CARDIAC CARE PROGRAM

STRATEGIC PLAN

2016-20

APPENDIX

Final Draft

October 14, 2016

2016
## Appendix

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Item 1, Rouge Valley Strategy Map

Strategic Plan 2015-2018

Our Vision
Together—the best at what we do
We will work creatively together with patients and families to best meet their health needs. To achieve this, we will work with healthcare and community partners to deliver integrated services, challenging everyone to be their best.

Our Mission
To provide the best healthcare experience for patients and their families

Our Strategic Directions

Patient Experience
Innovators of a quality patient experience
As the provider of choice, we will consistently offer exceptional quality services that exceed the expectations of patients, families and our communities through innovative practices and technological solutions.
Across the country, Rouge Valley Health System will be known for innovation, collaboration and professional care.

Champions of a connected health system for patients
We will ensure that the patient's perspective drives a more unified journey of care—a true system that is easier for patients and families to navigate.
As a trusted partner, we will work with other hospitals and community providers toward development of a seamless system of care.

Workplace of choice
We will promote innovation, excellence and continuous improvement throughout Rouge Valley Health System by attracting and keeping talented healthcare practitioners and professionals, administrative and support staff and volunteers, who are focused on creating a positive patient and team experience.
We will be recognized by our team, partners and community for creating a healthy, safe, respectful and diverse workplace that supports continuous learning and development of our people.

Our Values
In all that we do, we will be guided by our Values
• Responsive, respectful and caring for our patients, colleagues and community
• Value the diversity of our organization and community
• Honest, trustworthy and accountable for our resources, our services and our behaviours
• Strive for innovation, high performance and commitment to continuous learning
Item 2, Cardiovascular Strategy Map, 2015-20

Organizational Level: Vision
Mission & Goals

Multi-Year Goals to Achieve our Vision and Mission

Enablers:
Project Management Planning Framework
Accountability Framework

Rouge Valley Health System Strategic Vision:
Together—The best at what we do

Cardiac Care Program Vision:
Leaders in Community Cardiac Care

Cardiovascular Care Program Mission:
To be the leader in community cardiovascular care by providing an integrated cardiovascular care system committed to continuous improvement, clear performance targets and clear lines of communication within the program and our community.

1. Enhance Programs and Services
2. Continually improve operational and program efficiencies
3. Develop and support health human resources
4. Renew capital and invest in integrated models
5. Measure and evaluate program performance

Supporting Infrastructure:
Information Management, Marketing, Education, Volunteer Support
Item 3, Operationalizing the Plan

<table>
<thead>
<tr>
<th>Step</th>
<th>What’s Done</th>
<th>To Be Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Strategic Plan</td>
<td>Strategic Planning Process is complete.</td>
<td>Review with stakeholders and finalize</td>
</tr>
<tr>
<td>2. Goals and Objectives</td>
<td>Goals and objectives for plan components</td>
<td>Review with stakeholders and finalize</td>
</tr>
<tr>
<td>3. Operational Plans</td>
<td>Draft example plan, includes.</td>
<td>Develop, implement and project management to execute annual operating plan</td>
</tr>
<tr>
<td>4. Measurement &amp; Reporting</td>
<td>Development of application started. Interim IMS developed</td>
<td>Implement-Present strategy to Data Management Committee.</td>
</tr>
</tbody>
</table>
Item 4, Cardiac Care Program Organization 2016

Item 5, Medical Directors by Service

<table>
<thead>
<tr>
<th>Service</th>
<th>Medical Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cardiac Clinical Care Services</td>
<td>Dr. Nisha D’Mello</td>
</tr>
<tr>
<td>2. Cardiac Imaging Services</td>
<td>Dr. Paul Galiwango</td>
</tr>
<tr>
<td>3. Catheterization Laboratory Service</td>
<td>Dr. Saleem Kassam</td>
</tr>
<tr>
<td>4. Arrhythmia Management Services</td>
<td>Dr. Amir Janmohamed</td>
</tr>
<tr>
<td>5. Cardiovascular Rehabilitation and Secondary Prevention Services</td>
<td>Dr. Joe Ricci</td>
</tr>
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</table>
## Item 7, Health Quality Ontario Quality Dimensions

<table>
<thead>
<tr>
<th>Accessible</th>
<th>Effective</th>
<th>Safe</th>
</tr>
</thead>
<tbody>
<tr>
<td>People should be able to receive the right care at the right time in the right setting by the right health care provider.</td>
<td>People should receive care that works and that is based on the best available scientific information.</td>
<td>People should not be harmed by an accident or mistakes when they receive care.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient-centred</th>
<th>Equitable</th>
<th>Efficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care providers should offer services in a way that is sensitive to an individual's needs and preferences.</td>
<td>People should receive the same quality of care regardless of who they are and where they live.</td>
<td>The health system should continually look for ways to reduce waste, including waste of supplies, equipment, time, ideas and information.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appropriately resourced</th>
<th>Integrated</th>
<th>Focused on population health</th>
</tr>
</thead>
<tbody>
<tr>
<td>The health system should have enough qualified providers, funding, information, equipment, supplies and facilities to look after people's health needs.</td>
<td>All parts of the health system should be organized, connected and work with one another to provide high-quality care.</td>
<td>The health system should work to prevent sickness and improve the health of the people of Ontario.</td>
</tr>
</tbody>
</table>
Item 8, Input from 2014-15 Planning Consultation

Clinical Services—Consolidated Comments from 2014-15 Consultation

Strengths

1. Service Delivery and access
   - Allocated beds for regional PCI and arrhythmia patients
   - Hired NP for Cardiology (NP model for care)
   - CODE STEMI program extraordinaire
   - Dedicated STEMI – regional bed
   - Regional Cardiac Rehab – enhanced to include all patients at risk.
   - High usage of tools (order sets, protocols, pathways)
   - CHF order set
   - Complex arrhythmia, regional pacemaker program
   - New and revised standardized evidence-based order sets.
   - Expanded CSSU area to improve bed flow
   - Direct consult via GIM clinic, cardio-resp.
   - Integrated patient care services through the continuum of care (i.e. ER to CCU and diagnostics) for cardiac patients
   - Steadily growing
   - Organization of EP clinic
   - Responsiveness to ER
   - Resource Utilization
   - Transparent Process – flow/ patient needs
   - Rapid cardiac clinic access
   - Cath lab accessibility
   - Priority program- increased funding
   - Relationship with Foundation- MD’s, staff, grateful patients
   - Program based model (5 divisions in organization)
   - Cross site Cardiac MD coverage

2. Technology and Innovation
   - Introduction of technologies to support best practices
     - Therapeutic hypothermia
Cardiovascular Strategic Plan 2016-20--APPENDIX

- Auto pulse
- OCT/IVUS/Echo/ICE
- Cardiac MRI and CT
- Dedicated pacemaker room, 3 new Philip cath labs, procedure room dedicated to EP with best practice and evidence.

- CVIS
- Plan to introduce and develop a cardiac-focused unit

3. Partnerships and Linkages
   - Integrated partnerships – community partners: EMS, RVHS, central east LHIN, etc.

4. Education
   - Cardiac education day for RNs and allied health
   - RPN’s and RN’s trained in CCI +
   - Provide education opportunities regularly
   - Skilled and knowledgeably
   - In house ACLS program
   - Committed/dedicated staff, admin and medicine to best practice for patient-focused care.
   - Education for staff- Internal and external (weekly rounds & annual)
   - Support to attend conferences (national and international)
   - Availability of CME opportunities
   - Partnership with CCAC RRN program

5. Staff engagement
   - Team engagement
   - Focused/ Driven/ Strong leadership and vision
   - Interfaculty respect
   - Physician involvement from other sites
   - Inter program collaboration
   - Multidisciplinary engagement

6. Measurement and evaluation
   - Tracking of quality metrics
Themes: Opportunities

1. **How do we enhance our single service model as RVHS?**
   - Patients at both sites should have equal access to cardiac services (i.e. no wait at RVC or RVA)
   - More fluidity in bed management for cardiac patients – designated cardiology ward
   - Increased clerical staff trained in SMART and aware of RVHS cardiac services.
   - Transfer of care and accountabilities info – i.e. all instruction to patients by cardiologists from RVC should be accompanied by documentation, same info to receiving MRP or ongoing follow up by cardiologist when/once moved to Ajax.
   - Improve access to cardiologists at RVAP (same day consult)
   - On call cardiology patient ratio should be decreased (understand process at both sites)
   - Standardize access to RVA clinic
   - Create a rapid assessment process for cardiac
   - Weekend RVAP coverage
   - 24/7 Cardiology consult at RVAP, like RVC

2. **What should a cardiac ward look like at RVHS?**
   - All-RN staff
   - Elevate competencies required, i.e. CCU 2 and ACLS training for all RNs
   - Infrastructure to support needs of patients, i.e. Centralized place for patients to eat-increased mobility and socialization, Patient education room, meeting room, activity room.
   - Patient education (in social areas) in different languages, free in-room Cardiac Information channel.
   - Inter-collaborative education sessions/ rounds (1-2 times a week)
   - Inter-professional led group sessions. E.g. Class session on lifestyle, Q & A, multilingual.
   - Cardiac Education calendar for staff
   - Flexible cardiac unit, cardiac ward, tele, step-down unit, CCU 4.
   - Increased educational to front-line staff to increase knowledge – importance on ambulation, nutrition, risk factors, lifestyle, etc.
   - NP-managed cardiac unit in collaboration with MD.
   - Care maps
   - Cardiac ward should allow for high acuity patients (patients who do not need CCU but more attention than a regular ward
   - Cardiac ward should offer enhanced nursing services and expertise (highly trained nurses)
• Step down unit on 2W (3:1 nurse ratio, have own NP or shared with ICU)
• Shared internist with ICU
• Nurse-Pt standard ratio
• Should offer strong allied health support (dietitians, PT, OT, PT and REC)
• Dedicated Cardiologist for ward
• Include CHF and all other related cardiac issues
• Dedicated nurses and allied health team
• Dedicated Cardiology NP at each site
• Each bed equipped for telemetry monitoring
• More comprehensive and timely consult and coverage at RVAP

3. How should CHF care work at RVHS? (Role of cardiac rehab, should we have a CHF clinic? And for whom?)

• Identifying high-risk through risk assessment tools- NYHA
• Differentiated levels of care
• System navigators
• Look at admission and readmission rates.
• CHF Services or Clinic – Refer more to GIM clinic for follow up
• Computerized referrals to rehab.
• Chronic disease management in out-patient med clinic for CHF, diabetes, CRF (all at risk for CHF)
• Cardiac rehab should enhance COPD support/education and often combined co-morbidity
• CHF clinics in outpatient medical areas (to reduce re-admission and cross site service)
• CHF clinic is a must and should support all levels (mild/med/severe and combined diagnosis...like COPD)
• Satellite cardiac rehab for more accessibility
• CHF clinic should explore linkages with new post-discharge phone call process for medicine/surgery
• Clear CHF algorithms

4. How do we better integrate inpatient care? (Internal medicine, regional cardiac care services)

• Building bridges with community GPs
• Marketing e.g. site visits by regional GPs
• Pre-printed discharge prescription order forms.
• Integration of seamless inpatient accessibility to services/consults.
• Cardiac consults prioritized.
• Sharing order sets, protocols, guidelines, care maps.
• A centralized patient info link – a phone number that patients can call if they’re confused or unsure of their care plan.
• Ensure care pathway for CHF is used
• Consider NP’s or hospitalists
• Improve physician handoffs
• Collaborate on cases (consult, advice on patients who do not require full cardiology coverage)
• Direct cardiology referral from ED
• Internal medicine
• Regional cardiac care services
• Separate CCU from ward MD coverage
• Improve cardiology presence at RVAP
• Automatic referral to cardiovascular rehab for heart failure patients

5. How do we measure our effectiveness as a regional service?
   • Use CVIS to fullest capacity.
   • Resources to support quality management: Data / performance analyst, quality project manager or coordinator
   • Standardize metrics across CELHIN:
     • Refer to CCS Data definitions (HF)
     • Patient satisfaction survey across the continuum
     • Readmission rates.
   • Identify standard metrics across CELHIN
   • CELHIN access to services (i.e. all hospitals)- Wait times
   • Complications
   • Increased interest in becoming a member of RVHS cardiac team
   • Increased interest in community of medical professionals accessing RVHS services and education events.
   • Cardiac Central east regional cardiac care program recognized in media for its innovation – promote in media.
   • Volumes of patients/referrals
   • Identifying and trend outcome measures
   • Measure access to interventions
   • Measure improvement in referrals
   • Access to cardiac consult wait times
   • Uptake of regional services
   • Patient compliance- update of available recommended medications
   • Engagement of regional partners
## Clinical Services Short-Term Action Plan

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<th>What (Opportunities) and How</th>
<th>WHO</th>
<th>WHEN</th>
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<tr>
<td><strong>1. Implementation of a designated Cardiac Ward</strong></td>
<td>Clinical Services Committee</td>
<td>12 Months (Dec. 2015)</td>
</tr>
<tr>
<td>a. Develop process to achieve patients have equal access to cardiac services (i.e. no wait at RVC or RVA)</td>
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<td>b. Develop mechanisms for Transfer of Accountabilities from MRP to MRP across sites</td>
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<tr>
<td>c. Provide an NP Model of Care</td>
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<tr>
<td>d. Designated cardiology Inter-professional staff mix</td>
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<tr>
<td>e. Develop staff competencies in cardiac care i.e. ACLS</td>
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<td>f. Develop patient education room</td>
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<td>g. Develop staff educational resources</td>
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<tr>
<td>h. Develop standardized algorithms based on best practices and guidelines for ACS care</td>
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<tr>
<td>(STEMI and NON-STEMI) across organization and CELHIN</td>
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<tr>
<td>(AFib) across organization and CELHIN</td>
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| **2. Implement CHF Clinic or management**                                                    | Dr. Sarah Ipekian & Glyn Boatswain and project team | 12 Months (Dec. 2015) |
| Incorporate clinic into rehab infrastructure                                                |                                                        |                          |
| a. System navigators                                                                       |                                                        |                          |
|   - Identifying high-risk through risk assessment tools - NYHA                            |                                                        |                          |
|   - Differentiated levels of care                                                          |                                                        |                          |
| b. Hire data management and evaluations specialist to monitor and evaluate services        |                                                        |                          |
| c. Explore automation of referrals to rehab. (in electronic format)                        |                                                        |                          |
| d. Add physician support                                                                  |                                                        |                          |

| **3. ACCESSIBILITY FOR RVAP SITE TO MIRROR RVC SITE**                                        | Cardiac Chief and Affiliates                         | 3 months                  |
| - Standardize crosstie                                                                      |                                                        |                           |
| - Access to cardiology same day (physician /NP)                                             |                                                        |                           |

| **4. SEAMLESS CARE FOR PATIENTS FROM ED VISIT TO CARDIAC F/U AND DIAGNOSTICS**               | ED/ Cardiology/ IT                                     | 6 months                  |
| (6 months)                                                                                 |                                                        |                           |
| - Access to records, labs, electronic management and access to patient records              |                                                        |                           |
- Rapid clear transfer of information while in emergency and their F/U plan

5. Physician Coverage  
   - Separate CCU, MD coverage from ward  
   - Coverage RVAP M-F 8-4

| Performance Measurement and Evaluation - How do we measure effectiveness? |
|---|---|---|
| 6. Measurement and Evaluation  
   e. Use CVIS to fullest capacity.  
   f. Resources to support quality management: Data / performance analyst, quality project manager or coordinator | Medical Director PBM  
Program Director CVIS Committee Quality Manager | 12-18 months (June 2015) |

Standardize metrics across CELHIN:  
   g. Refer to CCS Data definitions (HF)  
   h. Patient satisfaction survey across the continuum  
   i. Readmission rates.  
   j. Identify standard metrics across CELHIN  
   k. CELHIN access to services (i.e. all hospitals)- Wait times  
   l. Complications  
   m. Increased interest in becoming a member of RVHS cardiac team  
   n. Increased interest in community of medical professionals accessing RVHS services and education events.  
   o. Cardiac Central east regional cardiac care program recognized in media for its innovation – promote in media.

Strategic Alliance and Linkages

| 7. Integration  
   a. Engage and support community GPs  
   b. Explore seamless accessibility to services/consults.  
   c. Promotion and marketing through cardiac website  
   - Sharing current order sets, protocols, guidelines, care maps.  
   d. Standardization of care through Order sets and pathways | Medical Director  
Program Director | 12 months (Dec. 2015) |

Education
<table>
<thead>
<tr>
<th></th>
<th>Education</th>
<th>Clinical Service Committee</th>
<th>12 - 18 months</th>
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<tbody>
<tr>
<td>8.</td>
<td>a. Annual Cardiology Day for nurses and allied health</td>
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<td>b. Develop patient and health care provider educational resources on Cardiac Care Website</td>
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<td></td>
<td>c. Expand ACLS to RN’s working on Cardiology Unit</td>
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<td></td>
<td>d. Support professional development through internal and external conferences</td>
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CATH/PCI STRATEGIC PLANNING SESSION

STRENGTHS

1. Service Excellence
   - High quality of services provided - Meets or exceeds standards
   - Collaborative to meet the needs of the region and regional partners
   - Evidence based practice/Best practices
   - High Quality care
   - Low complication and high success rate
   - Ability to service community and collaboration with the CELHIN
   - STEMI program
   - Broad catchment population
   - Data driven
   - Primary focus to advance services and technologies to improve patient care
   - Blend between interventional and non-interventional cardiologists
   - Provincial leaders in community based hospital with providing cardiac care
   - Physical location
     - ER
     - CL
     - CCU ICU
   - Fast transfer of care
   - Skilled ACLS certified staff
   - Facilities 3 CATH Labs
   - State of the art equipment

2. Access
   - Timely
   - Equal access 24/7
   - Improvement across region
- Short wait list
- Centralized regional approach
- D2B meets benchmarks
- Direct transfer from scene
- Facilitated bypass from L.H
- Accountability to funder
- Expanded PCI CTO-PCI service
- Input phase --- rapid
- Output transfer --- rapid
- Diversity of services offered

3. Fiscal
   - Increasing cardiac Volumes-**Fiscally responsible**
   - Good track record with government, budget, program level
   - Streamlined processes to decrease “waste” in system and improve patient access
   - Able to achieve volumes and targets with limited resources

4. Staff Engagement
   - Strong human resources, MD’s, nurses, management team and support staff
   - Innovative cardiac team with progressive ideas and strategies to continually enhance Cardiac Care in the CELHIN
   - Good relationship with regional partners

5. Patient Satisfaction
   - Patient centered care
   - Patient survey’s reflective of organizational improvement and “smart strategies”

6. Partnerships/Collaboration
   - Partnership EMS
   - Partnership collaboration other services (DI)
   - Regional collaboration
   - Leadership not ownership
- Partnership and engagement (HOSPITAL, EMS)
- Strong links with partnering hospitals, EMS, and community

7. Data Management and Reporting (Information Systems)
   - Introduction of Cardiovascular Information System (CVIS)
   - Electronic documentation XIM/XPER
   - Electronic physician reporting
   - CCN-BI tool

8. Education/Communication
   - Regional Cardiac Rounds every week
   - Multidisciplinary education approach
   - Professional Practice- Frequent lunch and learns to support learners (FFR/OCT/IVUS/Rotablation/IABP, AVANTA etc
   - Launch of Annual Cardiology educational day for program staff- multidisciplinary approach
   - Education at Bedside for medics

9. Quality and Outcomes
   - demonstrate quality and effectiveness
   - decrease LOC
   - decrease readmission patients
   - decrease mortality
   - quality experience- patient satisfaction
   - increase quality of life
   - good clinical outcomes

OPPORTUNITY TO ACHIEVE VISION

1. How do we integrate better across the LHIN?
   - Increased integration through the CELHIN (procedure booking, reports, films)
   - Increased media awareness of RVHS cardiologists
   - Community awareness and outreach to ethnic organizations for cardiac care (education, rehab, decreased challenges)
- Building internet website for ethnic community access in several languages
- Partnerships with academic centers
- Image and record access by all “MD” in CELHIN
- Cultural awareness
- Sharing RVHS experience
- Capture volumes done out of region
- Increase data support personal
- Increase IT support for Cardiac program
- Booking access for tests
- Standard work referrals
- Direct booking of procedure from MD office + mandatory documents sent
- Further integration and partnerships of DEMS, TEMS
- Plan and implement approach to NE cluster by working with identified stake holders
- Fix any gaps for Scarborough-Durham cluster
- Standardized booking for all cardiac procedures at RVHS
- Expand operating hours
  - Less overtime
  - More usual access
- Electronic diagrams with reporting
- New admissions for transfers
- QC survey --- post PCI transfer
- Regional communication
  - Bed alteration--- patient floor
- Hospital transfers
- Right patient –right doctor
- Communication
- Timely reporting
- Communication
  - Referral physicians
- Communication
  - Global integration of bed allocation
- Cardiology ward
- Leverage
  - Electronic database/portals
  - CCIS/NAVARI

2. How do we further improve CODE STEMI?
- CODE STEMI should be driven by transfer time
- Improve knowledge gap of ECG interpretation
- Increased lab time to accommodate CTO procedures and new procedures
- Access to/expansion increased hours of operation
- Closure devices
- Decreased cancellation of procedures due to: no lab time, no RN, no transport, no MD
- Build bridges with MSH to improve patient access to cardiac (PCI, Code STEMI)
- Additional Cath lab
- Increase interventional cardiac support driving 24/7 coverage
- RVHS to be leaders in cardiac education
- Education with community partners
- Cultural awareness
- Outreach opportunity (under serviced, increase prevalence)
- Marketing strategy ("call 911", door to door, flyers, bus, partner with industry)
- 24 hour Cath lab/CCSSU staffing to accommodate Code STEMI and support staff
- ACS algorithm across LHIM STEMI and NSTEMI
- Discharge summaries and instructions
- Education (modernized) PTs and Staff
- Repatriation REVISIT
- Follow patient early
  - Patient not physician obligation
- Hire interventionist
- Addition of level 3 bed or vented CCU
- Product review and evaluation refund
- Volumes match skillset
- Increase HR
  - Admin support
  - Staff (RNs)
  - Manager
  - Additional CPL support
  - Interventionist
- Impella program (decrease mortality) — left ventricular device
- Cardiac website (pt.) service

3. What are the roles of Diagnostic and Interventional Cardiologists?
- Patient focused care
- Access to any “references” to follow up on bookings (in-line with booking principles)
- Commit to new technologies, structural support?
- Peripheral intervention, TAVI, mitral clips, atrial appendage
- Increased partnerships with York EMS to improve patient care and access to timely code STEMI
- Formal review of the procedures
- Transparency of booking appropriateness
- Standard booking for all doctors
- Increase interventionist’s on site
- Structural heart disease
- Interventional cardiologists dedicated at partner sites
- Movement towards mostly inpatients and more outpatients done as +/- procedures (standard of care in many other jurisdictions)
- Radial Access-Cath mentoring program

4. How do we measure our effectiveness as a regional service?
- Appropriate indicators, review and apply
- Measure of wait times for improved regional access
- Patient satisfaction surveys
- Improve quality of life
- Community education
- Quality measures that are geared to patient experience and safety
- Cost per case, QBP funding
- Seamless transfer of patient care service and documents
- 24 hour CCSSU to improve patient access throughout the region
- Improve patient flow with bed availability at partner sites
- Collect more patient care data, obtain outcomes and report regularly
- Confidentiality agreements that cover our partner site, accountability of patient information
- Measurement and Evaluation:
  - Hire data quality manager to support (full time)
- Outcome and complication indicators
- Regional Outcomes must be transparent:
  - Mortality
  - Complications
  - F/U
  - LOS
  - Readmission rates
- EHR
  - Centralized databases (electronic)
- Are we using information systems to full capacity? (Meditech, CVIS, others)
### Cath/PCI Short Term Action Plan

<table>
<thead>
<tr>
<th>What- Opportunity</th>
<th>How</th>
<th>Who</th>
<th>When</th>
</tr>
</thead>
</table>
| 1. Improve service delivery and processes             | - Review processes and compliance to achieve optimal patient flow (booking, transportation and repatriation)  
- Improve inter MD communication  
- Increase interfacility communication  
- Enhance Reporting System  
- Revise Discharge summary  
- Data delivery/sharing during patient journey  
- Improve transport, CELHIN partnerships with hospitals guidelines, appropriateness, repatriation agreements | Cath/PCI Service committee Physician Lead Amelia, Glyn, Dr. Ricci, stakeholder hospitals | 3-12 months               |
| 2. Utilization of Lab time                            | - Existing resourcing,  
- Leveling resources                                                    | Dr. Davies, Dr. Vijay, Dr. Mukherjee, non cathing cardiologist  
Cath Lab Service Committee | 1-3 months for initial meeting                                       |
| 3. Measurement Evaluation (Quality Improvement)       | - Identifying outcome indicators  
- Build within current systems  
- Build process to F/U  
- Data quality analyst (across program)  
- Explore CPOE and relationship  
- continue participation with CCN  
- Increase utilization of CCN BI tool now available to Data clerks and RCCC | CATH  
DCT  
SC (IT) | 3-6 months for WG  
1 year- fully implemented |
| 4. Education (Cardiology, Internal Medicine, Nursing, Regional partners, partnerships with academia-fellows, cardiology residents) | - Leverage OTN and technology to  
- Bimonthly Rounds by Physician  
- Professional Practice Calendar  
- Patient education (modernize-video)  
- cardiac website) | Cath/PCI and Clinical Service Committee D'Mello, NP, RN's, Glyn, Dr. Davies Unit Council | Videos-1yr  
LVAD-1year |
5. Access of Information by healthcare professionals (IT Integration)  
   - Confidentiality agreement, CVIS Meditech  
   - Electronic MD Website Booking and IT structure  
   - Connect GTA, add Durham, interface of RVHS IT systems Meditech,  
   - Glyn, Thodoros, Dr. Ricci, Amelia, Glyn  
   - WG (IT Glyn, Amelia)  
   When: 1-2 years  
   1-2 years

6. Advanced PCI & Structural Heart Disease programs  
   - individual reports, education, internet groups, capital & resource requirements  
   - Admin, MD leads, Dr. Vijay  
   1-5 years
Arrhythmia Services—Consolidated Comments from 2014-15 Consultation

STRENGTHS

1. Service Delivery and Access
   - Multi-disciplinary team which includes anesthesia, anesthesia assistant, EP/MD/physician, arrhythmia specialist, respiratory technologist, nurse practitioner
   - Increased quality access for services and patients, including extending services to RVAP
   - Partnerships with hospitals, this includes supporting Lakeridge Oshawa services, and moving toward TSH pacemaker integration
   - New dedicated Lab, procedure room and Cath Lab recovering area with advanced equipment
   - Leaders in Cryo-ablation in Ontario
   - Low admission in post-procedure
   - Centralized, single point of entry
   - High volumes with CE LHIN and MOHLTC
   - Preferred provider for inpatient EP due to accommodation and quality
   - No wait for urgent patients
   - Quality and timely support from other cardiac and hospital programs
   - Leaders in arrhythmia care: 1st pro-MRI DF4 ICD in North America
   - Now doing S-ICD - Did first pro-MRI DF4 ICD in North America
   - High patient satisfaction (greater than 90% would recommend Arrhythmia services)
   - Excellent PRE + POST quality care
   - Caring and highly professional staff
   - Centralized database IT system
SESSION THEMES: OPPORTUNITIES

1. What should Regional EP look like for (a) Scarborough Durham Cluster and (b)CE LHIN?

- One stop shop for comprehensive care
- Central access - integrated timely and centralized accessed care
- Integrated regional arrhythmia service including pre-op, potential use of OTN
- Advanced subspecialty clinic (e.g. Genetics)
- Complex EP & procedures seen by an EP
- Patient education available electronically and online (like Prehab), this includes pre-procedure program for patients and families
- Create old patient clubs (e.g. pacemaker club)
- Be associated and participate in research
- Leader in remote monitoring
- Timely reports to referring MDs through existing databases

2. How do we better integrate our services as a system of care (a) RVHS and (b) Regional Partners (TSH, LHC)?

- Improve our current patient/family/provider education and have education ready when needed
- Use of OTN, patient education online (pre & post, rehab clinic)
- Create an arrhythmia club
- Regional education day with all partner hospitals
- Educate the community (systems level, regional level), going to primary-care physician offices to make them aware of regional services, cardiologists more than GPs. Also, Education for staff, patients and physicians.
- Complete an Environmental scan- needs assessment for CELHIN
- Comprehensive electronic data base for patient information across hospital sites - centralized
- Access to remote monitoring
- Use prep room for patients’ pre-operative assessment
- Risk stratification process for booking procedure
• Off-site local EP
• Improve post-op care by having transportation services
• Develop formal feedback mechanism, i.e. referring physician feedback.
• Policy and procedure to be created, updated, and shared regionally.
• Website to be developed/updated

3. **How do we measure our effectiveness as a regional service?**
• # of sites having remote monitoring
• Use of OTN
• Participation in research
• Patient and provider satisfaction
• Partners perspective/feedback
• Wait times
• Balanced budget
• Complication rate
• Quality of life- Morbidity & Mortality
• Hospital readmission rates
• Inclusion of ICD in CCN data collection
• Data collection through information systems- reduce manual data collection or redundant data collection
## Arrhythmia Services Short-Term Action Plan

<table>
<thead>
<tr>
<th>Top Opportunities and How</th>
<th>Who</th>
<th>When</th>
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</thead>
<tbody>
<tr>
<td><strong>Service Delivery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Fair accessibility that is timely</td>
<td>Arrhythmia Management Committee (AMC)</td>
<td>12 – 24 Months</td>
</tr>
<tr>
<td>● Weekend arrhythmia services coverage, off-hours and EP on call or 24/7</td>
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<tr>
<td>● Expand hours in both labs</td>
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<tr>
<td>● Dedicated recovery room</td>
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<tr>
<td>● Booking and scheduling processes</td>
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<tr>
<td>2. Comprehensive/Integrated Clinic</td>
<td>Rohan/Project Team</td>
<td>12 months</td>
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<tr>
<td>● Pre-op teaching</td>
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<tr>
<td>● OTN for consults</td>
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<tr>
<td>● Remote Monitoring Care across the region</td>
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<tr>
<td>● Linked to other services i.e. Cardiovascular Rehab</td>
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<tr>
<td><strong>Performance Measurement and Evaluation</strong></td>
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<tr>
<td>3. Central Regional database</td>
<td>Dr. Janmohamed, Anand Negi, Rohan Gonsalves</td>
<td>3 months to select 6 months to implement</td>
</tr>
<tr>
<td>● Create regional processes for data input</td>
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<tr>
<td>● Allow all providers to access patient information</td>
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<tr>
<td>4. Continuous Measurement and Evaluation</td>
<td>AMC IT</td>
<td>12-36 months</td>
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<tr>
<td>● Resources to support data collection and analysis.</td>
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<tr>
<td>● Develop standardize metrics across CELHIN</td>
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<tr>
<td>● Patient portal- access to their information</td>
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<tr>
<td><strong>Strategic Alliance and Linkages</strong></td>
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<tr>
<td>5. Integration and partnering</td>
<td>Medical Director AMC</td>
<td>12 – 36 months</td>
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<tr>
<td>● Off-site local EP</td>
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<tr>
<td>● Provide referring physician feedback.</td>
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<tr>
<td>● Explore opportunities for transportation funding</td>
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<tr>
<td>● Develop and or revise policies (standards of care) shared regionally.</td>
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<tr>
<td><strong>Education and Marketing</strong></td>
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<tr>
<td>6. Education (staff, patient &amp; family, providers, referring MD, community)</td>
<td>AMC</td>
<td>12 – 24 months</td>
</tr>
<tr>
<td>Task</td>
<td>Responsible Party</td>
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<td>---------------------------------------------------------------------</td>
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<tr>
<td>Annual Cardiology Day for nurses and allied health</td>
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<tr>
<td>Develop patient and health care provider educational resources on Cardiac Care Website (include You Tube videos, developed locally, advisory section)</td>
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<td>Support professional development through internal and external conferences</td>
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<tr>
<td>Resurrect Arrhythmia Club</td>
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<tr>
<td>Review and revise patient discharge</td>
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<tr>
<td>Integration of evidence best practice procedures</td>
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<tr>
<td><strong>CPL Marketing Committee</strong></td>
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</table>
Cardiac Imaging—Consolidated Comments from 2014-15 Consultation

Strengths

1. **Patient Satisfaction**
   - Accommodate patient needs
   - Time for patients
   - High rate of patient satisfaction
   - Quality of care
   - Going to extra mile
   - Same day cardiology consultations in diagnostics lab to care for high risk patients

2. **Staff Engagement**
   - Visionary leadership
   - Organizational structure is well established: working groups, and service committees
   - Access to complimentary technicians at each site, including MRI, CTA and Cath
   - Strong working relationships with ER, DI, Foundation, Cross site, IM, FD
   - Cooperative staff
   - Cohesive staff
   - Group involvement
   - Teamwork (staff to staff and staff to managers)
   - Multi-disciplinary
   - Qualified staff
   - Education
   - Support from Anesthesia and RT service for TEE’s
   - TEE training for all cardiologists
   - HR strong – MD, strong leadership, engaged knowledgeable staff, new cardiologist
   - Multiple skilled technicians available daily to assist with add on urgent cases
   - Technicians available on weekends, good flow through hospital
3. **Equipment and IT**
   - State of art technology
   - Newer and more up to date equipment
   - It improvement
   - New echo machines
   - Commitment from tech’s to achieve better service
   - CTA PTT both sites
   - MRI Cardiac program
   - Phillips: ECG paperless reporting and access on all computers
   - Cross site analysis of holters and accessibility of reports
   - Xclera: Paperless, faster reporting of reports hospital wide. Echo (new), BP, holter, and loop recorders

4. **Access**
   - Centralized booking for both sites
   - Multimodality imaging offered to patients in one department – very unique
   - Comprehensive imaging services
   - Seamless access to services
   - Scheduling office cross site
   - Doctor’s available in departments
   - Timely service
   - Same or next day testing availability
   - Access to PVI studies

5. **Integration**
   - Patients
   - Geographic
   - Departments
   - Coordination with other areas of cardiac i.e. rehab
   - Strong partnerships with other internal stake holders
   - Collaboration with our radiologists and DI technologists
Session Themes- Opportunities

1. **What should Cardiac Imaging look like for RVHS by 2020?**
   - Qualified and adequate human resources (physician/tech)
   - Regionalize Metabolic testing
   - Regional standard of care
   - Expand services, partnerships with ER, GIM in-patients
   - Expand Tee services
   - CCN accreditation of ECHO Lab
   - Expand TT program with streamlining referral process
   - Patient teaching resources
   - Patient educational site
   - Review policies and procedures
   - Continue to improve access to ALL imaging
   - Second level 3 trained echo tech
   - Referral- allowing patient to book appointments
   - Streamlined exam times
   - Daily TEE coverage
   - Another level 3 echo tech
   - Investing in regular education of technologists (ie. regular rounds)
   - Regional cardiac diagnostics program
   - OTN/Skype/FaceTime consults
   - 14 day holters
   - Acquire more metabolic carts to serve rehab patients
   - Live ECG monitoring
   - Determine best modality for each case
   - Ability to read from home
   - Increased MD coverage
   - More cardiologists who can supervise GXT in afternoon at Ajax
   - Wireless ECG machine
• More metabolic carts
• Block bookings for TEE

2. **What additional modalities should we have?**
   • Universal access to images for referring MD
   • Central Booking for CTA/MRI
   • Centralize TEE/CV Booking cross-site
   • Electronic medical record LHIN wide-access to reports
   • Increase regular education for all staff: MD, Techs, Clerks, etc.
   • Increase marketing to make MDs aware of our wide range of testing
   • One stop shop- integrated on cardiac website
   • Integrated information systems (HIS, CIS)
   • Expand TEE services (evidence based)
   • CT Angio services at RVC
   • Add PET/CT
   • Work more collaboratively with Oncology patients
   • Coordination with GP’s
   • More 3D echo training
   • App for registering and booking patients with ETA of patients
   • Paperless – all electronic
   • Physician and patient access to results
   • Same rules and procedures should be implemented for both sites
   • Same day exam service between modalities
   • Spread cardiac education across other working groups (diabetes, urology clinic)
   • Education through website
   • Shared database (i.e. with other LHIN hospitals)
   • MET testing for CHF (1. Predictability, 2. Meds adjustment)
   • Equal services at RVC/RVAP
   • Expand services – weekends for both sites
   • Same day turn around for MIBI reports
• Shuttle bus between RVC/RVAP
• CTA for ER patients (improved flow)
• Reduced inpatient wait times
• Daily TEE capacity needed
• Quality of life improvement for CHF patients
• Physician reporting from home
• Availability of extended exam hours

3. **How do we move to an accredited, evidence based service?**
   • Fully accredited Echo lab in 2015
   • Wait times, patient satisfaction, readmission rate
   • Feedback (patient, physician, staff)
   • Volumes
## Cardiac Imaging Short-Term Action Plan

<table>
<thead>
<tr>
<th>Opportunity and How</th>
<th>Who</th>
<th>When</th>
</tr>
</thead>
</table>
| 1. Integration- flow of information (access to referrals & reports)  
  - Determine model  
  Develop a project plan Electronic referrals, Centralized booking, | Anand, CDSC, Medical Director, IT director | Model: 3 months  
Capital requirements: 6 – 9 months  
Implement: 12 – 18 months |
| 2. Fully Accredited ECHO lab  
  - Establish working group.  
  - Review CCN documents, collaborate CCN, review/collaborate, collate sonographers, | Dr. Ipekian and team | End of 2015 |
| 3. Work more collaboratively with Oncology patients – PET scan  
  - Establish working group | Glyn Boatswain, Dr. Ricci, Dr. Galiwango and Oncology rep | 6 months (need business and clinical case) |
| 4. Regionalize Metabolic Testing | Cardiac Diagnostic Service Committee | 9 months |
| 5. Continuing Staff Education  
  - Interdisciplinary  
  - 3D Echo  
  - IV training  
  - In-service protected education time | Dr. Galiwango, CPL- and Cardiac Diagnostics Service Committee | Ongoing |
| 6. Implementation of CT Angio at RVC  
  - Establish working group and project plan | Michael Hierlihy, Glyn Boatswain, Jackie, Dr. Yan & Dr. Galiwango | 9-12 months |
| 7. Improve coordination of care when testing is abnormal  
  - Create guidelines/criteria | Dr. Yan, CPL Unit coordinator Cardiac Diagnostic Service Committee | 6 months |
<p>| 8. Access to Emergency Reports at RVAP- Consults | Rohan/Anand | ASAP |
| 9. Electronic Reporting, E-referral | Physician Committee/Anand | 6-12 months |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>10. Physician coverage at RVAP</td>
<td>Dr. Galiwango, Glynn and Cardiac Service Committee</td>
<td>6-12 months</td>
</tr>
<tr>
<td>11. Increase services</td>
<td>Cardiac Service Committee Physician Lead, Dr. Galiwango and Dr. Dmello</td>
<td>3 months</td>
</tr>
<tr>
<td>11. Increase services</td>
<td>• 14 day Holters, Level 3 Tee coverage</td>
<td></td>
</tr>
<tr>
<td>12. CTA for Emergency</td>
<td>Dr. Galiwango and Cardiac Diagnostic service Committee</td>
<td>12-18 months</td>
</tr>
</tbody>
</table>
CRSP Strategic Planning Session Consolidated Comments

STRENGTHS

1. Service
   - Regional integrated model
   - Regional service for community
   - Lean approach and harmonized administration
   - Collaboration amongst hospitals

2. Data Collection, Reporting, Information Flow
   - Implemented a web based database that is effective - CVIS
   - Accurate/complete data capture
   - Measurable outcomes
   - Accurate capture of referrals both successfully and unsuccessfully

3. Fiscal
   - Cardiac walk revenue to purchase extra equipment
   - Lowered cost per case effective

4. Best Practice
   - CHF order set based on best practice
   - Consistent evidence based to guide patient programming

5. Access
   - Services close to home
   - Close monitoring support
   - Rapid access
   - Assistance with secondary prevention
   - Smoking cessation
   - Dietician
   - Pharmacist
   - Follow up with patients after ED of help visit
• Centralized acceptance, referral and booking
• Increase sites in community where patients live
• Satellite locations
• Single point of contact
• Progress monitoring with regular cardiopulmonary testing

6. Education
• Regional cardiac rounds
• Education component in classes
• OTN, education, shared classes
• Training material is available in multiple media
• Partial training material available in secondary languages

7. Resources
• Expert staff
• Engaged exercise therapists
• Multidisciplinary teams
• Partnering with community resources
• Regional volunteers

8. Clinical and Performance Outcomes
• Indicators show “added volume” to services provided
• Good outcomes for patients
• Prevent hospital readmissions
• Spousal support
• Patient specific goals
• Strong collaboration
• Class structure has a “comfort” factor not present in solo rehabs
• Removal of fear to be active (patient and spouse)

9. Other
• Application of lean thinking
• Automatic referral
• Standardization of services
• Care close to home and close at hand
- Central booking of appointments (individual, workshops, grocery tours partnering with RD’s in the community)
- Excellent leadership
- Model of integration for others to follow
- Inter-professional support
- Input from pharmacists
- Full time dietician available
- Mindful eating workshop
- Craving change workshop

OPPORTUNITIES TO ACHIEVE VISION

1. How can we close the gap in the CELHIN?
   - Develop a plan to target North East region
     - Work with the north to find a solution for the north
   - Expand the program by creating new sites where needed
   - Automatic inpatient CHF referral at all sites
   - Increase volumes by partnering with local chronic disease programs
   - Diagnostics/metrics evidenced based and accessible
   - Each hospital is responsible for readmission rate therefore funding support at hospital level to support volumes and location
   - Volumes – educate FP/GP’s (primary care physicians) to identify potential patients
   - Linking with stakeholders (i.e. cardiologists especially for outpatient referrals)
   - Online visibility of class capacity at various locations for medical professionals and the ability to submit referrals electronically
   - CRSP is initial point of follow up for CHF patients
   - Enhance automation of referral upon discharge from hospital to CRSP
   - Utilize existing framework for new community partners
   - Build nurses into program to stratify/care plan for patients

2. How do we expand scope of services?
   - Work with existing programs who offer CHF support (i.e. RMH)
   - Improve funding support
   - Enhance services for chronic disease patients (diabetes, cardio, respiratory, etc.)
   - Utilize the expertise in geographic areas i.e. community health partners (official)
   - Utilize rehab assistants
   - Each hospital responsible for readmit rate therefore funding support at hospital level to support CHF (each hospital pays into CRSP programming)
• Include patients on strategic planning to understand what they want in a program
• Expand cardiac rehab to “other” services (ie. cancer, mental health)
• Increase access and improve home based exercise program (offer this to retirement homes, community health centres)
• Differentiated level of care (I-IV)
• System navigators
• Implement CRSP at PRHC, North Pickering
• Enhance patient educational resources
• Improve Cardiac and CRSP website
• Build custom reports in CVIS as backbone of data collection

3. **How do we measure our effectiveness as a regional service?**
   • Indicator review/validation of indicators
   • Data collection- conducting studies to assess effectiveness
   • Conduct real time surveys of patients conducted by volunteers to prevent bias
   • Measures effectiveness of nutrition education
   • Deliver consistent services across region/measures
   • Embrace opportunities as a “trial” (i.e. OTN to Haliburton)
   • Use of OTN for both exercise and education
   • Wait time
   • Collect essential data – CS per CCS guidelines (referral to reflect)
   • Identify evidence based metrics (6-minute walk test, 48 hr follow up)
   • Baseline echo for all heart failure patients
   • Quality of life
   • Readmission rate
   • ICES research
# CRSP Short-Term Action Plan

<table>
<thead>
<tr>
<th>Top Opportunities (not ranked)</th>
<th>Responsible Persons</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Automate Inpatients referrals at all sites</td>
<td>Rohan/Glyn/Project Team</td>
<td>3-12 months (dependent on sites)</td>
</tr>
<tr>
<td>• Mirror completed project plan from RVHS</td>
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<tr>
<td>• This includes CHF patients</td>
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<tr>
<td>2. Engage NE</td>
<td>Project Team</td>
<td>6-12 months</td>
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<tr>
<td>• Conduct a current state assessment engaging patients</td>
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<tr>
<td>• Conduct an environmental scan</td>
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<tr>
<td>• Experiment through pilot projects</td>
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<tr>
<td>• Work with community partners</td>
<td></td>
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<tr>
<td>3. Develop a program wide patient survey</td>
<td>Rohan Gonsalves</td>
<td>1-3 months</td>
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<tr>
<td>a. Includes focus groups for improvement</td>
<td></td>
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<tr>
<td>4. Enhance services/care for Chronic Disease Groups and CHF patients</td>
<td>Working Group</td>
<td>3-12 months</td>
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<tr>
<td>• Enhance education</td>
<td></td>
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<tr>
<td>• Create multidisciplinary team</td>
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<tr>
<td>• Build into current pathway</td>
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<tr>
<td>• Determine need for a CHF clinic</td>
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<tr>
<td>5. Improve communication &amp; education</td>
<td>Regional Cardiac Marketing and Fundraising</td>
<td>12 – 36 months</td>
</tr>
<tr>
<td>• Update cardiac website</td>
<td>Committee</td>
<td></td>
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<tr>
<td>• Review patient education and update as needed</td>
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<tr>
<td>• Provide referring physician feedback.</td>
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<tr>
<td>• Utilize OTN more</td>
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<tr>
<td>• Visit all community partners and potential partners communicating our services</td>
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### Item 9, Standard Quality Framework

#### Quality Framework

- **Principles**
  - Single cardiac care program standard of care across RVHS
  - Patient centered
  - Program based procedures, policies, care maps and protocols

- **Quality Management Processes**
  - Critical indicators
  - Pathways
  - Protocols
  - Care Maps
  - Annual Review process
    - Performance Review
    - Process review

- **Protocols**
  - Standardized Order Sets
  - Discharge Management Processes/protocols
    - Discharge Management/prescription form
    - Healthy targets form
    - Automatic referral to secondary prevention services (Rehab, CARE)
    - Pharmacy discharge review and medication list

- **Review processes (annual)**
  - Multidisciplinary Morbidity/Mortality
  - Patient satisfaction surveys
  - Policies/procedures/directives
  - Care maps
  - Clinical indicators
  - Utilization data

- **Performance review**
  - Management staff:
    - At each administrative level
    - 360 degree
  - Physicians:
    - Annual performance review by Medical director,
    - Reported to Chief, Medical Program
### Project: AOP Objective or Project Name

<table>
<thead>
<tr>
<th>Accountability</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee</td>
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<tr>
<td>Medical Lead</td>
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<tr>
<td>Admin Lead</td>
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</table>

#### Project Overview

**Overview statement**

<table>
<thead>
<tr>
<th>Priority</th>
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<th>Completion</th>
<th>Assigned To</th>
<th>Overall Status</th>
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<tbody>
<tr>
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<td></td>
<td>35-40%</td>
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#### Current Activities:

1. List of activities since last report

<table>
<thead>
<tr>
<th>Key Milestones/Deliverables</th>
<th>Planned</th>
<th>Actual</th>
<th>Status</th>
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#### Risks:

<table>
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<th>#</th>
<th>Risk Description</th>
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<th>Mitigation(s)</th>
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#### Additional Notes:
### Item 11, Annual CV Operating Plan, Example, Planning 2015-16

Location of file: [Annual Operating Plan 2015-16](#)

---

**Rouge Valley Health System Cardio Vascular Annual Operating Plan for 2015-16**

<table>
<thead>
<tr>
<th>ID</th>
<th>Deliverables</th>
<th>Lead</th>
<th>Support(s)</th>
<th>Status (% Complete)</th>
<th>April-June</th>
<th>July-September</th>
<th>October-December</th>
<th>January-March</th>
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<tr>
<td></td>
<td>(identify tasks to be completed to achieve deliverables)</td>
<td>(identify who the lead is)</td>
<td>(identify who and what program areas are required to provide support)</td>
<td></td>
<td>April</td>
<td>May</td>
<td>June</td>
<td>July</td>
</tr>
<tr>
<td>1.00</td>
<td>Planning</td>
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<td>Stakeholder Engagement</td>
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<tr>
<td>1.20</td>
<td>Draft Environmental Scan</td>
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<td>1.21</td>
<td>Finalize Environmental Scan</td>
<td>John</td>
<td>None</td>
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<td>1.30</td>
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<tr>
<td>1.31</td>
<td>Staff level final plan</td>
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<td>Team</td>
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<td></td>
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<tr>
<td>1.32</td>
<td>Review and Finalize with Clinical Lead</td>
<td>John</td>
<td>Team</td>
<td>0%</td>
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<td></td>
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</tr>
<tr>
<td>1.33</td>
<td>Presentation to Cardiac Program Management Committee</td>
<td>Dr. Ricci</td>
<td>John</td>
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<tr>
<td>1.34</td>
<td>Presentation to SMT as Information</td>
<td>Dr. Ricci</td>
<td></td>
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<td>1.40</td>
<td>One Day Staff Retreat</td>
<td>Dr. Ricci</td>
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<tr>
<td>1.50</td>
<td>Detailed Annual Report 2015-16</td>
<td>John</td>
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<td>Implementation</td>
<td>John</td>
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</table>
## Item 12, Clinical Code Set

### Code Groupings for Cardiac Analysis

<table>
<thead>
<tr>
<th>ICD10</th>
<th>Description</th>
<th>Group Level I</th>
<th>Group Level II</th>
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<tbody>
<tr>
<td>I44</td>
<td>Atrioventricular Block</td>
<td>AV and LBB Block</td>
<td></td>
</tr>
<tr>
<td>I45</td>
<td>Fascicular Block</td>
<td>Other Conductive Disorders</td>
<td></td>
</tr>
<tr>
<td>I47</td>
<td>Paroxysmal tachycardia</td>
<td>Paroxysmal Tachycardia</td>
<td>Arrhythmias</td>
</tr>
<tr>
<td>I48</td>
<td>Atrial fibrillation and flutter</td>
<td>Atrial Fibrillation and Atrial Flutter</td>
<td></td>
</tr>
<tr>
<td>I49</td>
<td>Other cardiac arrhythmias</td>
<td>Other Cardiac Arrhythmias</td>
<td></td>
</tr>
<tr>
<td>I20</td>
<td>Angina pectoris</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I21</td>
<td>Acute myocardial infarction</td>
<td>ST-Elevation Myocardial Infarction (Requires ICD10 (ALL) = R94.30)*</td>
<td>Ischaemic Heart Disease</td>
</tr>
<tr>
<td>I22</td>
<td>Subsequent myocardial infarction</td>
<td>Non-ST-Elevation Myocardial Infarction (Requires ICD10 (ALL) = R94.31)*</td>
<td></td>
</tr>
<tr>
<td>I240</td>
<td>Certain current complications following acute myocardial infarction</td>
<td>Other Acute Myocardial Infarction (ICD10 (ALL) = R94.38 or neither codes from above)*</td>
<td></td>
</tr>
<tr>
<td>I241 - I249</td>
<td>Dressler's Syndrome, Other Forms of Acute Heart Disease, Acute Ischaemic Heart Disease NOS</td>
<td>Other Acute Ischaemic Heart Disease</td>
<td></td>
</tr>
<tr>
<td>I25</td>
<td>Chronic ischemic heart disease</td>
<td>Chronic Ischemia Heart Disease</td>
<td></td>
</tr>
<tr>
<td>I11</td>
<td>Hypertensive heart disease</td>
<td>Hypertensive Diseases</td>
<td></td>
</tr>
<tr>
<td>I00</td>
<td>Acute pericarditis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I01</td>
<td>Other diseases of pericardium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I02</td>
<td>Pericarditis in diseases classified elsewhere</td>
<td></td>
<td></td>
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<tr>
<td>I03</td>
<td>Acute and subacute endocarditis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I04</td>
<td>Acute myocarditis</td>
<td>Other Forms of Heart Disease</td>
<td></td>
</tr>
<tr>
<td>I05</td>
<td>Myocarditis in diseases classified elsewhere</td>
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</tr>
<tr>
<td>I06</td>
<td>Cardiomyopathy</td>
<td></td>
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</tr>
<tr>
<td>I07</td>
<td>Cardiomyopathy in diseases classified elsewhere</td>
<td></td>
<td></td>
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<tr>
<td>I08</td>
<td>Complications and ill-defined descriptions of heart disease</td>
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<tr>
<td>I09</td>
<td>Other heart disorders in diseases classified elsewhere</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I10</td>
<td>Heart failure</td>
<td>Heart Failure (Including CHF)</td>
<td></td>
</tr>
<tr>
<td>I50</td>
<td>Rheumatic fever with heart involvement</td>
<td>Rheumatic Fever with Heart Involvement</td>
<td></td>
</tr>
<tr>
<td>I51</td>
<td>Rheumatic mitral valve diseases</td>
<td>Chronic Rheumatic Heart Diseases</td>
<td>Rheumatic Heart Disease</td>
</tr>
<tr>
<td>I52</td>
<td>Pulmonary valve disorders</td>
<td>Endocarditis, Valve Unspecified</td>
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</tr>
<tr>
<td>I53</td>
<td>Valve disease</td>
<td>Endocarditis and Heart Valve Disorders in Diseases Classified Elsewhere</td>
<td></td>
</tr>
<tr>
<td>I54</td>
<td>Other rheumatic heart diseases</td>
<td>Endocarditis and Heart Valve Disorders</td>
<td></td>
</tr>
<tr>
<td>I55</td>
<td>Nonrheumatic mitral valve disorders</td>
<td>Non-Rheumatic Mitral Valve Disorders</td>
<td></td>
</tr>
<tr>
<td>I56</td>
<td>Nonrheumatic aortic valve disorders</td>
<td>Non-Rheumatic Aortic Valve Disorders</td>
<td></td>
</tr>
<tr>
<td>I57</td>
<td>Nonrheumatic tricuspid valve diseases</td>
<td>Non-Rheumatic Tricuspid Valve Disorders</td>
<td></td>
</tr>
<tr>
<td>I58</td>
<td>Pulmonary valve disorders</td>
<td>Pulmonary Valve Disorders</td>
<td></td>
</tr>
<tr>
<td>I59</td>
<td>Other pulmonary heart diseases</td>
<td>Endocarditis and Heart Valve Disorders</td>
<td></td>
</tr>
<tr>
<td>I60</td>
<td>Rheumatic fever without mention of heart involvement</td>
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<td>Excluded</td>
</tr>
<tr>
<td>I61</td>
<td>Rheumatic chorea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I62</td>
<td>Essential (primary) hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I63</td>
<td>Hypertensive renal disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I65</td>
<td>Secondary hypertension</td>
<td></td>
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<tr>
<td>I66</td>
<td>Pulmonary embolism</td>
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<tr>
<td>I67</td>
<td>Other pulmonary heart diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I68</td>
<td>Other diseases of pulmonary vessels</td>
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</table>

The clinical scope of the analysis is defined by a subset of cardiac codes contained in Chapter IX “Diseases of the circulatory system” of ICD10. While the full range of codes in Chapter IX is from I00 to I99, the cardiac code subset used in this scan was I00 to I52 with the specific exclusions as noted in Table 1. The inclusion and exclusion of codes for the purpose of setting the clinical scope of the analysis was done after a literature review, particularly the review of established Canadian sources including the Institute of Clinical and Evaluative Studies (ICES), the Canadian Institute of Health Information (CIHI), and is consistent with the clinical code set used and vetted by CCN in their 2012 Road Map document. The ICD10 codes, groups, and subgroups outlined in Table 1 were applied to all data obtained from the Discharge Abstract Database (DAD), the National Ambulatory Care Reporting System (NACRS) Database, and the Vital Statistics Database.
Item 13, Service Committee Terms of Reference

<table>
<thead>
<tr>
<th>Committee Name:</th>
<th>Arrhythmia Management Committee</th>
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</thead>
<tbody>
<tr>
<td>Version Number:</td>
<td>1.0</td>
</tr>
<tr>
<td>Date last Updated</td>
<td>November 1, 2016</td>
</tr>
<tr>
<td>Approved by:</td>
<td>Voting members of the Arrhythmia Management Committee</td>
</tr>
</tbody>
</table>

1.0 Purpose

The Arrhythmia Management Committee is an interdisciplinary team responsible to the Cardiac Care Program. The purpose is to oversee the provision and delivery of evidence based arrhythmia services for patients accessing care.

2.0 Scope, Accountabilities and Responsibilities

2.1 Scope:

- The scope of this committee applies to all activities related to services and modalities used at the Rouge Valley Health System Cardiac Care Program located at the hospital’s two sites and regional network as provided as a regional service.

2.2 The Committee’s Accountabilities:

1. Plan and set overall direction for program development according to the Purpose and Scope of the Committee.
2. Conduct and annual planning exercise that includes internal and external stakeholders for the purpose of developing an annual program work plan (the Work Plan).
3. Based in input from the annual planning exercise, develop an annual plan for approval by the Program Management Committee that address the identified needs of the program;
4. Ensure that major goals and timelines of the Work Plan are achieved and are consistent with the current Cardiac Program Strategic Plan;
5. Collaborate with local healthcare providers and partners as required to achieve the vision, goals and objectives of the Work Plan;
6. Participate in other committee meetings as they relate to the implementation of the Work Plan and other matters before the Committee;
7. Work with to develop and recommend policies, position papers, guidelines and standards appropriate to service initiatives that affect the implementation of the Work Plan;
8. To consult and seek input from other stakeholders on matters before the Committee, if required.

2.3 Committee Responsibilities:

1. To develop and monitor quality care and risk management.
2. To provide utilization review (including waiting list preparation).
3. To prepare operation and staffing budgets and to contribute to the requirements in order to meet corporate, program and financial targets.
4. To propose strategic direction for service and to ensure that strategic planning is consistent for the cardiac program and with corporate direction.
5. To serve as a vehicle to facilitate staff, physician interaction-liaison and relationships.
6. To regularly review resource requirements and their cost effectiveness. Review, approve and/or reject proposals for new or replacement equipment (to assist in the purchasing/budget process) and to recommend purchases to Cardiac Program Management Committee.
7. To regularly review pharmacologic agents and medical devices utilized within the service.
8. Annually review standing orders, policies, procedures and sanctioned medical acts pertaining to staff, drugs and equipment within the service area and to provide reports to clinical committee.
9. To develop and administrate a certification program for medical acts delegated to staff within the service.
10. To encourage and facilitate education opportunities for staff and physicians.
11. To review and approve participation in research activities and to ensure that organizational approval is obtained.
12. To provide an annual report to the Cardiac Care Program Committee, including a bimonthly report of recommendations and improvement initiatives related to quality of care, utilization and administrative planning/budget.

3.0 Membership

3.1 The Committee comprises a representative from the following positions:

<table>
<thead>
<tr>
<th>Position</th>
<th>Member Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>RVHS, Director</td>
<td>Glyn Boatswain</td>
</tr>
<tr>
<td>Medical Manager, Arrhythmia Services</td>
<td>Dr. Amir Janmohamed (Chair)</td>
</tr>
<tr>
<td>Manager Arrhythmia Services and CRSP</td>
<td>Rohan Gonsalves (Co-Chair)</td>
</tr>
<tr>
<td>Coordinator Arrhythmia Services</td>
<td></td>
</tr>
<tr>
<td>Electrophysiologist (internal and external)</td>
<td></td>
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<tr>
<td>Booking Clerk</td>
<td></td>
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<tr>
<td>Arrhythmia specialist</td>
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<tr>
<td>Pharmacist</td>
<td></td>
</tr>
<tr>
<td>Clinical Educator</td>
<td></td>
</tr>
<tr>
<td>Manager Cardiac Care Unit</td>
<td></td>
</tr>
<tr>
<td>Coordinator CCN</td>
<td></td>
</tr>
<tr>
<td>Coordinator Cardiac Diagnostics</td>
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</tr>
<tr>
<td>Volunteer</td>
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<tr>
<td>Foundation</td>
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</tr>
<tr>
<td>IT Support</td>
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</tr>
<tr>
<td>Administrative Support (non-voting)</td>
<td></td>
</tr>
</tbody>
</table>

**Sponsors:**
- VP Patient Services                      | Amelia McCutcheon             |
- Chief of Cardiology                       | Dr. Joe Ricci                 |

- Quorum will be 50% of the voting membership.
- *Ad Hoc* members will not have voting rights.
### 3.2 Administrative Support:
- Administrative support will be provided by Rouge Valley.

### 3.3 Location:
- Meetings are located at the Rouge Valley Centenary site; members may participate by teleconference.

### 4.0 Committee Procedures

#### 4.1 Minutes and Agendas:
- Minutes will be taken and distributed by the Committee’s Administrative Support member. Agenda will be compiled in consultation with committee members.
- Agendas and minutes will be distributed prior to the meeting.

#### 4.2 Absences:
- If a member is absent for three consecutive meetings without notice or justifiable reason, the committee will review their membership.

#### 4.3 Sub-Committees:
- The Committee may establish *ad hoc* sub-committees from time-to-time as required.
- When establishing sub-committees, the Committee will:
  - Approve the sub-committee Terms of Reference;
  - determine membership;
  - establish aims;
  - clearly define a process for decision making

#### 4.4 Reporting Relationship:
- The Committee Chair is responsible for keeping the Program Management Committee informed concerning priorities, progress and evaluation of committee activities.

### 5.0 Meetings

- The committee will meet bi-monthly, every second Thursday, or as required by the Chair(s).
- A standard agenda format will be used for all meetings.
- Minutes and a record of decisions, salient discussions, and Action Items will be kept as documentation.
- Action Items from the previous meeting will be reviewed after the approval of minutes at every meeting.
- Terms of Reference will be reviewed annually.
Committee Name: Catheterization Laboratory Services
Version Number: 2.1
Date last Updated: November 1, 2016
Approved by: Voting Members of the Catheterization Laboratory Services

1.0 Purpose

1. Transform regional cardiac catheterization services to be more integrated with our partner hospitals across the CE LHIN to meet the needs of cardiovascular patients.
2. Provide recommendations, implement quality improvement initiatives and practice enhancement opportunities, based on best practice.

2.0 Scope and Objectives

2.1 Scope:

- The scope of this committee applies to all activities related to services and modalities used at the Rouge Valley Health System Cardiac Care Program located at the hospital’s two sites and regional network as provided as a regional service.

2.2 The Committee’s Accountabilities:

1. Plan and set overall direction for program development according to the Purpose and Scope of the Committee;
2. Conduct and annual planning exercise that includes internal and external stakeholders for the purpose of developing an annual program work plan (the Work Plan);
3. Based in input from the annual planning exercise, develop an annual plan for approval by the Program Management Committee that address the identified needs of the program;
4. Ensure that major goals and timelines of the Work Plan are achieved and are consistent with the current Cardiac Program Strategic Plan;
5. Collaborate with local healthcare providers and partners as required to achieve the vision, goals and objectives of the Work Plan;
6. Participate in other committee meetings as they relate to the implementation of the Work Plan and other matters before the Committee;
7. Work with to develop and recommend policies, position papers, guidelines and standards appropriate to service initiatives that affect the implementation of the Work Plan;
8. To consult and seek input from other stakeholders on matters before the Committee, if required.

2.3 Responsibilities:

1. To enhance the clinical nursing practice
2. To enhance patient, family and staff satisfaction
3. To provide unit-specific input to program and hospital committees as appropriate
4. To communicate team issues and decisions to all members of representative groups and others as appropriate
5. To develop a critical care and ward within the community that provides exemplary quality patient care and promotes best practice for nursing and the interdisciplinary team.
6. To effectively communicate with other non-cardiology physicians, nurses and allied professions, to develop and implement a plan of care for patients undergoing invasive cardiac evaluation.

### 3.0 Membership

#### 3.1 The Committee comprises a representative from the following positions:

<table>
<thead>
<tr>
<th>Position</th>
<th>Member Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>RVHS, Director</td>
<td>Glyn Boatswain</td>
</tr>
<tr>
<td>Medical Manager, Cardiac Catheterization Laboratory</td>
<td>Dr. Saleem Kassam (Chair)</td>
</tr>
<tr>
<td>Manager Cardiac Catheterization Laboratory</td>
<td>Donna Pynn (Co-Chair)</td>
</tr>
<tr>
<td>Cath Lab Nurses</td>
<td></td>
</tr>
<tr>
<td>Coordinator Arrhythmia Services</td>
<td></td>
</tr>
<tr>
<td>Cardiologist (internal and regional)</td>
<td></td>
</tr>
<tr>
<td>Booking Clerk</td>
<td></td>
</tr>
<tr>
<td>Pharmacist</td>
<td></td>
</tr>
<tr>
<td>Clinical Educator</td>
<td></td>
</tr>
<tr>
<td>Manager Cardiac Care Unit</td>
<td></td>
</tr>
<tr>
<td>Regional Managers (TSH, LH)</td>
<td></td>
</tr>
<tr>
<td>Coordinator CCN</td>
<td></td>
</tr>
<tr>
<td>Coordinator Cardiac Diagnostics</td>
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<tr>
<td>Volunteer</td>
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<td>Foundation</td>
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<tr>
<td>IT Support</td>
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<tr>
<td>Administrative Support (non-voting)</td>
<td></td>
</tr>
</tbody>
</table>

**Sponsors:**

| VP Patient Services                          | Amelia McCutcheon                  |
| Chief of Cardiology                          | Dr. Joe Ricci                      |

- Quorum will be 50% of the voting membership.
- *Ad Hoc* members will not have voting rights.

#### 3.2 Administrative Support:
- Administrative support will be provided by Rouge Valley.

#### 3.3 Location:
- Meetings are located at the Rouge Valley Centenary site; members may participate by teleconference.
### 4.0 Committee Procedures

#### 4.1 Minutes and Agendas:
- Minutes will be taken and distributed by the Committee’s Administrative Support member. Agenda will be compiled in consultation with committee members.
- Agendas and minutes will be distributed prior to the meeting.

#### 4.2 Absences:
- If a member is absent for three consecutive meetings without notice or justifiable reason, the committee will review their membership.

#### 4.3 Sub-Committees:
- The Committee may establish *ad hoc* sub-committees from time-to-time as required.
- When establishing sub-committees, the Committee will:
  - Approve the sub-committee Terms of Reference;
  - determine membership;
  - establish aims;
  - clearly define a process for decision making

#### 4.4 Reporting Relationship:
- The Committee Chair is responsible for keeping the Program Management Committee informed concerning priorities, progress and evaluation of committee activities.

### 5.0 Meetings

- The committee will meet bi-monthly every fourth Thursday or as required by the Chair(s).
- A standard agenda format will be used for all meetings.
- Minutes and a record of decisions, salient discussions, and Action Items will be kept as documentation.
- Action Items from the previous meeting will be reviewed after the approval of minutes at every meeting.
- Terms of Reference will be reviewed annually.
1.0 Purpose

The Central East Regional Cardiac Rehabilitation and Secondary Prevention Program Service Committee is an interdisciplinary team that oversees the integration and coordination of cardiac rehabilitation services across the Central East LHIN. The team’s commitment and emphasis is to ensure high quality, safe patient care and the application of evidence based practices.

2.0 Scope, Accountabilities and Responsibilities

2.1 Scope:

- The scope of this committee applies to all activities related to services and modalities used at the Rouge Valley Health System Cardiac Care Program located at the hospital’s two sites and regional network as provided as a regional service.

2.2 The CRSP Accountabilities:

1. Plan and set overall direction for program development according to the Purpose and Scope of the Committee.
2. Conduct an annual planning exercise that includes internal and external stakeholders for the purpose of developing an annual program work plan (the Work Plan).
3. Based in input from the annual planning exercise, develop an annual plan for approval by the Program Management Committee that addresses the identified needs of the program.
4. Ensure that major goals and timelines of the Work Plan are achieved and are consistent with the current Cardiac Program Strategic Plan.
5. Collaborate with local healthcare providers and partners as required to achieve the vision, goals and objectives of the Work Plan.
6. Participate in other committee meetings as they relate to the implementation of the Work Plan and other matters before the Committee.
7. Work with to develop and recommend policies, position papers, guidelines and standards appropriate to service initiatives that affect the implementation of the Work Plan.
8. To consult and seek input from other stakeholders on matters before the Committee, if required.

2.3 Primary Responsibilities:

1. To improve access to equitable and timely cardiac rehabilitation services across the CE LHIN.
2. To emphasize the importance of integration and seamlessness in service delivery.
   2.1. To improve quality and health/wellbeing.
   2.2. Commitment to high quality, safe patient care.
   2.3. Focuses on improving the patient experience.
3. To improve resource utilization and cost effectiveness.
   3.1. Regional partners will support and sustain fiscal responsibilities.
4. To ensure quality information management.
   4.1. Centralized referral and intake processes
   4.2. Single web based clinical management system (London CVIS)
   4.3. Robust outcome data to measure efficacy of service and guide quality improvement.
5. To provide a forum for discussion regarding strategic direction for service.
5.1. To ensure that strategic planning is consistent with the Central East LHIN Vascular Strategy and Rouge Valley’s Cardiac strategic vision.

6. To serve as a vehicle to facilitate interaction between staff, clinicians and other health professionals involved in the delivery of Cardiac Rehabilitation & Secondary Prevention services across the Scarborough and Durham region.

7. To regularly review pharmacologic agents and medical devices utilized within the service.
7.1. Recommendations for change to be provided to Cardiac Clinical Committee.

8. To review standing orders, policies, procedures and sanctioned medical acts pertaining to staff, drugs and equipment within the service area and to provide reports to clinical committee – policies affecting patient care require the approval of 50% of the physicians.

9. To ensure compliance for medical acts delegated to staff within the service.
10. To encourage and facilitate education opportunities for staff and physicians.
11. To review and approve participation in research activities and to ensure that organizational approval is obtained.
12. To provide quarterly reports to the Central East LHIN, including a report of recommendations and improvement initiatives related to quality of care, utilization and administrative planning/budget.

3.0 Membership

3.1 The CRSP Committee comprises representatives from the following positions:

<table>
<thead>
<tr>
<th>Position</th>
<th>Member Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>RVHS, Director</td>
<td>Glyn Boatswain</td>
</tr>
<tr>
<td>Medical Manager, Cardiac Catheterization Lab</td>
<td>Dr. Joe Ricci (Chair)</td>
</tr>
<tr>
<td>Manager, CRSP</td>
<td>Rohan Gonsalves (Co-Chair)</td>
</tr>
<tr>
<td>Cardiologist (internal and regional)</td>
<td></td>
</tr>
<tr>
<td>Pharmacist</td>
<td></td>
</tr>
<tr>
<td>Clinical Educator</td>
<td></td>
</tr>
<tr>
<td>Manager Cardiac Care Unit</td>
<td></td>
</tr>
<tr>
<td>Regional Administrative Managers Hospitals CE LHIN</td>
<td></td>
</tr>
<tr>
<td>Coordinator, Regional Cardiovascular Rehabilitation</td>
<td></td>
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<tr>
<td>Kinesiologists</td>
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<tr>
<td>Volunteer</td>
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<tr>
<td>Community Partners</td>
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<td>Foundation</td>
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</table>

Sponsors:

<table>
<thead>
<tr>
<th>VP Patient Services</th>
<th>Amelia McCutcheon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief of Cardiology</td>
<td>Dr. Joe Ricci</td>
</tr>
</tbody>
</table>

- Quorum will be 50% of the voting membership.
- Ad Hoc members will not have voting rights.
3.2 Administrative Support:
- Administrative support will be provided by Rouge Valley.

3.3 Location:
- Meetings are located at the Rouge Valley Centenary site; members may participate by teleconference.

4.0 Committee Procedures

4.1 Minutes and Agendas:
- Minutes will be taken and distributed by the Committee’s Administrative Support member. Agenda will be compiled in consultation with committee members.
- Agendas and minutes will be distributed prior to the meeting.

4.2 Absences:
- If a member is absent for three consecutive meetings without notice or justifiable reason, the committee will review their membership.

4.3 Sub-Committees:
- The committee may establish ad hoc sub-committees from time-to-time as required.
- When establishing sub-committees, the Committee will:
  o Approve the sub-committee Terms of Reference;
  o determine membership;
  o establish aims;
  o clearly define a process for decision making

4.4 Reporting Relationship:
- The Chair is responsible for keeping the Program Management Committee informed concerning priorities, progress and evaluation of committee activities.

5.0 Meetings

- The committee will meet bi-monthly every fourth Thursday or as required by the Chair(s).
- A standard agenda format will be used for all meetings.
- Minutes and a record of decisions, salient discussions, and Action Items will be kept as documentation.
- Action Items from the previous meeting will be reviewed after the approval of minutes at every meeting.
- Terms of Reference will be reviewed annually.
### 1.0 Purpose

The Data Management Committee (DMC) has been established to:

1. Provide for the governance, coordination, oversight and guidance to the development of IT solutions for the cardiovascular program at RVHS (the ‘Program’);
2. Work with stakeholder to identify and define business requirements for IT solutions;
3. Communicate business requirements to IT Branch for development;
4. Ensure patient confidentiality is protected.

### 2.0 Scope, Accountabilities and Responsibilities

#### 2.1 Scope:

- The scope of this committee applies to all activities related to IT services and modalities used at the Rouge Valley Health System Cardiac Care Program located at the hospital’s two sites or provided as a regional service.

#### 2.2 The DMC primary objectives are to:

1. Plan and set overall direction for IT development and solutions according to the Purpose and Scope of the Committee;
2. Identify and pursue strategies to improve efficiencies through the application of technology;
3. Recommend priorities for new technology initiatives that benefit the Program;
4. Develop methods and processes to ensure program data is available for program management;
5. Define the information needs and gaps of programs;
6. Develop change management and approval processes for the development and approval of information and IT solutions;
7. Develop an Annual IT Development Work Plan (the ‘Work Plan’) that address the identified IT and information needs and gaps of programs;
8. Ensure that major goals and timelines of the Work Plan are achieved;
9. Collaborate with local healthcare providers as required to achieve the goals of the Work Plan;
10. Participate in IT Department meetings as they relate to the implementation of the Work Plan and other matters before the Committee;
11. Work with IT to develop and recommend policies, position papers, guidelines and standards appropriate to technology initiatives that affect Program effectiveness and the implementation of the Work Plan;
12. To consult and seek input from other stakeholders on IT matters before the Committee, if required.
3.0 Membership

3.1 The DMC comprises a representative from the following positions:

<table>
<thead>
<tr>
<th>Position</th>
<th>Member Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>RVHS, Director</td>
<td>Glyn Boatswain</td>
</tr>
<tr>
<td>RVHS, Medical Manager (Co-Chair)</td>
<td>Dr. Joe Ricci</td>
</tr>
<tr>
<td>RVHS, VP and Sponsor</td>
<td>Amelia McCutcheon</td>
</tr>
<tr>
<td>Data Quality Manager (Co-Chair)</td>
<td>John Lohrenz</td>
</tr>
<tr>
<td>Regional Health Care Professional Manager</td>
<td>Donna Pynn</td>
</tr>
<tr>
<td>Regional Data Management</td>
<td>Rohan Gonsalves</td>
</tr>
<tr>
<td>Data Management Coordinator</td>
<td>Anand Negi</td>
</tr>
<tr>
<td>Director, Bio-Medical Engineering</td>
<td>Siamak Sadr</td>
</tr>
<tr>
<td>Physician Representative</td>
<td>Dr. Saleem Kassam</td>
</tr>
<tr>
<td>Physician Representative</td>
<td>Dr. Derek Yung</td>
</tr>
<tr>
<td>Philips Representative, ex officio</td>
<td>TBD</td>
</tr>
<tr>
<td>RVHS Cardiac Physician Research</td>
<td>Dr. Paul Galiwango</td>
</tr>
<tr>
<td>CELHIN CHF Physician Lead</td>
<td>Dr. Sarah Ipekian</td>
</tr>
<tr>
<td>CIO/VP or designate</td>
<td>Thodoros Topaloglou, PhD</td>
</tr>
<tr>
<td>Representative from established sub-committees</td>
<td>As Required</td>
</tr>
<tr>
<td>Administrative Support (non-voting)</td>
<td>TBD</td>
</tr>
</tbody>
</table>

- Quorum will be 50% of the voting membership.
- *Ad Hoc* members will not have voting rights.

3.2 Administrative Support:
- Administrative support will be provided by Rouge Valley.

3.3 Location:
- Meetings are located at the Rouge Valley Centenary site; members may participate by teleconference.

4.0 Committee Procedures

4.1 Minutes and Agendas:
- Minutes will be taken and distributed by the Committee’s Administrative Support member. Agenda will be compiled in consultation with committee members.
- Agendas and minutes will be distributed prior to the meeting.

4.2 Absences:
• If a member is absent for three consecutive meetings without notice or justifiable reason, the committee will review their membership.

4.3 Sub-Committees:
• The committee may establish *ad hoc* sub-committees from time-to-time as required.
• When establishing sub committees, the committee will:
  o Approve the sub-committee Terms of Reference;
  o determine membership;
  o establish aims;
  o clearly define a process for decision making

4.4 Reporting Relationship:
• The Chair is responsible for keeping the Program Management Committee informed concerning priorities, progress and evaluation of committee activities.

5.0 Meetings

• The committee will meet quarterly or as required by the Chair(s).
• A standard agenda format will be used for all meetings.
• Minutes and a record of decisions, salient discussions, and Action Items will be kept as documentation.
• Action Items from the previous meeting will be reviewed after the approval of minutes at every meeting.
• Terms of Reference will be reviewed annually.
• Sub-committee meetings will occur outside of Steering Committee times.
• The Chair of the sub-committee is responsible for providing updates to the Committee
1.0 Purpose

1. The interdisciplinary Cardiac Program Management Committee provides ongoing strategic direction in the areas of Clinical Service Activity, Quality Improvement, Risk Management, Communication, Education, Research, Operations, Budget and planning.
2. The strategic direction of the program committee will reinforce the overall strategic directions of the corporation and program.
3. To act as a decision making and oversight committee to review and approve service committee level reports, annual work plans, and any other documents needed to fulfill each committee’s purpose and scope.

2.0 Scope, Accountabilities and Responsibilities

2.1 Scope:

- The scope of this committee applies to all activities related to services and modalities used at the Rouge Valley Health System Cardiac Care Program located at the hospital’s two sites and regional network as provided as a regional service.

2.2 The Committee’s Accountabilities:

1. Plan and set overall direction for program development according to the Purpose and Scope of the Committee.
2. To provide service level committee approvals and oversight.
3. Conduct a strategic and annual planning exercise that includes internal and external stakeholders for the purpose of developing an annual program work plan (the Work Plan).
4. Based in input from the annual planning exercise, develop an annual plan that addresses the identified needs of the program.
5. Ensure that major goals and timelines of the Work Plan are achieved and are consistent with the current Cardiac Program Strategic Plan.
6. Collaborate with local healthcare providers and partners as required to achieve the vision, goals and objectives of the Work Plan.
7. Participate in other committee meetings as they relate to the implementation of the Work Plan and other matters before the Committee.
8. Work with to develop and recommend policies, position papers, guidelines and standards appropriate to service initiatives that affect the implementation of the Work Plan.
9. To consult and seek input from other stakeholders on matters before the Committee, if required.
2.3 Responsibilities:

1. To provide direction and support to Cardiac Program Services to ensure quality, customer-focused, evidence-based cardiac care delivery.
2. Receive regular standardized reports from medical and administration leadership teams related to:
3. Quality care and risk management indicators
4. Utilization indicators and related performance improvement initiatives
5. Budget and budget analysis
6. Identification of future resource requirements
7. To promote linkages and integration with other programs, services consumers and community.
8. To ensure follow-up on annual strategic planning recommendations utilizing measurement indicators.
9. To ensure Cardiac Program staff and physicians actively participate in external committees, task forces, government activities related to cardiac project planning and care at the regional, national and international levels.
10. To ensure clear lines of communication to internal program staff, hospital staff, CE LHIN, the Ministry of Health and Long-Term Care, hospital foundation, agencies, consumers, and the media.

3.0 Membership

3.1 The Committee comprises a representative from the following positions:

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>RVHS, Director</td>
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</tr>
<tr>
<td>Chief of Cardiology</td>
<td>Dr. Joe Ricci (Chair)</td>
</tr>
<tr>
<td>Medical Manager, Arrhythmia Services</td>
<td>Dr. Amir Janmohamed</td>
</tr>
<tr>
<td>Medical Manager, Cardiac Diagnostics</td>
<td>Dr. Paul Galiwango</td>
</tr>
<tr>
<td>Medical Manager, Catheterization Laboratory</td>
<td>Dr. Saleem Kassam</td>
</tr>
<tr>
<td>Medical Manager, Clinical Services</td>
<td>Dr. Nisha D’Mello</td>
</tr>
<tr>
<td>Medical Manager, CRSP</td>
<td>Dr. Joe Ricci</td>
</tr>
<tr>
<td>Administrative Manager, Catheterization Laboratory</td>
<td>Donna Pynn</td>
</tr>
<tr>
<td>Administrative Manager, CCU</td>
<td>Evangeline Andaya</td>
</tr>
<tr>
<td>Administrative Manager, CRSP and Arrhythmia</td>
<td>Rohan Gonsalves</td>
</tr>
<tr>
<td>Administrative Manager, IT</td>
<td>Thodoros Topaloglou</td>
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<tr>
<td>Foundation Chair</td>
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<tr>
<td>Administrative Support (non-voting)</td>
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<tr>
<td><strong>Sponsors:</strong></td>
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</tr>
<tr>
<td>VP Patient Services</td>
<td>Amelia McCutcheon</td>
</tr>
</tbody>
</table>

- Quorum will be 50% of the voting membership.
- *Ad Hoc* members will not have voting rights.
### 3.2 Administrative Support:
- Administrative support will be provided by Rouge Valley.

### 3.3 Location:
- Meetings are located at the Rouge Valley Centenary site; members may participate by teleconference.

### 4.0 Committee Procedures

#### 4.1 Minutes and Agendas:
- Minutes will be taken and distributed by the Committee’s Administrative Support member. Agenda will be compiled in consultation with committee members.
- Agendas and minutes will be distributed prior to the meeting.

#### 4.2 Absences:
- If a member is absent for three consecutive meetings without notice or justifiable reason, the committee will review their membership.

#### 4.3 Sub-Committees:
- The Committee may establish *ad hoc* sub-committees from time-to-time as required.
- When establishing sub-committees, the Committee will:
  - Approve the sub-committee Terms of Reference;
  - determine membership;
  - establish aims;
  - clearly define a process for decision making

#### 4.4 Reporting Relationship:
- The Committee Chair is responsible for keeping the Program Management Committee informed concerning priorities, progress and evaluation of committee activities.

### 5.0 Meetings

- The committee will meet bi-monthly on the first Thursday, or as required by the Chair(s).
- A standard agenda format will be used for all meetings.
- Minutes and a record of decisions, salient discussions, and Action Items will be kept as documentation.
- Action Items from the previous meeting will be reviewed after the approval of minutes at every meeting.
- Terms of Reference will be reviewed annually.
Committee Name: Cardiac Diagnostics
Version Number: 1.3
Date last Updated: November 1, 2016
Approved by: Voting members of the Cardiac Diagnostics Committee

1.0 Purpose

1. The Cardiac Diagnostics Committee is an interdisciplinary team responsible to the Cardiac Care Program. The purpose is to oversee the provision and delivery of evidence based services for patients accessing care.
2. Provide recommendations, implement quality improvement initiatives and practice enhancement opportunities, based on best practice.

2.0 Scope, Accountabilities and Responsibilities

2.1 Scope:
- The scope of this committee applies to all activities related to services and modalities used at the Rouge Valley Health System Cardiac Care Program located at the hospital's two sites and regional network as provided as a regional service.

2.2 The Committee’s Accountabilities:
1. Plan and set overall direction for program development according to the Purpose and Scope of the Committee;
2. Conduct and annual planning exercise that includes internal and external stakeholders for the purpose of developing an annual program work plan (the Work Plan).
3. Based in input from the annual planning exercise, develop an annual plan for approval by the Program Management Committee that address the identified needs of the program;
4. Ensure that major goals and timelines of the Work Plan are achieved and are consistent with the current Cardiac Program Strategic Plan;
5. Collaborate with local healthcare providers and partners as required to achieve the vision, goals and objectives of the Work Plan;
6. Participate in other committee meetings as they relate to the implementation of the Work Plan and other matters before the Committee;
7. Work to develop and recommend policies, position papers, guidelines and standards appropriate to service initiatives that affect the implementation of the Work Plan;
8. To consult and seek input from other stakeholders on matters before the Committee, if required.

2.3 Responsibilities:
1. To develop and monitor quality care and risk management indicators.
2. To provide utilization review
3. To review operation and staffing budgets and to contribute to the requirements in order to meet
4. To propose strategic direction for service and to ensure that strategic planning is consistent for the cardiac program and with corporate direction.
5. To serve as a vehicle to facilitate staff, physician interaction-liaison and relationships.
6. To regularly review resource requirements and their cost effectiveness. Review, approve and/or reject proposals for new or replacement equipment (to assist in the purchasing/budget process) and to recommend purchases to Cardiac Program Management Committee.
7. To regularly review pharmacologic agents and medical devices utilized within the service. Recommendations for change to be provided to Cardiac Clinical Committee, Cardiac Program Management and other committees as need.
8. Annually review standing orders, policies, procedures and sanctioned medical acts pertaining to staff, drugs and equipment within the service area and to provide reports to clinical committee.
9. To encourage and facilitate education opportunities for staff and physicians.
10. To review and approve participation in research activities and to ensure that organizational approval is obtained.
11. To provide an annual report to the Cardiac Program Management Committee, including a bimonthly report of recommendations and improvement initiatives related to quality of care, utilization and administrative planning/budget.

3.0 Membership

3.1 The Committee comprises a representative from the following positions:

<table>
<thead>
<tr>
<th>Position</th>
<th>Member Name</th>
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<tbody>
<tr>
<td>RVHS, Director</td>
<td>Glyn Boatswain</td>
</tr>
<tr>
<td>Medical Manager, Cardiac Diagnostic Imaging</td>
<td>Dr. Paul Galiwango (Chair)</td>
</tr>
<tr>
<td>Manager Arrhythmia Services and CRSP</td>
<td>Rohan Gonsalves (Co-Chair)</td>
</tr>
<tr>
<td>Charge Tech. Cardiac Diagnostics</td>
<td></td>
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<tr>
<td>Cardiologists</td>
<td></td>
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<tr>
<td>Echo Cardiographers, Cardiac Technicians</td>
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<tr>
<td>Booking Clerk</td>
<td></td>
</tr>
<tr>
<td>Coordinator, Arrhythmia Services</td>
<td></td>
</tr>
<tr>
<td>Manager Cardiac Catheterization Laboratory</td>
<td></td>
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<tr>
<td>Pharmacist</td>
<td></td>
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<tr>
<td>Clinical Educator</td>
<td></td>
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<tr>
<td>Manager Cardiac Care Unit</td>
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<tr>
<td>Coordinator CCN</td>
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<td>Coordinator Cardiac Diagnostics</td>
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<td>Volunteer</td>
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<td>Administrative Support (non-voting)</td>
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</table>

**Sponsors:**

- VP Patient Services: Amelia McCutcheon
- Chief of Cardiology: Dr. Joe Ricci
- Quorum will be 50% of the voting membership.
- *Ad Hoc* members will not have voting rights.

### 3.2 Administrative Support:
- Administrative support will be provided by Rouge Valley.

### 3.3 Location:
- Meetings are located at the Rouge Valley Centenary site; members may participate by teleconference.

### 4.0 Committee Procedures

#### 4.1 Minutes and Agendas:
- Minutes will be taken and distributed by the Committee’s Administrative Support member. Agenda will be compiled in consultation with committee members.
- Agendas and minutes will be distributed prior to the meeting.

#### 4.2 Absences:
- If a member is absent for three consecutive meetings without notice or justifiable reason, the committee will review their membership.

#### 4.3 Sub-Committees:
- The Committee may establish *ad hoc* sub-committees from time-to-time as required.
- When establishing sub-committees, the Committee will:
  - Approve the sub-committee Terms of Reference;
  - determine membership;
  - establish aims;
  - clearly define a process for decision making

#### 4.4 Reporting Relationship:
- The Committee Chair is responsible for keeping the Program Management Committee informed concerning priorities, progress and evaluation of committee activities.

### 5.0 Meetings

- The committee will meet bi-monthly every third Thursday or as required by the Chair(s).
- A standard agenda format will be used for all meetings.
- Minutes and a record of decisions, salient discussions, and Action Items will be kept as documentation.
- Action Items from the previous meeting will be reviewed after the approval of minutes at every meeting.
- Terms of Reference will be reviewed annually.
1.0 Purpose

The Cardiovascular Research Steering Committee (CRSC) has been established to:

1. Provide for the governance, coordination, oversight and guidance to the research of cardiovascular disease and services conducted at RVHS;
2. Identify research opportunities and promote the research of cardiovascular disease and services at RVHS;
3. Evaluate and recommend research opportunities;
4. Ensure patient confidentiality is protected;
5. Ensure compliance with RVHS Research Ethics Board policies and guidelines.

2.0 Scope, Accountabilities and Responsibilities

2.1 Scope:

1. The scope of this committee applies to all research related to the activities of the Rouge Valley Health System Cardiac Care Program or cardiovascular disease related services located within the hospital’s two sites or provided as a regional service; and,
2. Research related to clinical and process management outcomes with the potential to contribute to improvement in clinical outcomes or risk, increased service efficiency, secondary prevention and change in health care policy.

2.2 The CRSC primary objectives are to:

1. Plan and set overall direction for research according to the Purpose and Scope of the Committee;
2. Develop an Annual Cardiovascular Research Work Plan (the ‘Work Plan’);
3. Ensure that major goals and timelines of the Work Plan are achieved;
4. Receive, review and approve amendments to the Work Plan and research activities;
5. Receive, review, and approvals new research activities and projects;
6. Identifying and pursuing strategies to secure adequate funding needed to implement the approved Work Plan;
7. Adopt, develop, and apply best practices for the research of cardiovascular disease and services;
8. Develop, maintain and support collaborative research relationships with other hospitals, academic centres and research organizations;
9. Provide expert advice, or engage experts to provide advice on evaluation topics, methodologies, and research projects and activities;
10. Coordinate and integrate research activities and projects to ensure accuracy, data quality, and
consistency of results;
11. Ensure established data quality and quality assurance processes have been followed in the conduct of all research projects;
12. Review and approve research project results prior to their distribution or publication;
13. Establish the timing, content, scope, format and release of research project material;
14. Work internally and with other research organizations to facilitate access to clinical research data;
15. Actively promote knowledge translation of research results as the identification and implementation of best practices in health care, including knowledge synthesis, guideline development, and knowledge dissemination and implementation; and
16. Communicate and promote our activities within the RVHS, our stakeholders, within the larger academic, research, and clinical communities, and with the Ministry of Health and Long-Term Care and the Central East LHIN.

3.0 Membership

3.1 The CRSC comprises a representative from the following positions:

<table>
<thead>
<tr>
<th>Position</th>
<th>Member Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>RVHS Admin Manager CVRSP</td>
<td>Glyn Boatswain</td>
</tr>
<tr>
<td>RVHS Medical Manager CVRSP (Co-Chair)</td>
<td>Dr. Joe Ricci</td>
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<tr>
<td>RVHS Analytics (Co-Chair)</td>
<td>John Lohrenz</td>
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<tr>
<td>Regional CVRSP Health Care Professional Manager</td>
<td>Donna Pynn</td>
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<tr>
<td>Regional CVRSP Data Management</td>
<td>Rohan Gonsalves</td>
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<tr>
<td>Research Partner</td>
<td>TBD</td>
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<td>Research Partner</td>
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<td>Research Partner</td>
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<tr>
<td>Additional Project Leads as required</td>
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<tr>
<td>ICES Scientist</td>
<td>Dr. Neville Suskin</td>
</tr>
<tr>
<td>CELHIN Vascular Aim Committee</td>
<td>Kasia Luebke, PhD</td>
</tr>
<tr>
<td>RVHS Cardiac Physician Research</td>
<td>Dr. Paul Galiwango</td>
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<tr>
<td>CELHIN CHF Physician Lead</td>
<td>Dr. Sarah Ipekian</td>
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<tr>
<td>Director of IT/IM, or designate</td>
<td>Thodoros Topaloglou, PhD</td>
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<tr>
<td>Representative from established sub-committees</td>
<td>As Required</td>
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<tr>
<td>Administrative Support (non-voting)</td>
<td>TBD</td>
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- Members are asked to serve a two-year term with an option to serve an additional two-year term. For the first appointments only, terms may alternate between 1 and 2 years to assure committee transition.
- Quorum will be 50% of the voting membership.
- Ad Hoc members will not have voting rights.
- Additional Research Project Leads may be added as Research Projects are approved and added to the Work Plan.

3.2 Administrative Support:
- Administrative support will be provided by Rouge Valley.
3.3 Location:
- Meetings are located at the Rouge Valley Ajax or Centenary sites; members may participate by teleconference.

4.0 Cardiovascular Research Steering Committee Procedures

4.1 Minutes and Agendas:
- Minutes will be taken and distributed by the Committee’s Administrative Support member. Agenda will be compiled in consultation with committee members.
- Agendas and minutes will be distributed three days prior to the meeting. Minutes will be distributed within one week following the meeting.

4.2 Absences:
- If a member is absent for three consecutive meetings without notice or justifiable reason, the committee will review their membership.

4.3 Sub-Committees:
- The CRSC may establish ad hoc sub-committees from time-to-time as required.
- When establishing sub-committees, the Steering Committee will:
  - Approve the sub-committee Terms of Reference;
  - determine membership;
  - establish aims;
  - clearly define a process for decision making

4.4 Reporting Relationship:
- The Steering Committee Chair is responsible for keeping the Board of Directors informed concerning priorities, progress and evaluation of committee activities.

5.0 Meetings

- The committee will meet once per month or as required by the Chair(s).
- A standard agenda format will be used for all meetings.
- Project Leads will provide updates on their projects at each meeting.
- Minutes and a record of decisions, salient discussions, and Action Items will be kept as documentation.
- Action Items from the previous meeting will be reviewed after the approval of minutes at every meeting.
- Terms of Reference will be reviewed annually.
- Sub-committee meetings will occur outside of Steering Committee times.
  - The Chair of the sub-committee is responsible for providing updates to the Steering Committee
## Item 14, Engagement Events and Participants

<table>
<thead>
<tr>
<th>Cardiovascular &amp; Secondary</th>
<th>Clinical Services</th>
<th>Cath Lab</th>
<th>Cardiac Imaging</th>
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<tr>
<td><strong>Event Dates:</strong></td>
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<tr>
<td><strong>Cardiologists</strong></td>
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<tr>
<td>Dr. Nisha D’Mello</td>
<td>All cardiologists</td>
<td>Dr. Saleem Kassam</td>
<td>Dr. Galiwango, Paul</td>
<td>Dr. Amir Janmohamed</td>
</tr>
<tr>
<td>Dr. Sarah Armstrong</td>
<td>Dr. Ashok Mukherjee</td>
<td>Dr. Sarah Armstrong</td>
<td>Dr. Bhavanesh Makanjee</td>
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<tr>
<td>Dr. Galiwango, Paul</td>
<td>Dr. Peter Gladstone</td>
<td>Dr. Nisha D’Mello</td>
<td>Dr. Derek Yung</td>
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<tr>
<td>Dr. Saleem Kassam</td>
<td>Dr. Vijay</td>
<td>Dr. Roland Leader</td>
<td>Dr. Au</td>
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<td></td>
<td>Dr. Jason Burstein</td>
<td>Dr. Raymond Yan</td>
<td>Dr. Saleem</td>
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<td></td>
<td>Dr. Galiwango, Paul</td>
<td>Dr. Ashok Mukherjee</td>
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<td>Dr. Janmohamed</td>
<td>Dr. Jim Swan</td>
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<tr>
<td><strong>Regional Partners</strong></td>
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<tr>
<td>Dr J Cherry</td>
<td>Dr. J. Cherry</td>
<td>Dr. Mo Tahiliani</td>
<td>Dr. Davies</td>
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<td>Dr. R. Tahliani</td>
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<tr>
<td>Dr. Kirsh</td>
<td>Dr. James Cherry</td>
<td>Ethel Doyle</td>
<td>TSH vascular Surgeon</td>
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<td>Jodi Dunn</td>
<td>Dr. Davies</td>
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<tr>
<td>Sue Evans</td>
<td>Dr Michael Ling or Wayne Ho Pikong</td>
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<td>Dr. Mo. Tahiliani</td>
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<tr>
<td>Lorraine Carrington - Director</td>
<td>Dr. Assaad Bak Bak</td>
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<td>Patricia Osgood - TSH Manager</td>
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<td>Ethel Doyle</td>
<td>Dr. Chris Li</td>
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<td>Patricia Osgood</td>
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<td>Tabitta Carroll</td>
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<td><strong>Other RVHS Physicians and Leadership</strong></td>
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<tr>
<td>Katherine Craine</td>
<td>Dr. Ari Bay</td>
<td>Dr. Gary Mann</td>
<td>Dr. Patel (K)</td>
<td>Dr. Hartley</td>
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<td>Chad Hanna</td>
<td>Dr. Butchey</td>
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<td>Dr. Yassa Teraiza</td>
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<td>Dr. Medi Maki</td>
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<td>Dr. Gary Mann</td>
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<td>Dr. Jaweed Kokar (RVAP)</td>
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<tr>
<td><strong>Internal Staff</strong></td>
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<td>Pharmacist- Joseph Chin or Tony Cheng</td>
<td>9W Charge Nurse - Joann Black</td>
<td>Anita Feriera</td>
<td>Lana Kotyk</td>
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<tr>
<td>Lori Van Hangen</td>
<td>Camille Robinson</td>
<td>Anand Negi</td>
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<td>Paul Van Weichen</td>
<td>Vangie Andaya and Alison Eichler</td>
<td>CCU Charge - Kathy Grunberg or Lenora Simpson</td>
<td>Rosella - tech</td>
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<tr>
<td>Amber Heath - Coordinator</td>
<td>Kristen Turcotte</td>
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<td>Booking Clerk - Padma Manohar</td>
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<tr>
<td>Joseph Chin</td>
<td>Mira Finley</td>
<td>Booking Clerk - Andrea Wright</td>
<td>Jeff Plummer</td>
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<tr>
<td>CCU Charge Nurse RVC - Kelly Rainey</td>
<td>Booking Clerk – Grace Park</td>
<td>Jackie Yigotiv</td>
<td>Judy Tross</td>
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<tr>
<td>Tony Ho-Business Manager</td>
<td>Enteral - Nurse</td>
<td>Hesham (Sham) Khowessah</td>
<td>Tammy Murray</td>
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<td>Janet Traverse</td>
<td>Faye - Nurse</td>
<td>Mike Wilson</td>
<td>Liz Laporte</td>
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<td>Sheena</td>
<td>Glen Gardner</td>
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<td>Chris Jones</td>
<td>Tony Ho - business manager</td>
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<td>Booking Clerk – Michelle Mitchel</td>
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<td>Ramona Visser</td>
<td>Camille Robinson</td>
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<td>Andrea Allen - Charge Nurse</td>
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<td>Janoa Blaize</td>
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<td>Yolanda Chin - Nurse</td>
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<td>Mira Finley</td>
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<tr>
<th><strong>External Guests</strong></th>
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<tbody>
<tr>
<td>James Meloche</td>
<td>Adam Thurston - Toronto EMS</td>
<td>Avnish Mehta</td>
<td></td>
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<tr>
<td>Trixie Williams</td>
<td>Dave Mokendanz - Durham EMS</td>
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<tr>
<td>Michelle James</td>
<td>Trixie Williams</td>
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<thead>
<tr>
<th><strong>Core Group (Attended all events)</strong></th>
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</thead>
<tbody>
<tr>
<td>Dr. Ricci</td>
<td>Amelia McCutcheon</td>
<td>Glyn Boatswain</td>
<td>Donna Pynn</td>
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<tr>
<td>Scott Ovenden</td>
<td>Callum Anderson</td>
<td>Tara Theakston</td>
<td>Rohan Gonsalves</td>
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Item 15, Rouge Valley Regional Cardiac Care Program: An Integrated Regional Model of Cardiac Care

Background

The program contacted the consulting firm of Marriott and Mable in March 2016 as part of the basis for the strategic planning process to document the program’s “…fuller scheme of structures, processes and mechanisms that span a continuum of cardiac care” (Marriott and Mable, 2). The project team felt, consistent with comprehensive planning, that a third part assessment of the program would provide critical program information on our capability to achieve our transformational goals over the next five years. In particular, the West Durham report, while posing no threat to any single hospital program, has the potential to disrupt an integrated regional program whose geography spans and encompasses two geographies and hospital corporations. Although the Minister recognized and praised the program as a regional program, it is incumbent on the team to assess the program fit against as an integrated regional model. These models have their integrity based on a natural service catchment of patients and the delivery of care as a system of care. The outcome of this assessment is therefore a defining input into the strategic planning process and sets the path forward: Do we plan for a regional program with services delivered as a system of care, or do we plan for individual services within the program?

Process

The consultants worked closely with the project team to define and understand the program itself and ‘…its framework of integrated structures, processes and mechanisms’ (2). Interviews with all team staff were conducted to set the baseline of information, and this included providing the agreements, policies, terms of reference of committees, and other documents. A selected literature review was conducted to underpin the review and augment the author’s own work in health system integration and reform. The literature backdrop provided a contrast for the assessment of the program, and once the author’s settle on this, the program is compared and contrasted against the backdrop. The final stage of the assessment, having settled on the program as a regional model, is to present the program’s opportunities and challenges for its future.

What they Found

The consultants presented their model of regional health care, summarized in the Appendix of their report, and conclude that against those criteria the Rouge cardiac program is functional model of regional health care delivery, one that is unique in Ontario (i). The criteria used by the consultants for the backdrop are:

1. Responsibility, how much/to what extent for key elements/aspects of the program, organization.
2. People, or Populations as expressed in the aggregate, to identify communities of location or need.
3. Providers, individual or organizational, within and across various sectors of healthcare, collaboration.
4. Services for which providers or others are (or have been deemed) responsible and their interactivity.
5. Information and other technologies designed to support population focus and interactive services.
6. Funding available, whether and how it relates to population, range of services provided, goals (5).

The Rouge program was tested against these criteria were fully aligned in the program model, as outlined below:

- A Clear Definition of the Regional Population Served
- Tangible Commitment to a Regional Program (Population, Providers, Services)
- Regional Governance Structures and Mechanisms
  - LHIN oversight for the Province and overarching policy, input and support to RVRCCP
  - RV/Centenary Hospital Board and Regional Program Leadership
  - Corporate Agreements with Regional Hospital Partners and Physician Participants
  - Regional Management Committees
- Regional Program Administration: Unified Administrative and Medical Management
  - Unified Management Structure
  - Management Committees and Roles
  - Inclusive Strategic Planning
- A Patient-Centred Regional Continuum of Care That Begins in the Community
  - Systems of Care
  - Hub and Spoke Configuration
  - Motivations and Benefits for Stakeholders
  - Central referral, acceptance and booking, coordinating mechanisms across region
- Supportive Information and Technology
- Base and Focused Funding (9)

Recommendations for the Program

The analysis by the authors that compared the model of regional care to the Rouge program showed the two were fully aligned. This finding resulted in a set of recommendations for the program to first ‘do no harm’ and secondly, to enhance the program. These objectives are approached in three stages: First, there is a set of recommendations on interim steps, Second, development of proposals for a longer-term solution to solidify the regional program under a new governance structure, and Third, to address challenges for a program ahead of its time (28). The key recommendations under the first two stages are:

Interim Steps

1. Request public assurances from the Minister’s Representative/Advisor, Mr. Mark Rochon, to reinforce that the RVRCCP will remain intact.
2. Hold the RVRCCP structures, processes and mechanisms of its success paramount as a vision parallel to the hospital restructure process. Calibrate any concurrent initiatives to
not undermine but strengthen the capacity of the Regional Program.

3. Formal recognition of the RVRCCP - Consider maintaining the Program name as distinct from the hospital base, to clarify its positioning and ‘brand’ for best recognition by the public.

4. Establish a separate RVRCCP Advisory Board/of Directors - for Program oversight, accountable to the CE LHIN.

5. Maintain and strengthen ties between the Program and the CE LHIN to continue to build on their progress.

6. Strengthen the current Program MOU’s and Agreements to ensure a seamless transition for the Regional Program to continue with its two ‘new’ and other hospital organizational partners, based on expanded regional accountabilities and other areas desired for update.

7. Establish a RVRCCP Planning and Development group, comprised of Regional Program Leadership, to work with and support the goals of hospital restructuring and mergers, while guarding against divisive perceptions and inadvertent impacts.

8. Maintain an independent parallel track to the hospital restructuring and merger processes, to sustain Program framework and processes.

9. Strengthen and broaden local input, with the CE LHIN, provider and communities.

**Long Term Development**

1. Operation as an Independent, Regional Program - The Program could begin operation as a singular, independent, Regional Program and funding, across existing hospital relationships.

2. RVRCCP as a Formalized Regional/Corporate/Entity - The RVRCCP might also explore the development of a proposal to transform into a more formalized independent organization. This could include examining ways to build on existing suggestions to anticipate and create new underpinnings for its regional infrastructure.

The final two recommendations are the key bridging solutions proposed in the Strategic Plan, but before these longer-term objectives can be achieved, the interim steps are required to stabilize and secure the program as a necessary pre-condition for its long-term development.
Item 16, Physician Template Offer Letter

Date

Dear Dr. XXX:

We are pleased to extend to you a conditional offer to join the Rouge Valley Health System (“RVHS”) as an Associate Staff member in the Department of Medicine and the Cardiac Care Program as an ________ (Interventional, Cardiac Imaging, Arrhythmia Management) Cardiologist.

Please provide us with a reply to this conditional offer by DATE as well as confirmation of your start date to be arranged with Dr. Joseph Ricci, Chief of Cardiac Care RVHS. Failure to provide a signed acceptance by DATE will grant us the ability to rescind this offer. We look forward to your joining our team and the significant contribution you would make in helping us to provide excellent care for the regional cardiac care program and the RVHS communities of East Scarborough and West Durham.

This offer is conditional upon the following criteria that must be satisfied prior to the granting of any privileges:

(i) you are required to provide proof of licensure and good standing from the Ontario College of Physicians and Surgeons;

(ii) you are required to provide confirmation of your FRCPC designations in both Cardiology and Internal Medicine;

(iii) you must provide evidence of medical malpractice protection coverage with the Canadian Medical Protective Association (CMPA) in an amount that is satisfactory to the Board;

(iv) you are required to comply at all times with RVHS’ by-laws, all applicable laws including, without limitation, the Public Hospitals Act as amended and policies including, without limitation policies relating to confidentiality and the protection of personal health information;

(v) you are required to provide documentation of a criminal background and vulnerable sector check.

The offer is conditional upon a positive recommendation by the Credentials Committee and the Medical Advisory Committee with subsequent appointment by the Board of Directors. This process usually proceeds smoothly over a period of about 60 days, if not sooner. We will contact you if there are any issues.

The offer to join our medical staff is also contingent upon you being found medically fit to perform the essential duties of the position by our Occupational Health Department. An appointment will be made on your behalf within 14 days of your commencing practice within the organization. Please note, the
Occupational Health & Safety Department will require proof of immunization from communicable disease and TB status as well as ensure that you are mask fit tested.

It is understood that you will make a commitment to be a fully participating member of the Department of Medicine and Cardiac Care Program in accordance with the Corporation’s by-laws and policies.

**Responsibilities**

The primary responsibility of members of cardiac care program is to provide support for the emergency, critical care services, and inpatients of the Rouge Valley Health system and the Regional Cardiac Care Program.

Internal Medicine coverage is provided at both sites based on the current workload equity agreement and with support of both Program Chiefs of Medicine and Cardiac Care. Internal medicine responsibilities include internal medicine emergency department, inpatient consultation and MRP inpatient responsibilities within Rouge Valley Health System.

The Cardiac Care Program provides Cardiology support as a single service across both campuses of RVHS.

You will participate in the Cardiac Care and Internal Medicine services and share responsibility for the care of inpatients across the RVHS. It is understood you will participate in the Cardiac Care call schedule and with the Internal Medicine call schedule. The Cardiac Care program and Internal Medicine program supports a workplace equity policy that attempts to fairly distribute workload for members of the program. As discussed in your interview, you will be treated fairly and equitably with respect to the call schedule and inpatient care responsibility. The schedule will fairly and equitably distribute workload for evening and weekend call responsibilities amongst all cardiologists and internists covering the program and within the Department of Medicine. As an interventional cardiology providing specialized Emergency Department support, your responsibilities for internal medicine emergency department call are reduced to reflect the specific interventional on call workload.

You will have specific additional responsibilities that reflect your specific subspecialty skill set in ______ (Interventional, Cardiac Imaging, Arrhythmia Management). You will participate in cardiac catheterization and percutaneous angioplasty. ______ (Interventional, Cardiac Imaging, Arrhythmia Management) specific resources will be distributed equitably and fairly amongst ______ (Interventional, Cardiac Imaging, Arrhythmia Management Specialists consistent with the Corporate Resource Policy. The principles governing the equitable distribution of resources within cardiac care groups are similarly applied to both the arrhythmia management and cardiac imaging groups that comprise the cardiac care program based on the Cardiac Care Program Corporate Resource Policy.

A call schedule defining responsibilities for these hospital-based services will be provided by the Medical Director based on resource allocation policy and the cardiac care program which have been accepted by the Medical Advisory Committee.

You are expected to maintain fellowship in internal medicine and cardiology. Staff privileges at RVHS and in the Regional Cardiac Care Program require maintenance of professional certification and competency.
As a full member of the Medical Program, you will participate in its management through participation in program administrative structures and your clinical activities. Specifically, our expectations of you on receiving Associate staff privileges is to work with the Program Chief and Program Director to improve care for the medicine patient population and work at strengthening the integration of medical and program quality initiatives. Please note, we expect you to participate on medical or hospital committees as assigned by the Program Chief of Medicine RVC or the Chief of Staff.

Specific to the cardiac care program, you are expected to participate in the subcommittees in the Cardiac Care program and Central East LHIN. You are specifically required to attend the ____ (Catheterization Laboratory Service, Cardiac Imaging, Arrhythmia Management) Committee related to your specific specialty, Quality Assurance Rounds, Cardiac Care Clinical Committee and Regional Cardiac Care Regional Rounds. The minimum requirement is to achieve 50% attendance for these committees. This is in addition to responsibilities for participation in non-Cardiac Committees that are covered by the hospital bylaws (i.e. Medical Staff Society and Department of Medicine). There are committees outside of your subspecialty area including ____ (Cardiac Catheterization Services, Arrhythmia Management, Cardiovascular Secondary Prevention and Cardiac Imaging services) for which your attendance is not mandatory. You may at times be invited to participate in these committees and free to attend these if you desire to participate.

Medical Education is a priority for RVHS regional cardiac care program. You are expected to attend and participate in weekly cardiac care rounds, and education for non-physician hospital professionals that you are expected to support and you will be invited to participate in.

The Corporate Resource Policy links the use of program resources to sharing of inpatient and call responsibility as defined by the attached schedule. Furthermore, the program supports the distribution of hospital cardiac care resources equitably amongst members.

As part of an initiative that has been established by the Ministry of Health and Long Term Care of Ontario, and the Ontario Medical Association, you will be included in the Hospital On-call Coverage (HOCC) agreement whereby all active physicians who provide on-call after-hours coverage are remunerated for such services. Payments for on-call through that initiative will commence once you begin providing on-call coverage. HOCC funding attributed to Cardiology is shared equally amongst all Cardiologists. It is agreed that the Hospital is under no obligation to provide you with the equivalent monies provided by the HOCC where the Hospital does not receive such funding from the Ministry of Health and Long-Term Care or Ontario Medical Association. Should the Ministry of Health and Long-Term Care and Ontario Medical Association approve the request and flow such funds to the organization, this will be distributed to you upon the direction of the Chief of Cardiology. Where you utilize locum or transfer your emergency coverage to another individual you are expected to transfer the HOCC funding you receive as appropriate.

Medical and administrative leadership are important for the Cardiac Care Program. Members of the Department of Medicine and Cardiology Program have and will continue to be recruited based not only on their clinical expertise, service excellence, and demonstrated collegial working relationships, but also for their leadership potential. The Department of Medicine and Cardiology Program are committed to building leadership capacity and succession planning within its membership to ensure that elements of the Program are strategically grown to allow it to be responsive to the needs of the patients and communities it services. You will be provided leadership training and opportunities within the cardiac
care program. It is expected that you would participate in leadership training that the program and you will identify with you in the first year. The program will provide financial and related support to facilitate this training. There will be regular strategic planning events that you will be expected to attend. Further, should you be selected for a formal leadership position at RVHS, you will be expected to undertake formal leadership training as determined and paid for by the hospital.

Rouge Valley has adopted LEAN methodology as a fundamental management philosophy to process improvement. You will be expected to learn the basic tools associated with LEAN and participate in process improvements being undertaken within the hospital.

The Rouge Valley Health System Cardiac Care Program participates in a Group Purchasing Organization, Plexxus, and also has existing contracts for capital, device management and consumables products. The expectation is that you will utilize the agreed upon products as per the current and any future contracts to support RVHS commitments. The guidelines for procurement and contract management will be followed as per regular corporate protocol.

Both parties understand that this is a full-time commitment. This offer does not restrict you from performing services for other agencies provided that those activities or interests are consistent with your clinical role within the corporation and do not place you in a conflict of interest or adversely affect your ability to perform duties contemplated by this offer. You will be required to inform the Program Chief of Cardiac Care or Chief of Staff of other professional activities or commitments in which you may be involved that might conflict with your responsibilities to the RVHS and community.

Please note, each physician practicing within the Rouge Valley Health System is now receiving information specific to his or her own use of hospital resources. RVHS will be expecting you to perform to the clinical benchmarks related to both efficiency and quality established for the corporation based on best practices within the industry.

RVHS reserves the right to reallocate resources due to fiscal pressures and restraints in order for it to meet its external and patient care obligations. Should this reallocation occur, RVHS will endeavor to redistribute resources in an equitable manner involving key stakeholders who will be impacted by such changes. RVHS will be expecting you to perform to the clinical benchmarks related to both efficiency and quality established for the corporation based on best practices within the industry.

The Cardiac Program has finalized an accountability agreement that articulates expectation related to regional programming, physician roles and responsibilities and resource utilization. (see attached Memorandum of Understanding and Appendix “A” and “B.”) As a member of the Program, this offer requires that you sign off on the agreement and associated schedules.

It is understood that you will be absent for scheduled vacation and for continuing medical education at times. During such times, you will be required to arrange for, and advise the Program Chiefs, Cardiac Care and Medicine with respect to coverage of your patients, and responsibilities including call during your absences. The Medical Director has established annual coverage rotations for holiday, meeting, and other periods of absence that promote fairness and all members of the program are expected to comply with. The schedule is prepared at least 3 years in advance to assist members in planning their personal and professional lives. You will find your colleagues in the department helpful regarding cross-coverage. You will be expected to replace yourself with a locum should you be approved for an extended leave of absence. The Program Chief and Medical Administration office will provide you with
assistance in your efforts to source an appropriate locum with advance notice and planning for an extended absence.

You must attend a general orientation for new staff at RVHS within one (1) month of your start date. The Program will assign a mentor to assist with your transition to RVHS. Dr. XXX will provide regional mentorship for Cardiology and Internal Medicine over the first year of your practice. Your performance will be assessed within your first (6) months of being granted Associate Staff privileges and then annually thereafter to ensure that mutual expectations are met. The Program Chief, Cardiac Program and Administrative Program Director shall jointly participate in these reviews. In addition, you may be required to meet formally and informally with them to establish goals and conduct activities in alignment with the Medical and Cardiac Programs and Corporate goals and objectives.

We have enclosed two copies of this letter. Kindly sign both documents and return them to the Medical Administration Office. Upon receipt of your acceptance of this offer, we will finalize the execution of the letters and return a signed copy to you.

The signatures below confirm acceptance of the terms of this agreement.

I accept the terms of this offer.

_____________________________  ______________________________
Dr. __________________________   Date

I will be starting my practice at Rouge Valley Health System on _________________________

Date

On behalf of the Rouge Valley Health System

_____________________________  ______________________________
Medical Director, Program Chief   Program Vice President

Cardiac Program

Copy
Chief of Staff, RVHS
Chief Executive Officer
Chief Operating Officer
VP Finance and Chief Financial Officer
Program Chief Medicine, RVC
Accounts Finance
Item 17, Cardiac Care Program Resource Policy

PRINCIPLES:

a) the Cardiac Care Program is responsible for managing the on-call and in-patient services within the Program;

b) access to hospital resources within a program and or division should be related to and in proportion to the provision of on call services for the emergency department and inpatients of the hospital;

c) manpower planning for the provision of adequate on call service to the Emergency Department and inpatient services is a health system priority;

d) hospital resources within the Cardiac Care Program are to be managed and allocated by the Program Medical Director consistent with principle (b) above and supported by the Chief of Staff;

e) resource utilization principles apply to all physicians participating in the Cardiac Care Program at RVHS. This policy applies to members of the department of medicine and physicians on active staff at regional hospitals;

f) the Cardiac Care Program recognizes the value of long term commitment to provide acute care services at the health system;

g) competency should be evaluated and considered in the application of this Policy in accordance with applicable human rights laws. Age, or any other rights protected by law, should not form the sole basis for assessing competency.

h) resource utilization includes but is not limited to the participation in elective and non-elective cardiac diagnostic and interventional procedures, reading tests, hospital clinic or other similar services.

POLICY

1 To achieve the principle set out in (a) above, the Program Medical Director will be responsible for allocating the on-call responsibilities amongst the members of the medical staff in a manner that fairly distributes the workload and the medical staff will be responsible for providing the on-call services that have been allocated to them;

2 The Cardiac Care Program will use its best efforts to ensure that the resources will be distributed amongst the physicians who are participating in the cardiac care program at RVHS in a manner which ensures that the total system resource utilization is equitable.
between the physicians and proportionate to the provision of on call services as described in section (b) of the Principles above;

3 The Cardiac Care Program will set reasonable standards for minimum and maximum volumes in accordance with the professional standards for specific procedures to ensure that reasonable quality standards and the manpower needs of the hospital are maintained;

4 Resource equalization will be allocated based upon blocks of time measured in hours or procedure time although this may be modified by the program Chief where other factors such as efficiency create a significant inequity;

5 The Medical Director will publish the block distribution which may be reviewed by the Program and physicians participating in the Cardiac Care Program at RVHS;

6 Members of the Cardiac Care Program may elect to reduce coverage for inpatients, emergency and related acute care services by a proportion that is acceptable to RVHS and, if exercised, there will be a corresponding percentage reduction in utilization of hospital resources. This section applies to all active staff physicians at RVHS and other participating hospitals who are participating in the Cardiac Care Program;

7 For those physicians who are participating in the Cardiac Care Program at RVHS, EKG reading will be reserved for those physicians who provide evening and weekend coverage of the emergency department;

8 A member with long standing service at RVHS whose age in addition to years of service total 80 or higher years, may discontinue emergency service coverage and participate in hospital resources at 50% of the resource utilization for a period of 5 years, after which time his/her resource utilization will fall to zero;

9 Cardiologists who plan to reduce call under this Policy must provide notice in writing to the Medical Director or designate at least one year before implementation; and

10 Where a member reduces on call responsibility, the individual and program members are required to support the Medical Director’s effort to recruit replacement staff.
Item 18, MOU between Rouge Valley and Partner Hospitals

MEMORANDUM OF UNDERSTANDING ("MOU")

BETWEEN

ROUGE VALLEY HEALTH SYSTEM
(hereinafter "RVHS")
a public hospital incorporated pursuant to the laws of the Province of Ontario

AND

THE SCARBOROUGH HOSPITAL or LAKERIDGE HEALTH CORPORATION
(hereinafter "Hospital")
a public hospital incorporated pursuant to the laws of the Province of Ontario

PREAMBLE

The parties are participating in a Regional Cardiac Care Program ("Program") which is intended to provide equitable access to patients in the surrounding region. This MOU provides a framework for the Program and is intended to set out the roles and responsibilities of each of the parties and is based upon the principle that the resources of the Program are limited by the funding that is provided by the Ministry of Health and Long Term Care and the numbers of patients in the region who require the cardiac services provided by the Program. In addition, this MOU establishes a framework for maintaining standards of quality within the Program.

1. Roles and Responsibilities of RVHS

1.1 RVHS is responsible for:

(i) providing equitable access for the cardiac procedures performed within the Program at RVHS including, catheterization; percutaneous coronary intervention ("PCI") and electrophysiology ("EP") and other mutually agreeable services. Equitable access will be determined on the basis of the nature of the procedure, the timing of the referral made to RVHS, the goals and principles set out in Schedule B and any other matters that may be relevant at the time of the referral. Every effort will be made to ensure that the Hospital's patients receive similar levels of access as RVHS' patients to the Program.

(ii) facilitating the Hospital's opportunity to participate in quality assurance initiatives;

(iii) ensuring that the resources of the Program are allocated on a corporate level between the parties consistent with the regional manpower plan as described in Schedule A and not on the basis of individual physicians;

(iv) ensuring that any of the physicians who participate in the Program are notified of the rules, guidelines, policies and procedures that are applicable to the Program.
and for ensuring that the eligible physicians agree to be bound by the applicable rules, guidelines, policies and procedures;

(v) For the purpose of maintaining quality within the cardiology programs of each of the parties, RVHS will disclose information to the Hospital with respect to the performance of physicians who participate in the Program at RVHS. In the event that any such performance information specifically identifies a specific physician, RVHS agrees to ensure that any consents required by law are obtained prior to making the disclosure;

(vi) for maintaining the regional manpower plan. Modifications to the regional manpower plan will be made in consultation with the participating hospitals. The current manpower plan is attached as Schedule A and forms part of this MOU. It is based upon the principle that the resources of the Program are limited by the funding that is provided by the Ministry of Health and Long Term Care and the numbers of patients in the region who require the cardiac services provided by the Program.

1.2 The Hospital is responsible for:

(i) identifying physicians who are eligible to participate in the Program. The Hospital understands and agrees that the eligible physicians shall only include physicians who: (a) hold active staff privileges at the Hospital; (b) provide on call support for inpatients and the Emergency Department; and (c) meet RVHS’ credentialing criteria for the Program. RVHS agrees to provide the Hospital with the credentialing criteria that are applicable to the Program;

(ii) promoting the Program as the primary resource for patients in the surrounding region. The Hospital shall not engage in or support activities which may cause the patients in the surrounding region to be referred to facilities outside of the catchment area that is being served by the Program;

(iii) ensuring that it does not recruit physicians to the Hospital with an expectation that they will have access to the Program’s resources unless it has the consent of RVHS to provide that expectation. The parties agree that the process for selecting physicians who participate in the Program shall be consistent with the manpower plan attached as Schedule A and will include a consultation with each of the parties;

(iv) participating with regional participants in the activities which support the Program. Activities may include, but are not limited to, educational events and community promotions;

(v) assisting the Program with achieving quality assurance targets including the optimization of wait list strategies and patient access;

2. Confidential Information

Each party acknowledges that in participating in the Program through this MOU it may have
access to and receive personal health information concerning a patient of another party or confidential information relating to another party. Each party agrees to treat such information with the same degree of care as that which it uses to protect its own confidential information or the personal health information of its own patients, and shall comply with each of its respective obligations pursuant to the Personal Health Information Protection Act, 2004 as is amended from time to time.

3. **Liability for Patient Care**

Each party agrees that this MOU does not create any liability for any party relating to the actions or services that another party provides. This MOU does not affect each party’s responsibility, including legal responsibility, for the treatment and care of its patients.

4. **Indemnity**

Each party agrees to indemnify and save harmless the other party from any and all actions, claims and damages that relate to the negligence or breach of a provision of this MOU by an employee or agent of the indemnifying party. The indemnifying party shall indemnify the other party including its directors, officers, employees and agents for all direct costs and expenses incurred as a result of a claim made or proceeding commenced relating to a breach of a provision of this MOU by an employee or agent of the indemnifying party or others for whom the indemnifying party is legally responsible.

5. **Insurance**

Each party shall maintain general liability coverage for a minimum of $10,000,000 for any one occurrence relating to activities to which this MOU refers. Each party shall provide to any other party evidence of this insurance upon request.

6. **Independent Parties**

The parties are and will remain independent. This MOU does not create any employment, partnership, joint venture or agency relationship between any of the parties.

7. **Term**

This MOU shall commence on **DATE** and shall continue for a term of four (4) years. The MOU may be renewed for a term that is agreeable to the parties.

8. **Notice**

Any communications among the parties required under this MOU must be given in writing and shall be hand delivered or sent by registered mail, courier or fax and shall be addressed as set out below.

To: Chief Executive Officer  
THE SCARBOROUGH HOSPITAL  
3050 Lawrence Ave. E  
Scarborough, ON  
M1P 2V5
A notice sent by registered mail or courier is deemed to be received by the party to whom it is addressed on the date of its delivery. A notice transmitted by fax is deemed to have been received by the party to whom it was addressed on the date of transmission.

9. Termination of Agreement

Either party may terminate its participation in this MOU by providing the other party with at least 365 days written notice. A party may immediately terminate its participation in this MOU in the event that a material breach of the terms of this MOU occurs. In the event of a material breach, the non-defaulting party shall advise the defaulting party of the breach and the effective date of the termination.

The Hospital acknowledges that the termination of this MOU may result in the termination of the participation in the Program by the Hospital’s physicians. The Hospital will cooperate with the Program in taking steps to mitigate any adverse effect on the operation of the Program in connection with such termination.

The Hospital agrees to take all steps that are necessary in the circumstances to ensure that the physicians’ participation in the Program is terminated in a manner that is timely and which does not adversely interfere with the normal operation of the Program.

10. Dispute Resolution

The parties intend to conduct their relationship in a principled manner, and in accordance with ethical business practices. All differences, concerns, and disputes will be conducted through interest-based negotiation with the objective of achieving an amicable resolution.

If a difference, concern or dispute cannot be resolved between the parties, then a mediator will be selected from a list of names that has been submitted by the parties which consists of mediators who are acceptable to both parties.
The final step in the dispute resolution process will be an arbitration, the terms of which are outlined below:

a) Each party involved in the arbitration will be responsible for its own costs associated with the preparation for and presentation at any arbitration meeting.

b) The cost to facilitate the arbitration meetings will be equitably shared amongst the parties who are involved in the arbitration.

c) One independent and impartial arbitrator appointed by a majority vote by the parties who is experienced in the subject matter at hand will be appointed as the arbitrator.

d) The arbitrator will be limited in authority to only award compensatory damages.

e) All arbitration meetings will be held at a mutually agreed upon neutral location.

f) All arbitration will be considered to be binding upon the parties without the opportunity for appeal or recourse.


(a) The parties may not assign this MOU without prior written authorization of the other party;

(b) If any provision of this MOU is determined to be invalid or unenforceable in whole or in part, such invalidity or unenforceability shall attach only to such provision and the other provisions of the MOU shall continue in full force and effect;

(c) This MOU may be amended provided that any such amendments are made in writing with the agreement of the parties. The parties acknowledge that the applicable Local Health Integration Network may make changes to the health system which may affect the terms of this MOU. In the event that the Local Health Integration Network makes any such changes, the parties agree to negotiate any applicable amendments in good faith;

(d) This MOU may be executed in counterparts, each of which is so executed is deemed to be an original, and such counterpart together constitute but one and the same instrument;

(e) The laws of the Province of Ontario shall apply to this MOU and the parties attorn to the jurisdiction of the courts of the Province of Ontario.

(f) The terms and conditions of the schedules attached to this MOU are hereby incorporated by reference to the MOU and in the event of any inconsistency between the schedules and the MOU, the terms and conditions of this MOU shall prevail to the extent of any inconsistency.
The parties have agreed to this MOU as of the ______ day of ______________, XXX.

THE SCARBOROUGH HOSPITAL

Name: __________________________

Title: __________________________

ROUGE VALLEY HEALTH SYSTEM

Name: __________________________

Title: __________________________

Name: __________________________

Title: __________________________

Name: __________________________

Title: __________________________

Schedule “A”

Regional Manpower Plan

Rouge Valley Health System Regional Catheterization Laboratory

1) Physician Allocation Regional Catheterization Laboratory

   a. Cardiac Catheterization

      i. The Scarborough Hospital

         1. General Campus   3 physicians
         2. Grace Campus     2 physicians

      ii. Lakeridge Health Corporation  3 physicians

      iii. Rouge Valley Health System

         1. Centenary Site  6 physicians
         2. Ajax Site        2 physicians

   b. Percutaneous Coronary Intervention (PCI)  5 physicians

2) Operator Procedural targets per operator per year
a. Cardiac Catheterization operator
   i. Minimum 200 catheterization
   ii. Preferred 250-300 catheterization

b. PCI operator
   i. Minimum 200 PCI
   ii. Preferred 250-300 PCI

SCHEDULE “B”
Catheterization Laboratory Scheduling
Goals and Principles

Goals

1. To provide a high quality service
2. To provide timely service based upon urgency and time of referral
3. To provide equitable access for all patients in the region
4. To provide equitable access for regional inpatients
5. To achieve annual performance targets for volume
6. To work within available resources
7. To support CCNO triage processes

Catheterization Laboratory Services Booking Principles

1) The catheterization laboratory services schedule should be developed with sufficient fixed ‘blocks’ of time to:
   i) Achieve funded monthly and annual volume targets for services including PCI, Diagnostic Angiographies, and Arrhythmia Management.
   ii) Have sufficient regular capacity to protect opportunity and access due to variation in volumes (~10% above funded volume)

2) The number and types of procedures within blocks will be planned to support principle 1 and the following principles

3) To ensure timely service for diagnostic angiography and PCI
   i) Patients will be triaged to the first available time for cath or PCI
   ii) No patient booking will be made beyond the maximum recommended wait times published by CCN for the specific procedure
   iii) Prior to not accepting requests for cath/PCI bookings, the booking clerks will consult with the CCN Coordinator to determine the appropriateness of delaying their procedure.

4) To ensure equitable access based upon urgency
   i) Procedural allocation within blocks will have protected access for inpatient and elective cases
   ii) The daily allocation of inpatients will be chosen to match expected median need based upon the prior 12 months’ experience

5) To ensure equitable and timely access inpatient procedures for Diagnostic
Angiography and PCI, it is assumed
i) Inpatients studies are urgently indicated.
ii) Inpatient urgency is independent of referral site & similar at all regional centers
iii) Inpatients are expected to have a mean wait of $\leq 1$ day.
iv) Inpatient diagnostic angiography or PCI resources should not be reassigned for use by outpatients unless unfilled $<24$ hours from the available time and there is more than one unfilled opportunity.

6) For a subset of patients undergoing Angiography, ‘same day’ and/or ‘same sitting’ ‘ad hoc’ PCI may be desirable. To this end the PCI blocks will include
i) A limited number of protected in-patient same sitting "ad hoc Procedures"
ii) Protected inpatient spots to be used for patients identified at Angiography to benefit from in hospital potentially same day PCI.

7) Where the numbers of inpatients waiting for procedures are too great to be accommodated in reasonable time, the medical and administrative manager may
i) Request that elective and triage procedures be temporarily suspended and/or rebooked later to accommodate inpatients waiting, or
ii) Explore alternative facilities to accommodate the patients’ needs

8) Where the volume of PCI patients on a day exceed capacity the medical and administrative manager may move patients using a priority sequences as follows
i) Inpatient PCI: displaced to next available inpatient spot
ii) Elective PCI: When booking elective PCI’s there should be at least one spot left open later in each week to provide capacity for rescheduling of elective patients

9) These inpatient volumes and procedural volumes will be regularly reviewed to ensure that they
i) Match actual inpatient and triage service needs
ii) Achieve wait list targets
iii) Are within available resources related to funded service volume.

10) Physicians are responsible for:
   i) Providing professional services as scheduled and be available for the entirety of that scheduled block.
   ii) Efficiency and timeliness.
   iii) Professional behavior
   iv) Communication with regional referring responsible physicians as required providing the level of care expected by the patient and referring physician.
   v) Completed referrals
   vi) Participate at Service Committees
   vii) Participate in Radiation Safety
   viii) Participate in QA Rounds

11) Physicians and staff will
i) Endeavor to work within available resources
ii) Work collaboratively to support these principles
12) RVHS supports the CCNO triage process

Policies

1) Catheterization laboratory services booking staff will manage the booking of procedures consistent with the principles

2) The Catheterization flow manager will manage the flow of patients within the laboratory consistent with these principles and policies.

3) The distribution of procedures will be consistent with the principles above and proposed booking structure below

4) Inpatients within the region (Scarborough, Rouge Valley, Lakeridge), should be scheduled for procedures
   i) Based upon the time of booking
   ii) Without preference for location within the region served by the regional RVHS laboratory not the type of hospital bed or CCNO urgency rating scale.
   iii) However, the most responsible physician can request to the medical manager special consideration for a patient to move forward in the queue where clinical grounds warrant

5) Catheterization block will be managed to include
   i) 14 patients in total
   ii) Of which at least 5 will be protected for use by inpatients.
   iii) If an inpatient is unable to be placed on the day of the request for booking request they will be scheduled on the next working day.
   iv) Outpatients should be rescheduled to accommodate inpatients that cannot be booked within the RMT of 1 day.

6) PCI block will be managed to include 4.5 PCI composed of
   i) 1 elective PCI
   ii) 3 inpatient PCI
   iii) 1.5 potential same sitting ad hoc PCI

7) Management of high probability same sitting ad hoc candidate
   i) All ICU/ CCU patients will be listed as potential candidate
   ii) By 9 am each day the Interventionist will
      (a) Identify 1 patient considered most probable ad hoc candidate
      (b) Discuss with diagnostic angiographer and flow manager
   iii) This ad hoc patient will be added to PCI block as the first case
   iv) Urgent inpatient ad hoc (rescue, primary) procedures will count as one of the ad hoc for that day.
   v) A second same sitting ad-hoc from ICU/ CCU list can be added at the end of the block provided that there is sufficient time pending and all inpatients including those generated in the interim have been completed
   vi) A record will be kept by the CNN Coordinator of any patients that are rolled over both from Cath and PCI with documentation of the reasons
8) Time Pending PCI or Diagnostic procedures can be performed where
   i) Pre-specified time boundaries have not been crossed
   ii) There is a reasonable expectation that the procedure could be completed in
       the available time

9) Where there is insufficient time to complete planned procedures within a block,
   patients will be rescheduled to another block on another day within the RMT.
   i) Elective patients will be rescheduled into open elective spots which will be
      kept available each week for this purpose.
   ii) Inpatients will be shifted to a protected inpatient spot on the next working day

10) Same Day PCI will be facilitated for all inpatients following diagnostic catheterization:
    i) Candidates for PCI will be reviewed promptly and
    ii) if accepted for PCI be given next available inpatient PCI position

11) Urgent PCI procedures will
    i) Follow the algorithms developed for this purpose.
    ii) Displace less urgent PCI procedures if necessary,
    iii) Exchange laboratory time with diagnostic Angiography blocks consistent with the
        algorithm guidelines

12) Discussion and mutual agreement between the laboratory flow facilitator, diagnostic
    angiographer and interventional physician are expected to facilitate efficient decision making

13) Resolution of discordant issues
    i) Should follow the following administrative sequence: cath lab facilitator and
       physicians > Nursing or Physician service manager > medical director and/or
       program manager.
    ii) Should be logged by the Patient Flow Facilitator where breaches of service
        accountability may have occurred.

14) The managers will review volumes at least quarterly to ensure that
    i) volumes remain within 110% of target.
       (1) Where volume trends significantly exceed planned targets, the managers may
           adjust block number or volumes as necessary to remain within the funded
           volume range but will concurrently put in place measures to meet the needs of
           these patients of RVHS.
       (2) Where volume trends are significantly below planned targets, the managers will
           initiate a process to examine causation and strategies to achieve budgeted
           volume
    ii) RVHS is at or exceeds the median performance for RMT for each of the 3 urgency
        groups
Schematic of Scheduling Laboratory Blocks

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<tr>
<th>Time</th>
<th>Activity</th>
<th>Notes</th>
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<tbody>
<tr>
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<td>Pacemaker</td>
<td></td>
</tr>
<tr>
<td>07:00</td>
<td>Cath Block Cl</td>
<td>10 hour block</td>
</tr>
<tr>
<td>08:00</td>
<td>8 hour block</td>
<td></td>
</tr>
<tr>
<td>09:00</td>
<td>PCI</td>
<td>Cath Volume Targets</td>
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<tr>
<td></td>
<td></td>
<td>= (3600-425) * 110%</td>
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<tr>
<td></td>
<td></td>
<td>= (3175) * 110%</td>
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<td></td>
<td></td>
<td>= 3493/year</td>
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<tr>
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<td>PCI Volume Targets</td>
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<td></td>
<td>= 4.6 per block</td>
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<tr>
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<td>= 1.6 ahocs/block * 250 ahoc caths + 50 after hours PCI</td>
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