Thunder Bay Regional Health Sciences Centre

Board of Directors
Open Meeting
Wednesday, February 22, 2017 – 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 and WELCOME**						
2.0	**PATIENT STORY** – *Dr. Crocker Ellacott*						
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	Dr. Crocker Ellacott	Patient and Family Centred Care*		X		
5.0	**CONSENT AGENDA**						
5.1	-		Board of Directors Open Minutes – February 1, 2017*	X			X
5.2	-		Corporate Membership*				X
6.0	**REPORTS AND DISCUSSION**						
6.1	5	J. Bartkowiak	Report from the President and CEO*	X			X
6.1.1	10	A. Björn K. Meservia Collins	Indigenous Health Strategic Direction Update (Respect Training)*			X	X
6.2	10	Senior Leadership	Report from Senior Leadership*				X
6.2.1	10	Senior Leadership	Q3 2020 Strategic Plan Progress Report*				X
6.3	5	Dr. Porter	Report from the Chief of Staff*				X
6.4	5	Dr. Crocker Ellacott	Report from the Chief Nursing Executive*				X
6.5	5	Dr. Moody-Corbett	Report from the Northern Ontario School of Medicine*				X
6.6	5	Dr. Thibert	Report from the Professional Staff Association				
6.7	5	G. Craig	Report from the Foundation*				X
6.8	5	J. Bartkowiak	Proposed AGM Time Change*	X		X	
7.0	**COMMITTEE MATTERS**						
7.1	10	C. Freitag A. Björn	Quality Committee – February 14, 2017* 7.1.1 2017-18 Performance Based Executive Compensation Framework*				X X

#	Time (X)	Presenter	Item & Purpose (Y)	Expected Outcome (Z)			
				Recommendation /Decision/Action	Education	Discussion	Information
			7.1.2 2017-18 Quality Improvement Plan*				
7.2	10	D. Mannisto	Governance and Nominating Committee – February 15, 2017 Increase in number of elected Board members*	X			
8.0	**FOR INFORMATION**						
8.1	-		Board and Committee Work Plans*				X
8.2	-		Webcast Statistics*				X
8.3	-		Report from the Health Research Institute*				X
8.4	-		Environmental Compliance and Fire Safety Update*				X
8.5			2017 Pathology and Laboratory Medicine Annual Report*				
9.0	**BOARD MEMBER COMMENTS**					X	
10.0	**DATE OF NEXT MEETING** – April 5, 2017						X
11.0	**ADJOURNMENT**						

Ethical Framework

The Hospital is committed to ensuring decisions and practices are ethically responsible and align with our Vision, Mission and Values. 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 the needs, values, and expectations of our patients, their families, and the 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 the Hospital's Framework for Ethical Decision Making

BOARD OF DIRECTORS (Open)
February 22, 2017 – DRAFT

Agenda Item	Committee or Report	Motion or Recommendation	Approved or Accepted by:
3.3	Agenda – February 22, 2017	"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 February 1, 2017; 5. 5.3 Accepts the applications for membership to the Corporation for the 2017-2018 Corporate membership year, received for the period of January 28 to February 17, 2017; as presented."	Moved by: Seconded by:
6.0	Reports and Discussion	"That the Board of Directors: 6.1Accepts the Report from the President and CEO; 6.2Accepts the Report from Senior Leadership; 6.3 Accepts the Report from the Chief of Staff; 6.4 Accepts the Report from the Chief Nursing Executive; 6.5 Accepts the Report from the Northern Ontario School of Medicine; 6.6Accepts the Report from the Professional Staff Association; 6.7 Accepts the Report from the Foundation; Dated February 22, 2017 as presented."	Moved by: Seconded by:
7.1.1	2017-18 Performance Based Executive Compensation Framework	"Whereas the Quality Committee duly reviewed the Performance Based Executive Compensation Framework for inclusion in the 2017-18 Quality Improvement Plan, and, Whereas the Hospital must demonstrate accountability by advancing a quality patient experience that is socially and fiscally accountable,	Moved by: Seconded by:

Agenda Item	Committee or Report	Motion or Recommendation	Approved or Accepted by:
		be it resolved, That the Board of Directors approves the Performance Based Executive Compensation Framework for inclusion in the 2017-18 Quality Improvement Plan, as recommended by the Quality Committee."	
7.1.2	2017-18 Quality Improvement Plan	"Whereas the Quality Committee duly reviewed the 2017/18 Quality Improvement Plan, and Whereas the Hospital must demonstrate accountability by advancing a quality patient experience that is socially and fiscally accountable, be it resolved, That the Board of Directors approves the 2017/18 Quality Improvement Plan, as recommended by the Quality Committee."	Moved by: Seconded by:

Thunder Bay Regional Health Sciences Centre

980 rue Oliver Road
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P7B 6V4 Canada

Tel: (807) 684-6183
www.tbrhsc.net

Report from Nadine Doucette
Chair, Board of Directors
February 22, 2017

A growing number of hospitals in Ontario are now offering unrestricted visiting hours. Thunder Bay Regional Health Sciences Centre (our Hospital) has taken an innovative approach to this concept by consulting with our Patient Family Advisory (PFA) Council to offer 24/7 access to those identified by the patient as a Care Partner.

What's the difference between a Visitor and a Care Partner? Both are important to patients, and both help improve experiences in care. At our Hospital, Care Partners are important members of the patient's care team.

Our Patient and Family Centred Care philosophy is about working together – patients, families and health care providers. It means decisions are made as a team. That is why our Hospital distinguishes Visitors from Care Partners.

Patients determine who their Care Partners are. It may be a family member, friend, or significant other who provides physical, psychological, or emotional support. Care Partners have nearly unlimited access to the patient to support and participate in their care. Visitors are family members or friends of the patient, who have not been identified by the patient as a Care Partner. Regular visiting hours for visitors, excluding Care Partners, are from 10:00 a.m. to 8:30 p.m.

To ensure the visitation policy would best suit the expectations of our patients, the Patient Family Advisory (PFA) Council was engaged to provide insight and recommendations.

As part of its commitment to transparency and accountability to patients and families in Northwestern Ontario, our Hospital continues to make the open meetings of its Board of Directors accessible for viewing via a live webcast. The option makes it possible for anyone – whether they live in Thunder Bay, Northwestern Ontario, or beyond – who is interested in the decisions being made about the Hospital to watch the open Board meetings online. These meetings occur monthly and are webcast live via the Ontario Telemedicine Network (OTN).

On the day of an open Board meeting, viewers can go online to www.tbrhsc.net/webcast . There, they will find a link to the webcast, a meeting agenda, and a full schedule of upcoming open Board meetings. Webcasting begins at the time prescribed on the agenda, and ends immediately after the adjournment of the meeting. There's no need for viewers to register. Simply click, watch and learn. Webcasting our open Board meetings provides patients, families and stakeholders from across the region with a front row seat on the decisions being made about the Hospital, and it's another innovative way that we use technology to overcome the vast distance of Northwestern Ontario.

We have recently received the final report of the 2016 Operational Review and our President & CEO and the North West LHIN CEO have co-signed a letter to the Deputy Minister Bob Bell at the Ministry of Health and Long Term Care (MOHLTC) to inform him of the completion.

Patient & Family Centred Care

Thunder Bay Regional Health Sciences Centre

2020 healthy together

Patient Experience

Enhance the quality of the patient experience.

Overview:

- PFCC: at TBRHSC
- The Outcomes … Why we do it?
- Changing our Culture
- Key Accomplishments
- The Future …

What does PFCC mean?

Patients and Families are Partners in Care…

Boardroom to Bedside

… *the provision of care that is respectful of and responsive to individual, patient / family preferences, needs and values and ensures that patient values guide all clinical decisions****…***

IOM 2004

Why PFCC?

- Partnerships created
- Improved patient experience, outcomes and satisfaction
- Enhanced quality, safety
- Higher staff satisfaction
- Improved staff, physician and learner satisfaction
- Decreased medical errors
- Decrease LOS
- Reduced length of stay for patients
- Reduced complications

Embedding the Concept!

Values

Patients **ARE** First:

- Patients First
- Accountability
- Respect
- Excellence

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.

Philosophy

Patient and Family Centred Care is the philosophy that guides us. Patients and Families are at the centre of everything we do.

Changing our Culture…

Transforming our Care

THE JOURNEY

- Listening to Stories
- Partnering with Patients and Families
- Corporate Strategies:
  - Engagement
  - NOD
  - Listen
- Welcoming Patients and Families
  - PFA Council
  - PFAs are Patient Experience Experts

Thunder Bay Regional Health Sciences Centre

2020 healthy together

Key Clinical Tactics…

Key Accomplishments

Recognized Experts in PFCC

- **Regionally, Provincially, Nationally and Internationally**
  - MOLTC engaging our PFA's
  - Provincial OHA Patient Reported Performance Measurement Governance Committee
  - OHA Patient Experience Measurement Community of Practice Steering Committee
  - Accreditation Canada Standards development
  - International IPFCC Conference
  - OHA programming and education
  - Studer

Next Steps…

- Continue to engage staff and physicians to understand and identify root causes and opportunities to improve patient experience
- Ongoing alignment of Patient and Family Centred Care (PFCC) best practices with corporate initiatives and Studer tactics. E.g. Orientation redesign, simulation, Respect education plan)
- Emphasize use of Name, Occupation, Do (NOD), Whiteboards, and PFCC staff learning modules
- Support our partners in developing PFCC philosophy at regional sites

The perspectives of patients and families lend crucial insights to an organization's quest to improve safety and quality outcomes. The perspectives of patients and families are also essential to patient and family centred care, which aims to provide the most appropriate and highest quality care for each patient." **OHA Quality & Safety Governance Toolkit 4.1 Framework and Principles for Patient and Family Engagement**

Thunder Bay Regional Health Sciences Centre

Board of Directors - *Open*

Wednesday, February 1, 2017

Boardroom – 5:00 p.m.

Action

***Present*:**

Nadine Doucette, (*Chair*)	Dr. Gordon Porter*	John Friday
Jean Bartkowiak*	Doug Shanks	Grant Walsh
Gary Whitney	Matt Simeoni	Dr. Mark Thibert*
Dr. Rhonda Crocker Ellacott*	Anita Jean	Gerry Munt
Dick Mannisto		

By Invitation – Senior Leadership:

Peter Myllymaa	Dr. Stewart Kennedy	Glenn Craig
Dr. Rami Rudnick	Dr. Mark Henderson	Amanda Björn

By Invitation:

Jessica Nehrebecky, *Rec. Sec*.

Regrets:

Dr. Penny Moody-Corbett Georjann Morriseau

1. **CALL TO ORDER** – The Chair called the meeting to order at 5:01 p.m.

The Chair asked everyone to take a moment of silence for the victims and their families affected in the mosque shooting in Quebec City on Sunday.

The Chair welcomed Board members, Senior Leadership Team members, guests, and the webcast audience. Dr. Abraham (Rami) Rudnick, Vice President, Research at the Hospital and the Chief Scientist at the Institute was welcomed to his first Board meeting.

2.0 PATIENT STORY

Ms. Amanda Björn, Vice President, Human Resources, shared a patient story.

3.1 Quorum – Quorum was attained.

3.2 Conflict of Interest - None.

3.3 Approval of the Agenda

Motion

Moved by: ***Doug Shanks***
Seconded by: ***Anita Jean***

* Denotes Non-Voting Member

"That the Agenda be approved, as circulated."

CARRIED

3.4 Chair's Remarks - For Information.

The Chair thanked the staff and physicians for their work in providing care for the high number of patients in the Hospital. The President and CEO gave a special thank you to the regional hospitals for their help in addressing the patient repatriation challenges.

4.0 PRESENTATIONS

4.1 The Board's Role in Cyber Security

Ms. Dawn Bubar, Senior Director, Informatics and Mr. John Barro, Director, Information Technology provided an overview of cyber security and what tools are used at the Hospital to protect its software, databases and operating systems. Cyber security is the body of technologies, processes and practices designed to protect networks, computers, programs and data from attack, damages or unauthorized access.

The Hospital is currently investigating appropriate response should we fall victim to a ransomware; this is when malware encrypts files and then a sum of money is requested in exchange to decrypt the files. There is cyber-insurance available, however the Hospital currently does not have any; this is still under consideration.

The Hospital rates at above average in terms of protecting itself against cyber risk amongst other hospitals in the country; however we are behind most private industries, such as Google.

Ms. Bubar and Mr. Barro were excused from the meeting.

4.2 Credentialling Process

Dr. Gordon Porter, Chief of Staff provided an overview of the Professional Staff credentialing process at the Hospital, which attests to the due diligence exercised prior to the Board of Directors approving privileges.

When new applicants submit request for privileges, proof of relevant credentials is required prior to meeting with prospective members. Before Board approval, new applications are reviewed by the Chief of Staff, the relevant Chief of the Department, the

Credentials Committee and finally, the Medical Advisory Committee. Professional Staff can be declined privileges, and in that case, they are able to appeal the Board of Directors in accordance with legislation.

Dr. Mark Thibert was welcomed to the meeting.

A member asked why a photograph of the professional staff member is requested when they are applying to be credentialed and if this could be problematic with human rights violations. Dr. Porter will investigate further and report back to the Board. ***Action***

5.0 CONSENT AGENDA

The Governance and Nominating Terms of Reference were pulled from the consent agenda for discussion. Members agreed that the first paragraph should end after the word "manner", eliminating, "in ensuring its effective and efficient performance".

Moved by: ***Grant Walsh*** ***Motion***
Seconded by: ***Dick Mannisto***

"That the Board of Directors:
5.1 Approves the Board of Directors Minutes of December 7, 2016;
5.2 Accepts the Quality Committee Minutes of January 18, 2017;
5.3 Accepts the applications for membership to the Corporation for the 2017-2018 Corporate membership year, received for the period of January 14 to January 27, 2017;
5.4 Accepts the Q3 2015-16 Wages and Source Deduction Attestation, as recommended by the Resource Planning Committee;
5.5 Appoints Dr. Peter Voros to the position of the Hospital Research Ethics Board (REB) Chair for two years, effective February 1, 2017 until January 31, 2019 with the possibility of renewal, as recommended by the REB;
5.6 Approves the Governance and Nominating Terms of Reference, as recommended by the Governance and Nominating Committee, as amended;
5.7 Approves policy BD-35 Board of Directors Public Relations Policy, as recommended by the Governance and Nominating Committee,

as presented."

CARRIED

6.0 REPORTS AND DISCUSSION

6.1 Report from the President and CEO

The President and CEO highlighted the following:

- The President and CEO met Dr. Denis Roy, President and CEO, Health Sciences North (HSN), to explore the possibility of signing a Letter of Intent indicating their interest in purchasing isotopes, given their intent to purchase a PET scanner;
- A meeting was held with Dr. Roger Strasser, Dean, Northern Ontario School of Medicine (NOSM), where Dr. Stasser reported that an accreditation visit from the Royal College of Physicians and Surgeons of Canada regarding the psychiatry residency program was successful; the next visit will focus onthe internal medicine residency program;
- The Executive Committee of the Council of Academic Hospitals of Ontario (CAHO) met with the Council of Ontario Faculties of Medicine. Discussion related to governance as well collaborating in sharing research data indicators.

Ms. Tracie Smith was welcomed to the meeting.

6.1.1 Indigenous Health Strategic Direction Update (Traditional Knowledge and Practices)

Ms. Tracie Smith, Senior Director, Communications, Indigenous Affairs, and Engagement provided an update on the Indigenous Health Strategic Direction with respect to the traditional knowledge and practices goal.

The Hospital currently provides many traditional services such as: smudging, cleansing circles, pipe ceremonies and hand drumming. Mr. Michael Robinson, one of our Spiritual Care Providers, has been of great assistance in providing traditional services to patients and their families.

A working group made up of internal and external participants has been struck to research best practices with respect to improving traditional knowledge and practices. The Professional Staff is being engaged from a patient safety perspective as there are concerns relative to potential negative interactions of the traditional practices with treatment plans.

Ms. Smith was excused from the meeting.

6.2 Report from Senior Leadership

The following information was highlighted:

- Professional Staff recruitment is doing well overall, however there are challenges in pathology, psychiatry, urology and medical oncology. A vascular surgeon is awaiting approval from Immigration Canada prior to their anticipated start date in

the spring 2017;
- The Hospital is working on a integration project with NOSM and HSC to change the academic culture making medical leaders accountable to the academic mission;
- The VP, Research has spent the last few weeks engaging scientists, researchers, partners to discuss current and future research alignment with the Institute's Strategic Plan;

Dr. Rudnick and Dr. Kennedy were excused from the meeting.

- The Hospital has no outstanding orders under the Fire Code or Environmental Protection Act and is not aware of non-compliances in regard to the requirements of these legislations;
- As at December 31, 2016 the deficit is $3.5M compared to a budgeted deficit of $4.6M;
- The Data Centre relocation project will likely start in February, 2017;
- The Employee Recognition Week was well attended and the planning team was thanked for their work;
- Union leaders are now invited to the Leadership Forum sessions to engage and provide relevant information;
- Ms. Samantha Moir, Manager, Corporate Patient Flow, and her team were acknowledged for their efforts in managing the recent bed flow capacity;
- The Emergency Department was also commended in working through the challenges due to overcapacity;
- Dr. Nicole Laferriere, Chief of Oncology was commended for her work at the Hospital as well as her contribution on the provincial level with Cancer Care Ontario;
- The Indigenous PARTY Program was launched in January, 2017 offering culturally relevant curriculum for Indigenous students;
- A call was received from ADM Sharon Lee Smith, commending the Hospital on the care that was provided to the suicide pact children that were admitted from Wapepeka, the Indigenous community.

A Board member asked if the Hospital would be prepared in the event of a catastrophe (i.e. a shooting); staff confirmed that there are codes in place that are practiced throughout the year to effectively handle such crisis.

Mr. Aaron Skillen was welcomed to the meeting.

6.2.1 <u>Occupancy Update</u>

Mr. Aaron Skillen, Program Director, Chronic Disease Prevention & Management and

Medicine Services and Regional Director North West, Ontario Renal Network provided an occupancy update. The following was highlighted:

- The majority of the third quarter has been spent in surge;
- The Average Length of Stay (ALOS) YTD is 5.33 days compared to 5.85 days in 2014-15;
- Four Interventional Radiology procedures were cancelled in January, 2017;
- Poor weather conditions created repatriation challenges;
- There was an increase in acute patient demand due to seasonal influenza and outbreaks;
- The average patient census in January, 2017 was 414 compared to 424 in January, 2015;
- The average Alternate Level of Care (ALC) patients were 67;
- If the Hospital did not have ALC patients, it would be operating below its occupancy rate.

The nursing staff, physicians, allied healthcare workers, Ms. Moir and her staff were thanked for their contribution in improving patient flow.

Board members stressed that messaging is required to educate the community on factors impacting Hospital overcapacity. This education could also help to inform and sensitize the public when a family member is requested to be transferred to another level of care. Ontario legislation allows frail elderly patients to choose the Long Term Care Home they wish to be admitted to.

Mr. Skillen was excused from the meeting.

6.3 **Report from the Chief of Staff** - For information

6.4 **Report from the Chief Nursing Executive** - For information

6.5 **Report from the Northern Ontario School of Medicine** - For information

6.6 **Report from the Professional Staff Association**

The Professional Staff Association (the Association) will be meeting in February and continues to focus on medical staff engagement.

6.7 **Report from the Foundation**

The closing ceremony for the 21st Annual Bearskin Hope Classic will be held this Sunday. This event has risen close to $3M since its inception.

Moved by: ***Matt Simeoni*** ***Seconded by:*** ***Grant Walsh*** ***"That the Board of Directors:*** ***6.1Accepts the Report from the President and CEO;*** ***6.2Accepts the Report from Senior Leadership;*** ***6.3 Accepts the Report from the Chief of Staff;*** ***6.4 Accepts the Report from the Chief Nursing Executive;*** ***6.5 Accepts the Report from the Northern Ontario School of Medicine;*** ***6.6Accepts the Report from the Professional Staff Association;*** ***6.7 Accepts the Report from the Foundation;*** ***Dated February 1, 2017 as presented."*** **CARRIED** *Tracie Smith and Kathryn Shewfelt were welcomed to the meeting.*	***Motion***
6.8 Accessibility Annual Report and Four Year Plan Last year's Accessibility Plan was presented to the Board and will be posted on the Hospital's web page; all requirements have been completed as per legislation. The Plan's horizon has now been reduced from five to four years to align with the Hospital's 2020 Strategic Plan. ***Moved by:*** ***Grant Walsh*** ***Seconded by:*** ***Doug Shanks*** ***"Whereas the Quality Committee duly reviewed the 2016 Accessibility Plan update and the 2017-2020 Accessibility Plan at their January 18, 2017 meeting, and*** ***Whereas the Hospital must demonstrate accountability by advancing a quality patient experience that is socially and fiscally accountable,*** ***be it resolved,*** ***That the Board of Directors approves the 2016 Accessibility Plan update and the 2017-2020 Accessibility Plan, as presented."*** **CARRIED**	***Motion***

Ms. Smith and Ms. Shewfelt were excused from the meeting.

7.0 COMMITTEE MATTERS

7.1 Quality Committee Minutes – December 12, 2016

Ms. Cathy Covino was welcomed to the meeting by audio.

7.1.1 Annual Research Compliance Report

Mr. Doug Shanks spoke to the Annual Research Compliance Report which is submitted to the Board of Directors for information only. The Chair of the Quality Committee did not find anything within the report that is of concern.

Ms. Covino was excused from the meeting.

8.0 FOR INFORMATION

8.1 Board Comprehensive Work Plan - For information

8.2 Webcast Statistics - For information

8.3 Report from the Health Research Institute - For information

8.4 Report from the Volunteer Association – For information

8.5 OHA Role of the Board in Strategy Presentation with Notes – For information

8.6 Sub Regional in the NW LHIN – For information

9.0 BOARD MEMBERS COMMENTS

10.0 DATE OF NEXT MEETING – February 1, 2016

11.0 ADJOURNMENT - The meeting adjourned at 7:17 p.m.

_____ _____

Chair Board Secretary

_____

Recording Secretary

Thunder Bay Regional Health Sciences Centre
2017-2018 Corporate Membership List
Received for the period of January 28 to February 17, 2017

Surname	Name
Arnone	Margaret
Carr	Amy
Fidler	Wesley
Jeanpierred	Donna

Surname	Name
Mannisto	Dick
Nicholas	Bonnie
Powell	Dawn
Knibbs	Donald

Surname	Name
Simeoni	Matt
Strasser	Roger
Williamson	Sara
Tupker	Jules

Previously Approved

Surname	Name
Bartkowiak	Jean
Bjorn	Amanda
Culligan	Denyse
Doucette	Nadine
Friday	John
Hannaford	Joyce
Henderson	Mark
Heron	Anne-Marie
Hettenhausen	William

Surname	Name
Jean	Anita
Johnson	Rebecca
Josefchak	Joe
Kennedy	Stewart
Kutok	Angela
Masood	Khaja
Moody-Corbett	Penny
Myllymaa	Peter
Nehrebecky	Jessica

Surname	Name
Pikula	Jon
Porter	Gordon
Rudnick	Rami
Shanks	Doug
Sidorski	Stephen
Smith	Tracie
Walsh	Grant
Whitney	Gary
Young	Sophie

Strategic Plan 2020 Update
Indigenous Health

Strategic Initiative:
Improving the sensitivity of care to the Indigenous population

Presenter: Amanda Bjorn, Kelly Meservia -Collins

Date: February 22, 2017

Strategic Goal and Objective

- **Provide health care that respects traditional knowledge and practices and builds TBRHSC as a leader in the provision of health care for Indigenous patients**
  - Improve the sensitivity of care to the Indigenous population

Strategic Goal and Objective

Similar goals throughout the Strategic Plan

- Indigenous Health
- Patient Experience
- Seniors' Health
- Acute Mental Health
- Corporate Accessibility Plan

Thunder Bay Regional Health Sciences Centre

2020 healthy together

Indigenous Health

Enhance culturally appropriate care.

What does success look like?

I will be considerate and kind towards you.
I want to learn about and acknowledge your experiences, views and beliefs.


"CONSTRAINT OFFERS AN
UNPARALLELED OPPORTUNITY FOR
GROWTH AND INNOVATION"
- SCOTT DAVIS


results we get
Coaching
Leadership Rounding
Team Activities
actions (behaviour)
what we do & say
Simulation Activities
Instructor Pool
mindset
what we think & feel
E-learning modules
Coaching
self esteem
our beliefs
Safety Huddles
Lunch and Learns
our fears
our values
past experiences
Leadership Rounding
Team Activities


OUTCOME
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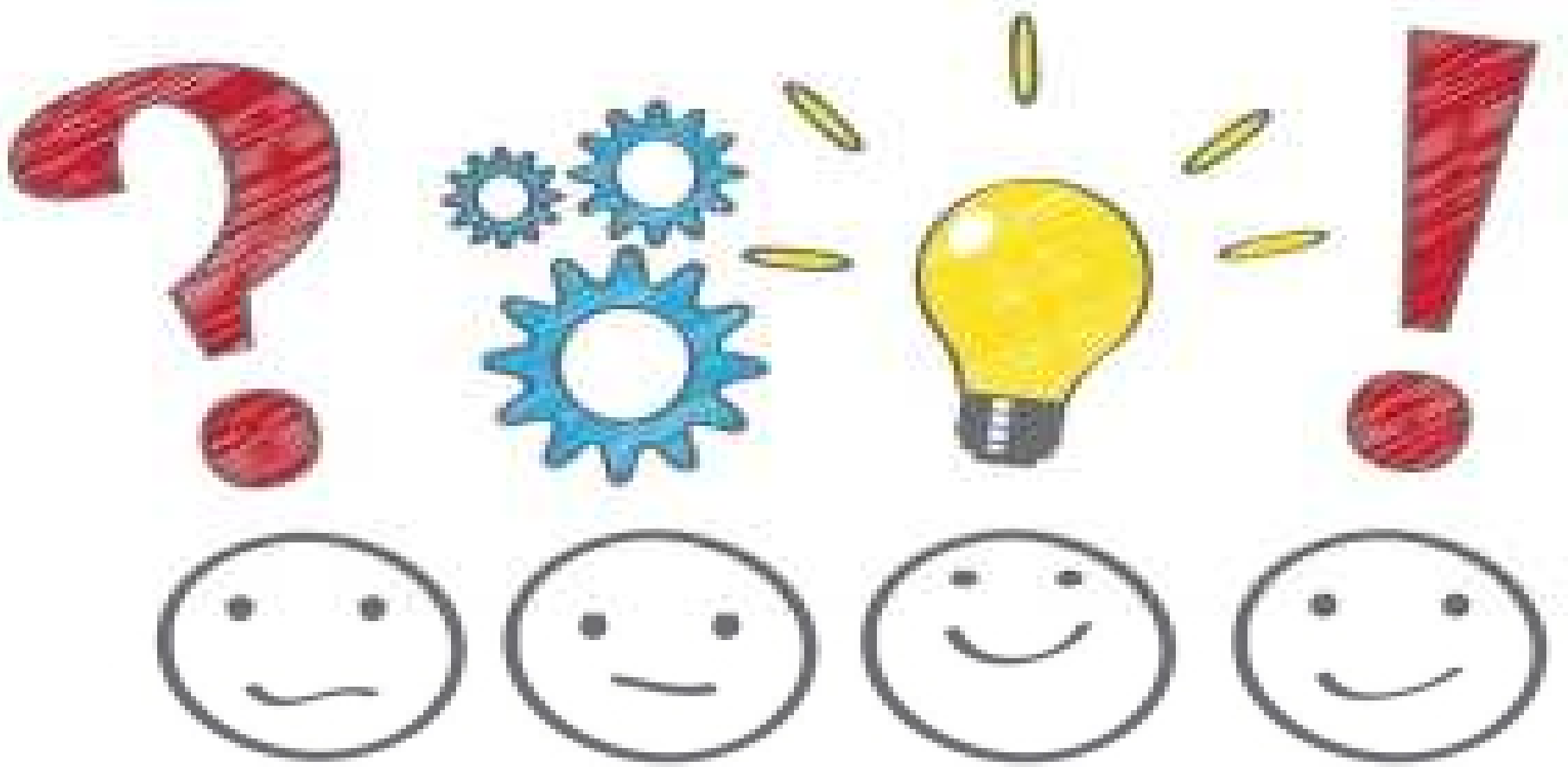
Next Steps

	2017												2018		
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M
E-learning (1 & 2)															
E-learning (3-6)															
Evaluation															
Simulation, huddles & team activities															
Instructor Train-the-trainer course & recruitment															
Supporting Tools and Resources															
Lunch and Learn Sessions															
Coaching Support															



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Enhance culturally appropriate care.

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Senior Leadership Report

to the
Board of Directors
Thunder Bay Regional Health Sciences Centre
February 22, 2017

Medical & Academic Affairs / Pharmacy

Academics and Interprofessional Education
Implement Best Practices in the Delivery of Education

- The following outcome was identified as the goal of the newly approved Respect education plan: "I will be considerate and kind towards you. I want to learn about and acknowledge your experiences, views and beliefs". This outcome will be achieved through simulation activities, e-learning modules, coaching and other learning approaches. Development of training material and methods are underway with initial training activities beginning in the fall.
- To meet organizational and regional needs for certificate training, we have increased our instructor pool for Advanced Cardiac Life Support (ACLS), Basic Life Support (BLS), Pediatric Life Support (PALS) and Non-Violent Crisis Intervention (NVCI).

Medical Affairs

- Dr. Sami Siddiqui (Pathology) has joined our Professional Staff
- Several site visits took place during the last month in Urology, Anesthesia, Gastroenterology, and Radiology.
- A letter of offer has been extended to an Anesthesiologist
- Dr. Sarah Fernandez and Dr. Katie Murphy (Pediatrics) have both accepted positions with start dates of July 31st and September 5th, respectively

Pharmacy
Medication Reconciliation

- The medication reconciliation admission rate for January was 64.7%, an increase over December 2016, which was at 60.6%.

EVP, Patient Services & Chief Nursing Executive

Emergency (ED) Patient Flow

- In January, ED continued to perform at or better than provincial targets for non-admitted high acuity patients with a length of stay (LOS) of 7 hours (target 7 or less) and low acuity LOS of 3.5 hours (target 4 or less)
- For January, ED LOS for admitted patients reached a peak of 46 hours (target 27 or less). On average, each morning, there were 26 patients waiting in ED for an in- patient bed.
- Factors contributing to January's prolonged ED admitted LOS include air transport delays (weather), overall high hospital occupancy and large numbers of isolated patients waiting for private rooms

Medical Emergency Team (MET)

- MET was established in 2007 as a Critical Care outreach team providing early intervention for deteriorating adult in-patients

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- Over the past 10 years, MET has consulted on 7,422 patients and completed 24,384 ICU follow-up assessments
- In the last decade, the Cardiology floor (2C) received the largest number of MET consults (1,205). Of these consults, 37% resulted in ICU admissions.
- In the next month, a media event is being planned to honour and recognize the 10th Anniversary of our MET at TBRHSC

Child and Adolescent Mental Health Unit (CAMHU)

- A youth suicide crisis occurred in the community of Wapekeka in January 2017. Wapekeka is approximately 600 kilometers north of Thunder Bay and is a fly in community with a population of ~ 360 resident. A state of emergency was declared by the community at the time and crisis management is still in progress for this community.
- CAMHU cared for several patients related to the crisis. TBRHSC has put in place a comprehensive discharge planning and coordination process, in collaboration with Wapekeka Band and Council, as well as Wapekeka Health Coordinators.
- TBRHSC continues to participate in regular Wapekeka community conference calls where ongoing crisis management and interim/future planning for the community is taking place by the Band and Council, Health Coordinators, Ministry of Health, Health Canada and other involved agencies

TBRHSC Participation to Enhance Patient Reported Performance Measurement

- In the Fall 2016, the OHA established a Patient Reported Performance Measurement (PRPM) Governance Committee. The purpose is to ensure Ontario hospitals are equipped with appropriate and effective patient reported performance measurement data collection and reporting services that enable them to better understand and improve the experiences and outcomes of their patients. TBRHSC's expertise in this area has led us to be a selected member of the Governance Committee with a mandate to provide oversight and performance accountability to the strategic management of the PRPM program and contract.

Patients First Act Consultation

- As part of a provincial initiative to engage Patient Family Advisory Councils across the province, the MOHLTC is visiting our PFA Council to solicit feedback on the Patients First Act and elements to consider in the formation of LHIN PFAC's

Research

Fine Tuning the Institute's 2020 Strategic Plan

- two Research Town Hall sessions are planned in early March to learn what research is important to health professionals and scientists;
- the sessions will give attendees an opportunity to identify and discuss research priorities and opportunities;
- individuals interested in research are also being asked to complete a brief survey related to the Institute's proposed strategic research goals and get ideas on research interests;
- results of the engagement sessions and the survey will inform revisions to the 2020 Strategic Plan.

Enhancing the Dialogue with the Indigenous Population

980 rue Oliver Road
Thunder Bay ON
P7B 6V4 Canada

Tel: (807) 684-6007
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- a focus for both the Hospital and the Institute is Indigenous health;
- staff have been actively involved in meeting with local and regional Chiefs, Health Councils, CEOs and other members of Indigenous communities in our region;
- at each opportunity, we are asking the following key questions:
  - ✓ What are some important health priorities or challenges in your community?
  - ✓ What kinds of research can help your community further address these priorities or challenges?
  - ✓ What are some of the barriers to conduct and learn from such research in your community?
  - ✓ How can we best communicate about such research with your community?
  - ✓ What research if any is your community currently involved with?
  - ✓ How can access to best care at/closest to home be improved (e.g. smart mobile technology)?
- Information obtained through these discussions will also be used to inform any changes to the current 2020 Strategic Plan.

Corporate Services & Operations

Financial Services

- As at January 31, 2017 the deficit is $5.3 million compared to a budget deficit of $5.3 million and prior year deficit of $6.4 million with:
  - Patient Days 0.23% less than budget and 3.43% less than prior year;
  - Surgical Cases 8.42% less than budget and 2.91% less than prior year;
  - ER Visits 2.82% more than budget and 2.4% more than prior period and;
  - ER Patient Days are 18.2% more than budget and 9.8% more than prior year.
- Incremental revenue anticipated to year end for Cardiovascular services, Renal services and overcapacity.

Capital Planning & Operations

- 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). On February 7, 2017 the Hospital was issued an Inspection order with respect to the fire doors leading from the Ambulance Bay to the Emergency Department. Education, enforcement and facility changes were made including communication with our external partners to ensure compliance.
- *The Capital Working Group's 2017-18 Capital Budget draft was approved as submitted. Planning for implementation has now commenced.*

Northern Supply Chain

- Several initiatives are underway and include Employee Benefits, Staff Scheduling Software, Nurse Call System, Actuarial Services and Procedure Utilization Booking Management Information System. This particular RFP has been structured in a manner where all Ontario LHINS could participate and up to 12 LHINS have shown interest to date and will be able to piggy back on the award should they choose to.
- Data Management and spend analytics software continues to be implemented in the East with completion targeted for August. Once finalized the Hospital, as the Administrator,will have

access to complete procurement History for 19 of our 36 Hospitals that will allow for a more thorough analysis and identify opportunites that may exist that will benefit the Hospital.

Decision Support

- Over the past month, Decision Support has been working closely with the local CCAC to identify Healthlinks patients (those with 4 or more co-morbidities and also high users of the Hospital services). Once identified, CCAC will coordinate supplemental services that should improve outcomes for these patients and reduce their need for hospital services. Finalization of the 17-18 budget workbooks and all related detailed financial and activity adjustments are nearing completion. As well, Decision Support is assisting in investigation and planning for implementation of a number of recommendations outlined in the Hay Group's Operational Review.

Patient Services and Cancer Care Ontario

Adult and Forensic Mental Health Program

- Adult Mental Health continues its recruitment efforts and discussions with SJCG in order to build our Inpatient Psychiatrist compliment back to an appropriate level. To assist with the need for psychiatric consultation throughout the building, we have begun to pilot a Consultation Liaison service that has a mental health nurse providing initial consultation. This should also assist with easing the workload on the limited number of Psychiatrists.

Cardiovascular Surgical Program Development

- The EVAR (endovascular aneurysm) program completed its second successful case with Drs. Mary MacDonald and Anatoly Shuster. The EVAR team has done a great job and continues with ongoing planning activities to ensure quality and efficiency.

Prevention & Screening Services

- A work plan established with Fort William First Nation for 2017/18 was finalized in January. The plan includes coordination of prevention and health promotion education, resources, and screening services, including planned screening days with the Screen for Life Coach.
- The Preventive Health Services team, with support from Communications and Engagement, completed the 2017 Staff Health and Wellness Calendar for our Hospital. It has been well-received and features more than 50 staff and their health stories.

Human Resources

Volunteer Services Update

- Planning for National Volunteer Week (April) celebrations is underway.
- The next ICE (Indigenous Career Experience) date is set for March 6 for Indigenous high school students from the Lakehead Public School Board and the Thunder Bay Catholic District School Board. Students will have an opportunity to learn more about volunteering and employment opportunities at the Hospital.
- Volunteer Services had an opportunity to present to students from Matawa Learning Centre at the PARTY program on February 15.
- We welcomed 10 new volunteers at orientation in January.

HELP Program Successes

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Thunder Bay ON
P7B 6V4 Canada

Tel: (807) 684-6007
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- St. Joseph's Care Group is planning to implement HELP (Hospital Elder Life Program) at their site and have consulted with us regarding the recruitment of volunteers for the program.
- Since implementing HELP at TBRHSC in September 2014, HELP volunteers have logged 8800 volunteer service hours and they have provided 14,758 interventions to patients; acute length of stay for those patients has dropped from 13 to 7 days; and more patients are being discharged back to their homes rather than long-term care.

	2A Audit (Mar-Aug 2014) Pre-HELP	**Total Enrollments (Sept 2014-February 2017)**
Total Patients	200 (Medical Patients)	1582 (Medical, Surgical)
Acute Length of Stay	13 days	7 days
Discharge Destination	10% LTC 21% SJCG 69% Home	1% LTC 28% SJCG 71% Home (Based on data collected for 1200 enrolled HELP patients)

Occupational Health and Safety

Funds received through participation in the OHA Safety Group have been used to help many departments purchase items to reduce injuries and improve the safety in their areas. Items purchased include headsets, office and staff chairs, bariatric lifts, and a motorized tug.

Influenza Vaccinations

Occupational Health and Safety (OHS) provided influenza vaccinations to approximately 725 of our 2800 permanent staff, as well as additional vaccinations to security staff, volunteers and students. The OHS department and managers promoted the immunizations through various clinics, roaming immunization carts, continuous advertising, and incentive draws. Staff who received their flu shot elsewhere (MD office, pharmacy) were encouraged to advise our OHS department for tracking purposes as well as to be included in one of the participation draws.

Year	Hospital Employees Only	Total Including All Categories (volunteers, students, other)
2016/17	714	959
2015/16	725	1026

BRIEFING NOTE

Thunder Bay Regional Health Sciences Centre

TOPIC	2016-17 Q3 Strategic Progress Report & Performance Results
PREPARED BY	Carolyn Freitag, Director, Strategy & Performance & Michael Del Nin, Manager, Decision Support
APPROVED BY	Jean Bartkowiak, President & CEO
PREPARED FOR:	SLC President & CEO Board of Directors X Other
DATE PREPARED	February 16, 2017

PURPOSE/ISSUE(S)

To highlight the accomplishments and progress for the 2016-17 Strategic Plan Q3 objectives and associated indicator results.

BACKGROUND

The report integrates the 2020 strategic initiatives and associated performance indicators to provide a progress report. The quarterly reports include a briefing note that outlines notable accomplishments in each strategic direction **focused on the performance indicators falling short of targets, including action for improvement.**

ANALYSIS/CURRENT STATUS

Accomplishments:

Patient Experience:

Quality & Academic environment: A major quality initiative that encourages the adoption of Quality Based Procedures (QBP) through the use of digital order sets supported by the MOHLTC, was endorsed by Senior Leadership Council (SLC). Access to a library of evidence based order sets was purchased with a goal to implement up to date standardized order sets for all admissions (in addition to QBPs) and to ensure successful management of the practice change. This initiative is endorsed by Medical Advisory Committee and is scheduled to begin in March.

Respect: The 'Respect' education plan is inclusive of the strategic objectives related to sensitivity, knowledge and competency in the strategic directions of acute mental health, indigenous health, seniors' health and patient experience. SLC recently approved the education plan. Development of the course curriculum is underway. The education encompasses learning principles that explore attitudes, self-awareness and supports behaviour change through scenario simulation training.

Leadership: The Leadership Enhancement initiative introduced the Strengths Finder Assessment tool at the Q3 session, November 16, 2016. This tool provides an analysis of strengths and how we can use them to achieve personal, professional, and leadership goals. The session inspired our leader participants who learned the benefits of appreciating others' strengths and how it helps us work better together.

Information Technology: Meditech 6.1 upgrade is a precursor to move forward with Computer Physician Order Entry. Healthtec Consultant was contracted to assess the regional hospital sites readiness in early January. Their report is expected in late March.

Comprehensive Clinical Care:

Chronic Disease & Prevention Management: Based on internal and external feedback, priorities were identified under Ontario's Chronic Disease Prevention and Management (CDPM) Framework including: a CDPM Steering Committee to oversee the project, a Chronic Disease Self-Management Patient Portal to access disease specific self management resources; adoption of QBPs for COPD and CHF, supporting CDPM technology initiatives, finalizing the Smoke Free Together and Eating Healthy models and developing relevant partnerships in the region.

Cardio Vascular Surgical Program: Staff visited University Health Network (UHN) to train for the first Endovascular Aortic Repair (EVAR) case. In January, the UHN team attended the first EVAR case to mentor the OR team. In addition to the on site team, the broader UHN team joined remotely to the OR suite using a new telehealth technology called "VisitOR1".

Patient Flow Strategy: Physician engagement with LOS data continues at the Physician LOS Working Group and cascaded to each Service. . We believe that these efforts contribute to the ALOS being below target, despite the increased occupancy in Q3.

Seniors Heath:

The Confusion Assessment Method (CAM) tool for delirium assessment and screening was implemented on 2B and ICU. The tool will help the health care team identify, mitigate and treat delirium in a timely and effective way.

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Indigenous Health:

A Virtual Visitation pilot project using tablets to connect patients to their families remotely began on 1A medicine/oncology in December.

Acute Mental Health:

Dr Peter Braunberger was appointed as the Medical Director of the Child & Adolescent Mental Health Unit, in September 2016, a milestone to develop a new medical oversight model. In addition, strategies are on track to implement a new care model and develop coordinated patient flow pathways with community partners.

A new model of care for Mental Health patients in the Emergency Department is being designed that includes space in the Emergency Department and near the Mental Health Unit.

Patient Health Questionnaire for Depression and Anxiety (PHQ-4) is a new admission screening tool to help identify patients experiencing signs of mental illness will be piloted on 1A in February 2017.

Performance Results:

Hand hygiene compliance:

Q3 results lower than previous quarters and below target; significant increase in survey volume in November combined with low compliance considerably reduced results for Q3.

Action: reinforcement of best practice at leadership meetings, and during staff rounding.

Medication reconciliation on admission:

Q3 results consistent with past quarters and below target. Proving difficult to sustain performance with current nurse-led model, especially when occupancy is high.

Action: A new model was recently approved by SLC for medication reconciliation on admission to trial beginning on 2B in March. The discharge model was also redesigned and is based on a physician-led model. It is dependent on the admission model and therefore, implementation will follow in 2017-18.

Surgical safety checklist compliance:

Q3 results nearly 100% target.

Action: None required other than ongoing monitoring.

Critical incidents:

Recorded critical incidents in each quarter of 2016-17 above stretch target of 0 incidents.

Action: Continue efforts to reduce incidents and review/adjust activities as required.

Percentage ALC days:

Q3 (Oct & Nov only) ALC days up sharply since Q1.

Action: This indicator reflects system challenges in accommodating post-acure care patients that cannot be discharged directly home; several tactics are currently being used, including engaging community hospital in streamlining repatriation processes and sponsoring an ALC assess and restore program with SJCG as the lead sponsor. This indicator was identified as a priority quality indicator for the 2017-18 Quality Improvement Plan.

Emergency Department length of stay (90^{th} Percentile in hours):

Q3 results up sharply from Q1 given considerable increase in overall occupancy.

Action: This indicator is partly driven by ALC patients, repatriation delays, ALOS, but also avoidable admissions; engaging local community health providers has started to reflect how they could help redirect these cases away from the ER. This indicator was identified as a priority quality indicator in the 2017-18 Quality Improvement Plan.

The Patient Flow Strategy refreshed its action plans to improve ALOS and discharge process to relieve the ED capacity pressures.

Percentage acute inpatient cases completed within NWLHIN:

New indicator for 2016-17 with Q1 & Q2 results down slightly from 15-16 average and slightly below target.

Action: Further investigation underway to identify patient populations that are receiving service outside the NWLHIN, as well as related trends and potential for improvement. It should be noted that results are for all of NWLHIN, so achieving improvements could prove challenging.

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Psychiatrist full-time equivalent staffing:

Q3 results declined from Q2 and below target.

Action: Recent attrition experienced in Q3. Increased recruitment efforts required as well as finalizing the governance model with SJCG is urgently required.

Total researchers:

Q3 consistent with prior quarters and year-to-date results is slightly below target. Individual quarterly reported results inconsistent with year-to-date results which could confuse readers, so a review of tracking methodology is considered.

Action: Further review underway to determine required actions, as well as tracking methodology.

RECOMMENDATION

N/A

NEXT STEPS

Board members could provide feedback to the President & CEO on the format and content of this report.

STAKEHOLDER REACTION

Expect that project teams, staff, physicians, volunteers, patient and family advisors and community will be proud of the progress.

COMMUNICATIONS

Communication of progress, challenges and remedial actions to staff, physicians, volunteers, patient and family advisors carried.

Success stories and profiles will be communicated to the community in Chronicle Journal articles and on public bulletin board in the Hospital.

FINANCIAL IMPACTS

The case for support for the Respect Education Plan implementation requires funding for 2017-18.

The case for support for the MedRec Admission model pilot, if successful, requires funding for 2017/18.

The case for support for the Digital QBP Order Set Project requires funding for 2017-18.

APPENDIX SECTION

2016-17 Q3 Balanced Scorecard – Strategic Indicators

The Hospital is committed to ensuring decisions and practices are ethically responsible and align with our Mission, Vision, and Values. 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 the Hospital's Framework for Ethical Decision Making

For more detailed questions to use on difficult decisions, please refer to the Hospital's Framework for Ethical Decision Making on the iNtranet under Quality and Risk Management>Ethics

Thunder Bay Regional Health Sciences Centre

Balanced Scorecard
Strategic Indicators: For Board Review
Report for 16-17 Q3

		2015-16 Fiscal	2016-17 Fiscal								
2020 alignment	**Indicators**	**YTD 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	91.17%	93.04%	93.64%	86.52%		93.00%	93.00%	85.26%	(7.74%)	
Patient Experience	30-day in-hospital deaths following major surgery	1.85	3.10				1.30	1.30	3.10	(1.80)	
Patient Experience	Number of critical events	4	1	2	3		0	0	6	(6)	
Seniors' Health	Pressure ulcer incidence			4.90%			7.00%	7.00%	4.90%	2.10%	
Comprehensive Clinical Care	90th Percentile ER length of stay (hours) for admitted patients (QIP)	31.7	30.8	34.0	39.5		29.7	29.7	34.8	(5.1)	
Indigenous Health	Acute hospital admissions per 1,000 population for patients from Indigenous communities	231	235	253					244		
Acute Mental Health	Psychiatrist full-time equivalent staffing as percentage of required full-time equivalent complement		53.3%	64.3%	58.3%		83.3%	83.3%	58.3%	(25.0%)	
Patient Experience	Patient satisfaction: Overall rating of care - Inpatients (QIP)	93.6%	92.9%	94.9%	95.1%		93.9%	93.9%	94.3%	0.4%	
	Staff satisfaction - organizational engagement	64.8%					n/a	n/a			
	Physician satisfaction - organizational engagement	55.2%					n/a	n/a			
Patient Experience	Total researchers		210	231	222		301	301	300	(1)	
Patient Experience	Learner satisfaction	86.1%		89.2%	88.5%		87.0%	87.00%	88.9%	1.9%	
Patient Experience	Paid sick hours as a percentage of worked hours	3.78%	3.47%	3.04%	3.47%		3.48%	3.48%	3.33%	0.15%	

	At or better than target
	Slightly (less than 5%) worse than target
	Significantly (5% or more) worse than target
	Data not expected for reporting period
Blue text	Incomplete period or result not yet finalized

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980 rue Oliver Road
Thunder Bay ON
P7B 6V4 Canada

Tel: (807) 684-6564
www.tbrhsc.net

Chief of Staff
Chef d'équipe

Chief of Staff Report

to the
Board of Directors
Thunder Bay Regional Health Sciences Centre

March 2017

Department Chiefs

- Interviews for the Chief of Midwifery position are pending

Incomplete Health Records

- The policy on record completion timelines is undergoing significant revisions and a draft will be presented to Medical Advisory Committee for feedback in the coming months

Physician Length of Stay (LOS)

- The working group is focused on Emerald data and strategizing on how to best share this information on discharge delays with Chiefs and individual physicians
- The group will be also be seeking feedback on the current data reports that have been provided to Chiefs over the last year to look for improvements

Professional Staff Leadership Development

- A new policy was approved to support bursaries for Professional Staff interested in developing leadership skills which will ensure our current leaders have the necessary skills required as well as assist with succession planning
- Forty-four potential leaders have been contacted seeking expressions of interest

Toolkit for Physicians Supervising a Physician Assistant (PA)

- A new toolkit for physicians supervising a PA or contemplating supervising a PA in the future has been developed
- The goal of the toolkit is to ensure clarity in the roles and responsibilities of supervising physicians and includes a number of resources as well as a performance evaluation tool to assess a PA's competencies
- The job des description and reporting structure for PAs were also updated to be consistent across the organization, clarifying the PA relationship to the Medical Advisory Committee and Professional Practice

Regional Chiefs of Staff Meeting

- Repatriation process to be standardized
- Medical Assistance in Dying (MAiD) process standardization for physicians in progress
- Orders sets/QBPs/Think Research Standardization

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980 rue Oliver Road
Thunder Bay ON
P7B 6V4 Canada

Tel: (807) 684-6018
www.tbrhsc.net

Chief Nursing Executive
Open Report
to the
Board of Directors

February 22, 2017

Patient Oriented Discharge Summary (PODS) ARTIC Proposal

- Health Quality Ontario ARTIC (Adopting Research to Improve Care) funding has been confirmed to support Patient Oriented Discharge Summaries
- TBRHSC will be one of 20 provincial hospitals to receive $35K (allocated over 2 years) to support implementation of a standardized tool to facilitate transitions in care and provide patients and caregivers with key information to effectively manage healthcare needs upon discharge
- The PODS tool and process contain five content sections for information that is actionable and useful for patients and their families including: i) medications; ii) changes to daily activities and diet; iii) follow-up appointments; iv) resources for patients and families, and; v) expected and worrisome symptoms to watch out for after leaving hospital. The implementation of PODS results in improved discharge processes, increased patient satisfaction, and increased understanding and adherence to discharge instructions, and significantly aligns with our Strategic Plan and QIP
- Pilot implementation of PODS (Year 1) will occur on the Oncology, Stroke/Cardio, Chronic Disease and Medicine units. This group represents ~8000 patient per year, and is ~45% of the annual discharges from the hospital.
- In Year 2, PODS will expand to Surgical Services. This represents another ~4500 patients per year, totaling ~12,500, which is ~75% of the annual discharges from hospital.
- The project start date is April 1, 2017

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 staff adherence to policy requirements; adult patients will have a Braden assessment completed within 24 hours of admission, and a follow-up Braden assessment at a minimum of once per week. This has been increased to a mandatory daily assessment effective January 2017.
- Since October 2014, biannual 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.

Thunder Bay Regional
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Centre

980 rue Oliver Road
Thunder Bay ON
P7B 6V4 Canada

Tel: (807) 684-6018
www.tbrhsc.net

- September 2016 P&I studies indicated a prevalence of 8.5% *(down from 10%: Feb. 2016),* and incidence of 4.8% (*down from 9%: February 2016*). The average prevalence rate for Acute Care Canadian hospitals with 300 to 399 beds is 14% (2015 Hill-Rom International Pressure Injury Survey).
- Enhanced accountability structures and focused clinical assessment practices have recently been implemented to engage and educate both Clinical Managers and front line staff in pressure ulcer prevention and management. This has resulted in a marked improvement in pressure injury P&I. Compliance with Braden assessments is now between 90-100% on all medical/surgical units.

NORTHERN ONTARIO SCHOOL OF MEDICINE

NORTHERN PASSAGES

VOLUME 17 | ISSUE 1

LOCAL INSPIRATION LEADS TO
GLOBAL ASPIRATIONS

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CONTRIBUTES TO HEALTH CARE IN THE NORTH

THIRD SEASON OF
HARD ROCK MEDICAL

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NORTHERN
PASSAGES

Newsletter of the Northern Ontario School of Medicine

Northern Ontario School of Medicine
Laurentian University

935 Ramsey Lake Rd.
Sudbury, ON
P3E 2C6
Tel: +1-705-675-4883
Fax: +1-705-675-4858

Northern Ontario School of Medicine
Lakehead University

955 Oliver Rd.
Thunder Bay, ON
P7B 5E1
Tel: +1-807-766-7300
Fax: +1-807-766-7370

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FEEDBACK

We welcome feedback and suggestions about *Northern Passages*. What stories would you like to read about your medical school? Send ideas to **communications@nosm.ca**.

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Cover Photo: Dr. Tricia Larose is a Postdoctoral Fellow with the International Agency for Research on Cancer and the Norwegian University of Science and Technology.
Photo Credit: Hege Gabrielsen Førsvoll

LOCAL INSPIRATION LEADS TO GLOBAL ASPIRATIONS

Born and raised in Sudbury, many of Dr. Tricia Larose's fondest childhood memories are from living on Bessie Street in the Donovan. She attended St. David's School and Marymount College (now Marymount Academy) before pursuing her post-secondary education at Laurentian University. Having grown up in Northern Ontario, Larose says her perception of the world was very small.

As an undergraduate student, Larose was part of Laurentian University's work-study program: a program designed to create part-time on-campus jobs, while helping students meet the cost of their studies. Larose secured a position at the Health and Wellness Centre and was mentored in health promotion and disease prevention activities by Nurse Practitioner and Manager, Lyne Rivet. "My first interview was 11 years ago," says Larose, "and I still remember what I was wearing and where I was sitting when she offered me the job! I walked away thinking, 'Oh my gosh, this is my first job in my field. Oh my gosh, I have a field!'"

Not long after, Larose came across a job ad in *The Sudbury Star* for Research Intern positions at the Northern Ontario School of Medicine (NOSM). Larose says she didn't think she had enough experience to work in a research laboratory. "I was interviewed by Dr. Marion Maar and Dr. Kristen Jacklin and was thoroughly inspired by their expertise in medical anthropology, and their participatory approach to rural health and Indigenous community health research," says Larose. "It was an absolute blessing to be hired as their Research Intern. Looking back, I realize now that my work-study experience positively influenced my success at NOSM."

After several months as a Research Intern, Larose was promoted to Research Assistant, and finally to Research Coordinator. Larose moved to London, England a few years later to complete her Masters of Science in Demography and Health from the London School of Hygiene and Tropical Medicine, followed by yet another

move to Norway, where she completed her PhD in Medicine at the Norwegian University of Science and Technology.

While still a research intern with NOSM, Larose says she would stand on the sidewalk under the Bridge of Nations on Paris Street in Sudbury and look up to the flags blowing in the wind. "I would imagine that I was standing at the front door of the World Health Organization. It seemed like an impossible dream at the time, but the more education I earned and the more experience I gained, I realized that my dream could become a reality," says Larose.

And it has. Larose is now a postdoctoral scientist with the International Agency for Research on Cancer—the specialized cancer agency of the World Health Organization—and the Norwegian University of Science and Technology. She will be working in Lyon, France for the first two years of a three-year postdoctoral fellowship, with the final year of research taking place in Norway. Larose will be part of a research group conducting one of the largest genetic epidemiology lung cancer studies in the world.

"What's so exciting about this project is that we have genetic data from 22 different countries and from 55,000 people. It's a case control study, which means we have an equal number of individuals with lung cancer and an equal number of controls who are matched for age, sex, ethnicity, and smoking status. We have people in the study who smoke, and people who don't," Larose explains. "A big part of the study is looking at the lifestyle factors of these people, including nutrition. Because we have such a large sample with data from so many countries, we have some certainty about cause and effect. And there's a reduced bias in this sample, which will enable us to be more certain about our study results."

"Sudbury, and all of Northern Ontario, is part of my identity and I miss home dearly. But I began to see the world as a much bigger place—full of different cultures, languages, and experiences. I want my research to make a difference, not just locally or regionally, but nationally and internationally as well," says Larose.

Larose hopes that by sharing her story, she can inspire youth in Northern Ontario to stay in school, work hard, take chances, and to not be afraid to fail. "I recognize that for many youth in Northern Ontario, the answer is not so simple," says Larose. "Early on in my research career, I was fortunate to be mentored by three strong, capable, inspiring—and patient—female leaders."

Dr. Tricia Larose (right), originally from Northern Ontario, says: "It's important for all of us to push ourselves beyond our self-perceived limitations."
Photo Credit: Hege Gabrielsen Førsvoll

NO "PROXY DENIED" FOR US: NOSM'S HEALTH SCIENCE LIBRARY CONTRIBUTES TO HEALTH CARE IN THE NORTH

by: Dr. Roger Strasser, NOSM Dean

Last year, in June, I participated in the Training for Health Equity network (THEnet) Evidence Group meeting in Sault Ste. Marie, Ontario. During the meeting, one of the speakers—Dr. Paul Grand'Maison from the Université de Sherbrooke—referred to an article in the journal *Academic Medicine*. Interested in learning more, I quickly hopped on the internet, accessed the Northern Ontario School of Medicine's Health Sciences Library, found, and downloaded the article. All of this took a few short minutes.

Sitting next to me was a friend and long-standing colleague from James Cook University (JCU) in Australia. Also interested in reading the article, she too tried to access it online, but with different results: "proxy denied." After a few frustrating and failed attempts, she reverted to Google Scholar, where she was able to access only the 250-word abstract.

Now, imagine yourself as a rural doctor (in fact, some of you reading this may very well be rural doctors), teaching a student or resident in your clinic. You and the learner see a patient with some unusual symptoms. You suspect the patient has a rare condition. In a big city, you might refer this patient to a specialist, but in this case, you know the closest one is hundreds of kilometres away. To be sure of the course of treatment, you consult your Faculty of Medicine's library to search for the best clinical practice guidelines for this illness. A relatively emergent case, your patient awaits you in the examination room, needing answers and treatment before they leave your office.

If you were this doctor (or the patient, for that matter), I bet you'd be hoping for the outcome I had in Sault Ste. Marie—the ability to seamlessly access the required resources. To me, this is one of the unsung ways that NOSM is contributing to the health of Northern Ontarians. Not only is the School training health professionals that stay and practice in the North, NOSM is also providing the ability for faculty members to retrieve up-to-date information and resources at the moment they need them—a fact that has a direct impact on patient care and teaching. Thanks to the School's digital library service, patients in Northern Ontario are likely to be receiving the same evidence-informed care as patients in urban university health networks.

It's not just the electronic access that sets NOSM's library apart, but also its service. Many university librarians believe that they should never perform literature searches for their clients—library users must learn this skill for themselves. Of course, this is an important skill, but in Northern Ontario we also work under different circumstances.

With 1,400 clinical faculty in more than 90 communities across Northern Ontario (and with patient caseloads much higher than their urban counterparts), our faculty have great demands on their time. The staff in NOSM's Health Sciences Library complete literature searches for faculty and researchers, and provide them with an expedited landing page to find all the resources they need. NOSM faculty members are able to quickly locate high quality research information, as well as the right types of services and support, depending on their needs.

Over the last few years, increasing operational costs and static governmental funding have caused rising financial pressure at the School. Because of the outstanding work of the Health Sciences Library, two very generous donors have committed to contributing a total of $50,000 in matching donations to ensure that the Health Sciences Library continues to support outstanding patient care, health research, and education in the North.

Dr. Roger Strasser is the Dean of the Northern Ontario School of Medicine. His Dean's Columns are featured in each issue of the Northern Ontario Medical Journal, *a quarterly publication of Northern Ontario Business.*

NOSM medical students at the School's Health Sciences Library in Sudbury.

For every dollar donated to NOSM's Health Sciences Library, your dollar will be matched by our committed donors to double the impact of your investment. If you'd like to support high-quality health care, research, and education throughout the North, contact NOSM's Advancement Office at **advancement@nosm.ca** or **1-800-461-8777**. I myself have recently made a personal financial commitment to our much-loved library, which has never failed to support me in my research and writing. — Dr. Roger Strasser

Kathy Needham
705-662-7154

Katie Biasiol
807-766-7424

NOSM MAKES ITS 'MARK' IN NORWAY

The Northern Ontario School of Medicine has a rapidly growing alternative name: No Ordinary School of Medicine. What is it about NOSM that makes it so unique?

One of the reasons is that NOSM's model is specifically designed to increase recruitment and retention and address priority health concerns in Northern Ontario. This is what is called a Distributed Community-Engaged Learning (DCEL) model, for which NOSM is famed around the world. Although NOSM is unique, the challenges that Northern Ontario is facing in terms of health care are common in rural, remote, and isolated parts of the world.

Over recent years, a growing number of health professional schools have developed distributed, community-engaged models around the world. One of those schools is Universitetet i Tromsø, known in English as UiT: The Arctic University of Norway. Members of the UiT leadership have begun to build curriculum based on NOSM's model. Like Northern Ontario, the county of Finnmark, where UiT is based, is the northernmost county of Norway with a dispersed and aging population. With only two regional hospitals, much of the health care in Finnmark is provided by general practitioners, of whom there are not enough.

In response to these community issues, UiT is undergoing a comprehensive curriculum revision to replicate many features of NOSM's model—early contact with patients, clinical learning, interprofessional learning, and distributed community learning.

"In proposing the Finnmark Model, faculty at UiT are planning to implement a NOSM DCEL-type model in the underserved region of northern Norway," says John Hogenbirk, Senior Research Associate, Centre for Rural and Northern Health Research (CRaNHR) at Laurentian University. "Their plan is to host fifth- and sixth-year medical students in communities in the county, including at least one community with a sizable percentage of the Sami Indigenous people. While there is currently some medical student placements in Finnmark, the new model would greatly increase the number and duration."

Research conducted by NOSM's Dean, Dr. Roger Strasser, shows that several countries with similar rural and remote areas to Northern Ontario and Finnmark have benefitted from decentralized medical education. The revisions to UiT's six-year medical program are designed to educate doctors with the necessary skills to serve rural areas.

With these substantial changes to their medical education program, the staff and faculty at UiT are eager to see if the changes are making a difference. To this end, UiT is collaborating with NOSM and CRaNHR staff—chief among them are Dr. Roger Strasser, Dr. David Musson, and John Hogenbirk—to evaluate UiT's new NOSM-inspired model and see how it may increase local economic activity, improve recruitment and retention in the area and, ultimately, improve patient outcomes in the region.

"NOSM and CRaNHR have engaged in and continue to engage in international research collaborations, the Finnmark-NOSM-CRaNHR investigation being the most recent research collaboration," says Hogenbirk. "These collaborative research programs benefit from our work on the NOSM Tracking and Socio-Economic Impact Studies and, equally important, help us to improve how we conduct our studies as well as how we understand, use, and share our findings. These collaborative international studies challenge our thinking, enhance our studies and provide more value for the people of Northern Ontario."

Back row (left to right): Dr. Peder Halvorsen, family physician and UiT Professor; Dr. Arnfinn Sundsfjord, UiT Dean; John Hogenbirk, Senior Research Associate CRaNHR and NOSM faculty member. Front row (left to right): Dr. Roger Strasser, NOSM Dean; Dr. Torben Wisborg (anaestiologist and UiT Professor; Dr. Ingrid Petrikke Olsen, gynaecologist and UiT Associate Professor and Finnmark Model Lead).

NEWLY-ACCREDITED NOSM PROGRAM CONTRIBUTES TO CANCER CARE IN THE NORTH

In early January, NOSM announced another in a long list of collaborations with the Thunder Bay Regional Health Sciences Centre (TBRHSC) in Thunder Bay and Health Sciences North (HSN) in Sudbury. The academic health sciences centres have partnered with NOSM to establish an accredited Medical Physics Residency Education Program to train medical physicists in the North, for the North.

Medical physicists are health-care professionals who have an honours degree in physics and complete specialized training in the medical applications of physics. Their work often involves the use of x-rays, ultrasounds, magnetic and electric fields, infrared and ultraviolet light, and heat and lasers in diagnosis and therapy. Most medical physicists work in hospital diagnostic imaging departments, cancer treatment facilities, or hospital-based research establishments.

"A lot of medical radiation is really customizing treatment to each individual patient. As physicists, we calculate the accurate measurement of the radiation output from radiation sources employed in cancer therapy," says Dr. Peter McGhee, Program Director of NOSM's Medical Physics Residency Education Program and Head of Medical Physics at TBRHSC.

With the support of Cancer Care Ontario, Thunder Bay and Sudbury have had medical physics training programs in place for nearly 20 years. "Although they evolved independently, there were many commonalities between the programs in existence at the Thunder Bay Regional Health Sciences Centre and Health Sciences North in Sudbury, so establishing a consolidated accredited program under the auspices of NOSM was a rather natural next step in advancing the standard of education for medical physicists," says McGhee.

"The objective of this Northern-based program is to provide practical training and experience in the clinical application of medical physics within the specialty of radiation oncology," says Dr. Michael Oliver, Associate Program Director and Medical Physicist at HSN. "The primary goal of the program is to provide, in a safe and professional environment, comprehensive clinical training in radiation oncology physics through the consolidation of clinical teaching faculty, staff, and educational resources of the Northern Ontario School of Medicine and the two Northern Ontario cancer centres."

During the course of the program, residents (one in Thunder Bay and one in Sudbury) are formal full-time employees of the academic health sciences centres. They are expected to enhance their learning experience with contributions to clinical work in a manner corresponding to the progression of their level of training.

Pictured (left to right): Muhammad Hafeez, Physics Assistant; Bans Arjune, Senior Physicist; and, Dr. Peter McGhee, Head of Medical Physics at the Thunder Bay Regional Health Sciences Centre.

THIRD SEASON OF HARD ROCK MEDICAL PREMIERES ON TVO

Hard Rock Medical is a 30-minute "dramedy" that was inspired by—and mostly follows—the School's curriculum. The series follows a diverse group of students as they navigate their way through a unique, Northern, hands-on medical school. After two exciting years of watching the students get their bearings with rural medicine, the third season of *Hard Rock Medical*, which premiered January 8, 2017 on TVO, puts the students through new and demanding medical and personal challenges.

"Our collaboration with NOSM has been exciting because the curriculum basically gives us a story," says Derek Diorio, Director/Producer of *Hard Rock Medical*. "When we are creating the show, we take real-life experiences from students and staff and we hang stories around them."

The third season was filmed entirely in North Bay and surrounding area, including scenes in Nipissing First Nation. As in the past, this season also features local actors and musicians for the soundtrack. Working closely with Canadore College's Digital Cinematography program, much of the show was staged out of Canadore College, which also housed the wardrobe and offices for the show.

"I think the show tackles the realities of becoming a doctor," says Jamie Spilchuk, originally from North Bay, who plays Cameron Cahill in the show. "It's a heightened, super-dramatized look at the experience of students going through this unconventional medical school where they take candidates and throw them in the deep end. And the North creates this amazing background to tell the stories that we wanted to get across in the Northern landscape."

Just as third-year NOSM medical students undertake their Comprehensive Community Clerkships in various communities across Northern Ontario—including North Bay—so too will the students in the third season of *Hard Rock Medical*. The third season focuses on taking the students out of the classroom and into diverse settings where the curriculum walks through the door.

"When we're shooting, we needed extras, and there were a few NOSM medical students at the North Bay Regional Health Sciences Centre doing their third year clerkship," says Diorio. "They came by to watch us set up the scene and ended up being on camera. Not only that, but they became medical consultants for the day. It was great to have them there—they showed us medical techniques, how much blood to put on the operating gowns in the OR, and how students would act in specific emergency situations."

There's still more excitement to be experienced with *Hard Rock Medical!* As the team films the fourth and final season in North Bay, be sure to tune in to TVO and catch the third season as it unfolds.

Third-year NOSM medical student Rhea Galbraith (centre) was an extra in this scene from *Hard Rock Medical* featuring Rachelle Casseus as Fardia Farhisal (right).
Photo Credit: Michael Tien

BEHIND THE SCENES
PUTTING CLEAN ENERGY INTO HEALTH RESEARCH

In each issue of Northern Passages*, individuals share a "behind-the-scenes" look at the Northern Ontario School of Medicine. This edition features Dr. Doug Boreham, NOSM's Division Head of Medical Sciences, and the NOSM and Bruce Power Research Chair in Radiation and Health, whose role is to support learners in studying medical sciences, and faculty and communities in investigating research relating to better human and environmental health.*

Tell us about your role at NOSM.
Forty percent of my time at the School is spent as the Division Head of Medical Sciences, where I support NOSM's Medical Sciences faculty in teaching medical students in their various areas of expertise, such as anatomy, physiology, immunology, genetics, microbiology, and pharmacology. The other 60 percent of my time is spent as the NOSM and Bruce Power Chair in Radiation and Health, which means that I work with graduate students and faculty to conduct research regarding health, the environment, and radiation.

What types of research projects are you working on now?
I am very lucky to work with many graduate students—from Masters to postdoctoral level students—and numerous NOSM faculty on a wide variety of research projects that have a ranging impact on the health of the people in our communities.

For example, we're doing a number of projects in Elliot Lake that look at community health. We just did a project to investigate the number of patients that go from Elliot Lake to Sudbury for CT scans, and the number is staggering. We're hoping this research will help Elliot Lake get a new CT scanner to save both lives and resources. In addition, the World Health Organization has started an initiative to support age-friendly communities—so we recently helped Elliot Lake with a study there to see if the community was friendly for people of all ages. In Sudbury, we are working with EMS to implement "PulsePoint" which is a mobile phone app that alerts CPR bystanders that a person nearby has had a sudden cardiac arrest.

Another big focus for our research is done in the SNOLAB—SNO stands for Sudbury Neutrino Observatory—just outside of Sudbury, located two kilometres underground in the Vale Creighton mine. We just brought down for a second year in a row more than 2,000 fish embryos to be grown down there during the winter to see what happens to an organism when they are shielded from cosmic and background radiation. We are also collaborating with two groups in the United States to grow cancer cells down there, to look at how lack of background radiation impacts cancer cell growth. We're purchasing a diagnostic x-ray machine to help us understand risks of being exposed to reduced background radiation and relate that to risks associated with medical radiation like mammograms, x-rays and CT scans. Interestingly, our research has shown that, contrary to what some people might think, low-dose medical radiation seems to have positive biological effects and increases life span and decreases cancer risk in our mouse model systems. Our current research is looking at how and why that might be.

What is your favourite part about your role at NOSM?
I really enjoy collaborating with faculty colleagues, and working with students to help them support research. Health research is important to me, and I find it rewarding to work with my colleagues to help people in our area live healthier lives, and inspire and support our students to conduct similar research that helps our communities.

Originally from Elliot Lake, Ontario, Dr. Doug Boreham is NOSM's Division Head of Medical Sciences and NOSM and Bruce Power Chair in Radiation and Health. Dr. Boreham was recently renewed as the Chair, along with an additional $5 million research funding investment from Bruce Power, the donation of a clean energy electric car for research at NOSM, and a car charging station that will be open in the spring of 2017 and will be available for free to the public.

Thunder Bay Regional Health Sciences Foundation
980 Oliver Road
Thunder Bay ON
P7B 6V4 Canada
TEL: 807 345 4673
www.healthsciencesfoundation.ca
info@healthsciencesfoundation.ca

Northern Cancer Fund
Northern Cardiac Fund
Health Sciences Discovery Fund

Report to the Thunder Bay Regional Health Sciences Centre Board of Directors
February 22 2017

Inspirational HOPE alive and well
The 2017 and the 21th anniversary Bearskin Airlines Hope Classic was a smashing success! These inspirational ladies raised $154,000 in support of breast cancer patients and their families, bringing their total to **over $3M**. This outstanding event has been pivotal in making possible the Linda Buchan Centre for Breast Screening and Assessment. Some of the most recent items that have been purchased are a breast MRI Coil and mammography biopsy equipment.

5 Forks Bachelors for Hope Charity Auction
Get your tickets now! Join us on Friday April 7 at the Valhalla Inn for a gourmet dinner and entertainment followed by the auction of 10 of Thunder Bay's finest and most eligible bachelors. Each bachelor comes with a fabulous date package including a main event, dinner at one of Thunder Bay's finest restaurants, and a pamper package for the successful bidder. Women have the option of taking the bachelor on the date or taking their significant other! 100% of money raised at this event is dedicated to breast cancer research, education, diagnoses, and treatment, and supports the needs of breast cancer patients in Northwestern Ontario. **Tickets are $95.00 and can be bought by calling Maureen Mills at 684-7278 or at healthsciencesfoundation.ca**

Media Coverage – Contact Heather 684-7111
Past

- Employee Gifts Celebrated at Luncheon (February 7)

Thank you to Employee Donors for being IN!
On February 7, staff at the Thunder Bay Regional Health Sciences Centre, Thunder Bay Regional Health Research Institute and Thunder Bay Regional Health Sciences Foundation were celebrated at a recognition luncheon for their contribution to world-class healthcare, but perhaps not in the way one would expect. Each employee at the luncheon was celebrated for his or her donation to the Thunder Bay Regional Health Sciences Foundation, made through payroll deduction. This year Employee Donors raised $84,835! If you have questions about Employee Giving please contact **Athena Kreiner at 684-7112**.

Leaving your mark on healthcare
March means that spring is just around the corner – warmer weather and new life are in the air! As you plan for what 2017 has in store for your family, it's important to consider the bigger picture of what you want to impact – the things that touch your family and friends closest. It's likely that you or someone you love has been a patient at the Health Sciences Centre in some way – from new babies born here to the Emergency Department or the Cath Lab – you know the impact health can have on all of our lives.

Every gift makes a difference and we hope that you've taken the time to think about what your legacy could be. Want to know where your gift could make a difference? Please contact **Terri Hrkac, Senior Director, Legacy and Major Gifts at 684-7109** for more information.

Thunder Bay Regional Health Sciences Centre

980 rue Oliver Road
Thunder Bay ON
P7B 6V4 Canada

Tel: (807) 684-6000
www.tbrhsc.net

Annual General Meeting
Proposed Time Change
June 22, 2017

In order to capitalize on Board members' times the following time change is proposed for the Annual General Meeting scheduled on June 22, 2017:

Time	Event	Location
2:30pm – 3:30pm	TBRHRI AGM	Auditorium A
3:30pm – 3:45pm	TBRHRI Inauguration	Boardroom
3:45pm – 4:00pm	Break	
4:00pm – 5:00pm	Speaker	Auditorium A
5:00pm – 5:15pm	Break	
5:15pm – 6:15pm	AGM	Auditorium A
6:15pm – 6:30pm	TBRRI Inaugural	Boardroom

BRIEFING NOTE

TOPIC	2017-18 Quality Improvement Plan(QIP) - Pay at Risk
PREPARED BY	Amanda Bjorn, Vice President, Human Resources
APPROVED BY	Jean Bartkowiak, President & CEO
PREPARED FOR:	SLC President &CEO Board of Directors **X** (February 22, 2017 Board of Directors)
DATE PREPARED	February 1, 2017

PURPOSE

To approve the recommended "Pay at Risk" Performance Based Executive Compensation Framework for inclusion in the Thunder Bay Regional Health Sciences Centre (the Hospital) 2017-18 Quality Improvement Plan (QIP).

BACKGROUND

The *Excellent Care for All Act* (ECFAA) requires the compensation of CEOs and other executives to be linked to the achievement of performance improvement targets laid out in the QIP of hospitals in Ontario; they are required to include a pay at risk compensation component as part of the QIP every fiscal year. The purpose is to drive accountability for the delivery of quality improvement plans.

Since 2011, executive compensation at the Hospital has been linked to performance indicators for the following executive positions:

- President & CEO;
- Executive VP, Corporate Services and Operations;
- Executive VP, Patient Services and Regional VP Cancer Care Ontario;
- Executive VP, Medical and Academic Affairs;
- Executive VP, Patient Services and CNE;
- VP, Human Resources;
- VP, Research;
- Chief of Staff.

Historical Pay at Risk Compensation Framework formulas were as follows:

- 2011 – 2016: 2% clawback of annual base salary divided by the number of indicators, each indicator weighted equally
- 2016 - 2017: 2 % clawback of annual base salary, divided by the number of indicators, each indicator weighted equally, each indicator having the following sub measures:
  - no improvement over the prior year's actual will receive 0% of the maximum for that target;
  - improvement above prior year's actual by up to 49% of target will receive 50% of the maximum for that target;
  - improvement above prior year's actual by up to 50-99% of target will receive 75% of the maximum for that target;
  - achievement of the 2016/17 target will receive 100% of the maximum for that target.

ANALYSIS/CURRENT STATUS

During the January 24, 2017 SLC meeting, QIP Indicators were chosen for recommendation to the Board to be linked to compensation. These indicators are recommended because we believe they represent priority goals to improve quality of care and system flow. In addition, a new compensation framework was developed for recommendation to the Board. The organization's Values of Patients First, Accountability and Excellence guided the development of the framework. It was important to the SLC to set a target for our performance. We recommend that our performance on the selected QIP indicators must be improved by at least 75% above the prior year's actual in order for the executive to earn back the reduced salary.

The proposed Pay at Risk Compensation for 2017-2018 is as follows:

The Pay at Risk Compensation applies to the following executive positions:

- President & CEO;

TOPIC	2017-18 Quality Improvement Plan(QIP) - Pay at Risk
PREPARED BY	Amanda Bjorn, Vice President, Human Resources
APPROVED BY	Jean Bartkowiak, President & CEO
PREPARED FOR:	SLC President &CEO Board of Directors **X** (February 22, 2017 Board of Directors)

- Executive VP, Corporate Services and Operations;
- Executive VP, Medical and Academic Affairs;
- Executive VP, Patient Services and Chief Nursing Executive;
- Executive VP, Patient Services and Regional VP Cancer Care Ontario;
- Vice President, Human Resources;
- Vice President, Research;
- Chief of Staff.

The following four priority quality improvement indicators will be linked to compensation:

1. Average length of stay (excluding alternate level of care days);
2. Percentage alternate level of care days;
3. Patient satisfaction: leaving hospital, did you receive enough information?;
4. Patient satisfaction: All dimensions – Inpatient.

Two percent (2%) of the executive salary will be linked to achieving of the quality improvement indicators. Each improvement target will be calculated equally at .50% per indicator (0.50% x 4 =2.0%). Following April 1, 2018, team achievements will be assessed against the quality indicators above. The executive will have the opportunity to earn back the reduced salary for each target that is achieved.

All indicators will each have the following sub-measures:

- No improvement over the prior year's actual = 0%;
- Improvement above prior year's actual by 75% of target will receive 75% of the maximum for that target;
- Improvement above prior year's actual by 76-100% of target will receive a directly proportionate 76-100% of the maximum for that target.

The resulting amount will be paid retroactively to April 1, 2017.

RECOMMENDATION

That Pay at Risk Performance Based Executive Compensation for the Quality Improvement Plan be approved as submitted.

NEXT STEPS

Draft 2017-18 QIP to be submitted at February QCOB meeting, including recommended indicators with related action plans and targets, narrative, pay at risk framework and progress report. – ***Complete***

Draft 2017-18 QIP submitted at March (Feb. 22) Board meeting for approval.

Once the Executive Compensation Framework for TBRHSC becomes effective, the structure for the pay to risk related to the QIP will be reevaluated in relation to the Executive Compensation Framework.

STAKEHOLDER REACTION

N/A

COMMUNICATIONS

N/A

FINANCIAL IMPACTS

APPENDIX SECTION

N/A

The Hospital is committed to ensuring decisions and practices are ethically responsible and align with our Vision, Mission, and Values. 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 the Hospital's Framework for Ethical Decision Making

For more detailed questions to use on difficult decisions, please refer to the Hospital's Framework for Ethical Decision Making on the iNtranet under Quality and Risk Management>Ethics

BRIEFING NOTE

TOPIC	2017-18 Quality Improvement Plan (QIP)
PREPARED BY	Carolyn Freitag, Director, Strategy & Performance & Michael Del Nin, Manager, Decision Support
APPROVED BY	Jean Bartkowiak, President & CEO
PREPARED FOR:	SLC President &CEO Board of Directors Other - Board
DATE PREPARED	February 22, 2017

PURPOSE

To submit for recommendation to the Board the 2017-18 Quality Improvement Plan (QIP), which includes:

1. 2017-18 priority indicators;
2. Indicator action plans and related targets ;
3. Narrative ; and
4. 2016-17 QIP progress report, for information.

BACKGROUND

In November 2016, the 2016- 17 Q2 Progress report was provided with the introduction of the draft 2017-18 priority QIP indicators. Through November to January, there was extensive engagement with leaders, physicians, staff, PFAs, relevant councils and committees were extensively engaged to select and develop the priority QIP indicators, targets and action plans.

On Jan. 18, 2017, the priority QIP indicators were accepted by Quality Committee of the Board (QCOB).

Data collection and trending in order to set targets confidently was a challenge for three particular indicators, including 30-day non-risk adjusted COPD & CHF readmission rates; patient satisfaction- In-patient; and, pressure ulcers. Managers, Decision Support & Health Records conducted comparison of raw to CIHI data for COPD & CHF to validate that a correlation exists to use the raw data.

The patient satisfaction survey methodology changed from last year therefore we now lack historic data to trend. Hence, it is recommended to wait for 2016-17 actual results for In-Patient, ED, and "Did you receive enough information at discharge" to establish improvement targets.

Last year, we began gathering incidence data for pressure ulcers in Q2 & Q4 which limits trending. Thus, it is recommended to wait for 2016-17 Q4 actual results to adjust target if necessary.

The Patient Flow Steering Committee, Patient & Family Advisor Council and most responsible Director Leads were consulted as the content experts on their respective QIP indicators to review the data available and recommend targets to inform Senior Leadership Council (SLC).

The ED LOS for admitted patients is a custom indicator; its target is not required to align with the HSAA agreement and can be determined by the Hospital.

The 2017-18 QIP Indicator action plans were developed by the most responsible leaders, including: Bonnie Nicholas, Aaron Skillen, Arlene Thomson, Lisa Beck, Deb Emery, Carolyn Freitag, Dawna Maria Perry, Gordon Porter and Dawn Bubar. The QIP planning process was used as a mechanism to establish the annual Patient Flow and Patient Experience Strategic action plans.

The QIP narrative was drafted in collaboration with PFCC Coordinator, Director of CDPM & Patient Flow, and the OH&S Manager & Safety Officer.

On Feb. 7th, 2017, the targets related to the priority indicators, the related work plan and narrative were endorsed by SLC.

On February 15, 2017, the Quality Improvement Plan was accepted by the QCOB.

ANALYSIS/CURRENT STATUS

The Committees and Leaders consulted provided the following feedback to inform SLC on developing performance targets:

- Patient Flow Steering Committee (Jan. 11th meeting) supports the recommended targets for the indicators related to Patient Flow as follow:
  - Acute Length of Stay (ALOS): 0.2 day reduction to 5.3 days (Strategic);

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- Alternate Level of Care (ALC): 12.7 % in patient days (HSAA);
- ER wait time for admitted patients down to 27.9 hours (HSAA);
- 30 Day Readmission Rates for CHF & COPD: trend data analysis in progress required to set targets.

The 30 Day Readmission Rates for CHF & COPD data analysis completed. Informed with the data, SLC set targets.

Patient satisfaction data is only available for Q1 & Q2 and partial Q3. Health Quality Ontario did not provide a target and NRC Picker's data is variable and unstable. By selecting "all domains" as a custom indicator there, are no comparators. This was explained and the PFA advice was sought at their

Jan 19th meeting; they were asked "If you were currently a patient or family member in our Hospital, what score would you expect?"; Council members provided the following targets:

- In Patient Satisfaction (All Domains): At the 25th percentile;
- ER Patient Satisfaction (All Domains):At the 25th percentile;
- "Did you receive enough information on discharge? At the 10th percentile

Decision Support modeled the existing data to show modest incremental improvements to further assist target setting. SLC set the targets based on the above information sources, as follow:

- IP All Dimensions and ER All Dimensions: patient satisfaction targets will be a 1% improvement on 2016-17 actual ;
- Sufficient information on Discharge: patient satisfaction target will be a 1% improvement on 2016-17 actual results.

The Director of Nursing suggests that incidence of Pressure Ulcer current target of 1% is over stretched based on evidence, expert opinion and lack of trend data. We currently perform well compared nationally and although further improvement initiatives were implemented in 2016-17, it is anticipated that subsequent reductions will be more difficult. SLC supported the rationale and set the target as follows:

- 6 % adjusted once Q4 results have been reviewed.

The ER LOS target proposed on Jan 11th was revisited by Senior Leadership. HQO indicator (ER LOS for admitted and non-admitted) was not selected because our non admitted performance is better than the Ontario average. Instead, a 'custom' indicator (ER LOS, admitted patients only) is suggested given our performance is lagging and could be influenced through ALOS and ALC reduction strategies. At Jan. 24th SLC, it a target relevant to the Hospital's custom indicator was suggested: 31 hours based on YTD average of 34.8 hours.

Medication Reconciliation on Admission & Discharge targets will not be reported on the QIP but tracked and reported internally on the BSC while new models are trialed in 2017-18.

Discharge Summaries sent within 48 hours is a developmental QIP indicator and therefore, does not require a target.

RECOMMENDATION

Accept indicators related 2017-18 action plans;

Accept targets for outcome indicators

Accept 2017-18 QIP narrative.

NEXT STEPS

N/A

STAKEHOLDER REACTION

The MAC, PFCC, PFA & Patient Flow Strategy Councils and Leads appreciated the consultation. They provided a deeper assessment of the QIP indicators and related data to inform SLC and Board decisions.

TOPIC	2017-18 Quality Improvement Plan (QIP)
PREPARED BY	Carolyn Freitag, Director, Strategy & Performance & Michael Del Nin, Manager, Decision Support
APPROVED BY	Jean Bartkowiak, President & CEO
PREPARED FOR:	SLC President &CEO Board of Directors Other - Board

COMMUNICATIONS

Following Board approval:

Most responsible Leader present 2017-18 QIP to Patient Flow Steering, PFCC & PFA Councils, MedRec Working Group, MAC & sections, and leadership

Post on internal and external website.

FINANCIAL IMPACTS

Budget impacts for Medication Reconciliation on Admission & Discharge may require resource and capital investments in the 2017-18 budgets.

APPENDIX SECTION

2016-17 QIP Progress Report;

2017-18 QIP Narrative;

2017-18 QIP Indicators and targets;

2017-18 Action Plans;

The Hospital is committed to ensuring decisions and practices are ethically responsible and align with our Mission, Vision, and Values. 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 the Hospital's Framework for Ethical Decision Making

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	Clinical Lead	Measure/Indicator from 16/17	Current Performance as Stated on 16/17 QIP	Target for Process Measure (Goal for Change Ideas)	16/17 Q2 Performance (Baseline, N/A, Suppressed)	Change Ideas from Last Year's QIP	Insert New Change Ideas Tested not Stated in 16/17 QIP	Was the Change Idea Implemented as Intended?	Lessons Learned: Consider What Were the Key Learnings?
	Bonnie Nicholas	Patient Satisfaction:Overall rating of care-Inpatients (%; All patients; October 2014 – September 2015; NRC Canada)	93.4	93.9	93.9	1. Enhance understanding and grow the Hospital's Patient and Family Centred Care (PFCC) philosophy, embed the best practices.	Spread PFCC philosophy to Region's community hospitals.	Yes	Aligning Patient and Family Centred Care (PFCC) best practices with Leadership Development "Studer" tactic "rounding for outcomes" was effective.
						2. Engage staff and physicians to understand and identify root causes and opportunities to improve lower patient satisfaction scores.		Yes	Department coaching by PFCC Coordinator and Decision Support was effective in identifying an organizational trend which then became a corporate improvement initiative.
						3. Engage those responsible and accountable for implementing change.		Yes	Restructuring the PFCC Leadership Council and providing support for the PFCC scorecard was effective in engaging those responsible and improving accountability.
	Bonnie Nicholas	Patient Satisfaction: Overall rating of care-Emergency (%; ED patients; October 2014 - September 2015; NRC Canada)	86.5	87	81	1. Enhance understanding and grow the Hospital's Patient and Family Centred Care philosophy, embed the best practices.		Yes	Patient & Family Advisors (PFA's) are an excellent resource to conduct real time surveys in the Emergency Department (ED). The information from the surveys facilitated timely small scale tests of change focused on care issues. PFA's involved in the ED redesign for mental health patients was an asset.
						2. Engage staff and physicians to understand and identify root causes and opportunities to improve lower patient satisfaction scores.		Yes	
						3. Engage those responsible and accountable for implementing change.		Yes	Sharing patient experience results monthly with program/service medical/administrative leadership encouraged accountability.
	Aaron Skillen	ALOS (excluding ALC) (Days; All acute patients; Dad and CIHI data; CIHI portal)	5.6	5.5	5.4	1. Use LHIN funding to assist with ongoing patient flow and ED wait times. Leverage patient flow software to enable understanding of root causes for longer patient stays.		Yes	The adoption of patient flow software reports by diagnostic and allied health services helped to determine delays to care plans. Unit Managers and Utilization Coordinators applying information provided through the patient flow software augmented discussions at morning rounds.
						2. Ensure physicians understand length of stay results and where improvements are required.		Yes	Chief of Staff leadership coupled with Decision Support and Health Records supported effective corporate messaging and educated physicians on Length of Stay (LOS) using data report customization at each medical section. Heightening awareness and improving overall knowledge proved to successfully engage physicians.
						3. Continue implementation of Quality Based Procedures (QBPs) and clinical pathways.		Yes	
						4. Update bed management and admission patient flow policies in standardized admission working group.		Yes	
						5. Develop targeted patient flow improvement strategies with standardized admission working group.		Yes	
						6. Develop targeted patient flow improvement strategies for patient repatriation.		Yes	

	Lisa Beck	Emergency LOS for admitted patients (90% in hours) (Hours; ED patients; January 2015 - December 2015; CCO iPort Access)	30.4	29.7	29	1. Optimize Pay for Performance strategies in the Emergency Department (ED) and throughout the organization.		Yes	Data analysis revealed infection control practices as a source of delay and therefore, identified the need for an Infection Control Process Improvement position to create strategies to facilitate early isolation clearance.
						2. Update bed management and admission patient flow policies in standardized admission working group.		Yes	
						3. Develop targeted patient flow improvement strategies with standardized admission working group.		Yes	Having Section Chiefs share response time data increased the awareness of delays. ED consultant response times were analyzed and service specific quarterly dashboards created for the Chief of Staff to monitor performance. Tactics to date to increase QBP/pathway adoption proved unsuccessful. Physician leadership was required and identified.
	Arlene Thomson	30 day readmission rate for patients with CHF (Rate; CHF QBP Cohort; January 2014 – December 2014; CIHI DAD)	22.09	22.09	Suppressed	1. Corporate participation in COACH Multicentre Research Trial.		No	COACH implementation date is an independent variable outside the control/ influence of the Quality Improvement Plan (QIP). Ongoing delays diminish the value of this strategy.
						2. Improved corporate adoption/implementation of Quality Based Procedures (QBP) pathways within first 24 hours (ED and in-pt units).		No	Work has been done on QBP uptake, but have been unable to influence utilization of pathways as expected at point of admission in the ED. Accountability and tools for implementing QBP pathways to be redeveloped.
						3. Support Most Responsible Physicians (MRP's) and ID team to manage this patient population to enhance continuity of care.		Yes	
						4. Review risk adjusted 30 day all cause readmission information when it is available.		Yes	Having Health Records develop proxy data reports facilitated the development of 17/18 performance targets.
						5. Explore advanced partnership with tele-homecare post discharge.		Yes	
	Aaron Skillen	30 day readmission rate for patients with COPD (Rate; COPD QBP Cohort; January 2014 – December 2014; CIHI DAD)	20.01	20.01	Suppressed	1. Corporate improvement in implementation of QBP pathways for COPD within first 24 hours.		Yes	While the COPD clinical pathway was developed in 16/17, with education completed and the pathway implemented, there is no evidence that the clinical pathway has been used to date. Future efforts focusing on physician engagement must be made to increase pathway utilization.
						2. Explore opportunity for enhanced linkages between in-patient care and COPD clinics/community care.		Yes	Enhancing referrals to telehomecare, the Hospital's COPD programs, and the North West Community Care Access Centre (CCAC) increased linkages.
						3. Support MRP's and ID team to manage this patient population to enhance continuity of care.		Yes	Having a Clinical Nurse Specialist educate the nursing population on COPD clinical pathway was key to the education and implementation plan. Support for COPD IP care requires additional resource investment to enable COPD Nurse Practitioner to initiate an IP service.
						4. Review risk adjusted 30 day all cause readmission information when it is available.		Yes	

	Deb Emery	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital (Rate per total number of admitted patients; Hospital admitted patients; most recent quarter available; Hospital collected data)	Collecting Baseline (CB)			1. Report and monitor compliance monthly and quarterly, using reports for units and balanced scorecards for senior leadership and program/service management.	Pilot designed for a dedicated Admission Nurse to complete BPMH on admission in addition to other required best practice assessments i.e. dementia, wound. Pilot proposes that specialty core group of nurses trained to take comprehensive BPMH will improve quality which in turn encourages physician confidence to complete medication reconciliation.	Yes	
						2. Pharmacists to complete medication reconciliation quality audits on admission.	To add new questions to Admission Med Rec audit(s).	Yes	
						3. Evaluate the medication reconciliation at admission process.		Yes	Evaluation of current model and performance results motivated the model redesign to improve results.
	Deb Emery	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged. (Rate per total number of discharged patients; Discharged patients; Most recent quarter available; Hospital collected data)	CB			1. Review approaches to medication reconciliation on discharge used by Ontario peers.		Yes	A comprehensive review of literature and environmental scan informed a change from the current pharmacy-led model to a physician-led model.
						2. Assess approaches to determine best fit for the hospital.		Yes	Engaging physicians in Discharge Med Rec process and form redesign was essential to success.
						3. Determine cost impacts and seek required approvals.		No	Business case not feasible at this time.
	Carolyn Freitag	Completion of strategic plan activities identified to impact equitable care at TBRHSC. (%; All patients; will be monitored quarterly; strategic plan completion)	CB		Not Available	1. Assess the organization's current status of outreach services.		Yes	Many informal relationships exist at the program/service level that require coordination and determination of priority relationships to pursue and formalize to move change ideas into action.
						2. Explore using the Health Equity Impact Assessment template.		Yes	

Thunder Bay Regional Health Sciences Centre
2017-18 Quality Improvement Plan Narrative

Overview:

Thunder Bay Regional Health Sciences Centre (the Hospital) began the journey as a Patient and Family Centred Care (PFCC) focused health care facility over ten years ago. Guided by the PFCC philosophy, we developed a formidable patient and family centred culture. In 2011, we were nationally recognized by Accreditation Canada as a leader in PFCC. The PFCC journey is nurtured in partnership with our patients and families with each Strategic Plan. Understanding the needs and expectations of the communities we serve and developing strategic priorities is accomplished through engagement with health professionals, health researchers, learners, policy-makers, and diverse community focus groups inclusive of vulnerable populations. In our Strategic Plan 2020, the community identified that a strategic priority must be to enhance the quality of the patient experience. The Patient Experience Strategic Direction overarches our Strategic Plan's four other Directions to Deliver Comprehensive Clinical Services, Optimize Seniors' Health, Enhance Culturally Appropriate Indigenous Health and Enhance Acute Mental Health.

The Hospital is the only academic specialized acute care facility serving critically ill patients in the Northwestern Ontario region. The Hospital is also an active regional provider involved in provincial networks coordinating cancer, stroke, renal, and cardiac care. The Hospital is affiliated with the Northern Ontario Medical School and Confederation College as an academic hospital, annually providing teaching to over one thousand seven hundred learners. The Thunder Bay Regional Health Research Institute (the Institute) is the research arm of the Hospital where thirty -one graduate students working in research labs, as well as eighty-five physicians and scientists actively engage in research; the Institute has committed in its Strategic Plan 2020 to a patient-centric research program that benefits the residents of Northwestern Ontario through indigenous population health research as well as innovative medical imaging and diagnostics. The Institute ranked recently thirty-fifth of the top forty health research facilities in Canada, and has maintained a position within the top forty health research institutions for the past six years. Recent accomplishments include the installation and commissioning of a cyclotron, the formation of two spin-off companies (XLV Diagnostics Inc. and Radials), and an ever-expanding roster of clinicians who are actively involved in research and clinical trials to provide better care for our patients. For the Strategic Plan 2020, the Institute will focus on leading research to improve the health outcomes of the people of Northwestern Ontario and beyond, advancing philanthropic support and generating revenue through science and partnerships, as well as enhancing the research environment.

Achievements:

The Hospital made a truly remarkable achievement in the past year by reducing the Acute Length of Stay on target by 0.2 days for the second consecutive year. Our Patient Flow Strategy improved our Length of Stay (LOS). One particularly successful initiative was engaging physicians with LOS data. The acting Chief of Staff took an active role in communicating to physicians the corporate challenges with overcapacity and our goal to improve LOS. The Medical Advisory Committee (MAC) was supportive and actively reviewed data and created action plans to address LOS at section meetings. The Decision Support and Health Records departments' resources customized reports and educated physicians at section meetings. Another achievement was the adoption of patient flow software by our Diagnostic Imaging and Allied Health Services to identify delays to care plans. As well, unit Managers and Utilization Coordinators applied information provided through the patient flow software to support morning bed rounds discharge decisions.

Another significant accomplishment last year was that our patient satisfaction scores for in-patient units reached the expected target. This is attributed to a rigorous analysis of scores conducted across all clinical units and to coaching in the development of action plans to address areas of concern for patient respondents. An accountability structure was implemented to monitor and report scorecard data to the PFCC Leadership Council. A leading practice ensures that Patient and Family Advisors (PFA) are part of Hospital councils and working groups; PFAs together with leaders, staff, and physicians, understand the indicators and design, monitor, and evaluate meaningful improvement activities and their impact for patients and families.

Contributing to the success of our patient satisfaction scores was the investment in a leadership development program last year, which launched with a best practice tactic of Leader Rounding for Outcomes. This practice involves leaders introducing themselves to new patients everyday and integrates compliance audits for Name, Occupation, Do (introducing yourself, stating your occupation and explaining what you will do) and patient whiteboards. Leader rounding for outcomes provided coaching opportunities for staff to improve their compliance with best practice tactics that matter to patients and their families.

While improvement in patient satisfaction scores was not achieved as expected for the Emergency Department despite this practice, several excellent improvement activities were implemented as a solid foundation for further improvement efforts in 2017-18. For example, a quick real-time survey process was implemented with the help of PFAs in the Emergency Department waiting room. The information gathered allowed the Emergency Department to respond to concerns, working on improvement activities in a timely manner. The Hospital's ongoing overcapacity burden weighs on the Emergency Department more than on the in-patient units, which makes improvements more challenging. Nevertheless, the Emergency Department continues to pursue improvement activities.

Finally, another achievement last year was the redesign of the medication reconciliation admission and discharge model by an improvement project team. A pilot project will be tested through a designated nurse admission model before March 2017. I if the model trial improves the quality and volume of medication reconciliation, then this project, including the necessary funds required will roll out to the rest of the Hospital.

Population Health:

The Hospital faces unique challenges in serving its patients, due to the sparsely populated but large geographic area it serves. Northwestern Ontario is half the Ontario land mass, and contains many isolated, northern rural communities, which are separated by vast distances. Our region is also characterized by scoring the worst population health score of Ontario. The Hospital serves 250,000 people; 19% of our population identify as Indigenous, which also represent 65% of all Ontario Indigenous residents. While our general population is not growing at the same rate as the rest of Ontario, our senior (aged 50+) and Indigenous populations are growing.

There are numerous health indicators that reflect a population's health. The population of Northwestern Ontario has poorer health outcomes than the rest of Ontario, yet they perceive themselves to be generally healthy. Northwestern Ontario has higher rates of smoking, hypertension, and obesity, which contribute to a higher incidence of chronic illness. The poor health status of the population contributes to significant demands on the health system. Current data indicate that the use of health services by Northwestern Ontario residents remain consistently among the highest in Ontario. The Hospital serves three vulnerable populations who markedly use health services more than the general population: seniors, Indigenous people, and people with acute mental illness. Health system differences also exist compared to the rest of Ontario and relate to the higher than average health needs of our population. Fundamental differences exist in the practice and usage of independent health facilities in the Northwest Local Health Integration Network (NW LHIN), in health system design and service, and in insufficient or ineffective access to primary care compared to other Local Health Integration Networks (LHIN's).

Through strategic engagement with the community (previously described), the Hospital identified Indigenous Health, Seniors' Health, and Acute Mental Health as three of the five Strategic Directions for our Strategic Plan 2020. The Hospital committed to overcoming the many barriers that these vulnerable populations face to make improvements in their health and to achieve our Vision of being "Healthy Together". Examples of strategic quality initiatives related to Indigenous Health, Seniors' Health, and Acute Mental Health are described in the section on Equity below.

Measuring the impact of the system, processes, or clinical practice improvements is important to know if the intended effect was achieved. . Of particular challenge is the difficulty in gathering data related to the Indigenous population. The Hospital is focused on gathering relevant data with our Indigenous partners and aims to develop indicators to track progress and measure health outcomes for Indigenous people. The strategic objectives for Indigenous Health focus on improving access to health services, self-management, transitions to home, and health system experience. Current indicators include wait times for surgeries or diagnostic tests, percentage of no-show rates to specialist appointments, and acute hospital admissions. We are seeking other meaningful indicators to measure achievements in this Strategic Direction.

Equity:

The Hospital takes seriously the incorporation of equity in the delivery of care provided to patients. The Hospital focuses on ensuring that patients and their families have equal access to care that enable them to lead healthy lives. The Hospital serves many specific populations and health equity is at the forefront of the Hospital's quality improvement initiatives. Particular attention is paid to quality improvement initiatives that improve the delivery of care for Indigenous, Francophone, senior, and acute mental health patients, and access to specialized acute services.

The Northwest Local Health Integration Network (NW LHIN) has the highest percentage of patients identifying as Indigenous. As the only specialized acute care centre in the NW LHIN, the Hospital faces many challenges in delivering equitable care to Indigenous patients. Several quality improvement initiatives to address these barriers were prioritized in the Hospital's Strategic Plan 2020. Overseeing these initiatives at a governance level is the Indigenous Advisory Committee, which includes Indigenous community representatives, Indigenous Patient Navigators, an Elder, the President and CEO of the Hospital, and other Hospital leadership representatives. The Indigenous Advisory Committee's purpose is to provide advice on the implementation of the Indigenous Health Strategic Direction objectives. Many of the Hospital's Strategic Plan 2020 initiatives aim to improve the Hospital's physical and cultural environment to reflect the values, practices, and traditions of Indigenous communities. For example, initiatives include the recruitment of Indigenous staff and volunteers, cultural sensitivity training and the development of a Respect Plan, integrating self-management education into discharge processes, and improving the use of and access to technology for pre-op, follow-up, and home care for patients in Indigenous communities. Currently the Hospital is trialing virtual visitation with electronic tablets through the Ontario Telemedicine Network (OTN) to connect patients with their families while they are receiving care at the Hospital, away from home.

The Hospital also serves a 3.5% Francophone population in the NW LHIN, with most living in smaller communities. Offering services in French in compliance with r the French Language Services Act (FLSA) is overseen by the Francophone Advisory Committee. The Francophone Advisory Committee purpose is to advise the President & CEO in the improvement and promotion of services to the Francophone population served by the Hospital. Membership includes the President and CEO, a Patient and Family Advisor (PFA), and representatives from the Francophone community and Hospital leadership. A French language internal working group is implementing quality improvement initiatives for Francophone patients, such as identifying and training staff to provide services in French when required, designating key positions as requiring French language skills, improving the awareness of services available, offering patient information materials in French, and organizing events for Franco-Ontarian Day to promote Francophone culture.

The population of those aged 65 and over is growing in Northwestern Ontario. Similar to provincial trends, we currently observe a high percentage of patients that no longer require acute care (commonly referred to as alternate level of care patients or ALC) in the local health system and in the Hospital. There are also a growing number of frail elderly and chronically disabled people in the community. As a result, the Hospital must episodically provide specialized acute care for these individuals when they can no longer cope in their homes due to acute illness. Recognizing the growing need for specialized care for seniors compelled the Hospital to commit to becoming a Senior Friendly Hospital. Within the Senior Friendly Hospital framework, a Seniors' Health Steering Committee has been established charged with overseeing the development, implementation, and evaluation of the framework elements, such as ensuring a safe hospital environment for seniors and optimizing function for seniors while hospitalized. As part of the plan, we look forward to implement a simulation-based Respect training program designed to meet the unique needs of seniors as well as Indigenous patients, patients with accessibility needs, and mental illness patients.

Mental health in-patient days have been gradually increasing at the Hospital. The demand for services for adults, adolescents, and children with mental illness in Northwestern Ontario, specifically with our vulnerable patient populations, far surpass the health providers' ability to deliver such services in current models of care. Enhancing access to and the delivery of mental health services is a key strategic direction in the Hospital's Strategic Plan 2020. Although physician recruitment for adult and child and adolescent psychiatry is a priority, the pursuit of quality initiatives related to child and adolescent mental health service delivery models, the Emergency Department's physical space, the expansion of the transitional discharge model, and the restructuring of the psychiatry governance model are also priorities to improve access to care for a growing vulnerable population.

In the NW LHIN, the Hospital is meeting the specialized acute care needs of almost 90% of the population. Some low volume, specialized care quaternary services, such as cardiovascular, organ transplants or pediatric critical care, require that patients travel vast distances.; Distance and transportation are barriers to accessible and timely service that result in poorer health outcomes for patients living in Northwestern Ontario. For example, patients suffer three times the incidence of amputation related to cardiovascular disease due to the absence of specialized cardiovascular service at the Hospital. An innovative partnership with the University Health Network- (UHN) has brought care closer to home. This year, the new vascular surgery program expanded services to offer advanced vascular surgery: endovascular aneurysm/aortic repair (EVAR). With this service comes the responsibility to monitor patient outcomes to ensure a standard of quality care equal to UHN.

Integration & Continuity of Care:

Guided by our PFCC philosophy, the Hospital has made great strides in ensuring the integration and continuity of care for our patients and their families. It is critical for our patients to have successful healthcare outcomes to receive the right care in the right location. The Hospital has made internal improvements and has developed successful programs or initiatives with regional healthcare system partners to ensure continuity of care.

For example, the Hospital's Critical Care Unit advocated for patients to receive safe, quality critical care closer-to-home with family supports where possible. Patients who become too ill for their regional community hospital to care for them require specialized critical healthcare professionals. In Northwestern Ontario, this presents a challenge due to our large geography. The Critical Care Outreach Team was developed so critically ill patients in the region now benefit from a program that uses videoconferencing through OTN to connect the Hospital's Critical Care Unit with the community emergency rooms. Over 400 patients' care was managed by community hospital emergency staff supported by Critical Care trained physicians and nurses, and transfers to the Hospital were avoided for over 80 of those patients, while those needing Critical Care were stabilized and safely transferred. Partnering with ORNGE resulted in timely and safe transitions in transport by standardizing equipment and processes.

Transportation for regional patients continues to be a barrier for patients' continuity of care. The Hospital provides service to approximately sixty regional patients a day. Data shows that regional patients stay up to one day longer than local patients. This increases the LOS regional patients' LOS as they have to wait for transportation to return to their community. Transport data is analyzed monthly, and it was determined that delays, while not large in volume, negatively impact patient satisfaction and ALOS. This is particularly true for Indigenous patients who may have longer transportation wait time and who have less supports for follow-up care. Furthermore, non-urgent travel is not well supported; To address this challenge, the Hospital engaged the support of ORNGE and Indigenous communities to explore innovative solutions.

The Hospital participates with healthcare system partners as a member of five Integrated District Network Health Links Committees to address integration and continuity of care issues. The Hospital led the development of the Thunder Bay Health Links and continues to support it as a partner. The Hospital's Emergency Department assists in linking patients to the Northwest Community Care Access Centre (NW CCAC), to optimize their care and connect them with the Health Links service to avoid admissions or longer LOS. Efforts such as adopting Quality Based Procedures (QBP) for COPD and CHF will benefit Heath Links patients and improve their continuity of care. The Hospital recently joined wave three of the Ministry of Health's QBP Digital Order Sets initiative, which we anticipate will improve quality and safety of the aforementioned patient populations.

One major initiative in progress to improve the integration and continuity of care is the creation of the Regional Orthopedic Program. The partnered with Dryden Regional Health Care, Riverside Health Care Facilities in Fort Frances, and Lake of the Woods District Hospital in Kenora as well as the NW LHIN. The program maximizes health outcomes for patients with musculoskeletal diseases and disabilities across Northwestern Ontario and shifts musculoskeletal care into a truly integrated system of quality care, closer to home. The program has transformed the way musculoskeletal care is provided in the region and has made a positive impact at a systems-level in providing sustainable, exceptional patient care. We are confident this model will serve as the template for other clinical regional programs.

Right Level of Care Access:

The Hospital is focused directly on addressing ALC challenges through patient flow efficiencies, by advocating for additional health systems capacity, and by developing formal partnerships with other community organizations to deliver comprehensive clinical services that support care in the appropriate location. The Board of Directors, Senior Leadership Council, and leadership conduct regular discussions to maintain focus on the primary challenge of overcapacity that the Hospital faces. The President and CEO engaged the community hospitals in Northwestern Ontario by touring all twelve hospitals in the summer of 2016. The feedback obtained from the community hospitals showed that there are shared ALC challenges, and by conducting tours, an openness to discuss and manage the issue collaboratively was created. Working with system partners is essential to addressing ALC and overcapacity challenges.

A number of initiatives demonstrate the positive impact of working with our system partners to address ALC. For example, Dilico Anishinabek Family Care located an Indigenous Discharge Planner in the Hospital to provide specialized discharge planning support for patients returning to remote communities. This helps in avoiding patients wait in the Hospital longer than necessary. Joint Weekly Crisis

Designation meetings are now being held with the Hospital, NW LHIN, and the NW CCAC in an effort to monitor Hospital overcapacity, including ALC and explore potential avenues to relieve the pressure. Another successful initiative to address ALC was the NW LHIN system-wide surge planning exercise conducted in the fall of 2016 to mitigate the potential surge on the local health system expected in the winter of 2016-17. The exercise resulted in four beds being added to the twenty-six bed Temporary Transitional Care Unit provided by the St. Joseph's Care Group, the involvement of the Hospital's Nurse-Led Outreach Team in long-term care home outbreaks to enhance outreach care and ensure that residents access to timely, quality care in their homes to minimize visits and transfers to the Emergency Department, and finally the implementation of daily bed management calls with system partners over the Holiday period enhanced communication, facilitated discharges, and led to a communication campaign to encourage local primary care clinics to maintain hours, and to inform the public of healthcare alternative options to avoid unnecessary visits to the Emergency Department, and finally.

The Hospital further addresses ALC challenges through an e-referral software program (Strata Resource Matching and Referral) which was recently expanded into the district for acute care to CCAC, CCAC to long-term care, and acute care to rehabilitative care discharge pathways. A Home First Operational Committee including representatives from the Hospital, the NW LHIN, and the NW CCAC was also formed to discuss system-level ALC challenges.

Staff, Clinicians & Leaders Engagement:

For the development of the 2017-18 Quality Improvement Plan (QIP), the Hospital engaged leaders and clinicians at our second quarterly planning and performance session. Hospital leadership, including Medical Directors and union leaders, were given an overview of last year's QIP progress, and the focus on quality improvement initiatives for the upcoming year. Participants were given the opportunity to review, discuss, select, and prioritize meaningful quality indicators. A core group of PFAs joined the leaders to share their perspectives on the quality indicators. For the first year, the Medical Advisory Committee (MAC) was engaged in indicator selection. As subject matter experts, the Patient Flow Steering Committee and the PFCC Council members reviewed the quality indicators and provided recommendations on priorities and targets. The Patient Flow Steering Committee and the PFCC Council are comprised of Senior Leaders, Directors, Managers, PFA's, and physicians. Following the development of all quality indicators, improvement project teams will be struck and comprised of Directors, Managers, PFA's, and front-line staff. The Hospital will aim to have staff participate in the planning and development of the 2018-19 QIP, in addition to their representation on the improvement project teams.

Patient, Family & Client Engagement:

Through our PFCC philosophy, the Hospital is committed to engaging patients and their families in our decision making processes. Even difficult decisions faced by our SLC are made with input from a PFA, as one representative sits on our Senior Leadership Council. PFAs are members of all programs, services councils, most committees and work groups; they contribute at all levels of the Hospital; policies and key issues, including the QIP , are vetted through a larger group of PFAs at the PFA Council. Our Strategic Plan 2020 annual review engaged our Five Partners in Healthcare, with over one thousand individuals engaged last spring. The Hospital realizes that our patients and their relatives are experts about themselves, their experiences, and what is important to them. Partnering with them allows us to develop and implement meaningful strategies that improve their experience.

The Hospital demonstrates its commitment to PFCC and patient engagement through our Vision, Mission and Values. Our Values state that "Patients ARE First":

- We are respectful of and responsive to the needs and values of our patients, families and communities and patient values guide all decisions;
- We are responsible to advance a quality patient experience and are committed to social and fiscal accountability to internal and external stakeholders and for the delivery of services to our patients;
- We honour the uniqueness of each individual and his/her culture; and
- We foster an environment of innovation and learning to advance a quality patient experience.

Our Values are embedded into the Hospital's decision making processes as they are expressly stated on all Hospital agendas, as well as on our framework for ethical decision making. The Hospital further demonstrates its commitment to PFCC by engaging patients through satisfaction surveys, hearing and considering their concerns, reviewing safety reports, and analyzing critical incidents. The information gathered from these tools is used to identify process improvements and ultimately, to make positive changes for patients and their families.

The 2017-18 QIP was informed through engagement with our key healthcare partners and PFA's. Our PFA's provided input in the selection of the priority indicators, informed the patient satisfaction targets, and they will work with improvement teams to implement action plans to meet the set targets. Our PFAs will also assist in evaluating the effectiveness of the action plans and if the plans are not achieving their intended outcomes, they will be called upon to help change them and evaluate the effectiveness of the new plans. Through our PFA's input, 3 priority indicators were chosen for next year (Patient Satisfaction In-Patient – All Domains, Patient Satisfaction Emergency Department – All Domains, and "Did you receive enough information on discharge"). We continue to engage our patients and their families to ensure we achieve quality care, safe patient experience and outcomes through evidenced-based medicine and compassionate and respectful care.

Staff Safety & Workplace Violence:

The Occupational Health and Safety (OHS) policy (OHS-os-245) states the Hospital's commitment to providing a safe and healthy work environment that is free of violence and harassment and making every reasonable effort to ensure that no employee or person under the Hospital's direction is subjected to violent acts, threats or harassment. The policy outlines worker and employer responsibilities in maintaining a safe and healthy work environment. It also outlines the actions to be taken in the workplace to prevent incidents of violence and to ensure the appropriate management of such incidents should they occur. An algorithm is included describing the steps to take with violent or aggressive individuals in different settings, and a workplace violence fact sheet depicts examples of workplace violence and staff roles and responsibilities.

Staff and patient incident reports are completed when harassment, violence and aggression incidents occur. Incidents are investigated, and controls or corrective actions and safety plans are initiated if applicable. Process reviews are completed by inter professional teams, including required changes. The Hospital has a Liaison Officer with the Thunder Bay Police Services who is contacted or consulted when judicial issues need to be addressed. Incidents are also reviewed by Unit Managers, the OHS department, and the Joint Occupation Health and Safety Committee. Incidents of harassment between staff are also reviewed by the Human Resources department. Acts of aggression or violence are reported, tracked and reviewed by the OHS department and JOHSC. Risk assessments of Hospital areas were completed in 2015. These assessments were reviewed and controls were put into place to reduce risks where applicable.

To further enhance the Hospital's commitment to providing a safe and healthy work environment, Non-Violent Crisis Intervention (NVCI) training is provided to staff identified as working in higher risk areas. The OHS department plans to have all staff trained on NVCI within the next three years. Violence in the workplace is also discussed at orientation, with a mandatory online learning program to be completed prior to orientation. Hospital staff must complete this online learning program on an annual basis. A trial of personal safety alarms was also successfully completed on one of the Hospital's medical units as well as in an administrative area. In the future, personal safety alarms will be rolled out to the entire Hospital through a wireless system that is presently used in the Mental Health areas as well as the Emergency Department. Lastly, the OHS department successfully trialed a pilot project in the Emergency Department to identify individuals who have current or previous acting-out behaviours, aggression, or violence; next steps include rolling out the identification feature and policy to the entire Hospital.

Performance Based Compensation:

Our executives' compensation is linked to performance in the following way:

The Pay at Risk Compensation applies to the following executive positions:

- President & CEO;
- Executive VP, Corporate Services and Operations;
- Executive VP, Medical and Academic Affairs;
- Executive VP, Patient Services and Chief Nursing Executive;
- Executive VP, Patient Services and Regional VP Cancer Care Ontario;
- Vice President, Human Resources;
- Vice President, Research;

- Chief of Staff.

The following four priority quality improvement indicators will be linked to compensation:

1. Average length of stay (excluding alternate level of care days);
2. Percentage alternate level of care days;
3. Patient satisfaction: leaving the hospital, did you receive enough information?;
4. Patient satisfaction: All dimensions – Inpatient.

Two percent (2%) of the executive salary will be linked to achieving the quality improvement indicators. Each improvement target will be calculated equally at .50% per indicator (0.50% x 4 =2.0%). Following April 1, 2018, team achievements will be assessed against the quality indicators above. The executive will have the opportunity to earn back the reduced salary for each target that is achieved.
All indicators will each have the following sub-measures:

- No improvement over the prior year's actual = 0%;
- Improvement above prior year's actual by 75% of target will receive 75% of the maximum for that target;
- Improvement above prior year's actual by 76-100% of target will receive a directly proportionate 76-100% of the maximum for that target.

The resulting amount will be paid retroactively to April 1, 2017.

Contact Information:

Other:

Thunder Bay Regional Health Sciences Centre

2017/18 Quality Improvement Plan Work Plan

2020 Strategic Plan Alignment	Quality Dimension	Objective	Lead	Measure/ Indicator	Planned Improvement Initiatives (Change Ideas)	Methods	Process Measures	Target for Process Measure (Goal for Change Ideas)
Patient Experience	Patient Experience	Improve Patient Satisfaction-All Dimensions	Bonnie Nicholas	Total of Top Box scores in the combined composite categories/domains of the CPES-IC survey	1) All Programs/services/departments to: a) understand their results,and b) develop patient experience improvement action plans to address lowest domain results. 2) Engage physician sectopm to increase awareness and understanding of patient experience results. 3) Programs/services/departments implement change initiative based on results.	1) Corporate sponsorship supports coordination of corporate inititatives. 2) Refrsh annual clinical action plans based on patient experience results. 3) Coach leaders on performance results. 4) Coach non-clinical departments on action plan development.	1) Percentage of service/program/department patient experience improvement action plans developed as a proportion of the total number of services/programs/departments. 2) Percentage of service/program/department patient experience improvement action plans implemented as a proportion of the total number of services/programs/departments. 3) Percent of physician engagement/coaching sessions that promote understanding of patient experience as a proportion of the total number of physician sections.	1) 100% of service/program/department action plans developed. 2) 80% of service/program/department action plans implemented. 3) 100% of physician engagement sessions completed.
Patient Experience	Safe	Trial a new process for Medication Reconciliation on admission	Deborah Emery	Medication Reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital	1) Engage physicians and staff in medication reconciliation process. 2) Improve participation and completion of medication reconciliation by Physicians at Admission. 3) Trial a pilot process on 2B Medical Unit using designated staff to capture Best Possible Medication History (BPMH). 4) Report and monitor compliance quarterly to Chief of Staff and Medical Advisory Committee. 5) Pharmacy to complete Med Rec Quality Audits on admission. 6) Evaluate Med Rec Admission process. 7) Develop sustainable model	1) Pilot an Admission Nurse process. 2) Utilize trained and designated staff to document the Best Possible Medication History (BPMH). 3) Designated staff support physician group to complete the med rec at admission. 4) Complete audits. 5) Evaluate pilot.	1) Percentage of the total number of patients with medications reconciled as a proportion of the total number of patients admitted to the Hospital in pilot. 2) Percentage of audits of Best Possible Medication History (BPMH) in pilot.	1) 10 % Increase compliance of Med Rec in pilot. 2) Increase BPMH quality in pilot.

Thunder Bay Regional Health Sciences Centre

2017/18 Quality Improvement Plan Work Plan

2020 Strategic Plan Alignment	Quality Dimension	Objective	Lead	Measure/ Indicator	Planned Improvement Initiatives (Change Ideas)	Methods	Process Measures	Target for Process Measure (Goal for Change Ideas)
Patient Experience	Safe	Trial a new process for Medication Reconciliation on discharge	Deborah Emery	Medication Reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged	1) Engage physicians in medication reconciliation process improvements. 2) Introduce a process that places the responsibility on the physician to complete the documentation for Med Rec at Discharge 3) Increase participation and completion of medication reconciliation by Physicians at Discharge. 4) Report and monitor compliance quarterly to SLC and monthly to Chief of Staff. 5) Pharmacy to complete Med Rec Audits on Discharge. 6) Evaluate Med Rec Discharge physician -led process.	1) Redesign the Med Rec discharge form. 2) Pharmacy support for physicians. 3) Implement sustainable audit process 4) Evaluate physician-led model	1) Percentage of physician engaged in the medication reconciliation process. 2) Percentage of compliance audits.	1) 60% physicians engaged. 2) 60 % compliance audits completed.
Comprehensive Clinical Care	Efficient	Decrease the ALOS	Aaron Skillen	ALOS (excluding ALC)	1) Leverage patient flow software to identify Length of Stay (LOS) improvement opportunities. 2) Engage physician leadership re: length of stay by physician service. 3) Support the implementation of Quality Based Procedures (QBP's). 4) Implement and evaluate policies and procedures related to bed utilization. 5) Improve timeliness of patient discharge to regional community hospitals.	1) a) Produce and disseminate reports from patient flow software system that identify and quantify care barrier delays. b) Develop process improvement plans to address the top three (3) care barrier delays. 2) a) Continue to produce and disseminate physician service length of stay reports to Department Chiefs. b) Develop and disseminate reports from patient flow software system that identify care barrier delays. 3) Advance the implementation of the digital order sets project. 4) a) Educate staff and physicians. b) Monitor compliance of new policies. 5) a) Produce and disseminate repatriation reports by regional community hospital that identify and quantify repatriation delays. b) Engage physician leadership and regional community hospital administrators to develop and implement solutions to address repatriation delays.	1) Average length of stay (excluding ALC days). 2) Number of care plan delay days related to the top three (3) care plan barriers. 3) Number of ALOS improvement action plans prepared by physician departments. 4) Percentage of patients repatriated from TBRHSC to regional community hospitals in 2 or less days.	1) 5.3 days. 2) 10% reduction (2017-18 vs. 2016-17) in care plan delay days for top three (3) care plan barriers. 3) One (1) ALOS improvement action plan each for five (5) largest physician services. 4) 50%.

Thunder Bay Regional Health Sciences Centre

2017/18 Quality Improvement Plan Work Plan

2020 Strategic Plan Alignment	Quality Dimension	Objective	Lead	Measure/ Indicator	Planned Improvement Initiatives (Change Ideas)	Methods	Process Measures	Target for Process Measure (Goal for Change Ideas)
Comprehensive Clinical Care	Efficient	Decrease ALC rate	Aaron Skillen	% ALC days	1) Advocate and demonstrate the need for additional health systems capacity. 2) Develop formal partnerships to deliver comprehensive clinical services that support care in the appropriate location. 3) Meet regularly with local health system partners to develop and implement Alternate Level of Care (ALC) mitigation strategies. 4) Ensure Long-Term Care Home residents have access to timely, high quality health care within their homes and to minimize avoidable resident transfers to TBRHSC. 5) Utilize software technology to facilitate patient discharges to: Home with Care Supports, Long-Term Care and Complex Continuing Care/Rehabilitation. 6) Review the existing working group committee structure within TBRHSC's Patient Flow Strategy Committee.	1) Regular and ongoing conversations at the Board, CEO, Executive Vice-President, Director and Manager level. Hogarth Riverview Manor Phase 2 scheduled to open April 2017. Bethammi Nursing Home will remain open in 2017-18 under a temporary long stay license. 2) a) Weekly Crisis Designation meetings. b) Weekly Joint Discharge Operational Team (JDOT) meetings. c) Quarterly Home First Operational Committee meetings. d) Seasonal Northwest Local Health Integrated Network (NW LHIN) System-Wide Surge Planning meetings. 3) Continue to operate the Nurse-Led Outreach Team in the Long-Term Care Home sector. 4) a) Continue to utilize Strata Resource Matching & Referral e-referral software. b) Continue to produce and distribute weekly internal Alternate Level of Care (ALC) reports (ALC overall and ALC-Unknown). 5) Update respective working group's terms of references and ensure that ALC reduction initiatives are addressed. Consider the creation of a specific working group dedicated to ALC reduction as required.	1) The total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute ALC information and monthly bed census data. 2) Number of ALC patients transferred to LTC (HRM) or Post-Acute (SJH) effective July 1, 2017.	1) 12.7%. 2) 30 ALC patients.

Thunder Bay Regional Health Sciences Centre

2017/18 Quality Improvement Plan Work Plan

2020 Strategic Plan Alignment	Quality Dimension	Objective	Lead	Measure/ Indicator	Planned Improvement Initiatives (Change Ideas)	Methods	Process Measures	Target for Process Measure (Goal for Change Ideas)
Comprehensive Clinical Care	Effective	Decrease 30 day Readmission for CHF	Arlene Thomson	30 day readmission rate for patients with CHF	1) Utilize clinical pathway for CHF at point of decision to admission within the Emergency Department (ED). 2) Develop a Meditech database to allow monitoring of index events and readmissions.	1) Ensure all CHF patients are placed on CHF pathway for index admissions and all readmissions. This requires linkage with ongoing Quality Based Procedure (QBP) initiatives and clinicians in the Emergency Deparmtent (ED) and beyond. 2) Assign Cardiology Nurse Practitioner as the lead for CHF inpatient care coordination (associated with implementation of COACH study). 3) Assess gaps/failures that lead to readmissions on an individualized patient basis (follow-up missed, socio-economic challenges, etc.). Collaborate with ED team to develop a small core team to handle this work. 4) Implement QBP digital order sets per Ministry of Long Term Care Provincial Project	1) Percentage of total CHF patients (index admission and readmission) supported by the implementation of digital CHF QBP order set. 2) Non-risk adjusted 30 day all cause readmission rate for patients with congestive heart failure.	1) 60% of CHF patients on QBP pathway in Q3 & Q4. 2) 22 %.
Comprehensive Clinical Care	Effective	Decrease 30 day Readmission for COPD	Aaron Skillen	30 day readmission rate for patients with COPD	1) Utilize clinical pathway for COPD within first 24 hours. 2) Develop a Meditech database to allow monitoring of index events and readmissions.	1) Ensure all COPD patients are placed on clinical pathway for index admissions and all readmissions. This requires linkage with ongoing Quality Based Procedure (QBP) initiatives and clinicians in the Emergency Department (ED) and beyond. 2) Leverage admission and re-admission data for COPD patients to ensure coordination of follow up care. 3) Connect appropriate patients with: a) TBRHSC telehomecare program. b) Northwest Community Care Access Centre (CCAC)/Local Health Integrated Network (LHIN) program. c) Primary care provider. 4) Implement QBP digital order sets per Ministry of Long Term Care Provincial Project	1) Percentage of COPD patients supported by the implementation of an digital COPD order sets in 2017-18. 2) Non-risk adjusted 30-day all-cause readmission rate for patients with chronic obstructive pulmonary disease.	1) 60% of COPD patients in Q3 & Q4 2017-18. 2) 19%.

Thunder Bay Regional Health Sciences Centre

2017/18 Quality Improvement Plan Work Plan

2020 Strategic Plan Alignment	Quality Dimension	Objective	Lead	Measure/ Indicator	Planned Improvement Initiatives (Change Ideas)	Methods	Process Measures	Target for Process Measure (Goal for Change Ideas)
Comprehensive Clinical Care	Timely	Decrease 90th % ER wait for admitted patients only	Lisa Beck	90 % LOS for ER admitted patients	1) Implement Pay for Results strategies. 2) Avoid unnecessary admission. 3) Support the implementation of Quality Based Procedures (QBP's).	1) Improve disposition decision times by: a) using physician extenders in both the Emergency Department (ED) & Hospitalist programs. b) maintaining Rapid Assessment Zone (RAZ) in ED for high acuity patients. 2) a) Participate in Senior Friendly Pathway Project. b) Analyze admission data to define cause of unnecessary admission. 3) a) Engage physician leadership. b) Advance the implementation of the digital order sets project.	1) a) Physician Initial Assessment (PIA) times remain <2.3 hours. b) Monitor consult times to share with the Chief of Staff and Department Chiefs (target consult time 2 hours). 2) ER LOS for admitted patients only	1) 90th percentile ED admitted LOS. 2) 34 hrs.
Comprehensive Clinical Care	Effective	Increase the information patients recieve prior to leaving hospital	Bonnie Nicholas	% of respondents who responded positively to the question: Did you receive enough information from the hospital staff about what to do if you were worried about your condition after you left the hospital?	1) Assess and implement best practices to a) ensure patient/care partner understanding of information provided, and b) improve safe transition to home.	1) Integrate Patient Oriented Discharge Summaries (POD's) to identify gaps in patient understanding of discharge information and improve the coordination of transitional care needs. 2) Update discharge information resources to meet the needs of senior populations. 3) Ensure that all patient information is reviewed by a Patient/Family Advisor (PFA).	1) Percentage of Patient Oriented Discharge Summaries (POD's) completed. 2) Percentage of discharge information resources updated. 3) Percentage of patient information reviewed by a Patient/Family Advisor (PFA).	1) 80% of Patient Oriented Discharge Summaries (POD's) completed. 2) 80% of discharge information resources updated. 3) 100% of patient information reviewed by a Patient/Family Advisor (PFA).

Thunder Bay Regional Health Sciences Centre

2017/18 Quality Improvement Plan Work Plan

2020 Strategic Plan Alignment	Quality Dimension	Objective	Lead	Measure/ Indicator	Planned Improvement Initiatives (Change Ideas)	Methods	Process Measures	Target for Process Measure (Goal for Change Ideas)
Comprehensive Clinical Care	Effective	Increase Discharge Summaries sent within 48 hrs of discharge	Gordon Porter	Process Indicator	1) Engage the Medical Advisory Committee (MAC) and the Professional Staff Association (PSA) on the objective. 2) Assess current state and identify barriers. 3) Engage a target group physicians to conduct a Plan, Do, Study, Act (PDSA) cycle. 4) Ensure Health Records has the resources to support the PDSA.	1) a) Identify Physician Leader and champions. b) Develop WIIFM message and conduct a series of presentations at the Medical Advisory Committee (MAC), section meetings and Professional Staff Association (PSA). 2) a) Map process. b) Conduct a root cause analysis. 3) a) Identify target group i.e. Hospitalists, Family Practice. b) Define the improvement activity. c) Implement a small scale change activity. 4) Explore methodologies to collect, collate and report compliance. 5) Develop a business plan for dictation system upgrade.	1) Percentage of physicians engaged (through presentations at meetings). 2) Percentage of small scale change activity implemented. 3) Data collection process.	1) 80% of physicians engaged. 2) 100% of small scaled change activity implemented.
Seniors' Health	Safety	Decrease the incidence of pressure injury	Dawna Maria Perry	Outcome Indicator - % of admitted adult patient who develop a stage II or greater pressure injury (excluding Woman and Children, Mental Health and Forensic units) while in hospital. Data collected biannually as a prevalence and incidence study.	1) Identify admitted adult patients earlier who are at risk for the development of pressure injury. 2) Implement off-loading devices to reduce the risk of pressure injury development for patient identified as at risk. 3) Develop additional methodology to track pressure injury incidence.	1) Increase the frequency for completion of the Braden risk assessment from once a week to daily. 2) a) Develop a pre-printed direct order for patient identified as at risk of the development of pressure injury. b) Trial the use of off-loading devices on at risk patients. 3) Complete incident reports for patients that develop a stage II or greater pressure injury during hospitalization.	1) Compliance with the completion of the Braden risk assessment on a daily basis. 2) a) Pre-printed medical directive endorsed by the Medical Advisory Committee (MAC). b) Percentage of pressure injuries developed by patients who were cared for using off-loading devices during trial. 3) Percentage of patients identified as developing a stage II or greater pressure injury while in hospital compared to the number of patients identified in the P&I study.	1) 90% compliance with the completion of the Braden risk assessment on a daily basis. 2) Off loading pilot incidence less than hospital incidene. 3) 90% of patients developing a stage II or greater pressure injury identified by incident report compared to the incidence studyl.

TBRHSC
17-18 QIP Indicators - Draft 9

	2015-16 Fiscal	2016-17 Fiscal									2017-18 Fiscal		
Indicators	**Actual**	**Q1 Actual**	**Q2 Actual**	**Q3 Actual**	**Q4 Actual**	**Annual Target**	**YTD Target**	**YTD Actual**	**YTD Variance**	**Trending (last 6 or available quarters)**	**Category**	**Proposed Target (preliminary)**	**Comments**
Medication reconciliation on admission	63.6%	62.5%	57.3%	60.0%		62.0%	62.0%	60.0%	(2.0%)		HQO Priority		Sustained improvement dependent on new model for completion of medication reconciliation and incremental resources for same. Briefing note submitted to SLC in Dec 2016. For 17-18, will treat as developmental indicator due to model re-design
Average length of stay (excluding alternate level of care days)	5.66	5.42	5.28	5.27		5.50	5.50	5.33	(0.17)		TBRHSC Priority	5.30	Target adjusted to reflect .2 day reduction from 16-17 target.
30-day readmission rate for patients with COPD (non-risk adjusted)	20.3%	21.9%	17.0%					19.8%			TBRHSC Priority	19.0%	HQO priority is risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort). Suggested indicator is limited to "TBRHSC only" readmissions and is not risk-adjusted but as a proxy, provides more timely data. Target is 1 point improvement on 16-17 YTD
30-day readmission rate for patients with CHF (non-risk adjusted)	18.8%	22.3%	23.5%					22.8%			TBRHSC Priority	22.0%	HQO priority is risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort). Suggested indicator is limited to "TBRHSC only" readmissions and is not risk-adjusted but as a proxy, provides more timely data. Target is 1 point improvement on 16-17 YTD
Percentage alternate level of care days	16.0%	14.7%	18.6%	22.1%		12.7%	12.7%	17.5%	(4.8%)		HQO & TBRHSC Priority	12.7%	Assumes transfer of 30 ALC patients to HRM effective Jul 1, 2017
90th Percentile ER length of stay (hours) for admitted patients	31.7	30.8	34.0	39.5		29.7	29.7	34.8	(5.1)		TBRHSC Priority	31.0	HQO priority is 90th percentile ED length of stay for complex patients, which includes admitted and non-admitted complex patients. TBRHSC waits for high acuity non-admitted patients are within target, so TBRHSC will continue to focus on admitted patients
% of patients with new pressure ulcers	9.1%		4.9%			7.0%	7.0%	4.9%	2.1%		TBRHSC Priority	6.0%	Added to 17-18 QIP per recommendation of SLC. Proposed target represents a reasonable stretch based on past and current performance although will be reassessed once Q4 results (expected Feb 2017) are known
Patient satisfaction: Leaving hospital, did you receive enough information	n/a	55.0%	78.7%	61.0%				66.0%			HQO & TBRHSC Priority	67.0%	New indicator recommended by HQO for 17-18. Note that indicator is for inpatient only and includes maternal newborn. Results are for "TopBox" from NRC tool. Ontario peer data is not yet available and NRC has expressed concerns about comparability of it. Given only 2 quarters of TBRHSC results available, considerable differences between quarters, and concerns re peer data, suggest awaiting Q3 and Q4 results (estimated available in June 2017) and setting target at 1 point improvement from 16-17 YTD
Patient satisfaction: All dimensions - Inpatient	n/a	61.2%	73.2%	61.8%				66.0%			TBRHSC Priority	67.0%	Replaces HQO's priority indicator "Patient experience: Would you recommend inpatient care?" and provides a more fulsome perspective on overall patient satisfaction results. Note that indicator is for inpatient only and includes maternal newborn. Results are for "TopBox" from NRC tool. Ontario peer data is not yet available as NRC has expressed concerns about comparability of it. Given only 2 quarters of TBRHSC results available, considerable differences between quarters, and concerns re peer data, suggest awaiting Q3 and Q4 results (estimated available in June 2017) and setting target at 1 point improvement from 16-17 YTD
Patient satisfaction: All dimensions - ED	n/a	68.0%	75.4%	60.7%				70.0%			TBRHSC Priority	71.0%	Replaces HQO's priority indicator "Patient experience: Would you recommend emergency department?" and provides a more fulsome perspective on overall patient satisfaction results. Note that indicator is for ED only. Results are for "TopBox" from NRC tool. Ontario peer data is not yet available as NRC has expressed concerns about comparability of it. Given only 2 quarters of TBRHSC results available, considerable differences between quarters, and concerns re peer data, suggest awaiting Q3 and Q4 results (estimated available in June 2017) and setting target at 1 point improvement from 16-17 YTD

At or better than target
Slightly (less than 5%) worse than target
Significantly (5% or more) worse than target
Data not expected for reporting period
Data reported in quarter is preliminary and subject to further change

Board Composition & Recruitment

The composition, size, turnover, nomination, and recruitment processes are perhaps some of the most important governance elements and processes that contribute to effective governance.

Board Size

Legal Requirements

For corporations governed by the Corporations Act (Ontario), the board size must be a fixed number of no fewer than three, and the fixed number must include the elected and ex officio Directors. the number of directors may be increased or decreased by a “special resolution” (a resolution passed by the directors and confirmed by at least two-thirds of the members voting at a general meeting).

The Public Hospitals Act permits the appointment of life directors, term directors and honourary Directors in accordance with and subject to the limitations of that Act.

Regulation 965 under the Public Hospitals Act mandates that the administrator (chief executive officer), chief nursing executive, chief of staff or chair of the medical advisory committee, and president of medical staff are ex officio members of the board who do not have the right to vote.

Under the Not-for-Pro t Corporations Act (Ontario), the number of directors must be at least three and the number must be set out in the articles and can, therefore, only be changed by articles of amendment unless the articles provide for a range of directors as described below. A hospital will meet the definition of a “public benefit corporation”, and therefore, no more than one-third of the directors may be employees of the hospital or any of its affiliates.

The Not-for-Profit Corporations Act (Ontario) will permit the articles to set out either a fixed number of directors or a range for the size of the board. For example, the articles may authorize the corporation to have a minimum and maximum number of directors. Where a range of directors is set out in the articles, the number must be fixed within the range by the members by special resolution from time to time, or the members may, by special resolution, empower the directors to determine the number. In such a case, the board would determine the number (within the minimum and maximum range) by ordinary resolution from time to time.

Governance Principles

The board needs to be large enough to ensure there are sufficient individuals to manage its workload. However, a board should not be so large as to impede effective discussion. All board members should have an opportunity for meaningful input.

Board size should be determined according to the context of the particular hospital corporation. A hospital board should determine its size based on the following factors:

- Board workload, which can be variable depending upon issues facing the organization, such as capital projects or system integration.
- Skills required by the board, which may vary from time to time depending upon the issues and challenges facing the organization.
- Board size has an impact on effective board discussions. All board members should have the opportunity to provide meaningful input without unduly lengthening board meetings.

- **If a board wishes to have rotating or staggered terms and directors are elected for three-year terms, then the board must have at least 12 elected directors, plus the required ex officio directors, to allow four directors' terms to expire each year, as required by the Public Hospitals Act.**

Except from Corbett, Ann et al., Guide to Good Governance, 3rd edition, Governance Centre of Excellence, pp. 135-136.

FISCAL ADVISORY COMMITTEE

2016-2017 as at November 14, 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	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 2017-18									x			
8	Stakeholder Communication and Accountability	Q3 2016-17 Financial Review									x			
9	Stakeholder Communication and Accountability	Financial Statements as at 2017-02-28									x			
10	Stakeholder Communication and Accountability	Terms of Reference Annual Approval									x			
11	Stakeholder Communication and Accountability	Work Plan 2017-18 Approval									x			

Governance/Nominating Committee 2016-17

Updated: February 17, 2017

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					Under revision
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					Under revision
20	Governance	Review and approve application for membership form	N							x					Under revision
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		
34	Governance	Determine Committee memberships	G												NEW ITEM - Committee to decide on timing

APPENDIX B - Quality Committee of the Board - 2017-18 Updated: Jan. 1, 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	Presenter	Comments
1	Quality Oversight	Programs & Services Presentations		x	x	x	x	x	x	x	x	x	Dyad Leads	No presentations were scheduled for October
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	Infection Prevention & Control Mandatory Patient Safety 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	Ethics										x	M. Allain	
19	Quality Oversight	Litigation									x		C. Covino	
20	Quality Oversight	Research Ethics Board					x					x	K. Bell	
21	Quality Oversight	Research Ethics Board Annual Report										x	K. Bell	
22	Quality Oversight	Annual Quality Research Report					x						A. M. Heron	
23	Quality Oversight	Quality-Based Procedures									x		S. Craig	

ǧional Health Sciences Centre Board of Directors Work Plan

Updated: February 17, 2017

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						Will be brougt to the February 15 Governance meeting prior to being sent for Board approval.

#	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		

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		x				Completed in January

RESOURCE PLANNING COMMITTEE WORK PLAN

2016-2017 as at February 14, 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	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						x			
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			x						Deferred to January
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								

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
21	Financial Oversight	HAPS 2017-18 Update				x		x						Deferred to January
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	x							Added to December
29	Financial Oversight	Operating Plan Approval 2017-18					x	x						Deferred to January
30	Legal Compliance	Public Sector Salary Disclosure								x				
31	Financial Oversight	Capital Budget 2017-18 Update			x		x							Added to December
32	Financial Oversight	Capital Budget 2017-18 Approval					x	x						Deferred to January
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		

Page Views: Open Board Meeting Webcast

September 2013 – February 2017

Month	# of Page Views	Month	# of Page Views	Month	# of Page Views	Month	# of Page Views
Sept 2013	32	Sept 2014	57	Sept 2015	68	N/A	--
Oct 2013	26	Oct 2014	34	Oct 2015	25	Oct 2016	85
Nov 2013	11	N/A	--	Nov 2015	44	Nov 2016	17
Dec 2013	5	N/A	--	Dec 2015	22	Dec 2016	19
Jan 2014	17	N/A	--	Jan 2016	30	Jan 2017	--
Feb 2014	10	Feb 2015	23	Feb 2016	41	Feb 2017	38
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		

Thunder Bay Regional Health Research Institute

Translational Research Office
980 Oliver Road
Thunder Bay ON
P7B 6V4 Canada

Pre-Clinical Research Office
290 Munro Street
Thunder Bay ON
P7A 7T1 Canada

Tel: (807) 684-7223
Fax: (807) 684-5892
www.tbrhri.ca

Thunder Bay Regional Health Research Institute Report for TBRHSC Board – February, 2017

Submitted by: Jean Bartkowiak, CEO
February 15, 2017

Indigenous Health Research

The Vice-President Research and others have been meeting with Indigenous leaders such as Chiefs and health leaders to exchange knowledge in relation to current and future Indigenous health research. This is informing the finalization of the Institute's 2020 Strategic Plan. On January 31st, Dr. Rudnick briefly attended the Chiefs Winter Assembly held at the Da Vinci Centre and on February 8th had an opportunity to speak at the Treaty #3 Health Council meeting in Ochiichagwe'Babigo'Ining. Meetings with Chief Peter Collins, Fort William First Nation, and Paul Capon, Matawa First Nations, are planned in the near future. Both Mr. Bartkowiak and Dr. Rudnick will be attending the upcoming Aboriginal Health Forum which is sponsored by the North West LHIN.

Also, the Vice-President Research is collaborating with research leadership at Lakehead University and the Northern Ontario School of Medicine in preparation for an Indigenous and remote health care Canada Excellence Research Chair application. Registration occurred on February 1st.

Recent Scientist Publications

The Ontario Neurodegenerative Disease Research Initiative (ONDRI) newsletter recently included a link to the first ONDRI paper that has been published. The Hospital is acknowledged in the paper that was published in The Canadian Journal of Neurological Sciences. Institute Scientist, Dr. Jane Lawrence Dewar is one of the scientists associated with this project. To read the full paper entitled: *The Ontario Neurodegenerative Disease Research Initiative (ONDRI)* visit the link below:
https://www.cambridge.org/core/services/aop-cambridge-core/content/view/3D9558108D69BBF1A4B158DCF2EF6329/S0317167116004157a.pdf/div-class-title-the-ontario-neurodegenerative-disease-research-initiative-ondri-div.pdf

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Translational Research Office
980 Oliver Road
Thunder Bay ON
P7B 6V4 Canada

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290 Munro Street
Thunder Bay ON
P7A 7T1 Canada

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Fax: (807) 684-5892
www.tbrhri.ca

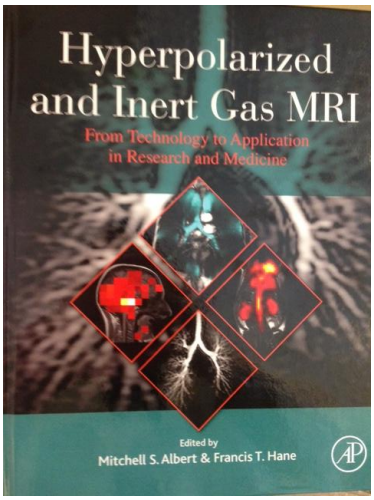
Update from Dr. Albert's Lab

Dr. Mitchell Albert and colleagues were awarded a Weston Brain Institute grant to conduct their research on **Novel Technology for Early Detection of Alzheimer's Disease.** To date, 18 participants have been scanned including both healthy volunteers and volunteers who have been diagnosed with Alzheimer's disease. Two abstracts on this exciting research have been submitted to the April, 2017 conference held by the International Society on Magnetic Resonance in Medicine: *Using hyperpolarized 129Xe MRI to detect cerebral profusion in Alzheimer's disease patients* and *Using hyperpolarized 129Xe in human participants to perform functional magentic resonance imaging (fMRI).*

For the first time ever, an Alzheimer's disease participant was scanned with the hyperpolarized xenon magnetic resonance imaging technique. Imaging data in the Alzheimer's disease volunteers compared to the normal volunteers suggests that there is slower blood flow in the brain of the Alzheimer's disease volunteers. This is an important finding for the discovery of drug treatments for Alzheimer's disease and for the potential to monitor disease progression. The team also obtained, for the first time ever, fMRI images using hyperpolarized xenon in healthy volunteers. Preliminary results have been encouraging, and the scientists are confident that this research will pave the way for early detection of Alzheimer's disease.

Dr. Albert's Latest Publication

Published in November, 2016, *Hyperpolarized and Inert Gas MRI: Theory and Applications in Research and Medicine* is the first comprehensive volume published on HP gas MRI. Since the 1990s, when HP gas MRI was invented by Dr. Albert and his colleagues, the HP gas MRI field has grown dramatically. The technique has proven to be a useful tool for diagnosis, disease staging, and therapy evaluation for obstructive lung diseases, including asthma, chronic obstructive pulmonary disease and cystic fibrosis.



HP gas MRI has also been developed for functional imaging of the brain and is presently being developed for molecular imaging, including molecules associated with lung cancer, breast cancer, and Alzheimer's disease. Taking into account the ongoing growth of this field and the potential for future clinical applications, the book pulls together the most relevant and cutting-edge research available in HP gas MRI into one resource.

BRIEFING NOTE

Thunder Bay Regional Health Sciences Centre

TOPIC	Fire & Environmental Compliance Update
PREPARED BY	Anne Marie Heron, Executive Director, Capital Planning & Operations Kathryn Shewfelt, Director, Environmental Services
APPROVED BY	Peter Myllymaa, Executive Vice President, Corporate Services & Operations
PREPARED FOR:	President & CEO ☐ Board of Directors ☒ Other
DATE PREPARED	February 14, 2017

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:

- On February 7, 2017 TBRHSC was issued an Inspection order with respect to the fire doors leading from the Ambulance Bay to the Emergency Department. Education, enforcement and facility changes were made, in addition to communication with our external partners to ensure compliance including EMS, AmbuTrans, Ornge, Thunder Bay Jail and Thunder Bay Correctional Centre.
- Fire Chief John Hay has contacted the Executive Vice President of Corporate Services & Operations to personally extend his thanks and appreciation for the hard work that has been completed to ensure the Hospital's compliance with the fire code.

Ministry of Environment & Climate Change:

Sterilization in MDRD

- Decommissioning of Ethylene Oxide system to occur after approval of amendment to ECA – awaiting final approval

Ministry of Energy:

Green Energy Act

- Next update due July 1, 2017

RECOMMENDATION

No further recommendations. Continue to implement projects and initiatives.

NEXT STEPS

N/A

TOPIC	Fire & Environmental Compliance Update
PREPARED BY	Anne Marie Heron, Executive Director, Capital Planning & Operations Kathryn Shewfelt, Director, Environmental Services
APPROVED BY	Peter Myllymaa, Executive Vice President, Corporate Services & Operations
PREPARED FOR:	President & CEO ☐ Board of Directors ☒ Other

STAKEHOLDER REACTION

N/A

COMMUNICATIONS

N/A

FINANCIAL IMPACTS

N/A

APPENDIX SECTION

N/A

The Hospital is committed to ensuring decisions and practices are ethically responsible and align with our Vision, Mission, and Values. 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.**

TBRHSC PATHOLOGY AND LABORATORY MEDICINE ANNUAL REPORT 2017

Again , the year closed with the pathology department facing significant manpower challenges. After achieving funding for an eighth pathology positon in 2016, and successful recruitment of a seventh pathologist the outlook seemed favourable, however it was short-lived as what followed were resignations of two pathologists, Dr. Ding in June and Dr. Amer in July. In addition, Dr. Kidanewold has submitted his resignation and will relocate by April 2017. Dr. Escott has given notice of his intention to leave his half-time status in April 2017. Recruitment has had some success, as Dr. Siddiqui will join the department in February. This will increase manpower to five pathologists. Dr. Nasser has accepted an offer of employment as well, and he will join us as a foreign graduate (US trained) pending successful navigation through the immigration process. At present the pathology department is entirely locum dependant and struggling to meet the needs of our physicians and patients. Recruitment efforts continue, with special attention placed on the recruitment of at least one other pathologist that has training in the clinical labs (General Pathology), as presently only one of the department's pathologists is trained to function in the day to day duties, or in an advisory capacity in the microbiology, biochemistry and hematology laboratories, or the transfusion medicine service.

Capital equipment installations include

- Installation of new automated analyser in Transfusion Medicine
- RFP currently in action for replacement of the Flow Cytometry analyser

Additions in human capital and departmental resource development include

- Approval for Charge Technologist in Flow Cytometry (in progress)
- Approval for third (board certified) Pathology Assistant (in progress)
- Training of existing Pathology Assistant for board certification (in progress)
- Implementation of Charge technologist in Cytopathology Department

These important additions will significantly positively impact the pathology department's duties and responsibilities and enhance quality and quality assurance. The addition of Pathology Assistants with a broader scope of duties will favourably impact pathologist manpower, allowing for more dedicated attention to microscopy and enhanced delivery of patient results.

Pathology Quality assurance initiatives/performance indicators are ongoing. Quality assurance activities and statistics include:

- Prospective case reviews on all malignant cases
- Random retrospective reviews
- External reviews of complex/controversial cases
- Cyopathology diagnostic rates
- Corrected report rates
- CCO synoptic reporting completion/compliance rates
- Rigorous external quality assurance proficiency testing exercises in the clinical labs (microbiology, hematology, biochemistry and transfusion medicine), cytopathology, hematopathology, and histology

Dr. Meagan Kennedy continues as Cancer Care Ontario Pathology lead for our LHIN and is helping to navigate through the numerous tasks and benchmarks imposed upon the Pathology service by Cancer Care Ontario. With the decrease in staffing, some of these benchmarks, such as attendance of CCO multidisciplinary case conferences may not continue to show the improvement it had briefly enjoyed the previous year. Dr. Kennedy has agreed to act as Facility Lead for the Quality Management Partnership, the recently developed and not yet implemented program developed through the CPSO and CCO. This is an effort to standardize processes and quality improvement activities in pathology practice through the implementation of metrics, which is predicted to significantly impact individual and departmental productivity given the current manpower crisis.

DEPARTMENTAL COMMITTEE HIGHLIGHTS

Laboratory Quality and Utilization Committee

- Successful transitioning of laboratory testing of outpatients to non-hospital community based labs. This recent implementation is the culmination of a lengthy process and was one of the improvements identified by the Hospitals Third Party Review of 2016. It is currently being fine-tuned to accommodate appropriate special interests
- Discontinued processing of outpatient pathology (restricted to TBRHSC and Regional Hospital patients (recommendation of Third Party Revue)
- Ongoing adoption and rationalization of laboratory tests. Current plans are to adopt the implementation of in-house methotrexate level testing for hematologic oncology patients, and urine ethyl glucuronide testing for the Adult Mental Health program (pending infrastructure/technologist manpower approval).
- Examination of serum Vitamin D assays, frequency and rationale as Choose Wisely Canada initiative

Transfusion Medicine Committee

- Successful implementation of the laboratory's Blood Shortages Contingency Plan into a "Hospital" Blood Shortages Contingency Plan
- Ongoing monitoring of the blood supply and utilization, balancing patient need with safe and responsible transfusion practices
- Monitoring frequency and types of transfusion reactions
- Continue the cooperative and advisory working relationship with the Ontario Regional Blood Coordination Network, and Canadian Blood Services
- Ongoing maintenance of a blood shortages "triage team" to manage local or national blood product shortages and how they impact patient demand
- Adoption as a Choose Wisely Canada initiative, the optimal utilization of packed RBC transfusion by rationalizing requests and delivery (ongoing)

Point of Care Committee

- New Activated Clotting Time analyser for the EVAR program

- New Blood Gas analyser in ICU
- RFP for to update existing glucometers at TBRHSC and the region
- New glucometer POC data management system upgrade for region, with capacity to interface various platforms into meditech

Goals and objectives for 2017

- Look forward to the arrival of two new pathologist recruits, and the recruitment of two additional pathologists to fully staff the department
- Attain enhanced supervisory capacity in the Clinical Labs through new hires (pathologists) or consultative services
- Continued monitoring of workload and case complexity and volumes to reassert ongoing and future departmental needs, including the implementation of a pathology workload unit capturing system
- Continued utilization of locum assistance and expert consultation
- Begin search for applicants for the new pathology assistant position
- Fully implement a technologically advanced Flow Cytometry analyser
- Continued involvement to ensure readiness of the laboratory's role in the coming Cardiovascular Surgery program, with attention to mirroring the UHN example in process, and equipment (point of care analysers)
- Continued effort to elevate the capacity of the pathology department to function and serve at the level commensurate with what is expected for a tertiary care and medical school affiliated centre
- Ongoing effort to update laboratory infrastructure and technology via replacement of failing and outdated equipment, including slide stainers, microtomes, immunohistochemistry stainers, biologic safety cabinets, and efforts to obtain and implement a patient tracking/barcoding system for pathology specimens

Respectfully submitted,

D. Welbourne