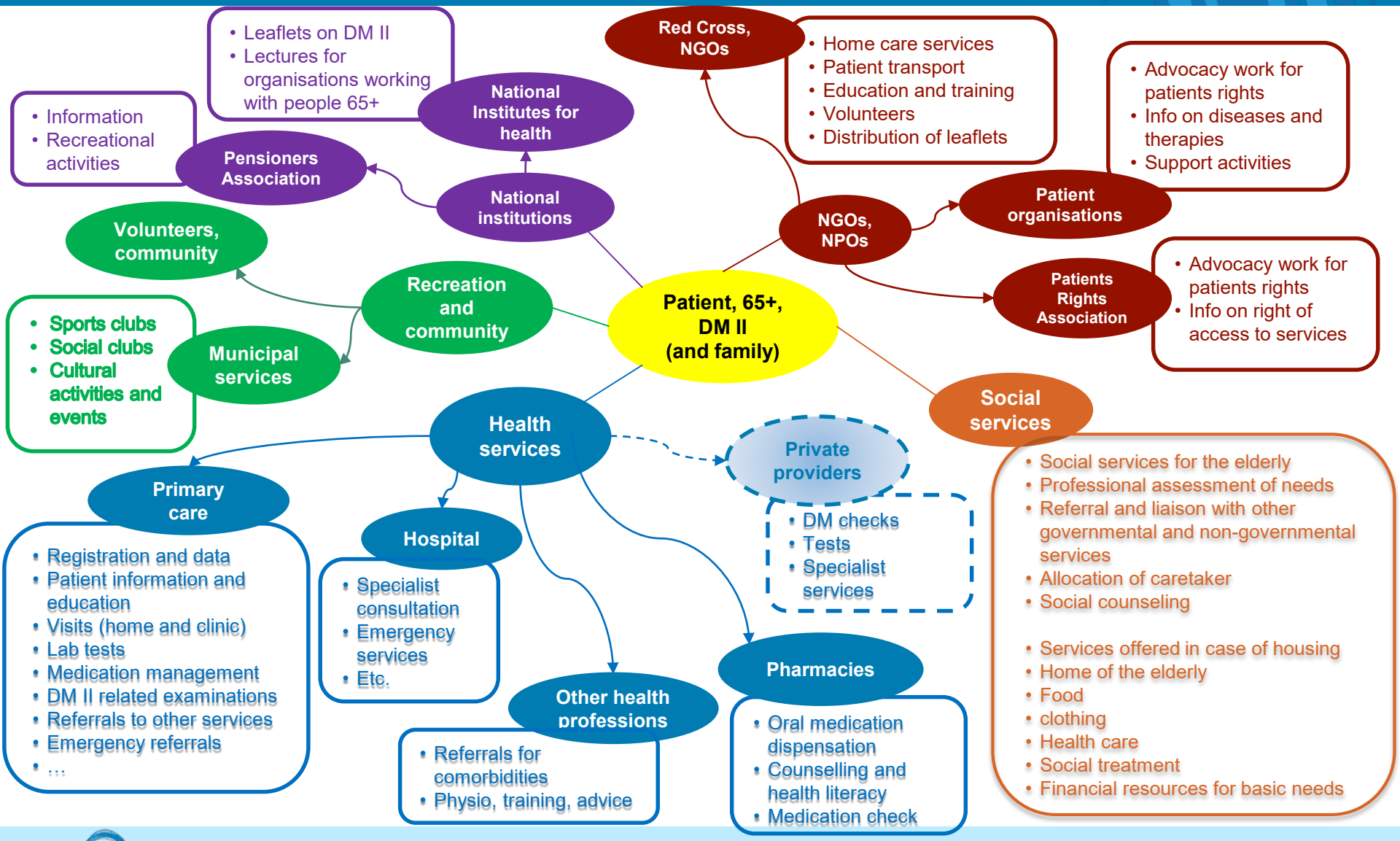
Tertiary care
Specialist unit
Inpatient ward
Outpatient clinic
Rehabilitation service
Palliative care service
Longterm care service

Informal care
Self care

Hours of self care = 8757 in a year

Adapted from Goodwin 2008 and 2014

Map of care for older person with chronic disease

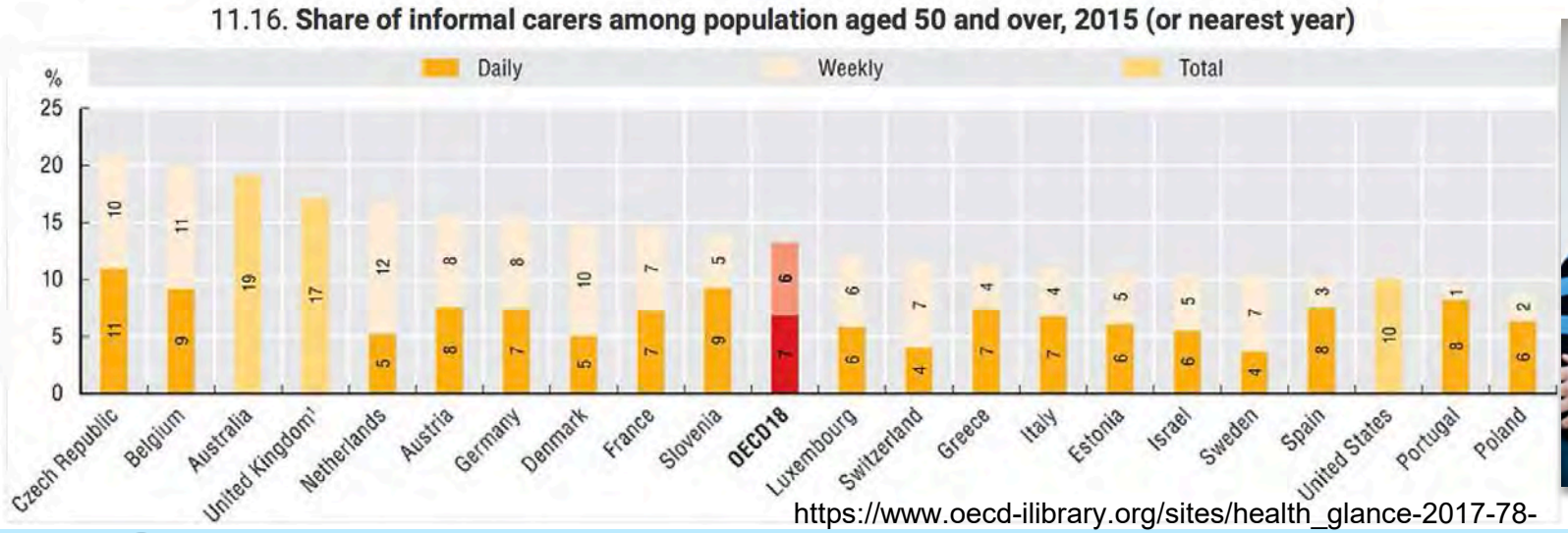


Based on Bytyci et al. 2019

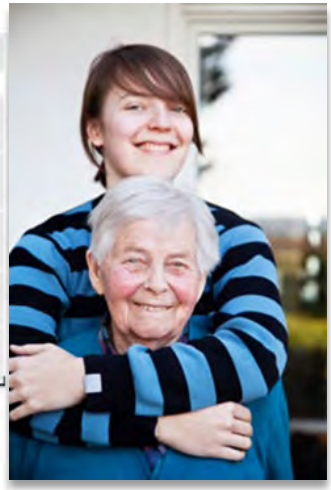
The situation of carers in Europe: The personal is political

- Across Europe, unpaid family carers and friends are the largest providers of health and social care support
- As demographic change, migration and changing family patterns increase demand, informal care becomes more challenging
- Informal care has significant impact on labour market participation, health outcomes and social integration
- Estimates on the economic value of unpaid informal care in EU Member States range from 50 to 90 percent of the overall costs of “formal” long-term care provision
- Estimated value of contribution made by carers in the UK: 140 billion € per year

Adapted from Eurocarers, https://eurocarers.org



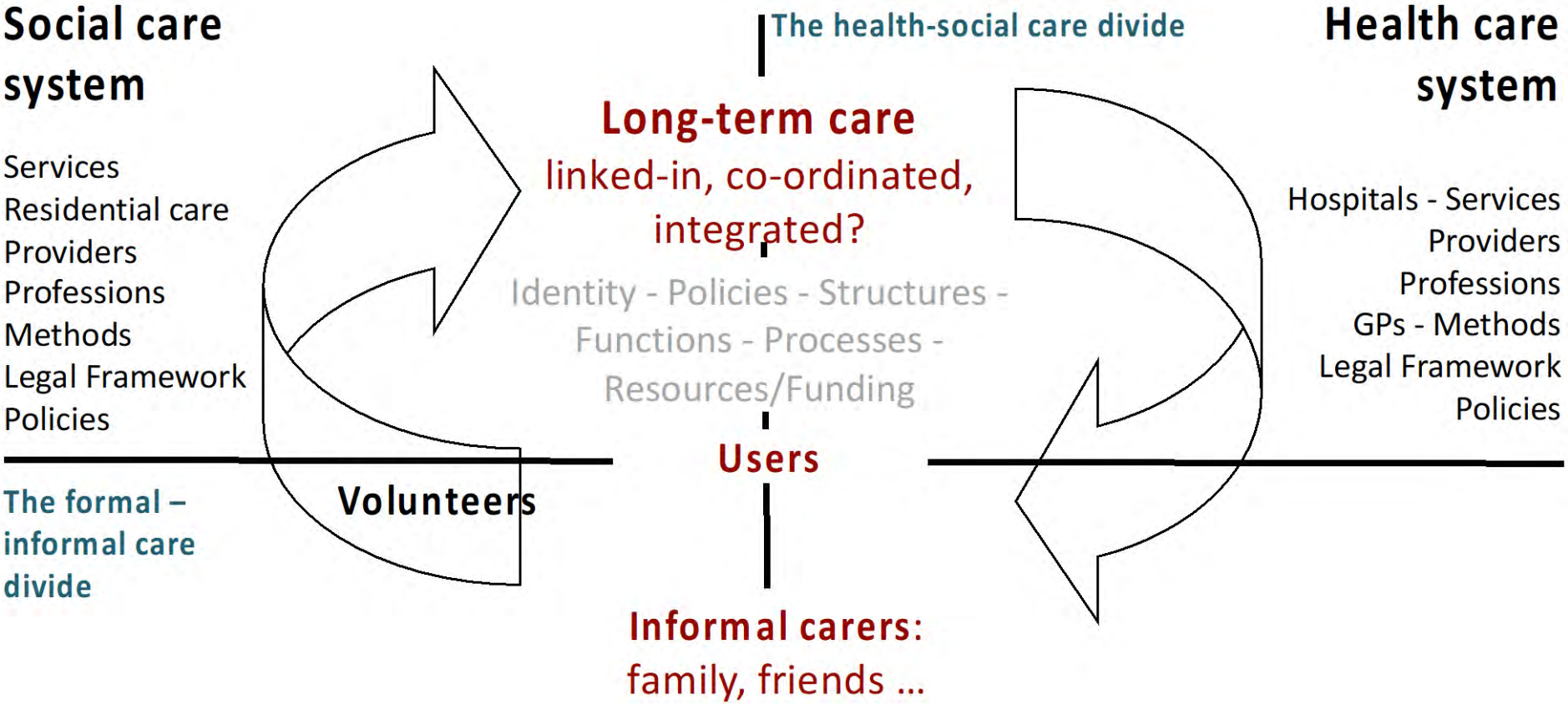
https://www.oecd-ilibrary.org/sites/health_glance-2017-78-en/index.html?itemId=/content/component/health_glance-2017-78-en



Bridging the gap between health and social care

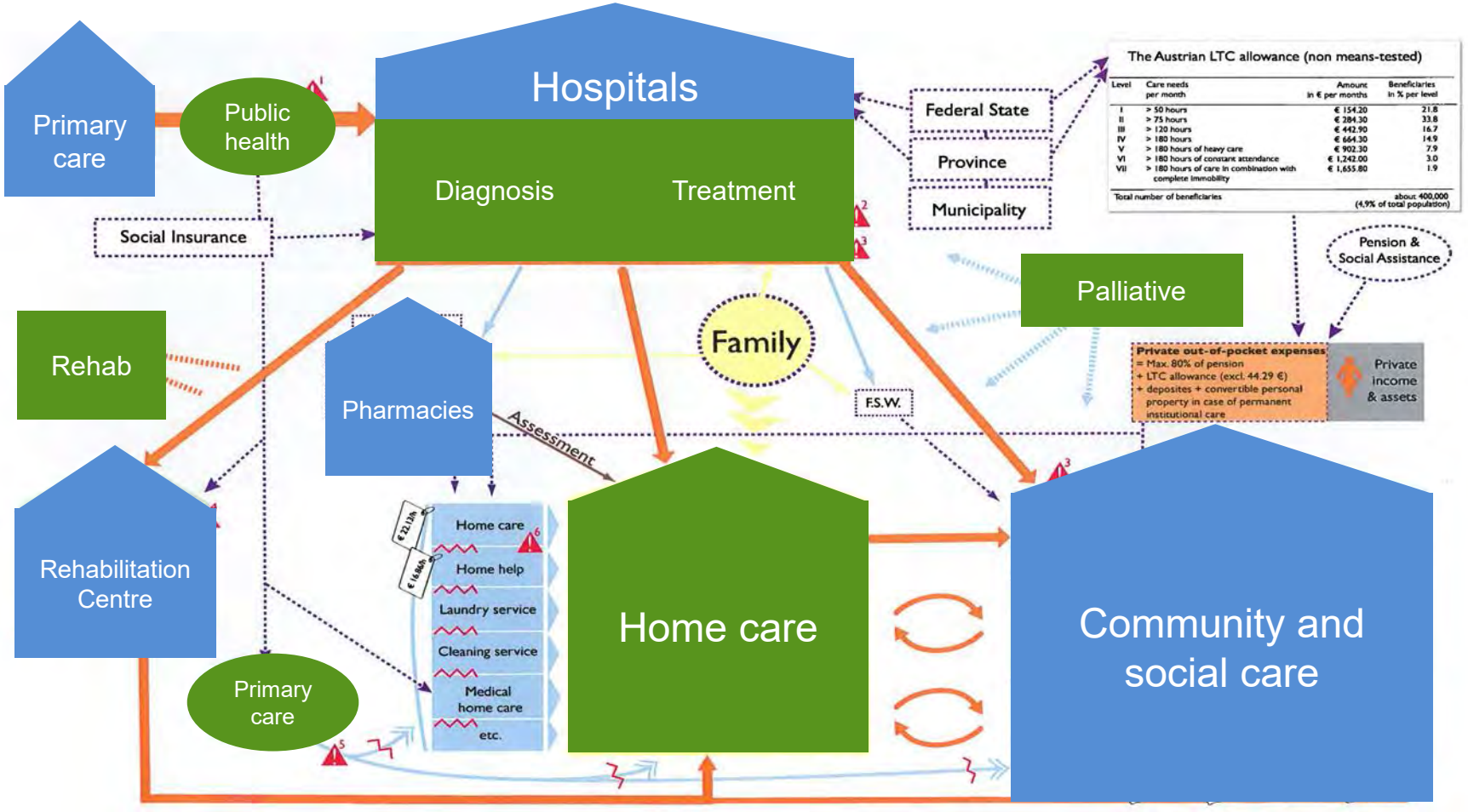
Definitions

Emerging long-term care systems



Leichsenring et al., 2013; http://interlinks.euro.centre.org

So how do we get from a fragmented, highly complex system without clear governance and accountability…



Source: Pathways for long-term care provision in Austria, Interlinks, European Centre 2009

…to an integrated system, where people and systems talk to each other?

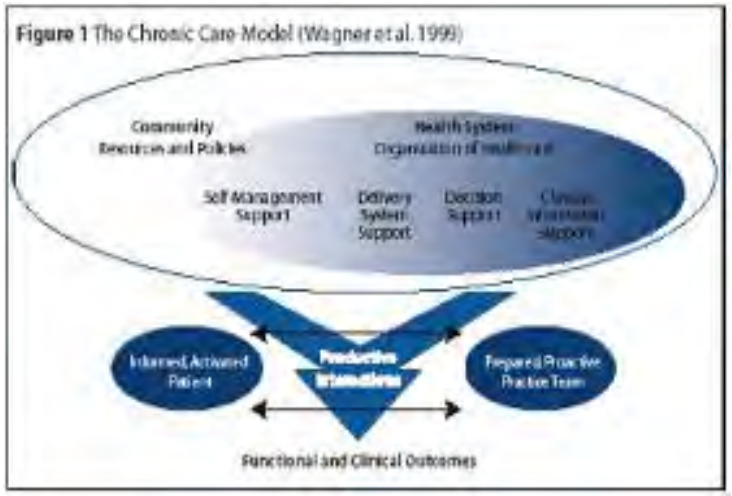
Approx. 600.000 inhabitants

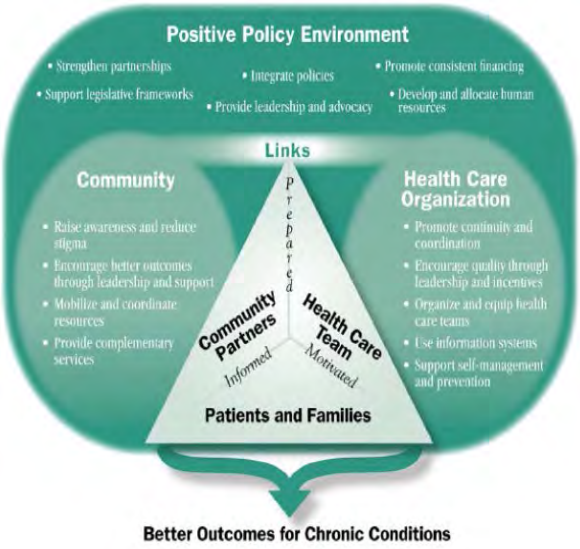
The Kings Fund
Ideas that change health care

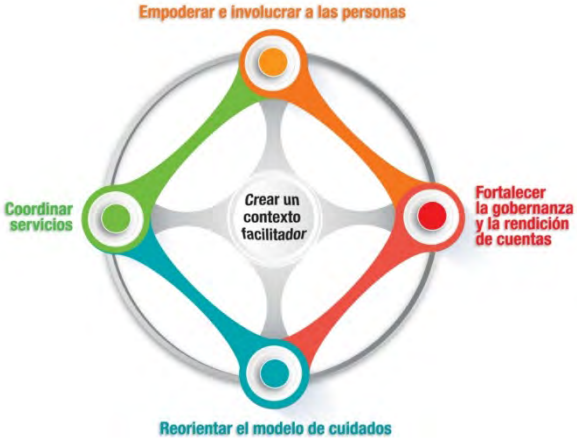
Canterbury District Health Board
Te Poari Hauora o Waitaha

Creating the conditions on the system level

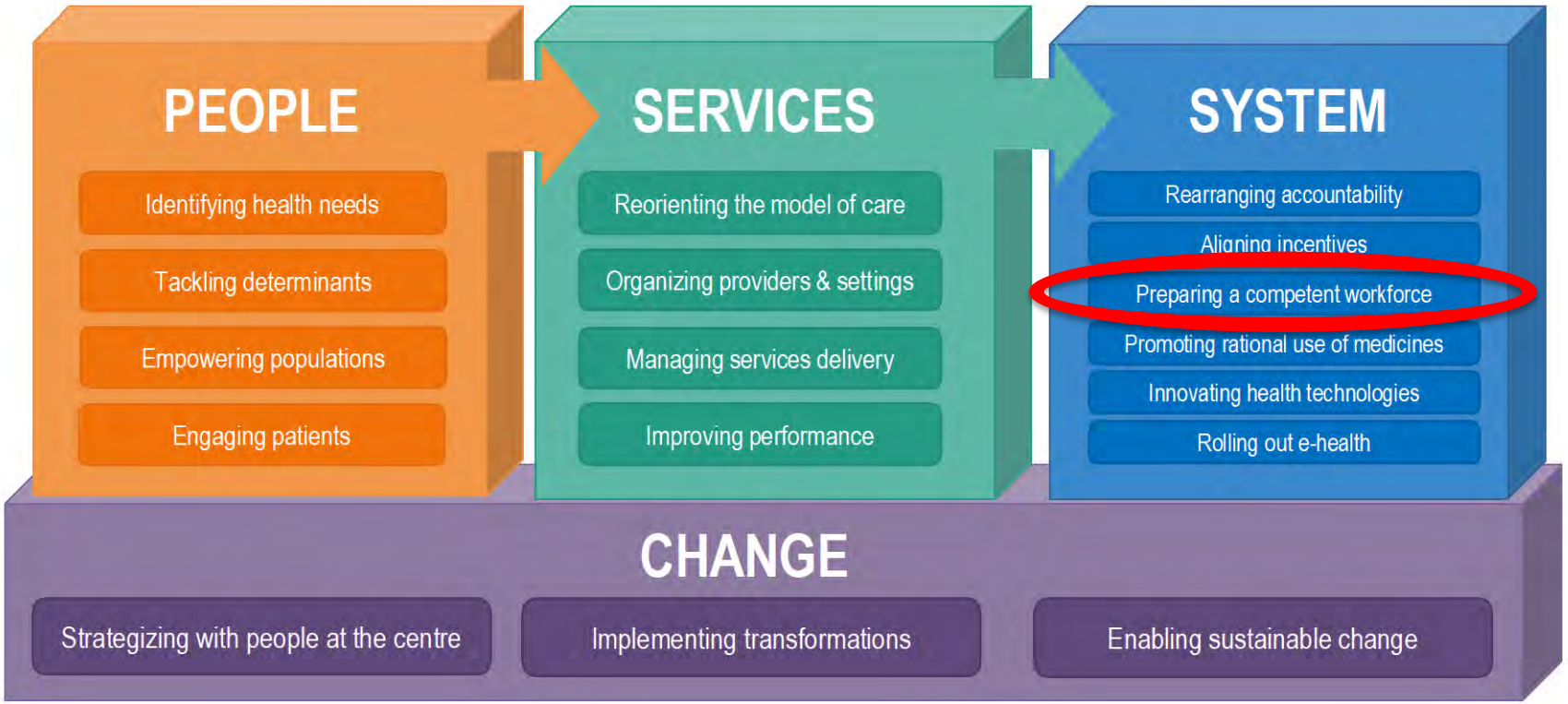
Many Frameworks Have Been Developed to Understand the Key Elements for Successful Integrated Care







The WHO European Framework for Action on Integrated Health Services Delivery



WHO Europe 2016

http://www.euro.who.int/en/health-topics/Health-systems/health-services-delivery/publications/2016/the-european-framework-for-action-on-integrated-health-services-delivery-an-overview-2016

Key elements for integrated care to happen

The Kings Fund

Ideas that change health care

Canterbury District Health Board
Te Poari Hauora o Waitaha

System wide focus

VISION: To integrate the care of patients, particularly those at risk of poor health outcomes, across the health system in order to improve patient and provider experience, health outcome and efficiency.

Stakeholders – how do we meet community need?

1. Joint planning
2. Community & patient engagement

Process perspective- what do we need to excel at?

3. ICT to share information
4. Shared clinical priorities agreed
5. Data available as measurement tool for QI

What do we need to achieve to ensure sustainability?

6. Focus of care on geographical population
7. Incentives for support care coordination

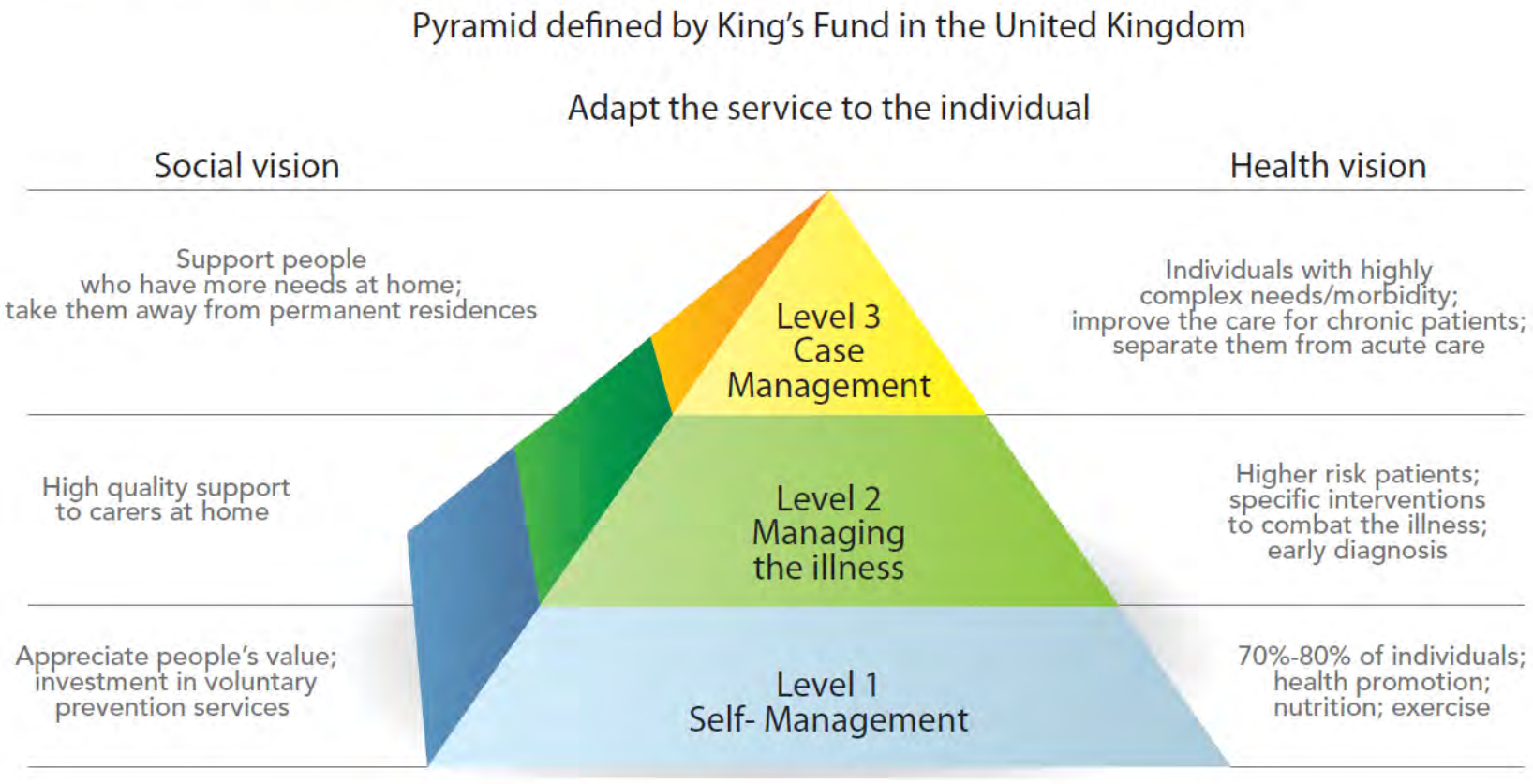
Learning, growth & change – people and culture

8. Appropriately train workforce with acceptance of values of working together
9. Culture of system innovation
10. Change supported and collaborative

VALUES: 'Right care, right place, right time'

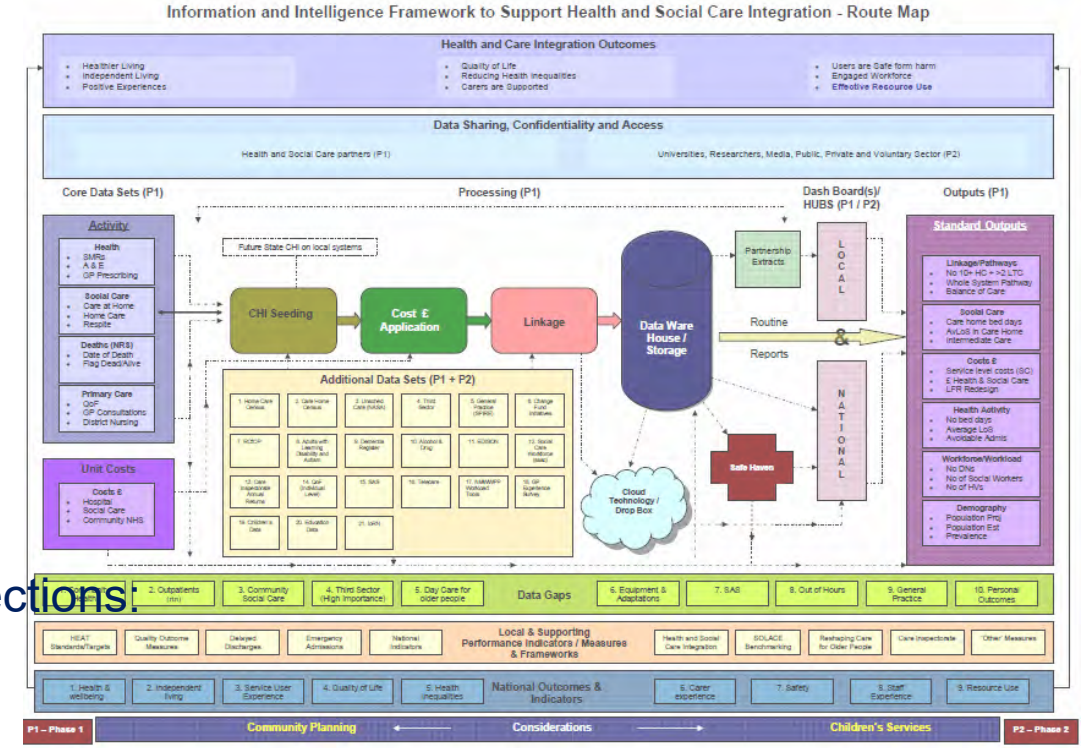
Organising services according to needs

Pyramid defined by King's Fund in the United Kingdom



Source: King's Fund (C.Ham)

Success through shared aims, shared learning and shared measures



Common Minimum Dataset - six sections:

1. Demographics
2. Referral
3. Home Care
4. Intervention
5. Discharge
6. Additional Referrals - within intermediate care

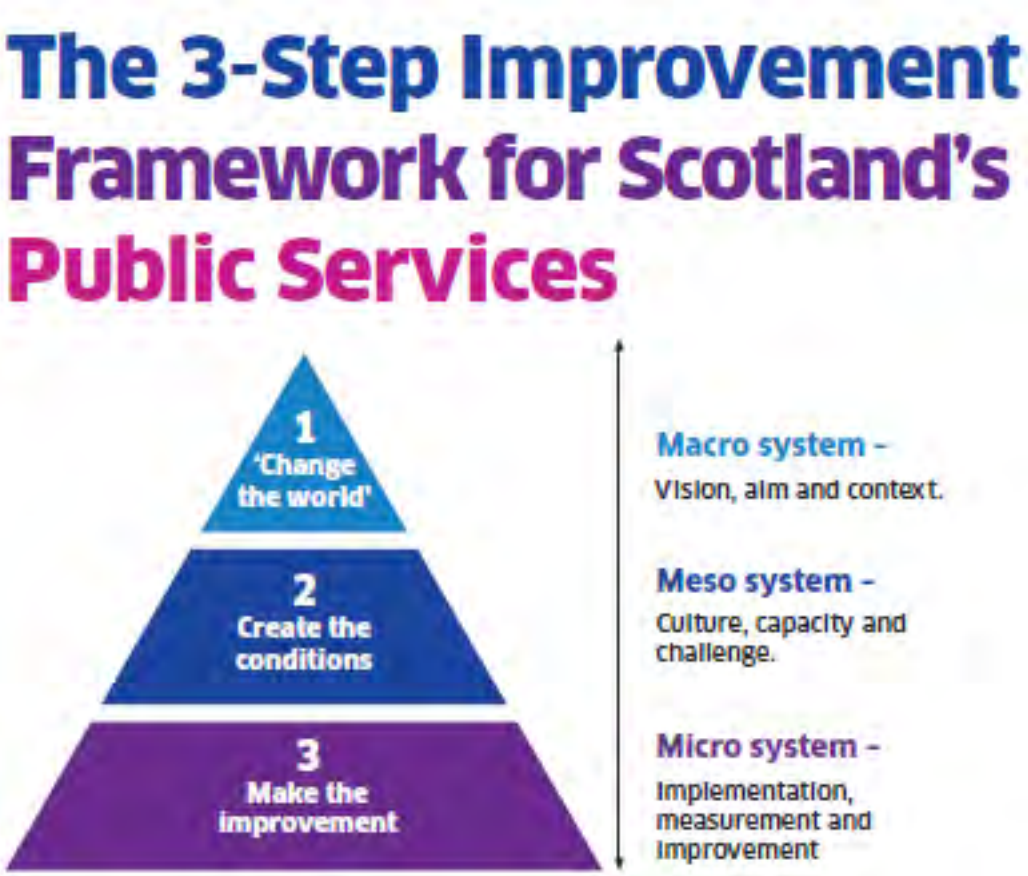
Full dataset document and more information can be found at:
http://www.knowledge.scot.nhs.uk/chin/intermediate-care.aspx

Competencies for integrated care: levels and roles

System	To create enabling framework and allow for flexible and creative environment; to adapt professional education and training systems; to have a vision and lead towards integrated care.
Organisation	To lead and manage integrated care across sectors and professions; to manage change processes; to understand integrated care needs and create continuous learning environment.
Professionals	To work in inter-disciplinary teams across settings; to actively engage patients, families and communities; to understand integrated care needs and participate in continuous education programmes.
People	To actively participate in own care management; to engage in building healthy communities; to understand integrated care needs and practice life-long learning.

Stein 2016

Scotland's national improvement programme



So you created the perfect system - but nobody cares…

Why people-centred is crucial for sustainability

"The people-centred approach meets these broader challenges by recognizing that **before people become patients, they need to be informed and empowered** in promoting and protecting their own health. There is a need to reach out to all people, to families and communities beyond the clinical setting. In addition, **health practitioners are people, and health care organizations and systems are made up of people**. Their needs should also be considered, and they must be empowered to change the system for the better. That is, a people-centred approach involves a balanced consideration of the rights and needs as well as the responsibilities and capacities of all the constituents and stakeholders of the health care system [and beyond]."

People-centred health care: a policy framework
WHO Western Pacific Region 2007

A Question of Trusted Relationships

Trust

- Contracts can't anticipate and resolve every type of problem; each party needs a genuine belief in integrity of the other side

The 'right' personalities

- Avoid competitive relationships where people are possessive and defensive about their areas of responsibility
- Need to share and openly address problems without fear of reprisal

- **Openness in communication**
  - High levels of communication between organisation, partnering team and individual

- **Organisational culture and organisational learning**
  - A shared culture enhances commitment and consistency of individual behaviours, aligns goals and promotes trust
- **Teambuilding**
  - Important for aligning the differing perspectives of participants and for building trust
- **Leadership and senior management**
  - Crucial for reinforcing partnering concept, countering arguments of detractors and nurturing partnering process

Trust - start sharing your milk!

The right people

"K(nowledge) S(kills) A(ttitudes) are the abilities and characteristics that enable a job holder to accomplish the activities described in a task statement that describes what the job holder does."

(Quinones, Ehrenstein 1997)

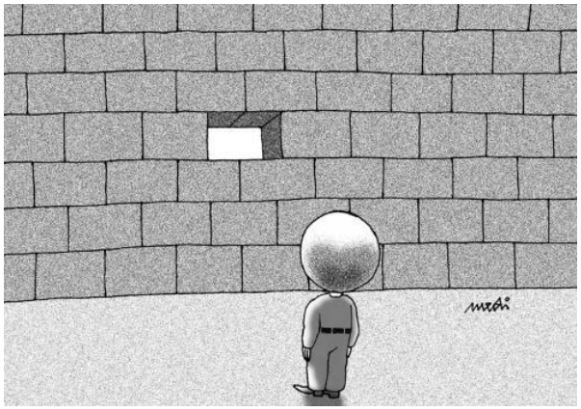
- Knowledge – what I know
- Skills – what I can do and how
- Attitudes – why I do it

Competencies

Openness in communication

"The two words 'information and 'communication' are often used interchangeably, but they signify quite different things. Information is giving out; communication is getting through."

Sydney J Harris



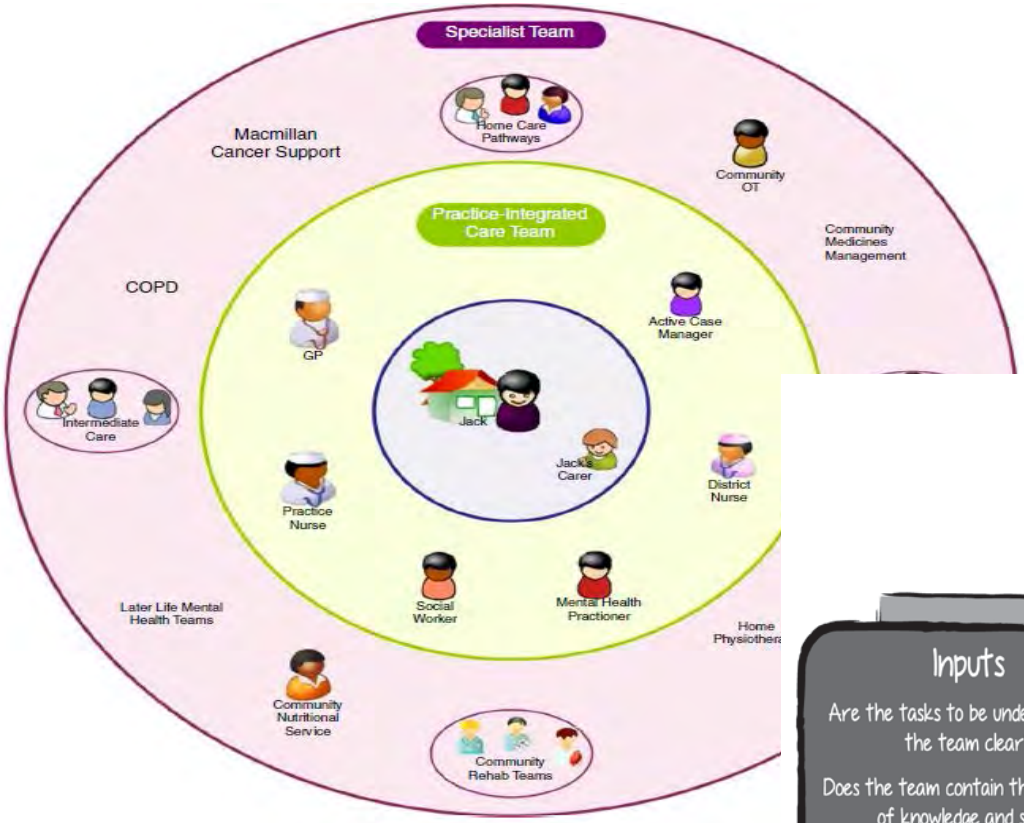
Organisational culture and organisational learning

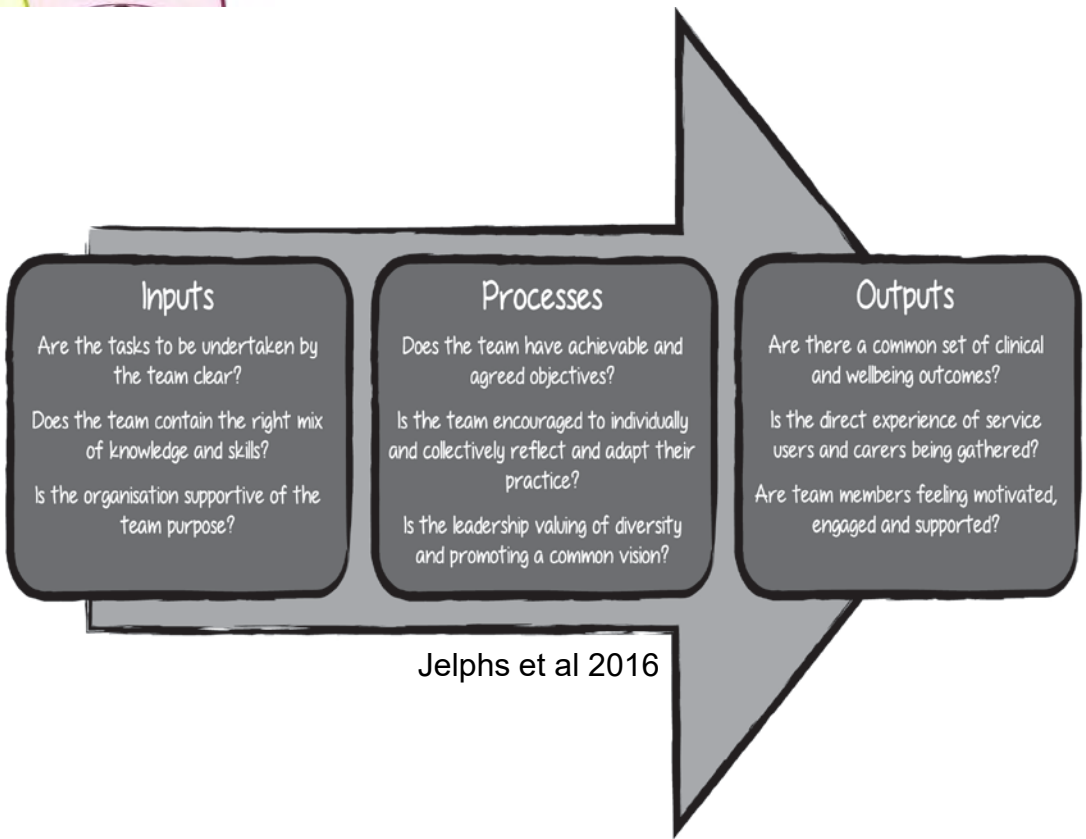
Culture of a Learning Healthcare System Builds Value

- Common Vision
- Clinical Work Processes
- Data and Evaluation Transparency

Intermountain Healthcare
Healing for life®

Teambuilding





Jelphs et al 2016

Leadership and senior management

- Visions of high quality care
- Clear objectives
- People and performance
- Engaging staff
- Learning and Improvement
- Team Working

'Leadership of all, by all, for all'

West et al 2014

Lessons from Europe and around the world in summary

Prerequisites for high quality home care services

- Developing a smooth, clear and national care transitioning process, e.g. National Framework for Intermediate Care Scotland
- Shifting care from hospital to community, e.g. ACSCs, outreach programmes, Hospital at Home
- Redefining the role of hospitals, e.g. Hospital Clinic Barcelona, Hälsostaden Sweden
- Providing high-quality care in hard to reach areas, e.g. EKSOTE Finland
- Enabling older people, families and communities as equal partners in care, e.g. Bulgaria
- Taking an asset-based approach, e.g. hairdressers, postman, fire services, existing networks

Based on Stein 2018

The WHO European Region:
53 Member States – 900 Mio inhabitants
10 Lessons learned from 85 cases across the Region

1. Put people and their needs first
2. Reorient the model of care
3. Reorganize the delivery of services
4. Engage patients, their families and carers
5. Rearrange accountability mechanisms
6. Align incentives
7. Develop human resources for health
8. Uptake innovations
9. Partner with other sectors and civil society
10. Manage change strategically

WHO Regional Office for Europe. Lessons from transforming health services delivery: Compendium of initiatives in the WHO European Region. WHO, Copenhagen 2016

It needs senior leadership and a top-down/bottom-up approach

TOP-DOWN

STANDARIZABLE INTERVENTIONS

STRATIFICATION

CALL CENTER

ELECTRONIC MEDICAL RECORD

FINANCING AND JOINT COMMISSIONING

ELECTRONIC PRESCRIPTION

BOTTOM UP

LOCAL INNOVATION

CASE NURSING

PATIENT EMPOWERMENT

HEALTH AND SOCIAL CARE COORDINATION

SUBACUTE CENTRES

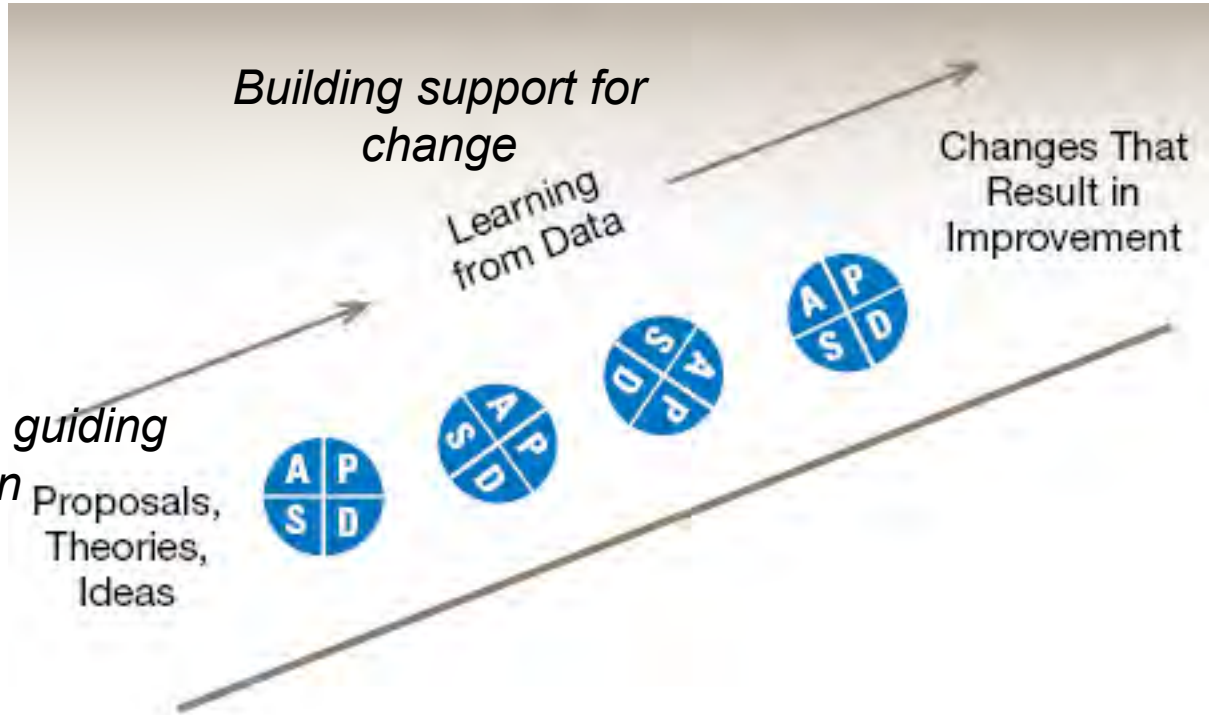
INTEGRATED CARE

Bengoa, Mota 2013

Integrating care is a continuous improvement and learning process – You‘re never done!

Time – relationship building

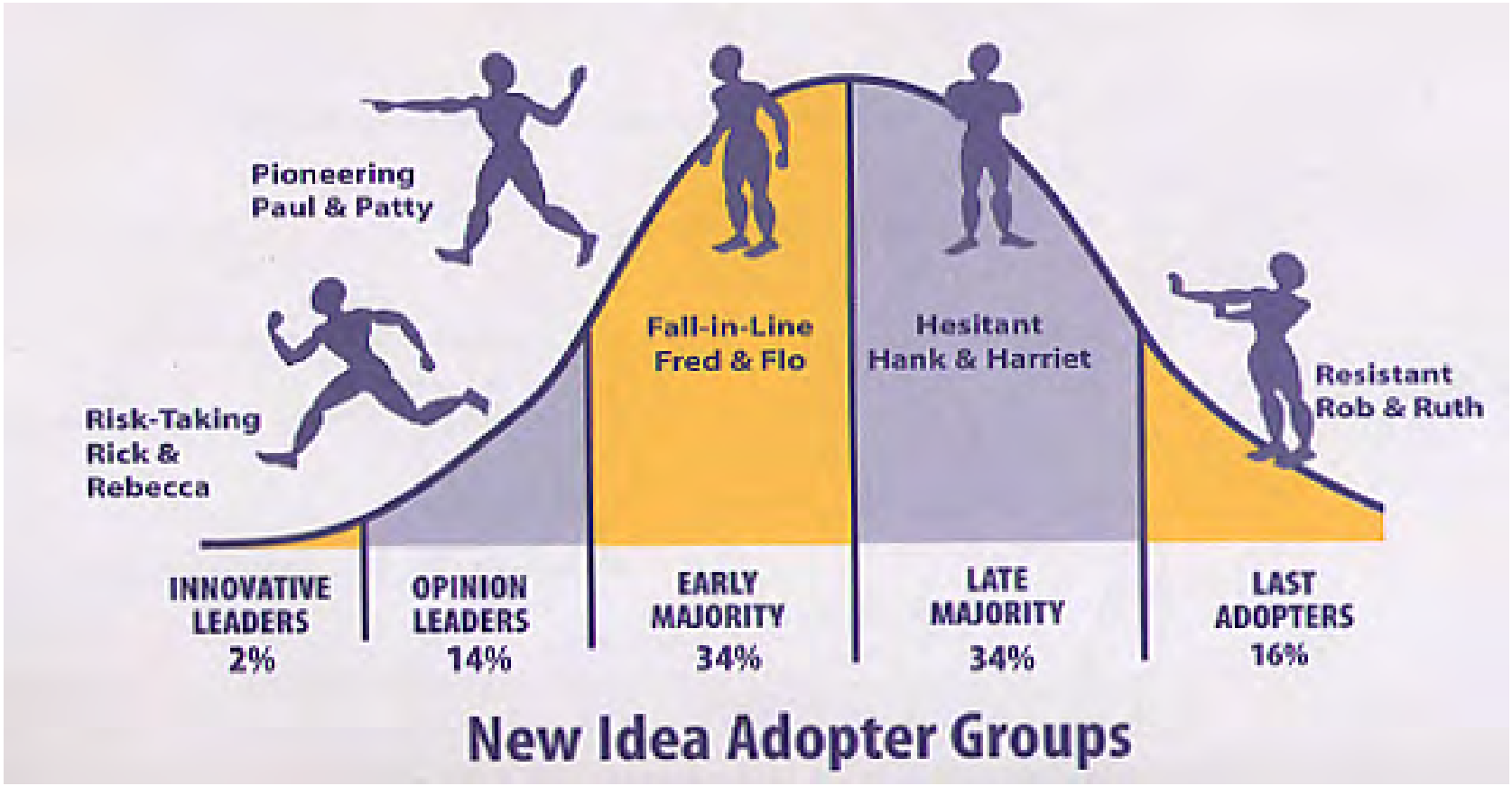
Developing Collaborative capacity



Time – organisational transformation

Stein 2019, based on Goodwin 2017 and Andrews 2018

Adoption of Innovation



https://brkyzz.wordpress.com/diffusion-of-innovations-rogers-e-1995/

Diffusion of Innovations / E. Rogers (1995)

Ultimately, what do we want?

Commission for the Provision of Quality Care in Scotland, 2015

See you in Šibenik in 2020

To conclude

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

National Voices 2013

K. Viktoria Stein, PhD

Director of Education and Training
International Foundation for Integrated Care
viktoriastein@integratedcarefoundation.org
www.integratedcarefoundation.org

The | Le Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

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.

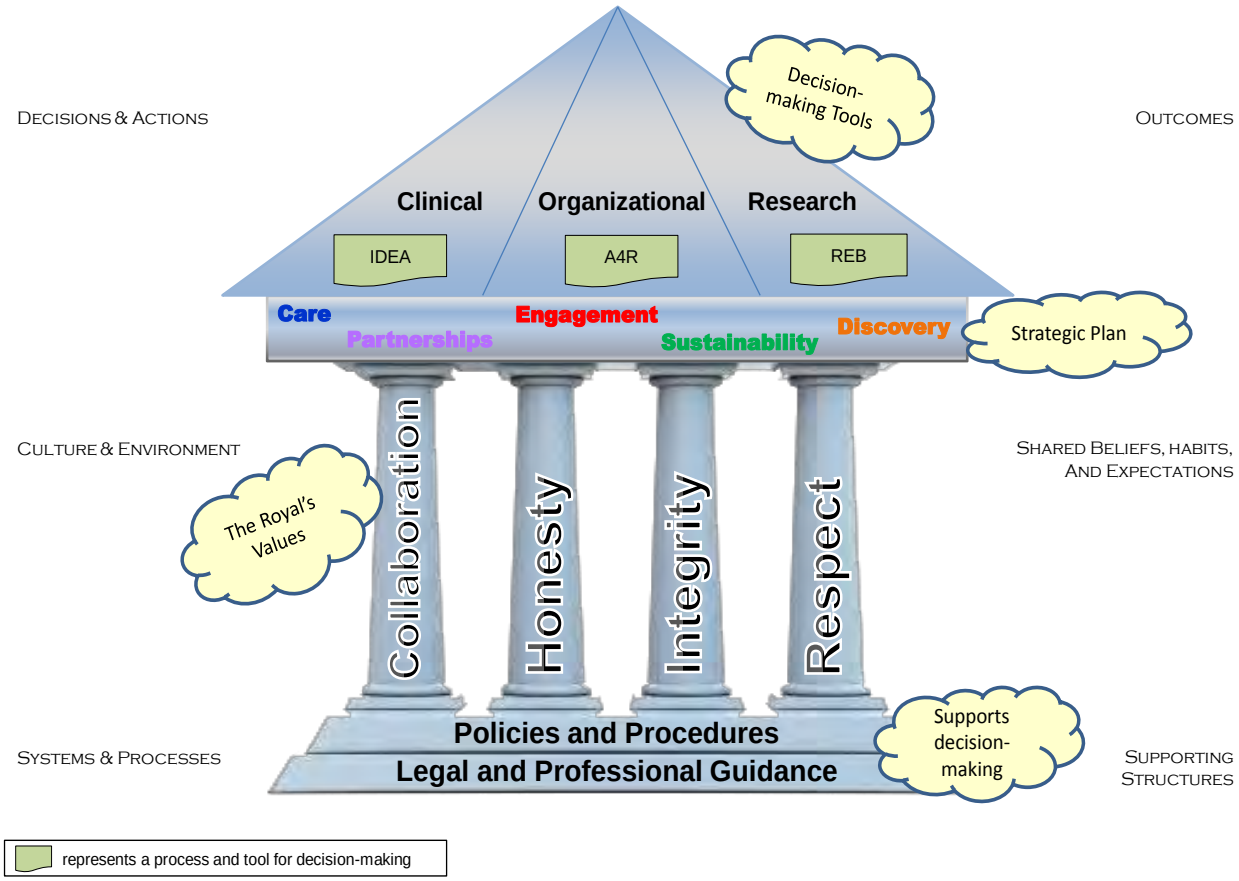
WHICH TOOLS FOR WHICH DECISIONS?

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



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

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