The Royal
Mental Health - Care & Research
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NOTICE OF MEETING
ROYAL OTTAWA HEALTH CARE GROUP
COMPENSATION & SUCCESSION PLANNING COMMITTEE
April 29, 2020 at 4:30 p.m.
Via Zoom

○ Oral presentation
● Paper enclosed
●● Paper to follow
●●● Paper at meeting
IN Information
DEC Decision required
** Guidance required

Time (min)	#	ITEM	REFERENCE	RESPONSIBILITY	STATUS	
05	**1.**	**CALL TO ORDER**			○	IN
05	**2.**	**ACCEPTANCE OF AGENDA**	a) Acceptance of the April 29, 2020 Agenda		●	DEC
		APPROVAL OF PREVIOUS MINUTES	b) Approval of the November 29, 2019 Minutes		●	DEC
10	**3.**	**SUCCESSION PLANNING**	a) COVID-19 Succession Planning	J. Bezzubetz	●○	IN
10			b) A Mini-Snapshot: Occupational Health Data in This C-Environment	C. Crocker	●○	IN
30	**4.**	**HOSPITAL WITHOUT WALLS**	Organization of the Future	J. Bezzubetz M. Daly S. Gilchrist	●○	IN
30	**5.**	**PERFORMANCE REVIEW**	a) President & CEO Objectives		●	DEC
30			b) Psychiatrist-in-Chief/Chief of Staff		●	DEC
	6.	**IN CAMERA SESSION**	*Motions attached*			
01	**7.**	**ADJOURNMENT**	The next meeting will be on November 25, 2020.		○	DEC

A. Graham, Chair

RSVP your attendance to P. Robb at patricia.robb@theroyal.ca

The Royal Mental Health - Care & Research Santé mentale - Soins et recherche	**MINUTES** **ROYAL OTTAWA HEALTH CARE GROUP** **COMPENSATION & SUCCESSION PLANNING COMMITTEE** **November 29, 2019 at 7:30 a.m.** **Royal Ottawa Mental Health Centre** **Executive Boardroom 2426-1**	○ Oral presentation ● Paper enclosed ●● Paper to follow ●●● Paper at meeting **IN** Information **DEC** Decision required ** Guidance required

Teleconference Dial-In: 1-888-875-1833 Passcode: 926707277#

Trustees	**Present**	**Regrets**	**Trustees**	**Present**	**Regrets**
A. Graham, Chair	X		D. Somppi	X	
I. Levy, Vice-Chair		X	S. McLean		X
J. Gallant	X				
Management Staff					
J. Bezzubetz	X		P. Robb	X	
R. Bhatla	X				
Guests					
R. Lashley	X		C. Crocker	X	
Observer					
N. Bhargava	X phone				

#	ITEM		ACTION REQUIRED
1.	**CALL TO ORDER**	A. Graham, Compensation and Succession Planning Committee Chair, called the meeting to order at 7:30 a.m. and declared the meeting to have been regularly called and properly constituted for the transaction of business. Welcome remarks were provided. The meeting was opened by acknowledging that the land on which we gather is the traditional and unceded territory of the Algonquin nation. The Chair noted that the meeting in the spring is focussed on compensation, whereas this meeting is focussed on succession planning. Another purpose, as requested by the Board, is to hear a report on the progress of objectives by the President & CEO and Chief of Staff/Psychiatrist-in-Chief. A report on HR issues and successes will also be heard later in the agenda. C Crocker and R. Lashley were welcomed to the meeting for this purpose.	
2.	**CONSENT AGENDA**	a) Acceptance of the November 20, 2019 Agenda b) Approval of the June 5, 2019 Minutes Moved by D. Somppi seconded by J. Gallant **BE IT RESOLVED THAT** the Consent Agenda, including the items outlined therein, be accepted as	

		presented. **CARRIED**	
	ITEMS MOVED FROM THE CONSENT AGENDA	There were no items removed from the Consent Agenda.	
3.	**DECISION/ INFORMATION ITEMS**	a) Review of Committee Terms of Reference This was a follow-up item from the Special August 8, 2019 Board of Trustees' meeting and will be brought back to the In-Camera session of the December 12, 2019 meeting to report back to the Board of Trustees and for final approval. A briefing note from the Governance Committee was included in the meeting package, which included the Terms of Reference and Performance Appraisal Process document with suggested changes noted in track changes. A document was also included with research into the ROHCG By-Laws and the *Public Hospitals Act* regarding the Board's responsibility to appoint a Chief of Staff. Discussion followed and further revisions were made and noted in track changes. The role of the Chief of Staff/Psychiatrist-in-Chief on the Committee was discussed and the membership section is to be adjusted to reflect that this is a non-voting ex-officio member of the Committee and will be added to the invite list for future meetings, but will leave when discussing matters relating only to the President & CEO. Moved by D. Somppi seconded by J. Gallant **BE IT RESOLVED THAT** the Compensation & Succession Planning Committee Terms of Reference be approved as amended and brought forward to the Board of Trustees for final approval. **CARRIED** Moved by D. Somppi seconded by J. Gallant **BE IT RESOLVED THAT** the performance review process for the President & CEO and Chief of Staff be approved as amended and brought forward to the Board of Trustees for final approval. **CARRIED**	P. Robb
		b) Human Resources Operational Plan – C. Crocker, R. Lashley	

		C. Crocker introduced this item. R. Lashley then presented on the Human Resources Operation Plan, which was included in the meeting package. The following was highlighted: - Focus is on upcoming retirements - To incorporate the LEADS framework - Support the Royal in the implementation of the Just Culture. - Complete a pay equity plan - Automate the new-hire experience process - Support organization redesign - Employ technology for conferences - Occupational health service nurses are available to support staff at both sites - The amount of safety legislation from the Ministry of Labour is a big focus for safety and emergency management. This includes codes, ensuring plans are up to date and that training is taking place so employees are well positioned to handle any emergency - Turnover has gone up a little for both sites, but it was seen as standard for health care. In comparison to other hospitals, we are consistent. It was agreed that it would be useful to add a benchmark in the report to show this comparison. This will be actioned for future reports - The age group for both sites is consistent with each of the regions - One area at the hospital is looking at being designated as bilingual. Front line staff are required to be bilingual and it is mandatory to be tested, otherwise it is voluntary testing - Since the Royal is federally funded, we need to conduct an employment equity survey. It is voluntary data - A slide was included on female/male percentages. The Royal is a female dominated organization. This is the first time this information has been provided in this report - The ONA collective agreement is coming up for re-negotiation. The agreement ends in March 2020. The province has legislated that the public sector will only receive a 1% increase, which will affect negotiations - Grievance numbers have come down. There were 40 grievances this year as compared to 80 last year Discussion ensued. A question was raised about	C. Crocker R. Lashley

		whether we track other languages spoken by staff. From a Human Rights perspective, this data is not collected to avoid employees feeling we are trying to get personal background information. However, in the different areas of the hospital, they do call on each other to help in situations where a certain language is needed. Emphasis on wellness was seen as important. Since we are in the care business, we should care about the people delivering the care. In that regard, a concern was raised about the e-learning opportunities as there is not always time to do it and staff may feel overwhelmed with the expectation to complete it. This was noted as a caution only. R. Lashley and C. Crocker were thanked for their presentation.	
		c) LEADS Overview – C. Crocker	
		C. Crocker provided some context to this item and it was reviewed with the Committee. Organizationally, we have done a lot of work on leadership and wanted a good framework that we were comfortable with. It was felt that LEADS allowed consistency in how we do this. The framework also helps to set the stage on what employees should expect from management and vice versa and allows the groundwork for getting that right. The LEADS Overview presentation was included in the meeting package for the information of the Committee. *C. Crocker and R. Lashley departed the meeting at 8:22 p.m.*	
		d) Executive Succession Plans – J. Bezzubetz	
		J. Bezzubetz pointed out that she did not come to the meeting with the names of who is doing what, because she wanted to take the Committee through the process first. She felt that having a plan to help succession is important rather than only identifying individuals. It was her intention to provide the names by the next meeting. Discussion and questions follow. The importance of having an emergency succession plan in place (what happens if…) was stressed. It was noted that this was discussed at last year's Committee meeting and this information is to be provided for the Board's	J. Bezzubetz

		background information at the December 12, 2019 In-camera meeting. In the meantime, it was seen as important that emergency names be captured for the President & CEO and the Chief of Staff/Psychiatrist-in-Chief positions. J. Bezzubetz is to provide an update on where she is at when she provides her progress against objectives to the Board of Trustees in April. The expectation is that something will be finalized and presented to the Board by June 2020. The Executive Succession Plans presentation document was included in the meeting package for the information and review of the Committee.	J. Bezzubetz
		e) Medical Succession Plan – R. Bhatla	
		R. Bhatla reported on the Medical Succession Plan. He is currently in the midst of conducting a literature search on what succession planning is for physicians. This includes recruitment and succession planning. He will report back at the April meeting. Future candidates for the Chief of Staff position were identified as the Associate Chiefs of both sites: Dr. P. Sedge and Dr. S. Gulati. They would share the responsibility and are aware of that. A question arose about their requirement to act jointly and it was noted that the Ottawa campus would take the lead on recruitment and various disciplinary procedures and Brockville would focus on forensics, FTU and STU. The Committee agreed with having a lead in the dual shared responsibility. The Board of Trustees will need to understand this and more clarity is to be provided at the April meeting. An example of the physician performance appraisal document was included in the meeting package. It was noted that during the performance appraisal process, some people self-identified that they wanted to be in a leadership role and through this process they have been successful in identifying people for leadership. The Committee liked the idea of using it for this purpose. R. Bhatla was thanked for his report. The Medical Succession Plan presentation document was included in the meeting package for	R. Bhatla R. Bhatla

		the information of the Committee. There was a brief discussion about the succession plans for IMHR and the Foundation. Currently, there is uncertainty whether they follow a process. This will be something we want to integrate as well. This item was for the Committee's information and consideration as the organization changes.	
		f) Org design for the future – J. Bezzubetz	
		As the organization started to shift and change at a high level (IMHR/Foundation/work Board has done at Board Development Days, etc.), it seemed to make sense to start to consider what new roles or functions we have to introduce. The organization structure we had has been in place for 10 years. In terms of execution, unsure if it was ever executed in the way it was intended. This year the Senior Management Team (SMT) has been engaged to start thinking about what the organization of the future is going to look like. In that regard, an external consultant has been hired to help with this and has spoken to all of SMT. In the spirit of engagement, SMT are having a retreat on December 11, 2019 to launch the discussion. By then they will all have been consulted with. There will be a process at the retreat to consider the LEADS framework, what the organization of the future looks like and what the roles are that we have to create. When an organization comes up with a strategic plan, the whole organization has to align. If we have a discussion on resource allocation, how do we set up the organization to execute on that. This is a push to try to develop the organization in a different way. Discussion ensued. It was noted that COO/CFO's role is very heavy and he has a diverse portfolio. If he left, it would be difficult to find a new person to do the same work. There is also a gap in HR organization development. Questions were raised about the organization chart as there seemed to be a mix of hard reporting relationships. It currently looks like IMHR and the Foundation Board report to the ROHCG Board. The Committee was worried that someone might misinterpret that. If this is being used to achieve unity and purpose, we should consider a way we can	

		provide more clarity on types of relationships and how we are going to make it happen. The Committee wants to continue to foster the progress made with the other Boards. Another item identified was that the difference between a governance reporting relationship and an operational reporting structure should be made more clear and formalized. Clarity is needed between a governance and business relationship as we want to mature both of these. This was seen as an action for the Governance Committee to look at Board structure: structure follows strategy, form follows function. An update will be provided on all these items at the meeting in April. The Organization of the Future presentation document was included in the meeting package for the information of the Committee.	Governance Committee J. Bezzubetz
4.	**TO REPORT AGAINST OBJECTIVES**	a) President & CEO – J. Bezzubetz	
		A status update document with the President & CEO's Objectives for 2019-2020 was included in the meeting package and reviewed with the Committee. J. Bezzubetz highlighted the following from the key themes of the 360 that she just went through. She will also share it with the her referees: - Compelling resonant vision and brand - Courage to undertake change - Shift in ROH leadership and culture - Authenticity builds trust and actions speak loudly - Key challenges: o Designing a cultural norm for performance o How do we set priorities? o How will we measure organization and individual performance? o The financial uncertainty of the Ontario climate is something to pay attention to. There was a lot of good feedback provided. She promised change when she was hired and it is actually happening.	
		b) Chief of Staff/Psychiatrist-in-Chief – R. Bhatla	
		A status update document with the Chief of Staff/Psychiatrist-in-Chief's Objectives for 2019-2020	

		was included in the meeting package and reviewed with the Committee. There will be some restructuring on the Quality framework. There will be a new structure looking at incidents. It will be a much broader Quality and Incident Review Committee. For the next report, the Committee requested that R. Bhatla talk more about why the numbers are down in Telemedicine (Objective #5). It was noted that in Appendix 3, Mood & Anxiety Update, under Vision – Sub Projects, the Gap Analysis and Program Design should not be highlighted in red because it is not at risk of not being completed, it is just yet to be completed.	R. Bhatla R. Bhatla
5.	**NEW BUSINESS**	*R. Bhatla departed the meeting at 9:25 a.m.* *N. Bhargava departed the meeting at 9:30 a.m.* A motion regarding the Chief of Staff's compensation was sent to the Committee members by separate email for consideration. J. Bezzubetz provided a background and discussion and questions followed. It was determined that the background documentation had not been sent with the motion, so in order to make an informed decision, it is to be sent by email to Committee members and the decision deferred to an e-meeting vote. Another piece of information that is to be included is where the Chief of Staff is on his term and the extension made, and to provide a copy of the contract. A. Graham will also touch base with S. McLean for corporate knowledge on this subject. If a further meeting is needed, a teleconference will be set up. *J. Bezzubetz departed the meeting at 9:39 a.m.* *P. Robb departed the meeting at 9:39 a.m.* An in-camera session was held at 9:39 to 9:40 a.m. For future agendas, an in-camera session will be added as a standing item.	J. Bezzubetz P. Robb P. Robb
6.	**ADJOURNMENT**	The next meeting will be on April 9, 2020. There being no further business the meeting was adjourned at 9:40 a.m.	

A. Graham **Chair**	**J. Bezzubetz** **Secretary**

Compensation and Succession Planning Meeting Action Items

Action Item	Individual Responsible	Status
November 29, 2019		
An in-camera session is to be added as a standing item on the Compensation & Succession Planning Committee agenda.	P. Robb	ONGOING
To touch base with S. McLean for corporate knowledge regarding the extension made to the Chief of Staff's term.	A. Graham	
To send email with background documentation regarding COS/PIC compensation request for an e-vote.	J. Bezzubetz	COMPLETED
For the next report, to talk more about why the numbers are down in Telemedicine (Objective #5).	R. Bhatla	April 29, 2020
To revise Appendix 3 to the Medical Succession Plan, Mood & Anxiety Update, under Vision – Sub Projects, the Gap Analysis and Program Design should not be highlighted in red because it is not at risk of not being completed, it is just yet to be completed.	R. Bhatla	
Another item identified was that the difference between a governance reporting relationship and an operational reporting structure should be made more clear and formalized. Clarity is needed between a governance and business relationship as we want to mature both of these. This was seen as an action for the Governance Committee to look at Board structure: structure follows strategy, form follows function. An update will be provided on the 'Org design for the future' at the meeting in April.	J. Bezzubetz	April 29, 2020
An update on the Executive Succession Plan to be provided when giving a report against Objectives to Board of Trustees.	J. Bezzubetz	April 29, 2020 Update June 18, 2020 Finalized

The importance of having an emergency succession plan in place (what happens if…) was stressed. It was noted that this was discussed at last year's Committee meeting and this information is to be provided for the Board's background information at the December 12, 2019 In-camera meeting. In the meantime, it was seen as important that emergency names be captured for the President & CEO and the Chief of Staff/Psychiatrist-in-Chief positions.	J. Bezzubetz	~~December 12, 2019~~ April 29, 2020
To add a benchmark to compare turnover of staff with other hospitals on HR plan.	R. Lashley C. Crocker	November 25, 2020
Various changes to be made to the Terms of Reference and performance appraisal process document.	P. Robb	COMPLETED
June 5, 2019		
To update various metrics	J. Bezzubetz R. Bhatla	COMPLETED To report against Objectives at November 29, 2019 meeting
The Chief of Staff's final approval of language on his 2019-2020 objectives was deferred and will be brought to the Board on June 20, 2019.	P. Robb	COMPLETED June 20, 2019 In-Camera Board meeting
If significant issues arise in the Human Resources Plan, a report will be made to the committee	C. Crocker	
Review strategies that can be used to encourage/support more patients and families to complete the survey	J. Bezzubetz	
Invite Chief of Staff and Psychiatrist in Chief to participate in the discussion of the physician experience results	J. Bezzubetz	
Engage physicians in planning	J. Bezzubetz	

Succession Management COVID-19

Top Layer Executive
April 22, 2020

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ROHCG - Succession Management Overview
Top Executive Layer- COVID-19

Legend:

1st level replacement
2nd level replacement

Display as at April 22, 2020

President & CEO	Chief Operating Officer & CFO	VP, Patient Care Services & Community Mental Health	VP, Patient Care Services, Professional Practice & CNE	Psychiatrist in Chief/Chief of Staff
Joanne Bezzubetz	**Cal Crocker**	**Susan Farrell**	**Esther Millar**	**Raj Bhatla**
Psychiatrist in Chief/Chief of Staff **Raj Bhatla**	Director, Finance **Kim Kealey**	Director, Patient Care Services **Carol-Anne Cumming**	Director, Allied Health Professional Practice **Emily Deacon (VP function)**	Psychiatrist, Associate Chief **Paul Sedge**
COO & CFO **Cal Crocker**	Director, Human Resources & Labour Relations **Rosanna Lashely (COO function)**	Director, Patient Care Services **Pam Jackson**	Director, Nursing Practice **Billie Pryer (CNE function)**	Psychiatrist, Associate Chief **Sanjiv Gulati**
	General Counsel, FOI Coordinator **Jacquie Dagher (COO function)**		Director, Patient Care Services **Joan Garrow**	Clinical Director's **Incumbent dependent on availability, unit status, skill set, and may be divided amongst Clinical Director's**
	Manager, Budgeting and Reporting **Craig St. Germain (CFO function)**			

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ROHCG - Succession Management Overview
IMS - Incident Management System

Legend:

1st level replacement
2nd level replacement

Display as at April 22, 2020

Crisis Leader
Joanne Bezzubetz
Psychiatrist in Chief/Chief of Staff **Raj Bhatla**

Finance/Admin Section Coordinator	Operations Section Coordinator	Emergency Command Manager
Cal Crocker	**Susan Farrell**	**Esther Millar**
Director, Finance **Kim Kealey**	Director, Patient Care Services **Carol-Anne Cumming**	COO & CFO **Cal Crocker**
Manager, Budgeting and Reporting **Craig St. Germain**	Director, Patient Care Services **Karen Daley**	VP, Patient Care Services & Comm. Mental Health **Susan Farrell**
	Psychiatrist, Associate Chief **Paul Sedge**	

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COVID-19 OHS Report

Occupational Health and Safety Team

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OHS COVID-19 Results

(as of April 21, 2020)

Total STAFF tested POSITIVE for COVID-19:

- -Ottawa - 2
- -Brockville - 0

Note:

- Tested positive within the community, not at the Royal
- One EllisDon employee tested positive within the community – bringing the total in the facility to three

Total STAFF off work for 14 days or more because of testing POSITIVE for COVID-19:

- Ottawa - 2
- Brockville – 0

Total STAFF off work for 14 days that SELF ISOLATED due to travel:

- Ottawa - 34
- Brockville – 19

Total STAFF that tested NEGATIVE for COVID-19:

- Ottawa - 95
- Brockville – 30

Total PATIENTS tested POSITIVE for COVID-19:

- Ottawa - 0
- Brockville - 0

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JHSC Recommendations

1. Total number of Covid-19 related JHSC recommendations submitted: 7

2. All recommendations have been responded to as per Section 9(20) of the OHS Act

3. Recommendations are centered on:
    - Staff leave/Childcare/Sick leave
    - Working from home accommodation
    - Initial and final workers inspection for new projects
    - Risk assessment
    - PPE Training / Mask Fit-Testing
    - New admission Protocol
    - Protocol for patients going between institutions

4. Ongoing Discussions:
    - Use of expired N95 masks being used as procedure masks
    - PPE (Personal Protective Equipment) Supply and Usage
    - Staff concerns/fears of the unknown and the constant changes in Ministry of Health directives
    - Redeployment and training of staff for new area of work

Ministry of Labour Complaints/Teleconference

Ministry of Labour Complaints	Ottawa	Brockville
	2	1

Location and Date	Complaint Synopsis	Finding Synopsis
Ottawa - Complaint 1 **March 19, 2020**	Concerns regarding JHSC involvement with pandemic planning and PPE	No Orders
Ottawa - Complaint 2	PPE/Risk Assessment Communication	No Orders
Brockville - Complaint 1 **April 6, 2020**	Concerns regarding risk assessments, information sharing, level of involvement in measures and procedures pertaining to COVID-19	Dismissed by MOL No Orders Issued

New Tools/Protocols developed by OHS during COVID-19

General Topic		Handout
Ergonomics	Working from Home	Guidelines and Handouts/A Guide to Working from Home ROHCG Mar 2020.pdf
Wellness	Peer Support Team	Guidelines and Handouts/Peer-Support_poster_final_rev.pdf
Process	What happens when a staff member or physician is diagnosed with COVID-19	Guidelines and Handouts\What happens when a staff member or physician is diagnosed with COVID-19.pdf
Managers	1. Dose of Health and Safety – Important Information for Managers during COVID-19 2. Universal Masking Decision Tree	Dose of Health and Safety - COVID-19.pdf Guidelines and Handouts\Universal Masking Decision Tree for Management April 2020.pdf
Health Management	Vulnerable Healthcare Worker Identification Form and Guidelines	Vulnerable HCP Identification/Vulnerable Healthcare Provider (HCP) Identification Form (v3).pdf
Risk Assessments	Developed new tool to address Covid -19 requirements	Seven (7) Risk assessments completed for newly-created units and PPE
Code White Protected Protocol	New Tool developed as an addendum to control potential cross contamination of in-patient units	Developed in conjunction with
Joint JOHSC	Representatives from 5 JHSC's meeting as one group – 3 days per week (Mon-Wed-Fri)	Allow ease of communication and follow upon JHSC activities

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Mask Fit Testing Updates

Focus for Mask Fit Testing has been our main priority for Staff, particularly those who are providing direct patient care on inpatient units

<u>Education during mask fit testing includes:</u>

- How to put on and remove an N95 mask correctly
- How to perform a mask seal check
- Education on wearing and removing full PPE – gloves, gowns, eyewear and procedural/surgical masks

N95 Mask Fit Testing Statistics for Priority 1 Staff

Tests completed since March 1, 2020:

- All Sites – All Priority Levels = 225 tests completed

Priority 1 Staff – within 2 year legislated requirement = 409/555 = 74%

Please note: This is a fluid target, numbers fluctuate daily based on due dates and fit testing completed

Human Resources COVID-19 Activities

- Deployment Centre created to reassign staff from units that suspended services to new or repurposed units/programs
- Canvassed all staff to self-identify if they were multi-employer Health Care Workers in High Risk areas and worked with hospital partners to avoid risks to our clients
- Track recruitment process to hire new staff to support on-going recruitment and new staffing needs as a result of COVID-19
- Supported staff who had child care/elder care obligations by allowing the borrowing of vacation from 2021 vacation banks or fast tracking leave approvals
- Paid staff for all pre-scheduled shifts during self-isolate period without drawing from vacation or sick leave banks
- Increased Peer Support Team members to support staff during COVID-19 pandemic
- Complimentary parking provided for all staff for the months of April and May
- Canvassed Royal staff to volunteer to work at LTC facilities in our region to alleviate unprecedented staff shortages

ROHCG

Designing the Organization of the Future

An Adaptive Model

An advance video presentation to the Compensation and Succession Management Committee of the Board

April 29th, 2020

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Welcome

Your Presenters

Joanne Bezzubetz
President and CEO,
Royal Ottawa HealthCare Group

Mary Daly
Organizational Strategist
Throughline Solutions Inc.

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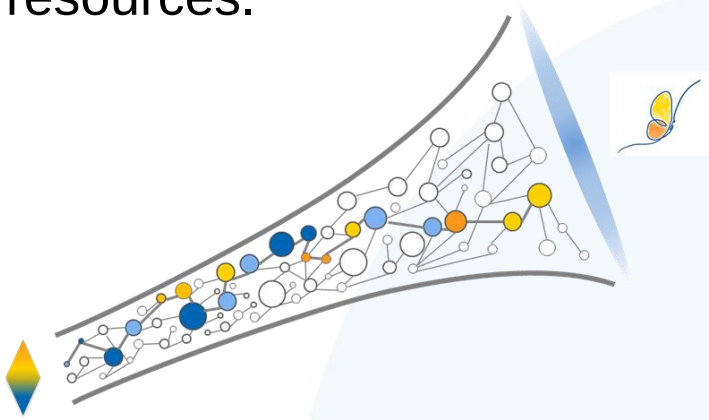
What is it?

A thinking path

… that enables us to bring our vision of the future into the present, so we can make the best decisions about how we organize and allocate our resources.



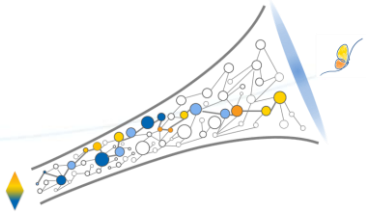
Adaptive Framework

Introduction

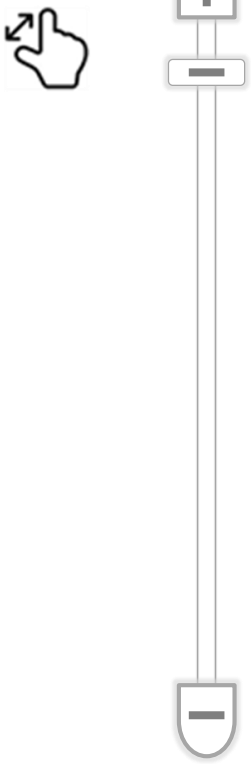
An adaptive, future-focused framework for designing our organization,

that allows us to imagine a **bold destination,**

and a means for **advancing now** towards that future
with **practical and productive** organization design efforts

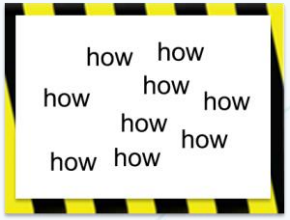


High level



Overview of Key features

Details



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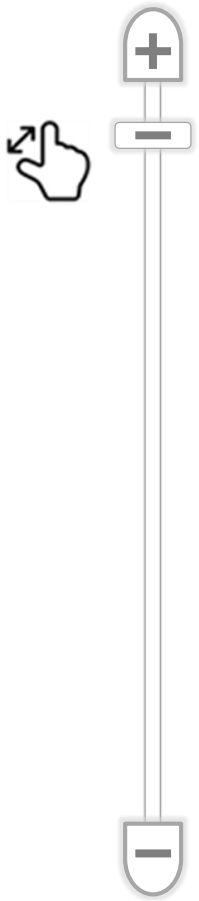
Adaptive Framework

Introduction



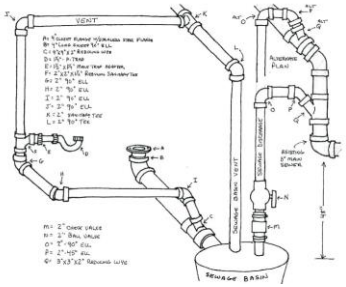
High Level

Architectural blueprint

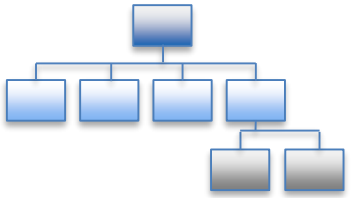
Organization of the Future

Details

Plumbing Diagram



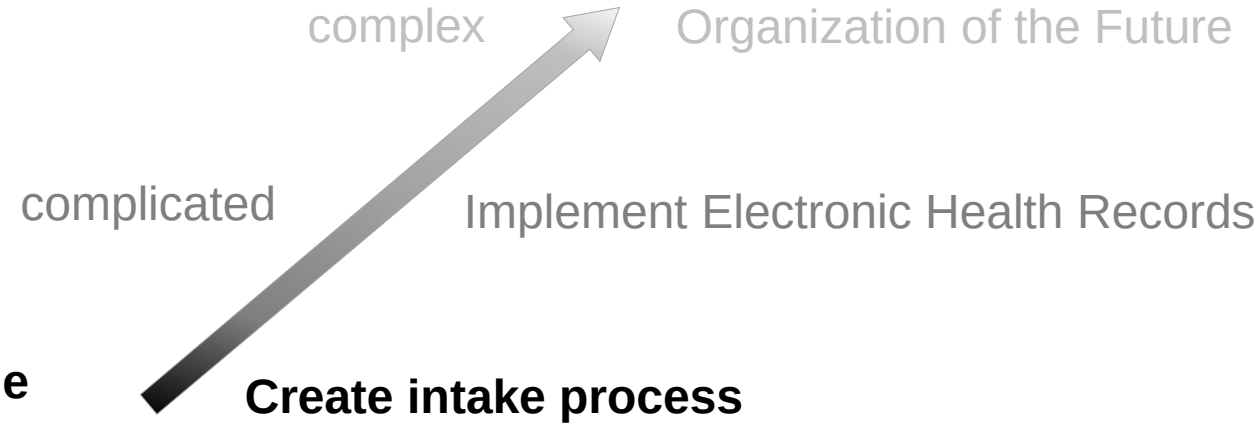
Sticks & boxes



Adaptive Framework

Introduction

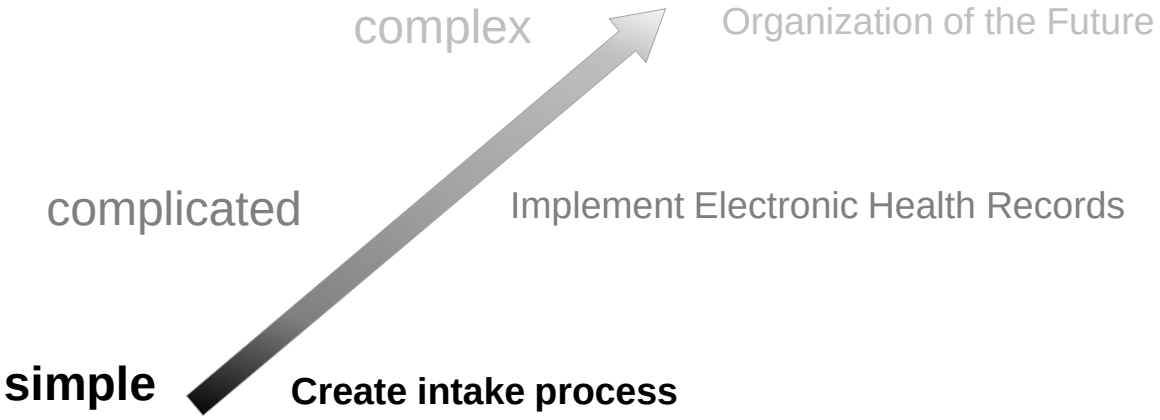
Long-term visioning is necessarily broad and complex.



Adaptive Framework

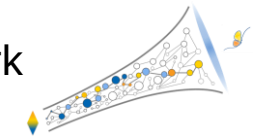
Introduction

Long-term visioning is necessarily broad and complex.



Planning Concepts

Adaptive Framework



Roadmap

Checklist

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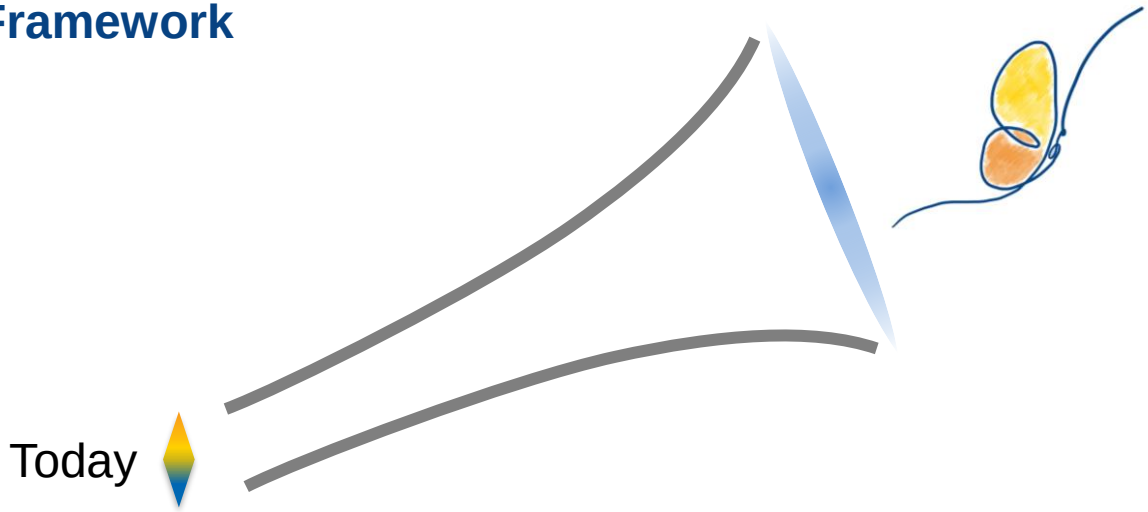
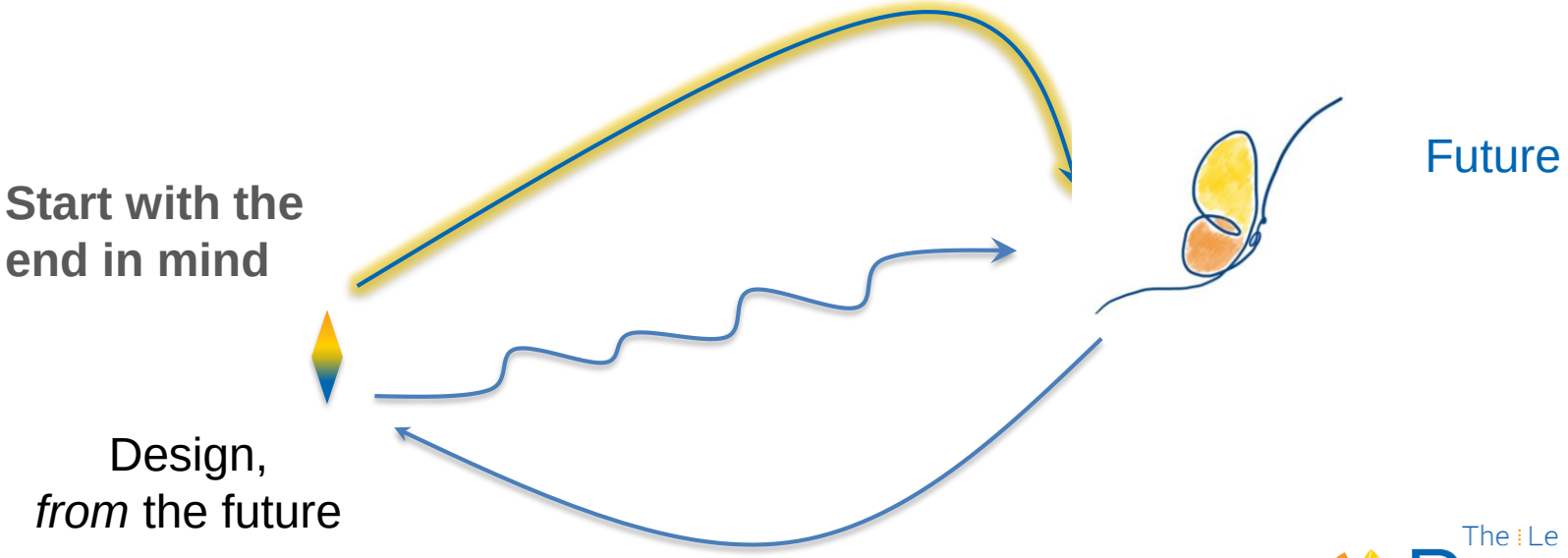
Adaptive Framework





From concept to
creation

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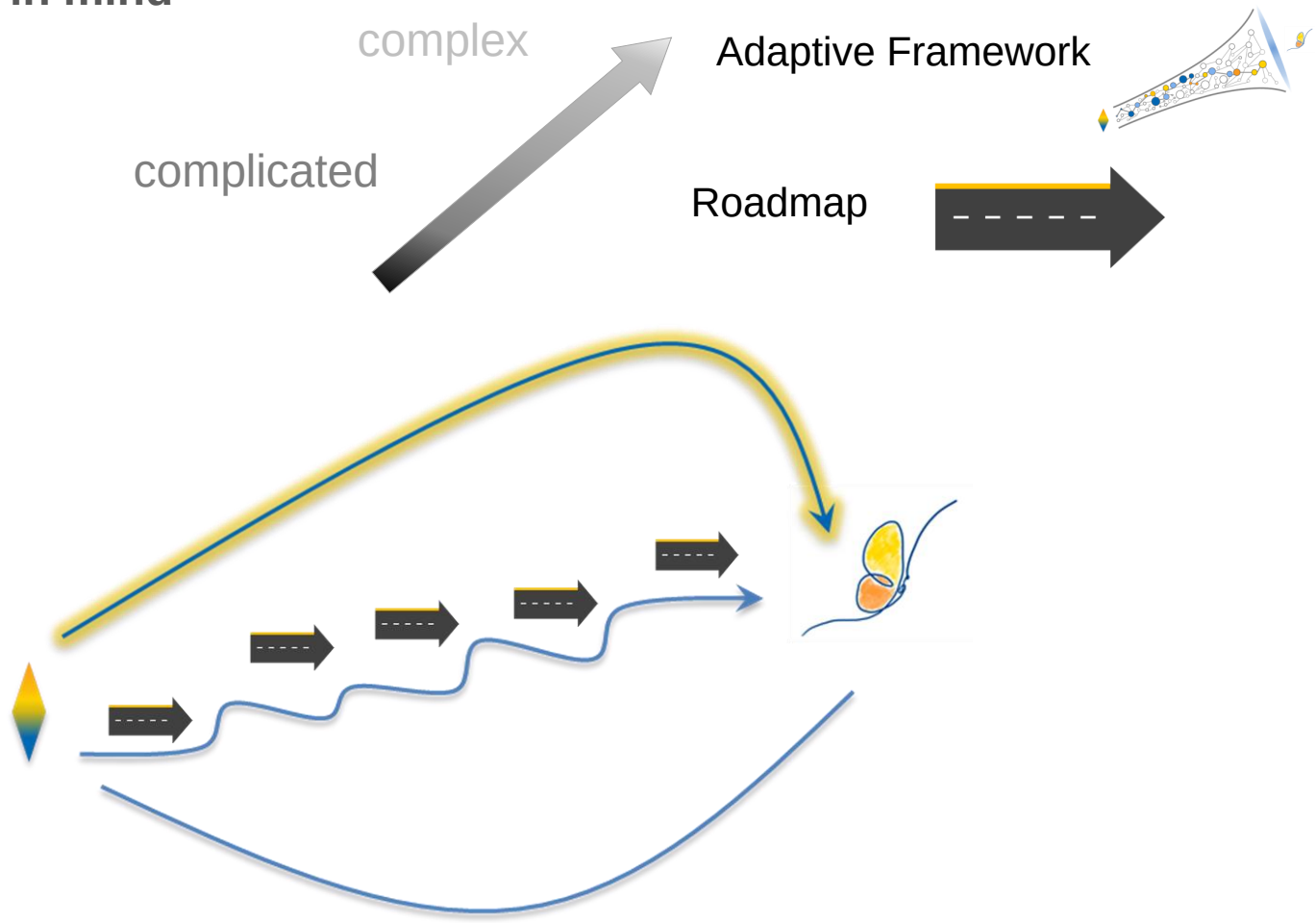
Adaptive Framework

Start with the end in mind

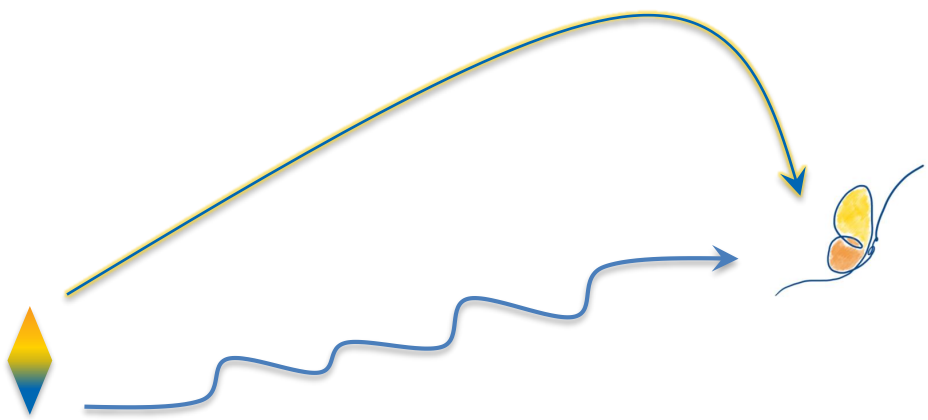


- Create an actionable view of our future
- What do we improve, change and create?
- What do we need to stop doing?

Adaptive Framework

Fit with Strategic Planning

Distinct, but not separate



1 **Strategic Plan**

POTENTIAL GROUP

2 **Strategic capabilities**

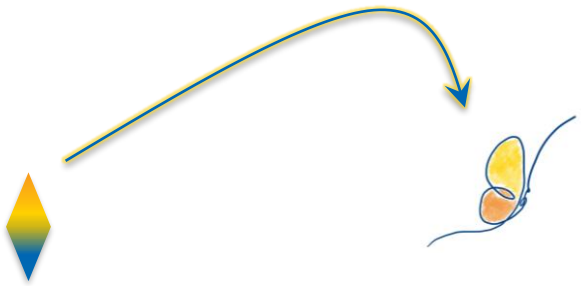
(Organizational)

3 Make resource decisions in a planful and deliberate way

Adaptive Framework

Fit with Strategic Planning

Distinct, but not separate



If this:

POTENTIAL GROUP

Representative concepts:

- ***Hospital without Walls***
- *Digital care*
- *Evidence-based care*
- *Learning & adapting based on evidence*
- *Research aligned & inspired care*
- *Client and family centred care*
- *Capacity building*
- *Population segmentation*

Then:

What does our role in the future mean for the work we will do?

Strategic capabilities

1 | | | |

1 **Partnerships & Alliances**

- Build & cultivate a network of relationships
  - Developing partnerships with the private sector
  - Explore digital collaborations
  - Develop $commercial partnerships

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Adaptive Framework

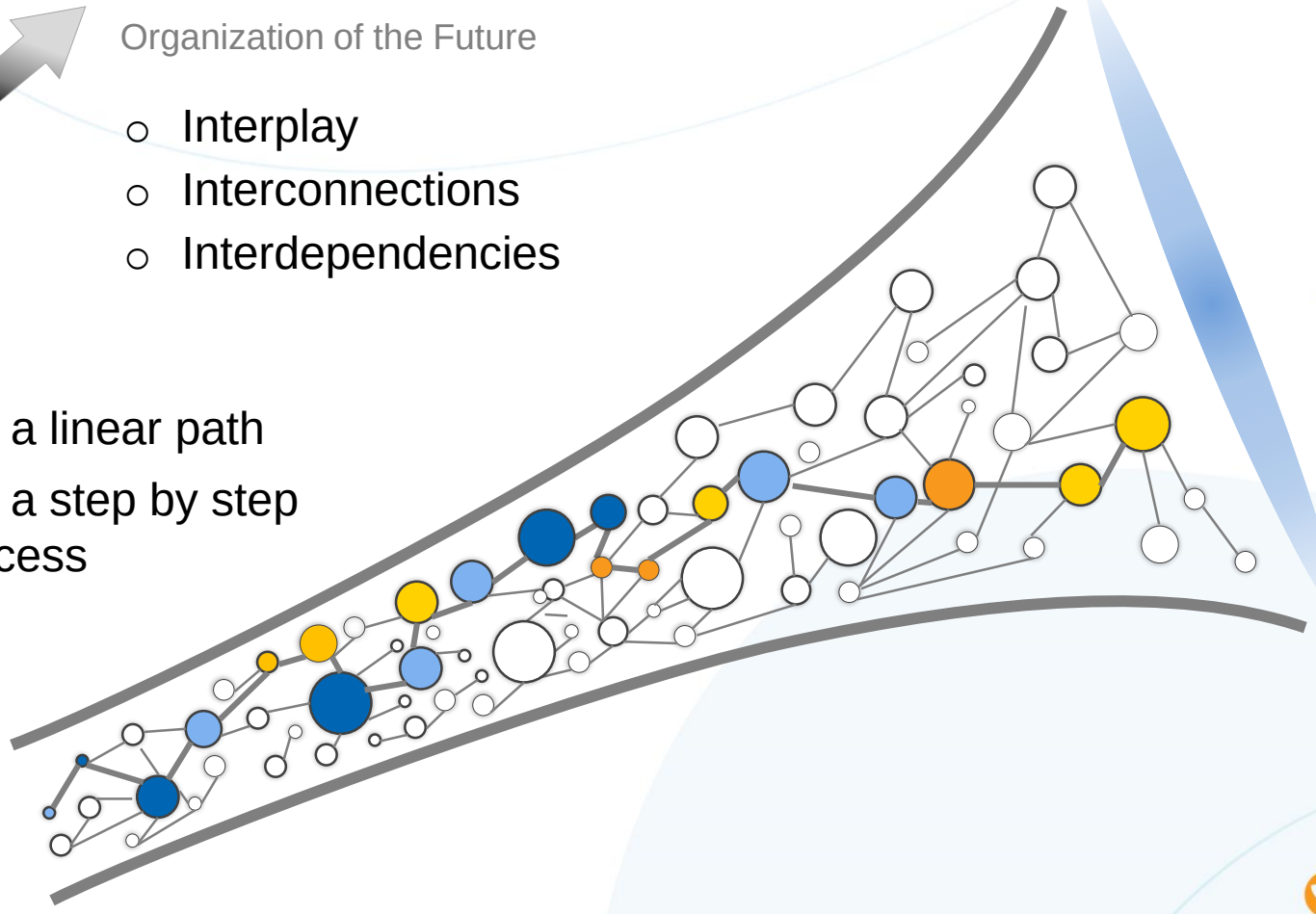
Start Building

Liberating bold thinking

complexity

Organization of the Future

- Interplay
- Interconnections
- Interdependencies



- Not a linear path
- Not a step by step process

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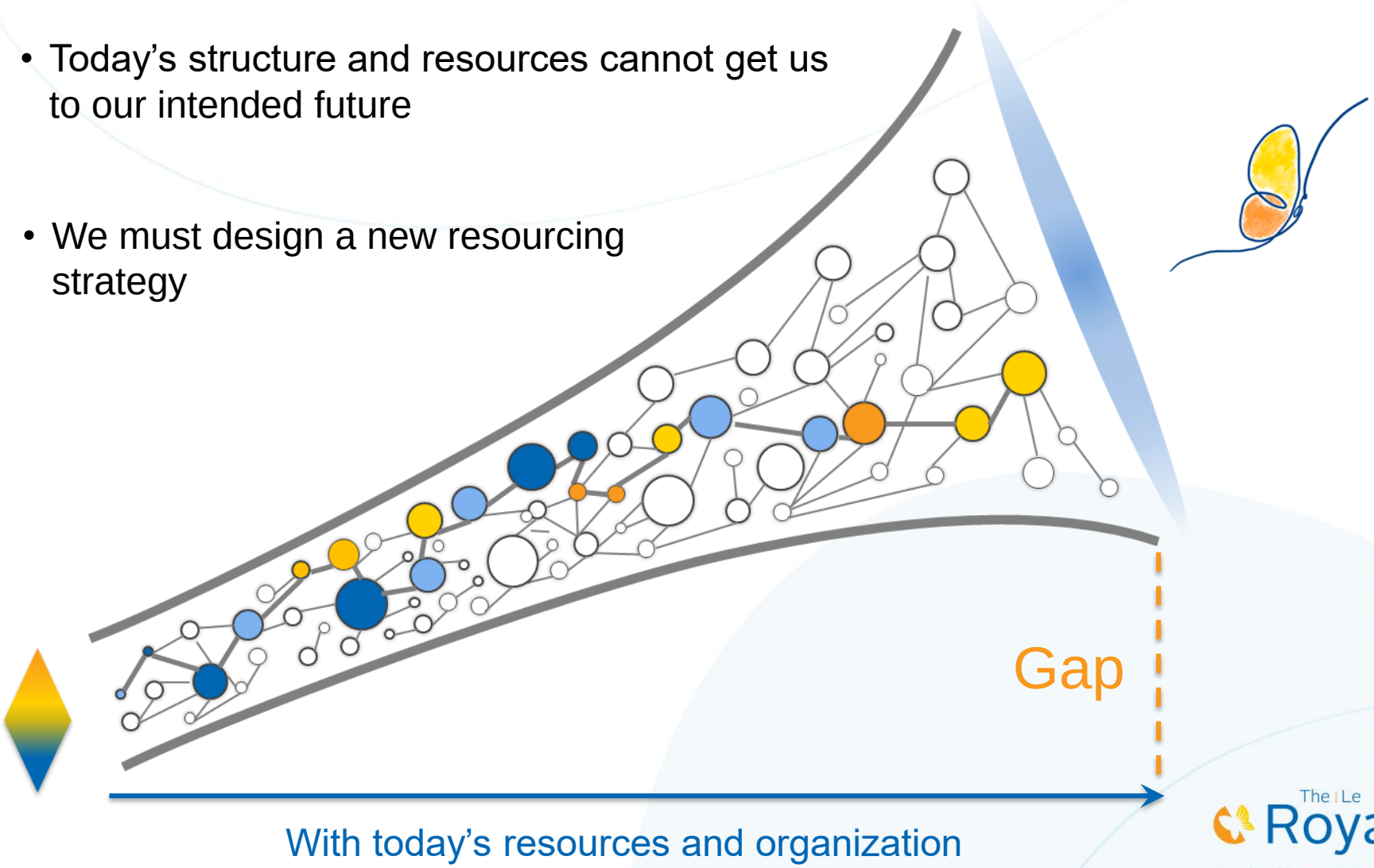
Adaptive Framework

Fit with Strategic Planning

- Today's structure and resources cannot get us to our intended future
- We must design a new resourcing strategy



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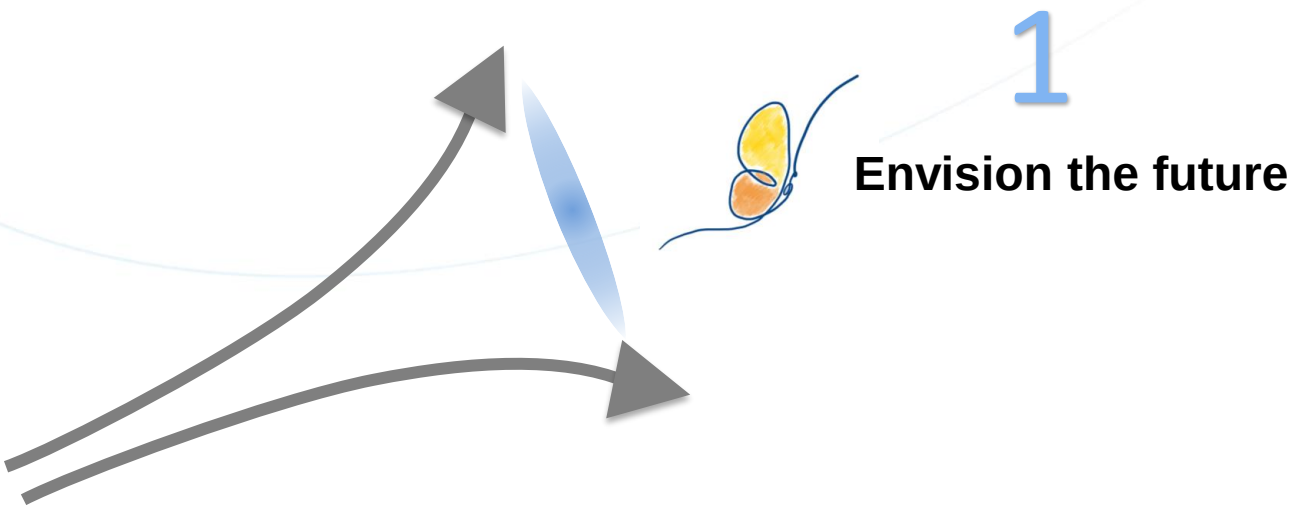
Adaptive Framework

Fit with Strategic Planning

Liberating bold thinking



- Our strategic planning work is about thinking openly and creatively about how we will serve best
- That creative thinking is divergent thinking – open to promising possibilities
- We can more easily adopt that wide open thinking when we are not constrained by how we are resourced today

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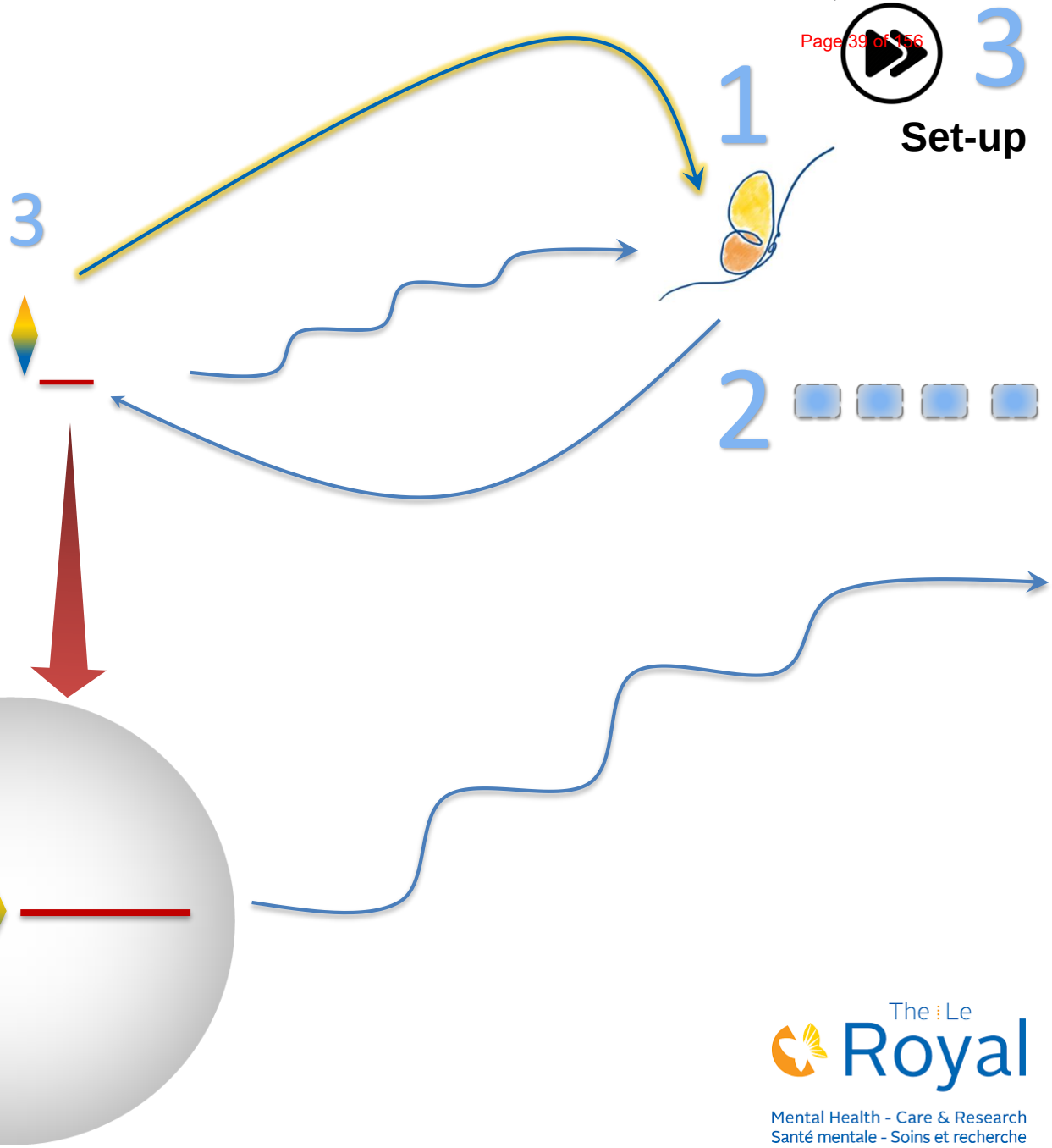
Adaptive Framework

Start Building



- Strategy has to do with *getting* to the future.
- The way we get to the future is by doing something now.

- What do we improve, change and create?
- What do we need to stop doing?

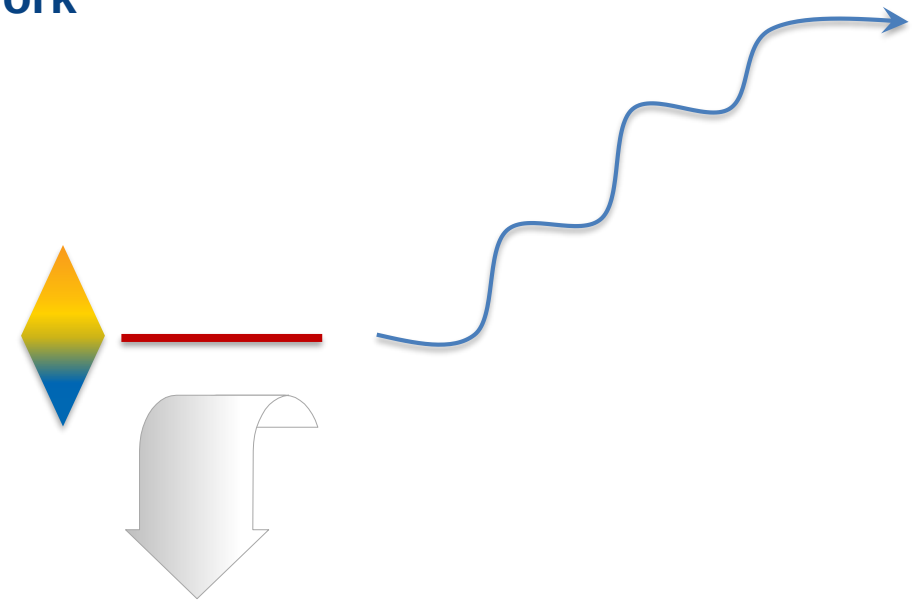
Adaptive Framework

Start Building

3

Set-up

- What do we improve, change and create?
- What do we need to stop doing?



Org design thinking path

What is	What matters	What if	What works	What now

Pause and learn

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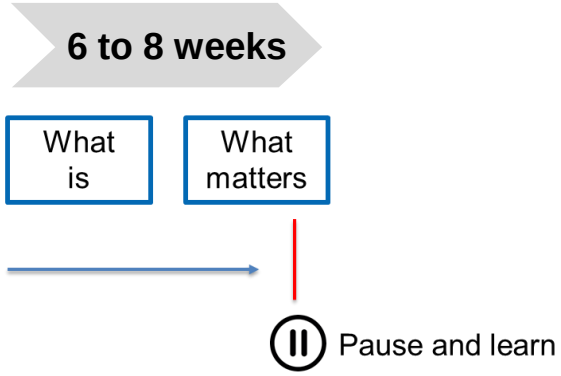
Adaptive Framework

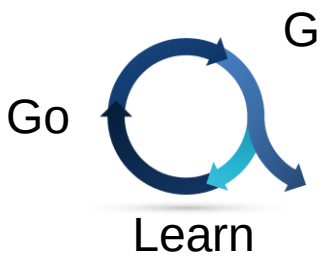
Start Building

3

Illustration

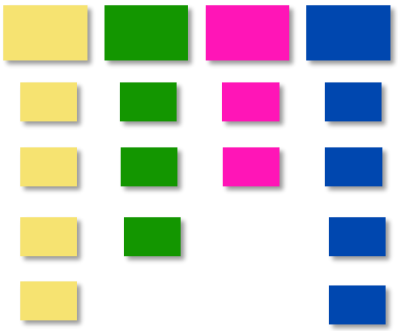
Illustration only





- You only can / need to go SO deep
- A *sufficient* level to learn what we need to and make proportionate decisions

Start with one organizational unit



Functions

Sub-Functions

- ‘Touchable chunks’ of work
- Maybe teams, maybe smaller pieces
- Discernibly different work, different ‘what’

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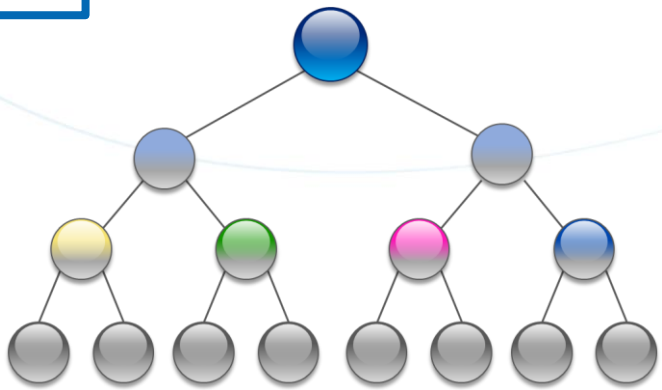
Adaptive Framework

Start Building – Approach

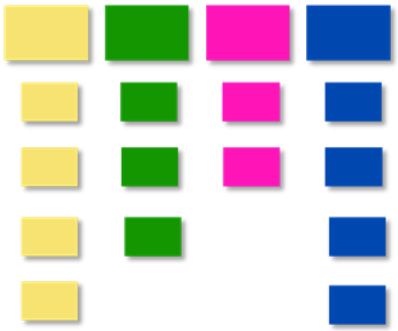
3

Illustration

What is



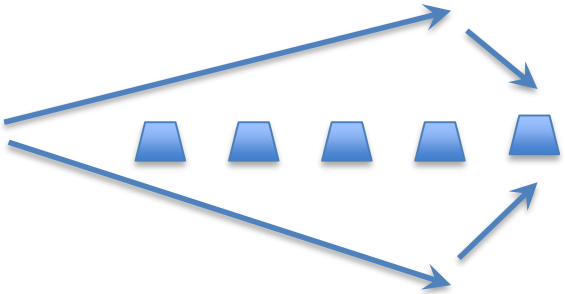
Start with one organizational unit



Functions

Sub-Functions

- Through structured processes, and the involvement of leaders and teams
- Data, discussion, debate



Hands-on workshops

- Build on the competence and cumulative learning of the teams
- Build capability

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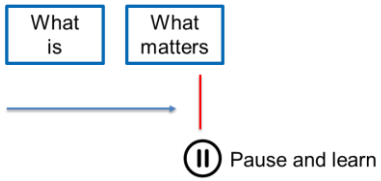
Adaptive Framework

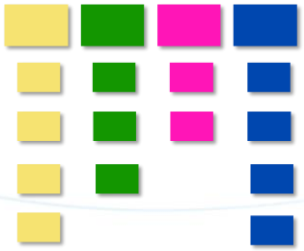
Start Building – Approach

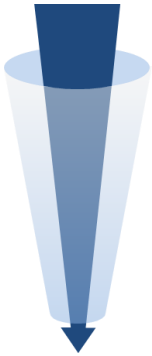


3

Illustration

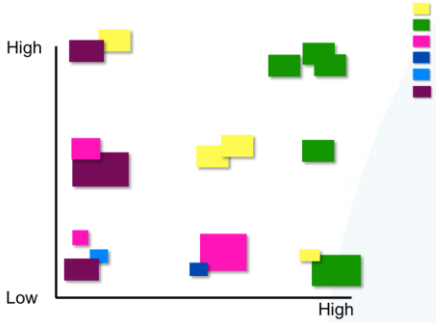
What is





“Sizing” and Sense-Making

Understand / diagnose each function from a variety of perspectives



- Time / resource heat map
- Core – core support, support
- Relative maturity
- Impact of technology

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Adaptive Framework

Start Building – Approach

3

Illustration

If this:

Then:

What is

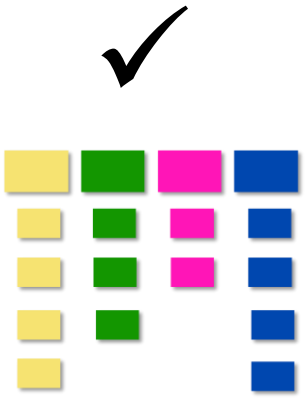
What matters

Strategic capabilities

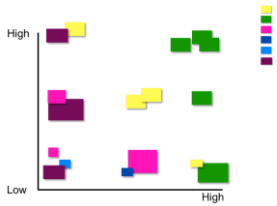
❑ **What does the future require?**

What's missing?

Current State



❑ **How is it going today?**



- ✓ To what extent does it serve us well now?
- ✓ What are the gaps we already know about?
- ✓ What might we stop doing?

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Adaptive Framework

Start Building – Approach

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Mission, Vision

Future Direction

Goals & Objectives

The WORK to be done

Strategic capabilities

Functions

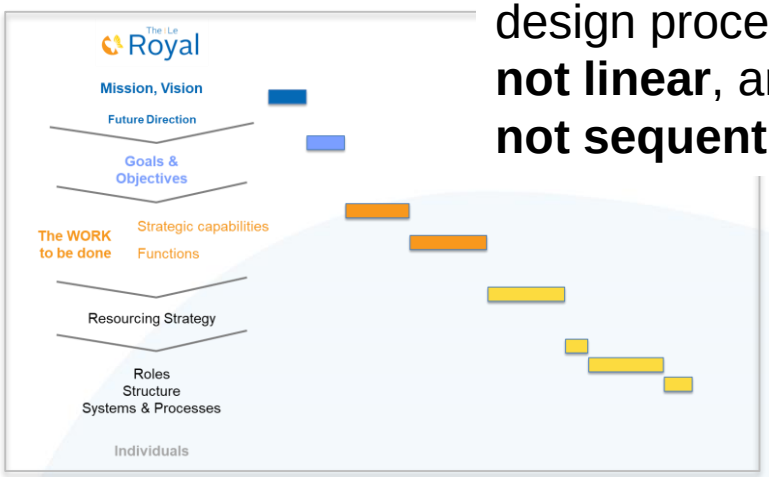
Resourcing Strategy

Roles
Structure
Systems & Processes

Individuals

The guiding logic starts from the top, and the future.

But the organization design process is **not linear**, and **not sequential.**



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Adaptive Framework

Start Building – Approach

Go again

Go

Learn

Mission, Vision

Future Direction

Goals & Objectives

The WORK to be done

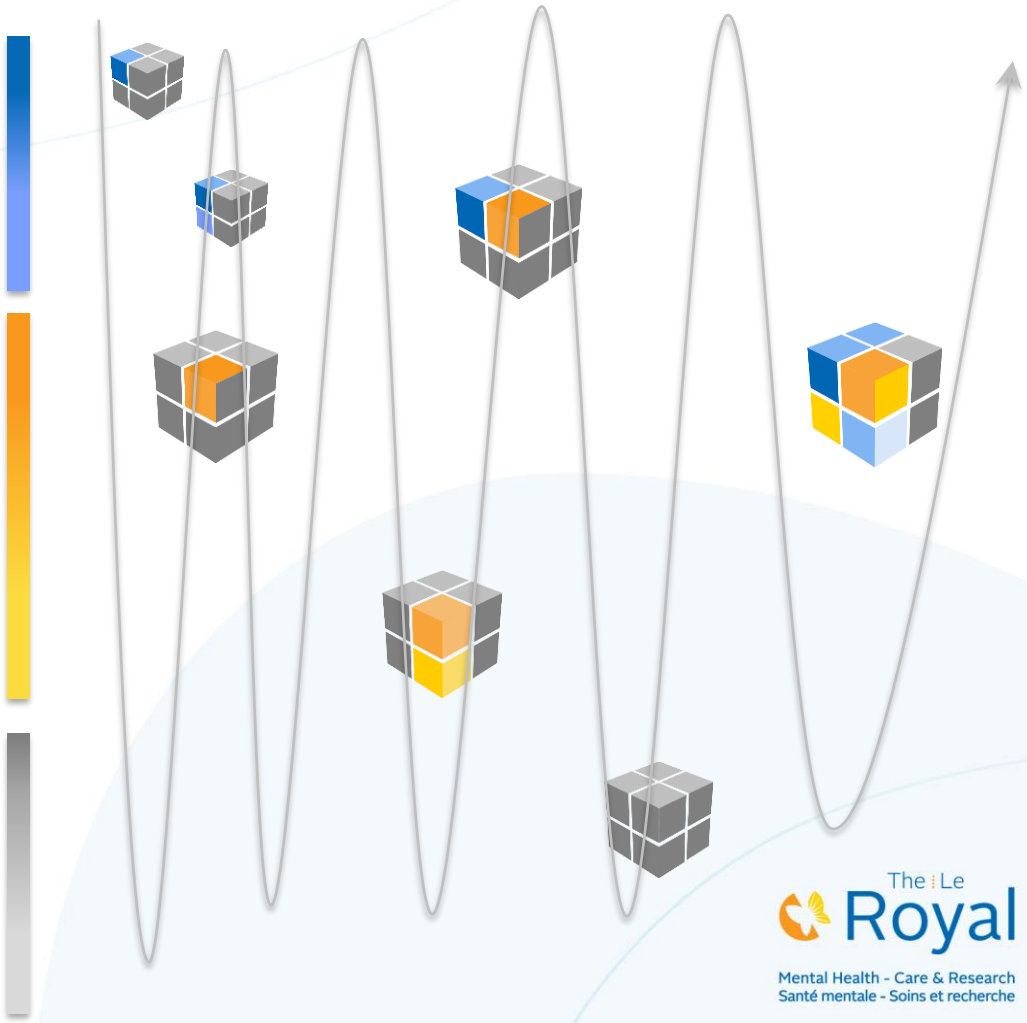
Strategic capabilities

Functions

Resourcing Strategy

Roles
Structure
Systems & Processes

Individuals



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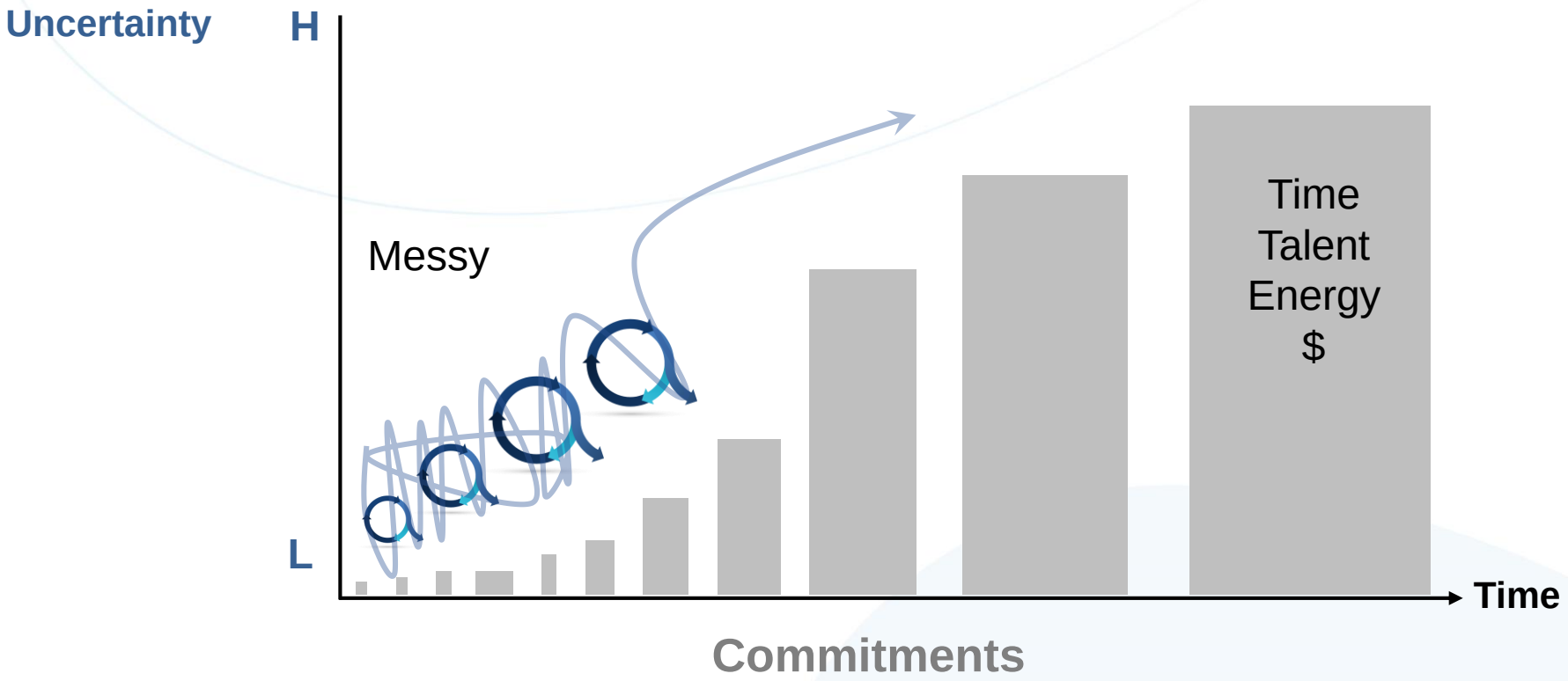
Adaptive Framework

Start Building - Principles



- Continuous learning loops
- Find & solve the right problems
- Engage everybody in continuous improvement
- Learn by doing


bloopers!

Thank you

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Confidential

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

Schedule A

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.

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

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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

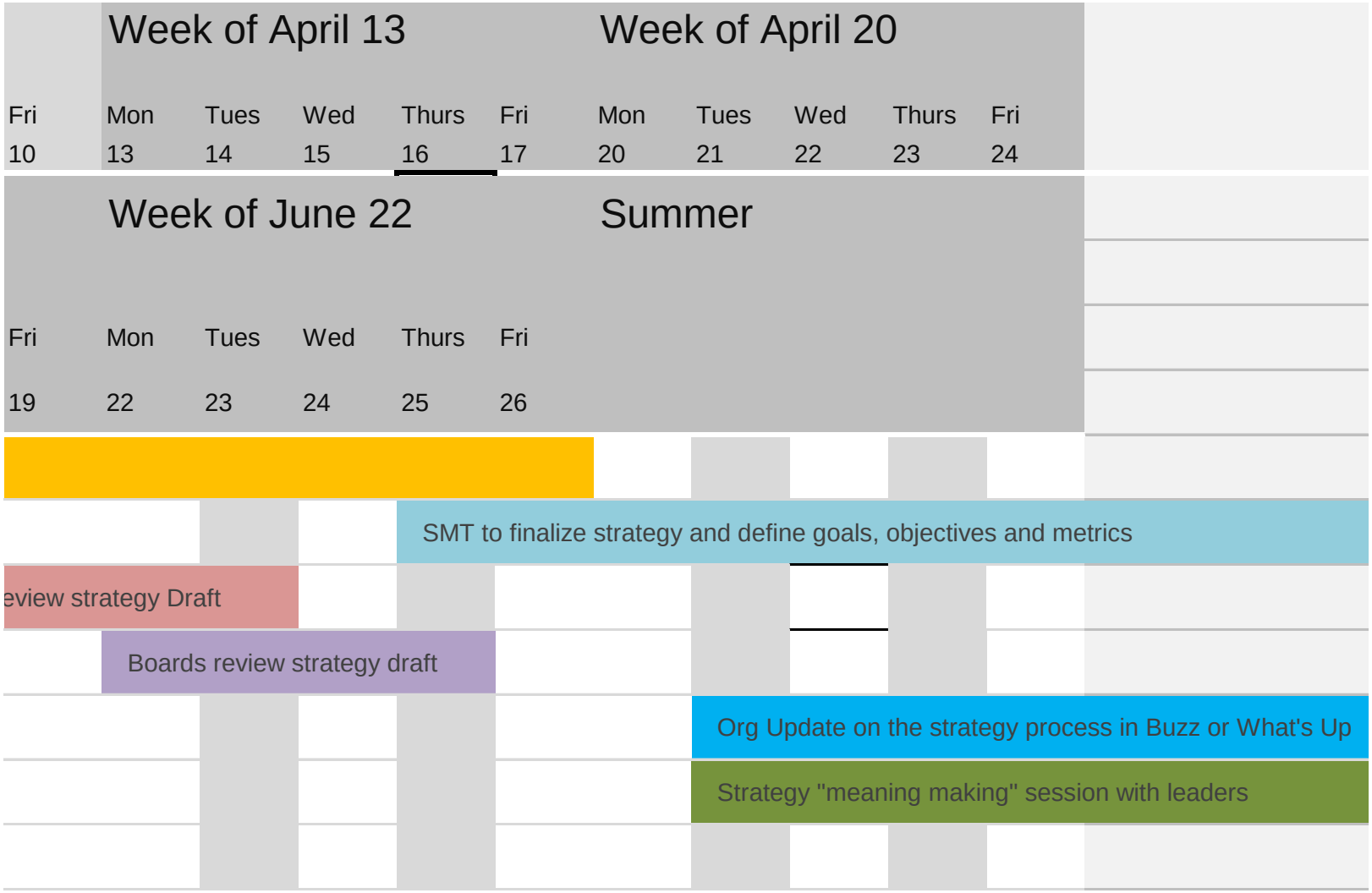
On target or better

Within 1% of the target

Greater than 1% away from the target

	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

APPENDIX C

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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

	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

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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.

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.

360 Evaluation
Suggested Areas of Improvement

APPENDIX E

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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

Schedule A

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

Proposed % BONUS	PERFORMANCE OBJECTIVE	TARGET/OUTCOME	STATUS REPORT JUNE 2021
20%	1. Quality Improvement Plan (as per legislation)	Meet QIP targets as adapted to Ontario Health QIP Implementation plans	
20%	2. Strategic Planning Completion	Operational plans developed for all three entities Monitoring indicators approved Organizational redesign plan	
20%	3. ROHCG/IMHR/ Foundation Integration	IMHR external review recommendations implemented Workplan developed for improved integration across three organizations (e.g. branding, corporate alignment, marketing, etc.) Development of plans for Health Hubs (IMHR and ROHCG)	
20%	4. Organizational Sustainability and Resource Allocation	Implementation of the Hospital Without Walls Branding and launch of the Brain Imaging Centre Recovery Plan developed for post-COVID environment Resume Long Term Care options post-COVID (ROP) Joint initiatives with Ontario Shores, Waypoint and CAMH Further investment in client and family centered care	
20%	5. Refocus Organizational Culture	New succession plan for organization (includes all entities) Professional development plans for leadership potential Enhanced plan for client and family centered care.	

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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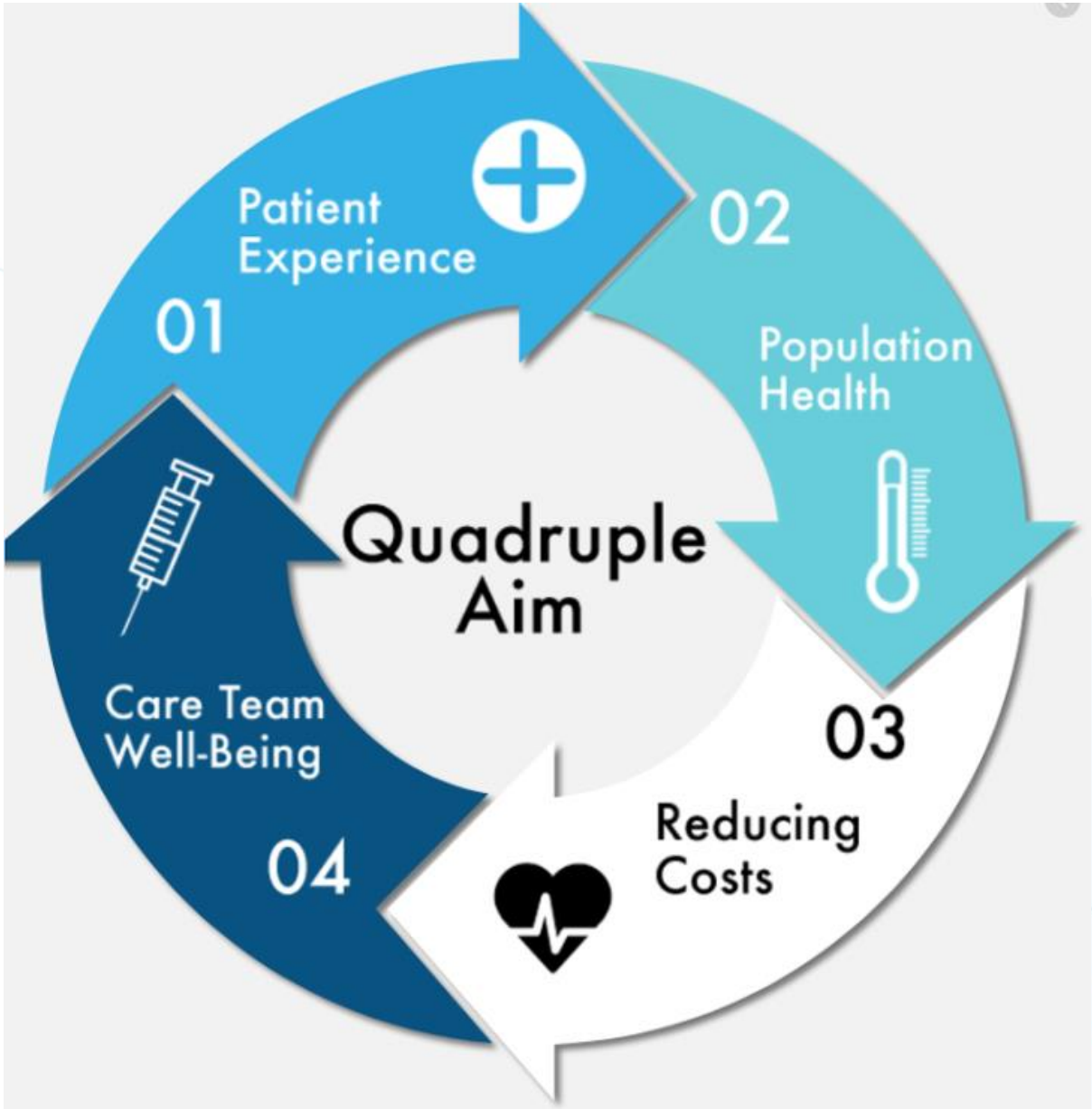
Quality Framework

- 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.

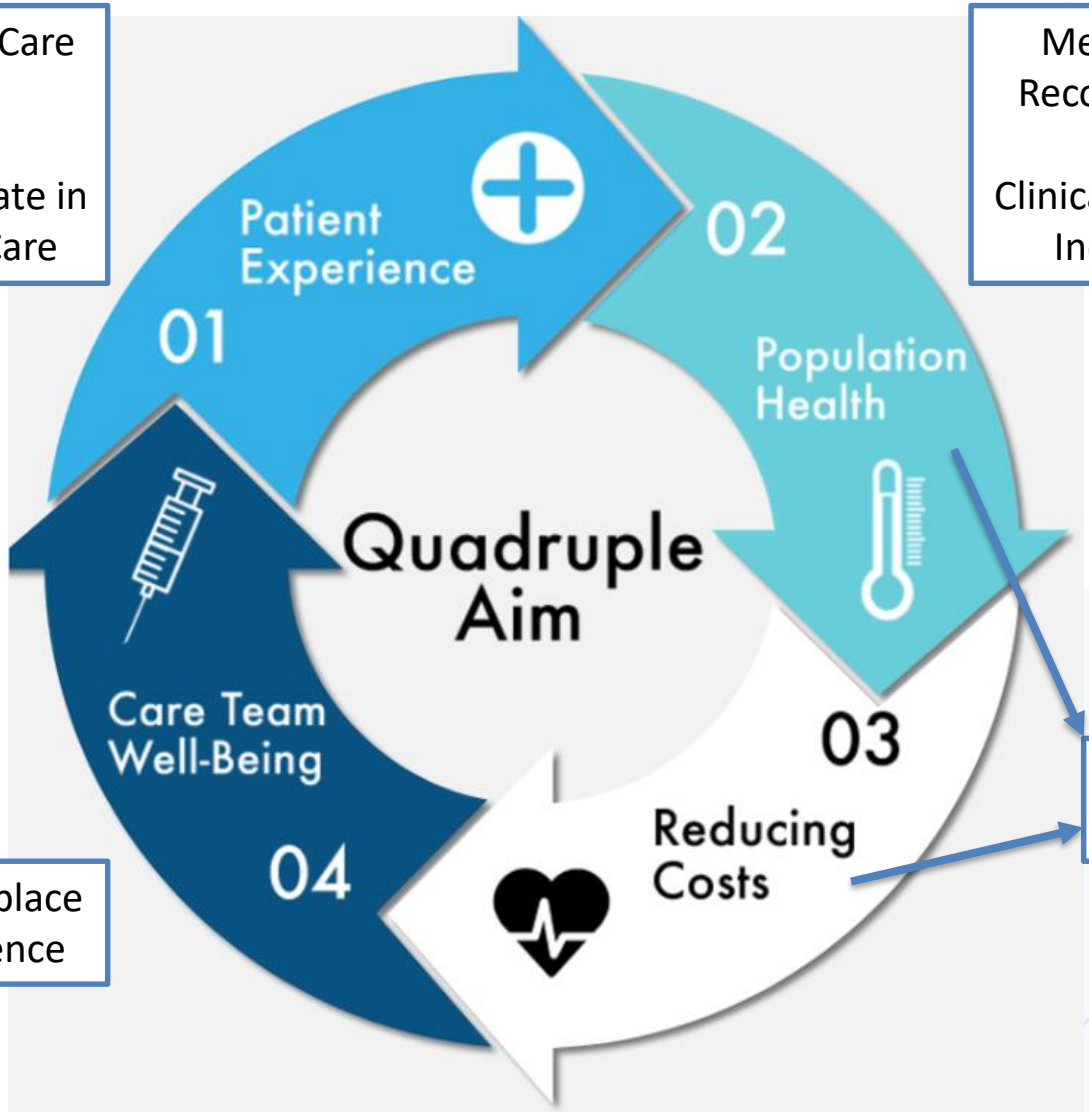
The Quadruple Aim Framework



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

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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

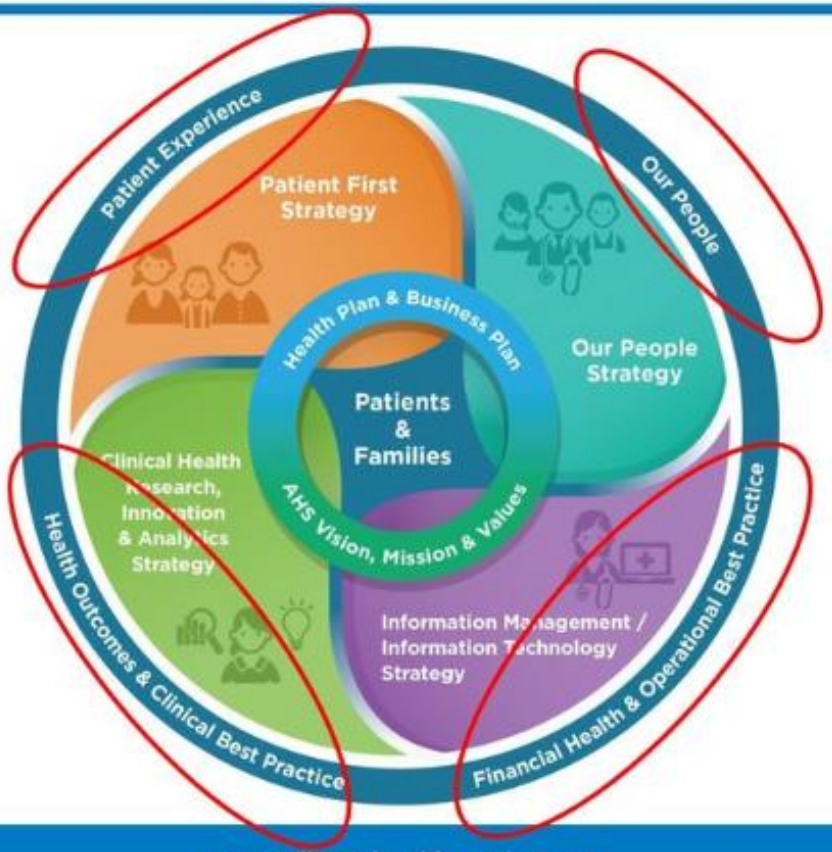
Domain Title Examples from Other Orgs.

	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	

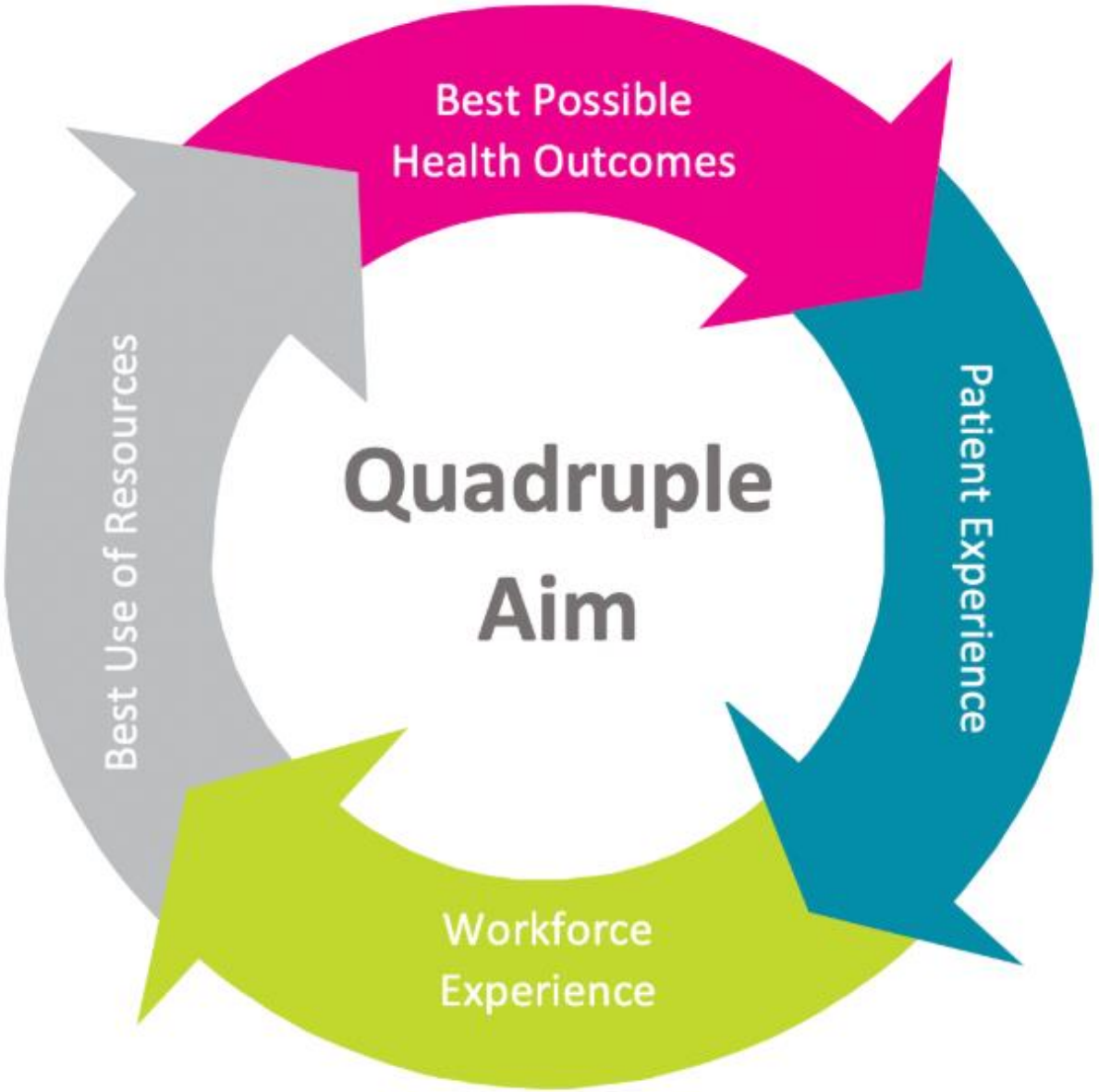
Alberta Health Services' Quality Framework

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

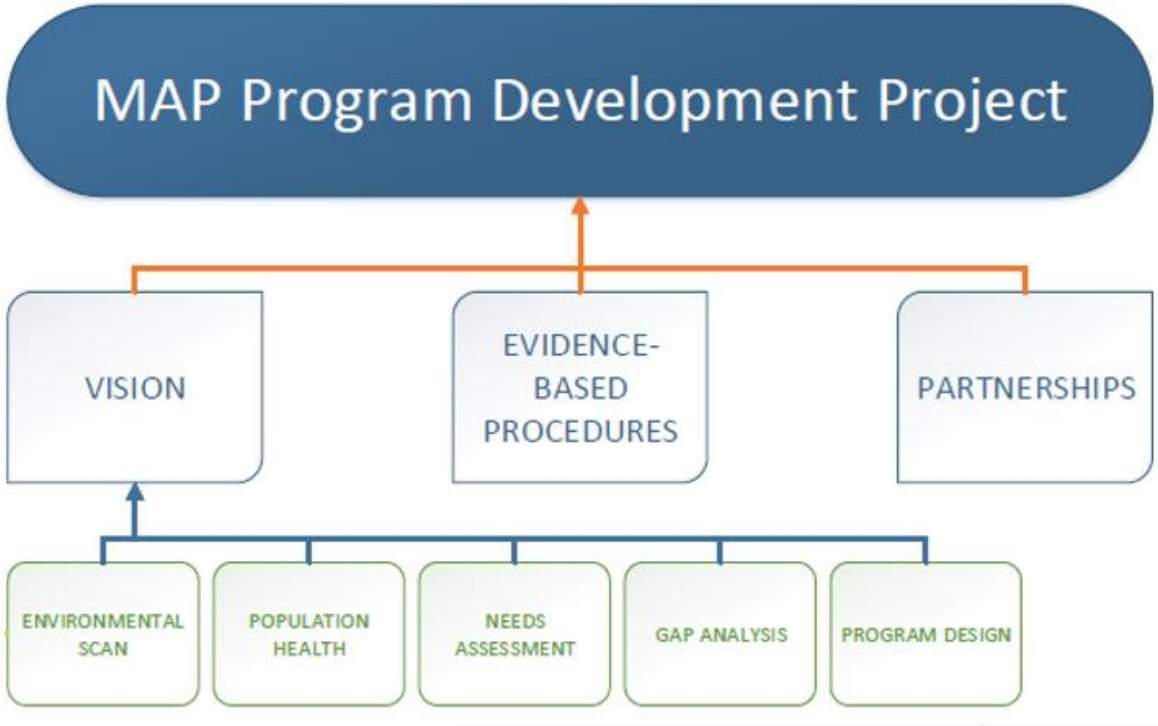
- As part of the MAP development project we want to gather feedback and comments from those that work on the front-line of the program every day.

- 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

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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

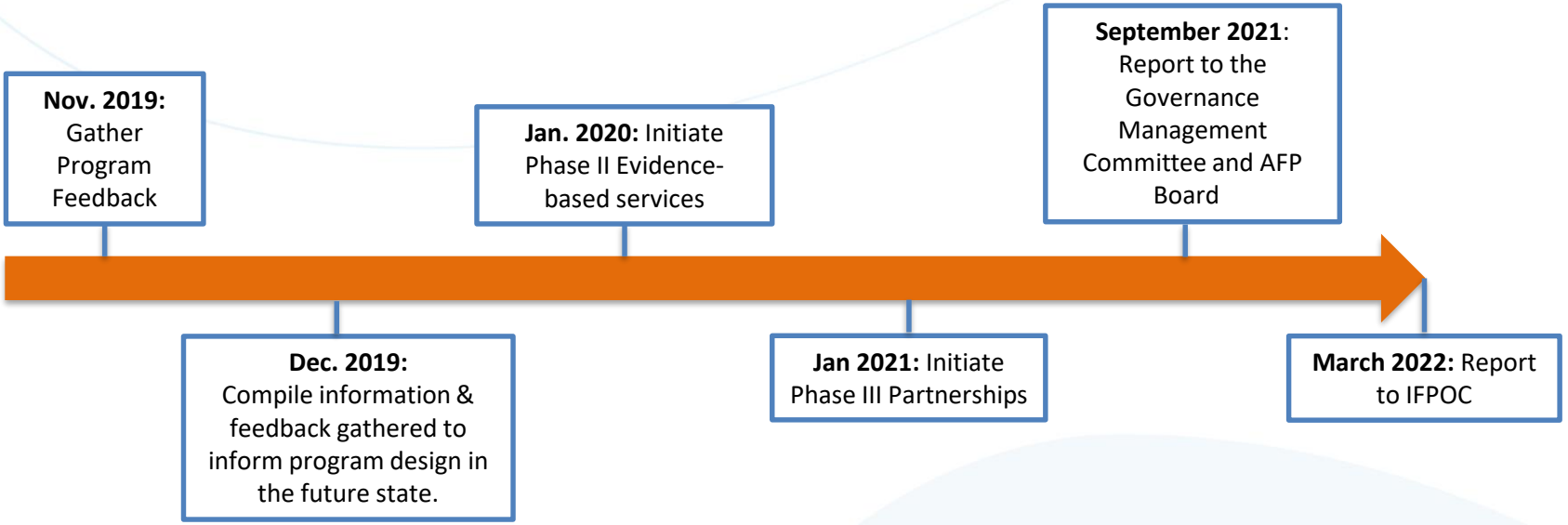
Patient Input

- 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).

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).

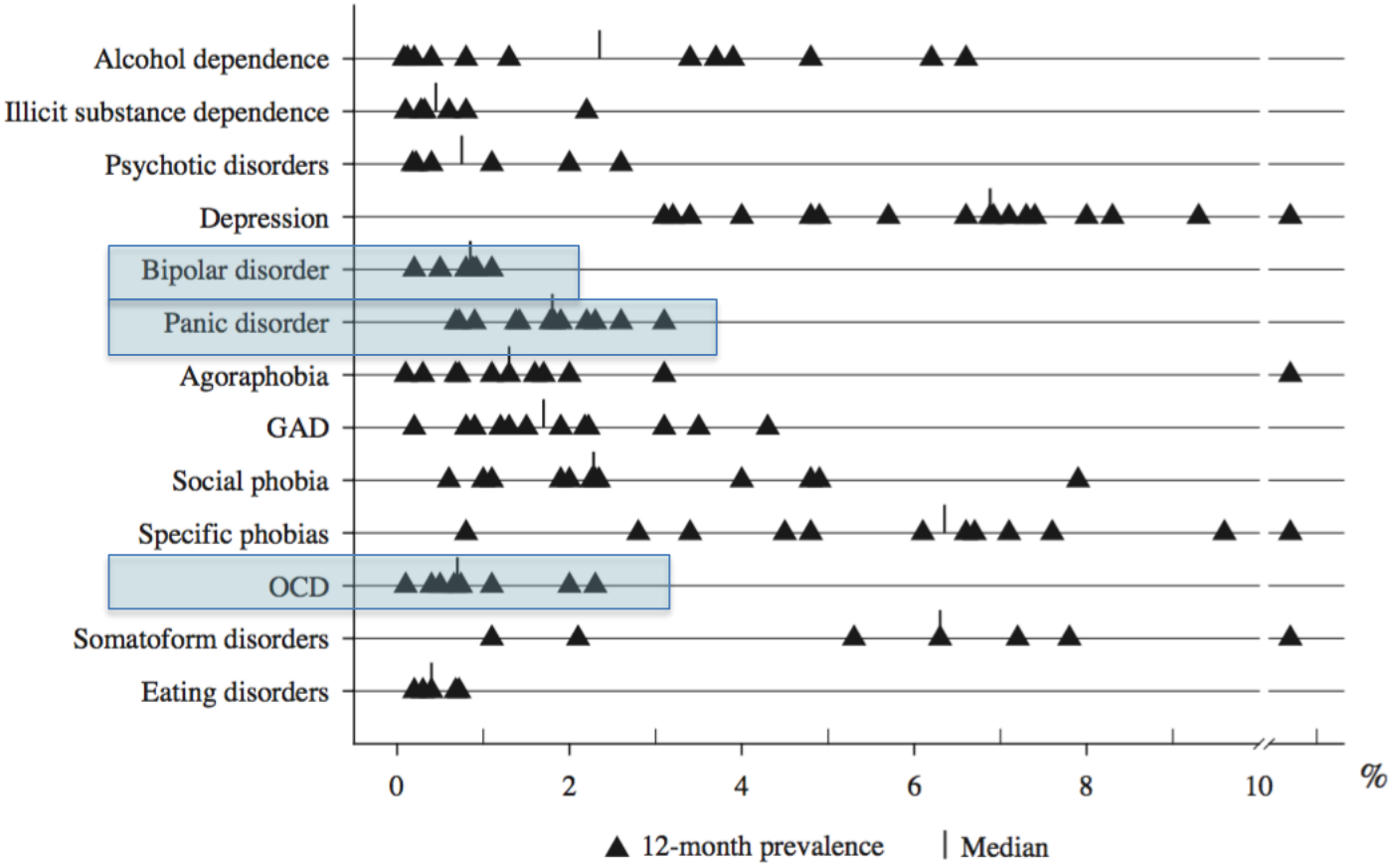
6/12-month Prevalence of Anxiety Disorders

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.

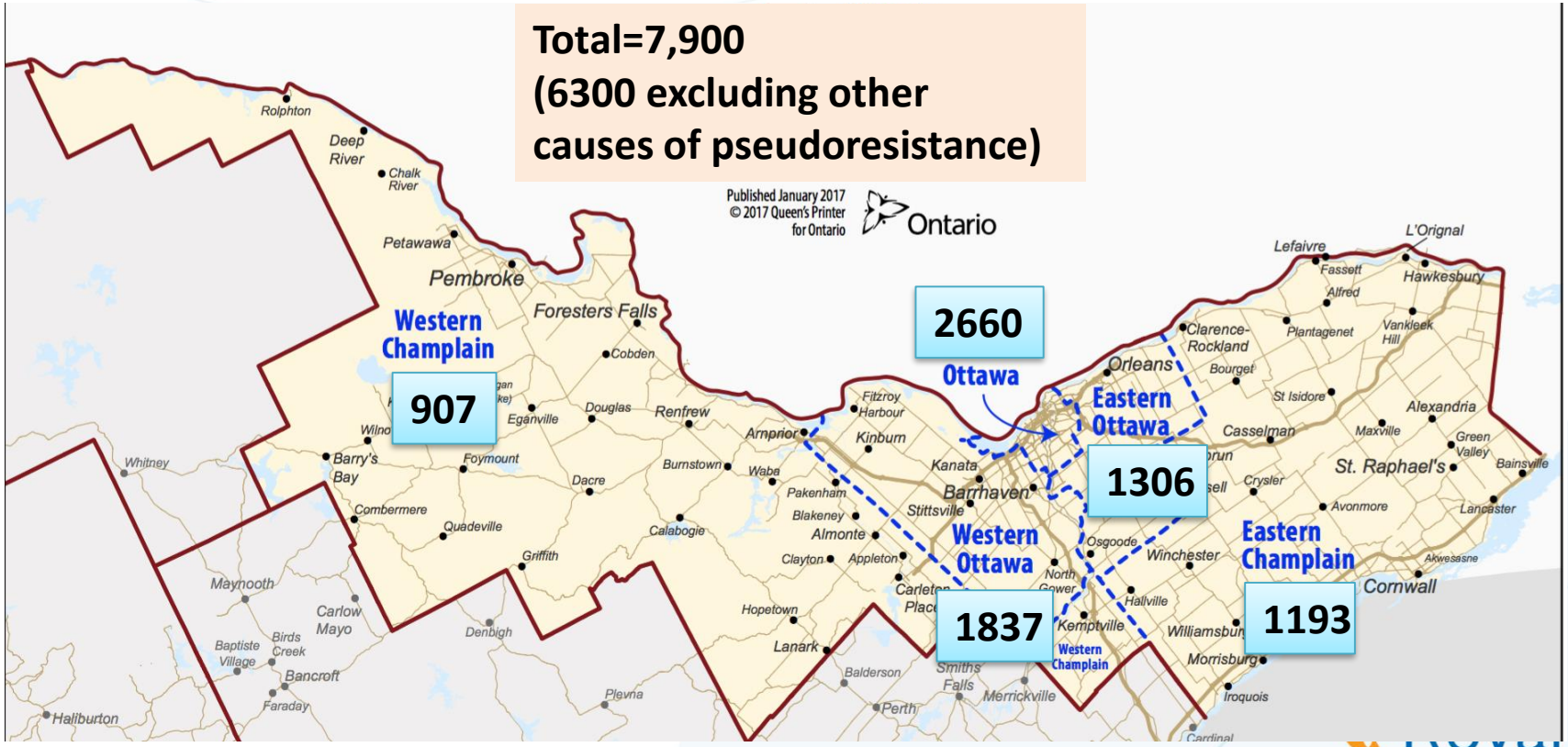


Total: 27 studies, conducted in 12 different countries, between 1980 and 2002 (Wittchen et al. 2005)

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).**

Estimated adult population with Treatment Resistant Mood/Anxiety



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

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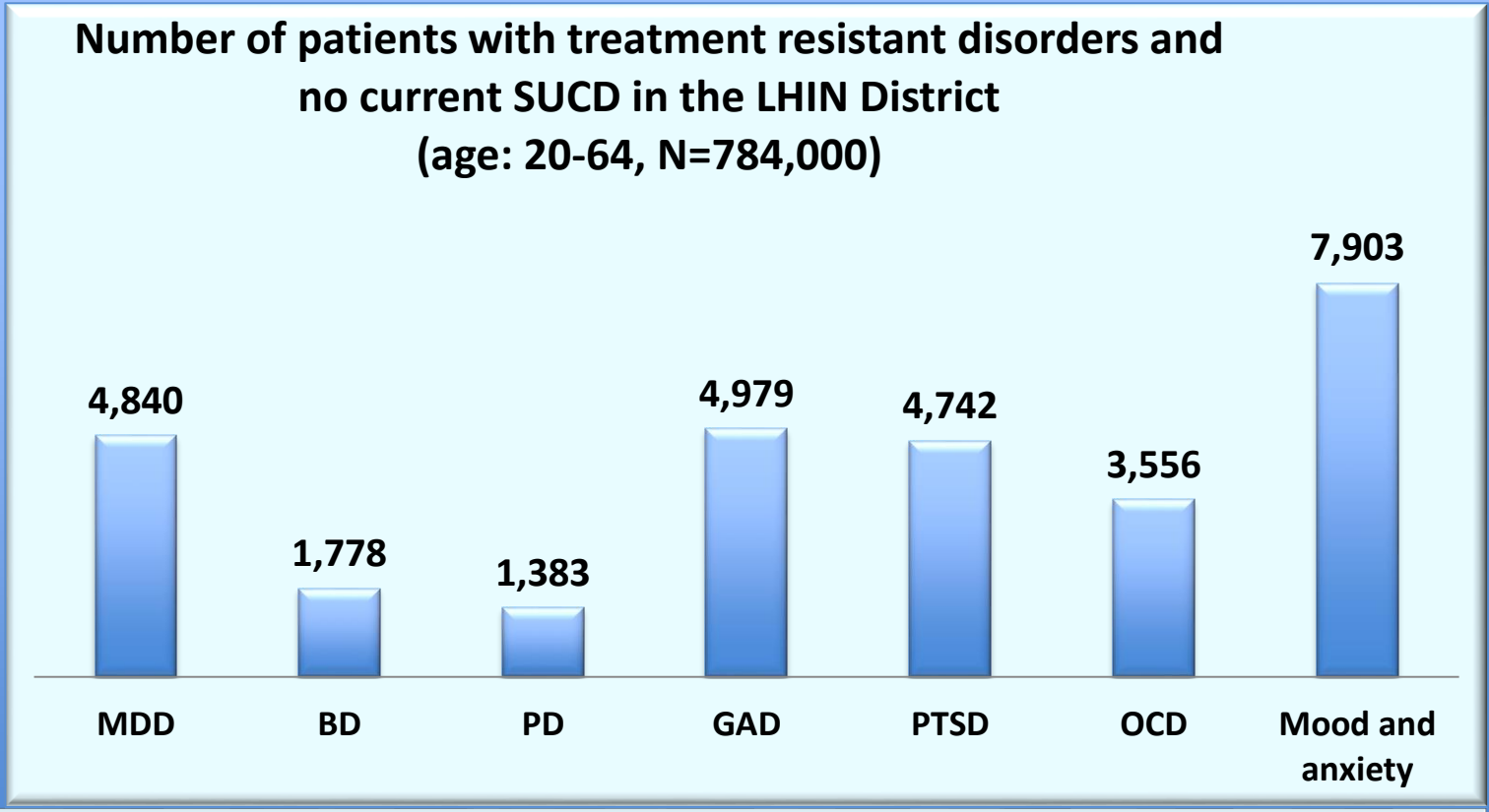
Estimated adult population with Treatment Resistant Mood/Anxiety



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

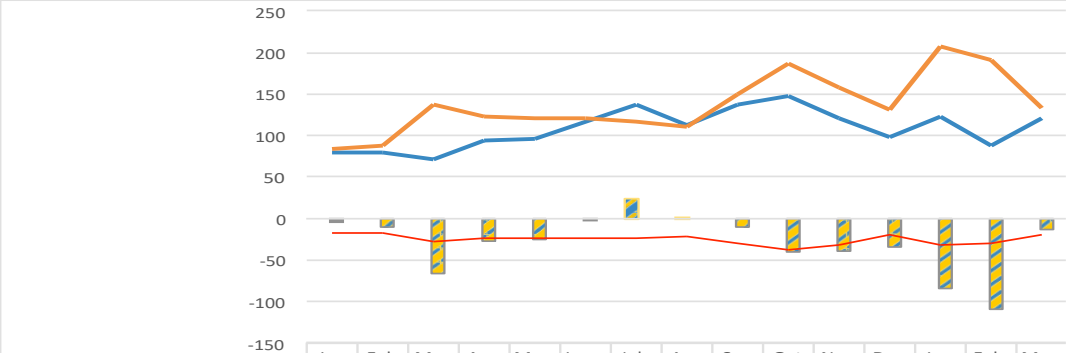
CONCLUSIONS

- 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

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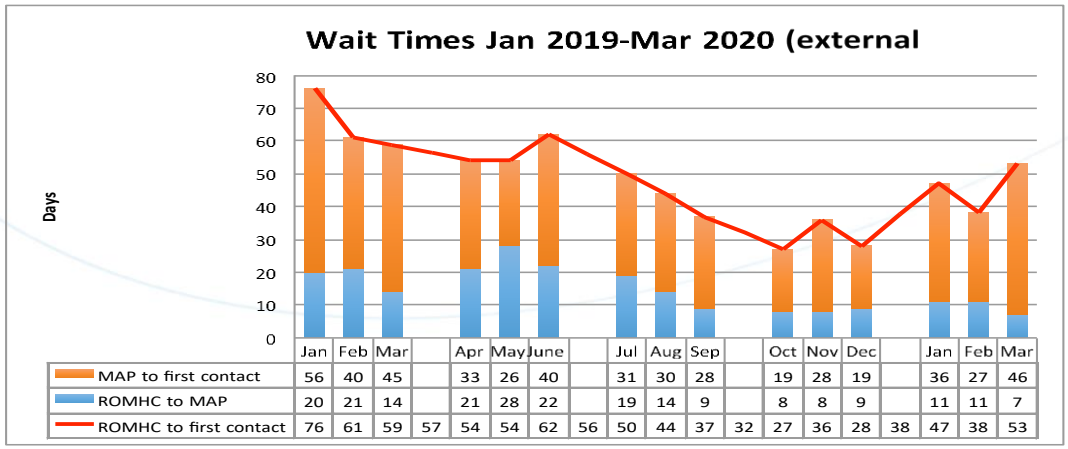
Average Monthly Wait Times of first contact with any staff in MAP (Referrals external to ROMHC)



	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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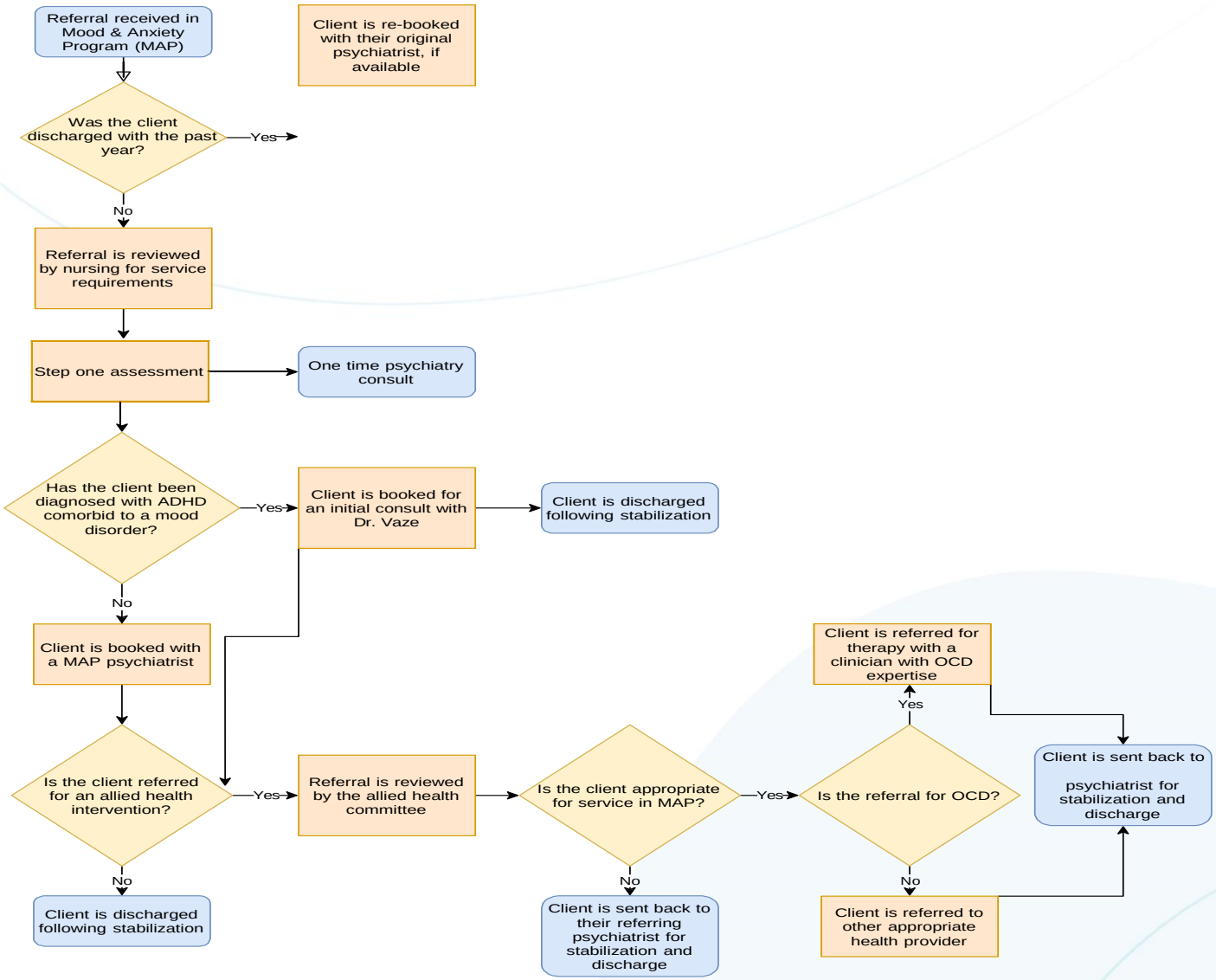
ADHD and OCD Flow



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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

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

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

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

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

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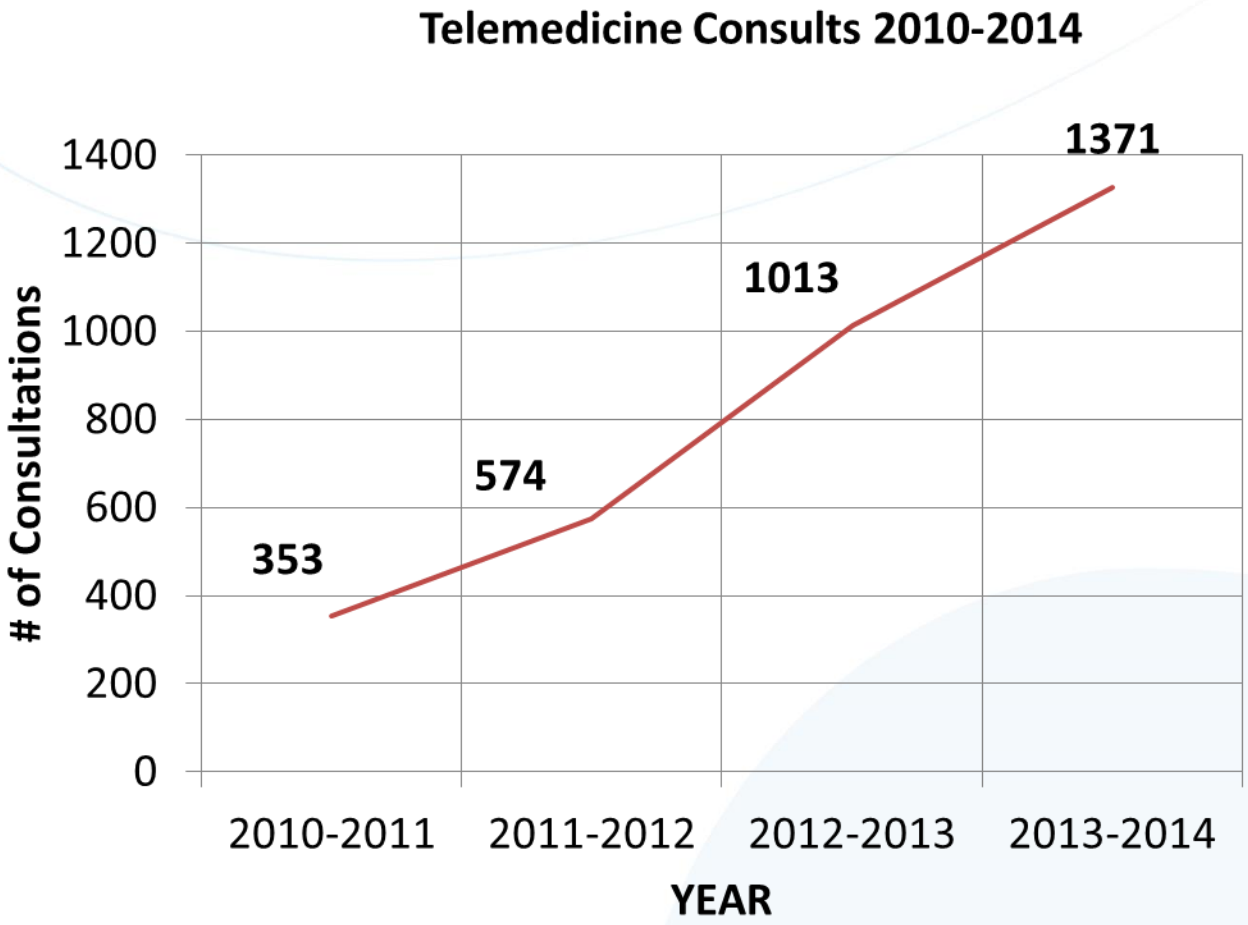
Telemedicine Consultations 2010-2014



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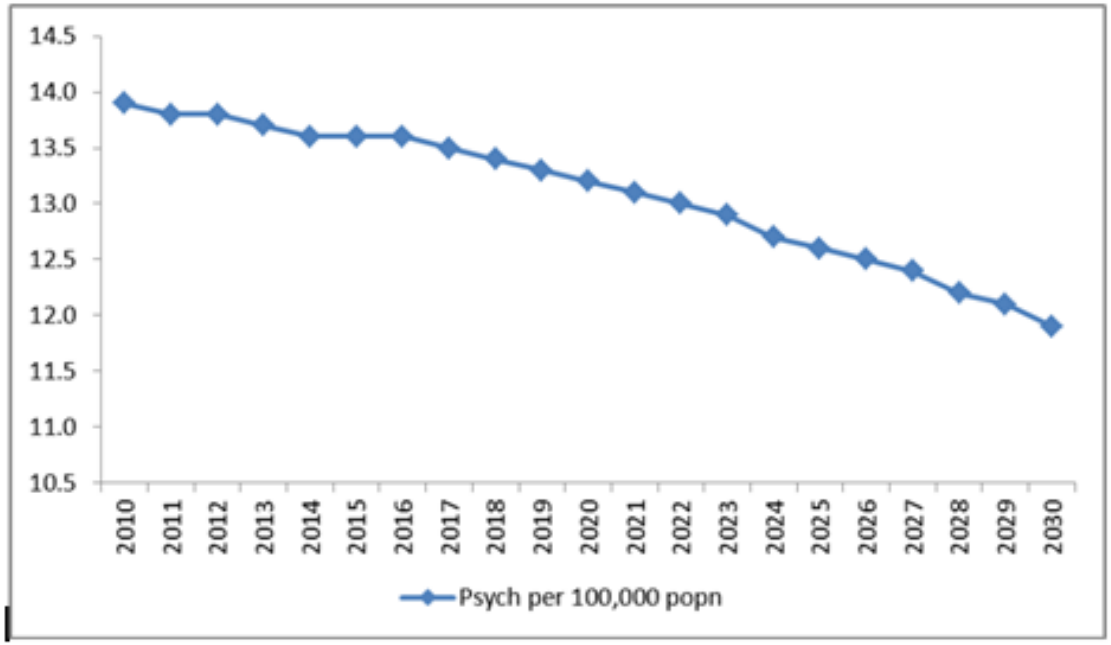
Forecasted Number of Psychiatrists per Capita in Ontario

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)?

Community Health Centres (CHCs)

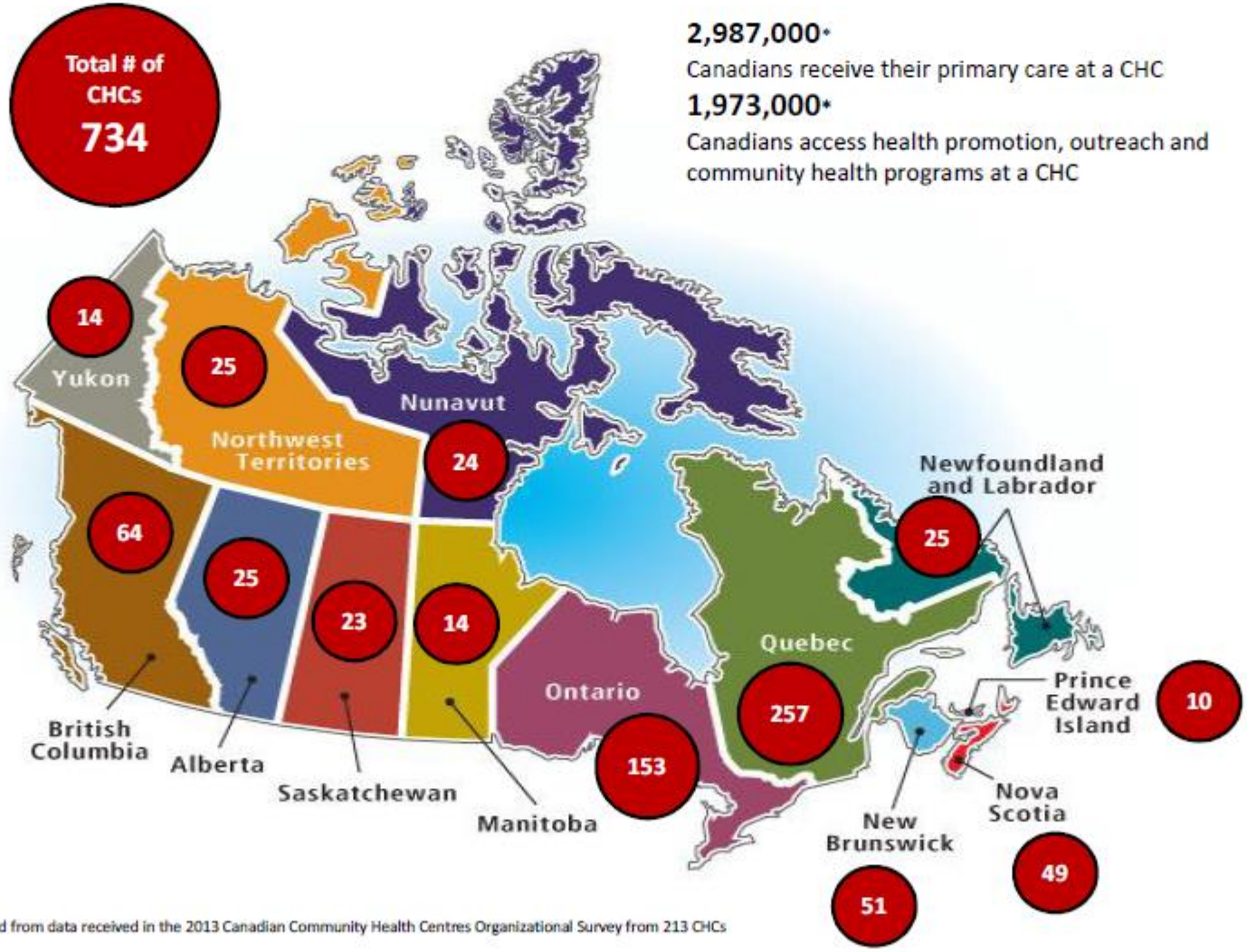
- Not-for-profit, publicly-funded primary health care organizations
- Collaborative approach care by various health care providers under one roof
- Designed to focus on the most appropriate services & programs for the local community

L'Association canadienne des centres de santé communautaire

Canadian Association of Community Health Centres

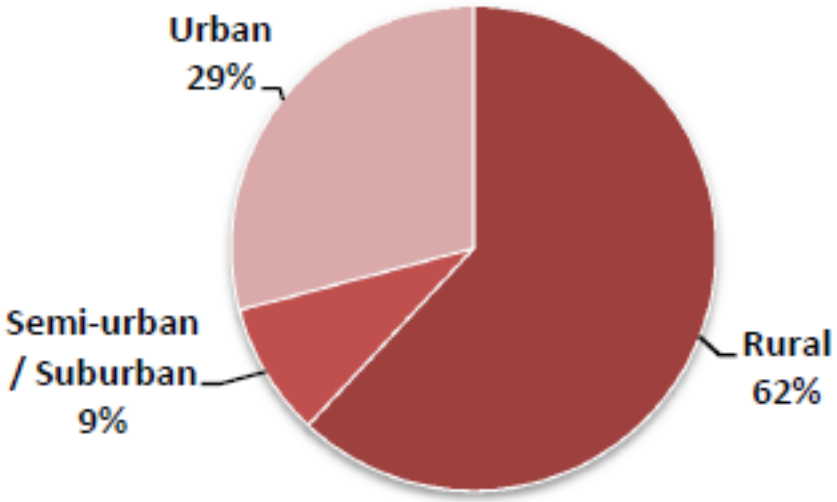
2013 CANADIAN COMMUNITY HEALTH CENTRES ORGANIZATIONAL SURVEY

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

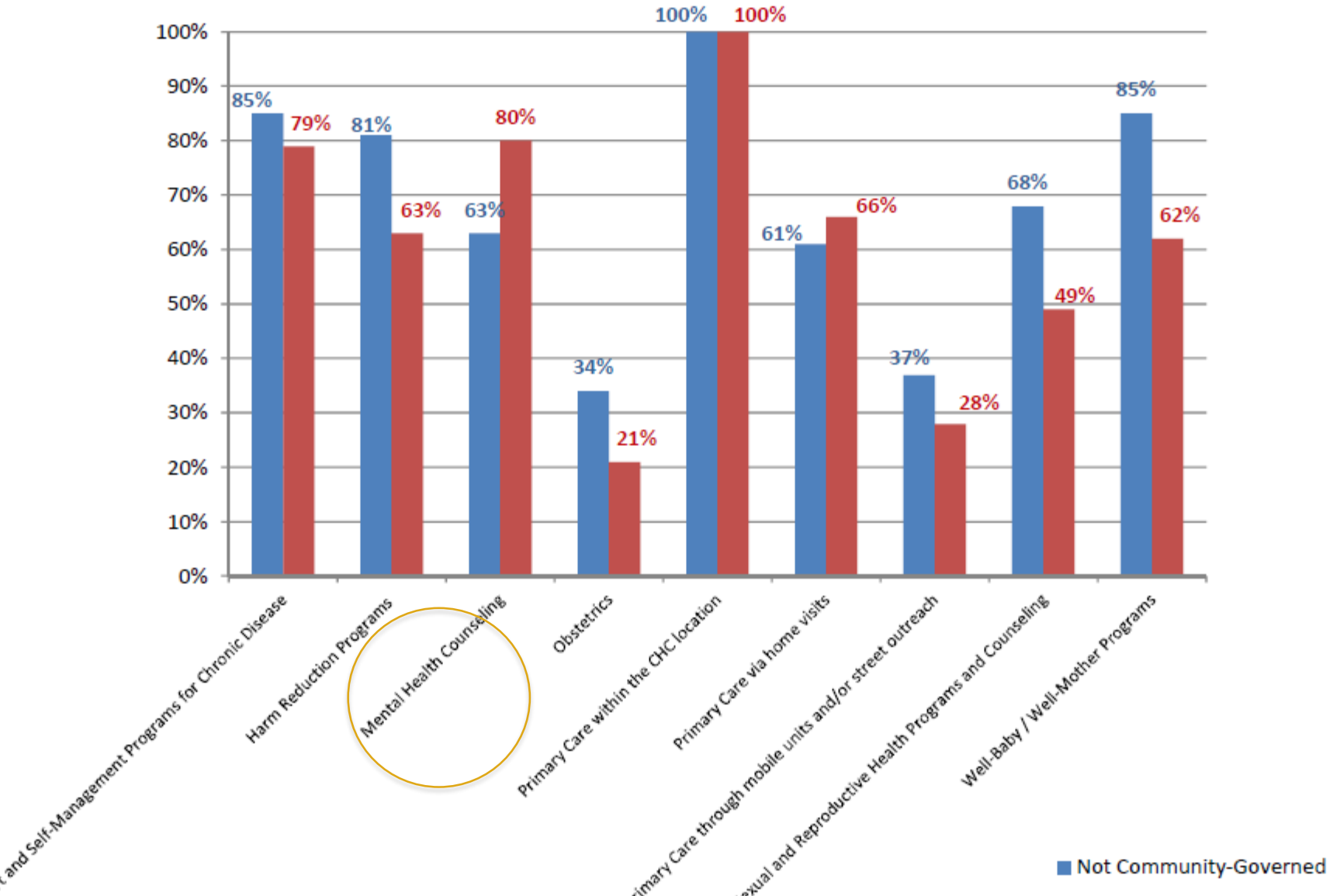
Distribution of CHCs by Population/Geographical Context (n = 213)



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?

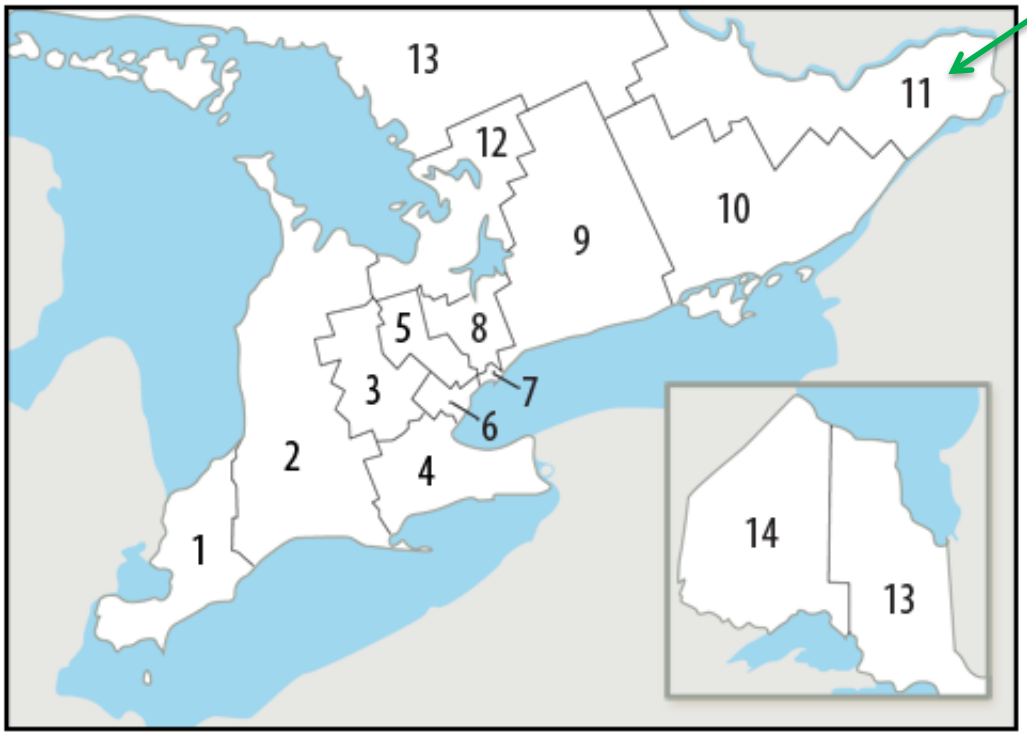
- They serve clients with complex needs
- Need for access to psychiatric consultation & care
- More than half are located in rural areas
- 14 CHCs in Champlain LHIN, 7 of which are in Ottawa

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

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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

Telemedicine Case Consultation Pilot - Challenges & Lessons Learned

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

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

Why Rural Clinics?

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

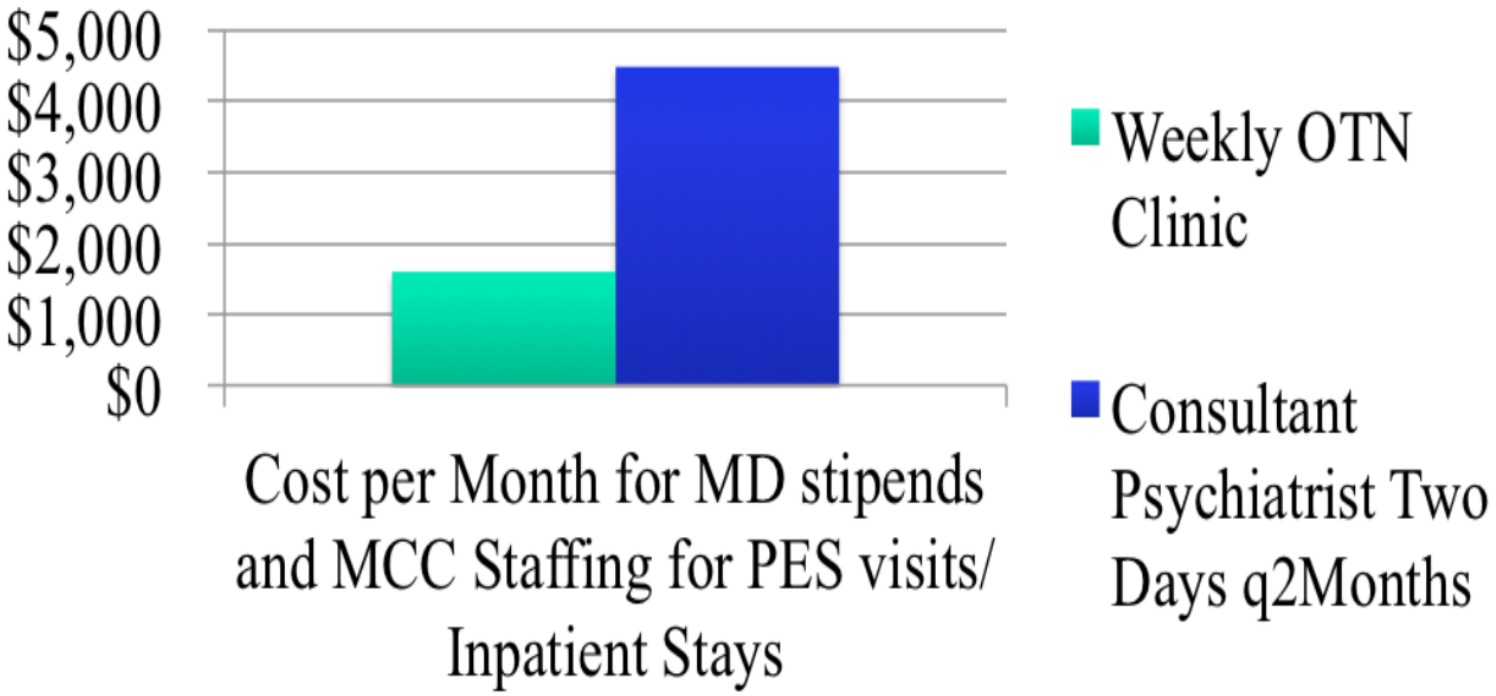
- Joint project between the ROHCG and the Ministry of Community Safety & Correctional Services (MCSCS)

- 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

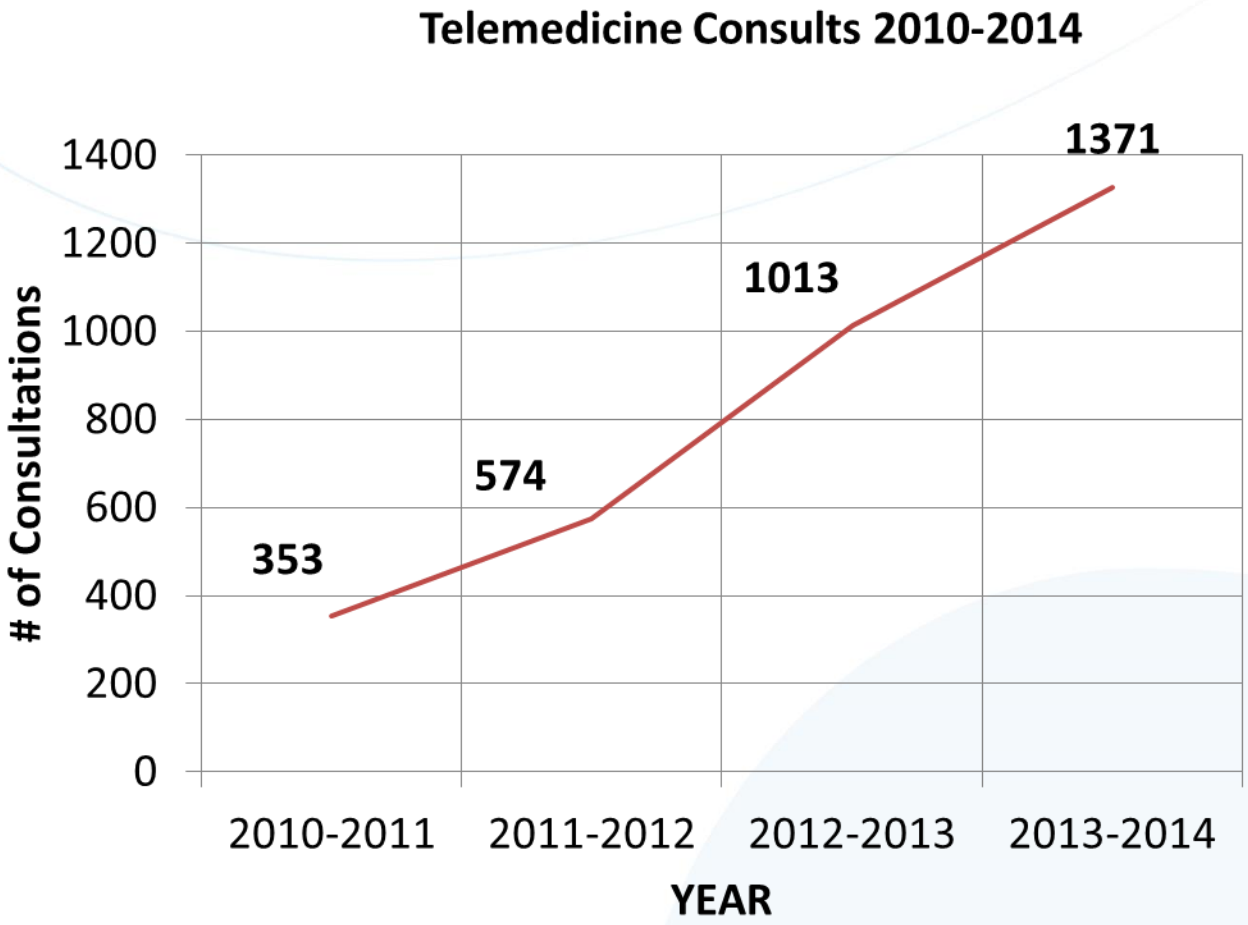


- $1600 per month for the OTN service vs $4489 per month for the 2 days every two months consultant psychiatrist, a savings of $2889 per month for the OTN clinic model

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

Summary

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

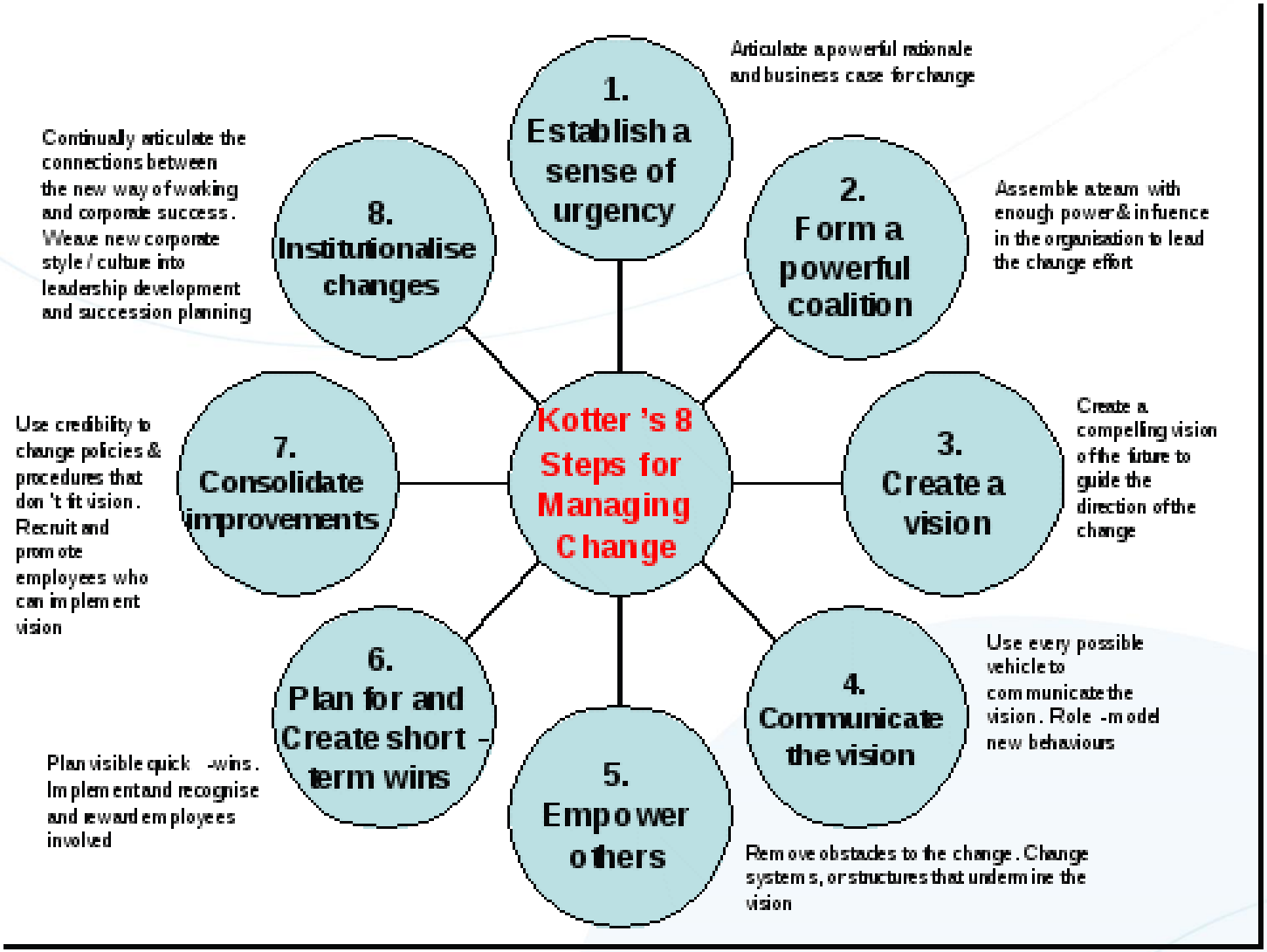
Telemedicine at The Royal

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

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

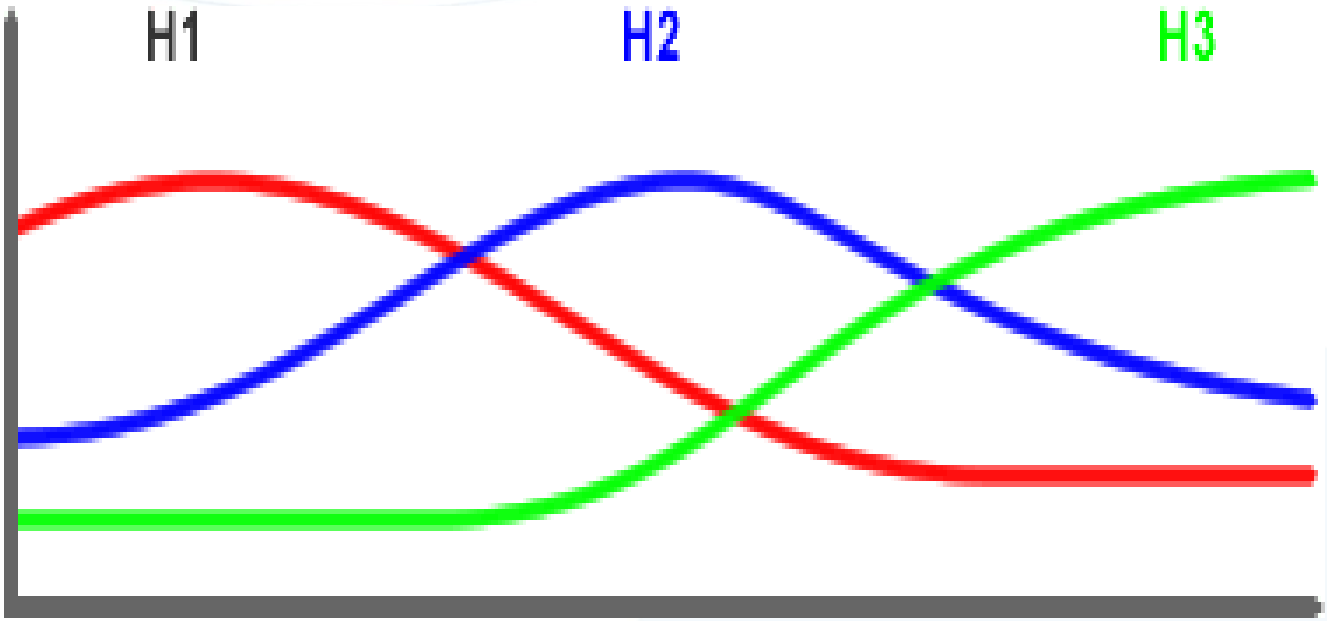
Selected Telemed accomplishments

- 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

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Website

- Corporate redesign - improved

Vanderbilt model

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Confidential

Royal Ottawa Health Care Group
Psychiatrist-in-Chief & Chief of Staff Proposed Performance Objectives
- April 1, 2020 to March 31, 2021

Schedule A

Proposed % BONUS	PERFORMANCE OBJECTIVE	TARGET/OUTCOME	MID-TERM STATUS REPORT	FINAL REPORT
20	1. Quality Improvement Plan (QIP)	Meet QIP targets as adapted to Ontario Health QIP implementation plans.		
20	2. Implement Vanderbilt professional model for ROHCG physicians.	Model implemented.		
20	3. Work with academic partners to create an Ottawa anxiety algorithm by September 1, 2021.	Objective progress made toward algorithm completion.		
20	4. Expand care offerings to Northern Ontario Francophone Psychiatric Program (NOFPP) beyond fly-up physician support.	Care offerings expanded.		
20	5. Optimize the use of the EHR for clinical care delivery.	Work with IT and Programs to enhance EHR clinical structures and the completion of meaningful clinical projects.		

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – In-Camera	**Priority:** Important

DATE: **April 29, 2020**

COMMITTEE: **Compensation & Succession Planning Committee**

PRESENTER:

SUBJECT: **President & CEO Performance Review**

BACKGROUND INFORMATION:

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 forwarded to the Board for approval.

CARRIED

Moved by:

Seconded by:

Motion approved:

ROYAL OTTAWA HEALTH CARE GROUP

BOARD APPROVAL REQUEST

Motion Number: 2019-2020 – In-Camera	**Priority:** Important

DATE: **April 29, 2020**

COMMITTEE: **Compensation & Succession Planning Committee**

PRESENTER:

SUBJECT: **Psychiatrist-in-Chief/Chief of Staff Performance Review**

BACKGROUND INFORMATION:

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 forwarded to the Board for approval.

CARRIED

Moved by:

Seconded by:

Motion approved: