Vision
Creating healthier communities, together

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

Values
Caring, Collaboration, Accountability, Innovation, Respect

BOARD OF DIRECTORS MEETING - OPEN

December 4, 2024
1700-1800
Virtual via Teams / C.1.229
Join the meeting now
Or call in (audio only)
833-287-2824,,UpdateCanada (Toll-free)
Phone Conference ID: Update

AGENDA

Agenda Item * indicates attachment / TBC – to be circulated	Page #	Time	Responsibility	Purpose
1. CALL TO ORDER				
1.1 Territorial Acknowledgement		1700	L. Woeller	
1.2 Welcome		1703	L. Woeller	
1.3 Confirmation of Quorum (7)		1704	L. Woeller	Confirmation
1.4 Declarations of Conflict of Interest		1705	L. Woeller	Declaration
1.5 Consent Agenda *(Any Board member may request that any item be removed from this consent agenda and moved to the regular agenda)*		1706	L. Woeller	Motion
1.5.1 Minutes of November 6, 2024*	3			
1.5.2 2024/25 Board of Directors Action Log*	6			
1.5.3 Board Attendance*	7			
1.5.4 Board Work Plan*	8			
1.5.5 Events Calendar / Meeting Dates*	15			
1.5.6 Committee Reports to the Board of Directors				
1.5.6.1 Executive Committee* (No Open Matters)				
1.5.6.2 Audit Committee* (Nov 18, 2024)	17			
1.5.6.3 Capital Projects Sub-Committee (No Open Matters)				
1.5.6.4 Resources Committee* (Nov 25, 2024)	19			
1.5.6.5 Medical Advisory Committee* (Nov 5, 2024)	21			
1.5.6.6 Governance Committee* (Nov 20, 2024)	22			
1.5.7 Governance Policy Summary* Policies for Approval: (track changes version found in Package 2) 2-A-14 Resources Committee Terms of Reference 2-A-18 Quality Committee Terms of Reference 2-C-40 Capital Projects – Change Order Approval Policy 2-D-20 Recruitment, Selection, and Nomination of Directors and Non-Director Committee Members 2-D-48 Whistleblower Policy	24			
1.5.8 Q2 CEO Certificate of Compliance*	55			
1.5.9 2024/25 Strategic Priorities Tracker Q2 Updates*	56			
1.5.9.1 Quality Monitoring Metrics*	73			

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

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

Agenda Item * indicates attachment / TBC – to be circulated	Page #	Time	Responsibility	Purpose
1.5.10 CMH President & CEO Report*	77			
1.5.11 Certificate of Compliance – Semi Annual Distribution of Psychiatric Sessional and Stipend Funding	85			
1.6 Confirmation of Agenda		1709	L. Woeller	Motion
2. PRESENTATIONS				
2.1 2024-27 Environmental Sustainability Plan*	86	1710	R. Howe	Motion
3. BUSINESS ARISING				
3.1 No Items for Discussion				
4. NEW BUSINESS				
4.1 Chair's Update				
4.1.1 Board Chair's Report*	111	1720	L. Woeller	Information
4.2 Governance Committee – Recommendations for 2025 Interview Team*	117	1725	J. Goyal	Motion
4.3 Quality Committee (Nov 20, 2024)				
4.3.1 Report to the Board of Directors*	118	1730	D. Wilkinson	Information
4.4 Resources Committee (Nov 25, 2024)				
4.4.1 October 2024 Financial Statements and Year-End Forecast*	122	1740	M. Hempel	Motion
4.4.2 Disbanding of the Capital Projects Sub-Committee*	130	1745	T. Dean	Motion
4.5 Medical Advisory Committee (Nov 5, 2024)				
4.5.1 New Credentialed Physicians October 2024*	132	1747	W. Lee	Information
4.6 PFAC Update		1750	N. Melchers	Information
4.7 CEO Update				
4.7.1 No Open Matters for Discussion				
5. UPCOMING EVENTS				
5.1 CMH Staff Holiday Lunch/Dinner, December 5, 2024 (11am-2pm / 9pm-10pm)		1755	L. Woeller	Information
5.2 CMH Wing B Opening, January 10, 2025, 2 pm. Community Open House – January 11, 2025 10 am – 2 pm				
5.3 Grand Rounds (Details to follow) January 23, 2025 8am-9am				
5.4 CMHReveal, February 21, 2025, Tapestry Hall, https://trellis.org/cmhreveal2025				
6. DATE OF NEXT MEETING	Wednesday February 5, 2025 Location: Hybrid			
7. TERMINATION		1800	L. Woeller	Motion
Link: Board/Committee Evaluation Survey	*Following the meeting, please complete within one week.*			

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

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CMH Board of Directors Motions Page

Agenda Item	Motions Being Brought Forward for Approval – December 4, 2024	
1.5	Consent Agenda	• That the CMH Board of Directors approves the Consent Agenda as presented/amended
1.6	Confirmation of Agenda	• That the agenda be adopted as presented/amended
2.1	Environmental Sustainability Plan	• That the CMH Board of Directors approves the FY 2024-27 Environmental Sustainability Plan
4.2	Recommendation for Interview Team	• That the CMH Board of Directors approves the recommendations for the 2025 interview team
4.4.1	Financial Statements	• That the CMH Board of Directors receives the October 2024 financial statements as presented by management and upon the recommendation of the Resources Committee at the meeting of November 25, 2024
4.4.2	CRP Sub-Committee	• That the CMH Board of Directors approves the disbandment of the Capital Projects Sub-Committee

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

Minutes of the open session of the Board of Directors meeting, held via hybrid model (video conference and within Cambridge Memorial Hospital, C.1.229) on November 6, 2024 at 1800h.

Present:

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

Regrets: J. Tulsani, V. Miropolsky

Staff Present: M. Iromoto, T. Clark, J. Legassie

Guests: None

Recorder: S. Fitzgerald

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1. **CALL TO ORDER**
The Chair called the meeting to order at 1800 hours.

1.1. **Welcome**
The Chair welcomed the Board members to the meeting.

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

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

1.4. **Consent Agenda**
Prior to approving the Consent Agenda, the Chair asked if any items required removal for further discussion.

The consent agenda was approved as presented:

1.5.1 Minutes of October 2, 2024
1.5.2 2024/25 Board of Directors Action Log
1.5.3 Board Attendance
1.5.4 Events Calendar / Meeting Dates
1.5.5 Committee Reports to the Board of Directors
1.5.6 CEO Report
1.5.7 Quality Monitoring Metrics Monthly Report

None opposed, **CARRIED.**

1.5. **Confirmation of Agenda**

MOTION: That**,** the agenda be approved as presented.

None opposed, **CARRIED.**

2. **PRESENTATIONS**
No presentations for discussion.

3. **BUSINESS ARISING**
No items for discussion.

4. **NEW BUSINESS**
No items for discussion.

5. **UPCOMING EVENTS**
The Chair reviewed the upcoming events as listed on the agenda.

6. **DATE OF NEXT MEETING**
The next scheduled Board of Directors meeting is December 4, 2024.

7. **TERMINATION**
MOTION: That, the meeting terminated at 1803h.
None opposed, **CARRIED.**

Lynn Woeller
Board Chair
CMH Board of Directors

Patrick Gaskin
Board Secretary
CMH Board of Directors

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

Meeting Date	Agenda # / Item Description	Action Item	Owner	Status
06-12-2023	1.5.3 Policy Approvals	2-A-15 & 2-C-40 to be brought back to the Board for review and revision if, upon completion of the Capital Redevelopment Project Sub-Committee is disbanded as of September 2024	P. Gaskin	**Complete – CRP disbandment will archive policy 2-A-15.** **Complete – 2-C-40 revisions included in agenda item 1.5.7**
06-12-2023	1.5 Consent Agenda	ABCDE Goals to track by % complete	P. Gaskin	Management will look to update the process / tracking systems
06-03-24	2.1 QIP Discussion	CMH to investigate the ability for Directors to take part in the Rainbow Health course	P. Gaskin	**Completed – Interested members have been registered.**

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

Board of Directors Attendance Report 2024/2025

	100%	100%	100%	100%	100%	100%	89%	100%	100%	89%	100%	67%
Meeting Dates	Lynn Woeller	Diane Wilkinson	Nicola Melchers	Margaret McKinnon	Julia Goyal	Sara Alvarado	Monika Hempel	Tom Dean	Miles Lauzon	Paulo Brasil	Bill Conway	Jay Tulsani
4-Oct-23	P	P	P	P	P	P	P	P	P	P	P	P
1-Nov-23	R	P	P	R	P	P	P	P	P	P	P	P
6-Dec-23	P	P	P	P	P	P	R	P	P	R	P	P
7-Feb-24	P	P	P	P	P	P	P	P	P	P	P	P
6-Mar-24	P	P	P	P	P	P	P	P	P	P	P	P
1-May-24	P	P	P	P	P	P	P	P	P	P	P	R
5-Jun-24	P	P	P	P	P	P	P	P	P	P	P	P
26-Jun-24	P	P	P	P	P	P	P	P	P	P	P	P
2-Oct-24	P	P	P	P	P	P	P	P	P	P	P	P
29-Oct-24	P	P	P	P	P	P	P	P	P	P	P	R
6-Nov-24	P	P	P	P	P	P	P	P	P	P	P	R

Agenda

Agenda Item 1.3.4

BOARD WORK PLAN – 2024-25

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

✓ = Due ND = Not Due C = Complete I = In progress D = Delayed 29 November 2024

Agenda Item 1.3.4

BOARD WORK PLAN – 2024-25

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

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Agenda Item 1.3.4

BOARD WORK PLAN – 2024-25

Charter Section #4	Action *(Italics-comments)*	Committee Responsible	Oct	Nov	Dec	Feb	Mar	May	Jun	Jun
e-i-A	Receive a summary report on: • CEO succession plan and process • COS succession plan and process • Succession plan for executive management and professional staff leadership	 Executive Executive Executive								 √ √ √
	Professional Staff									
f-i-A f-i-B/C	➢ Ensure the effectiveness and fairness of the credentialing process ➢ Monitor indicators of clinical outcomes, quality of service, patient safety and achievement of desired outcomes	MAC/Quality MAC	C	C	√	√	√	√	√	√
f-i-C	➢ Make the final appointment, reappointment and privilege decisions for Medical/Professional Staff ➢ Oversee the Medical/Professional Staff through and with the MAC and COS	Board COS	C C	C C	√ √	√ √	√ √	√ √	√ √	√ √
	Build Relationships									
g	➢ Build and maintain good relationships with the Corporation's key stakeholders ➢ The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, community leaders, patients, employees, families, other health service providers and other key stakeholders, donors and the Cambridge Memorial Hospital Foundation (" Foundation") and the Cambridge Memorial Hospital Volunteers Association. ➢ Invite Annual Volunteer Association Presentation	Board				 √				
	Financial Viability									

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Agenda Item 1.3.4

BOARD WORK PLAN – 2024-25

Charter Section #4	Action *(Italics-comments)*	Committee Responsible	Oct	Nov	Dec	Feb	Mar	May	Jun	Jun
h-i-A,C	➢ Review and approve multi-year capital strategy	Resources			√					
h-i-A,C h-i-A, B	➢ Review and approve annual operating plan – service changes, operating plan, capital plan, salary increases, material amendments to benefit plans, programs and policies	Resources/ Quality				√	√			
h-i-A	➢ Approve the year-end financial statements	Board							√	
i-i-C	➢ Approve key financial objectives that support the corporation's financial needs (including capital allocations and expenditures) (*assumptions for following year budget)* ➢ Review of management programs to oversee compliance with financial principles and policies	Resources Resources				√	√		√	
	➢ Affirm signing officers for upcoming year	Board								√
	➢ Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding	Resources			√				√	
	Board Effectiveness									
i	➢ Establish Board Work Plan – (CMH updating the work plan to the new format to reflect updated policies and terms of reference)	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							√	

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Agenda Item 1.3.4
BOARD WORK PLAN – 2024-25

Charter Section #4	Action *(Italics-comments)*	Committee Responsible	Oct	Nov	Dec	Feb	Mar	May	Jun	Jun
i-i-D	➢ Periodically review and revise governance policies, processes and structures as appropriate	Governance	C		√	√	√	√	√	
	➢ Review Progress on ABCDE Goals *(Director & Chair meet during July/August to establish goals for upcoming Board cycle)*	Board			√			√		√
	Fundraising									
k	➢ Support fundraising initiatives including donor cultivation activities. *(through Foundation Report and Upcoming Events)*	Foundation	C	C	√	√	√	√	√	√
	***Public Hospitals Act* required programs**									
l-i-A	➢ Ensure that an occupational health and safety program and a health surveillance program are established and require accountability on a regular basis - TBD	Audit								
l-i-B	➢ Ensure that policies are in place to encourage and facilitate organ procurement and donation	Quality								√
l-i-C	➢ Ensure that the Chief Executive Officer, Nursing Management, Medical/Professional staff, and employees of the Hospital develop plans to deal with emergency situations and the failure to provide services in the Hospital	Quality			√					
	Recruitment									
n	➢ Approve interview team membership (noted in By-law)	Governance			√					
	➢ Review recommendations for new Directors, non-director committee members (2-D-20)	Governance							√	
	➢ Conduct the election of officers (2-D-18)	Governance								√

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Agenda Item 1.3.4
BOARD WORK PLAN – 2024-25

Charter Section #4	Action *(Italics-comments)*	Committee Responsible	Oct	Nov	Dec	Feb	Mar	May	Jun	Jun
	➢ Review evaluation results and improvement plans for the Board, the Board Chair (by the Governance Chair), Board committees, committee chairs (2-D-40)	Governance							√	
	➢ Review committee reports on work plan achievements (2-A-16)	Governance								√

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	

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Agenda Item 1.3.4
BOARD WORK PLAN – 2024-25

ON GOING AS NEEDED

Charter Section #4	Charter Item	Action *(Italics-comments)*	Committee Responsible	Current Year 2023-24
h	Financial Viability	Approve collective bargaining agreements	Board	
h	Financial Viability	Approve capital projects	Resources	

DELAYED

Charter Section #4	Charter Item	Rationale

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

Board/Committee Meetings and Event Dates	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep (2025)
Patient Family Advisory Council (PFAC) 5:30pm - 7:30pm In Person / Hybrid	10	1	5	3	14	4	4		6	3			
OHT Joint Board Committee 5:30pm - 7:30pm - Virtual Zoom meeting	23		25	16	27	24	24	28	26	23			
2024-25 Events													
Staff Holiday Lunch - December 5, 2024				5									
Career Achievement								22					
Chamber Business Awards			14										
CMHF Diversity Dinner – CMH Celebration of Champions, Oriental Sports Club			7										
CMH Staff BBQ										12			
CMH Golf Classic - Thursday June 5, 2025 Galt Country Club Further Details to Follow										TBD			
CMH Reveal - Fiesta Mexicana						21							
Board Social - TBD May?													
Board Education Opportunities													
Governors Education Sessions													
Governance Essentials for New Directors - *N/A*													
Hospital Legal Accountability Framework													
Hospital Accountability Within the Health System													
Governance and Management - The Crucial Partnership													
CMH Leadership Learning Lab													
• *Project Management for the Unofficial PM*													
• *Crucial Conversations*													
• *7 Habits of Highly Effective People*													
• *Me2You DISC Profile*													
• *Quality Improvement*													
• *Guiding Organizational Change*													
• *5 Choices*													
• *Unconscious Bias*													
Mental Health First Aid													

BRIEFING NOTE

Date: November 27, 2024
Issue: Audit Committee Report to Board of Directors November 18, 2024 OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Bonnie Collins, Administrative Assistant
Approved by: Jay Tulsani, Chair

Attachments/Related Documents:

A meeting of the Audit Committee took place on Monday, November 18, 2024 at 1700h

Present:	Jay Tulsani (Chair), Bill Conway, Roger Ma, Nicola Melchers, Scott Merry, Brian Quigley, Chris Whiteley, Diane Wilkinson, Lynn Woeller
Regrets:	Bonita Bonn, Paulo Brasil
Staff:	Liane Barefoot, Trevor Clark, Lisa Costa, Patrick Gaskin, Rob Howe, Erin Rideout, Valerie Smith-Sellers, Jennifer Visocchi, Susan Toth
Guests:	Suk Bedi (KPMG)

Committee Matters – For information only

1. **Future of Risk Presentation**
   S. Bedi, a representative from KPMG, shared a presentation on the future of risk for Canadian public sector organizations. The Committee engaged in discussion with S. Bedi on managing risk for CMH. Management confirmed that, at CMH, risk management is viewed more as an asset than a cost. The Committee was invited to forward any further questions for S. Bedi to the Chair of the Audit Committee or management.
2. **Bill S-211 Forced Labour in Canada Supply Chain Education**
   Management provided the Audit Committee with refresher education on Bill S-211 and its application to CMH. Every year, CMH must submit its compliance attestation for Bill S-211, consisting of a report and questionnaire; no other minimum requirements currently exist. The next Board approval and submission are due May 2025.

   The 2025 report updates for CMH and Mohawk Medbuy (MMC - CMH's GPO) were highlighted. Questions were entertained, and management confirmed that 95% of consumable products used by CMH are procured through MMC contracts, and that hospital consumables and IT products are at highest risk of manufacture by forced and child labour. In many cases, CMH must rely on its purchasing partners to ensure compliance with Bill S-211. Management is confident in MMC's commitment to compliance with the Act. The Committee would like CMH to exceed the minimum requirements of the Act. Management provided examples of future initiatives that will be implemented to progress CMH in this important work with its non-MMC vendors (e.g.

including Bill S-211 compliance as part of procurement evaluations, being intentional to promote the importance of Bill S-211 compliance to CMH suppliers).

3. **Orientation and Training**

The Audit Committee Chair advised that a framework will be developed on hospital finances and reporting processes to prepare members to fully participate in the Audit Committee meetings. This training will be presented to the Committee and will be open to new and existing members.

4. **Bill 194, Strengthening Cyber Security and Building Trust in the Public Sector Act, 2024**

Management shared a briefing note outlining the new Bill 194 with the Audit Committee that was shared with the Governance Committee in September 2024. Since September, the bill has passed second reading but is yet to be enacted. CMH will leverage its Ontario Hospital Association (OHA) membership to gain a greater understanding of implications of this Act to the hospital.

5. **Public Sector Accounting Standards Update**

There are no new Public Sector Accounting Standards that will apply to CMH in fiscal 2024-25. There are exposure drafts related to employee benefits and financial statement presentation that may apply in fiscal 2026-27:

- Public Sector (PS) 3251 – Employee Benefits
- Public Sector (PS) 1202 – Financial Statement Presentation

BRIEFING NOTE

Date: November 28, 2024
Issue: Resources Committee Report to Board of Directors November 25, 2024 OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Bonnie Collins, Administrative Assistant
Approved by: Monika Hempel, Chair

Attachments/Related Documents: None

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

Present:	Monika Hempel (Chair), Sara Alvarado, Tom Dean, Miles Lauzon, Shannon Maier, Lori Peppler-Beechey, Janet Richter, Lynn Woeller, Diane Wilkinson
Regrets:	
Staff:	Trevor Clark, Lisa Costa, Patrick Gaskin, Rob Howe, Kyle Leslie, Stephanie Pearsall, Erin Rideout, Valerie Smith-Sellers, Susan Toth, Jennifer Visocchi
Guests:	

Committee Matters – For information only

1. **2024-27 Environmental Sustainability Plan:** Management presented the Environmental Sustainability Plan (ESP) to the Committee for approval. Work on the ESP has been ongoing since February 2024, with a significant amount of internal and external stakeholder feedback. Sustainability within the hospital is not a one-department initiative, and involvement across the hospital will be required to progress CMH's sustainability goals. The Committee noted that the ESP is a large, ambitious project and inquired if the savings reflected in the plan have been included in the 2025-26 budget; management confirmed that savings realized will create additional financial capacity. Sustainability initiatives that have already been implemented at CMH were outlined for the Committee's information.
   Further discussion of this item will take place during agenda item 2.1 of the December 4, 2024 Board of Directors meeting.
2. **Corporate Policies Review – 2-C-36 Borrowing:** The Borrowing policy was updated to reflect the Committee's feedback from the September 2024 meeting. In place of a borrowing limit on debt, management added a new guideline that requires Board approval for hospital borrowing, in line with other hospitals' borrowing policies. Management also recommended that a debt management plan with ongoing reporting to the Board be established to ensure strong management of cash flow. An annual borrowing update will be provided to the Resources Committee. The Committee was in

favour of management's proposed changes to the Borrowing policy. The policy will be forwarded to the Governance Committee for review and approval.

3. **Q2 Corporate Scorecard:** The corporate scorecard and strategic priorities tracker were reviewed with the Committee and the hospital's performance was outlined. In Q2, four targets were not met: ambulance offload, ED length of stay for admitted cases, percent on track with staffing targets, and DEI Rainbow Health training. Q2 "wins" were highlighted:
    - PCOP earnings exceeded target for Q2 (as was also the case for Q1); primary drivers were complex long stay medical cases earning higher weights than anticipated, and the return of fewer surgical blocks;
    - ED staffing increased to 94% in Q2, up from 80% in Q1, and ED overtime improved in Q2.

    Overtime increased in Q2, largely due to vacation, sick time, increases in census and admitted patients held in ED.
4. **October 2024 Financial Statements and Year-End Forecast:** In October, CMH reported a $3.9M year-to-date surplus position after building amortization and related capital grants. The major drivers of the surplus were the unused portion of the budgeted contingency ($3.8M), QBP revenue ($1.7M) and recoveries and other revenue ($1.1M), partially offset by unfavourable variances in salaries & wages and benefits ($2.1M), due primarily to higher overtime than budget. Overtime was $2.8M over budget and is forecast to be $4.8M over budget by fiscal year end. PCOP revenue was $600K favourable due to higher weighted cases in acute inpatient, offset by lower surgical volumes due to physician vacancies and returned OR blocks. CMH's unrestricted working capital at the end of October was $18M. A surplus of $3.6M is forecast for the 2024-25 fiscal year, including contingency and one-time funding for incremental surgical recovery of approximately $3M, which would partially offset salary and wage pressures. The forecasted year-end surplus does not include any prior year PCOP reconciliation, which management expects to be finalized shortly. Questions were entertained, and management expects that reconciliation for the anticipated $6.3M 2022-23 PCOP funding will be complete by January 2025. Approximately $5M is forecast for the 2023-24 PCOP adjustment and is expected to be reconciled the following year. System transformation expenses are forecast to be approximately $1.5M by fiscal year end.
    Further discussion of this item will take place during agenda item 4.4.1 of the December 4, 2024 Board of Directors meeting.
5. **Q2 Capital Equipment Spending:** An update on CMH capital spending to the end of September 2024 was provided. There was approximately $15.8M in outstanding capital spending at the end of Q2, and management will work to ensure that these purchases are completed by fiscal year end.
6. **Disbanding of the Capital Projects Subcommittee:** The Chair of the CMH Capital Redevelopment Subcommittee presented a history of the Subcommittee and expressed appreciation for the membership and the work accomplished. A wrap-up event was held at the end of the meeting of the Subcommittee on November 21. Having accomplished the work it was formed to do, the Subcommittee Chair proposed that the Capital Projects Subcommittee be disbanded.
    Further discussion of this item will take place during agenda item 4.4.2 of the December 4, 2024 Board of Directors meeting.

BRIEFING NOTE

Date: November 5, 2024
Issue: MAC Report to the Board of Directors November 5, 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

A meeting of the Medical Advisory Committee took place on November 5, 2024, at 1630h.

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

Committee Matters – For information only

1. **Medical Directives:** Medical directive “Ordering and Administration of Respiratory Syncytial Virus (RSV) for Neonates by the Registered Midwife” was discussed. This is a new medical directive that allows registered midwives to order and administer RSV prophylaxis for neonates. This directive aims to streamline the process and ensure timely access to care for newborns, especially those at high risk. The directive was developed in response to Ontario’s rollout of a monoclonal antibody for all newborns born in 2024 and high-risk infants born in 2023. The goal is to avoid the need for pediatric consultations for every injection and to allow midwives to manage patients to their full scope of practice.

   Medical directive “Indwelling Urinary Catheter Removal” was discussed. This is a new medical directive that allows nurses to discontinue Foley catheters under certain conditions without a physician's order. This initiative, aimed at improving efficiency, was initially designed for the medicine team but can be adapted for surgical services. Specific criteria are in place to ensure safety. This initiative also aligns with Choosing Wisely recommendations.
2. **Policy # 3-100 Consent to Treatment:** The Consent to Treatment Policy #3-100 was recently reviewed by Credentials Committee, Professional Practice, and ethics. An update to the policy includes the addition of a clause regarding the patients' rights to refuse, withhold, or withdraw consent to treatment.

BRIEFING NOTE

Date: November 28, 2024
Issue: Governance Committee Report to Board of Directors November 20, 2024 OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Administrative Assistant
Approved by: Patrick Gaskin - President & CEO, Julia Goyal - Governance Committee Chair

Attachments/Related Documents: None

A meeting of the Governance Committee took place on Wednesday November 20, 2024 at 1700 hours.

Attendees:	J. Goyal (Chair), J. Stecho, B. Conway, M. Protich, N. Melchers M. McKinnon
Staff Present:	P. Gaskin. M. Iromoto
Regrets:	A. Stewart

Committee Matters – For information only.

1. **Welcome & Territorial Acknowledgement:** The Chair presented the Territorial Acknowledgement and welcomed new and returning members.
2. **Policy Reviews and Approvals:** The Governance Committee reviewed and approved two Board policies. These policies are included as agenda item 1.5.7 of the December 4, 2024 Board of Directors meeting.
3. **2-C-55 Hospital Naming Policy:** Policy 2-C-55 was brought forward to the Governance Committee for awareness that the appendix has been updated to reflect the recently approved policy from the CMHF.
4. **Audit Committee Follow Up:** The outgoing Chair of Audit informed the Board Chair and Governance Chair about concerns regarding the recently revised Audit Committee Terms of Reference introduced to meet ONCA legislation, which might lead some members to consider not continuing in the upcoming year. The current Chair of Audit then had one-on-one conversations with those members. The Governance Committee was subsequently updated that these conversations had taken place, and it was confirmed that the members understand the changes and are willing to continue their roles, even though they are classified as expert advisors.
5. **Board/Committee Feedback Reports Review:** The Governance Committee reviewed the feedback reports from the September 2024 and October 2024 Board and Committee meetings. The Governance Committee will continue to monitor the response rates to

ensure low response rate trends are monitored and addressed with Committee Chairs if needed.

6. **Board/Committee 2023/24 Annual Survey Results:** The Governance Committee reviewed the feedback from the 2023/24 Board and committee annual survey results. They suggested including education on the use of consent agendas in future Board Orientations to enhance Board efficiency and accountability. CMH Management will update the orientation to incorporate this education for both new Directors and non-Directors.
7. **Interview Team Appointments:** The Governance committee appointed Nicola Melchers, Bill Conway, Jody Stecho. Margaret McKinnon and Julia Goyal for Chair for the 2024/25 Interview team with the addition of a community representative that will be determined at a future date.
   Further discussion of this item will take place during agenda item 4.2 of the December 4, 2024 Board of Directors meeting.
8. **OHA Updates:** The Governance Committee received updates on various OHA initiatives, including financial pressures in the sector, legislative changes, and the projected patterns of illness in Ontario.

BRIEFING NOTE

Date: November 15, 2024
Issue: Board Policy Review Summary
Prepared for: Board of Directors
Purpose: ☒ Approval ☒ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Executive Assistant
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: Policies

Recommendation/Motion

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

2-A-14	*Resources Committee Terms of Reference*
2-A-18	*Quality Committee Terms of Reference*
2-C-40	*Capital Projects Change Order Policy*
2-D-20	*Recruitment, Selection, and Nomination of Directors and Non-Director Committee Members*
2-D-48	*Whistleblower Policy*

Background

The following policies were reviewed and discussed at the November 20, 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	Rationale
2-A-14	Resources Committee Terms of Reference	Resources requesting minor change to 4.B.V (full policy reviewed by Governance in May 2023)
2-A-18	Quality Committee Terms of Reference	Quality Committee requesting minor change to reflect the new CMH organizational structure within their membership (full policy reviewed by Governance in May 2023)

At the October 2, 2024 Board of Directors meeting the following two policies were pulled from the consent agenda with a request for minor amendments. Amendments based on feedback from the Board were made and brought to the Governance Committee for awareness.

Policy No.	Policy Name	Status / Rationale
2-D-20	Recruitment, Selection, and Nomination of Directors and Non-Director Committee Members	The Board asked that the approach for filling mid-term member vacancies wording be consistent for both Directors and Non-directors – changes made to combine the

Policy No.	Policy Name	Status / Rationale
		two sections with a heading to read Filling Mid-Term Director and Non-Director Committee Member Vacancies
2-D-48	Whistleblower Policy	The Board asked for section 5.C. to have the CEO & COS wording added.

BOARD MANUAL

SUBJECT: Resources Committee Terms of Reference	**NO.: 2-A-14**
SECTION: Structure, Roles and Responsibilities	
APPROVED BY: Board of Directors	**DATE: TBD**

1. Application

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

2. Composition

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

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

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

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

(i) the President and Chief Executive Officer;

(ii) the Vice President Finance and Corporate Services;

(iii) the Director of Finance; and

(iv) other resources as directed by the Committee.

3. Meetings

The Committee shall:

(a) meet at least six (6) times annually, or more frequently as circumstances dictate;

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

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

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

4. Specific Duties and Responsibilities

(a) Finance

The Committee shall:

(i) inform and advise the Board on financial matters and make recommendations to the Board;

(ii) make recommendations to the Board on the adequacy of financial resources and the soundness of the financial implications of all capital and operating expenditures;

(iii) review the detailed financial statements and report thereon to the Board;

(iv) be responsible for matters relating to the banking, accounting and financial policies and procedures, and advise and inform the Board;

(v) review and make recommendations to the Board for approval regarding:

i. an annual operating and capital plan for the fiscal year;
ii. any other financial matter as requested by the Board;

(vi) ensure that there is financing of any capital projects;

(vii) evaluate the financial impact of proposals made for new and/or expanded services and programs;

(viii) review quarterly, the organization's compliance with mandated withholding requirements; and

(ix) review annually, the organization's compliance with the Broader Public Sector Accountability Act.

(b) Facilities

The Committee shall:

(i) advise the Board on all property matters;

(ii) ensure appropriate policies to provide for efficient and economic maintenance and repair of all corporate structures and property;

(iii) develop, evaluate, update, and make recommendations to the Board on physical plant infrastructure proposals, including alternate courses of action which support the Corporation's key strategies for achieving its mission and role;

(iv) establish priorities for future capital expenditure and resources; and

(v) Oversee and report to the Board on the progress of all Capital projects/expenditures.

(c) Insurance
The Committee shall:

(i) study and recommend to the Board the types and amounts of insurance to be carried by the Corporation and review these annually; and

(ii) receive annually from management a report on the status of liability insurance for Directors, Officers and Committee members and any changes to the policy.

(d) Investments/Donations/Bequests/Endowments
The Committee shall:

(i) recommend and monitor Board investment policy; and

(ii) advise the Board about donations, bequests, endowments, investments, banking, borrowing and long-term financial forecasts.

(e) Oversight of Risk
The Committee shall:

(i) oversee risk management in the following assigned categories: human resources, finances, information technology/information management, facilities and regulatory; and

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

(f) Human Resources and Benefit Plans
The Committee shall:

(i) review labour and human resources developments and legislative or regulatory changes that may have an impact on resources or Hospital performance;

(ii) review, make recommendations and monitor improvements related to human resource performance indicators;

(iii) review reports concerning human resource/staff issues and make recommendations to the Board in connection with major issues that may include health and workplace safety, wellness, compensation and contractual issues;

(iv) provide strategic supervision of the Corporation's benefit plans, programs and policies, and review and approve material amendments to the benefit plans,

programs and policies;

(v) recommend the approval of all collective bargaining agreements and annual salary increases.

General

The Committee shall:

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

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

(c) have the authority upon approval by the Board to engage independent legal counsel, consultants, or other advisors with respect to fulfilling its responsibilities and the hospital shall provide appropriate funding;

(d) 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 it fulfilled the purposes and responsibilities stated in the terms of reference;

(e) review and assess the adequacy of the terms of reference and the terms of reference(s) of its sub- committee(s) at least every three years and submitting any proposed amendments to the Governance Committee and the Board for approval;

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

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

DEVELOPED: September 28, 2011		
REVISED/REVIEWED:		
June 26, 2013	October 30, 2013	June 25, 2014
May 27, 2015	May 24, 2017	July 28, 2020
June 28, 2023	Click or tap to enter a date.	Click or tap to enter a date.

BOARD MANUAL

SUBJECT: Quality Committee Terms of Reference	**NO.: 2-A-18**
SECTION: Structure, Roles and Responsibilities	
APPROVED BY: Board of Directors	**DATE: TBD**

1. Application

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

2. Definitions

The "Quality Committee" operates under the authority of the Board and is the Quality Committee for the purposes of the *Excellent Care for All Act, 2010* ("the Act").

"Critical incident" means any unintended event that occurs when a patient receives treatment in the hospital that, (a) results in death, or serious disability, injury, or harm to the patient, and (b) does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing the treatment.

"Performance Metrics" means the Board approved organization performance metrics that provide an overview of the organization's performance in achieving quality, workplace safety as it relates to a quality metric, patient and staff satisfaction and such other performance metrics that the Board may approve from time to time.

3. Composition

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

(i) up to five (5) voting members of the Board to ensure, pursuant to the regulations under the *Excellent Care for All Act* that one third of the members of the Quality Committee are voting members of the hospital board, one of whom shall be appointed Chair;

(ii) up to four (4) members from the broader community who are resident, employed or carrying on business in the Region of Waterloo, appointed by the Board upon the recommendation of the Governance Committee;

(iii) a member of the Patient Family Advisory Committee (PFAC), appointed annually by PFAC;

(iv) the President and Chief Executive Officer (CEO);

(v) one member of the Medical Advisory Committee;

(vi) the Chief Nursing Executive; and

(vii) up to two hospital employee(s) who are not members of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario.

Subject to the approval of the Board, the members of the Quality Committee referenced at paragraphs (iv) and (vi) may appoint a delegate to sit as a member of the Quality Committee in their stead.

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

(i) VP People & Strategy; and

(ii) any other staff resources identified by the CEO in consultation with the Committee Chair.

(c) Members will be appointed annually by the Board with consideration given to re-appointing some members each year for the benefit of their knowledge and experience gained on the Committee.

4. Meetings

The Committee shall:

(a) meet at least four (4) times annually, or more frequently as circumstances dictate

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

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

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

5. Specific Duties and Responsibilities

(a) *Excellent Care for All Act, 2010*

The Committee, in accordance with its responsibilities under the Act, shall:

(i) monitor and report to the Board on quality issues and on the overall quality of services provided in the Corporation, with reference to appropriate data including:

(a) Performance Metrics and other performance indicators used to measure quality of care and services and patient safety;

(b) reports received from the Medical Advisory Committee identifying and making recommendations with respect to systemic or recurring quality of care issues;

(c) publicly reported patient safety indicators;

(d) critical incident; and

(e) annual program reviews of quality.

(ii) consider and make recommendations to the Board regarding quality improvement initiatives and policies;

(iii) ensure that best practices information supported by available scientific evidence is translated into materials that are distributed to employees and persons providing services within the health care organization, and to subsequently monitor the use of these materials by these people;

(iv) oversee the preparation of the Corporation's annual quality improvement plans;

(v) review and report to the Board on progress in achieving the goals of the quality improvement plan and the quality and safety plan;

(vi) oversee the establishment and monitoring of the patient declaration of values in collaboration with the Patient and Family Advisory Council;

(vii) oversee that a process is in place to collect and monitor patient and employee satisfaction (including staff and other persons working for or providing services within the organization), monitor the results of such surveys and, where applicable, the incorporation of the findings into the quality improvement targets;

(viii) develop and oversee the implementation of a policy that requires the posting of Board approved quality Performance Metrics and targets on the

Corporation's public website; and

(ix) perform such other responsibilities as may be provided under regulations under the Act.

(b) Accreditation
The Committee shall:

(i) oversee the Corporation's plan to prepare for hospital-wide accreditation and, as relevant, for department/program specific accreditations; and

(ii) review accreditation reports and any plans required to be implemented to improve performance and correct deficiencies.

(c) Critical Incidents
The Committee shall:

(i) in accordance with Regulation 965 under the *Public Hospitals Act* receive from the Chief Executive Officer, at least twice a year, aggregate critical incident data related to the critical incidents occurring at the hospital since the previous aggregate data was provided to the Committee and the actions taken to mitigate the risks associated with any such incidents; and

(ii) annually review and report to the Board on the Corporation's system for ensuring that, at an appropriate time following the disclosure of a critical incident, there be disclosure as required by Regulation 965 under the *Public Hospitals Act* of the systemic steps, if any, the Corporation is taking or has taken to avoid or reduce the risk of further similar critical incidents.

(d) Oversight of Risk
The Committee shall:

(i) oversee risk management in the following assigned categories: accreditation, care, regulatory and teaching; and

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

(e) Organ Donation
The Committee shall:

(i) ensure that procedures are in place to encourage the donation of organ and tissues in accordance with the Board's responsibilities in the regulations under the *Public Hospitals Act*

(f) Professional Staff Process
The Committee shall:

(i) Review at least every 3 years with the Chief of Staff the appointment and re-appointment process for the professional staff, including:

- Criteria for appointment;
- Application and re-application forms;
- Application and re-application process; and
- Processes for periodic review

6. General

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

(a) assisting the Board in the performance of the Board's governance role for the quality of patient care and service and reporting to the Board at each of its meetings;

(b) as and when requested by the Board, providing advice to the Board on the implications of budget proposals on the quality of care and services;

(c) as and when requested by the Board, providing advice to the Board on the quality and safety implications of the Hospital Annual Operating Plan and quality indicators proposed to be included in the Hospital's Service Accountability Agreement or in any other funding agreement;

(d) suggesting Board education and development relating to quality topics appropriate for Board level discussion and oversight;

(e) maintaining minutes or other records of meetings and activities of the Committee;

(f) having the authority, upon approval by the Board, to engage independent legal counsel, consultants, or other advisors with respect to fulfilling its responsibilities and the Hospital corporation shall provide appropriate funding;

(g) conducting 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 it fulfilled the purposes and responsibilities stated in this Terms of Reference;

(h) providing an orientation for new committee members;

(i) assessing the adequacy of this Terms of Reference at least every three (3) years and submitting any proposed amendments to the Governance Committee and the Board for approval; and

(j) performing such other functions and tasks as may be assigned from time to time by the Board.

DEVELOPED: September 28, 2011		
REVISED/REVIEWED:		
May 29, 2013	October 30, 2013	May 27, 2015
May 24, 2017	January 29, 2020	May 26, 2021
November 30, 2022	January 25, 2023	March 1, 2023
June 28, 2023		

CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

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

Policy

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

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

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

Change Orders Within Project Budget Approved by the Board of Directors

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

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

Change Orders Exceeding Project Budget Approved by the Board of Directors

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

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

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

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

Related Policies and Procedures:

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

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

BOARD MANUAL

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

Purpose

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

Policy

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

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

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

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

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

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

Guidelines for the Nomination of Directors

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

Universal Competencies

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

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

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

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

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

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

Collective Competencies

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

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

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

Conflict of Interest

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

Procedure

Recruitment of Candidates

The Governance Committee will:

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

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

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

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

5. Begin the recruitment process, which will include:

    - Inviting non-Director members of committees to apply for vacant Director positions
    - Encouraging current and previous Directors to recommend candidates possessing the competencies for consideration by the Nominating Subcommittee, and
    - Advertising vacancies on appropriate communication channels and the Corporation's website.

Nominations for Election to the Board

A) New Director Applicants

The Nominating Subcommittee will:

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

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

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

4. Select candidates for nomination for election as Directors.

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

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

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

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

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

B) Non-Director Committee Member Applicants

The Nominating Subcommittee will:

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

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

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

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

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

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

C) Re-Election of Existing Board Members

The Nominating Subcommittee will:

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

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

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

D) Filling Mid-Term Director and Non-Director Committee Member Vacancies

When directed by the Board, the Governance Committee will recommend nominees for vacancies that arise unexpectedly during the course of the current Board cycle. Appointments will be approved by the Board.

E) Reappointment of Non-Director Committee Members

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

The Nominating Subcommittee will:

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

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

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

APPENDIX A

Competency/Skills Definitions

Leadership and/or executive experience

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

Strategic planning experience

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

Board and Governance

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

Business Acumen

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

Resource and/or Audit

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

Health Care/ Clinical Practice

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

Health System Integration

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

board role or employment within the health sector

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

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

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

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

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

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

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

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

Patient and Healthcare Advocacy

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

Community Knowledge and Involvement

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

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

CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

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

This policy is identical to Corporate Manual Policy 2-340

Policy

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

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

Purpose

The purposes of this policy are as follows:

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

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

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

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

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

Definitions

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

Board: means the Board of Directors of the Hospital.

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

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

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

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

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

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

Standards

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

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

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

Procedure:

1. **Reporting**

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

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

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

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

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

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

(iii) by email to whistleblower@cmh.org

(iv) by letter addressed to the person

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

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

2. Matters of concern or wrongdoing

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

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

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

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

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

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

(i) abuse of patients by any party

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

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

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

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

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

(i) cultural, racial, and sexual harassment

(ii) discrimination of any kind as outlined in legislation

(iii) workplace safety and harassment violations.

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

(i) danger to health and safety

(ii) inappropriate release of confidential information

(iii) criminal offences of any kind.

3. No Retaliation

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

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

4. Confidentiality

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

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

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

5. Procedure for Investigation of a Complaint

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

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

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

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

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

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

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

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

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

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

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

6. Monitoring the Investigation

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

7. Acting upon the Investigation's Findings/Conclusions

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

8. Report to the Audit Committee and Board

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

b) The report will include:

(i) the total number of complaints

(ii) a description of each complaint

(iii) how the complaint was received

(iv) the relevant category of the complaint

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

(vi) whether the complaint could be substantiated

(vii) who was involved in the investigation

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

(ix) the status of the complaint.

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

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

DEVELOPED: October 25, 2006		
REVISED/REVIEWED:		
June 25, 2014	April 24, 2019	April 27, 2022
November 30, 2022	Click or tap to enter a date.	Click or tap to enter a date.
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

Patrick Gaskin
President and CEO
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CAMBRIDGE MEMORIAL HOSPITAL

MEMORANDUM

TO: Board of Directors, Cambridge Memorial Hospital

DATE: November 12, 2024

REPORTING PERIOD: July 1, 2024 – September 30, 2024

FROM: Patrick Gaskin
President and CEO

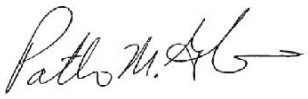
RE: CEO Certificate of Compliance

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

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

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

Exceptions: NIL



Patrick Gaskin
President and CEO

BRIEFING NOTE

Date: November 14, 2024
Issue: 2024/2025 Strategic Priorities Tracker Q2 Updates
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kyle Leslie, Director of Operational Excellence
Kristan Chamberlain, Senior Decision Support Specialist
Approved by: Mari Iromoto

Attachments/Related Documents: Appendix A – Strategic Priorities Package – Q2
Appendix B – Success and Wins Highlights Q2

Alignment with 2024/25 CMH Priorities:

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

Executive Summary

This briefing note provides an overview of our Strategic Priorities Tracker for fiscal year 2024/2025 and our Q2 performance in relation to targets set for Q2. The refreshed tracker is a robust tool designed to track and monitor our most critical in-year priorities and action plans aligned to our Strategic Plan, In-year Quality Improvement Plan and Integrated Risk Management (IRM) plan.

As per Q2 performance, the below priorities did not meet target and will continue to be a major organizational focus:

1) Organizational Flow Measured by: Ambulance Offload Times and EDLOS for Admitted Patients **(Organizational Risk-identified through IRM process and Quality Improvement Plan QIP)**
2) Optimal staffing and overtime reduction measured by: % on track with active staffing targets for MED, ED, ICU (**Organizational Risk-identified through IRM process)**
3) Advance Health Equity through developing our people measured through completion rates of Rainbow Health DEI training. **(Quality Improvement Plan QIP)**

Background

In alignment with our commitment to our Strategic Priorities and continuous improvement, we have revised our Strategic Priorities Tracker for 2024/25. The new tracker is designed to better reflect our organizational priorities and enhances our ability to measure success and share

progress towards achieving our most critical organizational priorities. The purpose of the Strategic Priorities Tracker is:

1) **Alignment-** It serves as a central hub to align priorities and actions with our strategic priorities to ensure firm focus on achieving our critical in-year priorities. The new tracker now aligns in-year metrics with the in-year actions from key Corporate Plans.
2) **Performance Monitoring-** This tool will be the primary performance monitoring and reporting instrument, providing comprehensive insights into our progress on a quarterly basis. Internally, this tool and associated action plans are embedded and monitored near real-time through weekly ops huddles, weekly flow meetings, department huddles and through real-time dashboard and analytics to enable informed decision making and action planning to optimize our trajectory towards success.

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

1) **Strategic Priorities Tracker:**
   - Monitors most critical in-year priorities identified through QIP, IRM, and the Strategic Plan
   - Presented Quarterly to Board Committees as a summary of actions and impact on success metrics
   - Performance on metrics monitored near real-time through various channels such as – OT/Staffing Task Force, Ops Huddle, Quality and Ops Councils, Clinical Operational Excellence Committee, Volume Weighted Case Meetings

2) **Quality Monitoring Scorecard:**
   - Monitors key quality and organizational metrics on a monthly cycle
   - Purpose is to ensure we sustain performance and identify quality issues early on to enable escalation and action

3) **Critical Risk (IRM) Escalated to More Frequent Reporting:**
   - Patient Flow and Organizational Staffing were identified through the IRM process as two top risks for our organization
   - Both have been elevated to more frequent reporting and will be reported on a monthly basis: Flow to Quality Committee and Staffing/OT to Resource Committee

Analysis

There are ten key priorities that are tracked on our 2024/25 Strategic Priorities Tracker that align to the Strategic Pillars of our Strategic Plan. The full Strategic Priorities Tracker including detailed action plans can be found in **Appendix A.** Each priority is evaluated and assigned a status: Red – Not meeting target; <90% of target met, Yellow – meeting 90% of target, Green – meeting target. Below is an overview of our Quarter 2 performance on these priorities:

Elevate Partnerships in Care:

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

This indicator measures the length of time from ambulance arrival to when the transfer of care from EMS is completed. Our 90th percentile ambulance offload time is **77 minutes (YTD Sep 2024)**, while the target is **<30 minutes**. In 2023-24, the 90th percentile ambulance offload time was **115 minutes; thus, we have seen a 33%** improvement in

the current fiscal year; however, we did see this number increase from 72.0 minutes in Q1 to 82.0 in Q2. A lower number for this indicator is better as it means patients are receiving timely emergency care.

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

This indicator measures the length of time from triage to when an admitted patient departs the emergency department for an available inpatient bed. Our 90th percentile length of stay for admitted patients in the ED is **50.5 hours (YTD Sep 2024),** while the target is **<33 hours**. In 2023-24, the 90th percentile length of stay for admitted patients was **58 hours, thus we have seen a 13%** improvement in the current fiscal year; however, we did see this number increase from 48.1 hours in Q1 to 51.7 in Q2. A lower number is better as it means patients are receiving care in the most appropriate setting.

A component of a patient's emergency length of stay is the time spent waiting for their initial provider assessment (PIA), which contributes to the overall length of stay patients' experience. The target is to see 90% of **patients within 4 hours or less**, as this means patients receive timely access to care. At the end of Q2, the 90th percentile YTD PIA time was **7.6 hours**, which is 0.8 hours longer than the same period last fiscal year. This has increased within the fiscal year, from 7.2 hours in Q1 to 7.9 in Q2.

Organizational patient flow was identified as a major organizational risk through the Integrated Risk Management (IRM) process for this fiscal year. The key metrics used to monitor this risk are the overall EDLOS for admitted patients, ambulance offload times as well as Provider Initial Assessment (PIA) LOS. Although we achieved some improvement from the previous fiscal year in the overall EDLOS for Admitted Patients and Ambulance Offload Metrics resulting from the initiatives completed YTD, we acknowledge that we have not yet mitigated the organizational risk related to patient flow and still have significant more work to do. The Actions we will focus on for Q3 are summarized in **Appendix A** within the Clinical Services Growth Plan.

Two major success and wins we would like to highlight related to our patient flow improvement work in Q2 include: **1) the implementation of a new real-time bed board** that pulls all of the information needed to facilitate bed flow meetings to one screen including staffing levels for each unit. This board has transformed our bed flow meetings from being information sharing meetings into action orientated bed flow meetings. **2)** The launch of the CMH Hospital to Home (H2) program which aims to aid in transitioning patients from hospital care to recovery at home to support overall patient flow.

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

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

Reimagine Community Health:

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

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

Both of the above priorities align to the initiatives within our Digital Health Plan. One of the major successes to highlight from this plan is the continued progress on the Workforce Planning System ensuring a successful system implementation which is included in **Appendix B**- Success and Wins Highlights.

Increase Joy in Work:

Priority 7: % on track with Active Staffing Targets (Not Meeting Target): This indicator measures the actual staffing as a percentage of the total staffing targets. It is measured by Full-Time Equivalents (FTEs) and includes RNs and RPNs from ED, ICU, MEDA, and MEDB. Our active staffing targets were **89% achieved (YTD Sep 2024),** while our target is 100%. A higher number is better as it means we are appropriately staffed.

Staffing and overtime usage was identified as a major organizational risk through the Integrated Risk Management (IRM) process for this fiscal year. To address this risk a staffing task force committee was formed to monitoring staffing and overtime usage and to develop recommendations for improvement. This work has resulted in enhanced data through the use of the electronic overtime request form for planning and decision making related to staffing and OT. We acknowledge that we have not yet mitigated this risk and will continue to work on mitigation strategies into Q3 including a benchmark analysis to similar sized hospitals. The action planned for Q3 are summarized in the Human Resources Plan update found in **Appendix A.**

A success we would like to highlight for staffing is the staff innovation project that was initiated in the ICU to develop an ICU acuity and staff resource prediction tool to support staff assignments and resourcing in the ICU. This initiative is highlighted in our Success and Wins in **Appendix B.**

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

Sustain Financial Health:

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

Post Construction Operating Plan (PCOP) Funding is a funding source available to hospitals with an approved Capital Redevelopment Plan (CRP). The PCOP is our planned growth for clinical activity due to growing capacity and beds through the CRP. The PCOP growth indicator measures the growth over our 2016-17 base volumes. For Acute IP, Day Surgery and Emergency Department, PCOP growth is measured by growth in weighted cases, which reflects the resource intensity of a case. IP Mental

Health Care is measured by growth in inpatient days, while clinic activity is measured by visits. If we reached our PCOP **target of $14.6 million dollars** this fiscal year, we would have achieved our planned clinical services growth for the year. As such, higher is better for this indicator.

At the end of Q2, **we saw our PCOP targets achieved, with $3.8 million earned in each quarter versus a target of $3.6 million/quarter.** This represents an **increase of $2.4 million from Q2 YTD in the previous fiscal year.** Our Q2 results were driven by medical discharges with high weighted cases, particularly in May, July, and September with many long-stay discharges. Surgical activity was lower than planned in the first two quarters of the fiscal year due to human resource challenges, a challenge that is expected to continue and contribute to the negative PCOP variance from budget projected for Year-End, putting this indicator at risk of not meeting annual targets and being at red status. Emergency department volumes continued to be lower than base volumes, resulting in no PCOP earned YTD, or expected for the year. Inpatient Mental Health occupancy continued to be low in Q2 (average 81%) as did ECT volumes, resulting in lower Mental Health PCOP than targeted.

Advance Health Equity:
Priority 10: Completion of Rainbow Health Diversity, Equity, & Inclusion Training (Not Meeting Target): This indicator measures the number of staff that have completed the Rainbow Health Foundations Course**. At the end of Q2, an additional 60** staff had done so, which is an improvement from Q1 when 39 staff had completed the training, though **our target is 88 or more** per quarter.

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

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

Strategic Priorities 24/25

"Creating Healthier Communities, Together"

Strategic Priority	Metric	Target	Q1	Q2	Q3	Q4	Aligned Corporate Plans
Elevate Partnerships in Care: Improve access to care by addressing wait-time to see a provider and time to in-patient bed	90th%tile ambulance offload time (minutes) (QIP/IRM)	<30	72.0	82.0			Clinical Services Growth Plan; Capital Redevelopment Plan; Emergency Preparedness Plan
	90th%tile EDLOS admitted patients (hours) (QIP/IRM)	<33	48.1	51.7			
	% on track Capital Redevelopment Plan (IRM)	100	100	100			
	% on track with Emergency Preparedness Plan (IRM)	100	100	100			
Reimagine Community Health: Prepare for digital health transformation	% on track with Health Information System (IRM)	100	100	100			Digital Health Plan
	% on track with Workforce Planning (IRM)	100	100	100			
Increase Joy in Work: Increase staff engagement by addressing staffing challenges	% on track with active staffing targets Med, ICU, ED (IRM)	100	88.8	89.1			HR Plan
	% on track with Corporate Change Management Strategy (IRM)	100	100	100			
Sustain Financial Health: Earn max eligible PCOP funding for 24/25	Post Construction Operating Plan revenue earned (IRM)	>$3.6M quarter	$3.75M	$3.81M			Multi-year financial plan
Advance Health Equity: Embrace diversity and build a culture of inclusion	Number of staff who have completed Rainbow Health Diversity, Equity, & Inclusion training (QIP)	>88 quarter	39	60			DEI Plan

Agenda

Elevate Partnerships in Care

Clinical Services Growth Plan

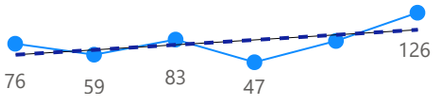
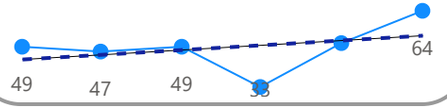
Click Here to Input Action Plans

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

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

Director Lead(s): April McCulloch, Donna Didimos

Project Manager(s): Jennifer Woo

In Year Measures of Success	Target	Q1	Q2	Q3	Q4	Monthly Trend
90th%tile Ambulance Offload Minutes	<30 mins	72.0	82.0			
90th%tile LOS Hours for Admitted Patients in ED	<33 hours	48.1	51.7			

Action Plan-Q2

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Achieve flow targets for provider initial assessment times and length of stay for complex and minors.	1. Implemented enhanced NP coverage for backfill (hired one PT NP); 2. Monitored & sustained CDU performance, meeting targets for last three months; 3. Created & provide training to staff focusing on ED metrics, P4R; 4. Began daily sub-acute huddles in ED; 5. Refreshed electronic huddle board with identified metrics; 5. Established weekly patient flow monitoring meeting with ED and Inpatient leadership to review identified metrics including P4R, ALC and long stay patients (ongoing)	1. Continue to hire for NP coverage for backfill (1 PT position); 2. Develop physician & staff education specific to patient disposition (Left without being seen- LWBS, Left without being treated- LWBT); 3. Review & revise sub acute sustainability plan with ED manager; 4. Develop organizational strategy for establishing a patient flow office - underway currently with recruitment of manager of staffing and patient flow, core objectives include refreshing organizational practices pertaining to patient flow	R1) Gaps in ED Physician Schedule; M1) Review & adjust NP schedule to bridge the gap; R2) NP recruitment; M2) Review & adjust physician schedule to bridge the gap; R3) Inconsistencies in process & standardized work at triage (nights) due to staffing; M3) Added budget enhancements for ED clerical
Achieve and maintain ALC throughput ratio of 1 and ALC census of <36	1. Updated ALC policy & process that supports all ALC work; 2.Reviewed new Home and Community Care performance target (% of new hospital patients that are contacted by HCC within 2 business days) & determined how to integrate into existing CMH process; 3. Continue with Cambridge Collaborative to support complex patients and discharges (ongoing)	1. Continue with Cambridge collaborative to support complex patients & discharges; 2. Develop & soft-launch Hospital to Home (H2H) Program by end of Oct with target of full implementation by Dec 15th, which supports ED admission avoidance, targeting potential ALC patients with high restorative capacity; 3. GIM and ED meeting to review support of General Internal Medicine Rapid Assessment Clinic (formerly CBMED) & ED Diversion; 4. Trial direct referral process for GIMRAC by ED physician, with anticipated go-live of Nov 4th; 5: Investigate & improve LOS on key case mix groups, such as COPD	R1) Launch H2H program as per project timelines; M1 & 2) Weekly meeting with OH West, Weekly CMH project team meetings; R2) Recruitment of patient navigator for H2H; M2) Review current staffing strategy to bridge the gap; R3) Delay in signing contracts with Service Provider for H2H; M3) Escalate to OH West for support
Achieve 30 min or less ambulance offload time	1. Refreshed electronic huddle board with identified metrics; 2. Completed CMH EMS escalation accountabilities	1. Implement EMS timestamp equipment to capture EMS arrivals ; 2. Review & revise AOT sustainability plan with ED manager; 3. Re-evaluate & reinforce standardized work for all roles (e.g. charge nurse, EMS offload nurse, EMS triage nurse, ED clerical); 4. Target go-live of CMH EMS escalation process for Nov 5th	R1) HHR for EMS Triage Nurse (staffing and education); M1) ED Nurses to attending triage class
Achieve time to in-patient bed target	1. Review & restructure unit rapid round, with physician involvement (in progress); 2. Refresh "Unit Census Board" whiteboard to enhance communication among team & identify barriers to discharge (in progress, align with target date); 3. Establish improved process for communicating estimated date of discharge (ongoing, align with target, updating patient white boards); 4. Medicine leadership rounding with patients regarding discharge expectations & prep with patients (ongoing); 6. Refreshed bed board & bed board meeting structure; 7. Refreshed electronic huddle board with identified metrics	1. Launch refreshed unit rapid rounds on Jan 5th; 2. "Unit Census Board" to align with rapid rounds implementation; 3. Refresh patient white boards to align with rapid rounds implementation; 4.Investigate paper-based SBAR to verbal TOA based on STEGH site visit; 4. Medicine leadership rounding with patients regarding discharge expectations and prep with patients	R1) Physician presence and engagement at rounds; M1) Launch unit rapid rounds & slowly integrate physicians into new structure (modify schedule if necessary)

Agenda

Sustain Financial Health

Multi-Year Financial Plan

Click Here to Input Action Plans

Executive Sponsor(s): Trevor Clark

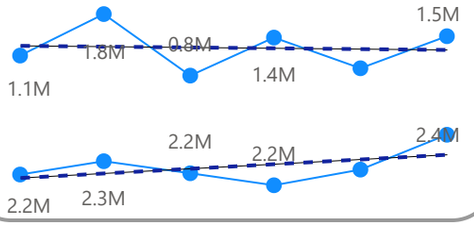
Physician Liaison(s): Dr. Green, Dr. Sharma, Dr. Nguyen

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

Project Manager(s): Jennifer Woo

In Year Measures of Success	Target	Q1	Q2	Q3	Q4
PCOP Revenue earned	>$3.6M per Quarter	$3.8M	$3.8M		
QBP Revenue earned	>$6.6M per Quarter	$6.7M	$6.8M		

Monthly Trend



Action Plan- Q2

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Quality Based Procedure Volumes & Revenue Achieved	1. Continued to monitor QBP volumes against targets to ensure QBP targets are met 2. Implemented Endo utilization policy	1. Continue to monitor QBP volumes against targets to ensure QBP targets are met; 2. . Establish protocols for the review and monitoring of Endo time	R1) Endo third room EUS volumes; M1) GI Endo and General Surgical Leads to continue to follow up with physicians; R2) Systemic Therapy QBP approx. (400K) Negative Variance, received QBP funding letter in September; M2) Continue to work with medical oncologists and finance to develop strategies for this fiscal year
Ensure effective in-year PCOP monitoring for Surgery	1. Reviewed Q2 performance to ensure PCOP was maximized; 2. Using the surgical efficiency to review upcoming blocks & plan accordingly to improve variance (ongoing); 3. Attended Family Medicine Meeting in September; 4. Held value-stream mapping session for OR Booking Process; 5. Successfully held 2 week trial in OR to improve turnaround times; 6. Re-allocated additional GYNE blocks to other services (ongoing)	1.Analyze Acute Care Surgery (ACS) time; 2. Prioritize, trial & implement actions of OR Booking VSM session; 3. Build standardized work for OR roles based on observations from turnaround time trial; 4. Analyze and create PACU simulation analysis to identify flows in patient flow; 5. Hold value-steam mapping session for patient flow from PACU to Inpatient Surgery; 6. Continue to finalize project with the University of Waterloo on OR	R1) Gaps in surgeon coverage for GYNE, urology & plastics; M1 & 2) Re-allocate blocks and job postings in multiple forums; R2) Lower referral volumes; M3 & 4) Monitor referral volumes and share at Surgical Council
Ensure effective in-year PCOP monitoring for Mental Health	1. Built reporting cadence to MH leadership, clinical leadership & physician leadership (through MH Quality & Operations, weekly huddles) (ongoing); 2. Investigated ECT volumes & will make adjustments for future budget planning	1. Re-introduce planning for ketamine administration; 2. Update external CMH website for MH services	R1) Occupancies are dependent on patient needs/ care plans; M1) Establish process for connecting with community partners, to ensure there are supports available in the region; R2) Ketamine administration requires recruitment of CEF position; M2) Leverage professional practice to provide support in the interim
Execute PCOP planning & forecasting for PCOP & volume prediction for 25/26 planning cycle	Q1/Q2: Continuous and ongoing monitoring of PCOP and data collection for PCOP forecasting in Q3/Q4	1. Engage key clinical teams for the discussion around PCOP forecasting and build out PCOP strategy as part of budget review cycle	R1) Prediction & planning is dependent on new construction & B tower occupancy; M1) Continue to monitor & track CRP milestones under Strategic Priorities; R2) Status of PHA4 agreements related to TCC and Clearvision are unknown, waiting for ministry guidance; M2) Build agreements into forecast
Ensure effective in-year PCOP monitoring for Medicine	1. Reviewed Q2 performance to ensure PCOP was achieved and maximized; 2. Sustained new practices & maintain long stay list; 3. Worked towards increased numbers for next day confirmed discharges	1. Continue daily review of long stay list and discharges; 2. Initiate planning for return of rehab and coordination of medical unit; 3.Understand the impact of H2H on funding and PCOP; 4. Understand the impact to PCOP and QBP due to EUS volume reduction to one day per week	R1) Weekend discharges; M1 & 2) Launch H2H program at the end of Oct, Added budget enhancements for Allied Health and Social Work, 7 days; R2) Daily discharge rounds; M3) Review & restructure with target implementation of Jan 5th; R3) Physician presence and engagement at rounds; M4) Launch unit rapid rounds and slowly integrate physicians into new structure (modify schedule if necessary)

Agenda

Elevate Partnerships in Care

Capital Redevelopment Plan

Click Here to Input Action Plans

Executive Sponsor(s):
Patrick Gaskin, Mari Iromoto

Physician Liaison(s):

Director Lead(s):
Amanda Thibodeau, Rob Howe

Project Manager(s):
Alyssa McCarthy, Bill Hibbs, Ryan Nurse

In Year Measures of Success

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

Action Plan- Q2

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

Agenda

Reimagine Community Health

Digital Health Plan

Executive Sponsor(s):
Trevor Clark

Physician Liaison(s):
Dr. Taseen

Director Lead(s):
Rob Howe

Project Manager(s):
HIS - TBD, WFP - Beth Jones

In Year Measures of Success

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

Action Plan- Q2

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Successful implementation of Workforce Planning (WFP) Q1 FY25/26	1. Project kickoff (August 2024) 2. Communications of system transformation project (July 2024) 3. Internal resourcing confirmed (August 2024) 4. Communicate WFP work under the Project Quantum (formerly System Transformation) work	1. Alignment of project with Organizational Scheduling Office with resourcing (September 2024) 2. Complete requirements gathering stage of project (November 2024) 3. Kickoff AndGo solution project (November 2024)	1R) Engagement of UKG Project Resources 1M) Escalation by CMH Executive Sponsor to UKG Executive, with on-going discussions around UKG performance 2R) Multiple critical path items required to come together for overall project success (ie. terminals, AndGo, scheduling) 2M) Extended internal Steering with full stakeholder review of overarching project plans
Implementation of a new Health Information System (HIS)	1. Investigate shared instance opportunity governance with Grand River Hospital and St. Mary's General Hospital (August 2024) 2. Engage vendor on contractual terms and project implementation strategy for shared instance 3. Communicate HIS work under the Project Quantum (formerly System Transformation) work (August 2024)	1. Complete investigation with Grand River and St. Mary's comparing financial, scope, and functionality implications of a regional instance (October 2024) 2. Recommend direction to CMH Board regarding single vs. shared instance (November 2024) 3. Complete Board approvals to proceed with agreed on direction (December 2024)	R1) Delays from Oracle Health in receiving required documents; M1) Bi-weekly escalation through CEO office with Oracle Health, common sense of urgency shared with GRH/SMGH CIO

Agenda

Increase Joy in Work

Human Resources Plan

Click Here to Input Action Plans

Executive Sponsor(s):
Patrick Gaskin, Mari Iromoto

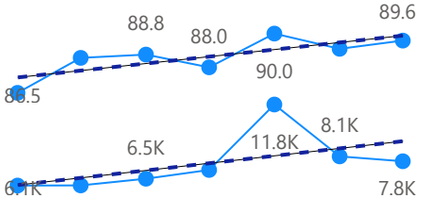
Physician Liaison(s):

Director Lead(s):
Susan Toth

Project Manager(s):
Soumya Saini

In Year Measures of Success	Target	Q1	Q2	Q3	Q4
% on track with staffing targets for MED/ICU/ED	100%	88.8	89.1		
OT hours per quarter	5552	18.7K	27.1K		

Monthly Trend



Action Plan- Q2

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Enhance HR Systems and Data to Support Staffing Decision Making (Workforce and ICIMS)	1. Ongoing excecution for optimization plan for existing HR/Staffing tools (ongoing); 2. Use current staffing data to support staffing decision making & monitoring of HR processes (ongoing); 3. Support the implementation of the workforce planning system (ongoing) 4. Executed monitoring tool for spreading the use of the electronic OT tool to all areas of the hospital; 5. Conducted VSM mapping session that reviews current staffing office systems & tools used for current state analysis as we prepare for Workforce Planning including the call in process	1) Establish optimization plan for existing HR/Staffing tools 3) Implement workforce management system including timekeeping, scheduling, absence management and analytics	R1) Capacity of the resources on the project for workforce management; M1) Hiring a co-op student and backfilling with SMEs to increase resources for the project; R2) Delays due to UKG resource support; M2) Adjust the timeline and stagger the go-live for the two modules
Focus on strategies to enhance retention by focusing on wellness and wellbeing	1. Socialized & developed strategy for rewards and recognition programs – ICCAIR, career achievement, hospital-wide events (BBQ, holiday meal, food drive, Thanksgiving event) with an established plan (ongoing); 2. Initiated WorkLife pulse survey realigned to the accreditation global engagement survey with the objective of raising the percentage of staff who agree or strongly agree that CMH is a great place to work from 42% to 48%. 3. Implemented process and organization standards for unit codes of conduct	1) Ongoing evaluation & feedback on reward recognition programs 2) Evaluate and rollout process and tools to enhance departmental onboarding practices by Q3 3) Evaluate process and organization standards for unit codes of conduct Q2	R1) Limited human resources/vacancies to complete this work; R2) New leaders that need to be onboarded/ integrated into their units; M1 & M2) Hiring for the role of Manager of Organizational Development or other
Enhance recruitment processes and establish CMH as a desirable place to work	1. Ongoing collaborate with ICU/Med/ED to increase active staffing from 86.5% to 89.6% on track by end of Q2; 2.Refreshed recruitment processes, structures & resources; 3. Increased internship opportunities; 4. Implemented varied recruitment strategies such as project search; 5. Reviewed & updated ICIMS to improve better candidate experience (ongoing)	1. Continue with ongoing collaboration to improve active staffing from 89.6% to a target of 100%; 3. Improve student conversion practices Q3 5. evaluate impact of various strategies including project Search which will be implemented and launch in Q3 and ongoing work with ICIMS	R1) Pool of qualified applicants does not meet requirements; M1) Internship opportunities will allow CMH to train employees; R2) Internships may lengthen training time & we may not be fully staffed; M2) Over hiring to allow staff to be fully trained
Focus on strategies to enhance staff retention (People Development)	1. Ongoing monitoring and enforcement of remaining VBCs to ensure we meet year end target; 2. Incorporated feedback on change management course into PM/QI course/Change Management tool kits Q1-Q3; 3. Ongoing evaluation of criteria for RN, RPN, & PSW requirements for ambulance runs; 4. Established a process to monitor & track scheduling gaps in real time; 5. Reviewed self-scheduling practices & identify opportunities for improvement. 7) 100% of leaders to have completed achievement competency assessment (ACA)	1) Incorporate standardize PM/QI/ Change Management framework to support major corp projects such as project quantum & other major cor projects 5) continue to evaluate Reward and recognition strategies refreshed for by Q3 2) ongoing monoitoring of 600 VBCs Q1-4 4) eveluation and refresh of CMH learning labs by Q1-4	R1) Turnover in lead for Change Management; M1) PMO to align PM/QI/Change Management Courses & tools, develop course skeleton for review in Q2

Agenda

Advance Health Equity

DEI Plan

Click Here to Input Action Plans

Executive Sponsor(s): Mari Iromoto

Physician Liaison(s):

Director Lead(s): Jennifer Backler

Project Manager(s): Soumya Saini

In Year Measures of Success

Achieve more than 350 staff completing Rainbow Health Foundations Course

Target	Q1	Q2	Q3	Q4
>88 per quarter	39	60		

Action Plan- Q2

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Create Safe Spaces	1. Diversity Council met in September to discuss safe spaces at CMH and inclusion commitment; 2. A proposed process developed for addressing interstaff conflict & de-escalation ahead of complaint process; 3. Observation of National Day of Truth and Reconciliation on Sept 30th including monthly LEARN challenge and Hawk Feather Reenergizing Ceremony	1. Re-evaluation of Inclusion Lead position with input from organization and Diversity Council; Role to be posted based on feedback; 2. Fall Leadership Camp developed with full day Indigenous activities including Blanket Ceremony; Drumming Circle activity planned	R1) Inclusion Lead position is vacant again M1) A staff resource has been identified to provide continuity support for Indigenous initiatives; DEI communications will continue to be executed by Communications Specialist
Enhance collection of sociodemographic data collection	1. Participated in Regional Working Group Meetings to understand approach across the region; 2. Reviewed Service Accountability Agreement Reporting Requirements; 3. Reviewed Ontario Health Guidance Documents on use & reporting of Sociodemographic data collection 4. Initiated internal working group to guide and execute plan for enhanced collection of sociodemographic data	1. Working group to continue to work of plan for enhanced sociodemographic data including engaging with PFAC 2. technical working group investigating tools and strategies 3. develop implementation plan with working group 4: establishing change management education plan, to support rollout of this initiative	R1) Competing projects for technical resources required ; M1) Continuous monitoring of projects and alignment of projects to strategic priorities
Inclusive Language & imagery	1. Updated process for name signage on doors to now include requests for preferred names& pronouns; 2. Launched digital accessibility feature on external website to allow more ease in accessing website content and ensure we remain AODA/WCAG compliant; 3. Continue to celebrate/observe events from DEI calendar - including profiling patients/staff/physicians in Voices of CMH series to observe International Day of Sign Language, Onam Festival	1. Profile staff & physicians during Islamic History Month - including developing a video series of Voices of CMH featuring a different staff/physician each week who identifies as Muslim; 2. Develop recommendations to begin demographic data collection of staff upon hire	
Key People, Processes, & Policies	1. Inclusion questions incorporated into refreshed interview templates;	1. Replace the corporate statement by the equity & inclusion commitment statement; 2. Develop relationships with organizations for internship placements (i.e.. Project Search, THRIVE);	
Rollout Education & Training	1. Assigned Rainbow Health training to a total of 324 staff, prioritizing leaders, working group members, ED, Mental Health, HR, and Central Reg Staff. 2. Ensured that 97% of leaders completed the Rainbow Health Course by the end of Q2. 3. Sent a direct message to Mental Health and ED on October 28th via B2L to complete Rainbow Health Foundations by November 8th, 2024; tracked the upload of certificates (12 completed since the message). 4. Integrated Rainbow Health training into the orientation process for all new clinical staff as part of their core eLearns. 5. Assigned the Rainbow Health Foundations Course to all board members.	1. Develop draft CMH specific 2SLGBTQI+ for B2L by Q4 2. ER and MH will pay their staff to complete the course to help with compliance.	R1) Ongoing professional development is required for CMH to be in alignment with the health service accountability agreement; M1) Ensure we reach the target of 350 by end of fiscal; R2) Staff were not uploading their certificates to mark course as complete. M2) DS and vendor to automate course monitoring and reminders to staff; R3) We do not pay staff to complete their B2L training. M3) Assigning the course to newly orientating staff will allow them to be paid to complete this core course

Agenda

Reimagine Community Health

Emergency Preparedness Plan

Click Here to Input Action Plans

Executive Sponsor(s): Mari Iromoto

Physician Liaison(s):

Director Lead(s): Liane Barefoot

Project Manager(s): TBD

In Year Measures of Success

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

Action Plan- Q2

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Enhance organizational Emergency Preparedness	1. Onboarded new Emergency Preparedness Lead (starts July 22) including meeting internal leaders, familiarity with CMH, and meetings with Cambridge Fire Department and City of Cambridge Emergency Preparedness Leads; 2. Meet with Waterloo Regional Police to start planning for Mock Code Silver table top; 3. Re-establish cadence of Emergency Preparedness Committee; 4. Conduct a gap analysis of current structures (post code debriefs, mock code schedules, evaluations for mocks, dissemination of learnings from actual and mocks); 5. Fire Prevention Week Booth in cafe to align with 1-year anniversary of CMH fire - very well attended	1. Leader IMS100 and IMS200 Training for 6 Leaders to be completed in October 2024; 2. Annual Mock Code Green with Cambridge Fire Department and ICU scheduled for October 2024; 3. Finalize content of the 3 designated internal Emergency Operations Centres (EOCs); 4. Training & Mocks for staff moving back into B-Wing;	

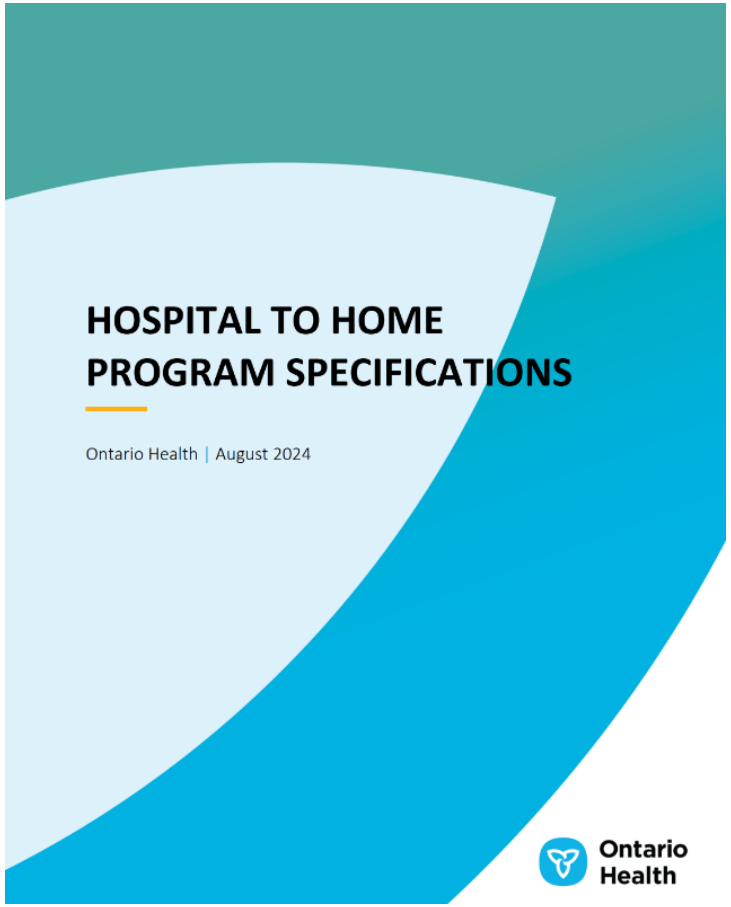
Elevate Partnerships in Care

Success and Wins

Description and Impact:

The Hospital to Home (H2H) Program is a 16-week initiative focused on aiding patients in their transition from hospital care to recovery at home. The program provides a comprehensive bundle of services, including nursing, personal support, physiotherapy, occupational therapy, and social work, tailored to meet each patient's unique needs. Every patient receives a personalized care plan, collaboratively developed with input from caregivers to ensure patient-centered, effective care.

The H2H Program positively impacts patient flow by enabling earlier discharges, reducing hospital length of stay (LOS), and alleviating pressures on Alternative Level of Care (ALC) resources. Additionally, the program strengthens collaboration and continuity of care by ensuring smooth handoffs to Ontario Health atHome, where patients can receive further support if needed, enhancing both immediate recovery outcomes and long-term health management.



Elevate Partnerships in Care

Success and Wins

Description and Impact:

A real-time bed board and new bed rounds were implemented to streamline discussions pertaining to patient flow. The enhancements to the bed board include notes about bed assignments, unit staffing status and relevant action plans. This upgrade has transformed the bed meeting from primarily information-sharing to one that is action-oriented.

As a result, the meeting time was significantly reduced, from 30 minutes to just 10-15 minutes, now conducted entirely virtually.

Increase Joy in Work

Success and Wins

The objective is to create an ICU acuity tool that uses the combination of CCIS (critical care information system) data, benchmark LOS, typical LOS, comorbidity and census information to make realistic and appropriate decisions on required staffing levels to support patient care.

The implementation of this tool will help guide conversations around staffing between leaders, physicians and nursing. Other benefits include improved staff satisfaction, reduction in ICU OT, reduction in ICU sick time and reduction in short-staffed shifts.

ICU charge nurses and clinical leadership have begun validation and testing of the tool, with planned go-live by the end of fiscal year.

Agenda

Reimagine Community Health

Success and Wins

PROJECT QUANTUM
Make the leap+

WORKFORCE PLANNING

Description and Impact:

On August 21, we held our official kick-off meeting with UKG, where our Workforce Planning (WFP) Steering Committee and newly established WFP Core Project team were introduced to the UKG consultants, tools, methodology, and overall scope and objectives of the software implementation.

Since then, the WFP Core Project team has been meeting weekly as a group, along with extensive sessions and follow-up work with individual UKG consultants who offer specialized guidance in areas like Timekeeping, Payroll, Advanced Scheduling, and Integration. The team's primary challenge is to transition our current, manual scheduling processes to a digital system. Our goal is to ensure compliance with all legislative, collective bargaining agreements (CBA), and organizational policies, while optimizing the software to automate, streamline, and standardize processes wherever possible.

In addition to system modernization, CMH is investing in re-designing our scheduling practices and processes, to support standardization and efficiency. This work is led by the Operational Excellence portfolio within CMH whish has started recruiting for the future state.

PROJECT OUTCOMES

Financial Sustainability:
Increase the efficiency and accuracy of all employee time activities and data.

Joy In Work:
Offer employees convenient and easy access to their time banks, schedules, and self-service functionality, while empowering managers to efficiently support time and attendance activities.

Reimagine Community Health:
Increase the ability to fill shifts more efficiently to reduce staffing shortages, thereby ensuring exceptional patient care.

BRIEFING NOTE

Date: November 14, 2024
Issue: Quality Monitoring Metrics
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kristan Chamberlain, Senior Decision Support Specialist
Kyle Leslie, Director Operational Excellence
Liane Barefoot, Director Patient Experience, Quality, Risk, Privacy & IPAC
Approved by: Mari Iromoto, VP Strategy and People
Attachments/Related Documents: Appendix A – Quality Monitoring Scorecard September 2024

Alignment with 2024/25 CMH Priorities:

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

Executive Summary

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

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

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

1) Overtime hours (Resources Committee)
2) Sick hours (Resources Committee)
3) ALC Throughput (Quality Committee)
4) Ambulance Offload Time (Quality Committee)
5) Emergency Department Length of Stay for Complex Patients (Quality Committee)
6) Emergency Department Wait time for Initial Assessment (PIA) (Quality Committee)
7) Low-Risk Caesarean Sections

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

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

Analysis:
Four (4) of the seven (7) indicators that are currently trending in red for three or more periods relate to overall flow/throughput and are collectively being addressed by focused work in the Emergency Department and inpatient discharge planning efforts. Flow/throughput has been elevated as an organizational Integrated Risk Management (IRM) priority as well as highlighted internally and publicly as an area of focus via our Quality Improvement Plan (QIP). It is a standing agenda item weekly at Senior Executive, weekly at Operations meeting, weekly meeting with ED and Medicine leadership to review details of outlier cases, and Quality and Operations Councils.

Two (2) of the seven (7) indicators are related to staffing, Sick and Overtime, and have Board oversight by Resources Committee who regularly tracks performance and mitigation strategies. Similar to flow/throughput, overtime in the targeted areas of Emergency department, ICU and Medicine has been elevated to an organizational Integrated Risk Management (IRM) priority.

The Low-Risk Caesarean Section Rate has now met the threshold where we will do a deeper dive to determine if any corrective actions need to take place.

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

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

Efficient:

1) **Overtime Hours** 

   This indicator measures the total number of overtime hours used vs. budgeted overtime hours. Currently we are significantly over budget, with an average of over 3500 overtime hours/pay period while the target is 850 hours/pay period. The majority of overtime hours (approx. 60%) can be attributed to the Emergency Department, Medicine, and ICU. A lower number on this indicator means that we are staffing less with OT, which has a positive impact to Joy in Work as it is an indication that we have improved staffing levels, leading to reduced staff burnout.

2) **Sick Hours** 

This indicator monitors the average sick hours per pay period per month. A lower number is better as that means there are less staff off and unable to work due to illness. Currently we are significantly over budget, with an average over 3000 sick hours/pay period while the target is 2090 hours/pay period.

Integrated & Equitable:

3) **ALC Throughput** 

This indicator monitors the level of ALC activity in the hospital. The ALC throughput ratio measures the new ALC cases vs. discharged ALC cases and is used to monitor turnover and flow of ALC cases. A throughput ratio of one means that for every new ALC case, one current ALC case is discharged. The current ALC Throughput Ratio is 0.74, meaning we are adding more cases than discharging.

Safe, Effective & Accessible:

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

This indicator measures the length of time from ambulance arrival to when the transfer of care from EMS is completed. Our 90th percentile ambulance offload time is 77 minutes (YTD Sep 2024), while the target is <30 minutes. A lower number for this indicator is better as it means patients are receiving timely emergency care.

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

This indicator measures the wait-time from triage to disposition from the ED. Currently, 90% of complex ED patients have a length of stay 9.7 hours or less (YTD Sep 2024), while our target is 8 hours or less. A lower number is better as it means patients are receiving care in a timely, effective and efficient way.

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

This indicator measures the wait-time from triage to being seen by a physician or nurse practitioner in the ED. Currently, 90% of ED patients were seen by a physician or nurse practitioner within 7.6 hours (YTD Sep 2024), while our internal target is to see 90% of patients within 4 hours. A lower number is better as it means that patients are seen by a physician or nurse practitioner within an appropriate timeframe in the emergency department.

7) **Low-Risk Caesarean Sections (Rate per 100 deliveries)** 

This indicator measures the rate of deliveries via Caesarean section among low-risk deliveries. This measure is intended to be used as a flag to identify areas for improvement and to help reduce C-section rates overall. Currently, 21.3% of low-risk deliveries have resulted in C-section (YTD Sep), while our target is <17.3%. A lower number is better as it indicates appropriate, effective and efficient care.

Next steps:

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

Agenda

Quality Monitoring Scorecard, 24/25

Status (Last 3 Periods)

Meeting Target	9	31%
Within 10% of Target	13	45%
Exceeding Target	7	24%

Quality Dimension		Unit of Measure	Target	YTD	Status (Last 3 periods)	Period
Efficient	Active Staffing Target Achieved (ED/MED/ICU)	%	100.00	90.60	▲	Nov-24
	Conservable Days Rate	%	30.00	34.41	▲	Sep-24
	Overtime Hours - Average per pay period	hours	850.00	3,580.58	◆	Oct-24
	Sick Hours - Average per pay period	hours	2,090.00	3,063.71	◆	Oct-24
Integrated & Equitable	ALC Throughput	Ratio	1.00	0.74	◆	Oct-24
	Percent ALC Days (closed cases)	%	20.00	26.25	▲	Sep-24
	Repeat emergency department visits for Mental Health Care	Patients	11.00	9.50	●	Sep-24
Patient & People Focused	Organization Wide Vacancy Rate	%	12.00	5.57	●	Oct-24
Safe, Effective & Accessible	30 Day CHF Readmission Rate	%	14.00	12.38	●	Aug-24
	30 Day COPD Readmission Rate	%	15.50	13.86	▲	Aug-24
	30 Day In-Hospital Mortality Following Major Surgery	%	1.90	0.73	●	Sep-24
	30 Day Overall Readmission Rate	%	8.80	6.58	●	Sep-24
	Ambulance Offload Time (90% Spent Less, in Minutes)	minutes	30.00	77.00	◆	Sep-24
	ED Length of Stay for Admitted Patients (90% Spent Less, in Hours)	hours	33.00	50.60	▲	Sep-24
	ED Length of Stay for Non-Admitted Complex Patients (90% Spent Less, in Hours)	hours	8.00	9.70	◆	Sep-24
	ED Wait Time for Inpatient Bed (90% Spent Less, in Hours)	hours	25.00	41.40	▲	Sep-24
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours)	hours	4.00	7.60	◆	Sep-24
	Hip Fracture Surgery Within 48 Hours	%	83.10	92.62	●	Sep-24
	Hospital Standardized Mortality Ratio (HSMR)	Ratio	100.00	95.93	▲	Sep-24
	In-Hospital Sepsis	per 1000 D/C	3.20	3.37	▲	Sep-24
	Long Waiters Waiting For All Surgical Procedures	%	20.00	17.12	●	Oct-24
	Low-Risk Caesarean Sections	%	17.30	21.34	◆	Sep-24
	Medication Reconciliation at Admit	%	95.00	97.00	▲	Oct-24
	Medication Reconciliation at Discharge	%	95.00	96.00	▲	Oct-24
	Obstetric Trauma (With Instrument)	%	14.40	18.50	▲	Sep-24
	Patient Safety Event - Falls with Harm	per 1000 PD	0.00	0.08	●	Oct-24
	Patient Safety Event - Medication Events with Harm	per 1000 PD	0.00	0.03	▲	Oct-24
	Revenue - Achieve budgeted PCOP growth (IRM)	$	7,341,144.00	7,560,565.00	▲	Sep-24
	Revenue - Achieve Quality Based Procedure Funding (IRM)	$	12,440,088.00	13,520,755.00	●	Sep-24

CMH President & CEO Report
December 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.

Project SEARCH has started, and you are an essential part of it!

- An exciting initiative was launched earlier this fall and our first interns have already started their journey at the hospital. Over the past few weeks staff have seen them navigate the halls in their bright red jackets, working alongside our teams.
- Project SEARCH is a school-to-work transition program designed to give young individuals with intellectual disabilities the opportunity to gain hands-on work experience. These interns are eager to learn and grow and staff involvement can make all the difference in their success. Whether answering their questions, sharing their expertise, or simply engaging with them during the day, all CMH personnel play a key role in their learning journey.
- The program spans nine months, with interns rotating through different areas like Food Services, Housekeeping, Stores, Administration, Medical Day Clinic and Diagnostic Imaging. Each rotation helps them build valuable skills and confidence for their future careers. Mentorship and support in a working environment are vital to shaping their experiences and empowering them to succeed.
- "Having this at our hospital speaks volumes to our commitment to diversity and inclusion and reinforces a workplace that values accessible and equitable employment opportunities," says Recruitment Specialist Cheryl Vandervalk who is the Business Liaison for the program. She adds that "having this program at CMH helps to create opportunities for our community."

CMH receives 2023/24 Ontario Health TGLN Hospital Achievement Award

- Cambridge Memorial Hospital (CMH) was honoured on Thursday, September 12 to receive the 2023/24 Ontario Health (Trillium Gift of Life Network [TGLN]) Hospital Achievement Award for the second year in a row.
- In 2023/2024, CMH supported two organ donors. This led to nine organs being donated for transplant, saving eight lives. In addition, there were 19 tissue donors that enhanced the lives of many more. The Hospital Achievement Award for Provincial Eligible Approach Rate recognizes the hospital for demonstrating leading practices and facilitating donor discussions with eligible patients and families of patients at end of life. CMH exceeded the target of 90% reaching a 100% eligible approach rate.
- A big thank you to the staff and physicians involved and whose commitment to supporting organ and tissue donation saves lives.

Take Your Kid to Work Day delivers exciting glimpse into hospital life

- On November 6, 2024, the hospital welcomed Grade 9 students for an unforgettable experience filled with exciting and immersive learning opportunities. The day began with presentations from both clinical and corporate roles, which I had the pleasure of

attending. The kick-off provided insights into a broad array of healthcare roles and inspiring stories of teamwork and dedication.

- Later, students received a hands-on introduction to clinical equipment with Registered Nurses, Denise and Sarah, who demonstrated cutting-edge vein-finder technology.
- The students explored different areas that make a hospital, including information technology, infection prevention and control, and privacy and confidentiality. Students also visited the laboratory, food services, diagnostic imaging, the operating room, and the nursery—where they even met a set of baby triplets, which many thought was a highlight of the tour.
- “I learned about the many roles at a hospital that make it function," said Anton, one of the visiting Grade 9 students. He added: “Visiting the OR was a cool experience—it is an opportunity not many people get—putting on the gown and understanding how it protects patients and staff from infection during surgical procedures.” Anton would later join the Communications department for special insights into how public relations builds relationships with internal and external stakeholders.
- After a pizza lunch, students shadowed their parents who worked in various departments, gaining firsthand insight into their jobs. They observed the day-to-day tasks involved in patient registration, administration, pharmacy, finance, and more.
- Take Your Kid to Work Day provides students with a unique, behind-the-scenes look at healthcare and its many rewarding career paths. The day was a huge success, leaving students inspired and eager to learn more about the healthcare field.
- Thank you to all staff, medical professionals, and volunteers that aided in giving these young minds a positive first-hand experience in the healthcare sector.

Welcome (back) Maria Fage, Integrated Care Manager, Ontario Health at Home

- Take #3 and third time is the charm! On Monday October 7 we welcomed back Maria Fage to CMH!
- She returns as the Integrated Manager which she previously fulfilled between 2018-2021 before leaving CMH to pursue a leadership role with the Ontario Health at Home Community Team in Cambridge.
- Maria is an Occupational Therapist with over 20 years of experience in patient care and healthcare leadership in the home and community care and hospital sectors. Maria has been dedicated to serving the Cambridge North Dumfries and Waterloo Wellington areas her entire career and as her photo indicates, she is a (519) for life!
- Maria and her husband make their home in Guelph and have two teenage children. When not at work, Maria can be found on a local soccer field cheering on her children, cycling country roads in Waterloo-Wellington or exploring cities on foot or bike.

Welcome Janine Kalmar, Manager of Staffing and Patient Flow

- In early November, we were pleased to announce that Janine Kalmar accepted the role of Manager of Staffing and Patient Flow. She begins her role on November 25.
- It is a critical role, one that will have Janine oversee the management of staffing operations, while optimizing patient flow processes, and collaborating with clinical and corporate teams to address their staffing needs.
- As the Medicine Program Clinical Coordinator, Janine brings extensive experience the role, that will facilitate the coordination of daily operations, including staffing and recruitment, supporting patient flow and discharges, and overseeing ALC designation and reporting.

- Janine has consistently demonstrated expertise in maintaining patient safety while collaborating with leaders to address patient flow, and staffing challenges.
- Her experience and skills will also be invaluable to supporting the transition to our new state-of-the-art workforce planning system under Project Quantum and driving sustainable patient flow and staffing models.
- Outside of CMH, Janine enjoys quite days at home reading and spending time with her new puppy (Nova). She can often be found outside playing with her boys (Oliver and Henry) or tending to her plants. Janine's husband, Steve, has been her biggest cheerleader throughout her dedication and career development at CMH.
- Thank you to the interview team, which included Clinical Managers, Directors, Staffing Office, Shift Admin, Human Resources and Patient and Family Advisory Council.
- Please join us in welcoming Janine to her new role!

Tracey marks 18 years at the CMHVA Tim Hortons

- It was a friendly voice urging Tracey Lewis to "come work with us" that beckoned her to apply for the job. She did and never looked back.
- Her first shift was on a cold November 11, 2006 – nearly two decades ago – a day she would not forget! "Oh, I remember that day," said Tracey. "The Tim Hortons was in its first location in the basement! So much has changed. We moved three times and introduced so many more products."
- Tracey is in fact a neighbour of CMH, living across from the hospital and watching it grow for over 25 years. Family and belonging are important for her. Working so close to home provided more time for her family and being present when they needed her most. This sentiment has only strengthened over the years, sharing: "I love the relationship we have with the hospital. We're always included in events and that makes us feel valued and part of the organization."
- To say Tracey is enthusiastic is an understatement. She is a genuinely happy person, always smiling and doing her job with pride. She is the Health and Safety rep for her team. It's a role she takes seriously, doing her part to keep the clientele safe by advising the team on safety procedures and keeping an eye out for issues. As a Team Member, she relishes in serving her customers and interacting with them, many of whom she knows by name and what they order!
- When asked what experience or advice she would share, she said Tim Hortons is a great starting point for young people. "It's improved my self-confidence, and my manager Tammy (Devereux) has really helped me come out of my comfort zone. She's an amazing person that supports and encourages staff to bring their best selves into the workplace."

One year later - reflecting on the teamwork and positive changes from the Oct. 3 fire

- It's hard to believe that a year has passed since a fire broke in the Wing B penthouse initiating concurrent codes Red, Green and Grey. As smoke billowed from the elevator shafts through the hallways, those working that sunny Oct. 3 afternoon faced a daunting challenge.
- You faced the adversity head-on, successfully coordinating an evacuation of staff, patients and visitors with no injuries. You came out on top, with high praise coming from the Fire Marshall. Not only that, you helped spark significant growth and improvement across the hospital. By sharing your feedback, you helped make CMH stronger, safer, and more prepared.
- Some significant changes that occurred over the past year include:

  - Formalizing the Emergency Preparedness role
  - Closer collaboration with Cambridge Fire Department
  - Leader Training for the Incident Command Centre protocols
  - Standardizing all three Incident Command Centre locations in hospital
  - Establishing emergency muster points outside of hospital
  - Enhancing available Mental Health Supports following critical incidents, including Ember's presence
- A heartfelt thank you to everyone for your unrelenting compassion and the role you played in keeping us all safe.

Code Red and Code Green "All Clear!", mock code in ICU a success

- On October 28, ICU was evacuated in 9 minutes 41 seconds; approximately 13 patients were evacuated beyond the Fire Separation Doors into the adjacent zone. Staff worked well together and effectively demonstrated roles and responsibilities for evacuation.
- When the code was called, the word "mock" was not used to ensure consistent response to an emergency situation. However, these "mock" exercises provide opportunity and insight as to how one would respond to an emergency.
- A big shout out to all the volunteers and staff that made the drill a success.

Transforming Patient Experiences one solution at a time

- In January 2023, the hospital introduced Voyce – a platform that would address language barriers in crucial moments at the point of patient-staff interaction and the bedside. Loved ones were often relied upon as interpreters, creating a dependency that put them at risk of misunderstandings in the care required. A new approach to health care at the most basic points of entry to the hospital were desperately needed.
- Voyce is that solution. Designed to connect patients with medically trained interpreters, it breaks down language barriers at crucial moments. By offering access to over 240 languages and dialects, it empowers patients to make informed healthcare decisions in their preferred language. As a tool for advancing health equity, Voyce reflects CMH's commitment to providing accessible, inclusive care.
- To truly understand the impact of this device, meet Para who recorded a video that can be accessed on CMH's YouTube channel. Her story highlights the challenges experienced accessing American Sign Language (ASL) interpretation at the hospital. The Patient Experience Team introduced her to CMH's virtual interpretation solution and worked with her to improve awareness and access to this service.

Voices of CMH: "I am Canadian" - Liberdo Gallego celebrates citizenship

- Clerical Associate Libardo Gallego has a passion for feeding others. He began his career as a dietitian more than 20 years ago in his home country of Venezuela.
- In September, after moving to Canada just over eight years ago, he received his Canadian Citizenship. "I came to Canada when the political issues in Venezuela started to get worse," he shared, describing how he had a desire to protect his family. So, began his journey, traveling with his (at the time) pregnant wife and young children, to start a new life filled with opportunities.
- Opportunities, he found. Libardo has been at CMH for about 2.5 years, finding his passion with the feeding of others growing.
- In his role, he manages tally and production sheets, and patient list notes; he also supports staff scheduling, reports to the supervisor, and tracks the diet change reporting for when patients change rooms.

- Put simply, he coordinates those 3,100 meals per week across the hospital!
- That passion is as strong today as it was when he began, saying: “I love that we are helping each other; patients and colleagues. I’m happy to help people who need a hand.” He speaks fondly of the team he has found here and the joy and safety his work and being in Canada brings him and his family.

Voices of CMH – Shaini Abraham: Understanding Onam

- Shaini Abraham is a Registered Nurse and is also part of CMH’s Diversity Council. She shares her story about Oman, which was observed on September 6, 2024. The following is an abridged version of her story; Onam, a festival of joy and tradition.
- Onam is the biggest and most significant festival of Kerala, a state in the Southern part of India. It is a harvest festival that is celebrated with much enthusiasm and joy, marking the homecoming of the legendary King Mahabali. According to tradition, King Mahabali’s reign was considered a golden era, and Onam is celebrated to honour the memory of this just and generous ruler.
- The festival spans 10 days, starting with Atham and culminating on Thiruvonam, the most important day. It is a time when people come together to celebrate the bountiful harvest, reflect on the values of unity and equality, and indulge in cultural festivities.
- Some of the most beautiful traditions of Onam include Pooklam, which are intricate carpets with floral designs. These are made using a variety of colourful flowers, and each day of the festival, a new layer is added, making the Pookalam larger and more elaborate.
- Onam Sadhya is a grand vegetarian feast that is an integral part of the Onam festival, celebrated with great joy and enthusiasm, especially in Kerala, India. This traditional meal is a colourful and delightful spread served on a fresh banana leaf, showcasing the rich culinary heritage of Kerala.
- It is more than just a festival; it’s a celebration of the values that bind us together as a community—love, equality, and togetherness. It’s a time when families and friends come together, share meals, exchange gifts, and create memories that last a lifetime. The festival is a reminder of the importance of living in harmony with one another and with nature.
- For those of us who grew up with these traditions, Onam brings a sense of nostalgia and a connection to our roots. It’s a time to pause, reflect, and appreciate the richness of our cultural heritage.
- Even though we may not be celebrating Onam here at CMH, I wanted to share this festival's significance with all of you. Understanding and appreciating each other’s cultures brings us closer as a team and enriches our shared experiences.
- Wishing everyone a season of happiness, prosperity, and peace. If you have any questions about Onam or would like to know more, feel free to ask—I’m always happy to share! Happy Onam to all!

Voices of CMH: October is Islamic History Month

- This year’s theme is Health and Healing. We appreciate and reflect on the generous support of Islamic community organizations that supported the hospital through CMH Foundation, and access resources and a little bit of history on Muslims in Canada.
- Throughout October, we had the opportunity to hear from the three of the CMH Regional Liver Health Clinic’s clinicians on video with their approach to patient care.
    - **Dr. Salman Aziz** joined the Toronto Centre for Liver Disease after completing medical school where he found his passion in the Gastroenterology Clinical

Fellowship. In Dr. Aziz's video profile, he describes his faith as approaching care holistically and treating the whole person instead of just the disease.

- **Sadia Mian** (she/her), a second-generation Canadian Muslim woman and Registered Dietitian (RD) at CMH's Regional Liver Health Centre. Sadia describes how she uses her faith for challenging situations, one is her use of reflection daily as a means to grow as a person and the second is gratitude and finding that one thing you can be grateful for when challenged.
- **Dr. M. Omair Sarfaraz**, CMH's lead Hepatologist was drawn to the community-focused clinic that was being offered at CMH's Regional Liver Health Centre. Today, it supports as many as 10,000 patients with liver disease and is a full-circle support system on their liver care journey. Listen to Dr. Sarfaraz speak about his values as a Muslim and how he approaches patient care by being honest with patients and providing hope when he is able.

Employee Engagement Council quarterly meeting highlights

- Employee Engagement Council (EEC) met during Healthy Workplace Month (October) to share key updates on initiatives across the hospital.
- This exceptional group is made up of 27 members that represent staff, physicians, union leadership and management across the organization. Their duties are nothing short of extraordinary as they team up to bring forward questions, ideas, and more on behalf of their teams.
- EEC meets quarterly to plan solutions to concerns and build upon CMH's 2022-2027 Strategic Plan. New this year was a 'What's On Your Mind?' segment to address questions and concerns that were used to inform the Town Hall on October 23, 2024
- Other topics included updates and feedback on incredible initiatives happening across the hospital, including:
  - Project Quantum
  - Career Achievement Refresh
  - Wing B Tower Updates
  - Environmental Sustainability Plan
  - Global Workforce Survey (Accreditation Canada)

Teamwork in Action: Updates from the Best Practice Committee

- On October 31, the Best Practice Committee held a productive meeting, bringing together staff from all areas of CMH to collaborate on important quality improvement projects.
- The working groups focused on key topics including social determinants of health (specifically, 2SLGBTQIA+), palliative care, wound care, malnutrition and diabetes, transitions in care, and medication safety—proven best practices aimed at enhancing patient care.
- The meeting was lively and well-attended, showcasing the organization's strong commitment to teamwork and quality care. Members from both the Nursing Advisory Council and the Professional Advisory Council contributed their insights, ensuring all voices are heard.
- The Best Practice Committee comprises dedicated champions who are excited to do just that - ensure high-quality and safe care at CMH.
  - *What does the Best Practice Committee do?*

        - The Best Practice Committee offers dedicated time for CMH staff and clinicians to come together to work on specific best practices that can be implemented across the hospital.
        - This is a collaborative effort includes membership from both the Nursing Advisory Council and the Professional Advisory Council, ensuring representation across clinical areas and professions.
    - *What are Best Practices?*
        - Best practices as related to healthcare refers to the strategies, approaches, or activities that have been proven through evidence and/or experience to be effective, safe and reliable. They can cover a wide range of topics that impact how teams' function together in the best interest of patients, visitors, and fellow colleagues.
        - The end result is to enhance the patient experience! Past examples include hand hygiene and using a surgical safety checklist. They have practical implications that contribute to the quality and safety of patient care. The new Best Practice Committee is comprised of dedicated champions who are excited to do just that - ensure high-quality and safe care at CMH.

Masking guidelines in clinical areas changed Oct. 21

- On Monday October 21, CMH changed the masking requirements in clinical areas. All team members, including volunteers must wear a hospital-issued mask when in direct contact with patients, when entering a patient room or when a two-metre distance cannot be maintained.
- This practice is in line with regional hospitals and hospital partners in OH West. The reason is that there has been a detectable increase in COVID-19 activity to varying degrees across the province, especially in recent weeks, including locally and at our hospital.
- When working or volunteering in a unit that is not in outbreak:
    - Masking is required for anyone during all direct inpatient and outpatient encounters, when entering a patient room and when two metres of distancing cannot be maintained.
    - In all circumstances staff are required to do their Point of Care Risk Assessment to determine whether additional PPE may be required (e.g., eye protection).
    - Masks are not required in non-clinical spaces (e.g., nursing stations, hallways, offices, meeting rooms) but continue to be available for anyone who prefers to wear one.
    - Encourage patients & Visitors to wear a mask in clinical areas, especially by the bed side. Likewise, and in the spirit of our mask-friendly policy, should a patient, visitor, or team member with whom you are interacting asks you to wear a mask, please put on a mask.
- When working in a unit that is in active outbreak
    - Universal masking is required on the unit except for breakrooms.
    - Maintain your distance in breakrooms and if needed, please utilize other breakrooms to help create space while eating and drinking unmasked.
    - We remind you that eating must occur only in designated areas (e.g., not at the bedside or nursing stations). Care Partner visits on these units are suspended, except in exceptional circumstances.

Orange shirt day!

- Many thanks to all that wore orange to commemorate Orange Shirt Day on Sept. 30, 2024. This day honoured Indigenous children, families, survivors, First Nations, Inuit and Métis communities who had their lives forever changed by the Residential School system across Canada.
- CMH was honoured to have learned so much from Indigenous partners in recent years.
- These opportunities to learn continue to reaffirm the hospital's commitment to ensure First Nations, Inuit, Métis and Indigenous Peoples all feel they can receive culturally safe care where identities are respected. It is CMH's privilege to have so many dedicated to showing their support across the hospital.

CAMBRIDGE MEMORIAL HOSPITAL

MEMORANDUM

TO: Patrick Gaskin

DATE: November 12, 2024

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

FROM: Dr. Anjali Sharma, Chief of Psychiatry
Donna Didimos, Director Emergency & Mental Health Programs

RE: Certificate of Compliance - Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding

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We 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 we have determined necessary for the purpose of this certificate.

In our capacity as leaders of the Mental Health program at CMH, and for the reporting period identified above, we hereby attest that to the best of our knowledge (except as set out below):

1. Psychiatric Sessional Funding has been allocated as per the Ministry of Health guidelines;
2. The Psychiatric Sessional Funding has been allocated as per the hospital process;
3. The sessional funding allocation for 2024-25 was shared with all physicians for information.

Exceptions: NIL

Anjali Sharma, MD
Chief of Psychiatry

Donna Didimos
Director, Emergency & Mental Health Programs

BRIEFING NOTE

Date: November 27, 2024
Issue: Environmental Sustainability Plan Approval
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Rob Howe, Director, Corporate Services & CIO
Approved by: Trevor Clark, VP Finance and Corporate Services / CFO

Attachments/Related Documents:
Appendix A: 2024-27 Environmental Sustainability Plan

Alignment with 2024-25 CMH Priorities:

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

Recommendation/Motion

Board Motion
Following review and discussion of the information provided, the Board of Directors approves the FY 2024-27 Environmental Sustainability Plan as presented.

Resources Committee Motion
Following review and discussion of the information provided, the Resources Committee of the Board recommends that the Board of Directors approves the FY 2024-27 Environmental Sustainability Plan as presented. **CARRIED.**

Executive Summary

Cambridge Memorial Hospital (CMH) has developed an Environmental Sustainability Plan (ESP) with feedback from staff, medical professionals, leadership, patients, and Resources committee members.

Background

In 2023, resources in the strategy portfolio summarized why sustainability is important to CMH and began to capture work done within CMH and sustainability resources. These documents formed the foundational materials for the Environmental Sustainability Committee (ESC), which kicked off in February 2024 with a cross functional group of leaders whose goal was to deliver on a Board approved plan by December 31, 2024.

Analysis

Internal Stakeholder Feedback

Positive feedback has been received on the plan from a large number of groups and individuals including:

- A call-out to all staff & medical professionals via internal survey
- Resources Committee of the Board
- Senior Management Committee
- Medical Advisory Committee (MAC)
- Nursing Advisory Council (NAC)
- Professional Advisory Council (PAC)
- Medical Professional Staff Association (MPSA)
- Operations Group (hospital management)
- Infection Prevention and Control department (IPAC)
- Patient and Family Advisory Council (PFAC)
- Employee Engagement Council (EE)
- Indigenous Council

The primary feedback received is that the plan is very ambitious with a large number of work plan items and priorities. This creates a general risk of being able to achieve all items, however sustainability has both corporate and department specific actions and the work plan reflects this.

External Stakeholder Engagement

While the plan has not been shared with external partners, there has been learnings from external events and partners who support this work, including:

- Choosing Wisely (both laboratory and pharmacy focusing).
- Greening Healthcare Coalition Annual Summit.
- Sustainability in the Perioperative Program Conference.
- Third party waste audits within CMH.
- De-carbonization study conducted for CMH.

Consultation

For all internal stakeholder groups noted above questions specific to those individuals or committees were formulated, similar to the initial review of the ESP with the Resources Committee on September 24, 2024.

Next Steps

1. Approval by the Board of Directors.
2. Communication and posting of the plan internally in January 2025.
3. Continued delivery of the ESC work plan through the internal ESC.
4. Semi-annual updates to Resources Committee in November and May on the progress made implementing plan.

2024-27

Environmental Sustainability Plan

Cambridge Memorial Hospital

Plan Owner: Rob Howe, Director of Corporate Services & CIO

Approval Date: December 2024

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3-Year Success Goal

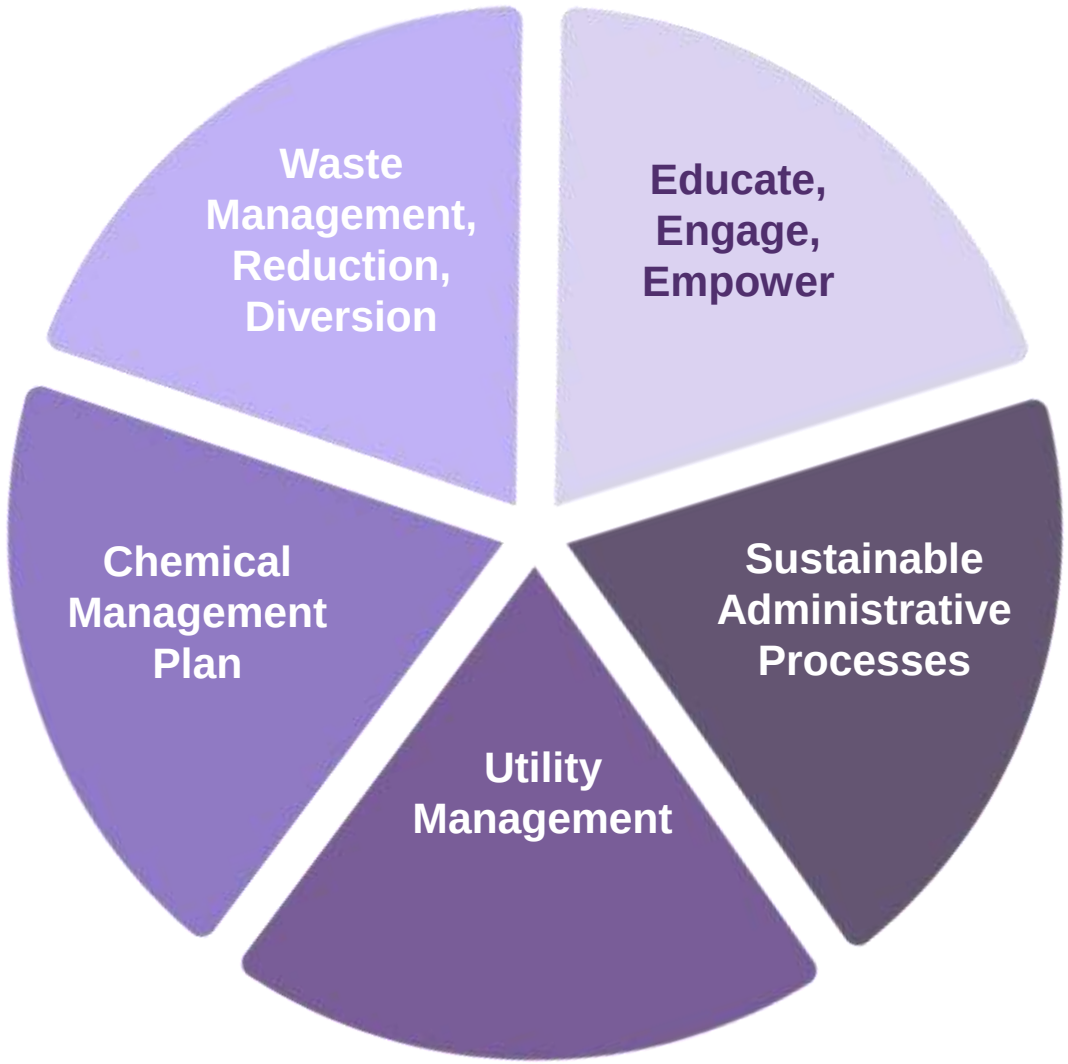
By fiscal year end 2027/28 achievement of:

1. 16% reduction in electricity consumption
2. 19% reduction in natural gas consumption
3. 19% reduction in GHG emissions

**this commitment is also made in our Energy Conservation and Demand Management (ECDM) plan*

See Appendix D for Strategic Alignment

Priority Themes and Focus Areas



#1 Waste Management, Reduction, Diversion

1. Hazardous Materials (benchmark and reduce hazardous waste creation)
2. Pharmaceutical Waste (reduce Desflurane use, support Choosing Wisely)
3. Recycling and Diversion (implement PVC recycling, reducing waste contamination)
4. Waste Reduction (reduce bottled water, paper, and furniture waste)

#2 Educate, Engage, Empower

1. Education & Training (acknowledge key days, support education efforts both internally and externally)
2. Community Engagement (build community partnerships, engage Patient and Family Advisory Council)
3. Staff / Provider Led Projects (engage and support ideas through funding and resources)

#3 Sustainable Administrative Processes

1. Procurement (sustainable supply chains, reduce waste, work with vendors)
2. Funding / Investment (exploring external funding sources, building sustainability into hospital budgeting process)
3. Project Management (build sustainability into project scoping)
4. Governance (formalizing accountabilities, standardizing reporting)

#4 Utility Management

1. Facilities Management (understanding real-time performance of the building and looking at the facility as a whole)
2. Utilities Management (strong tie to Energy Conservation & Demand Management plan)

#5 Chemical Management Plan

1. Cleaning and Infection Prevention and Control (evaluating chemical usage)
2. Facilities Management (reducing chemicals used in facility management)

#1 Waste Management, Reduction, Diversion

Priority Theme #1: Waste Management, Reduction, Diversion

Why does this matter?

1. Hospitals produce a significant amount of waste from different sources including general, biomedical and food, in addition to other sources.
2. Sustainable waste management has many benefits including conserving resources and reducing landfill demand, gas emissions, and waste management costs.

Key Objectives

Objectives were established under the following categories: **Hazardous Materials**; **Pharmaceutical Waste**; **Recycling and Diversion**; **Waste Reduction**

1. Conduct a hazardous waste audit to benchmark diversion and contamination rates for 2024/25. Create an action plan based on the audit for future years.
2. Monitor hazardous waste streams to ensure proper disposal, linking to staff education events for awareness. Review opportunities to reduce hazardous waste based on monitoring results.
3. Reduce Desflurane use by 50% in FY 2024/25 with a goal of 100% removal by FY 2025/26.
4. Investigate opportunities to support deprescribing efforts through Choosing Wisely recommendations.
5. Benchmark CMH waste diversion and contamination rates to inform future efforts.
6. Investigate and onboard PVC recycling program.
7. Reduce the use of bottled water at CMH by 50%.
8. Conduct department audits of paper usage and investigate how to reduce paper through enhanced electronically available information.
9. Reduce waste for furniture and other minor equipment and fixtures through garage sale type activities.

See Appendix E for additional information.

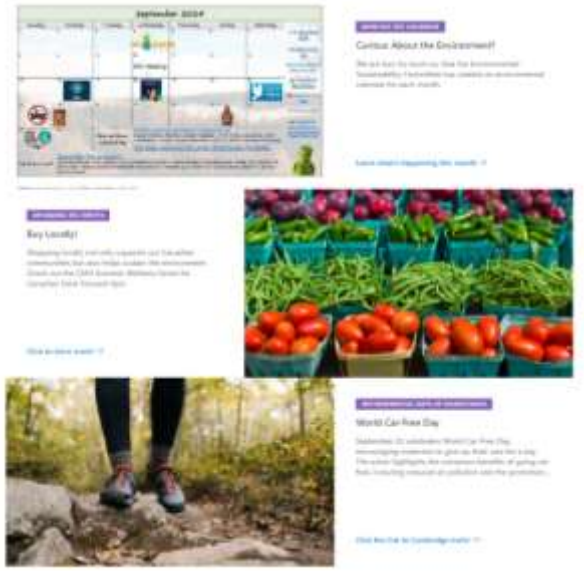
Agenda

#2 Educate, Engage, Empower

Priority Theme #2: Educate, Engage, Empower

Why does this matter?

1. By offering valuable insights and implementing environmentally friendly initiatives, we aim to build collaborative partnerships within our community fostering trust and credibility.
2. Promote sustainability efforts to empower and motivate our staff and community, making them feel capable and inspired.
3. Different members of CMH and the community have different perspectives which can inform our efforts.



Key Objectives

Objectives were established under the following categories: **Education & Training**; **Community Engagement**; **Staff / Provider Led Projects**

1. Acknowledge all significant environmental days by informing staff about their importance and how CMH is supporting these efforts.
2. Commit to two environmental-themed lunch and learn sessions per fiscal year.
3. Promote an environmental conference for Environmental Sustainability Committee (ESC) members to attend.
4. Build community partnerships to enhance education and engagement.
5. Work with the CMH Communications Team to provide monthly social media updates, highlighting CMH sustainability initiatives and local actions.
6. Collect sustainability suggestions from PFAC regarding patients and visitors.
7. Create a process to gather and theme staff and provider ideas to inform sustainability projects.
8. Investigate a green-themed innovation fund to support these ideas.

See Appendix E for additional information.

#3 Sustainable Administrative Processes

Priority Theme #3: Sustainable Administrative Processes

Why does this matter?

1. Governance processes and leadership who care about sustainability can create a culture and align resources to supporting green efforts.
2. Administrative processes can create a positive benefit across the organization impacting all departments.
3. Individuals and departments can make progressive impacts within their areas, but to make systemic improvements we need to build sustainability into key processes.

Key Objectives

Objectives were established under the following categories: **Procurement**; **Funding / Investment**; **Project Management**; **Governance**

1. Minimize supplier packaging during transportation, receiving, and internal delivery.
2. Develop processes to donate or repurpose expired and sample products to prevent waste.
3. Update contract templates to include sustainability criteria for vendor selection.
4. Collaborate with departments to adopt sustainable consumables, such as biodegradable gloves, and increase the use of value-added sustainability options in contracts.
5. Explore and apply for grants through sustainability coalitions and external committees.
6. Establish a budget for the Environmental Sustainability Committee (ESC) for targeted investments.
7. Incorporate sustainability investments into capital projects.
8. Build sustainability considerations into scope of projects for corporate, IT, and capital projects, including appropriate disposal of old equipment and scoping of environmental options during charter phase.
9. Establish a regular cadence and accountability measures for managing the Environmental Sustainability Plan.
10. Develop an environmental sustainability scorecard to ensure transparency and to track the impact of initiatives.

See Appendix E for additional information.

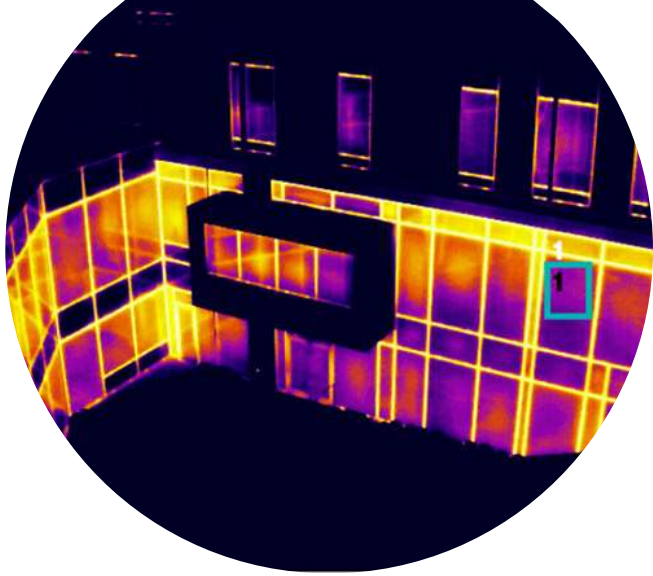
Agenda

#4 Utility Management

Priority Theme #4: Utility Management

Why does this matter?

1. Canada's healthcare system contributes to 4.6% of the country's total green house gas emissions.
2. Two thirds of newly built hospitals do not achieve energy and emissions targets that they were modelled upon.
3. Building systems' operations, maintenance, and controls are a key success factor in energy reductions.



Key Objectives

Objectives were established under the following categories: **Facilities Management**; **Utilities Management**

1. Investigate solutions to provide insight into CMH's real time performance.
2. Promote initiatives to reduce greenhouse gas emissions and electricity usage in alignment with the ECDM (Energy Conservation & Demand Management Plan).

See Appendix E for additional information.

#5 Chemical Management Plan

Priority Theme #5: Chemical Management Plan

Why does this matter?

1. If chemicals are not properly used, stored, or handled, they can lead to environmental damage.
2. Maintaining a chemical safety program will minimize health and safety risks, lessen environmental impact, and reduce operational costs.
3. Overuse of chemicals can highlight areas of operational inefficiency which negatively impacts energy and utility usage.

Key Objectives

Objectives were established under the following categories: **Cleaning / IPAC**; **Facilities Management**

1. Evaluate current chemical usage and identify opportunities to transition to less hazardous or more sustainable alternatives.
2. Optimize boiler and cooling systems and implement a preventative maintenance plan to reduce chemical water treatment.
3. Review winter salting methods and explore sustainable alternatives.

See Appendix E for additional information.

Appendix

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Appendix A: Environmental Sustainability Committee (ESC) and Plan Consultation

The ESC is a cross functional group of CMH leaders intended to provide the coordination that will develop and deliver on the Environmental Sustainability Plan and integrate environment / sustainability principles into CMH's decision-making.

Executive Sponsor:
Trevor C. (Admin)

Committee Chair:
Rob H. (Corporate Services)











Environmental Sustainability Plan Consultation

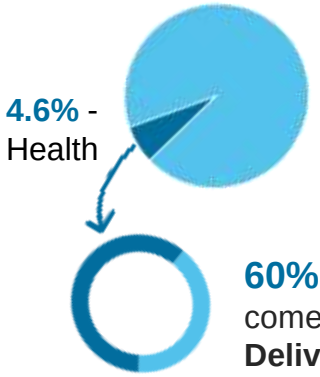
Although the work was led by the ESC, internal input has been gathered through:

- All staff & medical professional surveys
- CMH Senior Leadership Committee
- Directors' Council & Operations
- Employee Engagement Council
- Medical Professional Staff Association (MPSA) & Medical Advisory Committee (MAC)
- Nursing and Professional Advisory Committees (NAC & PAC)
- Patient and Family Advisory Committee (PFAC)
- Resources Committee of the Board
- Targeted department discussions

Appendix B: Health System Impacts on Climate Change

Climate change is impacting the health of populations, health systems, and the ecology of the planet and health care is a major contributor to the Green House Gas emissions which are causing climate change.

2019 National Greenhouse Gas Emissions by Sector (CMA, 2023)



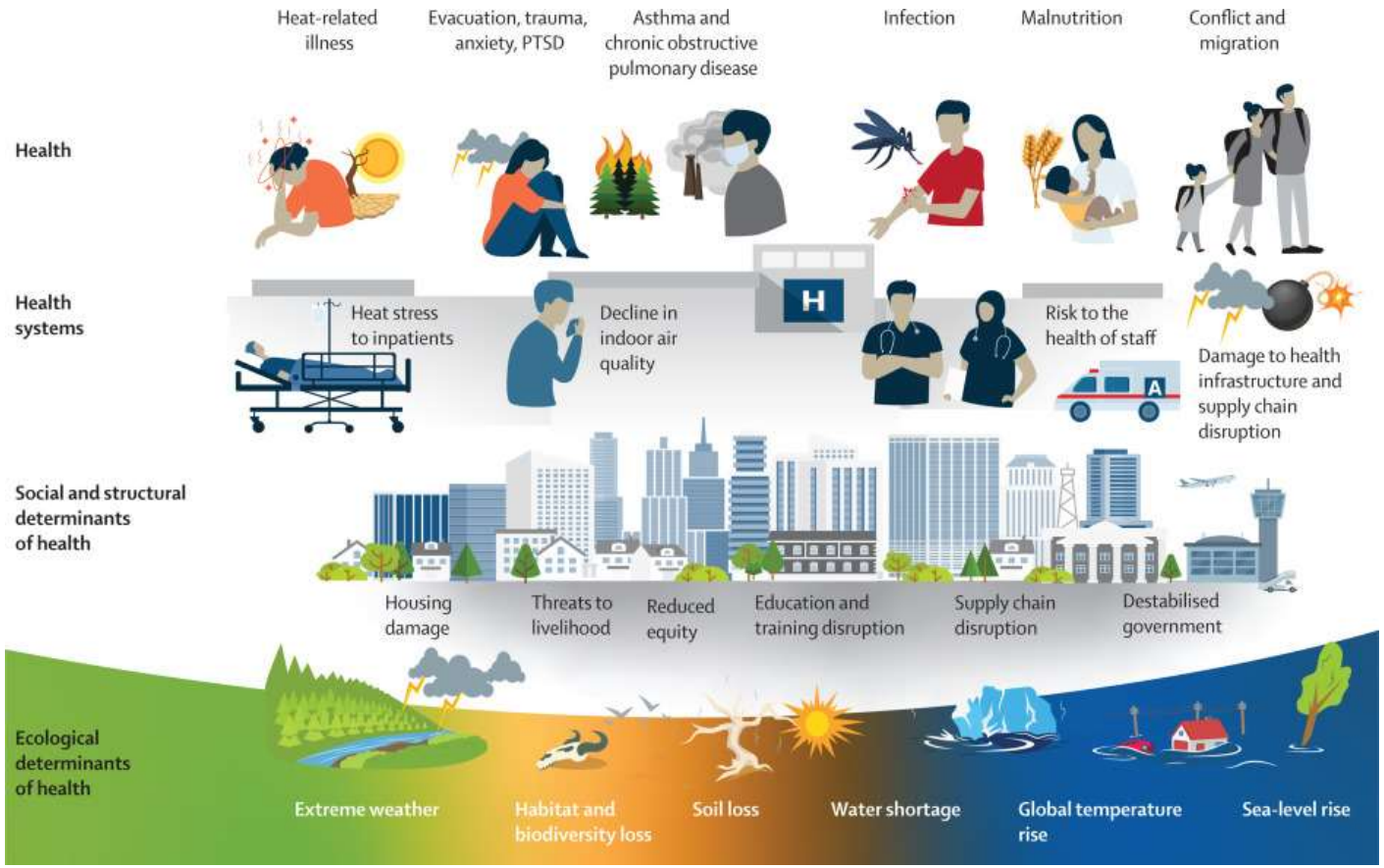
95.4% - Other

4.6% - Health

60% comes from **Care Delivery**

Canada's health care system alone accounts for nearly 5% of the country's total greenhouse gas emissions.

Climate Change Related Impacts to Health and Health Systems



Howard C, et al. Learning to treat the climate emergency together: social tipping interventions by the community. Lancet Planetary Health, March 2023. https://doi.org/10.1016/S2542-5196

Appendix C: Why Does CMH Need an Environmental Sustainability Plan?

Benefits of Environmental Sustainability in Retention and Recruitment:

- Creating an Environmental Sustainability Plan also contributes to the **retention and recruitment of staff and medical professionals**
- An organization with a strong commitment to environmental sustainability can help **individuals connect their work to a sense of purpose** (i.e., climate advocacy)

75%

of Canadians worry about climate change and its impacts

81%

of Canadians ages 18 to 34 are the most likely to be concerned about climate change

Source: Unite for Change (April 17, 2023)

nearly 60%

Of Canadian workers want to work for a company that is environmentally friendly and prioritizes green initiatives

Source: Citrix Canada (November 6, 2019)

Benefits of environmental sustainability in care delivery:

- Saving lives and preventing harm from climate change to **improve patient and community health outcomes**.
- **Long-term mitigation** of global climate change.
- **Environmental and financial benefits** as a result of improving energy efficiency and optimizing procurement and waste management.

New Requirement for Environmental Stewardship:

- **Accreditation Governance Standard:** ACCREDITATION CANADA

  The governing body ensures that the organization promotes environmental stewardship in its operations.

- **Canada's Commitment to an Environmentally Sustainable, Low Carbon, Climate Resilient Health System at COP 26**

  The goal is to mitigate and drive down emissions, enhance climate adaptation and resilience by protecting people and nature, mobilize international climate finance, and increase global cooperation.

Referenced: Canadian Medical Association. (2023). *Why Canada needs a net-zero health system*. Canadian Medical Association. https://www.cma.ca/why-canada-needs-net-zero-health-system
Canadian Coalition of Health Leaders. (2023). Leading climate resilient and low carbon, sustainable health systems - CCLS. https://cchl-ccls.ca/app/uploads/2022/12/3.-Leading-climate-resilient-and-low-carbon-sustainable-health-systems.pdf
Government of Canada. (2022, December 14). *UN conference on climate change: COP26 in Glasgow*. Canada.ca. https://www.canada.ca/en/services/environment/weather/climatechange/canada-international-action/un-climate-change-conference/cop26-summit.html

Appendix D: Strategic Plan Alignment

Vision

Creating healthier communities, together.

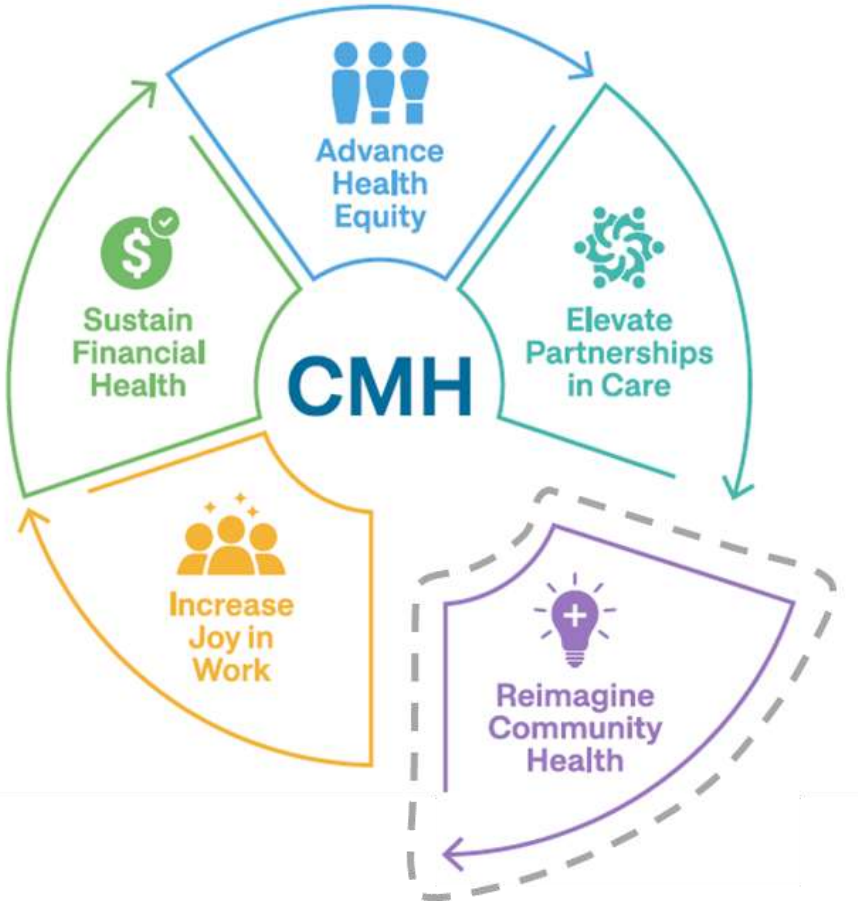
Mission

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

Values

Caring
Collaboration
Accountability
Innovation
Respect

Strategic Pillars



- The Environmental Sustainability Plan sits under the Reimagine Community Health pillar – however, it has impact across all hospital operations and contributes to the overall health of our community
- Other corporate plans under this strategic pillar include the Digital Health Plan, Ontario Health Team Plan, Innovation Plan, Operational Excellence Plan
- Through our Educate, Engage, and Empower priority we will look for strong connections with the Increase Joy in Work, and the Sustainable Administrative Processes will have strong links to Sustain Financial Health

Appendix E: External Resources

General

*Canadian Association of Physicians for the Environment : Provides education modules, press conferences, background documents, letters, briefing notes, and toolkits among other resources by issue area physicians to be advocates for healthier environment

Smart Hospitals Toolkit : An international resource that provides assessment tools, green checklists, training aids, lessons learned for part green initiatives and cost benefit analysis.

GHG + H20: Provides organizations with an action checklist, educational materials, awareness tools and technical resources. Provides recommendations and in depts information from leading healthcare organizations.

*Partnerships for Environmental Action by Clinicians and Communities for Hospitals (PEACH): Provides roadmap for sustainability, a hub to share information, resources and collaborate on projects.

*CASCADES: Provides education, tools, resources for implementation by area of opportunity as well as information and collaboration opportunities to support environmental stewardship.

*Community of Practice : Has initiatives relating to primary care, sustainable ORs, equity, organizational readiness, and sustainable procurement.

*The Canadian Coalition for Green Health Care: Platform for sharing ideas, resources, and support for building sustainable health service (purchasing, wellness, foods, chemical policies, building, transportation, and waste management).

Organizational Readiness Playbook - CASCADES Canada :Provides background information and implementation resources to address environmental sustainability in organizational readiness. Provides ideas, examples, and resource to help identify opportunities to make a difference.

Appendix E: External Resources

Procurement

GreenProcurement-PolicyandProcedureManual-DRAFT.pdf (greenhealthcare.ca): guide to implement policies and procedures for more sustainable, less toxic, and healthier procurement choices. Provides background and green procurement consideration.

Toolkit | Sustainability Advantage: Templates and tools that enable the integration of sustainable procurement elements.

Medline Programs : *Centurion*: sustainable option to recover premium surgical instruments. *ReNewal* medical device reprocessing. *Tote exchange program* as a packaging alternative.

*Honeywell: Works to develop innovative solutions to help healthcare organizations optimize processes and keep buildings and clinicians safe.

Facilities & EVS

Green Hospital Scorecard: benchmarking tool that measures energy conservation, water conservation, waste management and recycling, as well as corporate commitment and pollution prevention.

Pharmacy

CoP Sustainable Inhaler Initiative :Covers suitable prescribing practices for inhalers, alternatives to MDIs, appropriate inhaler techniques, and sustainable recovery and recycling practices.

Provincial Biomedical Waste Program: Guideline that details the Ministry of Environment's expectation for the management of biomedical waste.

Food Services

Coolfood: Helps your organization achieve a science-based target to reduce the climate impact of the food served. Provides a 3-step approach: Pledge, Plan, and promote.

*Nourish Leadership: A non-profit organization that works to see food as a powerful way to build health for both people and the planet.

Appendix E: External Resources

Clinical & OR

Greening the Operating Room: Covers anesthetic equipment choices, impacts of inhaled anesthetics, managing fresh gas flow, use of anesthetics and other pharmaceuticals, and waste stream management.
*Ontario's Anesthesiologists: New environmental sustainability working group that promote anesthetic practices to minimize effect on the environment.
*Ontario Surgical Quality Improvement Network**:** *Cut the Carbon Campaign*- Reducing Surgical Waste. Provides action steps on how to get started.

Wellness & Wellbeing

Travel Wise <internal CMHnet access only> : Program from Region of Waterloo that provides local sustainable transportation options

CRP

*Canada Green Building Council: Organization that provides products and services to the building sector to construct and manage more cost-effective and healthier buildings. They influence standards and award the Leadership in Energy and Environmental Design (LEED) certification to organizations.

Administration

Green Office Toolkit for Clinicians and Office Managers: Toolkit with practical and affordable ideas to make eco-friendly office improvements.

IPAC

Provincial Infectious Diseases Advisory Committee : Provides best practices and recommendations for environmental cleaning for prevention and control of infections in a healthcare setting.

Appendix F: Roadmap & Key Milestones

FY24-25				FY25-26				FY26-27				FY27-28			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Detailed work plan is available but not provided in this package

Board Chair's Report – October/November 2024

Message From the Chair

As the holiday season approaches, I reflect on the past year with gratitude for your dedication & commitment to CMH – and for keeping people at the heart of everything we do.

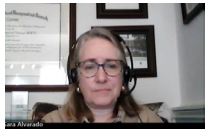
The holiday is a time for joy and celebration. It is also a time to cherish moments spent with family & friends and to rest and rejuvenate for the year to come! I wish you and your families a wonderful holiday season filled with peace, joy, and happiness.

Looking to the new year, I am excited for what 2025 will bring. Our collective efforts have set a strong foundation for continued success. Focusing on our values of caring, collaboration, accountability, innovation & respect, we will continue to create healthier communities, together!

Board Chair's Report – October 2024

Grand Rounds – Choosing Wisely

On October 24, the Choosing Wisely Canada & CMH Choosing Wisely in Action grand rounds took place, offering a very informative session. The presentation delivered a comprehensive overview of the program both nationally and at CMH, detailing various opportunities, strategies, and learnings, as well as the CMH journey CMH. The session was presented by Dr. Wendy Levinson and the CMH Choosing Wisely Team. Special thanks to the Board Members, including Lynn Woeller, Diane Wilkinson, Jay Tulsani, Bill Conway, Miles Lauzon, Tom Dean and Sara Alvarado, who attended the presentation.


CPSO QI Partnership

On October 24, Lynn Woeller joined the fourth session of the CPSO QI Partnership Program. Attendees were captivated by the insightful presentation on Digital Health. The session was presented by Rob Howe, Jennifer Backler, and Dr. Ryeyan Taseen, who delved into the current and future state of digital health at CMH. The presentation highlighted Project Quantum, a significant step towards enhancing patient care and operational efficiency. Additionally, various IT initiatives were discussed, emphasizing the crucial role of medical/professional staff in driving these advancements forward.

Drum Circle


On November 7, Tom Dean, Lynn Woeller, Paulo Brasil, Bill Conway and Miles Lauzon joined CMH and Scott Stevens, a local Indigenous drummer to share in a Drum Circle.

For Indigenous People, drums are more than communication tools and musical instruments; they are tools for a lifelong connection to and relationship with all living things and the Creator. A drum represents Mother Earth and her universal heartbeat. It facilitates the ability to “listen to our soul so we can understand our purpose and our connection to each other in the Circle of Life”. Drumming replicates, the first heartbeat we hear when we are in our mother’s wombs. Many drum teachings use the circle to represent balance and equality, wholeness and connection.

Drumming is certainly an integral part of Indigenous culture, tradition and teachings. It continues to be a part of the daily life of Indigenous peoples, reminding them that, the drum is a constant reminder of our responsibility to the preservation and health of Mother Earth.

Board Chair's Report –November 2024

Celebration of Champions – CMHF Event
On November 7, the CMH Foundation celebrated with donors and community supporters at the Oriental Sports Club at the Celebration of Champions event. Together, we heard some hospital updates from CMH CEO Patrick Gaskin and CMHF Executive Director Lisa Short. The highlight of the evening was Dr. Donna Kolyn's presentation on the “Ripple Effect”. We thank her for sharing her experience at CMH as both a General Surgeon and member of our community. She highlighted the importance of the best equipment for our physicians and how these tools make a real difference to our patients and healthcare providers. This event is the Foundation’s opportunity to bring together donors and the many diverse community groups who supported our Hospital in 2023 and share the impact of their generosity. Attending from the CMH Board were Sara Alvarado, Miles Lauzon, Bill Conway and Lynn Woeller.







Rainbow Health Course
Congratulations to Lynn Woeller, Diane Wilkinson, and Bill Conway for participating in and completing the Rainbow Health Foundations Course. Additionally, three other Directors have signed up to complete the course. If you would like to participate, please email Stephanie with your interest, and she will assist you in getting set up.

“The Rainbow Health Program provided great insights into the challenges and systemic barriers in health care for the 2SLGBTQ community. The importance of an inclusive environment was stressed. Not only the physical environment but the way in which we register patients, how we engage in conversations to understand their health care needs and the importance of recognizing our own biases and discriminatory judgements.” Diane Wilkinson



San’yas Indigenous Cultural Safety Training Program.
Congratulations to Miles Lauzon, Bill Conway, and Tom Dean on completing the San’yas program! This 10-week program covers a range of important topics, including colonization in Canada, uprooting racism, discrimination, and stereotyping, and their impacts on Indigenous peoples in health care contexts. It also addresses social and structural determinants of health in relation to Indigenous people, gaps in health equity for Indigenous people, and taking action to enhance Indigenous Cultural Safety in health care. Additionally, the program focuses on recognizing areas for organizational change and speaking up and advocating for social justice for Indigenous people.

“An informative, interactive and interesting mini-course that gave me much more perspective on the plight of the Indigenous regarding their health care needs” Tom Dean

Board Chair's Report –November 2024

Cambridge & North Dumfries Community Awards 2024
On November 14, Board members joined CMH and members of the community to recognize the remarkable achievements of the not-for-profits within our area. The CMH Foundation proudly received the award for Organization of the Year under 10 employees, showcasing their dedication and hard work. Additionally, our very own Nicola Melchers was honored with the Board Member of the Year Award, a testament to her exceptional contributions and commitment. On behalf of the Board, I extend heartfelt congratulations to the CMH Foundation and Nicola Melchers for their well-deserved wins!

Association of Fundraising Professionals – National Philanthropy Day Awards
On November 15, Lynn Woeller joined Patrick Gaskin and members of the Foundation Team and CMHF Board at the National Philanthropy Awards to honor the incredible power of philanthropy and the individuals and organizations that drive positive change within the community. National Philanthropy Day is a special day set aside each year to uphold the great contributions of philanthropy and recognize those who are active in the philanthropic community. Angelo Loberto, former CMH and CMHF Board member and Board Chair received the Outstanding Volunteer Award for the Waterloo Region, recognizing over 12 years of volunteer service to CMH and the CMHF.

Board Chair's Report –November 2024

Capital Projects Sub-Committee Bids Farewell
On November 20, 2024 our Capital Projects Sub-Committee celebrated during its final meeting. The Committee was formed in Autumn 2013 with the purpose of reporting to the Resources Committee in assisting with its responsibility for approving and monitoring contracts relating to the expansion or alteration of the physical resources of the Hospital, and planning capital projects. The sub-committee has played in the completion of the three phases of the Capital Redevelopment Project (CRP) construction. Amid some very difficult and challenging times, in collaboration with CMH staff resources, the Sub-Committee persevered and is proud to bring the final phase of construction to Substantial Completion this month. After adjournment of the final meeting, committee members celebrated this major milestone with a toast, construction-themed cupcakes, and lively conversation.

"Last night was the perfect wrap up to the CRP committee.

Achievement of Substantial Completion on November 15th, many months of minimal changes to the financial projections and the very short agenda with no significant decision items supported the decision to disband this committee and transfer ownership of any outstanding items to Resources.

The cupcakes, chocolates (tools!) and glasses were also so thoughtful and such a nice token of appreciation for the Committee members (some of whom joined the committee 10+ years ago and have been incredibly dedicated to the success of the project).

Congratulations to Amanda for your 7 year involvement with this project – and especially, for bringing it home as Director over the past year and calmly facing & managing the challenges that came along.

Thank you to Tom for the great job Chairing this committee and thanks to Trevor, Val & Kristen for your important roles." Lynn Woeller

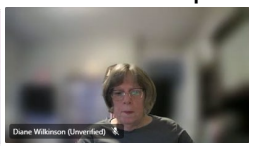
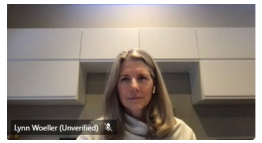
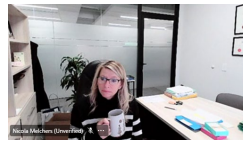
Board Chair's Report – November 2024

CMH Past Chairs Circle
On November 27, 2024 CMH held their first Past Chairs Circle which was an exciting opportunity to bring together past chairs of the Board to discuss and share their experiences. This initiative highlights the strong engagement and commitment of individuals who continue to contribute to the organization even after their tenure as chair has ended. By tapping into this collective brain trust, the organization can benefit from the wealth of knowledge and insights these leaders possess. This gathering not only draws on the experience and leadership within the organization but also leverages the broader community experience, fostering a rich and dynamic conversation.

"All of us around the table have made a significant investment in our hospital in our community over the past number of years. In that light, it was very gratifying to see The current strong Governance and very capable management continuing to provide strong leadership. I hope it was a beneficial to yourself and Lynn. I think I can speak for my fellow past directors that we could see there was a return on our investment. The clear message that I got, and as well known to you that we have to continue to fight on all fronts to ensure that we are not only recognized, but continue to grow in capabilities and services. I think by engaging (Re-engaging) This group can only help.
I am Appreciative of you and Dian for making this happen. Thanks."
John Bell

Grand Rounds – The Clinical Impact of Hospital Flow
On November 28, 2024 the Clinical Impact of Hospital Flow took place. Presented by Dr. Matt Runnalls, Chief of Emergency. The presentation focused on understanding patient flow through a hospital from a specific Ontario lens, appreciation of limitations of different care settings and evidence around the morbidity and mortality impact of poor hospital flow.

Special thanks to the Board Members, including Miles Lauzon, Diane Wilkinson, Lynn Woeller, Nicola Melchers, Bill Conway, Tom Dean, Paulo Brasil who attended the presentation.

PFAC Celebrates 10 Years
On November 28, 2024 Lynn Woller and Nicola Melchers joined CMH's Patient Family Advisory Committee and PFAC alumni at the Blackshop Restaurant in Cambridge to celebrate the Committee's 10th Anniversary – A slide show was presented entitled PFAC Adventure that took members on a short journey from 2014-2024. Happy anniversary PFAC!

BRIEFING NOTE

Date: November 27, 2024
Issue: Selection of Interview Team
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: None

Recommendation/Motion
That the Board appoint the following individuals as the interview team for the 2025-26 Board and committee member recruitment:

Julia Goyal – Interview Team Chair
Nicola Melchers
Margaret McKinnon
Jody Stecho
Bill Conway
Community Member - TBD

Executive Summary
As outlined in Policy 2-D-20 Recruitment, Selection, and Nomination of Directors and Non-Director Committee Members, the Governance Committee annually recommends to the Board the composition and member of a Nominating Subcommittee.

Next Steps
Recruitment for the 2025/26 Board cycle will go live in December. The interview process will begin in March.

BRIEFING NOTE

Date: November 21, 2024
Issue: Quality Committee Report to the Board of Directors, November 20, 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: None

A meeting of the Quality Committee took place on Wednesday, November 20, 2024 at 0700 hours.

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

Committee Matters – For information only

1. **Program Presentation: CRP and Operational Readiness:** The Director of Construction directed the Committee members to the pre-circulated presentation and explained the design of the construction. The following points wer. ighlighted: the design and construction of the CRP utilized a patient centred-approach; emphasis of the project included: prioritizing light in the patient spaces, maximizing light in the long-stay areas, creating flexible gathering spaces as well as the ease and use of furniture; all patient rooms are located on the perimeter of the unit thus maximizing light; support services are in the centre of the corridors; offices are directly on the floor, work is nearly complete for Phase 3; completion of the CRP – January 2025, and a total of 370,000 square feet of new space. The overall design supports organizational flow and removes infection and control barriers by having private rooms. Phase 3 has proved to be the most disruptive to patients, visitors, and staff. There were 43 construction sequences. Patients and visitors have been very accommodating despite all the construction and constant hallway changes. Staff and Volunteers have been key in helping navigate patients and visitors through the hospital. Management continued with the presentation and spoke of the quality priorities and metrics. Management also spoke about the streamlined change request process, which ensures validation of requests, being mindful of costs/budget, scope of project, and completion of work on time. The CRP Team is working closely with the various departments to ensure that we are building and

outfitting a space, which to meet the needs of patients and staff. The Committee members were directed back to the pre-circulated presentation. Transitional Planning, Milestones and Move Schedule was displayed. A high-level overview of each were provided. Program Risks and Mitigation strategies were summarized. Over the extended project timeline, one of the largest constraints were the available construction resources (plumbers, electricians, etc.). Priorities and resources were evaluated. To date, with assistance from Ellis Don, additional resources are sourced, overtime hours and weekend shifts are reviewed, and resources are available and on-site to maintain current schedule. The Planning Manager spoke of the CRP education initiatives. CRP has developed educational material to assist staff with orientation and training in the newly renovated areas. There is ongoing teamwork with the Clinical Educators to roll out this out. A question was posed about the immediate response and reaction of the staff during the Code Red/Green event. The Director of Construction described her experience and lessons learned moving forward. Management has ensured that all facility staff are readily available to answer any answers or assist others should another event occur. The Director acknowledged the collaboration with the clinical management team in ensuring the safety of staff, patients, and visitors. In response to another question, the Director added that Mock codes are scheduled, education and communication are reinforced at Huddles, and monthly checks are set. The Director of Construction emphasized the wonderful collaboration of the clinical teams and those teams who were actively impacted by the construction, as well as how cooperative everyone has been while working in the temporary environments, constant power outages and loss of services. Several other teams that were impacted by noise and such, who do not get a new home in the new build, were also very accommodating and respectful. **See package 2.**

2. **Hospital to Home (H2H) Program**: A detailed update was given. A copy of the pre-circulated presentation was displayed. When presenting the program highlights, A. McCulloch expressed her excitement about H2H: expansion of H2H programs to support standardization of new models in the future state of home care; H2H expansion will align to common program standards and specifications and utilize standard service schedules provided by OH; in September 2024, hospitals received a memo from Chief Regions Officers introducing program expansion. The purpose is two-fold: 1) to relieve hospital of Alternate Level of Care (ALC) pressures and 2) to foster standardization of the H2H programs in alignment with OH's goal to modernize Ontario's health care system. Inclusions were reported: patients registered in ED and/or inpatients who are designated ALC or at risk of being designated ALC, must meet the following requirements; requires at least one professional service and have optimization, restoration, re-activation or rehabilitation care needs; patients must live within Cambridge /North Dumfries and be discharged to their homes (or other treatment location); CMH@Home will not include patients with significant behavioral concerns, ALC to LTC, precariously housed or with significant wounds requiring "vac" dressings; goals and objectives are to reduce avoidable Emergency Department visits, hospital readmissions and ALC days. The Program components steps: 1) Referral and admission, 2) Assessment, 3) Care Planning and Delivery, 4) Transition Management and 5) Monitoring and Follow-up. The Director of Medicine spoke of the Bundles of Care plan which will provide patients with a comprehensive list of services to support their continued recovery while at home. In conjunction with the Service Provider organization (Bayshore), care plans will be developed, and resources will be identified. These may include nursing, Physiotherapy, Occupational Therapy, Speech Language, Dietitian, PSW or Social Work. Bundles are 16-weeks in duration; however, this timeline is variable based on the patient and their recovery. CMH will monitor and follow-up with patients, as well as evaluate their progress. Key Performance Indicators (KPIs) were explained. Management has

recruited a Patient Navigator (role is to identify those patients that could possibly be sent home prior to admission) and finalize the contract with the Service Provider organization. CMH has identified its first CMH patient for the H2H program. The soft launch of the H2H program was November 18, 2024. A formal launch is set for the week of December 9, 2024, with Service Provider, Bayshore, onsite at CMH, attending Huddles and conducting education sessions. CMH plans to enroll about 60-65 patients between now and March 31, 2025, Management has been advised to plan for up to 130 patients in FY 2025/26. One Committee member asked to elaborate on the KPIs, specifically about adverse events and falls. Work is underway with CMH's Risk Management team to link CMH data to Bayshore's Risk department (incorporate data into patient chart, monitor adverse events, etc.). Another member inquired about patients enrolled in existing services provided by the OntarioHealth@Home program. In response, Management stated that the H2H program will run parallel with the OntarioHealth@Home program, and the current services in place with Ontario Health at Home will not be disrupted. The Patient Navigator will be reporting into the Integrated Manager for Ontario Health@Home. Since there was an automatic link with that individual, and a fully integrated model at CMH, those teams will be working closely together. Discussions were had about medical oversight. Management noted that as long as the patient is with CMH, CMH will maintain clinical oversight and sit under an active roster from a physician lens. Review meetings will take place with Bayshore regularly. Another Committee member led a short dialogue about patients who reside in retirement homes and the possible barriers set by the Home. The Director of Medical Programs reported much work has already been done with retirement homes. It was implied that retirements homes will certainly welcome the H2H model and there are no foreseen barriers. **See package 2.**

3. **Integrated Risk Management (IRM) Priorities**: A slide presentation was pre-circulated. Following a comprehensive summary, the floor was opened. No questions were posed. The Privacy & Risk Lead for a thorough in-year update and clearly explaining the IRM process. **See package 2.**
4. **Emergency Preparedness:** Identified as one of the IRM priorities for this fiscal year, investment into the 2-year Emergency Preparedness Lead role commenced in July 2024. A work plan was set to include standardizing internal responses (mock code schedules, debrief templates, renewal of Emergency Preparedness Committee, tracking of all code calls and continuing to build/expand external relationships with community partners). Management conveyed the areas of focus for the next year will include: standardized and numbered Code 'stations' in all areas of the hospital; Incident Management System (IMS) mock code training for leaders; conduct a mock/tabletop Code Silver in partnership with Waterloo Regional Police Services (WRPS); develop a formalized business continuity plan; re-visit offsite patient relocation plan (currently contract in place with St. Benedict's high school); participate in planning efforts with City and Regional partners for large scale community disaster being planned for 2026; and continue cadence of Emergency Preparedness Committee meeting. CMH will be participating in planning efforts with the City of Cambridge and Regional partners for a large-scale community disaster (in 2026). As previous events focused on physical health management, it was requested of Management to add to the Tabletop agenda: managing an emergency response from a mental health perspective. **See package 2.**
5. **Trillium Gift of Life (TGLN) – Organ Donation Update**: A copy of the TGLN report was previously circulated, for information only. **See package 2.**
6. **Quality Monitoring Scorecard**: A copy of the Quality Monitoring Scorecard was previously circulated. Management reported on seven (7) indicators that are currently trending in red: Overtime hours, Sick hours, ALC Throughput, Ambulance Offload Time, Emergency Department Length of Stay for Complex Patients, Emergency Department

Wait time for Initial Assessment (PIA), and Low-Risk Caesarean Sections. One Committee member remarked that the Falls with Harm and Long Waiters Waiting for all Surgical Procedures metrics have improved from previous months (now green). Management was commended for their efforts.

BRIEFING NOTE

Date: November 14, 2024
Issue: October 2024 Financial Statements
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Maria Burzynski, Controller
Approved by: Trevor Clark, VP Finance and Corporate Services, CFO

Attachments / Related Documents: Financial Statements – October 2024

Alignment with 2024/25 CMH Priorities:

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

Recommendation/Motion

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

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

Executive Summary

Cambridge Memorial Hospital (CMH) has a $3.9M year-to-date surplus position at the end of October after building amortization and related capital grants. The major drivers of the surplus are the unused portion of the budgeted contingency ($3.8M), quality based procedures (QBP) ($1.7M), recoveries and other revenue ($1.1M) partially offset by unfavourable variances in salaries & wages and benefits ($2.1M), primarily due to higher overtime than budget.

CMH is forecasting a surplus of $3.6M for 2024-25 driven by unused contingency ($6.3M), Incremental Surgical Recovery Funding ($3M), however offset by ongoing salaries & wages pressures ($6M).

Risks

- Actual overtime costs continue to be much higher than budget ($2.8M YTD October). At the current rate, overtime costs are forecast to be $4.8M higher than budget by the end of the fiscal year. A working group focusing on strategies to reduce the amount of overtime is meeting on a bi-weekly basis. The unfavourable variance in overtime is partially offset by a favourable variance in worked salaries ($3.1M)
- Post construction operating plan (PCOP) volume targets YTD October are favourable to budget creating a $0.6M favourable variance. This was due to higher weighted cases in acute inpatient offset by surgery (physician vacancies and returned surgical blocks), lower occupancy rates in mental health than budgeted for and lower patient volumes in the Emergency Department. The PCOP funding shortfall is forecast to be $0.4M less than budget by the end of the fiscal year.
- $5.4M in funding for Bill 124 has been budgeted in 2024-25. CMH has received a funding letter in October to confirm the full 12 months of Bill 124 funding ($5.8M). Year-to-date $3.2M has been recorded. This funding represents approximately 85% of the total incremental wage costs budgeted.
- Alternate Level of Care (ALC) patients create bed flow pressures and generate low weighted cases putting PCOP volume targets at risk. On average there have been 36 ALC patients in 2024-25 which is comparable to fiscal 2023-24 (34 patients)
- CMH is undergoing system transformations and has included $600K of expenses in the financial statements presented. These costs are made up of compensation, software, and legal costs.

Summary

CMH has a $3.9M year-to-date surplus position at the end of October after building amortization and related capital grants. Actual results are $4.1M favourable to budget. The favourable variance has been driven by:

- $3.1M in other supplies & expenses mainly due to unused budgeted contingency ($3.8M) through the end of October;
- $1.3M in Quality Based Procedures (QBP) revenue due to increased hip, knee, and shoulder;
- $1.1M in recoveries and other revenue mainly comprised of $497K in Cancer Care Ontario (CCO) oncology drugs recovery and $312K in interest income;
- $0.5M in PCOP funding driven by higher acute impatient weighted cases and increase in discharges

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

- $2.1M unfavorable variance in salaries & wages and benefits primarily due to higher overtime than budget;

PCOP & QBP Volumes

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

PCOP

The hospital has budgeted to receive $15.8M in PCOP clinical funding in 2024-25, just over 72% of the available $21.9M PCOP funding allocation. Funding recognition is dependent on meeting volume targets.

The YTD $575K favorable variance is mainly due to higher acute impatient weighted cases offset by lower surgical volumes and weighted cases.

PCOP acute inpatient weighted cases has the biggest funding implication for the hospital. Each weighted case generates $4,517 in funding. There are 152 net weighted cases under budget through October which represents $687K in funding. The surgical department, emergency department and mental health team had lower patient volumes and have not met PCOP targets YTD in October.

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

QBP

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

Cancer Care Ontario (CCO) QBP revenue was $0.4M favorable to budget, due to higher numbers of prostate surgeries and endoscopy procedures and favorable results of $0.2M in reconciliation of 2022-23 fiscal year.

Bundled care and surgical QBP's was $2.6M favourable. Urgent medical QBPs funded through OH was $1.3M unfavorable to budget.

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

PCOP				
Funding Source	**Unit of Measure**	**Budget**	**YTD Achieved # *(coded volumes)***	**YTD Variance from Budget**
Acute IP	Weighted Cases	8,249	4,252	127
Day Surgery/TCC	Weighted Cases	2,983	1,348	(144)
Emergency	Weighted Cases	2,839	1,284	(135)
Mental Health IP	Inpatient Days	7,867	3,783	(150)

QBP				
Funding Source	**Unit of Measure**	**Budget**	**YTD Achieved # *(coded volumes)***	**YTD Variance from Budget**
OH Urgent Medical	**Cases**	**514**	**332**	**75**
OH Bundled Care	**Cases**	**1,062**	**639**	**108**
OH Surgical	**Cases**	**5,202**	**2,175**	**(426)**
CCO	**Cases**	**454**	**267**	**40**

MOH Funding – Base / One-Time / Other
The $505K year to date unfavourable variance is primarily $339K unfavourable variance on MOH one-time for funding driven by $138K claw-back for Human Health Resource (HHR) Preceptor funding and ERAFA $188K unfavourable variance.

Billable Patient Services
The $432K year to date favourable variance is primarily due to a $408K favourable variance for non-resident of Canada billing.

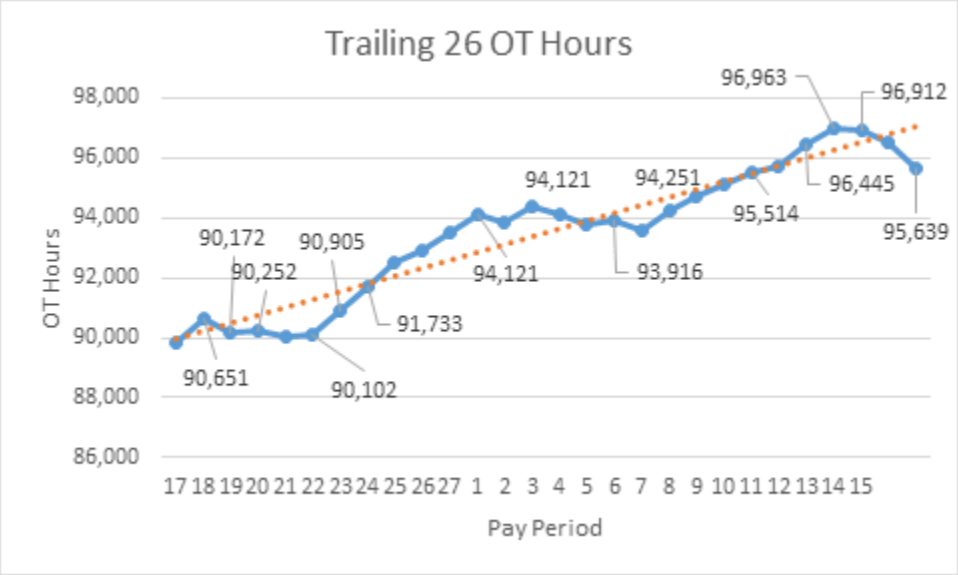
Recoveries and Other Revenue
The $1,091K year to date favorable variance is driven by a $496K recovery for oncology drugs from CCO, $312K favorable variance in interest income, and $122K for parking revenue.

Expenses

Salaries and Wages
Salaries and wages were $1.6M unfavorable to budget year to date. This was mainly due to higher overtime ($2.9M), staff training costs ($1.0M), and modified work ($0.3M), which was partially offset by a favorable variance in worked salaries ($3.1M) due to vacancies.
Overtime and sick time hours are summarized in the table below:

	October 2024			FY 2024-25		
HOURS	**Actual**	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**
Overtime	8,281	1,997	(6,283)	54,586	13,792	(40,794)
Sick	8,361	4,347	(4,013)	46,087	30,056	(16,032)

The overtime variance has primarily been driven by staffing shortages. The chart below summarizes the number of overtime hours for the past 26 pay periods. Overtime has decreased over the past year, peaking at 96,963 in pay period 14. The amount of overtime per pay period is on a slight increase over the past 3 pay periods. Efforts continue to reduce the amount of overtime.



Employee Benefits
The $498K YTD unfavourable variance has been driven by higher in lieu of benefits paid to part-time staff due to the higher number of hours worked by part-time staff compared to budget.

Medical Remuneration

The $403K favorable year to date variance is largely driven by a favourable variance in alternate funding for ER ($273K), oncology ($150K), pathology ($101K), and impatient mental health ($89K) offset with an unfavourable variance in CT ($192K).

Medical and Surgical Supplies
The $291K YTD unfavorable variance has been driven by IV sets ($153K), regents / chemical laboratory ($81K) and joint – hip replacement ($79K) partially offset savings in other areas.

Drug Expense
The $599K YTD unfavorable variance is driven higher spending on drugs for the oncology program ($512K). 98% of oncology drug costs are reimbursed by CCO.

Other Supplies and Expenses
The $3.1M YTD favorable variance is due to the unused contingency ($3.7M) offset by equipment maintenances costs in the operating room ($0.3M), and work force planning equipment ($0.2M).

Balance Sheet and Statement of Cash

CMH's current cash position is $102M, consisting of $77M of unrestricted cash and $25M of restricted cash. Unrestricted working capital available at the end of October is $18M. The working capital ratio is 1.24 and meets the requirements of the Hospital Service Accountability Agreement (H-SAA) target range of 0.8 to 2.0.

The accounts payable balance at the end of October was $41M, including general accounts payable ($35M) and MOH payable ($6M). The accounts receivable balance at the end of October was $13M, which includes MOH receivable ($6M) and general accounts receivable ($7M).

Forecast

CMH is forecasting a surplus of $3.6M for 2024-25.

The forecast includes unused contingency ($6.3M) offset by unfavorable variance in salary and benefits ($5.9M) and lower than budget revenue in PCOP ($0.4M). In August, MOH advised that Incremental Surgical Recovery funding (ISR) would be available this year. $3M in one-time funding has been estimated and included in the forecast.

Included in the forecast is MOH revenue of $5.8M to offset the 2024-25 incremental wage impact of Bill 124 arbitration awards at 85%.

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

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

Confidential
(Expressed in thousands of dollars)

Month of October 2024					Year to Date				2024-25	2024-25		2023-24 Prior Year Actuals	
Actual	Plan	Variance	% Variance		YTD Actual	YTD Plan	YTD Variance	% Variance	Forecast	Plan	Variance	October 2023	2023-24 YE
				Revenue:									
				MOH Funding									
$ 9,940	$ 9,940	$ -	0%	MOH - Base	$ 68,619	$ 68,619	$ -	0%	$ 117,037	$ 117,037	$ -	$ 7,971	$ 93,971
3,591	2,292	1,299	57%	MOH - Quality Based Procedure	17,091	15,439	1,652	11%	29,559	26,559	3,000	2,001	27,048
2,459	1,345	1,114	83%	MOH - Post Construction Operating Plan	9,861	9,286	575	6%	15,418	15,838	(420)	1,083	14,207
686	770	(84)	(11%)	MOH - One time / Other	4,949	5,454	(505)	(9%)	9,530	9,317	213	4,101	36,820
16,676	14,347	2,329	16%	Total MOH Funding	100,520	98,798	1,722	2%	**171,544**	**168,751**	**2,793**	15,156	172,046
1,396	1,386	10	1%	Billable Patient Services	10,003	9,571	432	5%	16,573	16,324	249	1,405	15,187
1,780	1,605	175	11%	Recoveries and Other Revenue	12,215	11,124	1,091	10%	21,619	19,152	2,467	1,367	22,461
321	334	(13)	(4%)	Amortization of Deferred Equipment Capital Grants	2,255	2,305	(50)	(2%)	3,865	3,952	(87)	336	3,888
328	295	33	11%	MOH Special Votes Revenue	2,145	2,040	105	5%	3,508	3,508	-	335	3,681
20,501	**17,967**	**2,534**	**14%**	**Total Revenue**	**127,138**	**123,838**	**3,300**	**3%**	**217,109**	**211,687**	**5,422**	**18,599**	**217,263**
				Operating Expenses:									
8,438	7,973	(465)	(6%)	Salaries & Wages	56,630	55,009	(1,621)	(3%)	99,743	95,025	(4,718)	8,596	92,991
2,095	2,064	(31)	(2%)	Employee Benefits	15,406	14,908	(498)	(3%)	26,381	25,155	(1,226)	2,033	24,424
1,910	1,864	(46)	(2%)	Medical Remuneration	12,478	12,881	403	3%	21,727	22,004	277	1,664	21,279
1,371	1,191	(180)	(15%)	Medical & Surgical Supplies	8,515	8,224	(291)	(4%)	14,543	14,047	(496)	1,278	13,891
1,183	1,061	(122)	(11%)	Drug Expense	7,925	7,326	(599)	(8%)	13,539	12,511	(1,028)	1,108	12,242
2,560	2,626	66	3%	Other Supplies & Expenses	15,094	18,208	3,114	17%	25,157	30,296	5,139	2,080	28,437
552	604	52	9%	Equipment Depreciation	3,945	4,171	226	5%	6,835	7,223	388	573	6,830
328	329	1	0%	MOH Special Votes Expense	2,145	2,308	163	7%	3,508	3,508	-	335	3,681
18,437	**17,712**	**(725)**	**(4%)**	**Total Operating Expenses**	**122,138**	**123,035**	**897**	**1%**	**211,433**	**209,769**	**(1,664)**	**17,667**	**203,775**
2,064	**255**	**1,809**	**709%**	**MOH Surplus / (Deficit)**	**5,000**	**803**	**4,197**	**523%**	**5,676**	**1,918**	**3,758**	**932**	**13,488**
(654)	(878)	224	(26%)	Building Depreciation	(4,499)	(4,696)	197	(4%)	(9,297)	(9,002)	(295)	(632)	(7,589)
484	699	(215)	(31%)	Amortization of Deferred Building Capital Grants	3,387	3,677	(290)	(7.9%)	7,171	7,084	87	483	5,802
$ 1,894	**$ 76**	**$ 1,818**		**Net Surplus / (Deficit)**	**$ 3,888**	**$ (216)**	**$ 4,104**		**$ 3,550**	**$ -**	**$ 3,550**	**$ 783**	**$ 11,701**

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

(Expressed in thousands of dollars)

	October 2024	March 2024
ASSETS		
Current Assets		
Cash and Short-term Investments	$ 76,927	$ 82,817
Due from Ministry of Health/Ontario Health	5,734	7,549
Other Receivables	6,911	4,616
Inventories	3,216	2,865
Prepaid Expenses	2,666	2,458
	95,454	100,305
Non-Current Assets		
Cash and Investments Restricted - Capital	25,074	29,359
Due from Ministry of Health - Capital Redevelopment	3,243	3,243
Due from CMH Foundation	475	475
Endowment and Special Purpose Fund Cash & Investments	214	206
Capital Assets	306,310	296,132
Total Assets	**$ 430,770**	**$ 429,720**
LIABILITIES & NET ASSETS		
Current Liabilities		
Due to Ministry of Health/Ontario Health	5,666	5,774
Accounts Payable and Accrued Liabilities	35,430	40,655
Deferred Revenue	35,952	32,449
	77,048	78,878
Long Term Liabilities		
Capital Redevelopment Construction Payable	5,124	4,035
Employee Future Benefits	4,368	4,223
Deferred Capital Grants and Donations	282,541	284,783
Asset Retirement Obligation	2,810	2,810
	294,843	295,851
Net Assets:		
Unrestricted	14,999	17,204
Externally Restricted Special Purpose Funds	210	206
Invested in Capital Assets	43,670	37,581
	58,879	54,991
Total Liabilities and Net Assets	**$ 430,770**	**$ 429,720**
Working Capital Balance	18,406	21,427
Working Capital Ratio (Current Ratio)	1.24	1.27

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

(Expressed in thousands of dollars)

	October 2024	March 2024
Cash Provided By (used in) Operations:		
Excess (deficiency) of Revenue over Expenses	$ 3,888	$ 11,701
Items not involving cash:		
Amortization of capital assets	8,444	14,419
Amortization of deferred grants and donations	(5,642)	(9,680)
Change in Non-Cash Operating Working Capital	(2,878)	(2,647)
Change in Employee Future Benefits	145	20
	3,957	13,813
Investing:		
Acquisition of Capital Assets & CRP	(18,621)	(33,552)
Capital Redevelopment Construction Payable	1,089	1,607
	(17,532)	(31,945)
Financing:		
Change in non-cash capital accounts receivable	-	341
Capital Donations and Grants & CRP	3,400	24,352
	3,400	24,693
Increase (Decrease) In Cash for the Period	(10,175)	6,561
Cash & Investments - Beginning of Year	112,176	105,615
Cash & Investments - End Of Period	**$ 102,001**	**$ 112,176**
Cash & Investments Consist of:		
Unrestricted Endowment and Special Purpose Investments	30	30
Cash & Investments Operating	76,897	82,787
Cash & Investments Restricted	25,074	29,359
Total	**$ 102,001**	**$ 112,176**

BRIEFING NOTE

Date: November 27, 2024
Issue: Disbanding of the Capital Projects Sub-Committee
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Kristen Hoch – Project Coordinator, Admin Assistant
Approved by: Tom Dean – Chair, Capital Projects Sub-Committee
Patrick Gaskin – President & CEO

Attachments/Related Documents: None

Alignment with 2024/25 CMH Priorities:

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

Recommendation/Motion

Board
Following review and discussion of the information provided, as Substantial Completion of the Capital Redevelopment Project (CRP) has been achieved, the Board approves the disbandment of the Capital Projects Sub-Committee

Resources Committee
Following review and discussion of the information provided, as Substantial Completion of the Capital Redevelopment Project (CRP) has been achieved, the Board Resources Committee recommends to the Board the disbandment of the Capital Projects Sub-Committee upon adjournment of the November 2024 meeting. **CARRIED.**

Capital Projects Sub-Committee
Following Substantial Completion of the Capital Redevelopment Project (CRP), the Capital Projects Sub-Committee of the Board recommends to the Board Resources Committee the disbandment of the Capital Projects Sub-Committee upon adjournment of the November 2024 meeting. **CARRIED.**

Background
The Capital Projects Sub-Committee was formed in Autumn 2013 with the purpose of reporting to the Resources Committee in assisting with its responsibility for approving and monitoring contracts relating to the expansion or alteration of the physical resources of the Hospital, and planning capital projects. Cambridge Memorial Hospital recognizes the important role this sub-

committee has played in the completion of the three phases of the Capital Redevelopment Project (CRP) construction. Amid some very difficult and challenging times, in collaboration with CMH staff resources, the Sub-Committee persevered and is proud to bring the final phase of construction to Substantial Completion this month. As such, it is proposed to now disband the Capital Projects Sub-Committee and thank all members for their wonderful contributions over its 11 years of service.

BRIEFING NOTE

Date: November 5, 2024
Issue: New Credentialed Physicians - October 2024
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Dr. Winnie Lee, Chief of Staff and Dr. Jenny Legassie, Chair of Credentials Committee
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: None attached.

Alignment with 2024/25 CMH Priorities:

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

This past month, we are thrilled to announce the addition of several highly skilled physicians to our hospital team. These new members bring a wealth of experience and expertise in various medical fields, further enhancing our commitment to providing exceptional patient care. The new medical professional staff joining CMH recently are:

1. Dr. Yeshale Chetty, Emergency Physician, Transitioned from Locum to Associate August 15, 2024. Dr. Yeshale Chetty is a highly accomplished medical professional with extensive experience in sports and exercise medicine. He completed his medical education at University of Queensland, Australia, Family Medicine Residency at McMaster University and a Sport and Exercise Medicine Fellowship at Western University, London, Ontario. Since July 2022, Dr. Chetty has been serving as a locum at the Emergency Department at Cambridge Memorial Hospital.

2. Dr. Isabella Callaghan, Community and Family Medicine Physician, Start date September 1, 2024. Dr. Isabella Callaghan is a dedicated family doctor currently working at Hespeler Medical Clinic. She completed her medical education at the Schulich School of Medicine and Dentistry, Western University.

Please join us in welcoming our new medical professionals as they embark or continue their journey with us, contributing to the health and wellness of our community. We look forward to having them as part of the CMH medical professional staff!