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

March 6, 2024

1700

Hybrid: Teams / C.1.229 Meeting Room

Click here to join the meeting

Or call in (audio only)

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

Phone Conference ID: 273 344 35#

CAMBRIDGE MEMORIAL HOSPITAL

AGENDA

Agenda Item * indicates attachment / TBC – to be circulated	Page #	Time	Responsibility	Purpose
1. CALL TO ORDER		1700		
1.1 Territorial Acknowledgement				
1.2 Welcome				
1.3 Confirmation of Quorum (7)			N. Melchers	Confirmation
1.4 Declarations of Conflict			N. Melchers	Declaration
1.5 Consent Agenda *(Any Board member may request that any item be removed from this consent agenda and moved to the regular agenda)*			N. Melchers	Motion
1.5.1 Minutes of February 7, 2024*	3			
1.5.2 Board Attendance Report*	11			
1.5.3 Events Calendar*	12			
1.5.4 Board Work Plan*	14			
1.5.5 2023/24 Board of Directors Action Log*	21			
1.5.6 MAC Report to the Board of Directors* (February 14, 2024)	22			
1.5.7 Quality Committee Report to the Board of Directors* (February 21, 2024)	26			
1.5.8 Governance Committee Report to the Board of Directors* (February 21, 2024)	29			
1.5.9 Governance Policy Summary* Policies for Approval: (track changes version found in Package 2) 1-C-02 Legislative Compliance 1-C-20 Reporting on Compliance 2-D-21 Staff Member Recruitment to Quality Committee	31			
1.5.10 Capital Projects Subcommittee Report to the Board of Directors* (February 26, 2024)	41			
1.5.11 Resources Committee Report to the Board of Directors* (February 26, 2024)	43			
1.5.12 Corporate Strategic and Operational Priorities Q3 Update & Quality Monitoring Scorecard*	45			
1.5.13 Q3 CEO Certificate of Compliance*	75			
1.5.14 CMH President & CEO Report*	76			
1.6 Confirmation of Agenda			N. Melchers	Motion
2. NEW BUSINESS				

Agenda Item * indicates attachment / TBC – to be circulated	Page #	Time	Responsibility	Purpose
2.1 2024 Quality Improvement Plan (QIP)*	81	1705	L. Barefoot	Motion
2.2 2022-27 Quality and Patient Safety Plan*	91	1715	L. Barefoot	Motion
2.3 January 2024 Financial Statements and Year End Forecast*	103	1725	L. Woeller	Motion
2.4 ONCA Legislation – Audit Committee Terms of Reference*	112	1730	M. Lauzon	Motion
2.5 MAC Credentials & Privileging January 2024*	122	1735	Dr. W. Lee	Motion
3. UPCOMING EVENTS		1740	N. Melchers	Information
3.1 Board Education – Unconscious Bias, April 6, 2024, CMH Further Details to Follow				
3.2 Career Achievement Event – April 22, 2024 2:30-4:00pm Speech @ 3:00pm – Further details to follow				
3.3 CMH MRI Walk from Cambridge to Paris, June 9, 2024, https //www justgiving com/fundraising/sara-alvarado				
3.4 CMH Golf Classic, June 2024, Galt Country Club, details to follow				
4. PRESENTATIONS				
4.1 None				
5. DATE OF NEXT MEETING	Wednesday May 1, 2024 Location: Hybrid			
6. ADJOURNMENT		1741	N. Melchers	Motion

AGENDA

Cambridge Memorial Hospital
BOARD OF DIRECTORS MEETING
Wednesday, February 7, 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 February 7, 2024 at 1700h.

Present:

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

Regrets: V. Miropolsky

Staff Present: S. Beckhoff, M. Iromoto

Guests:

Recorder: S. Fitzgerald

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1. **CALL TO ORDER**
N. Melchers, called the meeting to order at 1700 hours.

1.1. **Territorial Acknowledgement**
P. Brasil presented the Territorial Acknowledgement and shared personal reflections. N. Melchers noted that going forward Directors will be able to sign up to read the Territorial Acknowledgement at future meetings. The sign-up sheet will be available to Directors via the Board portal.

ACTION: S. Fitzgerald to email link to the sign-up sheet and updated Territorial Acknowledgement guidelines for Board of Directors and non-Director Committee members.

1.2. **Welcome**
N. Melchers welcomed the Board members to the meeting.

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

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

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

The consent agenda was approved as presented:

1.5.1 Minutes of December 6, 2023
1.5.2 Board Attendance Report
1.5.3 CMH President & CEO Report
1.5.4 Board Work Plan
1.5.5 2023/24 Board of Directors Action Log
1.5.6 Quality Metrics Scorecard
1.5.7 2023/24 Events Calendar
CARRIED (Dean/Tulsani)

ACTION: CMH Management to add a section at the bottom of the Board Work Plan to include commentary to items that are noted as delayed.

1.6. **Confirmation of Agenda**

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

2. PRESENTATIONS

2.1. Accreditation 2023 – Final Update

The Board reviewed the pre-circulated presentation provided in the agenda package. M. Iromoto highlighted key items from the presentation.

M. Iromoto reported that CMH has achieved exemplary standing in its accreditation process, meeting 99.7% of the criteria. However, there are currently four standards that remain unmet. CMH has until May 2024 to furnish Accreditation Canada with evidence for addressing the three high-priority standards.

The delay in finalizing the business continuity plan is attributed to resource constraints necessary for documentation and ongoing work. Despite this delay, CMH Management expresses confidence in submitting evidence of progress before the May deadline, although full completion within that timeframe may not be feasible. Discussions with Accreditation Canada have assured CMH that this delay will not impact their exemplary standing award.

During discussions, a member raised a question about the organizational aspects pertinent to succession planning, particularly emphasizing the necessity for redundancy plans for critical roles and functions. It was highlighted by M. Iromoto that while some documentation about this aspect already exists within CMH, there is a need to expand on it. Accreditation Canada provided examples such as departmental roles like Director of HR, rather than solely focusing on critical management roles. Therefore, an opportunity exists for CMH to enhance its succession and contingency planning in this area.

Another member suggested adding the accomplishment of received exemplary standing with Accreditation Canada to outgoing email signatures. P. Gaskin noted that CMH discourages against co-branding.

ACTION: CMH Management to follow up with the Manager of Communications for further confirmation / discussion.

3. BUSINESS ARISING

There were not items for discussion.

4. NEW BUSINESS

4.1. Chair's Update

4.1.1. Board Report

The Board reviewed the Board report that was pre-circulated in the meeting package. N. Melchers thanked the Directors who have taken part in training, education, and hospital events.

4.1.2. December 2023 Board Evaluation Results

The Board reviewed the feedback that was provided from the February 2024 meeting. N. Melchers noted that only two Directors completed the survey. The Directors were reminded of where access to the link to the survey could be found and were encouraged to ensure participation as the feedback is valuable to the Board.

4.1.3. Policy 2-C-40 Capital Projects – Change Order Approval Policy

N. Melchers updated the Board that an amendment to policy 2-C-40 has been made to state that the Board oversees the change order process specifically that the Board is to be informed once the change order budget exceeds 75%.

4.2. Governance Committee

No items for discussion. The next Governance Committee meeting is scheduled for February 21, 2024

4.3. Quality Committee

4.3.1. Report to the Board of Directors

D. Wilkinson provided the Board with highlights from the January 17, 2024 Quality Committee meeting as outlined in the pre-circulated briefing notes. D. Wilkinson highlighted that during the medical daycare quality presentation, attention was drawn to a risk associated with the electronic medical record system, known as Opus, within the oncology suite. Specifically, this system, utilized by physicians for chemotherapy orders, is being phased out by the Grand River Regional Cancer Center. Consequently, a transition to a new platform is imminent, potentially leading to a service gap. Staff are actively collaborating with Grand River to devise a solution, recognizing that this change affects not only CMH's system but also other satellite cancer centers like Guelph and Louise Marshall.

Acknowledging the risk to patient care, the Quality Committee emphasized the need for a timeline and progress reporting on the senior's friendly report, which has now been incorporated the report. Additionally, during discussions on our quality improvement plan, various indicators were thoroughly examined, with more developments anticipated.

Furthermore, a never event reporting webinar, organized by the ministry, was attended by several staff members and D. Wilkinson. However, concerns were raised about the standardized template's inability to capture unique details, leading us to postpone participation until the process is refined.

During discussions, a member raised a question about the talks about introducing a multidisciplinary transgender health mobile clinic and the timelines associated

with that. S. Pearsall noted that the team is actively pursuing community involvement through incremental steps, focusing on grassroots engagement. Dr. Kevin, an endocrinologist, is expected to play a key role in this initiative, alongside Doctors Sharma and Wadsworth, as well as other enthusiastic team members. Despite scheduling challenges, they stay committed to maintaining connections with community partners like Langs and supporting initiatives such as the grassroots summit. Dr. McKenzie is leading grassroots efforts to enhance existing healthcare services, particularly in surgical, medical, and psychiatric fields. Conversations with community members have emphasized the significance of their work, driving their commitment to consolidating services for improved access. They are optimistic about future prospects, scheduling meetings to review summit outcomes and plan next steps, while also organizing internal hospital meetings for further collaboration, potentially on the 26th or 27th.

Another member inquired about the possibility of some Ontario hospitals issuing a statement of support of the transgender community related to the legislative changes in Alberta. P. Gaskin thanked the member for their inquiring and noted that CMH has a robust process in place addressing how and when CMH comments on social issues. CMH Management will bring this forward to the Manager of Communications.

A robust discussion took place around the deliverables that have been put in place on the Senior Friendly Action Plan. S. Pearsall noted that CMH will continue to provide a level of care to seniors that is exceptional.

4.4. **Audit Committee**

4.4.1. **Report to the Board of Directors**

M. Hempel provided the Board with highlights from the January 22, 2024 Audit Committee meeting as outlined in the pre-circulated briefing notes. M. Hempel noted that the audit committee had begun to start preparations for this year's audit in collaboration with KPMG. Initial discussions centered around KPMG's audit strategy and anticipated risks, which remained consistent with previous years, focusing on funding and potential ministry-related implications. No new risks were identified, aligning the audit closely with the previous year's plan. Concerns were raised about the audit process, particularly whether auditors would conduct on-site visits, but it was clarified that most of the audit is conducted electronically between the finance team and KPMG, ensuring data security through secure methods. Fee negotiations for the audit, agreed upon over a five-year plan, remained consistent for this year, with the auditor confirming no independent issues. Additionally, the committee discussed challenges posed by ONCA's bill in October, requiring audit committee and board members to meet certain criteria, prompting ongoing review by governance to provide recommendations to address the implications for the committee's composition.

4.5. **Capital Projects Sub-Committee**

No items for discussion. The next Capital Projects Sub-Committee meeting is scheduled for February 26, 2024

4.6. **Resources Committee**

No items for discussion. The next Resource Committee meeting is scheduled for February 26, 2024

4.7. **Executive Committee**
No items for discussion. The next Executive Committee meeting is scheduled for March 12, 2024

4.8. **Medical Advisory Committee**

4.8.1. **MAC Credentials & Privileging December 2023**
Credentialing files were pre-circulated in the package.

MOTION: Whereas due diligence was exercised in reviewing the following privileging applications from the October 2023 Credentials Committee and upon the recommendation of the MAC, that the Board approves the following privileging applications. (Alvarado/Conway) **CARRIED.**

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

Dr. Mazin Al-Battran	Psychiatry		Locum	Requesting extension of locum privileges from November 3, 2023 – May 30, 2024	Dr. A. Sharma	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Yeshale Chetty	Emergency		Locum	Requesting extension of locum privileges from November 3, 2023 – December 31, 2023	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Laura Duncan	Emergency		Locum	Requesting extension of locum privileges from November 3, 2023 – December 31, 2023	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Jithin Varghese	Emergency		Locum	Requesting extension of locum privileges from November 3, 2023 – December 31, 2023	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Ashifa Jiwa	Emergency		Locum	Requesting extension of locum privileges from November 3, 2023 – May 30, 2024	Dr. M. Runnalls	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Julia Heyens	Women & Children	Midwife	Active	Requesting parental leave from October 2, 2023, for undetermined length of time	C. Witteveen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Mitra Sadeghipour	Women & Children	Midwife	Active	Resignation of privileges effective September 29, 2023	C. Witteveen	☒ Recommended ☐ Recommended with comments

						☐ Not Recommended
Krysta Barclay	Women & Children	Midwife	Active	Requesting leave of absence from February 1, 2024 – January 31, 2024	C. Witteveen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Brenda Dong	Women & Children	Midwife	Associate	Resignation of privileges effective February 5, 2024	C. Witteveen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Anupam Batra	Internal Medicine	Oncology	Active	Resignation of privileges effective December 30, 2023	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. L. Green	Surgery		Active	Requesting medical leave from call effective October 20, 2023 for approximately 6-8 weeks.	Dr. W. Lee	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

4.8.2. **MAC Report to the Board of Directors**

Dr. W. Lee provided the Board with highlights from the December 4, 2023 & January 10, 2024 MAC meeting as outlined in the pre-circulated briefing notes. Dr. W. Lee shared a special award received on behalf of CMH – "McMaster Regional Assistant Dean Award for Excellence in Medical Education" for 2023 in November. It really highlighted everyone's work to embrace and support the growth of medical education at CMH. In 2023, CMH hosted 138 medical learners across nine different Departments. More recently, McMaster Waterloo Regional Campus Clinical Education Committee hosted their meeting for the first time in the new Wing A of CMH, with positive feedback on the welcoming space and rich resources for medical learners at CMH. Dr. W. Lee also celebrated Dr. Tasha Stoltz, a CMH Pediatrician who received an award for Excellence in Undergraduate Teaching at McMaster Waterloo Regional Campus.

4.9. **PFAC Update**

N. Melchers provided highlights from the February 6, 2024 PFAC meeting. The Committee received a presentation on the rapid improvement event for ED that took

place at CMH on January 29, 2024. N. Melchers thanked P. Brasil for taking part in the event. PFAC reviewed the Quality and Safety Plan. This plan will be brought to the Board of Directors in March for final approvals.

4.10. **CEO Update**

4.10.1. **2023-24 Muli-Sector Service Accountability Agreement (M-SAA)**
On January 17, 2024, the Ontario Health (OH) provided the 2023/24 Multi-Sector Service Accountability Agreement (M-SAA) for CMH review and signature by January 31, 2024. The M-SAA has been signed and submitted by the due date.

MOTION: Following review and discussion of the information provided, the Board of Directors approves the 2023-24 Multi-Sector Service Accountability Agreement (M-SAA). (Woeller/Hempel) **CARRIED.**

4.10.2. **New CMH Website**
P. Gaskin noted that the new CMH website is up and running. Kudos was given to the team for their efforts and hard work on this project.

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

6. DATE OF NEXT MEETING
The next scheduled meeting is March 7, 2024

7. ADJOURNENT
The meeting adjourned at 1755h. (McKinnon)

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

Date of Meeting

Last 12 Months

2/24/2023 - 2/23/2024

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, February 07, 2024	P	P	P	T	P	T	T	P	P	P	P	T
Wednesday, December 06, 2023	P	P	P	P	P	P	P	R	P	R	P	T
Wednesday, November 01, 2023	T	T	T	T	R	R	T	T	T	T	T	T
Wednesday, October 04, 2023	P	P	P	T	T	T	P	T	P	P	P	T
Tuesday, July 18, 2023	T	T	T	T	T	T	T	T	T	T	T	T
Wednesday, June 28, 2023		P		P	P	T	P	P	P		P	P
Wednesday, May 24, 2023		T		T	T	T	T	T	T		T	T
Wednesday, April 26, 2023		T		T	P	P	T	T	P		P	R
Wednesday, March 01, 2023		T		T	T	R	T	T	T		T	T

Name	Attendance Rate
Bill Conway	100 %
Diane Wilkinson	100 %
Jay Tulsani	100 %
Julia Goyal	100 %
Lynn Woeller	89 %
Margaret McKinnon	78 %
Miles Lauzon	100 %
Monika Hempel	89 %
Nicola Melchers	100 %
Paulo Brasil	80 %
Sara Alvarado	100 %
Tom Dean	89 %

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

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

Board/Committee Meetings and Event Dates	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep (2024)
2023-24 Events													
Staff Holiday Lunch - December 7, 2023 11am-2pm / 6-8pm				15									
Career Achievement - April 22, 2024 2:30-4:00pm								13					
Chamber Business Awards - November 13, 2023			13										
CMHF Diversity Dinner – October 3, 2023		3											
CMH Staff BBQ - TBD													
CMH Golf Invitational - TBD													
CMH Reveal - February 29, 2024						29							
Board Education Opportunities													
Governors Education Sessions													
Governance Essentials for New Directors - *Paulo Brasil/Jay Tulsani/Bill Conway*													
Hospital Legal Accountability Framework		3											
Hospital Accountability Within the Health System		10											
Governance and Management - The Crucial Partnership		24											
CMH Leadership Learning Lab													
• *Project Management for the Unofficial PM*									3				
• *Crucial Conversations*			15/16						14/15				
• *7 Habits of Highly Effective People - Nicola Melchers*				5/8									
• *Me2You DISC Profile - Diane Wilkinson*							12						
• *Quality Improvement*		6											
• *Guiding Organizational Change - Lynn Woeller*		11											
• *5 Choices*													
• *Unconscious Bias*								6					
Mental Health First Aid													

BOARD WORK PLAN – 2023-24

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

✓ = Due ND = Not Due C = Complete I = In progress D = Delayed 1 March 2024

BOARD WORK PLAN – 2023-24

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

✓ = Due ND = Not Due C = Complete I = In progress D = Delayed 1 March 2024

BOARD WORK PLAN – 2023-24

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

✓ = Due ND = Not Due C = Complete I = In progress D = Delayed 1 March 2024

BOARD WORK PLAN – 2023-24

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

✓ = Due ND = Not Due C = Complete I = In progress D = Delayed 1 March 2024

BOARD WORK PLAN – 2023-24

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

✓ = Due ND = Not Due C = Complete I = In progress D = Delayed 1 March 2024

BOARD WORK PLAN – 2023-24

ON GOING AS NEEDED

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

✓ = Due ND = Not Due C = Complete I = In progress D = Delayed 1 March 2024

BOARD WORK PLAN – 2023-24

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

Charter Section #4	Charter Item	Action *(Italics-comments)*	Committee Responsible
j-i-A	Communication and Community Relationships	Establish processes for community engagement to receive public input on material issues	Board oversight Led by CEO
j-i-B	Communication and Community Relationships	Promote effective collaboration and engagement between the Corporation and its community, particularly as it relates to organizational planning, mission and vision	Board oversight Led by CEO/COS and Chair
j-i-C	Communication and Community Relationships	Work collaboratively with other community agencies and institutions in meeting the healthcare needs of the community	Board oversight Led by CEO/COS Quality
j-i-D	Communication and Community Relationships	Maintain information on the website	Board oversight Led by CEO
j-i-E	Communication and Community Relationships	Establish a communication policy for the Corporation; review periodically (2-D-11 – reviewed April 2019, next review 2022)	Board oversight Led by CEO
m	Communications Policy	Oversee the maintenance of effective stakeholder relations through the Corporation's communications policy and programs (updated communication plan (2020-2023) to be approved by Board in 2021)	Board oversight Led by CEO

DELAYED

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

AGENDA

2023/24 Board of Directors Action Log – 06-03-2024

Meeting Date	Agenda # / Item Description	Action Item	Owner	Status
25-01-2023	3.1.1 – Committee and Staff appointments	Governance to complete a policy review/update as it relates to staff & Community appointments, specifically when they occur outside of the regular appointment process	P. Gaskin	Will be brought to Governance at a future meeting
01-03-2023	3.9 – Foundation Events	Management to review and include the recommendation in the Board Policies	P. Gaskin	Will be brought to Governance at a future meeting
26-04-2023	4.10 – CND OHT Mental Health & Addictions Clinic	Management to review the data points that will be reviewed through the CND OHT evaluation process	P. Gaskin	In progress
06-12-2023	1.5.3 Policy Approvals	2-A-15 & 2-C-40 to be brought back to the Board for review and revision if, upon completion of the Capital Redevelopment Project Sub-Committee is disbanded as of June 2024	P. Gaskin	Will be brought to the Board if needed for review June 2024
06-12-2023		ABCDE Goals to track by % complete	P. Gaskin	Management will look to update the process / tracking systems
07-02-2024	1.1 Territorial Acknowledgement	Sign up sheet for Board to read the Territorial Acknowledgement & Updated Guidance Documents posted to Board Portal	S. Fitzgerald	Completed – Sign up sheet & guidance document found in the Resources section of the Board Portal
07-02-2024	Board Work Plan	Section at the bottom of the work plan to include commentary on delayed items	S. Fitzgerald	Completed
07-02-2024	Accreditation 2023	CMH Management to follow up with Manager of Communications for discussion/confirmation of adding accreditation to email signatures	P. Gaskin	Completed

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

AGENDA

BRIEFING NOTE

Date: February 14, 2024
Issue: MAC Report to the Board of Directors February 2024 OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Dr. Winnie Lee, Chief of Staff
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: None Attached

Alignment with 2023/24 CMH Priorities:

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

A meeting of the Medical Advisory Committee took place on Wednesday February 14, 2024, at 4:30 pm.

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

Committee Matters – For information only

1. **M&T Report:** The January M&T report was approved by MAC **(Legassie, Puopolo)**

2. **COVID-19 and Infectious Disease Update**
Dr. K. Nuri provided a COVID-19 and infectious disease update. There has been overall improvement in COVID-19 and flu prevalence. No COVID-19 outbreaks at CMH and low number of COVID-19 outbreaks in the community (i.e. LTC). Flu vaccines are still encouraged.

3. MD# 601 Perflutren (Definity ®) for Contrast Echocardiography
Dr. R. Matiasz, ECHO Lead at CMH, provided a summary of the updates to Medical Director #601. Contrast Echocardiography is currently performed with updates primarily on the inclusion criteria and administration technique of multi-use vial rather than single vial use. The Medical Directive was approved at MAC **(Holling, Nguyen).**

4. Quality & Patient Safety Plan
L. Barefoot presented the Quality and Patient Safety Plan 2022-2027. The plan focuses on four priorities of Just Culture, Robust Processes and Frameworks, Medication Safety, and Safe Transitions. The plan anchors on other corporate plans (DEI Plan, Patient Experience Plan, Digital Health Plan, and Employee and Physician Engagement Plan). It was noted at MAC that these priority themes expand on the work done previously, including generative discussion and a policy on Just Culture, efforts on standards of practice and Accreditation, importance of medication safety, and using innovations and digital enablers to support safe transitions in care. MAC was welcomed to provide feedback/input beyond the MAC meeting.

5. Primary Care Network (PCN)
Dr. T. Holling, Chief of Community and Family Medicine provided a presentation on Primary Care Networks (PCNs). The Ministry of Health and Ontario Health have established a vision that PCNs will connect, integrate, and support primary care providers within Ontario Health Teams (OHTs). Initial clinical priorities of PCNs include (a) improving access and attachment to comprehensive primary care (b) implementation of integrated chronic disease prevention, and (c) management and implementing additional local priorities. PCNs should represent family physicians and nurse practitioners at a minimum. PCNs aim to provide organized collective influence, improved connections, formalized opportunities to shape and inform integrated clinical and digital solutions for primary care providers through PCNs. Anticipated benefits of PCNs include clinical, political and wellness opportunities. For example, partnering to decrease ALC pressures, ED diversion, home care re-design, additional funding (i.e. team-based resources, SCOPE, LTC+), healthier and safer patient and provider transitions, recruitment, and retention of primary care with work options outside of the office setting (i.e. hospitalist, LTC, surgical assist). Primary care physicians in CND are coming together to deliberate on primary care self-organization of a PCN in our OHT on February 29, 2024. Primary Care Connection, a resource hub and questions/comment site, has been established for primary care physicians. Readiness activity, including advocacy to identify enablers for PCN success in the CND-OHT has begun.

6. Quality Presentation (Ambulatory Clinics & Medical Day Care)
Dr. A. Nguyen provided highlights from the Medical Day Care and Ambulatory Care presentations from the Quality Committee of the Board. The Ambulatory Care clinics include The Regional Liver Health Clinic, Neurology Clinic, Infectious Disease Clinic, Community Based Medicine Clinic, Seniors Health Clinic, and Orthopedic Assessment Clinic. There has been growth in many of the clinics. For instance, the regional health liver clinic has expanded to 5 days a week with recruitment of an additional hepatologist and nurse to support the volumes. As well, with the establishment of EEG services in the Neurology clinic, there are plans to include EMG services although specialized technologists have been a challenge to recruit. Dr. Nguyen also highlighted there has been changes in the oncology department with Dr. A. Batra moving his practice from CMH to a full-time position at GRH. CMH has recruited an experienced Oncologist who is currently working at Sunnybrook and will be starting February 20, 2024, at CMH. One of the oncology associates and one of the oncologists will be co-leads for the Oncology Division following Dr. A. Batra's departure from CMH.

7. Clinical Decision Support on Ocean e-Referral at CMH

Dr. W. Lee provided a briefing note in the MAC package. CMH is an early adopter of e-Referral Ocean Portal, as the beta site for the platform almost 10 years ago. In collaboration with e-Health Centre of Excellence, CMH Diagnostic Imaging (DI) department has expanded and will be launching a new Clinical Decision Support (CDS) tool in the Ocean e-Referral for DI requisitions, specifically focused on the new Canadian Association of Radiologists (CAR) "Palpable Breast Mass" June 2023 guidelines. CMH will be the first hospital launching this CDS tool, an addition to the current ones for Headache, Knee Pain, Low Back Pain, and Hip Pain. The CAR Palpable Breast Mass CDS tool on CMH's Ocean e-Referral site will be go-live at end of February 2024. eHealth Centre of Excellence and CMH DI Department will be monitoring quality metrics centered on appropriateness of referrals pre-and post-implementation of the CDS tool, especially across the various reasons for the referral and the different breast scenarios related to the guidelines.

8. Diagnostic Imaging Ultrasound Expansion of Hours

Dr. W. Lee and Dr. I. Isupov shared a recent Memo that was circulated to the DI and Emergency Department staff and physicians. In support of patient flow and access, there has been a collaborative effort to develop a phased approach to introducing expanded ED Ultrasound hours beginning March 4, 2024. US services will be expanding up to 2300 on weekdays, with maintenance of the ad-hoc sonographer on-call system from 2300-0700.There will be ongoing plans to improve ED US access. Expanded ED US hours may have impacts for some specialties on-call (i.e. obstetrics/gynecology, medicine, surgery).

9. CEO Report

P. Gaskin sent regrets to February 2024 MAC and the CEO report was pre-circulated in the MAC package as part of the consent agenda.

10. CNE Report

S. Pearsall's CNE report was pre-circulated in the MAC package. Highlights of the briefing note was provided to MAC:

- Access and flow have been top of mind across the organization. There was a recent rapid improvement event in the ED Subacute zone. Dr. Runnalls and Dr. Gill were instrumental with their participation in the event. Continued monitoring of the changes and early data suggests small improvements in the ED metrics. A similar rapid improvement event on ambulance off-loads is scheduled on February 21, 2024. The Board is focused on the ED metrics with a recent presentation by Dr. Runnalls and D. Didimos (ED Director) to provide reassurances on the mitigation strategies.
- Ongoing quality improvements in Diagnostic Imaging and continued attention to the wait times across various modalities. Multiple staff members have demonstrated interest in available Surgical Innovation Fund to support educational opportunities. The new Nuclear Medicine space will be opening in the next week. CMH is also now the host of the Regional DI Council for the next 2 years.

-New blood analyzers in the Lab arriving

-Medicine occupancy consistently over 100% with great efforts by the Hospitalist team to attend to complex patients and discharges.

-Dr. Sharma and the Psychiatry team have increased service offering with outpatient ECTs. The volumes of ECTs have been increasing. This is a welcomed service as it was halted during the COVID-19 pandemic.

-Dr. Sawa and the surgical team performed a surgical first with a Diagonal Upper Gracilis (DUG) free flap breast reconstruction procedure – huge congratulations to Dr. Sawa and the surgical team!

11. Board Report

D. Wilkinson provided a Board update. The Board met February 7, 2024 and received the final Accreditation report and plans to address the outstanding criteria before the May deadline to Accreditation Canada. They also received a presentation on the ED as it pertains to flow and the system challenges with ALC and access to care. The Board is watching the ED metrics very closely. Digital Health updates on the HIS project, including the financial approaches to support the new system. Details of the scope for the project and the next steps will be coming to the Board. The Board is concerned about the financial strain a new HIS will have on the organization but will develop a plan to mitigate these concerns. There was also discussion on cybersecurity and insurance coverage which arose from the Audit Committee. The Quality Committee had an initial meeting to discuss the quality indicators for the 24/25 Quality Improvement Plan. Final review will be occurring at the next Quality Committee Meeting prior to going to the Board for approval. There was also discussion on the status of our ongoing collaboration with the other Waterloo Wellington Regional Hospitals. There are some governance opportunities and early discussion on general principles on this topic that was discussed at the Board.

12. PFAC Report

Dr. W. Lee provided a PFAC update. PFAC received the presentation on the Quality Patient Safety Plan, in addition to a deep dive into the workplan and priorities for the Committee in the upcoming year.

AGENDA

Agenda Item 26

BRIEFING NOTE

Date: February 22, 2024
Issue: Quality Committee Report to the Board of Directors, February 21, 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, February 21, 2024 at 0700 hours.

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

Committee Recommendations/Reports – Board Approval Sought

That, the Board of Directors approves the three (3) 2024 Quality Improvement Plan (QIP) Metrics.

That, the Board of Directors approves the 2024 Quality Improvement Plan (QIP) Narrative.

That, the Board of Directors approves the 2022-2027 Quality and Patient Safety Plan.

Approved Committee Recommendations/Motions:

MOTION: (Adair/McCarthy) **that**, the Quality Committee endorses the three (3) 2024 Quality Improvement Plan (QIP) Metrics as presented, and forward to the Board of Directors for approval. **CARRIED**

MOTION: (Gandhi/Conway) **that**, the Quality Committee endorses the 2024 Quality Improvement Plan (QIP) Narrative, with minor modifications, and forward to the Board of Directors for approval. **CARRIED**

MOTION: (Adair/Bulla) **that**, the Quality Committee endorses the 2022-2027 Quality and Patient Safety Plan as presented, and forward to the Board of Directors for approval. **CARRIED**

Committee Motions/Recommendations/Report – Board Approval Not Sought

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

MOTION: (McCarthy/Hempel) **that**, the QIP Meeting Minutes of February 7, 2024 were approved. **CARRIED**.

Committee Matters – For information only

1. **2024 Quality Improvement Plan (QIP)** and **QIP Narrative**: At the February 7, 2024 QIP planning meeting, the draft 2024 QIP Metrics and draft 2024 QIP Narrative were presented. Suggested changes were made. The Committee was reminded that the QIP is a public facing document and will be posted to CMH's external website and OH Navigator. One Committee member questioned how CMH can incorporate all its achievements and successes within the limits of QIP Narrative template. A robust discussion took place about celebrating all of CMH's achievements and sharing this information with the community. It was reported that the Accreditation Canada's Decision Letter is also posted to the CMH website and other CMH achievements are shared on social media. There were no content changes to the QIP Narrative; however, it was suggested to Management to rearrange order of paragraphs in the Narrative to emphasize achievements first (further discussion during Agenda Item 2.1).
2. **2022-2027 Quality and Patient Safety Plan**: A detailed overview was given. Priority Themes are: Just Culture, Robust Processes & Frameworks, Medication Safety, Safe Transition (further discussion during Agenda Item 2.2)
3. **Program Presentation: ED**: A program overview was provided (see Package 2). The following items where highlighted: an overview was given: ED serves a diverse community, includes all age groups, concerns, and severity; YTD, the ED has seen 37,077 visits – equivalent to 121 patients a day. This is a slight decrease from previous fiscal; 80% of those visits are CTAS 1-3; 20% of lower non-complex CTAS 4-5; Admitted patients have increased to 12% from 11% of previous fiscal; 5% are mental health visits; 6% are Left Without Being Seen (LWBS); EMS arrivals: YTD, 29.2 average/day which is a slight increase (+1.6%) from previous year of 28.7 average/day; PIA, 90% percentile: 7 hours YTD; ED Staffing includes physicians, RNS, RPNs, Clerical, PSWs, NPs, GEM, SW. It was reported that recent work has been concentrated on access, flow, and throughput. Management has recently completed an ED Subacute Rapid Improvement Event that went live January 31, 2024. The event focused on improvements using a patient experience lens from the time a patient arrives to the ED entrance to the time a patient is either discharged or admitted. The goal is to decrease PIA to 3 hours and ED length of stay to 4 hours for non-complex and 8 hours for complex visits. On-going work continues, progressing through standard work for staff. There have been some improvements since initiation. With respect to the ED's quality priorities and metrics, Management will be working with corporate communications in emphasizing the work underway to improve flow to patients and reduce wait times. Regarding recruitment, much work has been done to decrease the number of vacancies – currently at 7 vacancies from 20. Another priority is improving access of care by reducing wait times and Ambulance Off-load times. CMH is currently working with EMS partners on streamlining the off-load delays. There is a rapid improvement event with EMS today to reduce offload delay. With respect to funding, Dr. M. Runnalls has seen a provincial influx in the management of ED. One on-going project that directly impacts physicians is

the Power Initiative, where the province is participating in a three-year study to understand how ED physician time is spent and how to allocate funds. This study is scheduled to be completed in 2026.

Annual Review of Return Visit Quality Program: A short summary was provided, and action items were highlighted: 51 charts were randomly selected plus 3 sentinel charts; 10/54 audits reflected QI opportunities. Of the 10, 4 reflected opportunities in the provision of care for all frail seniors, one reflected improvement to left against medical advice/left without being seen process. The remaining 5 had varied underlying causes. The 3 sentinel charts were events where patient chose to leave against medical advice (see Package 2). **Program Presentation: Professional Practice**: A program overview was provided (see Package 2). K. Garton is new to the role of Manager; K. Garton recently co-led CMH through the Accreditation process (November 2023); Successful launch of Learning Management System (Bridge2Learnig) on January 30, 2023. This system is used for corporate and clinical on-line training, as well as a system to track in-person classes for selected training; Enhanced Extern Program – CMH has onboarded 82 clinical externs over the fiscal year; currently 62 clinical externs are working across the organization; CMH has converted 12 clinical externs to registered clinical staff; further plans to convert upcoming graduates; Clinical Scholar Program – 3 clinical scholars (in Medicine, ED and Women's & Children); Nursing Graduate Guarantee – onboarded 4 new graduate nurses; Supervised Practice Experience Program (SPEP) – 4 staff have come to CMH via the SPEP program. This program supports internationally educated nurses and their entry to practice in Ontario; Work underway with HR to draft a new Standard Operating Procedure for student conversion; J. Backler will assist in leading the clinical portion on the HIS project. The HIS Clinical Informatics Specialist is conducting a current state workflow mapping of all inpatient and ambulatory areas. 105 maps have been completed so far. The goal is to understand the current state, review of the documentation system (paper or Meditech) and workflow.

4. **Corporate/Quality Metrics**: A copy of the briefing note and Quality Monitoring Scorecard were pre-circulated to the Committee.
5. **CNE Report**: Ms. Pearsall provided clinical programs update. The full CNE report is available in package 2.

AGENDA

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: February 22, 2024
Issue: Governance Committee Report to Board of Directors February 21, 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, Miles Lauzon - Governance Committee Chair

Attachments/Related Documents:

A meeting of the Governance Committee took place on Thursday February 21, 2024 at 1700 hours.

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

Staff Present: P. Gaskin,

Regrets: J. Stecho

Committee Recommendations/Reports – Board Approval Sought

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

1-C-02 Legislative Compliance
1-C-20 Reporting on Compliance
2-C-32 Resource Protection & Liability
2-D-10 Guidance to Decision Making Process
2-D-21 Staff Member Recruitment to Quality Committee

That, the Board of Directors approves policy 2-A-10 as amended.

Approved Committee Recommendations/Motions:

MOTION: (Protich/Stewart) that, following review and discussion of the information provided, the Governance Committee of the Board recommends to the Board of Directors that the following policies be approved as amended as discussed at the meeting: **CARRIED.**

1-C-02 Legislative Compliance
1-C-20 Reporting on Compliance
2-C-32 Resource Protection & Liability
2-D-10 Guidance to Decision Making Process
2-D-21 Staff Member Recruitment to Quality Committee

MOTION: (Protich/McKinnon) that, following review and discussion of the information provided, the Governance Committee of the Board recommends to the Board of Directors the approval of policy 2-A-10 with amendments as discussed at the meeting. **CARRIED.**

Committee Motions/Recommendations/Report – Board Approval Not Sought

MOTION: (Goyal/Conway) **that,** the consent agenda be approved as circulated
- Minutes of November 7, 2023
- Committee & Board Attendance Reports
- Policy Schedule Review
- Action Log

Committee Matters – For information only.

1. **Welcome & Territorial Acknowledgement:** J. Goyal presented the Territorial Acknowledgement and shared personal reflections.
2. **Policy Reviews and Approvals:** This year the Governance committee pre-reviewed 16 CMH Board Policies prior to the beginning of the 2023/24 Board cycle. Management incorporated the feedback received as tracked changes and noted policies that require further discussion to address members questions.
3. **Board/Committee Feedback Reports Review:** The Governance Committee reviewed the feedback reports from the September and October Board and Committee meetings. There were no concerns.
4. **ONCA Legislation Updates:** The Governance Committee reviewed the Audit Committee Terms of Reference as it relates to the recent amendments to ONCA. Further information will be discussed in agenda item 2.4.
5. **Foundation Representation on Hospital Boards:** The Governance Committee reviewed the pre-circulated briefing note provided in the meeting package. In January 2024, a member of the Medium-Sized Hospital Network initiated communication with colleagues about the representation of hospital foundation members on the hospital board. 19 participants completed the survey. According to the findings, 63% of hospitals lack a foundation member who is granted a seat on the hospital board. Among those with a seat, only 21% of hospitals confer voting trustee status. Notably, 95% of hospital foundation executive directors do not occupy a seat on the hospital board. The results of the survey were shared with the CMHF.
6. **Recruitment Strategy Discussion:** The interview team met for it first meeting. Currently CMH has received 18 candidates. Discussion took place about the needs of recruitment and strategy for the 2024/25 Board cycle. Additional follow up and discussions are planned to further guide the recruitment process.
7. **Bill C-62 to Delay Expansion of MAID:** The Governance Committee reviewed the recently released OHA Letter outlining the pause on expanding medical assistance in dying (MAID). The proposed legislation aims to postpone the extension of medical assistance in dying (MAID) to individuals whose sole underlying medical condition is a mental disorder (MD-SUMC) for a period of three years, until March 17, 2027. If enacted, the bill would necessitate a thorough review of MAID MD-SUMC by a Joint Committee comprised of members from both Houses of Parliament. The OHA will continue to monitor for developments on MAID and advise members of any updates. Management will continue to update the Governance Committee as new information is provided.

AGENDA

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: February 29, 2024
Issue: Governance Policy Summary
Prepared for: Governance Committee
Purpose: ☒ Approval ☒ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Executive Assistant
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: Policies

Recommendation/Motion

Following review and discussion of the information provided, the Governance Committee of the Board recommends to the Board of Directors that the following policies be approved with amendments:
1-C-02 Legislative Compliance
1-C-20 Reporting on Compliance
2-D-21 Staff Member Recruitment to Quality Committee
*(*Track changes version can be found in package 2)*

Background

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

Of those pre-reviewed, the following policies were reviewed again at the February 21, 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
1-C-02	Legislative Compliance
2-C-20	Reporting on Compliance
2-D-21	Staff Member Recruitment to Quality Committee

AGENDA

CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

SUBJECT: Legislative Compliance	**NO.: 1-C-02**
SECTION: Legal Structure	
APPROVED BY: Board of Directors	**DATE: TBD**

Policy

It is the responsibility of the Board of Directors to monitor compliance with all applicable laws and regulations (collectively "Legislation") as part of its oversight of risk management.

The Board will, through the Audit Committee, ensure that management has a process in place to ensure legislative compliance with respect to any legislation impacting CMH operations, which process will include:

- Identifying and determining the applicability of Legislation, including monitoring for changes in or new Legislation
- Identifying and prioritizing Legislation requiring review
- Review prioritized Legislation in conjunction with applicable Hospital policies and procedures
- Revise, as required, any affected policies or procedures
- Educate / train applicable employees about their legislative compliance requirements (including any changes to policies and procedures)

Procedure

The Audit Committee, on behalf of the Board, shall oversee management's responsibilities to ensure CMH has an adequate process in place to ensure legislative compliance. Management shall report areas of significant legislative non-compliance, associated risks and mitigating strategies or corrective action to the Audit Committee (or such other Board committee as may have responsibility for that area of legislative compliance) immediately, who will in turn report to the Board, as appropriate.

New Legislation or amendments to existing Legislation impacting on Hospital operations will be brought to the attention of the Audit Committee by management. The Audit Committee shall take action as required, including forwarding information on the new or amended Legislation to any other Board committee having responsibility for that specific Legislation.

From time to time, the Audit Committee may request management to provide an educational overview of selected Legislation and the steps taken to ensure compliance.

Reporting

The President and CEO shall report to the Board of Directors on legislative compliance in accordance with Policy 1-C-20.

DEVELOPED: November 26, 2014	**REVISED/REVIEWED:**	
May 30, 2018	April 28, 2021	Click or tap to enter a date.
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AGENDA

CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

SUBJECT: Reporting on Compliance	**NO.: 1-C-20**
SECTION: Legal Structure	
APPROVED BY: Board of Directors	**DATE: TBD**

Policy

To better meet their fiduciary obligations, the Directors need confirmation that the risk of claims against Cambridge Memorial Hospital ("CMH") and / or the Directors personally has been mitigated. The President and CEO shall ensure that processes and operating policies are in place to ensure compliance with government legislation, regulations and/or bylaws (federal/provincial/municipal), statutory filings and any associated risks identified and mitigated. The President and CEO shall report to the Board in accordance with the provisions of this policy.

Procedure

1. The President and CEO shall report to the Board on a quarterly basis on CMH's compliance with respect to the preparation of accurate financial statements and that CMH has, as required by by-law, paid all:
   (a) Salary, wages, and vacation pay owing to CMH employees.
   (b) Remittances for employee income tax deductions, Canada Pension Plan (CPP) and Employment Insurance (EI) premiums and contributions.
   (c) Workplace Safety and Insurance Board (WSIB) premiums;
   (d) Employer Health Tax (EHT).
   (e) Harmonized Sales Tax (HST).
   (f) If applicable, remittances for required deductions for payments to non-residents.

   The Certificate of Compliance will be in the form set out in Appendix A.

2. The President and CEO shall report to the Board, through the appropriate committee where applicable, on an annual or bi-annual basis on CMH's compliance with respect to the maintenance of applicable insurance and compliance with legislative obligations, including the following:

   (a) Compliance with health & safety legislation and regulations (Audit Committee).
   (b) Compliance with environmental legislation and regulations (Audit Committee).

(c) Compliance with all other legislation or regulations applicable to operation of CMH (Audit Committee).
(d) All property, casualty and liability insurance is in place and coverage is suitable and in accordance with risk, the indemnity amount is sufficient in light of risk, all premiums have been paid and the policy is up to date (Resource Committee).
(e) Directors' and Officers' liability insurance is in place and coverage is suitable and in accordance with risk, the indemnity amount is sufficient in light of risk, all premiums have been paid and the policy is up to date (Resource Committee).

The Certificate of Compliance will be in the form set out in Appendix B.

3. In accordance with the *Broader Public Sector Accountability Act, 2010*, the President and CEO shall prepare and submit to the Board for approval all required CEO attestations on CMH's compliance with:

(a) The completion and accuracy of reports required on the use of consultants.
(b) Compliance with the prohibition on engaging lobbyist services using public funds.
(c) Compliance with expense claim directives consistent with the Broader Public Sector Directives.
(d) Compliance with the perquisite directives issued by the Broader Public Sector Directives.
(e) Compliance with the procurement directives issued by Broader Public Sector Directives.
(f) Such other requirements as may be established under the *Broader Public Sector Accountability Act, 2010* from time to time.

CMH will post all approved attestations that are required to be posted on its website.

4. In accordance with the commitment to the *Future of Medicare Act 2004* the President and CEO shall prepare and submit to the Board for approval all required CEO attestations on CMH's compliance with the H-SAA and M-SAA with Ontario Health/Ministry of Health.

DEVELOPED: November 26, 2014	REVISED/REVIEWED:	
May 30, 2018	April 28, 2021	Click or tap to enter a date.
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.
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Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

AGENDA

Appendix A

Quarterly Report

TO: The Board of Directors, Cambridge Memorial Hospital

Date:

Reporting Period:

RE: CEO Certificate of Compliance

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

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

(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 or [describe exceptions]

[name], President and CEO

Appendix B

Annual Report TO: The Board of Directors, Cambridge Memorial Hospital

Date:

Reporting Period:

RE: CEO Certificate of Compliance

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

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

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

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

Exceptions: NIL or [describe exceptions]

[name], President and CEO

AGENDA

CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

SUBJECT: Staff member recruitment to Quality Committee	NO.: 2-D-21
SECTION: Board Process	
APPROVED BY: Board of Directors	DATE: TBD

Purpose

To outline the process for the recruitment of the Cambridge Memorial Hospital (CMH) staff members to serve as voting members on the Quality Committee of the Board of CMH.

Background

In accordance with the Excellent Care for All Act, 2010, the Quality Committee must have one Committee member who is employed by CMH and who is not a member of the College of Physicians and Surgeons of Ontario (CPSO) or the College of Nurses of Ontario (CNO).

The Quality Committee, based on its needs, may appoint up to 2 staff members.

The individuals selected are appointed as voting members of the Quality Committee.

Staff members are appointed annually and can serve for a maximum of 3 consecutive years. Any staff member who has served the maximum term limit is eligible for reappointment after one year of absence from the Committee.

Procedure for Selection

In general, the selection process would proceed as follow:

1. **Conduct a search:** The position will be advertised internally, and candidates are selected for interview by the Vice President, Clinical Programs & Chief Nursing Executive (VP & CNE) and Quality Committee Chair. The interview panel (the VP & CNE and the Committee Chair) recommend a preferred candidate to the Board for Board approval. Appointment is for an annual term from July 1 to June 30.

2. **Annually:** In January, the Committee may canvass the staff members as to whether they wish to be considered for appointment for another term, providing they have not reached their 3 year maximum. At the January or February Quality Committee meeting, the non-staff members of the Committee would consider the needs of the Committee to determine if a reappointment would be appropriate. If the incumbents are not interested in a subsequent year or the Committee determines that a search is necessary, the search process would be undertaken.

AGENDA

DEVELOPED: April 29, 2015	REVISED/REVIEWED:	
April 25, 2018	November 25, 2020	Click or tap to enter a date.
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AGENDA

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: February 26, 2024
Issue: Capital Projects Sub-Committee Report to Board of Directors – February 2024 - OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kristen Hoch – Project Coordinator, Admin Assistant
Approved by: Amanda Thibodeau – Director, Construction; & Tom Dean – Chair, Capital Projects Sub-Committee

Attachments/Related Documents: None

A meeting of the Capital Projects Sub-Committee took place on February 26, 2024 at 1700 hours.

Present:	Tom Dean (Chair), Miles Lauzon, Shannon Maier, Andrew McGinn, Jay Tulsani, Lynn Woeller, Horst Wohlgemut
Regrets:	
Staff:	Patrick Gaskin, Rob Howe, Valerie Smith-Sellers, Amanda Thibodeau, Kristen Hoch

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

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

- Minutes of November 27, 2023
- Capital Projects Sub-Committee Attendance Report
- Action Log

Committee Matters – For information only

1. **Welcome**: The meeting was conducted virtually. New staff resources attendees include Amanda Thibodeau, Director of Construction, and Rob Howe, Interim Director of Support Services & Director of Digital Health.

2. **Phase 3 Construction Update**:
   - Substantial completion date: 18-October-2024
   - Nuclear Medicine has been completed; the department moved in on February 24, 2024; a new SpectCT was procured and in the process of being installed.
   - The existing Nuclear Medicine area will be handed over to EllisDon this week: this gives the contractor the final area of main construction sequences.
   - Fracture Clinic & Phlebotomy and BMD & Mammography will be handed over at the same time; this is one of the last sequences.

- Next sequence to be handed over to CMH at the end of summer will be the Endoscopy pre- and post- space.
- The Tower is progressing well. This is the most time consuming are of construction. Level 2 is the furthest behind; Level 4 is nearing completion.
- There were no delays for the month of January.

Overall construction is moving along well and on schedule.

Committee discussion

- What state is the space in before CMH occupies?
  - A. Thibodeau reported that it depends on timelines: once EllisDon finalizes occupancy permits the space goes from the Construction team to the Planning team. It is up to Planning as to how long to hold on to a department prior to moving into the space. There are items of small ongoing cosmetic deficiencies: A. Thibodeau advised that the goal is to get deficiencies completed prior to Tower handover as this will be an active clinical space rather than an outpatient area.
- Inquiry about available worker resources, as noted in the risk register.
  - A. Thibodeau reported that this is an ongoing risk. It was noted that the main areas of concern are mechanical, electrical, and plumbing trades. This risk has been mitigated as work has been allocated on Saturdays. The member requested that mitigations be added to the risk register. It was noted that areas with big impacts are being addressed; manpower is being moved around as needed.

AGENDA

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: February 29, 2024
Issue: Resources Committee Report to Board of Directors February 26, 2024 OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Bonnie Collins, Administrative Assistant
Approved by: Lynn Woeller – Chair, Valerie Smith-Sellers - Director Finance

Attachments/Related Documents: None

A meeting of the Resources Committee took place on Monday, February 26, 2024 at 1900h

Present:	Lynn Woeller (Chair), Sara Alvarado, Tom Dean, Lori Peppler-Beechey, Janet Richter, Jay Tulsani, Gerry West
Regrets:	
Staff:	Patrick Gaskin, Rob Howe, Kyle Leslie, Stephanie Pearsall, Valerie Smith-Sellers, Susan Toth, Dr. Winnie Lee
Guests:	CMH Quality Committee – Kenneth Abogadil, Mike Adair, Paulo Brasil, Colleen Bulla, Bill Conway, Nalini Gandhi, Julie Goyal, Diane Wilkinson

Committee Recommendations/Reports – Board Approval Sought

THAT, following review and discussion of the information provided, the Board receives the January 2024 financial statements as presented by management.

Approved Committee Recommendations/Motions:

THAT, following review and discussion of the information provided, the Resources Committee of the Board recommends that the Board of Directors receives the January 2024 financial statements as presented by management. (Dean/Brasil) **CARRIED.**

Committee Motions/Recommendations/Report – Board Approval Not Sought

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

- 1.5.1 Minutes of November 27, 2023
- 1.5.2 Resources Committee Attendance Report
- 1.5.3 Resources Committee Evaluation Results – November 2023
- 1.5.4 OHA Updates
  - 1.5.4.1 OHA Letter to MOH – Financial and Operating Stability of Hospitals
  - 1.5.4.2 OHA Media release – Federal/Provincial Investment of $3.1M in Health Care Funding

1.5.4.3 OHA Bulletin – Court of Appeal of Ontario Ruling on Bill 124
1.5.5 2024-25 Accountability Planning Submissions/Service Accountability Agreements Update
1.5.6 Other Capital Projects
1.5.6.1 Kitchen Reno: Storage Rooms & Office Spaces
1.5.6.2 Parking Equipment Replacement
1.5.6.3 Parking Lot No 5 – Expansion and Upgrades
1.5.6.4 Wing D Elevator Replacement
1.5.7 Q3 Capital Equipment Spending
1.5.8 Q3 CEO Certification of Compliance
1.5.9 Liability and Crime Insurance Policy Rate Update
1.5.10 Action Log

Committee Matters – For information only

1. **October 2023 Financial Statements and Year-End Forecast:** In January, CMH reported a $2.6M year-to-date deficit position after building amortization and related capital grants. The major drivers of the deficit were the unfavourable variance in salaries and benefits ($12.8M) and lower PCOP revenue achieved than planned ($3.9M). This was partially offset by Bill 124 ONA, SEIU and OPSEU Reopener Awards ($4.7M), QBPs ($3.4M), the unused portion of the budgeted contingency ($3.2M), and interest income ($3.0M). Management is forecasting a balanced budget by the end of the fiscal year, based on the assumption that CMH will receive MOH funding to offset the 2023-24 incremental wage impact of Bill 124 arbitration awards. On February 9, 2024, the Ministry verbally indicated that the outstanding Bill 124 submissions would be paid at approximately 85%, which is sufficient to balance the 2023-24 fiscal year. Questions were entertained. (Agenda Item X.X)

2. **Q3 Corporate Scorecard:** Management reviewed the Q3 strategic scorecard results with the Committee, and highlighted the strategic initiatives that had improved significantly from the previous report (multi-year financial and capital plans, change management strategy). Mitigation strategies are in place for the strategic initiatives that have moved to a red status in Q3 (master plan, functional plan). In the operational indicators scorecard, the PCOP performance reflected growth in Q3 and overtime performance remained stable, despite the decrease in agency use. The Committee commended the work done in generating the scorecards.

3. **Resources Committee Work Plan:** The work plan for 2023-24 was reviewed and the January requirements were noted as complete.

AGENDA

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: February 14, 2024
Issue: Corporate Strategic and Operational Priorities Q3 Update
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kyle Leslie, Director Operational Excellence
Approved by: Mari Iromoto, Senior Director of Strategy, Performance & CIO

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

Alignment with CMH Priorities:

2022-2027 Strategic Plan No ☐	2022/23 CMH Priorities No ☐	2022/23 Integrated Risk Management Priorities No ☐
☒ Elevate Partnerships in Care	☒ Manage COVID Response & System Recovery	☒ Clinical Services, Recovery, Growth & Transformation
☒ Advance Health Equity	☒ Support Staff and Physicians Wellbeing & Engagement	
☒ Increase Joy In Work		☒ Staff Wellbeing
☒ Reimagine Community Health	☒ Undertake the HIS Evaluation	☒ Retention & Recruitment
☒ Sustain Financial Health	☒ Execute CRP Phase 3	☒ Operational Excellence

Executive Summary

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

Included in **Appendix A** is our Strategic Deliverables and Operational Priority Indicator Package for Q3.

Currently there are two strategic deliverables for Q3 that are at a "red status" meaning they will likely not be achieved by year end. There are also three strategic deliverables at a "yellow" status meaning that there is a mitigation plan in place to achieve by end of Q4.

The deliverables currently at a "Red" Status are"

1) Complete Board Approved Master Plan
2) Updated Functional Plan to align with current service delivery

The deliverables at a "Yellow" status are:

1) RNAO BPG Implementation- 2SLGBTQIA+
2) HIS Implementation Plan
3) Corporate Staff Engagement Strategies Specifically VBC's completed by end of fiscal year

To monitor our "in-year" operational priorities, there are eleven priority indicators aligned to the pillars of our Strategic Plan. Of the eleven indicators, seven are currently at a "red" status, meaning the performance for Q3 met less than 90% of the performance target. The indicators at a "red" status include:

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

Background

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

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

Strategic Priorities Analysis

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

1) **Sustain Financial Health:** Grow ministry revenue by $22 million by achieving budgeted revenue in multi-year financial plans by 2027
2) **Advance Health Equity:** Ensure CMH is representative of the communities served and that the communities across Cambridge North Dumfries are receiving equitable care by 2027
3) **Elevate Partnerships in Care:** Grow clinical services by approximately 30% (growth in beds) from baseline by 2027 (increase bed footprint to 200+ beds and achieve approximately 4800 incremental weighted cases in clinical services growth) and increase access to services and care in Cambridge North Dumfries
4) **Reimagine Community Health:** Leverage technology to transform how we deliver care by revolutionizing our Health Information Systems and Enterprise Resource Planning Systems and data assets by 2027
5) **Increase Joy in Work**- measured through "overall ranking of CMH as a place to work" increasing the excellent and very good responses from 42% to 48% by 2024 and to greater than 50% by 2027

Included in **Appendix A** is the Q3 status report of our strategic deliverables by strategic goal.

For quarter three, there are two strategic deliverables that have moved to a "Red" status, these deliverables are:

1) Complete Board Approved Master Plan
2) Updated Functional Plan to align with current service delivery

In addition, there are three deliverables at a "yellow" status meaning we are working on a mitigation to ensure we meet year end objectives. These deliverables are:

1) RNAO BPG Implementation- 2SLGBTQIA+
2) HIS Implementation Plan
3) Corporate Staff Engagement Strategies Specifically VBC's completed by end of fiscal year

In Q3, the multi-year financial plan, change management plan and ERP solutions all moved from a "yellow" to "green" status.

Operational Priority Indicator Analysis

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

Analysis of Operational Priority Indicators:

1) **Post Construction Occupancy Plan (PCOP) Funding (currently red status):**

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

   Q3 results were 8% below target, compared to 25% below target in both Q1 & Q2, due to increased surgical activity and continued elevated medical activity. Year-to-date Q3, we are 2.6% below our weighted cases target for acute inpatient activity. Medical activity has achieved targets YTD and is projected to surpass our budgeted PCOP growth for that population at year-end, while inpatient surgery has generated 19% fewer weighted cases than budgeted. Day surgery activity continues to ramp up, though we generated 4.4% less weighted cases than budgeted in Q3 due to decreased activity in December.

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

Mental health inpatient activity is currently slightly lower than budgeted due to lower occupancy at an average of 82%, while targets are based on 88% occupancy. ECT volumes were higher in Q3, surpassing volume targets by 19.8%.

2) **Quality Based Procedures (QBP) Revenue** (currently green status):

QBP revenue is volume based funding for specific procedures and is earned by achieving allocated procedure targets for funding. The QBP indicator monitors our completed QBP volumes. A higher number is better as it means we are achieving our budgeted QBP volumes and enabling access to care. Overall QBP targets have been surpassed by 15% Q3 YTD. Currently, we are meeting budgeted volumes for urgent medical QBPs, Cancer Surgery, and other Surgical QBPs.

3) **Budget Variance (currently red status):**

This indicator reflects the total hospital budget variance in dollars by measuring the difference between the amount that was budgeted for and the actual amount spent. A positive number is better as it means we are meeting our financial goals and thus the target is set to 0. Q3 YTD, we are ($1,746,000) above budget. Top drivers impacting the budget variance for Q3 are: PCOP weighted cases being lower than budget, Salaries and benefits and use of unbudgeted agency staff and overtime use over budget.

4) **Repeat Emergency Department visits for Mental Health care** (currently green status):

As part of the Collaborative Quality Improvement Plan (c-QIP), this indicator is intended to help establish a baseline understanding of the rate of emergency department visits as a first point of contact for mental health and addictions related care by monitoring repeat emergency department visits for mental health and addictions related care. This indicator looks at the number of individuals with four or more visits in a 365-day period and we have set a target of 11 such individuals per month. A lower number for this indicator is better as it means patients have access to the support they need in the community to prevent the need for emergency care. In Q3, an average of 10 individuals who have visited the emergency department 4 or more times in the past year were seen in the emergency department; YTD is 11.

5) **Emergency Department Length of Stay for Non-Admitted Complex Patients (currently red status):**

This indicator reflects the amount of time spent in the emergency department for complex patients who are not admitted. A lower number is better as it means patients are being treated within an appropriate timeframe, with the target that 90% of patients spend 8 hours or less. This indicator has been identified through our Integrated Risk Management (IRM) process as a key organizational risk for this fiscal year. Results for this indicator have been consistently over 9.5 hours. We have not met target in any period this year, and times have increased since the same period last fiscal year.

6) **Wait Time for Inpatient Bed for Emergency Department Patients (currently red status):**

This indicator reflects the amount of time between the disposition date/time and the date/time an admitted patient left the emergency department for admission to an inpatient bed. A lower number is better as it means patients are being admitted to an inpatient bed within an appropriate timeframe. This indicator has been identified through our Integrated Risk Management (IRM) process as a key organizational risk for this fiscal year. The wait time for inpatient bed increased from 34.4 hours in Q1 to 50.5 hours in Q3, with each month since Q2 surpassing the target of 36 hours by more than 10%. YTD, the 90th percentile is 45.8 hours.

7) **Percent ALC Days (currently red status):**

This indicator measures the Alternative Level of Care (ALC) days expressed as a percentage of all acute inpatient days. A lower number is better as it means patients are receiving care in the appropriate setting and inpatient beds are being utilized appropriately. This indicator is a priority for the hospital and the CND OHT to reduce the number of days' patients spend in hospital unnecessarily. "ALC" refers to care that would be better provided in a setting other than the hospital such as long term care or home with support. If we are successful at reducing this percentage, it indicates patients are receiving better, more appropriate care by being in the right care setting more often. In Q3, the percent ALC days continued to be above target (20%) and has increased from 23.6% in Q1 to 24.8%. YTD, 24% of days were ALC.

8) **Overtime Hours (currently red status) and Agency Hours (Currently Red Status):**

This indicator measures the total number of overtime hours used vs. budgeted overtime hours. Currently we are significantly over budget for overtime hours used and total overtime hours were similar in Q2 & Q3 at over 24,500. The majority of overtime hours (>60%) can be attributed to the Emergency Department, Medicine, ICU, Inpatient Mental Health, and Inpatient Surgery. A lower number on this indicator means that we are staffing less with OT which has a positive impact to Joy in Work as it is an indication that we have improved staffing levels, leading to reduced staff burnout. In addition to OT we are monitoring agency usage as this indicator also is representative of our staffing levels, the work we are doing on staffing and OT will also address our agency usage.

Next steps:

- The full Strategic and Operational Priority Indicator Package including action plans will be shared on a Quarterly Basis.
- Work is underway to refresh our Strategic Priorities Package for FY 2024/2025, a draft of this package will be shared at the March Board Meeting.

Overview of Strategic Priorities and Operational Indicators - End of Q3 (Dec)

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

Legend:

- ● **On Track- all quarterly deliverables achieved**
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-I Strategic Priorities Scorecard 2023/2024

stain Financial Health

oal 5: Grow ministry revenue by $22 million by achieving budgeted revenue in the multi-year financial plans by)27

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

Advance Health Equity

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

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

Elevate Partnerships in Care

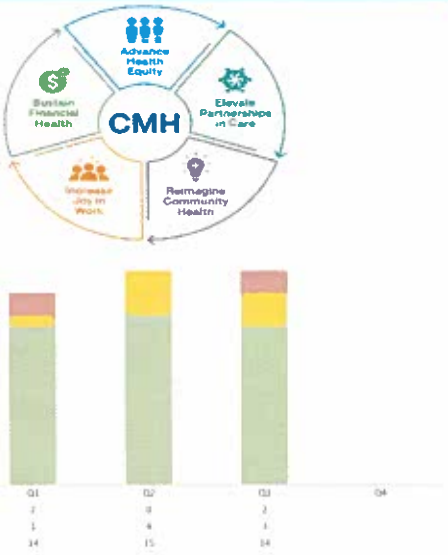
Goal 2: Grow our services by approximately 30% (Growth in beds) from baseline by 2026 (increase bed footprint to 200+ beds and achieve approximately 4800 incremental weighted cases)

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

crease Joy in Work

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

trategic Deliverable	Q1	Q2	Q3	Q4
Implement corporate strategies for staff engagement including uddles and VBC refresh by March, 2024	O - On Track	O - On Track	Δ - Progressing to On Track	
Renew and enhance recruitment and onboarding processes cluding HR support for leaders by March, 2024	O - On Track	O - On Track	O - On Track	
Execute wellness initatives for 23/24 by March, 2024	O - On Track	O - On Track	O - On Track	
Execute Change Management strategy for 23/24 by March, 2024	X - At Risk	Δ - Progressing to On Track	O - On Track	



Reimagine Community Health

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

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

Legend:

- ● **On Track - all quarterly deliverables achieved**
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AGENDA

Status Report

Advance Health Equity

STRATEGIC GOAL:

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

Strategic Deliverable	Executive Sponsor	Status	Achievements for Q3	Plan for Q4	Risk (R) and Mitigation (M) Strategy
1. Develop measurement tool and establish baseline for growth by October, 2023 and begin planning for how the measurement tool can be used to inform 24/25 initatives	M. Iromoto	**O - On Track**	- Dashboard shared with key members from the DEI council - Feedback incorporated into dashboard - Dashboard provides insight on -Catchment / population demographics, hospital utilization by catchment area for emergency care, left without being seen, hospital admissions, surgical wait-times, hospital mortality, hospital readmissions and utilization rates of translation services. The dashboard also captures rates of patients not connected to primary care as well as quality metrics for unhoused patients.	- Extracting RL data, reviewing instances of bias - Increase access to the dashboard and begin sharing through various forms: 1) Dashboard will be review with specific clinical programs through Quality and Operations Councils 2) Dashboard will be shared with leadership Team through Operations Huddle 3) Dashboard will be incorporated into our Operational Excellence Dashboard / Command Center performance package which is accessible via the Intranet 4) Dashboard will be shared to DEI council on a regular basis	R1) Availability for social determinates of health data M1) Incorporated into plan for new HIS
2. Execute DEI initiatives for 23/24 DEI Plan by March, 2024	M. Iromoto	**O - On Track**	- Drafted an Inclusive Corporate Communications Policy/Guidelines in partnership with Corporate Communications - Developed Tool for when CMH should comment on social issues - Launched CMHSmiles and opened photo submissions to CMH community to build repository of diverse CMH faces - Launched communications and shared educational resources for Q3 DEI Calendar Observances - Featured Voices of CMH story for Islamic Heritage Month (October) - Delivered Stage 2 of Unconscious Bias and Introduction to Inclusive Leadership Training to all leaders; Full day workshop - DEI calendar updated to highlight education events for leaders - Incorporated DEI-related assessment options into RL6 Incident Reporting Tool - Implemented new HR processes from Q2 (i.e., Recruitment Inclusion Statement, DEI interview questions, 30/90 Day Check-ins, VBCs, ACAs, and Exit Interviews)	- Submit CMH nomination for National CCHL Excellence in Inclusion, Diversity, Equity, and Accessibility (IDEA) Award - Test and operationalize Internal Decision Tool for communicating about social issues with topical examples - Conduct internal review to collect and centralize photos, enhance newly launched website to reflect diverse faces of CMH - Work with Diversity Council to finalize the 2024 DEI Calendar including the Levels of Acknowledgement for each observation - Create updated 2024 DEI Calendar based on Diversity Council feedback and post to CMHNet - Continue profiling diverse voices (Voices of CMH) - Enhance Black History Month celebrations including four Voices of CMH stories and musical performances from local artists - Implement L.E.A.R.N. Challenge for Black History month to support organization-wide education - Formalize usage of bias questions in Incident Reporting and Tracking RL - Internal Review of People Policies and Environmental Scan of policies from other hospitals (Q4 or Q1 initiative) - Analyze usage and effectiveness of DEI input into recruitment processes	R1) Inclusion Lead on medical leave M1) Appointed Strategic & Indigenous Projects Coordinator as interim lead for continuity of work

Legend:

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AGEND

Status Report

Advance Health Equity

STRATEGIC GOAL:

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

Strategic Deliverable	Executive Sponsor	Status	Achievements for Q3	Plan for Q4	Risk (R) and Mitigation (M) Strategy
3. RNAO BPG implementation – 2SLGBTQIA+ by March, 2024	S. Pearsall	Δ - Progressing to On Track	- Met with Rainbow Health to discuss licensing of Foundations course for 500 seats and 30 spots for Removing Barriers course - estimate 20 staff members have completed the 2SLGBTQ Removing Barriers course - Policy in draft and ready to be circulated to key stakeholders for feedback - DEI terminology bank available on intranet (from the Canadian Centre for Diversity and Inclusion)	Education in Health Service Organizations: - Nursing providers complete Rainbow Health Foundations training (85%); 30 key leaders to also take Removing the Barriers course Inclusive Communication: - Implement needed changes to ensure inclusive forms, TOA, documentation, whiteboards, signage, introductions Create posters etc. for public spaces Risk Assessment and Screening: - Review risk and assessment screening process for cervical cancer screening to ensure the comfort/safety of lesbian and bisexual women and trans and non-binary people Policy: - Finalize and approve policy related to Safe Spaces	R1) Family emergency for Director Professional. Practice and new onboarding of new Professional Practice manager has put the project behind schedule M1) Review outstanding work with Manager Professional Practice and NAC - revise project plan M2) Assign Informatics Student to work on outstanding deliverables with oversight of Manager/Director Professional Practice
4. Develop Action Plan for Indigenous Wellness, Truth and Reconciliation by March, 2024	P. Gaskin/ M. Iromoto	O - On Track	-Conducted inaugural CMH Indigenous Council meeting on December 14, 2023, to review Terms of Reference (TOR); explore frameworks from other Truth & Reconciliation (T&R) Action Plans; and brainstorm opportunities to improve staff/patient experience for Indigenous Peoples -Finalized the CMH Indigenous Council Terms of Reference; approved by Senior Leadership Team -Recruited CMH Spiritual Care Coordinator to join the Indigenous Council -awareness and provided education/resources for Treaties Recognition Week, Inuit Day, Indigenous Veterans Day, Louis Riel Day, and Indigenous Celebrations of the Winter Solstice -Developed a two-page summary of CMH's Truth & Reconciliation journey thus far - Begun discussions around a shared T&R Strategy with Regional Hospital Partners and an Indigenous Elder	-Introduce new format for Leader Territorial Acknowledgement and Reflections (Wednesday Operations Meetings) to continue practice of leaders sharing indigenous learnings -Establish regular meetings with Regional Hospital Partners to discuss Truth & Reconciliation -Foster relationships with local Indigenous leaders and Regional Hospital Partners by attending the first Regional T&R Dinner -Strengthen partnership with SOAHAC by introducing the CMH Indigenous Council to key SOAHAC individuals and having them learn more about SOAHAC services -Develop Road Map/Resource Guide for the Indigenous Truth & Reconciliation Action Plan -Evaluate Ontario Health's Indigenous Relationship and Cultural Awareness Courses; make recommendation based on evaluation	R1) Risk of capacity limitations of Indigenous Projects Coordinator assuming responsibilities for continuity of DEI initiatives M1) Managing and negotiating competing priorities

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AGENDA

Status Report

Elevate Partnerships in Care

STRATEGIC GOAL: 54

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

Strategic Deliverable	Executive Sponsor	Status	Achievements for Q3	Plan for Q4	Risk (R) and Mitigation (M) Strategy
1. Finalize clinical services growth plan by September, 2023 and begin to execute plan by March, 2024	Dr. Lee/ S Pearsall	**O - On Track**	Transgender Health Program: - Identified physician lead for the TGHP, meeting set with key Chiefs/physician leads for the TGHP - Inaugural Summit on Transgender Health - Plan partnerships with CND-OHT partners (i.e. Langs) - Recruited outpatient psychiatrist for MH program - ECT services expanded to 5 days/week - Trial of physician medicine/hospitalist model to improve ED Access and Flow: - COEC focused priority, including expanded membership - ED Rapid Improvement Event - RPN Scope of practice increased on Medicine units - Added skills include Telemetry, care of PICC lines, IV medication administration, team lead education	Transgender Health Program: - Introduce the TGHP Expand Mental Health Community: - Establish and sustain outpatient clinics and ECT access Introduce New Models of Care - Introduce team nursing model on multiple medicine units ED Access and Flow: - Expand membership to include ED Chief and Surgery Chief with dedicated focus by COEC - Establish Urgent Care physician model Team Based Model of Care Pilot: - Continuing our work with the Medicine program to introduce a Team Based model where a team of health professionals will work together to care for a cohort of patients - This work will include defining key responsibilities of each team member, team-based education, and patient acuity scoring for team assignment purposes	No risk to report
2. Complete Board approved Master Plan by March, 2024	M. Iromoto/ M. Sockett/ A. Thibodeau	**X - At Risk**	- Proposal obtained by Agnew Peckham to provide services to update CMH Stage 1 Master Program Update from the original plan submitted to Ministry of Health in March 2011 - 2 options proposed for consideration: 1) a partial update to focus on programs and services not included in recent CRP project; and 2) developing a new comprehensive plan	- Completion of internal stakeholder review - Conduct evaluation of options presented and present to SLT with final recommendation - Plan to present recommendation to Board by April - Work completion will range from 6 - 18 months from signed contract	R1) Adjustments to timelines will be required M1) Contract will be signed by Q4 but completion of work will be 6-18 months based on final decision

Legend:

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Status Report

Elevate Partnerships in Care

STRATEGIC GOAL:

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

Strategic Deliverable	Executive Sponsor	Status	Achievements for Q3	Plan for Q4	Risk (R) and Mitigation (M) Strategy
3. Update original functional plan to align with current service levels by March, 2024	M. Iromoto/ M. Sockett/ A. Thibodeau	X - At Risk	- Discussions with Stantec for quote to provide CMH with a Space Variance Report to reflect changes from original design - Goal to have action items completed by Q4	- Review Stantec's space comparison to support the functional program' s work by end of February - Agnew Peckham to complete work 6 weeks after receiving Stantec report - Produce blackline functional program for submission to the Ministry	R1) Will not meet March 31 timeline M1) Dependent on external vendor reports to complete
4. Patient experience plan developed and Board approved by October, 2023 and begin implementing plan by March, 2024	M. Iromoto/ L. Barefoot	O - On Track	- PXL vacancy from Oct.- Jan. combined with the other PXL seconded to lead Accreditation prep efforts/onsite in early November - ConnectMyHealth Specialist hired and working internally & externally to promote portal - Baseline (as a big dot measure for PX Plan) Beryl Institute Experience Assessment completed - Investigating reasons for low Qualtrics responses for med/surg admissions	- Second PXL started Jan 2nd - Innovation Project submission re: lost patient belongings approved - Prioritization of tactics for the next 3 years in the PX Plan with PFAC underway - Collaboration meeting with Beryl Institute regarding our Experience Assessment results planned	No risk to report

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AGENDA

Status Report

Reimagine Community Health

STRATEGIC GOAL:

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

Strategic Deliverable	Executive Sponsor	Status	Achievements for Q3	Plan for Q4	Risk (R) and Mitigation (M) Strategy
1. HIS implementation plan created by March, 2024	M. Iromoto	Δ - Progressing to On Track	- Initial negotiations still ongoing with preferred vendor - De-scoping exercise occurred with medical and admin input - Negotiation process validated and being followed and monitored through HIS Steering - Branding work is underway as part of broader comms plan for go-live, timing TBD as it is linked to negotiation/contract signing.	- Contract signed - Project plan identified with timing - Announcement and Project kickoff occurred - Preparations regarding decision making and governance structures which can be implemented post contract signing	R1) Vendor delays with returning negotiation documents M1) Internal pressure from both CMH negotiation lead and external legal counsel R2) Pricing gap is significant between vendor and hospital M2) No mitigation at this point - CMH has de-scoped already. We are following the process identified to get best price before elevating further
2. Complete all in year readiness activities required to proceed with ERP project by March, 2024	M. Iromoto	O - On Track	Note: CMH has moved away from readiness activities and moved to developing and delivering on a prioritized roadmap - Corporate roadmap progress continues to be monitored against - Regional meetings are booked to solidify commitment with priority on workforce management solution	Note: Change from original deliverable from all ERP readiness work to execution of the modernization roadmap - Timing, budget, and resource identification for workforce management work which puts CMH in a position to commit to a WFM Vendor - Budgetary revisions based on HIS project - On-going alignment with regional hospitals to proceed with a common platform	R1) CMH will delay work on the identified priorities due to focus on HIS M1) Project team continues to monitor, but no active mitigation at this point due to focus, budget, and change capacity of CMH. M2) Working on separating streams (corporate and HIS) to avoid unnecessary delays

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Status Report

Reimagine Community Health

STRATEGIC GOAL:

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

Strategic Deliverable	Executive Sponsor	Status	Achievements for Q3	Plan for Q4	Risk (R) and Mitigation (M) Strategy
3. Increase organizational capability to gain insight from data by improve data quality, access and governance by March, 2024	M. Iromoto	**O - On Track**	- Muli-year Operational Excellence Plan developed and presented to Director's Council, Senior Executive, MAC, will go to Board and Digital Health Subcommittee - Successfully hired and onboarded Decision Support Resource to lead training, build and deployment of AI and ML models - Established outline for data insight sessions with plan to launch in Q4 - Established specification and requirements for Server and computing needs to train and host AI /ML applications such as virtual assistant, chatbot and advanced wait-time clock algorithms - Decision Support Team built fully functioning Chatbot/virtual assistant for Beta testing. application leverages state of the art open source NLP, Machine Learning and AI and can be used for a wide range of applications- tested with unstructured survey data and the application performed extremely well a generating intelligence and insight from unstructured data	Data Literacy: - Data Lunch & Learns on how to access and use performance tools dashboards scorecards, will also offer session on AI - Refresh enhanced DS role at Quality and OPS to reinforce data literacy Data Integration: - Work with IT on server requirements to train, build, host and deploy AI / ML applications ensuing that infrastructure and computational needs are met Innovate how data is shared, access and used to Enhance Decision Making: - Rollout electronic huddle boards on MEDA, MEDB, ICU, DI - Rollout two new AI use cases: CDU flagging in ED, AI powered Resume Screening Engine - Complete OR schedule simulation work to ensure OR schedule maximizes available OR time, throughput and Weighted Cases / QBPs - Implement Central Command Center Dashboard that will provide streamlined access into all BI tools - Refresh Scorecards for 24/25 - Finalize and seek Approval for Operational Excellence Plan	R1) Vacancy in Decision Support Team M1) Proceed with hiring to full complement

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AGENDA

Status Report

Increase Joy in Work

STRATEGIC GOAL: 58

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

Strategic Deliverable	Executive Sponsor	Status	Achievements for Q3	Plan for Q4	Risk (R) and Mitigation (M) Strategy
1. Implement corporate strategies for staff engagement including huddles and VBC refresh by March, 2024	S. Toth	Δ - Progressing to On Track	- Additional sessions have been held for EVS supervisors/ ED Clinical Lead w/c December 11 - VBC on Track Completed to date –Target : 86/375 = 23% Tracker is up and being utilized - First Meeting (Directors) with External Partner (Verity) for Talent Review Board held in November	- VBC tool for staff to assist with completion - Meeting with Employee Engagement Team to review strategies for 2024 - Launch recruitment for new and more inclusive Employee Engagement Council	R1) Huddle sustainability M1) PMO to attend huddles regularly and offer support M1) Piloting electronic huddle board to streamline the process for gathering information and metrics given capacity constraints R2) Leader capacity to be trained M2) Consider alternative training dates and methods
2. Review and enhance recruitment and onboarding processes including HR support for leaders by March, 2024	S. Toth	O - On Track	- Onboard workflow mapping- complete - Survey of leaders–Recruit/Onboard- complete - Recruit/Onboard upgrades/process changes Presentation to Leaders/Ops-complete - Weekly Hospital-Wide Orientation- launched - Onboarding Coach Program (Healthcare Excellence Canada Initiative)- launched - Student conversion program development– "Fast Pass" for exemplary students (ongoing)- currently tracking conversion numbers - New Employee Survey Plan– 1st 100 Days- deferred to Q4 - Delivered 1 Recruitment training session to Hiring Managers- currently 64 clinical externs (health professional students) who we are actively monitoring for conversion to regulated health professional staff on graduation - continue to leverage Ministry funded programs as recruitment incentives i.e. nursing graduate guarantee, clinical scholar program, clinical externs, Specialized Experience Practice Program	- Create SOPs - Recruitment - Develop Recruitment Plan /Budget - Execute Recruit recommendations - process & procedure - Position Code Project: Create accurate active CMH Master Position List with defined Position Access and Position Education - master reference for sitewide use - Create Hiring Manager Resource Centre on CMH.net - One-to-one meetings with each manager (50% in Q4) - Interview Guides to Microsoft Forms - Reference Check to Microsoft Forms - Continue to leverage Ministry programs to draw new graduates and students to staff at CMH with a conscious effort to convert to regulated health professional staff on graduation -Develop a more robust way of tracking student conversions for reporting and tracking	R1) Resources M1) Offered a 1-year contract to a project person in HR

Legend:

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Status Report

Increase Joy in Work

STRATEGIC GOAL:

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

Strategic Deliverable	Executive Sponsor	Status	Achievements for Q3	Plan for Q4	Risk (R) and Mitigation (M) Strategy
3. Execute wellness initiatives for 23/24 by March, 2024	L. Rodrigues	O - On Track	- Your Health Space Wellness Huddles - 323 staff members seen across 26 units - Rapid Relief Team Appreciation BBQ - Night Staff: 220 meals; Day Staff: 630 meals - Education and awareness of wellness initiatives through Accreditation Fair - New Wellness supports flyers provided to all units/departments - TravelWise Program Visit - Winter Sustainability focus: 75 staff member interactions	- Mental Health Benefit extended into 2024 (launch & updated communications) - Continuation of The Wellness Loop passport program - Mental Health First Aid for Leaders secured for Jan 23 & 24 - Let's Talk Day Jan 24 (focus on mental health support) - Random Acts of Kindness Day Feb 17 - Nutrition Month (March) collaboration with Clinical Nutrition team - Employee Appreciation Day Mar 1 - Spring Colouring Contest Mar 1 to 25	No risk to report
4. Execute Change Management strategy for 23/24 by March, 2024	P. Gaskin/ M. Iromoto	O - On Track	- Change Management outline developed including revised "change streams" - Alignment with CMH OD Lead on roles and overlap to ensure alignment between CMH, HIS, and other major project change work - HIS work continues to engage and educate users with strong participation thus far	- Change Management plan finalized with first drafts of curriculum completed and tested on Senior Leaders at Spring Camp -Engagement across OD, HIS, and PMO to align resources and approach - Identifying external OD/HIS resource to provide ad hoc consultative services	No risk to report

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AGENDA

Status Report

Sustain Financial Health

STRATEGIC GOAL: 60

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

Strategic Deliverable	Executive Sponsor	Status	Achievements for Q3	Plan for Q4	Risk (R) and Mitigation (M) Strategy
1. Update multi-year financial and capital plans incorporating capital and ongoing operating costs to support new HIS and ERP by March, 2024	V. Smith-Sellers/ T. Clark	**O - On Track**	- Multi-year Capital plan has been finalized - Multi-year Financial plan - draft completed; Bill 124 funding information outstanding - HIS - ongoing vendor negotiations; discussion with MOH re HIS letter of support	- Multi-year Financial and Capital plans to be reviewed at Resources Committee in February - Incorporate Bill 124 funding into Financial plan when finalized by MOH - HIS - ongoing vendor negotiations; review OFA funding option - ERP - Work Force Management project plan to be developed	R1) Health Human Resource shortages M1) Mitigation is the recruitment and retention strategies- internships, new grads, clinical scholars
2. Establish budgeted volume targets to maximize PCOP funding for 24/25 and 25/26 by November, 2023	V. Smith-Sellers/ T. Clark	**O - On Track**	- Forecasts completed for PCOP, with significant focus on enhancing OR grid and scheduling to achieve targets	- Finalize and upload for 24/25 - Develop detailed tracking to monitor results in real-time	No risk to report
3. Improve financial literacy within CMH leadership team by March, 2024	V. Smith-Sellers/ T. Clark	**O - On Track**	- Detailed cost centre review completed with managers/directors - Review of Financial presentation underway - Ongoing use of huddles and Ops meetings to highlight financial items	- Financial presentation scheduled for March CPSO Physician meeting - Enhanced education and real-time support will be built into monthly variance meetings with leadership	No risk to report
4. Improve supply chain processes by March, 2024	J. Visocchi/ T. Clark	**O - On Track**	- All buyers have attended Ministry and MMC BPSAA training as well as BOBO training (Building Ontario Business Initiative) - Engaged with MMC to review quarterly opportunity report and actioning anything outstanding for maximum rebates - Clean-up of pandemic inventory underway, removal of expired products and confirmation of quantities to have on hand - For OR supply chain tackling the most problematic vendors for substitute products	- BPSAA training for managers scheduled for January Ops meeting - Review alternate warehouse option to determine if any efficiencies or savings can be achieved - Finalize entire substitute product list for the OR in conjunction with OR clinical staff - Complete OR min/max levels of inventory based on new forecasting tool	No risk to report

Legend:

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H Operational Indicators Scorecard 2023/2024

Sustain Financial Health

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

Operational goals / indicators for 2023-2024:

Indicator	Target	Q1	Q2	Q3	Q4	Monthly Trend
Revenue- Achieve budgeted PCOP growth for 2023/2024 (IRM)	$13.4M (Annual) $3.4M per Quarter	$2,593,630	$2,499,901	$3,877,681		
Revenue - Achieved-Quality Based Procedure Funding (IRM)	$22.2M (Annual) $5.5M per Quarter	$5,592,431	$5,510,036	$5,513,214		
YTD Budget Variance	0	$169,060	$ (1,934,000)	$ (1,746,000)		

Advance Health Equity

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

Operational goals / indicators for 2023-2024:

Indicator	Target	Q1	Q2	Q3	Q4	Monthly Trend
1. Repeat ED visits for MH care (4 or more in last 365 days) (c-QIP)	Quarterly / Annual <11 (Average per month)	12	11	10		

Elevate Partnerships in Care

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

Operational goals / indicators for 2023-2024:

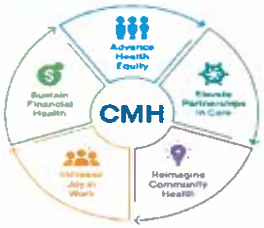
Indicator	Target	Q1	Q2	Q3	Q4	Monthly Trend
1. Access to care- ED Wait-time for in-patient bed (IRM)	Quarterly / Annual 90th%tile < 36 hours	34.4	48.2	50.5		
2. Access to Care- ED Length of Stay Complex CTAS 1-3 (IRM)	Quarterly / Annual 90th%tile < 8 hours	9.6	9.7	9.9		
3. Access to Care- Percent ALC Days (closed cases) (c-QIP)	Quarterly / Annual 20%	23.6%	24.7%	24.8%		

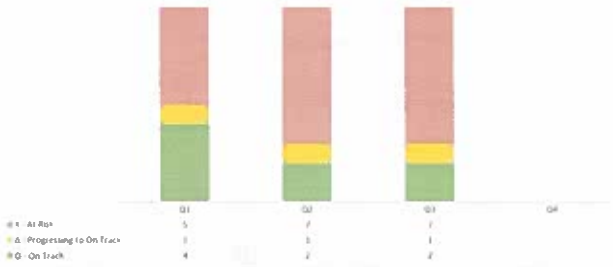
Increase Joy in Work

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

Operational goals / indicators for 2023-2024:

Indicator	Target	Q1	Q2	Q3	Q4	Monthly Trend
1. Overtime hours (IRM)	22208 Hours (Annual) 5552 Hours per Quarter	21,699	24,547	24,589		
2. Agency Hours Used (IRM)	0	7,492	6,384	4,951		





Reimagine Community Health

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

Operational goals / indicators for 2023-2024:

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

Legend:

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

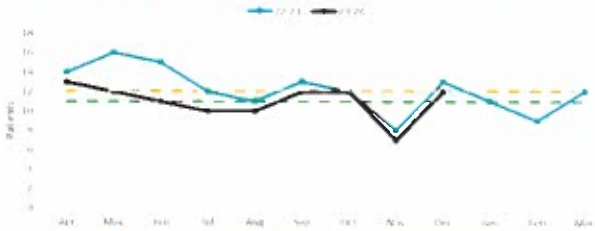
Indicator Update

Advance Health Equity

INDICATOR:

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

	Target	Q1 (Apr - Jun)	Q2 (Jul - Sep)	Q3 (Oct - Dec)	Q4 (Jan - Mar)	Status
Performance	Quarterly / Annual <11 (Average per month)	12	11	10		O - On Track



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

Actions	Lead(s)	Status	Achievements for Q3	Plan for Q4	Risk (R) and Mitigation (M) Strategy
1. Community Mental Health and Addictions Clinic (CMAC) Pilot Project	D. Didimos/ Dr. Runnalls/ Dr. Sharma	O - On Track	- Complete	- Complete	No risk to report
2. CMH is continuing its support of the initiative in a more permanent space off-site of the hospital. ED diversion continues to be an important outcome as well as CMH work with EMS to work through the alternate destination point	D. Didimos/ Dr. Runnalls/ Dr. Sharma	O - On Track	- Our OHT partners have submitted a proposal to restart the CMAC. Smaller working group met Jan 26th to share opportunities to start with current resources while awaiting response from submission	- Continuing bi- monthly Alternate Destination Clinical Committee work	No risk to report
3. Establish Process for managing cases	D. Didimos/ Dr. Runnalls/ Dr. Sharma	X - At Risk	- ED and MH stakeholders met to map the current state - The development of a standard care plan template (currently in paper format)	- Development of a process document with key stakeholder involvement	R1) PMO Availability M1) PM support/ prioritization of PM initiatives R2) Capability to make changes in Meditech M2) Development of a secured process to store and access care plans

Legend:

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

AGEND

Indicator Update

Elevate Partnerships in Care

INDICATOR:

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

	Target	Q1 (Apr - Jun)	Q2 (Jul - Sep)	Q3 (Oct - Dec)	Q4 (Jan - Mar)	Status
Performance	Quarterly / Annual 90th%til < 36 hours	34.4	45.2	51		X - At Risk

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

Actions	Lead(s)	Status	Achievements for Q3	Plan for Q4	Risk (R) and Mitigation (M) Strategy
1. To optimize discharge of patients	A. McCulloch/ Dr. Legassie	Δ - Progressing to On Track	- Discharge rounds firmly established with focus on discharge planning and identification of barriers	- EDD to be added to white boards consistently, making charge RN responsibility by Jan 31, 2024 - Continue with manager/director rounding with patients with a focus on discharge planning - Improvements to timelines for discharge – move to proactive discharge order being written in advance by MD to allow for earlier discharge and improved flow during the early part of the day (0900-1400), daily meetings at noon with Shift Admin, charge nurses Med A/B and Clinical Coordinator and/or manager for medicine to further discuss flow and discharges with development of a plan by March 31, 2024	R1) Not meeting medical discharges and time to bed rising M1) COEC focus on medical discharges
2. Re-establish Patient Flow Command Centre meetings monthly focusing on P4R metrics	K. Leslie/ Dr. Runnalls	Δ - Progressing to On Track	- Continue to monitor and identify improvement opportunities with support of COEC members	1) Discharge Planning by March 31, 2024 2) Admission Avoidance (short stay, palliative patients, admissions from LTC and RH) by March 31, 2024 3) ALC reduction strategy- (see ALC tab) by March 31, 2024	R1) Completing requests for DS support M1) Escalation not required at this time, prioritizing request for DS support
3. Implementation / Optimization of Critical Care Stepdown Beds	A. McCulloch/ Dr. Nguyen	O - On Track	- RPN recruitment complete - New staff are now progressing through orientation	- Confirm physician model for further expansion, leadership and physicians meeting Feb 2, 2024 - Review impact to acute medicine available beds - Continue with bi-weekly planning meetings, target for initial operationalization of 3- Level 2 beds by end of Q4 -Ontario Levels of Care for Adult critical care unit guidance document - review and identify gaps	No risk to report

Legend:

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

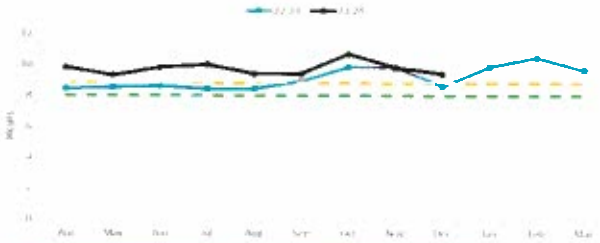
Indicator Update

Elevate Partnerships in Care

INDICATOR:

Access to care- ED LOS for CTAS 1-3

	Target	Q1 (Apr - Jun)	Q2 (Jul - Sep)	Q3 (Oct - Dec)	Q4 (Jan - Mar)	Status
Performance	Quarterly / Annual 90th%tile < 8 hours	9.6	9.7	9.9		X - At Risk



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

Actions	Lead(s)	Status	Achievements for Q3	Plan for Q4	Risk (R) and Mitigation (M) Strategy
1. Process review of ED Flow	D. Didimos/ Dr. Runnalls	X - At Risk	- Initiated EMS offload nurse assignment 24/7 on December 8 2023 - Development of a Proposed escalation process between CMH and EMS - Biweekly meetings with our EMS partners - Finalized ED Flow Monitor standard work - Development of Shift Administrator standard work - Changes to ED Physician schedule	1) Refresh and establish Code Surge policy- by March 31, 2024 2) Hold Subacute process improvement sessions- (Jan 29 to Jan 31st) 3) Hold Ambulance Offload process improvement session (Feb 21, 2024) 4) Sustain daily rounds in ED for admission avoidance 5) Implement ML/ AI tool for flagging RH and LTC admissions and establish process with HCC for streamlined discharge plan	R1) PMO resources engaged on many projects M1) Additional PM resources/ prioritization of PM projects R2) Availability of Physicians to attend value stream mapping session M2) Work with ED Chief on strategy to engage ED physicians
2. Optimization of Clinical Decision Unit	D. Didimos/ Dr. Runnalls	X - At Risk	- Completion of staff education on CDU - Development of CDU triggers using triage complaints	1) Leverage ML/AI to support identification of potential cases for CDU by Feb 15, 2024 - Refresh CDU policy - Monitor CDU compliance with target to increase CDU throughput from 3% of cases to 8% (maximize CDU capacity)	R1) Availability of Physicians to attend value stream mapping session M1) Work with ED Chief on strategy to engage ED physicians R2) Physician lead vacancy for CDU M2) Meeting established to reassign lead roles for CDU
3. Increase awareness of performance	D. Didimos/ Dr. Runnalls	Δ - Progressing to On Track	- Completion of staff education and importance of P4R Focus of P4R at ED huddles	1) Transform bed meeting with use of data by March 1,2024 - implement real time flow board to support daily bed rounds meetings 2) Continue to engage with ED physician lead to refine and share ED physician scorecard directly with ER docs 3) Enhance data sharing through ED huddle by March, 2024	No risk to report

Legend:

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

AGEND

Indicator Update

Elevate Partnerships in Care

INDICATOR:

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

	Target	Q1 (Apr - Jun)	Q2 (Jul - Sep)	Q3 (Oct - Dec)	Q4 (Jan - Mar)	Status
Performance	Quarterly / Annual 20%	23.6%	24.7%	25.0%		X - At Risk

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

Actions	Lead(s)	Status	Achievements for Q3	Plan for Q4	Risk (R) and Mitigation (M) Strategy
1. To optimize discharge of patients, aim for full complement of medical/ hospitalist physician staffing	A. McCulloch/ Dr. Legassie	O - On Track	- Cambridge Collaborative meeting held and scheduled monthly - New TOR developed - Developed list of countermeasures, action plan - Begun implementing action plan - New OH target of 36 open ALC cases, can we just pull from our A3 a few highlights for this	- Development and provision of education to staff and physicians regarding ALC definition and coding - education starting Jan 23, 2024 and will be ongoing - Focus on ED Flow and ALC Action plan development to achieve, focus on those patients being seen in ED from LTC and opportunities to return them to LTC with supports, as required - Continue to work on identified areas within self-assessment to align with ALC leading practices, implementation of activity carts, sip and go stations on TCU - Education on when to initiate ALC orders	No risk to report
2. Establishing relationships with regional partners	A. McCulloch/ Dr. Legassie	O - On Track	- Weekly meetings occurring between RH and HCCC and Medicine manager, re-establishing partnerships with community partners - Developed Cambridge Collaborative action plan	- Continue monthly Cambridge Collaborative meetings - Continue implementation of Cambridge Collaborative action plan Continue with OH West ALC Collaborative	R1) ALC pressure is a system issue currently being experience d by hospitals M1) Continue to connect with Community partners and stakeholders to collaboratively address ALC pressures
3. One Team Approach	A. McCulloch/ Dr. Legassie	O - On Track	- Development of updated role responsibilities for Social Workers and HCCC Coordinators	- Implementation of further countermeasure from A3 for CBD and ALC	No risk to report

Legend:

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

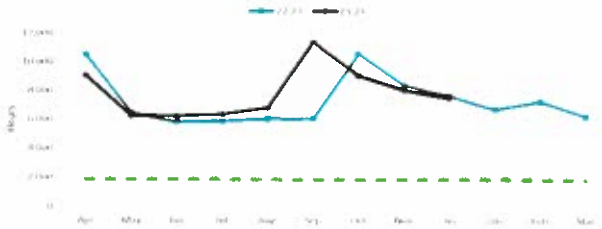
Indicator Update

Increase Joy in Work

INDICATOR:

Overtime Hours

	Target	Q1 (Apr - Jun)	Q2 (Jul - Sep)	Q3 (Oct - Dec)	Q4 (Jan - Mar)	Status
Performance	22208 Hours (Annual) 5552 Hours per Quarter	21,589	24,567	24,580		X - At Risk



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

Actions	Lead(s)	Status	Achievements for Q3	Plan for Q4	Risk (R) and Mitigation (M) Strategy
1. Develop SOP to support student conversion practices and process	J. Backler	O - On Track	'- Continue to manually track student conversions (both students and clinical externs who graduate and start working as registered staff) To date: 31 students and 12 clinical externs have been converted to staff in 2023 '- Continue to work with managers and CEFs to identify exceptional students with the goal to approach students about open positions while on placement with us. - Discussed with HR upcoming strategies to recruit and retain students and new grads. - SOP draft started	- Finalize SOP for student / clinical extern recruitment to registered staff on graduation - Continue to work with HR to expand strategies for student and new graduate recruitment and retention	No risk to report
2. Refresh and revise scheduling meetings with leader, HSW, Recruitment and Scheduler and staffing office tools	A. McCulloch/ A. Schrum	O - On Track	- Confirmed master templates to improve scheduling / timecard efficiency	- Continue review of scheduling office processes	No risk to report

Legend:

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

AGEND

Indicator Update

Increase Joy in Work

INDICATOR:

Overtime Hours

	Target	Q1 (Apr - Jun)	Q2 (Jul - Sep)	Q3 (Oct - Dec)	Q4 (Jan - Mar)	Status
Performance	22208 Hours (Annual) 5552 Hours per Quarter	21,589	24,567	24,580		X - At Risk

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

Actions	Lead(s)	Status	Achievements for Q3	Plan for Q4	Risk (R) and Mitigation (M) Strategy
3. Re-establish OT / staffing task force	S. Pearsall/ S. Toth/ K. Leslie	Δ - Progressing to On Track	1) Refreshed OT tracking dashboards for leaders 2) Created staff leave / modified work tracker to enhance staffing decision making 3) Standard operating procedures and interview training for leaders created	1) Implement monitoring tools and process for staffing targets and ratios by March 1, 2024 2) Address standby and agency use by March 31, 2024 (standby) 3) Implement staffing buffers into schedule for proactive sick call planning by March 31, 2024 4) Implement AI/ML tool to streamline application review process by March 1, 2024 5) Develop guidelines for staffing for ambulance runs by March 31, 2024 6) Refresh scheduling codes for enhanced reason for OT tracing by March 1, 2024	R1) Capacity to track and implement initiatives M1) Project Manager for PMO office pulled to support
5. Absence Reporting Processes & SOPs	S. Toth	O - On Track	- Continue to sustain and reinforce process	- Continue to sustain and reinforce process	R1) Staff returning from leaves and have not received communications M1) Continued education required to ensure compliance with new process

Legend:

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

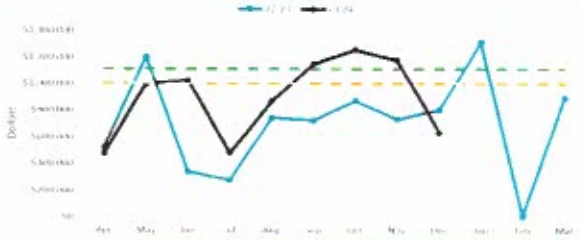
Indicator Update

Sustain Financial Health

INDICATOR:

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

	Target	Q1 (Apr - Jun)	Q2 (Jul - Sep)	Q3 (Oct - Dec)	Q4 (Jan - Mar)	Status
Performance	$13.4M (Annual) $3.4M per Quarter	$ 2,503,630.00	$ 2,499,901.00	$ 3,077,681.00		X - At Risk



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

Actions	Lead(s)	Status	Achievements for Q3	Plan for Q4	Risk (R) and Mitigation (M) Strategy
1. Surgical PCOP	K. Towes	X - At Risk	- Physician recruitment complete and successful candidate identified and offer is out to the individual - Recovery plan continues to be executed for 2023/24 to regain PCOP funding - Data and information required to plan for 24/25 GRID collected and GRID build started - Decision Support attending monthly meetings to discuss PCOP performance and risk for full transparency to the surgeon group	- Continue to work through and finalize the OR Grid for 24/25 to achieve the PCOP funding target within first month of Q4 - Plan and start to implement a process improvement project for flow between the OR, PACU and inpatient unit to improve efficiencies within the OR related to on-time starts, TAT (turnaround times) and throughput in order to achieve volume and funding targets - Engage all key stakeholders in process and develop a working group - Continue to monitor returned and unfilled blocks and address as required	R1) OR closures in July due to moisture exposure related to Chiller incident impact OR Core Supplies M1) FMEA completed with mitigations identified for Chiller incident, Value Stream Map completed for OR Supply Management with action items identified R2) Medical leadership awareness and understanding of Surgical PCOP performance M2) Decision Support to attend monthly department meeting to provide updates on PCOP performance
2. Medical PCOP	A. McCulloch	O - On Track	- Success with generation of PCOP, - Continue to work to ensure we meet target for discharges, decrease number of ED hold discharges for Medicine admits	- Continue to monitor performance, see continued work with CBD and ALC	R1) ALC bed blocks resulting in impacts to flow M1) ALC Quality Improvement Project in-progress

Legend:

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

AGEND

Indicator Update

Sustain Financial Health

INDICATOR:

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

	Target	Q1 (Apr - Jun)	Q2 (Jul - Sep)	Q3 (Oct - Dec)	Q4 (Jan - Mar)	Status
Performance	$13.4M (Annual) $3.4M per Quarter	$ 2,503,630.00	$ 2,499,901.00	$ 3,077,681.00		X - At Risk

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

Actions	Lead(s)	Status	Achievements for Q3	Plan for Q4	Risk (R) and Mitigation (M) Strategy
3. Mental Health PCOP	D. Didimos	X - At Risk	- Admission order set updated to reflect inpatient versus PCU - External website revised Open ECT to outpatients and collaborating with GRH to assist with their volume	- Working with ED partners on possibility of short term admission for our patients suffering from substance issues - Performing an environmental scan and what would be required to implement Ketamine infusions for patients suffering from depression	R1) Staff and Physician not ready for change M1) Leverage change management tools to enable engagement and adherence
4. ED PCOP	D. Didimos	X - At Risk	- Focus is on improving ED flow see Action plan for CTAS 1-3	- Focus is on improving ED flow see Action plan for CTAS 1-3	R1) Wait times and LWBS M1) ED process improvement work to address wait times

Legend:

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

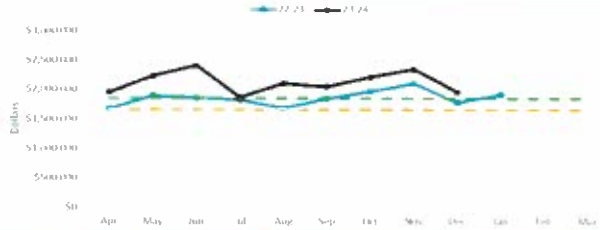
Indicator Update

Sustain Financial Health

INDICATOR:

Revenue- Achieved-Quality Based Procedure Funding (IRM)

	Target	Q1 (Apr - Jun)	Q2 (Jul - Sep)	Q3 (Oct - Dec)	Q4 (Jan - Mar)	Status
Performance	$22.2M (Annual) $5.5M per Quarter	$ 6,592,431.00	$ 6,010,095.00	$ 6,513,214.00		O - On Track



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

Actions	Lead(s)	Status	Achievements for Q3	Plan for Q4	Risk (R) and Mitigation (M) Strategy
Medical QBPs	A. McCulloch	**O - On Track**	- Continue to meet target with the exception of ST (CCO) related to medical oncologist staffing model changes	- New Med Oncologist starting	No risk to report
Surgical QBPs	K. Towes	**O - On Track**	- Continuing to meet target	- Monitor to ensure end of year targets are met	No risk to report

Legend:

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

AGENDA

BRIEFING NOTE

Date: February 15, 2024
Issue: Quality Monitoring Metrics
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Liane Barefoot, Director Patient Experience, Quality, Privacy, Risk & IPAC
Kyle Leslie, Director Operational Excellence, Decision Support, PMO and HIM
Approved by: Mari Iromoto, Senior Director of Strategy, Performance & CIO

Attachments/Related Documents: Appendix A Quality Monitoring Scorecard

Alignment with CMH Priorities:

2022-2027 Strategic Plan No ☐	2022/23 CMH Priorities No ☐	2022/23 Integrated Risk Management Priorities No ☐
☒ Elevate Partnerships in Care	☒ Manage COVID Response & System Recovery	☒ Clinical Services, Recovery, Growth & Transformation
☒ Advance Health Equity	☒ Support Staff and Physicians Wellbeing & Engagement	
☒ Increase Joy In Work		☒ Staff Wellbeing
☒ Reimagine Community Health	☒ Undertake the HIS Evaluation	☒ Retention & Recruitment
☒ Sustain Financial Health	☒ Execute CRP Phase 3	☒ Operational Excellence

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

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

There are nine indicators of the thirty-one that have had three periods of "red" performance in a row that we are monitoring to determine if an action plan for improvement is needed. The nine indicators are:

1) Conservable Bed Days
2) Overtime hours*
3) Sick hours
4) Emergency Department Length of Stay Admitted Patients*
5) Emergency Department Length of Stay for Complex Patients*
6) Emergency Department time to Inpatient Bed*
7) Emergency Department Wait time for Initial Assessment (PIA)*
8) Surgical Long Waiters
9) Medication Errors

Indicators denoted with an * have been addressed in the Q3 Strategic Priority package. Only indicators without the * will be presented in this briefing note.

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.

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

1) **Conservable Bed Days (Red status with three or more periods outside of performance threshold):**

   This indicator measures the total patient days over the benchmark length of stay as a rate of total acute inpatient days. A lower rate means a more appropriate length of stay based on a patient's case mix group, age, and resource intensity level. For this indicator we are currently thirteen percent over target. Our conservable bed day rate has trended up in Q3.

2) **Sick Hours (Red status with three or more periods outside of performance threshold):**

   This indicator monitors the average sick hours per pay period per month. A lower number is better as that means there are less staff off and unable to work due to illness. Currently, the average number of sick hours per pay period exceeds the target by 52% (YTD Dec). The work we are doing on OT and staffing will help to address staffing pressure from sick hours.

3) **ED Wait Time for Physician Initial Assessment (90% spent less, in hours) (Red status with three or more periods outside of performance threshold):**

   This indicator measures the wait-time from triage to being seen by a physician or nurse practitioner in the ED. A lower number is better as it means that patients are seen by a physician or nurse practitioner within an appropriate timeframe in the emergency department. While our internal target is to see 90% of patients within 4 hours, we have consistently seen results exceeding this with YTD Dec results of 7.0 hours. This value has increased over the last 12 months and the action plan for this indicator will be addressed within the action plan for the 'Emergency Department Length of Stay for Non-Admitted Complex Patients' indicator.

4) **Medication Error Rate (Red status with three or more periods outside of performance threshold):**

   This indicator measures the rate of medication errors. Our target for the incidence of medication errors for inpatients is 4.0/1000 patient days. Theoretically a lower number is better as it should illustrate fewer medication errors are occurring, however this is balanced with it being a staff reported indicator (vs. pulling documented data from the system).

Currently our medication error rate is 6.8/1000 patient days (YTD Dec). 60% of incidents are no harm incidents; 20% mild harm; 16% near miss; 1% moderate harm; <1% severe harm. The total number of medication error reports submitted by staff is up 15% over last year at the same time, but the distribution of severity and total patient days remain largely unchanged.

Recent work supporting a Just Culture including a new policy, huddle visits by the Patient Safety Lead, streamlining the RL reporting templates, Patient Safety Lead involvement in departmental level reviews, and notification of med error reports to now include the department pharmacist are collectively providing positive reinforcement for staff that reporting results in discussion and potential action/follow up.

5) **Surgical Long Waiters (Red status with three or more periods outside of performance threshold):**

This indicator monitors the percentage of cases on our current surgical wait-list over the targeted wait time for the procedure vs. the total cases on our wait-list. The lower the rate indicates a more appropriate wait-time for surgery. The work that is currently underway for surgical PCOP and QBPs is addressing the surgical wait-list. Work is also underway to review the surgical wait-list and clean and update to most accurately reflect true cases waiting. The target for this indicator is 20% or less. While we are still exceeding target, the percentage of long-waiters has decreased to 30% as of December 31, 2023, from 48.4% last fiscal year.

Next steps:

- The Quality Monitoring Scorecard will continue to be included on a monthly basis

CMH Quality Monitoring Scorecard, FY2023/24

Quality Dimension	Indicator	Unit of	Prior Year	YTD	Target	Trend	Status	Period
Efficient	Conservable Days Rate	%	33.8	34.1	30.0		◆	Dec-23
	Overtime Hours - Average per pay period	hours	3,369.7	3,623.5	850.0		◆	Jan-24
	Sick Hours - Average per pay period	hours	3,774.2	3,208.0	2,090.0		◆	Jan-24
Integrated & Equitable	ALC Throughput	Ratio	0.9	0.8	1.0		◆	Jan-24
	Percent ALC Days (closed cases)	%	28.0	24.2	20.0		◆	Dec-23
	Repeat emergency department visits for Mental Health Care (Average patients per month with four or more visits in 365 days)	Patients	12.2	11.0	11.0		●	Dec-23
Patient & People Focused	Organization Wide Vacancy Rate	%	10.4	8.2	12.0		●	Jan-24
Safe, Effective & Accessible	30 Day CHF Readmission Rate	%	15.3	19.6	14.0		◆	Nov-23
	30 Day COPD Readmission Rate	%	13.0	13.4	15.5		●	Nov-23
	30 Day In-Hospital Mortality Following Major Surgery	%	2.2	1.9	2.1		●	Nov-23
	30 Day Medical Readmission Rate	%	10.8	9.8	13.6		●	Nov-23
	30 Day Obstetric Readmission Rate	%	1.2	0.9	1.1		●	Nov-23
	30 Day Overall Readmission Rate	%	7.5	6.7	9.1		●	Nov-23
	30 Day Paediatric Readmission Rate	%	8.4	6.2	6.1		▲	Nov-23
	30 Day Surgical Readmission Rate	%	5.3	5.4	6.9		●	Nov-23
	ED Length of Stay for Admitted Patients (90% Spent Less, in Hours)	hours	49.1	54.7	44.0		◆	Dec-23
	ED Length of Stay for Non-Admitted Complex Patients (90% Spent Less, in Hours)	hours	9.1	9.8	8.0		◆	Dec-23
	ED Wait Time for Inpatient Bed (90% Spent Less, in Hours)	hours	40.5	45.8	36.0		◆	Dec-23
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours)	hours	6.3	7.0	4.0		◆	Dec-23
	Fall Rate	per 1000 PD	5.4	5.3	4.0		◆	Jan-24
	Hip Fracture Surgery Within 48 Hours	%	89.7	88.6	86.2		●	Nov-23
	Hospital Standardized Mortality Ratio (HSMR)	Ratio	94.0	93.6	100.0		●	Nov-23
	In-Hospital Sepsis	per 1000 D/C	5.6	4.8	3.9		◆	Nov-23
	Long Waiters Waiting For All Surgical Procedures	%	48.4	30.2	20.0		◆	Dec-23
	Low-Risk Caesarean Sections	%	14.9	15.1	17.3		●	Dec-23
	Medication Error Rate	per 1000 PD	5.9	6.8	4.0		◆	Jan-24
	Medication Reconciliation at Admit	%	93.0	94.0	95.0		▲	Jan-24
	Medication Reconciliation at Discharge	%	95.0	95.0	95.0		●	Jan-24
	Obstetric Trauma (With Instrument)	%	15.3	10.4	14.6		●	Nov-23
	Revenue - Achieve budgeted PCOP growth for 2023/2024 (IRM)	$	$8,411,329	$8,081,212	$10,385,865		◆	Dec-23
	Revenue - Achieve Quality Based Procedure Funding (IRM)	$	$22,210,690	$19,115,741	$16,862,355		●	Dec-23

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

AGENDA

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Agenda Item 1.5.13

Patrick Gaskin
President and CEO
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CAMBRIDGE MEMORIAL HOSPITAL

MEMORANDUM

TO: Board of Directors, Cambridge Memorial Hospital

DATE: February 13, 2024

REPORTING PERIOD: October 1, 2023 – December 31, 2023

FROM: Patrick Gaskin
President and CEO

RE: CEO Certificate of Compliance

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

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

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

Exceptions: NIL

Patrick Gaskin
President and CEO

CMH President & CEO Report
March 2024

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

Innovation Fund applications shortlisted

- Five bright ideas have been shortlisted for the second edition of the Staff Innovation Fund.
- After careful consideration, members from Team Innovation, CMH Foundation, Patient and Family Advisory Council, and the Board of Directors have shortlisted the following:
    - Development of an Acuity Calculator for our ICU to support the identification of staffing needs
    - Tracking small devices in the ED to avoid loss/re-purchase
    - Improving Histology specimen tracking within our OR, SDC, and Endo
    - Upgrading our ED tracking board to automatically identify patients from Retirement Homes, Long Term Care homes and those out of catchment to support discharge planning
    - Developing process to reduce lost patient belongings during the course of their stay
- The Project Management Office (PMO) will be meeting with the five submission teams to conduct a deep dive into project scope and required resources to ensure these Bright Ideas align with the Innovation Fund. CMH Executive Committee are meeting at the end of February for final approval.

Seeking staff feedback regarding Values Based Conversation

- The Values Based Conversation (VBC) is one of the many interactions that staff can have with their leader. Furthermore, it can be one of the most meaningful and important conversations in their career path and development.
- For these reasons, a confidential survey has been developed to seek staff's perspective of their experience. Upon completion and sign-off of the VBC, an HR Administrator will send staff a link and QR code to access the survey.
- The feedback will be used for two purposes:
    - Enhance and evolve the form/process to best meet the needs of all involved
    - Provide constructive coaching and feedback for managers/leaders in their own personal development

- The feedback will be aggregated and shared as combined results to the leader. Staff, however, will be encouraged to share their feedback directly with their leader as it is not meant to take the place of face-to-face conversations.

CMH celebrates Black History month

- The theme for Black History Month 2024 is "Black Excellence: A Heritage to Celebrate; a Future to Build."
- 2024 is also a Leap Year which means we get an extra day in February!
- For 29 days, stories were featured daily of Black CMH Team Members (*Voices of CMH*), inspiring Black Canadians and exceptional Black-led organizations.
- Staff were also invited to listen to podcasts, participate in Trivia challenges and enjoy local musicians and food truck Be sure to check back each day to read and be inspired by their stories. We invite you to learn and participate in upcoming activities throughout February. Click the links below to explore!

ICCAIR recipients featured

- Bill Hibbs, manager Physical Plant & Property (February) –Bill was nominated by two colleagues for the actions he took to save the life of a staff member.
    - *On January 10th, 2024, one of our employees in Facilities collapsed during huddle, resulting in a code blue. Bill Hibbs took immediate action providing scene safety followed by initiating CPR. CPR was initiated immediately, which aided to saving the employees life. On behalf of all the Maintenance crew and Security, Thanks Bill!* Matt Lukis, Security
    - *Not only has Bill been a valuable addition to our team, he definitely was caring this day. Saving a staff member's life right before our eyes!* Nick Hayward, Maintenance
- Dan Khoshabeh, volunteer, Medical Day Care (January)
    - *I nominate Dan for this award due to his consistent application of our values here at Cambridge Memorial Hospital.*

      Dan shows up to Medical Day Care on time for many shifts during the week, showing such accountability to his position. I regularly see Dan wiping chairs and tables right down to the legs to ensure patient safety in a respectful way.

      In the chemo suite, patients are offered beverages and snacks, which he delivers, at times on a cart because of how many people he is delivering the goods to.

      Dan is a quiet but powerful entity that always shows that he cares about the role he is in. During the re-routing of patients to the third floor to get to A-Wing, I've seen him diligently directing with pride and reassurance. Dan, in his youth shows exemplary traits that any facility should be proud to have as a member. Thanks Dan, for all you do. Tara Farias, Medical Day Care

- Amanda Hyjek, Physiotherapist
    - *Every department has 'a person' - an individual who everyone goes to - someone with years of experience and high emotional intelligence. That person for us is Amanda Hyjek. Amanda is our OTA/PTA for Med A and ICU. We call on her to support our programming for 46 patients. Not all in one day thank goodness - but that can add up to A LOT of programs.*

      And you know what? She's really good at it. It takes a special person to develop rapport with people of all ages and from a variety of social and cultural backgrounds. For Amanda - no problem!

      She also organizes everything around us - equipment, the office and decorations for holidays - keeping JOY in the workplace. Deb Taggart, Mara Thornsteinson & JC Caballes - Allied Health

CMH Staff Trust Fund Diversity Bursary recipients announced

- Since 2019, the Cambridge Memorial Hospital Staff Trust Fund Diversity Bursary has been assisting African Canadians, Indigenous people, persons of colour, persons with disabilities and/or those identifying as 2SLGBTQIA+ with their pursuit of post-secondary education in a health-related discipline. The longer-term goal of the fund is to promote a more diverse health care workforce.
- Three awards are given on an annual basis, each worth $1000. In 2023, S. Ming Chen (medicine), Kaeley Nelson (nursing) and Ryan Sudhakar (medicine) were the recipients of the diversity bursary.
    - S. Ming Chen is a third-year medical student studying at McMaster University – Waterloo Campus. His fascination with health care and the drive to become a cardiac surgeon started when he was an undergraduate at the University of Ottawa. However, it was in his medical rotations that he became aware of the systemic barriers that exist in our system. His reference noted: "Ming is self-reflective and understands that being a medical student is a privilege. He has turned this into a means to advocate for and lead outreach programs for those disadvantaged and in need of care."
    - Kaeley Nelson is an Emergency Department nurse who is bridging her diploma into a Nursing Degree. As a busy mom of two boys, she is currently enrolled part-time in the first year of the Nursing Degree program at Nipissing University. While she identifies with the 2SLBGTQIA+ community, her reference said she worked extremely hard – over four years - to rehabilitate from injuries sustained in a car accident. Kaeley could not get back to being Child & Youth worker despite her resilience. So instead, she parlayed her passion for helping people and retrained as a nurse – a role she absolutely loves.
    - Ryan Sudhakar is currently in his third year of study in the Medicine program at McMaster University - Waterloo Campus. Throughout his education journey, he remained fascinated with human psychology and how to help those who are struggling, which has led him to consider a

future in psychiatry. He is very active in the community, promoting in his free time cancer screening to underserved populations at local multicultural festivals. He also organized a teddy bear clinic to help young children become less afraid of health care through the 'diagnosis and treatment' of their stuffed animals.

New SPECT-CT delivered to DI

- Diagnostic Imaging received an important delivery on Tuesday, Feb. 20 - a brand new *Siemens Symbia Pro.SpectaX3*, also called a SPECT CT.
- This new addition will complement the three-year old Siemens Symbia Evo Gamma Camera and replace a 20-year old CT Scanner.
- The advantage to the new SPECT CT is that it can operate as both a 64-slice CT system and a Nuclear Medicine Gamma Camera! This allows our talented Nuclear Medicine Technologists to image patients for cardiology and general nuclear medicine studies, as well as, standalone diagnostic CT scans as back up, if required.
- Having both options during the same imaging session, allows for more direct comparison between CT and nuclear medicine images while improving the accuracy of the exam. The machine is currently being installed in the newly renovated Nuclear Medicine department which has the space to accommodate this state of the art technology.
- The SPECT CT was also chosen because it allows for improved image quality as it provides attenuation correction, a mechanism that removes soft tissue artifacts from images. Through the use of this technology, the Nuclear Medicine team will be better positioned to demonstrate organ function, disease processes and enhance treatment plans, furthering patient care at CMH.
- Nuclear Medicine officially moved into their new space on Saturday, February 24 after hosting a fantastic open house the day before.

AEDs installed in public areas of the hospital

- An Automated External Defibrillator (AED) is a vital tool that can save lives in critical moments of cardiac arrest. CMH now has five of these devices in public spaces.
- Knowing an AED is accessible provides reassurance in environments where cardiac emergencies may occur, offering peace of mind and potentially saving lives. With the recent donation of a new AED from a generous donor, they are located in the:
    - Main Lobby – by the Gift Shop (Wing A, Level 1)
    - Mental Health Unit/Day Hospital hallway leading to the elevator (Wing A, Level 3)
    - Outpatient Clinics (Wing C, level 2)
    - Switchboard/Wing C elevator lobby (Wing C, Level 1)
    - Wing D entrance (Wing D, Level 1)
- AEDs' automated functionality and easy visual guides provides individuals without medical training the ability to operate it effectively. Swift action can

significantly increase a person's chances of survival and reduce the risk of long-term complications.

BRIEFING NOTE

Date: February 14, 2024
Issue: Quality Improvement Plan (QIP) 2024 – Metrics and Narrative
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Liane Barefoot, Director Patient Experience, Quality, Risk, Privacy & IPAC; Chief Privacy Officer
Approved by: Mari Iromoto, Senior Director Strategy & Performance, CIO
Stephanie Pearsall, Vice President Clinical Programs, CNE

Attachments/Related Documents:

Appendix 1 – QIP 2024 – Narrative
Appendix 2 – QIP 2024 – Priorities by Sector

Alignment with 2023/24 CMH Priorities:

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

Recommendation/Motions

2024 QIP Metrics for Approval

Proposed motion, that the Quality Committee endorses the three (3) 2024 Quality Improvement Plan (QIP) Metrics as presented below, and forward to the Board of Directors for approval.

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

2024 QIP Narrative for Approval

Proposed motion, that the Quality Committee endorses the 2024 Quality Improvement Plan (QIP) Narrative as presented in Appendix 1, and forward to the Board of Directors for approval.

Background
Emerging from the COVID-19 pandemic, in 2023-24 Ontario Health (OH) resurrected the requirement for Hospitals to develop a QIP and to have it uploaded to the Navigator by March 31st annually.

As discussed at the February 7, 2024 QIP planning meeting and presented in Appendix 2 there are no Mandatory indicators for Hospitals for 2024/25. There are thirteen (13) Optional Indicators presented for Acute Care.

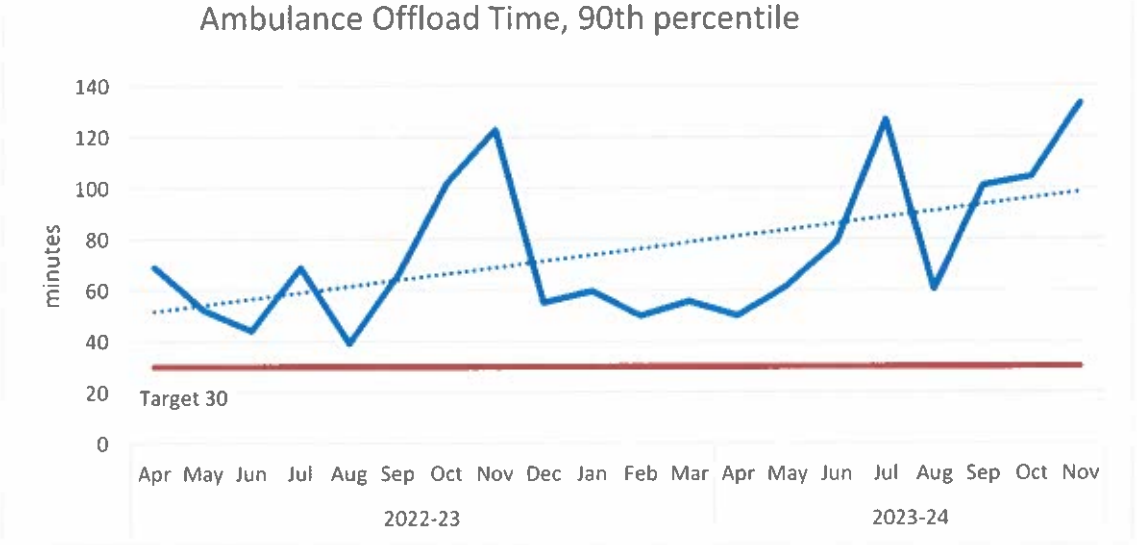
In addition to the work plan (metrics) all Hospitals are required to upload a Narrative to the Navigator with answers to questions provided by OH and included as Appendix 1.

The following indicators were discussed at the February 7, 2024 QIP planning meeting including current CMH performance and rationale for including or omitting each metric from the 2024 QIP as presented below.

2023/24 QIP Indicators		Include	Omit
# of patients/month with 4 or more ED visits for MH care in past 365 days			√
Alternative level of care (ALC) rate			√
Priority Issue	**2024/24 OH Optional Indicators**	**Include**	**Omit**
Access & Flow	90th Percentile ambulance offload time	√	
	90th Percentile ED length of stay – admitted patients	√	
	90th Percentile ED wait time to inpatient bed		√
	Alternate level of care throughput ratio		√
	% of patients who visited ED and left without being seen by a physician		√
Equity	% of staff who have completed relevant DEI and antiracism education – Rainbow Health Foundations course	√	√
	Average ED wait time to PIA for individuals with sickle cell disease (CTAS 1 & 2)		√
	Rate of ED 30-day repeat visits for individuals with sickle cell disease		√
	% of ED visits for individuals with sick cell disease triaged with high severity (CTAS 1 & 2)		
Experience	Did patients feel they received adequate info about their health and their care at discharge?		√
Safety	Rate of delirium onset during hospitalization		√
	Rate of medication reconciliation at discharge		√
	Rate of workplace violence incidents resulting in lost time injury		√

QIP 2024 Target Recommendations
90th Percentile Ambulance Offload Time
As presented at the February 7, 2024 special QIP planning meeting this indicator reflects the time between ambulance arrival at CMH emergency department until care is transferred to CMH staff from paramedics, measured in minutes.

The ambulance offload time has been increasing through Fall 2023. YTD 90th percentile results to end of November 2023 is 90 minutes, but has been over 100 minutes since September 2023.



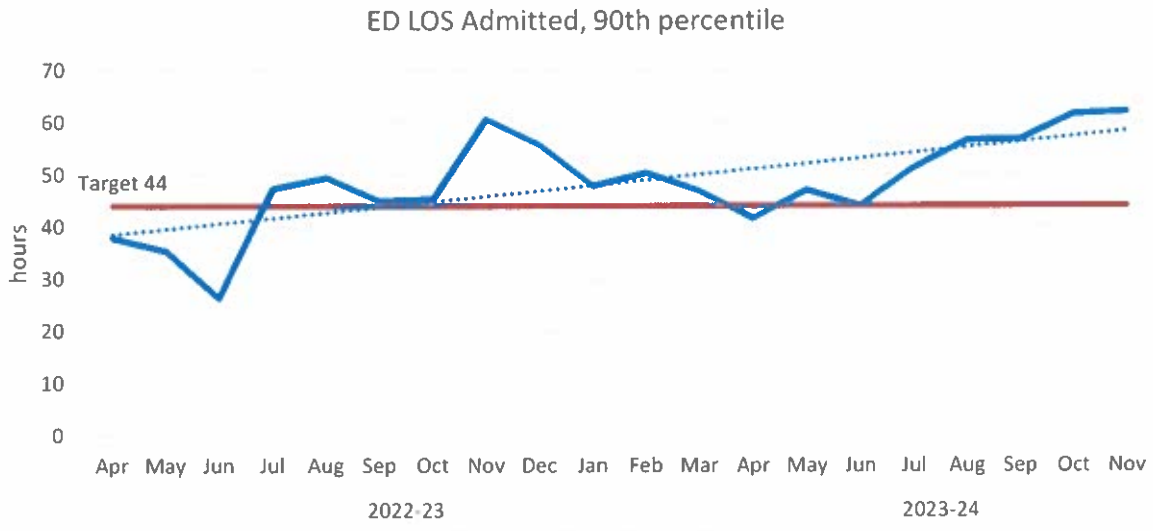
The 90th percentile Pay for Results (P4R) target for this metric is 30 minutes which is being recommended as the QIP 2024 target.

90th Percentile ED Length of Stay (for Admitted Patients)
There are three variations of this metric:

- ED length of stay – admitted
- ED length of stay – non admitted, high acuity
- ED length of stay – non admitted, low acuity

It was recommended by management at the February 7, 2024 special QIP meeting to include the ED LOS for Admitted patients as a major proxy measure to reflect hospital wide flow efforts including work on discharges in addition to work within the ED department.

90th percentile ED LOS for admitted patients is the time between triage and when an admitted patient leaves ED for an available inpatient bed, measured in hours.



The 90th percentile Pay for Results (P4R) target for this metric is 44.0 hours which is being recommended as the QIP 2024 target.

# of Staff who have completed the Rainbow Health Foundations Course
CMH has purchased 500 licenses for Rainbow Health Ontario Foundations course for staff which include seven online, self-directed modules on 2SLGBTQI+ health intended for healthcare and social services providers. With recognition that care for 2SLGBTQI+ individuals is only one aspect of providing equitable care, there was consensus to include this as an early indicator to signal commitment and movement in this space.

The target recommendation for this metric is set at 70% of the licenses purchased for the first year, or 350 staff to complete the course.

Narrative
The QIP Narrative is complimentary to the work plan (metrics) and contains standard questions for all organizations. The Narrative, along with the work plan are posted externally on the CMH website and therefore need to be written at a level intended for the public. The QIP 2024 Narrative is presented as Appendix 1.

Next Steps
Final QIP 2024 including metrics with targets and narrative endorsed by Quality Committee members.

Final QIP 2024 including metrics with targets and narrative to the Board of Directors on March 6, 2024 for approval.

Once approved by the Board of Directors the final QIP 2024 including metrics with targets and narrative loaded into the OH Navigator prior to March 31, 2024.

CAMBRIDGE MEMORIAL HOSPITAL

Cambridge Memorial Hospital

Quality Improvement Plan (QIP) Narrative – 2024

1. **Overview** In this section, you may wish to include a description of how you are working to improve care within your organization or an achievement your organization is most proud of. This opening paragraph will set the context for what your organization will be working toward through your QIP. Recommended Length: 250 words.

The 2022-27 CMH Strategic Plan has introduced an 'Advance Health Equity' pillar to the plan. The CMH Diversity Council members have been guiding the work contained in the Diversity Equity and Inclusion plan that will incorporate equity indicators.

In 2023 CMH welcomed four (4) surveyors from Accreditation Canada to assess our performance against approximately 2000 standards that are grounded in patient safety and quality. CMH voluntarily chose to include a Patient Surveyor as part of this survey team which provided an additional lens as to how we co-develop and deliver programs and services with patients and their family members. CMH achieved the highest possible ranking, Exemplary, from this assessment.

Emerging from the COVID-19 pandemic and defining a new normal has been a challenge for many sectors, and healthcare is certainly no exception to this. Throughout the pandemic Cambridge Memorial Hospital (CMH) has actively sought out unique and innovative ways to support staff; understanding that staff are essential in the care and service that is delivered to the residents of Cambridge and North Dumfries. CMH continues to face staffing challenges despite active recruitment strategies, which many organizations across the health care sector are experiencing. The recruitment of new staff and the retention of existing staff is an organizational priority.

Another identified priority for the organization in the upcoming year will be access and flow within the hospital; ensuring that residents of Cambridge and North Dumfries are receiving the right care, at the right time, in the right place. The organization will strive to meet provincial targets.

2. **NEW: Access and Flow** Optimizing system capacity, timely access to care, and patient flow ultimately improve outcomes and the experience of care for patients, clients, and residents. Health service organizations across the system, including inter-professional primary care, long-term care, and hospitals, are working in partnership and across care sectors on initiatives to avoid unnecessary hospitalizations and avoid visits to emergency departments through new models of care and by ensuring timely access to primary care providers. In this section, you are encouraged to share improvements that are supporting patient/client/resident access to care in the right place at the right time. Recommended Length: 250 words.

It is an organizational priority that patients within CMH are receiving timely access to care. Strategies to address access and flow allows for the efficient flow of patients through the hospital, ensuring timely access to care and improved patient outcomes. The inability to effectively and efficiently flow patients through Emergency Departments

(ED) negatively impacts performance with respect to ED pay for performance metrics, causes delays for Emergency Medical Services (EMS) such as offload delay all of which have an impact on patients within our community. The inability to effectively and efficiently flow patients through our inpatient units limits our ability to provide the right care to the right patients in the most appropriate setting and may result in delays in care. Provincial metrics such as provider initial assessment, Emergency department length of stay and EMS offload times are several metrics that CMH are currently focusing on to improve access to care. Improving the flow of patients through a hospital is identifying the barriers, breaking these barriers into smaller, more achievable goals with a focus on improvement. Based on this a number of rapid improvement events, with internal and external stakeholders, guided by continuous quality improvement principles are scheduled to identify areas of opportunity across the organization.

3. **Equity and Indigenous Health** Ontario Health is committed to driving improved and equitable outcomes to reduce health inequities across the province. Advancing health equity for communities in Ontario requires strategic and sustained efforts. Some health service organizations have established or are developing an Equity, Inclusion, Diversity and Antiracism work plan and First Nations, Inuit, Metis, Urban Indigenous work plan (that include existing provincial priorities such as French language health services, Disabilities Act, Black Health Plan, etc.) based on Service Accountability Agreement obligations. This is an opportunity to share your organization's quality improvement initiatives that are driving equity and Indigenous health and Indigenous cultural safety initiatives. Recommended Length: 250 words.

   To date in our Diversity, Inclusion, and Equity (DEI) journey CMH has appointed an executive champion, hired an Inclusion Lead, expanded the role of a manager to support this work, and formed a Diversity Council (DC). A DEI plan was developed in support of the DC with five (5) priority themes.

   CMH's Diversity Council (DC) acts as the voice and promotes all DEI initiatives across the organization. Each council member was interviewed to ensure diverse cross-representation and are encouraged to provide insight to topics through their unique lived experiences. This contributes to a more inclusive and equitable work environment for the groups they represent.

   Accomplishments over the past year include:
   - Inclusion Lead added to the hospital's Accessibility Committee
   - Added an overt and inclusive recruitment statement to job postings and incorporated inclusive-focused questions into interview guides
   - Created a CMH DEI event calendar
   - Formed a partnership with the Southwest Ontario Aboriginal Health Access Centre (SOAHAC) and introduced the role of an Indigenous Patient Navigator
   - Collaborated with SOAHAC to develop and implement a new Smudging Ceremony Policy
   - Successfully supported three smudging ceremonies

4. **Patient/Client/Resident Experience** This is an opportunity for you to share how you incorporate experience information (this may include from surveys, patient/client/resident

advisory committees, or other feedback you receive about care experiences and quality of life) into improvement activities. Recommended Length: 250 words.

In 2023 the CMH Board of Directors endorsed a CMH first, a multi-year Patient Experience Plan. Co-developed with our Patient and Family Advisory Council (PFAC) members, this plan contains five theme areas:

- Formalized Roles;
- Continuous Feedback Loop;
- Communication is a Cornerstone;
- Actions and Environment Demonstrate Respect for Diversity; and
- Adopt Innovative Digital Solutions

Over the past year CMH has implemented language translation tablets that allow staff to access live translators in 200+ languages to provide care in the patient's language of choice including American Sign Language. In 2023, CMH was fortunate to work with a member of the deaf community to create a learning video for staff on how to use the translation tablets and the benefits of doing so.

In 2023, as with other Ontario hospitals, CMH implemented a new electronic platform for patient surveying and has started to share the results of these surveys with various programs and the Patient and Family Advisory Council (PFAC). This work will continue into 2024 as this platform is expanded to include benchmarking opportunities. Benchmarking will allow CMH to compare results with other hospitals in Ontario and share learnings.

Based on feedback received from patients and their families the CMH Patient Experience team will be developing a more standardized process for managing patient belongings. The initial work will focus on medical required belongings such as hearing aids, dentures, glasses and walkers.

5. **Provider Experience** It continues to be a challenging time for health care organizations with unprecedented human resources challenges. Many organizations are currently implementing innovative practices to improve workplace culture, providing recruitment incentives, and optimizing staff to the full scope of practice. In this section, you are encouraged to share how you are improving staff experience and the practices your organization is undertaking to manage current health workforce challenges. Recommended Length: 250 words.

During the COVID-19 pandemic it became increasingly evident that CMH needed to support existing staff in new, enhanced, and creative ways. Pivotal to delivering on that commitment was the investment into a Wellness & Well-Being Specialist role.

A few uniquely "CMH" staff supports are as follows:

- Employee Engagement Council which is a group of staff from various roles and departments that advise leadership.
- Ember, our facility dog. CMH is the first hospital in North America to have a facility dog who 'attends' work daily with their handler, rounds frequently to various departments, attends all post-code debriefs, and is available ad hoc to support staff.
- Enhanced mental health coverage for staff for the past 2 years.

- A monthly wellness calendar that combines Wellness, Learning, and DEI appreciation events both at CMH, and in the broader community.
- Rotation of staff appreciation events throughout the calendar year (Children's holiday event, Thank-you event to coincide with Valentine's Day, Summer BBQ, holiday meal, May the 4th Star Wars day) organized and delivered by rotating teams of leaders.
- Wellness Loop passport program encouraging staff to participate in various activities related to physical, emotional, social, environmental, intellectual, and financial dimensions.
- Many values (Caring, Collaboration, Accountability, Innovation, Respect = CCAIR) based events – staff swag jackets with value of choice on the back; I-CCAIR peer to peer recognition award; values based performance appraisals

Despite the above initiatives, CMH continues to experience ongoing health human resource challenges. Recruitment, particularly in speciality areas, remains a top priority for CMH. Efforts to streamline and automate the entire cycle of recruitment are underway to support both the recruiting leader and newly on-boarded staff.

6. **Safety** Organizations are encouraged to use this section to share your approach or standardized process used to learn from patient safety events. It may be valuable to provide examples of any new innovations that you have used to share learnings about patient safety with patients/residents/families to prevent future occurrences. Recommended Length: 250 words.

   Safety of staff and patients is paramount for the organization. Central to this is that staff feel supported to report incidents and confident that they will be reviewed through a learning lens, without fear of reprisal.

   CMH has formally launched our commitment to a Just Culture. A Just Culture strives to balance systemic contributors with the professional accountability. While not synonymous with a blameless culture, a Just Culture looks for failures in the system before looking to individuals.

   In 2023 there was renewed effort into (re)defining roles and accountabilities related to the incident review process and in 2024 there will be the development of internal mechanisms to assess ourselves to ensure compliance.

   In 2023, CMH developed a patient facing brochure titled 'Your Role in Safety'. This highlights what patients and their family members can expect in the various areas of safety (infection control, preventing falls, medication safety, confirming your identity), and how and what they should question.

   CMH is poised to launch our inaugural Safe-T-Cast staff news letter in conjunction with IHI Global Patient Safety Awareness Week in March 2024 highlighting learnings from reviews and policy/process changes that have been implemented.

7. **NEW Population Health Approach** Population health-based approaches involve a broadening focus to include being proactive in meeting the needs of an entire population. This includes providing proactive services to promote health, prevent disease, and help people live well with their conditions in every interaction with the health system. In this section, you are encouraged to share how your organization is

working in partnership with other health system providers or for those who are part of an Ontario Health Team, on population-based approaches to care for the unique needs of their community. Recommended Length: 250 words.

The corporate Clinical Services Growth Plan was developed based on input from medical and professional staff, combined with data, about which services residents of Cambridge and North Dumfries could be potentially be leaving the region for. Two unique programs that have emerged as part of the Clinical Services Growth Plan are a multi-disciplinary Liver Health Clinic and a Transgender Health Clinic.

CMH is an active participant of the Cambridge North Dumfries Ontario Health Team (CND-OHT) and through this partnership has worked with system partners on initiatives over the past year to enhance access to community-based mental health services in an effort to divert these patients from the emergency department. Planning is currently underway to provide community-based mental health services to Indigenous patients in a culturally sensitive environment.

Integrating population health and health equity, CMH's data analysts have developed an Equity Dashboard to better understand how and to whom services are delivered, or equally important, potentially missed. For example, the patient population that leaves the Emergency Department without being seen is analyzed through a DEI lens to determine if there are groups or sub-groups we should be seeing/doing things differently for.

2024/25 Quality Improvement Plan Indicator Matrix

Priority issues	*Optional indicators* (by sector)		
	Hospital	**Interprofessional primary care**	**Long-term care**
Access and flow *A high-quality health system provides people with the care they need, when and where they need it.*	• 90th percentile ambulance offload time • 90th percentile ED length of stay • 90th percentile ED wait time to inpatient bed • Alternate level of care throughput ratio • % of patients who visited the ED and left without being seen by a physician	• Patient/client perception of timely access to care • Number of new patients/clients/enrolment	• Rate of potentially avoidable ED visits for long-term care residents
Equity *Advancing equity, inclusion and diversity and addressing racism to reduce disparities in outcomes for patients, families, and providers is the foundation of a high-quality health system.*	• % of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education • Average ED wait time to PIA for individuals with sickle cell disease (CTAS 1 or 2) • Rate of ED 30-day repeat visits for individuals with sickle cell disease • % of ED visits for individuals with sickle cell disease triaged with high severity (CTAS 1 or 2)	• % of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education • Completion of sociodemographic data collection	• % of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education
Experience *Better experiences result in better outcomes. Tracking and understanding experience is an important element of quality.*	• Did patients feel they received adequate information about their health and their care at discharge?	• Do patients/clients feel comfortable and welcome at their primary care office? • Do patients/clients feel involved in decisions about their care?	• Do residents feel they can speak up without fear of consequences? • Do residents feel they have a voice and are listened to by staff?
Safety *A high-quality health system ensures people receive care in a way that is safe and effective.*	• Rate of delirium onset during hospitalization • Rate of medication reconciliation at discharge • Rate of workplace violence incidents resulting in lost time injury		• % of long-term care residents not living with psychosis who were given antipsychotic medication • % of long-term care residents who fell in the last 30 days

Note: Organizations may also consider adding custom indicators to address their own improvement opportunities and collaborative work with other health service providers.

Abbreviations: *ED*, emergency department; *CTAS*, Canadian Triage and Acuity Scale; *PIA*, physician initial assessment

Need this information in an accessible format? 1-877-280-8538, TTY 1-800-855-0511, info@ontariohealth.ca

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CAMBRIDGE MEMORIAL HOSPITAL

Quality & Patient Safety Plan

2022-27

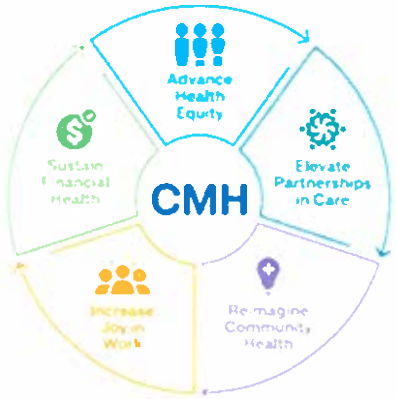
Liane Barefoot, Director, Patient Experience, Quality, Risk, Privacy & IPAC
Kellen Baldock, Patient Safety & Quality Lead

Corporate Plan Status Overview

There are 19 corporate plans housed within our five Strategic Pillars. Each corporate plan guides the work of its respective department to ensure alignment with our 2022-27 Strategic Plan.

Version Date: February 14, 2024

LEGEND:
ACTIVE = plan is approved and currently active
NET NEW = plan is the first of its kind and is undergoing development



Sustain Financial Health		
Corporate Plan	**Plan Owner(s)**	**Status / Approval Date**
Multiyear Financial Plan	Trevor Clark and Michelle D'Souza	March 2024
Multiyear Capital Plan	Trevor Clark and Valerie Smith-Sellers	March 2024

Increase Joy in Work		
Corporate Plan	**Plan Owner(s)**	**Status / Approval Date**
Human Resources Plan	Susan Toth and Trevor Clark	ACTIVE
Wellness and Wellbeing Plan	Susan Toth and Trevor Clark	ACTIVE
Employee and Physician Engagement Plan	Susan Toth and Trevor Clark	ACTIVE
Corporate Communications and Engagement Plan	Stephan Beckhoff	ACTIVE

Advance Health Equity		
Corporate Plan	**Plan Owner**	**Status / Approval Date**
Diversity, Equity, and Inclusion Plan (2022-27)	Mari Iromoto	ACTIVE
Indigenous Truth & Reconciliation Guide	Patrick Gaskin	NET NEW
Accessibility Plan (2023-28)	Liane Barefoot	ACTIVE
Senior Friendly Hospital Plan (2019-23)	Stephanie Pearsall	ACTIVE

Elevate Partnerships in Care		
Corporate Plan	**Plan Owner(s)**	**Status / Approval Date**
Clinical Services Growth Plan (2022-27)	Stephanie Pearsall and Dr. Winnie Lee	ACTIVE
Patient Experience Plan	Liane Barefoot	ACTIVE
Quality and Safety Plan	Liane Barefoot	March 2024
Capital Redevelopment Plan	Patrick Gaskin / Amanda Thibodeau	ACTIVE

Reimagine Community Health		
Corporate Plan	**Plan Owner**	**Status / Approval Date**
Ontario Health Team Plan (2022-25)	Patrick Gaskin and Kristina Eliashevsky	ACTIVE
Innovation Plan	Mari Iromoto	NET NEW
Digital Health (includes HIS) Plan	Rob Howe	March 2024
Operational Excellence Plan	Kyle Leslie	March 2024
Environmental Sustainability Guide	Rob Howe	March 2024

Quality & Patient Safety Plan

Corporate Plan Owner: Liane Barefoot; Director, Patient Experience, Quality, Risk, Privacy & IPAC

Vision: CMH provides safe, reliable care that is informed by best practices.

5-Year Success Goal: Strong culture of continuous quality improvement built on a fair and just culture.

Priority Themes:

1. Just Culture
2. Robust Processes & Frameworks
3. Medication Safety
4. Safe Transitions

Success Metrics:

- Implement Closed Loop Medication Management System
- Maintain Exemplary Standing with Accreditation Canada (2023, 2027)
- Measurement of Patient Safety Culture at CMH (Canadian Patient Safety Culture Survey)

Quality & Patient Safety Plan Themes

Priority Themes		
1	Just Culture	Fully adopting and formalizing Just Culture principles.
2	Robust Processes & Frameworks	Review, update and standardize quality and patient safety processes and frameworks.
3	Medication Safety	Implementing standardized, safe and comprehensive medication practices throughout all stages of the medication management process, supported by best practices and state of the art technology and equipment.
4	Safe Transitions	Integrated communication and coordination among patients, families, the hospital team and community partners at care transitions.

1. Just Culture

Aligned Corporate Plans

Diversity, Equity and Inclusion Plan

Employee & Physician Engagement Plan

*Joy in Work - psychological safety

Priority Theme:

Fully adopting and formalizing Just Culture principles

Supporting Explanation:

Creating an atmosphere of trust and shared accountability, where healthcare workers feel supported to identify and report potential and actual safety incidents to reinforce learning and in the spirit of continuous improvement.

Tactic Ideas:

1. Build Awareness and Integrate Principles of Just Culture into Regular Practices
2. Foster Environment for Reporting Near Miss and No Harm Patient Safety Incidents
3. Develop Communication Strategy to Disseminate Learnings from Patient Safety Incidents
4. Increase Transparency in Incident Reporting and Review Processes.
5. Integrate Equity and Inclusion into Incident Reviews
6. Develop Patient Safety Education Curriculum

2. Robust Processes & Frameworks

Aligned Corporate Plans

Patient Experience Plan

Operational Excellence Plan

Priority Theme:

Review, update and standardize quality and patient safety processes and frameworks.

Supporting Explanation:

Standardized roles, and accountabilities of individuals and committees, including the cascading of information aligned to an updated quality and patient safety framework.

Tactic Ideas:

1. Standardize Roles and Responsibilities in Incident Management
2. Enhance Disclosure of Harm Processes
3. Evaluate Existing Quality Framework
4. Build Organizational Capacity for Quality Improvement
5. Evaluate Use of Data to Facilitate Quality Improvement, Supporting Best Practices.
6. Standardize Best Practice Committees

3. Medication Safety

Aligned Corporate Plans

Patient Experience Plan   Digital Health Plan

Priority Theme:

Implementing standardized, safe and comprehensive medication practices throughout all stages of the medication management process, supported by best practices and state of the art technology and equipment.

Supporting Explanation:

Medication is the primary intervention in the treatment and prevention of disease and the risk of errors can occur at any and all stages, from procurement to patient administration. Implementing and/or optimizing a system that supports safe medication practices is an organizational priority.

Tactic Ideas:

1. Implement Closed Loop Medication Management, as part of the new Health Information System (HIS)
2. Advance Goal of Full Compliance with the Ontario College of Pharmacists (OCP) and the National Association of Pharmacy Regulatory Authorities (NAPRA) Standards of Practice
3. Establish Infrastructure for Order Set Oversight to Maintain/Support Computerized provider order entry (CPOE)
4. Optimize Narcotic Safety Practices and Explore Opportunities for Opioid Stewardship Program
5. Enhance Patient Education and Medication Counselling Practices at Discharge
6. Introduce State of the Art Pharmacy Equipment/ Technology

4. Safe Transitions

Aligned Corporate Plans

Patient Experience Plan

Diversity, Equity and Inclusion Plan

Digital Health Plan

Priority Theme:

Integrated communication and coordination among patients, families, the hospital team and community partners at care transitions.

Supporting Explanation:

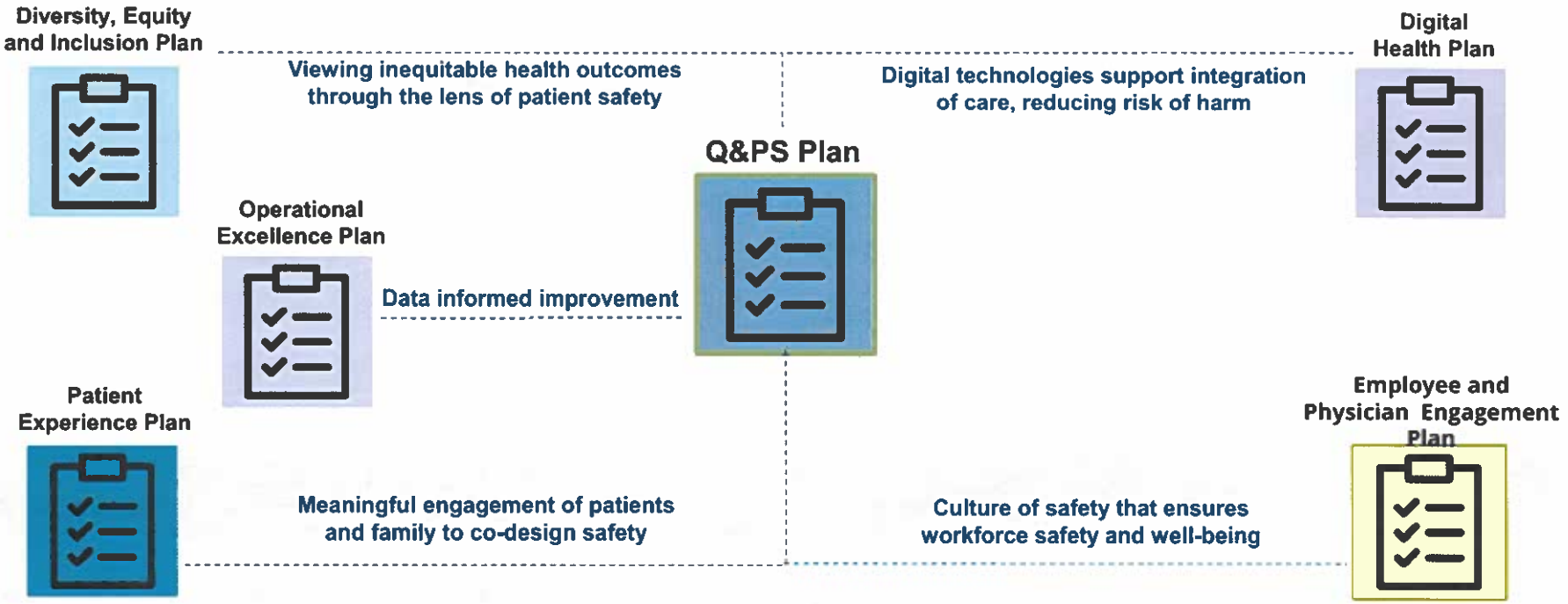
Transitions (in, out, and within CMH) inherently carry risk and require standardization, supporting documentation, rigor in processes and engaging patients as true partners.

Tactic Ideas:

1. Optimize Transition Processes as part of the new Health Information System.
2. Standardize processes for Patient-oriented Education
3. Enable Ease of Access to Personal Health Information
4. Develop Innovative Linkages to Community Partners

Aligning the Quality & Patient Safety Plan

To achieve the vision of health care that is safe, reliable, and free from harm, collective and coordinated action is necessary



Quality & Patient Safety – High-level Project Plan 1/2

Priority Themes	Tactics	2023/ 2024	2024/ 2025	2025/ 2026	2026/ 2027
1. Just Culture	a. Build Awareness and Integrate Principles of Just Culture into Regular Practices				
	b. Foster Environment for Reporting Near Miss and No Harm Patient Safety Incidents				
	c. Develop Communication Strategy to Disseminate Learnings from Patient Safety Incidents				
	d. Increase Transparency in Incident Reporting and Review Processes.				
	e. Integrate Equity and Inclusion into Incident Reviews				
	f. Develop Patient Safety Education Curriculum				
2. Robust Processes & Frameworks	a. Standardize Roles and Responsibilities in Incident Management				
	b. Enhance Disclosure of Harm Processes				
	c. Evaluate Existing Quality Framework				
	d. Build Organizational Capacity for Quality Improvement				
	e. Evaluate Use of Data to Facilitate Quality Improvement, Supporting Best Practices				
	f. Standardize Best Practice Committees				

Quality & Patient Safety – High-level Project Plan 2/2

Priority Themes	Tactics	2023/ 2024	2024/ 2025	2025/ 2026	2026/ 2027
3. Medication Safety	a. Implement Closed Loop Medication Management, as part of the new Health Information System				
	b. Advance Goal of Full Compliance with NAPRA and OCP Standards of Practice				
	c. Establish Infrastructure for Order Set Oversight to Maintain/Support CPOE				
	d. Optimize Narcotic Safety Practices and Explore Opportunities for Opioid Stewardship Program				
	e. Enhance Patient Education and Medication Counselling Practices at Discharge				
	f. Introduce State of the Art Pharmacy Equipment/ Technology				
4. Safe Transitions	a. Optimize Transition Processes as part of the new Health Information System.				
	b. Standardize processes for Patient-oriented Education				
	c. Enable Ease of Access to Personal Health Information				
	d. Develop Innovative Linkages to Community Partners				

Feedback & Suggestions

- Thoughts on the 4 themes?
- Tactics to meet the themes?
- General feedback

Q&PS Plan incorporates evolving patient safety best practices from the following organizations:

Healthcare Excellence Canada

Institute for Healthcare Improvement

Accreditation Canada

HIROC

BPSO RNAO Best Practice Spotlight Organization Canada

ismp Canada

BRIEFING NOTE

Date: February 21, 2024
Issue: January 2024 Financial Statements
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Valerie Smith-Sellers, Director, Finance & Interim CFO
Approved by: Patrick Gaskin, President & CEO

Attachments / Related Documents: Financial Statements - January 2024

Alignment with CMH Priorities

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

Recommendation / Motion

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

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

Executive Summary
Cambridge Memorial Hospital (CMH) has a $2.6M year-to-date deficit position at the end of January after building amortization and related capital grants. The major drivers of the deficit are the unfavorable variance in salaries & benefits ($12.8M) and lower Post Construction Operating Plan (PCOP) revenue achieved than planned ($3.9M). This is partially offset by the favorable variances from Bill 124 ONA, SEIU and OPSEU Reopener Awards ($4.7M), QBPs ($3.4M), the unused portion of the budgeted contingency ($3.2M) and interest income ($3.0M).

CMH is forecasting a balanced position as of March 31, 2024. The forecast assumes that CMH will receive MOH funding to offset the 2023-24 incremental wage impact of Bill 124 arbitration awards. CMH has submitted an application to the Ministry for this funding in November. On

February 9, 2024, MOH verbally indicated that the outstanding Bill 125 submissions would be paid at approximately 85%. Funding letters will follow later in February with cash flow anticipated before year end. This funding is sufficient to balance 2023-24 fiscal year.

Risks

- If CMH had not received incremental bed funding and used PCOP funding to operate the incremental beds, a $7.2M deficit would have been reported January YTD, due to lower weighted case volumes than budgeted for in fiscal 2023-24.
- CMH did not meet PCOP targets December YTD driven by lower weighted cases in emergency and surgery. This fall, the OR's have been closed for a total of 5 days due to water and equipment issues. As a result, PCOP funding tied to surgical volume growth is currently not being achieved. The risks of further decline have been mitigated by engaging a third-party short term to ensure CMH has necessary sterilized tools to perform surgical procedures. The cost of these purchased services was $1.0M.
- ALC patients create bed flow pressures and generate low weighted cases putting volume targets at risk. On average there have been 36 ALC patients in 2023-24 compared to 37 ALC patients in fiscal 2022-23.
- Inflationary pressures are being experienced across all expense lines in particular Food Services and Supplies.
- CMH has renewed fixed price contract with Blackstone Energy Services for 60% of its budgeted consumption of natural gas starting November 2023 for one year.
- The Ministry of Health (MOH) has not completed broad base funding reconciliations for incremental COVID funding the hospital received in 2021-22 and 2022-23. The Finance department has followed MOH guidelines for incremental funding, but there is a risk that MOH will apply rules associated with the guidelines differently, leading to the claw back of some of this funding.
- MOH has verbally indicated that Bill 124 reopener wage increases will be funded at 85%. CMH outstanding Bill 124 submissions total $10.9M. This reduced funding will leave $ 1.6M unfunded. MOH will confirm funding later in February.

Summary

CMH has a $2.6M year-to-date deficit position at the end of January after building amortization and related capital grants. Actual results are $2.5M unfavorable to budget. The fiscal budget favorable variance is driven by:

- $4.7M in Bill 124 ONA, SEIU and OPSEIU Reopener Awards from prior years;
- $3.2M allocation of the budgeted contingency to the end of January;
- $3.4M in Quality Based Procedures (QBP) revenue due to increased hip, knee, shoulder, cardiac, spine and Cancer Care Ontario surgeries;
- $3.0M in interest income;
- $1.2M in MOH Base funding received compared to budgeted;

The favorable variance has been partially offset by:

- $10.9M unfavorable variance in salaries and wages due to higher overtime than budget and use of staffing agencies;
- $3.9M in loss of expected PCOP revenue relating to 2023-24; due to lower than budgeted surgical cases, operational slowdown, and cancellation of procedures.
- $1.9M unfavourable in the benefits in lieu due to part time workers working higher hours;
- $1.0M off-site equipment sterilization cost;
- $0.7M maintenance and repair contracts for building and equipment.

PCOP & Quality Based Procedures Volumes

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

PCOP

PCOP acute inpatient weighted cases has the biggest funding implication for the hospital. Each weighted case generates $4,517 in funding. The 869 weighted case shortfall through January represents a $3.9M loss in funding. The main reasons to the shortfall are lower weighted cases seen in surgical program, operational slowdown, and cancellation of procedures. CMH has an operational slowdown from the last week of July to the first week of August, an OR humidity incident in July and 5 days of closure in September / October related to equipment issues that imposed necessary cancellations. In addition, Emergency experienced lower patient volumes and did not meet PCOP targets January YTD.

The hospital has budgeted to receive $11.1M in PCOP clinical funding in 2023-24, just over 58% of the available $19.3M PCOP funding allocation. Funding recognition is dependent on meeting volume targets. $4.9M of PCOP revenue associated with clinical volumes has been recognized for 2023-24. The YTD shortfall is attributed to the decline in surgical weighted cases and ED not meeting volume targets creating a $3.8M unfavorable variance.

QBP

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

Urgent Medical, Bundled Care and Surgical total revenue was $3.4M favorable to budget due to higher numbers of hip, knee and shoulder replacement surgeries, hip fracture surgeries, heart failure procedures and spinal operations.

Cancer Care Ontario (CCO) QBP revenue was $411K favorable to budget, due to higher numbers of breast surgeries and endoscopy procedures.

Performance Based Funding Summary 2023-24
YTD Period: December

Funding Source	Unit of Measure	Budget	YTD Budget	YTD Achieved	YTD Variance from Budget
PCOP					
Acute IP	Weighted Cases	8,370	5,580	5,350	(230)
Day Surgery/TCC	Weighted Cases	2,491	1,661	1,591	(70)
Emergency	Weighted Cases	2,833	1,889	1,869	(20)
Mental Health IP	Inpatient Days	8,029	5,353	5,117	(236)
QBP					
OH Urgent Medical	Cases	540	360	387	27
OH Bundled Care	Cases	857	571	746	175
OH Surgical	Cases	2,895	1,930	2,430	500
CCO	Cases	470	313	368	55

MOH Funding – Onetime / Other

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

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

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

The MOH confirmed total one time in year allocation of $1,283K for CT and MRI hours to reduce wait time. This is comprised of initial one-time funding of $962K and incremental $321K in November.

MOH Wait Time funding to operate additional CT & MRI hours resulted in a $558K favorable variance to budget. Funding model is changing for current fiscal year pending further details from the Ministry.

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

Billable Patient Services

The $1.1M year to date favourable variance is primarily due to a $1.4M favourable variance in professional fees (partially offset by higher medical remuneration costs), $210K favourable uninsured residents of Ontario, $117K favourable non residents, and $39K favourable variance for insured self pay. The favourable variance is partially offset by unfavourable variances in technical fees ($403K), Workplace Safety and Insurance Board (WSIB) ($177K), and preferred accommodation ($130K).

Recoveries and Other Revenue

The $5.2M year to date favorable variance is driven by $3.0M favorable variance in interest income, $1.8M recovery of Cancer Care Ontario (CCO) reimbursement of oncology drugs, and $0.4M from Recovery of External Services and Compensation.

Expenses

Salaries and Wages

The shortage of health human resources in Ontario has created staffing pressures in many areas across the organization. Salaries and wages were $10.9M unfavorable to budget year to date. The unfavorable variance drivers are Overtime ($4.3M), agency staffing costs ($2.3M), staff training costs ($1.8M), shift premium ($0.6M), sick ($0.6M), worked salaries ($0.5M), modified work ($0.4M) and non-agency Purchased Services ($0.2M).

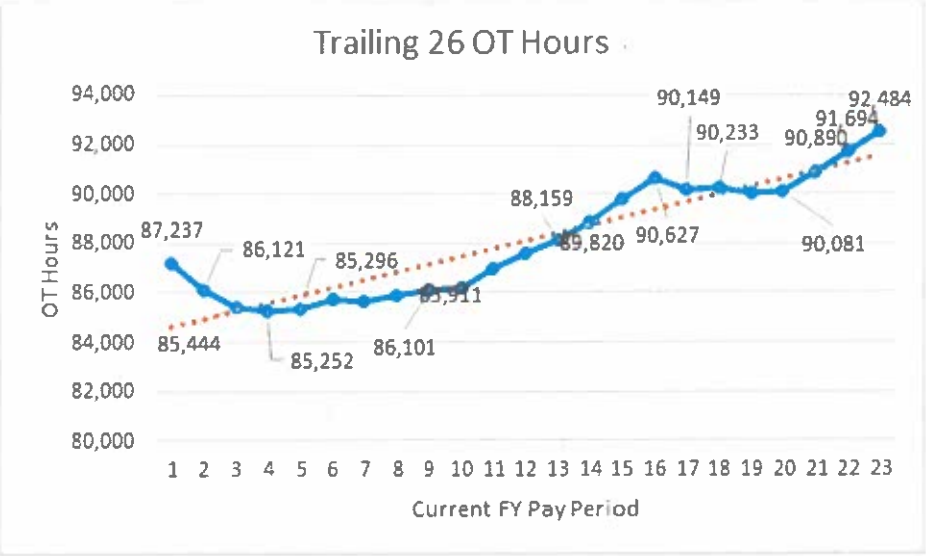
Overtime costs were ($586K) unfavorable to budget in January, increasing the year-to-date unfavorable variance to ($4.3M). Sick time costs were ($136K) unfavorable to budget, resulting

in a year-to-date unfavorable variance of ($637K). At CMH, ONA nurses are guaranteed four hours of pay at two-times their regular hourly rate when they are called in to work or called back from standby. The use of agency nurses ended on January 20, 2024.

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

	January 2024			FY 2023-24		
HOURS	Actual	Budget	Variance	Actual	Budget	Variance
Overtime	9,364	1,928	(7,436)	79,829	19,010	(60,819)
Sick	8,391	4,170	(4,221)	71,540	41,181	(30,359)

The overtime variance is driven by staffing shortages creating high level of vacancies. The chart below is the current fiscal year overtime trailing report. Each data point on the solid blue line identifies the actual results from the previous 26 pay periods – so it shows a rolling year. As you can see it peaked 92,484 hours. The orange dotted line shows that the overall trend is to higher overtime.



Employee Benefits
The $1.9 M unfavourable year to date variance is driven by the benefits in lieu provided to part times which is a result of part time workers working higher hours and a 10% increase in benefit plan premiums.

Medical Remuneration
The $1.5M unfavorable year to date variance is driven by additional professional services for CT (computerized tomography) and MRI (magnetic resonance imaging) ($1.1M), Hospital on Call Coverage New services ($0.2M) and Oncology Associates ($0.2M). There is funding to offset these variances.

Medical and Surgical Supplies
The $1.1M YTD unfavorable variance has been driven by supplies needed for the elective surgeries ($0.5M), general medical and surgical supplies ($0.5M) and Laboratory purchases ($0.1M).

Drug Expense

The $2.1M YTD unfavorable variance is driven by expensing ($405K) chemo medication waste from the room temperature malfunction and expired medications. In addition, higher spending on drugs for the Oncology program ($1.7M). 97% of oncology drug costs are reimbursed by Cancer Care Ontario.

Other Supplies and Expenses
The $0.8M YTD favorable variance is due to the unused contingency allocation of $3.2M, however it is offset by increased MDRD off-site equipment sterilization cost of $1.0M caused by water leakage incidents and operational issues, maintenance repairs and contracts $0.7M, price increase for Lifelabs services $0.5M, $0.4M Professional Fees for HIS and Legal, $0.3M Supplies and Food purchases and $0.3M Sundry Expenses.

Balance Sheet and Statement of Cash

CMH's current cash position is $98.0M, consisting of $79.3M of unrestricted cash and $18.7M of restricted cash. Accounts payable balance at the end of January was $53.4M, consisting of General Accounts Payable ($35.1M) and MOH Payable ($18.3M). Unrestricted working capital available at the end of January is $11.5M.

The working capital ratio is 1.13 and meets the requirements of the Hospital Service Accountability Agreement (H-SAA) target.

Forecast

CMH is forecasting a balanced position for 2023-24.

Higher than budget revenue in QBP ($4.4M), budgeted contingency ($3.9M), Interest income ($3.5M) and MOH one-time prior years funding of $4.7M for Bill 124 retroactive wage settlements offset the unfavorable variances in Overtime ($7.5M), PCOP ($5.3M), Benefits ($3.2M), Agency staffing ($2.3M), and Medical supplies ($1.4M).

Included in the forecast is MOH one-time revenue of $6.2M for 2023-24 incremental wage impact of Bill 124 arbitration awards. Confirmation of the funding rate (85%) is not expected until end of February 2024 with cash flow anticipated before year end.

The MOH is currently reconciling the PCOP funding for 2021-22 and 2022-23. The hospital is expecting a favorable 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 January 31, 2024

Confidential
(Expressed in thousands of dollars)

Month of January 2024					Year to Date				2023-24	2023-24		2022-23 Prior Year Actuals		
Actual	Plan	Variance	% Variance		YTD Actual	YTD Plan	YTD Variance	% Variance	Forecast	Plan	Variance	Jan. 2023	YTD Jan. 2023	2022-23 YE
				Revenue:										
				MOH Funding										
$ 8,012	$ 7,893	$ 119	2%	MOH - Base	$ 79,081	$ 77,909	$ 1,172	2%	$ 94,610	$ 93,185	$ 1,425	$ 7,731	$ 80,672	$ 90,924
2,615	2,064	551	27%	MOH - Quality Based Procedure	21,644	18,284	3,360	18%	25,865	21,434	4,431	2,378	18,970	24,124
563	937	(374)	(40%)	MOH - Post Construction Operating Plan	5,322	9,249	(3,927)	(42%)	5,802	11,062	(5,260)	546	3,702	9,901
1,692	1,654	38	2%	MOH - One time / Other	23,899	16,331	7,568	46%	33,778	19,533	14,245	2,159	17,817	29,486
12,882	12,548	334	3%	Total MOH Funding	129,946	121,773	8,173	7%	160,055	146,214	14,841	12,814	121,161	154,435
1,291	1,221	70	6%	Billable Patient Services	13,164	12,052	1,112	9%	15,795	14,414	1,381	1,457	13,193	15,669
1,752	1,143	609	53%	Recoveries and Other Revenue	16,473	11,281	5,192	46%	19,782	14,537	5,245	1,449	13,565	17,840
344	251	93	37%	Amortization of Deferred Equipment Capital Grants	3,329	2,482	847	34%	4,016	2,968	1,048	314	2,840	3,527
420	283	137	48%	MOH Special Votes Revenue	3,315	2,823	492	17%	3,370	3,370	-	321	2,993	3,910
16,689	**15,446**	**1,243**	**8%**	**Total Revenue**	**166,227**	**150,411**	**15,816**	**11%**	**203,018**	**180,503**	**22,515**	**16,355**	**153,752**	**195,381**
				Operating Expenses:										
7,990	6,773	(1,217)	(18%)	Salaries & Wages	77,802	66,857	(10,945)	(16%)	93,084	79,964	(13,120)	6,771	67,442	86,194
2,360	2,022	(338)	(17%)	Employee Benefits	19,929	18,011	(1,918)	(11%)	25,119	21,929	(3,190)	1,924	17,242	20,765
1,824	1,632	(192)	(12%)	Medical Remuneration	17,467	15,975	(1,492)	(9%)	20,959	19,133	(1,826)	1,832	18,087	22,602
1,269	1,056	(213)	(20%)	Medical & Surgical Supplies	11,495	10,421	(1,074)	(10%)	13,895	12,464	(1,431)	983	9,690	11,842
1,021	824	(197)	(24%)	Drug Expense	10,239	8,133	(2,106)	(26%)	12,312	9,727	(2,585)	817	8,086	9,737
1,786	2,233	447	20%	Other Supplies & Expenses	21,463	22,231	768	3%	25,648	26,575	927	2,374	20,433	26,620
592	485	(107)	(22%)	Equipment Depreciation	5,666	4,792	(874)	(18%)	6,848	5,731	(1,117)	542	5,107	6,194
420	288	(132)	(46%)	MOH Special Votes Expense	3,315	2,815	(500)	(18%)	3,370	3,372	2	321	2,993	3,910
17,262	**15,313**	**(1,949)**	**(13%)**	**Total Operating Expenses**	**167,376**	**149,235**	**(18,141)**	**(12%)**	**201,235**	**178,895**	**(22,340)**	**15,564**	**149,080**	**187,884**
(573)	**133**	**(706)**	**(531%)**	**MOH Surplus / (Deficit)**	**(1,149)**	**1,176**	**(2,325)**	**(198%)**	**1,783**	**1,608**	**175**	**791**	**4,672**	**7,497**
(633)	(640)	7	(1%)	Building Depreciation	(6,321)	(6,317)	(4)	0%	(7,585)	(7,555)	(30)	(634)	(6,307)	(7,573)
484	504	(20)	(4%)	Amortization of Deferred Building Capital Grants	4,833	4,973	(140)	(2.8%)	5,802	5,947	(145)	485	4,916	5,884
$ (722)	**$ (3)**	**$ (719)**		**Net Surplus / (Deficit)**	**$ (2,637)**	**$ (168)**	**$ (2,469)**		**$ -**	**$ -**	**$ -**	**$ 642**	**$ 3,281**	**$ 5,808**

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

(Expressed in thousands of dollars)

	January 2023	March 2023
ASSETS		
Current Assets		
Cash and Short-term Investments	$ 79,303	$ 83,456
Due from Ministry of Health/Ontario Health	6,137	8,317
Other Receivables	6,399	4,354
Inventories	2,635	2,483
Prepaid Expenses	2,902	2,879
	97,376	101,489
Non-Current Assets		
Cash and Investments Restricted - Capital	18,685	22,159
Due from Ministry of Health - Capital Redevelopment	3,243	3,243
Due from CMH Foundation	472	817
Endowment and Special Purpose Fund Cash & Investments	195	194
Capital Assets	291,728	276,999
Total Assets	**$ 411,699**	**$ 404,901**
LIABILITIES & NET ASSETS		
Current Liabilities		
Due to Ministry of Health/Ontario Health	18,255	10,516
Accounts Payable and Accrued Liabilities	35,144	39,599
Deferred Revenue	32,449	32,379
	85,848	82,494
Long Term Liabilities		
Capital Redevelopment Construction Payable	3,995	2,428
Employee Future Benefits	4,466	4,203
Deferred Capital Grants and Donations	274,371	270,121
Asset Retirement Obligation	2,377	2,377
	285,209	279,129
Net Assets:		
Unrestricted	6,782	14,792
Externally Restricted Special Purpose Funds	195	195
Invested in Capital Assets	33,665	28,292
	40,642	43,279
Total Liabilities and Net Assets	**$ 411,699**	**$ 404,902**
Working Capital Balance	11,528	18,995
Working Capital Ratio (Current Ratio)	1.13	1.23

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

(Expressed in thousands of dollars)

	January 2024	March 2023
Cash Provided By (used in) Operations:		
Excess (deficiency) of Revenue over Expenses	$ (2,637)	$ 5,809
Items not involving cash:		
Amortization of capital assets	11,987	13,767
Amortization of deferred grants and donations	(8,164)	(9,411)
Change in Non-Cash Operating Working Capital	3,658	9,262
Change in Employee Future Benefits	263	85
	5,107	19,511
Investing:		
Acquisition of Capital Assets & CRP	(26,716)	(28,165)
Capital Redevelopment Construction Payable	1,567	1,314
	(25,149)	(26,851)
Financing:		
Capital Donations and Grants & CRP	12,414	33,448
	12,414	33,448
Increase (Decrease) In Cash for the Period	(7,628)	26,108
Cash & Investments - Beginning of Year	105,615	79,507
Cash & Investments - End Of Period	**$ 97,987**	**$ 105,615**
Cash & Investments Consist of:		
Unrestricted Endowment and Special Purpose Investments	30	30
Cash & Investments Operating	79,272	83,426
Cash & Investments Restricted	18,685	22,159
Total	**$ 97,987**	**$ 105,615**

AGENDA

Agenda Item 2.4

BRIEFING NOTE

Date: February 29, 2024
Issue: *Amendments to Ontario Not-for Profit Corporations Act, 2010 (ONCA) – Audit Committee Composition*
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☒ Seeking Direction
Prepared by: Stephanie Fitzgerald, Administrative Assistant
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: Terms of Reference for Audit Committee

Proposed Motion

That the Board of Directors approve the amended Terms of Reference for the Audit Committee to increase the number of directors on the committee to five and change status of the non-director committee members from voting to non-voting ~~members~~.

Background

The Ontario *Not-for-Profit Corporation Act, 2010* ("ONCA") was proclaimed in force on October 19, 2021. Hospitals have until October 19, 2024 to transition to ONCA compliance. CMH updated the Corporate By-Law and related Board policies to ensure compliance with ONCA on June 28, 2023.

On April 3, 2023, the Ontario Government introduced Bill 91 or the Less Red Tape, Stronger Economy Act, 2023 ("Bill 91"). Bill 91 amends various pieces of legislation including the Ontario *Not-for-Profit Corporations Act, 2010* ("ONCA"). The amendments to ONCA are effective as of October 1, 2023.

Analysis

The amendments are mostly focused on making changes to the governance rules in the following areas:

- Telephonic and electronic meetings
- Director and Member participation in telephonic and electronic meetings
- Notice of meetings
- Temporary suspension period rules
- Audit Committee composition

Of the above, the most impactful is the amendment set forth for the composition of an Audit Committee. The amendment states:

"A corporation may have an audit committee comprising one or more directors and the majority of the committee must not be officers or employees of the corporation or any of its affiliates."

Apart from the composition of the Audit Committee, the amendments are relatively minor in nature.

The OHA and BLG have prepared a guidance document that provides an overview of the recent legal changes and impacts which is attached to this briefing note.

Discussion

Currently there is lack of consensus on this issue and Ministry guidance is not yet available. It has been interpreted that the effect of this amendment is that only Directors may serve on the Audit Committee of a corporation. Non-directors with finance or audit expertise may attend Audit Committee meetings as invited guests to ensure that the audit committee has sufficient expertise to perform its function.

In consultation with BLG, the OHA recommends hospitals comply with the amendment and ensure that the composition of any audit committee be limited to directors. Non-directors with finance or audit expertise may attend audit committee meetings as invited guests without a vote where necessary to ensure that the audit committee has sufficient expertise to perform its function.

The Governance Committee discussed this issue at its meeting on February 21, 2024 and agreed to recommend to the Board the change in voting status for non-director committee members and to increase the size of the committee to be up to 5 Board members.

Next Steps

Board members will be asked at the meeting of the Board on March 6, 2024 as to their willingness to join the Audit Committee and for their support for the changes. The next meetings of the Audit Committee are May 27, 2024 and June 24, 2024.

AGENDA

CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

SUBJECT: Audit Committee Terms of Reference	**NO.: 2-A-10**
SECTION: Structure, Roles and Responsibilities	
APPROVED BY: Board of Directors	**DATE: ~~June 28, 2023~~TBD**

1. Application

This terms of reference shall apply to Audit 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 Corporate By-Laws.

2. Composition and Independence, Financial Literacy and Authority

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

(i) Up to ~~two~~ five (~~2~~5) elected Directors, one of whom shall sit as Chair of the Committee.

(b) ~~Up to five (5) members appointed by the Board upon the recommendation of the Governance Committ~~Non-voting resources to the Committee will include:

(i) Up to five (5) members appointed by the Board upon the recommendation of the Governance Committee.

(ii) The Vice President Finance and Corporate Services/Chief Financial Officer;

(iii) The Director of Finance; and

(iv) The external auditor, who shall be invited and be heard at all meetings of the Committee

(c) Every member of the Committee shall be independent of the Corporation within the meaning of all applicable laws, rules and regulations including those particularly applicable to the Committee members and any other relevant consideration as determined by the Board.

In addition to the qualities set out in the Board policies on Board succession planning and recruitment, all members of the Committee should be financially literate or be willing and able to acquire the necessary knowledge. Financially literate means the

ability to read and understand financial statements that present a breadth and level of complexity of accounting issues that are generally comparable to the breadth and complexity of the issues that can reasonably be expected to be raised by the Corporation's financial statements. The Chair shall have a background in accounting or related financial management experience which would include any experience or background which results in the individual's financial sophistication, including being or having been an auditor, a Chief Executive Officer or a Chief Financial Officer or other senior officer with financial oversight responsibilities.

Committee members will enhance their familiarity with financial, accounting and other areas relevant to their responsibilities by participating in educational sessions or other opportunities for development.

(d) In fulfilling the responsibilities set out in this terms of reference, the Committee has the authority to conduct any investigation and access any officer, employee or agent of the Corporation appropriate to fulfilling its responsibilities, including the auditor. The Committee may obtain advice and assistance from outside legal, accounting or other advisors as the Committee deems necessary to carry out its duties and may retain and determine the compensation to be paid by the Corporation for such independent counsel or outside advisor in its sole discretion without seeking Board approval.

3. Meetings

The Committee shall:

(a) Meet at least two (2) times annually. The Committee can conduct all or part of any meeting in the absence of management, and it is the Committee's policy to include such a session on the agenda of each regularly-scheduled Committee meeting.

(b) Meet at the call of the external auditor or at the request of any committee member.

(c) Meet with the Chief Financial Officer in the absence of the Chief Executive Officer.

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

(e) Exclude from its meetings any persons it deems appropriate in order to carry out its responsibilities.

4. Specific Duties and Responsibilities

(a) Financial Reporting

The Committee shall be responsible for the oversight of reliable, accurate and clear financial reporting to members, including reviewing the Corporation's annual financial statements and management's discussion and analysis, prior to approval by the Board. Such review of the

financial reports of the Corporation shall include, where appropriate but at least annually discussion with management and the auditor of significant issues regarding accounting principles, practices, and significant management estimates and judgments.

(b) The Committee's Role in the Financial Reporting Process

(i) Work with management and the auditor to review the integrity of the Corporation's financial reporting processes;

(ii) Consider the scope of the audit work performed or to be performed, on an annual basis, and discuss with the auditor any matters arising out of the annual financial statements;

(iii) Review the process relating to and the certifications of the Chief Executive Officer and the senior financial officer on the integrity of the Corporation's quarterly and annual consolidated financial statements, performance metrics, and other public disclosure documents as required;

(iv) Consider the key accounting policies of the Corporation and key estimates and judgements of management and discussing such matters with management and/or the auditor;

(v) Keep abreast of trends and best practices in financial reporting in the public sector including considering, as they arise, topical issues and their applications to the Corporation;

(vi) Review with the auditor and management existing accounting policies and procedures and any significant audit adjustments made;

(vii) Consider and approve, if appropriate, major changes to the Corporation's accounting and financial reporting and policies as suggested by the auditor or management; and

(viii) Establish regular systems of reporting to the Committee by each of management and the auditor regarding any significant judgements made in managements preparation of the financial statements and any significant difficulties encountered during the course of the review or audit, including any restrictions on the scope of work or access to required information.

(c) Internal Financial Controls

The Committee shall be responsible for overseeing the establishment and maintenance of internal financial controls of the Corporation, including:

(i) require management to implement and maintain appropriate systems of

internal financial controls (including controls related to the prevention, identification and detection of fraud), and that also comply with applicable laws, regulations and guidance;

(ii) meet with management and the auditor to assess the adequacy and effectiveness of the Corporation's internal financial controls, including controls related to the prevention, identification and detection of fraud; and

(iii) as required, review reporting by the Corporation to its members regarding internal control over financial reporting.

(d) Oversight of Auditor

The Committee shall review and evaluate the performance, qualifications and independence of the auditor including the lead partners and annually make recommendations to the Board and members regarding the nomination of the auditor for appointment by the members. The Committee shall also make recommendations regarding remuneration and, if appropriate, termination of the auditor, and shall oversee the tendering and award of a multi-year contract for audit services, ensuring that the tendering process is in compliance with provincial public sector requirements. The auditor shall be accountable to the Committee and the Board, as representatives of the members, for its review of the financial statements and controls of the Corporation. In addition, the Committee shall:

(i) review and approve the annual audit plans and engagement letters of the auditor;

(ii) review the auditor's processes for assuring the quality of their audit services including any matters that may affect the audit firm's ability to serve as auditor;

(iii) discuss those matters that are required to be communicated by the auditor to the Committee in accordance with the standards established by the Chartered Professional Accountants of Canada, as such matters are applicable to the Corporation from time to time;

(iv) review with the auditor any issues that may be brought forward by it, including any audit problems or difficulties, such as restrictions on its audit activities or access to requested information, and management's responses;

(v) meet with the auditor and Resources Committee to review the annual audited financial statements and auditor's report prior to the annual meeting;

(vi) receive at any one of its meetings any written report and recommendation of the auditor;

(vii) review with the auditor concerns, if any, about the quality, not just acceptability, of the Corporation's accounting principles as applied in its financial reporting; and

(viii) provide a forum for management and/or the auditor to raise issues regarding their relationship and interaction. To the extent disagreements regarding financial reporting are not resolved, be responsible for the resolution of such disagreements between management and the auditor.

(e) Independence of Auditor

The Committee shall monitor and assess the independence of the auditor through various mechanisms, including:

(i) review and approve (or recommending to the Board for approval) the audit fees and other significant compensation to be paid to the auditor and reviewing, approving and monitoring the policy for the provision of non-audit services to be performed by the auditor, including the pre-approval of such non-audit services in accordance with the policy;

(ii) receive from the auditor, on an annual basis, a formal written statement delineating all relationships between the auditor and the Corporation consistent with the professional standards of the Chartered Professional Accountants of Canada or other regulatory bodies, as applicable;

(iii) review and discuss with the Board, annually and otherwise as necessary, and the auditor, any relationships or services between the auditor and the Corporation or any factors that may impact the objectivity and independence of the auditor;

(iv) review, approve and monitoring policies and procedures for the employment of past or present partners, or employees of the auditor as required by applicable laws; and

(v) review, approve and monitor other policies put in place to facilitate auditor independence, such as the rotation of members of the audit engagement team, as applicable.

(f) Compliance

The Committee shall oversee the establishment and maintenance of processes that ensure the Corporation is in compliance with the laws and regulations that apply to it as well as its own policies. Unless otherwise indicated, legislative compliance is the responsibility of the Audit Committee and includes the following:

(i) ensure compliance with the financial requirements stipulated by the Ministry of Health;

(ii) review with management the Corporation's compliance with applicable financial, legal and regulatory requirements and the legislative compliance management processes;

(iii) review professional pronouncements and changes to key regulatory requirements relating to accounting rules to the extent it applies to the financial reporting process of the Corporation; and

(iv) review with the Corporation's general counsel any legal matter arising from litigation, asserted claims or regulatory non-compliance that could have a material impact on the Corporation's financial condition or reputation.

(g) Oversight of Risk

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

The Committee shall have the primary responsibility for reviewing risk policies related to the following risk management groups: financial and regulatory.

In addition, the Committee has the responsibility to:

(i) review on an annual basis, the Integrated Risk Management Framework for any substantive changes;

(ii) review at least annually reports from Board committees on the status of their assigned risk groups;

(iii) discuss with management the Corporation's major risks and monitor the appropriate progress and completion of plans to mitigate risks identified through the Framework; and

(iv) oversee the monitoring and implementation of actions to improve upon the related performance metrics.

5. General

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

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

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

(c) conduct an annual evaluation of the Committee in which the Committee (and/or its individual members) reviews the Committee's performance for the preceding year for the purpose, among other things, of assessing whether the Committee fulfilled the purposes and responsibilities stated in the terms of reference;

(d) review and assess the adequacy of the terms of reference at least every three years and submitting any proposed amendments to the terms of reference to the Governance Committee and the Board for approval;

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

(f) perform such other functions and tasks as may be assigned from timeto time by the Board.

DEVELOPED: June 12, 2010		**REVISED/REVIEWED:**
November 1, 2012	June 25, 2014	May 27, 2015
May 24, 2017	July 28, 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.
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AGENDA

BRIEFING NOTE

Date: February 14, 2024
Issue: MAC Credentials & Privileging January 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: January 2024 Files for Review

Alignment with 2023/24 CMH Priorities:

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

A meeting of the Medical Advisory Committee took place on Monday February 14, 2024, at 4:30 pm.

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

Committee Recommendations/Reports – Board Approval Sought

Proposed Board Motion:

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

Approved Committee Recommendations/Motions:

THAT the Medical Advisory Committee recommend to the Board of Directors that the standard credentialing files be approved. (Puopolo, Morgan) **CARRIED. The attached Briefing Note**

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

MOTION: (Puopolo, Morgan) that the new credentialing files be approved as distributed. None opposed. **CARRIED. New Files**

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Credentialing Committee

Date of Meeting: January 23, 2024

MAC Meeting Date: February 14, 2024

Board of Directors Meeting Date: March 6, 2024

New Business:

Credentialing Files for Review:

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

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Credentialing Committee

Dr. Emily ndt	Women & Children	Pediatrics	Locum > Associate	New associate physician starting December 1, 2023	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Tasha Stoltz	Women & Children	Pediatrics	Associate > Courtesy	Requesting courtesy privileges effective December 1, 2023	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Vivian Ng	Women & Children	Pediatrics	Locum > Associate	New associate physician starting December 1, 2023	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Yen Foong	Women & Children	Pediatrics	Locum > Associate	New associate physician starting December 1, 2023	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Praveen Saroey	Women & Children	Pediatrics	Locum	Requesting extension of locum privileges from January 1, 2024 – January 31, 2024	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Praveen Saroey	Women & Children	Pediatrics	Locum > Associate	New associate physician starting February 1, 2024	Dr. M. Rajguru	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Nikhat Nawar	Hospital Medicine		Locum	Requesting extension of locum privileges from January 1, 2024 – June 30, 2024	Dr. J. Legassie	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Joy Kuncheria	Hospital Medicine		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. J. Legassie	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Yu-Han Chang	Hospital Medicine		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. J. Legassie	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Dr. James Easo	Anesthesia	Tri-City Colonoscopy	Locum	Requesting extension of locum privileges from January 1, 2024 – March 31, 2024	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Ahmad Tarakji	Internal Medicine	Nephrology	Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Kenneth Leung	Internal Medicine	Liver Clinic	Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. A. Nguyen	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Jessica Smith	Women & Children	OBGYN	Locum	Requesting extension of locum privileges from January 1, 2024 – September 1, 2024	Dr. K. Wadsworth	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Marinela Grabovac	Women & Children	OBGYN	Locum	Requesting extension of locum privileges from January 1, 2024 – September 1, 2024	Dr. K. Wadsworth	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Amy Tam	Oncology			Requesting medical leave of absence December 6, 2023 – January 15, 2024		☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Leigh Bishop	Surgery	Breast Reconstruction	Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024		☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Tabitha Tse	Surgery	Breast Reconstruction	Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024		☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Credentialing Committee

Dr. Mylene ard	Surgery	Breast Reconstruction	Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024		☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Andrew Davis	Surgery	Surgical Assist	Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024		☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Eriny Shams	Emergency Dept		Locum	Requesting extension of locum privileges from January 1, 2024 – June 30, 2024		☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Ariel Mendlowitz	Women & Children	OBGYN	Associate	Received 12-month evaluation		☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Emma Pollard	Women & Children	OBGYN	Associate	Received 12-month evaluation		☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Krysta Barclay	Women & Children	Midwife	Active	Resignation of privileges effective February 2, 2024		☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Cindy Shobbrook	Hospital Medicine	MAID Program	Locum	Requesting extension of locum privileges from November 15, 2023 – November 15, 2024		☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Mitch Abrams	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

Dr. Silvio Bruni	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended wit. comments ☐ Not Recommended
Dr. Maryann Bushara	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Michael Chan	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Keyur Shah	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Babak Maghdoori	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Terence Menezes	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Nirav Patel	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended
Dr. Navneet Singh	Radiology		Locum	Requesting extension of locum privileges from January 1, 2024 – December 31, 2024	Dr. Inga Isupov	☒ Recommended ☐ Recommended with comments ☐ Not Recommended

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

riority heme #5: ransform ata into nsights to rive mprovements n care

Why does this matter?

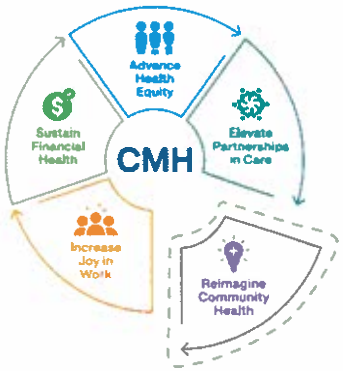
1. Digital health platforms and applications can gather large amounts of data which can be used to improve the delivery and quality of care
2. There are significant codependences and opportunities between digital and data ecosystems as health enablers
3. High quality data is a critical input into future models which will inform changes in operating and care models

Key Objectives

1. Deliver on the priorities embedded in the Operational Excellence plan
2. Achieve Stage 5 of Analytics Maturity Model
3. Ensure data integration between organizational platforms and enterprise business intelligence system
4. Invest in data informed priorities to improve care and business productivity
5. Gather and transform data which can be used to elevate care

Success Measures

1. Achievement of the Operational Excellence plan deliverables
2. Actively participate in the provincial collection of health data
3. Achievement and support of the HIMSS Analytics Maturity score (AMAM)



Note: This priority theme has a strong connection to the CMH Operational Excellence plan which falls under the Reimagine Community Health strategic pillar.

Appendix

Table of Contents

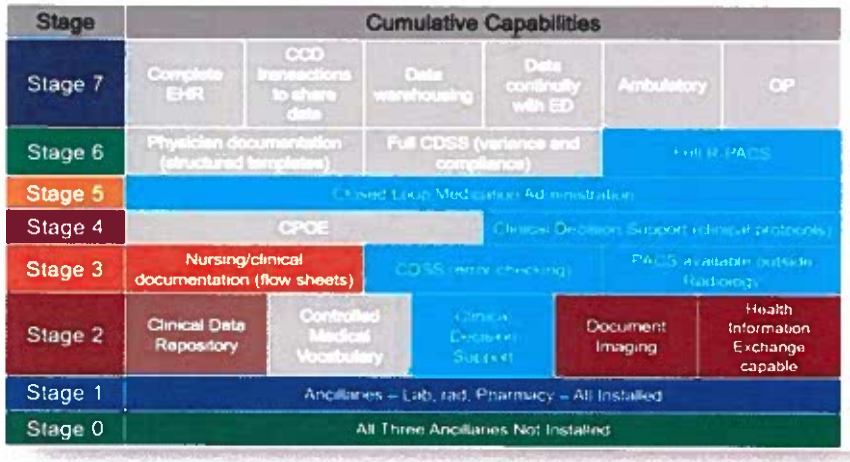
Appendix A: Consultation & Approach

1. Information / Background Gathering ✓
    1. Review findings of previous CMH strategic planning work including (but not limited to): ✓
        1. Comments / learnings from Strategic Planning engagement within community, hospital, and other stakeholders ✓
        2. Public and in-progress corporate plans which have a dependency on the Digital Health Plan ✓
    2. Environmental scan of provincial and national reference materials including (but not limited to): ✓
        1. Your Health: A Plan for Connected and Convenient Care (Ontario), Digital Health Playbook (Ontario), Taking Back Healthcare (Public Policy Forum), Digital Health Canadian Survey (Canada Infoway) ✓
    3. Consideration of publications and insights from international thought leaders including (but not limited to): ✓
        1. Healthcare Information and Management Systems Society (HIMSS), College of Healthcare Information Management Executives (CHIME), Consultancy groups including Garner, Accenture, Deloitte, and others. ✓
    4. Gathered insights from regional working groups and local stakeholders ✓
2. Review of core content for review by targeted internal and external stakeholders ✓
3. Implementing feedback into updated version of Digital Health Plan ✓
4. Approval through CMH Executive, Digital Health Sub-Committee, Resources Committee, and Board (in-progress)
5. Publishing of plan through determined communication strategy

Appendix B: Background

- FY12-17 IT Strategic Plan focused on EHR future profile, projects and budgets
- FY17-22 IT Strategic Plan focused on projects, prioritization matrix, and perception
- FY22-27 IT Corporate Plan will align with broader strategy plan and corporate priorities with a focus on priorities, platforms, and strategic goals. These will drive projects and operational (1-2 year) plans
  - Timing of this plan is aligned to other corporate plans and strategic plan roll-out

2012 – 2017 Plan EHR Profile – Future



FY17-22 Projects

Dietary Software Replacement
Foreign Exam Management
Endo PACs
EMAR & BMV
Allergy module
Med Rec
Appointment Reminder Software
Clinical Data Repository
ED Wait time Clock
Staff Scheduling
EDIS

Appendix C: Strategic Plan Alignment

Vision

Creating healthier communities, together.

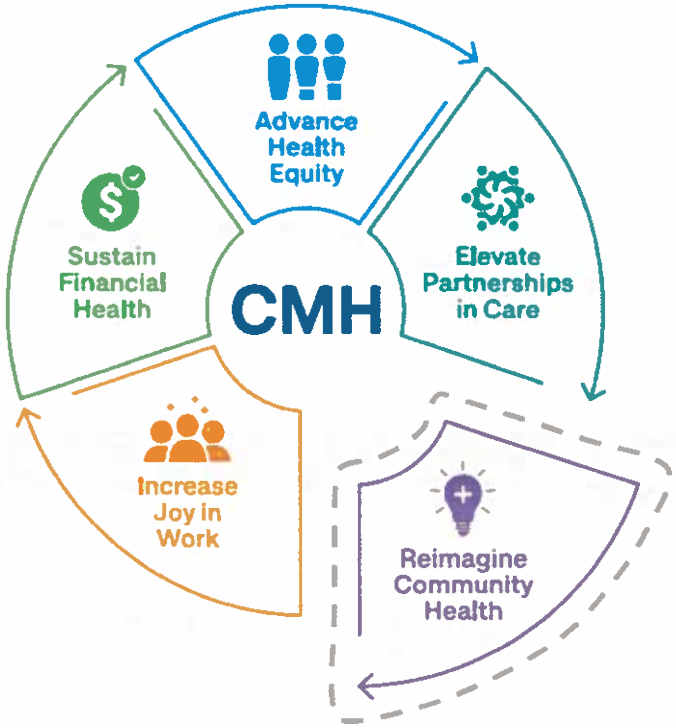
Mission

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

Values

Caring
Collaboration
Accountability
Innovation
Respect

Strategic Pillars



- The Digital Health Plan is housed under the Reimagine Community Health strategic pillar
- Other corporate plans under this strategic pillar include the Ontario Health Team Plan, Innovation Plan, Operational Excellence Plan, and Environmental Sustainability Plan
- Priority Themes #4 and #5 of the Digital Health Plan are strongly tied to other corporate plans such as the Patient Experience (housed under the Elevate Partnerships in Care strategic pillar) and the Operational Excellence Plan

Appendix D: Priority Themes – Additional Information

This table contains supplementary information and resources for each priority theme.

Priority Theme	Additional Information
#1: Establish a reliable and scalable digital health foundation	1. HIMSS INFRAM Model (here) & (here) 2. HIMSS EMRAM Model (here) & (here) 3. Corporate Solutions / ERP Definitions & Market (here) 4. Digital Governance (here) & (here) 5. Emerging Technology & Potential For Change (here)
#2: Optimize platforms for enabling future growth	1. Technology Platforms (here) & (here) 2. Best of Breed vs. Integrated Solutions (here) & (here) 3. Application consolidation (here) & (here) 4. Examples of Innovation Structures (here) & (here)
#3: Create an integrated digital health ecosystem	1. Ontario Digital Health Playbook (here – note page 6 and 7) 2. Ontario Your Health: A Plan for Connected and Convenient Care (here) 3. Digital Health Information Exchange Standard (here) 4. HIS Interoperability (here), (here), and (here) 5. Ontario Health Data Strategy (here)
#4: Adopt innovative digital solutions in patient & care partner engagement	1. CMH Patient Experience plan (here) 2. The Beryl Institute (here) 3. Virtual care maturity model (here) 4. Digital inequity (here) & (here)
#5: Transform data into insights to drive improvements in care	1. CMH Operational Excellence plan (TBD) 2. Ontario health data strategy (here) 3. Digital health and data connection (here), (here) & (here) 4. HIMSS AMAM (here) & (here)

Appendix E: Roadmap & Key Milestones