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

June 4, 2025
1845-1900
Virtual via Teams / MEC Classroom A.0.218
Join the meeting now
Or call in (audio only)
833-287-2824,,440193256Canada (Toll-free)
Phone Conference ID: 440 193 256#

AGENDA

Agenda Item * indicates attachment / TBC – to be circulated	Page #	Time	Responsibility	Purpose
1. CALL TO ORDER				
1.1 Confirmation of Quorum (7)		1845	L. Woeller	Confirmation
1.2 Declarations of Conflict of Interest		1846	L. Woeller	Declaration
1.3 Consent Agenda *(Any Board member may request that any item be removed from this consent agenda and moved to the regular agenda)*		1847	L. Woeller	Motion
1.3.1 Minutes of May 7, 2025*	4			
1.3.2 2024/25 Board of Directors Action Log*	8			
1.3.3 Board Attendance*	9			
1.3.4 Board Work Plan*	10			
1.3.5 Events Calendar*	17			
1.3.6 Proposed 2025/26 Board/Committee Meeting Dates*	19			
1.3.7 Committee Reports to the Board of Directors				
1.3.7.1 Quality Committee (May 21, 2025)	20			
1.3.7.2 Executive Committee* (May 20, 2025)	24			
1.3.7.3 Digital Health Strategy Sub-Committee (May 15, 2025)	25			
1.3.7.4 Audit Committee* (May 26, 2025)	26			
1.3.7.5 Resources Committee* (May 26, 2025)	27			
1.3.7.6 Medical Advisory Committee* (May 14, 2025)	28			
1.3.7.6.1 New Credentialed Physicians April 2025*	31			
1.3.7.7 Governance Committee* (May 15 & May 29, 2025)	32			
1.3.8 Governance Policy Summary* Policies for Approval: (track changes version found in Package 2) 2-D-50 Perquisite 2-D-61 Celebrating and Honouring Board Members	34 35 38			
1.3.9 CEO Annual Certificate of Compliance & CEO Certificate of Compliance May 30, 2025*	39			
1.3.10 2024/2025 Strategic Priorities Tracker Q4 Updates*	41			
1.3.10.1 Quality Monitoring Metrics – Monthly Report*	53			
1.3.11 CMH President & CEO Report*	79			

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
1.3.12 Certificate of Compliance - Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding*	87			
1.3.13 Broader Public Sector Accountability Act Attestation*	88			
1.3.14 Multi-Sector Service Accountability Agreement (M-SAA) Schedule F Declaration of Compliance *	100			
1.3.15 HSAA Article 8 – Declaration of Compliance *	104			
1.4 Confirmation of Agenda		1857	L. Woeller	Motion
2. PRESENTATIONS				
2.1 No Open Matters for Discussion				
3. BUSINESS ARISING				
3.1 No Open Matters for Discussion				
4. NEW BUSINESS				
4.1 No Open Matters for Discussion				
5. UPCOMING EVENTS		1858	L. Woeller	
5.1 CMH Golf Classic, Galt Country Club, June 5, 2025, CMH Golf Classic 2025 - Cambridge Memorial Hospital Foundation				
5.2 CMH Walk from Cambridge to Paris, June 8, 2025				
5.3 Board Social, June 10, 2025, 5:30pm – The Venue				
5.4 CMH Staff BBQ, June 12 – 11:00am-2:00pm / 9:00pm-10:00pm				
5.5 Armenian Prelacy Golf Tournament, location TBD, June 12, 2025				
5.6 Grand Rounds, June 26, 2025, virtual (details to follow)				
6. DATE OF NEXT MEETING	Wednesday June 25, 2025 Location: Hybrid			
7. TERMINATION		1900	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 – June 4, 2025	
1.3	Consent Agenda	• That, the Board of Directors approves the Consent Agenda as presented/amended
1.3.8		• That, the Board of Directors approves the following policies as presented/amended and upon recommendation of the Governance Committee at the meeting of May 15, 2025 ○ 2-D-50 Perquisite ○ 2-D-61 Celebrating and Honouring Board Members
1.3.13		• That, the Board of Directors approves the Broader Public Sector Accountability Act, 2010 (BPSAA) Appendix C - Attestation prepared by the President and CEO in accordance with Section 15 of the BPSAA for the period April 1, 2024 to March 31, 2025, and upon recommendation of the Resources Committee at the meeting of May 26, 2025
1.3.14		• That, the Board of Directors approves the submission of the Multi-Sector Service Accountability Agreement (M-SAA) Schedule F – Declaration of Compliance, confirming that CMH continues to meet its legal and contractual obligations and upon recommendation of the Resources Committee at the meeting of May 26, 2025
1.3.15		• That, the Board of Directors supports the submission of the HSAA Article 8 – Declaration of Compliance, and upon recommendation of the Resources Committee at the meeting of May 26, 2025
1.4	Confirmation of Agenda	• That, the agenda be approved as presented/amended

Agenda

Cambridge Memorial Hospital
BOARD OF DIRECTORS MEETING
Wednesday, May 7, 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 May 7, 2025.

Present:

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

Regrets: None

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

Guests: L. Barefoot

Recorder: S. Fitzgerald

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1. CALL TO ORDER
The Chair called the meeting to order at 1700 hours.

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

1.2. **Welcome**
The Chair welcomed the Board members and guests to the meeting.

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

1.4. **Declarations of Conflict 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. The Bill S-211 Forced Labour in Canada Supply Chain Submission was removed.

The consent agenda was approved as amended:
1.5.1 Minutes of March 5, 2025
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
1.5.6 Committee Reports to the Board of Directors
Executive 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
Resources Committee Report to the Board of Directors
Medical Advisory Committee Report to the Board of Directors
Governance Committee Report to the Board of Directors
1.5.7 Governance Policy Summary
Motion: That, the Board of Directors approve the following policies as presented and upon recommendation of the Governance Committee at the meeting of March 13, 2025
1.5.8 Quality Monitoring Metrics – Monthly Report
1.5.9 CEO Certificate of Compliance Q4 (Jan-Mar 2025)
1.5.10 CMH President & CEO Report
None opposed, **CARRIED.**

1.6. **Confirmation of Agenda**
Bill S-211 Forced Labour in Canada Supply Chain Submission was moved to agenda item 4.3

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

None opposed, **CARRIED.**

2. PRESENTATIONS

2.1. Accessibility Plan Update

The Board reviewed and discussed the information pre-circulated in the agenda package. CMH Leadership pointed out that this marks the Accessibility Committee's second year under the umbrella of Patient Experience, Risk, and Quality. An overview of the progress made towards the objectives outlined in the plan was shared, along with an emphasis on the Committee's goals for 2025. Additionally, it was noted that starting in June, a community member with lived experiences as a neurodivergent individual will be joining the committee as its second representative from the community.

L. Barefoot left the meeting.

3. BUSINESS ARISING

No open items for discussion.

4. NEW BUSINESS

4.1. Chairs Update

4.1.1. Board Chair's Report

The Board reviewed the information provided in the meeting agenda package. The Chair thanked the Board for all their support through the last few months by attending various events.

4.1.2. CCDI UnConference 2025

The Board received highlights from the CCDI UnConference. The conference was focused on intersectionality in various aspects of diversity, equity, inclusion, and

accessibility (DEIA). The discussions emphasized the importance of understanding intersectionality not as a synonym for diversity but as a lens through which to analyze power dynamics. The meeting stressed that DEIA initiatives should be viewed beyond the dominant culture and more through a justice lens, emphasizing mutual benefit rather than a zero-sum game. The panelists at the conference also discussed the need to shift perceptions around community building and mentorship programs, noting their importance for equity-deserving groups often left out of informal relationships. They addressed common barriers, such as the misconception that supporting DEIA initiatives means favoring people without merit. Several successful practices were presented, including partnership with organizations possessing traditional knowledge, adaptive inclusion efforts, and employee resource groups to foster a sense of belonging. The conference also touched on the growing diversity in workplaces and the need for different management approaches moving forward.

ACTION: N. Melchers and M. Iromoto to connect to review materials / tools from the conference that would be valuable to share with the Board.

4.2. Quality Committee

4.2.1. Quality Committee Report to the Board of Directors

The Board reviewed and discussed the information provided in the pre-circulated briefing note included in the meeting agenda package. The Chair of the Quality Committee highlighted that the Committee held a discussion on AI's impact on quality, which was well received by all members. The committee also reviewed a presentation from the Emergency Department, focusing on workflow metrics within the department. Prior to the presentation, committee members conducted a tour with CMH Leadership, highlighting that single-handed workflows are a significant barrier to efficiency and effectiveness. Methodology and streamlining processes were discussed as potential improvements once the new system is in place.

The staffing situation has shown some improvement, though overtime remains a concern. Physician staffing continues to be a key priority. The Committee emphasized the importance of creating a safe working environment, noting several upgrades such as panic buttons. These devices have been installed to ensure quicker responses during incidents, especially in mental health units. While the number of incidents has decreased compared to the previous year, violent events still occur approximately every three days. The Committee noted that these incidents can involve a broader range of clients than anticipated, highlighting the need for continued focus on safety measures. The ED Return Visit Report was reviewed and focused on enhancing senior-friendly practices during audits. The audit also revealed areas where patients were told to return if their condition changed but found it challenging to do so, indicating opportunities for improvement in communication and follow-up. Additionally, the committee reviewed the Global Workforce Survey results which showed progress in several areas such as staffing, scheduling, communication, staff well-being, education, quality, and patient safety.

An inquiry was made as to whether there was an opportunity for support from the Board for the Kindness cupboard.

ACTION: CMH Leadership to connect to review what opportunities are available to the Board to donate items.

4.2.2. **Bill S-211 Forced Labour in Canada Supply Chain Submission January 2025 Financial Statements and Year-End Forecast**

The Board reviewed and discussed the information provided in the briefing note included in the pre-circulated meeting agenda package. The Chair of the Audit Committee highlighted that CMH's procurement team have completed all necessary requirements. Specifically, they have finished the Bill S-211 training and updated the procurement templates to include relevant Bill S-211 language. Most consumables and capital equipment are purchased through Mohawk Medbuy, where staff have also completed Environmental, Social, and Governance (ESG) training. Mohawk Medbuy has conducted a supplier risk assessment of the top 200 vendors, and CMH is currently not aware of any instances of forced labor in its supply chain. While acknowledging that there could be potential risks of forced labor, CMH has not identified any such issues based on reports from Mohawk Medbuy or other suppliers. At this stage, CMH has not conducted additional work to identify risks outside of Mohawk Medbuy. Mohawk Medbuy has provided CMH with a letter detailing their efforts in due diligence.

MOTION: That, the Board of Directors approves CMH's Fighting Against Forced Labour and Child Labour in Supply Chains Act ("Act") questionnaire response and report and authorize the filing of the submission and report with the Government of Canada and the posting of the material on the CMH website on or before May 31, 2025, and upon recommendation of the Audit Committee at the meeting of April 28, 2025.

None opposed, **CARRIED.**

4.3. **CEO Update**

No open matters for discussion.

5. UPCOMING EVENTS

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

6. DATE OF NEXT MEETING

The next scheduled Board of Directors meeting is June 4, 2025.

7. TERMINATION

MOTION: That, the meeting terminated at 1755h.

None opposed, **CARRIED.**

Agenda

2024/25 Board of Directors Action Log – June 2025

Agenda Item 1.3.2

Meeting Date	Agenda # / Item Description	Action Item	Owner	Status
05-07-25	4.1.2 CCDI Conference	Review materials/tools from the conference that would be valuable to share with the Board	M. Iromoto / N. Melchers	Update to be provided at the meeting of June 25, 2025
05-07-25	4.2.1 Quality Committee Report to the Board	CMH Leadership to connect to review what opportunities are available to the Board to donate items.	S. Pearsall	Update to be provided at the meeting of June 25, 2025

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

Board of Directors Attendance Report 2024/2025

	100%	100%	100%	89%	100%	100%	100%	100%	100%	100%	100%	67%
Meeting Dates	Lynn Woeller	Diane Wilkinson	Nicola Melchers	Margaret McKinnon	Julia Goyal	Sara Alvarado	Monika Hempel	Tom Dean	Miles Lauzon	Paulo Brasil	Bill Conway	Jay Tulsani
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
5-Mar-25	P	P	P	R	P	P	P	P	P	P	P	P
7-May-25	P	P	P	P	P	P	P	P	P	P	P	P

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
	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

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	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	Complete
	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	Complete
	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	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
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events reported through Directors ABCDE Goals	Complete

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
	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					
		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)	Complete
	v	approving operating and capital plans	2-C-31	Resources	➢ review & approve the annual Operating Plan review & approve the Annual Capital Plan	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	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					

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	Complete
	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	Complete
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events reported through Directors ABCDE Goals	Complete
07-May-25	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	Complete
	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
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events ➢ reported through Directors ABCDE Goals	Complete
	4a Corporate Culture					

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)	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	Due
	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	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
	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	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
	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	Due
	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	Due
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➢ review & approve Board policies as recommended by Governance Committee	Due
	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	Due
	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	

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	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	
	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 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	
	4l Programs Required under the Public Hospitals Act					
	i	(i)ēnsure that an occupational health and safety program and a health surveillance program are established and regularly reviewed			➢ reported through annual attestations	
	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					

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	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	
	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					
		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

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 & 29				
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 AGM			
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 - The Venue - Cambridge Hotel & Conference Centre										10			
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													

Agenda

Proposed Schedule of Meetings - 2025/26

Board of Directors **Reg. Meeting 1700-2100hrs (4hrs) / Generative 1700-2000hrs (3hrs)** *Occurs First Wednesday Mth Following* *Admin Support: Stephanie Fitzgerald*	**Resources Committee 1700-1900hrs (2hrs)** *Occurs Fourth Monday of the Month* *Admin Support: Bonnie-Kay Collins*
Wednesday, October 1, 2025 ***Regular Board Meeting***	Monday, September 22, 2025
Wednesday, November 5, 2025 ***30m Board / Generative 90min***	Monday, November 24, 2025
Wednesday, December 3, 2025 ***Regular Board Meeting***	Monday, February 23, 2026
Wednesday, February 4, 2026 ***30m Board / Generative 90min***	Monday, April 27, 2026
Wednesday, March 4, 2026 ***Regular Board Meeting***	Monday, May 25, 2026
Wednesday, May 6, 2026 ***Regular Board Meeting***	Monday, June 22, 2026
Wednesday, June 3, 2026 ***30m Board / Generative 90min***	
Wednesday, June 24, 2026 ***Regular Board Meeting***	
Quality Committee 0700-0900hrs (2hrs) *Occurs Third Wednesday of the Month* *Admin Support: Iris Anderson*	**Medical Advisory Committee (MAC) 1630-1900hrs (2.5hrs)** *Occurs Second Wednesday of the month* *Admin Support: Nina Grealy*
Wednesday, September 17, 2025	Wednesday, September 10, 2025
Wednesday, October 15, 2025	Wednesday, October 8, 2025
Wednesday, November 19, 2025	Wednesday, November 12, 2025
Wednesday, January 21, 2026	Wednesday, December 10, 2025
Special QIP Meeting, Thursday, February 5, 2026	Wednesday, January 14, 2026
QC Joins Resources Monday, February 23, 2026 @ 1700hrs (Budget Review)	Wednesday, February 11, 2026
Wednesday, February 18, 2026	Wednesday, March 11, 2026
Wednesday, April 15, 2026	Wednesday, April 8, 2026
Wednesday, May 20, 2026	Wednesday May, 13, 2026
Wednesday, June 17, 2026	Wednesday June 10, 2026
Digital Health Strategy Sub Committee 1700-1830hrs (1.5hrs) *Occurs Third Thursday of the Month* *Admin Support: Kristen Hoch*	**Governance Committee 1700-1930hrs (2.5hrs)** *Occurs Second Thursday of the Month* *Admin Support: Stephanie Fitzgerald*
Thursday, September 18, 2025	Thursday, October 9, 2025
Thursday, November 20, 2025	Thursday, November 13, 2025
~~Thursday, January 15, 2026~~	Thursday, December 11, 2025
Thursday, February 19, 2026	Thursday, February 12, 2026
Thursday, April 16, 2026	Thursday. April 9, 2026
Thursday, May 21, 2026	Thursday, May 14, 2026
Thursday, June 18, 2026	
Audit Committee 1700-1900hrs (2hrs) *Occurs Third Monday of the Month* *Admin Support: Bonnie-Kay Collins*	**Executive Committee 1700-1900hrs (2hrs)** *Occurs Third Tuesday of the Month* *Admin Support: Stephanie Fitzgerald*
Monday, November 17, 2025	Tuesday, November 18, 2025
Monday, January 19, 2026	Tuesday, March 17, 2026
	Tuesday, May 19, 2026
Joint Audit & Resources Committee 1700-1900hrs (2hrs) *Occurs Fourth Monday of the Month*	
Monday, April 27, 2026	
Monday, May 25, 2026	

BRIEFING NOTE

Date: May 23, 2025
Issue: Quality Committee Report to the Board of Directors, May 21, 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, May 21, 2025 at 0700h

Attendees:	D. Wilkinson (Chair), N. Gandhi, K. Abogadil, P. Gaskin, T. Mohtsham, M. Adair, J. Goyal, S. Pearsall, R. Howe, C. Bulla, Dr. W. Lee, W. Conway, A. McCarthy
Staff Present:	L. Barefoot, M. Iromoto
Guests:	K. Towes, Dr. L. Green, Dr. M. Hindle, MJ Essau, H. Elliott, K. Grace
Observers:	None
Regrets:	P. Brasil, M. Adair, M. McKinnon

Committee Matters – For information only

1. **Program Presentation: Perioperative Services:** K. Towes, Director of Perioperative Services & Women and Children's Program, Dr. L. Green, Chief of Surgery, and Dr. M. Hindle, Chief of Anesthesia, joined the meeting. The Director of Perioperative & Women and Children's Program spoke to the Patient Story. The case emphasized the importance of collaboration, clear communication, and adaptability within a complex environment, resulting in significantly positive outcomes when the team worked together. The Director of Perioperative Services & Women and Children's Program highlighted some key points about the program: Project Profile – Optimizing OR performance (in partnership with University of Waterloo -students worked on creating a platform to enhance OR block and time utilization, focusing on efficiency improvements across the entire process - project outcomes were presented at various university events - the team won first place in Orchestrate Capstone Design Award competition - this successful collaboration opened opportunities for future projects with CMH, such as optimizing the OR supply pick list and potential involvement with the ED. The Program Risks were noted: recruitment of the following human resources: Surgeons (Plastics, Gyne, Orthopedics); Anesthesiologists; Surgical Assists; RPN in surgical daycare (maternity leave coverage); RPN's inpatient surgery (increase in beds, and vacancies). The Chief of Anesthesia spoke of the notable anesthesia shortage across Canada. CMH has thus far been protected due to no retirements in the past nine years. However, there will be an expected wave of retirements

on the horizon for CMH within the next five years. The Chief of Anesthesia continues efforts to recruit new staff to ensure the group's ongoing success and ability to manage future demands. He highlighted information about a different model of care for anesthesia that many other hospitals are using to assist with recruitment. The Director of Perioperative Services & Women and Children's Program continued with the presentation and spoke about sustainability initiatives, specifically Desflurane removal. CMH is also exploring ways to reduce waste within the ORs through customized supply packs, focusing on optimizing instrumentation, and ensuring trays contain precisely the tools needed for each procedure. This will minimize unnecessary sterilization and its associated environmental impact. Several surgeons have shown interest in getting more involved with these efforts. The Chief of Surgery explained the Acute Care Surgery Model, a common system throughout Ontario, which aims to improve continuity of care for surgical patients. In this model, one surgeon is designated on-call every week, working from 8:00 AM to 4:00 PM daily, including weekends, and covers one day during the week after hours. This ensures there is always a dedicated surgeon available to follow up with inpatient surgery cases. The model includes relief shifts. Patients are seen promptly in the ED and undergo necessary procedures sooner, often leading to same-day discharges. The system not only enhances patient flow but also ensures that surgical care is delivered efficiently and effectively, improving overall patient outcomes while allowing surgeons more flexibility with their office and private practice schedules when they are not on duty for acute care surgeries. Choosing Wisely was highlighted. One Committee member reflected on the Staff Story about an OR nurse recounting her experience with her parent's life-threatening illness and subsequent liver transplant. Management led a short discussion about the significant impact the Perioperative team has had on reducing surgical wait times, a priority for Ontario Health. Through strong community partnerships and a focused approach on streamlining patient care processes, the team effectively addressed long waiting lists by prioritizing timely surgeries and improving access to necessary procedures. This effort required dedication and coordination, resulting in remarkable improvements. The Committee gave accolades to the entire Perioperative team for their commitment and hard work. ***(Further information can be found in package 2.***

2. **Credentialling:** The Chief of Staff directed the Committee members to the pre-circulated slide presentation. A high level overview was given about how CMH has continued to update and refine the process to ensure that CMH has a robust credentialing system for the Medical Professional Staff while minimizing any gaps or risks in the process. The Deputy Chief of Staff noted that the CMH Credentials Committee boasts a broad representation. The Credentials Committee includes several members from the Medical Professional Staff Association (MPSA), with input from nursing administration. This diverse makeup facilitates multi-faceted evaluations of new and re-application processes, along with addressing any issues that arise. To ensure legal compliance and advice, hospital legal is often consulted. The Chief of Staff continued with the presentation by displaying a demo of the CPSO registration renewal system. An interactive demo/tutorial of the Dashboard application was shown. ***(Further information can be found in package 2.***
3. **Patient Experience (PX):** The Committee received the semi-annual update. The following highlights were presented: the volume of files (850) was higher than the previous fiscal year (740 in FY 2023/24). The number of complaints (478) was also higher than the previous fiscal year (392 in FY 2023/24). The number of compliments (153) was slightly lower than the previous fiscal year (165 in FY 2023/24). Recent Patient Suggestions and Actions: Inpatients expressed lack of clarity related to their follow-up appointments in Fracture Clinic / PX shared feedback with management / Patients are now given a Fracture Clinic appointment prior to discharge; PX was notified that the Arabic translation on Voyce posters was incorrect / PX corrected the posters and added translations for the most commonly used languages at CMH; Outpatients who were seen in D wing had to walk to C wing to pay

for parking / PX surveyed patients to determine preference and the parking kiosks were moved to D wing; ED patients expressed lack of knowledge about patient flow and what to expect during their wait / PX worked with ED and IT to add helpful information to TVs in the waiting room; Metrics of Rates of Complaints and Compliments: Rates are based on 1000 patient days for inpatient areas or 1000 visits for outpatient areas; continue to see a trend in the ED complaints moving up, which is mostly related to the wait times; compliments are shared directly with the care teams. Qualtrics Survey Feedback: Implementing the following OHA surveys in 2025: 1) Outpatient Clinics survey; 2) ICU survey and Family Satisfaction in the ICU, 3) Adult Mental Health & Addictions surveys for inpatient and outpatient mental health. CMH Declaration of Values – developed with assistance from PFAC, the updated Declaration of Values will be shared both internally and externally in the coming weeks. One of the PXLs reported that discussions have taken place of implementing additional measures to boost positive feedback, such as placing QR codes throughout the hospital. This would enable patients and visitors to easily share quick compliments about their experiences. This initiative aligns with one of our tactics outlined in the Patient Experience Plan: developing a standardized process for sharing kudos. Management reported that during Patient Experience Week (April 28-May 2, 2025), an initiative called the "Golden Ticket" was introduced (in collaboration with CMH Foundation). These tickets were distributed to patients who registered at central registration and were given out several times during the week via meal trays. The purpose of these Golden tickets was for patients to quickly recognize and commend a staff member or physician. Over 100 submissions were collected throughout the week, highlighting the willingness of patients and family members to share positive feedback when provided with the opportunity. The collected shout-outs are being compiled and will be shared back with the respective staff members. This example demonstrates how structuring processes to actively gather patient appreciation can lead to substantial positive feedback from those receiving care. Another Committee member posed a question about the category of complaints. In response, ED wait times and high patient volumes are trending. There has been an increase in parking-related complaints, particularly during winter months when snow accumulation is a factor. Complaints are fairly consistent across inpatient and outpatient units without any particular issue standing out significantly. However, there have been improvements in complaint numbers from units that have moved into newly renovated spaces. Another Committee member asked if there was an increasing number of complaints from patients or families regarding the quality of care received, considering access to information about healthcare standards via the internet. One of the PXLs responded. Efforts have been made to increase awareness among frontline staff regarding what types of complaints the Patient Experience office can assist with versus those that should be handled by the care team who specialize in patient treatment and discharge planning. The goal is to ensure patients are directed to the appropriate resources for their concerns, such as charge nurses or unit managers, thereby empowering them to receive more direct and timely clinical support. One Committee member observed that the language used in interactions and on platforms like websites can guide people's behavior and responses. The Committee member noted that when seeking balanced feedback, both positive and negative, the phrasing of questions can influence the type of feedback received. It was suggested to modify this language to encourage a broader spectrum of input, including recognition of what is working well alongside areas needing enhancement, thereby fostering more comprehensive and balanced communication. ***(Further information can be found in package 2.***

4. **Quality Monitoring Scorecard:** A copy of the Quality Monitoring Scorecard was pre-circulated. Red metrics were discussed during the Organizational Flow presentation.
5. **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: Ambulatory Clinic Hub Consolidation project is underway - comprehensive review of all current clinics.

DI efforts for Choosing Wisely. Inpatient Surgery New Manager has been hired. Laboratory Medicine Actively preparing for upcoming full-cycle Accreditation. Medicine Kindness Cupboard remains operational and continues to receive donations of new and gently used items (available for use to both patients and staff). Mental Health Occupancy rate in April 2025 was 75.6%, slightly below previous fiscal; ECT Volumes remain on target. Flow meetings will be structured in collaboration with the ED; Pharmacy is in the initial phase of updating the Omnicell service to support future HIS workflows. Professional Practice 22 Clinical Externs have been hired to join the team – the total is 51. Best Practice Fair is being held May 12-21, 2025. A simulation mannequin has been purchased which will assist the Clinical Educator Facilitators (CEFs) in providing more simulation-based training for supporting skill development and team-based learning. In the Women & Children's Program an Indigenous staff member conducted a comprehensive review to identify strategies for better supporting the Indigenous population.

BRIEFING NOTE

Date: May 21, 2025
Issue: Executive Committee Report to Board of Directors May 20, 2025 - OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Administrative Assistant
Approved by: Lynn Woeller, Executive Committee Chair & Patrick Gaskin, President & CEO

Attachments/Related Documents: None

A meeting of the Executive Committee took place on Tuesday, May 20, 2025 at 1700h

Attendees: L. Woeller (Chair), T. Dean, M. Hempel, D. Wilkinson, N. Melchers

Staff Present: P. Gaskin, Dr. W. Lee

Regrets: None

Committee Matters – For information only.

1. **Executive Committee Policy Review**: The Executive Committee undertook a thorough revision process focused on creating clearer and more concise policies. Following final review and discussion, these policies have been endorsed by the Executive Committee and will be reviewed by the Governance Committee in the Fall of 2025 and subsequently brought forward to the Board of Directors for final review and approval. The Chair expressed gratitude to Diane Wilkinson for her significant contributions in refining the policies. Additionally, it was noted that plans are underway to develop a more extensive non-emergency succession strategy for the CEO role. The Chair and CEO will engage in discussions regarding this broader approach, with details to be presented at an upcoming Executive Committee meeting in the fall of 2025.
2. **Executive Committee Feedback Survey Results:** The Executive Committee reviewed the comments provided from the March 2025 meeting. The Chair thanked the Committee members for their participation and feedback.
3. **Executive Committee Annual Survey Results:** The Executive Committee reviewed the results of the annual survey. Based on member feedback, the Chair addressed concerns about terms of reference, encouraging individuals who feel there is a lack of appropriate guidance to reach out privately. Regarding the orientation process, the Chair acknowledged that there has been a perceived shortfall in adequate orientation across all committees and noted that leadership is working to enhance this for next year. On gender balance, the Chair reported that, upon approval, the upcoming Executive Committee membership will have a 60:40 split, leading to improved gender balance compared to previous years.

BRIEFING NOTE

Date: May 15, 2025
Issue: Digital Health Strategy Sub-Committee Report to Board of Directors - OPEN
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kristen Hoch, Administrative Assistant
Approved by: Sara Alvarado, Digital Health Strategy Sub-Committee Chair

Attachments/Related Documents: None

A meeting of the Digital Health Strategy Sub-Committee took place on Thursday, May 15, 2025 at 1700h

Present:	Sara Alvarado (Chair), Joel Campbell, Masood Darr, Miles Lauzon, Paul Martinello, Suzanne Sarrazin, Lynn Woeller
Regrets:	Patrick Gaskin, Jim Gates, Margaret McKinnon, Richard Neidert
Staff:	Jennifer Backler, Trevor Clark, 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:** In May 2024, the Operational Excellence Plan was approved as one of Cambridge Memorial Hospital's (CMH) corporate plans supporting the FY22-27 Strategic Plan. This plan is supported by the Clinical Operational Excellence Committee (COEC), which meets monthly at CMH. Management outlined the work that is already underway, and the work that will be prioritized, to advance CMH to stage 5 on the AMAM scale by 2027. Management expressed confidence in achieving this goal. CMH will proceed with recruitment of the manager of informatics role, which is currently being evaluated. Patient data privacy was discussed, and management confirmed that some tools do require patient consent and that patients can request to have their data secured. The implementation of Scribe AI was discussed along with the impact of predictive analytical tools to help with patient flow.

BRIEFING NOTE

Date: May 30, 2025
Issue: Audit Committee Report to Board of Directors May 26, 2025 OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Bonnie Collins, Administrative Assistant
Approved by: Jay Tulsani, Chair

Attachments/Related Documents: None

A meeting of the Audit Committee took place on Monday, May 26, 2025 at 1700h	
Present:	Jay Tulsani (Chair), Bonita Bonn, Paulo Brasil, Bill Conway, Roger Ma, Nicola Melchers, Scott Merry, Diane Wilkinson
Regrets:	Brian Quigley, Chris Whiteley
Staff:	Trevor Clark, Rob Howe, Janet Short, Valerie Smith-Sellers
Guests:	Kim Haley (KPMG)

Committee Matters – For information only

1. Broader Public Sector Accountability Act Attestation: The Audit Committee reviewed the Broader Public Sector Accountability Act Attestation. ***(Further information found during agenda item 1.3.13)***
2. **2024-25 and 2025-26 Draft Audit Committee Goals and Objectives / Key Performance Indicators Review:** The goals and objectives of the Audit Committee for the 2024-25 Board cycle were confirmed as achieved. The Audit Committee was in agreement with the four proposed goals and objectives presented for the 2025-26 Board cycle.

BRIEFING NOTE

Date: May 30, 2025
Issue: Resources Committee Report to Board of Directors May 26, 2025 - OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Bonnie Collins, Administrative Assistant
Approved by: Tom Dean, Chair

Attachments/Related Documents: None

A meeting of the Resources Committee took place on Monday, May 26, 2025 at 1700h

Present:	Tom Dean (Chair), Sara Alvarado, Tom Dean, Miles Lauzon, Shannon Maier, Lori Peppler-Beechey, Janet Richter, Lynn Woeller
Regrets:	Monika Hempel
Staff:	Trevor Clark, Kyle Leslie, Rob Howe, Valerie Smith-Sellers, Susan Toth, Spencer Ogston
Guests:	Kim Haley (KPMG), Joshua Scace (TD Bank), Leah Switzer (TD Bank)

Committee Matters – For information only

1. **Broader Public Sector Accountability Act Attestation:** Management reviewed the Hospital Report on Consultant Use and the Mohawk Medbuy Hospital Report on procurement exceptions for the 2024-25 fiscal year. Management attested that Cambridge Memorial Hospital appropriately followed the requirements of the Broader Public Sector Accountability Act, Section 6 – Use of Consultants and Section 12 – Procurement Directives for Purchases Greater than $121,200, with no known exceptions. CMH used consultants and entered into limited tenders and non-compliance procurements in fiscal 2024-25, but the disclosure of these transactions as noted in the reports ensures CMH's compliance with the BPSAA for 2024-25. Mohawk Medbuy also attested that it was in compliance with provincial procurement requirements. ***(Further information can be found under agenda item 1.3.13)***
2. **Multi-Sector Service Accountability Agreement (M-SAA) Schedule F Declaration of Compliance:** Management presented the M-SAA Schedule F Declaration of Compliance for the Resources Committee's approval. ***(Further information can be found under agenda item 1.3.14)***
3. **HSAA Article 8 – Declaration of Compliance:** Management presented the HSAA Article 8 Declaration of Compliance for the Resources Committee's approval. ***(Further information can be found under agenda item 1.3.15)***

BRIEFING NOTE

Date: May 14, 2025
Issue: MAC Report to the Board of Directors, May 14, 2025 - OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Chief of Staff, Dr. Winnie Lee, Chief of Staff
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: None

A meeting of the Medical Advisory Committee took place on Wednesday, May 14, 2025, at 1630h

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

Committee Matters – For information only

1. **COVID-19 and Infectious Disease Update:** There is low activity for most respiratory viruses (COVID-19, influenza, RSV, etc.) at the provincial and hospital level in April and so far in May 2025. A gastroenteritis outbreak occurred in April 2025 at CMH, affecting 8 patients and 10 staff.
   There is significant concern regarding measles, with increasing numbers across the province. As of May 6, 2025, there were 1440 measles cases provincially (1221 confirmed), with a high percentage in the pediatric population (76.4%). Hospitalization rate was 7%, with 8 in ICU. Region of Waterloo measles activity is increasing, with 57 confirmed and 13 probable cases at the time of the report, primarily in Kitchener and Waterloo. A potential exposure occurred at CMH Emergency Department involving a pregnant patient from Kitchener with no previous immunization last week. The patient had an atypical presentation. The lesson learned from the case is that any patient presenting to the ED with any type of rash, especially with a concern for viral illness like measles or chickenpox, should be immediately taken to airborne isolation. The CMH staff involved in the case were confirmed to be immune, minimizing risk to them. IPAC has been working with Public Health to identify any potential risk for unimmunized individuals in the waiting area. Resistance to immunization is still contributing to ongoing transmission.
2. **Policies:** The following policy and medical directives were brought to the committee for approval.

#	Title	Motion
Policy # 12-62	Levels of Observation for Patient Care	Approved
MD # 757	Hyperbilirubinemia Management	Approved
MD # 234	Patients with hyperglycemia in the ED	Approved
MD # 202	Chest pain care for the patient in ED	Approved

3. **Fluency Flex/Fluency Direct Adoption & AI Scribe:** There is ongoing work to support front-end dictation for the medical professional staff with increased adoption of Fluency Flex. Currently, there are 80 medical professional staff who have been trained on Fluency Flex. There is work started to confirm the number of total credentialed medical professional staff that will require the transition to front-end dictation. There are ongoing drop-in sessions and individual/group training offered. In parallel, there is a Heidi AI Scribe pilot launching May 15, 2025, with eight ED physicians who will be trialing AI Scribe in the acute care setting. Heidi uses ambient listening to generate clinical notes in real-time, aiming to ease documentation burden. Privacy approvals are in place, and patient consent will be obtained by physicians when using Heidi AI Scribe. Workflows for transferring notes to Meditech have been developed with the ED team. Key metrics will be tracked (e.g. physician feedback, ease of use, documentation time, patient satisfaction). Feedback from the pilot will inform future rollouts at CMH. Heidi AI Scribe is the CND-OHT and CMH approved front-end AI Scribe tool. Non-approved AI Scribe tools will not be supported and have been blocked for use at CMH. Physicians are reminded of their responsibilities when using the AI Scribe tools and refer to the CMPA and CPSO guidelines for using these products. Front-end speech, once signed off, becomes the official record.
   Discussions at the May 2025 Patient and Family Advisory Council (PFAC) regarding AI Scribe in patient care visits with primary care has been positive. They are experiencing increasing use in primary care offices.
   Medical professional staff who currently dictate reports will be encouraged to convert to front-end dictation by fiscal year-end as part of the readiness work, in anticipation of the hospital information system (HIS) in the near future. Drop-in sessions and departmental onboarding support are available. Going forward, newly recruited physicians, learners, and locums will be directly onboarded to front-end dictation.
4. **Chair Update; Survey Results**: The Chair encouraged the MAC to complete the post-MAC survey as it helps to inform improvements to the MAC agenda/meeting.
5. **Pathology Department Update:** Chief and Deputy Chief of Laboratory Medicine and Pathology (Dr. J. Bourgeois and Dr. B. Courteau) provided a pathology department update. The pathology team includes 28 technologists, 24 assistants, 2 pathology assistants, 6 pathologists and 3 clerical supports. In the past year, the Core Lab has seen a significant increase in tests since Accreditation 2023, particularly with Chemistry and Hematology demonstrating a 62% increase in the number of tests, reflecting a combination of complexity of patients, increase volume of patients, and increase in services. Transfusion medicine and point-of-care glucose testing has also shown increase in testing volumes. whereas microbiology and outpatient diagnostic tests from Medical Daycare have remained stable. Pathology workload volume has also shown an increase since 2022, partly related to the endoscopy expansion. Specimen mix is 60% biopsies and 40% surgical excisions and 30-45 frozen sections/year. Areas of increased oncology volumes include breast cancer, colon cancer and melanoma. Breast and melanoma cases have increased in complexity (e.g., post-neoadjuvant breast oncology cases.
   Upcoming innovation in the department includes transitioning to Digital Pathology as a major

future focus, similar to radiology's PACS. The benefit is that it provides a more patient-centric workflow (access to old slides, radiology), better business analytics for planning, tag and search functionality for teaching/auditing, and facilitates remote work and easier M&M rounds, improved recruitment competitiveness, digital intra-departmental consultations with chat/annotations. Readiness work is occurring with the hope for a trial of anatomic pathology in late 2025. It will replace a labor-intensive validation process of lab results.
What matters to the Lab and Pathology team includes producing a uniform and accurate product, diagnostic accuracy, awareness of not being a "black box", accessibility (i.e. available for consultation), utilizing the wealth of knowledge among MLTs and charge technologists, being colleagues and consultants, encouraging notification of report errors and review requests if results do not correlate clinically.

6. **Psychiatry Department Update:** Dr. A. Sharma, Chief of Psychiatry, provided an update in the psychiatry department. The mental health team includes a small group of five psychiatrists. The psychiatrists provide inpatient, outpatient, ER mental health services and a Consult Liaison (CL) service. These services are supported by nurses, social workers, occupational therapists, recreational therapists, and peer support workers.
Services provided by the psychiatry department include the following:
    - ER mental health services: Psychiatric admission assessment (PAAN) nurse sees patients in crisis referred by ED physician, collaborates with psychiatry for disposition.
    - Inpatient Mental Health: 25 beds (5 of which are Psychiatric Care Unit - PCU, highly monitored). Average length of stay 10-15 days. Multidisciplinary team care.
    - Day Hospital: 6-week program for transitioning patients to community (in-hospital twice/week for group/individual therapy); two streams: Behavioral Activation and CBT-based.
    - CL Service: Consultations for patients admitted to other services (medicine, surgery, ICU) requiring mental health support, referred by the MRP and involves a CL nurse and psychiatrist.
    - Outpatient Mental Health: Referrals from community, ER, CL team. Patients seen by therapists and psychiatrists. Group therapy offered, usually a short waitlist.
    - Outreach Program: Psychiatrist makes visits to Bridges and Southern Ontario Aboriginal Health Access Centre (SOAHAC) to provide services on site; a relatively new initiative.
    - Electroconvulsive Therapy (ECT): Provided in collaboration with anaesthesia three times a week, with plans to expand this service.

    Observations from the outreach services indicate a clear need within the community. The challenge is the funding models to support these services in community settings. CMH's outreach program is thinking "outside the box" and doing the "right thing" beyond funding constraints.
    What matters to the Psychiatry department is “CCAIR”: **C** – Care (easy access for patients and reducing stigma), **C -** collaboration with community partners and ER (maintaining flow), **A -** accountability (feedback, QI projects), **I -** innovation (expansion of services and addressing gaps such as addictions services), **R -** respect and joy in the workplace (good team/leaders, joy in the workplace).

BRIEFING NOTE

Date: May 14, 2025
Issue: New Credentialed Physicians – April 2025
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Dr. Winnie Lee, Chief of Staff
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: None

This past month, we are thrilled to announce the addition of a new highly skilled physician to our hospital team. He will bring a wealth of experience and expertise to our surgical services, further enhancing our commitment to providing exceptional patient care. The new medical professional staff joining CMH include:

1. Dr. Roshan Navaratnam, Regional Urologist. Start date May 1, 2025. Dr. Roshan Navaratnam is primarily credentialed at Guelph General Hospital and will be part of the regional on-call program for urology. Dr. Navaratnam trained in Urology at the University of Toronto and is completing a Urology Fellowship in urologic oncology, with medical school training from Schulich School of Medicine and Dentistry.

Please join us in welcoming our new medical professional 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!

BRIEFING NOTE

Date: May 16, 2025
Issue: Governance Committee Report to Board of Directors May 15, 2025 - OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Administrative Assistant
Approved by: Julia Goyal - Governance Committee Chair, Patrick Gaskin - President & CEO,

Attachments/Related Documents: None

A meeting of the Governance Committee took place on Thursday May 15, 2025 at 1700h

Attendees:	J. Goyal (Chair), B. Conway, M. Protich, Dr. M. McKinnon, D. Wilkinson L. Woeller
Staff Present:	P. Gaskin, S. Pearsall
Regrets:	Dr. A. Stewart

Committee Matters – For information only.

1. **Policy Reviews and Approvals:** The Governance Committee reviewed two policies, and those policies will be reviewed for approval during agenda item 1.3.8 of the June 4, 2025 Board of Directors meeting for Board approval.
2. **Board/Committee Feedback Reports Review:** The Governance Committee reviewed the feedback reports from the Board and Committee meetings held in March and April 2025. The Committee highlighted the importance of the feedback being addressed at the Committee level at the following meeting. It was suggested to add this to part of the Chairs' tip sheet and discussion during the meeting of the Chairs in the summer.
3. **HSO Governing Body Assessment – Additional Survey Questions:** The Governance Committee reviewed the proposed additional questions for the survey. It was noted that some of these suggested questions have since been addressed effectively (e.g., use of a consent agenda) and may no longer be valuable as survey items. The CEO mentioned that, due to new timelines set by Accreditation Canada, there is an opportunity to revisit this matter at the first Governance meeting in the fall. The Committee agreed to the approach.
4. **Proposed Consolidation of the Nominating Sub-Committee and Governance Committee and Revised 2025/26 Committee Meeting Dates:** After careful review and consideration, CMH Leadership proposed the disbandment of the Nominating Sub-Committee and the establishment of a consolidated Governance & Nominating Committee in its place. This proposal aligns with good governance practices and will enable the committee to work through a more clear and concise requirement process, aligning meeting dates with key deliverables. This initiative aims to enhance efficiency and ensure our governance structure is both streamlined and effective. The Governance Committee supports the proposed approach and will review a revised Terms of Reference and work

plan in the Fall, subsequently being brought forward to the Board of Directors for consideration and final approval.

5. **Director Consent to Act:** Directors are required to complete an annual Director Consent to Act. All Directors with the exception of one have signed the annual consent. CMH Leadership will follow up with the individual who has not yet completed to ensure compliance prior to the Annual meeting in June.
6. **Review of Annual Governance Committee Evaluation Results for 2024/25:** The Chair highlighted that the Committee has received favorable feedback about the support structure and inclusive discussions, though there were mentions of challenges concerning meeting efficiency. It was noted that the pre-circulation of policies works well and CMH Leadership will continue to improve that process moving forward.
7. **2024/25 Board Survey Results Review:** The Governance Committee reviewed and discussed the following evaluation summaries; Director and non-Director personal assessments, Director and non-Director peer assessments, and assessments of the appointees of non-Board committees (PFAC/CMHF/CMHVA). The results of these surveys will be shared with the individuals as well as the appropriate Chair. The Board/Committee Chair will conduct reviews and discussions of the evaluations in meetings usually scheduled during the summer. These assessments serve as useful tools for personal growth.
8. **Timetable for Partnership Discussions:** The CEO highlighted that this year the inclusion of relationship management, community engagement and advocacy was added to the Governance Committee's Terms of Reference. It was noted that due to capacity constraints this has not yet been addressed. It was emphasized that while all partnerships are valuable, CMH must strategically decide which ones to focus on operationally and at a governance level. The committee plans to develop criteria for evaluating these partnerships, aiming to identify two or three high-impact organizations in the healthcare landscape. The process involves both strategic oversight from the Governance Committee and operational implementation by staff. The goal is to ensure that board-level activities align with the identified priorities and contribute meaningfully to CMH's mission. The committee will continue refining this approach over the summer, with plans to present a more detailed work plan for 2025-2026 in the fall.
9. **Guide to Good Governance:** The CEO highlighted that the OHA has released the Guide to Good Governance, Fourth Edition. This flagship resource is now available online and provides critical insights and updates to support hospital boards in navigating the demands of effective governance. The Guide to Good Governance, Fourth Edition will be made available to Directors and non-Directors on the GovHub under helpful information. An online version can accessed through the OHA's website here: Guide to Good Governance

   CMH Management will review the new guide over the summer/fall and do a preliminary audit against current CMH governance practices using the updated tools made available. These initial findings will be brought forward to the Governance Committee for discussion at a future meeting.
10. **More Convenient Care Act Re-Introduced in Legislature:** The CEO updated that the Government of Ontario re-introduced Bill 231, More Convenient Care Act, 2024 (now Bill 11) in the legislature. It proposes several legislative and regulatory changes related to governance and transparency, patient care, and service delivery. The OHA will review the bill in more detail should there be any additional detail related to hospital governance.

BRIEFING NOTE

Date: May 27, 2025
Issue: Board Policy Review Summary
Prepared for: Board of Directors
Purpose: ☒ Approval ☒ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Administrative Assistant
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: Policies

Recommendation/Motion

Board

That, the Board of Directors approves the following policies as presented/amended and upon recommendation of the Governance Committee at the meeting of May 15, 2025

Governance Committee

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

2-D-50	***Perquisite***
2-D-61	***Celebrating and Honouring Board Members***

Background

The following policies were reviewed and discussed at the May 15, 2025 Governance Committee meeting and were amended / updated as attached:
**Note track changes version found in Package 2)*

Policy No.	Policy Name
2-D-50	Perquisite
2-D-61	Celebrating and Honoring Board Members

CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

SUBJECT: Perquisites Policy	**NO.: 2-D-50**
SECTION: Board Process	
APPROVED BY: Board of Directors	**DATE: TBD**

This policy is identical to Corporate Manual Policy 7-07. The Board endorses and adheres to the corporate perquisites policy 7-07.

Policy

CMH complies with the Government of Ontario, Broader Public Sector (BPS) Perquisite Directive (issued by Management Board of Cabinet, dated August 2, 2011). As such, CMH does not permit perquisites unless they are a business requirement and comply with the appropriate authorization described in this policy.

Perquisite: Perquisite is defined by the Directive as "a privilege that is provided to an individual or to a group of individuals, provides a personal benefit, and is not generally available to others.

Scope

The rules set out herein apply to any person at CMH receiving perquisites, including:

- Board Directors and Board (non-director) Committee members
- President & Chief Executive Officer (CEO)
- Chief of Staff (COS)
- Members of the senior management – any senior executive reporting directly to the CEO
- Employees, medical professional staff, volunteers
- Consultants and contractors engaged by CMH to provide consulting or other services

This policy does not apply to the following:

- Provisions within collective agreements between CMH and a bargaining agent representing CMH employees.
- Insured benefits
- Items generally available on a non-discretionary basis for all/most employees (such as employee assistance program, pension plans)
- Health and safety requirements
- Employment accommodation made for human rights and/or accessibility considerations
- Expenses covered under policy 7-45
- Provision of parking passes to Volunteers and Board Committee members

Standards

1. **Principles:** This policy is built upon the 3 principles of the Directive
   - Accountability – CMH is accountable for the use of public funds
   - Transparency – CMH is transparent to stakeholders; perquisite policy is clear

and easily understood
- Value for money – Taxpayer dollars are used prudently and responsibly

2. **Unallowable Perquisites:** The following perquisites are not allowed under any circumstance:
   - Club memberships for personal recreation or socializing purposes, such as fitness clubs, golf clubs or social clubs
   - Seasons tickets to cultural or sporting events
   - Clothing allowances not related to health and safety or special job requirements
   - Access to private health clinics – medical services outside those provided by the provincial health care system or by the employer's group insured benefit plans
   - Professional advisory services for personal matters, such as tax or estate planning

3. **Requirements:** A perquisite must be related to a business requirement. Perquisites that are not related to business requirements are not allowed. Perquisites are allowed only in exceptional circumstances where it is demonstrated to be a business-related requirement for effective performance of an individual's job.

4. **Record Keeping:** The Directors of Finance and Human Resources maintain the records associated with the approved perquisites and provide these records for verification and auditing purposes, as required. Summary information, not including personal information, will be made publicly available on an annual basis.

Procedure

1. An allowable perquisite for the CEO, Chief of Staff, senior managing officers reporting directly to the CEO, any member of the Board of Directors, and/or any non-director Board Committee member, must be reviewed by the Executive Committee and approved by the Board.

2. An allowable perquisite for individuals or groups other than as provided in paragraph 1 above must be approved in writing by the President and Chief Executive Officer, and the Director, Human Resources.

3. A record of the approved allowable perquisites is maintained by the Director, Human Resources and the Director, Finance.

4. This policy is posted on the Hospital's website. On an annual basis, any allowable perquisite(s), excluding personal information, will be reviewed by the Executive Committee of the Board and the Board of Directors, and posted on the Hospital's website.

Developed in Consultation with:
VP Corporate Services/CFO/CIO
Director HR

DEVELOPED: February 22, 2012		
REVISED/REVIEWED:		
November 25, 2015	January 30, 2019	April 27, 2022
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BOARD MANUAL

SUBJECT: Celebrating and Honouring Board Members	**NO.: 2-D-61**
SECTION: Board Process	
APPROVED BY: Board of Directors	**DATE: TBD**

Policy
As a caring organization, the Board of Cambridge Memorial Hospital provides acknowledgement and support to Board members for milestones in their lives. This includes honouring the death of a loved one and celebrating new beginnings for Board members.

For the purposes of this policy, a Board member's loved one is defined as a spouse/partner, parent, child, and sibling.

Death of a Loved One
The CEO's office will arrange a donation to the charity of choice in the event of the passing of a Board member's loved one when made aware of the passing. The Board Chair will send a card of condolence on behalf of the Board.

Celebrating New Beginnings
The CEO's office will arrange for a card and gift on behalf of the Board to celebrate a Board member's marriage and/or the birth/adoption of a child when made aware of the event. The Board Chair will send a card of congratulations on behalf of the Board.

The amount for a donation or gift is to be alignment with the hospital practice in this regard that may be amended from time to time.

DEVELOPED: TBD		
REVISED/REVIEWED:		
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

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

CAMBRIDGE MEMORIAL HOSPITAL

MEMORANDUM

TO: The Board of Directors, Cambridge Memorial Hospital

DATE: May 27, 2025

REPORTING PERIOD: April 1, 2024 - March 31, 2025

FROM: Patrick Gaskin
President and CEO

RE: Annual CEO Certificate of Compliance

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

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

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

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

Patrick Gaskin
President and CEO

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

CAMBRIDGE MEMORIAL HOSPITAL

MEMORANDUM

TO: Board of Directors, Cambridge Memorial Hospital

DATE: May 30, 2025

REPORTING PERIOD: From April 1, 2025 to May 30, 2025

FROM: Patrick Gaskin
President and CEO

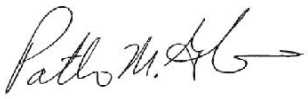
RE: CEO Certificate of Compliance

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: May 14, 2025
Issue: 2024/2025 Strategic Priorities Tracker Q4 Updates
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kyle Leslie, Director of Operational Excellence
Approved by: Mari Iromoto, VP People and Strategy

Attachments/Related Documents: Appendix A – Strategic Priorities Package – Q4

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 offers an overview of our achievements in the fiscal year 2024/25, with a specific focus on the final quarter (Q4). Our Strategic Priorities Tracker is designed to closely monitor our progress toward key organizational priorities. Despite meeting many strategic priorities, we recognize that patient flow remains a critical area for improvement, particularly concerning length of stay for admitted patients and Provider Initial Assessment (PIA) LOS.

Background

In alignment with our commitment to excellence and continuous improvement, we refreshed the Strategic Priorities Tracker for 2024/25. This tool ensures that all initiatives are aligned with our overarching strategic priorities and provides real-time insights into performance through various monitoring channels including weekly operations huddles, flow meetings, and comprehensive dashboards.

Our key performance monitoring tools include:

1. **Strategic Priorities Tracker:** Monitors critical in-year priorities identified via the Quality Improvement Plan (QIP), Integrated Risk Management (IRM) process, and Strategic Plan. This tool is refreshed quarterly.
2. **Quality Monitoring Scorecard:** Tracks key quality metrics monthly to ensure sustained performance.
3. **Critical Risks Escalated for Frequent Reporting:** Elevates patient flow and staffing concerns for more regular monitoring to Quality Committee and 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 progress on 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 4 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 for Q4 was 58 **minutes**, while the target is **<30 minutes**. In 2023-24, the 90th percentile ambulance offload time was **115 minutes,** for 2024-25, the offload time was 67 minutes, which represents a **42% improvement overall**.

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 **52 hours (YTD March 2025),** 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.

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 Q4, the 90th percentile YTD PIA time was **7.5 hours**, which is 0.6 hours longer than last fiscal year. Organizational patient flow will continue to be a major risk and critical focus for 25/26.

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 met our deliverables for 24/25.**

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 met our deliverables for 24/25.**

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; HIS will continue to be part of our major priorities that are tracked for 25/26.

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 with go-live targeted for June 2025.

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 **95.6% achieved in Q4,** while our target is 100%. A higher number is better as it means we have a higher level of staffing resources to appropriately staff and meet scheduling needs, there has been significant focus to achieve >90% active staffing which is starting to positively impact our overtime performance particularly in the emergency department.

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. At the end of Q4, **we saw our PCOP targets achieved, with $4.52 million earned in Q4.** Overall this means that we **met and exceeded our PCOP target for 24/25.**

Advance Health Equity:

Priority 10: Completion of Rainbow Health Diversity, Equity, & Inclusion Training (Meeting Target):

This indicator measures the number of staff that have completed the Rainbow Health Foundations Course**. At the end of Q4, an additional 192** staff completed the training **which resulted in us achieving our target for 24/25.**

Consultation

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

Next Steps

This year's achievements are a testament to the hospital's unwavering commitment to excellence and our patients' care. Despite challenges in specific areas such as patient flow, we remain dedicated to refining strategies and ensuring all strategic priorities are met in future fiscal

years. The 25/26 Strategic Priority Tracker draft will be shared with Board Committee's in June with the Q1 package being shared in September 2025.

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	58.0	Clinical Services Growth Plan; Capital Redevelopment Plan; Emergency Preparedness Plan
	90th%tile EDLOS admitted patients (hours) (QIP/IRM)	<33	48.0	51.7	51.5	55.6	
	% on track Capital Redevelopment Plan (IRM)	100	100	100	100	100	
	% on track with Emergency Preparedness Plan (IRM)	100	100	100	100	100	
Reimagine Community Health: Prepare for digital health transformation	% on track with Health Information System (IRM)	100	100	100	100	100	Digital Health Plan
	% on track with Workforce Planning (IRM)	100	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	95.6	HR Plan
	% on track with Corporate Change Management Strategy (IRM)	100	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	$3.51M	$3.60M	$5.19M	$4.52M	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	192	DEI Plan

Agenda

Elevate Partnerships in Care

Clinical Services Growth Plan

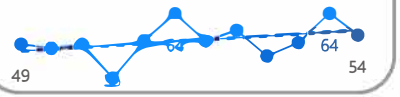
Click Here to Input Action Plans

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

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

Director Lead(s): April McCulloch, Donna Didimos

Project Manager(s): Jennifer Woo

In Year Measures of Success	Target	Q1	Q2	Q3	Q4	Monthly Trend
90th%tile Ambulance Offload Minutes	<30 mins	72.0	82.0	53.0	58.0	
90th%tile LOS Hours for Admitted Patients in ED	<33 hours	48.0	51.7	51.5	55.6	

Action Plan-Q4

In Year Objectives	Actions / Taken	Risks and Mitigations
Achieve 30 min or less ambulance offload time	1. Developed weekly audit for ambulances greater than 30 mins; 2. Revised Flow Monitor standard work to include EMS offload delay escalations; 3. Implemented EMS timestamp equipment to capture EMS arrivals	R1) 2025 CTAS guidelines changing; modifiers may affect ability to offload patients to EMS Nurse; M1) ED Nurses to attending triage class with new 2025 guidelines; R2) Multiple requests made to North York General Hospital to understand AOT tactics but unable to secure a date; M2) Reach out to London Health Sciences
Achieve and maintain ALC throughput ratio of 1 and ALC census of <36	1. Recruited second navigator (part time) to support discharge planning on weekends; 2.Expanded Cambridge Collaborative to include Community Support Services; 4. Established 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. Added ER Tracker Board enhancements: flag CTAS 2 patients to top of waiting to be seen; 2. Expanded Flow Monitor position to cover evening shift (1500-2300); 3. Developed process to align MD & NP schedules; 4. Developed and communicated flow expectations; 5. Developed and shared performance data with physicians, patients seen per shift per hour; 6. Developed 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
Achieve time to in-patient bed target	1. Held initial project scoping meetings with PMO for "Unit Census Board" project submission to 2025 Staff Innovation Fund, 2. Implemented new discharge rounds on all three medicine units as of January 20th, 2025; 3. Implemented 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. Reviewed 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)

Agenda

Sustain Financial Health

Multi-Year Financial Plan

Click Here to Input Action Plans

Executive Sponsor(s):	Physician Liaison(s):	Director Lead(s):	Project Manager(s):
Trevor Clark	Dr. Green, Dr. Sharma, Dr. Nguyen	Val Smith-Sellers, Kyle Leslie	Jennifer Woo

In Year Measures of Success	Target	Q1	Q2	Q3	Q4	Monthly Trend
PCOP Revenue earned	>$3.6M per Quarter	$3.5M	$3.6M	$5.2M	$4.5M	
QBP Revenue generated*	>$6.6M per Quarter	$7.4M	$7.0M	$7.6M	$7.7M	

Action Plan- Q4

In Year Objectives	Actions / Taken	Risks and Mitigations
Ensure effective in-year PCOP monitoring for Medicine	1. Continued to sustain new practices & maintain long stay list; 2. Worked towards increased numbers for next day confirmed discharges; 3. Achieved 61 discharges from H2H program since middle of Dec. 2024 (target was 64 discharges since starting Oct 31, 2024); 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. Recruited MH CEF; 2. Evaluated factors for implementing Ketamine administration program	R1) Did not meet MH PCOP target for FY24/25; M1) Develop and implement a focused strategy to optimize program utilization and increase funded activity, including increasing ECT capacity, expanding day hospital programming, enhanced referral coordination and performance monitoring
Ensure effective in-year PCOP monitoring for Surgery	1. Continue to monitor block utilization using the surgical efficiency dashboard and ensure OR bookings are complete; 2. Completed standardized work for roles within the OR to sustain turnaround time work; 3. Worked with Decision Support on the PACU simulation dashboard and analyze workflow; 4. Continue to collaborate with University of Waterloo on OR optimization project; 5. Finalized OR GRID for 25-26 to maximize PCOP; 6. Analyzed Acute Care Surgery (ACS) time; 7: Recruited Inpatient Surgery manager	R1) Gaps in surgeon coverage for GYNE, urology & plastics, anesthesia; M1) Re-allocated blocks and recruitment is ongoing; R2) Lower referral volumes; M2 & M3) Share QBP volume updates at Surgical Council, share monthly block returns with the surgical team, plan to review flow from the OR between 0800-0930 to determine adjustment of staff in PACU to receive
Execute PCOP planning & forecasting for PCOP & volume prediction for 25/26 planning cycle	1. Completed PCOP forecast for 25/26 using new PCOP methodology from Ministry PCOP branch; 2. Incorporated 25/26 PCOP targets into 25/26 budget; 3. Refreshed PCOP monitoring tools for 25/26	R1) Status of PHA4 agreements related to TriCity Endo and ClearVision are unknown, waiting for ministry guidance; M1) PHA4 agreements were renewed and signed
Quality Based Procedure Volumes & Revenue Achieved	1. Continue to monitor QBP volumes in systemic therapy and Endo; 2.Developed dashboard to monitor utilization of Endo blocks and policy regarding cancellation of block if not fully utilized, 3. Reviewed 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=$28.2M: $20.8M for OH Urgent + Non-Urgent Surgical 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): 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	100
% on track with transition planning activities	100%	100	100	100	100

Action Plan- Q4

In Year Objectives	Actions / Taken	Risks and Mitigations
Deliver CRP handover on time	1. Received project completions of the CRP and occupancy of the remaining areas on Level 1	No risks to report.
Successful transition of planning and Space to CMH Team	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. Establish process to manage, monitor and act on ongoing deficiencies	No risks to report.
Updated Functional Program	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.

Agenda

Reimagine Community Health

Digital Health Plan

Executive Sponsor(s):	Physician Liaison(s):	Director Lead(s):	Project Manager(s):
Trevor Clark	Dr. Taseen	Rob Howe	HIS - TBD, WFP - Beth Jones

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

Action Plan- Q4

In Year Objectives	Actions / Taken	Risks and Mitigations
Implementation of a new Health Information System (HIS)	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 readiness activities across clinical, medical, and corporate perspectives	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
Successful implementation of Workforce Planning (WFP) Q1 FY25/26	1. Completion of Build stage of project; 2. Kicked-off and completed of progressive testing cycles, moving from unit/system testing into enrollment of Emergency Department to create "real" data for testing; 3. Rolled-out of training programs for staff, management, and super-users; 4. Installed 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

Agenda

Increase Joy in Work

Human Resources Plan

Click Here to Input Action Plans

Executive Sponsor(s): Patrick Gaskin, Mari Iromoto

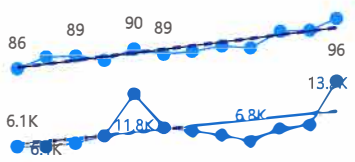
Physician Liaison(s):

Director Lead(s): Susan Toth

Project Manager(s): Soumya Saini

In Year Measures of Success	Target	Q1	Q2	Q3	Q4
% on track with staffing targets for MED/ICU/ED	100%	88.8	89.1	90.3	95.6
OT hours per quarter	5552	18.7K	27.3K	22.0K	29.8K

Monthly Trend



Action Plan- Q4

In Year Objectives	Actions / Taken	Risks and Mitigations
Enhance HR Systems and Data to Support Staffing Decision Making (Workforce and ICIMS)	1. Created an optimization plan for existing HR and staffing tools; 2. Identified data and information needs to support staffing decision-making and monitor HR processes; 3. Supported the implementation of Project Quantum; 4. Introduced an additional module in ICIMS for candidate testing; 5. Enhanced 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
Enhance recruitment processes and establish CMH as a desirable place to work	1. Received communication on the status of the application for Canada's Top 100 Employers and communicated the results organization-wide and through social media; 3. Reviewed leadership talent process and implemented actions resulting from the competency assessment conducted in Q3; 4. Updated 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
Focus on strategies to enhance retention by focusing on wellness and wellbeing	1. Modified the reward and recognition program for 2024/2025; 2. Researched verbal de-escalation support education and offer it to targeted non-patient-facing roles, in collaboration with CMHA leadership for de-escalation training; 3. Participated 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. Developed 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
Focus on strategies to enhance staff retention (People Development)	1. Created 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. Planned for PM/ Change Management education sessions for 25/26; 3. Implemented the Leads Program to support retention and career development; 4. Conducted 625 VBCs (93%) from Q1 to Q4; 5. Presented updated education reimbursement policy; 6. Developed the Leader Learning Series and identify key participants by HR	R1) Capacity for leaders and vacancies may impact VBC numbers; M1) adjust VBC targets as needed to maintain progress

Agenda

Advance Health Equity

DEI Plan

Click Here to Input Action Plans

Executive Sponsor(s):	Physician Liaison(s):	Director Lead(s):	Project Manager(s):
Mari Iromoto		Jennifer Backler	Soumya Saini

In Year Measures of Success

	Target	Q1	Q2	Q3	Q4
Achieve more than 350 staff completing Rainbow Health Foundations Course	>88 per quarter	52	78	37	192

Action Plan- Q4

In Year Objectives	Actions / Taken	Risks and Mitigations
Create Safe Spaces	1. Held Diversity Council on 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; 2. Inclusion Lead role posting postponed; hired Joy Braga (Strategic Projects Coordinator) to support DEI and Indigenous work in the interim; 3. Identified key organizations to support building a network of partners - partnership meeting with National Council of Canadian Muslims	No risks to report.
Enhance collection of sociodemographic data collection	1. Established process for collecting sociodemographic data from patients, including technical data capture and communication plan; 2. Strategy went live in Q4, received 80 submissions; 3. Beginning to model data and continuing to monitor to ensure sufficient collection of data to build up data repository	No risks to report.
Inclusive Language & imagery	1.Lunar New Year (Jan) - Launched educational post for the observance and gave out oranges to staff to celebrate; 2. Black History Month (Feb) - Held several events/activities including the BHM LEARN Challenge, Ken Daley Art (vendor), Starlie Steel Drum Band Performance, "Gwan Move" Soca Workout Sessions facilitated by Gayle Smith (CMH Staff member), and Lunch & Learn on Unwritten Stories: The Forgotten History of Waterloo Region's Black Residents facilitated by Peggy Plet; Launched two Voices of CMH stories - Gayle Smith and Nicole Patrick; 3. Other observances acknowledged via internal communications/social media posts include: January: World Braille Day, Orthodox Christmas, International Holocaust Remembrance Day, and National Day of Remembrance of the Quebec City Mosque Attack and Action Against Islamophobia; February: White Cane Week, Pink Shirt Day, and Ramadan March: Ash Wednesday, International Women's Day, St. Patrick's Day, Neurodiversity Celebration Week, Francophonie Day, Spring Equinox/Ostara/Eostre (new to calendar this year), World Down Syndrome Day, International Day for the Elimination of Racial Discrimination, Transgender Day of Visibility	No risks to report.
Rollout Education & Training	1. Developed draft CMH specific 2SLGBTQI+ for B2L; 2. Assigned Rainbow Health course to all CMH staff with removal of course once we meet our 500 license limit; 3. Created enhanced tracking and dashboard for leaders; 4. Offered incentives in the form of a chance to win high value gift cards for those that complete the training; 5. Achieved our goal with 360 completed staff members	R1)CMH Specific 2SLGBTQI+ training for B2L not complete by Q4 due to absence of a DEI Lead; M1) Continue utilizing the Best Practice Committee working group to develop learning; Seek input from community experts; Trial free learning with working group as a potential replacement for ongoing education (soginursing.ca - Sexual Orientation Gender Identity Nursing Course)

Agenda

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	100

Action Plan- Q4

In Year Objectives	Actions / Taken	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	

BRIEFING NOTE

Date: May 14, 2025
Issue: Quality Monitoring Metrics
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kyle Leslie, Director Operational Excellence
Liane Barefoot, Director Patient Experience, Quality, Risk, Privacy & IPAC
Approved by: Mari Iromoto, 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 along with a detailed indicator trending page for key clinical quality indicators.

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 eight (8) indicators of the twenty-nine that have had three subsequent periods of "**red**" performance and already have an action plan or are being monitored to determine if an action plan for improvement is needed. These indicators are:

1) Overtime hours
2) Sick hours
3) ALC Throughput and Percent ALC Days
4) Ambulance offload time (90% spent less, in minutes)
5) ED Length of stay for Admitted patients (90% spent less, in hours)
6) ED Length of Stay, Non-Admitted Complex (CTAS 1-3) (90% spent less, in hours)
7) ED Wait Time for Inpatient Bed (90% spent less, in hours)
8) ED Wait Time for Physician Initial Assessment (90% spent less, in hours)

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
Six (6) of the nine (9) indicators that are currently trending 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 eight (8) 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.

Below is a summary of the eight (8) quality monitoring metrics that are currently at a "**red**" status with three or more periods outside of the target threshold.

Efficient:

1) **Overtime Hours** 

   This indicator measures the total number of overtime hours used vs. budgeted overtime hours. Currently we are significantly over budget, with an average of over 3700 overtime hours/pay period while the target is 850 hours/pay period. The majority of overtime hours (approx. 60%) can be attributed to the Emergency Department, Medicine, and ICU. A lower number on this indicator means that we are staffing less with OT which has a positive impact to Joy in Work as it is an indication that we have improved staffing levels, leading to reduced staff burnout.

2) **Sick Hours** 

   This indicator monitors the average sick hours per pay period per month. A lower number is better as that means there are less staff off and unable to work due to illness. Currently we are significantly over budget, with an average of over 3100 sick hours/pay period while the target is 2090 hours/pay period.

Integrated & Equitable:

3) **ALC Throughput & Percent ALC Days** 

These indicators monitor 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 0.77, meaning we are adding more cases than discharging. The percentage of ALC days for closed cases measures the proportion of inpatient days occupied by patients who no longer require acute care but are waiting for appropriate care elsewhere. A lower ALC Rate is desirable as it indicates better resource utilization and access to appropriate care. YTD Mar, 25% of inpatient days are spent waiting for alternate level of care for acute patients, while the target is 20%.

Safe, Effective & Accessible:

4) **Ambulance offload time (90% spent less, in minutes)** 

This indicator measures the time from ambulance arrival to when transfer of care occurs between EMS and CMH care team in the ED. YTD Mar, 90% of ambulances had an offload time of 67 minutes or less, while our target is 30 min.

5) **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 inpatient bed. YTD Mar, 90% of admitted patients had a length of stay of 52 hours or less, while our target is 33 hours or less.

6) **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 inpatient bed. YTD Mar, 90% of admitted patients waited 43 hours or less for an inpatient bed, while our target is 25 hours or less.

7) **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 Mar), 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.

8) **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 7.5 hours (YTD Mar), while our internal target is to see 90% of patients within 4 hours. A lower number is better as it means that patients are seen by a physician or nurse practitioner within an appropriate timeframe in the emergency department.

Next Steps

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

- Indicators at a “red’ status are being reviewed with specific clinical teams at monthly program Quality and Operations Councils, department huddles, Ops Huddles, Director’s Council, Senior Leadership Committee and through various working groups.

Quality Monitoring Scorecard

Status (Last 3 Periods)

Meeting Target	9	31%
Within 10% of Target	12	41%
Exceeding Target	8	28%

Quality Dimension	Indicator	Unit of Measure	Target	YTD	Status (Last 3 periods)	Period
Efficient	Active Staffing Target Achieved (ED/MED/ICU)	%	100.00	95.93	▲	May-25
	Conservable Days Rate	%	30.00	34.84	▲	Mar-25
	Overtime Hours - Average per pay period	hours	850.00	3,747.47	◆	Apr-25
	Sick Hours - Average per pay period	hours	2,090.00	3,241.59	◆	Apr-25
Integrated & Equitable	ALC Throughput	Ratio	1.00	0.77	◆	Mar-25
	Percent ALC Days (closed cases)	%	20.00	25.06	▲	Mar-25
	Repeat emergency department visits for Mental Health Care	Patients	11.00	10.33	●	Mar-25
Patient & People Focused	Organization Wide Vacancy Rate	%	12.00	5.54	●	Apr-25
Safe, Effective & Accessible	30 Day CHF Readmission Rate	%	14.00	13.91	▲	Feb-25
	30 Day COPD Readmission Rate	%	15.50	9.96	●	Feb-25
	30 Day In-Hospital Mortality Following Major Surgery	%	1.90	1.54	▲	Feb-25
	30 Day Overall Readmission Rate	%	8.80	7.02	●	Feb-25
	Ambulance Offload Time (90% Spent Less, in Minutes)	minutes	30.00	67.00	◆	Mar-25
	ED Length of Stay for Admitted Patients (90% Spent Less, in Hours)	hours	33.00	52.00	◆	Mar-25
	ED Length of Stay for Non-Admitted Complex Patients (90% Spent Less, in Hours)	hours	8.00	9.70	◆	Mar-25
	ED Wait Time for Inpatient Bed (90% Spent Less, in Hours)	hours	25.00	42.80	◆	Mar-25
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours)	hours	4.00	7.50	◆	Mar-25
	Hip Fracture Surgery Within 48 Hours	%	83.10	92.90	●	Feb-25
	Hospital Standardized Mortality Ratio (HSMR)	Ratio	100.00	106.02	▲	Feb-25
	In-Hospital Sepsis	per 1000 D/C	3.20	3.32	▲	Feb-25
	Long Waiters Waiting For All Surgical Procedures	%	20.00	9.52	●	Apr-25
	Low-Risk Caesarean Sections	%	17.30	21.14	●	Mar-25
	Medication Reconciliation at Admit	%	95.00	96.77	▲	Apr-25
	Medication Reconciliation at Discharge	%	95.00	95.92	▲	Apr-25
	Obstetric Trauma (With Instrument)	%	14.40	18.67	▲	Feb-25
	Patient Safety Event - Falls with Harm	per 1000 PD	0.00	0.08	▲	Apr-25
	Patient Safety Event - Medication Events with Harm	per 1000 PD	0.00	0.03	▲	Apr-25
	Revenue - Achieve budgeted PCOP growth (IRM)	$	14,682,288.00	16,825,501.00	●	Mar-25
	Revenue - Achieve Quality Based Procedure Funding (IRM)	$	24,880,176.00	29,730,420.63	●	Mar-25

Agenda

Conservable Bed Days

Conservable Beds Dashboard

Description

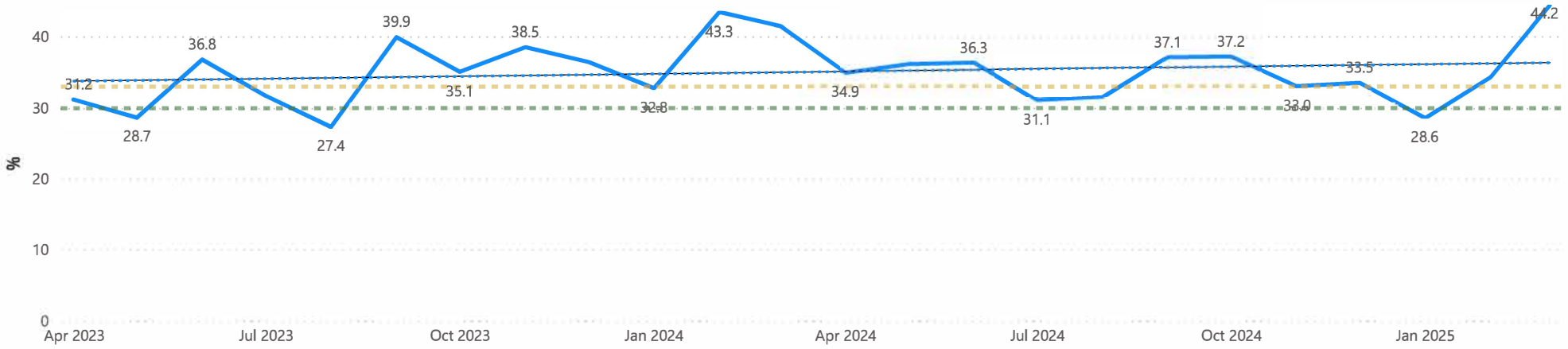
The total patient days over the benchmark LOS (conservable days) as a percentage of the total acute patient days for patients discharged from MEDA/MEDB. The benchmark LOS is determined by case mix group, age, and resource intensity level of a discharge.

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
30.0	35.5	34.8	▲

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	37.1	37.2	33.0	33.5	28.6	34.3	44.2

Agenda

Alternate Level of Care

ALC Dashboard

ALC Throughput

Description

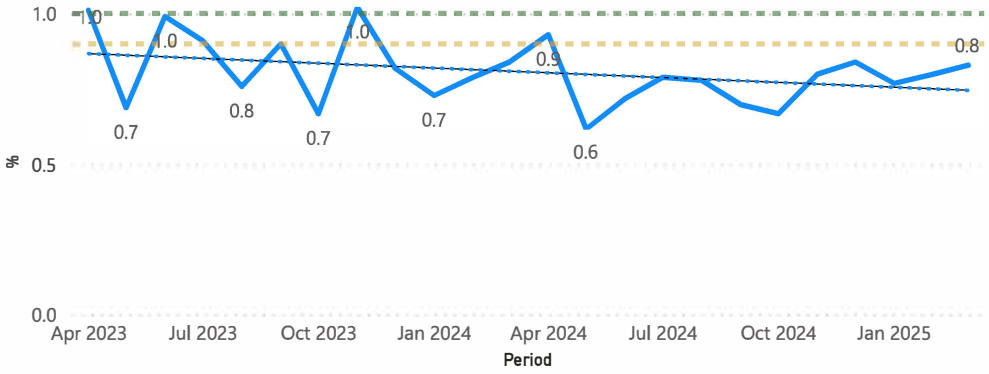
ALC Throughput is the ratio of the number of discharged ALC cases to the number of newly added and redesignated ALC cases

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	0.8	0.8	0.8

ALC Rate

Description

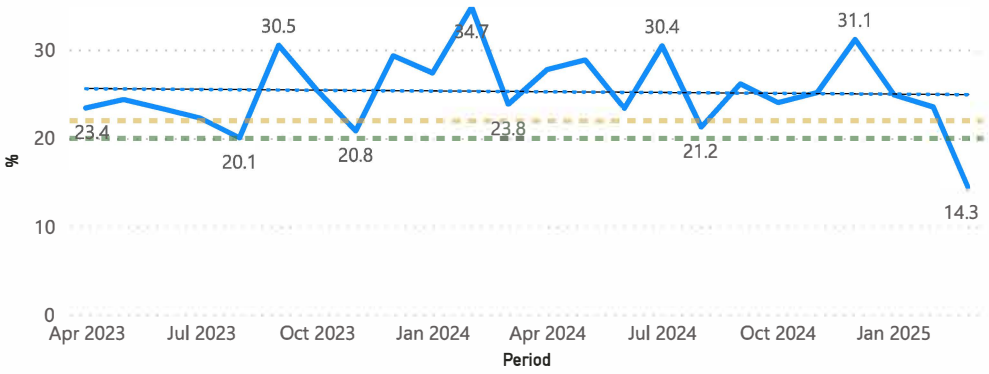
The proportion of total days that a patient was assigned to the alternate level of care (ALC) service. ALC patients are those who no longer need acute care services but continue to occupy an acute care bed or use acute care services.

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
20.0	25.4	25.1	

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	27.7	28.8	23.4	30.4	21.2	26.1	24.0	25.1	31.1	24.9	23.5	14.3

Agenda

Repeat ED Visits for Mental Health Care

Description

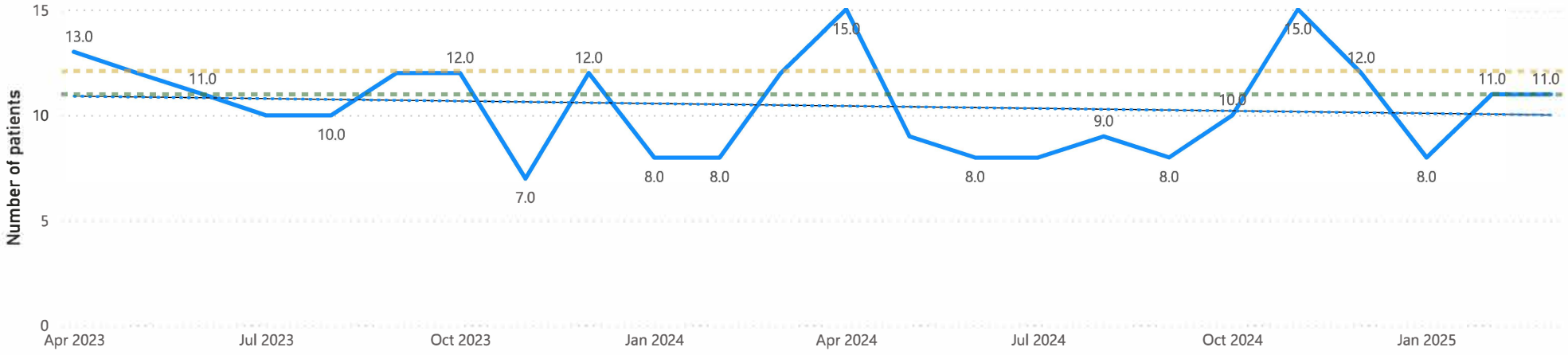
Number of patients who have four or more repeat unscheduled visits to the emergency department in the last 12 months for mental health or substance abuse condition

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
11.0	10.6	10.3	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	13.0	12.0	11.0	10.0	10.0	12.0	12.0	7.0	12.0	8.0	8.0	12.0
2024/2025	15.0	9.0	8.0	8.0	9.0	8.0	10.0	15.0	12.0	8.0	11.0	11.0

Agenda

Readmissions within 30 Days:

Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD)

CHF Readmissions

Description

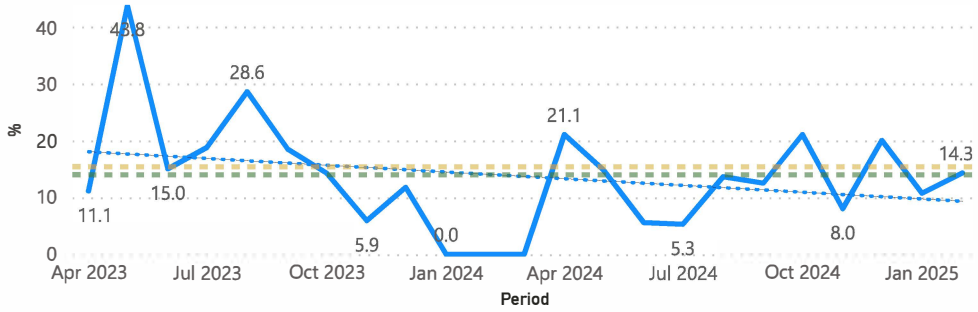
Rate of urgent readmission for any reason within 30 days of discharge for Congestive Heart Failure (CHF) at CMH

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
14.0	18.7	13.9	

CHF Readmission Rate, Trend



Fiscal Year		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	Rate	11.1	43.8	15.0	18.8	28.6	18.5	14.3	5.9	11.8	0.0	0.0	0.0
	Readmits	2	7	3	3	6	5	2	1	2	0	0	0
2024/2025	Rate	21.1	14.8	5.6	5.3	13.6	12.5	21.1	8.0	20.0	10.7	14.3	
	Readmits	4	4	1	1	3	3	8	2	5	3	3	5

COPD Readmissions

Description

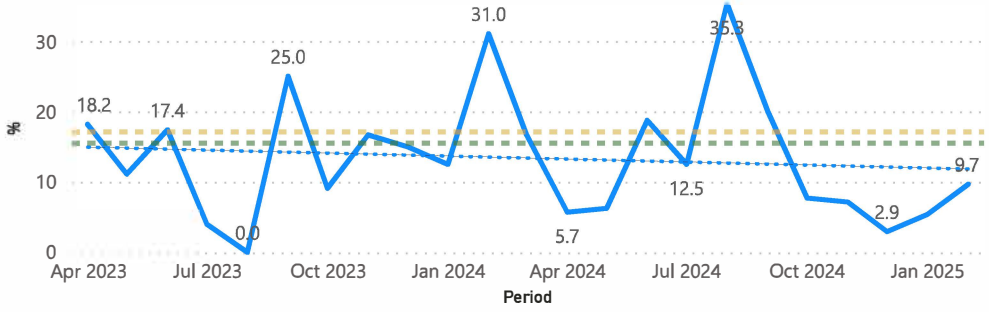
Rate of urgent readmission for any reason within 30 days of discharge for Chronic Obstructive Pulmonary Disease (COPD) at CMH

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
15.5	15.8	10.0	

COPD Readmission Rate, Trend



Fiscal Year		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	Rate	18.2	11.1	17.4	4.0	0.0	25.0	9.1	16.7	15.0	12.5	31.0	16.7
	Readmits	6	8	7	4	6	7	4	4	5	5	9	4
2024/2025	Rate	5.7	6.3	18.8	12.5	35.3	20.0	7.7	7.1	2.9	5.4	9.7	
	Readmits	6	5	4	3	9	6	10	4	6	5	6	6

Agenda

30 Day In-Hospital Mortality Following Major Surgery Rate

Description

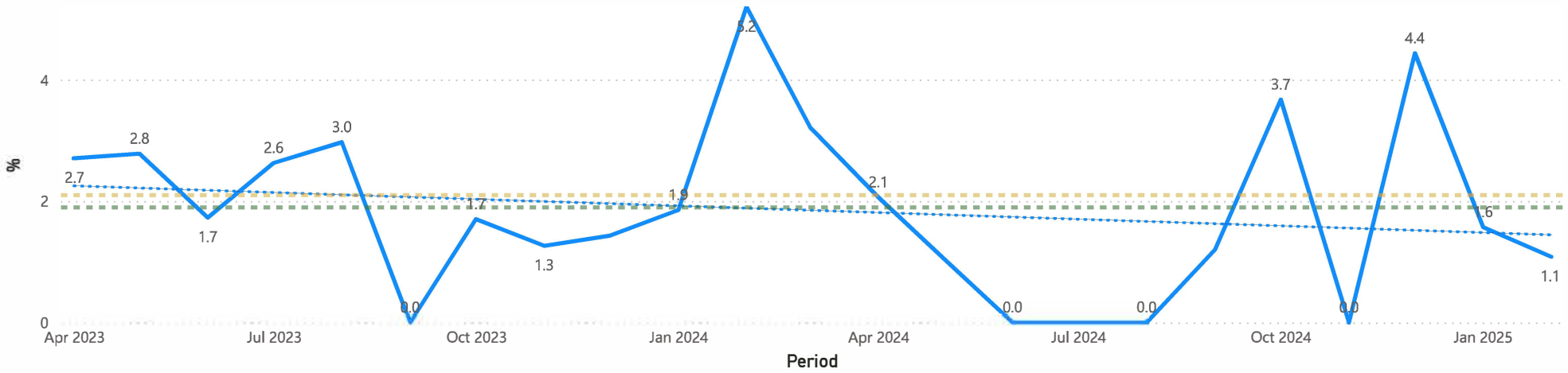
Risk-adjusted rate of in-hospital deaths due to all causes occurring within 30 days of major surgery (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
1.9	2.2	1.5	▲

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	2.7	2.8	1.7	2.6	3.0	0.0	1.7	1.3	1.4	1.9	5.2	3.2
2024/2025	2.1	1.0	0.0	0.0	0.0	1.2	3.7	0.0	4.4	1.6	1.1	

Agenda

30 Day Overall Readmission Rate

Description

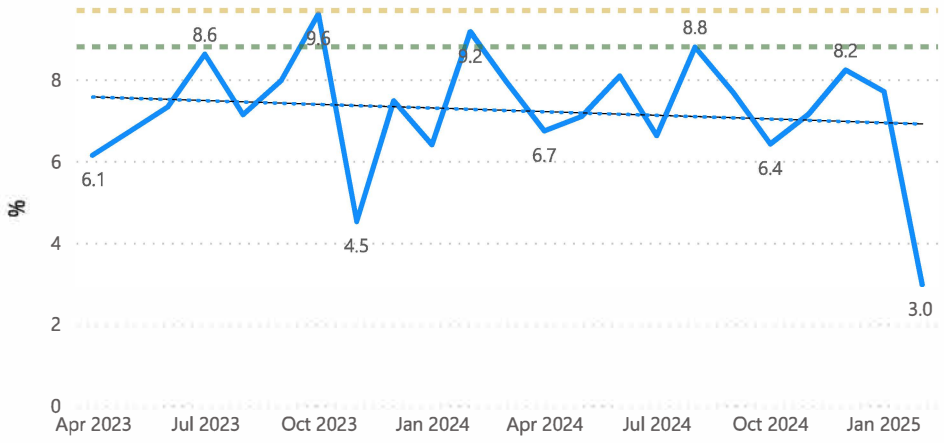
The rate of urgent readmissions within 30 days of discharge for episodes of care for the following patient groups: medical, obstetric, paediatric, and surgical. Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
8.8	7.4	7.0	

Trend

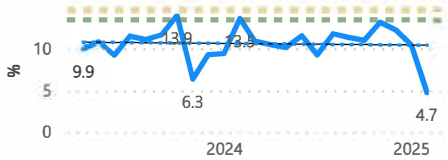


Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	6.1	6.7	7.3	8.6	7.1	8.0	9.6	4.5	7.5	6.4	9.2	8.0
2024/2025	6.7	7.1	8.1	6.6	8.8	7.7	6.4	7.1	8.2	7.7	3.0	

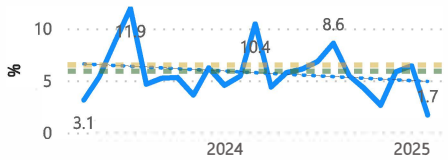
Readmissions, by Patient Group

IndicatorName	Target	YTD	Status (Last 3 periods)
30 Day Medical Readmission Rate	13.40	10.47	
30 Day Obstetric Readmission Rate	1.40	1.19	
30 Day Paediatric Readmission Rate	6.70	6.15	
30 Day Surgical Readmission Rate	5.90	5.27	

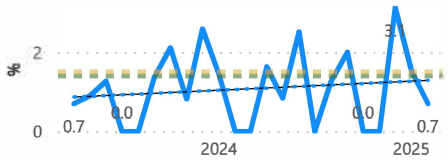
Medical Readmissions Trend



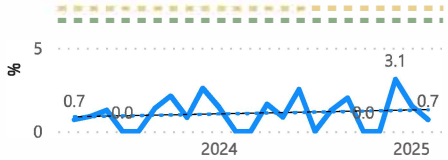
Surgical Readmissions Trend



Obstetric Readmissions Trend



Paediatric Readmissions Trend



Agenda

Ambulance Offload Time, minutes, 90th percentile

Description

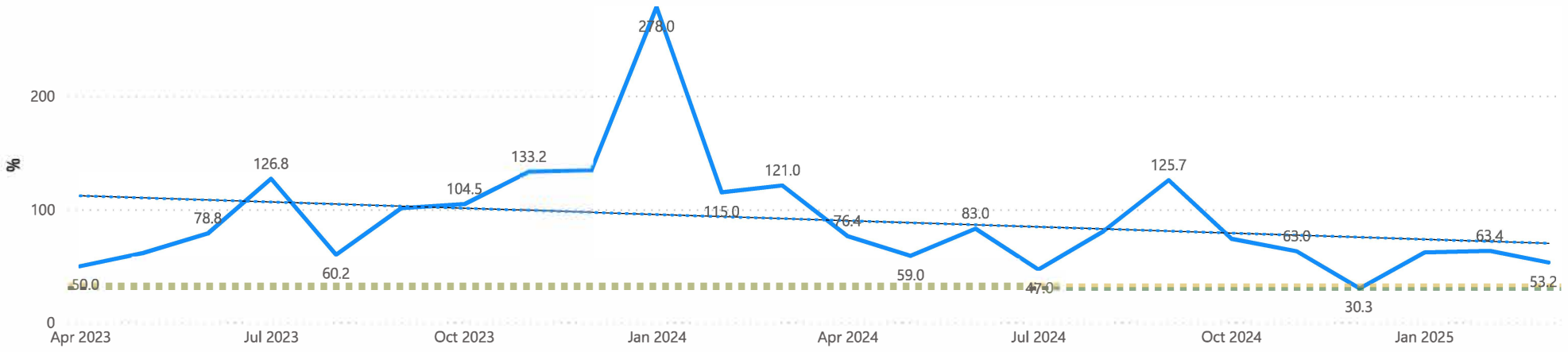
The total time, in minutes, in which 9 out of 10 patients who arrived via ambulance waited for transfer of care process to be completed, calculated as the total time elapsed from ambulance arrival to completion of transfer of care process.

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
30.0	115.0	67.0	

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	62.0	63.4	53.2

Agenda

ED LOS for Admitted Patients, hours, 90th percentile

Total ED LOS for Admitted Patients

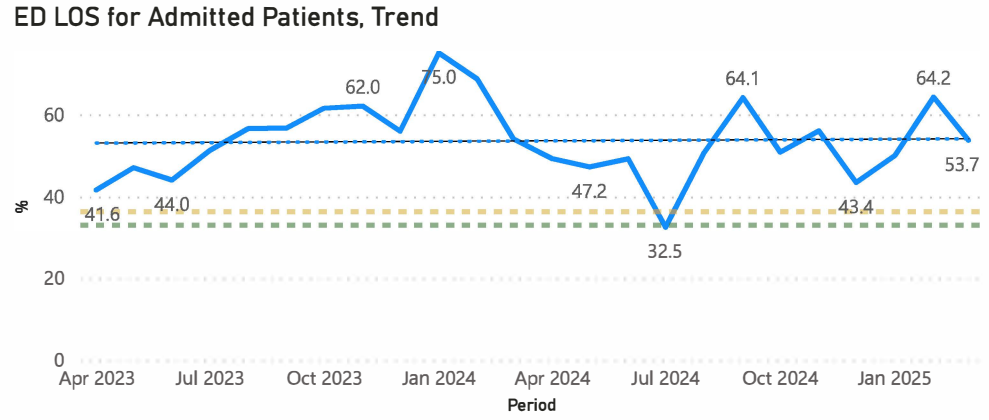
Description

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	52.0	



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	50.0	64.2	53.7

Time to Inpatient Bed

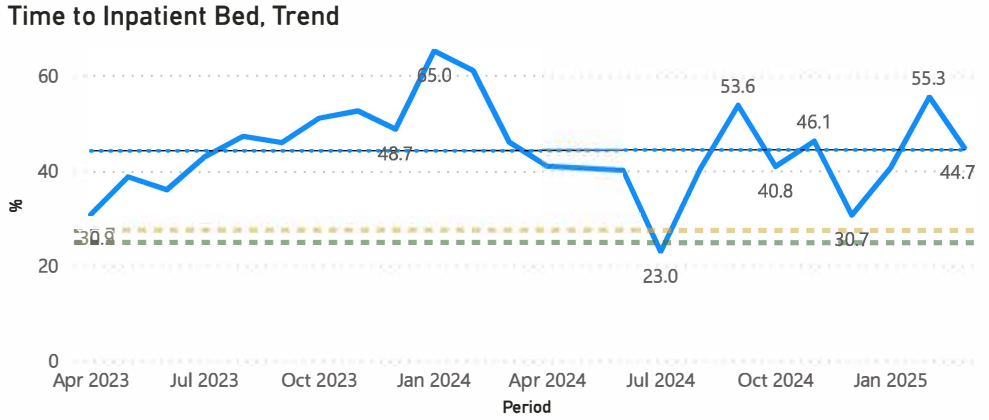
Description

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	42.8	



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	40.5	55.3	44.7

Agenda

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

Description

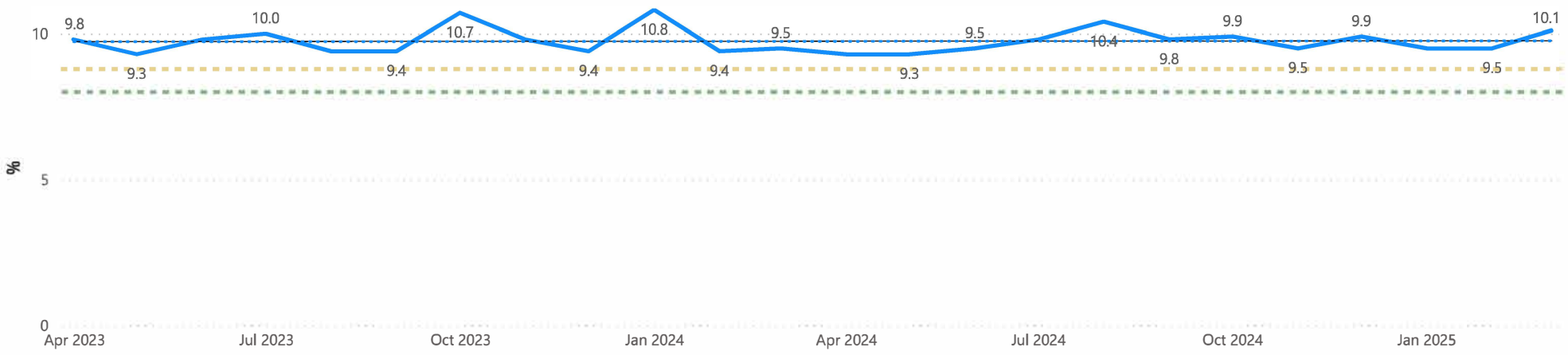
The total time, in hours, that 9 out of 10 high-urgency patients (CTAS 1-3) who were not admitted spent in the emergency department (ED), calculated as the total time elapsed from triage to when the patient left the ED

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	9.5	9.5	10.1

Agenda

Provider Initial Assessment Time, hours, 90th percentile

Description

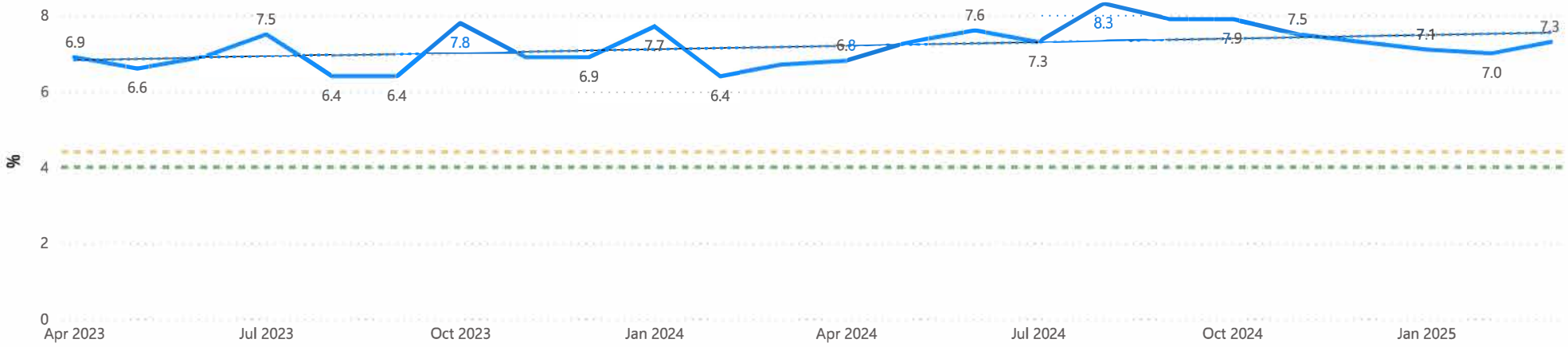
The total time, in hours, that 9 out of 10 patients spent waiting for their first assessment by a doctor or nurse practitioner in the emergency department (ED), calculated as the total time elapsed from triage to time of initial assessment

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
4.0	6.9	7.5	

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	7.1	7.0	7.3

Hip Fracture Surgery within 48 Hours

Description

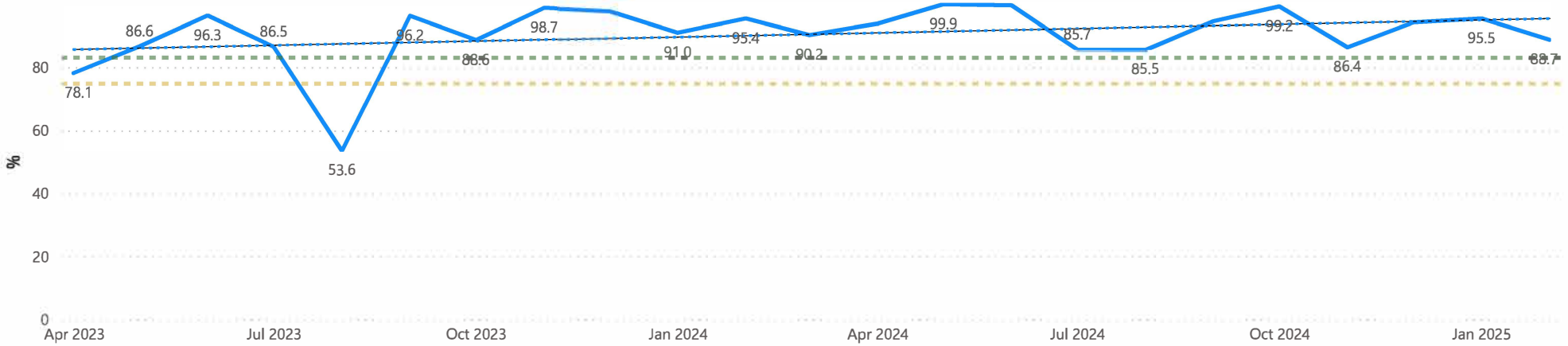
Risk-adjusted proportion of hip fractures that were surgically treated within 48 hours of initial admission (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
83.1	90.1	92.9	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	78.1	86.6	96.3	86.5	53.6	96.2	88.6	98.7	97.7	91.0	95.4	90.2
2024/2025	93.8	99.9	99.5	85.7	85.5	94.6	99.2	86.4	94.2	95.5	88.7	

Hospital Standardized Mortality Ratio (HSMR)

Description

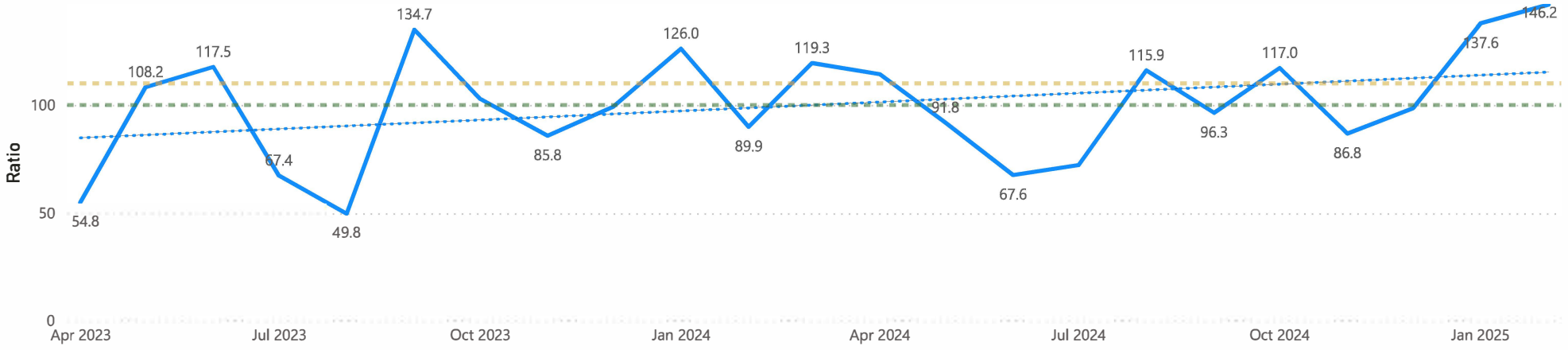
The ratio of the actual number of in-hospital deaths to the expected number of in-hospital deaths, for conditions accounting for about 80% of inpatient mortality

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
100.0	98.0	106.0	▲

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	54.8	108.2	117.5	67.4	49.8	134.7	102.9	85.8	99.1	126.0	89.9	119.3
2024/2025	114.2	91.8	67.6	72.2	115.9	96.3	117.0	86.8	98.4	137.6	146.2	

Agenda

In-Hospital Sepsis

Description

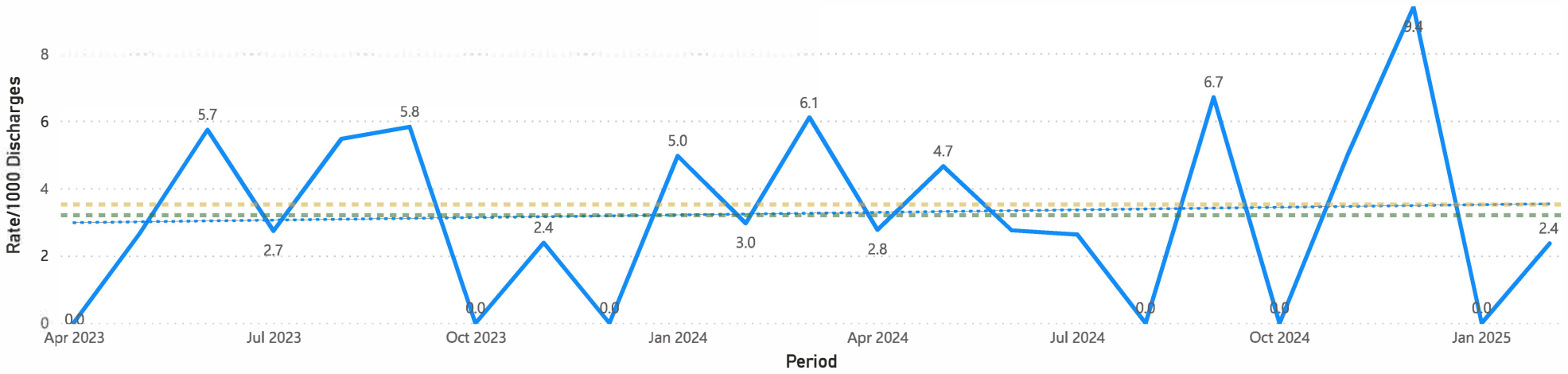
Risk-adjusted rate of sepsis that is identified after admission, per 1,000 discharges (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
3.2	3.2	3.3	▲

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	0.0	2.6	5.7	2.7	5.5	5.8	0.0	2.4	0.0	5.0	3.0	6.1
2024/2025	2.8	4.7	2.8	2.6	0.0	6.7	0.0	5.0	9.4	0.0	2.4	

Agenda

Low-Risk Caesarean Section Rate

Description

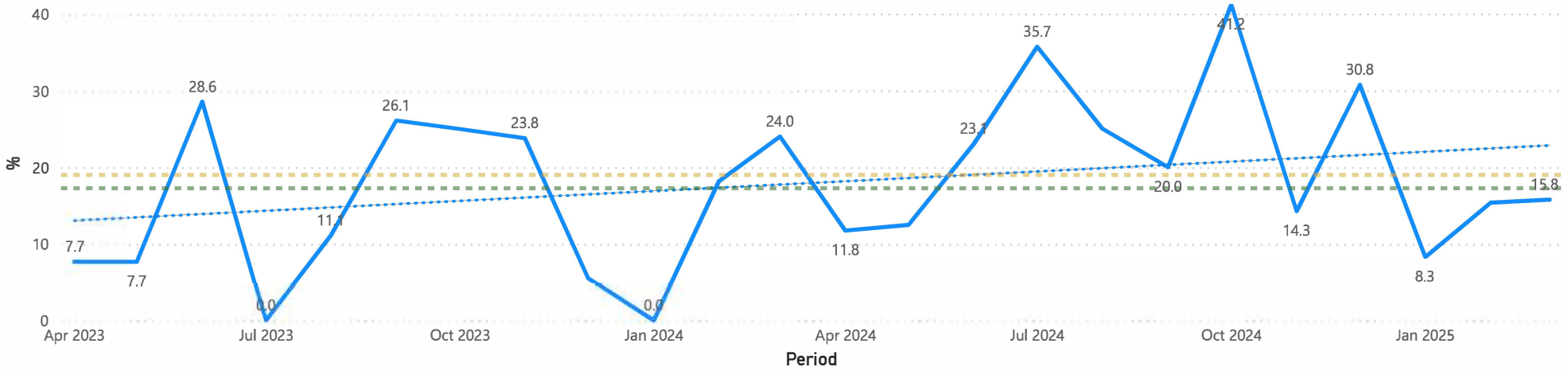
This indicator measures the rate of deliveries via Caesarean section among singleton term cephalic pregnancies for low-risk nulliparous women in spontaneous labour

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
17.3	14.8	21.1	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/2024	7.7	7.7	28.6	0.0	11.1	26.1	25.0	23.8	5.6	0.0	18.2	24.0
2024/2025	11.8	12.5	23.1	35.7	25.0	20.0	41.2	14.3	30.8	8.3	15.4	15.8

Agenda

Obstetric Trauma (with Instrument)

Description

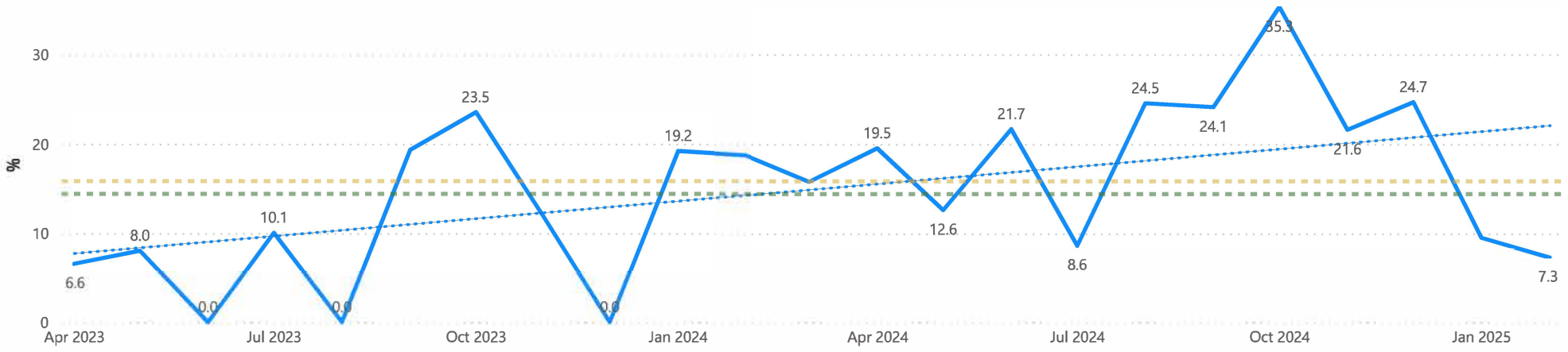
Risk-adjusted rate of obstetric trauma (lacerations that are third degree or greater in severity) for instrument-assisted vaginal deliveries (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
14.4	10.9	18.7	▲

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	24.7	9.5	7.3	

Agenda

Long Waiters Waiting for Surgical Procedures

Description

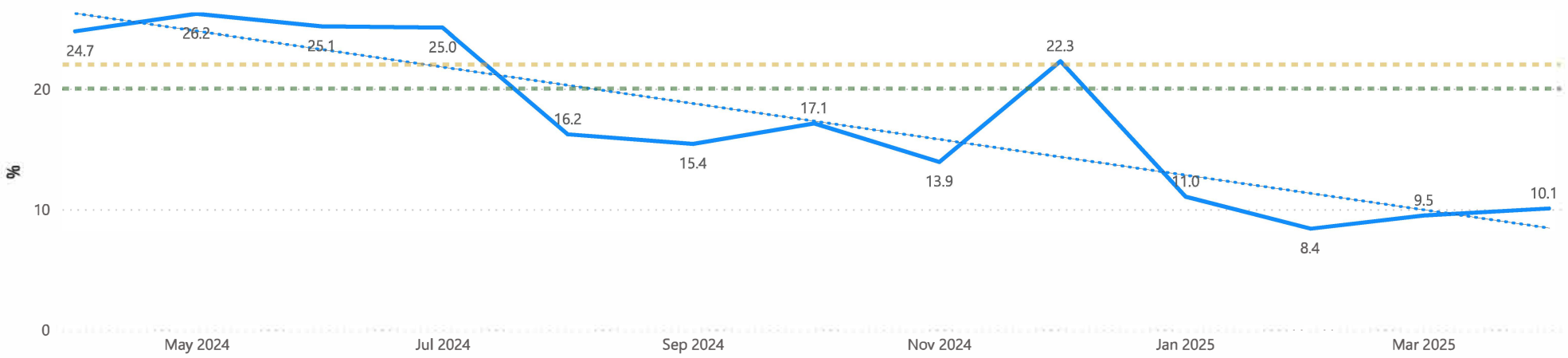
This indicator measures the percentage of patients waiting for a surgical procedure whose wait has exceeded the associated Priority Level Access Target (excludes DART days)

Data Source

WTIS

Target	Previous YE	YTD	Status (Last 3 periods)
20.0	26.3	9.5	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	24.7	26.2	25.1	25.0	16.2	15.4	17.1	13.9	22.3	11.0	8.4	9.5
2025/2026	10.1											

Agenda

Patient Safety Event - Falls with Harm Rate

Description

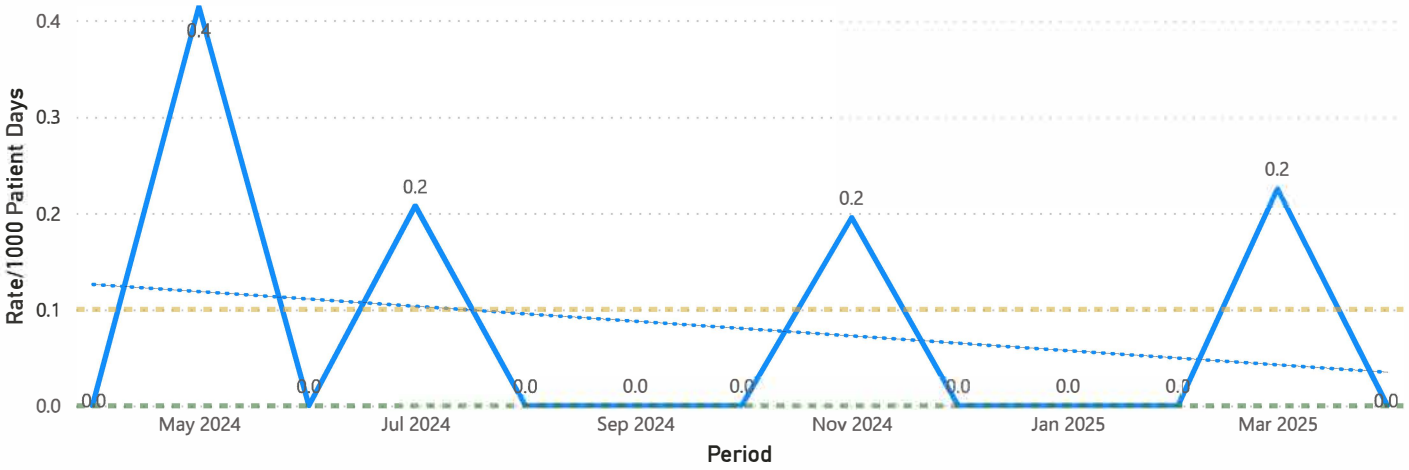
The number of falls with harm per 1,000 inpatient days. This includes events where after review, the severity is deemed to have incurred moderate or severe harm, or a critical incident involving death.

Data Source

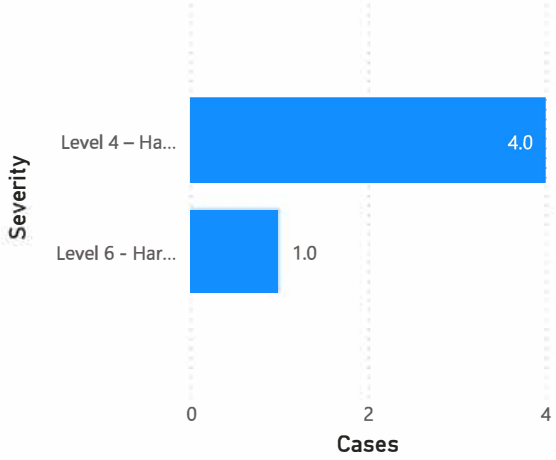
ReportLink, Meditech

Target	Previous YE	YTD	Status (Last 3 periods)
0.0	0.1	0.1	▲

Trend



Current FY Cases, by Severity



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	0.0	0.4	0.0	0.2	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.2
2025/2026	0.0											

Agenda

Patient Safety Event - Medication Events with Harm Rate

Description

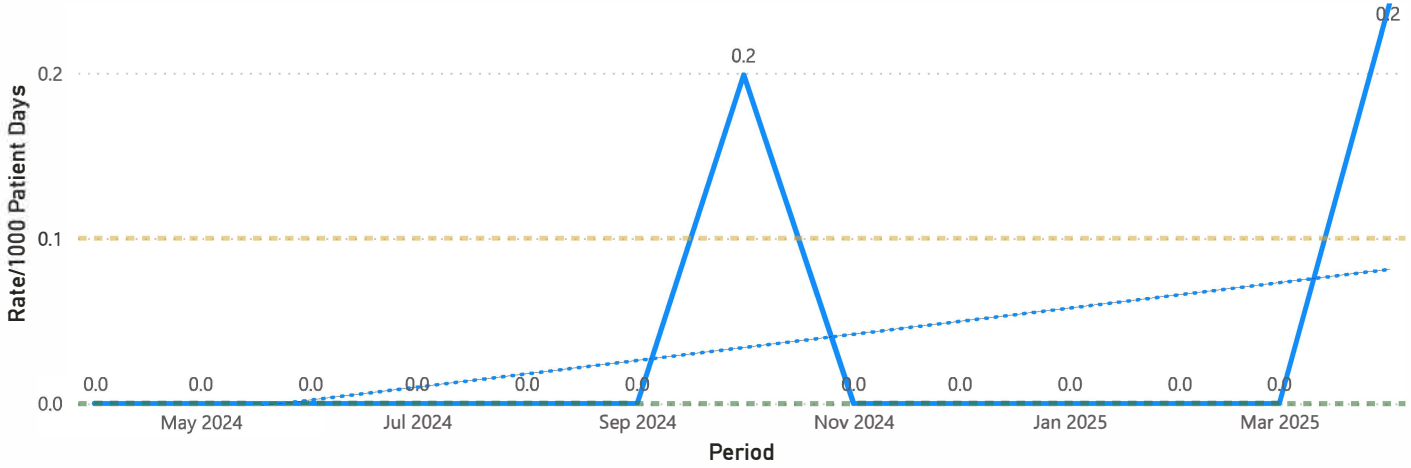
The number of medication events with harm per 1,000 inpatient days. This includes events where after review, the severity is deemed to have incurred moderate or severe harm, or a critical incident involving death.

Data Source

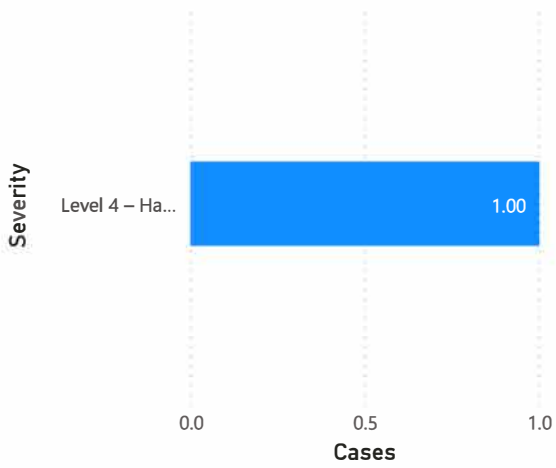
ReportLink, Meditech

Target	Previous YE	YTD	Status (Last 3 periods)
0.0	0.1	0.0	

Trend



Current FY Cases, by Severity



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0
2025/2026	0.2											

Agenda

Medication Reconciliation

Admission

Description

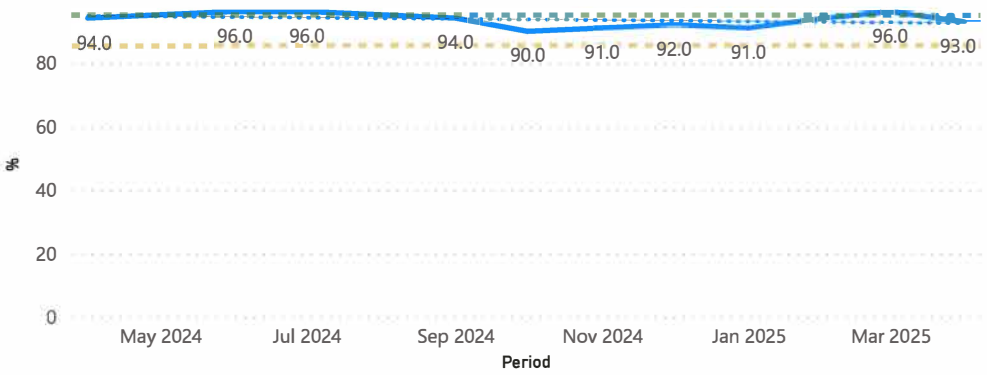
The total number of patients who were discharged who had a Best Possible Medication History (BPMH) completed divided by the total number of patients who were discharged home

Data Source

Meditech Pharmacy Patient Profile

Target	Previous YE	YTD	Status (Last 3 periods)
95	93	97	▲

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	94.0	95.0	96.0	96.0	95.0	94.0	90.0	91.0	92.0	91.0	94.0	96.0
2025/2026	93.0											

Discharge

Description

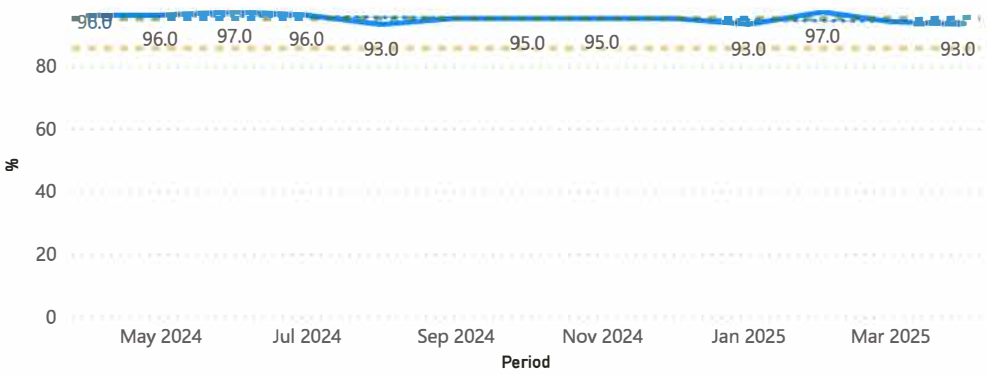
The percentage of Yes responses to the question "Was the CMH community pharmacy prescription completed? " for all inpatient locations participating in medication reconciliation at discharge

Data Source

Meditech

Target	Previous YE	YTD	Status (Last 3 periods)
95	(Bla...	96	▲

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	96.0	96.0	97.0	96.0	93.0	95.0	95.0	95.0	95.0	93.0	97.0	94.0
2025/2026	93.0											

Agenda

Post-Construction Operating Plan (PCOP) Revenue

Description

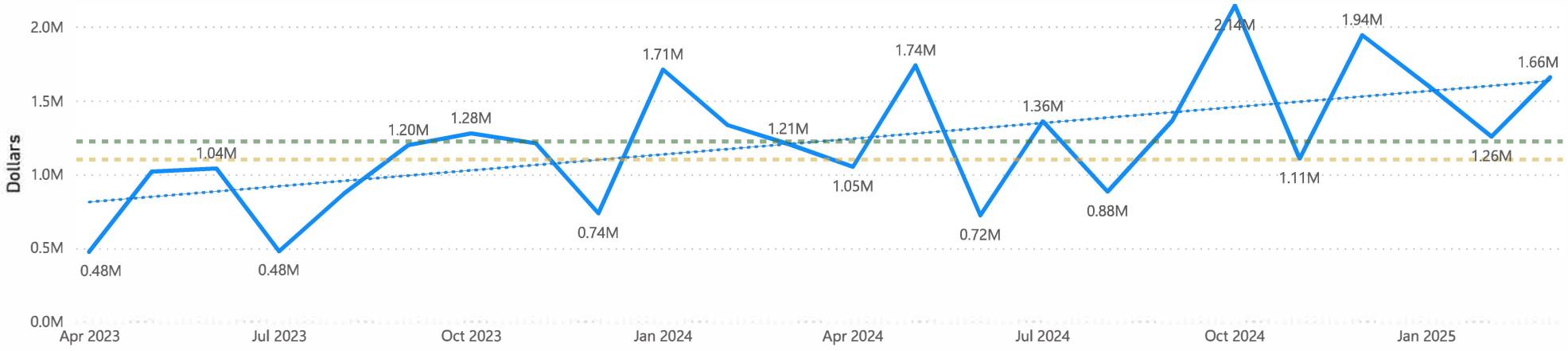
The revenue achieved through all PCOP service areas, including Acute Inpatient, ED, Day Surgery, Mental Health Day Hospital, Mental Health Inpatient, ECT, and Ambulatory Clinics (Mental Health, Paediatric, Fracture, Surgery)

Data Source

Discharge Abstract Database, National Ambulatory Care Reporting System, Meditech

Monthly Target	YTD Target	YTD Total	Status (Last 3 periods)
1.2M	14.7M	16.8M	

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	1,051,697	1,737,596	722,779	1,358,633	882,895	1,363,416	2,141,704	1,106,891	1,941,391	1,606,752	1,255,297	1,656,450

Agenda

Quality Based Procedure (QBP) Revenue

QBP Dashboard

Description

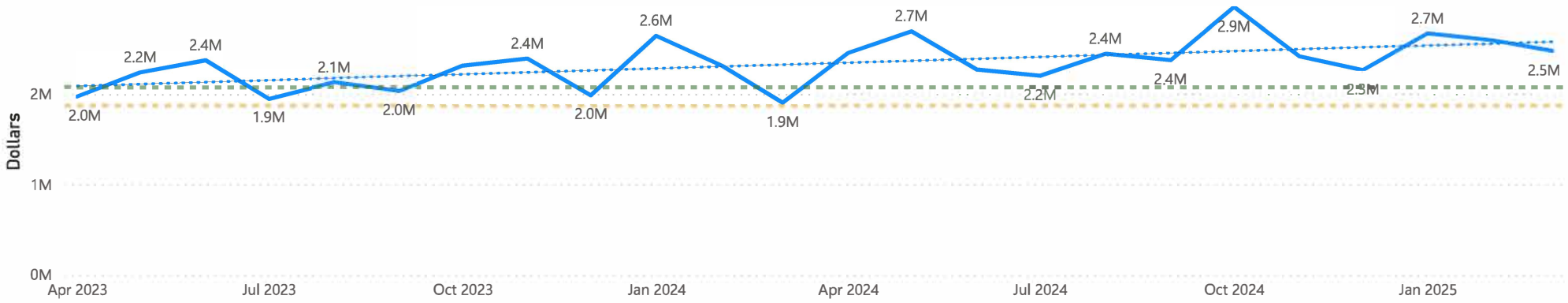
The revenue achieved through all Quality Based Procedures, including Urgent QBPs & Non-Urgent Surgical QBPs (OH), Systemic Treatment (CCO), GI Endoscopy (CCO), and Cancer Surgery (CCO).

Data Source

Discharge Abstract Database, National Ambulatory Care Reporting System

Monthly Target	YTD Target	YTD Total	Status (Last 3 periods)
2.1M	24.9M	29.7M	

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	2,445,693	2,682,601	2,265,445	2,197,474	2,436,657	2,368,276	2,944,766	2,409,880	2,258,532	2,663,573	2,586,914	2,470,610

**Please note Actual QBP Revenue will be capped at the Funding Available for each category (Total Funding=$28.2M: $20.8M for OH Urgent + Elective QBPs; $2.9M for Cancer Surgery QBPs; $2.0M for GI Endo QBP, $2.5M for Systemic Treatment QBP)*

CMH President & CEO Report
June 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.

Report summary
This month was all about putting people first—whether it was patients, staff, families, or our community. We launched an exciting trial of Heidi AI in the Emergency Department, helping clinicians spend more time with patients and less on charts. Staff stories—from Megan Rowe's powerful mental health education sessions to Mercedes Townsend's personal journey with organ donation—reminded us just how deeply care connects us.

We welcomed new team members like Ivy Saile and Kora Bennett, and proudly celebrated our people for their heart, hustle, and humanity. From heritage months to award wins, this was a time of reflection, recognition, and renewed energy. As we head into summer, let's carry forward this spirit of connection, care, and community!

Heidi AI puts the focus on the patient

- Cambridge Memorial Hospital is trying something new to improve how we deliver care. We've started a small trial of Heidi AI, a digital medical assistant (or scribe) in partnership with some Emergency Department physicians.
- Heidi listens in on the visit — with the patient's permission — and creates a first draft of the clinical note. It's like having an extra set of hands that types while providers focus on patients.
- This trial is part of our ongoing commitment to make care safer, reduce wait times, and improve the patient experience. With Heidi's help, providers spend less time on the computer and more time talking with patients.
- Notes are more accurate and completed faster — which helps everyone, especially when care transitions quickly.
- It's early days, and we're gathering feedback as we go. If the trial goes well, we hope to expand Heidi AI into more areas of the hospital.
- For now, thanks to the Emergency Department, Health Information Management, Patient, Experience, Risk & Quality for their involvement in testing this tool — their input will help shape where it goes next.

Voices of CMH: Challenging Mental Health stigma and misinformation

- Clinical Coordinator Megan Rowe understands how unreliable information about mental health can isolate people. That's why she launched the Family Education Mental Health Series.
- With more than 10 years' experience in the field of mental health, she, and members of CMH's mental health team use the program to tackle one of the most common challenges—misinformation.

- “Mental Health still carries the weight of stigma—for those who struggle with it and for those in a supportive role,” Megan shares. This insight is shaped by years supporting patients with complex illnesses and it inspired her to reach people beyond the clinical setting.
- The program is designed to equip people with accurate information and help them make informed decisions. Members from both Inpatient and Outpatient teams—psychiatrists, physicians, and mental health clinicians—come together to challenge that isolation and bring people together.
- But what unfolds this year exceeds her expectations.
- “Each session covers a unique topic, from self-care to addressing a mental health crisis,” she shares. What stood out most was how it became a journey of self-discovery—for her and participants.
- The real magic happens when participants get into a room together—they feel validated, heard, and they are able to relate with their own lived experiences.
- As they progress through the series, a sense of gratitude grows along with a quiet transformation of how they relate to one another.
- What begins as mere steps—a foundation built brick by brick—evolves into a safe, sheltered space where people can share their challenges and find hope.
- “It warms my heart,” Megan laughs, explaining how she wants to do more, but watching them lift each other up without professional intervention can be just as powerful. “Lived experiences deliver empathy far better than any professional can,” she admits.
- Megan credits the program’s success to the informal approach to the sessions—it puts a human face on service providers. It becomes less intimidating—less stressful. People just open up. “It opens a door,” she says, “to a unique approach to mental health, empathy, and connection.”
- The Family Education Mental Health series ran from February to March in 2025 with more planned in the near future.

Voices of CMH: Organ donation saved her parent’s life

- Mercedes Townsend, an Operating Room nurse, was barely 14 years old when a parent needed a life-saving liver transplant. “We made that life altering decision as a family, but I didn’t fully grasp the sense of the situation until the day of the surgery—I could lose them.”
- She describes them as full of life – “funny, down to earth, very much a prankster” but these vibrant moments were overshadowed by illness. “There would be days when they would have severe bouts of sickness…if they got sick—it was really sick.”
- Her parent contracted Hepatitis C (HCV) from a contaminated blood transfusion. It was this incident—a single moment—that ultimately led to liver failure.
- Throughout it all, Mercedes credits her family. “We really came together,” she says. Family vacations considered her loved one’s needs, including making sure they had their pager from the Trillium Gift of Life Network (TGLN).
- On the surface, it became another part of their lives. But Mercedes remembers clearly the day the call came. “We were always ready, even when my sister and I didn’t know all the details. When it came, it was real.”
- That call came while at a baseball tournament. “It was a rush of activity,” she says—the short window of time, the whirlwind of logistics—all while grappling with reality: this could be the last time she sees her loved one’s smile.
- “Organ donation saved their life,” Mercedes says, and it shaped hers.

- If Mercedes could meet the donor, she says, she would just say “Thank you” and hug them. “I’m grateful to have those years back.” Mercedes’s parent is alive today, nearly two decades later.
- One decision—made by a stranger—changed her family’s entire world.

Kora Bennett, Clinical Manager Medicine Program

- We are very pleased that Kora Bennett accepted the position of Clinical Manager for the for the Medicine Program, effective May 26.
- Kora is a registered Occupational Therapist who has been working clinically for 14 years. Kora has worked with all age ranges in a variety of clinical and community settings.
- She joined CMH in January of 2025 as the Clinical Coordinator of the Medicine Programs. In that short time, Kora established meaningful partnerships with staff, patients, and community partners.
- Kora has a passion for innovation when it comes to patient care and community health. Notably, she has built strong relationships with staff at all levels - her collaborative spirt and commitment to teamwork have been instrumental in enhancing the quality and efficiency of our day to day operations.
- Many thanks to the interview panel that supported this decision, including several Clinical Directors and Managers for their time and thoughtful input.
- Outside of work, Kora enjoys spending time with friends and family, and walking the family dog. Kora recently started to try yoga and enjoys reading and travelling.

Introducing Ivy Saile, Indigenous Patient Navigator!

- Ivy joins us as the Hospitals’ Indigenous Patient Navigator through the Southwest Ontario Aboriginal Health Access Centre (SOAHAC). She plays a critical role in advocating for culturally respectful healthcare for Indigenous patients in the Waterloo-Wellington regions.
- Working with Indigenous patients in our care, Ivy helps guide the patients she works with through their healthcare journeys. As part of her role, she enhances communication between patients and our teams, advocates for patient needs, and helps integrate community resources from SOAHAC into our care plans.
- Ivy works to help address barriers Indigenous patients face, such as limited access to traditional healers and healing practices, like smudging. She collaborates closely with hospital departments to bridge these gaps.
- Role and Responsibilities
    - As an Indigenous Patient Navigator, Ivy can support patients and teams by:
    - Providing in-person and telephone support to hospital in-patients in Waterloo-Wellington
    - Enhancing communication between healthcare teams and patients to ensure a culturally safe environment
    - Attending patient appointments to advocate for the needs of Indigenous patients
    - Working in tandem with healthcare teams to coordinate necessary support services
    - Assisting in both healthcare planning and discharge processes
- Ivy is available by referral, Monday through Friday 0830 – 1630h through SOAHAC.

Celebrating staff milestones in meaningful ways

- We have refreshed the Career Achievement Program to better reflect the dedication and spirit of our team members. With thoughtful input from the Employee Engagement Council, the updated program now includes expanded recognition — celebrating not only traditional service milestones but also the important 1- and 3-year marks and extending eligibility to casual staff.
- The updated program brings a fresh look, aligned with the hospital's strategic branding, and replaces traditional pins with milestone stickers and personalized celebration cards.
- The new Celebration Cart adds a joyful touch, bringing treats, photo props, and space for colleagues to leave handwritten notes — all designed to make each recognition moment more personal and memorable.
- These updates are more than cosmetic. They represent a deeper appreciation for the everyday contributions that shape CMH's culture and care. Each milestone tells a story of commitment, growth, and teamwork — and CMH is proud to honour those moments in a way that reflects their significance.

CMH physicians congratulated for award

- Congratulations to Tri-City Colonoscopy Clinic for receiving Platinum in the Physicians and Surgeons category for *CommunityVotes Kitchener-Waterloo 2025*.
- Some CMH physicians practice at this clinic, delivering expert care that supports patients across Cambridge and the surrounding region. This recognition is a reflection of their skill, compassion, and commitment to high-quality care – it's an honour well-deserved.
- The Tri-City Colonoscopy Clinic is a leading edge outpatient endoscopy clinic that helps patients navigate their health with confidence and clarity. CMH is proud to recognize them for their important work in advancing health as valued members of both the hospital and the community.
- *CommunityVotes Kitchener-Waterloo 2025* is a local platform where residents can vote for their favourite businesses and professionals across a wide range of categories.

Confirmed Measles case at CMH

- The Region of Waterloo Public Health has informed us that a confirmed case of measles was present in CMH's Emergency Department on Thursday May 8 (1725h – 0125h), and issued an exposure alert for anyone present in the Emergency Department during this period.
- The risk to those who are immune from complete vaccination or previous infection is considered low. Hospital workers are required at time of hire to demonstrate immunity against measles through documentation of having two doses of MMR or laboratory evidence of immunity.
- The higher risk groups include infants 12 months and under, pregnant individuals and immunocompromised individuals as they are more vulnerable to complications if they get the disease.
- Clinical staff approached with questions by patients and visitors were informed to advise them to contact their local health unit to help determine their eligibility for post-exposure measures.

May celebrations: Doctor's Day

- On May 1, 2025, CMH physicians were invited to enjoy a coffee and light breakfast in their honour, celebrating them for their dedication, compassion, and service. Doctor's

Day honours physicians across Canada for their contributions to supporting the health and wellbeing of our community. There are over 250 physicians and 91 locums practicing at CMH.

- Doctor's Day is celebrated on the birthday (May 1) of Canada's first female physician, Dr. Emily Stowe, who received her degree in 1867 and became the first practicing female physician in Ontario.

May Celebrations: International Day of the Midwife

- International Day of the Midwife (May 5, 2025) celebrated the role midwives play in providing care to women and their families throughout pregnancy, labour, and post-partum. Many misconceptions exist around access Ontarians have to the level of care they can provide.
- On this day, CMH published a video of CMH RPN Nikki N. who shared her unique insights as both a nurse and a mother-to-be. She reveals what she discovered about the comfort and care during her pregnancy journey with Cambridge Memorial Hospital and Cambridge Midwives. The video can be accessed from CMH's YouTube channel.
- Nikki gave birth to her second child Aiden, days after shooting the video!

May celebrations: Shout out to our amazing nurses

- From May 12 to 18, we hit pause to shine a spotlight on our incredible nurses. All across CMH, the week was filled with warm, joyful moments — pancakes stacked high and dripping with REAL maple syrup, buttery popcorn shared in the café, and cozy breakfasts hosted right on the units by Managers.
- These small gestures carried a big message: we see you, we value you, and we're so proud of you.
- This year's theme, "The Power of Nurses to Transform Health," couldn't be more fitting. We see that power every day — in how you care, how you lead, and how you lift each other up. You don't just support patients; you transform lives.
- And while we were celebrating, many of you were also taking part in our Best Practice Fair, showcasing the latest in nursing excellence and keeping your skills sharp and current. That's the kind of dedication that sets CMH apart.
- Thank you for the compassion, creativity, and strength you bring to every shift. You make a difference every single day.

May celebrations: PSWs celebrated for their vital role in care

- Personal Support Workers (PSWs) play a vital role in patient care across Cambridge Memorial Hospital. Whether helping with daily routines or offering a steady, calming presence, PSWs make sure patients feel safe, supported, and treated with dignity.
- Their compassion doesn't just support healing—it helps shape it, offering comfort during some of the most difficult moments in a patient's journey.
- More than 70 PSWs work across CMH's inpatient units, with their presence woven into every aspect of care. Their growing impact is also reflected in the new cohorts of PSW students they welcome and mentor—another sign of their leadership and commitment to the future of care.
- On Monday, May 19, 2025, CMH proudly recognized the essential contributions of its PSWs. Their kindness, respect, and hands-on care continue to make a meaningful difference every day.
- Messages of appreciation and gratitude—from PSWs and colleagues alike—filled a large banner, capturing just how much they mean to the teams around them.

Celebrating our amazing volunteers

- The Cambridge Memorial Hospital Volunteer Association offers volunteers meaningful experiences while giving back to the community. Over 270 dedicated volunteers contributed approximately 31,200 hours in 2024 across a wide range of roles and responsibilities.
- One of the first volunteers you may meet upon arriving at our hospital is a Hospital Ambassador. These welcoming individuals, help patients and visitors navigate the hospital and support check-ins at Patient Registration.
- Their impact doesn't end there, as beyond the front doors they fulfill a variety of support roles.
- Some serve in Diagnostic Imaging making bags and providing directions. Others participate in the Hospital Elder Life Program, helping patients maintain their cognitive, physical, and emotional well-being. In areas like Medical Day Care, volunteers offer comfort and care through companionship and refreshments, supporting patients undergoing cancer treatment.
- Every role, every hour, adds up to something bigger than any single moment. Like water — always ebbing and flowing — their collective efforts ripple, creating momentum and lasting impact.
- National Volunteer Week (April 27 - May 2) is our opportunity to recognize and celebrate the waves of change created by our volunteers. This coming week, be sure to thank our volunteers for their amazing contributions to our hospital.

May celebrations: Celebrating Human Resources

- The field of Human Resources (HR) formally took shape in the mid-20th century. Its purpose has remained timeless – helping people and organizations thrive. At this hospital, our small but mighty team of HR professionals embodies this purpose every day.
- On International Human Resources Day (May 20, 2025), let's recognize our HR team – this network of support is behind every new hire, every return-to-work plan, every benefit change, and are available for a quiet check-in when someone's having a tough week.
- Together, our hospital's HR team, which also includes: Volunteer Services, Health & Safety Wellness team, and even Ember – our facility dog – have contributed a combined 118 years of service!
    - 9 HR professionals | 89 years of service
    - 4 Health & Safety Wellness professionals | 23 years
    - 1 Volunteer professional | 3 years
    - 1 Amazing Facility Dog (Ember) | 3 years
- While their work happens behind the scenes, its impact creates ripples throughout our hospital. From hiring and onboarding to collaborating with other teams to support staff wellness and organizational culture, they help ensure CMH stays grounded, connected, and human even in the face of adversity.

- Thank you to our HR team for being the steady hands and open hearts that help keep CMH moving forward – one person at a time.

May is Jewish Heritage Month

- May is Jewish Heritage Month—a time to recognize and celebrate the rich cultural traditions and lasting contributions of Jewish communities.

- In 2018, Parliament unanimously passed legislation to establish Jewish Heritage Month, led by Senator Linda Frum and MP Michael Levitt. Both Jewish Canadians, they garnered strong support across party lines. Each May now serves as a national opportunity to honour the many contributions Jewish Canadians have made—and continue to make—throughout the country.
- From public service and law to culture and sports, Jewish Canadians have contributed to Canada's development for over 250 years.
- One relatable example for hospital care is the opening of Mount Sinai Hospital in 1923 in Toronto. The hospital was founded by members of the local Jewish community, including four Jewish immigrant women who spent nine years (1913-1922) knocking on countless neighbourhood doors to raise money for a down payment on a house. This house eventually evolved into Mount Sinai Hospital which played a significant role in providing care to marginalized individuals, offering kosher food, and serving a diverse population, including a generation of Yiddish-speaking immigrants.
- As we honour Jewish Heritage Month, we recognize the importance of preserving and promoting the diversity of Jewish heritage, while also recognizing the historical and contemporary lived experiences of racialized Jews, Sephardic, Ashkenazi, Mizrahi, and Ethiopian Jews. By learning about and celebrating Jewish culture and history, Jewish Heritage Month helps foster mutual respect, inclusivity, and a deeper understanding of one another.

May is Asian Heritage Month

- Each May, we recognize Asian Heritage Month, an opportunity to honour the many contributions of Canadians of Asian heritage and explore the rich cultural diversity they bring to our communities.
- Asian Heritage Month has been officially celebrated in Canada since May 2002, following a Senate motion introduced by Senator Vivienne Poy and an official declaration by the Government of Canada. It provides a time for reflection on the history, traditions, and achievements of people of Asian origin—including those from East, Southern, Western, Central, and Southeast Asia—who have helped shape Canada's past, present, and future.
- Fun Fact: Did you know that Asia is comprised of 48 countries* and is home to almost 60% of the world's population?
- According to the 2021 Census, individuals of Asian heritage make up nearly 7,380,320 (19.3%) of Canada's population. Locally, Cambridge is home to over 55,305 residents (9.7%) of Asian heritage, with roots in countries such as India, Pakistan, Syria, Japan, and many more. These vibrant communities continue to enrich every aspect of our society—from the arts and sciences to business, public service, and beyond.
- While Asian Heritage Month is a time of celebration, it is also a moment to acknowledge the ongoing challenges many Asian communities continue to face. For too many, anti-Asian racism is a daily challenge. Raising awareness and actively confronting and denouncing all forms of discrimination is essential – year-round.
- It's important to recognize that the Asian community is not a single, homogenous group, but a diverse collection of individuals with varied cultures and histories. Despite these challenges, Asian communities continue to thrive, advocate, and shape the cultural fabric of Canada.
- What you can do is learn about pan-Asian diversity and the unique cultures and histories of Asian communities. Recognize harmful stereotypes and learn about their historical roots.

- Reflect on unconscious biases and how they influence your decisions and actions. Let us stand in solidarity with Asian communities, celebrate their contributions, and commit to being allies in the continued fight against racism.

CMH reverts to friendly masking

- As part of our commitment to review and reassess the practices borne from the recent respiratory season, CMH's COVID Command adopted a masking recommendation forwarded by Health Safety & Wellness (HSW) and Infection Prevention & Control (IPAC) to return to masking friendly practices.
- This was made in light of recent epidemiology and the potential for outbreaks in the hospital at this time.
- Effective as of May 6:
    - All team members providing patient care or working in a patient space will conduct a Point of Care Risk Assessment (PCRA) to determine whether a mask is required for each unique situation.
    - Should you wish to remain masked, this remains your choice—one that will be supported and respected. Masks will always be available for anyone who chooses to wear one.
    - Masking protocols remain where care partners and team members are interacting with a patient in isolation, outbreak unit(s) or where AGMPs are in use. In each case, a sign will be posted on their door to communicate this change.
    - Regardless of whether you choose to wear a mask, if a patient requests that team members wear a mask while interacting with them, please respect their wishes and don a mask. This is important to the patient experience we provide, and the trust we earn every day with our patients and families.
    - Patients presenting in our Emergency Departments with a respiratory illness will be asked to wear a mask while waiting for care.
- CMH may choose to reintroduce universal masking based on disease activity, during respiratory season, and for outbreak management. Data shows that community activity has peaked, and we are far less likely to experience healthcare-acquired cases or outbreaks. We will keep monitoring the data and adjust our plans if needed.
- Thank you for all you do to care for our patients, families, communities, and each other.

CAMBRIDGE MEMORIAL HOSPITAL

MEMORANDUM

TO: Patrick Gaskin

DATE: May 21, 2025

REPORTING PERIOD: October 1, 2024 – March 31, 2025

FROM: Dr. Anjali Sharma, Chief of Psychiatry
Kenneth Abogadil, Director of Diagnostic Imaging, Laboratory Medicine, Diagnostic Cardiology Services and Mental Health (interim)

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

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

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

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

Exceptions: NIL

Anjali Sharma, MD
Chief of Psychiatry

Kenneth Abogadil, CHE, MRT(N)(MR), PMP
Director, of Diagnostic Imaging, Laboratory Medicine, Diagnostic Cardiology Services and Mental Health (interim)

BRIEFING NOTE

Date: May 21, 2025
Issue: Broader Public Sector Accountability Act Attestation
Prepared for Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Erin Rideout, Manager, Purchasing & Supply Chain
Approved by: Trevor Clark, VP Finance and Corporate Services, CFO

Attachments/Related Documents:

1. Appendix 3 Attestation – BPSAA Reporting April 1, 2024 to March 31, 2025
2. Hospital Report on Consultant Use
3. Hospital Report on Non-Compliant Exception List > $121,200
4. Mohawk Medbuy- 2024-25 Attestation Letter
5. Mohawk Medbuy- BPS Attestation Reporting April 1, 2024 to March 31, 2025
6. Approved Non-Compliant Procurement for Public Posting

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 Broader Public Sector Accountability Act, 2010 (BPSAA) Appendix C - Attestation prepared by the President and CEO in accordance with Section 15 of the BPSAA for the period April 1, 2024 to March 31, 2025, and upon recommendation of the Resources Committee at the meeting of May 26, 2025.

Resources Committee
Following review and discussion of the information provided, the Resources Committee of the Board recommends that the Board of Directors approves the Broader Public Sector Accountability Act, 2010 (BPSAA) Appendix C - Attestation prepared by the President and CEO in accordance with Section 15 of the BPSAA for the period April 1, 2024 to March 31, 2025.
CARRIED.

Motion reference document: BPS Appendix C – Attestation, April 1, 2024 to March 31, 2025 (Attachment 1).

Executive Summary

Cambridge Memorial Hospital (CMH) followed the requirements of the BPSAA during the fiscal year 2024-25. All exceptions noted were due to delays by Mohawk Medbuy (MMC), a supply chain shared services organization. MMC provided supporting documentation for the contracts that were extended to cover the period until the new contracts were put into place.

Background
CMH is required to abide by the updated Management Board of Cabinet Broader Sector Accountability Act, the Canada Free Trade Agreement (CFTA), and the new US procurement restrictions, to ensure that publicly funded goods and services are acquired by Broader Public Sector (BPS) organizations through a process that is open, fair and transparent.

As part of the accountability requirements from the BPSAA, the hospital is required to submit an attestation to Ontario Health and prepare a report concerning the use of consultants and compliance with applicable procurement directives for purchases over $121,200. The Board is required to approve this attestation and report on an annual basis.

Analysis
All costs allocated to consultant and professional fees for the fiscal year ending March 31, 2025, were reviewed to determine if they complied with the BPSAA guidelines. To determine if the expenditure was a consulting expenditure the following definition was used: “consultant means a person or entity that, under an agreement other than an employment agreement, provides expert or strategic advice and related services for consideration and decision making.”

The attached Section 6 - Hospital Report on Consultant Use (Attachment 2) lists consulting expenditures incurred during the 2024-25 fiscal year.

Professional fee expenditures were reviewed for the 2024-25 fiscal year, and the following areas were contacted to confirm the nature of the expenditure and the procurement process that was followed:

- Office of the President and Chief Executive Officer
- Environmental Services
- Finance
- Human Resources
- Information Technology
- Patient Experience
- Purchasing

The attached Section 12 - Exception Report on Procurement Directives (Attachment 3) for all CMH initiated contracts for purchases over $121,200 includes description and rationale for the exceptions.

CMH is a member of MMC, a supply chain shared services organization that represents member hospitals across Canada. The attached attestation letter (Attachment 4) and contract exception report (Attachment 5) confirm that MMC followed provincial procurement requirements.

The list of approved non-competitive procurements (Attachment 6) is attached for information and is required to be publicly posted to comply with BPSAA.

CMH will continue working with all departments to facilitate open and competitive processes where required or to join existing contracts through shared service organizations.

APPENDIX C - ATTESTATION

Prepared in accordance with section 15 of the *Broader Public Sector Accountability Act, 2010* (BPSAA)

TO: The Board Cambridge Memorial Hospital, (the "Board")

FROM: Patrick Gaskin
President & Chief Executive Officer
Cambridge Memorial Hospital

DATE: June 4, 2025

RE: **April 1, 2024 – March 31, 2025 ("the Applicable Period")**

On behalf of the Cambridge Memorial Hospital (the Hospital) I attest to:

- the completion and accuracy of reports required of the Hospital pursuant to section 6 of the BPSAA on the use of consultants;
- the Hospital's compliance with the prohibition in section 4 of the BPSAA on engaging lobbyist services using public funds;
- the Hospital's compliance with any applicable perquisite directives issued under section 10 of the BPSAA by the Management Board of Cabinet;
- the Hospital's compliance with any applicable perquisite directives issued under section 11.1 of the BPSAA by the Management Board of Cabinet; and
- the Hospital's compliance with any applicable procurement directives issued under section 12 of the BPSAA by the Management Board of Cabinet, during the Applicable Period.

In making this attestation, I have exercised care and diligence that would reasonably be expected of a CEO in these circumstances, including making due inquiries of Hospital staff that have knowledge of these matters.

I further certify that any material exceptions to this attestation are documented in the attached Schedule A.

Dated at Cambridge, Ontario this June 4, 2025.

Patrick Gaskin
President & Chief Executive Officer
Cambridge Memorial Hospital

I certify that this attestation has been approved by the board of the Cambridge Memorial Hospital on June 4, 2025**.**

Lynn Woeller
Board Chair
Cambridge Memorial Hospital

SCHEDULE A to Attestation

1. Exceptions to the completion and accuracy of reports required in section 6 of the BPSAA on the use of consultants;
   no known exceptions

2. Exceptions to the Hospital's compliance with the prohibition in section 4 of the BPSAA on engaging lobbyist services using public funds;
   no known exceptions

3. Exceptions to the Hospital's compliance with the expense claims directive issued under section 10 of the BPSAA by the Management Board of Cabinet;
   no known exceptions

4. Exceptions to the Hospital's compliance with the perquisites directive issued under section 11.1 of the BPSAA by the Management Board of Cabinet; and
   no known exceptions

5. Exceptions to the Hospital's compliance with the procurement directive issued under section 12 of the BPSAA by the Management Board of Cabinet.
   no known exceptions

Hospital Report on Consultant Use

Name of Hospital: Cambridge Memorial Hospital

NAME OF OH Region: Ontario Health West

REPORTING PERIOD: April 1, 2024 to March 31, 2025

No.	Consultant Firm Name	Name and Title of Consulting Contract	Contract Term *(If the contract term has been extended please include the original contract term and the amended contract term)*	Procurement Value *(A+B+C)* *A=Original Value* *B=Value of Amendments* *C=Total Procurement Value* *Total Paid ($)*	Consultant Selection Process *(Open Competitive, Invitational Competitive, Non-competitive – If non-competitive explanation required*	Modifications to Agreement *(if yes, did the procurement documents permit modifications to the term or value of the agreement?)*
1	Deloitte	HIS governance structure, risk mitigation	August 2024	$20,000	Non-competitive, CFTA Part III, Chapter 5, Article 513: Limited tendering. Would cause significant inconvenience or substantial duplication of costs for the procuring entity.	No modifications
2	Saige Leadership Consulting	Leadership Development program	March 2025	$20,000	Non-competitive, Non-competitive, CFTA Part III, Chapter 5, Article 513: Limited tendering. If strictly necessary, and for reasons of urgency brought about by events unforeseeable by the procuring entity, the goods or services could not be obtained in time using open tendering.	No Modifications
3	Dr. Marc Freeman	Nuclear Medicine Department optimization	August 2024	$10,000	Non-competitive, Non-competitive, CFTA Part III, Chapter 5, Article 513: Limited tendering. Due to an absence of competition for technical reasons	No Modifications
4	Healthtech	Regional instance HIS review	August 2024	$85,873	Non-competitive, Non-competitive, CFTA Part III, Chapter 5, Article 513: Limited tendering. If no tenders were submitted or no suppliers requested participation [provided that the	No Modifications

No.	Consultant Firm Name	Name and Title of Consulting Contract	Contract Term *(If the contract term has been extended please include the original contract term and the amended contract term)*	Procurement Value *(A+B+C)* *A=Original Value* *B=Value of Amendments* *C=Total Procurement Value* *Total Paid ($)*	Consultant Selection Process *(Open Competitive, Invitational Competitive, Non-competitive – If non-competitive explanation required*	Modifications to Agreement *(if yes, did the procurement documents permit modifications to the term or value of the agreement?)*
					requirements of the tender document are not substantially modified].	
5	Ernst & Young	Innovation Roadmap	January 2025	$80,000	Non Competitive, CFTA Part III, Chapter 5, Article 513: Limited tendering. Would cause significant inconvenience or substantial duplication of costs for the procuring entity.	No Modifications

Hospital Report on Consultant Use

Name of Hospital: Cambridge Memorial Hospital

Ontario Health Region: Ontario Health West

REPORTING PERIOD: April 1, 2024 to March 31, 2025

No.	Consultant Firm Name	Name and Title of Consulting Contract	Contract Term *(If the contract term has been extended please include the original contract term and the amended contract term)*	Procurement Value *(A+B+C)* *A=Original Value* *B=Value of Amendments C=Total Procurement Value* *Total Paid ($)*	Consultant Selection Process *(Open Competitive, Invitational Competitive, Non-competitive – If non-competitive explanation required*	Modifications to Agreement *(if yes, did the procurement documents permit modifications to the term or value of the agreement?)*
1	Deloitte	Health Information System (HIS) governance structure, risk mitigation	August 2024	$20,000	Non-Competitive	No modifications
2	Saige Leadership Consulting	Leadership Development program	March 2025	$20,000	Non-Competitive	No Modifications
3	Dr. Marc Freeman	Nuclear Medicine Department optimization	August 2024	$10,000	Non-Competitive	No Modifications
4	Healthtech Consultants	Regional instance HIS review	August 2024	$85,873	Non-Competitive	No Modifications
5	Ernst & Young	Innovation Roadmap	January 2025	$80,000	Non-Competitive	No Modifications

Attestation Reporting Period April 1, 2024 - March 31, 2025

Compliance with any applicable procurement directives BPSAA section 12
Known instances of vendor spend >$121,200.

No.	Vendor	24/25 Spend	Description and Rationale for Exception	Actions to be Taken
1	GE Healthcare Canada Inc	$158,245.19	MMC contract MMC-1807A extended past its original contract expiry date due to initiative delays at MMC.	CMH signed onto the contract extension with MMC via limited tender and participated in the new initiative with MMC.
2	Isologic Innovative	$222,802.51	MMC contract MMC-1807C extended past its original contract expiry date due to initiative delays at MMC.	CMH signed onto the contract extension with MMC via limited tender and participated in the new initiative with MMC.
3	Voyago, 947465 Ontario LTD.	$341,025.11	MMC contract MSS-1679B extended past its original contract expiry date due to initiative delays at MMC.	CMH signed onto the contract extension with MMC via limited tender and participated in the new initiative with MMC.
4	Abbvie Corporation	$145,384.45	MMC contract C10381 extended past its original contract expiry date due to initiative delays at MMC.	CMH signed onto the contract extension with MMC via limited tender and participated in the new initiative with MMC.

March 25, 2025

Attestation to the BPSAA Supply Chain Secretariat BPS Directive and Canada Free Trade Agreement (CFTA) Compliance

Dear Member,

Mohawk Medbuy Corporation fully understands and abides by the Ontario Ministry of Finance Broader Public Sector Supply Chain Directives and the Canada Free Trade Agreement (CFTA) meant to ensure that publicly funded goods and services are acquired by BPS organizations through a process that is open, fair, and transparent.

On behalf of Mohawk Medbuy Corporation, we attest that all contracting services performed on the Members' behalf for the applicable period of April 1, 2024 – March 31, 2025, are in compliance with the Broader Public Sector Supply Chain Directives and the Canada Free Trade Agreement (CFTA). Exceptions, for contracts on which the Member participated occurring during the twelve (12) month reporting period are noted on the attached document with supporting explanations.

In making this attestation, we have exercised care and diligence that would reasonably be expected in these circumstances, including making due inquires and reviewing results of the self-assessment audits we have completed.

I, Marc Lemaire, Senior Vice President, Strategic Sourcing, I, Dale Thomson, Senior Vice President, National Programs & Sourcing Operations, I, Raechel Griffin, Vice President, Capital, FFE, and Nutrition Services Procurement I, Ally Dhalla, Senior Vice President Pharmacy and Clinical Services & Innovation have the signing authority to make this commitment on behalf of Mohawk Medbuy Corporation.

MOHAWK MEDBUY CORPORATION

Marc Lemaire
Senior Vice President, Strategic Sourcing
mlemaire@mohawkmedbuy.ca

Dale Thomson
Senior Vice President, National Programs & Sourcing Operations
dthomson@mohawkmedbuy.ca

Raechel Griffin
Vice President, Capital, FFE and Nutrition Services Procurement
rgriffin@mohawkmedbuy.ca

Ally Dhalla
Senior Vice President, Pharmacy and Clinical Services & Innovation
adhalla@mohawkmedbuy.ca

MOHAWK MEDBUY

BPS Attestation Report - April 1, 2024 to March 31, 2025 - CMH

* Reported Spend indicates Member provided data for the Attestation Period. Note that contracts may have started or ended at various points within the Attestation period. Data compiled from October 2023 to September 2024

P - ND indicates Member participation on contract, however spend data not provided/available.
NP - Not Participating

CMH

CAMBRIDGE MEMORIAL HOSPITAL

Code	Contract No.	Contract Name	Supplier Name	Contract Start Date	Current Contract Expiry Date	New Contract Expiry Date (for extended contracts)	Exception Type	Justification Code	SC10022
OR	C10381	OR BIOLOGIC MESH 2018 - ABBVIE	ABBVIE CORPORATION	November 1, 2018	October 31, 2024	January 31, 2025	Appendix A - Limited Tender	D	$ 124,831
MILR	MMC-1807A	MILR RADIOPHARMACEUTICALS 2018 - GE	GE HEALTHCARE TECHNOLOG	September 10, 2018	September 9, 2024	December 31, 2024	Appendix A - Limited Tender	D	P-ND
MILR	MMC-1807C	MILR RADIOPHARMACEUTICALS 2018 - ISOLOGIC	ISOLOGIC INNOVATIVE RADIO	April 1, 2018	March 31, 2024	December 31, 2024	Appendix A - Limited Tender	D	P-ND
MMNCL	MSS-1679B	NON EMERGENT PATIENT TRANSFER	VOYAGEUR TRANSPORTATION	May 1, 2017	March 31, 2024	March 31, 2025	Appendix A - Limited Tender	D	P-ND

Report Definintions and Reference Tables

* Reported Spend indicates Member provided data for the Attestation Period. Note that contracts may have started or ended at various points within the Attestation period. Data compiled from October 2023 to September 2024
P - ND indicates Member participation on contract, however spend data not provided/available.
NP - Not Participating

	Appendix A – Limited Tendering (Article 513)
	Limited Tendering: means a procurement method whereby the procuring entity contacts a supplier or suppliers of its choice. In accordance with the CFTA Chapter 5 (Government Procurement), an organization may use Limited Tendering in the following circumstances, provided that it does not use this provision for the purpose of avoiding competition among suppliers or in a manner that discriminates against suppliers or any other Party or protects its own suppliers.
	☐(a) if:
A(i)	☐ (i) no tenders were submitted or no suppliers requested participation;
A(ii)	☐ (ii) no tenders that conform to the essential requirements of the tender documentation were submitted;
A(iii)	☐ (iii) no suppliers satisfied the conditions for participation; or
A(iv)	☐ (iv) the submitted tenders were collusive
	provided that the requirements of the tender documentation are not substantially modified;
	☐ (b) if the goods or services can be supplied only by a particular supplier and no reasonable alternative or substitute goods or services exist for any of the following reasons:
B(i)	☐ (i) the requirement is for a work of art;
B(ii)	☐ (ii) the protection of patents, copyrights, or other exclusive rights;
B(iii)	☐ (iii) due to an absence of competition for technical reasons;
B(iv)	☐ (iv) the supply of goods or services is controlled by a supplier that is a statutory monopoly;
B(v)	☐ (v) to ensure compatibility with existing goods, or to maintain specialized goods that must be maintained by the manufacturer of those goods or its representative;
B(vi)	☐ (vi) work is to be performed on property by a contractor according to provisions of a warranty or guarantee held in respect of the property or the original work;
B(vii)	☐ (vii) work is to be performed on a leased building or related property, or portions thereof, that may be performed only by the lessor; or
B(viii	☐ (viii) the procurement is for subscriptions to newspapers, magazines, or other periodicals;
	☐ (c) for additional deliveries by the original supplier of goods or services that were not included in the initial procurement, if a change of supplier for such additional goods or services:
C(i)	☐ (i) cannot be made for economic or technical reasons such as requirements of interchangeability or interoperability with existing equipment, software, services, or installations procured under the initial procurement; and
C(ii)	☐ (ii) would cause significant inconvenience or substantial duplication of costs for the procuring entity;
D	**☐ (d) if strictly necessary, and for reasons of urgency brought about by events unforeseeable by the procuring entity, the goods or services could not be obtained in time using open tendering;**
E	☐ (e) for goods purchased on a commodity market;
F	☐ (f) if a procuring entity procures a prototype or a first good or service that is developed in the course of, and for, a particular contract for research, experiment, study, or original development. Original development of a first good or service may include limited production or supply in order to incorporate the results of field testing and to demonstrate that the good or service is suitable for production or supply in quantity to acceptable quality standards, but does not include quantity production or supply to establish commercial viability or to recover research and development costs;
G	☐ (g) for purchases made under exceptionally advantageous conditions that only arise in the very short term in the case of unusual disposals such as those arising from liquidation, receivership, or bankruptcy, but not for routine purchases from regular suppliers;

	☐ (h) if a contract is awarded to a winner of a design contest provided that:
H(i)	☐ (i) the contest has been organized in a manner that is consistent with the principles of this Chapter, in particular relating to the publication of a tender notice; and
H(ii)	☐ (ii) the participants are judged by an independent jury with a view to a design contract being awarded to a winner; or
I	☐ (i) if goods or consulting services regarding matters of a confidential or privileged nature are to be purchased and the disclosure of those matters through an open tendering process could reasonably be expected to compromise government confidentiality, result in the waiver of privilege, cause economic disruption, or otherwise be contrary to the public interest.
	Appendix B – Non-Application (Article 504)
	Non-Application: means the CFTA Chapter 5 (Government Procurement) does not apply to:
A	☐ (a) public employment contracts;
B	☐ (b) non-legally binding agreements;
C	☐ (c) any form of assistance, such as grants, loans, equity infusions, guarantees, and fiscal incentives;
D	☐ (d) a contract awarded under a cooperation agreement between a Party and an international cooperation organization if the procurement is financed, in whole or in part, by the organization, only to the extent that the agreement includes rules for awarding contracts that differ from the obligations of this Chapter;
E	☐ (e) acquisition or rental of land, existing buildings, or other immovable property, or the rights thereon;
F	☐ (f) measures necessary to protect intellectual property, provided that the measures are not applied in a manner that would constitute a means of arbitrary or unjustifiable discrimination between Parties where the same conditions prevail or are a disguised restriction on trade;
	☐ (g) procurement or acquisition of:
G(i)	☐ (i) fiscal agency or depository services;
G(ii)	☐ (ii) liquidation and management services for regulated financial institutions; or
G(iii)	☐ (iii) services related to the sale, redemption, and distribution of public debt, including loans and government bonds, notes, and other securities;
	☐ (h) procurement of:
H(i)	☐ (i) financial services respecting the management of government financial assets and liabilities (i.e. treasury operations), including ancillary advisory and information services, whether or not delivered by a financial institution;
H(ii)	☐ (ii) health services or social services;
H(iii)	☐ (iii) services that may, under applicable law, only be provided by licensed lawyers or notaries; or
H(iv)	☐ (iv) services of expert witnesses or factual witnesses used in court or legal proceedings; or
	☐ (i) procurement of goods or services:
I(i)	☐ (i) financed primarily from donations that require the procurement to be conducted in a manner inconsistent with this Chapter;
I(ii)	☐ (ii) by a procuring entity on behalf of an entity not covered by this Chapter;
I(iii)	☐ (iii) between enterprises that are controlled by or affiliated with the same enterprise, or between one government body or enterprise and another government body or enterprise;
I(iv)	☐ (iv) by non-governmental bodies that exercise governmental authority delegated to them;
I(v)	☐ (v) from philanthropic institutions, non-profit organizations, prison labour, or natural persons with disabilities;
I(vi)	☐ (vi) under a commercial agreement between a procuring entity which operates sporting or convention facilities and an entity not covered by this Chapter that contains provisions inconsistent with this Chapter;
I(vii)	☐ (vii) conducted for the specific purpose of providing international assistance, including development aid, provided that the procuring entity does not discriminate on the basis of origin or location within Canada of goods, services, or suppliers; or
I(viii)	☐ (viii) conducted:
I(viii)(	☐ (A) under the particular procedure or condition of an international agreement relating to the stationing of troops or relating to the joint implementation by the signatory countries of a project; or
I(viii)(	☐ (B) under the particular procedure or condition of an international organization, or funded by international grants, loans, or other assistance, if the procedure or condition would be inconsistent with this Chapter.

LIST OF APPROVED NON COMPLIANT PROCUREMENT TO BE PUBLICALLY POSTED - 2024/25

Vendor	Product/Service description	Currency	Criteria Code Number	Criteria Code Description	Value (SUB-TOTAL)	PO Date (DD-MM-YYYY)
PICIS	Additional licenses required after audit for OR case charting software.	USD	33	(b)(v) to ensure compatibility with existing goods, or to maintain specialized goods that must be maintained by the manufacturer of those goods or its representative	$ 245,625.00	30-04-2024
UKG	Implementation fees not part of original scope of RFP leveraged by CMH.	CAD	31	(b)(iii) due to an absence of competition for technical reasons	$ 244,125.00	12-06-2024
Iatric	Maintenance fees for existing programs that interface with Meditech.	CAD	32	(b)(iv) the supply of goods or services is controlled by a supplier that is a statutory monopoly	$ 153,669.77	15-05-2024
Roche	To remain consistent with current fleet of analyzers that must communicate with each other.	CAD	33	(b)(v) to ensure compatibility with existing goods, or to maintain specialized goods that must be maintained by the manufacturer of those goods or its representative	$ 193,644.00	17-09-2024
PICIS	EREQ 39279 yearly maintenance fees due to new Health Information System (HIS) delay.	USD	33	(b)(v) to ensure compatibility with existing goods, or to maintain specialized goods that must be maintained by the manufacturer of those goods or its representative	$ 183,749.64	20-01-2025

BRIEFING NOTE

Date: May 21, 2025
Issue: M-SAA Schedule F – Declaration of Compliance
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Kenneth Abogadil, Director of Diagnostic Imaging, Laboratory Medicine, Diagnostic Cardiology Services and Mental Health (interim)
CC: Stephanie Pearsall, VP, Clinical Programs and Chief Nursing Executive
Trevor Clark, VP, Finance & Corporate Services, CFO
Approved by: Valerie Smith-Sellers, Director, Finance

Attachments / Related Documents: Schedule F – Declaration of Compliance

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 submission of the Multi-Sector Service Accountability Agreement (M-SAA) Schedule F – Declaration of Compliance, confirming that CMH continues to meet its legal and contractual obligations and upon recommendation of the Resources Committee at the meeting of May 26, 2025

Resources Committee

After reviewing the information provided, the Resources Committee recommends that the Board of Directors approves the submission of the Multi-Sector Service Accountability Agreement (M-SAA) Schedule F – Declaration of Compliance.

This declaration confirms that Cambridge Memorial Hospital (CMH) has:

- Followed all government requirements for purchasing goods and services,
- Met the expectations of the Local Health System Integration Act, and
- Complied with the Public Sector Compensation Restraint to Protect Public Services Act.

CARRIED.

Background

The M-SAA applies to select Outpatient Mental Health Services, which include:

- Counselling and Treatment Programs
- Psychiatric Assessment in the Emergency Department
- Injection Clinic Services
- Day Hospital Mental Health Programs

These services are provided to residents in the Cambridge North Dumfries community.

Analysis

Over the past two fiscal years, CMH has continued to provide outpatient mental health services funded under the Multi-Sector Service Accountability Agreement (M-SAA). These include counselling and treatment programs, psychiatric assessments in the Emergency Department, the injection clinic, and the day hospital program. While service volumes for these programs declined by approximately 10% in 2024-25 compared to the previous year, the outpatient team successfully improved patient attendance by reducing the no-show rate from 9.3% to 8.5%. This reflects a positive step in patient engagement, despite overall lower visit numbers.

A significant contributor to the lower service volumes in recent years has been a shortage of psychiatrists. For much of the year, only two full-time psychiatrists were available to support all outpatient mental health services. However, CMH successfully recruited a third psychiatrist in the final quarter of 2024-25. This addition has strengthened the team's capacity to meet patient needs and positions the program for growth in the year ahead.

Beyond the programs formally covered by the M-SAA, CMH has also continued to support additional mental health services for patients and families. Notably, multiple family education sessions have been introduced as part of a broader commitment to improving caregiver involvement and mental health literacy in the community. These efforts complement CMH's work to strengthen its regional presence, with the Interim Director of Mental Health and Chief of Psychiatry actively participating in various mental health and addictions planning tables and working groups across the region.

Looking ahead, CMH is taking further steps to improve access and responsiveness. The team is evaluating current program offerings with a focus on streamlining intake processes to make it easier for patients to enter care. In addition, work is underway to explore the development of new day hospital programming aimed at expanding service options for the community and increasing clinical activity.

While CMH also operates inpatient mental health services, which the M-SAA does not cover, it is worth noting that these services have experienced similar challenges related to capacity and staffing. Nevertheless, the hospital remains committed to continuous improvement across both inpatient and outpatient mental health care.

Declaration of Compliance

CMH's Director of Mental Health Programs confirms that CMH has fully met the M-SAA requirements for the period April 1, 2024, to March 31, 2025, including:

- Following all required procurement processes,
- Meeting the Connecting Care Act, 2019 obligations, and
- Complying with any government compensation restraint policies.

This declaration is made after internal review by CMH's leadership, including the President and CEO.

SCHEDULE F – DECLARATION OF COMPLIANCE

DECLARATION OF COMPLIANCE

To: **The Board of Directors** of Ontario Health Attn: Board Chair.

From: **The Board of Directors** (the "Board") of the Cambridge Memorial Hospital (the "HSP")

Date: [June 4, 2025

Re: April 1, 2024 – March 31, 2025 (the "Applicable Period"

Unless otherwise defined in this declaration, capitalized terms have the same meaning as set out in the multi-sector service accountability agreement between Ontario Health and the HSP in effect during the Applicable Period (the "Agreement").

The Board has authorized me, by resolution dated June 4, 2025], to declare to you as follows:

After making inquiries of the [Patrick Gaskin, President and CEO of Cambridge Memorial Hospital] and other appropriate officers of the HSP, and subject to any exceptions identified on Appendix 1 to this Declaration of Compliance, to the best of the Board's knowledge and belief, the HSP has fulfilled its obligations under the Agreement in effect during the Applicable Period.

Without limiting the generality of the foregoing, the HSP has complied with:

(i) Article 4.8 of the Agreement concerning applicable procurement practices;

(ii) The *Connecting Care Act*; 2019; and

(iii) Any compensation restraint legislation which applies to the HSP.

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[Lynn Woeller], [Chair, Cambridge Memorial Hospital Board of Directors]

SCHEDULE F – DECLARATION OF COMPLIANCE

Appendix 1 - Exceptions

[No exceptions.

BRIEFING NOTE

Date: May 21, 2025
Issue: HSAA Article 8 – Declaration of Compliance
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Valerie Smith-Sellers, Director, Finance
Approved by: Trevor Clark, VP Finance & Corporate Services, CFO

Attachments / Related Documents: HSAA Article 8 – Declaration of Compliance

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 supports the submission of the HSAA Article 8 – Declaration of Compliance, and upon recommendation of the Resources Committee at the meeting of May 26, 2025.

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

After making inquiries of the President and CEO and other appropriate officers of the HSP, and subject to any exceptions identified on Appendix 1 to this Declaration of Compliance, to the best of the Board's knowledge and belief, the HSP has fulfilled its obligations under Agreement during the Applicable Period (April 1, 2024 – March 31, 2025) and has received the required reports referred to in Section 8.6 of the Agreement.

Resources Committee

Following review and discussion of the information provided, the Resources Committee of the Board recommends that the Board of Directors supports the submission of the HSAA Article 8 – Declaration of Compliance.

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

HSAA ARTICLE 8 – FORM OF COMPLIANCE DECLARATION

DECLARATION OF COMPLIANCE

To: **Ontario Health** ("OH").

From: **The Board of Directors** (the "Board") of the [Cambridge Memorial Hospital] (the "HSP")

Date: [June 4, 2025]

Re: April 1, 2024 – March 31, 2025 (the "Applicable Period")

Unless otherwise defined in this declaration, capitalized terms have the same meaning as set out in the Hospital Service Accountability Agreement between OH and the HSP in effect during the Applicable Period (the "Agreement").

The Board has authorized me, by resolution dated [June 4, 2025], to declare to you as follows:

After making inquiries of the [Patrick Gaskin, President & Chief Executive Office] and other appropriate officers of the HSP, and subject to any exceptions identified on Appendix 1 to this Declaration of Compliance, to the best of the Board's knowledge and belief, the HSP has fulfilled its obligations under the Agreement during the Applicable Period and has received the required reports referred to in Section 8.6 of the Agreement.

_____

Lynn Woeller], [Board Chair]

Appendix 1 - Exceptions

[No exceptions.