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

December 6, 2023

1700-1850

Virtual via Teams / C.1.229 Room Name

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	B. Conway	
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 November 1, 2023*	3			
1.5.2 Board Attendance Report*	6			
1.5.3 Governance Policy Summary* Policies for Approval: (track changes version found in Package 2)	7			
1.5.4 CEO Certification of Compliance*	22			
1.5.5 ABCDE Goals for Board of Directors 2023/24 Update*	23			
1.5.6 Corporate Strategic and Operational Priorities Q2 Update*	24			
1.5.7 CMH President & CEO Report*	52			
1.5.8 Board Work Plan*	57			
1.5.9 2023/24 Board of Directors Action Log*	65			
1.5.10 2023/24 Events Calendar*	66			
1.6 Confirmation of Agenda		1714	N. Melchers	Motion
2. PRESENTATIONS				
2.1 IRM Mid-Year Executive Sponsor Update*	68	1715	L. Barefoot	Information
2.2 Accessibility Plan Update*	76	1725	D. Boughton	Information
3. BUSINESS ARISING				
3.1 Impact of WSIB Increases (Action Log)		1735	P. Gaskin	Information

1-A-05	Board Statement of Culture
2-D-02	Board Policy Development, Review and Approval
2-D-30	Board and Board Committee Orientation
2-A-15	Capital Projects Sub-Committee Terms of Reference
2-C-40	Capital Projects – Change Order Approval Policy

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. NEW BUSINESS				
4.1 Chairs Update		1737		
4.1.1 Board Report*	82		N. Melchers	Information
4.1.2 October/November 2023 Board Evaluation Results*	85		N. Melchers	Discussion
4.1.3 OHA Governance Essentials Course Reflections			B. Conway / J. Tulsani / P. Brasil	Information
4.1.4 Guiding Organizational Change Reflections			L. Woeller	Information
4.2 Governance Committee		1745		
4.2.1 Report to the Board of Directors* (November 7, 2023)	91		M. Lauzon	Information
4.2.2 Dissent of Director Process*	94		M. Lauzon	Motion
4.2.3 Recommendations for 2024 Interview Team*	96		M. Lauzon	Motion
4.2.4 Board Education*	97		M. Lauzon	Discussion
4.3 Quality Committee		1755		
4.3.1 Report to the Board of Directors* (November 15, 2023)	98		D. Wilkinson	Information
4.4 Audit Committee		1800		
4.4.1 Report to the Board of Directors – (November 20, 2023)	100		M. Hempel	Information
4.5 Capital Projects Subcommittee		1810		
4.5.1 Report to the Board of Directors* (November 27, 2023)	102		T. Dean	Information
4.6 Resources Committee		1815		
4.6.1 Report to the Board of Directors* (November 27, 2023)	104		L. Woeller	Information
4.6.2 October 2023 Financial Statements*	106		L. Woeller	Motion
4.7 Executive Committee				
4.7.1 No Open Matters				
4.8 Medical Advisory Committee		1825		
4.8.1 MAC Credentials & Privileging October 2023*	115		Dr. W. Lee	Motion
4.8.2 Report to the Board of Directors* (November 8, 2023)	120		Dr. W. Lee	Information
4.9 PFAC Update		1830	N. Melchers	Information
4.10 CEO Update		1840		
4.10.1 Accreditation Update*	123		M. Iromoto	Information
4.10.2 Staff Innovation Fund*			M. Iromoto	Information
5. UPCOMING EVENTS				
5.1 CMH Holiday Meal: December 7, 2023 @ CMH (11am – 2pm / 6pm – 8pm)				
5.2 CMH Reveal – Save the Date February 29, 2024				
6. DATE OF NEXT MEETING	Wednesday February 7, 2024 Location: Hybrid			
7. ADJOURNMENT		1850	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, November 1, 2023
OPEN SESSION

Minutes of the open session of the Board of Directors meeting, held virtually at Cambridge Memorial Hospital on November 1, 2023

Present:

N. Melchers, Chair	B. Conway
T. Dean	P. Brasil
M. Hempel	J. Tulsani
D. Wilkinson	S. Pearsall
S. Alvarado	W. Lee
J. Goyal	P. Gaskin
M. Lauzon	M. Hempel
I. Morgan	V. Miropolsky

Regrets: L. Woeller, M. McKinnon

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

Guests: S. Abdool
Recorder: S. Fitzgerald

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1. CALL TO ORDER
The Chair called the meeting to order at 1708 hours.

1.1. **Confirmation of Quorum (7)**
Quorum requirements having been met, the meeting proceeded, as per the agenda.

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

1.3. **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 October 4, 2023
1.5.2 Board Attendance Report
1.5.3 Events Calendar
1.5.4 Quality Metrics Scorecard
1.5.5 Quality Committee Report to the Board of Directors
1.5.6 MAC Report to the Board of Directors
1.5.7 CEO Report
1.5.8 Board Work Plan
1.5.9 Action Log
CARRIED (Alvarado/Wilkinson)

1.4. **Confirmation of Agenda**

MOTION: (Dean/Wilkinson) **that** the agenda be approved as amended. **CARRIED**

2. New Business

2.1. **September 2023 Privileging and Credentialing**

MOTION: Whereas due diligence was exercised in reviewing the following privileging applications from the September 2023 Credentials Committee and upon the recommendation of the MAC, that the Board approve the following privileging applications (Hempel/Lauzon) **CARRIED.**

3. Upcoming Events

The Chair highlighted the upcoming events and encouraged the Board members to participate if available.

4. Presentations - Ethics

S. Pearsall welcomed and introduced S. Abdool to the meeting. S. Abdool joins CMH on the Ethics Committee, rounding huddles, complex discharges and much more. His knowledge and contributions are valued by CMH.

Mr. Abdool provided a presentation on principle based ethical decision making to support CMH's upcoming accreditation. S. Abdool highlighted the leadership standards and ethics, organization ethics, common examples of ethical dilemmas, steps for resolving ethical dilemmas (YODA), and the ethical framework. A robust discussion took place and questions were entertained.

N. Melchers thanked S. Abdool for the presentation and continued support of CMH.

S. Abdool left the meeting.
D. Didimos,, K. Leslie, Dr. M. Runnalls joined the meeting

5. Education/Generative Discussion – Emergency Departments in the Current Healthcare System

S. Pearsall introduced and welcomed Dr. M. Runnalls – Chief of Emergency Medicine, D. Didimos – Director of Emergency and Mental Health Programs, K. Leslie – Director of Operational Excellence. The Board shared reflections on the pre-circulated articles sent in advance of the generative discussion. A presentation was received on the Emergency Department at CMH and what we are working towards to address the issues facing the healthcare system and our experiences at CMH.

A robust discussion took place and questions were entertained.

N. Melchers and the Board thanked the group for an informative presentation and discussion.

D. Didimos,, K. Leslie, Dr. M. Runnalls left the meeting

6. ADJOURNENT

The meeting adjourned at 18:47h. (Dean)

7. DATE OF NEXT MEETING

The next scheduled meeting is December 6, 2023.

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

Agenda

Date of Meeting

Last | 12 | Months

11/29/2022 - 11/28/2023

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, 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
Wednesday, April 26, 2023		T		T	P	P	T	T	P		P	R
Wednesday, March 01, 2023		T		T	T	R	T	T	T		T	T
Wednesday, January 25, 2023		T		T	T	T	T	T	T		T	T
Wednesday, November 30, 2022		P		T	P	R	P	T	P		T	T

Name	Attendance Rate
Bill Conway	100%
Diane Wilkinson	100%
Jay Tulsani	100%
Julia Goyal	100%
Lynn Woeller	89%
Margaret McKinnon	67%
Miles Lauzon	100%
Monika Hempel	100%
Nicola Melchers	100%
Paulo Brasil	100%
Sara Alvarado	100%
Tom Dean	89%

Committee

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

Legend

T-Conference
R-Regrets
P-Present

BRIEFING NOTE

Date: November 28, 2023
Issue: Governance Policy Summary
Prepared for: Governance Committee
Purpose: ☒ Approval ☒ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Executive Assistant
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: Policies with Track Changes

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:

1-A-05 Board Statement of Culture
2-A-15 Capital Projects Sub-Committee Terms of Reference
2-C-40 Capital Projects – Change Order Approval Policy
2-D-02 Board Policy Development, Review and Approval
2-D-30 Board and Board Committee Orientation
*(*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 November 7, 2023 Governance Committee meeting and were amended / updated as attached:
**Note only policies with tracked changes are attached to the package*

Policy No.	Policy Name
1-A-05	Board Statement of Culture
2-D-30	Board Policy Development, Review and Approval
2-D-02	Board and Committee Orientation

In addition, the following policies were reviewed at the November 7, 2023 Governance Committee meeting and were amended / updated as attached:

Policy No.	Policy Name
2-A-15	Capital Projects Sub-Committee Terms of Reference
2-C-40	Capital Projects – Change Order Approval Policy

BOARD MANUAL

SUBJECT: Board Statement of Culture	**NO.: 1-A-05**
SECTION: The Organization	
APPROVED BY: Board of Directors	**DATE: TBD**

Culture is the expression of the behaviours, expectations and interactions that enables or impedes the execution of the hospital's strategy.

As individuals, we each model the desired culture by:

a) Committing to the mission, vision, and values of the Hospital. We live the values through our demonstrable actions
b) Being prepared, welcoming, mindful, engaged, inquisitive, empathetic, and cooperative
c) Devoting time and effort for our ongoing learning and development
d) Aligning our public views with the Hospital's position

Individually, we measure how we are aligned to the culture:

a) By devoting time to attend and engage with staff, physicians and volunteers at the Hospital and Hospital events
b) Through our evaluation processes – peer and self assessments

In Board and Committee meetings, **as a collective**, we model the desired culture by

a) Being empathetic to and supporting an optimal patient experience for our patients (Caring)
b) Showing our appreciation and supporting the wellbeing of our staff, physicians, volunteers and each other (Caring)
c) Looking for synergies within and outside the organization (Collaboration)
d) Probing deeply into the issues and challenges of the organization (Accountability)
e) Adapting to change, new opportunities and challenges (Innovation)
f) Ensuring a diversity of perspective is encouraged in our discussions (Respect)

We measure how our performance aligns to our desired culture as a Board:

a) Through our evaluation and monitoring processes – attendance, committee/ Board performance, committee/Board chair performance, peer performance assessment
b) By tracking participation in education and Hospital/Foundation events
c) By devoting time at the Board to education and generative thinking

As governors of the organization responsible for **setting the tone at the top**, we "model the way"[1] and

a) Put the patient at the centre in making decisions for the organization (Caring)
b) Engage and cooperate with external stakeholders to improve our communities' wellbeing (Collaboration)
c) Meet the obligations set forth through legislative requirements (Accountability)
d) Encourage the organization's commitment to inquiry and critical thinking (Innovation)
e) Connect with patients, staff, physicians and volunteers (Respect)

We further share, measure and improve our culture by:

a) Communicating it to potential Board and committee members during the application and interview process
b) Discussing it at orientation for new Board and committee members
c) Communicating to the Hospital and community following each Board meeting
d) Setting annual personal *ABCDE* goals and tracking collectively our "*ABCDEs"*:
    a) **A**ttend – attend Board/committee meetings
    b) **B**e engaged – be an active contributor to the committee and Board work
    c) **C**onnect – attend staff huddles, events
    d) **D**onate – support the CMH Foundation
    e) **E**ducate – undertake education, courses

Goal setting and goal performance will be discussed between the Board member and the Board Chair as part of the annual Board Chair/Board member discussions.

DEVELOPED: April 28, 2021	**REVISED/REVIEWED:**	

[1] From The Leadership Challenge. James M. Kouzes and Barry Z. Posner. John Wiley & Sons. 1987.

BOARD MANUAL

SUBJECT: Capital Projects Sub Committee Terms of Reference	**NO.: 2-A-15**
SECTION: Structure, Roles and Responsibilities	
APPROVED BY: Board of Directors	**DATE: TBD**

Application

These Terms of Reference apply to the Capital Projects Sub-Committee (the "**Sub-Committee**") of the Cambridge Memorial Hospital (the "**Corporation**"). All capitalized terms not defined herein have the meaning set out in the Corporation's By-Law.

Composition

The Sub-Committee is a sub-committee of the Resources Committee, composed of the following voting members:

(i) Up to three (3) elected Directors, at least one of whom is from the Resources Committee and shall sit as chair of the Sub-Committee.
(ii) Up to five (5) other members from the broader community and have experience with law, capital construction, project management, and/or government processes.
(iii) The Chair of the Resources Committee, ex officio.

The following may attend as resources but shall have no vote:

(i) The President and Chief Executive Officer (CEO).
(ii) The Vice President Finance and Corporate Services and Chief Financial Officer.
(iii) The Senior Director Capital Projects and Chief Redevelopment Officer.

Meetings

(a) The Sub-Committee will meet at least four (4) times annually. The Sub-Committee can conduct all or part of any meeting in the absence of management, and it is the Sub-Committee's policy to include such a session on the agenda of each regularly-scheduled Sub-Committee meeting. Additional meetings of the Sub-Committee may be called by the Chair, and may be conducted in-person or virtually.

(b) The Sub-Committee may invite to its meetings any Director, member of management or such other person as it considers appropriate in order to carry out its duties and responsibilities.

Specific Duties and Responsibilities

The Sub-Committee shall be directed by and report to the Resources Committee in assisting with its responsibility for approving and monitoring contracts relating to capital projects.

The Capital Projects Sub-Committee shall:

(a) Recommend to the Resources Committee policies and parameters related to capital projects and redevelopment.
(b) Review and recommend to the Resources Committee the defined limits within which authority for commitment of funds may be delegated to management.
(c) Receive, discuss, and recommend to the Resources Committee approval of the annual plan for capital projects as well as any amendments to the plan brought forward by management.
(d) Review and recommend to the Resources Committee the budgets for capital projects.
(e) Recommend to the Resources Committee the awarding of contracts related to capital projects for architects, construction consultants, and building contractors after tender documents have been received and reviewed.
(f) Review regular detailed financial reports on all capital projects and advise the Resources Committee as appropriate.
(g) Review and advise on legal and insurance matters related to capital projects.
(h) Monitor and advise the Resources Committee on significant change orders during construction and progress on capital projects as defined by the Capital Projects – Change Order Approval Policy 2-C-40

General

The Sub-Committee shall have the following additional general duties and responsibilities:

(a) Reporting to the Resources Committee on material matters arising at the Sub-Committee meetings following each meeting of the Sub-Committee.
(b) Maintaining minutes or other records of meeting and activities of the Sub-Committee.
(c) Conducting an annual evaluation of the Sub-Committee in which the Sub-Committee (and/or its individual members) reviews the Sub-Committee's performance for the preceding year for the purpose, among other things, of assessing whether the Sub-Committee fulfilled the purposes and responsibilities stated in this Terms of Reference.
(d) Reviewing and assessing the adequacy of these Terms of Reference at least every three years and submitting any proposed amendments to these Terms of Reference to the Governance Committee and the Board for approval.
(e) Providing an orientation for new committee members.

(f) Performing such other functions and tasks as may be assigned from time to time by the Resources Committee.

The Resources Committee will review on an annual basis the continuing need and relevance of the Sub-Committee and make a recommendation concerning its ongoing existence through the Governance Committee to the Board.

DEVELOPED: June 27, 2012	**REVISED/REVIEWED:**	
October 30, 2013	June 25, 2014	May 27, 2015
May 30, 2018	April 28, 2021	September 29, 2021

BOARD MANUAL

SUBJECT: Capital Projects – Change Order Approval Policy	**NO.: 2-C-40**
SECTION: Corporate Performance and Oversight	
APPROVED BY: Board of Directors	**DATE: TBD**

Policy

This policy applies to all capital projects undertaken at Cambridge Memorial Hospital (CMH) to ensure that publicly funded capital goods and services, including construction, consulting services, and information technology are acquired by (CMH) through a process that is open, fair and transparent.

The Board through the Capital Projects Sub-Committee shall ensure that project budgeting, oversight and cost control procedures are in place to ensure that the project is completed within the approved budget and timeline. Minimum expectations for ensuring compliance with these requirements are set out in operational policies under the authority of the President & CEO.

The Board authorizes the individuals set out below to approve the following change orders.

Change Orders Within Project Budget Approved by the Board of Directors

Change Order Value	Senior Director	Senior Executive Committee	President & CEO	Capital Project Sub-Committee	Resources Committee of the Board	Board of Directors
$0-$500,000	✓	✓	Informed	Informed	Informed	Informed
$500,001 - $1,000,000	✓	✓	✓	Informed	Informed	Informed
$1,000,000+	✓	✓	✓	✓	✓	✓

✓ ***Denotes signature required on Change to provide approval to proceed***

Change Orders Exceeding Project Budget Approved by the Board of Directors

Change Order Value	Senior Director	Senior Executive Committee	President & CEO	Capital Project Sub-Committee	Resources Committee of the Board	Board of Directors
Any Amount	✓	✓	✓	✓	✓	✓

✓ ***Denotes signature required on Change to provide approval to proceed***

The project lead controls project costs and the timeline by using appropriate:

- procurement procedures
- scope control processes
- change and contingency management procedures and
- regular project reporting.

Related Policies and Procedures:

- Supply Chain Directive – Procurement Policy and Procedures 7-85
- Approval & Signing Authority 2-C-34

DEVELOPED: March 19, 2012	**REVISED/REVIEWED:**	
November 26, 2014	November 29, 2017	April 28, 2021

BOARD MANUAL

SUBJECT: Board Policy Development, Review and Approval	**NO.: 2-D-02**
SECTION: Board Process	
APPROVED BY: Board of Directors	**DATE: TBD**

Policy

From time to time, the Board will adopt and articulate policies that are designed to guide the work and decisions of the President & CEO (CEO) and the Board itself.

The Board is responsible for setting the strategic context in which policies are developed and for the formal review and approval of policies. The Board may delegate development of policies to a committee.

The Board will generally limit its policy making to matters of governance.

Development and Implementation

Except as set out below, the Governance Committee is responsible for the development of new policies.

Policies may be initiated, in consultation with the Governance Committee Chair, by any committee when it is recognized that a policy is required. Draft policies developed by a committee will be forwarded to the Governance Committee for review.

The Governance Committee will recommend all new policies and any revisions to existing policies to the Board for approval.

The Governance Committee will:

- Develop (in conjunction with other committees as required), recommend and maintain governance policies to promote effective functioning of the Board and committees
- Maintain a Board policy manual

The CEO is responsible for:

- Storage of hard copy and electronic policy files
- A system for the maintenance of policies, to ensure on-going review, version control and archiving of policies
- Referring policies that are due for review to the Governance Committee for policy oversight
- Reviewing policies to ensure consistent format and established guidelines are followed

Review and Revision

The Governance Committee will oversee the review process with assistance from the CEO's office staff. Policies will be reviewed at least every three years. Any Board committee may at any time, initiate a review of a Board policy within the scope of their terms of reference.

The "Date" date indicates the date of Board approval of the most recent version. The "Revised/Reviewed" dates record the dates of various policy amendments since the original policy was approved.

Approval

Policies are approved as a consent or discussion item on the agenda, and a vote in the open meeting of the Board.

A policy will be effective upon approval unless an effective date in the future is specified. The date when a new policy was first approved will be recorded on the policy footer as the "Developed". The "Developed" will never change over the life of the policy.

DEVELOPED: November 24, 2010	**REVISED/REVIEWED:**	
September 28, 2011	January 28, 2015	May 26, 2021
TBD		

BOARD MANUAL

SUBJECT: Board and Board Committee Orientation	**NO.: 2-D-30**
SECTION: Board Process	
APPROVED BY: Board of Directors	**DATE: TBD**

Purpose

The purpose of a Board and committee orientation program is to help new Directors and non-director committee members assume their responsibilities quickly, maximizing their potential contribution and the capacity of the Board and committees as a whole.

Policy

It is the responsibility of the Governance Committee to ensure that new Directors and non-director committee members receive an orientation to their role as a Board and/or non-director committee member.

Orientation will take place as close as possible to the appointment of members and may be more than one session.

All new Directors will be assigned a mentor by the Board Chair, in consultation with the President & CEO (CEO), who will assist in providing additional information and answering questions that the new Director may have. The committee Chair will act as a mentor for new non-director committee members.

Orientation will consist of;

1) General orientation for all new Board and non-director committee members; and
2) Committee specific orientation.

Topics for the general orientation may include those outlined in Appendix A and amended from time to time by the Board Chair, CEO and/or Governance Committee.

The Chair of each Board Committee is expected to conduct a committee specific orientation. This session will cover at minimum the mandate and terms of reference of the committee for which they are the chair.

Expectations

All new Board Directors and new non-director committee members will:

- Attend a mandatory orientation
- Read and be familiar with the Responsibilities of a Director (Policy 2-A-30) or the Responsibilities of Non-Director Committee Members (Policy 2-A-32)
- Consider registering on the Ontario Hospital Association (OHA), the Institute for Healthcare Improvement and The Beryl Institute to receive governance and healthcare information
- Complete an evaluation post-orientation

In addition, all new Board Directors will:

- Complete the Ontario Hospital Association (OHA) course, Essentials Certificate in Health Care Governance for new Directors (or equivalent certification) within 2 years of joining the Board
- Meet with their mentor at least once during their first three months of service or as often as required

Suggested Reading

- Initial recommended readings from the Board Manual include:
  - Organizational Chart
  - Information about the Ministry of Health, Ontario Health, CMH Volunteers Association and CMH Foundation
- Guide to Good Governance, Ontario Hospital Association
- Copy of the previous year's annual report of the CMH Foundation
- The minutes of the last three meetings of the Board (open and in-camera found on the CMH Board Portal, accessible only to Directors)
- Previous year's Committee minutes to which the new Director or non-director committee member is assigned (found on the Board Portal)
- Schedule of meeting dates

Other

The Director or committee member will:

- Obtain a criminal record check
- Be provided a photo identification card to be worn at all times on the Hospital premises
- Complete an access card information form to enable parking access
- Sign the Directors and non-Directors committee members declaration (2-D-22)
- Sign the confidentiality declaration
- Sign the Conflict of Interest declaration (CMH 9-40)
- Be provided the Board portal passwords
- Be provided a description of HIROC Insurance coverage (2-D-24)

- Sign the Indemnity Agreement (2-D-24)
- Provide a JPEG picture (portrait) for publication use

Appendix A

Board Orientation Topics

General Information

(i) Mission, Vision, Values
(ii) Strategic Plan and Drivers
(iii) Hospital Overview
(iv) Financial Overview
(v) Legal Framework

Responsibilities/Expectations of Directors and non-director committee members

(i) Differences
(ii) Responsibilities
(iii) Key Policies
  a. 1-A-04 Code of Conduct
  b. 2-A-36 Conflict of Interest
  c. 2-A-34 Confidentiality
  d. 2-A-38 Attendance
  e. 2-D-11 Communication with Media
(iv) FAQ: Spokespeople, Role, Mentorship, Hospital Events

Hospital Partners

(i) CMH Foundation
(ii) CMH Volunteer Association
(iii) Patient Family Advisory Committee
(iv) Cambridge North Dumfries Ontario Health Team

How the Board / Committees gets its work done

(i) Board Structure
(ii) Committees' Key Roles
(iii) Terms of References and Work Plans
(iv) Committee Support
(v) Board / Committee Meeting Materials
(vi) Board / Committee Evaluations
(vii) Board / Committee Portal

Key Issues facing the Hospital

DEVELOPED: September 28, 2011	REVISED/REVIEWED:	
September 30, 2015	September 27, 2017	October 17, 2018
November 25, 2020		

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

CAMBRIDGE MEMORIAL HOSPITAL

MEMORANDUM

TO: Board of Directors, Cambridge Memorial Hospital

DATE: November 21, 2023

REPORTING PERIOD: July 1, 2023 – September 30, 2023

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

ABCDE Goals for Board of Directors 2023/24

Goal	Annual Commitment Made	Performance Year to Date
Attend – attend Board/committee meetings	75% commitment by each Director	On Track
Be engaged - an active contributor to the committee and Board work	Pre-Read Agenda Materials	
	Support CMH through Social Media Channels	
	Directors each indicated willingness to be an active contributor in each of their respective committees	On Track
Connect - attend staff huddles, events	Attend Staff Huddles	(2) Members have joined huddles / department visits
	Attend ICCAIR Ceremonies	(4) Member have joined ICCAIR Ceremonies
	Volunteer at CMH Staff Events - Staff BBQ, Holiday Meal etc. - 100% commitment	(6)Members have volunteered to help at the upcoming Holiday Meal
	Attend Foundation Events (Sip & Taste etc.)	
	Attend Grand Rounds	4 Members have attended Grand Rounds
	Other	11 Board Members participated in the Holiday Cards
Donate - support the CMH Foundation	Each Director has committed to donate to support the Foundation	On Track
Educate - undertake education, courses	Participate in education sessions through OHA, Miller Thompson, CCDI, Advisory Board, CMH Learning Lab or any others of interest.	(3) Members - OHA Governance Essentials Course
		(1) Guiding Organizational Change (OHA)
		(1) Ontario Health Never Health Webinar

BRIEFING NOTE

Date: November 10, 2022
Issue: Corporate Strategic and Operational Priorities Q2 Update
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kyle Leslie, Director Operational Excellence
Approved by: Mari Iromoto, Senior Director of Strategy, Performance & CIO

Attachments/Related Documents: **Appendix A: Strategic Deliverables and Operational Priority Indicator Package**
Appendix B: Quality Monitoring Scorecard

Alignment with 2023/24 CMH Priorities:

2022-2027 Strategic Plan No ☐	2023/24 CMH Priorities No ☐	2023/24 Integrated Risk Management Priorities No ☐
☒ Elevate Partnerships in Care	☐ Ensure Equitable Care For CND Residents	☐ Change / Project Management
☒ Advance Health Equity	☐ Grow Clinical Services	
☒ Increase Joy In Work	☒ Increase Staff Engagement	☒ Staff Shortages
☒ Reimagine Community Health	☒ HIS/ERP Planning and Implementation	☒ Access to Care
☒ Sustain Financial Health	☐ Grow Ministry Revenue	☐ Revenue & Funding

Executive Summary

This briefing note is to provide an update on our Strategic Deliverables and Operational Priority Performance Indicators for quarter two of fiscal year 2023/2024.

Included in **Appendix A** is our Strategic Deliverables and Operational Priority Indicator Package for Q2. Included in **Appendix B** is our Quality Monitoring Scorecard.

Currently there are no strategic deliverables for Q2 that are at a "red status". However, there are four strategic deliverables at a "**yellow**" status meaning that there is a mitigation plan in place to achieve delayed deliverables in Q3/Q4.

The deliverables at a "**Yellow**" status are:

1) Update multi-year financial and capital plans incorporating capital and ongoing operating costs to support new HIS and ERP by March 2024.
2) Execute Change Management strategy for 23/24 by March 2024
3) Execute DEI initiatives for 23/24 DEI Plan by March, 2024
4) Complete all in year readiness activities required to proceed with ERP project by March, 2024

To monitor our "in-year" operational priorities, there are eleven priority indicators aligned to the pillars of our Strategic Plan. Of the eleven indicators, seven are currently at a "red" status, meaning the performance for Q2 met less than 90% of the performance target. The indicators at a red status include:

1) Post Construction Occupancy Growth Funding
2) YTD Budget Variance
3) Overtime Hours
4) Agency Hours
5) Emergency Department Length of Stay for Complex (CTAS 1-3) patients
6) Emergency Department Wait Time for Inpatient Bed
7) Rate of Alternative Level of Care Patient Days to Acute Patient Days

In addition to our Operational Priority Indicators, there are fifteen indicators of the thirty-one indicators on our Quality Monitoring Scorecard in **Appendix B** that we are monitoring to determine if an action plan for improvement is needed. Many of the fifteen indicators identified are already being addressed through the work on our Operational Priority Indicators. Of the fifteen indicators noted, five have had three periods consecutively trend below target performance. These indicators are:

1) Sick Hours
2) Emergency Department Length of Stay for Admitted Patients
3) Physician Initial Assessment Time
4) Surgical Long Waiters
5) Medication Error Rate

Background

For fiscal year 2023/2024 we have refreshed our performance monitoring tools to include:

1) **Strategic Priority Scorecard**- this tool monitors in-year strategic deliverables aligned to our five strategic pillars and overarching strategic goals. This tracker is future orientated and will influence future priority indicators that will be on our operational priority monitoring scorecard. The scorecard and action plans for each of our strategic deliverables will be presented on a quarterly basis.
2) **Operational Priority Indicator Scorecard-** this tool monitors in-year priority indicators that are critical for organizational success in the current fiscal year. The scorecard and action plans for in-year operational priority indicators will be presented on a quarterly basis.
3) **Quality Monitoring Scorecard-** this tool monitors key organizational indictors aligned to our quality framework that are important to monitor and sustain. Many of the indicators on the Quality Monitoring Scorecard are reported publically on 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 performance thresholds so that we can investigate if an improvement plan is needed to bring the indicator back on track. The Quality Monitoring Scorecard will be presented on a monthly basis.

Strategic Priorities Analysis

Aligned to the five pillars of our Strategic Plan, we have five overarching Strategic Goals with in-year strategic deliverables aimed to advance these goals. The goals are:

1) **Sustain Financial Health:** Grow ministry revenue by $22 million by achieving budgeted revenue in multi-year financial plans by 2027
2) **Advance Health Equity:** Ensure CMH is representative of the communities served and that the communities across Cambridge North Dumfries are receiving equitable care by 2027
3) **Elevate Partnerships in Care:** Grow clinical services by approximately 30% (growth in beds) from baseline by 2027 (increase bed footprint to 200+ beds and achieve

approximately 4800 incremental weighted cases in clinical services growth) and increase access to services and care in Cambridge North Dumfries

4) **Reimagine Community Health:** Leverage technology to transform how we deliver care by revolutionizing our Health Information Systems and Enterprise Resource Planning Systems and data assets by 2027
5) **Increase Joy in Work**- measured through "overall ranking of CMH as a place to work" increasing the excellent and very good responses from 42% to 48% by 2024 and to greater than 50% by 2027

Included in **Appendix A** is a Q2 status report of our strategic deliverables by strategic goal.

For quarter two, there are two strategic deliverables that have moved from a "Red" status to "**yellow**" status meaning that there is a plan in place to achieve Q3/Q4 objectives. These deliverables are:

1) Update multi-year financial and capital plans incorporating capital and ongoing operating costs to support new HIS and ERP by March, 2024
2) Execute Change Management strategy for 23/24 by March, 2024

For Q2, there is one strategic deliverable that moved from "Green" to "Yellow", meaning that Quarterly deliverables from Q2 are now being rescheduled into Q3 / Q4. This strategic priority is:

1) Execute DEI initiatives for 23/24 DEI Plan by March, 2024

Operational Priority Indicator Analysis

Included in **Appendix A** is the fiscal 2023/2024 Operational Priority Indicators aligned to our strategic pillars. These indicators are deemed as the highest priority indicators to monitor and improve as they are critical to organizational success for this fiscal year. These indicators were identified through our Quality Improvement Plan (QIP), Collaborative Quality Improvement Plan (c-QIP) and Integrated Risk Management (IRM).

Analysis of Operational Priority Indicators:

1) **Post Construction Occupancy Plan (PCOP) Funding (currently red status):**
   Post Construction Occupancy Plan (PCOP) Funding is a funding source available to hospitals with an approved Capital Redevelopment Plan (CRP). The PCOP is our planned growth for clinical activity due to growing capacity and beds through the CRP. The PCOP growth indicator measures the growth over our 2016-17 base volumes. For Acute IP, Day Surgery and Emergency Department, PCOP growth is measured by growth in weighted cases, which reflects the resource intensity of a case. IP Mental Health Care is measured by growth in inpatient days, while clinic activity is measured by visits. If we reach our PCOP target of $13.4 million dollars this fiscal year, we will have achieved our planned clinical services growth for the year. As such, higher is better for this indicator.

   Q2 results were 2.5% below Q1, largely due to OR closures. Year-to-date Q2, we are 4.4% below our weighted cases target for acute inpatient activity. Medical activity has achieved targets YTD and is projected to surpass our budgeted PCOP growth for that population at year-end, while inpatient surgery has generated 22.5% fewer weighted cases than budgeted. Day surgery activity continues to ramp up, though we generated 4.6% less weighted cases than budgeted in Q2.

Emergency department volumes continue to be lower than pre-pandemic levels, and we are not anticipating to earn any PCOP in this category this fiscal year.

Mental health inpatient activity is currently slightly lower than budgeted due to lower occupancy at an average of 84%, while targets are based on 88% occupancy. In Q2, we completed 82% of ECT volume targets.

2) **Quality Based Procedures (QBP) Revenue (currently green status):**
QBP revenue is volume based funding for specific procedures and is earned by achieving allocated procedure targets for funding. The QBP indicator monitors our completed QBP volumes. A higher number is better as it means we are achieving our budgeted QBP volumes and enabling access to care. Q2 results were 9% below Q1 results, largely due to OR closures, though the target overall was surpassed. Year-to-date Q2, we are meeting budgeted volumes for urgent medical QBPs, GI Endo, Cancer Surgery, and other Surgical QBPs.

3) **Budget Variance (currently red status):**
This indicator reflects the total hospital budget variance in dollars by measuring the difference between the amount that was budgeted for and the actual amount spent. A positive number is better as it means we are meeting our financial goals and thus the target is set to 0. Q2 YTD, we are ($1,934,000) above budget. Top drivers impacting the budget variance for Q2 are: PCOP weighted cases being lower than budget, Salaries and benefits and use of unbudgeted agency staff and overtime use over budget.

4) **Repeat Emergency Department visits for Mental Health care (currently green status):**
As part of the Collaborative Quality Improvement Plan (c-QIP), this indicator is intended to help establish a baseline understanding of the rate of emergency department visits as a first point of contact for mental health and addictions related care by monitoring repeat emergency department visits for mental health and addictions related care. This indicator looks at the number of individuals with four or more visits in a 365-day period and we have set a target of 11 such individuals per month. A lower number for this indicator is better as it means patients have access to the support they need in the community to prevent the need for emergency care. In Q2, an average of 10.7 individuals who have visited the emergency department 4 or more times in the past year were seen in the emergency department; YTD is 11.3.

5) **Emergency Department Length of Stay for Non-Admitted Complex Patients (currently red status):**
This indicator reflects the amount of time spent in the emergency department for complex patients who are not admitted. A lower number is better as it means patients are being treated within an appropriate timeframe, with the target that 90% of patients spend 8 hours or less. This indicator has been identified through our Integrated Risk Management (IRM) process as a key organizational risk for this fiscal year. Results for this indicator have been consistent for each quarter at 9.6 hours. We have not met target in any period this year, and times have increased since the same period last fiscal year.

6) **Wait Time for Inpatient Bed for Emergency Department Patients (currently red status):**
This indicator reflects the amount of time between the disposition date/time and the date/time an admitted patient left the emergency department for admission to an

inpatient bed. A lower number is better as it means patients are being admitted to an inpatient bed within an appropriate timeframe. This indicator has been identified through our Integrated Risk Management (IRM) process as a key organizational risk for this fiscal year. The wait time for inpatient bed increased from 34.5 hours in Q1 to 45.2 hours in Q2, with each month in Q2 surpassing the target of 36 hours. YTD, the 90th percentile is 42.5 hours.

7) **Percent ALC Days (currently red status):**
This indicator measures the Alternative Level of Care (ALC) days expressed as a percentage of all acute inpatient days. A lower number is better as it means patients are receiving care in the appropriate setting and inpatient beds are being utilized appropriately. This indicator is a priority for the hospital and the CND OHT to reduce the number of days' patients spend in hospital unnecessarily. "ALC" refers to care that would be better provided in a setting other than the hospital such as long term care or home with support. If we are successful at reducing this percentage, it indicates patients are receiving better, more appropriate care by being in the right care setting more often. In Q2, the percent ALC days continued to be above target (20%) and increased from 23.6% in Q1 to 24.7%. YTD, 24% of days were ALC.

8) **Overtime Hours (currently red status) and Agency Hours (Currently Red Status):**
This indicator measures the total number of overtime hours used for Q2 vs. budgeted overtime hours. Currently we are significantly over budget for overtime hours used and the total overtime hours increased by 13.7% in Q2 from Q1. The majority of overtime hours (>60%) can be attributed to the Emergency Department, Medicine, ICU, and Inpatient Surgery. 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. In addition to OT we are monitoring agency usage as this indicator also is representative of our staffing levels, the work we are doing on staffing and OT will also address our agency usage.

Quality Monitoring Indicators Analysis
The Quality Monitoring metrics can be found on our Quality Monitoring Scorecard in **Appendix B.**

Below is a summary of the quality monitoring metrics that are currently at a "red" status. In the analysis below we have noted indicators that have three or more consecutive data points outside of targeted threshold and these indicators are being investigated and will have an action plan for improvement created as needed.

1) **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. Currently, the average number of sick hours per pay period exceeds the target by 46% (YTD Oct). Approximately one-third of sick hours can be attributed to the Emergency Department, Medicine, ICU, and Inpatient Surgery. The work we are doing on OT and staffing will help to address staffing pressure from sick hours.

2) **ALC Throughput:**
ALC Throughput represents the flow of patients designated and discharged, with a Throughput Ratio less than 1 indicating that there are more newly added ALC cases

than ALC Discharged cases, which reflects growing pressures for patients waiting for an alternate level of care. Currently, the ALC Throughput is 0.9, with 395 ALC discharges, compared to 451 new cases (YTD Q2). The action plan for ALC is addressed within the QIP action plan for ALC rate.

3) **30 Day CHF Readmission Rate:**
This indicator monitors the readmission rate or patients returning to hospital within 30 days after receiving care for CHF. Currently, 23.1% of CHF patients have returned within 30 days, or 21/91 patients (YTD Aug). While not all readmissions are avoidable, readmission rates indicate quality of inpatient and outpatient care, effective care transition and coordination, and the availability and effective use of community-based resources, and thus a lower number is better. This indicator has fluctuating performance, though 3/5 periods have been red (May, Jul, Aug). We will continue to monitor this indicator and develop an action plan as needed.

4) **30 Day In-Hospital Mortality Following Major Surgery:**
This indicator monitors the rates of mortality for major surgical procedures and is used to increase awareness of surgical safety for best outcomes. Currently, the risk-adjusted in-hospital mortality rate following major surgery is 2.6%, versus the target of 2.1% (YTD Aug). There have been 7 in-hospital deaths within 30 days of major surgery, while only 5.4 were expected. We will continue to monitor this indicator and develop an action plan as needed.

5) **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. 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. While our internal target is to see 90% of patients within 4 hours, we have consistently seen results exceeding this at 6.8 hours. This value has increased over the last 12 months and the action plan for this indicator will be addressed within the action plan for the 'Emergency Department Length of Stay for Non-Admitted Complex Patients' indicator.

6) **Fall Rate:**
This indicator measures the rate of falls that could have been prevented in hospital. Our target for the incidence of falls for inpatients is 4.0/1000 patient days. A lower number is better as this means fewer falls are occurring. As of October, there have been 172 falls and our fall rate/1000 patient days is 5.2 (YTD Oct). Of these, 49% have been no harm incidents, 43% mild harm, 5% near misses, 2% moderate harm, and 1% unknown harm. A thorough analysis will occur to identify if there are any particular units experiencing an upward trend in falls and we will investigate the severity level of falls as well. This indicator uses our incident reporting data and is impacted by the reporting culture. There is currently work underway to strengthen the reporting, which would result in this indicator increasing.

7) **Medication Error Rate (Red status with three or more periods outside of performance threshold):**
This indicator measures the rate of medication errors that could have been prevented. Our target for the incidence of medication errors for inpatients is 4.0/1000 patient days. A lower number is better as this means fewer medication errors are occurring. As of October, there have been 226 falls and our fall rate/1000 patient days is 6.8 (YTD Oct).

Of these, 60% have been no harm incidents, 19% mild harm, 17% near misses, 2% unknown harm, 1% moderate harm, and <1% severe harm. A thorough analysis will occur to identify if there are any particular units experiencing an upward trend in falls and we will investigate the severity level of falls as well. This indicator uses our incident reporting data and is impacted by the reporting culture. There is currently work underway to strengthen the reporting, which would result in this indicator increasing.

8) **Long Waiters for Surgical Procedures (Red status with three or more periods outside of performance threshold):**
This indicator measures the percentage of patients who are currently waiting for a surgical procedure and whose wait has exceeded the associated Priority Level Access target. A lower number is better as this means that patients are receiving timely access to surgical care. The target for this indicator is 20% or less. While we are still exceeding target, the percentage of long-waiters has decreased to 28% as of September 30, 2023, from 42% at the end of Q1. Of those waiting, 74% are priority level 4, 25% priority 2, and 1% priority 2.

Next steps:

- The full Strategic and Operational Priority Indicator Package including action plans will be shared with Quality Committee on a Quarterly Basis. The Q3 package will be available at the February Quality Committee Meeting.
- The Quality Monitoring Scorecard will be included in the Quality Committee Package on a monthly basis

Overview of Strategic Priorities and Operational Indicators - End of Q2 (Sept)

Pillar	Strategic Deliverables	Status	Operational Indicators	Status
Advance Health Equity	1. Develop measurement tool and establish baseline for growth by October, 2023 and begin planning for how the measurement tool can be used to inform 24/25 initatives	O - On Track	1. Repeat ED visits for MH care (4 or more in last 365 days) (c-QIP)	O - On Track
	2. Execute DEI initiatives for 23/24 DEI Plan by March, 2024	Δ - Progressing to On Track		
	3. RNAO BPG implementation – 2SLGBTQIA+ by March, 2024	O - On Track		
	4. Develop Action Plan for Indigenous Wellness, Truth and Reconciliation by March, 2024	O - On Track		
Elevate Partnerships in Care	1. Finalize clinical services growth plan by September, 2023 and begin to execute plan by March, 2024	O - On Track	1. Access to care- ED Wait-time for in-patient bed (IRM)	X - At Risk
	2. Complete Board approved Master Plan by March, 2024	O - On Track	2. Access to Care- ED Length of Stay Complex CTAS 1-3 (IRM)	X - At Risk
	3. Update original functional plan to align with current service levels by March, 2024	O - On Track	3. Access to Care- Percent ALC Days (closed cases) (c-QIP)	X - At Risk
	4. Patient experience plan developed and Board approved by October, 2023 and begin implementing plan by March, 2024	O - On Track		
Reimagine Community Health	1. HIS implementation plan created by March, 2024	O - On Track	1. % on track with HIS milestones	O - On Track
	2. Complete all in year readiness activities required to proceed with ERP project by March, 2024	Δ - Progressing to On Track	2. % on track with ERP milestones	Δ - Progressing to On Track
	3. Increase organizational capability to gain insight from data by improve data quality, access and governance by March, 2024	O - On Track		
Increase Joy in Work	1. Implement corporate strategies for staff engagement including huddles and VBC refresh by March, 2024	O - On Track	1. Overtime hours (IRM)	X - At Risk
	2. Review and enhance recruitment and onboarding processes including HR support for leaders by March, 2024	O - On Track		
	3. Execute wellness initiatives for 23/24 by March, 2024	O - On Track		
	4. Execute Change Management strategy for 23/24 by March, 2024	Δ - Progressing to On Track		
Sustain Financial Health	1. Update multi-year financial and capital plans incorporating capital and ongoing operating costs to support new HIS and ERP by March, 2024	Δ - Progressing to On Track	Revenue- Achieve budgeted PCOP growth for 2023/2024 (IRM)	X - At Risk
	2. Establish budgeted volume targets to maximize PCOP funding for 24/25 and 25/26 by November, 2023	O - On Track	Revenue - Achieved-Quality Based Procedure Funding (IRM)	O - On Track
	3. Improve financial literacy within CMH leadership team by March, 2024	O - On Track		
	4. Improve supply chain processes by March, 2024	O - On Track		

Legend:

- 🟢 **On Track- all quarterly deliverables achieved**
- 🔺 **Progressing to On Track - quarterly deliverables not achieved, action plan in place to achieve deliverables by next quarter**
- 🔻 **At Risk- quarterly deliverables not achieved, must be rescheduled across the remaining quarters to be successful, developing action plan**

Agenda

Status Report

Advance Health Equity

STRATEGIC GOAL:

Goal 1: Increase culture of inclusion at CMH by ensuring CMH's workforce is representative of the population served, estimate 26% of population in CND will be visible minority by 2026 (CMH currently estimated at 19%). Increase Health Equity by ensure equal access to care by 2025.

Strategic Deliverable	Executive Sponsor	Status	Achievements for Q2	Plan for Q3	Risk (R) and Mitigation (M) Strategy
1. Develop measurement tool and establish baseline for growth by October, 2023 and begin planning for how the measurement tool can be used to inform 24/25 initatives	M. Iromoto	O - On Track	- Draft dashboard reviewed with Directors Council - Used dashboard data to identify areas of opportunity - Received feedback from Directors Council -Received feedback from inclusion lead - Incorporated access and flow indicators using DEI filters	-Begin socializing dashboard -Explore any process improvement opportunities the dashboard may help to inform -Plan for how dashboard can be used to inform future DEI initiatives	R1) Availability for social determinates of health data M1) Incorporated into plan for new HIS
2. Execute DEI initiatives for 23/24 DEI Plan by March, 2024	M. Iromoto/ S. Toth	Δ - Progressing to On Track	Priority Theme 1: Inclusive Languages & Images - Created internal communications and social media posts, provided education and resources for Emancipation Day, World Humanitarian Day, Raksha Bandhan, Rosh Hashanah, Internal Week of Deaf People, International Day of Sign Languages Priority Theme 2: Education & Tools - Identified and built partnerships with local organizations to provide further resources and support for staff as Gold Sponsor at the Cambridge Multicultural Festival; delivered Unconscious Bias Training for the Diversity Council and new leaders Priority Theme 3: Creating Safe Spaces - Diversity Council meeting (October 5, 2023); expanded Diversity Council to include CMHVA; incorporated assessment of bias in the Patient Relations RL6 Reporting Tool Priority Theme 4: People & Processes - Creation of Recruitment Inclusion Statement, developed DEI questions for staff and leader interviews, incorporated DEI into 30/90 Day Check-ins, added Diversity Awareness/Competency in VBCs and ACAs, addition of DEI lens in Exit Interviews; endorsed by Diversity Council on October 5, 2023	Priority Theme 1 - Create Inclusive Corporate Communications Policy/Guidelines; Begin development of photo repository of diverse CMH faces with launch of new corporate website Priority Theme 2 - Create communications and provide education/resources for Q3 DEI Calendar Events, provide Inclusive Leadership Training for all leaders, continue improving DEI intranet page to create a more comprehensive repository of information/resources for staff Priority Theme 3 - Enhance triage process and documentation of all DEI-related inquiries at CMH; incorporate DEI-related assessment options into RL6 Incident Reporting Tool Priority Theme 4 - Implement new HR processes from Q2 (i.e., Recruitment Inclusion Statement, DEI interview questions, 30/90 Day Check-ins, VBCs, ACAs, and Exit Interviews)	R1) Inclusion Lead on medical leave M1) Appointed Strategic & Indigenous Projects Coordinator as interim lead for continuity of work

Legend:

- On Track- all quarterly deliverables achieved
- Progressing to On Track - quarterly deliverables not achieved, action plan in place to achieve deliverables by next quarter
- At Risk- quarterly deliverables not achieved, must be rescheduled across the remaining quarters to be successful, developing action plan

Agenda

Status Report

Advance Health Equity

STRATEGIC GOAL:

Goal 1: Increase culture of inclusion at CMH by ensuring CMH's workforce is representative of the population served, estimate 26% of population in CND will be visible minority by 2026 (CMH currently estimated at 19%). Increase Health Equity by ensure equal access to care by 2025.

Strategic Deliverable	Executive Sponsor	Status	Achievements for Q2	Plan for Q3	Risk (R) and Mitigation (M) Strategy
3. RNAO BPG implementation – 2SLGBTQIA+ by March, 2024	S. Pearsall	O - On Track	- Professional Practice has secured funding for Rainbow Health education to be provided (500 licenses for registered nursing staff) - Nursing Advisory Committee BPG Working group meeting monthly to review policies and next steps related to signage/language review	- Education in Health Service Organizations - Nursing providers complete Rainbow Health Training (25% complete by end of Q3) Inclusive Communication: - Review History taking approach to ensure inclusive to 2SLGBITQIA+ (recommendations for changes by end of Q3) Review forms, documentation, and signage to ensure inclusive (NAC working group with DEI Council consultation) Group Based Interventions: - Review interventions for 2SLGBTQIA+ people that address social determinants of health that promote access to underserved 2SLGBTQIA+ people (two spirit, indigenous and people of colour, older adults, youth, migrants and people with disabilities)	No risks to report
4. Develop Action Plan for Indigenous Wellness, Truth and Reconciliation by March, 2024	P. Gaskin/ M. Iromoto	O - On Track	- Distribution of pre-ordered Orange T-shirts w/ educational note/pamphlet attached - Creation of Indigenous Truth & Reconciliation page on CMHnet, inventory of current Indigenous projects and partnerships within CMH, and Indigenous Days of Significance Calendar - Weekly L.E.A.R.N Challenge in September w/ focus on Truth and Reconciliation - Lunch & Learn with Katrina Graham, Indigenous Patient Navigator (Sep 18) - Hawk Feather Re-energizing Ceremony (Sep 27) with strong presence from leadership and Board of Directors - Group viewing of CCDI Webinar: Reconciliation to ReconciliACTION with Operations Team (Sep 28) - Acknowledgement of National Day for Truth & Reconciliation and Orange Shirt Day (Sep 30) - Soft launch of CMH Indigenous Council with a focus on recruitment of members with lived experience	- Host first CMH Indigenous Council meeting - Explore opportunities to improve the staff/patient experience of Indigenous community members and show CMH is an Indigenous-friendly space - Determine mandatory and optional Indigenous training opportunities for leaders and staff (e.g., Ontario Health Indigenous Relationship and Cultural Awareness Courses 2023) - Create more comprehensive list of tools and resources for Indigenous CMHnet Page - Develop Indigenous Action Resource Guide to help inform the development of the CMH Indigenous Wellness, Truth and Reconciliation Plan - Launch communications and educational initiatives for Treaties Recognition Week, Inuit Day, Indigenous Veterans Day, and Louis Riel Day	R1) Risk of capacity limitations of Indigenous Projects Coordinator assuming responsibilities for continuity of DEI initiatives M1) Managing and negotiating competing priorities

Legend:

- On Track- all quarterly deliverables achieved
- Progressing to On Track - quarterly deliverables not achieved, action plan in place to achieve deliverables by next quarter
- At Risk- quarterly deliverables not achieved, must be rescheduled across the remaining quarters to be successful, developing action plan

Agenda

Status Report

Elevate Partnerships in Care

STRATEGIC GOAL:

Goal 2: Grow our services by approximately 30% (Growth in beds) from baseline by 2026 (increase bed footprint to 200+ beds and achieve approximately 4800 incremental weighted cases)

Strategic Deliverable	Executive Sponsor	Status	Achievements for Q2	Plan for Q3	Risk (R) and Mitigation (M) Strategy
1. Finalize clinical services growth plan by September, 2023 and begin to execute plan by March, 2024	Dr. Lee/ S. Pearsall	**O - On Track**	Model of Care: - RPN education has been completed to increase scope of practice - Standardized role and responsibilities for each discipline devised ED Access and Flow: - Value stream mapping exercise completed August 9 to identify areas of opportunity - Working groups being established to address standard work, ED P4R metrics, education and training CMAC: - The model is being discussed at the alternate destination steering committee Director of ED/MH in attendance - CMHA has submitted a proposal for funding	Transgender Health Program: - Meet with clinical stakeholders and dyad leaderships for program planning - Develop overview of program Expand Mental Health Community: - Identification of new CMAC location, in conjunction with CND-OHT - Recruitment of outpatient psychiatrist and increase outpatient MH access Introduce New Models of Care: - Introduce team nursing model on medicine - Align medicine physician model ED Access and Flow: - Focused assessment and VSM of ED flow and access - Deep dive into barriers to ED access and flow at COEC	No risk to report
2. Complete Board approved Master Plan by March, 2024	D. Boughton	**O - On Track**	- Waiting on AP to provide a revised cost and timeline based on an update to the current A and B wing information and adding Wing C and D departments that were missing from the original Plan	- Internal stakeholder review and revision of Master Plan - Revise Master Plan	No risk to report
3. Update original functional plan to align with current service levels by March, 2024	D. Boughton	**O - On Track**	- AP have provided a reasonable quote for the work and a PO will be issued - Timeline for the project has been identified to meet the expectation for a revised plan by the end of the Fiscal year	- Internal stakeholder review and revision of functional plan	No risk to report
4. Patient experience plan developed and Board approved by October, 2023 and begin implementing plan by March, 2024	M. Iromoto	**O - On Track**	- Plan presented to leadership team for feedback - Electronic feedback tool for plan has been sent to get feedback into final plan - Plan will be presented at PFAC, MAC, Quality Committee of the Board - Reviewed and updated PFAC Terms of Reference - Implemented Corporate Smudging Policy	- Continued implementation of PX plan initiatives including: recruitment of ConnectMyHealth specialist to support patient registrations; increased patient profiles through PX office; strengthened data collection and analysis using Qualtrics and R/L	R1) Current vacancy of PX Lead M1) In process of being filled to resume progress on initiatives

Legend:

- 🟢 **On Track- all quarterly deliverables achieved**
- 🔺 **Progressing to On Track - quarterly deliverables not achieved, action plan in place to achieve deliverables by next quarter**
- 🔴 **At Risk- quarterly deliverables not achieved, must be rescheduled across the remaining quarters to be successful, developing action plan**

Agenda

Status Report

Reimagine Community Health

STRATEGIC GOAL:

Goal 3: Leverage technology to transform how we deliver care by revolutionizing our Health Information Management Systems and Enterprise Resource Planning Systems by 2025

Strategic Deliverable	Executive Sponsor	Status	Achievements for Q2	Plan for Q3	Risk (R) and Mitigation (M) Strategy
1. HIS implementation plan created by March, 2024	M. Iromoto	**O - On Track**	- Pricing evaluations completed and progressed into negotiations with the preferred vendor - Implementation planning will continue upon material progress in negotiations, specifically around start date and scope	- Complete initial negotiations with preferred vendor including approved scope - Have clearly defined process for signing of contract OR transition to secondary vendor within CMH Executive and Board - Have communications plan developed for the announcement of the vendor and brand.	R1) The desired scope dictates an unsustainable budget. M1) Negotiation team developed to provide input and balance into decisions. Roadmap to be developed for functionality that is not attainable during initial implementation R2) Negotiations failing with preferred vendor M2) Remains as a risk throughout negotiations. Risk needs to be balanced with risk of entering into less than optimal contract
2. Complete all in year readiness activities required to proceed with ERP project by March, 2024	M. Iromoto	**Δ - Progressing to On Track**	- CMH has identified our top priorities for corporate solution investment - Feedback has been provided to Deloitte and GRH/SMGH, the formation of a regional steering group has been delayed due to GRH/SMGH's lack of response	- Development and approval of corporate solutions roadmap which supports staggered roll-out - Identification of concrete regional opportunities - Detailing of required integrations with HIS based on HIS scope	R1) CMH will delay work on the identified priorities due to focus on HIS M1) Project team continues to monitor, but no active mitigation at this point due to focus, budget, and change capacity of CMH. M2) Will consider how prioritized work would overlap with timing and key resources.

Legend:

- 🟢 On Track- all quarterly deliverables achieved
- 🔺 Progressing to On Track - quarterly deliverables not achieved, action plan in place to achieve deliverables by next quarter
- 🔶 At Risk- quarterly deliverables not achieved, must be rescheduled across the remaining quarters to be successful, developing action plan

Agenda

Status Report

Reimagine Community Health

STRATEGIC GOAL:

Goal 3: Leverage technology to transform how we deliver care by revolutionizing our Health Information Management Systems and Enterprise Resource Planning Systems by 2025

Strategic Deliverable	Executive Sponsor	Status	Achievements for Q2	Plan for Q3	Risk (R) and Mitigation (M) Strategy
3. Increase organizational capability to gain insight from data by improve data quality, access and governance by March, 2024	M. Iromoto	**O - On Track**	Data Governance / Data Quality: - Program Quality and Operations Council Terms of Reference refreshed and approved by Directors Council - Applied and received approval to be a Beta testing site for the HIMSS AMAM version 2 model beginning in November 2023 - COEC expanded to include surgical leadership and ED Leadership - Standard COEC scorecard and metrics developed to support education on PCOP, QBPs and core metrics - Standard data quality audits built into COEC Access / Use of Data: - Data content gaps address- patient experience and supply chain data integrated into data warehouse - Real-time command center dashboard and visualization created and displayed in clinical directors office - Use advanced statistical predictive modeling to create real-time ED wait-time clock -Invested in a Data Science Specialist Position to begin building internal capability and expertise for AI / ML and advanced analytics	Data Governance: - Finalize draft of multi-year Operational Excellence Plan Data Capability: - Build skill set to enable advanced analytic capabilities to enhance decision making using Machine Learning / Artificial Intelligence - Create ML / AI education session Data Quality / Access: - Plan to expand / promote use of front end speech recognition NLP with key physician groups Business Intelligence Infrastructure for ML / AI - Investigate and address server and computing needs of data analytics team (DS) to be able to deploy advance ML / AI applications / tools - Beta test large language model for generative AI and establish potential use cases	R1) Vacancy in Decision Support Team M1) Proceed with hiring to full complement

Legend:

- On Track- all quarterly deliverables achieved
- Progressing to On Track - quarterly deliverables not achieved, action plan in place to achieve deliverables by next quarter
- At Risk- quarterly deliverables not achieved, must be rescheduled across the remaining quarters to be successful, developing action plan

Agenda

Status Report

Increase Joy in Work

STRATEGIC GOAL:

Goal 4: Increase staff engagement measured through "overall ranking of CMH as a place to work" by increasing the Excellent and Very Good responses from 42% of responses to 48% of responses by 2024

Strategic Deliverable	Executive Sponsor	Status	Achievements for Q2	Plan for Q3	Risk (R) and Mitigation (M) Strategy
1. Implement corporate strategies for staff engagement including huddles and VBC refresh by March, 2024	S. Toth	**O - On Track**	- VBC rolled out to leaders - Five (5) educations sessions held for leaders, majority of leaders received training - Tracker required for leaders to update their completion targets by Sept., 2023 -employee engagement council meeting held September, 2023 to endorse -Corporate completion of 375 VBC's by March 31, 2023 - ACA refreshed and rolled out to leaders. Goal to have 100% submitted to HR by November 17, 2023.	- Continue leader education roll out - Monitor VBC completion rate with organizational target established - Talent Review Board reviews leader ACAs -Create user friendly reference tool for staff to assist in completing VBC's	R1) Huddle sustainability M1) PMO to attend huddles regularly and offer support M1) piloting electronic huddle board to streamline the process for gathering information and metrics given capacity constraints R2) Leader capacity to be trained M2) Consider alternative training dates and methods
2. Review and enhance recruitment and onboarding processes including HR support for leaders by March, 2024	S. Toth	**O - On Track**	- Partnership with Workforce Planning Board to pilot WIN (Workplace and Immigration Network) to provide coaching into hiring practices and promote DEI - Participation in Healthcare Excellence Canada's Innovation Challenge - Refreshed new hire survey sent at 7/30 days after hire and implemented three (3) suggestions - HR dashboard is available - Leveraged Ministry-funded recruitment programs, i.e. Clinical externs, clinical scholars, nursing new graduate initiatives -Recruitment workflow mapping and Applicant Tracking System review complete - Increased recruitment admin support with modified worker	- Onboard workflow mapping complete (Nov. 2023) - Survey of leaders – Recruit/Onboard (Oct. 2023) - Development/Delivery of 1 Recruitment Training Session for Leaders (Dec. 2023) - Recruit/Onboard upgrades/process changes Presentation to Leaders/Ops (Oct. 2023) - Weekly Hospital-Wide Orientation (Nov. 2023) - Onboarding Coach Program (Healthcare Excellence Canada Initiative) (Nov. 2023) - Student conversion program development – "Fast Pass" for exemplary students (ongoing) - New Employee Survey Plan – 1st 100 Days (Nov. 2023) - Create SOPs for Recruitment (Dec. 2023)	R1) Resources M1) Offered a 1-year contract to a project person in HR

Legend:

- On Track- all quarterly deliverables achieved
- Progressing to On Track - quarterly deliverables not achieved, action plan in place to achieve deliverables by next quarter
- At Risk- quarterly deliverables not achieved, must be rescheduled across the remaining quarters to be successful, developing action plan

Agenda

Status Report

Increase Joy in Work

STRATEGIC GOAL:

Goal 4: Increase staff engagement measured through "overall ranking of CMH as a place to work" by increasing the Excellent and Very Good responses from 42% of responses to 48% of responses by 2024

Strategic Deliverable	Executive Sponsor	Status	Achievements for Q2	Plan for Q3	Risk (R) and Mitigation (M) Strategy
3. Execute wellness initiatives for 23/24 by March, 2024	S. Toth	**O - On Track**	- Focus on Family friendly, budget friendly summer activities- July - August - Walks with Ember were offered as a healthy lunch-time activity (2x's a month) - Ice-cream Truck August 9 - In the Loop – themes Social (July/August) Intellectual (September – Participate in LEARN challenge)	- Your HealthSpace return for Hospital Wide Huddles - Rapid Relief Team – Onsite bar-b-que including hot/fresh nighttime service (Oct 26/27) - Active support of Wellness initiative through Accreditation Fair - Sustainable Waterloo Region on-site to promote environmental conservation during winter -Offer additional mental health first aid training to leaders	No risk to report
4. Execute Change Management strategy for 23/24 by March, 2024	P. Gaskin/ M. Iromoto	**Δ - Progressing to On Track**	- Attendance of Key Project Team Members (HIS, PMO) of current Change Management Offering: Guiding Organizational Change (GOC) - Evaluation conducted on current CMH offering (GOC) with goal to align to major change initiatives: HIS, Models of Care - Early collaboration initiated between Organizational Development, HIS team and PMO to assess stakeholder training needs/tools (Pre – During – Post change) - HIS Change/Comms lead started July 18 - Initial draft of HIS Change and Communications plan developed	- Outline developed for revised Change Management training, including toolkit for those experiencing change - Build out the material to support the new curriculum - Design rollout of curriculum and tools based on different change stakeholder groups - owners, implementers and receivers - Branding strategy for HIS project developed and completed for roll-out when required - Increased knowledge of HIS project across organization to support need for change -Identify and evaluate priority change initiatives	R1) Delayed start time due to resourcing M1) Resources now in place to execute as planned

Legend:

- On Track- all quarterly deliverables achieved
- Progressing to On Track - quarterly deliverables not achieved, action plan in place to achieve deliverables by next quarter
- At Risk- quarterly deliverables not achieved, must be rescheduled across the remaining quarters to be successful, developing action plan

Agenda

Status Report

Sustain Financial Health

STRATEGIC GOAL:

Goal 5: Grow ministry revenue by $22 million by achieving budgeted revenue in the multi-year financial plans by 2027

Strategic Deliverable	Executive Sponsor	Status	Achievements for Q2	Plan for Q3	Risk (R) and Mitigation (M) Strategy
1. Update multi-year financial and capital plans incorporating capital and ongoing operating costs to support new HIS and ERP by March, 2024	V. Smith-Sellers/ T. Clark	Δ - Progressing to On Track	- Started vendor negotiations and detailed review of HIS sales order - Developing multi-year financial plan components - Finalizing 24/25 budget process for both operating and capital budgets	- Capital plan will be updated during 24/25 budget process in the Fall	R1) Health Human Resource shortages M1) Mitigation is the recruitment and retention strategies- internships, new grads, clinical scholars
2. Establish budgeted volume targets to maximize PCOP funding for 24/25 and 25/26 by November, 2023	V. Smith-Sellers/ T. Clark	O - On Track	- Ongoing monitoring and view of 23/24 PCOP volumes vs. targets - Draft version of PCOP forecast for 24/25 to 27/28 completed; to be reviewed with Clinical team	- Forecast weighted cases and volumes for 24/25, incorporating assumptions from Clinical Services Growth Plan - Establish achievable and stretch budget goals - Board approval of PCOP budget for 24/25	No risk to report
3. Improve financial literacy within CMH leadership team by March, 2024	V. Smith-Sellers/ T. Clark	O - On Track	- Ongoing financial literacy discussions with managers during monthly variance meetings - Refined budget enhancement decision making spreadsheet	- Refresh and update Financials 101 presentation - Present Financials 101 to Operations Council/ MAC	No risk to report
4. Improve supply chain processes by March, 2024	J. Visocchi/ T. Clark	O - On Track	- First review of all current MMC contracts complete to identify gaps and opportunities - Savings associated with joining GPO contracts is approx. $232K - Changed distribution picking process and initiated cycle counting process which has reduced inventory discrepancies significantly.	- Register for new Ministry training for new BPSAA requirements coming into effect Jan. 1, 2024 - Completion of MMC BPSAA training for all buyers - Review rebate report from MMC to identify further revenue opportunities - Review and clean-up of pandemic inventory - Finalized OR substitute product list for problem vendors	No risk to report

Legend:

- On Track- all quarterly deliverables achieved
- Progressing to On Track - quarterly deliverables not achieved, action plan in place to achieve deliverables by next quarter
- At Risk- quarterly deliverables not achieved, must be rescheduled across the remaining quarters to be successful, developing action plan

Agenda

CMH Strategic Priorities Scorecard 2023/2024

Sustain Financial Health

Goal 5: Grow ministry revenue by $22 million by achieving budgeted revenue in the multi-year financial plans by 2027

Strategic Deliverable	Q1	Q2	Q3	Q4
1. Update multi-year financial and capital plans incorporating capital and ongoing operating costs to support new HIS and ERP by March, 2024	X - At Risk	Δ - Progressing to On Track		
2. Establish budgeted volume targets to maximize PCOP funding for 24/25 and 25/26 by November, 2023	O - On Track	O - On Track		
3. Improve financial literacy within CMH leadership team by March, 2024	O - On Track	O - On Track		
4. Improve supply chain processes by March, 2024	O - On Track	O - On Track		

Advance Health Equity

Goal 1: Ensure CMH is representative of the communities served and that the communities across Cambridge North Dumfries are receiving equitable care

Strategic Deliverable	Q1	Q2	Q3	Q4
1. Develop measurement tool and establish baseline for growth by October, 2023 and begin planning for how the measurement tool can be used to inform 24/25 initatives	O - On Track	O - On Track		
2. Execute DEI initiatives for 23/24 DEI Plan by March, 2024	O - On Track	Δ - Progressing to On Track		
3. RNAO BPG implementation – 2SLGBTQIA+ by March, 2024	O - On Track	O - On Track		
4. Develop Action Plan for Indigenous Wellness, Truth and Reconciliation by March, 2024	O - On Track	O - On Track		

Elevate Partnerships in Care

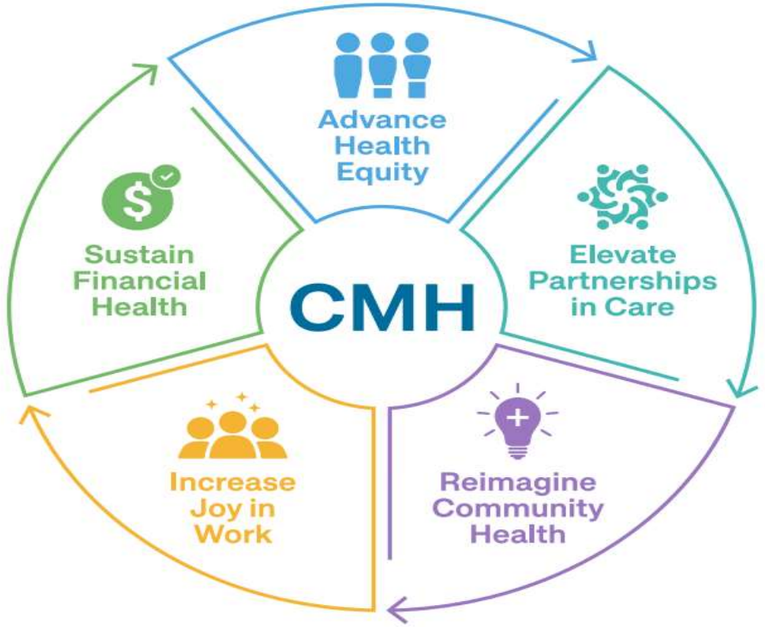
Goal 2: Grow our services by approximately 30% (Growth in beds) from baseline by 2026 (increase bed footprint to 200+ beds and achieve approximately 4800 incremental weighted cases)

Strategic Deliverable	Q1	Q2	Q3	Q4
1. Finalize clinical services growth plan by September, 2023 and begin to execute plan by March, 2024	O - On Track	O - On Track		
2. Complete Board approved Master Plan by March, 2024	O - On Track	O - On Track		
3. Update original functional plan to align with current service levels by March, 2024	O - On Track	O - On Track		
4. Patient experience plan developed and Board approved by October, 2023 and begin implementing plan by March, 2024	O - On Track	O - On Track		

Increase Joy in Work

Goal 4: Increase staff engagement measured through "over all ranking of CMH as a place work" by increasing the Excellent and Very Good responses from 42% of responses to 48% of responses by 2024

Strategic Deliverable	Q1	Q2	Q3	Q4
1. Implement corporate strategies for staff engagement including huddles and VBC refresh by March, 2024	O - On Track	O - On Track		
2. Review and enhance recruitment and onboarding processes including HR support for leaders by March, 2024	O - On Track	O - On Track		
3. Execute wellness initiatives for 23/24 by March, 2024	O - On Track	O - On Track		
4. Execute Change Management strategy for 23/24 by March, 2024	X - At Risk	Δ - Progressing to On Track		



Reimagine Community Health

Goal 3: Leverage technology to transform how we deliver care by revolutionizing our Health Information Management Systems and Enterprise Resource Planning Systems by 2025

Strategic Deliverable	Q1	Q2	Q3	Q4
1. HIS implementation plan created by March, 2024	O - On Track	O - On Track		
2. Complete all in year readiness activities required to proceed with ERP project by March, 2024	Δ - Progressing to On Track	Δ - Progressing to On Track		
3. Increase organizational capability to gain insight from data by improve data quality, access and governance by March, 2024	O - On Track	O - On Track		

Legend:

- 🟢 **On Track- all quarterly deliverables achieved**
- 🔺 **Progressing to On Track - quarterly deliverables not achieved, action plan in place to achieve deliverables by next quarter**
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Agenda

CMH Operational Indicators Scorecard 2023/2024

Sustain Financial Health

Goal 5: Grow ministry revenue by $22 million by achieving budgeted revenue in the multi-year financial plans by 2027

Operational goals / Indicators for 2023-2024:

Indicator	Target	Q1	Q2	Q3	Q4	Monthly Trend
Revenue- Achieve budgeted PCOP growth for 2023/2024 **(IRM)**	$13.4M (Annual) $3.4M per Quarter	$2,600,428	$2,536,254			
Revenue - Achieved-Quality Based Procedure Funding **(IRM)**	$22.2M (Annual) $5.5M per Quarter	$6,582,907	$5,991,483			
YTD Budget Variance	0	$169,000	$1,934,000			

Advance Health Equity

Goal 1: Ensure CMH is representative of the communities served and that the communities across Cambridge North Dumfries are receiving equitable care

Operational goals / Indicators for 2023-2024:

Indicator	Target	Q1	Q2	Q3	Q4	Monthly Trend
1. Repeat ED visits for MH care (4 or more in last 365 days) **(c-QIP)**	Quarterly / Annual <11 (Average per month)	12	11			

Elevate Partnerships in Care

Goal 2: Grow our services by approximately 30% (Growth in beds) from baseline by 2026 (increase bed footprint to 200+ beds and achieve approximately 4800 incremental weighted cases)

Operational goals / Indicators for 2023-2024:

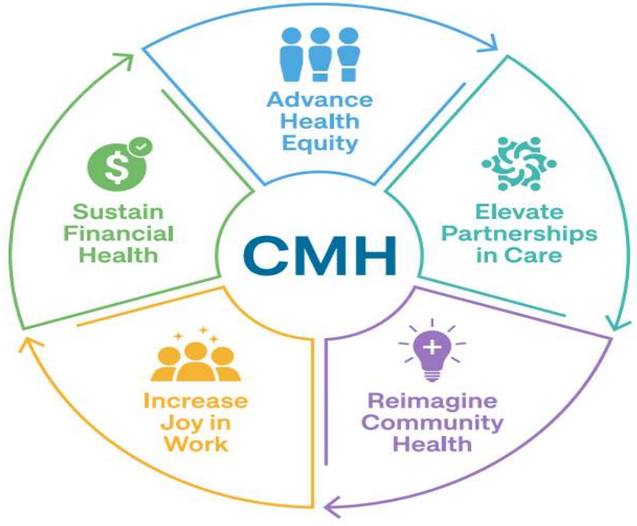
Indicator	Target	Q1	Q2	Q3	Q4	Monthly Trend
1. Access to care- ED Wait-time for in-patient bed **(IRM)**	Quarterly / Annual 90th%til < 36 hours	34.5	45.2			
2. Access to Care- ED Length of Stay Complex CTAS 1-3 **(IRM)**	Quarterly / Annual 90th%tile < 8 hours	9.6	9.6			
3. Access to Care- Percent ALC Days (closed cases) **(c-QIP)**	Quarterly / Annual 20%	23.6%	24.7%			

Increase Joy in Work

Goal 4: Increase staff engagement measured through "over all ranking of CMH as a place work" by increasing the Excellent and Very Good responses from 42% of responses to 48% of responses by 2024

Operational goals / Indicators for 2023-2024:

Indicator	Target	Q1	Q2	Q3	Q4	Monthly Trend
1. Overtime hours **(IRM)**	22208 Hours (Annual) 5552 Hours per Quarter	21,586	24,539			
2. Agency Hours Used **(IRM)**	0	7,402	6,384			



Reimagine Community Health

Goal 3: Leverage technology to transform how we deliver care by revolutionizing our Health Information Management Systems and Enterprise Resource Planning Systems by 2025

Operational goals / Indicators for 2023-2024:

Indicator	Target	Q1	Q2	Q3	Q4	Monthly Trend
1. % on track with HIS milestones	On Track	O - On Track	O - On Track			
2. % on track with ERP milestones	On Track	Δ - Progressing to On Track	Δ - Progressing to On Track			

Notes
Reporting Period- Q4 (Jan 2023- March 2023)
IRM- Integrated Risk Management
QIP = Quality Improvement Plan
Cqip= Collaborative Quality Improvement Plan

Legend:

- On Track- achieving performance target
- Progressing to On Track - within 10% of performance target
- At Risk- not meeting performance target

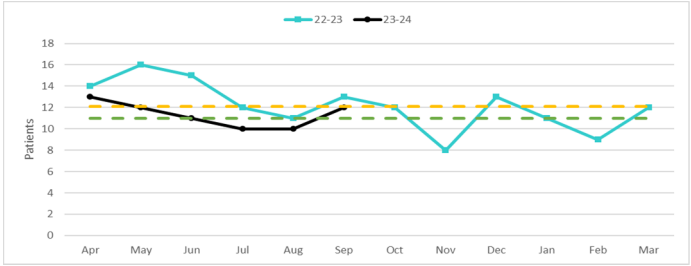
Indicator Update

Advance Health Equity

INDICATOR:

Repeat ED visits for MH Care (Average patients per month with four or more visits in 365 days)

	Target	Q1 (Apr - Jun)	Q2 (Jul - Sep)	Q3 (Oct - Dec)	Q4 (Jan - Mar)	Status
Performance	Quarterly / Annual <11 (Average per month)	12	11			O - On Track



Definition	Number of patients who have four or more repeat unscheduled visits to the emergency department in the last 12 months
Formula	Sum of the number of patients who visited the ED in the current month who had four or more visits in the last 12 months
Data Source	National Ambulatory Care Reporting System (NACRS)

Actions	Lead(s)	Status	Achievements for Q2	Plan for Q3	Risk (R) and Mitigation (M) Strategy
1. Community Mental Health and Addictions Clinic (CMAC) Pilot Project	D. Didimos/ Dr. Runnalls/ Dr. Sharma	**O - On Track**	- Complete	- Complete	No risk to report
2. CMH is continuing its support of the initiative in a more permanent space off-site of the hospital. ED diversion continues to be an important outcome as well as CMH work with EMS to work through the alternate destination point	D. Didimos/ Dr. Runnalls/ Dr. Sharma	**O - On Track**	- Monthly steering committee meetings continue for alternate destination - Selection of subcommittee working groups in progress	- Collaborating with Canadian Mental Health Association Waterloo Wellington (CMHAWW) on a project submission Finalizing Mission, Values and Vision Statement - Finalizing Sub Committee structure and objectives	No risk to report
3. Establish Process for managing cases	D. Didimos/ Dr. Runnalls/ Dr. Sharma	**Δ - Progressing to On Track**	- Internal environmental scan completed and high level gaps identified: currently 2 reports being sent to different stakeholders to flag patients revisits; no standard operating procedures for the development of care plans; no accessible care plan	- VSM planning meeting scheduled for Nov 20, 2023	R1) PMO Availability M1) PM support/ prioritization of PM initiatives

Legend:

- On Track- achieving performance target
- Progressing to On Track - within 10% of performance target
- At Risk- not meeting performance target

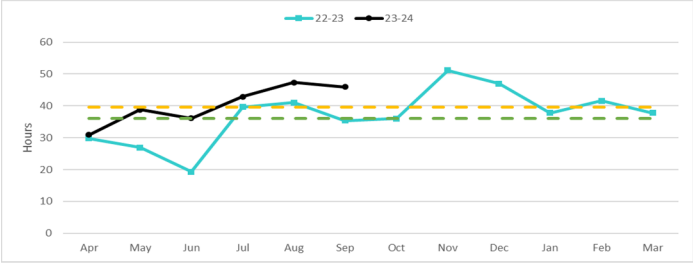
Indicator Update

Elevate Partnerships in Care

INDICATOR:

Access to care- ED Wait-time for IP Bed (IRM)

	Target	Q1 (Apr - Jun)	Q2 (Jul - Sep)	Q3 (Oct - Dec)	Q4 (Jan - Mar)	Status
Performance	Quarterly / Annual 90th%til < 36 hours	34.5	45.2			X - At Risk



Definition	The total time, in hours, that 9 out of 10 admitted patients spent waiting in the emergency department (ED) for a bed, calculated as the total time elapsed from disposition decision to when the patient left the ED.
Formula	(For admitted patients) The 90th percentile of left ED date time minus disposition decision date time.
Data Source	National Ambulatory Care Reporting System (NACRS)

Actions	Lead(s)	Status	Achievements for Q2	Plan for Q3	Risk (R) and Mitigation (M) Strategy
1. To optimize discharge of patients	A. McCulloch/ Dr. Legassie	Δ - Progressing to On Track	- Patient rounding with Manger Medicine and Director Medical Program - Re-established daily bullet rounds with multidisciplinary team - Development of Welcome to Medicine Program patient document	- Include physicians in Bullet Rounds - Establish weekly Grand Rounds for discussion patients with more complex discharge plans - Use of patient room whiteboards to communicate EDD and plan of care - Use of newly created Welcome to Medicine Document -COEC focus session on medical discharges in November 2023	R1) Not meeting medical discharges and time to bed rising M1) COEC focus on medical discharges
2. Re-establish Patient Flow Command Centre meetings monthly focusing on P4R metrics	K. Leslie/ Dr. Runnalls	Δ - Progressing to On Track	- Re-established patient flow- focused meetings as part of COEC refresh - Core metrics are shared through COEC	- COEC will continue to monitor and oversee patient flow metrics on monthly basis and provide guidance - COEC will work to establish top three improvement ideas for time bed	R1) Completing requests for DS support, data sources and refresh rates for backend data tables M1) Escalation not required at this time
3. Implementation / Optimization of Critical Care Stepdown Beds	A. McCulloch/ Dr. Nguyen	O - On Track	- New RPN role developed for Level 2 beds, positions posted for recruitment - Development of Level 2 admission criteria	- Finalize physician model - Continue recruitment to support program expansion - Confirmation of admission criteria - Operationalize 4 beds by end of Q3	No risk to report

Legend:

● On Track- achieving performance target

▲ Progressing to On Track - within 10% of performance target

◆ At Risk- not meeting performance target

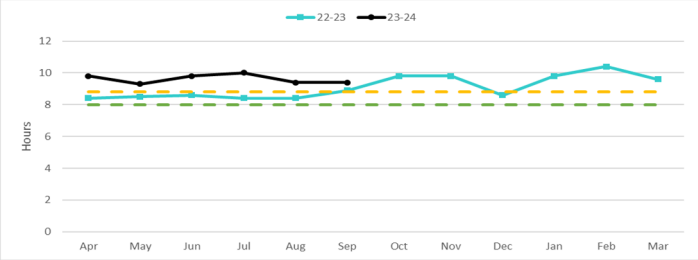
Indicator Update

Elevate Partnerships in Care

INDICATOR:

Access to care- ED LOS for CTAS 1-3

	Target	Q1 (Apr - Jun)	Q2 (Jul - Sep)	Q3 (Oct - Dec)	Q4 (Jan - Mar)	Status
Performance	Quarterly / Annual 90th%tile < 8 hours	9.6	9.6			X - At Risk



Definition	The total time, in hours, that 9 out of 10 high-urgency patients (CTAS 1-3) who were not admitted spent in the emergency department (ED), calculated as the total time elapsed from triage to when the patient left the ED. Excludes patients who left without being seen and cases with incomplete date and time stamps.
Formula	90 percentile of Date/Time Patient Left ED minus Triage/Registration Time, for non-admitted patients (discharge disposition code is not equal to 06 or 07) and where CTAS is equal to 1, 2, or 3.
Data Source	National Ambulatory Care Reporting System (NACRS)

Actions	Lead(s)	Status	Achievements for Q2	Plan for Q3	Risk (R) and Mitigation (M) Strategy
1. Process review of ED Flow	D. Didimos/ Dr. Runnalls	Δ - Progressing to On Track	- Staff identified 60 areas for improvement from VSM ranging from quick wins to major projects (EMS offload & Sub Acute sub value streams, ED Tracker improvements) - Physician presence in Sub Acute tracking initiated - Development of standard operating procedures (SOP) for each role in the ED - Charge Nurse and Flow Monitor SOPs completed - Wait Time Clock activated	- Plan to do deeper dive into specific target areas of focus, such as Sub Acute and EMS - Finalize attendees and date for Sub Acute process improvement session - Finalize attendees and date for EMS offload process improvement session - Increase hours of offload nurse to 24/7 from 11-23	R1) PMO resources engaged on many projects M1) Additional PM resources/ prioritization of PM projects R2) Availability of Physicians to attend value stream mapping session M2) Work with ED Chief on strategy to engage ED physicians
2. Optimization of Clinical Decision Unit	D. Didimos/ Dr. Runnalls	Δ - Progressing to On Track	- Compliant with CDU indicators for Q2 - Dashboard refreshed to reflect current CDU reporting methodology - Change in physician lead for CDU resulting in delay	- Optimization policy change proposal scheduled for November 16	R1) Availability of Physicians to attend value stream mapping session M1) Work with ED Chief on strategy to engage ED physicians R2) Physician lead vacancy for CDU M2) Meeting established to reassign lead roles for CDU
3. Increase awareness of performance	D. Didimos/ Dr. Runnalls	Δ - Progressing to On Track	- Developed monthly Physician scorecard to track key performance metrics specific to ED physicians - Education with ED staff for P4R metrics	- Leverage physician scorecard to provide real-time feedback on practice and identify potential opportunities for improvement	No risk to report

Legend:

- On Track- achieving performance target
- Progressing to On Track - within 10% of performance target
- At Risk- not meeting performance target

Agenda

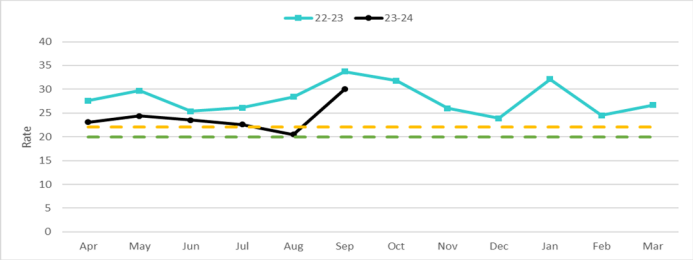
Indicator Update

Elevate Partnerships in Care

INDICATOR:

Access to Care- Percent ALC Days (closed cases) (c-QIP)

	Target	Q1 (Apr - Jun)	Q2 (Jul - Sep)	Q3 (Oct - Dec)	Q4 (Jan - Mar)	Status
Performance	Quarterly / Annual 20%	23.6%	24.7%			X - At Risk



Definition	The Alternate Level of Care (ALC) rate for closed cases is the sum of ALC patient days for discharged patients over the total patient days for patients discharged in the period. An ALC day is a day accrued by a patient who originally was admitted for acute care and has now completed the acute care phase of their care plan and is waiting for a more appropriate level of care placement while continuing to occupy an acute care bed.
Formula	The total number of ALC patient days divided by total patient days (excluding newborn/obstetrics), multiplied by 100
Data Source	Discharge Abstract Database (DAD)

Actions	Lead(s)	Status	Achievements for Q2	Plan for Q3	Risk (R) and Mitigation (M) Strategy
1. To optimize discharge of patients, aim for full complement of medical/ hospitalist physician staffing	A. McCulloch/ Dr. Legassie	**Δ - Progressing to On Track**	- Completed the A3, up to RCA - Completed site survey for leading practices - Reviewed recommendations from OH - WTIS data entry review and new process to ensure accuracy of data entry	- Develop and implement list of countermeasures, action plan - Completing education for front line staff and physicians - Hold first Cambridge Collaborative meeting in October -Cambridge Collaborative meeting held and scheduled monthly, new TOR developed, fishbone developed for root cause analysis - Achieve full complement of medical staff	No risk to report
2. Establishing relationships with regional partners	A. McCulloch/ Dr. Legassie	**O - On Track**	- Meetings with specific LTC/RH leadership with manager of HCCS and medicine to establish initial partnerships	- Hold first Cambridge Collaborative meeting in October	R1) ALC pressure is a system issue currently being experience d by hospitals M1) Continue to connect with Community partners and stakeholders to collaboratively address ALC pressures
3. One Team Approach	A. McCulloch/ Dr. Legassie	**Δ - Progressing to On Track**	- Initial meetings with Social Work and HCC - Review of current role descriptions and understanding of key accountabilities	- Continue to establish strong partnership between social work and HCCS	No risk to report

Legend:

- On Track- achieving performance target
- Progressing to On Track - within 10% of performance target
- At Risk- not meeting performance target

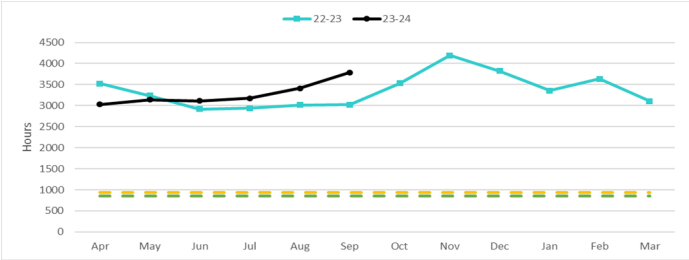
Indicator Update

Increase Joy in Work

INDICATOR:

Overtime Hours

	Target	Q1 (Apr - Jun)	Q2 (Jul - Sep)	Q3 (Oct - Dec)	Q4 (Jan - Mar)	Status
Performance	22208 Hours (Annual) 5552 Hours per Quarter	21,586	46,071			X - At Risk



Definition	This indicator measures the total overtime hours per month / quarter
Formula	The total sum of overtime hours per month / quarter
Data Source	Meditech Payroll

Actions	Lead(s)	Status	Achievements for Q2	Plan for Q3	Risk (R) and Mitigation (M) Strategy
1. Develop SOP to support student conversion practices and process	J. Backler	**O - On Track**	- In house delivery of preceptor training has been established and running three times/year (next sessions December 11, February 26, April 8) - Manually tracking conversions of students via Excel currently (28 students have been converted to staff since Fall 2022) - Working towards establishing a standard process to notify partnering institutions about current job postings/links - Working with managers to offer open positions to graduating students while they are students at the hospital and speaking to students about openings while they are completing their placements	- Develop standard automated tools with Decision Support to track conversion rates	No risk to report
2. Refresh and revise scheduling meetings with leader, HSW, Recruitment and Scheduler to plan for next schedule to optimize staffing	A. McCulloch/ A. Schrum	**O - On Track**	- All meetings with program leadership, HR,EHW and scheduler scheduled to occur prior to each schedule build - All schedules now electronic with access for all staff vis Teams	- Review of all Master Schedule templates to support OT initiative	No risk to report

Legend: ● On Track- achieving performance target ▲ Progressing to On Track - within 10% of performance target ◆ At Risk- not meeting performance target

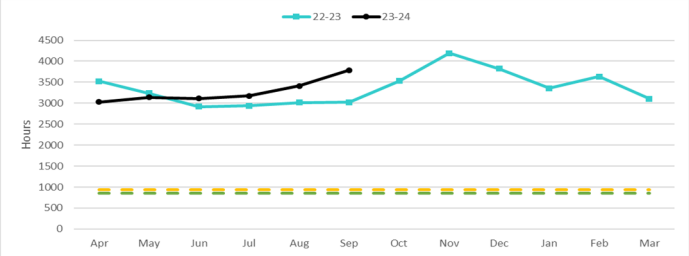
Indicator Update

Increase Joy in Work

INDICATOR:

Overtime Hours

	Target	Q1 (Apr - Jun)	Q2 (Jul - Sep)	Q3 (Oct - Dec)	Q4 (Jan - Mar)	Status
Performance	22208 Hours (Annual) 5552 Hours per Quarter	21,586	46,071			X - At Risk



Definition	This indicator measures the total overtime hours per month / quarter
Formula	The total sum of overtime hours per month / quarter
Data Source	Meditech Payroll

Actions	Lead(s)	Status	Achievements for Q2	Plan for Q3	Risk (R) and Mitigation (M) Strategy
3. Re-establish OT / staffing task force	S. Pearsall/ S. Toth/ K. Leslie	**O - On Track**	- Four (4) meetings with additional agencies to enhance ad hoc staffing - Renegotiated contract with current agency provider with $14/hour reduction on staff rates - Staff Force Committee established, key members are part of the task force - Cadence established as biweekly - Template to monitor staffing levels for Medicine, ED and ICU has been developed and will be reviewed at biweekly task force meetings	- Task for is planning to work on and monitor the following initiatives for Q3: 1) Plan for a "Why work at CMH campaign" social media and videos to showcase why CMH is an exceptional place to work- value proposition 2) Scheduling codes to help gain greater insights into reasons for OT 3) Audits of OT use for learning around what needs to be improved 4) Enhanced availability and reporting on staff leaves / short terms leaves for leaders	No risk to report
4. Refresh staffing office tools / master schedules	A. Schrum	**Δ - Progressing to On Track**	- Completed investigation of Meditech to determine staff that are templated - Developed a plan to ensure that all full time staff are templated in Meditech	- Training staffing office on how to use master schedule reports - Begin using master schedule tools from Meditech - Rollout electronic OT tracking form	R1) Limitations to functionality for Meditech M1) Address / plan for as part of ERP solution
5. Absence Reporting Processes & SOPs	S. Toth	**O - On Track**	- >90% of calls going through the new standardized system - all leaders (incl. on call leaders) have access to absence trending	- Continue to monitor compliance with the new tool	R1) Staff returning from leaves and have not received communications M1) Continued education required to ensure compliance with new process

Legend:

- On Track- achieving performance target
- Progressing to On Track - within 10% of performance target
- At Risk- not meeting performance target

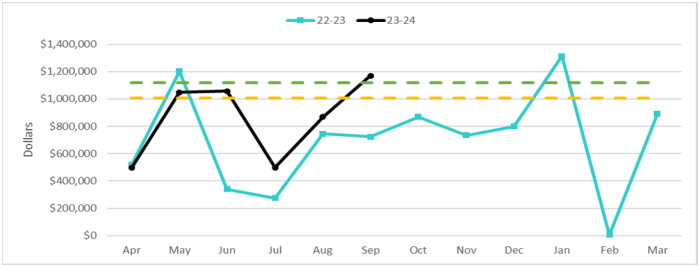
Indicator Update

Sustain Financial Health

INDICATOR:

Revenue- Achieve budgeted PCOP growth for 2023/2024 (IRM)

	Target	Q1 (Apr - Jun)	Q2 (Jul - Sep)	Q3 (Oct - Dec)	Q4 (Jan - Mar)	Status
Performance	$13.4M (Annual) $3.4M per Quarter	$ 2,600,428.00	$ 2,536,254.00			X - At Risk



Definition	Cambridge Memorial Hospital is currently eligible for Post Construction Operating Plan (PCOP) Funding. Our PCOP funding is awarded based on growth in volumes and weighted cases over and above our base year 2016
Formula	Current weighted cases achieved- base year 2016 weighted cases x funding rate for specific type of weighted case (note there are many inclusion and exclusion criteria to arrive at the final funded volumes) This indicator includes all PCOP buckets rolled-up
Data Source	Discharge Abstract Database (DAD), National Ambulatory Care Reporting System (NACRS), Meditech

Actions	Lead(s)	Status	Achievements for Q2	Plan for Q3	Risk (R) and Mitigation (M) Strategy
1. Surgical PCOP	K. Towes	**X - At Risk**	-Block tracking tool confirmed with implementation of use Nov 1, 2023 - Monitor block return by service - Grid reviewed, opportunities identified to maximize utilization working with DS to optimize and add a room for 24/25 - Investigation into current OR throughput challenges initiated, beginning to plan for recovery strategy for 23/24	- Physician recruitment – new General surgeon starting in Oct and another in Jan - Begin executing recovery plan for 2023/2024 to regain as much PCOP funding as possible by increasing throughput where possible - Begin establishing execution plan and surgical grid for 24/25	R1) OR closures in July due to moisture exposure related to Chiller incident impact OR Core Supplies M1) FMEA completed with mitigations identified for Chiller incident, Value Stream Map completed for OR Supply Management with action items identified R2) Medical leadership awareness and understanding of Surgical PCOP performance M2) Decision Support to attend monthly department meeting to provide updates on PCOP performance
2. Medical PCOP	A. McCulloch	**O - On Track**	- Continue to meet targets for weighted cases, -review of top HIG groups LOS, see work related to CBD and ALC	- Continue to monitor performance, see continued work with CBD and ALC	R1) ALC bed blocks resulting in impacts to flow M1) ALC Quality Improvement Project in-progress

Legend:

- On Track- achieving performance target
- Progressing to On Track - within 10% of performance target
- At Risk- not meeting performance target

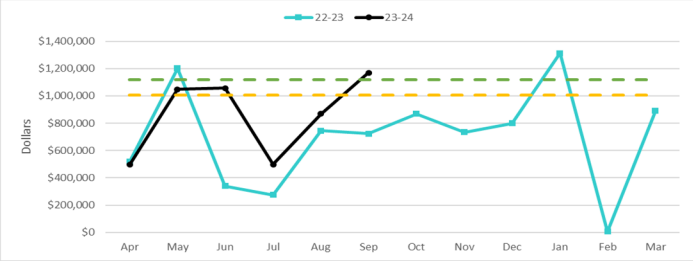
Indicator Update

Sustain Financial Health

INDICATOR:

Revenue- Achieve budgeted PCOP growth for 2023/2024 (IRM)

	Target	Q1 (Apr - Jun)	Q2 (Jul - Sep)	Q3 (Oct - Dec)	Q4 (Jan - Mar)	Status
Performance	$13.4M (Annual) $3.4M per Quarter	$ 2,600,428.00	$ 2,536,254.00			X - At Risk



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Formula	Current weighted cases achieved- base year 2016 weighted cases x funding rate for specific type of weighted case (note there are many inclusion and exclusion criteria to arrive at the final funded volumes) This indicator includes all PCOP buckets rolled-up
Data Source	Discharge Abstract Database (DAD), National Ambulatory Care Reporting System (NACRS), Meditech

Actions	Lead(s)	Status	Achievements for Q2	Plan for Q3	Risk (R) and Mitigation (M) Strategy
3. Mental Health PCOP	D. Didimos	X - At Risk	- No nursing vacancies in MH inpatient - Extended ECT to outpatient services - Working with OCEANS to switch referral process	- Developing admission criteria direct to inpatient versus PCU Work with Corporate Communications on updating MH on our external website	R1) Staff and Physician not ready for change M1) Leverage change management tools to enable engagement and adherence
4. ED PCOP	D. Didimos	X - At Risk	- Wait Time Clock active - Recruitment of 10 new nursing staff which will allows for the education of additional triage staff, decreasing door to registration times and ability to staff Subacute and other areas 24/7 - Model of Care review completed	- Develop Recruitment video - Left Without Being Seen policy/process revision meeting scheduled for November 15	R1) Wait times and LWBS M1) ED process improvement work to address wait times

Legend: On Track- achieving performance target | Progressing to On Track - within 10% of performance target | At Risk- not meeting performance target

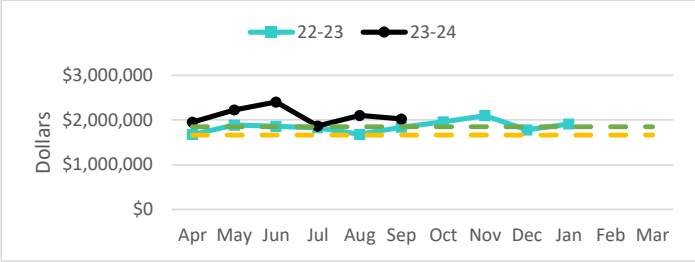
Indicator Update

Sustain Financial Health

INDICATOR:

Revenue- Achieved-Quality Based Procedure Funding (IRM)

	Target	Q1 (Apr - Jun)	Q2 (Jul - Sep)	Q3 (Oct - Dec)	Q4 (Jan - Mar)	Status
Performance	$22.2M (Annual) $5.5M per Quarter	$ 6,582,907.00	$ 5,991,483.00			O - On Track



Definition	The revenue achieved through all Quality Based Procedures, including Urgent Medical QBPs & Non-Urgent Surgical QBPs (OH), Systemic Treatment (CCO), GI Endoscopy (CCO), and Cancer Surgery (CCO).
Formula	The sum of revenue dollars, based on volumes achieved and funding rate.
Data Source	Discharge Abstract Database (DAD), National Ambulatory Care Reporting System (NACRS), Meditech

Actions	Lead(s)	Status	Achievements for Q2	Plan for Q3	Risk (R) and Mitigation (M) Strategy
Medical QBPs	A. McCulloch	**O - On Track**	- On track with budgeted volumes	- Continue to monitor	No risk to report
Surgical QBPs	K. Towes	**O - On Track**	- On track with budgeted volumes	- Continue to monitor	No risk to report

Legend:

- On Track- achieving performance target
- Progressing to On Track - within 10% of performance target
- At Risk- not meeting performance target

CMH Quality Monitoring Scorecard, FY2023/24

11-9-2023 10:17:17 AM

Quality Dimension	Indicator	Unit of	Prior Year	YTD	Target	Trend	Status	Period
Efficient	Conservable Days Rate	%	33.8	33.3	30.0		◆	Sep-23
	Overtime Hours - Average per pay period	hours	3,369.7	3,438.9	850.0		◆	Oct-23
	Sick Hours - Average per pay period	hours	3,774.5	3,099.0	2,090.0		◆	Oct-23
Integrated & Equitable	ALC Throughput	Ratio	0.9	0.9	1.0		◆	Sep-23
	Percent ALC Days (closed cases)	%	28.0	24.0	20.0		◆	Sep-23
	Repeat emergency department visits for Mental Health Care (Average patients	Patients	12.2	11.3	11.0		▲	Sep-23
Patient & People Focused	Organization Wide Vacancy Rate	%	10.4	8.6	12.0		●	Oct-23
Safe, Effective & Accessible	30 Day CHF Readmission Rate	%	15.3	23.1	14.0		◆	Aug-23
	30 Day COPD Readmission Rate	%	13.0	12.8	15.5		●	Aug-23
	30 Day In-Hospital Mortality Following Major Surgery	%	2.2	2.6	2.1		◆	Aug-23
	30 Day Medical Readmission Rate	%	10.8	8.4	13.6		●	Aug-23
	30 Day Obstetric Readmission Rate	%	1.2	0.6	1.1		●	Aug-23
	30 Day Overall Readmission Rate	%	7.5	5.9	9.1		●	Aug-23
	30 Day Paediatric Readmission Rate	%	8.4	3.5	6.1		●	Aug-23
	30 Day Surgical Readmission Rate	%	5.3	5.9	6.9		●	Aug-23
	ED Length of Stay for Admitted Patients (90% Spent Less, in Hours)	hours	49.1	51.2	44.0		◆	Sep-23
	ED Length of Stay for Non-Admitted Complex Patients (90% Spent Less, in Hours)	hours	9.1	9.6	8.0		◆	Sep-23
	ED Wait Time for Inpatient Bed (90% Spent Less, in Hours)	hours	40.5	42.5	36.0		◆	Sep-23
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours)	hours	6.3	6.8	4.0		◆	Sep-23
	Fall Rate	per 1000 PD	5.4	5.2	4.0		◆	Oct-23
	Hip Fracture Surgery Within 48 Hours	%	89.7	83.5	86.2		▲	Aug-23
	Hospital Standardized Mortality Ratio (HSMR)	Ratio	85.7	81.0	100.0		●	Aug-23
	In-Hospital Sepsis	per 1000 D/C	5.6	3.9	3.9		▲	Aug-23
	Long Waiters Waiting For All Surgical Procedures	%	48.4	28.4	20.0		◆	Sep-23
	Low-Risk Caesarean Sections	%	14.9	11.0	17.3		●	Aug-23
	Medication Error Rate	per 1000 PD	5.9	6.8	4.0		◆	Oct-23
	Medication Reconciliation at Admit	%	92.0	94.0	95.0		▲	Oct-23
	Medication Reconciliation at Discharge	%	91.0	95.0	95.0		●	Oct-23
	Obstetric Trauma (With Instrument)	%	15.3	5.4	14.6		●	Aug-23
	Revenue - Achieve budgeted PCOP growth for 2023/2024 (IRM)	$	8,411,329.0	$5,136,682	$6,923,910		◆	Sep-23
	Revenue - Achieve Quality Based Procedure Funding (IRM)	$	22,210,690.2	$12,574,391	$11,241,570		●	Sep-23

YTD Meeting Target ● 39%

YTD Within Target Threshold (within 10% of Target) ▲ 13%

YTD Exceeding Target Threshold ◆ 48%

CMH President & CEO Report
December 2023

This report provides a brief update on some key activities within CMH. Future reports will be aligned to the new Strategic Plan, 2022-2027. As always, I'm happy to answer questions and discuss issues within this report or other matters.

Ontario hospital first: AI used to detect low bone density in routine x-rays

- An exciting partnership between 16 Bit and Cambridge Memorial Hospital (CMH) has brought a state-of-the-art artificial intelligence enabled screening tool to the Region of Waterloo. It is the first time this technology has been deployed in an Ontario hospital setting for clinical use.
- Rho is an innovative, Health Canada approved, artificial intelligence-driven screening tool that assesses for low bone mineral density (BMD). Rho uses routinely acquired x-rays in patients aged 50+ years and analyzes them. If low BMD is detected, the system flags the patient's x-ray study for further review. Radiologists now have a powerful aide that can help them identify low bone density earlier, increasing the opportunity for further testing, earlier prevention and treatment.
- Osteopenia (low bone mass) and osteoporosis is a silent epidemic. Only about 22% of patients who are at risk for osteoporosis are ever screened with DXA, a specialized test for measuring bone mineral density. This gap can be bridged by proactively identifying patients that can benefit from DXA during routine x-ray exams.
- Rho is a tool that brings care closer to home and makes this advanced technology accessible to people in Cambridge, North Dumfries, and the Region of Waterloo. Good bone health also contributes to overall quality of life. By acting early, patients at risk of osteopenia lead can be helped to live full lives and avoid some of the fractures that might bring them to hospital.

Accreditation on-site visit

- We had an amazing week, November 6 through 9. Not only did our staff, physicians, midwives, and volunteers care for the 1000's of patients that came through our doors, we had four very determined Accreditation surveyors drop in for an intensive on-site visit. After eight tabletop exercises, 11 episodes of care, countless interviews and more than 3000 documents uploaded into the Accreditation Canada portal, we can say that we did very, very well - more than 99.7% well!!
- This was a true achievement and one that stated we were ready!

- It did not go unnoticed. Angela Coxe, lead Accreditation Canada Surveyor, summarized to senior leadership on the last day the impacts the people of CMH have on our community:
    - *"We heard that patients were proud to have a hospital of choice in their community. Some said they even traveled long distances to be treated by your staff. They told us they valued the compassionate care provided at CMH and the faster service. They told us of the support your staff provided them that went well beyond the transaction of medicine. They said that all of you – from leadership to the front line - understood what patients and their families needed when they came to CMH. You should be proud."*
- As for next steps, we wait.
- Accreditation Canada has received the surveyor's report and are in the process of reviewing. It is anticipated that by the end of November or beginning of December, we will be provided our official Accreditation status.

TGLN recognizes CMH for its conversion rate

- CMH was honoured to be recognized by Trillium Gift of Life (TGLN) with a Hospital Achievement Award. CMH is one of 25 to receive the Hospital Achievement Award - Provincial Conversion Rate.
- To receive this recognition, a hospital must reach a conversion rate that meets or exceeds the target of 63 percent set by Ontario Health (TGLN). The conversion rate is the percentage of potential organ donors (patients who die in a hospital setting and are deemed medically suitable for donation) who went on to become actual donors.
- This is our hospital's second award for exceeding the target conversion rate. CMH's rate was 75% for 2022-23.
- The Hospital Achievement Awards reflect the ongoing commitment Ontario Health (TGLN), and its hospital partners share in implementing leading donation practices, integrating donation as part of quality end-of-life care, and supporting a culture of donation in Ontario. Many thanks to Dr. David Cape, the ICU and all the staff that contributed to ensuring the wishes of potential donors are realized, honouring their selflessness and the legacy they intend to leave behind.

CMH Laboratory designated Choosing Blood Wisely

The *Choosing Blood Wisely* designation is an important initiative that prioritizes the thoughtful and efficient use of blood products at our hospital. The designation involves adopting evidence-based guidelines to ensure appropriate blood transfusions, while minimizing unnecessary risks and costs.

- By adhering to these guidelines, healthcare providers can enhance patient care by reducing the likelihood of adverse reactions and complications associated with blood transfusions. Furthermore, the initiative promotes resource efficiency, ensuring that blood products are allocated judiciously. Patients benefit from a more personalized and streamlined approach to their care, tailored to their medical needs. Ultimately, *Choosing Blood Wisely* improves overall healthcare quality, safety, and resource utilization.

- Congratulations to the Laboratory team and clinical staff throughout the hospital for all your hard work and for putting us one-step closer to achieving our goal of being a *Choosing Wisely* organization.

CND OHT partners share award

- The Association of Family Health Teams of Ontario (AFHTO) recognized Grandview Medical Centre and Two Rivers for their innovative partnership in identifying a community need for quick access to mental health and addiction services.
- The two Cambridge-based Family Health Teams collaborated with primary care and other CND OHT members, including CMH, to develop a Community Mental Health and Addictions Clinic or CMAC.
- Over an eight-week trial period, CMAC offered services to people of all ages in this vulnerable population providing equitable access to services that would have otherwise gone to the emergency department. CMAC served 123 unique clients in a CMH based clinic that also prevented 23 emergency department visits. The success of this pilot demonstrated the importance of integrated care in a community setting.
- Looking forward, the teams are wanting to continue CMAC services and are looking for partnership and funding opportunities.
- Congratulations on your well-deserved recognition!
- AFHTO's "Bright Lights" Awards recognize AFHTO members' leadership, outstanding work and the significant progress being made to improve the value inter-professional primary care teams across Ontario deliver.

Congratulations to Chamber Community Awards recipients

- On Nov. 13, the Cambridge Chamber of Commerce (Chamber) recognized the meaningful accomplishments of local not-for-profit sector and individuals that play a key role in Cambridge and North Dumfries.
- Ten awards were presented in several categories highlighting the valuable work undertaken by the volunteers and staff representing nearly 40 various organizations in terms of not only overall impact, but leadership, as well as collaboration.
- Of the ten awards, one went to past CMH Board Chair David Pyper and two for our dearest and closest affiliates, the CMH Foundation and CND OHT partner Langs.
- An independent group of judges selected recipients from among more than 60 nominations. The awards ceremony is one of the Chamber's most popular events and has honoured the contributions and achievements of community builders since 2012.
- David Pyper received the Board Member Award. This award is presented to a board member who have demonstrated outstanding service to a not-for-profit organization in City of Cambridge or Township of North Dumfries through the giving of their time, talents, and resources as a board member to further the goals and objectives of the organization. David served tirelessly on CMH's Board

of Directors for 11 years, retiring this past June. It's a well-deserved recognition for a person that worked hard for and helped shaped our local health care system. He continues to be an unabashed supporter for the hospital, for which we are truly grateful.

- CMH Foundation received the Best Event of the Year award. This award recognizes a group that has created an event or program which has made a significant impact that increased awareness and/or boosted the bottom line of the organization. The recipient of this award has worked tirelessly to ensure the quality of this event or program has left an indelible mark on their community.
- Langs Interprofessional Primary Outreach Team received the Community Impact People's Choice Award. This award recognizes new and better ways to address a need in the community despite the many demands, and sometimes too few resources available. Their efforts have a positive and meaningful impact on the broader community, resulting in clear and measurable change.
- Congratulations!

Nina Grealy joins the CMH Paws team

- In November, the CMH Paws Program welcomed Nina Grealy to the team.
- A key theme identified from a CMH Paws survey clearly indicated that staff wanted to see Ember more often.
- And with Nina now trained as an additional handler, it will now be possible to deploy Ember more often.
- Many thanks to staff that participated and offered suggestions to enhance the CMH Paws Program This survey yielded more interesting ideas, some of which will be implemented over the next few months.

ConnectMyHealth Health Records Patient Portal

- The Cambridge North Dumfries Ontario Health Team (CND OHT) in partnership with CMH invite all CMH personnel to register to the free ConnectMyHealth patient health records portal!
- ConnectMyHealth is a digital health solution developed by Hamilton Health Sciences that provides patients with an online, single access channel to view their integrated health records from 34 participating hospitals in Southwestern Ontario, including Cambridge Memorial Hospital.
- While registration is not mandatory, it is highly recommended for staff to better understand the registration process from a patient's perspective. By having this experience, staff and clinicians can offer the necessary guidance and empower patients to access their personal health files.
- As promotions and outreach roll out, it is quite likely CMH personnel will come into contact with a patient that may have questions about ConnectMyHealth
- By registering, can provide the necessary information and be empathetic toward the patient experience. Of course, they will also be set up to access and download their own health records!
- ConnectMyHealth can be used on desktops and mobile devices, and there is no cost to use it.

Wellness and Diversity at CMH

- Over the month of November and parts of October, the following were brought forward to help promote wellness and bring about a fair culture that embraces diversity, equity, and inclusion:
    - *Indigenous Veteran's Day* - National Indigenous Veterans Day was first observed on November 8, 1994, and has since been observed nationwide. The day is to recognize and acknowledge the many contributions and sacrifices of Indigenous Peoples in Canada's military service, particularly in the First World War, Second World War, and the Korean War. Indigenous peoples had to overcome many challenges to serve in uniform, which extended to their post-service life – for years, Indigenous military service was often overlooked and underappreciated.
    - *Louis Riel Day* - November 16 is Louis Riel Day. It is significant for the Métis people as the day commemorates the anniversary of Riel's execution in 1885. Riel made significant contributions for both Manitoba and Canada, fighting to protect the lands and rights of the Red River Métis. Riel was also the leader of two resistance movements
    - *World Hello Day* - World Hello Day is observed yearly on November 21as an encouragement to greet others with a smile and a friendly 'hello' to build connections and bring about peace.

Agenda Item 1.5.8

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			√				√	
	➢ Mid-year COS assessment input from Board				√				√	
	➢ Mid-year/Year-end CEO report and assessment	Executive			√					
	➢ Mid-year/Year-end COS report and assessment				√					
	➢ CEO evaluation/feedback – mid-year	Executive			√					
	➢ COS evaluation/feedback – mid-year				√					
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			√					
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		√			√		√
b-iii-c	➢ Approve annual Quality Improvement Plan (QIP)	Quality					√			

✓ = Due ND = Not Due C = Complete I = In progress D = Delayed 1 December 2023

Agenda Item 1.5.8

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				√ √ √ √	√ √ √			
b-iii-C	➢ Monitor performance indicators and progress toward achieving the quality improvement plan	Quality			√	√			√	
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-i-E	➢ Review the functioning of the Corporation, in relation to the objects of the Corporation the Bylaw, Legislation, and the HSAA	Governance	C		√	√		√		√
	➢ Receive and review the Corporate Scorecard	Board	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		√			√		√
	➢ Procedures to monitor and ensure compliance with applicable legislation and regulations	Audit							√	

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Agenda Item 1.5.8

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			√		√	
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	√	√	√	√	√	√
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	√ √	√ √	√ √	√ √	√ √	√ √
	Build Relationships									

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Agenda Item 1.5.8

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			√					
	Financial Viability									
h-i-A,C	➢ Review and approve multi-year capital strategy	Resources			√					
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				√	√			
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				√	√		√	
	➢ Affirm signing officers for upcoming year	Board								√
	➢ Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding	Resources			√				√	
	Board Effectiveness									

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Agenda Item 1.5.8

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		√	√	√	√	√	
	➢ Review Progress on ABCDE Goals *(Director & Chair meet during July/August to establish goals for upcoming Board cycle)*	Board			√		√			√
	Fundraising									
k	➢ Support fundraising initiatives including donor cultivation activities. *(through Foundation Report and Upcoming Events)*	Foundation	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 1.5.8
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			√					
	Recruitment									
n	➢ Approve interview team membership (noted in By-law)	Governance			√					
	➢ 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							√	√

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Agenda Item 1.5.8
BOARD WORK PLAN – 2023-24

ON GOING AS NEEDED

Charter Section #4	Charter Item	Action *(Italics-comments)*	Committee Responsible	Current Year 2022-23
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	

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Agenda Item 1.5.8
BOARD WORK PLAN – 2023-24

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 2019, next review 2022)	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 (2020-2023) to be approved by Board in 2021)	Board oversight Led by CEO

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Agenda

2023/24 Board of Directors Action Log – 28-11-2023 Agenda Item 1.5.9

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 CNH OHT evaluation process	P. Gaskin	In progress
04-10-2023	2.1 Patient Experience Plan	Management to incorporate a timeline to the 25 tactical ideas to track progress against the March 2027 completion date	L. Barefoot	**Completed – Information captured within the Corporate Strategic and Operational Priorities package**
04-10-2023	4.5.1 August 2023 Financial Statements	Management to follow up with HR to look at if CMH is currently seeing trends of WSIB increase now, the impact of further increases as CMH works to reduce agency staff	P. Gaskin	**Completed – Will be discussed under agenda item 3.1**

**Action logs are to be sent electronically to CMH Management after each meeting*
**Action logs should be included in the consent agenda of Committee meetings*
**Action logs should only contain items identified with an action for follow up or further work identified in the meeting minutes (not for regular meeting updates)*

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													
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		11		14		9				
Audit Committee 5:00pm - 6:30pm			13		22			22	27				
Executive Committee 5:00pm - 6:30pm	28		14				11		14				
OHT Joint Board Committee 5:30pm - 7:30pm - Virtual Zoom meeting	25	23	27	11	22	26	25	22	27	24			
2022-23 Events													
Staff Holiday Lunch - December 7, 2023 11am-2pm / 6-8pm				15									
Career Achievement - TBD													
Chamber Business Awards - November 13, 2023			13										

Board/Committee Meetings and Event Dates	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep (2024)
CMHF Diversity Dinner – October 3, 2023		3											
CMH Staff BBQ - TBD													
CMH Staff & Family Appreciation Day – TBD													
CMH Golf Invitational - TBD													
CMH Reveal - February 29, 2024						29							
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*													
● *Crucial Conversations*			15/16										
● *7 Habits of Highly Effective People - Nicola Melchers*				5/8									
● *Me2You DISC Profile - Diane Wilkinson*													
● *Quality Improvement*		6											
● *Guiding Organizational Change - Lynn Woeller*		11											
● *5 Choices*													
Mental Health First Aid													

IRM Mid-Year Executive Sponsor Update

Board of Directors

Report Compiled by: Liane Barefoot
Director Patient Experience, Quality, Risk, Privacy & IPAC

CMH

IRM OVERVIEW

IRM Overview

- Comprehensive process to evaluate all risk exposures confronting an organization
- Intended to minimize the siloed approach to risk management and mitigation
- CMH has had an IRM process in place since 2016 which it strives to continuously evaluate and evolve
- The 2023 (current) iteration includes linkage between identified IRM Risks & Operational Indicators in the quarterly Board & Committee packages
    - This slide deck is a cut/paste from the Q2 Strategic & Operational Indicators package allowing Executive Sponsors time to provide oversight committees with updates on the development and implementation of their mitigation plans & prediction for end of year status on the IRM Risks
- The 2024 iteration of the CMH IRM cycle will be improved by the addition of feedback from the Patient & Family Advisory Council (PFAC)

CMH

OVERVIEW

IRM Board & Committee Roles (Board Policy 2-C-20)

BOARD

Oversees the Hospital's risk management program as part of its duty to provide governance oversight and as stipulated by Accreditation Canada in the standard set for governance oversight of risk management.

AUDIT COMMITTEE

Has accountability, on behalf of the Board, to oversee the CMH integrated risk management framework and ensure that management has processes and tools in place that effectively identify risks to CMH and mechanisms to monitor plans to prevent and manage such risks.

BOARD COMMITTEES

Are responsible for overseeing risk management for their assigned risk category. This includes oversight of the development and implementation of mitigation strategies and action plans for identified risks within their applicable categories.

CMH

OVERVIEW

2023/24 – Top Risks, Executive Sponsor & Oversight Committee

Top Risk	Executive Sponsor	Operational Indicator(s)	Board Oversight Committee
Access to Care	Stephanie Pearsall Dr. Winnie Lee	ED Wait Time for Inpatient Bed ED LOS Complex CTAS 1 – 3	Quality Committee
Staffing Shortages	Susan Toth Stephanie Pearsall	Overtime hours Agency hours used	Resources Committee
Revenue Funding	Val Smith-Sellers	Achieve budgeted PCOP growth for 23/24 Achieve QBP funding	Resources Committee
Change & Project Management	Patrick Gaskin Mari Iromoto	Strategic milestones with operational metrics to be developed for Q4	Board of Directors

CMH

IRM – ACCESS TO CARE – STEPHANIE PEARSALL & DR. WINNIE LEE – QUALITY COMMITTEE

Operational Indicator	Target	Q1	Q2	Q3	Q4
1. Access to care- ED Wait-time for in-patient bed **(IRM)**	Quarterly / Annual 90th%til < 36 hours	35	45		
2. Access to Care- ED Length of Stay Complex CTAS 1-3 **(IRM)**	Quarterly / Annual 90th%tile < 8 hours	9.6	9.6		

Year End Prediction for IRM Risk: **RED**

Mitigation Strategy Highlights:

- Project Management Office engaged to facilitate value stream mapping session in ED as well as to conduct root cause analysis for conservable bed days
- Physicians to start attending daily discharge rounds
- Consistent use of patient in-room whiteboards to include an estimated date of discharge
- Optimization of critical care step down beds
- Re-implement public facing ED wait time clock
- Optimization of Clinical Decision Unit (CDU)
- Clinical Operational Excellence Committee (COEC) focused session planned on medical discharged in November 2023 and COEC will work to establish top three improvement ideas for time to bed

CMH

IRM – REVENUE & FUNDING – VAL SMITH-SELLERS – RESOURCES COMMITTEE

Operational Indicator	Target	Q1	Q2	Q3	Q4
Revenue- Achieve budgeted PCOP growth for 2023/2024 **(IRM)**	$13.4 million (Annual) / $3.4 million per Quarter	**$2,600,428**	**$2,536,254**		
Revenue - Achieved-Quality Based Procedure Funding **(IRM)**	$22.2 million (Annual) / $5.5 million per quarter	**$6,582,907**	**$5,991,483**		

Year End Prediction for IRM Risk: **RED**

Mitigation Strategy Highlights:

- Surgeon recruitment underway
- Master surgical block tracking tool developed, tracking for returned blocks and reallocation of blocks
- Surgical grid review underway to maximize utilization and throughput to recover in year PCOP and plan for 24/25 volumes
- Partnerships established to support surgical backlog – Endo / Cataracts
- Emergency department process improvement work to address wait-times and Left with out being seen (LWBS)
- Clinical Operational Excellence Committee – Monthly review of volumes and PCOP with discussion / feedback into barriers and challenges
- Decision Support attending Surgical Council to report volumes and weighted cases trends with surgeons for awareness and feedback
- Monthly weighted case and QBP reviewing meeting (Deep dive) with Clinical Directors, CNE, finance and Decision Support

CMH

IRM – STAFFING SHORTAGES –SUSAN TOTH & STEPHANIE PEARSALL – RESOURCES COMMITTEE

Operational Indicator	Target	Q1	Q2	Q3	Q4
1. Overtime hours **(IRM)**	< 22207 Hours (Annual) <5552 Hours (Quarterly)	**21,555**	**24,516**		
2. Agency Hours Used **(IRM)**	0	**7,402**	**6384**		

Year End Prediction for IRM Risk: **RED**

Mitigation Strategy Highlights:

- Ongoing staff recruitment and training
- Increased number of students moved to permanent positions
- Review of all Master Schedule templates
- Develop & implement net new scheduling codes for reasons for overtime
- Re-establish Overtime-Staffing task force
- Social media campaign “Why work at CMH”
- Development of ED staff recruitment video
- Development and implementation of recruitment and retention plan:
  - Refresh new hire survey
  - Refreshed Human Resources Dashboard
  - Leveraged Ministry Funded recruitment programs – clinical externs, clinical scholars, nursing new graduate initiatives
  - Recruitment workflow mapping and Applicant Tracking System review
  - Increased recruitment admin support with modified worker
  - Partnership with Workforce Planning Board to pilot WIN (Workplace and Immigration Network) to provide coaching into hiring practices and promote DEI

CMH

IRM – CHANGE MANAGEMENT STRATEGY – PATRICK GASKIN & MARI IROMOTO – BOARD OF DIRECTORS

Year End Prediction for IRM Risk: **YELLOW**

Mitigation Strategy Highlights:

- Evaluation of current Change Management Framework and tools
- Establish plan / outline for revised Change Management Training including toolkit
- Design rollout of curriculum and tools based on different change stakeholder groups-owners, implementers and receivers
- Initiate roll-out of curriculum in Q4
- Identify and evaluate priority change initiatives Q3/Q4
- Recruitment of Health Information System Change / Communications Lead completed
- Increased knowledge of HIS project across organization to support need for change

Annual Accessibility Plan Update 2023

Location / Area	Barrier	Solution	Responsibility	Target	2023 Update	2024-28 Priorities
Employment	Community Partners	Develop partnerships with community organizations to share ideas, resources, and knowledge.	Accessibility Committee	September 2023 New estimated target date: September 2024	Delayed. Connected with CMH DEI team members for additional community resources	Connect with various identified agencies. • Consult, as needed, other local Accessibility Committees who provide supports and works to enhance and improve community services for residents living with a disability • Book a community engagement volunteer (person that is blind/partially sighted) to deliver a presentation at the hospital in relation to sight loss and accessibility to help increase staff awareness and knowledge. Collaborating with CMH Professional Practice to book a lunch and learn session • Collaborate with individuals with lived disability experiences to obtain the most up to date information as to community supports, and to provide input when developing accessible programs or making accessibility changes • Collaborate with agency who provides support with home/vehicle modifications, assistive devices. This is a peer-to-peer volunteer service where a stroke patient with a lived experience supports a newly diagnosed patient transitioning back into the community
Employment	Community Partners	Develop partnerships with community organizations who support persons with disabilities in job searches.	Human Resources	January 2024	Due to staffing in HR, this work is scheduled to start in January 2024.	
Employment	Community Partners	Provide Mentorship support for job seekers e.g., coaching event.	Human Resources	January 2024		HR to connect with Communications
Employment	Recruitment	Increase knowledge of leaders regarding the hiring of persons with disabilities.	Human Resources	January 2024	• Online e-learn required course for all • Inclusive Job posting statement approved by DEI council embedded on all postings	HR to connect with Communications regarding information for weekly Managers & Operations meetings and internal website (CMHnet)

Annual Accessibility Plan Update 2023

Location / Area	Barrier	Solution	Responsibility	Target	2023 Update	2024-28 Priorities
					• Inclusive interview questions incorporated for staff, leaders and volunteers approved by DEI council • Unconscious Bias training conducted for all leaders and DEI council • Regular Wednesday weekly operations huddle DEI updates • Accommodation meetings held with leaders • Ergonomist contract in HR	
Employment	Accessibility Committee Terms of Reference	Review the current accessibility committee structure and include more community and staff members who have disabilities.	Accessibility Committee	Annually by May each year	Delayed due to unforeseen staffing absences	Added to next meeting's agenda (January 2024)
Information and Communication	Visibility of persons with disabilities	Increase the participation of persons with disabilities when creating CMH or program promotional opportunities.	Corporate Communications	July 2023 New target date: December 31, 2023	Delayed due to unforeseen staffing absences. DEI initiatives in partnership with communications are being implemented to address photographic representation of CMH personnel in promo materials. The project is called "CMH Smiles." It will be a photo repository that will be launched in December 2023.	
Information and Communication	Recruitment	Increase knowledge of leaders regarding the hiring of persons with disabilities.	Human Resources	August 2023 New target: March 31, 2024	• Online e-learn required course for all • Inclusive Job posting statement approved by DEI council embedded on all postings • Inclusive interview questions incorporated for staff, leaders and volunteers approved by DEI council • Unconscious Bias training conducted for all leaders and DEI council • Regular Wednesday weekly	HR to connect with Communications regarding information for weekly Managers & Operations meetings and internal website (CMHnet)

Annual Accessibility Plan Update 2023

Location / Area	Barrier	Solution	Responsibility	Target	2023 Update	2024-28 Priorities
					operations huddle DEI updates • Accommodation meetings held with leaders • Ergonomist contract in HR	
Information and Communication	General	Develop an information and communications campaign to share CMH's new multi-year Plan, including: • Communications broadcast reiterating the need and reason for CMH Accessibility Plan. • Email broadcast to reference Plan and link the current Plan on the CMH website.	Corporate Communications	April 2023	Completed. Accessibility messaging added to corporate communication when opportunity presents itself - i.e., internal construction alerts consistently address potential disruptions to accommodated parking and alternate sites. Another recent event was the implementation of VOYCE translations services which also offers American Sign Language to people that are deafened or hard of hearing. These are promoted internally and to the public through socials and website. Some broader, generic messaging has gone out to staff and social media channels, including when the board approved the current accessibility plan. CMH's website is up to date.	
Information and Communication	Policy Review	Review and update current CMH accessibility policies regarding current or changing regulations. Confirm the current policies still meet the requirements for accessibility and are aligned to our organizational goals.	Accessibility Committee	November 2023 New target: January 31, 2024	Delayed	Currently in progress. Being reviewed by internal stakeholders.
Information and Communication	Internal Signage and Wayfinding	Carry out a full review of the current wayfinding and Signage around the hospital paying special attention to the inclusion	Accessibility Committee	March 2024		

Annual Accessibility Plan Update 2023

Location / Area	Barrier	Solution	Responsibility	Target	2023 Update	2024-28 Priorities
		of Braille				
Information and Communication	Internet web site	Update the Cambridge Memorial Hospital customer websites with additional content and clarity	Corporate Communications	August 2023 New target: March 2024	CMH website is up to date.	New web site is delayed and slated to be on-line by March 2024. When published, it will provide more opportunities to engage and collect data from those that interact with the hospital through the web site.
Customer Service	AODA Training	As part of the initiation of the new multi-year Plan due to roll out in Jan 2023, undertake updated CMH Accessibility LMS learning module with staff.	Professional Practice	January 2023	Completed.	
Customer Service	AODA Training	Undertake a review of the AODA training provided as part of the CMH LMS system and confirm it addresses the current AODA requirements.	Accessibility Committee	July 2023 New target: June 2024	Patient Experience partnered with patient to create an instructional video for accessing Voyce when coming to the hospital and showcased the American Sign Language (ASL) feature in particular. This video was shared over social media and, on the intranet, to create awareness for both the community and staff regarding this service. About the video: Para, a CMH patient and deaf individual connected with Patient Experience to share her hospital visit story and challenges. Because of their support, Para kindly offered to help showcase how to access an ASL interpreter when arriving as a patient at CMH. https://youtu.be/VPP5iH9u140	Patient Experience would like to host 1-3 patients for a walkthrough related to accessibility during this time frame.
Customer Service	AODA Training	CMHAC terms of reference are revised every three years to ensure ongoing education of committee members.	Accessibility Committee	April 2025		

Annual Accessibility Plan Update 2023

Location / Area	Barrier	Solution	Responsibility	Target	2023 Update	2024-28 Priorities
Customer Service	Recruitment	Increase knowledge of leaders regarding the hiring of persons with disabilities.	Human Resources	August 2023	Completed • Online e-learn required course for all • Inclusive Job posting statement approved by DEI council embedded on all postings • Inclusive interview questions incorporated for staff, leaders and volunteers approved by DEI council • Unconscious Bias training conducted for all leaders and DEI council • Regular Wednesday weekly operations huddle DEI updates • Accommodation meetings held with leaders • Ergonomist contract in HR	
Built Environment	Capital Redevelopment Phase III	Review accessibility features / design of the inpatient wing with the involvement of community partners and AODA specialist Consultants considering best practice and AODA standards and guidelines.	CRP Planning	March 2025		
Built Environment	Accessible Washrooms	Carry out review of the current designated accessible washrooms focusing on those identified in the 2021 review and correct, if possible, any noted issues in respect to the current ADOA regulations.	Corporate Planning	April 2024		
Built Environment	Alarms, Alerts and Codes	Carry out a review of the current practice for alerts / alarms and codes to ensure that individuals	Facilities Management	April 2024		

Annual Accessibility Plan Update 2023

Location / Area	Barrier	Solution	Responsibility	Target	2023 Update	2024-28 Priorities
		who are hard of hearing are made aware using visual means. Implement findings of the review.				
Built Environment	Unknown Accessibility Barriers	Undertake an accessibility audit as has been undertaken in the past to identify any new or emerging issues; particularly as it relates to the completion of Phase 3 of the major Capital Redevelopment Renovation Project.	Facilities Management	Annually by March each year	Due to unforeseen circumstances this item was delayed and will now be addressed in the last quarter of this year's plan at which time more parts of the current redevelopment project will be completed	
Built Environment	Tactile Walking Surface Indicators (TWSI)	Carry out review of all means of egress, access, and paths of travel through the Hospital to identify where any areas require TWSI to be installed.	Facilities Management	April 2024		

Agenda

CAMBRIDGE MEMORIAL HOSPITAL

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Keeping People at the Heart of ALL we do

November 2023

Board Report

Accreditation – Ready Everyday

Diane Wilkinson, Sara Alvarado, Miles Lauzon, Nicola Melchers, Bill Conway, Julia Goyal, and Tom Dean joined CMH on site during accreditation week with the surveyors to take part in various focused group discussions.

Diane Wilkinson, Sara Alvarado, Miles Lauzon, Nicola Melchers, Paulo Brasil, Bill Conway, Julia Goyal, and Tom Dean joined CMH for the De-brief at the end of the week.

Thank you to the Board for your continued support and participation through the accreditation process!

Portering Huddle

Miles Lauzon spent some time with the Portering team on November 14, 2023. Miles was impressed with the ingenuity and extra effort of the porters in coping with the challenges resulting from disruptions of their normal travel routes caused by the renovations. Miles admits to be winded after accompanying porter Pedro Santiago for a fraction of the 20,000 steps made in Pedro's eight hour shift.

Women Take Charge

Monika Hempel joined CMH's Liane Barefoot at the October Women Take Charge event – a conversation with Fauzia Mazhar at Langdon Hall Country House. Fauzia has a big-picture outlook and a growth-focused mindset. She is a community builder and an engaged citizen, passionately bringing people and groups together to build a welcoming, inclusive, and safe community. Fauzia is also an optimist who likes a good laugh.

2023 Cambridge & North Dumfries Community Awards

The awards ceremony is one of the Chamber's most popular events and has honoured the contributions and achievements of these community builders since 2012. Julia Goyal and former Board Chair David Pyper were nominated for the Board Member award.

Board Award Recipient

David Pyper was the recipient of the 2023 Board Member Award. This award is presented to a board member who has demonstrated outstanding service to a not-for-profit organization through the giving of their time, talents, and resources as a board member to further goals and objectives of the organization. Way to go David!

Best Event of the Year Recipient

This award recognizes a group that has created an event or program which has made a significant impact which has increased awareness and/or boosted the bottom line of the organization. The recipient of this award has worked tirelessly to ensure the quality of this event or program has left a mark on the community – CMHF was the recipient for this award for the CMH Reveal.

Showing Support

Nicola Melchers, Miles Lauzon, Tom Dean, Monika Hemple, Sara Alvarado attended the event on November 13th to show their support.

Fundraising for MRI

This year, Sara Alvarado has teamed up with Board Chair Nicola Melchers and Vice Chair Lynn Woeller to walk to raise funds for the CMH MRI Campaign.

On June 9, 2024 Sara, Nicola and Lynn along with a group of 7 others will walk from Cambridge to Paris with two goals:

1. Raise awareness about hospital needs in the community
2. Raise funds for CMH and the new MRI

For more information or to donate go to:
[Sara Alvarado is fundraising for Cambridge Memorial Hospital Foundation (justgiving.com)]

Board Education >>>

Governance Essentials

Bill Conway, Paulo Brasil, and Jay Tulsani joined CMH's Stephanie Pearsall and Stephanie Fitzgerald for the OHA's Hospital Governance Essentials for New Directors course. This three-part virtual series aims to familiarize Board Directors with the legal and governance frameworks needed to govern effectively and support the development of good governance practices. This three part series took place in October 2023.

Guiding Organizational Change

On October 11, 2023, Lynn Woeller joined members from CMH for the Guiding Organization Change course offered through the CMH Learning Lab program. The focus of the learning was to understand the dynamics of change, executing change and the attributes of change agents.

final thoughts...

Never Events – Ontario Health

Ontario Health has announced the launch of the Never Events Hospital Reporting initative. Never events are a set of 15 preventable patient safety critical incidents that cause patient hard – and what is aimed to be reduced in Ontario's hospitals. Starting January 1, 2024 Ontario hospitals will be asked to begin the process of tracking and collecting quality improvement related information. Diane Wilkinson will be joining a webinar on December 4, 2023 which supports the launch of this work.

Good Morning Cambridge – A Conversation with Brian Riddell

On Tuesday November 7, Bill Conway attended the conversation with Brian Riddell highlighting labour shortages, lack of affordable housing and shortage of family physicians.

AFHTO Bright Lights Award

https://m.youtube.com/watch?v=CO6h7r6qKUE

CMHVA Annual Fall Meeting

Board Chair, Nicola Melchers joined the CMHVA at their Annual Meeting on November 23, 2023. Nicola brought greetings to the CMHVA on behalf of the CMH Board

Agenda

Meeting Evaluation Results

Please select the month of the meeting you are com...

September 1, 2023 *User entry error - These are October results*

Which Committee are you commenting on today

Board of Directors Meeting

To what degree were you satisfied with the dialogue and participation of the Committee/Board members on the key strategic issues?

Category	Weight	# of Responses
Strongly Satisfied	5.00	2
Weighted Average	**5.00**	2

To what degree were you satisfied that the meeting was conducted in a manner that encouraged;

Diversity of Perspectives

Category	Weight	# of Responses
Strongly Satisfied	5.00	1
Satisfied	4.00	1
Weighted Average	**4.50**	2

Open Communication

Category	Weight	# of Responses
Strongly Satisfied	5.00	2
Weighted Average	**5.00**	2

Meaningful Participation

Category	Weight	# of Responses
Strongly Satisfied	5.00	2
Weighted Average	**5.00**	2

Timely resolution of the issues

Category	Weight	# of Responses
Strongly Satisfied	5.00	2
Weighted Average	**5.00**	2

To what degree are you satisfied with the Committee's/Board's overall performance?

Category	Weight	# of Responses
Strongly Satisfied	5.00	2
Weighted Average	**5.00**	2

Agenda

Meeting Evaluation Results

Please select the month of the meeting you are com...

October 1, 2023

Which Committee are you commenting on today

Board of Directors Meeting

To what degree were you satisfied with the dialogue and participation of the Committee/Board members on the key strategic issues?

Category	Weight	# of Responses
Strongly Satisfied	5.00	4
Satisfied	4.00	2
Weighted Average	**4.67**	6

To what degree were you satisfied that the meeting was conducted in a manner that encouraged;

Diversity of Perspectives

Category	Weight	# of Responses
Strongly Satisfied	5.00	5
Satisfied	4.00	1
Weighted Average	**4.83**	6

Open Communication

Category	Weight	# of Responses
Strongly Satisfied	5.00	5
Satisfied	4.00	1
Weighted Average	**4.83**	6

Meaningful Participation

Category	Weight	# of Responses
Strongly Satisfied	5.00	4
Satisfied	4.00	2
Weighted Average	**4.67**	6

Timely resolution of the issues

Category	Weight	# of Responses
Strongly Satisfied	5.00	2
Satisfied	4.00	4
Weighted Average	**4.33**	6

To what degree are you satisfied with the Committee's/Board's overall performance?

Category	Weight	# of Responses
Strongly Satisfied	5.00	4
Satisfied	4.00	2
Weighted Average	**4.67**	6

Agenda

Meeting Evaluation Feedback

Please select the month of the meeting you are com...

September 1, 2023 *User entry error these are October Results*

Which Committee are you commenting on today

Board of Directors Meeting

Please provide any comments, concerns, or feedback you have in regard to the content of the meeting you are commenting on.

Very much appreciate the week's separation from the CRP / Resources meeting timing - much more time to prepare. Also, having a large Consent Agenda for Information-Only items is preferred. Well done. Good dialogue from Board Members for both meetings and it's obvious that hospital matters are being managed and measured effectively. Very pleased with the detail in the Financial Reports, especially with reconciling the CRP Budget and FEC - still some work to be done but there's a good path forward.

Please provide any suggestions on improving/changing the format of the meeting you are commenting on.

Meetings are still running a bit long - and I feel that some conversations could be curtailed somewhat to "move things along".

Agenda

Meeting Evaluation Feedback

Please select the month of the meeting you are com...

October 1, 2023

Which Committee are you commenting on today

Board of Directors Meeting

Please provide any comments, concerns, or feedback you have in regard to the content of the meeting you are commenting on.

Clear and concise briefing notes enable succinct reports in meetings. Shout out to Management and Staff for the continuing improvements.

I feel the agenda, topics and dialogue were productive and positive. The package was great and awesome to have it on Friday.

It is important for the Board to understand how CMH will pay for the $70M HIS, and if via debt that is not supported by a direct obligation from the Ministry of Health, how is this debt going to be repaid. Presumably this is an obligation of the Corporation, where board members are responsible.

Please provide any suggestions on improving/changing the format of the meeting you are commenting on.

If welcomed by the group, understanding scheduling balance/work/etc...to have a post meeting social opportunity to connect with each other and thank our executive branch for their amazing work and efforts to deliver. This may also be a great way to build our diversity awareness amongst our board.

Very good discussions and challenges being addressed, Thank you

Agenda

Meeting Evaluation Results

Please select the month of the meeting you are com...

Wednesday, November 01, 2023

Which Committee are y

Board of Directors Meeti

To what degree were you satisfied with the dialogue and participation of the Committee/Board members on the key strategic issues?

Category	Weight	# of Responses
Strongly Satisfied	5.00	6
Weighted Average	**5.00**	6

To what degree were you satisfied that the meeting was conducted in a manner that encouraged;

Diversity of Perspectives

Category	Weight	# of Responses
Strongly Satisfied	5.00	6
Weighted Average	**5.00**	6

Open Communication

Category	Weight	# of Responses
Strongly Satisfied	5.00	6
Weighted Average	**5.00**	6

Meaningful Participation

Category	Weight	# of Responses
Strongly Satisfied	5.00	6
Weighted Average	**5.00**	6

Timely resolution of the issues

Category	Weight	# of Responses
Strongly Satisfied	5.00	5
Satisfied	4.00	1
Weighted Average	**4.83**	6

To what degree are you satisfied with the Committee's/Board's overall performance?

Category	Weight	# of Responses
Strongly Satisfied	5.00	6
Weighted Average	**5.00**	6

Meeting Evaluation Feedback

Please select the month of the meeting you are com...

Wednesday, November 01, 2023

Which Committee are you commenting on today

Board of Directors Meeting

Please provide any comments, concerns, or feedback you have in regard to the content of the meeting you are commenting on.
The pre-meeting reading articles as well as all of the information presented in presentation and supported by speakers was well done and a good education session especially as a new member of the board
Excellent generative discussion on the Emergency Department. Kudos to Donna, Matt, Kyle and teams for their excellent work and commitment to improving the ED for patients and their families. Ethics Presentation was well done. I would have appreciated more time with Steve as he always provides insight and a great perspective to consider.
It was very enlightening and I really would love to get more touchpoints/followups/updates on the dashboard. It's such a powerful tool for CMH (not sure if I entirely understand it, but really look forward to reading more and understanding the barebones of it in own personal time)
Thank you for the ethnics based decision making process. What resonated with me were the words " collective wisdom by listening to your colleagues". Thank you to Dr. Runnalls and Donna Didimos for sharing a few insights into the ED. I appreciate the honesty that CMH could do a bit better in certain areas and those areas are under review. The quality scoreboard is a wonderful tool which much information and the dashboard reporting keeps us all focused on the goals and highlights areas of concern.
This was a great meeting. The Emergency Department generative discussion was excellent. To repeat what I said in the post adjournment session, I heard everything that I hoped I would hear: there is a focused, rigorous and continuing effort to understand and improve the process. I heard none of what I feared I might hear. Defenciveness, resignation or discourgment. It is good to know that we have someone of Steve Abdool's caliber as a resource.

Please provide any suggestions on improving/changing the format of the meeting you are commenting on.
None
Not applicable - it was wonderful!

BRIEFING NOTE

Date: November 8, 2023
Issue: Governance Committee Report to Board of Directors November 7, 2023 OPEN.
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Administrative Assistant
Approved by: Patrick Gaskin - President & CEO, Miles Lauzon - Governance Committee Chair

Attachments/Related Documents:

A meeting of the Governance Committee took place on Tuesday, November 7, 2023 at 1700 hours.

Attendees: M. Lauzon (Chair), J. Goyal, M. McKinnon, M. Protich, J. Stecho
A. Stewart, B. Conway

Staff Present: P. Gaskin, S. Pearsall

Regrets:

Committee Recommendations/Reports – Board Approval Sought

That, the Board of Directors approves the following policies as amended.

1-A-05 Board Statement of Culture
2-A-15 Capital Projects Sub-Committee Terms of Reference
2-C-40 Capital Projects – Change Order Approval Policy
2-D-02 Board Policy Development, Review and Approval
2-D-30 Board and Board Committee Orientation

That, the Board approve that registration of dissent will only be required at the Board of Directors level.

That, the Board of Directors appoint the following individuals as the interview team for the 2024-25 Committee member recruitment:

Miles Lauzon
Margaret McKinnon
Jody Stecho
Julia Goyal
Bill Conway
Milena Protich

Andrew Stewart
Community Member – TBD

Approved Committee Recommendations/Motions:

MOTION: (Protich/Goyal) that, 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: **CARRIED**

1-A-05 Board Statement of Culture
2-A-15 Capital Projects Sub-Committee Terms of Reference
2-C-40 Capital Projects – Change Order Approval Policy
2-D-02 Board Policy Development, Review and Approval
2-D-30 Board and Board Committee Orientation

MOTION: (Goyal/Stewart) that, following review and discussion of the information provided, the Governance Committee of the Board recommends to the Board of Directors that the process of registration of dissent only be required at the Board of Directors level.

Committee Motions/Recommendations/Report – Board Approval Not Sought

MOTION: (Protich/Stecho) **that,** the consent agenda be approved as circulated **CARRIED**

1.5.1 Minutes of September 19, 2023
1.5.2 Committee & Board Attendance Reports
1.5.3 Governance Work Plan
1.5.4 Policy Schedule Review
1.5.5 Action Log

Committee Matters – For information only.

1. **Welcome & Territorial Acknowledgement:** M. Lauzon welcomed the members to the meeting. B. Conway presented the Territorial Acknowledgement and provided personal reflections.
2. **Policy Reviews and Approvals:** This year the Governance committee pre-reviewed 16 CMH Board Policies prior to the beginning of the 2023/24 Board cycle. Management incorporated the feedback received as tracked changes and noted policies that require further discussion to address members questions. The committee reviewed and approved three of the four policies brought forward this meeting. Policy 2-D-21 Staff Member Recruitment to Quality Committee will be brought back to a future meeting. In addition to the pre-reviewed policies the Governance committee reviewed and approved two of four additional policies. 2-C-30 Financial Objectives and 2-C-34 require additional amendments and will be brought back to the Resources Committee and Governance Committee at a future date.
3. **Board/Committee Feedback Reports Review:** The Governance Committee reviewed the feedback reports from the September and October Board and Committee meetings. There were no concerns.
4. **Registration of Dissent:** The Governance Committee reviewed the standardized process for Directors to register dissent. A motion will be brought forward to the Board in agenda item 4.2.2 of the Board of Directors package.

5. **CMH Board Future Intentions Survey 2024/25:** The Committee reviewed the results of the 2024/25 Board and Committee Future Intentions survey. The survey was circulated early this year to align with the new recruitment timetable. All Directors have indicated the intent to return. Two non-directors have indicated their intent to retire from their committees at the end of the 2023/24 Board cycle.
6. **2024/25 Recruitment Strategies:** Based on the assumptions from the results of the Future Intentions survey the Governance Committee discussed the initial planning for the recruitment of non-directors. This year a targeted ad will be circulated looking for community members to join the CMH Board. Focus will be on social media ads, as well as targeted to indigenous publications and diversity networks.
7. **Diversity of the CMH Board:** To support DEI initiatives identified in September 2022, last year CMH added two skills to the matrix, Diversity Equity, and Inclusion and Environmental Social and Governance. A CMH Board Self Identification Survey (optional completion) was introduced and will be completed annually. The nominating committee advertised through two Indigenous partners recommended by a member of the Board. The Governance Committee reviewed the results from the most recent Self Identification Survey. A robust discussion took place. Committee members recognized the need for further education for the Board. Further information will be discussed in agenda item 4.2.4 of the Board of Directors package.
8. **Selection of Interview Team / Interview Dates:** The Governance Committee has recommended the 2024/25 interview team. A motion will be brought forward to the Board in agenda item 4.2.3 of the Board of Directors package.
9. **Bill S-211 An Act to Enact the Fighting Against Forced Labour and Child Labour in Supply Chains Act and to Amend the Customs Tariff:** The Governance Committee reviewed the OHA Backgrounder material provided by the OHA at the September 2023 meeting. The framework is set out by Bill S-211 to address the risk of forced labour and child labour in supply chains and consist of three key components including, entities subject to Bill S-211 obligations, annual reporting obligations, and enforcement powers and liability for failure to comply. With the upcoming January 1, 2024 effective date and the annual reporting obligations required to be submitted on or before May 31 of each year, Management has reached out to the legal and policy advisor of the OHA for any updated information that may be available. The OHA are having discussions internally with respect to how they may be able to support their members understand the new reporting obligations. CMH will continue to work with the OHA and provide the Governance committee with any current information as it becomes available to us.
10. **Bill 135: Convenient Care at Home Act 2023:** On October 4, 2023 the provincial government introduced Bill 135, Convenient Care at Home Act, 2023. The bill, if passed, is aimed at modernizing home care in Ontario and would amend the Connecting Care Act, 2019. The legislation proposes to consolidate the 14 Home and Community Care Services organizations into a single organization, named “Ontario Health at Home.” Ontario Health Teams would be made responsible for connecting people to home care services starting in 2025. The OHA has developed a backgrounder on the proposed bill, with additional details and context. The Ministry of Health (Ministry) has opened the proposed legislation to public consultation and has indicated that it is particularly interested in hearing about anticipated impacts of the proposed changes including operating and administrative costs or other concerns and challenges. The OHA will provide updates as they become available. CMH will continue to work with the OHA and provide the Governance committee with any current information as it becomes available.

BRIEFING NOTE

Date: November 8, 2023
Issue: Dissent of Director Process
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: None

Recommendation/Motion
That the Governance Committee recommends that following review and discussion of the information provided, the Board of Directors approve the process of registration of dissent only be required at the Board of Directors level.

Background
In June of 2023, the Board of Directors approved the updated CMH By-Law that was amended to comply with the new provisions set out by Ontario's New Not-for-Profit Corporations Act (ONCA).

Article 4, Section 4.9, Subsection (c) states
"A Director who was not present at a meeting at which a resolution was passed, or action taken is deemed to have consented to the resolution or action unless within seven days after becoming aware of the resolution, the Director:

i) Causes their dissent to be placed with the meeting minutes; or
ii) Submits their dissent to the corporation.

To comply with this requirement, in September 2023, CMH management implemented a standardized process for the Board and Committees of the Board for registration of dissent for Directors not present at meetings. A standard email message has been that outlines that the meeting minutes have been posted to the CMH Board Portal and are ready for review. A sample of that message is below.

Greetings Governance Committee members,

The draft minutes of the September 19, 2023 meeting are available for you to download from the CMH Board Portal:

https://www.cmh.org/user
(Please use your login credentials to access the information).

NEW For Directors Only*
For members of the committee who are Board members who did not attend the meeting, you are required to register any DISSENT to the motions passed by October 8, 2023 (7 days from date of this email)

As set out in Article 4, Section 4.9 (C)

A Director who was not present at a meeting at which a resolution was passed, or action taken is deemed to have consented to the resolution or action unless within seven days after becoming aware of the resolution, the Director:

causes their dissent to be placed with the meeting minutes; or

submits their dissent to the Corporation.

To register your dissent, please email the Committee Chair nozualam@gmail.com and the Administrative Support sfitzgerald@cmh.org

Analysis

After receiving feedback from the Chair of the Governance Committee and information provided at a recent OHA Governance Essentials course, management has an increased understanding of the provision within the By-Law. Registration of dissent is not required at a committee level. Although motions are passed, the motion is only a recommendation for board approval, not a resolution of the Board. Directors who are not present at a committee meeting will be made aware of the motion at the Board level and have the opportunity at that time to register their dissent. The Governance Committee considered two options:

1. Keep the process that was introduced in September at a committee level but include both Directors and non-Directors as good practice.
2. Remove the process at a committee level. Registration of dissent would only be practiced at the Board of Directors to comply with the provisions of the By-law.

The Committee agreed that the best approach would be to remove the requirement for registration of dissent at a committee level and only be required at the Board of Directors level.

BRIEFING NOTE

Date: November 8, 2023
Issue: Recommendations for 2024 Interview Team
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Administrative Assistant
Approved by: Miles Lauzon, Governance Committee Chair

Attachments/Related Documents: None

Recommendation/Motion

That the Board appoint the following individuals as the interview team for the 2024 Board and committee member recruitment:

1. Jody Stecho
2. Julia Goyal
3. Bill Conway
4. Margaret McKinnon
5. Milena Protich
6. Andrew Stewart
7. Miles Lauzon

Background

At the meeting of the Governance Committee on November 14, 2023, all members of the Governance Committee volunteered for the interview team for the 2024 Board and committee member recruitment. This will provide capacity to conduct, if necessary, a large number of interviews and permit having a broad range of perspectives in the evaluation process.

1. Jody Stecho
2. Julia Goyal
3. Bill Conway
4. Margaret McKinnon
5. Milena Protich
6. Andrew Stewart
7. Miles Lauzon

In addition to the above individual's hospital management will recruit a member from a partner organization, in efforts to have more diversification within our interview team, to participate in the process, if possible.

BRIEFING NOTE

Date: November 29, 2023
Issue: Board Education
Prepared for: Board of Directors
Purpose: ☐ Approval ☒ Discussion ☐ Information ☒ Seeking Direction
Prepared by: Stephanie Fitzgerald, Administrative Assistant
Approved by: Miles Lauzon – Governance Chair, Patrick Gaskin – President & CEO

Attachments/Related Documents: None

Background
At the November 7, 2023 Governance meeting, the Committee discussed the importance of future education for Board and Committee members to support the journey of developing a more diverse Board. The education is to help create a more inclusive, diverse, and equitable environment and foster an inclusive board meeting culture.

Next Steps
Three options for consideration are listed below. Input from the Board is sought.

Option 1 – To assign DEI education to the May 2024 Education/Generative session already scheduled. (90min of training/education)

Option 2 – To remove the May 2024 Board Education/Generative session and replace with the Unconscious Bias training course (full day training/education)

Option 3 – Add an additional date for Board/Committee members to attend the Unconscious Bias training course (Date TBD)

BRIEFING NOTE

Date: November 17, 2023
Issue: Quality Committee Report to Board of Directors November 15, 2023 OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Iris Anderson, Administrative Assistant to Clinical Programs
Approved by: Diane Wilkinson, Quality Committee Chair

Attachments/Related Documents: None

A meeting of the Quality Committee took place on Wednesday, November 15, 2023 at 0700 hours

Attendees:	D. Wilkinson (Chair), K. Abogadil, M. Adair, P. Brasil, C. Bulla, B. Conway, N. Gandhi, P. Gaskin, J. Goyal, M. Hempel, R. Howe, Dr. W. Lee , S. Pearsall
Staff Present:	L. Barefoot, M. Iromoto
Regrets:	A. McCarthy, T. Mohtsham
Observer:	S. Beckhoff
Guests:	E. Otterbein, Dr. K. Nuri, N. Evans, D. Boughton

Committee Recommendations/Reports – Board Approval Sought

None

Approved Committee Recommendations/Motions:

None

Committee Motions/Recommendations/Report – Board Approval Not Sought

MOTION: (Conway/Brasil) **that**, the consent agenda be approved, as circulated. **CARRIED**.

1.5.1. Minutes of October 18, 2023
1.5.2. Committee Attendance
1.5.3. 2023/24 Quality Committee Workplan
1.5.4. Trillium Gift of Life Network update
1.5.5. Emergency Preparedness – annual update

Committee Matters – For information only

1. **Trillium Gift of Life Network (TGLN):** A TGLN update was pre-circulated to the Quality Committee members, for information only (see Package 2). The briefing noted provided an update of the three publicly reported metrics: Routine Notification Rates, Conversion Rate, and Eligible Approach Rate.

2. **Emergency Preparedness:** A Year in Review updated was provided (see Package 2).
3. **Program Presentation: IPAC:** A program overview was provided (see Package 2). The IPAC Team has navigated through all challenges during pre-/post pandemic while making recommendations on construction and managing other new and emerging pathogens other than COVID, and assisting in situations of multiple Code Greys, Code Red and Code Green, and resumption of services as a result. An upcoming project for IPAC was discussed: HealthConnex – IPAC will be implementing a new software platform to allow easier tracking of isolation status, contract tracing, outbreak management and reporting. It was reported that IPAC staff have completed 90% of the annual target of hand hygiene observations (as of October 2023). Work is ongoing to identify strategies to enhance hand hygiene compliance.
   Program Presentation: EVS: A program overview was provided and summarized (see Package 2). N. Evans spoke of some challenges and changes the EVS team has been experienced: continued construction/ renovations have affected daily work, re-routing pathways due to closures, staffing challenges/turnovers and on-going recruitment.
4. **IRM In-year Progress:** L. Barefoot provided an update and noted that Board Committees are responsible for overseeing risk management for their assigned risk category. This includes oversight of the development and implementation of mitigation strategies and action plans for identified risks within their applicable categories. Top risks and the Quality Committee's role to oversight of Access to Care was discussed: 1) ED Wait Time for Inpatient Bed and 2) ED LOS. Ongoing collaboration with inpatient units is occurring to support patient flow. This indicator while sits with ED, it is an organizational indicator. CMH is working with community partners and reviewing what the hospital can influence internally. Other multiple strategies to improve the ED Wait Time metric are being considered such as fulsome staffing schedules in both ED and Medicine units. Decision Support Team is working on the accuracy of the ED Wait Clock feed. The information is based on an algorithm, and work is underway to refine the tracking.

5. **Accreditation:** L. Barefoot provided a verbal update of the preliminary Accreditation results. It was noted that four Accreditation Canada Surveyors were on-site from November 6-9, 2023 and reviewed priority processes and episodes of care. As in 2019, CMH voluntarily selected to have a patient surveyor (not required by Accreditation Canada). The patient surveyor met with eleven patients and their families. Accreditation Tabletop discussions were had. Several Board members participated in the meetings. One surveyor also attended a PFAC meeting. The Quality Committee members who participated shared their experiences. At the closing ceremony, it was reported that out of 1,700 standards assessed, CMH only missed four standards. This information was communicated to all staff. The final report should be received within fifteen business days.
6. **Corporate/Quality Metrics:** Ms. Barefoot provided an update on the Corporate/Metrics. Falls Rates and Medication Errors rates show an upward trend. Targets are based on previous year's performance. These indicators use our incident reporting data and is impacted by the reporting culture. There is continued work to strengthen reporting, which results in these indicators increasing.
7. **CNE Report:** Ms. Pearsall provided clinical programs update. The full CNE report is available in package two.

BRIEFING NOTE

Date: November 27, 2023
Issue: Audit Committee Report to Board of Directors November 20, 2023 OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Bonnie Collins, Administrative Assistant
Approved by: Monika Hempel – Chair, Valerie Smith-Sellers - Director Finance

Attachments/Related Documents:

A meeting of the Audit Committee took place on Monday, November 20, 2023 at 1700h

Present:	Monika Hempel (Chair), Bonita Bonn, Scott Merry, Brian Quigley, Chris Whiteley
Regrets:	Paulo Brasil, Roger Ma
Staff:	Patrick Gaskin, Lisa Costa, Rob Howe, Valerie Smith-Sellers
Guests:	

Committee Recommendations/Reports – Board Approval Sought

None.

Committee Motions/Recommendations/Report – Board Approval Not Sought

MOTION: (Whiteley/Merry) **that**, the consent agenda be approved as circulated. **CARRIED.**

1.5.1 Minutes of May 23, 2023
1.5.2 Audit Committee Attendance Report
1.5.3 Audit Committee Evaluation Results – May 2023
1.5.4 Action Log
1.5.5 Dangerous Goods Transportation Act Follow up

Committee Matters – For information only

1. **Public Sector Accounting Standards Update:** Three new accounting standards have taken effect in fiscal 2023-24:
   - PS 3160 Public Private Partnerships – does not apply to the CMH CRP; no impact to CMH financial statements;
   - PS 3400 Revenue – CMH is recognizing revenue in alignment with PS3400; no changes required to CMH financial statements;
   - PSG 8 Purchased Intangibles – CMH does not currently have any purchased intangible assets; no impact to CMH financial statements.

The Audit Committee requested a list of intangible assets. Management to bring forward a list of intangible assets to the January Audit Committee meeting. (For further information, please refer to package 2.)

2. **ONCA Update:** The Ontario Not-for-Profit Corporations Act (ONCA) has replaced the Ontario Corporations Act for hospitals, and CMH is required to confirm its compliance with ONCA to the Audit Committee by May 2024. Management reported that the work to ensure CMH's ONCA compliance is complete (all CMH bylaws and policies have been updated through the Governance Committee and the letters patent did not require amending), and reviewed items that will fall under the Audit Committee's purview. Management confirmed that the auditor has received invitations to all Audit Committee meetings in the 2023-24 Board cycle, as required. **(**For further information, please refer to package 2)

BRIEFING NOTE

Date: November 27, 2023
Issue: Capital Projects Sub-Committee Report to Board of Directors - November 2023 - OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kristen Hoch – Project Coordinator, Admin Assistant
Approved by: David Boughton – Senior Director, Capital Projects & Chief Redevelopment Officer; &
Tom Dean – Chair, Capital Projects Sub-Committee

Attachments/Related Documents: None

A meeting of the Capital Projects Sub-Committee took place on November 27, 2023 at 1700 hours.

Present:	Tom Dean (Chair), Miles Lauzon, Shannon Maier, Andrew McGinn, Jay Tulsani, Lynn Woeller
Regrets:	Horst Wohlgemut, Patrick Gaskin
Staff:	David Boughton, Bill Prokopowich, Valerie Smith-Sellers, Kristen Hoch

Committee Motions/Recommendations/Report – Resources Committee Approval Not Sought

THAT, items listed under consent agenda was review by the Sub-Committee members and the consent agenda was approved. **MOTION**: (McGinn / Lauzon) **CARRIED**

- Minutes of September 26, 2023
- Capital Projects Sub-Committee Attendance Report
- Action Log

Committee Matters – For information only

1. **Welcome**: The meeting was conducted virtually.

2. **Phase 3 Construction Update**:
   - Substantial completion date: 21-October-2024 (no change)
   - Turnover of Endoscopy (3-B305a) occurred at the end of October: milestone well received by staff and patients
   - Next area handed over to EllisDon was Periop & ENDO
   - Next critical path sequence is Nuc Med: anticipating turnover on schedule (16-February-2024)

- There are currently 12 active areas: critical path areas are being maintained; there is float time remaining in non-critical areas
- Average of 96 workers on site per day
- There was a fire in October:
    - Started at top of elevator shaft on roofing: removing old roof, putting in new; negative air being sucked out in construction areas, there was no smoke going up
    - Water damage to elevator shafts
    - No injuries
    - CMH responded well
    - Still under investigation to understand the extent of the damages for both CMH and EllisDon
- Work continues on Wing B roof
- Risk registry:
    - With the consultants, there issue regarding the Spect CT coring of hole for the unit was resolved
    - Other risks remain for visibility; resources remains a high priority risk which B. Prokopowich monitors on a regular basis
- There were no delays for the month of October

Committee discussion
Further discussion regarding the fire took place:

- A member commented that there have been two recent safety incidents (electrical and fire) sought further clarification on what started the fire. B. Prokopowich reported that a torch caught insulation. Monthly meetings between the CMH and EllisDon construction teams have been instituted to review safety infractions and determine what preventative measures are in place.
- Another member congratulated the hospital and its leadership on the response to the fire. Additionally, they asked what the estimated cost of the damages are. B. Prokopowich noted that we are currently unaware of the costs.
- The cost of the damage is insurable.
- Another member asked if all insulation is supposed to be fire rated. B. Prokopowich noted there was related smoke with the insulation.

A member commented that by having 12 active work areas this allows them to stay on site for longer when multiple work areas of the same nature. This helps maintain workers in multiple spaces; kudos to project team.

The CMH CRP Construction team meets weekly and do bi-weekly site walks. There are regular meetings with EllisDon. A different project management online system from IO was launched in early November. This online system is for project documentation which keeps and tracks change notices, change directives, change orders – everything is filtered through there to track and log progress. This is a project requirement from the Ministry. Documents have been backed up from the former system to the CMH network. Stantec is managing all current changes, and logging and tracking through the new system. The new system will become the permanent repository when the project is complete.

The Committee would like to acknowledge and thank Amanda & Alyssa for their CRP virtual tour video.

BRIEFING NOTE

Date: November 29, 2023
Issue: Resources Committee Report to Board of Directors November 27, 2023 OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Bonnie Collins, Administrative Assistant
Approved by: Lynn Woeller – Chair, Valerie Smith-Sellers - Director Finance

Attachments/Related Documents: None

A meeting of the Resources Committee took place on Monday, November 27, 2023 at 1900h

Present:	Lynn Woeller (Chair), Sara Alvarado, Tom Dean, Lori Peppler-Beechey, Janet Richter, Jay Tulsani, Gerry West
Regrets:	
Staff:	David Boughton, Lisa Costa, Kyle Leslie, Stephanie Pearsall, Valerie Smith-Sellers, Susan Toth
Guests:	

Committee Recommendations/Reports – Board Approval Sought

THAT, following review and discussion of the information provided, the Board receives the October 2023 financial statements as presented by management.

Approved Committee Recommendations/Motions:

THAT, following review and discussion of the information provided, the Resources Committee of the Board recommends that the Board of Directors receives the October 2023 financial statements as presented by management. (Woeller/Peppler-Beechey) **CARRIED.**

Committee Motions/Recommendations/Report – Board Approval Not Sought

THAT, the items on the consent agenda be approved as circulated. (Alvarado/Tulsani) **CARRIED.**

1.5.1 Minutes of September 26, 2023
1.5.2 Resources Committee Attendance Report
1.5.3 Action Log

Committee Matters – For information only

1. **October 2023 Financial Statements and Year-End Forecast:** In October, CMH reported a $1.9M year-to-date deficit position after building amortization and related capital grants. The major drivers of the deficit were the unfavourable variance in salaries and benefits ($8.1M) and lower PCOP revenue achieved than planned ($2.4M). This was partially offset by the favourable variances in the unused portion of the budgeted contingency ($2.3M), QBPs ($2.1M), interest income ($2.1M), Bill 124 ONA Reopener Awards ($2.0M), recovery of Cancer Care Ontario (CCO) reimbursement of oncology drugs ($1.3M), Billable Patient Services ($1.0M) and Wait-Time CT / MRI ($0.4M). Management is forecasting a balanced budget by the end of the fiscal year, based on the assumption that the Ministry will fully offset the incremental impact of Bill 124. (Agenda Item 4.6.2)
2. **Q2 Capital Equipment Spending:** Management highlighted the details of the Q2 capital spending report. The HIRF exceptional circumstances application was successful, and CMH has received $3.3M in additional 2023-24 HIRF funding. This funding will be used to complete the wing B roof repairs, and a few other HIRF related projects this fiscal year.
3. **Q2 Corporate Scorecard:** Management reviewed the Q2 strategic and operational priorities results with the Committee. Overall, the large majority of deliverables within the Strategic Priorities Scorecard are on track, while some have improved from red to yellow status. There are two operational priorities indicators that are meeting or exceeding performance targets – QBP funding and repeat ED visits for Mental Health care. Pressures persist for several other operational priorities. Mitigation strategies were outlined in the scorecard.
4. **2-C-32 Resource Protection and Liability Policy Review:** The Resource Protection and Liability Policy was reviewed with the Resources Committee. Management highlighted suggested changes. The Committee then recommended some additional changes. The updated policy will be forwarded to the Governance Committee for review and approval once all changes are incorporated.
5. **Integrated Risk Management Priorities Update:** L. Costa introduced the ongoing IRM work at CMH. The current iteration of the CMH IRM process includes the linkage between identified risks and operational indicators, and feedback from the Patient and Family Advisory Council (PFAC).
   The Resources Committee is responsible for overseeing the staffing shortages risk and the revenue and funding risk. The revenue and funding risk is related to PCOP and QBP revenue. The PCOP status is currently in “red”, and risk to CMH not achieving budgeted revenue was discussed extensively earlier in the meeting. CMH is currently meeting QBP targets, and is expected to continue meeting those targets through Q3 and Q4. The mitigation strategies and ongoing work for the staffing shortages risk were included in the briefing note. The Committee agreed that the revenue and funding risk and the staff shortages risk had been discussed adequately earlier during the meeting, and that no further discussion was required.
6. **Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding – Certificate of Compliance:** The certificate of compliance for the Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding was presented to the Committee for information; CMH is in compliance, with no exceptions.
7. **Q2 CEO Certification of Compliance:** The CEO Certificate of Compliance was presented to the Committee for information, with no exceptions.
8. **Resources Committee Work Plan:** The work plan for 2023-24 was reviewed and the November requirements were noted as complete.

BRIEFING NOTE

Date: November 22, 2023
Issue: October 2023 Financial Statements
Prepared for: Resources Committee
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Valerie Smith-Sellers, Director, Finance & Interim CFO
Approved by: Patrick Gaskin, President & CEO

Attachments / Related Documents: Financial Statements - October 2023

Alignment with CMH Priorities

2022-2027 Strategic Plan No ☐	2023-24 CMH Priorities No ☐	2023-24 Integrated Risk Management Priorities No ☐
☐ Elevate Partnerships in Care	☐ Ensure Equitable Care For CND Residents	☐ Change / Project Management
☐ Advance Health Equity	☐ Grow Clinical Services	
☐ Increase Joy In Work	☐ Increase Staff Engagement	☐ Staff Shortages
☐ Reimagine Community Health	☐ HIS/ERP Planning and Implementation	☐ Access to Care
☒ Sustain Financial Health	☒ Grow Ministry Revenue	☒ Revenue & Funding

Recommendation/Motion

Resources Committee
Following review and discussion of the information provided, the Resources Committee of the Board recommends that the Board of Directors receive the October 2023 financial statements as presented by management.

Board
Following review and discussion of the information provided, the Board receives the October 2023 financial statements as presented by management.

Executive Summary

Cambridge Memorial Hospital (CMH) has a $1.9M year-to-date deficit position at the end of October after building amortization and related capital grants. The major drivers of the deficit are the unfavourable variance in salaries & benefits ($8.1M) and lower PCOP revenue achieved than planned ($2.4M). This is partially offset by the favourable variances in the unused portion of the budgeted contingency ($2.3M), QBPs ($2.1M), interest income ($2.1M), Bill 124 ONA Reopener Awards ($2.0M), recovery of Cancer Care Ontario (CCO) reimbursement of oncology drugs ($1.3M), Billable Patient Services ($1.0M) and Wait-Time CT / MRI ($0.4M).

Risks

- If CMH had not received incremental bed funding and used PCOP funding to operate the incremental beds, a $6.9M deficit would have been reported October YTD, due to lower weighted case volumes than budgeted for in 2023-24.

- CMH did not meet PCOP targets October YTD driven by lower weighted cases in emergency and surgery. This fall, the OR's have been closed for a total of 5 days due to water and equipment issues. As a result, PCOP funding tied to surgical volume growth is currently not being achieved. The risks of further decline have been mitigated by engaging a third-party short term to ensure CMH has necessary sterilized tools to perform surgical procedures.
- ALC patients create bed flow pressures and generate low weighted cases putting volume targets at risk. On average there have been 37 ALC patients in 2023-24.
- Inflationary pressures are being experienced across all expense lines in particular Food Services and Supplies.
- CMH has renewed fixed price contract with Blackstone Energy Services for 60% of its budgeted consumption of natural gas starting November 2023, ending October 2024.
- The Ministry of Health (MOH) has not completed broad base funding reconciliations for incremental COVID funding the hospital received in 2021-22 and 2022-23. The Finance department has followed MOH guidelines for incremental funding, but there is a risk that MOH will apply rules associated with the guidelines differently, leading to the claw back of some of this funding.
- Bill 124 reopener clause allows unions the ability to re-negotiate the wages increase for the past three years that were capped at 1%. In 2022-23, CMH has set up a $5.2M wage accrual for the retroactive salary costs. In October 2023, CMH received payment of $2.0M for the ONA re-opener retro payments from April 1, 2020 to March 31, 2023.
- As of September 11, 2023, MOH has acknowledged the fiscal pressures from recent arbitration awards for years 2020-21 to 2023-24 and its intention to provide the required supplemental funding. No funding amount has been confirmed.

Summary

CMH has a $1.9M year-to-date deficit position at the end of October after building amortization and related capital grants. Actual results are $1.3M unfavourable to budget. The fiscal budget favourable variance is driven by:

- $2.3M allocation of the budgeted contingency to the end of October;
- $2.1M in Quality Based Procedures (QBP) revenue due to increased hip, knee, shoulder, cardiac, spine and Cancer Care Ontario surgeries;
- $2.1M in interest income;
- $2.0M in Bill 124 ONA Reopener Awards;
- $1.2M in OHIP Professional Fees;
- $0.8M in MOH Base funding received compared to budgeted.

The favourable variance has been partially offset by:

- $6.9M unfavourable variance in salaries and wages due to higher overtime than budget and use of staffing agencies;
- $2.4M in loss of expected PCOP revenue relating to 2023-24; due to lower than budgeted surgical cases, operational slowdown, and cancellation of procedures.
- $1.2M unfavourable in the benefits in lieu due to part time workers working higher hours.

PCOP & Quality Based Procedures Volumes

The achievement of volume base funding targets is critical to the hospital's long-term financial health. Growing volumes during the extended pandemic period has been very challenging for all hospitals eligible to earn volume-based funding. PCOP and QBP indicators are included in the hospital's corporate scorecard to monitor performance against budgeted targets.

<u>PCOP</u>

PCOP acute inpatient weighted cases has the biggest funding implication for the hospital. Each weighted case generates $4,517 in funding. The 523 weighted case shortfall through October represents a $2.4M loss in funding. The main reasons to the shortfall are lower weighted cases seen in surgical program, operational slowdown, and cancellation of procedures. CMH has an operational slowdown from the last week of July to the first week of August, an OR humidity incident in July and 5 days of closure in September / October related to equipment issues that imposed necessary cancellations. In addition, Emergency experienced lower patient volumes and did not meet PCOP targets October YTD.

The hospital has budgeted to receive $11.1M in PCOP clinical funding in 2023-24, just over 58% of the available $19.3M PCOP funding allocation. Funding recognition is dependent on meeting volume targets. $4.1M of PCOP revenue associated with clinical volumes has been recognized for 2023-24. The YTD shortfall is attributed to the decline in surgical weighted cases and ED not meeting volume targets creating a $2.4M unfavourable variance.

QBP

The hospital is exceeding performance for Ontario Health (OH) and Cancer Care Ontario (CCO) QBPs. Each QBP is funded at a different rate and has specific volume target.

Urgent Medical, Bundled Care and Surgical total revenue was $2.1M favourable to budget due to higher numbers of hip, knee and shoulder replacement surgeries, hip fracture surgeries, heart failure procedures and spinal operations.

Cancer Care Ontario (CCO) QBP revenue was $438K favourable to budget, due to higher numbers of breast surgeries, gynecology procedures and endoscopy procedures.

Performance Based Funding Summary 2023-24
YTD Period: September

Funding Source	Unit of Measure	Budget	YTD Budget	YTD Achieved	YTD Variance from Budget
PCOP					
Acute IP	Weighted Cases	8,370	4,185	5,113	928
Day Surgery/TCC	Weighted Cases	2,491	1,246	1,160	(86)
Emergency	Weighted Cases	2,833	1,417	1,247	(169)
Mental Health IP	Inpatient Days	8,029	4,015	3,817	(198)
QBP					
OH Urgent Medical	Cases	540	270	290	20
OH Bundled Care	Cases	857	429	542	114
OH Surgical	Cases	2,911	1,456	1,724	269
CCO	Cases	470	235	272	37

MOH Funding – Onetime / Other

The MOH confirmed $11.2M in incremental bed funding for 2023-24 will be part of base funding to continue additional bed capacity. CMH is receiving funding for 22 acute medical / surgical beds. The budget reflects this funding and is the main reason the hospital is not in a larger deficit position year to date.

The MOH confirmed one-time funding for the Health Human Resources (HHR) program of $657K which funds clinical externs, clinical mentor, and clinical preceptor. Total funds allocated will have 100% expense in offset.

The MOH confirmed one-time funding for the Clinical Care Nurse Training program of $332K which funds critical care and neonatal care nurse training for new registered nurses and mid-career registered nurses. Total funds allocated will have 100% expense in offset.

The MOH confirmed one time in year allocation of $229K for CT and MRI hours to reduce wait time.

The funding model for the Pay for results (P4R) program in the Emergency Department has changed for 2023-24, resulting in revenue decrease of $220K.

MOH Wait Time funding to operate additional CT & MRI hours resulted in a $363K favourable variance to budget. Funding model is changing for current fiscal year pending further details from the Ministry.

Billable Patient Services
The $1.0M year to date favourable variance is primarily due to a $1.2M favourable variance in professional fees (partially offset by higher medical remuneration costs), $139K favourable uninsured residents of Ontario, $127K favourable non residents, and $58K favourable variance for insured self pay. The favourable variance is partially offset by unfavourable variances in technical fees ($301K), funding from the Workplace Safety and Insurance Board (WSIB) ($129K), and preferred accommodation ($87K).

Recoveries and Other Revenue
The $3.5M year to date favourable variance is driven by $2.1M favourable variance in interest income, $1.3M recovery of Cancer Care Ontario (CCO) reimbursement of oncology drugs.

Expenses

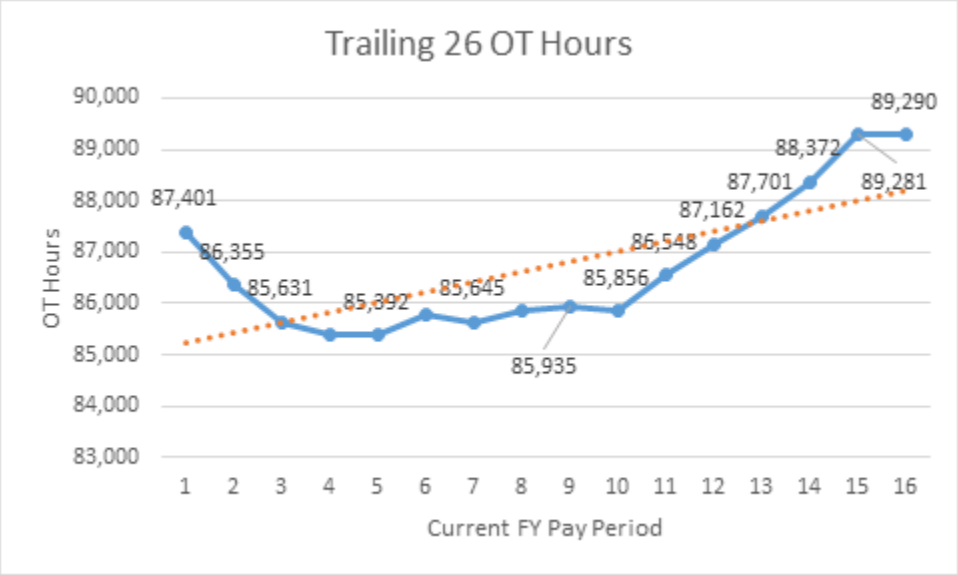
Salaries and Wages
The shortage of health human resources in Ontario has created staffing pressures in many areas across the organization. Salaries and wages were $6.9M unfavourable to budget year to date. The unfavorable variance drivers are Overtime ($2.7M), agency staffing costs ($1.8M), staff training costs ($1.2M), shift premium ($0.3M), modified work ($0.3M), sick ($0.3M), Purchased Services ($0.1M), and Special Projects ($0.1M).

Overtime costs were ($578K) unfavourable to budget in October, increasing the year-to-date unfavourable variance to ($2.7M). Sick time costs were ($87K) unfavourable to budget, resulting in a year-to-date unfavourable variance of ($314K). At CMH, ONA nurses are guaranteed four hours of pay at two-times their regular hourly rate when they are called in to work or called back from standby. This practice will continue to put budgetary pressure in the short term as we phase out the use of agency nurses.

Overtime and sick time hours are summarized in the table below:

	October 2023			FY 2023-24		
HOURS	**Actual**	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**
Overtime	9,726	1,928	(7,798)	53,855	13,289	(40,565)
Sick	7,798	4,170	(3,628)	47,685	28,803	(18,882)

The overtime variance is driven by staffing shortages creating high level of vacancies. The chart below is the current fiscal year overtime trailing report. The solid blue line identifies the actual results from the last 16 pay periods. The orange dotted line identifies the upward trend seen within the last 16 pay periods.



Employee Benefits
The $1.2 M unfavourable year to date variance is driven by the benefits in lieu provided to part times which is a result of part time workers working higher hours and a 14% increase in benefit plan premiums.

Medical Remuneration
The $975K unfavourable year to date variance is due to additional professional services for CT (computerized tomography) and MRI (magnetic resonance imaging) ($724K), Oncology Associates ($172K), In-Patient Hospitalists ($165K), and Hospital on Call Coverage New services ($158K). There is funding to offset these variances.

Medical and Surgical Supplies
The $0.6M YTD unfavourable variance has been driven by supplies needed for the elective surgeries ($375K), higher volumes in Endoscopy ($121K), MRI / CT ($77K) and Laboratory purchases ($56K).

Drug Expense
The $1.6M YTD unfavourable variance is driven by expensing ($395K) chemo medication waste from the room temperature malfunction. In addition, higher spending on drugs for the Oncology program ($1.2M) and the Emergency Department ($60K). 97% of oncology drug costs are reimbursed by Cancer Care Ontario.

Other Supplies and Expenses

The $1.2M YTD favourable variance is due to the unused contingency allocation of $2.3M, however it is offset by increased MDRD off-site equipment sterilization cost of $0.3M caused by water leakage incidents and operational issues, price increase for Lifelabs services $0.3M, $0.1M Professional Fees for HIS, water expense $0.1M, and maintenance repairs $0.1M.

Balance Sheet and Statement of Cash

CMH's current cash position is $101.9M, consisting of $80.2M of unrestricted cash and $21.7M of restricted cash. Accounts payable balance at the end of October was $53.8M, consisting of General Accounts Payable ($38.0M) and MOH Payable ($17.8M). Unrestricted working capital available at the end of October is $12.5M.

The working capital ratio is 1.14 and meets the requirements of the Hospital Service Accountability Agreement (H-SAA) target.

Forecast

CMH is forecasting a balanced position for 2023-24.

Higher than budget revenue in QBP ($3.5M), Interest income ($3.5M), budgeted contingency ($3.2M) and MOH one-time funding ($2.0M) for ONA Bill 124 retroactive wage settlement offset the unfavourable variances in Overtime ($4.6M), PCOP ($4.0M), Agency staffing ($2.4M) and Medical supplies ($1.2M).

Included in the forecast is MOH one-time revenue of $7.8M to fully offset the 2023-24 incremental wage impact of Bill 124 arbitration awards. CMH has submitted an application to the Ministry for this funding. Confirmation of the funding is not expected until February 2024 with cash flow anticipated before year end.

The MOH is currently reconciling the PCOP funding for 2021-22 and 2022-23. The hospital is expecting a favourable result that will create a one-time funding source to be invested in building infrastructure, service recovery and growth planning.

Cambridge Memorial Hospital
Statement of Income and Expense
For the period ending October 31, 2023

Confidential
(Expressed in thousands of dollars)

Month of October 31, 2023					Year to Date				23/24	2023-24		2022-23 Prior Year Actuals		
Actual	Plan	Variance	% Variance		YTD Actual	YTD Plan	YTD Variance	% Variance	Forecast	Plan	Variance	Oct. 2022	YTD Oct. 2022	2022-23 YE
				Revenue:										
				MOH Funding										
$ 7,971	$ 7,893	$ 78	1%	MOH - Base	$ 55,265	$ 54,485	$ 780	1%	$ 93,970	$ 93,185	$ 785	$ 7,731	$ 57,730	$ 90,924
2,001	1,901	100	5%	MOH - Quality Based Procedure	14,777	12,653	2,124	17%	24,919	21,434	3,485	2,105	12,903	24,124
1,083	937	146	16%	MOH - Post Construction Operating Plan	4,101	6,468	(2,367)	(37%)	7,031	11,062	(4,031)	334	2,413	9,901
4,101	1,654	2,447	148%	MOH - One time / Other	15,221	11,421	3,800	33%	33,208	19,533	13,675	1,639	10,758	29,486
15,156	12,385	2,771	22%	Total MOH Funding	89,364	85,027	4,337	5%	**159,128**	**145,214**	**13,914**	11,809	83,804	154,435
1,405	1,221	184	15%	Billable Patient Services	9,439	8,428	1,011	12%	16,180	14,414	1,766	1,333	8,972	15,669
1,367	1,143	224	20%	Recoveries and Other Revenue	11,427	7,890	3,537	45%	19,907	14,537	5,370	1,221	9,561	17,840
336	251	85	34%	Amortization of Deferred Equipment Capital Grants	2,305	1,736	569	33%	3,951	2,968	983	300	1,898	3,527
335	283	52	18%	MOH Special Votes Revenue	2,215	1,954	261	13%	3,370	3,370	-	409	2,075	3,910
18,599	**15,283**	**3,316**	**22%**	**Total Revenue**	**114,750**	**105,035**	**9,715**	**9%**	**202,536**	**180,503**	**22,033**	**15,072**	**106,310**	**195,381**
				Operating Expenses:										
8,596	6,777	(1,819)	(27%)	Salaries & Wages	53,708	46,754	(6,954)	(15%)	91,456	79,964	(11,492)	7,045	46,720	86,194
2,033	1,696	(337)	(20%)	Employee Benefits	13,983	12,831	(1,152)	(9%)	24,851	21,929	(2,922)	1,687	12,247	20,785
1,664	1,615	(49)	(3%)	Medical Remuneration	12,139	11,165	(974)	(9%)	20,810	19,133	(1,677)	1,675	12,627	22,602
1,278	1,056	(222)	(21%)	Medical & Surgical Supplies	7,946	7,288	(658)	(9%)	13,606	12,464	(1,142)	973	6,702	11,842
1,108	824	(284)	(34%)	Drug Expense	7,272	5,688	(1,584)	(28%)	12,527	9,727	(2,800)	816	5,778	9,737
2,080	2,249	169	8%	Other Supplies & Expenses	14,405	15,591	1,186	8%	26,890	26,575	(315)	1,995	13,843	26,620
573	485	(88)	(18%)	Equipment Depreciation	3,894	3,351	(543)	(16%)	6,759	5,731	(1,028)	522	3,484	6,194
335	276	(59)	(21%)	MOH Special Votes Expense	2,215	1,958	(257)	(13%)	3,370	3,372	2	409	2,075	3,910
17,667	**14,978**	**(2,689)**	**(18%)**	**Total Operating Expenses**	**115,562**	**104,626**	**(10,936)**	**(10%)**	**200,268**	**178,895**	**(21,373)**	**15,122**	**103,476**	**187,884**
932	**305**	**627**	**206%**	**MOH Surplus / (Deficit)**	**(812)**	**409**	**(1,221)**	**(299%)**	**2,268**	**1,608**	**660**	**(50)**	**2,834**	**7,497**
(632)	(640)	8	(1%)	Building Depreciation	(4,421)	(4,418)	(3)	0%	(7,580)	(7,555)	(25)	(636)	(4,404)	(7,573)
483	504	(21)	(4%)	Amortization of Deferred Building Capital Grants	3,380	3,478	(98)	(2.8%)	5,312	5,947	(635)	490	3,453	5,884
$ 783	**$ 169**	**$ 614**		**Net Surplus / (Deficit)**	**$ (1,853)**	**$ (531)**	**$ (1,322)**		**$ (0)**	**$ -**	**$ (0)**	**$ (196)**	**$ 1,883**	**$ 5,808**

Cambridge Memorial Hospital
Statement of Financial Position
As at October 31, 2023

(Expressed in thousands of dollars)

	October 2023	March 2023
ASSETS		
Current Assets		
Cash and Short-term Investments	$ 80,220	$ 83,456
Due from Ministry of Health/Ontario Health	9,037	8,317
Other Receivables	5,972	4,354
Inventories	2,559	2,483
Prepaid Expenses	3,025	2,879
	100,813	101,489
Non-Current Assets		
Cash and Investments Restricted - Capital	21,731	22,159
Due from Ministry of Health - Capital Redevelopment	3,243	3,243
Due from CMH Foundation	472	817
Endowment and Special Purpose Fund Cash & Investments	195	194
Capital Assets	288,378	276,999
Total Assets	**$ 414,832**	**$ 404,901**
LIABILITIES & NET ASSETS		
Current Liabilities		
Due to Ministry of Health/Ontario Health	17,827	10,516
Accounts Payable and Accrued Liabilities	38,004	39,599
Deferred Revenue	32,449	32,379
	88,280	82,494
Long Term Liabilities		
Capital Redevelopment Construction Payable	3,612	2,428
Employee Future Benefits	4,387	4,203
Deferred Capital Grants and Donations	274,751	270,121
Asset Retirement Obligation	2,377	2,377
	285,127	279,129
Net Assets:		
Unrestricted	8,250	14,792
Externally Restricted Special Purpose Funds	195	194
Invested in Capital Assets	32,980	28,292
	41,425	43,278
Total Liabilities and Net Assets	**$ 414,832**	**$ 404,901**
Working Capital Balance	12,533	18,995
Working Capital Ratio (Current Ratio)	1.14	1.23

Cambridge Memorial Hospital
Statements of Cash Flows
For the Month Ending October 31, 2023

(Expressed in thousands of dollars)

	October 2023	March 2023
Cash Provided By (used in) Operations:		
Excess (deficiency) of Revenue over Expenses	$ (1,853)	$ 5,809
Items not involving cash:		
Amortization of capital assets	8,316	13,767
Amortization of deferred grants and donations	(5,685)	(9,411)
Change in Non-Cash Operating Working Capital	3,567	9,262
Change in Employee Future Benefits	184	85
	4,529	19,511
Investing:		
Acquisition of Capital Assets & CRP	(19,694)	(28,165)
Capital Redevelopment Construction Payable	1,184	1,314
	(18,510)	(26,851)
Financing:		
Capital Donations and Grants & CRP	10,317	33,448
	10,317	33,448
Increase (Decrease) In Cash for the Period	(3,664)	26,108
Cash & Investments - Beginning of Year	105,615	79,507
Cash & Investments - End Of Period	**$ 101,951**	**$ 105,615**
Cash & Investments Consist of:		
Unrestricted Endowment and Special Purpose Investments	30	30
Cash & Investments Operating	80,190	83,426
Cash & Investments Restricted	21,731	22,159
Total	**$ 101,951**	**$ 105,615**

BRIEFING NOTE

Date: November 8, 2023
Issue: MAC Credentials & Privileging October 2023
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Dr. Winnie Lee, Chief of Staff
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: None

Alignment with 2023/24 CMH Priorities:

2022-2027 Strategic Plan No ☒	2023/24 CMH Priorities No ☒	2023/24 Integrated Risk Management Priorities No ☒
☐ Elevate Partnerships in Care	☐ Ensure Equitable Care For CND Residents	☐ Change / Project Management
☐ Advance Health Equity	☐ Grow Clinical Services	
☐ Increase Joy In Work	☐ Increase Staff Engagement	☐ Staff Shortages
☐ Reimagine Community Health	☐ HIS/ERP Planning and Implementation	☐ Access to Care
☐ Sustain Financial Health	☐ Grow Ministry Revenue	☐ Revenue & Funding

A meeting of the Medical Advisory Committee took place on Wednesday November 8, 2023, at 4:30 pm.

Present:	Dr. W. Lee, Dr. J. Legassie, Dr. K. Wadsworth, Dr. A. Mendlowitz, Dr. J. Bourgeois, Dr. A. Sharma, Dr. L. Green, C. Witteveen, Dr. M, Rajguru, Dr. A. Mendlowitz, Dr. V. Miropolsky, Dr. E. Thompson, Dr. T. Holling, Dr. I. Isupov, Dr. M. Runnalls, Dr. A. Nguyen,
Regrets:	Dr. M. Gill, Dr. M. Kumanan, Dr. A. Rowe,
Staff:	P. Gaskin, M. Iromoto, S. Pearsall, Dr. R. Taseen, R. Howe, K. Leslie, N. Grealy (Recorder)
Guests:	D. Wilkinson, C. Wilson

Committee Recommendations/Reports – Board Approval Sought

Proposed Board Motion:

WHEREAS due diligence was exercised in reviewing the following privileging applications from the October 2023 Credentials Committee and upon the recommendation of the MAC, that the Board approve the following privileging applications.

Approved Committee Recommendations/Motions:

THAT the Medical Advisory Committee recommend to the Board of Directors that the standard credentialing files be approved. (Holling, Bourgeois) **CARRIED.** The attached Briefing Note provided to the Committee will be noted as well as any further commentary or discussion that is necessary.

MOTION: (Holling, Bourgeois) that the new credentialing files be approved as distributed. None opposed. **CARRIED.**

Dr. A. Batra Resignation: Dr. A. Nguyen spoke to Dr. A. Batra resignation. Dr. A, Nguyen advised that Dr. Batra is doing an internal move within the Grand River Cancer Program and as it is within the Grand River Regional Program, we are asking for a potential delay on when Dr. Batra does the move until we are firm on the recruitment on the replacement physician and there is a plan for transfer of patient care. While the desire from Dr. Batra is to move in January, it may be delayed 1-2 months based on the logistics of recruitment to avoid a gap within the cancer program. Recognition of resignation but end date is TBD.

Agenda

Credentialing Committee

Date of Meeting: October 24, 2023

MAC Meeting Date: November 8, 2023

Board of Directors Meeting Date: December 6, 2023

New Business:

Credentialing Files for Review:

Name	Department	Specialty	Appointment	Reason	Supervisor	Recommended/Not Recommended
Dr. Shawn Vasdev	Psychiatry		Associate	New associate physician starting September 23, 2023	Dr. Anjali Sharma	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Lok Sang Lam	Internal Medicine		Associate	New Hire starting October 16, 2023	Dr. Augustin Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Helen Zhao	Surgery	Surgical Assist	Locum	Requesting extension of locum privileges from July 7, 2023 – July 6, 2024	Dr. L. Green	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Prima Moinul	Surgery	Ophthalmology	Locum	Requesting locum privileges from July 22, 2023 – July 21, 2024 for regional on-call	Dr. L. Green	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Mazin Al-Battran	Psychiatry		Locum	Requesting extension of locum privileges from November 3, 2023 – May 30, 2024	Dr. A. Sharma	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Yeshale Chetty	Emergency		Locum	Requesting extension of locum privileges from November 3, 2023 – December 31, 2023	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Dr. Laura Duncan	Emergency		Locum	Requesting extension of locum privileges from November 3, 2023 – December 31, 2023	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Jithin Varghese	Emergency		Locum	Requesting extension of locum privileges from November 3, 2023 – December 31, 2023	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Ashifa Jiwa	Emergency		Locum	Requesting extension of locum privileges from November 3, 2023 – May 30, 2024	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Julia Heyens	Women & Children	Midwife	Active	Requesting parental leave from October 2, 2023, for undetermined length of time	C. Witteveen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Mitra Sadeghipour	Women & Children	Midwife	Active	Resignation of privileges effective September 29, 2023	C. Witteveen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Krysta Barclay	Women & Children	Midwife	Active	Requesting leave of absence from February 1, 2024 – January 31, 2024	C. Witteveen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Brenda Dong	Women & Children	Midwife	Associate	Resignation of privileges effective February 5, 2024	C. Witteveen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Anupam Batra	Internal Medicine	Oncology	Active	Resignation of privileges effective December 30, 2023	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. L. Green	Surgery		Active	Requesting medical leave from call effective October 20, 2023	Dr. W. Lee	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

				for approximately 6-8 weeks.		

_____

Dr. W. Lee, Chair
Credentials Committee

_____

Dr. V. Miropolsky, President Medical & Professional Staff Association

_____

Dr. I. Morgan, Vice President & Professional Staff Association

_____

S. Pearsall, Vice President Clinical Programs & CNE

_____

Dr. A. Rowe, Secretary Medical & Professional Staff Association

_____

Dr. M. Gill, Treasurer Medical & Professional Staff Association

_____

Dr. J. Legassie, Chief of Hospital Medicine
MAC Member

_____

Corine Witteveen, Chief of Midwifery
MAC Member

BRIEFING NOTE

Date: November 8, 2023
Issue: MAC Report to the Board of Directors November 8, 2023 OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Dr. Winnie Lee, Chief of Staff
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: None

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Regrets:	Dr. M. Gill, Dr. M. Kumanan, Dr. A. Rowe,
Staff:	P. Gaskin, M. Iromoto, S. Pearsall, J. Visocchi, Dr. R. Taseen, R. Howe, B. McCaig, Dr. K. Nuri, K. Leslie, N. Grealy (Recorder)
Guests:	D. Wilkinson, C. Wilson

Committee Matters – For information only

1. **M&T Report:** The October M&T report was approved by MAC (Green, Bourgeois)

2. **COVID-19 and Infectious Disease Update**

Dr. K. Nuri provided an infectious disease update. Flu and COVID cases have continued to increase/remain high compared to the summer. The current circulating COVID-19 strain is HV-1. Wastewater data in Cambridge is currently higher than Kitchener. At CMH, there were 5 COVID cases in August, 14 COVID cases in September, 35 COVID cases in October, and 14 cases as of November 8, demonstrating the ongoing high / increasing prevalence of COVID. In the next 2 weeks, COVID-19 and RSV activity in Ontario is projected to increase while influenza

activity is projected to remain stable. CMH's COVID outbreak on Med A was declared over last week, but as of November 8, 2023, a COVID watch was declared in Med B. Flu and COVID-19 (XBB) vaccines are available now at CMH. Flu vaccination rates in the hospital remain low (approximately 15%). Staff are encouraged to get both COVID-19 and flu vaccinations.

3. Medical Directives (MD) Updates

Updates to the following Medical Directives were discussed and approved:
MD #562 - SLP delegated oral diet texture orders. **(Holling, Legassie)**
MD #558 - Ordering of Laboratory investigations **(Puopolo, Bourgeois)**
MD #556 - Blood Borne Pathogens Exposure Management **(Green, Sharma)**
MD #561 - Dietician Delegated Orders **(Legassie, Holling)**
MD #581 - Transvaginal (Endovaginal/Endocavity) (TV, EV, EC) Ultrasound – Initiation of **(Mendlowitz, Wadsworth)**

4. Policy 1-54 Driver Assessment

Dr. J. Legassie provided an update on Policy 1-54 which was revised to include Nurse Practitioners (NPs) and updated links to the Government of Ontario Medical Report form required by the Ministry of Transportation. Policy 1-54 was approved.

5. Choosing Blood Wisely

Dr. J. Bourgeois announced that CMH achieved the benchmarks required to be designated as a Using Blood Wisely Hospital. The application for the designation has been submitted.

6. B2L eLearning: Transfusion Medicine Bloody Easy

Recent accreditation in the Lab highlighted a non-conformance with respect to competency evaluation program for all medical, clinical, and support staff involved in any transfusion related activity including the preparation of blood components and blood products for administration. The competency assessment program applies to all team members, including prescribing physicians. Credentials Committee discussed the accreditation standard and supports Bloody Easy Lite as the recommended evaluation program for the medical professional staff as it fulfills the accreditation requirements (two modules – indications for blood transfusion and transfusion reactions) and available on the Bridge2Learn platform. If Bloody Easy has been completed at another hospital, only proof of completion is required. Renewal of the education would be every two years based on the discussion at MAC and Credentials Committee, which would be offered as part of annual credentialing cycle.

7. CCO 2022-2023 Performance Recognition

Letters/Certificates of recognition from Ontario Health was shared with MAC. CMH was recognized for (1) meeting target for OBSP Wait Times – Time from abnormal screen to diagnosis for cases with tissue biopsy and (2) meeting target for cancer surgery wait times – decision to treat to treatment (Wait 2). Dr. W. Lee congratulated those in Diagnostic Imaging, Surgery and Pathology who work collaboratively to ensure timely access to breast cancer care for our patients.

8. Chair Update and Chief's Corner

Dr. W. Lee thanked those who provided survey feedback and encouraged more participation in the surveys. Dr. W. Lee also provided an update on Value-Based Conversations (VBCs) which have been ongoing for the last couple of months. As of November 8, 2023, 14/15 VBCs have been completed and is anticipated to be all complete by end of November 2023. Themes from these conversations will be shared to the Chiefs at a later date, when all VBCs are complete.

9. CEO Report

P. Gaskin's CEO report was pre-circulated in the package. Highlights were provided below:

10. CNE Report

S. Pearsall's CNE report was pre-circulated. Highlights include stable wait times in DI, OBSP breast assessment center designation, go-live of a patient reminder system, and upcoming moves within the DI department that will involve relocation of Nuclear Medicine. There has been a slight increase in visit volumes in ED. A comprehensive value stream map exercise was recently completed for the ED Department, which has revealed opportunities and counter measures to address the current ED metrics. For instance, the CDU (clinical decision unit) has seen a decreased utilization rate and a group is meeting in November to finalize change in processes. Endoscopy recently moved into the new procedural space on October 30, 2023. Accreditation Canada Diagnostics mid-cycle assessment was a great success with only 5 non-conformances and corrective actions and process improvements are underway to address these non-conformances. In the Obstetrical program, the team has been working on revising the Induction/Augmentation of Labour policy, order sets, and induction booking sheets and patient handouts, aligning with the recommendation from the PCMCH (Provincial Council for Maternal and Child Health) Safe Administration Oxytocin toolkit. Medicine occupancy remains high (more than 100% occupied) with high ALC volumes. Hospitalists are attending bullet rounds and leader rounding continues on Medicine. A new psychiatrist was welcomed to CMH in September and will help support outpatient mental health referrals.

11. Board Report

D. Wilkinson provided an update on the November 2023 Board meeting which was generative discussion focused on the Emergency Department. Dr. M. Runnalls participated in the discussion and the recent deep dive into our Emergency Department, in addition to the reading material provided a springboard for good discussion at the Board. The Board also had an ethics presentation with Dr. Steve Abdool, in advance of Accreditation.

12. PFAC Report

November PFAC meeting was held without management, with dedicated time for the surveyor from Accreditation Canada.

Inaugural Staff Innovation Fund Projects Outcomes

Inaugural Staff Innovation Fund Projects

At the beginning of 2023, CMH's Board of Director's and Foundation engaged in a collaborative partnership to showcase staff innovations, launching the inaugural Staff Innovation Fund. This first round highlighted several bright ideas amongst CMH staff, resulting in the following projects:

1) Patient Registration Check-in System

2) Secure File Transfer and Electronic Payment

3) Improving Resuscitation by Providing High Quality CPR

Innovation #1: Patient Registration Check-in System

Purpose:

1. To implement a check-in system/ kiosk that displays a short form which allows the patient to be put on a wait list
2. Clerks can use the wait list to determine patient priority by appointment type

Objectives:

1. Optimize patient flow through the department
2. Ensure a positive patient experience

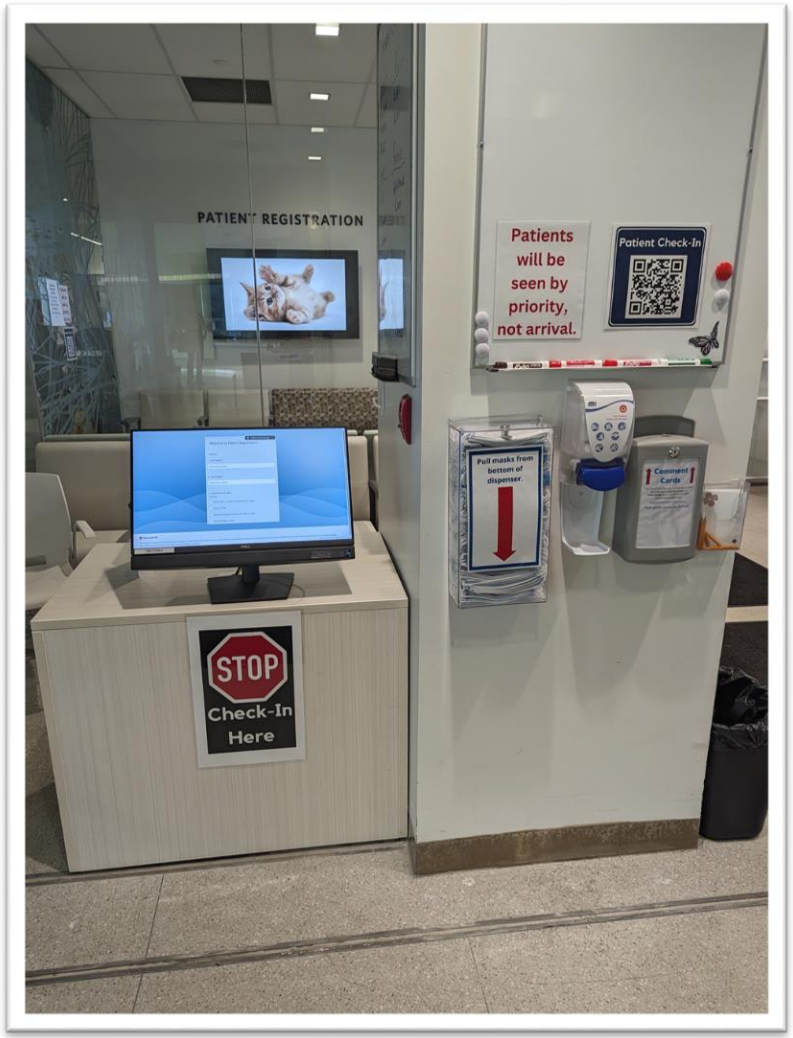
Innovation Fund Project Team

Patient Registration Team

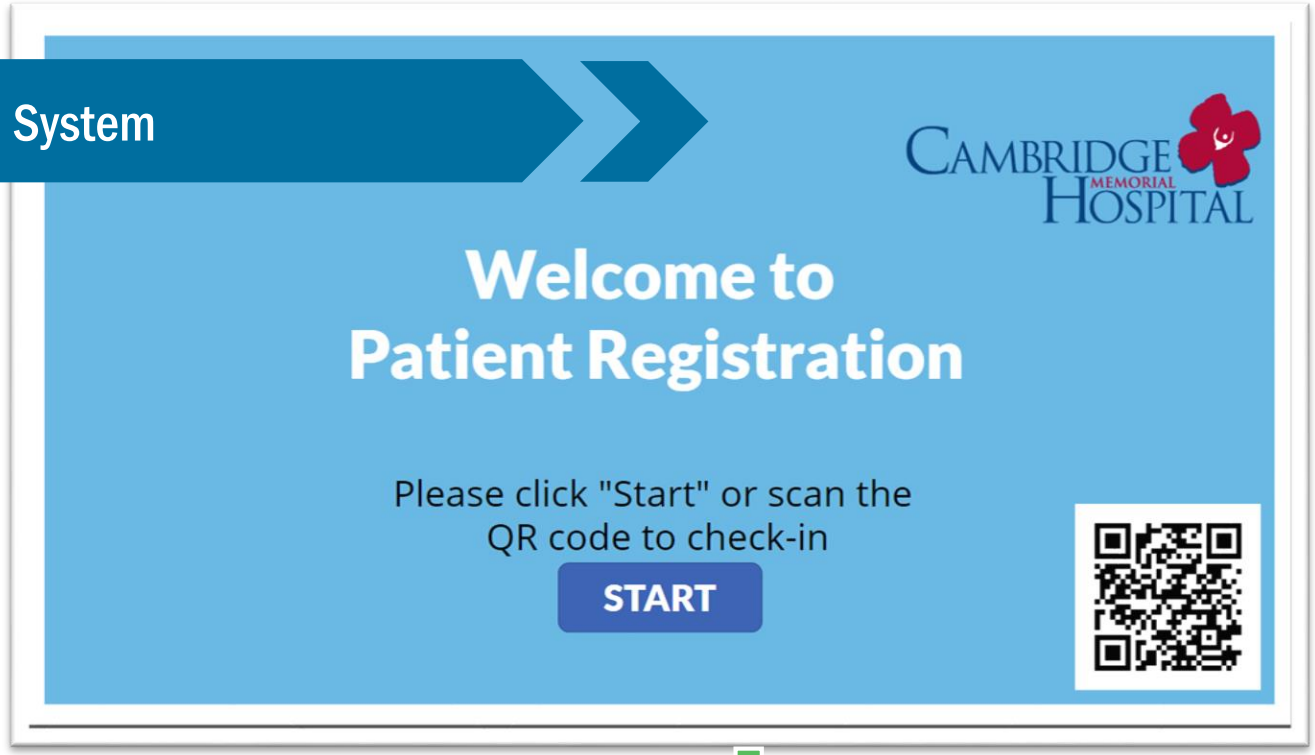
Innovation #1: Patient Registration Check-in System Video

Video Link is in the folder on the Board Portal

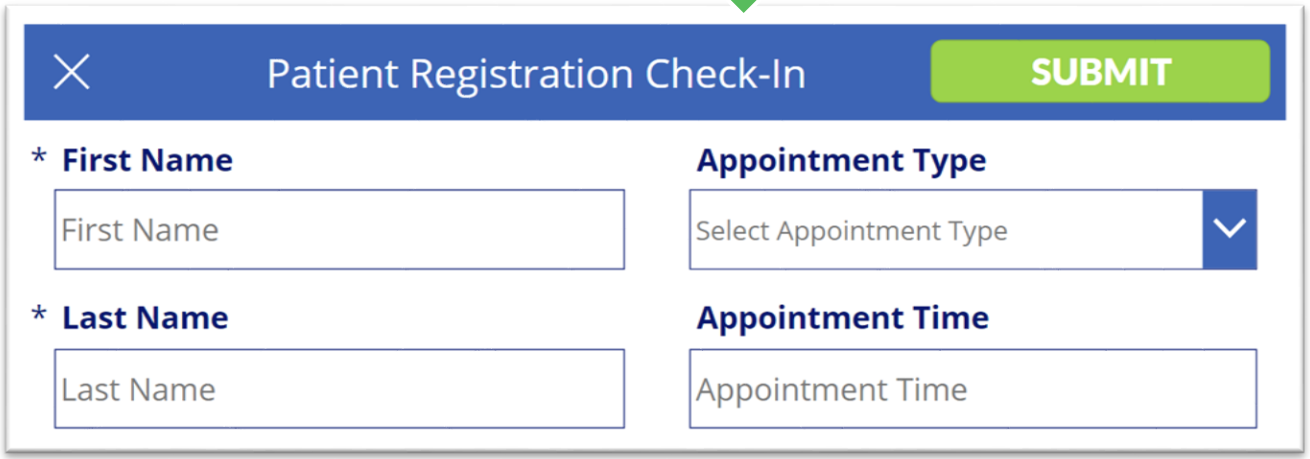
Innovation #1: Patient Registration Check-in System



24" Touchscreen Computer, Entrance of Patient Registration

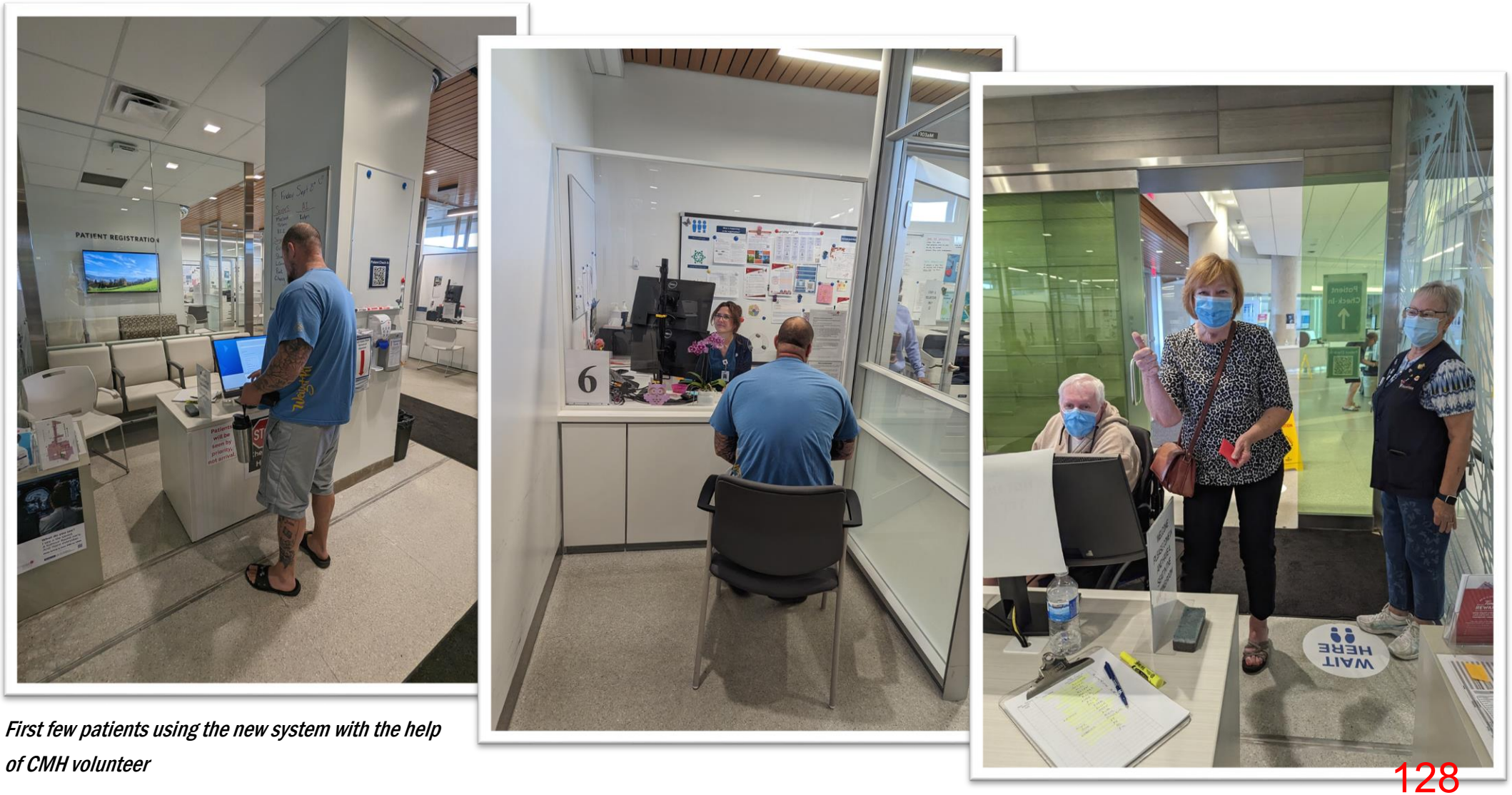


In-house Power App Solution, Welcome Screen



In-house Power App Solution, Check-in Form

Innovation #1: Check-in System Launch (September)



First few patients using the new system with the help of CMH volunteer

Innovation # 2: Secure File Transfer and Electronic Payment

Purpose:

To provide digital copy of records/reports through a secure file transfer system, or as a secure email, as well as providing an online payment option to patients

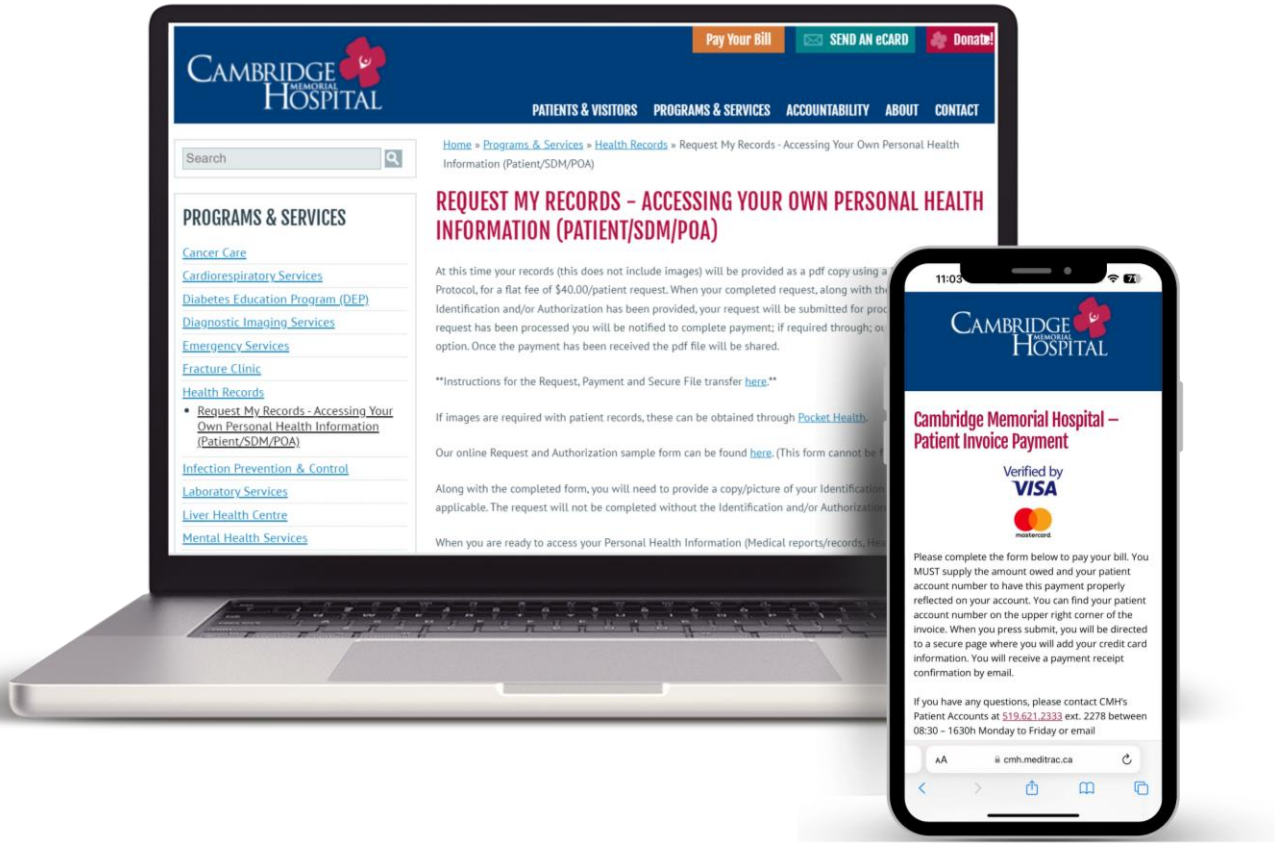
Objective:

1. Provide our patients a timelier, safer and more efficient method of retrieving their medical records/letters.
2. Accurately track documents and delivery confirmation

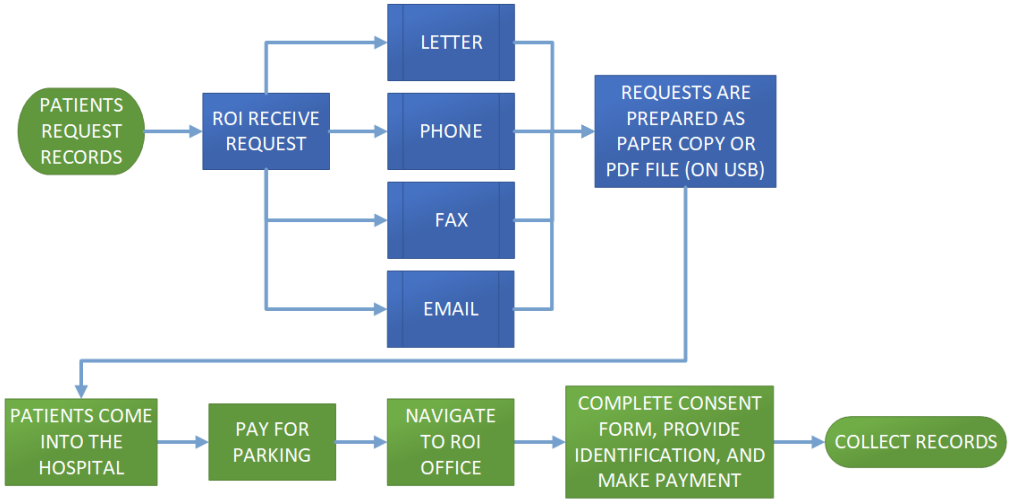
Innovation # 2: Secure File Transfer and Electronic Payment Video

Video Link is in the folder on the Board Portal

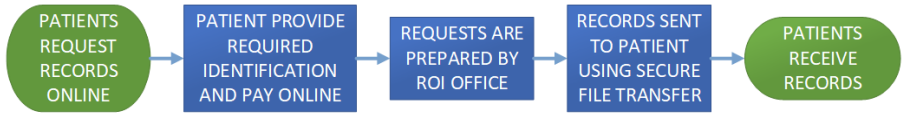
Innovation # 2: Secure File Transfer and Electronic Payment



Previous Process



New Process



Innovation # 2: Secure File Transfer and Electronic Payment

Outcomes

1. Requests and payments can be made online through CMH website eliminating patients presenting to the hospital to collect their records, and expedient delivery to out of province, or out of country recipients.
2. Identification will be received/ reviewed prior to processing the request
3. Payments for records can be made online
4. Reduction of paper usage has gone from approximately 20,000 sheets per month, to less than 1000.
5. utilize a hybrid work model to increase flexibility for the staff and increase joy in work.

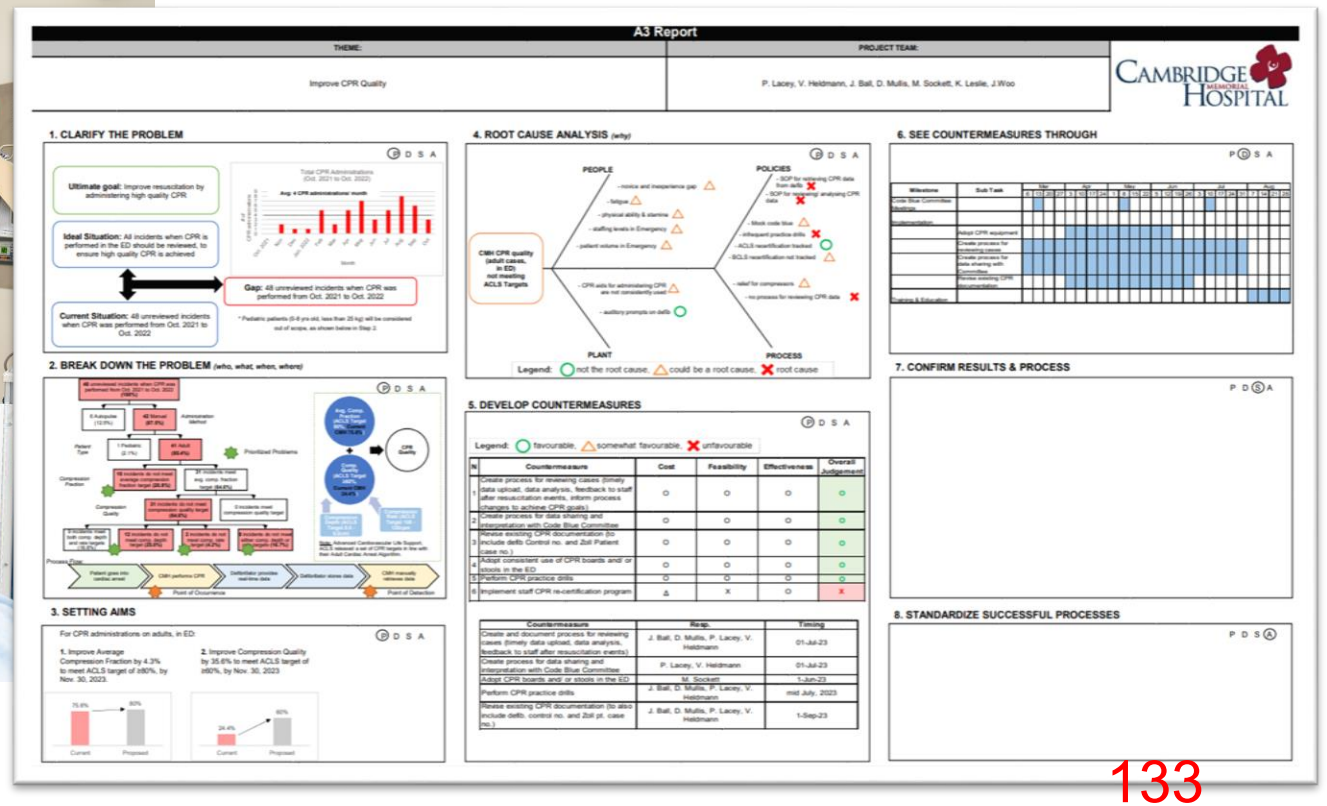
Innovation #3: Improving Resuscitation by Providing High Quality CPR

Purpose: To formally establish a process for analyzing CPR data, and then using the findings to inform process changes to ensure that CMH- ED is meeting Heart and Stroke for Advanced Cardiac Life Support targets

Objective: To maximize the capabilities of the defibrillators and educate staff on how to interpret its real time audio and visual cues to ensure the administration of high-quality CPR

Innovation Fund Project Team

Improve CPR Quality A3 Report



Innovation #3: Improving Resuscitation by Providing High Quality CPR Video

Video Link is in the folder on the Board Portal

Innovation #3: Improving Resuscitation by Providing High Quality CPR

Outcomes

1. Created a new process for uploading CPR data
2. Created a new process for analyzing CPR data
3. Performed numerous mock code blue drills in the ED and provided education to all staff
4. Confirmation of CPR aids, such as stools and boards are available in the ED

Innovation Fund Feedback

- Application process was easy to complete
- Amazing support and collaboration with PMO and other stakeholders, including IT, Privacy and Risk, Volunteers,
- Suggest to engage with Finance at the start of the project to discuss the allocation of funds and how they will be paid out
- It was a great opportunity to present an idea and be given the resources to follow through with it and have an opportunity to connect with other departments

"I am thankful to the Board of Directors for creating the Innovation Fund as it's been a great experience to be part of a project that is forward thinking and puts CMH in a better position to meet future technology needs as well as the needs of our patients and community."

- Kelli Cox

"We are grateful as it got us to brainstorm and think outside the box to come up with a project that would be both beneficial and engaging while living the values of CMH."

- Deanne Mullis

"Personally, I learned that no innovation is out of reach. Our hospital is all about innovation and coming up with ideas to make our patients' experience better."

- Stephanie Baker