Add
6.3 2025-02-Monthly Report-COS
6.3 2025-01-SRPC Letter
6.5 2025-02-Monthly Report-CNE
6.6 2025-02-Monthly Report-CFO

Huron Health System
South Huron Hospital

AGENDA

Committee:	**Medical Advisory Committee** -Revised		
Date:	February 13, 2025	Time:	8:00am-9:00am
Location:	Boardroom B110 / MS Teams		
Chair:	Dr. Sean Ryan, Chief of Staff	Recorder:	Alana Ross
Members:	All SHH Active / Associate, CEO, VPs, Clinical Managers		
Guests: *(Open Session Only)*	Shari Sherwood, Heather Zrini, Christie MacGregor (Board Representative), Holly Stokman, Rebecca McNaughton		

	Agenda Item	Presenter	Anticipated Actions	Time Allotted	Related Attachments
1	**Call to Order / Welcome** • Notifications: ○ Video/Audio recordings and transcriptions of the open session meeting are retained for the purpose of creating accurate minutes and will be expunged on final approval of the minutes by the Committee; in-camera sessions are not recorded or transcribed				
2	**Guest Discussion / Education Session**				
2.1	Medical Directive-Diabetes	Stokman / McNaughton	Presentation Acceptance	10min	• 2025 SHH DEP Insulin Adjustment Medical Directive-Revised • 2025 SHH DEP Insulin Directive Authorization Form
	Draft Motion: To accept the 2025 SHH DEP Insulin Adjustment Medical Directive-Revised.				
3	**Approvals and Updates**				
3.1	Previous Minutes	COS	Decision	1min	• 2025-01-09-MAC Minutes
	Draft Motion: To accept the January 9, 2025 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	
5.3	Antimicrobial Stewardship	Nelham	Information	as needed	
5.4	Pharmacy & Therapeutics	Pres. MS	Information	as needed	
5.5	Lab Liaison	Bueno	Information	as needed	
5.6	Recruitment and Retention Committee	COS	Information	as needed	
5.7	Quality Assurance Committee	Nelham / CNE	Information	as needed	
	Draft Motion: To accept the February 13, 2025 Medical Staff Reports to the MAC.				
6	**Other Reports**				
6.1	Lead Hospitalist	Pres. MS	Information	5min	
6.2	Emergency	Chief of ED	Information	20min	
6.3	Chief of Staff	COS	Information	5min	• 2025-02-Monthly Report-COS • 2025-01-SRPC Letter

6.4	President & CEO	CEO	Information	5min	• 2025-02-Monthly Report-CEO
6.5	CNE	CNE	Information	5min	• 2025-02-Monthly Report-CNE
6.6	CFO	CFO	Information	5min	• 2025-02-Monthly Report-CFO
6.7	Patient Relations	Klopp	Information	5min	• 2025-02-Monthly Report-Patient Relations
6.8	Patient Care Manager	Walker	Information	5min	
6.9	Clinical Informatics	Sherwood	Information	5min	
	Draft Motion: To accept the February 13, 2025 Other Reports to the MAC.				
7	**New and Other Business**				
8	**In-Camera Session** • Notifications: o Guests will be invited by the Committee Chair, as required; any members with conflicts of interest during in-camera discussion, can be recused as needed o All participants of the in-camera session are expected to ensure that their surroundings are secured from unauthorized participants				
8.1	Move into In-Camera • Credentialing	Chair	Motion, if needed		• 2025-02-Report to MAC-Credentials
	Draft Motion: To move into the in-camera session at XX:XXam.				
8.2	Move out of In-Camera	Chair			
	Draft recommendation made to move back into open session at XX:XXam.				
8.3	Motions made based on In-Camera discussion	Chair	Acceptance Recommendation		
	Draft Motion: To accept the Credentialing Report of February 13, 2025 as presented, and recommend to the Board for Final Approval.				
9	**Next Meeting & Adjournment**				
	Date	**Time**		**Location**	
	March 20, 2025	8:00am-9:00am		Boardroom B110 / MS Teams	

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Medical Directive	**Adult Insulin Dose Adjustment by Certified Diabetes Educators**
Directive #	MD-DIAB-4.3
Approval	Medical Advisory Committee
Date	January 2025
Signature	
Review Date	January 2027
Specific to	Huron Health System: South Huron Hospital Association

Description of Directive:

This medical directive authorizes a Registered Nurse (RN) or Registered Dietitian (RD) employed as a Certified Diabetes Educator with the Huron Health System: South Huron Hospital Association, to adjust insulin doses for the purpose of achieving and maintaining target blood glucose levels in adults with diabetes, including pregnant women, and those with gestational diabetes, who are under the care of an authorizing health care provider. This medical directive authorizes the adjustment of: 1) basal insulin only regimens; 2) pre-mixed insulin regimens; 3) multiple daily injection (MDI) regimens; 4) fixed dose basal insulin/GLP-1 combination injection therapies and; 5) continuous subcutaneous insulin infusion (CSII, Stratford and Goderich sites only).

Authorized to:

Certified Diabetes Educators working in the Huron Health System who have completed certification in insulin dose adjustment for adults according to the procedure outlined in the Huron Perth Diabetes Program (HPDP) Insulin Adjustment Manual and the Adult Insulin Dose Adjustment Protocols (Appendices A and B) in this Directive.

Implementation Criteria:

Patient must be registered with HPDP and meet the following criteria:

- Must be an adult (aged 18 years or older) under the care of an authorizing health care provider.
- Must have evidence of suboptimal blood glucose control according to current Diabetes Canada Clinical Practice Guidelines for the Management of Diabetes in Canada.
- Must be on an insulin regimen ordered by an authorizing health care provider including type(s), frequency, route and initial dosage.
- Must agree to have the Certified Diabetes Educator (CDE) adjust insulin.

Authorizing health care providers include physicians or Nurse Practitioners who hold credentials with the South Huron Hospital Association, or any other MD/NP indicating on referral that they authorize SHHA CDEs to implement this Directive (review of this Directive and sign-off for approval required).

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Exclusion Criteria:

- Excludes in-patients and Emergency (ER) patients unless specifically requested by MD.
- Patient or caregiver is not able to understand and follow the instructions.
- Patient or caregiver does not demonstrate potential for safe insulin dose adjustment (i.e. cognitive deficits or substance abuse).
- Client is unwilling or unable to attend follow up appointments either in person or virtual
- Authorizing health care provider revokes the use of the medical directive in writing (discontinues medical directive).

Reasons to seek immediate medical consultation or discontinue procedure/treatment/ intervention:

- Consultation with authorizing health care provider will occur when any exception criteria met.
- Consultation with the authorizing health care provider will occur when the Certified Diabetes Educator reaches the limit of their respective knowledge, skill and judgment to implement the medical directive independently.

Guidelines for Insulin Adjustment:

- The Certified Diabetes Educator ensures that the above criteria are met before making any adjustments to insulin(s).
- The Certified Diabetes Educator will review with the patient or caregiver the following guidelines prior to adjusting insulin(s). The patient or caregiver should:
  - Demonstrate a commitment to scheduled follow-up appointments either in-person, by telephone, email or fax to assess impact of insulin dose adjustment.
  - Be self-monitoring blood glucose (SMBG) at a frequency negotiated with the Certified Diabetes Educator either by capillary blood glucose (CBG) checks or interstitial glucose monitoring (via real-time CGM or flash monitor); the latter may still require CBG to verify results at times.
  - Provide results of SMBG (logbook, meter download, meter memory) or interstitial glucose (CGM or flash monitor download) at each appointment.
  - Verbalize some understanding of the interaction between carbohydrate intake, physical activity, medications & insulin. (RD assessment recommended)
  - Demonstrate the ability to follow the recommended dose changes.
  - Verbalize understanding and readiness to manage potential for hypoglycemia.
- The Certified Diabetes Educator, in collaboration with the patient or caregiver, adjusts the patient's insulin regimen according to the **Adult Insulin Dose Adjustment Protocols** (Appendix A and B).
- The Certified Diabetes Educator and the patient or caregiver will establish a plan for follow-up to review the patient's glycemic control.

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Documentation:

- All insulin dose adjustments made according to the protocol and pursuant to this medical directive will be documented in the respective hospital's medical patient record either written chart or electronic medical record (EMR).
- Documentation will include:
  - The patient assessment;
  - Indications for implementation of the specific medical directive, and;
  - Plan for follow-up in the patient's diabetes education chart.
- The Certified Diabetes Educator notifies the authorizing health care provider of the adjustment(s) in a timely manner.

Quality Assurance

The following processes will be used to maintain appropriate ongoing implementation of the directive:

- The Certified Diabetes Educator will demonstrate competency in providing comprehensive diabetes care and management through insulin dose adjustment recertification.
- The Certified Diabetes Educator will practice as per the standards of practice for nurses or dietitians within Ontario, according to his/her respective college.
- The Certified Diabetes Educator will ensure his/her own competence through ongoing participation in supervised learning opportunities and diabetes related conferences and workshops, and by reviewing current literature.
- This medical directive will be reviewed every 2 years.

Originator	Huron Perth Diabetes Program
Current Review/Revision	January 2025
Responsibility	Dr. Sean Ryan
Distribution	

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APPENDIX A
Adult Insulin Dose Adjustment Protocols: General Guidelines
Huron Perth Diabetes Program
Huron Health System: South Huron Hospital Association

Implementation Criteria

- Adjustments of insulin doses, as per protocol are performed by a Registered Nurse (RN) or Registered Dietitian (RD) who is employed as a Certified Diabetes Educator and who has demonstrated competency through certification in insulin dose adjustment for adults.
- Only RNs or RDs working in the Huron Perth Diabetes Program may be certified.
- Individual certification is granted for basic insulin adjustment which includes: 1) basal insulin only regimens; 2) pre-mixed insulin regimens; 3) multi-dose injection (MDI) regimens, 4) fixed dose basal insulin/GLP-1 combination injection therapies and; 5) continuous subcutaneous insulin infusion (CSII, Stratford and Goderich sites only)
- **An initial insulin regimen must be ordered by the authorizing health care provider including type(s), frequency, route and initial dosage.**

Procedure for Insulin Dose Adjustment

When making an insulin adjustment the certified RN/RD in collaboration with the patient will/may:

- Assess for signs and symptoms of hypoglycemia and hyperglycemia.
- Review signs and symptoms, treatment and prevention of hypoglycemia.
- Have a minimum of three days of glucose results relevant to the insulin(s) being adjusted.
- Screen for nocturnal hypoglycemia and rebound hyperglycemia by requesting nocturnal blood glucose testing or initiating real time CGM or flash monitoring of interstitial glucose.
- Assess for other factors that can affect glucose levels: carbohydrate intake, level of physical activity, concurrent illness, stress, depression, knowledge of diabetes self-management, other medications, pregnancy, travel, shift work, and diagnostic procedures, etc.
- Confirm the accuracy of the patient's monitoring of blood or interstitial glucose.
- Adjust each dose of basal and/or bolus insulin by a maximum of 10-20% per adjustment. Note that insulin degludec (Tresiba), insulin icodec (Awiqli), regular insulin u500 (Entuzity) and the insulin/GLP-1 combination therapy (Xultophy and Soliqua) have special adjustment criteria.
- Adjustments in excess of the above are acceptable during times of illness (as outlined for sick-day management), within the context of exercise management, fasting for minor medical procedures or preparing for colonoscopies.
- Glucose targets have been determined collaboratively by the physician/NP, RN/RD and the patient, and documented.

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The following glucose targets can serve as a standard reference point:

Adult Type 1 or Type 2

ac meals 4.0-7.0 mmol/L
2 hr pc meals 5.0-10.0 mmol/L

Pregnant Type 1 or Type 2 and Gestational Diabetes Mellitus

ac meals 3.5 – 5.2 mmol/L
1 hr pc meals less than 7.8 mmol/L
2 hr pc meals less than 6.7 mmol/L

General guidelines:

- Severe hypoglycemia and hypoglycemia unawareness may mandate an increase in the above goals.
- If both hypoglycemia and hyperglycemia episodes occur, **adjust for hypoglycemia first.**
- If all blood glucose values are high, start by adjusting the basal insulin first and/or assess basal: bolus balance.
- Discuss the change in insulin dose, rationale, validate patient understanding of the change, document.
- Suggest a blood glucose monitoring schedule to evaluate the adjusted insulin dose.
- Plan for follow-up with diabetes education team.
- Individualized pattern management and supplemental insulin dose adjustments (for carbohydrate intake/ratios, correction doses/scales, physical activity/exercise, illness/sick day management, travel, shift work) may be taught utilizing the guidelines provided in the HPDP Insulin Adjustment Manual, to patients who have established skill in diabetes and insulin self-management.

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APPENDIX B
Adult Insulin Dose Adjustment Protocols: Regimens
Huron Perth Diabetes Program
Huron Health System: South Huron Hospital Association

Basal insulins

- **Intermediate-acting:** insulin neutral protamine Hagedorn (Humulin N), insulin isophane (Novolin ge NPH)
- **Long-acting:** insulin glargine u100 (Lantus, Basaglar, Semglee), insulin glargine u300 (Toujeo), insulin detemir u100 (Levemir)
- Each dose of **basal** insulin may be adjusted up or down by a maximum of 2-4 units or 10-20% (whichever is greater) every 2-3 days based on pattern management. If a patient is capable and willing, they may be taught self-titration of 1-2 units or 10% on a daily basis to fasting and/or pre-meal glucose targets.
- **Insulin degludec** (Tresiba) may be adjusted by 2 units (or 10%) every 3-4 days. When starting patients on Tresiba they will be counselled on the action profile and duration and it will be noted they will need instruction for its dosing prior to a procedure or surgery.
- **Insulin icodec** (Awiqly) may be adjusted based on the *average* of 3 consecutive fasting blood sugar results just prior to the scheduled weekly injection. Pen devices deliver insulin in 10-unit increments. A minimum of 4 days must pass between injections (in event of delayed/missed doses). Patients should be encouraged to perform SMBG more frequently than typically required for basal only regimens during adjustments. Adjustments for short-term changes (i.e. illness or physical activity) are not applicable due to the long half-life of this insulin. Patients will be counselled on the action profile and duration and it will be noted they will need instruction for its dosing prior to a procedure or surgery.

Bolus Insulins

- **Short-acting:** insulin regular u100 (Humulin R, Novolin ge Toronto)
- **Rapid-acting:** insulin lispro u100 (Humalog, Admelog), insulin lispro u200 (Humalog), insulin aspart u100 (NovoRapid, Trurapi, Kirsty), insulin glulisine u100 (Apidra)
- **Faster-acting:** insulin aspart u100 (Fiasp)
- Each dose of **bolus** insulin may be adjusted up or down by a maximum of 1-2 units or 10-20% (whichever is greater) every 2-3 days based on pattern management. If a patient is capable and willing, they may be taught self-titration of 1-2 units or 10% on a daily basis to pre-meal or 2-hour post-meal glucose targets
- **Insulin regular u500** (Entuzity) is indicated for patients requiring more than 200 units of insulin per day (total from basal and bolus). Prefilled pens deliver insulin in 5-unit increments. It may be given two or three times daily. If taken twice daily, divide the total daily dose into initial proportions of 60% and 40% for administration 30 minutes before morning and evening meals, respectively; if taken three times daily, divide total daily dose into initial proportions of 40%, 30% and 30% for administration 30 minutes before morning, midday and evening meals, respectively.

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MDI (Multiple Daily Injections of basal/bolus insulin)

Assumptions

Blood Sugars	Primarily reflect the action of …
ac breakfast	basal/bolus given the evening prior
ac lunch	bolus given ac breakfast
ac supper	bolus given ac lunch and/or basal given ac breakfast
2 hours after a meal	bolus given before that meal
ac bedtime snack	bolus given ac supper
between 12 and 5 am	basal given before supper or before bed, or bolus given at bedtime

Adjustments

Blood glucose	Fasting	2 hours pc breakfast	ac lunch	2 hours pc lunch	ac supper	2 hours pc supper	Bedtime ac snack	12-5 am
If **LOW**	↓ **basal** from supper or bedtime	↓ **bolus** ac breakfast	↓ **bolus** ac breakfast	↓ **bolus** ac lunch	↓ **bolus** ac lunch or ↓ **basal** ac breakfast	↓ **bolus** ac supper	↓ **bolus** ac supper	↓ **bolus** ac bedtime snack or ↓ **basal** ac supper or bedtime
If **HIGH**	Rule-out rebound hyperglycemia, then ↑ **bolus** ac bedtime snack or ↑ **basal** ac supper or bedtime	↑ **bolus** ac breakfast	↑ **bolus** ac breakfast	↑ **bolus** ac lunch	↑ **bolus** ac lunch or ↑ **basal** ac breakfast	↑ **bolus** ac supper	↑ **bolus** ac supper	↑ **bolus** ac bedtime snack or ↑ **basal** ac supper or bedtime

Pre-mixed insulins

- **Premixed regular insulin:** insulin/insulin isophane (Humulin 30/70; Novolin ge 30/70, 40/60, 50/50)
- **Premixed insulin analogues:** biphasic insulin aspart (Novomix 30); insulin lispro/lispro protamine (Humalog Mix25 and Mix50)
- Making a dose adjustment with pre-mixed insulins automatically adjusts both insulins and may affect blood glucose levels at more than one time/day, which in turn complicates the “fine tuning” of blood glucose.

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- If both blood glucose levels related to the actions of the pre-mixed insulin are elevated, increase the present amount of the insulin dose by 1-2 units or 10-20% and reassess in a timely manner or PRN.
- If both blood glucose levels related to the action of the pre-mixed insulin are low, decrease the present amount of the insulin dose by 1-2 units or 10-20% and reassess in a timely manner or PRN.
- If only one blood glucose level related to the action of the pre-mixed insulin is low, decrease the present amount of the insulin dose by 1-2 units or 10-20% and consider a change in the insulin regimen as below.
- If only one blood glucose level related to the action of the pre-mixed insulin is elevated or low, then a change in the insulin regimen may need to be considered:
    - Different pre-mixed ratio;
    - Change to basal/bolus multiple daily injection insulin (MDI);
    - Intensify regimen, such as TID dosing of pre-mixed analogues or addition of rapid/short acting insulin to treat blood glucose levels outside of target ranges.
- Any recommended changes in the insulin regimen must be discussed with the authorizing health care provider and followed by a written order prior to implementation.

Fixed Dose Basal Insulin/GLP-1 Combination Therapy

- Xultophy (insulin degludec/liraglutide) has a maximum dose of 50 units daily. If less than 16 units daily is required on an ongoing basis, then an alternate treatment should be considered. Dosing may be titrated by 2 units every 3-4 days.

- Soliqua (insulin glargine/lixisenatide) has a maximum dose of 60 units daily. If less than 15 units daily is required on an ongoing basis, an alternate treatment should be considered. Dosing may be titrated by 2-4 units per week.

Protocol for Insulin Considerations and Precautions in Pregnancy

- Insulin is the therapy of choice in patients with gestational diabetes who cannot achieve glycemic control despite an adequate trial of diet and lifestyle interventions alone.
- Insulin therapy in the form of multiple daily injections (MDI) are the most effective regimen for pregnant women with diabetes.
- Data on the safety of some insulins during pregnancy is limited. The use of any insulin off-label in pregnancy warrants full disclosure and an informed discussion with the Endocrinologist or Internist.
- If patient is requiring less insulin with no apparent reason (in pregnancy, placenta insufficiency needs to be ruled out and the physician is to be notified immediately).

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References

American Diabetes Association. (2003). *Intensive Diabetes Management, 3rd edition*. Alexandria, VA.

Ash, C., Ludwig, S. (1998). The art of insulin adjustment. *Canadian Diabetes. 11(3*), 2-8.

Barnett, A.H., Owens, D.R. (1997). Insulin analogues. *Lancet, 349*, 47-51.

Braithwaite, S. (2005). Case Study: Five steps to freedom: dose titration for type 2 diabetes using basal prandial-correction insulin therapy. *Clinical Diabetes, 23(1),* 39-43.

Cheng, D. (2008). Diabetes Update 2008: Diabetes in pregnancy. *Pharmacy Practice, March/April*, 22-27,38,39.
College of Dietitians of Ontario (2014). Clients with Diabetes

College of Dietitians of Ontario, (2002). Insulin adjustments. *Resume, Fall, 2002*.

College of Dietitians of Ontario, (2008). Is adjusting insulin within the dietetic scope of practice? Resume, Fall, 2008.

College of Dietitians of Ontario, (2015). Jurisprudence Handbook for Dietitians in Ontario.

College of Nurses of Ontario, (2018). Practice Guideline: Authorizing Mechanisms.

College of Nurses of Ontario, (2014). Reference Document: Legislation and Regulation
RHPA: Scope of Practice, Controlled Acts Model.

College of Nurses of Ontario, (1995). When, why and how to use medical directives. *Communique, 20(3),* 10-14.

College of Physicians and Surgeons of Ontario, (2012). Delegation of Controlled Acts.

Diabetes Canada. (2018). Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada. *Canadian Journal of Diabetes, 37(S1).*

Diabetes Care Program of Nova Scotia Delegated Medical Function Committee. (2010). Insulin Dose Adjustment Policies & Guidelines Manual. Diabetes Care Program of Nova Scotia.

Diabetes Care Program of Nova Scotia Pregnancy and Diabetes Sub-Committee. (2000). The Pregnancy & Diabetes Management Guidelines Manual. Diabetes Care Program of Nova Scotia.

Diabetes Care Program of Nova Scotia Pregnancy and Diabetes Sub-Committee. (2006). The Pregnancy & Diabetes Management Guidelines Manual Revisions. Diabetes Care Program of Nova Scotia.

Eli Lilly Canada Inc., (2017). *Entuzity (insulin injection, human biosynthetic): Product Monograph including Patient Medication Information*, p.17-18, Retrieved from: 00040342.PDF

Federation of Health Regulatory Colleges of Ontario. An Inter Professional Guide on the Use of Orders, Directives & Delegation for Regulated Health Professionals in Ontario. Retrieved from http://www.medicaldirectives-delegation.com/why/default.asp

Gill, N. (1999). Insulin dosage adjustment in Canada: authority to perform and risk reduction. *Canadian Journal of Diabetes Care*. *23(suppl 2),* 95-99.

Halton Diabetes Program. Protocol for Insulin/Oral Antihyperglycemic Agent Dose Adjustments for Diabetes Nurse Educators.

Hirsch, I.B. (2005). Insulin analogues. *NEJM, 352,* 174-83.

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Hirsch, I.B., Bergenstal, R.M., Parkin, C.G., Wright, E., Buse, J.B. (20054). A real-world approach to insulin therapy in primary care practice. *Clinical Diabetes, 23(2),* 78-86.

Huron Perth Diabetes Program. *Insulin Adjustment Manual. Adapted from: Diabetes Care Program of Nova Scotia Nova Scotia Health Authority*.

Huron Perth Healthcare Alliance (January 2024). *Medical Directive: Adult Insulin Dose Adjustment by Certified Diabetes Educators or Designate*, MD-DIAB-4.3.

Jones, H, (2004). *Guidelines for Insulin Dose Adjustments: Policies, Indications, Competencies.* Toronto, ON: Leadership Sinai Centre for Diabetes, Mount Sinai Hospital.

Jovanovic L, ed. (2009). *Medical Management of Pregnancy Complicated by Diabetes*. Alexandria, VA: American Diabetes Association.

Jovanovic, L., & Pettitt, D.J. (2007). Treatment with insulin and its analogues in pregnancies complicated by diabetes. *Diabetes Care, 30(S2*), S220-224.

Kitzmiller J. (2008). *Managing Preexisting Diabetes and Pregnancy Technical Reviews and Consensus Recommendations for Care*. Alexandria, VA: American Diabetes Association.

Ministry of Health and Long-Term Care and Ontario's Local Health Integration Networks (February 2015). Policies and Procedures Manual for Diabetes Education Programs Funded to Serve Adult Patients.

Novo Nordisk Canada Inc. (2024). *Awiqli (insulin icodec injection): Product Monograph including Patient Medication Information*, 9-10. Retrieved from: awiqli-en-product-monograph-12-march-2024.pdf

Novo Nordisk Canada Inc. (2022). *Tresiba (insulin degludec injection): Product Monograph including Patient Medication Information*, 5-7. Retrieved from: tresiba-product-monograph.pdf

Novo Nordisk Canada Inc. (2018). *Xultophy (insulin degludec + liraglutide injection): Product Monograph including Patient Medication Information*, 15-16. Retrieved from: [Product Monograph Template - Schedule D]

Ontario Ministry of Health and Long-Term Care (1991). *Regulated Health Professions Act*.

Pearson, J., Bergenstal, R. (2001). Fine tuning control: pattern management versus supplementation. *Diabetes Spectrum, 14(2),* 75-78.

Retnakaran, R., Zinman, B. (2004). Using insulin effectively in the management of diabetes. *Endocrinology Rounds, 4(6).*

Sanofi-aventis Canada Inc. (2018). *Soliqua (insulin glargine and Lixisenatide injection): Product Monograph including Patient Medication Information*, 6-9. Retrieved from Microsoft Word - Approved Product Monograph 1.doc

Saskatchewan Health. (March, 2009). Saskatchewan Insulin Dose Adjustment Module.

Saskatchewan Health. (November, 2010). Saskatchewan Advanced Insulin Dose Adjustment Module.

Scheiner, G. (2004). *Think Like a Pancreas: A Practical Guide to Managing Diabetes with Insulin.* Cambridge, MA: De Capo Press.

Sempowski, I.P., & Houlden, r.L. (2003). Managing diabetes during pregnancy: Guide for family physicians. *Canadian Family Physician, 49,* 761-767.

Walsh, J., Roberts, R., Varma, C., Bailey, T. (2003). *Using Insulin: Everything You Need for Success with Insulin.* San Diego: Torrey Pines Press

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South Huron Hospital Association

Physician Approval Form

Medical Directive	**Adult Insulin Dose Adjustment by Certified Diabetes Educators**
Directive #	MD-DIAB-4.3

I, the undersigned physician, have:

- Reviewed the directive to fully understand the conditions under which it will be implemented, including knowing how the staff will be educated to provide this care and how they document or make me aware that the directive has been implemented so I can assume care appropriately, and

- Agree to assume the care of patients who have had an intervention performed as authorized by the directive

_____
Name of Physician (please print)

_____
Signature

_____
Date

Note: The above Medical Directive was reviewed and approved at the HPHA Medical Advisory Committee meeting _____. If agreeable, please sign and return this form to Medical Services, Attn: _____ .

Huron Health System
South Huron Hospital

MINUTES

Committee:	**Medical Advisory Committee**		
Date:	January 9, 2025	Time:	8:04am-9:01am
Chair:	Dr. Sean Ryan, Chief of Staff	Recorder:	Alana Ross
Present:	Dr. Bueno, Dr. Joseph, Dr. Kelly, Dr. Lam, Dr. Nelham, Dr. Patel, Dr. Ondrejicka, Dr. Ryan, Lynn Higgs, Heather Klopp, Robert Lovecky, Jimmy Trieu, Adrianna Walker		
Guests:	Shari Sherwood, Heather Zrini, Christie MacGregor (Board Representative)		

1	**Call to Order / Welcome**

1.1	• Dr. Ryan welcomed everyone and called the meeting to order at 9:01am
	  ○ Notifications:
	  ▪ Video/Audio recordings and transcriptions of the open session meeting are retained for the purpose of creating accurate minutes and will be expunged on final approval of the minutes by the Committee; in-camera sessions are not recorded or transcribed

2	**Guest Discussion / Education Session**
3	**Approvals and Updates**
3.1	Previous Minutes • Approval / Changes ○ None ***MOVED AND DULY SECONDED*** ***MOTION: To accept the December 12, 2024 MAC minutes. CARRIED.***
4	**Business Arising from Minutes**
5	**Medical Staff Reports**
5.1	Chart Audit Review: • No discussion

5.2	Infection Control:
	• Reviewed IPAC information received regarding the recent RSV positive patient surge; infection control standards were followed and RSV was well contained
	  ○ **'Job Well Done'** to everyone who was involved
	• Infection Control Audits are held on an ongoing basis; reminder to be compliant at all times regarding hand hygiene and masking
	  ○ Some masking non-compliance among visitors and staff was noted

5.3	Antimicrobial Stewardship:
	• Sexually Transmitted Infections (STIs)-Treatment Recommendations circulated and reviewed
	  ○ Date of acceptance at MAC will be included on the document
	  ○ Ms. Zrini / Ms. Sherwood are in the process of determining the most appropriate location to house these Clinical Guidelines for easy access by the physicians; location pending, i.e., SharePoint, SHH links, ED folder on the Desktop, etc.
	  ○ Available Clinical Guidelines now include UTIs, cDiff and now STIs; still to come include Pneumonia, Skin and Soft Tissue and Cellulitis
	
	MOVED AND DULY SECONDED
	MOTION: To approve the use of the STI Guidelines, as presented on January 9, 2025. CARRIED.
	
	• Antimicrobial Stewardship Program has been reviewing Performance Improvement Plan (PIP) tasks over the past 18 months
	• Over the past quarter it was noted that:
	  ○ 10% or 2/20 patients didn't have blood cultures ordered; down from last quarter

	○ There is a need to refocus on appropriateness of the dose of piperacillin-tazobactam (PIP-TAZ) that is being used; going forward Pharmacy will not be looking for blood cultures ordered prior to starting this antibiotic, and will instead look for the appropriateness of the indication and dose of this antibiotic ○ There are a lot fewer urine cultures being completed, resulting in a focus on what antibiotics are being chosen, particularly in the elderly population ▪ Dr. Patel has noted during his Hospice rounds between December and now, that a number of patients have been admitted with Urine Sepsis or UTI, with urinalysis done in the ED, but no urine cultures ordered ▪ Reminder that all patients admitted with UTI should have a culture drawn
	Action: • Discuss automatic UTI cultures with Lab — ***By whom / when:*** • Ryan; This week
5.4	Pharmacy & Therapeutics: • No discussion
5.5	Lab Liaison: • No discussion
5.6	Recruitment and Retention Committee: • Meeting held on Jan 7 ○ Town of Goderich invited representatives of OMA to discuss rural physician challenges; meeting held on Dec 19 – see Instagram post ▪ Good representation from AMGH Physicians present ▪ Focus was on the challenges within rural environments ▪ It has been noted that comprehensive medicine is not an interest of newer grads, instead they are looking at specialization ▪ Government has a strong interest in bringing internationally educated physicians back to Ontario, and based on information provided by Dr. Ford regarding the number of Canadian physicians who have trained in the US and are now hoping to return to Canada, OMA will be focusing on this opportunity ○ Practice Ready Program is not as successful as anticipated; OMA is aware ○ Attempting to have Jane Philpott visit for discussion of challenges in our areas
5.7	Quality Assurance Committee: • Next meeting scheduled for Jan 15
	MOVED AND DULY SECONDED ***MOTION: To accept the January 9, 2025 Medical Staff Reports to the MAC. CARRIED.***
6	**Other Reports**
6.1	Lead Hospitalist: • Census in early Dec was quite low, however, the last few weeks have been very busy, and consistently over capacity • Viral respiratory illness on the inpatient floor has been low to date
6.2	Emergency: • Volumes are high and staffing struggles continue ○ Schedule continues to show 5+ open shifts per month; one open shift remains this week to be filled ○ Waiting to hear if EDLP funding will continue past Mar 31 • Issues with orders not printing automatically at the Walk In Clinic, the way they used to ○ Discovered when a urine culture was missed ○ Contacted LHSC, and the issue has been rectified
6.3	Chief of Staff: • Clarification provided regarding who is MRP for admitted patients in ED ○ If a patient is admitted the next morning after 08:00am, responsibility falls on Hospitalist as MRP ○ This includes if the patient is transferred back to ED for a procedure that cannot be done on the unit, i.e., BiPAP, etc.; ED physician in this case is the assisting or consulting, and the Hospitalist is responsible for having the patient transferred out to another facility, as needed

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Reminder made that any patient being admitted from the ED, must have Admitting Orders which include direction for the next 6-12hrs, while the Hospitalist sorts the patients care out
This situation happened recently, causing chaos, and may be related to HFO/EDLP physicians
COS (SHH & AMGH), CEO and CNE attended Regional Clinical Services Planning in Dec
Discussed the need for change in resource allocation, and the number of 24/7 facilities in the Region
SHH continues to wait for news on the application for a CT scanner; expecting news in Feb
Locum physician completing CMaRS reapplication inquired about the need to have up-to-date ACLS and ATLS, which is a mandatory requirement of SHH, but not of larger / other hospitals in the area where the physician works in the ED frequently
Consensus of MAC is to provide an exemption for experienced physicians, and have the ED remain open; this can be reviewed on a case-by-case basis, as needed
ACLS is being offered in Stratford in Feb, and there is also an online version as well

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<tr><td></td><td><u>Action:</u>
• Remind Nursing Staff to follow up with HFO/EDLP Physicians to ensure Admitting Orders are completed for all admitted patients
• Review By-Laws re ACLS and ATLS; discuss potential for exemptions</td><td><u>By whom / when:</u>
• Ryan; This week
• Ryan; This week</td></tr>
<tr><td>6.4</td><td colspan="2"><u>President & CEO:</u>

2025-01-Monthly Report-CEO, circulated
Expecting the next three months to be extremely busy with respiratory illness (RSV / Influenza); CEO met with Ontario Health prior to the holidays, and they indicated that RSV hospitalization has surpassed numbers of 2023/24
This is primarily being driven by the 65+ population, which makes up 57% of current hospitalizations
It is anticipated that the SW Region will be short by 100 acute care beds over the next three months, elevating capacity issues further
SHH & AMGH continue to work with peer hospitals to ensure there is patient movement across the systems in response to capacity issues
Peak of respiratory illness is expected mid to late Feb, with a decline moving into Spring
Appreciation extended to the physicians and staff for their continued dedication and hard work
In regards to the CT Scanner, OHW provided support for the business case presentation; eagerly awaiting a response from the Ministry as official time line of the application runs out on Jan 31
Discussed increase in transportation costs as volumes continue to rise and patients require CT
Suggested a team get together and further discuss patient flow, transfer and CT location (in-hospital vs new medical centre)
</td></tr>
<tr><td></td><td><u>Action:</u>
• Contact Ms. Higgs with capacity issues
• Contact OHW / Ministry regarding CT Scanner</td><td><u>By whom / when:</u>
• All; Ongoing
• Trieu; By Jan 31</td></tr>
<tr><td>6.5</td><td colspan="2"><u>CNE:</u>

2024-12-Housing & Homelessness Monthly Share-Out, circulated
Working with unions to increase staff in SHH ED in response to increased volumes
A number of grants have been completed and submitted, i.e., Critical Care, New Grad, Surgical Pathways, Externs, etc.
Surgical pathways grant has been accepted
Search continues to fill management positions, may be changing the structure in order to attract more applicants
Working with Triage Nurses and EMS on over capacity guidelines; ‘Fit to Sit’ algorithm is almost complete
Discussed opening day surgery beds to assist with over capacity
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<tr><td>6.6</td><td colspan="2"><u>CFO:</u>

Current deficit for both hospitals is $1.8M; SHH portion is $800K, which is better than original forecast by $400K; HHS continues to be in a better position than most peer hospitals
Deficit expected for SHH at year-end is estimated at $1M
Factors in decreasing the deficit include one-time funding, collection of preferred accommodations, and increases in technical fee revenues
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	○ Working on offsetting patient transfers (over budget by $50K); consideration being given in development of the new budget • Executive Team is working on finalizing the new budget; presenting new and capital budgets to Board in Feb ○ Planning for CT scanner upon approval ○ Operationally, working on standardization of HIS, ERP and procurement systems, i.e., MediTech / Stratford vs Oracle / SHH / LHSC, gathering costs and determining impact of each • Struggle continues with Lab vacancies
6.7	<u>Patient Relations:</u> • 2025-01-Monthly Report-Patient Relations, circulated and reviewed ○ Discussed end-of-life patient story at SHH ▪ Patient asked for improvement in first hand communication ▪ Appreciated that care of the physicians and nursing staff and felt fortunate to have SHH ○ Own family attended AMGH; positive visits
6.8	<u>Patient Care Manager</u> • New ED Ultrasound machine has arrived at SHH; training scheduled for Feb., 6 from 4-6pm • Surveys for inpatients and ED continue to be submitted, and most provide excellent reviews of staff and physician care • Working with union to get extra staff for the ED; considering structure of added hours in terms of transfers, breaks, shift changes, visit numbers, and high volume times, etc.; can be trialled and reviewed for adjustments • In regards to generating revenue, staff are working hard on utilizing semi-private/private accommodations where possible ○ Working on reducing transportation costs where possible, although this continues to be over budget • ALC patients that no longer require acute care, but stay in hospital waiting for LTC, are charged per day, which may or may not be covered by patient's insurance • Inpatients has been very busy; past weekend had 24 admitted patients with 19 beds ○ Appreciation extended to all for a great job in supporting ongoing overflow • Suggested AMGH track turnover rates once they have switched over to the Hospitalist Model ○ Noted difficulty in the change of process, particularly with more seasoned physicians
6.9	<u>Clinical Informatics:</u> • Considering moving forward with stocking the ED face sheet in 1st week of March; testing of work flows and finalization needs to happen 1st • Appreciation extended to physicians for their work in getting diagnoses into clinical documentation • Attended Integrated Care Steering committee today for discussion of OneChart Phase II ○ Regarding Community Lab integration components, Oracle Health sites within Ontario are in agreement with doing a contextual launch of Olis-More in March, which will allow physicians to place lab orders online; results will flow back to OneChart ○ Working on negotiations to ensure that the there are no charges when physicians order for a patient in-hospital; to date there haven't been any of these charges, but it is outlined in the contract ▪ To be validated prior to moving forward ○ Lab-to-Lab ordering can move forward, as there are no billing components ▪ Working on interfacing, and turning fax process electronic; anticipating improved turnaround times • In response to some challenges in the ED, a Provider Documentation binder has been developed to assist HFO/EDLP physicians, who may only be here short term ○ Adding information as needed, i.e., CPOE ○ First Net Physician and Nursing Modules, and DynaDoc Modules have been shared as links, which can be accessed from any hospital computer ○ Links for Clinical Downtime Power Plans will be shared this week • EDP data numbers are looking great in the 97th percentile, meaning 97% of our data is meeting guidelines ○ Thank you to everyone for signing up and getting that data to our health records staff quickly
	<u>MOVED AND DULY SECONDED</u> ***<u>MOTION: To accept the January 9, 2025 Other Reports to the MAC. CARRIED..</u>***

7	**New Business**		
7.1	Annual Reappointment in CMaRS: • Available Jan – 2nd Week • Closing Date – Mar 31		
8	**In-Camera Session**		
9	**Adjournment / Next Meeting**		Regrets to alana.ross@amgh.ca
	Date	**Time**	**Location**
	February 13, 2025	8:00am	Boardroom B110 / MS Teams
	Motion to Adjourn Meeting ***MOVED AND DULY SECONDED*** ***MOTION: To adjourn the January 9, 2025 meeting at 9:01am. CARRIED.***		
Signature			
_____ Dr. Sean Ryan, Committee Chair			

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February 2025 South Huron Hospital Chief of Staff Report

We continue to see high volume and high acuity in our ED. There have been two shifts in the past month where we have lost EDLP physician coverage with less than 24 hours' notice. Thankfully, we filled these shifts locally, but this serves as another example of the fragility of our physician work force both locally and provincially.

There is still no word from the MOH regarding our CT application. This is becoming a major source of frustration for our physicians. The volume of CTs ordered and associated transfer costs (both monetary and human resource) continue to increase. Our physician group needs to be reassured that this is a top priority for the board and administration. We have had several potential ED locums choose NOT to work in South Huron due to a lack of in-house CT in the context of a higher-than-average acuity level compared to other single coverage departments.

Finally, I have attached a briefing note written by the Society of Rural Physician of Canada (SRPC) and sent to each federal political party last month. It outlines what the SRPC believes ought to be strategic priorities with respect to rural healthcare for the next federal election. It includes many of the same topics we have discussed at previous meetings, and I would respectfully ask that each board member have a read.

Please contact me with any questions or concerns.

Sean Ryan MD CCFP(EM) FCFP
ryanse7@gmail.com

SOCIETY OF Rural Physicians OF CANADA
SOCIÉTÉ DE LA Médecine Rurale DU CANADA

Briefing Note: Strategic Priorities for the Next Federal Election

Enhancing Canada's Rural Health Workforce Through Effective Health Human Resource Planning and a National Rural Health Workforce Strategy

Access to health care in rural communities

The crisis in rural health services is real and growing. The shortage of physicians in rural areas is having a significant impact on rural, remote, and Indigenous communities, affecting health outcomes across the lifespan. Rural physicians have a diverse set of skills, providing primary care, working in the office, hospital wards, birthing units, emergency departments, operating rooms, and long-term care facilities, among others. Barriers that patients in rural, remote, and Indigenous communities face when trying to access basic emergency services have dramatically worsened over the past 2 years, with Ontario alone reporting 868 emergency room (ER) closures in rural communities in 2023. Each week in 2024, ER closures have been reported in jurisdictions across the country. Even when the ER remains physically open, some have been forced to shift to virtual physician access only – a situation that the Canadian Association of Emergency Physicians (CAEP) has declared inadequate, and one that would never be acceptable in an urban centre. In addition to these effects, the shortage of rural physicians also has a negative impact on the availability of obstetrical and surgical services, forcing women from rural, remote, and Indigenous communities to leave their homes and families to give birth.

Despite calls from rural physicians and the communities they serve, a comprehensive health human resource (HHR) plan for Canada has not been developed. A national rural health care strategy that supports rural physicians and the teams with whom they work is urgently required so they can continue to practise medicine, enhance access to primary care, teach the next generation of health care providers, and contribute to the economic vibrancy of rural, remote, and Indigenous communities over the long term. Any plan must ensure that rural physicians have adequate time to participate in continuing professional development and maintain a healthy work-life balance so they are able to remain in communities long-term.

While rural, remote, and Indigenous communities are most directly affected by this crisis, the failure of health systems in all rural settings will continue to worsen the emerging crisis in urban settings as patients from rural, remote, and Indigenous communities will increasingly seek care in urban ERs. Urban hospitals expect rural healthcare facilities to provide care locally and minimize transfers in to the urban centre, to optimize capacity and system effectiveness. Health services in rural, remote, and Indigenous communities matter to urban health systems.

Indigenous communities are often served by rural physicians for primary, emergency, and hospital based care. Canada has an obligation to ensure culturally safe, reliable health systems

and skilled health providers for these communities, as part of its commitment to respond to the calls to action of the Truth and Reconciliation Commission. A national health workforce strategy must recognize the inherent need to support specific populations, including First Nations, Inuit, and Métis communities, as well as Canada's rural francophone population who rely on small rural health systems for their care.

A component of delivering optimum health care is ensuring that physicians practising in rural, remote, and Indigenous health care settings can access advanced skills training, enabling them to address areas of need and provide optimum health care to populations in their communities.

Due to the rapid erosion of the health care services on which Canadians in rural, remote, and Indigenous communities rely, there is limited time to stabilize, support, and re-build rural health services before they become irrecoverable in some settings.

SRPC calls on all parties to commit to immediate implementation of the following:

Short term solutions (up to 1 year):

1. ***Ensure that federal transfer payments include provincial commitments for:***
    a. ***Recruitment and retention supports:*** *Fund rural, remote, and Indigenous community initiatives to welcome and support newcomers and assist them in adapting to their new home, as well as to address the retention of the internationally trained health workforce and encourage them to stay in these communities and appreciate the benefits of living and working in them.*
    b. ***Education:*** *Strengthen rural, remote, and Indigenous community-based physicians' education at the level of medical schools, and other health disciplines, in order to support future workforce development for rural, remote, and Indigenous communities.*
    c. ***Pathways to licensure****: Ensure pathways to licensure for internationally trained physicians, and other internationally trained health care professionals, in all jurisdictions.*
2. ***Build on the success of the National Advanced Skills and Training Program pilot:*** *Create a 5-year program with a $25 million federal investment, providing $5 million each year for the delivery and evaluation of the National Advanced Skills and Training Program for Rural Practice, to support the sustainability of rural and remote health care teams and the ongoing training requirements for rural physicians to obtain necessary skills as identified by their communities. Continued funding to ensure the sustainability of this program after 5 years would benefit rural physicians as well as other members of*

healthcare teams in rural, remote, and Indigenous communities. A formative evaluation prior to the end of the 5 years will support the need for the continuation of the program.

a. *In its first year, with an investment of $7.4 million, the pilot program enabled 342 providers to develop skills for 187 communities, with at least 60 of those being Indigenous communities.*
b. *This investment has ensured that patients can receive care locally and without the costs of travel out of their community for care, resulting in cost savings to the health system as well.*

3. ***Implement Pan-Canadian licensure****: Work with all physician regulatory bodies to implement Pan-Canadian licensure for all regulated health care providers, including physicians, to enable inter-jurisdiction mobility.*
4. ***Federal tax incentives:*** *Ensure that the levers of federal funding as tools of recruitment and retention are optimized through:*
    a. *Expansion of federal loan forgiveness strategies beyond physicians and nurses to include other members of health care teams in rural, remote, and Indigenous communities, including paramedics, laboratory and imaging technologists and technicians, social workers, and others.*
    b. *Creation of a federal tax incentive for all health care providers living and working in rural areas to support recruitment and retention.*

The SRPC also calls on all parties to commit to the following medium-term strategies (within the next 3 years):

5. *The development and implementation of a **health workforce strategy specific to rural, remote, and Indigenous communities**, and aligned with and supported by the new Health Workforce Canada agency.*
6. *The **creation of an agency**, **led by a national rural health commissioner** with the mandate to liaise with other agencies of governments and to address health workforce and health systems issues in rural, remote, and Indigenous communities, including the need for a robust locum workforce to address physician shortages and closures of emergency departments and services in obstetrics, surgery, and anaesthesia.*
7. ***Create a fund to enable innovation in rural, remote, and Indigenous communities with technology** (e.g., AI, robotics, virtual care, et cetera) to support rural workforce and rural health services delivery.*

SOCIETY OF
Rural Physicians
OF CANADA

SOCIÉTÉ DE LA
Médecine Rurale
DU CANADA

Summary: Currently, Canadians living in rural, remote, and Indigenous communities do not have equitable access to health care services. There is no national, provincial, or territorial rural health care strategy to ensure that the needs of rural, remote, and Indigenous populations are supported and met. While there are gaps in knowledge about effective health workforce recruitment and retention strategies for rural, remote, and Indigenous communities, there is much that is known and must be implemented immediately.

Engagement is needed through a set of federally, provincially, and regionally supported networks that would encourage collaboration across Canada among rural physicians, policymakers, federal, provincial, and territorial leaders, and rural, remote, and Indigenous communities. It is important for policymakers to recognize that aligning rural medical education with rural physician workforce planning can successfully influence the development of a rural physician workforce pipeline and the longer-term retention of physicians in rural, remote, and Indigenous communities. Aligning rural medical education will require immediate and enduring effort to sustain the current rural physician workforce, which is also the clinical teaching workforce required to ensure the future workforce is trained and can be recruited.

Release: January 2025

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PRESIDENT & CEO REPORT

February 2025

METRICS

Area	AMGH	SHHA	Comment
Health Human Resources			Working on recruitment of nurses, physicians and MLT's. A priority is to recruit an MRI tech to prepare for MRI installation.
Master Plan and Functional Plan			OHW has endorsed HHS Master Plan and Master Programming proposal to the MoH. Final approval will depend on the provincial election and will not occur until late March.
Finance			HHS operations are running at a reduced deficit but are seeing increased bed capacity pressures. Continue to capture the cost of staying open.
SHH Medical Clinic			SHHF is working on acquiring the land where the medical centre will be built.
CT Scanner			Waiting on approval from MoH. Over 2000 applications were submitted for the ICHSC (private DI services).
MRI Scanner			Submitted operational plans to Capital Branch for approval to move forward on implementation.

TOP OF MIND

<u>Provincial Election:</u>

- Premier Ford called an election on January 29, 2025
  - Not going to be easy for his government as there were missteps on healthcare spending, the Greenbelt fiasco, and the suspension of supervised drug sites
  - There are 124 ridings in Ontario and only 88 candidates nominated for the PCs, 70 for the Liberals and 40 for the NDP (as of January 27, 2025)

<u>US Politics</u>

- With the second Trump Presidency, there is a plan his administration will impose significant tariffs on imported goods from key trading partners including Canada
- HealthPro Canada is a leader in procurement and connects healthcare organizations to the supplies and solutions they need to care for Canadians.
- HHS is a partner with HealthPro and we have achieved great savings from procurement activities
- HealthPro Canada is dedicated to ensuring seamless continuation of HHS operations and continues to monitor the situation and any developments

- They are working on business continuity for their partners and will be focusing on:
    - Identification of at-risk products for necessary contingency planning.
    - The diversity of suppliers' manufacturing and supply chains.
    - Plans to transition to tariff-exempt production facilities.
    - Exploration of alternative sourcing options or the introduction of new product lines.

BIG WINS | LEARNING

Master Plan and Master Program

- HHS has received formal endorsement from OHW to MoH to move forward with this crucial work
- Due to the election, formal approval from the MoH will not occur until late March
- This project will help Huron Health System improve patient safety and care and provide opportunity for collaborative and coordinated solutions to existing challenges across the healthcare system

Bill 7, More Beds, Better Care Act

- The Ontario Superior Court has thrown out a Charter challenge of a long-term care law that allows hospitals to move people into homes they didn't choose, or charge them $400 a day if they want to go elsewhere
- Bill 7 allows hospital placement co-ordinators to choose a nursing home for a patient who a doctor has deemed as needing an alternate level of care, without consent
- Patients are still allowed to choose long-term care homes they prefer. But if the home they want has a waitlist and the patient decides to stay in the hospital while they wait for the home to become available, they could be charged $400 a day
- Patients can be sent to nursing homes up to 70 kilometres from their preferred spot in southern Ontario and up to 150 kilometres away in northern Ontario
- The ruling may still be appealed at a later date

PRESIDENT & CEO SUMMARY

Dr. Jane Philpott and Minister of Health Sylvia Jones announced commitments for Ontario's Primary Care Action Team as they work to connect every Ontarian with a primary care provider over the next four years. The announcement included an investment of $1.8 billion over four years towards expanding primary care teams, enhancing primary care standards, expanding community-based teaching clinics, and modernizing primary care access and delivery through technology. The government also released *Ontario's Primary Care Action Plan* which outlines key priorities.

Highlights of the plan include:

- Creating and expanding 305 additional primary care teams, including an investment of $235 million in 2025-26 to expand 80 additional teams.
- Modernizing Health811 to enable patients to navigate care pathways, book appointments, and view their online health records.

- Improving Health Care Connect and ensuring those currently on a waitlist will be connected to a primary care provider by spring 2026.
- Supporting primary care providers by investing in strategies that will increase recruitment and retention of family doctors, nurse practitioners and allied health care professionals, with specific strategies for northern and rural communities.
- Adding and expanding the number of community-based primary care teaching clinics in collaboration with academic institutions and other partners.
- Investing in digital tools (such as AI scribes) to reduce the administrative burden on health care providers and enhance timely access.

Ontario's health system faces serious challenges in the coming years, including increased demand for care and more complex care needs with a rapidly growing and aging population. Over the next 20 years, the province's population will grow by 36%, and 3.1 million people will be living with chronic illnesses by 2040. Getting everyone access to team-based primary care is crucial to addressing these challenges. Increasing primary care capacity and attachment will ease hospital emergency departments and services pressures. Dr. Philpott's efforts will connect more people to vital healthcare services in their communities, ensuring people have access to interprofessional primary care teams and receive the most appropriate care close to home.

Investments to train more physicians in family medicine will grow the primary care workforce and help prepare for future healthcare needs. Leveraging digital tools and innovation in primary care delivery supports easing the administrative burden on healthcare workers and enables them to spend more time caring for patients, while also creating a more integrated and convenient system for Ontarians.

Once more details are known, pursuing FHT funding for SHH Medical Centre is advisable.

Respectfully submitted,

Jimmy Trieu
President & CEO

Huron Health System

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CNE/ VP Clinical Services
Monthly Board Report

FOCUS ON SAFE, QUALITY PT CARE, CLOSE TO HOME

- At AMGH, we have started the hospitalist model. I have heard very positive feedback from the staff as well as the physicians.
- Close auditing of medication safety show improvement in both patient and medication scan rates
- To help with ER overflow the NP is seeing pt's in an empty office. Extra chairs and stretchers will also be added to the ER area, at AMGH
- Both hospitals continue to provide many educational opportunities both in hospital and out.
- Applications for many educational grants have been completed
- Massive Hemorrhage Protocol almost complete for SHH. Training was completed during Nursing Education Days. Just waiting for finalized power plan and then all appropriate parties will sign off and a mock code to be arranged
- Finalizing an RN in the emergency department at South Huron three days a week
- Accreditation prioritized as we continue to strive for exemplary standing

FOCUS ON OUR PEOPLE AND WORKPLACE

WE HAVE BEEN SUCCESSFUL, in filling Clinical Manager roles! Please welcome our successful new Managers.

- Brenda Perriam has accepted the position for the OR department MDRU, and the Ambulatory Care Clinic
- Stephanie Black has accepted the position for the Mental Health and Addictions Inpt and Huron Community Mental Health outpatient units
- Marnie Mezger has accepted the position in the Emergency Department and will be assisting 20 % at South Huron as well as cross site pharmacy.

I would like to recognize staff and managers, as winter never seems to end. I know there has been a lot of planning to make sure the hospital continues function safely. Staff living in town have stepped up to assist and staff outside of town have stepped out of their comfort of their home to alternative housing to make sure there are available for their shift. Through rain, snow, sleet, closed roads and 9 stroke assessments just this month ER continues to remain open at AMGH and South Huron.

- Continuing to recruit for ICU and aware of some gaps potentially, coming in OB and emerg. (mainly maternity leaves)
- Increased social work is very helpful and very much appreciated (attending rounds)
- Improvements have been made to our online E-learning system and spring skills days are scheduled for AMGH. Review of code blue, pink, green, white, orange education along with wound care, pharmacy information and update on TGLN.
- Increase of births by 24% in our Obstetrics Department at AMGH
- Successfully recruited to the OR which should assist us with the on call schedule.
- Trialed a double day in the OR. Dr Ford did 3 GA cases and 1 local case Dr Kittmer did 4 scopes and 1 local. (Looking at the cost effectiveness)
- Continuing to see a rise in RSV/COVID/FLU cases continued providing influenza vaccines to staff

- Surgical site infections are now being monitored with outpatients from the Ambulatory Care Clinic.
- IPAC audits continued.
- Relationships between SHH AND AMGH are proven to be strong, with two inpatient admissions accepted to SHH during EROF at AMGH.
- 5 Additional Volunteers at South Huron Hospital for volunteer program.
- Specific Iron infusion schedule on the inpatient unit will benefit the patient and staff and improve overall patient care

FOCUS ON INCREASING THE VALUE OF OUR HEALTHCARE SYSTEM

The Cardiac Monitoring System replacement is overdue and will be a full RFP project as it involves equipment from multiple departments. (IT integration etc.) High cost with an increased risk of equipment failure and paying service fees of approx. 325 dollars an hour.

FOCUS ON WORKING WITH PARTNERS TOWARDS AN INTEGRATED AND SUSTAINABLE RURAL HEALTH CARE SYSTEM

Leadership participation in South West Access and Flow Working Group. Representation from all sectors including hospital organizations, retirement homes, LTC homes, EMS, Ontario Health, Ontario health at Home etc.
Ontario Health at Home staff are stepping out of Rehab/CCC application process. AMGH is the only hospital in Huron/Perth that does not have designated beds. Hoping this does not leave us in a comprisable situation.

Respectfully submitted by,

Lynn Higgs

Huron Health System

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CFO Report to Board

DATE:	**February 13, 2025**
FROM:	**Rob Lovecky, Vice President of Finance and CFO**
TOPIC:	**CFO Report to Board of Directors**

Financial Snapshot (Period 7, YTD December 2024/25):

- **Total HHS:** $1.12 million operating deficit, but $1.47 million positive variance compared to budget.

- Deficits and Year-End positive budget variances are expected to continue. The current year-end forecast is for a **total HHS deficit of $1.81 million. (approximately $2.6 million better than original budget)**

Finance:

- Preliminary Draft 2025/26 HHS Operating Budget is estimated at -$4.5 million compared to 2024/25 HHS Operating Budget of -$4.4 million.
- Preliminary Draft 2025/26 AMGH Capital Budget is estimated at $7.6 million that includes investments in DI equipment of $3.5 million, $2.4 Million for new ERP systems supporting Finance, Payroll, Procurement, HR and renewing IT Infrastructure Hardware and Services, $1.2 million of Facilities upgrades, and $0.5 million in other clinical equipment and systems.
- Preliminary Draft 2025/26 SHH Capital Budget is estimated at $2.6 million that includes investments in DI equipment of $0.9 million, $0.9 million for new ERP systems supporting Finance, Payroll, Procurement, and HR, $0.4 million in Pharmacy, $0.2 million of Facilities upgrades, and $0.2 million in other clinical equipment and systems.
- Final 2025/26 Operating and Capital Budgets will be presented to the HHS Board in March for their review and support.
- Continue to monitoring HHS Working Capital (cash and investments) and determine what portion is available for future IT Strategic Initiatives and what portion requires other sources of funding from each hospital's Foundation, bank debt financing, existing Transformational funds, and other possibly ministry funds.

ITS:

- HHS Executive continue to develop an IT Services MOU with regional hospital partner with a plan, scope, timing, and costs of implementing key IT Strategic Initiatives including;
  - HIS/EMR Standardization and Integration with regional,
  - ERP Transformation (Finance, Payroll, Procurement, and Human and Resources systems), and
  - IT Infrastructure Services

- Set up onsite demonstrations preferred HIS/EMR solution for physicians to participate in within the next 3 to 4 months

Laboratory:

- AMGH: The hospital wide Arm banding QIP audit was completed. Success rate of 99.5% (benchmark was 95%) AMGH is performing well. Numerous process improvements were identified and implemented throughout the course of the audit.
- SHH: The lab team has worked diligently at completing the validation for the new Sysmex hematology system with the goal of replacing our current ageing hematology system, which is a major root cause to recent lab service downtimes.
- HHS: Two Lab vacancies still on going and Lab management has opportunity to participate on external advisory panel for Fanshawe College as they being plans to kick start new MLT and MLA programs.

Cardiorespiratory:

- HHS: Replacing fleet or ECG carts in early 2025.
- AMGH: Successfully posted and recruited for a 3rd part-timer in the Cardiorespiratory department. This will help keep the staffing pool and operation stable for the long term.

Diagnostic Imaging:

- AMGH: Management has submitted plans to use tomosynthesis capabilities on the new digital mammography equipment to the MoH and are awaiting their response.
- AMGH: Management has entered into RFP with Mohawk Medbuy for MRI and for a replacement of our fluoroscopy / secondary Xray unit with an expected and date in September 2025.
- AMGH: Diagnostic imaging will be replacing the portable ultrasound in the ER, and have a delivery date of February 19th 2025.

Patient Relations, Registration, Privacy, and Health Records:

- HHS: 4 task chairs in Switchboard (used 24/7/365) and 2 task chairs in ACC are need to be replaced due to wear and tear and to provide correct ergonomics. Will be ordered in February.

- HHS: Promoting more positive culture of communication in all Registration departments by using DEI training material on positive communication:

How can we promote a great culture?

- Practice positive work habits in the workplace that promote working collaboratively towards a common goal
- Live up to and model the values of the hospital; contribute to your full potential and strive for excellence each day
- Recognize and respect others and their individuality
- Think before you speak and be sensitive to others
- Talk about your differences and ask tactful questions about how people want to be treated
- Eliminate all stereotypes and generalizations
- Accept colleagues and patients for who they are not what they are

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- AMGH: Health Records behind in scanning and require more resources to support sick and vacation time. Expected to use Registration pool to learn Health Records skills.
- SHH: OneChart Phase II implementation requires additional 0.2 FTE for scanning to be implemented in Health Records, thus added to 2025/26 budget.
- HHS: Leadership and Administrative support are challenged keeping up with RL6 risk management entries and incidents. Expected 2025/26 investment in new Quality and Risk Management lead will alleviate workload.

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Patient Experience Story for Feb 2025 MACs.

Submitted by Heather Klopp, Manager Patient Relations, Patient Registration, Privacy and Health Records.

In the age of eHealth expansion, patients' access to their own health information has been highlighted by the Ministry of Health. This is currently being achieved in the Ontario Health West Region via **ConnectMyHealth.**

In the words of an HHS patient:

"I can't say enough good things about ConnectMyHealth! As someone who likes to stay on top of my health, this portal has been an absolute lifesaver. Instead of waiting for phone calls or digging through paperwork, I can instantly access my medical records, lab results, and appointment details all in one place."

"One of the standout features is the ability to view lab results and medical history in real time. This has given me greater control over my health and allowed me to have more informed discussions with my doctors."

"Plus, the interface is intuitive and easy to navigate, making it accessible for users of all ages."

Overall, ConnectMyHealth is a fantastic tool for anyone looking to take charge of their health with convenience and confidence. I highly recommend it to anyone in need of a reliable and efficient healthcare portal!"

Other Testimonials on the **ConnectMyHealth website**:

> *"I receive care from many facilities and am also a caregiver for my family. Having access to ConnectMyHealth will be a game changer to help me coordinate care."*
> — **ConnectMyHealth Patient Advisor**

> *"More and more care is being transitioned from the hospital into the home. Having access to my hospital records at home is a huge benefit and really essential to be able to communicate effectively with my healthcare providers."*
> — **ConnectMyHealth Patient Advisor**

https://www.youtube.com/watch?v=0zp4YfQXwZg

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INTER-OFFICE MEMORANDUM

TO: SHH MAC / HHS Common Board

FROM: Dr. Sean Ryan, Dr. Craig McLean

DATE: February 13, 2025

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, 2025 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
BLICKER, Dr. Jamie	NEW	Locum-EDLP
DUNLOP, Dr. Bill	NEW	Locum-Hospitalist
ROWE, Dr. Matthew	NEW	Locum-EDLP
SKORETZ, Dr. Terry	RETURNING	Locum-EDLP