Vision
Creating healthier communities together

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

Values
Caring, Collaboration, Accountability, Innovation, Respect

BOARD OF DIRECTORS MEETING - OPEN
Wednesday June 3, 2026
1700-1745
Virtual via Teams / C.1.229
[Join the meeting now]
Or call in (audio only)
833-827-2824,978704436# Canada (Toll-free)
Phone Conference ID: 978 704 436#

AGENDA

Agenda Item *** indicates attachment / TBC – to be circulated**	**Page #**	**Time**	**Responsibility**	**Purpose**
1. CALL TO ORDER				
1.1 Territorial Acknowledgement		1700	L. Woeller	
1.2 Welcome		1703	L. Woeller	
1.3 Confirmation of Quorum (7)		1704	L. Woeller	Confirmation
1.4 Declarations of Conflict of Interest		1705	L. Woeller	Declaration
1.5 Consent Agenda *(Any Board member may request that any item be removed from this consent agenda and moved to the regular agenda)*		1706	L. Woeller	Motion
1.5.1 Minutes of May 6, 2026*	4			
1.5.2 2025/26 Board of Directors Action Log*	10			
1.5.3 Board Attendance*	11			
1.5.4 Board Work Plan*	12			
1.5.5 Events Calendar*	21			
1.5.6 Committee Reports to the Board of Directors				
1.5.6.1 Audit Committee* (May 25, 2026)	23			
1.5.6.2 Digital Health Strategy Committee* (May 21, 2026)	24			
1.5.6.3 Executive Committee* (May 19, 2026)	25			
1.5.6.4 Governance and Nominating Committee* (May 14, 2026)	26			
1.5.6.5 Medical Advisory Committee* (May 13, 2026)	29			
1.5.6.6 Resources Committee* (May 25, 2026)	32			
1.5.7 Governance Policy Approvals* 2-A-24 Confidentiality Policy 2-D-09 Procedure for Members of the Public Addressing the Board	34			
1.5.8 Strategic Priorities Q4 Updates*	39			
1.5.8.1 Quality Monitoring Scorecard*	55			
1.5.9 CEO Certificate of Compliance* (May 2, 2026 – May 29, 2026)	85			
1.5.10 Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding Certificate of Compliance*	86			
1.5.11 Broader Public Sector Accountability Act Attestation*	88			
1.5.12 Multi-Sector Service Accountability Agreement (M-SAA) Schedule F Declaration of Compliance*	97			
1.5.13 HSAA Article 8 – Declaration of Compliance*	101			

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

Agenda Item * indicates attachment / TBC – to be circulated	Page #	Time	Responsibility	Purpose
1.5.14 Employment Contract – Patrick Gaskin, President & CEO (August 16, 2025 to August 15, 2030)*	104			
1.6 Confirmation of Agenda		1709	L. Woeller	Motion
2. PRESENTATIONS				
2.1 Annual Truth & ReconciliACTION Plan*	117	1710	P. Gaskin	Information
3. BUSINESS ARISING				
3.1 No Open Matters for Discussion				
4. NEW BUSINESS				
4.1 Quality Committee (May 20, 2026)				
4.1.1 Report to the Board of Directors*	127	1720	B. Conway	Information
4.2 Next CMH Strategic Planning Cycle*	135	1730	M. Iromoto	Motion
4.3 Approach to 2026/27 Board & Committee Goals*	138	1740	D. Wilkinson	Discussion
5. UPCOMING EVENTS ***Visit GovHub for the most current listing of all upcoming events***		1744	L. Woeller	Information
5.1 Sara Alvarado's Walk from Cambridge to Paris: June 14, 2026 (morning); Galt, Cambridge to Paris – Walk to Paris 2026 by Sara Alvarado - Cambridge Memorial Hospital Foundation				
5.2 St. Nishan Armenian Apostolic Church Charity Golf Tournament, June 11, 2026, Dundee Golf Club, Charity Golf Tournament - Cambridge Memorial Hospital Foundation				
5.3 Galt Exotic Auto Show, June 14, 2026, Raffi Jewellers 299 Hespeler Rd, Cambridge, Galt Exotic Auto Show - Cambridge Memorial Hospital Foundation				
5.4 Klean Street Car Show, August 9, 2026, Cambridge Centre Honda 227 Hespeler Rd, Cambridge, Klean Street Car Show - Cambridge Memorial Hospital Foundation				
6. DATE OF NEXT MEETING	Wednesday June 24, 2026 Location: Hybrid			
7. TERMINATION		1745	L. Woeller	Motion
Link: Board/Committee Evaluation Survey	*Following the meeting, please complete within one week.*			

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

Ex officio Members: Patrick Gaskin, Dr. Winnie Lee, Dr. Vlad Miropolsky, Dr. Minta Patel, Stephanie Pearsall

CMH Board of Directors Motions Page

<table>
<tr><th>Agenda Item</th><th colspan="2">Motions Being Brought Forward for Approval</th></tr>
<tr><td>1.5</td><td>Consent Agenda

1.5.7

1.5.12

1.5.13

1.5.14</td><td>

- That, the CMH Board of Directors approves the Consent Agenda as presented/amended

The following motions are contained in the Consent Agenda:

- 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 May 14, 2026

<table><tr><td>2-A-24</td><td>Confidentiality Policy</td></tr><tr><td>2-D-09</td><td>Procedure for Members of the Public Addressing the Board</td></tr></table>

- That the CMH Board of Directors approves the Broader Public Sector Accountability Act, 2010 (BPSAA) Appendix C - Attestation prepared by the President and CEO in accordance with Section 15 of the BPSAA for the period April 1, 2025, to March 31, 2026, and upon recommendation of the Resources Committee at its meeting of May 25, 2026.
- That, the CMH Board of Directors approves the submission of the Multi-Sector Service Accountability Agreement (M-SAA) Schedule F – Declaration of Compliance, confirming that CMH continues to meet its legal and contractual obligations and upon recommendation of the Resources Committee at its meeting of May 25, 2026.
- That, the CMH Board of Directors approves the submission of the HSAA Article 8 – Declaration of Compliance and upon recommendation of the Resources Committee at its meeting of May 25, 2026.
  - HSAA Article 8 – Declaration of Compliance, attests that the Health Service Provider (HSP) has fulfilled its obligations under Agreement during the Applicable Period and has received the required reports referred to in Section 8.6 of the Agreement.
  - After making inquiries of the President and CEO and other appropriate officers of the HSP, and subject to any exceptions identified on Appendix 1 to this Declaration of Compliance, to the best of the Board's knowledge and belief, the HSP has fulfilled its obligations under Agreement during the Applicable Period (April 1, 2025 – March 31, 2026) and has received the required reports referred to in Section 8.6 of the Agreement.

</td></tr>
<tr><td>1.6</td><td>Confirmation of Agenda</td><td>

- That, the CMH Board of Directors approves the agenda as presented/amended

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</table>

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, May 6, 2026
***OPEN* Session**

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Minutes of the open session of the Board of Directors meeting, held via a hybrid model (video conference and at Cambridge Memorial Hospital, C.1.229) on Wednesday, May 6, 2026.

Present:

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

Regrets: J. Goyal, J. Tulsani, T. Barker, S. Pearsall

Staff Present: Dr. J. Legassie

Guests: L. Barefoot, K. Baldock

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 offered 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 remove any items from the consent agenda for separate discussion. No requests were made.

Before approving the consent agenda, clarification was requested regarding the MAC report reference to market share and meeting activity. Management explained that this related to early environmental scanning associated with master planning, including a review of current volumes and areas where there may be market leakage to other hospitals. It was noted that this was not necessarily due

to capacity issues, but rather a starting point to better understand the reasons for volume loss, such as access or community needs, and to inform future planning.

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 March 4, 2026
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 (April 27, 2026)
Digital Health Strategy Committee (April 16, 2026)
Executive Committee (March 17, 2026)
Governance and Nominating Committee (April 20, 2026)
Medical Advisory Committee (March 3 & April 8, 2026)
1.5.6.5.1 New Credentialed Physicians February 2026
Resources Committee (April 27, 2026)
1.5.7 Governance Policy Approvals
That, the CMH Board of Directors approves the following policies as presented and upon recommendation of the Governance and Nominating Committee at its meeting of April 20, 2026.

2-D-22	*Annual Consent to Act*

1.5.8 Quality Monitoring Scorecard
1.5.9 CEO Certificate of Compliance February 28-May 1, 2026
1.5.10 Bill S-211 Forced Labour in Canada Supply Chain Submission

1.6. Confirmation of Agenda

The meeting agenda was presented for approval. Board members were given the opportunity to raise questions or propose amendments to the agenda as circulated.

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. Advancing Just Culture: A Shared Framework for Fair and Accountable Decision Making

CMH's Patient Safety and Quality Lead presented on Just Culture, noting that this work has been widely shared across the organization, including with medical leadership, MAC, operational leaders, HR, and other groups, to support a shared understanding and culture change. From a Board perspective, Just Culture matters because it influences psychological safety, what issues surface, and whether responses are experienced as fair and consistent, with implications for trust, learning, patient safety, and enterprise risk.

The "See it, Know it, Apply it" framework was explained using interactive examples to demonstrate how focus, perspective, and bias can lead people to interpret the same situation differently, contributing to inconsistent responses to incidents in healthcare. Just Culture was described as shifting the focus away from blame or blame-free approaches toward understanding what happened,

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what made sense at the time, and what conditions shaped the outcome, while maintaining professional accountability.

The Board was guided through CMH's Just Culture Decision Tree, described as a shared decision-making and communication tool embedded in policy rather than a diagnostic or automatic answer. Through case examples, it was demonstrated how different facts can change where a situation falls within the tool, and it was noted that some cases may reasonably involve more than one category, including system failure, human error, impaired judgment, or reckless behaviour.

Board members asked how uncertainty in facts should be managed. It was noted that inability to confidently answer questions in the tool signals the need for further investigation. Discussion also addressed fatigue and extended shifts, with acknowledgement that individual and system factors may coexist.

Questions were raised about collaboration and escalation when applying the tool. It was noted that use of the tool often involves HR, Professional Practice, Health, Safety and Wellness, or the Chief of Staff's office, and that its value lies in providing a shared language across teams.

The Board also asked about implementation and measurement. CMH Leadership noted that the policy was approved in 2023 and that the organization remains on a journey. Staff surveys, including the Global Workforce Survey, may serve as indicators of progress, particularly in relation to staff feeling safe reporting mistakes.

The Board inquired about appeals and disagreement with outcomes. CMH Leadership clarified that the tool does not replace existing processes, but supports consistent decision-making within them, and that disagreement should focus on specific questions in the framework rather than personal judgment.

Board members commented positively on the approach, noting its role in moving away from punitive responses, reducing subjectivity for leaders, and supporting a culture of learning and safety.

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 thanked Board members for their continued participation in CMH events. The Chair emphasized the value of showing up and the opportunity to connect with staff and community members at various events.

4.1.2. CCDI Unconference 2026

The Board reviewed the information provided in the pre-circulated meeting package. It was highlighted that the conference consisted of two half-day sessions and included several keynote speakers. The Board was advised that the conference supported Directors in their learning and equity journey and provided helpful insight into current equity issues and workplace challenges.

4.2. Quality Committee

4.2.1. Report to the Board of Directors

The Chair of the Quality Committee provided an overview of the committee's recent work, highlighting discussions from the April meeting. The program presentation focused on the Emergency Department and its role as a primary entry point for inpatient medicine, surgical services, and specialty care, as

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well as a key driver of hospital-wide patient flow and access. The presentation reviewed key department metrics, including overall visit volumes, daily averages, ambulance arrivals, patient acuity distribution, and staffing complement.

The Quality Committee also reviewed the annual Emergency Department 72-hour return visit quality program. The Chair of the Quality Committee noted that the program focuses on identifying causes of patient returns and reviewed priority areas, including senior friendly initiatives, pediatric access, and communication. The review outlined key achievements, including the pediatric rapid assessment clinic, improved discharge practices, attention to pending diagnostic results, normalization of vital signs prior to discharge, strengthened management of frequent ED users, reductions in patients leaving without being seen, and improved communication and documentation when patients decline admission.
The Quality Committee received an update on the Clinical Service Growth Plan, aligned with the Elevated Partnership and Care strategic pillar. The presentation highlighted progress in specialized services, including the regional breast reconstruction program, enhancements to the liver health clinic, rapid assessment clinics to ease ED pressures, first trimester clinic development, integrated newborn care, and growth in clinical trials. It also referenced collaboration through the Ontario Health Team and Primary Care Network, initiatives for high-utilization patients, Level 3 ICU capability, diagnostic imaging pathway improvements, regional leadership in Choosing Wisely, innovation work including predictive analytics and automation, and access-to-care initiatives such as the external ED review and expedited endoscopy program.
The Quality Committee received an update on the Clinical Service Growth Plan, aligned with the Elevated Partnership and Care strategic pillar. The presentation highlighted progress in specialized services, including the regional breast reconstruction program, liver health clinic enhancements, rapid assessment clinics to ease ED pressures, first trimester clinic development, integrated newborn care, and growth in clinical trials. He also referenced collaboration through the Ontario Health Team and Primary Care Network, initiatives for high utilization patients, Level 3 ICU capability, diagnostic imaging pathway improvements, regional leadership in Choosing Wisely, innovation work including predictive analytics and automation, and access to care initiatives such as the external ED review and expedited endoscopy program.

Board members asked questions regarding how staff and teams are supported following patient deaths. Discussion highlighted the clinical realities during resuscitation, the transition to supporting families, and the importance of debriefing and ongoing supports. It was noted that Spiritual Care plays a key role by following up with staff across shifts, creating space for reflection, and recognizing that individuals process events differently. Members reflected on the emotional burden on staff and leaders and the importance of authenticity, shared reflection, and support following difficult events.

The Quality Committee Chair also noted that the committee reviewed the Quality Monitoring Scorecard and Medical Staff Committee updates, and that the meeting included strong engagement and thoughtful questions from members. Feedback on the quality of reporting was positive.

4.3. **Resources Committee**

4.3.1. **March 2026 Financial Statements and Year-End Forecast**

The Chair of the Resources Committee provided the financial update and advised that a late notification from the Ministry resulted in a $2.0 million

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reduction in PCOP revenue for 2025–26, along with approximately $300,000 in additional reconciliation costs. He noted that this adjustment changes the year-end position from a projected $9.6 million favourable to $7.3 million favourable. He further clarified that, when accounting for $8.8 million in prior-year PCOP reconciliation, this results in a $1.5 million deficit attributable to the current year. It was confirmed that the Ministry has advised that full PCOP funding will be honoured and reconciled in 2026–27.

Key drivers of financial performance were highlighted, noting positive revenue results from PCOP funding and quality-based procedures, while continuing pressures remain in salaries and wages, employee benefits, overtime, supplies, and drug costs. It was noted that the organization continues to maintain a strong cash position, with HSAA performance remaining within target range.

CMH Leadership further explained the PCOP funding context, noting that while volumes exceeded the approved allocation, the Ministry confirmed that funding would be capped at the approved level for 2025–26, with reconciliation to occur in 2026–27. It was noted that, despite these adjustments, the organization remains in a relatively strong financial position compared to peers, and leadership emphasized that 2026–27 will require close financial discipline.

Board members asked about the relationship between overtime costs and PCOP volumes. Leadership advised that increased volumes could drive incremental revenue but are also associated with incremental costs, and that operating unfunded beds is not a sustainable long-term approach. Questions were also raised regarding impacts on working capital. Management confirmed the adjustment would reduce unrestricted working capital by approximately $2.0 million, while noting that liquidity remains sufficient and cash position remains positive.

Additional discussion addressed expectations related to coding performance and the upcoming HIS implementation, with leadership advising that current coding practices are strong, though a short learning curve may occur during system transition.

Board members commented on the organization's overall financial performance, acknowledging management's leadership and the hospital's ability to remain in a favourable position in a challenging sector environment.

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

MOTION: That, the CMH Board of Directors receives the March 2026 preliminary unaudited financial statements as presented by management and upon recommendation of the Resources Committee at the meeting of April 27, 2026

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4.4. Patient & Family Advisory Council (PFAC) Update

The Board received an update on PFAC activities from its meeting held on May 6, 2026. It was highlighted that a tailored HIS update specific to PFAC had been provided. Discussion included the four-digit privacy code that patients may share with family members to allow access to personal information by phone. It was emphasized that the significance of this item was less about the code itself and more about CMH identifying limitations in the original vendor solution and successfully advocating for changes to better meet patient and family needs. It was noted that CMH has been able to influence changes where concerns have been raised regarding HIS functionality.

An update was also provided on patient and visitor parking. CMH Leadership reported on positive changes underway following the appointment of a new parking supervisor, including more active management of parking lists and vendor relationships, repainting of parking lots, and physical site and signage assessments. These changes were described as resulting in noticeable improvements.

The PFAC also received a presentation on artificial intelligence. It was noted that the presentation generated significant discussion and interest, and due to the volume of information, it was agreed that a second session would be scheduled to allow further questions and deeper discussion.

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 June 3, 2026.

7. TERMINATION

MOTION: That the meeting be terminated at 1815hrs.
None opposed, **CARRIED.**

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2025/26 Board of Directors Action Log

Meeting Date	Agenda # / Item Description	Action Item	Owner	Status
No Open Action Items				

Board of Directors Attendance Report 2025/2026

	89%	100%	100%	56%	100%	67%	78%	100%	89%	100%	100%	86%
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
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
04-Mar-26	P	P	P	P	P	P	R	P	P	P	P	P
06-May-26	P	P	P	R	P	R	P	P	P	P	P	R

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
	4a Corporate Culture					
	i	setting the tone for a culture throughout the Corporation that is consistent with the mission, vision and values and supports the Corporation's strategy	1-A-05		➢ share, measure and improve culture by setting ABCDE goals a) Attend – attend Board/committee meetings b) Be engaged – be an active contributor to the committee and Board work c) Connect – attend staff huddles, events d) Donate – support the CMH Foundation e) Educate – undertake education, courses	Complete
	4b Strategic Planning					
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality / Resources	➢ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker	Complete
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	Complete
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics ➢ receive and review the Strategic Priorities Tracker	Complete
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➢ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	Complete
	4f Oversight of Medical/Professional Staff					
01-Oct-25	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	Complete
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	Complete
	4g Relationships					
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➢ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	Complete
	4i Board Effectiveness					
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➢ review & approve Board policies as recommended by Governance Committee	Complete
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events ➢ reported through Directors ABCDE Goals ➢ receive CMH Board Giving Activity	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)	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	Complete
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics	Complete
	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
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	Complete
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	Complete
	4a Corporate Culture					
	ii	overseeing the establishment and monitoring of such a culture through appropriate mechanisms, including assessing the Chief Executive Officer, and Chief of Staff of the Corporation against this expectation	2-B-25 2-B-26	Executive	➢ receive & review the mid-year CEO and COS report and provide input	Complete
	4b Strategic Planning					
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality / Resources	➢ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker	Complete
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality 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
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	Complete
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	Complete

Cambridge Memorial Hospital Board of Directors - 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	4g Relationships					
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➢ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	Complete
	4i Board Effectiveness					
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➢ review & approve Board policies as recommended by Governance Committee	Complete
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events reported through Directors ABCDE Goals	Complete
	4l Programs Required under the *Public Hospitals Act*					
	ii	ensure that policies are in place to encourage and facilitate organ procurement and donation		Quality	➢ receive the annual Trillium Gift of Life Update	Complete
	iii	ensure that the Chief Executive Officer, Chief of Staff, nursing management, Medical/Professional Staff, and employees of the Hospital develop plans to deal with emergency situations and the failure to provide services in the Hospital		Quality	➢ receive the annual Emergency Preparedness update	Complete
	4n Director Recruitment, Orientation, and Evaluation					
		The Board shall ensure there is an appropriate, objective, and formal process for the recruitment of Directors, and the evaluation of the Board, the Board Chair, its committees, committee Chairs and individual Directors.	2-D-20		➢ approve the members of the Nominating Sub-Committee & Interview Team	Complete
04-Feb-26	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	Complete
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics	Complete
	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
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	Complete
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	Complete
	4i Board Effectiveness					
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➢ review & approve Board policies as recommended by Governance Committee	Complete

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

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
04-Mar-26	4b Strategic Planning					
	iv	ensuring that key corporate priorities are formulated that help the Corporation accomplish its mission and actualize its vision in accordance with the strategic plan. The corporate priorities shall be reflective of the Board's primary accountability to the Ministry of Health ("MOH") and Ontario Health and any applicable accountability agreements with the MOH or Ontario Health		Quality Resources	➢ review & approve Annual Quality Improvement Plan (QIP) ➢ review & approve Hospital Service Accountability Agreement (HSAA) ➢ review & approve Multi-Sector Service Accountability Agreement (MSAA) ➢ review & approve Community Accountability Planning Submission (CAPS) ➢ review & approve Hospital Accountability Planning Submission (HAPS)	Complete
	v	approving operating and capital plans	2-C-31	Resources	➢ review & approve the annual Operating Plan review & approve the Annual Capital Plan	Complete
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	Complete
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics	Complete
	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
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	Complete
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	Complete
	4g Relationships					
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➢ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	Complete
	4h Financial Viability					
	i	establish key financial objectives that support the Corporation's financial needs		Resources / Quality	➢ review & approve Annual Operating & Capital Plans - service changes, operating plan, capital plan, salary increases, material amendments to benefit plans, programs and policies	Complete
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events reported through Directors ABCDE Goals	Complete

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
06-May-26	4.c Corporate Performance					
	i	identify principal risks to the Corporation in line with the Board's Integrated Risk Management policy	2-C-20	Audit Quality Resources	➢ review & approve the IRM process undertaken by management to identify and develop the in-year IRM risks and associated mitigation strategies	Complete
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	Complete
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics ➢ receive and review the Strategic Priorities Tracker	Complete
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➢ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	Complete
	4e Succession Planning					
	i	provide for Chief Executive Officer succession plan and process	2-B-10	Executive	➢ receive confirmation that succession plans are in place through the Executive Committee Report to the Board of Directors	Complete
	ii	provide for Chief of Staff succession plan and process	2-B-12	Executive	➢ receive confirmation that succession plans are in place through the Executive Committee Report to the Board of Directors	Complete
	iii	ensure that the Chief Executive Officer and Chief of Staff establish an appropriate succession plan for both executive management and Medical/Professional Staff leadership	2-B-10 2-B-12	Executive	➢ receive confirmation that succession plans are in place through the Executive Committee Report to the Board of Directors	Complete
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	Complete
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	Complete
	4g Relationships					
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➢ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	Complete
	4i Board Effectiveness					
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➢ review & approve Board policies as recommended by Governance Committee	Complete
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events ➢ reported through Directors ABCDE Goals	Complete

Cambridge Memorial Hospital Board of Directors - 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
June 3, 2026 (Generative Session)	4a Corporate Culture					
	ii	overseeing the establishment and monitoring of such a culture through appropriate mechanisms, including assessing the Chief Executive Officer, and Chief of Staff of the Corporation against this expectation	2-B-25 2-B-26	Executive	➢ receive & review the annual CEO and COS survey results & self-appraisal and provide input	Due
	4b Strategic Planning					
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality Resources	➢ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker	Due
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	Due
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics	Due
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources Audit	➢ receive & approve Declaration of Compliance with MSAA Schedule F ➢ receive & approve Declaration of Compliance with BPSAA Schedule A ➢ receive & approve Certificate of Compliance – Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding (semi-annual) ➢ receive the legislative compliance review ➢ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	Due
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	Due
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	Due
	4h Financial Viability					
	ii	ensure that the organization undertakes the necessary financial planning activities so that resources are allocated effectively and within the parameters of the financial performance indicators		Resources	➢ receive updates on how the budget is being developed through the Resources Committee Report to the Board of Directors ➢ receive and approve the year-end financial statements	Due
	4i Board Effectiveness					
	i	monitor Board members' adherence to corporate governance principles and guidelines		Governance	➢ Declaration of conflict agreement signed by Directors ➢ Directors Consent to Act ➢ Governance Report to the Board of Directors	Due
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➢ review & approve Board policies as recommended by Governance Committee	Due
	4n Director Recruitment, Orientation, and Evaluation					
		The Board shall ensure there is an appropriate, objective, and formal process for the recruitment of Directors, and the evaluation of the Board, the Board Chair, its committees, committee Chairs and individual Directors.	2-D-20		➢ review recommendations for new Directors, non-Director committee members ➢ review the results of the annual evaluation surveys through the Governance Committee Report to the Board of Directors	Due

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
	4b Strategic Planning					
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality Resources	➢ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker	
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics ➢ receive and review the Strategic Priorities Tracker	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➢ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	
	4g Relationships					
24-Jun-26		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➢ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	
	4i Board Effectiveness					
	iii	ensure ethical behaviour and compliance with laws and regulations, audit and accounting principles, accreditation requirements and the By-Laws		Audit	➢ review & receive the annual Audit Findings Report review & approve the year-end financial statements	
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events reported through Directors ABCDE Goals	
	4l Programs Required under the Public Hospitals Act					
	i	(i) ensure that an occupational health and safety program and a health surveillance program are established and regularly reviewed			➢ reported through annual attestations	

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
	4n Director Recruitment, Orientation, and Evaluation					
		The Board shall ensure there is an appropriate, objective, and formal process for the recruitment of Directors, and the evaluation of the Board, the Board Chair, its committees, committee Chairs and individual Directors.	2-D-20		➢ conduct the election of officers ➢ receive committee reports on work plan achievements ➢ review Board annual survey results	
As Needed	4a Corporate Culture					
	iii	overseeing policies in respect of the Corporation's code of conduct	1-A-04		➢ review the organizations code of conduct policy every three years (last reviewed May 9. 2024)	
	4b Strategic Planning					
	i	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				
	4d Chief Executive Officer and Chief of Staff					
	i	select the Chief Executive Officer in accordance with the relevant Board policies	2-B-15	Executive	➢ recruit, select, and hire and individual with the requisite skills, abilities, and competencies to effectively perform the job as President and Chief Executive Officer (CEO) of the organization	
	ii	delegate responsibility for the management of the Corporation to the Chief Executive Officer and require accountability to the Board	2-B-05	Executive		
	iii	establish a Board policy for the performance evaluation and compensation of the Chief Executive Officer	2-B-20 2-B-25	Executive / Governance	➢ review & approve the Board's policies 2-B-20 CMH Executive Compensation Policy (last reviewed May 26, 2021) 2-B-25 CEO Performance Review Policy (last reviewed May 25, 2022)	
	iv	select the Chief of Staff in accordance with the relevant Board policies	2-B-16	Executive	➢ recruit, select, and hire and individual with the requisite skills, abilities, and competencies to effectively perform the job as President and Chief Executive Officer (CEO) of the organization	
	v	delegate responsibility for the management of the Corporation to the Chief of Staff and require accountability to the Board	2-B-06	Executive		
	vi	establish a Board policy for the performance evaluation and compensation of the Chief of Staff	2-B-20 2-B-26	Executive / Governance	➢ review & approve the Board's policies 2-B-20 CMH Executive Compensation Policy (last reviewed May 26, 2021) 2-B-26 CEO Performance Review Policy (last reviewed May 25, 2022)	

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
	4j Effective Communication and Community Relationships					
	i	establish processes for community engagement to receive public input on material issues	1-A-05 2-D-09		➢ Post meeting agenda packages and minutes publically on the CMH Website ➢ review & approve the Board policy 2-D-09 (last reviewed June 28, 2023)	
	ii	promote effective collaboration and engagement between the Corporation and its community, particularly as it relates to organizational planning, mission, and vision			➢ Strategic Plan	
	4m Communications Policy					
		The Board shall establish a communications policy for the Corporation and oversee the maintenance of effective relations with stakeholders (e.g. MOH, Ontario Health, CND OHT, other health service providers, clients, patients, employees, volunteers, Medical/Professional Staff, CMH Foundation, CMH Volunteer Association, federal, provincial, regional and city politicians) through the Corporation's communications policy and programs	2-D-11	Governance	➢ review & approve Board policy 2-D-11 every three years (last reviewed April 22, 2022)	
	General					
		On behalf of the Board, the Governance Committee shall review and assess the adequacy of the Board terms of reference at least every 3 years and submit proposed changes to the Board for consideration		Governance	➢ review & approve the Board of Directors Terms of Reference (last reviewed June 28, 2023)	

DELAYED

Date	ref #	Item	Rationale	New Due Date

Board/Committee Meetings and Event Dates	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep (2026)
Board of Directors Regular Meetings													
5:00pm - 9:00pm		1		3		4	4		6	3 & 24			
Board Generative/Education Discussion Meetings													
Hospital Integration (Generative Discussion)			5										
Overtime & Sick Time: A Deeper Dive (Education)										3			
Fostering a Robust Emergency Preparedness Culture at CMH (Mini Education)						4							
Advancing Just Culture: A Shared Framework for Fair and Accountable Decision Making (Education)									6				
Board Committee Meetings													
Audit Committee 5:00pm - 7:00pm			17		19			27	25				
Digital Health Strategy Committee 5:00pm – 7:00pm	18		20			19		16	21	18			
Executive Committee 5:00pm - 7:00pm			18				17		19				
Governance & Nominating Committee 5:00pm - 7:30pm		9	13	11		12		20	14				
Quality Committee 7:00 am – 9:00am	17	15	19		21	18		15	20	17			
Quality Committee QIP Meeting 7:00 am – 9:00am						5							
Resources Committee 5:00pm – 7:00pm	22		24			23		27	25	22			
Medical Advisory Committee (MAC) 4:30pm - 7:00pm	10	8	12	10	14	11	11	8	13	10			
CMHVA Board Meetings 9:30am - 11:15am - In Person / Hybrid	3	1	5 20 AGM	3	7	4	4	1	6	3 18 AGM			
CMHF Board Meetings 4:30pm - 6:30 - In Person / Hybrid	30		25		27		24		26	23 AGM			

Board/Committee Meetings and Event Dates	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep (2026)
Patient Family Advisory Council (PFAC) 5:00pm - 7:00pm In Person / Hybrid	9	7	4	2	13	3	3		5	2			
OHT Joint Board Committee 5:30pm - 7:30pm - Virtual Zoom meeting	22	27	24	15									
2025-26 Events													
Staff Holiday Lunch 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 - June 11 (11:00am-2:00pm / 9:00-10:00pm)										11			
Career Achievement June 11 (11:00am-2:00pm / 9:00-10:00pm)										11			
CMH Celebrate the Values						4							
CMH Golf Classic - June 1, 2026 Galt Country Club										1			
CMHF Reveal 2026 - Starlight Serenade - Tapestry Hall						27							
Board Social - 5:30-7:30 - Garden Events Centre								14					
Board Education Opportunities													
Governors Education Sessions													
Governance Essentials Program for New Directors (OHA)													
Hospital Legal Accountability Framework		16											
Hospital Accountability Within the Health System		23											
Hospital Funding and Accountability		28											
Governance Management Partnership			4										
Current Issues and Emerging Themes			11										

BRIEFING NOTE

Date: May 29, 2026
Issue: Audit Committee Report to Board of Directors June 3, 2026 – OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Bonnie Collins, Administrative Assistant
Approved by: Jay Tulsani, Audit Committee Chair

Attachments/Related Documents: None

A meeting of the Audit Committee took place on Monday, May 25, 2026 at 1700h.

Present:	Jay Tulsani (Chair), Bonita Bonn, Bill Conway, Miles Lauzon, Margaret McKinnon, Brian Quigley, Taariq Shaikh, Chris Whiteley, Diane Wilkinson, Lynn Woeller
Regrets:	Tom Barker
Staff:	Trevor Clark, Michelle D'Souza, Patrick Gaskin, Mari Iromoto, Janet Short, Valerie Smith-Sellers
Guests:	Kim Haley (KPMG)

The Audit Committee completed its scheduled work for the May 25, 2026, reporting period in accordance with its terms of reference and workplan. Key matters reviewed, discussed, and advanced by the committee are summarized below for Board awareness.

Committee Matters – For information only

1. **Broader Public Sector Accountability Act Attestation:** Ref. May 2026 Resources Committee Board summary report.

2. **2025-26 Audit Committee Goals and Objectives / Key Performance Indicators Review:** The goals and objectives of the Audit Committee for the 2025-26 Board cycle were confirmed as achieved. 2026-27 goals will be developed by the Board, with focus on the HIS project. There was discussion around the possible effect of partnership between WRHN and CMH.

BRIEFING NOTE

Date:	**May 22, 2026**
Issue:	**Digital Health Strategy Committee Report to Board of Directors – May 21, 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

A meeting of the Digital Health Strategy Committee took place on Thursday, May 21, 2026 at 1700h.

Present:	Sara Alvarado (Chair), Joel Campbell, Masood Darr, Miles Lauzon, Richard Neidart, Gloria Ringwood, Jay Tulsani, Lynn Woeller (Ex-Officio)
Regrets:	Jen Backler, Paul Martinello, Suzanne Sarrazin
Staff:	Trevor Clark, Patrick Gaskin, Mari Iromoto, Kyle Leslie, Stephanie Pearsall
Guests:	Maryam Kazar

The Digital Health Strategy Committee completed its scheduled work for the May 21, 2026, reporting period. Key matters reviewed, discussed, and advanced by the committee are summarized below for Board awareness.

Committee Matters – For information only

1. Operational Excellence / Spotlight on Innovation: CMH Management presented key highlights of Picktacular which addresses operating room inventory variation across surgeon picklists through standardization and improved supply management. Anticipated benefits include reduced SKU complexity, enhanced inventory visibility, and operational efficiencies. The project received the Sustainable Design Award from project collaborator the University of Waterloo. Existing governance structures are expected to support implementation and future integration with related initiatives.

BRIEFING NOTE

Date:	**May 20, 2026**
Issue:	**Executive Committee Report to the Board of Directors, May 19, 2026 – OPEN**
Prepared for:	**Board of Directors**
Purpose:	**☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction**
Prepared by:	**Stephanie Fitzgerald, Administrative Assistant**
Approved by:	**Lynn Woeller - Executive Committee Chair, Patrick Gaskin – President & CEO**

Attachments/Related Documents: None

A meeting of the Executive Committee took place on Tuesday, May 19, 2026 at 0700 hours.

Present:	L. Woeller (Chair), P. Brasil, B. Conway, J. Goyal, D. Wilkinson
Regrets:	None
Staff:	P. Gaskin, Dr. W. Lee
Guests:	None

The Executive Committee completed its scheduled work for the May 19, 2026 reporting period in accordance with its terms of reference and annual work plan. The key matters reviewed and discussed by the committee are summarized below for the information of the Board.

Committee Matters – For information only

1. **March 2026 Executive Committee Meeting Evaluation Results:** The committee reviewed the post-meeting evaluation results and noted that only one member had completed the survey. Members were reminded of the importance of completing evaluations following each meeting to support meaningful feedback and continuous improvement.

2. **2025/26 Executive Committee Annual Evaluation Results:** The committee reviewed the annual evaluation results, which reflected positive overall feedback, with responses largely in the agree or strongly agree range. The discussion also confirmed that any consideration of longer-term strategic planning must remain aligned with the committee's defined terms of reference and scope.

3. **2025/26 Senior Executive Evaluation Process:** The committee reviewed the senior executive evaluation process. Management advised that 360-degree feedback surveys would not be conducted this year due to organizational capacity constraints. The committee was supportive of the approach.

Agenda Item 1.5.6.4

BRIEFING NOTE

Date:	**May 15, 2026**
Issue:	**Governance and Nominating Committee Report to the Board of Directors, May 14, 2026– OPEN**
Prepared for:	**Board of Directors**
Purpose:	**☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction**
Prepared by:	**Stephanie Fitzgerald, Administrative Assistant**
Approved by:	**Patrick Gaskin – President & CEO**

Attachments/Related Documents: None

A meeting of the Governance and Nominating Committee took place on Thursday, May 14, 2026 at 1700 hours.

Present:	J. Goyal, D. Wilkinson, J. Herring, R. Ma, L. Woeller (ex-officio)
Regrets:	T. Barker
Staff:	P. Gaskin, S. Pearsall
Guests:	None

The Governance and Nominating Committee completed the following work at its May 14, 2026 reporting period in accordance with its terms of reference and annual work plan. The key matters reviewed and discussed by the committee are summarized below for the information of the Board.

Committee Matters – For information only

1. CMH Board Relationship Management Tool Update: The committee reviewed the updated Board Relationship Management and Community Engagement Tool and noted that revisions improved clarity, usability, and support for governance-level discussion. The committee identified a correction to the timing of the municipal and regional lame duck period, discussed how engagement with regional councillors should be reflected, and considered a potential future conflict of interest scenario involving a community member employed by municipal government. The committee supported a practical approach that would protect sensitive information while maintaining trust and minimizing administrative burden.

2. Communications Plan Annual Review: The committee received a high-level overview of the Communications and Engagement Plan and the work underway to strengthen strategic communications across the organization. The update highlighted modernization of communication channels through the intranet, public website, and digital screens, enhanced staff engagement through more interactive town halls and the “What’s on Your Mind” platform, and continued work to support accessibility, inclusion, and storytelling. Members acknowledged the breadth of work underway and raised no concerns.

3. **Next CMH Strategic Plan Planning Cycle:** The committee reviewed the proposed approach to the next strategic planning cycle and discussed the recommendation to extend the current strategic plan timeline, with formal planning to begin in fall 2027 and Board approval targeted for October 2028. Discussion focused on maintaining continuity through annual corporate plan reviews, the importance of clearly framing the approach as an extension rather than a deferral, and concerns regarding timing, optics, cost, and alignment with both the rebranding initiative and the fiscal cycle. Management will incorporate committee feedback into the recommendation prior to Board consideration. (Further information will be discussed during agenda item 4.2)

4. **Review of Board/Committee Feedback Reports (April 2026 Meetings):** The committee reviewed the April 2026 feedback reports and noted for information that Board Chairs and committee Chairs will also complete feedback reports going forward. No additional comments or observations were raised.

5. **Review GNC Annual Committee Evaluation Results for 2025/26:** The committee reviewed the annual evaluation results and noted that overall feedback reflected that the committee is functioning effectively. Members also discussed the ambition of committee agendas, the increasing scope and intensity of governance work, and the need to remain mindful of volunteer capacity. Suggestions included greater use of consent agendas, sharper prioritization, and continued focus on core governance work.

6. **2026/27 GNC Meeting Dates/Times:** The committee considered the proposed meeting dates and meeting length for 2026/27. Members supported maintaining the current 2.5-hour meeting length for one additional year to allow for further assessment, and a correction was noted to revise the February meeting date to February 11.

7. **2025/26 Annual Self & Peer Evaluation Survey Results Review:** The committee reviewed the results of the annual self and peer evaluation survey and noted that no broad areas of concern were identified. The Chair advised that one individual follow-up had been identified and would be addressed offline by the Board Chair and GNC Chair, consistent with the appropriate process for individual matters.

8. **Recruitment & Nominating Update – 2026/27 Recruitment / Board Appointments, Recommendations of Officers for 2026/27, Recommendations of Directors for 2026/27 & Renewal of Director Terms, Recommendations of CMH Board Committee Chairs for 2026/27, Recommendations of Non-Director Committee Members for 2026/27, and Recommendations of Director Committee Assignments and Appointments of CMH Directors to Non-CMH Boards for 2026/27:** The committee completed its year-end recruitment and nominating responsibilities and confirmed the recommendations to be brought forward to the Board for the 2026/27 Board year. These included recommendations related to Officers of the Board, election and re-election of Directors, committee chair appointments, non-Director committee members, committee assignments, and appointments of CMH Directors to non-CMH boards. Formal recommendations will be brought forward for approvals at the June 24, 2026, Board of Directors meeting, and Annual meeting.

9. **Policy Review – Policy Review and Approval / Review of CMH Code of Conduct:** The committee completed scheduled policy review work and recommended approval of the Confidentiality Policy and the Procedure for Members of the Public Addressing the Board. The committee also reviewed the updated Code of Conduct, noted the enhancements to language and equity and inclusion alignment, and supported continuing with the organization-wide Code of Conduct rather than developing a separate Board-specific code. *(Further information can be found in consent agenda item 1.5.7)*

10. **Session 5: Unpacking What's New in the Guide to Good Governance / Updates from the OHA Healthcare Leadership Summit:** The committee received Session 5 of the Guide to Good Governance educational materials as part of the ongoing governance education series.

BRIEFING NOTE

Date: May 13, 2026
Issue: MAC Report to the Board of Directors May 2026 - OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Dr. Jenny Legassie, Deputy Chief of Staff
Approved by: Dr. Jenny Legassie, Deputy Chief of Staff

Attachments/Related Documents: None

A meeting of the Medical Advisory Committee took place on Wednesday May 13, 2026 at 1700h.

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

This briefing note highlights the critical advancements in patient safety, interdepartmental quality initiatives, and community health initiatives from the Medical Advisory Committee (MAC) on May 13, 2026.

Committee Matters – For information only.

1. HIS Clinical Readiness: As CMH approaches HIS go-live, MAC will serve a key oversight role in review of "Power Plans" – digital, standardized order sets that support clinical workflows – to ensure they align with evidence-based practices and guidelines. The M&T committee has been doing an intensive comprehensive review of Power Plans. To facilitate staff education, a representative subset of these Power Plans have been prioritized to be completed in time for user training. This will ensure that the simulated environment for training reflects the different types of clinical workflows at the time of HIS go live. Remaining Power Plans are being triaged based on a formalized triage system shared between CMH and WRHN, with those Power Plans deemed by the subject matter experts as "unsafe without changes" being addressed first. The Committee has identified proposed/necessary changes as falling under common themes:
    - i. Safety
    - ii. Not applicable (i.e. cardiac catheterization power plans)
    - iii. Staff education needed to adopt existing power plan
    - iv. Adjustments to IV Pumps needed to adopt existing power plan
    - v. Formulary differences between WRHN and CMH need to be addressed
    - vi. Practice difference between WRHN and CMH need to be addressed
    - vii. Human Resource impact (i.e. automatic consults or who administers a medication)
    - viii. Impact to Choosing Wisely Designation

Clinical Risk Assessment and Mitigation: One of the most notable risks during the Power Plan review to date is the potential reintroduction of non-evidence-based laboratory testing. Due to inherent limitations in the current Oracle system architecture and resource constraints within the pre-go-live build window, some order sets may not fully align with "Choosing Wisely" standards. This not only results in unnecessary testing but an increased workload and cost and risk to CMH's Choosing Wisely designation. Concerns were raised about the timelines and structure for post-go-live optimization phase to resolve these limitations. Furthermore, to mitigate these risks during the HIS transition, the MAC has endorsed the following strategies:

- **Targeted Prescriber Education:** Explicitly informing clinicians of system limitations regarding evidence-based ordering and providing manual workarounds.
- **System Safeguards:** Collaborating with Oracle and WRHN technical teams to implement safeguards within the build where feasible.
- **Optimization Planning:** Establishing a formal post-implementation refinement schedule with physician leads at both CMH and WRHN.
- **Clinical Leadership Accountability:** Requiring final Medical Director sign-off on Power Plans to ensure departmental ownership of the digital workflow.

2. **Anesthesia Department Update:** Dr. Mark Hindle provided an update on the Anesthesia Department and quality activities/initiatives. This group is active in clinical service and in program development of their own accord as well as collaborating with and supporting the program development of other surgical and procedural services.
    a. **Program Advancements:**
        - Acquisition of new anesthesia machines equipped with advanced technology that reduces loss of anesthetic gases leading to both cost savings and environmental protection.
        - Active user of the new opioid disposal device that allows for safe disposal of unused opioids by denaturing the drug completely. This has increased patient and staff safety and eliminates the risks of drug diversion.
        - Actively pursuing hiring of an anesthesia assistant (AA), a highly trained professionals who assist in management of patients in the perioperative period and in the operating room to allow anesthesiologists to attend to other tasks. AAs can expand operating room abilities through their ability to perform tasks such as insertion of intravenous lines, airway management and monitoring of vitals. They work in concert with anesthesiologists to optimize care of all patients in the OR and PACU.

    b. **Collaboration.**
        - Strong supporter of growth in the endoscopy capabilities at CMH through their support for endoscopic ultrasound, and endoscopy hot time (blocks of endoscopy suite time dedicated to booking of urgent procedures, and procedures that can be performed in order to avoid admission or shorten length of inpatient stay).
        - Anesthesia has also facilitated reduction in surgical wait times through its support of orthopedic hot time for upper limb surgeries, and through dedicated operating room time for the acute care surgery program.

    c. **Choosing Wisely.**
        - In 2025 the anesthesia department successfully removed desflurane from their anesthesia carts. Desflurane has the strongest greenhouse gas effect of all commonly used anesthetics and can easily be removed from use in operating rooms without impacting patient care.

    d. **Sustain Financial Health**

- The department is working to streamline their pre-op clinical practices aligned with Choosing Wisely guidelines. In addition to preparing them for the new HIS, this will remove redundancies in documentation and use the most up-to-date clinical guidelines to reduce unnecessary pre-operative investigations and testing and improve patient experience.

e. **Recruitment**

   i. Successfully expanded to a team of 14 physicians, with a new anesthesiologist joining in January 2026 and a new physician joining in Summer 2027.

The department of Anesthesia has identified strong formal and informal leaders for their pending transition to Oracle. They are cautious but feel their experience using an electronic record for their current documentation and management puts them in good standing for the HIS implementation.

3. **Department of Pathology & Laboratory Medicine Update:** Dr. Brigitte Courteau presented an update on the quality activities/initiatives in the Department of Pathology & Laboratory Medicine. The team continues to drive changes that enables them to provide high quality work critical for patient care, and to support growth in all other areas of the hospital.

   a. **Clinical Services.**

      i. Number of laboratory testing requests has increased by 5-25% year over year and continues to be critically important to development of all inpatient and outpatient programs at CMH.

      ii. A dedicated phlebotomist in the emergency department to improve patient flow with prompt response to blood work requests, improving turnaround time from physician orders to results and decision making.

   b. **Patient Experience.**

      i. The outpatient laboratory has instituted the use of waitlist pagers that allows patients to leave the waiting area to walk or make use of hospital services such as Tim Hortons or the Gift Shop.

      ii. Patient experience staff now attend all laboratory quality meetings. This has facilitated opportunity to address patient feedback in a focused and sustained fashion.

   c. **Digital Advances.**

      i. The department is set to implement a Digital pathology system. This allows for scanning of slides to be viewed using computer software. This facilitates improved images, ease of sharing samples and increased capacity for education.

   d. **Human Resources.**

      i. Laboratory medicine is actively recruiting a pathologist to support current and future program growth.

   e. **Choosing wisely.**

      i. CMH has attained its Choosing Wisely Laboratory status through the concerted leadership of the laboratory team. They continue to sustain this status and to identify new areas for reducing costs without compromising patient care. Continuing the commitment to Choosing Wisely as we adapt to a shared instance of HIS is a top priority for 2026.

4. **Quality Improvement initiative:** Dr. Lee previewed the upcoming CPSO QI 2.0 event in May titled "The Theatre of Medicine" being offered to CMH physicians currently enrolled in the program. Led by the Shaw Festival movement director and co-developed by the Royal College of Physicians and Surgeons and The Shaw Festival, this workshop uses techniques taught in theatre and improvisation to improve skills critical for practicing medicine such as active listening, physical presence, self-awareness and empathy. Currently, about 75 physicians have signed up to attend.

BRIEFING NOTE

Date:	**May 29, 2026**
Issue:	**Resources Committee Report to Board of Directors June 3, 2026 – OPEN**
Prepared for:	**Board of Directors**
Purpose:	**☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction**
Prepared by:	**Bonnie Collins, Administrative Assistant**
Approved by:	**Paulo Brasil, Resources Committee Chair**

Attachments/Related Documents: None

A meeting of the Resources Committee took place on Monday, May 25, 2026 at 1700h.

Present:	Paulo Brasil (Chair), Sara Alvarado, Amanda Forrest, Julia Goyal, Monika Hempel, Shannon Maier, Janet Richter, Diane Wilkinson, Lynn Woeller
Regrets:	
Staff:	Trevor Clark, Michelle D'Souza, Patrick Gaskin, Mari Iromoto, Kyle Leslie, Janet Short, Valerie Smith-Sellers
Guests:	Kim Haley (KPMG), Chris Burgh (Ernst & Young), Maureen Palmer (Ernst & Young)

The Resources Committee completed its scheduled work for the May 25, 2026 reporting period in accordance with its terms of reference and workplan. Key matters reviewed, discussed, and advanced by the committee are summarized below for Board awareness.

Committee Matters – For information only

1. Broader Public Sector Accountability Act Attestation: The Resources Committee approved the annual attestation for the Broader Public Sector Accountability Act presented by management, highlighting the procurement review process, reliance on Mohawk Medbuy for supply chain, and the criteria for reporting consulting engagements.

   The Committees questioned the omission of some vendors from the report, and management confirmed CMH's definition of consultants. The Committees suggested adopting a broader approach to consulting definitions and procurement thresholds, which management will consider for future reporting. Management confirmed that Mohawk Medbuy has audit controls in place and will share details of Mohawk Medbuy's audit process at a future meeting. Management will confirm if the engineering firm engaged for the Cogen reconciliation should be included in the report as a consultant. (*Further information can be found in consent agenda item 1.5.12)*

2. Multi-Sector Service Accountability Agreement (M-SAA) Schedule F Declaration of Compliance: the Resources Committee approved the required annual compliance declaration for the Multi-Sector Service Accountability Agreement (M-SAA) Schedule F presented by management. *(Further information can be found in consent agenda item 1.5.13)*

3. **HSAA Article 8 – Declaration of Compliance:** The Resources Committee approved the required annual compliance declaration for the HSAA Article 8 – Declaration of Compliance presented by management. Questions concerning working capital ratio monitoring were addressed. *(Further information can be found in consent agenda item 1.5.14)*

Agenda Item 1.5.7

BRIEFING NOTE

Date: **May 25, 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 May 14, 2026, 2026.

2-A-24	*Confidentiality Policy*
2-D-09	*Procedure for Members of the Public Addressing the Board*

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 as with amendments: **CARRIED.**

2-A-24	*Confidentiality Policy*
2-D-09	*Procedure for Members of the Public Addressing the Board*

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-34	Confidentiality Policy	Minor changes to update language of the policy to keep current with the OHA's sample Board Policy on Confidentiality form 6.1 in the Guide to Good Governance
2-D-09	Procedure for Members of the Public Addressing the Board	Minor updates and grammatical changes reflected.

BOARD MANUAL

SUBJECT: Confidentiality Policy	NO.: 2-A-34
SECTION: Structure, Roles and Responsibilities	
APPROVED BY: Board of Directors	DATE: TBD

Purpose
To ensure that confidential matters are not disclosed until disclosure is authorized by the Board of Directors.

Policy
The Board Directors and non-Director committee members owe to the Hospital a duty of confidence not to disclose or discuss with another person or entity, or to use for their own purpose confidential information concerning the business and affairs of the Hospital received in their capacity as Directors or committee members unless authorized by the Board.

No Director or non-Director committee member shall make a statement to the media or public not authorized by the Board.

Application
This policy applies to all Directors of the Board and non-Director committee members. This policy continues to apply after a Director and non-Director committee member ceases to be a member of the Board and/or committee.

Confidential Matters
All matters that are the subject of *in-camera* sessions of the Board are confidential until disclosed in an open session of the Board.

All matters that are before a committee or task force of the Board are confidential, unless they have been determined not to be confidential by the Chair of the relevant committee or task force, or by the Board.

All matters that are the subject of open sessions of the Board are not confidential.

Procedure for Maintaining Minutes
Minutes of *in-camera* sessions of the Board shall be recorded by the secretary or designate, or if the secretary or designate is not present, by a Director designated by the Chair of the Board.

All minutes of *in-camera* sessions of the Board shall be handled in a secure manner.

All minutes of meetings of committees and task forces of the Board shall be handled in a secure manner.

Notwithstanding that information disclosed or matters dealt with in an open session are not confidential, no Director or non-committee member shall make a statement to the media or public not authorized by the Board

DEVELOPED: February 22, 2012		
REVISED/REVIEWED:		
April 23, 2014	September 28, 2016	November 27, 2019
February 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

SUBJECT:	Procedure for Members of the Public Addressing the Board	NO.: 2-D-09
SECTION:	Board Process	
APPROVED BY:	Board of Directors	DATE: TBD

Policy

Persons wishing to address the Board concerning matters relevant to the Hospital must follow the procedure outlined below.

1. Delegations wishing to make a presentation to the Board regarding governance and policy matters in relation to the Hospital's vision, mission, values, and directional plans are permitted to do so. Presentations and questions about an individual's care or a staff member's employment record are not permitted. Information about how to address the Board appears on the hospital's website.

2. Application to appear before the Board may be made by contacting the CEO's office by phone at 519- 621-2333 ext. 2350 or by email at CMHboardchair@cmh.org to access the Delegation Application Form.

3. The Delegation Application Form must be received no later than 10 working days prior to the meeting date. If a group wishes to appear, a spokesperson for the group must be identified.

4. If the Delegation Application Form is received less than 10 working days prior to the meeting date, the Board Chair, at their discretion, may permit the presentation. The decision to allow the presentation will be based on the urgency of the issue and to what extent the anticipated current agenda workload could accommodate the presentation.

5. Requests to address the Board on a specific item will be granted (generally in order of the receipt of the application) at the discretion of the Board Chair. The Board Chair may request that the matter be referred or redirected as appropriate. Persons or groups not permitted to address the Board shall be so notified in advance of the meeting.

6. The Board Chair is not obligated to grant a request to address the Board. The Board is not obligated to respond to or take any action on the presentation it receives.

7. The Board may limit the number and length of presentations at any meeting.

8. Delegations addressing the Board will be required to limit their remarks to their allotted time, as determined by the Board Chair.

9. Board members may ask questions of clarification following the presentation.

DEVELOPED: March 30, 2011	**REVISED/REVIEWED:**	
April 23, 2014	November 30, 2016	July 28, 2020
June 28, 2023	Click or tap to enter a date.	Click or tap to enter a date.
Click or tap to enter a date.	Click or tap to enter a date.	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.

Agenda Item 1.5.8

BRIEFING NOTE

Date: May 25, 2026
Issue: Strategic Priorities Q4 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 25/26 Tracker

Alignment with 2025/26 CMH Priorities:

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

Executive Summary
This briefing note provides a year-end summary of progress against CMH's 2025/26 strategic priorities, highlighting measurable improvements across digital transformation, workforce stabilization, and financial performance.

While key foundational initiatives—particularly Project Quantum and workforce optimization—have achieved significant milestones, ongoing system pressures continue to impact patient flow metrics, including Emergency Department wait times and discharge performance.

Overall, the organization has demonstrated strong progress in enabling long-term transformation while continuing to address immediate operational challenges.

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 included:

1. **Strategic Priorities Tracker:** Monitors critical in-year priorities identified via the QIP, IRM process, and strategic plan.
2. **Quality Monitoring Scorecard:** Tracks key quality metrics monthly to ensure sustained performance.
3. **Critical Risks Escalated for Frequent Reporting:** Elevates patient flow and staffing concerns for more regular monitoring by the Quality Committee and Resource Committee.

Analysis
Our in-year priorities are aligned with our strategic pillars. Below is a summary of Q4 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):**

   Overall Status: Not meeting targets (continued system flow pressures) Key Q4 Performance:
   - Ambulance Offload Time: 45 minutes (above ≤43 target)
   - Provider Initial Assessment (PIA): 7.0 hours (above <4.6 target)
   - Urgent PIA (CTAS 1–2): 6.3 hours (above <4.0 target)
   - Admissions in ED at 8 AM: 13.9 patients (above <10 target)
   - Discharges before 11 AM: 0.83/day (below >6 target)

   Key Actions and Progress:
   - Implemented and stabilized Rapid Assessment Zone (RAZ) and aligned into ED operations
   - Advanced Surge Plan policy development and operational readiness once approved
   - Continued bi-weekly ED leadership governance and flow monitoring
   - Introduced targeted interventions to improve discharges:
     - Discharge planning model with dedicated coordination
     - Earlier identification and communication of expected discharge dates (EDD)
     - Hospitalist model enhancements and staffing supports

   Risks / Considerations:
   - Sustained bed capacity pressures and high occupancy
   - Ongoing reliance on surge capacity (e.g., C3 unit) with workforce impact
   - Physician recruitment and coverage risks impacting ED flow

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

Overall Status: On Track

Health Information System (HIS) Implementation – Project Quantum:
- Achieved key milestones:
  - Completed Align Gateway and core project planning deliverables
  - Completed enterprise workflow workshops and partner alignment (WRHN, CMH, Oracle)
  - Finalized Anatomical Pathology and Oncology module planning
  - Established governance, risk frameworks, and change management structures
- Advanced:

  - Physician SME engagement and workflow validation
  - Change champion network and organizational readiness activities

Workforce Planning (WFP):
- Project phase completed with transition to operations
- Optimization supported through UKG advisory completed

Physician Digital Enablement:
- Achieved full adoption of front-end speech recognition tools, enabling removal of legacy dictation systems

Risks / Considerations:
- Scope expansion pressures managed through formal scope governance and change control
- ERP strategy remains dependent on regional alignment and external funding clarity

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

Overall Status: Not On Track, continued pressures in sick and Overtime

Key Q4 Performance:
- FTE Variance: achieve initial targeted staffing for across ED, ICU, Medicine, 26/27 staffing targets will be aligned with 26/27 budget and float pool strategy.
- Medical Staff Recruitment: 13 of 17 critical roles filled

Key Actions and Progress:
- Achieved targeted ICU staffing complement
- Continued recruitment across Medicine and ED
- Implemented and expanded nursing float pool
- Optimized scheduling and onboarding workflows
- Finalized decision to not proceed with UKG attendance module, implementing interim reporting solutions

Risks / Considerations:
- Workforce sustainability pressures tied to:
  - Surge capacity
  - Overtime and absenteeism patterns
- Recruitment challenges in specialized physician roles

4. Sustain Financial Health (Oversight by Resource Committee):

Overall Status: On Track

Key Q4 Performance:
- PCOP Revenue: On track / exceeding targets in-year
- Forecast supports full achievement of PCOP volumes
- Reconciliation process will extend into 26/27

Key Actions and Progress:
- Implemented monthly performance monitoring with clinical and financial leadership
- Optimized surgical and medical activity aligned to funded volumes
- Finalized 2026/27 budget and operating strategy based on full PCOP volume achievement

Risks / Considerations:

- Dependence on Ministry reconciliation (timing in 2026/27)
- Ongoing need to balance activity levels with capacity constraints

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

DEI Plan Status: Progressing to On Track

- Continued advancement of:
  - DEI Toolkit and training initiatives
  - Inclusive Communications Guide (near completion)
  - Employee Resource Groups (expanded and formalized)

- Successfully executed:
  - Black History Month initiatives
  - Launch of Photo Repository supporting inclusive representation
  - Formal cadence for CEO DEI communications

Truth and Reconciliation Plan Status: Progressing to On Track

- Strengthened:
  - Indigenous education and training (San'yas, L&L series)
  - Indigenous ERG formation and engagement

- Advanced:
  - Smudging policy updates and cultural safety initiatives
  - Indigenous art, partnerships, and community engagement efforts

Risks / Considerations:

- Dependency on regional partnerships and alignment (WRHN, community partners)
- Timing impacts from broader organizational priorities and capacity

Consultation
This report reflects consolidated input from Executive Sponsors, Project Leads, and operational leadership forums, including Directors' Council, Operations Huddles, and program-level Quality and Operations Councils.

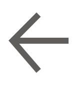
Next Steps
The strategic priorities tracker will be refreshed for 26/27 priorities, the Q1 performance data and action plans will be updated and presented to Board Committees starting in September 2026.

Agenda Item 1.5.8
Appendix-A

Strategic Priorities 25/26

"Creating Healthier Communities, Together"

Strategic Priority	Metric	Target	Q1	Q2	Q3	Q4	Aligned Corporate Plans
Elevate Partnerships in Care	90th percentile Ambulance Offload Time (minutes) (QIP/IRM)	<43	38	28	46.9	45	Clinical Services Growth Plan
Elevate Partnerships in Care	90th percentile Provider Initial Assessment in the ED (hours) (QIP/IRM)	<4.6	7.5	7.6	7.5	7.0	Clinical Services Growth Plan
Elevate Partnerships in Care	90th percentile Urgent Provider Initial Assessment in the ED (hours) (QIP/IRM)	<4.0	6.3	6.5	6.3	6.3	Clinical Services Growth Plan
Elevate Partnerships in Care	Average number of Admits in the ED at 08:00 (QIP/IRM)	<10	12.28	12.06	13.42	13.9	Clinical Services Growth Plan
Elevate Partnerships in Care	Dyad Partnership - Major project average medical discharges before 11AM	>6	0.78	0.56	0.67	0.83	Clinical Services Growth Plan
Reimagine Community Health	Project Quantum- % on track with identified milestones for 25/26 (IRM)	100	100	89	95	100	Digital Health Plan
Increase Joy in Work	FTE Variance from target for Medicine, ICU, & ED (IRM)	0	-29	-25	-17	4.7	HR Plan
Increase Joy in Work	Medical Professional Staffing (Targeted Positions) (IRM)	17 Year end target	3	13	13	13	HR Plan
Sustain Financial Health	Post Construction Operating Plan Revenue Earned	>$2.24M quarter	3.60M	2.65M	3.87M	5.10M	Multi-year Financial Plan
Advance Health Equity	% on track with DEI Action Plan	100	100	78	77	90	DEI Plan
Advance Health Equity	% on track with Truth and RoconciliACTION Plan	100	100	88	81	90	Truth & ReconciliACTION Plan



Elevate Partnerships in Care

Clinical Services Growth Plan (IRM- Quality Committee)

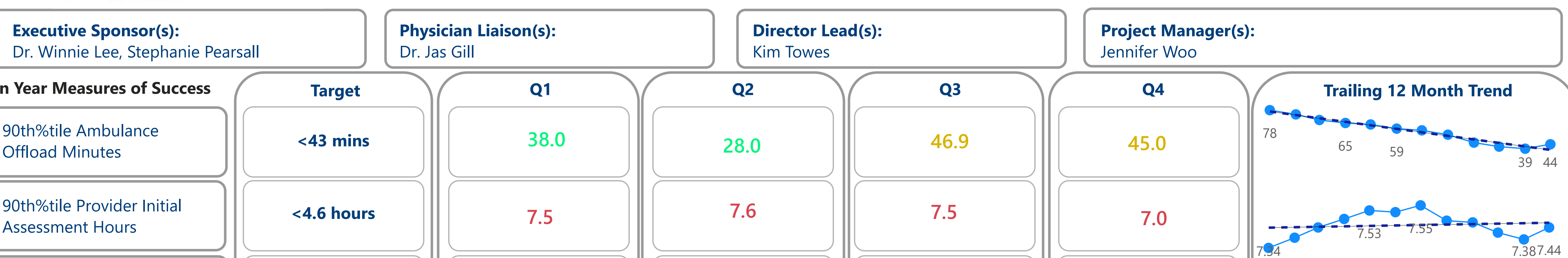
Click Here to Input Action Plans

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

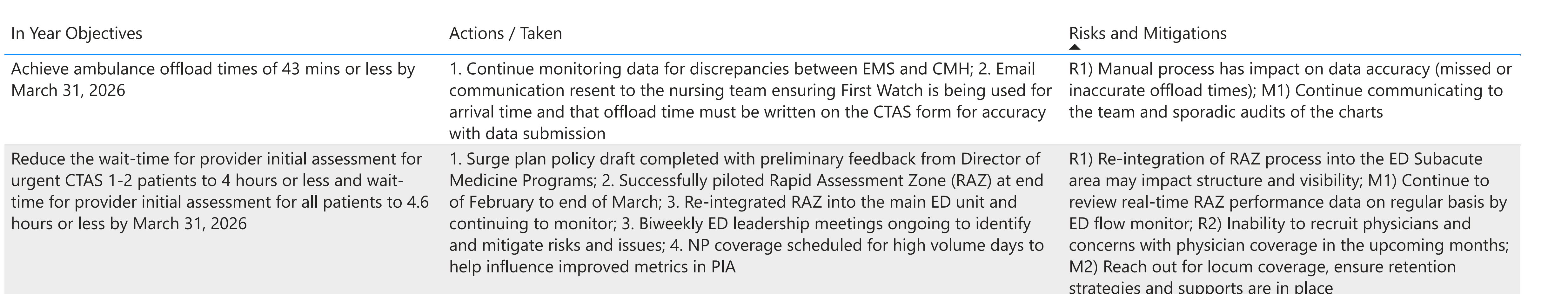
Physician Liaison(s): Dr. Jas Gill

Director Lead(s): Kim Towes

Project Manager(s): Jennifer Woo



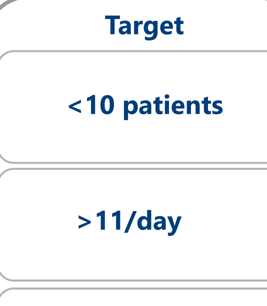
In Year Measures of Success	Target	Q1	Q2	Q3	Q4
90th%tile Ambulance Offload Minutes	<43 mins	38.0	28.0	46.9	45.0
90th%tile Provider Initial Assessment Hours	<4.6 hours	7.5	7.6	7.5	7.0
90th%tile Urgent Provider Initial Assessment Hours	<4.0 hours	6.3	6.5	6.3	6.3



In Year Objectives	Actions / Taken	Risks and Mitigations
Achieve ambulance offload times of 43 mins or less by March 31, 2026	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) Manual process has impact on data accuracy (missed or inaccurate offload times); M1) Continue communicating to the team and sporadic audits of the charts
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. Surge plan policy draft completed with preliminary feedback from Director of Medicine Programs; 2. Successfully piloted Rapid Assessment Zone (RAZ) at end of February to end of March; 3. Re-integrated RAZ into the main ED unit and continuing to monitor; 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) Re-integration of RAZ process into the ED Subacute area may impact structure and visibility; M1) Continue to review real-time RAZ performance data on regular basis by ED flow monitor; R2) Inability to recruit physicians and concerns with physician coverage in the upcoming months; M2) Reach out for locum coverage, ensure retention strategies and supports are in place

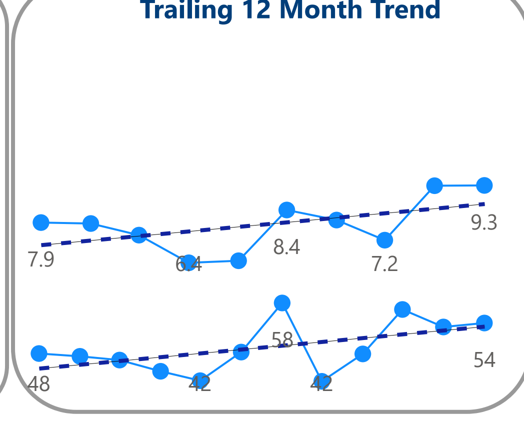
Clinical Services Growth Plan (IRM- Quality Committee)

Executive Sponsor(s):	**Physician Liaison(s):**	**Director Lead(s):**	**Project Manager(s):**
Dr. Winnie Lee, Stephanie Pearsall	Dr. Augustin Nguyen	Andrea Brissette	Jennifer Woo



In Year Measures of Success	Target	Q1	Q2	Q3	Q4
Average Admits in the ED at 08:00	<10 patients	12.28	12.06	13.42	13.91
Average Discharges/Day (Medical)	>11/day	7.9	6.7	7.9	9.3
90th%tile Time to Inpatient Bed (Hours) - Med/Surg	<25 hours	45.8	48.8	49.1	53.3

Trailing 12 Month Trend



In Year Objectives	Actions / Taken	Risks and Mitigations
Achieve time to bed target of < 25 hours	1. Implemented tracking in ICU, continuous monitoring by charge nurses; 2. Analysis of TTB variance from target and investigating reasons for performance	R1) Volume of no bed admits in the ED and lower discharges throughout organization, impacting patient flow; M1) Ensure adequate staffing to support surge unit; M2) Close unfunded surge beds
Minimize the number of admitted patients held in ED at 8 am to an average of 10 or less by March 31, 2026	1. Provided 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, badge cards were developed and implemented for staff to wear as a reminder of strategies; 2. Discharge rounds have focused on EDD and ensuring that when identified by the team that it is written on Whiteboard and communicated to patients/families. 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 developed in Q4 will be implemented in Q1 of 26/27; 5. New discharge planning model has been implemented , a coordinator of discharge was added to the medicine program to ensure that patients who are ALC have a program identified and oversees the application process for alternate level of care destinations; 6. CMH@ home met target and is now part of base funding; 7. Addition of 5th hospitalist to cover B3, allowing the other hospitalists to focus on acute patients; 8. Use of modified nurse to work swing shift to support discharges and ED admissions, coverage is aimed for the busier times of day and at shift change; 9. Continue to use Medically stable ready for discharge and ensure that ALC designation is used appropriately (patient has a discharge plan within 48hrs)	R1) Increased LOS for patients admitted in the ED; M1) Leverage Nursing Float Pool, staff ED with medically trained nurses
Strengthen dyad (medical / management) partnership model	1. Leveraged 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. Optimized existing dyad meetings: revise format and focus of COEC; 4. Timing of Launch: pause Program Council rollout until post-HIS launch	R1) ED Medical Director vacancy; M1) new Clinical Director ED and Patient Flow starting June 8, 2026; R2) Limited capacity and focus under the current context of HIS clinical transformation and Access and Flow challenges; M2) Strong support from CNE/VPMO/COS to support and strengthen this DYAD to support access and flow; focus on flow and HIS implementation

Clinical Services Growth Plan (IRM- Quality Committee)

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

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)

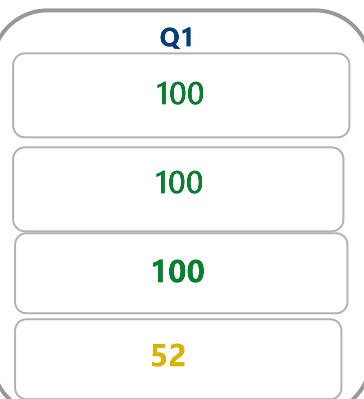
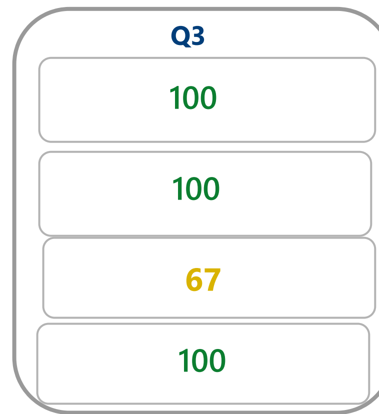
Executive Sponsor(s): Trevor Clark

Physician Liaison(s): Dr. Ryeyan Taseen

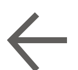
Director Lead(s): Kyle Leslie

In Year Measures of Success

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

In Year Objectives	Actions / Taken	Risks and Mitigations
% on track with Health Information System (HIS) implementation milestones	1. Completed Project Plan, Risk Governance, Risk Ranking and impact scales, Scope of Work Documentation, Project Tracking Documentations, Organizational Structure, Optimization Tracker; 2. Completed Align gateway on-time; 3. Completed workshops 1, 2 and and all related activities from the three partners; 4.Resource onboarding complete with hiring of Training and Testing Coordinator and other additional approved FTEs; 5. Finalized Decision on Anatomical Pathology Project; 6. Finalized the Oncology Module Planning; 7. Completion of Physician Resources assignment as SMEs and way forward for finalizing PowerPlans; 8. Initiation of Change Campaigns and Onboarding of Change Champions; 9. Completion of post workshop surveys and communicating results and improvemnet strategies with the leaders	R1) Receiving requests to add items outside the current scope can impact the budget and timeline; M1) Initiated Scope Freeze to prevent further addition of out of scope items. Change Request Board to assess requests carefully and decide based on the project resources. Optimization Tracker to track future optimization post go-live
% on track with Workforce Planning (WFP) implementation milestones	1. Through support of OSO department, optimized scheduling processes; 2. Established 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



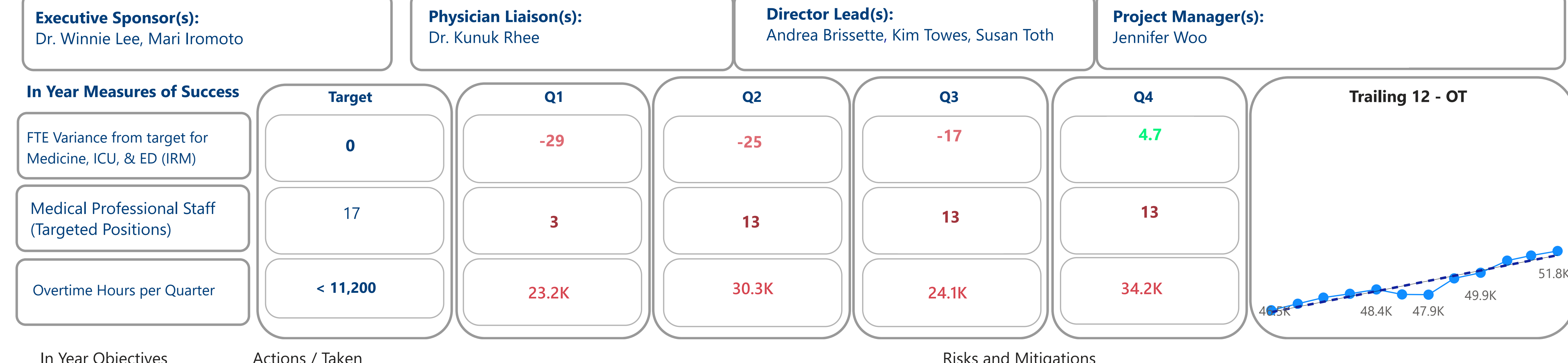
Digital Health Plan Cont. (IRM Digital Health / Resource Committee)

Executive Sponsor(s):	**Physician Liaison(s):**	**Director Lead(s):**	**Project Manager(s):**
Trevor Clark	Dr. Ryeyan Taseen	Kyle Leslie	HIS - Maryam Kazar

In Year Objectives	Actions / Taken	Risks and Mitigations
% of MDs using Front End Speech	Goal for this fiscal year was to convert all providers to front end speech by the end of this fiscal year. This goal was successfully achieved and we were fully able to remove our back end phone dictation line	
% on track with Enterprise Resource Planning (ERP) implementation milestones	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

Human Resources Plan (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 Measures of Success	Target	Q1	Q2	Q3	Q4
FTE Variance from target for Medicine, ICU, & ED (IRM)	0	-29	-25	-17	4.7
Medical Professional Staff (Targeted Positions)	17	3	13	13	13
Overtime Hours per Quarter	< 11,200	23.2K	30.3K	24.1K	34.2K

Trailing 12 - OT

In Year Objectives	Actions / Taken	Risks and Mitigations
Reduce overtime hours to budget by March 31, 2026	(HR) 1. Implemented nursing float pool to support Medicine (January start); 2. Re-introduced new graduate guarantee program (NGG) for RNs and RPNs by beginning discussions with unions and developing recruitment strategy (next fiscal year start); 3. Re-communicated to staff how to report unplanned absences; (ED) 1. Continued to monitor and review OT hours and trends, ensuring proper skill mix of nursing is reflected on the schedule; (Med) 1. Met with HR and Occupational Health to review sick time and staff on modified leave, setup meetings with staff; 2. Re-established float pool and continuing to recruit to support OT reduction, staffing ED admits and surge areas; 3. Staffed-up on Medicine A, using additional staff to reassign to other medicine areaas when covering sick calls; (ICU) 1. Achieved full staffing complement, staffing reviewed and staffed as per census; 2. Decision to not replace first sick call when census is low; 3. Orientation and internships reduced from 6 months to standard 300 hours of orientation	(HR) R1) Gaps in Director and Manager HR leadership; M1) Outstanding initiatives will be reprioritized and managed by HR department as interim solution (ED) R2) Bed admit occupancy and gaps in coverage for admitted patients; M2) Continue to work closely with medicine leadership to identify challenges; (Med) R3) Increased OT due to 1:1, ambulance runs, surge beds; M3) Close surge bed; M4) Plan to review 1:1 on daily basis and develop tool to support assessing needs for 1:1 and ambulance runs

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

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	Risks and Mitigations
Achieve active staffing targets in (ED ICU Medicine) by March 31, 2026	(HR) 1. Made final decision regarding viability of the UKG Attendance Module, deemed not suitable for CMH; 2. PMO facilitated workflow mapping session for current state onboarding processes; 3. Shared current state workflows and provided education to leaders at upcoming January 2026 Operations; 4. Ensure compliance with legislation effective Jan. 1, 2026 to enhance retention; (ED) 1. Developed Master schedule through our Decision Support team to ensure proper skill level and alignment throughout the nursing rotations; (Med) 1. Continued to hire vacancies; (ICU) 1. Achieved full staffing complement, staffing reviewed and staffed as per census	(HR) R1) UKG attendance module deemed not suitable for CMH needs; M1) Engage with Decision Support to build automated program that replicates former automated internal program; M2) Increased oversight into attendance and leaders holding conversations with staff; R2) Director and Manager HR leadeship; M3) Outstanding initiatives will be reprioritized and managed by HR department as interim solution (ED) R3) Unbalanced skill in certain rotations; M4) Schedule dates and sessions with ED leadership and educator to continue to provide upskilling to staff (Med) R4) Recruitment candidates are not as experienced, considered novice staff; M5) Leverage clinical clinical scholar, charge nurse training days and education spotlight; M6) Continue hands-on interviews and assessment
Ensure medical staffing is sufficient to meet core clinical operations	1. Sustained the total %of recruited physicians in the identified core clinical areas; 2. Recruited medical professional staff across all programs/departments; 3. Designed and implemented an e-learning platform integrated into the new e-credentialing platform which improves education compliance and tracking; 4. Introduced new hospitalist model to support organizational flow with ongoing evaluation; 5. Continue to ensure emergency/on-call services are covered.	R1) Continued challenges in recruitment for certain programs/departments – ED, Pediatrics, Plastics, Orthopedics; M1) Program/Department external reviews and new models of care strategies; R2) Medical professional staff leaves/retirements/relocation in departments/programs – ED and Pediatrics; M2) Expand e-credentialing offerings, including the introducing of an electronic initial applications to streamline onboarding process; M3) Increase medical education/academic affairs as a pipeline for recruitment and strategy for retention; M4) Modernize staffing grids to create redundancy to mitigate for volume/acuity surges and unplanned vacancies; M5) Modernize departmental organization to facilitate stronger team culture and support stronger intra-departmental accountabilities; M6) Modernize regional physician networks to mitigate for local staffing/service gaps.

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	Target	Q1	Q2	Q3	Q4
PCOP Revenue earned	>$2.24M per Quarter	3.6M	2.7M	3.9M	5.1M
QBP Revenue generated*	>$6.9M per Quarter	7.3M	7.3M	7.8M	8.2M

Monthly Trend

1.1M 1.5M 0.5M 1.6M 1.2M

2.9M 2.3M 3.0M 2.6M 2.8M

In Year Objectives	Actions / Taken	Risks and Mitigations
Achieve Medical PCOP growth target for 25/26	Implemented monthly PCOP performance review meetings with Medical Leadership, Finance, and Decision Support to monitor activity and trends. Conducted Q4 performance assessment, confirming that Medicine is on track to meet and exceed the 2025/26 PCOP target.	R1) Risk of additional surge beds M1) Continue to focus on optimization of LOS and conservable days to reduce surge bed use
Achieve Surgical PCOP growth target for 25/26	Established monthly surgical performance review meetings with Surgical Leadership, Finance, and Decision Support to monitor volumes and performance. Refreshed the 2026/27 surgical grid based on achieved volumes, aligning planned activity to available PCOP and QBP funded volumes.	
Based on PCOP Forecast determine QBP strategy for 26/27	Finalized the 2026/27 Operating Room (OR) grid aligned to available PCOP and QBP funding envelopes, ensuring planned surgical volumes are optimized within funded capacity.	R1) Max available PCOP / QBP; M1) Align surgical activity with available funded volumes through QBP / PCOP
Forecast PCOP for 25/26 and determine PCOP strategy for 26/27	Finalized the 2026/27 budget strategy based on the assumption that full PCOP will be achieved in 2025/26. Noted that, while full PCOP volumes have been realized, final reconciliation with the Ministry will occur in 2026/27 and remains a key dependency.	No risks to report.

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

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): Jennifer Woo, Joy Braga (temporary)

In Year Measures of Success

Measure	Target	Q1	Q2	Q3	Q4
% on track with DEI Action Plan	100	100	78	77	90

In Year Objectives	Actions / Taken	Risks and Mitigations
People & Processes	(DEI Policy): 1. Continued consultation and approval process; 2. Received Diversity Council input and endorsement on Implementation Plan; (HWO Presentation): 3. Updated PPT with the refreshed corporate template	R1) Competing priorities resulting in delays to HWO presentation updates; M1) Incorporate HWO presentation updates in 2026/27 work plan and spread work across multiple quarters
Education and Tools	(DEI Toolkit): 1. Integrated the toolkit into the DEI SharePoint page and promote it as a living resource by inviting ongoing feedback; (DEI Professional Development): 2. Promoted the annual CCDI Unconference event with the goal of having different representatives attend; attendees shared back their learnings and application to the work we do at CMH; (Organization-wide Training): 3. Collaborated with the Diversity Council and received their endorsement on a topic/focus for the next organization-wide training initiative; started developing the roll-out plan	No risks to report.
Inclusive Languages and Images	(Diversity Calendar): 1. Executed planned events and activities for Black History Month; 2. Initiated planning for Asian Heritage Month; (Photo Repository): 3. Officially launched 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): 4. Established a standard cadence and process for developing and publishing Quarterly CEO Communications.	R1) Delay in launch of Inclusive Communication Guide, pending consultations with all key collaborators (i.e., PFAC, Director's Council, and Senior Leadership); M1) Complete consultationand launc h Q1 FY 26/27
Creating Safe Spaces	(Diversity Council Meeting, January): 1. Solicited 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. Finalized Terms of Reference; launched SharePoint landing page; formed Asian ERG and Indigenous ERG; and continued promoting EREGs across the organization	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): Jennifer Woo, Joy Braga (temporary)

In Year Measures of Success

	Target	Q1	Q2	Q3	Q4
% on track with DEI Action Plan	100	100	88	81	90

In Year Objectives	Actions / Taken	Risks and Mitigations
Build and enhance capacity and education	(Indigenous Calendar): 1. Formed Indigenous ERG in preparation for National Indigenous History Month; (Indigenous L&L Series): 2. Hosted Third Session on the Colonization of Indigenous Food and Nutrition; (Staff Training): 3. Determined standard cadence and process for San'yas registration; 4. Outlined strategy for promoting the WW Indigenous Older Adults Training; (Smudging Ceremony Series): 5. Aligned next smudging ceremony education event with launch of revised Smudging Policy and outcome of Crow Shield Lodge Service Agreement exploration; (Orientation Enhancement): 6. Updated PPT with the refreshed corporate template	R1) WRHN Counterpart position vacancy, unable to resume regional T&R meetings and collaborate on regional projects (impacting indigenous Calendar, HWO Presentation); M1) Collaborate with WRHN and GGH to adjust imelines for regional projects accordingly; R2) Expanded scope of environmental scan, impacting CMHNet Indigenous landing page and external CMH website; M2) Align updates with Indigenous Patient/Family resources project and continue to collaborate with SOAHAC Indigenous Patient Navigator
Build and Sustain Productive Relationships	(IAC): 1. Attended regular meetings and host an retreat to support relationship, IAC member understanding of hospital processes/procedures, strategic planning, and focused discussions (Indigenous Calendar of Events and Smudging 101 Guides): 2. Crow Shield Lodge: Explored a Service Agreement for education and consultation	R1) WRHN Counterpart position vacancy, unable to resume regional T&R meetings and collaborate on regional projects (impacting indigenous Calendar, HWO Presentation); M1) Collaborate with WRHN and GGH to adjust imelines for regional projects accordingly

Truth and ReconciliAction Plan-Cont. (Board)

Executive Sponsor(s): Patrick Gaskin

Physician Liaison(s): TBD

Director Lead(s): Diana Crawford

Project Manager(s): Jennifer Woo, Joy Braga (temporary)

In Year Objectives	Actions / Taken	Risks and Mitigations
Equitable Access to Culturally Safe Care	(Indigenous Art): 1. Edited videos for the Four Directions murals and Eagle Feather art (video series); (Indigenous Clinical Recommendations Project): 2. Continued implementation	R1) Delays with Wing B art installation and video development as aritsts continue finalizing the design; M1) Work with artists to establish an updated project timeline; R2) CMH Master Plan development leading to delay of Staff and Indigenous Community Garden; M2) Pending finalization of CMH Master Plan; R3) WRHN Counterpart position vacancy, impact to Smuding Policy; M3) Leverage Crow Shield Lodge Service Agreement for consultation and develop a smudging micro-education huddle series to increase staff awareness; R4) Indigenous Women's Health session postponed; M4) Present and share Indigenous Clinical Recommendations Project update at upcoming session; R5) Expanded scope of environmental scan, impacting CMHNet Indigenous landing page and external CMH website; M5) Align updates with Indigenous Patient/Family resources project and continue to collaborate with SOAHAC Indigenous Patient Navigator
Measure, Monitor and Evaluate	(Service Accountability Agreements, SAA): 1. Evaluated status of 2025-26 obligations	No risks to report.

Agenda Item 1.5.8.1

BRIEFING NOTE

Date: May 25, 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: Quality Monitoring Scorecard

Alignment with 2025/26 CMH Priorities:

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

Executive Summary
The CMH Quality Monitoring Scorecard (Appendix A) provides an overview of our performance across key quality metrics. Overall, 10 indicators (33%) are meeting target, 9 indicators (30%) are at “yellow”, and 11 indicators (37%) are exceeding target thresholds (based on the most recent three reporting periods). Current underperforming indicators are primarily associated with organizational patient flow and workforce availability/capacity pressures (sick time and overtime).

Despite these challenges, several indicators remain on target or near target, and our sustained focus on organizational flow aligns with our 2026/27 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 remains a focal point within our Integrated Risk Management (IRM) strategy and our Quality Improvement Plan (QIP). These priorities are discussed routinely through weekly Senior Executive meetings and leadership huddles, and monthly at Director’s Council.

The following quality indicators are currently at a “Red” Status:

1. Conservable Bed Days Rate: Measures the proportion of conservable patient days compared to total acute patient days (lower is better, indicating length of stay closer to CIHI benchmark). Target: 30.0%. YE (March 2026): 46.55%, with slight improvement in March 2026 at 38.8%

2. Overtime Hours: Tracks average overtime hours used per pay period. Target: 1,723.06 hours or less. YTD (March 2026): 4,286.06 hours. This continues to reflect sustained capacity pressure across several cost centres, including impacts associated with the opening and sustained use of the C3 Overflow Unit, as well as shower remediations in B Tower.

3. Sick Hours: Sick Hours (average per pay period): Tracks total sick hours per pay period. Target: 2,359.11 hours or less. YE AVG (March 2026): 3,768.3 hours, remaining above target.

4. ALC Throughput: Measures the ratio of ALC discharges to newly added/redesignated ALC cases (a throughput closer to 1.0 indicates more efficient ALC flow). Target: 1.0. YTD (March 2026): 0.80.

5. Ambulance Offload Time: Measures total time from ambulance arrival at hospital to transfer of care. Target: 30 minutes or less. YTD (March 2026): 39.0 minutes.

6. Daily admitted patients in ED waiting for bed: Measures the number of patients in the emergency department waiting for an inpatient bed at 8 a.m. (waiting at least 2 hours since disposition). Target: 10.0 (average) or less. YTD (March 2026): 12.92.

7. ED Length of Stay for Admitted Patients (90% spent less, in hours): Measures time from triage to inpatient bed arrival. Target: 33.0 hours. YTD (March 2026): 54.40 hours.

8. ED Wait Time for Inpatient Bed (90% spent less, in hours): Measures time from admission decision to bed arrival. Target: 25.0 hours. YTD (March 2026): 45.80 hours.

9. ED Length of Stay for Non-Admitted Complex (CTAS 1-3) Patients (90% spent less, in hours): Measures time from triage to departure for complex non-admitted ED patients. Target: 8.0 hours. YTD (March 2026): 10.00 hours.

10. ED Wait Time for Provider Initial Assessment (PIA) (90% spent less, in hours): Measures time from triage to physician/nurse practitioner initial assessment. Target: 4.0 hours. YTD (March 2026): 7.40 hours overall and 6.40 hours for CTAS 1 and 2 patients.

Consultation

Senior leadership committees, including Director's Council, Operations Committee, and the Clinical Operational Excellence Committee, continue to review these indicators and support action planning to address sustained performance gaps.

Next Steps

- The Quality Monitoring Scorecard will continue to be reviewed monthly.

- Red status indicators will be discussed at Director's Council, the Weekly Operations Huddle, and Senior Leadership Committee meetings.
- Action plans for flow-related indicators will continue to be advanced through our 2026/27 Strategic Priorities and department-specific goals.

Quality Monitoring Scorecard

Agenda Item 1.5.8.1

Status (Last 3 Periods)

Status	Symbol	Count	Percent
Meeting Target	●	10	33%
Within 10% of Target	▲	9	30%
Exceeding Target	◆	11	37%

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Quality Dimension	Indicator	Unit of Measure	Target	YTD	Status (Last 3 periods)	Period
Efficient	Conservable Days Rate	%	30.00	46.55	◆	Mar-26
	Overtime Hours - Average per pay period	hours	1,723.06	4,286.04	◆	Mar-26
	Sick Hours - Average per pay period	hours	2,359.11	3,768.34	◆	Mar-26
Integrated & Equitable	ALC Throughput	Ratio	1.00	0.80	◆	Mar-26
	Percent ALC Days (closed cases)	%	20.00	17.28	▲	Mar-26
	Repeat emergency department visits for Mental Health Care	Patients	11.00	10.50	▲	Mar-26
Patient & People Focused	Organization Wide Vacancy Rate	%	12.00	5.44	●	Mar-26
Safe, Effective & Accessible	30 Day CHF Readmission Rate	%	14.00	19.93	▲	Feb-26
	30 Day COPD Readmission Rate	%	15.50	16.21	▲	Feb-26
	30 Day In-Hospital Mortality Following Major Surgery	%	1.90	0.10	▲	Feb-26
	30 Day Overall Readmission Rate	%	8.80	6.65	●	Feb-26
	Ambulance Offload Time (90% Spent Less, in Minutes)	minutes	30.00	39.00	◆	Mar-26
	Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m.	Average	10.00	12.92	◆	Mar-26
	ED Length of Stay for Admitted Patients (90% Spent Less, in Hours)	hours	33.00	54.40	◆	Mar-26
	ED Length of Stay for Non-Admitted Complex Patients (90% Spent Less, in Hours)	hours	8.00	10.00	◆	Mar-26
	ED Wait Time for Inpatient Bed (90% Spent Less, in Hours)	hours	25.00	45.80	◆	Mar-26
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours)	hours	4.00	7.40	◆	Mar-26
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours) CTAS 1,2	hours	4.00	6.40	◆	Mar-26
	Hip Fracture Surgery Within 48 Hours	%	83.10	92.11	●	Feb-26
	Hospital Standardized Mortality Ratio (HSMR)	Ratio	100.00	86.25	▲	Feb-26
	In-Hospital Sepsis	per 1000 D/C	3.20	2.80	●	Feb-26
	Long Waiters Waiting For All Surgical Procedures	%	20.00	7.36	●	Mar-26
	Low-Risk Caesarean Sections	%	17.30	17.73	▲	Mar-26
	Medication Reconciliation at Admit	%	95.00	93.00	▲	Mar-26
	Medication Reconciliation at Discharge	%	95.00	94.00	▲	Mar-26
	Obstetric Trauma (With Instrument)	%	14.40	3.66	●	Feb-26
	Patient Safety Event - Falls with Harm	per 1000 PD	0.00	0.03	●	Mar-26
	Patient Safety Event - Medication Events with Harm	per 1000 PD	0.00	0.03	●	Mar-26
	Revenue - Achieve budgeted PCOP growth (IRM)	$	8,955,635.04	15,057,391.01	●	Mar-26
	Revenue - Achieve Quality Based Procedure Funding (IRM)	$	26,834,175.96	32,815,919.86	●	Mar-26

Conservable Bed Days

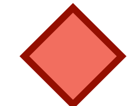
Conservable Beds Dashboard

Description

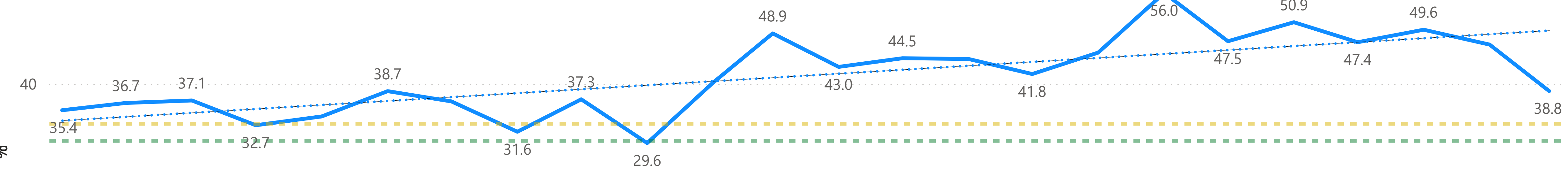
The total patient days over the benchmark LOS (conservable days) as a percentage of the total acute patient days for patients discharged from MEDA/MEDB. The benchmark LOS is determined by case mix group, age, and resource intensity level of a discharge.

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
30.0	36.8	46.55	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	35.4	36.7	37.1	32.7	34.3	38.7	36.9	31.6	37.3	29.6	40.3	48.9
2025/2026	43.0	44.5	44.4	41.8	45.5	56.0	47.5	50.9	47.4	49.6	46.9	38.8

Overtime, Average per pay period

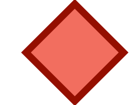
OT, Sick, Staffing Dashboard

Description

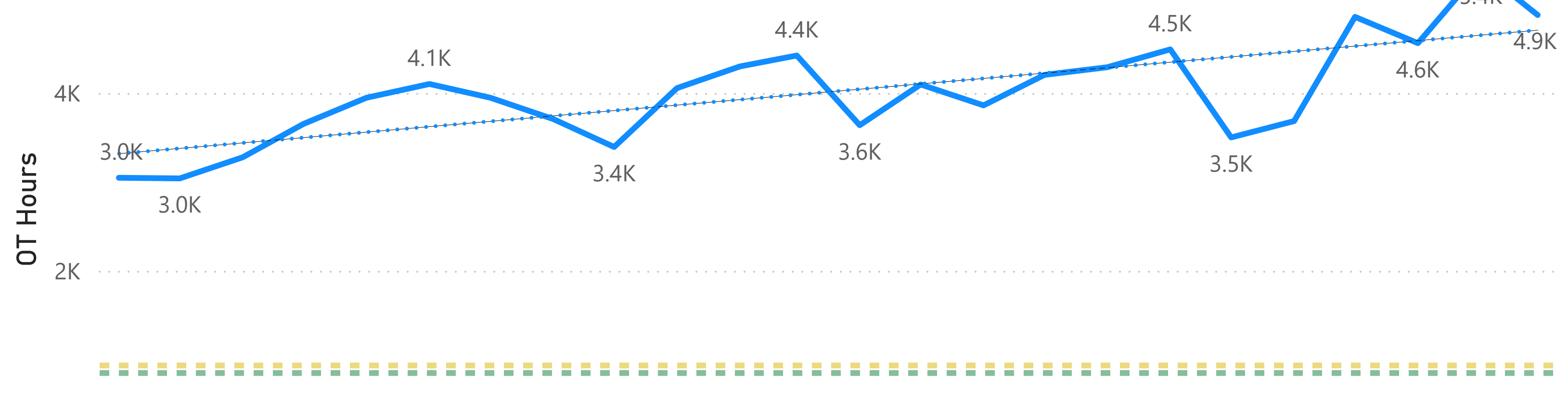
The total sum of overtime hours per pay period ending in a month, divided by the number of pay periods in a month

Data Source

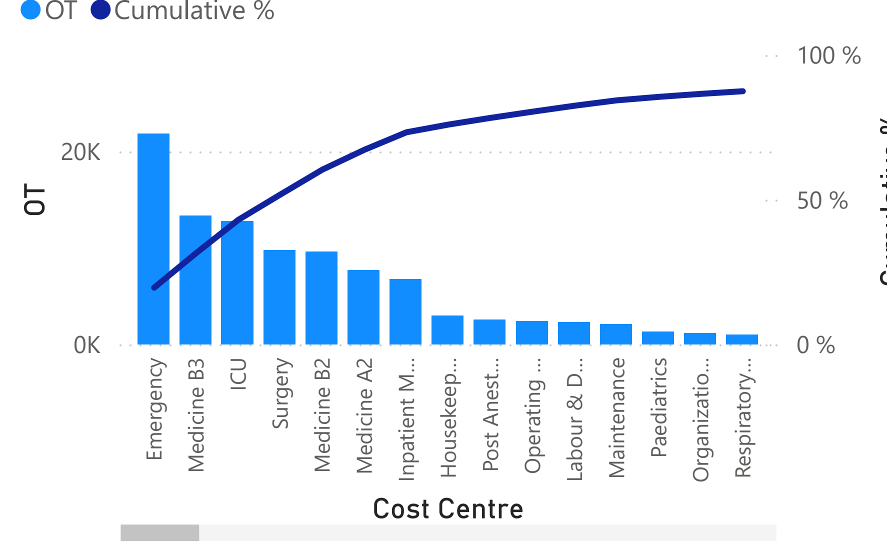
Meditech Payroll

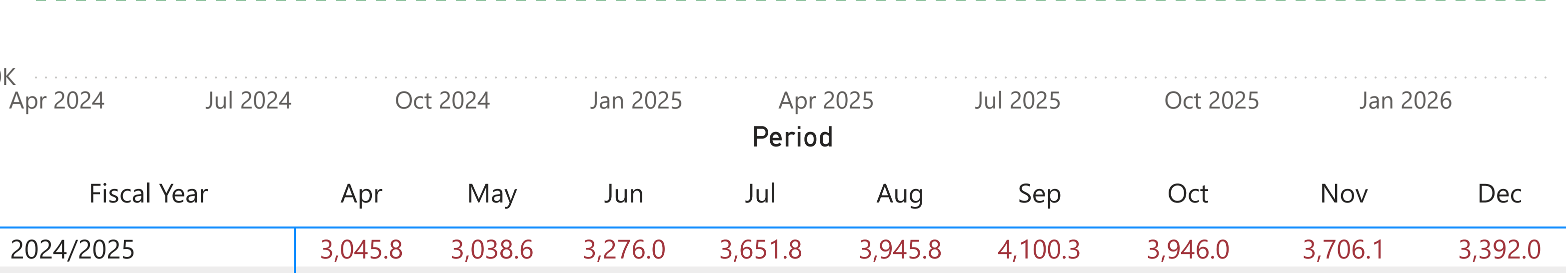
Target	Previous YE	YTD	Status (Last 3 periods)
1,723.1	3,790.3	4,286.0	

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	3,651.8	3,945.8	4,100.3	3,946.0	3,706.1	3,392.0	4,054.4	4,298.1	4,420.5
2025/2026	3,637.0	4,094.9	3,859.9	4,202.9	4,289.1	4,489.6	3,499.4	3,683.4	4,855.2	4,559.6	5,385.6	4,875.9

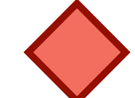
Sick Time, Average per pay period

Description

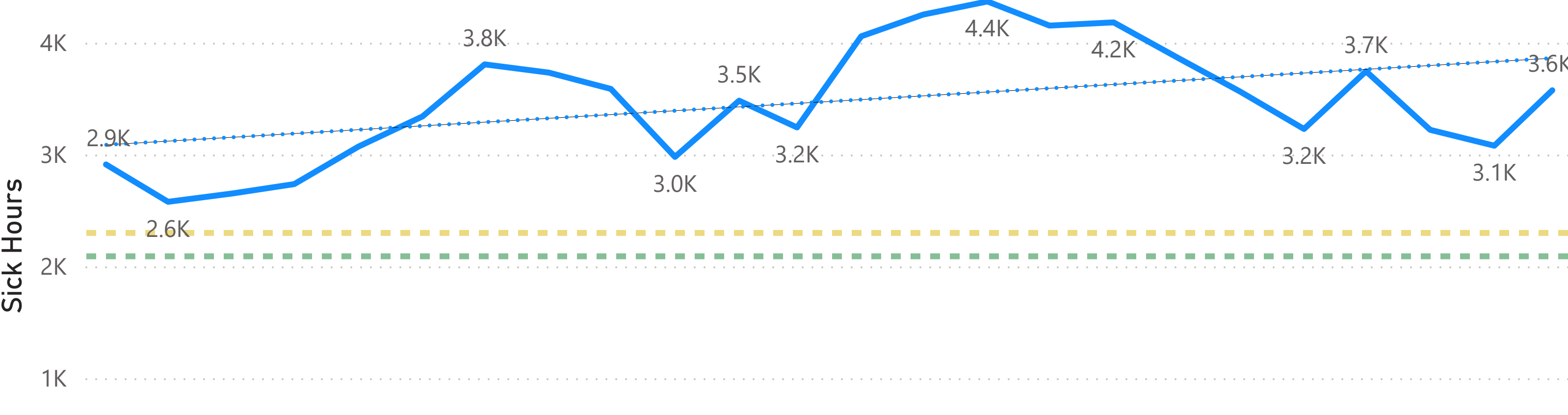
The total sum of sick hours per pay period ending in a month, divided by the number of pay periods in a month

Data Source

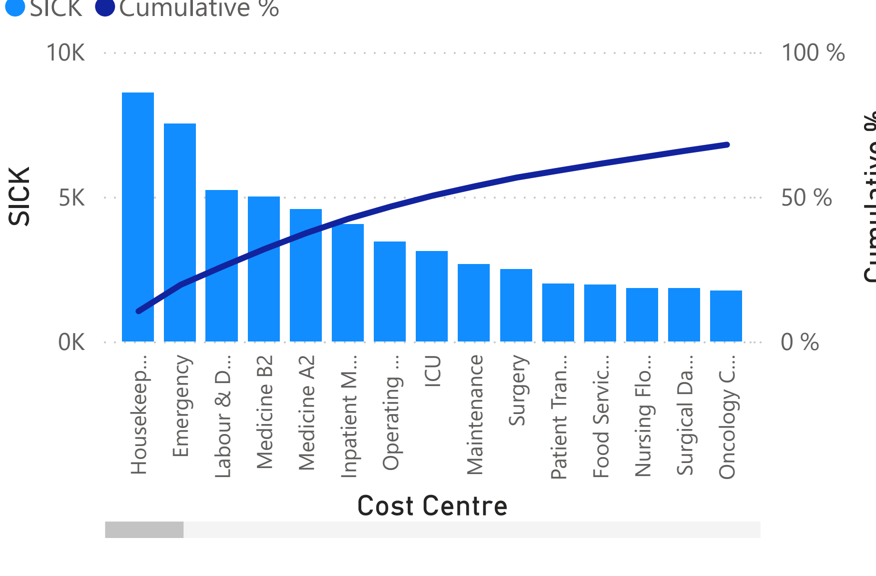
Meditech Payroll

Target	Previous YE	YTD	Status (Last 3 periods)
2,359.1	3,174.7	3,768.3	

Average Sick Hours per pay period, Trend



Total Sick Hours, by Cost Centre



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	2,911.2	2,577.4	2,651.6	2,735.5	3,070.8	3,340.9	3,806.1	3,732.4	3,586.7	2,978.7	3,481.6	3,242.2
2025/2026	4,057.1	4,251.5	4,368.5	4,152.8	4,181.5	3,865.0	3,564.2	3,228.3	3,744.5	3,220.6	3,078.9	3,574.6

Alternate Level of Care

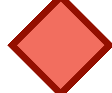
ALC Throughput

Description

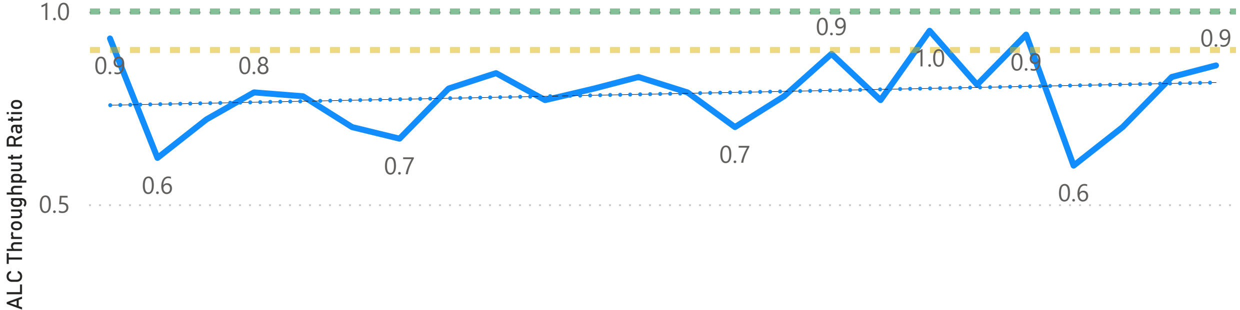
ALC Throughput is the ratio of the number of discharged ALC cases to the number of newly added and redesignated ALC cases

Data Source

WTIS

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

ALC Throughput Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	0.9	0.6	0.7	0.8	0.8	0.7	0.7	0.8	0.8	0.8	0.8	0.8
2025/2026	0.8	0.7	0.8	0.9	0.8	1.0	0.8	0.9	0.6	0.7	0.8	0.9

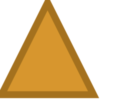
ALC Rate

Description

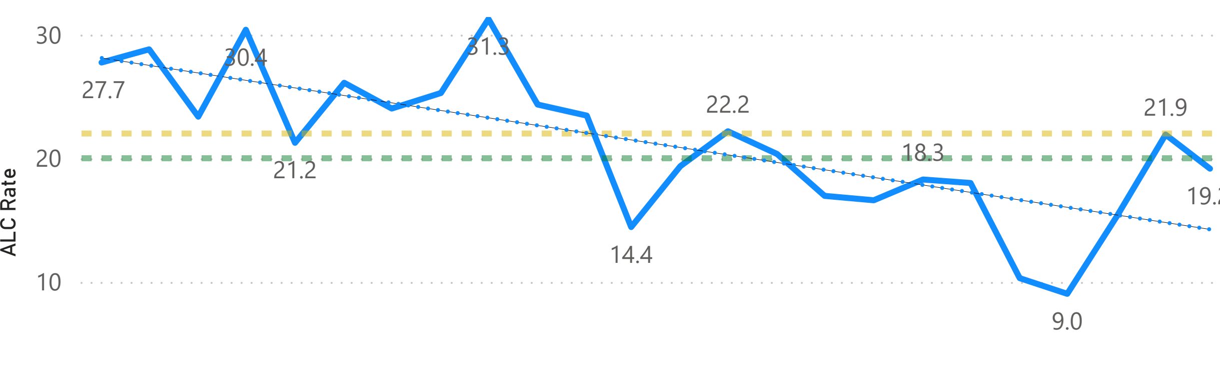
The proportion of total days that a patient was assigned to the alternate level of care (ALC) service. ALC patients are those who no longer need acute care services but continue to occupy an acute care bed or use acute care services.

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
20.0	25.0	17.28	

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	19.4	22.2	20.3	17.0	16.6	18.3	18.0	10.3	9.0	15.3	21.9	19.2

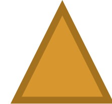
Repeat ED Visits for Mental Health Care

Description

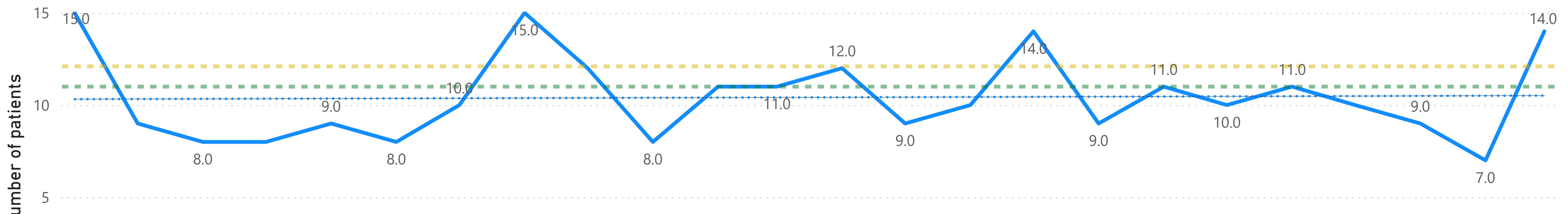
Number of patients who have four or more repeat unscheduled visits to the emergency department in the last 12 months for mental health or substance abuse condition

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
11.0	10.3	10.5	

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	9.0	7.0	14.0

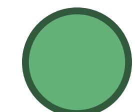
Organizational Vacancy Rate

Description

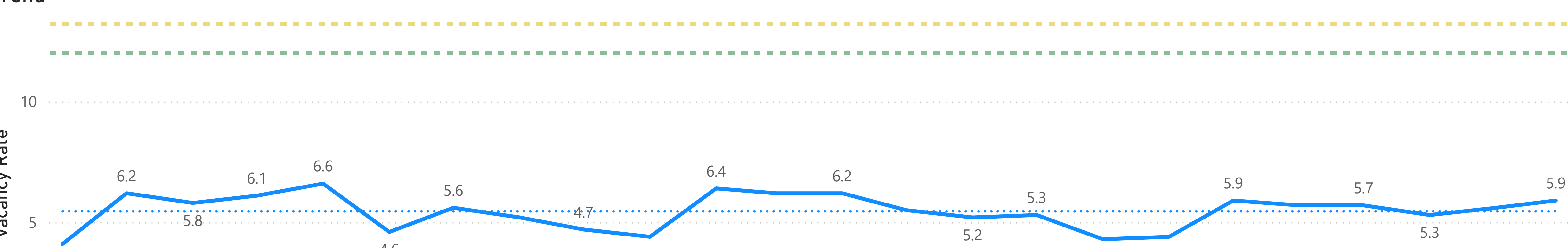
This indicator measures the organization wide vacancy rate for permanent full time and part time staff

Data Source

ICIMs Vacancy Report and Meditech Payroll

Target	Previous YE	YTD	Status (Last 3 periods)
12.0	5.5	5.44	

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	5.6	5.9

Readmissions within 30 Days:

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

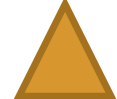
CHF Readmissions

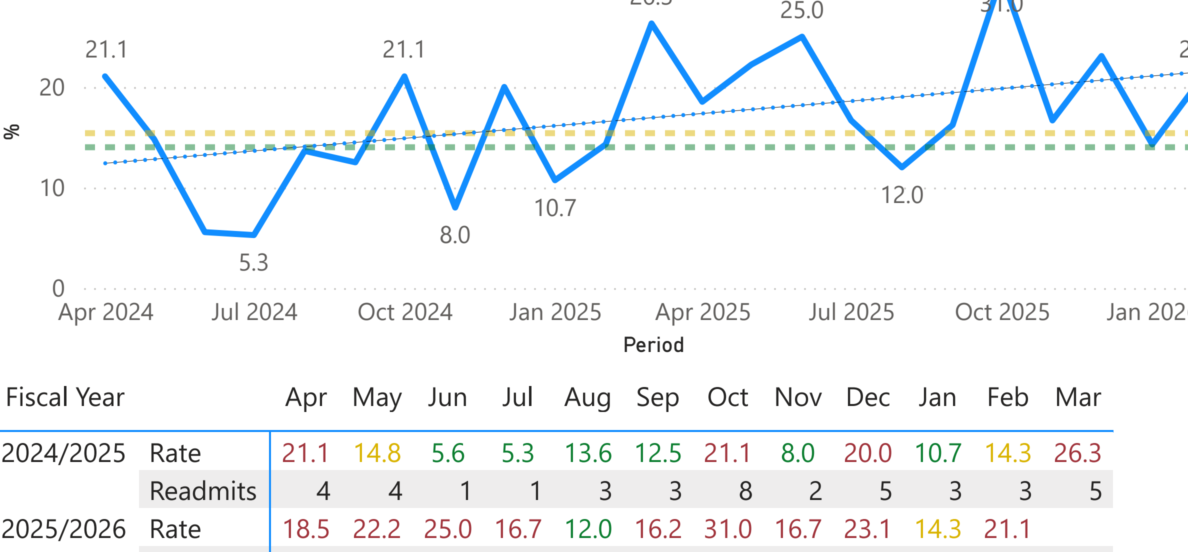
Description

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

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
14.0	14.7	19.93	



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	18.5	22.2	25.0	16.7	12.0	16.2	31.0	16.7	23.1	14.3	21.1	
	Readmits	5	6	9	4	3	6	9	3	6	4	4	5

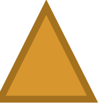
COPD Readmissions

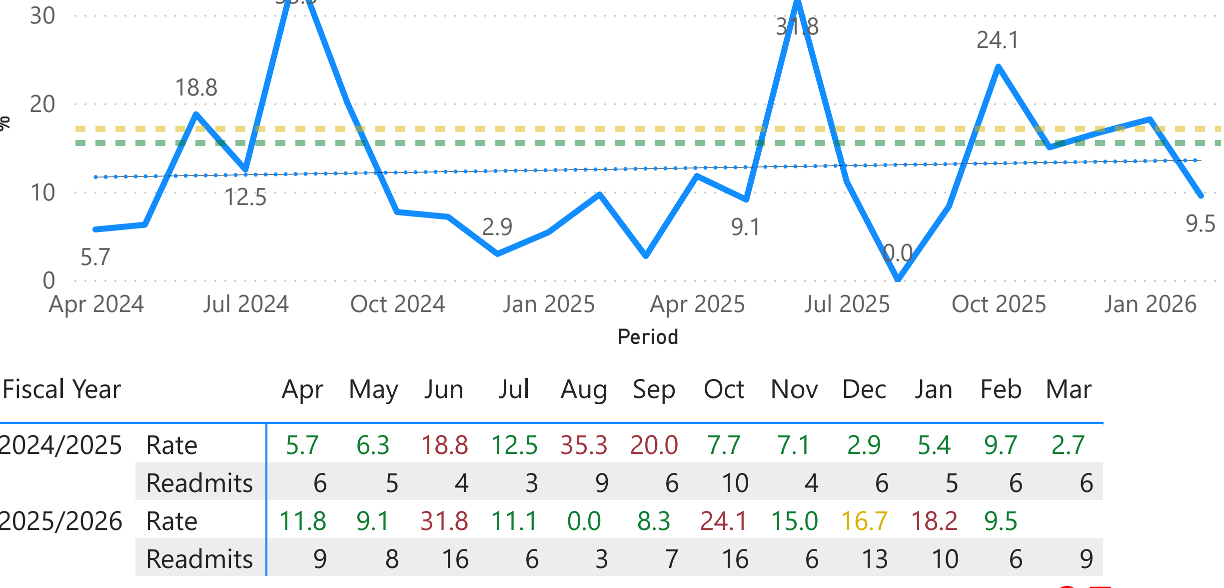
Description

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

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
15.5	9.1	16.21	



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	24.1	15.0	16.7	18.2	9.5	
	Readmits	9	8	16	6	3	7	16	6	13	10	6	9

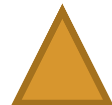
30 Day In-Hospital Mortality Following Major Surgery Rate

Description

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

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
1.9	1.3	0.1	

Trend

%

Period

Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	1.8	0.9	0.0	0.0	0.0	1.1	3.3	0.0	3.9	1.4	1.0	0.0
2025/2026	4.4	0.0	1.4	1.8	0.0	0.0				0.0	4.0	

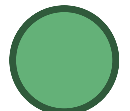
30 Day Overall Readmission Rate

Description

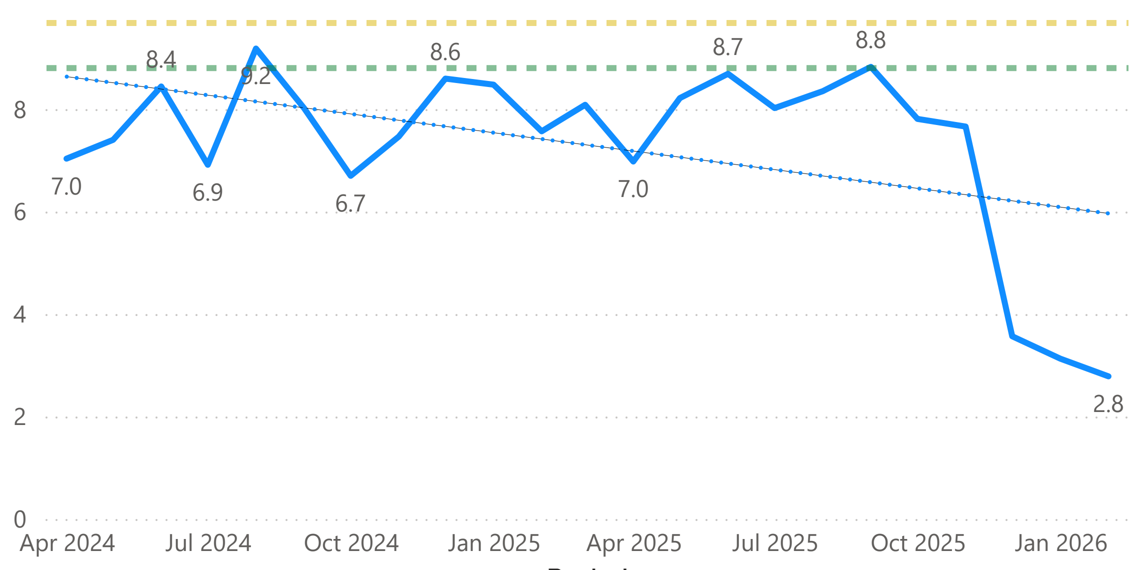
The rate of urgent readmissions within 30 days of discharge for episodes of care for the following patient groups: medical, obstetric, paediatric, and surgical. Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
8.8	7.8	6.65	

Trend

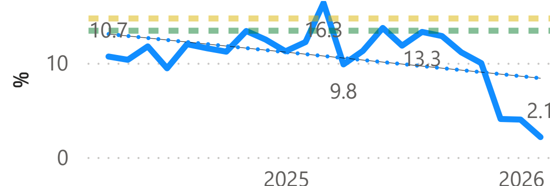


Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	7.0	7.4	8.4	6.9	9.2	8.0	6.7	7.5	8.6	8.5	7.6	8.1
2025/2026	7.0	8.2	8.7	8.0	8.3	8.8	7.8	7.7	3.6	3.1	2.8	

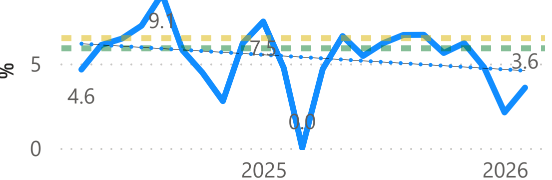
Readmissions, by Patient Group

IndicatorName	Target	YTD	Status (Last 3 periods)
30 Day Medical Readmission Rate	13.40	11.49	
30 Day Obstetric Readmission Rate	1.40	1.19	
30 Day Paediatric Readmission Rate	6.70	6.04	
30 Day Surgical Readmission Rate	5.90	5.91	

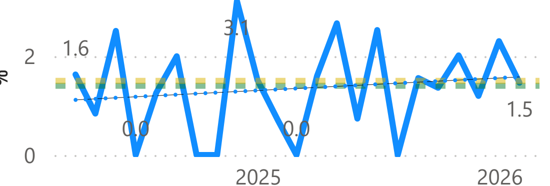
Medical Readmissions Trend



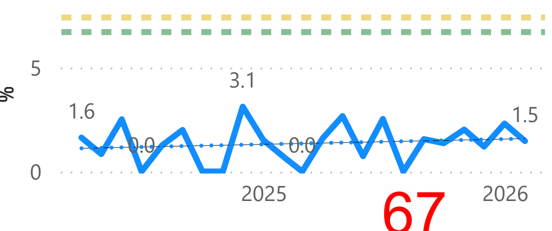
Surgical Readmissions Trend



Obstetric Readmissions Trend



Paediatric Readmissions Trend



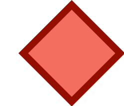
Ambulance Offload Time, minutes, 90th percentile

Description

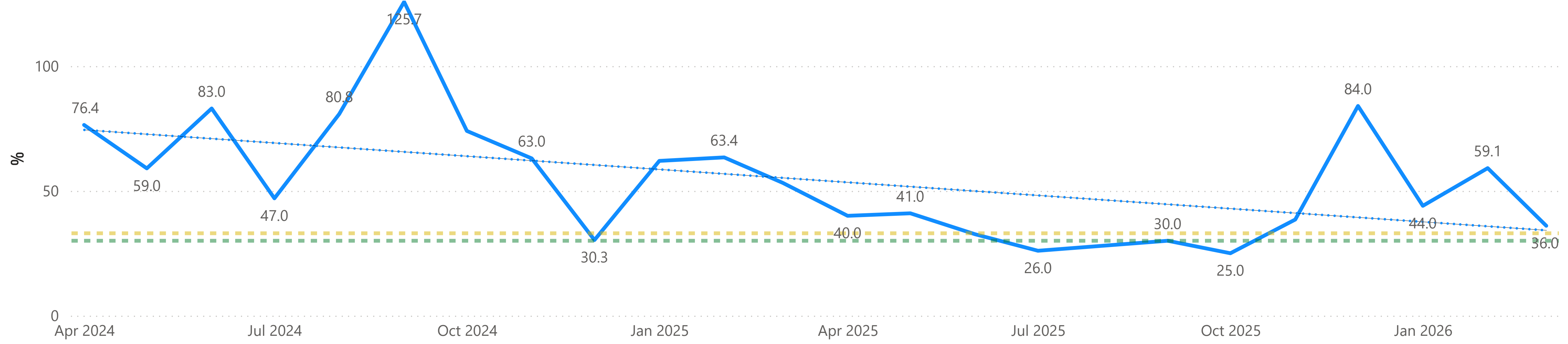
The total time, in minutes, in which 9 out of 10 patients who arrived via ambulance waited for transfer of care process to be completed, calculated as the total time elapsed from ambulance arrival to completion of transfer of care process.

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
30.0	67.0	39.0	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	76.4	59.0	83.0	47.0	80.8	125.7	74.0	63.0	30.3	62.0	63.4	53.2
2025/2026	40.0	41.0	32.6	26.0	28.0	30.0	25.0	38.5	84.0	44.0	59.1	36.0

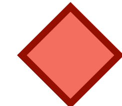
AVG Patients in ED at 8AM waiting for IP bed

Description

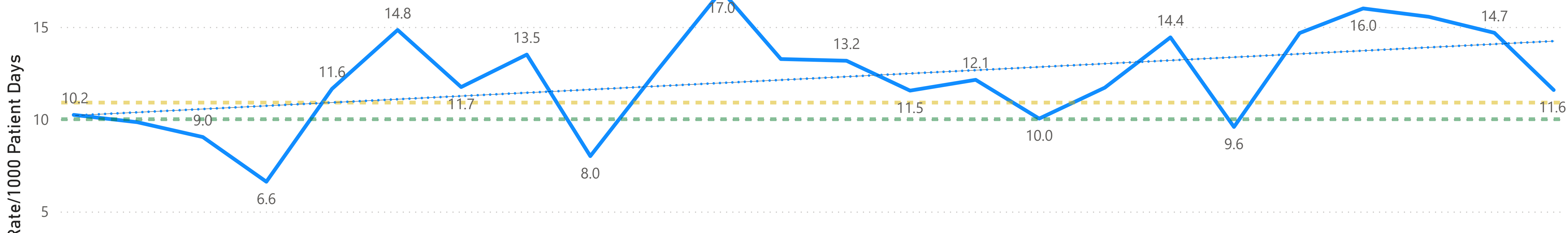
The number of patients in the emergency department waiting for an inpatient bed at 8 a.m. who have been waiting at least 2 hours since disposition. Average number of patients per day

Data Source

NACRS

Target	Previous YE	YTD	Status (Last 3 periods)
10.0	11.5	12.92	

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	15.5	14.7	11.6

ED LOS for Admitted Patients, hours, 90th percentile

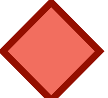
Total ED LOS for Admitted Patients

Description

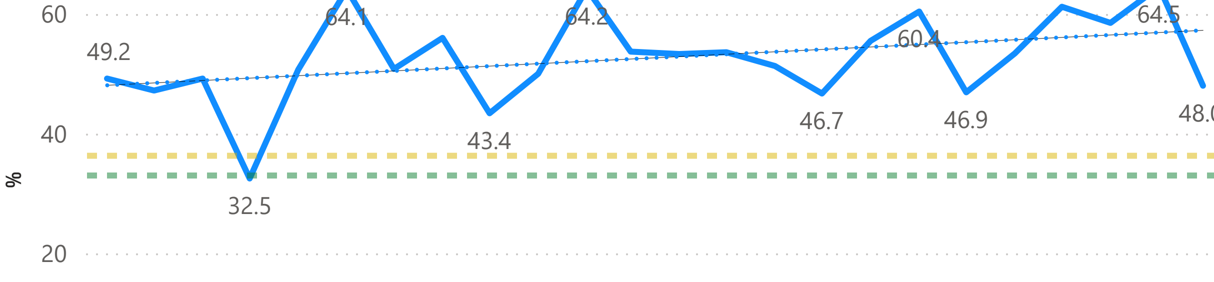
The total time, in hours, that 9 out of 10 admitted patients spent in the emergency department (ED), calculated as the total time elapsed from triage to when the patient left the ED

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
33.0	52.0	54.4	

ED LOS for Admitted Patients, Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	49.2	47.2	49.2	32.5	50.7	64.1	50.8	56.0	43.4	50.0	64.2	53.7
2025/2026	53.3	53.6	51.3	46.7	55.5	60.4	46.9	53.4	61.2	58.5	64.5	48.0

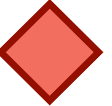
Time to Inpatient Bed

Description

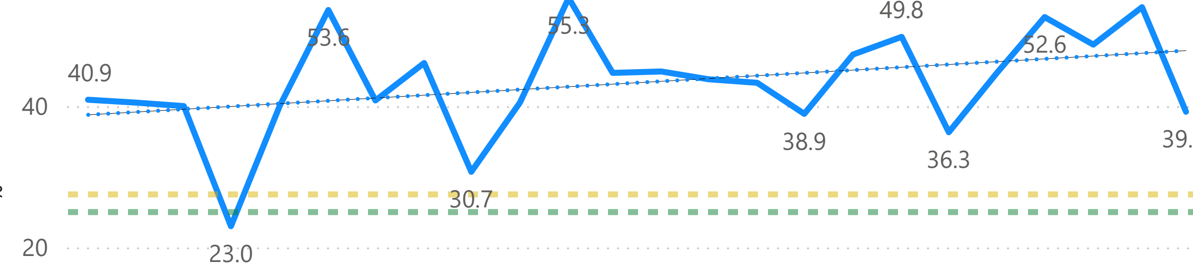
The total time, in hours, that 9 out of 10 admitted patients spent waiting in the emergency department (ED) for a bed, calculated as the total time elapsed from disposition decision to when the patient left the ED

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
25.0	42.8	45.8	

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	48.7	54.0	39.2

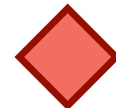
ED LOS for Non-Admitted, Complex Patients, hours, 90th percentile

Description

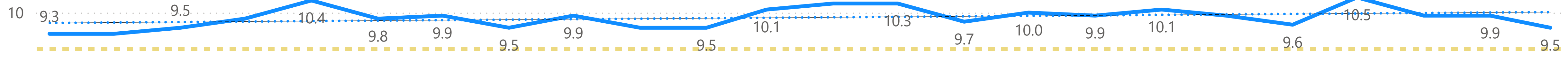
The total time, in hours, that 9 out of 10 high-urgency patients (CTAS 1-3) who were not admitted spent in the emergency department (ED), calculated as the total time elapsed from triage to when the patient left the ED

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
8.0	9.7	10.0	

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	9.9	9.9	9.5

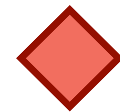
Provider Initial Assessment Time, hours, 90th percentile

Description

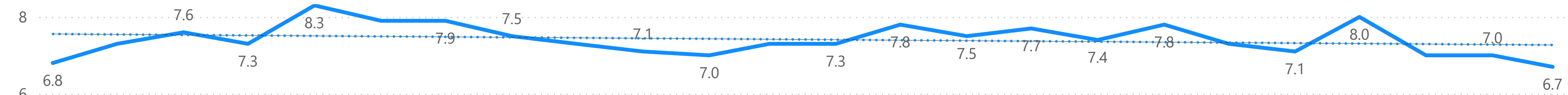
The total time, in hours, that 9 out of 10 patients spent waiting for their first assessment by a doctor or nurse practitioner in the emergency department (ED), calculated as the total time elapsed from triage to time of initial assessment

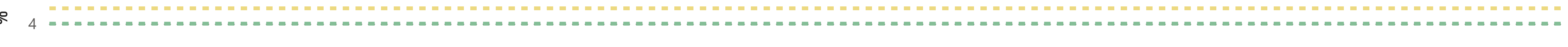
Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
4.0	7.5	7.4	

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	7.0	7.0	6.7

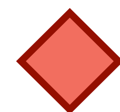
Urgent Provider Initial Assessment Time, hours, 90th percentile

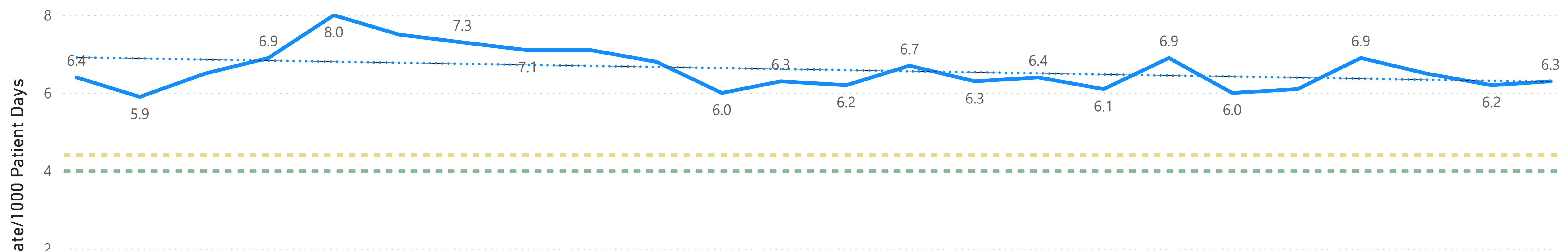
Description

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

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
4.0	6.9	6.4	



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	6.5	6.2	6.3

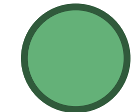
Hip Fracture Surgery within 48 Hours, %

Description

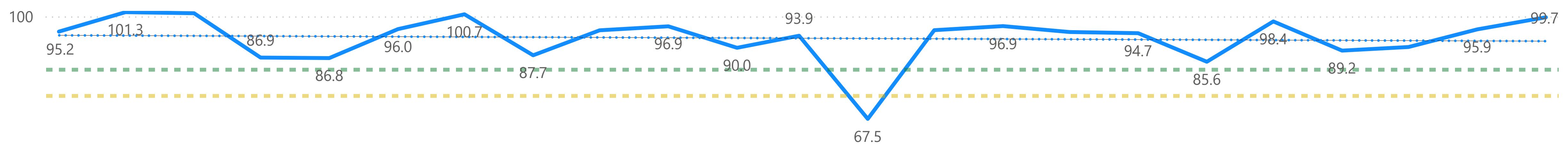
Risk-adjusted proportion of hip fractures that were surgically treated within 48 hours of initial admission (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
83.1	94.2	92.1	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	95.2	101.3	101.0	86.9	86.8	96.0	100.7	87.7	95.6	96.9	90.0	93.9
2025/2026	67.5	95.6	96.9	95.1	94.7	85.6	98.4	89.2	90.3	95.9	99.7	

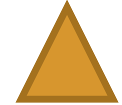
Hospital Standardized Mortality Ratio (HSMR)

Description

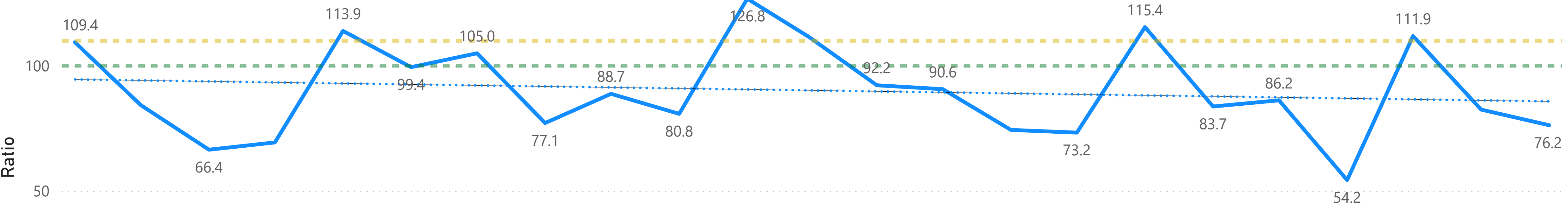
The ratio of the actual number of in-hospital deaths to the expected number of in-hospital deaths, for conditions accounting for about 80% of inpatient mortality

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
100.0	94.6	86.25	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	109.4	84.2	66.4	69.3	113.9	99.4	105.0	77.1	88.7	80.8	126.8	111.5
2025/2026	92.2	90.6	74.3	73.2	115.4	83.7	86.2	54.2	111.9	82.4	76.2	

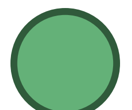
In-Hospital Sepsis

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	2.8	

Trend

Rate/1000 Discharges by Period: Apr 2024 2.5, 4.1, 2.4, Jul 2024 2.3, 0.0, 5.9, Oct 2024 0.0, 4.4, 8.3, Jan 2025 0.0, 2.1, 2.2, Apr 2025 4.6, 2.3, 2.2, Jul 2025 6.4, 0.0, 4.6, Oct 2025 7.3, 2.0, 0.0, Jan 2026 2.1, 0.0

Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	2.5	4.1	2.4	2.3	0.0	5.9	0.0	4.4	8.3	0.0	2.1	2.2
2025/2026	4.6	2.3	2.2	6.4	0.0	4.6	7.3	2.0	0.0	2.1	0.0	

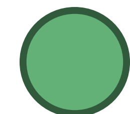
Long Waiters Waiting for Surgical Procedures

Description

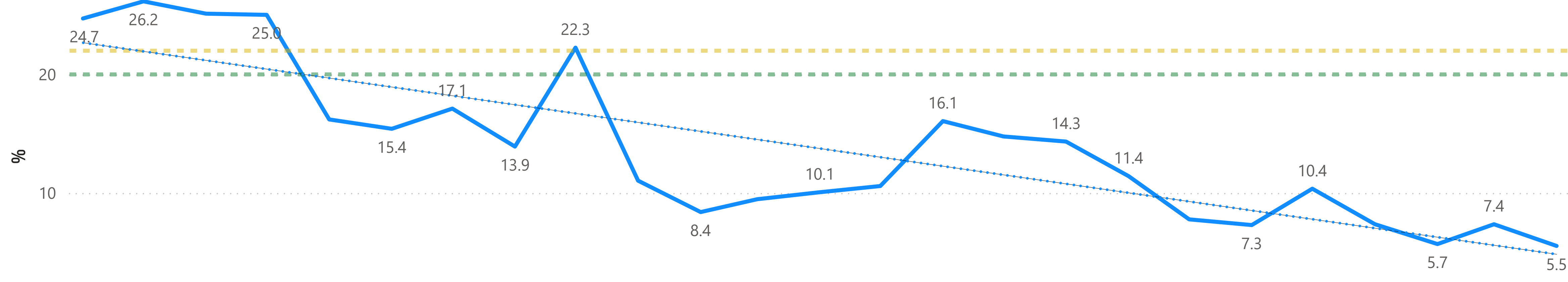
This indicator measures the percentage of patients waiting for a surgical procedure whose wait has exceeded the associated Priority Level Access Target (excludes DART days)

Data Source

WTIS

Target	Previous YE	YTD	Status (Last 3 periods)
20.0	9.5	7.36	

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	5.7	7.4
2026/2027	5.5											

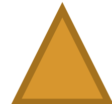
Low-Risk Caesarean Section Rate

Description

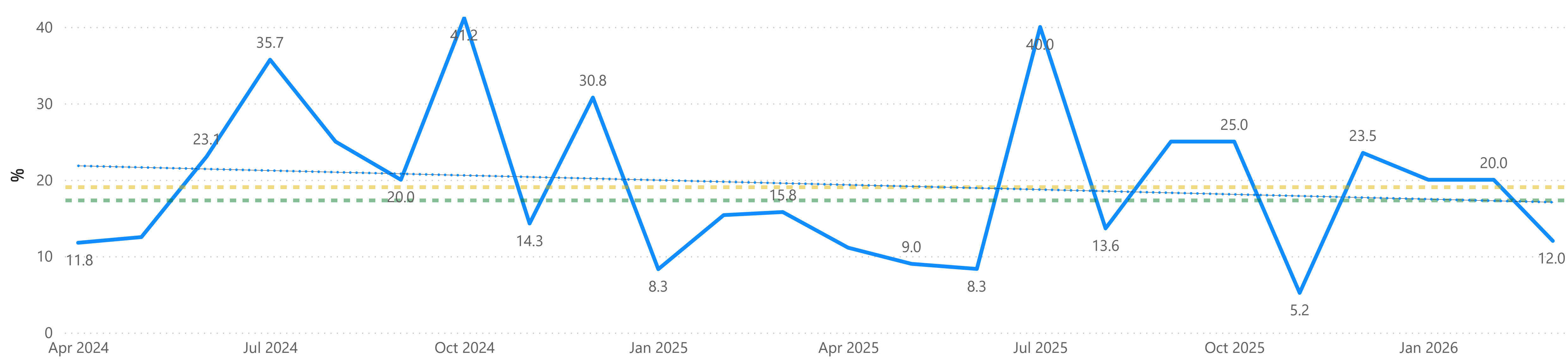
This indicator measures the rate of deliveries via Caesarean section among singleton term cephalic pregnancies for low-risk nulliparous women in spontaneous labour

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
17.3	21.1	17.73	

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	23.5	20.0	20.0	12.0

Medication Reconciliation

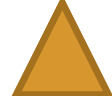
Admission

Description

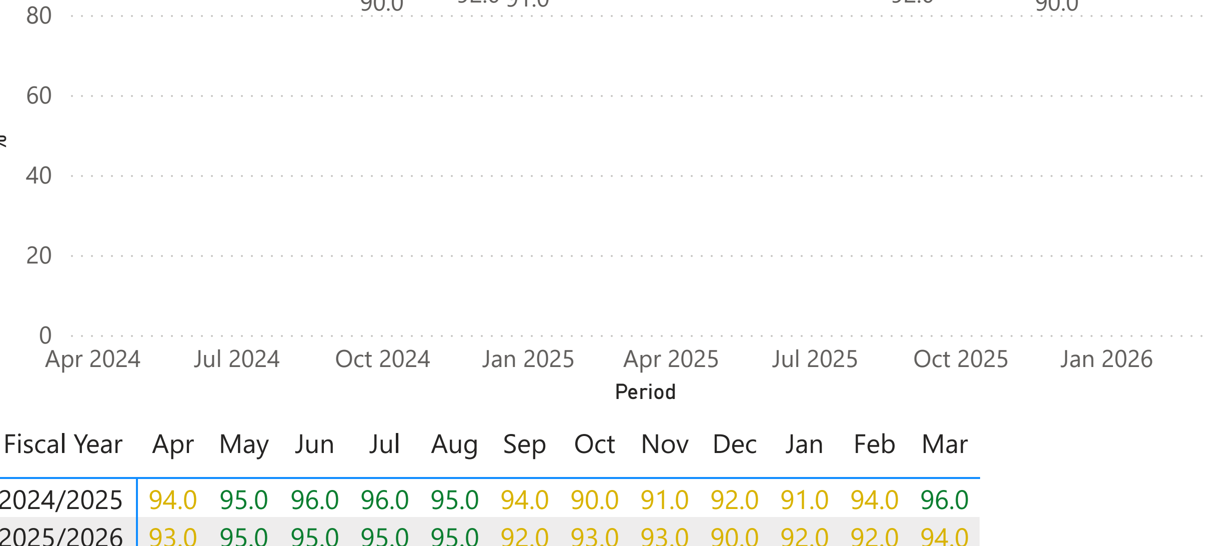
The total number of patients who were discharged who had a Best Possible Medication History (BPMH) completed divided by the total number of patients who were discharged home

Data Source

Meditech Pharmacy Patient Profile

Target	Previous YE	YTD	Status (Last 3 periods)
95	94	93	

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	92.0	94.0

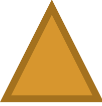
Discharge

Description

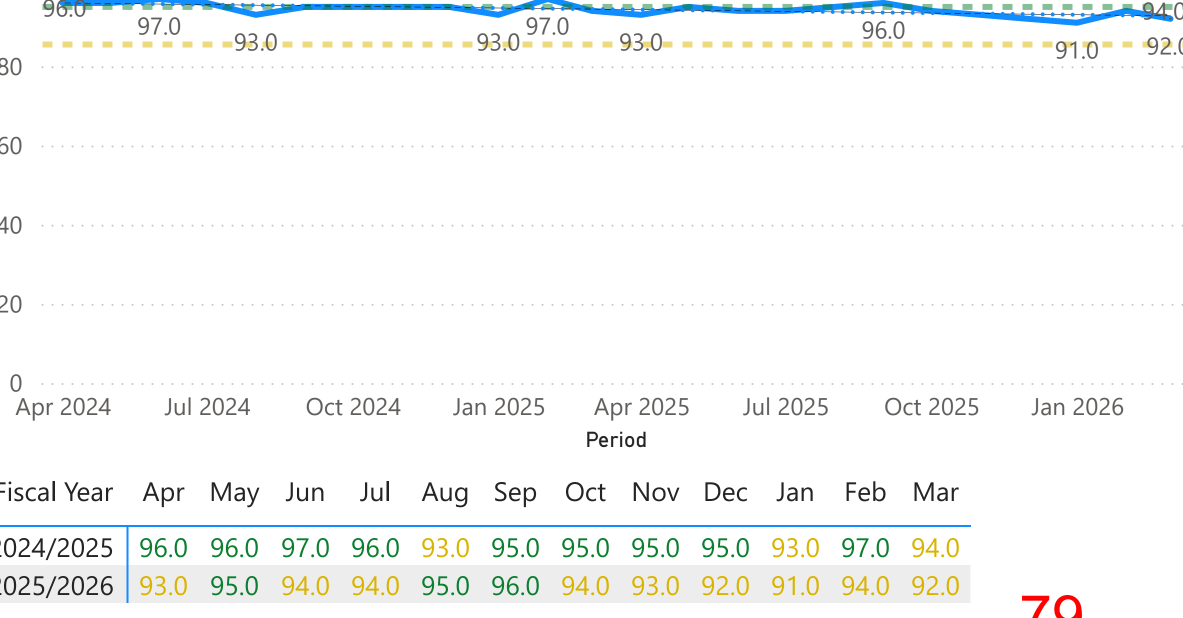
The percentage of Yes responses to the question "Was the CMH community pharmacy prescription completed? " for all inpatient locations participating in medication reconciliation at discharge

Data Source

Meditech

Target	Previous YE	YTD	Status (Last 3 periods)
95	95	94	

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	94.0	92.0

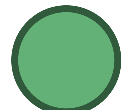
Obstetric Trauma (with Instrument)

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)

Target	Previous YE	YTD	Status (Last 3 periods)
14.4	21.2	3.66	

Trend

Month	Observed
Feb-26	3.00
Jan-26	1.00
Dec-25	0.00
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	20.9	13.5	23.2	9.2	26.3	25.8	37.8	23.1	26.4	10.2	7.8	30.2
2025/2026	23.6	9.6	0.0	42.7	18.5	0.0	18.6	21.5	0.0	0.2	14.2	

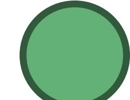
Patient Safety Event - Falls with Harm Rate

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

YTD	Previous YE	YTD	Status (Last 3 periods)
0.0	0.1	0.03	

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	0.0	0.0

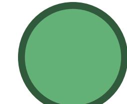
Patient Safety Event - Medication Events with Harm Rate

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

Target	Previous YE	YTD	Status (Last 3 periods)
0.0	0.0	0.03	

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

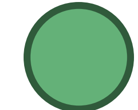
Post-Construction Operating Plan (PCOP) Revenue

Description

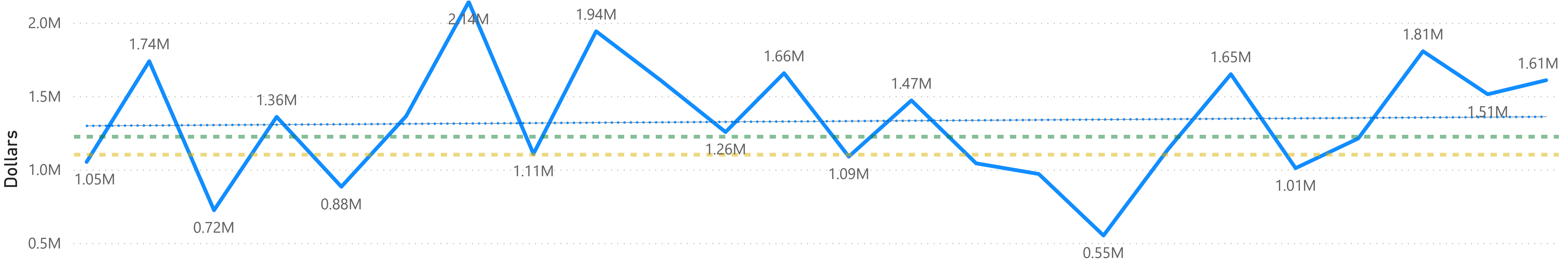
The revenue achieved through all PCOP service areas, including Acute Inpatient, ED, Day Surgery, Mental Health Day Hospital, Mental Health Inpatient, ECT, and Ambulatory Clinics (Mental Health, Paediatric, Fracture, Surgery)

Data Source

Discharge Abstract Database, National Ambulatory Care Reporting System, Meditech

Monthly Target	YTD Target	YTD	Status (Last 3 periods)
746.3K	9.0M	15.06M	

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	1,087,934	1,470,565	1,042,128	969,639	550,654	1,139,702	1,649,398	1,009,308	1,211,689	1,805,534	1,512,670	1,608,171

Quality Based Procedure (QBP) Revenue

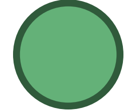
QBP Dashboard

Description

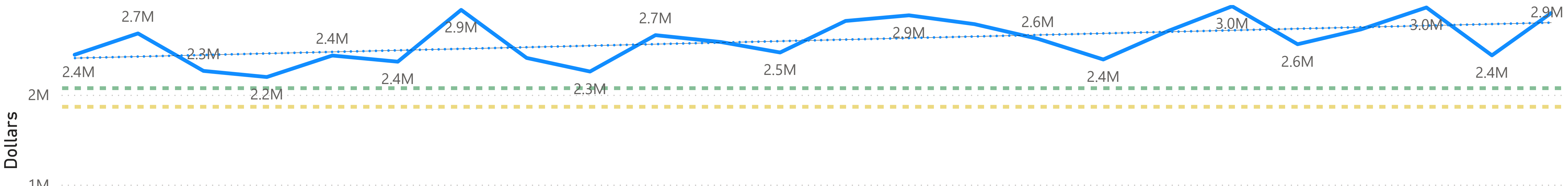
The revenue achieved through all Quality Based Procedures, including Urgent QBPs & Non-Urgent Surgical QBPs (OH), Systemic Treatment (CCO), GI Endoscopy (CCO), and Cancer Surgery (CCO).

Data Source

Discharge Abstract Database, National Ambulatory Care Reporting System

Monthly Target	YTD Target	YTD	Status (Last 3 periods)
2.2M	26.8M	32.82M	

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	2,821,779	2,884,276	2,786,256	2,623,374	2,392,726	2,713,002	2,984,799	2,562,609	2,727,721	2,971,688	2,438,749	2,908,940

**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)*

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

MEMORANDUM

TO: Board of Directors, Cambridge Memorial Hospital

DATE: May 29, 2026

REPORTING PERIOD: May 2, 2026 to May 29, 2026

FROM: Patrick Gaskin
President and CEO

RE: CEO Certificate of Compliance

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

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

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

Exceptions: NIL

Patrick Gaskin
President and CEO

Agenda Item 1.5.10

BRIEFING NOTE

Date: May 25, 2026
Issue: Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding Certificate of Compliance
Prepared for: Resources Committee
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kenneth Abogadil, Director of Diagnostic Imaging, Laboratory Medicine, Diagnostic Cardiology Services and Mental Health (interim)
Cc: Stephanie Pearsall, VP Clinical Programs, CNE
Approved by: Trevor Clark, VP Finance & Corporate Services, CFO

Attachments/Related Documents:
Certificate of Compliance – Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding

Alignment with 2025/26 CMH Priorities:

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

Executive Summary
This briefing note provides the Committee with the Certificate of Compliance for the Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding.

The certificate confirms that the 2025-26 psychiatric sessional funding has been allocated in accordance with the Ministry of Health guidelines and CMH's internal processes. It also confirms that the funding allocation has been communicated to all physicians for their awareness.

The certificate, attached to this briefing note, is presented for the Committee's information and records.

MEMORANDUM

DATE: May 20, 2026

TO: Patrick Gaskin

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

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

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

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

1. Psychiatric Sessional Funding has been allocated as per the Ministry of Health guidelines.
2. The Psychiatric Sessional Funding has been allocated as per the hospital process.
3. The sessional funding allocation for 2025-26 was shared with all physicians for information.

Exceptions: NIL

Anjali Sharma, MD
Chief of Psychiatry

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

BRIEFING NOTE

Date: **May 25, 2026**
Issue: **Broader Public Sector Accountability Act Attestation**
Prepared for: **Board of Directors**
Purpose: **☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction**
Prepared by: **Janet Short, Senior Financial Advisor**
Steve Baker, Interim Manager Purchasing & Supply
Approved by: **Trevor Clark, VP Finance & Corporate Services, CFO**

Attachments/Related Documents:

1. **Appendix C – BPSAA Attestation April 1, 2025 to March 31, 2026**
2. **Hospital Report on Consultant Use**
3. **Hospital Report on Non-Compliant Exception List > $121,200**
4. **Mohawk Medbuy – BPS 2025-26 Attestation Letter**
5. **Mohawk Medbuy – BPS Attestation Reporting April 1, 2025 to March 31, 2026**
6. **List of Approved Non-Compliant Procurement for Public Posting – 2025-26**

Alignment with 2025/26 CMH Priorities:

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

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

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Recommendation/Motion

Board
That the CMH Board of Directors approves the Broader Public Sector Accountability Act, 2010 (BPSAA) Appendix C - Attestation prepared by the President and CEO in accordance with Section 15 of the BPSAA for the period April 1, 2025 to March 31, 2026, and upon recommendation of the Resources Committee at its meeting of May 25, 2026.

Motion reference document: BPS Appendix C – Attestation, April 1, 2025 to March 31, 2026 (Attachment 1).

Resources Committee
Following review and discussion of the information provided, the Resources Committee of the Board recommends that the Board of Directors approves the Broader Public Sector Accountability Act, 2010 (BPSAA) Appendix C - Attestation prepared by the President and

CEO in accordance with Section 15 of the BPSAA for the period April 1, 2025 to March 31, 2026. **CARRIED.**

Executive Summary
Cambridge Memorial Hospital (CMH) followed the requirements of the BPSAA during the fiscal year 2025-26. All exceptions noted were within contracts provided by Mohawk Medbuy (MMC), a supply chain shared services organization. MMC had to single source/limited tender from certain vendors due to supply chain challenges. It should be noted that CMH did not spend more than $121k from many of the vendors on MMC's BPS Attestation Report but these vendors are listed for completeness purposes.

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

As part of the accountability requirements from the BPSAA, the hospital is required to submit an attestation to Ontario Health and prepare a report concerning compliance with applicable procurement over $121,200, expense directives, consultant use, and lobbyists, to ensure transparency, fairness, and value for taxpayer money. The Board is required to approve this attestation and report on an annual basis.

Analysis
All costs allocated to consultants and professional fees for the fiscal year ending March 31, 2026, were reviewed to determine if they complied with the BPSAA guidelines. To determine if the expenditure was a consulting expenditure the following definition was used: "consultant means a person or entity that, under an agreement other than an employment agreement, provides expert or strategic advice and related services for consideration and decision making."

The attached Section 6 - Hospital Report on Consultant Use (Attachment 2) lists consulting expenditures incurred during the 2025-26 fiscal year.

Professional fee expenditures were reviewed for the 2025-26 fiscal year and the following areas were contacted to confirm the nature of the expenditure and the procurement process that was followed:

- Human Resources
- Purchasing

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

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

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

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

APPENDIX C - ATTESTATION

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

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

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

DATE: June 3, 2026

RE: **April 1, 2025 – March 31, 2026 ("the Applicable Period")**

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

- the completion and accuracy of reports required of the Hospital pursuant to section 6 of the BPSAA on the use of consultants;
- the Hospital's compliance with the prohibition in section 4 of the BPSAA on engaging lobbyist services using public funds;
- the Hospital's compliance with any applicable expense claims directives issued under section 10 of the BPSAA by the Management Board of Cabinet;
- [to be added once ss. 15(1)(c.1) of the Act is proclaimed into force] the Hospital's compliance with any applicable perquisite directives issued under section 11.1 of the BPSAA by the Management Board of Cabinet; and
- the Hospital's compliance with any applicable procurement directives issued under section 12 of the BPSAA by the Management Board of Cabinet, during the Applicable Period.

In making this attestation, I have exercised care and diligence that would reasonably be expected of a insert applicable title i.e. hospital administrator/superintendent/CEO in these circumstances, including making due inquiries of Hospital staff that have knowledge of these matters.

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

Dated at Cambridge, Ontario this June 3, 2026.

Patrick Gaskin
President & Chief Executive Officer
Cambridge Memorial Hospital

I certify that this attestation has been approved by the board of the Cambridge Memorial Hospital on June 3, 2026**.**

Lynn Woeller
Board Chair
Cambridge Memorial Hospital

SCHEDULE A to Attestation

Instructions [Please delete instructions once you have completed the Schedule]:

If, on behalf of your Hospital, you have no material exceptions to declare, please include a "no known exceptions" statement in each section to this schedule.

If, on behalf of your Hospital, you have material exceptions to declare with respect to any of the matters set out below, please:

a) List them accordingly
b) Provide a rationale for each exception in respect of why the Hospital did not comply with the requirement, and
c) Describe what actions have been, or will be taken, to address each exception.

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

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

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

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

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

Hospital Report on Consultant Use

Name of Hospital: **Cambridge Memorial Hospital**

Ontario Health Region: Ontario Health West

REPORTING PERIOD: April 1, 2025 to March 31, 2026

No.	Consultant Firm Name	Name and Title of Consulting Contract	Contract Term *(If the contract term has been extended please include the original contract term and the amended contract term)*	Procurement Value *(A+B+C) A=Original Value B=Value of Amendments C=Total Procurement Value Total Paid ($)*	Consultant Selection Process *(Open Competitive, Invitational Competitive, Non-competitive – If non-competitive explanation required*	Modifications to Agreement *(if yes, did the procurement documents permit modifications to the term or value of the agreement?)*
1	Human Capital Investment	Non Union Salary Review	November 30, 2025	$5,795.00	Non Competitive, CFTA Part III, Chapter 5, Article 513: Limited tendering. Would cause significant inconvenience or substantial duplication of costs for the procuring entity.	No modifications.
2	Quess 360	Medical Daycare Hazard Clean Room	10 hrs – Jan/Feb 2026	$2,000.00	Non Competitive, CFTA Part III, Chapter 5, Article 513: Limited tendering. Would cause significant inconvenience or substantial duplication of costs for the procuring entity.	No modifications.

Attestation Reporting Period April 1, 2025 - March 31, 2026

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

No.	Vendor	25/26 Spend	Description and Rationale for Exception	Actions to be Taken
1	Isologic Innovative	$267,467.16	CMH is participating in MMC contract C13023. MMC established these contracts via limited tendering and have attested to this	At the expiration of the contracts, CMH will request that MMC competitively bid these contracts and not use limited tendering
2	Becton Dickinson Canada Inc	$131,200.35	CMH is participating in MMC contract C13023. MMC established these contracts via limited tendering and have attested to this	At the expiration of the contracts, CMH will request that MMC competitively bid these contracts and not use limited tendering

March 25, 2026

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

Dear Member,

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

On behalf of Mohawk Medbuy Corporation, we attest that all contracting services performed on the Members' behalf for the applicable period of April 1, 2025 – March 31, 2026, are in compliance with the Broader Public Sector Supply Chain Directives and the Canada Free Trade Agreement (CFTA). Exceptions, for contracts on which the Member participated occurring during the twelve (12) month reporting period are noted on the attached document with supporting explanations.

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

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

MOHAWK MEDBUY CORPORATION

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

Dale Thomson
Senior Vice President, Supply Chain and Distribution
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Ally Dhalla
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100-1107 Clay Ave.
Burlington, Ontario. L7L 0A1
289-337-5000

MOHAWK MEDBUY

BPS Attestation Report - April 1, 2025 to March 31, 2026

Attestation values are provided where available. Transactional spend corresponds to the date range applicable to your site, as identified in the email communication.
Values in green represent the full posted value.
P - ND indicates Member participation on contract, however spend data not provided/available.
NP - Not Participating

Code	Contract No.	Contract Name	Supplier Name	Contract Start Date	Current Contract Expiry Date	Option Terms	New Contract Expiry Date (for extended contracts)	Exception Type	Justification Code	SC10022 Cambridge Memorial Hospital
PH	C13032	PH SEVOFLURANE INHALATION ANESTHETIC ABB 2024	ABBVIE CORPORATION	October 1, 2024	September 30, 2026	1 Year		Appendix A - Limited Tender	B(v)	P-ND
PH	C13033	PH SEVOFLURANE INHALATION ANESTHETIC BAX 2024	BAXTER CORPORATION	October 1, 2024	September 30, 2026	1 Year		Appendix A - Limited Tender	B(v)	P-ND
PH	C13034	PH SEVOFLURANE INHALATION ANESTHETIC CHS 2024	CANADIAN HOSPITAL SPECIALTIES LTI	October 1, 2024	September 30, 2026	1 Year		Appendix A - Limited Tender	B(v)	P-ND
PH	C13327	PH SERVICE CERTIFICATION OF CONTROLLED AREAS + CONTAINMENT PRIMARY ENGINEERING CON	SUPERIOR TESTING SERVICES	November 1, 2024	November 30, 2026	None		Appendix A - Limited Tender	B(ii)	P-ND
PH	C13324	PH SERVICE CERTIFICATION OF CONTROLLED AREAS + CONTAINMENT PRIMARY ENGINEERING CON	BCE PHARMA INC.	November 1, 2024	November 30, 2026	None		Appendix A - Limited Tender	B(ii)	P-ND
PH	C13326	PH SERVICE CERTIFICATION OF CONTROLLED AREAS + CONTAINMENT PRIMARY ENGINEERING CON	H.E.P.A. FILTER SERVICES INC.	November 1, 2024	November 30, 2026	None		Appendix A - Limited Tender	B(ii)	P-ND
MILR	C13020	MILR RADIOPHARMACEUTICALS 2025 - NUCM - PA	NUCM RADIOPHARMA INC.	January 1, 2025	December 31, 2026	2 Years		Appendix A - Limited Tender	D	P-ND
MILR	C13023	MILR RADIOPHARMACEUTICALS 2025 - ISOLOGIC - PA	ISOLOGIC INNOVATIVE RADIOPHARMA	January 1, 2025	December 31, 2026	2 Years		Appendix A - Limited Tender	D	P-ND
MILR	C13024	MILR RADIOPHARMACEUTICALS 2025 - JUBILANT - PA	JUBILANT DRAXIMAGE INC.	January 1, 2025	December 31, 2026	2 Years		Appendix A - Limited Tender	D	$5,386
PH	C11374	PH CLOSED SYSTEM TRANSFER DEVICES BD 2021	BECTON DICKINSON CANADA INC.	November 1, 2021	October 31, 2026	2 Years & 9 Months		Appendix A - Limited Tender	B(ii)	$43,698
PH	C11861	PH PREFILLED LOCK FLUSH SYRINGES + DEVICES BD 2023	BECTON DICKINSON CANADA INC.	May 1, 2023	December 31, 2028	4 Years & 6 Months		Appendix A - Limited Tender	B(ii)	$55,992
PH	C12167	PH ORAL SOLID PHARMACEUTICALS EISAI 2023	EISAI LIMITED	July 20, 2023	March 31, 2027	2 Years & 10 Months		Appendix A - Limited Tender	B(ii)	P-ND
PH	C13036	PH ONCOLOGY PHARMACEUTICALS KNI 2024	KNIGHT THERAPEUTICS INC.	July 1, 2024	September 30, 2025	1 Year & 4 Months		Appendix A - Limited Tender	B(ii)	P-ND
PH	C13035	PH ORAL SOLID PHARMACEUTICALS KNI 2024	KNIGHT THERAPEUTICS INC.	July 1, 2024	May 31, 2027	2 Years & 11 Months		Appendix A - Limited Tender	B(ii)	P-ND
PH	C14202	PH INJECTABLE PHARMACEUTICALS LBI 2025	LEADIANT BIOSCIENCES, INC.	February 1, 2025	May 31, 2028	3 Years & 4 Months		Appendix A - Limited Tender	B(ii)	P-ND
INNOV	C12234	INNOV SERVICE RECYCLING PVC123 2024 - NORWICH PLASTICS INC. - PA	NORWICH PLASTICS INC.	March 1, 2024	September 30, 2024	2.5 Months		Appendix A - Limited Tender	B(ii)	P-ND
PH	C11715	PH PHARMACY SUPPLIES PHS 2022	PHARMASYSTEMS INC.	December 1, 2022	November 30, 2025	1 Year & 2 Months		Appendix A - Limited Tender	B(ii)	$1,219
MILR	C14012	MILR BLOOD COLLECTION PRODUCTS 2026 - BECTON DICKINSON (BD) - LT	BECTON DICKINSON CANADA INC.	January 1, 2026	December 31, 2029	None		Appendix A - Limited Tender	B(ii)	$7,734
OR	C14377	OR RESECTION ELECTRODES 2025 - OLYMPUS - LT	OLYMPUS CANADA INC	March 1, 2025	June 30, 2026	1 Year & 4 Months		Appendix A - Limited Tender	D	$77,500
OR	C14348	OR COBLATION WANDS 2025 - SOUTHMEDIC - LT	SOUTHMEDIC INC.	March 1, 2025	April 30, 2026	1 Year & 2 Months		Appendix A - Limited Tender	D	$26,850
OR	C13865	OR URODYNAMICS AND UROLOGY DILATATION PRODUCTS 2025 - LABORIE MEDICAL TECHNOLOGIES	LABORIE MEDICAL TECHNOLOGIES	January 1, 2025	December 31, 2026	2 Years		Appendix A - Limited Tender	B(v)	$6,779
MMCL	C14282	MMCL SAFETY HYPODERMIC CONVENTIONAL NEEDLES AND SYRINGES 2025 - BD	BECTON DICKINSON CANADA INC.	April 1, 2025	December 31, 2028	3 Years & 9 Months		Appendix A - Limited Tender	D	$44,283
PH	C13354	PH DRUG INFORMATION DATABASE MER 2025 EXCLUSIVE	MERATIVE CANADA HOLDCO UNLIMITE	April 15, 2025	November 14, 2027	1 Year		Appendix A - Limited Tender	B(ii)(v)	P-ND
PH	C13358	PH DRUG INFORMATION DATABASE VGS 2024	VIGILANCE SANTE	February 1, 2025	November 14, 2027	1 Year		Appendix A - Limited Tender	B(ii)(v)	P-ND
PH	C15992	PH ONCOLOGY PHARMACEUTICALS ASP 2025 EXCLUSIVE ONTARIO	ASPEN PHARMACARE CANADA INC	December 1, 2025	May 31, 2029	None		Appendix A - Limited Tender	A(i), A(ii), B(ii)	P-ND
PH	C16018	PH ONCOLOGY PHARMACEUTICALS ON BAY 2025	BAYER INC.	October 1, 2025	May 31, 2029	None		Appendix A - Limited Tender	A(i), A(ii), B(ii)	P-ND
PH	C16010	PH ONCOLOGY PHARMACEUTICALS BIO 2025	BIOCON BIOLOGICS CANADA INC.	October 1, 2025	May 31, 2029	None		Appendix A - Limited Tender	A(i), A(ii), B(ii)	P-ND
PH	C15127	PH ONCOLOGY PHARMACEUTICALS JAMP 2025	JAMP Pharma Corporation	October 1, 2025	May 31, 2029	None		Appendix A - Limited Tender	A(i), A(ii), B(ii)	P-ND
PH	C16079	PH ONCOLOGY PHARMACEUTICALS KNI 2025	KNIGHT THERAPEUTICS INC.	October 1, 2025	May 31, 2029	None		Appendix A - Limited Tender	A(i), A(ii), B(ii)	P-ND
PH	C15813	PH ONCOLOGY PHARMACEUTICALS MEDU 2025	MEDUNIK CANADA	October 1, 2025	May 31, 2029	None		Appendix A - Limited Tender	A(i), A(ii), B(ii)	P-ND
PH	C15976	PH ONCOLOGY PHARMACEUTICALS SS PFI 2025	PFIZER CANADA ULC	October 1, 2025	May 31, 2029	None		Appendix A - Limited Tender	A(i), A(ii), B(ii)	P-ND
PH	C15428	PH RESERVE ONCOLOGY PHARMACEUTICALS PFI 2025	PFIZER CANADA ULC	October 1, 2025	May 31, 2029	None		Appendix A - Limited Tender	A(i), A(ii), B(ii)	P-ND
PH	C15887	PH ONCOLOGY PHARMACEUTICALS TOL 2025	TOLMAR PHARMACEUTICALS CANADA	October 1, 2025	May 31, 2029	None		Appendix A - Limited Tender	A(i), A(ii), B(ii)	P-ND
PH	C15988	PH ONCOLOGY PHARMACEUTICALS VTY 2025	VERITY PHARMACEUTICALS	October 1, 2025	May 31, 2029	None		Appendix A - Limited Tender	A(i), A(ii), B(ii)	P-ND
PH	C15723	PH PARENTERAL NUTRITION SOLUTIONS + LIPIDS + CONSUMABLES BAX 2025	BAXTER CORPORATION	November 1, 2025	October 31, 2028	2 years		Appendix A - Limited Tender	B(ii)	P-ND
PH	C15722	PH PARENTERAL NUTRITION SOLUTIONS + CONSUMABLES BBC 2025	B. BRAUN OF CANADA LTD	November 1, 2025	October 31, 2028	2 years		Appendix A - Limited Tender	B(ii)	P-ND
PH	C15724	PH PARENTERAL NUTRITION SOLUTIONS + LIPIDS FRK 2025	FRESENIUS KABI CANADA LTD.	November 1, 2025	October 31, 2028	2 years		Appendix A - Limited Tender	B(ii)	P-ND
PH	C15725	PH PARENTERAL NUTRITION CONSUMABLES HTH 2025	HEALTHMARK SERVICES	November 1, 2025	October 31, 2028	2 years		Appendix A - Limited Tender	B(ii)	P-ND
MMCL	C14089	MMCL TOTAL CONTACT CAST 2025 - ESSITY	ESSITY PROFESSIONAL HYGIENE	November 1, 2025	October 31, 2028	2 years		Appendix A - Limited Tender	B(iii)	P-ND
MMCL	C14090	MMCL TOTAL CONTACT CAST 2025 - INTEGRA	INTEGRA CANADA ULC	December 1, 2025	October 31, 2028	2 years		Appendix A - Limited Tender	B(iii)	P-ND
PH	C12979	PH INJECTABLE PHARMACEUTICALS STM 2024	STERIMAX	October 1, 2024	August 20, 2026	None		Appendix A - Limited Tender	D	P-ND
PH	C12959	PH INJECTABLE PHARMACEUTICALS HCL 2024	HIKMA CANADA LTD.	October 1, 2024	August 20, 2026	None		Appendix A - Limited Tender	D	P-ND
PH	C13054	PH INJECTABLE PHARMACEUTICALS GMP 2024	GENERIC MEDICAL PARTNERS INC	October 1, 2024	August 20, 2026	None		Appendix A - Limited Tender	D	P-ND
PH	C12970	PH INJECTABLE PHARMACEUTICALS JPC 2024	JUNO PHARMA CANADA INC.	October 1, 2024	August 20, 2026	None		Appendix A - Limited Tender	D	P-ND
PH	C16082	PH ELASTOMERIC INFUSION PUMP DEVICES BAX 2025	BAXTER CORPORATION	December 1, 2025	November 30, 2028	None		Appendix A - Limited Tender	B (ii)	$31
PH	C16145	PH ELASTOMERIC INFUSION PUMP DEVICES BBC 2025	B. BRAUN OF CANADA LTD	December 1, 2025	November 30, 2028	None		Appendix A - Limited Tender	B (ii)	P-ND
PH	C16091	PH ELASTOMERIC INFUSION PUMP DEVICES NIP 2025	NIPRO CANADA CORPORATION	December 1, 2025	November 30, 2028	None		Appendix A - Limited Tender	B (ii)	P-ND
PH	C16264	PH ELASTOMERIC INFUSION PUMP DEVICES AND 2025	ANDONE PHARMACEUTICALS INC.	December 1, 2025	November 30, 2028	None		Appendix A - Limited Tender	B (ii)	P-ND
MILR	C10237	MILR IMPLANTABLE PORTS PICC AND ACCESSORIES 2018 - BARD	BARD CANADA INC	October 1, 2018	September 30, 2025	None	March 31, 2026	Appendix A - Limited Tender	D	$97,668
MILR	C10241	MILR IMPLANTABLE PORTS PICC AND ACCESSORIES 2018 - MCARTHUR	MCARTHUR MEDICAL SALES INC	October 1, 2018	September 30, 2025	None	March 31, 2026	Appendix A - Limited Tender	D	$730
MMCL	C10246	MM SAFETY HYPODERMIC, CONVENTIONAL NEEDLES AND SYRINGES 2018 - CARDINAL HEALTH	CARDINAL HEALTH CANADA INC.	April 1, 2018	March 31, 2025	None	December 31, 2028	Appendix A - Limited Tender	D	$99
MMCL	C10269	MMCL SAFETY HYPODERMIC CONVENTIONAL NEEDLES AND SYRINGES 2018 - NIPRO - PA	NIPRO CANADA CORPORATION	April 1, 2018	March 31, 2025	None	December 31, 2028	Appendix A - Limited Tender	D	$2,580
MMNCL	C10793	MMNCL WSIB CLAIMS AUDITING SERVICE 2020 - SEGA WORKPLACE	SE-GA WORKPLACE CONSULTING PRC	December 19, 2019	December 1, 2024	None	November 20, 2025	Appendix A - Limited Tender	C(ii)	P-ND
MILR	C11149	MILR IMPLANTABLE PORTS PICC AND ACCESSORIES 2021 - CHS	CANADIAN HOSPITAL SPECIALTIES LTI	June 1, 2021	September 30, 2025	None	March 31, 2026	Appendix A - Limited Tender	D	P-ND
MMCL	C11912	MMCL SAFETY HYPODERMIC CONVENTIONAL NEEDLES AND SYRINGES 2023 - EMBECTA	EMBECTA CANADA CO.	November 1, 2023	March 31, 2025	None	December 31, 2028	Appendix A - Limited Tender	D	$6,816
MMNCL	C9109	MMNCL DECONTAMINATION PRODUCTS 2017 - STERIS	STERIS CANADA SALES ULC	February 1, 2017	March 31, 2025	None	September 30, 2025	Appendix A - Limited Tender	D	$33,927
OR	C10180	OR LASER FIBERS 2017 - BOSTON SCIENTIFIC - PA	BOSTON SCIENTIFIC LTD.	November 1, 2017	July 31, 2025	None	July 31, 2026	Appendix A - Limited Tender	B(v)	P-ND
OR	C11699	OR LAVAGE PRODUCTS 2022 – STRYKER	STRYKER CANADA ULC	December 1, 2022	July 31, 2025	None	December 31, 2025	Appendix A - Limited Tender	B(v)	$42,306
OR	C11700	OR LAVAGE PRODUCTS 2022 – ZIMMER	ZIMMER BIOMET CANADA INC.	December 1, 2022	July 31, 2025	None	December 31, 2025	Appendix A - Limited Tender	B(v)	P-ND
OR	C8905	OR TRAUMA AND BONE FIXATION PRODUCTS - CRANIAL MAXILLOFACIAL PLATE & SCREW SYSTEMS	KLS MARTIN	April 1, 2016	July 31, 2025	None	July 31, 2026	Appendix A - Limited Tender	B(v)	$9,619
MMNCL	C10793	MMNCL WSIB CLAIMS AUDITING SERVICE 2020 - SEGA WORKPLACE	SE-GA WORKPLACE CONSULTING PRC	December 19, 2019	November 20, 2025	None	May 31, 2026	Appendix A - Limited Tender	C(ii)	P-ND
MMNCL	MSS-1895	MMNCL LABEL GENERAL MEDICAL	THE STEVENS COMPANY LIMITED	August 1, 2017	October 31, 2025	None	April 30, 2026	Appendix A - Limited Tender	A(ii)	$638
MMCL	C10378	MMCL IV CATHETERS SAFETY 2019 - BBRAUN - PA	B. BRAUN OF CANADA LTD	January 15, 2019	December 31, 2025	None	December 31, 2028	Appendix A - Limited Tender	D	P-ND
MMCL	C8631	MMCL CONVENTIONAL BUTTERFLIES 2015 - TERUMO	TERUMO MEDICAL CANADA	May 1, 2015	December 31, 2025	None	December 31, 2028	Appendix A - Limited Tender	D	P-ND
OR	C11069	OR MPSC ENDOVASCULAR STENTS 2022 - WL GORE	W L GORE & ASSOCIATES INC.	June 15, 2022	February 14, 2026	None	March 31, 2026	Appendix A - Limited Tender	D	P-ND
MEAL	C12455	MS M515 BEVERAGES 2023 - ON - SYSCO	SYSCO CANADA INC.	October 1, 2023	September 30, 2025	None	November 30, 2025	Appendix A - Limited Tender	D	$56,550
MMNCL	C10289	MMNCL HOUSEKEEPING SUPPLIES AND PAPER TOWEL AND TOILET TISSUE 2018 - STAPLES	STAPLES PROFESSIONAL CANADA	November 1, 2018	October 31, 2025	None	April 30, 2027	Appendix A - Limited Tender	D	$10,532
MMNCL	C12153	MMNCL DIETARY SUPPLIES 2023 - STAPLES - PA	STAPLES PROFESSIONAL CANADA	July 1, 2023	October 31, 2025	None	April 30, 2027	Appendix A - Limited Tender	D	P-ND
MMNCL	C10288	MMNCL DIETARY SUPPLIES 2018 - BUNZL	BUNZL CANADA INC	November 1, 2018	October 31, 2025	None	April 30, 2027	Appendix A - Limited Tender	D	$52,745
MMCL	C10671	MMCL POSITIONING DEVICES 2019 - AMT	AMT SURGICAL A DIVISION OF ACERNI	January 1, 2020	December 31, 2025	None	December 31, 2026	Appendix A - Limited Tender	D	$1,911
MMCL	C10672	MMCL POSITIONING DEVICES 2019 RFP - MEDLINE	MEDLINE CANADA INC.	January 1, 2020	December 31, 2025	None	December 31, 2026	Appendix A - Limited Tender	D	P-ND
MMCL	C10673	MMCL POSITIONING DEVICES 2019 RFP - JAC CELL	JAC CELL MEDIC	January 1, 2020	December 31, 2025	None	December 31, 2026	Appendix A - Limited Tender	D	P-ND
MMCL	C10674	MMCL POSITIONING DEVICES 2019 RFP - INTEGRA	INTEGRA CANADA ULC	January 1, 2020	December 31, 2025	None	December 31, 2026	Appendix A - Limited Tender	D	$5,280
MMCL	C12031	MMCL POSITIONING DEVICES 2019 - DERMA	DERMA SCIENCES CANADA INC.	April 1, 2023	December 31, 2025	None	December 31, 2026	Appendix A - Limited Tender	D	P-ND
OR	C11076	OR MPSC HEMODYNAMIC MONITORING PRODUCTS 2022 - EDWARDS LIFESCIENCES (CANADA)	EDWARDS LIFESCIENCES (CANADA) IN	June 1, 2022	February 28, 2026	None	April 30, 2026	Appendix A - Limited Tender	D	$257
OR	C11077	OR MPSC HEMODYNAMIC MONITORING PRODUCTS 2022 - ICU MEDICAL INC.	ICU MEDICAL INC.	March 1, 2022	February 28, 2026	None	April 30, 2026	Appendix A - Limited Tender	D	P-ND
OR	C11078	OR MPSC HEMODYNAMIC MONITORING PRODUCTS 2022 - ATES	ATES MEDICAL	March 1, 2022	February 28, 2026	None	April 30, 2026	Appendix A - Limited Tender	D	$303
OR	C11079	OR MPSC HEMODYNAMIC MONITORING PRODUCTS 2022 - TRUDELL	TRUDELL HEALTHCARE SOLUTIONS IN	March 1, 2022	February 28, 2026	None	April 30, 2026	Appendix A - Limited Tender	D	$279
OR	C11080	OR MPSC HEMODYNAMIC MONITORING PRODUCTS 2022 - TELEFLEX	TELEFLEX MEDICAL CANADA INC.	August 1, 2022	February 28, 2026	None	April 30, 2026	Appendix A - Limited Tender	D	$5,768

LIST OF APPROVED NON COMPLIANT PROCUREMENT TO BE PUBLICALLY POSTED - 2025/26

Vendor	Product/Service description	Currency	Criteria Code Number	Criteria Code Description	Value (SUB-TOTAL)	PO Date (DD-MM-YYYY)
Iatric	Maintenance fees for existing programs that interface with Meditech.	CAD	37	(c)(i) cannot be made for economic or technical reasons such as requirements of interchangeability or interoperability with existing equipment, software, services, or installations procured under the initial procurement	$ 181,759.00	14-04-2025
Siemens	MRI Service contract to ensure compatible parts and timely service to maximize uptime.	CAD	33	(b)(v) to ensure compatibility with existing goods, or to maintain specialized goods that must be maintained by the manufacturer of those goods or its representative	$ 172,476.00	03-07-2025
PICIS	Maintenance fee for software used to document Perioperative and Endoscopy programs.	USD	33	(b)(v) to ensure compatibility with existing goods, or to maintain specialized goods that must be maintained by the manufacturer of those goods or its representative	$ 196,515.06	22-12-2025
Quess 360	Medical Daycare Hazard Clean Room advise (Consulting)	CAD	38	(c)(ii) would cause significant inconvenience or substantial duplication of costs for the procuring entity	$ 2,000.00	19-01-2026

Agenda Item 1.5.12

BRIEFING NOTE

Date: May 25, 2026
Issue: M-SAA Schedule F – Declaration of Compliance
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Kenneth Abogadil, Director of Diagnostic Imaging, Laboratory Medicine, Diagnostic Cardiology Services and Mental Health (interim)
Cc: Stephanie Pearsall, VP, Clinical Programs and Chief Nursing Executive
Approved by: Trevor Clark, VP Finance & Corporate Services, CFO

Attachments/Related Documents:
Schedule F – Declaration of Compliance

Alignment with 2025/26 CMH Priorities:

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

Recommendation/Motion
Board
That, the CMH Board of Directors approves the submission of the Multi-Sector Service Accountability Agreement (M-SAA) Schedule F – Declaration of Compliance, confirming that CMH continues to meet its legal and contractual obligations and upon recommendation of the Resources Committee at its meeting of May 25, 2026.

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

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

- Followed all government requirements for purchasing goods and services,
- Met the expectations of the *Connecting Care Act, 2019*, and
- Complied with the Public Sector Compensation Restraint to Protect Public Services Act. CARRIED.

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

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

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

Analysis
Over the past fiscal year, CMH has continued to provide outpatient mental health services funded under the Multi-Sector Service Accountability Agreement (M-SAA), including counselling and treatment programs, psychiatric assessments in the Emergency Department, injection clinic services, and the day hospital program. While service volumes in FY 2025–26 declined by approximately 10% compared to the previous year, CMH continues to see ongoing community demand for outpatient mental health services.

Throughout the fiscal year, outpatient mental health services experienced physician capacity challenges which impacted overall program volumes and service throughput. Despite these pressures, the team continued efforts to improve patient engagement, access, and coordination of care.

Looking ahead, CMH is planning further enhancements to outpatient mental health services through recruitment efforts to add an additional psychiatrist and through the development of a future-state outpatient care model focused on streamlining referral and intake processes, optimizing psychiatrist capacity, improving patient flow, and enhancing timely access to the right level of care. This work is intended to strengthen service responsiveness and support sustainable growth of outpatient mental health services in alignment with regional approaches and community needs.

In addition to outpatient services, CMH continues to support inpatient mental health care services which have also experienced ongoing system pressures related to patient acuity, staffing, and increasing regional demand for mental health care.

CMH remains committed to advancing a more integrated, accessible, and sustainable mental health system that strengthens care delivery across the continuum, improves timely access for patients and families, and positions the organization to better meet the growing and evolving mental health needs of the Cambridge North Dumfries community.

Declaration of Compliance
CMH’s Director of Mental Health Programs confirms that CMH has fully met the M-SAA requirements for the period April 1, 2025, to March 31, 2026, including:

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

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

Schedule F – Form of Compliance Declaration

DECLARATION OF COMPLIANCE

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

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

Date: [June 3, 2026]

Re: April 1, 2025 – March 31, 2026 (the "Applicable Period")

Unless otherwise defined in this Declaration of Compliance, capitalized terms have the same meaning as set out in the Multi-sector Service Accountability Agreement between Ontario Health and the HSP in effect during the Applicable Period (the "Agreement").

The Board has authorized me, by resolution dated [June 3, 2026], to declare to you as follows:

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

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

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

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

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

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

Schedule F – Declaration of Compliance

Appendix 1 - Exceptions

[No exceptions.

Agenda Item 1.5.13

BRIEFING NOTE

Date: May 25, 2026
Issue: HSAA Article 8 – Declaration of Compliance
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Janet Short, Senior Financial Advisor
Approved by: Trevor Clark, VP Finance & Corporate Services, CFO

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

Alignment with 2025/26 CMH Priorities:

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

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

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Recommendation/Motion
Board
That, the CMH Board of Directors approves the submission of the HSAA Article 8 – Declaration of Compliance and upon recommendation of the Resources Committee at its meeting of May 25, 2026.

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

After making inquiries of the President and CEO and other appropriate officers of the HSP, and subject to any exceptions identified on Appendix 1 to this Declaration of Compliance, to the best of the Board's knowledge and belief, the HSP has fulfilled its obligations under Agreement during the Applicable Period (April 1, 2025 – March 31, 2026) and has received the required reports referred to in Section 8.6 of the Agreement.

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

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

HSAA Article 8 – Form of Compliance Declaration

DECLARATION OF COMPLIANCE

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

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

Date: [June 3, 2026]

Re: April 1, 2025 – March 31, 2026 (the "Applicable Period")

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

The Board has authorized me, by resolution dated [June 3, 2026], to declare to you as follows:

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

____
Signature
[Lynn Woeller], Chair

HSAA Article 8 – Form of Compliance Declaration

Appendix 1 - Exceptions

No exceptions.

THIS AGREEMENT is made effective the 16th day of August, 2025 (the "Effective Date"),

BETWEEN:

CAMBRIDGE MEMORIAL HOSPITAL

a corporation without share capital duly incorporated under the laws of the Province of Ontario having its head office in the City of Cambridge, in the Province of Ontario

(the "Hospital")

-and-

PATRICK GASKIN

of the [redacted], in the Province of Ontario

("P. Gaskin")

RECITALS

WHEREAS P. Gaskin commenced employment with the Hospital on September 16, 2009 in the position of Acting President and Chief Executive Officer;

AND WHEREAS P. Gaskin was appointed as President and Chief Executive Officer at the Hospital effective August 16, 2010 for a five-year term and was reappointed in 2015 and 2020;

AND WHEREAS the Hospital and P. Gaskin have now agreed to continue their employment relationship and P. Gaskin's appointment as President and Chief Executive Officer pursuant to a new five-year fixed term employment agreement;

AND WHEREAS the terms of the employment relationship have been negotiated between the Hospital and P. Gaskin and are set out in this Agreement.

NOW THEREFORE FOR GOOD AND VALUABLE CONSIDERATION RECEIVED, the parties agree as follows:

1. **DEFINITIONS**

In this Agreement, unless the context otherwise requires, each capitalized term shall have the following meaning attributed thereto:

(a) "Agreement" means this agreement, including its recitals and all schedules attached to this agreement, all as may be supplemented or amended from time to time in accordance with this Agreement;

(b) “Board” means Board of Directors of the Hospital;

(c) “Chair” means the director elected by the Board to serve as Chair of the Board;

(d) “Chief Executive Officer”, or its acronym (“CEO”), means in addition to ‘administrator’ as defined in Section 1 of the *Public Hospitals Act,* the President and Chief Executive Officer of the Hospital;

(e) “Minister” means the Minister of Health; and,

(f) “MOH” means the Ministry of Health.

2. **CHIEF EXECUTIVE OFFICER**

P. Gaskin agrees to serve as the President and Chief Executive Officer of the Hospital to the best of his ability in compliance with all applicable laws, the Hospital’s By-Laws, policies, procedures, rules and regulations, all as may be amended from time to time, and this Agreement.

3. **ACCOUNTABILITY**

(a) P. Gaskin shall be directly accountable to the Board in accordance with the Hospital’s By-Laws and applicable policies and procedures.

(b) The Chair shall act as the Board’s central point of official communication with P. Gaskin.

(c) P. Gaskin shall follow all lawful instructions and directions given to him by the Board.

4. **TERM**

(a) This Agreement shall be for the period of five (5) years commencing on the Effective Date and ending on August 15, 2030, unless terminated earlier by either party in accordance with Section 10.

(b) The Chair shall advise P. Gaskin on or before August 15, 2029 whether the Agreement may be renewed, and if so, for what further term and on what conditions. In the event a renewal is not offered, P. Gaskin shall continue to perform his responsibilities under this Agreement until the expiration of its term, subject to either party’s right to terminate this Agreement in accordance with Section 10.

5. **FULL TIME AND ATTENTION**

(a) P. Gaskin shall, throughout the term of his employment, devote his full time and attention to the business and affairs of the Hospital. P. Gaskin acknowledges that this position will

include the carrying out of duties in the evenings and weekends, as may be required from time to time, in addition to regular business hours.

(b) (i) P. Gaskin shall not undertake any other business or occupation or become an employee, partner or agent of any other corporation, partnership, firm or person ("Other Organizations").

(ii) Notwithstanding paragraph 5(b) (i) above, P. Gaskin may, with the Board's consent or as required under the *Public Hospitals Act,* undertake activities as a director or officer for Other Organizations which are consistent with his responsibilities in respect of raising the profile of the Hospital and/or improving the Hospital's relationship with key stakeholders such as government (Federal, Provincial or Municipal), other education or research organizations, and other healthcare providers or their respective associations, provided such activities do not interfere with P. Gaskin's ability to discharge his responsibilities to the Hospital.

6. **REMUNERATION**

(a) The Hospital agrees to pay P. Gaskin an annual base salary of three hundred forty-two thousand four hundred seventy-three dollars ($342,473), remitted on a bi-weekly basis ("Base Salary"). The Base Salary shall be reviewed every year by the Board taking into account the performance review conducted by the Executive Committee as more particularly described in Section 7. Such salary increases, if any, shall be effective as of April 1st of the calendar year.

(b) Notwithstanding anything else in this Agreement, P. Gaskin acknowledges and agrees that this Agreement is subject to the *Broader Public Sector Executive Compensation Act, 2014* and the Compensation Framework established under Ontario Regulation 406/18, and may be subject to other legislative restraints in the future. Any payments of salary, performance incentive payments or other compensation under this Agreement, including any future increases, will be made in compliance with all legislative restraints applicable to the Hospital and P. Gaskin's employment under this Agreement.

(c) Performance Incentive

i. P. Gaskin will be eligible to receive an annual lump sum payment up to a maximum of ten percent (10%) of his then annual Base Salary as a performance incentive payable in respect of achievement of objectives in the preceding fiscal year in accordance with the *Excellent Care for All Act, 2010,* or any successor or other related legislation. The Board's decision to pay a performance incentive payment under this paragraph shall not result in an adjustment to the future base salary payable to P. Gaskin.

ii. The determination of whether a performance incentive is payable shall be made by the Board prior to June 30 of each year and shall be based upon consideration of the

achievement of strategic goals, objectives and operational targets as are set annually by the Board.

iii. The performance incentive payable in accordance with subsection ii. above, if any, shall be paid on or before July 31 of each year.

iv. In the year that P. Gaskin's employment terminates, P. Gaskin shall be entitled to a performance incentive payment prorated to the end of the applicable minimum statutory notice period under the *Employment Standards Act, 2000* only, but only to the extent that an incentive is otherwise payable under the terms of the program. P. Gaskin will not be entitled to any performance incentive payment or for damages in lieu of a payment for any period of time following the minimum applicable statutory notice period, whether at common law or otherwise. Notwithstanding the foregoing, if P. Gaskin's employment is terminated for wilful misconduct or cause in accordance with sections 10(d) or (e), below, P. Gaskin shall not be entitled to a performance incentive payment.

7. **PERFORMANCE REVIEW**

(a) By no later than June 15th of each calendar year, the Executive Committee of the Board will undertake a review of P. Gaskin's performance for the prior fiscal period, which will provide for a review of:

(i) P. Gaskin's progress toward achievement of the Hospital's preceding fiscal year objectives as determined by the Board, including his performance in respect of achieving the Hospital's financial goals and objectives;

(ii) the job description of the CEO as approved by the Board from time to time;

(iii) the Hospital's performance under any accountability agreement between the Hospital and MOH or any governmental body or agency that may in the future fund or hold the Hospital accountable for its clinical or financial performance;

(iv) any notices, compliance directives or orders issued by the Minister pursuant to the *Commitment to the Future of Medicare Act* or any other similar legislation, including *Excellent Care for All Act, 2010, Broader Public Sector Accountability Act, 2010, Broader Public Sector Executive Compensation Act, 2014* or other legislation which may be enacted in the future; and

(v) other relevant matters, including compliance with Section 5.

(b) Based on the performance review, the Executive Committee will make recommendations to the Board in respect of P. Gaskin's compensation. Any amendments to P. Gaskin's remuneration (including the payment to P. Gaskin of any performance incentive in accordance with Section 6 (c) (i)) must be approved by the Board, taking into account any

relevant policies, the results of the performance review, as well as any legislated requirements including *Excellent Care for All Act, 2010* and the *Broader Public Sector Executive Compensation Act, 2014* or other legislation which may be enacted in the future.

(c) By no later than June 15th of each calendar year, the Executive Committee will develop, in consultation with P. Gaskin, and recommend to the Board measurable performance expectations and objectives, including both short-term and long-term objectives for the CEO which shall form the basis for performance incentive in the then current fiscal year.

8. **BENEFITS**

(a) The Hospital shall reimburse P. Gaskin for:

   i. leadership development and other professional development programs as approved by the Chair; and
   ii. professional membership fees incurred in no more than three (3) professional organizations that are reasonable and approved in advance by the Chair (e.g. Canadian College of Health Leaders, the American College of Healthcare Executives).

(b) P. Gaskin shall be entitled to continue participating in the benefits plans made available by the Hospital to its full-time senior administrative personnel. The benefit plans include dental, extended health, and group life insurance, each as amended from time to time ("Benefits Plans"). P. Gaskin shall participate in the Benefits Plans on the same terms as other employees of the Hospital who participate in the Benefits Plans, except with respect to Long Term Disability coverage which will be payable at the rate of sixty percent (60%) of his Base Salary without regard to the generally applicable maximum cap on salary. The Hospital reserves the right to amend, terminate or replace any of the Benefits Plans.

(c) P. Gaskin shall be eligible to participate in the Healthcare of Ontario Pension Plan ("HOOPP"), subject to the terms and conditions of HOOPP, as may be amended from time to time.

(d) The Hospital shall establish a healthcare spending account for P. Gaskin and fund it at the rate of five thousand dollars ($5,000) per fiscal year. This sum, or any unused balance thereof, is not transferrable from year to year.

9. **EXPENSES**

(i) It is understood and agreed that P. Gaskin will incur expenses in connection with his duties under this Agreement. The Hospital will reimburse P. Gaskin for all reasonable and substantiated expenses provided they were incurred and substantiated in accordance with established Hospital policies or as approved by the Chair or delegate. For greater certainty, the Hospital shall reimburse P. Gaskin for all work-related travel in accordance with Hospital policy in effect from time to time.

10. **TERMINATION**

(a) Outstanding Wages

The Hospital may terminate P. Gaskin's employment for any reason not prohibited by legislation in accordance with this section 10. Upon the termination of P. Gaskin's employment, and subject to the provisions of this section 10, the Hospital shall pay to P. Gaskin all outstanding wages, including without limitation vacation pay, that P. Gaskin has earned and remain owing, in accordance with the requirements of the *Employment Standards Act, 2000* and its regulations (collectively, the "ESA"). The Hospital shall also reimburse business-related expenses incurred prior to the date of termination, subject to section 9, above.

(b) Expiry of Agreement

If the parties do not renew this Agreement in accordance with Section 4(b), P. Gaskin's employment will terminate upon the expiry of the term on August 15, 2030. P. Gaskin will have no entitlement to reasonable notice or other damages at common law, but will be paid the minimum termination pay, severance pay, and any other minimum entitlements owed under the ESA upon termination of employment, including continued participation in the Benefits Plans and HOOPP only to the extent required under the statute. For greater certainty, P. Gaskin shall be eligible for a performance incentive payment to the end of the term determined in accordance with section 6(c)(iv), above.

(c) Resignation or Retirement

P. Gaskin may resign or retire at any time, and for any reason, upon providing four (4) months' notice of resignation or retirement in writing to the Chair. The Hospital may determine that P. Gaskin is not required to work during any portion of the resignation notice period, but will continue to pay P. Gaskin's full remuneration and benefits until the end of the four (4) month resignation notice period only. This shall not convert P. Gaskin's resignation to a termination of employment. For greater certainty, P. Gaskin shall be eligible for a performance incentive payment prorated to the effective date of the resignation in accordance with section 6(c)(iv), above.

(d) Termination for Wilful Misconduct

The Hospital may terminate this Agreement and P. Gaskin's employment at any time without notice, payment in lieu of notice or severance of any kind for wilful misconduct, disobedience or wilful neglect of duty that is not trivial and that has not been condoned by the Hospital. In accordance with section 6(c)(iv), above, P. Gaskin shall not be entitled to a performance incentive payment for the year in which a termination occurs under this section.

(e) Termination for Cause

If the Hospital has cause to terminate P. Gaskin's employment at common law that would not meet the standard in section 10(d), above, P. Gaskin will have no entitlement to reasonable notice or other damages at common law, but will be paid the minimum termination pay, severance pay and any other minimum entitlements owed under the ESA upon termination of employment, including continued participation in the Benefits Plans and HOOPP only to the extent required under the statute. In accordance with section 6(c)(iv), above, P. Gaskin shall not be entitled to a performance incentive payment for the year in which a termination occurs under this section.

(f) Termination without Wilful Misconduct or Cause

In any other case as permitted by law, the Hospital may terminate this Agreement and P. Gaskin's employment by providing P. Gaskin with the following entitlements:

(i) The Hospital shall provide salary continuance in lieu of notice at P. Gaskin's most recent Base Salary for a period of time equal to twelve (12) months plus a further one (1) month for each completed year of employment with the Hospital to a combined maximum of eighteen (18) months' salary continuance (the "Salary Continuance Period").

(ii) P. Gaskin shall be eligible for a prorated performance incentive payment determined in accordance with section 6(c)(iv), above.

(iii) P. Gaskin shall continue to participate in the Benefits Plans and health care spending account, subject to their respective terms and conditions, for the minimum statutory notice period only, as required under the ESA. Following the expiry of the minimum statutory notice period, P. Gaskin's short-term disability benefits, long-term disability benefits and life insurance benefits shall cease, and he shall have no further coverage under these plans. All other Benefits Plans and the health care spending account will continue until the end of the Salary Continuance Period, subject in all cases to the terms and conditions of the respective plans and policies. The parties shall make their respective contributions to maintain the Benefit Plans under this section.

(iv) P. Gaskin shall continue to be eligible to participate in HOOPP, subject to its terms and conditions, until the end of the Salary Continuance Period. The parties shall continue their respective contributions to HOOPP.

(g) Merger or Amalgamation

In the event of a merger or amalgamation with another entity regulated by the *Public Hospitals Act*, the following shall apply:

(i) If P. Gaskin applies for a position with the new entity but is unsuccessful, he shall

be entitled to the payments under section 10(f), except that the Salary Continuance Period shall be deemed to be twenty-four (24) months.

(ii) If P. Gaskin does not to apply for a position with the new entity, he shall be entitled to the payments under section 10(f), with the Salary Continuance Period determined in accordance with the formula in that section.

(iii) If P. Gaskin is appointed to the same or similar executive position with the new entity, his employment will be deemed to be continuous with the new entity and P. Gaskin shall therefore be ineligible for any payments under this section 10 or otherwise at law, except and only to the extent as may be required under the ESA.

(iv) If P. Gaskin applies for and accepts a position below the level of President and CEO with the new entity, his employment shall be deemed to be continuous with the new entity, but the Hospital shall pay to P. Gaskin a lump sum payment equivalent to six (6) months' Base Salary.

(h) Fair and Reasonable

P. Gaskin acknowledges that the payments and benefits described in this Section 10 constitute reasonable compensation upon the termination of his employment, and are inclusive of any termination pay, severance pay or any other wages that may be owing to him under the ESA. Upon the Hospital providing P. Gaskin with such payments and benefits, he shall not be entitled to any further notice, payment in lieu of notice, termination pay, severance pay, damages, costs or compensation in respect of his employment or the termination of his employment, whether under the ESA or at common law, and P. Gaskin shall have no action, cause of action, complaint, demand or claim against the Hospital, its employees or any member of the Board of Directors.

(i) Termination Payments Subject to Deductions

All payments made pursuant to Section 10 of this Agreement are subject to such deductions and withholdings as are required by law, and may be the subject of set-off against any amounts owed by P. Gaskin to the Hospital at the time of termination.

(j) Agreement Deemed Frustrated

(i) Subject to the Hospital's obligations under the *Human Rights Code*, P. Gaskin's employment with the Hospital shall be deemed to be frustrated at the discretion of the Hospital if:

(A) P. Gaskin becomes eligible for Long Term Disability benefits under the Hospital's general disability policy;

(B) the Board of Directors of the Hospital determine that P. Gaskin has been unable, due to illness, disease, mental or physical disability or similar cause, to fulfil his obligations as President and Chief Executive Officer of the Hospital either for any consecutive twelve (12) month period or for any period of sixteen (16) months (whether or not consecutive) in any consecutive twenty (24) month period; or

(C) a court of competent jurisdiction has declared P. Gaskin to be mentally incompetent or incapable of managing his affairs.

(ii) If the Hospital exercises its discretion under this section, P. Gaskin will have no entitlement to reasonable notice or other damages at common law, but will be paid the minimum termination pay, severance pay and any other minimum entitlements owed under the ESA upon termination of employment, including continued participation in the Benefits Plans and HOOPP only to the extent required under the statute. In addition, the Hospital shall pay to P. Gaskin an amount equal to two (2) months' Base Salary at the level in effect at that time.

11. **VACATION ENTITLEMENT**

P. Gaskin shall be entitled to six (6) weeks of vacation during each calendar year. Vacation not taken in a calendar year may be carried forward into any subsequent year(s) to a maximum of nine (9) weeks of vacation.

12. **LIABILITY INSURANCE**

The Hospital shall insure P. Gaskin under its general liability policy both during and after the term of his employment, for all acts done by him in good faith and in the execution of his office as CEO throughout the term of his employment, including where the CEO is specifically named in a lawsuit launched by a patient, employee, member of the Medical Staff, or any other party.

13. **OWNERSHIP OF INFORMATION AND NON-DISCLOSURE**

(a) "Confidential Information" includes, without limitation, information and facts relating to the operation and affairs of the Hospital acquired by P. Gaskin in the course of his employment, including information and facts relating to present and contemplated services, future plans, processes, procedures, suppliers, capital projects, financial information of all kinds, government relations strategies, patients or their health records, any product, device, equipment or machine, or employees. For greater clarity, Confidential Information shall not include:

(i) information and facts that are available to the public or in the public domain at the time of such disclosure or use, without breach of this Agreement; or

(ii) information and facts that become available to P. Gaskin on a non-confidential

basis from a source other than the Hospital.

(b) All Confidential Information of the Hospital, whether it is developed by P. Gaskin during his period of employment or by others employed or engaged by or associated with the Hospital, is the exclusive property of the Hospital and shall at all times be regarded, treated and protected as such.

(c) P. Gaskin shall not disclose Confidential Information to any person or use Confidential Information (other than necessary in carrying out his duties on behalf of the Hospital) at any time during or subsequent to his period of employment without first obtaining the written consent of the Chair, and P. Gaskin shall take all reasonable precautions to prevent inadvertent disclosure of any such Confidential Information.

(d) Within five (5) days after the termination of P. Gaskin's employment by the Hospital, for any reason, P. Gaskin shall promptly deliver to the Hospital all property belonging to the Hospital, including without limitation all Confidential Information (in whatever form) that is in his possession or under his control.

(e) Nothing in this Section precludes P. Gaskin from disclosing Confidential Information at any time if disclosure of such Confidential Information is required by law, regulation, governmental body or authority, or by court order, provided that before disclosure is made, notice of the requirement is provided to the Hospital, and to the extent possible in the circumstances, the Hospital is afforded an opportunity to dispute the requirement.

14. **ENTIRE AGREEMENT**

This Agreement expresses the entire agreement of the parties and cannot be amended unless there is written approval of both parties. Upon execution of this Agreement by the parties, this Agreement shall, as of the Effective Date, replace all previous agreements and shall govern the relationship of the parties.

15. **SECTION HEADINGS**

All paragraph headings have been inserted herein for convenience of reference only and do not form part of this Agreement.

16. **BINDING EFFECT AND NON-ASSIGNMENT**

This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective heirs, executors, administrators and successors, but shall not be capable of assignment by either party without the previous written consent of the other party thereto.

17. **NOTICE PROVISIONS**

Any notice to be given under this Agreement shall be in writing and shall be personally delivered or sent by registered mail to the following addresses or such other address as either party may from time to time designate to the other by notice given in accordance with this Section:

Notices to the Hospital:

Cambridge Memorial Hospital
700 Coronation Blvd. Cambridge, ON, N1R 3G2

Attention: Chair, Board of Directors

Notices to CEO:

Attention: Patrick Gaskin, Chief Executive Officer

18. **SEVERABILITY**

If any covenant or provision of this Agreement is determined to be void or unenforceable in whole or in part by any court, such determination shall not affect or impair the validity of any other covenant or provision of this Agreement, which shall remain in full force and effect as if the void or unenforceable covenant or provision had not been made part of this Agreement.

19. **WAIVER**

No waiver by either party of any breach of any provisions herein shall constitute a waiver of the provision except with respect to the particular breach giving rise to the waiver.

20. **DISPUTES**

Should a dispute arise between the Hospital and P. Gaskin as to the rights and obligations of the parties under this Agreement, the dispute shall be referred to arbitration pursuant to the *Arbitrations Act, 1991*. The prevailing party to the arbitration shall be entitled to receive reimbursement for their lawyer's fees and expenses on a full indemnity basis. This section shall not operate to prevent P. Gaskin from pursuing any statutory claims that he might have, whether under the ESA or otherwise, under the enforcement mechanisms provided for in any such statute

21. **GOVERNING LAW**

This Agreement shall be governed and construed in accordance with the laws of the Province of Ontario and the Federal laws of Canada applicable therein. All statutory references are to those enactments of the legislature in the Province of Ontario.

22. **CURRENCY and DEDUCTIONS**

All dollar amounts referenced in this Agreement, unless otherwise indicated, are expressed in Canadian Dollars. All payments pursuant to this Agreement are less deductions required or authorized by law.

23. **INDEPENDENT LEGAL ADVICE**

P. Gaskin confirms that, prior to the execution of this Agreement, he has had the full and complete opportunity to obtain independent legal advice and representation and that he has either done so or has freely chosen not to obtain such advice.

[Signature page to follow.]

IN WITNESS WHEREOF the parties hereto have executed this Agreement.

CAMBRIDGE MEMORIAL HOSPITAL

____
Lynn Woeller, Board Chair
Date:

____
Diane Wilkinson, Board Vice-Chair
Date:

I have read, understand and accept the terms and conditions of this Agreement,

SIGNED, SEALED AND DELIVERED
In the presence of

____
Witness:
Name:
Date:

____
Patrick Gaskin

Truth & ReconciliACTION Plan

2025-26 Status Update – as of April 2026

Patrick Gaskin – President & CEO
Mari Iromoto – VP, People & Strategy & Executive Champion, Diversity, Equity & Inclusion
Joy Braga – Diversity, Equity & Inclusion Specialist

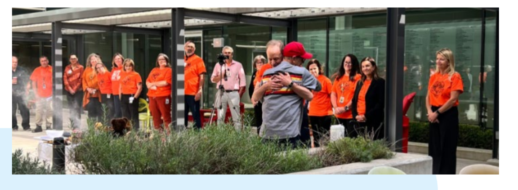
Plan Overview & Priority Themes

5-Year Success Goal

Advance the Truth & Reconciliation Commission of Canada's Call to Action #22: "We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients."

The 2022-27 Truth & ReconciliACTION Plan's priority themes adopt Ontario Health's framework for First Nations, Inuit, Métis and Urban Indigenous Health

CMH's T&R Journey (2018 to 2024)



2018: Introduced an 'Aboriginal Acknowledgement', which became a 'Land Acknowledgement' in May 2019, then a 'Territorial Acknowledgement in Jan 2022.

2020: Clarence Cachagee gifts hawk feather for CMH to hold at the Wing A Opening. Since then, CMH hosts annual feather re-energizing ceremonies.

2021: Opened San'yas Indigenous Cultural Safety Training to leaders and began formally recognizing Orange Shirt Day.

2021: Formed partnership with SOAHAC. CMH physician began providing SOAHAC clients with mental health services in spring 2024.

2022: Opened San'yas training to staff. By Dec 2022, 100+ staff, 100% of senior leadership team, and 80% of leaders and Board Directors completed the training.

Aug 2023: Hired an Indigenous Projects Coordinator to formally support T&R work and updated the CMH Smudging Policy.

Sept 2023: Introduced the first L.E.A.R.N Challenge for National Day of Truth & Reconciliation / Orange Shirt Day.

Dec 2023: Formed the CMH Indigenous Council and held the first meeting to guide the development of the 2024/25 T&R Plan.

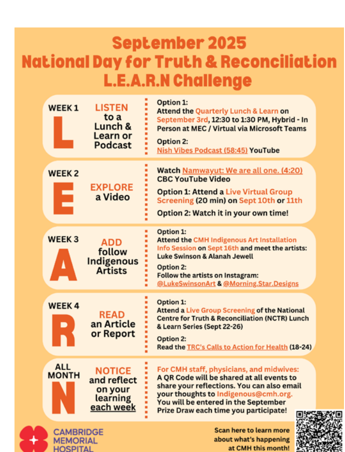
2024: Began developing the Regional Advisory Circle in partnership with Elder Myeengun Henry (Indigenous Knowledge Keeper), GRH & SMGH (now WRHN).

Build & Enhance Capacity and Education

Key Objectives:
- Enhance Indigenous Cultural Safety Training and Indigenous-focused education across the organization
- Increase engagement in Indigenous Calendar events and activities

Work Ahead:
- **Quarterly Lunch & Learn (May 2026):** Host session on Indigenous Women's and Gender Diverse Health
- **Red Dress Day (May 5):** Sell commemorative pins for the first time at CMH to increase awareness and understanding of MMIWG
- **Indigenous Council and Indigenous ERG (Apr to Jun 2026):** Promote to Indigenous staff members for recruitment
- **National Indigenous History Month (Jun 2026):** Partner with the Indigenous Council and Indigenous ERG on events and activities
- **Micro-education for front-line staff:** See next slide.

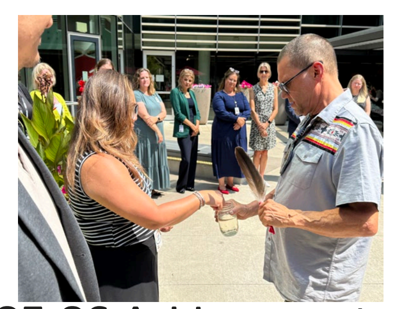
2025-26 Achievements:
- **San'yas Indigenous Cultural Safety Training (Aug to Oct 2025) :** registered 27 individuals (leaders, staff, board members), achieved a 93% overall completion rate, and sustained the 100% mandatory leader completion rate
- **Quarterly Indigenous Lunch & Learn Series Launch:** engaged with 90+ attendees across the first three sessions and collaborated with an Indigenous caterer to provide lunch at one of the sessions (Understanding the Colonization of Indigenous Nutrition and Food)
- **National Day for Truth & Reconciliation/Orange Shirt Day (Sep 2025):** sold out of the 100 newly introduced commemorative pins and sold 67 orange shirts, surpassing last year's order
- **September L.E.A.R.N Challenge:** saw over five times the engagement compared to previous years



Build & Sustain Productive Relationships

Key Objective:

- Establish and sustain trust-based, reciprocal partnerships with Indigenous communities, organizations, and regional partners



2025-26 Achievements:

- **Regional Indigenous Advisory Circle (IAC) (Sep to Nov 2025):** strengthened collaboration through increased engagement and consultation on the Indigenous Community Garden Project and 2025-26 Work Plan
- **Crow Shield Lodge:** enhanced relationship through the Annual Feather Feasting Ceremony (Jul 2025), accepting a new Eagle Feather to hold, and developing a Service Agreement to support the 2026-27 Work Plan (Mar 2026)
- **Truth & Reconciliation Community of Support (Sep 2025):** expanded our collaborative network of health partners by joining the new community of support group led by the SOAHAC Indigenous Cultural Safety Specialist
- **Regional Indigenous Cancer Program (May 2025):** formed new partnership with the Regional Indigenous Cancer Patient Navigator and Regional Cancer Program Coordinator

Work Ahead:

- **IAC Retreat (Apr 2026):** Partner with WRHN to coordinate a retreat to build the capacity of members to shape informed, community-driven recommendations
- **Crow Shield Lodge Service Agreement (Apr to Jun 2026):** Collaborate on key T&R projects including the 2026-27 T&R Work Plan, revised Smudging Policy, staff education (micro-education series and ceremonies), and CMH Territorial Acknowledgement
- **SOAHAC Partnership (Apr to May 2026):** Explore opportunities for enhanced integration of the Indigenous Patient Navigator role and other SOAHAC services at the hospital
- **Red Dress Day (May 5, 2026):** Sell commemorative pins for the first time at CMH and elevated education/awareness around MMIWG
- **Commitment Ceremony:** Continue the discussions between IAC and CMH Board to codesign an annual CMH commitm

Equitable Access to Culturally Safe Care

Key Objectives:

- Enhance access to Indigenous ways of healing and Indigenous-specific health resources
- Create a more welcoming hospital environment for Indigenous patients, families, and community members

Work Ahead:

- **Indigenous Art Installation:** Finalize and install Wing B art (focused on Traditional medicines)
- **Indigenous Art Video Series (Apr to Dec 2026):** Launch videos in alignment with the seasons, starting with the Eagle Feather video
- **Smudging Policy (May to Jun 2026):** Improve accessibility to smudging for Indigenous patients by launching a revised Smudging Policy and micro-education huddle series
- **Indigenous Clinical Recommendations Project (Apr to Jun 2025):** Launch the Women's and Children's Department 6-week education series

2025-26 Achievements:

- **Indigenous Art Installation (Aug to Sep 2025):** collaborated with local Indigenous artists to design and launch the Four Seasons mural series (Wing A Hallway) and Eagle Feather Ceiling Panel (Main Lobby), creating a more welcoming environment for Indigenous communities and acting as a visual representation of CMH's T&R commitment
- **Staff and Indigenous Community Garden Project (Sep to Nov 2025):** developed the final design concept through four consultation sessions with CMH staff and Indigenous community members in partnership with Stantec and Two Row Architect (Indigenous Architect Firm)
- **Indigenous Clinical Recommendations Project (Aug 2025):** developed a 6-week Indigenous education series for the Women's and Children's Department

Measure, Monitor & Evaluate

Key Objectives:

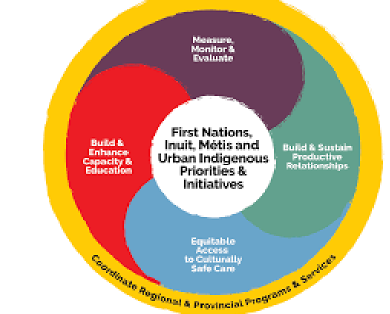
- Ensure T&R is measured separately from DEI
- Deliver on our HSAA obligations related to 'Goal: Advance Indigenous Health Strategies and Outcomes'

Work Ahead:

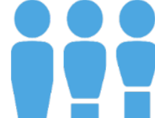
- **2026-27 T&R Work Plan:** Receive feedback and endorsement from Indigenous Council and IAC. Finalize plan
- **Service Accountability Agreement:** Submit 2025-26 report
- **Ontario Hospital Association (OHA) Operating Plan's Indigenous Health Goal:** Connect with the OHA on sector-wide themes related to the TRC health-related Calls to Action and their new standardized measure to capture impact of anti-Indigenous racism on hospital care (OHA Operating Plan 2026/2027)
- **SOAHAC Organizational Assessment:** Review the summary of findings once available
- **OH EIDAR & Indigenous Survey (Apr 2026):** Attend share back session of the survey's emerging themes

2025-26 Achievements:

- **Internal reporting:** Enhanced reporting structures to ensure success of the Indigenous Truth & ReconciliACTION Plan is measured, monitored and evaluated separately from the DEI Plan
- **SOAHAC Organizational Assessment (Dec 2025):** Conducted an Indigenous-created organizational evaluation (Indigenous Primary Health Care Council) of the current state of reconciliation at CMH and submitted the assessment to SOAHAC



Truth & ReconciliACTION Plan: 2025/26 Goals



Lead(s):
Patrick Gaskin
Joy Braga

Exec Sponsor(s):
Patrick Gaskin
Mari Iromoto

Overall Status

Updated: April 2026

#	Key Performance Measure	Target	Actual	Comments
1	% of registrants who successfully complete San'yas Indigenous Cultural Safety Training	100%	93%	• 27 total registrants (staff, leaders, board members) • 100% of leaders and board members successfully completed
2	% of established Indigenous partnerships (IAC, Regional T&R Group, Crow Shield Lodge) with ongoing, reciprocal engagement and co-defined priorities	100%	98%	How it's measured: • Attending regularly scheduled meetings and engagements • Shared goals • Evidence of two-way benefit (e.g., honoraria, capacity support, joint initiatives)
3	% of recommendations in the Clinical Recommendations Project actioned	100%	100%	
4	Deliver on the Hospital Service Accountability Agreement obligations related to 'Goal: Advance Indigenous Health Strategies and Outcomes'	100%	TBD	

Strategic Priorities 25/26

Advance Health Equity		Target	Q1	Q2	Q3	Q4	
	% on track with DEI Action Plan	100	100	78	77		DEI Plan
	% on track with Truth and RoconciliACTION Plan	100	100	88	81		Truth & ReconciliACTION Plan

Overall Status Legend: Achieved/Forecasted to achieve > 50% of all KPMs | Achieved/Forecasted to achieve 25%-50% of KPMs | Achieved/Forecasted to achieve < 25% of KPMs

Next Steps

2026-27 Truth & ReconciliACTION Work Plan currently in development

<u>Consultation (feedback and endorsement):</u>

- Indigenous Council – May 2026
- Indigenous Advisory Circle – May 2026

AMBRIDGE
HOSPITAL

WING B

Language 101
Language 101

BRIEFING NOTE

Date: May 22, 2026
Issue: Quality Committee Report to the Board of Directors, May 20, 2026 – ***OPEN***
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Jennifer Morgan, Administrative Assistant to Clinical Programs
Approved by: William Conway, Quality Committee Chair

Attachments/Related Documents: None

A meeting of the Quality Committee took place on Wednesday, May 20, 2026 at 0700 hours.

Attendees: W. Conway (Chair), P. Brasil, D. Wilkinson, Dr. W. Lee, N. Gandhi, A. Schrum, J. Herring, K. Baldock, S. Pearsall, D. Haughton, P. Gaskin, A. McCarthy, M. Adair, T. Mohtsham, M. McKinnon

Staff Present: Dr. J. Legassie, M. Iromoto, Dr. K. Rhee, L. Barefoot

Guests: Dr. M. Hindle, Dr. L. Green, K. Towes

Regrets: None

Committee Matters – For information only

1. Program Presentations:
   Perioperative Services (includes Patient and Staff Stories): The Committee received an update on the successful reintroduction of Breast Reconstruction Awareness Day (BRA Day), held on October 15 in partnership with the Waterloo Wellington Regional Cancer Program. The event marked the return of the initiative following a pause during the COVID-19 pandemic and showcased the breast reconstruction program at CMH, led by Dr. Sawa. Attendance exceeded 100 participants, with a strong focus on patient education, empowerment, and peer connection. The program featured presentations from surgical and physician leaders and provided a supportive environment for open dialogue, including opportunities for patients to engage with individuals who had undergone reconstruction. Hands-on components, such as private viewing sessions, supported informed decision-making. Given the positive patient impact and strong physician engagement, planning is underway to establish this as an annual event.

   A departmental quality review was presented regarding a 2025 case involving a patient requiring urgent surgery following an Emergency Department presentation for a gastrointestinal bleed. While no patient harm occurred, several process gaps were identified, including communication breakdowns between the ED, OR, and PACU, incomplete transfer of information, unclear orders, and the absence of a defined process for priority one (P1) surgical cases. Concerns were also noted regarding the interim practice of transferring patients to PACU, which may introduce safety risks. In response, a revised process has been implemented whereby an operating room

attendant facilitates direct transfer from the ED to the OR, improving continuity and reducing delays. The new process has been communicated to key stakeholders, with early indications demonstrating improved workflow and no further concerns reported.

An update was also provided on ongoing collaboration with the University of Waterloo to improve operating room efficiency. Building on prior work in OR grid optimization, a new software tool ("Picktacular") has been introduced to support the analysis and standardization of surgeon pick lists, including instruments and supplies used during procedures. The tool enables comparison across surgeons, identification of variation, and assessment of cost implications, replacing a previously manual and resource-intensive process. The initiative is expected to enhance standardization and drive cost efficiency, with implementation supported by Decision Support. Further updates on rollout and impact are anticipated.

The Committee received an overview of the planned implementation of an Anesthesia Assistant (AA) role, identified as a significant advancement aligned with established team-based anesthesia care models widely adopted in other centres. The introduction of AAs at CMH is expected to enhance operational efficiency, particularly in high-demand operating rooms, by supporting medication and equipment preparation and improving workflow during case transitions. The AA role will also strengthen patient safety and clinical responsiveness by providing an additional qualified provider to monitor anesthetized patients when anesthesiologists are required to respond to simultaneous urgent needs. AAs are trained to perform key clinical functions, including airway management, sedation support, and vascular access, enabling timely intervention for unstable patients. Additional benefits include improved access to anesthesia services across the organization, including support for emergency response outside the operating room and facilitation of regional anesthesia procedures, which may improve surgical efficiency and reduce reliance on general anesthesia for higher-risk patients. The implementation is also expected to support physician recruitment efforts, as the model aligns with current training environments and expectations among anesthesia residents. Overall, the AA program represents an important step in advancing care delivery, improving efficiency, and aligning CMH with modern anesthesia practice.

A Committee member requested clarification regarding surgical volume metrics, noting discrepancies between reported totals and subcategory figures. In response, the Director confirmed that main operating room volumes exclude procedures performed in other areas, such as cataract surgeries at the Clear Vision site and cases in the Minor Surgery department, which are reported separately.
The Director also noted that recent surgical activity has been elevated due to temporary COVID-19 recovery funding aimed at addressing backlogs, particularly in cataracts and joint replacement procedures, as well as expanded capacity following post-construction operating plans. Volumes are expected to decline in 2026–2027, aligning with funded levels under the Quality-Based Procedure framework, as incremental funding will no longer be available and exceeding allocated volumes does not generate additional reimbursement.

A Committee member expressed appreciation for the comprehensive presentation and acknowledged the breadth and complexity of the surgical program. Particular recognition was given to the Medical Device Reprocessing (MDRD) team for their critical, yet often under-recognized, contribution to patient safety. The member also commended the program's consistently high patient satisfaction scores, as reflected in Qualtrics data and supported by positive patient and family feedback. Clarification was sought regarding the "Picktacular" initiative, with the Director confirming that the project received a Sustainability Design Award through the University of Waterloo, with

supporting documentation available. The Committee also discussed potential recruitment considerations for the planned Anesthesia Assistant (AA) role. The Chief, Anesthesia noted that while initial recruitment may be challenging given the newness of the program and single-position rollout, there has been early informal interest. Strategies such as engaging AA students through training placements are expected to support future recruitment, alongside the department's strong team culture and positive working environment as key attractors.

A Committee member expressed appreciation for the presentation, particularly recognizing the inclusion of frontline leadership demonstrated by an Operating Room Attendant (ORA), highlighting the value of acknowledging contributions from all roles within the care team. Interest was also expressed in the "Picktacular" initiative, with a request for information on comparative analysis and realized cost savings.
The Director advised that the tool was recently implemented and, while early indications suggest potential cost savings through standardization of surgical pick lists, these have not yet been quantified. Initial analysis will focus on high-volume, high-cost areas such as orthopedics, and the tool includes supporting documentation to guide implementation. The Director also acknowledged the contributions of the highlighted team member, emphasizing her strong advocacy, commitment to quality improvement, and positive impact on staff and patient experience. The Committee member further expressed interest in applying the Picktacular tool within the Endoscopy program, and the Director confirmed that relevant data is available and will be shared.

A Committee member expressed strong appreciation for the Breast Reconstruction Awareness Day (BRA Day), highlighting personal attendance at a previous event and commending the quality of the program, including patient stories, partner contributions, and overall engagement. Support was conveyed for the continuation of the initiative given its positive impact. The Committee also discussed the strategic direction for overtime (OT) in 2026–2027. The Director identified overtime management as a key operational focus, particularly in the OR and PACU, where after-hours callbacks are a significant driver. Efforts are underway to better differentiate and manage overtime incurred during regular and after-hours operations, including optimizing daytime scheduling to reduce reliance on overtime. Overtime pressures were noted to be multifactorial, including staffing shortages, sick coverage, patient acuity, and flow challenges such as transportation requirements. While some recent increases were attributed to temporary factors, improvements are being observed. Ongoing mitigation strategies include oversight through an overtime task force, enhanced scheduling practices, cross-unit collaboration, and proactive staffing management. Overtime remains a key operational risk requiring sustained attention.

A Committee member sought clarification on whether cataract procedures performed at the Clear Vision site are included within CMH reporting. The Director confirmed that while these volumes are incorporated into overall CMH metrics, they are also tracked and reported separately to differentiate off-site activity from on-site surgical volumes. Director further noted ongoing collaboration with Clear Vision leadership and identified opportunities to adopt elements of their care model—particularly related to efficiency and throughput—to inform and enhance CMH's cataract program.

A Committee member sought clarification on the "on-time OR start" metric. The Director confirmed that this is an externally defined measure under Ontario Health's Surgical Efficiency Target Program (SET-P), reported monthly alongside other performance indicators such as turnaround times. Recent improvements have been observed, with only a small number of operating rooms requiring ongoing monitoring. Discussion also addressed specimen labeling errors, with confirmation that the target remains zero. The Director noted that recent increases were primarily linked to

workflow issues in surgical daycare and minor procedures areas. Corrective actions, including staff communication and process reinforcement, have been implemented. It was also highlighted that reported data reflects a three-month aggregate, capturing earlier periods of higher error rates. Ongoing monitoring and education are in place to support sustained improvement. *(The program presentation is included in Package 2.)*

2. **Patient Experience – Semi-Annual Report:** The Committee received the semi-annual Patient Experience/Relations report, presented in alignment with requirements under the Excellent Care for All Act. The report was structured in two parts, with the initial focus on performance metrics, including patient relations case volumes and Qualtrics survey data, followed by a subsequent update on program initiatives and ongoing project work. Patient Relations case volumes have increased by approximately 10% year over year, approaching 1,000 files annually, indicating a sustained high workload. While complaints have slightly decreased and compliments have increased, there has been a notable rise in requests, largely attributed to the centralized lost belongings process, which is now stabilizing following earlier implementation efforts.

   Patient experience survey data continues to mature, with improved response rates driven by enhanced collection of patient email addresses. Surgical Day Care was highlighted for strong performance, achieving both high response volumes and top satisfaction scores. The Emergency Department has also demonstrated improvement, with increased patient experience scores since October, though continued focus remains necessary. Internal complaint rates, standardized per 1,000 patient encounters, demonstrate overall improvement across most programs, with targeted review underway for areas requiring further attention. Qualitative feedback continues to identify communication—particularly clarity of expectations and next steps—as the primary driver influencing patient experience.

   A Committee member inquired whether lost items reported through the Patient Relations process commonly include medically necessary belongings. The Director, Patient Experience, Quality, Privacy, Risk & IPAC confirmed that many reported items are essential medical devices, such as eyeglasses, dentures, hearing aids, and mobility aids. It was noted that the centralized lost belongings initiative was initially designed to focus on these medically necessary items, supported by visual prompts within care areas to improve tracking and recovery. Over time, the scope has expanded to include all lost belongings; however, medically necessary items continue to represent a significant proportion of reported cases.

   A Committee member commended the strong patient experience performance, with particular recognition of the Med B unit for achieving results exceeding prior benchmarks. Interest was expressed in identifying transferable lessons that could be applied across the organization. In response, the Director and Leadership attributed Med B's success to a combination of factors, including the transition to a newly renovated care environment and enhanced supports for longer-stay patients. Key elements included improved dining and social spaces, as well as the integration of recreational therapy services, which were identified as significant contributors to improved patient experience outcomes. *(The program presentation is included in Package 2.)*

3. **Patient Experience Plan – Annual Update:** The Committee received an update on the 2022–2027 Patient Experience Plan, a corporate initiative aligned with the organization's strategic priorities. The finalized Patient Declaration of Values has been implemented and is now publicly displayed across the hospital to support awareness and engagement. The centralized lost belongings initiative continues to evolve, with support from Project SEARCH interns contributing to process standardization and the

development of accessible, pictograph-based tools. Their involvement has enhanced workflow and team engagement. Improvements to language interpretation services were also highlighted following the rapid implementation of the LINGO platform, with early adoption demonstrating positive results. Progress was also noted on the My Connected Care patient portal, being advanced in collaboration with regional partners, including WRHN. The dual-branded portal will integrate with the Oracle system and is progressing alongside ongoing promotion of ConnectMyHealth, supported by strong partner engagement.

A Committee member recommended improving patient access to pathology results through the patient portal, noting that other organizations provide results following physician review and that timely access would benefit patients and families.
In response, the Director, Patient Experience, Quality, Privacy, Risk & IPAC confirmed that pathology results are currently available through ConnectMyHealth with an approximate 35-day delay. It was noted that access timelines within the My Connected Care portal may differ and would require alignment among regional partners. Adjustments to access are technically feasible, pending joint decision-making.

A Committee member sought clarification on whether the Patient Experience Plan scorecard should include defined numerical targets and actual performance data.
In response, the Director, Patient Experience, Quality, Privacy, Risk & IPAC clarified that the plan is structured around key milestones rather than quantitative targets. Progress is therefore reported through qualitative updates and milestone achievement rather than numeric performance indicators.

A Committee Member raised a question regarding how access to patient information is managed within the My Connected Care and ConnectMyHealth portals when a patient is not directly accessing their information, such as in cases involving family members or substitute decision-makers. In response, the Director Patient Experience, Quality, Privacy, Risk & IPAC explained that within ConnectMyHealth, patients can designate proxy access, allowing them to authorize another individual to view their health information. This proxy access can be customized to allow full or partial visibility of the patient's information. Noted that while there is a technical component to setting up proxy access, support is available on-site to assist patients with registration and navigation. For the My Connected Care portal, detailed processes are still under development; however, it is anticipated that similar functionality will be available.
A Committee member expressed appreciation for patient experience initiatives and inquired about how the LINGO language interpretation service is accessed and whether it is patient-initiated or staff-driven. The Director, Patient Experience, Quality, Privacy, Risk & IPAC confirmed that access is both patient- and staff-initiated. Patients are informed of available services through multilingual signage at registration points, while frontline staff can proactively identify language needs and provide interpretation support. It was noted that 21 interpretation tablets have been deployed across the organization, each with designated locations to ensure accessibility and timely use, supporting improved communication for patients requiring language assistance. *(The program presentation is included in Package 2.)*

4. **Medical Health Human Resources Plan:** The Committee received an overview of the Medical Health Human Resources Plan, presented for information and aligned with prior review by the Resources Committee. The plan is focused on three interconnected priorities, with initial emphasis on building a sustainable workforce. Key challenges include ensuring the appropriate number and mix of physicians across specialties in a highly competitive recruitment environment. Positive progress was noted, including successful recruitment in over 75% of core specialties, the introduction of international

recruitment strategies, and the implementation of an electronic credentialing system to improve onboarding efficiency.
Next steps focus on addressing remaining recruitment gaps in critical areas such as Emergency, Pediatrics, and Cardiology. Strategies include strengthening training and education pathways, developing fellowship opportunities, and advancing team-based models of care. Building on existing clinical strengths was identified as essential to supporting program growth and more advanced care delivery.
A significant emphasis was placed on strengthening medical leadership and fostering a culture of excellence. Initiatives include investment in leadership development programs, adoption of standardized leadership frameworks, and implementation of a hospital-wide quality improvement program. These efforts are supported by structured talent management, performance monitoring, and educational forums to promote continuous learning and improvement.
The importance of physician well-being was also highlighted, with recognition of burnout and administrative burden as key risks. Mitigation strategies include establishing a physician wellness lead, implementing AI-supported documentation tools, and expanding access to wellness supports. Digital innovation and partnerships with academic institutions are expected to further enhance recruitment, retention, and workload management. Overall, the plan's core themes—building a sustainable workforce, developing leaders, and investing in people—were noted as mutually reinforcing, with positive progress achieved to date.

A Committee member raised a question regarding potential risks associated with AI-supported dictation, referencing external concerns about accuracy and errors.
In response, the Chief of Staff confirmed that CMH has established formal AI governance, including organizational policies and oversight processes to guide the safe and responsible use of AI tools. It was noted that AI-supported technologies are subject to review through established governance structures, including the Research and Innovation Committee, ensuring appropriate safeguards and risk mitigation are in place.

In response to concerns regarding AI-supported dictation, the Chief of Staff outlined CMH's structured governance framework, emphasizing that all AI tools undergo a rigorous approval process aligned with organizational policy and informed by regulatory guidance (e.g., CMPA and CPSO). The organization utilizes a single vetted vendor, restricts alternative tools, and requires physician attestations to ensure appropriate use. Ongoing oversight, including annual reviews, is in place, and no issues consistent with those identified in the Auditor General's report have been observed to date. It was acknowledged that AI-supported documentation introduces inherent risks, particularly as it requires physicians to shift from generating documentation to reviewing and editing machine-generated content. To mitigate this, implementation has been intentionally limited in scope, supported by strong governance, monitoring, and evaluation processes. A phased approach is being taken to ensure safe adoption, with appropriate training, oversight, and safeguards in place as integration advances, including alignment with the upcoming HIS environment.

A Committee member commended the emphasis on academic appointments within the Medical HR Plan and highlighted the importance of supporting physician advancement beyond initial academic ranks, particularly for clinician-educators. The member offered support in guiding promotion processes and emphasized the need to clarify that advancement is not solely dependent on research output.
An external update was also provided regarding recent federal discussions on medical assistance in dying (MAiD) for mental health, with an indication that policy advancement in this area is unlikely at this time. In response, the VPMO and Chief of Staff acknowledged the importance of developing local expertise and mentorship to support academic progression. They also highlighted the value of aligning educational

initiatives, such as Grand Rounds, with emerging topics of clinical and system relevance, including MAiD.

A Committee member inquired about how patient consent is managed when using AI-supported transcription during clinical encounters. In response, the Chief of Staff confirmed that obtaining patient consent is a mandatory requirement prior to use. Patients must be informed and provided the option to decline, in which case AI-supported transcription is not used. It was noted that patient familiarity with similar technologies in community settings has contributed to broader acceptance, while safeguards remain in place to ensure patient preferences are respected. *(The program presentation is included in Package 2.)*

5. Strategic Priorities Tracker – Q4: The Committee received the Q4 Strategic Priorities Tracker, providing an overview of organizational progress, with a focus on quality and patient flow indicators. Overall, solid progress has been achieved across foundational priorities, including digital transformation, workforce stabilization, and financial sustainability. However, ongoing system pressures persist, particularly related to patient flow and access, including occupancy, discharge performance, and Emergency Department metrics. It was noted that the tracker will be refreshed to align with 2026–2027 organizational priorities, with updated Q1 performance data and revised action plans to be presented to Board committees in September.
   In response to a Committee inquiry, Leadership confirmed that there are no current indications from the Ministry suggesting increased supervision or oversight of the organization, with recent regional interactions providing reassurance. *(Further information provided in consent agenda item 1.5.8)*

6. Quality & Patient Safety Plan- Update: The Committee received a Quality and Patient Safety Plan update, highlighting progress across four key priority areas. Under Culture, continued implementation of Just Culture education was noted across all levels of the organization, supported by tools such as the Just Culture Decision Tree and enhanced event tracking through SafeTCast to improve consistency and transparency.
   Under Robust Processes, strong frontline engagement was demonstrated through Best Practice Committee initiatives, including projects such as “Discovery Day” to enhance care for individuals with developmental disabilities. Additional advancements included expanded patient safety dashboards, standardized incident management processes, and positive trends in safety culture metrics.
   Progress in Medication Safety included preparation for barcode-enabled workflows aligned with the new HIS, updates to high-alert medication standards, implementation of a narcotic destruction process, and introduction of new pharmacy technologies to improve safety and efficiency. Under Safe Transitions, key achievements included the successful implementation of the CMH@Home program, improved communication with long-term care partners, and strengthened community partnerships. Overall, the update reflected steady progress, strong frontline involvement, and continued collaboration across the organization. *(The full update is included in Package 2.)*

7. Incident Analysis- Precursor Safety Evens (Level 1 & 2): The Committee received an overview of precursor safety event reporting, defined as low-severity incidents where no patient harm occurs. It was emphasized that higher reporting rates reflect a stronger safety culture, characterized by increased psychological safety, staff engagement, and trust in reporting processes. Reporting volumes have remained stable over the past seven years, with precursor events accounting for approximately 80% of all reported incidents. Common categories include medication-related events, care coordination issues, patient falls, and laboratory specimen incidents, with data used to identify system vulnerabilities and inform proactive improvements.

Survey results from the Global Workforce Survey demonstrated positive trends in organizational culture, including improvements in learning, communication, and follow-up on incident reporting, indicating continued maturation of the organization's safety culture. In response to a Committee inquiry regarding workload pressures, it was clarified that survey findings—indicating that 51% of staff felt they were caring for more patients than they could safely manage—were reported at an aggregate organizational level. More detailed, department-specific analysis is limited due to privacy protections intended to support psychological safety and encourage candid staff participation. *(The full update is included in Package 2.)*

8. **Quality Monitoring Scorecard**: The Committee noted that the indicators presented largely duplicated those reviewed through the Strategic Priorities Tracker, particularly in relation to patient flow and access. Given the earlier comprehensive discussion, detailed review was deferred. It was highlighted that eleven indicators are currently trending out of target, including two workforce-related metrics (sick time and overtime) and nine related to patient flow and access, consistent with previously identified system pressures.
   In response to a Committee inquiry regarding the timing of updates for the 30-day COPD readmission metric, it was clarified that these indicators rely on coded data, resulting in inherent reporting delays. As such, they are typically reported retrospectively and are reviewed in greater detail through the appropriate oversight committee. *(Further information provided in consent agenda item 1.5.8)*

9. **Medical Advisory Committee Update:** The Committee received a brief update indicating that recent Medical Advisory Committee discussions have primarily focused on preparation for the upcoming Health Information System (HIS) implementation. Significant effort has been dedicated by physicians and subject matter experts to the development, review, and standardization of clinical order sets ("power plans") to ensure alignment with CMH and partner practices, supporting safety, usability, and readiness for training and clinical use.
   Additional updates included departmental presentations from Anesthesia and Laboratory Services, highlighting ongoing modernization efforts and contributions to patient care. Participation in an upcoming Quality Initiative Program ("Theatre of Medicine") was also noted, aimed at enhancing physician leadership and non-clinical competencies, supporting continuous professional development. *(Further information provided in consent agenda item 1.5.6.5)*

10. **OHT Quarterly Update:** Leadership provided an update on Ontario Health Team (OHT) activities, highlighting the introduction of a revised reporting format under new leadership to enhance clarity and oversight. A $3.7 million investment in primary care was noted, supporting initiatives such as the Scope Clinic and Primary Care Connect Clinic to improve access for unattached patients. The OHT performance scorecard reflects a mix of indicators meeting targets and areas requiring improvement. Leadership emphasized a commitment to providing timely and regular reporting, along with ongoing sector updates to support transparency and informed oversight. *(The full update is included in Package 2.)*

Agenda Item 4.2

BRIEFING NOTE

Date: **May 26, 2026**
Issue: **Next CMH Strategic Planning Cycle**
Prepared for: **Board of Directors**
Purpose: ☒ **Approval** ☒ **Discussion** ☐ **Information** ☐ **Seeking Direction**
Prepared by: **Mari Iromoto – VP, People & Strategy**
Approved by: **Patrick Gaskin, President & CEO**

Attachments/Related Documents: None

Alignment with 2025/26 CMH Priorities:

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

Executive Summary
This briefing note is presented to the Board for endorsement of a proposed two-year extension of the current 2022–2027 Strategic Plan, approved in June 2022 and originally anticipated to be renewed by June 2027. Considering the significant organizational priorities impacting capacity, it is proposed that the current Strategic Plan be extended through 2029, with development of the next Strategic Plan commencing in Fall 2027 and Board approval targeted for October 2028. The subsequent Strategic Plan would cover the period 2029–2034. This approach reflects feedback received from the Governance & Nominating Committee and supports a deliberate, phased approach to organizational planning while maintaining continuity and strategic focus.

In parallel, CMH will advance its rebranding initiative - building on work initiated in 2025 with Design de Plume and intentionally paused - to align with the next Strategic Plan. This integrated approach will enable coordinated staff and community engagement and support a unified launch of a refreshed CMH brand alongside the new 2029–2034 Strategic Plan. The proposed alignment of strategic planning and rebranding activities also reflects a coordinated and financially responsible approach to future organizational investments.

Background
The organization is currently guided by the 2022–2027 Strategic Plan, approved by the Board in June 2022. The next Strategic Plan was originally anticipated for approval in June 2027. Over the next 12–24 months, CMH is managing several concurrent, resource-intensive priorities, including the HIS go-live in November, workforce pressures, system transformation initiatives, and broader health system demands. Collectively, these

pressures constrain the organization's capacity to undertake additional major initiatives in the near term.

In 2025, CMH initiated work with Design de Plume to refresh its brand identity. This work was subsequently paused to ensure alignment with the next Strategic Plan, recognizing the importance of integrating a refreshed organizational identity with future strategic direction.

Analysis

Extending the current Strategic Plan through 2029 reflects a deliberate and sequenced approach to managing organizational capacity and ensuring quality outcomes. While the HIS implementation is a significant factor, it is one of several competing priorities impacting the organization.

Advancing a full strategic planning process currently presents risks, including:

- Limited capacity for meaningful engagement across staff, physicians, and partners
- Reduced ability to conduct thorough analysis and consultation
- Potential misalignment with a rapidly evolving internal and external environment

Extending the current plan will enable CMH to:

- Achieve greater operational stability across multiple priority areas
- Incorporate lessons learned from HIS and other major initiatives
- Engage stakeholders more effectively and comprehensively
- Position the next Strategic Plan within a more stable, post-implementation context

Importantly, the proposed timing creates an opportunity to intentionally integrate the strategic planning process with the CMH rebranding initiative. This integrated approach will:

- Ensure alignment between CMH's strategic direction and its refreshed brand identity
- Strengthen organizational clarity, positioning, and storytelling
- Leverage a coordinated engagement process with staff, physicians, community members, and partners
- Maximize impact through a unified launch of the new Strategic Plan and refreshed brand

Strategic planning and rebranding activities will proceed in parallel beginning in Fall 2027, with coordinated consultation activities to inform both streams of work. The proposed timeline supports a comprehensive, inclusive, and integrated process culminating in Board approval of the new 2029–2034 Strategic Plan in October 2028 and launch in 2029.

To ensure continuity during the extension period, CMH's existing corporate plans will continue to evolve through regular annual updates and reporting processes aligned with the Board Committees' workplan schedule. The current corporate plans will be timed to extend through to March 2029.

Following the October 2028 approval of the new Strategic Plan, development of the next set of corporate plans will occur over approximately 3–6 months to ensure alignment with the new strategic directions and support timely operationalization.

The proposed integrated approach also reflects consideration of the financial investment associated with rebranding activities. Aligning the rebranding initiative with the development and launch of the next Strategic Plan is intended to maximize organizational

value, streamline engagement and communication activities, and reduce the need for separate implementation and launch processes.

Consultation
Preliminary discussions have been held with the Senior Leadership Team regarding timing, capacity, and risks. Initial engagement has also begun with Design de Plume to consider next steps for the rebranding work.

The proposed extension and revised planning timeline were also reviewed with the Governance & Nominating Committee, whose feedback has informed this recommendation and the proposed approach to maintaining continuity through existing corporate planning and reporting mechanisms.

Governance & Nominating Committee discussion also emphasized the importance of being mindful of the financial implications associated with rebranding activities. The proposed approach to align rebranding with the future Strategic Plan reflects this feedback and is intended to support a coordinated and cost-conscious implementation approach.

Early outreach with external partners, including the City of Cambridge, has been initiated as one component of broader alignment considerations across the health system and community. Future consultation will integrate both strategic planning and rebranding engagement with staff, physicians, patients, and community stakeholders.

Next Steps
- Seek Board endorsement of the proposed extension of the current Strategic Plan through 2029 and approval of the revised planning timeline
- Continue monitoring organizational capacity and readiness post-HIS go-live
- Re-engage Design de Plume to refine scope and timing of the rebranding initiative
- Develop an integrated roadmap for strategic planning and rebranding in late 2026
- Continue advancing and monitoring corporate plans through annual status updates aligned with Board Committees' workplan schedules
- Plan and implement coordinated engagement processes beginning in Fall 2027
- Initiate development of new corporate plans following approval of the 2029–2034 Strategic Plan

Agenda Item 4.3

BRIEFING NOTE

Date: May 28, 2026
Issue: Approach to 2026/27 Board & Committee Goals
Prepared for: Board of Directors
Purpose: ☐ Approval ☒ Discussion ☐ Information ☒ Seeking Direction
Prepared by: Patrick Gaskin, President & CEO
Approved by: Diane Wilkinson, Vice Chair

Attachments/Related Documents: None

The CEO and the Vice Chair (Incoming Chair) met to discuss a streamlined approach to Board and committee goals for 2026/27 in recognition of current leadership and staff capacity pressures due to the implementation of the HIS. Rather than establishing separate committee-specific goals, the proposed approach is for each committee to monitor the progress and impact of the HIS within its existing mandate and workplan. This would keep HIS oversight visible across the Board's committee structure, support governance focus on a key organizational priority, and avoid creating additional planning and reporting requirements for staff. This matter is being brought forward to the Board of Directors to determine whether there is support for this approach for 2026/27.

Next Steps
The Board of Directors should discuss whether separate committee goals are required for 2026/27 or whether committees can instead incorporate oversight of HIS progress and impact into their existing mandates and annual workplans. Subject to Board feedback, the agreed approach should be confirmed and reflected in 2026/27 committee planning materials.