EXCLUDED SESSIONS	1. **RESTRICTED** - Independent Board Members and CEO a) IMHR Audit
	2. **IN CAMERA** - Independent Board Members only Approval of minutes of the June 3, 2020 Special Board meeting a) President & CEO's Performance Evaluation b) Psychiatrist-in-Chief/Chief of Staff's Performance Evaluation

BRIEFING NOTE - CONFIDENTIAL

June 08, 2020

To: **Royal Ottawa Health Care Group – Board of Trustees**

Re: **Summary of findings and status report**
REB # 2018005
The Safety, Tolerability and Behavioural Effects of Souroubea-Platanus in Healthy Volunteers
(Health Canada File No. 242676)

Prepared by: Dr. Florence Dzierszinski, IMHR interim COO, and Director, Research Development and Partnerships

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As per briefing note to the ROHCG Board of Trustees (March 25, 2020), this file includes various dimensions of risk and compliance. As the contractual and financial aspects have been addressed, this status report focusses on the aspects that were recently closed or ongoing:

1) Compliance: research involving humans (REB)
2) Compliance: conflict of interest
3) REB processes: audit and mitigation measures

1) Compliance: research involving humans (REB)

On April 09, 2020, The Royal's Research Ethics Board (REB) held an ad hoc meeting and withdrew its approval of the clinical trial sponsored by Souroubea Botanicals Inc. based on the findings of the audit report, including:

- Research not being conducted in accordance with the REB-approved protocol or requirements,
- Failure to properly obtain or document consent from research participants,
- Failure to comply with conditions placed on the research by the REB, by the sponsor, or by other agencies,
- Failure to obtain prior REB review and approval of modifications to the research consent forms and study procedures,
- Failure to maintain accurate research records,
- Failure to comply with Good Clinical Practice (GCP) guidelines and Health Canada regulations to ensure the safety of participants (e.g., the administration of a novel agent in a Phase I trial without documentation of a negative pregnancy test prior to administration of the product), and the appropriate care and monitoring of research participants (e.g., lack of documented evidence of MD oversight of abnormal lab results) as outlined in GCP.

This withdrawal precludes any further steps in the study, any publications of the clinical data in their present form, or attempts to commercialize.

All mitigation points are summarized in the table below:

Item	Comments	Action owner / Status
Risk to participants' health	The REB deemed this risk rather low, given the fact that participants were included as healthy participants, and that a natural product was assessed; however, given the quality of the conduct of research, an external expert opinion was sought [Dr. Dugald Seely, ND]. "After reviewing un-blinded data relating to surrogates for harm and the timeline since study completion I don't believe it is necessary for further follow up on the participants and testing. It is my opinion that it is very unlikely that any residual effect on safety and persistent harm to participants	Completed. Full confidential report on file.

	could have occurred if indeed they were even present during the trial."	
Consent, participants	The PI (Dr Shlik) has an ethical obligation to notify participants that REB approval for this study has been terminated. A template letter was drafted and reviewed institutionally.	REB Office / PI: ongoing; the REB Office will provide support.
Reporting: Health Canada	The trial Sponsor, Souroubea, has reported the withdrawal of the REB approval to Health Canada	Completed.
Possible audit by Health Canada	HC has not audited closed trials in the past; given this, and given the current COVID-related clinical trials that were launched since March, the risk is rather low; however, planning for audits on a risk basis is ongoing (as per section 3 of this document)	Ongoing.
Reporting: HIROC	This file was added to The Royal's and the IMHR's risk registers	Completed.
Reporting: uOttawa	Ongoing collaborative approach to the file; please see also below under 2) COI	Completed.
Reporting: Secretariat on Responsible Conduct of Research (RCR)	Please see below under 2) COI	
Reporting: CMPA	This item is related to the activities of an MD on site without privileges (Dr. Holland)	Dr Bhatla – completed.
Role of REB Chair at the time	The REB Chair at the time was not aware of the specific activities taking place post REB approval	Completed. A process for post-approval monitoring is now place.
Publications	As the REB approval was withdrawn, publication of the data in their current state is not authorized	Completed. The investigators have acknowledged.
Communication plan	To mitigate any potential escalation	Joanne / Nicole / Florence - prepared
Appeal	Researchers may appeal the REB decision and / or retain a lawyer. An appeal is deemed unlikely given the nature of the findings and the time since REB approval withdrawal. However, processes are in place.	IMHR / Legal, should this occur Appeal process as per REB TORs clauses 7.4 and 7.5; the appeal board's decision is final

2) Compliance: Conflict of Interest (COI)

Item	Comments	Action owner / Status
Internal and external review	Perceived or actual COI confirmed.	Completed (Legal opinion report)
Breach to ROHCG COI policy	Addressed in a letter to Dr. Merali.	Completed
uOttawa	We have kept uOttawa informed and have asked whether a COI management plan was developed at uOttawa; no disclosure was made at uOttawa	Joanne / Florence – completed
Disclosure as per Responsible Conduct of Research (RCR) policy, to TCPS2/federal Secretariat	Once the RCR report is completed (June 2020), a small internal working group will be formed as per academic practices; this group includes representation of: The Royal, the IMHR, the uOttawa FOM Dean's office for both research	

	and academic matters, Faculty of Science, Faculty of Social Sciences, the uOttawa VP Research office, uOttawa Ethics office. Note: academic institutions address these cases on occasion; it is a serious case, but we have the expertise and collaboration in place to manage the file. Estimated : summer 2020

3) REB processes: audit and mitigation measures

- In November 2018, the IMHR hired an expert in clinical research compliance to manage the REB Office – Ms. Tammy Beaudoin, succeeding to Dr. Keith Busby, who retired in December 2018.

- While compliant processes are now all in place (all details reported at the Dec 2019 Board of Trustees meeting), it is clear that the Souroubea-sponsored study took place in the transition period, prior to the implementation of such processes.

- As of April 2019, all compliant SOPs were developed and implemented.

- New processes were developed and implemented, including applications for Health Canada-regulated trials (by Summer 2019).

- The clinical research audit process (QARE) was developed and launched in the summer 2019; the first audit revealed a few findings, which were mitigated; the second audit corresponds to the present Souroubea-sponsored trial; the third and upcoming audit will be scheduled shortly, and as soon as possible given the current COVID-crisis.

- The REB Terms of Reference were significantly reviewed and are now being finalized, including process to appoint, evaluate and renew REB Chairs and Vice-Chairs. It is estimated that a call for expression of interest to appoint a REB Chair will be launched in the summer 2020.

4) Conclusions at this point in time

- While the file is still active at this point in time, it is estimated that the level of risk related to this clinical trial decreased between March and June 2020.

- Most importantly, the expert opinion on potential risks to participants' health is reassuring.

- Processes are in place to prevent potential reoccurrences.

- In addition, the breach to the ROHCG policy on Conflict of Interest was addressed.

- The next stage (disclosure as per RCR policy) is planned for the Summer 2020; as per collaborative approach with uOttawa: because due diligence was carried out on all aspects of the file, the risk of a recommendation of an external investigation by the RCR Secretariat is estimated as 'low'.

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 1-IC	**Priority:** Important

DATE:	June 18, 2020
COMMITTEE:	
PRESENTER:	A. Graham
SUBJECT:	Approval of June 3, 2020 Special Board meeting minutes

BACKGROUND INFORMATION:
LEGAL REVIEW AND/OR APPROVAL:
MOTION FOR APPROVAL:
BE IT RESOLVED THAT, the minutes from the June 3, 2020 Special Board meeting be approved, as presented.

Moved by:

Seconded by:

Motion approved:

MINUTES
ROYAL OTTAWA HEALTH CARE GROUP
Board of Trustees
Special Meeting
June 3, 2020 at 4:30 p.m.
via Zoom (see details in calendar)

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

MEMBERS		**STAFF**		**GUESTS**
Present	**Regrets**	**Present**	**Regrets**	
A. Graham, Chair I. Levy, Vice Chair C. Coulter, Vice Chair L. Leikin N. Bhargava J. Gallant S. Squire D. Somppi J. MacRae L. Gillen J. Charette	R. Anderson	J. Bezzubetz R. Bhatla		**SCRIBE** P. Robb

#	ITEM	REFERENCE	ACTION ITEMS
1.	**CALL TO ORDER**	A. Graham, Chair, called the meeting to order at 4:31 p.m. and declared it to have been regularly called and properly constituted for the transaction of business. This meeting was called as part of the Compensation & Succession Committee process for the Board to provide feedback on the performance objectives of the President & CEO and Psychiatrist-in-Chief/Chief of Staff.	
2.	**AGENDA AND MINUTES**	**a. Acceptance of Agenda**	
		Moved by D. Somppi and seconded by C. Coulter **BE IT RESOLVED THAT,** the June 3, 2019 agenda be accepted, as presented. **CARRIED**	
		b. Approval of the In-camera Minutes of February 20, 2020	
		Moved by D. Somppi and seconded by L. Leikin **BE IT RESOLVED THAT,** the February 20, 2020 in-camera minutes be approved, as presented. **CARRIED**	
3.	**PERFORMANCE GOALS**	**a. Discussion on Performance Goals of President & CEO and Psychiatrist-in-Chief/Chief of Staff**	

		Board members were provided with an opportunity to comment on the CEO and COS/PIC's 2019-2020 objectives. Before proceeding, the Board members were unanimous in wanting to commend both J. Bezzubetz and R. Bhatla for the organization they have had to do in terms of surviving and thriving to manage the situation with Covid-19 and to continue moving the organization forward with the strategic plan. They have lead the teams in such a way that they have been able to pivot quickly into this new Covid-19 environment. The only comment made on the 2019-2020 objectives was in regards to the QIP metrics relating to performance and that everyone in the organization should own that. The discussion then moved on to the 2020-2021 objectives with the following feedback given: - Recognizing that organizations everywhere are dealing with looking at the next year through a lens of uncertainty, should a specific objective be set on returning the hospital to stability in a post-Covid-19 world and proving resilience in 2021? How do you measure vision and leadership? This is going to be at the heart of the new strategic plan and bringing the three boards together. Leadership in culture of organization was embodied in how you were able to pivot readily in response to Covid-19. Next phases will be more complicated and you will need to make sure you are maintaining competence and place in community. This is valued in our leader and we don't want to lose it. - Objectives are measureable, but they need to be tightened. Would prefer that objectives are more than what is expected by government. Be as specific as possible. Not just meet what is expected, but exceed it, understanding that there are uncontrollable factors. - Are there other measures, and what is our aspiration from an organization cultural perspective? - In looking at next year's objectives, where does the academic mandate fit into it? There is a desire to see the integration between IMHR and The Royal to transition towards evidence-informed care. J. Bezzubetz noted that this topic can fit into Corporate Alignment and can be defined with the vision of becoming a research hospital/academic centre and executing on it differently (integrating clinical care and research). The feedback through the strategic planning process will describe those. The objective will be modified to include targets and be specific in how we would measure it. - Would like to see a bit closer alignment between these strategic ideas. This would give the Board some comfort on the research and care alignment piece. - R. Bhatla commented on the culture in relation to the Vanderbilt model that was included in his objectives. The medical staff are having good discussions about holding each other accountability. Discussions should	

		be had with peers about any concerns with performance and should be dealt with early. We engage managers and directors in peer to client behavior that is not as professional as we'd like. The way to keep it front and centre and really make a dent is to make sure colleagues are talking to each other and talk early when see any interaction or problems. This should bear fruit in future surveys. - The QIP is there because it is legislated. In the same way we talked about accreditation because it is the right thing to do, when having a discussion on what we learned in QIP a year from now, we should have that same sense. We did it because it was good for us, not because we had to do it. Why are we doing it and what are we learning from it? - Three specific comments/suggestions were given: 1) suggest we don't use the words 'that will meet'. Either exceed or we identify a learning that is going to be valuable from that. Enhance that with more clarity on what we want to achieve. 2) Respect hospital without walls vision. Access comes up all the time. Measurement on wait times is quite specific. Access feels like it demands a different measurement other than improving wait times. Be more specific on access measure. 3) One of the objectives includes implementation of innovation. If we could have three, at least one should be virtual care or digital. We have a window of opportunity right now. Sustaining that would be a good innovation. - J. Bezzubetz noted she could easily add the above suggestion, which fits best in the category of Organization Sustainability. Can include the three examples that are tangible and implementable. We have already started talking about sustainability, which are not easy discussions. The challenge is what to stop in favour of what we want to continue to do. Can modify targets and outcomes. - Agree that innovation point should be in goals and the suggestion of virtual technology is good. The goals didn't seem inspiring - aspiration was missing. On the leadership side on how we engage a better culture, the outcomes we want to measure through this is more the how. We have to find a way to put qualitative around this and need to leave ourselves wiggle room. There has to be some flexibility around this from the Board. It can't be all documented to a 't' - our strategic plan is still under construction. - R. Bhatla noted that he took seriously the commentary on lack of measurability on some of the objectives. One of the things we got feedback on when calling primary care providers and clients was they were hearing about the depression algorithm. This has opened up for clients and families to look at a care pathway where they can download information and resources and then have a good discussion with primary care providers. Looking at something similar for anxiety, which was well received and could be created quite quickly, but it has to be put in place. We are trying to open up something to the much broader	

		community, especially post-Covid-19. It is anticipated that anxiety will explode. - There is nothing in the objectives about the strategic plan. Presumably some of these objectives will fall in the strategic plan. Given that one of the key responsibilities is implementation of the strategic plan, should it be added as a sixth point that can be flushed out prior to Christmas? - Performance Measures are a key instrument and need to be aligned with what we are trying to achieve. We have a good and open Board, but it is hard to work in uncertainty. The Board will be understanding that some factors will not be able to be predicted. This is an important topic to provide focus from the Board on what we would like to achieve. - It is good in the sense that it has lots of objectives and we can measure against targets, but it is not inspiring. Want leadership to be inspiring and to think outside the box and take organization where they haven't been before. This is a piece of paper where we can check off the boxes. Targets are good if you want to check off boxes. For example, meeting the QIP targets. It has to be done because it is part of the legislation, but it is expected of leadership to look after that. Suggest take QIP out and substitute with strategic plan and expect leadership will meet QIP targets. - Do all of these require an equal rating? Was there any thought given to a different rating strategy? Are some of these more impactful and should be weighted differently? There is an opportunity to be more aspirational and forward thinking. This is specific to both CEO and COS. - There are activities, behaviors and then results. It is results oriented. There are a lot of activities and behaviors that speak to moving culture toward direction we want to head in. Is there an ability to have some of these activities and behaviors in some of the broad pieces? This is what we are going to do from a leadership perspective. If focus on results, can't have conversations and give you credit. Is it possible to set activity and behaviors in there as well so we can have a conversation when it comes to performance? - R. Bhatla noted that in terms of the QIP, only one of the four is mandatory. The others were driven by the Quality Committee and vetted through stakeholder groups. - Was originally inspired by the passion around a hospital without walls. What does that mean and then broaden that out in integration of the three boards and broader access to healthcare issues. How are we capturing all of these activities that are driving a transformational change? If access to healthcare in an integrated pathway will be a key focus of the strategic plan, how is that weighted in here and how does Board see it? - We have a ways to go before we can say that everyone in the organization understands what targets are set in the QIP and what everyone who works in organization can do to make sure those targets are	

		set. Interested in how they made it happen, rather than what happened. QIP should be here, but measure what leadership did to get organization behind it to make that happen. Don't measure the numbers reported, but how we got to those numbers. - J. Bezzubetz looked back at her original objectives and thought they were more in line with aspirational goals and strategic plan. She sent the previous objectives to Anne to look at. It touches more on leadership and strategic plan targets, but also includes some measures in terms of improving access and wait times. The first set of objectives were on onboarding and aspirational, but hearing from group they want more meat and substance to drive to goals and outcomes, but less quantitative. Need to find a bit of balance between the two types. The Chair wrapped up the discussion. There was some good clarity given. The Board appreciates both J. Bezzubetz and R. Bhatla's patience and receptivity to the feedback and hope this has been helpful to them. We'll all be looking to next year to be aspirational and Covid-19 smart. The Committee agreed that this was a helpful dialogue, which is important and healthy to have for the executive leaders and the Board.	
4.	**NEXT MEETING**	The Chair thanked everyone for the discussion and noted the tremendous progress that has been made over the last few years. The next meeting is on June 18, 2020 at 3:30 p.m.	
5.	**ADJOURNMENT**	**BE IT RESOLVED THAT**, the meeting be adjourned at 5:30 p.m.	

_____ _____

A. Graham
Chair, Board of Trustees

J. Bezzubetz
Secretary, Board of Trustees

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 2-IC	**Priority:** Important

DATE:	June 18, 2020
COMMITTEE:	Compensation & Succession Planning Committee
PRESENTER:	A. Graham
SUBJECT:	President & CEO's Performance Evaluation

BACKGROUND INFORMATION:
The role of the Committee is to deal with the overall executive compensation policy and succession planning, including the performance evaluation for the President & CEO and the Psychiatrist in Chief/Chief of Staff.
LEGAL REVIEW AND/OR APPROVAL:
MOTION FOR APPROVAL:
BE IT RESOLVED THAT the President & CEO's 2020-2021 objectives and performance pay (a portion of the percentage set out in the Variable Compensation Plan for Senior Management) based on the achievement of her 2019-2020 objectives be approved, as presented.

Moved by:

Seconded by:

Motion approved:

SCHEDULE "A"

Royal Ottawa Health Care Group
President & Chief Executive Officer
Proposed Performance Plan – 2020-2021

Proposed % BONUS	PERFORMANCE OBJECTIVE	TARGETS & ACTIVITIES	STATUS REPORT JUNE 2021
25%	1. Exceed targets set for Quality Improvement Plan (as per legislation)	**Target:** An engaged workforce focused on quality care and excellence **Activities:** Design and implement an organization-wide strategy to exceed the QIP targets	
20%	2. Implement the new Strategic Plan	**Target:** Develop and implement year-1 of Strategic Plan recommendations/strategies **Activities**: Each Royal entity has an operational plan; redesign the Organization to match our new Strategic purpose **Target:** Improve Access for current and new populations **Activities**: Expand care to North Eastern Ontario; provide additional virtual care options; redesign outpatient services to increase new clients; expand service delivery options to include evenings and weekends; offer modernized cared through innovative technologies (Ketamine and RTMS) **Target**: Implement the Hospital Without Walls Strategy	

SCHEDULE "A"

Royal Ottawa Health Care Group
President & Chief Executive Officer
Proposed Performance Plan – 2020-2021

Proposed % BONUS	PERFORMANCE OBJECTIVE	TARGETS & ACTIVITIES	STATUS REPORT JUNE 2021
		Activities: C-Prompt transitions to new, secondary-level of care options in a community clinic either in person or through virtual options; programs integrate care and research **Target**: Implement a strategy to actualize the vision of the Royal as an Academic Research Hospital **Activities**: Integrated research and clinical care in program areas; implementation of measurement based care; clients and family members are participating in the design of research studies	
20%	3. Innovation Implementation	**Target:** Implement three key strategic, Innovations **Activities**: Develop a prototype for a Digital Health Strategy; Develop a prototype for a Prompt Clinic; Develop a prototype for the development of partnerships with the technology sector	
20%	4. Transform the Royal's Organizational Culture	**Target**: Continue the integration of the Royal, the IMHR and the Foundation; **Activities**: Operational plan alignment synchronized with strategic plan	

SCHEDULE "A"

Royal Ottawa Health Care Group
President & Chief Executive Officer
Proposed Performance Plan – 2020-2021

Proposed % BONUS	PERFORMANCE OBJECTIVE	TARGETS & ACTIVITIES	STATUS REPORT JUNE 2021
		Target: Improved performance related to Client and Family Satisfaction **Activities**: Greater emphasis on Client and Family Centered Care; implementation of the Client and Family Centered Care framework **Target**: Higher workforce satisfaction ratings **Activities:** Workforce engagement in the development and implementation of strategic initiatives; workforce engagement in designing the Royal's future organization (the organization of the future)	
15%	5. Organizational Sustainability and adaptation related to Covid-19	**Target:** Resume and reimagine services within the newly set parameters for safety **Activities**: Expanded treatment hours spread throughout a longer workday to accommodate client flow in an infection-controlled environment; uninterrupted care; care options more client-convenient and preferred including, but not limited to Virtual Care and technology-aided service delivery	

Royal Ottawa Health Care Group
President and Chief Executive Officer
Performance Objectives - June 2019 to March 31, 2020

Proposed % BONUS	PERFORMANCE OBJECTIVE	TARGET/OUTCOME	MID-TERM STATUS REPORT NOVEMBER 2019	STATUS REPORT APRIL 2020
25	1. Quality Improvement Plan – language from legislation	As indicated in the Quality Improvement Plan. See Appendix 1&2 for Quality Improvement Plan and Workplan	See Appendix 1 for outcomes	See Appendix A for status report. - 6 - achieved - 3 - within 1% - 6 - not achieved (4 improved, 2 not improved)
20	2. Implement Strategic Planning process to link the ROHCG, the IMHR and the Foundation; select external facilitator as recommended to the Board	Three operating plans for 1 strategic plan; organization-wide alignment. Clear timelines established for each phase	See Appendix 2 for updated timetable including milestones No external facilitator required	New, refreshed plan developed with Potential (Strategic Planning Consultants). See Appendix B for new timetable and milestones. Target still Fall 2020 for final report.
10	3. Implement a process for community engagement with community partners to create a coordinated access to the mental health and addictions options in the region to serve clients, families and Ontario Health Teams	Process developed and endorsed by Community partners; process and implementation plan in place. Preparation of action plan as alternative if necessary	See Appendix 3 for implementation status Summer event occurred – 42 community partners attended	See Appendix C for written summary of the original coordinated access plan and COVID-19 response.
20	4. Improve access to ROH offerings for clients and families in the region through a vision of a Hospital Without Walls by making care options available in the community to clients and their referral sources	Support and empower VP's of Patient Care Services to transform services for easier access; implementation plan in place by the end of the year	See Appendix 4 for list of transformation initiatives and status reports	See Appendix D for transformation initiatives, including those related to the COVID 19 pandemic.

Royal Ottawa Health Care Group
President and Chief Executive Officer
Performance Objectives - June 2019 to March 31, 2020

Proposed % BONUS	PERFORMANCE OBJECTIVE	TARGET/OUTCOME	MID-TERM STATUS REPORT NOVEMBER 2019	STATUS REPORT APRIL 2020
10	5. Leadership evaluation of CEO in August of 2019	360 evaluation complete and reviewed with Board Chair – plan developed - execution of the plan and measurement of that plan according to feedback in collaboration with the Board Chair	Completed Developing Action Plan	See Appendix E for letter sent to my referees outlining areas for improvement.
15	6. IMHR Scientific Review takes place (March 2020) VP Research/IMHR – leader of selection committee (March 2020)	New VP Research/IMHR selected and key priorities identified for year 1 of employment	External consultants secured Search Firm in place Selection Committee in place Target date to identify VP/P is April 1/20	Top 2 candidates in last stages of interview process.

_____
Joanne Bezzubetz
President & CEO
ROHCG

_____
Anne Graham
Chair, Board of Trustees
ROHCG

_____
Date

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

Quality Improvement Snapshot 2019-2020

Strategic Plan Domain	Indicator	2019/2020 Target	Current Value	Status since last quarter
CARE Delivering person and family centred care, quality and safety	Satisfaction with Services "I think the services provided here are of high quality"	87%	88.0%	Not Improved
	Rate of MH&A episodes of care that followed within 30 days by another MH&A admission	9.91%	10.5%	Improved
	Reduction in the use of physical restraints	3%	3.8%	Improved
	% of medication reconciliations at admission for outpatients, where a medication reconciliation is warranted	65%	47.5%	Improved
	% of complaints acknowledged to the individual who made a complaint within 5 business days	80%	76.0%	Improved
	ROP - Overall resident satisfaction (resident reporting rate and overall satisfaction)	70% reporting	76.0%	Improved
		92% satisfaction	92.5%	Improved
	ROP - % of residents with worsening bladder control during a 90 day period	9%	7.8%	Improved
	ROP - Hand Hygiene compliance for staff and residents	80%	20.0%/24.0%	Improved
	ROP - Prevalence of falls in the quarter as a percentage of residents	12%	12.7%	Improved
PARTNERSHIPS Working together to increase capacity in our region	Reduce wait times in Mood and Anxiety Outpatient Services	90 days	27 days	Improved
	% of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital	50%	38%	Improved
ENGAGEMENT Fostering a Culture of Collaboration	Number of workplace violence incidents reported by hospital workers in a 12 month period	772	602	Unchanged
	Number of lost time claims related to workplace violence events	0.17	0.33	Not Improved
	WSIB days lost related to workplace violence events	0.25	3.12	Not Improved

On target or better

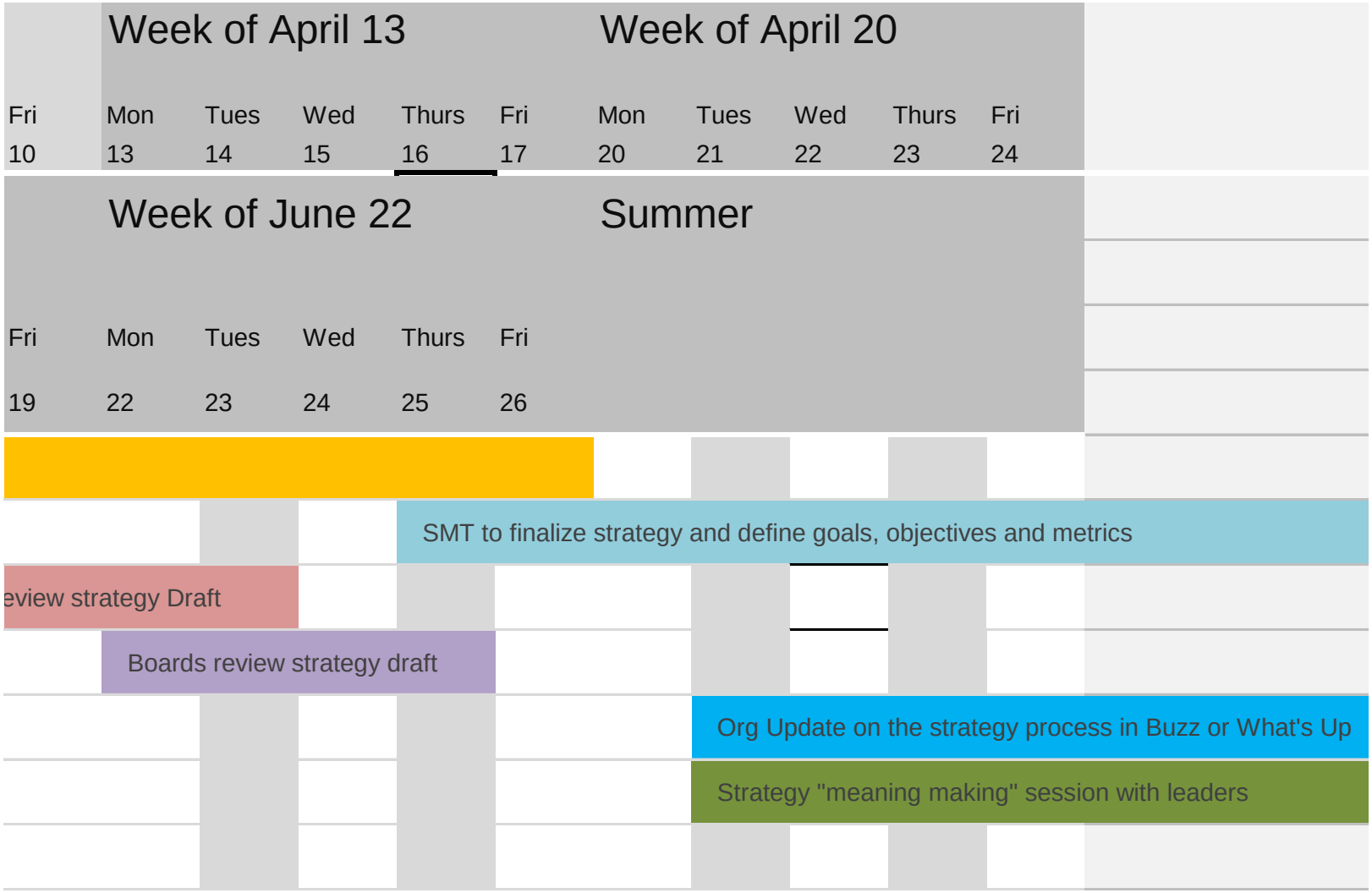
Within 1% of the target

Greater than 1% away from the target

Strategic Plan Timetable and Milestones

	Week of March 23					Week of March 30					Week of April 6			
	Mon	Tues	Wed	Thurs	Fri	Mon	Tues	Wed	Thurs	Fri	Mon	Tues	Wed	Thurs
POLLINATION	23	24	25	26	27	30	31	1	2	3	6	7	8	9

	Week of June 1					Week of June 8					Week of June 15			
	Mon	Tues	Wed	Thurs	Fri	Mon	Tues	Wed	Thurs	Fri	Mon	Tues	Wed	Thurs
HARVESSTING / STRATEGY DEVELOPMENT	1	2	3	4	5	8	9	10	11	12	15	16	17	18
TPG	TPG to draft initial strategy framework for review								TPG iterates the strategy based upon feedback					
SMT									SMT to review draft 1			SMT to review draft 2		
MAC														MAC re
Boards of Directors														
Communicaton	Org Update on the strategy process in Buzz or What's Up													
Management Council														


Week of April 13
Week of April 20
Fri 10
Mon 13
Tues 14
Wed 15
Thurs 16
Fri 17
Mon 20
Tues 21
Wed 22
Thurs 23
Fri 24
Week of June 22
Summer
Fri 19
Mon 22
Tues 23
Wed 24
Thurs 25
Fri 26
SMT to finalize strategy and define goals, objectives and metrics
eview strategy Draft
Boards review strategy draft
Org Update on the strategy process in Buzz or What's Up
Strategy "meaning making" session with leaders

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

REGIONAL COORDINATED ACCESS PROJECT

The Royal, in collaboration with community and hospital partners, clients and families, and primary care providers, completed the second phase of our Regional Coordinated Access project, which included the development of a governance/leadership structure, costing model, and implementation plan. The report detailing this work is in the process of being finalized (expected completion in the next 2-3 weeks). We have also proposed an urgent implementation of the Regional Coordinated Access model in response to the COVID-19 pandemic.

In response to COVID-19, The Center of Excellence for Mental Health and Addictions asked The Royal to be a central point of access, coordination, and connection to care for healthcare workers (HCWs) impacted by COVID-19. Led by The Royal, and in partnership with our regional community partners, the HCW Access Point is expected to launch within the next 1-2 weeks. Implementation will initially cover the Champlain region, and then expand geographically (through leveraging partnerships) to cover the eastern region as well as the north. We have received funding ($300K) for 6 months, with more funds available as we expand. The HCW Access Point allows us to implement components of our regional coordinated access model, and moves us one step closer to coordinated access for mental health and addictions in our region and beyond.

***Appendix A*- IMPROVED ACCESS TO SERVICE** Transformation Initiatives Including Covid-19 Pandemic

Summary Report of New Initiatives – As per Performance Objective #4
Susan Farrell, VP Patient Care Services & Community Mental Health (April 2020)

Title of Initiative	Brief Description	Resources	Outcomes	Status Report
Women's Mental Health				
WMH – Ottawa Birth & Wellness Centre Fall 2019-	New partnership offering on-site WRAP groups for women with mental health issues Staff capacity building at OBWC Evaluation (needs and outcome) and education re: new application for WRAP	New WRAP Facilitator (Mental health Worker) = won award from Hope and Grace Fund WMH Facilitator = reallocation	Improved mental health for prenatal and postpartum women who would not otherwise receive support Improved training to OBWC staff Program development and evaluation of innovation, education re: innovation	Programming and evaluation in place Won award from Hope and Grace (first US grant via Foundation) for one year pilot Won Partner of the Year from OBWC
WMH – Violence Against Women (VAW) Shelters Summer 2019-	Similar model to above but to add WRAP to VAW shelters and increase staff capacity to recognize and respond to mental illness On-site at VAW agencies	Reallocation of WMH Facilitator time In-kind time from VAW for peer facilitator	As above re: service to marginalized women, increasing staff capacity and contributing to research on WRAP with VAW agencies Increased community education	Needs assessment to modify WRAP and understand staff knowledge needs begun
WMH – Education Series Fall 2019-	Women in Mind Conference (Nov 8, 2019) - Gender Diversity, Healthy Sexuality & Mental Health	Paid/subsidized conference with WMH/Foundation support	Increased public and service provider education	Conference had 160+ participants – evaluation results pending

LEGEND:

WMH = Women's Mental Health

WRAP = Wellness Recovery Action Plan (evidence based treatment that is co-led by professional and trained peer with lived experience)

	VAW Education Series in 3 lunch and learn sessions (also taped for public view)	Speaker stipends – VP CMH and CMHP subsidized	Improved client care and client outcomes	VAW education series to be held November 12, 19, 26
Telemedicine				
Telemedicine Education Partnership – Algonquin College Fall 2019	New Partnership with Algonquin College to offer consultation to students via telemedicine (virtual connection) Partnership via telemedicine to Algonquin counselling staff for education series, treatment training and supervision	Algonquin funding Some reallocation of Telemedicine staff resources at The Royal Applications in for funding from TD and RBC Education Grants	Faster and more convenient access to specialized mental health care for Algonquin students Improved staff knowledge and capacity by training and supervision	Official launch with Algonquin College October 2019 (including media coverage) 45 Virtual clinics to date (88 people served) 8 education sessions- 200 attended 1 full day education session – 40 attended 4 week therapy training – 24 clinicians attended See note re: Grant won
Telemedicine Education Partnership – University of Ottawa March 2020 –	Building on Algonquin partnership, new partnership with Student Counselling Services of University of Ottawa	Foundation from The Royal for year 1, UOttawa for years 2 and 3	Similar objectives to Algonquin College	Launched in March 2020 5 mental health clinics held to date (15 people served)

Mobile Mental Health Services				
Telus Health For Good Mobile Service	New Partnership to offer mobile physical health and psychiatric services to persons using safe injection sites within Ottawa (vulnerable population often not accessing care) Among other national Telus initiatives this is the first in Canada to offer on-van psychiatric services (part of Psychiatric Outreach Team, The Royal)	First three years funded by Telus In-kind resources from The Royal to support planning, implementation and evaluation	Access to simultaneous physical and psychiatric services for a population that is not typically connected to care Improved health outcomes and health education Connection of clients to additional services	Official launch in January 2020 – The Royal featured in media Psychiatry offered by The Royal 2x/week
Proposals Prepared for Community-Based Care and Improved Access (These are as Primary Author – supported 4 additional proposals as Secondary Author)				
Prompt Care Clinic	Community based clinic in partnership with TOH (and future community partners) to offer prompt access to consultation and short-term treatment	New funding within Foundation Case for Support re: Access HSIP also prepared for LHIN	Faster access for community members to mental health consultation, short-term treatment and education (for them and families) Stepped care model to include consultation for community partners and their clients Telemedicine expansion to consult to rural and remote clients	Ongoing planning meetings with partners Reviewed by Board HSIP submitted See note below re: C-Prompt pilot
Gender, Diversity & Mental Health – New Community Centre for Service	Plan for new storefront model of service to provide WRAP, service navigation, support groups, consultation, telemedicine outreach/care – focus on vulnerable populations not accessing care, indigenous persons, LGBTQ2S+ populations & Family support	New funding	Improved awareness of mental health issues and services for range of women and gender-diverse persons in community and their supports Store-front access re: service receipt and navigation	Proposals written for both the Foundation Case for Support and for a Private Donor

			Improved access to selected types of WRAP, consultation, navigation Increased access for rural and remote populations via Telemedicine connection	
Pandemic Preparedness Initiatives				
C-Prompt Clinic	Based on Prompt Care Clinic model, developed clinic in response to partner hospital and mental health agencies closing services or reducing care during COVID-19 precautions	Deployed staff Some new funding for physician sessionals and clinic supplies	Access to assessment, short-term therapy, medication consultation and long acting injections for community members via their primary care provider or mental health provider no longer able to provide care Most care delivered virtually but physical space also developed within OSI clinic	Opened April 6, 2020 (print, radio and TV coverage) April 20: 128 referrals 11.6 FTE clinical staff positions including 9 part-time psychiatrists and psychiatry and psychology residents
Consultation Liaison (CL) Teams to Small Hospitals and LTC	Expanded the Geriatric Outreach team and Regional Dual Diagnosis Consultation Team models to support patients with mental health issues and behavioral challenges Created General Psychiatry CL team for any additional sites needing support not covered in above-noted models	Addition of deployed staff to existing teams Deployed staff to new team	Virtual care provision of multi-disciplinary care (Psychiatry, Nursing, Behavior Therapy) to support inpatient in small hospital (and care team) for improved symptom and behavioral management Reduces risk of transfer of patient – allows patient to shelter in place Supports quality of life in patient and safe space within hospital or LTC	Existing teams supported to convert to virtual care end of March 2020 New General Psychiatry CL team to start week of April 27

The Royal – Overview of Responsive Regional Surge Plan

Prepared by Dr Paul Sedge, Associate Chief (Ottawa) & Dr Susan Farrell, VP Patient Care and Community Mental Health

Update for CEO and Chief of Staff - April 21, 2020

In response to the COVID-19 pandemic and in collaboration with our regional community and hospital partners, The Royal has developed a range of services to support patient and provider needs in several key areas:

Provision of Virtual Care - outpatient services at The Royal have converted to the provision or virtual care. March 1st – 31st 2020 there were 1048 patients seen virtually by 97 providers, representing a 38% increase in patients seen and 41% in providers using virtual care in just the early weeks of the pandemic. More providers and services have been added to additional virtual care platforms in April 2020. In addition, all 15 Regional Mental Health Telemedicine clinics transitioned to support seeing patients at home rather than in the rural primary care clinic setting with no down time.

Provision of virtual care has also been supported by the Telus Mobility for Good program who donated 163 phones to support patient connectivity with providers (if outpatients) or with loved ones (in inpatients) during the physical distancing requirements of COVID-19. Media interviews about virtual care provision and to thank Telus with CFRA April 3 and scheduled for April 25 (S. Farrell)

Regional ECT services – the Royal has become the primary provider of acute ECT services for critical care for patients in support of The Ottawa Hospital and with potential to expand care delivery to other hospitals as needed. This began the week of March 23, 2020. Thus far, our capacity to provide ECT services has been severely limited secondary to safety concerns surrounding the risk of aerosolization of COVID during the procedure. As a result, ECT has been limited to those patients identified as extreme risk of imminent death or harm.

Long Acting Injections – The Royal has established three accessible LAI spaces that are located at Carlingwood site, ROMHC (RM 1425), and through the C-Prompt Clinic. With these sites, we are safely managing all of the Royals 600+ patients on depot medication as well as some community-based patients. We have the flexibility and capacity to assume provision of LAIs for our partner hospitals should the need arise.

C-Prompt Urgent Care Clinic –As the pandemic has progressed, our community has seen an unprecedented closure of community health care services, reduced hours for accessing

primary care, and suspension of day programs and most out-patient services. The burden of

mental illness will only increase over the coming weeks and a serious gap in mental health care has developed. To address this need, the Royal launched a unique, temporary, referral-based mental health care clinic. The clinic operates out of the current Operational Stress Injury Clinic and provides rapid access to multidisciplinary care including psychiatry, psychology, social work and mental health nursing. In addition, the clinic has the capacity to assist community partners with accessing LAIs, lab work and mental health system navigation. *(Please see the public flyer attached)*

C-Prompt opened its doors on April 6, 2020. Its arrival was marked by an article in the Ottawa Citizen (P. Sedge & S. Farrell), a CBC radio interview (S. Farrell) and a two CTV interviews (S. Hale, Director). There is a multi-disciplinary staff compliment that includes partial time from Psychiatry (n=9 + 3 Residents), Psychology (n=2 + 1 resident), Nursing (n=8; 4 full-time and 4 part-time), Social Work (n=10) and a part-time Manager and Director. As of April 20th there were 128 referrals for care. An evaluation framework has been developed to include measures of client and system outcomes.

Expanding In-Patient Bed Capacity – As part of our surge response in the region, The Royal has endeavored to open as many in-patient beds as possible while ensuring patient and staff safety throughout the pandemic. Planning and consultation with our community partners was completed to determine how best to alleviate the demands on acute care hospitals and support resources in a range of hospitals within the region. This effort was also supported by a specialized on-site public health consultation. Through a combination of accelerated patient discharges and conversion of existing bed spaces (see below), The Royal has opened over 30 beds to support a potential surge. Despite the fact that a COVID 19 surge has yet, and may not occur in our partner hospitals, we have been collaborating with them to coordinate safe patient transfer and alleviate the current demands on their beds. As part of our overall approach to the pandemic, we have made several major adjustments to our units and our admission process.

Observation/Surge Unit – the Concurrent Disorders Unit has been closed at this time to usual programming and has been converted to an 11-bed general psychiatry unit. This unit has become our admissions area for all patient transfers. Recognizing the risk of receiving patients from hospitals that are COVID positive, we hold all new admissions for 14 days in a separate area to reduce the risk of COVID exposure and spread in our facility. We have admitted 6 patients to this unit this far with an expectation that we will continue to admit patients until our capacity is met.

Containment Unit – The Youth Inpatient Unit has been closed at this time to usual programming and has been transformed into a COVID containment unit for any inpatient at The Royal (outside of Forensics) who tests COVID-positive. At this time, The Royal has no patients who have tested positive for COVID so our containment unit remains dormant but ready to respond if needed.

Multi-Disciplinary Consultation-Liaison Teams to Hospital Inpatient Units – Previous to the pandemic The Royal delivered community-based outreach models within the Geriatric Psychiatry and Community Mental Health programs. The model is a multi-disciplinary team (Psychiatry, Nursing, sometimes Behavior Therapy) that supports patients in community hospitals or long-term care facilities by managing their mental illness and responsive behaviors and provides education to care providers. In the Geriatric Psychiatry program this is for persons over age 65 who often present with dementia. In the Community Mental Health Program this is persons of all ages with a dual diagnosis (intellectual disability and mental illness). These teams have continued during this time by shifting their model to virtual care.

In response to current circumstances and in an effort to prevent transfers from community hospitals to larger urban hospitals, additional Consult-Liaison Teams have been developed. The first is an expansion of the Geriatric Outreach Behavioural Supports Ontario Team to younger adults and the second is the creation of an additional General Psychiatry team. The expanded team from Geriatrics capitalizes on the team already having established relationships with community hospital staff. By extending their mandate at this time to provide services to any adult inpatient with mental illness they will be able to quickly support known partners. The new General Psychiatry team is smaller and is in place to support patients in the few hospitals not served by the Geriatric Psychiatry Program. The extended and new team begin on April 27, 2020; the others teams have remained active. The demand is not known at this time but the comprehensive response is available.

COVID-19 Peer Support Team – Access to mental health services for Health Care Workers is available in the region from Mindabilty and from C-Prompt, depending on the need. In addition to these formal services, The Royal has supported the development of the COVID-19 Peer Support Team at both the Ottawa and Brockville campuses. This is multi-disciplinary team of peers that provide an early opportunity to talk about an event/situations, discuss healthy coping strategies and/or discuss options for ongoing care.

In conclusion, these services were developed to address the multi-faceted needs of our community and our partners during the restrictions of COVID-19. These services highlight the diversity of specialized skills within the programs and providers at The Royal and are offered with the intent to be a responsive regional partner. All services will be evaluated at the end of the pandemic and will inform future service planning and delivery.

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C-PROMPT CLINIC at The Royal

Quick access to essential mental health services during the COVID-19 pandemic

Increased stress associated with the COVID-19 pandemic, coupled with reduced access to mental health supports and services, has the potential to exacerbate mental health issues for many individuals within our community. In order to ensure that people can get the care they need during this difficult time, The Royal has opened a temporary urgent-care mental health clinic called C-PROMPT. The goal of C-PROMPT is to prevent urgent needs from becoming emergencies.

What services does C-PROMPT offer?

The C-PROMPT Clinic will be staffed by a team of Mental Health Nurses, Psychiatrists, Psychologists and Social Workers who can provide:

- Urgent assessment
- Medications (including long-acting injections, and Clozapine support with bloodwork)
- Short-term psychotherapy (maximum four sessions per client)
- Support accessing other services as required (systems navigation)

IMPORTANT: The C-PROMPT clinic is not an emergency service. Patients who require emergency mental health care should continue to be directed to the nearest Emergency Department.

Where is C-PROMPT?

C-PROMPT services will be delivered primarily by videoconference or phone; in-person sessions may occur when deemed necessary by the clinical team. The clinic is located at the Royal Ottawa Mental Health Centre.

How can I make a referral?

Psychiatrists and primary care providers may refer patients (aged 18+) using the referral form located at WEB PAGE

What is C-PROMPT?

The C-PROMPT clinic is a temporary outpatient clinic established at The Royal to meet urgent mental health care needs during the COVID-19 pandemic

Who are these services for?

C-Prompt is for adults (age 18 and older) who are at risk of worsening mental health or hospitalization due to mental illness of any kind during the course of the COVID-19 pandemic.

How can patients access these services?

The C-PROMPT clinic is referral based. Patients can access these services with a referral from a primary care provider (physician or nurse practitioner) or a psychiatrist. C-PROMPT is not a walk-in service; the referral process enables our team to do advance screening to determine each client's healthcare needs and ensure prompt access to care.

When are C-PROMPT services available?

The C-PROMPT clinic will open on April 6 and remain open as long it is needed to address mental health needs associated with the COVID-19 pandemic. Clinic hours are 8 am to 4 pm Monday to Friday.

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December 9, 2019

Dear ,

Thank you for taking the time to participate in my recent 360 review. I truly appreciate your honest feedback about my skills and performance as President and CEO of The Royal. I will seize the opportunity to learn and grow based on what you have shared.

My 360 review included evaluations from a broad range of colleagues including staff at The Royal, board members, and community partners. These diverse perspectives have come together to form a robust analysis of strengths that I can build on and opportunities for improvement. Here is some of what I learned:

360 Key Themes:

- Compelling resonant vision – has become a brand – courage to undertake change
- Noticeable shift in ROH leadership and culture
- Collaborative leadership - has helped to make significant change
- Authenticity builds trust – actions speak loudly

Key Challenges:

- Defining a cultural norm for performance - priorities related to the vision; how will we measure, assess and evaluate performance
- CEO presence with the Board – build more confidence; progress has been made but some growth and learning still needed
- Financial uncertainty in Ontario climate

I have already started working on my action plan based on these learnings and I look forward to work the plan so that I can be a better leader for my organization and my community.

Sincerely,

Joanne Bezzubetz
President and CEO, The Royal

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – 3-IC	**Priority:** Important

DATE:	June 18, 2020
COMMITTEE:	Compensation & Succession Planning Committee
PRESENTER:	A. Graham
SUBJECT:	Psychiatrist-in-Chief/Chief of Staff's Performance Evaluation

BACKGROUND INFORMATION:

The role of the Committee is to deal with the overall executive compensation policy and succession planning, including the performance evaluation for the President & CEO and the Psychiatrist in Chief/Chief of Staff.

LEGAL REVIEW AND/OR APPROVAL:

MOTION FOR APPROVAL:

BE IT RESOLVED THAT the Psychiatrist-in-Chief/Chief of Staff's 2020-2021 objectives and performance pay (a portion of the percentage set out in the Variable Compensation Plan for Senior Management) based on the achievement of his 2019-2020 objectives be approved, as presented.

Moved by:

Seconded by:

Motion approved:

SCHEDULE "A"

Royal Ottawa Health Care Group
Psychiatrist-in-Chief & Chief of Staff
Proposed Performance Plan – 2020-2021

Proposed % BONUS	PERFORMANCE OBJECTIVE	TARGETS & ACTIVITIES	STATUS REPORT JUNE 2021
25	1. Exceed targets set for Quality Improvement Plan (as per legislation)	**Target:** An engaged workforce focused on quality care and excellence **Activities:** Design and implement an organization-wide strategy to exceed the QIP targets	
25	2. Quality Organization	**Target:** Improved quality of care **Activities:** Implement organizational quality framework; implement quality teams in all programs; develop and implement a continuous readiness model for organizational accreditation. Integrate research, clinical care and infrastructure to improve quality of care.	
25	3. Innovation	**Target:** Implement strategic innovations **Activities:** Work with academic partners to create an Ottawa anxiety algorithm; completion of clinically meaningful EHR projects (ie. Client portal, Meditech Expanse upgrade); Expand care to North Eastern Ontario - provide additional virtual care options; Esketamine use	
25	4. Transform The Royal's Organizational Culture	**Target:** Improved performance related to client and family satisfaction **Activities:** Implementation of the client and family centered care framework **Target:** Professional engagement **Activities:** Implement the Vanderbilt professionalism model for ROHCG physicians	

Compensation and Succession Planning Commitee

R. Bhatla, MD, FRCPC, DABPN
Psychiatrist-in-Chief & Chief of Staff, ROHCG
Associate Professor, University of Ottawa

April 29, 2020

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SCHEDULE "A"
Royal Ottawa Health Care Group
Psychiatrist-in-Chief & Chief of Staff
Performance Objectives – June 2019 to March 31, 2020

Proposed % BONUS	PERFORMANCE OBJECTIVE	TARGET/OUTCOME	STATUS REPORT APRIL 2020
25	1. Quality Improvement Plan – language from legislation.	As indicated in the Quality Improvement Plan. See Appendix 1 for Quality Improvement Plan and Workplan.	See Slide #3 for update. Mixed results. For discussion.
25	2. Establish and implement a quality framework for The Royal with an emphasis on client and family centered care as well as physician and staff engagement.	Agreed-upon quality framework in place.	See Slide #4 for update. Essentially completed. Final April discussion cancelled secondary to COVID-19 planning/activities.
15	3. Monitor volumes and wait times for the MAP.	Maintain wait times at two months or lower.	See Slide #43 for update. Wait Time = 47 days
30	4. Plan for the development & implementation of specialty service in MAP (ie. Bipolar, ADHD, OCD).	Plan developed with early stage implementation.	See Slide #44 for update. Flow developed within program to specialized expertise for ADHD and OCD.
5	5. Hospital without walls.	Grow telemedicine encounters by 5% and OTN invite encounters by 10%.	See Slide #84 for update. Telemedicine increase of 24%. OTN Invite increase of 45%
-	6. Hospital without walls.	Clinically sound client and family resources posted on The Royal's webpage.	

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Quality Improvement Snapshot 2019-2020 – April 20,2020

Strategic Plan Domain	Indicator	2019/2020 Target	Current Value	Status since last quarter
CARE Delivering person and family centred care, quality and safety	Satisfaction with Services "I think the services provided here are of high quality" (Q4)	87%	**88.0%**	Not Improved
	Rate of MH&A episodes of care that followed within 30 days by another MH&A admission (Q3)	9.91%	**10.5%**	Improved
	Reduction in the use of physical restraints (Q3)	3%	**3.8%**	Improved
	% of medication reconciliations at admission for outpatients, where a medication reconciliation is warranted (Q3)	65%	**47.5%**	Improved
	% of complaints acknowledged to the individual who made a complaint within 5 business days (Q4)	80%	**91%**	Improved
	ROP - Overall resident satisfaction (resident reporting rate and overall satisfaction) (Q4)	70% reporting	**76.0%**	Improved
		92% satisfaction	**92.5%**	Improved
	ROP - % of residents with worsening bladder control during a 90 day period (Q4)	9%	**10.9%**	Not Improved
	ROP - Hand Hygiene compliance for staff and residents (Q3)	80%	**20.0%/24.0%**	Improved
	ROP - Prevalence of falls in the quarter as a percentage of residents (Q4)	12%	**9.4%**	Improved
PARTNERSHIPS Working together to increase capacity in our region	Reduce wait times in Mood and Anxiety Outpatient Services (Q4)	90 days	**50 days**	Not Improved
	% of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital (Q4)	50%	**12.4%**	Not Improved
ENGAGEMENT Fostering a Culture of Collaboration	Number of workplace violence incidents reported by hospital workers in a 12 month period (Q4)	772	**819**	Improved
	Number of lost time claims related to workplace violence events (Q3)	0.17	**0.33**	Not Improved
	WSIB days lost related to workplace violence events (Q3)	0.25	**3.12**	Not Improved

On target or better

Within 1% of the target

Greater than 1% away from the target

Quality Framework

April 16, 2020

Information Gathering Phase on Creating a Quality Framework (April to September 2019)

- Met with all programs to gather feedback on their quality work and ideas for improving Quality at The Royal.
- Met with hospitals across the Champlain region and province to review their quality program and their quality frameworks.
- Masters of Health Administration Residency Project provided the organization with a comprehensive overview of quality frameworks across the region and province, and recommendations for changes to The Royal's quality program.

Implementation of Changes to Improve the Quality Program at The Royal (September 2019 to April 2020)

- A recommendation was made to change name of the Quality of Care Committee to the Incident Review Committee, and to create an organization wide Quality Committee. The terms of reference for the new organization wide Quality Committee and Incident Review Committee were written and approved by SMT in the fall of 2019. Time was spent communicating the new structure to key stakeholders in the organization and inviting representatives from various groups to join.
- The new Quality Committee started in February 2020 and includes representation from front line staff, managers, directors, the quality team, senior leaders, and patients. The Family Advisory Council has been invited to sit on the committee and is currently looking for a member to join the committee.
- At the first meeting of the Quality Committee, the responsibilities of the committee were reviewed. A discussion about upcoming work took place, including the adoption of a quality framework for The Royal.
- The agenda for the second meeting included reviewing the proposed quality framework at The Royal. Due to the pandemic, the second meeting was cancelled and subsequent meetings have been put on hold as the majority of committee members are involved in the hospital's response to COVID-19.

Developing a Quality Framework for The Royal

Danielle Simpson
Director of Quality & Patient Safety

Dr. Raj Bhatla
Psychiatrist-in-Chief/Chief of Staff

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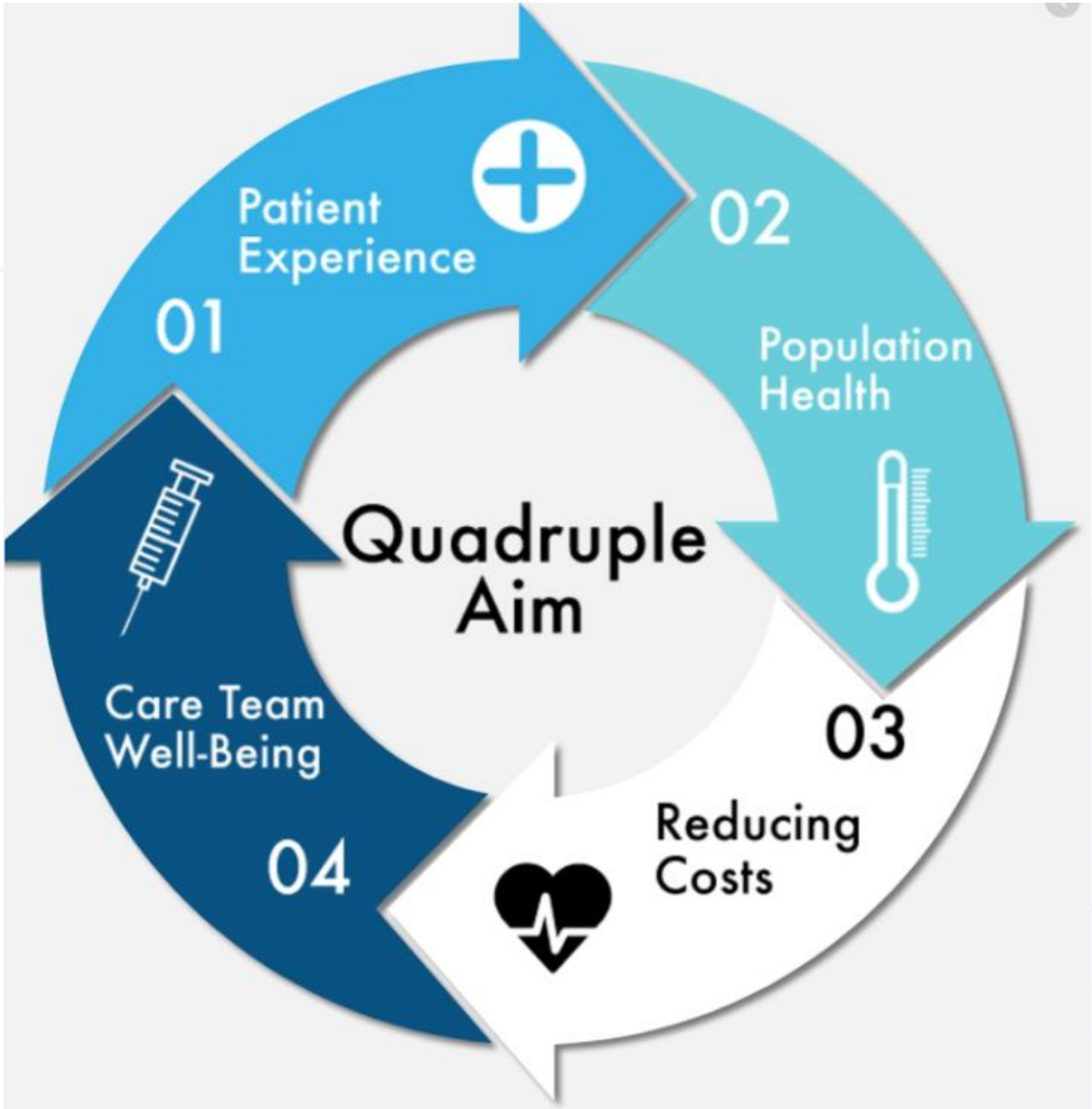
Quality Framework

- A quality framework is a supporting structure that can help to guide our efforts and support key decisions related to quality at The Royal.

- Several quality frameworks exist, and rather than re-inventing the wheel, we want to look at some existing quality frameworks and decide if they would meet the needs of The Royal or if modifications are required.

The Quadruple Aim Framework



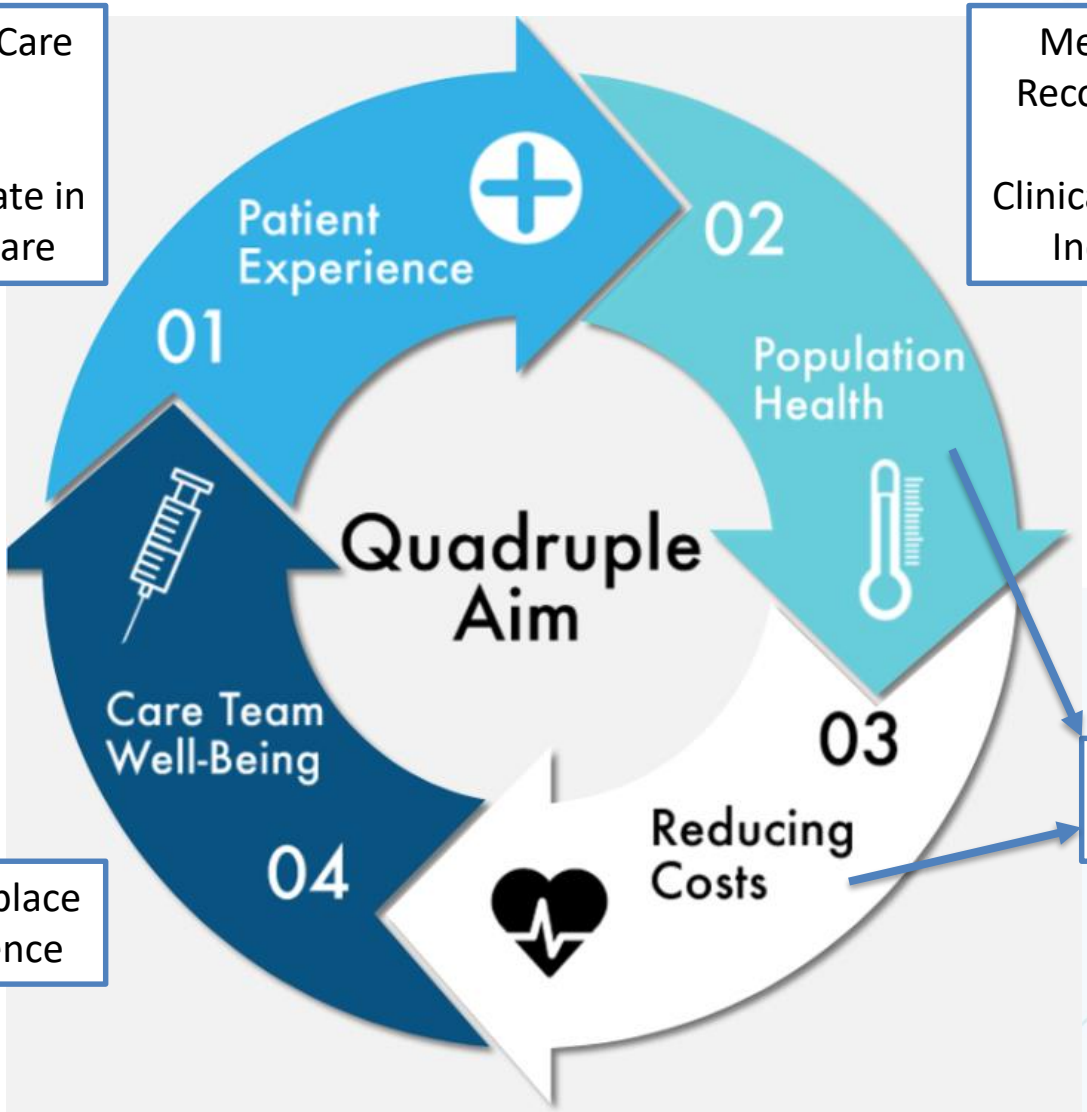
Practical Application of the Quality Framework – The QIP

Palliative Care (LTC)

CAPS Update in Plan of Care

Medication Reconciliation

Clinical Outcome Indicators



Clients Involved in Research Studies

Workplace Violence

Many organizations have chosen to adapt the quadruple aim framework…

Ask of the Quality Committee…

Does the quadruple aim resonate with you as a quality framework for The Royal?

APPENDIX

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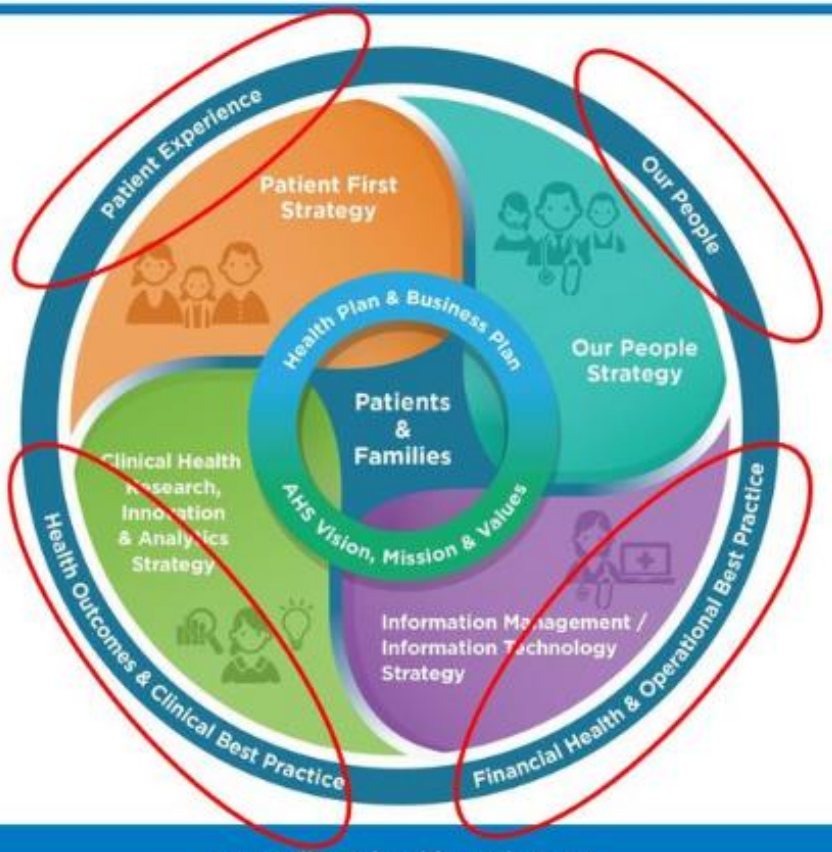
Domain Title Examples from Other Orgs.

	Quadruple Aim Domains				
Organization	**Patient Experience**	**Population Health**	**Care Team Well-Being**	**Reducing Costs**	Other Categories not mentioned in Quad. Aim.
The Ottawa Hospital	Better patient experience	Healthier populations	Better Staff Experience	Better quality at less cost	
Women's College Hospital	Patient Experience	Best Possible Health Outcomes	Workforce Experience	Best Use of Resources	
Vancouver Coastal Health	Exceptional Care	Convenient health care	VCH is a great place to work	Innovation for Impact	
Interior Health	Deliver high quality care	Improve health and wellness	Cultivate an engaged workforce and healthy workplace	Ensure sustainable health care by improving innovation, productivity & efficiency	
Alberta Services	Bringning appropriate care to community	Partnering for better health outcomes	Our People	Achieving health system sustainability	
Waypoint	People We Serve	Partnerships	People Who Serve	Corporate Performance	Research and Academics (description is around improving clinical care)
Ontario Shores	Be Caring	Be Bold	Be Inspiring	Be Extraordinary	
Markham Stouffville Hospital	Delivering an extraordinary patient experience	Embracing our community	Empowering our people		
Selkirk MH Center	Pursue Excellent by Focusing on Quality and Safety	Strength Recovery-Oriented Programs and Services		Align and Integrate with the Health System	
Ontario Health	Improving the Patient and Caregiver Experience	Improving the Health of Populations	Improving the Work Life of Providers	Reducing the per capita Cost of Health Care	

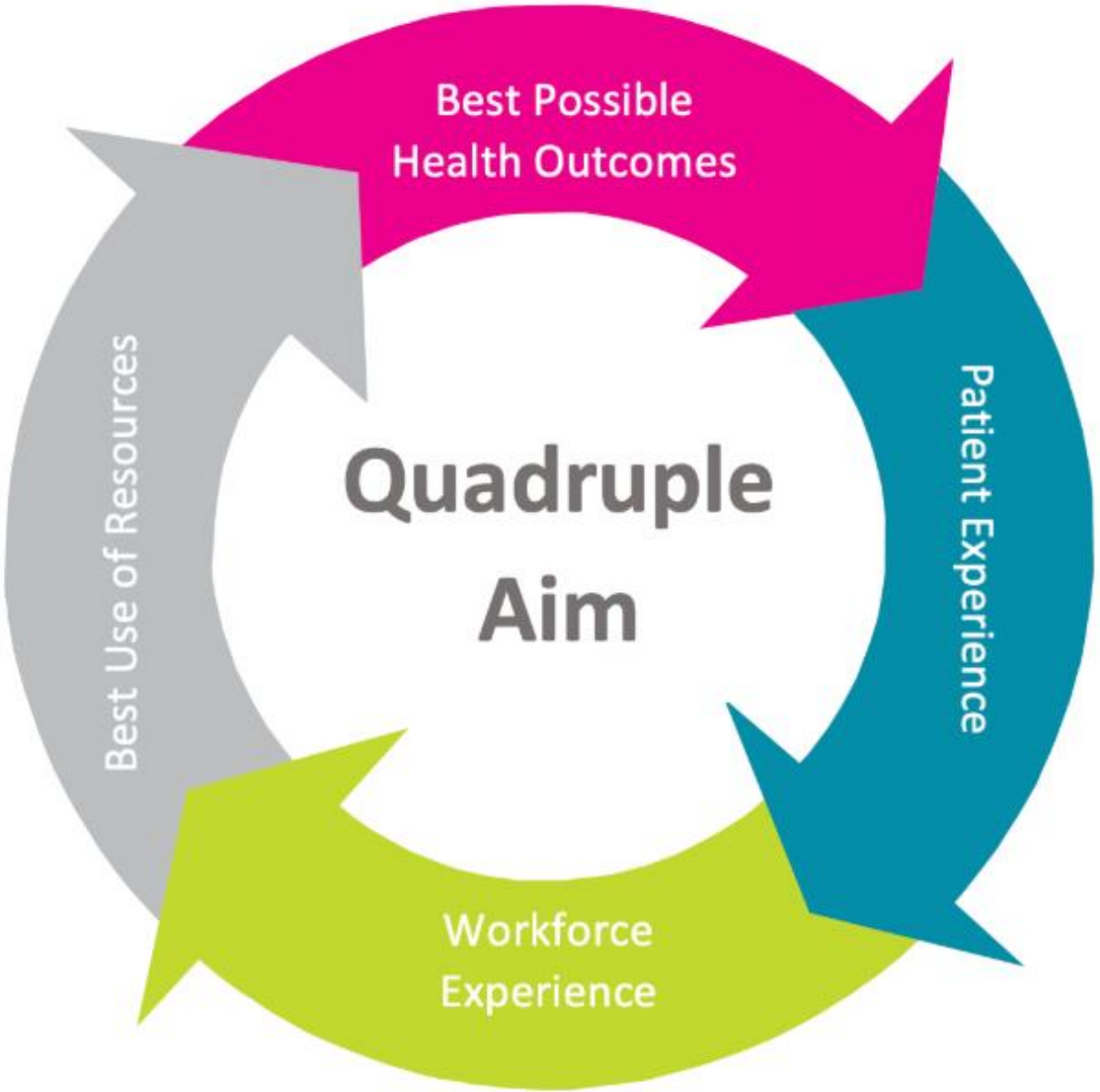
Alberta Health Services' Quality Framework

Alberta Health Services

Quadruple AIM – Balanced Scorecard



Women's College Hospital Quality Framework



Mood & Anxiety Program Development Project

PHASE 1 - UPDATE

November 2019

The Le Royal

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Project Background

- Project is focusing on addressing system challenges, specifically **access to services**.
- Reflecting on the current services and delivery methods in response to the population's needs to identify a **desired future state** based on evidence and the needs of clients and families.

Context for this Session

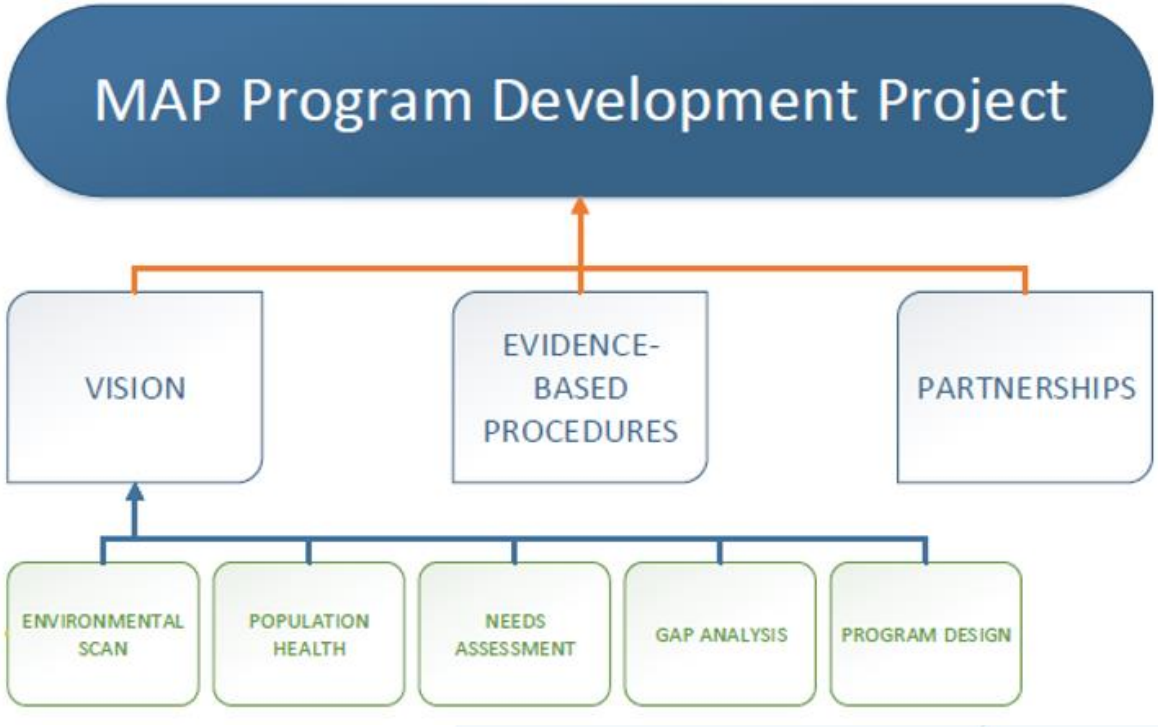
- As part of the MAP development project we want to gather feedback and comments from those that work on the front-line of the program every day.

- Please note that there are external deciding factors about how we proceed with program development.

- With that in mind, while all feedback is important and appreciated, improvements to the program must fit within the Royal's mandate, the current political context and be reasonably attainable.

Approach

- Realigning the MAP **vision** to focus on the needs of clients and families and to address identified gaps in mood and anxiety services within the region.
- Identifying the gaps between the **evidence-based services** provided and the needs of the target population in the program and develop consistent care pathways to optimize the effectiveness of the treatment delivered.
- Leverage **partnerships** to create a stepped care model based on the needs of clients and families as well as align with other provincial resources such as Increased Access to Structures Psychotherapy, Big White Wall, and BounceBack.



Vision – Sub-projects

Subproject	Description	Progress to Date
Environmental Scan	A scan of existing similar tertiary MAPs within Ontario, Canada in order to learn from other program's successes and enable the Royal to better align service provision with other similar programs.	
Population Health Analysis	Gain a better sense of the region's population health needs for Mood and Anxiety to allow the Royal to build a MAP that meets the demand.	
Needs Assessment	Explore the patient demographics, clinical characteristics and feedback on what they would like to see available in a revamped MAP to gain a better sense of our patient's needs.	
Stakeholder Consultations	Conduct consultations with various groups to gain a sense of the needs of our community.	
Patient and Caregiver Input	Involve patients and caregivers in a meaningful way in this work, by having representatives as part of the project team, holding consultations with patients and caregivers, and gathering data from current patients of the MAP program through experience surveys, etc.	
Gap Analysis	Look at available community and outpatient services with resources for Mood & Anxiety to identify gaps in services as well as identify complementary and competing programs.	
Program Design	Based on the above sub-projects a reconceptualization of the target population in the program may need to occur. Program design will include identifying the "new" target population, services to be provided, delivery systems for the services (who should offer what service), acuity level of services, etc.	

VISION

FINDINGS TO DATE

Environmental Scan

- Compared the Royal's MAP program to similar programs in the following organizations:
  - **CAMH**
  - **St. Joseph's Healthcare**
  - **Representative for the UK model**
  - **Ontario Shores**
  - **Waypoint**
  - **The Douglas**
- Opportunities to explore in the future state:
  - Standardized integrated care pathways
  - Standardized assessments
  - Bridging between inpatient and outpatient programs
  - Enhanced interdisciplinary team functioning & supports
    - Not every client in OP requiring a psychiatrist
    - Interdisciplinary case conferences with care team to discuss diagnoses and treatment options

Population Health Analysis:
Treatment Resistant Depression (TRD)

- The number of patients with mood disorders in the Champlain district is around **50,000** (73% MDD & 27% BD)
  - Estimate almost ***20,000 new cases of mood disorders per year***
  - Most of the cases of mood disorders (74%) come from Ottawa (Western, Eastern, Central), which has the highest density of population.
  - About one third of all cases of mood disorders (~17,000) live in Central Ottawa
- More than **7,000** people living on the Champlain district have presented a TRMD in the last year
  - Two third of cases have MDD and one third BD (5,704 vs. 2,070).
  - More than **5,000 of people with TRMD live in Ottawa** (Western, Eastern, Central)

The prevalence of treatment resistant mood disorders in Champlain outweighs the available resources.

Needs Assessment

- Goal: To identify and describe the nature of the needs of patients in the MAP outpatient program
  - What are the demographic, clinical, and psychosocial characteristics of the population served in MAP?
- Quantitative analyses of program data from May 2016 to December 2018 (*n*=1295 patients) completed
- Comprehensive findings disseminated to the program development team and MAP team for feedback
  - Comprehensive presentation available upon request

Needs Assessment Findings to Date: Demographics Highlights & Implications

- Majority (60+%) patients presenting to MAP are women
  - Applying a gender lens to treatment considerations
- Emerging adults are a significant and unique population (22-26%)
  - New group to be piloted in MAP this year
- Approximately 65% are single/separated/divorced/widowed
  - Consideration for those who are more isolated/have less social support
- Significant proportion of patients work full-time (19-25%)
  - Consideration for whether these patients require tertiary-level care, and consideration of redirection to the IASP program

The findings highlight important **social determinants of health** (Gender, Social Support, Social Exclusion) that may warrant special consideration in the treatment of MAP patients.

Needs Assessment Findings to Date: Clinical Characteristics Highlights & Implications

- Depressive Disorders affect the most MAP patients, followed by Anxiety Disorders, then Bipolar and Related Disorders
- There is a high level of comorbidity with Anxiety Disorder diagnoses
- Generalized Anxiety Disorder is the most common diagnosis in MAP patients
- Percentage of patients diagnosed with a Bipolar Disorder is higher in the Consultation Clinic Stream
- Most patients report low levels of substance use
- Significant levels of distress (suicidal ideation, severe functional impairment, low levels of life satisfaction) are identified in both MAP Stream and Consult Clinic Stream patients

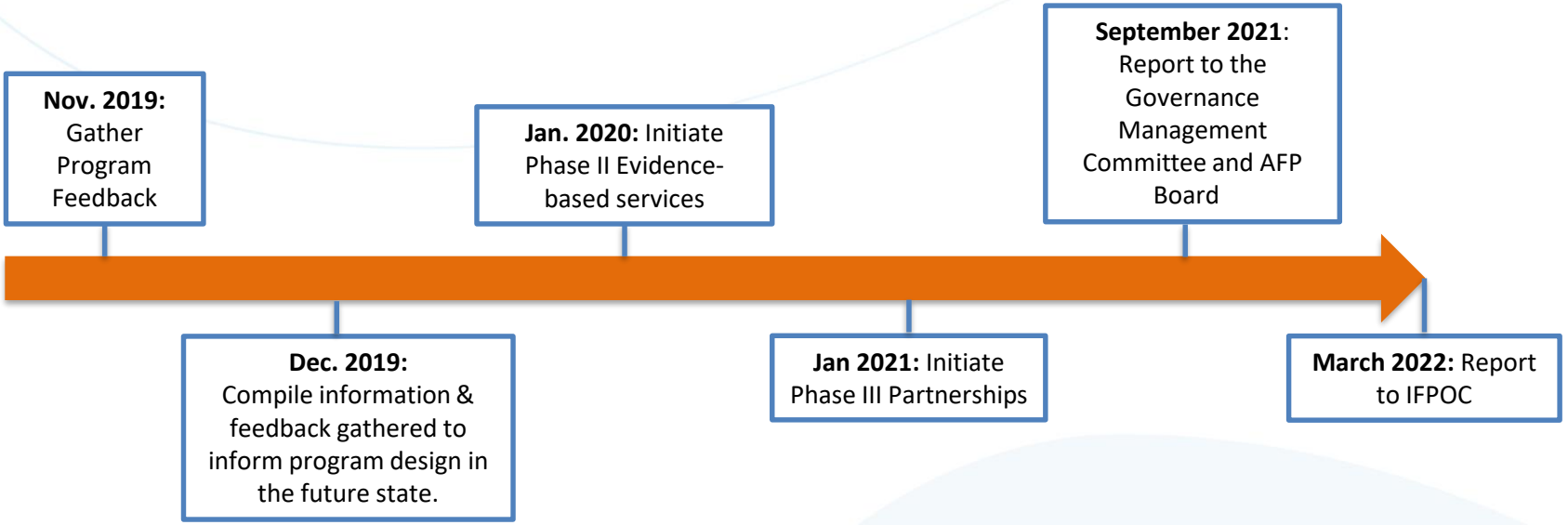
Patient Input

- Glenda O'Hara has been recruited to sit on the project team
  - Glenda is the current Chair of the Client Advisory Council
  - Glenda sits on many hospital committees
    - Quality Committee of the Board
    - Client & Family Centred Care committee
  - Glenda is an avid Royal volunteer
    - Hosts WRAP groups
    - Visits residents at ROP
    - Externally, Glenda also volunteers with the Centrepointe Theatre and the Great Canadian Theatre Company
- Glenda is working with the managers of the IP & OP units to develop focus groups for client feedback on services
- OPOC survey results
- A client satisfaction survey is being run in Consult Clinic (see next slide)

Stakeholder Consultations

- Completed to Date:
  - Consult clinic client survey (CSQ 8)
    - 80 people have completed the survey to date, yielding a mean score of 28 out of 32, which indicates that most clients are **very satisfied** with the consult clinic service.
    - The overwhelming majority of comments are extremely positive.
      - Common themes include gaining increased clarity and understanding following the consultation, compliments to the physician and program staff, and satisfaction with the efficiency of the program.
    - Negative comments represent roughly a third of responses, with nearly all of them stating the client desired more service than a one time consult.
- Outstanding:
  - MAP Patient & Family (IP & OP) focus groups
  - Program staff/physicians
  - Other Royal programs
  - Primary care physicians

Project Timeline



As information is gathered throughout this process, initiatives for enhancement of MAP can begin at anytime along the above timeline.

MAP review of Population Health

- Focus on treatment resistance (TR) and complex care

Population Health

Goal:

To estimate the prevalence of treatment-resistant mood and anxiety disorders in the LHIN district

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Treatment Resistant Depression

- **Most common definition:**
- ***"MDE that does not improve after at least two adequate trials of ADs from different classes".***

“Staging” TRD: Maudsley method

Dimension	Specification	Score
Duration	≤12 Months 13-24 Months >24 Months	1 2 3
Symptom severity at baseline	Subsyndromal Mild Moderate Severe, no psychosis Severe, psychosis	1 2 3 4 5
Treatment failures		
Antidepressants	1-2 medications 3-4 medications 5-6 medications 7-10 medications >10 medications	1 2 3 4 5
Augmentation	Not used Used	0 1
ECT	Not used Used	0 1
Total		15

Pseudoresistance

- ***More than 20% of TRD would be related to "pseudoresistance"***:
- Diagnosis is not correct
- Inadequate trials for duration or dosage
- Medication intolerance
- Lack of compliance
- Interaction with other medications/substances
- Underlying medical conditions

Prevalence of mood disorders in the LHIN District

Disorder (DSM-IV)	Estimated Prevalence (%)	Projection per population 15+
Major Depressive Disorder	4.9	57,466
Bipolar Disorder	1.8	20,853
Generalized Anxiety Dis.	2.5	29,859

Unpublished data derived from CCHS 1.2 Mental Health and obtained with permission from Palay et al. (under review for Canadian Journal of Psychiatry).

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Prevalence of TRD

- **21.7%** of depressed patients from primary care centres in Ontario were treatment-resistant to 2 or more trials of antidepressants. (Rizvi et al., 2014).
- **25%** of depression from general population in Canada is chronic, based on CCHS-MH 2002 data (Satyanarayana et al., 2009).
- **10-17%** of patients with MDD from community and general practice had a chronic course, according with a review of literature (Steinert et al 2014)
- We will consider that **15%** of patients from general community will present Treatment Resistant Mood disorders (two third unipolar and one third bipolar depression).

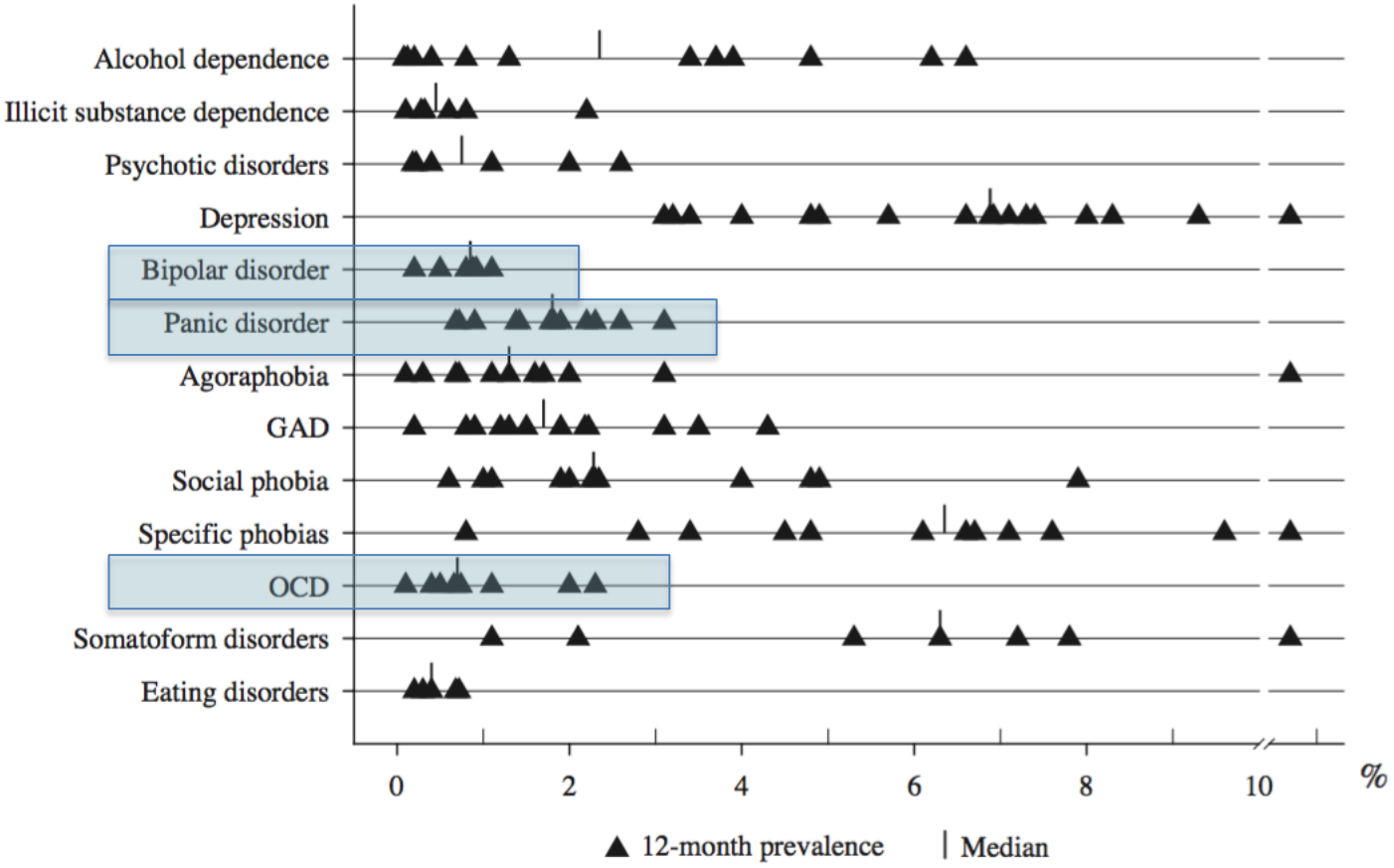
6/12-month Prevalence of Anxiety Disorders

Disorder	ECA, US 1980-82 6 m	ESEMeD Europe 2000, 12 m	NCS-R, US 2005 12 m	Canada 6 m
Panic D	0.8	1.2	2.7	0.7
Phobias	7.7			6.2
Agoraph.	3.4	0.4	0.8	1.9
Specific	6.4	3.5	8.7	4.1
Social	1.5	1.2	6.8	1.2
GAD	2.3 (12 m)		3.1	2.52
PTSD			3.5	2.4 (1 m)
OCD	1.5		1.0	1.8
Total	10.1	9.8	18.1	7.6

Data from CANADA: Edmonton, 1988 | LHIN District CCHS, 2012

Nationally representative sample of 2991 people 18+, 2002 (Van Ameringen, 2008)

Distribution and medians of published European 12-month prevalence estimates of mental disorders.



Total: 27 studies, conducted in 12 different countries, between 1980 and 2002 (Wittchen et al. 2005)

Treatment Resistant Anxiety Disorder

- **Most common definition: resistant to one pharmaceutical or psychotherapy trial**
  - 40-60% fail a first-line treatment
- **Treatment-resistance as non restoration of functional status:**
  - **30% of anxiety disorders**
- **High comorbidity of anxiety disorders and mood disorders**
- **Among general population in Canada, *16% of patients with a a mood or anxiety disorders report a current substance use disorder* (Khan et al 2017, CCHS 2012).**

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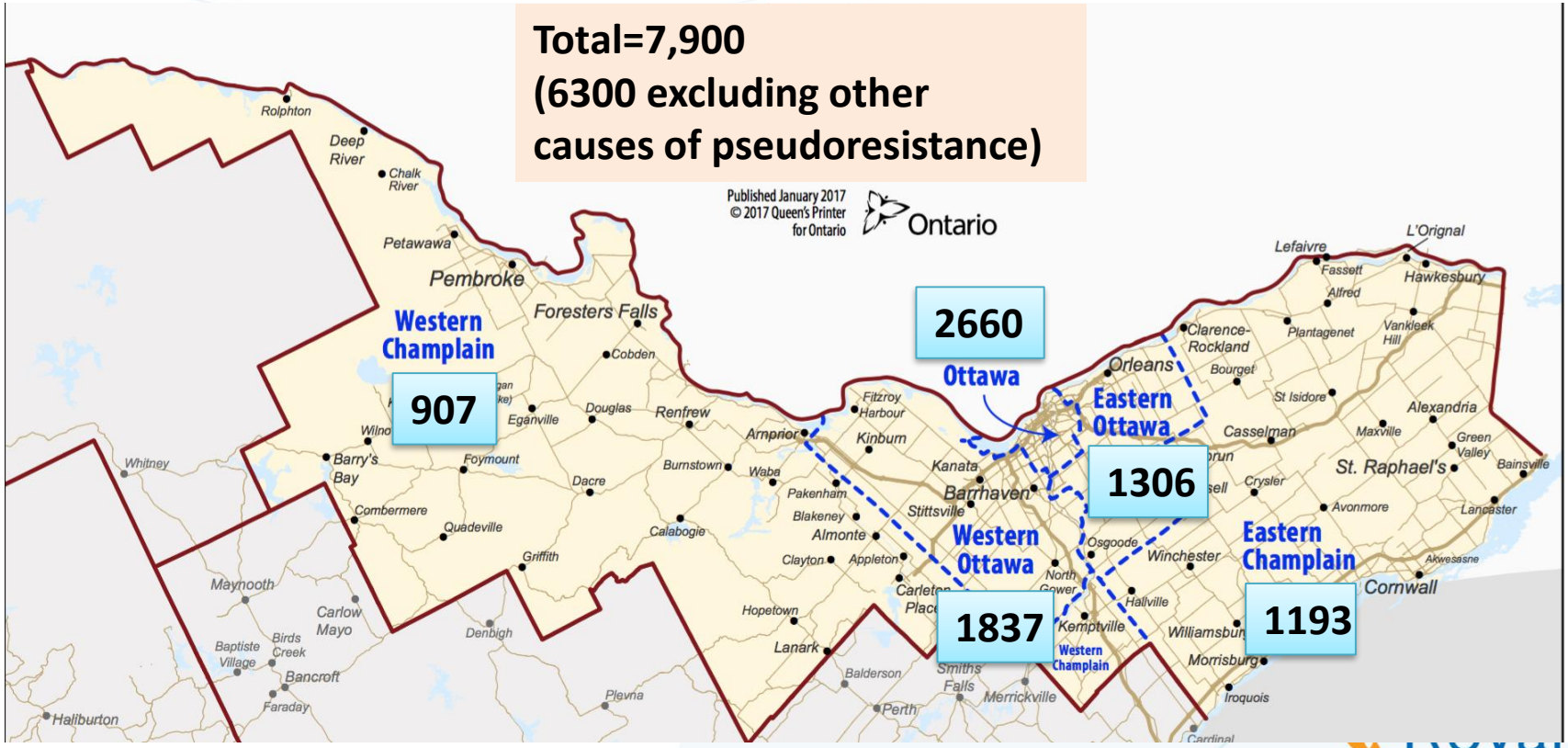
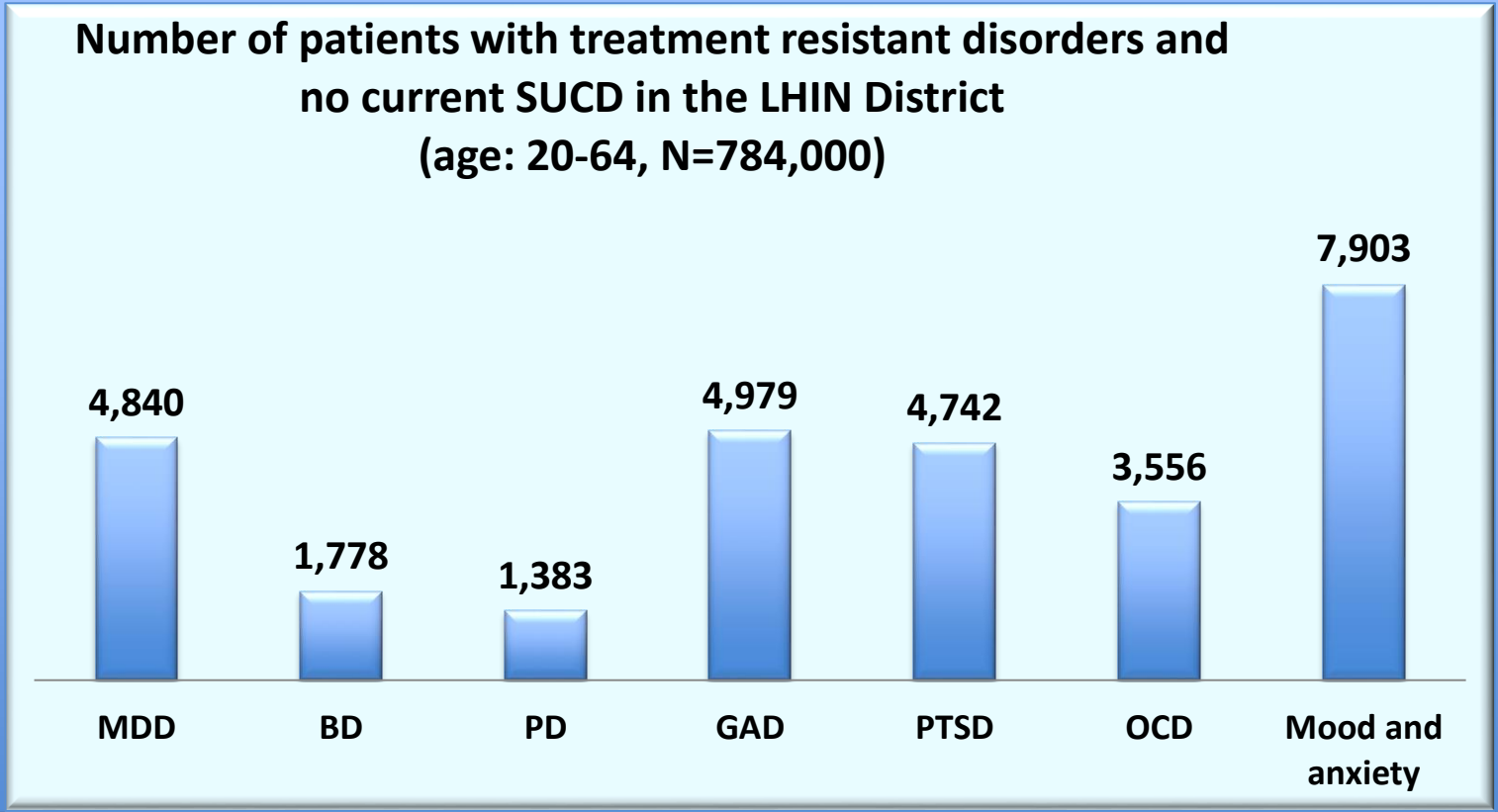
Estimated adult population with Treatment Resistant Mood/Anxiety



population*0.067 (mood/anxiety)-16% with SUD*0.15 (TRD/A)

Estimated adult population with Treatment Resistant Mood/Anxiety



Prevalence (%)	4.9	1.8	0.7	2.52	2.4	1.8	8
% TR	15	15	30	30	30	30	15

% with SUCD: 16% of patients with disorders

CONCLUSIONS

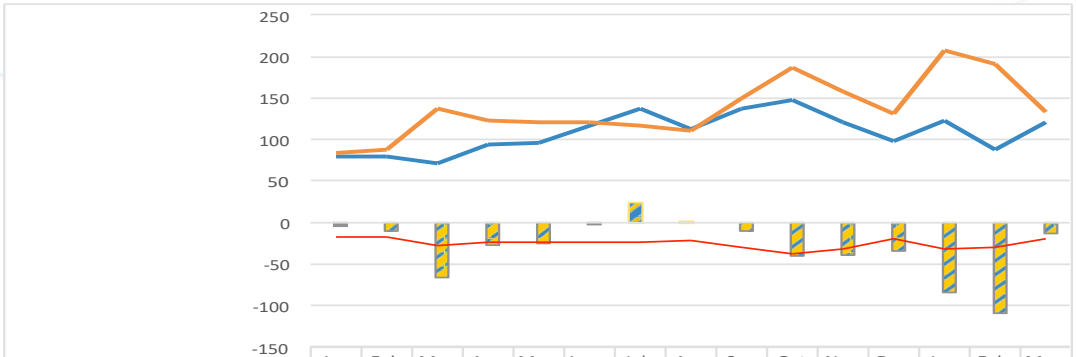
- Treatment resistant depression and anxiety are a very large population, exceeding the capacity of our service
- We could better specify the population of Treatment Resistant patients who can benefit of highly specialized services, also considering:
  - Pseudo resistance
  - Severity of symptoms and level of functioning
  - Indications for specialized care
- GAP analysis: evaluate the services available in community for TR mood and anxiety disorders and unmet needs

APRIL 15, 2020

MAP Dashboard

Monthly update on indicators of MAP functioning

External referrals sent to the MAP and consultations booked
Update March 2020



	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Booked-received (+)							24	2							
Booked-received (-)	-4	-10	-66	-27	-25	-1			-10	-40	-39	-34	-84	-109	-13
First contact booked	80	79	71	95	96	117	137	112	138	147	121	98	123	87	121
-20% referral received	-16.8	-17.8	-27.4	-24.4	-24.2	-23.6	-22.6	-22	-29.6	-37.4	-32	-19.8	-31.1	-29.4	-20.1
Referrals received	84	88	137	122	121	120	116	110	149	187	159	131	207	192	134

24%

DECREASE IN REFERRALS

in March

110

CONSULTATIONS

booked per month, in the last three months

There has been a 24% decrease in the number of external referrals to the ROMHC, with 134 referrals in March, compared with an average of 177 referrals per month in December-February, likely due to the COVID-19 epidemic. The number of consultations has maintained globally constant, with about 110 consultations per month, so that the program has had the capacity of reabsorb the backlog, which has decreased of almost 25% (from 180 to 147) in the first two weeks of April.

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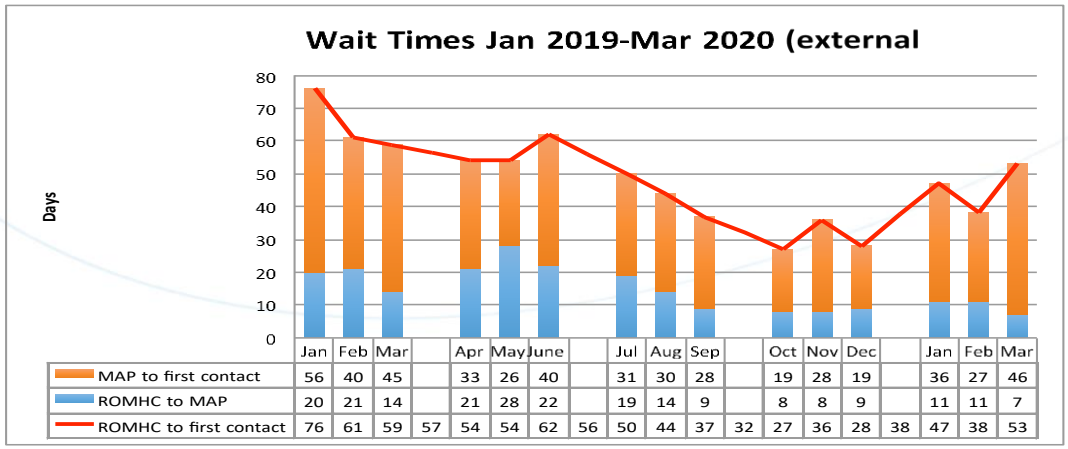
Average Monthly Wait Times of first contact with any staff in MAP (Referrals external to ROMHC)



	Jan	Feb	Mar		Apr	May	June		Jul	Aug	Sep		Oct	Nov	Dec		Jan	Feb	Mar
MAP to first contact	56	40	45		33	26	40		31	30	28		19	28	19		36	27	46
ROMHC to MAP	20	21	14		21	28	22		19	14	9		8	8	9		11	11	7
ROMHC to first contact	76	61	59	57	54	54	62	56	50	44	37	32	27	36	28	38	47	38	53

the average wait time for first contact in MAP

47 days

in the first quarter 2020

The wait times have remained largely below 60 days in the the last year. The average wait time in the first quarter 2020 has been 47 days. This value is consistent with the values during 2019 (Jan-Mar: 65; Apr-Jun: 57; Jul-Sep: 44; Oct-Dec: 30).

Backlog on April 16, 2020:

- **103 patients in CCL (half of them have already been called), to be booked in May-June;**
- **44 patients in MAP.**
- **All patients in the backlog were referred in January 2020 or later.**

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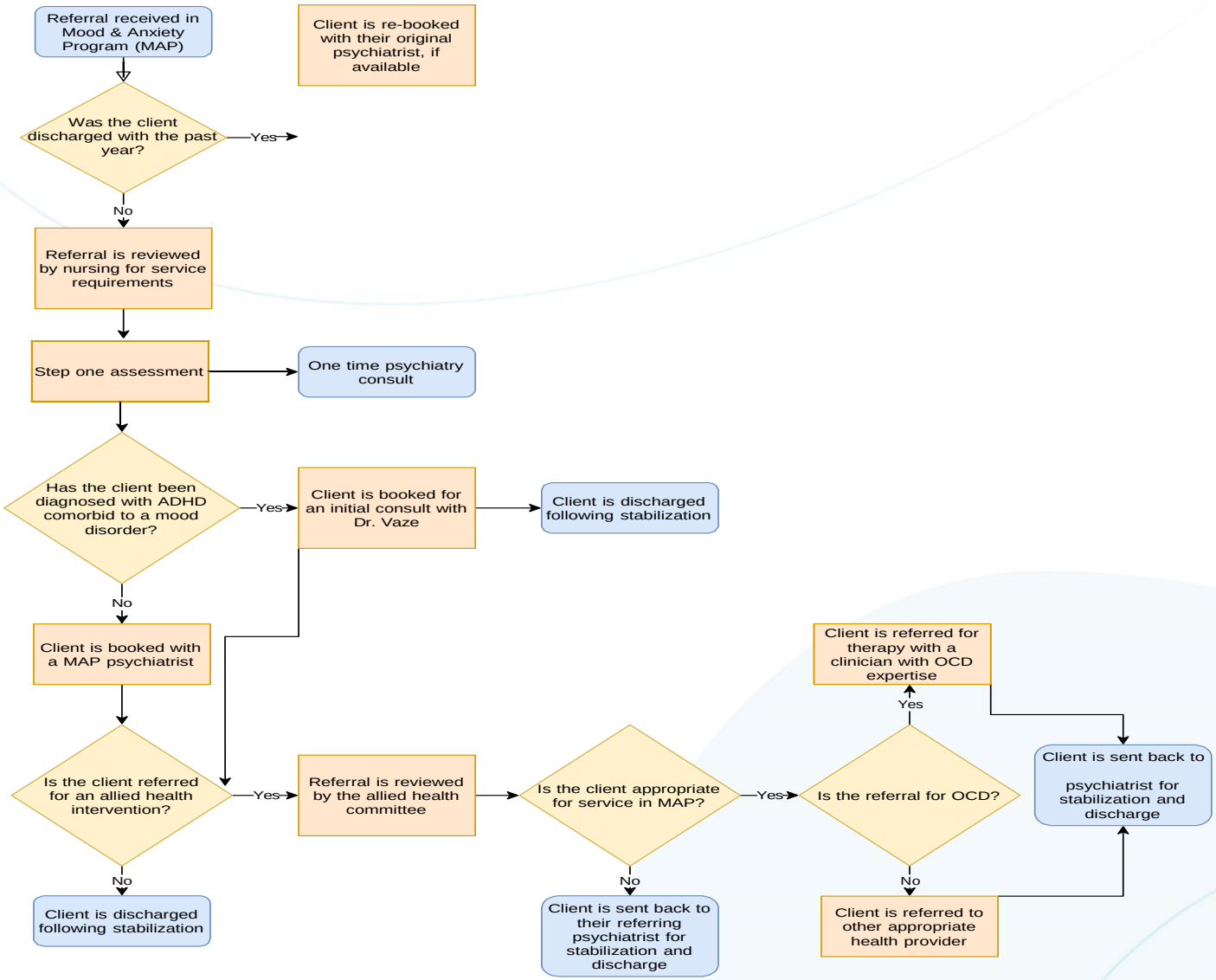
ADHD and OCD Flow



Partner to create an anxiety algorithm similar to the depression algorithm

Telemedicine

- Background/2014 presentation
- Selected awards/accomplishments
- Numbers
- 3 horizons

Developing a Telemedicine Service in a Specialized Mental Health Care Organization

Rajiv Bhatla, MD, FRCPC
Tabitha Rogers, MD, FRCPC
Ameneh Mirzaei, MD, FRCPC
Sarah Joynt, Telemedicine Coordinator

e- Health Conference 2014, Vancouver

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Who We Are

The Royal consists of:

The Royal Ottawa Mental Health Centre

- One 188-bed state-of-the-art mental health facility and one 96-bed facility (32 recovery beds and 64 long term care beds) located in Ottawa.
- First hospital in Canada to open under P3/AFP concept in 2006

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Who We Are *cont'd*

The Brockville Mental Health Centre

- A specialized psychiatric facility located in Brockville
- 161 inpatient beds (61 Forensic, 100 STU)
- 183 beds in the community – Homes for Special Care

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Who We Are *cont'd*

The University of Ottawa
Institute of Mental Health Research

- Multidisciplinary research programs that investigate the biological and psychological factors contributing to mental illness and innovative treatments

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Who We Are *cont'd*

- **The Royal Ottawa Foundation for Mental Health**
  Fundraising organization that supports mental health research, capital projects and equipment purchases

The Royal is one of Ontario's 24 academic health science centers

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Who We Serve

- Delivering specialized mental health care (tertiary level) for people living with serious and persistent mental illness, complex diagnoses and/or severe behavioral problems where the illness is:
  - Refractory to multiple treatments at the first line and intensive level of service;
  - Requires more specialized assessment or care;
  - Includes complex or rare conditions;
  - Requires longer term treatment and/or rehabilitation in a specialized setting

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Who We Serve *cont'd*

- Primary care physicians through consultative / shared care
- Service providers and institutions through capacity building (education, briefings, studies, etc)
- The general public through awareness building and education

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Beginnings: 1996-2009

- 1996: The Royal's first Telemedicine Clinical Event
- 2001: CHIPP funds The Royal & University of Ottawa NOFPP to lead outreach, a Telemental Health initiative for clients in rural communities of Northern Ontario
- 2002: The Royal delivers first Telemental Health clinics to northern partners
- 2004: The Royal joins CareConnect to lead the development of Adult Mental Health Telemedicine in Eastern Ontario
- 2005: The Royal developed a new Telemedicine Service for 10 – 15 new wireless video conference systems around The Royal

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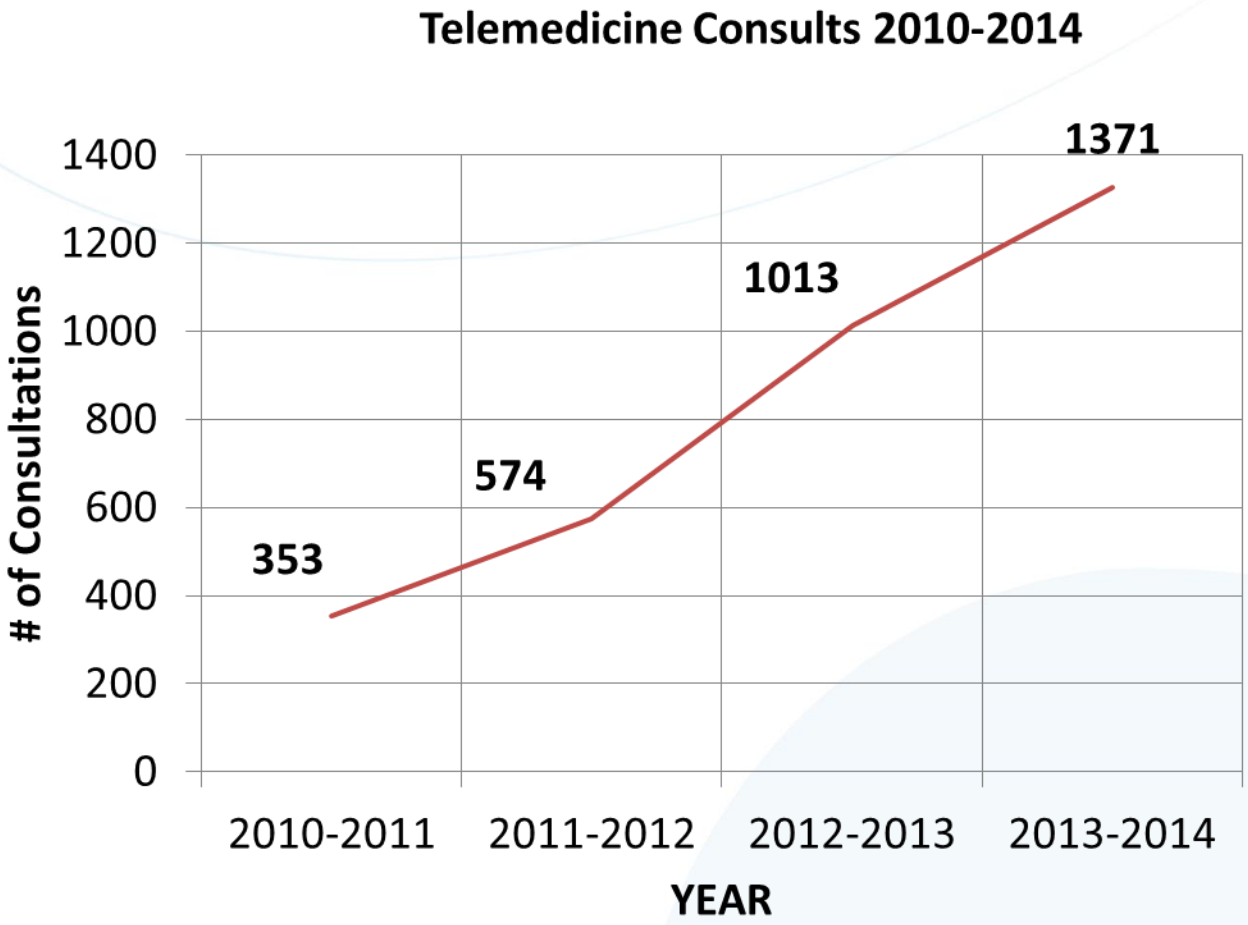
Recent Developments: 2010-Present

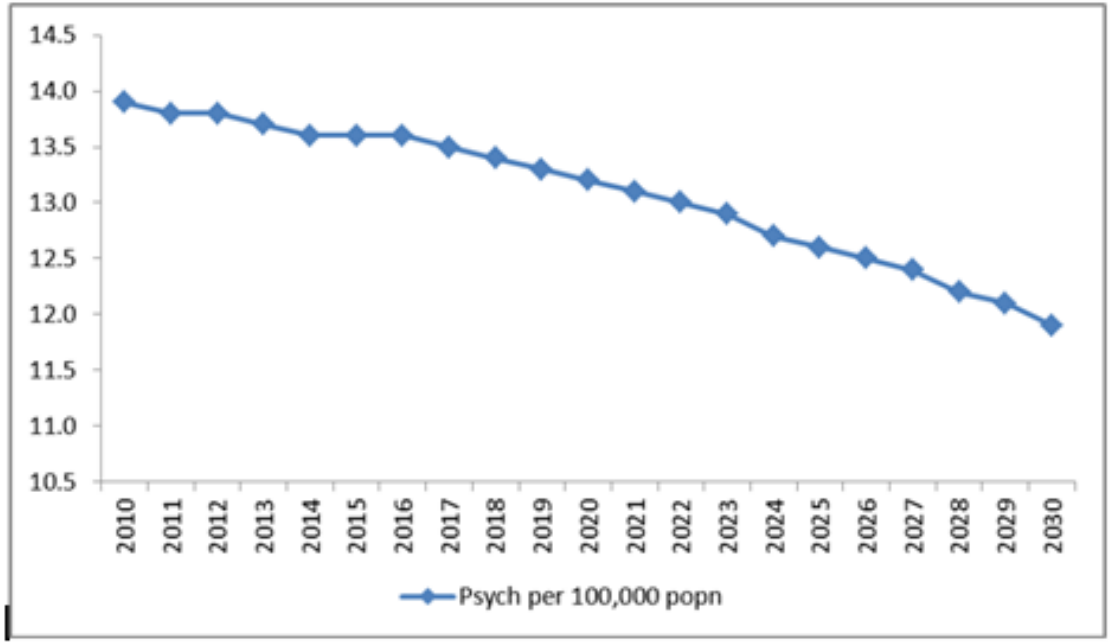
- 2010: $1 million Bell Donation
    I. Addition of a Telemedicine Coordinator
    II. New Telemedicine suites
    III. Consultations increase by 80%
- Increase in Community Clinics: Deep River, St. Francis Memorial Hospital, Renfrew Community Mental Health, Renfrew Victoria Hospital, Carleton Place District Hospital, South East Ottawa CHC, North Lanark CHC, Seaway Valley CHC, Monteith Correctional Facility

Telemedicine Consultations 2010-2014



Forecasted Number of Psychiatrists per Capita in Ontario

Psychiatrists in Ontario per 100,000 – Status Quo Scenario 2012



Canadian Collaborative Centre for Physicians Resources (C3PR). Canadian Medical Association (2012).

Given the past and current training levels, there will be fewer Psychiatrists in the future.

Why Community Health Centres (CHCs)?

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Community Health Centres (CHCs)

- Not-for-profit, publicly-funded primary health care organizations
- Collaborative approach care by various health care providers under one roof
- Designed to focus on the most appropriate services & programs for the local community

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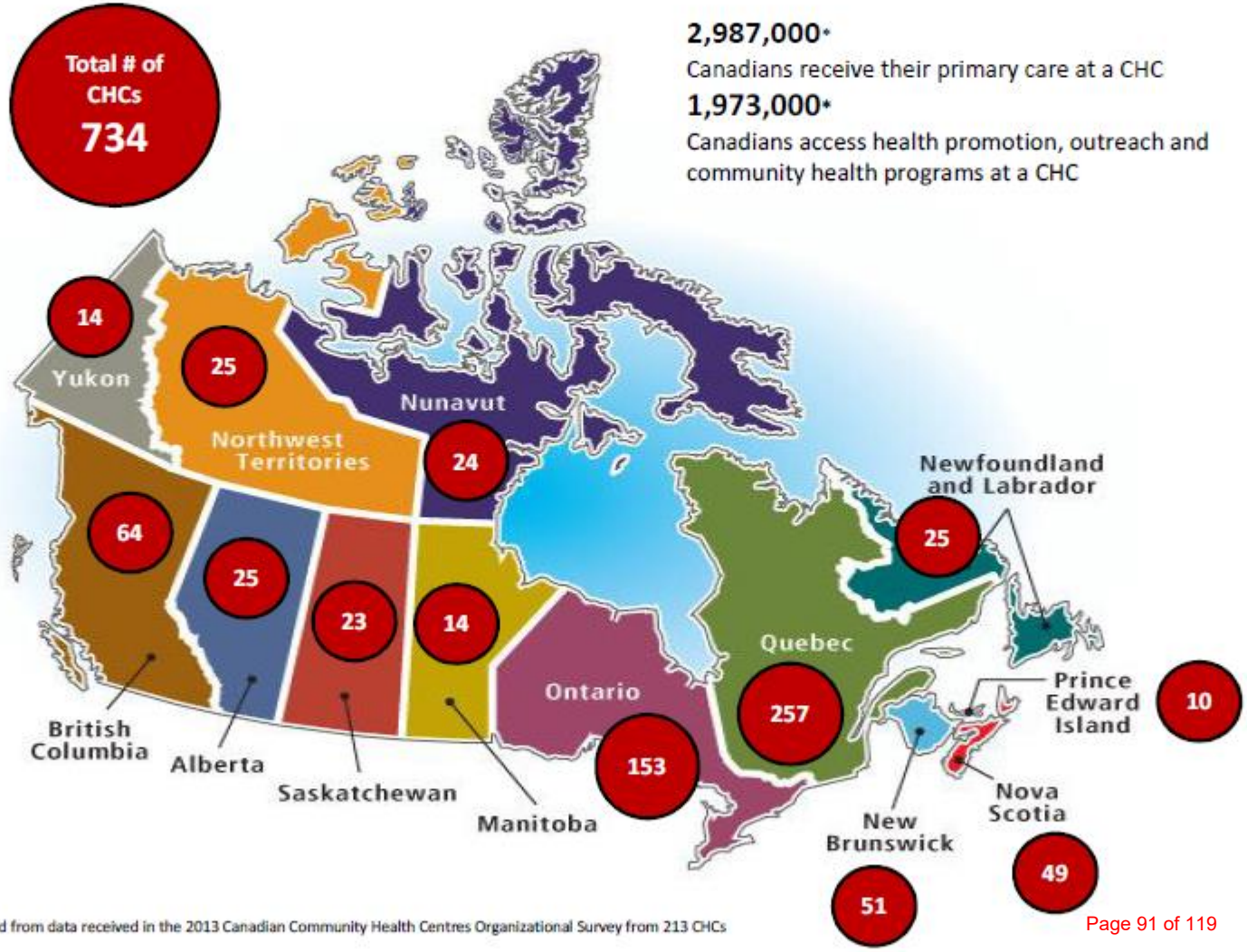
L'Association canadienne des centres de santé communautaire

Canadian Association of Community Health Centres

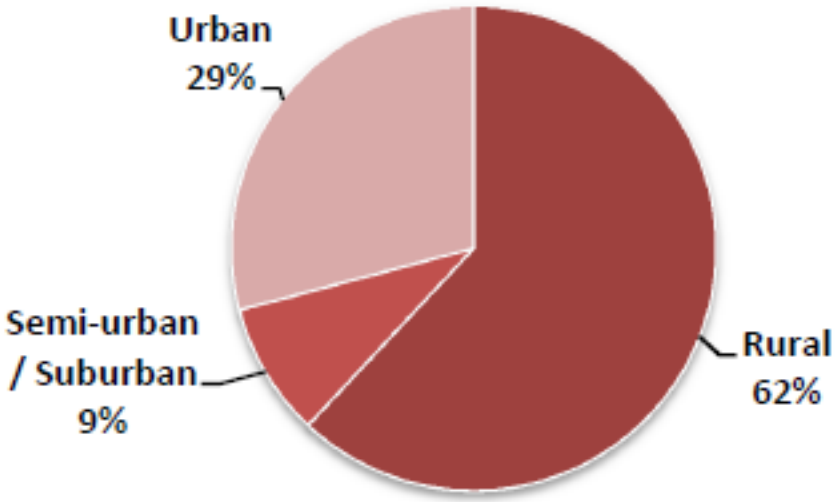
2013 CANADIAN COMMUNITY HEALTH CENTRES ORGANIZATIONAL SURVEY

SNAPSHOT: Community Health Centres across Canada, by province and territory



*extrapolated from data received in the 2013 Canadian Community Health Centres Organizational Survey from 213 CHCs

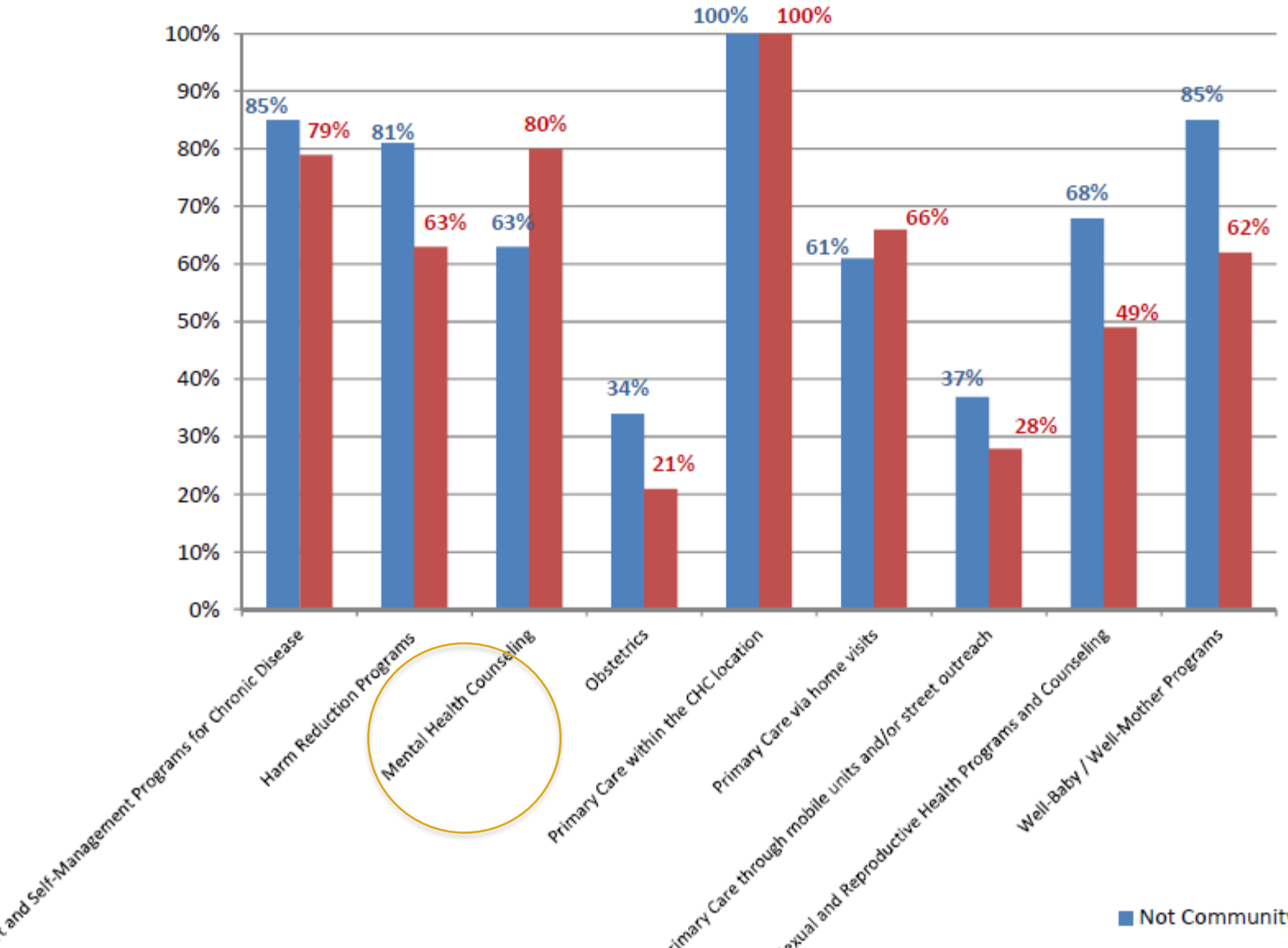
Distribution of CHCs by Population/Geographical Context (n = 213)



Canadian Association of Community Health Centres

2013 CANADIAN COMMUNITY HEALTH CENTRES ORGANIZATIONAL SURVEY

FACT SHEET: Profile of Primary Care Services/Programs at CHCs, by Governance Type



Why connect with CHCs?

- They serve clients with complex needs
- Need for access to psychiatric consultation & care
- More than half are located in rural areas
- 14 CHCs in Champlain LHIN, 7 of which are in Ottawa

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Local Health Integration Networks (LHINs)

- Created by the Ontario government in March 2006 to address community's health needs & priorities
- 14 not-for-profit corporations
- Plan, integrate and fund local health services, including:
  - Hospitals
  - Community Care Access Centres
  - Community Support Services
  - Long-term Care
  - Mental Health and Addictions Services
  - Community Health Centres

Ontario LHINs Map

1. Erie St. Clair
2. South West
3. Waterloo Wellington
4. Hamilton Niagara Haldimand Brant
5. Central West
6. Mississauga Halton
7. Toronto Central
8. Central
9. Central East
10. South East
11. Champlain
12. North Simcoe Muskoka
13. North East
14. North West

Champlain

Ways we have connected with the CHCs

- Traditional Shared care model
  - One day per month
  - On site direct patient consultations & case discussions

- 6- month pilot targeting all the CHCs in Ottawa
  - Two half days per month
  - Innovative use of telemedicine to build capacity
  - Case discussions with GPs, NPs, allied health
  - Monthly 1 hour educational sessions

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Telemedicine Case Consultation Pilot - Challenges & Lessons Learned

- Health care providers' availability
- Obtaining consent from patients
- Access to direct patient consultations

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Ways we have connected with the CHCs - Current Models

- Ongoing Shared care model for CHCs in Ottawa
- Half a day per month of telemedicine clinics for Lanark & Cornwall
- Hybrid model of direct patient consultations & case discussions
- Telemedicine as a tool for ongoing capacity building

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Why Rural Clinics?

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Rural Clinics

- Access to mental health care for rural populations
- Closer to home
- Builds MH&A capacity in home community
- Consultant develops a relationship with the community

The Monteith Clinic

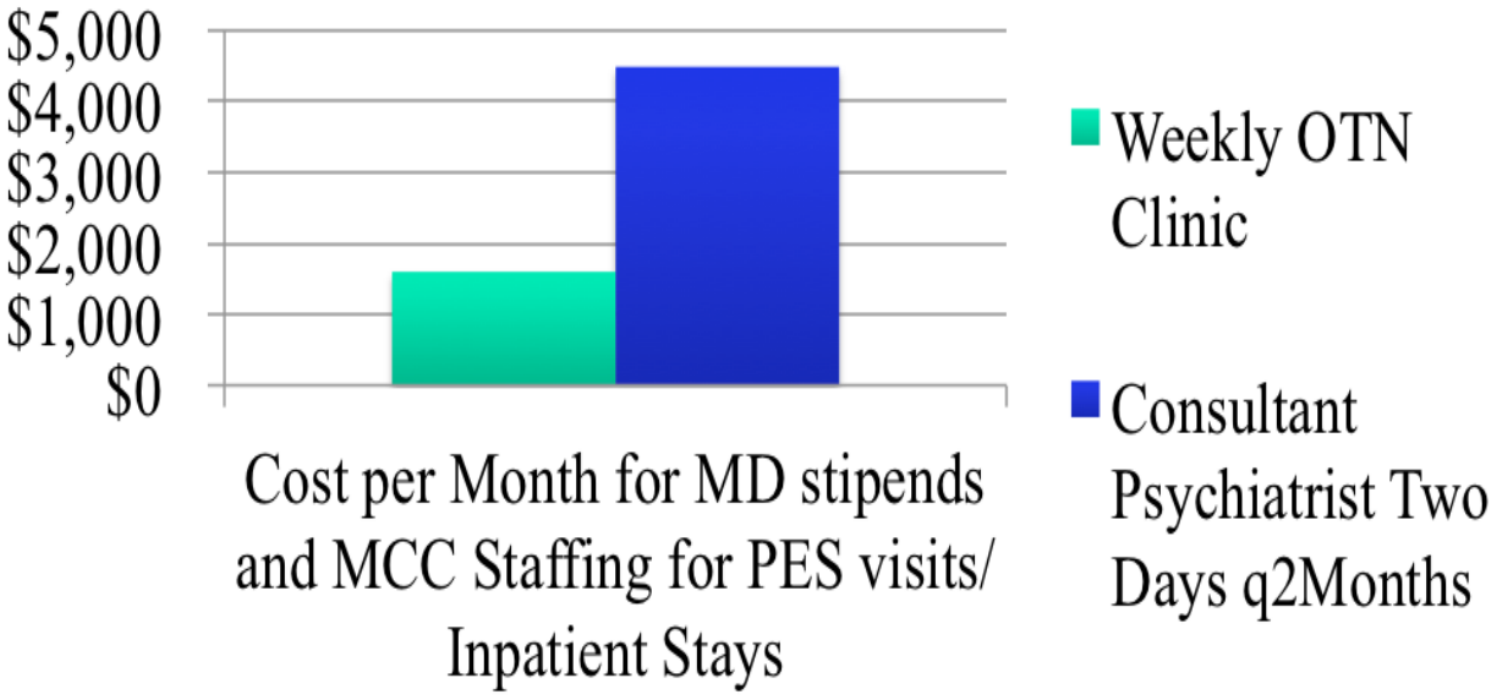
- Joint project between the ROHCG and the Ministry of Community Safety & Correctional Services (MCSCS)

- The Monteith Correctional Complex (MCC) is 242 bed correctional facility located about 50km north of Timmins, which serves as both a remand and correctional centre for north eastern Ontario, including the James Bay coast.

Services Provided

- The Royal clinical staff with the Monteith Correctional Complex (MCC) health care staff to provide psychiatric consultation and treatment
  - weekly 4 hour clinics - mean of 4 clinics or 16 hours per month
  - Pre-case consultation, assessment/treatment
  - post case consultation provided per offender
  - Physician roster of 8 psychiatrists
  - The Royal Health Records opened a chart for consultation purposes only – records remain with MCSCS.

Cost Savings



- $1600 per month for the OTN service vs $4489 per month for the 2 days every two months consultant psychiatrist, a savings of $2889 per month for the OTN clinic model

Note: data from January 6, 2012 - April 24, 2012 cohort

Summary

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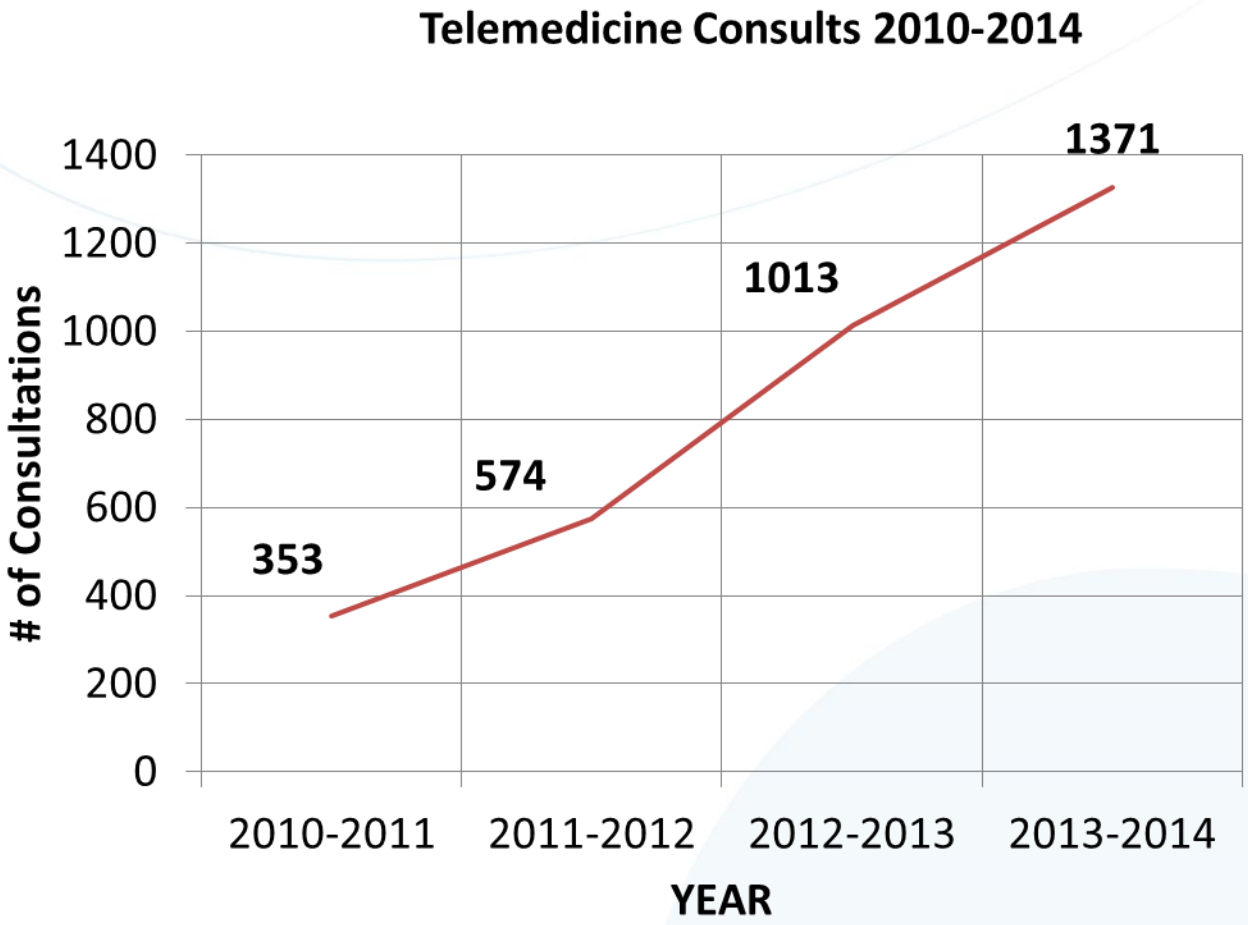
Telemedicine Consultations 2010-2014



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Who is Using Telemedicine

- **Over 50 Clinicians** are using Telemedicine – 8 of those clinicians have provided 50 or more consultations
- **Increase in the number of Allied Healthcare Professional using Telemedicine**
  - Clinicians are finding ways to use Telemedicine in their own practice
  - Clinicians are looking for ways to support clients in their home community
- **Social Workers use Telemedicine** for Therapy Groups, Follow-up visits, Family Planning and After Care
- **Nurses** use Telemedicine for medications management, discharge planning, education, networking with community agencies
- **Psychologists** use Telemedicine for Therapy Groups, Cognitive Behavioral Therapy, and follow-up

Telemedicine at The Royal

2014

- **All** programs at The Royal are using Telemedicine
- **Mobile Systems** - the ability to take Telemedicine to the clinicians has increased access to Telemedicine
- **PCVC** enables Providers to go directly into a patient's home from their desktop/ laptop 16 clinicians registered
- **Medical Services** via Telemedicine; currently providing Cardiology Clinic, developing Dermatology & Endocrinology Clinics

Strategies for Developing a Telemedicine Service

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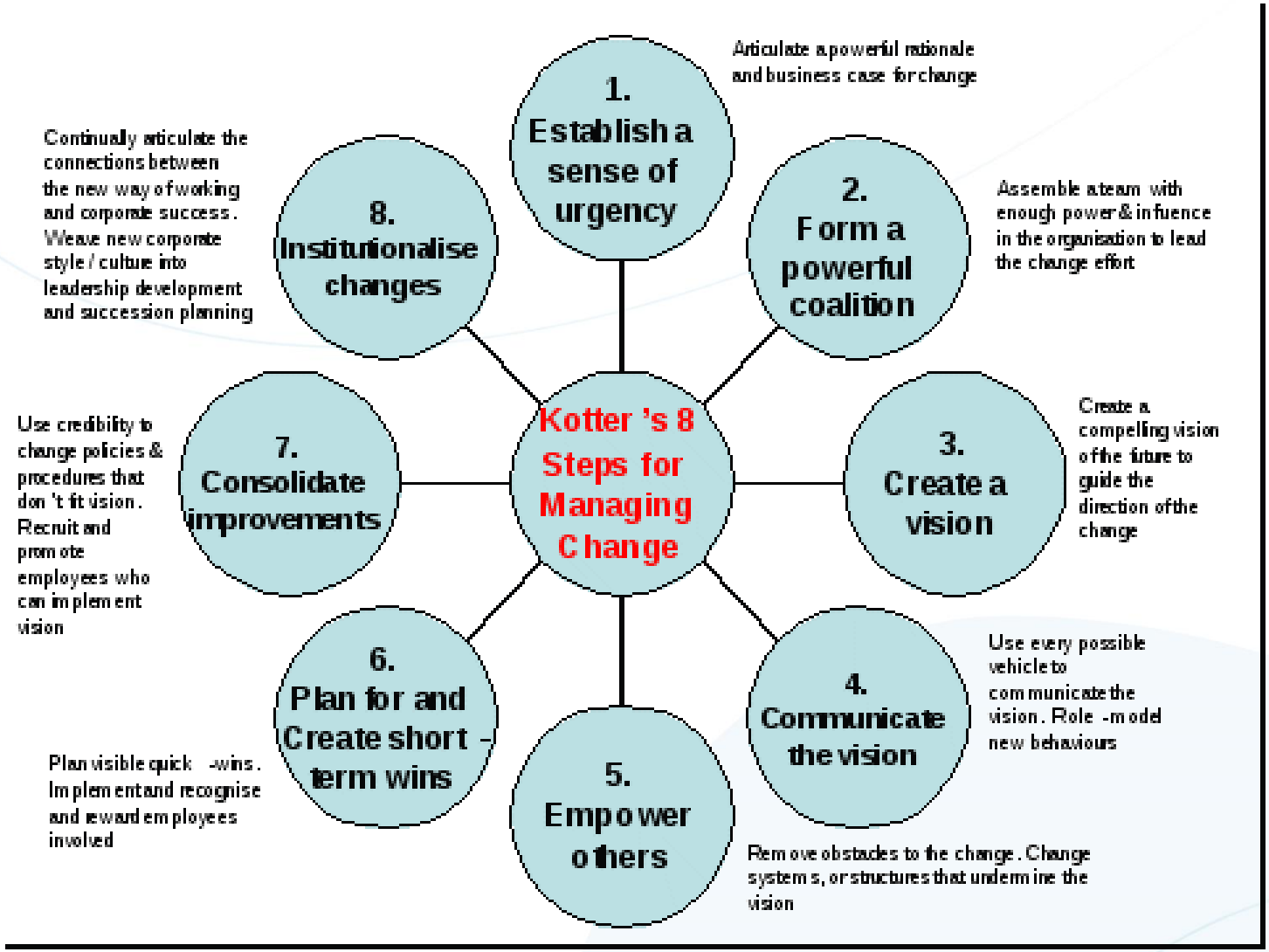
PDSA cycle


Kotter 's 8 Steps for Managing Change
1. Establish a sense of urgency
Articulate a powerful rationale and business case for change
2. Form a powerful coalition
Assemble a team with enough power & influence in the organisation to lead the change effort
3. Create a vision
Create a compelling vision of the future to guide the direction of the change
4. Communicate the vision
Use every possible vehicle to communicate the vision. Role -model new behaviours
5. Empower others
Remove obstacles to the change. Change systems, or structures that undermine the vision
6. Plan for and Create short - term wins
Plan visible quick -wins. Implement and recognise and reward employees involved
7. Consolidate improvements
Use credibility to change policies & procedures that don 't fit vision. Recruit and promote employees who can implement vision
8. Institutionalise changes
Continually articulate the connections between the new way of working and corporate success. Weave new corporate style / culture into leadership development and succession planning

Questions / Discussion

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Selected Telemed accomplishments

- 2013 - Chair, American Telemedicine Association (ATA) Canadian Discussion Group
- Shore, J et.al. A Lexicon of Assessment and Outcome Measures for Telemental Health. Telemedicine and e-Health. (2014) 20(3): 282-292.
- Community Appreciation Award, CMHA, 2014

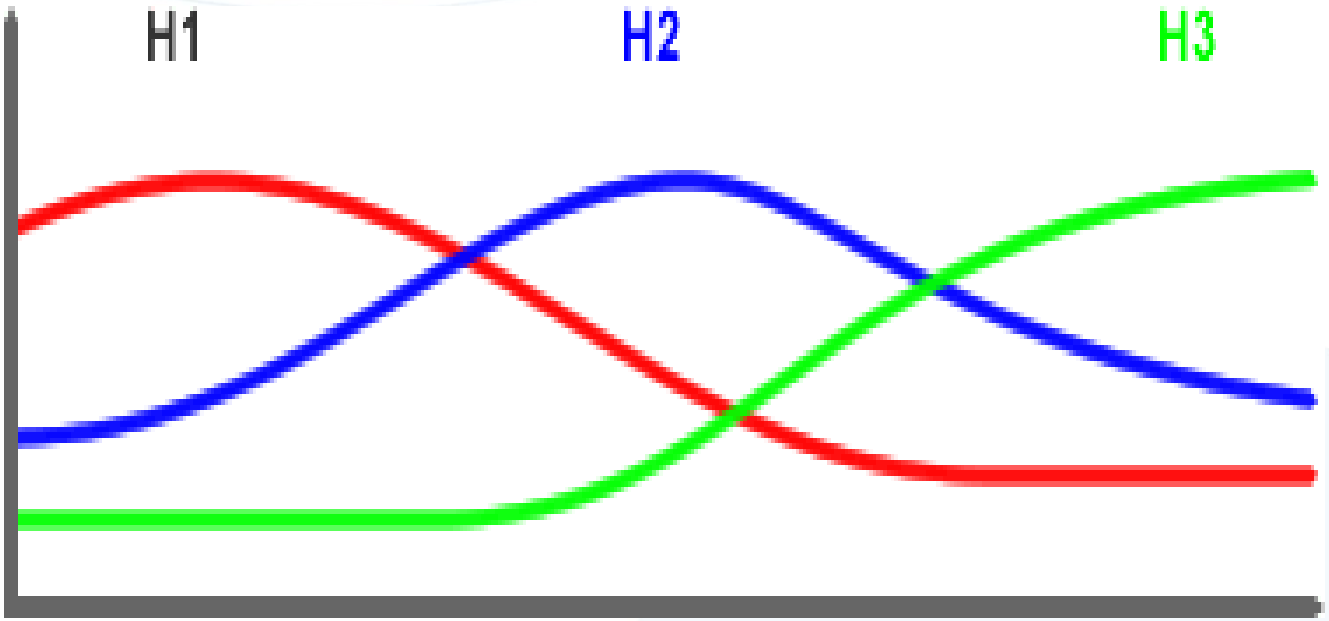
Selected Telemed accomplishments

- 2015 - Champion of Telemedicine Award, Champlain LHIN
- Schubert NJ, Backman PJ, Bhatla R, Corace KM. Telepsychiatry and Patient-Provider Concordance. Canadian Journal of Rural Medicine, Vol. 24, Issue 3 (July 2019)
- Numerous academic presentations (national/international)

Telemedicine numbers 2018/19 to 2019/20 growth

- OTN becoming more precise in reporting
- OTN invite – 524 to 758 - 45% increase
- Telemedicine – 7070 to 8786 (inc. mindability) – 24% increase

Telemedicine & 3 horizons



Mental Health: Past, Present and Future

UOHS,
January 21, 2017

Raj Bhatla MD, FRCPC, DABPN
Psychiatrist-in-Chief and
Chief of Staff
Associate Professor, U of O

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

Website

- Corporate redesign - improved

Vanderbilt model