Vision
Creating healthier communities, together

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

Values
Caring, Collaboration, Accountability, Innovation, Respect

BOARD OF DIRECTORS MEETING - OPEN

March 5, 2025
1700-1815
Virtual via Teams / C.1.229
Join the meeting now
Or call in (audio only)
833-287-2824,,430276600#Canada (Toll-free)
Phone Conference ID: 430 276 660#

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 February 5, 2025*	4			
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*	18			
1.5.6 Committee Reports to the Board of Directors				
1.5.6.1 Executive Committee – No Report (Next Meeting Mar 18, 2025)				
1.5.6.2 Audit Committee – No Report (Next Meeting Apr 28, 2025)				
1.5.6.3 Digital Health Strategy Sub-Committee* (Feb 20, 2025)	20			
1.5.6.4 Resources Committee* (Feb 24, 2025)	21			
1.5.6.5 Medical Advisory Committee* (Feb 12, 2025)	23			
1.5.6.6 Governance Committee – No Report (Next Meeting Mar 13, 2025)				
1.5.7 Q3 CEO Certificate of Compliance*	26			
1.5.8 2024/25 Strategic Priorities Tracker Q3 Updates*	27			
1.5.8.1 Quality Monitoring Metrics – Monthly Report*	44			
1.5.9 CMH President & CEO Report*	59			
1.6 Confirmation of Agenda		1719	L. Woeller	Motion
2. PRESENTATIONS				
2.1 Patient Declaration of Values*	64	1720	L. Barefoot	Motion
3. BUSINESS ARISING				
3.1 No Items for Discussion				
4. NEW BUSINESS				

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, Stephanie Pearsall, Dr, Mark Shafir

Agenda Item * indicates attachment / TBC – to be circulated	Page #	Time	Responsibility	Purpose
4.1 Chair's Update				
4.1.1 Board Chair's Report*	74	1735	L. Woeller	Information
4.2 Quality Committee (Feb 6 & 19, 2025)				
4.2.1 Report to the Board of Directors*	81	1740	D. Wilkinson	Information
4.2.2 2025 Quality Improvement Plan*	84	1745	L. Barefoot	Motion
4.3 Resources Committee (Feb 24, 2025)				
4.3.1 January 2025 Financial Statements and Year-End Forecast*	97	1755	M. Hempel	Motion
4.4 Medical Advisory Committee (Feb 12, 2024)				
4.4.1 New Credentialed Physicians January 2025*	106	1800	Dr. W, Lee	Information
4.5 Patient Family Advisory Council (PFAC) Update		1805	N. Melchers	Information
4.6 CEO Update				
4.6.1 No Open Matters for Discussion				
5. UPCOMING EVENTS				
5.1 Grand Rounds, March 27, 2025, 8:00-9:00 am, virtual, *Details to Follow*				
5.2 Grand Rounds, April 24, 2025, 8:00-9:00 am, virtual, *Details to Follow*				
6. DATE OF NEXT MEETING	Wednesday May 7, 2025 Location: Hybrid			
7. TERMINATION		1815	L. Woeller	Motion
Link: Board/Committee Evaluation Survey	*Following the meeting, please complete within one week.*			

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

Ex officio Members: Patrick Gaskin, Dr. Winnie Lee, Dr. Vlad Miropolsky, Stephanie Pearsall, Dr, Mark Shafir

CMH Board of Directors Motions Page

Agenda Item	Motions Being Brought Forward for Approval – March 5, 2025	
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	Patient Declaration of Values	• That, the Board of Directors approves the updated CMH Patient Declaration of Values that was created in partnership with the CMH Patient and Family Advisory Council and upon recommendation of the Quality Committee at the meeting of February 19, 2025.
4.2.2	2025 Quality Improvement Plan	• That, the Board of Directors approves the four (4) 2025 Quality Improvement Plan (QIP) Metrics as presented below and upon the recommendation of the Quality Committee at the meeting of February 19, 2025: 1. Reduce the 90th Percentile Ambulance Offload time from x min to 43 minutes 2. Reduce the 90th Percentile Physician Initial Assessment (PIA) time for CTAS 1&2's combined from x to 4.0 hours 3. Reduce the 90th Percentile Physician Initial Assessment time for all CTAS levels combined from x hours to 4.6 hours 4. Reduce the daily average number of patients waiting in the ED for an inpatient bed at 8 AM from x to 10 • That, the Board approves the 2025 Quality Improvement Plan (QIP) Narrative as presented in Appendix 1 and upon recommendation of the Quality Committee at the meeting of February 19, 2025.
4.3.1	January Financial Statements & Year End Forecast	• That, the Board receives the January 2025 financial statements as presented by management and upon the recommendation of the Resources Committee at the meeting of February 24, 2025.

AGENDA

Cambridge Memorial Hospital
BOARD OF DIRECTORS MEETING
Wednesday, February 5, 2025
OPEN SESSION

Minutes of the open session of the Board of Directors meeting, held via hybrid model (video conference and within Cambridge Memorial Hospital, C.1.229) on February 5, 2025.

Present:

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

Regrets: Dr. V. Miropolsky

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

Guests: None

Recorder: S. Fitzgerald

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1. CALL TO ORDER
The Chair called the meeting to order at 1852 hours.

1.1. **Territorial Acknowledgement**
The Chair presented the Territorial Acknowledgement**.**

1.2. **Welcome**
The Chair welcomed Dr. Mark Shafir, VP of the MPSA and the Board members to the meeting.

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

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

1.5. **Consent Agenda**
Prior to approving the Consent Agenda, the Chair asked if any items required removal for further discussion. No items were removed for further discussion.

The consent agenda was approved as presented:
1.5.1 Minutes of December 4, 2024
1.5.2 2024/25 Board of Directors Action Log
1.5.3 Board Attendance

1.5.4 Board Work Plan
1.5.5 Events Calendar / Meeting Dates
1.5.6 Committee Reports to the Board of Directors
Quality Committee Report to the Board of Directors
Audit Committee Report to the Board of Directors
Digital Health Strategy Sub-Committee Report to the Board of Directors
Medical Advisory Committee Report to the Board of Directors
New Credentialed Physicians November 2024
Governance Committee Report to the Board of Directors
1.5.7 Governance Committee – Recommendations for 2025 Interview Team
1.5.8 Governance Policy Summary
2-C-36 Borrowing Policy
1.5.9 CMH President & CEO Report
1.5.10 Quality Monitoring Metrics Monthly Report
None opposed, **CARRIED.**

1.6. **Confirmation of Agenda**

MOTION: That**,** the agenda be approved as presented.
None opposed, **CARRIED.**

2. PRESENTATIONS

No presentations

3. BUSINESS ARISING

No open items for discussion.

4. NEW BUSINESS

No open items for discussion.

5. UPCOMING EVENTS

The Chair reviewed the upcoming events and encouraged Directors to take part when able.

The Chair highlighted that on February 18th, CMH and the Board Chair will present at a City of Cambridge Council meeting, which will also be available to attend for any interested Directors. This session will be a workshop rather than a regular Council meeting, meaning there will not be any public delegations, and the focus will be solely on CMH's presentation. The goal of the meeting is to educate the Council about the hospital's role in community health, without requesting any decisions or funding. The event will also offer an opportunity for informal discussions and networking with Council members, helping to foster relationships and address community concerns, such as mental health and detox services. The team aims to strengthen their partnership with the Council for future initiatives, with a focus on positive governance and community engagement.

6. DATE OF NEXT MEETING

The next scheduled Board of Directors meeting is March 5, 2025.

7. TERMINATION

MOTION: That, the meeting terminated at 1901h.
None opposed, **CARRIED.**

AGENDA

2024/25 Board of Directors Action Log – March 2025

Agenda Item 1.5.2

Meeting Date	Agenda # / Item Description	Action Item	Owner	Status
No Action Log Items to Report				

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

AGENDA

Board of Directors Attendance Report 2024/2025

	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	60%
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
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
4-Dec-24	P	P	P	P	P	P	P	P	P	P	P	R
5-Feb-25	P	P	P	P	P	P	P	P	P	P	P	P

AGENDA

Agenda Item 1.5.4

Cambridge Memorial Hospital Board of Directors - 2024-25 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
02-Oct-24	4a Corporate Culture					
	i	setting the tone for a culture throughout the Corporation that is consistent with the mission, vision and values and supports the Corporation's strategy	1-A-05		➢ share, measure and improve culture by setting ABCDE goals a) Attend – attend Board/committee meetings b) Be engaged – be an active contributor to the committee and Board work c) Connect – attend staff huddles, events d) Donate – support the CMH Foundation e) Educate – undertake education, courses	Complete
	4b Strategic Planning					
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality / Resources	➢ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker	Complete
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	Complete
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics ➢ receive and review the Strategic Priorities Tracker	Complete
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➢ receive and approve the quarterly CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	Complete
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	Complete
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	Complete
	4g Relationships					
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➢ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	Complete
	4i Board Effectiveness					
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➢ review & approve Board policies as recommended by Governance Committee	Complete

AGENDA

Agenda Item 1.5.4

Cambridge Memorial Hospital Board of Directors - 2024-25 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events reported through Directors ABCDE Goals	Complete
November 6, 2024 (Generative Session)	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	Complete
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics	Complete
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	Complete
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	Complete
	4a Corporate Culture					
	ii	overseeing the establishment and monitoring of such a culture through appropriate mechanisms, including assessing the Chief Executive Officer, and Chief of Staff of the Corporation against this expectation	2-B-25 2-B-26	Executive	➢ receive & review the mid-year CEO and COS report and provide input	
	4b Strategic Planning					
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality / Resources	➢ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker	Complete
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality Audit / Quality / Resources	➢ review critical incident reports (as per the Excellent Care for all Act) ➢ receive mid-year IRM report	Complete Complete
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics ➢ receive and review the Strategic Priorities Tracker	Complete
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➢ receive & approve the quarterly CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements ➢ receive & approve Certificate of Compliance – Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding (semi-annual)	Complete
	4e Succession Planning					
	i	provide for Chief Executive Officer succession plan and process	2-B-10	Executive	➢ receive confirmation that succession plans are in place through the Executive Committee Report to the Board of Directors	Delayed (See Below)

AGENDA

Agenda Item 1.5.4

Cambridge Memorial Hospital Board of Directors - 2024-25 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
04-Dec-24	ii	provide for Chief of Staff succession plan and process	2-B-12	Executive	➢ receive confirmation that succession plans are in place through the Executive Committee Report to the Board of Directors	Delayed (See Below)
	iii	ensure that the Chief Executive Officer and Chief of Staff establish an appropriate succession plan for both executive management and Medical/Professional Staff leadership	2-B-10 2-B-12	Executive	➢ receive confirmation that succession plans are in place through the Executive Committee Report to the Board of Directors	Delayed (See Below)
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	Complete
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	Complete
	4g Relationships					
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➢ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	Complete
	4i Board Effectiveness					
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➢ review & approve Board policies as recommended by Governance Committee	Complete
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events reported through Directors ABCDE Goals	Complete
	4l Programs Required under the *Public Hospitals Act*					
	ii	ensure that policies are in place to encourage and facilitate organ procurement and donation		Quality	➢ receive the annual Trillium Gift of Life Update	Complete
	iii	ensure that the Chief Executive Officer, Chief of Staff, 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	➢ receive the annual Emergency Preparedness update	Complete
	4n Director Recruitment, Orientation, and Evaluation					

AGENDA

Agenda Item 1.5.4

Cambridge Memorial Hospital Board of Directors - 2024-25 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
		The Board shall ensure there is an appropriate, objective, and formal process for the recruitment of Directors, and the evaluation of the Board, the Board Chair, its committees, committee Chairs and individual Directors.	2-D-20		➢ approve the members of the Nominating Sub-Committee & Interview Team	Complete
February 5, 2024 (Generative Session)	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	Complete
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics	Complete
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	Complete
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	Complete
	4i Board Effectiveness					
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➢ review & approve Board policies as recommended by Governance Committee	Complete
05-Mar-25	4b Strategic Planning					
	iv	ensuring that key corporate priorities are formulated that help the Corporation accomplish its mission and actualize its vision in accordance with the strategic plan. The corporate priorities shall be reflective of the Board's primary accountability to the Ministry of Health ("MOH") and Ontario Health and any applicable accountability agreements with the MOH or Ontario Health		Quality Resources	➢ review & approve Annual Quality Improvement Plan (QIP) ➢ review & approve Hospital Service Accountability Agreement (HSAA) ➢ review & approve Multi-Sector Service Accountability Agreement (MSAA) ➢ review & approve Community Accountability Planning Submission (CAPS) ➢ review & approve Hospital Accountability Planning Submission (HAPS)	Due
	v	approving operating and capital plans	2-C-31	Resources	➢ review & approve the annual Operating Plan review & approve the Annual Capital Plan	Due
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	Due
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics	Due
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	Due
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	Due
	4g Relationships					

Cambridge Memorial Hospital Board of Directors - 2024-25 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➢ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	Due
	4h Financial Viability					
	i	establish key financial objectives that support the Corporation's financial needs		Resources / Quality	➢ review & approve Annual Operating & Capital Plans - service changes, operating plan, capital plan, salary increases, material amendments to benefit plans, programs and policies	Due
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events reported through Directors ABCDE Goals	Due
	4a Corporate Culture					
	ii	overseeing the establishment and monitoring of such a culture through appropriate mechanisms, including assessing the Chief Executive Officer, and Chief of Staff of the Corporation against this expectation	2-B-25 2-B-26	Executive	➢ receive & review the annual CEO and COS survey results & self-appraisal and provide input	
	4b Strategic Planning					
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality Resources	➢ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker	
	4.c Corporate Performance					
	i	identify principal risks to the Corporation in line with the Board's Integrated Risk Management policy	2-C-20	Audit Quality Resources	➢ review & approve the IRM process undertaken by management to identify and develop the in-year IRM risks and associated mitigation strategies	
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics ➢ receive and review the Strategic Priorities Tracker	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➢ receive and approve the quarterly CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	
	4f Oversight of Medical/Professional Staff					

AGENDA

Agenda Item 1.5.4

Cambridge Memorial Hospital Board of Directors - 2024-25 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
07-May-25	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	
	4g Relationships					
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➢ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	
	4i Board Effectiveness					
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➢ review & approve Board policies as recommended by Governance Committee	
	4l Programs Required under the Public Hospitals Act					
	i	(i) ensure that an occupational health and safety program and a health surveillance program are established and regularly reviewed				
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events reported through Directors ABCDE Goals	
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources Audit	➢ receive & approve Declaration of Compliance with MSAA Schedule F ➢ receive & approve Declaration of Compliance with BPSAA Schedule A ➢ receive & approve Certificate of Compliance – Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding (semi-annual) ➢ receive the legislative compliance review	
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	

Cambridge Memorial Hospital Board of Directors - 2024-25 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
June 4, 2025 (Generative Session)	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	
	4h Financial Viability					
	ii	ensure that the organization undertakes the necessary financial planning activities so that resources are allocated effectively and within the parameters of the financial performance indicators		Resources	➢ receive updates on how the budget is being developed through the Resources Committee Report to the Board of Directors ➢ receive and approve the year-end financial statements	
	4i Board Effectiveness					
	i	monitor Board members' adherence to corporate governance principles and guidelines		Governance	➢ Declaration of conflict agreement signed by Directors ➢ Directors Consent to Act ➢ Governance Report to the Board of Directors	
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➢ review & approve Board policies as recommended by Governance Committee	
	4n Director Recruitment, Orientation, and Evaluation					
		The Board shall ensure there is an appropriate, objective, and formal process for the recruitment of Directors, and the evaluation of the Board, the Board Chair, its committees, committee Chairs and individual Directors.	2-D-20		➢ review recommendations for new Directors, non-Director committee members review the results of the annual evaluation surveys through the Governance ➢ Committee Report to the Board of Directors	
	4b Strategic Planning					
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality Resources	➢ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker	
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics ➢ receive and review the Strategic Priorities Tracker	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➢ receive and approve the quarterly CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	Complete
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	

AGENDA

Agenda Item 1.5.4

Cambridge Memorial Hospital Board of Directors - 2024-25 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
25-Jun-25	4g Relationships					
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➢ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	
	4i Board Effectiveness Fundraising					
	iii	ensure ethical behaviour and compliance with laws and regulations, audit and accounting principles, accreditation requirements and the By-Laws		Audit	➢ review & receive the annual Audit Findings Report review & approve the year-end financial statements	
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events reported through Directors ABCDE Goals	
	4n Director Recruitment, Orientation, and Evaluation					
		The Board shall ensure there is an appropriate, objective, and formal process for the recruitment of Directors, and the evaluation of the Board, the Board Chair, its committees, committee Chairs and individual Directors.	2-D-20		➢ conduct the election of officers ➢ receive committee reports on work plan achievements ➢ review Board annual survey results	
	4a Corporate Culture					
	iii	overseeing policies in respect of the Corporation's code of conduct	1-A-04		➢ review the organizations code of conduct policy every three years (last reviewed May 9. 2024)	
	4b Strategic Planning					
	i iii	ensuring that a strategic planning process is undertaken with Board, employees and Medical/Professional Staff involvement and approved by the Board from time to time contributing to the development of and approving the mission, vision, values, and strategic plan of the Corporation			➢ Strategic Plan: approve process, participate in development, approve plan - (last completed in 2022, will be done again in 2027)	
	4d Chief Executive Officer and Chief of Staff					
	i	select the Chief Executive Officer in accordance with the relevant Board policies	2-B-15	Executive	➢ recruit, select, and hire and individual with the requisite skills, abilities, and competencies to effectively perform the job as President and Chief Executive Officer (CEO) of the organization	

Cambridge Memorial Hospital Board of Directors - 2024-25 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
As Needed	ii	delegate responsibility for the management of the Corporation to the Chief Executive Officer and require accountability to the Board	2-B-05	Executive		
	iii	establish a Board policy for the performance evaluation and compensation of the Chief Executive Officer	2-B-20 2-B-25	Executive / Governance	➢ review & approve the Board's policies 2-B-20 CMH Executive Compensation Policy (last reviewed May 26, 2021) 2-B-25 CEO Performance Review Policy (last reviewed May 25, 2022)	In Progress
	iv	select the Chief of Staff in accordance with the relevant Board policies	2-B-16	Executive	➢ recruit, select, and hire and individual with the requisite skills, abilities, and competencies to effectively perform the job as President and Chief Executive Officer (CEO) of the organization	
	v	delegate responsibility for the management of the Corporation to the Chief of Staff and require accountability to the Board	2-B-06	Executive		
	vi	establish a Board policy for the performance evaluation and compensation of the Chief of Staff	2-B-20 2-B-26	Executive / Governance	➢ review & approve the Board's policies 2-B-20 CMH Executive Compensation Policy (last reviewed May 26, 2021) 2-B-26 CEO Performance Review Policy (last reviewed May 25, 2022)	In Progress
	4j Effective Communication and Community Relationships					
	i	establish processes for community engagement to receive public input on material issues	1-A-05 2-D-09		➢ Post meeting agenda packages and minutes publically on the CMH Website review & approve the Board policy 2-D-09 (last reviewed June 28, 2023) ➢	
	ii	promote effective collaboration and engagement between the Corporation and its community, particularly as it relates to organizational planning, mission, and vision			➢ Strategic Plan	
	4m Communications Policy					
		The Board shall establish a communications policy for the Corporation and oversee the maintenance of effective relations with stakeholders (e.g. MOH, Ontario Health, CND OHT, other health service providers, clients, patients, employees, volunteers, Medical/Professional Staff, CMH Foundation, CMH Volunteer Association, federal, provincial, regional and city politicians) through the Corporation's communications policy and programs	2-D-11	Governance	➢ review & approve Board policy 2-D-11 every three years (last reviewed April 22, 2022)	In Progress
	General					

AGENDA

Cambridge Memorial Hospital Board of Directors - 2024-25 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
		On behalf of the Board, the Governance Committee shall review and assess the adequacy of the Board terms of reference at least every 3 years and submit proposed changes to the Board for consideration		Governance	➢ review & approve the Board of Directors Terms of Reference (last reviewed June 28, 2023)	

DELAYED

Date	ref #	Item	Rationale	New Due Date
04-Dec-24	i	provide for Chief Executive Officer succession plan and process	updating timeline to reflect the timelines of the organizations Achievement and Competency Assessment (ACA) process completion - reporting for 2024/25 will take place at the March Executive Committee meeting (previously done in May) and for future years November	May-25
	ii	provide for Chief of Staff succession plan and process		
	iii	ensure that the Chief Executive Officer and Chief of Staff establish an appropriate succession plan for both executive management and Medical/Professional Staff leadership		

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 - February 18						18							
Board Committee Meetings													
Quality Committee 7:00 am – 9:00am	18	16	20		15	19		16	21	18			
Quality Committee QIP Meeting 7:00 am – 9:00 am						6							
Resources Committee 5:00pm – 7:00pm	24		25			24		28	26	23			
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	3	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				5									
Chamber Business Awards			14										
Cambridge City Council Workshop - Bowman Room, City Hall						18							
CMHF Diversity Dinner – CMH Celebration of Champions, Oriental Sports Club			7										
CMH Staff BBQ										12			
Career Achievement										12			
CMH Golf Classic - Galt Country Club Further Details to Follow										5			
CMHF 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: February 27, 2025
Issue: Digital Health Strategy Subcommittee Report to Board of Directors February 20, 2025 OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Bonnie Collins, Administrative Assistant
Approved by: Sara Alvarado, Chair

Attachments/Related Documents: None

A meeting of the Digital Health Strategy Subcommittee took place on Thursday, February 20, 2025 at 1700h

Present:	Sara Alvarado (Chair), Joel Campbell, Jim Gates, Miles Lauzon, Richard Neidert, Suzanne Sarrazin, Lynn Woeller
Regrets:	Masood Darr, Paul Martinello, Margaret McKinnon
Staff:	Jennifer Backler, Trevor Clark, Patrick Gaskin, Kristen Hoch, Rob Howe, Mari Iromoto, Dr. Winnie Lee, Kyle Leslie, Stephanie Pearsall, Valerie Smith-Sellers
Guests:	

Committee Matters – For information only

1. Operational Excellence Plan Update:
The Operational Excellence Plan (data and digital tools) was approved by the Board in May 2024. Management provided highlights of some of the key accomplishments for the plan this fiscal year, including CMH's data maturity progression from Stage 3 on the Healthcare Information Management Systems Society (HIMSS) Adoption Model for Analytics Maturity (AMAM) in 2023 to Stage 4 in 2024. The Subcommittee congratulated management on the progress and successes within the Operational Excellence Plan.

AGENDA

BRIEFING NOTE

Date: February 27, 2025
Issue: Resources Committee Report to Board of Directors February 24, 2025 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 Monday, February 24, 2025 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, Patrick Gaskin, Bill Hibbs, Rob Howe, Mari Iromoto, Dr. Winnie Lee, Kyle Leslie, Stephanie Pearsall, Valerie Smith-Sellers, Susan Toth
Guests:	

Committee Matters – For information only

1. **Q3 Corporate Scorecard:** The corporate scorecard and strategic priorities tracker were reviewed with the Committee and the hospital's top priorities and Q3 performance were outlined.
   - Achieved greater than 90% active staffing in Medicine, ICU and ED;
   - Improvement in overtime performance;
   - PCOP earnings continued above target with a significant increase (greater than $5M) for Q3, due to discharges of longer stay medical patients and high surgical block usage in Q3.

   The Committee congratulated management on the hospital's Q3 performance.

2. **January 2025 Financial Statements and Year-End Forecast:** In January, CMH reported a $9.7M 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 ($5M), additional unbudgeted Bill 124 funding ($3.3M), higher PCOP revenue ($2.7M), quality-based procedures (QBP) revenue ($2.6M) and recoveries/other revenue ($1.4M) than budget. These favourable variances are partially offset by unfavorable variances in salaries & wages and benefits ($3.9M), primarily due to higher overtime than budget. Overtime continues to be higher than budget at $4.2M YTD, forecast to be $5M by the end of the fiscal year. A year-end surplus of $9M is forecast

which does not include the expected one-time prior year recovery of PCOP funding which has been reconciled by the Ministry. The forecast year-end surplus is due to the unbudgeted Bill 124 funding, incremental surgical funding, higher PCOP and QBP funding, and prior year adjustment. Unrestricted working capital at the end of January was $21M and will be used to partially self-fund Project Quantum. Questions were entertained, and management confirmed that, while CMH is in a unique position compared to other hospitals with respect to its large surplus, after the PCOP funding period and post-system modernization CMH will be in a similar position to other hospitals. CMH's large surplus and working capital are defensible due to PCOP funding resulting from the hospital's Capital Redevelopment Project (CRP), and the Committee agreed that proper messaging of this position is essential. Further information will be discussed during agenda item 4.3.1.

BRIEFING NOTE

Date: February 12, 2025
Issue: MAC Report to the Board of Directors February 2025 OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Dr. Jenny Legassie, Deputy Chief of Staff
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: None Attached

A meeting of the Medical Advisory Committee took place on Wednesday, February 12, 2025, at 1630h virtually via MS Teams Boardroom.

Present:	Dr. W. Lee, Dr. J. Legassie, Dr. L. Green, Dr. M. Patel, Dr. A. Nguyen, Dr. J. Bourgeois, Dr. V. Corner, Dr. K. Wadsworth, Dr. T. Holling, Dr. M. Hindle, Dr. B. Courteau, Dr. M. Shafir, Dr. A. Sharma, C. Witteveen, Dr. A. Mendlowitz, Dr. V. Miropolsky, Dr. E. Thompson, Dr. M. Runnalls, Dr. I. Isupov
Regrets:	Dr. M. Rajguru, Dr. R. Shoop, P. Gaskin, M. Iromoto
Staff:	S. Pearsall, K. Leslie, M. Hasan, Dr. K. Nuri, J. Visocchi
Guests:	D. Wilkinson, D. Pereira

Committee Matters – For information only

1. **M&T Report:** January M&T report was shared with MAC.

   MOTION: That the January M&T report be approved as distributed.
   None Opposed. **CARRIED**.
2. **COVID-19 and Infectious Disease Update:** Ontario continues to see a high incidence of respiratory illness. Over the next two weeks, it is expected that COVID19 and RSV rates will decline while influenza will rise. Largest increase in overall respiratory illness is expected to occur in the in the adult population.

   A COVID outbreak on the surgical inpatient unit was declared January 17, 2025 and ended February 3, 2025. Five patients did develop COVID19.

   As of January 1, 2025, Candida auris is a reportable disease in Ontario. Policies and practices for reporting to public health already exist and will be updated to include Candida Aurisl.
3. **Front-End Speech Dictation**: Front end speech continues to gain traction with the physician group with 25% of active physicians receiving training and having access to the software. Training sessions are held regularly and continue to attract additional users.

CMH is exploring the use of AI scribes to assist with documentation. A small number of physicians have been asked to test out the software platforms.

4. **Policy # 2-409 Most Responsible Practitioner Status**: Policy # 2-409 was brought back to the committee. Motion was made to approve the updated policy.

   MOTION: That policy 2-409 Most Responsible Practitioner Status be approved as distributed.
   None Opposed. **CARRIED**.
5. **Medical Directives:** Following medical directives were brought to MAC for approval. The following medical directives were brought to the committee for approval.

MD #	Title	Motion
209	Oxygen Therapy	Approved
210	Ophthalmic Anesthetic	Approved
213	Urine Collection	Approved
214	Abdominal Pain	Approved
218	Vaginal Bleeding	Approved
230	Sepsis and Febrile Neutropenia Management	Approved
231	Nausea and Vomiting in Adults	Approved with amendment of the title to “Nausea and Vomiting in Adults in the Emergency Department”
232	Nausea and Vomiting in Pediatrics	Approved with amendment to title to be confirmed at March MAC
233	Geriatric Patient	Approved
234	Hyperglycemia	Approved
385	Newborn Hypoglycemia	Approved

6. **Pneumatic Tube Blood Products Go Live:** The process for sending blood products, using a secure PIN was presented to MAC. Blood products not picked up from the tube after 15minutes will be automatically returned to the lab so they are not wasted.

   Code transfusion blood products will not be sent via the tube system; these will continue to be delivered by a designated porter.
7. **Diagnostic Imaging Department Update**: Diagnostic Imaging continues to be a very busy service; actively working within CMH and community to improve access to imaging and to accommodate needs of patients.
   Designated imaging spots have been made available for long term care and retirement homes to reduce need to visit the emergency department. A designated ultrasound technician has been assigned to the liver clinic to facilitate physician visit and ultrasound in same space,
8. **Hospitalist Department Update:** The hospitalist service provides inpatient care to medical patients within the medical units and those patients admitted to off-service beds. They continue to work with the medical leadership to address volumes through reduction of length of stay and addressing number of patients deemed Alternate Level of Care (ALC). Specific projects have addressed the communication between physicians and other team members through Rapid Rounds, language used regarding ALC status. Medical directives and order sets are being used to gain efficiencies in patient care.

9. **PFAC Report:** PFAC update included a discussion on changes in DI shielding practices and patient portals (i.e. Connect MyHealth) and Pocket Health. A Patient Experience Office update and a status of the Patient Declaration of Values was also discussed at the February PFAC meeting.

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

MEMORANDUM

TO: Board of Directors, Cambridge Memorial Hospital

DATE: February 19, 2025

REPORTING PERIOD: October 1, 2024 – December 31, 2024

FROM: Patrick Gaskin
President and CEO

RE: CEO Certificate of Compliance

I have reviewed, or caused to be reviewed, such files, books of account and records of CMH and have made, or caused to be made, such enquiries of the financial, accounting and other personnel of CMH as I have determined necessary for the 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: February 11, 2025
Issue: 2024/2025 Strategic Priorities Tracker Q3 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, VP People and Strategy

Attachments/Related Documents: Appendix A – Strategic Priorities Package – Q3
Appendix B – Success and Wins Highlights Q3

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 Q3 performance in relation to targets set for Q3. 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 Q3 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) (Oversight by Quality Committee)**
2) Advance Health Equity through developing our people measured through completion rates of Rainbow Health DEI training. **(Quality Improvement Plan QIP) (Oversight by Quality Committee)**

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 **69 minutes (YTD Dec 2024)**, while the target is **<30 minutes**. In 2023-24, the 90th percentile

ambulance offload time was **115 minutes, thus we have seen a 40%** improvement in the current fiscal year. In Q3 we achieved 53 mins, which is our best performance of all quarters.

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 **50.9 hours (YTD Dec 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 12%** improvement in the current fiscal year. Since Q1, our emergency department volumes have grown by greater than 6% from 125 average visits per day in Q1 to 132 visits per day in Q3 Despite rising volumes in our ED the Q3 performance for this indicator remained stable at **51.5 hours**.

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 Q3, the 90th percentile YTD PIA time was **7.6 hours**, which is 0.7 hours longer than the same period last fiscal year. For Q3 of this fiscal year we see slight improvement in our PIA time from 7.8 hours in Q2 to 7.6 hours in Q3

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, we are putting focus on improving PIA times for our sickest CTAS 1-2 patients. The Actions we will focus on for Q3 are summarized in **Appendix A** within the Clinical Services Growth Plan.

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.

Two major success and wins we would like to highlight aligned our Strategic Pillar of Elevate Partnerships in Care are: 1) The implementation of our CMH@Home program and 2) the opening of our Wing B patient care space. These two projects are showcased in **Appendix B**

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 through Project Quantum. One of the major successes to is the progress toward implementing our new state of the art workforce planning system in **Appendix B**

Increase Joy in Work:

Priority 7: % on track with Active Staffing Targets (Moving to 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 **90.3% achieved in Q3,** while our target is 100%. A higher number is better as it means we are appropriately staffed, there has been significant focus to achieve >90% active staffing which is starting to positively impact our overtime performance.

A success we would like to highlight for staffing is the work underway to establish our Organizational Scheduling Office which is highlighted 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):

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 Q3, **we saw our PCOP targets achieved, with $5.17 million earned in Q3.** This represents an **increase of $1.34 million from Q2.** Our Q3 results were driven by medical discharges with high weighted cases and an increase in Surgical activity. The growth in PCOP funding is a significant organizational accomplishment.

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 Q3, an additional 37** staff completed the training though **our target is 88 or more** per quarter. Strategies have been developed to meet our targets by year end.

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	53.0		Clinical Services Growth Plan; Capital Redevelopment Plan; Emergency Preparedness Plan
	90th%tile EDLOS admitted patients (hours) (QIP/IRM)	<33	48.1	51.7	51.5		
	% on track Capital Redevelopment Plan (IRM)	100	100	100	100		
	% on track with Emergency Preparedness Plan (IRM)	100	100	100	100		
Reimagine Community Health: Prepare for digital health transformation	% on track with Health Information System (IRM)	100	100	100	100		Digital Health Plan
	% on track with Workforce Planning (IRM)	100	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	90.3		HR Plan
	% on track with Corporate Change Management Strategy (IRM)	100	100	100	100		
Sustain Financial Health: Earn max eligible PCOP funding for 24/25	Post Construction Operating Plan revenue earned (IRM)	>$3.6M quarter	$3.76M	$3.83M	$5.17M		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	52	78	37		DEI Plan

Elevate Partnerships in Care

Clinical Services Growth Plan

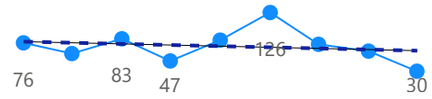
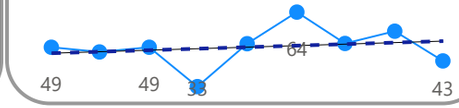
Click Here to Input Action Plans

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	53.0		
90th%tile LOS Hours for Admitted Patients in ED	<33 hours	48.1	51.7	51.5		

Action Plan-Q3

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Achieve 30 min or less ambulance offload time	1. Reviewed & revised AOT sustainability plan with ED manager; 2. Re-evaluated & reinforced standardized work for all roles (e.g. charge nurse, EMS offload nurse, EMS triage nurse, ED clerical); 3. Implemented CMH EMS escalation process on Nov 5th	1. Develop weekly audit for ambulances greater than 30 mins; 2. Revise Flow Monitor standard work to include EMS offload delay escalations; 3. Submit request for North York General Hospital to attend CMH to present on the work they did with AOT; 4. Implement EMS timestamp equipment to capture EMS arrivals	R1) HHR for EMS Triage Nurse (staffing and education); M1) ED Nurses to attending triage class
Achieve and maintain ALC throughput ratio of 1 and ALC census of <36	1. Continue with Cambridge Collaborative to support complex patients & discharges; 2. Developed & launched Hospital to Home (H2H) Program, which supports ED admission avoidance, targeting potential ALC patients with high restorative capacity; 3. Held General Internal Medicine and ED meeting to review support of General Internal Medicine Rapid Assessment Clinic (GIMRAC, formerly CBMED) & ED Diversion; 4. Trialed direct referral process for GIMRAC by ED physician; 5: Investigated & improved LOS on key case mix groups, such as COPD; 6. Expanded Allied Health team with dedicated resource to ED (ongoing); 7. Weekly rounds with leadership, Ontario Health at Home, CMH@Home to review ALC patients (ongoing); 8. Established new process for approval of ALC to LTC with Ontario Health at Home and CMH	1. Recruitment of second navigator (part time) to support discharge planning on weekends; 2. Continue expansion of Allied Health team; 3.Expansion of Cambridge Collaborative to include Community Support Services; 4. New process for ALC designation – physicians to write "Medically Stable, Ready for Discharge (Planning)"; 5. Continue weekly rounds with leadership, Ontario Health at Home, CMH@Home to review current ALC patients; 6. Monitor and evaluate new ALC process	R1) Ongoing ALC pressure; M1) Appropriate use of CMH@Home, Ontario Health at Home, community resources; M2) Continue to engage with community partners through the Cambridge Collaborative to work on ALC strategies
Achieve flow targets for provider initial assessment times and length of stay for complex and minors.	1. Implemented enhanced NP coverage for backfill; 2. Developed physician & staff education specific to patient disposition (Left without being seen- LWBS, Left without being treated-LWBT); 3. Reviewed & revised sub acute sustainability plan with ED manager; 4. Developed organizational strategy for establishing a patient flow office; 5. Hired Manager of staffing and patient flow; 6. Established weekly patient flow monitoring meeting with ED and Inpatient leadership to review identified metrics including P4R, ALC and long stay patients (ongoing)	1. Build ER Tracker Board enhancements: flag CTAS 2 patients to top of waiting to be seen; 2. Expand Flow Monitor position to cover evening shift (1500-2300); 3. Develop process to align MD & NP schedules; 4. Develop and roll out communication, re: flow expectations; 5. Develop and share performance data with physicians, patients seen per shift per hour,; 6. Develop strategy to maintain patient volumes, to support throughput and wait times	R1) Gaps in ED Physician Schedule; M1) Review & adjust NP schedule to bridge the gap; R2) NP recruitment (1 contract PT position); M2) Review and revise orientation plan; R3) Evening flow position was funded by one time funding, until March 31, potential for not further funding; M3) Review plan for evenings without flow monitor
Achieve time to in-patient bed target	1. Launched refreshed unit rapid rounds on Jan 5th; 2. Refreshed patient white boards to align with rapid rounds implementation; 3. Investigated paper-based SBAR to verbal TOA based on STEGH site visit; 4. Medicine leadership rounding with patients regarding discharge expectations and prep with patients (ongoing)	1. "Unit Census Board" project submission to 2025 Staff Innovation Fund, to align with rapid rounds implementation; 2. Implementation of new discharge rounds on all three medicine units as of January 20th, 2025; 3. Implement new format to rounds to focus on barriers to discharge; 4. Setup Phone/Teams link for physicians to participate in rounds; 5.Timing of rounds changed to earlier in shift to allow for real time information to be shared at 1000 bed meeting; 6. Review of estimated date of discharge – standard use on patient white boards and unit patient white board; 7. Increased awareness and focus on moving patient to bed within 60 minutes of patient being assigned to bed	R1) Physician presence and engagement at rounds; M1) Launch unit rapid rounds & slowly integrate physicians into new structure (modify schedule if necessary)

Sustain Financial Health

Multi-Year Financial Plan

Click Here to Input Action Plans

Executive Sponsor(s): Trevor Clark

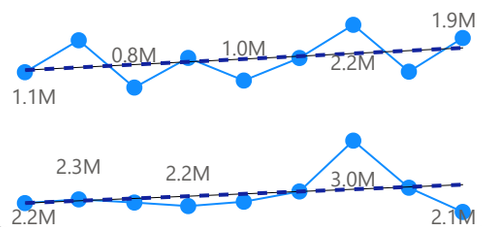
Physician Liaison(s): Dr. Green, Dr. Sharma, Dr. Nguyen

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	$5.2M	
QBP Revenue generated*	>$6.6M per Quarter	$6.7M	$6.8M	$7.5M	

Monthly Trend



Action Plan- Q3

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Ensure effective in-year PCOP monitoring for Medicine	1. Reviewed Q3 performance to ensure PCOP was achieved and maximized; 2. Sustained new practices & maintain long stay list (ongoing); 3. Worked towards increased numbers for next day confirmed discharges (ongoing); 4. Initiated the planning for return of rehab and coordination of medical unit; 5. Reviewed the impact of H2H on funding and PCOP; 6. Reviewed the impact to PCOP and QBP due to Endoscopic Ultrasound (EUS) volume reduction to one day per week	1. Review Q4 performance to ensure PCOP was achieved and maximized; 2. Continue to sustain new practices & maintain long stay list; 3. Worked towards increased numbers for next day confirmed discharges; 4. Continue planning for return of rehab on April 1, 2025; 5. Focus on increasing number of discharges to reach target of 64 discharges through H2H program; 6. Monitor Endo and EUS volumes, expansion to two days per week starting mid- February	R1) Weekend discharges; M1 & 2) Implementation of new discharge rounds and identify discharges < 48hours
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. Completed planning for ketamine administration; 3. Updated external CMH website for MH services	1. Recruitment of CEF to support ketamine administration; 2. Develop process for short admissions for patients with substance use disorder in collaboration with ED & Medicine; 3. Complete an environmental scan of out of region schedule 1 facilities surge needs and how we can support	R1) Ketamine administration requires recruitment of CEF position; M1) Leverage professional practice to provide support in the interim; R2) Out of region facilities decline accepting their patients back; M2) Develop and sign a MOU to ensure patients return to sending facility and leverage PHRS process for repats.
Ensure effective in-year PCOP monitoring for Surgery	1. Reviewed Q3 performance to ensure PCOP was maximized; 2. Using the surgical efficiency to review upcoming blocks & plan accordingly to improve variance (ongoing); 3. Re-allocated additional GYNE blocks to other services (ongoing); 4. Created standardized work for OR roles based on turnaround time trial; 5. Analyzed and created PACU simulation analysis to identify flows in patient flow; 6. Finalize project with University of Waterloo on OR optimization of master OR schedule using AI (ongoing)	1. Continue to monitor block utilization using the surgical efficiency dashboard and ensure OR bookings are complete; 2. Continue to work on standardized work for roles within the OR to sustain turnaround time work; 3. Work with Decision Support on the PACU simulation dashboard and analyze workflow; 4. Continue to collaborate with University of Waterloo on OR optimization project; 5. Finalize OR GRID for 25-26 to maximize PCOP; 6. Analyze Acute Care Surgery (ACS) time	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; R3) Recruitment of Inpatient Surgery Manager; M5) Continue recruitment process, interim manager in place
Execute PCOP planning & forecasting for PCOP & volume prediction for 25/26 planning cycle	1. Engaged with key clinical teams for the discussion around PCOP forecasting and build out PCOP strategy as part of budget review cycle; 2. Engaged surgical leadership to establish projected 25/26 surgical grid	1. Refresh 25/26 PCOP forecast to reflect new PCOP methodology for 25/26 using 22/23 as the revised PCOP base as per announcement by ministry PCOP branch; 2. Finalize 25/26 budget using new PCOP methodology; 3. Update multi-year PCOP forecast for 26/27 and 27/28 to align to remaining eligible PCOP	R1) Status of PHA4 agreements related to TriCity Endo and Clearvision are unknown, waiting for ministry guidance; M1) Build agreements into forecast
Quality Based Procedure Volumes & Revenue Achieved	1. Continued to monitor QBP volumes against targets to ensure QBP targets are met 2. Established protocols to review and monitor Endo time	1. Continue to monitor QBP volumes in systemic therapy and Endo; 2.Develop of dashboard to monitor utilization of Endo blocks, policy regarding cancellation of block if not fully utilized, 3. Review of EUS physician HHR to allow for 2 days per week	R1) Endo third room EUS volumes; M1) GI Endo and General Surgical Leads to continue to follow up with physicians

**Please note Actual QBP Revenue will be capped at the Funding Available for each category (Total Funding=$27.2M: $19.8M for OH QBPs; $2.9M for Cancer Surgery QBPs; $2.0M for GI Endo QBP, $2.5M for Systemic Treatment QBP)*

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	100	
% on track with transition planning activities	100%	100	100	100	

Action Plan- Q3

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Deliver CRP handover on time	1. Completed biweekly with Stantec, Perini, EllisDon to discuss risks and mitigation strategies in order to hit substantial completion 2. In Q3 CMH received substantial Completion of the CPR, including occupancy of the Wing B tower, level 2, 3, & 4	1. Received project completions of the CRP and occupacny of the remaining areas on Level 1	No risks to report.
Successful transition of planning and Space to CMH Team	1. Completed 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 2. Complete reviews and walkthroughs of existing departments, prior to moves, indentifying possible problematic issues for during the moves 3. Sucessfull moved the Endoscopy adn Day Srugery programes inot their final spaces.	1. Successfully executed transition plan to occupy renovated space; 2. All units moved to new spaces	No risks to report.
Successful transitions of warranty / deficiencies documentation to facilities	1. Completed weekly meetings with EllisDon, CRP, and Facilities to discuss warranty	1. Establish process to manage, monitor and act on ongoing deficiencies	No risks to report.
Updated Functional Program	1. Updated bed maps to align to new proposed Functional Plan; 2. Incorporated bed map into 25/26 budgeting; 3. Volume analysis completed and will be updated in Q4 to finalize Functional Plan	1. Finalize Functional Plan by March 31, 2025, in collaboration with DS, Finance, CRP, Agnew- Peckham and Clinical Services Growth Plan	No risks to report.
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)

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	100	
% on Track with workforce management ERP implementation	100%	100	100	100	

Action Plan- Q3

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Successful implementation of Workforce Planning (WFP) Q1 FY25/26	1. Completed requirements gathering stage of project; 2. AndGo solution project kicked-off; 3. WFP project continues to be aligned with Organizational Scheduling Office (OSO) leadership and resources; 4. Go-live planning process kicked off with common go-live date set	1. Completion of Build stage of project; 2. Kick-off and completion of progressive testing cycles, moving from unit/system testing to full parallel tests; 3. Roll-out of training programs for staff, management, and super-users; 4. Installation of terminals for signing in/out and employee self-service	R1) Findings of testing activities and impact of findings; M1) The testing activity is a required step and any impact to scope, schedule, or budget of the project will be noted as a separate risk/issue; R2) Multiple critical path items required to come together for overall project success (i.e.. terminals, AndGo, scheduling); M2) CMH Project Manager has gathered feedback across multiple programs and workstreams to gain visibility into work. Accountability for workstreams are being clarified
Implementation of a new Health Information System (HIS)	1. Initial drafting and review of contractual documents by CMH and Grand River Hospital (GRH); 2. External legal review of relevant documents, including GRH and St. Mary's General Hospital (SMGH) contracts; 3. Continued work around internal workflow mapping and order set review to prepare CMH for standardization and changes; 4. Approved motions from CMH Committees and Board around process and budget	1. Ongoing negotiations with Oracle Health regarding order document (Sales Order) and any impacted changes to underlying GRH business agreement; 2. Further development of MOU or other governing documents formalizing obligations and accountabilities of CMH and GRH; 3. On-going current state and order set reviews by CMH Informatics and Pharmacy departments	R1) Delays in negotiation related to terms and conditions of agreement; M1) CMH, GRH, and SMGH leadership have agreed to a negotiation strategy including appropriate escalation paths

Increase Joy in Work

Human Resources Plan

Click Here to Input Action Plans

Executive Sponsor(s): Patrick Gaskin, Mari Iromoto

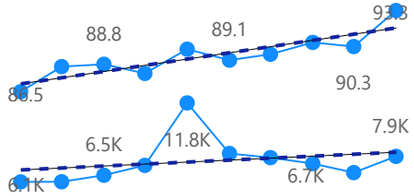
Physician Liaison(s):

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	90.3	
OT hours per quarter	5552	18.7K	27.2K	22.0K	

Monthly Trend



Action Plan- Q3

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Focus on strategies to enhance staff retention (People Development)	1. Incorporated a standardized PM/QI/Change Management framework to support major corporate projects such as Project Quantum including workforce planning, Organizational Scheduling Office (OSO), and other key initiatives; 2. Continued evaluation of Reward and Recognition strategies, with updates; 3. Ongoing monitoring of 600 VBCs from Q1 to Q4	1. Create and adopt additional change management templates to ensure project sustainability within the Project Management Toolkit. Evaluate effectiveness of change management tools currently being used for Project Quantum; 2. Plan for PM/ Change Management education sessions for 25/26; 3. Implement the Leads Program to support retention and career development in Q4; 4. Conduct 600 VBCs from Q1 to Q4; 5. Improve and update the education reimbursement policy, with recommendations for enhancement to be presented in Q4; 6. Develop the Leader Learning Series and identify key participants by HR in Q4.	R1) Capacity for leaders and vacancies may impact VBC numbers; M1) adjust VBC targets as needed to maintain progress
Enhance HR Systems and Data to Support Staffing Decision Making (Workforce and ICIMS)	1. Established an optimization plan for existing HR/Staffing tools; 2. Continued to implement a workforce management system, including timekeeping, scheduling, absence management, and analytics	1. Create an optimization plan for existing HR and staffing tools; 2. Identify data and information needs to support staffing decision-making and monitor HR processes; 3. Support the implementation of Project Quantum; 4. Introduce an additional module in ICIMS for candidate testing; 5. Enhance the Indeed job posting package	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. Continuously evaluated and gathered feedback on reward and recognition programs, with the refreshed iCCAIR and Career Achievement program relaunching in Q4; 2. Evaluated the process and organizational standards for unit codes of conduct in Q3.	1. Modify the reward and recognition program for 2024/2025 as needed; 2. Research verbal de-escalation support education and offer it to targeted non-patient-facing roles, in collaboration with CMHA leadership for de-escalation training; 3. Participate in an assessment session to evaluate CMH for Excellence Canada's Healthy Workplace Standard, assess how CMH would rank, and identify next steps and potential gaps; 4. Develop a refreshed attendance support program, leveraging UKG platform	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. Continued collaboration to improve active staffing for Medicine, ED and ICU. Q1 to Q3 improved percent on track for staffing from 86.5% in April to 93.3%; 2. Improved student conversion practices; 3. Evaluated the impact of various strategies, including Project Search, which was implemented and launched; 4 Stabilized turnover and reduced the number of vacancies to below 80; 5. Completed the build of the Leader Toolkit for recruitment, now available on SharePoint.	1. Continue to work towards achieving staffing targets; 2. Receive communication on the status of the application for Canada's Top 100 Employers by Q4 and determine how to communicate the results organization-wide and through social media; 3. Review leadership talent process in Q4 and implement actions resulting from the competency assessment conducted in Q3; 4. Update the career page on CMHnet.	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; R3) Delay in onboarding process, no dedicated onboarding support staff; M3) Reallocate existing resources and standardize procedures to ensure a more efficient and consistent workflow

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	52	78	37	

Action Plan- Q3

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Create Safe Spaces	1. Fall Leadership Camp on Oct 17th focused on indigenous blanket teachings and exercises; Indigenous Council meeting held on Oct 31; Indigenous Drum Circle on Nov 7; 2. Community partnerships continue to be developed with CMH participation in key collaborative sessions including: Nov 14/15 Forward Together Conference; Dec 5 DEI Health Equity Exchange	1. Next Diversity Council scheduled for Jan 17th with goal to: Solicit input on Inclusion Lead posting, approve 2025 Diversity Calendar for CMH, share ideas and strategies to achieve Rainbow Health training targets; Inclusion Lead role to be posted in Q4; 2. Begin to identify key organizations to support building a network of partners - partnership meeting with National Council of Canadian Muslims in January 2025	No risks to report.
Enhance collection of sociodemographic data collection	1. Participated in Regional Working Group Meetings to understand approach across the region (ongoing); 2. CMH strategy developed by the CMH working group, which was informed by regional working group and Ontario Health guidance documents	1. Beginning to execute strategy to collect data; 2. Incorporate data into our DEI dashboards; 3. Begin to develop strategy to enhance awareness and sharing of DEI dashboards; 4. Establish 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. Series of staff and medical professionals profiled for Islamic Heritage Month as part of Islamic History Month	1. Planning underway for Lunar New Year and Black History Month. Voices of CMH will continue to profile our diverse staff	No risks to report.
Rollout Education & Training	1. Assigned Rainbow Health training to a total of 324 staff, prioritizing leaders, working group members, ED, MH, HR, and Central Registration Staff; 2. Ensured that 97% of leaders completed the Rainbow Health Course by the end of Q3. 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 eLearning; 5. Assigned the Rainbow Health Foundations Course to all board members; 6. Central Registration staff fully completed training; 7. Extracted B2L data to data warehouse; 8. Monthly compliance reporting to departmental leaders who have course assigned to their staff; 9. Presented to Diversity Council current status, actions taken, survey results, and mitigation for hesitation to complete. Sought input from group.	1. Develop draft CMH specific 2SLGBTQI+ for B2L by Q4 (in progress); 2. Assign Rainbow Health course to all CMH staff with removal of course once we meet our 500 license limit; 3. Create enhanced tracking and dashboard for leaders; 4. Offer incentives in the form of a chance to win high value gift cards for those that complete the training.	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; M4) Offering incentives to those that complete in the form of a chance to win a high value gift card will incentivize staff; M5) Assigning the training to all CMH staff will cast a wider net with a greater chance of success; R4)CMH Specific 2SLGBTQI+ training for B2L not complete by Q4 due to absence of a DEI Lead; M6) Continue utilizing the Best Practice Committee working group to develop learning; M7) Seek input from community experts

Reimagine Community Health

Emergency Preparedness Plan

Click Here to Input Action Plans

Executive Sponsor(s):	Physician Liaison(s):	Director Lead(s):	Project Manager(s):
Mari Iromoto		Liane Barefoot	TBD

In Year Measures of Success

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

Action Plan- Q3

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

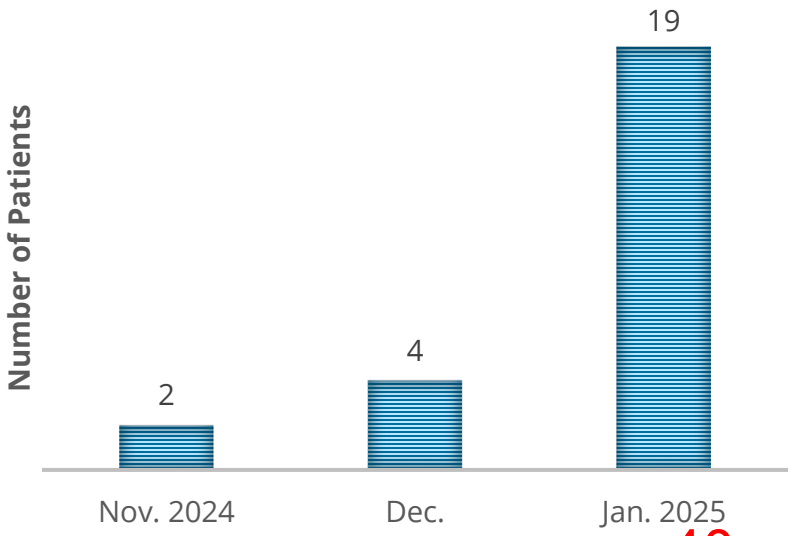
CMH@Home

Description and Impact:

CMH@Home has now been successfully implemented, supporting patients at risk of prolonged hospital stays or ALC designation. Aligned with Ontario Health's Hospital to Home (H2H) standards, the program provides up to 16 weeks of home-based services, including nursing, personal support, physiotherapy, occupational therapy, and social work, helping to reduce Emergency Department visits, hospital admissions, length of stay, and ALC days. A dedicated patient navigator identifies eligible patients in the Emergency Department and inpatient units, ensuring smooth transitions to home with Bayshore HealthCare, our community partner.

The program strengthens continuity of care through personalized discharge plans, timely follow-ups, and coordination with primary care providers. Early results show positive patient feedback and improved transition efficiency, reinforcing its impact. We continue to monitor key performance indicators—including service timeliness, readmission rates, and patient satisfaction—to refine and enhance effectiveness. While not designed for individuals with significant behavioural challenges, precarious housing, or those awaiting long-term care, CMH@Home ensures eligible patients receive high-quality care at home, supporting Ontario Health's modernization goals.

Since initiation, total of **25 patients** are active in the program



Elevate Partnerships in Care

Success and Wins

Description and Impact:

Over two weekends in January, CMH proudly celebrated the opening of its newest patient care wing, marking a historic milestone for health care in Cambridge and North Dumfries. This state-of-the-art expansion enhances patient care, modernizes hospital services, and reflects years of dedication, planning, and investment in the community's well-being.

On January 10, CMH held a ribbon-cutting ceremony, bringing together government officials, municipal and health care leaders, staff, volunteers, and community members to mark this momentous occasion. The following day, more than 1,000 visitors attended the community open house, getting an exclusive look at the new Wing B facility, expanded care areas, and an impressive Innovation Fair showcasing 23 staff-led projects that are already making a difference in patient care.

Thanks to months of careful planning, teamwork, and dedication, Medicine B, Inpatient Surgery, Transitional Care Unit, Laboratory Patient Services, Fracture Clinic, Diagnostic Imaging – Mammography, BMD, Ultrasound and Endoscopy all moved into their new homes smoothly and on schedule. The success of these moves reflects the extraordinary commitment of staff and volunteers to delivering the best possible care to patients.

With this expansion complete, Cambridge Memorial Hospital is well-positioned to serve the community with enhanced care, advanced technology, and a renewed focus on innovation for years

Increase Joy in Work

Success and Wins

Description and Impact:

The Organizational Scheduling Office (OSO) announced the successful expansion of its operations with the implementation of the short call desk. This change will extend the OSO's hours of operation from 6 a.m. to 10 p.m., significantly enhancing scheduling coverage across the organization.

To date, the OSO has successfully integrated over 85% of departments into the new system. The team has also seen great success in engaging with staff through huddles and the introduction of a personalized "meet your scheduler" approach, fostering a deeper connection with the scheduling process.

In addition, the OSO is actively working to standardize practices across all departments to ensure a consistent scheduling experience for all staff. This standardization is a key step in preparing for the upcoming transition to UKG, as we align role responsibilities with the processes that will be implemented within the UKG system. The initiative will have a positive impact to overtime, staff experience and will ensure fewer vacant shifts, scheduling errors, daily scheduling shortages.

AGENDA

Reimagine Community Health

PROJECT QUANTUM
Make the leap+

WORKFORCE PLANNING

Success and Wins

Description and Impact:

The Workforce Planning (WFP) Project Team has successfully reached the first major milestones in implementing the UKG Pro Workforce Management software. We have completed the Requirements Phase, and the majority of the system has been built to align with CMH's rules, guidelines, and specifications. As we move forward, we are entering the most critical and intensive phase—comprehensive system testing. This phase ensures that UKG's configuration meets our compliance requirements, resolves potential issues before Go-Live, integrates with our payroll system, and delivers a seamless user experience for our employees.

Additionally, we have received, configured, and strategically mapped the placement of 21 biometric time clock terminals. These terminals will allow staff to clock in and out efficiently and we will gradually incorporate additional functionalities.

Lastly, we are committed to driving optimal user adoption through a thoughtful and engaging approach. This includes leveraging innovative communication tools, incentives, branding, positive messaging, and leader and employee feedback forums. Our goal is to implement a robust training plan that thoroughly prepares users before launch and provides ongoing support for both current and future employees.

BRIEFING NOTE

Date: February 13, 2025
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 People and Strategy

Attachments/Related Documents: Appendix A – Quality Monitoring Scorecard

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 ten (10) 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 which one's have Quality Committee Oversight are:

1) Conservable days rate (Quality Committee Oversights)
2) Overtime hours
3) Sick hours
4) ALC Throughput (Quality Committee Oversights)
5) Percentage ALC Closed Days (Quality Committee Oversights)
6) ED Length of stay for Admitted patients (90% spent less, in hours) (Quality Committee Oversights)

7) ED Length of Stay, Non-Admitted Complex (CTAS 1-3) (90% spent less, in hours) (Quality Committee Oversights)
8) ED Wait Time for Inpatient Bed (90% spent less, in hours) (Quality Committee Oversights)
9) ED Wait Time for Physician Initial Assessment (90% spent less, in hours) (Quality Committee Oversights)
10) Obstetric Trauma (with Instrument) (Quality Committee Oversights)

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

Seven (7) of the ten (10) 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 ten (10) 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 Obstetric Trauma indicator is being reviewed at program Quality and Operations councils for corrective action and is also having a review of coded data by the Health Information Management Team.

Below is a summary of the ten (10) quality monitoring metrics that are currently at a "**red**" status with three or more periods outside of the target threshold.

Efficient:

1) **Conservable Bed Days** 
This indicator measures the total patient days over and above the benchmark length of stay as a percentage of the total acute patient days for medical discharges. Lower

means that our acute length of stay is closer to the benchmark length of stay. YTD Dec performance is 35.21 vs target of 30.

2) **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 3600 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.

3) **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 3100 sick hours/pay period while the target is 2090 hours/pay period.

Integrated & Equitable:

4) **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 0.76, meaning we are adding more cases than discharging.

5) Percentage ALC Closed Cases
This indicator monitors our ALC patient days for discharged cases vs. our total patient days. A lower rate means that fewer of our total patient days can be attributed to ALC patients meaning that more of our bed days are being used for acute vs. ALC. Our target is 20, current YTD performance is 26.

Safe, Effective & Accessible:

6) **ED Length of Stay for Admitted patients (90% spent less, in hours)**
This indicator measures the wait-time from triage to the time an admitted patient arrives to an inpatient bed. A shorter time means that patients are more efficiently and effectively flowing from ED to an IP bed. Our YTD Dec performance is 50.9 hours, while our target is 33 hours or less.

7) **ED Wait Time for Inpatient Bed (90% spent less, in hours)**
This indicator measures the time elapsed between the decision to admit a patient to when the patient arrives to an inpatient bed. A shorter time means that patients are more efficiently and effectively flowing from ED to an IP bed. Our YTD Dec performance is 41.4 hours, while our target is 25 hours or less.

8) **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 Dec), 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.

9) **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 Dec), 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.

10) **Obstetric Trauma (with Instrument)** 
This indicator monitors obstetrics trauma with instrument and is calculated as the rate per 100 instrument-assisted deliveries. Lower is better, it means that there were fewer lacerations that were third degree or greater in severity. YTD Nov our performance is 20.7% while our target is <14.4%.

Appendix A includes the indicator details for the indicators trending at a “red” status along with Ambulance of load which trended to a yellow status as well as our PCOP and QBP trends.

Next steps

- The Quality Monitoring Scorecard will continue to be included on a monthly basis
- Indicators at a “red’ status are being reviewed with specific clinical teams at monthly program Quality and Operations Councils.

Quality Monitoring Scorecard, 24/25

Status (Last 3 Periods)

Meeting Target	6	21%
Within 10% of Target	13	45%
Exceeding Target	10	34%

Quality Dimension	Indicator	Unit of Measure	Target	YTD	Status (Last 3 periods)	Period
Efficient	Active Staffing Target Achieved (ED/MED/ICU)	%	100.00	93.26	▲	Jan-25
	Conservable Days Rate	%	30.00	35.21	◆	Dec-24
	Overtime Hours - Average per pay period	hours	850.00	3,609.61	◆	Jan-25
	Sick Hours - Average per pay period	hours	2,090.00	3,125.68	◆	Jan-25
Integrated & Equitable	ALC Throughput	Ratio	1.00	0.76	◆	Dec-24
	Percent ALC Days (closed cases)	%	20.00	26.42	◆	Dec-24
	Repeat emergency department visits for Mental Health Care	Patients	11.00	10.44	▲	Dec-24
Patient & People Focused	Organization Wide Vacancy Rate	%	12.00	5.32	●	Jan-25
Safe, Effective & Accessible	30 Day CHF Readmission Rate	%	14.00	13.09	▲	Nov-24
	30 Day COPD Readmission Rate	%	15.50	12.35	▲	Nov-24
	30 Day In-Hospital Mortality Following Major Surgery	%	1.90	1.30	▲	Nov-24
	30 Day Overall Readmission Rate	%	8.80	6.51	●	Nov-24
	Ambulance Offload Time (90% Spent Less, in Minutes)	minutes	30.00	69.00	▲	Dec-24
	ED Length of Stay for Admitted Patients (90% Spent Less, in Hours)	hours	33.00	50.90	◆	Dec-24
	ED Length of Stay for Non-Admitted Complex Patients (90% Spent Less, in Hours)	hours	8.00	9.70	◆	Dec-24
	ED Wait Time for Inpatient Bed (90% Spent Less, in Hours)	hours	25.00	41.40	◆	Dec-24
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours)	hours	4.00	7.60	◆	Dec-24
	Hip Fracture Surgery Within 48 Hours	%	83.10	92.98	●	Nov-24
	Hospital Standardized Mortality Ratio (HSMR)	Ratio	100.00	101.46	▲	Nov-24
	In-Hospital Sepsis	per 1000 D/C	3.20	3.10	▲	Nov-24
	Long Waiters Waiting For All Surgical Procedures	%	20.00	22.26	▲	Dec-24
	Low-Risk Caesarean Sections	%	17.30	23.81	▲	Dec-24
	Medication Reconciliation at Admit	%	95.00	97.00	▲	Dec-24
	Medication Reconciliation at Discharge	%	95.00	96.00	●	Dec-24
	Obstetric Trauma (With Instrument)	%	14.40	20.77	◆	Nov-24
	Patient Safety Event - Falls with Harm	per 1000 PD	0.00	0.08	▲	Jan-25
	Patient Safety Event - Medication Events with Harm	per 1000 PD	0.00	0.02	●	Jan-25
	Revenue - Achieve budgeted PCOP growth (IRM)	$	11,011,716.00	12,755,018.00	▲	Dec-24
	Revenue - Achieve Quality Based Procedure Funding (IRM)	$	18,660,132.00	21,050,481.49	●	Dec-24

Conservable Bed Days

Conservable Beds Dashboard

Description

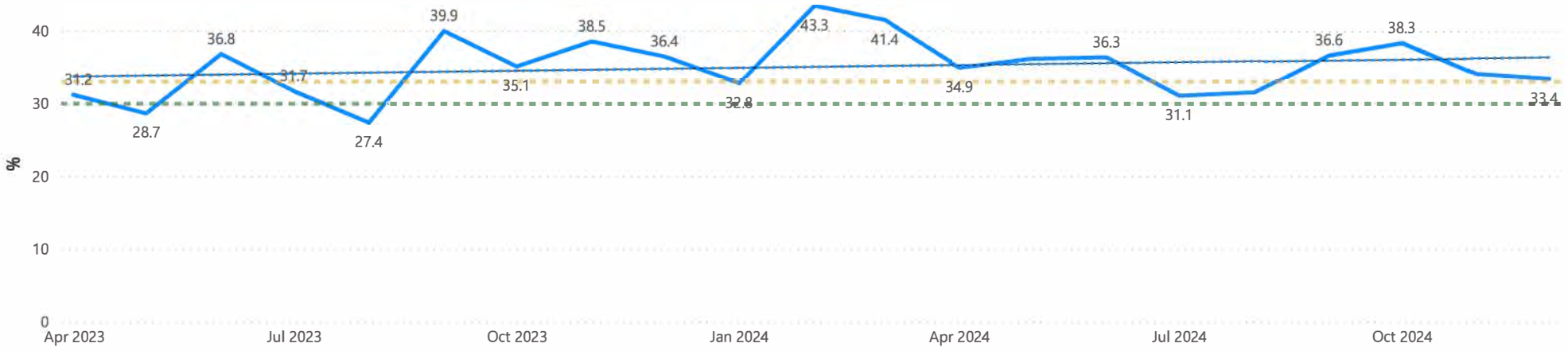
The total patient days over the benchmark LOS (conservable days) as a percentage of the total acute patient days for patients discharged from MEDA/MEDB. The benchmark LOS is determined by case mix group, age, and resource intensity level of a discharge.

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
30.0	36.5	34.7	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	31.2	28.7	36.8	31.7	27.4	39.9	35.1	38.5	36.4	32.8	43.3	41.4
2024/2025	34.9	36.1	36.3	31.1	31.5	36.6	38.3	34.0	33.4			

Alternate Level of Care

ALC Dashboard

ALC Throughput

Description

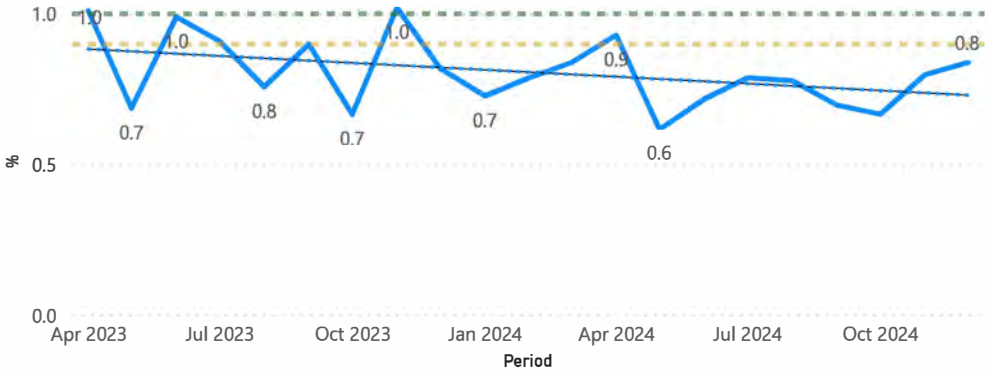
ALC Throughput is the ratio of the number of discharged ALC cases to the number of newly added and redesignated ALC cases

Data Source

WTIS

Target	Previous YE	YTD	Status (Last 3 periods)
1.0	0.8	0.8	

ALC Throughput Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	1.0	0.7	1.0	0.9	0.8	0.9	0.7	1.0	0.8	0.7	0.8	0.8
2024/2025	0.9	0.6	0.7	0.8	0.8	0.7	0.7	0.8	0.8			

ALC Rate

Description

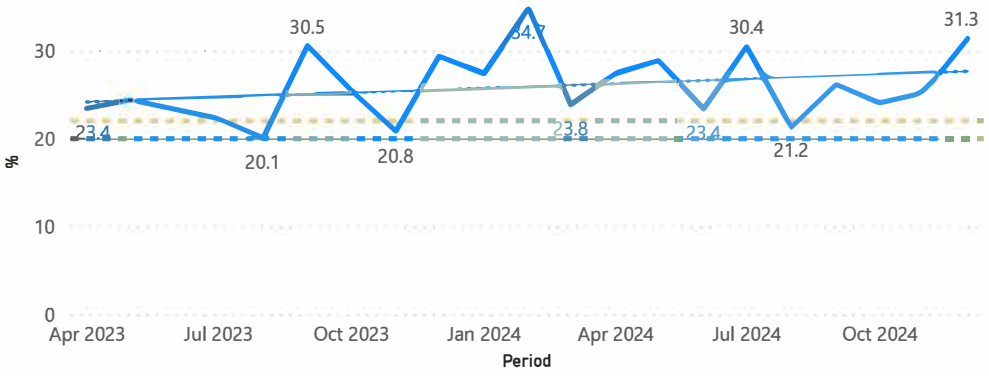
The proportion of total days that a patient was assigned to the alternate level of care (ALC) service. ALC patients are those who no longer need acute care services but continue to occupy an acute care bed or use acute care services.

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
20.0	25.4	26.4	

ALC Rate Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	23.4	24.4	23.3	22.2	20.1	30.5	25.4	20.8	29.3	27.3	34.7	23.8
2024/2025	27.4	28.8	23.4	30.4	21.2	26.1	24.0	25.2	31.3			

Ambulance Offload Time, minutes, 90th percentile

Description

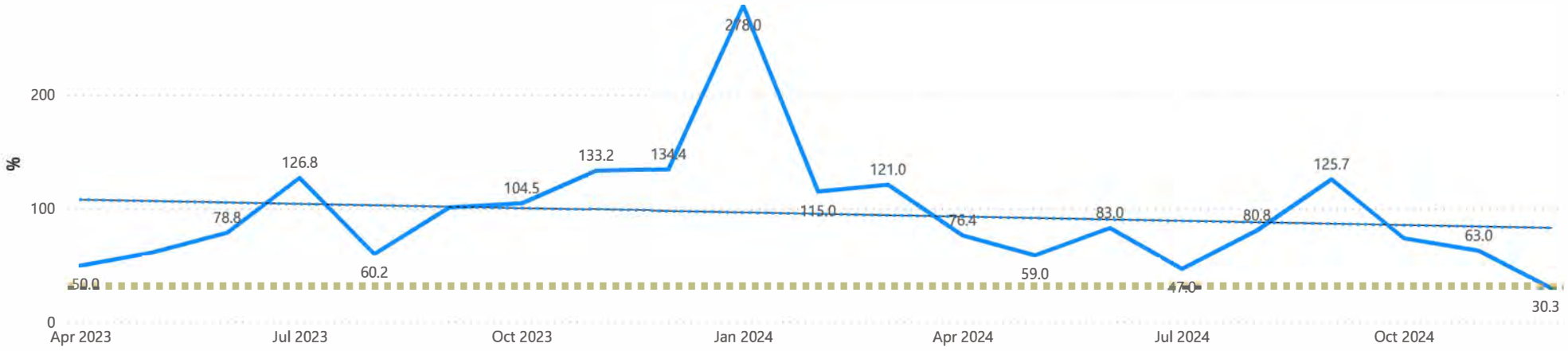
The total time, in minutes, in which 9 out of 10 patients who arrived via ambulance waited for transfer of care process to be completed, calculated as the total time elapsed from ambulance arrival to completion of transfer of care process.

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
30.0	115.0	69.0	▲

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	50.0	61.6	78.8	126.8	60.2	101.0	104.5	133.2	134.4	278.0	115.0	121.0
2024/2025	76.4	59.0	83.0	47.0	80.8	125.7	74.0	63.0	30.3			

ED LOS for Admitted Patients, hours, 90th percentile

Total ED LOS for Admitted Patients

Description

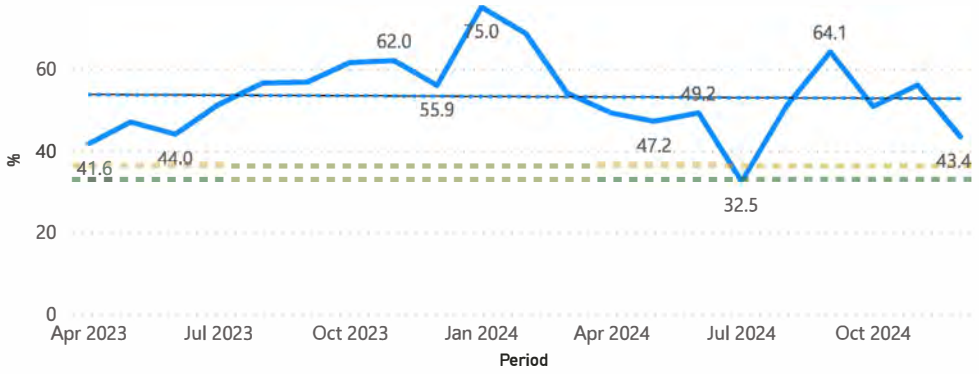
The total time, in hours, that 9 out of 10 admitted patients spent in the emergency department (ED), calculated as the total time elapsed from triage to when the patient left the ED

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
33.0	58.1	50.9	

ED LOS for Admitted Patients, Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	41.6	47.0	44.0	51.2	56.5	56.7	61.5	62.0	55.9	75.0	68.6	54.0
2024/2025	49.2	47.2	49.2	32.5	50.7	64.1	50.8	56.0	43.4			

Time to Inpatient Bed

Description

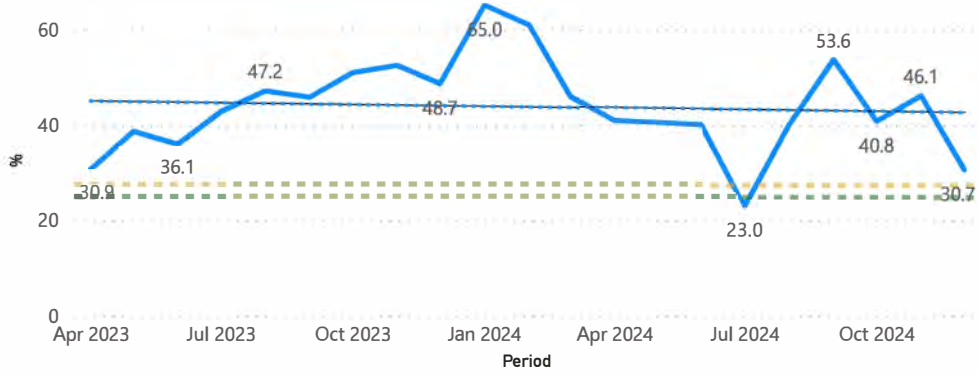
The total time, in hours, that 9 out of 10 admitted patients spent waiting in the emergency department (ED) for a bed, calculated as the total time elapsed from disposition decision to when the patient left the ED

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
25.0	48.5	41.4	

Time to Inpatient Bed, Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	30.9	38.8	36.1	42.9	47.2	45.9	51.0	52.5	48.7	65.0	60.9	46.0
2024/2025	40.9	40.5	40.0	23.0	40.0	53.6	40.8	46.1	30.7			

ED LOS for Non-Admitted, Complex Patients, hours, 90th percentile

Description

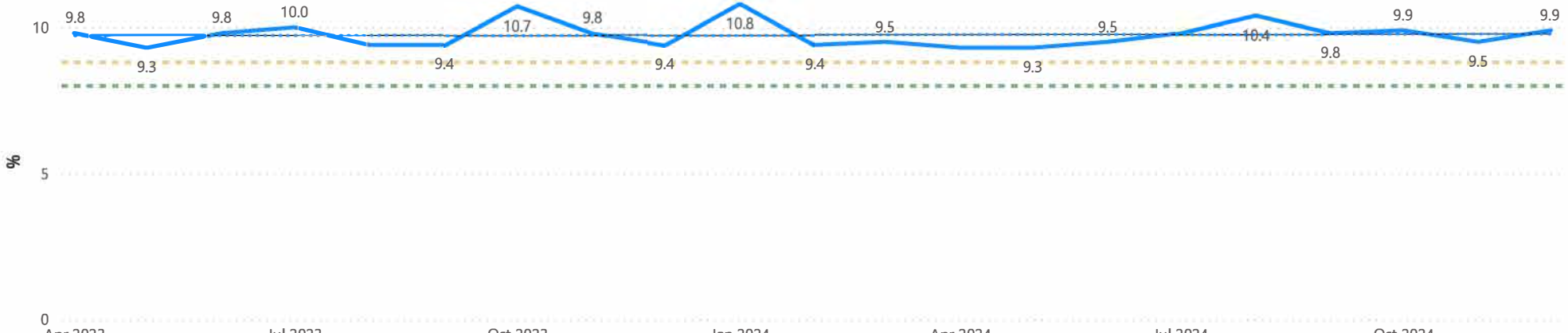
The total time, in hours, that 9 out of 10 high-urgency patients (CTAS 1-3) who were not admitted spent in the emergency department (ED), calculated as the total time elapsed from triage to when the patient left the ED

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
8.0	9.8	9.7	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	9.8	9.3	9.8	10.0	9.4	9.4	10.7	9.8	9.4	10.8	9.4	9.5
2024/2025	9.3	9.3	9.5	9.8	10.4	9.8	9.9	9.5	9.9			

Provider Initial Assessment Time, hours, 90th percentile

Description

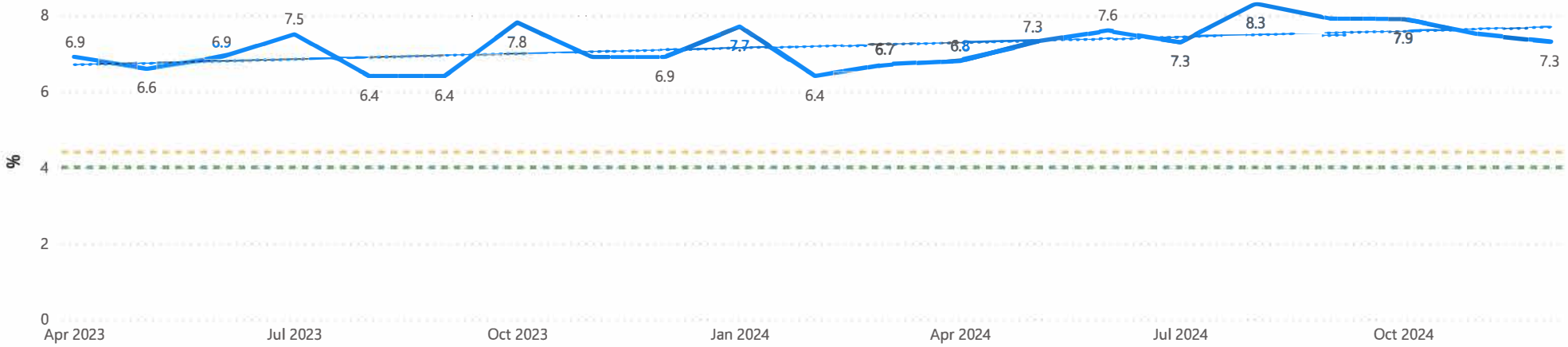
The total time, in hours, that 9 out of 10 patients spent waiting for their first assessment by a doctor or nurse practitioner in the emergency department (ED), calculated as the total time elapsed from triage to time of initial assessment

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
4.0	6.9	7.6	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	6.9	6.6	6.9	7.5	6.4	6.4	7.8	6.9	6.9	7.7	6.4	6.7
2024/2025	6.8	7.3	7.6	7.3	8.3	7.9	7.9	7.5	7.3			

Obstetric Trauma (with Instrument)

Description

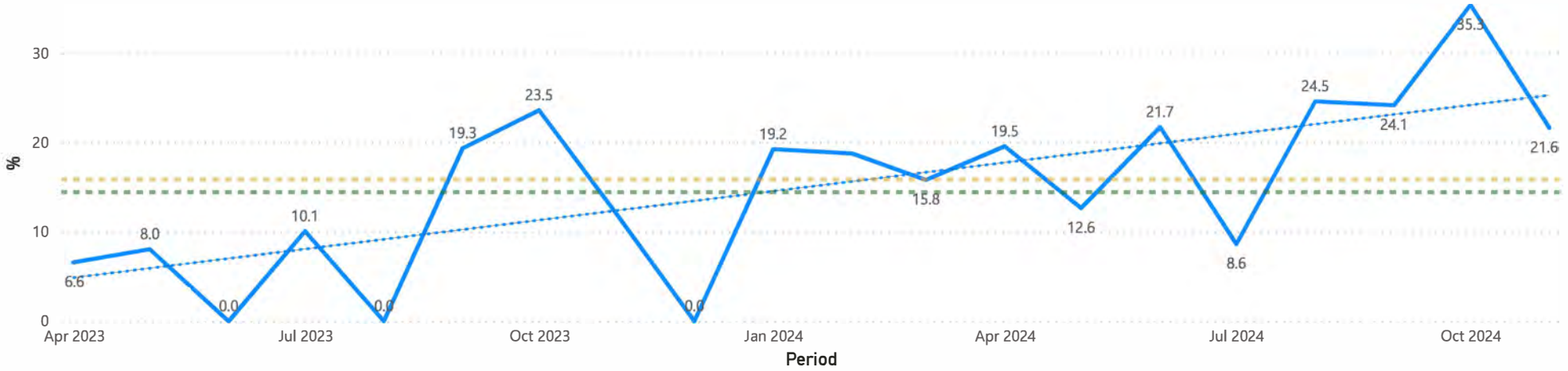
Risk-adjusted rate of obstetric trauma (lacerations that are third degree or greater in severity) for instrument-assisted vaginal deliveries (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
14.4	10.9	20.8	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	6.6	8.0	0.0	10.1	0.0	19.3	23.5	11.7	0.0	19.2	18.7	15.8
2024/2025	19.5	12.6	21.7	8.6	24.5	24.1	35.3	21.6				

Long Waiters Waiting for Surgical Procedures

Description

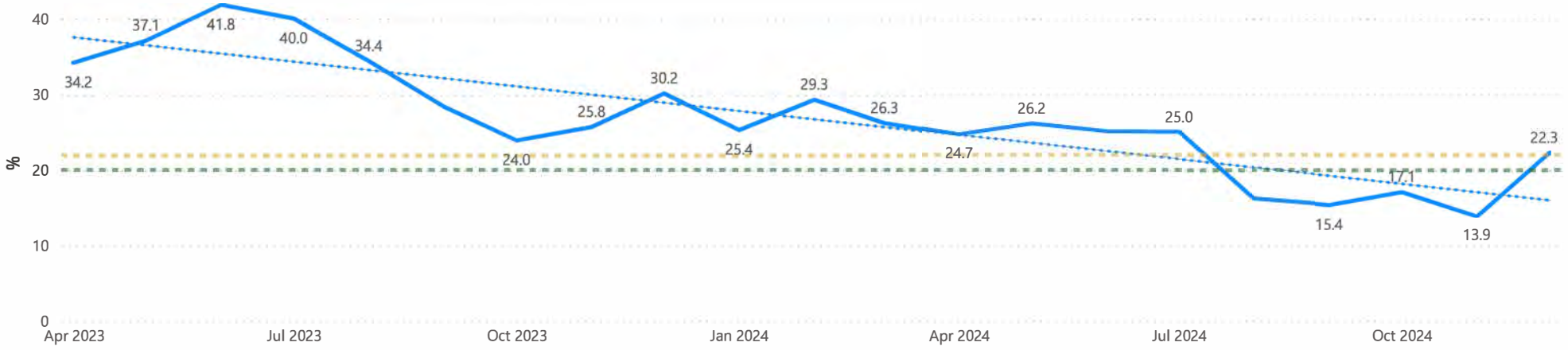
This indicator measures the percentage of patients waiting for a surgical procedure whose wait has exceeded the associated Priority Level Access Target (excludes DART days)

Data Source

WTIS

Target	Previous YE	YTD	Status (Last 3 periods)
20.0	26.3	22.3	▲

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	34.2	37.1	41.8	40.0	34.4	28.4	24.0	25.8	30.2	25.4	29.3	26.3
2024/2025	24.7	26.2	25.1	25.0	16.2	15.4	17.1	13.9	22.3			

Post-Construction Operating Plan (PCOP) Revenue

Description

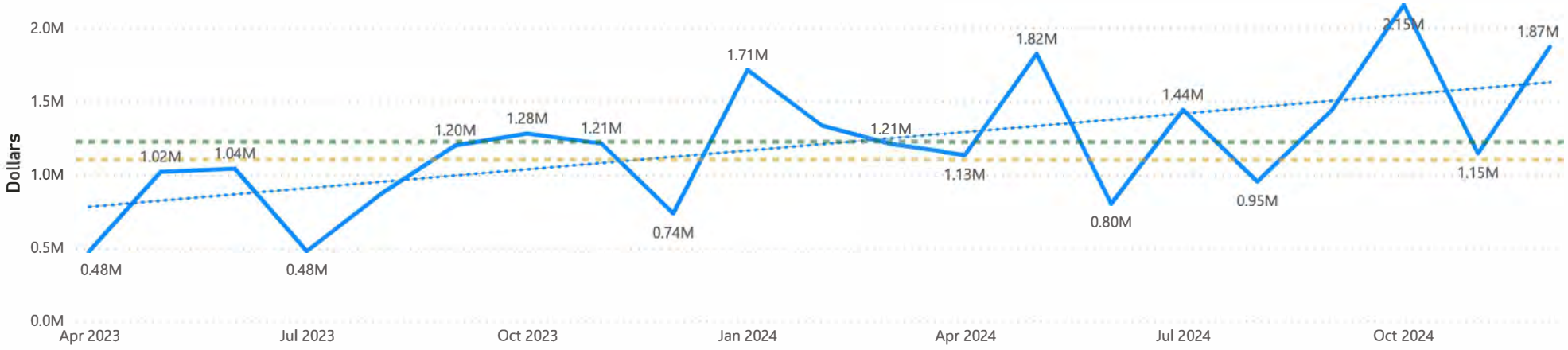
The revenue achieved through all PCOP service areas, including Acute Inpatient, ED, Day Surgery, Mental Health Day Hospital, Mental Health Inpatient, ECT, and Ambulatory Clinics (Mental Health, Paediatric, Fracture, Surgery)

Data Source

Discharge Abstract Database, National Ambulatory Care Reporting System, Meditech

Monthly Target	YTD Target	YTD Total	Status (Last 3 periods)
1.2M	11.0M	12.8M	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	476,064	1,018,286	1,039,991	479,434	868,333	1,197,393	1,277,651	1,210,179	736,381	1,709,051	1,332,977	1,206,082
2024/2025	1,133,139	1,819,579	803,252	1,440,756	954,081	1,438,839	2,151,909	1,145,043	1,868,420			

Quality Based Procedure (QBP) Revenue

QBP Dashboard

Description

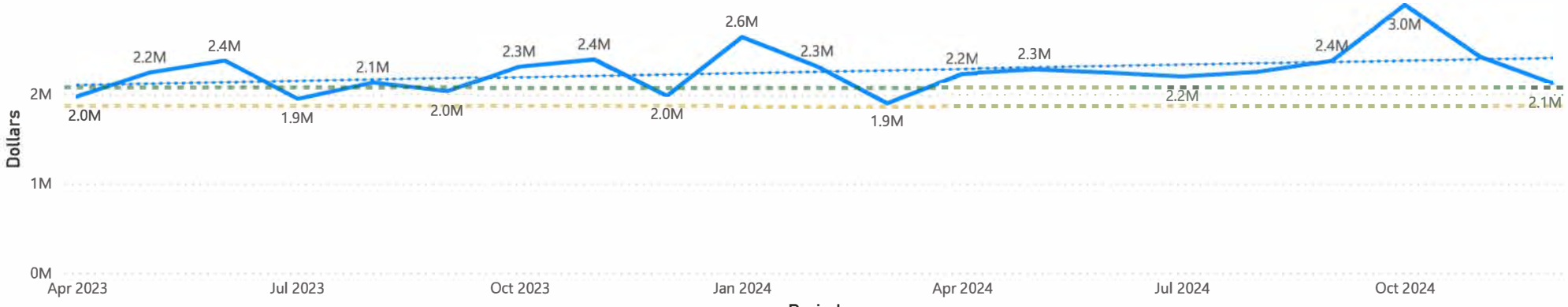
The revenue achieved through all Quality Based Procedures, including Urgent QBPs & Non-Urgent Surgical QBPs (OH), Systemic Treatment (CCO), GI Endoscopy (CCO), and Cancer Surgery (CCO).

Data Source

Discharge Abstract Database, National Ambulatory Care Reporting System

Monthly Target	YTD Target	YTD Total	Status (Last 3 periods)
2.1M	18.7M	21.1M	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	1,972,527	2,235,688	2,367,270	1,946,141	2,126,125	2,028,233	2,306,078	2,385,196	1,984,618	2,632,629	2,309,502	1,903,172
2024/2025	2,226,714	2,271,709	2,233,498	2,190,537	2,243,537	2,367,858	2,983,775	2,413,114	2,119,739			

**Please note Actual QBP Revenue will be capped at the Funding Available for each category (Total Funding=$27.2M: $19.8M for OH QBPs; $2.9M for Cancer Surgery QBPs; $2.0M for GI Endo QBP, $2.5M for Systemic Treatment QBP)*

CMH President & CEO Report
March 2025

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

CMH's permanent wayfinding in place

- With the completion of our Capital Redevelopment Project (CRP) and recent moves into the Wing B facility, the temporary numbered wayfinding system has come to an end. The numbers and removable stickers us well, allowing us to quickly change paths during a disruption.
- With CMH's permanent wayfinding in place, it aligns with industry standards and other Healthcare organizations.
- This redesign actually started with the 2017 wing, level and room renumbering project and marked the shift in focus to the physical location of programs (wing and level). This change made level 1 the ground level instead of 2, which is more intuitive for visitors.
- In all the system is intended to be patient-focused, providing visible directions in public spaces, and not in back-of-house areas.
- It also complements the architectural intent to locate most services a patient might access around the main courtyard: Patient Registration, Surgery, Patient Laboratory, Diagnostic Imaging and the Fracture Clinic, with Emergency and the Birthing unit close-by. Furthermore, the challenges of hallway closures and redirection are no more as the main public hallway to access all hospital services is now a fairly straight line.
- When directing patients, the Wing, Level, along with proper building entrance (e.g., Main Entrance, C and D) should provide the necessary guidance when first coming to hospital.
- Once within the desired wing and level, local wayfinding will direct visitors to the specific area where they need to go. Main Directories are located at the most popular patient entry points/ circulation.

2024 CMH Staff Trust Fund Diversity Bursary recipients

- Since 2019, the Cambridge Memorial Hospital Staff Trust Fund Diversity Bursary has been assisting African Canadians, Indigenous people, persons of colour, persons with disabilities and/or those identifying as 2SLGBTQIA+ with their pursuit of post-secondary education in a health-related discipline. The longer-term goal of the fund is to promote a more diverse health care workforce.

- Three awards are given on an annual basis, each worth $1000. In 2024, George Boella, Cam Schnarr, and Shahnawaz Towheed were the recipients of this year's diversity bursary and featured on CMH's social channels.
- *George Boella* (he/him)
    - "Life is better when you help your neighbour," George Boella said. An ED clerk at Cambridge Memorial Hospital, George was inspired by the ED nurses' commitment to healthcare. Sharing this passion with his spouse, he decided to go back to school for nursing. Even when some may think it seems small, he knows he's making an impact in the lives of others.
    - George is a volunteer with St. John's Ambulance KW, supporting community events as a first aid responder. This experience comes with many challenges, but is fulfilling. He plans to pursue volunteer opportunities for the Registered Nurses Association of Ontario as a student leader.
    - Currently, George is enrolled in his second year in the Bachelor of Sciences in Nursing at McMaster University. He looks forward to completing the program, becoming a Registered Nurse and furthering his career in the healthcare sector.
- *Cam Schnarr* (they/he)
    - An advocate for the 2SLGBTQAI+ community, Cam hopes to shape their career in healthcare as a first responder who offers compassionate, knowledgeable, and inclusive care for all patients. Their passion to make a difference in the lives of others is combined with their journey in finding their identity as a trans individual.
    - In their second-year of the Paramedic Program at Conestoga College, Cam also has a degree in kinesiology from Wilfred Laurier University where they completed a minor in psychology. This understanding of how physical and psychological factors influence health introduced them to holistic, patient-centered care.
    - Cam, with this passion and skillset in mind, adds: "Becoming a paramedic gives me the opportunity to be out there in the community. There's a lot of variety in what you can do, learn, and how you can help people."
    - Currently, Cam volunteers and works for many local ringette associations in Southern Ontario, helping with goalie and goalie coach development in both competitive and non-competitive sports. They hope to act as a role model, create connections, and mentor young athletes in a world that struggles to accept LGBTQ+ athletes.
- *Shahnawaz Towheed* (he/him)
    - Shahnawaz Towheed is a Pakistani-Canadian currently completing his one-month Emergency Medicine placement at Cambridge Memorial Hospital. A second year medical student in the Undergraduate Medical Education MD Program at McMaster University, Shahnawaz is driven by a personal commitment to fostering meaningful change in healthcare through empathy and innovation. Diagnosed with vitiligo at the age of six—an autoimmune condition that caused his naturally dark brown skin to become uniformly pale by the time he was eleven, Shahnawaz's journey

of navigating dual skin tones and societal perceptions has profoundly shaped his career aspirations and dedication to healthcare advocacy.
    - "My passion for helping others and embracing learning opportunities has come full circle through my lived experiences," he shared. Shahnawaz is actively involved in research addressing gaps in skincare practices and advocating for improved health outcomes among marginalized communities. He also co-founded Vitiligo Voices Canada, the first national support group dedicated to vitiligo patients.
    - Shahnawaz thoroughly enjoys his role in the Emergency Department, finding it both challenging and fulfilling. He looks forward to continuing his contributions to the healthcare of the Waterloo Region throughout his clerkship training and beyond, with a long-term interest in the intersection of dermatology and mental health.

CMH celebrates Black History Month

- Black History Month honours the legacy and contributions of Black Canadians, or African Canadians, who are people of African or Caribbean ancestry. The role of Black people and their communities in Canada have largely been ignored as a key part of Canada's history – including the loyalists who came here after the American revolution, the soldiers of African descent that scarified much during the War of 1812, their part in the World Wars and other conflicts that followed. Their contributions extend beyond – building into our society's innovation, leadership, community, medicine, arts, and working to build a strong, inclusive Canada for generations to come.
- In February, we focus on their legacy and leadership; their contributions to building upon who we are as Canadians and uplifting future generations. Some of the events that took place include:
    - Black History Month Learn Challenge - Each week, staff were invited to select a learning challenge that covered a number of topics about the many contributions of the Black community in Canada – from science to the arts.
    - *Lunch & Learn: Unwritten Stories: The Forgotten History of Waterloo Region's Black Residents* - Facilitated by local author Peggy Plet, this presentation spoke to the region's rich history and shared the important stories and contributions of local Black culture that are often overlooked. By bringing these voices to the forefront, Ms. Plet aims to deepen our collective understanding of the past and make our shared heritage more inclusive, complete and meaningful.
    - *Ken Daley* - Ken is a Cambridge-born artist whose work draws inspiration from his African-Caribbean roots, life experiences and the people and cultures he encounters along the way. His work has been featured in children's books, print publications as well as on television.
    - *Starlite Steelband* - This local family group brought vibrant sounds of Calypso and Reggae to the cafeteria area, creating a fun and energizing atmosphere. In addition to the musical performance, audience members

learned about the history of the steel drum and provided an opportunity to play it.

- *Soca Workout Sessions* - This workout session, facilitated by CMH nurse Gayle Smith, provided staff an opportunity to move, dance, and learn about the history of Soca while commemorating Black History Month. Soca is an upbeat music that originated in Trinidad and Tobago in the 1970s.

CMH Wishlist goes live

- In partnership with the CMH Foundation, the CMH Wishlist Campaign addresses the increasing number of community requests to donate items, like stuffed animals and toys, to CMH.
  As such, the Wishlist Campaign harnesses this generosity to better focus and direct these types of gifts to the most urgent needs across the hospital. This can include items for Care Carts, transportation support, stuffed toys for the ED or Fracture Clinic and clothing.
- By keeping the community informed of a unit's specific needs, whether large capital items or smaller items that enhance the patient experience, this initiative will help focus fundraising efforts to make the biggest possible impact.

Let Kindness Grow: Pink Shirt Day 2025

- February 26 is Pink Shirt Day, when pink is worn to show support for anti-bullying efforts.
- This year's theme - *Let Kindness Grow* - highlights how small acts of kindness can create a ripple effect, spreading positivity and fostering supportive communities. By choosing to be kind, we can make a meaningful difference in the lives of those around us and contribute to a world where everyone feels valued and included.
- Pink Shirt Day raises awareness about the impact of bullying and encourages people to take a stand against bullying while promoting kindness and inclusivity.
- It began in Nova Scotia when students took a stand after a fellow student was bullied for wearing a pink shirt. To show solidarity, they purchased and distributed pink shirts to classmates, creating a powerful anti-bullying statement that has since grown into a world-wide movement.

CMH offers hotel accommodations during times of inclement weather

- Our personnel's safety is our first priority. With the recent weather warnings and alerts, CMH has adapted a program that was first implemented during the pandemic.
- If the weather is such that staff, physicians or midwives do not feel safe driving home or coming back the next day for their shift, they may contact Cambridge Hotel to see if it has any rooms. If some are available, they only need to show their CMH ID badge at check-in and the hospital will be invoiced.

- If no rooms are available, they may access another local hotel to a maximum of $150 a night for reimbursement.

Rehabilitation Unit move rescheduled to October

- As we continue navigating high patient volumes, we remain focused on making decisions that support both patient care and our staff. After careful assessment, a decision was made to reschedule the Acute Rehabilitation program's move back to CMH from March 31 to October 2025.
- Occupancy remains high across the hospital and this sustained demand is adding pressure on our emergency department and inpatient units.
- This pressure was fully evident the week of February 17 when we temporarily opened up an additional 10 beds for 36 hours to ease the record number of admitted patients in the Emergency Department
- By keeping the current arrangements in place a little longer, the organization will be able to maintain much needed bed capacity during this period of heightened need.
- While this delay may be disappointing for some, ensuring that we have the right space and resources available for all patients remains our priority.

BRIEFING NOTE

Date: February 19, 2025
Issue: Updated CMH Patient Declaration of Values
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Heather Elliott, Patient Experience Lead
Approved by: Liane Barefoot, Director Patient Experience, Quality, Risk, Privacy & IPAC; Chief Privacy Officer

Attachments/Related Documents:

1. Waterloo Wellington Patient Declaration of Values
2. Patient, Family and Caregiver Declaration of Values for Ontario
3. Updated CMH Patient Declaration of Values
4. PDV Measurements of Success

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

That, the Board of Directors approves the updated CMH Patient Declaration of Values that was created in partnership with the CMH Patient and Family Advisory Council and upon recommendation of the Quality Committee at the meeting of February 19, 2025.

Quality

That the Cambridge Memorial Hospital (CMH) Quality Committee of the Board approves the updated CMH Patient Declaration of Values (PDV) that was created in partnership with the CMH Patient and Family Advisory Council (PFAC). **CARRIED.**

Background

The *Excellent Care for All Act (2010)* legislates that hospitals develop, with public consultation, a PDV. Though they should be aligned, the PDV is to be distinctly different from the organizational mission, vision and values. The PDV should reflect what patients can expect when receiving service and a commitment to delivering patient-centred care. The PDV should be publicly available.

In 2018, the Waterloo Wellington LHIN (WWLHIN) PFAC led a revision of the 2011 regional PDV. In April 2018, four (4) of CMH's then PFAC members and a CMH Board member attended a session to provide input. The WWLHIN PFAC then drafted the new PDV over the spring and summer months based on the input from WWLHIN organizations. Attachment #1 is the PDV that was approved by the WWLHIN Board, CMH PFAC and the CMH Board in November 2018. This remains the current CMH PDV.
In 2021, all Ontario Health Teams (OHTs) were required to review and adopt the provincial Patient, Family and Caregiver Declaration of Values (attachment #2). OHT member organizations, of which CMH is one, were not required to adopt the provincial PDV, however, CMH management did take the provincial PDV to CMH PFAC for discussion with the option to adopt. The consensus was that the Ontario version (attachment #2) was more contemporary in regards to diversity, equity and inclusion (DEI) work underway at CMH but was felt to be too wordy. As such, CMH PFAC recommended *not* adopting the provincial PDV.

In CMH's 2022-2027 Patient Experience Plan, there is an identified tactic to "Update the 2018 CMH Patient Declaration of Values". In the spring of 2024, the Patient Experience (PX) and Communications teams confirmed with regional hospitals that there was not currently a desire and/or capacity to revise the 2018 PDV; however, many hospitals expressed interest in hearing of CMH's progress.

As such, the CMH team began to work with CMH PFAC to update the 2018 PDV independently. On May 28, 2024, the Directors Council unanimously supported that CMH work with PFAC to update the PDV at the local level (CMH only), and on June 18, 2024, Senior Executive approved this recommendation.

Analysis
In summer 2024, the PX office developed a workgroup with interested PFAC members to evaluate the current PDV and draft updated values.

At the September PFAC meeting, an update was provided regarding general suggested changes to the PDV that the workgroup had agreed upon. During this meeting, a number of additional considerations and ideas were brought forward by CMH staff members in attendance. In a debrief after the meeting, the PFAC workgroup felt that the PDV would feel more meaningful and empowering to them if the drafted values came solely from the patient perspective. Going forward with the October and November PFAC meetings, a decision was made for the PDV to be discussed between the Patient Experience Leads and the PFAC members rather than the PFAC group with staff.

The PDV workgroup meetings continued throughout the fall; and the new drafted values were provided to PFAC members (without staff present) at the October and November PFAC meetings for feedback.

Consultation
In order to solicit feedback from patients and staff on the drafted values, the PX office arranged for a table to be set up with a PFAC member in the main lobby of CMH on December 17 and December 31. The PX office and PFAC set up a table at the CMH Community Open House on January 11, 2025 to share the updated values and solicit feedback from members of the public. Feedback from the sessions was overall positive and many patients expressed that the values resonated with them.

On January 7, 2025, the feedback from the sessions was shared with PFAC who subsequently approved the updated PDV. The PDV was then presented to the Operations Group, Directors

Council, Senior Executive and Medical Advisory Committee and received approval (see attachment #3 for the final version). This version received endorsement to go to the Quality Committee of the Board and the Board of Directors for final approval.

Next Steps
With Quality Committee of the Board endorsement, these updated PDV will be taken to the Board of Directors for approval. Once approved, the PX office will work to ensure the updated poster of the PDV is on brand to post internally and electronically. Subsequently, this poster will be shared with PX and Communications counterparts at regional hospitals.

The PX office will explore how the PDV will be measured in order to determine how best we are succeeding at meeting patient's expectations and providing quality care. In order to do so, preliminary exploration of CMH online Patient Experience survey questions have been chosen that appear to be related to each value (attachment #4). The PX office will work with Decision Support to complete a regression analysis to see which of these survey questions most strongly correlate to overall satisfaction. We will then analyze these scores to see which values are being met and which may benefit from improvement.

To continue the progress of the 2022-2027 Patient Experience Plan, the PX office plans to begin work on adopting a formal "Patient Experience" definition in fiscal year 2025/2026.

WATERLOO WELLINGTON
PATIENT DECLARATION OF VALUES

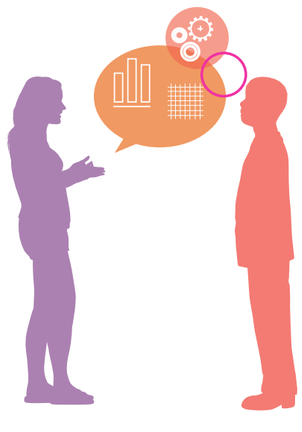
You can expect your health care to include:

PATIENT-CENTRED CARE

- That understands that you are a whole person,
- Treats you with compassion and respect, and
- Includes your family and support system in your care.

A PARTNERSHIP WITH YOUR CARE PROVIDER

- That shares responsibility and accountability with you,
- Provides care and support to achieve your health goals, and
- Considers all your health needs, connecting you to health and community services.



COMMUNICATION

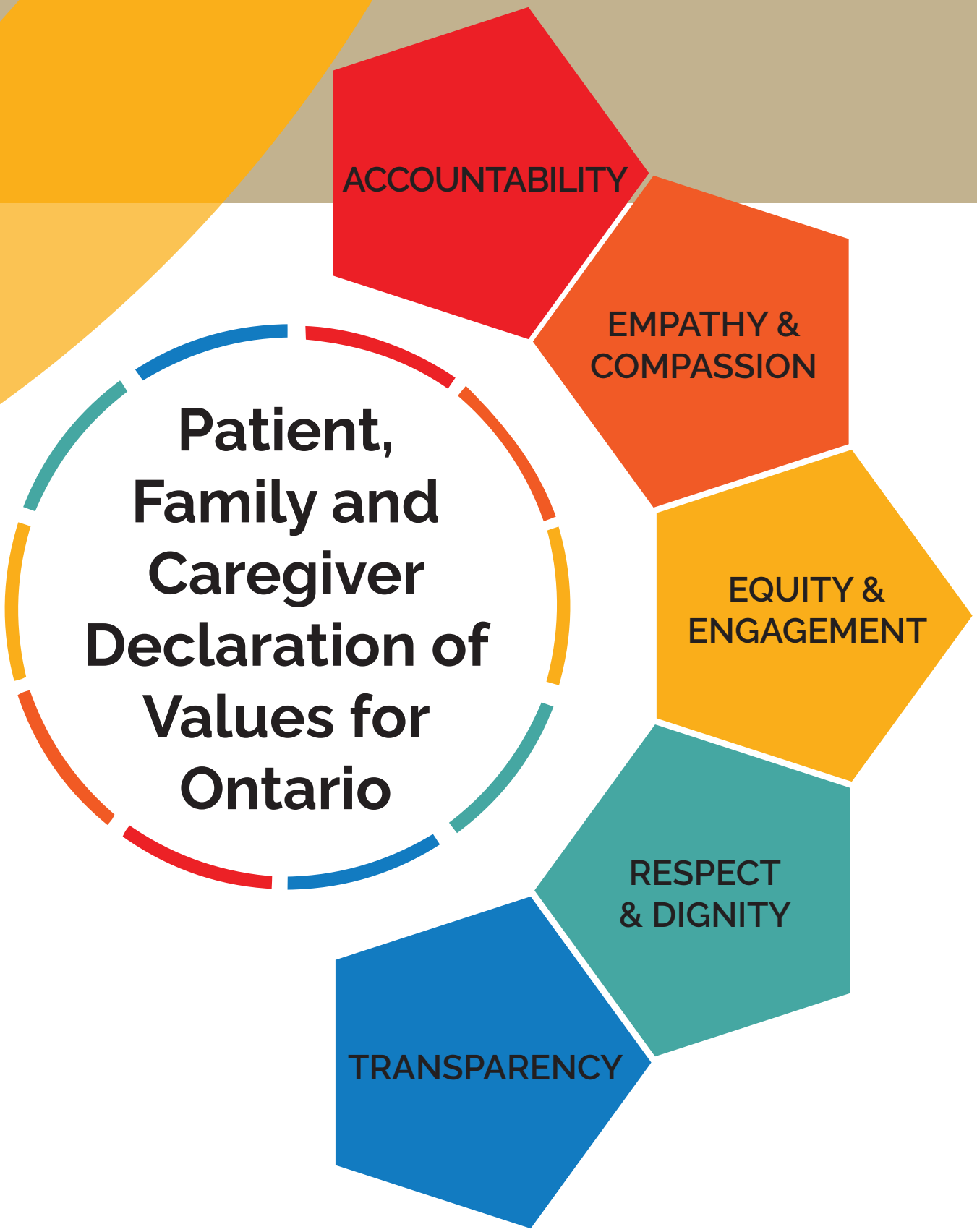
- That allows you to be heard in a safe and caring environment,
- Provides clear health information that you can understand, and
- Shares open and transparent information with you and your care teams.

EQUITABLE CARE

- That puts your needs first regardless of your situation,
- Eliminates barriers to receiving timely and safe services, and
- Is free of prejudice, stigma and judgment.

CONTINUOUS IMPROVEMENT IN HEALTH CARE

- That provides you with access to the best quality of care,
- Increases access to new innovative technology and treatments, and
- Contributes to your confidence and trust in the health system.



Patient, Family and Caregiver Declaration of Values for Ontario

Patient, Family and Caregiver Declaration of Values for Ontario

ACCOUNTABILITY

- We expect open and seamless communication about our care.
- We expect that everyone on our care team will be accountable and supported to carry out their roles and responsibilities effectively.
- We expect a health care culture that demonstrates that it values the experiences of patients, families and caregivers and incorporates this knowledge into policy, planning and decision making.
- We expect that patient, family and caregiver experiences and outcomes will drive the accountability of the health care system and those who deliver services, programs and care within it.
- We expect that health care providers will act with integrity by acknowledging their abilities, biases and limitations.
- We expect health care providers to comply with their professional responsibilities and to deliver safe care.

EMPATHY & COMPASSION

- We expect that health care providers will act with empathy, kindness and compassion.
- We expect individualized care plans that acknowledge our unique physical, mental, emotional, cultural and spiritual needs.
- We expect that we will be treated in a manner free from stigma, assumptions, bias and blame.
- We expect health care system providers and leaders will understand that their words, actions and decisions strongly impact the lives of patients, families and caregivers.

EQUITY & ENGAGEMENT

- We expect equal and fair access to the health care system and services for all regardless of ability, race, ethnicity, language, background, place of origin, gender identity, sexual orientation, age, religion, socioeconomic status, education or location within Ontario. We further expect equal and fair access to health care services for people with disabilities and those who have historically faced stigmatization.
- We expect that we will have opportunities to be included in health care policy development and program design at local, regional and provincial levels of the health care system.
- We expect an awareness of and efforts to eliminate systemic racism and discrimination, including identification and removal of systemic barriers that contribute to inequitable health care outcomes (with particular attention to those most adversely impacted by systemic racism).

RESPECT & DIGNITY

- We expect that our individual identity, beliefs, history, culture and ability will be respected in our care.
- We expect health care providers will introduce themselves and identify their role in our care.
- We expect that we will be recognized as part of the care team, to be fully informed about our condition, and have the right to make choices in our care.
- We expect that patients, families and caregivers be treated with respect and considered valuable partners on the care team.
- We expect that our personal health information belongs to us, and that it remain private, respected and protected.

TRANSPARENCY

- We expect that we will be proactively and meaningfully involved in conversations about our care, considering options for our care, and decisions about our care.
- We expect that our health records will be accurate, complete, available and accessible across the provincial health system at our request.
- We expect a transparent, clear and fair process to express a complaint, concern, or compliment about our care that does not impact the quality of the care we receive.

Updated: July 2021

Note: The purpose of this Patient, Family and Caregiver Declaration of Values, drafted by the Minister's Patient and Family Advisory Council in consultation with Ontarians, is to articulate patient, family and caregiver expectations of Ontario's health care system. The Declaration is intended to serve as a compass for the individuals and organizations who are involved in health care and reflects a summary of the principles and values that patients, families and caregivers say are important to them. The Declaration is not intended to establish, alter or affect any legal rights or obligations, and must be interpreted in a manner that is consistent with applicable law.

Ontario

Cambridge Memorial Hospital's

Patient Declaration of Values

The purpose of the Patient Declaration of Values is to share what we, as patients, expect from our health care team.

I receive PATIENT-CENTRED CARE which means:

- I am recognized as a unique person with personal values, beliefs, expectations, wishes, and choices that are respected; and
- My family and/or the people who support me are welcomed and involved in my care.

I am WORKING TOGETHER WITH MY CARE TEAM which means:

- I am treated as an equal partner in the care team;
- I am involved in conversations about my care, can ask questions, and will receive clear and honest answers;
- Options about my care are explained in a way that I understand; and
- My care team considers all of my health needs and connects me to health and community services.

I encounter EFFECTIVE COMMUNICATION which means:

- My care team will communicate with me in a kind, compassionate, and empathetic way;
- My care team members will introduce themselves and let me know what their role is;
- My health information will be kept confidential; and
- My health records will be accurate, complete and available to me and my care team in a timely manner.

I receive EQUITABLE, ACCESSIBLE, AND UNBIASED CARE which means:

- My individual needs will be recognized and treated appropriately without prejudice, stigma, assumptions, and judgment; and
- I will receive timely and safe services that are provided in my preferred language.

I receive HIGH QUALITY HEALTH CARE which means:

- My care team will deliver safe and reliable care;
- My care team is always striving to use the most up to date methods and technology in my care; and
- My feedback to improve patient care will be taken seriously and I am given the option to stay informed of the outcome of my feedback.

Attachment: Proposed Measurement of Success for CMH Patient Declaration of Values

Value	Indicators
I receive PATIENT-CENTRED CARE which means: • I am recognized as a unique person with personal values, beliefs, expectations, wishes, and choices that are respected; and • My family and/or the people who support me are welcomed and involved in my care.	Day Surgery survey: • Q21: How much information about your condition or procedure was given to your family, caregiver or someone close to you? Emergency Department (ED) survey: • Q5: Did you get the emotional support you needed to help you with any anxieties, fears or worries you had during this hospital visit? Ontario Adult Inpatient Short-form Patient Experience Survey (OAIP) – sent to inpatient Medicine, Surgery and Maternity patients: • Did you get the support you needed to help you with any anxieties, fears or worries you had during this hospital stay?
I am WORKING TOGETHER WITH MY CARE TEAM which means: • I am treated as an equal partner in the care team; • I am involved in conversations about my care, can ask questions, and will receive clear and honest answers; • Options about my care are explained in a way that I understand; and • My care team considers all of my health needs and connects me to health and community services.	Day Surgery survey: • Q24: How often, during your most recent day surgery experience, were you involved as much as you wanted to be in decisions about your care and treatment? Maternity module survey: • Q9: While in the hospital, did your doctor, midwife, or nurse answer your questions about your childbirth in a way you could understand? OAIP survey: • Q4: Were you involved as much as you wanted to be in decisions about your care and treatment?
I encounter EFFECTIVE COMMUNICATION which means: • My care team will communicate with me in a kind, compassionate, and empathetic way; • My care team members will introduce themselves and let me know what their role is; • My health information will be kept confidential; and • My health records will be accurate, complete and available to me and my care team in a timely manner.	Day Surgery: • Q20: did the health professionals treating and examining you introduce themselves? ED Survey: • Q3: How often did care providers explain things in a way you could understand? • Q4: Do you feel that there was good communication about your care between doctors, nurses and other hospital staff? OAIP survey: • Q1: Do you feel that there was good communication about your care between doctors, nurses and other hospital staff?

Value	Indicators
I receive EQUITABLE, ACCESSIBLE, AND UNBIASED CARE which means: • My individual needs will be recognized and treated appropriately without prejudice, stigma, assumptions, and judgment; and • I will receive timely and safe services that are provided in my preferred language.	ED Survey: • Q2: How often did care providers treat you with courtesy and respect? Day Surgery survey: • Q36: Overall, did you feel you were treated with respect and dignity while you were at the hospital?
I receive HIGH QUALITY HEALTH CARE which means: • My care team will deliver safe and reliable care; • My care team is always striving to use the most up to date methods and technology in my care; and • My feedback to improve patient care will be taken seriously and I am given the option to stay informed of the outcome of my feedback.	Canadian Institute for Health Information (CIHI) Metrics such as readmission, infection, hospital death rates, etc.

Board Chair's Report – December 2024 – February 2025

Message From the Chair

As we enjoy these beautiful snowy winter days (and never-ending snow shovelling!), I reflect on the past few months and the incredible efforts put forth by this Board. Your presence at CMH activities enriches our community and demonstrates to our staff, physicians and midwives your support of the work they do every day to optimize the patient experience at CMH. You helped us to celebrate numerous milestones with great enthusiasm and success. Thank you once again for being such an integral part of our journey.

Board Chair's Report – December 2024

Giving Tuesday

Giving Tuesday is a global movement for giving and volunteering, taking place each year after Black Friday. The “Opening day of the giving season,” it’s a time when charities, companies and individuals join together and rally for favourite causes. In the same way that retailers take part in Black Friday, the giving community comes together for Giving Tuesday. The CMHF raised more than $57,000 this Giving Tuesday – with over $22,000 of that coming from our dedicated volunteers. Cheryl Hugill, CMHF Board Chair donated a board matching gift of $10,000 to help support the foundation. Thank you to all of the Directors who were able to contribute!

Board Adopted Family

With the support of you all, the Board was able to support a family through neighborhood association, providing games, toys and $550 in grocery gift cards for a mom and her three boys. The Boards efforts helped make the family’s holiday season brighter and added some food security for 2025. Thanks to all for your generosity in donating and shopping!

Past Chair – Charlie Wilson

On December 11, 2024, Lynn Woeller and Patrick Gaskin visited former Board Chair Charlie Wilson (served as Board Chair from 2002 to 2003) to update him on the activities at CMH and learn more about his time and contribution to the CMH Board. It was also an opportunity to thank him for his service to the community.

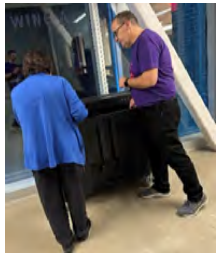
Good Morning Cambridge" Breakfast: Vision 1 Million, A Conversation with Chair Redman, Region of Waterloo and Tony LaMantia, CEO & President, Waterloo EDC

On December 12, 2024 Stephanie Pearsall and Patrick Gaskin along with Bill Conway took part in the conversation with Chair Redman and Tony La Mantia discussing the most significant growth period in our region's history. By 2050, the population is projected to surpass 1 million, marking an increase of over 300,000 people in the next 25 years. To put this in perspective, it took 35 years to expand Cambridge Memorial Hospital, and 20 years to complete phase one of the LRT. Yet, in the coming decades, we face the challenge of building a new hospital, completing phase two of the LRT, implementing two-way, all-day GO transit to Toronto, and constructing 70,000 homes for our growing population.

Board Chair's Report – December 2024

CMH Holiday Meal

On December 5, 2024 CMH held its annual holiday meal. This year the event took place in the newly renovated Wing B tower, giving the CMH family the first look at the space. Thank you to Sara Alvarado, Diane Wilkinson, Miles Lauzon, Nicola Melchers, Bill Conway, Tom Dean, Paul Martinello (non-Director), Paulo Brasil and Lynn Woller for lending a helping hand!



"To the CMH Board and Sub-Committee members who joined us yesterday during the day and last night, a huge thank you from Team Caring (the Management team responsible for organizing).

Lynn, Diane, Miles, Nicola, and Tom - you were amazing ambassadors, greeting people with a smile and a dollop of hand sanitizer
Paul - you were a huge help in keeping things running smoothly at the container/cutlery table and freed me up to wander the halls and eat dessert
Sara - our resident photographer, I know some staff who felt appreciated for you asking them for a picture and recognizing their cheer and spirit
Paulo - keeping the dessert line running smoothly and welcoming people to the new rehab unit
Bill - owning the drink station and making sure people didn't miss out on beverages if they wanted it"

Board Chair's Report – January 2025

CMH Wing B Celebration

On January 10, Director joined in the ribbon-cutting ceremony for Wing B at CMH, marking a significant milestone in the organization's journey. The following day, on January 11, the community was invited to an open house where both directors and non-directors joined together to explore the new space. Attendees marveled at the transformation as they took guided tours through the facility. This wonderful celebration highlighted the collaborative efforts that went into creating a vibrant and welcoming environment for everyone involved with CMH

Salute to Women

On January 22, Sara Alvarado joined Patrick Gaskin and other members of the CMH family for the Salute to Women event. 100% of the money raised from the event was for growing local breast reconstruction services at the Cambridge Memorial Hospital. This will ensure we have the tools to offer surgery locally and allow patients to access specialized care closer to home.

Board Chair's Report – January 2025

Women's Breakfast Series – Conversation with Angela Asadoorian

On January 29, Nicola Melchers, Monika Hempel and Lynn Woeller visited Langdon Hall for a conversation with Angela Asadoorian, Broker of Record for Royal LePage Crown Realty Services. Angie is known as an avid volunteer in the local not-for-profit sector, with a focus on primary healthcare with a 'calling' to ensure that every Canadian has access to a family doctor. Through the Cambridge Doctor Recruitment Task Force, she chaired the development of our local Health Link clinic, which ultimately took 10,000 Cambridge residents off the waiting list for a doctor. She also spent nearly a decade on the Langs board of directors and wrapped up her not-for-profit work as the chair of the Ontario Health Team for Cambridge and North Dumfries.

Kairos Blanket Exercise

On January 13, CMH offered the Kairos Blanket Exercise - an experiential teaching tool that explores the historic and contemporary relationship between Indigenous and non-Indigenous peoples in the land we now know as Canada. Responding to the 1996 Report of the Royal Commission on Aboriginal Peoples, the Aboriginal Rights Coalition (which became part of KAIROS in 2001) worked with Indigenous elders and educators in 1996 to develop an interactive way to learn the history that most Canadians are never taught. KAIROS and its partners have since offered the KAIROS Blanket Exercise thousands of times, presenting Canada's history from the perspective of Indigenous peoples to churches, schools, community centres, businesses and government departments and agencies from coast-to-coast-to-coast. Paulo Brasil, Sara Alvarado, Bill Conway, Lynn Woeller, and Nicola Melchers joined CMH staff in this educational opportunity.

Board Chair's Report – February 2025

Cambridge City Council Workshop

On February 18, Diane Wilkinson, Sara Alvarado, Miles Lauzon, Tom Dean, Monika Hempel, and Bill Conway attended the CMH presentation to City Council. Lynn Woeller co-presented with Patrick Gaskin, detailing the current activities and initiatives of the organization. The presentation was well-received by the councillors, offering a valuable opportunity to bolster partnerships and support for the hospital.

"I was very pleased to attend this workshop once again and learned quite a bit more about Cambridge Councillors and CMH programs as well. I felt the CMH slide deck was very well presented as all Councillors seemed alert and attentive. Their questions also seemed on-point and concerning. Overall it was a very good event for us to bring Council up to speed and hope this event continues annually." – Tom Dean

CPSO QI Partnership at CMH – Session 6 Sustainability

On February 26, 2025, Julia Goyal and Lynn Woeller participated in the final session of the CPSO Quality Initiative series which was a presentation on Sustainability. Discussion centered around the importance of sustainability practices in healthcare, emphasizing the potential positive impact on patient care, cost savings and environmental health, while also addressing challenges and solutions within hospital operations.

Board Chair's Report – February 2025

Emergency Department Huddle
On February 26, 2025, Sara Alvarado and Paulo Brasil joined the team in our Emergency Huddle to learn more about how Flow is discussed in the organization

Grand Rounds – Understanding the Role of the Coroner in Ontario
On February 27, 2025, Bill Conway, Nicola Melchers, Diane Wilkinson, Julia Goyal and Lynn Woeller attended a Grand Rounds session led by Dr. Reuvan Jhirad, Deputy Chief Coroner of Ontario. The presentation aimed to provide insights into the importance of reporting deaths to the coroner, explore the role of the coroner in documenting and investigating fatalities, and review scenarios where mandatory reporting is required.

BRIEFING NOTE

Date: February 21, 2025
Issue: Quality Committee Report to the Board of Directors, February 19, 2025 – 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, February 19, 2025 at 0700 hours.

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

Committee Matters – For information only

1. **Recruitment – Employee Position on the Quality Committee Update:** The Chair gave thanks to the current QC staff members, R. Howe and K. Abogadil, for serving on the committee for the last several years. The QC staff members will end their tenure in June of 2025. The Chair noted that the recruitment process to replace K. Abogadil and R. Howe is currently underway. The posting was closed on January 31, 2025 and there are five (5) candidates. Interviews will take place on March 7, 2025. It was requested of the Committee members if they are interested in participating in the interviews to contact the Quality Committee Chair directly.
2. **Program Presentation – Medicine:** The Chair welcomed the Director of Medical Programs, the Deputy Chief of Staff / Chief of Hospital Based Medicine and the Chief of Internal Medicine. A story was shared about a patient on the Medicine unit. This story reflected the passion and desire to assist patients, particularly on the Medicine units. A staff member learned that the patient disclosed that he had been sleeping on the floor for the past year, and did not have a bed or any linens. The staff member recognized that this would be a barrier for discharge due to the patient's medical diagnosis. With help from a local community thrift shop, a bed was delivered to the patient's home. Several staff members donated linens. The patient was very thankful for the generosity of the staff and was successfully discharged home. The Director of Medical Programs also shared a staff story regarding patient experience. One staff member expressed her passion for palliative care during her VBC with her Manager and established a multidisciplinary palliative care team to identify and support end-of-life care for patients

in the hospital. The creation of the Palliative Care Cart was formed (cart includes personal care items for both patient and family). A new symbol for the patient's room door is posted to inform staff when entering, and a quilt is presented to either the patient or their family. After a patient's passing, the staff will "light a candle" (battery operated) at the Nursing Station. The Director of Medical Programs continued by highlighting the following key points: 1) Medicine 7-day Heat Map – displays admissions, discharges, number of ALC patients. This report provides present census data and opportunities for immediate discharge; 2) Falls and Delirium Prevention – staff led Committee; meets every 4-6 week; focuses on delirium, prevention, falls prevention and least restraint. Policies are reviewed and interventions developed/implemented by this team to keep patients safe. Falls kits in the supply rooms with socks, alarms, batteries and the falling leaf symbol for the door that signifies that a patient has fallen previously and to alert all staff the patient is high risk for falls. Admission kits are placed in each room that includes a pamphlet on delirium prevention, falls risk armband for those at risk, and a pair of yellow fall prevention socks; 3) CMH@HOME – presented to CMH by Ontario Health with an ask to launch in late Fall of 2024. Partnered with BayShoreHealthcare, CMH officially launched in mid-December 2025, and now has 28 patients enrolled. To support the program, an additional part-time Patient Navigator has been recruited (who started today, February 19, 2025) to further assist; 4) Discharge Bullet Rounds are held daily, focusing on barriers to discharge. Unit white boards are updated during rounds and throughout the day to reflect real time status updates; 5) New Recruitment Strategy – The Medicine team identified the challenges that come with hiring novice staff and conducting interviews virtually. The process was changed to in-person interviews. The Clinical Educators developed clinical scenario simulation and candidates are asked to participate in the simulation, demonstrating their clinical knowledge and assessment skills and to provide them with insight into the patients they will be caring for. This program has been very successful and is looking to expand. The Deputy Chief of Staff/Chief of Hospitalist Medicine spoke of working on an ongoing project at improving patient handovers so there is less uncertainty when a physician goes off and another physician takes over. The use of the White Board also helps in optimizing patient care. The Director of Medical Programs explained the multi-layers of training provided to new staff members. Management provided clarification of the indicators noted in the Medicine Scorecard. ALC Throughput is reviewing the number of ALC patients coming off and being discharged versus the number of patients designated as ALC. The Chief of Internal Medicine spoke of the high ALC volumes and acuity of patients. The population that CMH has served has changed over the last several years. Planning of how to adjust to the trends of the population is currently under review. A potential change in the physician model will also be considered. A discussion took place about the Hospital to Home discharge program and its impact throughout the hospital. Management detailed the challenges with patterns related to increased sick and overtime. Management is working closely with Human Resources to develop and/or revamp CMH's Attendance Management Program. **See Package 2.**

3. **Quality Monitoring Scorecard:** A copy of the Quality Monitoring Scorecard was previously circulated. Management reported. There are currently ten (10) indicators of the twenty-nine that have had three subsequent periods of "red" performance and are being monitored. Seven indicators related to Flow and Access are: 1) Conservable days rate (Quality Committee Oversights); 2) Overtime hours; 3) Sick hours; 4) ALC Throughput (Quality Committee Oversights); 5) Percentage ALC Closed Days (Quality Committee Oversights); 6) ED Length of stay for Admitted patients (90% spent less, in hours) (Quality Committee Oversights); 7) ED Length of Stay, Non-Admitted Complex (CTAS 1-3) (90% spent less, in hours) (Quality Committee Oversights); 8) ED Wait Time for Inpatient Bed (90% spent less, in hours) (Quality Committee Oversights); 9) ED

Wait Time for Physician Initial Assessment (90% spent less, in hours) (Quality Committee Oversights); and 10) Obstetric Trauma (with Instrument) (Quality Committee Oversights). It was reported that Obstetric Trauma (with Instrument) was recently discussed at Medical Advisory Committee (MAC). Management and the Chief of Obstetrics conducted a chart review and have not found any trends or similarities with regard to provider or locum. The OBS Quality and Operations committee will continue to monitor this indicator. *(Further information found in agenda item 1.5.8.1)*

4. **CNE Report:** A copy of the CNE report was pre-circulated to the Committee members. The key portfolio/program updates continue to focus on the organizational priorities: 1) Diagnostic Imaging/Cardio Services – installation of a new state-of-the-art (replacement) Echocardiography Ultrasound unit. This unit replaces an older unit that was at the end of its life. This new unit allows CMH to increase outpatient echocardiograms, which support flow and discharge; 2) Ultrasound hours were expanded on January 6, 2025 in the ED to 2300h on weekends from our current 1700h. The ad-hoc sonographer on-call system will continue from 2300h to 0700. This has been well received by the ED physicians; 3) ICU – The official launch of Dedicated Level 2 Beds was implemented in the week of January 27, 2025. Three (3) beds have been transitioned to Step Down beds and an additional three beds will come online in March; 4) Go live of the Pneumatic Tube System – eliminating waste of steps for Porters so they focus on patients; specimens are sent through the Pneumatic Tube; 5) In May 2025, alongside other leaders at CMH, laboratory team members will attend the Choosing Wisely Canada Conference 2025. At this conference, the Manager of Laboratory Medicine, alongside Dr. J. Bourgeois, will be presenting about CMH's journey in reducing RBC Folate testing; and 6) MDRD is planning the Polyvinyl Chloride (PVC) 123 Launch (recycling), set for February 24, 2025. This is one of CMH's environmental sustainability initiatives. *(Further information found in agenda item 1.3.8 of the in-camera agenda package)*
5. **CMH Patient Declaration of Values**: Committee members were directed to the previously circulated presentation. Background information was provided, followed by a detailed summary. A proposed motion was brought forward and endorsed by the Quality Committee of the Board approved the updated CMH Patient Declaration of Values (PDV) that was created in partnership with the CMH Patient and Family Advisory Council (PFAC). *(Further information found in agenda item 2.1)*
6. **Quality Improvement Plan (QIP):** At the February 6, 2025 QIP planning meeting, the draft 2025 QIP Metrics and draft 2025 QIP Narrative were presented. The Committee members were asked review each of the 2025 QIP Indicators. As previously discussed at the February 6, 2025, suggested changes and recommendations have been incorporated into the 2025 QIP. A proposed motion was brought forward and approved. The Quality Committee endorsed the four (4) 2025 Quality Improvement Plan (QIP) Metrics as presented. Management then proceeded to the previously circulated 2024 QIP Narrative and opened the floor for feedback. Changes were noted. A proposed motion was brought forward and approved. The Quality Committee endorsed the 2025 Quality Improvement Plan (QIP) Narrative as presented. *(Further information found in agenda item 4.3.2)*

BRIEFING NOTE

Date: February 10, 2025
Issue: Quality Improvement Plan (QIP) 2025 – Metrics and Narrative
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Liane Barefoot, Director Patient Experience, Quality, Risk, Privacy & IPAC; Chief Privacy Officer
Kyle Leslie, Director Operational Excellence
Approved by: Mari Iromoto, VP People and Strategy
Stephanie Pearsall, VP Clinical Programs, CNE

Attachments/Related Documents:

Appendix 1 – QIP 2025 – Narrative
Appendix 2 – QIP 2025 – Priorities by Sector

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

2025 QIP Metrics for Approval

Proposed motion, **that** the Quality Committee endorses the four (4) 2025 Quality Improvement Plan (QIP) Metrics as presented below, and forward to the Board of Directors for approval.

1. Reduce the 90th Percentile Ambulance Offload time from x min to 43 minutes
2. Reduce the 90th Percentile Physician Initial Assessment (PIA) time for CTAS 1&2's combined from x to 4.0 hours
3. Reduce the 90th Percentile Physician Initial Assessment time from for all CTAS levels combined from x hours to 4.6 hours
4. Reduce the daily average number of patients waiting in the ED for an inpatient bed at 8 AM from x to 10

NOTE – 'x' for each metric will be updated to reflect current state at the time the QIP is loaded into the OH Navigator

2025 QIP Narrative for Approval

Proposed motion, **that** the Quality Committee endorses the 2025 Quality Improvement Plan (QIP) Narrative as presented in Appendix 1, and forward to the Board of Directors for approval.

Background

Following the COVID-19 pandemic, Ontario Health (OH) reinstated the requirement for hospitals to develop a Quality Improvement Plan (QIP) for the 2023-24 period, with the expectation that it be uploaded to the Navigator by March 31st each year.

As discussed at the February 6, 2025 QIP planning meeting and presented in Appendix 2 there are no mandatory indicators for Hospitals for 2025/26. There are three (3) Priority indicators all related to Access & Flow, and thirteen (13) additional Optional indicators spread across the remaining areas of Equity, Experience, and Safety that have been identified.

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

The following indicators were discussed at the February 6, 2025 QIP planning meeting including current CMH performance and rationale for including or omitting each metric from the 2025 QIP as presented below. At the request of Quality Committee members, the chart below has been updated to include information on which indicators are ED PayForResults (P4R) metrics and/or are currently on, or recommended to be added to, the Quality Committee Quality Monitoring Scorecard (QMS on the chart below).

2024/25 QIP Indicators	Include	Omit
90th Percentile ambulance offload time	√	
90th Percentile ED length of stay – admitted patients		√
Number of staff who have completed Rainbow Health DEI Training		√

Priority Issue	2025/26 OH Indicators	Include	Omit	P4R	QMS
Access & Flow	90th Percentile ambulance offload time (Priority)	√		√	
	90th Percentile emergency department wait time to physician initial assessment (Priority)	√		√	
	90th Percentile emergency department wait time to physician initial assessment for CTAS 1 & 2 (Custom)	√			
	Daily average number of patients waiting in the emergency department for an inpatient bed at 8 AM (Priority)	√			
	90th Percentile emergency department length of stay – admitted patients (Optional)		√	√	√
	90th Percentile emergency department length of stay for non-admitted patients with low acuity (Optional)		√	√	√
	90th Percentile emergency department length of stay for non-admitted patients with high acuity (Optional)		√	√	√
	90th Percentile emergency department wait time to inpatient bed (Optional)		√	√	√

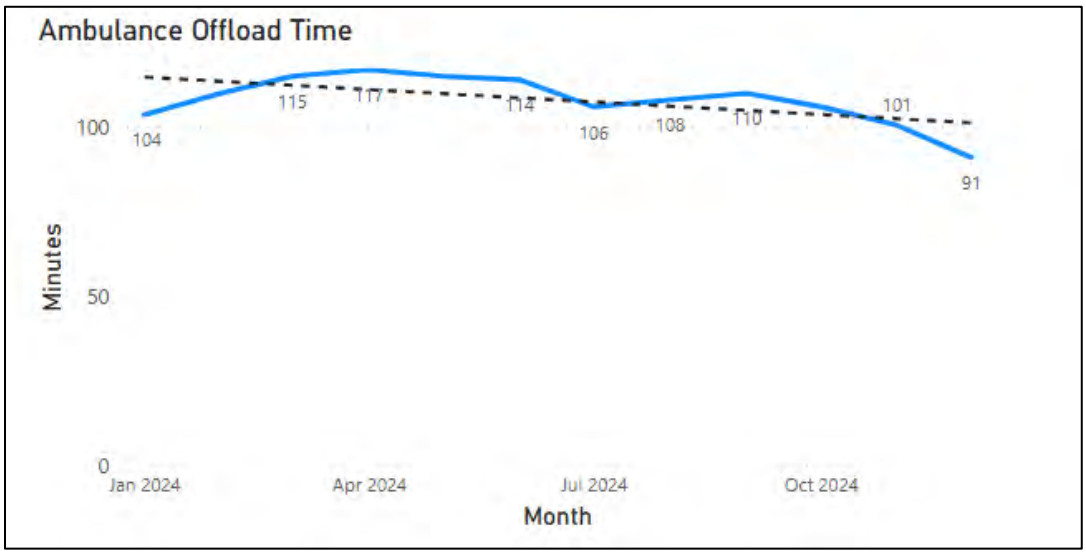
Priority Issue	2025/26 OH Indicators	Include	Omit	P4R	QMS
	Percentage of patients who visited the emergency department and left without being seen by a physician (Optional)		√		√
Equity	% of staff (executive-level, management, or all) who have completed relevant DEI and antiracism education		√		
	Average ED wait time to PIA for individuals with sickle cell disease (CTAS 1 & 2)		√		
	Rate of ED 30-day repeat visits for individuals with sickle cell disease		√		
	% of ED visits for individuals with sick cell disease triaged with high severity (CTAS 1 & 2)		√		
Experience	Did patients feel they received adequate info about their health and their care at discharge?		√		√
Safety	Rate of delirium onset during hospitalization		√		
	Rate of medication reconciliation at discharge		√		
	Rate of workplace violence incidents resulting in lost-time injury		√		

QIP 2024 Target Recommendations

1. 90th Percentile Ambulance Offload Time (Priority, P4R & QMS)

Ambulance offload time is the time between when a patient arriving by ambulance is triaged and when the patient is seen by a provider in the emergency department for initial assessment.

The chart below shows the trailing 12 month trending downwards through FY2024-25. The current FY2024-25 target is set at 30 mins which is in line with the provincial and P4R targets, however, remains a large stretch from current performance. The 50th%tile performance for 2024/2025 P4R report was 52 mins. Average performance of our benchmark hospitals was 43 mins. 50th %tile of our benchmark hospitals is 40 minutes.



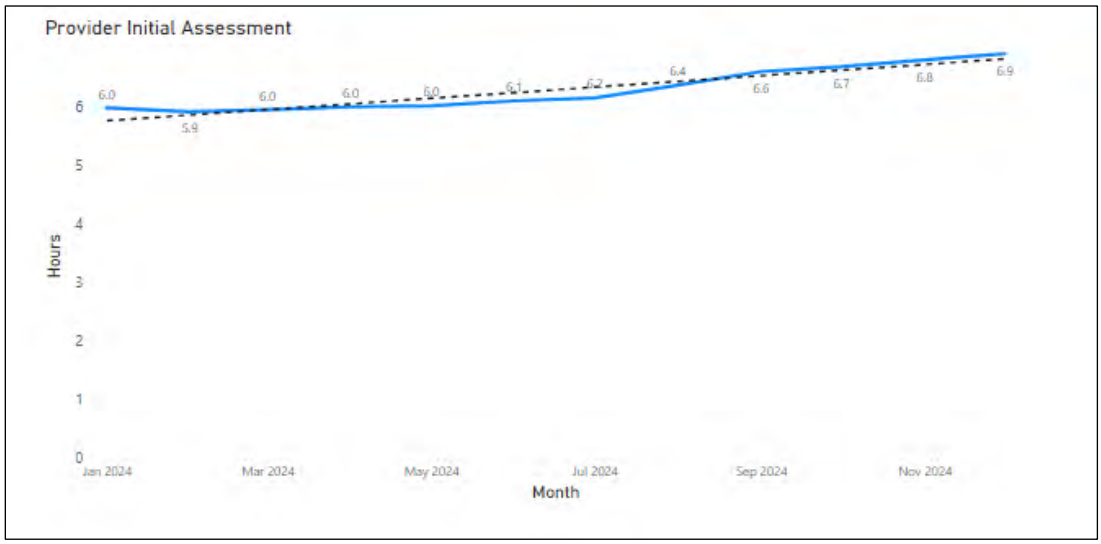
Target recommendation: 43 minutes

2. 90th Percentile emergency department wait time to physician initial assessment for CTAS 1&2 (Custom, QMS)

Reflects the time between when an urgent patient (CTAS 1-2) is triaged and when that patient is seen by a provider in the ED for initial assessment. Ontario Health has put an elevated focus on the wait times for our CTAS 1&2 as an area for improvement as these represent our sickest patients arriving to ED.

The PIA wait time for CTAS 1&2's in the ED has trended up in FY2024-25 as shown in the trailing 12-month graph below. The average performance of our benchmark hospitals is 4.0 hours.

90th %tile Trailing 12 – PIA – Urgent CTAS 1&2 (hours)



Target recommendation: 4.0 hours for CTAS 1&2's combined

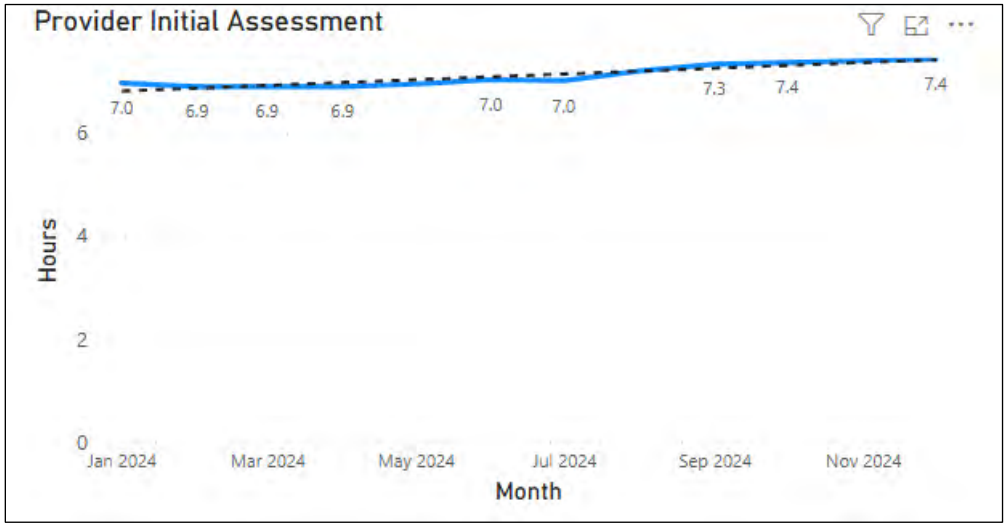
3. 90th Percentile emergency department wait time to physician initial assessment for all CTAS levels (Priority, P4R, QMS)

Reflects the time between when any patient (all CTAS levels) is triaged and when that patient is seen by a provider in the ED for initial assessment. The wait time for physician initial assessment in the ED has trended up in FY2024-25 as shown in the trailing 12 chart below. Our current FY2-24-25 target is 4.0 hours which is in line with provincial and PR4 targets, however, remains a stretch from current performance.

Given the proportionality low volume of CTAS 1&2's versus all ED visits, Quality Committee members recommended to include this metric, in addition to the custom one of 90th %tile Trailing 12 – PIA – Urgent CTAS 1&2 (hours).

50th Percentile PIA for benchmark hospitals is 4.6 hours.

90th %tile Trailing 12 – PIA – All CTAS Levels (hours)



Target recommendation: 4.6 hours for all CTAS levels combined

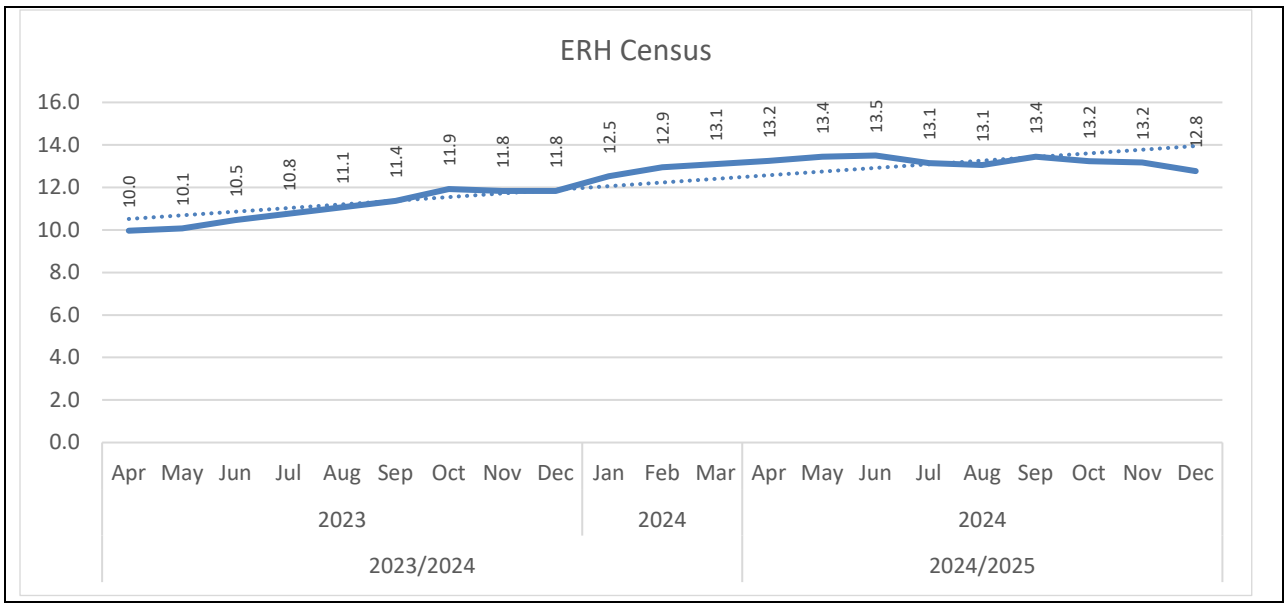
4. Daily average number of patients waiting in the ED for an inpatient bed at 8 AM

This indicator measures the number of patients admitted in the emergency department who are waiting for an inpatient bed at 8 AM AND have waited for at least two hours since their disposition time (referred to as "no-bed admits").

The number of patients in the emergency department waiting for an inpatient bed at 8 AM has been trending upwards as illustrated in the trialing 12 chart shown below. This creates significant pressures within the ED and has been shown in regression analysis to be one of the strongest predictors for patient flow through the remainder of the day. This indicator serves as a proxy measure of hospital-wide flow and output efficiency.

As this is a new indicator and specific to each organization size, there is no benchmark data available. Previous 2023-24 YE was 13.1 and current FYTD2024-25 is 11.5.

Daily average number of patients waiting in the ED for an inpatient bed at 8 AM Trailing 12



Target recommendation: 10 patients daily

Narrative
The QIP Narrative is complimentary to the work plan (metrics) and contains answers to standard questions for all organizations set out by Ontario Health. The Narrative, along with the work plan are posted externally on the CMH website and therefore need to be written at a level intended for the public. The QIP 2025 Narrative is presented as Appendix 1.

Next Steps
Final QIP 2025 including metrics with targets and narrative endorsed by Quality Committee members on February 19, 2025.

Final QIP 2025 including metrics with targets and narrative to the Board of Directors on March 5, 2025 for approval.

Once approved by the Board of Directors the final QIP 2025 including metrics with targets and narrative uploaded into the OH Navigator and www.cmh.org website prior to March 31, 2025.

Cambridge Memorial Hospital

Quality Improvement Plan (QIP) Narrative – 2025

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

The past year has been a year of celebrations for Cambridge Memorial Hospital (CMH)!

After 10-years, 3 major Capital Redevelopment phases, and multiple wayfinding challenges for staff and patients, CMH has moved into a newly renovated B-Wing tower. This upgrade means that all inpatient areas, emergency department, perioperative services, and most diagnostic areas are now state-of-the-art, bright and inviting. The B-Wing tower opening ceremony was co-chaired by the Chair of the Board of Directors and the Chair of Patient and Family Advisory Council; showcasing CMH's commitment to the community and strategic pillar 'Elevating Partnerships in Care'

The celebrations continued as CMH was designated as a top employer; once as Waterloo Area's Top Employer and another as Southwestern Ontario's Top Employer. These awards, and more importantly, the efforts behind them, exemplify our strategic pillar 'Joy at Work.

Having successfully achieved both Choosing Labs Wisely and Choosing Blood Wisely designations, CMH continues to advance quality initiatives that enhance patient safety and resource stewardship.

The 2022-27 CMH Strategic Plan introduced an 'Advance Health Equity' pillar. The CMH Diversity Council members have been leading the efforts outlined in the Diversity Equity and Inclusion Plan, reinforcing CMH's commitment to this crucial work.

The guiding principles for CMH's Quality Improvement Plan this year were to achieve the flow and access priorities set by Ontario Health, enabled by the collective and diverse strength of staff, physicians and midwives.

2. **Access and Flow** Optimizing system capacity, timely access to evidence-based care that meets the needs of the population, and patient flow ultimately improve outcomes and the experience of care for patients, clients, and residents. Health service organizations across the system – inter-professional teams, primary care, home and community care, long-term care, and hospitals – are working in partnership and across sectors on initiatives to support individuals in remaining in the community as long as possible and in avoiding unnecessary hospitalization or emergency department visits through the implementation of leading practices and new models of care, and by ensuring timely access to primary care providers. While individual organizations can implement leading practices on their own, they are encouraged to ensure that integrated care is woven into improvement plans by co-developing quality improvement plans with organizations in other sectors. In this section, describe improvement work that your

organization has planned to support patients, clients, and residents in accessing the right care in the right place at the right time. *Recommended length: 250 words*

Cambridge Memorial Hospital remains dedicated to aligning the flow and access initiatives with the priorities that have been identified by community members and Ontario Health. Specifically, we will continue to focus on ambulance offload times to ensure that ambulances can return to the community promptly, and on minimizing the time between patient arrival and initial assessment by a physician.

As a strategy to ensure patients are receiving care in the most appropriate setting, Cambridge Memorial Hospital has been working closely with Ontario Health to implement a Hospital-to-Home program that provides in-home assistance to appropriate patients to avoid lengthy hospitalizations. Early feedback from patients, and providers has been extremely positive.

3. **Equity and Indigenous Health** Ontario Health is committed to driving improved and equitable access, experiences, and outcomes to reduce health inequities and advance Indigenous health across the province. Advancing health equity and Indigenous health for communities in Ontario requires strategic and sustained efforts. Please share your organization's plans for quality improvement initiatives to improve equity and foster Indigenous health and cultural safety (for example, implementation of workplans such as an Equity, Inclusion, Diversity, and Antiracism workplan; First Nations, Inuit, Métis, Urban Indigenous health workplan, or a workplan that includes existing provincial priorities (such as populations who experience significant barriers to accessing care and health services), which may be based on Service Accountability Agreement obligations). *Recommended length: 250 words*

Cambridge Memorial Hospital remains unwavering in our commitment to the strategic pillar 'Advance Health Equity'. CMH has an active and engaged Diversity Council (DC) that is comprised of staff from varied backgrounds who collectively advise on, and promote, DEI initiatives across the organization. We celebrate and honour diversity through a cadence of 3 – 5 holidays and observations per month, many of which are personalized through an article series titled 'Voices of CMH' that highlight stories from CMH staff and physicians about their unique journeys.

All leaders are expected to participate in the San'yas Indigenous Cultural Safety training which is also regularly offered to interested staff. The leadership team has participated in the Blanket Exercise, a powerful experiential workshop that explores the historical relationships between Indigenous and non-Indigenous peoples in Canada. CMH has welcomed Indigenous Elders to the hospital to lead drum circles, hawk feather nourishing ceremonies, and sacred fire ceremonies. CMH is represented on a regional Indigenous health council, has incorporated a smudging policy, and has access to an Indigenous Navigator role through Southwestern Ontario Aboriginal Health Access Network (SOAHAC).

Beginning in 2025-26 the organization will start to voluntarily collect sociodemographic data through an electronic survey from patients to better understand the diverse

backgrounds of the population we serve. This information will assist with service and care delivery planning.

4. **Patient/Client/Resident Experience** Share how your organization plans to incorporate information from experience surveys; or other feedback received about care experiences into improvement activities. *Recommended length: 250 words*

Over the past year, Patient and Family Advisory Council (PFAC) members have been active in refreshing the Patient Declaration of Values, advising on flow and access challenges, and advocating for easier patient access to personal health information with a common goal of impacting the patient experience positively.

The updated Patient Declaration of Values is a modernized version of the one from 2018; adding emphasis on diversity, equity and inclusion and a focus on timely access to, and confidentiality of, their personal health information.

5. **Provider Experience** Many organizations are implementing innovative practices to improve recruitment and retention, (such as through incentive-based programs for nurses and personal support workers) workplace culture, and staff experiences. Describe practices or initiatives your organization has planned to improve recruitment, retention, workplace culture, or staff experience. *Recommended length: 250 words*

The verdict is in - Cambridge Memorial Hospital is a fantastic place to work! This past year CMH was designated as a top employer twice; once as Waterloo Area's Top Employer and as Southwestern Ontario's Top Employer. Collectively these awards, and more importantly, the work behind them, embody the strategic pillar 'Joy at Work'. This is the culmination of efforts over a number of years when the organization adopted the Institute for Healthcare Improvement's (IHI) Joy at Work Framework.

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

- Employee Engagement Council which is a group of staff from various roles and departments that advise leadership.
- Ember, CMH's facility dog. CMH is the first hospital in North America to have a facility dog who 'attends' work daily with their handler, rounds frequently to various departments, attends all post-code debriefs, and is available ad hoc to support staff.
- Enhanced mental health coverage for all staff (full and part time) and physicians for the past 3 years.
- A monthly wellness calendar that combines Wellness, Learning, and DEI appreciation events both at CMH, and in the broader community.
- Rotation of staff appreciation events throughout the calendar year (Children's holiday event, Thank-you event to coincide with Valentine's Day, Summer BBQ, holiday meal) organized and delivered by rotating teams of leaders.
- Many values (Caring, Collaboration, Accountability, Innovation, Respect = CCAIR) based events – staff swag jackets with value of choice on the back; I-CCAIR peer to peer recognition award; values based performance appraisals

6. **Safety** Describe a quality improvement project or initiative that is part of your organization's efforts to create and sustain a culture of safety to prevent or reduce patient safety incidents. Consider sharing system approaches of addressing all forms of harm by leveraging Healthcare Excellence Canada's Rethinking Patient Safety report or including activities related to participation in Ontario Health's Never Events Hospital Reporting initiative. *Recommended length: 250 words*

Some key achievements from the Patient Safety office over the past year include:

- Standardized incident management processes with a focus on Just Culture, including the introduction of a new patient safety dashboard, launch of a Just Culture policy, and a new patient safety newsletter, all aimed at improving transparency, engagement, and accountability.

- The patient safety newsletter, Safe-T-Cast, is published six times per year and highlights/disseminates learnings from case reviews, policy updates, and individuals or teams doing great work.

- In partnership with Professional Practice, established an inter-professional Best Practice Committee in 2024 to promote cross-profession and cross-program collaboration. By engaging frontline staff through the use of quality improvement and project management tools to focus on implementing clinical best practices, the committee fosters Joy in Work and cultivates a culture of continuous improvement ultimately focused on enhancing patient safety.

- The hospital's Choosing Wisely Oversight Committee ensures a focused and sustainable approach, embedding best practices into daily operations. As part of its next steps, CMH is actively working through a Quality Improvement project led by the Pharmacy team to reduce unnecessary proton pump inhibitor (PPI) use, further optimizing medication stewardship. As CMH progresses towards Choosing Wisely Leadership designation, it remains dedicated to continuous quality improvement and responsible healthcare delivery.

7. **NEW Palliative Care** Describe how your organization has delivered (or plans to deliver) high-quality palliative care. Please provide up to 3 specific examples of activities within your organization that demonstrate a commitment to meeting this objective. Consider themes such as organizational readiness; health human resource competency; patient, resident, and care partner engagement; patient, resident education; and the organization's focus on processes to support care when identifying key activities that your organization may be engaged in. Describe how the activities achieve the standard of care exemplified by quality statements in the Quality Standard for Palliative Care or Ontario Palliative Care Network model of care recommendations. *Recommended length: 250 words*

Supporting patients and their family during their palliative care journey is important to staff at CMH. Below are examples of initiatives that the organization is doing that demonstrate the commitment to offering high-quality palliative care:

1. Palliative care carts that enhance the patient/family experience while the patient is receiving palliative or end of life care. Each cart has a kettle, coffee machine, mood lighting, personal hygiene products, and snacks. Each cart also has a quilt that has been donated. The quilt is given to the patient to accompany them to the funeral home or the family may keep it as a keepsake. All supplies are donated.

2. With consent, a consistent symbol is placed on the door of all patients receiving palliative care to inform all team members.

3. 20 Registered staff received funding to complete the de Souza certification in 2024 and 18 staff completed the mini LEAP education in April of 2024.

4. A staff led, multi-disciplinary, Palliative Care committee was developed. Education has been developed on how to provide as well as how to document when palliative care has been delivered. The team has planned the delivery of this education to the medicine team in the spring of 2025 with a plan to spread wherever palliative care is delivered. throughout the organization.

5. Finally, the newly constructed and renovated patient care areas with over80% private rooms, ensure that the majority of palliative care and end of life patients can receive care in a private room.

8. **Population Health Management** *Population health management*, as defined by the Rapid Improvement Support Exchange (RISE) program, is an iterative process which involves gathering data and insights from many partners (including non-traditional health care partners) about an entire population's health and social needs. These insights inform the co-design of proactive, integrated, person-centred, cost-effective, equitable, and efficient solutions with the goal of improving the health needs of persons along the continuum of care and well-being. In this section, share how your organization is partnering with other health service organizations to care for the unique needs of people in the community. For organizations that are part of an Ontario Health Team, consider including work (or planned work) related to population identification or co-design with people with lived experience. *Recommended length: 250 words*

Beginning in 2025-26 the organization will start to voluntarily collect sociodemographic data from patients through an electronic survey to better understand the diverse backgrounds of the population we serve. This will support and enhance the work already underway at CMH to understand the variation in health status and access points/frequency of the population we serve.

Collectively this information will help in collaboration with community partners to achieve the strategic pillar of 'Reimagine Community Health' enabling the plan and delivery of services and care best suited to Cambridge and North Dumfries.

CMH has strong community partnerships in our Cambridge North Dumfries Ontario Health Team (CND-OHT), Collaborating Communities, Primary Care Networks, Ontario Health at Home and the many organizations that support patients as they transition to their discharge destination.

9. **NEW – Quality Improvement and Emergency Department Return Visit Quality Program** Each site that is part of a hospital participating in the Emergency Department Return Visit Quality Program (EDRVQP) should answer either the large-volume site or small-volume site questions:

For Large-Volume Sites (Emergency Departments with More Than 30,000 Annual Visits)

1. Provide a status update for 1 or 2 of your hospital site's quality improvement priorities from the preceding year's EDRVQP audit. Include results and data where possible.

2. Share some of the quality issues identified during this year's audit. Describe quality improvement initiatives that are being planned or worked on to address these issues.

This section will be submitted to the Ontario Health Navigator portal by March 31, 2025 and brought to the April Quality Committee meeting as part of the Emergency Department program presentation.

2025/26 Quality Improvement Plan Program: Indicator Matrix

Priority issues	Optional indicators (unless marked priority), by sector		
	Hospital	**Interprofessional primary care**	**Long-term care**
Access and flow *A high-quality health system provides people with the care they need, when and where they need it.*	• 90th percentile ambulance offload time (Priority) • 90th percentile emergency department wait time to physician initial assessment (Priority) • Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m. (Priority) • 90th percentile emergency department length of stay for admitted patients • 90th percentile emergency department length of stay for nonadmitted patients with low acuity • 90th percentile emergency department length of stay for nonadmitted patients with high acuity • 90th percentile emergency department wait time to inpatient bed • Percentage of patients who visited the emergency department and left without being seen by a physician	• Patient/client perception of timely access to care • Number of new patients/clients/enrolments • Percentage of clients with type 2 diabetes mellitus who are up to date with HbA1c (glycated hemoglobin) blood glucose monitoring • Percentage of screen-eligible people who are up to date with colorectal tests • Percentage of screen-eligible people who are up to date with cervical screening • Percentage of screen-eligible people who are up to date with breast screening	• Rate of potentially avoidable emergency department visits for long-term care residents
Equity *Advancing equity, inclusion and diversity and addressing racism to reduce disparities in outcomes for patients, families, and providers is the foundation of a high-quality health system.*	• Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education • Average emergency department wait time to physician initial assessment for individuals with sickle cell disease (CTAS 1 or 2) • Rate of emergency department 30-day repeat visits for individuals with sickle cell disease • Percentage of emergency department visits for individuals with sickle cell disease triaged with high severity (CTAS 1 or 2)	• Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education • Completion of sociodemographic data collection • Percentage of clients actively receiving mental health care from a traditional provider • Number of events and participants for traditional teaching, healing, or ceremony	• Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education
Experience *Better experiences result in better outcomes. Tracking and understanding experience is an important element of quality.*	• Did patients feel they received adequate information about their health and their care at discharge?	• Do patients/clients feel comfortable and welcome at their primary care office?	• Do residents feel they can speak up without fear of consequences? • Do residents feel they have a voice and are listened to by staff?
Safety *A high-quality health system ensures people receive care in a way that is safe and effective*	• Rate of delirium onset during hospitalization • Rate of medication reconciliation at discharge • Rate of workplace violence incidents resulting in lost-time injury	• Number of faxes sent per 1,000 rostered patients • **Provincial digital solutions suite (6 indicators):** Percentage of clinicians in the primary care practice using… [eReferral, eConsult, OLIS, HRM, electronic prescribing, online appointment booking]	• Percentage of long-term care residents not living with psychosis who were given antipsychotic medication • Percentage of long-term care residents who fell in the last 30 days

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

Abbreviations: *CTAS*, Canadian Triage and Acuity Scale; *HRM*, Health Report Manager; *OLIS*, Ontario Laboratory Information System.

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

ISBN 978-1-4868-8536-7 (PDF)

BRIEFING NOTE

Date: February 12, 2025
Issue: January 2025 Financial Statements
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Maria Burzynski, Controller
Approved by: Valerie Smith-Sellers, Director, Finance
Trevor Clark, VP Finance and Corporate Services, CFO

Attachments / Related Documents: Financial Statements – January 2025

Alignment with CMH Priorities

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

Recommendation/Motion

Board
That, the Board receives the January 2025 financial statements as presented by management and upon the recommendation of the Resources Committee at the meeting of February 24, 2025.

Resources Committee
Following review and discussion of the information provided, the Resources Committee of the Board recommends that the Board of Directors receives the January 2025 financial statements as presented by management. **CARRIED**.

Executive Summary
Cambridge Memorial Hospital (CMH) has a $9.7M year-to-date surplus position at the end of January after building amortization and related capital grants. The major drivers of the surplus are the unused portion of the budgeted contingency ($5M), additional Bill 124 funding not budgeted for ($3.3M), higher Post Construction Operating Plan (PCOP) revenue ($2.7M), quality based procedures (QBP) revenue ($2.6M) and recoveries / other revenue ($1.4M) than budget. These favourable variances are partially offset by unfavorable variances in salaries & wages and benefits ($3.9M), primarily due to higher overtime than budget.

CMH is forecasting a surplus of $9M for 2024-25 driven by unused contingency ($6.4M), additional Bill 124 funding ($3.9M), Incremental Surgical Recovery Funding ($3M) and PCOP

funding ($2.2M), partially offset by ongoing salaries & wages pressures ($4.2M) and in-year approved budget enhancements ($3M).

Risks

- Actual overtime costs continue to be much higher than budget ($4.2M YTD January). At the current rate, overtime costs are forecast to be $5M higher than budget by the end of the fiscal year. A working group focusing on strategies to reduce the amount of overtime is meeting on a bi-weekly basis. The unfavorable variance in overtime is partially offset by a favorable variance in worked salaries ($4M)
- PCOP volume targets YTD January are favorable to budget creating a $2.7M favorable variance. This was due to higher weighted cases in acute inpatient, partially offset by surgery (physician vacancies and returned surgical blocks), lower occupancy rates in mental health than budget, and lower patient volumes in the emergency department. PCOP funding is forecast to be $2.2M higher than budget by the end of the fiscal year.
- $5.4M in funding for Bill 124 has been budgeted for in fiscal 2024-25. CMH received a funding letter in October 2024 to confirm the full twelve months of Bill 124 funding ($5.8M). In addition, CMH received a funding letter in December 2024 to fully cover the impact of Bill 124 for all union and non-bargaining, non-executive staff. In total, the hospital will receive $3.9M more than what was budgeted for. $3.3M in incremental Bill 124 has been recognized year-to-date.
- 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 37 ALC patients in 2024-25 compared to 34 in fiscal 2023-24.
- CMH is undergoing system transformations and have included $979K of expenses in the financial statements presented. These costs are made up of compensation, software and legal costs.

Summary

CMH has a $9.7M year-to-date surplus position at the end of January after building amortization and related capital grants. Actual results are $9.6M favorable to budget. The favorable variance has been driven by:

- $3.7M in other supplies & expenses mainly due to unused budgeted contingency ($5M) through the end of January;
- $3.3M in Ministry of Health (MOH) base funding relating to Bill 124 wage impacts for all union and non-bargaining, non-executive staff;
- $2.7M in PCOP funding driven by higher acute impatient weighted cases and increase in discharges;
- $2.6M in Quality Based Procedures (QBP) revenue due to increased hip, knee, and shoulder;
- $1.4M in recoveries and other revenue mainly comprised of $0.5M in Cancer Care Ontario (CCO) oncology drugs recovery, $0.3M in interest income and $0.3M in parking revenue.

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

- $3.9M unfavorable variance in salaries & wages and benefits primarily due to higher overtime than budget;
- $0.5M unfavorable variance in medical surgical supplies due to IV sets, regents for chemical laboratory and contrast media injections required for additional CT & MRI volumes

MOH Funding – Base
In December 2024, CMH received funding approval to cover the cost implications from the Bill 124 fully for all union and non-bargaining, and non-executive staff. This is $3.9M more funding than was budgeted for. $3.3M has been recognized year to date.

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 $2.7M favorable variance in PCOP funding is mainly due to higher acute inpatient weighted cases offset by lower surgical volumes, lower emergency department weighted cases and lower patient days in inpatient mental health than budget.

PCOP acute inpatient weighted cases has the biggest funding implication for the hospital. Each weighted case generates $4,517 in funding. The hospital has generated 346 acute inpatient weighted cases more than budget through December which represents $1.6M in funding. The surgical department, emergency department and mental health teams have had lower patient volumes than budget and have not met PCOP targets YTD.

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

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

Bundled care and surgical QBPs were $3.1M favorable. Urgent medical QBPs funded through OH was $1.2M unfavorable to budget.

CCO QBP revenue was $0.6M favorable to budget, due to final reconciliation from 2022-23 and 2023-24 fiscal years resulting in a net pick up ($0.5M) and higher systemic volumes ($0.2M).

Performance Based Funding Summary: Fiscal 2024-25
YTD January 2025 (Actual January coded data not available)

PCOP					
Funding Source	Unit of Measure	Budget	YTD Budget	YTD Achieved # *(coded volumes)*	YTD Variance from Budget
Acute IP	Weighted Cases	8,249	6,187	6,532	346
Day Surgery/TCC	Weighted Cases	2,983	2,237	2,054	(184)
Emergency	Weighted Cases	2,839	2,129	1,969	(161)
Mental Health IP	Inpatient Days	7,867	5,900	5,428	(472)

QBP				
Funding Source	Unit of Measure	Budget	YTD Achieved $ *(coded volumes)*	YTD Variance from Budget
OH Urgent Medical	Cases	989	$ 4,052,614	(171)
OH Bundled Care	Cases	882	$ 8,424,105	315
OH Surgical	Cases	3,010	$ 4,348,107	967
CCO	Cases	559	$ 2,069,659	(19)

MOH Funding – One-Time / Other
The $193K year to date unfavorable variance is primarily due to a $319K unfavorable variance on MOH one-time for funding driven by a $138K claw-back in Human Health Resource (HHR) preceptor funding.

Billable Patient Services
The $756K year to date favourable variance is primarily due to a $516K favourable variance for non-resident of Canada billing.

Recoveries and Other Revenue
The $1.4M year to date favorable variance is driven by a $0.5M recovery for oncology drugs from CCO, $0.3M for parking revenue, and $0.3M favorable variance in interest income.

Expenses

Salaries and Wages
Salaries and wages were $2.8M unfavorable to budget year to date. This was mainly due to higher overtime ($4.2M), staff training costs ($1.3M), sick ($0.4M), modified work ($0.4M), partially offset by a favorable variance in worked salaries ($4M) due to vacancies.
Overtime and sick time hours are summarized in the table below:

	January 2025			FY 2024-25		
HOURS	Actual	Budget	Variance	Actual	Budget	Variance
Overtime	9,373	2,041	(7,332)	78,913	19,799	(59,114)
Sick	5,919	4,510	(1,409)	68,396	43,210	(25,186)

The overtime variance has primarily been driven by staffing shortages. The chart below summarizes the number of overtime hours for the past 26 pay periods. Overtime has increased over the past year, peaking at 97,003 in pay period 12. The amount of overtime per pay period is on a slight decrease from the peak. Efforts continue to reduce the amount of overtime.

Employee Benefits
The $1.1M 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 $115K favorable year to date variance is mainly driven by favorable variances in Oncology ($245K), alternate funding for ED ($194K), and offset with an unfavorable variance in CT & MRI ($410K).

Medical and Surgical Supplies
The $486K YTD unfavorable variance has been driven by IV sets ($228K), regents / chemical laboratory ($132K) and contrast media injections required for additional CT & MRI volumes ($64K).

Drug Expense
The $666K YTD unfavorable variance is driven by higher spending on drugs for the Oncology program ($508K). 98% of oncology drug costs are reimbursed by CCO.

Other Supplies and Expenses
The $3.7M YTD favorable variance is due to the unused contingency ($5M), offset by equipment maintenances costs in the surgical and endoscopy programs ($0.4M), workforce planning equipment ($0.3M), Housekeeping ($0.2M).

Balance Sheet and Statement of Cash
CMH's current cash position is $102.2M, consisting of $83.4M of unrestricted cash and $18.8M of restricted cash. Unrestricted working capital available at the end of January is $21M. The working capital ratio is 1.31 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 January was $41.8M, including general accounts payable ($36.4M) and MOH payable ($5.4M). The accounts receivable balance at the end of January was $12.1M, which includes MOH receivable ($8M) and general accounts receivable ($4.1M).

Forecast

CMH is forecasting a surplus of $9M for 2024-25. This does not include the prior year one-time recovery of PCOP funding which has been reconciled by the MOH.

The forecast includes unused contingency ($6.4M) offset by unfavorable variance in salary and benefits ($4.2M) and approved one-time, in-year enhancements ($3M). In August, MOH advised that Incremental Surgical Recovery funding (ISR) would be available this year. $3M in ISR one-time funding has been estimated and included in the forecast. PCOP funding is forecasted to be $2.2M over budget, driven by higher inpatient acute weighted cases.

Included in the forecast is $9.3M of MOH revenue to offset the 2024-25 incremental wage impact of Bill 124. This is $3.9M more than the budgeted amount.

The MOH is currently reconciling the PCOP funding for 2022-23 and 2023-24. The hospital is expecting a favorable result that will create a one-time funding source to be invested in system modernization and building infrastructure. This has not been included in the current year-end forecast.

AGENDA

Cambridge Memorial Hospital
Statement of Income and Expense
For the period ending January 31, 2025

Confidential
(Expressed in thousands of dollars)

Month of January 2025					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	January 2024	2023-24 YE
				Revenue:									
				MOH Funding									
$ 10,265	$ 9,940	$ 325	3%	MOH - Base	$ 101,368	$ 98,119	$ 3,249	3%	$ 120,935	$ 117,037	$ 3,898	$ 8,012	$ 93,971
3,508	2,646	862	33%	MOH - Quality Based Procedure	25,162	22,612	2,550	11%	26,851	26,559	292	2,615	27,048
2,974	1,345	1,629	121%	MOH - Post Construction Operating Plan	15,938	13,278	2,660	20%	18,005	15,838	2,167	563	14,207
932	770	162	21%	MOH - One time / Other	7,548	7,741	(193)	(2%)	12,910	9,317	3,593	1,692	36,820
17,679	14,701	2,978	20%	Total MOH Funding	150,016	141,750	8,266	6%	**178,701**	**168,751**	**9,950**	12,882	172,046
1,664	1,386	278	20%	Billable Patient Services	14,441	13,685	756	6%	16,905	16,324	581	1,292	15,187
1,603	1,605	(2)	(0%)	Recoveries and Other Revenue	17,272	15,888	1,384	9%	21,703	19,152	2,551	1,752	22,461
323	341	(18)	(5%)	Amortization of Deferred Equipment Capital Grants	3,225	3,303	(78)	(2%)	3,858	3,952	(94)	344	3,888
501	295	206	70%	MOH Special Votes Revenue	3,329	2,946	383	13%	3,508	3,508	-	420	3,681
21,770	**18,328**	**3,442**	**19%**	**Total Revenue**	**188,283**	**177,572**	**10,711**	**6%**	**224,675**	**211,687**	**12,988**	**16,690**	**217,263**
				Operating Expenses:									
8,688	8,274	(414)	(5%)	Salaries & Wages	82,176	79,381	(2,795)	(4%)	98,325	95,025	(3,300)	7,990	92,991
2,572	2,311	(261)	(11%)	Employee Benefits	21,865	20,749	(1,116)	(5%)	26,012	25,155	(857)	2,360	24,424
2,192	1,880	(312)	(17%)	Medical Remuneration	18,540	18,425	(115)	(1%)	21,721	22,004	283	1,824	21,279
1,313	1,198	(115)	(10%)	Medical & Surgical Supplies	12,252	11,766	(486)	(4%)	14,627	14,047	(580)	1,269	13,891
1,157	1,067	(90)	(8%)	Drug Expense	11,147	10,481	(666)	(6%)	13,311	12,511	(800)	1,021	12,242
2,369	2,369	-	0%	Other Supplies & Expenses	22,074	25,767	3,693	14%	29,397	30,296	899	1,786	28,437
550	641	91	14%	Equipment Depreciation	5,596	6,001	405	7%	6,737	7,223	486	592	6,830
497	340	(157)	(46%)	MOH Special Votes Expense	3,329	3,310	(19)	(1%)	3,508	3,508	-	420	3,681
19,338	**18,080**	**(1,258)**	**(7%)**	**Total Operating Expenses**	**176,979**	**175,880**	**(1,099)**	**(1%)**	**213,638**	**209,769**	**(3,869)**	**17,262**	**203,775**
2,432	**248**	**2,184**	**881%**	**MOH Surplus / (Deficit)**	**11,304**	**1,692**	**9,612**	**568%**	**11,037**	**1,918**	**9,119**	**(572)**	**13,488**
(656)	(878)	222	(25%)	Building Depreciation	(6,468)	(7,308)	840	(11%)	(8,625)	(9,002)	377	(633)	(7,589)
484	699	(215)	(31%)	Amortization of Deferred Building Capital Grants	4,838	5,752	(914)	(16%)	6,570	7,084	(514)	484	5,802
$ 2,260	**$ 69**	**$ 2,191**		**Net Surplus / (Deficit)**	**$ 9,674**	**$ 136**	**$ 9,538**		**$ 8,982**	**$ -**	**$ 8,982**	**$ (721)**	**$ 11,701**

Cambridge Memorial Hospital
Statement of Financial Position
As at January 31, 2025

(Expressed in thousands of dollars)

	January 2025	March 2024
ASSETS		
Current Assets		
Cash and Short-term Investments	$ 83,350	$ 82,817
Due from Ministry of Health/Ontario Health	7,954	7,549
Other Receivables	4,131	4,616
Inventories	3,300	2,865
Prepaid Expenses	3,013	2,458
	101,748	100,305
Non-Current Assets		
Cash and Investments Restricted - Capital	18,847	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	216	206
Capital Assets	311,593	296,132
Total Assets	**$ 436,122**	**$ 429,720**
LIABILITIES & NET ASSETS		
Current Liabilities		
Due to Ministry of Health/Ontario Health	5,393	5,774
Accounts Payable and Accrued Liabilities	36,377	40,655
Deferred Revenue	35,952	32,449
	77,722	78,878
Long Term Liabilities		
Capital Redevelopment Construction Payable	5,624	4,035
Employee Future Benefits	4,431	4,223
Deferred Capital Grants and Donations	280,870	284,783
Asset Retirement Obligation	2,810	2,810
	293,735	295,851
Net Assets:		
Unrestricted	21,035	17,204
Externally Restricted Special Purpose Funds	216	206
Invested in Capital Assets	43,414	37,581
	64,665	54,991
Total Liabilities and Net Assets	**$ 436,122**	**$ 429,720**
Working Capital Balance	24,026	21,427
Working Capital Ratio (Current Ratio)	1.31	1.27

Cambridge Memorial Hospital
Statements of Cash Flows
For the Month Ending January 31, 2025

(Expressed in thousands of dollars)

	January 2025	March 2024
Cash Provided By (used in) Operations:		
Excess (deficiency) of Revenue over Expenses	$ 9,674	$ 11,701
Items not involving cash:		
Amortization of capital assets	12,064	14,419
Amortization of deferred grants and donations	(8,063)	(9,680)
Change in Non-Cash Operating Working Capital	(2,076)	(2,647)
Change in Employee Future Benefits	207	20
	11,806	13,813
Investing:		
Acquisition of Capital Assets & CRP	(27,524)	(33,552)
Capital Redevelopment Construction Payable	1,589	1,607
	(25,935)	(31,945)
Financing:		
Change in non-cash capital accounts receivable	-	341
Capital Donations and Grants & CRP	4,150	24,352
	4,150	24,693
Increase (Decrease) In Cash for the Period	(9,979)	6,561
Cash & Investments - Beginning of Year	112,176	105,615
Cash & Investments - End Of Period	**$ 102,197**	**$ 112,176**
Cash & Investments Consist of:		
Unrestricted Endowment and Special Purpose Investments	30	30
Cash & Investments Operating	83,320	82,787
Cash & Investments Restricted	18,847	29,359
Total	**$ 102,197**	**$ 112,176**

BRIEFING NOTE

Date: February 12, 2025
Issue: New Credentialed Physicians/Midwives – February 2025
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 medical professional staff 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 include:

1. **Dr. Elizabeth Anago, Mental Health Physician, Start date: February 1, 2025**
   Dr. Elizabeth Unoma Anago earned her MBBS from Imo State University, Nigeria, then trained and practiced psychiatry in Ireland. Recently Dr. Anago passed the written component of the Royal College of Physicians and Surgeons of Canada exams in February 2024. She has extensive experience in psychiatry and is focused on General Adult Psychiatry with an interest in Child and Adolescent Psychiatry and Perinatal Psychiatry.

2. **Kamara Ukachukwu, Midwife, Start date: July 1, 2025**
   Kamara Ukachukwu is a registered midwife currently practicing at Uptown Midwives & Family Wellness in North York, providing evidence-based care for clients since May 2022. She graduated with a Bachelor of Science in Midwifery from Toronto Metropolitan University in June 2023.

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