



**BOARD OF DIRECTORS MEETING - OPEN**  
**Wednesday March 4, 2026**

**1700-1850**

**Virtual via Teams / C.1.229**

**[Join the meeting now](#)**

**Or call in (audio only)**

**[833-827-2824](tel:833-827-2824), [978704436](tel:978704436)#Canada (Toll-free)**

**Phone Conference ID: 978 704 436#**



**AGENDA**

<b>Agenda Item</b> * indicates attachment / TBC - to be circulated	<b>Page #</b>	<b>Time</b>	<b>Responsibility</b>	<b>Purpose</b>
<b>1. CALL TO ORDER</b>				
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 <i>(Any Board member may request that any item be removed from this consent agenda and moved to the regular agenda)</i>		1706	L. Woeller	Motion
1.5.1 Minutes of February 4, 2026*	4			
1.5.2 2025/26 Board of Directors Action Log*	8			
1.5.3 Board Attendance*	9			
1.5.4 Board Work Plan*	10			
1.5.5 Events Calendar*	19			
1.5.6 Committee Reports to the Board of Directors				
1.5.6.1 Audit Committee* (Next Meeting April 27, 2026)				
1.5.6.2 Digital Health Strategy Committee* (Feb 19, 2026)	21			
1.5.6.3 Executive Committee* (Next Meeting Mar 17, 2026)				
1.5.6.4 Governance and Nominating Committee* (Feb 12, 2026)	23			
1.5.6.5 Medical Advisory Committee* (Feb 11, 2026)	25			
1.5.6.5.1 New Credentialed Physicians January 2026*	28			
1.5.6.6 Resources Committee* (Feb 23, 2026)	29			
1.5.7 Governance Policy Approvals*	30			
2-A-36 Board and Committee Meeting Attendance				
2-D-06 Board Meeting Agenda Preparation				
2-A-30 Responsibilities of a Director				
2-A-32 Responsibilities of a Non-Director				
1.5.8 Strategic Priorities Q3 Update*	44			
1.5.8.1 Quality Monitoring Scorecard*	65			
1.5.9 CEO Certificate of Compliance* (January 31, 2026 - February 27, 2026)	95			
1.6 Confirmation of Agenda		1709	L. Woeller	Motion
<i>Move to Agenda Item 4.3.1</i>				
1.7 Motion to Move to <i>IN-CAMERA (Agenda Section 4.3)</i>		1719	L. Woeller	Motion

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, Dr. Minta Patel, Stephanie Pearsall

<b>Agenda Item</b> * indicates attachment / TBC – to be circulated	<b>Page #</b>	<b>Time</b>	<b>Responsibility</b>	<b>Purpose</b>
<b>2. PRESENTATIONS</b>				
2.1 Quality Improvement Plan (QIP) 2026 – Metrics and Narrative for Approval*	96	1810	L. Barefoot	Motion
<b>3. BUSINESS ARISING</b>				
3.1 No Open Matters for Discussion				
<b>4. NEW BUSINESS</b>				
4.1 Chair's Update				
4.1.1 Board Chair's Report*	118	1830	L. Woeller	Information
4.2 Quality Committee (Feb 18, 2026)				
4.2.1 Report to the Board of Directors*	124	1835	B. Conway	Information
4.3 Resources Committee (Feb 23, 2026)				
4.3.1 January 2026 Financial Statements and Year-End Forecast*	130	1710	P. Brasil	Motion
<i>Move to Agenda Item 1.7</i>				
4.4 Patient Family Advisory Council (PFAC) Update (Mar 3, 2026)		1845	L. Woeller	Information
4.5 CEO Update				
4.5.1 No Open Matters for Discussion				
<b>5. UPCOMING EVENTS</b>				
Visit <a href="#">GovHub</a> for the most current listing of all upcoming events			L. Woeller	Information
5.1 Grand Rounds: March 26, 2026 – 8:00-9:00am, virtual Details to follow				
5.2 Board Social: Save the Date – April 14, 2026 5:30-7:30pm, Details to follow				
5.3 Sara Alvarado's Walk from Cambridge to Paris: June 14, 2026 (morning); Galt, Cambridge to Paris – <a href="#">Walk to Paris 2026 by Sara Alvarado - Cambridge Memorial Hospital Foundation</a>				
<b>6. DATE OF NEXT MEETING</b>	Wednesday May 6, 2026 Location: Hybrid			
<b>7. TERMINATION</b>		1850	L. Woeller	Motion
Link: <a href="#">Board/Committee Evaluation Survey</a>	<i>Following the meeting, please complete within one week.</i>			

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

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### CMH Board of Directors Motions Page

Agenda Item	Motions Being Brought Forward for Approval – March 4, 2026									
1.5	Consent Agenda	<ul style="list-style-type: none"> <li>• That, the CMH Board of Directors approves the Consent Agenda as presented/amended  <i>The following motions are contained in the Consent Agenda:</i> <ul style="list-style-type: none"> <li>○ That, the CMH Board of Directors approves the following polices as presented/with amendments and upon recommendation of the Governance and Nominating Committee at its meeting of February 12, 2026. <table border="1" style="margin-left: 40px; width: 100%;"> <tr> <td style="width: 15%;">2-A-36</td> <td>Board and Committee Meeting Attendance</td> </tr> <tr> <td>2-D-06</td> <td>Board Meeting Agenda Preparation</td> </tr> <tr> <td>2-A-30</td> <td>Responsibilities of a Director</td> </tr> <tr> <td>2-A-32</td> <td>Responsibilities of a Non-Director</td> </tr> </table> </li> </ul> </li> </ul>	2-A-36	Board and Committee Meeting Attendance	2-D-06	Board Meeting Agenda Preparation	2-A-30	Responsibilities of a Director	2-A-32	Responsibilities of a Non-Director
2-A-36	Board and Committee Meeting Attendance									
2-D-06	Board Meeting Agenda Preparation									
2-A-30	Responsibilities of a Director									
2-A-32	Responsibilities of a Non-Director									
1.6	Confirmation of Agenda	<ul style="list-style-type: none"> <li>• That, the CMH Board of Directors approves the agenda as presented/amended</li> </ul>								
2.1	QIP	<ul style="list-style-type: none"> <li>• That, the CMH Board of Directors approves the six 2026 Quality Improvement Plan (QIP) Metrics as presented below and upon recommendation of the Quality Committee at its meeting of February 18, 2026: <ol style="list-style-type: none"> <li>1. Reduce the 90<sup>th</sup> percentile Ambulance Offload time from x min to 30 minutes</li> <li>2. Reduce the 90<sup>th</sup> percentile Physician Initial Assessment (PIA) time for CTAS 1's from x to 30 minutes</li> <li>3. Reduce the 90<sup>th</sup> percentile Physician Initial Assessment (PIA) time for all CTAS levels combined from x hours to 4.5 hours</li> <li>4. Reduce the daily average number of patients waiting in the ED for an inpatient bed at 8 AM from x to 9.15</li> <li>5. Reduce the Medicine program conservable bed days from x to 27</li> <li>6. Increase the % of respondents with the top box answer "completely" from x to 74.27%</li> </ol> <p style="margin-left: 20px;">NOTE: 'x' for each metric will be updated to reflect current state at the time of the QIP is loaded into the OH navigator</p> </li> <li>• That, the CMH Board of Directors approves the 2026 Quality Improvement Plan (QIP) Narrative as presented and upon recommendation of the Quality Committee at its meeting of February 18, 2026</li> </ul>								
4.3.1	Financial Statements	<ul style="list-style-type: none"> <li>• That, the CMH Board of Directors receives the January 2026 financial statements as presented by management and upon recommendation of the Resources Committee at the meeting of February 23, 2026.</li> </ul>								

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, Dr. Minta Patel, Stephanie Pearsall

Cambridge Memorial Hospital  
BOARD OF DIRECTORS MEETING  
Wednesday, February 4, 2026  
*OPEN* Session

Minutes of the open session of the Board of Directors meeting, held virtually via MS Teams on February 4, 2026.

Present:

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

Regrets: J. Tulsani, Dr. V. Miropolsky

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

Guests: L. Barefoot

Recorder: S. Fitzgerald

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**1. CALL TO ORDER**

The Chair called the meeting to order at 1700h.

**1.1. Territorial Acknowledgement**

The Chair presented the Territorial Acknowledgement. This acknowledgement was provided in keeping with the Hospital's commitment to reconciliation.

**1.2. Welcome**

The Chair welcomed Board members and guests to the meeting.

**1.3. Confirmation of Quorum (7)**

Quorum was confirmed, and 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 related to the open session of the meeting. No conflicts were declared.

**1.5. Consent Agenda**

The consent agenda was presented to approve routine Board materials that had been reviewed in advance of the meeting and did not require further discussion.

Board members were asked whether they wished to have any items removed from the consent agenda for separate discussions. No requests were made by any member to remove an item.

The following motion was duly made, seconded and carried with no members opposed:

**MOTION:** that, the CMH Board of Directors approves the consent agenda as presented.

- 1.5.1 Minutes of December 3, 2025
- 1.5.2 2025/26 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
  - Audit Committee (January 19, 2026)
  - Governance Committee (December 11, 2025)
  - Medical Advisory Committee (December 4, 2025 & January 14, 2026)
  - 1.5.6.5.1 New Credentialed Physicians December 2025
- 1.5.7 Governance Policy Approvals
 

That, the CMH Board of Directors approves the following polices as presented and upon recommendation of the Governance and Nominating Committee at its meeting of December 11, 2025

2-B-06	Chief of Staff Role Description
2-C-20	Integrated Risk Management
2-D-16	Session of Independent Directors and Committee Members
2-A-28	Role Description for Committee Chair
2-D-40	Evaluation of Board, Committee, and Individual Performance
- 1.5.8 Quality Monitoring Metrics Scorecard
- 1.5.9 CEO Certificate of Compliance November 29, 2025-January 30, 2026
- 1.5.10 CMH President & CEO Report

1.6. **Confirmation of Agenda**

The meeting agenda was presented for approval. Board members were provided with the opportunity to raise questions or propose amendments to the agenda as circulated. No changes were requested.

The following motion was duly made, seconded, and **CARRIED** with no members opposed:

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

2. **PRESENTATIONS**

2.1. **Mini Education Session: Fostering a Robust Emergency Preparedness Culture at CMH**

The Board received a mini-education session titled Fostering a Robust Emergency Preparedness Culture at CMH. The presentation provided an overview of the Hospital’s approach to emergency preparedness, including the use of standardized incident management frameworks, leadership training and simulation exercises, emergency code activation processes, and coordination with municipal and regional emergency partners. The presentation also addressed staff wellness supports following critical incidents and highlighted ongoing collaboration with external agencies to strengthen preparedness and response capabilities.

The Board discussed emergency readiness, leadership training coverage, escalation processes, and the importance of regional coordination, including considerations related to staff and public mental-health supports following significant incidents.

*Guests left the meeting.*

3. **BUSINESS ARISING**

There were no open matters for discussion.

#### 4. NEW BUSINESS

##### 4.1. Chair's Update

###### 4.1.1. Board Chair's Report

The Board Chair provided an update highlighting the exceptional efforts of staff, physicians, and midwives during the recent holiday surge, noting the significant commitment demonstrated across the organization. The Chair also acknowledged Board members' participation in recent hospital and community engagement activities and thanked them for their continued support.

##### 4.2. Governance and Nominating Committee (GNC)

###### 4.2.1. Proposed Approach to Policy Review – Policy 2-D-20

The Board reviewed and discussed a proposed refinement to the Board's policy development, review, and approval process intended to support effective governance oversight while ensuring sustainability of the GNC's annual workload. The proposed approach introduced a staggered policy review cycle, applying three-year and five-year review intervals based on the nature, stability, and risk profile of individual Board policies.

The Board considered the current volume of policies under GNC and Board oversight noting that many policies remain well aligned with best practices over extended periods, while others require more frequent review due to regulatory, operational, or risk considerations. The proposed staggered approach was discussed as a means of maintaining rigorous oversight for higher-risk or more dynamic policies, while allowing more stable policies to be reviewed on a longer cycle, without diminishing accountability.

The Board discussed the importance of ensuring that the revised review cycle continues to support transparency, responsiveness to emerging risks, and alignment with governance best practices. It was noted that the GNC would continue to monitor policy relevance and could recommend off-cycle reviews where circumstances warrant.

The following motion was duly made, seconded, and carried with no members opposed:

**MOTION:** That, the CMH Board of Directors approves policy 2-D-02 Board Policy Development, Review, and Approval as presented to reflect a 3-year/5-year review schedule as outlined in the Policy Review Schedule, and upon recommendation of the Governance and Nominating Committee at its meeting of December 11, 2025.

##### 4.3. Quality Committee

###### 4.3.1. Report to the Board of Directors

The Chair of the Quality Committee provided the Board with an update on the work completed and items discussed at its meeting of January 21, 2026.

The update included highlights from a presentation on the Mental Health Program, progress toward integrated care models, patient, staff, and learner experience examples, and a review of selected quality indicators.

A Board member suggested the Quality Monitoring Metrics be reviewed as a standing discussion item at each Board meeting. In its discussion, the Board acknowledged the role of the Quality Committee in providing detailed oversight and analysis of the scorecard, including identifying trends, risks, and indicators requiring further attention, and reporting key matters to the Board through its briefing notes.

The Board agreed that maintaining the Quality Monitoring Metrics Scorecard within the consent agenda remains appropriate, provided that Board members continue to review the materials in advance and exercise the ability to remove the item from consent when clarification, discussion, or escalation is required. The Board reaffirmed that the Quality Committee will continue to bring forward matters of concern or emerging risk for Board-level discussion, as necessary.

The Board further noted the value of periodic education and discussion on selected quality indicators to support shared understanding and effective governance oversight, to be considered through existing Board education opportunities.

4.4. **Patient & Family Advisory Council (PFAC) Update**

The Board received updates on PFAC activities from meetings held on January 13 and February 3, 2026. Updates included information on the implementation of the My Connected Care patient portal, feedback from a CMH space tour, and education on Just Culture principles. The Board was also advised of the upcoming discontinuation of the VOYCE translation service effective March 31, 2026, and the steps being taken to identify interim and longer-term alternatives.

4.5. **CEO Update**

No open matters for discussion.

5. **UPCOMING EVENTS**

The Chair reviewed the upcoming events

6. **DATE OF NEXT MEETING**

The next scheduled Board of Directors meeting will be held on March 4, 2026.

7. **TERMINATION**

**MOTION:** That, the meeting terminated at 1807hrs.  
None opposed, **CARRIED.**

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**2025/26 Board of Directors Action Log**

Meeting Date	Agenda # / Item Description	Action Item	Owner	Status
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 GNC for final review at a future meeting. <b>Complete – Policy 2-D-06 updates, agenda item 1.5.7</b>
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**

	<b>89%</b>	<b>100%</b>	<b>100%</b>	<b>67%</b>	<b>100%</b>	<b>78%</b>	<b>78%</b>	<b>100%</b>	<b>89%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
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
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
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	P	P	P	P
01-Oct-25	P	P	P	P	P	P	P	P	P	P	P	P
05-Nov-25	R	P	P	R	P	R	P	P	P	P	P	P
03-Dec-25	P	P	P	P	P	P	R	P	P	P	P	P
04-Feb-26	P	P	P	R	P	P	P	P	P	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	<b>4a Corporate Culture</b>					
	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		<ul style="list-style-type: none"> <li>➤ share, measure and improve culture by setting ABCDE goals</li> <li>a) <del>A</del>ttend – attend Board/committee meetings</li> <li>b) <del>B</del>e engaged – be an active contributor to the committee and Board work</li> <li>c) <del>C</del>onnect – attend staff huddles, events</li> <li>d) <del>D</del>onate – support the CMH Foundation</li> <li>e) <del>E</del>ducate – undertake education, courses</li> </ul>	Complete
	<b>4b Strategic Planning</b>					
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality / Resources	<ul style="list-style-type: none"> <li>➤ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker</li> </ul>	Complete
	<b>4c Corporate Performance</b>					
	ii	monitor, mitigate and respond to the principal risks		Quality	<ul style="list-style-type: none"> <li>➤ review critical incident reports (as per the Excellent Care for all Act)</li> </ul>	Complete
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	<ul style="list-style-type: none"> <li>➤ receive and review the Quality Monitoring Metrics</li> <li>➤ receive and review the Strategic Priorities Tracker</li> </ul>	Complete
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	<ul style="list-style-type: none"> <li>➤ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements</li> </ul>	Complete
	<b>4f Oversight of Medical/Professional Staff</b>					
	i	credential Medical/Professional Staff	1-C-13	MAC	<ul style="list-style-type: none"> <li>➤ make the final appointment, reappointment, and privilege decisions</li> <li>➤ ensure the effectiveness and fairness of the credentialing process</li> </ul>	Complete
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	<ul style="list-style-type: none"> <li>➤ receive the MAC Report to the Board of Directors</li> </ul>	Complete
	<b>4g Relationships</b>					
		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			<ul style="list-style-type: none"> <li>➤ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient &amp; Family Advisory Council Others as needed</li> </ul>	Complete
<b>4i Board Effectiveness</b>						
iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	<ul style="list-style-type: none"> <li>➤ review &amp; approve Board policies as recommended by Governance Committee</li> </ul>	Complete	
<b>4k Fundraising</b>						
	The Board supports fundraising initiatives of the Foundation	2-A-30		<ul style="list-style-type: none"> <li>➤ review upcoming events</li> <li>➤ reported through Directors ABCDE Goals</li> <li>➤ receive CMH Board Giving Activitv</li> </ul>	Complete	

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
November 5, 2025 (Generative Session)	<b>4c Corporate Performance</b>					
	ii	monitor, mitigate and respond to the principal risks		Quality	➤ review critical incident reports (as per the Excellent Care for all Act)	Complete
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➤ receive and review the Quality Monitoring Metrics	Complete
	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	Complete
	<b>4f Oversight of Medical/Professional Staff</b>					
	i	credential Medical/Professional Staff	1-C-13	MAC	➤ make the final appointment, reappointment, and privilege decisions ➤ ensure the effectiveness and fairness of the credentialing process	Complete
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➤ receive the MAC Report to the Board of Directors	Complete
	<b>4a Corporate Culture</b>					
	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	Complete
	<b>4b Strategic Planning</b>					
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality / Resources	➤ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker	Complete
	<b>4c Corporate Performance</b>					
	ii	monitor, mitigate and respond to the principal risks		Quality Audit / Quality / Resources	➤ review critical incident reports (as per the Excellent Care for all Act) ➤ receive mid-year IRM report	Complete Complete
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➤ receive and review the Quality Monitoring Metrics ➤ receive and review the Strategic Priorities Tracker	Complete
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➤ receive & approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements ➤ receive & approve Certificate of Compliance – Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding (semi-annual)	Complete
	<b>4f Oversight of Medical/Professional Staff</b>					
	i	credential Medical/Professional Staff	1-C-13	MAC	➤ make the final appointment, reappointment, and privilege decisions ➤ ensure the effectiveness and fairness of the credentialing process	Complete
iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➤ receive the MAC Report to the Board of Directors	Complete	

Cambridge Memorial Hospital Board of Directors - 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
03-Dec-25	<b>4g Relationships</b>					
		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			<ul style="list-style-type: none"> <li>➤ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient &amp; Family Advisory Council Others as needed</li> </ul>	Complete
	<b>4i Board Effectiveness</b>					
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	<ul style="list-style-type: none"> <li>➤ review &amp; approve Board policies as recommended by Governance Committee</li> </ul>	Complete
	<b>4k Fundraising</b>					
		The Board supports fundraising initiatives of the Foundation	2-A-30		<ul style="list-style-type: none"> <li>➤ review upcoming events reported through Directors ABCDE Goals</li> </ul>	Complete
	<b>4l Programs Required under the <i>Public Hospitals Act</i></b>					
	ii	ensure that policies are in place to encourage and facilitate organ procurement and donation		Quality	<ul style="list-style-type: none"> <li>➤ receive the annual Trillium Gift of Life Update</li> </ul>	Complete
iii	ensure that the Chief Executive Officer, Chief of Staff, nursing management, Medical/Professional Staff, and employees of the Hospital develop plans to deal with emergency situations and the failure to provide services in the Hospital		Quality	<ul style="list-style-type: none"> <li>➤ receive the annual Emergency Preparedness update</li> </ul>	Complete	
04-Feb-26	<b>4n Director Recruitment, Orientation, and Evaluation</b>					
		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		<ul style="list-style-type: none"> <li>➤ approve the members of the Nominating Sub-Committee &amp; Interview Team</li> </ul>	Complete
	<b>4c Corporate Performance</b>					
	ii	monitor, mitigate and respond to the principal risks		Quality	<ul style="list-style-type: none"> <li>➤ review critical incident reports (as per the Excellent Care for all Act)</li> </ul>	Complete
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	<ul style="list-style-type: none"> <li>➤ receive and review the Quality Monitoring Metrics</li> </ul>	Complete
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	<ul style="list-style-type: none"> <li>➤ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements</li> </ul>	Complete
	<b>4f Oversight of Medical/Professional Staff</b>					
	i	credential Medical/Professional Staff	1-C-13	MAC	<ul style="list-style-type: none"> <li>➤ make the final appointment, reappointment, and privilege decisions</li> <li>➤ ensure the effectiveness and fairness of the credentialing process</li> </ul>	Complete

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	
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➤ receive the MAC Report to the Board of Directors	Complete	
<b>4i Board Effectiveness</b>							
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➤ review & approve Board policies as recommended by Governance Committee	Complete	
04-Mar-26	<b>4b Strategic Planning</b>						
	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	<ul style="list-style-type: none"> <li>➤ review &amp; approve Annual Quality Improvement Plan (QIP)</li> <li>➤ review &amp; approve Hospital Service Accountability Agreement (HSAA)</li> <li>➤ review &amp; approve Multi-Sector Service Accountability Agreement (MSAA)</li> <li>➤ review &amp; approve Community Accountability Planning Submission (CAPS)</li> <li>➤ review &amp; approve Hospital Accountability Planning Submission (HAPS)</li> </ul>	Due	
	v	approving operating and capital plans	2-C-31	Resources	<ul style="list-style-type: none"> <li>➤ review &amp; approve the annual Operating Plan</li> <li>➤ review &amp; approve the Annual Capital Plan</li> </ul>	Due	
	<b>4c Corporate Performance</b>						
	ii	monitor, mitigate and respond to the principal risks		Quality	➤ review critical incident reports (as per the Excellent Care for all Act)	Due	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➤ receive and review the Quality Monitoring Metrics	Due	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➤ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	Due	
	<b>4f Oversight of Medical/Professional Staff</b>						
	i	credential Medical/Professional Staff	1-C-13	MAC	<ul style="list-style-type: none"> <li>➤ make the final appointment, reappointment, and privilege decisions</li> <li>➤ ensure the effectiveness and fairness of the credentialing process</li> </ul>	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	
	<b>4g Relationships</b>						
		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				<ul style="list-style-type: none"> <li>➤ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient &amp; Family Advisory Council Others as needed</li> </ul>	Due
	<b>4h Financial Viability</b>						

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	establish key financial objectives that support the Corporation's financial needs		Resources / Quality	➤ review & approve Annual Operating & Capital Plans - service changes, operating plan, capital plan, salary increases, material amendments to benefit plans, programs and policies	Due
<b>4k Fundraising</b>						
		The Board supports fundraising initiatives of the Foundation	2-A-30		➤ review upcoming events reported through Directors ABCDE Goals	Due
<b>4.c Corporate Performance</b>						
	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	
<b>4e Succession Planning</b>						
	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	
<b>4f Oversight of Medical/Professional Staff</b>						
	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	
<b>4g Relationships</b>						
		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	
<b>4i Board Effectiveness</b>						

06-May-26

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	
	<b>4k Fundraising</b>					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➤ review upcoming events ➤ reported through Directors ABCDE Goals	
June 3, 2026 (Generative Session)	<b>4a Corporate Culture</b>					
	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	
	<b>4b Strategic Planning</b>					
	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	
	<b>4c Corporate Performance</b>					
	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	
	<b>4f Oversight of Medical/Professional Staff</b>					
	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	
	<b>4h Financial Viability</b>					
	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	
	<b>4i Board Effectiveness</b>					
	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		

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
		<b>4n Director Recruitment, Orientation, and Evaluation</b>				
		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		<ul style="list-style-type: none"> <li>➤ review recommendations for new Directors, non-Director committee members</li> <li>➤ review the results of the annual evaluation surveys through the Governance Committee Report to the Board of Directors</li> </ul>	
		<b>4b Strategic Planning</b>				
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality Resources	<ul style="list-style-type: none"> <li>➤ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker</li> </ul>	
		<b>4c Corporate Performance</b>				
	ii	monitor, mitigate and respond to the principal risks		Quality	<ul style="list-style-type: none"> <li>➤ review critical incident reports (as per the Excellent Care for all Act)</li> </ul>	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	<ul style="list-style-type: none"> <li>➤ receive and review the Quality Monitoring Metrics</li> <li>➤ receive and review the Strategic Priorities Tracker</li> </ul>	
	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	<ul style="list-style-type: none"> <li>➤ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements</li> </ul>	
		<b>4f Oversight of Medical/Professional Staff</b>				
	i	credential Medical/Professional Staff	1-C-13	MAC	<ul style="list-style-type: none"> <li>➤ make the final appointment, reappointment, and privilege decisions</li> <li>➤ ensure the effectiveness and fairness of the credentialing process</li> </ul>	
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	<ul style="list-style-type: none"> <li>➤ receive the MAC Report to the Board of Directors</li> </ul>	
		<b>4g Relationships</b>				
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			<ul style="list-style-type: none"> <li>➤ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient &amp; Family Advisory Council Others as needed</li> </ul>	
		<b>4i Board Effectiveness</b>				
	iii	ensure ethical behaviour and compliance with laws and regulations, audit and accounting principles, accreditation requirements and the By-Laws		Audit	<ul style="list-style-type: none"> <li>➤ review &amp; receive the annual Audit Findings Report</li> <li>➤ review &amp; approve the year-end financial statements</li> </ul>	
		<b>4k Fundraising</b>				
		The Board supports fundraising initiatives of the Foundation	2-A-30		<ul style="list-style-type: none"> <li>➤ review upcoming events reported through Directors ABCDE Goals</li> </ul>	
		<b>4l Programs Required under the Public Hospitals Act</b>				

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	Ensure that an occupational health and safety program and a health surveillance program are established and regularly reviewed			➤ reported through annual attestations	
<b>4n Director Recruitment, Orientation, and Evaluation</b>						
		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	
<b>4a Corporate Culture</b>						
	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)	
<b>4b Strategic Planning</b>						
	i	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			➤ Strategic Plan: approve process, participate in development, approve plan - (last completed in 2022, will be done again in 2027)	
	iii	contributing to the development of and approving the mission, vision, values, and strategic plan of the Corporation				
<b>4d Chief Executive Officer and Chief of Staff</b>						
	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		
As Needed	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)	

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
<b>4j Effective Communication and Community Relationships</b>						
	i	establish processes for community engagement to receive public input on material issues	1-A-05 2-D-09		<ul style="list-style-type: none"> <li>➤ Post meeting agenda packages and minutes publicly on the CMH Website</li> <li>➤ review &amp; approve the Board policy 2-D-09 (last reviewed June 28, 2023)</li> </ul>	
	ii	promote effective collaboration and engagement between the Corporation and its community, particularly as it relates to organizational planning, mission, and vision			<ul style="list-style-type: none"> <li>➤ <a href="#">Strategic Plan</a></li> </ul>	
<b>4m Communications Policy</b>						
		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	<ul style="list-style-type: none"> <li>➤ review &amp; approve Board policy 2-D-11 every three years (last reviewed April 22, 2022)</li> </ul>	
<b>General</b>						
		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	<ul style="list-style-type: none"> <li>➤ review &amp; approve the Board of Directors Terms of Reference (last reviewed June 28, 2023)</li> </ul>	

**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)
<b>Board of Directors Regular Meetings</b>													
5:00pm - 9:00pm		1		3		4	4		6	24			
<b>Board Generative/Education Discussion Meetings</b>													
Hospital Integration (Generative Discussion)			5										
Governance (Generative Discussion)									3				
Fostering a Robust Emergency Preparedness Culture at CMH (Mini Education)						4							
<b>Board Committee Meetings</b>													
<b>Audit Committee</b> 5:00pm - 7:00pm			17		19			27	25				
<b>Digital Health Strategy Committee</b> 5:00pm - 7:00pm	18		20			19		16	21	18			
<b>Executive Committee</b> 5:00pm - 7:00pm			18				17		19				
<b>Governance &amp; Nominating Committee</b> 5:00pm - 7:30pm		9	13	11		12		9	14				
<b>Quality Committee</b> 7:00 am - 9:00am	17	15	19		21	18		15	20	17			
<b>Quality Committee QIP Meeting</b> 7:00 am - 9:00am						5							
<b>Resources Committee</b> 5:00pm - 7:00pm	22		24			23		27	25	22			
<b>Medical Advisory Committee (MAC)</b> 4:30pm - 7:00pm	10	8	12	10	14	11	11	8	13	10			
<b>CMHVA Board Meetings</b> 9:30am - 11:15am - In Person / Hybrid	3	1	5 20 AGM	3	7	4	4	1	6	3 18 AGM			
<b>CMHF Board Meetings</b> 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)
<b>Patient Family Advisory Council (PFAC)</b> 5:00pm - 7:00pm In Person / Hybrid	9	7	4	2	13	3	3		5	2			
<b>OHT Joint Board Committee</b> 5:30pm - 7:30pm - Virtual Zoom meeting	22	27	24	15	24								
<b>2025-26 Events</b>													
Staff Holiday Lunch 11:00am-2:00pm & 9:00pm-10:00pm				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 - February 9 5:00pm-7:00pm						9							
CMHF Diversity Dinner – CMH Celebration of Champions, Oriental Sports Club		22											
CMH Staff BBQ										11			
Career Achievement										11			
CMH Celebrate the Values						4							
CMH Golf Classic - Galt Country Club June 1										1			
CMHF Reveal 2026 - Starlight Serenade - Tapestry Hall						27							
Walk from Cambridge - Paris, hosted by Sara Alvarado										14			
Board Social - April 14 5:30-7:30 - Details to Follow								14					
<b>Board Education Opportunities</b>													
<b>Governors Education Sessions</b>													
Governance Essentials Program for New Directors (OHA)													
<i>Hospital Legal Accountability Framework</i>		16											
<i>Hospital Accountability Within the Health System</i>		23											
<i>Hospital Funding and Accountability</i>		28											
<i>Governance Management Partnership</i>			4										
<i>Current Issues and Emerging Themes</i>			11										

## BRIEFING NOTE

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**Date:** February 20, 2026  
**Issue:** Digital Health Strategy Committee Report to Board of Directors – February 19, 2026 – 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; & Sara Alvarado – Chair, Digital Health Strategy Committee

**Attachments/Related Documents:** None

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A meeting of the Digital Health Strategy Committee took place on Thursday, February 19, 2026 at 1700h.

**Present:** Sara Alvarado (Chair), Joel Campbell, Masood Darr, Miles Lauzon, Paul Martinello, Richard Niedart, Gloria Ringwood, Suzanne Sarrazin, Lynn Woeller  
**Regrets:** Jay Tulsani, Maryam Kazar, Dr. Winnie Lee  
**Staff:** Jen Backler, Trevor Clark, Diana Crawford, Patrick Gaskin, Mari Iromoto, Kyle Leslie, Stephanie Pearsall  
**Guests:** None

The Digital Health Strategy Committee completed its scheduled work for the February 19, 2026 reporting period. Key matters reviewed, discussed, and advanced by the committee are summarized below for Board awareness.

### **Committee Matters – For information only**

- Cyber Preparedness and Emergency Response:** CMH Management presented key highlights. The discussion focused on the following key areas: organizational phishing training, where employees automatically receive refresher training after clicking on phishing emails but face challenges in ensuring compliance and tracking completion; the use of RACI charts to capture roles and responsibilities for ongoing operations and cyber assessments; storing paper-based documentation electronically in the cloud-based HIS for off-site access during outages, which is under development; and making training a board-level metric, with CMH Management reporting the development of a tracking tool and dashboard to monitor executive compliance and ensure consistent training uptake.
- HIS Governance:** CMH Management provided the committee with key highlights. The HIS project organizational structure was shared, detailing leadership roles, committee, and council structures, CMH and WRHN team member resources, and project working groups. All CMH and WRHN executives, including CEOs, are members of project committees. CMH leaders actively participate in various meetings in preparation for go-live.
- Research and Innovation Plan – Highlights:** CMH Management presented key highlights of the plan. Priority themes are Innovation: Strategy and Governance; Ecosystem;

Culture; & Scale and Spread. Prioritization of human and financial resources among various projects is handled through the Research and Innovation Impact Committee, evaluating project value, feasibility, and strategic alignment. The next Innovation Showcase is at the end of March.

## BRIEFING NOTE

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**Date:** February 20, 2026  
**Issue:** Governance and Nominating Committee Report to the Board of Directors February 12, 2026 – OPEN  
**Prepared for:** Board of Directors  
**Purpose:**  Approval  Discussion  Information  Seeking Direction  
**Prepared by:** Stephanie Fitzgerald, Administrative Assistant  
**Approved by:** Julia Goyal, Governance and Nominating Committee, Patrick Gaskin, President & CEO

**Attachments/Related Documents:** None

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A meeting of the Governance and Nominating Committee took place on Thursday, February 12, 2026 at 1700h.

**Present:** Julia Goyal (Chair), Tom Barker, Jayne Herring, Roger Ma, Milena Protich, Diane Wilkinson, Lynn Woeller (ex-officio)

**Regrets:** None

**Staff:** Patrick Gaskin, Stephanie Pearsall, Dr. Winnie Lee (ex-officio)

**Guests:** Mohammad Baseer, Brad Ratz

The Governance and Nominating Committee completed its scheduled work for the February 12, 2026 reporting period. Key matters reviewed, discussed, and advanced by the committee are summarized below for Board awareness.

### **Committee Matters – For information only**

1. **CMH Board Relationship Management Tool:** The committee reviewed, for discussion, an update to the Board Relationship Management Tool, which is intended to support a structured and risk-informed approach to Board-level external relationships.

Through discussion, the committee provided specific direction to refine the tool, including clarifying the scope of municipal relationships to encompass full City Council and senior administrative leadership, adding provincial representation where appropriate, and recognizing the relevance of regional governance bodies in system planning and development matters. The committee also reinforced the importance of clearly distinguishing relationships requiring governance-level oversight from those more appropriately managed operationally, to ensure Board focus remains aligned with strategic value and capacity.

Outcome: The Committee reached consensus on refinements to be incorporated and directed management to update the tool and return with a refined analysis of priority relationships at a future meeting.

2. **Governance Policy Review and Recommendations:** As part of its regular policy review cycle, the committee reviewed several governance policies to ensure continued alignment with legislative requirements, best practices, and the

Hospital's by-laws. The committee reviewed and discussed clarity of language, consistency of terminology, and appropriateness of roles and responsibilities.

The committee recommended approval of four governance policies with amendments and deferred one policy (Annual Declaration and Consent) for further refinement due to the need for clearer articulation of conflicts of interest, affiliations, and statutory consent requirements.

Outcome: Recommended policies have been advanced to the Board for approval. The deferred policy will be returned to the committee following further development.

*(This item is included in the consent agenda item 1.5.7 for Board approval)*

3. **Board and Committee Effectiveness Monitoring:** The committee reviewed and discussed the results of Board and committee feedback surveys. Discussion focused on participation rates, interpretation of results, and contextual factors influencing engagement. The committee reaffirmed the importance of governance feedback mechanisms as part of ongoing Board and committee effectiveness monitoring.

Outcome: The committee will continue to monitor the completion rate and survey results to inform the governance improvement efforts.

4. **OHA Governance Compliance Update – “Ten Tips for Hospital Governance Compliance”:** The committee reviewed and discussed the OHA's Ten Tips for Hospital Governance Compliance as part of its ongoing governance oversight and continuous improvement responsibilities. The committee considered the guidance as a high-level compliance and assurance tool rather than a prescriptive checklist and discussed how CMH's current governance practices align with the intent of the recommendations.

The committee noted that CMH demonstrates strong alignment, particularly in areas related to Board roles and responsibilities, committee structure, policy oversight, and separation of governance and management accountabilities. Discussion focused on a small number of areas identified as opportunities for refinement rather than material gaps. These included record retention and documentation practices for Board and committee materials, clarity, and consistency in how consent agenda items are documented, and whether additional guidance would be helpful regarding expectations for virtual meeting participation and etiquette. The committee discussed that several of these items are largely procedural in nature and do not represent governance risk, while others may warrant further consideration to strengthen clarity and consistency over time.

The committee agreed that not all Ten Tips require immediate action and that a prioritization approach is appropriate. The committee also emphasized that the guidance should be used to support continuous improvement rather than reactive compliance.

Outcome: The committee agreed to retain oversight of the Ten Tips review, with further discussion and prioritization to occur at a future meeting. This item remains at the committee level at this time and is provided to the Board for awareness and assurance only.

### Summary

Through its February 12, 2026 meeting, the Governance and Nominating Committee exercised oversight of governance practices, policy stewardship, Board effectiveness, and governance education.. The committee provided direction where refinement was required, advanced recommendations to the Board where appropriate.

## BRIEFING NOTE

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**Date:** February 11, 2026  
**Issue:** MAC Report to the Board of Directors – February 11, 2026  
**OPEN**  
**Prepared for:** Board of Directors  
**Purpose:**  Approval  Discussion  Information  Seeking Direction  
**Prepared by:** Dr. Winnie Lee, Chief of Staff  
**Approved by:** Dr. Winnie Lee, Chief of Staff

**Attachments/Related Documents: None**

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A meeting of the Medical Advisory Committee took place on Wednesday, February 11, 2026 at 1700h.

**Present:** Dr. W. Lee, Dr. J. Legassie, Dr. A. Sharma, C. Witteveen, Dr. J. Bourgeois, Dr. B. Courteau, Dr. A. Nguyen, Dr. T. Holling, Dr. L. Green, Dr. J. Gill, Dr. A. Mendlowitz, Dr. I. Isupov, Dr. V. Miropolsky, Dr. Yu Ming Wang,

**Regrets:** Dr. M. Rajguru, Dr. M. Hindle, Dr. E. Thompson, Dr. M. Patel, Dr. R. Shoop

**Staff:** P. Gaskin, M. Iromoto, Dr. K. Rhee, Dr. K. Nuri

**Guests:** B. Conway

The Medical Advisory Committee completed its scheduled work for the February 11, 2026 reporting period. Key matters reviewed, discussed, and advanced by the committee are summarized below for Board awareness.

### **Committee Matters – For information only.**

#### **1. Clinical Standardization, Alignment with Guidelines and Safety Risk Mitigation:**

Standardizing clinical practice and ensuring alignment with current standards is necessity in a high-complexity environment to minimize variation and ensure best-practice. The M&T Committee report highlighted several areas that aimed to achieve this:

- (a) Align policies with Accreditation Canada's new Required Safety Practices (RSPs), supported by education (i.e. Grand Rounds) or e-learning modules to ensure ongoing compliance with accreditation standards. This includes updates to Policy 5-12 (VTE prevention) and Policy 12-10 (Corporate Abbreviation).
- (b) Standardization of calcium gluconate intermittent dosing for neonates to ensure alignment with IV pumps and monographs. This also reduces clinical practice variations.
- (c) Code Blue Medical Directive updates to align with 2025 ACLS guidelines and RACE Medical Directives reference updates.

**2. National Leadership in High-Value Care - Choosing Wisely Canada (CWC):** Fostering a culture of high-value care is essential for both patient safety and organizational sustainability. CMH's journey, which began with *Choosing Blood Wisely* in November 2023 and progressed to *Choosing Lab Wisely* in late 2024, and *Quality Improvement* status in August 2025 is now focused on achieving national *Leadership Status*.

CMH's leadership in Choosing Wisely was recently validated during the CWC national abstract submission process. Of the numerous submissions received, all three CMH abstracts were accepted by CWC. The topics include antibiotic stewardship; environmental sustainability initiatives in endoscopy (to be delivered as a webinar on February 25, 2206); and a presentation/workshop at the annual CWC conference in May 2026 addressing the cultivation of a high-value CW culture through governance and organizational engagement. These acceptances establish a strong presence for CMH at this year's CWC conference.

Additional highlights from CW projects underway at CMH was shared, including:

- **Laboratory Stewardship:** Achieved an 80% reduction in ESR (Erythrocyte Sedimentation Rate) utilization.
- **Clinical Specialty Projects:** The elimination of unnecessary peritoneal fluid cultures in the Regional Liver Health Clinic.
- **Appropriateness Tools:** Incorporation of CWC guidelines in Ocean eReferrals to ensure imaging requests are appropriate and provided at the right place or time.

**3. A Spotlight on Hospitalist Medicine and Diagnostic Imaging:** The MAC received updates from the Hospitalist Medicine and Diagnostic Imaging Department, which showcased the high-quality work taking place in both areas.

***Hospitalist Medicine:*** The presentation described a robust hospital medicine team consisting of 13 full-time and 4 part-time physicians who provide comprehensive daily coverage throughout the year. Recent staffing additions have allowed for enhanced support for Alternate Level of Care (ALC) patients. While staffing levels remain stable, the team is encountering increasing patient complexity rather than simply higher patient volumes. Challenges include a rise in community-based MRSA cases requiring vancomycin management, elderly unhoused patients facing unsafe discharge options, increased substance use among various age groups, and an overall trend toward greater medical complexity. Recognizing that increasing workload is not a sustainable solution, the team is instead prioritizing innovative approaches—such as strengthening health equity education, cultivating partnerships (including direct admissions and collaborative skill-sharing like tPA chest tube management), improving communication and care continuity, reducing length of stay and antibiotic overuse, and streamlining discharge processes. Key priorities encompass fostering resilience, enhancing multidisciplinary support, optimizing transitions of care, and implementing creative system redesigns to effectively manage complex discharges while upholding quality and fiscal responsibility.

***Diagnostic Imaging:*** This presentation highlighted the Diagnostic Imaging (DI) department's strategic growth, quality initiatives, and alignment with the organization's clinical services plan. Despite being a small and nimble team, DI plays a critical backbone role across the hospital, supporting expanding programs such as the Regional Liver Clinic by embedding ultrasound services directly into the clinic footprint to improve patient experience and reduce repeat visits. Major achievements include completion of the MRI procurement process, expansion of OBSP breast screening, upgrades in nuclear medicine with new SPECT-CT technology to improve resilience during CT downtimes, and leadership in provincial e-referral and the Central Intake model for diagnostic imaging. The department has experienced a 12.5% year-over-year growth in imaging volumes while maintaining access and turnaround times through cross-training, operational redesign, and strategic reinvestment of generated revenue. Looking ahead to 2026, priorities include operationalizing the new MRI, planning for a second CT, advancing quality with ISO 15189 accreditation through Accreditation Canada, HIS integration, and continuing to strengthen culture, engagement, and financial sustainability. These strategies will ensure that DI continues to serve as an innovative, high-quality, and resilient clinical backbone for the hospital and broader community.

**4. Addressing Fiscal Stewardship and Strategic Outlook:** CMH is projecting a balanced budget for 2026-2027 despite sector-wide financial pressures. For CMH, this pressure includes a 2% funding model next year which will be lower than prior projections. As well, in a post-capital redevelopment phase, CMH must balance financial constraints with proactive risk management. The hospital has initiated a new master plan to address population growth and program expansion, ensuring that long-term vision is not sacrificed for short-term fiscal pressures. This work allows the organization to take a proactive approach and ensures coordination and alignment with broader planning efforts throughout Waterloo region. CMH's recent recognition as a Forbes top employer was celebrated.

**5. Supporting Physician Leadership Development:** The hospital is committed to developing the next generation of medical leaders to navigate the fiscal and relational complexities, as identified in this report. A new Ontario Hospital Association (OHA) Physician Leadership Program was shared titled *Navigating Healthcare Complexity with Confidence*. It is a series of three virtual sessions scheduled for April, May, and June 2026 covering the topics of legal accountabilities, financial accountabilities of hospitals and relational dynamics. Leaders were encouraged to attend the program and share their learnings with MAC.

The February MAC session highlighted significant initiatives aimed at ensuring CMH remains innovative and focused on excellence. The work of MAC is grounded in medical quality, safety and well-being of the community we serve.

## BRIEFING NOTE

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**Date:** February 11, 2026  
**Issue:** New Credentialed Physicians – January 2026  
**Prepared for:** Board of Directors  
**Purpose:**  Approval  Discussion  Information  Seeking Direction  
**Prepared by:** Dr. Winnie Lee, Chief of Staff  
**Approved by:** Dr. Winnie Lee, Chief of Staff

**Attachments/Related Documents: None**

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A meeting of the Medical Advisory Committee took place on Wednesday, February 11, 2026 at 1700h.

**Present:** Dr. W. Lee, Dr. J. Legassie, Dr. A. Sharma, C. Witteveen, Dr. J. Bourgeois, Dr. B. Courteau, Dr. A. Nguyen, Dr. T. Holling, Dr. L. Green, Dr. J. Gill, Dr. A. Mendlowitz, Dr. I. Isupov, Dr. V. Miropolsky, Dr. Yu Ming Wang

**Regrets:** Dr. M. Rajguru, Dr. M. Hindle, Dr. E. Thompson, Dr. M. Patel, Dr. R. Shoop

**Staff:** P. Gaskin, M. Iromoto, Dr. K. Rhee

**Guests:** B. Conway

### Executive Summary

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

1. Dr. Dorcas Yan, Hospital Based Medicine (Associate)
2. Dr. Maaz Shanjer, Emergency Medicine (Associate)
3. Dr. Menachem Loewenthal, Emergency Medicine (Associate)
4. Dr. Raphael Hanna, Surgery, Regional ENT (Courtesy with Admitting)

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

## BRIEFING NOTE

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**Date:** February 27, 2026  
**Issue:** Resources Committee Report to Board of Directors February 23, 2026 – 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

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A meeting of the Resources Committee took place on Monday, February 23, 2026 at 1700h.

**Present:** Paulo Brasil (Chair), Sara Alvarado, Amanda Forrest, Julia Goyal, Monika Hempel, Shannon Maier, Diane Wilkinson, Lynn Woeller

**Regrets:** Janet Richter

**Staff:** Trevor Clark, Michelle D'Souza, Patrick Gaskin, Kyle Leslie, Stephanie Pearsall, Dr. Kunuk Rhee, Valerie Smith-Sellers,

**Guests:** None

The Resources Committee completed its scheduled work for the February 23, 2026 reporting period. Key matters reviewed, discussed, and advanced by the Committee are summarized below for Board awareness.

### Committee Matters – For information only

- 1. Strategic Priorities Q3 Update:** Management provided an overview of the progress of the strategic priorities for Q3, highlighting key challenges and accomplishments. Questions were entertained, and management confirmed that the discrepancy in the presentation of ambulance offload times between the Trailing 12 Month Trend and the Q3 data was not an error and was a result of the use of different data timelines. The Committee received the overview with no comments or concerns. *(Further information provided in consent agenda item 1.5.8)*
- 2. January 2026 Financial Statements and Year-End Forecast:** Management presented the January 2026 financial statements, reflecting a \$7.5M year-to-date surplus and forecasting a \$3.5M year end surplus, for acceptance by the Resources Committee. Questions were entertained and management confirmed that the hospital is not permitted to record additional PCOP revenue over the maximum allocation amount. The decrease of \$427K in Inpatient Mental Health revenue was due to decreased volume. Although the unit has not been fully occupied throughout 2025-26, and despite surge across other areas of the hospital, patients could not be reallocated from other units due to lack of required staff skillset. *(Further information provided in agenda item 4.3.1)*

# BRIEFING NOTE

**Date:** February 13, 2026  
**Issue:** Policy Review  
**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: Final Draft Policies for Approval**

**Recommendation/Motion**

*Board*

That, the CMH Board of Directors approves the following policies as presented/with amendments and upon recommendation of the Governance and Nominating Committee at its meeting of February 12, 2026.

2-A-36	<i>Board and Committee Attendance Policy</i>
2-D-06	<i>Board and Meeting Agenda Presentation</i>
2-A-30	<i>Responsibilities of a Director</i>
2-A-32	<i>Responsibilities of a Non-Director</i>

**Governance and Nominating Committee**

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

2-A-36	<i>Board and Committee Attendance Policy</i>
2-D-06	<i>Board and Meeting Agenda Presentation</i>
2-A-30	<i>Responsibilities of a Director</i>
2-A-32	<i>Responsibilities of a Non-Director</i>

**Background**

These policies were pre-circulated to the Governance & Nominating Committee (GNC) through a new policy review process designed to accommodate the considerable number of policies up for renewal this year. GNC members were provided with key factors to consider and supplementary rationale for each policy.

Attached to this briefing note is a clean version of the final draft of each policy. CMH leadership and the GNC have considered the feedback as well as audited the policies against the guidance of the most recent version of the OHA's Guide to Good Governance.

**GNC Reviewed Policies**

*\*These policies have undergone thorough review by the most relevant committee where applicable and the GNC. None of them involve significant process changes.*

Policy No.	Policy Name	Rationale
2-A-36	Board and Committee Meeting Attendance	This policy has been updated to include additional guidance provided in the sample form included in the GtoGG. (Form 8.16) and feedback from the

Policy No.	Policy Name	Rationale
2-D-06	Board Meeting Agenda Preparation	November 13, 2025, and February 12, 2026, GNC meeting. This policy was updated to provide clearer guidance when using the consent agenda. (Part of the GNC action log) *Note – this policy was adapted using sample forms included in the GtoGG (Form 8.13 & 8.14) and updated to include feedback from the November 13, 2025, and February 12, 2026, GNC meeting.
2-A-30	Responsibilities of a Director	This policy has been updated to include a process step that requires Directors to report any changes in response to the annual declaration of consent during the current Board year. This aligns with policy 2-D-22 and updated to include feedback from the February 12, 2026, GNC meeting.
2-A-32	Responsibilities of a Non-Director	This policy has been updated to include a process step that requires non-Directors to report any changes in response to the annual declaration of consent during the current Board year. This aligns with policy 2-D-22 and updated to include feedback from the February 12, 2026, GNC meeting.

**BOARD MANUAL**

<b>SUBJECT: Board and Committee Meeting Attendance Policy</b>	<b>NO.: 2-A-36</b>
<b>SECTION: Structure, Roles and Responsibilities</b>	
<b>APPROVED BY: Board of Directors</b>	<b>DATE: TBD</b>

**Purpose**

To ensure that the Directors and non-Directors committee members contribute their expertise and judgement to the business and affairs of Cambridge Memorial Hospital by attending and participating in Board and committee meetings.

**Application**

This policy applies to all Directors and non-Directors committee members. This policy does not apply to Directors who are *ex officio* members of the Board and/or committees.

**Policy**

Directors are expected to attend all Board meetings, all Board generative and education sessions, and all meetings of the committees to which they are assigned.

Non-Directors are expected to attend all meetings of the committees to which they are assigned as well as any committee-related education sessions.

It is recognized that Directors and non-Directors may be unable to attend some meetings due to conflicts with other commitments or other unforeseen circumstances. An attendance rate of at least 75% is acceptable.

All Directors and non-Directors are required to attend the Board /committee orientation sessions.

**Process – Board Meetings**

1. Where a Director fails to attend 75% of the meetings of the Board (including Board generative / education sessions) in a 12-month period, or is absent for three consecutive meetings, the Board Chair shall discuss the reasons for the absences with the Director.
2. The Board Chair shall, at the Chair’s sole discretion, determine if the Director’s absences are excusable. The Board Chair may grant the Director a limited period to rearrange their schedule so that there are no conflicts with regularly scheduled meeting.
3. If the Director is unwilling or unable to meet the attendance requirements, the Board Chair shall ask the Director to resign. If the Director does not resign, the Board Chair may recommend termination which will be done in accordance with policy 2-D-45, Removal of a Director, Officer or Committee Member.

4. The Director's record of attendance shall be considered with respect to renewal of a Board term or future assignment to a committee.
5. The Board Chair will communicate with the Chair of the Governance & Nominating Committee on any absence related issues.
6. If the attendance matter relates to the Board Chair, the Vice Chair shall perform the duties of the Board Chair described in steps 1 to 6 above.

### **Process – Committee Meetings**

1. Where a committee member fails to attend 75% of the meetings of a committee to which the individual is assigned in a 12-month period, the committee Chair shall discuss the reasons for the absences with the committee member directly and may consult with the Chair of the Governance & Nominating Committee on this matter.
2. Where a committee member is absent for 3 consecutive committee meetings (or 2 consecutive meetings when a committee meets fewer than 6 times a year), the committee Chair shall discuss the reasons for the absences with the committee member directly and may consult with the Chair of the Governance & Nominating Committee on this matter.
3. The committee Chair shall determine if a committee member's absences are excusable. The committee Chair may choose to consult with the Chair of the Governance and Nominating Committee in making such determination. The committee Chair may grant a committee member a limited period to rearrange their schedule so that there are no conflicts with regularly scheduled meetings,
4. If the committee member is a Director and the Director is unwilling or unable to meet the attendance requirements, the matter shall be referred to the Board. If the issue is with a non-Director, the committee chair shall ask the non-Director committee member to resign. If the non-director committee member does not resign, the Board shall be asked to revoke the membership of such non-director committee member.
5. In circumstances where a committee Chair has failed to attend meet the attendance requirements of the committee, the Board chair shall be responsible for the steps outlined above.

<b>DEVELOPED: March 30, 2011</b>		
<b>REVISED/REVIEWED:</b>		
February 26, 2014	September 28, 2016	September 25, 2019
September 28, 2022	Click or tap to enter a date.	Click or tap to enter a date.
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

## BOARD MANUAL

<b>SUBJECT: Board Meeting Agenda Preparation</b>	<b>NO.: 2-D-06</b>
<b>SECTION: Board Process</b>	
<b>APPROVED BY: Board of Directors</b>	<b>DATE: TBD</b>

### Purpose

To ensure that Board members understand the process for the development of, and have an opportunity to have input into, the Board's meeting agenda.

### Policy

The Board Chair, in consultation with the President and Chief Executive Officer (CEO), develops the agenda for Board meetings.

### Procedure

1. The Board Chair and CEO meet to prepare the agenda for a Board meeting approximately 10 days before the meeting. In advance of that meeting, Board members may contact the Board Chair to request an item for the Board agenda. If the Board Chair does not agree to include the item in the Board agenda, then the Board member may raise the request during the call for other business or approval of the agenda at the opening of the Board meeting, and the matter shall be determined by the Board.
2. The agenda, together with supporting materials, is distributed to Board members at least two business days before the Board meeting.
3. At the opening of the Board meeting, Board members may request an item to be added to the agenda.
4. The Board approves the agenda, as circulated or amended, at each meeting.

### Consent Agenda

#### Purpose

The purpose of the consent agenda is:

- To promote efficiency and effectiveness of Board meetings, and
- To provide an efficient process for approval of regular or routine issues that come before the Board or matters where no debate or discussion is anticipated.

## Policy

Efficient meeting management is essential for effective governance and decision-making processes. To streamline deliberations, this policy establishes guidelines for the use of consent agenda matters. Consent agenda items are those that are routine or recurring in nature or where no debate is anticipated, such as verification of minutes from previous meetings, certain administrative reports, and other procedural motions. The purpose of a consent agenda is to expedite the Board's/committee's business by allocating more time for substantive matters requiring detailed discussion.

### Consent Agenda Procedure

1. The Chair, in consultation with the CEO/VP, identifies the items for inclusion in the consent agenda for each Board/committee meeting.
2. Consent items and supporting documents are clearly identified and included in the agenda package.
3. Board/committee members are expected to review these materials before the meeting.
4. The consent agenda states: "Any Board/Committee member may request that any item be removed from this consent agenda and moved to the regular agenda."
5. At the beginning of the meeting, the Chair asks members what items they wish to be removed from the consent agenda and discussed individually. Any member may request that an item be removed from the consent agenda.
6. Any member may request a correction to an item in the consent agenda. The Chair determines whether to remove the item or permit the amendment to the item.
7. If one item in a committee or other report is requested to be moved to the regular agenda, that item is moved. The rest of the items in that committee or other report remain on the consent agenda.
8. When an item has been removed, the Chair decides its placement on the agenda.
9. When there are no more items to be removed, the Chair confirms the remaining consent items. The Chair seeks a motion to approve the consent agenda items and, upon approval, the Chair declares the consent business to be approved.
10. The consent agenda motion is documented in the Board meeting minutes and includes the full text of resolutions or recommendations adopted and references to reports or other matters received.

### Common Consent Agenda Items

Items included in the consent agenda are at the discretion of the Chair. Examples of common consent agenda items may include but are not limited to:

- Minutes of Previous Meetings: Approving the minutes from the last Board meeting.
- Committee Reports: Reports from committees that are intended to inform the Board of work completed on its behalf.
- Executive Reports: Executive reports that provide information without requiring a vote or decision.
- Information Reports: Reports that provide information without requiring a vote or decision.

- By-laws: Amendments or updates to by-laws that have been previously reviewed and recommended by a Board committee.
- Correspondence: Letters or communications that require no Board action or have already been addressed or reviewed through an appropriate committee or process.
- Routine Financial Reports: Regularly presented financial reports that have been reviewed and recommended by the Resources Committee.
- Routine Policy Approvals: Updates to existing policies that have been reviewed and recommended by the Governance and Nominating Committee.

DEVELOPED: February 22, 2012		REVISED/REVIEWED:
May 25, 2016	October 17, 2018	November 24, 2021
May 1, 2024	Click or tap to enter a date.	Click or tap to enter a date.
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

**BOARD MANUAL**

<b>SUBJECT: Responsibilities of a Director</b>	<b>NO.: 2-A-30</b>
<b>SECTION: Structure, Roles and Responsibilities</b>	
<b>APPROVED BY: Board of Directors</b>	<b>DATE: TBD</b>

**Responsibilities**

As a member of the Board, and in contributing to the collective achievement of the role of the Board, each Director shall be responsible for the following:

**Fiduciary Duties**

As a fiduciary of the Corporation, a Director acts honestly and in good faith with a view to the best interests of the Corporation, and exercises the care, diligence, and skill that a reasonably prudent person would exercise in comparable circumstances. In so doing, a Director supports the Board in fulfilling its mission and discharging its responsibilities. All Directors, including ex-officio Directors, are held to the same duties and standard of care.

A Director does not represent the specific interests of any constituency or group. A Director acts and makes decisions that are in the best interest of the Corporation as a whole.

**General**

Each Director shall:

- understand the difference between oversight and management, respecting the responsibilities delegated by the Board to the CEO and the Chief of Staff
- comply with the Policy 1-A-04 Board’s Code of Conduct
- comply with the Policy 2-A-03 Board Conflict of interest Policy and Article 5 of the Corporation By-law
- respect the confidentiality of matters brought before the Board and all committees
- always support the Board’s decisions and policies even if the Director holds another view or voiced another view during the Board discussion or was absent from the Board meeting
- comply with the Board and Corporation policies that are applicable to the Board
- advise the Chair of the Governance and Nominating Committee and the CEO of any changes to responses provided on the Annual Declaration of Consent during the current Board year, as well as any changes in employment that may be perceived as a potential conflict of interest.

**Contribution to Governance**

Each Director shall:

- read materials in advance of meetings and come prepared to contribute to discussions

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Board Manual 2-A-30  
Cambridge Memorial Hospital  
TBD

- offer constructive contributions to Board and committee discussions
- contribute special expertise, skills and attributes
- respect the role and terms of references of the Board and Board committees
- participate in the Board evaluation processes

### **Attendance and Availability for Board and Committees**

Each Director shall:

- commit the necessary time for Board meetings, committee meetings and Board education in accordance with the Policy 2-A-36, Board and Committee Meeting Attendance Policy
- serve as an active member of at least one committee and contribute to its purpose
- when absent, record their dissent to any action of the Board or its committees in accordance with the requirement in Article 4.9 of the Corporation's Corporate By-law

### **Communication and Interaction**

Each Director shall:

- work positively, cooperatively and respectfully with all members of the Board and the management team
- promote a welcoming and inclusive environment
- participate fully and frankly in the deliberations and discussions of the Board
- demonstrate an openness to other people's opinions and the willingness to listen
- have the confidence and will to make tough decisions, including the strength to challenge the majority view
- advise the Chair in advance when introducing significant and/or previously unknown information or material at a Board meeting

### **Community Representation**

Each Director shall:

- not speak on behalf of the Board and the Hospital in the community unless asked to do so by the Board Chair in keeping with Policy 2-D-11, Communications Policy and Article 10.2 of the Corporate Bylaw regarding Board spokesperson
- align their public views with the Hospital's position.

### **CMH Foundation (CMHF)**

Each Director shall:

- financially support the work of the Foundation on an annual basis, when possible
- attend events to represent CMH, when asked by CMHF/CMH and available (attendance at which is paid for by CMHF or CMH)
- attend, when possible, events sponsored by the CMHF (self-paid)

### **Goals Setting**

As per Policy 1-A-05, Board Statement on Culture, as a member of the Board, each Director shall set, in collaboration with the Board Chair, annual personal development goals and report on the performance related to these goals in the following categories:

- Attend – attend Board and committee meetings
- Be engaged – be an active contributor to the committee and Board work

Responsibilities of a Director  
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TBD

- Connect – attend staff huddles and events
- Donate – support the CMH Foundation
- Educate – undertake education and courses

**Knowledge**

Recognizing that decisions can only be made by well-informed Directors, each Director shall participate in Board and committee orientation, Board education and other education sessions in accordance with Board Policy 2-D-32 and understand:

- the Corporation's strategic direction
- the current provincial, regional, and local health care environment
- the role and responsibilities of the Board and a Director
- the key performance indicators for Board oversight of the Corporation

**Appointment and Term**

A Director is elected for a three-year term. An elected Director may not serve for more than nine consecutive years.

**Conclusion of Term**

Upon conclusion of service the Director shall return all items and materials, delete all electronic materials as requested by the Corporation, and confirm compliance with these activities as instructed by the CEO.

<b>DEVELOPED: February 23, 2011</b>		
<b>REVISED/REVIEWED:</b>		
November 28, 2012	June 25, 2014	November 26, 2014
January 24, 2018	November 25, 2020	May 26, 2021
October 2, 2024	Click or tap to enter a date.	Click or tap to enter a date.

## BOARD MANUAL

<b>SUBJECT: Responsibilities of Non-Directors on Board Committees</b>	<b>NO.: 2-A-32</b>
<b>SECTION: Structure, Roles and Responsibilities</b>	
<b>APPROVED BY: Board of Directors</b>	<b>DATE: TBD</b>

In accordance with the Corporation’s Corporate By-Law, the Board may appoint additional individuals to Board committees who are not Directors. These individuals are referred to as “non-director committee members”. Non director committee members are entitled to vote at the committee to which they are assigned, except in the case of Audit Committee, where they do not vote, nor count towards quorum for the meeting.

### Role

A non-director may be appointed to a Board committee to contribute one or more of the following:

- special expertise, skills and attributes
- the perspective of a member of the community
- valuable experience as a former Director, and/or
- skills and knowledge for consideration as a potential future Director.

### Responsibilities

#### General

The non-director committee member shall:

- attend and participate at meetings of the Board committee to which the non-director is appointed.
- vote at meetings of the Board committee to which the non-director is appointed, except in the case of the Audit Committee.
- comply with the Policy 1-A-04 Board’s Code of Conduct.
- comply with the Policy 2-A-03 Board Conflict of Interest Policy and Article 5 of the Corporation’s Corporate By-Law.
- in the case of all committees except Audit Committee, always support the committee’s decisions and policies even though the individual holds another view or voiced another view during the discussion or was absent from the meeting.
- respect the confidentiality of matters brought before the Board committee.
- comply with the applicable Board and Corporation policies that are applicable to the Board.
- advise the Chair of the Governance and Nominating Committee and the CEO of any changes to responses provided on the Annual Declaration of Consent during the current Board year, as well as any changes in employment that may be perceived as a potential conflict of interest.

#### Contribution to Committee Business

Non-director committee members shall:

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Cambridge Memorial Hospital  
TBD

- read materials in advance of meetings and coming prepared to contribute to discussions
- offer constructive contributions to committee discussions
- contribute special expertise, skills and attributes
- respect the role and charter of the Board committee, and
- participate in annual Board evaluation processes.

### **Attendance and Availability**

Each non-director committee member shall:

- commit the time required to perform committee duties and attend relevant education sessions in accordance with the Board attendance policy, and
- participate in relevant orientation session(s).

### **Communication and Interaction**

Each non-Director committee member shall:

- work positively, cooperatively and respectfully with all members of the Board committee and the management team;
- participate fully and frankly in the deliberations and discussions;
- demonstrate an openness to others' opinions and the willingness to listen;
- have the confidence and will to make tough decisions, including the strength to challenge the majority view, and
- where possible, advise the chair in advance when introducing significant and/or previously unknown information or material at a committee meeting.

### **Community Representation**

Each non-Director committee member shall

- not speak on behalf of the Board and the Hospital in the community unless asked to do so by the Board Chair (see the communications policy regarding Board spokesperson).
- align their public views with the Hospital's position.

### **Appointment and Term**

The Board of Directors appoints non-Director committee members for a one-year term. The non-Director committee members may be reappointed for successive one-year terms.

### **Conclusion of Term**

Upon conclusion of service the non-Director shall return all items and materials, delete all electronic materials as requested by the Corporation and confirm compliance with these activities as instructed by the CEO.

<b>DEVELOPED: February 23, 2011</b>		
<b>REVISED/REVIEWED:</b>		
November 28, 2012	September 30, 2015	November 25, 2020
May 26, 2021	June 28, 2023	Click or tap to enter a date.
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# BRIEFING NOTE

**Date:** February 19, 2026  
**Issue:** Strategic Priorities Q3 Update  
**Prepared for:** Board of Directors  
**Purpose:**  Approval  Discussion  Information  Seeking Direction  
**Prepared by:** Kyle Leslie, Director Analytics, Innovation and CIO  
**Approved by:** Mari Iromoto, VP People and Strategy  
 Trevor Clark, VP Finance, Corporate Services and CFO

**Attachments/Related Documents: Appendix A – Strategic Priorities Tracker**

**Alignment with 2025/26 CMH Priorities:**

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

**Executive Summary**

This briefing note provides an in-depth overview of our performance during Quarter 3 (Q3) of fiscal year 2025/26, highlighting notable achievements alongside ongoing challenges in patient flow and staffing/overtime management.

**Background**

The Strategic Priorities Tracker aligns key organizational priorities derived from the Quality Improvement Plan (QIP), Integrated Risk Management (IRM) process, and our strategic plan.

This tool ensures that our priorities are coordinated and provides performance insights through various monitoring channels, including weekly operations huddles, flow meetings, staffing overtime task force meetings, and departmental Quality and Operations councils.

Key tools for performance monitoring in 2025/26 include:

- Strategic Priorities Tracker:** Monitors critical in-year priorities identified via the QIP, IRM process, and strategic plan.
- Quality Monitoring Scorecard:** Tracks key quality metrics monthly to ensure sustained performance.
- 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 Q3 performance, including key highlights from our action plans; full details can be found in **Appendix A**:

### 1. Elevate Partnerships in Care (Oversight by Quality Committee):

- **Ambulance Offload Time (Minutes) - 90th%tile (Not-Meeting Target):**
  - Target: ≤43 minutes, Q3 Performance: 49 minutes, this time is still an improvement from where we were last fiscal year, however an increase from Q2.

#### **Actions Taken:**

- Collaborated closely with EMS and regional partners to align on definitions related to ambulance offload times.
- Conducted ongoing biweekly meetings with EMS for continued coordination and communication.

#### **Actions Planned for Next Quarter:**

- Collaborated closely with EMS and regional partners to align on definitions related to ambulance offload times.
- Conducted ongoing biweekly meetings with EMS for continued coordination and communication.

- **Provider Initial Assessment in ED (Hours) - 90th%tile (Not-Meeting Target):**
  - Target: <4.6 hours. Q3 Performance: 7.5 hours, slightly better than Q3 performance which was 7.6 hours.
- **Provider Initial Assessment Urgent CTAS 1-2 (Hours) - 90th%tile (Not-Meeting Target):**
  - Target: <4 hours. Q3 Performance: 6.3 hours, this is an improvement from Q2 performance of 6.5 hours

#### **Actions Taken:**

- Reviewed policies from regional partners to guide improvements.
- Completed a program review with input from Unity Health ED physicians.
- Provided ongoing training to develop nursing competency across multiple areas.
- Held regular bi-weekly meetings for ED leadership to monitor and address concerns and barriers that delay patient assessment.
- Educated the department on P4R metrics and their impacts during departmental meetings.

#### **Actions Planned for Next Quarter:**

- Finalize and share the Surge Plan Policy.
- Review priority items and recommendations from Unity Health ED physicians and develop an action plan.
- Continue bi-weekly ED leadership meetings to identify and mitigate risks and issues.
- Schedule NP coverage on high-volume days to influence improved metrics in provider initial assessment (PIA).

- **Average Admission in ED at 8 AM (Not-Meeting Target):**

- Target: <10 patients held at 8 AM. Q3 Performance: 13.42 average admissions held in the ED at 8 AM, slightly higher than prior quarter.
- **Inpatient Medical Discharges before 11 AM (Not-Meeting Target):**
  - Target: Discharge more than six inpatient medicine patients per day before 11 AM. Q3 Performance: 0.67 discharges per day on average before 11 AM, consistent with the previous quarter.

**Actions Taken:**

- Developed a discharge-planning model and decoupled from OH@Home.
- Scheduled a site visit at London Health Sciences Centre to review discharge and patient flow processes.
- Added a 5th dedicated hospitalist for the ALC Unit to improve patient flow, reduce ALC volumes, and increase organizational capacity until March 31, 2026.

**Actions Planned for Next Quarter:**

- Provide education to front-line staff on discharge planning strategies (e.g., diabetic education, effective documentation) to identify barriers early and ensure timely discharges.
- Restart patient rounding and improve questions related to the expected date of discharge (EDD), and audit whiteboards to ensure EDD communication.
- Continue working with physician partners to confirm and get early identifications of EDDs, writing orders in advance for earlier discharges.
- Develop and pilot an Innovation Fund Medicine Patient Board project.

**2. Reimagine Community Health (Oversight by Digital Health Committee):**

- **Percentage on Track with Identified Milestones for FY 25/26 (Progressing to on Track):**
  - This includes core milestones related to major systems modernization projects under Project Quantum, such as workforce planning, HIS, 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:**

- Completed the “Initiation Gateway”
- Kicked off project steering committee and councils
- Initiated “Enterprise Workflow Workshops”
- Conducted the “Change Management Workshops” and “Engagement Focus Groups”
- Officially kicked off the project on December 8<sup>th</sup>

**Actions Planned for Next Quarter**

- Complete the Project Management Plan and Project
- Finalize validation workshops by January 9<sup>th</sup>
- Complete Workshops 1 & 2 and all related activities from the three partners (WRHN, CMH, Oracle).
- Complete the "Align Gateway" by late March 6<sup>th</sup>.

- Make a decision on the Anatomical Pathology Project.
- Finalize Oncology Module Planning.
- Assign Physician Resources as SMEs.
- **Workforce Planning (WFP) Implementation:**

**Actions Taken:**

- WFP project officially closed
- Urgent optimization action items completed

**Actions Planned for Next Quarter:**

- Deliverables outstanding from project phase have transitioned to operations which includes attendance management and leaves module workflows
- UKG Advisor was engaged to assess further optimization action items that will be led operationally to continue to enhance processes and system functionality.

**2. Increase Joy in Work (Oversight by Resource Committee):**

- **Full-Time Equivalent (FTE) Variance (Not-Meeting Target):**
  - Q3 Performance: 17 FTE variance across RNs, RPNs, and PSWs from main clinical programs (ED, ICU, and Medicine), contributing to increased overtime and strain to cover ER holds and replacement needs.

**Actions Taken:**

- Hired a Talent Acquisition lead and on-boarded effectively.
- Determined suitability of the UKG Attendance Module; held meetings with UKG and reached out to other organizations for implementation insights.
- Created internal mechanisms to identify problematic sick time issues, requiring mandatory leader follow-up as an interim solution.
- Finalize rebuild of master schedule in ED
- Initiated project to re-establish float pool

**Actions Planned for Next Quarter:**

- Make the final decision on the execution and viability of the UKG Attendance Module.
- Continue to improve efficiencies within existing hiring processes and leader education.
- PMO will facilitate workflow mapping sessions for current state onboarding, transfers, and off-boarding processes.
- Share workflows and provide education to leaders at upcoming January 2026 Operations meetings.
- Ensure compliance with legislation effective January 1, 2026, to enhance retention.
- Continue with efforts to recruit and implement float pool

- **Medical Professional Staff Recruitment (Progressing to on-track):**
  - Identified 17 core medical professional staff positions critical to hospital operations; as of Q3 13 of the positions have been filled.

**3. Sustain Financial Health (Oversight by Resource Committee):**

- **Post Construction Operating Plan Revenue Earned (On-track):** Indicator measures our PCOP revenue earned. For Q3, we achieved our budgeted PCOP revenue.

**Actions Taken:**

- Assessed Q2/Q3 performance, which is on track to achieve the targeted PCOP.
- Built a 2026/2027 budget-assuming maximum PCOP earned in 2025/2026.
- Focused on discharges; developed new monitoring tools for medically stable ready-for-discharge cases.

**Actions Planned for Next Quarter:**

- Continue monthly PCOP review meetings with Medical Leadership, Finance, and Decision Support to monitor activity.
- Monitor discharge volume and any changes in average weight per case that could impact the year-end forecast.
- Finalize the 2025/26 forecast for use in 2026/27 budget planning.
- Continue regional efforts on preferred accommodations and
- Execute surgical strategy to secure Incremental Surgical Recovery (ISR) Funding

**4. Advance Health Equity (Oversight by Board of Directors):**

- **Percentage on Track with Diversity, Equity & Inclusion (DEI) Plan (progressing to on track):** Currently at "yellow" status as some deliverables have been reprioritized, which includes rollout of ERGs (launch ERG Landing Page on CMHNet), Staff Sociodemographic Data Collection Survey (launch),

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- **Inclusive Languages and Images:**

**Action Taken:**

- Engaged over 400 people through Islamic History Month (IHM) activities.
- Key activations included the Cultural Snack Cart, "Myth or Fact?" activity, cafeteria engagement spinning wheel, DEI/IHM information table, Lunch & Learn session on Caring for Muslim Patients and CMH's first-ever Quran Recitation event.
- Transitioned the Inclusive Communications Policy into a more practical and accessible guide.
- Advanced awareness of the upcoming Photo Repository with a "Sneak Peek" launch.
- Launched the second Quarterly CEO Communication to reinforce organizational DEI momentum.

**Actions Planned for Next Quarter:**

- Execute planned events and activities for Black History Month and initiate planning for Asian Heritage Month.
- Finalize and promote the Inclusive Communications Guide.
- Officially, launch the Photo Repository on SharePoint with usage tips.
- Establish a standard cadence and process for Quarterly CEO Communications.

- **Education and Tools:**

**Actions Taken:**

- Completed an inventory of existing DEI resources and developed a draft table of contents for the DEI Toolkit.
- Promoted participation in CCDI Community of Practice events.
- Delivered de-escalation training to leaders at Fall Camp, expanding access to additional staff.
- Initiated assessment of organization-wide DEI learning offerings.

**Actions Planned for Next Quarter:**

- Integrate the DEI Toolkit into the SharePoint page and promote it as a living resource.
- Promote the annual CCDI Unconference event with different representatives attending and sharing learnings.
- Collaborate with the Diversity Council to receive endorsement on the next organization-wide training initiative and begin developing the roll-out plan.

- **Creating Safe Spaces:**

**Actions Taken:**

- Secured input and endorsement for the ERG Pilot Phase, updated the Inclusion Policy, and reviewed Code Yellow Form updates.
- Advanced ERG rollout by onboarding Pride and IHM Planning Committee members and initiating Black ERG recruitment in partnership with Black staff.

**Actions Planned for Next Quarter:**

- Solicit Diversity Council input on the Draft Inclusive Communications Guide, DEI Policy Implementation Plan, ERG promotion strategies, and organization-wide DEI training.
- Finalize Terms of Reference, launch SharePoint landing page, form Asian and Indigenous ERGs, and continue promoting EREGs across the organization.

- **People & Processes:**

**Actions Taken:**

- Expanded the Inclusion Policy into a comprehensive DEI Policy.
- Engaged Human Resources and Patient Experience for DEI-related case reporting and tracking.
- Developed foundational structure for an updated HWO presentation, collecting visuals and examples highlighting key DEI initiatives.

**Actions Planned for Next Quarter:**

- Continue consultation and approval process for the DEI Policy.
- Receive Diversity Council input and endorsement on the Implementation Plan.
- Update the HWO presentation to improve DEI awareness among new hires using the refreshed corporate template.

- **Percentage on Track with Truth and Reconciliation Plan (Progressing to On-Track):** Currently at “Yellow” status as some deliverables have been reprioritized such as: Smudging Ceremony Series (indoor ceremony), Orientation Updates (finish updating presentation), Indigenous art (wing b elevator bay) and Regional Smudging 101 Guides

- **Build and Enhance Capacity and Education:**

**Actions Taken:**

- **Indigenous Calendar & T&R:** Commemorated the Winter Solstice via SharePoint, reviewed CMH Indigenous Calendar, initiated regional T&R events calendar.
- **Staff Training & Cultural Safety:** Announced winners of the Cultural Safety Passport Activity, achieved 89% staff completion and 100% leader/Board registration for San'yas training.
- **Orientation Enhancement:** Advanced HWO and Clinical Orientation updates, developed an updated HWO presentation framework.
- **Landing Page & Website Refresh:** Completed environmental scan to inform updates to CMHNet and cmh.org.

**Actions Planned for Next Quarter:**

- Post refreshed calendar on SharePoint and form Indigenous ERG.
- Host the Third Session of the Indigenous L&L Series.
- Determine standard cadence and process for San'yas registration; promote WW Indigenous Older Adults Training.
- Align next smudging ceremony education event with revised Smudging Policy and Crow Shield Lodge Service Agreement exploration.
- Finish updating HWO presentation, develop action plan for clinical orientation enhancements, begin implementing website updates.

- **Build and Sustain Productive Relationships:**

**Actions Taken:**

- **Indigenous Advisory Circle (IAC):** Participated in monthly IAC meetings, contributed to the CMH Staff and Indigenous Community Garden Project.
- **Regional Truth & Reconciliation Touchpoints:** Maintained active participation in regional meetings, advanced collaborative initiatives.
- **Regional Indigenous Calendar of Events:** Initiated development for key Indigenous observances.

**Actions Planned for Next Quarter:**

- Attend regular IAC meetings and host a retreat to support strategic planning.
- Collaborate with WRHN and GGH on revising timelines for regional projects.
- Explore Service Agreement with Crow Shield Lodge for education and consultation.

- **Equitable Access to Culturally Safe Care:**

**Actions Taken:**

- Installed Eagle Feather artwork and began developing a video series with artists.
- Provided input on the Staff and Indigenous Community Garden design concept.
- Drafted revised Smudging Policy and relevant appendices.
- Initiated 6-week education series in Labour & Delivery and Postpartum.

**Actions Planned for Next Quarter:**

- Install Wing B artwork, edit videos for Four Directions murals and Eagle Feather art, and develop video for Wing B art.
  - Begin detailed planning phase for Staff and Indigenous Community Garden construction.
  - Finalize revised Smudging Policy, appendices, and implementation plan.
  - Continue Indigenous Clinical Recommendations Project and share status updates at the Fourth Indigenous Lunch & Learn.
  - Implement cmh.org updates and develop resource list for Indigenous patients and families.
- **Develop Quality Indicators to Measure, Monitor and Evaluate Success:**

**Actions Taken:**

- Completed SOAHAC Organizational Assessment Tool to evaluate T&R progress.
- Evaluated status of Service Accountability Agreements (SAA) for 2025-26 obligations.

**Consultation**

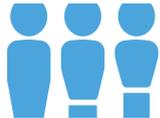
This report was developed by Executive Sponsors and Project Leads, with input from the Directors' Council, Weekly Leadership, and Operations Huddle.

**Next Steps**

The strategic priorities tracker, including summaries of actions taken and planned actions, will be shared quarterly. The next updates are scheduled for May 2026 (Q4).

# Strategic Priorities 25/26

"Creating Healthier Communities, Together"

	Metric	Target	Q1	Q2	Q3*	Q4	Aligned Corporate Plans
 <p><b>Elevate Partnerships in Care</b></p>	90th percentile Ambulance Offload Time (minutes) (QIP/IRM)	<43	38	28	49		Clinical Services Growth Plan
	90th percentile Provider Initial Assessment in the ED (hours) (QIP/IRM)	<4.6	7.5	7.6	7.5		
	90th percentile Urgent Provider Initial Assessment in the ED (hours) (QIP/IRM)	<4.0	6.3	6.5	6.3		
	Average number of Admits in the ED at 08:00 (QIP/IRM)	<10	12.28	12.06	13.42		
	Dyad Partnership - Major project average medical discharges before 11AM	>6	0.78	0.56	0.67		
 <p><b>Reimagine Community Health</b></p>	Project Quantum- % on track with identified milestones for 25/26 (IRM)	100	100	89	95		Digital Health Plan
	FTE Variance from target for Medicine, ICU, & ED (IRM)	0	-29	-25	-17		HR Plan
 <p><b>Increase Joy in Work</b></p>	Medical Professional Staffing (Targeted Positions) (IRM)	17 Year end target	3	13	13		
	 <p><b>Sustain Financial Health</b></p>	Post Construction Operating Plan Revenue Earned	>\$2.24M quarter	3.58M	2.66M	3.77M	
 <p><b>Advance Health Equity</b></p>	% on track with DEI Action Plan	100	100	78	77		DEI Plan Truth & ReconciliACTION Plan
	% on track with Truth and RoconciliACTION Plan	100	100	88	81		



**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**

**Trailing 12 Month Trend**

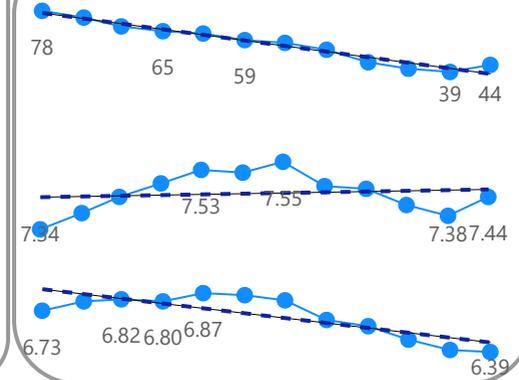
90th%tile Ambulance Offload Minutes

<43 mins

38.0

28.0

49.0



90th%tile Provider Initial Assessment Hours

<4.6 hours

7.5

7.6

7.5

90th%tile Urgent Provider Initial Assessment Hours

<4.0 hours

6.3

6.5

6.3

**In Year Objectives**

**Actions / Taken**

**Actions Planned for Next Quarter**

**Risks and Mitigations**

Reduce the wait-time for provider initial assessment for urgent CTAS 1-2 patients to 4 hours or less and wait-time for provider initial assessment for all patients to 4.6 hours or less by March 31, 2026

1. Reviewed policies from regional partners for guidance; 2. Program review completed by Unity Health ED physicians; 3. Provided ongoing training to develop nursing competency to support multiple areas; 4. Hold regular bi-weekly meetings arranged for ED leadership to monitor concerns and barriers being experienced that will lead to delay in assessing patients and achieving target PIA; 5. Provided education at Department meeting around P4R metrics and physician impacts

1. Finalize and share Surge Plan Policy; 2. Review priority items and recommendations by Unity Health ED physicians and develop action plan; 3. Biweekly ED leadership meetings ongoing to identify and mitigate risks and issues; 4. NP coverage scheduled for high volume days to help influence improved metrics in PIA

R1) Engagement and buy-in from the team around recommendations from program review; M1) Ensure shared vision between, leadership, frontline and organization as a whole; M2) Prioritize recommendations with input from the team; M3) Focus on communication and develop change management strategy

Achieve ambulance offload times of 43 mins or less by March 31, 2026

1. Work with EMS and regional partners to ensure clear understanding of definitions related to offload times; 2. Continue biweekly EMS meetings; 3. NYGH has not rescheduled however presentation provided by their Director was recorded and shared with our team

1. Continue monitoring data for discrepancies between EMS and CMH; 2. Email communication resent to the nursing team ensuring First Watch is being used for arrival time and that offload time must be written on the CTAS form for accuracy with data submission

R1) Inconsistent capture of offload times; M1) Provide education to CMH staff and ensure that first watch is being utilized as source of truth



**Executive Sponsor(s):**  
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**Physician Liaison(s):**  
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**Director Lead(s):**  
Andrea Brissette

**Project Manager(s):**  
Jennifer Woo

**In Year Measures of Success**

**Target**

**Q1**

**Q2**

**Q3**

**Q4**

**Trailing 12 Month Trend**

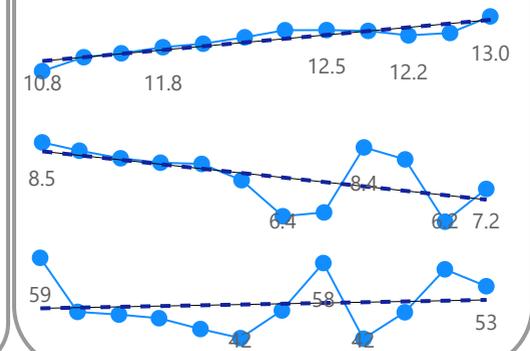
Average Admits in the ED at 08:00

**<10 patients**

**12.28**

**12.06**

**13.42**



Average Discharges/Day (Medical)

**>11/day**

**8.0**

**6.8**

**7.5**

90th%tile Time to Inpatient Bed (Hours) - Med/Surg

**<25 hours**

**45.8**

**48.8**

**49.1**

**In Year Objectives**

**Actions / Taken**

**Actions Planned for Next Quarter**

**Risks and Mitigations**

Achieve time to bed target of < 25 hours

1. Requested pricing for companion phone and licensing required to successfully adopt process improvement (includes improved communication between ED flow, charge and inpatient unit) for sending patient up within 30 minutes

1. Review pricing and assess feasibility of equipment required to implement process improvement; 2. If feasible, provide training sessions to charge nurses and spread initiative to remaining inpatient units (ICU, W&C, Paeds, Inpatient Surgery)

R1) Volume of no bed admits in the ED and lower discharges throughout organization, impacting patient flow; M1) Adding additional hospitalist to medicine program and continuing to identify patients ready for discharge through bullet rounds; M2) Ensure adequate staffing to support surge unit

Strengthen dyad (medical / management) partnership model

1. Continue to leverage and augment Clinical Operational Excellence Committee (COEC); 2. Distributed engagement letters to external reviewers re: program management; 3. Soft-launched of Program Council in November pre-MAC

1. Leverage external review(s): virtual meetings completed in December 2025 and on-site meetings in January 2026 scheduled in ED- utilize learnings from external review to shape optimal dyad structure for Quality and Ops meetings; 2. "Model-the-way": continue dyad check-ins between VP Clinical + VPMO with Chief/Med Director and Clinical Director in all programs; 3. Optimize existing dyad meetings: revise format and focus of COEC; 4. Timing of Launch: pause Program Council rollout until post-HIS launch

R1) Limited capacity and focus under the current context of HIS clinical transformation and Access and Flow challenges; M1) Focus will be to continue to build foundational enablers to developing strong dyad structures



**Executive Sponsor(s):**

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**Physician Liaison(s):**

Dr. Augustin Nguyen

**Director Lead(s):**

Andrea Brissette

**Project Manager(s):**

Jennifer Woo

**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. Developed discharge planning model, in conjunction with decoupling from OH@Home; 2. Scheduled site visit at London Health Sciences Centre to review discharge and patient flow processes; 3. Added a 5th dedicated hospitalist for the ALC Unit, with a focus on improving patient flow, reducing ALC volumes, and increasing organizational capacity in anticipation of surge season (to be trialed until March 31, 2026)

1. Provide education with front-line staff on discharge planning strategies (i.e. use of diabetic education, effective documentation of behaviors and strategies) to assist with identifying barriers early and implementing strategies to ensure timely discharges; 2. Restart patient rounding and improve questions related to patient's awareness of EDD and audit whiteboards to ensure EDD communication; 3. Ongoing work with Physician Partners re: confirming and getting early identifications of EDD. Writing orders in advance to promote earlier in the day discharges; 4. Development and pilot of Innovation Fund Medicine Patient Board project

R1) Inpatient bed capacity, with high occupancy rates or delayed discharges; M1) Strengthen bed meeting structure and escalation pathways for real-time flow decisions; M2) Optimize discharge planning with early identification of ALC and medically ready patients; R2) Competing priorities and limited resources shared across programs; M3) Coordinate with community partners and leverage CMH@Home to expedite discharges; M4) Expand float pool to manage surge volumes; R3) C3 Surge Unit is being used to manage increased patient admissions and support showering remediation; however, it was designed as a short-term surge solution. Prolonged operations risk unsustainable staffing pressures, including increased overtime, fatigue, and potential impacts on staff well-being and quality of care; M5) Define clear triggers and timelines to de-escalate C3 use as admissions stabilize and remediation concludes, with patient volumes transitioned back to base units where possible. Monitor staffing indicators closely and implement short-term staffing supports and contingency options if surge conditions persist.



# Digital Health Plan (IRM- Digital Health / Resource Committee)

**Executive Sponsor(s):**  
Trevor Clark

**Physician Liaison(s):**  
Dr. Ryeyan Taseen

**Director Lead(s):**  
Kyle Leslie

**In Year Measures of Success**

	Target	Q1	Q2	Q3	Q4
% on track with HIS readiness and implementation milestones	100%	100	100	100	
% on Track with ERP Project	100%	100	100	100	
% on Track with workforce planning	100%	100	67	67	
% of Physicians using Front-End Speech	100%	52	60	100	

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
% on track with Workforce Planning (WFP) implementation milestones	1. Stabilization of Phase 1 complete with urgent items being completed, non-urgent items transitioned as operational projects; 2. Completed failure mode effects and analysis to identify if there are any outstanding unmitigated risks, process verified that urgent items that were completed as part of phase 1 stabilization mitigated outstanding risks; 3. CMH continues to pay staff successfully through Meditech with UKG as the timecard source of truth; 4. Phase 2 data analytics complete with analytics being shared across the platform, working to finalize attendance management strategy (outstanding from scope of work)	1. Through support of OSO department, continue to optimize scheduling processes; 2. Establish UKG / OSO Office hours available to support staff and leaders as an ongoing process to continue to hardwire and provide support on UKG and OSO processes 3. All project deliverables have been completed with the exception of attendance management module and leaves module, project phase has been closed and the outstanding deliverables with respect to these two modules has transitioned to operations	R1) Attendance management module; M1) Escalated with UKG to confirm hospital sites using module continue to explore feasibility to meet CMH needs, interim workflows and automated reports to staff and leaders developed as interim solution
% on track with Enterprise Resource Planning (ERP) implementation milestones	1. Completed Market Survey, preferred vendor identified; 2. Current procurement options documented with future opportunities identified	1. MMC Update TCO 2. Several ERP solutions have been evaluated including Oracle Fusion, UKG and ADP. For CMH these systems would all be seen as significant improvement 3. Implementing any of these systems would involve significant investment 4. Recommendation is to extend and explore partnership with WRHN to implement a shared ERP solution. 5. Work is underway at a regional level to advocate with Ontario Health to seek clarity on investment opportunities by end of 2026. if external funding is not available CMH would need to consider alternative internal funding strategies	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 potential future opportunities and impact to timeline; R3) Increase in TCO making investment too costly for CMH at this time; M3) Complete evaluation of TCO for more cost effective solutions and update strategy to include a potential bridge solution to the future integrated state with WRHN partnership
% of MDs using Front End Speech	1. Continued to successfully spread use of scribe AI; 2. Significantly expanded adoption of Front-End Speech Technologies reaching nearly 80% of providers using the technology; 3. Finalized policies for scribe AI and front end speech; 4. Developed downtime procedures in the event	1. Continue to expand the adoption of advanced front-end speech technologies with target of full adoption by end of fiscal; 2. Phase out phone dictation by end of fiscal year; 3. Provide training and support for physicians to transition smoothly from phone dictation to front-end speech solutions	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



## Digital Health Plan Cont. (IRM Digital Health / Resource Committee)

**Executive Sponsor(s):**  
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**Physician Liaison(s):**  
Dr. Ryeyan Taseen

**Director Lead(s):**  
Kyle Leslie

**Project Manager(s):**  
HIS - Maryam Kazar

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
% on track with Health Information System (HIS) implementation milestones	1. Hired a Project Coordinator, Corporate PM, and Project SMEs; 2. Completed the Project Pre-Planning Phase; 3. Completed the "Initiation Gateway"; 4. Kicked-off the project Steering Committees and Councils; 5. Developed the Pre-Approval and Plan project documents; 6. Completed the "Customer Readiness Checklist"; 7. Developed the Item Master; 8. Scheduled the "Enterprise Workflow Workshops"; 9. Held the "Data Management Workshops"; 10. Conducted the "Change Management Workshops" and "Engagement Focus Groups". 11. Project Scope completed; 12. Project officially was kicked off on Dec 8th; 13. Validation workshops started as off Dec 9th across the WRHN,CMH and Oracle Teams	1. Complete Project Management Plan and Project Charter; 2. Completion of validation workshops by Jan 9th; 3. Complete workshops 1 & 2, and all related activities from the three partners; 4. Complete the second Gateway, which is "Align Gateway," by late March 6th; 5. Decision on Anatomical Pathology Project; 6. Finalizing the Oncology Module Planning; 8. Completion of Physician Resources assignment as SMEs	R1) Receiving requests to add items outside the current scope can impact the budget and timeline; M1) Assess these requests carefully and decide based on the project resources
% on track with Enterprise Resource Planning (ERP) implementation milestones	1. Completed Market Survey, preferred vendor identified; 2. Current procurement options documented with future opportunities identified	1. MMC Update TCO 2. Several ERP solutions have been evaluated including Oracle Fusion, UKG and ADP. For CMH these systems would all be seen as significant improvement 3. Implementing any of these systems would involve significant investment 4. Recommendation is to extend and explore partnership with WRHN to implement a shared ERP solution. 5. Work is underway at a regional level to advocate with Ontario Health to seek clarity on investment opportunities by end of 2026. if external funding is not available CMH would need to consider alternative internal funding strategies	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 potential future opportunities and impact to timeline; R3) Increase in TCO making investment too costly for CMH at this time; M3) Complete evaluation of TCO for more cost effective solutions and update strategy to include a potential bridge solution to the future integrated state with WRHN partnership
% on track with Workforce Planning (WFP) implementation milestones	1. Stabilization of Phase 1 complete with urgent items being completed, non-urgent items transitioned as operational projects; 2. Completed failure mode effects and analysis to identify if there are any outstanding unmitigated risks, process verified that urgent items that were completed as part of phase 1 stabilization mitigated outstanding risks; 3. CMH continues to pay staff successfully through Meditech	1. Through support of OSO department, continue to optimize scheduling processes; 2. Establish UKG / OSO Office hours available to support staff and leaders as an ongoing process to continue to hardwire and provide support on UKG and OSO processes 3. All project deliverables have been completed with the exception of attendance management module and leaves module, project phase has been closed and the outstanding deliverables with respect to these two modules has transitioned to operations	R1) Attendance management module; M1) Escalated with UKG to confirm hospital sites using module continue to explore feasibility to meet CMH needs, interim workflows and automated reports to staff and leaders developed as interim solution



# Human Resources Plan (Resource Committee)

[Click Here to Input Action Plans](#)

<b>Executive Sponsor(s):</b> Dr. Winnie Lee, Mari Iromoto	<b>Physician Liaison(s):</b> Dr. Kunuk Rhee	<b>Director Lead(s):</b> Andrea Brissette, Kim Towes, Susan Toth	<b>Project Manager(s):</b> Jennifer Woo
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In Year Measures of Success	Target	Q1	Q2	Q3	Q4	Trailing 12 - OT
FTE Variance from target for Medicine, ICU, & ED (IRM)	0	-29	-25	-17		
Medical Professional Staff (Targeted Positions)	17	3	13	13		
Overtime Hours per Quarter	< 11,200	23.1K	35.0K	24.0K		

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Reduce overtime hours to budget by March 31, 2026	<p>(HR): 1. Continued focus on a variety of tactics to pilot to improve sick and overtime (e.g. trial all sick calls to also go to manager, mandatory meetings with all staff with 3+ absences in a 4 week period); 2. Created strategy for re-establishing nursing float pool to support Medicine to reduce overtime; 3. Continue implementation of Shift Guarantee configuration (over/under), educate and communicate staff and leaders; 4. Implemented pay-to-schedule for all non-union employees with UKG and educated leaders; 5. Additional focus on departments with high sick time and assist with OT strategies with the support of a second abilities case manager;</p> <p>(ED): 1. Continue to monitor OT and requests on a daily basis; 2. Developed new master schedule to ensure appropriate balance of skill mix;</p> <p>(Med): 1. Continue to evaluate unit processes &amp; educational needs &amp; resources required to ensure to provide safe working environment and reduce staff burn out; 2. Pilot "Code Lavender" to ensure that the team's wellbeing is supported after a difficult or traumatic situation</p>	<p>(HR) 1. Implement nursing float pool to support Medicine (January start); 2. Re-introduce new graduate guarantee program (NGG) for RNs and RPNs by beginning discussions with unions and developing recruitment strategy (next fiscal year start); 3. Re-communicate to staff how to report unplanned absences</p> <p>(ED) 1. Continue to monitor and review OT hours and trends, ensuring proper skill mix of nursing is reflected on the schedule;</p> <p>(Med) 1. Continued focus on in-progress items</p>	<p>(ED) R1) Bed admit occupancy and vacant positions impact OT; M1) Implement new schedule in FY 25/26 Q4 or FY 26/27 Q1, due to union contracts and approval process required; M2) Revise unit-specific guidelines to advise OSO on staffing according to unit's operational needs</p> <p>(Med) R1) Surge and sick time impact; M1) Recruitment of in-house discharge planners to support increase discharges and improved efficiency; M2) Proactively scheduling staff to support surge beds and prevent OT</p>



# Human Resources Plan - Cont. - (IRM- Resource Committee)

[Click Here to Input Action Plans](#)

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

**Physician Liaison(s):**  
Dr. Kunuk Rhee

**Director Lead(s):**  
Andrea Brissette, Kim Towes, Susan Toth

**Project Manager(s):**  
Jennifer Woo

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Achieve active staffing targets in (ED ICU Medicine) by March 31, 2026	(HR) 1. Hired Talent Acquisition lead and onboard effectively; 2. Continue to focus on determining suitability of the UKG Attendance Module, held meetings with UKG and have reached out to other organizations to confirm implementation; 3. Created internal mechanisms to identify to leaders and staff with problematic sick time, requiring mandatory leader follow-up as interim solution; (ED) 1. Ensure successful onboarding experience for retention; 2. Finalized master schedule to ensure efficiency of scheduling; (Medicine): 1. Began development of hands-on interview for PSWs; 2. Continue to evaluate vacancies and hire to support LOAs	(HR) 1. Make final decision of execution and viability of the UKG Attendance Module; 2. Continuing to look at efficiencies and improvements within existing hiring processes and leader education; 2. PMO to facilitate workflow mapping session for current state onboarding, transfers and offboarding processes; 3. Share workflows and provide education to leaders at upcoming January, 2026 Operations; 4. Ensure compliance with legislation effective Jan. 1, 2026 to enhance retention (ED) 1. Master schedule continues to be developed through our Decision Support team to ensure proper skill level and alignment throughout the nursing rotations; (Med) 1. Continued focus on in-progress items	(HR): R1) Risk with UKG not being able to configure our requirements; M1) Evaluate and relaunch former automated internal program; M2) Increased oversight into attendance and leaders holding conversations with staff
Ensure medical staffing is sufficient to meet core clinical operations	1. Sustained the % of recruited in the identified core clinical areas; 2. Medical Professional Staff HR planning by Chiefs; 3. Completed a 2025-2026 Medical Professional Staff HR Plan, in partnership with Dr. Kunuk Rhee, VPMO; 4. Continue to expand the functionality of the new electronic credentialing platform with e-learning to support onboarding of new medical professional staff and support reappointment of medical professional staff - ongoing and near completed; 5. Recruited physicians to support programs/departments, in addition to the core clinical areas to support organizational flow and the clinical services growth plan	1. Sustain the total % of recruited physicians in the identified core clinical areas and identify recruited physicians across all programs/departments; 2. Review and complete Medical Professional staff HR planning for 2026-2027; 3. Introduce enhanced onboarding process for recruitment of medical professional staff and update credentialing platform; 4. Introduce and evaluate a new hospitalist model to support organizational flow; 5. Continue to ensure emergency/on-call services are covered	R1) Impact to medical staffing in the ED; M1) Continue to ensure emergency on-call services are covered by department; R2) Recruitment and retention risk; M2) Enhance the onboarding process with updates to the new electronic credentialing platform; M3) Creative models of care to recruit and to sustain clinical services - External reviews of ED, Hospitalist/Medicine and Psychiatry programs; M4) Continue to increase medical learners as a recruitment strategy

# Multi-Year Financial Plan (Resource Committee)

[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**

PCOP Revenue earned

**>\$2.24M per Quarter**

QBP Revenue generated\*

**>\$6.9M per Quarter**

**Target**

**Q1**

**Q2**

**Q3**

**Q4**

**3.6M**

**2.7M**

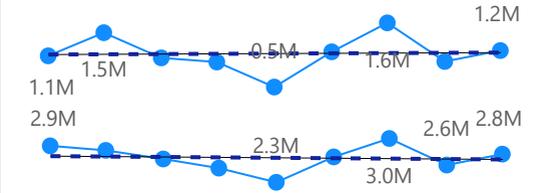
**3.8M**

**8.4M**

**7.6M**

**8.4M**

**Monthly Trend**



**In Year Objectives**

**Actions / Taken**

**Actions Planned for Next Quarter**

**Risks and Mitigations**

Forecast PCOP for 25/26 and determine PCOP strategy for 26/27

1. Finalized PCOP forecast and determined budget impacts for 26/27 based on earning full PCOP for 25/26

1. Finalize budget strategy for 26/27 based on assumption full PCOP will be earned in 25/26

No risks to report.

Achieve Medical PCOP growth target for 25/26

1. Assessed Q2/ Q3 performance, performance on track to achieve targeted PCOP; 2. Built 2026/2027 budget assuming max PCOP earned in 2025/ 2026; 3. Focus on discharges continued, new monitoring tools developed for medically stable ready for discharge cases to support achieving discharge targets

1. Continue with monthly PCOP review meetings monthly to continue to monitor activity with Medical Leadership, Finance and Decision Support; 2. Monitor discharge volume and any change in average weight per case that could change year end forecast; 3. Finalize forecast for 25/26 for use in 26/27 budget planning

R1) Drop in medical discharges / weighted cases; M1) Monitor discharge and average weight per case volumes closely

Achieve Surgical PCOP growth target for 25/26

1. Assessed Q2/ Q3 performance, performance over all in surgical programs is on track to achieve targeted PCOP; 2. Re-established surgical grid for 26/27 with assumption max PCOP would be achieved in 26/27; 3. Participated in WW regional work on analyzing OR Grid and surgical room usage

1. Continue to monitor surgical activity at monthly reviewing meetings with Surgical Leadership, Finance and Decision Support; 2. Finalize 26/27 grid based on PCOP forecast and planned QBP funding; 3. Continue to work with WW working group to maximize use of surgical rooms; 4. Review surgical wait-list and determine impact of 26/27 surgical plan on wait-list

R1) Incremental surgical recovery funding reduction; M1) Adjust surgical grid for 26/27 accordingly given change in funding

Based on PCOP Forecast determine QBP strategy for 26/27

1. QBP volumes reviewed and grid OR grid simulation complete assuming QBP volumes for 26/27 will align with 25/26 funded volumes

1. Finalize 26/27 OR grid to max available QBP funding for 26/27; 2. Execute strategies from WW working group to maximize ISR funding and Preferred Accommodations revenue

R1) Max available PCOP; M1) Need to analyze the impact to QBPs and plan accordingly

\*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)



# DEI Plan (Board)

[Click Here to Input Action Plans](#)

### Executive Sponsor(s):

Mari Iromoto

### Physician Liaison(s):

TBD

### Director Lead(s):

Diana Crawford

### Project Manager(s):

Mike OSO, Joy Braga

### In Year Measures of Success

% on track with DEI Action Plan

#### Target

100

#### Q1

100

#### Q2

78

#### Q3

77

#### Q4

### In Year Objectives

### Actions / Taken

### Actions Planned for Next Quarter

### Risks and Mitigations

**People & Processes** (DEI Policy, formerly Inclusion Policy): 1. Expanded the Inclusion Policy into a comprehensive DEI Policy, incorporating broader organizational scope; 2. Engaged Human Resources and Patient Experience to align on DEI-related case reporting and tracking, and updated the project plan to reflect the expanded scope and associated timelines; (HWO Presentation): 3. Developed the foundational structure for an updated HWO presentation and initiated collection of visuals and examples highlighting key DEI initiatives

(DEI Policy): 1. Continue consultation and approval process; 2. Receive Diversity Council input and endorsement on Implementation Plan; (HWO Presentation): 3. Finish updating the HWO presentation to improve DEI awareness and engagement amongst new hires; 4. Update PPT with the refreshed corporate template

R1) Cannot launch Staff Sociodemographic Data Collection Survey due to factors including missed opportunity to launch alongside UKG registration, limited organizational capacity/competing priorities due to HIS work, and survey fatigue; M1) Align the launch of the Staff Sociodemographic Data Collection survey with the next Global Worklife Survey. This would limit the amount of survey fatigue and take place when there is more organizational capacity (e.g., less organizational demand with the HIS project).

**Creating Safe Spaces** (Diversity Council, October): 1. Secured input and endorsement for the ERG Pilot Phase, with emphasis on driving organization-wide engagement; 2. Provided status update on the Inclusion Policy (consultation progress, timeline, next steps); 3. Reviewed Code Yellow Form updates, and aligned on the direction for Inclusive Communications tools and standards; (Employee Resource Groups, ERG): 1. Advanced ERG rollout by onboarding Pride and Islamic History Month Planning Committee members into respective ERGs; 2. Initiated Black ERG recruitment and planning in partnership with Black staff members

(Diversity Council Meeting, January): 1. Solicit input on the Draft Inclusive Communications Guide, DEI Policy Implementation Plan, ERG promotion strategies, topic/focus for organization-wide DEI training, and DEI Toolkit; (Employee Resource Group, ERG, Roll-out): 2. Finalize Terms of Reference; launch SharePoint landing page; form Asian ERG and Indigenous ERG; and continue promoting EREGs across the organization

No risks to report.



**Executive Sponsor(s):**

Mari Iromoto

**Physician Liaison(s):**

TBD

**Director Lead(s):**

Diana Crawford

**Project Manager(s):**

Mike OSO, Joy Braga

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Education and Tools	(DEI Toolkit): 1. Completed an inventory of existing DEI resources on CMHnet and developed the draft table of contents to guide creation of a centralized DEI Toolkit; (DEI Professional Development): 2. Promoted participation in CCDI Community of Practice events to broaden organizational exposure, strengthen DEI capability, and enable cross-sector learning through engagement with DEI professionals and champions; (Leadership Mental Health Training): 3. Delivered Canadian Mental Health Association-led de-escalation training to leaders at Fall Camp and expanded access to additional staff and medical professionals following strong leader recommendations, supporting psychological safety and effective leadership response; (Organization-wide Learning): 4. Initiated assessment of organization-wide DEI learning offerings, including Inclusive Leadership training, to support consistent capability building across CMH	(DEI Toolkit): 1. Integrate the toolkit into the DEI SharePoint page and promote it as a living resource by inviting ongoing feedback; (DEI Professional Development): 2. Promote the annual CCDI Unconference event with the goal of having different representatives attend; have attendees share back their learnings and application to the work we do at CMH; (Organization-wide Training): 3. Collaborate with the Diversity Council and receive their endorsement on a topic/focus for the next organization-wide training initiative; begin developing the roll-out plan	No risks to report.
Inclusive Languages and Images	1. Engaged with 400+ people through the Islamic History Month (IHM) LEARN Challenge via the Cultural Snack Cart and "Myth or Fact?" Challenge; 2. Key activations included the Cultural Snack Cart and "Myth or Fact?" activity, a cafeteria engagement spinning wheel, a DEI/IHM information table at the Healthy Workplace Fair, and a Lunch & Learn session on Caring for Muslim Patients led by Dr. Ahmad Tarakji; the initiative also amplified representation through three Voices of CMH features and marked a milestone with CMH's first-ever Quran Recitation event, led by Imam Mubeen; (Inclusive Communications Guide, formerly a Policy): 3. Transitioned the Inclusive Communications Policy into a more practical and accessible Inclusive Communications Guide; the first draft has been developed to support consistent, inclusive language and messaging across the organization; (Photo Repository – Photo Day): 4. Advanced awareness and adoption of the upcoming Photo Repository through a "Sneak Peek" launch on CMHnet, featuring six preview images; the initiative acknowledged participant contributions, generated anticipation, and positioned the repository as a key resource for inclusive organizational communications; (Quarterly CEO Communication) : 5. Launched the second Quarterly CEO Communication, reinforcing organizational momentum in advancing DEI and Truth & ReconciliACTION. The communication highlighted key Q2 milestones, including leadership endorsement of the ERG Pilot Phase, integration of inclusive practices into emergency preparedness, and organizational celebration of diversity through Photo Day	(Diversity Calendar): 1. Execute planned events and activities for Black History Month; 2. Initiate planning for Asian Heritage Month; (Inclusive Communications Guide): 3. Finalize guide and begin promoting its use across the organization; (Photo Repository): 4. Officially launch repository on SharePoint, celebrating CMH's culture and diversity and share tips on how to use the repository in an inclusive way; (Quarterly CEO Communication): 5. Establish a standard cadence and process for developing and publishing Quarterly CEO Communications.	No risks to report.



# Truth and ReconciliAction Plan (Board)

[Click Here to Input Action Plans](#)

**Executive Sponsor(s):**

Patrick Gaskin

**Physician Liaison(s):**

TBD

**Director Lead(s):**

Diana Crawford

**Project Manager(s):**

Mike Oso, Joy Braga

**In Year Measures of Success**

% on track with DEI Action Plan

**Target**

100

**Q1**

100

**Q2**

88

**Q3**

81

**Q4**

**In Year Objectives**

**Actions / Taken**

**Actions Planned for Next Quarter**

**Risks and Mitigations**

Measure, Monitor and Evaluate

(SOAHAC Organizational Assessment Tool): 1. Completed assessment to evaluate current state of T&R at CMH and submitted to SOAHAC

(Service Accountability Agreements, SAA): 1. Evaluate status of 2025-26 obligations

No risks to report.



**Executive Sponsor(s):**

Patrick Gaskin

**Physician Liaison(s):**

TBD

**Director Lead(s):**

Diana Crawford

**Project Manager(s):**

Mike Oso, Joy Braga

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Build and enhance capacity and education	(Indigenous Calendar & Truth and Reconciliation, T&R): 1. Commemorated the Winter Solstice through a SharePoint feature highlighting CMH’s Four Directions art installation, including the Winter Mural and artists Alanah and Luke; 2. Reviewed the CMH Indigenous Calendar and initiated development of a regional T&R events calendar to strengthen alignment with WRHN and GGH. (Staff Training & Cultural Safety): 3. Announced winners of the Cultural Safety Passport Activity and shared participant reflections via SharePoint; 4. Achieved 89% staff completion and 100% completion among leaders and Board registrants for San’yas Indigenous Cultural Safety Training, demonstrating strong leadership accountability; (Orientation Enhancement): 5. Advanced work to strengthen HWO and Clinical Orientation, including development of an updated HWO presentation framework and initial curation of Truth & Reconciliation initiatives for inclusion; (Landing Page & Website Refresh): 6. Completed an environmental scan of regional and community resources to inform updates to CMHNet and cmh.org, supporting improved access to Indigenous and T&R-related information	(Indigenous Calendar): 1. Post refreshed calendar on SharePoint and form Indigenous ERG in preparation for National Indigenous History Month Indigenous L&L Series: Host Third Session on the Colonization of Indigenous Food and Nutrition (rolled over from Q3); (Staff Training): 2. Determine standard cadence and process for San’yas registration. Determine approach for promoting the WW Indigenous Older Adults Training; (Smudging Ceremony Series): 3. Align next smudging ceremony education event with launch of revised Smudging Policy and outcome of Crow Shield Lodge Service Agreement exploration; (Orientation Enhancement): 4. Finish updating the HWO presentation to improve T&R awareness and engagement amongst new hires; update PPT with the refreshed corporate template; develop action plan for clinical orientation enhancements; (Landing Page and Website Refresh): 5. Begin implementing updates based on environmental scan	No risks to report.
Build and Sustain Productive Relationships	(Indigenous Advisory Circle, IAC): 1. Participated in all monthly IAC meetings, including consultation supporting the CMH Staff and Indigenous Community Garden Project, contributing to development of the final design concept; (Regional Truth & Reconciliation Touchpoints): 2. Maintained active participation in scheduled regional meetings and continued advancing collaborative regional T&R initiatives; (Regional Indigenous Calendar of Events): 3. Initiated development of a regional Indigenous Calendar of Events, recognizing key Indigenous observances and recurring community events (e.g., Sacred Fires) to support coordinated planning and engagement	(IAC): 1. Attend regular meetings and host an retreat to support relationship, IAC member understanding of hospital processes/procedures, strategic planning, and focused discussions (Regional T&R Touchpoints): 2. Attend regular meetings and collaborate with WRHN and GGH to revise timelines for regional projects; (Indigenous Calendar of Events and Smudging 101 Guides): 3. Crow Shield Lodge: Explore a Service Agreement for education and consultation	R1) WRHN Counterpart (Manager, Indigenous Health and Reconciliation) will no longer be in their role and there is no replacement identified yet, impact to Regional Indigenous Calendar of Events; M1) Confirm WRHN's recruitment plan for the role and collaborate with them and GGH to adjust timelines for regional projects accordingly.
Equitable Access to Culturally Safe Care	(Indigenous Art): 1. Installed Eagle Feather artwork and began developing video series with the artists; (Staff and Indigenous Community Garden): 2. Reviewed and provided input on updated final concept via virtual consultation (October) and presented finalized design concept via in-person presentation (November); (Smudging Policy): 3. Drafted a revised Smudging Policy and began drafting relevant appendices; (Smudging 101 Guides, regional project): 4. Continued developing guides Indigenous Clinical Recommendations Project: Initiated 6-week education series in Labour & Delivery and Postpartum (Indigenous Patient/Family Resources): 5. Began collecting resources and information to include on cmh.org and resource list	(Indigenous Art): 1. Install Wing B artwork (rolled over from Q3); 2. Edit videos for the Four Directions murals and Eagle Feather art (video series); 3. Begin developing video for Wing B art; (Staff and Indigenous Community Garden): 4. Begin detailed planning phase for construction in fall 2026/spring 2027; (Smudging Policy): 5. Finalize revised policy, appendices, and implementation plan; (Indigenous Clinical Recommendations Project): 6. Continue implementation and share status update at Fourth Indigenous Lunch & Learn focused on Indigenous Women's Health; (Indigenous Patient/Family Resources): 7. Implement cmh.org updates and develop resource list for Indigenous patients and families	R1) WRHN Counterpart (Manager, Indigenous Health and Reconciliation) will no longer be in their role (last day is Jan 23, 2026) and there is no replacement identified yet, impact to Regional Smudging 101 Guides; M1) Confirm WRHN's recruitment plan for the role and collaborate with them and GGH to adjust timelines for regional projects accordingly.

# BRIEFING NOTE

**Date:** February 19, 2026  
**Issue:** Quality Monitoring Scorecard  
**Prepared for:** Board of Directors  
**Purpose:**  Approval  Discussion  Information  Seeking Direction  
**Prepared by:** Kyle Leslie, Director Analytics and Innovation and CIO  
**Approved by:** Mari Iromoto, VP People and Strategy

**Attachments/Related Documents: Appendix A – Quality Monitoring Scorecard**

**Alignment with 2025/26 CMH Priorities:**

2022-2027 Strategic Plan No <input type="checkbox"/>	2025/26 CMH Priorities No <input type="checkbox"/>	2025/26 Integrated Risk Management Priorities No <input type="checkbox"/>
<input checked="" type="checkbox"/> Elevate Partnerships in Care	<input checked="" type="checkbox"/> Improve Patient Flow (AOT, PIA, ED Admits)	<input checked="" type="checkbox"/> Organizational Flow
<input checked="" type="checkbox"/> Reimagine Community Health	<input checked="" type="checkbox"/> Prepare for Digital Health Transformation	<input checked="" type="checkbox"/> Project Quantum
<input checked="" type="checkbox"/> Increase Joy In Work	<input checked="" type="checkbox"/> Increase Staff Engagement Through Improved Staffing (Med, ICU, ED, Physicians)	<input checked="" type="checkbox"/> Optimization of Staff/Medical Staff Levels <input checked="" type="checkbox"/> Management/Medical Staff Partnership
<input checked="" type="checkbox"/> Sustain Financial Health	<input checked="" type="checkbox"/> Earn the Maximum Eligible PCOP Funding	
<input checked="" type="checkbox"/> Advance Health Equity	<input checked="" type="checkbox"/> 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 quality metrics. Currently, all "red" indicators are linked to organizational flow, sick hours, and overtime hours. Despite these challenges, other critical indicators are either meeting or showing improvement toward their respective targets. Our focus on organizational flow is consistent with our 2025/26 strategic priorities.

**Background**

The CMH Quality Monitoring Scorecard tracks key performance indicators aligned with our quality framework, many of which are publicly reported by the Canadian Institute for Health Information (CIHI). The scorecard monitors these metrics monthly to identify trends deviating from set thresholds. Internal forums regularly review the scorecard for action planning and awareness.

**Analysis**

Organizational patient flow 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 quality indicators are currently underperforming:

Organizational patient flow has been a focal point in our Integrated Risk Management (IRM) strategy, as well as 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 quality indicators are currently underperforming:

1. **Conservable Bed Days Rate:** Measures the rate of conservable patient days vs. total acute patient days. A lower rate indicates that a patient's acute length of stay is closer to benchmark. Year-to-Date (YTD) Dec, the Conservable Days Rate stands at 46.67%, trending away from target over the last three periods.
2. **Overtime Hours:** Tracks average overtime hours used per pay period; our target is 1,723 hours or less. YTD Jan performance shows an average of 4,483 hours per pay period.
3. **Sick Hours:** Measures average sick hours per pay period, with a target of 2,359 hours or less. YTD Jan performance indicates an average of 3,842 hours.
4. **ED Length of Stay for Admitted Patients (90% spent less, in hours):** Tracks wait-time from triage to inpatient bed arrival. As of YTD Dec 90% of admitted patients waited 54 hours or less, compared to a target of 33 hours.
5. **ED Wait Time for Inpatient Bed (90% spent less, in hours):** Measures the time between admission decision and bed arrival. As of YTD Dec, 90% of admitted patients waited 45.40 hours or less, against a target of 25 hours.
6. **ED Length of Stay for Non-Admitted Complex (CTAS 1-3) Patients (90% spent less, in hours):** Tracks wait-time from triage to disposition for complex ED patients. YTD Dec data shows that 90% had a stay of 10.10 hours or less, while the target is 8 hours.
7. **ED Wait Time for Provider Initial Assessment (PIA) (90% spent less, in hours):** Monitors the time from triage to physician/nurse practitioner assessment. As of YTD Dec, 90% were seen within 7.5 hours overall and 6.4 hours for CTAS 1-2 patients, versus an internal target of <4 hours.

### **Consultation**

Senior leadership committees, including Director's Council, Operations Committee, and Clinical Operational Excellence Committee, have been actively involved in addressing these issues.

### **Next Steps**

- The Quality Monitoring Scorecard will continue to be reviewed at each Board of Directors meeting.
- Red status indicators will be discussed at the Director's Council, Weekly Operations Huddle, and Senior Leadership Committee meetings.
- Flow indicator action plans are continuously being worked on through our Strategic Priorities and department-specific goals.



# Quality Monitoring Scorecard

Status (Last 3 Periods)

- Meeting Target ● 10 33%
- Within 10% of Target ▲ 12 40%
- Exceeding Target ◆ 8 27%

Quality Dimension	Indicator	Unit of Measure	Target	YTD	Status (Last 3 periods)	Period
Efficient	Conservable Days Rate	%	30.00	46.67	◆	Dec-25
	Overtime Hours - Average per pay period	hours	1,723.06	4,483.64	◆	Jan-26
	Sick Hours - Average per pay period	hours	2,359.11	3,842.83	◆	Jan-26
Integrated & Equitable	ALC Throughput	Ratio	1.00	0.80	▲	Dec-25
	Percent ALC Days (closed cases)	%	20.00	17.22	●	Dec-25
	Repeat emergency department visits for Mental Health Care	Patients	11.00	10.67	●	Dec-25
Patient & People Focused	Organization Wide Vacancy Rate	%	12.00	5.37	●	Jan-26
Safe, Effective & Accessible	30 Day CHF Readmission Rate	%	14.00	19.91	▲	Nov-25
	30 Day COPD Readmission Rate	%	15.50	16.03	▲	Nov-25
	30 Day In-Hospital Mortality Following Major Surgery	%	1.90	1.24	▲	Sep-25
	30 Day Overall Readmission Rate	%	8.80	6.91	●	Nov-25
	Ambulance Offload Time (90% Spent Less, in Minutes)	minutes	30.00	36.00	▲	Dec-25
	Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m.	Average	10.00	12.59	▲	Dec-25
	ED Length of Stay for Admitted Patients (90% Spent Less, in Hours)	hours	33.00	54.00	◆	Dec-25
	ED Length of Stay for Non-Admitted Complex Patients (90% Spent Less, in Hours)	hours	8.00	10.10	◆	Dec-25
	ED Wait Time for Inpatient Bed (90% Spent Less, in Hours)	hours	25.00	45.40	◆	Dec-25
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours)	hours	4.00	7.50	◆	Dec-25
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours) CTAS 1,2	hours	4.00	6.40	◆	Dec-25
	Hip Fracture Surgery Within 48 Hours	%	83.10	89.55	●	Nov-25
	Hospital Standardized Mortality Ratio (HSMR)	Ratio	100.00	83.78	●	Nov-25
	In-Hospital Sepsis	per 1000 D/C	3.20	4.66	▲	Nov-25
	Long Waiters Waiting For All Surgical Procedures	%	20.00	7.37	●	Jan-26
	Low-Risk Caesarean Sections	%	17.30	18.34	▲	Dec-25
	Medication Reconciliation at Admit	%	95.00	95.00	▲	Jan-26
	Medication Reconciliation at Discharge	%	95.00	95.00	▲	Jan-26
	Obstetric Trauma (With Instrument)	%	14.40	16.63	▲	Nov-25
	Patient Safety Event - Falls with Harm	per 1000 PD	0.00	0.04	▲	Jan-26
	Patient Safety Event - Medication Events with Harm	per 1000 PD	0.00	0.04	●	Jan-26
	Revenue - Achieve budgeted PCOP growth (IRM)	\$	6,716,726.28	10,011,549.47	●	Dec-25
	Revenue - Achieve Quality Based Procedure Funding (IRM)	\$	20,125,631.97	24,421,043.30	●	Dec-25



Description

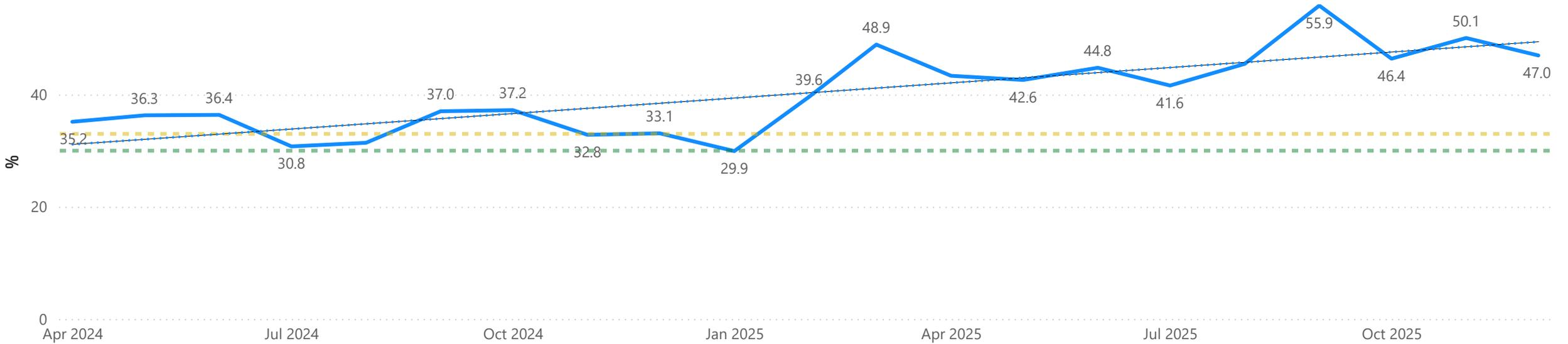
The total patient days over the benchmark LOS (conservable days) as a percentage of the total acute patient days for patients discharged from MEDA/MEDB. The benchmark LOS is determined by case mix group, age, and resource intensity level of a discharge.

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
<b>30.0</b>	<b>36.1</b>	<b>46.67</b>	◆

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	29.9	39.6	48.9
2025/2026	43.4	42.6	44.8	41.6	45.5	55.9	46.4	50.1	47.0			



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

1,723.1

Previous YE

3,786.5

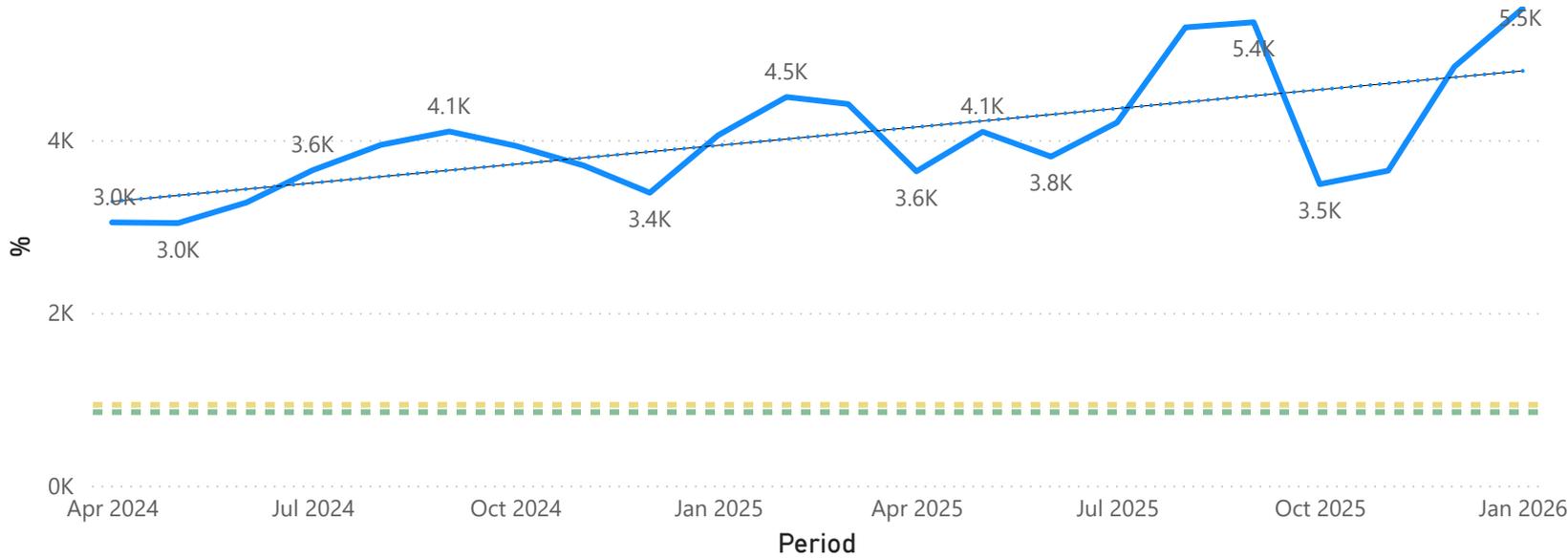
YTD

4,483.6

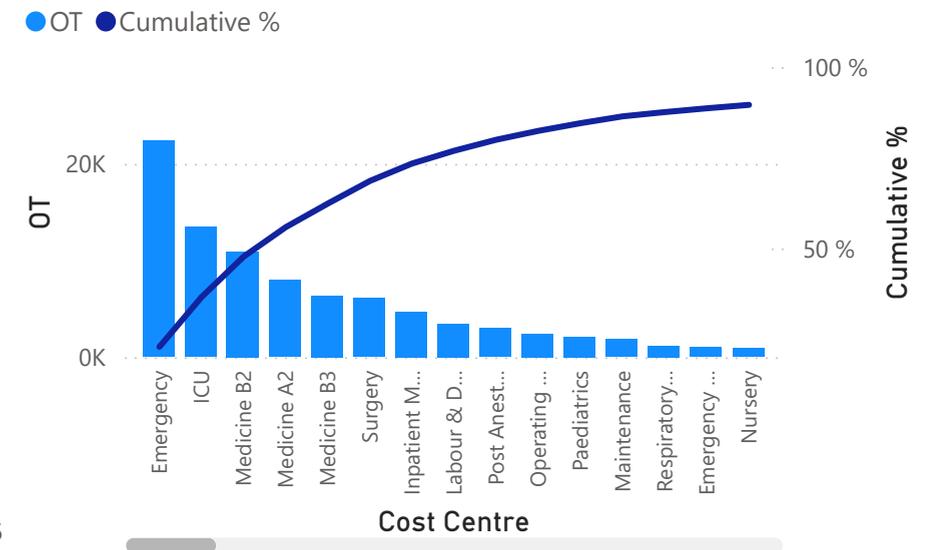
Status (Last 3 periods)



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	3,045.8	3,038.6	3,276.0	3,649.5	3,943.0	4,098.1	3,933.0	3,704.1	3,389.1	4,054.4	4,497.2	4,415.7
2025/2026	3,637.0	4,094.6	3,807.3	4,201.8	5,303.1	5,363.0	3,488.8	3,644.4	4,846.0	5,521.7		



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

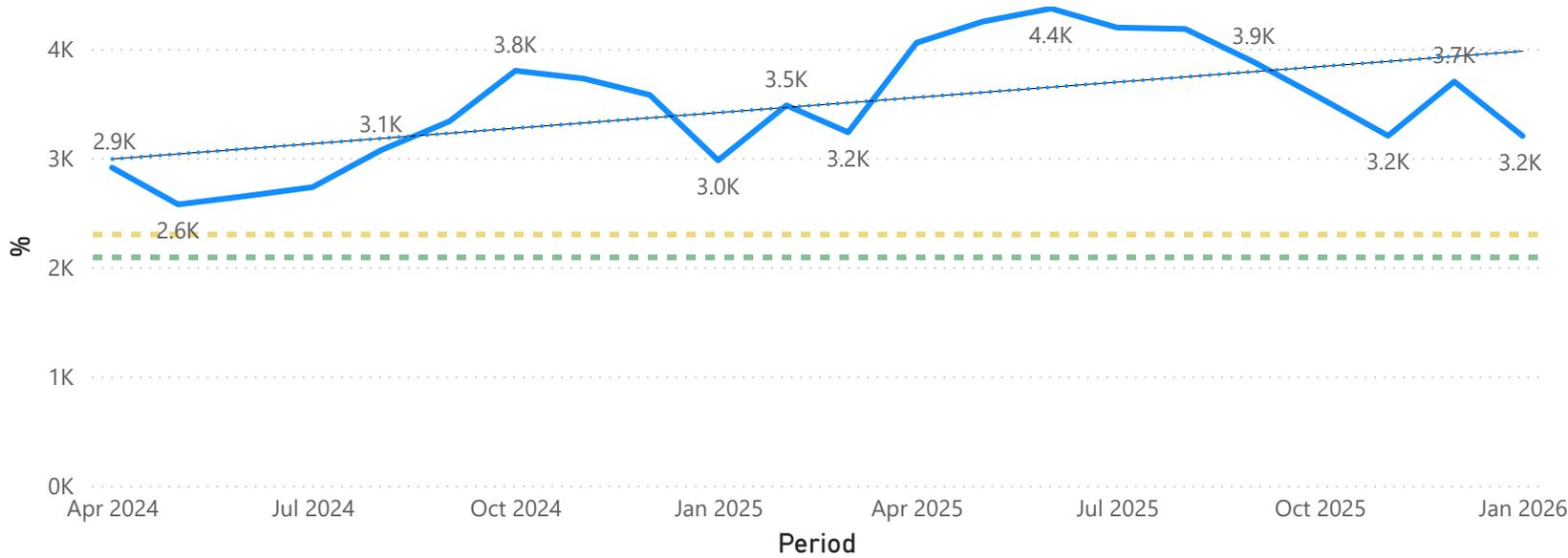
Meditech Payroll

Target	Previous YE	YTD
<b>2,359.1</b>	<b>3,171.0</b>	<b>3,842.8</b>

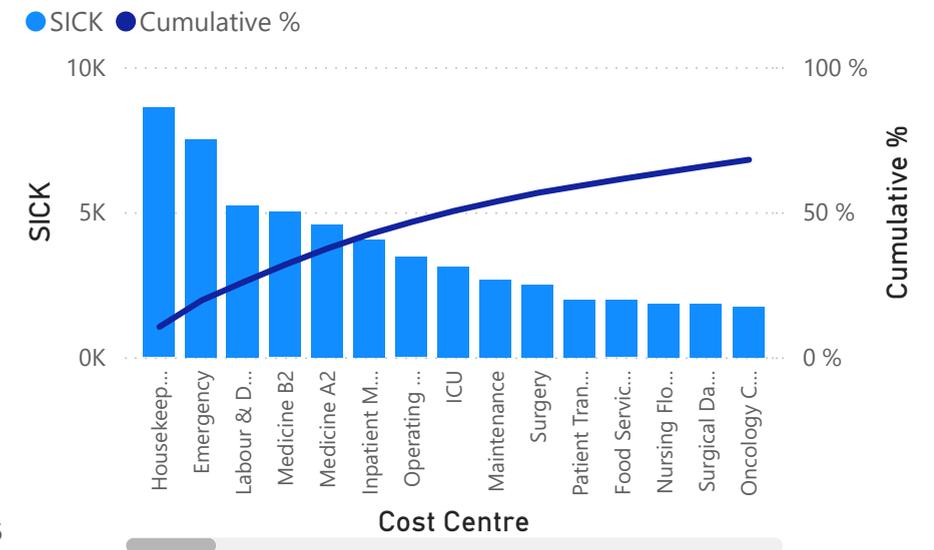
Status (Last 3 periods)



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	2,977.7	3,481.6	3,234.7
2025/2026	4,054.1	4,248.5	4,368.5	4,194.0	4,181.0	3,879.0	3,551.1	3,202.8	3,699.5	3,201.4		



## 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)
<b>1.0</b>	<b>0.8</b>	<b>0.8</b>	

## ALC Rate

Description

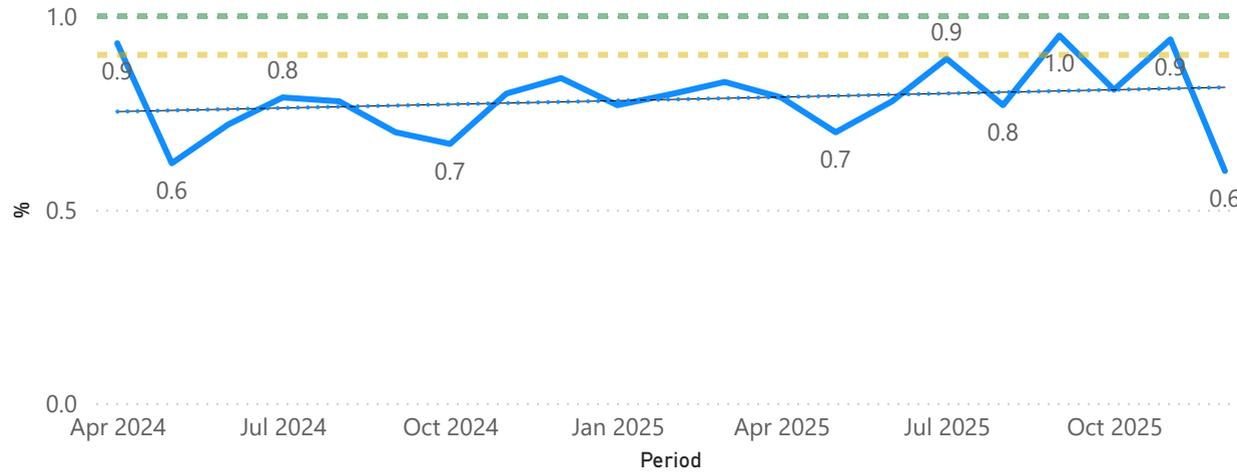
The proportion of total days that a patient was assigned to the alternate level of care (ALC) service. ALC patients are those who no longer need acute care services but continue to occupy an acute care bed or use acute care services.

Data Source

Discharge Abstract Database (DAD)

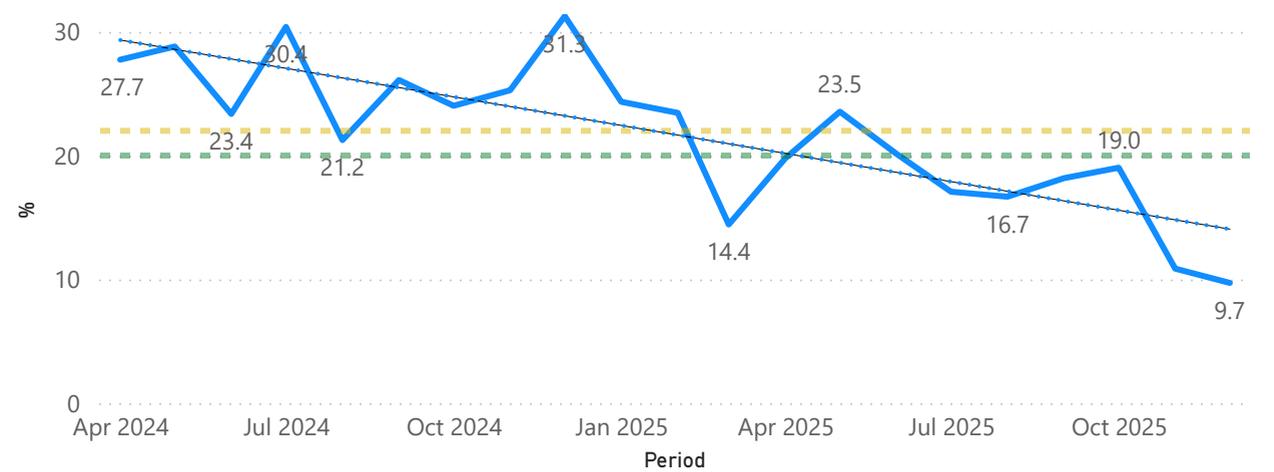
Target	Previous YE	YTD	Status (Last 3 periods)
<b>20.0</b>	<b>25.0</b>	<b>17.2</b>	

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	1.0	0.8	0.9	0.6			

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	19.8	23.5	20.1	17.1	16.7	18.2	19.0	10.9	9.7			

# Repeat ED Visits for Mental Health Care



## Description

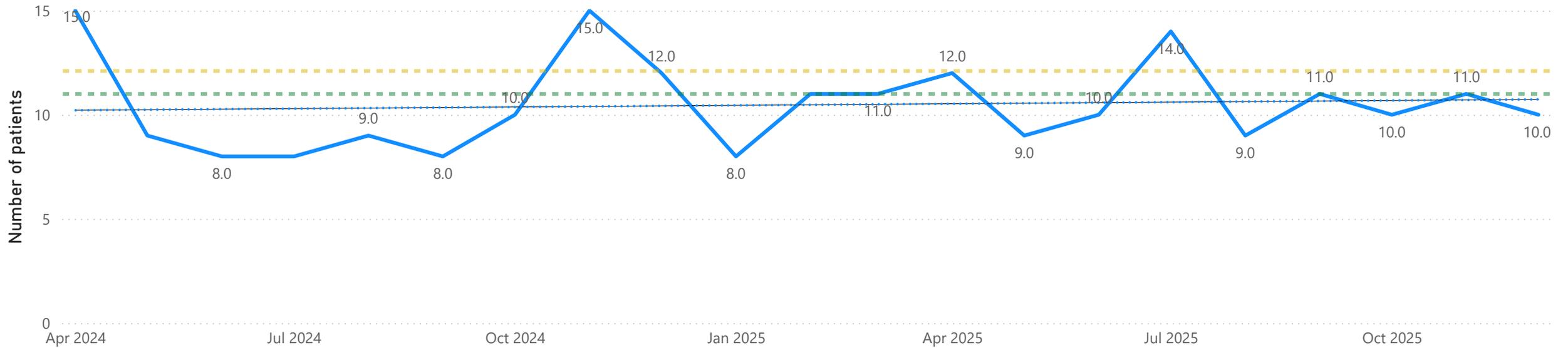
Number of patients who have four or more repeat unscheduled visits to the emergency department in the last 12 months for mental health or substance abuse condition

## Data Source

National Ambulatory Care Reporting System (NACRS)



## 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	9.0	11.0	10.0	11.0	10.0			

# Organizational Vacancy Rate



Description

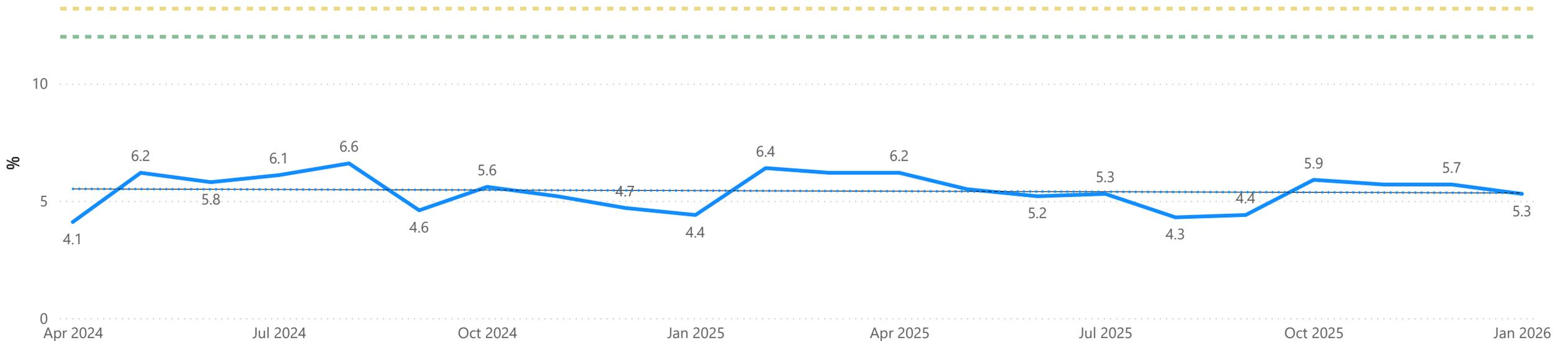
This indicator measures the organization wide vacancy rate for permanent full time and part time staff

Data Source

ICIMs Vacancy Report and Meditech Payroll

Target	Previous YE	YTD	Status (Last 3 periods)
<b>12.0</b>	<b>5.5</b>	<b>5.4</b>	<span style="color: green;">●</span>

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	4.4	5.9	5.7	5.7	5.3		



# Readmissions within 30 Days:

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

### CHF Readmissions

### COPD 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)

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)      Target      Previous YE      YTD      Status (Last 3 periods)

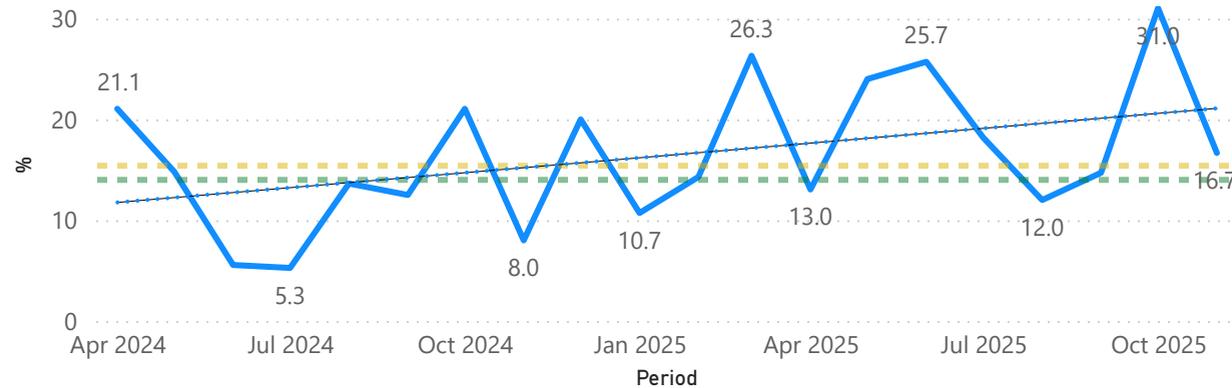
14.0      14.7      19.9



15.5      9.1      16.0

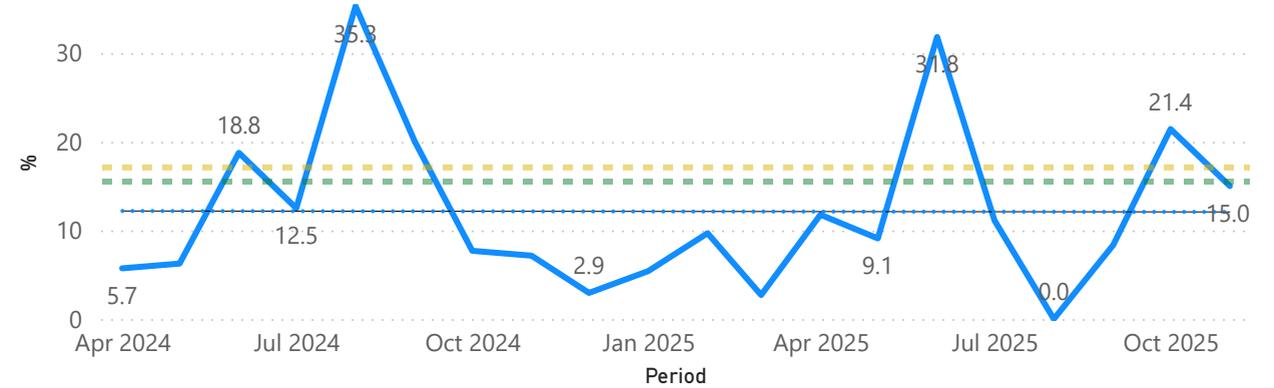


CHF Readmission Rate, Trend



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	25.7	18.2	12.0	14.7	31.0	16.7				
	Readmits	3	6	9	4	3	5	9	3	6	0		

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	11.1	0.0	8.3	21.4	15.0				
	Readmits	7	8	16	6	3	6	15	6	12	0		

# 30 Day In-Hospital Mortality Following Major Surgery Rate



Description

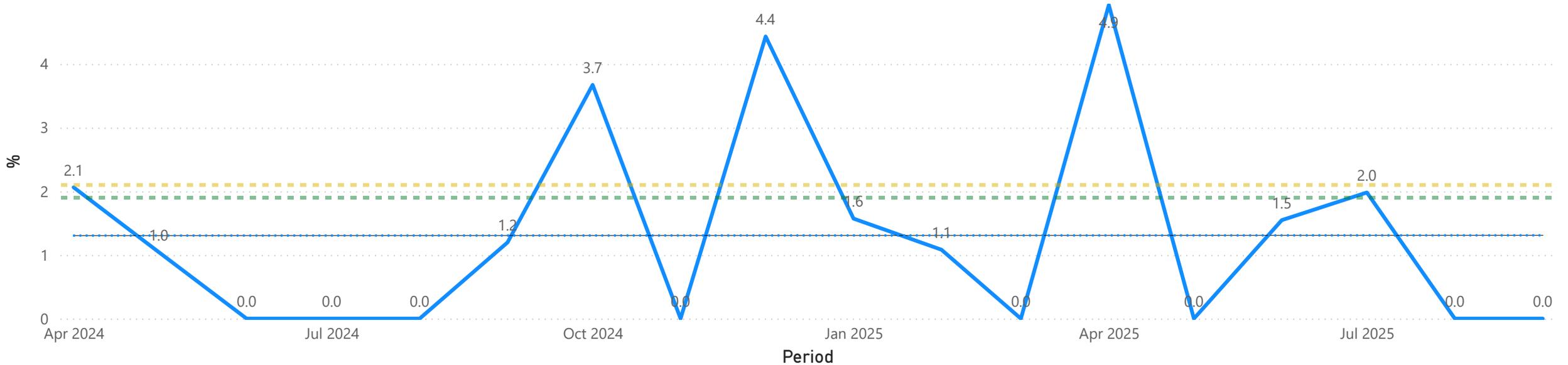
Risk-adjusted rate of in-hospital deaths due to all causes occurring within 30 days of major surgery (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
<b>1.9</b>	<b>1.5</b>	<b>1.2</b>	<b>▲</b>

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	2.0	0.0	0.0						

# 30 Day Overall Readmission Rate



## Description

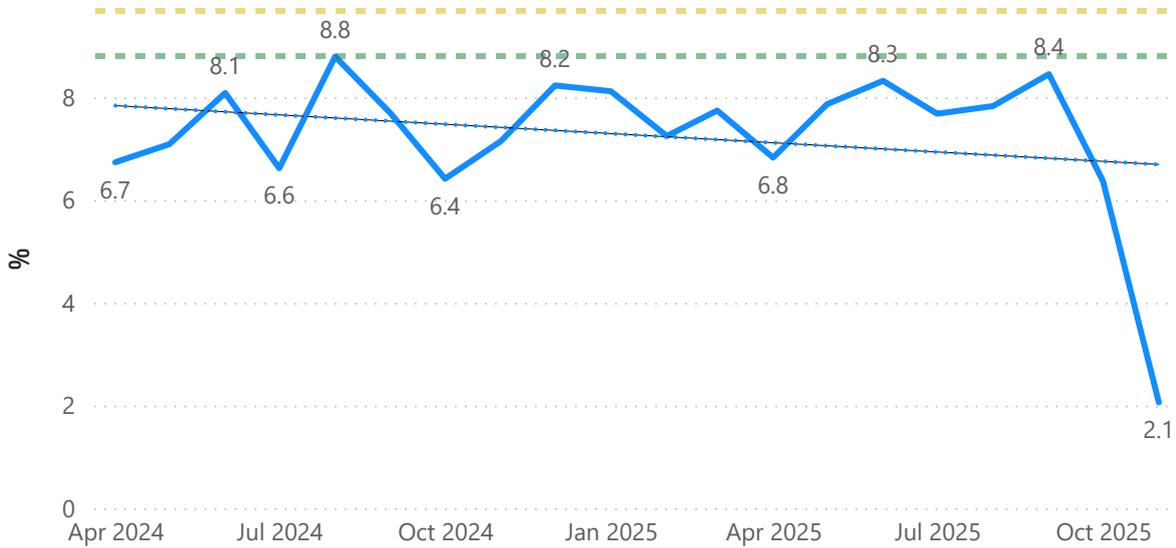
The rate of urgent readmissions within 30 days of discharge for episodes of care for the following patient groups: medical, obstetric, paediatric, and surgical. Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average

## Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
8.8	7.5	6.9	<span style="color: green; font-size: 2em;">●</span>

## 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	6.8	7.9	8.3	7.7	7.8	8.4	6.4	2.1				

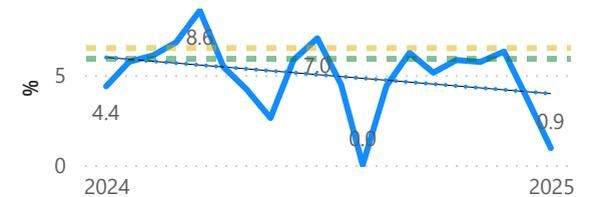
## Readmissions, by Patient Group

IndicatorName	Target	YTD	Status (Last 3 periods)
30 Day Medical Readmission Rate	13.40	11.25	<span style="color: green;">●</span>
30 Day Obstetric Readmission Rate	1.40	1.19	<span style="color: orange;">▲</span>
30 Day Paediatric Readmission Rate	6.70	6.32	<span style="color: orange;">▲</span>
30 Day Surgical Readmission Rate	5.90	5.57	<span style="color: orange;">▲</span>

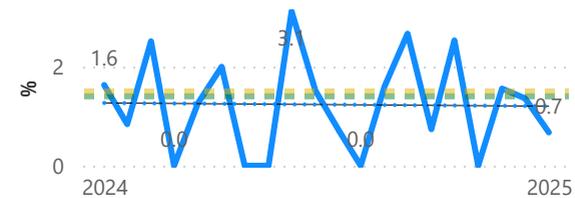
## Medical Readmissions Trend



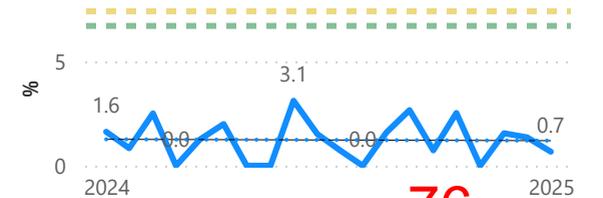
## Surgical Readmissions Trend



## Obstetric Readmissions Trend



## Paediatric Readmissions Trend



76

# Ambulance Offload Time, minutes, 90th percentile



## Description

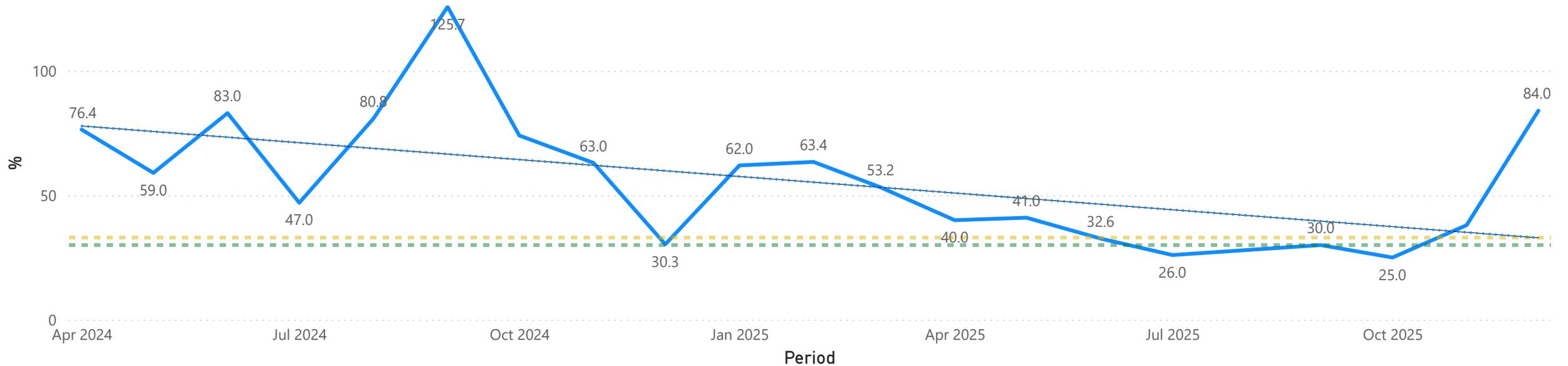
The total time, in minutes, in which 9 out of 10 patients who arrived via ambulance waited for transfer of care process to be completed, calculated as the total time elapsed from ambulance arrival to completion of transfer of care process.

## Data Source

National Ambulatory Care Reporting System (NACRS)



## 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	28.0	30.0	25.0	38.0	84.0			



# 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

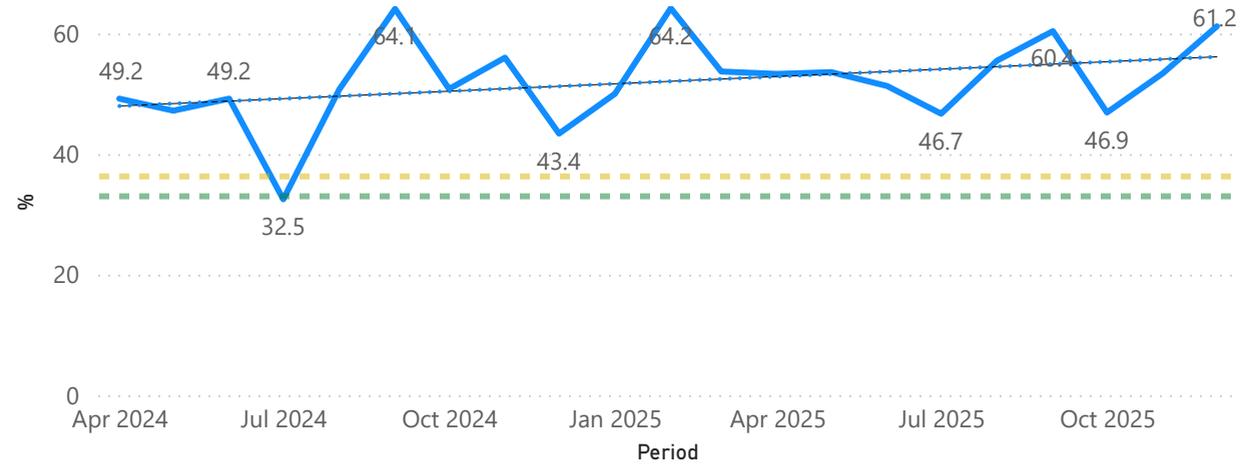
### Data Source

National Ambulatory Care Reporting System (NACRS)

Target      Previous YE      YTD      Status (Last 3 periods)

**33.0**      **52.0**      **54.0**

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	55.5	60.4	46.9	53.4	61.2			

## 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

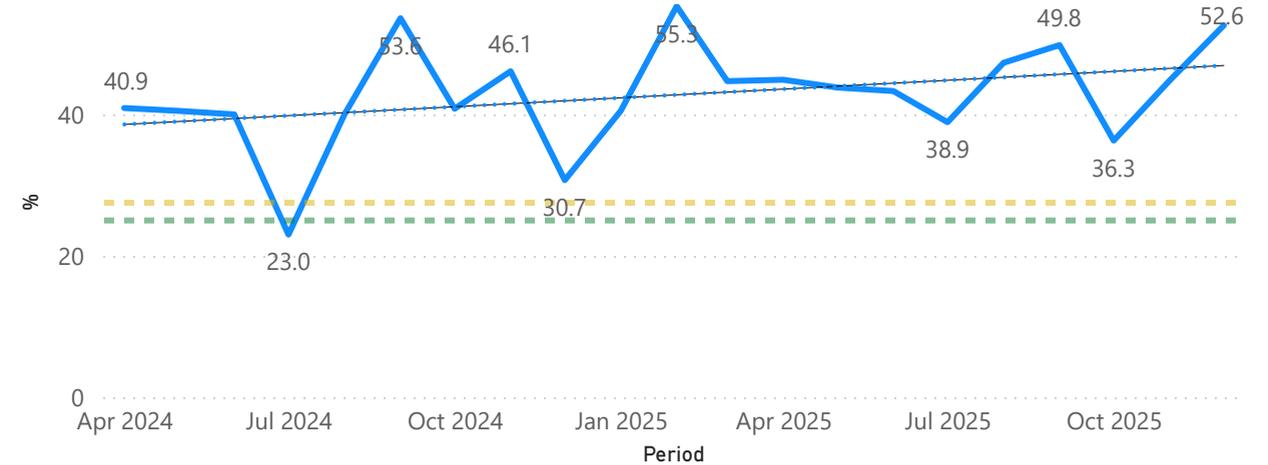
### Data Source

National Ambulatory Care Reporting System (NACRS)

Target      Previous YE      YTD      Status (Last 3 periods)

**25.0**      **42.8**      **45.4**

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	47.3	49.8	36.3	44.8	52.6			



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



## Description

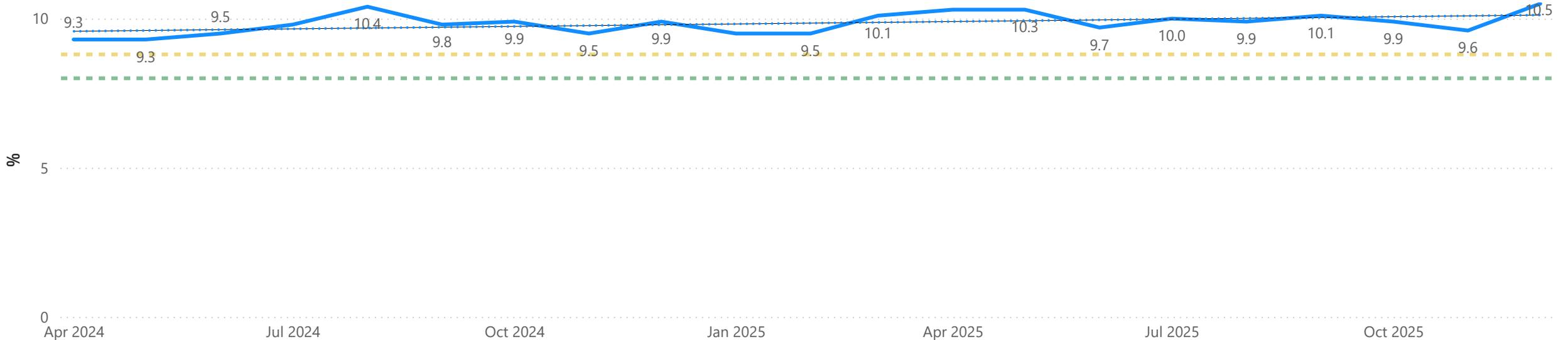
The total time, in hours, that 9 out of 10 high-urgency patients (CTAS 1-3) who were not admitted spent in the emergency department (ED), calculated as the total time elapsed from triage to when the patient left the ED

## Data Source

National Ambulatory Care Reporting System (NACRS)



## 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	9.9	10.1	9.9	9.6	10.5			



# Provider Initial Assessment Time, hours, 90th percentile



## Description

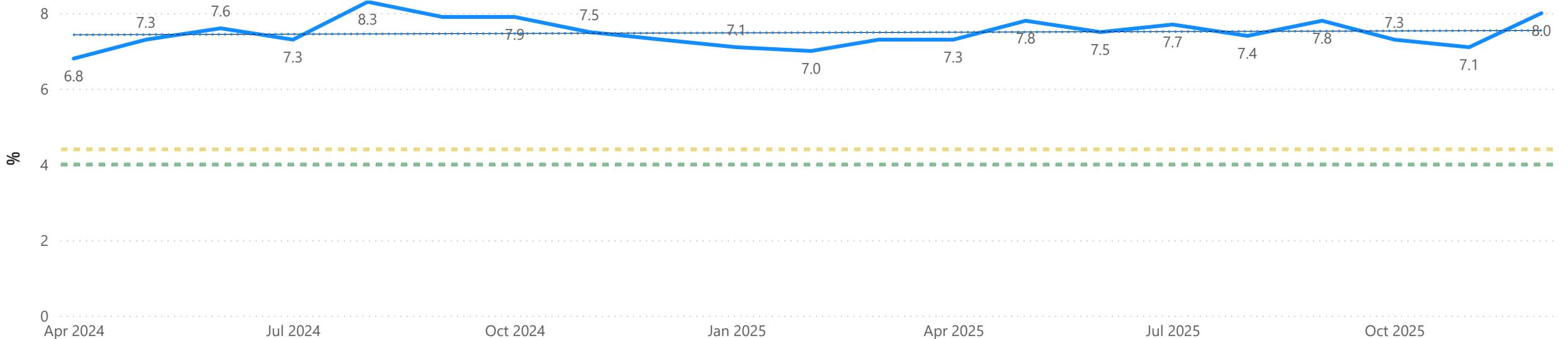
The total time, in hours, that 9 out of 10 patients spent waiting for their first assessment by a doctor or nurse practitioner in the emergency department (ED), calculated as the total time elapsed from triage to time of initial assessment

## Data Source

National Ambulatory Care Reporting System (NACRS)

<b>Target</b>	<b>Previous YE</b>	<b>YTD</b>	<b>Status (Last 3 periods)</b>
<b>4.0</b>	<b>7.5</b>	<b>7.5</b>	

## 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	7.4	7.8	7.3	7.1	8.0			



# Urgent Provider Initial Assessment Time, hours, 90th percentile



## Description

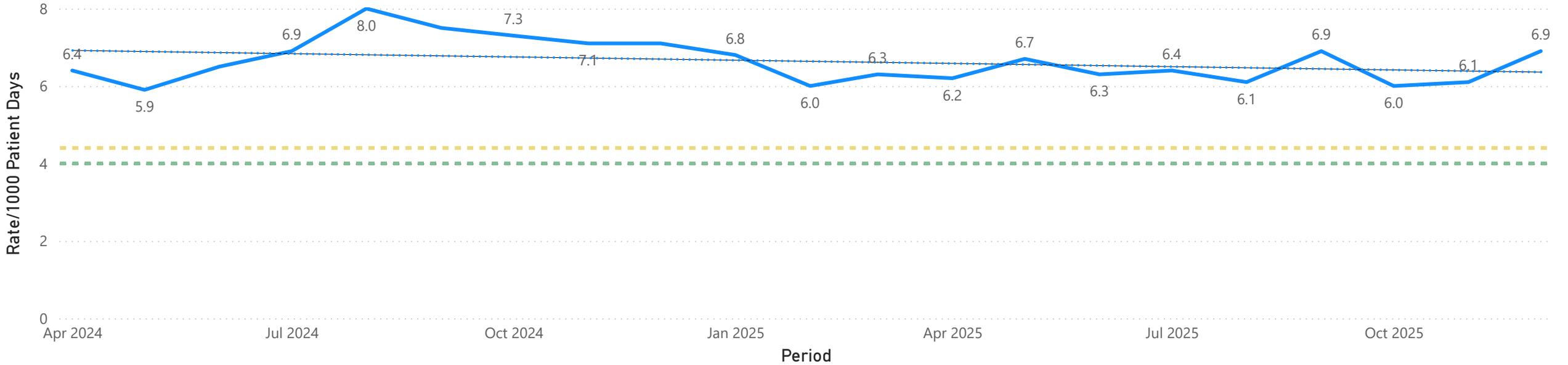
The total time, in hours, that 9 out of 10 patients spent waiting for their first assessment by a doctor or nurse practitioner in the emergency department (ED), calculated as the total time elapsed from triage to time of initial assessment

## Data Source

National Ambulatory Care Reporting System (NACRS)



## 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	6.1	6.9	6.0	6.1	6.9			

# Hip Fracture Surgery within 48 Hours, %



## Description

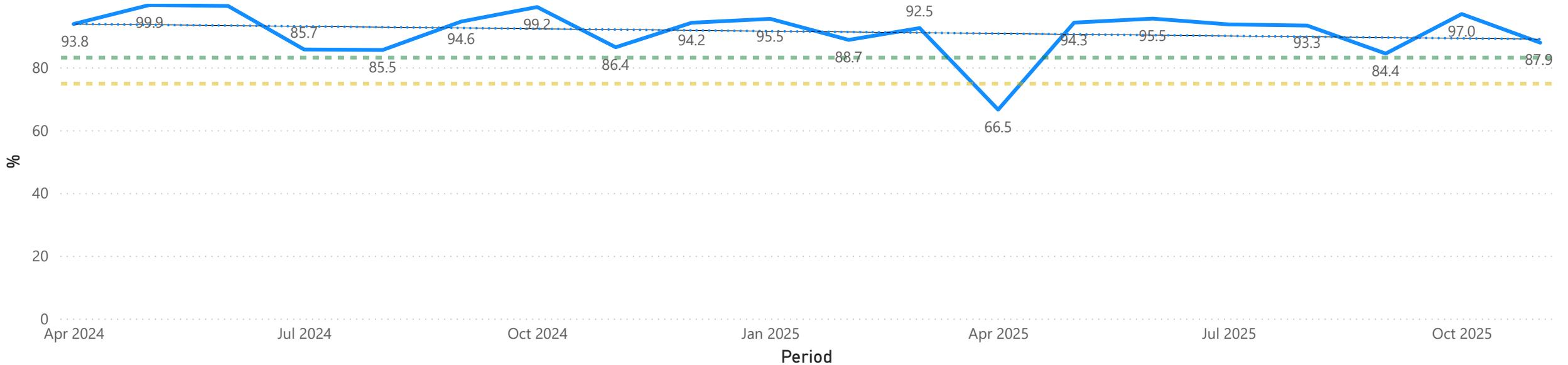
Risk-adjusted proportion of hip fractures that were surgically treated within 48 hours of initial admission (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

## Data Source

Discharge Abstract Database (DAD)



## 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	93.7	93.3	84.4	97.0	87.9				



# Hospital Standardized Mortality Ratio (HSMR)



## Description

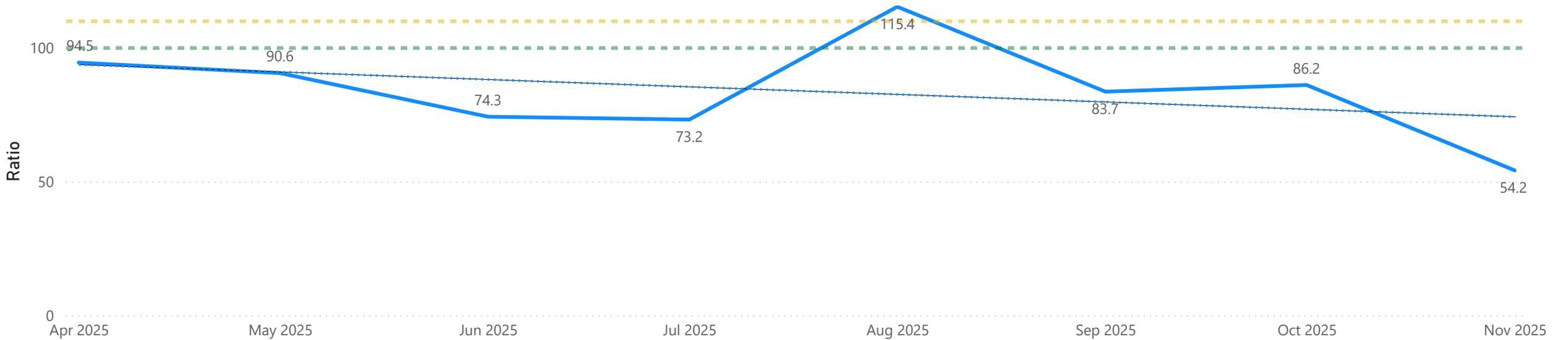
The ratio of the actual number of in-hospital deaths to the expected number of in-hospital deaths, for conditions accounting for about 80% of inpatient mortality

## Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
<b>100.0</b>	<b>94.6</b>	<b>83.8</b>	

## Trend



### Period

Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
2025/2026	94.5	90.6	74.3	73.2	115.4	83.7	86.2	54.2

# In-Hospital Sepsis



### Description

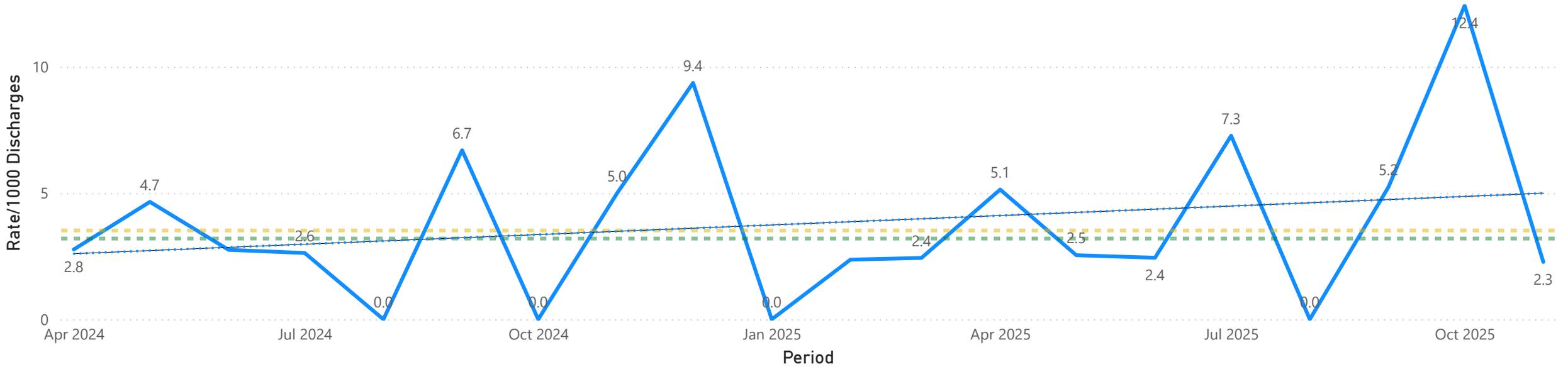
Risk-adjusted rate of sepsis that is identified after admission, per 1,000 discharges (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

### Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
3.2	3.2	4.7	

### 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	7.3	0.0	5.2	12.4	2.3				

# Low-Risk Caesarean Section Rate



### Description

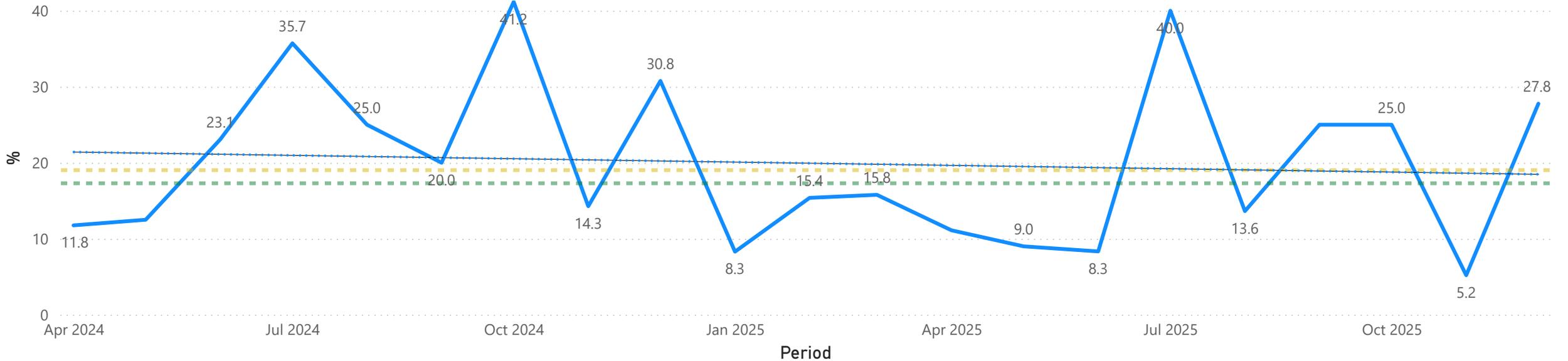
This indicator measures the rate of deliveries via Caesarean section among singleton term cephalic pregnancies for low-risk nulliparous women in spontaneous labour

### Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
<b>17.3</b>	<b>21.1</b>	<b>18.3</b>	

### 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	40.0	13.6	25.0	25.0	5.2	27.8			

# Obstetric Trauma (with Instrument)



## Description

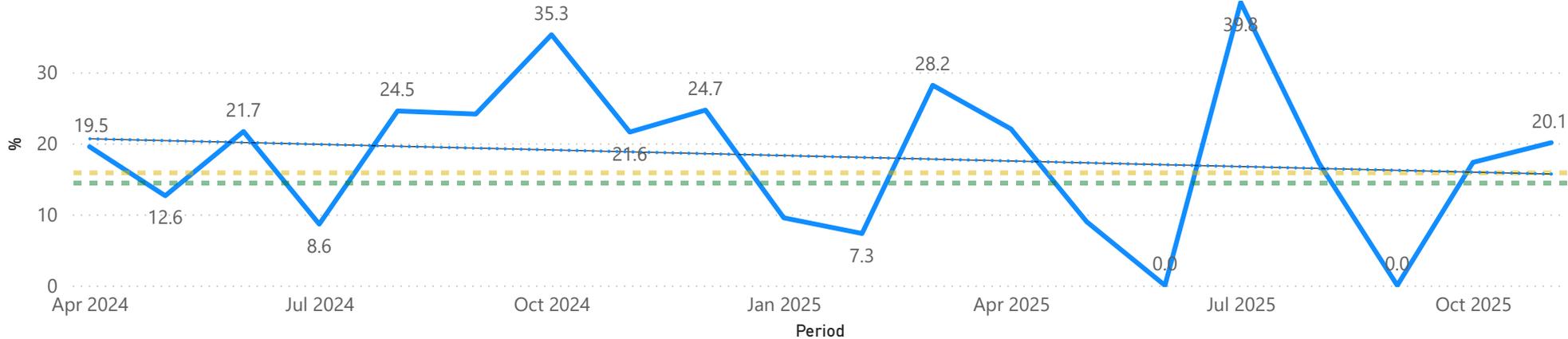
Risk-adjusted rate of obstetric trauma (lacerations that are third degree or greater in severity) for instrument-assisted vaginal deliveries  
 (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average,18.4)

## Data Source

Discharge Abstract Database (DAD)



## Trend



Month	Observed
Nov-25	3.00
Oct-25	2.00
Sep-25	0.00
Aug-25	4.00
Jul-25	4.00
Jun-25	0.00
May-25	1.00
Apr-25	3.00

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	39.8	17.2	0.0	17.3	20.1				

# Long Waiters Waiting for Surgical Procedures



## Description

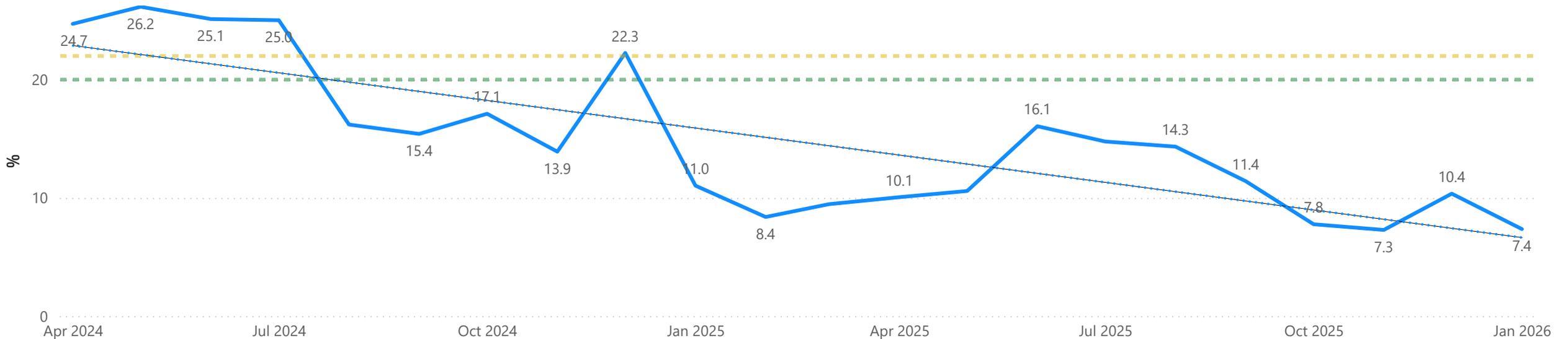
This indicator measures the percentage of patients waiting for a surgical procedure whose wait has exceeded the associated Priority Level Access Target (excludes DART days)

## Data Source

WTIS



## 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	11.4	7.8	7.3	10.4	7.4		

# Patient Safety Event - Falls with Harm Rate



## Description

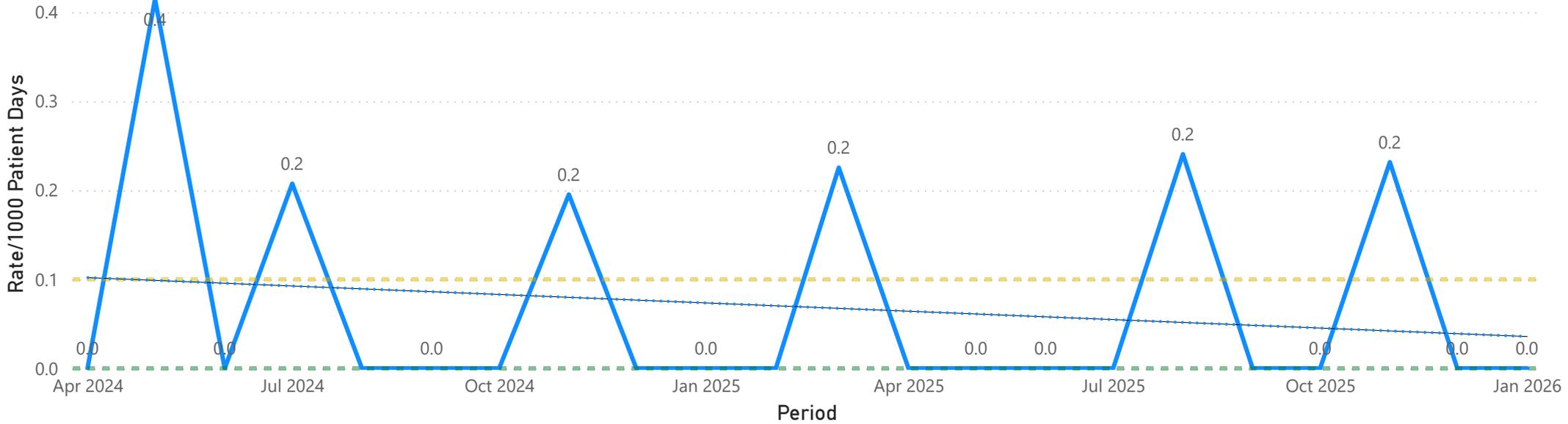
The number of falls with harm per 1,000 inpatient days. This includes events where after review, the severity is deemed to have incurred moderate or severe harm, or a critical incident involving death.

## Data Source

ReportLink, Meditech

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

## Trend



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	0.0	0.0	0.2	0.0	0.0		

# Patient Safety Event - Medication Events with Harm Rate



## Description

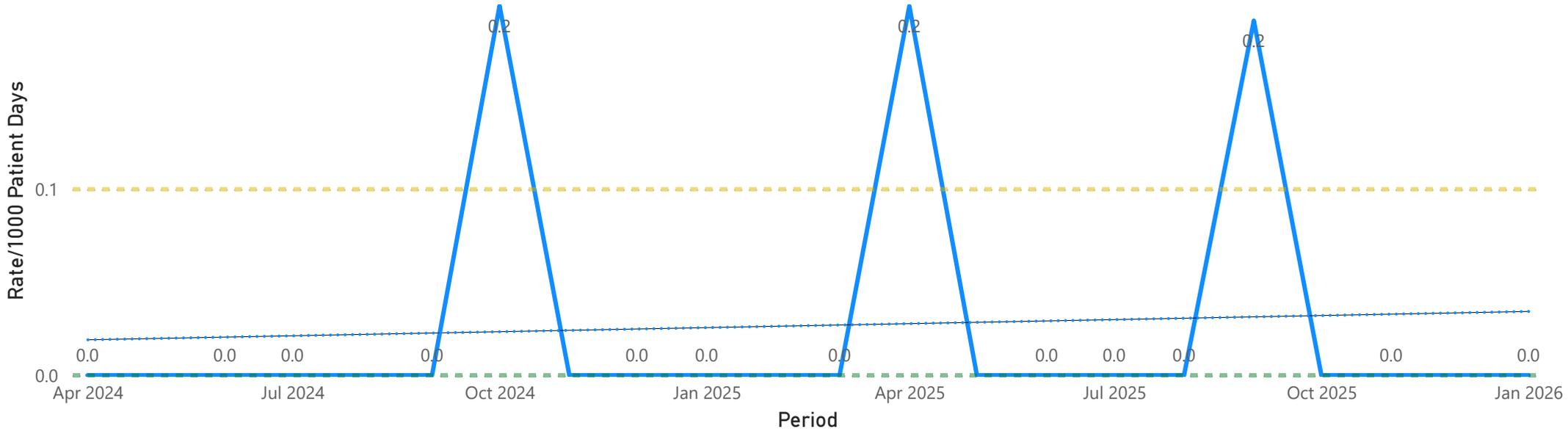
The number of medication events with harm per 1,000 inpatient days. This includes events where after review, the severity is deemed to have incurred moderate or severe harm, or a critical incident involving death.

## Data Source

ReportLink, Meditech



## Trend



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	0.2	0.0	0.0	0.0	0.0	0.0	0.0

# Medication Reconciliation



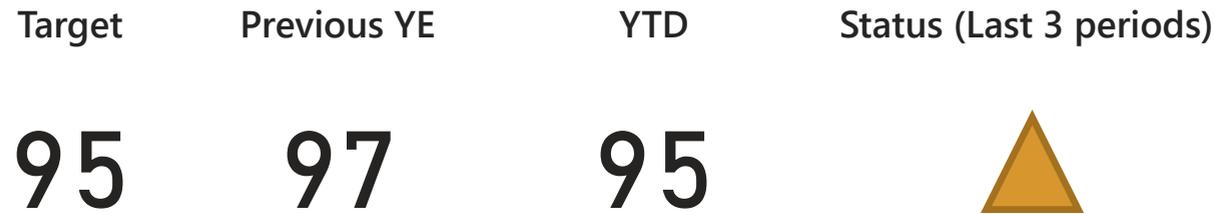
## Admission

### Description

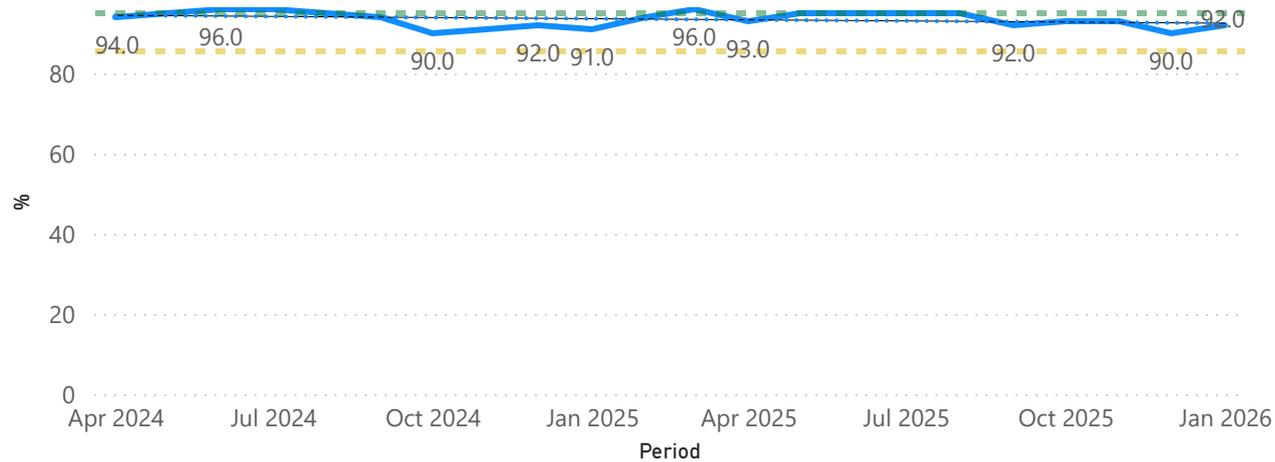
The total number of patients who were discharged who had a Best Possible Medication History (BPMH) completed divided by the total number of patients who were discharged home

### Data Source

Meditech Pharmacy Patient Profile



### 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	92.0	93.0	93.0	90.0	92.0		

## Discharge

### Description

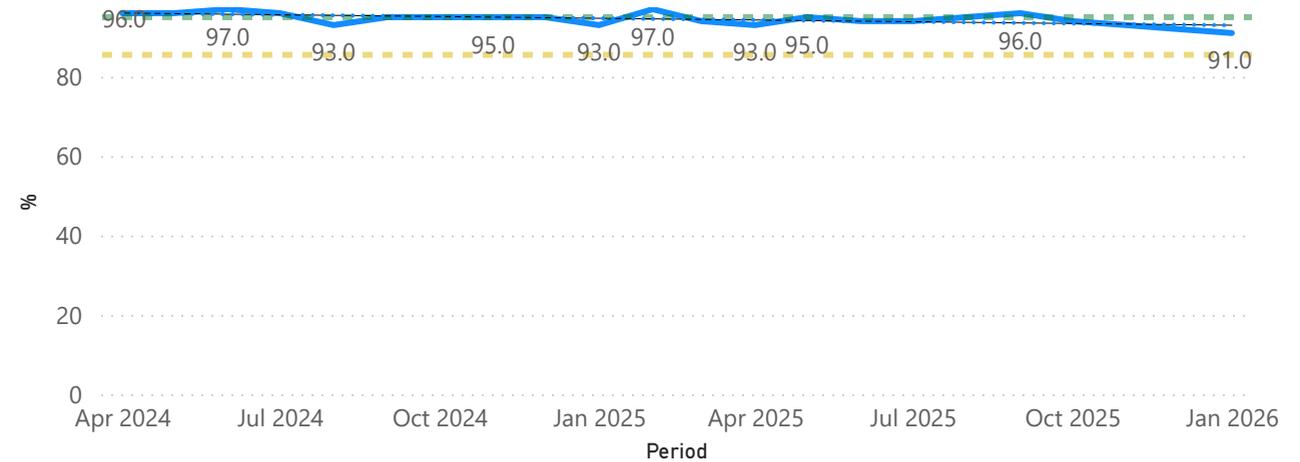
The percentage of Yes responses to the question "Was the CMH community pharmacy prescription completed?" for all inpatient locations participating in medication reconciliation at discharge

### Data Source

Meditech



### 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	96.0	94.0	93.0	92.0	91.0		



# 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

**746.3K**

YTD Target

**6.7M**

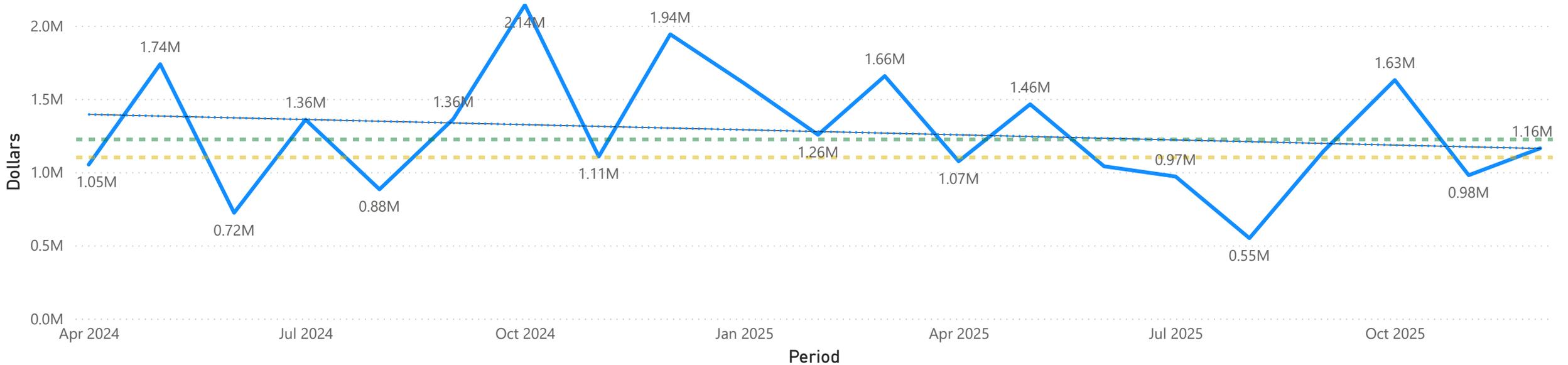
YTD Total

**10.0M**

Status (Last 3 periods)



## 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	1,074,504	1,463,623	1,040,111	970,515	549,453	1,142,109	1,628,880	979,273	1,163,081			



# Quality Based Procedure (QBP) Revenue



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

2.2M

YTD Target

20.1M

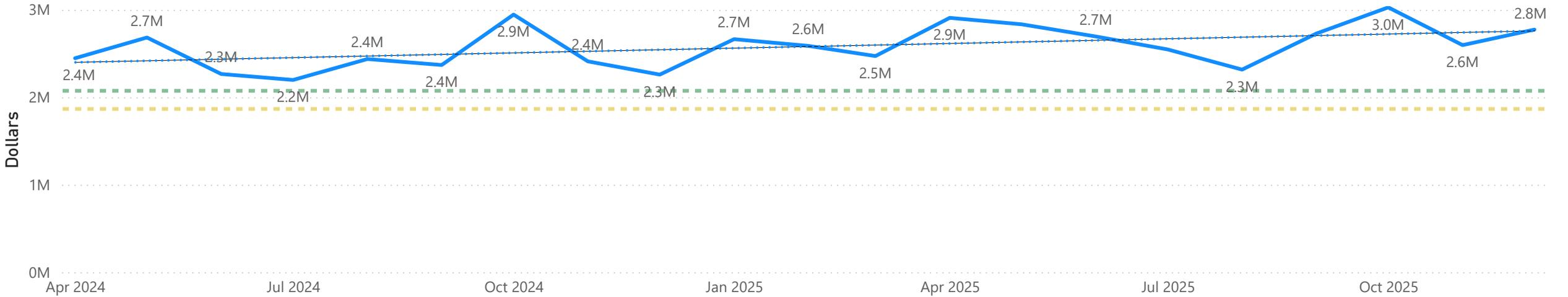
YTD Total

24.4M

Status (Last 3 periods)



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	2,907,448	2,833,622	2,694,206	2,545,912	2,315,777	2,727,955	3,027,090	2,595,678	2,773,356			

\*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

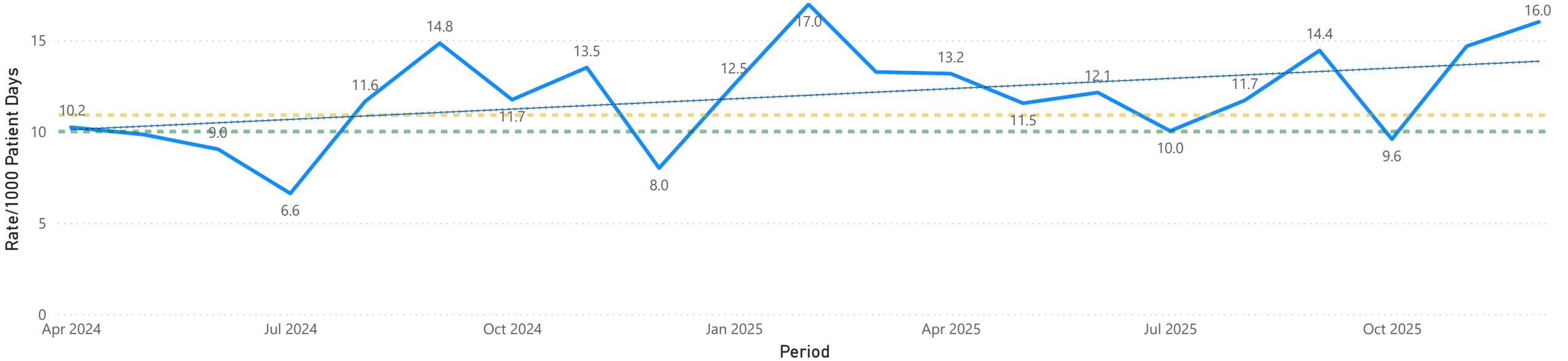
The number of patients in the emergency department waiting for an inpatient bed at 8 a.m. who have been waiting at least 2 hours since disposition. Average number of patients per day

Data Source

NACRS



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	11.7	14.4	9.6	14.7	16.0			



Description

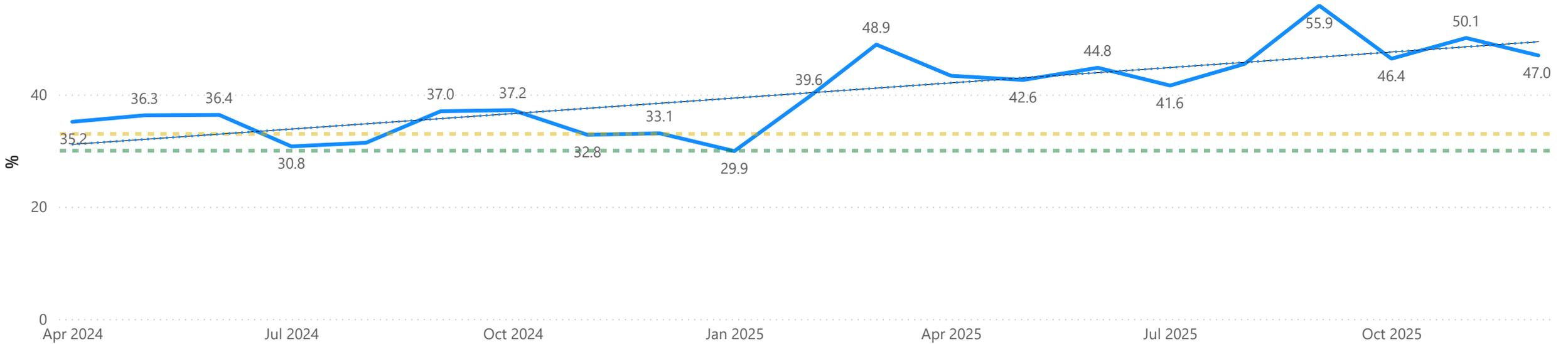
The total patient days over the benchmark LOS (conservable days) as a percentage of the total acute patient days for patients discharged from MEDA/MEDB. The benchmark LOS is determined by case mix group, age, and resource intensity level of a discharge.

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
<b>30.0</b>	<b>36.1</b>	<b>46.67</b>	

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	29.9	39.6	48.9
2025/2026	43.4	42.6	44.8	41.6	45.5	55.9	46.4	50.1	47.0			



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

## MEMORANDUM

**TO:** Board of Directors, Cambridge Memorial Hospital

**DATE:** February 27, 2026

**REPORTING PERIOD:** January 30, 2026 to February 27, 2026

**FROM:** Patrick Gaskin  
President and CEO

**RE:** CEO Certificate of Compliance

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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

A handwritten signature in black ink that reads "Patrick M. Gaskin".

Patrick Gaskin  
President and CEO

# BRIEFING NOTE

**Date:** February 19, 2026  
**Issue:** Quality Improvement Plan (QIP) 2026 – Metrics and Narrative for Approval  
**Prepared for:** Board of Directors  
**Purpose:**  Approval  Discussion  Information  Seeking Direction  
**Prepared by:** Liane Barefoot, Director Patient Experience, Quality, Risk, Privacy & IPAC  
**Approved by:** Quality Committee of the Board of Directors

- Attachments/Related Documents:**
1. QIP 2026 – Priorities by Sector
  2. QIP 2026 – Summary Slides
  3. QIP 2026 – Narrative

**Alignment with 2025/26 CMH Priorities:**

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

**Alignment with 2025/26 CMH Corporate Plans: Quality and Safety Plan**

**Recommendation/Motion  
 2026 QIP Metrics for Approval**

**Board**

That, the CMH Board of Directors approves the six 2026 Quality Improvement Plan (QIP) Metrics as presented below and upon recommendation of the Quality Committee at its meeting of February 18, 2026:

1. Reduce the 90<sup>th</sup> Percentile Ambulance Offload time from x min to 30 minutes
2. Reduce the 90<sup>th</sup> Percentile Physician Initial Assessment (PIA) time for CTAS 1's from x to 30 minutes
3. Reduce the 90<sup>th</sup> Percentile Physician Initial Assessment time for all CTAS levels combined from x hours to 4.5 hours
4. Reduce the daily average number of patients waiting in the ED for an inpatient bed at 8 AM from x to 9.15
5. Reduce the Medicine program conservable bed days from x to 27
6. Increase the % of respondents with the top box answer “completely” from x to 74.27%

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

### **Quality Committee**

**Proposed motion, that** the Quality Committee endorses the six (6) 2026 Quality Improvement Plan (QIP) Metrics as presented below, and forward to the Board of Directors for approval.

1. Reduce the 90<sup>th</sup> Percentile Ambulance Offload time from x min to 30 minutes
2. Reduce the 90<sup>th</sup> Percentile Physician Initial Assessment (PIA) time for CTAS 1's from x to 30 minutes
3. Reduce the 90<sup>th</sup> Percentile Physician Initial Assessment time for all CTAS levels combined from x hours to 4.5 hours
4. Reduce the daily average number of patients waiting in the ED for an inpatient bed at 8 AM from x to 9.15
5. Reduce the Medicine program conservable bed days from x to 27
6. Increase the % of respondents with the top box answer “completely” from x to 74.27%. **CARRIED.**

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

### **2026 QIP Narrative for Approval**

#### **Board**

That, the CMH Board of Directors approves the 2026 Quality Improvement Plan (QIP) Narrative for the following sections and upon recommendation of the Quality Committee at its meeting of February 18, 2026:

- Overview
- Access and Flow
- Equity and Indigenous Health
- Patient/Client/Resident Experience
- Provider Experience
- Safety
- Palliative Care
- Population Health Management

### **Quality Committee**

#### **2026 QIP Narrative for Approval**

**Proposed motion, that** the Quality Committee endorses the 2026 Quality Improvement Plan (QIP) Narrative as presented in Appendix 1, and forward to the Board of Directors for approval. **CARRIED.**

### **Background**

All Hospitals in Ontario are required to submit a Quality Improvement Plan (QIP) annually by April 1st. This plan includes metrics with specific targets, and answers to pre-set narrative questions. Given that the QIP is a public-facing document, careful consideration should be given to how the information is presented, ensuring a coherent and strategic, yet understandable, narrative.

As depicted in Appendix 1, the metrics in the QIP are divided into four priority areas: access & flow, equity, experience, and safety. While the Minister of Health has the authority to set mandatory indicators, there are no mandatory indicators for the 2026/27 fiscal year. However, some metrics are classified as Priority Indicators, and hospitals must provide a rationale if they opt not to focus on these areas. Hospitals may also choose to submit Custom indicators reflective of local level work/area(s) of focus.

### **Analysis**

The chart below includes a summary of all Ontario Health (OH) metrics from Appendix 1, which ones will be included in the CMH 2026/27 QIP, and a notation on which indicators

are part of the PayForResults (P4R) program and/or are currently on, the Quality Committee Quality Monitoring Scorecard (QMS on the chart below).

Priority Issue	2026/27 OH Indicators	Include	Omit	P4R	QMS
Access & Flow	90 <sup>th</sup> Percentile ambulance offload time (Priority)	√		√	√
	90 <sup>th</sup> Percentile emergency department wait time to physician initial assessment (Priority)	√		√	√
	90 <sup>th</sup> Percentile emergency department wait time to physician initial assessment for CTAS 1 (Custom)	√			√
	Daily average number of patients waiting in the emergency department for an inpatient bed at 8 AM (Priority)	√			√
	90 <sup>th</sup> Percentile emergency department length of stay – admitted patients (Optional)		√	√	√
	90 <sup>th</sup> Percentile emergency department length of stay for non-admitted patients with low acuity (Optional)		√	√	√
	90 <sup>th</sup> Percentile emergency department length of stay for non-admitted patients with high acuity (Optional)		√	√	√
	90 <sup>th</sup> Percentile emergency department wait time to inpatient bed (Optional)		√	√	√
	Percentage of patients who visited the emergency department and left without being seen by a physician (Optional)			√	
	Average conservable bed days – Medicine only (Custom)	√			√
	Percentage of people who undergo hip fracture surgery within 48 hours of first arrival at any hospital		√		√
Equity	% of staff (executive-level, management, or all) who have completed relevant DEI and antiracism education		√		
	Average ED wait time to PIA for individuals with sickle cell disease (CTAS 1 & 2)		√		
	Rate of ED 30-day repeat visits for individuals with sickle cell disease		√		
	% of ED visits for individuals with sick cell disease triaged with high severity (CTAS 1 & 2)		√		
Experience	Did patients feel they received adequate info about their health and their care at discharge?	√			√
Safety	Rate of delirium onset during hospitalization		√		
	Rate of medication reconciliation at discharge		√		√
	Rate of workplace violence incidents resulting in lost-time injury		√		

**Consultation**

Appendix 2 includes summary slides including historical performance, and target justification for the six (6) selected indicators from the Quality Committee discussion on February 5, 2026.

In addition to the work plan (metrics) all hospitals are required to upload a Narrative to the Navigator with answers to questions provided by OH and included as Appendix 3.

**Next Steps**

Final QIP 2026 including metrics with targets and narrative presented to the Board of Directors on March 4, 2026 for approval.

Once approved by the Board of Directors, the final QIP 2026 including metrics with targets and narrative uploaded into the OH Navigator and [www.cmh.org](http://www.cmh.org) website prior to March 31, 2026.

Priority issues	Indicators (optional unless marked priority), by sector		
	Hospital	Interprofessional primary care	Long-term care
<p><b>Access and flow</b></p> <p><i>A high-quality health system provides people with the care they need, when and where they need it.</i></p>	<ul style="list-style-type: none"> <li>90th percentile ambulance offload time <b>priority</b> <b>prepopulated</b></li> <li>90th percentile emergency department wait time to physician initial assessment <b>priority</b> <b>prepopulated</b></li> <li>Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m. <b>priority</b> <b>prepopulated</b></li> <li>90th percentile emergency department length of stay for nonadmitted patients triaged as low acuity <b>priority</b> <b>prepopulated</b></li> <li>90th percentile emergency department length of stay for nonadmitted patients triaged as high acuity <b>priority</b> <b>prepopulated</b></li> <li>90th percentile emergency department length of stay for admitted patients <b>prepopulated</b></li> <li>90th percentile emergency department wait time to inpatient bed <b>prepopulated</b></li> <li>Percentage of patients who visited the emergency department and left without being seen by a physician <b>prepopulated</b></li> <li>Percentage of people who undergo hip fracture surgery within 48 hours of first arrival at any hospital <b>prepopulated</b></li> </ul>	<ul style="list-style-type: none"> <li>Patient/client perception of timely access to care <b>priority</b></li> <li>Number of new patients/clients/enrolments <b>priority</b></li> <li>Percentage of clients with type 2 diabetes mellitus who are up to date with HbA1c (glycated hemoglobin) blood glucose monitoring</li> <li>Percentage of screen-eligible people who are up to date with colorectal tests</li> <li>Percentage of screen-eligible people who are up to date with cervical cancer screening (updated definition)</li> <li>Percentage of screen-eligible people who are up to date with breast screening</li> </ul>	<ul style="list-style-type: none"> <li>Rate of potentially avoidable emergency department visits for long-term care residents <b>priority</b> <b>prepopulated</b></li> </ul>
<p><b>Equity</b></p> <p><i>Advancing equity, inclusion and diversity and addressing racism to reduce disparities in outcomes for patients, families, and providers is the foundation of a high-quality health system.</i></p>	<ul style="list-style-type: none"> <li>Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education</li> <li>Average emergency department wait time to physician initial assessment for individuals with sickle cell disease (CTAS 1 or 2) <b>prepopulated</b></li> </ul>	<ul style="list-style-type: none"> <li>Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education</li> <li>Completion of sociodemographic data collection</li> <li>Percentage of clients actively receiving mental health care from a traditional provider</li> <li>Number of events and participants for traditional teaching, healing, or ceremony</li> </ul>	<ul style="list-style-type: none"> <li>Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education</li> </ul>
<p><b>Experience</b></p> <p><i>Better experiences result in better outcomes. Tracking and understanding experience is an important element of quality.</i></p>	<ul style="list-style-type: none"> <li>Did patients feel they received adequate information about their health and their care at discharge?</li> </ul>	<ul style="list-style-type: none"> <li>Do patients/clients feel comfortable and welcome at their primary care office?</li> </ul>	<ul style="list-style-type: none"> <li>Do residents feel they can speak up without fear of consequences?</li> <li>Do residents feel they have a voice and are listened to by staff?</li> </ul>
<p><b>Safety</b></p> <p><i>A high-quality health system ensures people receive care in a way that is safe and effective</i></p>	<ul style="list-style-type: none"> <li>Rate of delirium onset during hospitalization <b>prepopulated</b></li> <li>Rate of medication reconciliation at discharge</li> <li>Rate of workplace violence incidents resulting in lost-time injury</li> </ul>	<ul style="list-style-type: none"> <li>Number of faxes sent per 1,000 rostered patients <b>priority</b></li> <li>Provincial digital solutions suite (<b>7 indicators</b>): Percentage of clinicians in the primary care practice using... [eReferral, eConsult, OLIS, HRM, electronic prescribing, online appointment booking, AI scribe]</li> </ul>	<ul style="list-style-type: none"> <li>Percentage of long-term care residents not living with psychosis who were given antipsychotic medication <b>prepopulated</b></li> <li>Percentage of long-term care residents who fell in the last 30 days <b>prepopulated</b></li> <li>Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened <b>prepopulated</b></li> <li>Percentage of long-term care residents in daily physical restraints <b>prepopulated</b></li> </ul>

**Note:** Organizations may also consider adding custom indicators to address their own improvement opportunities and collaborative work with other health service providers. **Abbreviations:** CTAS, Canadian Triage and Acuity Scale; HRM, Health Report Manager; OLIS, Ontario Laboratory Information System.

**Need this information in an accessible format?** 1-877-280-8538, TTY 1-800-855-0511, [info@ontariohealth.ca](mailto:info@ontariohealth.ca)

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# Quality Improvement Plan (QIP) Metrics – 2026/27



**CMH** CAMBRIDGE  
MEMORIAL  
HOSPITAL

Liane Barefoot  
Director Patient Experience, Quality, Privacy, Risk & IPAC  
Chief Privacy Officer

# QIP2026 Executive Summary

Hospitals are required to submit a Quality Improvement Plan (QIP) annually by April 1st. This plan includes metrics with specific targets, and answers to pre-set narrative questions.

Given that the QIP is a public-facing document, careful consideration should be given to how the information is presented, ensuring a coherent and strategic, yet understandable, narrative.

The metrics in the QIP are divided into four priority areas: access & flow, equity, experience, and safety. While the Minister of Health has the authority to set mandatory indicators, there are no mandatory indicators for the 2026/27 fiscal year.

However, some metrics are classified as Priority Indicators, and hospitals must provide a rationale if they opt not to focus on these areas.

This slide deck summarizes the six (6) indicators and targets endorsed by Quality Committee members at the February 5, 2026 meeting.

# Metric & Target Recommendation Summary

Indicator	Ontario Health (P4R) Target for 25/26	Recommended Y26/27 Target	Why (Logic / Rationale)
Ambulance Off-Load Time	≤ 30 minutes	30 minutes	OH explicitly sets <b>30 min or less</b> as the ED system flow expectation. It's the most defensible public QIP target and supports throughput + EMS offload efficiency.
PIA – All (90th Percentile Time to Physician Initial Assessment)	≤ 3.4 hours ( <i>OH 90th percentile target</i> )	4.5 hours	OH has a clear provincial target for <b>90th percentile PIA</b> . Even if performance is currently above target, aligning to OH keeps QIP standardized and comparable.
PIA – CTAS 1	<i>Not explicitly specified in OH excerpt</i>	0.5 hours	Since no specific OH target is provided for CTAS 1&2 in the excerpt, maintaining the current target supports continuity. If performance remains higher YTD, results can be contextualized without increasing the target publicly.
No-Bed Admits at 8AM ( <i>Avg # waiting for IP bed at 8AM</i> )	<b>25% reduction from baseline</b>	9.15	OH recommends a <b>25% reduction from baseline</b> . Using baseline of FY2025/26 YTD 12.2, the target is 9.15
Adequate Information at Discharge ( <i>“Completely” response</i> )	<i>No OH provincial numeric target</i>	74.27%	This is patient-reported experience (public-facing), and improvement targets should be <b>clear and achievable</b> . Our Focus is to move 25% of the ‘Quite a Bit’ into ‘Completely’
Conservable Bed Days (Medicine) ( <i>Avg bed-days per day</i> )	<i>No OH numeric target (reported as %/benchmarking)</i>	27(4 Beds reduction)	Same methodology as OH. We are presenting Medicine conservable bed-days as <b>Avg Bed Days/day</b> instead of % for easier interpretation. Our Target is to reduce 4 beds on an average to support improved inpatient flow and reduced ED boarding.

# Ambulance Offload Time (90th%tile) (Priority)

## Description:

Ambulance offload time is the duration (time elapsed) between the time of ambulance arrival at the emergency department and the time the ambulance transfer of care process is complete.

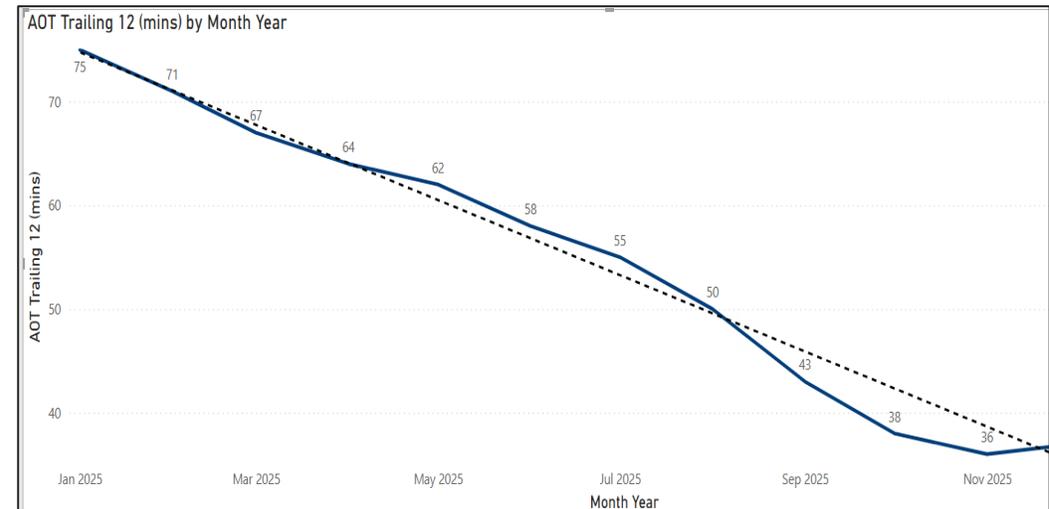
## Analysis:

The ambulance offload time has shown sustained improvement throughout FY2025-26 YTD, as depicted in Chart 1. Monthly performance has been closely aligned with the 30-minute target. The current year-to-date performance is 32 minutes, marginally exceeding the 30-minute benchmark, signaling a stable yet improvable trend. Chart 2 is the trailing 12 performance which shows significant improvement in our offload times.

Chart 1: Monthly AOT Trend



Chart 2: Trailing 12



## Recommendation:

Recommended to include in QIP	Recommended QIP Target	OH Target	Rationale
Yes	30 Min	30 Min	Monitor and Sustain

# Emergency Department PIA (90<sup>th</sup>%tile) (Priority)

## Description:

Emergency department wait time to physician initial assessment is the duration (time elapsed) between a patient being triaged or registered (whichever comes first) and physician initial assessment

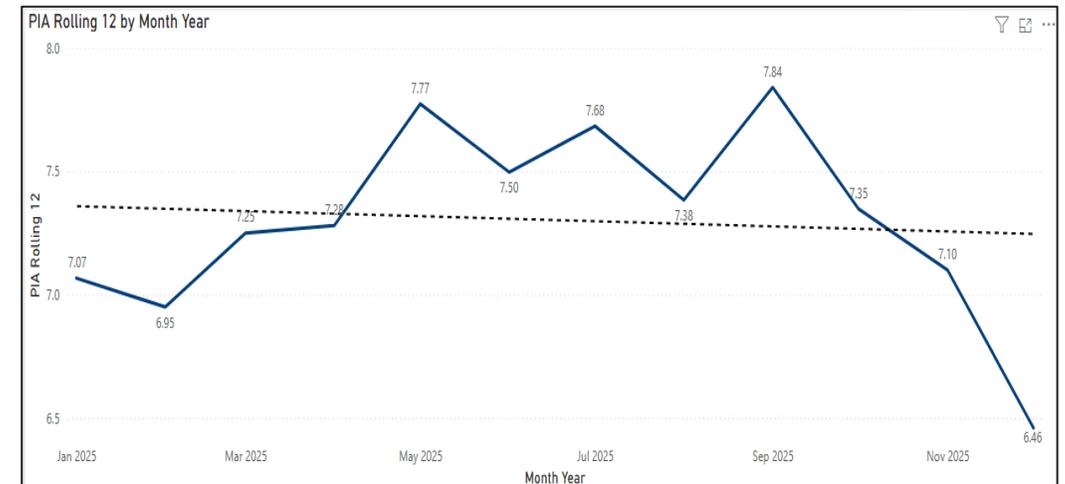
## Analysis:

The wait time for initial assessment in the ED has remained elevated throughout FY2025-26 YTD. As of November, the year-to-date performance stands at 7.5 hours, an increase from the 6.9 hours reported at the end of FY2024-25, and continues to exceed the target of 4.0 hours.

Chart 1: Monthly PIA Wait-time



Chart 2: Trailing 12



## Recommendation:

Recommended to include in QIP	Recommended QIP Target	OH Target	Rationale
Yes	4.5 Hours	3.4 Hours	Critical indicator to improve, target set to top performance in our sub region

# Emergency Department PIA - Urgent (90<sup>th</sup> %tile) (Priority)

## Description:

Emergency department wait time to physician initial assessment (CTAS 1-2) is the duration (time elapsed) between a patient being triaged or registered (whichever comes first) and physician initial assessment

## Analysis:

The wait time for initial assessment of urgent ED patients (CTAS 1-2) has remained above the 4.0-hour target in FY2025-26 YTD, with a year-to-date performance average of 6.3 hours. Chart 1 illustrates that monthly performance generally ranges between approximately 6 to 7 hours. Chart 2, which measures the 90th percentile wait time for our most critical CTAS 1 patients, demonstrates significant improvements. It is crucial that we sustain these gains moving into FY2026-27.

Chart 1: 90<sup>th</sup>%tile CTAS 1-2 PIA LOS

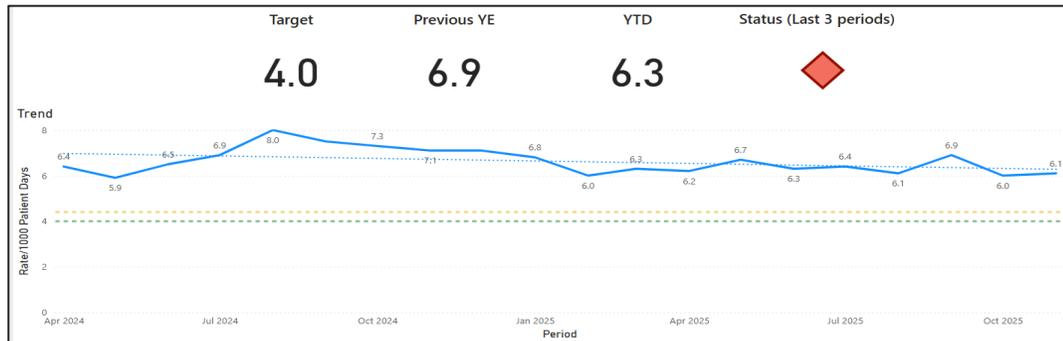
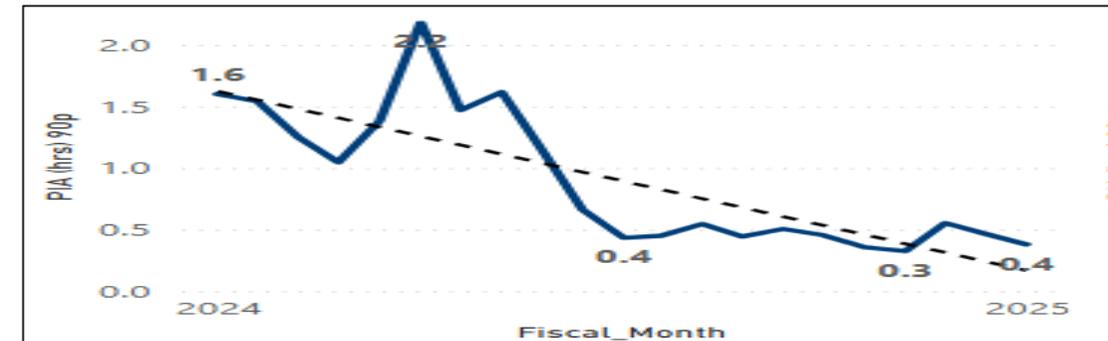


Chart 2: 90<sup>th</sup>%tile CTAS 1 PIA LOS



## Recommendation:

Recommended to include in QIP	Recommended QIP Target	OH Target	Rationale
No			Already captured in overall PIA

Recommended to include in QIP	Recommended QIP Target	OH Target	Rationale
Yes	0.5 Hours		Sustain performance for sickest patients

# Daily average number of patients waiting in the emergency department for an inpatient bed at 8 AM (Priority)

## Description:

The number of patients in the emergency department waiting for an inpatient bed at 8 a.m. (also known as no bed admits) is the number of people who had been admitted but who, by 8 a.m., had been waiting at least 2 hours since disposition, were still in the emergency department (i.e., not yet in an inpatient bed), and then left the emergency department.

## Analysis:

The daily average number of patients has remained elevated in FY2025-26 YTD, with Chart 1 showing monthly ER holds generally above the target of 10 patients. Current YTD performance is 12.2, compared to 11.5 in the previous year, indicating increased pressure on ED flow and inpatient capacity. Chart 2 suggests this pressure is expected to persist through year-end, with the forecast remaining above target and trending closer to the upper range, highlighting the need for continued focus on bed availability and patient flow initiatives.

Chart 1: Monthly ER Holds at 8am\*

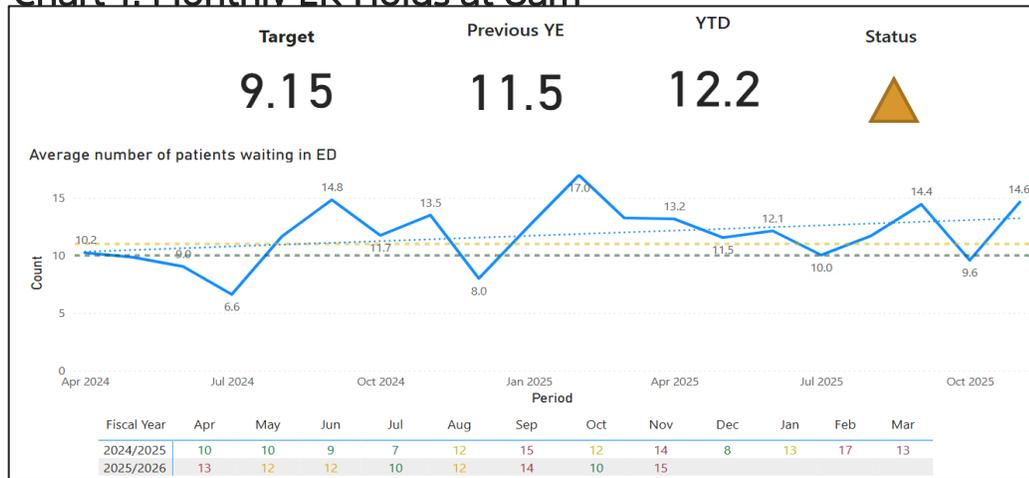
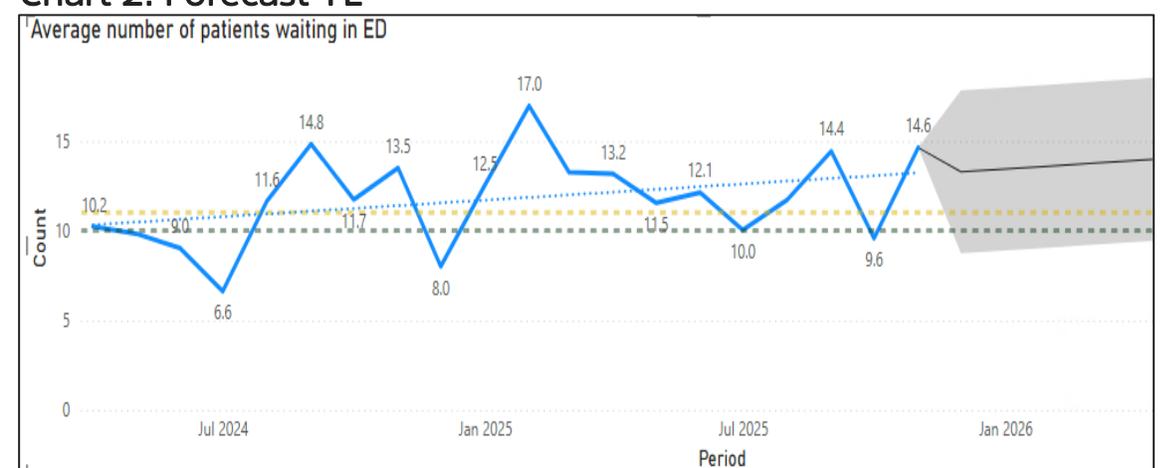


Chart 2: Forecast YE



## Recommendation:

Recommended to include in QIP	Recommended QIP Target	OH Target	Rationale
YES	9.15	25% reduction on YTD Performance	Critical to patient flow

# Conservable Bed Days – Medicine Only

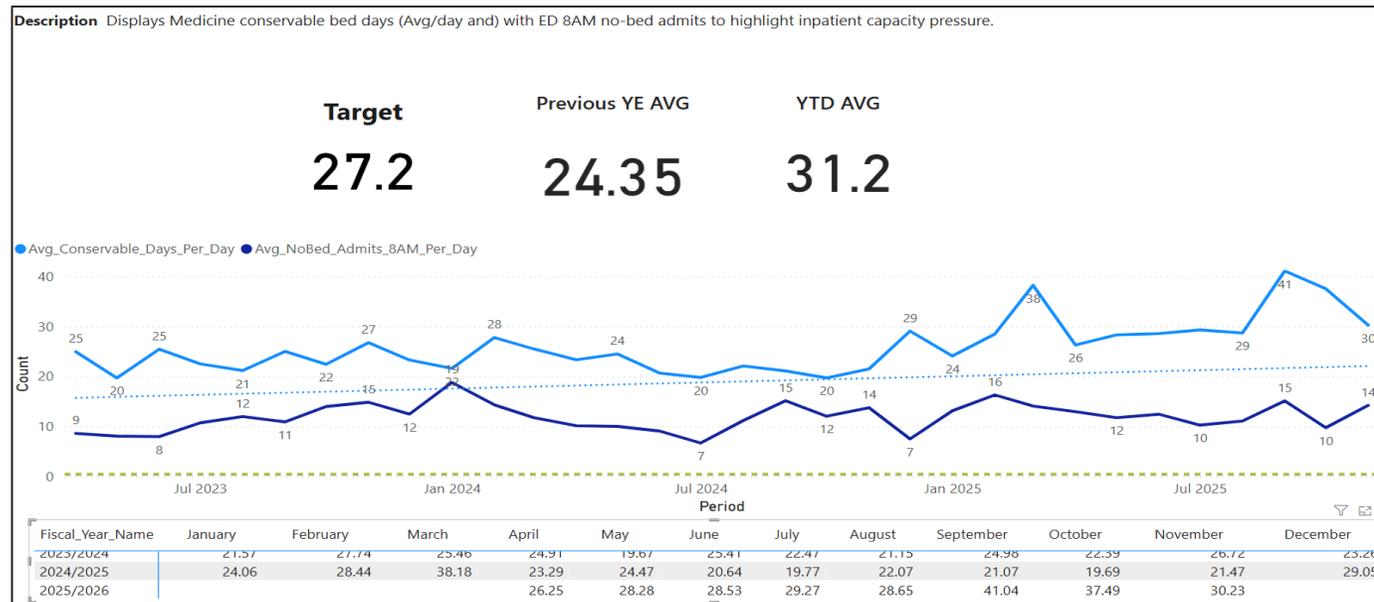
## Description:

This represents the number of inpatient days that could potentially be avoided or reduced through improved patient flow, timely discharge planning, and earlier transition of care. This measures bed days (avg/day) over the expected length of stay.

## Analysis:

Medicine conservable bed-days are higher in FY2025–26 YTD (31.2/day) compared to the previous year average (24.35/day), indicating increased LOS over expected LOS and reduced inpatient bed availability. ED admitted holds at 8AM remain elevated, suggesting inpatient capacity pressures may be contributing to ongoing ED boarding.

Chart 1: Conservable Bed Days



## Recommendation:

Recommended to include in QIP	Recommended QIP Target	OH Target	Rationale
YES	27(4 Beds reduction)		Strong measure of bed efficiency and link to ED Holds

# Did patients feel they received adequate information about their health and their care at discharge? (Optional)

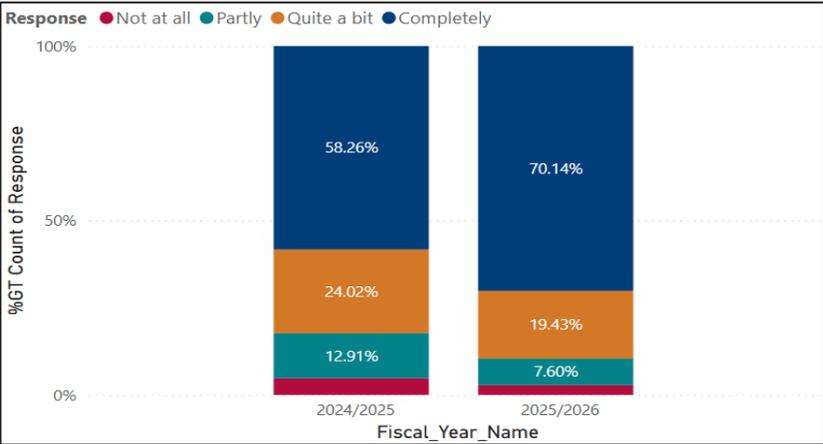
**Description:**

Percentage of respondents who responded “Completely” to the following question: “Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?”

**Analysis:**

In inpatient settings, the proportion of respondents selecting “Completely” increased from 58.3% in FY2024–25 to 70.1% in FY2025–26 YTD, indicating improvement in patients’ perception of receiving adequate information at discharge. With Surgery at 70% , OB at 75%, Medicine at 56% and ED at 32 % (not included – captured in separate ED survey)

**Inpatient**  
Total Respondents  
2024/25 -510 25/26- 817



**Recommendation:**

Recommended to include in QIP	Recommended QIP Target	OH Target	Rationale
Yes – inpatient only	74.27		Move 25% of the ‘Quite a Bit’ into ‘Completely’

## QIP Narrative Questions 2026/27

Quality improvement plan (QIP) narrative questions enable organizations to provide context for their quality improvement work. In each section, organizations are encouraged to share details that they believe people in Ontario would like to know about.

### Cambridge Memorial Hospital

#### Quality Improvement Plan Narrative 2026/27

##### Overview

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

Cambridge Memorial Hospital (CMH) continues to advance its vision of *Building Healthier Communities Together* through coordinated improvement efforts that strengthen quality, safety, equity, and system integration. Recognized by Forbes as a top employer, CMH's performance is grounded in a culture that prioritizes patient safety, staff well-being, and responsible stewardship.

Our five strategic themes guide corporate planning and regional collaboration, ensuring alignment with Ontario Health priorities and the needs of our growing community.

CMH is one of seven hospitals in Canada with the Choosing Wisely Quality Improvement designation. Over the next 24 months, we will pursue Choosing Wisely Leadership Status, reinforcing our commitment to evidence-based care and resource stewardship.

In November 2026, CMH will implement a new regional Health Information System (HIS). This transformation will modernize clinical documentation, strengthen medication safety through closed-loop medication administration and computerized prescriber order entry, reduce duplication, and improve continuity of care across partner organizations.

CMH continues to advance health equity and Indigenous reconciliation through structured action plans and strengthened community partnerships.

CMH is participating in a regional Master Planning process to forecast infrastructure needs over the next 25 years, ensuring long-term capacity aligns with projected population growth.

Despite ongoing fiscal pressures across the healthcare system, CMH is forecasting a balanced financial position this year, reflecting disciplined management and operational efficiency.

## **Access and Flow**

**Ensuring good access and flow means that the right care is received in the right place at the right time across the health care system. Health service organizations are being asked to focus on initiatives that support access and flow, such as initiatives that support individuals in remaining in the community as long as possible and in avoiding unnecessary hospitalization or emergency department visits, and initiatives that ensure timely access to primary care providers. In this section, describe improvement work that your organization has accomplished or planned to ensure people across Ontario receive the right care in the right place and at the right time.**

Improving access and patient flow remains a core focus of CMH's 2026/27 QIP.

Over the past year, CMH achieved measurable improvements in ambulance offload times - a critical system indicator reflecting coordination between hospital and paramedic services. These gains contribute to improved regional flow and emergency response capacity.

Time to provider initial assessment in the Emergency Department remains an area of focus. In 2026/27, CMH will streamline triage and intake processes, standardize workflows, and use data analytics to improve timeliness and patient experience.

CMH is also targeting reductions in conservable bed days by strengthening discharge planning, enhancing interprofessional coordination, and improving partnerships with community providers. Reducing unnecessary bed occupancy will increase acute care capacity and reduce delays for patients awaiting admission.

Together, these initiatives support the delivery of the right care, in the right place, at the right time, while contributing to improved system performance.

## **Equity and Indigenous Health**

**Ontario Health is committed to driving improved and equitable access, experiences, and outcomes to reduce health inequities and advance Indigenous health across the**

province. Advancing health equity and Indigenous health for communities in Ontario requires strategic and sustained efforts.

In this section, please share work that your organization has accomplished or planned to improve equity and Indigenous health (for example, implementation of an equity, inclusion, diversity, and antiracism workplan or a First Nations, Inuit, Métis, and Urban Indigenous health workplan [which may be based on Service Accountability Agreement obligations]).

CMH's Diversity, Equity, and Inclusion (DEI) Plan is guided by four priority themes: Inclusive Language and Images, Education and Tools, People and Processes, and Creating Safe Spaces.

- Inclusive Language and Images: Increased engagement in Diversity Calendar events, development of an Inclusive Communications Guide, and creation of a CMH Photo Repository.
- Education and Tools: Launch of a DEI Toolkit, expanded professional development opportunities, and the L.E.A.R.N. Challenge to promote continuous learning and allyship.
- Creating Safe Spaces: Strengthening the Diversity Council's advisory role and establishing Employee Resource Groups (ERGs).
- People and Processes: Development of a formal DEI policy and refreshed Hospital Wide Orientation to embed equity principles organization-wide.

CMH's Truth & ReconciliACTION Plan aligns with Ontario Health's framework and focuses on: building and sustaining relationships, ensuring equitable access to culturally safe care, enhancing education and capacity, and ongoing measurement and evaluation.

Key initiatives include:

- Strengthening partnerships with the Regional Indigenous Advisory Circle (IAC).
- Advancing the Indigenous staff-led Clinical Recommendations Project.
- Revising the Smudging Policy to improve access and awareness.
- Promoting Indigenous Cultural Safety Training, with a goal of 100% completion among leaders.

Progress is monitored regularly to ensure accountability and sustained impact.

## **Patient/Client/Resident Experience**

**In this section, share how your organization plans to incorporate information from experience surveys (or other feedback received about care experiences) into quality improvement activities.**

Patient experience data, including surveys and feedback from the Patient and Family Advisory Council (PFAC), informs CMH's quality improvement priorities.

Emergency Department wait times continue to be a primary concern identified by patients and families. In response, CMH is implementing improvements in communication and transparency to better inform patients during their visit and improve comfort while waiting.

The 2026/27 QIP also prioritizes improving the discharge experience. Clear discharge instructions and appropriate follow-up support are essential to patient recovery and to preventing avoidable readmissions. Improvement efforts will focus on ensuring patients leave hospital confident in managing their care at home.

PFAC members played a key role in updating CMH's Patient Declaration of Values, which has been approved by the Board and publicly posted. A performance scorecard has been developed to measure alignment with these values and reinforce transparency and accountability.

## **Provider Experience**

**Many organizations are implementing innovative practices to improve recruitment and retention (e.g., through incentive-based programs for nurses and personal support workers), workplace culture, and staff experiences.**

**In this section, describe practices or initiatives your organization has planned to improve recruitment, retention, workplace culture, or staff experience.**

A stable and supported workforce is foundational to high-quality care.

In July 2025, CMH achieved Gold Level Healthy Workplace Certification through Excellence Canada, reflecting sustained efforts to enhance psychological health and workplace culture.

To support staff during the upcoming HIS implementation, CMH launched a Change and Wellness Champion program, identifying 52 champions across programs to promote engagement, resilience, and psychological safety.

Additional workforce initiatives include:

- Expanded mental health benefits at no additional cost to staff and medical professionals
- A trial on-site fitness space to promote physical wellness
- Recruitment and retention strategies, including referral bonuses, participation in the New Graduate Guarantee Program, Clinical Extern and Clinical Scholar roles, and engagement with the Community Commitment Program for Nurses

CMH was also recognized again as a Waterloo Region Top Employer in 2026, reflecting continued investment in workforce sustainability.

## **Safety**

**Never events are serious patient safety incidents that should not occur if proper preventive measures are in place.**

**In this section, describe your organization’s approach to the prevention of never events as part of its overall patient safety strategy. What steps are in place to prevent never events, particularly in areas such as pressure injury prevention, surgery, or medication safety? Please provide a specific example from one of these areas to illustrate your organization’s approach.**

Preventing never-events remains central to CMH’s patient safety strategy.

The implementation of the new HIS in fall 2026 will significantly strengthen medication safety through barcode-enabled closed-loop medication administration and computerized prescriber order entry. These enhancements reduce transcription errors, support real-time decision-making, and improve care coordination through a regional patient record.

CMH continues to foster a culture of safety through:

- Choosing Wisely quality improvement initiatives and pursuit of Leadership Status
- Targeted Spotlight education sessions addressing high-risk clinical areas
- High-fidelity simulation training to proactively identify and mitigate system risks
- Gamified learning approaches to improve engagement and knowledge retention

These efforts support continuous systems improvement and align with provincial patient safety priorities.

## **Palliative Care**

**In this section, describe how your organization integrates palliative care into care along the illness trajectory (including end-of-life care) and how the care provided improves the quality of life of patients with life-limiting illnesses (and their families and care partners); consider the Themes and corresponding considerations below. Please provide 3 specific examples of activities within your organization that demonstrate a commitment to enhancing quality of life. Describe how these activities achieve the standard of care set out in the Quality Standard for Palliative Care or in the Palliative Care Health Services Delivery Framework. If applicable, describe how data and feedback are used to improve care.**

CMH integrates palliative care throughout the illness trajectory to improve quality of life for patients with life-limiting illness and to support families and care partners. Our approach aligns with the Ontario Palliative Care Health Services Delivery Framework and Quality Standard by emphasizing early identification, interdisciplinary care, education, and family engagement.

Three key initiatives demonstrate this commitment:

1. Interdisciplinary Education and Capacity Building

CMH has implemented a five-hour palliative care education program for new Medicine and Surgical nurses, with expansion to the Emergency Department in partnership with Hospice Wellington. This builds frontline capacity to identify patients earlier, support goals-of-care discussions, and manage complex symptoms. The program builds on prior DeSouza certification training completed by nursing staff across Medicine, ICU, and Surgery.

2. Family-Centred Supports and End-of-Life Resources

To enhance the experience of patients and families, CMH has introduced palliative care carts and developed educational materials that outline what to expect during the dying process. These tools support informed decision-making, prepare families emotionally and practically, and promote compassionate bedside care. By normalizing conversations about end-of-life and ensuring access to clear information, CMH improves patient and family experience during critical moments.

3. Medical Assistance in Dying (MAID) Education

CMH provides structured MAID education through lunch-and-learn sessions led by a Clinical Scholar. These sessions ensure that nursing staff understand clinical procedures, ethical considerations, and communication approaches related to MAID. This education strengthens provider confidence, ensures safe and compliant practice, and supports compassionate, patient-centred end-of-life care.

Together, these initiatives enhance clinical capacity, promote early and informed care planning, and improve the overall quality of life for patients and families receiving palliative care at CMH. Ongoing feedback from staff and families informs continuous improvement efforts in this area.

## **Population Health Management**

**Population health management, as defined by the Rapid Improvement Support Exchange (RISE) program, is an iterative process that involves gathering data and insights from many partners (including nontraditional health care partners) about an entire population’s health and social needs. These insights inform the co-design of proactive, integrated, person-centred, cost-effective, equitable, and efficient solutions with the goal of improving people’s health needs along the continuum of care and well-being.**

**In this section, share how your organization is partnering with other organizations (other health care partners or within Ontario Health Teams) and using population health-management concepts to serve the unique health and social needs of people in the community. Focus on the important considerations mentioned in the Resources below when describing your organization’s partnerships and planned work.**

As a founding member of the Ontario Health Team (OHT), CMH plays a leadership role in advancing integrated, population-based care across the sub-region. Through active participation in governance and working groups, CMH contributes to coordinated planning, shared accountability, and system-level solutions that address the evolving health and social needs of the community.

CMH is engaged in OHT initiatives focused on improving primary care attachment and timely access to care. In 2026/27, this includes continued support for the OHT Stabilization Clinic and SCOPE (Seamless Care Optimizing the Patient Experience) program, which aim to improve care coordination, reduce avoidable emergency department visits, and strengthen transitions between hospital and community providers.

To better serve equity-deserving populations, CMH partners with community organizations to address mental health, addictions, and housing instability. A key

initiative is the collaboration between the Department of Psychiatry and Bridges Shelter, which provides on-site outreach and coordinated care for individuals experiencing homelessness and mental health challenges. CMH also works closely with Langs, Porchlight, and regional partners to support the CND HART Hub, improving access to integrated mental health and addictions services.

In addition, CMH has engaged with Ontario Health's Preventative Care Program leadership, including the Population Health Clinical Lead, to incorporate Social Medicine approaches in managing seasonal surge pressures. These efforts reflect a proactive, data-informed strategy that integrates clinical care with social supports to improve outcomes and system sustainability.

Through these partnerships and system leadership roles, CMH continues to advance coordinated, equitable, and person-centred care across the continuum.



# Board Chair's Report



# Board Chair's Report – February 2026

## Message From the Chair



As another year unfolds, I am struck by both the pace of change around us and the steady commitment of this Board. The healthcare landscape continues to evolve—bringing new pressures, new expectations, and new complexities—but also opportunities to think differently, adapt thoughtfully, and lead with purpose.

Throughout the year, your engagement, insight, and willingness to lean into both challenge and possibility have made a meaningful difference. Whether navigating shifting priorities, responding to system pressures, or celebrating moments of progress, your presence and leadership continue to send a powerful message to our staff, physicians, and midwives: that they are supported, valued, and not facing this work alone.

While the road ahead will undoubtedly present its share of challenges, I am confident in the strength of this Board and the collective resolve we bring to the table. Together, we remain focused on what matters most—supporting exceptional care, fostering resilience, and ensuring CMH continues to serve our community with compassion and excellence.

Thank you for your time, your thoughtful contributions, and your unwavering commitment. It is a privilege to work alongside such a dedicated group as we move forward together.

# Board Chair's Report – February 2026

## CMH Recognized as a Waterloo Area & Southwestern Ontario Top Employer

On February 4, 2026, members of the Board of Directors joined CMH leaders in participating in CMH's annual Celebrate the Values event. During the event, staff were formally recognized, and CMH announced its designation as one of Waterloo Area's and Southwestern Ontario's **Top Employers** for the second consecutive year.

This recognition reflects CMH's ongoing commitment to living its CCAIR values through compassionate care, strong collaboration, and meaningful support for one another across the

The Board's presence was felt across all three early-morning shifts, with Directors generously volunteering their time between 6:30 a.m. and 9:00 a.m. Their participation demonstrated continued Board engagement and support for staff and organizational culture.



# Board Chair's Report – February 2026

## CMH Board & City of Cambridge Council Workshop

On February 9, 2026, the CMH Board of Directors participated in a joint workshop with the City of Cambridge Council. The session provided an opportunity to update Council on recent CMH activities and organizational priorities, and to support continued dialogue between the hospital and the City.

The workshop reinforced the strong and collaborative relationship between CMH and the City of Cambridge, highlighting shared interests in community health, system planning, and local partnerships.

*“To the Board – having 9 of 12 Board members in attendance demonstrates to Council how seriously we take our stewardship & oversight role. While the Board does not participate during the actual workshop, being present matters. The opportunity to interact with Council members during the meal is also very important for relationship building.*”

*A huge thank you to everyone!” Lynn Woeller*

*“I learned from their questions how CMH is perceived in the community and what their perspectives and concerns are with the hospital.*”

*At board meetings it is usually us asking the questions from governance perspective. Listening last night to everyone so diligently and with such aplomb answer the many questions posed, made me feel extremely proud of the entire team” Sara Alvarado*



# Board Chair's Report – February 2026

## Good Morning Cambridge Breakfast – Conversation with Chief Crowell



On February 11, 2026, members of the CMH Board and leadership team participated in the City of Cambridge Chamber of Commerce Good Morning Cambridge Breakfast, which featured an engaging conversation with Mark Crowell, Police Chief for the Waterloo Region.

Sara Alvarado, Jayne Herring, Bill Conway, and Lynn Woeller joined Stephanie Pearsall, Liane Barefoot and Patrick Gaskin representing CMH and the Board, demonstrating CMH's continued commitment to fostering strong relationships with community partners and staying engaged in conversations that impact the health and safety of the communities we serve.



## Indigenous Advisory Council (IAC) Meeting

As part of the ongoing work of the CMH Commitment Ceremony Working Group, Directors Jayne Herring and Diane Wilkinson participated in a meeting of the Regional Indigenous Advisory Council (IAC) on February 25, 2026.

This engagement provided an important opportunity for the group to deepen its understanding of the meaning, responsibilities, and commitments involved for CMH in taking part in a commitment ceremony.

The Board of Directors extends its sincere thanks to the members of the Indigenous Advisory Council and the Commitment Ceremony Working Group for their guidance and generosity in sharing their knowledge and perspectives throughout this journey.



# Board Chair's Report – February 2026

## CMH Huddles

On February 25, 2026, Tom Barker visited CMH to participate in Emergency Department and Pharmacy huddles. These on-site conversations provided an opportunity to connect directly with frontline teams, hear firsthand about their experiences, and reinforce the Board's ongoing commitment to visibility, engagement, and support for staff delivering care across the organization



## Grand Rounds – “I Have Stage IV Cancer – How Much Time do I Have to Live?”

On February 26, 2026, Lynn Woeller, Jayne Herring, Miles Lauzon, Bill Conway, and Sara Alvarado participated in a Grand Rounds presentation focused on the complex and sensitive question of prognosis in Stage IV cancer.

Presented by Sr. Skander Ghedira, MD, Medical Oncologist, the session explored key clinical and personal factors that inform prognosis discussions, highlighted meaningful endpoints for conversations with patients, and emphasized the importance of aligning care decisions with patient and family intentions.



## BRIEFING NOTE

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**Date:** February 20, 2026  
**Issue:** Quality Committee Report to the Board of Directors, February 18, 2026 – OPEN  
**Prepared for:** Board of Directors  
**Purpose:**  Approval  Discussion  Information  Seeking Direction  
**Prepared by:** Jennifer Morgan, Administrative Assistant to Clinical Programs  
**Approved by:** Bill Conway, Quality Committee Chair

**Attachments/Related Documents:**  
**Patient Declaration of Values Measurements of Success Scorecard**

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A meeting of the Quality Committee took place on Wednesday, February 18, 2026 at 0700h.

**Present:** W. Conway (Chair), D. Wilkinson, Dr. W. Lee, N. Gandhi, A. Schrum, J. Herring, P. Brasil, K. Baldock, S. Pearsall, D. Haughton, P. Gaskin, A. McCarthy, M. Adair, Dr. K. Rhee, L. Barefoot, K. Baldock

**Regrets:** T. Mohtsham, M. McKinnon

**Staff:** M. Iromoto

**Guests:** Dr. J. Legassie, Dr. A. Nguyen, A. Brissette, K. Garton

The Quality Committee completed its scheduled work for the February 18, 2026 reporting period. Key matters reviewed, discussed, and advanced by the committee are summarized below for Board awareness.

### **Committee Matters – For information only**

#### **1. Program Presentations:**

**Medicine Program (includes Patient and Staff Stories):** The committee received an overview of the Medicine Program, including a patient success story demonstrating the impact of interdisciplinary care and intentional discharge planning. The program operates 83 funded beds across acute and alternate level of care units, supported by a multidisciplinary team of clinical staff and physicians.

Discussion focused on discharge planning as a core daily practice, supported by multidisciplinary rounds, dedicated hospitalist coverage on Medicine B3, and strengthened coordination with community partners. New models, including a complex discharge coordinator role and CMH@Home supports, are improving patient transitions and reducing unnecessary length of stay. Investments such as therapy space and an ADL suite were highlighted as key enablers of safe, confident discharges.

The committee also reviewed trends in conservable bed days and alternate level of care pressures, noting increased patient complexity and volume. Mitigation strategies underway include targeted physician deployment, workflow redesign, and the use of technology to support real-time communication and discharge efficiency. *(The program presentation is included in Package 2.)*

**Leveraging Best Practice Committee to ensure that Quality is embedded in a Hospital Information System (HIS) Presentation:** The committee received an update on the Best Practice Committee's work to embed quality improvement into daily practice and align frontline initiatives with organizational priorities and accreditation standards.

Highlights included:

- Completion of six frontline-led quality improvement projects in Year One
- Increased staff capability and engagement in quality improvement methods
- Continued progress in Year Two, including staff education on best practice guidelines and active projects supported by internal and community partners
- Integration of quality and safety priorities into Health Information System (HIS) workflows, orientation, and policy development

Committee members noted the high level of staff engagement demonstrated through posters and video storytelling, reinforcing a culture of continuous improvement and "joy at work." (*The program presentation is included in Package 2.*)

2. **Review of Patient Declaration of Values – Annual Update:** The committee reviewed the annual update to the Patient Declaration of Values and associated measurement approach. Work is underway to refine survey questions across care settings to better reflect patient-centred care and to develop an electronic dashboard to support clearer visualization and decision-making. The committee discussed the importance of demonstrating measurable impact from values-based initiatives. The Patient Declaration of Values scorecard is attached to this briefing note.
3. **Quality Monitoring Scorecard:** The Quality Monitoring Scorecard was reviewed, noting several metrics trending out of target for multiple months. These largely relate to patient flow pressures already addressed through recent Medicine and flow-focused discussions. Workforce metrics such as sick time and overtime continue to be monitored through the Resources Committee. (*Further information is included in the consent agenda item 1.5.8.1*)
4. **Quarterly Strategic Priorities:** The Committee received updates on organizational strategic priorities and system performance, with discussion centered on patient flow, digital transformation, workforce stabilization, and equity initiatives.

Patient flow remains a significant pressure, with ambulance offload times, emergency department provider initial assessments, and timely discharges below target; leadership outlined ongoing, focused improvement efforts with EMS, emergency department leadership, physicians, and inpatient teams, with particular emphasis on strengthening discharge planning practices and early identification of expected discharge dates.

The committee was advised that Q3 marked the successful launch of the Health Information System (HIS) under Project Quantum, with governance structures and workflow change-management activities now in place to support stabilization and optimization; future Quality Committee reporting will focus on the system's impact on quality and safety outcomes.

Workforce challenges were reviewed, with staffing variances in key clinical areas contributing to increased overtime; leadership reported mitigation strategies underway, including enhanced recruitment, rebuilt schedules, re-establishment of the float pool, and continued improvements in attendance management and onboarding, alongside ongoing progress in medical staff recruitment.

Financial performance remains on track, with planned PCOP revenue achieved for Q3, and continued advancement was reported in health equity and Truth and Reconciliation initiatives, supported by strong staff engagement, education, and policy development.

During discussion, the committee sought clarification on a reported discrepancy in hiring figures; leadership explained that differences between headcount and full-time equivalent metrics, including the classification of the float pool within the Medicine Program, may account for the variance rather than reflecting a true misalignment.

The committee also inquired about the status of Indigenous navigation supports following a recent departure, and leadership confirmed continuity and enhancement of services through the onboarding of a new Indigenous navigator and the addition of a dedicated navigator supporting the cancer and oncology program through regional partnership. *(Further information is included in the consent agenda item 1.5.8)*

5. **Medical Advisory Committee Update:** The committee was informed of key MAC quality initiatives, including continued alignment with Accreditation Canada standards, national leadership in Choosing Wisely Canada, accepted conference abstracts, and ongoing departmental quality work responding to patient complexity and demand. *(Further information is included in the consent agenda item 1.5.6.5)*

**Proposed Measurements of Success for CMH Patient Declaration of Values – draft**

<b>Value Statment</b>	<b>Indicators/Questions (from Qualtrics survey's)</b>	<b>FY2024-25 % Top Box</b>	<b>FYTD 2025-26 % Top Box</b>	<b>Subjective Overall</b>
<b>I receive PATIENT-CENTRED CARE which means:</b> <ul style="list-style-type: none"> <li>I am recognized as a unique person with personal values, beliefs, expectations, wishes, and choices that are respected; and</li> <li>My family and/or the people who support me are welcomed and involved in my care.</li> </ul>	Day Surgery (DS) survey Q21: How much information about your condition or procedure was given to your family, caregiver or someone close to you?	Right amount: 40%	Right amount: 39%	
	Emergency Department (ED) survey Q5: Did you get the emotional support you needed to help you with any anxieties, fears or worries you had during this hospital visit?	Always: 18%	Always: 23%	
	Ontario Adult Inpatient survey (OAIP) Q7: Did you get the support you needed to help you with any anxieties, fears or worries you had during this hospital stay?	Always: 62%	Always: 69%	
<b>I am WORKING TOGETHER WITH MY CARE TEAM which means:</b> <ul style="list-style-type: none"> <li>I am treated as an equal partner in the care team;</li> <li>I am involved in conversations about my care, can ask questions, and will receive clear and honest answers;</li> <li>Options about my care are explained in a way that I understand; and</li> <li>My care team considers all of my health needs and connects me to health and community services.</li> </ul>	DS survey Q24: How often, during your most recent day surgery experience, were you involved as much as you wanted to be in decisions about your care and treatment?	Always: 91%	Always: 87%	
	Maternity Module (MM) survey Q9: While in the hospital, did your doctor, midwife, or nurse answer your questions about your childbirth in a way you could understand?	Always: 91%	Always: 87%	
	OAIP survey Q4: Were you involved as much as you wanted to be in decisions about your care and treatment?	Always: 67%	Always: 72%	
<b>I encounter EFFECTIVE COMMUNICATION which means:</b>	DS survey Q20: Did the health professionals treating and examining you introduce themselves?	Yes, all: 88%	Yes, all: 85%	

Value Statment	Indicators/Questions (from Qualtrics survey's)	FY2024-25 % Top Box	FYTD 2025-26 % Top Box	Subjective Overall
<ul style="list-style-type: none"> <li>• My care team will communicate with me in a kind, compassionate, and empathetic way;</li> <li>• My care team members will introduce themselves and let me know what their role is;</li> <li>• My health information will be kept confidential; and</li> <li>• My health records will be accurate, complete and available to me and my care team in a timely manner.</li> </ul>	ED survey Q3: How often did care providers explain things in a way you could understand?	Always: 46%	Always: 51%	
	ED survey Q4: Do you feel that there was good communication about your care between doctors, nurses and other hospital staff?	Always: 50%	Always: 61%	
	OAIP survey Q1: Do you feel that there was good communication about your care between doctors, nurses and other hospital staff?	Always: 50%	Always: 61%	
<b>I receive EQUITABLE, ACCESSIBLE, AND UNBIASED CARE which means:</b> <ul style="list-style-type: none"> <li>• My individual needs will be recognized and treated appropriately without prejudice, stigma, assumptions, and judgment; and</li> <li>• I will receive timely and safe services that are provided in my preferred language.</li> </ul>	ED survey Q2: How often did care providers treat you with courtesy and respect?	Always: 57%	Always: 60%	
	DS survey Q36: Overall, did you feel you were treated with respect and dignity while you were at the hospital?	Definitely: 95%	Definitely: 96%	
<b>I receive HIGH QUALITY HEALTH CARE which means:</b> <ul style="list-style-type: none"> <li>• My care team will deliver safe and reliable care;</li> <li>• My care team is always striving to use the most up to date methods and technology in my care; and</li> <li>• My feedback to improve patient care will be taken seriously and I</li> </ul>	Canadian Institute for Health Information (CIHI) Metrics such as readmission, infection, hospital death rates, etc.	TBD	TBD	

Value Statment	Indicators/Questions (from Qualtrics survey's)	FY2024-25 % Top Box	FYTD 2025-26 % Top Box	Subjective Overall
am given the option to stay informed of the outcome of my feedback.				

Red	Top box score from current year is below 50%
Yellow	Top box score from current year is 51% to 69%
Green	Top box score from current year is greater than 70%

DRAFT

# BRIEFING NOTE

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**Date:** February 24, 2026  
**Issue:** Financial Statements – January 2026  
**Prepared for:** Board of Directors  
**Purpose:**  Approval  Discussion  Information  Seeking Direction  
**Prepared by:** Spencer Ogston, Financial Analyst  
 Maria Burzynski, Manager, Finance  
**Approved by:** Valerie Smith-Sellers, Director, Finance  
 Resources Committee of the Board of Directors

**Attachments/Related Documents:**  
**Financial Statements – January 2026**

**Alignment with 2025/26 CMH Priorities:**

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

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

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**Recommendation/Motion**

***Board***

That, the CMH Board of Directors receives the January 2026 financial statements as presented by management and upon recommendation of the Resources Committee at the meeting of February 23, 2026

***Resources Committee***

Following review and discussion of the information provided, the Resources Committee of the Board recommends that the Board of Directors receives the January 2026 financial statements as presented by management. **CARRIED.**

**Executive Summary**

Cambridge Memorial Hospital (CMH) is in a \$7.5M year-to-date surplus position at the end of January 2026 after building amortization and related capital grants. This is primarily due to higher revenue than budget for Post Construction Operating Plan (PCOP) funding (\$4.4M) and Quality Based Procedures (QBP) (\$3.7M). The favourable variance in QBP funding is due to timing and is expected to be \$0.6M favourable to budget by March 31, 2026.

The hospital is forecasting a \$3.5M surplus for fiscal 2025-26, primarily due budgeted contingency (\$5.6M), higher PCOP funding than budget (\$3.4M) and higher QBP funding

than budget (\$0.6M) due to prior year reconciliation adjustments. This is offset by higher compensation costs (\$4.3M) due to the operation of unfunded beds in the Emergency Department and surge beds on Wing B and Wing C, increased sick time and overtime, and higher medical and surgical supplies costs (\$2.0M).

The surplus does not include the expected pickup of prior year PCOP funding (\$8.8M) 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.

### **Analysis**

CMH is in a \$7.5M year-to-date surplus position at the end of January 2026 after building amortization and related capital grants. Actual results are \$9.0M favourable to budget.

The favourable variance is driven by:

- \$4.7M in budgeted contingency.
- \$4.4M PCOP funding driven by higher weighted cases.
- \$3.7M QBP revenue due to increased hip, knee, and shoulder volumes.

The favourable variance is partially offset by the following unfavourable variances:

- \$3.4M variance in salaries & wages and benefits, primarily due to higher overtime driven by sick time, training, staffing unfilled shifts due to absences and vacancies, and operating unfunded beds.
- \$1.8M variance in medical surgical supplies due to expensing of just-in-time inventory as part of the adoption of Healthcare Materials Management System (HMMS) as CMH's new just-in-time inventory vendor (\$0.5M), and higher spending on general and orthopedic supplies, as a result of higher joint volumes.

### Revenue Highlights

- QBPs are \$3.7M favourable to budget year to date due to higher bundled care and surgical volumes (\$3.9M) and cancer care volumes (\$0.8M). This is partially offset by a negative variance in non-elective QBP volumes (\$1.0M). Once QBP funding has been reached, volumes over the QBP funding envelope will generate Incremental Surgical Recovery (ISR) funding (\$3.0M). QBP funding is forecast to be \$0.6M favourable to budget by the end of the fiscal year due to prior year reconciliation adjustments.
- The hospital has budgeted to receive \$20.3M in PCOP funding in 2025-26, just over 86% of the available \$23.7M PCOP funding allocation. Funding recognition is dependent on meeting volume targets. The year to date \$4.4M favourable variance is due to higher weighted cases. CMH is anticipating to achieve full eligible funding by fiscal year end (\$23.7M).
- Billable patient services is \$770K favourable to budget year to date. The variance is primarily driven by higher volumes and physician rate increases in Diagnostic Imaging (\$717K), which are fully offset by higher medical remuneration costs.
- Recoveries and other revenue is \$2.1M favourable to budget year to date. The variance is primarily due to recovery for oncology drugs (\$1.3M) from Ontario Health (OH), which is fully offset by higher drug expenses, and \$0.6M driven by rebates from WSIB and insurance surplus proceeds.

### Expense Highlights

- Salaries and wages are \$2.2M unfavourable to budget year to date. This is mainly due to higher overtime (\$3.1M), sick time (\$0.7M), and training (\$0.5M), partially offset by a favourable variance in worked salaries (\$2.3M). Higher overtime costs have been driven by sick time, training, staffing unfilled shifts due to absences and vacancies, and the operation of unfunded beds in the Emergency Department and surge beds on Wing B and Wing C. A working group continues to meet on a bi-weekly basis focusing on strategies to reduce the overtime spend rate. The budget assumed that the rehabilitation program would come back on site in October. The rehabilitation program will remain off-site until the end of the fiscal year as the hospital works to finalize an

agreement to permanently transfer the program to the Waterloo Regional Health Network (WRHN). This has resulted in a positive variance of \$0.8M in salaries and wages, which is fully offset by the cost being paid to WRHN to operate the program, which is accounted for in other supplies and expenses. The budget also assumed Health Information System salaries would be included in operating expenses, but these costs are primarily being capitalized. This has resulted in a \$0.5M positive variance in salaries and wages.

- Employee benefits are \$1.2M 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 \$1.8M 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 as part of the OHIP relativity payments (2.8%) offset by OHIP revenue, and retro payments to physicians offset by additional revenue.
- Medical and surgical supplies costs are \$1.8M unfavourable to budget year to date. In November, CMH adopted HMMS as the new just-in-time inventory vendor where supplies are delivered straight to the units and are expensed upon their arrival. All items on hand that were a part of this program at the time of the switchover were expensed, resulting in higher expenses in November (\$0.5M). Additional negative variance is due to general and orthopedic medical surgical supplies driven by higher joint volumes (\$0.6M), and general medical supplies in part due to the operation of unfunded beds.
- Drug expenses are \$1.3M unfavourable to budget year to date. The variance is due to higher cost of drugs for the Oncology Program (\$1.4M). 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 (\$0.2M).
- Other supplies and expenses are \$4.0M favourable to budget year to date. The variance is primarily due to budgeted contingency (\$4.7M) and a positive variance in natural gas (\$0.8M) generated by the end of the carbon tax. This is partially offset by unfavourable variances to budget in contracted-out expenses for the rehabilitation program (\$1.0M) being offsite, minor equipment (\$0.4M), and general equipment repairs and maintenance (\$0.2M).
- \$1.5M of expenses related to Project Quantum are included in the YTD financial statements. These costs include compensation, software, and legal costs.

CMH is forecasting a surplus of \$3.5M for 2025-26. The forecast includes budgeted contingency (\$5.6M) and higher PCOP revenue than budget (\$3.4M) due to higher forecast weighted cases volumes in fiscal 2025-26, offset by an unfavourable variance in salaries and benefits (\$4.3M) and medical and surgical supplies (\$2.0M). The surplus does not include the expected pickup of prior year PCOP funding (\$8.8M) 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 \$77.6M, consisting of \$62.3M of unrestricted cash and \$15.2M of restricted cash. The working capital ratio is 1.37 and meets the requirements of the Hospital Service Accountability Agreement (HSAA) target range of 0.8 to 2.0.

Unrestricted working capital available at the end of January is \$28.7M, which is expected to decrease to \$18.0M by the end of March as summarized below:

	\$M
<b>Unrestricted Bank Balance – January 31, 2026</b>	<b>62.3</b>
Add: Other Current Assets (\$0.5M Due from CMH Foundation - Capital Funding)	23.6
Less: Current Liabilities (\$3.5M due to MOH)	(62.5)
<b>Subtotal - Net Current Assets</b>	<b>23.4</b>
Add: Vacation Bank Accrual (consistent with MOH working capital calculation)	5.3
<b>Working Capital Available – January 31, 2026</b>	<b>28.7</b>
<b>Add:</b>	
2023-24 PCOP Reconciliation	8.8
MOH Health Infrastructure Renewal Funding	0.5
Amortization on hospital funded assets- February 1, 2026 - March 31, 2026	0.8
CMHF & Third Party Funding for Approved Equipment	7.2
<b>Less:</b>	
Outstanding Health Information System Commitments	(10.8)
Outstanding 2025-26 Capital Budget Commitments	(2.8)
2025-26 Capital Budget Commitments to be completed in 2026-27	(7.2)
Reduction in Forecast Operating Surplus Between February 1, 2026 - March 31, 2026	(4.0)
Outstanding Approved POs	(3.2)
<b>Forecast Unrestricted Working Capital - March 31, 2026</b>	<b>18.0</b>

Cambridge Memorial Hospital  
Statement of Operations  
For the period ending January 31, 2026

Confidential  
(Expressed in Thousands of Dollars)

Month of January 2026				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	January 2025	2024-25 YE
<b>Revenue:</b>												
<b>MOH Funding</b>												
\$ 10,767	\$ 10,646	\$ 121	1%	\$ 105,418	\$ 105,085	\$ 333	0%	\$ 125,743	\$ 125,347	\$ 396	\$ 10,265	\$ 120,936
3,080	2,747	333	12%	27,228	23,578	3,650	15%	28,340	27,698	642	3,508	27,732
2,852	1,726	1,126	65%	21,453	17,039	4,414	26%	23,729	20,324	3,405	2,973	24,284
1,373	797	576	72%	9,693	7,871	1,822	23%	13,738	12,844	894	932	10,917
18,072	15,916	2,156	14%	163,792	153,573	10,219	7%	191,550	186,213	5,337	17,678	183,869
<b>Operating Expenses:</b>												
1,444	1,391	53	4%	14,472	13,702	770	6%	17,265	16,349	916	1,664	17,116
2,510	1,758	752	43%	19,212	17,112	2,100	12%	22,682	20,458	2,224	1,602	22,151
259	281	(22)	(8%)	2,600	2,763	(163)	(6%)	3,101	3,297	(196)	323	3,861
439	421	18	4%	3,808	4,096	(288)	(7%)	4,553	4,899	(346)	501	4,227
22,724	19,767	2,957	15%	203,884	191,246	12,638	7%	239,151	231,216	7,935	21,768	231,224
<b>Operating Expenses:</b>												
9,428	9,428	-	0%	90,675	88,495	(2,180)	(2%)	109,447	106,127	(3,320)	8,688	99,184
2,962	2,660	(302)	(11%)	24,795	23,559	(1,236)	(5%)	29,551	28,575	(976)	2,572	26,302
2,022	1,899	(123)	(6%)	20,451	18,622	(1,829)	(10%)	24,280	22,239	(2,041)	2,192	22,511
1,376	1,236	(140)	(11%)	13,970	12,176	(1,794)	(15%)	16,479	14,528	(1,951)	1,313	14,870
1,315	1,128	(187)	(17%)	12,413	11,103	(1,310)	(12%)	14,661	13,251	(1,410)	1,157	13,346
2,437	2,881	444	15%	23,720	27,684	3,964	14%	28,862	33,204	4,342	2,370	32,872
458	497	39	8%	4,481	4,752	271	6%	5,374	5,699	325	550	6,636
473	421	(52)	(12%)	3,961	4,096	135	3%	4,738	4,899	161	497	4,545
20,471	20,150	(321)	(2%)	194,466	190,487	(3,979)	(2%)	233,392	228,522	(4,870)	19,339	220,266
2,253	(383)	2,636	(688%)	9,418	759	8,659	1,141%	5,759	2,694	3,065	2,429	10,958
(816)	(893)	77	(9%)	(8,126)	(8,815)	689	(8%)	(9,688)	(10,515)	827	(656)	(8,162)
621	664	(43)	(6%)	6,210	6,557	(347)	(5%)	7,404	7,821	(417)	484	6,121
\$ 2,058	\$ (612)	\$ 2,670		\$ 7,502	\$ (1,499)	\$ 9,001		\$ 3,475	\$ -	\$ 3,475	\$ 2,257	\$ 8,917

**Cambridge Memorial Hospital  
Statement of Financial Position  
As at January 31, 2026**

(Expressed in Thousands of Dollars)

	January 2026	March 2025
<b>ASSETS</b>		
<b>Current Assets</b>		
Cash and Short-term Investments	\$ 62,341	\$ 74,166
Due from Ministry of Health / Ontario Health	10,782	4,807
Other Receivables	6,622	5,831
Inventories	2,668	3,083
Prepaid Expenses	3,447	2,600
	85,860	90,487
<b>Non-Current Assets</b>		
Cash and Investments Restricted - Capital	15,227	13,629
Due from Ministry of Health - Capital Redevelopment	7,691	7,691
Due from CMH Foundation	579	475
Endowment and Special Purpose Fund Cash & Investments	224	218
Capital Assets	302,589	302,411
<b>Total Assets</b>	<b>\$ 412,170</b>	<b>\$ 414,911</b>
<b>LIABILITIES &amp; NET ASSETS</b>		
<b>Current Liabilities</b>		
Due to Ministry of Health / Ontario Health	3,525	3,964
Accounts Payable and Accrued Liabilities	36,318	41,512
Deferred Revenue	22,680	22,680
	62,523	68,156
<b>Long Term Liabilities</b>		
Capital Redevelopment Construction Payable	210	168
Employee Future Benefits	4,293	4,085
Deferred Capital Grants and Donations	270,839	275,699
Asset Retirement Obligation	2,884	2,884
	278,226	282,836
<b>Net Assets:</b>		
Unrestricted	19,044	18,246
Externally Restricted Special Purpose Funds	224	218
Invested in Capital Assets	52,153	45,455
	71,421	63,919
<b>Total Liabilities and Net Assets</b>	<b>\$ 412,170</b>	<b>\$ 414,911</b>
Working Capital Balance	23,337	22,331
Current Ratio	1.37	1.33

**Cambridge Memorial Hospital**  
**Statement of Cash Flows**  
For the period ending January 31, 2026

(Expressed in Thousands of Dollars)

	January 2026	March 2025
<b>Cash Provided By (Used In) Operations:</b>		
Excess (Deficiency) of Revenue over Expenses	\$ 7,502	\$ 8,917
Items not Involving Cash:		
Amortization of Capital Assets	12,607	14,798
Amortization of Deferred Grants and Donations	(8,810)	(9,982)
Change in Non-Cash Operating Working Capital	(12,941)	(9,556)
Change in Employee Future Benefits	208	(138)
	(1,434)	4,039
<b>Investing:</b>		
Acquisition of Capital Assets & Capital Redevelopment Project	(12,785)	(21,077)
Capital Redevelopment Project Construction Payable	42	(3,867)
	(12,743)	(24,944)
<b>Financing:</b>		
Change in Non-Cash Capital Accounts Receivable	-	(4,374)
Capital Donations and Grants & Capital Redevelopment Project	3,950	898
	3,950	(3,476)
<b>Increase (Decrease) In Cash for the Period</b>	<b>(10,227)</b>	<b>(24,381)</b>
<b>Cash &amp; Investments - Beginning of Year</b>	<b>87,795</b>	<b>112,176</b>
<b>Cash &amp; Investments - End Of Period</b>	<b>\$ 77,568</b>	<b>\$ 87,795</b>
<b>Cash &amp; Investments Consist of:</b>		
Unrestricted Endowment and Special Purpose Investments	30	30
Cash & Investments Operating	62,311	74,136
Cash & Investments Restricted	15,227	13,629
<b>Total</b>	<b>\$ 77,568</b>	<b>\$ 87,795</b>