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

October 2, 2024
1700-1800
Virtual via Teams / C.1.229
Join the meeting now
Or call in (audio only)
833-287-2824,,UpdateCanada (Toll-free)
Phone Conference ID: Update

AGENDA

Agenda Item * indicates attachment / TBC – to be circulated	Page #	Time	Responsibility	Purpose
1. CALL TO ORDER				
1.1 Territorial Acknowledgement		1700	L. Woeller	
1.2 Welcome		1703	L. Woeller	
1.3 Confirmation of Quorum (7)		1705	L. Woeller	Confirmation
1.4 Declarations of Conflict		1706	L. Woeller	Declaration
1.5 Consent Agenda *(Any Board member may request that any item be removed from this consent agenda and moved to the regular agenda)*		1707	L. Woeller	Motion
1.5.1 Minutes of June 26, 2024* and Open (2)	4			
1.5.2 2024/25 Board of Directors Action Log*	15			
1.5.3 Board Attendance*	16			
1.5.4 Board Work Plan*	17			
1.5.5 Events Calendar / Meeting Dates*	25			
1.5.6 Committee Reports to the Board of Directors				
1.5.6.1 Executive Committee (No Update next meeting Oct 22, 2024)				
1.5.6.2 Audit Committee (No Update next meeting Nov 18, 2024)				
1.5.6.3 Capital Projects Sub-Committee (No Open Matters)				
1.5.6.4 Resources Committee* (Sept 24, 2024)	27			
1.5.6.5 Medical Advisory Committee* (Sept 11, 2024)	29			
1.5.6.6 Governance Committee* (Sept 10, 2024)	32			
1.5.7 Governance Policy Summary* Policies for Approval: (track changes version found in Package 2)	35			

2-A-30	Responsibilities of a Director
2-D-08	Board and Committee Meetings
2-D-12	Freedom of Information and Protection of Privacy Act (FIPPA) Delegation of Duties
2-D-20	Recruitment, Selection, and Nomination of Directors and Non-Directors Committee Members
2-D-32	Education for Board Members and Non-Director Committee Members
2-D-60	Recognition of Board Service
2-D-48	Whistleblower Policy

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

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
1.5.8 CEO Report*	65			
1.5.9 Q1 CEO Certificate of Compliance*	74			
1.5.10 2024/25 Strategic Priorities Tracker Q1 Updates*	75			
1.5.10.1 Quality Monitoring Metrics – August 2024	94			
1.5.11 Chairs Tips Sheet*	98			
1.6 Confirmation of Agenda		1710	L. Woeller	Motion
2. PRESENTATIONS				
2.1 No Presentations				
3. BUSINESS ARISING				
3.1 No Items for Discussion				
4. NEW BUSINESS				
4.1 Chair's Update				
4.1.1 Recognition of Service Award – Monika Hempel*	100	1711	L. Woeller	Information
4.1.2 Board Chair's Report*	101	1715	L. Woeller	
4.2 Governance & Partnerships – (Review and approval of policy 2-A-16)*	104	1720	J. Goyal	Motion
4.3 Quality Committee (Sept 18, 2024)				
4.3.1 Report to the Board of Directors*	111	1730	D. Wilkinson	Information
4.4 Resources Committee (Sept 24, 2024)				
4.4.1 August 2024 Financial Statements and Year-End Forecast*	114	1735	M. Hempel	Motion
4.5 Medical Advisory Committee				
4.5.1 August 2024 Privileging and Credentialing*	122	1740	Dr. W. Lee	Motion
4.5.2 September 2024 Privileging and Credentialing*	131	1745	Dr. W. Lee	Motion
4.6 PFAC Update		1750	N. Melchers	Information
4.7 CEO Update				
4.7.1 No Open Matters for Discussion				
5. UPCOMING EVENTS		1755		
5.1 CMHF Celebration of Champions – Oriental Sports Club - November 7, 2024 for information email kmcmullen@cmh.org (Donor appreciation event)				
5.2 Cambridge & North Dumfries Community Awards – Hamilton Family Theatre, Cambridge – November 14, 2024 5:00pm-7:30pm				
5.3 CMHF Giving Tuesday – December 3, 2024				
5.4 CMH Wing B Opening, January 10 & 11, 2025 – Details to follow				
5.5 CMHReveal, February 21, 2025, Tapestry Hall, email kmcmullen@cmh.org for details				
6. DATE OF NEXT MEETING	Wednesday November 6, 2024 (Generative Session) Location: Hybrid			
7. TERMINATION		1800	L. Woeller	Motion
Link: Board/Committee Evaluation Survey	*Following the meeting, please complete within one week.*			

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

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

CMH Board of Directors Motions Page

Agenda Item	Motions Being Brought Forward for Approval – October 2, 2024	
1.5	Consent Agenda	• Be it RESOLVED that the CMH Board of Directors APPROVES the Consent Agenda as presented (amended)
1.6	Confirmation of Agenda	• Be it RESOLVED that the Agenda be adopted as presented (amended)
4.3.1	Financial Statements	• Be it RESOLVED that the CMH Board of Directors RECEIVES the August 2024 financial statements as presented by management and upon the recommendation of the Resources Committee at the meeting of September 24, 2024
4.5.1	Privileging & Credentialing	• Be it RESOLVED that the CMH Board of Directors APPROVES the privileging applications from the June 2024 Credentials Committee and upon the recommendation of the MAC at the meeting of September 11, 2024
4.5.2	Privileging & Credentialing	• Be it RESOLVED that the CMH Board of Directors APPROVES the privileging applications from the August 2024 Credentials Committee and upon the recommendation of the MAC at the meeting of September 11, 2024

Cambridge Memorial Hospital
BOARD OF DIRECTORS MEETING
Wednesday, June 26, 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 26, 2024 at 1730h.

Present:

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

Regrets: V. Miropolsky, I. Morgan

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

Guests: None

Recorder: S. Fitzgerald

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1. CALL TO ORDER
The Chair called the meeting to order at 1736 hours.

1.1. **Territorial Acknowledgement**
The Chair presented the Territorial Acknowledgement and shared personal reflections.

1.2. **Welcome**
The Chair welcomed the Board members and guests 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 Minutes of May 1, 2024 & June 5, 2024
1.5.2 Board Attendance Report
1.5.3 Governance Policy Summary
2-A-16 Governance Committee Terms of Reference

2-D-40 Evaluation of Board, Committees, and Individual Performance
2-C-55 Hospital Naming Policy

1.5.4 Committee Reports of the Board of Directors
Governance Committee (May 9, 2024)
Resources Committee (May 27 & June 24, 2024)
Medical Advisory Committee (May 8 & June 6, 2024)
1.5.5 Board Chairs Report
1.5.6 CMH President & CEO Report
1.5.7 Board Work Plan
1.5.8 2023/24 Board of Directors Action Log
1.5.9 Events Calendar
1.5.10 Education Topics 2024/25 Survey Results
1.5.11 Q4 CEO Certificate of Compliance
1.5.12 Patient & Family Advisory Council (PFAC) – Annual Update
1.5.13 Quality Monitoring Metrics & Scorecard

None opposed, **CARRIED** (Woeller/Brasil)

1.6. **Confirmation of Agenda**

MOTION: (Alvarado/Hempel) **that** the agenda be approved as amended.

None opposed, **CARRIED.**

2. PRESENTATIONS

2.1. CMH Accessibility Committee Update

L. Barefoot provided the Board with an update on the work that has been completed relevant to the Multi-year Accessibility Plan. The Board also reviewed the presentation provided in the pre-circulated meeting agenda package. L. Barefoot highlighted the re-alignment of the Accessibility Committee to fall within the Patient Experience portfolio and the focus of the work for 2024. The Board complimented L. Barefoot on this expanded focus.

2.2. Refreshed 24/25 Strategic Priorities Tracker

The Board reviewed the materials provided in the pre-circulated meeting agenda package. K. Leslie provided an overview of the refreshed tracker. K. Leslie highlighted that the tracker is a robust tool designed to track and monitor the most critical in-year priorities and action plans aligned to the Strategic Plan, In-year Quality Improvement Plan, and Integrated Risk Management (IRM) Plan. The tracker was built with feedback from the Board and the CMH Leadership team, ensuring its alignment with CMH's overarching goals. The Board thanked K. Leslie and team for all the work and effort in refreshing the tracker.

3. BUSINESS ARISING

No open items for discussion.

4. NEW BUSINESS

4.1. Chairs Update

No open items for discussion.

4.2. Quality Committee Update

4.2.1. The Board reviewed the pre-circulated briefing note provided in the pre-circulated meeting package. The Chair of the Quality Committee highlighted the focus on patient experience highlighted through patient stories and quality indicators, demonstrating efforts to improve efficiency and effectiveness. These stories resonate deeply with the community. The concept of joy in work was evident for the first time in quality presentations, with shared staff stories showcasing leadership and staff efforts to address staffing shortages and a positive work environment. The "Choosing Wisely" initiative, a national program, has been adopted to enhance best practices. The pharmacy department shared their efforts to reduce the use of certain drug classifications. Innovation was a key theme, with projects like surgical scheduling improvements, potential robotics in the lab, and AI and DI implementations. HIS preparedness was emphasized, particularly in the pharmacy's review of order sets and planning for capital purchases to improve medication distribution. Organizational flow remains a priority, with recent visits to St. Thomas Elgin General Hospital providing additional insights. Physician leadership is crucial for improving patient discharge processes, but physician recruitment remains a concern, affecting various departments. Despite onboarding 50 new physicians, continuous support for recruitment and retention is necessary to maintain quality care.

4.3. **Resource Committee**

4.3.1. **May 2023 Financial Statements**

The Board reviewed the pre-circulated briefing note provide in the meeting agenda package. 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) at the time of these statement had not yet supplied fiscal 2024-25 funding letters, causing Ministry of Health (MOH) base and one-time revenue to be unfavourable to budget. Funding letters have been received as of June 24, 2024. Reducing the amount of overtime is a key organizational priority in fiscal 2024-25

MOTION: (Woeller/McKinnon) that, following review and discussion of the information provided, the Board receives the May 2024 financial statements as presented by management.
None opposed, **CARRIED.**

4.4. **Medical Advisory Privileging & Credentialing**

4.4.1. Credentialing files were pre-circulated in the package.

MOTION: (Lauzon/Goyal) 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.
None opposed, **CARRIED.**

Name	Department	Specialty	Appointment	Reason	Supervisor
Dr. Fatemeh Bakhtiari	Emergency		Locum	Requesting locum tenens privileges effective April 1, 2024 – March 31, 2025	Dr. M. Runnalls
Dr. Abdallah Bin Maither	Internal Medicine		Locum	Requesting extension of locum privileges from June 2, 2024 – December 31, 2024	Dr. A. Nguyen
Dr. Maaz Shanjer **(Restricted Registrant Resident)**	Emergency		Locum	Requesting locum tenens privileges effective July 1, 2024 – June 30, 2025	Dr. M. Runnalls
Dr. Jeremy Cepek	Surgery	Urology (Regional)	Locum	Requesting locum privileges for regional call effective June 1, 2024 – May 30, 2025	Dr. L. Green
Dr. Kelsi Cole	Emergency Department		Locum	Requesting extension of locum privileges from June 1, 2024 – December 31, 2024	Dr. M. Runnalls
Dr. Menachem Loewenthal	Emergency Department		Locum	Requesting extension of locum privileges from June 1, 2024 – December 31, 2024	Dr. M. Runnalls

Dr. Mazin Al-Battran	Mental Health		Locum	Requesting extension of locum privileges from June 1, 2024 – May 31, 2025	Dr. A. Sharma
Dr. Laura Duncan	Emergency		Locum > Associate	Transitioning from Locum to Associate effective June 1, 2024	Dr. M. Runnalls

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
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

4.5. **Patient Family Advisory Council (PFAC) Update**

The Board delegate for PFAC provided an update from the June PFAC meeting. N. Melchers highlighted that PFAC discussed and approved the removal of the question on marital status as part of the registration process. Patient Experience provided an excellent update on their recent initiatives discussing the lost belongings project and shared insights from their listening sessions at the Bridges and 150 Main St Drop-in Centre for the homeless community. This was the second year conducting these sessions, and the team has received valuable feedback, including common concerns about ED wait times and feelings of stigmatization, alongside positive comments about caring staff in various departments. Patient Experience additionally highlighted that Arabic has become the top language for interpretation services, surpassing ASL for the first time. S. Pearsall also gave a brief update on the site visit to St. Thomas Elgin General Hospital.

4.6. **CEO Update**

The Board reviewed the Indigenous ReconciliACTION Plan pre-circulated in the meeting package. The CEO highlighted that the plan reflects the efforts of CMH's Indigenous Council. Each strategic priority in the plan is detailed, such as building capacity and education, with a notable effort from Board members who completed the San'yas education training. CMH aims to have 67% of its Board trained by year-end and continues to advocate for Indigenous cultural training. CMH is monitoring and evaluating our obligations under service accountability agreements. Building and sustaining productive relationships remains a focus, with an emphasis on integrating Indigenous voices into governance processes. Finally, ensuring equitable access to culturally safe care is crucial, with initiatives like enhancing care through Aboriginal healing practices and smudging.

One member inquired on what systemic barriers exist to accessing hospital care for the Indigenous patients, particularly regarding transportation. For example, transportation has long been identified as a significant barrier that remains unaddressed despite repeated community concerns for the Six Nations of the Grand River. Management answered that while CMH has addressed individual barriers and had positive experiences working with the SOAHAC Patient Navigator, systemic barriers like transportation, have not been addressed. The regional advisory circle will facilitate discussions on broader healthcare barriers. According to one member, despite episodic approaches to barriers, transportation remains a significant and recurring issue for the community, highlighting a need for consistent and effective solutions.

ACTION: The progress of the plan will be annually reviewed by the Board. CMH will collaborate with the Board to determine the suitable frequency of reporting and the responsible committees.

5. DATE OF NEXT MEETING

The next scheduled meeting is October 2, 2024.

6. TERMINATION

MOTION: (McKinnon) That, the meeting terminated at 1832h.
None opposed, **CARRIED.**

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

Agenda

Cambridge Memorial Hospital
BOARD OF DIRECTORS MEETING
Wednesday, June 26, 2024
OPEN SESSION (2)
(After Annual Meeting)

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 26, 2024.

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

Regrets: Dr. V. Miropolsky, Dr. I. Morgan

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

Guests: None

Recorder: Ms. S. Fitzgerald

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1. CALL TO ORDER

N. Melchers called the meeting to order at 2127 hours.

1.1. **Confirmation of Quorum**

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

1.2. **Declarations of Conflict**

Board members were asked to declare any known conflicts of interest regarding this meeting.

1.3. **Confirmation of Agenda**

MOTION: (Alvarado/Hempel) **that,** the agenda be approved as circulated
None opposed, **CARRIED.**

2. DISCUSSION ITEMS

2.1. Election of the Officers

M. Lauzon put forward a motion to elect the Board Chair and Board Vice Chair.

MOTION: (Lauzon/Goyal) That, Lynn Woeller be elected as Chair of the Board and Diane Wilkinson be elected as Vice Chair of the Board for a 1-year term.
None opposed, **CARRIED.**

2.2. Committee Assignments

The Committee assignments were pre circulated.
There have been two amendments to the committee roster 2-A-06 that was included in the pre-circulated meeting agenda package.

Lynn Woeller will remain as the appointed director for the CMHVA and Nicola Melchers will continue as the appointed director for PFAC for the 2024/25 year.

MOTION: (Melchers/Conway) That, the Board approve the committee assignments as amended.
None opposed, **CARRIED.**

3. **Notice of 2023-24 Board meetings and the Annual Meeting of the Corporation**
Meeting dates and Annual Meeting dates were circulated for review.

MOTION: (Brasil/Wilkinson) that, the Board approve the meeting dates as presented.
None opposed, **CARRIED.**

4. **ABCDE Goals Review for 2023/24 and Planning for 2024/25**
Board members are asked to complete column C of their 2023/24 summaries and submit to Stephanie Fitzgerald by July 19, 2024. Meetings will be scheduled with the Board Chair and Past Chair to review the results for 2023/24 and complete the 2024/25 goals.

For the development of the 2024/25 Individual Director ABCDE Goals, CMH will collaborate with the Board Chair to create an improved form that enhances progress tracking for both individual Directors and the Board as a whole. This new form will be distributed to Directors before the summer meetings.

The Chair outlined the peer evaluation process. Chairs are asked to meet with their committee members to gather feedback on their experiences over the past year, including strengths and weaknesses. For transitioning Chairs, the outgoing chair will meet with the committee members and then share this feedback with the incoming Chair. Chairs will receive peer evaluations conducted for committee members to ground these discussions. These evaluations will be distributed within the next week and should be used to facilitate conversations about peer feedback and committee performance.

5. **DATE OF NEXT MEETING**
The next scheduled Board meeting is October 2, 2024.

6. **TERMINATION**
MOTION: (Brasil) That, the meeting adjourned at 2133h.
None opposed, **CARRIED.**

6. **DISCUSSION OF INDEPENDENT DIRECTORS AND MANAGEMENT**

7. **DISCUSSION OF INDEPENDENT DIRECTORS**

Lynn Woeller
Board Director
CMH Board of Directors

Patrick Gaskin
Board Secretary
CMH Board of Directors

2024/25 Board of Directors Action Log – October 2024 Agenda Item 1.5.2

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 & non-director committee member appointments, specifically when they occur outside of the regular appointment process	P. Gaskin	**Completed** – Agenda Item 1.5.7
01-03-2023	3.9 – Foundation Events	Management to review and include the recommendation in the Board Policies	P. Gaskin	**Completed** – Agenda Item 1.5.7
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	2-C-40 – Reviewed by Governance will be brought forward for Board approval at the December 2024 meeting 2-A-15 – Will be reviewed at the November Governance Committee meeting and brought forward for Board approval at the December 2024 meeting
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.

**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)*

Date of Meeting

Last | 12 | Months

7/3/2023 - 7/2/2024

Date of Meeting	Bill Conway	Diane Wilkinson	Jay Tulsani	Julia Goyal	Lynn Woeller	Margaret McKinnon	Miles Lauzon	Monika Hempel	Nicola Melchers	Paulo Brasil	Sara Alvarado	Tom Dean
Wednesday, June 26, 2024	P	P	T	P	P	P	P	P	P	P	P	T
Wednesday, June 05, 2024	P	P	P	T	P	P	P	T	P	P	P	T
Wednesday, May 01, 2024	P	P	R	T	P	P	P	P	P	P	P	P
Wednesday, March 06, 2024	P	P	T	T	P	T	T	T	P	P	P	P
Wednesday, February 07, 2024	P	P	P	T	P	T	T	P	P	P	P	T
Wednesday, December 06, 2023	P	P	P	P	P	P	P	R	P	R	P	T
Wednesday, November 01, 2023	T	T	T	T	R	R	T	T	T	T	T	T
Wednesday, October 04, 2023	P	P	P	T	T	T	P	T	P	P	P	T
Tuesday, July 18, 2023	T	T	T	T	T	T	T	T	T	T	T	T

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

Committee

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

Legend

T-Conference
R-Regrets
P-Present

Agenda

Agenda Item 1.5.4

BOARD WORK PLAN – 2024-25

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

✓ = Due ND = Not Due C = Complete I = In progress D = Delayed 27 September 2024

Agenda Item 1.5.4

BOARD WORK PLAN – 2024-25

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

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Agenda Item 1.5.4

BOARD WORK PLAN – 2024-25

Charter Section #4	Action *(Italics-comments)*	Committee Responsible	Oct	Nov	Dec	Feb	Mar	May	Jun	Jun
c-ix-G	➢ Board Generative/Education Discussions ○ Emergency Department ○ Digital Health ○ HIS Board Generative Discussion	Board		√			√		√	
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	√	√	√	√	√	√	√	√
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	√ √	√ √	√ √	√ √	√ √	√ √	√ √	√ √
	Build Relationships									

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Agenda Item 1.5.4

BOARD WORK PLAN – 2024-25

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

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Agenda Item 1.5.4
BOARD WORK PLAN – 2024-25

Charter Section #4	Action *(Italics-comments)*	Committee Responsible	**Oct**	**Nov**	**Dec**	**Feb**	**Mar**	**May**	**Jun**	**Jun**
i	➢ Establish Board Work Plan	Board	√							
i-i-A	➢ Ensure Board Members adhere to corporate governance principles and guidelines ➢ Declaration of conflict agreement signed by Directors ➢ Director Consent to Act	Governance								√ √
i-i-B	➢ Ensure the Board's own effectiveness and efficiency, including monitoring the effectiveness of individual Directors and Board officers and employing a process for Board renewal that embraces evaluation and continuous improvement	Governance/ Board								√
i-i-C	➢ Ensure compliance with audit and accounting principles	Audit							√	
i-i-D	➢ Periodically review and revise governance policies, processes and structures as appropriate	Governance	√		√	√	√	√	√	
	➢ Review Progress on ABCDE Goals *(Director & Chair meet during July/August to establish goals for upcoming Board cycle)*	Board			√			√		√
	Fundraising									
k	➢ Support fundraising initiatives including donor cultivation activities. *(through Foundation Report and Upcoming Events)*	Foundation	√	√	√	√	√	√	√	√
	***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 1.5.4
BOARD WORK PLAN – 2024-25

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

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Agenda Item 1.5.4
BOARD WORK PLAN – 2024-25

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	

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Agenda Item 1.5.4
BOARD WORK PLAN – 2024-25

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

✓ = Due ND = Not Due C = Complete I = In progress D = Delayed 27 September 2024

Board/Committee Meetings and Event Dates	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep (2025)
Board of Directors Regular Meetings													
5:00pm - 8:00pm		2		4			5		7	25			
Board Generative/Education Discussion Meetings													
Mergers/Consolidations			6										
Innovation & Technology in Health Care						5							
Heathcare Trends and the Ontario Landscape										4			
Meeting with City Council and CMH Board of Directors - TBD		TBD											
Board Committee Meetings													
Quality Committee 7:00 am – 9:00am	18	16	20		15	19		16	21	18			
Quality Committee QIP Meeting 7:00 am – 9:00 am						6							
Resources Committee 5:00pm – 7:00pm	24		25			24		28	26	23			
Capital Projects Sub - Committee 5:00pm – 6:30pm	23												
Digital Health Strategy Sub - Committee 5:00pm – 6:30pm	19		21		16	20		17	15	19			
Governance Committee 5:00pm - 7:00pm	12		14		9		13		15				
Audit Committee 5:00pm - 6:30pm			18		20			28	26				
Executive Committee 5:00pm - 6:30pm			19				18		20				
Medical Advisory Committee (MAC) 4:30pm - 7:00pm	11	9	19	11	8	12	12	9	14	11			
CMHVA Board Meetings 9:30am - 11:15am - In Person / Hybrid	25	30	14 / 27 (14 TBC)		29	26	26	30	28	12 / 25			
CMHF Board Meetings 4:30pm - 6:30 - In Person / Hybrid	25	23	27	11	22	26	25	22	27	25			

Board/Committee Meetings and Event Dates	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep (2025)
Patient Family Advisory Council (PFAC) 5:30pm - 7:30pm In Person / Hybrid	10	1	5	3	14	4	4		6	3			
OHT Joint Board Committee 5:30pm - 7:30pm - Virtual Zoom meeting													
2024-25 Events													
Staff Holiday Lunch - December 5, 2024				5									
Career Achievement -								22					
Chamber Business Awards -			14										
CMHF Diversity Dinner –		TBD											
CMH Staff BBQ -										12			
CMH Golf Classic -										TBD			
CMH Reveal - Fiesta Mexicana						21							
Board Social -									TBD				
Board Education Opportunities													
Governors Education Sessions													
Governance Essentials for New Directors - *N/A*													
Hospital Legal Accountability Framework													
Hospital Accountability Within the Health System													
Governance and Management - The Crucial Partnership													
CMH Leadership Learning Lab													
• *Project Management for the Unofficial PM*													
• *Crucial Conversations*													
• *7 Habits of Highly Effective People - Nicola Melchers*													
• *Me2You DISC Profile - Diane Wilkinson*													
• *Quality Improvement*													
• *Guiding Organizational Change - Lynn Woeller*													
• *5 Choices*													
• *Unconscious Bias*													
Mental Health First Aid													

BRIEFING NOTE

Date: September 27, 2024
Issue: Resources Committee Report to Board of Directors September 24, 2024 OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Bonnie Collins, Administrative Assistant
Approved by: Monika Hempel, Chair

Attachments/Related Documents: None

A meeting of the Resources Committee took place on Tuesday, September 24, 2024 at 1700h.

Present:	Monika Hempel (Chair), S. Alvarado, Tom Dean, Miles Lauzon, Shannon Maier, Lori Peppler-Beechey, Janet Richter, Lynn Woeller
Regrets:	
Staff:	Trevor Clark, Rob Howe, Kyle Leslie, Stephanie Pearsall, Valerie Smith-Sellers, Susan Toth
Guests:	

Committee Matters – For information only

1. **Corporate Scorecard – Fiscal 2024-25:** Management highlighted the refreshed performance monitoring tools for 2024-25. The Strategic Priorities tracker, aligned with the QIP and IRM, includes the corresponding corporate action plans, and the Quality Monitoring Scorecard includes some of the key funding indicators (PCOPs and QBPs).

2. **Q1 Corporate Scorecard:** For Q1, there were 4 priorities that did not meet performance thresholds ("red" status"): Organizational Flow (Ambulance Offload Times, ED LOS for Admitted Patients), Optimal Staffing and Overtime (OT) Reduction, Advance Health Equity (Rainbow Health DEI training), and Post Construction Operating Plan (PCOP). PCOP was "green" for Q1, but a $1.2M shortfall ("red") has been projected year-end. Although there was improvement on these priorities from the previous fiscal year, these priorities will continue to be major areas of organizational focus.

   Successes and wins were highlighted. An ED wait-time information tool was implemented and has seen 100% uptake from physicians, and work on the inpatient areas resulted in a reduction of the long-stay patients list. An innovative partnership with the University of Waterloo will support OR scheduling and address OR optimization.

   Questions were entertained. The Committee was pleased with the updated scorecard, and the use of predictive artificial intelligence (AI) models to improve scorecard indicators.

3. **Environmental Sustainability Plan Review:** Management presented the CMH Environmental Sustainability Plan, developed by the Environmental Sustainability Committee (ESC) in conjunction with engaged stakeholders, for the Committee's feedback. A draft will be brought back to the Committee in November for endorsement to the Board. Management requested feedback on questions posed in the briefing note.

   In response to question 4, concerning key objectives, the Committee recommended including qualitative aspects to the evaluation, and that equal weight be put on the qualitative as well as the quantitative aspects of the evaluation. The Committee recommended developing a sustainability report, including baselines, benchmarks and reduction tracking. Management confirmed that CMH has partnered with a third party and has also joined a green healthcare coalition. The Committee inquired about legislative requirements with which the hospital must comply that dictate specific environmental metrics. Management confirmed that the only legal requirement is for the hospital to publicly post an Environmental Conservation Demand Management Plan, highlighting the hospital's goals and current state.

   The Committee will review the plan and provide additional feedback to management after the meeting. briefing note.

4. **Capital Policies Review – 2-C-36 Borrowing:** Management presented the Borrowing policy to the Committee for review and input. Any modifications will be forwarded to the Governance Committee for review and approval. Management did not identify any changes to the policy as CMH has not needed to rely on debt financing for the last several years, however this is likely to change going forward with the system modernization. The Committee recommended updating the policy to include borrowing limits.

5. **Resources Committee Terms of Reference Review:** Management presented the Resources Committee Terms of Reference to the Committee for review and input. Any modifications will be forwarded to the Governance Committee for review and approval. The Committee recommended the following update for the "Facilities" section: change subparagraph (v) "Oversee and report to the Board on the progress of all Capital Redevelopment and infrastructure projects" to "…on the progress of all capital projects/expenditures."

BRIEFING NOTE

Date: September 11, 2024
Issue: MAC Report to the Board of Directors September 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

A meeting of the Medical Advisory Committee took place on September 11, 2024, at 1630h.

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

Committee Matters – For information only

1. **M&T Report:** The August M&T report was approved by MAC.

2. **COVID-19 and Infectious Disease Update:** Committee received an update on infectious disease. During the summer months, there was activity seen with COVID-19 and respiratory viruses in general. Enterovirus was the most prevalent during the summer months while COVID-19 activity was in the moderate range. More recently, COVID-19 prevalence has been increasing, with a positivity rate of 15.8%. The most common strain currently is KP 3.1.1. Influenza activity remains low. COVID-19 vaccines will be available later in September, with new vaccines for the current KP strain. CMH has seen COVID-19 activity over the summer: 7 cases in June, 11 cases in July, 5 cases in August, and 4 cases in September to date. No COVID-19 outbreaks over the summer. There continues to be point of care assessment for masking use. Masking requirements may change as COVID-19 activity changes, and with provincial/regional direction.

   Ontario has experienced 25 confirmed measles cases, 14 in children and 11 in adults. In this region, there has been one child less than 1 year. In the case of Mpox cases rising in Africa, there was some spread globally, but there have been no confirmed cases in this region.

Lastly, an update was provided on rabies. There was one confirmed case of rabies recently, the first case since 1976. There is also a current backorder on rabies vaccine.

3. **Medical Directives:** The following medical directives were approved by MAC.
556: Blood Borne Pathogens Exposure Management
558: Ordering of Laboratory Investigations – IPAC

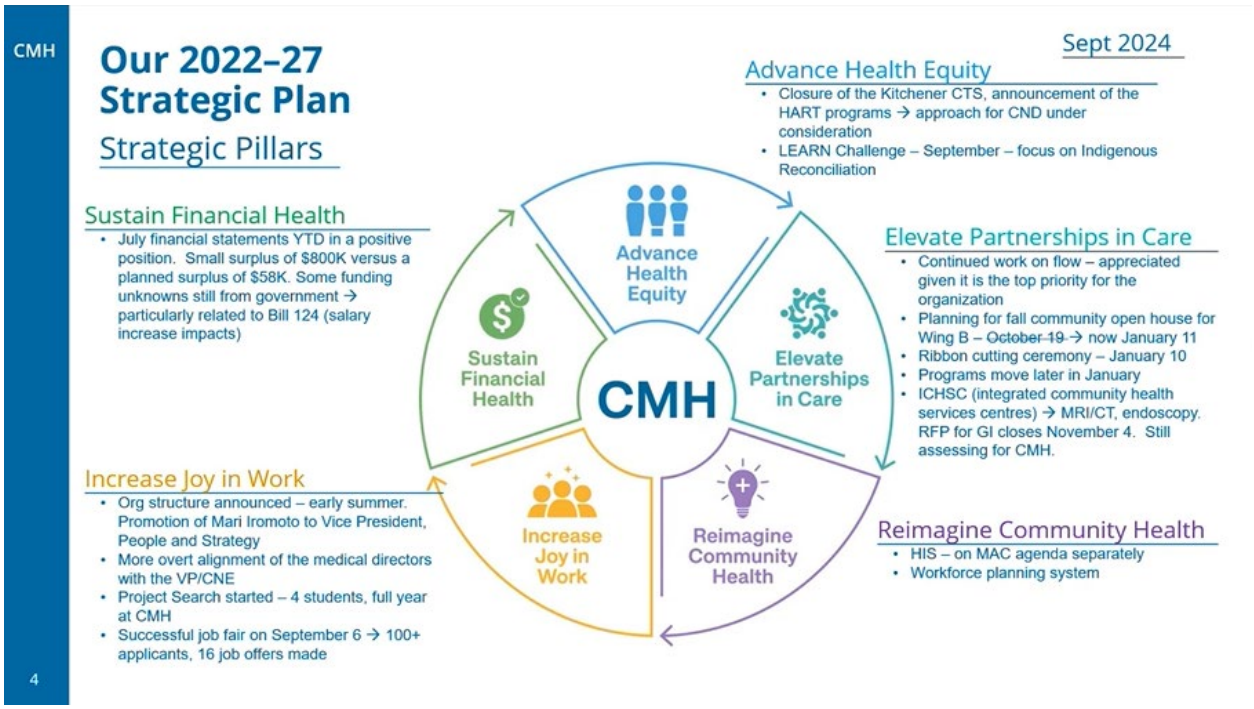
4. **CND-OHT Survey:** Committee chair shared a survey that has been released by the Primary Care Network (PCN) with the support of the CND-OHT to better understand the challenges with specialists' referrals. There has been support by the CND-OHT to support a reciprocal survey to understand the challenges faced by specialists / hospital-based physicians when transitioning care from acute to community care. MAC was asked to provide feedback on the hospital-based physician / specialists survey. The confidential survey results will be collated to help inform an upcoming CND-OHT event in November that aims to create further dialogue, networking, and collaboration within the CND-OHT providers. The aim is also to better streamline the transitions in care within the CND-OHT. The hospital-based physician/Specialist survey will be shared with CMH medical professional staff in September/October 2024.

5. **Policies:** Policy #2-415 On-Call Sleep Room was updated to be reviewed every 3 years, which was approved by MAC.

   Policy #2-409 Most Responsible Practitioner (MRP) was discussed. Dr. M. Runnalls and Dr. J. Legassie will further review and update the policy to align with the current Admission Criteria document. The policy will be brought back with updates for MAC approval.

6. **Front-End Speech Dictation:** Committee received a presentation on the opportunity to participate in this initiative of front-end speech dictation - specifically with fluency and fluency flex. Key benefits include flexibility, efficiency, superior data quality and accuracy, and transfer of care. Data shared has demonstrated uptake by the physicians since its launch earlier this year, with the ED department leading the utilization. Committee member shared a positive experience with using the product. It allows for clear clinical notes for family physicians and other providers. Suggestion was made for a one-pager summary to support physicians to onboard the product for front-end speech dictation. Chiefs were invited to have M. Hassan join their department meetings to further introduce the product to the medical professional staff.

7. **CEO Report:** CEO report was pre-circulated in the MAC package. Summary of the activities was provided supporting each of CMH's strategic pillars.



8. **Non-OHIP Patients Update:** As follow-up to a previous discussion in June 2024 MAC, CEO has engaged the other Waterloo Wellington hospitals with regards to a regional approach to manage non-OHIP patients. It is a shared challenge across the region. Further information will be shared as the hospitals work together to address this issue.

9. **CNE Report:** CNE report was pre-circulated in the MAC package.

10. **Board Report:** Board update was presented to the MAC. Lynn Woeller has started her role as the new Board Chair in July 2024. Subcommittees of the Board will be starting this week. Next Board meeting is October 2, 2024.

11. **PFAC Report:** An update on the PFAC committee was provided. PFAC met in person. Highlights of the PFAC discussion included:

    1. An update on the PXO which included a summary of complaints and compliments received by departments. Most departments are GREEN for complaints. Overall, there have been less complaints based on targets that were set to reflect the last couple of years.
    2. Patient flow - feedback from several PFAC members emphasized the importance of keeping patients informed while waiting in ED.
    3. PFAC work plan was updated.
    4. Patient Declaration of Values refresh.
    5. Presented a Beryl Institute Humanity in Healthcare collaborative project which is seeking participants (physician and PFAC members) to participate in a project focused on the patient-physician relationship thru storytelling. Collected data will be shared at the 2026 Beryl Institute conference.

BRIEFING NOTE

Date: September 11, 2024
Issue: Governance Committee Report to Board of Directors September 10, 2024 - OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Administrative Assistant
Approved by: Patrick Gaskin - President & CEO, Julia Goyal - Governance Committee Chair

Attachments/Related Documents: None

A meeting of the Governance Committee took place on Tuesday September 10, 2024 at 1700 hours.

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

Staff Present: P. Gaskin. M. Iromoto

Regrets: M. McKinnon, N. Melchers

Committee Matters – For information only.

1. **Welcome & Territorial Acknowledgement:** The Chair presented the Territorial Acknowledgement and welcomed new and returning members.

2. **Policy Reviews and Approvals:** The Governance Committee reviewed four in-cycle policies and four off cycle policies. These policies are captured in agenda item 1.5.7 of the October 2, 2024 Board of Directors meeting for Board approval.

3. **Board/Committee Feedback Reports Review:** The Governance Committee reviewed the feedback reports from the May 2024 and June 2024 Board and Committee meetings. The Governance Committee will continue to monitor the response rates to ensure low response rate trends are monitored and addressed with Committee Chairs if needed.

4. **Board Orientation 2024/25 Survey Results:** The Governance Committee reviewed the feedback received from the 2024/25 committee members orientation. For 2024/25 there were two new non-directors appointed to the Digital Health Strategy Sub-Committee. Incorporating feedback received from the post orientation survey the Governance Committee has recommended that CMH Management follow up with one of the comments for further clarification.

5. **Survey Timelines and Suggestions:** The Governance Committee reviewed the briefing note included in the meeting package. Following discussion, the Committee agreed that

the current surveys are valuable and do not require further review at this time. However, the Governance Committee will continue to assess the surveys or tools as issues arise.

6. **Adding Names of Survey Respondents to Survey Summary:** Over the summer, the Chair of the CMH Board met with all the Board Committee Chairs. At this meeting, the issue of the survey response rate for Committee and Board evaluations was raised. The Governance Committee supports the suggestion to include a list of respondents when the results are summarized. The names will not be linked to specific comments to protect anonymity (in the unlikely event of only one respondent the Administrative Assistant who summarizes the results would not include the name).

7. **Improvements to Board Recruitment/Application Process:** Feedback from the Board of Directors was received on the importance of including a synopsis of the candidates' qualifications for consideration in the absence of a CV. The Governance Committee supports adopting a process of including a profile summary for the Board's consideration in lieu of full CVs to support nominations for appointments.

8. **Governance and Partnerships:** The Governance Committee wants to expand its role from what is currently outlined in the terms of reference. This discussion was sparked by the need to address governance work related to relationship management, community engagement, and advocacy. The idea originated from a Board conversation in October 2022 about partnerships, which was revisited briefly in May 2023. A proposed working group for partnerships did not materialize, so staff developed a current state of partnership arrangements instead. The Governance Committee supports the amendments to Policy 2-A-15, Governance Terms of Reference, to reflect the Committee's expanded role. This will be discussed further during agenda item 4.2 of the October 2, 2024 Board of Directors meeting for Board approval.

9. **Integrated Community Health Services Centres Act (ICHSCA):** The Ministry of Health (Ministry) is actively moving forward with the licensing process under the ICHSCA. Recently, it announced the first call for applications concerning MRI and CT services, with a submission deadline of August 12, 2024. The Ministry anticipates issuing new licenses in Fall 2024. Notably, applications for new MRI or CT ICHSCs cannot be located within the same building or premises as a public hospital. Ontario's Call for Applications to license more Gastrointestinal (GI) Endoscopy services through community surgical and diagnostic centres opened on August 26, 2024 Applications will close at 11:59 p.m. on Monday, November 4, 2024. The Government's call for applications has been marketed as a key step in making it faster and easier for people to connect to publicly funded surgeries and procedures in Ontario. Together with health care partners, the Government is aiming to help connect an additional 60,000 people to GI Endoscopy procedures each year. The OHA will continue to monitor developments related to the ICHSCA, including upcoming calls for applications. Management will continue to update the Governance Committee as new information is provided and the implications or opportunities for CMH.

10. **Bill 194, Strengthening Cyber Security and Building Trust in the Public Sector Act, 2024:** On May 13, 2024, the provincial government introduced Bill 194, titled the Strengthening Cyber Security and Building Trust in the Public Sector Act, 2024. This landmark legislation aims to enhance cyber security measures, establish guidelines for the ethical use of artificial intelligence (AI), and bolster privacy protections across the public sector. This information will be shared with the Audit Committee and Digital Health Strategy Sub-Committee for information purposes. Management is assessing the

implications for CMH. This work is ongoing. The OHA is expected to provide some support to hospitals. The OHA will continue to monitor developments related to Bill 194 and will provide further updates as they become available. Management will continue to update the Governance Committee, Audit Committee and Digital Health Strategy Sub-Committee as new information is provided.

BRIEFING NOTE

Date: September 13, 2024
Issue: Board Policy Review 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-30	Responsibilities of a Director
2-D-08	Board and Committee Meetings
2-D-12	Freedom of Information and Protection of Privacy Act (FIPPA) Delegation of Duties
2-D-20	Recruitment, Selection, and Nomination of Directors and Non-Director Committee Members
2-D-32	Education for Board Members and Non-Director Committee Members
2-D-48	Whistleblower Policy
2-D-60	Recognition of Board Service

Background

The following policies were reviewed and discussed at the September 10, 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-30	Responsibilities of a Director
2-D-08	Board and Committee Meetings
2-D-12	Freedom of Information and Protection of Privacy Act (FIPPA) Delegation of Duties
2-D-20	Recruitment, Selection, and Nomination of Directors and Non-Director Committee Members
2-D-32	Education for Board Members and Non-Director Committee Members
2-D-48	Whistleblower Policy
2-D-60	Recognition of Board Service

CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

SUBJECT: Responsibilities of a Director	**NO.: 2-A-30**
SECTION: Structure, Roles and Responsibilities	
APPROVED BY: Board of Directors	**DATE: June 28, 2023**

Responsibilities

As a member of the Board, and in contributing to the collective achievement of the role of the Board, each Director is responsible for the following:

Fiduciary Duties

As a fiduciary of the Corporation, a Director acts honestly and in good faith with a view to the best interests of the Corporation, and exercises the care, diligence, and skill that a reasonably prudent person would exercise in comparable circumstances. In so doing, a Director supports the Board in fulfilling its mission and discharging its responsibilities. All Directors, including ex-officio Directors, are held to the same duties and standard of care.

A Director does not represent the specific interests of any constituency or group. A Director acts and makes decisions that are in the best interest of the Corporation as a whole.

General

As a member of the Board, each Director will:

- understand the difference between oversight and management, respecting the responsibilities delegated by the Board to the CEO and the Chief of Staff
- each Director will comply with the Boards Code of Conduct
- comply with the Policy 2-A-03 Board Conflict of interest Policy and Article 5 of the Corporation By-law
- respect the confidentiality of matters brought before the Board and all committees
- support the Board's decisions and policies at all times even if the Director holds another view or voiced another view during the Board discussion or was absent from the Board meeting
- comply with the Board and Corporation policies that are applicable to the Board

Contribution to Governance

Directors are expected to contribute to the governance role of the Board through:

- reading materials in advance of meetings and coming prepared to contribute to discussions
- offering constructive contributions to Board and committee discussions
- contributing special expertise, skills and attributes

- respecting the role and terms of references of the Board and Board committees
- participate in the Board evaluation processes

Attendance and Availability for Board and Committees

Each Director will:

- have the ability to commit the necessary time for Board meetings, committee meetings and Board education in accordance with the Policy 2-A-38, Board and Committee Meeting Attendance Policy
- serve as an active member of at least one committee and contribute to its purpose
- when absent, record their dissent to any action of the Board or its committees in accordance with the requirement in Article 4.9 of the Corporation's Corporate By-law

Communication and Interaction

As a member of the Board, each Director will:

- work positively, cooperatively and respectfully with all members of the Board and the management team
- promote a welcoming and inclusive environment
- participate fully and frankly in the deliberations and discussions of the Board
- demonstrate an openness to other people's opinions and the willingness to listen
- have the confidence and will to make tough decisions, including the strength to challenge the majority view
- advise the Chair and the CEO in advance when introducing significant and/or previously unknown information or material at a Board meeting

Community Representation

As a member of the Board, each Director will:

- not speak on behalf of the Board and the Hospital in the community unless asked to do so by the Board Chair in keeping with Policy 2-D-11, Communications Policy and Article 10.2 of the Corporate Bylaw regarding Board spokesperson
- align their public views with the Hospital's position.

CMH Foundation (CMHF)

As a member of the Board, each Director will:

- financially support the work of the Foundation on an annual basis, when possible
- attend events to represent CMH, when asked by CMHF/CMH and available (attendance at which is paid for by CMHF or CMH)
- attend, when possible, events sponsored by the CMHF (self-paid)

Goals Setting

As per Policy 1-A-05, Board Statement on Culture, as a member of the Board, each Director will set, in collaboration with the Board Chair, annual personal development goals and report on the performance related to these goals in the following categories:

- Attend – attend Board and committee meetings
- Be engaged – be an active contributor to the committee and Board work
- Connect – attend staff huddles and events
- Donate – support the CMH Foundation
- Educate – undertake education and courses

Knowledge

Recognizing that decisions can only be made by well-informed Directors, each Director will participate in Board and committee orientation, Board education and other education sessions in accordance with Board Policy 2-D-32 and understand:

- the Corporation's strategic direction
- the current provincial, regional, and local health care environment
- the role and responsibilities of the Board and a Director
- the key performance indicators for Board oversight of the Corporation

Appointment and Team

A Director is elected for a three-year term. An elected Director may not serve for more than nine consecutive or cumulative years.

Conclusion of Term

Upon conclusion of service the Director will return all items and materials and delete all electronic materials as requested by the CEO and confirm compliance with these activities as instructed by the CEO.

DEVELOPED: February 23, 2011		
REVISED/REVIEWED:		
November 28, 2012	June 25, 2014	November 26, 2014
January 24, 2018	November 25, 2020	May 26, 2021
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

BOARD MANUAL

SUBJECT: Board and Committee Meetings	**NO.: 2-D-08**
SECTION: Board Process	
APPROVED BY: Board of Directors	**DATE: TBD**

Policy

As the Hospital is a publicly funded corporation, the Board wishes to be as open and transparent in its deliberations as possible. Therefore, in the interest of good governance, meetings of the Board are open to the public. There are, however, specific occasions when the Board is required to meet in closed session ("*in camera*").

A. Open Sessions of Meetings of the Board

Members of the public are invited to attend the meetings of the Board in accordance with the following policy.

Notice of Meeting

A schedule of the date, location and time of the Board's regular meetings is available from the President & CEO's office and is posted on the Corporation's website. Changes in the schedule are posted on the website. Instructions for attending are also provided.

Agendas and Board Materials

Agendas are available on the Corporation's website and are distributed at the meeting. Printed copies of the agenda material are available upon request.

Public Attendance at Board Meetings

Any person wishing to attend open meetings of the Board in the capacity of an observer is entitled to do so and is welcomed by the Board. When meeting in person, seating is available at the meeting on a first come, first served basis due to space constraints. To comply with fire and other regulations, attendance may be restricted. When meeting virtually (or in a combined virtual/in-person format), any person wishing to attend the open meeting may contact the CEO's office to receive information on how to virtually attend the open meeting.

Delegations to the Board

Members of the public may not address the Board or ask questions of the Board without the permission of the Chair, granted at the meeting.

Delegations to the Board will be considered according to Policy 2-D-9, Procedure for Members of the Public Addressing the Board.

Conduct During the Meeting

Members of the public may be asked to identify themselves. Recording devices, videotaping and photography are prohibited without consent of the Board Chair.

The Chair may require anyone who displays disruptive conduct to leave.

B. Closed Sessions of Meetings of the Board

As a broad principle, meetings of the Board are open to all who choose to attend unless disclosures made in the presence of non-directors are reasonably likely to prejudice the interests of either the Hospital or any other person whose interests the Hospital has an obligation to protect.

The Chair, prior to regular Board meetings, shall determine the need for an *in camera* session. Also, if a matter arises during a meeting that triggers the need for an *in camera* session, the Board may move any meeting or part of a meeting to an *in camera* session of the Board.

Topics to be addressed *in camera* include, but are not limited to, the following:

- Collective bargaining
- Legal advice and litigation
- Issues regarding identifiable staff including terms of employment, performance evaluation, discipline etc.
- Discussions related to privileges for medical/professional staff
- Acquisition, sale, lease, and exchange of property
- The disclosure of intimate, personal or financial information about an identifiable person
- Negotiation of contracts
- Sensitive information which if disclosed could prejudice the interests of the Hospital or a third party

Only those persons authorized by the Board to remain at an *in camera* meeting will be permitted to remain.

Minutes of *in camera* meetings shall be created, approved at a subsequent meeting and kept in a manner to maintain confidentiality and in accordance with the records retention policy.

C. Committee Meetings

Meetings of committees are not open to the public.

DEVELOPED: March 30, 2011		
REVISED/REVIEWED:		
June 25, 2014	September 27, 2017	November 24, 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.

CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

SUBJECT:	**Freedom of Information and Protection of Privacy Act (FIPPA) Delegation of Duties**	**NO.: 2-D-12**
SECTION:	**Board Process**	
APPROVED BY:	**Board of Directors**	**DATE: TBD**

This policy is identical to Corporate Manual Policy 2-21. The Board endorses and adheres to the Corporate FIPPA Delegation Policy 2-21

Policy

Section 2 (1) (a.1) of the *Freedom of Information and Protection of Privacy Act*, 1990 (FIPPA) defines "head" in the case of a public hospital, as the chair of the board of the hospital.

Section 62 (1) of FIPPA specifies that a head may, in writing, delegate a power or duty granted or vested in the head, to an officer of the institution.

The term "officer" is not explicitly defined in FIPPA and as such, is interpreted in this policy to mean an employee with oversight for the privacy program at Cambridge Memorial Hospital who holds the title Chief Privacy Officer.

The officer to whom the accountabilities are delegated must ensure:

- The Hospital responds to Freedom of Information (FOI) requests in compliance with FIPPA; and
- Personal information is collected, used, disclosed, retained, and disposed of in accordance with FIPPA.

Procedure

1. Delegation under Section 62 (1) of FIPPA shall be made in writing as described in Appendix A. Changes to, or cancellation of a delegation must also be in writing.
2. A delegation is made to a position or title and not to a named individual. CMH has named the position Chief Privacy Officer as the delegated position and the position Privacy Officer as the alternate.
3. The Hospital maintains records of the delegation of duties for FIPPA in the CEO's office

DEVELOPED: December 7, 2020		
REVISED/REVIEWED:		
April 28, 2021	April 27, 2022	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.

Appendix A

Delegation of the Chair of the Board's FIPPA Duties

I, (Name), as Chair of the Board of Cambridge Memorial Hospital, delegate all of my powers and duties under *Freedom of Information and Protection Act*, 1990 to the Chief Privacy Officer. When the Chief Privacy Officer is not reasonably available (e.g. due to illness, vacation), Chief Privacy Officer has the authority to delegate their powers to a designated CMH Privacy Officer.

Board Chair	Director, Patient Experience, Risk & Quality & Chief Privacy Officer
mm/dd/yyyy	mm/dd/yyyy
Witness Name	Witness Name
mm/dd/yyyy	mm/dd/yyyy

BOARD MANUAL

SUBJECT:	**Recruitment, Selection, and Nomination of Directors and Non-Director Committee Members**	**NO.: 2-D-20**
SECTION:	**Board Process**	
APPROVED BY:	**Board of Directors**	**DATE: TBD**

Purpose

Effective governance depends upon the right mixture of skills, experience, personal qualities, and diversity among the members of the Cambridge Memorial Hospital ("**Corporation**") Board of Directors ("**Board**") and Board committees.

Policy

The Governance Committee is charged with the process of recruiting and recommending to the Board the nomination of individuals for election or appointment to the Board of the Corporation.

The Board will be composed of competent Directors who work effectively both individually and collectively. They must possess the appropriate skills and experience to monitor performance and add value to the Corporation.

Through the nomination and election process, the Board will select Directors according to their skills, experience, and personal qualities.

The Board will seek a balance within the Board concerning the skills and experience of Directors, while considering any unique or special requirements of the Corporation at the current time.

The Board will ensure all Directors possess the personal qualities necessary to perform their role as Directors. The Board should reflect the diversity of the community served, including demographic, linguistic, cultural, economic, geographic, gender, ethnic, and social characteristics of the communities served by the Corporation.

The Governance Committee is also charged with recruiting and recommending to the Board the appointment of non-Director members to Board committees.

Guidelines for the Nomination of Directors

The Governance Committee and Nominating Subcommittee shall consider the following factors while balancing the need of ensuring ongoing expertise on the Board and the need to plan for the succession of the Board officer positions.

Universal Competencies

The Board requires that all Directors have the following skills and personal qualities:

- Commitment and Effective Communication
  - make an active contribution at meetings and on behalf of the Board where required
  - demonstrate a willingness to devote the time necessary to Board work, including orientation and education

- Integrity
  - personal integrity
  - objectivity
  - high ethical standards
  - respect for the views of others

- Analytical Decision-Making
  - a capacity for resolving difficult and complex issues
  - an awareness and understanding of identified issues and proposed recommendations and impacts
  - an ability to analyze situations and problems from a system perspective
  - the capacity and ability to provide valued knowledge, experience, and counsel to the Board, the CEO, and the Chief of Staff

- Strategic Leadership
  - a commitment to the mission, vision, and values of the Corporation, the internal strategic plan of the Corporation and its responsibilities to the Ministry of Health
  - the capability to give leadership to the development of the Corporation
  - the capability of exercising leadership and consensus building
  - the demonstrated ability to work as a member of a team and the ability to express a dissenting opinion in a constructive manner

- Governance Acumen
  - understand the distinction between the strategic and policy role of the Board and the day-to-day operational responsibilities of management
  - understand the range of obligations and constraints imposed upon Directors of the Corporation

Collective Competencies

The Nominating Subcommittee should strive to ensure that the following collective competencies are present in the Board.

- Leadership and/or executive experience
- Strategic planning experience
- Board and governance
- Previous health sector and/or not-for-profit board or committee experience
- Business acumen
- Resource and/or audit experience
- Health care/clinical practice
- Health system integration
- Government relations
- Legal
- Risk management
- Quality and performance management
- Human resources/labour management
- Health informatics
- Ethics
- Public affairs, communications
- Patient and healthcare advocacy
- Community involvement
- Such other specific knowledge and/or experience that the Governance Committee may identify from time to time.

See Appendix A for a description of the knowledge, skills, and experience that are relevant when recruiting for the Hospital Board.

Conflict of Interest

The Nominating Subcommittee will ask each candidate proposed for election or appointment to disclose any material relationships that may potentially result in a conflict of interest or interfere with the exercise of the individual's independent judgment. The Nominating Subcommittee will consider potential conflicts within the context of the Bylaw and the Conflict of Interest Policy (2-A-36) in assessing the suitability of the candidate for nomination.

Procedure

Recruitment of Candidates

The Governance Committee will:

1. Annually, recommend to the Board the composition and members of a Nominating Subcommittee.

2. Conduct an annual survey of all current Board members to request a self-assessment of their skills. See *Skills Matrix Survey,* Board Manual 2-D-40, Appendix D.

3. In consultation with the Directors, identify a list of competencies or characteristics that would be an asset to the Board in the next year and future years, given the Board's strategic priorities and needs.

4. Review the Board's current composition (Skills Matrix Survey results), the list of competencies identified in step 3, anticipated vacancies, and competencies identified in new Directors.

5. Begin the recruitment process, which will include:

    - Inviting non-Director members of committees to apply for vacant Director positions

    - Encouraging current and previous Directors to recommend candidates possessing the competencies for consideration by the Nominating Subcommittee, and

    - Advertising vacancies on appropriate communication channels and the Corporation's website.

Nominations for Election to the Board

A) New Director Applicants

The Nominating Subcommittee will:

1. Receive and retain from persons eligible to be elected as a Director their completed applications (the application form may be amended without Board approval by the Governance Committee from time to time, the most current version appears as Appendix B), indicating their interest in serving on the Board or Board committee and their qualifications.

2. Review prospective Board candidates against the Board skills profile (see Competency Definitions, Appendix A) and develop a short list of candidates for interview.

3. Interview short listed candidates to assess the prospect's interest and qualifications against the Board's needed competencies. Conduct reference checks.

4. Select candidates for nomination for election as Directors.

5. Provide the Board with information about the selected candidates and consider the Board's feedback. The decision of the Board as to whether or not a candidate is qualified to stand for election shall be final.

6. Instruct the Corporation's management to ask selected candidates to obtain police checks.

7. At the annual meeting, nominate the selected candidates for election as Directors by the Members of the Corporation.

8. Via the Chair of the Governance Committee, communicate the decisions to the candidates.

Nominations made for the election of Directors at a Members' meeting may only be made in accordance with the Corporation's Corporate By-law.

B) Non-Director Committee Member Applicants

The Nominating Subcommittee will:

1. Evaluate applications from current non-Director committee members by consideration of the following:
    a. Applications
    b. Ability to contribute to a competency required by the Corporation
    c. Attendance at committee meetings
    d. Feedback obtained from relevant committee chair(s) including contribution to the committee and applicant's strengths and weaknesses
    e. Interview

2. Select candidates for nomination for election as non-Director committee members.

3. Provide the Board with information about the candidates and consider the Board's feedback. The decision of the Board as to whether or not a candidate is qualified to serve on a committee shall be final.

4. Instruct the Corporation's management to ask selected candidates to obtain police checks.

5. At the Board meeting following the annual meeting, appoint non-Director committee members to committees, as appropriate.

6. Via the Chair of the Governance Committee, communicate the decisions to the candidates.

C) Re-Election of Existing Board Members

The Nominating Subcommittee will:

1. Evaluate Board members eligible for election to another term on their performance as a Director and committee member (see *Evaluation of Board, Committee and Individual Performance*, Board Manual 2-D-40) and their ability to contribute a competency that is still needed by the Corporation.

2. As appropriate, at the annual meeting nominate Directors for re-election as Directors by the Members of the Corporation. As per the Corporation's Corporate By-Law, the

decision of the Board as to whether or not a candidate is qualified to stand for election shall be final.

D) Filling Mid-Term Director Vacancies

When directed by the Board, the Governance Committee will recommend nominees for vacancies that arise to fill an unexpired term. Appointments will be approved by the Board until an election is held at the next annual meeting.

E) Filling Mid-Term Non-Director Committee Member Vacancies

When directed by the Board, the Governance Committee will recommend nominees for vacancies that arise to fill an unexpected non-director committee member vacancy. The recruitment process will be developed by the Governance Committee. Appointments will be approved by the Board.

F) Reappointment of Non-Director Committee Members

Non-Director committee members are appointed for a 12-month period. The Governance Committee may, in its sole discretion, recommend to the Board that non-Director committee members be appointed for subsequent terms as non-Director committee members.

The Nominating Subcommittee will:

1. Evaluate existing non-Director committee members on their performance as committee members (see *Evaluation of Board, Committee and Individual Performance*, Board Manual 2-D-40) and their ability to contribute a competency that is still needed by the Corporation.

2. Assess the skills, qualifications, and interest of any new candidates interviewed.

3. Recommend to the Board the appointment of non-Director committee members.

APPENDIX A

Competency/Skills Definitions

Leadership and/or executive experience

- Experience in a professional leadership role and/or broad management experience

Strategic planning experience

- Involved in processes to define an organization's direction and make decisions on allocating its resources to pursue a strategy
- Able to look at issues in a wide context, consider a wide range of influences and situations, and see the implication of decisions
- Responsible for setting objectives for a greater than one-year time horizon

Board and Governance

- Understanding of the roles/responsibilities of senior executives and their accountability to the Board
- Experience with corporate governance structures and planning, including broad board experience
- Previous board or committee experience
- Certification or governance courses e.g., Ontario Hospital Association

Business Acumen

- Broad management experience involving human, financial, technological, and other resources
- Able to determine how a particular initiative or opportunity will support the implementation of the corporate strategy and deliver on key performance objectives

Resource and/or Audit

- Strong business acumen and financial literacy to monitor financial performance effectively-- and to recognize red flags
- Understanding of financial operational management and the proper application of internal controls for public sector, private sector, or not-for-profit boards
- Understanding of financial reporting, and knowledge of other considerations and issues associated with the auditing requirements for public sector, private sector, or not-for-profit boards
- Experience/understanding of not-for-profit accounting rules

Health Care/ Clinical Practice

- Understands the key indicators and drivers of clinical quality, including patient safety, and their impact on the Corporation
- Experience in health planning, quality improvement, etc.

Health System Integration

- Senior executive and/or board member in a health system, regional health model, or government health ministry
- Exposure to and/or experience with collaboration models and integration through a

board role or employment within the health sector

Government Relations
- Understanding of the legislative and regulatory process as well as the roles and decision-making processes of key governmental and regulatory entities
- Experience in relationship building with elected government representatives

Legal
- Familiarity with governing legislation
- Corporate and business law
- Experience with regulated industries

Risk Management
- Knowledge and experience in integrated risk management
- Experience in the process of identifying principal corporate risks and to ensure that management has implemented the appropriate systems to manage risk

Quality and Performance Management
- Quality and safety expertise in business or industry
- Understanding of quality of care issues and performance measurement
- Benchmarking experience
- Experience in process improvement methodology

Human Resources/ Labour Relations
- Understanding of human resources issues for executive recruitment, compensation structures, and performance review among public sector, private sector, or not-for-profit boards
- Knowledgeable of evidence-based methods for successful workforce recruitment and retention, understands key drivers of employee satisfaction, and stays informed on general and industry trends associated with unionization activities

Health Informatics
- Skilled in seeking out information and applying new technology and practices to improve processes and generate unique solutions to emerging concerns
- Background in the application of population health and health planning statistics in a research, academic, or health administration environment
- Operations and strategic planning experience for information technology

Ethics
- Experience in working with an ethics review Board, ethics frameworks, health care ethics, setting up processes

Public Affairs, Communications
- Experience in engaging the public
- Experience in setting corporate communication policies
- Media experience

Patient and Healthcare Advocacy

- Experience with advocacy groups, committees, or boards of a social or healthcare-related background
- Experience as a healthcare professional

Community Knowledge and Involvement

- Knowledge of the community and stakeholders
- Service or volunteer work in the community
- Has networks and/or is able to find common ground with a widening range of stakeholders, including both the community and clients served by the Corporation. Uses contacts to build and strengthen support bases
- Experience working with diverse stakeholder groups
- Has general knowledge about cultural beliefs, values, attitudes, and behaviors, including effective ways for building trust and relationships
- Understands key local and provincial issues, can communicate the impact the Corporation has on the community

DEVELOPED: November 24, 2010		
REVISED/REVIEWED:		
November 28, 2012	February 26, 2014	January 25, 2017
September 25, 2019	June 28, 2023	Click or tap to enter a date.
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

BOARD MANUAL

SUBJECT:	**Education for Board Members and Non-Director Committee Members**	**NO.: 2-D-32**
SECTION:	**Board Process**	
APPROVED BY:	**Board of Directors**	**DATE: TBD**

Policy

It is important that the Board and non-director committee members have the skills, knowledge and experience required to fulfill their duties. In addition to the initial orientation program (see Board Policy Manual, 2-D-30 Board and Board Committee Orientation), the Board will provide opportunities for ongoing relevant skills development, and education with respect to the background and context of the decisions that Board members and non-director committee members are called upon to make. All new Board members must complete the Ontario Hospital Association (OHA) Essentials Certificate in Health Care Governance for New Directors course (or equivalent) within two years of joining the Board.

It is expected that all Board members will participate in continuing education sessions held for Board members. Education may take place in separate educational sessions, during regular Board and committee meetings, or as part of a Board retreat. Other opportunities for education may include Hospital tours, OHA sponsored education and other governance related programs.

Board members will identify their individual development needs through feedback questionnaires that follow education sessions and an annual self-assessment. Board members also set annual goals related to education as outlined in the Board Statement of Culture Policy, 1-A-05.

Expenses for attending education programs will be reimbursed according to established policy (see CMH Policy, Board Travel and Expenses Policy 2-D-34.)

In general, non-director committee members are encouraged to attend free educational opportunities only. Paid education is generally reserved for Board members only.

Board members/non-director committee members who attend conferences or educational events are required to provide a report to the Board and/or relevant committee(s).

Procedure

1. The CEO's office will inform Board members and/or non-director committee members about relevant upcoming education events.
2. A Board member/non-director committee members will communicate interest in attending an education program with associated registration fees or expenses to the Board Chair or

committee Chair, as appropriate.

3. The Board Chair, in consultation with the CEO, determines whether or not to support the education request.
4. If approved, the CEO's office will facilitate registration and payment for the program or provide reimbursement to the Board member.
5. The Board member/non-director committee member will arrange with the Board Chair/committee Chair to present a summary of the education session at the meeting following the education event or at a time determined by the Board/committee Chair.

DEVELOPED: November 24, 2010		
REVISED/REVIEWED:		
April 23, 2014	November 30, 2016	May 30, 2018
November 27, 2019	November 25, 2020	September 29, 2021
June 28, 2022	Click or tap to enter a date.	Click or tap to enter a date.

BOARD MANUAL

SUBJECT: Recognition of Board Service	**NUMBER: 2-D-60**
SECTION: Board Processes	**APPROVED BY: Board of Directors**
DATE: May 30, 2012	**REVISED/REVIEWED: September 30, 2015, November 28, 2018, April 27, 2022**

Policy

As appreciation for their volunteer service, Board members and non-director committee members will be recognized for every five years of service and upon completion of their service on the Board or committee.

Years of Service
To express appreciation for their volunteer services, all Directors and non-Director committee members will be awarded a certificate and a years of service pin for every five years of service from the time of appointment. For Directors who have also served in non-Director capacities, the cumulative years of service are used for calculation purposes. Awards will be presented at the May/June committee/Board meetings by the committee Chair/Board Chair.

End of Service
As appreciation for their volunteer service, Directors will be recognized upon completion of service to the Board. The President & CEO, in consultation with the Board Chair, will arrange for appropriate recognition of service to the Hospital which will not exceed a monetary value of $750.

All non-Director committee members will receive a letter of appreciation from the Board Chair after their final year of appointment.

CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

SUBJECT: Whistleblower Policy	**NO.: 2-D-48**
SECTION: Board Process	
APPROVED BY: Board of Directors	**DATE: TBD**

This policy is identical to Corporate Manual Policy 2-340

Policy

Cambridge Memorial Hospital ("Hospital") is committed to open, accountable, ethical, and transparent governance which encourages a culture of integrity and honesty. An important aspect of accountability and transparency is a mechanism to enable the Individuals, as defined in this policy, to voice concerns in a responsible and effective manner when they discover information which may be unethical or illegal.

Every Individual has the responsibility to promptly report any such Whistleblower matter in accordance with this policy.

Purpose

The purposes of this policy are as follows:

- to establish procedures for the receipt, retention and handling of complaints and concerns that Cambridge Memorial Hospital ("Hospital") receives relating to, among other things, alleged or suspected violations of the Code of Conduct/Conflict of Interest Policy, other internal policies and guidelines, or any applicable law or regulation

- to encourage and enable the reporting of violations of Hospital policy relating to ethical behavior and business conduct, including the Code of Conduct/Conflict of Interest Policy (together referred to a "codes of conduct")

- to encourage and enable reporting of concerns relating to:
  - financial, internal accounting controls, or audit practices
  - quality of care
  - environmental issues
  - health and safety
  - human resource policies and legislation
  - breach of contract and negligence
  - privacy
  - violations of any other relevant provincial and/or federal legislation.

- to ensure there is no retaliation against those Individuals who make reports in Good Faith under this policy

- to protect the confidentiality of those making reports to the maximum extent possible, consistent with the need to conduct an adequate investigation.

Definitions

Bad Faith: includes concepts such as malicious conduct, improper motive, dishonesty, recklessness, and gross negligence. Bad faith is more than just "being wrong" about an event. A bad faith complaint is one where the Individual makes and steadfastly maintains as a complaint that the Individual knows or ought to know is a false claim.

Board: means the Board of Directors of the Hospital.

Designated Investigator(s): The Designated Investigator(s) is/are assigned by the Audit Committee, CEO or COS, as the case may be, to be the person responsible for reviewing and investigating, when appropriate, the complaint.

Disclosing/Discloses/Disclosure means the communication of information and specifically the process of bringing forward information, as described in this policy.

Good Faith: means to act honestly or with sincere intention. The legal test for determining whether the complaint is made in good faith is objective.

Individual: Any Board Director, non-director committee member, employee, medical/professional staff member, contractor, consultant, student and/or volunteer.

Vexatious: refers to a situation, communication or information presented which is lacking sufficient grounds for action and, when viewed objectively, is serving only to annoy or harass.

Whistleblower: An Individual who discloses information that the Individual, in Good Faith, has reasonable grounds for believing is evidence of: a violation of any law, rule, regulation or policy; a gross mismanagement; a gross waste of funds; an abuse of authority; a substantial and specific danger to public health and/or; a substantial and specific danger to public safety.

Standards

- This policy does not supersede any other reporting mechanisms covered by hospital policy or legislation.

- This policy is intended to be used in cases where the standard Hospital reporting mechanisms do not result in an outcome acceptable to the complainant or in cases where the complainant chooses to use this method for raising a complaint.

- The Hospital maintains high standards of business and ethical conduct, as expressed in its codes of conduct. The Hospital applies these standards to all matters of business.
- The Hospital expects all Individuals to observe these standards while fulfilling their responsibilities to the Hospital.
- This policy will be posted on the Hospital's intranet.
- On a regular basis, the Hospital will make known to Individuals and members of the public the process for reporting complaints on a confidential basis.
- The Hospital will, at least annually, communicate reminders to Individuals of the process for reporting complaints. This may be accomplished by electronic or other means (i.e., email, written memos and Hospital newsletters).
- To the best of its ability based on the information supplied, the Hospital will conduct an investigation when it receives a complaint.
- The Hospital will maintain records and issue reports in accordance with this policy.

Procedure:

1. **Reporting**

a) Any Individual who is aware of or suspects a breach of the codes of conduct or matters of concern or wrongdoing is responsible for disclosing the breach or concern promptly using either standard reporting mechanisms as referred to in existing policies, or this policy.

b) Members of the public who are aware of or suspect a breach of the of codes of conduct or matters of concern or wrongdoing are encouraged to disclose the breach or concern using the reporting mechanisms referred to in this policy.

c) It is expected that matters of concern will be reported in a timely manner and within one year of when the issue became known to the Individual.

d) A concern may be disclosed in the following manner:

(i) by telephone to the confidential Whistleblower hotline extension 2585

(ii) by filing a report through the on-line "Whistleblower" system

(iii) by email to whistleblower@cmh.org

(iv) by letter addressed to the person

(v) in person to the Director, Patient Experience, Quality, Risk, Privacy & IPAC.

e) All whistleblower submissions are routed to the Director, Patient Experience, Quality, Risk, Privacy & IPAC and the Chair of the Audit Committee. The submission is provided for information only to the Chair of the Audit Committee unless the matter relates to the President & CEO (CEO) and/or Chief of Staff COS).

2. Matters of concern or wrongdoing

a) Examples of concerns relating to financial, accounting and auditing practices may include, but are not limited to, situations such as:

(i) the appearance of fraud, including falsification of records

(ii) unauthorized dealings with contractors for personal benefit, including receiving kickbacks or gifts which breach the Hospital's procurement policies

(iii) unethical or illegal practices, including misappropriation of funds or abuse of expense accounts

(iv) violation or circumvention of the Hospital's financial policies or accounting practices.

b) Examples of concerns relating to quality of care may include, but are not limited to, situations such as:

(i) abuse of patients by any party

(ii) negligence of patient care in violation of Hospital policies.

c) Examples of environmental issues may include, but are not limited to, situations such as:

(i) disposal or destruction of dangerous goods or products in violation of legislated requirements

(ii) failure to appropriately report disposal or destruction of dangerous goods or products in accordance with Federal or Provincial legislation.

d) Examples of violations of human resources policies and legislation may include, but are not limited to, situations such as:

(i) cultural, racial, and sexual harassment

(ii) discrimination of any kind as outlined in legislation

(iii) workplace safety and harassment violations.

e) Examples of breach of contract and negligence may include, but are not limited to, situations such as:

(i) danger to health and safety

(ii) inappropriate release of confidential information

(iii) criminal offences of any kind.

3. No Retaliation

a) No one will be penalized for making a Good Faith Disclosure. The Hospital will not retaliate and will not allow any retaliation or discrimination by its Individuals of any kind against any Individual who submits a Good Faith complaint. Specifically, the Hospital will not discharge, demote, suspend, threaten, harass or in any other manner discriminate or retaliate against any Individual submitting a Good Faith complaint.

b) Bad Faith and/or Vexatious complaints will not be tolerated, and appropriate disciplinary measures will be taken by the Hospital if they are initiated up to and including termination.

4. Confidentiality

a) All Board Directors and management will keep whistleblower reports, subject to any legal obligations to disclose. There may be certain circumstances where confidentiality cannot be guaranteed such as: a court order requiring disclosure; and/or any other legal requirement for disclosure such as a statute or case law; or where disclosure is required for the hospital to conduct an effective investigation.

b) No one shall in any manner attempt to identify an Individual who reports in Good Faith on a confidential basis and any such action may result in disciplinary action, up to and including termination.

c) In the interest of ensuring accountability and responsibility in reporting, anonymous complaints are discouraged as they may create limitations to the investigation and resolution procedures available. Notwithstanding, anonymous complaints will be reviewed and addressed to the extent possible.

5. Procedure for Investigation of a Complaint

a) It is anticipated that in the ordinary course, the CEO and/or delegate, and COS will complete their assessment of the complaint and assign the investigation of such complaint to a Designated Investigator generally within ten business days of receiving such complaint.

b) In matters involving the CEO or COS, the Audit Committee will determine the process to be utilized based on the nature of the complaint.

c) The Designated Investigator will assess the seriousness of the complaint promptly and determine, in consultation with others, if necessary, the manner in which the complaint will be investigated, using internal and/or external resources, and will determine who will lead such investigation. The Audit Committee may also request additional resources (including external experts) to facilitate an investigation.

d) The Designated Investigator assigned for the investigation of the complaint shall:

(i) notify the complainant that the Hospital has received the complaint and that it will be investigated

(ii) treat the complaint, as well as its investigation and disposition on a confidential basis

(iii) involve, in the investigation, only those persons who need to be involved in order to properly carry out such investigation

(iv) ensure appropriate support to staff by allowing union representation or legal counsel as applicable

(v) conduct the investigation in a timely manner to a maximum of 3 weeks from the date of assignment. Any extension of this time period requires approval of the CEO, COS or the Audit Committee, as the case may be

(vi) document the investigation and subsequent follow up (including issuing a report to the complainant) in a manner consistent with hospital investigations

(vii) retain the records of the investigation consistent with the Personal Health Information - Retention and Destruction policy.

6. Monitoring the Investigation

a) The investigation of a complaint will be monitored on an ongoing basis by the Audit Committee, CEO, COS or delegate, as appropriate.

7. Acting upon the Investigation's Findings/Conclusions

a) Once completed, the report will be reviewed, and appropriate corrective action will be taken by the Hospital.

8. Report to the Audit Committee and Board

a) A report of all complaints filed will be presented by the CEO or delegate to the Audit Committee of the Board at least annually.

b) The report will include:

(i) the total number of complaints

(ii) a description of each complaint

(iii) how the complaint was received

(iv) the relevant category of the complaint

(v) whether contact information was provided by the Individual registering the complaint

(vi) whether the complaint could be substantiated

(vii) who was involved in the investigation

(viii) the resolution to the complaint, any policy changes implemented and/or any actions taken

(ix) the status of the complaint.

c) The Audit Committee will share the report with the Board.

d) In the event that the Audit Committee or the Board, as the case may be, is not satisfied with the report of the investigation, the Board may require that a further investigation be completed.

DEVELOPED: October 25, 2006		
REVISED/REVIEWED:		
June 25, 2014	April 24, 2019	April 27, 2022
November 30, 2022	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.

CMH President & CEO Report
September/October 2024
for CMHF (Sept.), CMHVA (Aug.), CMH (Oct.), MAC (Sept.)

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.

CMH opens Research & Innovation Office

- Building on a strong foundation of research and innovation at CMH, we were very excited to establish and centralize oversight of these efforts to the new Research & Innovation Office! Its mandate is to support projects that advance patient care and make a real difference to the communities we serve.
- The office will be responsible for:
    - Endorsing and coordinating with Waterloo Wellington Research Ethics Board to ensure ethics protocols continue to be followed for all CMH initiated research and innovation initiatives
    - Refreshing and establishing policies and procedures related to research and innovation
    - Cultivating partnerships with leading academic institutions, technology firms, and industry experts to drive collaborative research and development efforts
    - Leading and establishing protocols and policies to govern and ensure compliance with regulatory and best practice standards for the ethical use and deployment of artificial intelligence (AI).
    - Collaborating with interdisciplinary teams to implement innovative solutions including AI-driven solutions that optimize clinical workflows and increase operational efficiencies

- CMH Data Science Specialist Dr. Waqas Muhammad is the lead for the Research & Innovation Office. In the coming months, the team will create a corporate plan, set up project oversight, and improve communication for those interested in research and innovation.
- The Research & Innovation Office is part of our mission to Reimagine Community Health, using innovation to transform healthcare.
- We look forward to all the exciting work we'll do together!

Welcome Paladin, CMH's new Security Provider

- CMH welcomed Paladin Security as its security services provider effective July 1, 2024.
- Paladin Security is renowned for its rigorous training programs, ensuring all site security staff are equipped with the most current and relevant training for an acute care hospital environment. They are well-prepared to handle various situations, including code white responses, assistance with restraints, and both verbal and physical de-escalation techniques. Locally, they provide security services to 32 health care facilities across Southwestern Ontario, including all hospitals in the Waterloo Wellington regions.
- Paladin Security has worked closely with the CMH team to ensure their service delivery meets our specific needs. Many of the familiar security guards our staff have come to trust have chosen to join Paladin and continue to provide security for our hospital.
- The only noticeable changes that occurred were a change in security uniforms (blue) and the addition of a lead Security Guard (in white shirt) to enhance response times.
- Contact numbers did not change. Security is available at ext. 1316 and they share a primary phone that can be connected through Switchboard. If you have a Security related emergency, call ext. 2222 to initiate the appropriate code.

CMH's first Sacred Fire Ceremony was held on June 26

- On June 26, our hospital had the privilege of hosting its first Sacred Fire Ceremony led by local Indigenous healer and knowledge keeper, Myeengun Henry.
- The ceremony was a significant step towards our growing relationship with Myeengun and the Indigenous community. A traditional Sacred Fire Ceremony is a powerful practice that fosters a deep sense of community and cultural continuity. It's a time of reflection, healing, and connecting to the spirit world. It involves lighting a fire, and offering prayers and tobacco to the flames.
- During the ceremony, Myeengun highlighted the stark reality of Canada's need to provide Indigenous communities with basic needs—critical social determinants of health, which underscores why Indigenous health outcomes are lower than those of non-Indigenous populations.
- Thank you Myeengun Henry for sharing your knowledge and helping us deepen our understanding of these important issues.

Welcome Kass Haworth Integrated Manager for CMH and Patient Services Manager, Ontario Health at Home

- We are looking forward to welcoming Kassandra (Kass) Haworth to the position of Integrated Manager for CMH and Patient Services Manager, Ontario Health at Home, effective September 5. She takes over from Kora Bennett, who is transitioning to a role within Ontario Health later in September.

- She is a Registered Nurse, holding a BScN degree and working towards her master's degree in Health Management. She has been a valuable team member in Hamilton Niagara Haldimand Brant since 2019.
- There she worked in Community Care Coordination and Rapid Response Nurse positions in addition to working as a Specialty Team (Palliative) Patient Services Manager.
- As a manager, she brings a collaborative approach to a multidisciplinary team environment.
- Furthermore, her experiences as an RN in the Hospital sector include the Emergency Department, Labour and Delivery and Acute Medicine.
- Kass is mom to two children – a 10yr old son and 9yr old daughter old. She describes her family as "total dog people" with their two miniature black and tan Doxins. For Halloween last year, the dogs accompanied the children in full costume.
- She and her family are avid campers – this year, however, she has discovered the advantages of glamping and as such, graduated to a new level of vacationing outdoors.

Welcome Saleha Khan – inclusion lead

- On July 22, We welcomed Saleha Khan as our Inclusion Lead.
- Saleha has an extensive background and passion in the areas of human rights, diversity, anti-racism, and inclusive practices. Much of Saleha's career has been with police services (Peel, Toronto, and Brantford that included being the Equity and Inclusion Instructor and Unit Lead at the Ontario Police College for more than 12 years.
- Saleha has spent time with the City of London as their Diversity and Inclusion Specialist, building understanding and awareness for both the corporation and the citizens of London as a whole.
- Saleha has worked to strengthen Indigenous relations through policy and the development of relationships including First Nations in South Western Ontario. Most recently Saleha has supported Indigenous, Racialized, and New Migrant communities' relationship building and partnership development at the Brantford Police Service, in addition to supporting the design and implementation of safety and wellbeing for the employees and their engagement within the service.
- Saleha's focus at CMH will be dedicated towards healthcare and to help support and evolve the progressive steps that we have been taking here at CMH.
- Saleha is a proud mother of four adult children and two cats. She is a life-long learner, currently completing a Masters in Public Administration (Western) and an ISO 100 Certification in Diversity, Equity and Inclusion.
- Saleha is multi-lingual speaker fluent in English, Arabic and Urdu, Hindi and Punjabi. Feel free to come speak to Saleha about the cuisines they have tried and their love for colorful palettes in clothes and jewelry.
- The interview panel, including members from PFAC, Communications, Human Resources, Clinical Leadership, Patient Experience, and Wellness, were all

impressed by Saleha's ease of building trust and relationships, and extensive and diverse experience in building a learning culture. We would like to thank everyone involved in the interview selection.

- Welcome Saleha! We look forward to learning and growing our cultural awareness and increasing our knowledge around equity, inclusion and human rights issues.

Organizational Changes

- Since joining CMH, our services and commitments to the community have grown significantly, with more expansion planned as the CRP concludes at the end of the year. With this in mind, we made a commitment to a review our current portfolios for future needs and did a comprehensive evaluation of CMH's organizational structure.
- To better meet our obligations to the hospital, the community, the healthcare system, and government, the CMH Hospital Board approved an organizational realignment at their June 26 meeting. This realignment does not involve adding new leadership positions but instead streamlines our organization into three portfolios, each supported by VPs. Effective immediately, the hospital's new organizational structure is as follows:

    - Clinical Programs (Stephanie Pearsall)
    - Finance & Corporate Services (Trevor Clark)
    - People & Strategy (Mari Iromoto)

- In relation to this, some departments have been moved to balance out the respective portfolios.

    - The Clinical Programs portfolio will assume Diagnostic Imaging, Laboratory and Pharmacy, ensuring all departments that have direct patient contact are in one place. Physician Medical Directors will now report to Stephanie Pearsall to strengthen alignment within all departments.
    - Information Management and Technology and Support Services move to the Finance & Corporate Services portfolio. Rob Howe has accepted the role Director of Corporate Services and also takes on the role of Chief Information Officer, previously held by Mari.
    - Human Resources will now report to the People & Strategy portfolio joining Organizational Change and Public Affairs & Communications that moved earlier in the year. Susan Toth, Director of HR also becomes CMH's Chief Human Resources Officer to better reflect the growing HR accountabilities in a health care setting.

- This new structure aligns CMH with similar sized hospitals and ensures we continue to deliver on our commitments efficiently and effectively, without adding more leadership roles.

CMH Volunteers receive the 2024 Ontario Volunteer Service Awards

- Congratulations to 25 CMH volunteers who received the 2024 Ontario Volunteer Service Awards. “These awards are great recognition for those who have gone above and beyond. It brings more exposure to why volunteers are out there—the things we are doing to help people,” said Marion, who has been a volunteer for 30 years. This was her second time receiving the award.
- The Ontario Volunteer Service Awards recognizes adult and youth volunteers for their outstanding contributions to organizations and causes. In her mid-eighties and retired since her late 40s, Marion is still giving back. “*I’m healthy. Many people are not. A hospital is a good place to help—it’s where I can put a smile on their face to make them feel a little lighter during their visit*.”
- She says spending time with each patient and “meeting people and making them smile” is rewarding.
- The ceremony, held on Tuesday, July 9 at Bingeman’s in Kitchener, attracted over 100 attendees and was one of 46 similar events conducted across the province since April 2024.
- Over 6,000 volunteers have been recognized for their contributions, many of whom also serve as board members or organize fundraisers, continually strengthening various recreational and community sectors in their unique ways.

Wing B Tower to open January 2025 after small set back

- In early July, we were informed of a heating line burst in Wing B, Level 4, causing water damage on levels 2, 3 and 4. Over the ensuing week, assessments were made to determine the extent of this damage.
- The report brought some positive news. The damage was not as extensive as initially feared. It did, however adjust the handover timelines by some six weeks.
- The move in time frames have now been adjusted for these last remaining areas:

    - **Endoscopy Pre/Post move in**: Late November/Early December 2024
    - **Mammography, Ultrasound & BMD move in**: Early January 2025
    - **Phlebotomy and Fracture Clinic move in**: Early January 2025
    - **Inpatient Units move in**: January 2025

- While we were looking forward to moving into our new areas tin the fall, this slight adjustment still puts us ahead of the original completion date EllisDon first proposed in 2020.
- I want to thank all staff, physicians, midwives and volunteers for their hard work and resilience. Your dedication and commitment to maintaining high standards of care and service throughout this project have been remarkable.

Voices of CMH: Meet Christian, he wants to change how we think about IT

- Christian D’Amore wants to help people. Always has. From interpreting medical terminology for his immigrant parents to setting up devices and networks for his

siblings, this powerful attribute enabled him to pursue a successful career in information technology.

- Christian joined CMH this past June as the Manager of Information Management & Technology (IMT). His interest in healthcare started when his son needed care. “I was impressed by the efficiency of the emergency nurses and remember encouraging my son about how important it was to support frontline workers,” he said, “That’s when I started to rethink my motivations.”
- Christian’s previous roles provided him a wealth of skills, experiences and career growth. But the lengthy daily commutes from his home in Cambridge started to take a toll. “I was left with this strange feeling of not belonging. I felt like my home had become like a hotel and my life was always elsewhere,” conceding, “I did not feel a connection to my community, which is very important to me.”
- Inspired by a new found purpose, Christian chose healthcare to renew that connection.
- As part of his approach, Christian’s first month at CMH was marked by engaging staff and leadership from across the hospital with the simple goal of meeting new and interesting people. He described it as a need to “…listen and build relationships. My role is to provide a perspective that complements healthcare and makes things simpler for people to do their work. To do this, I think it’s important for me to learn the mindset of others, who may not be technical, and build trust.”
- “I want to change how people think of our IMT department — it should be more than a reliable service. I want to make IMT a partner that supports decision-making in all areas of the hospital.”
- He cited CMH’s acquisition of a system that connects patients with real time, on demand medical interpreters in 240 languages, including sign language. This use of technology quickly removes a barrier, bridging the patient with staff and enhancing the overall experience for both. “These are the kinds of solutions where I think we can thrive as partners,” added Christian.

PocketHealth expands with Provider to Provider capability

- Since February 2020, CMH registered patients have been able to access their medical images from a networked computer for personal use, for a fee and a few easy steps.
- In the spirit of access to care, CMH’s Diagnostic Imaging (DI) team expanded their relationship with PocketHealth to include a Provider Sharing interface. This feature went into effect in July 2024 and builds on the existing secure, online platform.
- The Provider to Provider expansion means easy, secure sharing with referring care providers and others within the patient’s circle of care. Patients no longer need to pick up imaging disks, wait for the courier or deliver the images to their physician. It also comes at no additional cost to our patients.
- The new platform is accessed via an online page. DI staff can share images on a patient’s behalf by sending a secure access code to the referring physician or nurse practitioner.

Audited financial statements published

- At the June 26, 2024 Annual Meeting, the Board of Directors approved the hospital's audited financial statements.
- CMH has posted an $11.7M surplus for the fiscal year 2023-24. Thanks to the Ministry of Health, this surplus is largely due to Post Construction Operating Plan (PCOP) funding that helps hospitals grow their services during and after a major construction project. Specifically, CMH received one-time PCOP funding of $8M and $3M from volume-based surgical recovery funding.
- This comes as a much-needed boost for our hospital and the community. It allows us to invest in the future without adding financial strain.
- As highlighted in the recent Project Quantum announcement, the hospital's focus over the next few years is to modernize CMH's antiquated health information and workforce planning systems. Hospitals are required to self-fund their information technology systems and this project is estimated to cost over $80M.
- This investment is needed as it will significantly enhance patient safety, improve patient experiences, strengthen clinical programs, while reducing the current frustrations felt by staff. In short, it will bolster the health care services offered in Cambridge, North Dumfries and in the regions we serve.
- Significant investments like Project Quantum highlight the importance of maintaining financial discipline and continuing to produce surpluses for our future. For the past 14 years, our positive balances at year-end afforded us the ability to purchase equipment and advance services that are crucial for our community.
- We are committed to transparency and responsible financial management to ensure the best outcomes for the community. You can find the most current audited financial statement on our website at cmh.org under the Financial Accountability tab in the Hospital section.
- Thank you for your ongoing support as we work through financial challenges and opportunities together. Let's look forward to a future of new opportunities with these investments in place.

CMH receives the CAR Accreditation, ensuring highest standards of care

- A critical requirement for OBSP Breast Assessment Sites to be accredited by the Canadian Association of Radiologists (CAR).
- Mammography Accreditation is part of CAR’s Mammography Accreditation Program (MAP). This designation ensures healthcare facilities meet the highest standards of breast image quality and patient safety.
- MAP involves a rigorous process to meet compliance in four key areas1: image quality, radiologist reporting, equipment function, and radiation safety. Sonia Bryson, Senior Mammography Technologist, explains, “We have a month to collect high-quality images.” These are analyzed for quality, and the process takes about two weeks before results are shared.
- CMH’s Mammography team comprises of four radiologists that report breast imaging and four Medical Imaging Technologists with specialized training in Mammography.

- The MAP designation is a testament to CMH's commitment to maintaining high quality standards and patient safety. MAP is so critical to operations that it is done whenever new Mammography equipment is introduced into the program. This ensures the equipment is thoroughly tested and that personnel are trained to use it to the highest safety and clinical standards.
- While this accreditation is routine for over 500 Canadian hospitals providing this crucial service, it follows on the heels of the recent growth and innovation in CMH's Breast Health services. Most notably:

    - Becoming the third designated OBSP2 Breast Assessment Site in Waterloo Wellington (April 2023)
    - Being the first regional hospital to introduce Magseed technology to precisely locate and mark lesions within the breast
    - Introducing MagTrace in March 2024 to aid in sentinel lymph node biopsies within the operating room
    - Having a pathology department that routinely meets or exceeds test results and staging wait times
    - Having robust Breast Cancer Surgery and Breast Reconstruction programs, the latter of which continues to innovate and introduce new options to the region.

- Many thanks to the Mammography team and those that support it for their commitment to providing safe, reliable patient care to the community.

Patient focused: Fracture Clinic to remain in the MEC until their move

- At the beginning of July, the Fracture Clinic relocated from Wing C.1 to A.0 due to an unforeseen construction-related request. This request required the closure of the main public corridor connecting all four wings.
- The Medical Education Campus (MEC) classrooms were chosen for their proximity to Patient Registration and their size, which is suitable for the clinic.
- Since the move, a lot of positive feedback was received from a number of collaborators and perspectives. Furthermore, the clinic was running more efficiently due to easier way finding, and the close proximity to Wing A services.
- Focusing on what is best for our patients, the Fracture Clinic is to remain in this location until it moves to its new, permanent home on A.1 in January 2025. The feedback received indicated that this temporary move has improved the patient experience, and as such, compelled to maintain this positive impact.
- As the MEC is a vital location for staff education, meetings, and, when unoccupied, as a staff dining area. Additional space for dining and meeting was protected to accommodate this temporary relocation.

Promoting diversity in healthcare through the Staff Trust Fund

- Guided by the Advance Health Equity strategic pillar, our organization is committed to promoting diversity, equity, and inclusion (DEI). The goals of DEI

promotion are to increase equitable access to healthcare and to support a work culture where everyone can reach their full potential.

- The Cambridge Memorial Hospital Staff Trust Fund Diversity Bursary (Diversity Bursary) was created in 2021 and is funded 100% through staff donations.
- While its creation was independent of the hospital, it nicely complements CMH's strategy to build upon and further the understanding of diverse experiences.
- A diverse health care workforce strengthens our culture; greater representation leads to more cultural sensitivity, thereby promoting a supportive workplace while advancing health equity for patients.
- Last year, Kaeley Nelson, an Emergency Department nurse who identifies as a member of the 2SLBGTQIA+ community, used her $1,000 Diversity bursary to support her passion for helping people. After an accident left her unable to continue as a Child & Youth Worker, the Diversity Bursary assisted her in bridging her diploma to a Nursing Degree. As a busy mom of two boys, she is currently enrolled part-time in the Nursing Degree program at Nipissing University. CMH staff contributing to the Staff Trust Fund is very proud to have contributed to Kaeley's continued education journey in a health-related discipline.
- The Diversity Bursary assists 2SLGBTQIA+, African Canadians, Indigenous people, persons of colour, and persons with disabilities with their pursuit of post-secondary education in a health-related discipline.
- The CMH Staff Trust Fund has been supporting local charities for almost 50 years. Funds raised during a given year are distributed to the United Way (40%), to a local charity that member-donors can choose through a vote (30%) and it supports three (3) awards of $1,000 each for the Diversity Bursary.

Patrick Gaskin
President and CEO
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Fax: (519) 740-4953
Email: pgaskin@cmh.org

CAMBRIDGE MEMORIAL HOSPITAL

MEMORANDUM

TO: Board of Directors, Cambridge Memorial Hospital

DATE: September 18, 2024

REPORTING PERIOD: April 1, 2024 – June 30, 2024

FROM: Patrick Gaskin
President and CEO

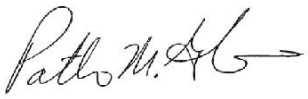
RE: CEO Certificate of Compliance

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

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

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

Exceptions: NIL



Patrick Gaskin
President and CEO

BRIEFING NOTE

Date: September 10, 2024
Issue: 2024/2025 Strategic Priorities Tracker Q1 Updates
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kyle Leslie Director of Operational Excellence
Approved by: Mari Iromoto, Vice President, Strategy & People

Attachments/Related Documents: Appendix A – Strategic Priorities Package – Q1
Appendix B – Success and Wins Highlights Q1

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 provides an overview of the new Strategic Priorities Tracker for fiscal year 2024/2025 and our Q1 performance in relation to targets set for Q1. The refreshed tracker is a robust tool designed to track and monitor our most critical in-year priorities and action plans aligned to our Strategic Plan, In-year Quality Improvement Plan and Integrated Risk Management (IRM) plan.

As per Q1 performance, the below priorities did not meet target and will continue to be a major organizational focus:

1) Organizational Flow Measured by: Ambulance Offload Times and EDLOS for Admitted Patients **(Organizational Risk-identified through IRM process and Quality Improvement Plan QIP)**
2) Optimal staffing and overtime reduction measured by: % on track with active staffing targets for MED, ED, ICU (**Organizational Risk-identified through IRM process)**
3) Advance Health Equity through developing our people measured through completion rates of Rainbow Health DEI training. **(Quality Improvement Plan QIP)**
4) Post Construction Operating Plan (PCOP) Currently at a green status however projected to decline to a red status by year end (**Organizational Risk-identified through IRM process)**

Background
In alignment with our commitment to our Strategic Priorities and continuous improvement, we have revised our Strategic Priorities Tracker for 2024/25. The new tracker is designed to better reflect our organizational priorities and enhances our ability to measure success and share progress towards achieving our most critical organizational priorities. The purpose of the Strategic Priorities Tracker is:

1) **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 in-year metrics with the in-year actions from key Corporate Plans.
2) **Performance Monitoring-** This tool will be the primary performance monitoring and reporting instrument, providing comprehensive insights into our progress on a quarterly basis. Internally this tool and associated action plans are embedded and monitored near real-time through weekly ops huddles, weekly flow meetings, department huddles and through real-time dashboard and analytics to enable informed decision making and action planning to optimize our trajectory towards success.

The Strategic Priorities Tracker is one of three key performance monitoring tools that is being used for 2024/25. Our three performance monitoring tools for 2024/25 are:

1) **Strategic Priorities Tracker:**
   - Monitors most critical in-year priorities identified through QIP, IRM, and the Strategic Plan
   - Presented Quarterly to Board Committees as a summary 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

2) **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 to enable escalation and action

3) **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

Analysis
There are ten key priorities that are tracked on our 2024/25 Strategic Priorities Tracker that align to the Strategic Pillars of our Strategic Plan. The full Strategic Priorities Tracker including detailed action plans can be found in **Appendix A.** Each priority is evaluated and assigned a status: Red – Not meetings target <90% of target met, Yellow-meeting 90% of target, Green – meeting target. Below is an overview of our Quarter 1 performance on these priorities:

Elevate Partnerships in Care:
Priority 1: Ambulance Offload Time (90% spent less, in minutes) (Not Meeting Target):

This indicator measures the length of time from ambulance arrival to when the transfer of care from EMS is completed. Our 90th percentile ambulance offload time is **72 minutes** (YTD June 2024), while the target is **<30 minutes**. In 2023-24, the 90th percentile ambulance offload time was **115 minutes; thus, we have seen a 37%** improvement in Q1 of the current fiscal year. A lower number for this indicator is better as it means patients are receiving timely emergency care.

Priority 2: ED Length of Stay for Admitted Patients (90% spent less, in hours) (Not Meeting Target):

This indicator measures the length of time from triage to when an admitted patient departs the emergency department for an available inpatient bed. Our 90th percentile length of stay for admitted patients in the ED is **48.1 hours (YTD June 2024),** while the target is **<33 hours**. In 2023-24, the 90th percentile length of stay for admitted patients was **58 hours, thus we have seen a 17%** improvement in Q1 of the current fiscal year. A lower number is better as it means patients are receiving care in the most appropriate setting.

A component of a patient's emergency length of stay is the time spent waiting for their initial provider assessment (PIA), which contributes to the overall length of stay patients experience. The target is to see 90% of **patients within 4 hours or less**, as this means patients receive timely access to care. At the end of Q1, the 90th percentile PIA time was **7.2 hours**, which is 0.4 hours longer than the same period last fiscal year.

Organizational patient flow was identified as a major organizational risk through the Integrated Risk Management (IRM) process for this fiscal year. The key metrics used to monitor this risk are: the overall EDLOS for admitted patients, ambulance offload times as well as Provider Initial Assessment (PIA) LOS. Although we have achieved some improvement in the overall EDLOS for Admitted Patients and Ambulance Offload Metric resulting for the initiatives completed in Q1, we acknowledge that we have not yet mitigated the organizational risk related to patient flow and still have significant more work to do. The Actions we will focus on for Q2 are summarized in **Appendix A** within the Clinical Services Growth Plan.

Two major success and wins we would like to highlight related to our patient flow improvement work include: **1) the implementation of a new ED wait-time information system with over 95% utilization by our physicians**, which will improve management of patients waiting to be seen with the intent of improving PIA and subsequently Emergency Length of Stay, and **2) The improvements made to our long stay medical patient list which we achieved a 20% reduction in long stay cases** from April to June 2024. Both of these initiatives are included in **Appendix B**- Success and Wins Highlights.

Priority 3: % on track Capital Redevelopment Plan (Meeting Target): This tracks our % on track with milestones within CMH's span of control to keep the CRP project on track. We are currently on track.

Priority 4: % on track with Emergency Preparedness Plan (Meeting Target): This tracks our completion of milestones related to the execution of the in-year objectives for our emergency preparedness plan. We are currently on track.

Reimagine Community Health:

Priority 5: % on track with Health Information System (HIS) (Meeting Target): This tracks our completion of milestones related to the execution of the in-year objectives for the HIS project. We are currently on track.

Priority 6: % on track with Work Force Planning System (Meeting Target): This tracks our completion of milestones related to the execution of the in-year objectives for the Workforce Planning project. We are currently on track.

Both of the above priorities align to the initiatives within our Digital Health Plan. One of the major successes to highlight from this plan is the official launch or our Workforce Planning System into the project Execution Phase. Which is included in **Appendix B**- Success and Wins Highlights.

Increase Joy in Work:

Priority 7: % on track with Active Staffing Targets (Not Meeting Target): This indicator measures the actual staffing as a percentage of the total staffing targets. It is measured by Full-Time Equivalents (FTEs) and includes RNs and RPNs from ED, ICU, MEDA, and MEDB. Our active staffing targets were **88% achieved (YTD June 2024),** while our target is 100%. A higher number is better as it means we are appropriately staffed.

Staffing and overtime usage was identified as a major organizational risk through the Integrated Risk Management (IRM) process for this fiscal year. To address this risk a staffing task force committee was formed to monitoring staffing and overtime usage and to develop recommendations for improvement. This work has resulted in enhanced data through the use of the electronic overtime request form for planning and decision making related to staffing and OT. We acknowledge that we have not yet mitigated this risk and will continue to work on mitigation strategies into Q2 including a benchmark analysis to similar sized hospitals. The action planned for Q2 are summarized in the Human Resources Plan update found in **Appendix A.**

Priority 8: % on track with Corporate Change Management Strategy (Meeting Target): This tracks our progress towards achieving milestones established for refreshing and revising our organizational change management strategy and tools. Currently this work is on track.

Sustain Financial Health:

Priority 9: Post Construction Operating Plan (PCOP) Revenue Earned (Meeting Target, however, Year-End Forecast Red):

Post Construction Operating Plan (PCOP) Funding is a funding source available to hospitals with an approved Capital Redevelopment Plan (CRP). The PCOP is our planned growth for clinical activity due to growing capacity and beds through the CRP. The PCOP growth indicator measures the growth over our 2016-17 base volumes. For Acute IP, Day Surgery and Emergency Department, PCOP growth is measured by growth in weighted cases, which reflects the resource intensity of a case. IP Mental Health Care is measured by growth in inpatient days, while clinic activity is measured by visits. If we reached our PCOP target of $14.6 million dollars this fiscal year, we would have achieved our planned clinical services growth for the year. As such, higher is better for this indicator.

At the end of Q1, **we saw our PCOP targets achieved, with $3.8 million earned versus a target of $3.6 million/quarter.** This represents an **increase of $1.3 million from Q1 in the previous fiscal year.** Our Q1 results were driven by medical discharges with high weighted cases, particular in May with many long-stay discharges. Surgical activity was lower than planned in the first quarter of the fiscal year due to human resource challenges, a challenge that is expected to continue and contribute to the negative PCOP variance from budget projected for Year-End, putting this indicator at risk of not meeting annual targets and being at red status. Emergency department volumes continued to be lower than base volumes, resulting in no PCOP earned in Q1 or expected for the year. Inpatient Mental Health occupancy continued to be low in Q1 (average 81%) as did ECT volumes, resulting in lower Mental Health PCOP than targeted.

This aligns with the initiatives in our Multi-Year Financial Plan. Two of the major successes to support this work includes: **1) the implementation of a real-time surgical grid tracker** used internally to monitor and manage grid utilization and returns, insights from this tool are used for projections and decision making related to surgical utilization **2) The partnership with the University of Waterloo in the Graham Seed Fund-sponsored project, "Optimal Operating Room Scheduling at the Cambridge Memorial Hospital".** This project involves building advanced analytic and artificial intelligence models to support master OR schedule decision making with the aim of optimizing specific variables such as OR utilization and patient wait-times.

Advance Health Equity:
Priority 10: Completion of Rainbow Health Diversity, Equity, & Inclusion Training (Not Meeting Target): This indicator measures the number of staff that have completed the Rainbow Health Foundations Course**. At the end of Q1, 39** staff had done so, while **our target is 88 or more** per quarter. We did not meet target for Q1.

Consultation
Developed by the respective Executive Sponsor, Project Leads and consulted by Director's Council, Weekly Leadership and Operations Huddle.

Next Steps

- Continue to provide monthly updates for flow and staffing
- Strategic Priorities Tracker will be presented on a Quarterly Basis
- Quality Monitoring Scorecard will be reported on a Monthly Basis

Strategic Priorities 24/25

"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 (minutes) (QIP/IRM)	<30	72.0				Clinical Services Growth Plan; Capital Redevelopment Plan; Emergency Preparedness Plan
	90th%tile EDLOS admitted patients (hours) (QIP/IRM)	<33	48.1				
	% 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 Planning (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)	>$3.6M quarter	$3.8M				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	39				DEI Plan

Agenda

Elevate Partnerships in Care

Clinical Services Growth Plan

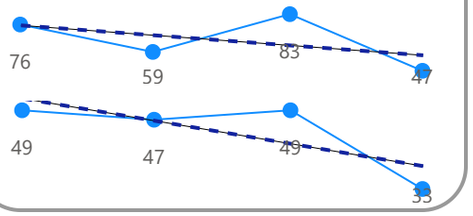
Click Here to Input Action Plans

Executive Sponsor(s): Dr. Winnie Lee / Stephanie Pearsall

Physician Liaison(s): Dr. Runnalls / Dr. Nguyen

Director Lead(s): April McCulloch/ Donna Didimos

Project Manager: Jennifer Woo

In Year Measures of Success	Target	Q1	Q2	Q3	Q4	Monthly Trend
90th%tile Ambulance Offload Minutes	<30 mins	72.0				
90th%tile LOS Hours for Admitted Patients in ED	<33 hours	48.1				

Action Plan-Q1

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Achieve time to in-patient bed target	1. Conducted value stream map exercise with multidisciplinary team including physician leadership to identify barriers to discharge; 2. Established audit process to review Monday, Tuesday discharges to identify barriers to weekend discharges; 3. Established weekly patient flow monitoring meeting with ED and Inpatient leadership to review identified metrics including P4R, ALC and long stay patients; 4. Attended site visit with STEGH to gain insights into improvements to enhance organizational flow	1. Review and restructure unit rapid round, with physician involvement; 2. Refresh "Unit Census Board" whiteboard to enhance communication among team and identify barriers to discharge; 3. Establish improved process for communicating estimated date of discharge; 4. Investigate paper-based SBAR to verbal TOA based on STEGH site visit; 5. Medicine leadership rounding with patients regarding discharge expectations and prep with patients; 6. Refresh bed board and bed board meeting structure; 7. Refresh format for unit rapid rounds, with physician involvement; 8. Refresh electronic huddle board with identified metrics	No risk to report.
Achieve flow targets for provider initial assessment times and length of stay for complex and minors.	1. Implemented machine learning (ML) algorithm to support identification of patients eligible for Clinical Decision Unit (CDU); 2. Maximized CDU by increasing CDU usage from 2.5% of eligible cases to 8%; 3.Implemented real-time provider initial assessment (PIA) tracking system and ER tracker board improvements utilized by physicians and nurse practitioners (NP) (97% adoption rate); 4. Established weekly patient flow monitoring meeting with ED and Inpatient leadership to review identified metrics including P4R, ALC and long stay patients; 5. Attended site visit with St. Thomas Elgin General Hospital (STEGH) for insight into ED flow improvements; 6. Attended site visit with Guelph General Hospital (GGH) for insight into ED flow improvements	1. Implement enhanced NP coverage for backfill; 2. Sustain process improvements at triage; 3. Develop physician and staff education specific to patient disposition (Left without being seen- LWBS, Left without being treated- LWBT); 4.Monitor and sustain CDU performance build and execute action plan established from site-visit; 5. Create and provide training to staff focusing on ED metrics, P4R; 6. Begin daily sub-acute huddles in ED; 7. Refresh electronic huddle board with identified metrics	R1) Gaps in ED Physician Schedule (July day coverage); M1) Review insights from STEGH visit and evaluate potential changes to ED physician schedule
Achieve and maintain ALC throughput ratio of 1 and ALC census of <36	1. Developed pathways to support DI and infusion pump support; 2.Implemented algorithm to alert and flag cases from LTC and RH to support early return and admission avoidance; 3. Established weekly patient flow monitoring meeting with ED and Inpatient leadership to review identified metrics including P4R, ALC and long stay patients	1. Update ALC policy and process that supports all ALC work; 2.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; 3. Continue with Cambridge collaborative to support complex patients and discharges	No risk to report.
Achieve 30 min or less ambulance offload time	1. Established EMS Triage Nurse from 0900-2100; 2. Finalized and educated teams on standard work for EMS offload; 3. Established bi-weekly meetings with ED and EMS leadership to address flow-related issues; 4. Weekly sharing of AOT metrics with staff, including comparison to regional hospitals	1. Implement EMS timestamp equipment to capture EMS arrivals; 2.Sustain EMS offload process by monitoring EMS arrival to offload time; 3. Execute action plan established from site visit; 4. Refresh electronic huddle board with identified metrics	R1) HHR for EMS Triage Nurse (staffing and education); M1) ED Nurses to attending triage class

Agenda

Sustain Financial Health

Multi-Year Financial Plan

Click Here to Input Action Plans

Executive Sponsor(s): Patrick Gaskin

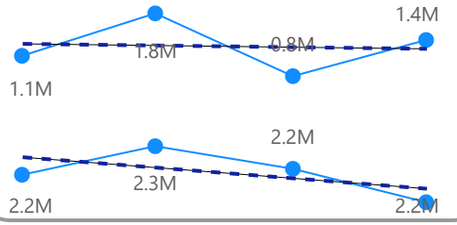
Physician Liaison(s): Dr. Green, Dr. Sharma, Dr. Nguyen

Director Lead(s): Val Smith-Sellers; Kyle Leslie

Project Manager: Jennifer Woo

In Year Measures of Success	Target	Q1	Q2	Q3	Q4
PCOP Revenue earned	>$3.6M per Quarter	$3.8M			
QBP Revenue earned	>$6.2M per Quarter	$6.7M			

Monthly Trend



Action Plan- Q1

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Ensure effective in-year PCOP monitoring for Mental Health	1. Established monthly PCOP meeting with director & physician lead; 2. Established reporting cadence & monitoring tools for MH occupancies & ECT	1. Build reporting cadence to MH leadership, clinical leadership & physician leadership; 2. Investigate ECT volumes	R1) Occupancies are dependent on patient needs/ care plans; M1) Establish process for connecting with community partners, to ensure there are supports available in the region
Quality Based Procedure Volumes & Revenue Achieved	1. Continue to monitor QBP volumes against targets to ensure QBP targets are met	1. Continue to monitor QBP volumes against targets to ensure QBP targets are met	R1) Endo third room EUS volumes; M1) TBD R2) Systemic Therapy QBP >(500K) Negative Variance; M2) TBD
Ensure effective in-year PCOP monitoring for Surgery	1. Built, tested & implemented block monitoring tool; 2. Established monthly PCOP meeting with surgical director &lead; 3. OR block simulation with University of Waterloo, using machine learning AI to ensure that we are fully maximizing available OR time & optimize OR room scheduling (project is ongoing); 4. Identified & executed on mitigation strategies based on OR block utilization rate (project is ongoing); 5. Through COEC, deeper dive focus & audit on OR cases to ensure accurate capture of weights to maximize PCOP funding (ongoing); 6. Reviewed returned blocks & re-allocated, established template for reporting returned blocks, & reasons why returned; 7. Conducted a value-stream mapping session to focus on OR patient flow through OR/ PACU/ SDC & room turnover (ongoing); 8. Investigate Central Intake	1. Review Q1 performance to ensure PCOP was maximized; 2. Attend Family Medicine Meeting in September; 3. Hold value-stream mapping session for OR Booking Process; 4. Re-allocate additional GYNE blocks to other services; 5. Analyze ACS time	R1) Gaps in surgeon coverage for GYNE, urology, OMF & plastics; M1) Re-allocate blocks
Ensure effective in-year PCOP monitoring for Medicine	1. Measured & reviewed medical admissions & discharge throughput ratios, with focus on time of day on weekdays vs. weekends; 2. Measured, reviewed & reporedt ALC throughput ratio; 3. Established process &cadence for escalating long stay patients. Weekly review of long stay list (went from avg long stay census of 50 to 35); 4. Met weekly with Home & Community Care & developed escalation process	1. Review Q1 performance to ensure PCOP was maximized; 2. Sustain new practices & maintain long stay list; 3. Work towards increase numbers for next day confirmed discharges	R1) Weekend discharges; M1) Elevate conversations regarding weekend discharges R2) Daily discharge rounds; M2) Follow up STEGH visit with plans to refresh rounds, develop escalation procedure, physician engagement
Execute PCOP planning & forecasting for PCOP & volume prediction for 25/26 planning cycle	No applicable Q1/Q2 actions	Q3/Q4: Review Q1/Q2 performance & identify enhancements required to meet 25/26 multi-year plan PCOP target	R1) Prediction & planning is dependent on new construction & B tower occupancy; M1) Continue to monitor & track CRP milestones under Strategic Priorities

Agenda

Elevate Partnerships in Care

Capital Redevelopment Plan

Click Here to Input Action Plans

Executive Sponsor(s):	Physician Liaison(s):	Director Lead(s):	Project Manager:
Patrick Gaskin / Mari Iromoto		Amanda Thibodeau	Alyssa McCarthy

In Year Measures of Success

	Target	Q1	Q2	Q3	Q4
% on track with CRP project handover	100%	100			
% on track with transition planning activities	100%	100			

Action Plan- Q1

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Deliver CRP handover on time	1. Meet biweekly with Stantec, Perini, EllisDon to discuss risks and mitigation strategies in order to hit substantial completion; 2. EllisDon has now submitted their 90-day notice on behalf of Zurich North America	1. Continue biweekly meetings with Stantec, Perini, EllisDon; 2.Monitor progress on the inpatient tower and other sequences	R1) Lack of resources and workforce; M1)Regular meetings to address and mitigate risks; focus on high-priority areas (inpatient tower) to ensure substantial completion and work on deficiencies in remaining sequences prior to Final Completion
Successful transition of planning and Space to CMH Team	1. Regularly scheduled meetings with clinical teams and support services to ensure staff are aware of their new environment, prepared for the move and have the necessary equipment and training for a successful move	1. Continue meetings and begin move planning meetings; 2. Keep support services informed of move timelines and clinical needs	R1) Staff engagement related to work schedules and vacation; M1) Long lead time for scheduling meetings to allow for schedule coordination R2) Risk of delay to move dates and planning; M2) Strategy-regular communication with construction team
Successful transitions of warranty / deficiencies documentation to facilities	1. Current weekly meetings with EllisDon, CRP, and Facilities to discuss warranty	1. Continue weekly meetings to ensure smooth transition of documentation; 2. Address any emerging issues related to warranty and deficiencies	R1) Potential gaps in documentation, miscommunication; M1) Regular meetings to ensure all parties are aligned; thorough review and tracking of documentation to avoid gaps; prompt resolution of any issues that arise during the transition
Updated Functional Program	1. The originally forecast for programs within CMH have changed from the original FP therefore requests for updated volumes and projections has been made to Finance and DS to then update our FP	1. Meeting planned with Agnew-Peckham to discuss changes in scope and receive update pricing and to revise the PO	R1) Delays in receiving the data puts us at risk for not having the Ministry Submission completed to align with Project Closeout
Updated Master Plan/Master Program	On Hold		Develop guiding principals' for our projections for a short term plan (current to 18 months), an intermediate plan (18 months-5years) and a long term master plan (beyond 5 years)

Agenda

Reimagine Community Health

Digital Health Plan

Executive Sponsor(s): Mari Iromto

Physician Liaison(s): Dr. Taseen

Director Lead(s): Rob Howe

Project Manager: HIS - TBD; WFP - Beth Jones

In Year Measures of Success	Target	Q1	Q2	Q3	Q4
% on track with HIS readiness and implementation milestones	100%	100			
% on Track with workforce management ERP implementation	100%	100			

Action Plan- Q1

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Implementation of a new Health Information System	1. Complete best and final single instance contract with recommendation being brought to Board (June 2024)	1. Investigate regional instance opportunity governance with Grand River Hospital and St. Mary's General Hospital (August 2024); 2. Compare financial, scope, and functionality implications of a regional instance (August 2024 - September 2024); 3. Communicate HIS work under the Project Quantum (formely System Transformation) work	R1) Delays from Oracle Health in recieving required documents; M1) Bi-weekly escalation through CEO office with Oracle Health, common sense of urgency shared with GRH/SMGH CIO R2) Delays in regional governance due to resource availability through summer; M2) Will not be asking individuals to shift vacations - will look to progress quickly through September
Successful implementaton of Workforce Planning (WFP) Q1 FY25/26	1. WFP contract signed (April 2024); 2. WFP steering setup (April 2024); 3. WFP project team roles in recruitment (June 2024)	1. Project kickoff (August 2024); 2. Communications of system transformation project (July 2024); 3. Progress to requirements gathering stage of project (September 2024)	1R) Change of resources assigned by UKG - specifically Project Manager 1M) Ongoing communication between CMH Executive Sponsor/Project Lead and UKG Executive Sponsor

Agenda

Increase Joy in Work

Human Resources Plan

Click Here to Input Action Plans

Executive Sponsor(s):
Patrick Gaskin, Mari Iromoto

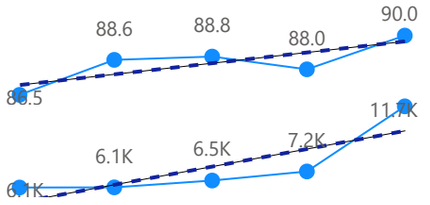
Physician Liaison(s):

Director Lead(s):
Susan Toth

Project Manager:
Soumya Saini

In Year Measures of Success	Target	Q1	Q2	Q3	Q4
% on track with staffing targets for MED/ICU/ED	100%	88.8			
OT hours per quarter	5552	18.7K			

Monthly Trend



Action Plan- Q1

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Enhance HR Systems and Data to Support Staffing Decision Making (Workforce and ICIMS)	1. Established optimization plan for existing HR / Staffing tools (ongoing); 2. Identified data and information needs to support staffing decision making and monitoring of HR processes (ongoing); 3. Launched workforce planning project which includes timekeeping, scheduling, absence management and analytics (ongoing); 4. Establish plan for enhance monitoring and planning related to OT	1. Execute optimization plan for existing HR / Staffing tools (ongoing); 2. Use current staffing data to support staffing decision making and monitoring of HR processes (ongoing); 3. Support the implementation of the workforce planning system (ongoing) 4. Execute monitoring tool for spreading the use of the electronic OT tool to all areas of the hospital; 5. Hold mapping session that reviews current staffing office systems and tools used for current state analysis as we prepare for Workforce Planning including the call in process	R1) Capacity of the resources on the project for workforce management; M1) Hiring a co-op student and backfilling with SMEs to increase resources for the project R2) Delays due to UKG resource support; M2) Adjust the timeline and stagger the go-live for the two modules
Focus on strategies to enhance retention by focusing on wellness and wellbeing	1. Evaluated and developed strategy for improved rewards and recognition programs – ICCAIR, career achievement, hospital-wide events (BBQ, holiday meal, food drive, Thanksgiving event) with an established plan (ongoing); 2. Developed and implemented peer support program; 3. Established process and organization standards for unit codes of conduct	1. Socialize and developed strategy for rewards and recognition programs – ICCAIR, career achievement, hospital-wide events (BBQ, holiday meal, food drive, Thanksgiving event) with an established plan (ongoing); 2. Rollout process and organization standards for unit codes of conduct. 3. Establish plan for WorkLife pulse survey with the objective of raising the percentage of staff who agree or strongly agree that CMH is a great place to work from 42% to 48%	R1) Limited human resources to complete this work; R2) New leaders that need to be onboarded/ integrated into their units; M1 & M2) Hiring for the role of Manager of Organizational Development or other
Enhance recruitment processes and establish CMH as a desirable place to work	1. Collaborated with ICU / Med / ED to increase active staffing pool from 82% to 88.8% on track (ongoing); 2. Completed and implemented recommendations from non-union and executive compensation review; 3. Refreshed attendance program; 4. Reviewed and updated ICIMS to improve better candidate experience (ongoing); 5. Implemented AI application screen to assist leaders in application review and reduce bias screening	1. Continue to support and collaborate with ICU / Med / ED to increase active staffing pool from 88.8% to 100% on track by end of Q2; 2.Refresh recruitment processes, structures and resources; 3. Increase internship opportunities; 4. Implement varied recruitment strategies such as project search; 5. Review and update ICIMS to improve better candidate experience (ongoing)	R1) Pool of qualified applicants does not meet requirements; M1)Internship opportunities will allow CMH to train employees R2) Internships may lengthen training time and we may not be fully staffed; M2) Over hiring to allow staff to be fully trained
Focus on strategies to enhance staff retention (People Development)	1. Establish VBC strategy including targets and begin conducting VBCs for 24/25; 2. Refreshed change management materials and tools and piloted with leaders; 3. Increased attendance rates at CMH learning labs (ongoing); 4. Reviewed and updated criteria for RN, RPN, and PSW requirements for ambulance runs; 5. Quantified scheduling gaps at the time schedules were posted; 6. Refreshed and relaunched the attendance management program	1. Conduct remaining VBCs (ongoing); 2. Evaluate feedback on change management course and align with PM / QI course and make necessary adjustments to PM / QI / Change Management tool kits Q1-Q3; 3. Increase attendance rates at CMH learning labs (ongoing); 4. Implement updated criteria for RN, RPN, and PSW requirements for ambulance runs; 5. Establish a process to monitor and track scheduling gaps in real time; 6. Review self-scheduling practices and identify opportunities for improvement.	R1) Turnover in lead for Change Management; M1) PMO to align PM/QI/Change Management Courses and tools, develop course skeleton for review in Q2

Agenda

Advance Health Equity

DEI Plan

Click Here to Input Action Plans

Executive Sponsor(s): Mari Iromoto

Physician Liaison(s):

Director Lead(s): Jennifer Backler

Project Manager: Soumya Saini

In Year Measures of Success

	Target	Q1	Q2	Q3	Q4
Achieve more than 350 staff completing Rainbow Health Foundations Course	>88 per quarter	39			

Action Plan- Q1

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Create Safe Spaces	1. Review of Inclusion Statement completed;	1. New Equity & Inclusion Commitment by CMH as an organization under development & will be reviewed by the Diversity Council, Indigenous Council, Employee Engagement Council, Accessibility Council; 2. Streamline the current tool & process for reporting complaints from patients; 3. Developing a process for addressing interstaff conflict & de-escalation ahead of the complaint process; 4. Onboarding of new Inclusion Lead	
Enhance collection of sociodemographic data collection	1. Participated in Regional Working Group Meetings to understand approach across the region; 2. Reviewed Service Accountability Agreement Reporting Requirements; 3. Reviewed Ontario Health Guidance Documents on use & reporting of Sociodemographic data collection	1. Assemble working group including how to engage PFAC; 2. Review current practices: Evaluate the hospital's existing processes for collecting, utilizing, & governing sociodemographic data. Including current methods for collecting sociodemographic data, including patient interviews, surveys, or electronic health records (EHRs); 3. Based on the assessment & analysis, provide actionable suggestions for improving sociodemographic data collection, utilization, & governance as well as training requirements	R1) If this work is not done we will not be in compliance with the Service Accountability Agreement; M1) Ensure that this work is initiated & CMH is an active member part of the regional group
Inclusive Language & imagery	1. Changes to registration process: pronouns, chosen name, parent vs. mother/father (wristbands, labels etc.) (ongoing); 2. Updated website, TOA, whiteboards, introductions (Inclusive Communication with Patients) (ongoing); 3. Profiling and celebrating our diverse staff	1. Update the policy for name signage on doors for offices to include preferred name & pronouns; 2. Launched digital accessibility feature on external website to allow more ease in accessing website content and ensure we remain AODA/WCAG compliant; 3. Continue to celebrate/observe events from DEI calendar - including profiling min 3 staff in Voices of CMH series	
Key People, Processes, & Policies	1. Developed a corporate statement around inclusive recruiting & remove barriers on all job postings; 2. Evaluate applicants aligned to CMH DEI strategy & philosophy with inclusion of specific DEI interview questions;	1. Replace the corporate statement by the equity & inclusion commitment statement; 2. Develop relationships with organizations for internship placements (ie. Project Search, THRIVE);	
Rollout Education & Training	1. Rainbow health assigned to a total of 324 staff. Priority was given to leaders, working group members, ED, Mental Health, HR, and Central Reg Staff. Of the 324 assigned staff members, 71 staff volunteered to take the training via our Pride Month celebrations. 2. In Q1, 97% of our leaders have completed their training. 3. Weekly monitoring of completion rates has been completed with monthly reporting to relevant leaders for continued engagement of staff.	1. Begin assigning Rainbow Health Foundations course to all new clinical staff during orientation as part of the core required eLearns. Staff are provided time during orientation to complete their required training; 2. Rainbow Health Removing the Barriers (36 licenses) to be completed by CMH Operational Leadership November 2024; 3. Develop CMH specific 2SLGBTQI+ training for B2L by Q4 (ongoing)	R1) Ongoing professional development is required for CMH to be in alignment with the health service accountability agreement; M1) Ensure we reach the target of 350 by end of fiscal; R2) Staff were not uploading their certificates to mark course as complete. M2) DS and vendor to automate course monitoring and reminders to staff; R3) We do not pay staff to complete their B2L training. M3) Assigning the course to newly orientating staff will allow them to be paid to complete this core course

Agenda

Reimagine Community Health

Emergency Preparedness Plan

Click Here to Input Action Plans

Executive Sponsor(s):
Mari Iromoto

Physician Liaison(s):

Director Lead(s):
Liane Barefoot

Project Manager:
TBD

In Year Measures of Success

	Target	Q1	Q2	Q3	Q4
% on track with Emergency Preparedness Plan	100%	100			

Action Plan- Q1

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Enhance organizational Emergency Preparedness	1. 2 year schedule for Mock Code Reds developed & approved by Cambridge Fire Department; 2. Standardized monthly schedule for Mock Code Reds (Week 1 leader meeting; Week's 2 & 3 staff education; Week 4 conduct Mock). All Mock Code Red reports are now submitted to monthly OPS and Joint Occupational Health & Safety ; 3. Code Transfusion policy revised following an incident review; 4. Additional AED unit purchased/implemented and Code Blue policy updated regarding responding to an outside Code Blue following an incident review; 5. Participated in a City of Cambridge/Cambridge Fire Department mock training exercise at St. Benedict's high school (? CTV news link) June 17, 2024; 6. Posted & hired 2-year contract Emergency Preparedness Lead role; 7. Supplementary evidence completed and submitted to Accreditation Canada (May 2024); 8. Outdoor Muster Point signs ordered	1. Onboard new Emergency Preparedness Lead (starts July 22) including meeting internal leaders, familiarity with CMH, and meetings with Cambridge Fire Department and City of Cambridge Emergency Preparedness Leads; 2. Meet with Waterloo Regional Police to start planning for Mock Code Silver table top; 3. Re-establish cadence of Emergency Preparedness Committee; 4. Conduct a gap analysis of current structures (post code debriefs, mock code schedules, evaluations for mocks, dissemination of learnings from actual and mocks); 5. Leader IMS 200 training (if offered by City of Cambridge) for up to 6 leaders	

Elevate Partnerships in Care

Success and Wins

Description and Impact:

This is a photo that was taken during the sub acute rapid improvement event 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 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. The ER tracker board was revamped to support the PIA tool and serves as an interactive communication tool for the department.

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

Elevate Partnerships in Care

Success and Wins

Description and Impact:

Since the start of this fiscal year, significant focus and attention from our Medical Leadership has been directed towards improving the number of patients that stay in hospital past their benchmark LOS. In April 2024, a "long stay" report was developed which is monitored continuously by the medical team. Since starting this work, the team achieved a 20% improvement in long stay cases from April to June 2024.

"Creating awareness around our long stay patients helps us as a team identify our current challenges or barriers to discharge planning while also addressing the complex needs of our patient population. In addition, it holds us accountable to ensuring our patients are experiencing effective and efficient care while in hospital." – Medicine clinical coordinator

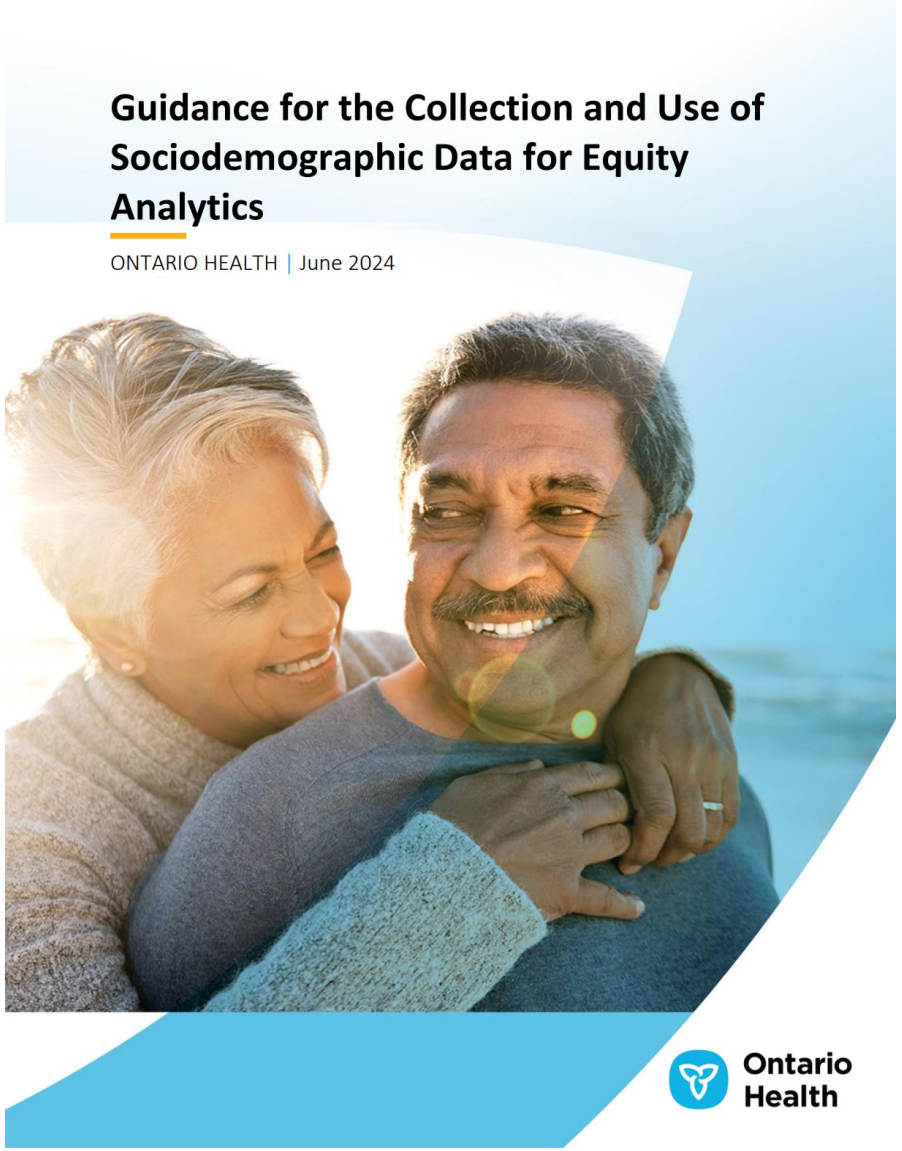
Advance Health Equity

Success and Wins

Description and Impact:

The purpose of this project is to assess our current practices related to the collection, utilization, and governance of sociodemographic data within our hospital. The goal is to identify areas for improvement and recommend changes that will enhance the effectiveness and equity of our data collection processes, ultimately leading to enhanced data for decision making and planning to advance health equity and improve patient experience for all.

In Q1, a group of stakeholders came together to begin the conversation of how we could make this data capture possible including what key considerations we would need to be aware of to ensure we obtain this information in a respectful meaningful way. Obtaining this information would allow for us to analyze our data from a new lens and plan improvement initiatives that ensure equitable care for all.



Agenda

Reimagine Community Health

Success and Wins

PROJECT QUANTUM
Make the leap+
WORKFORCE PLANNING

Description and Impact:

In April, we officially signed the contract with UKG, our new Workforce Planning (WFP) software. This is the first step in a project that will change the way we schedule employees, manage time and attendance, and subsequently use gathered data for greater accuracy, efficiency, and ultimately improved patient care. We are using this project as a catalyst to reimagine how we schedule staff in CMH and are focused on redesigning our processes and structures in parallel to our system.

Since signing, the WFP Steering Committee has continued to meet bi-weekly to establish resources and have established a strong core project team, which includes support subject matter experts from required areas. Project leads have also collaborated with regional partners using or implementing the same software to ensure alignment and informed decision making. Our Communications & Change Management Lead has been establishing communication rhythms and methods to ensure effective and positive change for employees.

In addition to Reimagine Community Health the WFP Project will impact 2 of the other Strategic Pillars:

- **Increase Joy in Work:** Convenience, access, and efficiency for employees to obtain their time banks, schedules, pay stubs. Reduction in unfilled shifts which can also support our delivery of high-quality care.
- **Sustain Financial Health:** Increase the accuracy of our employee time data and efficiency in scheduling processes.

Agenda

Increase Joy in Work

Success and Wins

Description and Impact:

The overtime request process moved away from paper forms to an electronic system using Microsoft Forms. All staff now complete this online form prior to overtime approval.

Switching to an electronic overtime request form will provide data to support overtime reduction strategies. This change aims to improve efficiency and enable better management of overtime resources. In Q1, the online overtime form was successfully implemented in all clinical areas with positive feedback from staff and leaders. This is now being spread organization wide.

CAMBRIDGE MEMORIAL HOSPITAL

OT Requests

Banked 427

Paid out 915

Department: All

Position: All

8/1/2024 – 8/30/2024

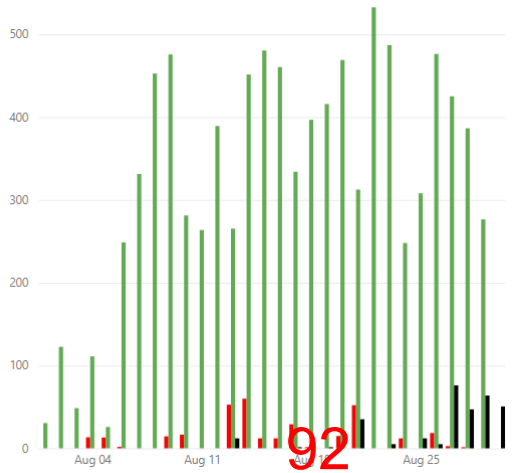
Requests by Department

Department	No	Yes	Yet to be Reviewed	Total
Emergency Department (ED)	8	181		189
Intensive Care Unit (ICU)	8	156	3	167
Medicine B	4	143	2	149
Medicine A	1	101	3	105
Inpatient Surgery	4	85	9	98
Operating Room (OR)		78		78
Labour & Delivery	13	63		76
Post Anesthesia (PACU)		54	4	58
Inpatient Mental Health		51	2	53
Occupational Therapy, Physiotherapy, OTA, PTA	1	50	2	53
Transitional Care Unit (TCU)	1	37	1	39
Nursery		36		36
Maintenance/Biomedical Engineering	1	17	15	33
Surgical Day Care		29		29
Respiratory Therapy (RT)	1	27		28
Endoscopy		26	1	27
Paediatrics	1	25	1	27
MDRD		21	1	22
Total	**46**	**1248**	**48**	**1342**

Request by Reason for OT

ReasonforOT	No	Yes	Yet to be Reviewed	Total
Full time- Worked extra shift	14	416	14	444
Stayed late to work past regular hours	14	335	19	368
Missed break	5	88	2	95
Called Back	2	79	4	85
Change in Patient Acuity / Code blue/ Critical event	4	65		69
Part-time - Worked in excess of 75 hours in pay period		65	4	69
Short turnaround	3	43	1	47
Partial Shift	2	31		33
Procedure room ran late		25	1	26
Stayed late because oncoming staff where late for shift change to do TOA		21		21
On call / Standby (Endo/PeriOP only)	1	19		20
Phone Consult		13	3	16
Patient Transfer or Transport	1	14		15
Consecutive weekends (as per collective agreement)		12		12
Agitated/ confused patient		8		8
Total	**46**	**1248**	**48**	**1342**

Aprox Requested OT Hours by Date and Approval

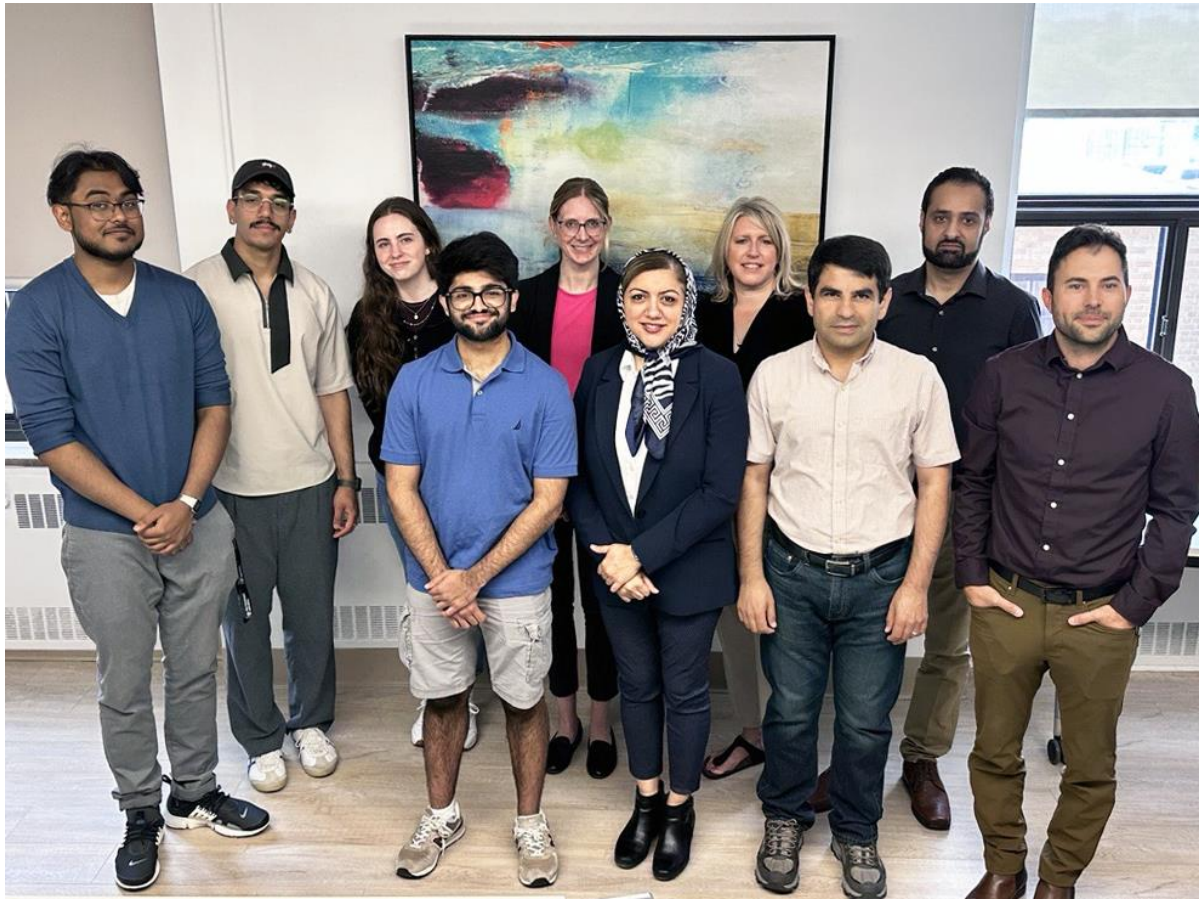


Sustain Financial Health

Success and Wins

Description and Impact:

In Q1, the CMH Surgical team committed to developing new tools to support monitoring of operating room block utilization and tools to support master surgical schedule creation. The team submitted a proposal to partner with the University of Waterloo through the Graham Seed Fund to develop a state-of-the-art innovative solution that leverages machine learning (ML) and artificial intelligence (AI) to solve a complex optimization problem such as maximizing operating room utilization while balancing wait-times, resources and commitments to Quality Based Procedure Targets and PCOP growth.



BRIEFING NOTE

Date: September 9, 2024
Issue: Quality Monitoring Metrics – August 2024 Report
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kristan Chamberlain, Senior Decision Support Specialist
Kyle Leslie, Director Operational Excellence
Liane Barefoot, Director Patient Experience, Quality, Risk, Privacy & IPAC
Approved by: Mari Iromoto, Vice President, Strategy & People

Attachments/Related Documents: Appendix A – Quality Monitoring Scorecard August 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

Executive Summary

Included in **Appendix A** is the 2024/25 CMH Quality Monitoring Scorecard.

The status for each indicator is reflective of the most recent three reporting periods. A "**red**" status means that the indicator is meeting less than 90% of the performance threshold. A "**green**" status means that the indicator is meeting the performance threshold. A "**yellow**" status means that the indicator is at risk of not meeting target.

There are currently seven (7) indicators of the twenty-nine that have had three subsequent periods of "**red**" performance and are being monitored to determine if an action plan for improvement is needed. These indicators, including Board oversight committee are:

1) Overtime hours (Resources Committee)
2) Sick hours (Resources Committee)
3) ALC Throughput (Quality Committee)
4) Percentage ALC Days (Closed / discharged cases) (Quality Committee)
5) Ambulance Offload Time (Quality Committee)
6) Emergency Department Length of Stay for Complex Patients (Quality Committee)
7) Emergency Department Wait time for Initial Assessment (PIA) (Quality Committee)

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

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

Analysis
Five (5) of the seven (7) 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 seven (7) indicators are related to staffing, Sick and Overtime, and 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.

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

Below is a summary of the seven (7) quality monitoring metrics that are currently at a "**red**" status with three or more periods outside of the target threshold.

Efficient:

1) **Overtime Hours** 

   This indicator measures the total number of overtime hours used vs. budgeted overtime hours. Currently we are significantly over budget, with an average of over 3400 overtime hours/pay period while the target is 850 hours/pay period. The majority of overtime hours (approx. 60%) can be attributed to the Emergency Department, Medicine, and ICU. A lower number on this indicator means that we are staffing less with OT which has a positive impact to Joy in Work as it is an indication that we have improved staffing levels, leading to reduced staff burnout.

2) **Sick Hours** 

   This indicator monitors the average sick hours per pay period per month. A lower number is better as that means there are less staff off and unable to work due to illness. Currently we are significantly over budget, with an average of over 2800 sick hours/pay period while the target is 2090 hours/pay period.

Integrated & Equitable:

3) **ALC Throughput & Percent ALC Days (closed cases)** ◆

Both of these indicators monitor the level of ALC activity in the hospital. The percentage of ALC closed cases is measuring the number of days that patients are in hospital with an ALC designate vs. number of days in hospital for acute care. The lower the percentage means better access to post-acute care. YTD July, 28% of acute days are considered to be for alternate level of care, which is above target (20%). The ALC throughput ratio measures the new ALC cases vs. discharged ALC cases and is used to monitor turnover and flow of ALC cases. A throughput ratio of one means that for every new ALC case, one current ALC case is discharged. The current ALC Throughput Ratio is 0.8, meaning we are adding more cases than discharging.

Safe, Effective & Accessible:

4) **Ambulance Offload Time (90% spent less, in minutes)** ◆

This indicator measures the length of time from ambulance arrival to when the transfer of care from EMS is completed. Our 90th percentile ambulance offload time is 65 minutes (YTD July 2024), while the target is <30 minutes. A lower number for this indicator is better as it means patients are receiving timely emergency care.

5) **ED Length of Stay Complex (CTAS 1-3) (90% spent less, in hours)** ◆

This indicator measures the wait-time from triage to disposition from the ED. Currently, 90% of complex ED patients have a length of stay 9.5 hours or less (YTD July 2024), while our target is 8 hours or less. A lower number is better as it means patients are receiving care in a timely, effective and efficient way.

6) **ED Wait Time for Physician Initial Assessment (90% spent less, in hours)** ◆

This indicator measures the wait-time from triage to being seen by a physician or nurse practitioner in the ED. Currently, 90% of ED patients were seen by a physician or nurse practitioner within 7.3 hours (YTD July 2024), while our internal target is to see 90% of patients within 4 hours. A lower number is better as it means that patients are seen by a physician or nurse practitioner within an appropriate timeframe in the emergency department.

Next steps

The Quality Monitoring Scorecard will continue to be included on a quarterly basis.

Agenda

Quality Monitoring Scorecard, 24/25

Status (Last 3 Periods)

Meeting Target	7	24%
Within 10% of Target	15	52%
Exceeding Target	7	24%

Quality Dimension	Indicator	Unit of Measure	Target	YTD	Status (Last 3 periods)	Period
Efficient	Active Staffing Target Achieved (ED/MED/ICU)	%	100.00	90.03	▲	Aug-24
	Conservable Days Rate	%	30.00	34.57	▲	Jul-24
	Overtime Hours - Average per pay period	hours	850.00	3,409.08	◆	Aug-24
	Sick Hours - Average per pay period	hours	2,090.00	2,811.75	◆	Aug-24
Integrated & Equitable	ALC Throughput	Ratio	1.00	0.77	◆	Jul-24
	Percent ALC Days (closed cases)	%	20.00	27.54	◆	Jul-24
	Repeat emergency department visits for Mental Health Care	Patients	11.00	10.00	●	Jul-24
Patient & People Focused	Organization Wide Vacancy Rate	%	12.00	5.82	●	Aug-24
Safe, Effective & Accessible	30 Day CHF Readmission Rate	%	14.00	14.29	▲	Jun-24
	30 Day COPD Readmission Rate	%	15.50	8.82	▲	Jun-24
	30 Day In-Hospital Mortality Following Major Surgery	%	1.90	1.12	▲	Jun-24
	30 Day Overall Readmission Rate	%	8.80	5.18	●	Jun-24
	Ambulance Offload Time (90% Spent Less, in Minutes)	minutes	30.00	65.00	◆	Jul-24
	ED Length of Stay for Admitted Patients (90% Spent Less, in Hours)	hours	33.00	46.60	▲	Jul-24
	ED Length of Stay for Non-Admitted Complex Patients (90% Spent Less, in Hours)	hours	8.00	9.50	◆	Jul-24
	ED Wait Time for Inpatient Bed (90% Spent Less, in Hours)	hours	25.00	37.80	▲	Jul-24
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours)	hours	4.00	7.30	◆	Jul-24
	Hip Fracture Surgery Within 48 Hours	%	83.10	97.71	●	Jun-24
	Hospital Standardized Mortality Ratio (HSMR)	Ratio	100.00	94.53	▲	Jun-24
	In-Hospital Sepsis	per 1000 D/C	3.20	3.47	▲	Jun-24
	Long Waiters Waiting For All Surgical Procedures	%	20.00	16.20	▲	Aug-24
	Low-Risk Caesarean Sections	%	17.30	20.76	▲	Jul-24
	Medication Reconciliation at Admit	%	95.00	97.00	●	Aug-24
	Medication Reconciliation at Discharge	%	95.00	96.00	▲	Aug-24
	Obstetric Trauma (With Instrument)	%	14.40	16.98	▲	Jun-24
	Patient Safety Event - Falls with Harm	per 1000 PD	0.00	0.12	▲	Aug-24
	Patient Safety Event - Medication Events with Harm	per 1000 PD	0.00	0.00	●	Aug-24
	Revenue - Achieve budgeted PCOP growth (IRM)	$	4,894,096.00	5,142,287.00	▲	Jul-24
	Revenue - Achieve Quality Based Procedure Funding (IRM)	$	8,293,392.00	8,856,107.12	●	Jul-24

Chair Tip Summary Page (August 2024)

Leader

- Bring voice to Board of your Committee
- Bring voice of Board to Committee
- Bring new ideas to Committee
- Prepare well for meetings
- Be in regular contact with Board Chair – any issues of performance, conflict, etc.
- "Be the guide on the side to help others do"

Use the Technology

- Encourage committee members to mute when not speaking
- Use "hands up" – both in person and virtual and when hybrid model starts
- Feel free to engage others in managing with you – ask a committee member to keep eye on hands up
- Encourage cameras to be on – all the time is ideal – or at least when person is talking

Committee Meeting Preparation

- In advance of the Committee meeting, meet with the executive lead two weeks in advance to prepare the agenda. Review the feedback from the previous meeting at that meeting.
- Regularly discuss ways to improve the staff's work
- Remember: more is not always better! Think of ways to reduce unnecessary work/activities. Ensure new work is value-added.

Meeting Evaluations

- Discuss at the meeting, when possible
- Don't simply say "thanks for the feedback, keep it coming."
- Call out a comment, highlight a positive
- Ask questions and discuss issues or suggestions with full Board/committee
- Make improvements where needed

At the Committee Meetings

- Ensure input from all → keep a list of members handy (can't always see them all on the screen)
- Avoid binary: Ask committee members *"What questions do you have?" This will stimulate discussion!* Don't ask *"Any questions?"*

Bring it together

- Encourage input and discussion
- When done, bring it to a vote or conclusion
- If it is not a voting matter, provide a summary of the conclusions, validate what you heard and what the next steps are.
- Try to tie it up!

Engaging the Members

- If you have a quiet member, (and if you are comfortable)… welcome them into the discussion. Sometimes people need to know their input is welcomed Ask them to offer a perspective… "what do you think? What concerns or questions do you have?"
- Or if you prefer, email or call any quiet member after the meeting right away → seek to understand why they were quiet
- Avoid the "go around the room and ask everyone for their comment"

Agenda

Chair Tip Summary Page (August 2024)

Territorial Acknowledgement

- Share the territorial acknowledgement at each meeting, as written. Do not include a personal reflection.

Inclusive Language

- Avoid the use of certain non-inclusive words – such as "guys"
- Be comfortable addressing when non-inclusive words or phrases are used. Simply, pause, guide, educate….do it with sensitivity as we are all on a journey of learning.

Committee Chair Summary at Board

- Use the committee summary briefing note – present discussion at Board about the issues, concerns raised at the meeting. Give a flavor of the discussion – issues, choices, why it matters

Board/Committee Recognition

- As much as possible, recognize CMH staff/ physicians who have presented at the Board committee
- If possible, send a handwritten note to a designated department or individual sharing the Board/ committee's appreciation - send to home address (through CEO's office)

How should committee members interact with the Executive Lead about an issue/question

- Through the Committee chair only
- Committee members are encouraged to funnel questions they have to the chair in advance of the meeting. Chair will share with the executive lead in advance.
- Communicate approach with members and hospital staff at the meeting

Cell phone numbers:
Patrick 519-240-0618
Winnie 519-212-5784
Stephanie 226-218-1236
Mari 226-218-6809
Trevor 519-212-0371

Use of the Action Log

- Record follow up items and questions

Use of the Consent Agenda

- Maximize the use of the consent agenda - information only documents
- Build an open and safe space for folks to remove items for discussion – *any comments or concerns on the items in the consent agenda?*
- Use your judgement to decide if item pulled can be discussed right away (clarification matters) or needs placing on the agenda (needs discussion)

Post meeting with your Executive Lead

- Meet with your executive lead within 24 hours post meeting to close the loop on issues raised in the meeting without management.

Managing Time at the Meeting

- Be flexible about the time – give yourself permission to move things around. Difficult at times to know where the committee needs to focus.
- Encourage presenters not to rehash their slide deck.
- If you see the meeting will finish late, seek permission to extend and/or defer items. Give the committee a short break as needed.

CAMBRIDGE MEMORIAL HOSPITAL

CMH Board of Directors

Recognition of Service Achievement Award

Congratulations Monika Hempel 10yrs

Thank you for all your contributions and dedication to our Community

2014-2024

Board Chair's Report – Summer 2024

Message From the Chair

Welcome back to the 2024/25 CMH Board of Directors cycle. I hope you enjoyed your summer. I thank you all for your commitment and dedication to CMH and thank those that took time over the summer to take part in various events to support CMH.

Board Chair's Report – Summer 2024

Community Events

Members of the Board joined CMH Leadership at Mayor Jan Liggett's State of the City 2024 address on September 12, 2024.

On September 19, 2024 Miles Lauzon, Lynn Woeller, Tom Dean, Nicola Melchers, Diane Wilkinson, Sara Alvarado and Bill Conway attended panel discussion for Vision 1 Million Series: The Future of Healthcare in Waterloo Region where Stephanie Pearsall spoke on behalf of CMH.

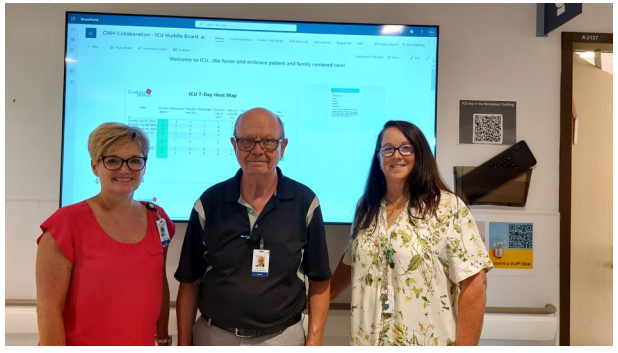
Lynn Woeller attended the "Women Take Charge" Breakfast Series: Conversation with The Honourable Bardish Chagger - Member of Parliament for Waterloo. The Hon. Bardish Chagger was elected as the Member of Parliament for the riding of Waterloo on October 19th, 2015. She was named as Minister of Small Business and Tourism by Prime Minister Justin Trudeau on November 4th, 2015.

Department / CMH Visits

Sara Alvarado joined members of CMH during department huddles to kick off Project Quantum

"I saw a lot of interest around the room, a lot of smiley faces and thumbs up with Beth and Mackenzie mentioned app capabilities for scheduling etc." *Sara Alvarado*

Miles Lauzon attended huddles for the ICU and Endoscopy departments.



Diane Wilkinson joined Dr. Jenny Legassie for two mornings on September 12 & 13, shadowing on Dr. Legassie' s rounds as a Hospitalist to observe the physician perspective and organizational flow. Time was spent in the Emergency Department, Medicine A, and Medicine B seeing patients and attending rounds.

Tom Dean joined the Manager of Women's & Childrens for the Peads huddle on July 30, 2024

Board Chair's Report – Summer 2024

CMH Events

Feasting the Feather Ceremony

On September 4, 2024 members of the Board CMH at the Feasting the Feather Ceremony, providing opportunity to learn more about Indigenous teachings.

Sacred Fire Ceremony

On June 26, our hospital had the privilege of hosting its first Sacred Fire Ceremony led by local Indigenous healer and knowledge keeper, Myeengun Henry. This was a significant step towards our growing relationship with Myeengun and the Indigenous community. A traditional Sacred Fire Ceremony is a powerful practice that fosters a deep sense of community and cultural continuity. It's a time of reflection, healing, and connecting to the spirit world. It involves lighting a fire, and offering prayers and tobacco to the flames.

During the ceremony, Myeengun highlighted the stark reality of Canada's need to provide Indigenous communities with basic needs—critical social determinants of health, which underscores why Indigenous health outcomes are lower than those of non-Indigenous populations. Thank you Myeengun Henry for sharing your knowledge and helping us deepen our understanding of these important issues.

BRIEFING NOTE

Date: September 25, 2024
Issue: Governance & Partnerships
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald – Administrative Assistant
Approved by: Julia Goyal – Chair, Governance Committee, Patrick Gaskin – President & CEO

Attachments/Related Documents: Policy 2-A-16 Governance Terms of Reference

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Recommendation/Motion
That, the Board of Directors approve policy 2-A-16 - Governance Terms of Reference as presented, to include the addition of Relationship Management, Community Engagement and Advocacy.

Executive Summary
The Governance Committee is looking to broaden its role beyond the framework outlined in its current terms of reference. This initiative emerged from the necessity to enhance governance activities related to relationship management, community engagement, and advocacy efforts. The conversation began during a Board meeting in October 2022, where partnerships were a focal point, and it was revisited briefly in May 2023.

Although a proposed ad hoc working group of the Board dedicated to partnerships did not materialize, CMH staff has developed an inventory of CMH partnerships.

Following a review of the suggested policy changes and discussions, the Governance Committee has expressed its support for amending Policy 2-A-16, Governance Terms of Reference, to officially incorporate this expanded scope of responsibilities.

The Committee believes that these adjustments will enable it to more effectively oversee and guide initiatives that foster collaboration and strengthen community ties, ultimately enhancing the organization's impact. By formalizing this expanded role, the Governance Committee aims to position itself as a vital player in driving strategic partnerships and promoting a culture of engagement and advocacy throughout the organization.

Next Steps
Upon Board approval of the updated Governance Terms of Reference, the Governance Committee will review and update the committee's work plan to include key deliverables to support relationship management, community engagement and advocacy.

BOARD MANUAL

SUBJECT: Governance Committee Terms of Reference	**NO.: 2-A-16**
SECTION: Structure, Roles and Responsibilities	
APPROVED BY: Board of Directors	**DATE: ~~June 26, 2024~~TBD**

1. 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.

2. 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.

3. 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.

4. 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; and

(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) Relationship Management, Community Engagement and Advocacy

The Committee shall:

(i) ~~Align~~Consider and advise the Board on Board policies and directions related to governance relationships, partnerships and community engagement with the current external environment and the hospital's mission, vision, values and strategic directions; and

(ii) Support the Board on activities related to strategic governance partnerships, community engagement and advocacy.

~~(h)~~(i) Board Independence

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

~~(i)~~(j) 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)~~(k) 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.

5. 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	June 26, 2024
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BRIEFING NOTE

Date: September 19, 2024
Issue: Quality Committee Report to the Board of Directors, September 18, 2024, 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, September 18, 2024 at 0700 hours.

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

Committee Matters – For information only

1. **2024/25 Quality Committee Workplan**: A copy of the 2024/25 Quality Committee Workplan was pre-circulated to the Committee members for review. The Committee approved the 2024/25 Quality Committee Workplan as presented. See package 2.
2. **2024/25 Quality Committee Plans & Goals**: A copy of the 2024/25 Quality Committee Plans & Goals was previously circulated, for information only. See package 2.
3. **ECFAA Annual Update**: A copy of the briefing note was pre-circulated to the Committee. See package 2.
4. **Excellent Care for All Act (ECFAA) 2010 – Annual update**: A copy of the annual update report was pre-circulated to the Committee. See package 2.
5. **Quality and Patient Safety Plan (QPSP)**: The Patient Safety & Quality Lead directed the Committee members to the pre-circulated slide presentation and spoke briefly providing context to the QPSP. The following areas were highlighted:
   - In the Corporate Plan, QPSP is listed under Elevate Partnerships in Care
   - QPSP is connected and coordinated with other corporate plans (DEI Plan, Patient Experience Plan, Operational Excellence Plan, Digital Health Plan and Employee/Physician Engagement Plan)
   - The four Priority Themes are: Just Culture, Robust Processes/Frameworks, Medication Safety and Safe Transitions

- SafeT Cast – CMH's Patient Safety Newsletter. This newsletter keeps patient safety top-of mind, provides a culture of safety through recognition and feedback. This newsletter also spotlights individuals, programs and projects that are driving forward patient, patient safety work or learnings from incident reviews that programs are actioning on. To date, four issues have been published. A copy of the SafeT Cast newsletter will be included in the October Quality Committee meeting material, for information.
- Standardizing roles and responsibilities in Incident Management process; leveraging Report Link System by capturing and standardizing data input, time-stamping actions, ability to track and trend data.
- The development of Patient Safety Dashboard is underway.
- Best Practice Committee has been established; in collaboration with Professional Practice councils; engage/empower front line staff.

6. **Corporate Priorities Tracker & Quality Monitoring Scorecard**: A generative discussion was had. CMH Management guided the Committee members through the refreshed electronic tools, and explained the top priorities, performance in relation to targets set, and action plans aligned to the Strategic Plan, Quality Improvement Plan (QIP) and Risk Management (IRM) plan. The 2024/25 Strategic Priorities Tracker was designed to better reflect organizational priorities and enhance the ability to measure success and share progress towards achieving the most critical organizational priorities. The purpose of the Tracker is to align priorities and actions with the Strategic priorities. The Tracker is used as a performance tracking tool and monitored in real-time. The Quality Scorecard was displayed. The Quality Monitoring Scorecard is aligned with the Quality Framework. The Quality Scorecard enables performance monitoring and sustainability on core indicators related to patient safety, access to care, staffing and the financial performance of the organization. The Quality Monitoring Scorecard is the central performance monitoring hub – to sustain and identify performance issues early on for corrective action. Board members can use the information presented in these tools to challenge Leadership and hold them accountable. The goal of these tools is to provide the Board and subcommittees enhanced insights into CMH performance. The following priorities continue to be a major organizational focus:1) Organizational flow measured by Ambulance Offload Times and Emergency Department Length of Stay (EDLOS) for Admitted Patients; 2) Optimal staffing and overtime reduction; 3) Advance Health Equity through developing our people measured through completion rates of Rainbow Health Diversity, Equity and Inclusion (DEI) training; and 4) Post Construction Operating Plan (PCOP). On a weekly basis, staffing and flow metrics are reviewed at Leadership Huddles. The metrics on the Quality Monitoring Scorecard are reported on the Departmental Scorecards that monitor departmental performance. It is an expectation that departments review and develop any necessary departmental action plans to address performance at monthly Quality and Operations Councils meetings. Regarding Ambulance Offload Time, one Committee member asked about what other opportunities of improvement or work was underway. CMH Management indicated that it monitors Ambulance Offload Time daily. The improvement noted was due to ED staffing improving, and the Rapid Improvement event with EMS partners. A main contributor to Offload pressure is the number of admitted patients in ED, and how to flow patients off EMS stretchers. Funding strategies and Ministry expectations were discussed. It was reported that an extensive review and analysis is conducted yearly in terms of Ministry targets, benchmarking, and comparisons to regional partners, as well as historical data and performance. Further conversation took place regarding how some resource tools can help the Quality Committee monitor quality and risk, and what the contributing factors are to performance. In response to a question about Ambulance Offload, CMH meets with EMS partners on a bi-weekly schedule to discuss transfer of care, patient

transport, process improvements and efficiencies. In February 2024, CMH hosted an EMS Rapid Improvement Event, and input received from the EMS staff was invaluable. Communication between CMH and EMS partners have greatly improved. Though work continues, the process is more streamlined. CMH Management referred to the pre-circulated Quality Monitoring Scorecard, and the Successes and Wins were highlighted. Reducing Overtime hours was discussed. CMH reported continued effort to maximize staffing levels in all departments but focusing primarily on ED, ICU, and medicine. The hospital understands the importance of respecting staff member's time away from work but there are times when we call staff in to at overtime to ensure the units are staffed. A continued focus on recruitment and retention is a mitigation strategy. Managers have the ability to select more than one candidate should there be applicants that have the skill set required.

BRIEFING NOTE

Date: September 12, 2024
Issue: August 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 - August 2024

Alignment with 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	☐ Staffing Shortages
☐ Reimagine Community Health	☐ Prepare for Digital Health Transformation	☐ Change Management
☒ Sustain Financial Health	☒ Earn the Maximum Eligible PCOP Funding	☒ Revenue & Funding

Recommendation/Motion

Board

That, the Board receives the August 2024 financial statements as presented by management and upon the recommendation of the Resources Committee at the meeting of September 24, 2024.

Resources Committee

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

Executive Summary

Cambridge Memorial Hospital (CMH) has a $2.2M year-to-date surplus position at the end of August after building amortization and related capital grants. The major drivers of the surplus are the unused portion of the budgeted contingency ($2.7M), recoveries and other revenue ($0.7M) partially offset by unfavourable variances in salaries & wages and benefits ($1.2M), primarily due to higher overtime than budget.

Risks

- Actual overtime costs continue to be much higher than budget ($1.9M YTD August). At the current rate, overtime costs are forecast to be $4.5M higher than budget by the end of the fiscal year. A working group focusing on strategies to reduce the amount of overtime is meeting on a bi-weekly basis.

- Post construction operating plan (PCOP) volume targets YTD August are unfavourable to budget creating a $0.1M financial pressure. This was due to lower weighted cases in surgery (physician vacancies and returned surgical blocks), lower occupancy rates in mental health than budgeted for and lower patient volumes in the Emergency Department. The PCOP funding shortfall is forecast to be $1.5M less than budget by the end of the fiscal year.
- $5.4M in funding for Bill 124 has been budgeted in 2024-25. CMH has received a funding letter to confirm the first six months of Bill 124 funding ($3M). Year-to-date $2.3M has been recorded. This funding represents approximately 80% of the total incremental wage costs budgeted. It is unclear how much funding for Bill 124 will be received in the second half of the fiscal year.
- 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 36 ALC patients in 2024-25 which is comparable to fiscal 2023-24 (34 patients)

Summary
CMH has a $2.2M year-to-date surplus position at the end of August after building amortization and related capital grants. Actual results are $2.5M favourable to budget. The favourable variance has been driven by:

- $2.7M in other supplies & expenses mainly due to unused budgeted contingency through the end of August;
- $725K in recoveries and other revenue mainly comprised of $278K in interest income and $333K in Cancer Care Ontario (CCO) oncology drugs recovery;

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

- $1.2M unfavorable variance in salaries & wages and benefits primarily due to higher overtime than budget;

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.

<u>PCOP</u>

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 $112K unfavorable variance is mainly due to lower surgical volumes and weighted cases.

PCOP acute inpatient weighted cases has the biggest funding implication for the hospital. Each weighted case generates $4,517 in funding. There are 79 net weighted cases under budget through August which represents $356K in funding. The surgical department, emergency department and mental health team had lower patient volumes and have not meet PCOP targets YTD August.

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 have been budgeted for.

QBP

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

Cancer Care Ontario (CCO) QBP revenue was $2K favorable to budget, due to higher numbers of breast surgeries and endoscopy procedures.

Bundled care and surgical QBP's was $1.3M favourable. Urgent medical QBPs funded through OH was $1.3M unfavorable to budget.

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

PCOP				
Funding Source	**Unit of Measure**	**Budget**	**YTD Achieved # *(coded volumes)***	**YTD Variance from Budget**
Acute IP	Weighted Cases	8,249	2,838	88
Day Surgery/TCC	Weighted Cases	2,983	914	(80)
Emergency	Weighted Cases	2,839	859	(87)
Mental Health IP	Inpatient Days	7,867	2,521	(101)
QBP				
Funding Source	**Unit of Measure**	**Budget**	**YTD Achieved # *(coded volumes)***	**YTD Variance from Budget**
OH Urgent Medical	**Cases**	**514**	**227**	**56**
OH Bundled Care	**Cases**	**1,062**	**414**	**60**
OH Surgical	**Cases**	**5,202**	**1,511**	**(223)**
CCO	**Cases**	**454**	**177**	**26**

MOH Funding – Base / One-Time / Other
The $217K year to date unfavourable variance is primarily due to a $163K favourable variance in the CT wait time funding and $39K in MRI wait time funding offset by $216K unfavourable variance on MOH one-time for funding driven by $138K claw-back for HHR SPEP Preceptor funding.

Billable Patient Services
The $432K year to date favourable variance is primarily due to a $315K favourable variance for non-resident of Canada billing, $151K favourable variance in uninsured residents of Ontario.

Recoveries and Other Revenue
The $735K year to date favorable variance is driven by a $278K favorable variance in interest income, $333K recovery for oncology drugs from CCO and $78K for miscellaneous revenue.

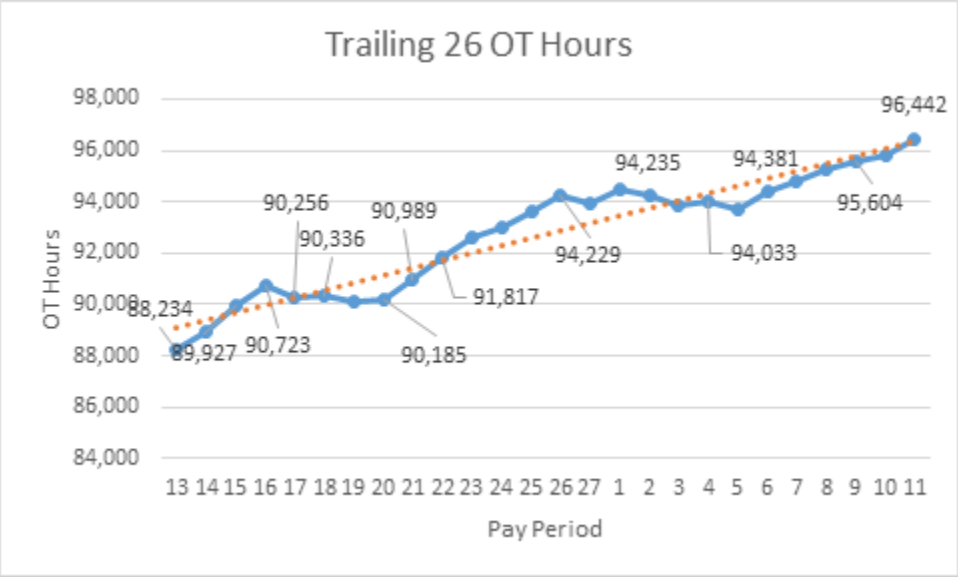
Expenses

Salaries and Wages
Salaries and wages were $782K unfavorable to budget year to date. This was mainly due to higher overtime ($1.9M), staff training costs ($735K), and modified work ($193K), which was partially offset by a favorable variance in worked salaries ($2.1M) due to vacancies.

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

	August 2024			FY 2024-25		
HOURS	Actual	Budget	Variance	Actual	Budget	Variance
Overtime	9,646	1,997	(7,649)	37,589	9,861	(27,728)
Sick	7,173	4,349	(2,825)	30,441	21,458	(8,983)

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 96,442 in pay period 11. The amount of overtime per pay period is on a slight increase over the past 6 pay periods. Efforts continue to reduce the amount of overtime.



Employee Benefits
The $402K YTD unfavourable variance has been driven by higher in lieu of benefits paid to part-time staff due to the higher number of hours worked by part-time staff compared to budget.

Medical Remuneration
The $450K favorable year to date variance is largely driven by a favourable variance in oncology ($172K), pathology ($101K), alternate funding for ER ($69K) and impatient mental health ($64K).

Medical and Surgical Supplies
The $210K YTD unfavorable variance has been driven by IV sets ($88K), med surge general supplies ($87K) and regents / chemical laboratory ($54K) partially offset savings in other areas.

Drug Expense
The $357K YTD unfavorable variance is driven higher spending on drugs for the oncology program ($339K). 98% of oncology drug costs are reimbursed by CCO.

Other Supplies and Expenses
The $2.9M YTD favorable variance is due to the unused contingency ($2.7M).

Balance Sheet and Statement of Cash

CMH's current cash position is $105M, consisting of $78M of unrestricted cash and $27M of restricted cash. Unrestricted working capital available at the end of August is $18M. The working capital ratio is 1.25 and meets the requirements of the Hospital Service Accountability Agreement (H-SAA) target.

The accounts payable balance at the end of August was $41M, including general accounts payable ($35.6M) and MOH payable ($5.6M). The accounts receivable balance at the end of August was $8M, which includes MOH receivable ($1M) and general accounts receivable ($7M).

Forecast

CMH is forecasting a surplus of $3M for 2024-25.

The forecast includes unused contingency ($6.3M) offset by unfavorable variance in salary and benefits ($3.7M) and lower than budget revenue in PCOP ($2.2M). In August, MOH advised that Incremental Surgical Recovery funding (ISR) would be available this year. $3M in one-time funding has been estimated and included in the forecast.

Included in the forecast is MOH revenue of $5.4M to offset the 2024-25 incremental wage impact of Bill 124 arbitration awards at 80%.

The MOH is currently reconciling the PCOP funding for 2022-23 and 2023-24. The hospital is expecting a favourable result that will create a one-time funding source to be invested in building infrastructure, service recovery and growth planning.

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

Confidential
(Expressed in thousands of dollars)

Month of August 2024					Year to Date				2024-25	2024-25		2023-24 Prior Year Actuals	
Actual	Plan	Variance	% Variance		YTD Actual	YTD Plan	YTD Variance	% Variance	Forecast	Plan	Variance	August 2023	2023-24 YE
				Revenue:									
				MOH Funding									
$ 9,888	$ 9,940	$ (52)	(1%)	MOH - Base	$ 48,831	$ 49,059	$ (228)	(0%)	$ 117,037	$ 117,037	$ -	$ 7,967	$ 93,971
2,241	2,127	114	5%	MOH - Quality Based Procedure	11,145	11,155	(10)	(0%)	26,560	26,559	1	2,189	27,048
2,027	1,345	682	51%	MOH - Post Construction Operating Plan	6,527	6,639	(112)	(2%)	13,642	15,838	(2,196)	453	14,207
583	770	(187)	(24%)	MOH - One time / Other	3,721	3,938	(217)	(6%)	12,018	9,317	2,701	1,853	36,820
14,739	14,182	557	4%	Total MOH Funding	70,224	70,791	(567)	(1%)	**169,257**	**168,751**	**506**	12,462	172,046
1,842	1,386	456	33%	Billable Patient Services	7,275	6,843	432	6%	16,500	16,324	176	1,335	15,187
1,778	1,605	173	11%	Recoveries and Other Revenue	8,689	7,964	725	9%	19,565	19,152	413	2,050	22,461
323	334	(11)	(3%)	Amortization of Deferred Equipment Capital Grants	1,611	1,648	(37)	(2%)	3,864	3,952	(88)	332	3,888
276	295	(19)	(6%)	MOH Special Votes Revenue	1,494	1,457	37	3%	3,508	3,508	-	325	3,681
18,958	**17,802**	**1,156**	**6%**	**Total Revenue**	**89,293**	**88,703**	**590**	**1%**	**212,694**	**211,687**	**1,007**	**16,504**	**217,263**
				Operating Expenses:									
7,993	7,976	(17)	(0%)	Salaries & Wages	40,087	39,305	(782)	(2%)	97,855	95,025	(2,830)	7,973	92,991
2,336	2,064	(272)	(13%)	Employee Benefits	11,305	10,903	(402)	(4%)	26,068	25,155	(913)	2,032	24,424
1,632	1,863	231	12%	Medical Remuneration	8,765	9,215	450	5%	21,036	22,004	968	1,730	21,279
1,300	1,191	(109)	(9%)	Medical & Surgical Supplies	6,090	5,880	(210)	(4%)	14,774	14,047	(727)	1,230	13,891
1,184	1,061	(123)	(12%)	Drug Expense	5,594	5,237	(357)	(7%)	13,517	12,511	(1,006)	1,079	12,242
2,044	2,639	595	23%	Other Supplies & Expenses	10,089	13,020	2,931	23%	23,956	30,296	6,340	2,153	28,437
562	604	42	7%	Equipment Depreciation	2,831	2,982	151	5%	7,151	7,223	72	553	6,830
296	331	35	11%	MOH Special Votes Expense	1,514	1,664	150	9%	3,508	3,508	-	325	3,681
17,347	**17,729**	**382**	**2%**	**Total Operating Expenses**	**86,275**	**88,206**	**1,931**	**2%**	**207,865**	**209,769**	**1,904**	**17,075**	**203,775**
1,611	**73**	**1,538**	**2,107%**	**MOH Surplus / (Deficit)**	**3,018**	**497**	**2,521**	**507%**	**4,829**	**1,918**	**2,911**	**(571)**	**13,488**
(649)	(647)	(2)	0%	Building Depreciation	(3,191)	(3,192)	1	(0%)	(8,278)	(9,002)	724	(632)	(7,589)
484	504	(20)	(4%)	Amortization of Deferred Building Capital Grants	2,420	2,489	(69)	(2.8%)	6,519	7,084	(565)	483	5,802
$ 1,446	**$ (70)**	**$ 1,516**		**Net Surplus / (Deficit)**	**$ 2,247**	**$ (206)**	**$ 2,453**		**$ 3,070**	**$ -**	**$ 3,070**	**$ (720)**	**$ 11,701**

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

(Expressed in thousands of dollars)

	August 2024	March 2024
ASSETS		
Current Assets		
Cash and Short-term Investments	$ 78,174	$ 82,817
Due from Ministry of Health/Ontario Health	3,192	7,549
Other Receivables	7,045	4,616
Inventories	3,359	2,865
Prepaid Expenses	3,092	2,458
	94,862	100,305
Non-Current Assets		
Cash and Investments Restricted - Capital	27,434	29,359
Due from Ministry of Health - Capital Redevelopment	3,243	3,243
Due from CMH Foundation	551	475
Endowment and Special Purpose Fund Cash & Investments	212	206
Capital Assets	301,950	296,132
Total Assets	**$ 428,252**	**$ 429,720**
LIABILITIES & NET ASSETS		
Current Liabilities		
Due to Ministry of Health/Ontario Health	5,666	5,774
Accounts Payable and Accrued Liabilities	35,622	40,655
Deferred Revenue	35,058	32,449
	76,346	78,878
Long Term Liabilities		
Capital Redevelopment Construction Payable	4,884	4,035
Employee Future Benefits	4,327	4,223
Deferred Capital Grants and Donations	282,647	284,783
Asset Retirement Obligation	2,810	2,810
	294,668	295,851
Net Assets:		
Unrestricted	15,042	17,204
Externally Restricted Special Purpose Funds	210	206
Invested in Capital Assets	41,986	37,581
	57,238	54,991
Total Liabilities and Net Assets	**$ 428,252**	**$ 429,720**
Working Capital Balance	18,516	21,427
Working Capital Ratio (Current Ratio)	1.24	1.27

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

(Expressed in thousands of dollars)

	August 2024	March 2024
Cash Provided By (used in) Operations:		
Excess (deficiency) of Revenue over Expenses	$ 2,247	$ 11,701
Items not involving cash:		
Amortization of capital assets	6,023	14,419
Amortization of deferred grants and donations	(4,031)	(9,680)
Change in Non-Cash Operating Working Capital	(1,891)	(2,647)
Change in Employee Future Benefits	104	20
	2,452	13,813
Investing:		
Acquisition of Capital Assets & CRP	(11,840)	(33,552)
Capital Redevelopment Construction Payable	849	1,607
	(10,991)	(31,945)
Financing:		
Change in non-cash capital accounts receivable	76	341
Capital Donations and Grants & CRP	1,895	24,352
	1,971	24,693
Increase (Decrease) In Cash for the Period	(6,568)	6,561
Cash & Investments - Beginning of Year	112,176	105,615
Cash & Investments - End Of Period	**$ 105,608**	**$ 112,176**
Cash & Investments Consist of:		
Unrestricted Endowment and Special Purpose Investments	30	30
Cash & Investments Operating	78,144	82,787
Cash & Investments Restricted	27,434	29,359
Total	**$ 105,608**	**$ 112,176**

BRIEFING NOTE

Date: September 11, 2024
Issue: MAC Credentials & Privileging June 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 June 2024

Recommendation/Motion

Board

WHEREAS due diligence was exercised in reviewing the following privileging applications from the June 2024 Credentials Committee and upon the recommendation of the MAC, that the Board approve the following privileging applications.

MAC

That, the Medical Advisory Committee recommends to the Board of Directors that the standard credentialing files be approved. None Opposed, Motion **CARRIED.** The attached Briefing Note provided to the Committee will be noted as well as any further commentary or discussion that is necessary.

MOTION that the new credentialing files be approved as distributed. None opposed. **CARRIED.**

Executive Summary

The Medical Advisory Committee (MAC) reviewed the credentials and privileging files for June 2024 at the September 11, 2024 MAC meeting.

Agenda

Credentialing Committee

Credentialing Files for Review June 2024

Date of Meeting: June 25, 2024

MAC Meeting Date: September 11, 2024

Board of Directors Meeting Date: October 2, 2024

New Business:

Credentialing Files for Review:

Name	Department	Specialty	Appointment	Reason	Supervisor	Recommended/Not Recommended
Dr. Matthew Purser	Women & Children	Pediatrics	Associate > Courtesy with Admitting	Requesting change of privileges from associate to Courtesy with admitting effective January 1, 2025	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Jithin Varghese	Emergency		Locum > Associate	Transitioning from Locum to Associate effective June 24, 2024	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Mohammed Bazarah	Women & Children	OBGYN	Locum	Requesting locum privileges effective July 1, 2024 – June 30, 2025	Dr. A. Mendlowitz	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Shawn Khan	Emergency		Locum	Requesting locum privileges for the mentorship program effective July 1, 2024 – June 30, 2026	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Andrea Martin	Community & Family Medicine		Associate	New associate physician starting July 1, 2024	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Saud Alfayez	Surgery	Orthopedics	Locum	Requesting locum tenens privileges effective July 1, 2o24 – December 31, 2024	Dr. L. Green	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Agenda

Credentialing Committee

Dr. Alexandra Allard-Coutu	Surgery		Associate	New associate physician starting July 15, 2024	Dr. L. Green	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Sebastian Vuong	Anesthesia		Locum	Requesting locum tenens privileges effective July 1, 2024 – June 30, 2025	Dr. L. Puopolo	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Melissa Hanson	Surgery		Locum	Requesting locum tenens privileges effective July 1, 2024 – June 30, 2025	Dr. L. Green	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Emily Arndt	Women & Children	Pediatrics	Associate > Courtesy with Admitting	Requesting change of privileges from **associate** to Courtesy with admitting effective January 1, 2025	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Fouad Majeed	Emergency		Locum	Requesting locum tenens privileges effective June 20, 2024 – June 19, 2025	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Babak Pourmomenarabi	Surgery	ENT	Locum	Requesting locum privileges effective July 1, 2024 – June 30, 2025, to cover Dr. Nateghifard	Dr. L. Green	☐ Recommended ☐ Recommended with comments ☒ Not Recommended No longer beginning at CMH
Dr. Andrea Martin	Community & Family Medicine		Associate	Requesting associate privileges effective June 1, 2024	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Fuad Elghamari	Emergency		Locum	Requesting extension of locum privileges from July 1, 2024 to December 31, 2024	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Agenda

Credentialing Committee

Dr. Cecile Davey	Women & Children	Pediatrics	Courtesy with Admitting	New physician starting July 1, 2024	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Kirk Roth	Surgery	Urology	Active	Resignation of privileges effective September 1, 2024	Dr. L. Green	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Jatinder Juss	Internal Medicine		Locum	Requesting extension of locum privileges effective July 1, 2024 – June 30, 2025	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Tianyang Dai	Internal Medicine		Locum	Requesting extension of locum privileges effective July 1, 2024 – June 30, 2025	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Kaiser Quereshy	Surgery	Regional ENT	Locum	Requesting extension of locum privileges effective July 1, 2024 – June 30, 2025	Dr. L. Green	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Hasaan Chaudhry	Surgery	Spine Surgeon	Locum	Requesting extension of locum privileges effective July 1, 2024 – June 30, 2024	Dr. L. Green	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Preveshen Moodley	Surgery	Regional Urology	Locum	Requesting extension of locum privileges effective July 1, 2024 – June 30, 2025	Dr. L. Green	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Guarav Vasisth	Surgery	Regional Urology	Locum	Requesting extension of locum privileges effective July 1, 2024 – June 30, 2025	Dr. L. Green	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Abdulrhman Emsalem	Internal Medicine		Locum	Requesting extension of locum privileges effective July 1, 2024 – June 30, 2025	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Agenda

Credentialing Committee

Dr. Abdurraouf Elbueishi	Internal Medicine		Locum	Requesting extension of locum privileges effective July 1, 2024 – June 30, 2025	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Mohammed Farooqi	Internal Medicine		Locum	Requesting extension of locum privileges effective July 1, 2024 – June 30, 2025	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Avijeet Sarker	Internal Medicine		Locum	Requesting extension of locum privileges effective July 1, 2024 – June 30, 2025	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Yo Han Kevin Um	Internal Medicine		Locum	Requesting extension of locum privileges effective July 1, 2024 – June 30, 2025	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Dan Kottachchi	Internal Medicine		Locum	Requesting extension of locum privileges effective July 1, 2024 – June 30, 2025	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Matthew Feldman	Pediatrics	Endocrinology	Locum	Requesting extension of locum privileges effective July 1, 2024 – December 31, 2025	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Emily Slusarek	Women & Children	Midwifery	Locum	Requesting extension of locum privileges effective July 1, 2024 – December 31, 2024	C. Witteveen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Keith Hankinson	Community and Family Medicine		Active	Retiring May 31, 2024 – not renewing privileges	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. David Arnott	Community and Family Medicine		Active	Not renewing privileges for 2024-2025	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Agenda

Credentialing Committee

Dr. Harpreet Arora	Community and Family Medicine		Affiliate	Not renewing privileges for 2024-2025	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Shefali Arora	Community and Family Medicine		Affiliate	Not renewing privileges for 2024-2025	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Sharon Bal	Community and Family Medicine		Active	Not renewing privileges for 2024-2025	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Victor Cherniak	Community and Family Medicine		Active	Not renewing privileges for 2024-2025	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Kathryn Bennett	Community and Family Medicine		Affiliate	Not renewing privileges for 2024-2025	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Paula Carere	Community and Family Medicine		Affiliate	Not renewing privileges for 2024-2025	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Randy Davis	Community and Family Medicine		Affiliate	Not renewing privileges for 2024-2025	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Jeff Main	Community and Family Medicine		Affiliate	Retired and will not be renewing privileges		☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Annada Pandey	Community and Family Medicine		Affiliate	Not renewing privileges for 2024-2025	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Agenda

Credentialing Committee

Dr. Alexandra Pennell	Community and Family Medicine		Affiliate	Not renewing privileges for 2024-2025	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Dana Pennell	Community and Family Medicine		Affiliate	Not renewing privileges for 2024-2025	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Laura Siddall	Community and Family Medicine		Affiliate	Not renewing privileges for 2024-2025	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Beth Vallieres	Community and Family Medicine		Active	Not renewing privileges for 2024-2025	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Kathryn Walker	Community and Family Medicine		Active	Not renewing privileges for 2024-2025	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Adam Wilson	Community and Family Medicine		Affiliate	Not renewing privileges for 2024-2025	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Andrew Worster	Community and Family Medicine		Affiliate	Retired and will not renew privileges	Dr. T. Holling	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Nicholas McFarlane	Surgery	Regional Urology	Courtesy with Admitting	Retired May 31, 2024	Dr. L. Green	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Diana Doe	Women & Children	Midwifery	Active	Not renewing privileges for 2024-2025	C. Witteveen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Agenda

Credentialing Committee

Julia Heyens	Women & Children	Midwifery	Active	Not renewing privileges for 2024-2025	C. Witteveen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Beverly Langlois	Women & Children	Midwifery	Active	Resignation of privileges March 31, 2024	C. Witteveen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Richard Clarke	Emergency		Active	Resignation of privileges effective April 1, 2024	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Michael Lim	Emergency		Courtesy with admitting	Not renewing privileges for 2024-2025	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Johannes Redelinghuys	Emergency		Active	Not renewing privileges for 2024-2025	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. James Gowing	Oncology		Senior Emeritus	Not renewing privileges for 2024-2025	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Nori Frape	Oncology		Senior Emeritus	Not renewing privileges for 2024-2025	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

2024-25 E-Reappointment Applications for Approval

Department of Medicine

Bishara Phoebe Affiliate

_____ _____ _____

Dr. J. Legassie, Chair
Credentials Committee

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

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

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Agenda

Credentialing Committee

S. Pearsall, Vice President Clinical Programs & CNE

Dr. B. Courteau, Treasurer Medical & Professional Staff Association

Corine Witteveen, Chief of Midwifery
MAC Member

_____

Dr. W. Lee, Chief of Staff and Diagnostic Imaging
MAC Member

BRIEFING NOTE

Date: September 11, 2024
Issue: MAC Credentials & Privileging August 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 August 2024

Recommendation/Motion

Board

WHEREAS due diligence was exercised in reviewing the following privileging applications from the August 2024 Credentials Committee and upon the recommendation of the MAC, that the Board approves the following privileging applications.

MAC

That, the Medical Advisory Committee recommends to the Board of Directors that the standard credentialing files be approved. None Opposed, Motion **CARRIED.** The attached Briefing Note provided to the Committee will be noted as well as any further commentary or discussion that is necessary.

MOTION that the new credentialing files be approved as distributed. None opposed. **CARRIED.**

Executive Summary

The Medical Advisory Committee (MAC) reviewed the credentials and privileging files for August 2024 at the September 11, 2024 MAC meeting.

Agenda

Credentialing Committee

Credentialing Files for Review August 2024

Date of Meeting: August 15, 2024

MAC Meeting Date: September 11, 2024

Board of Directors Meeting Date: October 2, 2024

New Business:

Credentialing Files for Review:

Name	Department	Specialty	Appointment	Reason	Supervisor	Recommended/ Not Recommended
Dr. Prima Moinul	Surgery	Ophthalmology	Locum	Requesting extension of locum privileges effective July 22, 2024 – June 30, 2025	Dr. L. Green	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Mashael Alhrbi	Diagnostic Imaging		Locum	Requesting extension of locum privileges effective July 1, 2024 – June 30, 2025	Dr. I. Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Eric Durrant	Diagnostic Imaging		Locum	Requesting extension of locum privileges effective July 1, 2024 – June 30, 2025	Dr. I. Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Juliana Duffy	Emergency		Locum	Requesting extension of locum privileges effective July 1, 2024 -September 1, 2024	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Kedar Patil	Diagnostic Imaging		Locum	Requesting extension of locum privileges effective July 1, 2024 – June 30, 2025	Dr. I. Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Paul Joonchul Yoon	Diagnostic Imaging		Locum	Requesting extension of locum privileges effective Aug 15, 2024 – June 30, 2025	Dr. I. Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Agenda

Credentialing Committee

Dr. Milton Wybenga	Anesthesia		Locum	Requesting extension of locum privileges effective July 1, 2024 – June 30, 2025	Dr. L. Puopolo	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Khalid Tahir	Internal Medicine		Locum	Requesting extension of locum privileges effective August 29, 2024 – June 30, 2025	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Rehman Jinah	Internal Medicine		Locum	Requesting extension of locum privileges effective July 1, 2024 – June 30, 2025	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Trevor Semplonius	Internal Medicine		Locum	Requesting extension of locum privileges effective June 24, 2024 – June 30, 2025	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Samantha Shiplo	Women & Children	OBGYN	Locum	Requesting locum tenens privileges effective July 1, 2024 – June 30, 2025	Dr. A. Mendlowitz	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Sarion Street	Women & Children	Midwifery	Locum	Requesting locum tenens privileges effective July 1, 2024 – December 31, 2025	C. Witteveen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Yuan (Helen) Zhao	Surgery	Surgical Assist	Locum	Requesting extension of locum privileges effective July 7, 2024 – June 30, 2025	Dr. L. Green	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Andrew Stewart	Women & Children	OBGYN	Locum	Requesting locum tenens privileges effective July 19 – July 22, 2024	Dr. A. Mendlowitz	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Agenda

Credentialing Committee

Dr. Andrew Stewart	Women & Children	OBGYN	Locum	Requesting locum tenens privileges effective August 22-23, 2024	Dr. A. Mendlowitz	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Vivian Corner	Women & Children	Pediatrics	Courtesy > Active	Requesting transition of privileges from Courtesy to Active.	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Deborah Butler	Women & Children	OBGYN	Active	Requesting medical leave of absence effective -July 23, 2024, for approximately 2 months.	Dr. A. Mendlowitz	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Hamid Nasser	Surgery	Surgical Assist	Locum	Requesting extension of locum tenens privileges effective July 1, 2024 – June 30, 2025	Dr. L. Green	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Alexa Chidiac	Women & Children	Midwifery	Active	Requesting maternity leave effective October 1, 2024 – September 30, 2025	C. Witteveen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Alexandra Munn	Surgery	Orthopedics	Locum	Requesting extension of locum tenens privileges from September 1, 2024 – August 31, 2025	Dr. L. Green	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Prabhpreet Hundal	Women & Children	OBGYN	Locum	Requesting locum tenens privileges effective August 2, 2024 – July 31, 2025	Dr. A. Mendlowitz	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Asra Varind	Women & Children	Midwifery	Locum	Requesting locum tenens privileges effective August 9, 2024 – July 31, 2025	C. Witteveen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Agenda

Credentialing Committee

Dr. Alexander Quinlan	Emergency		Locum	Requesting locum tenens privileges effective August 9, 2024 – July 31, 2025	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

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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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Dr. S. Pearsall, Vice President Clinical Programs & CNE

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Dr. B. Courteau, Treasurer Medical & Professional Staff Association

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Corine Witteveen, Chief of Midwifery
MAC Member

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Dr. W. Lee, Chief of Staff and Diagnostic Imaging
MAC Member