Huron Health SYSTEM
South Huron Hospital

AGENDA

Committee:	**Medical Advisory Committee**		
Date:	March 7, 2024	Time:	8:00am-9:00am
Location:	Boardroom B110 / MS Teams		
Chair:	Dr. Sean Ryan	Recorder:	Alana Ross
Members:	All SHH Active / Associate, CEO, VPs, Clinical Managers		
Guests: *(Open Session Only)*	Heather Zrini, Shari Sherwood		

	Agenda Item	Presenter	Anticipated Actions	Time Allotted	Related Attachments
1	**Call to Order / Welcome**				
2	**Guest Discussion**				
3	**Approvals and Updates**				
3.1	Previous Minutes	Ryan	Decision	1min	• 2024-01-11-MAC Minutes • 2024-02-08-MAC Minutes
	Draft Motion: To accept the January 11 and February 8, 2024 MAC Minutes.				
4	**Business Arising from Minutes**				
5	**Medical Staff Reports**				
5.1	Chart Audit Review	Nelham / McLean	Information	as needed	
5.2	Infection Control	Kelly	Information	as needed	• C.Diff-Adults • Pneumonia QIP • Skin & Soft Tissue Infection-Adults • UTI QIP
5.3	Antimicrobial Stewardship	Nelham	Information	as needed	• SHH Antimicrobial Stewardship Terms of Reference DRAFT
5.4	Pharmacy & Therapeutics	Patel	Information	as needed	
5.5	Lab Liaison	Bueno	Information	as needed	
5.6	Community Engagement Committee	Ondrejicka	Information	as needed	
5.7	Recruitment and Retention Committee	Ryan	Information	as needed	
5.8	Quality Assurance Committee	Nelham / Wick	Information	as needed	
	Draft Motion: To accept the March 7, 2024 Medical Staff Reports to the MAC.				
6	**Other Reports**				
6.1	Lead Hospitalist	Patel	Information	5min	
6.2	Emergency	McLean	Information	20min	
6.3	Chief of Staff	Ryan	Information	5min	• 2024-03-Monthly Report-COS • 2024-02-Monthly Report-COS
6.4	President & CEO	Trieu	Information	5min	• 2024-02-Monthly Report-CEO
6.5	CNE	Wick	Information	5min	
6.6	COO	Trovato	Information	5min	• 2024-02-Monthly Report-COO

6.7	Patient Relations	Klopp	Information	5min	
	Draft Motion: To accept the March 7, 2024 Other Reports to the MAC.				
7	**New and Other Business**				
7.1	Credentialing Report	Ryan	Acceptance Recommendation	1min	• 2024-03-07-Report to MAC-Credentials
	Draft Motion: To accept the Credentialing Report of March 7, 2024 as presented, and recommend to the Board for Final Approval.				
8	**Education / FYI**				
8.1	Sessions Available	Walker	Information	1min	
9	**Next Meeting & Adjournment**				
	Date	**Time**		**Location**	
	April 11, 2024	8:00am-9:00am		Boardroom B110 / MS Teams	

Huron Health SYSTEM
South Huron Hospital Association

MINUTES

Committee:	**Medical Advisory Committee**		
Date:	January 11, 2024	Time:	8:10am-9:11am
Chair:	Dr. Sean Ryan	Recorder:	Alana Ross
Present:	Dr. Bueno, Dr. Chan, Dr. Kelly, Dr. S. McLean, Dr. Ondrejicka, Dr. Patel, Dr. Ryan, Heather Klopp, Jimmy Trieu, Matt Trovato, Adrianna Walker, Michelle Wick		
Guests:	Heather Zrini, Shari Sherwood, Aileen Knip (Board Representative)		

1	**Call to Order / Welcome**
1.1	• Dr. Ryan welcomed everyone and called the meeting to order at 8:10am
2	**Guest Discussion**

2.1	<u>Oracle:</u>
	• Migration over to Office 365 is beginning
	  ○ For those who are accessing SHH emails accounts and staff WiFi, there is a new cybersecurity password policy being introduced within the next month; expect communication
	  ○ Password parameters will become more complex and change prompts will happen every six months
	• Health Information Exchange (HIE)
	  ○ Presentation re Ontario eHUB-HIE; beginning of a provincial patient database
	  ▪ Allows electronic exchange of patient information between Hospitals & Long Term Care Homes
	  ▪ eHUB connects Oracle/Cerner healthcare systems throughout the province; see Menu Bar-Outside Records for external patient information, i.e., notes, allergies, Med lists, etc.
	  ▪ Does not replace Clinical Connect
	  ▪ Point and click environment
	  ▪ Data flows with the patient upon Discharge/Transfer
	  ▪ Training materials available Jan 8; training available from Jan 8-29; GO LIVE Jan 30
	• OneChart Phase II
	  ○ Presentation re OneChart History-Orientation; various modules to be rolled out over 2024
	  ▪ Involves electronic work queue management, upgrading patient education materials
	  ▪ Preliminary work being done to implement Dragon dictation; IT is sorting out what hardware is required for this project, i.e., microphones at physician stations
	  ▪ Mobile image capture and sharing with specialists
	  ▪ Potential for physicians to dictate though their smartphones into the patient chart; requires PowerChartTouch and related App
	  ▪ Focusing on ambulatory documentation and ED documentation expansion
	  ▪ Infection control module to be implemented, which will enhance monitoring and reporting capabilities for our Antimicrobial Stewardship Program

3	**Approvals and Updates**
3.1	<u>Previous Minutes</u> • Approval / Changes ○ None ***<u>MOVED AND DULY SECONDED</u>*** ***<u>MOTION: To accept the December 14, 2023 MAC minutes. CARRIED.</u>***
4	**Business Arising from Minutes**
4.1	<u>Goderich CTs:</u> • Current process is in place as there is not always a Radiologist on-site at AMGH to prioritize the requisitions; the process triggers the expedition of the actual CT Scans ○ CT reqs are stored in a folder and reviewed by a tech during business hours, and then faxed to London X-Ray Associates; the coversheet and phone call are what triggers the process as urgent

	○ It is expected that the process will be similar once SHH has a CT scanner on site • SHH nursing staff have been calling MI tech at AMGH, and have been directed to call the Radiologist every time a CT is needed ○ Goal is to discontinue unnecessary phone calls	
	Action: • Contact London X-Ray Associates to discuss process	***By whom / when:*** • Wick; Jan
5	**Medical Staff Reports**	
5.1	Chart Audit Review: • Will be reviewing whole process late Jan / Feb	
5.2	Infection Control: • No discussion	
5.3	Antimicrobial Stewardship: • SHHA Antimicrobial Stewardship Terms of Reference Draft circulated • QIP / Medical Directive processes	
	Action: • Forward TOR and all updated QIP flowsheets to next MAC for review and approval	***By whom / when:*** • Kelly; Feb
5.4	Pharmacy & Therapeutics: • No discussion	
5.5	Lab Liaison: • Meeting scheduled later in Jan; report available in Feb	
5.6	Community Engagement Committee: • No discussion	
5.7	Recruitment and Retention Committee: • Meeting postponed to February; report available in Feb	
5.8	Quality Assurance Committee: • Meeting scheduled later in Jan; report available in Feb	
	MOVED AND DULY SECONDED ***MOTION: To approve the Medical Staff Reports as presented for the January 11, 2024 MAC Meeting.*** ***CARRIED.***	
6	**Other Reports**	
6.1	Lead Hospitalist: • Inpatients slowed down a little over the Christmas season, however, it is now much busier, and SHH has been over capacity in the last two weeks; quality and efficiency has been maintained	
6.2	Emergency: • Discussed uncovered ED shifts in Feb	
	Action: • Email physician group to determine if trades are available	***By whom / when:*** • McLean; Today
6.3	Chief of Staff: • Discussed AFA threshold; visits per year must reach 12,500; SHH is very close to target ○ Number of visits has been around 10K/yr, but is increasing and it is suspected that the threshold will be easily met this coming year and on an ongoing basis • Will be meeting with AMGH General Surgery team to develop a formal arrangement ○ There were issues with nursing gaps, however, that has been rectified and there are no gaps in Jan ○ Anaesthesia coverage is at 80%	
	Action: • Submit AFA numbers to Ministry	***By whom / when:*** • McLean / Trovato; as required
6.4	President & CEO: • 2024-01-Monthly Report-CEO circulated	

	• CEO is scheduled to meet with the Parliamentary Assistant to the Minster of Health in the coming weeks, and will be discussing the FHT and CT Scanner applications for South Huron o Will be noting the increased pressures related to growth of South Huron and the new LTC home that is being built
6.5	<u>CNE:</u> • 2024-01-Monthly Report-CNE circulated o NARCAN initiative and staff training re dispensing NARCAN through the ED ▪ Dispensed 13 NARCAN kits and 2 doses of SUBNOXONE this past year o A number of initiatives will be flowing through the ED o Cardiac monitors are going LIVE Jan 16; 'arms' are being installed ▪ New central station and monitors will be installed; two-way capability o Meeting scheduled with EMS to discuss bypass process for CTAS 3s, 4s and 5s, during crisis situations ▪ HPHA has asked for a formalized process; expected criteria will be challenging to meet, i.e., phone calls ▪ EMS is reviewing contracts in regards to bypass situations o EMS has been notified regarding the elevator shut down o Laurie Hakkers, Clinical Nurse Educator, has started her position o Discussed continuing Stress Testing Program at SHH; equipment is coming to end-of-life ▪ Stratford Internal Medicine is providing services at AMGH; were offered come to SHH as well, however, they currently don't have the resources o Looking into any initiatives, models of care, or grants related to integration with LTC o Discussed implementation of a palliative care Nurse Practitioner as part of the FHT application
	<u>Action:</u> • Discuss Stress Testing Program with Dr. N. McLean ***<u>By whom / when:</u>*** • Wick; Jan / Feb
6.6	<u>COO:</u> • 2024-01-Monthly Report-COO circulated o Reviewed Period 8 financials; anticipated deficient for year-end ▪ Deficit is mostly related to the repeal of Bill 124, and the cost of staying open and receiving increased patient volume from EDs that are closing; pressures due to increased volume are felt throughout the organization ▪ All hospitals in the region are in a deficit position, however, SHH is performing slightly better ▪ Funding announcements are expected in Feb o Work continues with DynaCare and Life Labs to keep the blood draw clinic available at the Walk In Clinic; an expression of interest has been received and a formal proposal is being developed o Issue of delayed morning labs has been investigated and is now considered rectified
6.7	<u>Patient Relations:</u> • 2024-01-Monthly Report-Patient Relations circulated o Shout out to Dr. Treasurywala received o Please note that complaint information added into RL6 is captured the way the patient or family member conveys it and is not the opinion of the person entering the data o Working on consistent messaging regarding patient relations, registration and the elevator shut down, and direction for the small population that will have difficulty with use of stairs o Kind reminder for physicians to please sign all notes, charts and requisitions
	<u>MOVED AND DULY SECONDED</u> ***<u>MOTION: To approve the Other Reports as presented for the January 11, 2024 MAC Meeting. CARRIED.</u>***
7	**New Business**
8	**Education / FYI**
8.1	<u>Education:</u> • Discussed VOYCE Interpreter system o Professional, easy access, pay per minute, no monthly fees, app available, integrates with Cerner; looking further into initiative

	• Discussion held last meeting to determine if Blood Transfusions can be admitted through the ED; pending decision • Process changing around ED Form 1s as there are issues with the pop-ups		
	Action: • Follow up on admission of Blood Transfusions • Forward communication re Form One to ED physicians		***By whom / when:*** • Walker; Jan • Walker; This week
9	**Adjournment / Next Meeting**		Regrets to alana.ross@amgh.ca
	Date	**Time**	**Location**
	February 15, 2024	8:30am	Boardroom B110 / WebEx
	Motion to Adjourn Meeting ***MOVED AND DULY SECONDED*** ***MOTION: To adjourn the January 11, 2024 meeting at 9:11am. CARRIED.***		
Signature			
_____ Dr. Sean Ryan, Committee Chair			

Huron Health System
South Huron Hospital Association

MINUTES

Committee:	**Medical Advisory Committee**		
Date:	February 8, 2024	Time:	8:05am-8:44am
Chair:	Dr. Sean Ryan	Recorder:	Alana Ross
Present:	Dr. Hammond, Dr. Joseph, Dr. Kelly, Dr. Lam, Dr. Nelham, Dr. Patel, Dr. Ondrejicka, Dr. Ryan, Heather Klopp, Jimmy Trieu, Matt Trovato, Adrianna Walker, Michelle Wick, Mike		
Guests:	Aileen Knip (Board representative), Shari Sherwood, Heather Zrini,		

1	**Call to Order / Welcome**	
1.1	• Dr. Ryan welcomed everyone and called the meeting to order at 8:05am	
2	**Guest Discussion**	
3	**Approvals and Updates**	
3.1	<u>Previous Minutes</u> • Approval / Changes ○ Deferred to March	
4	**Business Arising from Minutes**	
5	**Medical Staff Reports**	
5.1	<u>Chart Audit Review:</u> • No discussion	
5.2	<u>Infection Control:</u> • No discussion	
5.3	<u>Antimicrobial Stewardship:</u> • Draft Terms of Reference; will be submitted to Accreditation Canada as part of ROP requirements	
	<u>Action:</u> • Forward Terms of Reference to MAC for approval prior to Accreditation • Forward draft Terms of Reference and ASP protocols to Accreditation Canada	***<u>By whom / when:</u>*** • EA; Mar 7 • Zrini / Nelham; As required
5.4	<u>Pharmacy & Therapeutics:</u> • Next meeting to be held late Feb / early Mar	

5.5	<u>Lab Liaison:</u>
	• As of Mar 4
	  ○ High-Sensitivity Troponins will start
	  ○ Removing Amylase and adding Lipase; change related to best practice guidelines
	• Bloody Easy training; physicians and nurses are to complete training related to blood transfusions
	  ○ Having physicians review the material and sign an attestation was discussed in the past, however, work is now being done to make this an accredited program
	• Massive Hemorrhage Protocol
	  ○ PowerPoint available	

	<u>Action:</u> • Follow up with Tim Brown re Troponin protocol; communicate to protocol and algorithm to physicians	***<u>By whom / when:</u>*** • Walker; This week
5.6	<u>Community Engagement Committee:</u> • No discussion	
5.7	<u>Recruitment and Retention Committee:</u> • Meeting held on Feb 6	

	• 30 internationally Family medicine/ED trained physicians have applied to work in Ontario through Health Force Ontario; 16 have applied to AMGH / Goderich; unfortunately, South Huron was not chosen o AMGH will be required to designate a physician supervisor o A group has been formed to review the candidates and determine which are the best fit o Space issues
5.8	Quality Assurance Committee: • Reviewed QIP indicators; in process of choosing indicators for the F2425 QIP o Determining if tracking sickle cell anemia will be an indicator; seem in ED with immigrant population o No critical incidents to report
	MOVED AND DULY SECONDED ***MOTION: To approve the Medical Staff Reports as presented for the February 8, 2024 MAC Meeting. CARRIED.***
6	**Other Reports**
6.1	Lead Hospitalist: • No discussion
6.2	Emergency: • New cardiac monitors went live 2-3 weeks ago; working well • Very few open shifts in ED; next one is in March • Government has not yet made any announcements related to extending the EDLP funding program beyond Mar 31
6.3	Chief of Staff: • OH responded regarding the CT Scanner application; discussion meeting scheduled for next week
6.4	President & CEO: • Working with OHA to advocate for Ministry funding, particularly the extension or permanency of the EDLP program o Discontinuation of the program will lead to massive ED closures across the province • Contribution of smaller hospitals towards the CT wait times; reduction of volumes in the area • SouthWest was working on a review of ED services in the region; plan is to meeting with OHW and discussion the findings; this remains pending o CEO Table meeting scheduled for Feb 14; will discuss move this review forward • Discussed HP&A OHT Accreditation survey process o Although this type of survey process is a first for Accreditation Canada, AC was quite satisfied with our last submissions as a hospital, and it is not anticipated that this survey will be a lot different o One challenge is parcelling out the accreditors to different sites and still maintaining continuity over the sectors; waiting to hear final plan details o The last SHH Accreditation was only partial and bridges with the HP&A survey this year o Anticipating leadership meetings with AC at both sites o Another change is the partnership and new governance structure in place since the last accreditation
6.5	CNE: • Physician education opportunities available for CME credits; information circulated o Register online • IPAC will reach out to physicians if any eligible patients are identified for the RSV vaccine; must be ordered as it is limited to specific criterion, i.e., LTC, Dialysis, and transplant recipients • SHH has started rolling out Occ Health annuities, updating blood work, vaccines, TB skin tests, etc. • Accreditation Canada will be looking at how cohesively we work with the OHT partners, i.e., closure support, communication, EMS destination protocol, etc. • HPHA & EMS have scheduled another meeting to discuss the EMS Destination Protocol o Pushing for EMS to bypass Seaforth and Clinton with OBs, traumas, pediatrics, oncology, mental health, etc. o HHS has declined this protocol o Concern regarding funding following the patients • Oracle Health / Cerner / One Chart is starting up a regional Digital Health Committee o Tom Janzen (OHA) will be Chair o Looking for physician participation from member hospitals; monthly meetings, 2 hours

	○ Purpose of the committee is to oversee decision making around physician documentation ▪ OneChart has a number of physician components including expanded physician documentation for ED, inpatients and ambulatory, with more to be added ▪ Physician input will assist in moving some of the decision making away from the professional practice group ○ Hospital will commit to $125/hr for physician participation; Dr. Nelham has agreed to attend some of the meetings, find out more about the committee, and report back to MAC ○ Dr. Nelham will discuss OneChart / electronic documentation with the newer physicians to see if one of them would be interested in becoming part of the committee	
	Action: • Digital Health Committee survey response	***By whom / when:*** • Sherwood; Next week
6.6	COO: • Update re Blood Draw Clinic at SHMC ○ Team has been working on a model to bring the MLA resource back into the hospital ○ A temporary solution has been reached through discussion with the union, whereby a staff member has volunteered for extra shifts; model is working well and staff member is happy ▪ Will be discussing this as a permanent solution with the union • Proposal submission from Life Labs is pending	
6.7	Patient Relations: • HyperCare is being reviewed in terms of physician usage; attestation regarding use to be made ○ It is being set up for use between some of the home care providers • A test project is under way to investigate a form of virtual care (K303 code), where physicians can text asynchronously with patients	
	Action: • For physicians not using HyperCare, please discuss with Ms. Klopp	***By whom / when:*** • All; As needed
	MOVED AND DULY SECONDED ***MOTION: To approve the Other Reports as presented for the February 8, 2024 MAC Meeting. CARRIED.***	
7	**New Business**	
8	**Education / FYI**	
9	**Adjournment / Next Meeting**	Regrets to alana.ross@amgh.ca

	Date	**Time**	**Location**
	March 7, 2024	8:00am	Boardroom B110 / WebEx

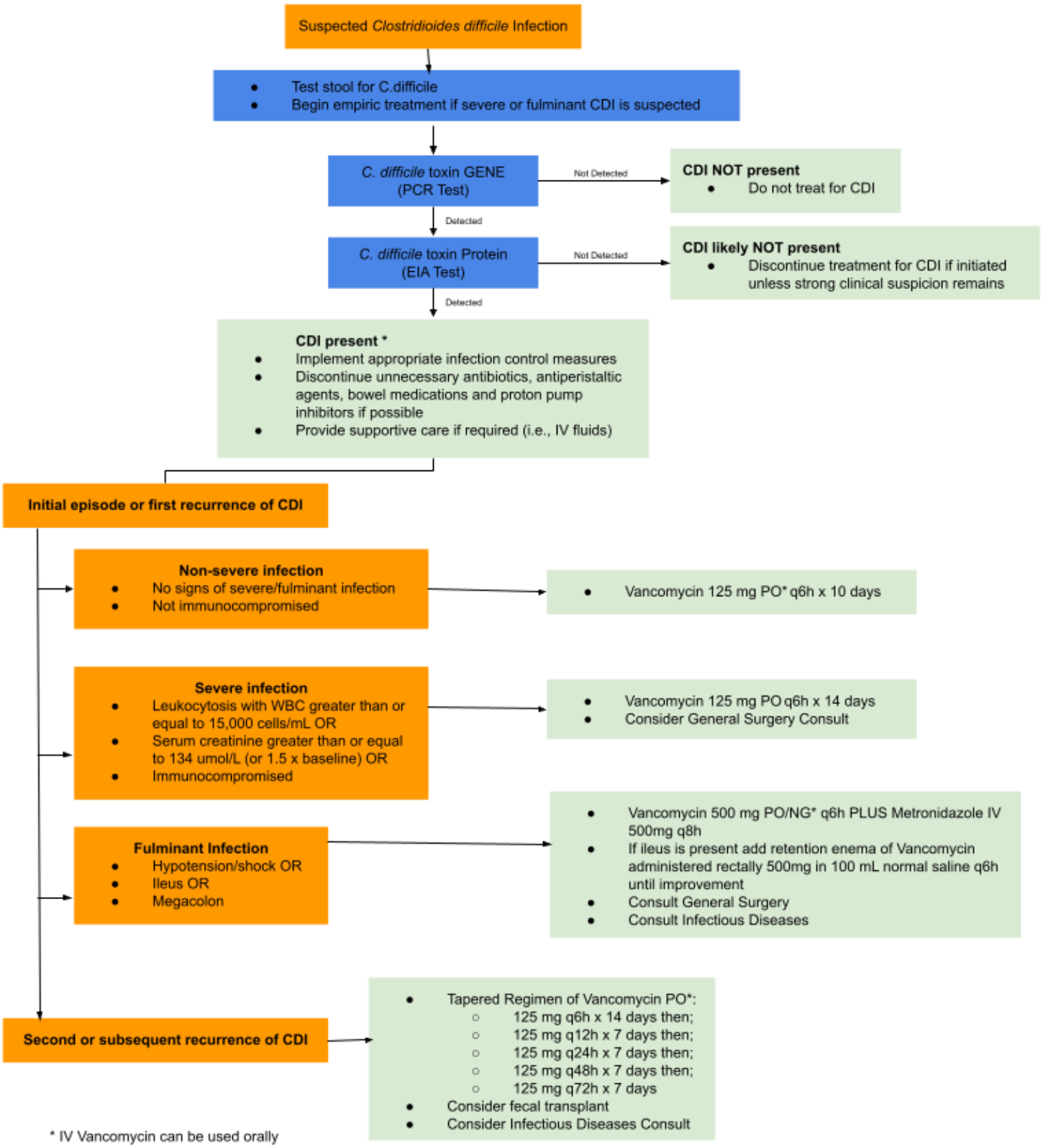
Motion to Adjourn Meeting

MOVED AND DULY SECONDED
MOTION: To adjourn the February 8, 2024 meeting at 8:44am. CARRIED.

Signature

_____
Dr. Ryan, Committee Chair

Clostridioides difficile infection (CDI) - Adults



* IV Vancomycin can be used orally

Testing for Diagnosis

- Testing should only be performed for patients with diarrhea and only on samples of unformed stool, unless there is clinical suspicion of ileus due to *Clostridioides difficile* infection (CDI).
- Only one stool sample should be tested per patient per diarrheal episode unless testing is inconclusive, in which case testing can be repeated
- A stool specimen for suspected CDI will first be processed via a PCR (DNA) test for the toxin A/B genes. If this test comes back negative, the *C. difficile* can be considered to be absent. If the PCR test comes back positive then the next step will be to perform an enzyme immunoassay (EIA) for toxins A/B. If both of the PCR and EIA tests come back positive, the *C. difficile* can be considered to be present. However, if the PCR is positive and the toxin A/B EIA is negative then the patient carries a toxin-producing strain of *C. difficile* (which may or may not be associated with CDI).
- Testing for cure is not recommended.

Infection Control Measures

- Follow local infection control guidelines for all patients with CDI. Every person entering the room of a person with CDI must use gloves and gowns.
- Every person who has made contact with a patient with CDI must wash their hands with soap and water (or an alcohol hand sanitizer if soap and water are not available) *C. difficile* spores are resistant to alcohol hand rubs.
- Contact precautions should be maintained for the duration of diarrhea.

Treatment of *Clostridioides difficile* infection

- Probiotics are not recommended for the treatment or prevention of *C. difficile*.
- In most cases, a positive stool test for *C. difficile* is required before treatment but if severe or fulminant CDI is suspected clinically, then empiric treatment can proceed without a positive stool test.
- Diagnostic testing is not sufficient to completely rule out CDI. Thus, even in the cases of a negative test, clinical judgment and patient risk factors should guide treatment.
- In cases of recurrent CDI, other therapeutic options can be considered such as a fecal transplant OR fidaxomicin (especially in patients at high risk of relapse; use of this antibiotic is restricted to the Infectious Diseases Service).
- Metronidazole may be used in patients with first occurrence, non-severe CDI if vancomycin or fidaxomicin are not available.
- Outpatient drug coverage is available for oral vancomycin capsules under a limited use code for patients eligible for Ontario Drug Benefits
  https://www.formulary.health.gov.on.ca/formulary/limitedUseNotes.xhtml?pcg9Id=081228075
  (Case by case requests for higher doses, prolonged tapers or liquid vancomycin may be obtained through EAP Forms)
- Outpatient drug coverage for fidaxomicin is available through EAP Telephone Request Service for patients eligible for Ontario Drug Benefits.
  http://health.gov.on.ca/en/pro/programs/drugs/docs/frequently_requested_drugs.pdf

Authored by: Emily Stephenson, Michael Juba, Rita Dhami, Dr. S. Elsayed (09/2021)
Reviewed by: Dr. A. Cabrera, Dr. M. Payne, Antimicrobial Stewardship Team (09/2021)
Approved by: Drug & Therapeutics Committee Executive (09/2021)

References

Aas J, Gessert CE, and Bakken JS. Recurrent *Clostridium difficile* Colitis: Case Series Involving 18 Patients Treated with Donor Stool Administered via a Nasogastric Tube, *Clin Infect Dis.* 2003;36:580-5.

Ananthakrishnan AN, *Clostridium difficile* infection: epidemiology, risk factors and management, *Nat Rev Gastroenterol Hepatol.* 2011;8:17–26.

Bakken JS *et al.*, Treating *Clostridium difficile* Infection With Fecal Microbiota Transplantation, *Clin Gastroenterol Hepatol* 2011;9:1044–9.

Bartlett JG and Gerding DN. Clinical Recognition and Diagnosis of *Clostridium difficile* Infection , *Clin Infect Dis* 2008;46:S12–S18.

Bauer MP, Kuijper EJ, and van Dissel JT. European Society of Clinical Microbiology and Infectious Diseases (ESCMID): treatment guidance document for *Clostridium difficile* infection (CDI). *Clin Microbiol Infect. 2009;15:*1067–79.

Cheng AC *et al.*, Australasian Society for Infectious Diseases guidelines for the diagnosis and treatment of *Clostridium difficile* infection, *Med J Aust*, 2011;194:353–8.

Debast SB, Bauer MP, and Kuijper EJ. European Society of Clinical Microbiology and Infectious Diseases: update of the treatment guidance document for *Clostridium difficile* infection. *Clin Microbiol Infect.* 2014;20:1-26.

Gough E, Shaikh H, and Manges AR. Systematic Revi of Intestinal Microbiota Transplantation (Fecal Bacteriotherapy) for Recurrent *Clostridium difficile* Infection, *Clin Infect Dis.* 2011;53:994–1002.

Martin JSH, Monaghan TM, and Wilcox MH. *Clostridium difficile* infection: epidemiology, diagnosis and understanding transmission, *Nat Rev Gastroenterol Hepatol.* 2016;13:206-16.

McDonald LC et al. Clinical Practice Guidelines for *Clostridium difficile* Infection in Adults and Children: 2017 Update by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA). Clin Infect Dis. 2018;66:987-94.

Novak-Weekley SM et al. *Clostridium difficile* Testing in the Clinical Laboratory by Use of Multiple Testing Algorithms. *J Clin Microbiol.* 2010;48:889–93.

Planche TD et al. Differences in outcome according to *Clostridium difficile* testing method: A prospective multicentre diagnostic validation study of C. difficile infection, *Lancet Infect Dis.* 2013;13:936–45.

Polage CR et al. Overdiagnosis of *Clostridium difficile* Infection in the Molecular Test Era, *JAMA Intern Med. 2015;*175:1792

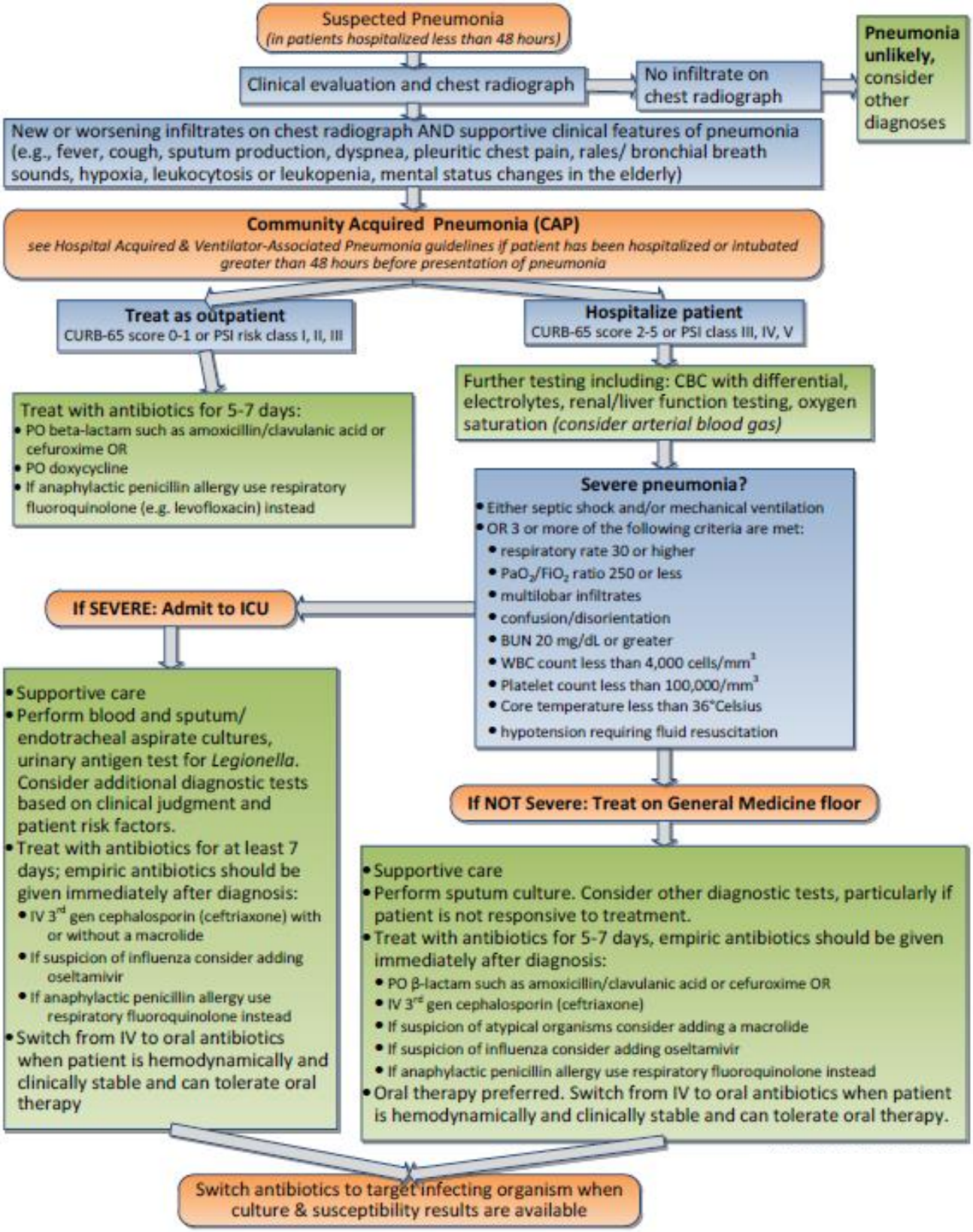
Surawicz CM et al. Guidelines for Diagnosis, Treatment, and Prevention of *Clostridium difficile* Infections, *Am J Gastroenterol.* 2013; 108:478–98.

Australasian Society of Infectious Diseases updated guidelines for the management of *Clostridium difficile* infection in adults and children in Australia and New Zealand, *Intern Med J.* Duodenal Infusion of Donor Feces for Recurrent *Clostridium difficile*, *N Engl J Med*, 2013: 368: 401-415.

Wullt M, Odenholt I, and Walder M. Activity of three disinfectants and acidified nitrite against *Clostridium difficile* spores, *Infect. Control Hosp Epid.* 2003;24:765-8.

Zar FA, Bakkanagari SR, Moorthi KMLST, and Davis MB. A comparison of vancomycin and metronidazole for the treatment of *Clostridium difficile*-associated diarrhea, stratified by disease severity. Clin

Clinical Pathway for Community Acquired Pneumonia in Adults



Key Points

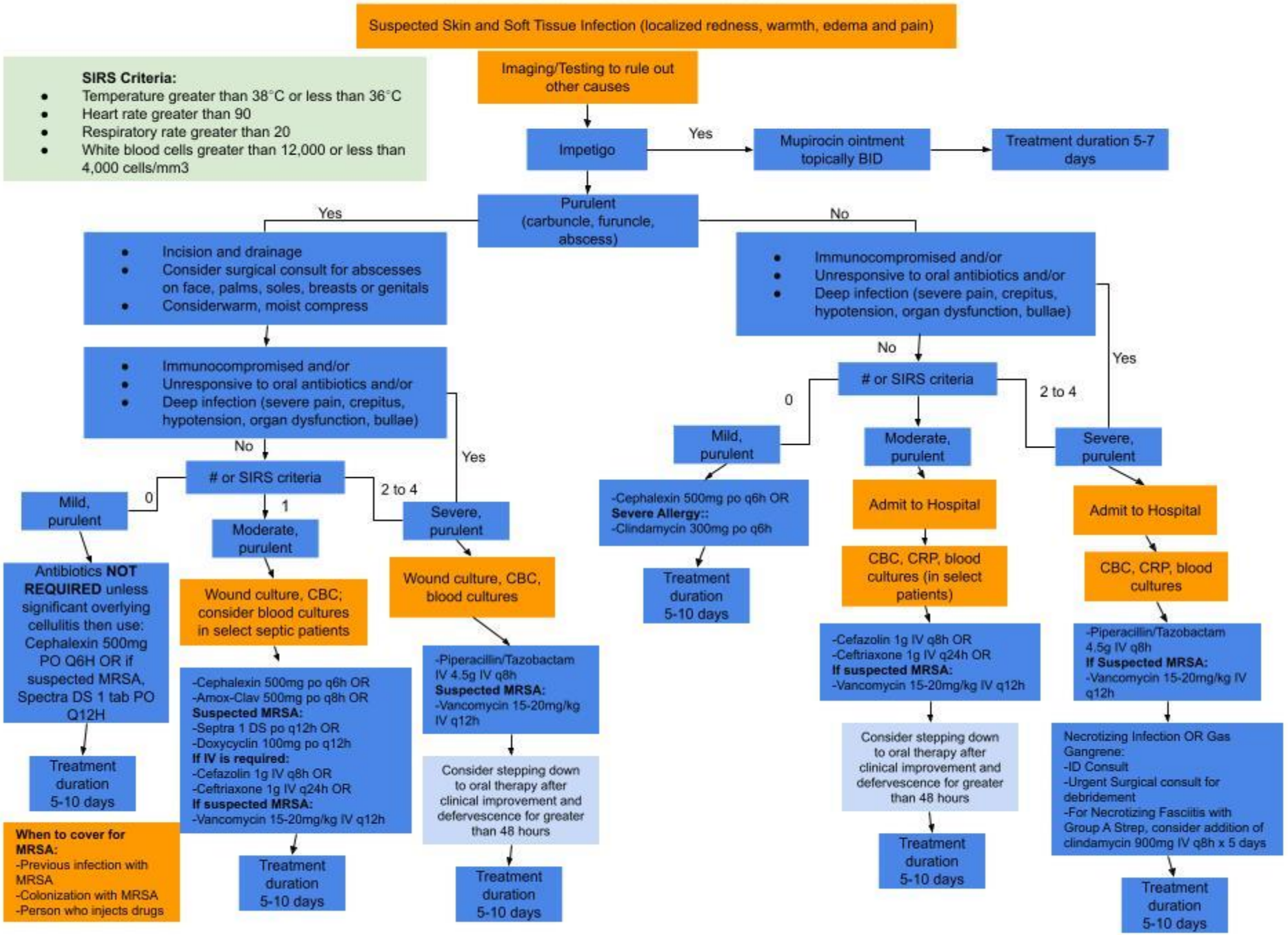
- Use diagnostic scoring tools such as the Pneumonia Scoring Index (PSI) and CURB-65 in conjunction with clinical judgment, and patient factors (ability to take oral medication, social/ family supports, etc.) to determine appropriate site of care in patients with CAP.
- To evaluate a patient's CURB-65 score, give one point for each of the following criteria: **c**onfusion (not orientated to person, place or time), **u**remia (BUN greater than 19 mg/dL), **r**espiratory rate greater than 30, **b**lood pressure < 90/60 mm Hg, age greater than **65** years.
- The Pneumonia Scoring Index (PSI) is a more complicated scoring tool, resources with more information and PSI calculators can be found online.
- Consider additional diagnostic tests in all patients with community-acquired pneumonia, if there is clinical and epidemiological suspicion and the results of these tests would alter patient management.
- In patients that are hospitalized with CAP but not in ICU, consider blood cultures, sputum cultures, urinary antigen tests for legionella and pneumococcus and other testing based on clinical judgment and risk factors
- Consider HIV, TB and pneumocystis testing in patients with risk factors (high-risk sexual behavior, IV drug use, etc.).
- If patients are not improving clinically within 3 days of starting antibiotic therapy consider transferring patient to higher level of care, further diagnostic tests (including evaluating for TB and other less common infecting organisms), imaging/evaluating for complications/ other sites of infection (such as empyema or lung abscesses), switching antimicrobial agents and/ or considering other diagnoses.
- Routine use of steroids is not recommended.

Authors: Emily Stephenson, Rita Dhami PharmD, Dr. Sameer Elsayed MD
LHSC Drugs & Therapeutics Committee Approval Date: December 2018

References

[1] T. M. File, "Community-acquired pneumonia," *Lancet*, vol. 362, no. 9400, pp. 1991–2001, Dec. 2003.
[2] A. C. Kalil *et al.*, "Management of Adults With Hospital-acquired and Ventilator-associated Pneumonia: 2016 Clinical Practice Guidelines by the Infectious Diseases Society
of America and the American Thoracic Society," *Clin. Infect. Dis.*, vol. 63, no. 5, pp. e61–e111, Sep. 2016.
[3] A. Kaysin and A. J. Viera, "Community-acquired pneumonia in adults: Diagnosis and management," *Am. Fam. Physician*, vol. 94, no. 9, pp. 698–706, 2016.
[4] L. A. Mandell *et al.*, "Infectious Diseases Society of America/American Thoracic Society Consensus Guidelines on the Management of Community-Acquired Pneumonia in
Adults," *Clin. Infect. Dis.*, vol. 44, no. Supplement 2, pp. S27–S72, Mar. 2007.
[5] R. G. Wunderink and G. W. Waterer, "Community-Acquired Pneumonia," *N. Engl. J. Med.*, vol. 370, no. 6, pp. 543–551, Feb. 2014.

Skin and Soft Tissue Infection - Adults



For all patients, switch antibiotics based on culture and sensitivity results when available (if applicable) AND/OR reassess in 72 hours after therapy initiation. If no improvement consider:

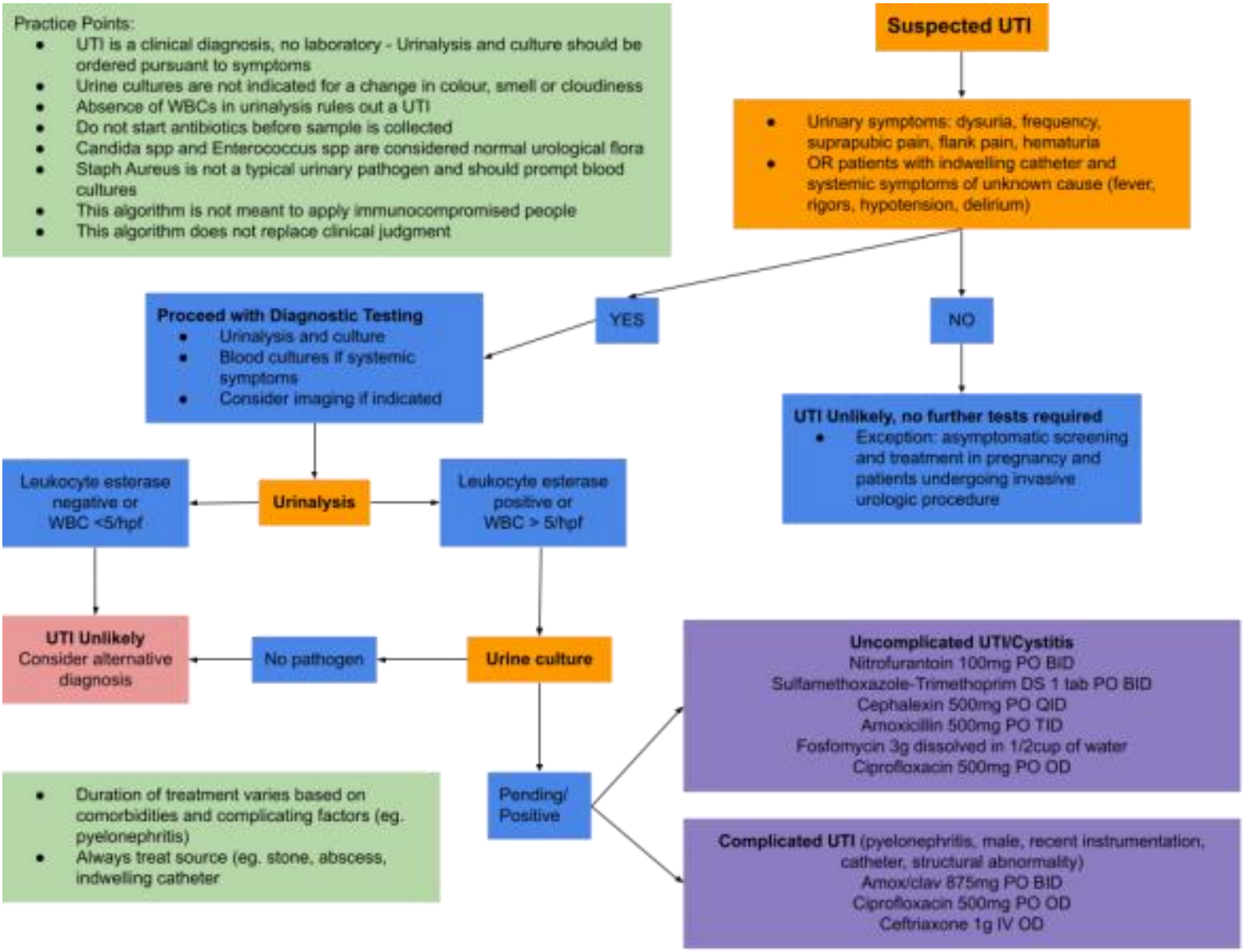
- Other diagnoses (consider Infectious Diseases Consult)
- Repeating incision and drainage (if necessary)
- Imaging to detect complications such as abscess (ultrasound), osteomyelitis (x-ray or MRI) or necrotizing fasciitis (MRI)
- Switching antibiotics to expand coverage of possible infecting organisms (especially MRSA)

Key Points

- Necrotizing Fasciitis and other necrotizing infections are rapidly progressive infections that are often fatal. Necrotizing infections are a surgical emergency that require urgent surgical debridement and IV Antibiotics.
- Cellulitis is a clinical diagnosis. Initial laboratory investigations including needle aspiration, biopsies, and blood cultures are not typically helpful for diagnosis and management. A thorough history and physical examination is imperative. It is especially important to inquire about the inciting/trauma an exposure history (e.g., animal bites, aquatic injury, human bite/ "fight bite", etc.) because this can give an indication of the likely infecting organism.
- Although in the majority of cases they are not indicated, blood cultures should be performed in patients with serious/complicated infections and patients with unusual exposures (including patients with extensive cellulitis, sepsis, malignancy, neutropenia, suspected endocarditis, failed antibiotic therapy, recurrent infection, immunodeficiency, aquatic injuries, animal bites etc.). Needle aspiration culture and tissue biopsy culture can also be considered in the above cases.
- Cellulitis has many mimickers including lymphedema, deep venous thrombosis (DVT), gout, stasis dermatitis and contact dermatitis among others. A thorough history and physical can help to distinguish cellulitis. Cellulitis is typically rapidly progressive and presents unilaterally with a smooth, indistinct borders. If the presentation of 'cellulitis' is slowly progressing, chronic, bilateral, clearly demarcated or diffusely scattered, cellulitis is unlikely and other diagnoses should be considered. If DVT is suspected, a duplex ultrasound should be performed to rule out this condition. AN Infectious Diseases consult can be useful in establishing a definitive diagnosis of cellulitis. If cellulitis does not improve with antibiotics alternate diagnoses should be considered.
- Tetanus immunization status should be up to date in all patients.
- Imaging can be considered in patients where there is a suspected foreign body, osteomyelitis, septic arthritis or tissue gas.
- Optimal blood sugar control should b achieved in patients with diabetes.
- In addition to treating acute infection, physicians should also target associated conditions such as obesity, tinea pedis, venous stasis, lymphedema and eczema to prevent future recurrence.

Authors: Michael Juba BScPhm, Emily Stephenson M3, Sameer Elsayed MD
Approved by: Drugs and Therapeutics Committee (October 2019)
References: LHSC Skin and Soft Tissue Infection – Adults: Flow Chart

Clinical Pathway for Urinary Tract Infection Treatment in Non-pregnant Adults



Diagnostic testing for urinary tract infection

· A negative urinalysis (i.e., negative for leukocyte esterase/WBCs and nitrites) is sufficient to rule out cystitis and a urine culture should NOT be done.

· Urine cultures should NOT be ordered to document clearance of bacteria from the urine after treatment (except in special populations such as pregnant women & patients preparing to undergo an invasive urologic procedure (e.g.,TURP).

· Screening and treatment for asymptomatic bacteriuria is only done in pregnant women and patients preparing to undergo an invasive urologic procedure (i.e., TURP), (remove: redundent) these patients should also have a urinalysis/urine culture done after treatment to document clearance of bacteria from the urine.

· Healthy, premenopausal women with no known co-morbidities can be treated empirically for uncomplicated cystitis based on clinical diagnosis alone (i.e., dysuria and frequency with no vaginal symptoms), ALL other patients should have diagnosis confirmed with laboratory testing.

Indications for imaging and functional testing

· Imaging modalities include renal and pelvic ultrasound with post void residual, intravenous pyelogram, CT or MRI. Specialist referral for functional testing such as cystoscopy, retrograde pyelogram and urodynamic studies may also be done if the patient is suspected to have a functional/ anatomical abnormality (including but not limited to): ○ male

patients of any age, post-menopausal women, recurrent/new onset urinary tract infection after gynecological surgeries like bladder suspension (may suggest bladder outlet obstruction) and women with recurrent urinary tract infections with systemic symptoms.

· Imaging should also be done in patients who do not respond to initial therapy within 2-3 days and patients who are severely ill (e.g., urosepsis) to rule out any correctable problems like urinary retention or abscesses.

Treatment for urinary tract infection

· (Remove) Delay treatment until culture results are available when possible.

· To reduce incidence of catheter-associated urinary tract infections, use aseptic technique when placing catheters and only place catheters when needed and remove at earliest possible date.

Recurrent uncomplicated cystitis treatment

· Defined by 2 or more urinary tract infections within 6 months or 3 or more urinary tract infections within 1 year.

· Treat each recurrence the same as uncomplicated urinary tract infection.

· Use urinalysis and urine culture to confirm diagnosis and direct treatment.

· Additionally, consider patient-directed treatment and antimicrobial prophylaxis (either post-coital or continuous). · Consider imaging if suspicion of functional/ anatomic abnormality and complications.

Adopted from LHSC and edited: Dr. Michaela Ondrejicka MD for South Huron Hospital

Authors: Emily Stephenson M3, Brian Zimmer BScPhm ACPR, Rita Dhami, PharmD, Dr. Sameer Elsayed MD
Reviewed by: LHSC Antimicrobial Stewardship Team (04/2019)

Approved by: Drug and Therapeutics Committee [04/2019]

References

M. S. Bader, J. Hawboldt, and A. Brooks, “Management of Complicated Urinary Tract Infections in the Era of Antimicrobial Resistance,” *Postgrad. Med.*, vol. 122, no. 6, pp. 6–15, 2013.

J. M. Caterino *et al.*, “Accuracy of Current Diagnostic Criteria for Acute Bacterial Infection in Older Adults in the Emergency Department,” *J. Am. Geriatr. Soc.*, Apr. 2017.

E. A. Coyle *et al.*, “Urinary Tract Infections and Prostatitis,” in *Harrison’s Principles of Internal Medicine. 18th ed. New*, 2005, pp. 2081–2095. R. Garcia and E. D. Spitzer, “Promoting appropriate urine culture management to improve health care outcomes and the accuracy of catheter-associated urinary tract infections,” *Am. J. Infect. Control*, May 2017.

M. Grabe *et al.*, “Guidelines on Urological Infections,” *Eur. Assoc. Urol.*, pp. 33–40, 2015.

K. Gupta *et al.*, “International Clinical Practice Guidelines for the Treatment of Acute Uncomplicated Cystitis and Pyelonephritis in Women: A 2010 Update by the Infectious Diseases Society of America and the European Society for Microbiology and Infectious Diseases,” *Clin. Infect. Dis.*, vol. 52, no. 5, pp. e103–e120, Mar. 2011.

T. M. Hooton *et al.*, “Diagnosis, prevention, and treatment of catheter-associated urinary tract infection in adults: 2009 International Clinical Practice Guidelines from the Infectious Diseases Society of America.,” *Clin. Infect. Dis.*, vol. 50, no. 5, pp. 625–63, Mar. 2010. M. E. Levison and D. Kaye, “Treatment of Complicated Urinary Tract Infections With an Emphasis on Drug-Resistant Gram-Negative Uropathogens,” pp. 109–115, 2013. [9] M. Loeb *et al.*, “Development of Minimum Criteria for the Initiation of Antibiotics in Residents of Long-Term–Care Facilities: Results of a Consensus Conference • ,” *Infect. Control Hosp. Epidemiol.*, vol. 22, no. 2, pp. 120–124, 2001.

L. E. Nicolle and AMMI Canada Guidelines Committee*, “Complicated urinary tract infection in adults.,” *Can. J. Infect. Dis. Med. Microbiol. = J. Can. des Mal. Infect. la Microbiol. medicale*, vol. 16, no. 6, pp. 349–60, Nov. 2005.

L. E. Nicolle, S. Bradley, R. Colgan, J. C. Rice, A. Schaeffer, and T. M. Hooton, “Infectious Diseases Society of America Guidelines for the Diagnosis and Treatment of Asymptomatic Bacteriuria in Adults,” pp. 643–654, 2005.

N. D. Stone *et al.*, “Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria,” *Infect. Control Hosp. Epidemiol.*, vol. 33, no. 10, pp. 965–977, 2012.

J. W. Warren, E. Abrutyn, J. R. Hebel, J. R. Johnson, A. J. Schaeffer, and W. E. Stamm, “Guidelines for Antimicrobial Treatment of Uncomplicated Acute Bacterial Cystitis and Acute Pyelonephritis in Women,” *Clin. Infect. Dis.*, vol. 29, no. 4, pp. 745–758, Oct. 1999.

Management of suspected bacterial urinary tract infection in adults: a national clinical guideline. Scottish Intercollegiate Guidelines Network (SIGN), 2012

SHHA Antimicrobial Stewardship Terms of Reference (TOR)

Background: The Antimicrobial Stewardship Program (ASP) is a multidisciplinary patient safety initiative designed to promote the appropriate use of antimicrobials in clinical practice. It is broadly defined as a practice that ensures the optimal indication, selection, dose, route, and duration of antimicrobials for the treatment or prevention of infection. It leads to the best possible clinical outcome while producing the fewest possible side effects and the lowest risk for subsequent resistance. Antimicrobials include antibiotic, antiviral, antifungal, and antiparasitic drugs.

Purpose: The Antimicrobial Stewardship Committee (ASC) is responsible for providing strategic direction on the prioritization, implementation, and evaluation of antimicrobial stewardship initiatives within South Huron Hospital. The ASC will share the relevant activities, processes, and outcomes of the program with stakeholders across the organization.

Goals: The ASC shall provide effective leadership for:

- Overseeing the implementation of institution-wide antimicrobial stewardship processes and services
- Ensuring that quality of care and patient safety are factored into all program decision-making activities by promoting safe, timely, equitable, patient-centered, efficient, and effective use of antimicrobial agents.
- Guiding the program on all matters related to judicious antimicrobial use within the organization
- Reviewing and implementing processes for antimicrobial formulary restrictions and approvals involving high-cost, high-risk, and/or broad-spectrum agents
- Promoting the appropriate use of antimicrobial agents in accordance with accepted national and international standards, including the development of clinical practice guidelines.
- Reviewing antibiograms, local antimicrobial resistance trends, and antimicrobial resistance patterns on a national and global scale
- Ensuring that all program decisions are unbiased, being free from the influence of industry or other external parties
- Ensuring that process and outcome measures are reported to senior hospital leaders and other stakeholders
- Continuous quality improvement activities through: ○
    - Annual review of prescribing practices for restricted antimicrobial agents
    - Quarterly audit of unit-specific and provider-specific compliance with program recommendations

Governance: Who will the ASC committee report to and how often?

Membership Area of Representation	**Representative**	**Voting Status**
Physician Lead, ASP	Dr. Mark Nelham	Chair
Antimicrobial stewardship Pharmacist	Heather Zrini	Co-Chair
Antimicrobial Stewardship Physician	Sandra Mekhaiel	Voting
Infectious Disease Specialist??		Voting
Infection Prevention & Control	Jaime Murray	Voting
Clinical Educator, Nursing Professional Practice	TBD	Voting
Clinical Informatics	Shari Sherwood	Voting
Nursing Staff Representative (Inpatient Unit)	Hallie Caughy	Voting
Pharmacy Staff Representative	Brittany Beauchamp	Voting
Patient Care Manager	Adrianna Walker	Voting
Senior Lab Technician	Allison Rammello	Voting

Chief of Staff Report, South Huron Hospital – March 2024

Prepared by: Sean Ryan MD CCFP(EM) FCFP

Some mixed news this month. On the positive side, we received a response from Ontario Health regarding our application for a CT scanner in Exeter. They asked for a meeting with their Diagnostic Imaging Regional Working Group which was held on February 14. Matt did most of our presentation and did an excellent job. The response was extremely positive, and they are supportive of our application. We are hoping to get official approval from Ontario Health very soon.

On the negative side, our application for Primary Care Team funding was denied. This is extremely disappointing, and likely occurred mainly due to our Ontario Health Team supporting multiple applications as opposed to strongly supporting one. An existing Family Health Team in our region was awarded increased funding to add a mobile nurse practitioner clinic. We remain one of only two primary care groups in Huron Perth without funding for team-based care (the other group did not apply). With the provincial government's new agreement for increased federal healthcare spending, we are hoping there will be another opportunity for us to secure funding.

Form an operations perspective, after a short period of reduced ER visits and hospital admissions, our numbers have increased again to what has become the new normal.

Please feel free to contact me at any time with questions or concerns. My email address is ryanse7@gmail.com

Chief of Staff Report, South Huron Hospital – February 2024

Prepared by: Sean Ryan MD CCFP(EM) FCFP

Our new cardiac monitors have been installed in the emergency department and are working well. They have improved functionality compared to the previous ones and were a much-needed addition.

With respect to our application for a CT scanner in Exeter, we have been contacted by Ontario Health regarding next steps. We will be meeting with them this month.

The MOH has not yet announced an extension of the Emergency Department Temporary Summer Locum Program funding beyond March 31. We are hoping that after almost two years of extensions they will finally make this funding permanent.

Finally, we continue to look for a solution regarding space for expanding our primary care capacity. Discussions continue with the municipality, hospital foundation and the administration.

Please feel free to contact me at any time with questions or concerns. My email address is ryanse7@gmail.com

Huron Health System

Alexandra Marine and General Hospital
120 Napier Street
Goderich, ON N7A 1W5
T 519-524-8323 | F 519-524-8504

South Huron Hospital
24 Huron Street West
Exeter, ON N0M 1S2
T 519-235-2700 | F 519-235-3405

PRESIDENT & CEO REPORT

February 2024

METRICS

Area	AMGH	SHHA	Comment
Health Human Resources			Continue to recruit and retain staff.
Master Plan and Functional Plan			Capital Branch is reviewing Master Plan proposal. Waiting for approval to move forward.
Finance			Continue to capture cost of staying open. Working budget for next year.

TOP OF MIND

Accreditation

- Scheduled for week of April 22-26
- Jane Sager has volunteered to be the HHS board representative for governance
- Teams across the hospitals have been busy reviewing standards and making sure we are in compliance

Funding

- Discussions continue with Ontario Health and the OHA around future funding
- Many hospitals are using lines of credit for day-to-day operations

Recruitment and Retention

- The Recruitment and Retention Committee is in the process of reviewing a recruitment and retention strategy
- Over the next few months HHS will be working with local businesses on recruitment intiatives

BIG WINS | LEARNING

- Cyber security is hot topic in healthcare currently with several hospitals in the SW region that had their systems compromised by bad actors
- SHH will be implementing a new network password policy and multi-factoral authentication to further enhance and secure its networks
- SHH will also be migrating to MS365
- HHS has redundacy built into our systems and both hospitals belong to the Provincial Cyber Security Operating Model (CSOM) which manages cybersecurity for the organization. We are 1 of 10 Local Delvery Groups (LDGs)

PRESIDENT & CEO SUMMARY

Despite the healthcare system's ongoing commitment to delivering exceptional healthcare services, we are confronting significant pressures in several key areas.

1. Staffing Pressures:

The system is currently experiencing increased staffing pressures, primarily due to higher patient volumes, extended working hours, and the ongoing healthcare workforce shortage. The strain on our healthcare professionals has been exacerbated by the need for additional personnel to handle the surge in patients, especially in critical care and emergency departments.

To address this challenge, OH continues to actively explore recruitment strategies, including partnerships with local educational institutions and temporary staffing agencies. Additionally, efforts are underway to enhance staff retention through targeted wellness programs and professional development opportunities.

2. Funding Pressures:

Financial pressures continue to impact hospital operations. The increased demand for healthcare services, coupled with rising costs of medical supplies and staffing, has strained everyone’s budgets. Despite our rigorous cost-saving initiatives, the hospital system faces challenges in maintaining financial sustainability. To mitigate funding pressures, OH is actively engaging with government agencies, seeking grants, and exploring partnerships with private entities.

3. Effects of Increased Viruses:

The recent surge in virus cases, including COVID-19, RSV and the flu, has placed additional strain on hospital resources. The increased demand for testing, treatment, and isolation facilities has stretched our capacity to the limit. OH is actively monitoring the situation and adjusting our protocols in line with the latest medical guidelines to protect both patients and staff.

As we navigate these challenges, the hospital remains committed to providing high-quality care to our community. Moving forward, we will continue to work with OHW on advocating for increased government support and exploring alternative funding sources.

Respectfully,

Jimmy Trieu
President & CEO

COO Report to Board

DATE:	**February 1, 2024**
FROM:	**Matt Trovato, VP Corporate Service and Chief Operating Officer**
TOPIC:	**COO Report to Board of Directors**

Financial Snapshot (Period 9, year to date):

- See December Financial Results Package for fulsome detail
- **AMGH**: $862k deficit, but $568k positive budget variance. Variance primarily due to unknown, unbudgeted funding (both permanent and one-time funding), offset by Bill 124 repeal cost impacts
- **SHH**: $1.2M deficit, and $350K negative budget variance. Variance primarily due to Bill 124 repeal impacts, offset by some one time funding
- Deficits expected to be reduced in February/March results, pending Ontario Health funding announcements

Notable Funding Updates:

- No material new funding received since last report
- Expecting Bill 124 Retroactive Impact Funding in February (per Ontario Health; more info and specifics to come)

Provincial Picture – how we compare to peers:

- As has been noted, all hospitals across the province are experiencing financial challenges. The OHA has released data showing the average margin and current ratio as of Q2. Both organizations are performing better than average compared to our peer hospitals.
- Working in conjunction with OHA for advocacy for additional funding to support increased volumes, impacts of closures, and address funding shortfalls for things like Bill 124 repeal.

Hospital-wide pressures/staffing:

- With increased patient volumes and hospital activity (see December Financial Results Package), it is important to note that workload across all departments is impacted. Support services (eg. Lab, DI, cleaning, Food Services, Health Records, Registration, etc.) all increase workload at the same rates as volume growth. Similarly, administrative support (eg. Finance, HR, etc.) are required to complete significantly more reporting for Ontario Health, and internal analysis to support our growing operations. All examples of the increased workload across the system, without increased resources.

Finance:

- F24/25 budgeting process underway; planning for March Audit and Finance presentation and recommendation.
- Bill 124 Retro payments fully completed for all groups across both organizations in November results (I.e. no further large retroactive impacts, but increased comp costs ongoing):
    - AMGH $2.63M total cost
    - SHH $1.05M total cost
    - Funding TBD; optimistic that MOH will support most of these costs at least on a one-time basis for current year

ITS:

- Increased cyber security, including updating password policies, and leveraging regional IT systems/policies with enhanced security measures,
- AMGH Sharepoint project to replace intranet/Docushare nearing final completion
- SHH Microsoft 365 project progressing well with LHSC's guidance, licensing evaluations under way, targeting an April launch for the full Office 365 suite.
- Exploring new voice translation service (Voyce), which has real-time, live translators in hundreds of languages, accessible through apps on all devices.

Human Resources/Education/Occupational Health:

- Provincial Benefits Strategy – actively involved and participating in the Healthcare Collaborative Benefits (CO), which is a province-wide benefits initiative. The provincial plan is to move benefits for hospitals starting April 1, 2024; we are able to join at anytime after. Cost savings, enhanced fraud protections, new technology and enhanced customer support are expected; potential for $150K savings annually for same coverage.
- As of the end of the calendar year, completed 169 job postings for AMGH and 69 for SHH.
- Unionization: Allied Health departments at AMGH have ratified; notice to bargain issued in January; collective bargaining likely to being in February.
- Diversity, Equity Inclusion Committee developed communication to celebrate Black History Month

Laboratory:

- SHH Clinic Blood Draws: Blood Clinic continues to run from January 1 – March 31 under temporary arrangement (2.5 days/week, supported by union only in temporary capacity). This has allowed us to bring MLA resource back into the SHH Lab, while also continuing to offer this community service. The employee who has taken on the extra shifts is enjoying the work, and we are working with the union to pursue this as a permanent solution (net annual cost of approximately $6K; total incremental cost of $21K annually including benefits; offset by $15K from Dynacare).
- MLT shortage continues to provide significant challenges, with massive holes in schedules at both organizations due to unfillable vacancies (being filled graciously by current staff and casuals, but not sustainable). Exploring alternatives to create stability, all of which will require financial investment.

Diagnostic Imaging:

- SHH CT Business Case: MOH has preliminarily reviewed, and has invited us to present to the OH Regional DI Working Group, where we will further articulate the need for a CT and its benefits.

Facilities and Capital Projects:

- SHH: Electrical Project continues to be on track , next panel upgrade scheduled for February 20th; New HVAC for patient care area scheduled to arrive on site Feb 20; Elevator project has commenced with estimated completion March 25th; many other small capital projects (Lab AC, video surveillance, doors) all underway and expected to be completed by March 31
- AMGH: ER secure room now fully in service; Mental Health renovation: tub room expected completion Feb 12, upgrade to secure/observation room and storeroom will then commence, other renovation opportunities being deliberated by AMGH Foundation

Joint Contracts:

- Currently working with HPHA to refresh and update contracts for shared services (ITS and Pharmacy), which are set to expire March 31, 2024. Ensuring that contracts are updated to reflect the value/work that is being provided for AMGH, rather than previous terminology that specified a flat rate. Also, ensuring flexibility in contract and exit clauses to provide ability to adjust course as we move down the Cerner path in the future.

Huron Health SYSTEM

Alexandra Marine and General Hospital
120 Napier Street
Goderich, ON N7A 1W5
T 519-524-8323 | F 519-524-8504

South Huron Hospital
24 Huron Street West
Exeter, ON N0M 1S2
T 519-235-2700 | F 519-235-3405

INTER-OFFICE MEMORANDUM

TO: Medical Advisory Committee, South Huron Hospital

FROM: Dr. Sean Ryan, Dr. Craig McLean

DATE: March 7, 2024

RE: **Applications for SHH Professional Staff**

It is the recommendation of the credentialing process to appoint the following named individuals to the SHH professional staff. Privileges will be extended to June 30, 2024 and then subject to the re-application process, with the exception of HFO-EDLP physicians, which run from Jan-Dec. New LCAP are requested for HFO-EDLP physicians at the beginning of each year.

LOCUM	CHANGE / STATUS	COMMENTS
JAIRATH, Dr. Ashish	NEW-Radiologist (RAD-Consulting)	
MORDEN, Dr. David	NEW-Emergency (EDLP)	