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

Wednesday, June 26, 2024

1730-1830

Virtual via Teams / C.1.229 Meeting Room

Click here to join the meeting

Or call in (audio only)

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

Phone Conference ID: 273 344 35#

AGENDA

Agenda Item * indicates attachment / TBC – to be circulated	Page #	Time	Responsibility	Purpose
1. CALL TO ORDER		1730	N. Melchers	
1.1 Territorial Acknowledgement			N. Melchers	
1.2 Welcome Guests			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 consent agenda and moved to the regular agenda)*			N. Melchers	Motion
1.5.1 Minutes of May 1, 2024 & June 5, 2024*	3			
1.5.2 Board Attendance Report TBC	6			
1.5.3 Governance Policy Summary* Policies for Approval (track changes can be found in package 2)	7			
1.5.4 Committee Reports to the Board of Directors*				
1.5.4.1 Governance Committee* (May 9, 2024)	20			
1.5.4.2 Resources Committee (May 27, 2024* & June 24, 2024 TBC)	23			
1.5.4.3 Capital Projects Sub-Committee TBC (June 24, 2024)	27			
1.5.4.4 Medical Advisory Committee* (May 8, 2024 & June 6, 2024)	28			
1.5.5 Board Chairs Report*	36			
1.5.6 CMH President & CEO Report*	38			
1.5.7 Board Work Plan*	44			
1.5.8 2023/24 Board of Directors Action Log*	52			
1.5.9 2023/24 Events Calendar*	54			
1.5.10 Education Topics 2024/25 Survey Results*	56			
1.5.11 Q4 CEO Certificate of Compliance*	59			
1.5.12 Patient Family Advisory Council (PFAC) – Annual Update*	61			
1.5.13 Quality Monitoring Metrics & Scorecard*	64			
1.6 Confirmation of Agenda			N. Melchers	Motion

#	Policy Name
2-A-16	Governance Committee Terms of Reference
2-D-40	Evaluation of Board, Committees, and Individual Performance
2-C-55	Hospital Naming 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
2. PRESENTATIONS				
2.1 CMH Accessibility Committee Update*	75	1735	L. Barefoot	
2.2 Refreshed 24/25 Strategic Priorities Tracker*	87	1745	K. Leslie	
3. BUSINESS ARISING				
3.1 None			N. Melchers	
4. NEW BUSINESS				
4.1 Chair's Update				
4.1.1 No Open Items for Discussion				
4.2 Quality Committee		1800		
4.2.1 Report to the Board of Directors* (May 15 & June 19, 2024)	94		D. Wilkinson	Information
4.3 Resources Committee		1805		
4.3.1 May 2023 Financial Statements*	99		L. Woeller	Motion
4.4 Medical Advisory Privileging & Credentialing		1810		
4.4.1 MAC Credentials & Privileging May 2024*	107		Dr. W. Lee	Motion
4.5 PFAC Update		1815	N. Melchers	Information
4.6 CEO Update		1820		
4.6.1 Indigenous ReconciliACTION Plan	114		P. Gaskin	Information
5. DATE OF NEXT MEETING	Wednesday October 2, 2024 Hybrid			
6. TERMINATION		1830	N. Melchers	Motion

Board Members: Nicola Melchers (Chair), Sara Alvarado, Tom Dean, Julia Goyal, Elaine Habicher, Monika Hempel, Miles Lauzon, Dr. Margaret McKinnon, David Pyper, Jody Stecho, 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, June 5, 2024
OPEN SESSION

Minutes of the open session of the Board of Directors meeting, held via hybrid model (video conference and within Cambridge Memorial Hospital, C.1.229) on June 5, 2024 at 1700h.

Present:

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

Regrets: V. Miropolsky, I. Morgan

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

Guests: J. Legassie

Recorder: S. Fitzgerald

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1. CALL TO ORDER

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

1.1. **Territorial Acknowledgement**

B. Conway presented the Territorial Acknowledgement and shared personal reflections**.**

1.2. **Welcome**

N. Melchers welcomed the Board members to the meeting.

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

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

1.4. **Declarations of Conflict**

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

1.5. **Consent Agenda**

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

The consent agenda was approved as presented:

1.5.1 Board Resolution Bill S-211
1.5.2 CEO Certificate of Compliance

CARRIED (Wilkinson/Brasil)

1.6. **Confirmation of Agenda**

MOTION: (Tulsani/Conway) **that** the agenda be approved as amended. **CARRIED**

2. NEW BUSINESS

2.1. **Broader Public Sector Accountability Act Attestation**

The Board of Directors reviewed the briefing note that was pre-circulated in the meeting package. L. Woeller noted that a lot of work has been completed over the past year by the Purchasing group to increase the level of compliance and understanding of the act. The members had no further questions.

MOTION: (Lauzon/Tulsani) That, following review and discussion of the information provided, the Board approves the Broader Public Sector Accountability Act, 2010 (BPSAA) Appendix C - Attestation prepared by the President and CEO in accordance with Section 15 of the BPSAA for the period April 1, 2023 to March 31, 2024. **CARRIED**

2.2. **Multi-Sector Service Accountability Agreement (M-SAA) Schedule F Declaration of Compliance**

The Board of Directors reviewed the briefing note that was pre-circulated in the meeting package. The members had no further questions.

MOTION: (Lauzon/Tulsani) That, following review and discussion of the information provided, the Board supports the submission of the Multi-Sector Service Accountability Agreement (M-SAA) Schedule F – Declaration of Compliance.

Schedule F, Declaration of Compliance, describes that the Health Service Provider (HSP) has complied with applicable procurement practices, the Local Health System Integration Act, 2006 and the Public Sector Compensation Restraint to Protect Public Services Act, 2010. **CARRIED**

2.3. **HSAA Article 8 – Declaration of Compliance**

The Board of Directors reviewed the briefing note that was pre-circulated in the meeting package. The members had no further questions.

MOTION: (Lauzon/Tulsani) That, the Board supports the submission of the HSAA Article 8 – Declaration of Compliance.

HSAA Article 8 – Declaration of Compliance, attests that the Health Service Provider (HSP) has fulfilled its obligations under Agreement during the Applicable Period and has received the required reports referred to in Section 8.6 of the Agreement. **CARRIED**

2.4. **MAC Credentials & Privileging April 2024**

The Board of Directors reviewed the briefing note that was pre-circulated in the meeting package. The members had no further questions.

MOTION: (McKinnon/Wilkinson) Whereas due diligence was exercised in reviewing the following privileging applications from the February 2024 Credentials Committee and upon the recommendation of the MAC at the meeting of May 8, 2024, that the Board approve the following privileging applications. **CARRIED**

3. UPCOMING EVENTS

N. Melchers highlighted the upcoming events and encouraged the Board members to participate if available.

4. DATE OF NEXT MEETING

The next scheduled meeting is June 26, 2024

5. ADJOURNENT

The meeting adjourned at 1709h. (McKinnon)

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

Placeholder for Board Attendance Report - TBC Monday June 24

BRIEFING NOTE

Date: June 20, 2024
Issue: Governance Policy Summary
Prepared for: Board of Directors
Purpose: ☒ Approval ☒ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Executive Assistant
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: Policies

Recommendation/Motion

Following review and discussion of the information provided, the Governance Committee of the Board recommends to the Board of Directors that the following policies be approved with amendments:

2-A-16 Governance Committee Terms of Reference
2-D-40 Evaluation of Board, Committees, and Individual Performance
2-C-55 Hospital Naming Policy

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 May 9, 2024 Governance Committee meeting and were amended / updated as attached:
**Note only policies with tracked changes are attached to the package*

Policy No.	Policy Name
2-A-16	Governance Terms of Reference
2-D-40	Evaluation of Board, Committees, and Individual Performance
2-C-55	Hospital Naming Policy

BOARD MANUAL

SUBJECT: Governance Committee Terms of Reference	**NO.: 2-A-16**
SECTION: Structure, Roles and Responsibilities	
APPROVED BY: Board of Directors	**DATE: TBD**

Application

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

Composition

(a) The Committee shall be composed of the following voting members:

(i) up to four elected (4) Directors one of whom shall sit as Chair of the Committee; and

(ii) up to three (3) members from the broader community who are appointed by the Board upon the recommendation of the Governance Committee.

(b) Non-voting resources to the Committee will include:

(i) the President and Chief Executive Officer and;

(ii) other staff resources, as directed by the Committee.

Meetings

The Committee shall:

(a) meet at least four (4) time annually.

(b) conduct all or part of any meeting in the absence of management, and, at a minimum, conduct such a session at each regularly scheduled Committee meeting.

(c) invite to its meetings any Director, member of management or such other persons as it considers appropriate in order to carry out its duties and responsibilities.

(d) exclude from its meetings any persons it considers appropriate in order to carry out its responsibilities.

Specific Duties and Responsibilities

(a) Board and Committee Structure and Composition

The Committee shall make recommendations to the Board with respect to the appropriate structure and composition of the Board and its committees, consistent with policy 2-D-20, so they may fulfill their functions and comply with all legal requirements and all relevant Board policies. The Committee shall:

(i) recommend to the Board criteria for the composition of the Board and its committees, including total size, independence of Directors and the number and role of the ex-officio voting and non-voting Directors on the Board and its committees;

(ii) recommend to the Board criteria for the tenure of Directors;

(iii) recommend to the Board each year the allocation of Board members and non-Director committee members to each of the applicable Board committees, and where a vacancy occurs at any time in the membership of any committee, recommend to the Board a member to fill such vacancy;

(iv) recommend the appointment of committee chairs to the Board; and

(v) recommend the appointment of non-director committee members to Board committees.

(b) Nominations for Election to the Board and Appointment to other Boards

The Committee shall:

(i) undertake the nominating process;

(ii) provide recommendations to the Board as to the appointment of its Officers.

(iii) recommend to the Board the appointment of the Corporation's Directors to other organizations or groups, including but not limited to, the Cambridge Memorial Hospital Foundation, Cambridge Memorial Hospital Volunteer Association, Patient and Family Advisory Council (PFAC), Medical Advisory Council (MAC), and the Cambridge North Dumfries Ontario Health Team (CND OHT)

(c) Resignation and Removal of Directors

The Committee shall:

(i) Undertake the review, and when warranted, recommend the removal of a Director, Officer or non-director committee member as outlined in policy 2-D-45 Removal of a Director, Officer or Committee Member.

(d) Director and Committee Orientation

The Committee shall:

(i) be responsible for monitoring that new Directors, and non-director committee members receive an orientation to their role as a Board or committee member as outlined in policy 2-D-30 Board and Board Committee Orientation.

(e) Evaluations

The Committee shall:

(i) establish, revise as necessary, and facilitate an effective process for the ongoing evaluation of the performance and effectiveness of the:

- Board
- Committees
- Board Chair
- Committee Chairs
- Individual Directors
- non-director committee members

as outlined in policy 2-D-40 Evaluation of Board, Committee and Individual Performance.

(ii) report to the Board the results of the annual evaluation processes and, based on those results, recommend any action plans that the Committee considers appropriate; and

(iii) conduct an annual evaluation of the Committee in which the members of the Committee review the Committee's performance for the preceding year for the purpose, among other things, of assessing whether it fulfilled the purposes and responsibilities stated in these Terms of Reference.

(f) Corporate Governance

The Committee shall:

(i) develop and, where appropriate, recommend to the Board for approval corporate governance policies aimed at fostering high standards of corporate governance, including ongoing review and assessment of the Corporation's governing and constating documentation, including letters patent, supplementary letters patent, by-laws and Board policies and procedures;

(ii) keep informed of the latest regulatory requirements, trends and guidance in corporate governance and update the Board on corporate governance issues as necessary; and

(iii) review every 3 years and update, when required, the indemnity agreement to be signed by all directors and committee members and confirm that the Directors and Officers liability insurance has been reviewed by the Resource Committee.

(g) Board Functioning

The Committee shall:

(i) be responsible for considering and assessing the functioning of the Board;

(ii) recommend issues to be discussed at Board meetings and committee meetings;

(iii) be responsible for reviewing the Terms of Reference for any committee in conjunction with the Board or the relevant committee or any task force that the Board may wish to establish from time to time; and

(iv) monitor the quality of the relationship between management and the Board and recommend improvements.

(h) Board Independence

The Committee shall be responsible to assess and facilitate the independent functioning of the Board as set out in Board Policy

(i) Conduct and Ethical Behaviour

The Committee shall:

(i) review, and where appropriate, recommend for approval policies in respect of ethical, personal, and business conduct at the Corporation, including the Corporation's conduct and ethics policies. The Committee shall also monitor any actual, perceived or potential conflicts of interest brought to its attention; and

(ii) oversee and monitor compliance with policies in respect of ethical, personal, and business conduct including, where appropriate, any waiver from such policies.

(j) Oversight of Risk

The Committee shall, on behalf of the Board, ensure that management has an adequate policy in place for integrated risk management. The Committee shall review the integrated

risk management policy on a regular basis, but not less than every three (3) years.

In addition, the Committee shall:

(i) oversee risk management in the following assigned category – regulatory; and

(ii) oversee the progress and completion of plans to mitigate risks identified through the integrated risk management priority setting process and report annually to the Audit Committee.

General

The Committee shall:

(a) report to the Board on material matters arising at Committee meetings following each meeting of the Committee;

(b) maintain minutes or other records of meetings and activities of the Committee

(c) have the authority, upon approval by the Board, to engage appropriate independent legal counsel, consultants, or other advisors with respect to fulfilling its responsibilities, the funding for which shall be provided by the Hospital;

(d) conduct an annual evaluation of the Committee in which the Committee members review the Committee's performance for the preceding year for the purpose, among other things, of assessing whether it complied with these Terms of Reference;

(e) review and assess the adequacy of these Terms of Reference at least every (3) three years and submit any proposed amendments to this charter to the Board for approval;

(f) provide an orientation for new Committee members; and

(g) perform such other functions and tasks as may be assigned from time to time by the Board

DEVELOPED: September 28, 2011	**REVISED/REVIEWED:**	
November 28, 2012	June 25, 2014	January 28, 2015
May 24, 2017	November 27, 2019	Click or tap to enter a date.
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

SUBJECT:	**Evaluation of Board, Committees, and Individual Performance**	**NO.: 2-D-40**
SECTION:	**Board Process**	
APPROVED BY:	**Board of Directors**	**DATE: TBD**

Purpose

Evaluation of the Board and committee performance provides a means to:

- ensure the hospital is effectively and efficiently governed
- take action to improve Board and committee performance
- be guided by best practice
- ensure alignment with the hospital's Mission, Vision and Values
- identify continuing education and development needs

Policy

The Governance Committee will establish and conduct the processes for evaluation.

The evaluation methods will address the structure of the Board as a whole, its committees, leaders, Directors, and non-director committee members.

The evaluation process will include:

- key indicators and evaluation tools through which Board and committee effectiveness and performance may be measured
- tools and processes for individual assessment and for identifying future Board leadership candidates
- reports from the Governance Committee to the Board on the results of evaluation, key issues and recommended action for improvement
- external resources as defined by the Governance Committee as appropriate to help develop an effective process
- peer feedback to individuals to recognize their contribution and opportunities for improvement
- confidential and respectful communication by the Board Chair or relevant committee Chair in giving feedback to individuals
- periodic review and revision of the evaluation tools to support the ongoing effectiveness and utility and alignment with the Board's goals and objectives

Assessments that may be conducted by the Governance Committee or committee Chairs are summarized in Table 1: Tools for Board Evaluation

DEVELOPED: November 24, 2010	**REVISED/REVIEWED:**	
May 29, 2013	May 25, 2016	September 27, 2017
April 28, 2021	Click or tap to enter a date.	Click or tap to enter a date.
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

Table 1

Tools for Board Evaluation[1]

Type of Evaluation	Purpose	Frequency	Review of Results and Action
Orientation (Appendix A)	To plan effective orientation for new Directors and committee members	Survey completed after the orientation program (done for general orientation and committee orientation)	Governance Committee reviews and makes suggestions for improvements to be incorporated into the next year's orientation program
Meeting (Appendix B)	To improve the effectiveness of Board/ committee meetings	At the end of each Board/ committee meeting	The Board/Board committee and Governance Committee review the results and implement improvements when warranted
Board Education (Appendix C)	To improve educational sessions	At the end of each education session	Governance Committee reviews results. The results taken into consideration for future sessions
Future Intentions of the Board members (Appendix D)	To plan for recruitment for the Board and committees	Annual – Sent October, Reviewed December	Reviewed and taken into consideration by the Governance Committee to aid in the development of the annual recruitment strategy
Future Intentions of the Committee members (Appendix E)	To plan for the leadership positions on the Board and committee preferences	Annual – Sent October, Reviewed December	Reviewed and taken into consideration by the Governance Committee to aid in the development of the annual recruitment strategy
Skills Matrix (Appendix F)	To identify skill gaps within the Board and committees to plan for recruitment	Annual – Sent October, Reviewed December	Reviewed and taken into consideration by the Governance Committee to aid in the development of the annual recruitment strategy

[1] Surveys may be amended by the Governance Committee from time to time.

Type of Evaluation	Purpose	Frequency	Review of Results and Action
Self Identification Survey – Optional Participation (Appendix G)	To support continued work to increasing Diversity within the CMH Board and understanding Board demographics	Annual – Sent October, Reviewed December	Reviewed and taken into consideration by the Governance Committee to aid in the development of the annual recruitment strategy
Individual Director and Non-Director Committee Member Personal Assessment (Appendix H)	Self-Improvement, to plan for recruitment, renewal of term	Annual – Sent April, Reviewed May	For Directors, results reviewed by Governance Committee and Board Chair. Board Chair or delegate discusses results with Directors as necessary. The Chair reports results to Governance Committee (particularly in cases where the Director is being considered for term renewal) For non-director committee members, results reviewed by Governance Committee and relevant committee Chair. As necessary, committee Chairs discuss results with non-director committee members. Results reported to Governance Committee Chair, as necessary. Individual results for Directors and non-director committee members provided to individuals for review
Individual Director and Non-Director Committee Member Peer Assessment (Appendix I)	Self-Improvement To plan for recruitment, renewal of term	Annual – Sent April, Reviewed May	For Directors, results reviewed by Governance Committee and Board Chair. Board Chair or delegate discusses results with Directors as necessary. The Chair reports results to Governance Committee (particularly in cases where the Director is being considered for a renewal term) For non-director committee members, results reviewed by Governance Committee and relevant committee Chair. As necessary, committee Chairs discuss results with non-director committee members. Results reported to Governance Committee Chair, as necessary Individual results for Directors and non-director committee members provided to individuals for review

Type of Evaluation	Purpose	Frequency	Review of Results and Action
Board Chair/ Committee Chair Evaluation (Appendix J)	Self-improvement; renewal of term	Annual – Sent April, Reviewed May	Chair of Governance Committee reviews and discusses with Board Chair
	Self-improvement; Renewal of Chair term	Annual – Sent April, Reviewed May	Chair of Governance Committee or Board Chair reviews and discusses with the Committee Chair, considers results in reappointing. Individual results are shared with each Chair
Board (Annual) Committees (Annual) (Appendix K)	To improve Board performance	Annual – May	Reviewed by the Governance Committee and Board. The Board and Governance Committee review and makes recommendations for improvement
	To improve committee performance	Annual – May	Reviewed by the Governance Committee and relevant committee. The relevant committee and Governance Committee review and make recommendations
Appointees for non-Board Committees (PFAC, CMHVA, CMHF) (Appendix L, M, N)	Self-improvement; renewal of term	Annual – Sent April, Reviewed May	Governance Committee and Board Chair. Board Chair or delegate discuss results with Directors as necessary, individual results provide to individuals for review
ABCDE Goals (Appendix O)	Self improvement, to improve Board performance	November/February/ June Annual – Summer	Progress reviewed by at the Board meetings Board Chair and Director review progress of goals/ finalize future goals

*Appendices are in package 2

BOARD MANUAL

SUBJECT: Hospital Naming Policy	**NO.: 2-C-55**
SECTION: Corporate Performance and Oversight	
APPROVED BY: Board of Directors	**DATE: TBD**

Purpose

This policy provides guidance to the Board to ensure that Cambridge Memorial Hospital is in compliance with the Ministry of Health (MOH) direction related to hospital naming activities.

Background

As directed by the MOH, hospitals are not required to obtain approval from the Ministry prior to adopting a new corporate or business name. Hospitals are expected to adhere to the following Ministry expectations related to hospital naming activities:

i) Each hospital should have in place a naming policy to ensure a consistent approach to the adoption of corporate and business names.
ii) Meaningful consultation with stakeholders and the community concerning the adoption of a proposed name is an essential step in determining whether to adopt a new corporate or business name.
iii) A hospital corporation and business names are valuable assets to the hospital and community. A decision to adopt a new corporate or business name in recognition of philanthropy should be made where the level of philanthropy corresponds with the value of that asset.
iv) Any agreement concerning the adoption of a corporation or business name should not include a contractual term to the effect that a hospital will use a name indefinitely.
v) Hospitals will continue to provide the Ministry's Hospitals Branch with notice of the anticipated adoption of a new corporate or business name[1].

Process

In consideration of any request to rename the hospital and to adhere to the Ministry direction, the Board will participate in the process described in the CMH Foundation Policy 6, Appendix A, as amended from time to time by the CMH Foundation (awaiting final version from CMHF).

[1] Changes to the Hospital Naming Directive | Ontario Newsroom. Published December 18, 2019. Also outlined in a letter from the Minister of Health & Deputy Premier to the CMH Board Chair dated December 18, 2019.

DEVELOPED: September 30, 2020	REVISED/REVIEWED:	
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.
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BRIEFING NOTE

Date: May 10, 2024
Issue: Governance Committee Report to Board of Directors May 9, 2024
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: None

A meeting of the Governance Committee took place on Thursday May 9, 2024 at 1700 hours.

Attendees:	M. Lauzon (Chair), J. Goyal, M. McKinnon, J. Stecho, A. Stewart B. Conway,
Staff Present:	P. Gaskin, S. Pearsall
Regrets:	M. Protich

Committee Recommendations/Reports – Board Approval Sought

That, the Board of Directors approves the following policies as amended.
2-A-16 Governance Committee Terms of Reference
2-D-40 Evaluation of Board, Committees, and Individual Performance

Approved Committee Recommendations/Motions:

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 following policies be approved as amended. **CARRIED**
2-A-16 Governance Terms of Reference
2-D-40 Evaluation of Board, Committees, and Individual Performance

Committee Motions/Recommendations/Report – Board Approval Not Sought

MOTION: (Conway/Stewart) **that,** the consent agenda be approved as circulated. **CARRIED**
- Minutes of March 14, 2024
- Committee & Board Attendance Reports
- Governance Work Plan
- Policy Schedule Review
- Action Log

Committee Matters – For information only.

1. **Welcome & Territorial Acknowledgement:** A. Stewart presented the Territorial Acknowledgement.
2. **Policy Reviews and Approvals:** The Governance Committee reviewed three new policies and one returning policy as pre-circulated in the meeting agenda package. 2-C-30 Financial Objectives, Financial Planning & Performance will be brought back to the September Governance meeting once reviewed further with CMH's Finance department. 2-A-16 Governance Committee Terms of Reference and 2-D-40 will be brought forward to the Board for approval at the June 26, 2024 meeting.
3. **Board/Committee Feedback Reports Review:** The Governance Committee reviewed the feedback reports from the April Board and Committee meetings. There were no concerns.
4. **Governance Committee 2023/24 Board Summary:** The Governance Committee worked through completing the 2023/24 Annual Committee Summary for presentation at the June 26, 2024 Annual meeting.
5. **Board Unconscious Bias Education Feedback:**
   The Governance Committee reviewed the feedback responses from the education event held at CMH in April. The feedback was positive and there were no concerns.
6. **2023/24 Annual Board Surveys Review:**
   Annual surveys were completed for the following;
   - Personal Assessment Survey (Director and non-director)
   - Peer Assessment Survey (Director and non-director)
   - Appointees for non-board committees (PFAC/CMHF/CMHVA)

   The Governance Committee reviewed the summary reports from the responses received. Surveys were sent on April 26, 2024. Directors and non-Directors were asked to complete the surveys by May 3, 2024.
7. **2023/24 Annual Declaration and Consent:**
   Annually the Corporation and Board of Directors needs to ensure that all new and returning Directors and non-Director committee members fulfill the requirements for the Board and/or Board Committees. In 2023 an annual process was implemented for members to sign and complete an annual declaration and consent form that was updated to incorporate changes withing the new ONCA legislations. There are currently twelve returning Directors and twenty-three returning non-Directors that make up the Cambridge Memorial Hospital governors. Eleven Directors and eleven non-Directors have completed the declaration. There were no items of concern. CMH Management will follow up with the individuals who have not yet submitted their declarations.
8. **2024/25 Recruitment / Board Appointments:**
   The Governance Committee received and reviewed recommendations from the interview team for the 2024/25 Board Cycle. Recommendations for the following will be brought forward to the Board of Directors for information at the June 6 meeting and then for motions at the June 26, 2024 meeting:
   - Non-Director committee member appointments (Resources & Digital Health Strategy Sub-Committee)
   - Recommendations of Officers for 2024/25
   - Recommendations of appointment of CMH Board Committee Chairs
   - Recommendations for appointment of CMH Directors to non CMH Boards.
9. **OHA Fall/Winter Legislative Regulatory Summary:**
   Throughout fall 2023, and winter 2024, the OHA was actively engaged in a wide range of legislative and regulatory areas including medical assistance in dying, Ontario Health Teams, integrated community health service centres, not-for-profit corporations, forced and child labour, and health profession regulation. The Governance Committee reviewed

the OHA fall/winter legislative and regulatory summary provided by the OHA. There were no concerns on reporting or legislative compliance for CMH The OHA is monitoring a number of potential regulatory and legislative developments. Information will be shared with the Governance Committee as updates become available.

BRIEFING NOTE

Date: June 20, 2024
Issue: Resources Committee Report to Board of Directors May 27, 2024 OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Bonnie Collins, Administrative Assistant
Approved by: Lynn Woeller – Chair
Attachments/Related Documents: None

A meeting of the Resources Committee took place on Monday, May 27, 2024 at 1700h	
Present:	Lynn Woeller (Chair), Sara Alvarado, Tom Dean, Lori Peppler-Beechey, Janet Richter, Gerry West
Regrets:	
Staff:	Trevor Clark, Patrick Gaskin, Mari Iromoto, Erin Rideout, Valerie Smith-Sellers, Susan Toth
Guests:	Kim Haley (KPMG), Pream Luckhoo (KPMG)

Committee Recommendations/Reports – Board Approval Sought

None (Motions approved at the June 5, 2024 Board of Directors Meeting)

Approved Committee Recommendations/Motions:

None (Motions approved at the June 5, 2024 Board of Directors Meeting)

Committee Motions/Recommendations/Report – Board Approval Not Sought

THAT, the items on the consent agenda be approved with the following correction to the April 22, 2024 minutes:

- 4.4.1 Minutes of April 22, 2024
  - Page 6: 5.4 CMH-JCCLP Settlement – "The JCCLP settlement was approved by the Board at a special meeting on March 22, 2024…" should read, "The JCCLP settlement was approved by the Board at a special meeting on March 25, 2024…"
- 4.4.2 Resources Committee Attendance Report
- 4.4.3 Q4 Capital Spending Update
- 4.4.4 Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding Certificate of Compliance
- 4.4.5 Action Log
  - 4.4.5.1 March 2024 Sick Time Update. (Peppler-Beechey/Richter) **CARRIED.**

Committee Matters – For information only

1. **Bill S-211 Board Presentation**
   Management presented Bill S-211 Act to Enact Fighting Against Forced Labour and Child Labour in Supply Chains Act, the reporting requirements, and CMH's report to the Resources Committee. The purpose of the Act is to report on the work completed to combat forced and child labour within the reporting year. Currently, the only mandatory requirements are to submit the report and complete the questionnaire for the 2023-24 fiscal year. Posting the reports on the CMH website is also mandatory. The Committee looks forward to CMH's updated plan outlining targets for 2024-25 and going forward. The Committee requested that management confirm the responses to questions 11 and 13 of the questionnaire before submission.

2. **Multi-Sector Service Accountability Agreement (M-SAA) Schedule F Declaration of Compliance**
   Management presented the M-SAA Schedule F Declaration of Compliance for the Resources Committee's approval.

3. **HSAA Article 8 – Declaration of Compliance**
   Management presented the HSAA Article 8 Declaration of Compliance for the Resources Committee's approval.

4. **2023-24 Resources Committee Summary and Draft 2024-25 Resources Committee Goals and Objectives and Key Performance Indicators**
   The goals and objectives of the Resources Committee for the 2023-24 Board cycle were acknowledged as achieved or in progress during the year.

   The Resources Committee will review the updated goals and objectives for the 2024-25 Board cycle, and L. Woeller will meet briefly with each Committee member for input.

5. **2023-24 Resources Committee Board Summary**
   The Resources Committee will review the 2023-24 Board Summary, and L. Woeller will meet briefly with each Committee member for input.

Placeholder for Resources Committee Report to the Board - TBC June 25

Placeholder for Resources Committee Report to the Board - TBC June 25

Placeholder for Capital Projects Sub-Committee Report to the Board - TBC Tuesday June 25

BRIEFING NOTE

Date: May 8, 2024
Issue: MAC Report to the Board of Directors May 8, 2024 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 Attached

Alignment with 2024/25 CMH Priorities:

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

A meeting of the Medical Advisory Committee took place on Wednesday May 8, 2024, at 4:30 pm.

Present:	Dr. W. Lee, Dr. J. Legassie, Dr. A. Mendlowitz, Dr. J. Bourgeois, Dr. A. Nguyen, Dr. K. Wadsworth, Dr. L. Green, Dr. E. Thompson, Dr. M. Runnalls, Dr. M, Rajguru, Dr. I. Morgan, Dr. T. Holling, Dr. A. Sharma, Dr. I. Isupov Dr. V. Miropolsky
Regrets:	C. Witteveen, Dr. L. Puopolo, Dr. B. Courteau,
Staff:	P. Gaskin, S. Pearsall, L. Barefoot, K. Baldock, A. Omollo, H. Elliott, Dr. K. Nuri, J. Visocchi, N. Grealy (Recorder)
Guests:	D. Wilkinson

Committee Matters – For information only

1. **M&T Report:** The April M&T report was approved by MAC (Holling, Sharma)

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

Dr. K. Nuri provided an infectious disease update. COVID-19 positivity is 6.3% and remains steady. Influenza positivity is low at 2.8% and Respiratory Syncytial Virus (RSV) with a 0.7% positivity. The most common COVID-19 lineage is JN.1. Region of Waterloo has had 20 new

COVID-19 cases and 6 hospitalizations and 2 ICU. Ontario's spring 2024 COVID-19 vaccine campaign is currently underway and will run from April to June 2024. To protect the most at risk of severe outcomes, the Ministry of Health has recommended the following receive an additional dose of COVID-19 this spring: adults 65 years and older; adult residents of long-term care homes, retirement homes and other congregate living settings for seniors; individuals 6 months of age and older who are moderately to severely immunocompromised; individuals 55 years and older who identify as First Nations, Inuit, and Métis and their non-Indigenous household members who are 55 years and older. Eligibility includes those who are six months from the previous COVID-19 vaccine dose or known COVID-19 infection (whichever is later). Receiving a COVID-19 vaccine this spring is particularly important for individuals listed above who did not receive a dose during the Fall 2023 campaign. There were 14 confirmed measles cases in Ontario as of April 24, 2024 with 13 cases associated with travel and 1 individual with an unknown source of exposure. Dr. Nuri commented that avian influenza has been monitored by Public Health but no confirmed cases at this time.

3. Patient Experience Semi-Annual Update

H. Elliott and A. Omollo provided a semi-annual report of the Patient Experience Office. The presentation was included in the MAC package. Highlights of the presentation included:

1. As an identified staff innovation fund project this year, the patient experience office will be embarking on an initiative to address accidental loss of medically necessary belongings. The Staff Innovation Fund project will be focused on prevention of these lost patient belongings, and the first collaborative working group has already met to determine process gaps and strategies. The plan includes testing in the ED and Medicine with eventual hospital-wide implementation.
2. In 2023/2024, there has been a 5.5% decrease in volume of complaints and 39.3% increase in volume of compliments.
3. Tactics for each of the priority themes was shared (formalized roles; continuous feedback loop; communication is a cornerstone; actions & environment demonstrate respect for diversity; and adopt innovation solutions).
4. Response time to patient complaints/compliments has gradually improved over the past few years, 99.3% within 5 days of the feedback in 2023-2024. For both compliments and complaints, care/treatment attitude and communication are the common themes, which impacts patient perceptions of care both negatively and positively. Overall trend of our compliments meeting/exceeding targets in 2023-2024.
5. Several projects to improve patient experience: DEI initiatives, standardized external patient experience measurement, PX Staff development; patient belongings project, patient declaration of values refresh.
6. Collaborative efforts to draft the CMH Personal Pet Visiting Policy, Patient relations policy approved that guide the work of leaders and PXLs with a standard response chart to ensure feedback is being shared and received consistently between those involved. "PX Spotlight" was launched on SharePoint which showcases program-level work that enhances the patient experience.

Dr. W. Lee thanked the PX team for their efforts for standardizing the format for managing patient relations submissions and the Chiefs for aiming for a timely response to queries by the PX Office team, as it enables timely service recovery. To date, it has been positively received and effective in managing patient relations submissions from the physician leader perspective.

4. Patient Safety Incident Management – Overview of RL System

K. Baldock, Quality and Patient Safety Lead, provided a presentation on the Patient Safety Incident Management process and system. K. Baldock reviewed (a) Just Culture at CMH (b)

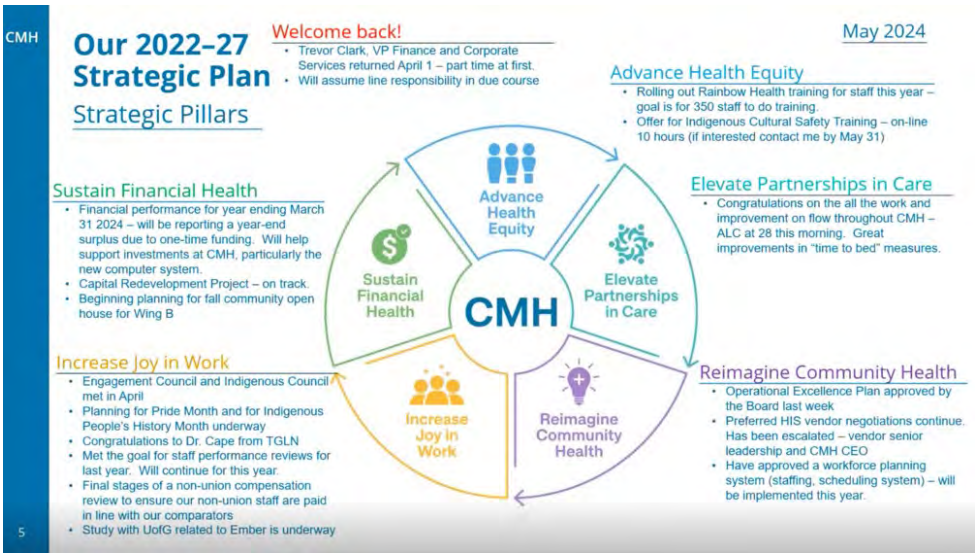
Responding to patient safety incidents (i.e., disclosure to harm (c) the Report Link (RL) system and (d) incident reviews. Details of the RL severity levels, the type of incident review associated with the levels and the action that occurs with each of the severity levels. Physicians may be asked to support information gathering, analysis of the incident, and may participate in an incident review (which can occur at the department or organizational level). Dr. A. Nguyen did comment that education across the organization is required as he has noted that RL severity level of reported incidents are often logged based on the outcome of the incident rather than the circumstances that impacted the outcome in the incident. L. Barefoot recognizes that this occurs and shared that K. Baldock has been attending multiple venues across the organization (e.g., Huddles, various quality committees) to educate staff and leaders. Additionally, a level of severity on a RL submission may be changed based on the incident or quality review. Chiefs were invited to reach out to K. Baldock to speak more on the patient safety incident management system at Department meetings.

5. Choosing Wisely Update – Folate

Dr. J. Bourgeois shared an update on a Lab's journey towards a Choosing Lab Wisely designation. Scorecard for CMH's lab testing for PTT and PTT/INR, AST to ALT ratio, Urea to creatinine ratio, CK-MB per 100 bed-days and Folate per 100 bed-days was shared. Data from 2018-2023 has shown that CMH has performed well in all these tests with the exceptions of Folate per 100 bed-days. Evidence and CMH data for folate testing was shared. Given that folate deficiency is rare in Canada, for patients at risk of/or suspected of folate deficiency, it is more practical and economical to treat with multivitamin supplement. In 2019-2020, 229 requests for RBC folate were performed at CMH with only one report of folate deficiency. In March 2020, RBC folate was no longer available for routine ordering, with all orders requiring a call to the lab. Despite this, in 2022-2023, the requests for RBC folate testing increased to 238 and none were abnormal. Given the CMH data and evidence for eliminating the testing, the proposed plan will be that RBC folate will no longer be available for routine ordering. The ordering physician will be required to complete a request form with an indication for the testing and approval by the Lab Director or delegate. Dr. J. Legassie thought the approach was reasonable and that education at the time of ordering or on the request form would reinforce the choosing wisely approach to ordering tests.

6. CEO Report

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



7. CNE Report

S. Pearsall's CNE report was pre-circulated in the MAC package. Highlights include ongoing strategies for recruitment of staff including internships and extern programs, 2SLGBTQIA+ health equity education through Rainbow Health Foundation training, perioperative Value Stream Mapping session, and efforts across various departments to address flow in the organization. Dr. W. Lee also highlighted Dr. A. Sharma's participation and leadership in providing psychiatry physician support at SOAHAC (Southwestern Ontario Aboriginal Heath Access Network) once a week, an outreach model that will provide much needed mental health access for our aboriginal community.

8. Board Report

D. Wilkinson provided a Board update. The Board met on May 1, 2024, and had presentations from the Operational Excellence team, Patient Experience team, AI in resume screening at CMH, organizational flow and an update on the Staff Innovation Fund. Board committee updates include a draft year-end financial statement which showed a projected deficit to be a surplus at year-end, which places CMH at a positive position. In contrast, many hospitals are reporting a deficit this year. Quality Committee highlighted the great work of Dr. A. Sharma and the psychiatry team after their quality presentation and the Food Services team, as the committee was able to experience first-hand how CMH meals are prepared with new technology that enhances the patient experience. There was discussion on the announcement of the GRH-SMGH planned merger with a planned generative discussion at the June 2024 Board meeting. Two Board meetings are planned in June, one of which is the Annual General Meeting.

9. PFAC Report

Dr. W. Lee and S. Pearsall provided an update on the May PFAC meeting which included the Patient Experience Office Semi-Annual Update, the Palliative Cart and Three Wishes initiatives, and a discussion on mixed gender rooms. Members of PFAC have been included in recent leader interviews which have been a valuable experience.

BRIEFING NOTE

Date: June 6, 2024
Issue: MAC Report to the Board of Directors June 6, 2024 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 Attached

Alignment with 2024/25 CMH Priorities:

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

A meeting of the Medical Advisory Committee took place on Thursday June 6, 2024, at 4:30 pm.

Present:	Dr. W. Lee, Dr. J. Legassie, Dr. A. Mendlowitz, Dr. J. Bourgeois, Dr. A. Nguyen, Dr. K. Wadsworth, Dr. L. Green, C. Witteveen, Dr. L. Puopolo, Dr. M. Runnalls, Dr. T. Holling, Dr. I. Isupov
Regrets:	Dr. B. Courteau, Dr. E. Thompson, Dr. M, Rajguru, Dr. A. Sharma, Dr. V. Miropolsky, Dr. I. Morgan
Staff:	P. Gaskin, S. Pearsall, M. Iromoto, J. Visocchi, Dr. K. Nuri, N. Grealy (Recorder)
Guests:	D. Wilkinson, C. Wilson

Committee Matters – For information only

1. **M&T Report:** The May M&T report was approved by MAC (Mendlowitz, Witteveen)

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

Dr. K. Nuri provided an infectious disease update. Respiratory virus activity has been decreasing. Positivity for COVID-19 has also been trending down to 9.1%. The dominant COVID-19 lineage is KP.3 followed by LB.1. At CMH, in May, there were a total of 9 COVID-19 cases and 2 cases as of the time of June MAC). The influenza activity is also decreasing with a positivity rate of 0.7%. Wastewater data shows that there is increasing COVID-19 in Kitchener and variable in Cambridge. Universal masking has been dropped in Ontario, with plans to re-

implement next Fall flu season. Measles cases have increased, and Dr. Nuri reminded about the importance of vaccination.

3. Choosing Wisely Update

Dr. J. Bourgeois provided an update on the Choosing Wisely journey for CMH. In 2022, CMH Lab joined the Choosing Wisely Canada (CWC) for Using Blood Wisely and in 2023, CMH Lab joins Choosing Lab Wisely. In April 2024, a CMH team from Diagnostic Imaging, Lab/Pathology, Surgery, Pharmacy and Medicine attended the CWC Annual Conference to identify clinical areas of quality improvement as part of a larger goal of becoming a designated Choosing Wisely Canada Hospital. The CMH group include a number of dyad leaders in key programs. Dr. J. Bourgeois provided an overview of the qualifiers that will lead CMH to achieving the CWC hospital designation, which includes a quality improvement project and a final application for the Choosing Wisely Hospital Designation. Areas of interest for a quality improvement project include lab testing, treatment interventions / de-prescribing, and medication interventions with an environmental impact. A project roadmap for achieving the CWC Hospital "Quality Improvement" Status designation was shared. Steering Committee will be meeting in June with planning for the quality improvement project over the next 1-2 months, with an official kick-off in the fall. Goal will be to achieve the CWC designation in 2025 (8-10 month duration for the quality improvement project).

Dr. L. Green and Dr. J. Legassie shared their experience at the conference, which has led to ideas being implemented at CMH, such as having a medical directive for foley catheter removal by nursing, with specific inclusion criteria for catheter removal, to prevent long stay admissions.

4. Midwives Prescribing and Administering Authority Expanded

C. Witteveen shared an update on an expanded scope of midwives as of May 3, 2024, which includes new designated drug and substance regulations. This will be beneficial for clients and reduce the need for consultation of Obstetricians or family physicians to provide certain medications. The expanded scope includes administering analgesia, additional antibiotics, hormonal contraceptives, hemostatic and iron infusions, and morphine. Through their College, midwives must complete education (webinar) to be in good standing. This change in scope is supported by Dr. A. Mendlowitz and the Obstetrics/Gynecology Department, as it would reduce the need for a separate consultation to allow for clients to access the medications. Dr. Mendlowitz offered education/teaching on certain topics to the midwifery group, such as hormone contraceptives to support this change in scope. C. Witteveen has discussed the expansion of scope at the recent Women's and Children's Department meeting, at the May Credentials Committee meeting, and will be presenting at the M and T meeting at the end of June. C. Witteveen will also be working with Pharmacy to ensure the expanded scope is incorporated in order sets and communicated for awareness.

5. Medical Directive # 220: Emergency Department Adult Asthma Care Pathway

Dr. M. Runnalls discussed Medical Directive #220 which has been updated as per the Ontario Lung Association guidelines. It was also updated to allow nursing to administer the appropriate medications, especially the administration of steroids which was limited previously. The accompanying pre-printed order was also updated to reflect the changes in the Medical Directive.

Medical Directive #220 approved by MAC (Holling, Legassie).

6. Policy Updates

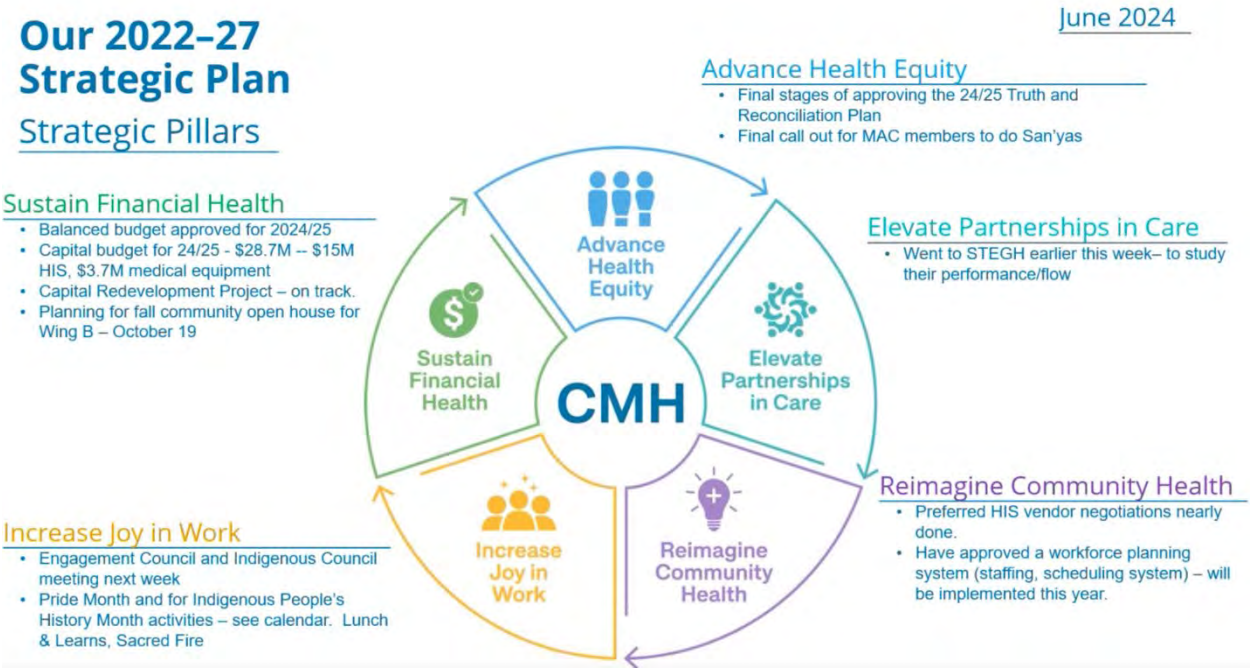
Three policies were shared by Dr. Bourgeois for information (previously approved) for awareness which will be posted on the intranet at the end of the month and is also referenced in

the M and T report. These policies include:

14-194 Measles – Post Exposure Prophylaxis
14-193 Guidelines for Immune Serum Globulin (ISG) – GamaSTAN®
14-111 Immune Globulin – Varicella Zoster

7. CEO Report

P. Gaskin's CEO report was pre-circulated in the MAC package. P. Gaskin shared highlights of the new Indigenous Truth and Reconciliation plan. The framework for the plan aligns with the Ontario Health's framework, with four dimensions: Equitable Access to Culturally Safe care, Build & Enhance Capacity & Education, Measure, Monitor & Evaluate, and Build & Sustain Productive Relationships. The plan will be included as part of our onboarding of new staff and exploring mandatory training for staff. P. Gaskin also provided an update on the five pillars of our Strategic Plan (included below).



8. CNE Report

S. Pearsall provided a CNE update, highlighting the professional practice and clinical informatics programs. The professional practice team is implementing eHealth solutions best practice guide, and a new clinical informatics specialist has joined to focus on workflow. Two staff members received RNAO fellowships for clinical orientation and baby-friendly breastfeeding guideline implementation.

Crisis intervention training is now offered in-house with 10 trainers, essential due to significant onboarding of new staff. Additionally, CMH is partnering with Conestoga College on a We RPN research grant which is about assessing new graduate RPNs' readiness for acute care, which is particularly relevant given the number of novice staff being onboarded.

9. Board Report

D. Wilkinson provided a Board update. The board met for a generative discussion and approved the audited financial statements from the KPMG showing strong 2023-24 results and will be

using the surplus towards the new HIS system. All annual attestations and credentials from MAC were approved. Governance committee has reviewed recruiting two new community representatives and upcoming committee meetings. The board also reviewed the set performance goals for the CEO and COS for 2024-25. Formal annual meeting will be held at the end of the month.

10. PFAC Report

S. Pearsall provided an update on the PFAC committee, which met in person. Advisors unanimously supported the removal of marital status from patient registration. There was a discussion about the lost belongings working group, emphasizing the importance of items like hearing aids, glasses, and dentures. An overview of VOYCE showed that Arabic had become the top language used for interpretation services, surpassing ASL. There was also a discussion on the recent visit to STEGH and ambulance offload times which was well received by the group.

CAMBRIDGE MEMORIAL HOSPITAL

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May/June 2024

Board Report

Backlot BBQ

Despite the heat, Board members came to lend a helping hand at this years Backlot BBQ, showcasing their dedication to CMH!

CMHVA AGM

Lynn Woeller & Nicola Melchers attended the CMHVA's annual meeting to offer greetings and support on behalf of the Board.

Lunch & Learn

On June 20, 2024, Bill Conway, Tom Dean, and Miles Lauzon took part in the Two-Spirit Lunch & Learn with local indigenous author, Sarah Siembida.

OHA

Patrick Gaskin, Nicola Melchers, Lynn Woeller, and Julia Goyal attended OHA's Healthcare Leadership Summit. The session focused on critical themes in health system transformation. Held in Toronto, this year's summit brought together hospital Board Chairs, and CEO's to discuss innovative approaches to impriving healthcare delivery. Key topics included the future role of hospitals, enhancing patient care, and

Symphony at CMH

Sara Alvarado, and member of the Cambridge Symphony Orchestra visited CMH on June 18, 2024 performing in the Wing A main entrance. The brief performance brought pleasure to patients, visitors, and staff who stopped to listen. The visit was a pop-up in celebration of the 20th anniversary for the Orchestra.

Good Morning Cambrdige

On June 9, 2024, Sara, Nicola, Lynn and Val, along with other participants, walked from Cambridge to Paris to raise awareness about community hospital needs and to raise funds for Cambrdge Memorial Hospital and the new MRI.

Congratulations!

Grand Rounds

Steatotic-what? "Fatty Liver" Nomenclature Update and Review

Bill Conway, Nicola Melchers and Tom Dean attended the May 23 Grand Rounds session with Dr. Olgun Akman – Gastroenterologist / hepatologist. The sessions learning objectives included:

- ✓ New nomenclature for patients with "Fatty Liver"
- ✓ Epidemiology and Differences between MASLD and ALD
- ✓ Non-pharmacologic interventions in patients with SLD

Let's Celebrate

On May 13, 2024 CMH hosted a celebratory event & construction tour to honour the efforts of the CMH Capital Projec Sub-Committee. Committee members both past and present along with members of our Board of Directors gatherd for the event.

CMH President & CEO Report
July 2024

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

June is Pride & Indigenous History Month

- June is a significant month at CMH, as we celebrate both Indigenous History Month and Pride. This is a time for reflection, education, and action, reinforcing our promise to foster an inclusive and supportive healthcare environment for all.
- Indigenous History Month invites us to honour and recognize the rich traditions, resilience, and contributions of First Nations, Inuit, and Métis peoples. It is a time to reflect on their enduring strength and celebrate their stories and achievements despite historical challenges.
- In support of this, we will host a Lunch & Learn focusing on Two-Spirit identities and host a Sacred Fire Ceremony led by local elder and traditional medicine healer Myeengun Henry. These events are offered to deepen our understanding and respect for Indigenous cultural practices and healing traditions within our hospital.
- Alongside, Pride Month provides an opportunity to emphasize our commitment to creating safe and welcoming spaces for the 2SLGBTQIA+ community. Our theme this year, "Inclusive First Impressions and Interactions," highlights the importance of inclusive communication and environments.
- Guided by Best Practice Spotlight Organization (BPSO) principles, we strive for continuous education and the creation of safer spaces to improve the sense of belonging and health outcomes for all individuals.
- Both observances highlight our collective mission to advance health equity and keep people at the heart of all we do. We believe that everyone deserves access to quality care, free from discrimination and bias.
- We encourage you to participate in the planned events, broaden your understanding, and engage actively. Your involvement is vital in making a positive impact on our patients and colleagues.
- Let's work together to make this June a month of learning, growth, and unity.

Leigh Anne Lacourciere - Manager of Inpatient Surgery, Allied Health & Social Work

- We are very pleased to announce that Leigh Anne Lacourciere (pronounced La-Core-See-Air) is joining the CMH leadership team as Manager of Inpatient Surgery, Allied Health & Social Work, effective July 22, 2024.

- Leigh Anne comes to us from Guelph General Hospital, currently serving as Interim Director of Inpatient Surgery, Allied Health & Social Work. Her strong background in clinical leadership and education punctuates her commitment to evidence-based patient care. Eager to bring her skills and experience to CMH, Leigh Anne aims to support the organization's mission of delivering high-quality, patient-centered care.
- Leigh Anne holds a Master of Arts in Organizational Leadership from the University of Guelph and is completing a Certificate in Risk Management from York University. Additionally, she is certified in LEAN Healthcare, cultural safety, and advanced clinical education.
- The interview panel included Directors, Managers, Clinical Educator Facilitator (CEF), Social Work, and Registered Staff from Inpatient Surgery, all of whom were impressed with her focus on quality, patient safety, collaboration with patients and families, and team engagement.
- She is married with three teenage daughters. Leigh Anne's oldest daughter attends the University of Guelph, her middle daughter is heading to Laurier this fall and the youngest is about to start high school. The family has two black Labradors: Dyson & Gibson. A lover of books and baking, she is also a secret "Swiftie." Leigh Anne's proudest non-work accomplishment is completing the Dopey Challenge at Walt Disney World; this is a 4-day running event made up of a 5K, 10K, half-marathon and full-marathon.
- She is thrilled to join the CMH team and looks forward to meeting everyone, making new friends and developing relationships that will positively impact the patients and families we serve.
- Please join us in welcoming Leigh Anne to our program and the CMH leadership team.

HR project to onboard staff wins award

- Many thanks to Beth Jones, Manager, Volunteer Services and HR Project Management for her leadership to revamp and improve CMH's onboarding process which also includes orientation.
- This project won a $5000 Sustainable Solution award from Healthcare Excellence Canada in June 2024.
- The successful onboarding of new staff can lead to reduced costs associated with recruitment, overtime and even sick time when teams are short-staffed. CMH's entire onboarding process was reviewed in a self-funded project over the 2023-24 period. It saw many enhancements, including an increased frequency of orientation days.
- The new approach embraces a concierge, customer-focused experience that brings services like IT set-up and parking sign-up to staff rather than sending them to different areas within hospital. With the addition of an onboarding coach that does regular check-ins with new staff, the feedback has been highly rated, with staff feeling 'ready to go' as part of the team and managers feeling supported that their new staff's needs were met.

Graham Seed Fund Award

- CMH was honoured to have two projects selected for the University of Waterloo's Graham Seed Fund (GSF). This fund seeks to leverage and build health system partnerships by providing resources for collaborating directly with a full range of health providers and clinicians. This collaborative, interdisciplinary model will help to quickly advance solutions for challenging areas in health technology.
- Last month, we celebrated the Laboratory Department's winning submission. Below is the Decision Support, Surgery Program submission to optimize OR schedules using machine learning and artificial intelligence:

    - A major challenge for many hospitals is addressing surgical wait times and optimizing Operating Room (OR) utilization to ensure timely patient care and efficient resource management.
    - Without advanced predictive and prescriptive analytics, forecasting surgical capacity, volume, duration, or bed demand is difficult, leading to wasted resources and overcrowding. This results in patient flow bottlenecks and overcapacity issues in surgical and recovery areas.
    - The University of Waterloo's Graham Seed Fund-sponsored project, "Optimal Operating Room Scheduling at the Cambridge Memorial Hospital," proposes using artificial intelligence and machine learning to improve OR scheduling. It is estimated that efficient patient scheduling can reduce cancellations by 30-40%. The project aims to develop innovative software as a decision support tool, enhancing current practices by addressing the complexities of OR scheduling.
    - By analyzing historical data, the system will predict patient volumes, surgery times, and resource needs, dynamically adjusting to varying demands. This approach will optimize OR schedules, address bottlenecks, and ensure efficient use of OR time. Additionally, adaptable models will simulate scenarios and recommend actions to increase efficiency, improve patient care and reduce surgical backlogs.
    - The project's success holds significant commercial potential, offering a market-ready solution to a widespread problem. A successful predictive and prescriptive algorithm in an OR scheduling system can address Canada's sizable backlog in medical surgeries. In Ontario alone, over 200,000 patients await procedures. Reducing wait times will alleviate patients' pain, anxiety, and health risks. Improved wait times enhance the overall efficiency of the healthcare system, while reducing financial burdens on hospitals.
    - This project is a collaboration between University of Waterloo's team comprising Dr. Houra Mahmoudzadeh, Associate Professor Department of Management Science and Engineering; Dr. Hossein Abouee Mehrizi, Professor Department of Management Science and Engineering; and CMH's team comprising Kyle Leslie, Director of Operational Excellence; Kim Towes, Director of Surgical Services; Dr. Waqas Muhammad, Data Scientist Lead; Kristan Chamberlain, Senior Decision Support Specialist; Jennifer Mason

Shepherd, Surgical Booking; Rob Howe, Director of Digital Health; and Michelle Tavares, PICIS Software Coordinator.

Medical students ROMP at CMH for the day

- CMH was proud to host first and second year medical students from Queen's University and University of Toronto during *Rural Ontario Medical Program* (ROMP) week for some hands-on experience in local family practices and CMH.
- Over two days, they met with several specialists, shadowing them in radiology, endoscopy, ORs, Liver Health, and the Emergency Department. They ended their stay in a suture clinic under the expert guidance of Dr. Jay Geddes, Family Physician and Surgical Assist.
- As part of the fun and to introduce the amazing community we are part of, the students participated in a scavenger hunt and visited family medicine clinics.
- Rural Ontario Medical Program (ROMP) is a voluntary association of physicians who share a commitment to providing quality educational experiences in rural medical practices. Locally, it is organized by Doctors for Cambridge and has placed ROMP students at CMH for over a decade.

My Cast Buddy Project: staff-led initiative brings comfort to patients

- A hospital can be a scary experience for a child, especially when the pain of an injury is mixed with new people providing necessary medical care. That's why Liliana Gramada, Orthopaedic Technologist, introduced the My Cast Buddy Project – conceived by one of the most creative minds known - that of a child!
- "My daughter visited the hospital when she was six and suggested we cast a bear that had been donated to the Fracture Clinic. By doing this, it made her more relaxed to see the doctor," said Gramada. So, she researched and found different studies that used stuffed animals to help calm and educate young patients during medical procedures.
- Liliana has been part of CMH's Fracture Clinic for 10 years. Being witness to children experiencing fear or pain and having searched for ways to help, this child-inspired idea was just the ticket. My Cast Buddy Project was officially launched April 2024 with the hope to shine a light and bring comfort to children on their worst day when some procedures can be quite painful. The toy functions as a distraction, bringing the patient joy at a frightening moment.
- The stuffed animals come from the Pediatrics department. Tracy Astorino, Child Life Specialist says: "Toys are usually donated around Christmas time and other holidays of giving, and then distributed throughout the year to children in all areas of the hospital. This provides them some comfort from either a stuffed animal, or something to just pass the time while they're with us."
- Thank you, Liliana, Tracy and all staff involved in this patient centred initiative!

Voices of CMH: Jude Veber, RN (they/them)

- What does Pride mean to me?
- It took me a long time to fully understand and accept myself as trans and non-binary. I came out to my friends and family in October of 2019 and due to the pandemic, did not get to experience Pride until 2 years ago. Back then, Pride was something new to me, and was an experience that I was not familiar with, but overall, it was good timing to make me feel included and less alone in my gender diversity. Nowadays, it is not only a place for me to feel less alone but also a time to celebrate how far I have come. It gives me hope for the future of the 2SLGBTQ+ community. There has been a rise in anti-LGBTQ laws in the USA and an increase in hate speech towards the community over the last few years that has filled me with fear, but going to Pride this week and seeing so many people like me helped give me hope that we will continue to fight, and be present, despite the increase of hate that has been growing recently.
- Pride is a space for everyone, and it does an amazing job of bringing people of every background together, whether through protest, dance, or simply local activities in the community. Even seeing Pride flags more frequently helps me and other queer people to know we are recognized and cared about. For those who are not part of the 2SLGBTQ+ community, it is important to note that as fun as Pride is, it is also a protest. We don't only celebrate who we are and how far we have come but we also have Pride to protest the hate and marginalization that exists within the broader community. Even if you are not part of the 2SLGBTQ+ community, you are still welcome at Pride; it is for everyone, even allies. You can show your support by going to a Pride event, or by listening to those who are queer in the community. By doing so, you are helping to make a big difference. As an ally, it is important to make sure you are giving the spotlight to those in the queer community and supporting them without speaking on their behalf.
- In the past, I have gone to Toronto's Pride event, which is very large and busy. It is nice to spend the weekend in Toronto and meet many other people who are like you. Usually there are marches that people can participate in on the Friday and Saturday before the Sunday parade. These marches are part of the protest piece of Pride which is very important. There is a lot of fun to be had as well, with drag shows and many shops on Church Street in Toronto that have events over the weekend.
- The Voices of CMH is an initiative that celebrates CMH's diverse culture and backgrounds with the goal to educate and learn more about one another.

Pronoun Usage: Fostering inclusivity

- Building a culture of Inclusive First Impressions and Interactions where everyone feels like they belong is possible. Chosen pronoun usage when engaging with others, whether verbally, visibly printed on our badges and name-cards, or in our email signatures, is a small but meaningful way to foster inclusion, especially toward 2SLGBTQIA+ patients.

- *What is gender identity, gender expression, and why do pronouns matter?*
    - **Gender identity** is each person's internal and individual sense of being a woman, a man, both, neither or anywhere along the gender spectrum. It is how people perceive themselves with respect to their gender and who they are as a person.
    - **Gender expression** is how a person publicly expresses or presents their gender. This can include behaviour and outward appearance such as dress, hair, make-up, body language, and voice. A person's chosen name and pronoun can also be a way of expressing gender.
    - The way people describe themselves and being referred to by the right terms are important parts of affirming identities. Using the wrong language about a person can imply that their gender identity is not respected and even when done unintentionally, can have long-lasting harmful impacts. When we're working with people of all gender identities and gender expressions, it is important to consider our use of gender specific pronouns.
    - **Pronouns** are part of a person's identity, just like names are. It's important that like a name, we take the time to learn preferred pronouns rather than making assumptions about how to refer to people in conversation or writing. While it may be a learned habit to refer to everyone as "he" or "she" based on appearances or names, we need to recognize that gender is a spectrum, and no one can assume a person's gender or a person's preferred pronouns based on their appearance.
    - **It is also important to note** that the 2SLGBTQIA+ community is diverse, and that language and terminology are constantly evolving. While terms and definitions are generally accepted today, they may continue to evolve over time.
- *What are some of the pronoun sets and what do they mean?* This list is not exhaustive and is important to give a person the opportunity to state the pronoun that is correct when referring to that person.
- **They/them/their** - In addition to its use as a plural pronoun, they/them/their has a rich history of use as a gender neutral singular pronoun in the English language. The Oxford English Dictionary sources the singular "they" as far back as 1375. "They" is often used in reference to a singular person whose gender pronouns are unknown, such as in the sentences "Someone left their umbrella here. How can we find out who they are?" or "I'm not sure what their pronouns are. I should ask them next time." It's also very important to honor that some people specifically use they/them/their pronouns instead of "he" or "she" to represent their identity outside of the gender binary.
- **Ze/hir/hirs, ze/zir/zirs** - The ze/hir, ze/zir pronoun sets come from the trans community as another gender-neutral pronoun set. It's up to each individual to decide which pronoun best fits them and their identities. Ze (zee) is typically pronounced similar to how some people may pronounce the letter Z. Hir is typically pronounced like the word "here." Zir (zee-ee-r) is typically pronounced like "here" with a Z in front.

Agenda Item 1.5.7

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						C	C	
	➢ Approve COS goals and objectives							C	C	
	➢ Mid-year CEO assessment input from Board	Board			C				C	
	➢ Mid-year COS assessment input from Board				C				C	
	➢ Mid-year/Year-end CEO report and assessment	Executive			C					
	➢ Mid-year/Year-end COS report and assessment				C					
	➢ CEO evaluation/feedback – mid-year	Executive			C					
	➢ COS evaluation/feedback – mid-year				C					
a-iii	➢ CEO evaluation/feedback –year end and performance based compensation	Executive							C	√
	➢ COS evaluation/feedback –year end and performance based compensation								C	√
	➢ Reviewing the performance assessments of the VPs – summary report provided to the Board (as per policy 2-B-10)	Executive			C					
b	➢ Strategic Plan: approve process, participate in development, approve plan (done in 2022, will be done again in 2027)	Board								
b	➢ Progress report on Strategic Plan – Updates completed through the corporate scorecard	Board	C		C			C		√
b-iii-c	➢ Approve annual Quality Improvement Plan (QIP)	Quality					C			

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Agenda Item 1.5.7

BOARD WORK PLAN – 2023-24

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

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Agenda Item 1.5.7

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 HIS Board Generative Discussion	Board		C			C		C	
e-i-A	Receive a summary report on: • CEO succession plan and process • COS succession plan and process • Succession plan for executive management and professional staff leadership	Executive Executive Executive								√ √ √
	Professional Staff									
f-i-A f-i-B/C	➢ Ensure the effectiveness and fairness of the credentialing process ➢ Monitor indicators of clinical outcomes, quality of service, patient safety and achievement of desired outcomes	MAC/Quality MAC	C	C	C	C	C	C	C	√
f-i-C	➢ Make the final appointment, reappointment and privilege decisions for Medical/Professional Staff ➢ Oversee the Medical/Professional Staff through and with the MAC and COS	Board COS	C C	C C	C C	C C	C C	C C	C C	√ √
	Build Relationships									

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Agenda Item 1.5.7

BOARD WORK PLAN – 2023-24

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

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Agenda Item 1.5.7
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							C	
i-i-D	➢ Periodically review and revise governance policies, processes and structures as appropriate	Governance	C		C	C	C	C	C	
	➢ Review Progress on ABCDE Goals *(Director & Chair meet during July/August to establish goals for upcoming Board cycle)*	Board			C			C		√
	Fundraising									
k	➢ Support fundraising initiatives including donor cultivation activities. *(through Foundation Report and Upcoming Events)*	Foundation	C	C	C	C	C	C	C	√
	***Public Hospitals Act* required programs**									
l-i-A	➢ Ensure that an occupational health and safety program and a health surveillance program are established and require accountability on a regular basis - TBD	Audit								
l-i-B	➢ Ensure that policies are in place to encourage and facilitate organ procurement and donation	Quality								√

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Agenda Item 1.5.7
BOARD WORK PLAN – 2023-24

Charter Section #4	Action *(Italics-comments)*	Committee Responsible	Oct	Nov	Dec	Feb	Mar	May	Jun	Jun
l-i-C	➢ Ensure that the Chief Executive Officer, Nursing Management, Medical/Professional staff, and employees of the Hospital develop plans to deal with emergency situations and the failure to provide services in the Hospital	Quality			C					
	Recruitment									
n	➢ Approve interview team membership (noted in By-law)	Governance			C					
	➢ Review recommendations for new Directors, non-director committee members (2-D-20)	Governance							C	
	➢ 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							C	√

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Agenda Item 1.5.7
BOARD WORK PLAN – 2023-24

ON GOING AS NEEDED

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

Agenda Item 1.5.7
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 2022, next review 2025)	Board oversight Led by CEO
m	Communications Policy	Oversee the maintenance of effective stakeholder relations through the Corporation's communications policy and programs (updated communication plan (2023-2027) to be approved by Board in 2023)	Board oversight Led by CEO

DELAYED

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

Agenda

2023/24 Board of Directors Action Log – 17-06-2024 Agenda Item 1.5.8

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 discussed at September's Governance Committee meeting
01-03-2023	3.9 – Foundation Events	Management to review and include the recommendation in the Board Policies	P. Gaskin	Will be discussed at September's Governance Committee meeting
26-04-2023	4.10 – CND OHT Mental Health & Addictions Clinic	Management to review the data points that will be reviewed through the CND OHT evaluation process	P. Gaskin	**Complete** – please see the attached infographic summarizing the evaluation. The full evaluation can be found at https://cndoht.com/Projects.htm
06-12-2023	1.5.3 Policy Approvals	2-A-15 & 2-C-40 to be brought back to the Board for review and revision if, upon completion of the Capital Redevelopment Project Sub-Committee is disbanded as of September 2024	P. Gaskin	Will be addressed by Governance Committee in September.
06-12-2023	1.5 Consent Agenda	ABCDE Goals to track by % complete	P. Gaskin	Management will look to update the process / tracking systems
06-03-24	2.1 QIP Discussion	CMH to investigate the ability for Directors to take part in the Rainbow Health course	P. Gaskin	Directors – please contact Patrick if interested. Your enrolment is possible.
06-03-24	2.3 Financials	CMH to discuss Trauma Informed Principles presentation at CMH with M. McKinnon	P. Gaskin	**Complete** – Meeting set up

**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)*

Agenda

CAMBRIDGE NORTH DUMFRIES | OHT

Community Mental Health and Addictions Clinic (C-MAC) Pilot Project

Over the course of 8 weeks in March-April 2023, the C-MAC pilot was collaboratively operated to test a new integrated model of care to support quick access to mental health and addictions care in Cambridge and North Dumfries. The full evaluation report is available at www.cndoht.com.

Evaluation Report Highlights

The C-MAC pilot met intended objectives

- Redirect appropriate mental health and addictions visits from the emergency department.
- Help to reduce the rate of mental health and addictions visits as the first point of contact to the hospital emergency department.
- Increase access to immediate mental health and addictions services and remove barriers to accessing care.
- Increase access to providers that can write prescriptions for common mental health and addictions conditions.

Clients were highly satisfied with their care

- **50%** of clients indicated that if this clinic didn't exist, they would have gone to emergency room
- **94%** felt that their immediate needs were adequately addressed by the clinic
- **97%** of clients were satisfied with the care they received

There is a demonstrable need for these services in Cambridge & North Dumfries

123 individual clients served
451 client encounters
23 emergency department diversions

Clients visiting the clinic were receiving care in the right place

Top Reasons Why Clients Visited the C-MAC

- Anxiety/Panic Attacks: **35.8%**
- Depression/low mood/feeling down: **28.5%**
- Addictions: **17.1%**
- Self harm/suicidal thoughts: **13.8%**
- General mental health: **8.9%**

> I left with a sense of hope and relief that someone cared to help me get better. I will forever be grateful for the experience and hope that this clinic can continue to serve patients that are in need of care and feel like they have to where to go.

Evaluation Recommendations

1. Continue the clinic and seek sustainability funding
2. Refine the clinic model and allow time for training
3. Establish a core team for C-MAC
4. Continue to offer a mix of walk-in and pre-booked appointments
5. Find a documentation solution that works for all partners
6. Continue to collect data and plan for an economic evaluation of the model

July 2023

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						
HIS										5			
Meeting with City Council and CMH Board of Directors - TBD													TBD
Quality Committee 7:00 am – 9:00am	20	18	15		17	21		17	15	19			
Quality Committee QIP Meeting 7:00 am – 9:00 am						7							
Resources Committee 7:00pm – 9:00pm	26		27			26		22	27	24			
Capital Projects Sub - Committee 5:00pm – 6:30pm	26		27			26				24			
Digital Health Strategy Sub - Committee 5:00pm – 6:30pm	21		16		18	15		18	16	20			
Governance Committee 5:00pm - 7:00pm	19		7			21	14		9				
Audit Committee 5:00pm - 6:30pm			13		22			22	27				
Executive Committee 5:00pm - 6:30pm	28		14				11		14				
CMHVA Board Meetings 9:30am - 11:15am - In Person / Hybrid	27	25	29		31	28	27	24	29	26			
CMHF Board Meetings 4:30pm - 6:30 - In Person / Hybrid	25	23	27	11	22	26	25	22	27	25			
OHT Joint Board Committee 5:30pm - 7:30pm - Virtual Zoom meeting	25	23	27	11	22	26	25	22	27	24			
2023-24 Events													

Board/Committee Meetings and Event Dates	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep (2024)
Staff Holiday Lunch - December 7, 2023 11am-2pm / 6-8pm				15									
Career Achievement - April 22, 2024 2:30								22					
Chamber Business Awards - November 13, 2023			13										
CMHF Diversity Dinner – October 3, 2023		3											
CMH Staff BBQ - June 20, 2024 11:00am-2:00pm / 9:00pm-10:00pm										20			
CMH Sacred Fire Ceremony - June 26, 2024 12pm-1pm										26			
CMH Golf Classic - June 6, 2024, Galt Country Club										6			
CMH Reveal - February 29, 2024						29							
Board Social - May 30, 2024 5pm-7pm - Location TBD									30				
Board Education Opportunities													
Governors Education Sessions													
Governance Essentials for New Directors - *Paulo Brasil/Jay Tulsani/Bill Conway*													
Hospital Legal Accountability Framework		3											
Hospital Accountability Within the Health System		10											
Governance and Management - The Crucial Partnership		24											
CMH Leadership Learning Lab													
● *Project Management for the Unofficial PM*									3				
● *Crucial Conversations*			15/16						14/15				
● *7 Habits of Highly Effective People - Nicola Melchers*				5/8									
● *Me2You DISC Profile - Diane Wilkinson*							12						
● *Quality Improvement*		6											
● *Guiding Organizational Change - Lynn Woeller*		11											
● *5 Choices*													
● *Unconscious Bias*								6					
Mental Health First Aid													

BRIEFING NOTE

Date: June 21, 2024
Issue: Board Generative/Education Topics for 2024/25
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Patrick Gaskin, President & CEO
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: None

Background

We recently conducted a survey among the directors to gather suggestions for topics that could be incorporated into our education and generative discussion sessions for the 2024/25 Board year. Based on the valuable input received, a second survey was compiled featuring these suggested topics. Directors were then asked to rate the choices using a scale of 1 to 5, where 1 signifies the least important and 5 signifies the most important. This process was completed so the Board's educational and generative discussions are closely aligned with the priorities and interests of its members, promoting more relevant sessions throughout the year.

Analysis

The top three topics are outlined below.

Mergers/consolidations- more discussion about whether CMH should merge with GRH/SMGH, including lesson learned from other mergers, consolidations, hearing from experts leading multi-hospital networks.

- Timely. Forward looking.
- Better to be proactive and position for trends than be assimilated without a strategy for our community.
- This will be an ever-present topic and should be on our radar for the future. Impact of HIS decision, direction of govt; all key and requires a good understanding by the Board.
- A potential merger with GRH/SMGH has been discussed for many years. I would like to see the above done - but also, an independent consultant report assessing the pros and cons. We need to be able to make a fully informed decision on what is optimal for patient care in our community.
- This is an important topic that the board needs to continue discussing and exploring to have a better understanding on the strengths and weaknesses of a merger/consolidation with GRH/SMGH to inform future decisions and communication.
- I feel it's important for the Board to understand the implications of a potential merger with Kitchener hospitals.
- Very important and timely discussion; Board members should be kept up to date on developments and well versed on this topic.
- Given the environment of mergers (especially in our region), HR concerns (talent) and pressures to deliver high standards of care. Understanding how a shared network or merger would or would not work would add insightful value even if it is in joint venture situations like HIS as an example.

Innovation & Technology in Health Care - Discussing artificial intelligence (AI) at CMH, innovation trends in health care, AI developments and trends, governance implications.

- Forward looking. Strategic viewpoint is important on this issue.
- CMH would benefit enormously from continuing to lead in this space, as AI may help provide efficiencies and better care across the province. Not making this a priority would put the hospital behind.
- I first used CHATGBT about four months ago. I found responses to my questions interesting but somewhat “wishy washy”. Today I find the quality of the answers much more sophisticated, relevant, articulate and yet understandable. My point. This technology is growing and improving literally in leaps and bounds. We need to get ready for the use of AI in clinical medicine.
- I would like us to build on the discussion from our recent meeting; there is much more for the Board to learn and understand in this regard.
- This is a key area for advancing & improving healthcare and the work experience at CMH. Also provides potential opportunities for commercialization/revenue generation.
- AI is an emerging technology that will be used in more and more application at CMH it will be important for the board to understand and discuss the trends to maximize the implementation and to ensure effective governance is in place for the role out and evaluation of these applications.
- The power of AI to help hospitals make "data driven decisions" has great potential to drive efficiency and effectiveness. The Board should help steer the use of this technology.
- I think coupled with this topic is CMH's decision making on HIS; I think it's imperative that the Board understands the strengths/opportunities/weaknesses/threats in the AI/tech space because that knowledge would extend to excellent oversight (NOT IMPLEMENTATION because that's not in the purview of the Board) of the HIS system and roll-out.
- AI seems to be a strong technological force and the more informed we can be as board members the better prepared we can be to support CMH and community with development and change.

Healthcare Trends and the Ontario Landscape - Understanding trends and the strategic direction in Ontario, the work of the Ontario Hospital Association, the advocacy needed, how we could contribute to this.

- It’s always important to be aware of the environment in which you are operating.
- Big picture trends so we can position CMH within those challenges and opportunities.
- The health care system is broken. Major changes will be required to fix it. We as a hospital and member of OHA need to anticipate and understand the impact of government policy, planned initiatives and “trial balloons” that have been floated.
- We need to know trends and directions from OH/govt. to understand the landscape in which we are operating and what's expected from us/CMH.
- So much needs to change with how healthcare is funded in the province ie. funding of HISs, funding envelopes, remuneration constraints, other Board should understand how they can play a more active role in advocacy and effecting change.
- Further learning of trends and direction of health care in Ontario would be a benefit to all board members.
- The Board should understand the trends of healthcare in Ontario on a regular basis.
- Advocacy is super important in the health sector (the funding development of WAHA is an excellent example of the power of collective voice & advocacy); I'm biased because of my involvement at OHA but I would really love to see a stronger link between CMH and OHA; making strong ties to local MPPs etc.

- Any help to understand Ontario's healthcare landscape is appreciated. In my little world I try to advocate for health care as best as I can, but it would help to know how to advocate on a larger scale.
- It is important we understand the provincial needs and landscape to deliver patient care for the future.

Next Steps

The Board Chair and CEO will meet to determine the timing, speakers and other details to effectively integrate the sessions into the 2024/25 Board meeting.

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

MEMORANDUM

TO: Board of Directors, Cambridge Memorial Hospital

DATE: June 19, 2024

REPORTING PERIOD: April 1, 2023 – March 31, 2024

FROM: Patrick Gaskin
President and CEO

RE: CEO Certificate of Compliance

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

In my capacity as 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:

1. Insurance:
   (a) All property, casualty and liability insurance is in place and coverage is suitable and in accordance with risk, the indemnity amount is sufficient in light of risk, all premiums have been paid and the policy is up-to-date;
   (b) Directors' and Officers' liability insurance is in place and coverage is suitable and in accordance with risk, the indemnity amount is sufficient in light of risk, all premiums have been paid and the policy is up-to-date
   (c) CMH is not in default with respect to any provisions contained in any insurance policy; and
   (d) CMH has provided all notices and presented all claims under any insurance policy in accordance with the notice periods established by the insurer.

2. Compliance:
   (a) CMH is in compliance, in all material respects, with applicable health & safety legislation and regulations
   (b) CMH is in compliance, in all material respects, with applicable environmental legislation and regulations
   (c) CMH is in compliance, in all material respects, with all other applicable legislation or regulations applicable to operation of CMH

Exception:

- Broader Public Sector Accountability Act (BPSAA) – Section 12 – Procurement Directives for purchases greater than $100,000 that did not have an open and competitive procurement process.

Patrick Gaskin
President and CEO

BRIEFING NOTE

Date: June 13, 2024
Issue: Patient & Family Advisory Council (PFAC) Annual Report 2023-24
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Liane Barefoot, Director Patient Experience, Quality, Risk, Privacy & IPAC
Colleen Bulla, PFAC Chair
Approved by: Mari Iromoto, Senior Director Strategy & Performance

Alignment with 2024/25 CMH Priorities:

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

Executive Summary

This briefing note will provide Quality Committee members with an overview of the activities and accomplishments of the PFAC from September 2023 → June 2024.

The Terms of Reference for PFAC were refreshed in Fall 2023 and now include two (2) appointed Senior Executive members annually. These spots have been filled by Stephanie Pearsall and Dr. Winnie Lee for the 2023-24 year.

Much of this past year has been back to basics and laying the groundwork for the next few years. The corporate Patient Experience Plan including the sequencing of tactics was approved by the Board of Directors. PFAC members played an active role in Accreditation. They provided input on many organizational policies and have taken a keen interest in the organizational priorities of Access and Flow and DEI.

Background

Cambridge Memorial Hospital was the first acute care hospital in Waterloo-Wellington to form a PFAC in December 2014. We currently have six (6) active PFAC members and are actively recruiting additional members. In September 2023 Colleen Bulla moved from member to Chair.

Year in Review

Patient Experience Plan

1. Over the past 2 years PFAC members have had the opportunity to co-design the Patient Experience (PX) Plan from the ground up. This included defining the pillars, the tactics, the tactic sequencing, and baseline Beryl Institute Experience Assessment measurement which will be one of measures of success for the plan. The PX Plan was

approved by the Board of Directors in Fall 2023 and work on many tactics contained within is well underway.

Corporate

2. PFAC members were prepared in Fall 2023 for Accreditation and spent a full meeting (November 2023) being interviewed by the Patient Surveyor from Accreditation Canada.
3. PFAC members had provided input last year into the design 'wish list' for the public/external facing website. This fall they had the opportunity to preview the website before public launch and were thrilled at how the website designers had incorporated their feedback into the final design.
4. PFAC members were engaged through the process of setting/selecting Quality Improvement Plan (QIP) metrics and top organizational Integrated Risk Management priorities for fiscal 2024-25.
5. PFAC members are now receiving a monthly update on Access and Flow work (e.g. In the ED) – providing input as eyes/ears of the community on what is working (or not) and advocating on behalf of CMH throughout the broader community.

Innovation Ideas & Net New Projects

6. PFAC members received summary presentations from last year's Innovation Idea projects including the Release of Information (ROI) transformation from paper/onsite to digital/secure file transfer.
7. PFAC members had multiple presentations and discussions about the patient portal ConnectMyHealth and provided their unwavering support for patients to have timely access to their health information, questioned how/why some reports are available and others are not, and the ethics behind CMH continuing to promote a pay for service app (Pocket Health) when a free option (ConnectMyHealth) is now available.
8. A PFAC member participated as part of the Innovation Idea selection team reviewing and scoring all of the idea submissions.
9. PFAC members regularly receive updates on the Lost Belongings Innovation Idea workgroup.
10. PFAC members were very pleased to hear about the Palliative Care Carts developed and launched on the Medicine programs.

Diversity, Inclusion, Equity

11. PFAC members provided input to management that CMH Accessibility Committee should contain a member of the DEI team … a change that has been implemented in addition to shifting the reporting of Accessibility to align with Patient Experience.
12. PFAC members received a presentation and provided input into CMH's current DEI work
13. PFAC members provided input into CMH Accessibility Committee work
14. PFAC members provided their support following a presentation on the removal of marital status from the registration process
15. PFAC members have received regular updates on the outreach work that the 2 Patient Experience Leads have done over the past 18 months with vulnerable populations (Bridges, 150 Main Street, ACCKWA) and the themes of the feedback garnered.
16. PFAC members and management engaged in a generative discussion about the use of mixed gender rooms – balancing access/flow with patient preference

Policy Input & Endorsement

17. A new format for soliciting PFAC input to policies was launched this year that includes a brief summary of the 'patient facing' salient points and targeted questions/input sought from PFAC members. Individuals bringing forward policies for input were discouraged from including the entire policy, so as to target feedback.

18. PFAC members provided input to the following polices:
    i) Privacy Code
    ii) Lockbox
    iii) Use of Patient Emails
    iv) Disclosure of Harm
    v) Patient Relations Process
    vi) Human Rights
    vii) Language Interpretation Services
    viii) Patient Directed Visiting
    ix) Advanced Care Planning

Committee & Hospital Work

19. PFAC members collectively participated in many panel interviews over the past year – from leadership roles to the Inclusion Lead.
20. Ethics Committee
21. Digital Sub-Committee of the Board
22. Quality Committee of the Board
23. PFAC members have reviewed numerous handouts/brochures/survey's and provided input on readability and implementation recommendations.
24. PFAC members provided input into the June 2024 parking rate increases
25. A few PFAC members were onsite during Patient Experience Week to educate staff and the public about the role of PFAC and to walk around the various units meeting and interacting with staff (handing out treats!).

Provincial

26. PFAC members reviewed and discussed the annual Patient Ombudsman Report

Next Steps

PFAC members will continue to be involved in the tactics contained within the Patient Experience Plan.

BRIEFING NOTE

Date: June 11, 2024
Issue: Quality Monitoring Metrics – May 2024 Report
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kyle Leslie, Director Operational Excellence
Liane Barefoot, Director Patient Experience, Quality, Risk, Privacy & IPAC
Approved by: Mari Iromoto, Senior Director Strategy & Performance, CIO

Attachments/Related Documents:
Appendix A – Quality Monitoring Scorecard May 2024

Alignment with 2024/25 CMH Priorities:

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

Included in **Appendix A** is the CMH Quality Monitoring Scorecard including detailed indicator pages for metrics with three or more periods at a "red" performance status.

We are currently in the process of refreshing the Quality Monitoring Scorecard for fiscal year 24/25. The Quality Monitoring Scorecard is a critical performance monitoring tool aimed at elevating quality and performance issues requiring attention and action.

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

There are ten indicators of the thirty-two that have had three periods of "red" performance in a row that we are actively working on and monitoring for improvement. These indicators, including Board oversight committee are:

1) Conservable Bed Days (Quality Committee)
2) Overtime hours (Resources Committee)
3) Sick hours (Resources Committee)
4) Percentage ALC Days (Closed / discharged cases) (Quality Committee)
5) Emergency Department Length of Stay Admitted Patients (Quality Committee)
6) Emergency Department Length of Stay for Complex Patients (Quality Committee)
7) Emergency Department time to Inpatient Bed (Quality Committee)

8) Emergency Department Wait time for Initial Assessment (PIA) (Quality Committee)
9) Surgical Long Waiters (Quality Committee)
10) PCOP growth revenue earned for 24/25
11) Medication Errors (Quality Committee)

Background
To ensure high-quality patient care and operational efficiency, we require a robust performance monitoring tool. To meet this, need the Quality Monitoring Scorecard was developed to provide insight into our performance and to alert us to performance issues that require attention and action. The CMH Quality Monitoring Scorecard tracks performance on key performance indicators aligned to our quality framework. Many of the indicators on the Quality Monitoring Scorecard are reported publically on an annual basis by the Canadian Institute for Health Information (CIHI).

The Scorecard indicators are regularly reviewed at many internal forums for action planning and awareness. On a weekly basis Staffing and Flow metrics are reviewed at our leadership huddles. The metrics on our Quality Scorecard are also reported on the Departmental Scorecards and it is an expectation that departments review and develop any necessary departmental action plans to address performance on a monthly basis through Departmental Quality and Operations Councils.

Analysis
Six (6) of the eleven (11) indicators that are currently trending in red for three or more periods relate to overall flow/throughput and are collectively being addressed by focused work in the Emergency Department and inpatient discharge planning efforts. Flow/throughput has been elevated as an organizational Integrated Risk Management (IRM) priority as well as highlighted internally and publicly as an area of focus via our Quality Improvement Plan (QIP). It is a standing agenda item weekly at Senior Executive, weekly at Operations meeting, weekly meeting with ED and Medicine leadership to review details of outlier cases, and Quality and Operations Councils.

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

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

Comprehensive analysis of the past six (6) years of medication errors was undertaken in April 2024 and details can be found in the April 2024 Quality Committee agenda package.

Appendix A includes the Quality Monitoring Scorecard as well as the detailed pages for indicators that have trended at a “red” status for three or more periods in a row.

Next steps
The Quality Monitoring Scorecard will continue to be included on a monthly basis.

Agenda

Quality Monitoring Scorecard

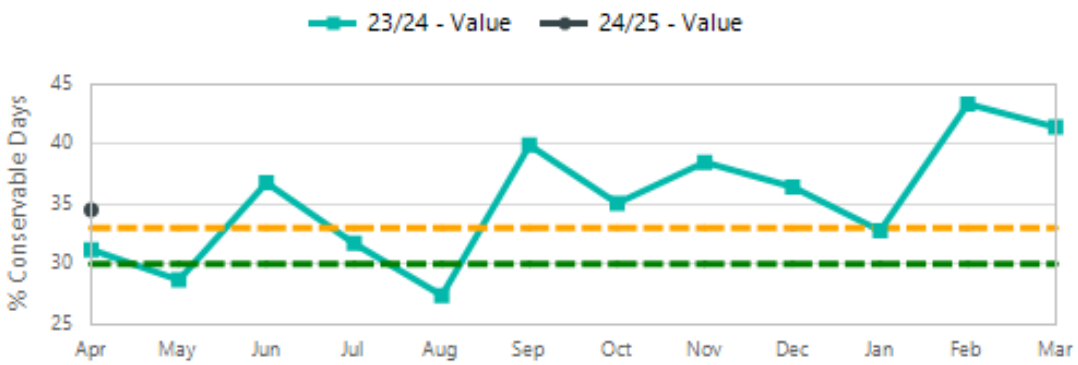
Quality Dimension	Indicator	Unit of Measure	Prior Year	YTD	Target	Trend	Status	Period
Efficient	% on track with active staffing targets (Med/ICU/ED)	%		88.5	100.0			Jun-24
	Conservable Days Rate	%	35.5	34.5	30.0			Apr-24
	Overtime Hours - Average per pay period	hours	3,625.8	3,004.9	850.0			May-24
	Sick Hours - Average per pay period	hours	3,134.3	2,781.2	2,090.0			May-24
Integrated & Equitable	ALC Throughput	Ratio	0.8	0.8	1.0			May-24
	Percent ALC Days (closed cases)	%	25.4	27.6	20.0			Apr-24
	Repeat emergency department visits for Mental Health Care (Average patients per month with four or more visits in 365 days)	Patients	10.6	15.0	11.0			Apr-24
Patient & People Focused	Organization Wide Vacancy Rate	%	7.6	5.3	12.0			May-24
Safe, Effective & Accessible	30 Day CHF Readmission Rate	%	15.3	18.7	14.0			Mar-24
	30 Day COPD Readmission Rate	%	13.0	15.4	15.5			Mar-24
	30 Day In-Hospital Mortality Following Major Surgery	%	2.2	2.2	2.1			Mar-24
	30 Day Medical Readmission Rate	%	10.8	10.5	13.6			Mar-24
	30 Day Obstetric Readmission Rate	%	1.2	1.1	1.1			Mar-24
	30 Day Overall Readmission Rate	%	7.5	7.3	9.1			Mar-24
	30 Day Paediatric Readmission Rate	%	8.4	7.3	6.1			Mar-24
	30 Day Surgical Readmission Rate	%	5.3	5.8	6.9			Mar-24
	ED Length of Stay for Admitted Patients (90% Spent Less, in Hours)	hours	58.0	49.2	44.0			Apr-24
	ED Length of Stay for Non-Admitted Complex Patients (90% Spent Less, in Hours)	hours	9.8	9.3	8.0			Apr-24
	ED Wait Time for Inpatient Bed (90% Spent Less, in Hours)	hours	48.4	40.9	36.0			Apr-24
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours)	hours	6.9	7.1	4.0			Apr-24
	Fall Rate	per 1000 PD	4.9	3.0	4.0			May-24
	Hip Fracture Surgery Within 48 Hours	%	89.7	90.1	86.2			Mar-24
	Hospital Standardized Mortality Ratio (HSMR)	Ratio	94.0	97.3	100.0			Mar-24
	In-Hospital Sepsis	per 1000 D/C	5.6	3.2	3.9			Mar-24
	Long Waiters Waiting For All Surgical Procedures	%	26.3	26.2	20.0			May-24
	Low-Risk Caesarean Sections	%	14.8	11.8	17.3			Apr-24
	Medication Error Rate	per 1000 PD	8.3	6.2	4.0			May-24
	Medication Reconciliation at Admit	%	94.0	95.0	95.0			May-24
	Medication Reconciliation at Discharge	%	95.0	96.0	95.0			May-24
	Obstetric Trauma (With Instrument)	%	15.3	10.9	14.6			Mar-24
	Revenue - Achieve budgeted PCOP growth for 2023/2024 (IRM)	$	12,551,822.9	$1,026,929	$1,311,557			Apr-24
	Revenue - Achieve Quality Based Procedure Funding (IRM)	$	26,439,619.9	$2,433,080	$1,873,595			Apr-24

CAMBRIDGE MEMORIAL HOSPITAL

Legend		This Period		Last Period	
Meeting target	●	15	47%	13	41%
Within 10% of Target	▲	1	3%	3	13%
Meeting <10% of Target	◆	16	50%	16	50%

"Creating Healthier Communities Together"

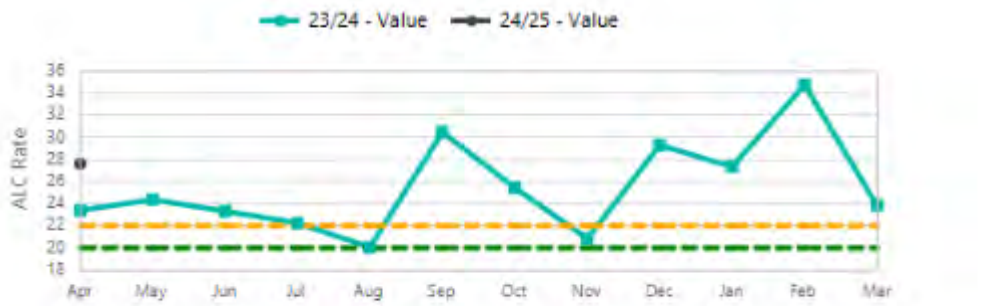
Conservable Bed Days Rate



Previous Fiscal Year	Target	Current (FYTD Apr 24)	Status
35.5	30.0	34.5	◆
Definition	The total patient days over the benchmark LOS by HIG (conservable days) as a percentage of the total acute patient days for patients discharged from MEDA, MEDB, MEDC		
Formula	Total conservable bed days per month divided by the total acute patient days in a month multiplied by 100		
Data Source	Discharge Abstract Database (DAD)		

- The conservable bed days rate continues to exceed target, with April at 34.5% of acute days over benchmark. This is equivalent to 20.9 beds.
- Actions:
  - Long stay patients are reviewed daily by clinical teams
  - Weekly deep dive on Tuesday mornings of long stay patients to identify and escalate barriers to discharge
  - Benchmark analysis completed and shared through Clinical Operational Excellence Committee and MAC to highlight CMH length of stay vs. benchmark hospitals
  - Site visit to STEG occurred with detailed action plan to follow

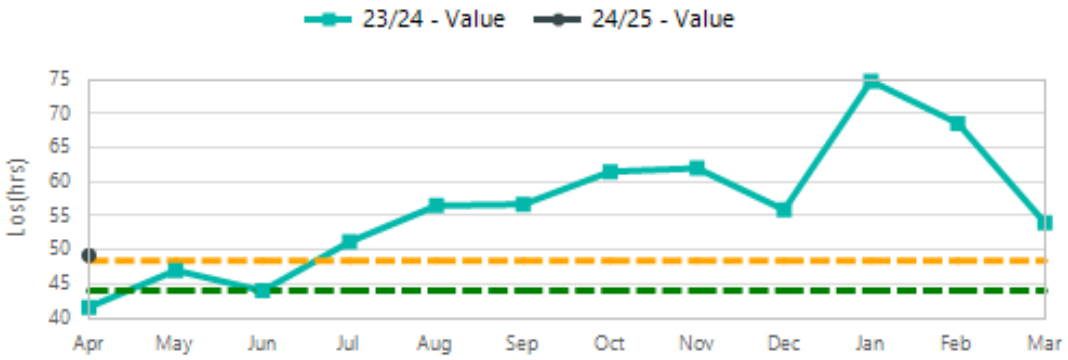
Percent ALC Days



Previous Fiscal Year	Target	Current (FYTD Apr 24)	Status
25.4	20.0	27.6	◆
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)		

- In April, the percent ALC days continued to be above target (20%) at 27.6%.
- Actions:
  - ALC trends monitored weekly at OPS huddle, Daily at bed rounds, monthly at Quality and Operations Council
  - ALC leading practices are in place
  - Actively working on ALC education for documentation and coding
  - Participating in Cambridge Collaborative and OH West meetings with community partners, specialized programs and shelters

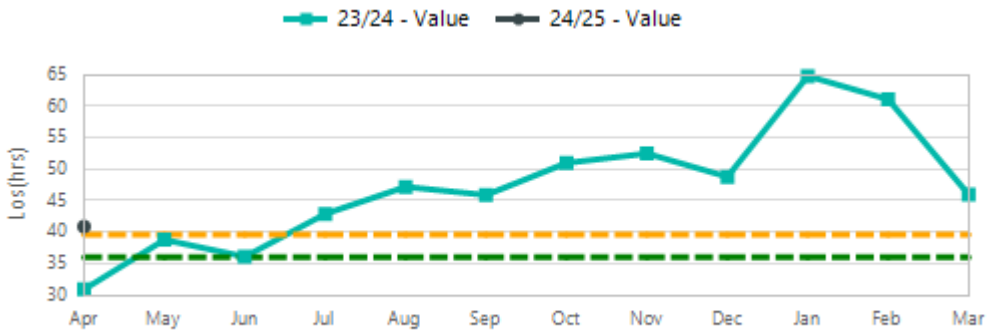
ED Length of Stay for Admitted Patients (90% Spent Less, in Hours)



Previous Fiscal Year	Target	Current (FYTD Apr 24)	Status
58.0	44.0	49.2	◆
Definition	The total time, in hours, that 9 out of 10 admitted patients spent in the emergency department (ED), calculated as the total time elapsed from triage to when the patient left the ED.		
Formula	The 90 percentile of Date/Time Patient Left ED minus Triage/Registration Time, for admitted patients (discharge disposition code is equal to 06 or 07).		
Data Source	NACRS		

- Our 90th percentile length of stay for admitted patient in the ED is 49.2 hours in April. While still exceeding target (< 44 hours), this is an improvement over the previous 9 months while the admit rate remains consistent at 12%.
- Actions:
  - Action Plan is in development based on practices observed from STEG site visit
  - Weekly flow meeting will be used to monitor action plan
  - Pull times are monitored at unit huddles and monthly performance is reviewed at Quality and Operations Councils

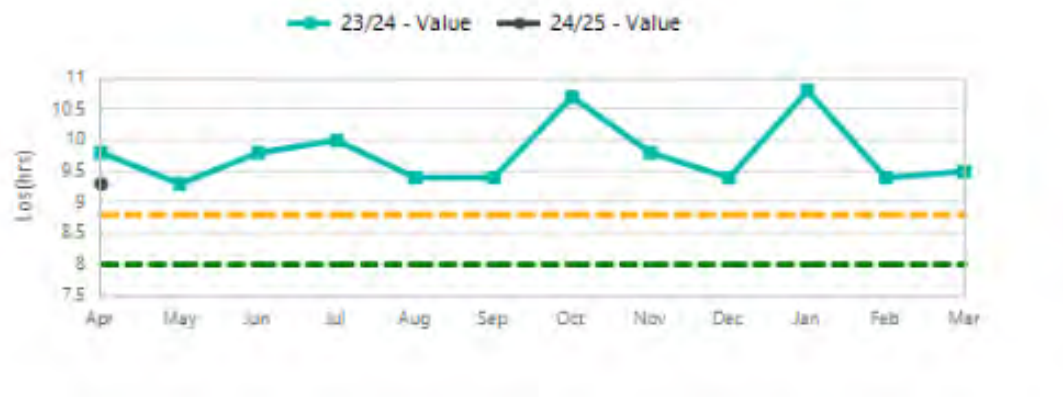
ED Wait Time for Inpatient Bed (90% Spent Less, in Hours)



Previous Fiscal Year	Target	Current (FYTD Apr 24)	Status
48.4	36.0	40.9	◆
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 datetime minus disposition decision datetime.		
Data Source	NACRS		

- Our 90th percentile time to inpatient bed is 40.9 hours in April. While still exceeding target (< 36 hours), this is an improvement over the previous 9 months.
- Actions:
  - Action Plan is in development based on practices observed from site visit
  - Weekly flow meeting will be used to monitor action plan
  - Pull times are monitored at unit huddles and monthly performance is reviewed at Quality and Operations Councils

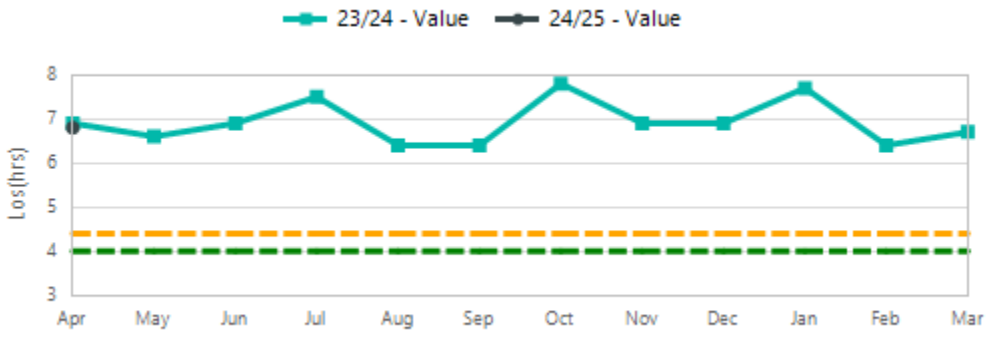
ED Length of Stay for Non-Admitted Complex Patients (90% Spent Less, in Hours)



Previous Fiscal Year	Target	Current (FYTD Apr 24)	Status
9.8	8.0	9.3	◆
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	NACRS		

- Currently, 90% of complex ED patients have a length of stay 9.3 hours (April 2024), while our target is <8 hours.
- Actions:
  - PIA tool to assist with flow
  - Action plan from STEG site visit in development specific to flow with in ED
  - Action plan will be monitored at weekly flow meetings

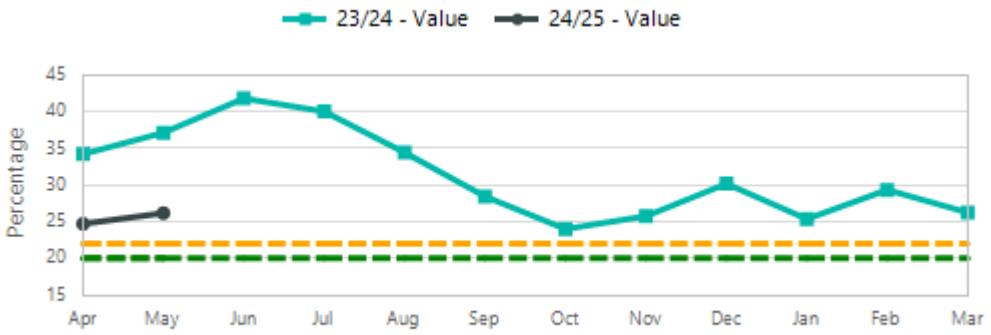
ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours)



Previous Fiscal Year	Target	Current (FYTD Apr 24)	Status
6.9	4.0	7.1	◆
Definition	The total time, in hours, that 9 out of 10 patients spent waiting for their first assessment by a doctor or nurse practitioner in the emergency department (ED), calculated as the total time elapsed from triage to time of initial assessment. Includes all CTAS levels.		
Formula	The 90th percentile of PIA datetime minus triage datetime.		
Data Source	NACRS		

- Our 90th percentile time to provider initial assessment remains consistent, at 6.9 hours in April, while our internal target is that 90% of patients are seen by a physician or nurse practitioner within 4.0 hours.
- Actions:
  - Real-time PIA tool created in collaboration with the ED physicians to give ED physicians full transparency and ability to monitor wait-times and select patients to add to their roster
  - Tool is being fine tuned based on feedback from docs
  - Action plan from STEG site visit in development specific to flow with in ED
  - Action plan will be monitored at weekly flow meetings

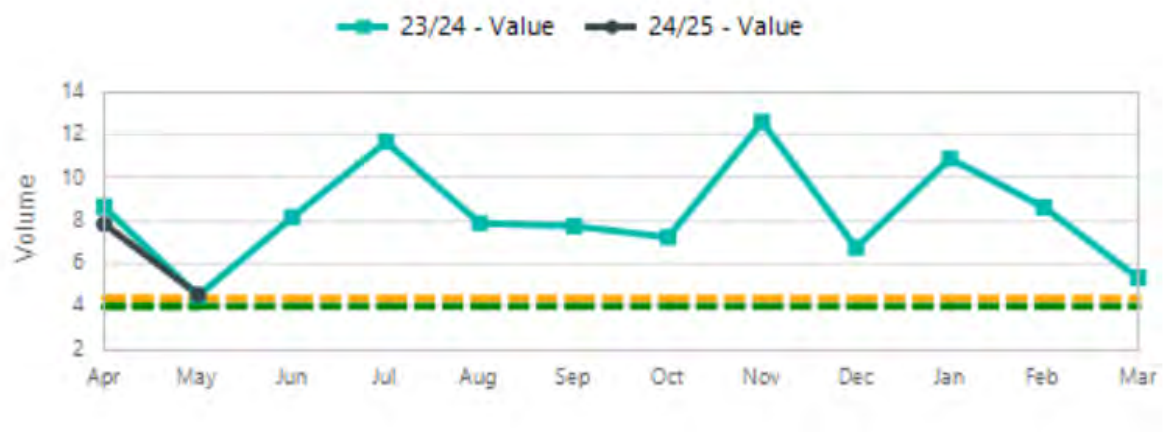
Long Waiters Waiting For All Surgical Procedures



Previous Fiscal Year	Target	Current (FYTD May 24)	Status
26.3	20.0	26.2	◆
Definition	This indicator measures the percentage of patients waiting for a surgical procedure whose wait has exceeded the associated Priority Level Access Target.		
Formula	The indicator is expressed as the rate of total number of cases waiting (i.e. open wait list volume) minus DART days at the end of the period whose days waiting exceeds the procedure specific Access Target for Priority Levels 2, 3, and 4.		
Data Source	WTIS		

- Currently (as of May 31, 2024), 26.2% of patients waiting for a surgical procedure have a wait exceeding the Priority Level Access Target, while our target is 20% or less.
- Actions:
  - Ongoing surgical wait-list review to ensure accurate reflection of cases waiting
  - OR block monitoring tool developed to monitor OR utilization and throughput
  - Weekly huddle established with OR team to monitor blocks
  - Surgeon recruitment underway to fill vacancies in surgeon schedule

Medication Errors



Previous Fiscal Year	Target	Current (FYTD May 24)	Status
8.3	4.0	6.2	◆
Definition	The incidence of medication errors per 1,000 patient days		
Formula	The number of medication errors divided by the number of patient days, multiplied by 1,000.		
Data Source	RL, MT ADM		

- Our target is 4.0/1000 patient days and YTD for FY 2024-25 is currently at 6.2/1000 patient days. As reported previously, this indicator uses our incident reporting data and can be influenced by the reporting culture. Generally speaking, a lower number is better as this means fewer medication errors are occurring. The caveat to this is that low level reporting (levels 1 → 4) means that errors are being caught and reported by front line staff as 'near misses' or 'no/low levels' of harm. There have been no incidents of severe harm (level 5+) reported this FY.
- Actions:
  - Monthly reporting at Quality and Operations Council Meetings, at Nursing Advisory Council, and at Safe Medication Practice Committee.

Agenda

CMH Accessibility Committee Update

Liane Barefoot – Executive Sponsor

Leadership Structure & Accessibility Committee

- The Accessibility Committee has been realigned under the Patient Experience, Risk and Quality portfolio, establishing a direct connection to Diversity, Equity and Inclusion

Updated Terms of Reference – Integrations of DEI Representation

- Terms of Reference have undergone a thorough review
- A significant update includes the addition of a representative from the Diversity, Equity, and Inclusion team, a recommendation that was proposed by members of PFAC
- This integration reflects the interconnectedness of Accessibility and DEI initiatives

2024 Accessibility Committee Refresh & Corporate Focus

- With organizational changes, Accessibility Committee refreshed responsibilities for 2024 and beyond. Initiatives were aligned to enhance collaboration with other departments and ‘widen’ the lens of Accessibility beyond physical.
- Examples include:
  - Patient Experience Office (Medically Required) Lost Belongings Project supported by the Board Innovation Fund. This project is focused on strategies for managing items such as glasses, dentures and hearing aids.
  - Project SEARCH supported by HR department. This project is a school-to-work internship training program for students with disabilities; some of which are invisible disabilities.

2024 Accessibility Committee Refresh & Corporate Focus Cont'd

In 2024, the Accessibility Committee will prioritize several key areas:

- Enhancing accessibility awareness through education and training opportunities
- Structured walk-throughs of newly constructed and renovated areas from an accessibility lens
- Establishing partnerships with local service providers dedicated to supporting individuals with disabilities
- Call for Community Members to join the Accessibility Committee

(stay tuned - more info to come, including a Lunch & Learn!).
promoted across communities and workplaces, and a time to
nity to recognize the efforts of Canadians who are actively rem
nce to participate in all aspects of Canadian society.

nts to share free learning opportunities offered by the City of

CAMBRIDGE MEMORIAL HOSPITAL

2024 Success

- Hosted a Lunch & Learn for Accessibility Week 2024
- Celebrated Red Shirt Day
- Provided free learning opportunities with CMH
- Collaborated with Purchasing & CRP to ensure our new Parking machines met AODA standard and the needs of our patients and visitors.

Agenda

Annual Accessibility Plan Update 2024

Location / Area	Barrier	Solution	Responsibility	Target	2024 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: In Progress	Will work in collaboration with Patient Experience, DEI, Professional Practice and other departments to align with the 2024 Committee goals.	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	Complete – • Web-Ex training offered through the City of Cambridge	
Employment	Community Partners	Provide Mentorship support for job seekers e.g., coaching event.	Human Resources	January 2024	Complete – • Web-Ex training offered through the City of Cambridge	
Employment	Recruitment	Increase knowledge of leaders regarding the hiring of persons with disabilities.	Human Resources	January 2024	Complete • Online e-learn required course for all • Inclusive Job posting statement approved by DEI council embedded	

Annual Accessibility Plan Update 2024

Location / Area	Barrier	Solution	Responsibility	Target	2024 Update	2024-28 Priorities
					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 • Web-Ex training offered through the City of Cambridge	
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	Completed	
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, 2024	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	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	

Annual Accessibility Plan Update 2024

Location / Area	Barrier	Solution	Responsibility	Target	2024 Update	2024-28 Priorities
					• 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	
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: September 2024	In Progress	Currently in progress. Being reviewed by internal stakeholders.
Information and	Internal	Carry out a full review of	Accessibility	March 2024	New process has been put in place	

Annual Accessibility Plan Update 2024

Location / Area	Barrier	Solution	Responsibility	Target	2024 Update	2024-28 Priorities
Communication	Signage and Wayfinding	the current wayfinding and Signage around the hospital paying special attention to the inclusion of Braille	Committee		for all newly renovated spaces to conduct an accessibility walkthrough.	
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	
Customer Service	AODA Training	CMHAC terms of reference are revised every three	Accessibility Committee	April 2025		

Annual Accessibility Plan Update 2024

Location / Area	Barrier	Solution	Responsibility	Target	2024 Update	2024-28 Priorities
		years to ensure ongoing education of committee members.				
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	Washrooms are in compliance with current AODA standards	

Annual Accessibility Plan Update 2024

Location / Area	Barrier	Solution	Responsibility	Target	2024 Update	2024-28 Priorities
Built Environment	Alarms, Alerts and Codes	Carry out a review of the current practice for alerts / alarms and codes to ensure that individuals who are hard of hearing are made aware using visual means. Implement findings of the review.	Facilities Management	April 2024	Completed Staff have gone through mock codes and have been trained on how to aid persons who may need assistance during various codes.	
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	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	

Refreshed 24/25 Strategic Priorities Tracker

Executive Summary

We are pleased to introduce the refreshed Strategic Priorities Tracker for FY24/25. The refreshed tracker is a robust tool designed to track and monitor the most critical in-year priorities and action plans aligned to Our Strategic Plan, In-year Quality Improvement Plan and Integrated Risk Management (IRM) Plan.

The refreshed Strategic Priorities Tracker was built with invaluable feedback received both from Board and CMH leadership team, ensuring its alignment with our overarching goals.

The purpose of the Strategic Priorities Tracker is:

- **Alignment**- It serves as a central hub to align priorities and actions with our strategic priorities to ensure firm focus on achieving our critical in year priorities, the new tracker now aligns our in-year metrics with the in-year actions from our Corporate Plans.
- **Performance Monitoring-** This tool will be the primary performance monitoring and reporting instrument, providing comprehensive insights into our progress on a quarterly basis. This tool is meant to assist the board in fulfilling its performance monitoring responsibilities as outlined in the Board Manual Policy Number 2-C-50.

The Strategic Priorities Tracker is one of five performance monitoring tools that will be used for 24/25- slide 3 outline the five performance monitoring tools for 24/25

The Strategic Priority Tracker aligns to our core value of accountability, and embodies our commitment to transparency. We are confident that it will further enhance a culture of continuous improvement and drive CMH towards achievement of our priorities.

Included in this package is:

- Overview of 24/25 performance monitoring tools
- Draft 24/25 Strategic Priorities Tracker

Agenda

Performance Monitoring 24/25

- **Strategic Priorities Tracker-**
  - Monitors most critical in year priorities identified through, QIP, IRM, Strategic Plan
  - Presented Quarterly to Board Committees as a re-cape of actions and impact on success metrics
  - Performance on metrics monitored near real-time through various channels such as – OT /Staffing Task Force, Ops Huddle, Quality and Ops Councils, Clinical Operational Excellence Committee, Volume Weighted Case Meetings
- **Quality Monitoring Scorecard-**
  - Monitors key quality and organizational metrics on a monthly cycle
  - Purpose is to ensure we sustain performance and identify quality issues early on for escalation and action
- **Critical Risk (IRM) Escalated to More Frequent Reporting-**
  - Patient Flow and Organizational Staffing were identified through the IRM process as two top risks for our organization
  - Both have been elevated to more frequent reporting and will be reported on a monthly basis. Flow to Quality Committee and Staffing OT to resource committee via standard slide template
- **Executive Reports-**
  - Propose that executive reports serve two purposes:
    - Highlight portfolio updates / changes
    - Look ahead provide insights into upcoming initiatives and milestones from corporate plans (future strategic focus)
- **Weekly Ops Huddle-**
  - Support leaders on the execution of operational priorities
  - Monitor performance near real-time and surface issues and barriers that are impacting performance that can be addressed by collective leadership team

Strategic Priorities 24/25 DRAFT

"Creating Healthier Communities, Together"

Strategic Priority	Metric	Target	Q1	Q2	Q3	Q4	Aligned Corporate Plans
Elevate Partnerships in Care: Improve access to care by addressing wait-time to see a provider and time to in-patient bed	90th%tile ambulance offload time (QIP/IRM)	<30	67.0				Clinical Services Growth Plan; Capital Redevelopment Plan
	90th%tile EDLOS admitted patients (hours) (QIP/IRM)	<44	47.9				
	% on track Capital Redevelopment Plan (IRM)	100	100				
	% on track with Emergency Preparedness Plan (IRM)	100	100				
Reimagine Community Health: Prepare for digital health transformation	% on track with Health Information System (IRM)	100	100				Digital Health Plan
	% on track with Workforce Management (IRM)	100	100				
Increase Joy in Work: Increase staff engagement by addressing staffing challenges	% on track with active staffing targets Med, ICU, ED (IRM)	100	88.8				HR Plan
	% on track with Corporate Change Management Strategy (IRM)	100	100				
Sustain Financial Health: Earn max eligible PCOP funding for 24/25	Post Construction Operating Plan revenue earned (IRM)	>$3.9M quarter	$1.0M				Multi-year financial plan
Advance Health Equity: Embrace diversity and build a culture of inclusion	Number of staff who have completed Rainbow Health Diversity, Equity, & Inclusion training (QIP)	>88 quarter	37				DEI Plan

Note: Q1 Data is Incomplete

DRAFT

Clinical Services Growth Plan

Elevate Partnerships in Care

Executive Sponsor(s):	Physician Liaison(s):	Director Lead(s):	Project Manager:
Dr. Winnie Lee / Stephanie Pearsall	Dr. Runnalls / Dr. Nguyen	April McCulloch/ Donna Didimos	Jennifer Woo

	Target	Q1	Q2	Q3	Q4	Monthly Trend
90th%tile LOS Hours for Admitted patients in ED	<44hours	47.9				49.2 → 47.3
90th%tile Ambulance offload Minutes	<30min	67.0				76 → 59

Action Plan-Q1

Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Achieve flow targets for provider initial assessment times and length of stay for complex and minors.	• Implemented machine learning (ML) algorithm to support identification of patients eligible for Clinical Decision Unit (CDU) • Implemented real-time PIA tracking system utilized by physicians and nurse practitioners • Established weekly patient flow monitoring meeting with physician and clinical leads • Held site visit with St. Thomas Elgin General hospital for insight into ED flow improvements	• Implement enhanced nurse practitioner (NP) coverage for backfill • Develop physician and staff education specific to patient disposition (LWBS, LWBT) • Monitor and sustain CDU performance • build and execute action plan established from site-visit • Build real-time escalation alerts for CTAS 1-2 patients that are beyond wait-time targets	R1) Gaps in ED Physician Schedule (July day coverage) M1) Review insights from STEGH visit and evaluate potential changes to ED physician schedule
Achieve 30 min or less ambulance offload time	• Established EMS Triage Nurse from 00900-2100 • Finalize and educate teams on standard work for EMS offload • Established bi-weekly meeting cadence with EMS leadership to monitor and improve offload times	• Implement EMS timestamp equipment to capture EMS arrivals • Sustain EMS offload process by monitoring EMS arrival to offload time • Execute action plan established from site visit	R1) HHR for EMS Triage Nurse (staffing and education) M1) ED Nurses to attending triage class
Achieve time to in-patient bed target	• Conducted value stream map exercise with multidisciplinary team including physician leadership to identify barriers to discharge • Established audit process to review Monday, Tuesday discharges to identify barriers to weekend discharges • Long stay tracking tool established and reviewed weekly to identify barriers and mitigation strategies for discharges • Held site visit with St. Thomas Elgin General hospital to gain insights into improvements to enhance organizational flow	• Review and restructure physician attended rounds • Refresh "Unit Census Board" whiteboard to enhance communication among team and identify barriers to discharge • Establish improved process for communicating estimated date of discharge • Investigate paper-based SBAR to verbal TOA based on STEGH site visit • Medicine leadership rounding with patients regarding discharge expectations and prep with patients	No risk to report
Achieve and maintain ALC throughput ratio of 1 and ALC census of <36	• Developed pathways to support DI and infusion pump support • Implemented algorithm to alert and flag cases from LTC and RH to support early return and admission avoidance • Weekly review of ALC patients to escalate discharge planning	• Update ALC policy and process that supports all ALC work • Review new Home and Community Care performance target (% of new hospital patients that are contacted by HCC within 2 business days) and determine how to integrate into existing CMH process • Continue with Cambridge collaborative to support complex patients and discharges	No risk to report

Elevate Partnerships in Care

Success and Wins

Description and Impact:

This is a photo that was taken during one the value stream mapping exercises that was held with the ED Team. The session included physicians, nursing, clerical and was facilitated by our Process Improvement Team / Project Management Office.

The session resulted in process improvements to triage, CDU, ambulance offload and identified the need for the real-time PIA tracking tool for ED physicians and NPs which was fully adopted in Q1 by all ED physicians and NPs

Quote (Patients / Staff / Physicians):

"This PIA tool gives us full control and transparency into patient flow and patients waiting to be seen" – ED Physician

Next Steps- Proposed Reporting Cycle for 24/25

Committee	Q1	Q2	Q3	Q4
Quality Committee	Sep 18	Nov 20	Feb 19	May 21
Resource Committee	Sep 23	Nov 25	Feb 24	May 26
Board	Oct 2	Dec 4	Mar 5	Jun 4

- The strategic Priorities Package would begin rotation in Board Packages starting with Quality Committee on Sept 18th

BRIEFING NOTE

Date: May 17, 2024
Issue: Quality Committee Report to the Board of Directors, May15, 2024 – 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:

A meeting of the Quality Committee took place on Wednesday, May 15, 2024 at 0700 hours

Attendees:	D. Wilkinson (Chair), K. Abogadil, M. Adair, P. Brasil, C. Bulla, B. Conway, P. Gaskin, N. Gandhi, J. Goyal, M. Hempel, R. Howe, Dr. W. Lee, A. McCarthy, T. Mohtsham S. Pearsall
Staff Present:	L. Barefoot, M. Iromoto
Regrets:	None
Observer:	S. Beckhoff
Guests:	S. Bradshaw, G. de los Santos, A. Graham-Mendoza, Dr. L. Green, A. McCulloch, Dr. S. Penner, Dr. L. Puopolo, Dr. A. Nguyen, A. Schrum, K. Towes

Committee Recommendations/Reports – Board Approval Sought

None

Approved Committee Recommendations/Motions:

None

Committee Motions/Recommendations/Report – Board Approval Not Sought

MOTION: (McCarthy/Hempel) **that**, the Minutes of April 17, 2024 were approved. **CARRIED**.

Committee Matters – For information only

1. **Program Presentation: Perioperative Program**: A program overview was provided (see Package 2). The Perioperative team highlighted some key initiatives, as well as successes and challenges. Value Stream Mapping (VSM) occurred in March 2024 – this project is currently in progress with the OR and focusing on meeting patient volumes and PCOP targets. With four members throughout the department nearing retirement age, CMH is currently recruiting for general surgeons, anaesthesiologists, and surgical assists. The Perioperative

program is using extended hours and adding weekend options. There is also dedicated OR time for acute care cases or patients in the ED. By having protected time, this decreases the amount of time a patient may wait in ED for urgent surgery as well as reduce the number of surgeries that may occur later in the evening. This has been well received by members of the community. CMH surgical team completed the first Diagonal Upper Gracillis (DUG) free flap breast tissue reconstruction procedure in this region. This is a highly specialized procedure that is only performed at a select few breast reconstruction centers across North America. Another procedure highlighted is the use of Magtrace - a single injection tracer that uptakes in minutes and remains in sentinel lymph nodes for 30 days. Patients are no longer are required to go to nuclear medicine and wait for their appointment within 24 hours of their diagnosis and staging procedure, reducing impacts to patients and diagnostic imaging. In collaboration with the Fracture Clinic and CMH's Child Life Specialist, Cast Buddies program was brought forward and presented to pediatric patients to help alleviate their stress and anxiety during their visit to the Fracture Clinic. This program is focused on children 10 years or younger. Patients are offered stuffed animals and stickers upon arrival.

Endoscopy Program: A program overview was provided (see Package 2). The following items where highlighted: Regional Endoscopic Ultrasound Program (EUS) - launched in September 2022; Endo team consists of Gastroenterologists, General Surgeons, Anesthetists, Registered Nurses, Registered Practical Nurses, and other support staff; Endo currently operates 2 suites Monday to Friday, with an on-call team to support urgent cases after hours and on weekends; the Endo program has added a 3rd suite currently running 3 days a week with the plan to be fully operational by July 2024. Upon completion of the CRP work, the Endoscopy program will have 5 admitting bays, 3 endoscopy suites, 9 recovery bays and a patient waiting area; EUS program will be expanded further potentially doubling capacity by the end of 2024.

2. **2023/24 Committee Overview Summary – draft**: The draft 2023/24 Committee Overview Summary was presented to the Committee. D. Wilkinson spoke to the 2023/24 Committee Goals, achievements, and accomplishments. The Committee members reviewed the proposed 2024/25 Committee Goals: Meetings – shift meetings to hybrid format; Patient Experience – tour units or experience a patient process to enhance understanding; Education – invite Indigenous Patient Navigator to future meeting and conduct a generative discussion on patient safety or patient issue.
3. **Quality Monitoring Scorecard**: A copy of the briefing note and Quality Monitoring Scorecard were pre-circulated to the Committee.
4. **Corporate/Quality Metrics**: A copy of the briefing note and Quality Monitoring Scorecard were pre-circulated to the Committee.
5. **CNE Report**: Ms. Pearsall provided clinical programs update. The full CNE report is available in package 2.

BRIEFING NOTE

Date: June 20, 2024
Issue: Quality Committee Report to the Board of Directors, June 19, 2024 – 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:

A meeting of the Quality Committee took place on Wednesday, June 19, 2024 at 0700 hours

Attendees:	D. Wilkinson (Chair), K. Abogadil, M. Adair, P. Brasil, C. Bulla, B. Conway, P. Gaskin, N. Gandhi, J. Goyal, M. Hempel, R. Howe, Dr. W. Lee, A. McCarthy, T. Mohtsham S. Pearsall
Staff Present:	L. Barefoot, M. Iromoto
Regrets:	None
Observer:	S. Beckhoff
Guests:	J. Visocchi, C. Lau, D. Pereira, H. Hamilton, Dr. J. Bourgeois, K. Rose, Dr. I. Isupov, Dr. A. Nguyen

Committee Recommendations/Reports – Board Approval Sought

None

Approved Committee Recommendations/Motions:

None

Committee Motions/Recommendations/Report – Board Approval Not Sought

MOTION: (McCarthy/Hempel) **that**, the Minutes of May 15, 2024 were approved. **CARRIED**.

Committee Matters – For information only

1. **Program Presentations: Pharmacy**: A program overview was provided (see Package 2). A patient story about a 73-year-old patient was shared. J. Visocchi spoke of the tremendous collaboration between the patient, renal and hematology transplant team, infection disease physician, ICU medical staff and nurse. The following items about the Pharmacy program were highlighted: 27 Pharmacy Technicians, 12 Pharmacists; 1.1M doses dispensed from Omnicell cabinets each year; Human Resources Strategy: 7 conversions of students to staff; an Intern placement; Cunningham Estate donation for pharmacy equipment (will cover the

cost of the Omnicell replacement, Laminar Air Flow hood, Biological Safety Cabinet, Unit Dose Packager as well as the associated interfaces and server upgrades); the Pharmacy department supports Ronald McDonald House; Unconscious Bias training - through small group sessions, all pharmacy staff will have completed training by the end of the fiscal year (2024/25). There is heavy focus on HIS preparation and capital equipment. HIS is going to significantly change pharmacy workflow and how medication was managed in the hospital. There will be a lot of pre-work that needs to be done to ensure a smooth transition. Examples of the HIS preparation initiatives were given. Order Set Standardization (complete tracking of order sets, drug formulary clean-up), review active and inactive drug mnemonics, Barcode Scanning Preparation (enable scanning on restock of Omnicell cabinets and will require a barcode software to progress). The Pharmacy team, with Dr. J. Legassie (Physician Champion for Choosing Wisely) attended the Choosing Wisely National Conference in Montreal and connected with providers in how to improve quality care and reduce waste. The Choosing Wisely Canada Pharmacy Quality Improvement Initiative: Deprescribing PPIs. The Pharmacy team gave details of planning the PPI campaign and displayed the t-shirt “Bye Bye PPI.” One strategy is reducing waste and overuse of a particular class of medication called Proton Pump Inhibitors (PPI). Evidence has shown there has been lots of overuse in the community and hospitals. Over 50% of CMH hospital admissions were on PPIs (per May 2024 data). The goal of this project is to review/reduce PPIs during patient’s admission through to discharge. A project plan as been established to engage patients, families, pharmacists, nursing staff and insurance prescribers. At the end of the project plan, data will be presented to Choosing Wisely Canada. In working in conjunction with Diagnostic Imaging, the ultimate goal is to receive a hospital Choosing Wisely Qi Designation by May 2025. J. Visocchi spoke of the program risks and mitigation plan: there are many great initiatives however project timeframes are overlapping. Pharmacy will leverage other hospital resources when needed (Project Management office); Pharmacy is very well staffed currently, so will continue with student placements and student conversions to our benefit; management has received support from the senior leadership team to proceed with planning of pharmacy renovation. Pharmacy is reviewing the purchase of a pharmacy carousel replacement (inventory management system) in early 2025. A new unit dose packager will be installed in September 2024. All unit dose systems containing packaged pills/tablets will be dispensed with a bar code.

Laboratory: A patient story about the services that the Lab provides and frequent patient visits. It is with these repeated interactions that solid relationships are established. The patient voice is a solid force that leads the Laboratory Medicine program to strive for top performance. A program overview was provided (see Package 2). The following areas were highlighted: With rising costs and an expiring contract with Life Labs, CMH Laboratory submitted a request for proposal for referred-out laboratory services. The results of the RFP led to a partnership with Dynacare laboratories for specialized testing. It is estimated that CMH laboratory will save approximately $700,000 annually; The Lab program achieved the Using Wisely Hospital designation in November 2023; As with Pharmacy, the Lab program will put forward an application to be a Choosing Wisely Hospital designation; the Lab program is fully staffed despite the shortage of Medical Laboratory Technologists (MLTs). In collaboration with the ED, CMH Lab introduced a dedicated Medical Laboratory Assistant evening shift in the ED to improve the efficiency of laboratory services.

Diagnostic Imaging: A Staff story was shared. A program overview was provided (see Package 2). The DI program is staffed with 5 highly skilled radiologists, 60

Medical Radiation Technologists (MRTs) and Diagnostic Medical Sonographers (DMS), offers expertise in a wide range of imaging modalities. A new DI patient reminder system project through Pocket Health is currently in the pre-planning phase. Choosing Wisely designation – Diagnostic Imaging leadership is instrumental. With the support of a new ultrasound unit, DI plans to institute a dedicated sonographer by September 2024 within the CMH Regional Liver Health Centre; Ontario Breast Screening Program (OBSP) expansion (for ages 40-49) will commence in the Fall 2024. DI is participating in the Project SEARCH - an internship program that supports high school students with disabilities in acquiring the essential skills for the workforce. With the support of the Foundation, CMH was able to complete the MRI campaign and exceeding the $5,000,000 goal. A new MRI RFP is underway (installation is set for 2025). DI is the champion for the e-Referral Platform. CMH will be the first to incorporate AI technology for osteoporosis screening. DI is in the planning stages to implement Pocket Health – this solution aims to eliminate CD burning across CMH completely and improve patient experience; one feature of Pocket Health includes an appointment reminder system; the key driver to include the appointment reminder system with Pocket Health is zero implementation costs. **Diagnostic Cardiology Services**: A brief summary of the program was given (see Package 2).

2. **Organizational Flow:** An update on Patient Flow was given (data from week of June 10, 2024). Debriefs were held following a site visit to St. Thomas Elgin General Hospital on June 4, 2024. Management is concentrating on flow from ED to Medicine, with focused attention on discharge rounds and bed flow opportunities: balancing measures, re-establishing daily huddles with education, hosting bed meetings that are more technology supported, using a pro-active approach versus reactive approach, reviewing White Boards in patient rooms as well as Unit White Board, conducting Rapid Rounds with attendance by physicians.
3. **Patient Family Advisory Council – Annual Update:** C. Bulla gave a recap of the activities and accomplishments of the PFAC from September 2023 to June 2024. PFAC members had multiple presentations and discussions about the patient portal ConnectMyHealth and provided their unwavering support for patients to have timely access to their health information. It was reported that Patient Experience Plan was approved by the Board of Directors. PFAC members played an active role in Accreditation. Under PFAC's recommendation, the DEI Inclusion Lead will sit at the Accessibility Committee table. (Consent Agenda Item 1.5.12)
4. **Quality Monitoring Scorecard**: A copy of the briefing note and Quality Monitoring Scorecard were pre-circulated to the Committee. (Consent Agenda Item 1.5.13)
5. **CNE Report**: Ms. Pearsall provided clinical programs update. The full CNE report is available in package 2.

BRIEFING NOTE

Date: June 11, 2024
Issue: May 2024 Financial Statements
Prepared for: Resources Committee
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Valerie Smith-Sellers, Director, Finance
Approved by: Trevor Clark, VP Finance and Corporate Services, CFO

Attachments / Related Documents: Financial Statements - May 2024

Alignment with 2024-25 CMH Priorities:

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

Recommendation/Motion

Board

Following review and discussion of the information provided, the Board receives the May 2024 financial statements as presented by management.

Resources Committee

Following review and discussion of the information provided, the Resources Committee of the Board recommends that the Board of Directors receives the May 2024 financial statements as presented by management.

Executive Summary

Cambridge Memorial Hospital (CMH) has a $147K year-to-date surplus position at the end of May after building amortization and related capital grants. The major drivers of the surplus are the favourable variance in the unused position of the budgeted contingency ($669K), supplies and other expenses ($422K) and billable patient revenue ($353K), offset by the unfavourable variances in Ministry of Health (MOH) revenue ($1.4M) and salaries and wages ($0.5M), primarily due to higher overtime and sick time than budget. Ontario Health (OH) has not yet provided fiscal 2024-25 funding letters, causing Ministry of Health (MOH) base and one-time revenue to be unfavourable to budget. Funding letters are expected later in June. Reducing the amount of overtime is a key organizational priority in fiscal 2024-25

Risks

- Overall Post Construction Operating Plan (PCOP) volume targets YTD May have been achieved, however lower weighted cases in emergency (lower volumes) and surgery (physician vacancies and returned surgical blocks) are expected in June.
- Alternate Level of Care (ALC) patients create bed flow pressures and generate low weighted cases putting PCOP volume targets at risk. On average there have been 33 ALC patients in 2024-25 which is comparable to fiscal 2023-24 (34 patients)
- $5.4M in funding for Bill 124 has been budgeted in 2024-25. CMH had not received a funding letter to confirm Bill 124 funding. This funding represents approximately 80% of the total incremental wage costs budgeted.

Summary

CMH has a $147K year-to-date surplus position at the end of May after building amortization and related capital grants. Actual results are $59K unfavourable to budget. The favourable variance has been driven by:

- $669K in unused budgeted contingency through the end of May;
- $422K in supplies and other expense;
- $353K in billable patient revenue;
- $161K in equipment maintenance and repair expense;
- $143K in interest income;
- $121K in Cancer Care Ontario (CCO) oncology drugs recovery;
- $120K in Quality Based Procedures (QBP) revenue due to increased hip, knee, shoulder, cardiac, and spine surgeries;
- $57K in equipment depreciation.

The favorable variance has been partially offset by the following unfavourable variances:

- $909K in one-time funding for Bill 124 not confirmed to date;
- $536K in base funding. To date, OH has not confirmed new funding allocations for the hospitals in fiscal 2024-25;
- $491K unfavorable variance in salaries and wages primarily due to higher overtime than budget;
- $184K unfavourable variance in medical and surgical supplies.

PCOP & QBP Volumes

The achievement of volume base funding targets is critical to the hospital's long-term financial health. PCOP and QBP indicators are included in the hospital's corporate scorecard to monitor performance against budgeted targets.

PCOP

The hospital has budgeted to receive $14.5M in PCOP clinical funding in 2024-25, just over 66% of the available $21.9M PCOP funding allocation. Funding recognition is dependent on meeting volume targets.

The YTD $23K favorable variance is mainly due to clinical and amortization revenue

PCOP acute inpatient weighted cases has the biggest funding implication for the hospital. Each weighted case generates $4,517 in funding. The 5 weighted case shortfall through May represents a $23K loss in funding. In addition, the emergency department and mental health team had lower patient volumes and did not meet PCOP targets May YTD.

Due to physician turnover and unexpected leaves there is a risk that the surgical program will not achieve its weighted case volume targets, due to fewer surgical blocks being utilized than were budgeted for.

QBP

The hospital is exceeding performance for OH and CCO QBPs. Each QBP is funded at a different rate and has specific volume target.

Cancer Care Ontario (CCO) QBP revenue was $141K favorable to budget, due to higher numbers of breast surgeries and endoscopy procedures.

Urgent medical, bundled care and surgical QBPs funded through OH was $21K unfavorable to budget due to lower volumes of pneumonia and congestive heart failure cases which was partially offset by higher numbers of hip, knee and shoulder replacement surgeries.

Performance Based Funding Summary: Fiscal 2024-25
YTD April 2024 (Actual May coded data not available)

PCOP					
Funding Source	**Unit of Measure**	**Budget**	**YTD Budget**	**YTD Achieved # *(coded volumes)***	**YTD Variance from Budget**
Acute IP	Weighted Cases	8,370	698	698	**1**
Day Surgery/TCC	Weighted Cases	2,491	208	198	**(9)**
Emergency	Weighted Cases	2,833	236	210	**(26)**
Mental Health IP	Inpatient Days	8,029	669	608	**(61)**
QBP					
Funding Source	**Unit of Measure**	**Budget**	**YTD Budget**	**YTD Achieved # *(coded volumes)***	**YTD Variance from Budget**
OH Urgent Medical	**Cases**	**540**	**45**	**68**	**23**
OH Bundled Care	**Cases**	**857**	**71**	**104**	**33**
OH Surgical	**Cases**	**3,012**	**251**	**330**	**79**
CCO	**Cases**	**470**	**39**	**44**	**5**

MOH Funding – Base / One-Time / Other

Ontario Health has not confirmed base funding increases and one-time funding for Bill 124 in fiscal Bill 124 creating a $1.4M budget pressure year to date- $909K due to Bill 124 and $536K in base funding. $5.4M in one-time funding for Bill 124 has been budgeted for in fiscal 2024-25. The hospital is expecting to receive funding letters in June.

Billable Patient Services
The $353K year to date favourable variance is primarily due to a $145K favourable variance for insured self pay patients and a $143K favourable variance in professional fees. The favourable variance is partially offset by unfavourable variances in-non residence provincial plan ($11K), preferred accommodation ($2K) and Workplace Safety and Insurance Board (WSIB) claims ($2K).

Recoveries and Other Revenue

The $363K year to date favorable variance is driven by a $143K favorable variance in interest income, $121K recovery for oncology drugs from CCO, $65K for the recovery of external services and compensation and $36K from parking income.

Expenses

Salaries and Wages

Salaries and wages were $491K unfavorable to budget year to date. This was mainly due to higher overtime ($648K), staff training costs ($361K), and modified work ($105K), which was partially offset by a favorable variance in worked salaries ($550K) due to vacancies.

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

	May 2024			FY 2024-25		
HOURS	**Actual**	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**
Overtime	6,725	1,997	(4,727)	13,112	3,933	(9,179)
Sick	5,687	4,349	(1,338)	12,119	8,555	(3,564)

The overtime variance has primarily been driven by staffing shortages. The chart below summarizes the number of overtime hours for the past 26 pay periods. Overtime has increased over the past year, peaking at 94,124 hours in March 2024. The amount of overtime per pay period has stabilized in April and May with continued efforts to reduce the amount of overtime.

Employee Benefits

The $39K YTD unfavourable variance has been driven by higher in lieu of benefits paid to part-time staff due to higher number of hours worked by part-time staff.

Medical Remuneration

The $33K favorable year to date variance is largely driven by Oncology ($55K), physician invoices not being received.

Medical and Surgical Supplies
The $184K YTD unfavorable variance has been driven by supplies needed for general medical and surgical supplies ($55K), drug antineoplastic ($50K) and IV sets ($32K).

Drug Expense
The $87K YTD unfavorable variance is driven higher spending on drugs for the Oncology program ($94K). 98% of oncology drug costs are reimbursed by CCO.

Other Supplies and Expenses
The $1.3M YTD favorable variance is due to the unused contingency ($669K), supplies and other expense ($422K), and equipment maintenance and repairs expense ($161K).

Balance Sheet and Statement of Cash

CMH's current cash position is $108M, consisting of $78M of unrestricted cash and $30M of restricted cash. Unrestricted working capital available at the end of May is $19M. The working capital ratio is 1.26 and meets the requirements of the Hospital Service Accountability Agreement (H-SAA) target.

The accounts payable balance at the end of May was $40M, including general accounts payable ($35M) and MOH payable ($5.7M). The accounts receivable balance at the end of May was $12M, including MOH receivable ($7.1M) and general accounts receivable ($4.9M).

Cambridge Memorial Hospital
Statement of Income and Expense
For the period ending May 31, 2024

Confidential
(Expressed in thousands of dollars)

Month of May 2024					Year to Date				2024-25	2022-23 Prior Year Actuals	
Actual	Plan	Variance	% Variance		YTD Actual	YTD Plan	YTD Variance	% Variance	Plan	May. 2023	2023-24 YE
				Revenue:							
				MOH Funding							
$ 9,162	$ 9,434	$ (272)	(3%)	MOH - Base	$ 18,029	$ 18,565	$ (536)	(3%)	$ 111,083	$ 7,958	$ 93,971
1,784	2,286	(502)	(22%)	MOH - Quality Based Procedure	4,403	4,283	120	3%	24,880	2,051	27,048
1,672	1,345	327	24%	MOH - Post Construction Operating Plan	2,670	2,647	23	1%	15,838	741	14,207
748	1,231	(483)	(39%)	MOH - One time / Other	1,520	2,422	(902)	(37%)	14,495	1,773	36,820
13,366	14,296	(930)	(7%)	Total MOH Funding	26,622	27,917	(1,295)	(5%)	**166,296**	12,523	172,046
1,535	1,352	183	14%	Billable Patient Services	3,014	2,661	353	13%	15,801	1,225	15,187
1,814	1,603	211	13%	Recoveries and Other Revenue	3,518	3,155	363	12%	18,642	1,615	22,461
320	334	(14)	(4%)	Amortization of Deferred Equipment Capital Grants	639	657	(18)	(3%)	3,952	324	3,888
323	284	39	14%	MOH Special Votes Revenue	606	558	48	9%	3,371	332	3,681
17,358	**17,869**	**(511)**	**(3%)**	**Total Revenue**	**34,399**	**34,948**	**(549)**	**(2%)**	**208,062**	**16,019**	**217,263**
				Operating Expenses:							
8,131	7,874	(257)	(3%)	Salaries & Wages	15,986	15,495	(491)	(3%)	96,136	7,104	92,991
2,287	2,323	36	2%	Employee Benefits	4,542	4,503	(39)	(1%)	25,621	1,991	24,424
1,802	1,793	(9)	(1%)	Medical Remuneration	3,500	3,533	33	1%	20,998	1,693	21,279
1,331	1,191	(140)	(12%)	Medical & Surgical Supplies	2,528	2,344	(184)	(8%)	13,890	1,179	13,891
1,125	1,087	(38)	(3%)	Drug Expense	2,226	2,139	(87)	(4%)	12,974	915	12,242
1,799	2,387	588	25%	Other Supplies & Expenses	3,430	4,685	1,255	27%	25,930	2,180	28,437
566	604	38	6%	Equipment Depreciation	1,132	1,189	57	5%	7,223	548	6,830
310	292	(18)	(6%)	MOH Special Votes Expense	606	573	(33)	(6%)	3,372	317	3,681
17,351	**17,551**	**200**	**1%**	**Total Operating Expenses**	**33,950**	**34,461**	**511**	**1%**	**206,144**	**15,927**	**203,775**
7	**318**	**(311)**	**(98%)**	**MOH Surplus / (Deficit)**	**449**	**487**	**(38)**	**(8%)**	**1,918**	**92**	**13,488**
(636)	(647)	11	(2%)	Building Depreciation	(1,270)	(1,273)	3	(0%)	(9,002)	(632)	(7,589)
484	504	(20)	(4%)	Amortization of Deferred Building Capital Grants	968	992	(24)	(2.4%)	7,084	483	5,802
$ (145)	**$ 175**	**$ (320)**		**Net Surplus / (Deficit)**	**$ 147**	**$ 206**	**$ (59)**		**$ -**	**$ (57)**	**$ 11,701**

Cambridge Memorial Hospital
Statement of Financial Position
As at May 31, 2024

(Expressed in thousands of dollars)

	May 2024	March 2024
ASSETS		
Current Assets		
Cash and Short-term Investments	$ 77,789	$ 82,817
Due from Ministry of Health/Ontario Health	3,771	7,549
Other Receivables	4,947	4,616
Inventories	2,861	2,865
Prepaid Expenses	2,512	2,458
	91,880	100,305
Non-Current Assets		
Cash and Investments Restricted - Capital	30,184	29,359
Due from Ministry of Health - Capital Redevelopment	3,243	3,243
Due from CMH Foundation	491	475
Endowment and Special Purpose Fund Cash & Investments	208	206
Capital Assets	296,661	296,132
Total Assets	**$ 422,667**	**$ 429,720**
LIABILITIES & NET ASSETS		
Current Liabilities		
Due to Ministry of Health/Ontario Health	5,774	5,774
Accounts Payable and Accrued Liabilities	34,641	40,655
Deferred Revenue	32,449	32,449
	72,864	78,878
Long Term Liabilities		
Capital Redevelopment Construction Payable	4,090	4,035
Employee Future Benefits	4,265	4,223
Deferred Capital Grants and Donations	283,500	284,783
Asset Retirement Obligation	2,810	2,810
	294,665	295,851
Net Assets:		
Unrestricted	18,001	17,204
Externally Restricted Special Purpose Funds	208	206
Invested in Capital Assets	36,929	37,581
	55,138	54,991
Total Liabilities and Net Assets	**$ 422,667**	**$ 429,720**
Working Capital Balance	19,016	21,427
Working Capital Ratio (Current Ratio)	1.26	1.27

Cambridge Memorial Hospital
Statements of Cash Flows
For the Month Ending May 31, 2024

(Expressed in thousands of dollars)

	May 2024	March 2024
Cash Provided By (used in) Operations:		
Excess (deficiency) of Revenue over Expenses	$ 147	$ 11,701
Items not involving cash:		
Amortization of capital assets	2,401	14,419
Amortization of deferred grants and donations	(1,608)	(9,680)
Change in Non-Cash Operating Working Capital	(2,649)	(2,647)
Change in Employee Future Benefits	41	20
	(1,668)	13,813
Investing:		
Acquisition of Capital Assets & CRP	(2,930)	(33,552)
Capital Redevelopment Construction Payable	55	1,607
	(2,875)	(31,945)
Financing:		
Change in non-cash capital accounts receivable	16	341
Capital Donations and Grants & CRP	324	24,352
	340	24,693
Increase (Decrease) In Cash for the Period	(4,203)	6,561
Cash & Investments - Beginning of Year	112,176	105,615
Cash & Investments - End Of Period	**$ 107,973**	**$ 112,176**
Cash & Investments Consist of:		
Unrestricted Endowment and Special Purpose Investments	30	30
Cash & Investments Operating	77,759	82,787
Cash & Investments Restricted	30,184	29,359
Total	**$ 107,973**	**$ 112,176**

BRIEFING NOTE

Date: June 6, 2024
Issue: MAC Credentials & Privileging May 2024
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: Credentialing Files for Review May 2024

Alignment with 2024/25 CMH Priorities:

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

A meeting of the Medical Advisory Committee took place on Thursday June 6, 2024, at 4:30 pm.

Present:	Dr. W. Lee, Dr. J. Legassie, Dr. A. Mendlowitz, Dr. J. Bourgeois, Dr. A. Nguyen, Dr. K. Wadsworth, Dr. L. Green, C. Witteveen, Dr. L. Puopolo, Dr. M. Runnalls, Dr. I. Morgan, Dr. T. Holling, Dr. I. Isupov
Regrets:	Dr. B. Courteau, Dr. E. Thompson, Dr. M, Rajguru, Dr. A. Sharma, Dr. V. Miropolsky
Staff:	P. Gaskin, K. Leslie, S. Pearsall, M. Iromoto, R. Howe, 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 May 2024 Credentials Committee and upon the recommendation of the MAC at the meeting of June 6, 2024, 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. (Mendlowitz, Holling) **CARRIED. The attached Briefing Note**

provided to the Committee will be noted as well as any further commentary or discussion that is necessary.

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

MOTION: (Puopolo, Holling) that the Department of Laboratory Medicine Reapplication credentialing files be approved as distributed. None opposed. **CARRIED.**

MOTION: (Witteveen, Morgan) that the Department of Community and Family Medicine Reapplication credentialing files be approved as distributed. None opposed. **CARRIED.**

MOTION: (Mendlowitz, Morgan) that the Department of Community and Family Medicine Division of Night Surgical Assist Reapplication credentialing files be approved as distributed. None opposed. **CARRIED.**

MOTION: (Puopolo, Morgan) that the Department of Emergency Medicine Reapplication credentialing files be approved as distributed. None opposed. **CARRIED.**

MOTION: (Holling, Green) that the Department of Mental Health Reapplication credentialing files be approved as distributed. None opposed. **CARRIED.**

MOTION: (Holling, Puopolo) that the Department of Women and Children, Division of Midwifery Reapplication credentialing files be approved as distributed. None opposed. **CARRIED.**

MOTION: (Bourgeois, Holling) that the Department of Women and Children, Division of Obstetrics and Gynecology Reapplication credentialing files be approved as distributed. None opposed. **CARRIED.**

MOTION: (Morgan, Mendlowitz) that the Department of Women and Children, Division of Pediatrics Reapplication credentialing files be approved as distributed. None opposed. **CARRIED.**

MOTION: (Witteveen, Morgan) that the Department of Surgery Reapplication credentialing files be approved as distributed. None opposed. **CARRIED.**

MOTION: (Puopolo, Morgan) that the Department of Dental/Oral Surgery Reapplication credentialing files be approved as distributed. None opposed. **CARRIED.**

MOTION: (Witteveen, Mendlowitz) that the Department of Medicine Reapplication credentialing files be approved as distributed. None opposed. **CARRIED.**

Agenda

Credentialing Committee

CREDENTIALING COMMITTEE

Dr. Jenny Legassie, Chair, Chief of Hospital Medicine, Medical Advisory Committee Member

Dr. Winnie Lee, Chief of Staff, Chief of Radiology, Medical Advisory Committee Member

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

Dr. Ingrid Morgan, Vice President, Medical & Professional Staff Association

Corine Witteveen, Chief of Midwifery, Medical Advisory Committee Member

Dr. Brigitte Courteau, Treasurer, Medial & Professional Staff Association

Stephanie Pearsall, Vice President, Clinical Programs; Chief Nursing Executive

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Date of Meeting: May 28, 2024

MAC Meeting Date: June 6, 2024

Board of Directors Meeting Date: June 26, 2024

New Business:

Credentialing Files for Review:

Name	Department	Specialty	Appointment	Reason	Supervisor	Recommended/Not Recommended
Dr. Fatemeh Bakhtiari	Emergency		Locum	Requesting locum tenens privileges effective April 1, 2024 – March 31, 2025	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Abdallah Bin Maither	Internal Medicine		Locum	Requesting extension of locum privileges from June 2, 2024 – December 31, 2024	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Maaz Shanjer **(Restricted Registrant Resident)**	Emergency		Locum	Requesting locum tenens privileges effective July 1, 2024 – June 30, 2025	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Jeremy Cepek	Surgery	Urology (Regional)	Locum	Requesting locum privileges for regional call effective June 1,	Dr. L. Green	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

				2024 – May 30, 2025		
Dr. Kelsi Cole	Emergency Department		Locum	Requesting extension of locum privileges from June 1, 2024 – December 31, 2024	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Menachem Loewenthal	Emergency Department		Locum	Requesting extension of locum privileges from June 1, 2024 – December 31, 2024	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Mazin Al-Battran	Mental Health		Locum	Requesting extension of locum privileges from June 1, 2024 – May 31, 2025	Dr. A. Sharma	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Laura Duncan	Emergency		Locum > Associate	Transitioning from Locum to Associate effective June 1, 2024	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Department of Laboratory Medicine

Taher	Altaf	Temporary until August 23, 2024

Department of Community and Family Medicine

Sefin	Ashraf	Affiliate
Shah	Raj	Associate
Mehan	Upender	Affiliate
Baker	Jay	Courtesy No admitting
Zhu	Cindy	Associate
Schuster	Martin	Associate
Attalla	Amy	Active
Harvey	Robert	Affiliate
Misra	Amit	Affiliate
Morar	Champ	Affiliate
Morar	Shaheen	Affiliate
Oey	Audrey	Affiliate
Sandor	Celine	Associate
Bulanski	Emily	Active

Department of Community and Family Medicine
Night Surgical Assist

Light	Thurairajan	Active
Williams	Taryn	Active

Department of Emergency Medicine

Gill	Jaskirat	Associate
Eugenio	Arthur	Active
Rowe	Andrea	Active
Runnalls	Matthew	Active
Shafir	Mark	Active
Shoop	Rebekah	Active
Glover	Alexander	Active
Voros	Gabor	Active
Poon	Derek	Active
Gilles	Roy	Active
De Gouveia	Paulo	Associate
Zhang	Tracy	Active

Department of Mental Health

Awoniyi	Olubunmi	Associate
Esan	Fola	Active
Nosheen	Saadia	Active

Department of Women & Children
Division of Midwifery

Raftermann	Stacey	Associate

Department of Women & Children
Division of Obstetrics & Gynecology

Butler	Deborah	Active
Strauss	Paul	Active
Wadsworth	Kristin	Active

Department of Women & Children
Division of Pediatrics

Foong	Yen	Associate
Leonard	Sean	Courtesy with Admitting
Moyo	Margaret	Affiliate
Paikatt	Santosh	Affiliate
Saroey	Swarnlata	Active
Stoltz	Tasha	Courtesy with Admitting
Purser	Matthew	Associate

Kapalanga	Joachim	Courtesy with Admitting
Rajguru	Manjulata	Active

Department of Surgery

Wilkinson	John	Active
Leone	James	Active
Martin	Glynn	Active
Sawa	Kathryn	Active
Hirshberg	Eric	Courtesy with Admitting
Kim	Dennis	Active
Morris	Christopher	Courtesy with Admitting
Roth	Kirk	Active
Whitehead	Ingrid	Active
Yang	Mei	Active

Department of Dental/Oral Surgery

Chapeskie	Corina	Active
Cho	Stephen	Active
Ciavarro	Cesare	Active
Diamond	Leslie	Active
Furst	Ian	Active
Hartwig	Angelica	Active
Sheikh	Sufian	Active
Weitz	Daniel	Active

Department of Medicine

Ding	Jason	Courtesy No admitting
Evans	Lyndsay	Active
Hahn	Sara	Active
Halligan	Rachel	Active
Lin	Helen	Active
Scotchmer	Emma	Active
Tam	Amy	Courtesy No admitting
Koke	Michael	Courtesy with Admitting
Kuk	Joda	Courtesy No admitting
Martin	Glenn	Active
Matiasz	Richard	Active
Pandey	Shekhar	Active
Shaikholeslami	Roya	Active
Vizel	Saul	Active
Cape	David	Active
Marhong	Jonathan	Active
Morgan	Ingrid	Active
MacKenzie	Heather	Active

Agenda

Credentialing Committee

Waters	Braden	Active
Didyk	Nicole	Associate
Diab	Azzam	Active
Lee	Mark	Active
Nguyen	Augustin	Active
Akman	Olgun	Associate
Aziz	Salman	Associate
Sarfaraz	Omair	Active
Nuri	Khuloud	Active
Zaidi	Sidra	Associate
Ilyas	Amir	Associate
Ali	Rashad	Active
Taseen	Ryeyan	Associate
Pace	Paulo	Associate
Alhendi	Alaa	Courtesy with Admitting
Naser	Mohammed	Courtesy with Admitting
Sang	Lam Lok	Associate
Sekhon	Gurbir	Courtesy with Admitting
Sivakumaran	Thevaki	Active
Wang	Yu Ming	Associate
Bishara	Phoebe	Affiliate

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Dr. J. Legassie, Chair
Credentials Committee

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

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

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Corine Witteveen, Chief of Midwifery
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2024-2025

Truth and ReconciliACTION Plan

Cambridge Memorial Hospital

Plan Owner: Patrick Gaskin, Mari Iromoto

Approval Date: June 21, 2024

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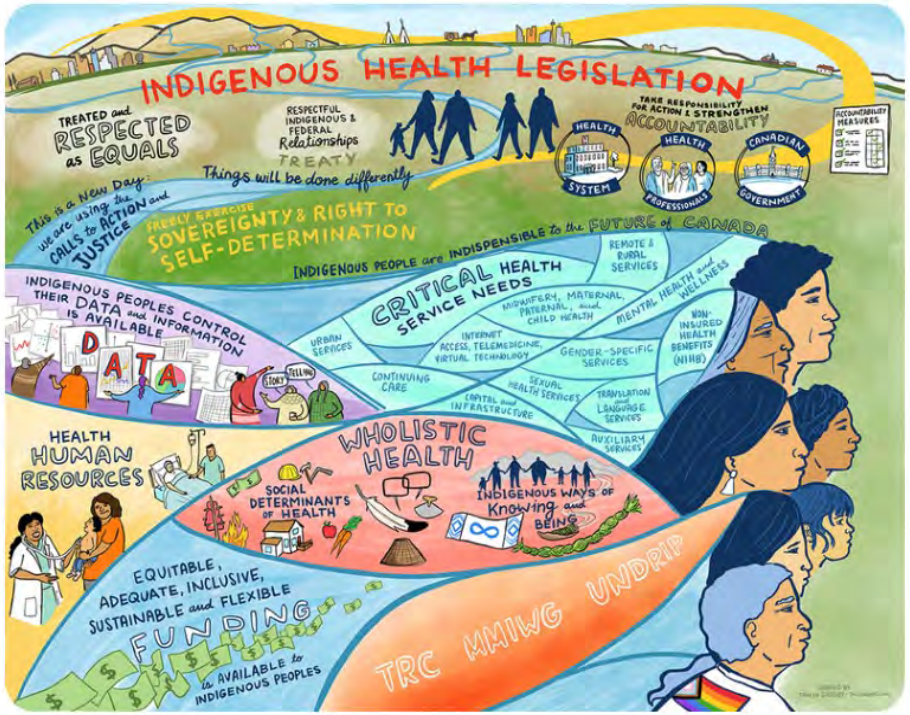


What is CMH's 24/25 Success Goal for Indigenous Truth and Reconciliation?

CMH's goal for 2024/25 is to nurture our relationships with Indigenous partners, fostering deep connections that pave the way for meaningful reconciliatory endeavors.

Inaugural Indigenous Advisory Circle meeting with SOAHAC, GRH, SMGH, Crow Shield Lodge, Myeengun Henry, and CMH

As we continue our journey towards Truth and Reconciliation, CMH is committed to improving Indigenous health equity through proactive collaboration, inclusive education, economic reconciliation, and strategic recruitment/retention efforts. Together, alongside Indigenous communities, we pledge to drive tangible change in healthcare outcomes, data equity, and patient support. By cultivating strong partnerships and fostering continuous dialogue, we will dismantle barriers and nurture a healthcare environment grounded in equity and respect.

Why is CMH Prioritizing Indigenous Health Equity?

Why do Indigenous populations have poorer health outcomes than non-Indigenous populations?

Health and social conditions are intrinsically linked. Many Indigenous communities are missing the key indicators associated with a healthy lifestyle. This is a result of colonization, and the cultural genocide Indigenous peoples have endured.

How is Indigenous health impacted within our region?

Compared to all Waterloo Region residents, **First Nations, Métis and Inuit peoples in Waterloo Region have significant disparities in health**, with more chronic health conditions occurring at younger ages. This is evidenced through social determinants of health measures, including education, income, employment and housing. Indigenous communities also face reduced access to health care, especially for Indigenous traditional healing.

How is Indigenous health impacted within Canada?

Indigenous Canadians have a life expectancy 12 years lower than the national average and experience higher rates of preventable chronic diseases compared with non-Indigenous Canadians. Intergenerational trauma from past assimilation policies has negatively impacted the health of Indigenous populations.

*What is an Indigenous Medicine Wheel? (ictinc.ca)

Truth and Reconciliation Commission's Calls to Action in Health Care

18. We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

20. In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.

21. We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

23. We call upon all levels of government to: 1) increase the number of Aboriginal professionals working in the health care field, 2) ensure the retention of Aboriginal health care providers in Aboriginal communities, 3) provide cultural competency training for all health care professionals

24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

In 2015, The TRCC released 94 Calls to Action with the aim of improving reconciliation between Canada and Indigenous, Metis and Inuit peoples. The Calls to Action highlighted on this page target healthcare specifically. CMH is using these to help further reconciliatory efforts within our hospital.

Truth and Reconciliation Commission of Canada

CMH's Work to Date

In **2018**, CMH introduced an Aboriginal acknowledgement for use in the organization, which later morphed into a land acknowledgement in **May 2019**, and finally, a territorial acknowledgement in **January 2022**.

In **2020**, Clarence Cachagee gifted CMH a hawk feather to celebrate the opening of Wing A. We have since hosted hawk feather re-energizing ceremonies at the hospital.
Survey in **2020** identified 2% of Indigenous staff at CMH (approx. 25% of staff completed the survey)

In **2021**, CMH rolled out San'Yas Cultural Safety Training for leaders, with 100% of senior leaders completing the training. CMH also started formally participating in Orange Shirt Day events which have continued to grow each year (ex. more shirts sold each September, more recognition given to September 30th)

In **2022**, CMH opened the San'Yas training up to staff, and 80% of the leadership team completed the San'Yas training. As of **December 2022**, 100+ staff members have completed this training

In **2022**, CMH leaders started preparing Truth and Reconciliation reflections. This requires one leader to reflect on their personal journey to Truth and Reconciliation. (see pg. 7)

In **2021**, SOAHAC opened a centre across the street from our hospital, which signalled the start of a new partnership and working with an Indigenous patient navigator. In **spring 2024**, a CMH physician started working with SOAHAC clients to support mental health services.

In **August 2023**, CMH introduced an Indigenous Projects Coordinator to support Truth & Reconciliation work across the hospital. CMH updated its smudging policy and procured a smudging kit.

In **September 2023**, the L.E.A.R.N. challenge was introduced.

In December **2023**, CMH held its inaugural Indigenous Council meeting. This group guided the development of this Truth and ReconciliACTION Plan for 24/25.

Work in **2024** has included the approval of our Indigenous Council's Terms of Reference, attending GRH's Sacred Fire Ceremony, engaging in the development of a Regional Advisory Circle, and meetings with local Indigenous leaders to talk about regional Truth & Reconciliation work, as well as CMH's journey moving forward.

Orange Shirt Day growing in participation over the years at CMH

L.E.A.R.N.: Listen, Explore, Add, Read, Notice

An Example of CMH's Work to Date

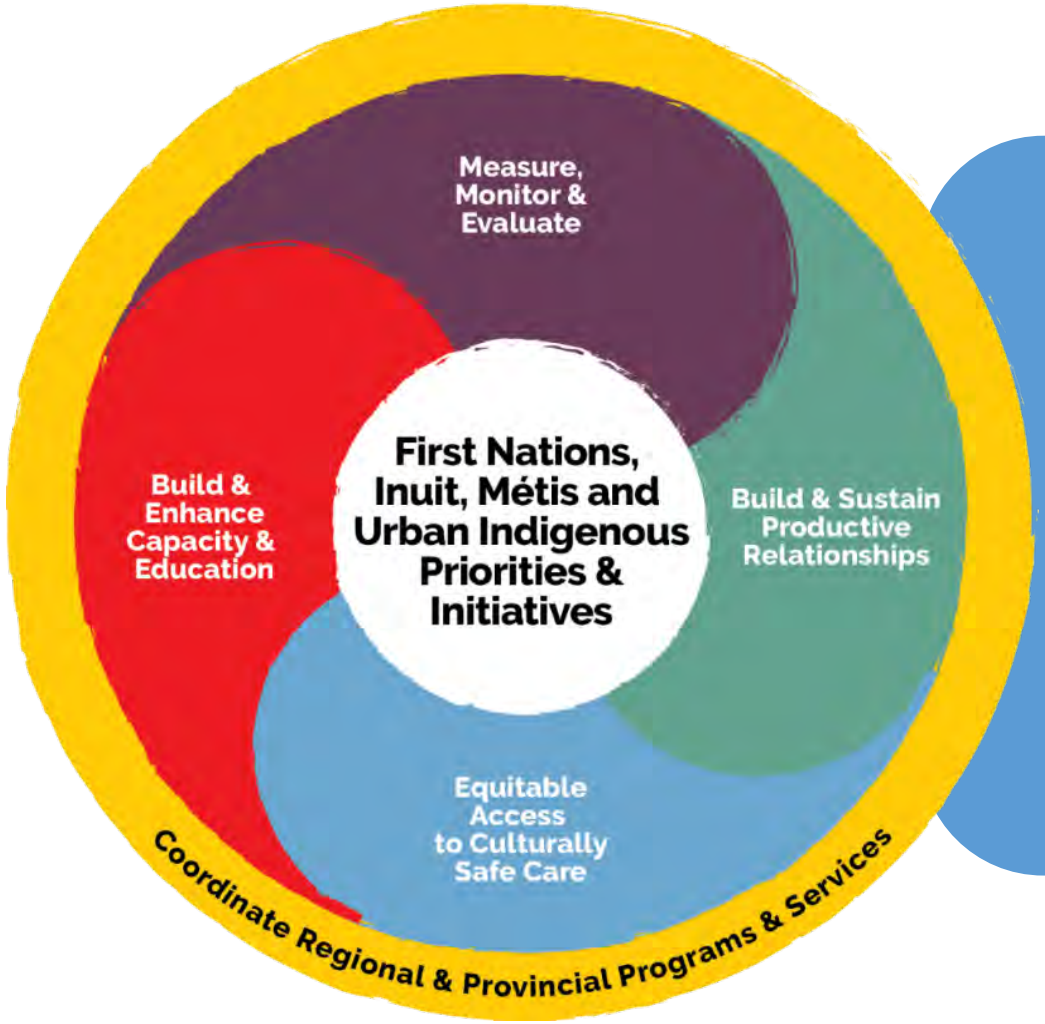
Every Wednesday, during CMH's Operations Huddle with the leadership team, one leader presents a reflection on Truth and Reconciliation. This requires leaders to reflect on and share any knowledge they have gained on their personal journey towards Indigenous Truth and Reconciliation.

These reflections are guided by the following questions:

- What is an Indigenous way of knowing, being, and/or doing that you learned recently?
- What Indigenous-focused resource did you find particularly interesting or helpful regarding your personal learning journey?
- What Indigenous artist, organization, or business would you like to recommend to the group?

*To date, 66 leaders have provided a territorial acknowledgement reflection.

CMH's Truth and ReconciliACTION Framework

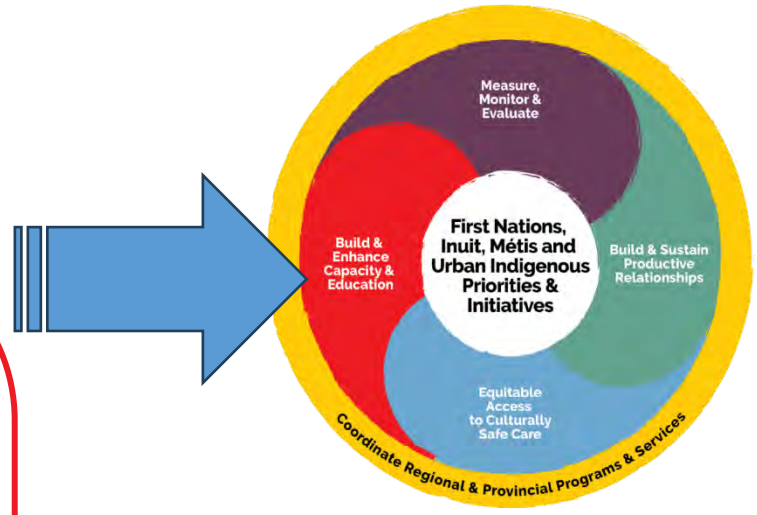


CMH has adopted the framework outlined by Ontario Health. This framework complements CMH's long-term goals for Truth and Reconciliation: improving education, supporting Indigenous owned and operated businesses, increasing recruitment and retention efforts, and building foundational relationships with Indigenous leaders and organizations in the region. Ontario Health's priorities and initiatives look to promote collaboration within communities across the province. CMH wants to align with this vision, which is why we have chosen to utilize this existing framework as opposed to developing new framework. If health care providers across the province commit to a similar approach, we are more likely to be united in our steps towards Indigenous Truth and Reconciliation.

More information about the First Nations, Inuit, Métis and Urban Indigenous Health Framework can be found at https://www.ontariohealth.ca/about-us/our-programs/provincial-equity-indigenous-health/indigenous-health-equity-coordination/indigenous-health-framework

The "Coordinate Regional & Provincial Programs & Services" part of the Ontario Health framework falls outside the scope of the CMH plan.

CMH's Truth and ReconciliACTION Framework



Build and Enhance Capacity and Education

- CMH will encourage staff to participate in the Waterloo Wellington Indigenous Older Adults Training; this is a Region-centric Indigenous cultural safety training that takes approximately 1.5 hours to complete
- Members of the CMH leadership team and Board who have not completed San'Yas training will be encouraged to undertake the program.
- CMH will explore the development of a specialised, region centric Indigenous cultural safety training in collaboration with Grand River Hospital and St. Mary's General Hospital.
- CMH will continue to recognize and enhance Indigenous days/months of significance, such as Red Dress Day, National Indigenous History Month, the L.E.A.R.N. challenge and Orange Shirt Day to increase knowledge and awareness across our hospital.

Caring for Indigenous Older Adults in Waterloo Wellington

60 MINS

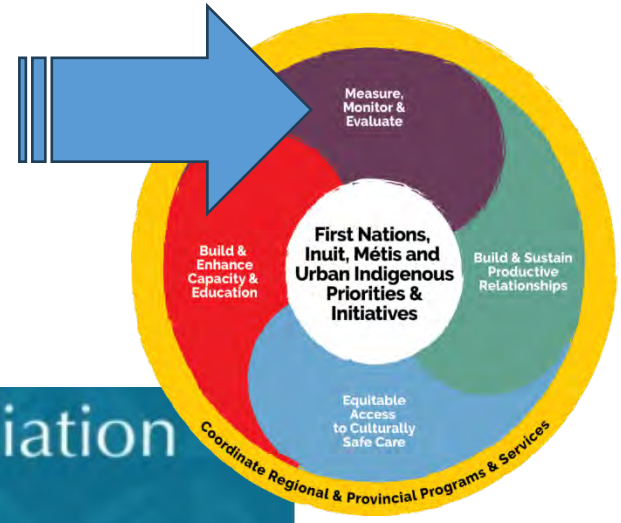
This 1 hour learning experience introduces healthcare providers to the care needs and preferences of Indigenous older adults living in Waterloo Wellington. You may pause as needed to complete the course, for example in 20-minute increments. The course will resum

Key words: Indigenous, buildin Centred Care, Aboriginal healin

San'yas Indigenous Cultural

Knowledge • Awareness • A

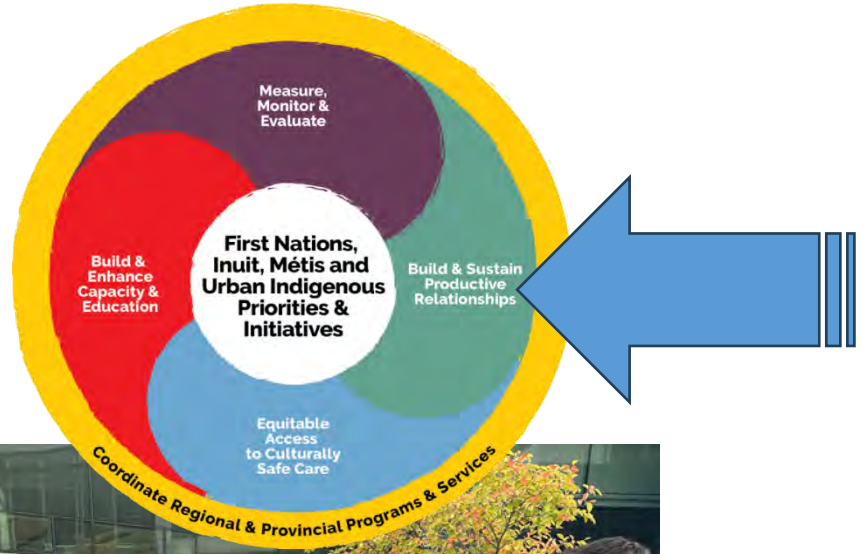
CMH's Truth and ReconciliACTION Framework



Measure, Monitor & Evaluate

- CMH will work with partner organizations to explore mechanisms to measure, monitor, and evaluate our progress towards Indigenous Truth and Reconciliation.
- CMH will meet the performance obligations and report on these obligations as outlined in our 2024/25 Service Accountability Agreements.

CMH's Truth and ReconciliACTION Framework



Build and Sustain Productive Relationships

- CMH will collaborate on the development of a Regional Advisory Circle which seeks to connect local healthcare providers with community, ensuring Indigenous voices are heard, and T&R work is not being done without Indigenous consultation and partnership.
- CMH will explore the development of a strategy to procure local Indigenous artists
- CMH will develop a strategy to support more Indigenous owned and operated businesses.
- CMH will investigate requirements for becoming an Aboriginal Procurement Champion with the Canadian Council for Aboriginal Businesses.
- The CMH Board, through its Governance Committee, will enhance its efforts to recruit Indigenous community members to serve in a governance capacity.

CMH staff with local leader and founder of Crow Shield Lodge, Clarence Cachagee at our Hawk Feather Re-Energizing Ceremony in September 2023.

CMH's Truth and ReconciliACTION Framework

Equitable Access to Culturally Safe Care

- For 24/25, CMH will work with staff to improve the environment for safe care for Indigenous patients. This will include
  - Working with selected clinical programs to enhance care for Indigenous patients.
  - Working with SOAHAC and the Indigenous patient navigator to facilitate care at CMH (e.g. birthing, end of life, ED and mental health policy development).
  - Focusing on creating a welcoming environment at CMH. This may include a displaying a commitment to truth and reconciliation statement in main entrance, displaying the T&R flag, purchasing and displaying Indigenous artwork, participating in Indigenous days of significance.
  - Updating our new staff onboarding processes to include information about CMH's Truth & ReconciliACTION Plan 2024/25.
  - Exploring mandatory training for new staff.

CMH's Truth and ReconciliACTION Framework – Work Plan for 2024/25

	Q1	Q2	Q3	Q4
Goals	Action Items to Achieve Goals			
Build and Enhance Capacity and Education	• Promote Waterloo-Wellington Indigenous Older Adults Training for staff • Enrolment in first round of San'Yas training • Hold Indigenous History Month Events throughout June • Explore regional training	• Promote September L.E.A.R.N. challenge for Truth and Reconciliation • Engage in Orange Shirt Day recognition • Host Hawk Feather Re-energizing ceremony	• Enrolment in second round of San'Yas training	• Achieve HSAA and MSAA obligations by end of Q4 (100% of senior leaders complete training)
Develop Quality Indicators to Measure, Monitor and Evaluate success (Developed with Indigenous Council using SMART Goal framework)	• CMH has hosted all Indigenous History Month events	• CMH has updated our current smudging ceremony • CMH has attended all regional meetings	• CMH has policies for Indigenous ceremonies for beginning and end of life in place • 100% of leadership has been enrolled in San'Yas training	• 100% of clinical huddles have been attended as a means of education for staff
Build and Sustain Productive Relationships	• Attend Indigenous Youth Conference • Engage in regional Truth and Reconciliation meeting	• Engage in regional Truth and Reconciliation meeting	• Attend second regional Advisory Circle meeting with CMH, GRH, SMGH, Crown Shield Lodge, SOAHAC, and local Indigenous Elder	• Engage in regional Truth and Reconciliation meeting
Equitable Access to Culturally Safe Care	• Host Sacred Fire ceremony • Hold Two-Spirit Lunch & Learn	• Planning to accommodate Indigenous ceremonies at CMH that are used for beginning and end of life	• Develop policies for Indigenous ceremonies for beginning and end of life	• Implement policies for traditional Indigenous healing practices

Next Steps

CMH's primary focus for 24/25 will be centred around building relationships with community, as we believe this is the foundation upon which our Truth and ReconciliACTION framework should be predicated.

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