Vision
Creating healthier communities, together

Mission
An exceptional healthcare organization keeping people at the heart of all we do

Values
Caring, Collaboration, Accountability, Innovation, Respect

BOARD OF DIRECTORS MEETING - OPEN

May 1, 2024

1700-1830

Virtual via Teams / C.1.229 Meeting Room

Click here to join the meeting

Or call in (audio only)

833-287-2824,,27334435# Canada (Toll-free)

Phone Conference ID: 273 344 35#

AGENDA

Agenda Item * indicates attachment / TBC – to be circulated	Page #	Time	Responsibility	Purpose
1. CALL TO ORDER		1700		
1.1 Territorial Acknowledgement		1701	D. Wilkinson	
1.2 Welcome		1704	N. Melchers	
1.3 Confirmation of Quorum (7)			N. Melchers	Confirmation
1.4 Declarations of Conflict			N. Melchers	Declaration
1.5 Consent Agenda *(Any Board member may request that any item be removed from this consent agenda and moved to the regular agenda)*			N. Melchers	Motion
1.5.1 Minutes of March 6, 2024*	3			
1.5.2 Board Attendance Report*	15			
1.5.3 Governance Policy Summary* Policies for Approval: (track changes version found in Package 2) 2-C-32 Resource Protection & Liability 2-C-34 Approval & Signing Authority 2-D-06 Board Meeting Agenda 2-D-10 Guidance to Decision Making Process	16			
1.5.4 CMH President & CEO Report*	31			
1.5.5 Board Work Plan*	38			
1.5.6 2023/24 Board of Directors Action Log*	46			
1.5.7 Quality Monitoring Metrics*	47			
1.5.8 2023/24 Events Calendar*	52			
1.5.9 Q4 CEO Certificate of Compliance*	54			
1.6 Confirmation of Agenda			N. Melchers	Motion
2. PRESENTATIONS				
2.1 Patient Story		1705	A. Omollo / H. Elliott	Information
2.2 AI-based Resume Screening Platform for Hiring Managers*	55	1715	K. Leslie / W. Muhammad	Presentation
2.3 Operational Excellence Plan*	67	1730	K. Leslie	Motion
2.4 Staff Innovation Fund – Project Status Update*	91	1745	K. Leslie	Information
3. BUSINESS ARISING				
3.1 None				
4. NEW BUSINESS				
4.1 Chair's Update				

Board Members: Nicola Melchers (Chair), Sara Alvarado, Paulo Brasil, William Conway, Tom Dean, Julia Goyal, Monika Hempel, Miles Lauzon, Dr. Margaret McKinnon, Jay Tulsani, Diane Wilkinson, Lynn Woeller

Ex officio Members: Patrick Gaskin, Dr. Winnie Lee, Dr. Vlad Miropolsky, Dr. Ingrid Morgan, Stephanie Pearsall

Agenda Item * indicates attachment / TBC – to be circulated	**Page #**	**Time**	**Responsibility**	**Purpose**
4.1.1 Board Report*	95	1755	N. Melchers	Information
4.2 Governance Committee				
4.2.1 Report to the Board of Directors* – (March 14, 2024)	98	1800	M. Lauzon	Information
4.3 Quality Committee				
4.3.1 Report to the Board of Directors* (April 17, 2024)	100	1805	D. Wilkinson	Information
4.4 Audit Committee				
4.4.1 Report to the Board of Directors* – (April 22, 2024)	102	1810	M. Hempel	Information
4.5 Capital Projects Subcommittee				
4.5.1 No Update – (Next Meeting June 24, 2024)				
4.6 Resources Committee		1813	L. Woeller	Information
4.6.1 Report to the Board of Directors* – (April 22, 2024)	104			
4.7 Executive Committee				
4.7.1 Report to the Board of Directors* – (March 12, 2024)	105	1815	N. Melchers	Information
4.8 Medical Advisory Committee				
4.8.1 MAC Credentials & Privileging February 2024*	107	1820	Dr. W. Lee	Motion
4.8.2 MAC Credentials & Privileging March 2024*	110	1822	Dr. W. Lee	Motion
4.8.3 Report to the Board of Directors* (March 19, 2024) (April 10, 2024)	115	1825	Dr. W. Lee	Information
4.9 PFAC Update – No Update - (Next Meeting May 7, 2024)				
4.10 CEO Update				
4.10.1 No Open Matters for Discussion				
5. UPCOMING EVENTS				
5.1 CRP Subcommittee Celebration & Tour – Save the Date May 13, 2024 5pm-7pm				
5.2 Board Social – Save the Date May 30, 2024 5pm-7pm				
5.3 CMH Golf Classic, June 6, 2024, Galt Country Club Registration				
5.4 CMH MRI Walk from Cambridge to Paris, June 9, 2024, https://www.justgiving.com/fundraising/sara-alvarado				
6. DATE OF NEXT MEETING	Wednesday June 5, 2024 (Generative Session) Location: Hybrid			
7. ADJOURNMENT		1830	N. Melchers	Motion
Link: Board/Committee Evaluation Survey	*Following the meeting, please complete within one week.*			

Board Members: Nicola Melchers (Chair), Sara Alvarado, Paulo Brasil, William Conway, Tom Dean, Julia Goyal, Monika Hempel, Miles Lauzon, Dr. Margaret McKinnon, Jay Tulsani, Diane Wilkinson, Lynn Woeller

Ex officio Members: Patrick Gaskin, Dr. Winnie Lee, Dr. Vlad Miropolsky, Dr. Ingrid Morgan, Stephanie Pearsall

Cambridge Memorial Hospital
BOARD OF DIRECTORS MEETING
Wednesday, March 6, 2024
OPEN SESSION

Minutes of the open session of the Board of Directors meeting, held via hybrid model (video conference and within Cambridge Memorial Hospital, C.1.229) on March 6, 2024 at 1700h.

Present:

N. Melchers, Chair	W. Lee
S. Alvarado	M. McKinnon
B. Conway	I. Morgan
T. Dean (virtual)	S. Pearsall
P. Gaskin	D. Wilkinson
J. Goyal	L. Woeller
M. Lauzon	P. Brasil
M. Hempel	J. Tulsani

Regrets: V. Miropolsky

Staff Present: S. Beckhoff, M. Iromoto, V. Smith-Sellers, L. Barefoot

Guests:

Recorder: S. Fitzgerald

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1. CALL TO ORDER

N. Melchers, called the meeting to order at 1700 hours.

1.1. **Territorial Acknowledgement**

T. Dean presented the Territorial Acknowledgement and shared personal reflections**.**

1.2. **Welcome**

N. Melchers welcomed the Board members to the meeting. Dr. W. Lee reflected on the passing of Dr. Scott Geddes.

1.3. **Confirmation of Quorum (7)**

Quorum requirements having been met, the meeting proceeded, as per the agenda.

1.4. **Declarations of Conflict**

Board members were asked to declare any known conflicts of interest regarding this meeting. There were no conflicts declared.

1.5. **Consent Agenda**

Prior to approving the Consent Agenda, the Chair asked if any items required removal for further discussion. There were no items to be set aside.

The consent agenda was approved as presented:

1.5.1 Minutes of February 7, 2024
1.5.2 Board Attendance Report
1.5.3 Events Calendar
1.5.4 Board Work Plan

1.5.5 2023/24 Board of Directors Action Log
1.5.6 MAC Report to the Board of Directors
1.5.7 Quality Committee Report to the Board of Directors
1.5.8 Governance Committee Report to the Board of Directors
1.5.9 Policies for Approval
- 1-C-02 Legislative Compliance
- 1-C-20 Reporting on Compliance
- 2-D-21 Staff Member Recruitment to Quality Committee
1.5.10 Capital Projects Sub-Committee Report to the Board of Directors
1.5.11 Resources Committee Report to the Board of Directors
1.5.12 Corporate Strategic & Operational Priorities Q3 Update & Quality Monitoring Scorecard
1.5.13 Q3 CEO Certificate of Compliance
1.5.14 CMH President & CEO Report
CARRIED (Dean/Conway)

1.6. **Confirmation of Agenda**

MOTION: (Brasil/Woeller) **that** the agenda be approved as amended. **CARRIED**

2. NEW BUSINESS

2.1. 2024 Quality Improvement Plan (QIP)

The Board reviewed the pre-circulated presentation provided in the agenda package. L. Barefoot provided an overview of the QIP to the Board. It was noted that the table on page 82 has a slight error on the third metric – % of staff who have completed relevant DEI and antiracism education – Rainbow Health Foundations course should be noted as include. Questions were entertained. One member inquired about the ambulance offload time and the drivers behind that. Management noted that the most significant driver is the ED admits.

MOTION: that, the Board of Directors approve the (QIP) Metrics as presented below

1. Reduce the 90th Percentile Ambulance Offload time from 115 minutes (Dec 2023) to 30 minutes
2. Reduce the 90th Percentile Emergency Department Length of Stay for Admitted Patients from 54.7 hours (Dec 2023) to 44.0 hours
3. Increase the number of staff who have completed the Rainbow Health Foundations course from 0 to 350

CARRIED. (Wilkinson/Dean)

The Board reviewed the pre-circulated briefing note provided in the agenda package. L. Barefoot provided highlights of the proposed QIP narrative.

MOTION: that, Board of Directors approve the 2024 Quality Improvement Plan (QIP) Narrative. **CARRIED.** (Wilkinson/Conway)

ACTION: CMH Management to investigate further if the Board of Directors are able take part in the rainbow health course. It was also noted that alternative education is provided in package 2.

2.2. **2022-27 Quality and Safety Patient Plan**

The Board reviewed the pre-circulated presentation provided in the agenda package. L. Barefoot highlighted key element of the Quality and Safety Patient Plan. It was noted that work is already well underway in the progress of the deliverables of the plan. Questions were entertained. One member inquired if there would be numbers / percentages or dates assigned to the tactics to provide trackable dashboard. CMH management assured the Board that for most CMH will have a way to measure if the tactic was met.

> **MOTION:** that, the Board of Directors approve the Quality and Safety Patient Plan as presented. **CARRIED.** (Wilkinson/Hempel)

ACTION: CMH Management to have further discussion about the date of the plan (2024 vs 2022).

2.3. **January 2024 Financial Statements and Year End Forecast**

The Board reviewed the pre-circulated briefing note provide in the agenda package. V. Smith-Sellers provided highlights to the Board. At the end of January 31st, 2024, the organization is showing a year-to-date deficit of approximately $2.6 million. The main contributors to this deficit are salaries, benefits, overtime costs, and agency staffing, partly due to incremental payments and the impact of Bill 124. Additionally, lower-than-expected revenue from the PCOP (Provincial Case Mix Program) due to underperforming surgical and ED volumes has further exacerbated the deficit. However, these are partially offset by exceeding targets in QPS (Quality-Based Procedures) and higher interest income. Despite the deficit, the forecast to March 31st, 2024, anticipates a balanced position, primarily due to the confirmation of funding for Bill 124 payments by the ministry, although there remains a residual amount of approximately $1.6 million to absorb by year-end. This forecast reflects a positive outcome for the fiscal year, particularly compared to other hospitals facing deficits.

> **MOTION:** that, following review and discussion of the information provided, the Board receives the January 2024 financial statements as presented by management. **CARRIED**. (Woeller/Dean)

ACTION: CMH Management to circle back with M. McKinnon on the possibility of presenting on trauma informed principles at CMH.

2.4. **ONCA Legislation – Audit Committee Terms of Reference**

The Board reviewed the pre-circulated briefing not provided in the agenda package. M. Lauzon noted that the motion should read up to 5. M. Lauzon highlighted that the changes to the Audit Committee Terms of Reference are based on the new ONCA legislation and the advice of the OHA and BLG.

MOTION: that, the Board of directors approve the amended terms of reference for the Audit Committee to increase the number of directions directors on the committee to up to five and change the status of non-director Committee members from voting to non-voting members. **CARRIED.** (Lauzon/Alvarado)

M. Lauzon noted that currently there are only two Directors who sit on the Audit Committee. J. Tulsani has agreed to move from the Resources Committee to the Audit Committee. N. Melchers asked the Directors if anyone other Directors would be

interested to join this Committee for the balance of the Board cycle. B. Conway volunteered.

MOTION: that, the Board approves the appointment of Jay Tulsani and Bill Conway to the Audit Committee for 2023/24. **CARRIED.** (Lauzon/Hempel)

2.5. **MAC Credentials & Privileging January 2024.**
Credentialing files were pre-circulated in the package.

MOTION: that, due diligence was exercised, interviewing the following privileging applications from the January 2024 Credentialing Committee and upon recommendation of the Mac that the board approves the following privileging applications**. CARRIED.** (Wilkinson/Conway)

Name	Department	Specialty	Appointment	Reason	Supervisor	Recommended/Not Recommended
Dr. Ajay Manjoo	Surgery	Orthopedics (Assist)	Locum	Requesting Locum privileges effective January 1, 2024 – June 30, 2024	Dr. L. Green	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Abdurraouf Elbueishi	Internal Medicine		Locum	Requesting Locum privileges effective December 1, 2023 - June 30, 2024	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Megan Laupacis	Women & Children	Pediatrics	Locum > Associate	New associate physician starting December 1, 2023	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Sean Leonard	Women & Children	Pediatrics	Locum > Associate	New associate physician starting December 1, 2023	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Ashley White	Emergency		Locum	Requesting extension of locum privileges from June 1, 2023 – May 30, 2024	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Name	Department	Specialty	Appointment	Reason	Supervisor	Recommended/Not Recommended
Dr. Jas Gill	Emergency		Locum > Associate	New associate physician starting December 1, 2023	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Emily Arndt	Women & Children	Pediatrics	Locum > Associate	New associate physician starting December 1, 2023	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Tasha Stoltz	Women & Children	Pediatrics	Associate > Courtesy	Requesting courtesy privileges effective December 1, 2023	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Vivian Ng	Women & Children	Pediatrics	Locum > Associate	New associate physician starting December 1, 2023	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Yen Foong	Women & Children	Pediatrics	Locum > Associate	New associate physician starting December 1, 2023	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Praveen Saroey	Women & Children	Pediatrics	Locum	Requesting extension of locum privileges from January 1, 2024 – January 31, 2024	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Praveen Saroey	Women & Children	Pediatrics	Locum > Associate	New associate physician starting February 1, 2024	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Agenda

Name	Department	Specialty	Appointment	Reason	Supervisor	Recommended/Not Recommended
Dr. Nikhat Nawar	Hospital Medicine		Locum	Requesting extension of locum privileges from January 1, 2024 – June 30, 2024	Dr. J. Legassie	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Joy Kuncheria	Hospital Medicine		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. J. Legassie	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Yu-Han Chang	Hospital Medicine		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. J. Legassie	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. James Easo	Anesthesia	Tri-City Colonoscopy	Locum	Requesting extension of locum privileges from January 1, 2024 – March 31, 2024	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Ahmad Tarakji	Internal Medicine	Nephrology	Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Name	Department	Specialty	Appointment	Reason	Supervisor	Recommended/Not Recommended
Dr. Kenneth Leung	Internal Medicine	Liver Clinic	Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Jessica Smith	Women & Children	OBGYN	Locum	Requesting extension of locum privileges from January 1, 2024 – September 1, 2024	Dr. K. Wadsworth	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Marinela Grabovac	Women & Children	OBGYN	Locum	Requesting extension of locum privileges from January 1, 2024 – September 1, 2024	Dr. K. Wadsworth	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Amy Tam	Oncology			Requesting medical leave of absence December 6, 2023 – January 15, 2024		☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Leigh Bishop	Surgery	Breast Reconstruction	Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024		☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Tabitha Tse	Surgery	Breast Reconstruction	Locum	Requesting extension of locum privileges from January 1, 2024 –		☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Name	Department	Specialty	Appointment	Reason	Supervisor	Recommended/Not Recommended
				December 31, 2024		
Dr. Mylene Ward	Surgery	Breast Reconstruction	Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024		☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Andrew Davis	Surgery	Surgical Assist	Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024		☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Eriny Shams	Emergency Dept		Locum	Requesting extension of locum privileges from January 1, 2024 – June 30, 2024		☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Ariel Mendlowitz	Women & Children	OBGYN	Associate	Received 12-month evaluation		☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Emma Pollard	Women & Children	OBGYN	Associate	Received 12-month evaluation		☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Krysta Barclay	Women & Children	Midwife	Active	Resignation of privileges effective February 2, 2024		☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Name	Department	Specialty	Appointment	Reason	Supervisor	Recommended/Not Recommended
Cindy Shobbrook	Hospital Medicine	MAID Program	Locum	Requesting extension of locum privileges from November 15, 2023 – November 15, 2024		☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Mitch Abrams	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Silvio Bruni	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Maryann Bushara	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Michael Chan	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Name	Department	Specialty	Appointment	Reason	Supervisor	Recommended/Not Recommended
Dr. Keyur Shah	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Babak Maghdoori	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Terence Menezes	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Nirav Patel	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Navneet Singh	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Name	Department	Specialty	Appointment	Reason	Supervisor	Recommended/Not Recommended
Dr. Peter Szpakowski	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Gurbir Sekhon	Internal Medicine		Locum > Courtesy with Admitting	New Courtesy with admitting privileges starting January 1, 2024	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Mohamed Naser	Internal Medicine		Locum > Courtesy with Admitting	New Courtesy with admitting privileges starting January 1, 2024	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Kelly Cranstoun	Radiology		Locum	Requesting Locum privileges from January 15, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Mandeep Gill	Surgery	ENT	Active	Resignation of privileges effective April 9, 2024. Closing practice.	Dr. Lawrence Green	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

3. **UPCOMING EVENTS**
   N. Melchers highlighted the upcoming events and encouraged the Board members to participate if available.

4. **DATE OF NEXT MEETING**
   The next scheduled meeting is May 1, 2024

5. **ADJOURNENT**
   The meeting adjourned at 1746h. (Dean)

Nicola Melchers Board Chair CMH Board of Directors	Patrick Gaskin Board Secretary CMH Board of Directors

Agenda

Date of Meeting

Last | 12 | Months

4/27/2023 - 4/26/2024

Date of Meeting	Bill Conway	Diane Wilkinson	Jay Tulsani	Julia Goyal	Lynn Woeller	Margaret McKinnon	Miles Lauzon	Monika Hempel	Nicola Melchers	Paulo Brasil	Sara Alvarado	Tom Dean
Wednesday, March 06, 2024	P	P	T	T	P	T	T	T	P	P	P	P
Wednesday, February 07, 2024	P	P	P	T	P	T	T	P	P	P	P	T
Wednesday, December 06, 2023	P	P	P	P	P	P	P	R	P	R	P	T
Wednesday, November 01, 2023	T	T	T	T	R	R	T	T	T	T	T	T
Wednesday, October 04, 2023	P	P	P	T	T	T	P	T	P	P	P	T
Tuesday, July 18, 2023	T	T	T	T	T	T	T	T	T	T	T	T
Wednesday, June 28, 2023		P		P	P	T	P	P	P		P	P
Wednesday, May 24, 2023		T		T	T	T	T	T	T		T	T

Name	Attendance Rate
Bill Conway	100 %
Diane Wilkinson	100 %
Jay Tulsani	100 %
Julia Goyal	100 %
Lynn Woeller	88 %
Margaret McKinnon	88 %
Miles Lauzon	100 %
Monika Hempel	88 %
Nicola Melchers	100 %
Paulo Brasil	83 %
Sara Alvarado	100 %
Tom Dean	100 %

Committee

- ☐ Audit Committee
- ■ Board of Directors
- ☐ Capital Projects Sub-Com...
- ☐ Digital Health Sub-Commi...
- ☐ Executive Committee
- ☐ Governance Committee
- ☐ Quality Committee
- ☐ Resource Committee

Legend
T-Conference
R-Regrets
P-Present

BRIEFING NOTE

Date: April 25, 2024
Issue: Governance Policy Summary
Prepared for: Board of Directors
Purpose: ☒ Approval ☒ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Executive Assistant
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: Policies

Recommendation/Motion
Following review and discussion of the information provided, the Governance Committee of the Board recommends to the Board of Directors that the following policies be approved with amendments:
2-C-32 Resource Protection & Liability
2-C-34 Approval & Signing Authority
2-D-06 Board Meeting Agenda
2-D-10 Guidance to Decision Making Process
*(*Track changes version can be found in package 2)*

Background
This year the Governance committee pre-reviewed 16 CMH Board Policies prior to the beginning of the 2023/24 Board cycle.

Of those pre-reviewed, the following policies were reviewed again at the March 14, 2024 Governance Committee meeting and were amended / updated as attached:
**Note only policies with tracked changes are attached to the package*

Policy No.	Policy Name
2-C-32	Resource Protection & Liability
2-C-34	Approval & Signing Authority
2-D-06	Board Meeting Agenda
2-D-10	Guidance to Decision Making Process

BOARD MANUAL

SUBJECT: Resource Protection and Liability	**NO.: 2-C-32**
SECTION: Corporate Performance and Oversight	
APPROVED BY: Board of Directors	**DATE: TBD**

Policy

The President & Chief Executive Officer (CEO) is accountable to the Board of Directors at Cambridge Memorial Hospital to ensure that human resources and physical resources/assets are reasonably protected, adequately maintained and not placed at unnecessary risk. The CEO will ensure that appropriate administrative policies and procedures are in place to ensure the protection of human resources and physical resources/assets, and that these policies and procedures are monitored for compliance and reviewed annually by the Resources Committee of the Board.

The CEO will ensure that:

a) Adequate insurance against fire, theft, and casualty losses, with an appropriate deductible, is maintained
b) There is adequate property, boiler and machinery insurance coverage for all assets owned by the corporation which may be subject to replacement or repair as a result of theft or casualty loss
c) There is an asset registry and asset tag program
d) There is a program to ensure that plant, equipment and systems are well maintained and calibrated if required, comply with legislative requirements and are not subjected to improper wear and tear, and that there is a proactive strategy in place to replace and renew equipment as it ages
e) Adequate insurance coverage (including, but not limited to, crime, cyber liability, errors and omission) is maintained for the organization, its Board members, its non-Director members of Board committees, its employees, the CMH Volunteer Association and its members, and other appropriate parties while engaged in their activities on behalf of the organization
f) The organization has procedures in place to minimize exposure to unnecessary litigation for it, its employees, volunteers and Medical/Professional Staff members
g) There are appropriate and adequate internal controls regarding the receipt, disbursement, and processing of funds, and that these controls are reviewed bi-annually by the Audit Committee and the external auditors
h) Unbonded/uninsured individuals do not have access to cash in excess of $1,000
i) The organization has procedures in place to safeguard Cambridge Memorial Hospital's goodwill, including public image and credibility
j) An Integrated Risk Management process in accordance with policy 2-C-20 is in place
k) Adequate human resources policies are in place to ensure staff are treated in

accordance with appropriate legislative requirements, guidelines and negotiated agreements, with a focus on ensuring that staff have a safe, healthy, and accessible workplace and that staff are engaged and are presented with opportunities for ongoing development and learning

DEVELOPED: March 26, 2012	**REVISED/REVIEWED:**	
January 29, 2013	January 28, 2015	April 25, 2018
April 28, 2021	Click or tap to enter a date.	Click or tap to enter a date.
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

BOARD MANUAL

SUBJECT: Approval & Signing Authority	**NO.: 2-C-34**
SECTION: Corporate Performance and Oversight	
APPROVED BY: Board of Directors	**DATE: TBD**

Policy

The President & Chief Executive Officer (CEO) shall ensure that the organization has policies and procedures in place for the approvals, purchasing, contracting, leasing, acquisition or disposal of goods, services, capital and real property. This policy sets out the approvals required to commit CMH resources and to identify individuals who are authorized signing officers on behalf of the Corporation. This information is supplemented by the Approval Authority Schedule set out in hospital policy 7.85 Corporate Supply Chain Directive – Procurement Policy and Procedures.

The Board authorizes the CEO to make commitments contained within the approved operating and capital plan or otherwise approved by motion of the Board or its delegated authorities, including all: contracts, requisitions, purchase orders, travel authorizations and any other agreement, financial or otherwise.

If emergency expenditures or commitments are necessary, the CEO must secure the support of the Board Chair and Chair, Resources Committee before committing to the expenditure. The Board or its delegated authority must be informed at their next appropriate meeting.

Prior approval of the Board is required for the following:

1. The annual operating and capital plans
2. Capital purchases in excess of the annual approved capital plan
3. Hospital Service Accountability Agreement (HSAA) and the Multi-Sector Accountability Agreement (MSAA) between CMH and Ontario Health (OH)
4. Redevelopment-related approvals as required by the Ministry of Health and/or Infrastructure Ontario
5. Subject to applicable Ministry of Health (MOH) asset disposition policies, the sale or transfer of any assets of the Corporation, which individually or cumulatively exceeds $100,000
6. The taking or instituting of proceedings for the winding-up, reorganization or dissolution of the Corporation
7. The enactment, ratification or amendment of any by-laws of the Corporation
8. The sale, lease, exchange or other disposition of all or substantially all of the assets or undertakings of the Corporation
9. The provision of financial assistance, whether by loan, guarantee or otherwise to any person whatsoever

10. Real estate purchases and sales
11. Internal and external space leases greater than $50,000 per annum
12. Union contract agreements

Signing Authority

In addition to the provisions of the Corporations By-law, the Board may from time to time by resolution direct the way in which and the person or persons by whom any particular instrument or class of instruments or document may or shall be signed. Any signing officer may affix the seal of the Corporation to any instrument or document and may certify a copy of any instrument, resolution, by-law or other document of the Corporation to be a true copy.

Electronic signatures may be used to automate the disbursement authorization process, subject to appropriate safeguards. CMH uses a recognized third party software, for electronic signatures where possible, which has built in security features to validate the signature, based on the user login credentials. If third party software is unavailable, the use of an electronic picture of an individual's signature with email approval from the signer noting its use will suffice.

In conjunction with CEO, the Board will identify the designated signing officers of the Corporation and their authority and will review the slate of designated signing officers at least annually and at the time of turnover of so designated Board members and staff.

The CEO is accountable to the Board for ensuring that adequate internal controls and processes are in place. Employees are not authorized to bind the Corporation to contracts or incur expenditures unless they have been delegated that authority.

Reporting Requirements

The CEO or designate will report to the Board annually on compliance with this policy. The reporting will be at least annually unless there are significant breaches to these rules and/or controls. In that case, the CEO will inform the Resources Committee and the Board at their next regularly scheduled meeting.

Policy Compliance

The Finance and Procurement departments shall put in place processes to ensure that the above authorization policies are adhered to. The Finance and Procurement department shall report instances of unauthorized expenditure or commitment to the CEO as soon as possible and, where material, the CEO will inform the Resources Committee of the Board at their next regularly meeting. "Material" in this context would include unauthorized expenditures or commitments which are beyond the authority of the CEO or lesser amounts at the discretion of the CEO.

Signing Authorities For Disbursements:

Disbursement signing authority is approved by the Board and generally consists of the holders of the following positions (or designates):

- Chair of the Board
- Vice-Chair of the Board

- CEO
- Vice President, Finance and Corporate Services and CFO
- Vice President of Clinical Programs and Chief Nursing Executive
- Director of Finance
- Controller

For disbursements (including HST, payroll and HOOP payments)

- Less than $100,000, any two of the above signatures are required
- Over $100,000 requires the signature of two of the following: CEO, Chair of the Board, Vice-Chair of the Board, Vice President, Finance and Corporate Services and CFO or Vice President of Clinical Programs and Chief Nursing Executive

Unless otherwise set out in this policy, this authority may not be further delegated. No other staff or Board member may sign disbursements on behalf of the Corporation.

Electronic funds transfers (EFTs) are initiated, executed and approved in a secure manner. All EFT payments will be coordinated and submitted through the Finance department. The Controller or their designate will approve all new and amended EFT requests, ensuring all required documentation is provided and appropriately approved, and that the request and banking account information is accurate and valid. EFTs are subject to the same financial policies, procedures and controls that govern disbursement by any other payment mechanism.

The total value of a disbursement shall not be split into smaller segments to avoid the approval requirements and signing authorities set out in this policy.

Signing Authorities For Staff And Board Member Expenses

All reimbursable expenses incurred by CMH staff or Board members must be approved by one level higher than the individual claiming the expenses as follows:

(i) Staff requires their leader/manager approval
(ii) Vice President requires CEO approval
(iii) CEO requires Board Chair approval
(iv) Board Members require Board Chair approval
(v) Chief of Staff requires Board Chair approval
(vi) Board Chair requires Chair of Resources Committee

Signing Authorities

The CEO will ensure that the organization does not order, receive or process goods in a manner that does not meet good business practices, the Ontario Broader Public Sector Directive and applicable CMH procurement policies.

All purchases of supplies, services, capital, or for a contract, lease or agreement, shall be completed in accordance with the signing authorities set out in the Policy 7.85 Supply Chain Directive – Procurement Policy and Procedures.

All purchases in excess of $5,000, require a purchase order except for:

(i) Collective Agreements
(ii) Employment Contracts

(iii) Utilities Agreements
(iv) Transfer Payments to other Health Service Providers
(v) Payroll disbursements
(vi) Physician payments
(vii) Staff Expense Reimbursements

Signing Officers For Specific Legal Documents

a. Changes to Capital Project Budgets

All changes to capital project cost will be approved and signed in accordance with CMH Capital Projects Change Order Request and Approval Policy 2-C-40.

b. Contracts for which CMH Receives Money or Monies Worth (i.e. Property; Goods; or Services); Affiliation Agreements; Service Transfer Agreements; Estate Administration; Performance Contracts (i.e. Wait Times)

The President & CEO or individual(s) designated set out in this policy or otherwise established in writing by the President & CEO shall have the power to sign contracts, documents or instruments in writing where CMH will receive money or monies worth (i.e. property, goods, services).

This section also applies to contracts where CMH is transferring a service to another service provider, affiliation agreements and estate administration documents.

c. Research Agreements & Physician / Professional Staff Agreements

The President & CEO or delegate, is authorized to sign the following documents:

(i) Affiliation Agreements with Colleges (Private and Public) and Universities;
(ii) Affiliation Agreements with other public entities for education;
(iii) Memorandum of Understandings (Research and Education);
(iv) Research contracts – every research project;
(v) "Notification of Research Study to Commence" authorization letters;
(vi) Clinical Trials Ontario ("CTO") attestation documents. For the purpose of CTO documents, the Vice-President of Clinical Programs and Chief Nursing Executive has specifically designated the Privacy & Risk Lead / Privacy Officer as the Primary Institutional Representative for CMH and authorized signatory for attestations or other CTO documents.

The Chief of Staff and President & CEO (or designates) are authorized to sign the following documents if the financial commitment does not exceed $500,000:

(i) Physician Clinical Service Agreements / Contracts; and
(ii) Physician Leadership Agreements / Agreements.

d. Confidentiality/Data Sharing Agreements

Confidentiality/data sharing agreements may be signed by any two of the President & CEO, a Vice President, a Director (corporate employee) or Chief of Staff. The President & CEO may also designate in writing specific individuals not listed under this category who may sign confidentiality agreements on behalf of CMH.

All confidentiality/data sharing agreements relating to the collection, use, disclosure and/or access to personal health information must be reviewed by Health Information Management and the Privacy Officer prior to signature.

e. Commercial Leases; Real Property

All lease documents, regardless of the term or financial commitment must be reviewed, approved and signed by any one of the President & CEO or Vice President, Finance and Corporate Services and CFO (or designates). This also applies to leases where CMH's space is leased to third parties.

Subject to Ontario Government requirements, the sale, mortgage hypothecation (i.e. pledging something as security for a loan), or other disposition of real property shall be authorized with the approval of 2/3rds of the Board. Once approved, the legal document may be signed by any two of the Board Chair, Vice-Chair, President & CEO, or such other person or persons as approved by a Board resolution.

f. Bank Signing Authority

Any two of the following individuals (or designates) are the designated signing officers for banking transactions.

- Chair, Board of Directors
- President & CEO
- Vice President, Finance and Corporate Services and CFO
- Vice-President of Clinical Programs and Chief Nursing Executive
- Director of Finance
- Controller

New Bank Accounts: All bank accounts holding hospital funds must be opened in the name of Cambridge Memorial Hospital. Documentation for all new and existing accounts requires signatures of two (2) of the CMH designated signing officers described above.

Cash Transfers: Authorized Controller are permitted to transfer funds between CMH bank accounts, subject to the approval of the Director of Finance, regardless of the amount transferred. All transfer approvals and bank statements indicating the transfer will be retained by Finance.

Cheque Release Approvals: Prior to the release of cheques, the Director of Finance, or delegate, will approve the cheque register and/or the Electronic Funds Transfer (EFT) listing. All cheques/EFTs that do not have a purchase order will be reviewed prior to approval.

Release of Banking Information:

(i) Release of banking information to vendors must be authorized by a Controller.
(ii) Banking information for the purposes of pre-authorized payments must be supported by the appropriate internal documentation. A vendor request for banking information must be completed and approved.
(iii) The release of banking information will be sent directly from Finance to the approved vendor.
(iv) Copies of all documentation are to be retained in the Finance Department.

Documentation of Authorized Signatures: A list of authorized personnel and sample signatures will be maintained by the Accounts Payable department.

Reporting Requirements

The reporting will be at least annually unless there are significant breaches to these rules and/or controls. In that case, the Resources Committee and the Board will be informed at their next regularly scheduled meeting.

DEVELOPED: March 26, 2012	**REVISED/REVIEWED:**	
January 29, 2013	September 24, 2014	November 24, 2014
January 24, 2018	April 28, 2021	Click or tap to enter a date.
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BOARD MANUAL

SUBJECT: Board Meeting Agenda	**NO.: 2-D-06**
SECTION: Board Process	
APPROVED BY: Board of Directors	**DATE: TBD**

Purpose

To ensure the Board members understand the process for the development of, and have an opportunity to have input into, the Board's meeting agenda.

Policy

It is the responsibility of the Board Chair, in consultation with the President and Chief Executive Officer (CEO), to develop the agenda for Board meetings.

Board agendas for regular meetings of the Board are usually determined 10 days before a meeting.

A Board member who wishes to add an item to the Board's agenda or to be provided with additional information with respect to a Board matter should speak with the Board Chair. If the Board member and the Chair are not in agreement, then the Board member may, on notice to the Chair, raise the request during the call for other business or approval of the agenda at the opening of the Board meeting, and the matter shall be determined by the Board.

The agenda, together with supporting materials, will be distributed to Board members at least two full business days before the Board meeting date. For Board meetings held on a Wednesday for example, the package will be sent to Board members on the preceding Friday.

Consent Agenda Overview
A consent agenda is a set of items that is previously distributed and approved without discussion. It is presented by the Chair at the beginning of a meeting.

The consent agenda promotes good time management by streamlining the process for approval of regular, routine issues that come before the Board. Consent items are self-explanatory and/or confirm a previously discussed issue.

For example, the following items will not be included on the consent agenda:

- Quality reports that require discussion by the Board

- Financial reports that require discussion by the Board
- Decisions that have broad implications
- Professional staff privileges that require Board approval
- Any reports from the auditor

Unless a Board member believes that an item should be discussed and requests the removal of that item ahead of time, all consent items are voted on at once without added explanation or discussion.

Consent Agenda Procedure

1. The Chair, in consultation with the CEO, develops the consent agenda for each Board meeting.
2. The list of consent items and supporting documents are clearly identified and included in the Board's agenda package in sufficient time to be read by all members prior to the meeting. Any items not included in the regular Board package will not be included on the consent agenda.
3. The consent agenda will state: "Any Board member may request that any item be removed from this consent agenda and moved to the regular agenda."
4. Board members should thoroughly review the consent agenda items and other pre-mailed materials prior to the meeting and expect that no verbal reports will be presented.
5. At the beginning of the meeting, the Chair asks members what items they wish to be removed from the consent agenda and discussed individually. Any Director may request that an item be moved out of the consent agenda.
6. If one item in a committee or other report is requested to be moved to the regular agenda, that item shall be moved. The rest of the items in that committee or other report will remain on the consent agenda.
7. When an item has been removed, the Chair will decide its placement on the agenda.
8. When there are no more items to be removed, the Chair confirms the remaining consent items. The Chair will seek a motion to approve the consent agenda material and, upon approval, the Chair will declare the consent business to be approved.
9. Acceptance of the consent agenda is documented in the Board meeting minutes. Minutes will include the full text of resolutions or recommendations adopted and references to reports or other matters received.

DEVELOPED: February 22, 2012	**REVISED/REVIEWED:**	
May 25, 2016	October 17, 2018	November 24, 2021
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BOARD MANUAL

SUBJECT: Guidance for Decision Making Process	**NO.: 2-D-10**
SECTION: Board Process	
APPROVED BY: Board of Directors	**DATE: TBD**

Policy

The intent of this guidance is to support the Board in its role as the ultimate decision-making body in the organization. The purpose of this guidance is to:

- Facilitate rigorous, comprehensive discussion on difficult decisions
- Ensure that risk and ethics are appropriately addressed in the decision-making process
- Include an appropriate hierarchy of decision-making authority within the organization

Context for Decision-Making

The health care environment is characterized by a variety of factors, including but not limited to the following, which provide the context for decision-making:

- Limited resources
- Changing demographics and shifting cultural values in society
- Increased emphasis on patient and family member/care giver involvement in decision making
- Increased public awareness and interest in health care issues
- Changing public expectations and increased requirement for public accountability and transparency
- New and evolving technologies and approaches to care
- Emphasis on individual rights and freedoms
- Respect for privacy and confidentiality
- Increased need for interdisciplinary and inter-institutional collaboration, co-operation, and integration
- Evolving governance structures and accountabilities
- The Board's accountability as included in, but not limited to, Policy 1-A-03 Board Accountability.

Guiding Principles

The following principles will guide decision-making at the Board level:

- Consistency with the organization's mission, vision, and values.
- Commitment to quality and patient centred care

- Appropriate engagement with those impacted – patients, families, staff, physicians, and or volunteers as applicable
- Appropriate due diligence to assess available options and the impact on all stakeholders
- System capacity and sustainability
- Effective and efficient use of resources
- Social costs and benefits including access and equity
- Open, transparent, and accountable processes
- Evaluation of and learning from outcomes
- Healthcare regulations and legislative responsibilities

The Decision-Making Framework

In addition to using the guiding principles above, the Decision-Making Framework includes five components:

1. Decision-making criteria and evidence of due diligence
2. Risk management
3. Financial oversight
4. Ethical Considerations
5. Delegation of Authority

1. Decision-Making Criteria

Decisions will be made based on relevant key criteria and afterevidence that due diligence has occurred. The Board makes informed decisions, based on the best information available at the time, including an evaluation of alternatives and criteria for reviewing options and the rationale for a recommended option, if applicable. Materials prepared by management for the Board meetings shall, when considered appropriate by management, provide detailed information that incorporates the decision-making criteria in Appendix A.

2. Risk Management

The Integrated Risk Management Policy outlines categories of risks which the Board oversees. Management is responsible for the implementation of policies and processes to mitigate the occurrences of risk. In making decisions, the Board will consider what risks the Corporation may need to assume, the probability those risks may occur and any action to mitigate the impact of risks.

3. Financial Oversight

The Corporation's financial policies, practices and processes exist to guide the Board in governing the Corporation and protecting its overall financial health and viability.

Decisions about program changes or expansions, replacements/changes to the medical/professional staff, and capital projects will be considered based on a full business case or impact analysis.

4. Ethical Considerations

Where appropriate, the Board has access to ethical resources to guide its decision making that include access to the hospital's ethicist. The hospital uses The Ethical Decision-Making Process – the You Observe Deliberate Act (YODA) model. The process identifies potential questions to consider through the decision-making process. The extent to which the questions and/or process is applicable will be dependent on the nature of the decision. Further information is detailed in the following documents:

- Ethics Framework for Health Care Providers – YODA model
- Ethics Framework for Leaders – YODA model

5. Delegation of Authority

The role descriptions for both the CEO and Chief of Staff identify decisions delegated to the CEO and Chief of Staff.

Related Policies

2-B-5 Role Description of the CEO
2-B-6 Role Description of the Chief of Staff
2-C-20 Integrated Risk Management
2-C-30 Financial Objectives
2-C-31 Financial Planning and Performance
2-C-34 Approval and Signing Authority

DEVELOPED: January 15, 2014	**REVISED/REVIEWED:**	
January 28, 2015	September 27, 2017	May 26, 2021
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Appendix A - BOARD OF DIRECTOR'S DECISION MAKING SUPPLEMENTARY GUIDE

CRITERIA	DEFINITIONS
Quality & Safety	• outcomes are measurable and as good as can be achieved • services are safe and error free and where appropriate in alignment with best practices • personnel are qualified and demonstrably competent • relevant staff/providers/patients have been consulted about the option(s) • program/service meets the health needs of intended service recipients by providing the right service in the right place at the right time • decisions are evidence-based
Sustainability	• resources are available to fund capital and/or operating expenditures required to pursue the proposed option(s) (affordability) • the option is not obsolete in the near future and can accommodate changing circumstances and needs (adaptable) • qualified providers can be recruited and retained • desired outcomes are achieved, consuming minimal resources (efficiency) • waste and redundancy are minimized • Medical/Professional Staff use their knowledge and skills to the maximum extent possible
Equity, Diversity, Inclusion and Access	• the needs of high risk, high needs, marginalized populations are effectively met and health disparities are reduced • reasonable and fair geographic access to services is achieved • timely access to services in relation to need is provided • need governs where services are located and how services and benefits are distributed
Maximum Benefit to Health / Risk of Not Proceeding	• greater improvement in health status than the alternatives is achieved or achievable • benefits more people than the alternatives
Public Consultation	• public affected have been consulted with the option(s) under consideration • public affected are willing to use the services as organized and located
Consistency / Alignment with Vision	• the option(s) under consideration is consistent and aligned with the CMH Vision
Patient and Family Engagement	• patients and families are provided the opportunity to engage in a meaningful way in considering the option(s) • patient values, experiences and perspectives have been incorporated into the option(s)

CMH President & CEO Report
May 2024

This report provides a brief update on some key activities within CMH. As always, I'm happy to answer questions and discuss issues within this report or other matters.

Paws and Relax: U of G Studies Mental Wellness Among Hospital Staff

- The University of Guelph shared a media release in April highlighting an upcoming research project led by Dr. Bosem Gohar. The research project is looking to measure the impact a facility dog can have on health care professionals
- Gohar builds on previous studies that assessed the mental health of various health care providers. Gohar is a clinical psychologist and professor in the Department of Population Medicine at the Ontario Veterinary College where he leads U of G's Research in Occupational Health and Wellness Lab.
- In partnership with CMH, Gohar's team is taking an in-depth and open-ended approach through one-on-one interviews with CMH staff. Research focusing on human and animal interaction is a first for Gohar and he's excited to see what can be learned from Ember.
- The study announcement tracked well locally through social channels and media. CTV and CBC picked up the story, featuring our facility dog Ember doing what she does best.
- The research is set to start in May 2024.

TGLN lauds Dr. Cape and team for organ donation case

- The Trillium Gift of Life Network recently sent a heartfelt note of appreciation, along with an official letter to the team that provided 'invaluable support' for a recent organ donation case.
- The note singled out Dr. David Cape for his quick work and actions ("*It was truly impressive…the fastest I've ever seen*.") and went on to say that the donation saved four lives, with five organs transplanted, including a double transplant.
- Many thanks to Dr. Cape and team for helping save lives and for ensuring CMH continues to be an active partner in Ontario's organ donation and transplantation network. The official letter expressed the same gratitude stating:
    - *[The team was] involved in the management of a patient who sustained a devastating […] injury and ultimately succumbed […] despite receiving the best medical care. Knowing that there was no chance of recovery, the*

patient's loved ones generously affirmed the patient's registered consent decision in the hope that something positive could result from their tragedy. Your team's dedication and expert care played a crucial role in ensuring that we could honour the decision for donation.

Real-time data empowers clinical teams to make informed decisions

- Tapping into the power of real-time data for decision-making enhances hospital operations and can elevate patient care to new heights.
- As part of a month-long collaboration between a number of CMH's corporate and clinical teams, Senior Decision Support Specialist Kristan Chamberlain played a pivotal role to help visualize and rollout cutting-edge, digital boards across the hospital.
- These monitors are more than just screens. These are invaluable tools supporting patient flow.
- By providing clinical teams with real-time data, staff are empowered to devise strategies and make informed decisions on the spot. It could mean proactively allocating beds or ensuring a room is cleaned the moment a patient is discharged.
- With valuable information near the bedside and across the hospital, it enables collaboration between departments. Everyone at CMH can now play a role in the hospital's strategic priorities to expand services, welcome more patients and reduce wait times.

Women in Construction Week at CMH

- CMH celebrated Women in Construction Week March 3 through 9.
- The organization's Capital Redevelopment Project (CRP) boasts a woman-led construction team that includes Amanda Thibodeau, Director of Construction; Alyssa McCarthy, Project Manager; and Lilian Heldmann, IPAC Practitioner, Construction Lead.
- The CRP project is the single largest construction project in CMH's history that will fundamentally change the way it offers care to the community when it is completed.
- These talented women come from different backgrounds with diverse experiences and support critical facets of the project. Lilian ensures infection, prevention and control standards and practices are diligently followed to all construction sites through audits and record reviews. Alyssa supervises site coordination, architectural installations and large equipment installations like the recent delivery of the new SPECT-CT. Amanda has a close pulse on the entire project having worked through a number of progressive roles since joining CMH and currently has oversight of this strategically important project.
- Together, they are breaking down barriers and proving that women can excel in any role they choose. Thank you to Amanda, Alyssa, and Lillian for setting an

example of what can be accomplished and empowering women to pursue construction work.

Wing C flood displaces staff

- Early morning Sunday March 17, the on-call maintenance technician received an emergency call at 0400h regarding a flood that started from a leak in a Wing C, level 2 bathroom.
- Three levels of Wing C sustained heavy damage, including the Scheduling Office, CRP meeting room, Foundation, Finance, Accounts Payable/Payroll, the C.1 hallway and a Medical Health Records storage room in C.0. Further to the Wing C.1 hallway, it needed to be sealed off, blocking patients and staff from using this most convenient pathway to and from Wing D.
- On-call management that day quickly formed an Incident Management Command Centre. They called in contractors, ensured staff were informed, confirmed Code Blue paths of travel and provided the means to relocate affected staff to temporary work spaces in other parts of the hospital.
- More than 30 industrial dehumidifiers were deployed to dry out the affected areas so that the damage could be properly assessed. Through water mapping, the full extent of the damage was surveyed. Given the age of the building, environmental consulting firm Pinchin Ltd. was brought for a second opinion to ensure no hazards were hidden about.
- The Wing C corridor opened up 17 days later on April 3, with Finance moving back into their space.
- On April 5, a work schedule was circulated that estimated many areas to be repaired by end of April, leaving a few larger projects finished by mid-May. As this issue was deemed to be in remediation, the Command Centre dissolved that same day after sharing their final update to all staff.

Welcome Lyndsay Kowalyk, Manager of Women and Children's Program

- We are very happy to welcome Lyndsay Kowalyk to the leadership team as Manager, Women and Children's Program, effective Monday, April 22.
- Lyndsay has been a Registered Nurse for 17 years. She's held leadership roles for the last eight years at Hamilton Health Sciences serving as Clinical Manager for Women's Reproductive Health and Newborn Care/WRH Critical Care Unit. Most recently, she was the Clinical Manager in their Diagnostic Imaging department.
- Lyndsay spent her early career as a RN in Obstetrics, moving into a Clinical Instructor role and later as an Education and Development Clinician and Part-time Faculty Continuing Education Instructor.
- Lyndsay's knowledge of obstetrics, education and management will be a strong addition to CMH. She holds a Master of Science in Neuroscience, Bachelor of

Science degree in Nursing, as well as a Bachelor of Arts in Psychology from Western University.

- The interview panel included the Chiefs of the Women's & Children program, Clinical Directors and Managers, as well as Charge Nurses, all of whom were impressed with Lyndsay's emphasis on patient safety, improved process and team engagement and support.
- Lyndsay is a proud mother to three children. Her oldest is a recent graduate from Law School and her two youngest are very active in sports. You will often find her in a hockey rink, baseball/soccer field or cheer gym. Lyndsay enjoys watching sports both live or on TV, and her favourite teams are the Leafs, Blue Jays and Ticats.
- During off time, Lyndsay enjoys kayaking, biking and camping. Lyndsay is a coffee enthusiast and loves walking her dog, Finnigan, with a warm coffee in hand on the trails.

Masking Guidelines changed

- That day has arrived!
- As part of its commitment to review and reassess the practices borne out of the pandemic, COVID Command adopted a masking recommendation forwarded by Infection Prevention & Control (IPAC) and Health Safety & Wellness (HSW) to return to pre-pandemic practices. This was made in light of recent epidemiology and the decreasing number of outbreaks in hospital at this time.
- The change occurred March 18. Staff interacting with patients may use a mask as guided by their point of care risk assessment. Like before, a mask-friendly environment will continue to be promoted for visitors and patients.
- Mandatory masking will remain in place within Isolation rooms and units in outbreak.
- Many thanks to all staff, physicians, midwives and volunteers for their tireless efforts to keep our patients and one another safe since March 11, 2020, when the pandemic was first declared.

Spend a day with me in Ramadan, by Sadia Mian - Registered Dietitian

- This story was publsihed as part of the Voices of CMH initiative. Its purpose is to celebrate and acknowledge CMH personnel that have lived experience or want to share a story from their perspective.

- With the lunar calendar, the month of Ramadan moves back 10 days every year. This means the timing and duration of fasts changes every year. Over a lifetime, Muslims get to observe fasting during the long hot summer months as well as shorter winter days. This year Ramadan will be approximately from March 11th to April 9th.

Agenda

- A usual day in Ramadan for my family follows like this (the timing changes every day by a few minutes based on sunrise & sunset):
    - ~5:00 a.m. – Get up for Tahajjud (early morning voluntary prayers). This prayer has high significance as it is a special time for seeking closeness to God through prayers and reflection. It is a peaceful and humbling experience to wake up when most of the world is still sleeping, and to spend time reflecting on our blessings and seeking guidance.
    - ~5:30 a.m. – Suhoor (pre-dawn morning meal). We have this early breakfast to start the fasting day. There are no special foods associated with this meal, but we try to always include dates along with a high fibre and protein meal like oatmeal and eggs to give us energy for the day. Caffeine withdrawal is one of the most challenging aspects of Ramadan, and this is usually the only time of day I can have my cup of tea in Ramadan.
    - ~6:10 a.m. – Fajr prayer- this is the morning Fard (compulsory) prayer. There are five daily compulsory prayers for Muslims at different times of the day. The Adhan (call to prayer) for Fajr marks the closing time for eating/drinking and starts the fast.
- After the prayer, we get ready for our day and work. Sleep is very limited on weekdays. So on weekends we look forward to going back to bed after Suhoor and catching up on some sleep.
- Through the day we carry out our normal day-to-day activities and work as usual. However, with fasting, we need to pay more attention to our behaviour, language and interactions. Fasting is not just refraining from food and drink (physical discipline), but also refraining from harmful habits and behaviours (spiritual discipline). The goal is to achieve a higher personal awareness and strengthen good character while experiencing discomforts of hunger and thirst.
- I often get asked if it is difficult to fast at work when others around you are having lunch or drinking water. It was more challenging when I was younger and fasting in high school. However, as I have gone through more years of experiencing Ramadan and understood its purpose, I don't find it difficult to be around others eating. A simple self-reminder that also helps is that I get to eat whatever I want in a few hours compared to many people around the world who have no hopes of getting any food or clean water.
- There are two more compulsory prayers during the day: Dhur (noon) and Asr (late afternoon).
    - ~6:00 p.m. - An hour or so before sunset, we start getting our Iftar (breaking the fast meal) prepared. Muslims around the world come from many different cultures so the types of foods eaten in Ramadan varies by culture and region. My family's heritage is Pakistani, so we break our fasts with a date, followed by appetizers like Chaat (spicy chickpea or spicy fruit salad), Pakoras (fried vegetables in chickpea flour), Samosas or Dahi baray (lentil dumplings in yogurt). We also try to spend the last hour of the fast reading Quran or discussing prophet stories with the kids.

- ~7:25 p.m. – We break our fast, and then say the fourth daily prayer Maghreb together as a family at home. Following the prayer, we have our dinner meal.
- ~8:45 p.m. - The fifth and last compulsory prayer Isha is followed by special voluntary prayers that can only be offered in Ramadan. These are called Taraweeh. The Taraweeh prayer is offered daily in congregation at the Mosque, and can be done at home individually as well. Through the month of Ramadan, the whole Quran is recited from beginning to end in the Tarwaweeh prayers at mosques. Since this prayer can go late into the evenings, we usually try to go to the Mosque on Friday evenings and weekends with the kids, and do our prayers at home on school/work days. On weekends, the community also gets together for community Iftars at the mosque where community members sponsor the evening meal for everyone to eat together. The Taraweeh prayer is followed by bedtime and then we continue the same routine every day for the whole month of Ramadan.

Embracing Diversity through Eid ul-Fitr, by Anam Fazal - DEI Director, CMHVA

- This story was published as part of the Voices of CMH initiative. Its purpose is to celebrate and acknowledge CMH personnel that have lived experience or want to share a story from their perspective

- Introduction:
  - In our pursuit of diversity, equity, and inclusion (DEI), it's essential to celebrate the cultural tapestry enriching our societies. Eid ul-Fitr*, a significant religious holiday for Muslims worldwide, offers a unique lens to understand diversity and compassion. Join us on a journey to uncover the beauty of Eid ul-Fitr and explore one individual's heartfelt experiences celebrating this joyous occasion.
- Unveiling Eid ul-Fitr:
  - Eid ul-Fitr, known as the 'Festival of Breaking the Fast,' holds deep spiritual significance for Muslims. It marks the end of Ramadan, a month of fasting, prayer, and self-reflection. The day begins with Eid ul-Fitr prayers, expressing gratitude and seeking blessings. Beyond its religious context, Eid ul-Fitr embodies themes of compassion, generosity, and unity, fostering hope and inclusivity.
- A Personal Journey of Celebration:
  - Eid ul-Fitr is more than a date on the calendar—it's a celebration of compassion, tradition, and family bonds. Growing up, my family eagerly awaited Eid ul-Fitr, preparing for the festivities together. The day started with the aroma of homemade treats, a tradition we cherished.
- Spreading Joy Beyond Borders:
  - One cherished Eid ul-Fitr tradition was visiting the local orphanage, rooted in compassion and inclusivity. With baskets of sweets, we shared the joy

of Eid with those less fortunate, transcending differences through kindness and humanity.

- The Tradition of Generosity:
  - Eid ul-Fitr also includes the tradition of Eidi, symbolizing love and generosity exchanged among family and friends. As a child, receiving envelopes filled with tokens of affection highlighted the bonds uniting us, regardless of background or belief.
- Celebrating Diversity and Unity:
  - Reflecting on Eid ul-Fitr, it reminds us to embrace diversity and foster inclusivity in our communities. Eid ul-Fitr celebrates our shared humanity, encouraging us to celebrate traditions, extend kindness, and embrace differences for a more inclusive society.
- Conclusion:
  - As we celebrate Eid ul-Fitr, let's embrace the opportunity to cultivate understanding, compassion, and unity. Through Eid, we champion diversity, equity, and inclusion, fostering a brighter, more inclusive future for all. Eid Mubarak!

Agenda Item 1.5.5

BOARD WORK PLAN – 2023-24

Charter Section #4	Action *(Italics-comments)*	Committee Responsible	Oct	Nov	Dec	Feb	Mar	May	Jun	Jun
	Tone at the Top									
a-i, ii	➢ Approve CEO goals and objectives	Executive						√	√	
	➢ Approve COS goals and objectives							√	√	
	➢ Mid-year CEO assessment input from Board	Board			C				√	
	➢ Mid-year COS assessment input from Board				C				√	
	➢ Mid-year/Year-end CEO report and assessment	Executive			C					
	➢ Mid-year/Year-end COS report and assessment				C					
	➢ CEO evaluation/feedback – mid-year	Executive			C					
	➢ COS evaluation/feedback – mid-year				C					
a-iii	➢ CEO evaluation/feedback –year end and performance based compensation	Executive							√	√
	➢ COS evaluation/feedback –year end and performance based compensation								√	√
	➢ Reviewing the performance assessments of the VPs – summary report provided to the Board (as per policy 2-B-10)	Executive			C					
b	➢ Strategic Plan: approve process, participate in development, approve plan (done in 2022, will be done again in 2027)	Board								
b	➢ Progress report on Strategic Plan – Updates completed through the corporate scorecard	Board	C		C			√		√
b-iii-c	➢ Approve annual Quality Improvement Plan (QIP)	Quality					C			

✓ = Due ND = Not Due C = Complete I = In progress D = Delayed 26 April 2024

Agenda Item 1.5.5

BOARD WORK PLAN – 2023-24

Charter Section #4	Action *(Italics-comments)*	Committee Responsible	**Oct**	**Nov**	**Dec**	**Feb**	**Mar**	**May**	**Jun**	**Jun**
b-iii-c	➢ Review and approve the Hospital Services Accountability Agreement (H-SAA) ➢ Review and approve Multi-Sector Accountability Agreement (MSAA) ➢ Review and Approve Community Annual Planning Submission (CAPS) ➢ Review and Approve Hospital Accountability Planning Submission (HAPS)	Resources, Quality				C C C C				
b-iii-C	➢ Monitor performance indicators and progress toward achieving the quality improvement plan	Quality			C	C			√	
c-i-B c-i-B	➢ Critical incidents report – (as per the *Excellent Care for All Act*). *(Brought forward to Board at each meeting – approved Nov 27, 2019)* ➢ Monitor, mitigate, decrease and respond to principal risks	Quality Audit	C		C	C		√	√	√ √
c-i-E	➢ Review the functioning of the Corporation, in relation to the objects of the Corporation the Bylaw, Legislation, and the HSAA	Governance	C		C	C		√		√
	➢ Receive and review the Corporate Scorecard	Board	C		C			√		√
	➢ Declaration of Compliance with M-SAA Schedule F (due 90 days after fiscal year end)	Resources	C						√	
c-i-F	➢ Declaration of Compliance with BPSAA Schedule A (due May 31 to the OH)	Resources							√	
c-i-F c-i-F	➢ Receive and review quarterly the CEO certificate of compliance regarding the obligations for payments of salaries, wages, benefits, statutory deductions and financial statements	Resources	C		C			√		√
	➢ Procedures to monitor and ensure compliance with applicable legislation and regulations	Audit							√	

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Agenda Item 1.5.5

BOARD WORK PLAN – 2023-24

Charter Section #4	Action *(Italics-comments)*	Committee Responsible	Oct	Nov	Dec	Feb	Mar	May	Jun	Jun
c-ix-G	➢ Board Generative/Education Discussions o Emergency Department o Digital Health o TBD	Board		C			C		√	
e-i-A	Receive a summary report on: • CEO succession plan and process • COS succession plan and process • Succession plan for executive management and professional staff leadership	Executive Executive Executive								√ √ √
	Professional Staff									
f-i-A f-i-B/C	➢ Ensure the effectiveness and fairness of the credentialing process ➢ Monitor indicators of clinical outcomes, quality of service, patient safety and achievement of desired outcomes	MAC/Quality MAC	C	C	C	C	C	√	√	√
f-i-C	➢ Make the final appointment, reappointment and privilege decisions for Medical/Professional Staff ➢ Oversee the Medical/Professional Staff through and with the MAC and COS	Board COS	C C	C C	C C	C C	C C	√ √	√ √	√ √
	Build Relationships									

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Agenda Item 1.5.5

BOARD WORK PLAN – 2023-24

Charter Section #4	Action *(Italics-comments)*	Committee Responsible	Oct	Nov	Dec	Feb	Mar	May	Jun	Jun
g	➢ Build and maintain good relationships with the Corporation's key stakeholders ➢ The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, community leaders, patients, employees, families, other health service providers and other key stakeholders, donors and the Cambridge Memorial Hospital Foundation (" Foundation") and the Cambridge Memorial Hospital Volunteers Association. ➢ Invite Annual Volunteer Association Presentation	Board			D				√	
	Financial Viability									
h-i-A,C	➢ Review and approve multi-year capital strategy	Resources			C					
h-i-A,C h-i-A, B	➢ Review and approve annual operating plan – service changes, operating plan, capital plan, salary increases, material amendments to benefit plans, programs and policies	Resources/ Quality				I	C			
h-i-A	➢ Approve the year-end financial statements	Board							√	
i-i-C	➢ Approve key financial objectives that support the corporation's financial needs (including capital allocations and expenditures) (*assumptions for following year budget)* ➢ Review of management programs to oversee compliance with financial principles and policies	Resources Resources				I	C		√	
	➢ Affirm signing officers for upcoming year	Board								√
	➢ Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding	Resources				C			√	
	Board Effectiveness									

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Agenda Item 1.5.5

BOARD WORK PLAN – 2023-24

Charter Section #4	Action *(Italics-comments)*	Committee Responsible	Oct	Nov	Dec	Feb	Mar	May	Jun	Jun
i	➢ Establish Board Work Plan	Board	C							
i-i-A	➢ Ensure Board Members adhere to corporate governance principles and guidelines ➢ Declaration of conflict agreement signed by Directors ➢ Director Consent to Act	Governance								√ √
i-i-B	➢ Ensure the Board's own effectiveness and efficiency, including monitoring the effectiveness of individual Directors and Board officers and employing a process for Board renewal that embraces evaluation and continuous improvement	Governance/ Board								√
i-i-C	➢ Ensure compliance with audit and accounting principles	Audit							√	
i-i-D	➢ Periodically review and revise governance policies, processes and structures as appropriate	Governance	C		C	C	C	√	√	
	➢ Review Progress on ABCDE Goals *(Director & Chair meet during July/August to establish goals for upcoming Board cycle)*	Board			C			√		√
	Fundraising									
k	➢ Support fundraising initiatives including donor cultivation activities. *(through Foundation Report and Upcoming Events)*	Foundation	C	C	C	C	C	√	√	√
	***Public Hospitals Act* required programs**									
l-i-A	➢ Ensure that an occupational health and safety program and a health surveillance program are established and require accountability on a regular basis - TBD	Audit								
l-i-B	➢ Ensure that policies are in place to encourage and facilitate organ procurement and donation	Quality								√

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Agenda Item 1.5.5

BOARD WORK PLAN – 2023-24

Charter Section #4	Action *(Italics-comments)*	Committee Responsible	**Oct**	**Nov**	**Dec**	**Feb**	**Mar**	**May**	**Jun**	**Jun**
l-i-C	➢ Ensure that the Chief Executive Officer, Nursing Management, Medical/Professional staff, and employees of the Hospital develop plans to deal with emergency situations and the failure to provide services in the Hospital	Quality			C					
	Recruitment									
n	➢ Approve interview team membership (noted in By-law)	Governance			C					
	➢ Review recommendations for new Directors, non-director committee members (2-D-20)	Governance							√	
	➢ Conduct the election of officers (2-D-18)	Governance								√
	➢ Review evaluation results and improvement plans for the Board, the Board Chair (by the Governance Chair), Board committees, committee chairs (2-D-40) ➢ Review committee reports on work plan achievements (2-A-16)	Governance Governance							√	√

BOARD WORK PLAN – 2023-24

ON GOING AS NEEDED

Charter Section #4	Charter Item	Action *(Italics-comments)*	Committee Responsible	Current Year 2023-24
i-i-E	Board Effectiveness	Compliance with the By-Law	Governance	
c-i-A, B	Corporate Performance	Ensure there are systems in place to identify, monitor, mitigate, decrease and respond to the principal risks to the Corporation: o financial o quality o patient/workplace safety	Audit, Resources Quality	
c-i-C	Corporate Performance	Oversee implementation of internal control and management information systems to oversee the achievement of the performance metrics	Resources	
c-i-D	Corporate Performance	Processes in place to monitor and continuously improve upon the performance metrics	Resources/ Quality	
c-i-G	Corporate Performance	Policies providing direction for the CEO and COS in the management of the day-to-day processes within the hospital	Governance/ Executive	
d-ii-A,B	CEO and COS	Select the CEO, delegate responsibility and authority, and require accountability to the Board	Executive	
d-ii-C	CEO and COS	Policy and process for the performance evaluation and compensation of the CEO	Governance/ Executive	
d-ii-D, E	CEO and COS	Select the COS, delegate responsibility and authority, and require accountability to the Board	Executive	
d-ii-F	CEO and COS	Policy and process for the performance evaluation and compensation of the COS	Governance/ Executive	
h	Financial Viability	Approve collective bargaining agreements	Board	
h	Financial Viability	Approve capital projects	Resources	

ON GOING AS NEEDED – Led by CEO/COS – reported in CEO report/Quality Presentations

Charter Section #4	Charter Item	Action *(Italics-comments)*	Committee Responsible
j-i-A	Communication and Community Relationships	Establish processes for community engagement to receive public input on material issues	Board oversight Led by CEO
j-i-B	Communication and Community Relationships	Promote effective collaboration and engagement between the Corporation and its community, particularly as it relates to organizational planning, mission and vision	Board oversight Led by CEO/COS and Chair
j-i-C	Communication and Community Relationships	Work collaboratively with other community agencies and institutions in meeting the healthcare needs of the community	Board oversight Led by CEO/COS Quality
j-i-D	Communication and Community Relationships	Maintain information on the website	Board oversight Led by CEO
j-i-E	Communication and Community Relationships	Establish a communication policy for the Corporation; review periodically (2-D-11 – reviewed April 2022, next review 2025)	Board oversight Led by CEO
m	Communications Policy	Oversee the maintenance of effective stakeholder relations through the Corporation's communications policy and programs (updated communication plan (2023-2027) to be approved by Board in 2023)	Board oversight Led by CEO

DELAYED

Charter Section #4	Charter Item	Rationale
g	Invite Annual Volunteer Association Presentation	Originally planned for December, due to timing issues and Board meeting content has been re-scheduled for the June Board of Directors meeting

Agenda

Meeting Date	Agenda # / Item Description	Action Item	Owner	Status
25-01-2023	3.1.1 – Committee and Staff appointments	Governance to complete a policy review/update as it relates to staff & Community appointments, specifically when they occur outside of the regular appointment process	P. Gaskin	Will be brought to Governance at a future meeting
01-03-2023	3.9 – Foundation Events	Management to review and include the recommendation in the Board Policies	P. Gaskin	Will be brought to Governance at a future meeting
26-04-2023	4.10 – CND OHT Mental Health & Addictions Clinic	Management to review the data points that will be reviewed through the CND OHT evaluation process	P. Gaskin	In progress
06-12-2023	1.5.3 Policy Approvals	2-A-15 & 2-C-40 to be brought back to the Board for review and revision if, upon completion of the Capital Redevelopment Project Sub-Committee is disbanded as of June 2024	P. Gaskin	Will be brought to the Board if needed for review June 2024
06-12-2023	1.5 Consent Agenda	ABCDE Goals to track by % complete	P. Gaskin	Management will look to update the process / tracking systems
06-03-24	2.1 QIP Discussion	CMH to investigate the ability for Directors to take part in the Rainbow Health course	P. Gaskin	
06-03-24	2.3 Financials	CMH to discuss Trauma Informed Principles presentation at CMH with M. McKinnon	P. Gaskin	In the process of setting up a meeting for further discussion with teams.

BRIEFING NOTE

Date: April 10, 2024
Issue: Quality Monitoring Metrics
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kyle Leslie, Director Operational Excellence
Liane Barefoot, Director Patient Experience, Quality, Risk, Privacy & IPAC
Approved by: Mari Iromoto, Senior Director of Strategy, Performance & CIO

Attachments/Related Documents: Appendix A – Quality Monitoring Scorecard

Alignment with 2024/25 CMH Priorities:

2022-2027 Strategic Plan No ☐	2024/25 CMH Priorities No ☐	2024/25 Integrated Risk Management Priorities No ☐
☒ Elevate Partnerships in Care	☒ Improve Patient Flow (PIA, Time to Bed, ALC)	☒ Access to Care
☒ Advance Health Equity	☐ Embrace Diversity, Build a Culture of Inclusion	☐ Business Continuity
☒ Increase Joy In Work	☒ Increase Staff Engagement Through Improved Staffing	☒ Workforce Planning
☒ Reimagine Community Health	☒ Prepare for Digital Health Transformation	☒ Change Management
☒ Sustain Financial Health	☐ Earn the Maximum Eligible PCOP Funding	☐ Revenue & Funding

Executive Summary
Included in **Appendix A** is the CMH 2023/2024 Quality Monitoring Scorecard.

Currently there are fourteen of our thirty-one quality monitoring indicators at a "**red**" status meaning that the indicator is meeting less than 90% of the performance threshold. Fifteen of the indicators are currently at a "**green**" status meaning that they are meeting the performance threshold for the indicator.

There are 11 indicators of the thirty-one that have had three periods of "**red**" performance in a row that we are monitoring to determine if an action plan for improvement is needed. These indicators, including Board oversight committee are:

1) Conservable Bed Days (Quality Committee)
2) Overtime hours (Resources Committee)
3) Sick hours (Resources Committee)
4) ALC Throughput Ratio (Quality Committee)
5) Percentage ALC Days (Closed / discharged cases) (Quality Committee)
6) Emergency Department Length of Stay Admitted Patients (Quality Committee)
7) Emergency Department Length of Stay for Complex Patients (Quality Committee)
8) Emergency Department time to Inpatient Bed (Quality Committee)
9) Emergency Department Wait time for Initial Assessment (PIA) (Quality Committee)
10) Surgical Long Waiters (Quality Committee)
11) Medication Errors (Quality Committee)

Background
The CMH Quality Monitoring Scorecard tracks performance on key performance indicators aligned to our quality framework. Many of the indicators on the Quality Monitoring Scorecard are reported publically on an annual basis by the Canadian Institute for Health Information (CIHI). The scorecard monitors the indicators on a monthly basis and is used to identify indicators that are trending outside of established performance thresholds.

The Scorecard indicators are regularly review at many internal forums for action planning and awareness. On a weekly basis Staffing and Flow metrics are reviewed at our leadership huddles.

The metrics on our Quality Scorecard are also reported on the Departmental Scorecards to monitor departmental performance and it is an expectation that departments review and develop any necessary departmental action plans to address performance on a monthly basis at the Department Quality and Operations Councils.

Analysis
Seven (7) of the eleven (11) indicators that are currently trending in red for three or more periods relate to overall flow/throughput and are collectively being addressed by focused work in the Emergency Department and inpatient discharge planning efforts. Flow/throughput has been elevated as an organizational Integrated Risk Management (IRM) priority as well as highlighted internally and publically as an area of focus via our Quality Improvement Plan (QIP). It is a standing agenda item weekly at Senior Executive, weekly at Operations meeting, weekly meeting with ED and Medicine leadership to review details of outlier cases and Quality and Operations Councils.

Two (2) of the eleven (11) indicators, namely Sick and Overtime, have Board oversight by Resources Committee who regularly tracks performance and mitigation strategies. Similar to flow/throughput, overtime in the targeted areas of Emergency department, ICU and Medicine has been elevated to an organizational Integrated Risk Management (IRM) priority.

Additional analysis of the past six (6) years of medication errors was undertaken this month and details are provided below.

Addressing Surgical Long Waiters has been built into the PCOP action plan that sits under the Financial Health strategic pillar. These are addressed at Surgical Council, weekly Operations meetings, and using a newly developed real time dashboard that has a view over the upcoming 6 weeks to proactively fill OR blocks to both maximize throughput and address wait lists.

A full Board Scorecard package is provided to all Board Committees and the Board quarterly that includes performance in addition to details of the plans and mitigation strategies.

Below is a summary of the quality monitoring metrics that are currently at a "red" status with three or more periods outside of the target threshold.

1) **Conservable Bed Days (Red status with three or more periods outside of performance threshold):**
   This indicator measures the total patient days over the benchmark length of stay as a rate of total acute inpatient days. A lower rate means a more appropriate length of stay. For this indicator we are currently thirteen percent over target. Our conservable bed day rate has trended up in Q3 and came down slightly in January of Q4 and increased significantly in February of Q4.

2) **Overtime Hours (Red status with three or more periods outside of performance threshold):**
This indicator measures the total number of overtime hours used vs. budgeted overtime hours. Currently we are significantly over budget for overtime hours used. Majority of the overtime variance approximately >60% can be attributed to the Emergency Department, Medicine programs and Intensive Care Unit. A lower number on this indicator means that we are staffing less with OT which has a positive impact to Joy in Work as it is an indication that we have improved staffing levels, leading to reduced staff burnout.

3) **Sick Hours (Red status with three or more periods outside of performance threshold):**
This indicator monitors the average sick hours per pay period per month. A lower number is better as that means there are less staff off and unable to work due to illness. Throughout the month of March, we had roughly a 23% reduction in sick-time compared to the previous month.

4) **ED Length of Stay for Admitted Patients (90% spent less, in hours) (Red status with three or more periods outside of performance threshold):**
This indicator measures the length of time from Triage to when a patient departs the emergency department to go to an available inpatient bed. Our 90th percentile length of stay for admitted patient in the ED is 58.8 hours (YTD Feb-2024), our target is < 44 hours. A lower number is better as it means patients are receiving care in the most appropriate setting. This indicator has continued to trend up over the course of this fiscal year with Jan and Feb 2024 exceeding 60 hours.

5) **ED Length of Stay Complex (CTAS 1-3) (90% spent less, in hours) (Red status with three or more periods outside of performance threshold):**
This indicator measures the wait-time from triage to disposition from the ED. Currently, 90% of complex ED patients have a length of stay 9.8 hours (YTD Feb-2024), our target is 8 hours. A lower number is better as it means patients are receiving care in a timely, effective efficient way.

6) **ED Wait time for Inpatient Bed (90% spent less, in hours) (Red status with three or more periods outside of performance threshold):**
This indicator measures the length of time in hours from when a patient is admitted in the emergency department to when they are pulled to the inpatient bed. Our YTD (Feb-2024) wait time for this indicator is 48.9 hours, our target is 36 hours or less.

7) **ED Wait Time for Physician Initial Assessment (90% spent less, in hours) (Red status with three or more periods outside of performance threshold):**
This indicator measures the wait-time from triage to being seen by a physician or nurse practitioner in the ED. Currently, 90% of ED patients were seen by a physician or nurse practitioner within 6.9 hours (YTD Feb-24), while our internal target is to see 90% of patients within 4 hours. A lower number is better as it means that patients are seen by a physician or nurse practitioner within an appropriate timeframe in the emergency department.

8) **Medication Error Rate (Red status with three or more periods outside of performance threshold):**
This indicator measures the number of medication errors as a rate per 1000 inpatient days. Our target is 4.0/1000 patient days. This indicator uses our incident reporting data and can be influenced by the reporting culture. Generally speaking, a lower number is

better as this means fewer medication errors are occurring. The caveat to this is that low level reporting (levels 1 → 4) means that errors are being caught and reported by front line staff as 'near misses' or 'no/low levels' of harm. Currently our medication error rate is 6.7 (YTD Mar). 60% of incidents are no harm incidents; 21% mild harm; 16% near miss; 1% moderate harm; <1% severe harm. This indicator is reported monthly at Quality and Operations Council Meetings, at Nursing Advisory Council and at Safe Medication Practice Committee.

Historical analysis for the past six (6) years of medication errors shows we have fluctuated between 6.4 and 9.6 per 1000 inpatient days. While the most recent fiscal year was higher than the one prior (6.7 vs. 5.9/1000 patient days), we are in a downward trend since the start of the pandemic when the rate peaked at 9.6/1000 patient days. Despite fluctuations in the total number of medication incidents reported by front line staff, the distribution in severity has remained stable over the six (6) years analyzed with >99% being closed at levels 1 → 4. Low level (near miss/no harm/low harm) incident reporting is a positive indicator of a strong/improving reporting culture and staff are encouraged to actively look for, and report.

We continue to encourage staff to report all incidents including medication errors and falls through many avenues including: overtly promoting incident reporting to front line staff, med error reports now electronically being sent to the unit Pharmacist for input/review at the time of staff submission, Patient Safety Lead meeting regularly with leaders to review outstanding files, staff receiving electronic confirmations when a leader is working on their submitted incident file, and, corporate publications socializing and normalizing terms such as Just Culture. Collectively these are intended to improve (increase) the amount of reporting and use these to build strong processes to prevent 'with harm' (level 5 and 6) incidents.

9) **Surgical Long Waiters (Red status with three or more periods outside of performance threshold):**
This indicator monitors the percentage of cases on our current surgical wait-list over the targeted wait time for the procedure vs. the total cases on our wait-list. The lower the rate indicates a more appropriate wait-time for surgery. The work that is currently underway for surgical PCOP and QBPs is addressing the surgical wait-list. Work is also underway to review the surgical wait-list and clean and update to most accurately reflect true cases waiting.

10) **ALC Throughput Ratio and Percent ALC days (Red status with three or more periods outside of performance threshold):**
Both of these indicator monitor the level of ALC activity in the hospital. The percentage of ALC closed cases is measuring the number of days' patients are in hospital with an ALC designate vs. Number of days in hospital for acute care, the lower the percentage means better access to post-acute care. The ALC throughput ratio measures the new ALC cases vs discharged ALC cases and is used to monitor turnover and flow of ALC cases. A throughput ratio of one means that for every new ALC one current ALC case is discharged.

Next steps:

- The full Strategic and Operational Priority Indicator Package including action plans will be shared on a Quarterly Basis.
- The Quality Monitoring Scorecard will continue to be included on a monthly basis

CMH Quality Monitoring Scorecard, FY2023/24

Quality Dimension	Indicator	Unit of Measure	Prior Year	YTD	Target	Trend	Status	Period
Efficient	Conservable Days Rate	%	33.8	35.1	30.0		◆	Feb-24
	Overtime Hours - Average per pay period	hours	3,369.7	3,621.7	850.0		◆	Mar-24
	Sick Hours - Average per pay period	hours	3,774.2	3,133.8	2,090.0		◆	Mar-24
Integrated & Equitable	ALC Throughput	Ratio	0.9	0.8	1.0		◆	Mar-24
	Percent ALC Days (closed cases)	%	28.0	25.6	20.0		◆	Feb-24
	Repeat emergency department visits for Mental Health Care (Average patients per month with four or more visits in 365 days)	Patients	12.2	10.5	11.0		●	Feb-24
Patient & People Focused	Organization Wide Vacancy Rate	%	10.4	7.6	12.0		●	Mar-24
Safe, Effective & Accessible	30 Day CHF Readmission Rate	%	15.3	18.7	14.0		◆	Jan-24
	30 Day COPD Readmission Rate	%	13.0	13.3	15.5		●	Jan-24
	30 Day In-Hospital Mortality Following Major Surgery	%	2.2	1.9	2.1		●	Jan-24
	30 Day Medical Readmission Rate	%	10.8	9.4	13.6		●	Jan-24
	30 Day Obstetric Readmission Rate	%	1.2	1.1	1.1		●	Jan-24
	30 Day Overall Readmission Rate	%	7.5	6.7	9.1		●	Jan-24
	30 Day Paediatric Readmission Rate	%	8.4	6.4	6.1		▲	Jan-24
	30 Day Surgical Readmission Rate	%	5.3	5.5	6.9		●	Jan-24
	ED Length of Stay for Admitted Patients (90% Spent Less, in Hours)	hours	49.1	58.8	44.0		◆	Feb-24
	ED Length of Stay for Non-Admitted Complex Patients (90% Spent Less, in Hours)	hours	9.1	9.8	8.0		◆	Feb-24
	ED Wait Time for Inpatient Bed (90% Spent Less, in Hours)	hours	40.5	48.9	36.0		◆	Feb-24
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours)	hours	6.3	6.9	4.0		◆	Feb-24
	Fall Rate	per 1000 PD	5.4	4.9	4.0		◆	Mar-24
	Hip Fracture Surgery Within 48 Hours	%	89.7	89.9	86.2		●	Jan-24
	Hospital Standardized Mortality Ratio (HSMR)	Ratio	94.0	98.0	100.0		●	Jan-24
	In-Hospital Sepsis	per 1000 D/C	5.6	3.0	3.9		●	Jan-24
	Long Waiters Waiting For All Surgical Procedures	%	48.4	29.3	20.0		◆	Feb-24
	Low-Risk Caesarean Sections	%	14.9	14.0	17.3		●	Feb-24
	Medication Error Rate	per 1000 PD	5.9	6.7	4.0		◆	Mar-24
	Medication Reconciliation at Admit	%	93.0	94.0	95.0		▲	Mar-24
	Medication Reconciliation at Discharge	%	95.0	95.0	95.0		●	Mar-24
	Obstetric Trauma (With Instrument)	%	15.3	9.8	14.6		●	Jan-24
	Revenue - Achieve budgeted PCOP growth for 2023/2024 (IRM)	$	8,411,329.0	$11,190,679	$12,693,835		◆	Feb-24
	Revenue - Achieve Quality Based Procedure Funding (IRM)	$	22,210,690.2	$24,156,101	$20,609,545		●	Feb-24

YTD Meeting Target ●
YTD Within Target Threshold (within 10% of Target) ▲
YTD Exceeding Target Threshold ◆

Board/Committee Meetings and Event Dates	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep (2024)
Board of Directors Regular Meetings													
5:00pm - 8:00pm		4		6		7			1	26			
Board Generative Discussion Meetings													
Emergency Department			1										
Digital Health							6						
TBD										5			
Meeting with City Council and CMH Board of Directors - TBD											TBD		
Joint CMH/CMHF/CMHVA Board Meeting - TBD													
Quality Committee 7:00 am – 9:00am	20	18	15		17	21		17	15	19			
Quality Committee QIP Meeting 7:00 am – 9:00 am						7							
Resources Committee 7:00pm – 9:00pm	26		27			26		22	27	24			
Capital Projects Sub - Committee 5:00pm – 6:30pm	26		27			26				24			
Digital Health Strategy Sub - Committee 5:00pm – 6:30pm	21		16		18	15		18	16	20			
Governance Committee 5:00pm - 7:00pm	19		7			21	14		9				
Audit Committee 5:00pm - 6:30pm			13		22			22	27				
Executive Committee 5:00pm - 6:30pm	28		14				11		14				
CMHVA Board Meetings 9:30am - 11:15am - In Person / Hybrid	27	25	29		31	28	27	24	29	26			
CMHF Board Meetings 4:30pm - 6:30 - In Person / Hybrid	25	23	27	11	22	26	25	22	27	24			
OHT Joint Board Committee 5:30pm - 7:30pm - Virtual Zoom meeting	25	23	27	11	22	26	25	22	27	24			

Board/Committee Meetings and Event Dates	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep (2024)
2023-24 Events													
Staff Holiday Lunch - December 7, 2023 11am-2pm / 6-8pm				15									
Career Achievement - April 22, 2024 2:30								22					
Chamber Business Awards - November 13, 2023			13										
CMHF Diversity Dinner – October 3, 2023		3											
CMH Staff BBQ - TBD													
CMH Golf Classic - June 6, 2024, Galt Country Club										6			
CMH Reveal - February 29, 2024						29							
Board Social - May 30, 2024 5pm-7pm - Location TBD									30				
Board Education Opportunities													
Governors Education Sessions													
Governance Essentials for New Directors - *Paulo Brasil/Jay Tulsani/Bill Conway*													
Hospital Legal Accountability Framework		3											
Hospital Accountability Within the Health System		10											
Governance and Management - The Crucial Partnership		24											
CMH Leadership Learning Lab													
● *Project Management for the Unofficial PM*									3				
● *Crucial Conversations*			15/16						14/15				
● *7 Habits of Highly Effective People - Nicola Melchers*				5/8									
● *Me2You DISC Profile - Diane Wilkinson*							12						
● *Quality Improvement*		6											
● *Guiding Organizational Change - Lynn Woeller*		11											
● *5 Choices*													
● *Unconscious Bias*								6					
Mental Health First Aid													

Patrick Gaskin
President and CEO
Phone: (519) 621-2333, Ext. 2301
Fax: (519) 740-4953
Email: pgaskin@cmh.org

MEMORANDUM

TO: Board of Directors, Cambridge Memorial Hospital

DATE: April 17, 2024

REPORTING PERIOD: January 1, 2024 – March 31, 2024

FROM: Patrick Gaskin
President and CEO

RE: CEO Certificate of Compliance

I have reviewed, or caused to be reviewed, such files, books of account and records of CMH and have made, or caused to be made, such enquiries of the financial, accounting and other personnel of CMH as I have determined necessary for the purpose of this certificate.

In my capacity of President and CEO, and for the reporting period identified above, I hereby attest that to the best of my knowledge, except as set out below:

a) Salaries, Wages and Benefits – CMH has met all of its obligations in respect of the payment of all employee salaries and wages, vacation pay, holiday pay, termination pay, severance pay and benefits.
b) Statutory Deductions – CMH has met all of its obligations in respect of the deduction, withholding and/or remittance of funds under the Income Tax Act (Canada), the Income Tax Act (Ontario), the Employer Health Tax Act (Ontario) (EHT), the Excise Tax Act (Canada) (HST), Workplace Safety and Insurance Act (Ontario) (WSIB), the Employment Insurance Act (Canada) (EI), the Canada Pension Plan Act (Canada) (CPP), and if applicable, remittances for required deductions for payments to non-residents.
c) Financial Statements – the CMH financial statements, as at the date of their preparation were accurate and complete in all material respects.

Exceptions: NIL

Patrick Gaskin
President and CEO

Agenda Item
2.2

Introducing CMH AI Resume Screening Platform

Kyle Leslie, Director of Operational Excellence.
Waqas Muhammad, Data Science Specialist.

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Resume Screening Platform Overview

The CMH Resume Screening Platform represents a significant advancement in recruitment technology, utilizing a blend of Artificial Intelligence (AI) techniques to enhance the efficiency and effectiveness of the hiring process. This platform incorporates advanced natural language processing (NLP), machine learning (ML), and computer vision technologies, each tailored to address specific aspects of resume screening in a comprehensive and sophisticated manner.

The platform was designed and programed by CMH's Data Science Specialist and Decision Support Team in collaboration with the CMH Human Resources and Recruitment Team.

Avg. applicants last nine posted jobs

308

Highest number applicants for a position (based on last 9 posted jobs)

613

Approx. Hours Required for Initial Resume Review (last nine posted jobs)

52

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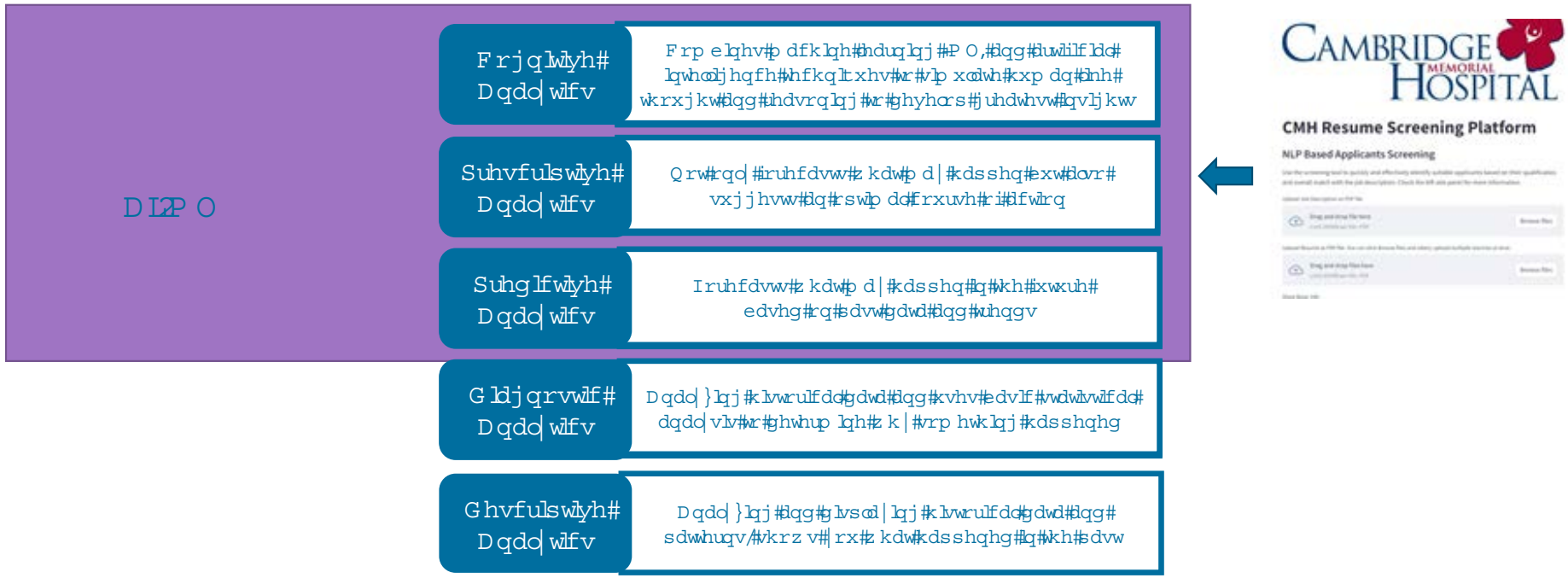
Alignment

Operational Excellence Corporate Plan: The CMH Operational Excellence Corporate Plan serves as a road map to enabling exceptional patient care and operational efficiency through innovation and data driven decision making. The plan guide our effort to advancing our analytic maturity and is aligned to our Reimagine Community Health Strategic Pillar which demonstrates how we will use innovation and embrace transformation to improve the way we deliver care.

Analytic Maturity Model



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AI explained in Resume Screening Platform

Artificial Intelligence (AI): Is the overarching field of Computer Science aimed at creating machines that are capable of intelligent behavior that simulates human-like cognitive functions. Below is an overview of the sub fields of AI.

	Overview	Application Within the Platform
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Enhancing Fairness in Hiring with AI Technology

- **AI-Driven Analysis**
  - Utilizes NLP and ML to deeply parse and understand the content of resumes.
  - Analyzes textual and semantic relationships without the influence of human subjective judgment.

- **Comprehensive Candidate Assessments**
  - Automatically generates detailed evaluations covering education, skills, and work experience.
  - Ensures each candidate is assessed based on merit and alignment with job-specific requirements without subjective bias.

- **Reduction of Human Bias**
  - Minimizes the impact of unconscious bias by focusing on quantifiable metrics and objective data.
  - Provides uniform analysis across all applications to maintain consistent evaluation standards.

- **Advanced Data Analysis**
  - Performs detailed analyses of both textual and visual-scanned data, enhancing the accuracy and equity of screenings.
  - Enables comprehensive evaluation capabilities, crucial for processing diverse document formats.

- **Supporting EDI Principles**
  - Supports Equity, Diversity, and Inclusion by ensuring a diverse pool of candidates is fairly evaluated.
  - Aligns with hospital's core values by promoting an equitable recruitment environment.

- **Streamlined Recruitment Process**
  - Decreases the time and effort needed for manual resume screening, making the hiring process more efficient.
  - Speeds up the recruitment cycle while ensuring accuracy and fairness in candidate selection.

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Platform Demo

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Appendix – Evaluation and Scoring Explained

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Resume Screening Platform – Scoring Evaluations Explained

- The platform uses a mix of natural language processing (NLP), machine learning (ML) and conventional similarity match algorithms to quickly and effectively identify suitable candidates based on their qualifications and overall match with the uploaded job description.
- The platform scores each individual resume using six different evaluation methods. A score of between 0 to 100 is assigned for each method.
- Each score offers a different perspective on the suitability of a candidate, ranging from simple keyword matching to complex semantic analysis and skill alignment. High scores in all areas typically suggest a candidate closely matches the job requirements, while low scores in specific areas highlight potential gaps or misalignments.

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Overview Scoring Evaluations Performed by The Platform (Score 1-3)

Score 1 - Raw Term Frequency: A high Score1 indicates many terms from the job description are present in the resume. It measures direct word overlap without considering the rarity or importance of those words.

Score 2 - Term Frequency & Uniqueness: Balances raw term frequency with the distinctiveness of the terms. High scores show both relevance and uniqueness in terms of terminology; low scores may indicate either a lack of matching terms with job description or a lack of unique terms.

Score 3 - Uniqueness w.r.t Applicants Pool: Identifies terms that are unique in the applicant's resume compared to the entire pool, reflecting a candidate's unique skills or experiences. This score highlights candidates with qualifications or skills that stand out from the rest of the applicant pool in relation to the job requirements.

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Overview Scoring Evaluations Performed by The Platform (Score 4-6)

Score 4 - Based Similarity: Measures how effectively the resume aligns with key terms in the job description, factoring in the frequency and uniqueness of these terms as well as the overall length of the resume. A longer resume won't automatically get a higher score just because it has more content while a shorter resume won't be at a disadvantage if it has relevant terms concentrated within a smaller amount of content.

Score 5 - Semantic & Contextual Match: Particularly valuable for identifying candidates whose qualifications are contextually relevant to the job, even if they don't use the exact keywords or phrases found in the job description. It can capture relevance that might not be explicitly stated through specific keywords, thus identifying potentially suitable candidates who may otherwise be overlooked with traditional keyword-based screening.

Score 6 – Skills Match (Optional): Directly measures how many of the desired skills listed by the employer are present in the resume.

Overall Score (Optional): High Overall Score suggest a strong match across various criteria; low Overall Score may indicate weaknesses in several areas or a lack of overall alignment.

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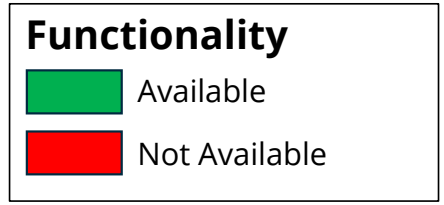
Score Summary



	Functionality						
	Term Match	Term Uniqueness	Term Uniqueness (Applicant's Pool)	Account for Resume Length	Contextual & Semantic Match	Skill Match	Overall Match
Score 1							
Score 2							
Score 3							
Score 4							
Score 5							
Score 6							
Overall Score							

- Case 1: An applicant might score high on Score 1-4 and low on Score5, highlighting less thematic match with job description (Not ideal)
- Case 2: An applicant might score low on Score 1-4 but high on Score5, highlighting lack of keywords matching (Not ideal)
- Case 3: High on all scores, suggests a close match with the job requirements

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Thank you

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