Thunder Bay Regional Health Sciences Centre

Board of Directors
Open Meeting
Wednesday, October 5, 2016 – 5:00 pm Boardroom, Level 3, TBRHSC
980 Oliver Road, Thunder Bay
AGENDA

Vision: *Healthy Together*
Mission: *We will deliver a quality patient experience in an academic health care environment that is responsive to the needs of the population of Northwestern Ontario*
Values: *Patients ARE First (Accountability, Respect and Excellence)*

#	Time (X)	Presenter	Item & Purpose (Y)	Expected Outcome (Z)			
				Recommendation /Decision/Action	Education	Discussion	Information
1.0	**CALL TO ORDER**						
2.0	**PATIENT STORY** –*Jean Bartkowiak*						
3.1	1	N. Doucette	Quorum (8 members total required, 6 being voting)				
3.2	1	N. Doucette	Conflict of Interest				
3.3	1	N. Doucette	Approval of the Agenda	X			
3.4	3	N. Doucette	Chair's Remarks*				X
4.0	**PRESENTATIONS/EDUCATION**						
4.1	15	J. Nesti G. Craig	Foundation Accomplishments, Future Priorities and Challenges*				X
4.2	15	Dr. Kennedy	Choosing Wisely Project*		X		X
4.3	15	Dr. Thibert Dr. Crocker Ellacott	Fracture Clinic Process Improvement Project*			X	X
5.0	**CONSENT AGENDA**						
5.1	-		Board of Directors Open Minutes – June 6, 2016*	X			X
5.2			Clinical Trials Ontario Participation Agreement*				X
5.3	-		Resource Planning Committee – September 20, 2016 5.3.1 Q1 2016-2017 Board Wages and Source Deduction Attestation* 5.3.2 BD-16 Investment Policy Amendment*				X
5.4	-		Appointment – Research Ethics Board Member*				X
5.5	-		Quality Committee Minutes – September 20, 2016*				X
6.0	**REPORTS AND DISCUSSION**						
6.1	10	Senior Management	Report from Senior Leadership*	X		X	X
6.2	5	J. Bartkowiak	Report from the President and CEO*			X	X
6.2.1	10	J. Bartkowiak	Updates				
6.2.2	5	J. Bartkowiak	President and CEO 2016-17 Objectives*			X	X
6.2.3	5	J. Bartkowiak	2020 Strategic Plan 2016-17 Q1 Progress Report*			X	X
6.3.	5	J. Bartkowiak	Rescheduling of March Board meeting			X	X
6.4	5	J. Bartkowiak	Board Meeting in the Region			X	X

#	Time (X)	Presenter	Item & Purpose (Y)	Expected Outcome (Z)			
				Recommendation /Decision/Action	Education	Discussion	Information
6.5	5	J. Bartkowiak	Annual General Meeting Logistics			X	X
6.6	5	J. Bartkowiak	Holiday Staff Recognition Activities			X	X
6.7	5	G. Craig	Report from the Foundation*			X	X
6.8	5	Dr. Thibert	Report from the Professional Staff Association			X	X
6.9	5	Dr. Porter	Report from the Chief of Staff*			X	X
6.10	5	Dr. Crocker Ellacott	Report from the Chief Nursing Executive*			X	X
6.11	5	Dr. Moody-Corbett	Report from the Northern Ontario School of Medicine*			X	X
7.0	**COMMITTEE MATTERS**						
7.1	10	D. Mannisto	Governance Committee – September 21, 2016 7.1.1 – CEO Performance Evaluation and Compensation Policy Amendments* 7.1.2 – COS Performance Evaluation and Compensation Policy Amendments*	X X			
8.0	**FOR INFORMATION**						
8.1	-		Board and Committee Work Plans*				X
8.2	-		Webcast Statistics*				X
8.3	-		Letter from Minister Hoskins re: HSRF*				X
8.4	-		Environmental Compliance and Fire Safety Update*				X
8.5	-		Article – The Cultural Erosion of Indigenous People in Health Care*				X
8.6	-		Report from the Institute*				X
8.7	-		Report from the Volunteer Association*				
9.0	**BOARD MEMBER COMMENTS**					X	
10.0	**DATE OF NEXT MEETING** – November 2, 2016						X
11.0	**ADJOURNMENT**						

Ethical Framework

TBRHSC is committed to ensuring decisions and practices are ethically responsible and align with our mission/vision/values. All leaders should consider decisions from an ethics perspective including their implications on patients, staff and the community.

The following questions should be considered for each decision.

1. Does the course of action put '**Patients First'** by responding respectfully to needs & values of our patients, families, and communities?
2. Does the course of action demonstrate '**Accountability**' by advancing a quality patient experience that is socially and fiscally accountable?
3. Does the course of action demonstrate '**Respect**' by honouring the uniqueness of each individual and his/her culture?
4. Does the course of action demonstrate '**Excellence**' by fostering an environment of innovation and learning to advance a quality patient experience?

For more detailed questions to use on difficult decisions, please refer to TBRHSC's Framework for Ethical Decision Making

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BOARD OF DIRECTORS (Open)
October 5, 2016 – DRAFT

Agenda Item	Committee or Report	Motion or Recommendation	Approved or Accepted by:
3.3	Agenda – October 5, 2016	"That the Agenda be approved as circulated."	Moved by: Seconded by:
5.0	Consent Agenda	"That the Board of Directors: 5.1 Approves the Board of Directors Minutes of June 6, 2016; 5.2 Endorses proceeding with signing an agreement with Clinical Trials Ontario to become an accruing site; 5.3.1 Accepts the Q1 2016-2017 Board Wages and Source Deduction Attestation, upon recommended from the Resource Planning Committee; 5.3.2 Approves the revised BD-16 Investment Policy, upon recommendation from the Resource Planning Committee; 5.4. Appoints Mr. Claude Camirand to a three (3) year term (September 1, 2016 to September 30, 2019, as a core community member as recommended by the Research Ethics Board Selection Panel; 5.5 Accepts the Quality Committee Minutes of September 20, 2016; as presented."	Moved by: Seconded by:
6.0	Reports and Discussion	"That the Board of Directors: 6.1Accepts the Report from Senior Leadership; 6.2 Accepts the Report from the President and CEO; 6.3 Accepts the Report from the Foundation; 6.4 Accepts the Report from the Professional Staff Association; 6.5 Accepts the Report from the Chief of Staff; 6.6 Accepts the Report from the Chief Nursing Executive; 6.7 Receives the Report from the Northern Ontario School of Medicine; Dated October, 2016 as presented."	Moved by: Seconded by:

Agenda Item	Committee or Report	Motion or Recommendation	Approved or Accepted by:
7.1	CEO/COS Performance Evaluation and Compensation Policy	"That upon recommendation from the Governance Committee, the Board of Directors approves the revised policy BD-05 CEO Performance Evaluation and Compensation, as presented." "That upon recommendation from the Governance Committee, the Board of Directors approves the revised policy BD-07 COS Performance Evaluation and Compensation, as presented."	Moved by: Seconded by: Moved by: Seconded by:

Thunder Bay Regional Health Sciences Centre

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www.tbrhsc.net

Report from Nadine Doucette
Chair, Board of Directors
October, 2016

It gives me great pleasure to offer this first report of my second term as Chair of the Board of Directors for Thunder Bay Regional Health Sciences Centre (the Hospital). It is an honour to serve with the dedicated volunteer Board of Directors that firmly believe in our Hospital's commitment to Patient and Family Centred Care. As Directors representing the population of Northwestern Ontario, we regularly hear from our community members about the quality of care, compassion and energy put forth by the staff, professional staff, volunteers and donors who make us leaders in Patient and Family Centred Care (PFCC).

The annual PFCC Sharing & Caring event, held last week at our Hospital, provided an opportunity to showcase our PFCC successes, and celebrate new initiatives. We are involving patients and family members in clinical and administrative decisions like nowhere else in Ontario. Our Board of Directors applies the PFCC philosophy to ensure that, even at the governance level, decisions are unfailingly focused on the best outcomes for patients and families. I would like to acknowledge Ms. Anita Jean who has embraced the PFCC philosophy and expanded her role by volunteering as a Patient Family Advisor (PFA). As a PFA, Anita will share her perspective to positively impact the overall patient experience. She has also agreed to participate as a valuable member of the Francophone Advisory Committee.

At the request of the Research Ethics Board (REB), the Governance Committee was asked to expand its membership to address an ever increasing volume of research project application reviews. Two additional members are required on the REB, which brings the total REB membership from 7 to 9 members. I want to take this opportunity to thank Gary Whitney who kindly accepted to represent the Board on the Selection Committee this summer. The Committee interviewed several prospective candidates to fill the REB vacancies that are submitted for approval at the October Board meeting.

In the last few weeks, several members of the Board were interviewed by the Hay Group consultants as part of the operational review process; the consultants were particularly interested in understanding our Board's governance processes as they relate to our clinical and financial performance governance oversight. I would like to recognize Grant Walsh's contribution to this review as he serves as our representative on the Operational Review Committee.

A sub-committee of the Quality Committee of the Board chaired by Dick Mannisto met in the last few months to review our compliance with Accreditation Canada's current Governance Standards in anticipation of the next accreditation survey in 2018. The Committee will be tabling a compliance report and recommendations in the fall so we have time to address any compliance issue well in advance of the next survey.

As part of our Indigenous Health Strategic Direction, I want to recognize Ms. Georjann Morisseau's support in identifying activities and priorities that will be most impactful in achieving our goals relative to that population. Georjann has provided guidance to support Indigenous Health initiatives, including the introduction of an Indigenous Health update as a standing item of Board of Directors meeting agendas beginning in November. She has also become a member of the Indigenous Advisory Committee.

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This summer, the Executive Committee of the Board reviewed and approved the President & CEO's 2016-17 annual objectives. These are included below and in the October Board meeting documentation for your information:

Bed Management

Engage internal and external stakeholders to:

- Reduce Average Length of Stays (QIP) to 5.5 (without ALC);
- Reduce ED wait times (QIP);
- Reduce readmission rates to of patients with Cardiac Heart Failure (QIP);
- Reduce readmission rates to of patients with Chronic Obstructive Pulmonary Disease (QIP);
- Assist in discharging Alternate Level of Care patients to the most appropriate community destination;
- Assist in preventing or redirecting Emergency Department patients deemed not requiring specialized acute care;
- Segregate emergency patients requiring mental health evaluation to provide expert assessment and improve patient flow, accessibility and ED lengths of stay; and
- Engage region hospitals to avoid transfers and improve discharges post specialized acute care.

2020 Strategic Plan

- Implement and monitor progress in achieving year 2 of the Strategic Directions.

Hospital Governance

- Review and recommend amendments as needed to the Hospital Bylaws and Board policies.
- Assist the Chief of Staff and Medical Advisory Committee in reviewing and amending as needed the Medical Staff Bylaws.

Cardiovascular Surgery Program

- Ensure Hamilton Health Science, University Health Network, Cardiac Care Network and Ministry of Health and Long Term Care all sign off on the Hospital's Cardiovascular Surgery Program.

Senior Leadership Team

- Fill all interim Senior Leadership Team positions.
- Review the organizational structure to ensure fit with the Strategic Directions and Division responsibilities.
- Review and recommend amendments to the Pay at Risk policy.

System Partners

- Develop a shared understanding of expectations from the region's hospitals regarding transfers for specialized acute care and referral back for convalescent care; and
- Develop an inventory of Clinical Services Agreements to ensure pertinence, currency and gaps in specialized acute care services to the region.
- Meet with Indigenous community leaders to gather their expectations regarding access to regional specialized acute care.

Patient Satisfaction

- Improve ED patient satisfaction with overall care and services. (QIP)
- Improve inpatient satisfaction with overall care and services. (QIP)

Patient Safety

- Increase proportion of patients receiving medication reconciliation at admission. (QIP)
- Increase proportion of patients receiving medication reconciliation at discharge. (QIP)

Medical Staff Engagement

- Support the Chief of Staff strategy to improve Medical Staff engagement.
- Request a revision of the current code blue process to ensure appropriate response time and team composition.

Staff Engagement

- Support the new Vice-President, Human Resources in implementing a comprehensive staff engagement strategy.

Financial Viability

Through SLC engagement and third party review, improve the Hospital's financial viability as follows:

- Proceed with an internal budget review of spending and revenues to offset the forecasted 2016-17 budget shortfall;
- Implement the findings of the third party review to ensure the 2017-18 budget forecast is in balance;
- Support the Foundation in planning the Cardio-vascular Surgery major campaign; and
- Review the Research Institute funding to offset the forecasted deficit and shift the spending model from back office cost centres to science.

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Research Institute Governance

- Review and recommend a governance model that supports the local nature of the Research Institute's new Strategic Directions.

Research Institute 2020 Strategic Plan

- Ensure the plan is approved and implemented.

Philanthropy

- Assist Foundation in securing resources to achieve the Health Sciences Centre's Strategic Plan.

Academic Mission

- Collaborate with Lakehead University, Northern Ontario School of Medicine (NOSM), and Confederation College to grow their respective health sciences teaching programs.
- Specifically, support (NOSM) Department of Internal Medicine in achieving Royal College of Physicians and Surgeons of Canada accreditation.
- Support the development of an onsite simulation program in partnership with NOSM.

The CEO will be assessed based on the objectives for the CEO's annual performance next spring.

Concerns about wait times in our Fracture Clinic were brought to the Board's attention last winter; the Quality Committee was briefed on a process improvement project to address these concerns. You will be happy to learn that patients' average wait times have been reduced from 100 minutes last year to an average of 54 minutes in September. I congratulate the Fracture Clinic team for that achievement.

Finally, planning is underway for an annual Tri-Board Retreat, and we look forward to discussing the common goals and respective challenges of our Hospital, Research Institute and Foundation boards. Collaborative governance is one way we will achieve our Vision of Healthy Together.

Thunder Bay Regional Health Sciences Foundation

Northern Cardiac Fund | Health Sciences Discovery Fund | Northern Cancer Fund

TBRHSF Presentation to TBRHSC Board of Directors

October 5, 2016

To inspire the people of Northwestern Ontario to give generously to advance our healthcare at Thunder Bay Regional Health Sciences Centre

Board List

Jody Nesti	Chair
Kyle Shaen	Vice Chair/ Chair, Finance and Audit
Barry Streib	Chair, Governance
Tracey Nieckarz	Past Chair
Dr. Steve Adams	Chair, Development
Dave Knutson	Director
Tony Bossio	Director
Mary Poulter	Director
Parker Jones	Director
Sue Dubinsky	Director
Tom Mihaljecvic	Director
Sean Davies	Director
Glenn Craig	Ex-officio – HSF President & CEO
Jean Bartkowiak	Ex-officio – HSC President & CEO
Pat Skula	Observer – Volunteer Association
Anita Jean	Observer – HSC Board of Directors
Dr. Mark Thibert	Observer – Professional Staff Association
Clint Harris	Observer – RI Board of Directors

Thunder Bay Regional
Health Sciences
Foundation

Key Staff Members	
Terri Hrkac	Senior Director Major and Legacy Giving
Athena Kreiner	Director, Annual Giving (Special Events)
Ashley Rooney	Associate Development Officer
Heather Vita	Director, Marketing and Communications

Thunder Bay Regional Health Sciences Foundation

Cardiovascular Prep

- Building Campaign Cabinet
- Research Major Gift Prospects
- Building the Case for Support
- Pre-Quiet Phase Solicitation
  $1,000,000+ gifts

Thunder Bay Regional
Health Sciences
Foundation

Annual Giving
Top Priorities

- Committed Donors
- Mid-Level Program
- New Donor Program

Thunder Bay Regional
Health Sciences
Foundation

Special Events
Top Priorities

- Maximize Revenue per Event
- Grow Community Event Relationships and Revenue
- Create a Spirit of Philanthropy in Event Attendees

Thunder Bay Regional
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Major Gifts
Top Priorities

- Cardiovascular Campaign Plan
- Women in Action
- Vendor Program
- Physician Giving Circle

Thunder Bay Regional
Health Sciences
Foundation

Legacy Giving
Top Priorities

- Legacy Giving Thunder Bay
- Internal marketing of Legacy Giving

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Health Sciences
Foundation

Other Priorities

- Investigate RE NXT & online solutions for potential upgrade
- Succession planning and mentorship with the recruitment of new Board Members

Thunder Bay Regional Health Sciences Foundation

Other Priorities 2

- Collaboration with HSC Volunteer Program
- Brand Story
- Stewardship

Thunder Bay Regional Health Sciences Foundation

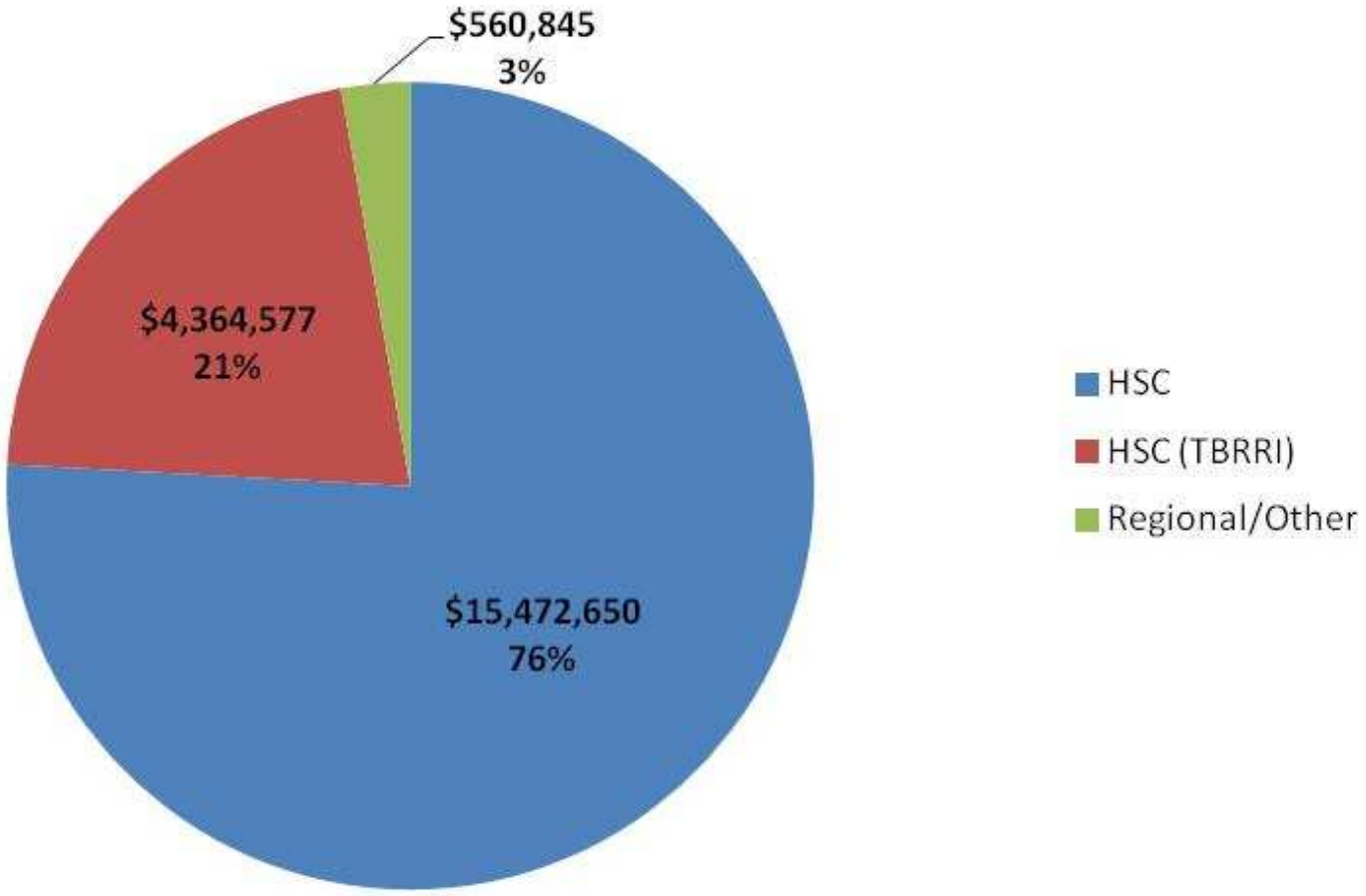
Thunder Bay Regional Health Sciences Foundation

Fund Distribution to Health Sciences Centre & Region/Other - Breakdown by Fiscal

	HSC	Regional/Other	Total
2015/2016	$ 5,112,432	$ 43,441	$ 5,155,873
2014/2015	$ 2,689,859	$ 50,408	$ 2,740,267
2013/2014	$ 2,457,758	$ 18,522	$ 2,476,280
2012/2013	$ 2,975,349	$ 48,000	$ 3,023,349
2011/2012	$ 2,103,287	$ 108,188	$ 2,211,475
	$ 15,338,685	**$ 268,559**	**$ 15,607,244**
2010/2011	$ 1,802,564	$ 53,946	$ 1,856,510
2009/2010	$ 1,377,758	$ 14,090	$ 1,391,848
2008/2009	$ 1,318,130	$ 224,250	$ 1,542,380
	$ 19,837,137	**$ 560,845**	**$ 20,397,982**

Thunder Bay Regional Health Sciences Foundation

TBRHSF Fund Distribution Since 2008



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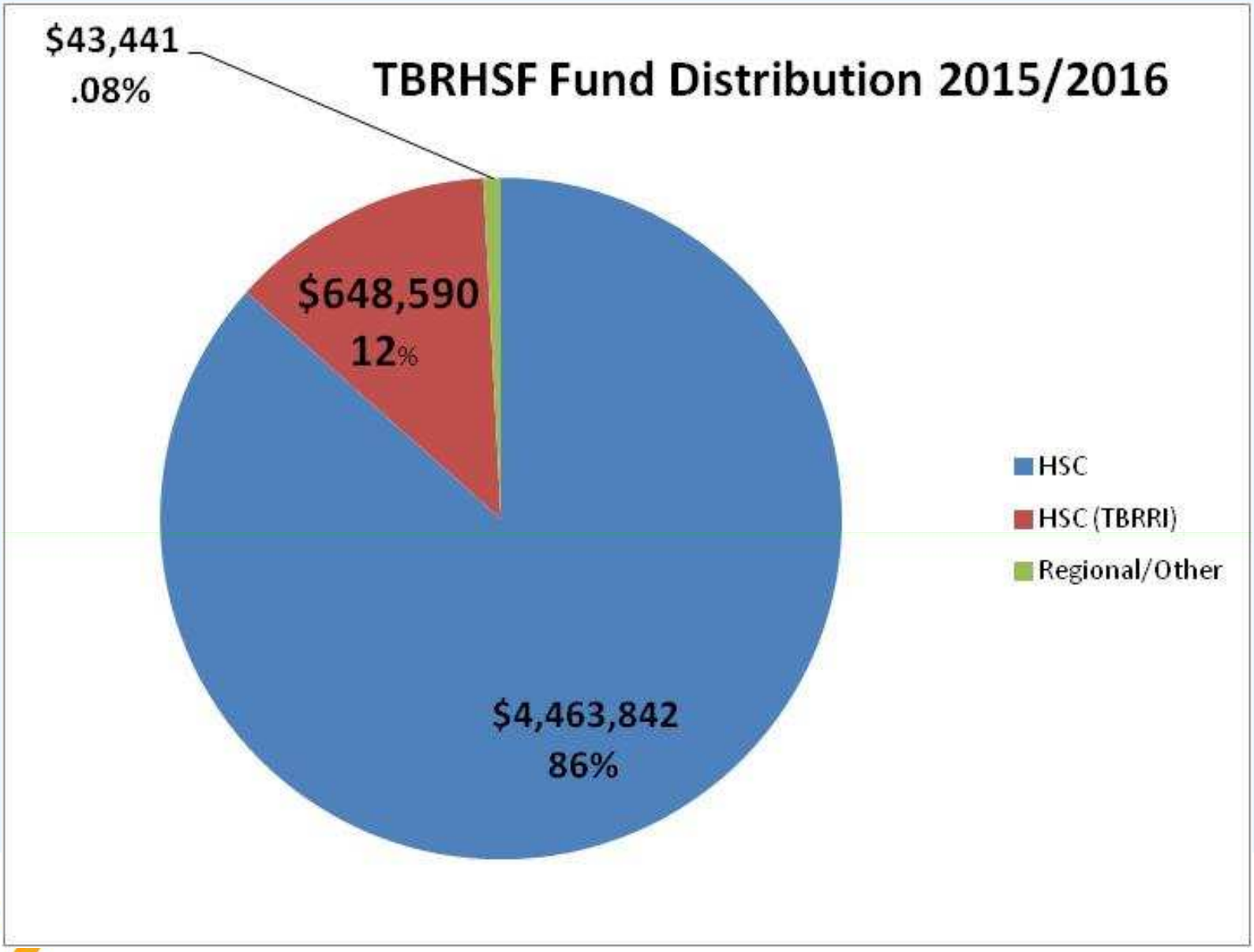

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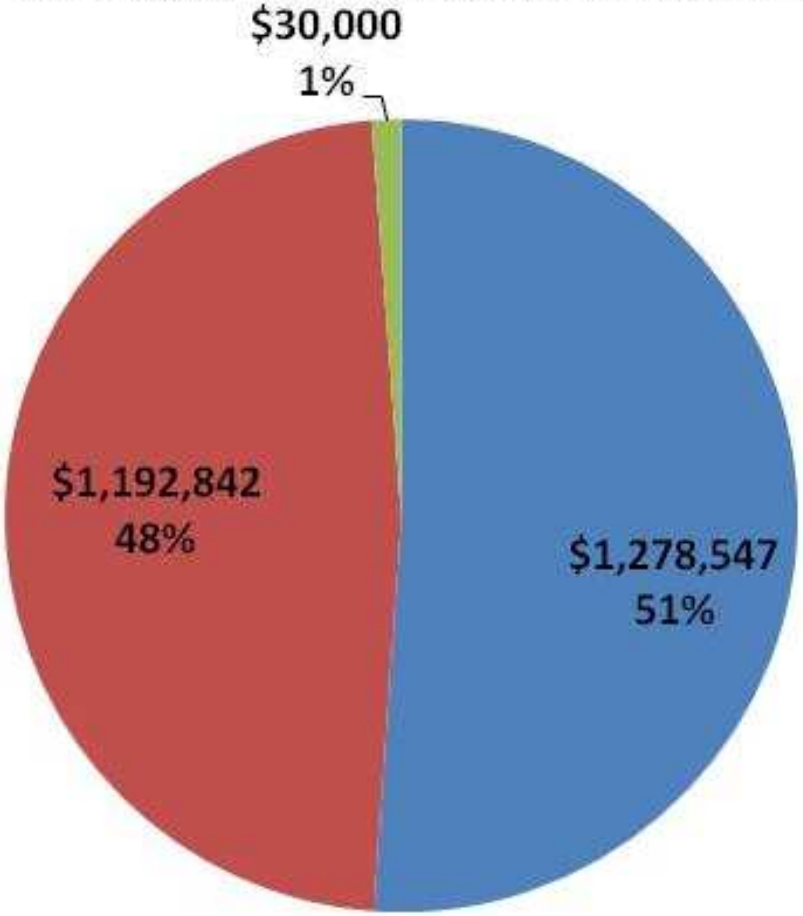
TBRHSF Fund Distribution 2016/2017



Thunder Bay Regional
Health Sciences
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QUESTIONS

Thunder Bay Regional
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Foundation

Choosing Wisely Canada

Choisir avec soin

ChoosingWiselyCanada.org | ChoisirAvecSoin.org

@ChooseWiselyCA | @ChoisirAvecSoin

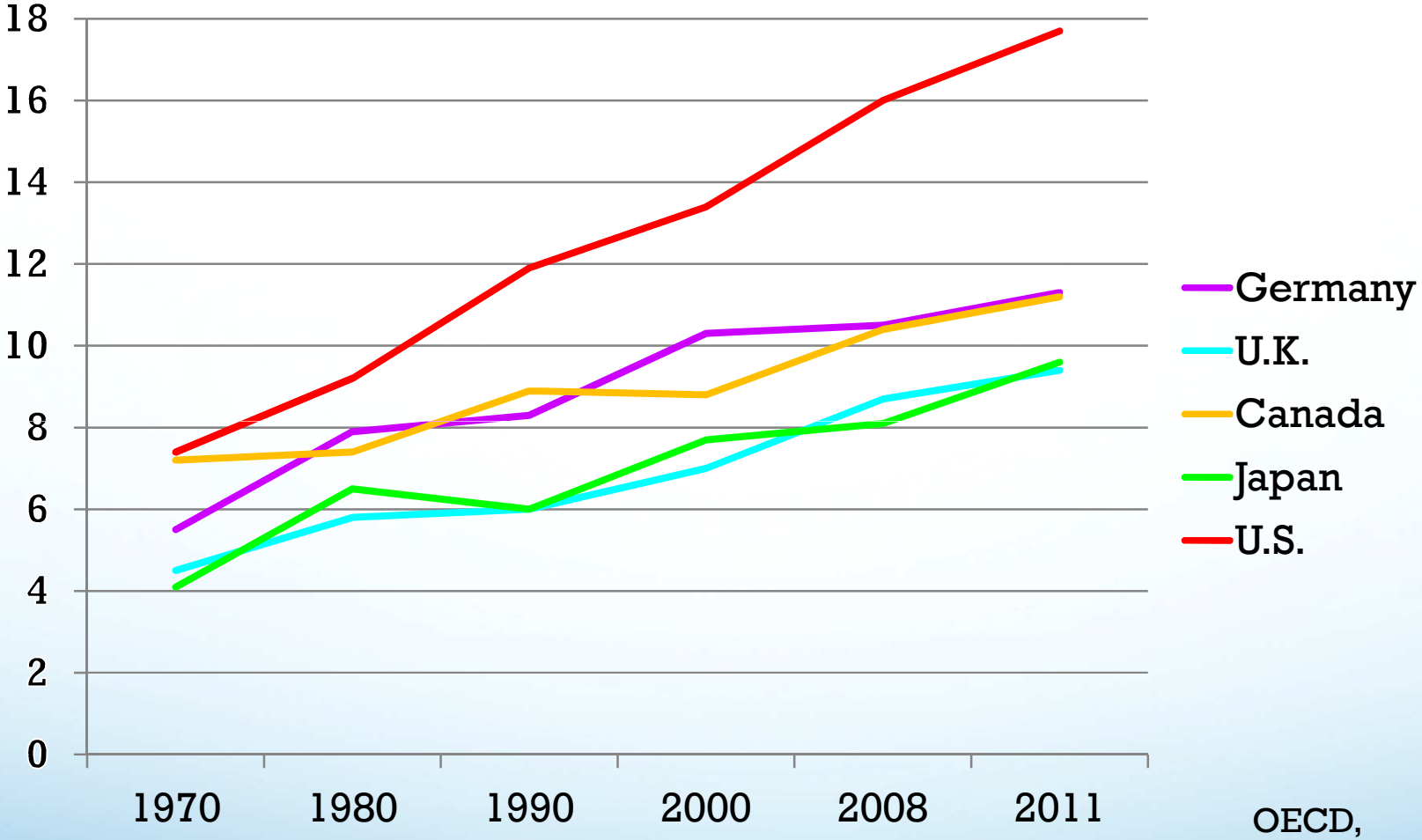
Thunder Bay Regional Health Sciences Centre

healthy together

Objectives

1. To describe the reasons that physicians may order tests that don't add value or may harm patients
2. To describe the Choosing Wisely Canada campaign
3. To share specific strategies to implement Choosing Wisely in practice and medical education

Total Health Expenditures as Percentage of Gross Domestic Product (1970-2011)



OECD, 2013

Physicians Determine Care

Which patients are seen and how frequently

Which patients are hospitalized

Which tests, procedures and surgical operations are administered

Which technologies are used

Which medications are prescribed

Emanuel EJ. *JAMA*. 2013.

I've always done this

The patient wants it

$$

New tests are good

I don't want to get sued

Referring doctor wants it

Better to do something than nothing

Choosing Wisely Canada (CWC) is a campaign to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures, and to help physicians and patients make smart and effective choices to ensure high-quality care.

Facts

- Choosing Wisely® campaign began in 2012 in US; 70 medical societies are participating
- Choosing Wisely Canada launched in April 2014
- More than 45 national specialty societies engaged

Campaign Approach

Physicians	• Societies develop lists • Disseminate through multiple channels
Patients	• Develop patient materials • Disseminate broadly through multiple channels
Media	• Coordinated approach toward media • Multiple voices, a common message
Stakeholders	• Work through health care stakeholder organizations to implement and support adoption

Choosing Wisely Canada
In partnership with the Canadian Medical Association

Canadian Association of Pathologists

CSIM
Canadian Society of Internal Medicine

Choosing Wisely Canada is a campaign to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures, and to help physicians and patients make smart and effective choices to ensure high-quality care.

For more information on Choosing Wisely Canada or to see other patient materials, visit www.choosingwiselycanada.org.
Join the conversation on Twitter @ChooseWiselyCA

Lab tests before surgery

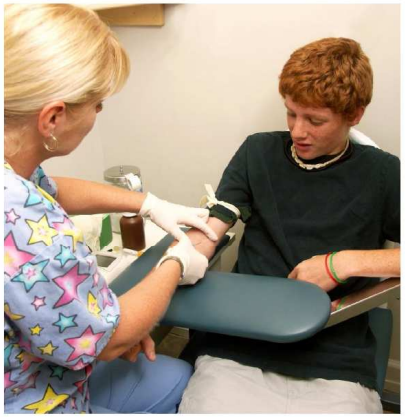
When you need them—and when you don't

If you're going to have surgery, you may have blood and urine tests first. These tests may be helpful if you have certain health conditions or diseases. For example, if you have a blood-clotting problem, a test can show if you're at risk of too much bleeding during surgery.

But most healthy people don't need the tests, especially before low-risk surgery. Here's why:

The tests usually aren't helpful for low-risk surgery.
Many healthy people have routine lab tests before surgery. In these cases, test results rarely change their surgeon's decision to operate or make surgery safer.

The tests are especially unnecessary before low-risk surgery—such as eye, hernia, or skin surgery, or a breast biopsy. In these and many other surgeries, the risk of complications is very low.



The lab tests can lead to more tests.
Blood and urine tests are very safe, but they can cause false alarms. This can lead to anxiety and more tests. And it can needlessly delay your surgery. For example, one test may be followed up with a repeat test, an ultrasound, a biopsy, or a test that exposes you to radiation, such as an X-ray or CT scan.

When are the lab tests a good idea?
If you have certain health conditions or diseases, or your medical history shows the need, the tests may give your doctor helpful information. For example:

- If you bruise easily, use a blood-thinning medicine, had bleeding problems in an earlier surgery or dental procedure, or have a family history of bleeding problems, you may need a blood test to find out if your blood clots normally.
- If you have a disease such as diabetes, you will probably need to have a test to make sure it is under control.
- Women of childbearing age may need a pregnancy test.

You may also need the tests before a major operation such as heart, lung, or brain surgery. Based on the test results, your doctor may watch your condition more closely during or after your surgery. You may need to delay the surgery until a problem is under control. Or your doctor may change the procedures and anesthesia.

How should you prepare for surgery?

Your doctor or the hospital's pre-surgery team will examine you and review your medical history.

- If they order any tests, ask why.
- Ask your doctor to check your test records for the past four to six months. Usually you don't need to repeat a recent test if your condition hasn't changed.
- Bring a list of the names and doses for all your supplements, medicines, and vitamins.
- Report any new symptoms—even if they occur after your exam.

These steps can help make your surgery safer:

Quit smoking, at least for the surgery. It is important not to smoke on the day of your surgery. The sooner you quit, the lower your risk of complications. If you need help quitting, ask your doctor.

Ask about banking your own blood. You can have some of your blood drawn and stored before surgery. That way, if you need a blood transfusion, you will get your own blood. This reduces the risk of infection or a bad reaction.

Ask about pain relief. Ask your doctor if you should stop aspirin or other blood thinners. You may want to use acetaminophen (Tylenol and generic) for pain relief. Avoid ibuprofen (Advil, Motrin IB, and generic) and naproxen sodium (Aleve and generic) because they can cause bleeding.

Ask for help. Ask someone to drive you to and from the hospital and stay overnight with you. You may want to ask someone to be with you at your doctor's appointments, particularly in stressful situations, to be sure all instructions and information is retained. Ask about nursing or rehab care, too.

Pack a bag. Don't bring valuables, but do bring:

- Provincial health card and hospital card.
- Storage containers for dentures, contact lenses, and eyeglasses.
- A few items for comfort, such as a music player and headphones, photos, and a robe or pillow.


MORE IS
NOT
ALWAYS
BETTER
The same is true for medical tests and treatments.
Talk to your doctor about what you need, and what
you don't. To learn more, visit www.choosingwisely.ca
Choosing
Wisely
Canada


ORDEM E PROGRESSO

IMPLEMENTATION IS WHERE THE RUBBER HITS THE ROAD

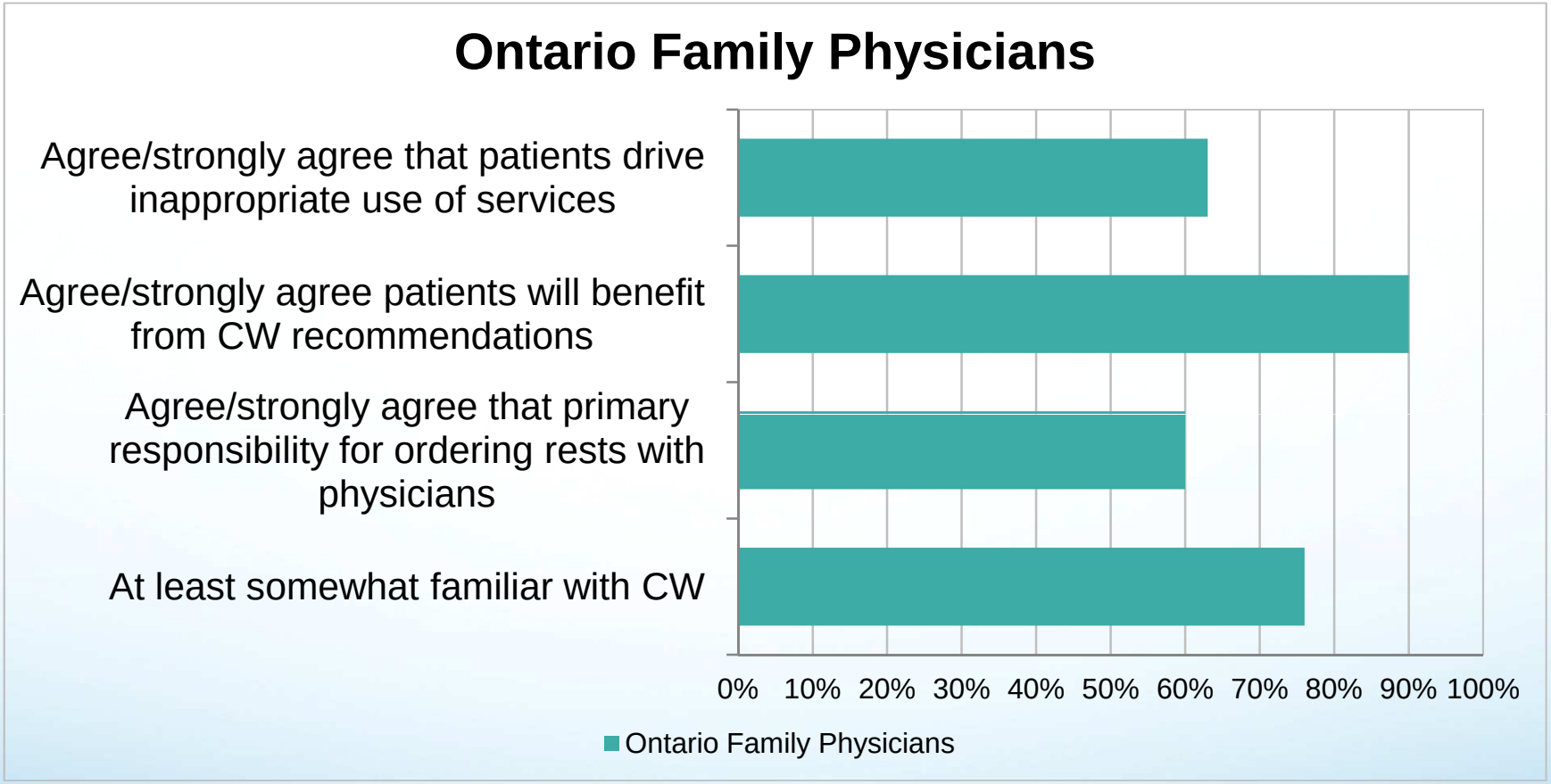
Thunder Bay Regional Health Sciences Centre - Corporate Choosing Wisely Initiatives

- Review of order sets, preprinted direct orders
- Pre-operative lab orders
- Routine pre-operative visits
- Review of preference cards
- Lose the Tube – appropriate use of catheters in hospital
- Inpatient echocardiograms
- Daily bloodwork orders
- Individual physician ordering in ED – CTs and MRIs

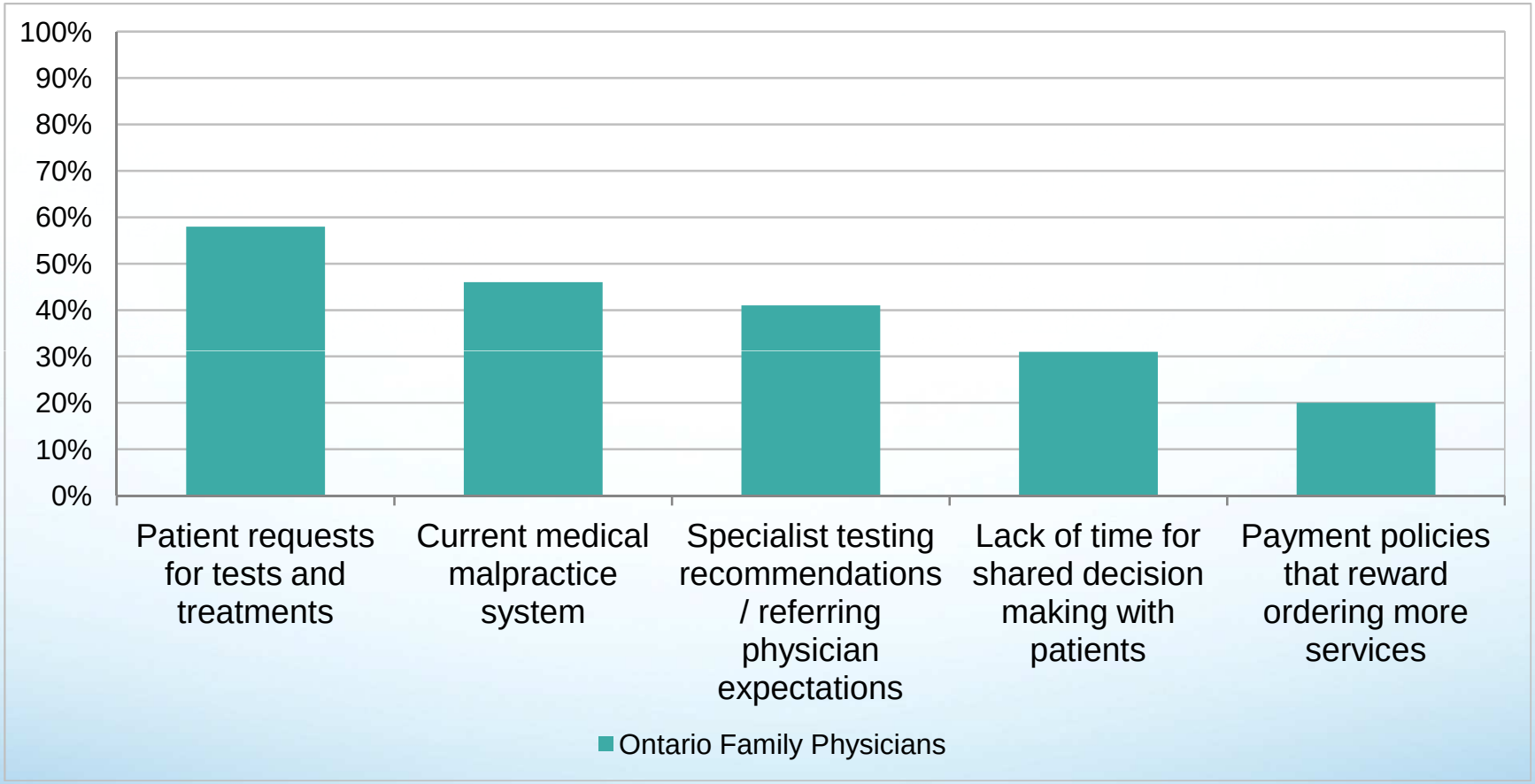
The Implementation Spectrum

ENGAGEMENT & EDUCATION	QUALITY IMPROVEMENT	HARD CODING
o Leadership engagement o Physician education o Patient education	o QI projects o Measurement o Audit and feedback	o Policy changes o EMR/CPOE integration o Order set changes

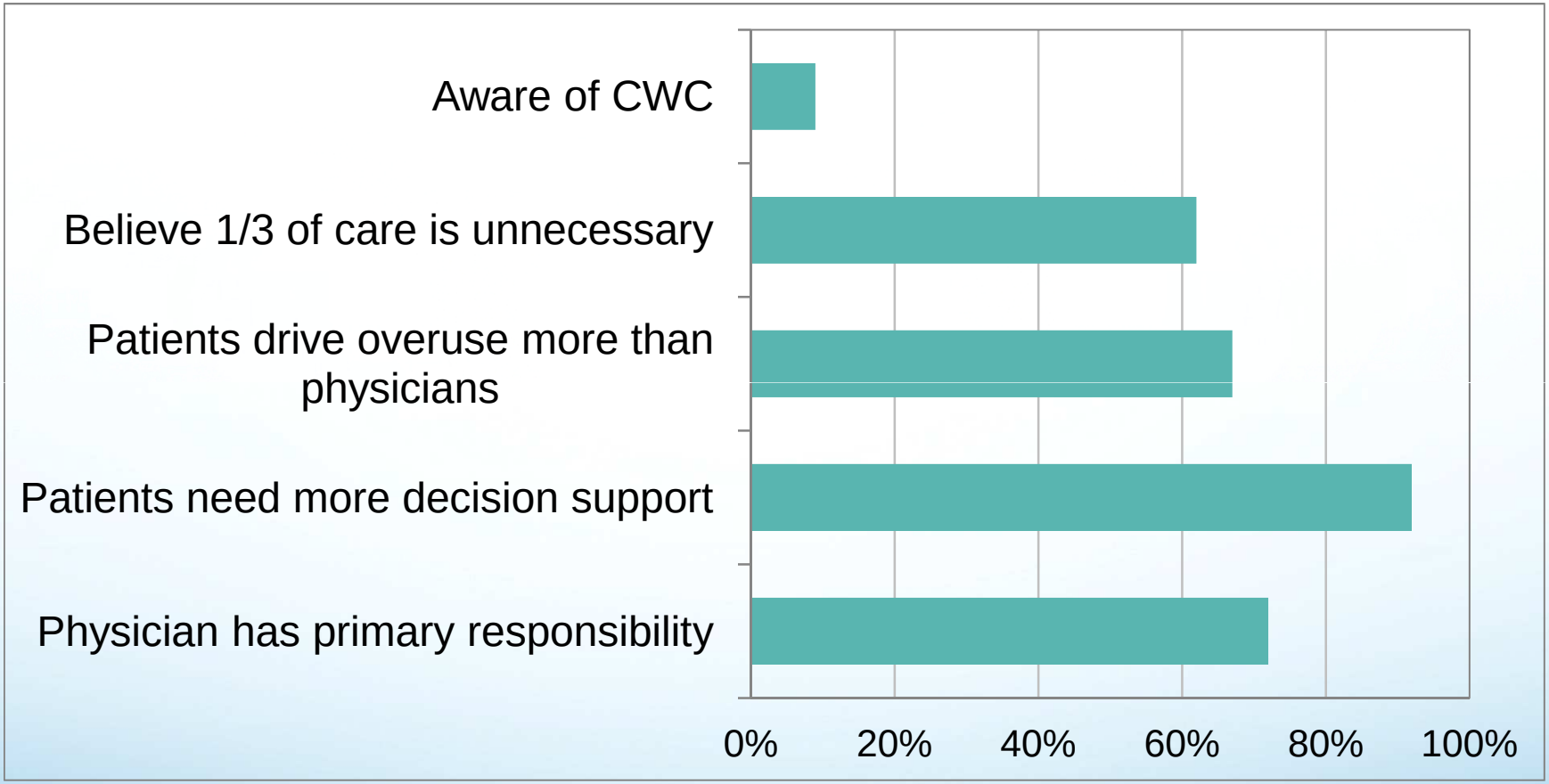
Physician Attitudes & Awareness



Major Barriers to Implementation



Patient Attitudes & Awareness



Ipsos Reid (2015). Awareness and Attitudes towards Choosing Wisely Campaign.

Potential Barriers for Success at Thunder Bay Regional Health Sciences Centre

- Lack of Buy-in from Physicians
- Medical Legal Medicine
- Lack of Computerized Provider Order Entry (CPOE)

Tools to Enhance Successful Implementation

- Medical Leadership Accountability
- Journey Towards CPOE

Questions?

Fracture Clinic Performance Review

Presentation to the Board of Directors

Dr. Mark Thibert, Chief of Surgery

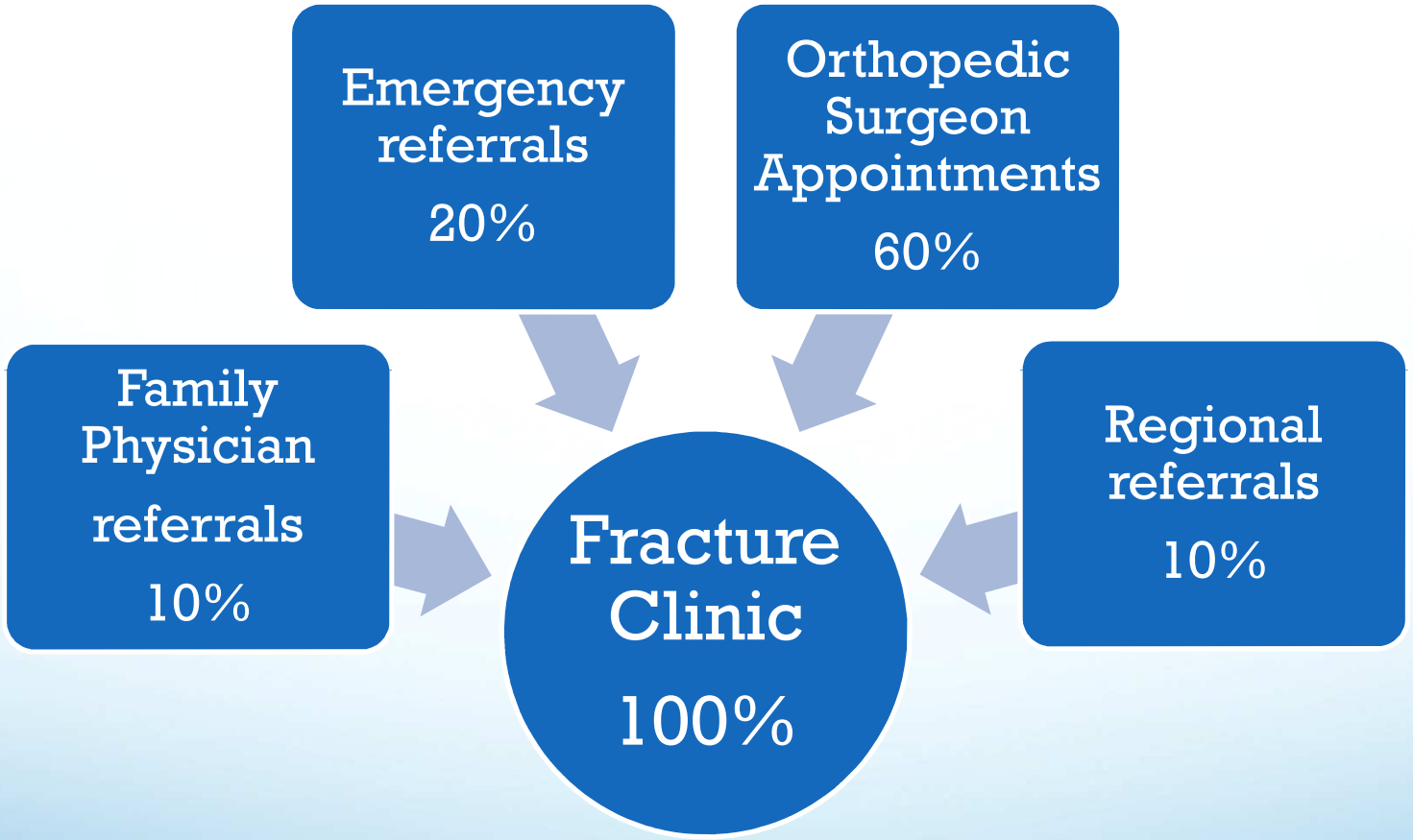
Dr. Rhonda Crocker Ellacott
Executive Vice President, Patient Services & CNE

October 5, 2016

Fracture Clinic Overview

- **Initial TBRHSC Functional Planning accounted for:**
  - 15,000 Fracture Clinic visits annually
  - 30 patients per Clinic/Surgeon, scheduled 4 patients an hour in a 7.5 hour day
- **The Fracture Clinic operates 5 days a week, with two Orthopedic Surgeons working simultaneously**
- **In general terms, the Fracture Clinic manages ~ 86 appointments every day (~43 patients per Surgeon)**
- **In 2015/16, there were 21,477 patient visits**
- **In 2015/16, total length of stay 108 minutes (90th percentile)**
- **Local & Regional Patients are seen for:**
  - acute care and follow up treatment of fractures and dislocation
  - post operative review, follow-up until 1 year post surgery
  - cast applications and changes
  - orthopedic wound checks
  - suture and staple removal
  - cortisone/steroid injections

Pathway: Who is arriving at Fracture Clinic?



Fracture Clinic Quality Improvement Overview

- **Quality Improvements in Fracture Clinic have been ongoing with small changes over time**
- **Quality Improvement Goal: To achieve a patient's total length of stay under 70 minutes (90th percentile)**
- **New Quality Improvement Plan initiated on June 9, 2016 to address increasing Regional Consultation Requests and Wait Time Challenges**
- **Engaged a comprehensive Quality Improvement Team**
  - Chief of Staff
  - Director of Surgery
  - Medical Director of Surgery
  - Chief of Surgery
  - Orthopaedic Surgeons (4)
  - Manager of Fracture Clinic
  - Patient Family Advisors (3)
  - Director and Manager of Diagnostic Imaging
  - Front line Fracture Clinic staff (5)
  - Strategy and Performance Consultant

Fracture Clinic Quality Improvement Overview

- **Quality improvement solutions**
  - Decrease number of patients booked per day to meet booking time goal (unless physician is meeting total length of stay target)
  - Create 6 emergency capacity slots to accommodate emergent or urgent referrals
  - Spread booking times from 0800 to 1430 hours versus double booking and early booking
  - Telemedicine appointments available from 1430 to 1600 hours versus throughout the day
  - No patients to be booked at the same time (except for 3 appointments at 0800 hours)
  - Physician start time at 0800 hours
  - Improved tracking time methodology
  - Posting patient total length of stay time by physician dictation number, in the Fracture Clinic physician office
  - Physician to write patient discharge time on Fracture Clinic chart to enhance reliable data collection
- **Quality Improvement Plan implemented on August 20, 2016**

Commitment to Length of Stay

- **Set Length of Stay Target**
  - Total length of stay target of 70 minutes (90th percentile)

- **Results: August 20, 2016 to September 20, 2016**
  - Total length of stay is 54 minutes (90th percentile) and 1,314 patients were seen during this time period
  - Patient satisfaction rate 92% positive responses and 8% negative responses
    - Comments include: "**Great service", "Quick appointment wait", "Getting better!!", "Much improved from last visit!" (n=146)**
  - Prior to September 2015, patient tracking methods and wait time reporting captured only 19.95% of patients. From August 20, 2016 to September 20, 2016, wait time was captured on 69% of patients.

August 20, 2016 to September 20, 2016	August 20, 2015 to September 20, 2015
54 minutes 90th % percentile 69% of patients total length of stay captured	102.79 minutes 90th % percentile 33.9% of patients total length of stay captured

Next Steps

- Adherence and continued monitoring to 70 minute total length of stay target
- Continued efforts to improve patient experience and length of stay
- Integration with Regional Orthopedic Program
- Efforts to continue to streamline pathways
- Engagement of staff, physicians, patients, providers

Commitment to Continue

- **What is your experience ?**
  - *Comments from community*
- **Goal: Maintain wait times at 70 minutes or better (90th%)**
  - *Support for the goal …*
- ***Gaps in Expectation ?***
  - *Meeting the need, respecting patient appointment times, improving wait times, and creating better experiences …*

Thunder Bay Regional Health Sciences Centre

Board of Directors - *Open*

Wednesday, June 8, 2016

Boardroom – 5:00 p.m.

Action

***Present*:**

Nadine Doucette, (*Chair*)	Dr. Gordon Porter*	Dick Mannisto
Jean Bartkowiak*	Doug Shanks	Grant Walsh
Gary Whitney	Gerry Munt	Dr. Mark Thibert*
Dr. Rhonda Crocker Ellacott*	Georjann Morriseau	Anita Jean
Dr. Penny Moody-Corbett		

By Invitation – Senior Leadership:

Peter Myllymaa	Dr. Stewart Kennedy	Glenn Craig
Anne-Marie Heron	Dr. Mark Henderson	Amy Carr

By Invitation:

Jessica Nehrebecky, *Rec. Sec.*	Dr. Andrew Turner	Shameema Warsallee
Amanda Bjorn		

Regrets Board of Directors:

John Friday

1.0 CALL TO ORDER – The Chair called the meeting to order at 5:00 p.m.

The Chair welcomed Board members, Senior Leadership, guests, and the webcast audience. Dr. Gordon Porter was welcomed as the new Chief of Staff and Dr. Andrew Turner was thanked for filling in that role in the interim. Ms. Amy Carr was thanked for her role as Acting Senior Director, Human Resources. Ms. Carr will continue in this role until August 1, 2016.

The President and CEO introduced and welcomed Ms. Amanda Bjorn, Vice President, Human Resources, effective August 2, 2016.

2.0 PATIENT STORY

Dr. Stewart Kennedy, Executive Vice President, Medical and Academic Affairs, shared a patient story.

3.1 Quorum – Quorum was attained.

3.2 Conflict of Interest - None.

3.3 Approval of the Agenda

Moved by:	*Doug Shanks*	*Motion*
Seconded by:	*Georjann Morriseau*	

"That the Agenda be approved, as circulated."

CARRIED

3.4 Chair's Remarks - For Information.

On June 8, 2016, Ms. Nadine Doucette, Mr. Grant Walsh, Mr. Doug Shanks and Ms. Shameema Warsallee participated in the Governance Centre of Excellence (GCE)'s webcast "Medical Assistance in Dying: The Role of the Board".

After the information session, members felt reassured that the Hospital is on the right track and will be prepared once the legislation is enacted. It was noted that the University of Toronto, Centre for Bioethics, is developing various policies and toolkits that can be used and adopted by the Hospital for its use.

4.0 PRESENTATIONS

4.1 Physician Staffing in the Region

Dr. Stewart Kennedy provided an overview of physician human resources in Ontario and the impact at the Hospital. The following was highlighted:

- The total number of physicians in Ontario continues to grow annually. The net addition in Ontario from 2014 to 2015 was almost 1,000;
- In the past, there was on average one physician for every 700 patients whereas the ratio is now 1 to every 450 patients;
- Funding in Northwestern Ontario is an issue as the population has decreased and part of the funding allocation is based on the number of patients;
- 90% of students who complete their medical school and post graduate training in the North, remain in the North.

Dr. Gary Polonsky was welcomed to the meeting.

4.2 Thunder Bay Regional Research Institute Update

Dr. Gary Polonsky, Board Chair, and Mr. Jean Bartkowiak, CEO, Thunder Bay Regional Research Institute (the Institute) provided an update on the Institute.

The Institute's draft 2020 Strategic Plan was presented, speaking to the Vision, Mission and Values, as well as the three Strategic Directions and goals within each. Ms. Carolyn Freitag, Director, Strategy and Performance Improvement, was thanked for her work on the Plan.

There was brief discussion regarding the partnership and governance model between the Hospital and the Institute. More discussion and research on best practices will occur prior to any decisions been made.

Dr. Naana Juma, Clinical Researcher, will be invited to speak about her research at an upcoming Board meeting. ***Action***

Dr. Polonsky was excused from the meeting.

5.0 CONSENT AGENDA ***Motion***

Moved by: ***Doug Shanks***
Seconded by: ***Dick Mannisto***

"That the Board of Directors:
5.1 Approves the Board of Directors Minutes of May 4, 2016;
5.2.1 Approves the Broader Public Sector Travel and Expense Report, for the period October 1, 2015 to March 31, 2016, upon recommendation from the Resource Planning Committee;
5.2.2 Approves the Broader Public Sector Accountability Act Attestation Certificate, for the period April 1, 2015 to March 31, 2016, in accordance with Section 15 of the Broader Public Sector Accountability Act (BPSAA), 2010, confirming that the Hospital attests to:

- ***(i) the completion and accuracy of reports required of the Hospital pursuant to section 6 of the BPSAA on the use of consultants;***
- ***(ii) the Hospital's compliance with the prohibition in section 4 of the BPSAA on engaging lobbyist services using public funds;***
- ***(iii) the Hospital's compliance with any applicable expense claims directives issued under section 10 of the BPSAA by the Management Board of Cabinet;***
- ***(iv) the Hospital's compliance with any applicable perquisite directives issued under section 11.1 of the BPSAA by the Management Board of Cabinet;***
- ***(v) the Hospital's compliance with any applicable procurement and directives issued under section 12 of the BPSAA by the Management Board of Cabinet,***

upon recommendation from the Resource Planning Committee;

5.2.3 Approves the Hospital Service Accountability Agreement (the Agreement) Declaration of Compliance for the period of April 1, 2015 to March 31, 2016 confirming that the Hospital has complied with the following:

- *(i) the Hospital has complied with the provisions of the Local Health System Integration Act, 2006 and the BPSAA that apply to the Hospital;*
- *(ii) the Hospital has complied with its obligations in respect of CritiCall that are set out in the Agreement;*
- *(iii) every Report submitted by the Hospital is complete, accurate in all respects and in full compliance with the terms of the Agreement; and;*
- *(iv) the representations, warranties and covenants made by the Board on behalf of the Hospital in the Agreement remain in full force and effect,*

upon recommendation from the Resource Planning Committee;

5.2.4 Approves the Multi Sector Service Accountability Agreement (M-SAA) Declaration of Compliance for the period of April 1, 2015 to March 31, 2016 confirming that the Hospital has complied with the following:

- *(i) Article 4.8 of the M-SAA concerning applicable procurement practices;*
- *(ii) The Local Health System Integration Act, 2006; and*
- *(iii) The Public Sector Compensation Restraint to Protect Services Act, 2010;*
- *(iv) The following specific performance requirements as outlined in Schedule E4 of the 2014-2017 M-SAA:*
  - *a. "Home First" Philosophy;*
  - *b. Diversity Planning requirement;*
  - *c. Behavioural Supports Ontario Action Plan;*
  - *d. Emergency Preparedness Plans;*
  - *e. E-Health requirement;*
  - *f. Information Technology requirement;*
  - *g. Health Services Blueprint — Community Engagement;*

upon recommendation from the Resource Planning Committee;

5.3 Accepts the Governance Committee Minutes of May 18, 2016;

5.3.1 Approves the 2016-2017 workplans for the Audit Committee, Fiscal Advisory Committee, Resource Planning Committee, Governance/Nominating Committee and Quality Committee, as recommended by the Governance Committee;

5.3.2 Approves the terms of reference for the Audit Committee, Fiscal Advisory Committee, Resource Planning Committee, and Board/Privileged Staff Committee, upon recommendation from the Governance Committee ;

5.3.3a Approves changes to Policy BD-81 Roles and Responsibilities of the Board, upon recommendation from the Governance Committee;

5.3.3b Approves changes to Policy BD-45 Selection Criteria for Board and Community Members, upon recommendation from the Governance Committee;

5.3.3c Approves changes to Policy BD-25 Education and Development, upon recommendation from the Governance Committee;

5.3.3d Approves changes to Policy BD-55 CEO Succession Planning, upon recommendation from the Governance Committee;
5.3.3e Approves the Policy Criminal Record Checks for Board of Directors Policy, upon recommendation from the Governance Committee;
5.3.4 Approves the amendment to the 2020 Strategic Plan Values statement, upon recommendation from the Governance Committee;
5.3.5 Accepts amendments to the Framework for Ethical Decision Making, upon recommendation from the Governance Committee;
5.3.6 Approves the proposed changes to the Thunder Bay Regional Health Sciences Centre Corporate By-Laws to be confirmed at the Annual Meeting of the Corporation, upon recommendation from the Governance Committee,
5.4 Accepts the Accreditation Sub Committee Minutes of May 4, 2016;
5.5 Accepts the Accreditation Sub Committee Minutes of May 17, 2016,

as presented."

CARRIED

Ms. Bjorn was excused from the meeting.

6.0 REPORTS AND DISCUSSION

6.1 Report from Senior Leadership

The following information was highlighted from the report:

- The Hospital hosted Health Quality Ontario (HQO) Patient Advisor Council and provided an education session on how the Hospital has become a leader in patient and family engagement;
- The Hospital received a total of 38 orders during the April 11-15, 2016 Annual Ministry of Labour inspection visit and all orders have been complied with;
- The Hospital has no outstanding orders under the Fire Code (as overseen by the Fire Department) or Environmental Protection Act (as overseen by the Ministry of Environment) and is not aware of any non-compliances in regard to the requirements of these legislations;
- One-time funding in the amount of $5.2M has been allocated by the North West Local Health Integration Network (NW LHIN); as a consequence, the Hospital closed the 2015-16 fiscal year with a deficit of $727,819;
- As part of the benchmarking exercise, the Hospital has been identified as being efficient and is receiving calls from various partners to provide efficiency advice;
- The Ontario Breast Screening Program Coach is expected to be repaired and fully operational by mid July, 2016.

6.1.1 **Environmental Compliance and Fire Safety Update** – For information

6.2 **Report from the President and CEO**

The President and CEO highlighted the following:

- As of May 13, 2016, the Hospital has been out of surge capacity. The President and CEO commended all Staff, Privileged Staff and system partners for their continued efforts. The NW LHIN was also thanked for their commitment to maintaining finding support of the Bethammi Nursing Home.
- The Hospital has been selected as a Smoke-Free Champion Award recipient by the Associate Ministry of Health and Long-Term Care of Ontario due to the ongoing support of the legislation. All staff involved in the initiative was congratulated.

Dr. Mark Henderson was excused from the meeting.

6.2.1 **Board Meeting Frequency**

The President and CEO is currently doing a thorough By-Law revisions; he recommends an amenment to reduce the obligation of the Board to meet eight times a year instead of ten, removing the September and January meetings from the regular schedule. It was noted that the Board could meet more than eight times should there be business to be addressed.

Members agreed to the amendment proposal and revised schedule.

6.3 **Report from the Foundation**

The President and CEO, Thunder Bay Regional Health Sciences Foundation (the Foundation) highlighted that a new fundraiser, with the Stall Brothers and a road hockey game has raised over $30k.

6.4 **Report from the Professional Staff Association**

The President of the Professional Staff Association (the Association) highlighted the following:

- The Association met on June 7, 2016;
- Progress on the Choosing Wisely initiative was presented.

6.5 **Report from the Chief of Staff**

The Chief of Staff highlighted the following:

- Dr. Andrew Turner, Acting Chief of Staff was thanked for his work during the interim period;
- A new virtual fracture clinical for remote patients has been successfully implemented.

6.6 Report from the Chief Nursing Executive

The Chief Nursing Executive highlighted the following:

- The Registered Nurses Association of Ontario renewed the Best Practice Spotlight Organization (BPSO) designation for the Hospital and awarded continued BPSO status for 2016 to 2018. Members of the nursing staff were commended by the Board, for achieving this status.

6.7 Report from the Northern Ontario School of Medicine - For information

Moved by:	***Anita Jean***	***Motion***
Seconded by:	***Gerry Munt***	

"That the Board of Directors:
6.1 Accepts the Report from Senior Leadership;
6.2 Accepts the Report from the President and CEO;
6.3 Accepts the Report from the TBRHS Foundation;
6.4 Accepts the Report from the Professional Staff Association;
6.5 Accepts the Report from the Chief of Staff;
6.6 Accepts the Report from the Chief Nursing Executive;
6.7 Receives the Report from the Northern Ontario School of Medicine;

dated June 2016, as presented."

CARRIED

7.0 COMMITTEE MATTERS - None

8.0 FOR INFORMATION

8.1 Board Comprehensive Work Plan - For information

8.2 Webcast Statistics - For information

8.3 Report Thunder Bay Regional Research Institute - For information

8.4 **Quarterly Performance Results (Scorecard)** - For information

8.5 **Strategic Indicators Summary Views** - For information

8.6 **Research Ethics Board Annual Report** - For information

8.7 **Critical Incidents Update** – For information

9.0 BOARD MEMBERS COMMENTS

Board members thanked the staff for their continued support and work.

10.0 DATE OF NEXT MEETING – TBD

11.0 ADJOURNMENT - The meeting adjourned at 6:44 p.m.

_____ _____

Chair Board Secretary

_____

Recording Secretary

BRIEFING NOTE

Thunder Bay Regional Health Sciences Centre

TOPIC	Clinical Trials Ontario – Thunder Bay as a Recruitment Site
PREPARED BY	Anne-Marie Heron, Acting VP Research
APPROVED BY	
PREPARED FOR: President &CEO☐Board of Directors☐ Other: Senior Leadership Council	
DATE PREPARED	June 17, 2016

PURPOSE/ISSUE(S)

To be aware of an agreement to be put in place to leverage opportunity for greater interaction with Clinical Trials Ontario.

BACKGROUND

TBRRI/TBRHSC recognizes the importance of clinical trials in providing the best opportunities for patients to receive state-of-art and leading edge care and treatment. Clinical Trials Ontario (CTO) is leading the movement for a single ethics review for multi-centre clinical research in Ontario, which is all part of enhancing the climate for clinical research in Ontario.

TBRRI/TBRHSC has been provided with the opportunity to become a site in multi-centre clinical trial research in Ontario.

A summary of options has been developed by TBRHSC and is attached as Appendix 1.

ANALYSIS/CURRENT STATUS

The Research Institute's Executive Management Council recently endorsed signing a participation agreement with CTO – to join as an accruing site only at this time. The TBRHSC REB is not at the point where they'd like to pursue becoming certified by CTO.

RECOMMENDATION

Endorse proceeding with signing an agreement with CTO to become an accruing site.

NEXT STEPS

The Institute and the Clinical Research Services Department will be working on these next steps over the next 6 months:

- Sign an agreement with CTO following their assessment/review;
- Adapt the TBRRI/TBRHSC Research Program Authorization processes to account for projects receiving REB approval through a CTO-qualified REB; and
- Develop a process to communicate between the CTO-qualified REB and the TBRHSC Board of Directors.

STAKEHOLDER REACTION

TOPIC	Clinical Trials Ontario – Thunder Bay as a Recruitment Site
PREPARED BY	Anne-Marie Heron, Acting VP Research
APPROVED BY	

PREPARED FOR: President &CEO☐Board of Directors☐ Other: Senior Leadership Council

As this decision will enhance the opportunity for patients in Thunder Bay to be recruited into new clinical trials, no negative reaction is anticipated.

COMMUNICATIONS

None at this time.

FINANCIAL IMPACTS

No additional costs involved.

APPENDIX SECTION

See attached.

TBRHSC is committed to ensuring decisions and practices are ethically responsible and align with our mission/vision/values. All leaders should consider decisions from an ethics perspective including their implications on patients, staff and the community. The following questions should be considered for each decision.

1. Does the course of action put '**Patients First'** by responding respectfully to needs & values of our patients, families, and communities?
2. Does the course of action demonstrate '**Accountability**' by advancing a quality patient experience that is socially and fiscally accountable?
3. Does the course of action demonstrate '**Respect**' by honouring the uniqueness of each individual and his/her culture?
4. Does the course of action demonstrate '**Excellence**' by fostering an environment of innovation and learning to advance a quality patient experience?

For more detailed questions to use on difficult decisions, please refer to TBRHSC's Framework for Ethical Decision Making

For more detailed questions to use on difficult decisions, please refer to TBRHSC's Framework for Ethical Decision Making on the iNtranet under **Quality and Risk Management > Quality > ECFAA (Excellent Care for All Act) > Presentations.**

Thunder Bay Regional
Health Sciences
Centre

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Thunder Bay ON
P7B 6V4 Canada

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ATTESTATION

TO: The Board of Thunder Bay Regional Health Sciences Centre, (the "Board")

FROM: Jean Bartkowiak, MHSc, CHE
President and Chief Executive Officer

DATE: September 20, 2016

RE: **Q1 2015-16** Wages and Source Deductions for Fiscal Year Beginning April 1, 2016 and ending March 31, 2017 (the "Applicable Period")

On behalf of the Thunder Bay Regional Health Sciences Centre (the "Hospital") I attest that:

- all wages owing to employees have been recorded, processed, accrued and/or paid accordingly as per established payroll cycle and other scheduled payouts;
- all source deductions relating to the employees, which the Corporation is required to deduct and remit, pursuant to all applicable legislation, including without limitation, the Income Tax Act (Canada), the Canada Pension Plan (Canada), the Unemployment Insurance Act (Canada), and Employer Health Tax Act (Ontario), have been made and remitted to the proper authorities within established timelines;
- all taxes collected pursuant to the Harmonized Sales Tax have been collected, claims filed and/or remitted as required to the proper authorities;
- the Corporations Information Act Annual Return required of Registered Charities under the Income Tax Act (Canada) has been filed;
- that the systems in place, as established by the Board, for the preparation and submission to the Board of compliance certificates, confirming that wages, source deductions and other taxes have been accomplished, are in place, are functional, adequate and monitored

during the Applicable Period.

In making this attestation, I have exercised care and diligence that would reasonably be expected of a President and CEO in these circumstances, including making due inquiries of Hospital staff that have knowledge of these matters.

Dated at Thunder Bay, Ontario this 29 day of September, 2016.

Jean Bartkowiak, MHSc, CHE
President and Chief Executive Officer
Thunder Bay Regional Health Sciences Centre
Chief Executive Officer
Thunder Bay Regional Research Institute

BRIEFING NOTE

Thunder Bay Regional Health Sciences Centre

TOPIC	Investment Policy BD-16
PREPARED BY	Peter Myllymaa
APPROVED BY	Jean Bartkowiak
PREPARED FOR: President & CEO ☐ Board of Directors ☒ Other	
DATE PREPARED	September 12, 2016

PURPOSE/ISSUE(S)

To recommend a change in the investment guidelines for Operating Funds.

BACKGROUND

Investment Policy BD-16 is reviewed on an annual basis, and revised as necessary.

ANALYSIS/CURRENT STATUS

In section III of the current policy, the guidelines for the investment of operating funds has the following limits:

	Minimum	Maximum
Cash, Cash Equivalents & Short Term Fund	10%	100%
Bonds	0%	90%
Investment Grade Preferred Shares	0%	25%
Marketable Securities/Equity Funds	0%	25%

The hospital portfolio has returned 4.88% per year over the last 3 years, and 4.49% per year over the last 5 years (up to and including August 31, 2016). For the same periods, the equity portfolio returned 11.37% and 11.73%.

When the current guidelines were established:

- Interest rates were significantly higher than they are presently;
- The hospital had no prior experience with equity investments;
- TBRHSC was engaged in a major capital project for which funding had not been completely secured.

Current investment environment:

- Interest rates are at historic lows and are not likely to rise materially in Canada for the foreseeable future;
- Central bank monetary policy is likely to allow inflation to trend higher than the current level;
- The Hospital has been an equity investor for 15 years with positive outcomes;
- An investment portfolio could have up to 65-70% equity exposure and still be regarded as "balanced".

"Prudent" investor considerations:

- General economic conditions;
- The possible effects of inflation or deflation;
- The role each investment or course of action plays within the portfolio;
- The expected total return from income and growth of capital.
- Needs for liquidity, regularity of income and preservation or appreciation of capital

TOPIC	Investment Policy BD-16
PREPARED BY	Peter Myllymaa
APPROVED BY	Jean Bartkowiak

PREPARED FOR: President & CEO ☐ Board of Directors ☒ Other

Current legislative requirements have been reviewed, and discussions with the LHIN have determined that there are no known legislative restrictions which would impact the Hospital policy. Specific legislation, acts, regulations and directives reviewed include:

- BOND Policy;
- BPSAA (Broader Public Sector Accountability Act);
- CFMA (Commitment to the Future of Medicare Act);
- CFP, 2015 (Community Financial Policy);
- ECFAA (Excellent Care For All Act);
- FAA (Financial Administration Act);
- FTAA (Fiscal Transparency Accountability Act);
- HCIIA (Hospitals & Charitable Institutions Inquiries Act);
- H-SAA (Hospital Service Accountability Agreement;
- IOA (Investing in Ontario Act);
- LHSIA (Local Health System Integration Act);
- MBCA (Management Board of Cabinet Act);
- MOHLTCA (Ministry of Health and Long-term Care Act);
- MRA (Ministry of Revenue Act);
- PHA (Public Hospitals Act);
- TPAD (Transfer Payment Accountability Directive).

RECOMMENDATION

That the maximum limit for Investment Grade Preferred Shares and for Marketable Securities/Equity Funds be increased from 25% to 35%.

NEXT STEPS

Rebalance investment portfolio.

STAKEHOLDER REACTION

COMMUNICATIONS

FINANCIAL IMPACTS

Potential for increased return on invested funds.

APPENDIX SECTION

Policy BD-16

TBRHSC is committed to ensuring decisions and practices are ethically responsible and align with our mission/vision/values. All leaders should consider decisions from an ethics perspective including their implications on patients, staff and the community.
The following questions should be considered for each decision.

1. Does the course of action put '**Patients First'** by responding respectfully to needs & values of our patients, families, and communities?
2. Does the course of action demonstrate '**Accountability**' by advancing a quality patient experience that is socially and fiscally accountable?
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Thunder Bay Regional Health Sciences Centre

Policies, Procedures, Standard Operating Practices

No. BD-16

Title: Investment Policy	**X Policy** ☐ **Procedure** ☐ **SOP**
Category: Board of Directors **Dept/Prog/Service:** Board of Directors	**Distribution:** Corporate Services, Financial Services
Approved: Board of Directors, President & CEO **Signature**:	**Approval Date:** Feb 3, 2016 **Reviewed/Revised Date:** Nov. 18, 2015 **Next Review Date:** Nov. 2016

CROSS REFERENCES: *if applicable*

PURPOSE

To establish and formulate investment principles and guidelines appropriate to the objectives of TBRHSC.

POLICY

The Board of Directors (the "Board") of Thunder Bay Regional Health Sciences Centre (TBRHSC) is responsible for the investment of the assets of the Fund and, as such, has promulgated and adopted this Statement of Investment Policies and Procedures (the "Policy") for the investment of those assets.

This document constitutes the investment policy which shall apply to the investments of TBRHSC reserve operating funds, capital funds and special purpose funds.

PROCEDURE

The CEO, on behalf of the Board of Directors, designates the Executive Vice President, Corporate Services & Operations to carry out the day to day management of the investments in accordance with this Policy. Alternatively, the Board may select an Investment Manager who will carry out the day to day management of the investments in accordance with this Policy. A mandate will be developed which will outline the objectives which the Investment Manager will be required to achieve.

As required, the Executive Vice President, Corporate Services & Operations, will obtain a minimum of two investment proposals by telephone from local financial institutions or the Investment Manager will provide comparative rates for available investment instruments. The investment transaction will be confirmed in writing by the financial institution.

The Board shall satisfy themselves that investments made by, and all other actions of the Investment Manager, are in compliance with this Policy. The performance of the investments as measured against the objectives, as set out in this Policy, will be monitored and measured against the terms of the Mandate.

The Resource Planning Committee shall review this Policy and the Mandate at least annually for its continuing applicability and, if appropriate, recommend changes to the Board. If necessary, the Policy and/or Mandate may be amended at any time by the Board. Any such changes shall be promptly communicated to the Investment Manager.

I. Fund Description

The Operating Fund's purpose is to support the daily operations of TBRHSC and preserve the value of TBRHSC's operating reserves. The Capital Fund's purpose is to provide cash flow matching capital expenditure while maximizing investment returns and preserving principal amounts. A Special Purpose Fund may be designated from time to time and incorporates aspects of both operating and capital funds.

II. Investment Objectives

1. Preservation of the Hospital's principal plus earned interest.

2. Liquidity must be sufficient to meet periodic drawdown requirements as established by Management. An aggregate cash and money market position of no less than 10% of the total market value of the portfolio should be sufficient to cover unexpected contingencies.

3. The Executive Vice President, Corporate Services will be restricted to investing operating funds in Canadian cash and fixed income funds. The maturity dates will be selected based on projected cash flow needs.

4. The Executive Vice President, Corporate Services will be restricted to investing capital funds in fixed income securities. The maturity dates will be selected based on projected cash flow needs.

5. The Investment Manager will have the authority to purchase on behalf of the Hospital fixed income securities, investment grade preferred shares, marketable securities or equity funds in accordance with the mandate set out by the Board.

6. The investment earnings objective will be to maximize the return using the instruments identified within this policy. Given market conditions a range for expected returns will be mutually established, amended as the market changes and reported to the Board.

The Investment Manager shall maintain a policy consistent with the Hospital policy overseeing the Hospital investments.

III. Guidelines

1. The categories of investment in which the Fund may be invested and the limits on each category of investment valued at book-cost are as follows:

Category	**Minimum**	**Maximum**
Operating Funds		
Cash, Cash Equivalents & Short Term Fund	10%	100%
Bonds	0%	90%
Investment Grade Preferred Shares	0%	~~25~~35%
Marketable Securities/Equity Funds	0%	~~25~~35%
Capital Funds		
Cash, Cash Equivalents and Short Term Fund	10%	100%
Bonds	0%	90%
Special Purpose Funds		
Cash, Cash Equivalents & Short Term Fund	10%	100%
Bonds	0%	90%
Investment Grade Preferred Shares	0%	40%
Marketable Securities/Equity Funds	0%	20%

2. Except as to securities issued or guaranteed by the Government of Canada or a province or municipal corporation, the maximum amount of the Fund which shall be invested in the securities of any one issuer shall not exceed 10% of the total book value of the Fund at the time the investment is made, except that for Schedule A banks.

3. The investment portfolios will be rebalanced to the target allocations as draws are made and in consideration of anticipated cash requirements and fund objectives.

4. Cash and Cash Equivalents

The Fund may be invested in the subcategories set out below:

a) debt obligations issued or guaranteed by the Government of Canada or a province thereof;

b) debt obligations issued or guaranteed by a Canadian municipal government provided that they are rated at least A-1 by the Canadian Bond Rating Service (CBRS) or R-1 by the Dominion Bond Rating Service (DBRS);

c) debt obligations and overnight investments issued or guaranteed by a corporation or bank, incorporated under the laws of Canada or a province thereof, provided that they are rated at least A-1 (CBRS) or R-1 by (DBRS) or an investment rating of BBB or above.

d) bankers acceptances of a bank listed as Schedule A according to the Bank Act (Canada) provided that they are rated at least A-1 (CBRS) or R-1 by (DBRS);

e) term deposit receipts of a bank listed as Schedule A according to the Bank Act (Canada) provided that they are rated at least A-1 (CBRS) or R-1 (DBRS);

5. Bonds

The following rules apply to the investment of the Fund in bonds:

(a) The Fund may be invested in the sub-categories set out below:

i) debt obligations issued or guaranteed by the Government of Canada or a province,

ii) debt obligation issued or guaranteed by a Canadian municipal government,

iii) debt obligations issued or guaranteed by a corporation, incorporated under the laws of Canada or a province, and shall be at investment grade or above including debentures (non-convertible.)

The Fund shall not invest in any bond unless the debt obligations of the issuer are rated at least A by CBRS or A by DBRS.

6. Preferred Shares

The following rules apply to the investment of the Fund in preferred shares:

(a) preferred shares issued or guaranteed by a corporation, incorporated under the laws of Canada or a province, and shall be at investment grade P1 to P3 or above,

(b) preferred shares whose redemptions date or reset date closely matches the funding requirements of the Fund.

7. Marketable Securities and Equity Funds

As per specific guidelines established with the Investment Manager or as approved by the Board of Directors.

Thunder Bay Regional Health Sciences Centre

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September 13, 2016

Ms. Nadine Doucette
Chair, Board of Directors
Thunder Bay Regional Health Sciences Centre

Dear Ms. Doucette,

The Terms of Reference for the TBRHSC REB requires all REB members to be appointed by the Board of Directors following recommendation and support by the Chair of the REB and the selection committee. Each member is allowed to serve for 3 consecutive terms, each term being 3 years in duration. This appointment would expire September 30, 2019.

Mr. Claude Camirand has been serving as an alternate for the community member with no affiliation with the institution since September 2014. We are recommending that Mr. Camirand be appointed as core member of the REB in the role of community member with no affiliation to the institution. If this recommendation is approved, please see the attached appointment letter for your signature.

The Research Ethics Office is currently recruiting for an alternate member to serve in this capacity.

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

Sincerely,

(original signed)

Ms. Katherine Bell
Manager, Quality and Research Ethics

e-copied: Michelle Allain
Vice-Chair, TBRHC Research Ethics Board

Attachment

Claude Camirand, B.A., M.S.W, B.Ed. **807.631.9743**
422 Norah St. S., Thunder Bay ON P7E 1N9 camirand@yahoo.com

Educational Background

09/99-04/00	Bachelor of Education (Junior/Intermediate) École des Science de l'éducation, Laurentian University
09/95-09/97	Master of Social Work School of Graduate Studies and Research, University of Ottawa
09/91-04/95	Bachelor of Arts, Honors in Psychology Faculty of Social Sciences, University of Ottawa

Additional Courses and Qualifications

01/13	Guidance and Career Education, part 1, Lakehead University
04/11	NCCP Level II Technical Coaching Certification: Volleyball, Ontario Volleyball Association (Instructor: Chris Green)
07/09	Religious studies part 1, *CSC du Nouvel-Ontario*
04/09	French as a Second Language, Lakehead University
12/08	English as a Second Language, Lakehead University
05/08	NCCP Level 1 Technical Coaching Certification: Volleyball, Ontario Volleyball Association (Instructor: Peter Jaun)
12/07	First Aid Instructor for Canadian Red Cross
05/07	Canoeing Certificate, ORCA Level C, (Instructor : Bill Day)
04/07	Introduction to GPS, Confederation College (Instructor : Rod Coates)
05/06	NCCP Level 1 Technical Coaching Certification: Mountain Bike, Lakehead Public Schools (Instructor: Harry Curtis)
03/06	NCCP Introduction to Competition A, Lakehead University (Instructor: Dave Patterson)
09/05	Coaching in Ontario Schools, Lakehead Public Schools (Insructor: Dave McCallum)
05/05-06/05	Special Education Part 1, University of Ottawa
01/03-01/05	Professional Photography, New York Institute of Photography
02/04	St. John Ambulance Standard First Aid & CPR B
07/03	Additional Basic Qualification, Primary Division Faculty of Education, University of Ottawa
07/97-09/97	*Svenska 1* and Modern Swedish Social Institutions Uppsala University International Summer Session, Uppsala, Sweden

Professional Affiliations

Member in good standing of the Ontario College of Teachers (435116).

Claude Camirand, B.A., M.S.W, B.Ed. **807.631.9743**
422 Norah St. S., Thunder Bay ON P7E 1N9 camirand@yahoo.com

Employment Experience

09/12 – pres. Guidance counsellor, École secondaire catholique de La Vérendrye, Thunder Bay ON.

07/11 – 08/12 Year off work to travel around the world with my wife.

09/05 – 06/11 Teacher, École secondaire catholique de La Vérendrye, Thunder Bay ON

- Teacher of various subjects in alternative program/regular classroom;
- Volleyball and mountain biking coach;
- Participant/coordinator of school canoe trip in grade 12 leadership course.

08/04-06/05 Teacher, Grades K-3. Colville Lake School NT

- Split-Grade K to 3, all subjects.

08/03-06/04 Teacher/Coordinator, Sahtu Conservation-Education Program, Norman Wells NT

- Live in a remote camp and oversee camp operations and logistics;
- Develop and implement outdoor education curriculum for at-risk youth (teach academics, wilderness survival, trades skills, social skills and healthy lifestyle);
- Plan, coordinate and organize various components of the program;
- Report to agencies providing funding.

08/01-06/03 Teacher, Grades 7, 8, 9. *?ehtseo Ayha School*, Deline, NT

- Split-Grade 7, 8 and 9 Classroom Teacher, all subjects.

08/00-06/01 Teacher, Grades 7 to 12. *Chief T'Selihye School*, Fort Good Hope NT

- English Language Arts (7-9); Phys. Ed. (7-12).

09/97-08/00 Addictions and Mental Health Counsellor, Family Counselling Centre of Sault Ste. Marie and District, Sault Ste. Marie ON

- Work as a member of a multi-disciplinary team in the provision of assessment, individual, family & group counselling and treatment of dually-disordered youth and their families;
- Develop and deliver Adventure-Based Learning Program;
- Participate in development of treatment goals and program goals;
- Provide community development as well as culturally sensitive services throughout the District of Algoma;
- Provide outreach services in out-lying schools and drop-in centre.

Claude Camirand, B.A., M.S.W, B.Ed. **807.631.9743**
422 Norah St. S., Thunder Bay ON P7E 1N9 camirand@yahoo.com

Publications

Camirand, C. (June 2004). Sahtu Conservation-Education Program: Bush School Model. Sahtu Divisional Education Council: Norman Wells, NT

Blais, L., Mulligan-Roy, L. et **Camirand, C.** (1998). « *Un Chien Dans un jeu de quilles. Le mouvement des psychiatrises et la politique de sante mentale communautaire en Ontario* », Revue canadienne de politique sociale / Canadian Review of Social Policy, 42(2), 15-35.

Camirand, C. (1997). « *Resultats du sondage-Reflets* », *Reflets : Revue ontaroise d'intervention sociale et communautaire* », 3(1), 168-173.

Roussy, F., **Camirand, C.**, Foulkes, D., De Konninck, J., Loftis, M. & Kerr, N. H. (1996). "Does Early-Night REM Dream Content Reliably Reflect Presleep State of Mind?", Dreaming, 6(2), 121-129.

Roussy, F., **Camirand, C.** Mercier, L., De Konninck, J. & Foulkes, D. (1995). « Is REM Dream Content Predictable From Presleep Ideation? », Sleep Research, 24, 149.

Thunder Bay Regional Health Sciences Centre

Quality Committee

September 20, 2016

Administration Boardroom – 4:30 - 6:30 p.m.

Present:
Doug Shanks (Chair), Jean Bartkowiak, Nadine Doucette, John Friday, Anita Jean, Georjann Morriseau, Dr. Gordon Porter, Matt Simeoni, Dave Van Wagoner, Dr. Peter Voros

***Regrets*:**
Dr. Rhonda Crocker Ellacott

By Invitation:
Stephanie Craig, Lead, Patient Safety and Evidence Based Process
Laurel Knowles, Officer, Research Ethics
Katherine Bell, Manager, Quality and Research Ethics
Dr. Michelle Langlois, Manager, Medical Affairs
Mary Wrigley, Manager, Regional Renal Service
Dawna Maria Perry, Director, Nursing Practice
Nancy Persichino, Director, Women and Children's Program
Aaron Skillen, Director, Chronic Disease Prevention and Management Program
Dr. Teresa Bruni, Medical Director, Women and Children's Program
Cathy Covino, Senior Director, Quality and Risk Management
Katrina Sutton, Rec. Sec.

1.0 CALL TO ORDER – The Chair called the meeting to order at 4:32 p.m.

1.1 Quorum – Attained.

1.2 Conflict of Interest – None.

1.3 Approval of the Agenda

Moved by:	***Anita Jean***	***Motion***
Seconded by:	***John Friday***	

"The agenda be approved as circulated."

CARRIED

2.0 PRESENTATIONS/REPORTS

2.1 Chronic Disease Management Program: Renal Care Team

Mr. Aaron Skillen, Director, Chronic Disease Prevention and Management, and Ms. Mary Wrigley, Manager, Regional Renal Service, provided an overview of the North West Regional Renal Program at Thunder Bay Regional Health Sciences Centre (the Hospital). Key highlights included the Program's Patient and Family Centred Care (PFCC) initiatives and quality improvement projects, such as patients from remote First Nations communities being able to access home dialysis. The Program also recently celebrated the success of the first patient in a remote community receiving independent hemodialysis.

The significant growth of the Program in the past few years and the ongoing challenges related to staffing and physical space were discussed. The Hospital's recruitment of vascular surgeons will address one of the current staffing challenges.

Mr. Skillen and Ms. Wrigley were excused from the meeting.
Ms. Perry and Dr. Langlois were welcomed to the meeting.

2.2 Credentialing and Licensing Processes for Professional Staff and Health Professionals

Ms. Dawna Maria Perry, Director, Nursing Practice, and Dr. Michelle Langlois, Manager, Medical Affairs, provided an overview of the credentialing and licensing processes for Professional Staff and Health Professionals at the Hospital. The credentialing process for Professional Staff is governed by the Northwest Regional Credentialing Policy and Procedure which uses the Northwest Regional Electronic Credentialing System (N-Recs). The credentialing process can take up to three months for new applicants, but applicants can also be expedited based on needs. External healthcare providers enter into one of four types of agreements with the Hospital in order to provide services at the Hospital.

All Health Professional staff must provide a vulnerable sector check or criminal record check upon hire and their regulatory licenses are checked annually. The provision of either a vulnerable sector check or criminal record check upon hire is determined by the Thunder Bay Police Service based on the Health Professional staff member's position.

The disclosure by Professional Staff who have been criminally investigated was discussed. It is the duty of Professional Staff who have been part of a criminal investigation and are up for their annual reappointment to disclose the investigation to the Hospital. A policy is in the process of being created to regulate such disclosure.

Ms. Perry and Dr. Langlois were excused from the meeting.

Ms. Craig was welcomed to the meeting.

2.3 Patient Safety / Public Indicators

Ms. Stephanie Craig, Lead, Patient Safety and Evidence Based Process, provided an overview of the 2016/17 Q1 highlights for Patient Safety. Key highlights included a larger proportion of incidents caused less harm to patients and a change to the most frequently reported incident categories compared to the last seven quarters. A mock medication error simulation was also trialed and was well received.

The participation of nursing and non-nursing units in safety huddles was discussed. Ms. Craig noted that a guidebook has been drafted to enhance the effectiveness of safety huddles in the Hospital and improve compliance.

Ms. Craig was excused from the meeting.
Ms. Persichino and Dr. Bruni were welcomed to the meeting.

2.4 Women and Children's Program: Maternal Child Team

Ms. Nancy Persichino, Director, Women and Children's Program, and Dr. Teresa Bruni, Medical Director, Women and Children's Program, provided an overview of Maternal Child Services at the Hospital. Key highlights included a review of the Program's quality indicators and recent quality improvement projects for patients and their families as well as staff.

The percentage of Alternative Level of Care (ALC) days and the patients within the Program who are identified as ALC was discussed. The lack of available housing and/or community services in Thunder Bay for babies born with addictions and their families was identified as making many of these situations socially complex. Ms. Persichino noted that 5.8% of babies born in 2015 were born to mothers who admitted to consuming either alcohol or drugs during their pregnancy.

Ms. Persichino and Dr. Bruni were excused from the meeting.
Ms. Bell and Ms. Knowles were welcomed to the meeting.

2.5 Research Ethics Board

Ms. Katherine Bell, Manager, Quality and Research Ethics, and Ms. Laurel Knowles, Officer, Research Ethics, provided an overview of the 2016/17 Q1 activities of the Research Ethics Board (REB). Key highlights included the approval of ten new clinical research projects, the penultimate draft of the Lakehead University-Hospital REB reciprocity

agreement, and building capacity for researchers who wish to conduct research in Indigenous communities. The Hospital is comparable to similarly sized academic hospitals such as Health Sciences North in the number of REB projects and approval time lines.

Ms. Bell and Ms. Knowles were excused from the meeting.

3.0 CONSENT AGENDA

Moved by:	***Dave Van Wagoner***	***Motion***
Seconded by:	***Nadine Doucette***	

"That the Quality Committee of the Board approves the Quality Committee of the Board minutes of May, 17 2016, and receives the Research Ethics Board minutes of April 25, 2016, as presented."

CARRIED

4.0 WORK PLAN

4.1 Quality Committee of the Board: Review of 2016-2017 Work Plan

The Committee reviewed the pre-circulated work plan for information.

The expectations of presentations/reports were discussed. It was noted that some presentations/reports are read verbatim and exceed allotted time limits. It was agreed to impress upon presenters to highlight key points only and allow time for Committee discussion.

The Committee agreed to separate the reporting of the patient safety indicators from the public indicators and to present the public indicators annually instead of quarterly. The Committee also agreed to have the REB annual report presented to the Committee in May.

4.2 Quality Committee of the Board: Review Terms of Reference

The Committee reviewed the terms of reference for information. It was identified that the terms of reference are reviewed in September in case any necessary changes are identified, prior to approval by the Committee in January.

5.0 BUSINESS/COMMITTEE MATTERS

5.1 Quality Committee Meeting Schedule: Change to Wednesdays

The Chair proposed that the meetings of the Committee be changed to Wednesday evenings from Tuesday evenings in order for new Committee members to not have two meetings in one day. It was identified that the Governance Committee meets Wednesday mornings and that this would impact other Committee members. The Committee agreed to change the meeting schedule to Wednesday evenings on a go forward basis.

5.2 Quality Committee: Addition of Community Member and Preferred Skill Set

The Chair of the Committee advised that the Board of Directors is considering adding community members to its Committees, as allowed per the By-laws. This practice is ideal for succession planning and mentorship. The Committee agreed that this strategy would be beneficial.

6.0 FOR INFORMATION

6.1 COMMITTEE MEETING EVALUATION

Committee members completed their meeting evaluations.

7.0 RECOMMENDATIONS TO THE BOARD – None.

8.0 BOARD MEMBER COMMENTS – None.

9.0 DATE OF NEXT MEETING

The next meeting is scheduled for October 19, 2016.

10.0 ADJOURNMENT - The meeting adjourned at 6:27 p.m.

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Senior Leadership Report

to the
Board of Directors
Thunder Bay Regional Health Sciences Centre
October 5, 2016

Academics and Interprofessional Education

Advance the Academic Environment

- Academics has partnered with NOSM and Health Sciences North (HSN) to lead an Academic Health Sciences Integration in Northern Ontario project. The committee will be exploring 5 key themes: Leadership accountability for teaching and research in clinical sites; Models that support protected time for education and research work in clinical environments; Administrative support and coordination of education and research work in clinical environments; Research support services in clinical settings; Strategic collaboration and governance. Findings will be shared during a symposium in April 2017 followed by recommendations and agreement templates in May/June 2017.

Identify opportunities to implement inteprofessional education

- A new tracking tool for Interprofessional Education events has been implemented. According to the data we have been able to collect from 2015 to 2016, the number of participants in Interprofessional Education has almost tripled.

Education supports and structures

- Interprofessional Education introduced a web-based software to assist with certificate course registration, payment and attendance. All internal and external participants can securely register and pay for certificate courses through the internet increasing accessibility to training and more efficient payment processes. It also provides us with a method for collecting valuable education data.

Medical Affairs

- A warm welcome is extended to several new physicians that joined us over the last few months:
  - Dr. Marlon Hagerty, Radiation Oncology
  - Dr. Lindsay Churchley, Obstetrics and Gynecology
  - Dr. Wendy Liu, Emergency
  - Dr. Meghan Garnett, Emergency
  - Dr. Radu Rozenberg, Interventional Radiology
  - Dr. Kushal Dighe, Interventional Radiology
  - Dr. Ikenna Okorafor, Psychiatry
  - Dr. Kevin Bezanson, Palliative Care
  - Dr. Muhand Al Habash, Hospitalist Service

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- Five site visits took place over the summer months with candidates from Obstetrics and Gynecology, Pathology and Psychiatry and Vascular Surgery
- The following physicians have accepted positions at TBRHSC:
  - Dr. Haitham Nasser, Pathology (start date TBD)
  - Dr. Mehran Midia, Radiology (expected start date of January 2017)
  - Dr. Alireza Bagherli, Interventional Cardiology (start date TBD)
  - Dr. Mary MacDonald, Vascular Surgery (start date TBD)
- We are pleased to announce the appointment of the following medical leadership positions:
  - Dr. David Puskas, Regional Medical Director, Musculoskeletal Health
  - Dr. Melanie Toman, Medical Lead, Acute Pain Service (APS)
  - Dr. Margaret Anthes, Medical Lead, Radiation Oncology
  - Dr. Elena Poliakova, Medical Lead, Sexual Assault and Domestic Violence
- Our Physician Recruitment Assistant attended the Canadian Association of Pathologists Annual Meeting in Vancouver in July to promote TBRHSC

Pharmacy

Medication Reconciliation

- The medication reconciliation admission rate for August 2016 was 60.6%. This was an increase from the July admission rate of 55.6%.

Regional Pharmacy Program

- The first quarter scorecard was provided to the 7 hospitals that are part of the Regional Pharmacy Program. We are in the process of preparing a new service agreement for the 2017-18 year.

Ontario College of Pharmacists

- Subsequent to our baseline assessment in July 2015 and submission of registration materials, we recently received a copy of our 'Certificate of Accreditation Hospital Pharmacy'. The certificate is renewable annually.
- We had our annual on-site assessment on September 13, 2016. We received a verbal report at the end of the day and are awaiting their final report.
- The main areas of focus for improvement are related to new emerging standards i.e. implementation of new guidelines pertaining to sterile compounding of hazardous and non-hazardous drugs (annual certification of staff and facility design/equipment).

EVP, Patient Services & Chief Nursing Executive

Fracture Clinic Quality Improvement

- A new Fracture Clinic Improvement Strategy was initiated on June 9, 2016, with a goal to achieve a patient's total length of stay less than 70 minutes (90th percentile)
- The Fracture Clinic implemented a number of quality improvement solutions on August 20, 2016 with improvement solutions resulting in a total length of stay of 54

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minutes (90th percentile) from August 20, 2016 to September 20, 2016. During this time, 146 patients filled out patient satisfaction forms. Feedback included 135 positive and 11 negative responses.

Acute Pain Service (APS)

- The APS has had a successful launch and started to see patients on July 4, 2016. This new service has enhanced the pain management of postoperative patients and has treated 309 patients in two months (July and August).

Emergency (ED) Patient Flow

- In July/August 2016, ED continued to perform at or better than provincial targets for non-admitted high acuity patients with a length of stay (LOS) of 6.5/6.6 hours (target 7 or less) and low acuity LOS of 3.3/3.25 hours (target 4 or less)
- Over July and August, ED total LOS for admitted patients remained above the target with wait times of 34.42/32.98 hours (target 27 or less)

Critical Care Services Ontario

- TBRHSC hosted a NW LHIN Critical Care Services Ontario (CCSO) Town Hall meeting on September 20, 2016. This forum provided the opportunity to discuss leadership and accountability for quality and safety related to Critical Care Services including performance against the provincial Life or Limb policy, One Number to Call, hospital repatriation rates and patient flow activity.

Northwest Regional Trauma Network (NWRTN)

- In collaboration with Critical Care Services Ontario (CCSO), all Lead Trauma hospitals in Ontario are required to create a Regional Trauma Network (RTN) for their catchment area to create system improvements
- TBRHSC, as a Lead Trauma Hospital, will advance this initiative to create an integrated quality trauma system in our region
- On September 27, 2016, our kick-off NWRTN meeting was held with participation from all regional and local stakeholders
- Activities of the NWRTN will include implementing best practices, education initiatives, improving coordination of care, addressing transportation issues and optimizing expertise and resources to improve trauma care throughout the continuum

Regional Critical Care Response (RCCR)

- RCCR provides 24 hour access to Critical Care physicians and nurses via telemedicine to support regional hospitals
- In 2015-2016, RCCR provided 325 consultations, supported 212 individual patients, and avoided 75 air ambulance transfers and ICU admissions
- Since July, RCCR has been providing collaborative daily rounds to the 3-bed ICU at Lake of the Woods Hospital (LWH) in Kenora. Each day, the RCCR team connects with LWH to provide support and consultation.

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- RCCR has saved lives, facilitates care closer to home and has resulted in savings to the Ontario health care system of greater than $1M by deferring avoidable air transfers

Transition of Out Patient Community Pathology Services

- Effective October 1, 2016, Community Pathology Services (specimens collected in physician offices) will transition from TBRHSC to Life Labs
- Approximately 1,700 specimens will be transitioned to a community Lab where they are funded through OHIP
- This initiative will allow TBRHSC Pathologists to focus on acute care patients and improve pathology turn around times

Laboratory Accreditation Surveillance Assessment

- A q2 year mid-cycle accreditation surveillance assessment is scheduled for October 12, 2016 in our Clinical Laboratory. This surveillance is necessary as our Lab holds an ISO 15189 Plus^{TM} certificate for competence of testing and calibration. Assessors will be following up on the September 2014 visit to review current practice compliance including organizational structure, personnel policies, training, Laboratory Management, Quality Management, and all new equipment.

PFCC

- TBRHSC participated in the 4th Annual National Patient Experience Forum in Toronto September 20-21, 2016. Keith Taylor, PFA chaired the conference and Rhonda Crocker Ellacott was a keynote speaker at the 4th National Patient Experience Forum.
- Education was provided to Northwest Regional CEOs at their Annual Retreat in Longlac on September 16/17, 2016

Corporate Services & Operations

Financial Services

- As at August 31, 2016 the deficit is $3 million compared to a budget deficit of $2.8 million and prior year deficit of $2.3 million with:
  - Paid Hours on budget and 1.7% less than prior year
  - Patient Days 4.8% less than budget and 6.4% less than prior year
  - Surgical Cases within 1% of last year
  - ER Visits 3.8% more than budget and 3.3% more than prior period whereas,
  - ER Patient Days are 3.6% less than budget and 5.8% less than prior year.

Capital Planning & Operations

- TBRHSC has no outstanding orders under the Fire Code (as overseen by the Fire Department) or Environment Protection Act (as overseen by Ministry of Environment) - and TBRHSC is not aware of any non-compliances in regards to the requirements of these legislations.

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- *$850k was received from the MOHLTC through their HIRF / ECG (Hospital Infrastructure Renewal Fund – Exceptional Circumstances Grant). Work is underway on the Operating Room suite roof, along with other key infrastructure projects.*
- *Heavy summer rainfalls resulted in a flooding of the ICR Discoveries building at 290 Munro St. Remediation is underway through the insurer. A review is being conducted with True Grit Consulting to determine root cause.*
- *The capital budget planning cycle has started. Over the next few years there are significant requests for capital dollars to replace equipment, address accreditation needs, and develop or expand programs.*

Northern Supply Chain

- The NSC program officially signed off on the Transfer Payment Agreement(TPA) in July. The TPA includes $4 million in payments over 48 months with a $400,000 contingency fund available. We also received $425,000 from the NELHIN for on boarding twenty four (24) Hospitals from LHIN 13.
- Our first combined NSC Steering Committee was held September 22.
- Data Management/Spend Analytics software expansion to 13 NE Hospitals is underway which will assist with effeciency gains and identify contracting opportunites for the North.
- Our first RFx initiative is underway for a Staff Scheduling System with approximately 20 Hospitals participating.

Decision Support

- In July 2016, the Hospital successfully met its final case costing implementation milestone by submitting a complete fiscal year of Acute Inpatient, Ambulatory, and Mental Health data. Work continues on addressing outstanding issues identified during the implementation process and improving data quality for ongoing annual submissions. The Hospital was commended for its commitment to ensuring the success of the implementation project.

Patient Services and Cancer Care Ontario

Adult and Forensic Mental Health Program

- Three new Psychiatrists have successfully been recruited to TBRHSC. Dr. Kyle Hampe has begun providing services in the Emergency Department and Dr. Ikenna Okorafor has begun working on the Adult Mental Health Unit. This has resulted in improvements in patient flow and ED wait times. Further improvements should occur when Dr. Carolina Vidal joins the Adult Mental Health Unit in November.

Cardiovascular and Stroke Program

- The CV&S Program welcomes Dr. Ali Bagherli and Dr. Kushul Dighe, both interventional cardiologists. Another echocardiography specialty cardiologist is expected from the Netherlands in October.

- Discussions are underway with the MOHLTC around the development of a new funding stream for implantable cardiac defibrillator follow-up services. This care has always been provided by TBRHSC, but it was an un-funded service.
- The time to treat acute strokes has continued to drop since the implementation of "Code Stroke" overhead paging (59 min. in Q1 and 49 min. in Q2). TBRHSC is now well within the best-practice recommendation of 60 min. and hopes to achieve future targets of 30 minutes.

Cardiovascular Surgical Program Development

- TBRHSC received approval as a developing Level 2 Vascular Surgical Centre. EVAR (Endovascular
  Aneurysm Repair) funding will be included in our annual funding.
- TBRHSC hosted a visit by a team (including the Director) from the MOHLTC Provincial Programs Branch to improve our shared understanding of the program's needs. A letter was sent to Minister Hoskins in August requesting his attention to smooth various challenges related to TBRHSC approvals to support ongoing program development.
- Dr. Mary MacDonald, vascular surgeon, will join TBRHSC in November. Dr. Abdulrehman's departure in early September was challenging for our developing program.
- Dr. R. Rozenberg joined the Diagnostic Imaging team as a vascular interventional radiologist.

Prevention & Screening Services

- The Screen for Life Coach returned to Thunder Bay in August, after being out of service for 6 months, and is now back on the road following a condensed travel season schedule this fall. After the travel season, the coach will be in Thunder Bay over the winter months, providing cancer screening services, and then will resume its regular travel season schedule in April 2017.
- On May 31, 2016, Prevention & Screening Services accepted a Smoke-Free Champion Award on behalf of TBRHSC. TBRHSC was one of 23 recipients in the region that was honoured by the Northwest Tobacco Control Area Network for best embodying the spirit of Smoke-Free Ontario. The awards were based on open nominations.

Spiritual Care, Palliative Care and Telemedicine Services

- The Spiritual Care department hosted its annual community clergy appreciation brunch on September 23, 2016. TBRHSC's Bioethicist, Michelle Allain, presented on MAID (Medical Assistance in Dying). An engaged discussion followed exploring implications for patients, families, and providers.
- The Tamarack House continues to see increased utilization year over year, with typical rates of 70% full. Numerous times in the past short while, staff have reported that the Tamarack House has been fully booked. Patients and families are very understanding when being asked to "double up" in a room for short periods.

Tamarack House has 19 rooms, each with 2 beds and two of the rooms are accessible for patients and families with mobility issues.

Research

Clinical Research Update

- new Manager, Clinical Research Services (Daniel Horne), is in place
- recruitment to trials is improving and potential new studies are being evaluated
- review and development of policies under the Research Quality Oversight Program is nearing completion
- a new draft Project Authorization process will be piloted in the fall once the new Clinical Research Services Assistant is in place

Research Institute Releases 2020 Strategic Plan

- plan was launched at the Institute's Annual General Meeting on June 23rd
- three major directions were identified and 4-5 goals have been identified for each
- staff are finalizing action plans and measures
- you can view a summary of the new Strategic Plan and a full copy of the 2015/16 Annual Report at www.tbrri.com under the News & Media tab

Business Development

- new Manager, Business Development, Amarjit Chahal, started in early September
- focus will be on the cyclotron business plan, commercialization activities and other business development opportunities

Human Resources

Bill 132 and the Occupational Health and Safety Act

On March 8, 2016, the government passed Bill 132, Sexual Violence and Harassment Action Plan Act (Supporting Survivors and Challenging Sexual Violence and Harassment), 2015. Bill 132 amends the Occupational Health and Safety Act (OHSA) and changes the requirements and duties of employers effective September 8, 2016. The legislation is designed to make workplaces, campuses and communities safer and more responsive to the needs of survivors, as well as, sexual violence and harassment complaints. The legislation will also specifically impact practices, policies and procedures regarding sexual violence in settings such as hospitals. TBRHSC policies and programs are being updated to reflect this new legislation.

Leadership Enhancement Institute (LEI)

On September 14, 2016 leaders attended the third LEI session where they learned evidence based leadership practices to enhance leadership skills and ultimately the patient experience. The topics included leader rounding for outcomes and leader rounding on patients and internal customers. The leaders also shared feedback and experiences based on the tactics introduced in the first two sessions that help us on our journey to excellence.

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Labour Relations

The OPSEU Central settlement (3 years) and ONA Arbitration Award (2 years) have been received. Both have financial impacts of 1.4% general wage increase, plus minor benefit/premiums increases throughout the life of the agreements. ONA local Issues will be proceeding to coordinated arbitration on October 1, 2016.

Sick Time Management Strategy

At the Q4 meeting held May 2016 the leadership team was engaged to review sick time trends and discuss opportunities to enhance our current attendance support programs and consistently adhere to policy in an effort to reduce sick time utilization. Various initiatives have been developed to enhance existing sick time strategies including the following:

- Revising tools for managers to utilize for 1-3 day absences;
- process is in place to ensure modified work is offered (if required) during pregnancy to avoid sick leave prior to maternity leave;
- revision of short term sick leave management program to ensure consistency, timely reviews, and early and safe return to work;
- psychological health and safety strategies with the goal of early detection of decline in psychological health and directing staff to appropriate supports.

Results are in!! - The Standardized Volunteer Opinion Survey

TBRHSC volunteers participated in the 2015 province-wide Standardized Volunteer Opinion Survey. This comprehensive survey tool provides a unique opportunity to seek feedback from volunteers and to benchmark with organizations from across the hospital sector. Questions are captured in seven survey dimensions: volunteer experience, orientation, recognition, volunteer impact, teamwork, patient safety, and general safety. TBRHSC scored above the provincial average in every category and scored first among 36 Ontario hospitals in general safety, orientation, and impact.

Indigenous Staff and Volunteer Recruitment Initiative.

As a result of community engagement through the 2020 strategic planning process, TBRHSC set an objective to increase the recruitment of Indigenous staff and volunteers. As such, we have expanded our Indigenous Career Experience program to reach out to all school boards in Thunder Bay and invite Indigenous students to learn about volunteering and career opportunities at TBRHSC. This joint initiative between Human Resources and Volunteer Services to offer a city-wide Indigenous Student Career Day, will offer the students a more formal and personalized form of invitation and support in applying for positions. The event is planned for February 2017.

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President and CEO
Président directeur général

Report from Jean Bartkowiak
President and CEO
October 5, 2016

On June 9, I had the privilege of participating in my first Engagement session with our 5 Partners in Health, including Health Leaders, Policy Makers, Health Professionals, Academics and Community representatives. The participants engaged in reviewing our progress and advising us on ensuring we achieve the directions we set out to accomplish in our Strategic Plan 2020; this was the first annual accountability progress forum for our Strategic Plan. Those in attendance provided input on our strategic activities, including methods to improve patient satisfaction survey response rates. I am sincerely grateful to all of our 5 Partners representatives that volunteered their time to help us guide our priorities in caring for our patients and their families.

I take this opportunity to report on some of the accomplishments so far in some of our Strategic Directions, including the addition of a dedicated Anesthesiologist and Nurse Practitioner in the Acute Pain Management Service, and the implementation of Endovascular Aneurysm Repair (EVAR) surgery later this fall as part of our Cardiovascular Surgery program. The Patient Flow Strategy aiming to reduce length of stays has improved with the implementation of a new digital tracking tool that documents delays in consultations, diagnostic procedures, etc. Last year, we successfully reduced Average Length Of Stay (ALOS) by 0.2 day. According to our first quarter data, we are on target to a further ALOS reduction this year.

Addressing the surge capacity challenge is one of my main priorities; this summer I regularly attended Bed Flow Rounds with Utilization Coordinators (UC), Unit Managers and Discharge Planners (DP) to learn more about the barriers to effective discharge, especially for the Alternate Level of Care (ALC) patients, those patients that no longer require specialized acute in-patient care. While we observed a two months reprieve in the last part of the first quarter, our rate of ALC patients spiked back this summer, in part, as I learned, because, as a cost cutting strategy, we did not fill vacancies for DPs, UCs. I was informed also that all Occupational Therapists and Physiotherapists, responsible for frail patient assessments prior to their designation as ALCs, are actually St. Joseph's Health Care Group staff and that the contract that ties us to them does not provide for their replacement in the summer which impacts delays in processing these assessments. I have already asked that this be revisited in anticipation of next summer season. I also observed similar issues at our District Hospitals. This allowed me to engage our partners in removing some of those barriers. I look forward to continued improvements in this area.

In June, we celebrated the launch of a new Strategic Plan for our research arm, the Thunder Bay Regional Research Institute. I am confident that the plan will enable our Research Institute to be an international leader in medical imaging research, and discovery that improves the health of the people of Northwestern Ontario. One of the highlights of the plan is its focus on population health especially as it pertains to indigenous communities in our region. This will also support our Hospital's direction in that respect.

On September 16, interviews were held for the position of Vice President, Research and Chief Scientist. I want to recognize the participation of the members of the Selection Committee that supported the process; these include Dr. Andy Dean, Dr. Penny Moody Corbett, Dr. Stewart Kennedy, Ms. Anne Marie Heron, and Ms. Amanda Björn. I am pleased to report that a candidate has been selected and will begin in this role on January 3rd, with a focus on leading the implementation of the

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Research Institutes new Strategic Plan. I hope to be able to announce his name and credentials at next week's Tri-Board meeting.

I was particularly pleased to visit communities throughout Northwestern Ontario over the summer, meeting with hospital CEOs in Dryden, Manitouwadge, Marathon, Terrace Bay, Geraldton, Sioux Lookout, Red Lake, Atikokan, Kenora, Fort Frances and Nipigon. These meetings provided opportunities to discuss our successes and challenges; among other subjects, we talked about the Nurse Transfer Project, the Regional Critical Care Response Program, the Pharmacy Support service, the Regional Meditech functions in our IT/IS system, the Regional Orthopaedic Surgery Program, discharge and repatriation issues, and Foundation support to name a few.

As part of that 2016 Regional CEO Tour, I was fortunate to meet with Chief Waboose from the Long Lake #58 Community and discuss some of her members' challenges accessing health care services. More recently, I met with Matawa Indigenous Communities Health Directors to discuss our Hospital potential support of their project to develop Health Coop Hub on one, preferably two of their nine communities.

I also met with representatives of the Ministry of Health and Long-Term Care (MoHLTC) regarding our Cardiovascular Surgery Program. This was an opportunity to impress on them our challenges in moving forward with expansion of our vascular surgery service and implementation of our cardiac surgery program, given the current provider's reluctance to sign off on our partnership with the University Health Network. I want to recognize Dr. Mark Henderson, EVP Patient Care Services, and his team's command of the subject, especially as it relates to staffing, capital investment and funding of the program.

I would like to recognize the leadership and support of Mr.Peter Myllyma, EVP Corporate Services and Operations in co-chairing the 2016 Operational Review Steering Committee. This is proving to be a very demanding project for him and his team. I want also to bring to the Board's attention that my Executive Assistant, Renée Laakso, retired this summer. After a call for application, Ms. Jessica Nehrebecky, Board Liaison, was the successful applicant. She and I agreed that in an effort to mitigate costs, and given new tools available, we will on a trial basis support the Board and my Office without replacing her in her former role. Furthermore, Ms. Janet Northan, Senior Director, Strategic Partner Relations and Special Project, retired this summer as well; thanks to Ms. Tracie Smith, Senior Director, Communications, Indigenous Affairs and Engagement, the decision was made to share Ms. Northan's responsibilities among different portfolios rather than replace her. We continue to monitor the impacts of both decisions.

In August, several members of the Senior Leadership Team and I met with North West Local Health Integration Network (NW LHIN) representatives and a private MoHLTC designated provincial vendor regarding our Hospital's participation in the roll-out of a digital application that supports compliance with Quality Based Procedures Order Sets; these are standardized care pathways for certain common medical conditions; this tool is intended to support clinicians to manage the patients' care plans according to evidence to improve outcomes.

In September, Dr. Gordon Porter, Chief of Staff, and I resumed our engagement meetings with individual medical departments. So far we met with the following departments: Paediatric, Obstetrics & Gynaecology and the Emergency Department. These encounters allow us to be aware of and support physicians in overcoming challenges at the department level.

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On September 21, Dr. David Paskus, Medical Director, Regional Orthopaedic Program; Ms. Carolyn Fanti, Director of the program; Dr. Rhonda Crocker Ellacott, EVP Patient Services and Chief Nursing Executive; Mr. Ted Scholten, President & CEO, Riverside Health Care Facilities; Mr. Mark Balcaen, President & CEO, Lake of the Woods District Hospital; Mr. Wade Petranik, Dryden Regional Health Centre, and I met to iron out concerns and barriers to overcome as we move forward with the implementation of the Regional Orthopaedic Program; next step will involve the NW LHIN in committing additional operational funding to be allocated to the participating hospitals.

As an academic health sciences centre, one of our priorities involves the development of a Simulation Laboratory for our staff and students; academic partner, Confederation College developed one such laboratory several years ago in partnership with Lakehead University and our Hospital. Best simulation practice in the teaching hospital world calls for such facilities to be based on hospital site. Dr. Jim Madder, President of Confederation College, and I met this summer to discuss this. I am happy to report that Dr. Madder was very understanding and offered to support simulation at the Hospital, provided college students could access it while in training at the Hospital. Also, last week I was pleased to attend, with Board Chair Ms. Nadine Doucette, the Confederation College Partners Evening in support of their students.

Finally, I am happy to report that our Screen for Life Coach is back on the road, providing access to screening services. The coach had been out of service due to damage sustained in a motor vehicle accident while it was in the United States for warranty repairs. Although this year's travel season schedule had to be condensed, I applaud our Prevention and Screening Services team for facilitating appointments for women to get a mammogram at one of the five other regional Ontario Breast Screening Program affiliated sites.

The following reports from my portfolio include more highlights of recent activities.

Quality and Risk Management (QRM)

Patient Safety:

- National Patient Safety Week will be held Oct 24th-28th;
- In conjunction with the Northwest Health Alliance and hospitals across the region, the Hospital is participating in a Patient Safety System Standardization Project;
- QRM along with Interprofessional Education department held the first adverse event high fidelity simulation. The simulation scenario was well received and provided a learning opportunity for staff from various areas across the Hospital;
- The Patient Safety Plan for 2016-2018 has been finalized and will be presented to the Clinical Leadership group for feedback.

Quality:

- A Quality Healthcare Framework is being developed to guide the Hospital's Strategic Direction, to enhance the quality of the patient experience. The Framework, builds on the Patient and Family Centred Care philosophy (PFCC), guides and focuses our efforts to deliver reliable quality care and achieve measurable improvements;
- The Framework is a natural progression in advancing PFCC by outlining definitions, guiding principles, enablers and drivers key to develop and sustain an integrated quality structure, accountability, systems, processes and improvement strategies. The framework is currently in consultation;

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- A Patient Experience Group has been formed to review the current compliments and concern process using the Ontario Hospital Association's (OHA) Patient Experience toolkit. The group has reviewed and environmental scan and gaps analysis;
- The Hospital is also participating in a pilot project with Health Quality Ontario to develop indicators for tracking and reporting of concerns.

Infection Prevention and Control

PCR Initiative:

- In collaboration with Laboratory, the two departments are establishing the early discontinuation of isolation thus improving patient flow. A total of 181 patients have been tested with 628 isolation days from April to September.

Cohorting Initiative:

- A working group is reviewing the possibility of cohorting patients with similar Antibiotic Resistant Organisms.

Hand Hygiene:

- AS evidenced on the Balanced Scorecard data for the first quarter, Hospital staff is steadily improving on hand hygiene which helps maintaining low positive rates for Hospital Acquired Antibiotic Resistant Organism.

Communications, Indigenous Affairs & Engagement

Communications:

- We are developing large-font patient resources, an initiative that supports Seniors' Health;
- Media events hosted include the 7th Annual National Aboriginal Day celebrations (funded by Heritage Canada), Franco Ontarian Day, 7th Annual PFCC Sharing & Caring Together, and Mental Illness Awareness Week;
- In collaboration with Strategy & Planning, an internal awareness campaign was rolled out to inform staff about Strategic Plan 2020 year one progress;
- Current projects the team is engaged in:
    - TBRRI website content development;
    - Regional Cancer Program website development;
    - Occupational Health & Safety internal campaign;
    - Regional Stroke Network congress posters development.

Indigenous Affairs:

- The Traditional Practices & Knowledge Working Group welcomed additional members. A survey of other hospitals has provided valuable information. Internal and external environmental scans are being conducted to identify current processes, barriers and opportunities to improve access to these practices;
- An e-module on Indigenous cultural sensitivity is in development;
- At the September 19 Indigenous Advisory Committee meeting, the proposed definition of a welcoming environment, as well as the recommended activities to support enhancing a welcoming environment for Indigenous patients and their families were approved;
- On October 17, we will begin offering staff free Ojibwe language lessons, focusing on health care;
- A report on Indigenous Patient Satisfaction surveys received between April and June, 2016 was provided to PFCC and the Indigenous Advisory Committee. Results are largely positive;
- Recent indigenous engagement activities include:

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- A Memorandum of Understanding was signed to proceed with a research project with Dr Mitch Albert, Principal Investigator, at the Fort Williams Community;
- We are planning a meeting with Non-Insured Health Benefits Branch, Health Canada and our CEO regarding among other issues, appointments missed by patients;
- We met with Stroke Program staff to address travel barriers for patients in remote communities;
- We also met with Keewaytinook Okimakanak representatives regarding mental health services access and discharge planning for patients living in the north;
- We provided volunteer experiences for students of Dennis Franklin Cromarty High School.

Engagement:

- An engagement session was held with internal leaders on September 28 with a focus on accessing data from new patient flow software;
- Another Leadership Engagement is scheduled in October, to acquire input on the draft Quality Framework.

Strategy & Performance

- Over the summer, the Research Institute team developed the 2020 Strategic Plan work plan. The team aims to finalize the strategic indicators in October. We will hold off on the finalization of the plan until the VP, Research has had an opportunity to review the plan;
- A Staff and Community Communication Plan was developed over the summer in collaboration with Communications, Indigenous Affairs & Engagement, was launched in September. Communication templates aim to provide simple messaging that help staff see themselves within the plan, assist Leaders connect strategic initiatives to staff's daily work and celebrate successes. Additionally, the content will inform the Chronicle Journal stories and the Annual Report, thereby aligning all messaging across multiple mediums;
- The June Leadership Engagement session provided valuable feedback for the Committee Structure Review Project Team. The team is engaged in trying to understand our culture of meetings;
- Support is provided to planning the Tri-Board Engagement scheduled Oct. 21/22;
- At the request of Dr. Crocker Ellacott, CEO, Nipigon Hospital, we will facilitate the development of their Strategy Plan starting in October;
- Development of the 2017/18 Quality Improvement Plan began with the OHA planning webcast September 29th.

Thunder Bay Regional Health Sciences Centre

President & CEO

2016-17 Annual Objectives

Bed Management	Engage internal and external stakeholders to: * Reduce Average Length of Stays (QIP) to 5.5 (without ALC); * Reduce ED wait times (QIP); * Reduce readmission rates to of patients with Cardiac Heart Failure (QIP); * Reduce readmission rates to of patients with Chronic Obstructive Pulmonary Disease (QIP); * Assist in discharging Alternate Level of Care patients to the most appropriate community destination; * Assist in preventing or redirecting Emergency Department patients deemed not requiring specialized acute care; *Segregate emergency patients requiring mental health evaluation to provide expert assessment and improve patient flow, accessibility and ED lengths of stay; and * Engage region hospitals to avoid transfers and improve discharges post specialized acute care.
2020 Strategic Plan	Implement and monitor progress in achieving year 2 of the Strategic Directions.
Hospital Governance	Review and recommend amendments as needed to the Hospital Bylaws and Board policies. Assist the Chief of Staff and Medical Advisory Committee in reviewing and amending as needed the Medical Staff Bylaws.
Cardiovascular Surgery Program	Ensure Hamilton Health Science, University Health Network, Cardiac Care Network and Ministry of Health and Long Term Care all sign off on the Hospital's Cardiovascular Surgery Program.
Senior Leadership Team	Fill all interim Senior Leadership Team positions. Review the organizational structure to ensure fit with the Strategic Directions and Division responsibilities. Review and recommend amendments to the Pay at Risk policy.
System Partners	Develop a shared understanding of expectations from the region's hospitals regarding transfers for specialized acute care and referral back for convalescent care; and Develop an inventory of Clinical Services Agreements to ensure pertinence, currency and gaps in specialized acute care services to the region. Meet with Indigenous community leaders to gather their expectations regarding access to regional specialized acute care.

Patient Satisfaction	Improve ED patient satisfaction with overall care and services. (QIP) Improve inpatient satisfaction with overall care and services. (QIP)
Patient Safety	Increase proportion of patients receiving medication reconciliation at admission. (QIP) Increase proportion of patients receiving medication reconciliation at discharge. (QIP)
Medical Staff Engagement	Support the Chief of Staff strategy to improve Medical Staff engagement. Request a revision of the current code blue process to ensure appropriate response time and team composition.
Staff Engagement	Support the new Vice-President, Human Resources in implementing a comprehensive staff engagement strategy.
Financial Viability	Through SLC engagement and third party review, improve the Hospital's financial viability as follows: * Proceed with an internal budget review of spending and revenues to offset the forecasted 2016-17 budget shortfall; * Implement the findings of the third party review to ensure the 2017-18 budget forecast is in balance; * Support the Foundation in planning the Cardio-vascular Surgery major campaign; and * Review the Research Institute funding to offset the forecasted deficit and shift the spending model from back office cost centres to science.
Research Institute Governance	Review and recommend a governance model that supports the local nature of the Research Institute's new Strategic Directions.
Research Institute 2020 Strategic Plan	Ensure the plan is approved and implemented.
Philanthropy	Assist Foundation in securing resources to achieve the Health Sciences Centre's Strategic Plan.
Academic Mission	Collaborate with Lakehead University, Northern Ontario School of Medicine (NOSM), and Confederation College to grow their respective health sciences teaching programs. Specifically, support (NOSM) Department of Internal Medicine in achieving Royal College of Physicians and Surgeons of Canada accreditation. Support the development of an onsite simulation program in partnership with NOSM.

Thunder Bay Regional Health Sciences Centre

Balanced Scorecard
Indicators for: Board of Directors
Report for 16-17 Q1

		2015-16 Actual	2016-17 Fiscal								
Domain	**Indicators**	**Actual**	**Q1 Actual**	**Q2 Actual**	**Q3 Actual**	**Q4 Actual**	**Annual Target**	**YTD Target**	**YTD Actual**	**YTD Variance**	**Trending (last 6 or available quarters)**
Patient Experience	Rate of hand hygiene compliance before initial patient/environment contact	91.2%	93.0%				93.0%	93.0%	93.0%	0.0%	
Patient Experience	30-day in-hospital deaths following major surgery	1.85	3.00				1.30	130.0%	3.00	(1.70)	
Patient Experience	Number of critical events	4	0				0	0	0	0	
Patient Experience	Patient satisfaction: Overall rating of care - Inpatients	93.6%	92.9%				93.9%	93.9%	92.9%	(1.0%)	
Patient Experience	Staff satisfaction: Organizational engagement										
Patient Experience	Physician satisfaction: Organizational engagement										
Patient Experience	Total researchers		196				301	75	196	121	
Patient Experience	Learner satisfaction	86.1%					87.0%	87.0%			
Patient Experience	Paid sick hours as a percentage of worked hours	3.78%	3.47%				3.48%	3.48%	3.47%	0.01%	
Comprehensive Clinical Care	90th Percentile ER length of stay (hours) for admitted patients	31.7	30.8				29.7	29.7	30.8	(1.1)	
Seniors' Health	Pressure ulcer incidence						7.0%	7.0%			
Indigenous Health	Acute hospital admissions for patients from Indigenous communities						TBD	TBD			
Acute Mental Health	Psychiatrist full-time equivalent staffing as percentage of required full-time equivalent complement						83.3%	83.3%			

At or better than target
Slightly (less than 5%) worse than target
Significantly (5% or more) worse than target

BRIEFING NOTE

TOPIC	2016-17 Q1 Balanced Scorecard Results – Board Strategic Indicators
PREPARED BY	Carolyn Freitag & Michael Del Nin, Manager, Decision Support
APPROVED BY	Jean Bartkowiak, President & CEO
PREPARED FOR: President &CEO Board of Directors Other	
DATE PREPARED	September 29, 2016

PURPOSE/ISSUE(S)

To highlight progress over 2016-17 strategic plan objectives and associated indicator results with a focus on those falling short of target and actions undertaken to improve.

BACKGROUND

The strategic progress reporting cycle and format was revised and is being trialed for this report. The 2020 strategic initiatives and associated performance metrics are integrated into one report to provide a performance progress report. Reporting will occur quarterly. The format will include a Briefing Note that outlines notable accomplishments in each strategic direction focusing on the performance indicators falling short of targets, including action plans for improvement.

Additionally, the strategic Balanced Scorecard (BSC) and related indicators format were recently adjusted to clearly present results and related trends.

ANALYSIS/CURRENT STATUS

Accomplishments:

Patient Experience: Leadership Enhancement Institute progressed to the second 90-day cycle, with training on staff rounding.

Comprehensive Clinical Care: Patient Flow Strategy shows continued ALOS improvement. Acute pain management service went live July 4th.

Seniors Heath: Steering committee launched.

Indigenous Health: Welcoming environment has been defined.

Acute Mental Health: Psychiatrist recruitment.

Patient Experience: Enhance the quality patient experience

30-day in-hospital deaths following major surgery

Reason: This indicator is new for 2016-17, adopted from CIHI. 16-17 Q1 results are up considerably from 1.85 15-16 average.

Action: Numerator and denominator data has been sourced from CIHI. Work is underway to source detailed patient-level data to ensure a clear understanding of root causes for results and to enable any required improvements. Further details will be shared during October 2016 and presented at the 16-17 Q2 review.

Patient satisfaction: Overall rating of care - Inpatients

Reason: 16-17 Q1 results are slightly below target. Results fluctuated considerably over the past 6 quarters. Results for medical units remain considerably lower than surgical units. Lowest results are related to communications (i.e. discussed anxieties/fears, enough to say about treatment, when to resume normal activities), need for a care plan, and better coordination of care (consistent most responsible physician).

Action: Detailed improvement plans have been developed in consultation with Hospital leadership, and are being implemented. The plans combined with broader adoption of patient rounding are expected to lead to improvements later in 16-17.

TOPIC	2016-17 Q1 Balanced Scorecard Results – Board Strategic Indicators
PREPARED BY	Carolyn Freitag & Michael Del Nin, Manager, Decision Support
APPROVED BY	Jean Bartkowiak, President & CEO

PREPARED FOR: President &CEO Board of Directors Other

Staff satisfaction: Organizational engagement - No data to report in Q1

Reason: This indicator is not relevant in 2016-17. The next survey takes place in 2018-19. There was some discussion about developing a proxy for this but nothing meaningful was proposed.

Physician satisfaction: Organizational engagement - No data to report in Q1

Reason: This indicator is not relevant in 2016-17. The next survey takes place in 2018-19.

Learner satisfaction – No data to report in Q1

Reason: This data is collected via a survey monkey survey and coincides with academic year. Expect data in Q2.

Comprehensive Clinical Care Enhance the delivery of our clinical services.

Emergency Department length of stay (90th Percentile in hours)

Reason: 16-17 Q1 results are slightly above target.

Action: Ongoing improvements underway within the ED and the Patient Flow Strategy.

Seniors' Health Enhance the care provided to an aging population.

Pressure Ulcer Incidence - No data to report in Q1

Reason: New data collection methodology began 15/16 Q4 and will occur in Q2 & Q4 annually. Preliminary Q2 data collection shows improvement from 9 % to 4.8%

Indigenous Health

Acute hospital admissions for patients from Indigenous communities - No data to report in Q1

Reason: Data sourced from CIH portal and Q1 not yet available.

Acute Mental Health…

Psychiatrist full-time equivalent staffing as percentage of required full-time equivalent complement - No data to report in Q1

Reason: However, recruitment efforts over the past 2 years show results in Q2. In September, two new psychiatrist were recruited and another is expected in November.

RECOMMENDATION

N/A

NEXT STEPS

Senior Leaders are leading project teams to adjust activity to meet the projected timelines to reach the 2016-17 targets. Board members could provide feedback to the CEO on new format and content of report.

STAKEHOLDER REACTION

None anticipated.

COMMUNICATIONS

TOPIC	2016-17 Q1 Balanced Scorecard Results – Board Strategic Indicators
PREPARED BY	Carolyn Freitag & Michael Del Nin, Manager, Decision Support
APPROVED BY	Jean Bartkowiak, President & CEO
PREPARED FOR: President &CEO Board of Directors Other	
Progress, challenges and remedial actions will be communicated to staff in the organization.	
FINANCIAL IMPACTS	
N/A	

APPENDIX SECTION
2016-17 Balanced Scorecard Strategic Indicators Q1.

TBRHSC is committed to ensuring decisions and practices are ethically responsible and align with our mission/vision/values. All leaders should consider decisions from an ethics perspective including their implications on patients, staff and the community. The following questions should be considered for each decision.

1. Does the course of action put '**Patients First'** by responding respectfully to needs, values, and expectations of our patients, families, and communities?
2. Does the course of action demonstrate '**Accountability**' by advancing a quality patient experience that is socially and fiscally accountable?
3. Does the course of action demonstrate '**Respect**' by honouring the uniqueness of each individual and his/her culture?
4. Does the course of action demonstrate '**Excellence**' by fostering an environment of innovation and learning to provide a quality patient experience?

For more detailed questions to use on difficult decisions, please refer to TBRHSC's Framework for Ethical Decision Making

For more detailed questions to use on difficult decisions, please refer to TBRHSC's Framework for Ethical Decision Making on the iNtranet under **Quality and Risk Management > Quality > ECFAA (Excellent Care for All Act) > Presentations.**

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Northern Cancer Fund
Northern Cardiac Fund
Health Sciences Discovery Fund

Report to the Thunder Bay Regional Health Sciences Centre Board of Directors
October 2016

Past Event Highlight – The Staal Foundation Open, presented by Tbaytel
This summer the Health Sciences Foundation took a large part in the Staal Foundation Open and between the #TeamStaal2016 Video Challenge, the PGA Canada Golf Tournament, the 50/50 draw and the Bombardier Charity Walk what a week it was! All together the week raised over $66,461 and was a week full of fun and memories! Thank you for everyone that helped make the week happen!

Upcoming Events – Purchase tickets at healthsciencesfoundation.ca or 345-4673
1. Oct 7: Tbaytel Luncheon of Hope ($65/person)
Guest speaker: Becky Olsen; a 3-time breast cancer survivor
Supports: Breast Cancer Fund for Linda Buchan Centre, and Breast MRI

2. Oct 22: Resolute Save a Heart Ball ($150/person or Table of 8 for $1,200)
Gala evening includes auctions, champagne reception, gourmet dinner, live music
Supports: Northern Cardiac Fund for cardiac care at TBRHSC

Upcoming Grant Applications – Due Oct 28, 2016 – Contact Megan at ext.7276
The Volunteer Association and Health Sciences Foundation have teamed up to offer the Family CARE (Care Advancement Recommended by Employees) Grants again. Grants give employees a chance to make a difference to improve patient care where they work. Past grants profiled at: healthsciencesfoundation.ca/familycare

Media Coverage – Contact Heather ext. 7111
Past
- Bombardier Charity Walk Launches (June 3)
- Winners of #TeamStaal2016 Announced (June 10)
- 'Queens' Take to the Links to Celebrate 10 Years at the Re/Max Queen of Hearts Ladies Golf Classic (June 15)
- Roaring to Fight Prostate Cancer (June 18)
- Donors Fund Over $100,000 in New Equipment for Operating Room (July 5)

Upcoming
- Tbaytel Luncheon of Hope (Oct 7)
- Ophthalmology Retinal Imaging Camera (Direct Mail appeal) (Oct)
- Funding for PCR Equipment for Lab (Oct)

Fall 'to do' list – Make a Will – Contact Terri Hrkac ext. 7109
Back to routine after a beautiful summer, many days are consumed by tasks and 'to do' lists. Revising your Will is an important part of keeping your affairs in order, including understanding how your estate can make a difference in healthcare for our region. There are few key questions that you can ask yourself to see if your Household is in order. Do you know what the first step over every estate plan is? It is important to plan now for your future.

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Chief of Staff Report

to the
Board of Directors
Thunder Bay Regional Health Sciences Centre

October 2016

Medical Assistance in Dying (MAID)

- A small working group led by Quality & Risk Management with several physician representatives continued to meet over the summer months to develop a process, review patient requests and offer support to physicians and employees involved in MAID at TBRHSC

Physician Length of Stay (LOS)

- The working group reconvened at the end of September
- An information sheet was circulated in July to all Professional Staff regarding the new patient flow software and what this may mean for physicians
- The group will continue to strategize on how to engage physicians in length of stay data and ensure that they have tools and resources necessary to make improvements

Meetings with Department Chiefs

- Over the summer months, one-on-one meetings were held with the Chief of Staff and Department Chiefs to discuss a number of items such as roles and responsibilities, department specific goals, academics and physician engagement

Fracture Clinic Wait Times

- The success of the recent Fracture Clinic quality improvement plan was celebrated at MAC
- Data will be reviewed regularly and continued physician engagement will be essential

Communication and Engagement Strategy

- MAC endorsed the completion of a review and the development of a quality improvement plan to determine expectations for methods of communication with Professional Staff

Incomplete Health Records

- A meeting was held with the Managers of Health Records and Medical Affairs to look at process improvement under a quality improvement plan for incomplete health records

Policies and Procedures

- All Professional Staff were given the opportunity to provide feedback over the summer on several draft new policies including Professional Staff Resignation, Disclosure Requirements for Professional Staff and Transfer of Responsibility

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- Revisions to MS-23 Clinical Consultation for Most Responsible Physician – Emergency Department was discussed at the MAC meeting in June; further discussions will take place at section meetings in September

Medical Affairs Newsletter

- The inaugural issue of the Medical Affairs Newsletter was released in September
- This was an initiative introduced by Medical Affairs staff to increase Professional Staff engagement and satisfaction
- The newsletter will be trialed for a year with an issue released each quarter

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Chief Nursing Executive
Open Report
to the
Board of Directors

October 2016

Summary of Pressure Injury Monitoring and Prevention Strategies

- TBRHSC utilizes the Braden Skin Risk Assessment Tool to identify patients at highest risk for pressure injuries. Random chart audits monitor adherence to policy requirements of Braden assessment completed within 24 hours of admission, and follow-up Braden assessment at a minimum of once a week. Data since January 2016 indicates an average compliance of 88%.
- Since October 2014, bi-annual pressure ulcer prevalence and incidence (P&I) studies have measured the extent of pressure injuries at TBRHSC. These studies help inform the development of appropriate intervention strategies and education programs for staff.
- Recent P&I studies (Feb. 2016) indicated a prevalence of 10%, and incidence of 9%. The average prevalence rates for Acute Care Canadian hospitals of 300 to 399 beds are 14% (2015 Hill-Rom International Pressure Injury Survey). A subsequent P& I study (September 2016) indicated an improvement in prevalence (8.5%) and incidence (4.8%).

Leader Rounding on Patients

- Patient Rounding was "soft launched" in all clinical areas in 2015. It was informal, unrestricted, and focused on identifying patient expectations and addressing unmet patient needs.
- Effective September 2016, Clinical Inpatient Managers have been provided protected time in their daily schedules to establish a more disciplined approach to patient rounding
- Purposeful Patient Rounding processes connect Managers with patients to reinforce care, identify process improvement opportunities, verify nursing behaviours and reinforce best practices. It enables Managers to be present on their Units to engage, mentor and coach staff, while directly supporting patient care.
- Current implementation activities provide Managers with necessary supports to guide the rounding process including: questions they should be asking patients, how to use patient responses to inform improvement strategies, how to handle negative feedback from patients, and how to hardwire patient rounding into daily routines
- Measures and accountabilities related to Patient Rounding will be defined and the tactic will be evaluated at the 3, 6 and 12 month intervals

Recent Professional Appointments

- Erin Woodbeck, Registered Dietitian Practice Lead, was appointed as the President of the College of Dietitians of Ontario (CDO); and member of the Discipline/Fitness to Practice Committee member (CDO), June 2016

Northern Ontario School of Medicine
École de médecine du Nord de l'Ontario

Activity Report

Dr. Roger Strasser, Dean-CEO

August – September 2016

Welcome to the 2016-17 Academic Year

July and the first half of August are usually a quieter time which provides the opportunity to enjoy the warmth and outdoor activities of summer. I was able to do this and I hope you were too. Like all medical schools, many NOSM activities and programs continued through the summer. In particular: a new group of residents joined NOSM at the beginning of July; fourth year medical students continued their studies; Health Science Summer Camps for high school students were held at both Universities; and dietetic interns received their certificates at a graduation event.

On August 17th, NOSM Staff and Faculty took part in a *Be Active with NOSM* Break organized by the NOSM Healthy Workplace Group. This half-day event brought together over 90 staff and faculty for an afternoon in Bell Park in Sudbury and Boulevard Lake in Thunder Bay where there were many physical activities to enjoy, including canoeing, kayaking, stand-up paddle boarding, volleyball, lawn games. In addition, there was a bocce ball round robin, where participants were able to enjoy some friendly competition with their colleagues. Both of the events were a resounding success, encouraging staff to lead a healthy and active lifestyle.

On August 22 to 26th, the MD program entry class of 2016 joined NOSM for Orientation Week. Although only starting with NOSM on August 22nd, these students have been through quite a journey already. They were amongst 2153 applicants for this year's intake to the School. From the applicant pool, 308 were interviewed for the 64 available first year places. 57 of the students (89%) come from Northern Ontario and the other seven (11%) are from remote and rural parts of the rest of Canada. Within the class: 48 are women (75%); eight of the students are Indigenous (13%); and there are 12 Francophone students (19%). Like students in all medical schools, these students have been selected from a very competitive field and are extremely academically able as reflected by a mean grade point average (GPA) of 3.80 on a four point scale.

The members of the entry class of 2016 had a full Orientation Week ahead of them. Today, students, family and friends will be welcomed to NOSM at each University including video linked sessions connecting the whole class. Over the following days, students began learning about the practical aspects of the NOSM curriculum model and the four year MD program ahead of them, as well as exploring the cultural dimensions of the School guided by our Social Accountability mandate, and participating in the Oath Ceremony. On Friday, the new medical students participated in activities with the upper year student volunteers. Please join me in welcoming the entry class of 2016 to the NOSM family.

Health Sciences and Interprofessional Education

Although a "school of medicine", NOSM is involved in educating a wide range of other members of the health workforce. Through Distributed Community Engaged Learning (DCEL), NOSM provides clinical learning in a variety of settings ranging from Regional Hospitals to Community Health Centres and Family Health Teams, as well as in rural and remote, Indigenous and Francophone communities. The Northern Ontario Dietetic Internship Program (NODIP) may be described as the "Quiet Achiever" of NOSM. 85% of NODIP graduates are practising in rural and Northern Ontario. Through partnerships with other institutions, NOSM is involved in educating future physiotherapists, occupational therapists, speech language pathologists, audiologists, physician assistants, pharmacists and radiation physicists.

For NOSM, Interprofessionalism is a key Academic Principle which includes the key features of participation, collaboration and collegial decision making processes to improve learning and patient care. Interprofessional Education (IPE) occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care. In this context, IPE is essential to NOSM's success in preparing health professional graduates to practice as team players in providing care which is responsive to the needs of the people and communities they have the privilege to serve. One contributor to successful IPE is the Northern Interprofessional Collaborative in Health Education (NICHE) which connects post-secondary educational institutions, hospitals and other interprofessional health-care organizations across Northern Ontario.

NOSM Partners with HealthForceOntario to Improve Access to Health Care in the North

The Northern Ontario School of Medicine (NOSM) and HealthForceOntario Marketing and Recruitment Agency (HFO MRA) have signed a collaboration agreement in order to increase access to health professionals in Northern Ontario. The goal of this collaboration agreement is to help create sustainable

health systems in the communities of Northern Ontario, resulting in better health outcomes for patients in the North.

The Federal Minister of Indigenous and Northern Affairs Visits NOSM

NOSM is committed to meeting the needs of the people of Northern Ontario, including Indigenous and Francophone communities in the North. On August 20, the Honourable Carolyn Bennett, MD, the Federal Minister of Indigenous and Northern Affairs, visited NOSM to tour Canada's newest medical school and learn about the ways in which NOSM is working to improve the health of Northern, Indigenous, and Francophone peoples. Pictured here (from left to right) are: Dominic Giroux, President of Laurentian University; Ray Hunt, NOSM's CAO; Dr. Roger Strasser, NOSM Dean; the Honourable Carolyn Bennett, Federal Minister of Indigenous and Northern Affairs; Dr. Greg Ross, NOSM Professor; Paul Lefebvre, Sudbury Member of Parliament; and, Jennifer Wakegijig, NOSM Project Manager.

Collection of NOSM Videos on YouTube

When NOSM opened in 2005, we had the idea of producing a video about the inaugural year. Dr Hoi Cheu who teaches filmmaking at Laurentian University stepped up and produced "High Hopes" which follows the Charter Class students from orientation week to the end of their first year. Subsequently, Hoi continued to be involved with NOSM interviewing students as part of the Tracking Studies and then last year he produced "The Rural Challenge" to mark NOSM's 10th anniversary. Most recently, Hoi brought his camera to ICEMEN 2016 and has produced a series of videos. I encourage you to view the full collection of Hoi Cheu NOSM videos which are available on YouTube below.

High Hopes: https://youtu.be/lQZds0FJ9go
The Rural Challenge: https://youtu.be/gU3LE3vPt_4
Conference on the Move: https://youtu.be/dKdDtcUoISE
Indigenous Research Gathering: https://youtu.be/UKPqFvortEg
The Fire keeper's story: https://youtu.be/ZTAVgBAISTs
Dr. Cynthia Wesley-Esquimaux's complete keynote address: https://youtu.be/hRuOziYmWWc
Dot Beaucage-Kennedy's vision: https://youtu.be/ZI653fpvpBg
Dr. Frank Sullivan: https://youtu.be/A5jaIYf0_QA
Dr. Jill Konkin: https://youtu.be/DXclSIhMafg
Dr. Greville Wood: https://youtu.be/ORw-ngOnD4o
Dr. Emma Kennedy: https://youtu.be/CQ4cDPCI5iE
Dr. Ross Lawrenson: https://youtu.be/M3gZgAbJI70
The Oxford Debate: https://youtu.be/qmwwfAOaUdw

***Northern Passages*:** Spring/Summer 2016 **[English]** **[Français]**

The ***Scope:*** **http://nosm.ca/uploadedFiles/Research/Scope%20Fourth%20Issue%20Web.pdf**

For more news and information visit **www.nosm.ca**

Respectfully submitted,

Dr Roger Strasser AM
Professor of Rural Health
Dean and CEO
Northern Ontario School of Medicine

Northern Ontario School of Medicine
École de médecine du Nord de l'Ontario
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Memorandum

Date	September 7, 2016
To	NOSM Staff and Faculty
From	Dr. Roger Strasser, Dean
Re	***"Sustaining our Success"***

Over the past several years, the Northern Ontario School of Medicine (NOSM) has been facing fiscal challenges due to province-wide fiscal restraint. As you may remember, we are not alone; virtually all publicly funded organizations are encountering similar challenges.

Through your dedication to achieving a healthier North, we have been able to overcome many obstacles in delivering our distributed, community-engaged learning (DCEL) model across NOSM's wider campus of Northern Ontario. I know this has not been an easy task, and I am truly grateful for all that you do to realize our social accountability mandate.

Since 2010, NOSM's leadership team has embarked on various advocacy strategies to increase our base funding. During this time, we have secured interim and/or one-time funding envelopes that have assisted in the implementation of various initiatives at the School. While additional provincial funding is always welcomed and appreciated, one-time funding does not enable our School to move forward with stable financial footing.

This past summer, members of the Executive Group initiated a tactical communication approach that correlates the success of NOSM (i.e. the School's ability to increase the supply of physicians in the North) with the sustainability of our DCEL model. I have attached a paper entitled ***"Sustaining our Success"*** which provides more information, and was used to advocate for the School with various agencies. As a NOSM Ambassador, I invite you to familiarize yourself with this document in hopes that it may assist you in explaining NOSM's financial situation to our colleagues or stakeholders. From my perspective, the more our Northern collaborators are aware of our challenges, the more it may help in our advocacy efforts to improve our fiscal situation. In the current fiscal environment, every voice helps.

I am pleased to report that, based on recent meetings I have had with municipal and provincial political leaders, it appears that our messaging is being heard. There are signs that our current approach may yield a positive outcome. In fact, just recently, the Minister of Health and Long-Term Care, the Honourable Dr. Eric Hoskins, was quoted as saying, *"I don't think any of us really understood just how impactful the Northern Ontario School of Medicine might be–adding that sixth medical school to the province. It has been pretty remarkable."*

I encourage you to read ***"Sustaining our Success."*** Should you have any questions or require additional information related to this communication strategy, please do not hesitate to approach your manager.

Again, I want to thank you for all you do every day in making NOSM remarkable.

Dr. Roger Strasser

Northern Ontario School of Medicine

Sustaining Its Success

Issue

Since its inception, the Northern Ontario School of Medicine (NOSM) has significantly improved the health-care landscape of Northern Ontario and has exceeded expectations guided by its social accountability mandate to help improve the health of people in the North.

Despite this success, NOSM is now at a crossroads. The cumulative effect of a prolonged fiscal constraint will adversely impact NOSM's ability to yield a critical mass of physician services in Northern Ontario. This will result in future challenges and pressures in health-care delivery, leaving much of the Northern population vulnerable and at risk.

Summary of Challenges and Opportunities

- Status quo is unsustainable. The projected funding shortfall, starting in 2017, will put medical education in the North at risk and will dismantle the gains made since the School's charter class of 2005.
- Some Government operating grants have been flat-lined since NOSM's inception in 2002 (while costs have increased annually by an average of 2%).
- Significant reliance on Government funding (which is not adjusted for annual inflation, collective bargaining increases, fixed costs, etc.) has placed NOSM in an annual structural deficit situation.
- Reduced funding has also negatively impacted staff (contributing to turnover, recruitment/retention, burnout/morale).
- An opportunity exists for the Government to help offset NOSM's structural deficit by making NOSM eligible for the "***Northern Ontario Grant.***" This grant is currently added to the base funding of four other universities (Lakehead, Laurentian, Hearst, and Nipissing). Extending it to NOSM would address its financial sustainability challenges.
- NOSM will continue to review/explore opportunities to become more efficient while maintaining accreditation standards and its social accountability mandate.
- An immediate increase in base funding (even on an interim basis) is needed, while the province establishes a new funding formula for universities and colleges in Ontario.

NOSM's Success

- Much of NOSM's success can be attributed to an internationally recognized ***Distributed Community Engaged Learning*** (DCEL) model that was developed by NOSM.
- The unique DCEL model depends on the partnerships and collaborations with individuals, communities, and organizations across the North including strong ties with Indigenous and Francophone communities.
- Together, over 90 organizations/communities and over 1,300 faculty dispersed across the 820,000 sq. km of Northern Ontario (***the NOSM campus***) all play a vital role in educating and supporting learners so that they develop a personal understanding of the challenges and rewards of living and working in Northern Ontario.
- While preparing its graduates to work in a complex environment, DCEL also facilitates the recruitment and retention of physicians and other health professionals in rural and remote communities.
- To date, **94% of the doctors who completed their undergraduate and postgraduate education with NOSM are today practicing in Northern Ontario, including 33% in remote rural communities**.

- Since 2011**, 149 NOSM family medicine graduates now practice in the North. This translates to better access to care for an additional 180,000 patients in the North** (about 20% of the Northern population who would have been without a family doctor).
- In addition to its profound influence on Northern health, NOSM has a positive socio-economic impact in the region. A study completed in 2009 by the Centre for Rural and Northern Health Research (CRaNHR), entitled *"Exploring the Socio-Economic Impact of the Northern Ontario School of Medicine,"* demonstrated that **NOSM is generating $67 - $82 million per year of new economic activity in the North.**
- CRaNHR notes in another study that many Northern Ontario communities that have historically suffered from chronic physician shortages and reduced access to health care, are now, for the first time in decades, no longer in crisis.
- NOSM and Northern Ontario cannot rest on its laurels. There are still many communities that are underserved and a growing elderly population (in the North) that will need a specialized medical focus that is a key feature of NOSM's academic curriculum and learning model.
- CRaNHR also predicts that, with an aging physician workforce, Northern Ontario is at risk of experiencing a 50% physician retirement/attrition rate within the next five years. It is well recognized that it takes approximately two physicians to replace a retiring physician (due to a difference in practice style/preference). This phenomenon will require NOSM to achieve even greater success than it has already realized.

Financial Context

- NOSM currently receives the majority of it funding (84%) from two Government ministries – MTCU (now known as the Ministry of Advanced Education and Skills Development) and MOHLTC. 14% is derived from student tuition fees that NOSM collects.
- Other than tuition fees and Government funding, NOSM's business model has limited opportunities to raise revenues (due to NOSM's relative newness and advancement restrictions put in place by its two affiliated universities).
- The original 2002 PricewaterhouseCoopers (PwC) Business Plan (the plan which the Government used to create NOSM) had recommended a much higher (per student) Government grant due to a higher cost associated with operating a "distributed" medical school with all of the North as its campus. Despite PwC's recommendation, provincial funding was set at a lower amount.
- NOSM's expenditures (as a percentage) are not out of line with other academic institutions. For example:
  - 70% related to salaries/wages (including teaching fees) – subject to annual increases due to collective agreements.
  - 5% related to administrative expenses (below provincial average) despite the fact that NOSM operates at two universities (1,000 km apart) along with 90 teaching sites across the North.
- As part of the Government's fiscal constraint strategy, and a focus to eliminate the provincial deficit by 2017-18, NOSM's funding has been frozen for the past several years. While the province did increase the number of residency positions in 2015, resulting in new and much needed revenues, years of frozen revenues has the risk of eroding the gains that have been made in NOSM's first 10 years.
- The following diagram (Exhibit 1) illustrates the current pressures associated with the lingering funding freeze. Exhibit 2 shows how NOSM's deficit will trend by 2019-20:

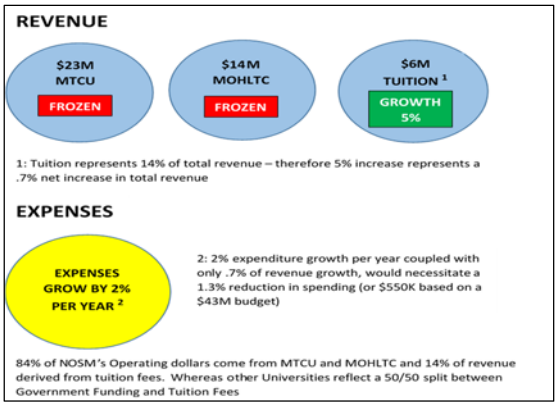

Exhibit 1

Revenue & Expenses $(000's)	Actual Budget 2014-15 $(000)	Actual Budget 2015-16 $(000)	Proposed Budget 2016-17 $(000)	Projected Budget 2017-18 $(000)	Projected Budget 2018-19 $(000)	Projected Budget 2019-20 $(000)
Revenues	$43,100	$43,450	$44,075	$44,400	$44,700	$45,075
Expenses	$43,100	$43,450	$44,075	$44,950	$45,775	$46,675
Surplus (Deficit)	$000	$000	$000	($550)	($1,075)	($1,600)

Exhibit 2

- In response to financial sustainability concerns raised by NOSM in 2013/14, MTCU recently funded a report, entitled ***Organizational Blueprint*** (OB), completed by Deloitte, to determine how NOSM could reduce costs while maintaining its *social accountability mandate*.
- Findings of the report suggested that even after reducing costs through operational realignment/efficiencies, integration, and consolidation of select services with the universities (Lakehead and Laurentian), NOSM would still have an annual structural deficit of $1.4M by 2020.
- Prior to the completion of the OB, NOSM was projecting an annual deficit of $2.24M by 2019-20.
- As NOSM has continued to implement operational efficiencies that were identified in the OB, it has now reduced its projected deficit from $2.24M to $1.6M by 2019-20. With further work on OB implementation over the next two years, NOSM is confident that it can achieve Deloitte's target of $1.4M deficit by 2019.
- Despite this effort, expenditure reductions alone will not place NOSM in a positive financial position. As noted in the OB, a new funding formula is needed to sustain the NOSM model.

Background

- On May 8, 2002, Cabinet directed three ministries (MTCU, MOHLTC, and MNDM) to develop a single Northern medical school with two universities… one in Sudbury (Laurentian University) and one in Thunder Bay (Lakehead University).
- The Ontario Government's approval of NOSM's original 2002 Business Plan included a ***"social accountability mandate"*** to:
  - help improve the health of the people and communities of Northern Ontario, and;
  - design and teach curriculum, and undertake research, that responds to the unique needs of the geographically, socially and culturally diverse population (including a focus on Indigenous and Francophone populations)
- NOSM is unique as it is:
  - the only Canadian medical school to be established as a stand-alone, not-for-profit corporation, with a governance that is controlled by the two universities
  - not degree granting institution (MD degree granted jointly by Laurentian and Lakehead)
  - serves as the "Faculty of Medicine" of two universities
  - required to deliver medical education across a vast geography in keeping with its *social accountability mandate*
  - is responsible for 100% of both direct and indirect costs of its operations (whereas other universities cover/subsidize some of these costs for their medical schools)
- NOSM just celebrated its 10th Anniversary from admitting the MD charter class in 2005.

Thunder Bay Regional Health Sciences Centre **Policies, Procedures, Standard Operating Practices**	No. BD-05
Title: CEO Performance Evaluation and Compensation	**X Policy** **X Procedure** ☐ **SOP**
Category: Board of Directors **Dept/Prog/Service:** Board of Directors	**Distribution:** n/a
Approved: Board of Directors **Signature**:	**Approval Date:** ~~March 4~~Oct 5, 201~~6~~5 **Reviewed/Revised Date:** ~~Feb. 18~~Sept 21, 201~~6~~5 **Next Review Date:** Nov.~~19~~, 201~~7~~5

CROSS REFERENCES: *If applicable.*

PURPOSE

To outline the process for the CEO Performance Evaluation.

POLICY

The performance of the CEO must be reviewed annually as a basis for compensation adjustments.

Performance Evaluation:

The CEO Performance Evaluation is comprised of two elements, which are comprised of the following ~~in total represent the required elements for performance review. These elements are as follows~~:

1. CEO ~~Goals and~~ Objectives;~~.~~
2. CEO Competencies.

~~PROCEDURE~~PROCESS

The Chair ~~shall~~ initiates the CEO Performance Evaluation in March of each year. The voting members of the Executive Committee will assist the Chair in the CEO evaluation. ~~The Chair shall appoints an Evaluation and Compensation Committee as a Sub-Committee of the Executive Committee comprised of at least four (4) members.~~

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CEO ~~Goals and~~ Objectives:

~~Each~~ In March of each year, the CEO ~~will~~ submits to the voting members of the Executive ~~Evaluation and Compensation~~ Committee, the proposed annual objective priorities for the next fiscal year, including related performance indicators~~metrics~~ such as desired outcomes and timing. The CEO ~~Goals and~~ Objectives must be ~~will be~~ consistent with the Hospital's~~TBRHSC~~ Quality Improvement Plan (QIP).

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Once approved, the CEO ~~Goals and~~ Objectives ~~will~~ represent the CEO's Aannual Wwork Pplan founded on the ~~(~~Job Description, Quality Improvement Plan, Strategic Plan and the Balanced Scorecard~~)~~. Quarterly ~~Throughout the year~~, progress is~~shall be~~ reviewed by the Board Chair in order to ~~review and~~ assess ~~progress and~~ any appropriate changes to the Wwork Pplan.

At year end, the completed Wwork Pplan, including the CEO input on achievements, is forwarded~~shall be given~~ to the ~~Evaluation and Compensation Committee~~voting members of the Executive Committee.

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The final assessment of the achievements ~~shall~~ represents one of the two parts of the CEO Performance Evaluation. ~~A~~A summary is presented to the ~~shall be given to the total~~ Board by the voting members of the Executive Committe~~Evaluation and Compensation Committee~~.

This annual process ~~shall be repeated annually~~is subject to ~~any~~ changes proposed by the Governance Committee as ~~and~~ approved by the Board of Directors (see ~~S~~section: Role of the Governance and ~~CEO Evaluation and Compensation~~voting members of the Executive Committees).

CEO Competencies:

The essential competencies ~~which are essential~~ to the success of the CEO ~~shall~~ comprise the second element of the CEO's Performance Evaluation.

A competency is defined as any knowledge, skill, trait, motive, attitude, value, or other personal characteristics that are~~is~~ essential to discharge the responsibilities of the CEO~~perform the job an~~ and that differentiate~~s~~ good from superior performance. The essential competencies and their subsets are as follows:

Achieving Results:
1. Building s~~S~~trategic p~~P~~artnerships;
2. Collaboration;
3. Impact and i~~I~~nfluence;
4. Organizational a~~A~~wareness;
5. Results o~~O~~rientation;
6. Service and q~~Q~~uality o~~O~~rientation.

Leading Effectively:
1. Building o~~O~~rganizational c~~C~~apacity;
2. Holding s~~S~~elf and o~~O~~thers a~~A~~ccountable;
3. Visionary ~~L~~leadership.

Thinking Critically:
1. Business a~~A~~cumen;
2. Strategic o~~O~~rientation.

Personal Effectiveness:
1. Interpersonal s~~S~~ensitivity;
2. Leadership p~~P~~resence.

~~The Chair will initiate annually the evaluation of the CEO in terms of these competencies.~~

In April, ~~all~~ Board members are~~will be~~ asked to participate in the CEO performance Evaluation ~~via a web-based tool~~ to assist in the competency assessment.

~~In a~~Additionally, ~~at the discretion of the CEO and the Chair, up to six (6) other peers and direct reports may be asked to participate.~~. ~~These six are in addition to the Board members and are a combination of internal and external stakeholders.~~Furthermore, the President and CEO may elect to have up to six peers and direct reports participate in the evaluation process, in addition to the Board members. Should he/she elect this option, the peers/direct reports selected by the President and CEO must be agreeable to the Board Chair.

By the end of ~~April, a summary report prepared by the Executive Vice-President, Health Human Resources, Planning and Strategy is provided will be sent to the~~April, the Board Chair prepares a summary report.

The Board Chair ~~will~~ meets with the CEO for a preliminary review of the competency assessment.

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The Board Chair, with the voting members of the Executive Committee~~Evaluation and Compensation Committee members~~, ~~shall~~ meets with the CEO to review the results from the competency assessment, and to discuss the achievements in the CEO annual ~~Goals and~~ Objectives.

A summary representing both elements ~~will be~~is presented to the Board by the Chair at the May Board meeting.

CEO Compensation

The benchmark for comparing the CEO compensation ~~shall be~~is the OHA annual survey of hospitals with 300 to ~~-~~499 beds. ~~-~~The target rate is set at the 50th percentile.

Compensation ~~shall~~ includes base salary, pay at risk, pay for performance, and relevant p~~r~~re~~e~~quisites. ~~-~~To ensure an appropriate record of performance evaluation and compensation, the Chair on behalf of the voting members of the Executive Committee~~Evaluation and Compensation Committee~~ shall write to the CEO confirming the performance evaluation results and any compensation adjustment~~increases~~ the Board ~~would~~ elects to grant consistent with Hospital ~~TBRHSC's~~ policy and any relevant ~~appropriate~~ legislation.

Role of the ~~CEO Evaluation and Compensation~~voting members of the Executive and Governance Committees

The ~~CEO Evaluation and Compensation~~voting members of the Executive Committee ~~will~~ reviews annually the process of the CEO Performance ~~E~~Evaluation and recommend any changes to the Governance Committee. The Governance Committee ~~will~~ then recommends changes to the Board of Directors. This process ~~will~~ occurs at the end of the CEO Performance Evaluation cycle, and should be completed by September of each year.

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Thunder Bay Regional Health Sciences Centre Policies, Procedures, Standard Operating Practices		No. BD-07
Title: Chief of Staff (COS) Performance Evaluation and Compensation	**X Policy** **X Procedure** ☐ **SOP**	
Category: Board of Directors **Dept/Prog/Service:** Board of Directors	**Distribution:** n/a	
Approved: Board of Directors **Signature**:	**Approval Date:** **Reviewed/Revised Date:** **Next Review Date:**	Oct 5, 2016 Sept 21, 2016 Nov. 2017

CROSS REFERENCES: *if applicable*

PURPOSE

To outline the process for the COS Performance Evaluation.

POLICY

The performance of the COS must be reviewed annually as a basis for compensation adjustments.

Performance Evaluation:

The COS Performance Evaluation is comprised of two elements, which are comprised of the following:

1. COS Objectives.
2. COS Competencies.

PROCESS

The Chair and President & CEO initiates the COS Performance Evaluation in March of each year. The voting members of the Executive Committee and the President & CEO will assist the Chair in the COS evaluation.

COS Objectives

In March of each year, the COS will submit to the voting members of the Executive Committee and the President & CEO, the COS proposed annual objective priorities for the next fiscal year, including related performance indicators such as desired outcomes and timing. The COS Objectives must be consistent with the Hospital's Quality Improvement Plan (QIP).

Once approved, the COS Objectives represent the COS Annual Work Plan. Quarterly progress is reviewed by the Board Chair and the President & CEO in order to review and assess progress and any appropriate changes to the Work Plan.

At year end the completed Work Plan, including the COS input on achievements is forwarded to the voting members of the Executive Committee and the President & CEO.

The final assessment of the achievements represents one of the two parts of the COS Performance Evaluation. A summary is presented to the Board by the voting members of the Executive Committee and the President & CEO.

This annual process is subject to changes proposed by the Governance Committee as and approved by the Board of Directors (see section: Role of the Chief of Staff Evaluation and Compensation and Governance Committees).

COS Competencies

The essential competencies to the success of the COS shall comprise the second element of the COS' Performance Evaluation.

A competency is defined as any knowledge, skill, trait, motive, attitude, value, or other personal characteristic that are essential to discharge the responsibility of the COS and that differentiates good from superior performance. The essential competencies and their subsets are as follows:

Teamwork:
1. Teambuilding;
2. Team leadership;
3. Leading by example.

Interpersonal Skills:
1. Building relationships;
2. Relationship management;
3. Resolving conflict.

Communicates Effectively:
1. Communication style;
2. Promoting internal communication;
3. Listening.

Demonstrates Flexibility:
1. Adaptability;
2. Leading change;
3. Time management.

Continuous Improvement:
1. Championing innovation;
2. Innovative problem solving;
3. Focus on customers/quality.

Drives Outcomes:
1. Decision making;
2. Planning;
3. Directing and delegating.

Continuous Learning:
1. Professional development;
2. Performance management;
3. Developing leadership.

In April, Board members are asked to participate in the COS Performance Evaluation to assist in the competency assessment.

Furthermore, the COS may elect to have up to six peers and direct reports participate in the evaluation process, in addition to the Board members. Should he/she elect this option, the peers/direct reports selected by the COS must be agreeable by the Board Chair and the President and CEO.

By the end of April, the President and CEO prepares a summary report.

The Board Chair and President & CEO will meet with the COS for a preliminary review of the competency assessment.

The Board Chair and the President & CEO, with the voting members of the Executive Committee, meets with the COS to review the results from the competency assessment, and to discuss the achievements in the COS annual Objectives.

A summary representing both elements is presented to the Board by the Chair at the May Board meeting.

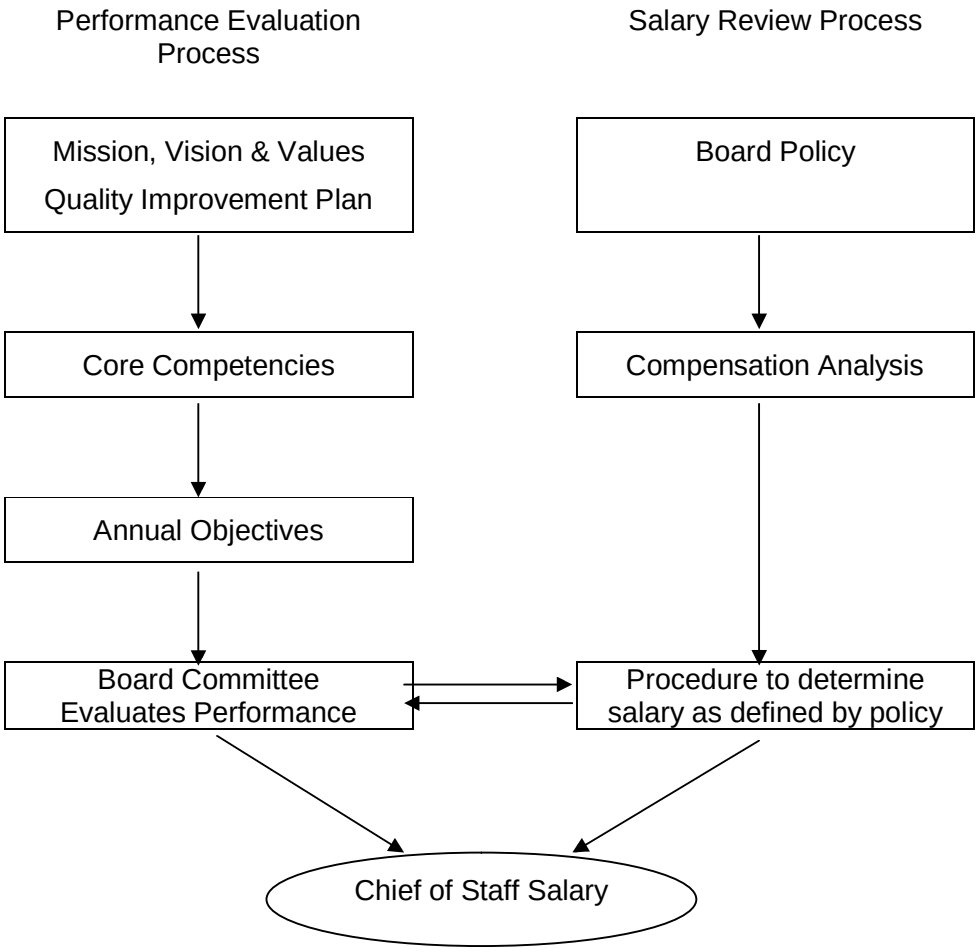
COS Compensation

The COS compensation is consistent with compensation paid to other physicians in executive positions at the Hospital to ensure appropriate record of performance evaluation and compensation. The Chair on behalf of the voting members of the Executive Committee and President & CEO writes to the COS confirming the performance evaluation results and any compensation adjustments the Board elects to grant consistent with the Hospital's policy and any relevant legislation.

Role of the voting membes of the Executive Committee, President & CEO and Governance Committees

The voting members of the Executive Committee and the President and CEO reviews annually the process of the COS Performance Evaluation and recommends changes to the Governance Committee. The Governance Committee then recommends changes to the Board of Directors. This process occurs at the end of the COS Performance Evaluation cycle, and should be completed by September of each year.

Chief of Staff Performance Evaluation and Salary Review Process



RESOURCE PLANNING COMMITTEE WORK PLAN

2016-2017 as at September 20, 2016

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
1	Oversight of Management	2016-17 Work Plan for information only		x	x	x	x	x	x	x	x	x		
2	Financial Oversight	ALC, LOS and Emergency Admissions Monthly Report for information only		x	x	x	x	x	x	x	x	x		
3	Financial Oversight	Board Attestation: Wages and Source Deductions		x	x			x			x			
4	Financial Oversight	Financial Statements and Variance Report		x		x			x			x		
5	Financial Oversight	Financial Statements for information only		x	x		x	x		x	x			
6	Financial Oversight	Investment Policy Annual Review		x										
7	Financial Oversight	Investment Portfolio Reviews		x							x			
8	Financial Oversight	Northwest Supply Chain Performance and Medbuy Update		x							x			Deferred to October
9	Oversight of Management	Work Plan Review 2016-17		x										
10	Oversight of Management	Work Plan Approval 2017-18							x					
11	Governance	Terms of Reference Review		x										
12	Governance	Terms of Reference Annual Approval							x					
13	Performance Measurement and Monitoring	Corporate Balanced Scorecard			x			x			x			
14	Financial Oversight	H-SAA 2016-17 Operating Plan Submission			x									
15	Financial Oversight	CAPS Submission to LHIN			x									
16	Performance Measurement and Monitoring	Human Resources and Organizational Development Update		x	x	x	x	x	x	x	x	x		
17	Financial Oversight	Broader Public Sector Travel & Expense Report				x						x		
18	Financial Oversight	Budget Planning Targets and Directives Report				x								
19	Financial Oversight	Budget Planning Process Update				x								
20	Financial Oversight	Funding HBAM and Quality Based Procedures Update				x								
21	Financial Oversight	HAPS 2017-18 Update				x								

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
22	Financial Oversight	TBRRI and Sustainability Updates				x					x			
23	Financial Oversight	Capital Equipment and Capital Projects 2016-17 Update						x			x			
24	Financial Oversight	Insurance Review						x						
25	Risk Identification and Oversight	Data Centre Disaster Recovery Plan Update								x				
26	Performance Measurement and Monitoring	Labour Relations, Grievances and Arbitrations Update								x				
27	Legal Compliance	Occupational Health and Safety Program Update								x				
28	Financial Oversight	Operating Plan Update 2017-18		x	x	x								
29	Financial Oversight	Operating Plan Approval 2017-18					x							
30	Legal Compliance	Public Sector Salary Disclosure								x				
31	Financial Oversight	Capital Budget 2017-18 Update			x									
32	Financial Oversight	Capital Budget 2017-18 Approval					x							
33	Legal Compliance	Broader Public Sector Accountability Attestation Certificate										x		
34	Legal Compliance	Broader Public Sector Use of Consultants Attestation										x		
35	Oversight of Management	H-SAA Declaration of Compliance Attestation										x		
36	Oversight of Management	M-SAA Declaration of Compliance Attestation										x		
37	Risk Identification and Oversight	Non Patient Legal Matters Annual Review										x		
38	Financial Oversight	Numbered Companies Unaudited Financial Statements 2016-17										x		
39	Risk Identification and Oversight	TBRRI 2017-18 Operating and Capital Budget Report										x		
40	Risk Identification and Oversight	TBRRI 2016-17 Unaudited Financial Statements Review										x		
41	Financial Oversight	Unaudited Preliminary YE Financial Statements to 2017-03-31										x		

APPENDIX B - Quality Committee of the Board - 2016-17 Updated: Sept. 28, 2016

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	Presenter	Comments
1	Quality Oversight	Programs & Services Presentations		x	x	x	x	x	x	x	x	x	Dyad Leads	
2	Quality Oversight	Comments / Compliments / Complaints			x				x				C. Covino	
3	Quality Oversight	Credentialing and Licensing Processes for Professional Staff and Health Professionals		x									M. Addison / Dr. M. Langlois	
4	Quality Oversight	Critical Incidents / MAC Recommendations				x					x		C. Covino	
5	Quality Oversight	Emergency Preparedness					x					x	C. Covino /K. Bell/F. Pennie	
6	Quality Oversight	Financial Pressures Relating to Risk	x										P. Myllymaa	
7	Quality Oversight	Patient Safety		x			x			x		x	S. Craig	
8	Quality Oversight	Patient Safety / Public Indicators									x		H. McIver	
9	Quality Oversight	Accreditation			x				x				G. Ferguson	
10	Quality Oversight	Quality and Risk Management Policies						x					C. Covino	
11	Quality Oversight	Quality Improvement Plan Excerpt from Balanced Scorecard			x		x			x			C. Covino / M. Del Nin	
12	Quality Oversight	Quality Improvement Plan Updates / Approval						x	x				All	
13	Quality Oversight	Risk Management / Enterprise Risk Management			x			x					C. Covino /K. Bell/F. Pennie	
14	Quality Oversight	Terms of Reference Review		x									D. Shanks / C. Covino	
15	Quality Oversight	Terms of Reference Approval						x					D. Shanks / C. Covino	
16	Quality Oversight	Work Plan 2016-17 Review		x									D. Shanks / C. Covino	

17	Quality Oversight	Work Plan 2017-18 Approval						x				D. Shanks / C. Covino	
18	Quality Oversight	Litigation									x	C. Covino	
19	Quality Oversight	Research Ethics Board		x		x				x		x	K. Bell	
20	Quality Oversight	Research Ethics Board Annual Report										x	K. Bell	
21	Quality Oversight	Annual Quality Research Report					x						A. M. Heron	
22	Quality Oversight	Quality-Based Procedures									x		S. Craig	

DRAFT-Governance/Nominating Committee 2016-17

Updated: September 30, 2016

Colour Legend
Completed by target
In progress but not
Not in progress, and not

Committee legend:
G - Governance
N - Nominating

Meetings Held:
Governance-September. November, February, May
Nominating-March, April (interviews)

#	Accountability	Activity	Committee	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
1	Governance	Review Gov/Nom Committee work plan for upcoming year	G		x										
2	Governance	Review Gov/Nom Committee terms of reference	G				x								
3	Governance	Board members identify education needs for coming year	G		x										
4	Governance	Review Board vacancies	G							x					
5	Oversight of Management	Review CEO/COS Performance Evaluation Process	G		x										
6	Governance	Review Board forms	G		x										Forms to be reviewed every three years moving forward
7	Governance	Review all Board policies - identify revisions required	G				x								
8	Governance	Plan annual Board retreat	G										x		Annual Retreat to be held in September of each year
9	Governance	Review all Board committee terms of reference	G										x		

#	Accountability	Activity	Committee	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
10	Governance	Review all Board committees work plans	G							x					**Beginning in 2016-17:** all Committee workplans for the for next year's Board cycle will be reviewed at the Febraury Governance with approval at the March Board meeting
11	Governance	Review meeting evaluations for the quarter	G				x						x		
12	Governance	Review Board and Board Committee attendance summary	G										x		
13	Governance	Review team effectiveness scale summary	G							x			x		Distributed to Board members at December/April Board meetings.
14	Governance	Board Chair to review self assessment questionnaire	G							x					Only reviewed by the Board Chair
15	Governance	Appoint community member	N							x					
16	Governance	Review and approve nominating action plan	N							x					
17	Governance	Review Policy BD-45 Preferred Selection Criteria for Board Membership	N							x					
18	Governance	Review current Board member skills matrix inventory	N							x					Current Board members to complete at November Board meeting
19	Governance	Review and approve skills matrix for Board of Directors applicants	N							x					
20	Governance	Review and approve application for membership form	N							x					
21	Governance	Review and approve ad	N							x					
22	Governance	Review of Board of Directors applications	N								x				

#	Accountability	Activity	Committee	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
23	Governance	Review and approve letters to applicants	N								x				
24	Governance	Review and approve interview questions	N								x				
25	Governance	Review and approve interview schedule	N								x				
26	Governance	Interview candidates	N									x			
27	Governance	Review incumbents	N									x			
28	Governance	Review of applicant interviews	N									x			
29	Governance	Propose slate of nominees	N									x			
30	Governance	Review By-Laws	G										X		
31	Governance	Review orientation program	G										x		
32	Governance	Review Board annual evaluation tool summary	G										x		Distributed at April Board meeting
33	Governance	Review annual education session summary	G										x		

AUDIT COMMITTEE

2016-2017 WORK PLAN

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
1	Oversight of Management	2016-2017 Work Plan for information only						x		x		x		
2	Financial Oversight	2016-2017 Audit Plan Overview - Grant Thornton						x						
3	Governance	Terms of Reference Annual Approval						x						
4	Performance Measurement and Monitoring	Review Results of May 2016 Evaluation of Auditors						x						
5	Financial Oversight	Independence Questionnaire 2016-2017						x						
6	Risk Identification and Oversight	Policy Reviews: Admin-19 & Admin-28						x						
7	Risk Identification and Oversight	Expense Test Audit						x						
8	Risk Identification and Oversight	Interim Audit Review 2016-2017								x				
9	Performance Measurement and Monitoring	Discussion of Year End Reporting Issues 2016-2017								x				
10	Financial Oversight	Audit Statement Review 2016-2017								x				
11	Financial Oversight	Individual Program Audit Reports								x				
12	Financial Oversight	Update on New Hospital Capital Audit								x				
13	Financial Oversight	Summary of Audit Fees Paid for 2016-2017								x				
14	Financial Oversight	2016-2017 Year End Financial statements for Board Approval										x		
15	Financial Oversight	2016-2017 Audit Results - Grant Thornton										x		
16	Oversight of Management	2016-2017 Management Letter										x		
17	Risk Identification and Oversight	2016-2017 Claims Summary										x		
18	Risk Identification and Oversight	Analysis of Legal Fees as at March 31, 2017										x		
19	Performance Measurement and Monitoring	Evaluation of Auditors for 2016-2017										x		
20	Performance Measurement and Monitoring	Recommend Appointment of Auditors for 2017-2018										x		
21	Oversight of Management	2017-2018 Work Plan Approval								x				

FISCAL ADVISORY COMMITTEE

2016-2017

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
1	Stakeholder Communication and Accountability	Financial Statements and Variance Report				x								
2	Stakeholder Communication and Accountability	Operating Plan 2016-17				x								
3	Stakeholder Communication and Accountability	Q2 2016-17 Financial Review				x								
4	Stakeholder Communication and Accountability	Work Plan 2016-17 For Information Only				x								
5	Stakeholder Communication and Accountability	Financial Statements as at 2016-08-31				x								
6	Stakeholder Communication and Accountability	Financial Statements and Variance Report									x			
7	Stakeholder Communication and Accountability	Operating Budget 2016-17									x			
8	Stakeholder Communication and Accountability	Q3 2016-17 Financial Review									x			
9	Stakeholder Communication and Accountability	Financial Statements as at 2016-02-28									x			
10	Stakeholder Communication and Accountability	Terms of Reference Annual Approval									x			
11	Stakeholder Communication and Accountability	Work Plan 2017-18 Approval									x			

gional Health Sciences Centre Board of Directors Work Plan

Updated: September 30, 2016

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

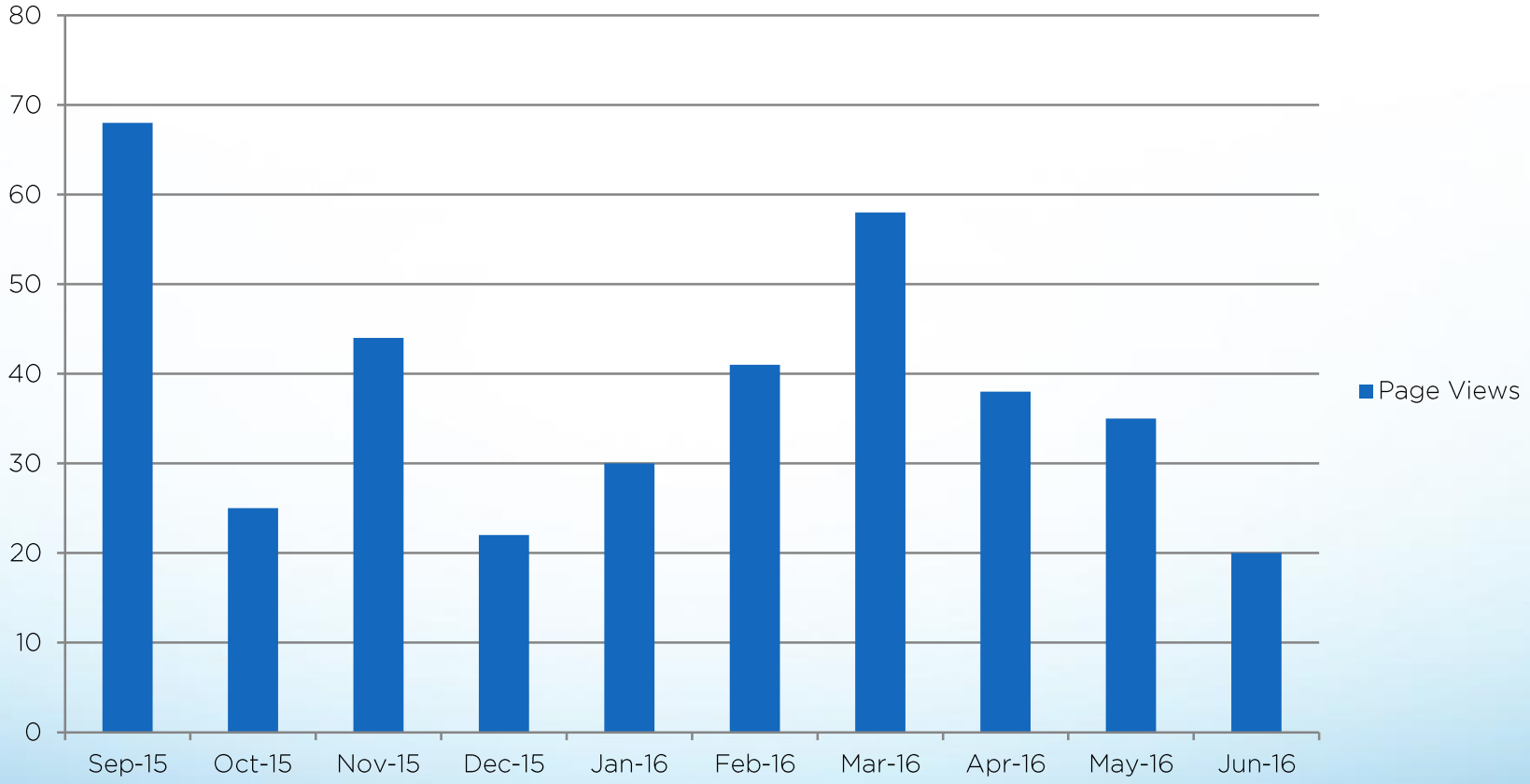
Legend:
BD: Board of Directors
EC: Executive Committee

#	Accountability	Activity	Responsible Body	As Needed	October	November	December	February	March	April	May	June	Comments
2	Governance	Monthly education topics for the Board	BD		x	x	x	x	x	x	x	x	
3	Oversight of Management	Participate in CEO evaluation via website	BD							x			
4	Oversight of Management	Participate in COS evaluation via website	BD							x			
5	Governance	Approval of By-Laws	BD								x		
6	Governance	Approve Slate of Nominees to fill Board vacancies	BD								x		
7	Oversight of Management	Approve CEO evaluation	BD									x	
8	Oversight of Management	Approve COS evaluation	BD									x	
9	Governance	Approval of Committee terms of reference and work plans	BD				x						

#	Accountability	Activity	Responsible Body	As Needed	October	November	December	February	March	April	May	June	Comments
10	Legal Compliance	Environmental compliance and fire safety update	BD		x		x		x			x	
11	Legal Compliance	Accessibility update	BD										
12	Quality Oversight	Critical Incidents Presentation	BD				x				x		
13	Oversight of Management	Physician recruitment plan update	BD										
14	Performance Measurement and Monitoring	Strategic plan update	BD							x			
15	Quality Oversight	Research Ethics Board appointments	BD		x								
16	Quality Oversight	Research Ethics Board report	BD									x	
17	Performance Measurement and Monitoring	Scorecard update	BD									x	
18	Governance	TBRRI update	BD			x					x		
19	Governance	TBRHS Foundation update	BD		x								
20	Governance	Occupancy update	BD			x		x			x		
21	Oversight of Management	Evaluation of CEO	EC								x		
22	Oversight of Management	Evaluation of COS	EC								x		

Page Views: Open Board Meeting Webcast

September 2015 – June 2016

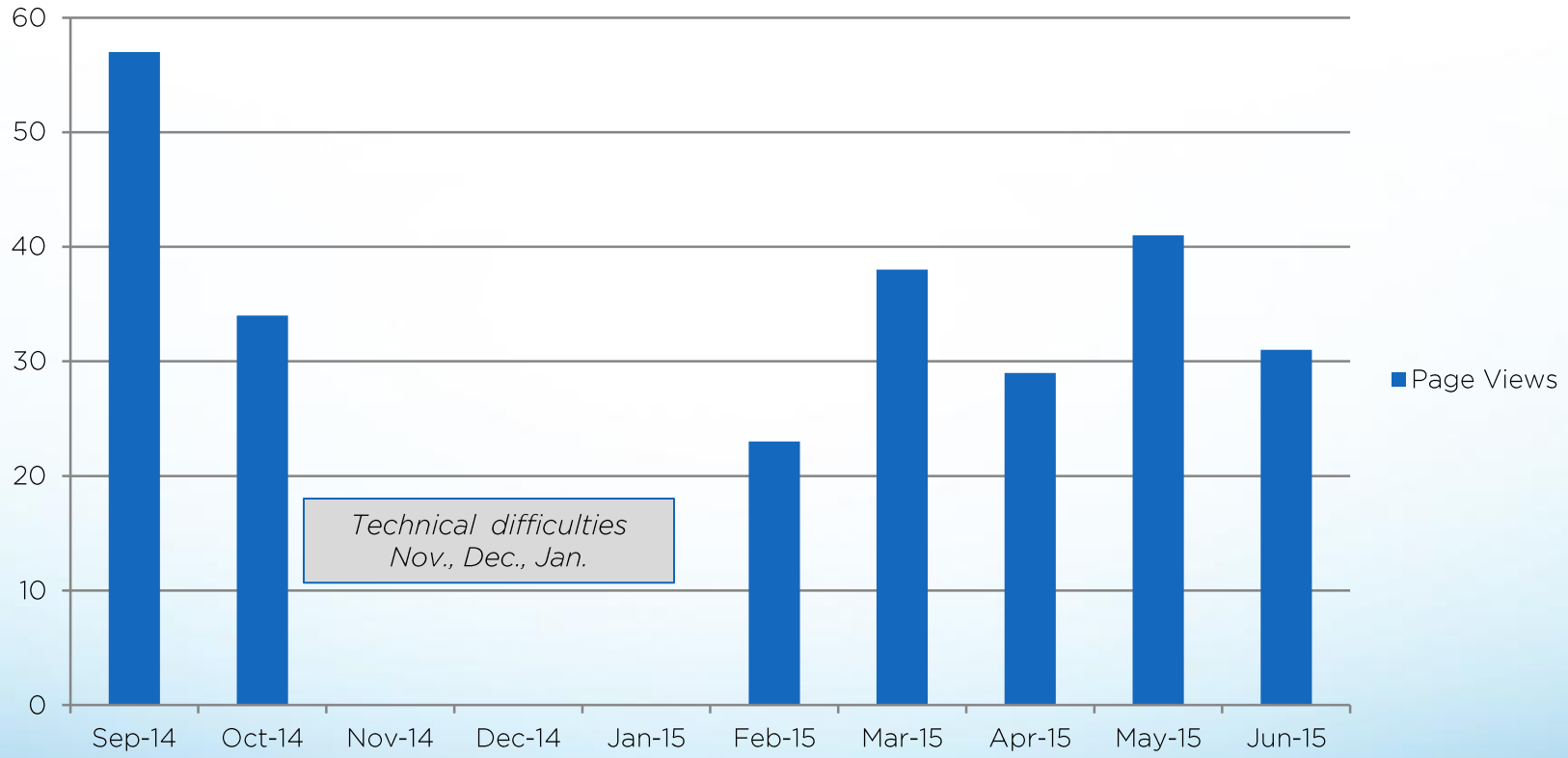


Thunder Bay Regional Health Sciences Centre

healthy together

Page Views: Open Board Meeting Webcast

September 2014 – June 2015

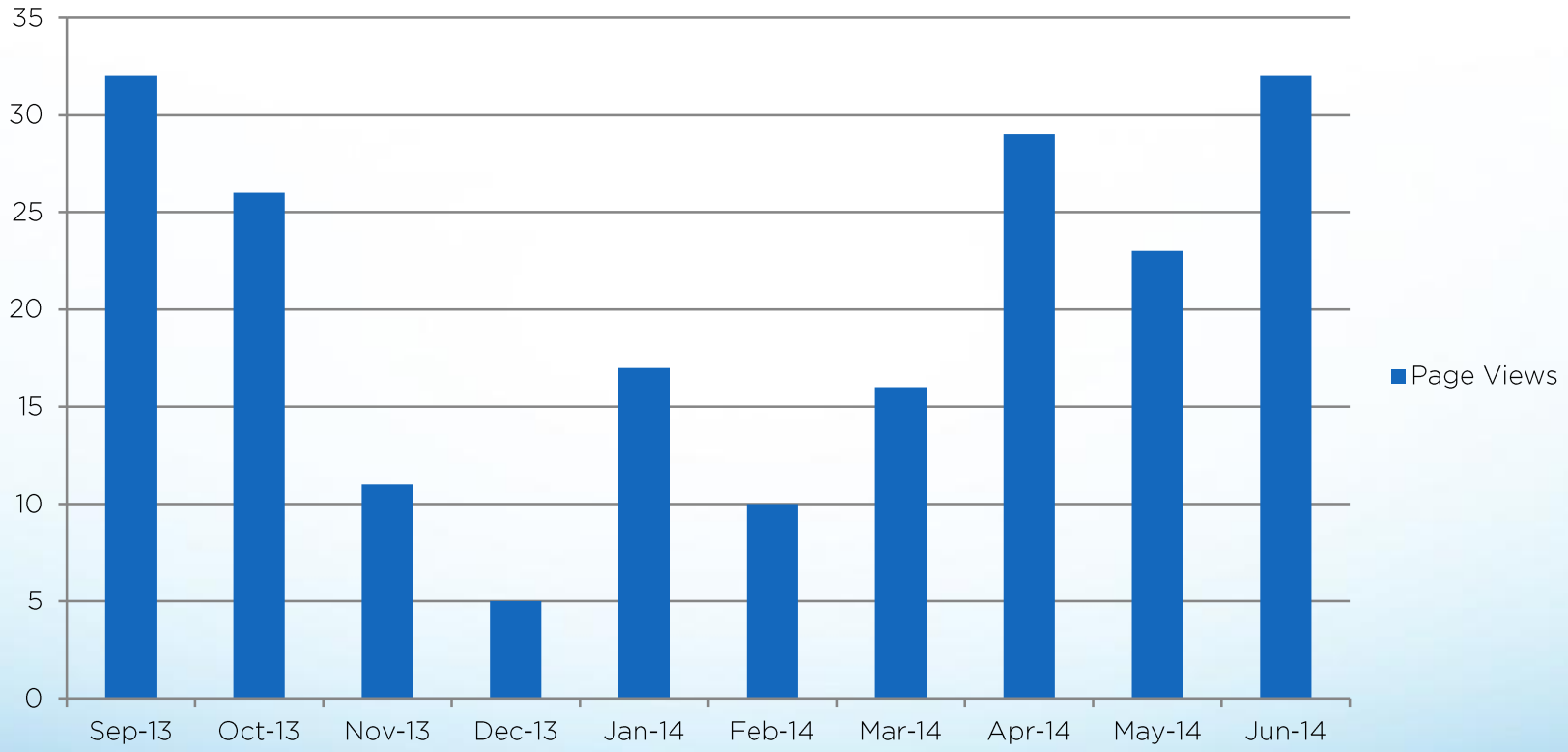


Thunder Bay Regional Health Sciences Centre

healthy together

Page Views: Open Board Meeting Webcast

September 2013 – June 2014



Page Views: Open Board Meeting Webcast

September 2013 – June 2016

Month	# of Page Views	Month	# of Page Views	Month	# of Page Views
September 2013	32	September 2014	57	September 2015	68
October 2013	26	October 2014	34	October 2015	25
November 2013	11	N/A	--	November 2015	44
December 2013	5	N/A	--	December 2015	22
January 2014	17	N/A	--	January 2016	30
February 2014	10	February 2015	23	February 2016	41
March 2014	16	March 2015	38	March 2016	58
April 2014	29	April 2015	29	April 2016	38
May 2014	23	May 2015	41	May 2016	35
June 2014	32	June 2015	31	June 2016	20
Yearly Total # of Page Views	201		253		381

Ministry of Health and Long-Term Care

Office of the Minister

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Ontario

JUL 25 2016

Jean Bartkowiak
President & CEO, Thunder Bay Regional Health Sciences Centre (TBRHSC)
CEO, Thunder Bay Regional Research Institute (TBRRI)
980 Oliver Road
Thunder Bay ON P7B 6V4

Anne-Marie Heron
Acting VP Research, TBRHSC
Acting CAO, TBRRI
980 Oliver Road
Thunder Bay ON P7B 6V4

Dear Mr. Bartkowiak and Ms. Heron:

Michael Gravelle, MPP for Thunder Bay-Superior North, forwarded me your letter dated April 13, 2016. I appreciate the opportunity to respond.

We appreciate the impact of the decision to pause the Program Awards and Targeted Call for Nursing Research in 2016/17. The pause will allow for an internal review of the Fund and possible re-alignment.

We recognize that the research funded by the Health System Research Fund (HSRF) provides a substantial evidence-base for decision-making and remain committed to health system research.

As outlined in your letter, the proposals researchers at Thunder Bay Regional Health Sciences Centre and Thunder Bay Regional Research Institute plan to develop are well-aligned with ministry priorities. We strongly encourage these researchers to participate in future HSRF calls.

We look forward to future productive discussions with Thunder Bay Regional Health Sciences Centre and Thunder Bay Regional Research Institute on how we can work together to support health system research in Ontario.

Yours sincerely,

Dr. Eric Hoskins
Minister

...2

Mr. Bartkowiak and Ms. Heron

c: Michael Gravelle, MPP for Thunder Bay-Superior North
Dr. Bob Bell, Deputy Minister, MOHLTC
Ms. Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation, MOHLTC
Mr. Patrick Dicerni, Assistant Deputy Minister, Strategic Policy and Planning Division, MOHLTC
Ms. Anne Hayes, Director (A), Research, Analysis, and Evaluation Branch, SPPD, MOHLTC

BRIEFING NOTE

Thunder Bay Regional Health Sciences Centre

TOPIC	Fire & Environmental Compliance Update
PREPARED BY	Anne Marie Heron and Kathryn Shewfelt
APPROVED BY	Peter Myllymaa
PREPARED FOR: President & CEO ☐ Board of Directors ☒ Other	
DATE PREPARED	September 22, 2016

PURPOSE/ISSUE(S)

To provide the Hospital Board of Directors with an update on Fire and Environmental Compliance.

BACKGROUND

The Hospital has no outstanding orders under the Fire Code (as overseen by the Fire Department) or Environment Protection Act (as overseen by Ministry of Environment) - and the Hospital is not aware of any non-compliances in regards to the requirements of these legislations.

ANALYSIS/CURRENT STATUS

Summary of status:

Fire Code

- Annual Fire Inspection with Thunder Bay Fire and Rescue set for October 13, 2016
- Annual minimum staffing drill with Thunder Bay Fire and Rescue set for October 26, 2016
- No major issues identified at last inspection

Sterilization in SPD

- Usage of Ethylene Oxide (EtO) system for sterilization ceased in 2014 (replaced with peroxide-based sterilizer)
- Decommissioning of system to occur after approval of amendment to ECA received – awaiting final approval from Ministry of Environment; removal plan under development with Steris

Co-Generation

- ECA amendment – approval received July 2015
- Noise and emission testing completed as part of the requirements under the ECA amendment
- Reports submitted to MOE

Green Energy Act (Ministry of Energy)

- Annual energy reporting commenced July 2013 for all BPS establishments
- July 2014 five-year energy reduction program posted
- **Next update due July 1, 2017; submission for this year was completed on time**

RECOMMENDATION

No further recommendations. Continue to implement projects and initiatives.

TOPIC	Fire & Environmental Compliance Update
PREPARED BY	Anne Marie Heron and Kathryn Shewfelt
APPROVED BY	Peter Myllymaa

PREPARED FOR: President & CEO ☐ Board of Directors ☒ Other

NEXT STEPS

N/A

STAKEHOLDER REACTION

N/A

COMMUNICATIONS

N/A

FINANCIAL IMPACTS

N/A

APPENDIX SECTION

TBRHSC is committed to ensuring decisions and practices are ethically responsible and align with our mission/vision/values. All leaders should consider decisions from an ethics perspective including their implications on patients, staff and the community. The following questions should be considered for each decision.

1. Does the course of action put '**Patients First'** by responding respectfully to needs & values of our patients, families, and communities?
2. Does the course of action demonstrate '**Accountability**' by advancing a quality patient experience that is socially and fiscally accountable?
3. Does the course of action demonstrate '**Respect**' by honouring the uniqueness of each individual and his/her culture?
4. Does the course of action demonstrate '**Excellence**' by fostering an environment of innovation and learning to advance a quality patient experience?

For more detailed questions to use on difficult decisions, please refer to TBRHSC's Framework for Ethical Decision Making

For more detailed questions to use on difficult decisions, please refer to TBRHSC's Framework for Ethical Decision Making on the iNtranet under **Quality and Risk Management > Quality > ECFAA (Excellent Care for All Act) > Presentations.**

Early release, published at www.cmaj.ca on September 12, 2016. Subject to revision.

MEDICINE AND SOCIETY

The cultural erosion of indigenous people in health care

Idealized versions of health care are common, and access to health care is often viewed as an unambiguous good. In the social determinants of health literature, for example, access to health care is treated as an intermediate determinant of health. This conceals a simplistic inference: the better your access to health care, the better your health. The reality is more complex: a modern industrial health care system can be a determinant of *ill* health, especially where it is culturally unsafe. At present, Canadian health care for indigenous people is not culturally safe owing to the ways that health law, health policy and health practice continue to erode indigenous cultural identities.

The origins lie at the colonial foundations of Canada. Colonialism is the primary distal determinant of indigenous ill health.[1,2] As a process of enforced assimilation of indigenous peoples, the drive to assimilate indigenous communities into mainstream Canada continues to this day.[3] Contemporary health care contributes to assimilation through what one Anishnabe healer describes as "cultural erosion" (Tom Chisel, Sioux Lookout First Nations Health Authority: personal communication, 2015). As I use the phrase, it refers to the damage to individual and cultural indigenous identities, with consequent ill health, that is inflicted by Canada's health care system. It is a problem of racism arising from the imposition of Canadian health law and health policies on indigenous communities.

Racism impacts every aspect of health care delivery for indigenous peoples in Canada.[4] To understand cultural erosion, systemic and epistemic racism merits particular attention. Systemic racism concerns the unjust distribution of power that is built into law, policy and economic practice. It is the imposition and perpetuation of inequities through

Dream/escape: Dundas Street Car, Toronto, Ont. (www.jeff-thomas.ca; the photographer has obtained consent from the boy in this image.)

governance, rather than through individual intention, decision or behaviour. Examples are commonly bureaucratic. Dr. Michael Kirlew, a community physician for Wapekeka First Nation, cites two (personal communications, 2015/16). First, federal Non-insured Health Benefits medical referral forms require physicians to provide a patient's personal health information irrespective of consent from the indigenous patient. If the physician does not provide the information, the referral is denied. Second is the routine denial of requests for medical transportation — for example, indigenous children from remote communities being denied travel for care despite their physicians' judgment. Another familiar example is the underfunding of the nursing stations of northwestern Ontario and Manitoba.[5]

Canadian health care is founded on systemic racism through the violent unilateral imposition of Canadian social, economic, cultural and political dominance over indigenous land and lives under section 91(24) of the Constitution Act, 1867, Indians, and Land Reserved for the Indians, as well as under the Indian Act, 1985. The Truth and Reconciliation Commission of Canada[6] describes it succinctly:

> Canada asserted control over Aboriginal land. In some locations, Canada negotiated Treaties with First Nations; in others, the land was simply occupied or seized. The negotiation of Treaties, while seemingly honourable and legal, was often marked by fraud and coercion, and Canada was, and remains, slow to implement their provisions and intent.

Indigenous peoples were tricked out of, robbed of or pushed off their traditional lands, with the consequent erosion of their own complex systems of spirituality, law, trade, governance and health. Health law and policy in Canada is part of this unilateral assertion of governance, and thus, despite the technical excellence or best intentions of individual practitioners, is a priori systemically racist.

Epistemic racism — the imposition of one world view over another — also

contributes to cultural erosion. One example is the privileging of mainstream biomedical knowledge over indigenous healing practices and traditions. Anishinabek health laws, customs and practices, for instance, are often not permitted to influence local health institution practices, regardless of their merits. Where they are permitted, they are subordinated to provincial and federal legal and health norms. Epistemic racism explains the diminution and alienation experienced by indigenous healers owing to disrespect for their knowledge and cultural roles. Epistemic racism is also evident in resource allocation — for example, if a health care facility that serves a substantial indigenous population upgrades technology instead of building a requested sweat lodge.

Systemic and epistemic racism work in tandem. They ensure that only biomedical knowledge is taken seriously; they shape how scarce economic resources are distributed and to whom; they allocate and deny respect and thereby determine who is paid and how much; and they influence medical training, determining what counts as a medicine, medical intervention or treatment. Such inequities affect which patients have access to which health care resources, as well as the quantity and quality of the care. Hence, contemporary Canadian health law, policy and practices continue the cultural erosion of indigenous healing and cultural traditions begun at the foundation of Canada.

Nonetheless, much can be done. The Truth and Reconciliation Commission calls to action provide systemic suggestions:[6]

- recognize the indigenous health care rights enshrined in international and national law
- dialogue with indigenous peoples to identify and eliminate health care inequities
- acknowledge, respect and address the distinct health needs of Métis, Inuit and off-reserve First Nations people
- provide sustainable funding for existing and new Aboriginal healing centres to address the harms caused by residential schools
- in collaboration with indigenous healers and elders, recognize as medically legitimate the value of traditional healing practices
- hire and retain indigenous health care professionals, as well as ensure that all staff have cultural competency training.

Two principles from the cultural safety literature are also invaluable: first, that indigenous peoples should be empowered to determine what is culturally safe; and, second, that health care professionals need to recognize how their advantages and power may distort health care decision-making.[7,8] In particular, we must share power and compensate for or eliminate unjust advantages. Health worker expertise becomes considerably more valuable for marginalized communities once cultural safety is priortized. For example, a skilled emergency department doctor is no use if patients don't come to emergency departments because of systemic or interpersonal racism. Referrals for medical interventions are pointless if Health Canada won't allocate appropriate resources. A proper dialogical relationship with indigenous groups allows indigenous peoples to coshape a culturally safe health care environment and ensures that health institutions adequately serve indigenous interests.

Practical options for action are many: engage with indigenous healers and elders; pay them well and include them in policy-making; provide ongoing antiracism education; build, maintain and adequately staff sweat lodges, where appropriate; advocate for change to harmful policies like those of the Non-insured Health Benefits to make them consistent with superior provincial health care norms; advocate for transformation of health law; and perhaps most important, support indigenous sovereignty and the treaty relationships — especially as they relate to health care.

The basic moral principles familiar to all health care professionals oblige us to end cultural erosion. Restitution for the extraordinary harms inflicted on indigenous peoples is required by moral *justice*; recognition of human and cultural identity is mandated by *respect for persons*; and *beneficence* and *nonmaleficence*, interpreted through the lens of cultural safety, promote the best health outcomes. Ending the ongoing erosion of indigenous cultures requires integration of these principles, as well as the TRC's calls to action, into personal behaviours, health policy-making and health law.

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Thunder Bay Regional Research Institute Report for TBRHSC Board – September/October, 2016

Submitted by: Jean Bartkowiak, CEO – TBRRI and President & CEO – TBRHSC – September 26, 2016

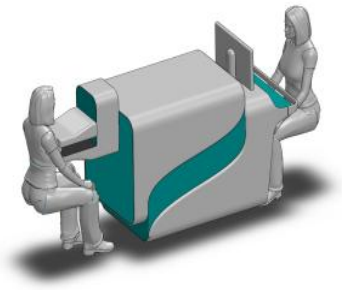
Institute Releases 2020 Strategic Plan

At the June 23rd Annual General Meeting, the Institute formally launched its 2020 Strategic Plan. The plan will guide patient-centred research for the next five years and also serves as the research plan for the Hospital. Three major directions have been identified as follows:

1. **Healthier:** Lead research to improve the health outcomes of the people of Northwestern Ontario and beyond;
2. **Wealthier:** Advance philanthropic support and generate revenue through science and partnerships; and
3. **Smarter:** Enhance the academic environment.

These directions will focus the work of the Institute and help it achieve its Vision - to be an international leader in medical imaging research and discovery that improves the health of the people of Northwestern Ontario. Staff are in the process of mapping out action plans for each of the goals associated with the three directions.

Radialis Medical Inc. Working to Develop New Mammography Screening Device



Launched in partnership with Lakehead University in February, 2016, the Institute's newest spin-off company **Radialis** has been working throughout the summer to design a clinical system and collect data for new technology that will provide a breast imaging alternative to traditional mammography. Under Dr. Alla Reznik's leadership, this new low-dose Positron Emission Mammography (PEM) imaging system is being developed and will provide better and safer screening for high-risk individuals as it can detect breast cancer in its earliest stages, when it is most treatable. As work on this groundbreaking device is being undertaken right here in Thunder Bay, local and regional residents will be among the first to benefit from this new technology.

Research Quality Oversight Program

After two years this initiative is nearing completion. A detailed update report was released over the summer noting progress that has been made in the three phases of the program related to the Research Ethics Board redesign; creation of a Research Quality Oversight Framework; and the development or revision of policies and procedures to ensure oversight for research quality. This last phase, looked at ten policies/process gaps. Policies related to six areas have been approved, several are in the process of being approved and the last, related to authorization will be piloted before being finalized. A roll-out and soft launch of the new policies and procedures will take place in the fall.

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Cyclotron Update

The Cyclotron is moving closer to being able to provide isotopes to patients at the Hospital. Staff at the facility are completing Health Canada requirements for producing F-18 FDG. This will be the first locally produced pharmaceutical and will be used in the diagnosis and staging of cancer for patients in our region. The production of radiopharmaceuticals will not stop with FDG, as staff and industrial partners are developing longer lived isotopes for distribution across North America. So far the facility has successfully provided several batches of F-18 to the Cancer Centre for use in calibrating the Hospital's PET scanner. The ability to produce isotopes locally provides the Hospital with increased flexibility with scheduling.

Staff have also assisted with the creation of the first cyclotron and radiopharmacy based course to be available at Lakehead University. It is hoped that this will be the first in a growing number of courses that can be offered to help attract students to both Lakehead University and Confederation College. As well, the Institute's new Manager of Business Development is positioned to make the facility self-sustainable and will be looking for new markets for the Cyclotron's products and services.

Staffing Updates

Manager, Business Development: Amarjit Chahal commenced work with the Institute on September 6th. Amarjit brings extensive industry experience in turning ideas into revenue generating services. His previous experience includes working as a Business Development Manager for Dynacare Medical Laboratories.

Manager, Clinical Research Services: Daniel Horne was promoted from his position as Compliance Coordinator on September 14th. Daniel will manage and oversee administration, development, and implementation activities associated with clinical research projects and clinical trials conducted at the Hospital and the Institute.

Highlighting Two Research Projects

Capturing Images of the Brain for Alzheimer's Disease: Dr. Albert has been awarded funding from The Weston Brain Institute to research a way to provide a more sensitive measurement of brain function in Alzheimer's patients using hyperpolarized xenon. The research will also offer advantages for testing new treatments for the condition, especially drug testing. The study will be the first large scale clinical trial in the world using hyperpolarized gas to take an image of the brain.

Local Researcher Collaborates with SickKids to Develop New MRgHIFU Technique: Dr. Pichardo is working with SickKids to develop a new non-invasive treatment method for premature babies to reduce the likelihood and the severity of brain injury using magnetic resonance-guided high intensity focused ultrasound (MRgHIFU). This technique would safely destroy clots in the brain and reduce swelling without ever having to use a scalpel.

Volunteer Association
to Thunder Bay Regional
Health Sciences Centre

BOARD REPORT – JUNE – September 2016

Our annual meeting was held on June 10, 2016. The new Executive was sworn in and took oaths of confidentiality. We have two new board members bringing our total to 8. Our transition to a governance board is on going but is proving to be a sound decision. Our primary focus is Seasons Gift Shop as it provides us with the funds to donate to the Family care Grants, Bursaries and other hospital needs.

Annual bursaries of $2,000.00 each were paid to Lakehead University, Confederation College and the Northern Ontario School of Medicine. During Nurse's Week a bursary of $1,000.00 was also presented to a Staff nurse toward continuing education.

We will also be partnering with T.B.R.H.S.Foundation with a donation of $30,000 towards the Patient and Family Care Grants.

Our vision in 2016 was to develop a Director's Handbook. A committee of three began this project in June and it was presented to the Directors on September 21. A motion was proposed to accept. This will be an essential tool for the present Directors and will educate any new volunteer interested in leadership positions with the Volunteer Association Board.

Two Directors will be attending the HAAO Convention in November in Toronto. They will present their reports at our December meeting. The Fall Conference will be a teleconference with all executives of the Auxiliaries/Associations in Northern Ontario.

Respectfully submitted
Margaret Power
President