To: St. Joseph's Board of Directors
From: Dr. Gillian Kernaghan, President and CEO
Date: March 16, 2016

On March 18, I had the great pleasure of taking part in our St. Joseph's Day celebrations and the Sisters of St. Joseph Awards for Excellence ceremony. Both events are cherished and meaningful annual traditions for our organization.

For St. Joseph's Day, otherwise known as The Feast of St. Joseph, pastries, fruit and refreshments were served at all sites from 8:00 to 10:00 am in deep appreciation for staff, physicians and volunteers and the difference they make in the lives of those we serve. The day commemorates the life of St. Joseph, who is patron to many occupations and organizations, including the Catholic Church, the Sisters of St. Joseph and many St. Joseph's health care organizations around the world. It's most fitting that gratitude marks the celebration of St Joseph's Day. All staff, physicians and volunteers were invited to attend the site celebrations, where they were greeted by members of the Senior Leadership Team. I took part in the festivities at the Southwest Centre for Forensic Mental Health Care.

In the afternoon, to coincide with St. Joseph's Day, the Sisters of St. Joseph Awards of Excellence ceremony honoured this year's recipients, who are listed in this report. I was joined by Phil Griffin, who brought remarks on behalf of the Board, and Sister Jacqueline Janisse representing the Sisters of St. Joseph. The ceremony, which has been referred to by past recipients as the "Oscars" of St. Joseph's, was, as always, a touching event. Particularly poignant was a performance by our own Western Counties Wing veterans, ages 89 to 98, who came together and practiced specifically for this event.

Also this month, I have enjoyed teaching Crucial Conversations to Board and Board committee members. It is a small way we can give back to volunteers who gift us with their time.

As always, if you have suggestions to improve the context or format of this report, I welcome your input. Should you have questions regarding any items in this report, please ask questions during my verbal report at the meeting or email me directly at gillian.kernaghan@sjhc.london.on.ca.

Our Patients

MRI and CT wait times on the decline
A quality improvement project focused on reducing wait times for semi urgent (priority 3) CT scans is showing tremendous results. The goal was to improve the percent completed within 10 days (the Ministry of Health target) from 34 per cent to 45 per cent. For Q3, 73 per cent was completed within the target, far surpassing the goal.

As a result of improved priority 3 wait times, non-urgent (priority 4) CT wait times have also decreased significantly – from 97 to 80 days for the 90th percentile for October, November December 2015. (The provincial 90th percentile average is 48 days for priority 4, and the Ministry of Health target is 28 days).

The quality improvement project involved a demand analysis to review volumes and access for CT priority 3 cases, and a realignment of resources.

Work to reduce MRI wait times is also showing excellent results – decreasing for non-urgent (priority 4) cases from 115 to 72 days for the 90th percentile for October, November December 2015, which is far below the provincial 90th percentile average of 101 days but still above the Ministry of Health target of 28 days. (Our MRI priority 3 cases are at 49 per cent, which exceeds our target of 33 per cent completed within 10 days.)

To improve MRI wait times, services were realigned to support access for in-house programs/physicians first. This required a total rebuild of the MRI schedule. As well, physicians who are not part of the St. Joseph's family were told how long their patients would have to wait for their test and it was recommended they refer the patient to another site. This has deferred about 75 per cent of the current work away from St. Joseph's – a significant benefit since the consumption of MRI services by in-house programs has grown from 17 per cent to more 50 per cent over the past two years.

In other good news, a joint submission to the Ministry of Health from St. Joseph's and London Health Sciences Centre (LHSC) was successful. Wait time funding for both MRI and CT has moved from being an annual allocation to being an addition to our base funding allocation. While all the same rules apply in accounting for how the resources are used, we no longer have to wait each year to find out how much funding we will be receiving. The amount received in 2015- 2016 will now be received annually.

LHSC has also done much work to internally address the CT and MRI wait time issue. Together, both organizations have a truly collaborative model to address semi-urgent and non-urgent cases in an integrative manner, particularly for cancer patients

Rediscovering My S.E.L.F
A new therapy group titled Rediscovering My S.E.L.F (Social Life, Expression. Leisure, Food) has been created for patients of the Operational Stress Injury Clinic (OSIC) at Parkwood Institute. The group, which began February 26, 2016, with 16 participants, is facilitated by a dietitian, therapeutic recreation, music therapy and Veterans Arts staff from the Veterans Care Program, along with nurses and psychologists from the OSIC. The group will run weekly until May 20, 2016. It's the first group of its kind within the national operational stress injury support network. Evaluations have been developed to assess outcomes and effectiveness with plans to share the results nationally.

Competing for chili honours
Therapeutic recreation staff at the Southwest Centre for Forensic Mental Health Care held their 8th Annual Chili Cook Off. Each unit decided on a recipe and therapeutic recreation staff and patients planned and prepared their batch of chili. This event was attended by 28 patients and 51 staff. All were asked to taste and vote on the best tasting chili. The "Golden Spoons Award" was won by the Assessment Unit A3.

Curing C.difficile with fecal transplants
Infectious disease specialist Dr. Michael Silverman is looking for healthy stool donors (particularly staff for the sake of convenience) for fecal transplants, a highly successful treatment for C. difficile. Medical Director of St. Joseph's Infectious Diseases Care Program, Dr. Silverman is a Canadian pioneer in fecal transplants to treat C. difficile and the only physician in Southwestern Ontario offering the break-through treatment, which has a 91 per cent cure rate.

C. difficile – or Clostridium difficile – causes severe watery diarrhea, abdominal pain, loss of appetite, nausea and fever, and can lead to severe colitis (inflammation of the large bowel) resulting in the need for colon removal or even death. Most cases of C. difficile occur in individuals who are taking antibiotics and some acquire it while hospitalized. Antibiotics can destroy the normal bacteria found in the gut, causing C. difficile bacteria to grow. When this occurs, the C. difficile bacteria produce toxins, which can damage the bowel and cause diarrhea and the other complications. Treating the C.difficile with antibiotics kills even more of the helpful normal gut bacteria. When these antibiotics are stopped, the C.difficile returns. This can happen repeatedly, making C. difficile a challenge to treat.

For people with C.difficile, a fecal transplant replaces the normal healthy gut bacteria. The problem, however, is a lack of donors, partly due to the unsavoury topic. Potential donors also have to meet certain criteria and pass a screening test stipulated by Health Canada.

In the search for donors, a story appears in the latest issue of Imprint.

Our People

Protecting patient privacy and our information technology resources
A new Authorized Technology (AT) Standard has been developed at St. Joseph's and London Health Sciences Centre (LHSC) to ensure unauthorized hardware or software is not added or downloaded. It also ensures third party services are not introduced or implemented on our network.

Effective March 14 all new information technology resource requests, regardless of potential use or funding source, (e.g. operating, capital, research) must be reviewed through a process managed by Information Technology Services (ITS) before purchasing or downloading, which will enable us to enforce a higher degree of cyber security for our hospital network.

This new standard is applicable to all staff, physicians, students, volunteers and associates in every area of both St. Joseph's and LHSC. It applies to all hospital network system devices such as computers, laptops, patient care systems, printers, USB drives, tablets, smart phones etc.

In addition, ITS must be engaged before changing, moving or decommissioning any existing IT resources.

All existing information technology resources not previously approved through ITS must be inventoried and managed. Information technology resources that do not meet the standards or that have not received approval through the AT process will be removed from the hospital network.

The new standard will help reinforce our commitment to protecting patient's privacy and ensure our systems are available to provide patient care 24/7.

Engaging and creative education
At the Southwest Centre for Forensic Mental Health Care, engaging and creative education initiatives are helping staff further their knowledge, practice skills and foster a culture of inquiry and clinical excellence:

- A series of "Lunch & Learns" has been developed. In the first session, Dr. Brian Daly, Southwest Centre's Assessment Unit psychiatrist, facilitated a discussion on fitness to stand trial and criminal responsibility. The series is an opportunity for new staff to further their knowledge of forensic-specific assessment and offers a refresher for existing staff. The goal of the lunch and learn series is to support and encourage self-directed learning.
- Mental Status Exam (MSE) "cue" cards that can be attached to staff lanyards/ID badges, for quick reference to the components of the MSE have been created. The goal is to standardize the MSE assessment and ensure knowledge of the components required for assessment and documentation. In providing feedback, staff have said they find the resource very useful in their practice as they learn both the assessment process and required documentation.
- A 'Jeopardy' game was created to review the diagnostic criteria (symptoms), screening, and treatment required for individuals with depression, delirium, and dementia – the "3-Ds". The Registered Nurses' Association of Ontario Best Practice Guidelines were incorporated and highlighted during this review in order to enhance assessment and treatment for the 3-Ds.

Our Finances

Provincial budget – hospital funding increase announced
On February 25, 2016 Ontario's Minister of Finance released the 2016 Ontario Budget, announcing an increase of $345 million in 2016-2017 for Ontario's hospitals. The Ontario Hospital Association (OHA) welcomed the budget announcement, which follows a call for a funding increase in the OHA's pre-budget submission.

In the budget, Finance Minister Charles Sousa acknowledged that "Ontario hospitals have demonstrated leadership in their efforts to help transform the province's health system... They have maintained and increased services over the past four years in the absence of an increase to base operating costs."

Among highlights of the budget for hospitals are:

- All Health System Funding Reform (HSFR) hospitals will receive a one per cent increase (to be confirmed) to the global base portion of their funding in 2016-2017, and a further one percent increase to the Health Based Allocation Model (HBAM) funding envelope (approximately $50 million).
- Small, rural and northern hospitals (not included in HSFR) will also receive a one percent increase in funding, which represents $7.5 million.

- A targeted investment of $50 million will also be made to fund additional Quality Based Procedure (QBP) volumes. This funding will be invested in both hospitals and Cancer Care Ontario.
- $175 million will be invested in provincial programs, specialty hospitals for children and mental health and Post-Construction Operating Plans (PCOPs), and to address access and wait times.
- The Hospital Infrastructure Renewal Fund (HIRF) will grow by $50 million, from $125 million to $175 million.
- An additional $130 million will be invested in cancer care services over the next three years, allowing for the delivery of more services and preventive programs.
- An additional $10 million annually will be invested in Behavioural Supports Ontario to help long-term care home residents with dementia and other complex behaviours and neurological conditions.

Site-specific allocations are still to be determined and will be communicated in the coming weeks.

Clinical, Education and Research Excellence

New Lawson website launched
Lawson Health Research Institute has launched its redeveloped public website. As Lawson's most widely accessible communication vehicle, the new public website is an important platform to highlight the work of Lawson and why it's important. The website also reflects the strong collaboration between Lawson and its hospital, industry, academic and other partners.

Visit Lawson's website at www.lawsonresearch.ca and provide your thoughts about the site by completing a short survey.

Academic Health Sciences Network National Symposium 2016
On February 25, 2016 members of HealthCareCAN (HCC), the Association of Faculties of Medicine of Canada and colleagues across the sector met for the fifth annual Academic Health Sciences Network (AHSN)/HCC Symposium.

The focus of the national symposium was "Crucial Conversations with the Champions of Change", designed to engage participants in a discussion on the future of academic health sciences in this country and to advance a policy and funding framework for AHSNs into the future. As part of the symposium, Dr. David Hill, Scientific Director, Lawson Health Research Institute, chaired a sold-out session with Dr. Alain Beaudet, President, Canadian Institutes of Health Research; Dr. Gilles Patry, President and CEO, Canada Foundation for Innovation; and Marc Lepage, President and CEO, Genome Canada. Each was asked to provide a brief overview of the expectations of their granting councils from the new Liberal Government, specifically their views on how they will balance research with innovation and the issue of how to support early career investigators. A 'call to action' followed their presentations.

Capturing, and learning from, the patient voice
'Assess and restore' (A&R) is an approach to care for seniors and other people who have experienced a reversible loss of their functional ability and who are at risk of losing their independence. The goal is to extend functional independence of frail seniors and others.

The A&R Guideline (2014) was developed by the Ministry of Health and Long-Term Care in collaboration with the LHINs, health service providers and clinical experts from across the province. The guideline outlines expectations and defines the roles and responsibilities of LHINs, health service providers and care providers in delivering A&R interventions across five areas: screening, assessment, navigation and placement, care delivery and transitions home.

Currently, Specialized Geriatric Services at St. Joseph's Parkwood Institute is the lead in initiating/piloting these guidelines across the South West LHIN.

As part of the A&R project there is a commitment to understand and improve the patient experience by capturing the patient voice. At Parkwood Institute, this is being done by conducting and videotaping semi structured interviews with patients. The interviews will be used to guide future quality improvement initiatives and improve health care delivery. Five patient videos have been completed with one more pending. Next steps are to review the videos and explore themes. The plan is to create a short, final video incorporating the key findings of each interview. This will be used as a teaching tool as a means of capturing, understanding, improving and measuring quality of care provided.

Improving access to diabetes education to reduce severe hypoglycemia
St. Joseph's endocrinologist Dr. Tamara Spaic is working with emergency physician Dr. Mike Peddle to reduce the frequency of calls to emergency medical services (EMS) due to severe hypoglycemia. The pair has received a grant from the Academic Medical Organization of Southwestern Ontario for their project "Assessment of a Strategy to Reduce Severe Hypoglycemia Needing Emergency Medical Services in Patients with Diabetes in London Middlesex County".

The project will review the outcomes of a direct referral from EMS to the Diabetes Education Centre (DEC) at St. Joseph's Hospital for patients with a severe hypoglycemic event who were treated by EMS. Up to one quarter of EMS calls for severe hypoglycemia are recurrent events. Providing diabetes education can lower the risk for these events, which can lead to serious adverse health outcomes and Emergency Department visits.

Programing has been developed in the DEC to support education specific for this patient population. The project is expected to begin July 1, 2016.

Fostering our Partnerships

Regional Stroke Project
As previously reported, in September 2013 the South West LHIN Hospital/CCAC Leadership Forum identified stroke, vision care/ophthalmology, and endoscopy as the first three areas of focus for clinical services planning to improve care in the South West LHIN. You have read reports on the Vision Care Project, which resulted in numerous recommendations, several of which are now being implemented. Work is now underway on the Regional Stroke Project.

The South West LHIN, in partnership with the Southwestern Ontario Stroke Network and other stakeholders, is developing and implementing initiatives to improve care for transient ischemic attack (TIA – or mini stroke) and stroke survivors. The project has two phases:

- Phase 1: Realigning stroke inpatient acute care and stroke rehabilitation from 28 hospitals to seven designated stroke centres by spring 2017, as follows:

- acute stroke care will be provided at London Health Sciences Centre (University Hospital)
- acute and rehabilitative stroke care will be provided at Huron Perth Healthcare Alliance (Stratford General Hospital), Grey Bruce Health Services (Owen Sound Hospital), and St. Thomas Elgin General Hospital.
- telestroke care will be provided at Alexandra Marine and General Hospital (Goderich).
- rehabilitative care will be provided at St. Joseph's (Parkwood Institute) and Woodstock General Hospital.

- Phase 2: Assessing current state and developing recommendations for best practices for post-hospital rehabilitation and secondary stroke prevention care for TIA and stroke survivors by spring 2017.

Representatives from Parkwood Institute are playing an integral role in Phase 2 by contributing their expertise to the future state of rehabilitative stroke care in our region while continuing to provide best practice care through inpatient and outpatient programs, as well as through the Community Stroke Rehabilitation Teams.

Some of the stroke initiatives underway at Parkwood Institute to further improve care include streamlining patient referrals and transfers, developing ways to meet length of stay targets, and increasing stroke therapy frequency and intensity to three hours a day, seven days a week.

Mayor's Poverty Panel
St. Joseph's hosted a consultation session in February 2016 at the Parkwood Institute Mental Health Care Building for the Mayor's Poverty Panel – a City of London initiative. Objectives of the six-member panel include mapping current methods to address poverty in London, engaging stakeholders and people with lived experience, and identifying gaps in the city's current poverty-reduction tools. The overall goal is to develop a set of recommendations on how to address poverty more effectively in London.

About 12 individuals attended the Parkwood Institute consultation session, including representatives from our Family Advisory Council and Patient Council, as well as frontline mental health care staff, including members of the ACT teams.

The panel sent two members to attend, facilitate the discussion and compile the group's feedback. Many concerns were recorded including the need for improved supportive housing, transportation, advocacy, and social determinants of health. By all accounts, it was an extremely positive, meaningful session that generated much feedback for the panel.

Sharing our knowledge
On February 4, 2016, Penny Welch-West, a speech language pathologist at Parkwood Institute's Main Building, presented to a large group of speech language pathologists within the Thames Valley District School Board (TVDSB) on the topic of concussion, specifically return-to-school interventions. The session was well received. The organizer within the TVDSB continues to field questions and provide educational materials to the interested participants.

Improving communication to family physicians
On February 17, 2016, a presentation was made at the citywide Department of Family Medicine Retreat by Brenda O'Reilly-Brunelle, Integrated Director of Health Information Management (HIM) for St. Joseph's and London Health Sciences Centre. The presentation was on providing discharge summaries to primary care providers and the work HIM is doing on improving

physician documentation to provide more valuable information in the discharge summary. During panel and focus group discussions at the retreat, the physicians provided feedback and suggestions on how HIM can better meet the needs of primary care providers.

Recognitions and Celebrations

Sisters of St. Joseph Awards – 2016 recipients
Congratulations go to this year's recipients of the Sisters of St. Joseph Awards for Excellence. To be nominated and to be a recipient is a distinguished honour. The awards recognize an individual or a team for their excellence, positive attitude, reliability, honesty, efficiency, creativity, respect, caring, compassion, empathy and appreciation for the work of others. All were nominated by their colleagues. Without knowing anyone's identity, an awards selection committee comprised of representatives from across St. Joseph's sites, rates the nominations and selects the recipients. The 2016 recipients are:

- Sharon Molnar, pharmacist, St. Joseph's Hospital
- Izabela Irving, registered nurse, Veterans Care Program, Parkwood Institute
- Chris Fraser, registered dietitian, Regional, Spinal Cord Injury and Acquired Brain Injury rehabilitation programs, Parkwood Institute
- Cathy Slaa, Coordinator, Treasury and Capital, St. Joseph's Hospital

Each year, the ceremony for these prestigious awards coincides with St. Joseph's Day on March 19. Since the day fell on a Saturday, this year's celebration was held on March 18 at Parkwood Institute's Main Building Auditorium.

Award winning research
St. Joseph's chaplain Stephen Yeo was awarded the Award of Excellence in Research – Group Research, by the Canadian Association for Spiritual Care Research Committee for his project on the use of the labyrinth for patients at the Southwest Centre for Forensic Mental Health Care.

A labyrinth is a solitary path that winds its way toward a centre of destination and then follows the same pathway to exit. Used as a therapeutic tool to reduce stress and support reflection with patients, the labyrinth allows individuals to explore personal wellness in a sacred setting. Participants walk silently to engage their spirituality, meditate, or quiet their mind.

Research findings from Stephen's Walking the Labyrinth study, conducted in collaboration with occupational therapists Dr. Clark Heard and Jared Scott, indicate the program markedly impacts participants and supports feelings of spiritual connectedness, relaxation, peace, success, escape and meaning making

Indoor and outdoor labyrinths were incorporated into the designs of both Parkwood Institute's Mental Health Care Building and the Southwest Centre and are easily accessible to patients, families, staff and volunteers.

Other

Federal physician-assisted death report released
On February 25, 2016, the federal Special Joint Committee on Assisted Dying released its final report, Medical Assistance in Dying: A Patient-Centred Approach. This committee, comprised of both members of parliament and senators, was convened to consult with stakeholders and to

make recommendations for the government to consider when developing a framework on physician-assisted dying. The 70-page report makes 21 recommendations. Among them are:

- That medical assistance in dying be available to individuals with terminal and non-terminal grievous and irremediable medical conditions that cause enduring suffering that is intolerable to the individual in the circumstances of his or her condition.
- That individuals not be excluded from eligibility for medical assistance in dying based on the fact that they have a psychiatric condition.
- That physical or psychological suffering that is enduring and intolerable to the person in the circumstances of his or her condition should be recognized as a criterion to access medical assistance in dying.
- That the capacity of a person requesting medical assistance in dying to provide informed consent should be assessed using existing medical practices, emphasizing the need to pay particular attention to vulnerabilities in end-of-life circumstances.
- That the federal government implement a two-stage legislative process, with the first stage applying immediately to competent adults 18 years or older, to be followed by a second stage applying to competent mature minors, coming into force at a date no later than three years after the first stage. It is also recommended that the federal government immediately commit to facilitating a study of the moral, medical and legal issues surrounding the concept of "mature minor" and appropriate competence standards that could be properly considered and applied to those under the age of 18.
- That the permission to use advance requests for medical assistance in dying be allowed any time after one is diagnosed with a condition that is reasonably likely to cause loss of competence or after a diagnosis of a grievous or irremediable condition but before the suffering becomes intolerable. An advance request may not, however, be made, prior to being diagnosed with such a condition.
- That the federal government establishes a process that respects a health care practitioner's freedom of conscience while at the same time respecting the needs of a patient who seeks medical assistance in dying. At a minimum, the objecting practitioner must provide an effective referral for the patient.
- That the federal government ensures all publicly funded health care institutions provide medical assistance in dying.

Province passes legislation to stop sexual violence and harassment

On March 8, 2016, Ontario passed the *Sexual Violence and Harassment Action Plan Act (Bill 132).* The legislation is designed to make workplaces, campuses and communities safer and more responsive to the needs of survivors and to complaints about sexual violence and harassment. The legislation is one of the 13 commitments within *It's Never Okay*, the government's action plan to stop sexual violence and harassment. The Ontario Hospital Association has prepared a backgrounder on Bill 132.

Proposed measures to enhance accessibility

On February 25, 2016, the 2016 Ontario Budget was released, including budget implementation legislation in Bill 173, *Jobs for Today and Tomorrow Act (Budget Measures), 2016*. Specifically, Bill 173 proposes amendments that support The Path to 2025: Ontario's Accessibility Action Plan and are intended to make it easier for people with disabilities to participate in their workplaces and communities. The bill proposes amendments to 11 statutes, targeting areas that represent barriers to accessibility, including the *Accessibility for Ontarians with Disabilities Act*; the *Freedom of Information and Protection of Privacy Act*; the *Public Hospitals Act*; and the *Substitute Decisions Act*.

The Ontario Hospital Association has developed a backgrounder summarizing the relevant changes proposed in the legislation.

Funding restored for refugee health care
On February 18, 2016, the Canadian government announced it will be providing full health care coverage through a restored Interim Federal Health Program to all refugees and asylum claimants.

Starting April 1, 2016, the Interim Federal Health Program will provide health care coverage for all eligible beneficiaries, including basic, supplemental, and prescription drug coverage. Similar to provincial/territorial health care insurance, the coverage will include hospital and physician services. By April 1, 2017, the Interim Federal Health Program will expand to cover certain services for refugees who have been identified for resettlement before they come to Canada.

Environmental Scan

Domestic sex assaults spike in London
Reports of domestic related sexual assaults in London were at a five-year peak in 2015, nearly doubling from the year before, according to London police 2015 crime statistics released February 25, 2016.

Throughout the year, police responded to 57 reports of domestic-related sexual assault, more than the five-year average of 40 for such reports.

“The domestic violence stats go up every year,” said Kate Wiggins of Women’s Community House shelter for women. “It’s continuing to get increasingly stressful, the economy’s in the toilet and there is much more sensitivity to issues that affect women.”

The London Abused Women’s Centre has seen a “huge increase” in the number of women who report being sexually assaulted by their partners, said executive director Megan Walker. “Police are asking better questions when they go out,” she said. “We’ve found when you ask questions about it, women are more likely to respond than just volunteer the information themselves.”

London Free Press, February 25, 2016

Nearly 40 per cent of long term care residents on antipsychotic medication
Despite the known health risks of antipsychotics, 39 per cent of residents in long-term care (LTC) facilities were prescribed an antipsychotic at least once in 2014. This is the finding of a new report released by the Canadian Institute for Health Information (CIHI) – Use of Antipsychotics Among Seniors Living in Long-Term Care Facilities, 2014 – that looks at the overall use of these drugs, including cases where use may be appropriate.

Antipsychotics are often prescribed to seniors to treat symptoms of dementia, such as aggression and agitation, as well as schizophrenia and other psychoses, but they can have harmful side effects.

The study also found that antipsychotic use was highest among residents with severe cognitive impairment and those exhibiting highly aggressive behaviour. However, the rate of use among seniors exhibiting highly aggressive behaviours (51.3 per cent) suggests that even in the most

severe cases, where residents or caregivers may be at risk of harm, non-drug treatment options are being considered.

Risperidone, which has a very narrow approved use for the treatment of symptoms of dementia in seniors, is the second most commonly prescribed drug for this purpose (14 per cent). Quetiapine, which is not approved to treat symptoms of dementia in Canada, is the most commonly used antipsychotic, used by 19 per cent of residents.

The use of antipsychotics with other psychotropic drugs increases the risk of side effects, including falls. Among 22 per cent of residents regularly taking antipsychotics, nearly two-thirds (64 per cent) were taking a regular antidepressant, and approximately 1 in 6 residents were also regularly taking a benzodiazepine, which can increase the risk of side effects.

Canadian Institute for Health Information, February 25, 2016

Catholic health agency's position on assisted dying reveals fault lines in B.C.
A Catholic-run health authority in British Columbia that runs major hospitals in the province, including the flagship St. Paul's Hospital in downtown Vancouver, has sent a memo to staff saying doctor-assisted death is not permitted in its institutions, even as a new parliamentary report says the service should be widely available across the country.

Although B.C. Health Minister Terry Lake says the province can accommodate both a pending new law on physician-assisted dying and the boundaries set by Providence Health Care, others say something has to give, underscoring fault lines sure to show up elsewhere across the country as governments and health care providers grapple with the realities of helping people die.

"We think the government should say to St. Paul's, 'You've got to fall in line,'" Josh Paterson, executive director of the B.C. Civil Liberties Association, said on February 25, 2016, after the parliamentary report was released. "With respect, we don't think you can have it both ways. We don't think those kinds of institutions, whether it is Providence [Health Care], whether it is St. Joseph's Hospital in Toronto, whether it is St. Mary's in Kitchener-Waterloo … they cannot hold themselves apart from having to respect patients' rights on this."

However, Lake suggested that patients who seek doctor-assisted deaths could be accommodated by other, non-Providence Health Care facilities, and that the province has to balance patients' rights with those of health care professionals who have conscientious objections.

Élisabeth Bruyère Hospital in Ottawa has also told staff it will not offer the practice or refer patients to doctors who do when physician-assisted suicide becomes legal. Bruyère president and CEO Daniel Levac said in a memo the organization is "obligated" to stand behind its sponsor, the Catholic Health Sponsors of Ontario.

Globe and Mail, February 25, 2016

Ontario's doctors call on government to implement a province-wide dementia strategy
In a report released February 29, 2016, Ontario's doctors outlined seven key recommendations that must be addressed in a province-wide dementia strategy to improve care, coordination, and the ability of the health care system to meet the needs of both patients and caregivers.

According to the report, Ontario Physicians Supporting Patients with Dementia – A Call for an Ontario Dementia Strategy, the risk for the condition doubles every five years after age 65 and by 2020 approximately 250,000 seniors in Ontario will be living with dementia, putting considerable pressure on the Ontario health care system in the coming years. Yet there is no coordinated approach to ensure that patients and caregivers have access to medical care, allied health professionals, self-care resources, community supports and long-term care equally across the province.

In addition, doctors see first-hand the overwhelming strain of caring for someone with dementia and the physical and/or mental illness experienced by many caregivers who are often elderly husbands, wives, or family members, the report finds. As many as 25 per cent of caregivers have two or more chronic health conditions of their own.

Ontario doctors are putting forward seven recommendations that should be part of an Ontario dementia strategy including:

- Educating the public about dementia, its symptoms, and benefits of early diagnosis.
- Facilitating the creation of system approaches that support access to timely medical and supportive care for dementia patients.
- Addressing access to community, respite care and home support services to provide relief for informal caregivers.
- Providing for specialized long-term care services that are designed to care for patients with dementia.

Ontario Medical Association, February 29, 2016

De-prescribing medications for seniors a safety priority
Health care workers, patient groups and governments are striving to cut inappropriate prescriptions for seniors by 50 per cent by 2020. The Canadian Deprescribing Network focuses on discontinuing or tapering off three classes of medications: sedative hypnotics known as benzodiazepines; proton pump inhibitors; and some long-acting oral diabetes drugs.

The 50 per cent target is an ambitious one that reflects the degree of over-prescription for these three medication classes, said Dr. James Silvius, a geriatrician at Rockyview General Hospital in Calgary and principal investigator with the Canadian Deprescribing Network.

Silvius said sedative hypnotics have been prescribed for years to older individuals who see their doctor complaining of not getting enough sleep. "The problem is very rapidly people habituate to them and when they try to stop taking them, they don't sleep. They make the association in their mind that the sleeping pill is required to get sleep and it becomes a vicious cycle."

When benzodiazepines are taken for years, problems can arise because the drugs are associated with significant side-effects including risk of falls, daytime sleepiness and confusion.

CBC News, February 26, 2016

Catholic hospitals refuse to comply with new doctor-assisted dying law
In an interview on CBC Radio's "The Current", David Nash spoke as chair of the Catholic Health Association of Ontario (CHAO) about CAHO's position on physician assisted-death. He talked about organizational conscience, individual conscience, the Catholic health care position and the complexity of physician-assisted death. Also interviewed was a medical ethicist who argued

the position of Catholic institutions and any exemption by Catholic hospitals from physician-assisted death legislation. The podcast is available here.

CBC Radio, March 1, 2016

Providing doctor-assisted death option an obligation, claims expert
Hospitals that receive public funding have an obligation to offer legal health services, including doctor-assisted death, says a member of the provincial-territorial expert advisory group on physician-assisted dying.

Jocelyn Downie, a Dalhousie University law professor and expert on end-of-life law and policy, said provinces and territories should withhold funding from public institutions that refuse to offer legal health services on their premises, or a reasonable option for transfer.

"If you get public funding, you as an institution have an obligation to provide legal health services. I think we need to confront that," Downie said.

Her comments come as officials with Catholic health institutions in the province say they will not offer doctor-assisted death or directly or explicitly refer patients to receive the procedure elsewhere.

The issue of institutional objection on religious grounds – entire institutions that do not offer a service because it conflicts with their religious values – adds another layer to an already complex issue of how physician-assisted death will translate into practice in Canada. Although there is wide support for doctors to conscientiously object, groups that represent physicians are grappling with what exactly that means. The Ontario College of Physicians and Surgeons says in interim guidelines that doctors can't be compelled to offer assisted death, but if they decline, they must do so in a way that maintains the patient's dignity. And physicians, the college says, must refer patients to someone who will offer the service in a way that is effective.

Downie said the response of religious institutions to the Supreme Court of Canada ruling allowing doctor-assisted death is "entirely predictable and it is something that we just need to get worked out as a country – how do we balance these competing rights and interests?"

Ottawa Sun, March 1, 2016

Doctors urge Ottawa to provide more clarity on assisted dying law
Canada's doctors are pleading with the federal government to put specific guidelines in its medically-assisted dying law regarding patients who want to end their lives because of psychological suffering.

"There are still a lot of grey areas, and a lot of unknowns," said Jeff Blackmer, vice-president of medical ethics at the Canadian Medical Association. "Before we sort of open that Pandora's box, we need to have a lot more clarity as to what would qualify, and exactly what the process would be."

A recent parliamentary report intended to give the government guidance on how to write the new law, to be passed before June 6, said patients should be able to access medical aid in dying if they have a "grievous and irremediable" medical condition that causes enduring and intolerable suffering. The condition should not have to be terminal, and suffering can be physical

or psychological, the report said, and those with mental illness or other psychiatric conditions should not be excluded if they meet other criteria, such as consent.

Dr. Blackmer said doctors recognize that psychological suffering can be as painful as physical suffering. But he said he hopes the law will not leave the definition of it "open to interpretation," and will require the patients to see a psychiatrist or mental health team throughout the process. They also want detailed regulations for the provinces.

"We see patients all the time right now who come in [under] difficult circumstances, suffering psychologically, who want to harm themselves or kill themselves, and we help them through that," he said. "Now we're being asked to flip that on its head, and not only not help them through it, but actually actively help them to commit suicide. And that is an extremely daunting prospect for physicians."

Globe and Mail, March 1, 2016

Study to begin looking at eye scans to help homeless get health care
London researchers are launching a study that will look at eye scans to help homeless people get around the problem of lost identification. The project, directed by Cheryl Forchuk of Lawson Health Research Institute, aims to help those without a home deal with lack of ID, which makes it almost impossible to get health care.

"When you are homeless, you can't carry a wallet because it will get stolen. About one-third of homeless people don't have ID," said Forchuk, who presented her project at Queen's Park on March 2, 2016. "You can't access routine health services without a health card."

Forchuk, who heads a Lawson team trying to create a smart mental health system, said the ID issue was brought to researchers by homeless people. "It got me thinking, in 20 years, are we going to be accessing health care with a plastic card? In speaking with the people about alternate forms of ID, we heard that they didn't want fingerprints because it was too close to the justice system, and facial recognition might not work because people lose so much weight."

The iris scan project will begin later this month. First, researchers will ask those at the Salvation Army Centre of Hope whether they'd be comfortable having their irises – the coloured part of the eye – scanned as a form of ID.

Western engineering students have developed an algorithm that takes iris scans – which are unique to each person, much like fingerprints – and turns them into a number that becomes the person's unique ID number. The same number comes up every time the same eye is scanned.

"This is still very much in the preliminary stages," said Forchuk. "People might like it, they might not."

London Free Press, March 2, 2016

Assisted Death: A Survivor's Story
In this National Post article, Mark Jewitt, who had been diagnosed with HIV in 1988, recounts how, in 1995, he attempted to take his own life with the assistance of physician Maurice Généreux, who had prescribed a high-powered barbiturate notorious for its use in suicides. Instead, Jewitt survived, and made medical history when Généreux became the first doctor in Canada to be convicted for assisting suicide.

Jewitt, now 59, has not spoken publicly about the case in nearly two decades. But he agreed to an exclusive interview with the National Post because of his deep concerns as legislators race to craft a new federal assisted-death law. He worries that, as the country prepares for legalized assisted dying, any death wish might be granted. He knows those wishes can change.

Read the full article here.

National Post, March 3, 2016

Province strengthens end-of-life care with $75 million investment
As part of the 2016 Budget, Ontario is proposing to invest an additional $75 million over three years to provide patients with more options and access to palliative and end-of-life care. This investment would improve community-based hospice and palliative care services including:

- Supporting up to 20 new hospices across Ontario and increasing the funding for existing facilities
- Increasing supports for caregivers that will help families and loved ones support palliative patients at home and in the community
- Promoting advance care planning so that families and health care providers understand patients' wishes for end-of-life care
- Establishing the Ontario Palliative Care Network, a new body to advance patient-centred care and develop provincial standards to strengthen services.

The province is also partnering with Hospice Palliative Care Ontario to provide training and support to new hospice volunteers each year. A new online training system will give volunteers throughout Ontario better access to standardized training and tools, which will be especially beneficial for rural and remote communities.

Ontario is also releasing the Palliative and End-of-Life Care Provincial Roundtable Report, which compiles feedback from recent consultations led by John Fraser, parliamentary assistant to the Minister of Health and Long-Term Care. The consultations included 16 roundtables with more than 325 stakeholders across the province, including patients, families, doctors, nurses and health system leaders. The roundtable report will help Ontario develop a comprehensive strategy on palliative and end-of-life care, which will focus on supporting families and caregivers, and ensuring access to coordinated quality care where patients want it.

Ministry of Health and Long Term Care, March 11, 2016

Removing breasts to prevent cancer doing more harm than good, study says
Thousands of women are needlessly having their breasts removed to prevent cancer even though it may do more harm than good, a study suggests.

Every year around 4,000 women with breast cancer in Britain opt for a double mastectomy in the belief that it will prevent cancer appearing in the healthy breast. But a study by Brigham and Women’s Hospital in Boston, U.S., shows that the majority of women would never have developed cancer in the healthy tissue.

Unnecessary surgery leaves women open to complications, the researchers warn, as well as psychological problems, such as depression.

The U.S. researchers studied more than 500,000 breast cancer patients for eight and a half years to see whether the disease came back. They found that although there had been a rise in women opting for contralateral prophylactic mastectomy (CPM) — the surgical removal of a breast unaffected by cancer — there had been no change in survival rates.

Although the researchers say that breast removal may be beneficial for high-risk patients, such as those with a genetic mutation which increases the chance of breast cancer, the majority of women are at low risk of developing the disease in the unaffected breast.

National Post, March 12, 2016

Ruetz: Catholic health care responds to greatest needs
In this editorial, John Ruetz, President and CEO of Catholic Health Sponsors of Ontario, talks about physician-assisted death and what it will mean to Catholic hospitals.

"It has been suggested by some that the recent Supreme Court of Canada ruling on physician assisted death will force our 125 Catholic health care centres and our 68,000 employees and physicians across the country to abandon our commitment to provide compassionate, high quality care," he says. "Nothing could be further from the truth."

A patient requesting physician assisted death in a Catholic organization "will be met with respect, support, compassion and kindness," says Ruetz. "Being patient-centred means that we have a moral obligation to be engaged with the patient, and to provide factually relevant information to inform a patient's decisions. At all times, we will support the principle of patient choice, and will respect the person who is making that choice.

"This may require informing the person of other options for care and, if necessary, safely transferring care when the person's needs are best met at another location. This allows clinicians to meet their informed consent responsibilities, while remaining true to the position that we will not refer for the specific procedure of physician-assisted death.

Ottawa Sun, March 13, 2016

Study finds Ontarians ready for privatization in health care
In a landmark report released March 15, 2016, the Ontario Chamber of Commerce (OCC) has outlined an opportunity to bring real and meaningful change to Ontario's health care system. The report, Transformation through Value and Innovation: Revitalizing Health Care in Ontario, coincides with new survey data showing the province is ready for health care modernization and service delivery reform, including privatization.

According to a poll released within the report, 77 percent of Ontarians are concerned about the sustainability of their health care system, and 80 percent agree with the statement that "Ontario's health care system will need to undergo broad reform in order to meet the challenges of changing demographics".

The report marks the beginning of the OCC's year-long Health Transformation Initiative, which will convene expert stakeholders and industry leaders to develop a blueprint for the future of sustainable health care in Ontario – including an opportunity for a partnership with the private sector within the single-payer model.

“Canadians have a genuine fear of what they perceive as ‘American-style’ health care, but this ignores both the considerable share of health coverage already delivered by the private sector as well as the integral role of industry in other countries with a single-payer model, like the UK and Australia,” said Ilan O’Dette, president and CEO of the OCC. “When it comes to health care, we must work collaboratively across industry sectors and institutions in order to build a system that is sustainable for generations to come.”

Ontario Chamber of Commerce, March 15, 2016

St. Joseph’s in the News

Dozens of London hospital patients may have been exposed to tuberculosis, Tech Times, February 25, 2016

New therapy helping patients cycle to independence, Hospital News (page 20 in flip edition, March 2016

Lending a hand in exceptional education, Hospital News (page 23 in flip edition), March 2016

London to help settle 900 more Syrian refugees, London Free Press, February 25, 2016

Shoppers Home Health Care winding down wheelchair work to focus on other business, London Free Press, February 27, 2016

Former St. Thomas health care centre attracting urban explorers: OPP, AM980, February 29, 2016

Canadian researchers considering iris biometrics to help homeless get health care, Biometric Update.com, March 6, 2016

Decrying hospital cuts, CTV London, March 12, 2016

Briefing Note

To: St. Joseph's Board of Directors

From: Dr. Gillian Kernaghan, President & CEO

Date: March 21, 2016

Subject: President's Leadership in Mission Award name change

In honour of the memory of Kathy Burrill, former Vice President of Communication, Patient and Public Relations, and with the support of the Mission Committee, St. Joseph's will amend the name of the President's *Leadership in Mission* to be the *Kathy Burrill Leadership in Mission Award*. Kathy, who passed away in November 2015, dedicated 31 years to cultivating and nurturing partnerships and relationships. She was committed to advancing London's integrated hospital system, academic science network and Catholic health care in Ontario. Through her work with the Mission Committee, Kathy made remarkable contributions to St. Joseph's. Kathy helped to create recommendations of commitment from St. Joseph's to the Ministry of Health, ensured St. Joseph's shared stories of mission effectiveness and always reflected the chain of mission to honour the spirituality of the Sisters of St. Joseph. Given each year, the award celebrates extraordinary efforts to exemplify and advance St. Joseph's roles and values as a Catholic, academic and community-oriented health care provider.

Criteria for Selection - the following criteria are used to evaluate nominations:

Servant leadership

- Fosters healthy work and care environments for staff
- Develops, supports and engages in a team approach to leadership
- Empowers and supports human potential of colleagues
- Walks with people during challenging personal and organizational times of change

Mission driven

- Demonstrates a passion and commitment to the mission and values of the organization
- Participates in and leads activities related to deepening our mission awareness
- Demonstrates knowledge of the complexities of health care with unique moral, ethical and social expectations as a Catholic health care provider

Ethically driven

- Understands and applies values and principles to the business of health care – issues of management, finance, human resources and networking
- Creates an environment where ethical discernment is encouraged
- Assists in conflict management process when ethical issues arise

Inspires a shared vision

- Demonstrates importance of congruence of personal, program and organizational values and vision
- Inspires and motivates others to be committed to the organization's mission, vision and values
- Promotes right relationships and partnerships throughout the organization and community

Personal attributes

- Invites, listens and responds to the voices of colleagues
- Establishes mutually beneficial relationships with diverse groups of people
- Manifests personal presence characterized by honesty, integrity and caring
- Engages in life-long learning, self-reflection and development
- Models a leadership style that is collaborative, flexible and goal oriented