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

Wednesday October 1, 2025
1700-1745
Virtual via Teams / C.1.229
Join the meeting now
Or call in (audio only)
833-827-2824,978704436#Canada (Toll-free)
Phone Conference ID: 978 704 436#

AGENDA

Agenda Item * indicates attachment / TBC – to be circulated	Page #	Time	Responsibility	Purpose
1. CALL TO ORDER				
1.1 Territorial Acknowledgement		1700	L. Woeller	
1.2 Welcome		1703	L. Woeller	
1.3 Confirmation of Quorum (7)		1704	L. Woeller	Confirmation
1.4 Declarations of Conflict of Interest		1705	L. Woeller	Declaration
1.5 Consent Agenda *(Any Board member may request that any item be removed from this consent agenda and moved to the regular agenda)*		1706	L. Woeller	Motion
1.5.1 Minutes of June 25, 2025* and Open (2)	4			
1.5.2 2025/26 Board of Directors Action Log*	11			
1.5.3 Board Attendance*	12			
1.5.4 Board Work Plan*	13			
1.5.5 Events Calendar*	21			
1.5.5.1 Healthcare Quality Canada Conference*	23			
1.5.6 Committee Reports to the Board of Directors				
1.5.6.1 Audit Committee (No Meeting - Next Meeting Nov 17, 2025)				
1.5.6.2 Digital Health Strategy Committee* (Sept 18, 2025)	28			
1.5.6.3 Executive Committee (No Meeting - Next Meeting Nov 18, 2025)				
1.5.6.4 Governance & Nominating Committee (No Meeting - Next Meeting Oct 9, 2025)				
1.5.6.5 Medical Advisory Committee* (Sept 10, 2025)	29			
1.5.6.6 Resources Committee* (Sept 22, 2025)	32			
1.5.7 Governance Policy Approvals (No Policies for Approval)				
1.5.8 CEO Certificate of Compliance* (June 21, 2025 – September 26, 2025)	33			
1.6 Confirmation of Agenda		1709	L. Woeller	Motion
2. PRESENTATIONS				
2.1 No Presentations				
3. BUSINESS ARISING				
3.1 No Open Matters for Discussion				
4. NEW BUSINESS				
4.1 Chair's Update				

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

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

Agenda Item * indicates attachment / TBC – to be circulated	**Page #**	**Time**	**Responsibility**	**Purpose**
4.1.1 Board Chair's Report*	34	1710	L. Woeller	Information
4.1.2 2025/26 Board Generative Topics*	39	1712	L. Woeller	Information
4.2 2025/26 Strategic Priorities Tracker Q1 Updates and Quality Monitoring Metrics*	40	1715	M. Iromoto / K. Leslie	Information
4.3 Quality Committee (Sept 17, 2025)				
4.3.1 Report to the Board of Directors*	83	1725	B. Conway	Information
4.4 Resources Committee (Sept 22, 2025)				
4.4.1 August 2025 Financial Statements and Year-End Forecast*	86	1730	P. Brasil	Motion
4.5 Patient Family Advisory Council (PFAC) Update (Sept 9, 2025)		1735	L. Woeller	Information
4.5.1 Beryl Institute Experience Assessment*	93	1740	M. Iromoto	Discussion
4.6 CEO Update				
4.6.1 No Open Matters for Discussion				
5. UPCOMING EVENTS ***Visit GovHub for the most current listing of all upcoming events***		1744	L. Woeller	Information
5.1 Celebration of Champions: October 22, 2025, Galt Country Club – 5:30-8:00pm *Invitations from the Foundation have been sent – Donor event*				
5.2 Grand Rounds: October 23, 2025 – 8:00-9:00am, virtual *Details to follow*				
6. DATE OF NEXT MEETING	Wednesday November 5, 2025 (Generative Session) Location: Hybrid			
7. TERMINATION		1745	L. Woeller	Motion
Link: Board/Committee Evaluation Survey	*Following the meeting, please complete within one week.*			

Board Members: Lynn Woeller (Chair), Sara Alvarado, Tom Barker, Paulo Brasil, William Conway, Julia Goyal, Monika Hempel, Jayne Herring, Miles Lauzon, Dr. Margaret McKinnon, 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 – October 1, 2025	
1.5	Consent Agenda	• That, the CMH Board of Directors approves the Consent Agenda as presented/amended
1.6	Confirmation of Agenda	• That, the agenda be adopted as presented/amended
4.3.2	August 2025 Financial Statements	• That, the Board of Directors received the August 2025 financial statements as presented by management and upon recommendation of the Resources Committee at the meeting of September 22, 2025

Cambridge Memorial Hospital
BOARD OF DIRECTORS MEETING
Wednesday, June 25, 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 June 25, 2025.

Present:

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

Regrets: Dr. M. Shafir

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

Guests: T. Barker, J. Herring, K. Leslie

Recorder: S. Fitzgerald

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1. CALL TO ORDER
The Chair called the meeting to order at 1712hrs.

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 none

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

The following items were removed from the consent agenda to the regular agenda for further discussion:
1.5.11 Education Topics 2025/26 Survey Results

The consent agenda was approved as amended:

1.5.1 Minutes of June 4, 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
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
New Credentialed Midwife
1.5.8 Quality Monitoring Metrics – Monthly Report
1.5.9 CEO Annual Certificate of Compliance & CEO Certificate of Compliance
May 31, 2025 – June 20, 2025)
1.5.10 CMH President & CEO Report
None opposed, **CARRIED.**

1.6. **Confirmation of Agenda**

The following items were added to the regular agenda:

4.1.2 Board Generative Topics
4.1.3 Change of Digital Health Strategy Sub-Committee to a Committee

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

None opposed. **CARRIED.**

2. PRESENTATIONS

Research & Innovation Plan – Kyle Leslie presented the Research & Innovation Plan for approval. The plan has received endorsement from Digital Health Strategy Sub-Committee and Resources Committee. CMH Leadership highlighted that the primary objective of the plan is to elevate CMH's innovation capabilities and establish it as a strong collaborator within the Waterloo Region innovation ecosystem. Significant progress has already been made, including collaborations with the University of Waterloo on co-designing award-winning optimization algorithms to enhance surgical planning and supply chain utilization.

This plan is a core enabler of our strategic pillar focused on Reimagining Community Health, emphasizing improved care delivery and enhanced operational excellence at CMH. The work is grounded in a comprehensive assessment conducted by EY using the EY innovation maturity model, evaluating CMH's current state and guiding future actions. CMH is executing approximately 35 action items to propel towards higher levels of innovation maturity, with a goal of advancing from Level 1 to Level 3 on the EY model.

To ensure progress and success, key metrics, and targets for fiscal year 2026 have been identified and linked to the actions outlined in the work plan.

Kyle Leslie also shared with the Board that last night an innovation workshop was held, co-facilitated by CMH staff and physicians alongside McMaster University's Med Tech Accelerator, Accelerate. The engagement involved approximately 30 highly motivated team members who explored human-centered design principles to reimagine hospital rounds and discharge planning, ultimately aiming to enhance patient flow and care experience.

MOTION: That, the Board approves the Research and Innovation Plan as presented in Appendix A and outlined in this briefing note and upon recommendation of the Resources Committee at the meeting of June 23, 2025 and the Digital Health Strategy Sub-Committee at the meeting of June 19, 2025.
None opposed, **CARRIED.**

3. BUSINESS ARISING

No open matters for discussion.

4. NEW BUSINESS

4.1. Chair's Update

4.1.1. Board Generative Topics

The Chair highlighted that a few changes around generative and education. The number of generative discussion slots will decrease from three to two for the 2025/26 Board cycle, aimed at supporting CMH's significant ongoing initiatives and ensuring the Board stays focused on key priorities. Additionally, there will be flexible opportunities for brief 10–20-minute education sessions throughout Committee and Board meetings. For instance, educational content about Digital Health will be delivered at the committee level, with presentation materials later shared with the Board via GovHub.

4.1.2. Change of Digital Health Sub-Committee to a Committee

With the approval of the Research and Innovation plan, which would fall under the Terms of Reference for the Digital Health Strategy Sub-Committee, it is recommended that this Sub-Committee be elevated to a full Committee that reports directly to the Board of Directors. The Chair noted that there will still be some overlap with the Resources Committee, particularly about financial reporting for HIS, which will continue to flow through both the Digital Health and Resources Committees. Discussion took place around the official name of the Committee, and it was agreed that conversation would be followed up offline.

MOTION: That, the Board of Directors approves the change of the Digital Health Strategy Sub-Committee, which shall report directly to the Board of Directors. Further, that Policy 2-A-17 be amended to reflect the change.
None opposed, **CARRIED.**

ACTION: Review of the name of the Digital Health Strategy Committee

4.2. Quality Committee Update

4.2.1. Report to the Board of Directors

The Chair of the Quality Committee noted that presentations from Diagnostic Imaging, Cardiology Services, and Laboratory Medicine were given. These presentations highlighted significant increases in procedural volumes and tests, with a strong emphasis on efficiency. The upcoming start of a new pathologist in June was also viewed positively.

Additionally, the committee conducted a tour of the lab, which showcased innovation and workflow improvements.

CMH Leadership provided an update on the OB trauma metric from the Quality Metric Scorecard, noting that out of 132 births in March, 5 required instrumentation.

4.2.2. **Care Cupboard**
CMH Leadership highlighted that CMH is in a good place for supplies currently. In the future if there are current needs Leadership will provide the Board with updates on what may be needed.

ACTION: The Board has asked that the Care cupboard be kept as an ongoing item on the Action log as a reminder.

4.3. **PFAC Update**
An update of the June 3, 2025 meeting was provided to the Board. It was highlighted that PFAC was involved in a parking analysis session providing input into the overall parking supply and layout challenges, as well as how parking affects the broader community. PFAC was also joined by the Manager of the Emergency Department leading a presentation and discussion on how the patient experience can be improved and the role of a patient navigator. The Manager of Communications provided an update on the rebranding initiative underway at CMH.

4.4. **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 October 1, 2025.

7. TERMINATION
MOTION: That, the meeting terminated at 1938hrs.
None opposed, **CARRIED.**

Agenda

Cambridge Memorial Hospital
BOARD OF DIRECTORS MEETING
Wednesday, June 25, 2025
OPEN SESSION (2)
(After Annual Meeting)

Minutes of the open session of the Board of Directors meeting, held via hybrid model (video conference and within Cambridge Memorial Hospital, C.1.229) on June 25, 2025.

Present:

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

Regrets: Dr. M. Shafir

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

Guests:

Recorder: S. Fitzgerald

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1. CALL TO ORDER
The Chair called the meeting to order at 2014 hours.

1.1. **Confirmation of Quorum**
Quorum requirements having been met, the meeting proceeded, as per the agenda.

1.2. **Declarations of Conflict**
Board members were asked to declare any known conflicts of interest regarding this meeting. There were none.

1.3. **Confirmation of Agenda**
MOTION: That**,** the agenda be approved as amended.
None opposed. **CARRIED.**

2. PRESENTATIONS
No open presentations for discussion.

3. BUSINESS ARISING
No open matters for discussion.

4. NEW BUSINESS
4.1. Election of the Officers
The Chair of Governance put forward a motion to elect the Board Chair and Board Vice Chair.

MOTION: That, the Board of Directors elects Lynn Woeller as Chair of the Board and Diane Wilkinson as Vice Chair of the Board for a 1-year term. None opposed, **CARRIED.**

4.2. Appointment of Chairs, Directors, and Non-Director Committee Members/Expert Advisors to CMH Board Committees & Appointment of Directors to Non CMH Board Committees

The Board of Directors reviewed and discussed the pre-circulated briefing note included in the meeting package. The Chair of the Governance Committee highlighted that the CMH Board welcomes the following new non-Director/expert advisor Committee members:

- Amanda Forrest – Resource Committee Member
- Gloria Ringwood – Digital Health Strategy Committee Member
- Taariq Shaikh – Audit Committee Expert Advisor

Roger Ma has been reassigned as Governance Committee Member.
All other non-Director/expert advisors remain the same and are renewed for another 1-year term as outlined in 2-A-06

This year the following Directors will take on a Chair role:

- Paulo Brasil – Resources Committee, Monika Hempel will remain as a member of the committee to help provide ongoing mentorship throughout the Board year.
- Bill Conway – Quality Committee, Diane Wilkinson will remain as a member of the committee to help provide ongoing mentorship throughout the Board year.

In addition to new Chairs, this year many Directors have been assigned to new committees.

- Miles Lauzon & Margaret McKinnon will be a member of the Audit Committee
- Julia Goyal will be a member of the Resources Committee
- Jay Tulsani will be a member of the Digital Health Strategy Committee
- Paulo Brasil, Bill Conway, and Julia Goyal will be members of the Executive Committee

All other Committee Chair and Director appointments remain the same as outlined in 2-A-06.

The following Directors have been newly appointed to the following non CMH Board Committees/organizations:

- Bill Conway will represent the Board on the CMH Foundation Board, MAC, and MPSA Executive meetings.
- Diane Wilkinson will represent the Board on the CMH Volunteer Association Board
- Lynn Woeller will represent the Board on PFAC

All other appointments to non CMH Board Committees remain the same and are outlined in 2-A-06.

MOTION: That, upon recommendation of the Governance Committee at the meeting of May 29, 2025, the Board of Directors appoints/renews the non-Director committee

members and/or expert advisors to serve on CMH Board committees for a 1-year term as outlined on 2-A-06.
None opposed. **CARRIED.**

That, upon recommendation of the Governance Committee at the meeting of May 29, 2025,the Board of Directors approves the appointment of committee Chairs and Directors to the applicable Board/non-Board committees as outlined in 2-A-06.
None opposed. **CARRIED.**

5. **Notice of 2025-26 Board meetings and the Annual Meeting of the Corporation**
Meeting dates and Annual Meeting dates were circulated for review.

MOTION: **That,** the Board approves the following meeting dates for the 2025/26 Board cycle;

Wednesday October 1, 2025
Wednesday November 5, 2025
Wednesday December 3, 2025
Wednesday February 4, 2026
Wednesday March 4, 2026
Wednesday May 6, 2026
Wednesday June 3, 2026
Wednesday June 24, 2026

The Annual Meeting will take place on Wednesday June 24, 2026.

All meetings take place on the 1st Wednesday of each month following with one exception. Meetings will start at 5:00pm and will be held in hybrid format.
None opposed, **CARRIED.**

6. **ABCDE Goals Review for 2024/25 and Planning for 2025/26**
The Chair provided background of the ABCDE Goals for new Directors. Directors will meet with the Chair over the summer to review last year's goal and prepare new goals for the 2025/26 Board cycle. The Chair encouraged Board members to continue engaging with CMH through the summer months when possible.

5. **DATE OF NEXT MEETING**
The next scheduled Board meeting is October 1, 2025.

6. **TERMINATION**
MOTION: (Brasil) That, the meeting adjourned at 2033h.
None opposed, **CARRIED.**

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

7. **DISCUSSION OF INDEPENDENT DIRECTORS**

2025/26 Board of Directors Action Log – October 2025

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	**Complete**
06-04-25	4.1 Broader Public Sector Accountability Act Attestation	Governance Committee to review the current Board Consent Agenda Policy and discuss the approach to Declarations of Compliance.	Governance Committee	Will be brought to the Governance Committee for review at the October 2025 meeting.
06-25-25	4.1.2 Digital Health Strategy Committee – Review of Committee Name	CMH Management to review and discuss the naming of the Digital Health Strategy Committee	P. Gaskin	**Complete** At this stage, management's recommendation is to leave the name unchanged.
06-25-25	4.2.2 Care Cupboard	CMH Leadership to provide the Board with updates when items are needed	CMH Leadership	Ongoing

Board of Directors Attendance Report 2025/2026

	100%	100%	100%	64%	100%	91%	91%	100%	82%	100%	100%	100%
Meeting Dates	Lynn Woeller	Bill Conway	Diane Wilkinson	Jay Tulsani	Jayne Herring	Julia Goyal	Margaret McKinnon	Miles Lauzon	Monika Hempel	Paulo Brasil	Sara Alvarado	Tom Barker
02-Oct-24	P	P	P	P	NA	P	P	P	P	P	P	NA
29-Oct-24	P	P	P	R	NA	P	P	P	P	P	P	NA
06-Nov-24	P	P	P	R	NA	P	P	P	P	P	P	NA
04-Dec-24	P	P	P	R	NA	P	P	P	P	P	P	NA
05-Feb-25	P	P	P	P	NA	P	P	P	P	P	P	NA
05-Mar-25	P	P	P	P	NA	P	R	P	P	P	P	NA
07-May-25	P	P	P	P	NA	P	P	P	P	P	P	NA
07-May-25	P	P	P	P	NA	P	P	P	P	P	P	NA
04-Jun-25	P	P	P	P	NA	R	P	P	R	P	P	NA
20-Jun-25	P	P	P	R	NA	P	P	P	P	P	P	NA
25-Jun-25	P	P	P	P	P	P	P	P	R	P	P	P

Cambridge Memorial Hospital Board of Directors - 2025-26 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
01-Oct-25	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	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 ➢ receive and review the Strategic Priorities Tracker	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	➢ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	Due
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	Due
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	Due
	4g Relationships					
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➢ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	Due
	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	Due
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events ➢ reported through Directors ABCDE Goals ➢ receive CMH Board Giving Activity	Due
November 5, 2025 (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)	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➢ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	

Cambridge Memorial Hospital Board of Directors - 2025-26 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
	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	
03-Dec-25	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	
	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	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics ➢ receive and review the Strategic Priorities Tracker	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➢ receive & approve the 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)	
	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	
	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	
	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	
	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					

Cambridge Memorial Hospital Board of Directors - 2025-26 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
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➢ review & approve Board policies as recommended by Governance Committee	
	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*					
	ii	ensure that policies are in place to encourage and facilitate organ procurement and donation		Quality	➢ receive the annual Trillium Gift of Life Update	
	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	
	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	
February 4, 2026 (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)	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➢ receive and approve the 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	
	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	
	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)	
	v	approving operating and capital plans	2-C-31	Resources	➢ review & approve the annual Operating Plan review & approve the Annual Capital Plan	
	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	

Cambridge Memorial Hospital Board of Directors - 2025-26 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-Mar-26	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 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	
	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	
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events reported through Directors ABCDE Goals	
06-May-26	4.c Corporate Performance					
	i	identify principal risks to the Corporation in line with the Board's Integrated Risk Management policy	2-C-20	Audit Quality Resources	➢ review & approve the IRM process undertaken by management to identify and develop the in-year IRM risks and associated mitigation strategies	
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics ➢ receive and review the Strategic Priorities Tracker	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➢ receive and approve the 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					

Cambridge Memorial Hospital Board of Directors - 2025-26 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	
	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	
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events ➢ reported through Directors ABCDE Goals	
June 3, 2026 (Generative Session)	4a Corporate Culture					
	ii	overseeing the establishment and monitoring of such a culture through appropriate mechanisms, including assessing the Chief Executive Officer, and Chief of Staff of the Corporation against this expectation	2-B-25 2-B-26	Executive	➢ receive & review the annual CEO and COS survey results & self-appraisal and provide input	
	4b Strategic Planning					
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality Resources	➢ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker	
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources Audit	➢ receive & approve Declaration of Compliance with MSAA Schedule F ➢ receive & approve Declaration of Compliance with BPSAA Schedule A ➢ receive & approve Certificate of Compliance – Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding (semi-annual) ➢ receive the legislative compliance review ➢ receive and approve the 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	
	4h Financial Viability					
	ii	ensure that the organization undertakes the necessary financial planning activities so that resources are allocated effectively and within the parameters of the financial performance indicators		Resources	➢ receive updates on how the budget is being developed through the Resources Committee Report to the Board of Directors ➢ receive and approve the year-end financial statements	
	4i Board Effectiveness					

Cambridge Memorial Hospital Board of Directors - 2025-26 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
	i	monitor Board members' adherence to corporate governance principles and guidelines		Governance	➢ Declaration of conflict agreement signed by Directors ➢ Directors Consent to Act ➢ Governance Report to the Board of Directors	
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➢ review & approve Board policies as recommended by Governance Committee	
	4n Director Recruitment, Orientation, and Evaluation					
		The Board shall ensure there is an appropriate, objective, and formal process for the recruitment of Directors, and the evaluation of the Board, the Board Chair, its committees, committee Chairs and individual Directors.	2-D-20		➢ review recommendations for new Directors, non-Director committee members review the results of the annual evaluation surveys through the Governance ➢ Committee Report to the Board of Directors	
	4b Strategic Planning					
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality Resources	➢ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker	
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics ➢ receive and review the Strategic Priorities Tracker	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➢ receive and approve the 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					
24-Jun-26		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					
	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)ensure 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					

Cambridge Memorial Hospital Board of Directors - 2025-26 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
		The Board shall ensure there is an appropriate, objective, and formal process for the recruitment of Directors, and the evaluation of the Board, the Board Chair, its committees, committee Chairs and individual Directors.	2-D-20		➢ conduct the election of officers ➢ receive committee reports on work plan achievements ➢ review Board annual survey results	
As Needed	4a Corporate Culture					
	iii	overseeing policies in respect of the Corporation's code of conduct	1-A-04		➢ review the organizations code of conduct policy every three years (last reviewed May 9. 2024)	
	4b Strategic Planning					
	i iii	ensuring that a strategic planning process is undertaken with Board, employees and Medical/Professional Staff involvement and approved by the Board from time to time contributing to the development of and approving the mission, vision, values, and strategic plan of the Corporation			➢ Strategic Plan: approve process, participate in development, approve plan - (last completed in 2022, will be done again in 2027)	
	4d Chief Executive Officer and Chief of Staff					
	i	select the Chief Executive Officer in accordance with the relevant Board policies	2-B-15	Executive	➢ recruit, select, and hire and individual with the requisite skills, abilities, and competencies to effectively perform the job as President and Chief Executive Officer (CEO) of the organization	
	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)	
	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)	
	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					

Cambridge Memorial Hospital Board of Directors - 2025-26 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 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)	
	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		1		3			4		6	3 & 24			
Board Generative/Education Discussion Meetings													
Hospital Integration (Generative Discussion)			5										
Governance (Generative Discussion)						4							
Boards Role in Emergency Prepardness (Education)										3			
Board Committee Meetings													
Audit Committee 5:00pm - 7:00pm			17		19			27	25				
Digital Health Strategy Committee 5:00pm – 6:30pm	18		20			19		16	21	18			
Executive Committee 5:00pm - 7:00pm			18				17		19				
Governance & Nominating Committee 5:00pm - 7:30pm		9	13	11		12		9	14				
Quality Committee 7:00 am – 9:00am	17	15	19		21	18		15	20	17			
Quality Committee QIP Meeting 7:00 am – 9:00 am						5							
Resources Committee 5:00pm – 7:00pm	22		24			23		27	25	22			
Medical Advisory Committee (MAC) 4:30pm - 7:00pm	10	8	12	10	14	11	11	8	13	10			
CMHVA Board Meetings 9:30am - 11:15am - In Person / Hybrid	3	1	5 20 FGM	3	7	4	4	1	6	3 AGM			
CMHF Board Meetings 4:30pm - 6:30 - In Person / Hybrid	30		25		27		24		26	23 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) 5:00pm - 7:00pm In Person / Hybrid	9	7	4	2	13	3	3		5	2			
OHT Joint Board Committee 5:30pm - 7:30pm - Virtual Zoom meeting	22	27	24	15									
2025-26 Events													
Staff Holiday Lunch				4									
Cambridge & North Dumfries Community Awards - Hamilton Family Theatre 5:00pm - 7:00pm		10											
Cambridge City Council Workshop - Meeting with City Council and CMH Board of Directors - January / February TBD													
CMHF Diversity Dinner – CMH Celebration of Champions, Oriental Sports Club		22											
CMH Staff BBQ										11			
Career Achievement										11			
CMH Golf Classic - Galt Country Club Further Details to Follow													
CMHF Reveal 2026 - Starlight Serenade - Tapestry Hall						27							
Board Social - Tentative April								TBD					
Board Education Opportunities													
Governors Education Sessions													
Governance Essentials Program for New Directors (OHA)													
Hospital Legal Accountability Framework		16											
Hospital Accountability Within the Health System		23											
Hospital Funding and Accountability		28											
Governance Management Partnership			4										
Current Issues and Emerging Themes			11										
CMH Leadership Learning Lab													
• *Project Management for the Unofficial PM*													
• *Crucial Conversations*													
• *7 Habits of Highly Effective People*													
• *Me2You DISC Profile*													
• *Quality Improvement*													
• *Guiding Organizational Change*													
• *5 Choices*													
• *Unconscious Bias*													
• *Mental Health First Aid*													

BRIEFING NOTE

Date: September 26, 2025
Issue: Healthcare Quality Canada Conference
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: None

CMH will be virtually attending the 2nd Annual Healthcare Quality Canada Conference from November 20-21, 2025. All sessions will be live streamed at CMH.

This is a great opportunity to learn from healthcare leaders across Canada and bring new insights to work at CMH.

If you are interested in joining one or more of the sessions, please contact Stephanie Fitzgerald sfitzgerald@cmh.org and she will get an invite with details sent to you.

The agenda below provides details on the sessions:

Agenda
DAY 1 – Nov 20
9:30-10:15 **Keynote** David Kaplan, VP, Quality OH
10:15-11:00 **It Starts with Optimizing our Workforce: Elevating Service Excellence for Priority Populations by Implementing a Disruptive and Transformative Strategic Plan** Valerie Grdisa, CEO, Canadian Nurses Association Transforming healthcare quality requires a bold, people-centered approach. In this session, Dr. Valerie Grdisa, CEO of Canadian Nursing Association, will share how a midsize organization embedded a four-year strategic plan within a Total Quality Management framework to drive measurable improvements in care. Grounded in extensive staff and stakeholder engagement, the strategy addressed critical issues such as the opioid crisis, housing challenges, mental health and addictions service gaps, and workforce retention. By implementing 92 targeted actions for 22 initiatives across four pillars—Quality & Reporting, Documentation & Data, Innovation & Integration, and Access & Impact—the organization achieved a 100% Accreditation Canada score, a 50% increase in base budget, and significant gains in staff and patient satisfaction. This case study demonstrates how disruptive, inclusive, and transformative planning can elevate service excellence for vulnerable populations. **Key Takeaways:** • Strategic Transformation in Action – Learn how a midsize healthcare organization designed and executed a comprehensive, data-driven plan that aligned people, processes, and systems to achieve excellence.

Agenda
• Workforce Optimization as a Quality Lever – Explore innovative approaches to recruitment, retention, and workplace culture—including blended work models, self-scheduling, digital solutions, and Just Culture—that improved staff experience and organizational performance. • Driving Measurable Impact for Priority Populations – Understand how aligning a strategic plan with Total Quality Management enabled tangible improvements in access, quality (STEEEP = safe, timely, effective, efficient, equitable, person-centred), satisfaction, program growth, and health outcomes for a diverse range of populations.
11:30-12:15 **From Frontline to Enterprise: Hamilton Health Sciences' 10-Year Journey with Lean and CQI** Tim Dietrich, VP, Quality& Performance, HHS Diane Miller, Senior Quality Advisor, HHS Hamilton Health Sciences (HHS) is currently 10 years into a journey of implementing a daily lean management system and operational excellence principles at all levels of the organization. The lean management system, branded CQI (Continuous Quality Improvement), has been implemented in over 200 teams across six sites, including such areas as acute, pediatric, rehabilitation, ALC, clinical and administrative support. While most of the historical focus of the CQI system has been on mobilizing frontline efforts towards solving local quality and safety problems (6000+ improvement opportunities completed), over the last few years the focus has been on enterprise-alignment of unit-based improvement efforts towards improving key corporate performance metrics. The infrastructure and principles of the management system, building off of years of mobilizing a culture of improvement, were effectively utilized to define and drive best practices, align and advance local improvement efforts and achieve new levels of performance that HHS has never seen before in these metrics. Over the last two years, the corporate in-hospital sepsis rate was reduced by 33% and the hand hygiene rates improved by 35%. This session will highlight how the lean management system at HHS is structured, how a culture shift was created in improvement, enterprise alignment and leadership behaviours, and the connection to significant improvement in key corporate quality and safety outcomes. **Key Takeaways:** • Learn how Hamilton Health Sciences implemented its CQI (Continuous Quality Improvement) system across 200+ teams, embedding lean principles into both clinical and administrative areas. • Understand how frontline engagement generated over 6,000 completed improvement opportunities and created a strong foundation for organization-wide performance change. • Discover how HHS evolved from local problem-solving to strategic enterprise alignment—connecting unit-level improvements to corporate priorities and key metrics. • Explore the leadership practices that fostered accountability, psychological safety, and visible support for continuous improvement. • See how a decade of improvement infrastructure contributed to a 33% reduction in in-hospital sepsis and a 35% improvement in hand hygiene compliance across six hospital sites.
1:15-2:00 **Alberta's Evolving Healthcare Quality Framework: Driving System-Wide Excellence Across Seven Dimensions** Mollie Cole, Exec Director, Health System Improvement, Health Quality Alberta Alberta has undertaken a significant step forward in advancing healthcare quality by introducing an updated quality framework that spans seven core dimensions of care. This session will highlight how the framework has been designed, tested, and implemented across a

Agenda
complex provincial healthcare system to improve outcomes, enhance accountability, and strengthen patient and staff experiences. Attendees will hear real-world insights from Alberta's journey to create a coordinated, scalable quality strategy that bridges gaps between organizations, supports leadership decision-making, and fosters a culture of continuous improvement across a province-wide health system. The session will also explore how lessons from Alberta's approach can inform other jurisdictions seeking to move from local, fragmented initiatives to a truly integrated system of quality care. **Key Takeaways:** • Understanding Alberta's Framework: Gain an overview of Alberta's seven-dimension quality framework and how it provides a unified structure for measuring and advancing healthcare quality across diverse settings. • Scaling System-Wide Quality: Learn strategies for achieving alignment and consistency in quality initiatives across a large, complex health system while respecting local context and needs. • Leadership and Collaboration: Explore how leadership engagement and cross-sector collaboration have been critical in moving from isolated quality projects to a cohesive, province-wide approach that drives measurable improvements in patient outcomes and experience.
2:00-2:45 **New Brunswick's Nursing Home Without Walls: A Case Study on Scaling Social Supports for Seniors** The Nursing Home Without Walls (NHWW) program facilitates access to services and resources for older adults living in the community to enhance their ability to age in place. Following a successful pilot phase, the Government of New Brunswick's Department of Social Development committed to expanding the program across the province. Presenters will share the lessons learned from this expansion initiative, focussing on the program's design, establishing a measurement and evaluation framework, and institutional enablers. This session will provide a roadmap for other jurisdictions looking to enhance community-based social support systems for their aging populations. **Key Takeaways:** • Lessons in Implementation: Discover the practical strategies and challenges in scaling a new model of social service provision. • Evaluation and Measurement for Impact: Gain insight into the development of a measurement framework to track the impact of the NHWW initiative. This includes metrics on the impact of enhanced social supports for seniors on the healthcare system. • Institutional Enablers for Success: Learn how partnerships between government, improvement organizations, and community health providers are making this vision possible. • Scale and Spread: Identify opportunities to adapt and scale this model across other provinces.
3:15-4:00 **Bridging the Gaps: Strengthening Team-Based Care and Communication in Newfoundland's Healthcare System** Julia Trahey, Medical Director, Virtual Care, Eastern Health, NLHS Healthcare delivery depends not only on clinical expertise but on how well teams work together, communicate, and share information. Drawing on her extensive experience as a general internal medicine specialist and healthcare leader in Newfoundland and Labrador, Dr. Julia Trahey will share candid insights into the real-world challenges of implementing family care teams in a fragmented system.

Agenda
From team turnover driven by collaboration issues to the lack of standardized communication protocols and interoperable data systems, Julia highlights the barriers that often derail quality care despite good intentions and skilled professionals. This session will blend patient stories, statistics, and frontline realities to explore how health systems can strike the right balance between flexibility and structure, ensuring patients experience seamless, safe, and effective care. **Key Takeaways:** • Why teamwork matters: Understanding the link between poor collaboration and patient safety outcomes, including real data from Newfoundland's family care teams. • The communication challenge: Lessons learned from non-standardized data sharing and fractured patient record systems during hospital-to-home transitions. • Balancing flexibility with structure: How to maintain adaptability in rural and diverse regions while standardizing key protocols and expectations. • Cultural and behavioral change: Insights on how teams and communities adapt to healthcare change, and how leadership can foster alignment and accountability. • Practical steps for improvement: Strategies for role clarity, standardized communication (drawing parallels to aviation safety), and building effective, resilient care teams.
DAY 2 – Nov 21
9:30-10:15 **Raising the Leadership Bar: Empowering Teams for Lasting Quality Improvement** Stephanie Roy, Executive Director, Centre de santé Saint-Boniface Quality improvement (QI) in healthcare is often seen as a technical exercise—but real, sustainable success depends on people. This session will explore how investing in leadership at every level, fostering authentic staff engagement, and applying data-driven feedback tools like 360 evaluations can transform organizational culture and drive measurable improvements in patient care. Drawing from real-world results—including significant increases in engagement scores, leadership growth through structured evaluations, and stronger team-driven QI initiatives—this session highlights practical strategies to build empowered, accountable, and high-performing healthcare teams. **Key Takeaways:** • Building Effective Teams First: Learn how tools like DISC profiles, mentorship, and structured development plans create diverse, resilient, and change-ready teams—the foundation for any successful quality improvement initiative. • Leadership Multiplies Quality: Understand how leadership "lids" can limit or unlock organizational potential, and how developing leaders at every level accelerates quality improvement outcomes. • Engagement Drives Results: Discover how targeted staff engagement strategies—not just surveys—improve workplace culture, retention, and patient care quality. • Data-Driven Growth: Explore how 360-degree evaluations and transparent metrics lead to accountable leadership and sustained improvement. • Sustainable QI is Possible: Take away practical, proven steps to create a psychologically safe environment where experimentation is encouraged, innovation is fostered, and quick wins are celebrated—making lasting improvement achievable.
10:15-11:00 Session by HIROC – still TBA
12:15-1:00 **A Community Hospital's Success with Improving Quality by Reducing ALC** Brian Pollard, Exec, Lakeridge Health Jaclyn McLeod, Lakeridge Health

Agenda
In this session learn how Lakeridge Health, a multi-site healthcare system located in the Region of Durham in the Greater Toronto area, improved capacity and flow and became more efficient by reducing ALC volume and ALC days by over 50% in less than a year by forming community and system partnerships, making organizational changes, and implementing process improvements. Lakeridge Health (LH) was regularly hitting over 300 ALC cases accounting for almost 30% of all hospital bedded capacity and stressing all areas of the healthcare system. With a focused approach starting in the ED and then expanding to the inpatient units, LH reduced the ALC cases to 120 (summer 2025) and still believes there is more opportunity to go lower. With this success, ED performance, hospital flow and capacity and system performance metrics across all six key dimensions of quality in healthcare: safety, effectiveness, patient-centredness, timeliness of care, efficiency and equity have all improved.

Next Steps

If you are interested in joining one or more of the sessions, please contact Stephanie Fitzgerald sfitzgerald@cmh.org and she will get an invite with details sent to you.

BRIEFING NOTE

Date: September 18, 2025
Issue: Digital Health Strategy Committee Report to Board of Directors – September 18, 2025 – OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kristen Hoch – Administrative Assistant
Approved by: Mari Iromoto – VP, People & Strategy, Miles Lauzon – Acting Chair

Attachments/Related Documents: None

A meeting of the Digital Health Strategy Committee took place on Thursday, September 18, 2025 at 1700h

Present:	Sara Alvarado (Chair), Joel Campbell, Masood Darr, Miles Lauzon (Acting Chair), Paul Martinello, Richard Niedart, Gloria Ringwood, Suzanne Sarrazin, Lynn Woeller
Regrets:	Jay Tulsani, Diane Wilkinson
Staff:	Jen Backler, Trevor Clark, Patrick Gaskin, Rob Howe, Mari Iromoto, Dr. Winnie Lee, Kyle Leslie, Stephanie Pearsall

Committee Matters – For information only

1. **New Members**: New members Gloria Ringwood and Jay Tulsani were welcomed.

2. **Board Policy #2-A-17: Digital Health Strategy Committee Terms of Reference**: Previously reporting to Resources as a sub-committee, the Digital Health Strategy Committee has elevated to a direct report of the Board. This change recognized that digital health will likely be a permanent aspect of hospital operations. The committee oversees three corporate plans. The revised policy was approved and will go forward to Governance in October.

3. **Digital Health Plan:** CMH Management presented key highlights of the Digital Health Plan. The Innovation Fund supports tactical projects like virtual oncology visits and patient reminders, with such modern digital practices enhancing staff and patient experiences. The focus is on integrating digital, AI, and data governance. Delays in key deliverables due to Oracle Health contract timing and WRHN work continue, but progress towards Digital Health Plan goals persists. New change management education is essential for digital transformation support. A risk is the plan's heavy reliance on Project Quantum.

BRIEFING NOTE

Date: September 10, 2025
Issue: MAC Report to the Board of Directors September 10, 2025 OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Dr. Winnie Lee, Chief of Staff
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: None

A meeting of the Medical Advisory Committee took place on Wednesday, September 10, 2025, at 1700h.

Present:	Dr. W. Lee, Dr. I. Isupov, Dr. J. Gill, Dr. L. Green, Dr. A. Sharma, Dr. A. Mendlowitz, C. Witteveen, Dr. T. Holling, Dr. J. Bourgeois, Dr. B. Courteau, Dr. E. Thompson, Dr. A. Nguyen, Dr. M. Hindle, Dr. V. Miropolsky, Dr. M. Shafir
Regrets:	Dr. M. Rajguru, Dr. J. Legassie, Dr. R. Shoop, Dr. M. Patel
Staff:	P. Gaskin, S. Pearsall, M. Iromoto, Dr. K. Rhee, Dr. K. Nuri, J. Visocchi, K. Baldock, M. Hassan, K. Leslie
Guests:	B. Conway

Committee Matters – For information only
This briefing note provides a summary of the main proceedings and decisions from the Cambridge Memorial Hospital (CMH) Medical Advisory Committee (MAC) meeting on September 10, 2025. The session focused on topics including medical quality, quality improvement initiatives, HIS readiness and implementation, and workforce planning.

1. **Key Updates to Medication Safety and Treatment Protocols:** Discussions highlighted the essential role of the Medication & Therapeutics (M&T) Committee in driving patient safety and standardizing care. The committee approved several updates to the hospital's formulary and clinical procedures, reflecting commitment to continuous improvement in medication management. Key updates from the M&T Committee report include:
   - **New pleural effusion treatment** (Dornase Alfa) used by respirologists and intensivists.
   - **Standardized Neonatal Care:** A new standardized procedure for preparation and administration of oral morphine for newborns with Neonatal Abstinence Syndrome (NAS).
   - **Formulary and Order Update:** Removal of Flora, a neonatal probiotic from all pre-printed orders, as the product is no longer commercially available.

2. **Deepened Strategic Commitment to Quality Improvement:** CMH was recently recognized for quality care after receiving its Choosing Wisely Canada Quality Improvement (QI) Status, demonstrating the MAC's and the organization's commitment to quality care and

patient-centered care. The meeting highlighted the progress of several key initiatives aimed at appropriate resource use and enhancing patient outcomes.

Embracing Choosing Wisely has led to a number of QI projects across the organization including an ongoing hospital-wide pharmacy-led project focused on appropriate proton pump inhibitor use and an antimicrobial stewardship initiative to reduce antibiotic prescribing.

The CMH CPSO QI 2.0 Initiative has formally been approved by the CPSO. All credentialed physicians at CMH are invited to be involved in the QI project, which will continue until 2030, ensuring a long-term commitment to system-wide QI efforts at CMH.

MAC celebrated the Laboratory Department's successful Accreditation in September 2025.

3. **Advancements in HIS Readiness and Implementation:** The committee reviewed the progress in adopting new clinical technologies, a strategic priority aimed at reducing physician documentation burden, improving clinical efficiency, and supporting the hospital's readiness for the future Health Information Systems (HIS).

   Key achievements in technology adoption include:

   - **Front-End Speech Technology:** Adoption has steadily increased, currently 52% of all eligible credentialed physicians for front-end speech dictation. Going forward, there will be a more targeted approach to support adoption of front-end speech in departments.
   - **AI Scribe Expansion:** The number of licensed Heidi AI scribe users has reached 18, increased since its implementation in May 2025, with new users beyond the Emergency Department.
   - **Future Rollouts:** There are active plans to expand the AI scribe program in the General Internal Medicine Rapid Assessment Clinic (GIMRAC) and the Oncology Clinic.

   It was noted that the integration of AI Scribe in the Emergency Department has been well-received by patients and physicians. With ongoing adoption, it provides an opportunity to streamline processes while balancing the need for robust validation to ensure the accuracy of AI-generated information. These technological enhancements are foundational to enabling direct improvements in clinical workflows and overall patient care and experience.

4. **Focus on Strategic Workforce Planning and Departmental Updates:** Two departmental updates were presented to the committee which addressed key human resources updates and specialty-specific challenges.
   - **Midwifery:** The department continues to face significant human resources challenges following the closure of a midwifery practice in the community 18 months ago. The team is focused on developing models of care that better integrate midwifery into the Women's and Children's program at CMH. This would support recruitment of new midwives to help manage the service demands within the current system.
   - **Obstetrics & Gynecology:** The department experienced a significant human resource challenge last year with medical illnesses, a retirement, and transition of a physician to another organization. More recently, the department hired 3 additional Obstetricians/Gynecologists and is actively recruiting an eighth member to meet growing community needs. The group has demonstrated resilience over the past year, and this strategic expansion is essential for ensuring comprehensive care and positioning the

clinical service for the future. A first trimester clinic was identified as a future program initiative.

5. **Medical Professional Staff HR Planning:** Dashboard shared with the MAC which shows momentum in Q1 and Q2 for hiring physicians in key departments (e.g., ED, Pathology, Surgery). A more comprehensive medical human resource plan is being developed with the VPMO and will be shared at October MAC. In preparation, all Chiefs have been tasked with updating their departmental HR plans for 2026-2027 to inform future recruitment and workforce planning.

   The common theme across the updates is the effort to align workforce strategy with service needs (i.e., Clinical Services Growth Plan), whether through the Midwifery team's pursuit of new efficiency models, the Obstetrics/Gynecology strategic expansion, or the Chief's updated departmental HR plans.

6. **Cultivating a Culture of Psychological Safety and Leadership Development:** The meeting concluded with a focus on fostering a positive organizational culture through two key initiatives: the "Just Culture 2.0" philosophy and the "MAC Learning Lab."

   The core principle of the "Just Culture 2.0" initiative is to encourage a “just” mindset. This approach promotes reflection and constructive dialogue over immediate blame when incidents occur, supporting open communication among all team members and leaders. Just Culture 2.0 will be brought back to MAC in October, using a “case-based” approach to support leaders to embrace Just Culture from concept to practice.

   To support leadership development, the new MAC Learning Lab series was introduced. Topics shared included: leadership, change management, Just Culture, and credentialing.

   Together, these initiatives are foundational to supporting leaders with the successful implementation of the clinical, technological, and quality improvement advancements discussed throughout the meeting.

BRIEFING NOTE

Date: September 26, 2025
Issue: Resources Committee Report to Board of Directors September 22, 2025 – OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Bonnie Collins, Administrative Assistant
Approved by: Paulo Brasil, Chair

Attachments/Related Documents: None

A meeting of the Resources Committee took place on Monday, September 22, 2025 at 1700h.

Present:	Paulo Brasil (Chair), Sara Alvarado, Amanda Forrest, Julia Goyal, Monika Hempel, Shannon Maier, Janet Richter, Diane Wilkinson, Lynn Woeller
Regrets:	
Staff:	Maria Burzynski, Trevor Clark, Patrick Gaskin, Rob Howe, Kyle Leslie, Dr. K. Rhee, Valerie Smith-Sellers, Susan Toth
Guests:	Steve Hood, AERA Energy Solutions

Committee Matters – For information only

1. **Fiscal 2025-26 Corporate Scorecard and Q1 Update:** Management provided an overview of the progress of the strategic priorities for Q1, highlighting key accomplishments (achieving targeted PCOP growth funding, significant advancements on major systems modernizations projects under Project Quantum) and challenges (patient flow optimization, work workforce management). The Strategic Priorities Tracker for 2025-26 has been refreshed to align with the hospital's quality, financial and integrated risk objectives, particularly concerning staffing and overtime management. The Committee was pleased with the improvement in ambulance offload times, and management confirmed that the improved performance should be sustainable. *(Further information provided in agenda item 4.2)*

2. **August 2025 Financial Statements and Year-End Forecast:** In August, CMH reported a $3.5M year-to-date surplus position after building amortization and related capital grants. The major drivers of the surplus were higher revenue than budget for Quality Based Procedures (QBP) and Post Construction Operating Plan (PCOP) ($3.2M) and unused budgeted contingency. A $1.3M surplus is forecast for year-end, comprised of higher PCOP funding than budget ($2.2M). Budgeted contingency and a portion of the forecast PCOP funding are expected to be fully utilized to cover increased expenses (unfunded Emergency Department (ED) beds and Wing B surge beds, sick and overtime). An expected pick up of 2023-24 PCOP funding ($8.8M) will be recognized at fiscal year-end and is not included in the forecasted surplus.

Patrick Gaskin
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MEMORANDUM

TO: Board of Directors, Cambridge Memorial Hospital

DATE: September 26, 2025

REPORTING PERIOD: June 21, 2025 to September 26, 2025

FROM: Patrick Gaskin
President and CEO

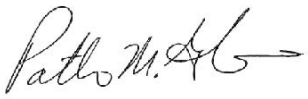
RE: CEO Certificate of Compliance

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

Board Chair's Report – Summer 2025

Message From the Chair

Welcome to the 2025/26 CMH Board of Directors' cycle! I hope you all had a wonderful summer.

I greatly appreciate the effort made by Board members over the summer, supporting CMH through various events. Thank you for your contributions.

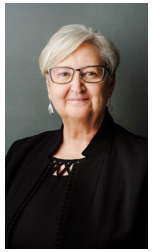
As we look forward, let's build on our previous successes, embracing the values that define CMH. Together, we can achieve great things in the year ahead!

Thank you once again for your commitment & dedication. Here's to an exciting 2025/26 Board year!

Board Chair's Report – June 2025

Smudging Ceremony
On June 25, 2025 Lynn Woeller and Bill Conway joined CMH in the first session of a regular smudging ceremony series that is being held at CMH. The event provided learning opportunities about smudging, its significance, and how to participate.

Grand Rounds – Psychedelics in Psychiatry – From Taboo to Treatment
On June 26, 2025, Lynn Woeller, Sara Alvarado, Bill Conway, and Jayne Herring, attended the Grand Rounds session – “Psychedelics in Psychiatry: From Taboo to Treatment” presented by Dr. Anjali Sharma, Chief and Medical Director or Mental Health. Attendees learnt about the historical and cultural aspect of Psychedelics, reviewed the clinical indications and evidence, and heard about the future of Psychedelics in Psychiatry.



Board Chair's Report – July 2025

Smudging Ceremony

Paulo Brasil, Sara Alvarado, and Jayne Herring joined members of CMH for the July Smudging Ceremony facilitated by Indigenous Patient Navigator Ivy Saille. The event provides education about smudging, the significance, and how to participate in smudging ceremonies. It is an opportunity for mindfulness and to increase understanding of traditional Indigenous healing practices.

“Women Take Charge” Conversation with Kim Decker, Chief Executive Director, YWCA

Sara Alvarado and Lynn Woeller attended the Women take charge Breakfast Series for a conversation with Kim Decker. Kim Decker is a passionate advocate for gender equity and a leading voice for women, girls, and gender-diverse individuals in Cambridge and North Dumfries. As CEO of YWCA Cambridge she has spearheaded impactful programs like 'Small Steps to Success,' 'The W,' and 'TechGyrls.'

Sara acknowledged that the session was amazing “the crowd just burst in applause on the new YWCA women’s shelter. Kim’s leadership has built such a legacy in our community!”

MedTech Innovation Showcase

Sara Alvarado, joined CMH on July 16, 2025 for the MedTech Innovation Showcase. “Dear all, I wanted to take this opportunity to congratulate you for such great event yesterday, and to thank you for including me.

Yesterday's event brough me back to my EIB days, where a sister department of mine (I was in transport new products and special transactions) was dedicated to bridging the financing gap between the prototyping and full commercialization stages with EU support.

Whereas there is some support here for early stages, the market generally waits for regulatory approvals etc., before fully writing investment cheques, reason why many of these innovations have historically moved south of the border. Conversations yesterday confirmed this gap is still here but given tariffs situation, they want to keep their IP rights here creating more competition for funding. Fascinating developments.

Thanks so much for this idea, it elevates our conversation on the Innovation front.
I couldn't be prouder of the team!”

Board Chair's Report – August 2025

Annual Eagle Feather Re-energizing Ceremony
CMH is honoured to hold an Eagle Feather as gifted by Clarence Cachagee, a member of Chapleau First Nation and founder of Crow Shield Lodge, a space for reconciliation, land-based teachings, and healing.

On September 4, 2024, Clarence visited with plans to feast the Hawk Feather but instead shared an Eagle Feather with the hospital. The Eagle Feather is one of the most sacred gifts that can be given by an Indigenous person. It symbolizes trust, honour, strength, wisdom, and freedom. "The Hawk is just beneath the Eagle," Clarence said, “and this Eagle Feather represents a new direction in allyship and Reconciliation. Its strength and vision make it fitting for this moment.”

The Eagle Feather now hangs in our Main Lobby, offering its spirit and strength to everyone who enters the hospital seeking service. It is a sign of understanding and compassion for First Nations, Inuit and Métis people entering the hospital and supports those on their ongoing journey toward reconciliation.

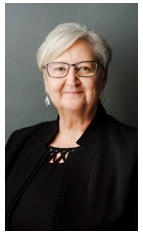
On August 7, 2025 a Re-energizing Ceremony, also known as a Feasting the Feather Ceremony took place starting with Clarence offering a “Smudge,” burning of sacred medicine like sweet-grass, sage, or tobacco to wash and feed the Eagle Feather.

Directors, Diane Wilkinson, Paulo Brasil, Bill Conway, Lynn Woeller, Sara Alvarado, and Jayne Herring joined the ceremony.

Board Chair's Report – September 2025

Grand Rounds - GLP-1 Agonists, Lean Muscle Mass & Orthopedic Surgery
On September 25, 2025, Paulo Brasil, Jayne Herring, Julia Goyal, and Bill Conway, attended the Grand Rounds session – GLP-1, Agonists, Leand Muscle Mass & Orthopedic Surgery presented by Dr. Ingrid Whitehead, topics included the effects of GLP-1 Agonists, Sarcopenia, and GLP-1 Agonist and the post-operative outcomes.



Visits to CMH
CMH extends appreciation to the Board for its regular site visits to CMH. It is worth noting that certain events, like Paulo Brasil's recent facilities tour and meeting with our maintenance team, may occasionally not be fully documented in our reports. We are grateful for your continuous commitment and support to CMH.

National Centre for Truth and Reconciliation's Lunch and Learn Series
During the month of September CMH hosted group screenings of the lunch and learn series. Sara Alvarado joined CMH in the screening of “The Ongoing Legacy of the Residential School System through Child Welfare. The session explored the direct throughline from the residential school system to the Sixties Scoop through the overwhelming number of Indigenous children in child welfare today, including the directly related aspect of forced and coerced sterilizations of Indigenous women. CFS worker Roxanne Balan moderated a discussion between Residential School Survivor Vivian Ketchum and reproductive justice support worker Shelby Ponace

BRIEFING NOTE

Date: September 24, 2025
Issue: Updates on Generative and Educational Sessions for 2025/26 Board Cycle
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Administrative Assistant
Approved by: Lynn Woeller – Board Chair, Patrick Gaskin – President & CEO

Attachments/Related Documents: None

At the June 25, 2025 meeting, the Chair of the Board informed Directors that, beginning in the current cycle (2025/26), the number of generative sessions will be reduced from three to two. This adjustment is to ensure we align with current CMH and Ministry priorities..

Based on feedback from the Generative and Education Topics survey, the following generative discussion and education sessions are scheduled for this year:

Board Generative Sessions:

1. Hospital Integration Part 2 – November 4, 2025.
   - This session will be a continuation from the June 4, 2025 generative session with Deloitte. The CMH Foundation Board members will again be invited to participate. We will build upon the work we did at the June session and the use the post meeting survey result to continue to conversation

2. Governance in Hospitals – February 4, 2026.
   - Given the recent formation of the Health Sector Governance and Oversight Office and the release of the Guide to Good Governance Fourth Edition, this session is highly relevant. Discussions will cover provincial government mandates, alignment with best practices as outlined by the Ontario Hospital Association (OHA), and Anne Corbett's role in influencing hospital governance policy.

Education Session:

1. The Boards Role in Emergency Preparedness – June 4, 2026
   CMH's Emergency Preparedness Lead, Brenda Dennis, will join the Board to educate Directors on their role and responsibilities during emergencies.

A few Board members requested further education related to cybersecurity threats and CMH plans. This will be referred to the Digital Health Strategy Committee for consideration.

BRIEFING NOTE

Date: September 24, 2025
Issue: Strategic Priorities Q1 Update
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 Tracker

Alignment with 2025/26 CMH Priorities:

2022-2027 Strategic Plan No ☐	2025/26 CMH Priorities No ☐	2025/26 Integrated Risk Management Priorities No ☐
☒ Elevate Partnerships in Care	☒ Improve Patient Flow (AOT, PIA, ED Admits)	☒ Organizational Flow
☒ Reimagine Community Health	☒ Prepare for Digital Health Transformation	☒ Project Quantum
☒ Increase Joy In Work	☒ Increase Staff Engagement Through Improved Staffing (Med, ICU, ED, Physicians)	☒ Optimization of Staff/Medical Staff Levels
		☒ Management/Medical Staff Partnership
☒ Sustain Financial Health	☒ Earn the Maximum Eligible PCOP Funding	
☒ Advance Health Equity	☒ Embrace Diversity, Build a Culture of Inclusion	

Executive Summary

This briefing note provides an in-depth overview of our performance during Quarter 1 (Q1) of fiscal year 2025/26, highlighting notable achievements alongside ongoing challenges in patient flow and staffing/overtime management.

Background

In alignment with our commitment to excellence and continuous improvement, we have updated the Strategic Priorities Tracker for FY 2025/26. This tracker aligns key organizational priorities identified through our Quality Improvement Plan (QIP), Integrated Risk Management (IRM) process, and strategic plan. The tool ensures that our priorities are synchronized and provides performance insights shared through various monitoring channels such as weekly operations huddles, flow meetings, staffing and overtime task forces, and department quality and operations councils.

The primary tools for key performance monitoring in 2025/26 include:

1. **Strategic Priorities Tracker:** Monitors critical in-year priorities identified via the QIP, IRM process, and strategic plan.
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 by the Quality Committee and Resource Committee.

Analysis
Our in-year priorities are aligned with our strategic pillars. Below is a summary of Q1 performance, including key highlights from our action plans; full details can be found in **Appendix A.**

1. **Elevate Partnerships in Care:**

- **Ambulance Offload Time (Minutes) - 90th%tile (On-track):**
  - Target: ≤43 minutes, Q1 Performance: 38 minutes, a significant improvement from 83 minutes during the same period last fiscal year.
  - Actions Taken: Continued meetings with EMS leadership, monitored triage to registration delays, and ensured standard work was followed.
  - Actions Planned for Next Quarter: Reschedule site visit with NYGH, meet with EMS leadership on data accuracy, continue bi-weekly meetings and data monitoring.
- **Provider Initial Assessment in ED (Hours) - 90th%tile (Not-Meeting Target):**
  - Target: <4.6 hours. Q1 Performance: 7.5 hours, consistent with prior year performance.
- **Provider Initial Assessment Urgent CTAS 1-2 (Hours) - 90th%tile (Not-Meeting Target):**
  - Target: <4 hours. Q1 Performance: 6.3 hours, showing slight improvement over the same period last fiscal year.
  - Actions Taken: Conducted training on efficient triage protocols, reviewed physician schedules, and collaborated with PMO to facilitate process reviews for CTAS 1 and 2 patient flow.
  - Actions Planned for Next Quarter: Update standard operating procedures, review reference material for triage, and continue advancing use of advanced dictation tools such as AI scribe to enhance operational efficiency and capacity.
- **Average Admission in ED at 8 AM (Not-Meeting Target):**
  - Target: <10 patients held at 8 AM. Q1 Performance: 11.72 average admissions held in the ED at 8 AM, slightly higher than prior year.
- **Inpatient Medical Discharges before 11 AM (Not-Meeting Target):**
  - Target: Discharge more than six inpatient medicine patients per day before 11 AM. Q1 Performance: 0.78 discharges per day before 11 AM, consistent with the previous fiscal year.
  - Actions Taken: Verified utilization of GIMRAC appointment slots and enhanced discharge planning through Innovation Fund projects.
  - Actions Planned for Next Quarter: Conduct physician surveys, develop awareness campaigns for GIMRAC, and improve patient rounding and discharge rounds to facilitate effective discharge planning.

2. Reimagine Community Health:

- **Percentage on Track with Identified Milestones for FY 25/26 (On-track):**
  - This includes core milestones related to major systems modernization projects under Project Quantum, such as workforce planning, health information management, and ERP project. Additionally, we are tracking the adoption of advanced digital solutions by our physicians for enhanced documentation efficiencies through speech recognition and AI ambient listening tools.

- **Health Information System (HIS) Implementation:**
- Actions Taken: Contract signing is in progress, Project Director has been hired.
- Actions Planned for Next Quarter: Complete contract signing, onboard project team members, and kick off project workgroups.

- **Workforce Planning (WFP) Implementation:**
  - Actions Taken: Phase 1 of WFP went live; process stabilization structures are in place.
  - Actions Planned for Next Quarter: Execute phase 2 of UKG Project, refine system configurations, and optimize staffing processes within OSO.

4. **Increase Joy in Work:**

- **Full-Time Equivalent (FTE) Variance (Not-Meeting Target):**
  - Q1 Performance: 29 FTE variance across RNs, RPNs, and PSWs from main clinical programs (ED, ICU, Medicine), contributing to increased overtime due to higher sick leave.
  - Actions Taken: Reviewed roles for PSW coverage as part of 1 to 1 strategy, implemented trial models, held comprehensive interviews, and established unit-specific scheduling guidelines.
  - Actions Planned for Next Quarter: Evaluate model changes, continue hiring, re-evaluate nursing lines, operationalize unit-specific scheduling guidelines, establish and implement a renewed resource pool to enhance relief for increasing sick time, rollout new attendance management program.
- **Medical Professional Staff Recruitment (Not-Meeting Target):**
  - Identified 17 core medical professional staff positions critical to hospital operations; successfully recruited three of these in Q1.

5. **Sustain Financial Health:**

- **Post Construction Operating Plan Revenue Earned (On-track):**
  - Indicator measures our PCOP revenue earned; for Q1, we achieved our budgeted PCOP revenue.
  - Actions Taken: Established monitoring tools and targets.
  - Actions Planned for Next Quarter: Determine budget and operational impact, begin planning for FY26/27.

6. **Advance Health Equity:**

- **Percentage on Track with Diversity, Equity & Inclusion (DEI) Plan (On-track):** No major milestones unmet in Q1.

  - **Inclusive Languages and Images:**
    - Actions Taken: Celebrated Pride Month; started draft of DEI Communications Policy.
    - Actions Planned for Next Quarter: Prepare for Islamic History Month; complete draft policy.
  - **Education and Tools:**
    - Actions Taken: Created inventory of current DEI tools/resources on CMHNet.
    - Actions Planned for Next Quarter: Develop list of additional tools and resources to add.

- **Percentage on Track with Truth and Reconciliation Plan:** No major milestones unmet in Q1 **(On-track)**:
    - **Build and Enhance Capacity and Education:**
    - Actions Taken: Commemorated Indigenous days; launched quarterly Lunch & Learn series.
    - Actions Planned for Next Quarter: Host second session in September, open San'yas registration.

Consultation

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

Next Steps

- The strategic priorities tracker including the summary of actions taken and planned actions will be shared quarterly. The next quarterly updates are planned as follows:
    - Q2- November 2025
    - Q3- February 2026
    - Q4- May 2026

Strategic Priorities 25/26

"Creating Healthier Communities, Together"

	Metric	Target	Q1	Q2	Q3	Q4	Aligned Corporate Plans
Elevate Partnerships in Care	90th percentile Ambulance Offload Time (minutes) (QIP/IRM)	<43	38				Clinical Services Growth Plan
	90th percentile Provider Initial Assessment in the ED (hours) (QIP/IRM)	<4.6	7.5				
	90th percentile Urgent Provider Initial Assessment in the ED (hours) (QIP/IRM)	<4.0	6.3				
	Average number of Admits in the ED at 08:00 (QIP/IRM)	<10	11.72				
	Dyad Partnership - Major project average medical discharges before 11AM	>6	0.78				
Reimagine Community Health	Project Quantum- % with identified milestones for 25/26 (IRM)	100	100				Digital Health Plan
Increase Joy in Work	FTE Variance from target for Medicine, ICU, & ED (IRM)	0	-29				HR Plan
	Medical Professional Staffing (Targeted Positions) (IRM)	17 Year end target	3				
Sustain Financial Health	Post Construction Operating Plan Revenue Earned (IRM)	>$2.24M quarter	3.49M				Multi-year Financial Plan
Advance Health Equity	% on track with DEI Action Plan	100	100				DEI Plan Truth & ReconciliACTION Plan
	% on track with Truth and RoconciliACTION Plan	100	100				

Elevate Partnerships in Care

Clinical Services Growth Plan

Click Here to Input Action Plans

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

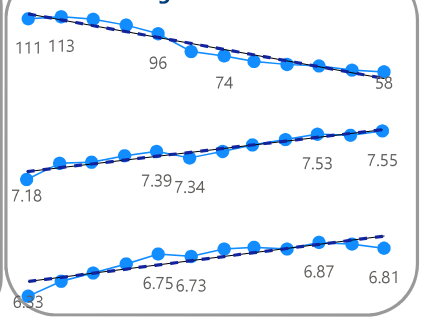
Physician Liaison(s): Dr. Jas Gill

Director Lead(s): Kim Towes

Project Manager(s): Jennifer Woo

In Year Measures of Success	Target	Q1	Q2	Q3	Q4
90th%tile Ambulance Offload Minutes	<43 mins	38.0			
90th%tile Provider Initial Assessment Hours	<4.6 hours	7.5			
90th%tile Urgent Provider Initial Assessment Hours	<4.0 hours	6.3			

Trailing 12 Month Trend



In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Achieve ambulance offload times of 43 mins or less by March 31, 2026	1. Continue meeting with EMS leadership to monitor performance and discuss opportunities for improvement; 2. Monitored triage to registration delays; 3. Ensured standard work being followed by triage and DON; 4. Monitored department flow utilizing all spaces and efficiencies with ambulance offload stretchers; 4. Meeting with Leadership of North York Hospital on their AOT successes, presentation to the team on June 16.	1. Reschedule site visit with NYGH to help identify opportunities for improvement; 2. Meet with EMS leadership team to discuss data accuracy and ensure arrival time is being documented accurately; to ensure accuracy first watch timestamp with be the source of truth; 3. Continue biweekly meetings and data monitoring	No risks to report.
Reduce the wait-time for provider initial assessment for urgent CTAS 1-2 patients to 4 hours or less by March 31, 2026	1.Conducted training on efficient triage protocols and new ectas updates to ensure triage accuracy; 2.Reviewed physician schedule and revised to provide overnight coverage; 3. Collaborated with PMO to begin using A3 report to target improvements on CTAS 2 patients with chest pains; 4. Complete ED toolkit provided by the Ministry for opportunities for additional improvements; 5. Addition of CEO to escalation e-mail for CTAS 1-2	1. View and update standard operating procedure for triage process; 2. CEF to review reference material for triage; 3. Continue to evaluate NP coverage, currently improving; 4. Ongoing assessment of nursing competency to support multiple areas in ED; 5. Revise surge policy; 6. Continue Heidi AI pilot and seek feedback from physicians; 7. Leadership to discuss next steps for improvements targeting CTAS 2 patients with chest pains	No risks to report.
Reduce the wait-time for provider initial assessment for all patients to 4.6 hours or less by March 31, 2026	1. Continue to monitor escalation process of CTAS 1/2; 2. Audit CTAS 2 charts for opportunities within the process; 3. Began development of an interdepartmental (ED/DI) real-time notification system, as part of the Innovation Fund, to streamline communication and patient flow; 4. Reviewed physician schedule; 5. Implemented alternative flagging of CTAS 2/3/4/5	1. View and update standard operating procedure for triage process; 2. CEF to review reference material for triage; 3. Ongoing assessment of nursing competency to support multiple areas in ED; 4. Revise surge policy; 5. Continue Heidi AI pilot and seek feedback from physicians; 7. Audit CTAS 2 charts for opportunities of improvement within the process; 8. Review initial prototype of real-time notification system between ED and DI	No risks to report.

Agenda

Clinical Services Growth Plan

Elevate Partnerships in Care

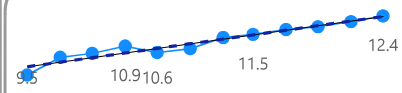
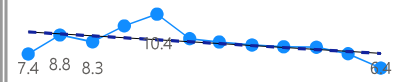
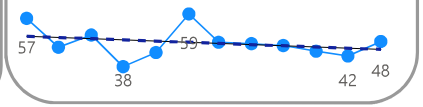
Click Here to Input Action Plans

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

Physician Liaison(s): Dr. Augustin Nguyen

Director Lead(s): Ken Abogadil

Project Manager(s): Jennifer Woo

In Year Measures of Success	Target	Q1	Q2	Q3	Q4	Trailing 12 Month Trend
Average Admits in the ED at 08:00	<10 patients	11.72				
Average Discharges/Day (Medical)	>11/day	8.0				
90th%tile Time to Inpatient Bed (Hours) - Med/Surg	<25 hours	45.8				

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Minimize the number of admitted patients held in ED at 8 am to an average of 10 or less by March 31, 2026	1. Verified that GIMRAC appointment slots allocated for ER referrals are being utilized; 2. Held preliminary Innovation Design Event with key collaborators, in collaboration with Maccelerate under the Innovation Fund- Medicine Patient Unit Board to enhance discharge planning and streamline inpatient medicine rounds; 3. Increased usage of CMH@Home for admission avoidance and bed capacity (100 patients as of Juny 16th); 4. Added Shelter Corporation and SOAHC to the Cambridge Collaborative; 5. Manager and Director reviewed barriers to discharge with Chief of Hospitalists; 6. Implemented new format for discharge rounds on Med A2 and B2, along with colour system for EDD and "medically stable, ready for discharge" vs. "ALC" education; 7. Continue patient rounding twice a month with manager and director	1. Physician surveys (both GIMRAC and ED) sent out to garnish feedback on the utilization of the program to identify barriers to its utilization; 2. Develop an awareness campaign for ED and hospitalists to highlight the resource to support admission avoidance and earlier discharge; 2. Implement EDD introduction at rounds, LOS HIC for chronic health conditions; 3. Educate physicians on HIC and team on the use of HIC guidelines around chronic diseases; 4. Re-establish review of long LOS list; 5. Evaluate the "right people" from multidisciplinary teams attending rounds; 6. Explore with physicians how to communicate EDD, if unable to attend rounds; 7. Improve patient rounding to include questions related to patient's awareness of EDD and audit whiteboards to ensure EDD communication	No risks to report.
Strengthen dyad (medical / management) partnership model	1. Joint Learning Sessions Planned (CPSO, departmental presentations @ MAC and QC); 2. Reinforced shared leadership competencies, using CCHL LEADS framework for Achievement Competency Assessments (ACAs) and Value-based Conversations (VBCs); 3. Major Projects aligned to BIG Healthcare Benchmark Report - Daily Discharges and Discharges before 11 am, completed co-design workshop with physicians and interdisciplinary team supported by Maccelerate	1. Continue to align LEADS framework 2. Execute joint learning sessions 3. Finalize solution to enhance discharge planning and predictive discharges	R1) Resource constraints; M1
Achieve time to bed target of < 25 hours	1. Collaborate with ED Flow, Shift Admin, Inpatient Charge Nurses and Clinical Coordinator to map future state process for sending the patient up within 30 minutes of sending the SBAR/ TOA; 2. Implement improved communication plan and process between ED, Bed Flow and Medicine to improve time-to-bed performance; 3. Begin tracking time of discharge by physician and time patient leaves CMH	1. Monitor and evaluate the process improvements for sending the patient up within 30 minutes, implemented in all Medicine as preliminary trial; 2. Spread initiative to remaining inpatient units (ICU, W&C, Paeds, Inpatient Surgery), and collect feedback	No risks to report.

Agenda

Reimagine Community Health

Digital Health Plan

Executive Sponsor(s): Trevor Clark

Physician Liaison(s): Dr. Ryeyan Taseen

Director Lead(s): Rob Howe

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

In Year Measures of Success

	Target	Q1	Q2	Q3	Q4
% on track with HIS readiness and implementation milestones	100%	100			
% on Track with workforce management ERP implementation	100%	100			
% of Physicians using Front-End Speech	100%	52%			

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
% on track with Workforce Planning (WFP) implementation milestones	1. Phase 1 of the WFP (UKG and Organizational Scheduling Office (OSO)) project has gone live as of June 8, 2025; 2. CMH continues to pay staff successfully through Meditech with UKG as the timecard source of truth; 3. Process stabilization and optimization structures have been put in place	1. Complete Phase 2 Execution of UKG Project: Ensure the successful completion of phase 2, including the enhancement of analytics from the UKG platform to provide deeper insights and more actionable data. 2. Continue System Configuration Enhancements: Continuously refine and enhance system configurations to maximize functionality and user satisfaction. 3. Optimize Staffing Processes within OSO: Leverage initial learnings and experiences with the new system to further optimize staffing processes within OSO, aiming for greater efficiency and effectiveness.	R1) Impact of new processes related to scheduling, timecard management, and employee attendance create long term additional burden on staff, management, or key departments (e.g. Payroll, OSO); M1) Management of optimization list including weekly WFP Steering meetings to prioritize and progress the actions; M2) Additional resources allocated to project and OSO departments
% on track with Health Information System (HIS) implementation milestones	1. Contract signing-in progress; 2. Hired Project Director, 3. Governance structure in partnership with WRHN-in progress; 4. Started hiring of Project Team	1. Completion of Contract signing; 2. Onboarding of Project Director; 3. Hiring of Manager, Informatics and Project Coordinator; 4. Hiring the Project SMEs; 5. Starting the Project "Initiation" Phase; 6. Completion of Project Governance; 7. Completion of TORs based on the governance; 8. Kicking off the project WGs, Sub-Committees, and Steerings; 9. Strengthening partnership with Waterloo Regional Health Network (WRHN) and our vendor, Oracle Health; 10. Developing a "Project Plan" with clear milestones and timelines for the teams; 11. Developing "Risk Management", " Change Management" and "Communication" Plans for the project	R1) Challenges with ONA for hiring the nurses for over a year contracts; M1) Our team is discussing with ONA as well as working on other options
% on track with Enterprise Resource Planning (ERP) implementation milestones	1. Initial evaluation of four HR/Payroll and two Finance/Supply Chain vendors completed, scoring functionality, usability, and costs; 2. Identification of preferred vendor(s)	1. Secondary evaluation of preferred vendor focusing on detailed reviews of functionality, technical/data implications, and solution/pricing models; 2. Evaluation of procurement contracts which can be leveraged to purchase functionality maintaining compliance with BPS guidelines; 3. Updating total cost of ownership (TCO) for preferred vendor	R1) Gaps in functionality identified during secondary evaluation highlights need for supporting software, additional costs, or reliance on manual processes; M1) Proceed with evaluation to confirm risk; R2) Existing procurement contracts do not meet full needs to CMH; M2) Evaluate risks associated with existing contracts against risk to issuing targeted RFx or sole source; R3) Increase in TCO making investment too costly for CMH at this time; M3) Complete evaluation of TCO and consider phased roll-out of functionality to balance cost and organizational requirements

Reimagine Community Health

Digital Health Plan Cont.

Executive Sponsor(s): Trevor Clark

Physician Liaison(s): Dr. Ryeyan Taseen

Director Lead(s): Rob Howe

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

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
% of MDs using Front End Speech	1. Pilot Tested Scribe AI in the Emergency Department (ED): Successfully completed a pilot test of scribe AI technology within the ED to evaluate its effectiveness and gather initial feedback. 2. Significantly Expanded Adoption of Advanced Front-End Speech Technologies: Substantially increased the adoption of advanced front-end speech technologies across the hospital and established a goal for full adoption by March 31, 2026. 3. Establish process for any newly onboarded physicians to receive training and access to front-end speech tools	1. Accelerate Full Adoption of Front-End Speech Technology: Continue to expand the adoption of advanced front-end speech technologies across all clinical departments. 2. Spread Scribe AI technology based on a thorough needs assessment. 3. Begin Phasing Out Phone Dictation: Develop and communicate a phased approach to phase out traditional phone dictation systems in favor of front-end speech technology. 4. Provide training and support for physicians to transition smoothly from phone dictation to front-end speech solutions. Monitor adoption rates and gather feedback regularly to make necessary adjustments to the roll-out plan. 5. Enhance User Training and Support: Offer comprehensive training sessions and ongoing support to ensure all users are proficient in using the new front-end speech technologies.	R1) Ensure accurate tracking of adoption rates based on eligible credentialed physicians for front end speech; M1) Continue to collaborate with COS office to ensure most up to date eligible credentialed physicians list is used for planning and tracking adoption

Agenda

Increase Joy in Work

Human Resources Plan

Click Here to Input Action Plans

Executive Sponsor(s): Dr. Winnie Lee, Mari Iromoto

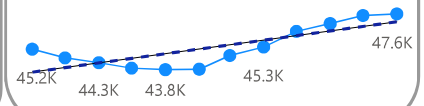
Physician Liaison(s): Dr. Kunuk Rhee

Director Lead(s): Ken Abogadil, Kim Towes, Susan Toth

Project Manager(s): Jennifer Woo

In Year Measures of Success	Target	Q1	Q2	Q3	Q4
FTE Variance from target for Medicine, ICU, & ED (IRM)	0	-29			
Medical Professional Staff (Targeted Positions)	17	3			
Overtime Hours per Quarter	< 11,200	23.0K			

Trailing 12 - OT



In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Reduce overtime hours to budget by March 31, 2026	(Medicine): 1. Hired 10 PSWs, 5 RPNs and 3RNs for float pool	(HR): 1. Focused attention with new tactics for ED, ICU, Medicine; 2. New absence reporting email to go to staff with fiscal history provided to support attendance at work and reduced sick time; 3. Investigate and implement a renewed resource pool	No risks to report.
Achieve active staffing targets in (ED ICU Medicine) by March 31, 2026	(Medicine): 1. Reviewed roles and responsibilities for improved PSW coverage on days and nights; 2. Implemented a trial model, 16 hour PSW coverage on Med A2 and B2; 3. Continue to hold interviews that are comprised of a full assessment using clinical scenario and simulation to evaluate nursing skills; 4. Created project plan to implement Model of Care projects on Medicine B2 in June (ICU): 1.5 staff have complete internships; 2. Hired 1 ICU-trained RN; (HR): 1. Tested and implemented ICIMS candidate text to applicant module by June 30, 2025; 2. Provided leader education session- Managing in a Unionized Environment on June 4th; 3. Created 5 leader education modules (WFP/UKG HR Standards, Managing in a Unionized Environment, Conducting an Investigation, Performance Management, Accommodation/ Return to Work and Confirm Date Offerings; 4. Held Student Career Fair in April; 5. Collaborated with ED/ ICU/ Med to support execution of targeted recruitment strategies to meet staffing targets from current # to 100% on track with active staffing; 6. Establish templated for leaders to conduct workforce audit which will aid in the development of a comprehensive workplan for per department	(Medicine): 1. Evaluate model change for PSW shifts based on feedback from PSW and Nursing; 2. Continue with interviewing and hiring of PSW in Medicine and Float Pool; 3. Re-evaluating and revising nursing lines on Med A2 and B2 to ensure the complement of nursing skills is balanced across all nursing lines (used the Benner's tool to evaluate skills); 4. Continue to interview RN and RPNs; 5. Implement PSW hands-on interview (ICU): 1. Recruiting 3 FT and 3 PT to begin staffing to complement; (HR): 1. Fill 2 vacancies in Health, Safety and Wellness and onboard a third new hire to the team; 2. Onboard and orient all new members; 3.Ensure stabilization and renewed focus on Safety; 4. New speaking notes created for all leaders to have conversations with staff experiencing high sick time in order to support improved performance; 5. Launch new Attendance Support Program; 6. Fill 2 recruitment vacancies to ensure ongoing hiring; 7. Redevelop one vacancy to be a talent acquisition lead; 8. Work with UKG project lead to investigate and implement non-union, non-management departments/job categories that can transition to a pay-to-schedule model to reduce leader timecard exceptions	(HR): R1) Delayed hiring or time to onboard vacant roles. Delayed return to work for Abilities case manager due to surgical leave, M1) Other specialties in HR to support, when needed.

Increase Joy in Work

Human Resources Plan - Cont.

Click Here to Input Action Plans

Executive Sponsor(s): Dr. Winnie Lee, Mari Iromoto

Physician Liaison(s): Dr. Kunuk Rhee

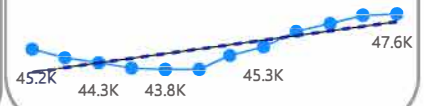
Director Lead(s): Ken Abogadil, Kim Towes, Susan Toth

Project Manager(s): Jennifer Woo

In Year Measures of Success

	Target	Q1	Q2	Q3	Q4
FTE Variance from target for Medicine, ICU, & ED (IRM)	0	-29			
Medical Professional Staff (Targeted Positions)	17	3			
Overtime Hours per Quarter	< 11,200	23.0K			

Trailing 12 OT



In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Ensure medical staffing is sufficient to meet core clinical operations	1. Strong interest and strong applicants for key departments 2. Stable staffing in key subspecialty programs in Surgery and Medicine has resulted in achieving PCOP/QBPs 3. Emergency on-call services were covered for all key areas despite HR needs 4. Explored process for recruitment of US physicians as a recruitment tactic 5. Sustain medical learners in all key departments	1. Implementation of a recruitment process for US physicians 2. Comprehensive recruitment with Doctors4Cambridge 3. Comprehensive onboarding (credentialing, orientation) 4. Offer educational / leadership opportunities to support physician recruitment and retention	1. Continue to ensure emergency on-call services are covered by department internally +/- locum physician supports. 2. Develop a comprehensive recruitment information package for Chiefs 3. Enhance the onboarding process with new electronic credentialing platform 4. Creative models of care to recruit and to sustain clinical services 5. Continue to increase medical learners as a recruitment strategy

Agenda

Sustain Financial Health

Multi-Year Financial Plan

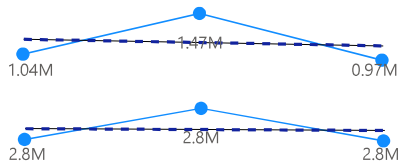
Click Here to Input Action Plans

Executive Sponsor(s): Trevor Clark

Physician Liaison(s): Dr. Lawrence Green (in absence of medical director), Dr. Augustin Nguyen

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

Project Manager(s): Jennifer Woo

In Year Measures of Success	Target	Q1	Q2	Q3	Q4	Monthly Trend
PCOP Revenue earned	>$2.24M per Quarter	3.5M				
QBP Revenue generated*	>$6.9M per Quarter	8.4M				

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Achieve Medical PCOP growth target for 25/26	1. Established PCOP monitoring tools and targets for Medical for 25/26	1. Based on Q1 performance determine budget and operational impact, begin planning for 26/27 budget	No risks to report.
Achieve Surgical PCOP growth target for 25/26	1. Establish PCOP monitoring tools and targets for surgical	1. Based on Q1 performance determine budget and operational impact, begin planning for 26/27 budget	R- incremental surgical funding M- Determine impact and surgical pl
Based on PCOP Forecast determine QBP strategy for 26/27	1. Receive and analyze QBP funding letters for 25/26 - funding letters received in August	1. Determine QBP impact based on funding letters	R1) Max available PCOP; M1) Need to analyze the impact to QBPs an
Forecast PCOP for 25/26 and determine PCOP strategy for 26/27	1. Build PCOP forecast for 25/26 year end	1. Based on 25/26 year-end forecast determine PCOP strategy for 26/27 with the potential PCOP will be fully earned in 25/26	No risks to report.

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

Agenda

Advance Health Equity

DEI Plan

Click Here to Input Action Plans

Executive Sponsor(s): Mari Iromoto

Physician Liaison(s): TBD

Director Lead(s):

Project Manager(s): Mike OSO, Joy Braga (temporary)

In Year Measures of Success

	Target	Q1	Q2	Q3	Q4
% on track with DEI Action Plan	100	100			

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Creating Safe Spaces	1. Diversity Council: Meeting held on April 23 - focus on Asian Heritage Month and Pride Month planning; 2. Community Partnerships: Explored Cambridge Pride Week opportunity (Grand River Pride), explored Lunch & Learn opportunities with OK2BME; 3. Employee Resource Groups (ERG) Roll-out: Tested idea with Pride Committee	1. Diversity Council: Meeting July 16 – focus on Islamic History Month planning, get endorsement of ERGs proposal; 2. ERG Roll-out: Create ERG TOR, Form IHM Planning Committee for Oct, Officially launch ERGs (announcement), Involve IHM and Pride Planning Committees into ERGs after official launch	R1) The official ERG announcement finalization of ERG TOR; M1) Plan to share draft TOR with key cc then launch official announcement
Education and Tools	1. Intranet Tool Kit: Created inventory of current DEI tools/Resources available on CMHNet and identified gaps	1. Intranet Tool Kit: Develop list of tools and resources to add to CMHNet and request for feedback from organization	No risks to report.
Inclusive Languages and Images	1. Celebrated Pride Month (June); 2. 2025 Calendar: Diversity Bingo for celebrate Diversity Month (April), Voices of CMH for Asian Heritage Month (May), Pride Month (June), Pride Month LEARN Challenge (June); 3. Started draft of Inclusive Communication Policy, in collaboration with Communications	1. 2025 Calendar: Prepare for Islamic History Month (IHM), 2. Complete draft of Inclusive Communication Policy; 3. Photo Repository: Photo Day; 4. First Quarterly CEO Communication	R1) Manager Corporate Communic draft and review of policy; M1) Work with the Communications Sp draft policy
People & Processes	1. Staff Sociodemographic Data Collection: Received endorsement from Diversity Council on survey; 2. Inclusion Policy: Conducted research and gathered policy examples; 3. HWO Presentation Update: Test run newly updated DEI slides	1. Staff Sociodemographic Data Collection Survey: Launch survey; 2. Inclusion Policy: Create draft policy; 3. HWO Presentation Update: Incorporate specific examples of DEI initiatives; 4. Emergency Codes: Apply DEI Lens to Code Yellow Form and Process Updates	R1)There may be limited organizat Competing priorities such as the in leadership; M1) Connect with HR o

Agenda

Advance Health Equity

Truth and ReconciliAction Plan

Click Here to Input Action Plans

Executive Sponsor(s): Patrick Gaskin

Physician Liaison(s): TBD

Director Lead(s):

Project Manager(s): Mike Oso, Joy Braga (temporary)

In Year Measures of Success

	Target	Q1	Q2	Q3	Q4
% on track with DEI Action Plan	100	100			

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Build and enhance capacity and education	1. Indigenous Calendar: Commemorated Red Dress Day (May 5), National Indigenous History Month (June), and National Indigenous Peoples Day (June 21); 2. Quarterly Indigenous Lunch & Learn Series: Launched in June (Understanding Indigenous Perspectives); 3. Hospital Wide Orientation (HWO): Incorporated slides on Indigenous Truth and Reconciliation (May); 4. Smudging Ceremony Series: Launch in June (SOAHAC Indigenous Patient Navigator)	1. Indigenous Calendar: Commemorate Orange Shirt Day/National Day for Truth & Reconciliation (Sept 30), Orange shirt and pin orders (Aug), September LEARN Challenge; 2. Indigenous L&L Series: Host Second Session in Sept (Truth & Reconciliation), 3. Staff Training: Open First Round San'yas Registration for all staff and leaders (July) - rolled over from Q1, Promote WW Indigenous Older Adults Training (Sept); 4. Smudging Ceremony Series: Annual Eagle Feather Re-energizing Ceremony (Aug 7)	No risks to report.
Build and Sustain Productive Relationships	1. Regional Indigenous Advisory Circle (IAC): Attended meetings on April 16 and May 26; 2. Regional T&R Touchpoints: Resumed monthly meetings; 3. Community Partnerships: Met with SOAHAC Indigenous Cultural Safety (ICS) Specialist + attend ICS Kick-off (June)	1. IAC: Attend regular meetings: Sept 23; 2. Regional T&R Touchpoints: Working Retreat (July); 3. Community Partnerships: Attend first Community of Support meeting, led by SOAHAC ICS Specialist (Aug 7)	No risks to report.
Develop Quality Indicators to Measure, Monitor and Evaluate success	1. Service Accountability Agreements (SAA): Submitted 2024/25 Report	1. Advance Health Equity Strategic Priority Tracker: Ensure Indigenous T&R is measured, monitored and evaluated separately from DEI; 2. SOAHAC Organizational Assessment Tool: Complete assessment to evaluate current state of T&R at CMH; submit to SOAHAC; 3. Attend Regional Indigenous Identity Confirmation Processes: Design & Implementation Webinar	No risks to report.
Equitable Access to Culturally Safe Care	1. Indigenous Art: Reviewed/approved Wing A artwork; 2. Indigenous Community and Staff Outdoor Space: Host first visioning session (May); 3. Indigenous Clinical Recommendations: Review and discuss action plan	1. Indigenous Art: Install Wing A artwork; review/approve Eagle Feather and Wing B artwork; develop artwork education/narrative with artists; 2. Outdoor Space: Host second visioning session (July) and first virtual consultation (Sept); 3. Smudging Policy: Revised version by Sept 30; 4. Smudging 101 Guides (Regional Project): Begin draft; 5. Indigenous Clinical Recommendations: Finalize action plan	No risks to report.

BRIEFING NOTE

Date: September 23, 2025
Issue: Quality Monitoring Scorecard – Monthly Report
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 & Strategy

Attachments/Related Documents:
Appendix A Quality Monitoring Scorecard

Alignment with 2025/26 CMH Priorities:

2022-2027 Strategic Plan No ☐	2025/26 CMH Priorities No ☐	2025/26 Integrated Risk Management Priorities No ☐
☒ Elevate Partnerships in Care	☒ Improve Patient Flow (AOT, PIA, ED Admits)	☒ Organizational Flow
☒ Reimagine Community Health	☒ Prepare for Digital Health Transformation	☒ Project Quantum
☒ Increase Joy In Work	☒ Increase Staff Engagement Through Improved Staffing (Med, ICU, ED, Physicians)	☒ Optimization of Staff/Medical Staff Levels
		☒ Management/Medical Staff Partnership
☒ Sustain Financial Health	☒ Earn the Maximum Eligible PCOP Funding	
☒ Advance Health Equity	☒ Embrace Diversity, Build a Culture of Inclusion	

Executive Summary
The CMH Quality Monitoring Scorecard, detailed in **Appendix A.** provides an overview of our performance across key performance indicators.

Currently, all “red” indicators are linked to organizational flow, over-time and sick-time. Despite these challenges, our other key indicators are either meeting or showing improvement towards their respective targets.

This focus on organizational flow overtime and staffing is consistent with our 2025/26 strategic priorities.

Background
The CMH Quality Monitoring Scorecard tracks our key performance indicators aligned with the quality framework, many of which are publicly reported by CIHI.

The scorecard monitors these indicators monthly to identify trends deviating from set thresholds. Internal forums regularly review the scorecard for action planning and awareness.

Analysis

Organizational flow and over-time has been a focal point in our Integrated Risk Management (IRM) strategy as well in our Quality Improvement Plan (QIP). These priorities are discussed weekly at Senior Executive meetings, leadership huddles and monthly at Director's Council.

The following indicators related to organizational flow and staffing are currently underperforming:

1. ALC Throughput Ratio: Measures the efficiency of placing ALC patients in appropriate care destinations. The YTD ratio for July is 0.79.

2. ED Length of Stay for Admitted Patients (90% spent less, in hours): Tracks wait-time from triage to inpatient bed arrival. As of YTD July, 90% of admitted patients waited 51 hours or less, compared to a target of 33 hours.

3. ED Wait Time for Inpatient Bed (90% spent less, in hours): Measures the time between admission decision and bed arrival. By YTD July, 90% of admitted patients waited 43 hours or less, against a target of 25 hours.

4. ED Length of Stay, Non-Admitted Complex (CTAS 1-3) (90% spent less, in hours): Tracks the wait-time from triage to disposition for complex ED patients. YTD July data shows that 90% had a stay of 10.10 hours or less, while the target is 8 hours.

5. ED Wait Time for Physician Initial Assessment (90% spent less, in hours): Monitors the time from triage to physician/nurse practitioner assessment. As of YTD July, 90% were seen within 7.6 hours overall and 6.3 hours for CTAS 1-2 patients, versus an internal target of <4 hours.

6. Overtime Hours: Monitors our organizational use of overtime to staff. Currently we are averaging 4,024 overtime hours per pay period, our target is 1,723 hours or less per pay period.

7. Sick Hours: this indicator monitors our trends in sick-time per pay period. Currently we are averaging 4,173 hours per pay period while our target is 2,359 hours or less per pay period.

Consultation
Senior leadership Committee, Director's Council, Operations Committee, Clinical Operational Excellence Committee.

Next steps:

- The Quality Monitoring Scorecard will continue to be reviewed monthly.
- Red status indicators will be discussed at the Director's Council, weekly Operations Huddle, and Senior Leadership Committee meetings.

Quality Monitoring Scorecard

Status (Last 3 Periods)

Meeting Target	9	29%
Within 10% of Target	13	45%
Exceeding Target	8	26%

Quality Dimension	Indicator	Unit of Measure	Target	YTD	Status (Last 3 periods)	Period
Efficient	Conservable Days Rate	%	30.00	35.02	▲	Jul-25
	Overtime Hours - Average per pay period	hours	1,723.06	4,024.84	◆	Aug-25
	Sick Hours - Average per pay period	hours	2,359.11	4,173.30	◆	Aug-25
Integrated & Equitable	ALC Throughput	Ratio	1.00	0.79	◆	Aug-25
	Percent ALC Days (closed cases)	%	20.00	20.02	▲	Jul-25
	Repeat emergency department visits for Mental Health Care	Patients	11.00	11.25	▲	Jul-25
Patient & People Focused	Organization Wide Vacancy Rate	%	12.00	5.32	●	Aug-25
Safe, Effective & Accessible	30 Day CHF Readmission Rate	%	14.00	20.48	▲	Jun-25
	30 Day COPD Readmission Rate	%	15.50	16.67	▲	Jun-25
	30 Day In-Hospital Mortality Following Major Surgery	%	1.90	1.85	▲	Jun-25
	30 Day Overall Readmission Rate	%	8.80	5.35	●	Jun-25
	Ambulance Offload Time (90% Spent Less, in Minutes)	minutes	30.00	34.00	▲	Jul-25
	Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m.	Average	10.00	11.72	▲	Jul-25
	ED Length of Stay for Admitted Patients (90% Spent Less, in Hours)	hours	33.00	51.40	◆	Jul-25
	ED Length of Stay for Non-Admitted Complex Patients (90% Spent Less, in Hours)	hours	8.00	10.10	◆	Jul-25
	ED Wait Time for Inpatient Bed (90% Spent Less, in Hours)	hours	25.00	43.00	◆	Jul-25
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours)	hours	4.00	7.60	◆	Jul-25
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours) CTAS 1,2	hours	4.00	6.30	◆	Jul-25
	Hip Fracture Surgery Within 48 Hours	%	83.10	86.71	▲	Jun-25
	Hospital Standardized Mortality Ratio (HSMR)	Ratio	100.00	88.22	●	Jun-25
	In-Hospital Sepsis	per 1000 D/C	3.20	3.35	▲	Jun-25
	Long Waiters Waiting For All Surgical Procedures	%	20.00	14.34	●	Aug-25
	Low-Risk Caesarean Sections	%	17.30	9.48	●	Jun-25
	Medication Reconciliation at Admit	%	95.00	95.00	●	Aug-25
	Medication Reconciliation at Discharge	%	95.00	95.00	▲	Aug-25
	Obstetric Trauma (With Instrument)	%	14.40	9.81	▲	Jun-25
	Patient Safety Event - Falls with Harm	per 1000 PD	0.00	0.04	▲	Aug-25
	Patient Safety Event - Medication Events with Harm	per 1000 PD	0.00	0.04	●	Aug-25
	Revenue - Achieve budgeted PCOP growth (IRM)	$	2,238,908.76	3,488,257.00	●	Jun-25
	Revenue - Achieve Quality Based Procedure Funding (IRM)	$	6,708,543.99	8,354,819.68	●	Jun-25

Conservable Bed Days

Conservable Beds Dashboard

Description

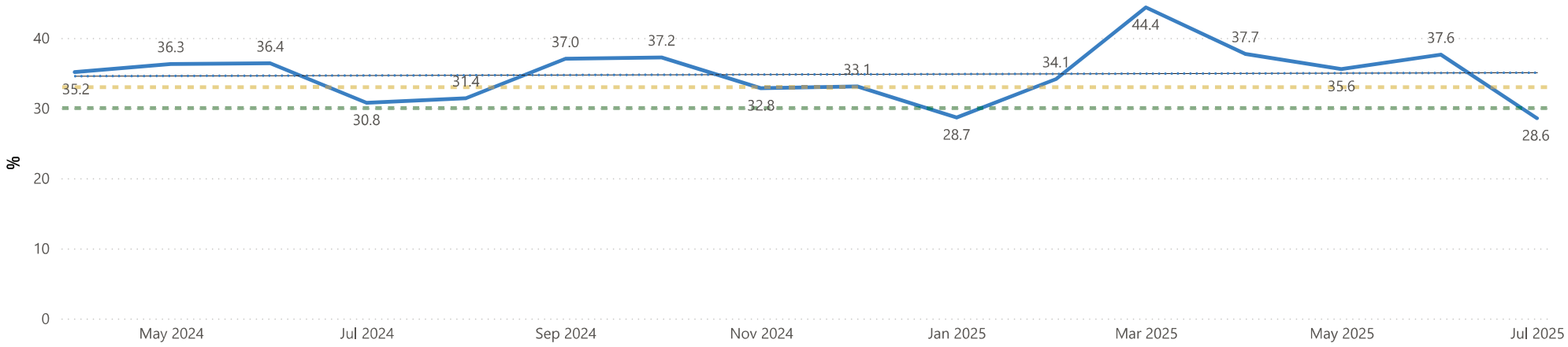
The total patient days over the benchmark LOS (conservable days) as a percentage of the total acute patient days for patients discharged from MEDA/MEDB. The benchmark LOS is determined by case mix group, age, and resource intensity level of a discharge.

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
30.0	34.8	35.02	▲

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	35.2	36.3	36.4	30.8	31.4	37.0	37.2	32.8	33.1	28.7	34.1	44.4
2025/2026	37.7	35.6	37.6	28.6								

Overtime, Average per pay period

OT, Sick, Staffing Dashboard

Description

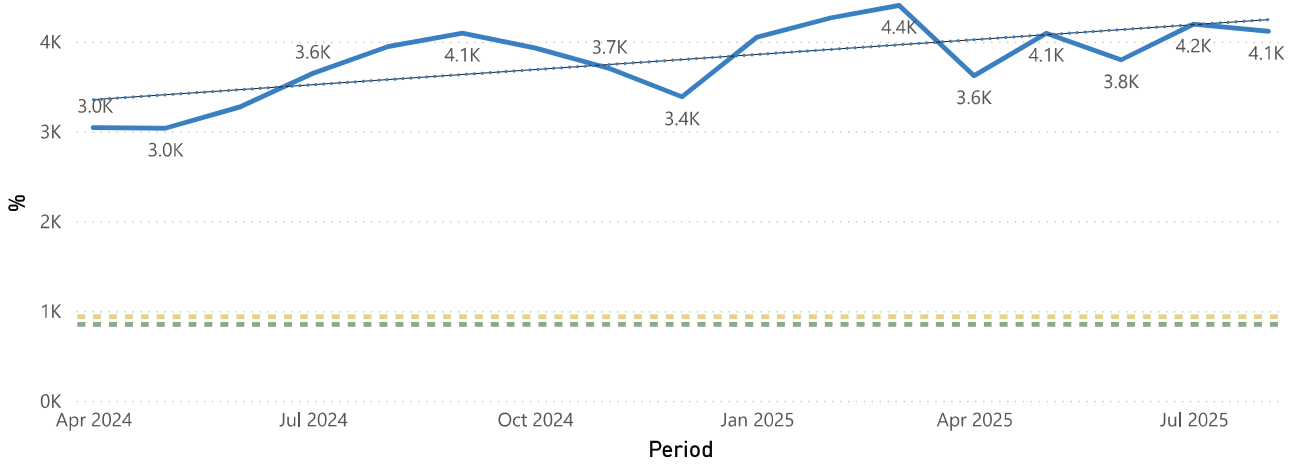
The total sum of overtime hours per pay period ending in a month, divided by the number of pay periods in a month

Data Source

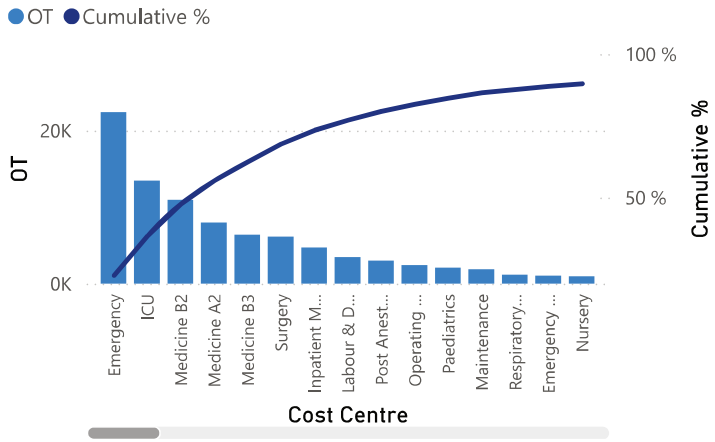
Meditech Payroll

Target	Previous YE	YTD	Status (Last 3 periods)
1,723...	3,764.6	4,024.8	

Average OT Hours per pay period, Trend



Total OT Hours, by Cost Centre



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	3,042.5	3,036.6	3,274.4	3,645.1	3,942.5	4,094.8	3,928.7	3,699.0	3,384.3	4,049.3	4,266.5	4,403.0
2025/2026	3,620.0	4,092.4	3,796.7	4,195.1	4,114.1							

Sick Time, Average per pay period

OT, Sick, Staffing Dashboard

Description

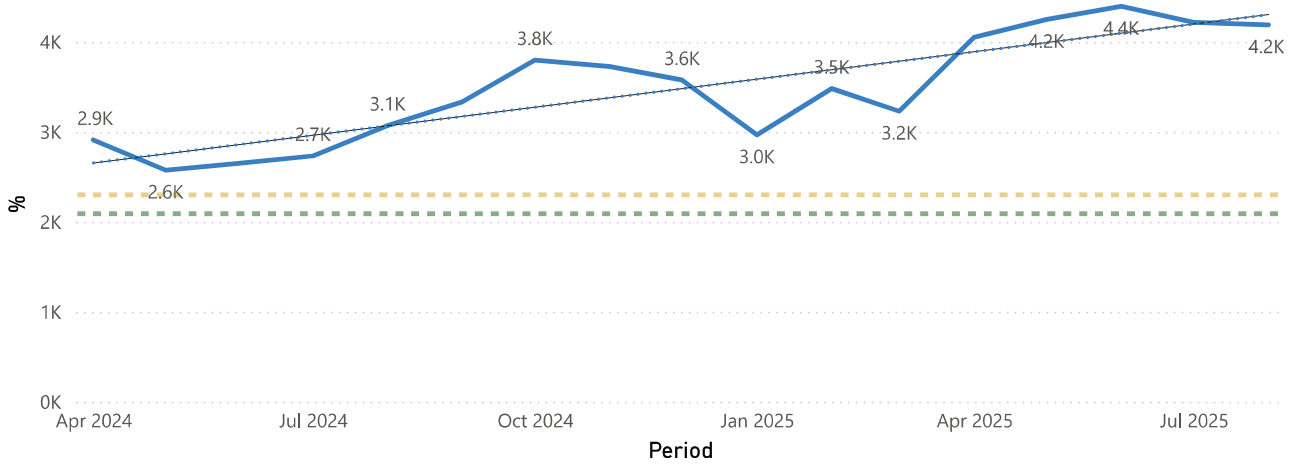
The total sum of sick hours per pay period ending in a month, divided by the number of pay periods in a month

Data Source

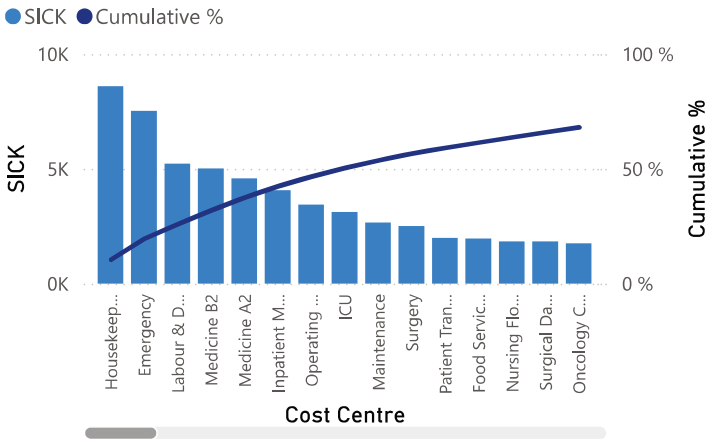
Meditech Payroll

Target	Previous YE	YTD	Status (Last 3 periods)
2,359.1	3,169.6	4,173.3	

Average Sick Hours per pay period, Trend



Total Sick Hours, by Cost Centre



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	2,911.2	2,574.4	2,651.6	2,732.5	3,070.8	3,334.1	3,798.6	3,726.4	3,576.9	2,966.4	3,481.6	3,229.7
2025/2026	4,050.4	4,248.5	4,394.7	4,216.5	4,189.8							

Alternate Level of Care

ALC Dashboard

ALC Throughput

Description

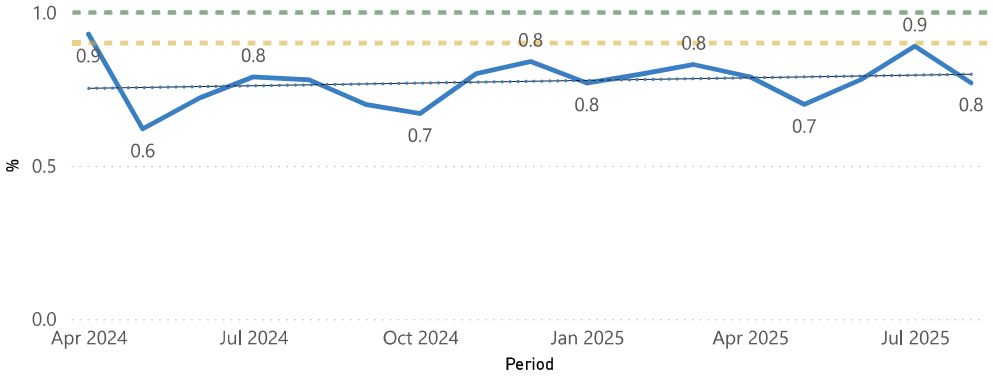
ALC Throughput is the ratio of the number of discharged ALC cases to the number of newly added and redesignated ALC cases

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
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
2025/2026	0.8	0.7	0.8	0.9	0.8							

ALC Rate

Description

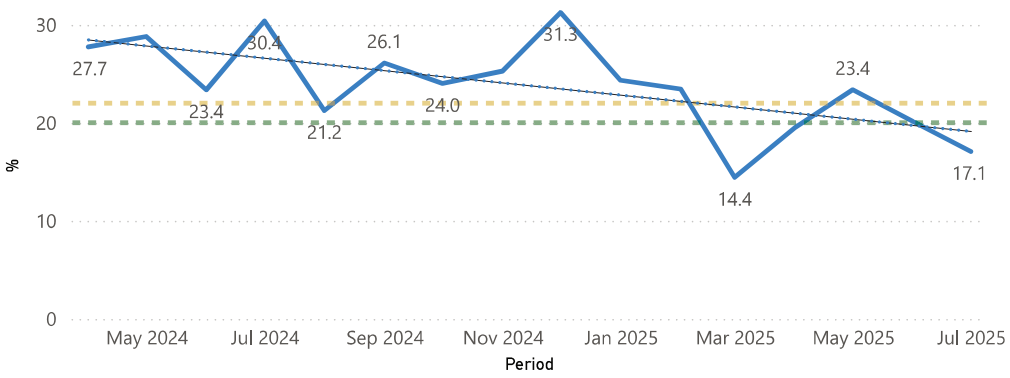
The proportion of total days that a patient was assigned to the alternate level of care (ALC) service. ALC patients are those who no longer need acute care services but continue to occupy an acute care bed or use acute care services.

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
20.0	25.0	20.0	

ALC Rate Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	27.7	28.8	23.4	30.4	21.2	26.1	24.0	25.3	31.3	24.3	23.4	14.4
2025/2026	19.5	23.4	20.1	17.1								

Repeat ED Visits for Mental Health Care

Description

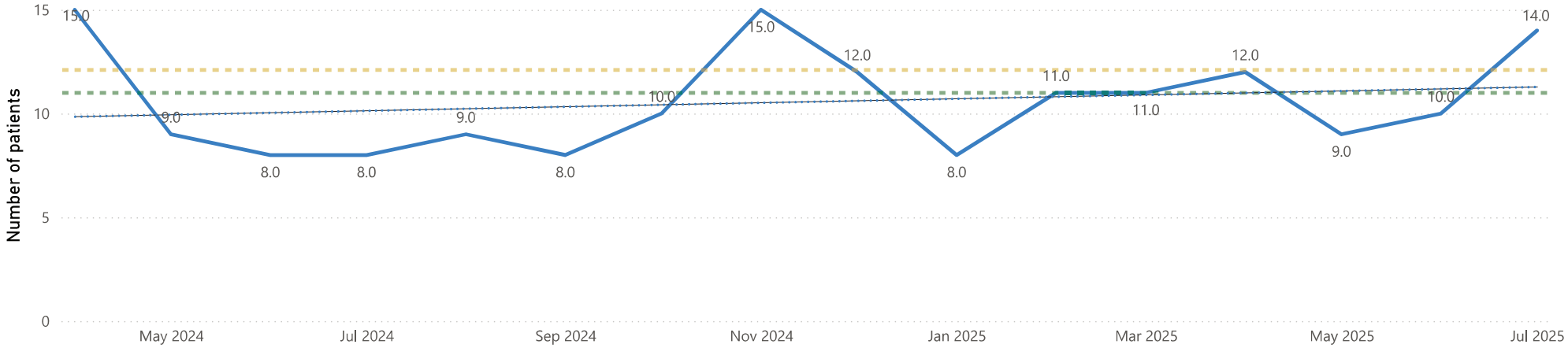
Number of patients who have four or more repeat unscheduled visits to the emergency department in the last 12 months for mental health or substance abuse condition

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
11.0	10.3	11.3	▲

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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
2025/2026	12.0	9.0	10.0	14.0								

Organizational Vacancy Rate

Description

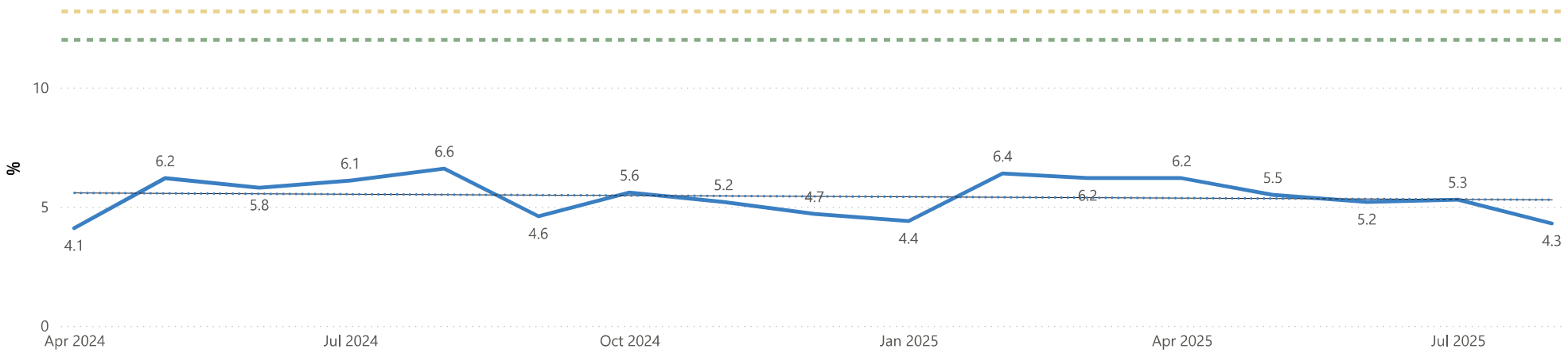
This indicator measures the organization wide vacancy rate for permanent full time and part time staff

Data Source

ICIMs Vacancy Report and Meditech Payroll

Target	Previous YE	YTD	Status (Last 3 periods)
12.0	5.5	5.3	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	4.1	6.2	5.8	6.1	6.6	4.6	5.6	5.2	4.7	4.4	6.4	6.2
2025/2026	6.2	5.5	5.2	5.3	4.3							

Readmissions within 30 Days:

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

CHF Readmissions

Description

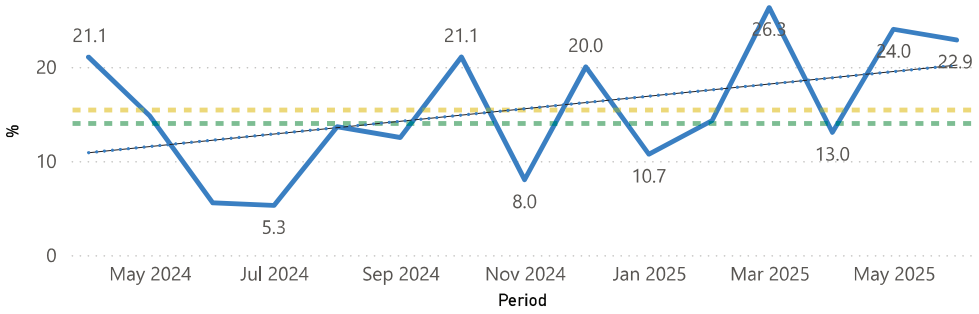
Rate of urgent readmission for any reason within 30 days of discharge for Congestive Heart Failure (CHF) at CMH

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
14.0	14.7	20.5	▲

CHF Readmission Rate, Trend



Fiscal Year		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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	26.3
	Readmits	4	4	1	1	3	3	8	2	5	3	3	5
2025/2026	Rate	13.0	24.0	22.9									
	Readmits	3	6	8	4	0							

COPD Readmissions

Description

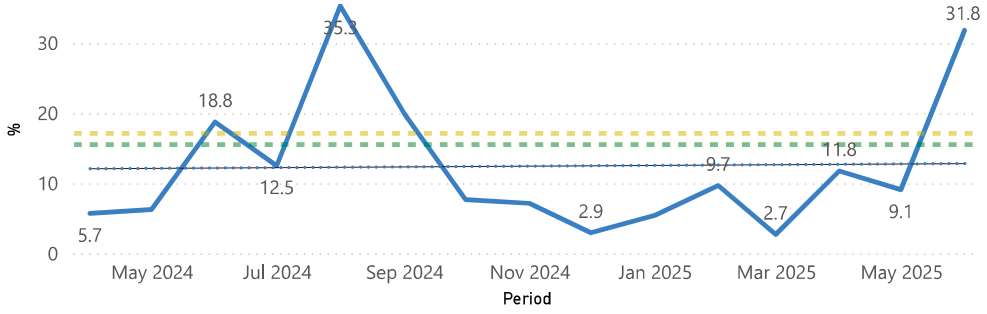
Rate of urgent readmission for any reason within 30 days of discharge for Chronic Obstructive Pulmonary Disease (COPD) at CMH

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
15.5	9.1	16.7	▲

COPD Readmission Rate, Trend



Fiscal Year		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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	2.7
	Readmits	6	5	4	3	9	6	10	4	6	5	6	6
2025/2026	Rate	11.8	9.1	31.8									
	Readmits	7	8	15	6	0							

30 Day In-Hospital Mortality Following Major Surgery Rate

Description

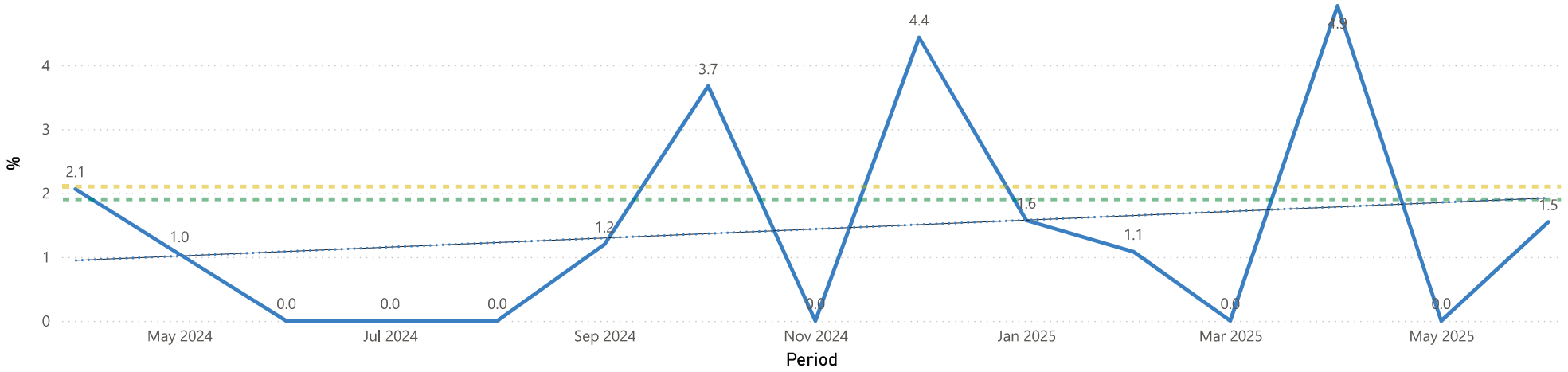
Risk-adjusted rate of in-hospital deaths due to all causes occurring within 30 days of major surgery (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
1.9	1.5	1.8	▲

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	2.1	1.0	0.0	0.0	0.0	1.2	3.7	0.0	4.4	1.6	1.1	0.0
2025/2026	4.9	0.0	1.5									

30 Day Overall Readmission Rate

Description

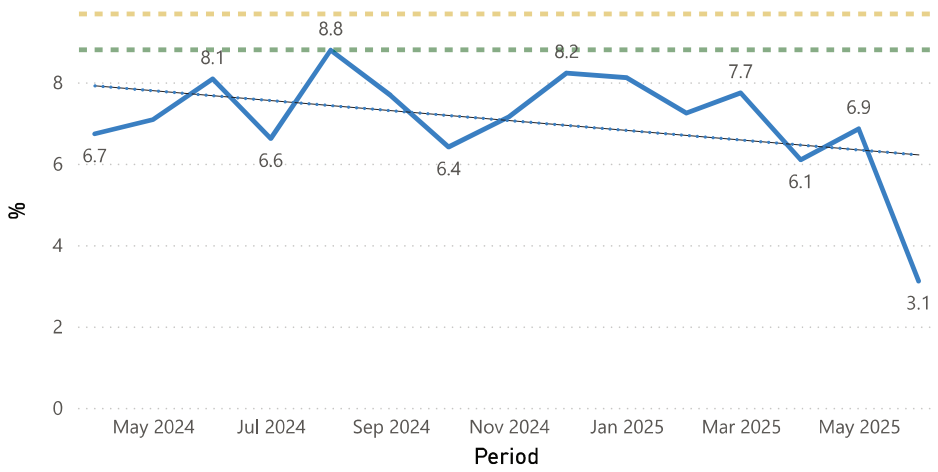
The rate of urgent readmissions within 30 days of discharge for episodes of care for the following patient groups: medical, obstetric, paediatric, and surgical. Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
8.8	7.5	5.3	

Trend

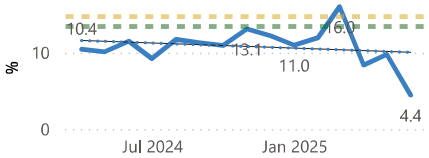


Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	6.7	7.1	8.1	6.6	8.8	7.7	6.4	7.1	8.2	8.1	7.2	7.7
2025/2026	6.1	6.9	3.1									

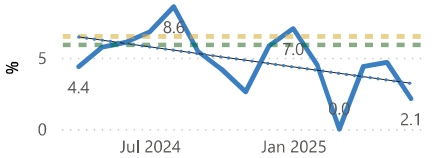
Readmissions, by Patient Group

IndicatorName	Target	YTD	Status (Last 3 periods)
30 Day Medical Readmission Rate	13.40	11.25	
30 Day Obstetric Readmission Rate	1.40	1.19	
30 Day Paediatric Readmission Rate	6.70	6.32	
30 Day Surgical Readmission Rate	5.90	5.57	

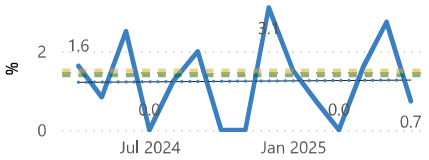
Medical Readmissions Trend



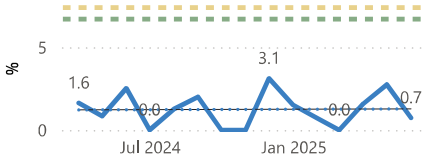
Surgical Readmissions Trend



Obstetric Readmissions Trend



Paediatric Readmissions Trend



Ambulance Offload Time, minutes, 90th percentile

Description

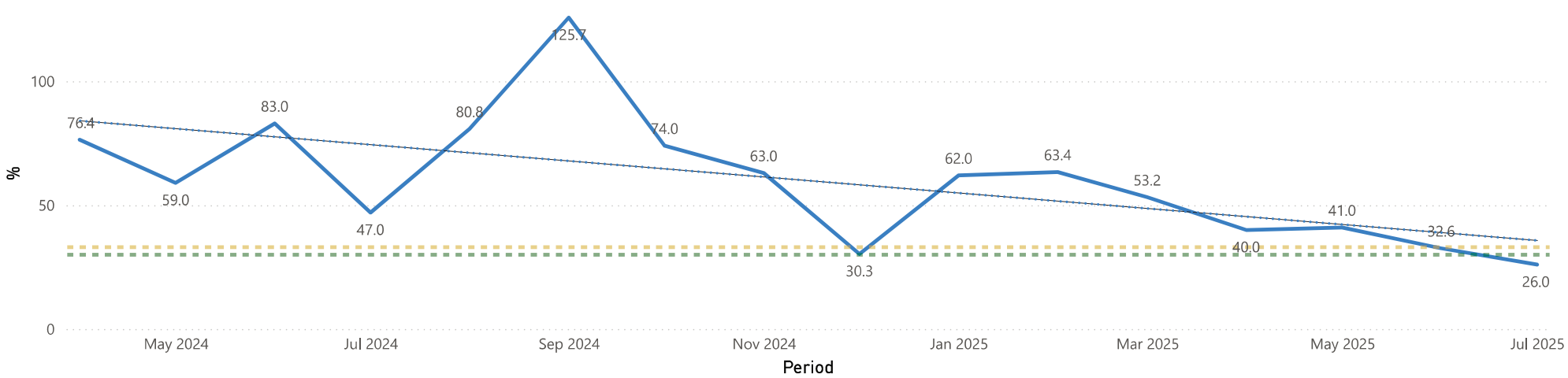
The total time, in minutes, in which 9 out of 10 patients who arrived via ambulance waited for transfer of care process to be completed, calculated as the total time elapsed from ambulance arrival to completion of transfer of care process.

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
30.0	67.0	34.0	▲

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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
2025/2026	40.0	41.0	32.6	26.0								

ED LOS for Admitted Patients, hours, 90th percentile

Total ED LOS for Admitted Patients

Description

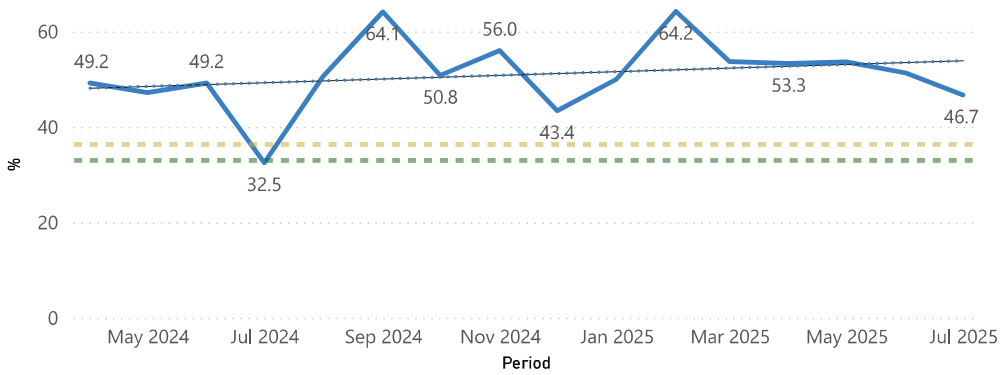
The total time, in hours, that 9 out of 10 admitted patients spent in the emergency department (ED), calculated as the total time elapsed from triage to when the patient left the ED

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
33.0	52.0	51.4	

ED LOS for Admitted Patients, Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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
2025/2026	53.3	53.6	51.3	46.7								

Time to Inpatient Bed

Description

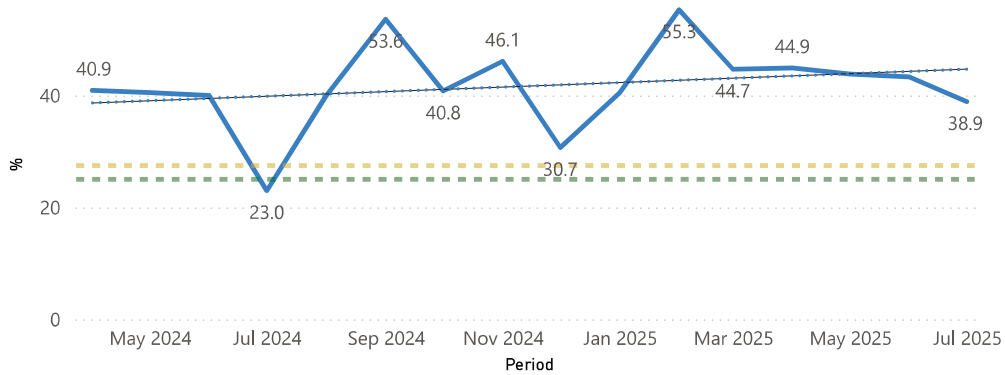
The total time, in hours, that 9 out of 10 admitted patients spent waiting in the emergency department (ED) for a bed, calculated as the total time elapsed from disposition decision to when the patient left the ED

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
25.0	42.8	43.0	

Time to Inpatient Bed, Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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
2025/2026	44.9	43.8	43.3	38.9								

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

Description

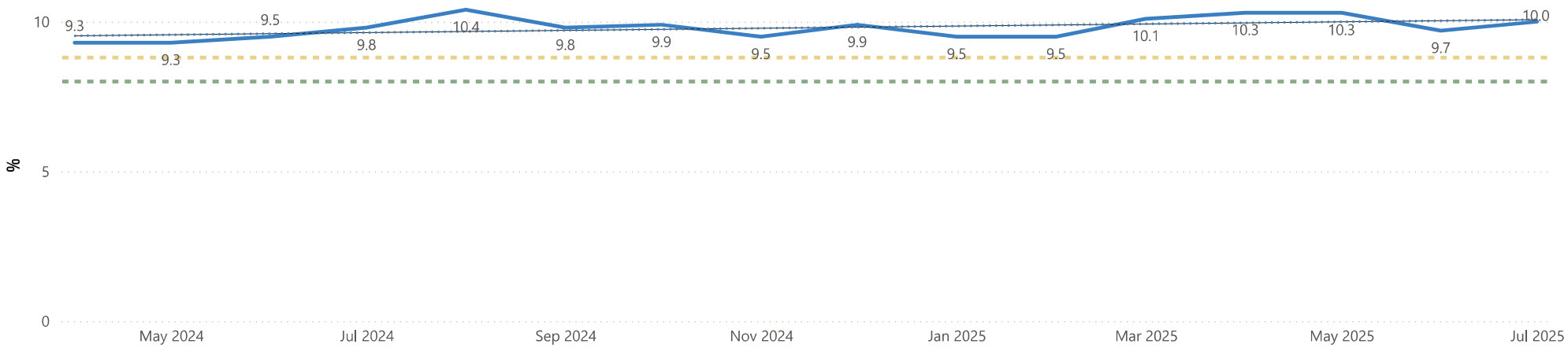
The total time, in hours, that 9 out of 10 high-urgency patients (CTAS 1-3) who were not admitted spent in the emergency department (ED), calculated as the total time elapsed from triage to when the patient left the ED

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
8.0	9.7	10.1	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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
2025/2026	10.3	10.3	9.7	10.0								

Provider Initial Assessment Time, hours, 90th percentile

Description

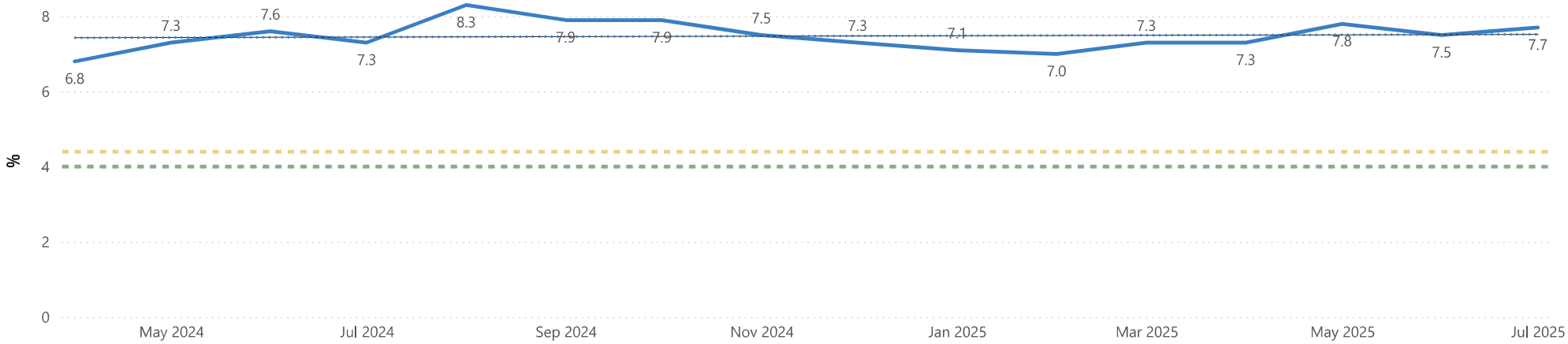
The total time, in hours, that 9 out of 10 patients spent waiting for their first assessment by a doctor or nurse practitioner in the emergency department (ED), calculated as the total time elapsed from triage to time of initial assessment

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
4.0	7.5	7.6	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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
2025/2026	7.3	7.8	7.5	7.7								

Urgent Provider Initial Assessment Time, hours, 90th percentile

Description

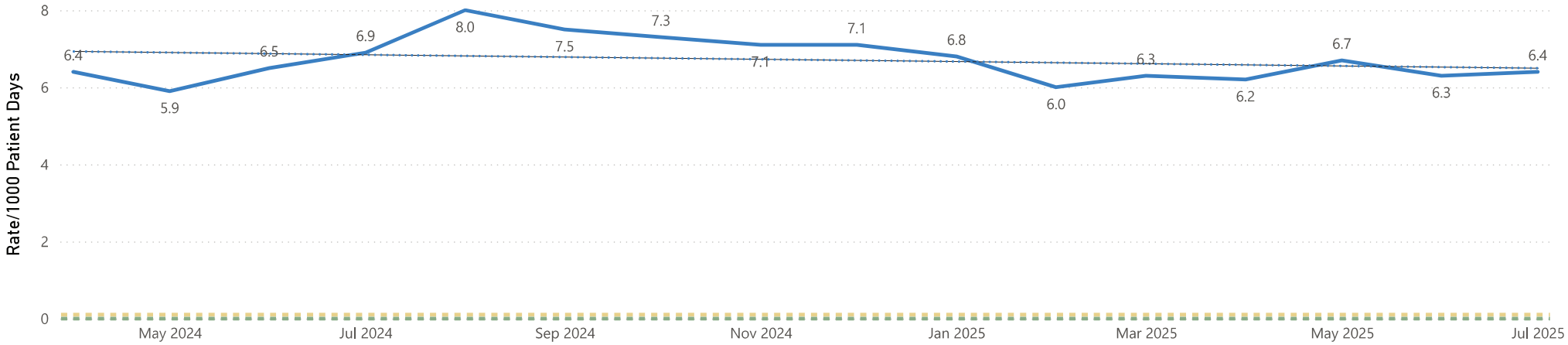
The total time, in hours, that 9 out of 10 patients spent waiting for their first assessment by a doctor or nurse practitioner in the emergency department (ED), calculated as the total time elapsed from triage to time of initial assessment

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
4.0	6.9	6.3	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	6.4	5.9	6.5	6.9	8.0	7.5	7.3	7.1	7.1	6.8	6.0	6.3
2025/2026	6.2	6.7	6.3	6.4								

Hip Fracture Surgery within 48 Hours

Description

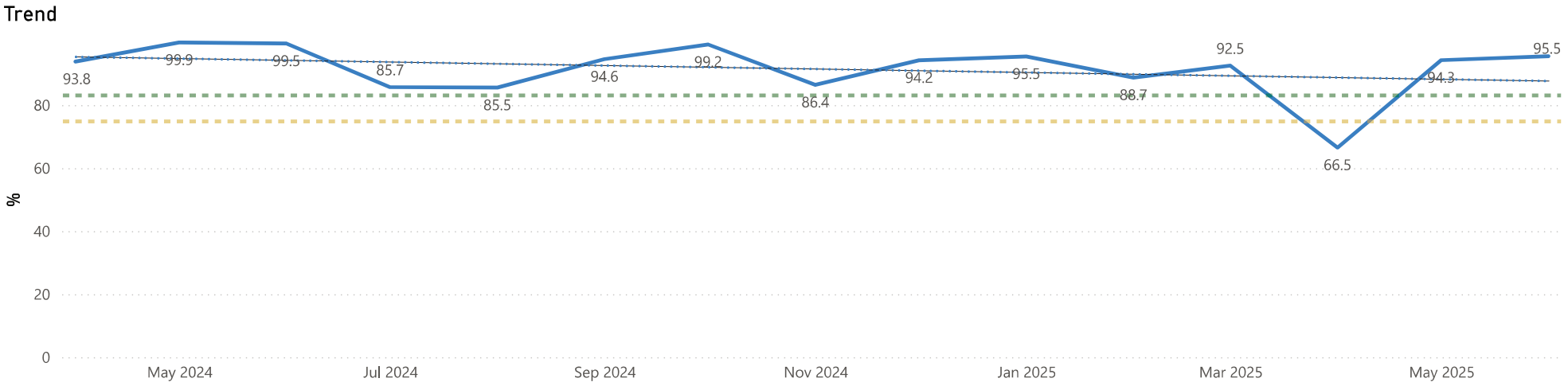
Risk-adjusted proportion of hip fractures that were surgically treated within 48 hours of initial admission (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
83.1	92.9	86.7	▲

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	93.8	99.9	99.5	85.7	85.5	94.6	99.2	86.4	94.2	95.5	88.7	92.5
2025/2026	66.5	94.3	95.5									

Agenda

Hospital Standardized Mortality Ratio (HSMR)

Description

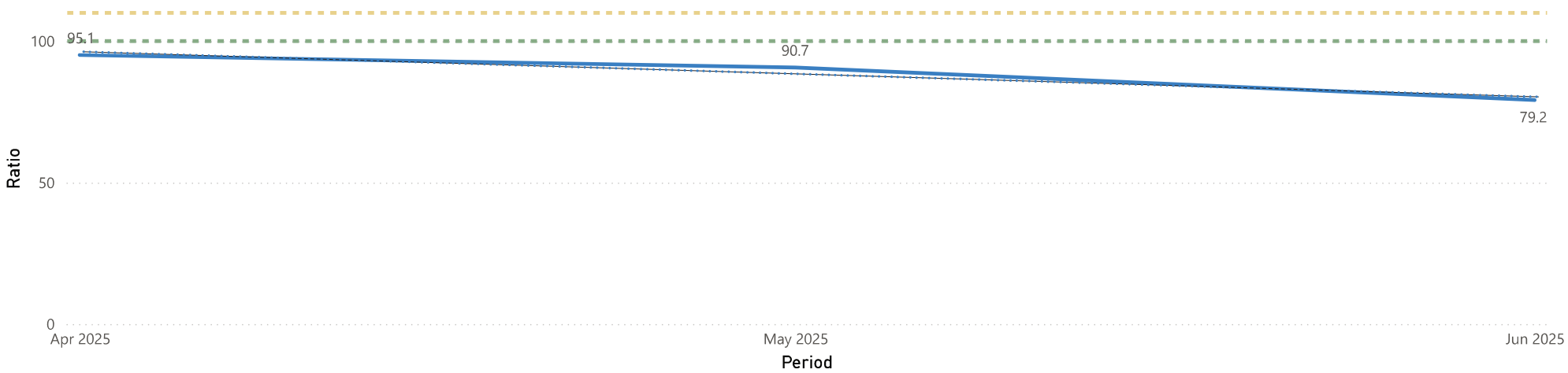
The ratio of the actual number of in-hospital deaths to the expected number of in-hospital deaths, for conditions accounting for about 80% of inpatient mortality

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
100.0	94.6	88.2	

Trend



Fiscal Year	Apr	May	Jun
2025/2026	95.1	90.7	79.2

In-Hospital Sepsis

Description

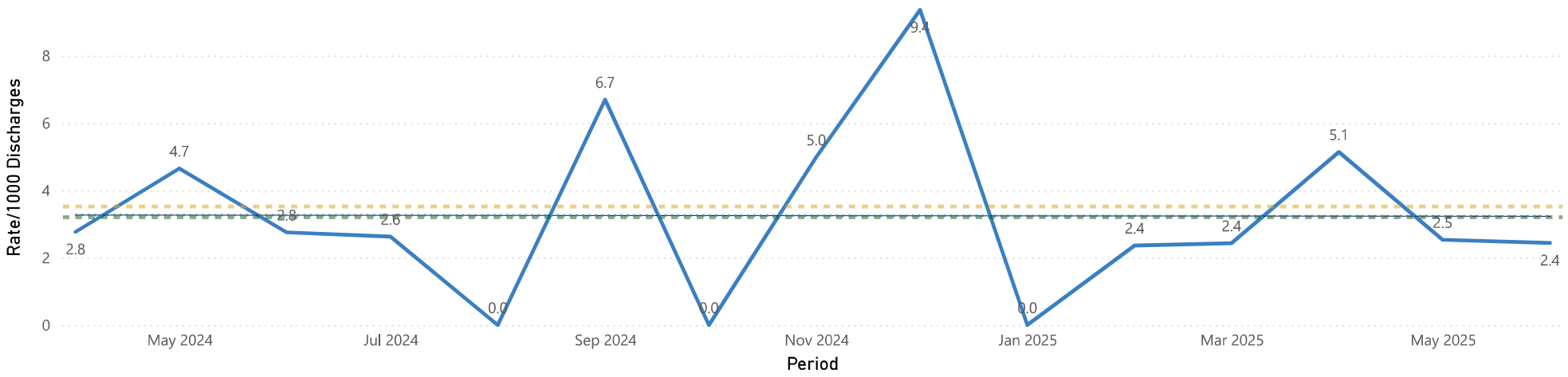
Risk-adjusted rate of sepsis that is identified after admission, per 1,000 discharges (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

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
2024/2025	2.8	4.7	2.8	2.6	0.0	6.7	0.0	5.0	9.4	0.0	2.4	2.4
2025/2026	5.1	2.5	2.4									

Low-Risk Caesarean Section Rate

Description

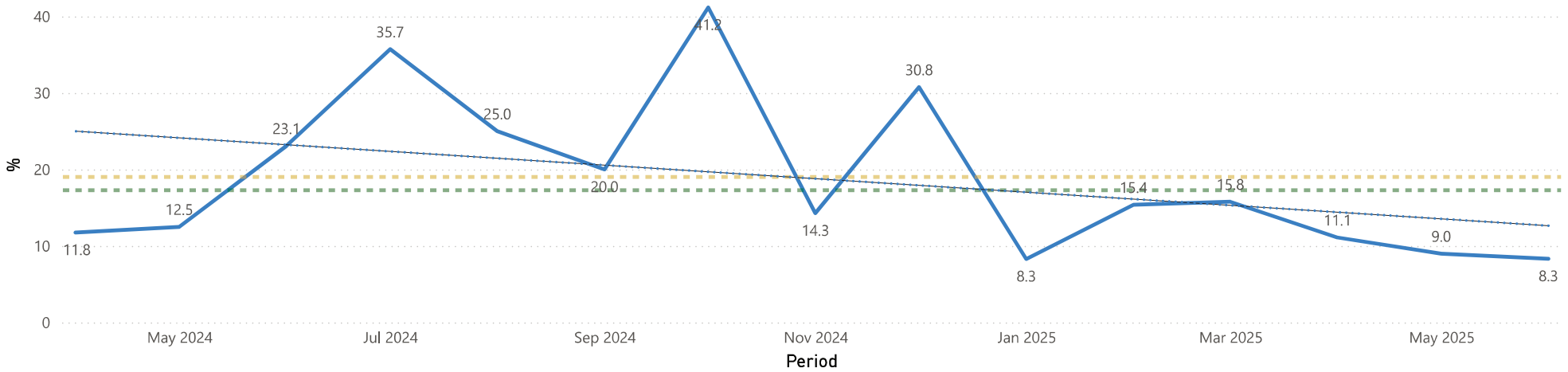
This indicator measures the rate of deliveries via Caesarean section among singleton term cephalic pregnancies for low-risk nulliparous women in spontaneous labour

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
17.3	21.1	9.5	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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
2025/2026	11.1	9.0	8.3									

Obstetric Trauma (with Instrument)

Description

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

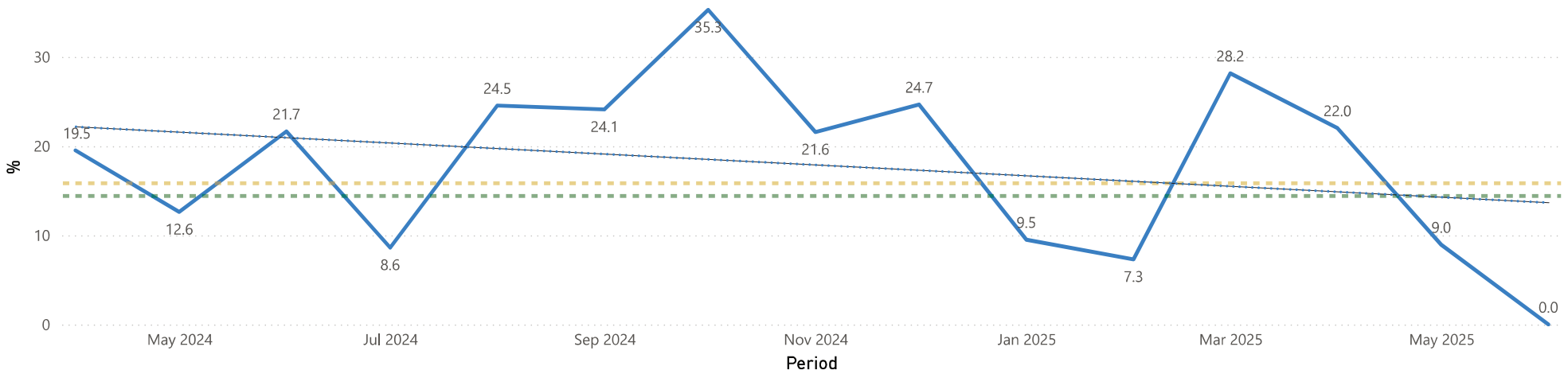
Data Source

Discharge Abstract Database (DAD)

Currently reviewing the recommendation to add n-value for this indicator

Target	Previous YE	YTD	Status (Last 3 periods)
14.4	19.8	9.8	▲

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	19.5	12.6	21.7	8.6	24.5	24.1	35.3	21.6	24.7	9.5	7.3	28.2
2025/2026	22.0	9.0	0.0									

Long Waiters Waiting for Surgical Procedures

Description

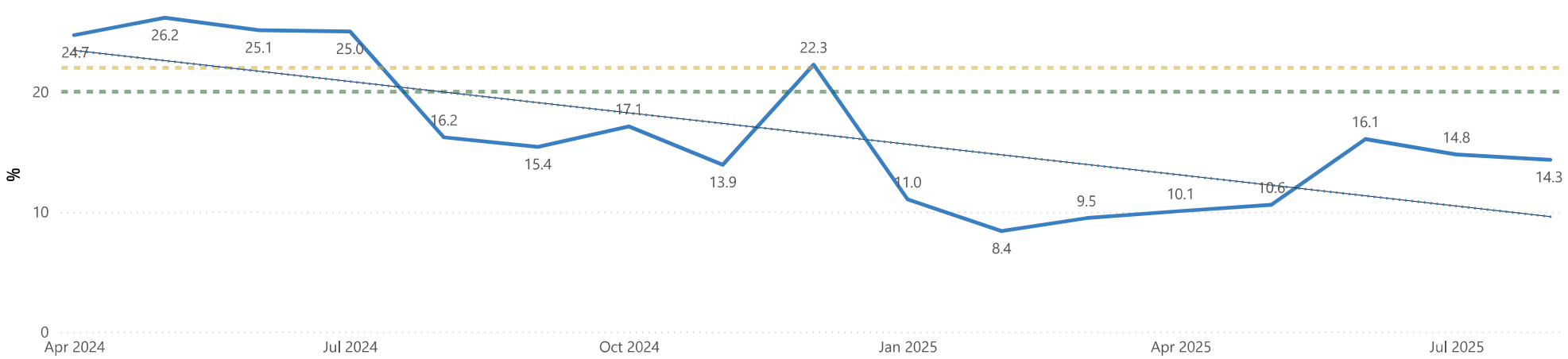
This indicator measures the percentage of patients waiting for a surgical procedure whose wait has exceeded the associated Priority Level Access Target (excludes DART days)

Data Source

WTIS

Target	Previous YE	YTD	Status (Last 3 periods)
20.0	9.5	14.3	

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	10.6	16.1	14.8	14.3							

Patient Safety Event - Falls with Harm Rate

Description

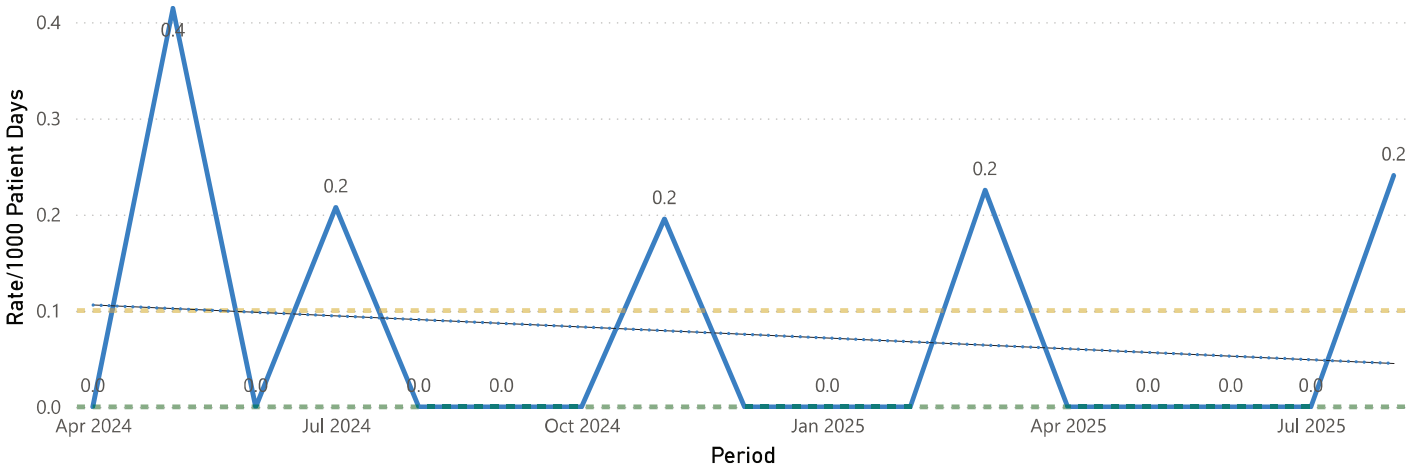
The number of falls with harm per 1,000 inpatient days. This includes events where after review, the severity is deemed to have incurred moderate or severe harm, or a critical incident involving death.

Data Source

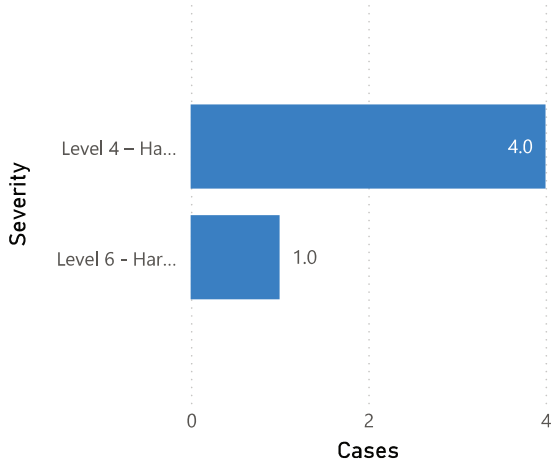
ReportLink, Meditech

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

Trend



Current FY Cases, by Severity



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

Patient Safety Event - Medication Events with Harm Rate

Description

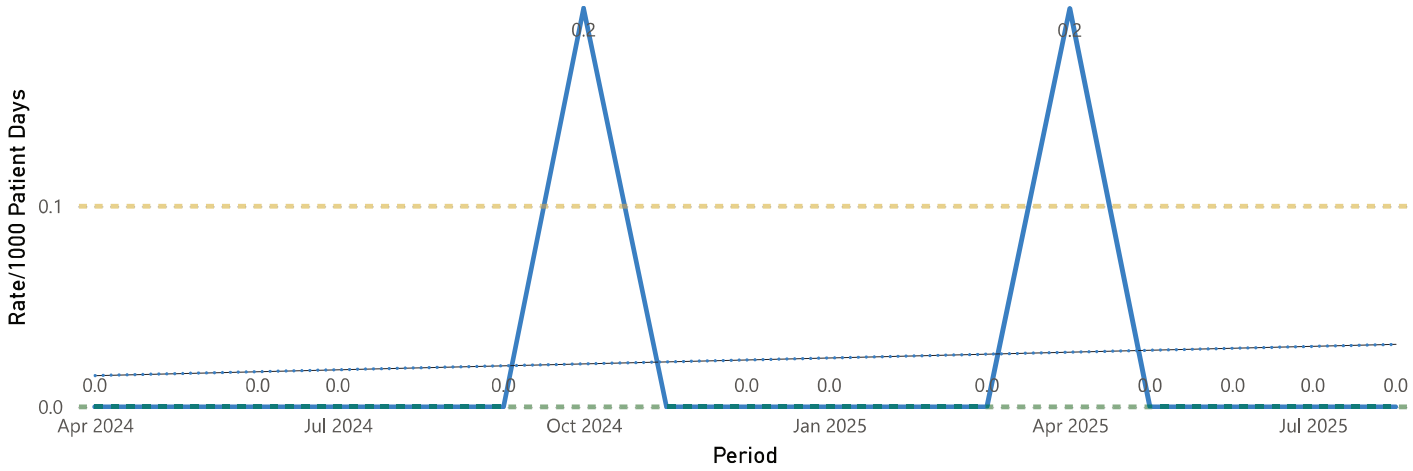
The number of medication events with harm per 1,000 inpatient days. This includes events where after review, the severity is deemed to have incurred moderate or severe harm, or a critical incident involving death.

Data Source

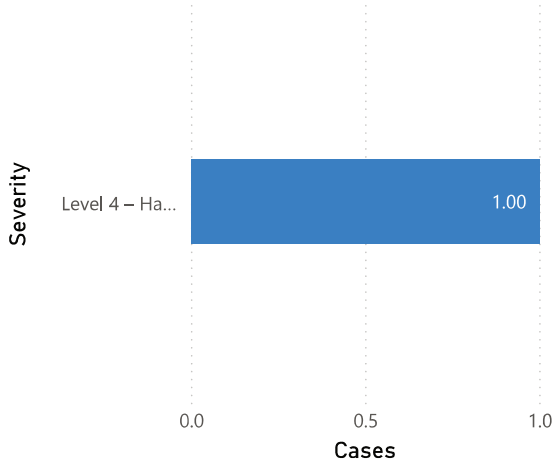
ReportLink, Meditech

Target	Previous YE	YTD	Status (Last 3 periods)
0.0	0.0	0.04	

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	0.0	0.0	0.0	0.0							

Agenda

Medication Reconciliation

Admission

Description

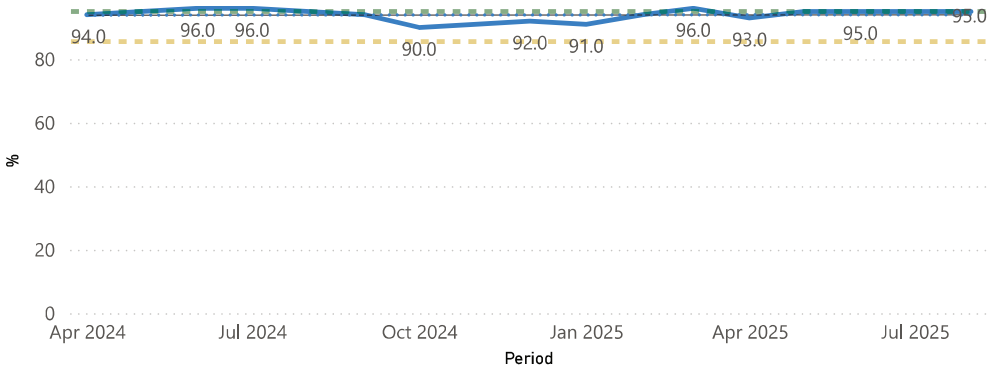
The total number of patients who were discharged who had a Best Possible Medication History (BPMH) completed divided by the total number of patients who were discharged home

Data Source

Meditech Pharmacy Patient Profile

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

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	95.0	95.0	95.0	95.0							

Discharge

Description

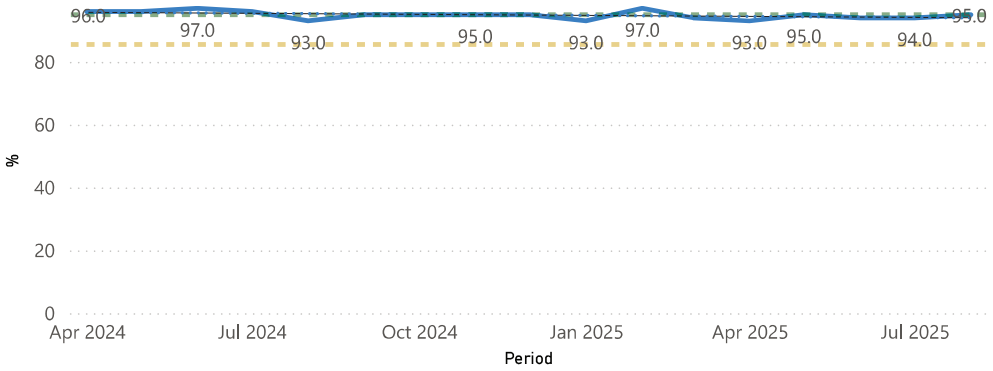
The percentage of Yes responses to the question "Was the CMH community pharmacy prescription completed? " for all inpatient locations participating in medication reconciliation at discharge

Data Source

Meditech

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

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	95.0	94.0	94.0	95.0							

Post-Construction Operating Plan (PCOP) Revenue

Description

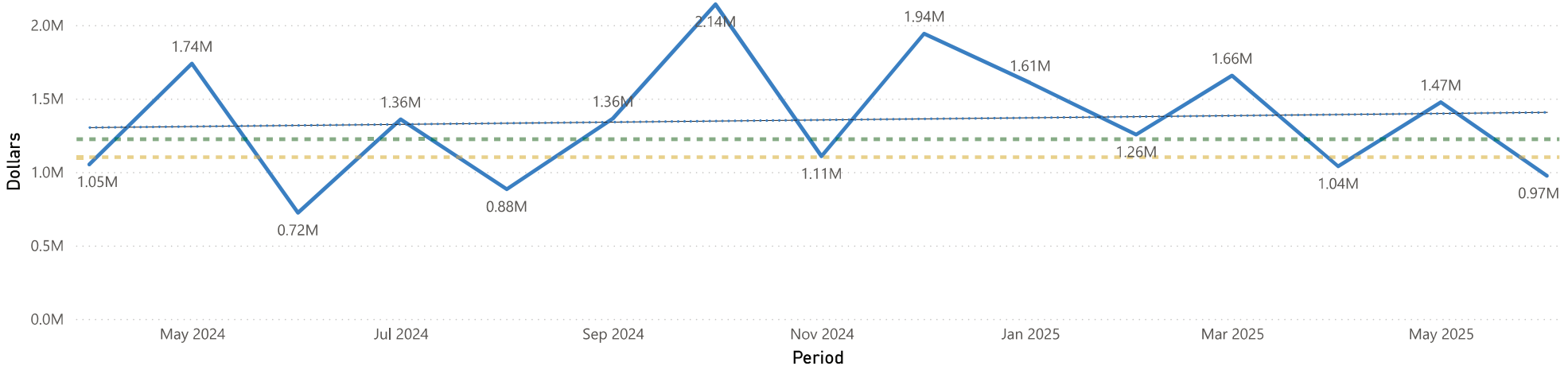
The revenue achieved through all PCOP service areas, including Acute Inpatient, ED, Day Surgery, Mental Health Day Hospital, Mental Health Inpatient, ECT, and Ambulatory Clinics (Mental Health, Paediatric, Fracture, Surgery)

Data Source

Discharge Abstract Database, National Ambulatory Care Reporting System, Meditech

Monthly Target	YTD Target	YTD Total	Status (Last 3 periods)
746.3...	2.2M	3.5M	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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
2025/2026	1,039,034	1,474,897	974,326									

Quality Based Procedure (QBP) Revenue

QBP Dashboard

Description

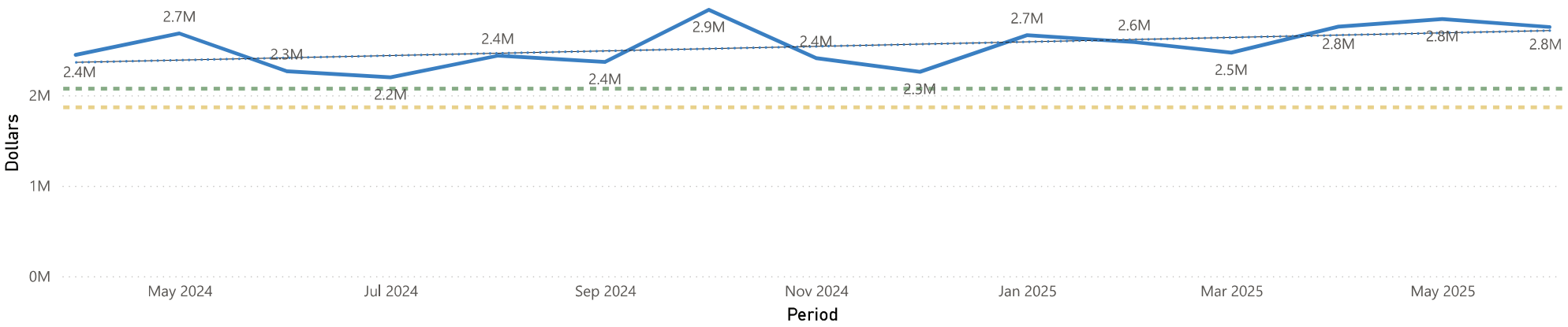
The revenue achieved through all Quality Based Procedures, including Urgent QBPs & Non-Urgent Surgical QBPs (OH), Systemic Treatment (CCO), GI Endoscopy (CCO), and Cancer Surgery (CCO).

Data Source

Discharge Abstract Database, National Ambulatory Care Reporting System

Monthly Target	YTD Target	YTD Total	Status (Last 3 periods)
2.2M	6.7M	8.4M	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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
2025/2026	2,757,892	2,843,049	2,753,879									

**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)*

AVG Patients in ED at 8AM waiting for IP bed

Description

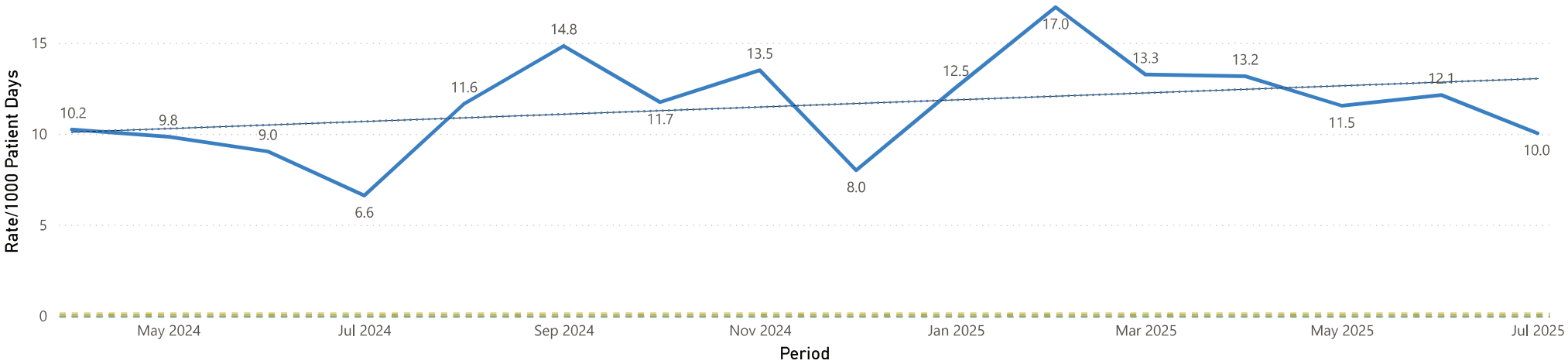
The number of patients in the emergency department waiting for an inpatient bed at 8 a.m. who have been waiting at least 2 hours since disposition. Average number of patients per day

Data Source

NACRS

Target	Previous YE	YTD	Status (Last 3 periods)
10.0	11.5	11.7	▲

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	10.2	9.8	9.0	6.6	11.6	14.8	11.7	13.5	8.0	12.5	17.0	13.3
2025/2026	13.2	11.5	12.1	10.0								

BRIEFING NOTE

Date: September 19, 2025
Issue: Quality Committee Report to the Board of Directors, September 17, 2025 – OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Jennifer Morgan, Administrative Assistant to Clinical Programs
Approved by: William Conway, Quality Committee Chair

Attachments/Related Documents: None

A meeting of the Quality Committee took place on Wednesday, September 17, 2025 at 0700 hours.

Present:	Bill Conway (Chair), Diane Wilkinson, Dr. Winn Lee (V), M. Adair, Nalini Gandhi, Dr. Margaret McKinnon (V), A. Schrum, J. Herring, Tooba Mohtsham, Paulo Brasil, Kellen. Baldock, Stephanie. Pearsall, Dilys Haughton, Patrick Gaskin, Dr. Kunuk Rhee
Regrets:	Alison McCarthy
Staff:	Liane Barefoot, Mari Iromoto
Guests:	Jennifer Visocchi

Committee Matters – For information only

1. Program Presentation:
The Director of Pharmacy & Supply Chain, and the Pharmacy Manager, provided a summary of the pharmacy program. The Committee members reviewed a circulated presentation that highlighted key aspects of the department's operations and achievements.

The presentation noted that Pharmacy Awareness Month is observed every March, with an annual group photo taken each year. A patient story was shared involving an ICU pharmacist and physician managing a complex case of serious infection, emphasizing the importance of smooth transitions from hospital to home or another care setting to prevent readmissions and adverse outcomes. In this specific case, despite initial challenges with Home and Community Care supplier Bayshore, the pharmacist and physician ensured no gaps in care for the patient's IV antifungal therapy at home. A checklist was created to ensure all necessary steps were followed for patients going home on IV therapies.

The Pharmacy department consists of pharmacists, pharmacy technicians, student learners, and specialized roles. Key metrics from 2024-2025 included total medication expenditures exceeding $13 million, with the oncology program expenditure just under $10 million. The

department's role in managing healthcare resources was highlighted, emphasizing financial stewardship responsibilities.

The presentation also covered the Medical Day Clinic team, which includes pharmacists, pharmacy technicians, and a drug access navigator. A video showcased the collaborative efforts within the department, including successful work on HIS (Health Information System) readiness to ensure all equipment, technology, and servers were prepared for upcoming changes. Updates on Omnicell cabinets, packaging software for barcoding, and new packager support were noted as completed.

The pharmacy department is 90-95% staffed with the hiring of four new Pharmacy Technicians by year-end. Key metrics such as Med Rec Admission and Discharge, VT prophylaxis, and Accreditation Canada metrics were discussed. The focus has been on achieving a closed-loop medication system to promote patient safety through HIS implementation.

The department is involved in several quality improvement initiatives, including the Choosing Wisely Canada initiative since 2022, with successful efforts in reducing proton pump inhibitor use and removing desflurane from anesthetic practices. A new project focused on antimicrobial stewardship aims to optimize antibiotic use, duration, and outcomes by reducing unnecessary broad-spectrum antibiotic usage.

A five-year plan includes upgrades to equipment and improvements in sterile rooms, with the goal of completing key projects such as server upgrades, room renovations, and finalizing the HIS project by 2027-2028. The department is working on a new space equipped with updated systems like carousels, inventory management, closed-loop medication systems, and CPOE (Computerized Provider Order Entry).

Regarding oncology medications, approximately 90-98% of the $10 million spent is funded through reimbursement and adherence to Cancer Care Ontario guidelines. Pharmacy students have been beneficial in achieving a high medication reconciliation rate of 95%. The department collaborates with WRHN as part of the Regional Ethics Board for clinical trials.

The dispensing alert system was discussed, with plans to visit the pharmacy to better understand Omnicell equipment operation and devise mitigation strategies from ISMP Canada. For patients without insurance coverage upon discharge, pharmacists work closely with interdisciplinary teams to find cost-effective alternatives or access support programs, ensuring continuity of care.

The Quality Committee Board commended the Pharmacy department for their proactive and collaborative approach. No further questions were raised.

2. Proposed Strategic Priorities Tracker for 2025/26

The VP of People & Strategy reported that the proposed Strategic Priorities Tracker for 2025/26 will be forwarded to the Board of Directors for review, with a subsequent presentation to the Quality Committee in the fall of 2025. The overview of the Tracker for the first quarter of the fiscal year highlighted its alignment with Strategic Pillars and integration of quality improvement plans and risk management processes. It provides a high-level summary slide followed by detailed slides for each indicator, including goals, action plans from the past quarter, and approaches for the next quarter based on set targets.

This year’s supporting slides include additional information to enhance detail and transparency into ongoing work. The Tracker is presented quarterly to the committee with a consistent format that aligns identified priorities with the organization's Strategic Pillars. Priorities are determined

through an integrated process combining quality improvement plans and risk management programs, streamlining organizational processes and enhancing transparency for Quality Committee Board members. Detailed slides outline specific indicators with associated goals, action plans from the past quarter, and strategies for the upcoming quarter based on set targets. This year's Tracker includes trailing 12-month data to display performance trends over time. For instance, ambulance offload times have improved significantly from 111 minutes a year ago to 38 minutes currently, while Provider Initial Assessment (PIA) physician initial assessment has remained relatively flat, moving from 7.1 hours to 7.5 hours over the past 12 months.

Priorities such as flow metrics and HIS are discussed weekly at Senior Leadership Committee and leadership huddles, with other indicators reviewed during weekly operations huddles and various organizational structures and committees. The Quality Committee focuses on flow metrics detailed under the "Elevate Partnerships and Care" pillar, while the rest of the package is provided for informational purposes to the broader committee.

Quality Committee Board members appreciated the clean and transparent presentation of data, noting its clarity in showing historical performance and current status. Feedback from various committees has helped refine and improve these reports for better understanding and ease of use. *(Further information provided in agenda item 4.2)*

3. 2025/26 Quality Committee Goals – draft

The Quality Committee approved the following goals for 2025/26:

- **Meetings**: Two in-person meetings will be held: one today and another in June. Department tours will be included at these two respective in-person meetings.
- **Patient Experience** (Insight to Action): Strengthen culturally safe practices in women and children's health through Indigenous nursing leadership. A presentation by an indigenous nurse working in the women and children's programs, with recommendations based on an environment scan.
- **Education:** Embed excellence and leverage best practices committee initiatives. Ensure qualities are embedded in the HIS (Health Information System) implementation, a significant topic discussed during summer meetings.

4. Review Quality Terms of Reference and Approval of draft 2025/26 Quality Workplan

The committee reviewed and approved the Quality Committee Terms of Reference and the 2025/26 Quality Workplan.

5. Quality Monitoring Scorecard:

The Quality Committee reviewed the quality monitoring scorecard.

- A Committee Member recommended adding an n-value for a specific indicator as the Board of Directors may react to the rate. The n will reflect the number of patients. If the n-value is low, it will skew or increase the rate.
- A Committee Member noted increases in readmissions for CHF, mental health, and COPD. In response, Management indicated that the overall readmission rates are performing well. Discussion on potential changes in discharge plans to help avoid re-admissions.
- Management commented that the Clinical Operational Excellence (COEC) team has also identified these trends and is conducting a deeper analysis.
- The COEC team will focus on wrap-around services for CHF patients, supporting transitions from hospital to community.
- Also noted that sometimes longer lengths of stay may prevent readmissions.
- A deeper dive into the relationship between length of stay and readmission rates is planned.

BRIEFING NOTE

Date: September 23, 2025
Issue: Financial Statements – August 2025
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Spencer Ogston, Financial Analyst
Approved by: Valerie Smith-Sellers, Director, Finance
Trevor Clark, VP Finance & Corporate Services, CFO

Attachments/Related Documents:
Financial Statements – August 2025

Alignment with 2025/26 CMH Priorities:

2022-2027 Strategic Plan No ☐	2025/26 CMH Priorities No ☐	2025/26 Integrated Risk Management Priorities No ☐
☐ Elevate Partnerships in Care	☐ Improve Patient Flow (AOT, PIA, ED Admits)	☐ Organizational Flow
☒ Reimagine Community Health	☐ Prepare for Digital Health Transformation	☒ Project Quantum
☐ Increase Joy In Work	☐ Increase Staff Engagement Through Improved Staffing (Med, ICU, ED, Physicians)	☐ Optimization of Staff/Medical Staff Levels
		☐ Management/Medical Staff Partnership
☒ Sustain Financial Health	☒ Earn the Maximum Eligible PCOP Funding	
☐ Advance Health Equity	☐ Embrace Diversity, Build a Culture of Inclusion	

Alignment with 2025/26 CMH Corporate Plans: Multi-Year Financial Plan

Recommendation/Motion

Board
That, the Board receives the August 2025 financial statements as presented by management and upon the recommendation of the Resources Committee at the meeting of September 22, 2025.

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

Executive Summary
Cambridge Memorial Hospital (CMH) is in a $3.5M year-to-date surplus position at the end of August after building amortization and related capital grants. This is primarily due to higher revenue than budget for Quality Based Procedures (QBP) and Post Construction Operating Plan (PCOP) ($3.2M) and unused budgeted contingency.

The hospital is forecasting a $1.3M surplus for fiscal 2025-26, primarily due to higher PCOP funding than budget ($2.2M). Higher compensation costs ($5.6M) due to the operation of unfunded beds in the Emergency Department and surge beds on Wing B, increased sick time and overtime, and higher medical and surgical supplies costs ($1.4M) due to increased volumes are expected to fully utilize budgeted contingency ($5.9M) and a portion of higher PCOP funding forecast to be earned.

The surplus does not include the expected pickup of prior year PCOP funding resulting from the Ministry of Health's (MOH) reconciliation of fiscal 2023-24 volumes ($8.8M). This funding will be recognized at fiscal year-end in March 2026.

Background
In March 2025, the Board of Directors approved a balanced budget for fiscal 2025-26 with $238.2M in revenue and expenses. In August, the MOH confirmed new funding for fiscal 2025-26 and management is recommending that the balanced budget be amended to be $239M in revenue and expenses. Financial statements and year-end forecasts are prepared on a monthly basis and provided to the Board at regular intervals during the year.

Analysis
CMH is in a $3.5M year-to-date surplus position at the end of August after building amortization and related capital grants. Actual results are $3.7M favourable to budget.

The favourable variance is driven by:
- $2.3M in savings in budgeted contingency.
- $1.9M QBP revenue due to increased hip, knee, and shoulder volumes.
- $1.3M PCOP funding driven by higher weighted cases.
- $0.7M in billable patient services due to physician rate increases and higher Diagnostic Imaging volumes.

The favorable variance is partially offset by the following unfavourable variances:
- $1.8M variance in salaries & wages and benefits, primarily due to higher overtime driven in part by the operation of twelve unfunded beds in the ED and surge beds on Wing B, sick time, and training.
- $0.6M variance in medical surgical supplies due to general and orthopedic supplies, due to higher joint volumes.

<u>Revenue Highlights</u>
- In August, the MOH confirmed a 3% base funding increase for the hospital in fiscal 2025-26, consistent with what was budgeted for.
- QBPs are $1.9M favourable to budget year to date due to higher bundled care and surgical volumes ($2.3M) and cancer care volumes ($0.1M). This is partially offset by a negative variance in medical QBP volumes ($0.5M). Once QBP funding has been fully earned for each major category, volumes over the QBP funding envelope will generate PCOP funding. By the end of the fiscal year QBP funding is forecast to equal budget.
- The hospital has budgeted to receive $20.3M in PCOP funding in 2025-26, just over 91% of the available $22.2M PCOP funding allocation. Funding recognition is dependent on meeting volume targets. The year to date $1.3M favourable variance is due to higher weighted cases.
- Billable patient services are $731K favourable to budget year to date. The variance is primarily driven by higher volumes in Diagnostic Imaging ($623K), in the anticipation of receiving additional wait time funding, and physician rate increases which are fully offset by higher medical remuneration costs.

- Recoveries and other revenue are $692K favourable to budget year to date. The variance is primarily due to recovery for oncology drugs from Ontario Health (OH), which is fully offset by higher drug expenses.

Expense Highlights

- Salaries and wages are $1.4M unfavourable to budget year to date. This is mainly due to higher overtime ($1.5M), sick time ($0.5M), and training ($0.3M), partially offset by a favourable variance in worked salaries ($0.7M). Higher costs have been driven by the operation of unfunded beds in the Emergency Department and surge beds on Wing B, sick time and staffing shortages in specific areas. A working group continues to meet on a bi-weekly basis focusing on strategies to reduce the overtime spend rate.
- Employee benefits are $362K unfavourable to budget year to date. The variance is driven by higher in lieu of benefits payments to part-time staff, due to a higher number of hours worked by part-time staff compared to budget.
- Medical remuneration costs are $278K unfavourable year to date. The variance is driven by additional remuneration paid to physicians in Diagnostic Imaging due to high volume of diagnostics completed, and physician rate increases offset by OHIP revenue.
- Medical and surgical supplies costs are $602K unfavourable to budget year to date. The variance is due to general and orthopedic medical surgical supplies driven by higher joint volumes ($302K), and general medical supplies ($198K) in part due to the operation of unfunded beds.
- Drug expenses are $427K unfavourable to budget year to date. The variance is due to higher spending on drugs for the Oncology Program ($622K). 98% of oncology drug costs are reimbursed by Ontario Health. The unfavourable variance is partially offset by a favourable variance to budget in pharmacy off contract drugs ($190K).
- Other supplies and expenses are $2M favourable to budget year to date. The variance is primarily due to budgeted contingency ($2.3M), which has been partially utilized to operate unfunded beds in the ED and Wing B.
- $0.8M of expenses related to Project Quantum are included in the YTD financial statements. These costs have been budgeted for and include compensation, software, and legal costs.

CMH is forecasting a surplus of $1.3M for 2025-26. The forecast includes budgeted contingency ($5.9M) and higher PCOP revenue than budget ($2.2M) - due to higher forecast weighted cases volumes in fiscal 2025-26, offset by an unfavourable variance in salaries and benefits ($5.6M) and medical and surgical supplies ($1.4M). The surplus does not include the expected pickup of prior year PCOP funding resulting from the Ministry of Health's (MOH) reconciliation of fiscal 2023-24 volumes. This funding will be recognized at fiscal year-end in March 2026.

Balance Sheet and Statement of Cash

CMH's current cash position is $80.9M, consisting of $68.6M of unrestricted cash and $12.3M of restricted cash. The working capital ratio is 1.42 and meets the requirements of the Hospital Service Accountability Agreement (H-SAA) target range of 0.8 to 2.0.

Unrestricted working capital available at the end of August is $26.7M, which is expected to decrease to $13.7M by the end of March as summarized below:

	$M
Unrestricted Bank Balance – August 31, 2025	**68.6**
Add: Other Current Assets ($0.6M Due from CMH Foundation - Capital Funding)	21.8
Less: Current Liabilities ($3.9M due to MOH)	(63.7)
Subtotal - Net Current Assets	**26.7**
Add: Vacation Bank Accrual (consistent with MOH working capital calculation)	4.9
Working Capital Available – August 31, 2025	**31.6**
Add:	
2023-24 PCOP Reconciliation	8.8
MOH Health Infrastructure Renewal Funding	3.1
CMHF & Third Party Funding for Approved Equipment	3.6
Amortization on hospital funded assets- September 1, 2025 - March 31, 2026	3.2
Less:	
Outstanding Health Information System Commitments	(14.2)
Outstanding Enterprise Resource Planning Commitments	(7.4)
Outstanding Rebranding Commitments	(0.1)
Outstanding 2025-26 Capital Budget Commitments	(10.2)
Outstanding Approved POs	(2.4)
Reduction in Forecast Operating Surplus Between September 1, 2025 - March 31, 2026	(2.3)
Forecast Unrestricted Working Capital - March 31, 2026	**13.7**

Cambridge Memorial Hospital
Statement of Operations
For the period ending August 31, 2025

Confidential
(Expressed in Thousands of Dollars)

Month of August 2025					Year to Date				2025-26	2025-26		2024-25 Prior Year Actuals	
Actual	Budget	Variance	% Variance		YTD Actual	YTD Budget	YTD Variance	% Variance	Forecast	Budget	Variance	August 2024	2024-25 YE
				Revenue:									
				MOH Funding									
$ 10,559	$ 10,646	$ (87)	(1%)	MOH - Base	$ 52,543	$ 52,543	$ -	0%	$ 125,347	$ 125,347	$ -	$ 9,434	$ 120,936
2,461	2,220	241	11%	MOH - Quality Based Procedures	13,505	11,627	1,878	16%	$ 27,698	27,698	-	2,241	27,732
1,397	1,726	(329)	(19%)	MOH - Post Construction Operating Plan	9,783	8,519	1,264	15%	$ 22,506	20,324	2,182	2,027	24,284
882	802	80	10%	MOH - One Time / Other	4,148	3,961	187	5%	$ 12,844	12,844	-	1,036	10,917
15,299	15,394	(95)	(1%)	Total MOH Funding	79,979	76,650	3,329	4%	**188,395**	**186,213**	**2,182**	14,738	183,869
1,429	1,388	41	3%	Billable Patient Services	7,586	6,855	731	11%	$ 18,067	16,349	1,718	1,843	17,116
1,902	1,757	145	8%	Recoveries and Other Revenue	9,133	8,441	692	8%	$ 19,988	20,458	(470)	1,778	22,151
255	279	(24)	(9%)	Amortization of Deferred Equipment Capital Grants	1,298	1,379	(81)	(6%)	$ 3,297	3,297	-	323	3,861
321	413	(92)	(22%)	MOH Special Votes Revenue	1,940	2,053	(113)	(6%)	$ 4,899	4,899	-	276	4,227
19,206	**19,231**	**(25)**	**(0%)**	**Total Revenue**	**99,936**	**95,378**	**4,558**	**5%**	**234,646**	**231,216**	**3,430**	**18,958**	**231,224**
				Operating Expenses:									
8,940	8,804	(136)	(2%)	Salaries & Wages	44,637	43,207	(1,430)	(3%)	$ 110,784	106,127	(4,657)	7,993	99,184
2,507	2,361	(146)	(6%)	Employee Benefits	12,596	12,234	(362)	(3%)	$ 29,544	28,575	(969)	2,336	26,302
1,933	1,875	(58)	(3%)	Medical Remuneration	9,589	9,311	(278)	(3%)	$ 23,586	22,239	(1,347)	1,632	22,511
1,206	1,232	26	2%	Medical & Surgical Supplies	6,683	6,081	(602)	(10%)	$ 15,973	14,528	(1,445)	1,300	14,870
1,065	1,123	58	5%	Drug Expense	5,967	5,540	(427)	(8%)	$ 13,061	13,251	190	1,184	13,346
2,654	2,823	169	6%	Other Supplies & Expenses	11,719	13,679	1,960	14%	$ 27,156	33,204	6,048	2,045	32,872
449	470	21	4%	Equipment Depreciation	2,226	2,322	96	4%	$ 5,699	5,699	-	562	6,636
321	413	92	22%	MOH Special Votes Expense	2,039	2,053	14	1%	$ 4,899	4,899	-	296	4,545
19,075	**19,101**	**26**	**0%**	**Total Operating Expenses**	**95,456**	**94,427**	**(1,029)**	**(1%)**	**230,702**	**228,522**	**(2,180)**	**17,348**	**220,266**
131	**130**	**1**	**1%**	**MOH Surplus / (Deficit)**	**4,480**	**951**	**3,529**	**371%**	**3,944**	**2,694**	**1,250**	**1,610**	**10,958**
(812)	(893)	81	(9%)	Building Depreciation	(4,048)	(4,408)	360	(8%)	$ (10,515)	(10,515)	-	(649)	(8,162)
621	664	(43)	(6%)	Amortization of Deferred Building Capital Grants	3,105	3,278	(173)	(5%)	$ 7,821	7,821	-	484	6,121
$ (60)	**$ (99)**	**$ 39**		**Net Surplus / (Deficit)**	**$ 3,537**	**$ (179)**	**$ 3,716**		**$ 1,250**	**$ -**	**$ 1,250**	**$ 1,445**	**$ 8,917**

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

(Expressed in Thousands of Dollars)

	August 2025	March 2025
ASSETS		
Current Assets		
Cash and Short-term Investments	$ 68,594	$ 74,166
Due from Ministry of Health / Ontario Health	8,429	4,807
Other Receivables	7,005	5,831
Inventories	3,152	3,083
Prepaid Expenses	3,225	2,600
	90,405	90,487
Non-Current Assets		
Cash and Investments Restricted - Capital	12,255	13,629
Due from Ministry of Health - Capital Redevelopment	7,691	7,691
Due from CMH Foundation	576	475
Endowment and Special Purpose Fund Cash & Investments	221	218
Capital Assets	298,955	302,411
Total Assets	**$ 410,103**	**$ 414,911**
LIABILITIES & NET ASSETS		
Current Liabilities		
Due to Ministry of Health / Ontario Health	3,936	3,964
Accounts Payable and Accrued Liabilities	37,056	41,512
Deferred Revenue	22,680	22,680
	63,672	68,156
Long Term Liabilities		
Capital Redevelopment Construction Payable	208	168
Employee Future Benefits	4,189	4,085
Deferred Capital Grants and Donations	271,694	275,699
Asset Retirement Obligation	2,884	2,884
	278,975	282,836
Net Assets:		
Unrestricted	22,544	18,246
Externally Restricted Special Purpose Funds	221	218
Invested in Capital Assets	44,691	45,455
	67,456	63,919
Total Liabilities and Net Assets	**$ 410,103**	**$ 414,911**
Working Capital Balance	26,733	22,331
Current Ratio	1.42	1.33

Cambridge Memorial Hospital
Statement of Cash Flows
For the Month Ending August 31, 2025

(Expressed in Thousands of Dollars)

	August 2025	March 2025
Cash Provided By (Used In) Operations:		
Excess (Deficiency) of Revenue over Expenses	$ 3,537	$ 8,917
Items not Involving Cash:		
Amortization of Capital Assets	6,274	14,798
Amortization of Deferred Grants and Donations	(4,403)	(9,982)
Change in Non-Cash Operating Working Capital	(10,078)	(9,556)
Change in Employee Future Benefits	104	(138)
	(4,566)	4,039
Investing:		
Acquisition of Capital Assets & Capital Redevelopment Project	(2,818)	(21,077)
Capital Redevelopment Project Construction Payable	40	(3,867)
	(2,778)	(24,944)
Financing:		
Change in Non-Cash Capital Accounts Receivable	-	(4,374)
Capital Donations and Grants & Capital Redevelopment Project	398	898
	398	(3,476)
Increase (Decrease) In Cash for the Period	(6,946)	(24,381)
Cash & Investments - Beginning of Year	87,795	112,176
Cash & Investments - End Of Period	**$ 80,849**	**$ 87,795**
Cash & Investments Consist of:		
Unrestricted Endowment and Special Purpose Investments	30	30
Cash & Investments Operating	68,564	74,136
Cash & Investments Restricted	12,255	13,629
Total	**$ 80,849**	**$ 87,795**

BRIEFING NOTE

Date: September 26, 2025
Issue: Beryl Institute Experience Assessment
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Liane Barefoot – Director Patient Experience, Quality, Privacy, Risk & IPAC
Approved by: Mari Iromoto – VP, People & Strategy

Attachments/Related Documents:
Beryl Institute Experience Assessment – Sample Report
Sample Experience Assessment

Alignment with 2025/26 CMH Priorities:

2022-2027 Strategic Plan No ☐	2025/26 CMH Priorities No ☐	2025/26 Integrated Risk Management Priorities No ☒
☒ Elevate Partnerships in Care	☐ Improve Patient Flow (AOT, PIA, ED Admits)	☐ Organizational Flow
☐ Reimagine Community Health	☐ Prepare for Digital Health Transformation	☐ Project Quantum
☐ Increase Joy In Work	☐ Increase Staff Engagement Through Improved Staffing (Med, ICU, ED, Physicians)	☐ Optimization of Staff/Medical Staff Levels
		☐ Management/Medical Staff Partnership
☐ Sustain Financial Health	☐ Earn the Maximum Eligible PCOP Funding	
☒ Advance Health Equity	☒ Embrace Diversity, Build a Culture of Inclusion	

Alignment with 2025/26 CMH Corporate Plans: Patient Experience Plan

Executive Summary

The 2022-27 Patient Experience (PX) Plan has several tactics grouped into five (5) theme areas:

1. Formalized roles
2. Continuous Feedback Loop
3. Communication is a Cornerstone
4. Actions & Environment Demonstrate Respect for Diversity
5. Adopt Innovative Digital Solutions

Two overall success measures for the PX plan were defined and one was the Beryl Institute Human Experience Index Score. A baseline measurement was conducted in December 2023, and the Beryl Institute recommends measuring this about every 18 – 24 months to assess an organization's patient experience efforts.

Recommendation

After consultation with CMH Patient and Family Advisory Council (PFAC), the recommendation is to send an invitation to participate to the same target group as 2023 to allow for comparison.

Similar to 2023 invitations to participate would be emailed to all members of OPS, all members of PFAC, all members of MAC, and Board members. In addition, in 2023 OPS members were advised that they could extend the invite in a targeted manner (i.e., charge nurses, educators). The survey link will be active beginning October 27, 2025 for 3 weeks, closing on November 17, 2025. Results will be discussed with PFAC at their January 2026 meeting and subsequently with other participating groups (MAC, OPS, Board).

Background

The Success Measures for the plan were defined as:

1. Would you recommend CMH to family and friends?
   This measure was historically a 'big dot' indicator on the mailed external patient survey. During the early part of this 2022-27 PX Plan there was a delayed implementation from the Ontario Hospital Association (OHA) in moving from the mailed survey provider (NRC) to our new electronic platform, Qualtrics; however, we now have regular access to these results.

2. Increase CMH Human Experience Index Score
   The Human Experience Index score is a survey tool developed and validated by the Beryl Institute to evaluate an organization's Patient Experience efforts. When the 2022-27 PX Plan was given final approval by the Board of Directors, a baseline survey was conducted in December 2023. The Beryl Institute recommends implementing this survey about once every 18-24 months. As such, we will plan to conduct this survey in Fall 2025 and again in 2027 at the end of this plan to evaluate our efforts.

Analysis

A sample pdf of the survey questions and how results are displayed is attached for your information. We are unable to make any changes to the survey questions, acknowledging that some questions are more US-centric than others.

A dedicated CMH link is sent to participants inviting them to complete the survey which takes about 10 – 15 minutes to complete. Intentionally and so as not to skew the results, I am choosing not to circulate the 2023 CMH results at this time but rather will send as a comparison when we receive the 2025 results.

In 2023 we had 37 participants complete the survey comprised of OPS members (19), board members (2), physicians (5), nurses (3), non-clinical employees (2), PFAC (2) and other (4).

Consultation

CMH PFAC was consulted and had robust dialogue on the pros/cons of sending the invitation to participate to the same target group as 2023 vs. an open invite to all staff and medical/professional staff. Ultimately a consensus was reached to limit the invites to the same groups as 2023; that is, all of OPS, all of PFAC, all of MAC and the board of directors to allow for comparison of results.

Next Steps

The Board of Directors will receive an invitation to participate in this assessment on October 27, 2025. Results will be shared with the Board in Winter/Spring 2026 following discussion with PFAC.

Agenda

THE BERYL INSTITUTE

EXPERIENCE ASSESSMENT RESULTS REPORT
(Organization Name)

The Experience Assessment is grounded in The Beryl Institute's Experience Framework and built on global research identifying factors seen as critical to positive experience outcomes by both high performing healthcare organizations and consumers of healthcare.

This report provides a summary of insights based on your organization's responses to questions aligned with each of the eight strategic lenses that comprise the framework . It is designed to be reviewed with an Institute team member for further reflection and action planning. With this report you will:

- Gain insight into your organization's overall experience efforts.
- Clarify the strengths and gaps of those experiencing, delivering and improving care.
- Identify your priorities for improvement within the eight strategic lenses.
- Connect to resources to support your experience journey.

The Experience Assessment Results Report contains four main sections:

1. Your organization's overall Human Experience Index Score.
2. Your organization's scoring on each lens of the Experience Framework.
3. A review of your organization's average score per item and respondent breakdown.
4. A separate Appendix - Review and Reflection Worksheet - for guiding analysis of results.

Agenda

Total Respondents: (number of respondents)

Section 1. Your Human Experience Index Score

The *Human Experience Index* (HXI) provides insights into the breadth, integration and outcomes associated with your organization's experience effort. The HXI serves as both a measure of current state and a means to track progress as you work to develop, implement and refine your efforts.

Level (Score Range)	Description
Leading (169-200)	Organizations at this level are ensuring an integrated, focused and consistent effort across the experience landscape and are working continuously to both sustain and continually improve on their outcomes. While seeing consistent results, organizations at this level do not believe they have achieved experience success. Rather they recognize the need for continued focus and action.
Sustaining (137-168)	Organizations at this level are making significant strides across all aspects of the experience landscape and are seeing sustained results in a large portion of their experience effort.
Progressing (104-136)	Organizations at this level are beginning to see some level of progress across all areas of their experience effort and are starting to realize some consistent results in their efforts.
Integrating (72-103)	Organizations at this level are beginning to integrate the various components of their experience effort, but may have not yet realized consistent performance and outcomes across all areas.
Starting (40-71)	Organizations at this level are at the starting point in many of their experience endeavors or are revisiting or reengaging in experience efforts. They may just be beginning to see the initial impact of their actions.

Section 2. Your Scores by Strategic Lens

The eight strategic areas of The Beryl Institute Experience Framework reinforce the broad and integrated nature of efforts that impact the experience of those served by and working in healthcare. The lenses provide a means to evaluate where organizations are excelling or have opportunities for improvement and offer a direct bridge from identified needs to knowledge, resources and solutions. The scores below summarize how your organization is performing in each lens and are rated on the scale to the right.

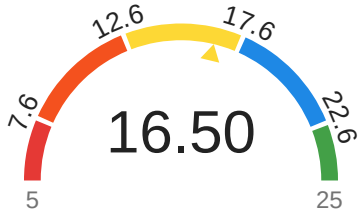
Level (Score Range)
Excelling (22.6-25.0)
Seeing Success (17.6-22.5)
Making Progress (12.6-17.5)
Getting Started (7.6-12.5)
Needs attention (5.0-7.5)

Culture and Leadership

The foundation of any successful experience effort is set on who an organization is, its purpose and values, and how it is led.

Environment & Hospitality

The space in which a healthcare experience is delivered and the practices implemented to ensure a positive, comfortable and compassionate encounter must be part of every effort.



Infrastructure & Governance

Effective experience efforts require both the right structures and processes by which to operate and communicate and the formal guidance in place to ensure sustained strategic focus.

Section 2. Your Scores by Strategic Lens - Continued

Innovation & Technology

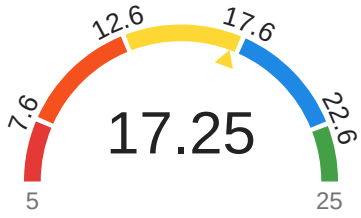
As a focus on experience expands, it requires new ways of thinking and doing and the technologies and tools to ensure efficiencies, expand capacities and extend boundaries of care.

Patient, Family & Community Engagement

Central to any experience effort are the voices of, contributions from and partnerships with those receiving care and the community served.

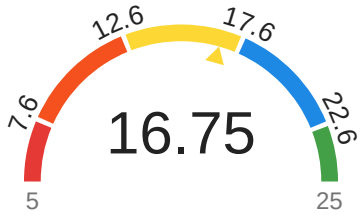
Policy & Measurement

Experience is driven and influenced by external factors and systemic and financial realities and requires accepted and understood metrics to effectively measure outcomes and drive action.



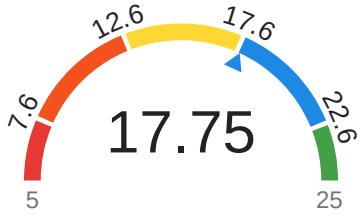
Quality & Clinical Excellence

Experience encompasses all an individual encounters and the expectations they have for safe, quality, reliable, and effective care focused on positively impacting health and well-being.



Staff & Provider Engagement

Caring for those delivering and supporting the delivery of care and reaffirming a connection to meaning and purpose is fundamental to the successful realization of a positive experience.



Agenda

Section 3. Average Score per Item

Item level scores are presented as the average score of all respondents in your organization. The response options for each item follow the five-point scale: Not at all, To a minimal extent, To some extent, To a great extent, To the greatest extent.

Scores for each item are grouped by strategic lens. They should be reviewed based on the following scoring ranges:

- **NEEDS ATTENTION:** Average score from 1.0 to 1.5
- **GETTING STARTED:** Average score from 1.6 to 2.5
- **MAKING PROGRESS:** Average score from 2.6 to 3.5
- **SEEING SUCCESS:** Average score from 3.6 to 4.5
- **EXCELLING:** Average score from 4.6 to 5.0

Culture & Leadership	Value
Our leadership expresses and acts upon a clear commitment to experience efforts.	3.75
We consistently treat patients, family members and care partners with compassion, courtesy and respect.	3.00
We consistently treat each other (as team members and colleagues) with compassion, courtesy and respect.	3.50
We have a clear definition of experience for our organization shared by everyone.	2.25
We have the ability to change processes and procedures quickly when needed.	2.75

Environment & Hospitality	Value
Our environment is clean and comfortable.	3.50
Our environment is quiet and peaceful.	2.50
Our facility is easy for patients, family members and care partners to access.	3.50
Our facility is one in which you can find your way around easily.	3.75
We provide for a comfortable diagnostic and/or testing experience.	3.25

Section 3. Average Score per Item - Continued

Infrastructure & Governance	Value
Our board is aware of, engaged in and supportive of our experience efforts.	3.00
We ensure the ability for patients to schedule an appointment or procedure within a reasonable time period.	3.25
We have wait times that patients, family members and care partners feel are reasonable.	2.75
We offer an understandable and easy process for transitioning personal health information between care providers.	3.50
We provide a discharge/check out process in which patients' treatment plans and/or next steps in care are clearly explained.	3.25

Innovation & Technology	Value
We invest in the newest technologies to best serve our patients, their family members and care partners.	2.75
We offer access to digital/electronic interfaces such as tablets, phone-based applications or patient portals.	2.75
We offer access to technology that is patient-friendly.	3.50
We provide a way to easily access medical information or test results.	2.25
We provide open access to personal health records.	2.50

Patient, Family & Community Engagement	Value
Our care teams intentionally focus on communicating clearly to patients, family members and care partners in a way they can understand.	3.25
We consistently ensure our patients and their family members and care partners feel listened to.	3.25
We consistently invite patients, family members and care partners to ask questions of their care provider(s) and our organization.	3.00
We have formal processes and structures to partner with and engage both patients and community members, such as co-design processes, community forums, patient and family advisory councils, etc.	2.50
We work to ensure consistent effective communication with patients, family members and care partners.	3.75

Agenda

Section 3. Average Score per Item - Continued

Policy & Measurement	Value
We have a means to gather and act on real-time feedback from patients, family members and care partners.	4.25
We work consistently to address issues of bias and prejudice in our work and foster an environment of inclusion and belonging for both our patients and our colleagues.	3.00
We use our patient experience survey data to drive action and improvement.	3.25
We use our patient comments and narratives to drive action and improvement.	3.50
We work to ensure equitable access to care for all in the communities we serve.	3.25

Quality & Clinical Excellence	Value
Patients and families believe we take their pain seriously and responsibly.	3.25
We achieve the best clinical outcomes as a result of our prescribed treatment, intervention and/or therapy.	2.50
We consistently provide effective coordination of care during and between encounters.	3.75
We ensure we provide every patient a clear plan of care and the reason(s) we are following that plan.	4.00
We work to consistently instill confidence in our skills and abilities to the patients we serve.	3.25

Staff & Provider Engagement	Value
Our staff and clinicians feel a clear connection to purpose.	3.75
We ensure our team members feel valued and recognized for the work they do.	4.25
We have a commitment to staff/team well-being.	3.75
We have a highly engaged team of employees/associates/staff members.	3.00
We reinforce the importance of and ensure teamwork among our care teams.	3.00

Section 4. Respondent Breakdown

The following provides a breakdown of respondent type for your organizational responses.