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 December 3, 2025
1700-1830
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#

CAMBRIDGE MEMORIAL HOSPITAL

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 October 1, 2025*	6			
1.5.2 2025/26 Board of Directors Action Log*	11			
1.5.3 Board Attendance*	12			
1.5.4 Board Work Plan*	13			
1.5.5 Events Calendar*	21			
1.5.6 Committee Reports to the Board of Directors				
1.5.6.1 Audit Committee* (Nov 17, 2025)	23			
1.5.6.2 Digital Health Strategy Committee* (Nov 20, 2025)	24			
1.5.6.3 Executive Committee* (Nov 18, 2025)	26			
1.5.6.4 Governance and Nominating Committee* (Oct 9 & Nov 13, 2025)	28			
1.5.6.5 Medical Advisory Committee* (Oct 8 & Nov 12, 2025)	33			
1.5.6.5.1 New Credentialed Physicians September & October 2025*	36			
1.5.6.6 Resources Committee* (Nov 24, 2025)	41			
1.5.7 Governance Policy Approvals*	43			

2-A-17	Digital Health Strategy Committee Terms of Reference
2-B-10	Succession Planning for the President & Chief Executive Officer, Chief of Staff and Executive Team
2-B-15	Recruitment and Selection of the President & Chief Executive Officer and Chief of Staff
2-B-20	CMH Executive Compensation Policy
2-B-25	President & Chief Executive Officer & Chief of Staff Annual Performance Review
2-C-10	Quality and Patient Safety
2-C-34	Approval & Signing Authority

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

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

Agenda Item * indicates attachment / TBC – to be circulated	Page #	Time	Responsibility	Purpose
2-C-38 Investment Policy 2-D-04 Board and Committee Annual Work Plans 2-D-48 Whistleblower Policy				
1.5.8 2025/26 Strategic Priorities Q2 Update*	80			
1.5.8.1 Quality Monitoring Metrics Scorecard*	85			
1.5.9 CEO Certificate of Compliance* (September 26, 2025 – November 28, 2025)	127			
1.5.10 CMH President & CEO Report*	128			
1.6 Confirmation of Agenda		1709	L. Woeller	Motion
1.7 Motion to move to *IN-CAMERA*		1710	L. Woeller	Motion
2. PRESENTATIONS				
2.1 Major Gifts Presentation by the CMHF*	131	1715	K. Wilson/C. Barker	Information
2.2 Motion to move out of *IN-CAMERA*		1729	L. Woeller	Motion
3. BUSINESS ARISING				
3.1 No Open Matters for Discussion				
4. NEW BUSINESS				
4.1 Chair's Update				
4.1.1 Board Chair's Report*	134	1730	L. Woeller	Information
4.2 Governance Committee (Oct 9 & Nov 13, 2025)				
4.2.1 HSO Governing Body Assessment – Final Survey Questions and Timeline*	140	1735	J. Goyal	Motion
4.2.2 Proposed Changes to the Non-Director Peer Assessment Process*	142	1740	J. Goyal	Motion
4.2.3 Proposed Process Change of Review of Terms of Reference and Workplans*	144	1745	J. Goyal	Motion
4.2.4 2-D-19 Selection of Officers Policy*	145	1750	L. Woeller	Motion
4.2.5 Selection of Interview Team*	149	1800	J. Goyal	Motion
4.3 Quality Committee (Oct 15 & Nov 19, 2025)				
4.3.1 Report to the Board of Directors*	151	1805	B. Conway	Information
4.4 Resources Committee (Nov 24, 2025)				
4.4.1 Financial Statements – October 2025*	162	1815	P. Brasil	Motion
4.5 Patient Family Advisory Council (PFAC) Update (Oct 7 & Nov 4, 2025)		1820	L. Woeller	Information
4.6 CEO Update				
4.6.1 No Open Matters for Discussion				
5. UPCOMING EVENTS ***Visit GovHub for the most current listing of all upcoming events***		1825	L. Woeller	Information
5.1 Grand Rounds: November 27, 2025 – 8:00-9:00am, virtual, *Details to follow*				
5.2 CMH Holiday Staff Meal: December 4, 2025 – 11:00-2:00pm / 9:00-10:00pm				
5.3 Grand Rounds: January 22, 2026 – 8:00-9:00am, virtual, *Details to follow*				

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

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Agenda Item * indicates attachment / TBC – to be circulated	Page #	Time	Responsibility	Purpose
5.4 20th Annual Amigas Gala: February 21, 2026 – 5:30pm – 12:00am, Oriental Sports Club – *Details to Follow*				
5.5 Grand Rounds: February 26, 2026 – 8:00-9:00am, virtual Details to follow				
5.6 CMHReveal: February 27, 2026 – 5:30pm-12:00am, Tapestry Hall - CMHReveal 2026 - Cambridge Memorial Hospital Foundation				
5.7 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				
6. DATE OF NEXT MEETING	Wednesday February 4, 2026 (Generative Session) Location: Hybrid			
7. TERMINATION		1830	L. Woeller	Motion
Link: Board/Committee Evaluation Survey	*Following the meeting, please complete within one week.*			

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

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

CAMBRIDGE MEMORIAL HOSPITAL

CMH Board of Directors Motions Page

<table>
<tr><th>Agenda Item</th><th colspan="2">Motions Being Brought Forward for Approval – December 3, 2025</th></tr>
<tr><td>1.5</td><td>Consent Agenda</td><td>• That, the CMH Board of Directors approves the Consent Agenda as presented/amended
The following motions are contained in the Consent Agenda:
o That, the Board of Directors approves the following polices as presented/with amendments and upon recommendation of the Governance and Nominating Committee at its meeting of October 9, 2025 and November 13, 2025.
<table>
<tr><td>2-A-16</td><td>Digital Health Strategy Committee Terms of Reference</td></tr>
<tr><td>2-B-10</td><td>Succession Planning for the President & Chief Executive Officer, Chief of Staff, and Executive Team</td></tr>
<tr><td>2-B-15</td><td>Recruitment and Selection of the President & Chief Executive Officer and Chief of Staff</td></tr>
<tr><td>2-B-20</td><td>CMH Executive Compensation Policy</td></tr>
<tr><td>2-B-25</td><td>President & Chief Executive Officer & Chief of Staff Annual Performance Review</td></tr>
<tr><td>2-C-10</td><td>Quality and Patient Safety</td></tr>
<tr><td>2-C-34</td><td>Approval & Signing Authority</td></tr>
<tr><td>2-C-38</td><td>Investment Policy</td></tr>
<tr><td>2-D-04</td><td>Board and Committee Annual Work Plans</td></tr>
<tr><td>2-D-48</td><td>Whistleblower Policy</td></tr>
</table></td></tr>
<tr><td>1.6</td><td>Confirmation of Agenda</td><td>• That, the agenda be adopted as presented/amended</td></tr>
<tr><td>1.7</td><td>Move to IN-CAMERA</td><td>• Motion that, the Board of Directors move to IN-CAMERA.</td></tr>
<tr><td>2.2</td><td>Move out of IN-CAMERA</td><td>• Motion that, the Board of Directors move out of IN-CAMERA.</td></tr>
<tr><td>4.2.1</td><td>HSO Governing Body Assessment</td><td>• That, the Board of Directors approves the following questions for inclusion in the Health Standards Organization (HSO) Governing Body Assessment, and upon recommendation from the Governance and Nominating Committee at its meeting of October 9, 2025:
1. We are informed about significant risk issues in a timely manner.
2. There is a sound plan for the CEO’s development and succession.
3. The organization engages relevant stakeholders when considering strategic planning and service integration opportunities.
4. There is sufficient diversity of skills, experience, and backgrounds for good governance.
5. In-camera sessions are used appropriately.
6. The consent agenda is utilized effectively without compromising oversight and important items are flagged for detailed discussion when necessary.
7. We can apply knowledge gained from educational/generative discussions to our Board responsibilities and decision-making processes.
8. As Board members, our contributions effectively support the organization’s goals and initiatives related to Diversity, Equity, and Inclusion (DEI).
9. We have sufficient training opportunities and a clear understanding of where to access resources.
10. The Board demonstrates accountability and transparency to government and other key stakeholders.</td></tr>
</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, Stephanie Pearsall, Dr. Mark Shafir

Agenda Item	Motions Being Brought Forward for Approval – December 3, 2025	
4.2.2	Peer Assessment Process	• That, the Board of Directors approves the discontinuation of the peer evaluation survey for non-Director Committee members and adopting the process as outlined below that will be further reflected in policy 2-A-38 Role of Committee Chair, and as recommended by the Governance and Nominating Committee at their meeting of November 13, 2025.
4.2.3	Terms of Reference / Workplan Review	• That, the Board of Directors adopt a standard annual review process for Board/Committees to review the Committee Terms of Reference and Workplans and upon recommendation of the Governance and Nominating Committee at its meeting of October 9, 2025.
4.2.4	2-D-19 Selection of the Officers Policy	• That, the Board of Directors approves and adopts policy 2-D-19 Board Officer Selection Process as presented, and upon recommendation of the Governance and Nominating Committee at its meeting of November 13, 2025.
4.2.5	Interview Team	• That, the Board appoints the following internal individuals as part of the interview team for the 2026-27 Board and committee member recruitment and upon recommendation of the Governance and Nominating Committee at its meeting of November 13, 2025.recommended by the Governance and Nominating Committee at their meeting of November 4, 2025: Julia Goyal Diane Wilkinson Jayne Herring Tom Barker
4.4.1	October 2025 Financial Statements	• That, the Board of Directors receives the October 2025 financial statements as presented by management and upon recommendation of the Resources Committee at its meeting of November 24, 2025.

Cambridge Memorial Hospital
BOARD OF DIRECTORS MEETING
Wednesday, October 1, 2025
OPEN SESSION

Minutes of the open session of the Board of Directors meeting, held via hybrid model (video conference and within Cambridge Memorial Hospital, C.1.229) on October 1, 2025.

Present:

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

Regrets: Dr. V. Miropolsky

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

Guests: K. Leslie

Recorder: S. Fitzgerald

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

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

1.2. **Welcome**
The Chair welcomed the Board members and guests to the meeting and introduced Dr. Kunuk Rhee to the Board of Directors meeting.

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

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

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

No items were removed.

The Consent Agenda was approved as presented:

1.5.1 Minutes of June 25, 2025 and Open (2)
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
1.5.5.1 Healthcare Quality Canada Conference
1.5.6 Committee Reports to the Board of Directors
Digital Health Strategy Sub-Committee Report to the Board of Directors (Sept 18, 2025)
Resources Committee Report to the Board of Directors (Sept 22, 2025)
Medical Advisory Committee Report to the Board of Directors (Sept 10, 2025)
1.5.8 CEO Annual Certificate of Compliance
(June 21, 2025 – September 26, 2025)
None opposed, **CARRIED.**

1.6. **Confirmation of Agenda**

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

2. PRESENTATIONS
No presentations.

3. BUSINESS ARISING
No open matters for discussion.

4. NEW BUSINESS

4.1. **Chair's Update**

4.1.1. **Board Chairs Report**
The Board of Directors reviewed the information provided in the pre-circulated meeting agenda package. The Chair thanked the Directors for their support of CMH attending events over the summer.

4.1.2. **2025/26 Board Generative Topics**
The Board of Directors reviewed the briefing note provided in the pre-circulated meeting agenda package. The Chair highlighted that the Board has agreed to reduce the number of generative sessions from three to two, as discussed at the June 25, 2025 Board of Directors meeting. The first session in November will focus on part 2 of the work with Deloitte. The February session will address governance in hospitals. Mini education sessions will take place across the Board and Committees as needed.

4.2. **2025/26 Strategic Priorities Tracker Q1 Updates and Quality Monitoring Metrics**
The Board of Directors reviewed the information provided in the pre-circulated meeting agenda package. CMH Leadership highlighted that the Strategic Priorities Tracker guides senior team discussion, including operations. The 2025/26 version has been refined based on feedback from leaders and committees to improve data clarity and tracking over a 12-month period.

CMH Leadership provided the Board of Directors with Q1 performance highlights. Ambulance offload times have improved significantly, and the Post Construction Operating Plan (PCOP) target has been met. CMH continues to be challenged in meeting the PIA targets.

The Board of Directors received education on the calculation “90th percentile”. An example was provided using Provider Initial Assessment wait-time. Management explained that 90% of patients are seen within the 90th percentile time, while 10% wait longer. The Board suggested providing staff with the educational slide explaining the 90th percentile.

Discussion took place around how frontline staff may perceive these metrics. CMH Leadership noted that the team frames the message positively while recognizing the challenges.

One Director inquired about the automation of time stamping. CMH Leadership highlighted that significant efforts have been made over the past year, and further enhancements will continue with the implementation of the new HIS.

Additionally, CMH Leadership highlighted that there has been significant momentum in adopting front-end speech technology and Scribe AI in the Emergency Department (ED), enhancing documentation and efficiency.

The Quality monitoring metrics tool now includes monthly trend analysis, flagging indicators outside thresholds to ensure proactive management. Focus areas include organizational flow and overtime staffing.

4.3. **Quality Committee Report to the Board of**

The Board of Directors reviewed and discussed the briefing note included in the pre-circulated meeting agenda package. The Chair of the Quality Committee provided key highlights from the September 17, 2025 meeting. During this meeting, the Committee received a comprehensive presentation from the Pharmacy Department. The presentation included a touching patient story that highlighted how CMH maintained ongoing communication and support post-discharge, which inspired the development of a checklist for patients transitioning home with IV therapy. The presentation also covered important statistics and updates on the master plan for the sterile room.

Committee members had the opportunity to tour the Pharmacy facilities. Additionally, an update was provided on accreditation, noting that the next on-site survey is scheduled for fall 2028 due to changes within Accreditation Canada. The program has been revised to have fewer levels of accreditation (now either accredited or not accredited).

The 2025/26 Quality Committee goals were established and approved during the meeting.

4.4. **August 2025 Financial Statements and Year End Forecast**

The Board of Directors reviewed and discussed the briefing note included in the pre-circulated meeting agenda package. The Chair of the Resources Committee provided key highlights from the September 22, 2025 meeting. CMH is in a $3.5M year-to-date surplus at the end of August after building amortization and related capital grants. This

is primarily due to higher revenue than budget for Quality Based Procedures (QBP) and PCOP ($3.2M) and unused budgeted contingency.

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

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

MOTION: That, the Board receives the August 2025 financial statements as presented by management and upon the recommendation of the Resources Committee at the meeting of September 22, 2025.
None opposed. **CARRIED.**

4.5. **Patient Family Advisory Council (PFAC) Update**

The Board of Directors received highlights from the September 9, 2025 PFAC meeting. Moving forward, PFAC will be included in the integrated risk and management (IRM) process for the 2025-2026 fiscal year, marking a first for the Council. Extensive discussion centered on how PFAC members can enhance the adoption of the Connect My Health tool. It was noted that while Pocket Health is more widely advertised at CMH, it costs money and does not provide as comprehensive information as Connect My Health. Strategies to increase adoption include leveraging volunteers, staff, physicians, and various communication channels.

Additionally, PFAC is redrafting the surgery prep sheet to remove outdated COVID-related language and improve clarity for patients.

4.5.1. **Beryl Institute Experience Assessment**

The Board of Directors reviewed and discussed the briefing note included in the pre-circulated meeting agenda package. Two overall success measures for the PX plan were defined and one was the Beryl Institute Human Experience Index Score. A baseline measurement was conducted in December 2023, and the Beryl Institute recommends measuring this about every 18 – 24 months to assess an organization's patient experience efforts. After consultation with PFAC, the recommendation is to send an invitation to participate to the same target group as 2023 to allow for comparison. Similar to 2023 invitations to participate would be emailed to all members of OPS, all members of PFAC, all members of MAC, and Board members. In addition, in 2023 OPS members were advised that they could extend the invite in a targeted manner (i.e., charge nurses, educators). The survey link will be active beginning October 27, 2025 for 3 weeks, closing on November 17, 2025. Results will be discussed with PFAC at their January 2026 meeting and subsequently with other participating groups (MAC, OPS, Board).

The Chair of the Board encouraged Directors to complete the survey with a goal of 100% completion.

ACTION: CMH to confirm how the survey link is sent to the Board – if sent directly from Beryl, Stephanie Fitzgerald will inform the Board that the link has been sent.

5. UPCOMING EVENTS

The Chair reviewed the upcoming events and encouraged Directors to take part when able. The Chair also highlighted that the CMH Reveal is February 27, 2025 and tickets are now on sale through the CMH Foundation's website.

6. DATE OF NEXT MEETING

The next scheduled meeting a generative session being held on November 4, 2025.

7. TERMINATION

MOTION: That, the meeting terminated at 1750hrs.
None opposed, **CARRIED.**

2025/26 Board of Directors Action Log – December 2025

Meeting Date	Agenda # / Item Description	Action Item	Owner	Status
06-04-25	4.1 Broader Public Sector Accountability Act Attestation	Governance Committee to review the current Board Consent Agenda Policy and discuss the approach to Declarations of Compliance.	Governance Committee	Will be brought to the GNC for final review at the December 2025 meeting.
06-25-25	4.2.2 Care Cupboard	CMH Leadership to provide the Board with updates when items are needed	CMH Leadership	Ongoing
10-01-25	4.5.1 Beryl Institute Experience Assessment	CMH to confirm how the survey link is to be sent – if sent directly CMH will inform the Board that the link has been sent	CMH Leadership	**Complete** – Link was sent October 27 to the Board via email.

Board of Directors Attendance Report 2025/2026

CAMBRIDGE MEMORIAL HOSPITAL

	90%	100%	100%	70%	100%	80%	90%	100%	90%	100%	100%	100%
Meeting Dates	Lynn Woeller	Bill Conway	Diane Wilkinson	Jay Tulsani	Jayne Herring	Julia Goyal	Margaret McKinnon	Miles Lauzon	Monika Hempel	Paulo Brasil	Sara Alvarado	Tom Barker
4-Dec-24	P	P	P	R	NA	P	P	P	P	P	P	NA
5-Feb-25	P	P	P	P	NA	P	P	P	P	P	P	NA
5-Mar-25	P	P	P	P	NA	P	R	P	P	P	P	NA
7-May-25	P	P	P	P	NA	P	P	P	P	P	P	NA
7-May-25	P	P	P	P	NA	P	P	P	P	P	P	NA
4-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
1-Oct-25	P	P	P	P	P	P	P	P	P	P	P	P
5-Nov-25	R	P	P	R	P	R	P	P	P	P	P	P

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

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
01-Oct-25	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					
	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
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)	Delayed
	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	Delayed
	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	Delayed

CAMBRIDGE MEMORIAL HOSPITAL

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

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	Delayed
	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	Delayed
03-Dec-25	4a Corporate Culture					
	ii	overseeing the establishment and monitoring of such a culture through appropriate mechanisms, including assessing the Chief Executive Officer, and Chief of Staff of the Corporation against this expectation	2-B-25 2-B-26	Executive	➢ receive & review the mid-year CEO and COS report and provide input	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 Audit / Quality / Resources	➢ review critical incident reports (as per the Excellent Care for all Act) ➢ receive mid-year IRM report	Due Due
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics ➢ receive and review the Strategic Priorities Tracker	Due
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➢ receive & 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)	Due
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	Due
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	Due
	4g Relationships					
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➢ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	Due
	4i Board Effectiveness					
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➢ review & approve Board policies as recommended by Governance Committee	Due
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events reported through Directors ABCDE Goals	Due
	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	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
	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	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		➢ approve the members of the Nominating Sub-Committee & Interview Team	Due
February 4, 2026 (Generative Session)	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➢ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	
	4i Board Effectiveness					
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➢ review & approve Board policies as recommended by Governance Committee	
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)	
	v	approving operating and capital plans	2-C-31	Resources	➢ review & approve the annual Operating Plan review & approve the Annual Capital Plan	
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics	
	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	

CAMBRIDGE MEMORIAL HOSPITAL

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

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

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➢ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	
	4i Board Effectiveness					
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➢ review & approve Board policies as recommended by Governance Committee	
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events ➢ reported through Directors ABCDE Goals	
June 3, 2026 (Generative Session)	4a Corporate Culture					
	ii	overseeing the establishment and monitoring of such a culture through appropriate mechanisms, including assessing the Chief Executive Officer, and Chief of Staff of the Corporation against this expectation	2-B-25 2-B-26	Executive	➢ receive & review the annual CEO and COS survey results & self-appraisal and provide input	
	4b Strategic Planning					
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality Resources	➢ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker	
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources Audit	➢ receive & approve Declaration of Compliance with MSAA Schedule F ➢ receive & approve Declaration of Compliance with BPSAA Schedule A ➢ receive & approve Certificate of Compliance – Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding (semi-annual) receive the legislative compliance review ➢ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	
	4h Financial Viability					
	ii	ensure that the organization undertakes the necessary financial planning activities so that resources are allocated effectively and within the parameters of the financial performance indicators		Resources	➢ receive updates on how the budget is being developed through the Resources Committee Report to the Board of Directors ➢ receive and approve the year-end financial statements	
	4i Board Effectiveness					

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

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
	i	monitor Board members' adherence to corporate governance principles and guidelines		Governance	➢ Declaration of conflict agreement signed by Directors ➢ Directors Consent to Act ➢ Governance Report to the Board of Directors	
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➢ review & approve Board policies as recommended by Governance Committee	
	4n Director Recruitment, Orientation, and Evaluation					
		The Board shall ensure there is an appropriate, objective, and formal process for the recruitment of Directors, and the evaluation of the Board, the Board Chair, its committees, committee Chairs and individual Directors.	2-D-20		➢ review recommendations for new Directors, non-Director committee members review the results of the annual evaluation surveys through the Governance ➢ Committee Report to the Board of Directors	
	4b Strategic Planning					
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality Resources	➢ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker	
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➢ review critical incident reports (as per the Excellent Care for all Act)	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➢ receive and review the Quality Monitoring Metrics ➢ receive and review the Strategic Priorities Tracker	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➢ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➢ make the final appointment, reappointment, and privilege decisions ➢ ensure the effectiveness and fairness of the credentialing process	
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➢ receive the MAC Report to the Board of Directors	
	4g Relationships					
24-Jun-26		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➢ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	
	4i Board Effectiveness					
	iii	ensure ethical behaviour and compliance with laws and regulations, audit and accounting principles, accreditation requirements and the By-Laws		Audit	➢ review & receive the annual Audit Findings Report review & approve the year-end financial statements	
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➢ review upcoming events reported through Directors ABCDE Goals	
	4l Programs Required under the Public Hospitals Act					
	i	(i)ēnsure 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 iii	ensuring that a strategic planning process is undertaken with Board, employees and Medical/Professional Staff involvement and approved by the Board from time to time contributing to the development of and approving the mission, vision, values, and strategic plan of the Corporation			➢ Strategic Plan: approve process, participate in development, approve plan - (last completed in 2022, will be done again in 2027)	
	4d Chief Executive Officer and Chief of Staff					
	i	select the Chief Executive Officer in accordance with the relevant Board policies	2-B-15	Executive	➢ recruit, select, and hire and individual with the requisite skills, abilities, and competencies to effectively perform the job as President and Chief Executive Officer (CEO) of the organization	
	ii	delegate responsibility for the management of the Corporation to the Chief Executive Officer and require accountability to the Board	2-B-05	Executive		
	iii	establish a Board policy for the performance evaluation and compensation of the Chief Executive Officer	2-B-20 2-B-25	Executive / Governance	➢ review & approve the Board's policies 2-B-20 CMH Executive Compensation Policy (last reviewed May 26, 2021) 2-B-25 CEO Performance Review Policy (last reviewed May 25, 2022)	
	iv	select the Chief of Staff in accordance with the relevant Board policies	2-B-16	Executive	➢ recruit, select, and hire and individual with the requisite skills, abilities, and competencies to effectively perform the job as President and Chief Executive Officer (CEO) of the organization	
	v	delegate responsibility for the management of the Corporation to the Chief of Staff and require accountability to the Board	2-B-06	Executive		
	vi	establish a Board policy for the performance evaluation and compensation of the Chief of Staff	2-B-20 2-B-26	Executive / Governance	➢ review & approve the Board's policies 2-B-20 CMH Executive Compensation Policy (last reviewed May 26, 2021) 2-B-26 CEO Performance Review Policy (last reviewed May 25, 2022)	
	4j Effective Communication and Community Relationships					
	i	establish processes for community engagement to receive public input on material issues	1-A-05 2-D-09		➢ Post meeting agenda packages and minutes publically on the CMH Website review & approve the Board policy 2-D-09 (last reviewed June 28, 2023) ➢	
	ii	promote effective collaboration and engagement between the Corporation and its community, particularly as it relates to organizational planning, mission, and vision			➢ Strategic Plan	
	4m Communications Policy					

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

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
		The Board shall establish a communications policy for the Corporation and oversee the maintenance of effective relations with stakeholders (e.g. MOH, Ontario Health, CND OHT, other health service providers, clients, patients, employees, volunteers, Medical/Professional Staff, CMH Foundation, CMH Volunteer Association, federal, provincial, regional and city politicians) through the Corporation's communications policy and programs	2-D-11	Governance	➢ review & approve Board policy 2-D-11 every three years (last reviewed April 22, 2022)	
	General					
		On behalf of the Board, the Governance Committee shall review and assess the adequacy of the Board terms of reference at least every 3 years and submit proposed changes to the Board for consideration		Governance	➢ review & approve the Board of Directors Terms of Reference (last reviewed June 28, 2023)	

DELAYED

Date	ref #	Item	Rationale	New Due Date
04-Feb-25	All items deferred to December 3, 2025 Board of Directors meeting		This approach was to support the November meeting being specifically for the generative session	Dec-25

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

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: November 28, 2025
Issue: Audit Committee Report to Board of Directors November 17, 2025 – 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, November 17, 2025 at 1700h.

Present:	Jay Tulsani (Chair), Tom Barker, Bonita Bonn, Bill Conway, Miles Lauzon, Margaret McKinnon, Taariq Shaikh, Chris Whiteley, Lynn Woeller
Regrets:	Brian Quigley
Staff:	Trevor Clark, Lisa Costa, Patrick Gaskin, Rob Howe, Valerie Smith-Sellers
Guests:	None

Committee Matters – For information only

1. **2024-25 Audit Committee Goals and Objectives:** The Audit Committee approved the goals for the 2025-26 Board cycle

2. **Public Sector Accounting Standards Update:** In 2025, PS 1202 Financial Statement Presentation (a new Public Sector Accounting (PSA) standard) was introduced and revisions were made to PS 3150 Tangible Capital Assets. Management confirmed that these changes are not expected to affect CMH's audited financial statements for 2025-26 or any retrospective financial reporting periods or change the audit scope.

3. **September 2025 Financial Statements:** Management shared the September financial statements with the Audit Committee and presented key highlights. *(Further information provided under agenda item 4.4.1 of the Board of Directors December 3, 2025 meeting agenda package.)*

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: November 20, 2025
Issue: Digital Health Strategy Committee Report to Board of Directors – November 20, 2025 – OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kristen Hoch – Administrative Assistant
Approved by: Mari Iromoto – VP, People & Strategy; & Sara Alvarado – Chair

Attachments/Related Documents: None

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

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

Committee Matters – For information only

1. **HIROC – Shared Experiences: Cyber Preparedness in Healthcare**: Members shared their reflections from the November 18, 2025 conference. The discussion highlighted: iincident response plan readiness; availability of hard copies in case of cyber-attacks; Board involvement in ransomware decisions; strengthening risk management and resource allocation; enhancing a risk management culture through education and communication plans; conducting mock drills; demonstrations of hacker actions were found enlightening; PHIPA guidelines for public disclosure; financial constraints impacting cyber preparedness, focusing on risk minimization; and existing emergency preparedness and EOC processes at CMH.

2. **Operational Excellence Plan:** CMH Management presented key highlights of the Operational Excellence Plan. A major milestone was achieved with 72% of physicians trained on digital documentation tools, forecasted to reduce transcription services by 32%. Data quality is monitored through monthly Clinical Operational Excellence Committee (COEC) meetings, which have helped reduce the hospital standardized mortality ratio. Collaborations with the University of Waterloo are advancing ED flow and analytics. Twenty-six electronic huddle boards automate analytics across departments, and patient-facing tools like the ED wait time clock are being enhanced in collaboration with PFAC. The discussion highlighted: governance policies for approved tools and compliance tracking;

patient-friendly information and enhance communication during their wait in the ED while maintaining confidentiality; and consolidation of AI data in a single repository and its impact.

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: November 25, 2025
Issue: Executive Committee Report to Board of Directors November 18, 2025 – OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Administrative Assistant
Approved by: Lynn Woeller, Executive Committee Chair

Attachments/Related Documents: None

A meeting of the Executive Committee took place on Tuesday, November 18, 2025 at 1700h.

Present:	Lynn Woeller (Chair), Paulo Brasil, Bill Conway, Julia Goyal, Diane Wilkinson
Regrets:	None
Staff:	Patrick Gaskin, Dr. Winnie Lee
Guests:	None

Committee Matters – For information only

1. **Welcome:** New members Paulo Brasil, Bill Conway, and Julia Goyal were welcomed by the Chair to the Executive Committee.

2. **May 2025 Evaluation Results:** The Executive Committee reviewed the evaluation summary from the May 2025 meeting. In response to a suggestion to extend meetings to 2-2.5 hours, the Committee Chair clarified that the Committee would maintain its standard 2-hour time slot. However, the March meeting, being more comprehensive, may occasionally exceed this duration; extensions will be communicated via meeting invitations when necessary.

   The Committee Chair also discussed the request to review the questions associated with the CEO and COS evaluation survey. These questions will be revisited by the Committee in March 2026 as part of the annual work plan. It was noted that this would be the final year for the current survey format, since CMH has appointed a new Director of Organizational Development and Culture who is developing a revised organizational review process. The CEO and COS evaluations will transition to this new process starting in 2027, while continuing with the existing method for the 2026 reviews.

3. **Review of Executive Committee Terms of Reference and 2025/26 Annual Workplan:** The Executive Committee discussed the Executive Committee Terms of Reference (TOR) and 2025-26 Committee workplan. CMH Leadership completed a thorough comparison between the TOR and work plan to ensure that all specified duties and responsibilities of the Executive Committee are reflected in the 2025/26 workplan. The TOR have been updated with minor grammar corrections and alignment with

standard terminology that is being used across all committee TOR. The responsibility of monitoring costs and budget associated with the Board of Directors Cost Centre has been added. The workplan has been updated to include several components that were not specifically outlined previously. These additions have been integrated into the appropriate meetings where they align with current processes or included in the “as needed” section of the TOR.

4. **COS Role Description:** The Executive Committee reviewed the Chief of Staff Role Description Policy, which is past due for its 3-year review. The specific duties and responsibilities of the Chief of Staff are outlined in the Medical/Professional Staff By-law. CMH Management proposed that to maintain consistency, policy 2-B-06 should directly mirror the relevant section from the By-law to avoid any confusion or discrepancies. This suggestion has been endorsed by the Executive Committee and will be submitted to the Governance and Nominating Committee (GNC) for further consideration and subsequent recommendation to the Board of Directors for approval. Additionally, the Executive Committee asked the GNC to examine strategies for reviewing the Medical/Professional By-laws, which were last revised in October 2020.

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: November 25, 2025
Issue: Governance and Nominating Committee Report to Board of Directors October 9, 2025 – OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Administrative Assistant
Approved by: Julia Goyal, Governance and Nominating Committee Chair

Attachments/Related Documents: None

A meeting of the Governance and Nominating Committee took place on Thursday, October 9, 2025 at 1700h.

Present:	Julia Goyal (Chair), Tom Barker, Jayne Herring, Roger Ma, Milena Protich, Diane Wilkinson, Lynn Woeller (ex-officio)
Regrets:	None
Staff:	Patrick Gaskin, Stephanie Pearsall, Mari Iromoto
Guests:	Joy Braga, Sargun Madan

Committee Matters – For information only

1. **Welcome:** New members Tom Barker, Jayne Herring, Roger Ma, and Diane Wilkinson were welcomed by the Chair to the Governance and Nominating Committee (GNC).

2. **HSO Governing Body Assessment:** According to recommendations from Accreditation Canada, it is advised that the Board completes the HSO Governing Body Assessment within the first or second year of the accreditation cycle. The GNC finalized the proposed questions for inclusion in the survey. *(Further information provided under agenda item 4.2.1 of the Board of Directors December 3, 2025 meeting agenda package)*

3. **GNC 2025-26 Goals:** The GNC approved the committee goals for 2025-26
   - Strengthen Governance Framework and Tools
   - Monitor and Engage with the Heath Sector Government and Oversight Office (HSGO)
   - Develop and Implement a Relationship Management Approach Consistent with the Expanded Terms of Reference
   - Advance Diversity, Equity, Inclusion (DEI) & Indigenous Reconciliation – Carry Forward Priority
   - Strengthen Board Development and Succession Planning – Carry Forward Priority

   Members of the GNC discussed the number of policies requiring review for the 2025/26 period and expressed concern about achieving these goals and all the policy reviews. It

was agreed that CMH Leadership and the Chair of the GNC would explore a revised approach to the policy review process, allowing the GNC to focus more effectively on the goals and strategic priorities of the GNC.

4. **Updated Terms of Reference and Work Plan Related to the Consolidation of the Nominating Sub-Committee and Governance Committee:** The terms of reference for the GNC have undergone minimal updates, with no significant changes in policies or processes since the last review in 2024. Although the two committees have been consolidated, the Nominating Sub-Committee's terms of reference were only developed last year to outline specific responsibilities and reporting structures. At that time, there were no changes to the Governance Committee's terms of reference, as the Nominating Sub-Committee's terms of reference were designed to support Policy 2-D-20, Recruitment, Selection, and Nomination of Directors and Non-Director Committee Members.

   The GNC's workplan has been revised to incorporate an additional meeting established to support the consolidated responsibilities. The workplan was reviewed to ensure that the responsibilities outlined in the GNC's terms of reference are aligned and the work is captured appropriately.

5. **Updated Board of Directors Generative Session Feedback Survey:** In line with best governance practices, continuous evaluation is essential for enhancing the effectiveness of the Board's operations. Over recent years, CMH's approach to these generative sessions has evolved significantly; however, a formal mechanism to assess their efficacy has not been developed. Constructive feedback plays a pivotal role in ensuring that these sessions are well-organized, address pertinent issues, and provide significant value to CMH Board members. This survey will be implemented following the November 5, 2025 Board Generative session.

   The questions are as follows:
   - How relevant did you find the discussion in today's session to our current strategic goals? (Scale from 1-5, with 1 being not at all relevant and 5 being very relevant)
   - In your opinion, how well did the content of this discussion align with fostering innovation and new ideas for our organization? (Likert scale: Strongly Aligned to Strongly not Aligned)
   - How would you rate the effectiveness of the facilitation in guiding the conversation and ensuring all voices were heard? (Scale from 1-5, where 1 is ineffective and 5 is highly effective)
   - Did today's session provide clear outcomes or actionable insights that can be implemented by our team? (Multiple choice: Yes, No, Somewhat)
   - Please share any suggestions you have for improving the effectiveness of future generative discussion sessions.

   Each question will be followed by a space for additional comments or feedback.

6. **Proposed Process Change of Review of Terms of Reference and Workplans:** Currently, terms of reference are reviewed every three years, unless there is a notable change in the committee's mandate. However, current best governance practices recommend an annual review of both workplans and terms of reference to ensure alignment with the dynamic healthcare landscape and the strategic direction of the organization. The GNC discussed the proposal to have all committees adopt a

consistent process for conducting an annual review of their terms of reference and work plans during their first meeting of each Board cycle. *(Further information provided under agenda item 4.2.3 of the Board of Directors December 3, 2025 meeting agenda package)*

7. **Policy Review:** The GNC reviewed two of the seven polices outlined on the agenda. The remaining 5 policies were deferred to the November 13, 2025 GNC meeting. There were no comments or concerns related to the policies brough forward. *(Further information provided under agenda item 1.5.7 of the Board of Directors December 3, 2025 meeting agenda package)*

8. **2025 OHA Hospital Governance Survey:** The GNC received the briefing note about the OHA Governance Survey.

9. **Approach to Guide to Good Governance:** OHA has recently published the fourth edition of the Guide to Good Governance and provided hospitals with a summary document that highlights notable revisions, additions, and shift in emphasis within the guide. Over the course of this year's GNC meetings, each of the highlighted topics will be reviewed and discussed. The GNC expressed support for this approach.

10. **Legal & Regulatory Highlights for Hospitals – January to June:** The GNC reviewed the summary that included key legislative updates, new privacy regulations, employment standards changes, emergency management provisions, healthcare staffing agency reforms, and important dates for hospital compliance. CMH Leadership proposed the process of receiving these updates semi-annually in line with the resources provided by OHA. Any immediate updates requiring attention will be brought forward as required. The GNC expressed support for this approach.

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: November 27, 2025
Issue: Governance and Nominating Committee Report to Board of Directors November 13, 2025 – OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Administrative Assistant
Approved by: Julia Goyal, Governance and Nominating Committee Chair

Attachments/Related Documents: None

A meeting of the Governance and Nominating Committee took place on Thursday, November 13, 2025 at 1700h.

Present:	Julia Goyal (Chair), Tom Barker, Jayne Herring, Roger Ma, Milena Protich, Diane Wilkinson, Lynn Woeller (ex-officio)
Regrets:	Mari Iromoto
Staff:	Patrick Gaskin, Stephanie Pearsall
Guests:	Sargun Madan

Committee Matters – For information only

1. **Update to the non-Director Peer Assessment Process:** At the GNC meetings of October 9 & November 13, 2025 the GNC discussed the proposal to discontinue the peer evaluation process for non-Directors. At the meeting of October 9, 2025 the GNC emphasized the importance of a need for an alternate avenue to discuss performance with non-Directors. To address this concern, at the November 13, 2025 GNC meeting the proposal was brought back a proposal to eliminate the peer evaluation for non-Directors and an introduction of a new process was presented. The GNC supported the discontinuation of the peer-assessment of the non-Directors and introduction of the new process. *(Further information provided under agenda item 4.2.2 of the Board of Directors December 3, 2025 meeting agenda package)*

2. **Exit Interview Survey Results:** The GNC reviewed and discussed the submissions of the Exit Interview Survey for Directors and non-Directors who parted from the CMH Board in 2025. Most retirements last year were due to personal circumstances, competing commitments or reaching the end of a nine-year term. Respondents who completed the survey consistently highlighted positive relationships, meaningful contributions and pride in major initiatives like the HIS project. Constructive suggestions included better alignment of committee assignment with skills, clear communication when committee mandates shift, and continued streamlining of briefing notes. Overall, the feedback reinforces the strength of the culture of the Board and CMH. The GNC had no further comments or concerns.

3. **Finalize the Interview Team:** Based on insights gained from the 2025/26 interview process it was proposed to form a single interview team to conduct all interviews this year. The Team will consist of four GNC members and a representative from an external community partner as well as a member of the Patient & Family Advisory Council. *(Further information provided under agenda item 4.2.5 of the Board of Directors December 3, 2025 meeting agenda package)*

4. **Proposed Draft 2-D-19 Selection of Officers:** Previously, CMH lacked a formalized process for selecting officers within its Board of Directors, relying instead on informal methods. With an increasing number of Directors expressing interest in serving as Board officers during their tenure, it has become imperative to establish a transparent and structured procedure.

   To address this need, CMH has developed a new policy for the selection of Board officers, drawing from the sample Board Chair Selection Process Guidelines (Form 8.2) provided by the Ontario Hospital Association (OHA). The GNC supports the policy and approach and provided minor amendments to the policy. *(Further information provided under agenda item 4.2.4 of the Board of Directors December 3, 2025 meeting agenda package)*

5. **Policy Review:** The GNC reviewed twelve policies. Four of the twelve will be further updated based on feedback from the GNC. Eight polices are being brought forward to the Board of Directors for approval. *(Further information provided under agenda item 1.5.7 of the Board of Directors December 3, 2025 meeting agenda package)*

6. **Guide to Good Governance Series - Unpacking What's New in the Guide to Good Governance:** CMH Leadership has initiated a five-part series for the GNC aimed at delving into the recent updates within the Guide to Good Governance. This series was crafted with reference to the OHA's document titled "Exploring the Latest Edition of the Guide to Good Governance," which underscores key changes, additions, and altered emphases. The first session was centered on the themes of Governance Framework and Board Responsibilities. *(Further information can be found in package 2 of the Board of Directors December 3, 2025 meeting agenda package)*

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: October 8, 2025
Issue: MAC Report to the Board of Directors October 8, 2025 - OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Dr. Winnie Lee, Chief of Staff
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: None

A meeting of the Medical Advisory Committee took place on Wednesday, October 8, 2025, at 1700h.

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

Committee Matters – For information only
This briefing note provides an executive summary of the key proceedings and decisions from the Cambridge Memorial Hospital (CMH) Medical Advisory Committee (MAC) meeting held on October 8, 2025. The following summary offers an overview of the committee's key discussions, decisions, and strategic direction, highlighting how the committee is balancing major systemic challenges with targeted initiatives to improve internal culture, physician excellence, and patient safety.

1. **Navigating Systemic Challenges and Intensifying Financial Pressures:** The meeting underscored the significant operational and fiscal headwinds facing CMH within the broader provincial healthcare system. Discussions highlighted a proactive and strategic response to these intensifying pressures.

    - **Fiscal Instability** – The CEO's report brought the external financial environment into sharp focus, citing a projected $12 billion deficit for Ontario hospitals. This forecast signals significant budgeting difficulties ahead, requiring a disciplined and forward-looking approach to resource stewardship. The discussions detailed in this section underscored the hospital's acknowledgment of these challenges and the work ahead to ensure long-term sustainability and operational efficiency.

    - **Core Operational Risks:** An Integrated Risk Management (IRM) presentation highlighted the importance of the process to identify areas of emerging risk for the

organization and aligning that with organizational objectives. The cross-functional approach supports improved decision-making and increased organizational resilience. Early themes from the IRM process to date include fiscal and funding concerns, challenges associated with implementing the new Health Information System (HIS), and persistent pressures on ED performance and wait times.

- **Strategic Response Through Leadership:** In direct response to these pressures, the hospital is relaunching its Program Management Council (PMC). This council's renewed mandate will address looming fiscal pressures by driving savings and efficiencies, leading large-scale transformation projects like Project Quantum, and planning for the next five-year clinical services growth plan. This represents a strategic pivot towards more centralized and data-driven management of clinical services.

2. **Fostering a Just Culture and Investing in Professional Development**: A recurring theme was the critical link between a supportive, transparent organizational culture and the hospital's ability to retain talent, promote safety, and deliver high-quality patient care. The committee reviewed several initiatives aimed at strengthening this foundation.

- **Embedding "Just Culture 2.0" –** The committee reviewed the Just Culture 2.0 initiative framework by applying it in a sample scenario, demonstrating a systematic approach to addressing staff concerns and practice issues. The framework is built on several core principles: (a) ensuring a consistent and fair approach, (b) standardized language to categorize behaviours, such as distinguishing between human error and at-risk behaviour, and (c) integrating the framework directly into corporate policy to formalize the commitment to transparency and fairness. The initiative received positive feedback from the committee, which also noted the development of a practical algorithm tool to help leaders consistently frame and analyze potential practice concerns, while encouraging open dialogue and a system-focused approach to learning. Embedding Just Culture in the organization is a strategic asset, essential for promoting transparency, psychological safety, and organizational learning.

- **Strengthening Physician Onboarding and Retention:** The success of the ED Mentorship Program was highlighted for its effectiveness in preparing new physicians and generating substantial interest in CMH from residency programs. Ongoing efforts to enhance training were noted for those physicians participating in the ED mentorship program. The mentorship initiative demonstrates a successful strategy where targeted investment in professional development yields a direct return in talent acquisition and retention, strengthening the hospital's long-term clinical capacity. It was noted that this strategy was led purely by strong ED leadership and MAC's collective support in participating in the program. It has demonstrated how effective mentorship is strategically vital for attracting and retaining highly skilled physicians, particularly in critical environments like the Emergency Department.

- **Balancing Improvement with Culture:** Leadership advised the MAC of a plan for external programmatic reviews to identify areas of opportunity as it relates to organizational flow. The concern that such reviews have a risk of impacting the current positive culture was acknowledged. This reflects the nuanced approach to change management that seeks to balance the drive for operational excellence with the preservation of staff morale and engagement. Introduction of the reviews will have full engagement of the department Chiefs/Medical Directors and Clinical Directors, in a phased approach. Clear communication will be provided to the MAC and departments involved.

3. **Advancing Clinical Protocols and Medication Safety**: The committee's work on specific clinical directives and safety protocols forms the foundation of quality patient care. The review of several medication-related updates demonstrates a tangible commitment to continuous improvement in clinical practice.

    - Key medication safety improvements were approved based on the M&T Report:
        - **New Adult IV Dilution Table:** A proactive medication error risk mitigation strategy, embedding safety directly into frontline clinical workflows. This quick-reference guide was created to support nurses and prevent medication errors, such as incorrect mixing of Acyclovir.
        - **Updated Oxytocin Pump Settings:** Infusion rate limits were increased to allow for more aggressive management of postpartum hemorrhage, aligning practice with new evidence-based guidelines.
        - **New Medical Directive #757 (Hyperbilirubinemia Management):** The approval of the new medical directive streamlines the screening and follow-up process for newborns. It aligns practice with 2025 Canadian Pediatric Society (CPS) guidelines and supports appropriate testing. A reduction in unnecessary testing is anticipated through best practice guidelines and standardization of practice.

4. **Strengthening Governance and Accountability**: The meeting highlighted a clear focus on reinforcing the hospital's structural and collaborative frameworks.

    - **Clarifying Leadership Collaboration:** A joint presentation by the Chief of Staff (COS) and Vice President of Medical Operations (VPMO) clarified their commitment to collaborate on patient safety, clinical protocols, and resource management. This formally delineates accountability at the highest level of medical and operational leadership.

    - **Adapting to New Accreditation Standards:** Accreditation Canada is shifting to "short notice scheduling" for on-site visits. This new format promotes continuous readiness and daily operational excellence across the organization, embedding quality as a constant rather than a periodic focus.

    - **Enhancing Organizational Transparency:** A new third-party whistleblower system is now active, providing an accessible and confidential channel for staff to raise concerns regarding "fraud or concern." This strengthens the hospital's ethical infrastructure and reinforces a culture of integrity.

    The October 8, 2025, Medical Advisory Committee meeting demonstrated a clear dual focus. The committee is proactively discussing significant external pressures—most notably system-wide financial constraints and evolving accreditation standards—while simultaneously driving critical internal improvements. These internal initiatives aim to strengthen organizational culture, accelerate physician development, and refine patient safety protocols. The MAC's focus remains squarely on advancing patient safety and quality of care through a combination of evidence-based practice, strategic leadership, and a deep commitment to its people and principles.

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

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

Attachments/Related Documents: None

A meeting of the Medical Advisory Committee took place on Wednesday, November 12, 2025, at 1700h.

Present: Dr. W. Lee, Dr. J. Legassie, Dr. I. Isupov, Dr. A. Sharma, Dr. M. Rajguru, Dr. A. Mendlowitz, C. Witteveen, Dr. J. Bourgeois, Dr. B. Courteau, Dr. A. Nguyen, Dr. V. Miropolsky, Dr. M. Shafir, Dr. M. Patel, Dr. T. Holling, Dr. L. Green, Dr. E. Thompson

Regrets: Dr. R. Shoop, Dr. M. Hindle, Dr. J. Gill

Staff: P. Gaskin, S. Pearsall, M. Iromoto, Dr. K. Rhee, Dr. R. Taseen, J. Backler, K. Leslie

Guests: B. Conway, C. Wilson

Committee Matters – For information only
This briefing note provides an executive summary of the key proceedings and decisions from the Cambridge Memorial Hospital (CMH) Medical Advisory Committee (MAC) meeting held on November 12, 2025. This summary highlights the committee's main discussions, decisions, and strategic direction as it addresses challenges and works to improve culture, physician excellence, and patient safety.

1. **Advancing Clinical Efficiency Through AI Technology Adoption:** The Medical Advisory Committee (MAC) supports modernizing clinical practices with the strategic adoption of Artificial Intelligence (AI) powered tools aiming to streamline documentation processes and allow medical staff to dedicate more time to direct patient care. This focus on technological innovation was a key theme of the November meeting.

   A major outcome was the MAC's formal approval of the new policy **"AI Scribe Technology Use in Clinical Documentation."** This policy establishes a clear governance framework for integrating these advanced tools into daily clinical workflows. The discussion highlighted substantial progress and outlined clear operational directives for this initiative.

   - **Adoption Rate:** The use of front-end speech technology among credentialed physicians has reached 73%, a notable increase from 60% in September.

- **Named Technologies:** The two AI Scribe platforms currently being implemented are Flex and Heidi.
- **Core Policy Principles:** The approved policy is built on a foundation of protecting patient privacy, ensuring safety, and maintaining regulatory compliance.
- **Usage Protocols:** Two critical rules govern the use of this technology:
    1. Physicians are required to personally review and verify any notes generated by the Heidi platform before they are finalized in the patient record.
    2. The technology is restricted to use for Cambridge Memorial Hospital (CMH) patients only, ensuring the hospital maintains its role as the privacy custodian.
- **Operational Transition:** A phased plan is in place to decommission traditional phone lines for dictation. Timelines will be communicated to department chiefs for dissemination to their teams, ensuring a managed transition to the Flex and Heidi platforms.

The successful integration of these AI tools demonstrates a commitment to operational excellence, which runs parallel to the committee's enduring focus on enhancing clinical quality and patient safety.

2. **Reinforcing a Culture of Quality and Patient Safety:** Embedding a culture of continuous quality improvement and patient safety into the hospital's core operations is a fundamental component of institutional excellence. The committee's deliberations reinforced this priority, highlighting new leadership roles and engagement initiatives designed to strengthen oversight and encourage broad participation in quality-related work. In particular, Dr. K. Rhee will be supporting the Chief of Staff office as the interim Physician Quality Lead, filing a long-vacant role. This position was created to provide dedicated physician leadership and assistance with ongoing quality reviews and critical patient safety initiatives, signaling a deeper integration of quality oversight within the medical staff structure.

   The following activities and expectations were also outlined to support this focus on quality improvement:

   - **Patient Experience Survey:** An upcoming Beryl Institute survey will gather crucial feedback. A request was issued for physician participation to ensure data is comprehensive.
   - **Departmental Presentations:** Beginning in 2026, each department will be providing updates highlighting the quality work in each program and its alignment with the Clinical Services Growth Plan.
   - **Workflow Management:** The Chief Nursing Executive (CNE) reported that improved workflow management has resulted in stable staffing levels and a decrease in overtime hours, even while managing surgery scheduling challenges, indicating that operational efficiencies are positively impacting the care environment.

   This internal focus on quality provides a strong foundation for the hospital’s broader, forward-looking strategic planning and its role within the wider healthcare community.

3. **Focusing on Long-Term Strategy and Community Integration:** Beyond immediate operational improvements, the committee dedicated significant attention to the strategic necessity of long-term planning and strengthening integration with community-based healthcare providers. This forward-looking perspective is crucial for building a seamless continuum of care for patients as they move between hospital and primary care settings.

To this end, the CNE and VPMO have initiated high-level discussions on "program development and long-term goals for the next decade." This signals a proactive approach to anticipating future healthcare needs and positioning the hospital to meet them effectively.

The Primary Care Network in partnership with CMH has submitted a concrete proposal aimed at enhancing the hospital’s connection with the primary care community. The following programs were presented as key opportunities for collaboration and service expansion:

- An application to expand primary care teams, addressing community-level healthcare capacity.
- The creation of a CMH-based SCOPE (Seamless Care Optimizing Patient Experience) program to improve communication and transitions between hospital specialists and family physicians.
- The establishment of a stabilization clinic to provide targeted support for patients and prevent unnecessary hospital readmissions.

Two notable achievements recognized during the roundtable discussion: Dr. Mohamed Naser's receipt of the Michael G. DeGroote School of Medicine, McMaster University, Excellence in Teaching Award and Dr. Winnie Lee's Chartered Director (C.Dir) designation from the Director’s College, DeGroote School of Business, McMaster University.

Collectively, the meeting's focus on technological modernization through AI, enhanced accountability in quality reporting, and strategic outreach via community integration signals the Medical Advisory Committee’s clear and forward-moving direction.

BRIEFING NOTE

Date: October 8, 2025
Issue: New Credentialed Physicians – September 2025
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Dr. Winnie Lee, Chief of Staff
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: None

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

1. Dr. Kunuk Rhee, VPMO and Hospitalist (Active)
2. Dr. Alexandra Lao, Pathologist (Associate)
3. Dr. Dhiraj Dhanjani, Urologist (Associate)
4. Dr. Cheryl Axelrod, OBGYN (Associate)
5. Dr. Samuel Yoon, Regional Spine Surgeon (Courtesy with Admitting)
6. Dr. Mohamed Sarraj, Regional Spine Surgeon (Courtesy with Admitting)
7. Asra Varind, Midwife (Associate)
8. Dr. Yu-Han Chang, Hospitalist (Courtesy with Admitting)
9. Dr. Prima Moinul, Regional Ophthalmologist (Courtesy with Admitting)
10. Dr. Guarav Vasisth, Regional Ophthalmologist (Courtesy with Admitting)
11. Dr. Preveshen Moodley, Regional Urologist (Courtesy with Admitting)

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

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: November 12, 2025
Issue: New Credentialed Physicians – October 2025
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Dr. Jenny Legassie, Deputy Chief of Staff and Dr. Winnie Lee, Chief of Staff
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents: None

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

1. Dr. Cindy Ge, Community and Family Physician and Surgical Assist (Associate)
2. Dr. Yuchen Zhang, Community and Family Physician (Affiliate)

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

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: November 28, 2025
Issue: Resources Committee Report to Board of Directors November 24, 2025 – OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Bonnie Collins, Administrative Assistant
Approved by: Paulo Brasil, Chair

Attachments/Related Documents: None

A meeting of the Resources Committee took place on Monday, November 24, 2025 at 1700h.

Present:	Paulo Brasil (Chair), Sara Alvarado, Amanda Forrest, Julia Goyal, Monika Hempel, Shannon Maier, Janet Richter, Diane Wilkinson, Lynn Woeller
Regrets:	None
Staff:	Maria Burzynski, Trevor Clark, Lisa Costa, Patrick Gaskin, Hayley Hamilton, Rob Howe, Kyle Leslie, Stephanie Pearsall, Dr. Kunuk Rhee, Janet Short, Valerie Smith-Sellers,
Guests:	None

Committee Matters – For information only

1. **Strategic Priorities Q2 Update:** Management provided an overview of the progress of the strategic priorities for Q2, highlighting key accomplishments (achieving targeted PCOP growth funding, medical professional staff recruitment) and challenges (workforce management). Questions were entertained, and management confirmed that the number of manual payroll adjustments have been decreasing with the use of the new Workforce Planning (WFP) system. To date, UKG has not met the functional requirements of the proposed CMH attendance program, and an internal solution is being explored. *(Further information provided under agenda item 1.5.8 of the Board of Directors December 3, 2025 meeting agenda package)*

2. **October 2025 Financial Statements and Year-End Forecast:** In October, CMH reported a $5.9M year-to-date surplus position after building amortization and related capital grants. The major drivers of the surplus were higher revenue than budget for Quality Based Procedures (QBP) and Post Construction Operating Plan (PCOP) and unused budgeted contingency, partially offset by negative variance in salaries and wages, and medical and surgical supplies. Unfunded beds have contributed $0.2M to the overtime pressure. PCOP earning are forecast at $23.3M by March 31, 2026, and CMH is actively working to achieve full PCOP funding ($23.7M) by fiscal year end. A $2.9M surplus is forecast for year end. An expected pick up of 2023-24 PCOP funding ($8.8M) which will be recognized at fiscal year end is not included in the forecasted

surplus and would result in a total forecast year-end surplus of $11.7M. Unrestricted working capital is forecast to be $19.1M at fiscal year-end. *(Further information provided under agenda item 4.4.1 of the Board of Directors December 3, 2025 meeting agenda package)*

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: November 25, 2025
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

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Recommendation/Motion

Board

That, the Board of Directors approves the following polices as presented/with amendments and upon recommendation of the Governance and Nominating Committee at its meeting of October 9, 2025 and November 13, 2025.

2-A-16	*Digital Health Strategy Committee Terms of Reference*
2-B-10	*Succession Planning for the President & Chief Executive Officer, Chief of Staff, and Executive Team*
2-B-15	*Recruitment and Selection of the President & Chief Executive Officer and Chief of Staff*
2-B-20	*CMH Executive Compensation Policy*
2-B-25	*President & Chief Executive Officer & Chief of Staff Annual Performance Review*
2-C-10	*Quality and Patient Safety*
2-C-34	*Approval & Signing Authority*
2-C-38	*Investment Policy*
2-D-04	*Board and Committee Annual Work Plans*
2-D-48	*Whistleblower Policy*

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-16	*Digital Health Strategy Committee Terms of Reference*
2-B-10	*Succession Planning for the President & Chief Executive Officer, Chief of Staff, and Executive Team*
2-B-15	*Recruitment and Selection of the President & Chief Executive Officer and Chief of Staff*
2-B-20	*CMH Executive Compensation Policy*
2-B-25	*President & Chief Executive Officer & Chief of Staff Annual Performance Review*
2-C-10	*Quality and Patient Safety*
2-C-34	*Approval & Signing Authority*

2-C-38	*Investment Policy*
2-D-04	*Board and Committee Annual Work Plans*
2-D-48	*Whistleblower Policy*

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.

The following polices were reviewed and discussed at the October 9, 2025 and November 13, 2025 GNC meeting.

GNC & Board Committees Pre-Reviewed Policies
**These policies have undergone thorough review by the most relevant committee and the GNC, and none of them involve significant process changes.*

Policy No.	Policy Name	Rationale
2-A-17	Digital Health Strategy Committee Terms of Reference	This policy has been reviewed by the Digital Health Strategy Committee and updated to reflect it's change from Sub-Committee to a full Committee
2-B-10	Succession Planning for the President & Chief Executive Officer, Chief of Staff, and Executive Team	Extensive review (3 reviews) by the Executive Committee. Merged 2-B-10 and 2-B-12 into one policy.
2-B-15	Recruitment and Selection of the President & Chief Executive Officer and Chief of Staff	Extensive review (3 reviews) by the Executive Committee. Merged 2-B-15 and 2-B-16 into one policy.
2-B-20	CMH Executive Compensation Policy	Extensive review (3 reviews) by the Executive Committee.
2-B-25	Annual Performance Review for the President & Chief Executive Officer and Chief of Staff	Extensive review (3 reviews) by the Executive Committee. Merged 2-B-25 and 2-B-26 into one policy.
2-C-10	Quality & Patient Safety	This policy has been reviewed by members of the CMH Leadership team, and the Quality Committee. Key changes: • The policy defines CMH's framework for corporate oversight of quality and patient safety, outlining clear accountabilities for the QC Board, Leadership, and clinical teams across four quality quadrants: safe, accessible, and integrated, people focused, efficient, and equitable. • The descriptions within each quadrant have been modernized to include a just culture. An

Policy No.	Policy Name	Rationale
		environmental scan confirmed that CMH's structure and processes align with peer hospitals and provincial best practices. The policy aims to reinforce continuous improvement through transparent reporting, evidence-based measurements, and a strong culture of accountability and engagement. Emphasized the importance of maintaining quality and patient safety as central to corporate performance.
2-C-34	Approval & Signing Authority	This policy was reviewed by the Resources Committee with a minor amendment of including the just in time inventory program payments as not requiring a purchase order.
2-C-38	Investment Policy	This policy has been reviewed by the Resources Committee. No process updates, minor wordsmithing only.

GNC Pre-Reviewed Policies

**These polices have been pre-reviewed by the GNC only, and none of them involve significant process changes.*

Policy No.	Policy Name	Rationale
2-A-38	Board and Committee Meeting Attendance	This policy has been updated to include additional guidance provided in the sample form included in the GtoGG. (Form 8.16)
2-D-04	Board and Committee Annual Work Plans	This policy has been updated to align with the new process to review workplans annually. Minor edits were required. Aligns with current best governance practices.
2-D-06	Board Meeting Agenda Preparation	This policy was updated to provide clearer guidance when using the consent agenda. (Part of the GNC action log) *Note – this policy was adapted using sample forms included in the GtoGG (Form 8.13 & 8.14)
2-D-16	Meeting of Independent Directors and Committee Members	No process changes, updates were to adapt to the sample from included in the GtoGG that was written in a clearer manner. (Form 8.21)
2-D-22	Annual Declaration & Consent	This policy was updated to incorporate the new laws under ONCA and aligns with the sample form included in the GtoGG. (Form 6.7)
2-D-48	Whistleblower Policy	Extensively reviewed by CMH leadership and has been updated to align with modern digital practices. This policy mirrors CMH's corporate policy.

CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

SUBJECT:	**Digital Health Strategy Committee Terms of Reference**	**NO.: 2-A-17**
SECTION:	**Structure, Roles and Responsibilities**	
APPROVED BY:	**Board of Directors**	**DATE:** TBD

1. Application

Reporting to the Board of Directors, the Digital Health Strategy Committee of the Board (the "Committee") provides governance oversight, strategic direction and assurances to the Board regarding the development, implementation and evaluation of the Cambridge Memorial Hospital's Digital Health Plan, Operational Excellence Plan, and Research & Innovation Plan.

The Committee monitors these initiatives in alignment with hospital priorities, regulatory requirements and best practices in digital health, innovation and patient-centred care.

2. Composition

a. The Committee shall be composed of the following voting members:
   i. Up to three (3) elected Directors, one of whom shall sit as Chair of the Committee; and

   ii. Up to five (5) other members from the broader community who have experience in clinical informatics, information technology and digital health, appointed by the Board upon the recommendation of the Governance Committee; and

   iii. One (1) member, appointed by the Patient Family Advisory Committee (PFAC), appointed by management in consultation with PFAC

b. Non-voting resources to the Committee may include:
   i. President & Chief Executive Officer (CEO)

   ii. Vice President, Finance and Corporate Services and Chief Financial Officer

   iii. Vice President, People and Strategy

   iv. Director, Corporate Services & Chief Information Officer

v. Director, Operational Excellence

vi. Clinical Representative(s)

3. Meetings

The Committee shall:

(a) meet at least four (4) times annually, or more frequently as circumstances require;

(b) conduct all or part of any meeting in the absence of management, and, at a minimum, conduct such a session at each regularly-scheduled Committee meeting;

(c) invite to its meetings any Director, member of management or such other persons as it considers necessary to carry out its duties and responsibilities;

(d) exclude from its meetings any persons it considers necessary to carry out its duties and responsibilities.

4. Specific Duties and Responsibilities

The Committee shall:

(a) Monitor project performance for digital health operational excellence and research and innovation projects and make recommendations with respect to:

1. Reporting and progress updates
2. Risk mitigation strategies on project deliverables
3. Benefits realization and return on investment
4. Innovation and further intellectual capital development opportunities

(b) Review and recommend the use of expenditures from each project's contingency and/or change requests, as guided by policy

(c) Provide strategic advice informed by private sector and/or international best practices in digital health implementation and

(d) Optimize opportunities for effectiveness and certainty for project deliverables of scope and function, capital and operating costs, schedule, quality, communication and risk management

(e) Provide regular progress updates to the Board of Directors.

5. General

The Committee shall have the following additional general duties and responsibilities:

(a) report to the Board of Directors on matters arising at Committee meetings following each meeting of the Committee;

(b) maintain minutes or other records of meetings and activities of the Committee;

(c) have the authority upon approval by the Board to engage independent legal counsel, consultants, or other advisors with respect to fulfilling its responsibilities and the hospital shall provide appropriate funding;

(d) conduct an annual evaluation of the Committee in which the Committee reviews its performance for the preceding year for the purpose, among other things, of assessing whether the Committee fulfilled the purposes and responsibilities stated in these terms of reference;

(e) review and assess the adequacy of these terms of reference annually and submit any proposed amendments to the Governance Committee and the Board for approval;

(f) provide an orientation for new committee members; and

(g) perform such other functions and tasks as may be assigned from time to time by the Board of Directors.

At the completion of the Digital Health Plan, Operational Excellence Plan, and Research and Innovation Plan, the Governance and Nominating Committee shall review the continuing need and relevance of this Committee and make a recommendation concerning its continuance to the Board of Directors.

DEVELOPED: April 27, 2022		
REVISED/REVIEWED:		
May 7, 2025	Click or tap to enter a date.	Click or tap to enter a date.
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CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

SUBJECT:	**Succession Planning for the President & CEO, Chief of Staff and Executive Team**	**NO.: 2-B-10**
SECTION:	**Oversight of Management and Professional Staff**	
APPROVED BY:	**Board of Directors**	**DATE: TBD**

Policy

Cambridge Memorial Hospital (CMH) shall have a written succession plan for the President and CEO (CEO), Vice Presidents (referred to as "Executive Staff Members") and Chief of Staff (COS) that shall be reviewed and updated annually.

The Succession Plan shall identify and assess potential leadership and identify a process for the leadership development of such individuals. The succession plan shall be implemented if the CEO, Executive Staff Members or COS are unable to perform their duties or have departed from the organization.

Responsibilities

The CEO shall:

1. Maintain, review and update a written succession plan annually for the positions of CEO and Executive Staff Members.

2. Review the succession plan with the Executive Committee annually and provide an update related to leadership development and the status of the Executive Staff Members' performance and potential to serve as the interim CEO.

3. Update the Executive Committee on the succession plan annually including the identification of potential appointees to Executive Staff Member positions should the need arise.

The CEO/Executive Staff Member Succession Plan shall:

1. Include documentation on each Executive Staff Member including their skills, abilities, attributes, development plans and ability to assume the role of CEO should the need arise.

2. Identify potential leaders to replace Executive Staff Members should it be required.

3. Identify potential risks or concerns related to the succession plan.

4. Be reported annually to the Board of Directors.

5. Be available to the Board in the event of an unplanned CEO or Executive Staff Member absence.

The COS shall:

1. Maintain, review and update a written succession plan annually for the role of COS.

2. Review the succession plan annually with the Executive Committee including an update related to leadership development and the status of physician leaders who may assume the role on a temporary basis.

The Chief of Staff Succession Plan shall:

1. Include documentation on physician leaders, their skills, abilities, attributes, development plans and ability to assume the role of COS should the need arise.

2. Identify opportunities to physician leaders to cover functions of the COS.

3. Identify potential risks or concerns related to the succession plan.

4. Be reported annually to the Board of Directors.

5. Be available to the Board in the event of an unplanned COS absence or vacancy.

The Appointment of an Interim President & CEO

1. When possible, the CEO shall notify the Board Chair & COS of any unplanned absence as soon as possible.

2. The Executive Committee shall review the succession plan and identify potential candidate(s) for appointment as interim CEO.

3. The Executive Committee shall report to the Board the recommended appointment of interim CEO and any temporary adjustment to the priority job responsibilities and expectations of the interim CEO and/or other members of the leadership team.

4. The recommended appointment shall be presented to the Board for consideration.

5. The Executive Committee shall support, monitor and provide guidance to the interim CEO.

6. The Executive Committee, on the advice of Human Resources and using information contained within the executive compensation framework, shall negotiate a salary adjustment based on the scope of responsibilities.

7. The Board Chair shall initiate a communication strategy to inform staff, physicians/midwives, volunteers, partners, the community and others as required.

The Appointment of an Interim Chief of Staff

1. When possible, the COS shall notify the Board Chair & CEO of any unplanned absence as soon as possible.

2. The Executive Committee shall review the succession plan and identify potential candidate(s) for interim coverage.

3. The Executive Committee shall report to the Board the recommended appointment, priority job responsibilities and expectations.

4. The recommended appointment shall be presented to the Board for consideration.

5. The Executive Committee and CEO shall support, monitor and provide guidance to the Interim COS.

6. The Executive Committee, on the advice of Human Resources and the executive compensation framework, shall negotiate appropriate compensation based on the scope of responsibilities.

7. The Board Chair shall initiate a communication strategy to inform staff, physicians/midwives, volunteers, partners, the community and others as required.

The Appointment of an Interim Executive Staff Member

1. The CEO shall review the succession plan and determine the appointment of an interim Executive Staff Member.

2. The CEO shall notify the Board Chair and leadership team.

3. The CEO shall support, monitor and provide guidance to the interim Executive Staff Member

4. The CEO, on the advice of Human Resources, shall negotiate a salary adjustment as required.

5. The CEO shall initiate a communication strategy to inform staff, physicians/midwives, volunteers, partners, the community and others as required.

DEVELOPED: May 30, 2012		
REVISED/REVIEWED:		
May 25, 2016	April 24, 2019	April 27, 2022
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CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

SUBJECT:	**Recruitment and Selection of the President & Chief Executive Officer and Chief of Staff**	**NO.: 2-B-15**
SECTION:	**Oversight of Management and Professional Staff**	
APPROVED BY:	**Board of Directors**	**DATE: TBD**

Policy

President and Chief Executive Officer

The Board shall be responsible for the recruitment, selection, and appointment of an individual with the required skills, abilities, experience, and competencies to execute the duties of the President and Chief Executive Officer (CEO). The Board shall be responsible to guide, advise and evaluate the CEO on an annual basis.

Chief of Staff

The Board shall be responsible for the recruitment, selection, and appointment of an individual with the required skills, abilities, experience, and competencies to execute the duties of the Chief of Staff (COS). In accordance with the Medical/Professional Staff By-laws, the Board shall establish a Search Committee. The Board shall be responsible to guide, advise and evaluate the COS on an annual basis.

Process

1. The Board shall establish a Search Committee.
   CEO Search Committee shall include the Board Chair or designate, Chief of Staff, selected Board Members, and, as required, the Chief Human Resources Officer, and others as determined by the Board.
   COS Search Committee shall include the Board Chair or designate, CEO, selected Members of the Medical Advisory Committee (MAC), members of the management team, selected Board Members, and, as required, the Chief Human Resources Officer and others as determined by the Board.
2. The Search Committee may initiate a procurement process to engage an external search firm to assist with recruitment.
3. The Search Committee shall meet to confirm the recruitment process, review the CEO/COS job description, select the Interview Committee(s) and prepare the interview questionnaire. This may be done in collaboration with the Human Resources Department and/or an external search firm.

4. Should the CEO/COS leave the organization prior to the selection of a new CEO/COS, an interim CEO/COS may be appointed by the Board of Directors in accordance with the succession planning policy.
5. Applicants shall be provided with information regarding the Hospital mission, vision and values, organizational operations and structure, job description and other relevant materials.
6. The Search Committee shall screen all applicants and prepare a short list of candidates.
7. The Search Committee shall conduct initial interviews with the short-listed candidates.
8. The Search Committee shall require a minimum of 4 references and perform background checks including but not limited to a Vulnerable Sector Check.
9. The Search Committee shall select at least 2 candidates for second round interviews.
10. The Search Committee shall conduct second interviews. Other individuals, at the discretion of the Search Committee, may be invited by the Search Committee to take part in the second-round process.
11. The Search Committee shall compile interview feedback, reference checks and the Record Vulnerable Sector Check to select the preferred candidate. The preferred candidate shall declare any conflicts of interest in accordance with corporate policy.
12. The Search Committee shall present the preferred candidate to the Board for consideration and provide the Board with information about the candidate, selection criteria utilized, reference checks and other relevant information.
13. The Board of Directors shall consider the preferred candidate.
14. Upon the approval of the Board of a candidate to fill the position, the Board Chair shall ensure the candidate receives an offer setting out the terms and conditions of employment/service for review and acceptance. Legal counsel may be used to develop the agreement. The agreement shall comply with the Executive Compensation Policy.
15. Upon written acceptance of the offer letter and contract of employment/service, the Board Chair shall initiate an appropriate communication strategy to the staff, physicians, partners, and community announcing the appointment of the new CEO or COS.

DEVELOPED: May 30, 2012		
REVISED/REVIEWED:		
January 27, 2016	May 29, 2019	March 3, 2022
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CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

SUBJECT: CMH Executive Compensation Policy	**NO.: 2-B-20**
SECTION: Oversight of Management and Professional Staff	
APPROVED BY: Board of Directors	**DATE: TBD**

Policy

The Board is responsible for the development, implementation, oversight and management of the Executive Compensation Program that meets legislative requirements (Broader Public Sector Accountability Act, 2010, Excellent Care for All Act, 2010, Broader Public Sector Executive Compensation Act, 2014) and best practices in the health care industry.

For the purposes of this policy, the term “Executive” refers to the President and CEO (CEO), Chief of Staff (COS) and the Vice Presidents.

The Executive Compensation Program is a structured framework that defines how Cambridge Memorial Hospital (CMH) rewards and incentivizes the Executive and is based on the scope of responsibilities of the Executive and the performance of the Executive in achieving predetermined goals and objectives. The Program’s primary goal is to attract, retain and motivate high-performing executives and aligning their interests and actions with CMH’s strategic objectives.

The Executive Compensation Program is made available to the public upon written request.

Executives have performance related pay (at-risk compensation) directly linked to the annual Quality Improvement Plan (QIP) and other key performance indicators for the organization.

The Executive Committee of the Board is responsible annually for evaluating the performance of the CEO and COS and making recommendations to the Board on their at-risk compensation. Mid-year and year-end evaluation are conducted. The compensation related to performance is determined through the assignment of goals and objectives and the achievement of those goals and objectives.

The CEO is responsible for annually evaluating the performance of the Vice Presidents and deciding on their at-risk compensation. The compensation related to Vice President performance is determined through the assignment of goals and objectives and the achievement of those goals and objectives.

DEVELOPED: April 29, 2015		
REVISED/REVIEWED:		
April 25, 2018	May 26, 2021	Click or tap to enter a date.
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CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

SUBJECT:	**President & Chief Executive Officer & Chief of Staff Annual Performance Review**	**NO.: 2-B-25**
SECTION:	**Oversight of Management and Professional Staff**	
APPROVED BY:	**Board of Directors**	**DATE: TBD**

Policy

The Board shall be responsible for approving annual goals and objectives and undertaking the mid-year and annual evaluation of the President and Chief Executive Officer (CEO) and Chief of Staff (COS).

Annually, the CEO and COS shall develop draft goals and objectives in consultation with the Executive Committee for approval by the Board. Goals and the evaluation period are aligned with the organization's fiscal year. The CEO's and COS's year end evaluation shall be completed by June 30.

The Board delegates the responsibility to develop and oversee the evaluation process to the Executive Committee. The Executive Committee provides completed evaluations to the Board for approval. The evaluation process includes the determination of the at-risk compensation assigned to the achievement of the goals and objectives determined annually.

The comprehensive evaluation is undertaken annually and includes commentary on the:

- Achievement of the annual Quality Improvement Plan metrics
- Achievement of the Strategic Priority initiatives
- Achievement of the Operating Plan
- Achievement of the Capital Plan
- 360-degree feedback from selected evaluators (approved by the Executive Committee)
- Feedback from the Board
- Self reflection by the CEO and COS

Mid-year review: A mid-year review shall be conducted in November to assess progress and performance on the established goals, objectives, and metrics.

Year-end review: A year-end review shall be conducted between March and June to assess final progress and performance on the established goals, objectives, and metrics.

Procedure

Date	Action
Goals and Objectives Development	
March	The CEO and COS shall prepare annual goals & objectives including quality improvement plan metrics, strategic priority initiatives and the operating and capital plans
March to May	Executive Committee shall review and recommend the annual goals and objectives to the Board including the allocation of at-risk compensation.
June	The Board shall approve annual goals and objectives and an at-risk compensation allocation.
Mid-year Review	
November	The CEO and COS shall prepare a mid-year assessment of the progress on their goals and objectives and provide to the Executive Committee.
November - December	The Executive Committee shall review the mid year assessment with the CEO and COS. The Board Chair shall solicit input from Board members. The Board Chair, the Vice Chair, or alternate shall meet with the CEO/COS to discuss the mid-year performance.
December/ February	The Board Chair shall update Board members on the discussion with the CEO and COS.
Year-end Review	
March	The CEO and COS shall submit suggested evaluators for their 360-feedback survey to the Executive Committee. The Executive Committee shall develop and approve the list of the evaluators and provide an update to the Board.
April to May	The CEO and COS shall compile a self-evaluation (using the 360-feedback survey), the year end assessment of their goals and objectives, and a draft at-risk compensation analysis (collectively referred to as the "year end documents").
May	The Executive Committee shall review the year end documents and develop a recommendation for at-risk compensation for consideration by the Board.
May	The Chair and Vice Chair shall discuss the year-end documents with the CEO and COS and provide feedback to the CEO and COS.
June	The Board shall approve the final year end evaluation and approve the at-risk compensation based on the achievements of the CEO and COS.
June	The Chair and Vice Chair shall provide the year-end evaluation to the CEO and COS.

DEVELOPED: November 30, 2011		
REVISED/REVIEWED:		
January 27, 2016	May 29, 2019	May 25, 2022
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CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

SUBJECT: Quality and Patient Safety	**NO.: 2-C-10**
SECTION: Corporate Performance and Oversight	
APPROVED BY: Board of Directors	**DATE: TBD**

Policy

Exceptional healthcare is defined as the provision of care that is safe, effective and efficient provided by knowledgeable and caring people. It is enabled through continuous improvement in service, a just culture that prioritizes seeking systemic improvements over individual blame, and is guided by strategic planning, risk identification, goal setting, measurement, and accountability.

Framework

Quality is monitored using the 4 dimensions of quality in the CMH quality framework: (1) safe, accessible and integrated; (2) people focused; (3) efficient; and (4) equitable.

Safe, accessible and integrated

Patient safety is an integral component of quality that focuses on reducing the risk of harm to patients. Cambridge Memorial Hospital (CMH) strives to implement systems and processes to ensure patients shall not be harmed by accident or mistakes from care received at CMH. Patients shall receive timely and appropriate healthcare that is based on scientific evidence known to achieve the best possible outcomes. Health service providers shall collaborate with regional and community partners, stakeholders, suppliers and funders to provide high quality care integrated throughout the continuum of care. Staff shall collaborate with providers of services not available within our region to ensure access.

People focused

Whenever possible, the hospital shall co-design with patients so that patients shall receive care and services that are sensitive to the individual's needs and uniqueness. Co-design involves the patients in the design process and works with them to understand their met and unmet needs. The hospital shall evaluate feedback received via multiple channels to make improvements to care and service delivery.

CMH shall continue to promote and enhance a safe and healthy work environment so that staff, medical/professional staff, and volunteers are supported as individuals and as members of a team. CMH shall create multiple channels for feedback and strive to continually improve.

Efficient

Staff, medical/professional staff and volunteers shall strive to achieve the best value of health service for the community's health care needs. Health service providers shall continually look for ways to reduce waste, including waste of supplies, equipment, and time. They shall gather ideas and information with the aim of providing appropriately resourced care within the fiscal capacity of CMH.

Equitable

Patients and families shall receive quality care regardless of who they are and where they live. Care and services shall be designed and delivered based on socioeconomic and health outcome data; acknowledging that a one-size fits all approach does not always work. CMH shall actively work to understand the community its serve.

Key components of quality and patient safety include:

- the oversight role of the Board,
- the operational roles and accountability of administrative and medical/professional leadership,
- teamwork and communication,
- commitment to a just culture that prioritizes systemic improvements over individual blame,
- transparency of data,
- and active patient and family engagement.

Standards

Some of the standards, legislation and organizations that guide the hospital's quality work include:

- Accreditation Canada (Accreditation Canada)
- Beryl Institute (Home - The Beryl Institute)
- Canadian Institute for Health Information (Patient safety | CIHI)
- *Excellent Care for All Act, 2010*, S.O 2010, c. 14 (Excellent Care for All Act, 2010, S.O. 2010, c. 14 | ontario.ca)
- Healthcare Excellence Canada (Healthcare Excellence Canada)
- Ontario Health (Home | Ontario Health)
- *Public Hospitals Act, 1990*, Reg. 965 Hospital Management (R.R.O. 1990, Reg. 965 HOSPITAL MANAGEMENT | ontario.ca)
- *Quality of Care Information Protection Act, 2016*, S.O. 2016, c.3, Schedule B
- Office of the Chief Coroner (Office of the Chief Coroner and the Ontario Forensic Pathology Service | ontario.ca)
- Institute for Safe Medication Practice Canada (Home - ISMP Canada)

Procedure

The Board is accountable for ensuring the establishment, monitoring and oversight of appropriate structures, processes and other systems to support its responsibility for quality and patient safety. The Quality Committee, the Resources Committee and the Medical Advisory Committee (MAC) are key structures for monitoring and supporting quality and patient safety (see Figure 1: Quality Monitoring Committees). The Board uses evidence-informed methods for evaluating performance in quality and patient safety.

Board oversight includes, but is not limited to:

- developing and monitoring of the annual Quality Improvement Plan (QIP)
- approving and monitoring of system collaborative QIPs
- ensuring that appropriate policies and safety standards exist, exploring opportunities for continued improvement in quality and patient safety
- overseeing compliance with quality and safety related issues, including accreditation standards and related legislation (*Excellent Care for All Act, Quality of Care Information Protection Act*)
- ensuring recommendations are implemented in a timely manner following critical incidents
- reviewing and approving a multi-year quality and safety plan that sets out goals and objectives as part of the strategic plan
- reviewing at least quarterly, a scorecard containing up-to-date measures, analyses and action plans on the performance indicators
- reviewing the quality of programs and departments on an established schedule, and other events or issues at its discretion
- reviewing, at least twice per year, aggregate patient relations data and themes

The President and Chief Executive Officer (CEO), Chief of Staff (COS) and senior executive members (collectively referred to as the “senior executives”) are responsible for developing an annual quality and patient safety plan in conjunction with the Quality Committee, implementing processes, structures and systems to support and achieve quality and patient safety goals.

The senior executives foster an environment of transparency and accountability, teamwork and communication on issues related to quality and patient safety for the purpose of continuous improvement and goal achievement. This includes fostering a just culture that prioritizes systemic improvements over individual blame, where staff are comfortable raising quality and safety concerns without fear of retribution.

The senior executives work with health service providers to ensure processes and structures are in place to include patient and their families in their care, including a patient relations process.

The senior executives provide leadership and fosters the development of leadership abilities

and skills throughout the organization with the aim of achieving quality and patient safety.

The senior executives' responsibilities include, but are not limited to:

- establishing in conjunction with the Quality Committee a quality and patient safety plan on an annual basis, and revising the goals and measures with the aim of continuous improvement, in areas of highest priority and with attention to all 4 dimensions of quality and patient safety
- reviewing and disseminating performance results to the Board, Board committees, MAC, Quality and Operations Councils, and other stakeholders, including the public
- receiving information from all quality forums and taking actions and planning as required
- implementing best practice methods and techniques known to enhance quality and patient safety, such as:
    - performance measurement and reporting
    - credentialing of physicians through the Medical Advisory Committee
    - skills review and enhancement of clinical and corporate staff
    - patient safety education for staff
    - incident reporting
    - staff engagement
    - patient and family engagement
    - patient relations process
    - process improvement using tools such as value stream mapping and prospective analysis reviews

DEVELOPED: September 30, 2020		
REVISED/REVIEWED:		
May 25, 206	September 30, 2020	
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CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

SUBJECT: Approval & Signing Authority	**NO.: 2-C-34**
SECTION: Corporate Performance and Oversight	
APPROVED BY: Board of Directors	**DATE: TBD**

Policy

The President & Chief Executive Officer (CEO) shall ensure that the organization has policies and procedures in place for the approvals, purchasing, contracting, leasing, acquisition or disposal of goods, services, capital and real property. This policy sets out the approvals required to commit CMH resources and to identify individuals who are authorized signing officers on behalf of the Corporation. This information is supplemented by the Approval Authority Schedule set out in hospital policy 7.85 Corporate Supply Chain Directive – Procurement Policy and Procedures.

The Board authorizes the CEO to make commitments contained within the approved operating and capital plan or otherwise approved by motion of the Board or its delegated authorities, including all: contracts, requisitions, purchase orders, travel authorizations and any other agreement, financial or otherwise.

If emergency expenditures or commitments are necessary, the CEO shall secure the approval of the Board Chair and Chair, Resources Committee before committing to the expenditure. The Board or its delegated authority shall be informed at their next meeting.

Prior approval of the Board is required for the following:

1. The annual operating and capital plans
2. Capital purchases in excess of the annual approved capital plan
3. Hospital Service Accountability Agreement (HSAA) and the Multi-Sector Accountability Agreement (MSAA) between CMH and Ontario Health (OH)
4. Redevelopment-related approvals as required by the Ministry of Health and/or Infrastructure Ontario
5. The sale or transfer of any assets of the Corporation, which individually or cumulatively exceeds $100,000, subject to applicable Ministry of Health (MOH) asset disposition policies
6. The taking or instituting of proceedings for the winding-up, reorganization or dissolution of the Corporation
7. The enactment, ratification or amendment of any by-laws of the Corporation
8. The sale, lease, exchange or other disposition of all or substantially all of the assets or undertakings of the Corporation
9. The provision of financial assistance, whether by loan, guarantee or otherwise to any person whatsoever
10. Real estate purchases and sales
11. Internal and external space leases greater than $50,000 per annum

12. Union contract agreements

Signing Authority

In addition to the provisions of the Corporations By-law, the Board may from time to time by resolution direct the way in which and the person or persons by whom any particular instrument or class of instruments or document may or shall be signed. Any signing officer shall affix the seal of the Corporation to any instrument or document and shall certify a copy of any instrument, resolution, by-law, or other document of the Corporation to be a true copy.

Electronic signatures may be used to automate the disbursement authorization process, subject to appropriate safeguards. CMH uses a recognized third party software, for electronic signatures where possible, which has built in security features to validate the signature, based on the user login credentials. If third party software is unavailable, the use of an electronic picture of an individual's signature with email approval from the signer noting its use shall suffice.

In conjunction with CEO, the Board shall identify the designated signing officers of the Corporation and their authority and shall review the slate of designated signing officers at least annually and at the time of turnover of so designated Board members and staff.

The CEO shall be accountable to the Board for ensuring that adequate internal controls and processes are in place. Employees are not authorized to bind the Corporation to contracts or incur expenditures unless they have been delegated that authority.

Reporting Requirements

The CEO or designate shall report to the Board on compliance with this policy. The reporting shall be at least annually unless there are significant breaches to these rules and/or controls. In that case, the CEO shall inform the Audit Committee, Resources Committee, and the Board at their next regularly scheduled meeting.

Policy Compliance

The Finance and Procurement departments shall put in place processes to ensure that the above authorization policies are adhered to. The Finance and Procurement department shall report instances of unauthorized expenditure or commitment to the CEO as soon as possible and, where material, the CEO shall inform the Audit Committee, and Resources Committee of the Board at their next regularly meeting. "Material" in this context should include unauthorized expenditures or commitments which are beyond the authority of the CEO or lesser amounts at the discretion of the CEO.

Signing Authorities For Disbursements:

Disbursement signing authority is approved by the Board and generally consists of the holders of the following positions (or designates):

- Chair of the Board
- Vice-Chair of the Board
- CEO
- Vice President, Finance and Corporate Services and CFO
- Vice President of Clinical Programs and Chief Nursing Executive

- Director of Finance
- Controller

For disbursements (including HST, payroll and HOOP payments)

- Less than $100,000, any two of the above signatures are required
- Over $100,000 requires the signature of two of the following: CEO, Chair of the Board, Vice-Chair of the Board, Vice President, Finance and Corporate Services and CFO or Vice President of Clinical Programs and Chief Nursing Executive

Unless otherwise set out in this policy, this authority shall not be further delegated. No other staff or Board member shall sign disbursements on behalf of the Corporation.

Electronic funds transfers (EFTs) are initiated, executed, and approved in a secure manner. All EFT payments shall be coordinated and submitted through the Finance department. The Controller or their designate shall approve all new and amended EFT requests, ensuring all required documentation is provided and appropriately approved, and that the request and banking account information is accurate and valid. EFTs are subject to the same financial policies, procedures and controls that govern disbursement by any other payment mechanism.

The total value of a disbursement shall not be split into smaller segments to avoid the approval requirements and signing authorities set out in this policy.

Signing Authorities For Staff And Board Member Expenses

All reimbursable expenses incurred by CMH staff or Board members shall be approved by one level higher than the individual claiming the expenses as follows:

(i) Staff requires their leader/manager approval
(ii) Vice President requires CEO approval
(iii) CEO requires Board Chair approval
(iv) Board Members require Board Chair approval
(v) Chief of Staff requires Board Chair approval
(vi) Board Chair requires Chair of Resources Committee

Signing Authorities

The CEO shall ensure that the organization does not order, receive or process goods in a manner that does not meet good business practices, the Ontario Broader Public Sector Directive and applicable CMH procurement policies.

All purchases of supplies, services, capital, or for a contract, lease or agreement, shall be completed in accordance with the signing authorities set out in the Policy 7.85 Supply Chain Directive – Procurement Policy and Procedures.

All purchases in excess of $5,000, shall require a purchase order except for:

(i) Collective Agreements
(ii) Employment Contracts
(iii) Utilities Agreements
(iv) Transfer Payments to other Health Service Providers
(v) Payroll disbursements

(vi) Physician payments
(vii) Staff Expense Reimbursements
(viii) Just in Time Inventory Program Payments

Signing Officers For Specific Legal Documents

a. Changes to Capital Project Budgets

All changes to capital project cost shall be approved and signed in accordance with CMH Capital Projects Change Order Request and Approval Policy 2-C-40.

b. Contracts for which CMH Receives Money or Monies Worth (i.e. Property; Goods; or Services); Affiliation Agreements; Service Transfer Agreements; Estate Administration; Performance Contracts (i.e. Wait Times)

The President & CEO or individual(s) designated as set out in this policy or otherwise established in writing by the President & CEO shall have the power

- to sign contracts, documents or instruments in writing where CMH shall receive money or monies worth (i.e. property, goods, services)
- to sign contracts where CMH is transferring a service to another service provider, and
- to enter into affiliation agreements and estate administration documents.

c. Research Agreements & Physician / Professional Staff Agreements

The President & CEO or delegate, shall be authorized to sign the following documents:

(i) Affiliation Agreements with Colleges (Private and Public) and Universities;
(ii) Affiliation Agreements with other public entities for education;
(iii) Memorandum of Understandings (Research and Education);
(iv) Research contracts – every research project;
(v) "Notification of Research Study to Commence" authorization letters;
(vi) Clinical Trials Ontario ("CTO") attestation documents. For the purpose of CTO documents, the Vice-President of Clinical Programs and Chief Nursing Executive has specifically designated the Privacy & Risk Lead / Privacy Officer as the Primary Institutional Representative for CMH and authorized signatory for attestations or other CTO documents.

The Chief of Staff and President & CEO (or designates) shall be authorized to sign the following documents if the financial commitment does not exceed $500,000:

(i) Physician Clinical Service Agreements / Contracts; and
(ii) Physician Leadership Agreements / Agreements.

d. Confidentiality/Data Sharing Agreements

Confidentiality/data sharing agreements shall be signed by any two of the President & CEO, a Vice President, a Director (that is, an employee, not a Board director) or Chief of

Staff. The President & CEO may also designate in writing specific individuals not listed under this category who may sign confidentiality agreements on behalf of CMH.

All confidentiality/data sharing agreements relating to the collection, use, disclosure and/or access to personal health information shall be reviewed by Health Information Management and the Privacy Officer prior to signature.

e. Commercial Leases; Real Property

All lease documents regardless of the term or financial commitment, including leases where CMH space is leased to third parties, shall be reviewed, approved and signed by any one of the President & CEO or Vice President, Finance and Corporate Services and CFO (or designates).

Subject to Ontario Government requirements, the sale, mortgage hypothecation or other disposition of real property shall be authorized with the approval of 2/3rds of the Board. Once approved, any two of the Board Chair, Vice-Chair, President & CEO, or such other person or persons as approved by a Board resolution shall be authorized to execute any document required to effect such disposition.

f. Bank Signing Authority

Any two of the following individuals (or designates) shall be the designated signing officers for banking transactions.

- Chair, Board of Directors
- President & CEO
- Vice President, Finance and Corporate Services and CFO
- Vice-President of Clinical Programs and Chief Nursing Executive
- Director of Finance
- Controller

<u>New Bank Accounts:</u>

All bank accounts holding hospital funds shall be opened in the name of Cambridge Memorial Hospital. Documentation for all new and existing accounts requires signatures of two (2) of the CMH designated signing officers described above.

<u>Cash Transfers:</u>

Authorized Controller shall be permitted to transfer funds between CMH bank accounts, subject to the approval of the Director of Finance, regardless of the amount transferred. All transfer approvals and bank statements indicating the transfer shall be retained by Finance.

Cheque Release Approvals: Prior to the release of cheques, the Director of Finance, or delegate, shall approve the cheque register and/or the Electronic Funds Transfer (EFT) listing. All cheques/EFTs that do not have a purchase order shall be reviewed prior to approval.

<u>Release of Banking Information:</u>

(i) Release of banking information to vendors shall be authorized by a Controller.
(ii) Banking information for the purposes of pre-authorized payments shall be supported by the appropriate internal documentation. A vendor request for banking information shall be completed and approved.
(iii) The release of banking information shall be sent directly from Finance to the approved vendor.
(iv) Copies of all documentation shall be retained in the Finance Department.

Documentation of Authorized Signatures:

A list of authorized personnel and sample signatures shall be maintained by the Accounts Payable department.

Reporting Requirements

The reporting shall be at least annually unless there are significant breaches to these rules and/or controls. In that case, the Resources Committee and the Board shall be informed at their next regularly scheduled meeting.

DEVELOPED: March 26, 2012		
REVISED/REVIEWED:		
January 29, 2013	September 24, 2014	November 24, 2014
January 28, 2018	April 28, 2021	May 1, 2025
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

BOARD MANUAL

SUBJECT: Investment Policy	**NO.: 2-C-38**
SECTION: Corporate Performance and Oversight	
APPROVED BY: Board of Directors	**DATE: TBD**

Policy
The Board of Cambridge Memorial Hospital (CMH) shall be authorized to make or receive any investments which the Board in its discretion considers advisable. The Board shall be permitted to invest pursuant to the *Ontario Trustee Act*, as amended from time to time, as follows:

i) all monies given in trust to CMH for the use of the organization;
ii) all monies not required for operating expenses; and
iii) the Board may, in its discretion, retain investments not authorized by the *Trustee Act* which are given to CMH.

The primary objectives of these funds in order of priority are safety of principal (which include preserving as much of the purchasing power of the capital and income as possible from the eroding effects of inflation over the longer term), liquidity, and return on investment having regard to permissible investments. In all respects, maturity dates of investments must recognize the forecasted cash flow requirements of the organization.

Responsibilities:
The Board of CMH has assigned oversight of investment management for the Hospital to the Resources Committee.

The Resources Committee shall:
- Establish and amend the Investment Policy;
- Review this policy at least every 3 years;
- Review the status of such investments on an annual basis; and
- Be responsible for the delegation of any responsibility not specifically mentioned.

Return on Investments
The Hospital's objective is to generate a total investment return that results in enhanced yield versus short term rates, protecting the long-term purchasing power of capital, with sufficient liquidity to meet all CMH capital requirements as needed.

Excess funds, not required for operating and capital needs, shall be invested with the following investment objectives:

1. Capital preservation and growth through principal-protected investment options, including cash term deposits;
2. Maintenance of adequate liquidity to ensure availability of funds when needed by the Hospital; and
3. The exercise of the care, skill, diligence, and judgment of a prudent investor.

Risk Tolerance
Investment activities shall be undertaken in a manner designed to preserve capital.

DEVELOPED: March 26, 2012		
REVISED/REVIEWED:		
February 27, 2013	January 27, 2016	October 17, 2018
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.

CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

SUBJECT: Board and Committee Annual Work Plans	**NO.: 2-D-04**
SECTION: Board Process	
APPROVED BY: Board of Directors	**DATE: TBD**

Policy

Each committee Chair and the Board Chair, together with the staff that support the committee/Board, shall develop the committee's or Board's annual work plan. The Board Chair and President & CEO (CEO) shall work to ensure the committee work plans and Board work plan are consistent. The work plans shall guide the work of the Board/committee and the development of meeting agendas.

The work plans shall incorporate activities consistent with:

- the roles and responsibilities of the Board/committees, as defined in the terms of references;
- the current strategic priorities and objectives of the Hospital;
- the annual objectives, if any, developed by the committees; and
- the Hospital's planning process.

Process

1. Board/committee work plans shall be developed and reviewed by the Board/committee at the Board/committee's first meeting in the fall.
2. Throughout the year, Board/committee work plans shall be reviewed by the committee Chair/Board Chair and the staff to ensure the expectations of terms of reference are addressed.
3. The current Board/committee work plans shall be provided in each Board/committee package.
4. Board/committee work plans shall be kept current by the staff.
5. Changes to committee work plans that affect the Board work plan shall be sent to the Board Chair and CEO for review. If necessary, the amendments to the committee work plan shall be reviewed and approved by the Board.

DEVELOPED: November 24, 2010		
REVISED/REVIEWED:		
April 23, 2014	November 30, 2016	November 27, 2019
September 28, 2022	Click or tap to enter a date.	Click or tap to enter a date.
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

BOARD MANUAL

SUBJECT: Whistleblower Policy	**NO.: 2-D-48**
SECTION: Board Process	
APPROVED BY: Board of Directors	**DATE: TBD**

This policy is identical to Corporate Manual Policy 2-340

Policy:

Cambridge Memorial Hospital ("Hospital") is committed to open, accountable, ethical, and transparent governance which encourages a culture of integrity and honesty. An important aspect of accountability and transparency is a mechanism to enable the Individuals, as defined in this policy, to voice concerns when they discover information which may be unethical or illegal.

Every Individual shall have the responsibility to promptly report Whistleblower matters in accordance with this policy.

The purpose of this policy shall be:

- To establish procedures for the receipt, retention and handling of complaints and concerns that the Hospital receives relating to, among other things, alleged or suspected violations of the Code of Conduct (see Policy #9-257: Respectful Workplace Program), Conflict of Interest Policy (see Policy #9-40: Conflict of Interest), other internal policies and guidelines, or any applicable law or regulation.
- To encourage and enable the reporting of violations of Hospital policy relating to ethical behaviour and business conduct, including the Code of Conduct, Conflict of Interest Policy.
- To encourage and enable reporting of concerns relating to:
  - financial, internal accounting controls, or audit practices
  - quality of care
  - environmental issues
  - health and safety
  - human resource policies and legislation
  - breach of contract and negligence
  - privacy
  - violations of any other relevant provincial and/or federal legislation

  Refer to **Appendix A – Reporting Categories, Definitions, and Additional Questions**
- To ensure there is no retaliation against those Individuals who make reports in Good Faith under this policy.
- To protect the confidentiality of those making reports to the maximum extent possible, consistent with the need to conduct an adequate investigation

Definitions:

Bad Faith: includes malicious conduct, improper motive, dishonesty, recklessness and gross negligence. Bad faith is more than just "being wrong" about an event. A bad faith complaint is one where the Individual makes and steadfastly maintains as a complaint that the Individual

knows or ought to know is a false claim.

Board: means the Board of Directors of the Hospital.

Designated Investigator(s): The Designated Investigator(s) is/are assigned by the Director, Human Resources and CHRO; or Audit Committee; or President & Chief Executive Officer (CEO); or Chief of Staff (COS), as the case may be, to review and investigate the complaint, where appropriate. The Administrative Assistant, People & Strategy shall be notified of report submissions and shall support the Director, Human Resources and CHRO from an administrative capacity.

Disclosing/Discloses/Disclosure: means communicating or providing information, as described in this policy.

Good Faith: means to act honestly or with sincere intention. The legal test for determining whether the complaint is made in good faith is objective.

Individual: Any Board Director, non-director committee member, employee, medical/ professional staff member, contractor, consultant, student and/or volunteer, patient, or community member.

Vexatious: refers to a situation, communication or information presented which is lacking sufficient grounds for action and, when viewed objectively, is serving only to annoy or harass.

Whistleblower: An Individual who discloses information that the Individual, in Good Faith, has reasonable grounds for believing is evidence of a violation of any law, rule, regulation or policy; a gross mismanagement; a gross waste of funds; an abuse of authority; a substantial and specific danger to public health and/or a substantial and specific danger to public safety.

Standards:

- This policy does not supersede any other reporting mechanisms covered by hospital policy or legislation.
- This policy is intended to be used in cases where the standard Hospital reporting mechanisms do not result in an outcome acceptable to the complainant or in cases where the complainant chooses to use this method for raising a complaint.
- The Hospital maintains high standards of business and ethical conduct, as expressed in its codes of conduct. The Hospital applies these standards to all matters of business.
- The Hospital expects all Individuals to observe these standards while fulfilling their responsibilities to the Hospital.
- This policy shall be posted on the Hospital's intranet.
- The Hospital shall, at least annually, communicate reminders to Individuals of the process for reporting complaints. This may be accomplished by electronic or other means (i.e. email, written memos and Hospital newsletters).
- To the best of its ability based on the information supplied, the Hospital shall conduct an investigation when it receives a complaint.
- The Hospital shall maintain records and issue reports in accordance with this Policy.

Procedure:

1. Reporting:

There are several channels at CMH through which concerns may be reported. Consideration should be given to the nature of the concern in choosing the most appropriate channel. CMH reporting mechanism include an Individual's leader, Human Resources, Report Link, What's on Your Mind, etc.

The Whistleblower Policy provides a comprehensive approach to disclosure complaints that can be submitted confidentially and/or anonymously.

a. Any Individual who is aware of a real or perceived conflict of interest that has not been appropriately mitigated
b. Any Individual who is aware of or suspects a breach of the codes of conduct or matters of concern or wrongdoing is responsible for disclosing the breach or concern promptly using either standard reporting mechanisms as referred to in existing policies, or this policy.
c. Members of the public who are aware of or suspect a breach of the codes of conduct or matters of concern or wrongdoing are encouraged to disclose the breach or concern using the reporting mechanisms referred to in this policy.
d. It is expected that matters of concern shall be reported in a timely manner and within one year of when the issue became known to the Individual.
e. A concern may be disclosed to an external third-party provider. (Clearview Connects). Cambridge Memorial Hospital has established a mechanism for confidential and anonymous submissions through a secure website. Complaints may be reported online at http://www.clearviewconnects.com/.
f. All whistleblower submissions are routed to the Director, Human Resources and CHRO. If the submission is regarding the Administrative Assistant, People and Strategy, the Director of Human Resources and CHRO, the Vice President, People and Strategy, the CEO and/or the COS, the concern shall be routed to the Chair of the Audit Committee.

2. Matters of concern or wrongdoing:

a. Examples of concerns relating to financial, accounting and auditing practices may include, but are not limited to, situations such as:
    i. The appearance of fraud, including falsification of records;
    ii. Unauthorized dealings with contractors for personal benefit, including receiving kickbacks or gifts which breach the hospital's procurement policies;
    iii. Unethical or illegal practices, including misappropriation of funds or abuse of expense accounts;
    iv. Violation or circumvention of the hospital's financial policies or accounting practices.
b. Examples of concerns relating to quality of care may include, but are not limited to, situations such as:
    i. Abuse of patients by any party;
    ii. Negligence of patient care in violation of Hospital policies.
c. Examples of environmental issues may include, but are not limited to, situations such

as:

i. Disposal or destruction of dangerous goods or products in violation of legislated requirements;
ii. Failure to appropriately report disposal or destruction of dangerous goods or products in accordance with Federal or Provincial legislation.

d. Examples of violations of human resources policies and legislation may include, but are not limited to, situations such as:
   i. Cultural, racial and sexual harassment;
   ii. Discrimination of any kind as outlined in legislation;
   iii. Workplace safety and harassment violations.
e. Examples of breach of contract and negligence may include, but are not limited to, situations such as:
   i. Danger to health and safety;
   ii. Inappropriate release of confidential information.
f. Criminal offences of any kind.

3. No Retaliation:

a. No one shall be penalized for making a Good Faith Disclosure. The Hospital shall not retaliate and shall not allow any retaliation or discrimination by its Individuals of any kind against any Individual who submits a Good Faith complaint. Specifically, the Hospital shall not discharge, demote, suspend, threaten, harass or in any other manner discriminate or retaliate against any Individual submitting a Good Faith complaint.
b. Bad Faith and/or Vexatious complaints shall not be tolerated, and appropriate disciplinary measures shall be taken by the Hospital if they are initiated up to and including termination or loss of privileges.

4. Confidentiality:

a. All Board Directors and management shall keep Whistleblower reports confidential, subject to any legal obligations to disclose. There may be certain circumstances where confidentiality cannot be guaranteed such as: a court order requiring disclosure; and/or any other legal requirement for disclosure such as a statute or case law; or where disclosure is required for the hospital to conduct an effective investigation.
b. No one shall in any manner attempt to identify an Individual who reports in Good Faith on a confidential basis and any such action may result in disciplinary action up to and including termination or loss of privileges.
c. In the interest of ensuring accountability and responsibility in reporting, anonymous complaints are discouraged as they may create limitations to the investigation and resolution procedures available. Notwithstanding, anonymous complaints shall be reviewed and addressed to the extent possible.

5. Procedure for Investigation of a Complaint:

a. It is anticipated that in the ordinary course, the Director, Human Resources and CHRO shall complete their assessment of the complaint and assign the investigation of such complaint to a Designated Investigator generally within ten business days of receiving such complaint.

b. In matters involving the Director, Human Resources and CHRO, the President & CEO shall determine the process to be utilized based on the nature of the complaint.

c. The Designated Investigator shall assess the seriousness of the complaint promptly and determine, in consultation with others, if necessary, the manner in which the complaint shall be investigated, using internal and/or external resources, and shall determine who shall lead such investigation. When the investigation relates to the CEO or COS, the Audit Committee may also request additional resources (including external experts) to facilitate an investigation.

d. The Designated Investigator assigned for the investigation of the complaint shall:
   i. Notify the complainant that the Hospital has received the complaint and that it shall be investigated;
   ii. Treat the complaint, as well as its investigation and disposition on a confidential basis;
   iii. Involve, in the investigation, only those persons who need to be involved in order to properly carry out such investigation;
   iv. Ensure appropriate support to staff by allowing union representation or legal counsel as applicable;
   v. Conduct the investigation in a timely manner to a maximum of 3 weeks from the date of assignment. Any extension of this time period requires approval of the Director, Human Resources and CHRO, CEO, COS or the Audit Committee, as the case may be;
   vi. Document the investigation and subsequent follow up (including issuing a report to the complainant) in a manner consistent with hospital investigations;
   vii. Retain the records of the investigation consistent with the Personal Health Information - Retention and Destruction policy.

6. Monitoring the Investigation:

a. The investigation of a complaint shall be monitored on an ongoing basis by the Audit Committee, Director of Human Resources and CHRO, CEO, COS or delegate, as appropriate

7. Acting upon the Investigation's Findings/Conclusions:

a. Once completed, the report shall be reviewed, and appropriate corrective action shall be taken by the Hospital.

8. Report to the Audit Committee and Board:

a. A report of all complaints filed shall be presented by the CEO or delegate to the Audit Committee of the Board at least annually.

b. The report shall include:
   i. The total number of complaints;
   ii. A description of each complaint;
   iii. How the complaint was received;
   iv. The relevant category of the complaint;
   v. Whether contact information was provided by the Individual registering the complaint;

vi. Whether the complaint could be substantiated;
vii. Who was involved in the investigation;
viii. The resolution to the complaint, any policy changes implemented and/or any actions taken;
ix. The status of the complaint.

c. The Audit Committee shall share the report with the Board.

d. In the event that the Audit Committee or the Board, as the case may be, is not satisfied with the report of the investigation, the Board may require that a further investigation be completed.

References:

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Developed in consultation with:

1. Audit Committee of the Board of Directors
2. Board of Directors
3. Clearview Connects
4. President & CEO
5. Director, Patient Experience, Quality & Risk, IPAC and Chief Privacy Officer

DEVELOPED: October 25, 2006		
REVISED/REVIEWED:		
June 25, 2014	April 24, 2019	April 27, 2022
November 30, 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.
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BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: October 11, 2025
Issue: Strategic Priorities Q2 Update
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kyle Leslie, Director of Operational Excellence
Approved by: Mari Iromoto, VP People and Strategy

Attachments/Related Documents:
Appendix A – Strategic Priorities Tracker

Alignment with 2025/26 CMH Priorities:

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

Alignment with 2025/26 CMH Corporate Plans: Choose an item.

Executive Summary

This briefing note provides an in-depth overview of our performance during Quarter 2 (Q2) of fiscal year 2025/26, highlighting notable achievements alongside ongoing challenges in patient flow and staffing/overtime management.

Background

The Strategic Priorities Tracker aligns key organizational priorities derived from the Quality Improvement Plan (QIP), Integrated Risk Management (IRM) process, and our strategic plan. This tool ensures that our priorities are coordinated and provides performance insights through various monitoring channels, including weekly operations huddles, flow meetings, staffing overtime task force meetings, and departmental Quality and Operations councils.

Key tools for performance monitoring in 2025/26 include:

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 Q2 performance, including key highlights from our action plans; full details can be found in **Appendix A:**

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

- **Ambulance Offload Time (Minutes) - 90th%tile (On-track):**
  - Target: ≤43 minutes, Q2 Performance: 28 minutes, a significant improvement from 85 minutes during the same period last fiscal year.
  - Actions Taken: Focus has been on sustainability, bi-weekly meetings continued with EMS leadership to monitor and maintain improvement and to elevate standard practices between EMS and CMH in terms of transfer of care and arrival time capture.
  - Actions Planned for Next Quarter: Continue collaboration with EMS and regional partners to clarify and standardize practice for transfer of accountability and offload. EMS bi-weekly meetings will continue.
- **Provider Initial Assessment in ED (Hours) - 90th%tile (Not-Meeting Target):**
  - Target: <4.6 hours. Q2 Performance: 7.6 hours, slightly better than the prior year's performance during the same period, which was 7.8 hours.
- **Provider Initial Assessment Urgent CTAS 1-2 (Hours) - 90th%tile (Not-Meeting Target):**
  - Target: <4 hours. Q2 Performance: 6.5 hours, this is an improvement from same period last fiscal year.
  - Actions Taken: During Q2 there was a focus on reviewing and updating standard operating procedures to ensure triage effectiveness and accuracy in capture of CTAS levels in collaboration with our CEF team. Nurse practitioner (NP) cover was evaluated and enhanced where possible to reduce days without NP coverage. The scribe AI tool continued to be elevated with ED physicians to support documentation efficiency and patients seen per shift.
  - Actions Planned for Next Quarter: Focus on refresh and development of surge policy, elevate bi-weekly meetings with ED leadership through Dyad model to monitor and address concerns and barriers that may lead to delays in assessing patients and achieving overall PIA targets. Support ongoing training and development for nursing competencies to support all areas in the ED to ensure smooth coverage and flow. Elevate focus in subacute areas ensuring rooms are filled, and patients are ready to be seen.
- **Average Admission in ED at 8 AM (Not-Meeting Target):**
  - Target: <10 patients held at 8 AM. Q2 Performance: 12.06 average admissions held in the ED at 8 AM, slightly higher than prior year.
- **Inpatient Medical Discharges before 11 AM (Not-Meeting Target):**
  - Target: Discharge more than six inpatient medicine patients per day before 11 AM. Q2 Performance: 0.56 discharges per day on average before 11 AM, consistent with the previous fiscal year.
  - Actions Taken: Developed awareness campaign to highlight resources supporting admission avoidance and early discharge. Implemented estimated date of discharge tracking into rounds focusing on length of stay improvement. Re-established review process for long stay cases. Medical directive for catheter removal to remind staff of discharge barriers at rounds. Focused on process improvements in communication between ED flow, Charge Nurse and Inpatient

units to enhance TOA and coordination of patients with target of pulling to the IP bed within 30 minutes of bed becoming available.
- Actions Planned for Next Quarter: Focus on developing discharge model as part of transition with OH@Home. Enhance education for front-line staff on discharge planning strategies to identify and escalate barriers early. Continue to focus on identifying and awareness of estimated dates of discharge (EDD) and communication among care teams and patients of EDDs. Continuing with innovation, focus on automating and enhancing bullet rounds with electronic communication and real-time visualizations.

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

- **Percentage on Track with Identified Milestones for FY 25/26 (Progressing to on Track):**
  - This includes core milestones related to major systems modernization projects under Project Quantum, such as workforce planning, health information management, and ERP project. Additionally, we are tracking the adoption of advanced digital solutions by our physicians for enhanced documentation efficiencies through speech recognition and AI ambient listening tools.
    - **Health Information System (HIS) Implementation:**
      - Actions Taken: completed contract signing, hired manager of informatics, established and finalized project governance, Terms of Reference Developed and subcommittee structure being initiated.
      - Actions Planned for Next Quarter: On-boarding of project coordinator and subject matter experts, kick-off project steering committees and councils, schedule workshops and complete readiness checklists.
    - **Workforce Planning (WFP) Implementation:**
      - Actions Taken: Focus has been on stabilization of WFP implementation, monitoring to ensure successful pays and focused on establishing scope of phase 2 targeting close out in Q3
      - Actions Planned for Next Quarter: complete phase 2 scope, consolidate WFP steering with broader corporate applications steering, and close all urgent optimization action items.

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

- **Full-Time Equivalent (FTE) Variance (Not-Meeting Target):**
  - Q2 Performance: 25 FTE variance across RNs, RPNs, and PSWs from main clinical programs (ED, ICU, and Medicine), contributing to increased overtime and strain to cover ER holds and replacement needs.
  - Actions Taken: Filled vacancies in Health Safety Wellness, created script for leaders to elevate conversations with staff experiencing high sick-time. Work underway with UKG to build attendance program, collaborated with project team to develop system enhancements for pay to schedule model for non-union and non-management departments to enhance timecard efficiency. Automated reporting and emails to staff with history of sick time when absence is reported.
  - Actions Planned for Next Quarter: finalize talent acquisition lead role, continue to build attendance program, focus on development and implementation of staffing float pool. Spread OT improvement work completed in Medicine to other

applicable units such as use and monitoring of OT data daily and OT / staffing guardrails implemented in UKG.

- **Medical Professional Staff Recruitment (Progressing to on-track):**
  - Identified 17 core medical professional staff positions critical to hospital operations; successfully recruited to 13 of the positions in Q2.

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

- **Post Construction Operating Plan Revenue Earned (On-track):** Indicator measures our PCOP revenue earned. For Q2, we achieved our budgeted PCOP revenue.
  - Actions Taken: focused on performance monitoring for main PCOP funding categories, forecasting was completed as part of the 26/27 budget build to predict year end PCOP and impact on 26/27 budget strategy. Regional Collaboration project initiated for operating room utilization and targeted revenue from preferred accommodations.
  - Actions Planned for Next Quarter: Continue to focus on active monitoring and action as needed if we start to see shift in performance that impacts year-end predictions. Targeting to achieve maximum PCOP in 25/26. Continue to focus on budget process for 26/27. Participation in regional initiatives will continue focusing on operating room utilization, surgical waitlist, and preferred accommodations.

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

- **Percentage on Track with Diversity, Equity & Inclusion (DEI) Plan (progressing to on track):** Deliverables such related to inclusive communications, hospital wide orientation and some planning committees needed to be reprioritized to Q3 due to competing priorities and resourcing. Below is a summary of actions taken in Q2:

  - **Inclusive Languages and Images:**
    - Prepared initiatives for Islamic History Month.
    - Organized a Photo Day event to foster inclusivity through visual representation.
    - Distributed the first Quarterly CEO Communication aimed at enhancing awareness of DEI efforts.
  - **Education and Tools:**
    - Created a list of tools and resources to add to CMHNet, but this action was postponed to Q3 due to the focus on Indigenous Truth & ReconciliACTION Plan educational initiatives (e.g., rollout of San'yas Indigenous Cultural Safety Training, September LEARN Challenge, and Cultural Safety Passport Activity).
  - **Creating Safe Spaces:**
    - Employee Resource Group (ERG) Rollout: Received endorsement from the Diversity Council for rolling out ERGs across CMH. Developed ERG Terms of Reference (TOR) and presented the rollout plan and TOR to the Operations Team for feedback. Official launch of the Pilot Phase rollout plan was postponed to Q3 to allow input from the new Director of Organizational Development.

  - **People & Processes:**
    - Drafted a new policy aimed at enhancing DEI practices within our organization.

- Applied a Diversity, Equity, and Inclusion lens to update the Code Yellow form and process to better align with inclusive practices.
- Staff demographics data postponed to Q3 due to limited capacity (survey Fatigue) and staff concern with linking to UKG registration
- Hospital Wide Orientation (HWO) postponed updating inclusive vs. non-inclusive scenarios to be more CMH-specific until Q3 due to capacity limitations.

- **Percentage on Track with Truth and Reconciliation Plan (Progressing to On-Track):** Two actions such as Smudging Policy and SOAHAC Assessment tools needed to be reprioritized from Q2 to Q3 due to completing demands and resourcing. Below is a summary of actions taken in Q2:

  - **Build and Enhance Capacity and Education:**
    - Commemorated Orange Shirt Day / National Day for Truth and Reconciliation
    - Indigenous Learning Series hosted
    - Annual Eagle Feather Re-energizing Ceremony
  - **Build and Sustain Productive Relationships:**
    - Regular attendance at Indigenous Advisory Committee
    - Participated in regional indigenous events
  - **Equitable Access to Culturally Safe Care:**
    - Initiated Wing A art installation
    - Begun drafting Smudging guidelines
    - Indigenous Clinical Recommendations finalized in action plan
  - **Develop Quality Indicators to Measure, Monitor and Evaluate Success:**
    - Ensure that Indigenous Council Terms of Reference are measured, monitored, and evaluated separately by DEI Council. Established a tracker for Indigenous Truth & Reconciliation initiatives to measure, monitor, and evaluate separately from DEI.

Consultation

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

Next Steps

The strategic priorities tracker, including summaries of actions taken and planned actions, will be shared quarterly. The next updates are scheduled for February 2026 (Q3) and May 2026 (Q4).

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: November 26, 2025
Issue: Quality Monitoring Scorecard
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kyle Leslie, Director of Operational Excellence and Organizational Scheduling Office
Liane Barefoot, Director, Patient Experience, Risk & Quality & CPO
Approved by: Mari Iromoto, VP People & Strategy

Attachments/Related Documents:
Appendix A Quality Monitoring Scorecard

Alignment with 2025/26 CMH Priorities:

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

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

Currently, most “red” indicators are linked to organizational flow, sick hours and overtime hours with the exception on Congestive Heart Failure (CHF) readmissions, which had previously been trending outside of target and has now improved to targeted performance in August.

Despite these challenges, our other key indicators are either meeting or showing improvement towards their respective targets.

The focus on organizational flow is consistent with our 2025/26 strategic priorities.

Background
The CMH Quality Monitoring Scorecard tracks our key performance indicators aligned with our quality framework, many of which are publicly reported by Canadian Institute for Health Information (CIHI).

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

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

The following quality indicators are currently underperforming:

1. Conservable Bed Days Rate. Measures the rate of patients' days that are considered conservable vs. total acute patient days. A lower rate means that a patient's acute length of stay is closer to benchmark. YTD Sep Conservable Days Rate is 45.78%. This indicator has been trending away from target over the last three periods.

2. Overtime Hours: this indicator tracks average overtime hours used per pay period, our target is 1,723 hours or less, YTD Oct performance is 4,334.

3. Sick Hours: This indicator tracks our average sick hours per pay period, our target is 2,359 hours or less, YTD Oct performance is 4,076.

4. ED Length of Stay for Admitted Patients (90% spent less, in hours): Tracks wait-time from triage to inpatient bed arrival. As of YTD Sep, 90% of admitted patients waited 53.80 hours or less, compared to a target of 33 hours. This indicator has trended away from target over the last two periods.

5. ED Wait Time for Inpatient Bed (90% spent less, in hours): Measures the time between admission decision and bed arrival. By YTD Sep, 90% of admitted patients waited 45 hours or less, against a target of 25 hours. This indicator has trended away from target over the last two months.

6. ED Length of Stay, Non-Admitted Complex (CTAS 1-3) (90% spent less, in hours): Tracks the wait-time from triage to disposition for complex ED patients. YTD Sep data shows that 90% had a stay of 10.10 hours or less, while the target is 8 hours. This indicator has been stable over the last three periods above target.

7. ED Wait Time for Provider Initial Assessment (PIA) (90% spent less, in hours): Monitors the time from triage to physician/nurse practitioner assessment. As of YTD Sep, 90% were seen within 7.6 hours overall and 6.4 hours for CTAS 1-2 patients, versus an internal target of <4 hours. Our urgent PIA LOS from Jul to Aug improved slightly from 6.4 to 6.1 however Sep increased to 6.9 hours.

In addition to the aforementioned indicator, the Readmission Rate within 30 Days following Congestive Heart Failure (CHF) discharge was elevated requiring focused attention due to performance continuing outside of target for three months. This concern was addressed and reviewed in detail at both the Medical Quality and Operations Council meetings as well as during the Clinical Operational Excellence Committee (COEC). Between May and Jul there were 19 CHF cases discharged that were readmitted within 30 days, case reviews are still underway to determine if there are any gaps or learning that needs to be acted on. We are pleased to report that performance for August has shown improvement and now aligns with our targeted benchmarks. Nevertheless, this indicator will remain under close surveillance to guarantee sustained performance moving forward.

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

Next steps

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

Quality Monitoring Scorecard

Status (Last 3 Periods)

Meeting Target	7	23%
Within 10% of Target	15	50%
Exceeding Target	8	27%

Quality Dimension	Indicator	Unit of Measure	Target	YTD	Status (Last 3 periods)	Period
Efficient	Conservable Days Rate	%	30.00	45.78	◆	Sep-25
	Overtime Hours - Average per pay period	hours	1,723.06	4,334.51	◆	Oct-25
	Sick Hours - Average per pay period	hours	2,359.11	4,076.46	◆	Oct-25
Integrated & Equitable	ALC Throughput	Ratio	1.00	0.81	▲	Sep-25
	Percent ALC Days (closed cases)	%	20.00	19.28	●	Sep-25
	Repeat emergency department visits for Mental Health Care	Patients	11.00	10.83	▲	Sep-25
Patient & People Focused	Organization Wide Vacancy Rate	%	12.00	5.28	●	Oct-25
Safe, Effective & Accessible	30 Day CHF Readmission Rate	%	14.00	19.38	▲	Aug-25
	30 Day COPD Readmission Rate	%	15.50	15.63	▲	Aug-25
	30 Day In-Hospital Mortality Following Major Surgery	%	1.90	1.53	▲	Aug-25
	30 Day Overall Readmission Rate	%	8.80	6.70	●	Aug-25
	Ambulance Offload Time (90% Spent Less, in Minutes)	minutes	30.00	32.00	●	Sep-25
	Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m.	Average	10.00	12.17	▲	Sep-25
	ED Length of Stay for Admitted Patients (90% Spent Less, in Hours)	hours	33.00	53.80	◆	Sep-25
	ED Length of Stay for Non-Admitted Complex Patients (90% Spent Less, in Hours)	hours	8.00	10.10	◆	Sep-25
	ED Wait Time for Inpatient Bed (90% Spent Less, in Hours)	hours	25.00	45.00	◆	Sep-25
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours)	hours	4.00	7.60	◆	Sep-25
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours) CTAS 1,2	hours	4.00	6.40	◆	Sep-25
	Hip Fracture Surgery Within 48 Hours	%	83.10	89.75	●	Aug-25
	Hospital Standardized Mortality Ratio (HSMR)	Ratio	100.00	93.53	▲	Aug-25
	In-Hospital Sepsis	per 1000 D/C	3.20	4.02	▲	Aug-25
	Long Waiters Waiting For All Surgical Procedures	%	20.00	7.77	●	Oct-25
	Low-Risk Caesarean Sections	%	17.30	17.85	▲	Sep-25
	Medication Reconciliation at Admit	%	95.00	95.00	▲	Oct-25
	Medication Reconciliation at Discharge	%	95.00	95.00	▲	Oct-25
	Obstetric Trauma (With Instrument)	%	14.40	16.21	▲	Aug-25
	Patient Safety Event - Falls with Harm	per 1000 PD	0.00	0.03	▲	Oct-25
	Patient Safety Event - Medication Events with Harm	per 1000 PD	0.00	0.07	▲	Oct-25
	Revenue - Achieve budgeted PCOP growth (IRM)	$	4,477,817.52	5,982,606.85	▲	Sep-25
	Revenue - Achieve Quality Based Procedure Funding (IRM)	$	13,417,087.98	15,996,467.71	●	Sep-25

Conservable Bed Days

Conservable Beds Dashboard

Description

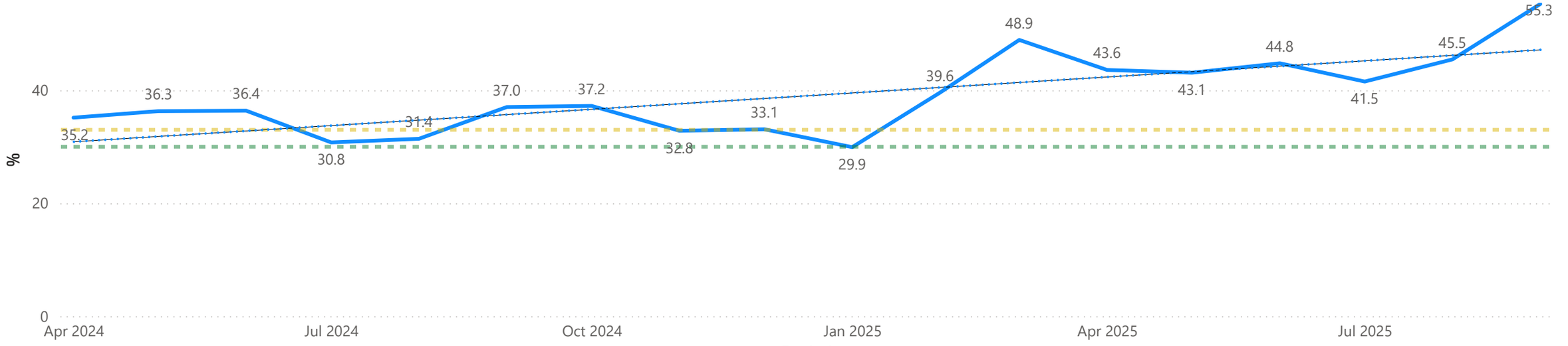
The total patient days over the benchmark LOS (conservable days) as a percentage of the total acute patient days for patients discharged from MEDA/MEDB. The benchmark LOS is determined by case mix group, age, and resource intensity level of a discharge.

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
30.0	36.1	45.78	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	35.2	36.3	36.4	30.8	31.4	37.0	37.2	32.8	33.1	29.9	39.6	48.9
2025/2026	43.6	43.1	44.8	41.5	45.5	55.3						

Overtime, Average per pay period

OT, Sick, Staffing Dashboard

Description

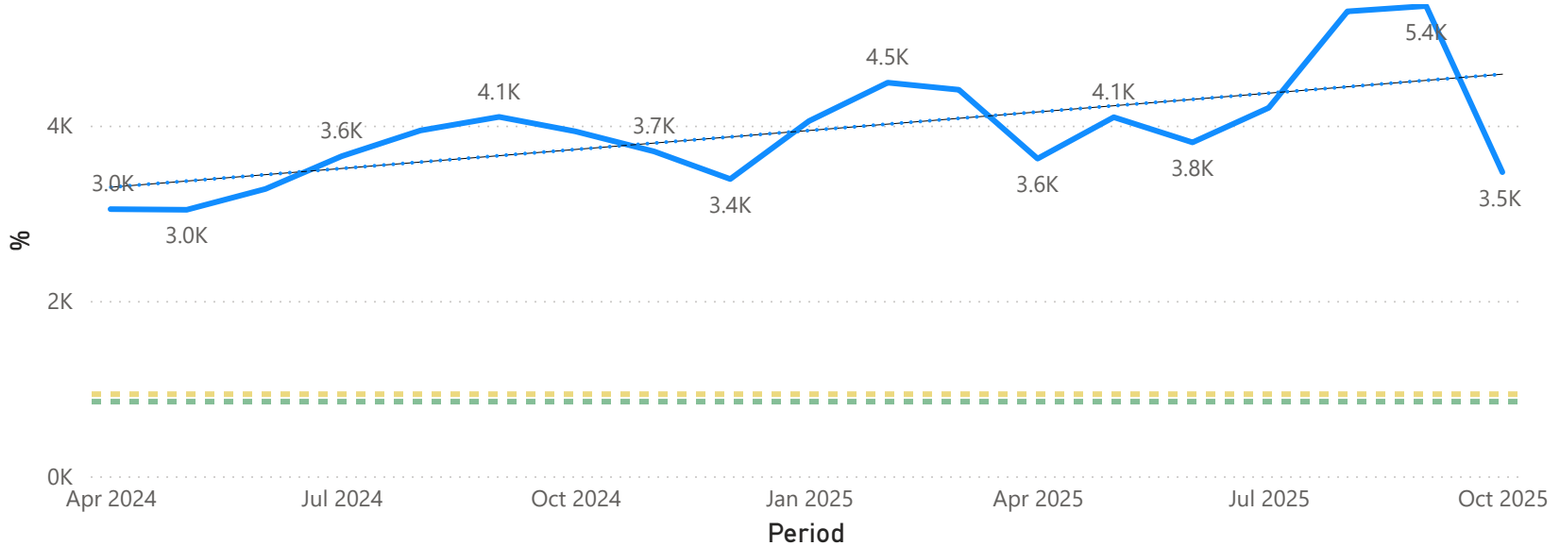
The total sum of overtime hours per pay period ending in a month, divided by the number of pay periods in a month

Data Source

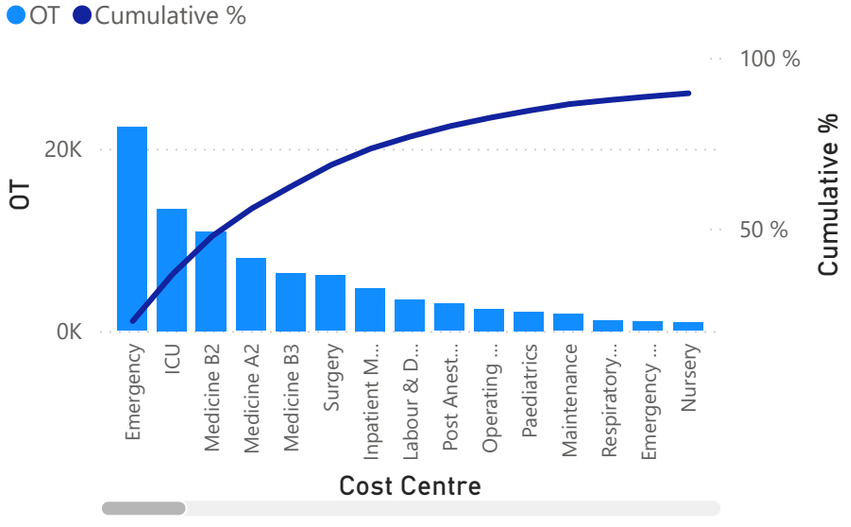
Meditech Payroll

Target	Previous YE	YTD	Status (Last 3 periods)
1,723.1	3,784.6	4,334.5	

Average OT Hours per pay period, Trend



Total OT Hours, by Cost Centre



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	3,045.8	3,038.6	3,276.0	3,649.5	3,943.0	4,098.1	3,933.0	3,704.1	3,389.1	4,050.6	4,488.6	4,407.7
2025/2026	3,622.0	4,094.6	3,807.3	4,201.8	5,301.7	5,363.0	3,467.6					

Sick Time, Average per pay period

OT, Sick, Staffing Dashboard

Description

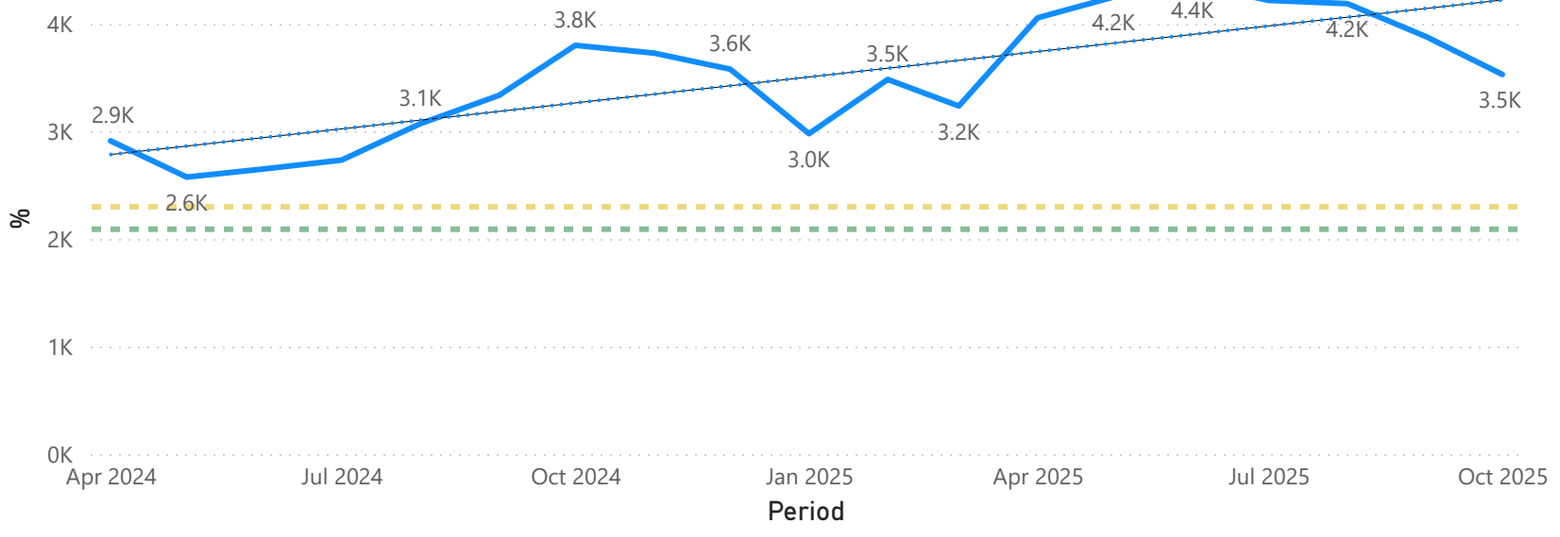
The total sum of sick hours per pay period ending in a month, divided by the number of pay periods in a month

Data Source

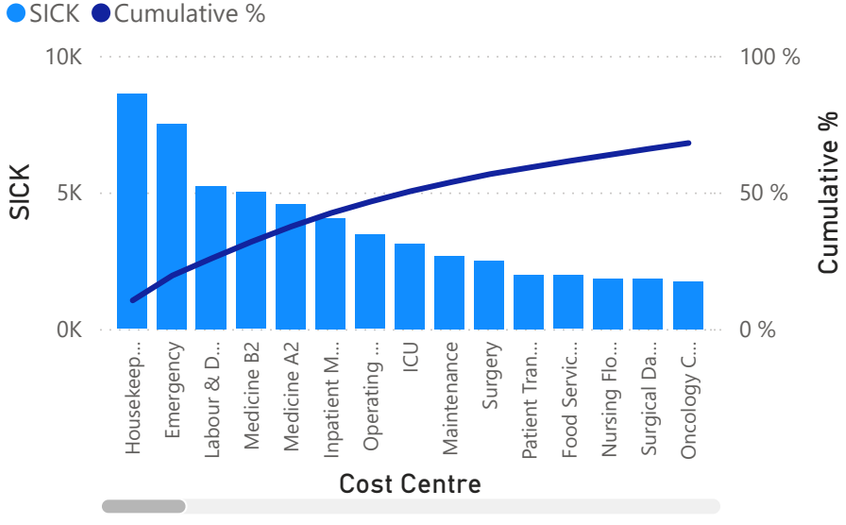
Meditech Payroll

Target	Previous YE	YTD	Status (Last 3 periods)
2,359.1	3,171.0	4,076.5	

Average Sick Hours per pay period, Trend



Total Sick Hours, by Cost Centre



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	2,911.2	2,574.4	2,651.6	2,732.5	3,070.8	3,334.1	3,798.6	3,726.4	3,576.9	2,977.7	3,481.6	3,234.7
2025/2026	4,054.1	4,248.5	4,368.5	4,216.5	4,186.0	3,879.0	3,527.8					

Alternate Level of Care

ALC Dashboard

ALC Throughput

Description

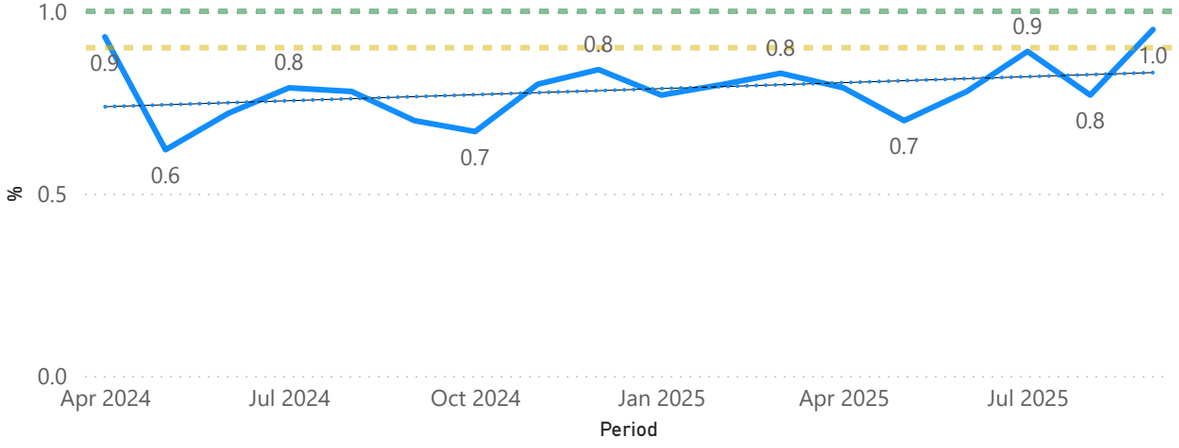
ALC Throughput is the ratio of the number of discharged ALC cases to the number of newly added and redesignated ALC cases

Data Source

WTIS

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

ALC Throughput Trend



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

ALC Rate

Description

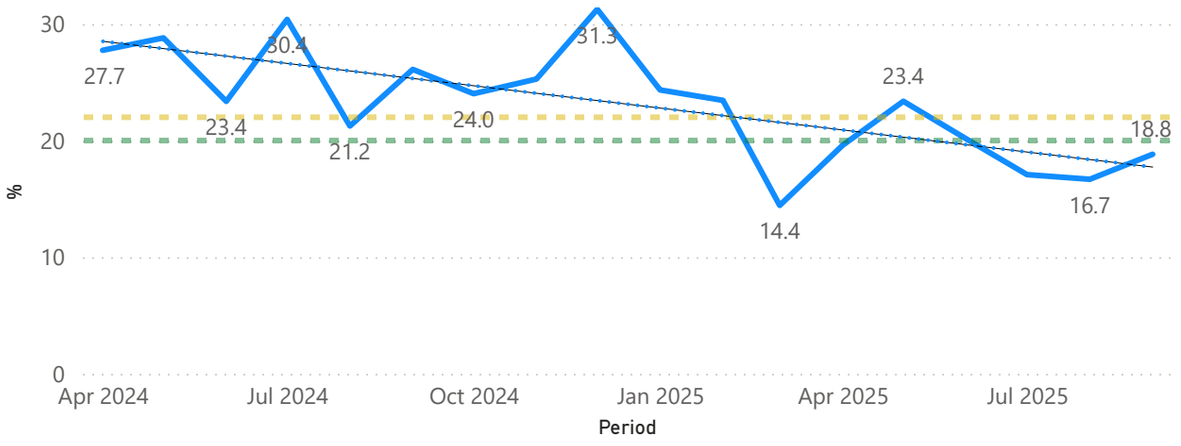
The proportion of total days that a patient was assigned to the alternate level of care (ALC) service. ALC patients are those who no longer need acute care services but continue to occupy an acute care bed or use acute care services.

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
20.0	25.0	19.3	●

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	19.6	23.4	20.1	17.1	16.7	18.8						

Repeat ED Visits for Mental Health Care

Description

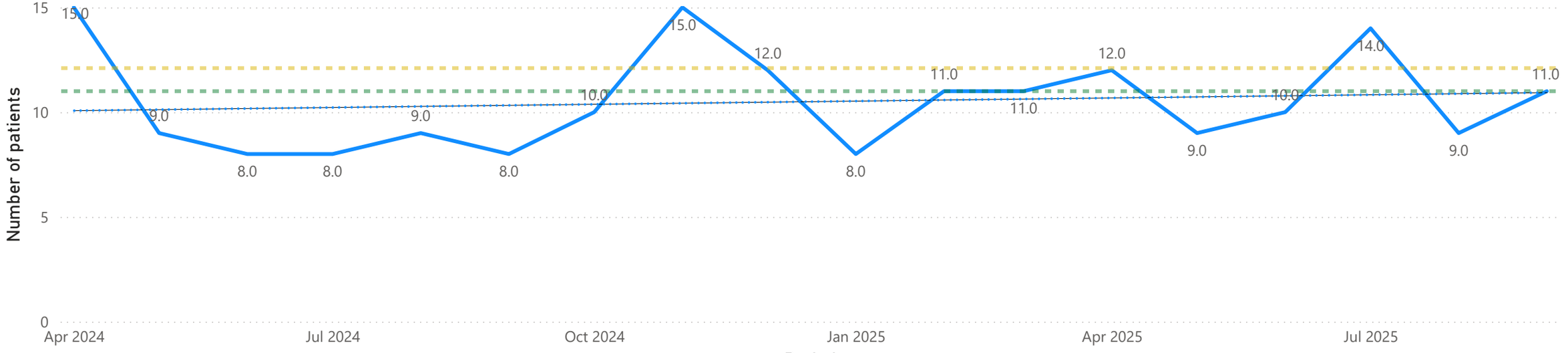
Number of patients who have four or more repeat unscheduled visits to the emergency department in the last 12 months for mental health or substance abuse condition

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
11.0	10.3	10.8	▲

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						

Organizational Vacancy Rate

Description

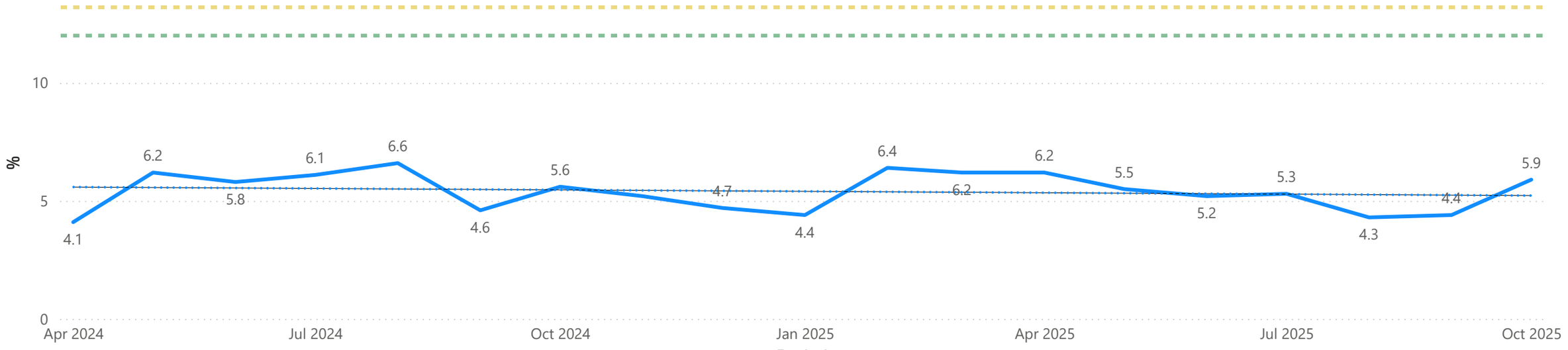
This indicator measures the organization wide vacancy rate for permanent full time and part time staff

Data Source

ICIMs Vacancy Report and Meditech Payroll

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

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	4.1	6.2	5.8	6.1	6.6	4.6	5.6	5.2	4.7	4.4	6.4	6.2
2025/2026	6.2	5.5	5.2	5.3	4.3	4.4	5.9					

Readmissions within 30 Days:

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

CHF Readmissions

Description

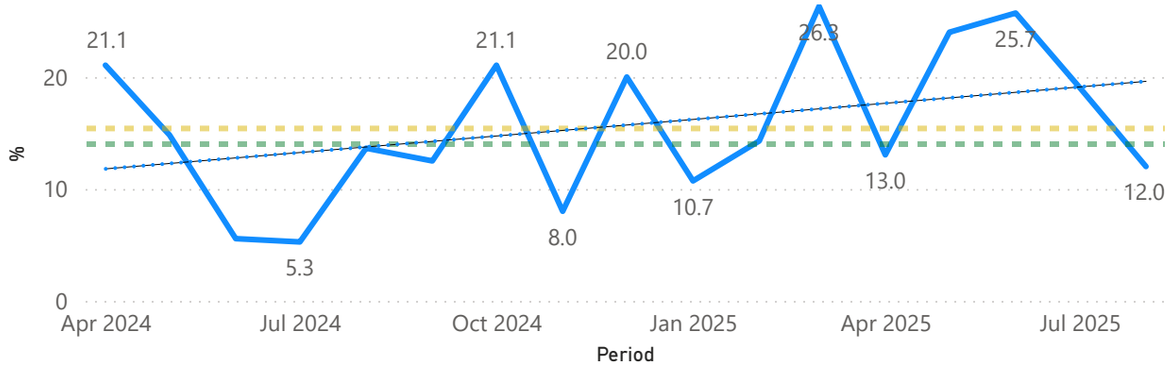
Rate of urgent readmission for any reason within 30 days of discharge for Congestive Heart Failure (CHF) at CMH

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
14.0	14.7	19.4	▲

CHF Readmission Rate, Trend



Fiscal Year		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	Rate	21.1	14.8	5.6	5.3	13.6	12.5	21.1	8.0	20.0	10.7	14.3	26.3
	Readmits	4	4	1	1	3	3	8	2	5	3	3	5
2025/2026	Rate	13.0	24.0	25.7	19.0	12.0							
	Readmits	3	6	9	4	3	5	0					

COPD Readmissions

Description

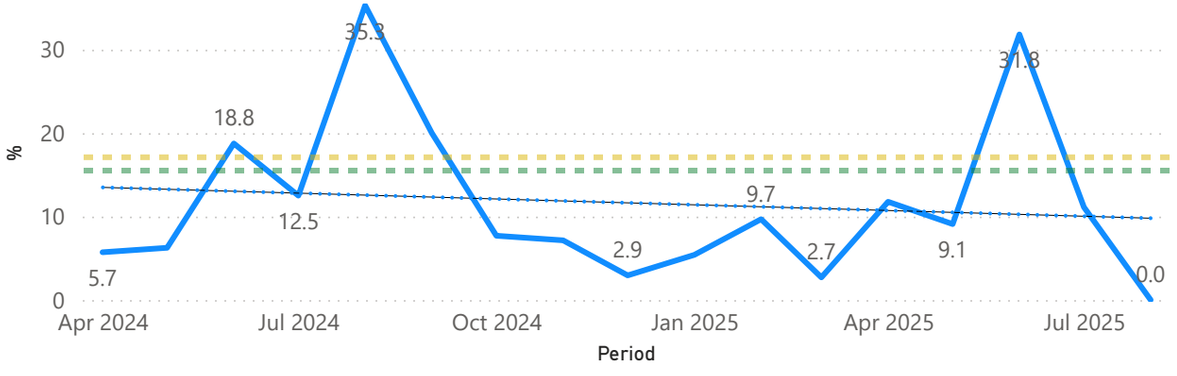
Rate of urgent readmission for any reason within 30 days of discharge for Chronic Obstructive Pulmonary Disease (COPD) at CMH

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
15.5	9.1	15.6	▲

COPD Readmission Rate, Trend



Fiscal Year		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	Rate	5.7	6.3	18.8	12.5	35.3	20.0	7.7	7.1	2.9	5.4	9.7	2.7
	Readmits	6	5	4	3	9	6	10	4	6	5	6	6
2025/2026	Rate	11.8	9.1	31.8	11.1	0.0							
	Readmits	7	8	16	6	3	6	0					

30 Day In-Hospital Mortality Following Major Surgery Rate

Description

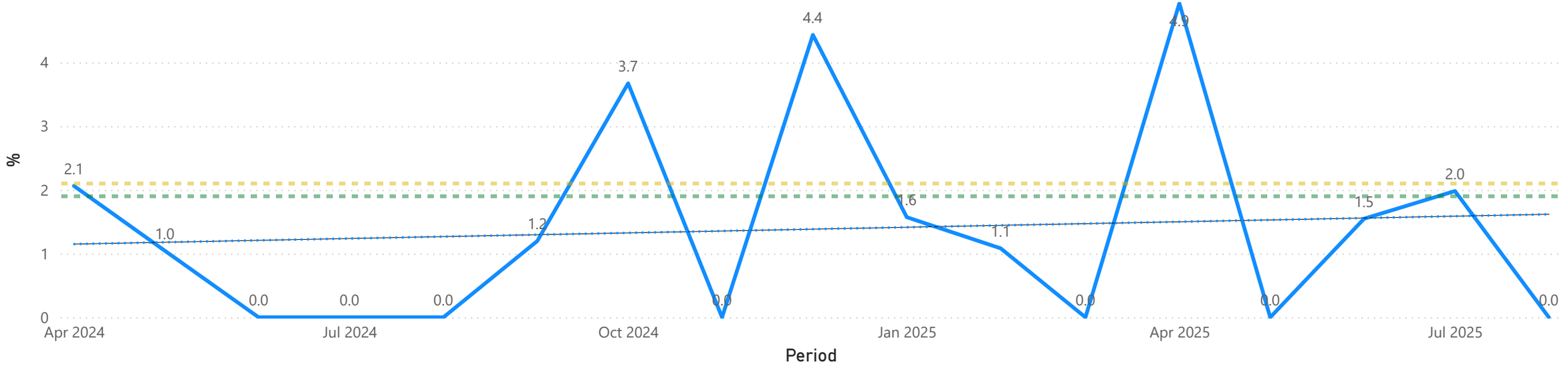
Risk-adjusted rate of in-hospital deaths due to all causes occurring within 30 days of major surgery (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

Data Source

Discharge Abstract Database (DAD)

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

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	2.1	1.0	0.0	0.0	0.0	1.2	3.7	0.0	4.4	1.6	1.1	0.0
2025/2026	4.9	0.0	1.5	2.0	0.0							

30 Day Overall Readmission Rate

Description

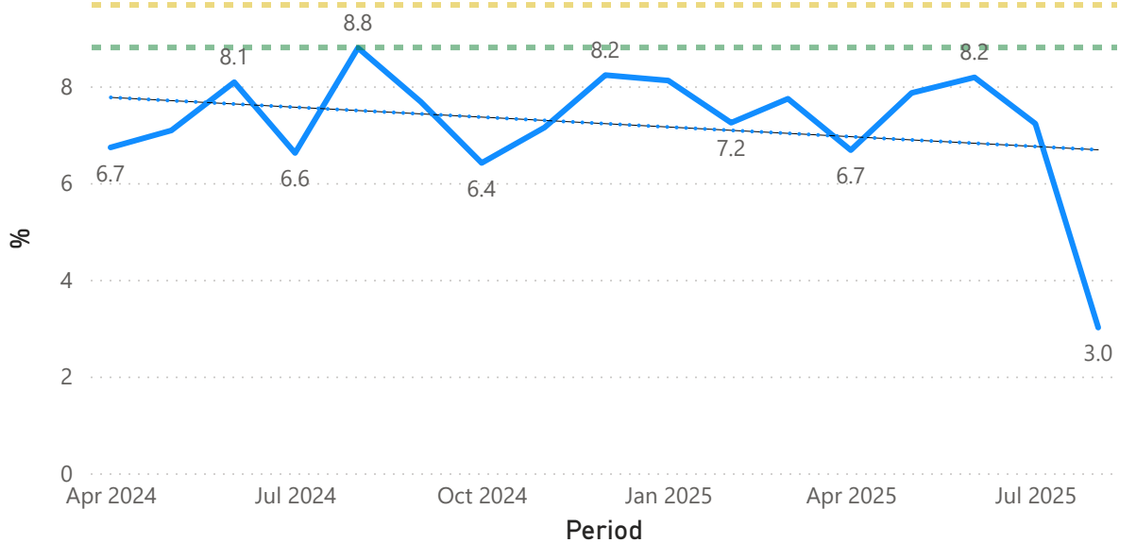
The rate of urgent readmissions within 30 days of discharge for episodes of care for the following patient groups: medical, obstetric, paediatric, and surgical. Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
8.8	7.5	6.7	

Trend

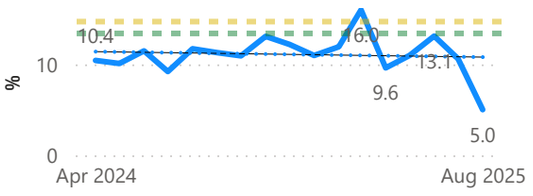


Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	6.7	7.1	8.1	6.6	8.8	7.7	6.4	7.1	8.2	8.1	7.2	7.7
2025/2026	6.7	7.9	8.2	7.2	3.0							

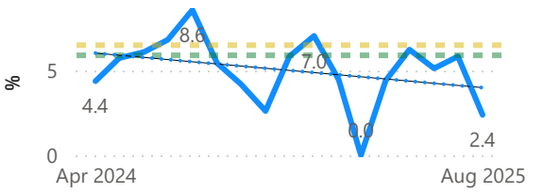
Readmissions, by Patient Group

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

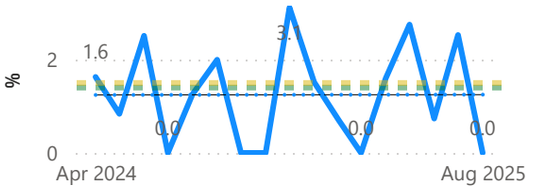
Medical Readmissions Trend



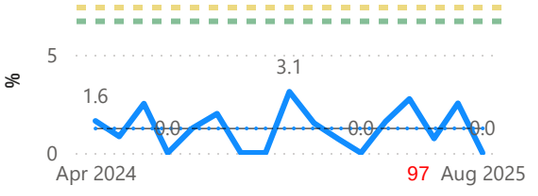
Surgical Readmissions Trend



Obstetric Readmissions Trend



Paediatric Readmissions Trend



Ambulance Offload Time, minutes, 90th percentile

Description

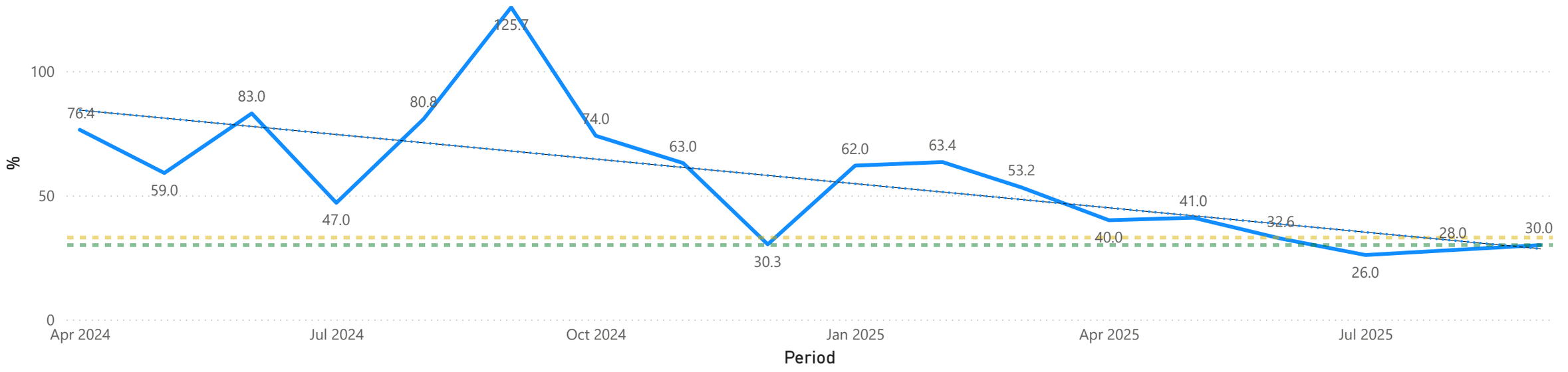
The total time, in minutes, in which 9 out of 10 patients who arrived via ambulance waited for transfer of care process to be completed, calculated as the total time elapsed from ambulance arrival to completion of transfer of care process.

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
30.0	67.0	32.0	

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						

ED LOS for Admitted Patients, hours, 90th percentile

Total ED LOS for Admitted Patients

Description

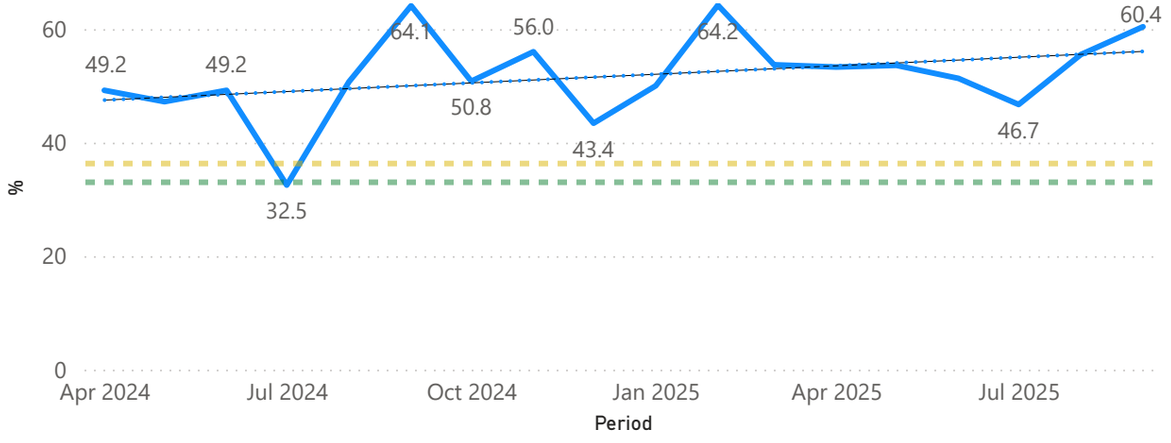
The total time, in hours, that 9 out of 10 admitted patients spent in the emergency department (ED), calculated as the total time elapsed from triage to when the patient left the ED

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
33.0	52.0	53.8	

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						

Time to Inpatient Bed

Description

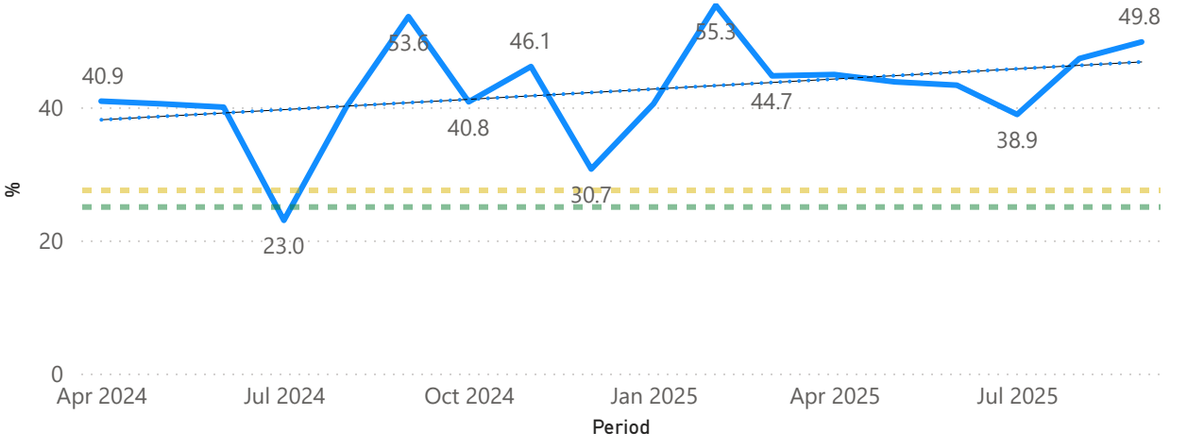
The total time, in hours, that 9 out of 10 admitted patients spent waiting in the emergency department (ED) for a bed, calculated as the total time elapsed from disposition decision to when the patient left the ED

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
25.0	42.8	45.0	

Time to Inpatient Bed, Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	40.9	40.5	40.0	23.0	40.0	53.6	40.8	46.1	30.7	40.5	55.3	44.7
2025/2026	44.9	43.8	43.3	38.9	47.3	49.8						

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

Description

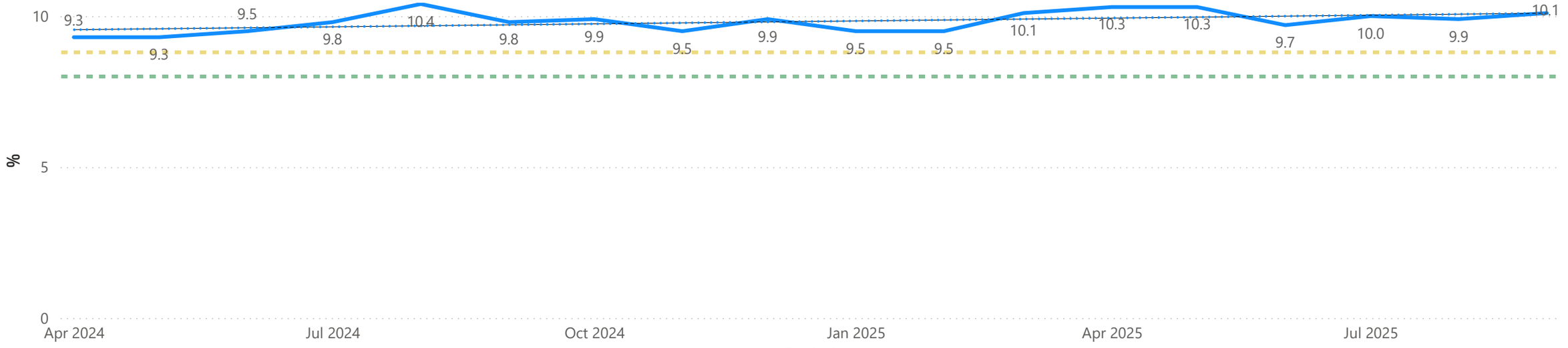
The total time, in hours, that 9 out of 10 high-urgency patients (CTAS 1-3) who were not admitted spent in the emergency department (ED), calculated as the total time elapsed from triage to when the patient left the ED

Data Source

National Ambulatory Care Reporting System (NACRS)

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

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	9.3	9.3	9.5	9.8	10.4	9.8	9.9	9.5	9.9	9.5	9.5	10.1
2025/2026	10.3	10.3	9.7	10.0	9.9	10.1						

Provider Initial Assessment Time, hours, 90th percentile

Description

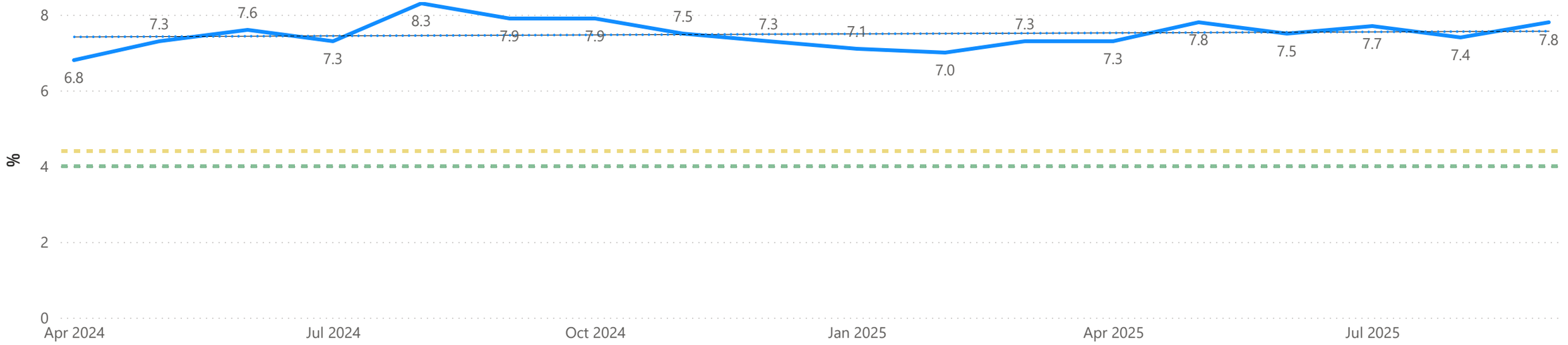
The total time, in hours, that 9 out of 10 patients spent waiting for their first assessment by a doctor or nurse practitioner in the emergency department (ED), calculated as the total time elapsed from triage to time of initial assessment

Data Source

National Ambulatory Care Reporting System (NACRS)

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

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	6.8	7.3	7.6	7.3	8.3	7.9	7.9	7.5	7.3	7.1	7.0	7.3
2025/2026	7.3	7.8	7.5	7.7	7.4	7.8						

Urgent Provider Initial Assessment Time, hours, 90th percentile

Description

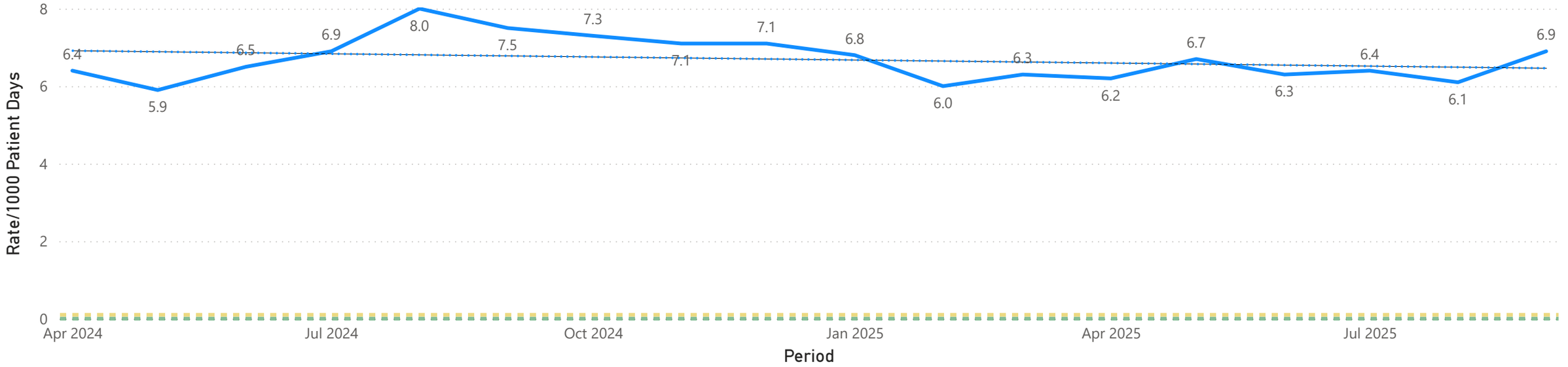
The total time, in hours, that 9 out of 10 patients spent waiting for their first assessment by a doctor or nurse practitioner in the emergency department (ED), calculated as the total time elapsed from triage to time of initial assessment

Data Source

National Ambulatory Care Reporting System (NACRS)

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

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	6.4	5.9	6.5	6.9	8.0	7.5	7.3	7.1	7.1	6.8	6.0	6.3
2025/2026	6.2	6.7	6.3	6.4	6.1	6.9						

Hip Fracture Surgery within 48 Hours, %

Description

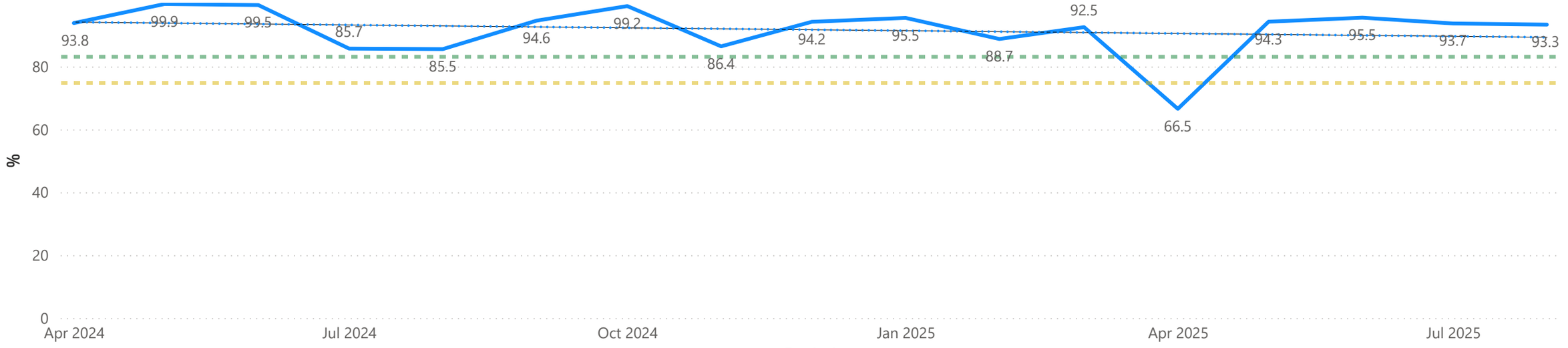
Risk-adjusted proportion of hip fractures that were surgically treated within 48 hours of initial admission (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
83.1	92.9	89.7	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	93.8	99.9	99.5	85.7	85.5	94.6	99.2	86.4	94.2	95.5	88.7	92.5
2025/2026	66.5	94.3	95.5	93.7	93.3							

Hospital Standardized Mortality Ratio (HSMR)

Description

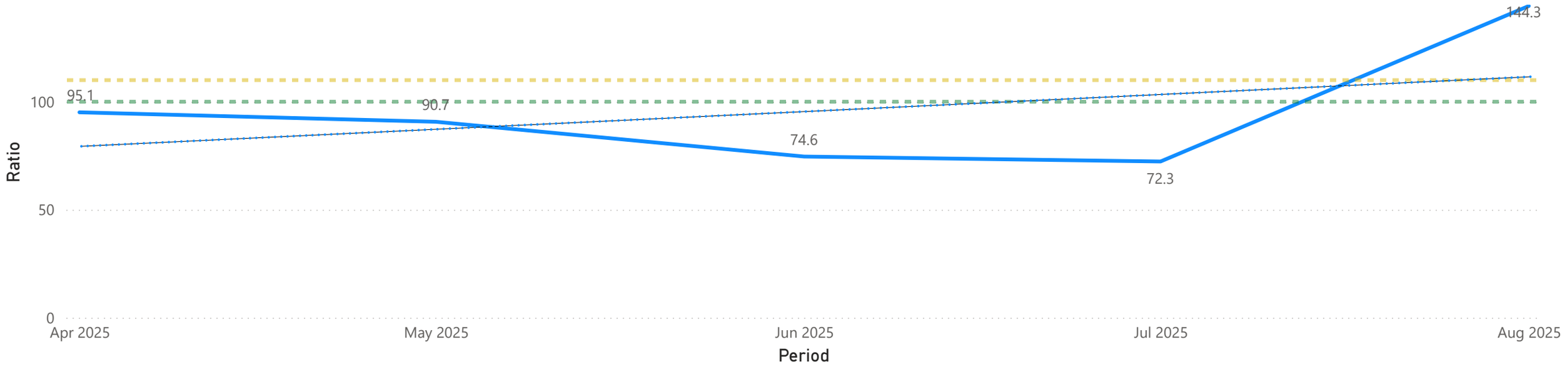
The ratio of the actual number of in-hospital deaths to the expected number of in-hospital deaths, for conditions accounting for about 80% of inpatient mortality

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
100.0	94.6	93.5	▲

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug
2025/2026	95.1	90.7	74.6	72.3	144.3

In-Hospital Sepsis

Description

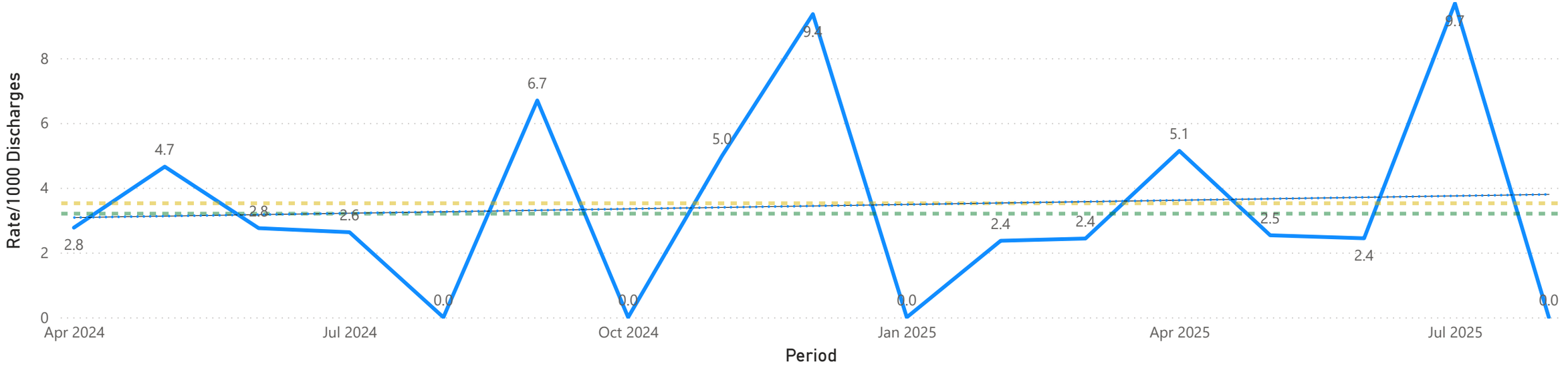
Risk-adjusted rate of sepsis that is identified after admission, per 1,000 discharges (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
3.2	3.2	4.0	▲

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	2.8	4.7	2.8	2.6	0.0	6.7	0.0	5.0	9.4	0.0	2.4	2.4
2025/2026	5.1	2.5	2.4	9.7	0.0							

Low-Risk Caesarean Section Rate

Description

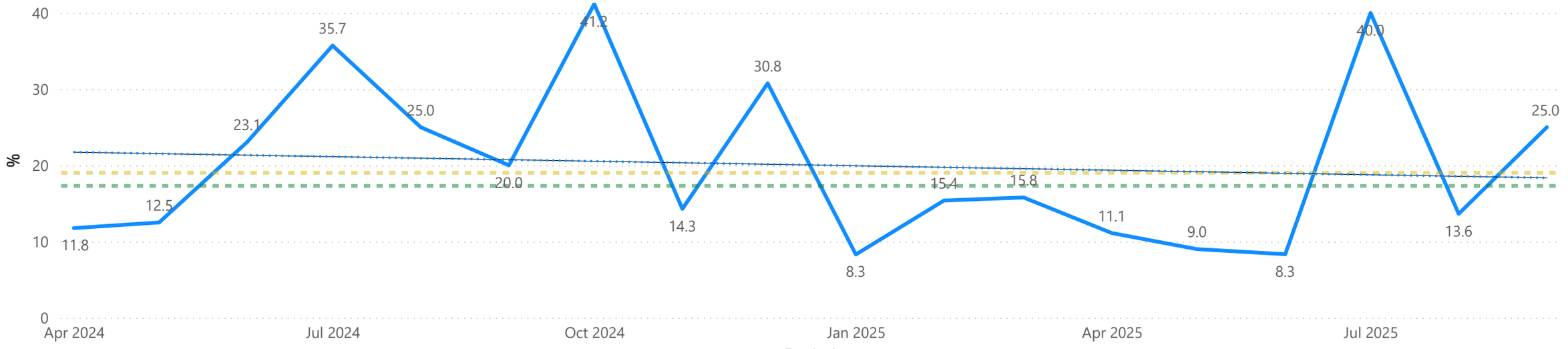
This indicator measures the rate of deliveries via Caesarean section among singleton term cephalic pregnancies for low-risk nulliparous women in spontaneous labour

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
17.3	21.1	17.8	▲

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						

Obstetric Trauma (with Instrument)

Description

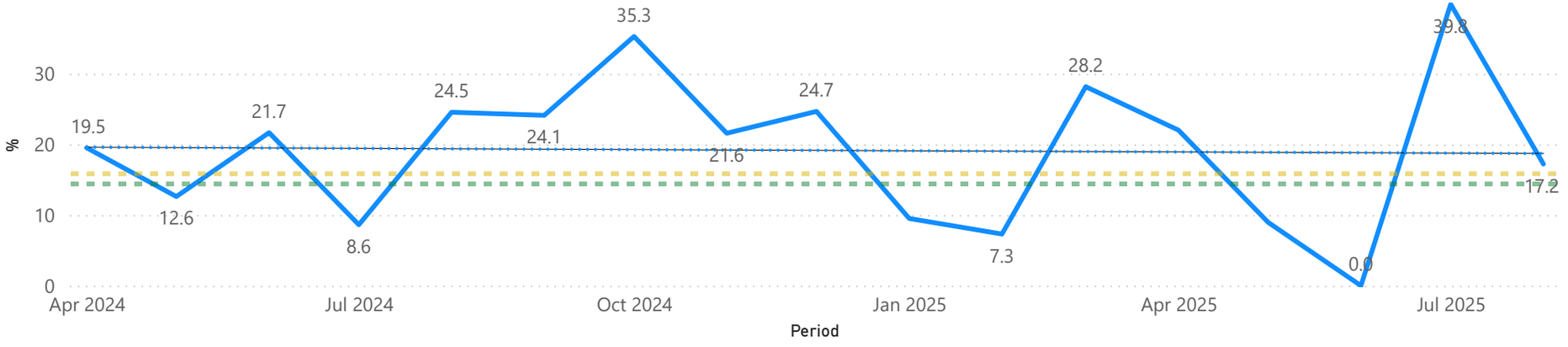
Risk-adjusted rate of obstetric trauma (lacerations that are third degree or greater in severity) for instrument-assisted vaginal deliveries (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average,18.4)

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
14.4	19.8	16.2	▲

Trend



Month	Observed
Aug-25	4.00
Jul-25	4.00
Jun-25	0.00
May-25	1.00
Apr-25	3.00

Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	19.5	12.6	21.7	8.6	24.5	24.1	35.3	21.6	24.7	9.5	7.3	28.2
2025/2026	22.0	9.0	0.0	39.8	17.2							

Long Waiters Waiting for Surgical Procedures

Description

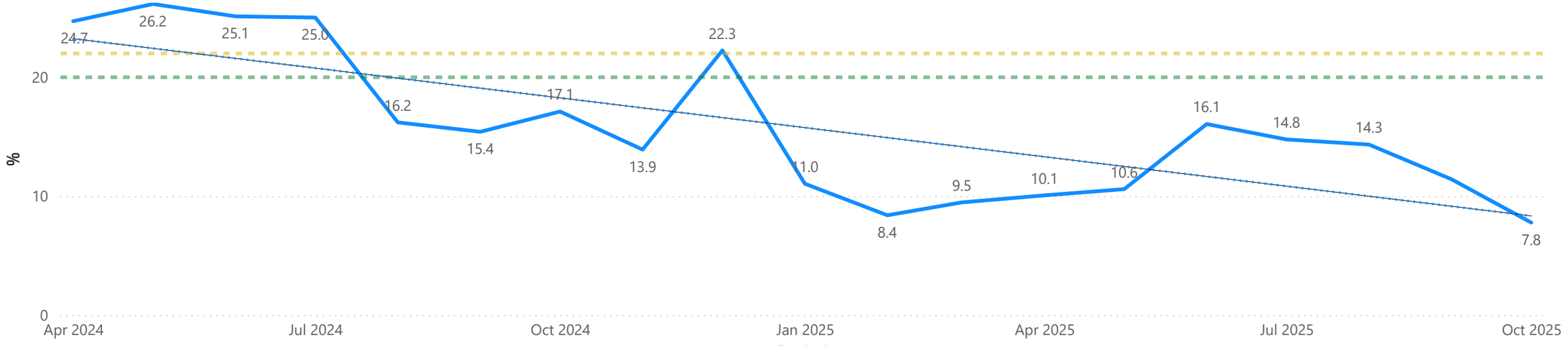
This indicator measures the percentage of patients waiting for a surgical procedure whose wait has exceeded the associated Priority Level Access Target (excludes DART days)

Data Source

WTIS

Target	Previous YE	YTD	Status (Last 3 periods)
20.0	9.5	7.8	

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					

Patient Safety Event - Falls with Harm Rate

Description

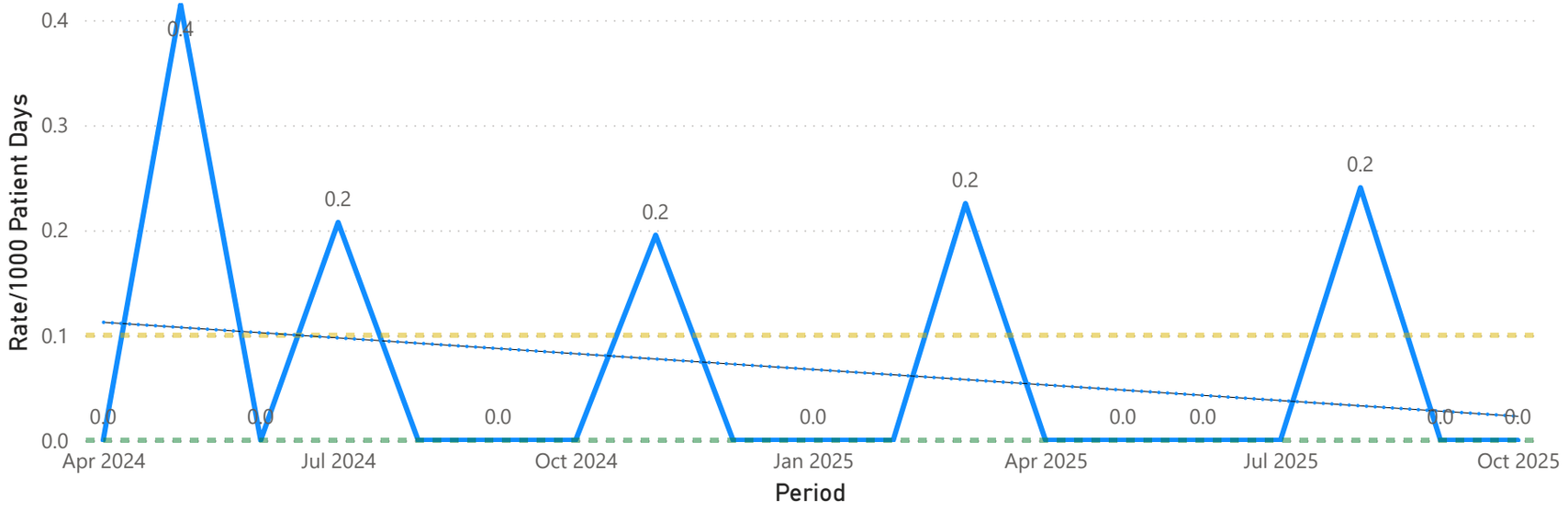
The number of falls with harm per 1,000 inpatient days. This includes events where after review, the severity is deemed to have incurred moderate or severe harm, or a critical incident involving death.

Data Source

ReportLink, Meditech

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

Trend



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

Patient Safety Event - Medication Events with Harm Rate

Description

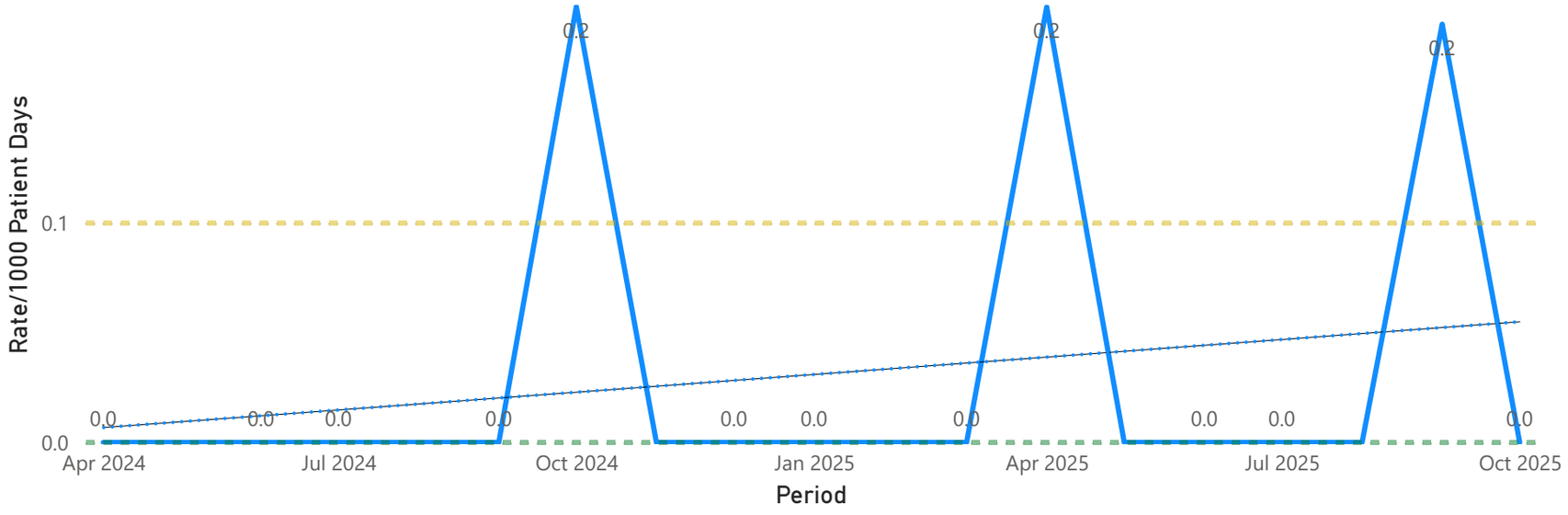
The number of medication events with harm per 1,000 inpatient days. This includes events where after review, the severity is deemed to have incurred moderate or severe harm, or a critical incident involving death.

Data Source

ReportLink, Meditech

Target	Previous YE	YTD	Status (Last 3 periods)
0.0	0.0	0.07	

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					

Medication Reconciliation

Admission

Description

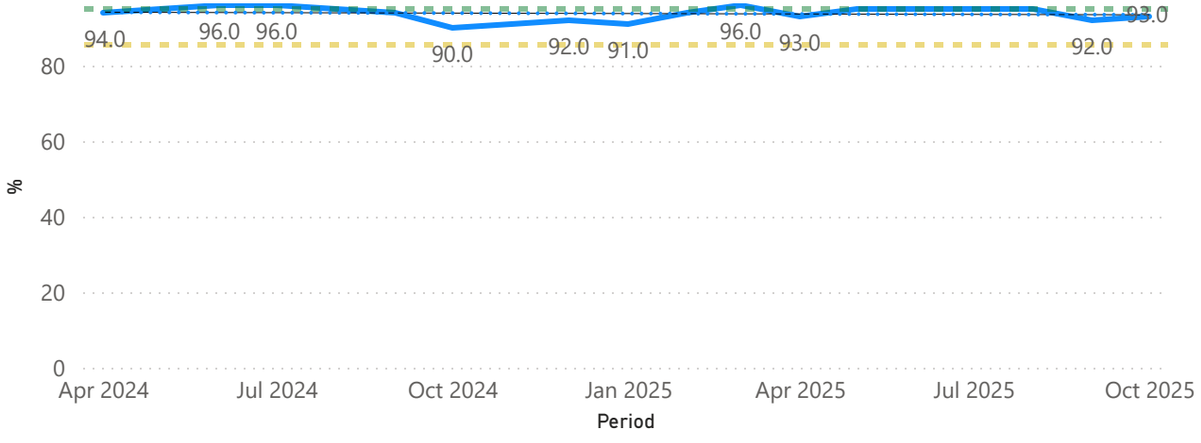
The total number of patients who were discharged who had a Best Possible Medication History (BPMH) completed divided by the total number of patients who were discharged home

Data Source

Meditech Pharmacy Patient Profile

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

Trend



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

Discharge

Description

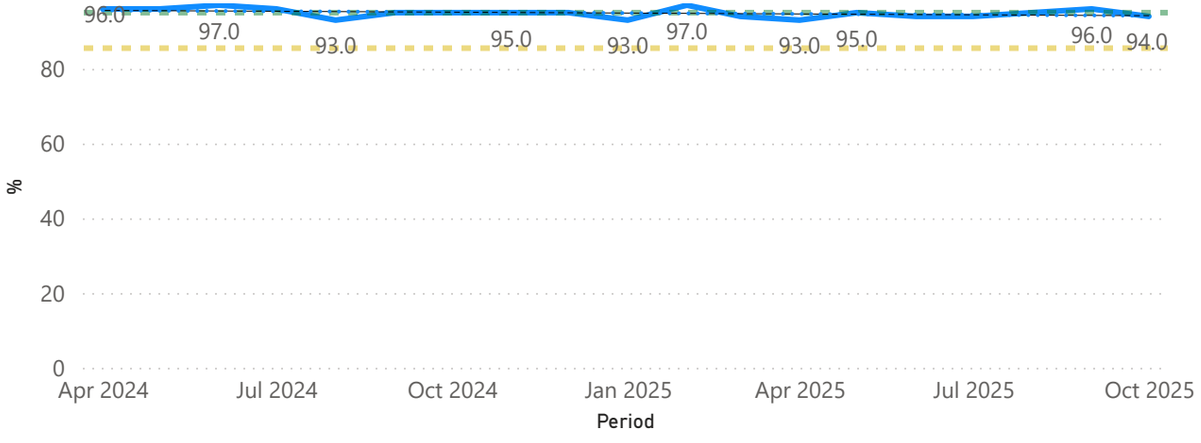
The percentage of Yes responses to the question "Was the CMH community pharmacy prescription completed? " for all inpatient locations participating in medication reconciliation at discharge

Data Source

Meditech

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

Trend



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

Post-Construction Operating Plan (PCOP) Revenue

Description

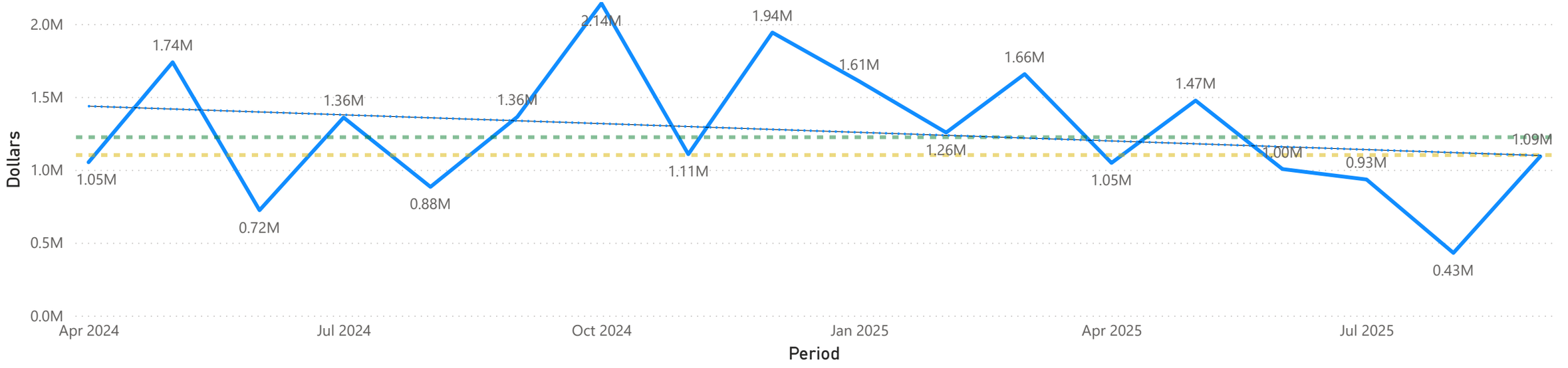
The revenue achieved through all PCOP service areas, including Acute Inpatient, ED, Day Surgery, Mental Health Day Hospital, Mental Health Inpatient, ECT, and Ambulatory Clinics (Mental Health, Paediatric, Fracture, Surgery)

Data Source

Discharge Abstract Database, National Ambulatory Care Reporting System, Meditech

Monthly Target	YTD Target	YTD Total	Status (Last 3 periods)
746.3K	4.5M	6.0M	▲

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	1,047,226	1,474,857	1,004,994	933,520	430,037	1,091,972						

Quality Based Procedure (QBP) Revenue

QBP Dashboard

Description

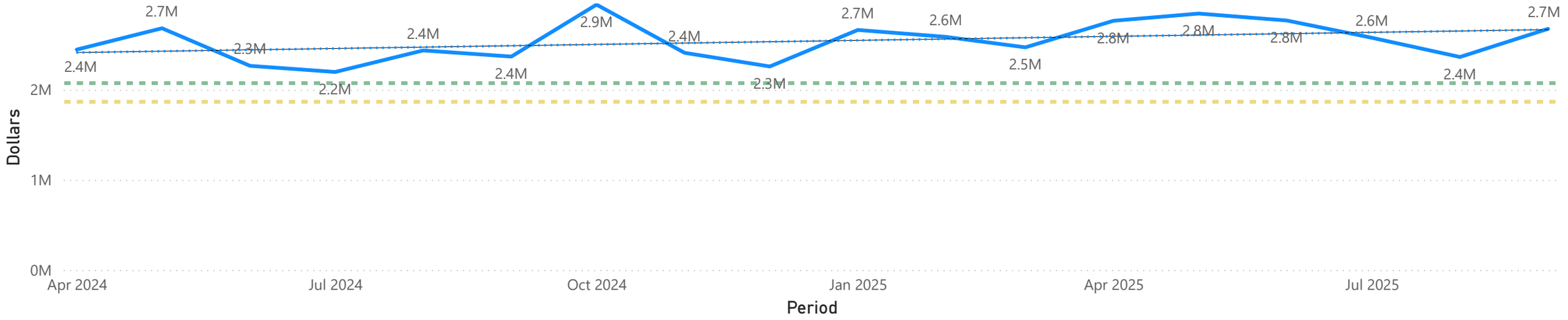
The revenue achieved through all Quality Based Procedures, including Urgent QBPs & Non-Urgent Surgical QBPs (OH), Systemic Treatment (CCO), GI Endoscopy (CCO), and Cancer Surgery (CCO).

Data Source

Discharge Abstract Database, National Ambulatory Care Reporting System

Monthly Target	YTD Target	YTD Total	Status (Last 3 periods)
2.2M	13.4M	16.0M	

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	2,765,594	2,845,484	2,768,764	2,576,783	2,363,731	2,676,112						

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

AVG Patients in ED at 8AM waiting for IP bed

Description

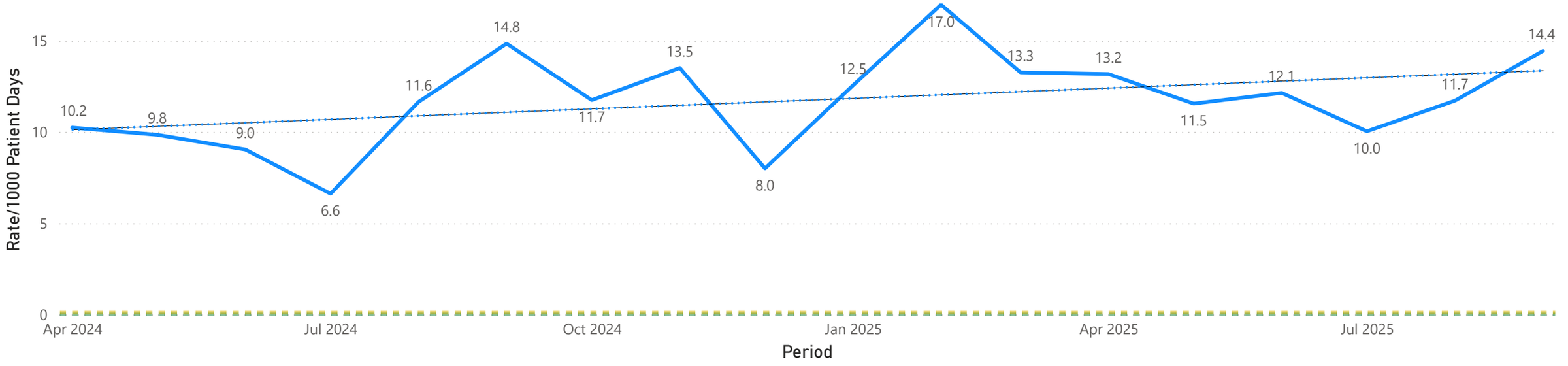
The number of patients in the emergency department waiting for an inpatient bed at 8 a.m. who have been waiting at least 2 hours since disposition. Average number of patients per day

Data Source

NACRS

Target	Previous YE	YTD	Status (Last 3 periods)
10.0	11.5	12.2	▲

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						

CAMBRIDGE MEMORIAL HOSPITAL

Strategic Priorities 25/26

"Creating Healthier Communities, Together"

	Metric	Target	Q1	Q2	Q3	Q4	Aligned Corporate Plans
Elevate Partnerships in Care	90th percentile Ambulance Offload Time (minutes) (QIP/IRM)	<43	38	28			Clinical Services Growth Plan
	90th percentile Provider Initial Assessment in the ED (hours) (QIP/IRM)	<4.6	7.5	7.6			
	90th percentile Urgent Provider Initial Assessment in the ED (hours) (QIP/IRM)	<4.0	6.3	6.5			
	Average number of Admits in the ED at 08:00 (QIP/IRM)	<10	12.28	12.06			
	Dyad Partnership - Major project average medical discharges before 11AM	>6	0.78	0.56			
Reimagine Community Health	Project Quantum- % on track with identified milestones for 25/26 (IRM)	100	100	89			Digital Health Plan
Increase Joy in Work	FTE Variance from target for Medicine, ICU, & ED (IRM)	0	-29	-25			HR Plan
	Medical Professional Staffing (Targeted Positions) (IRM)	17 Year end target	3	13			
Sustain Financial Health	Post Construction Operating Plan Revenue Earned	>$2.24M quarter	3.53M	2.46M			Multi-year Financial Plan
Advance Health Equity	% on track with DEI Action Plan	100	100	78			DEI Plan Truth & ReconciliACTION Plan
	% on track with Truth and RoconciliACTION Plan	100	100	88			

Clinical Services Growth Plan (IRM- Quality Committee)

Elevate Partnerships in Care

Click Here to Input Action Plans

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

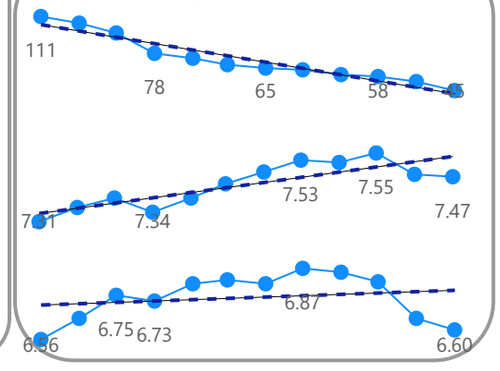
Physician Liaison(s): Dr. Jas Gill

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		
90th%tile Provider Initial Assessment Hours	<4.6 hours	7.5	7.6		
90th%tile Urgent Provider Initial Assessment Hours	<4.0 hours	6.3	6.5		

Trailing 12 Month Trend



In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Achieve ambulance offload times of 43 mins or less by March 31, 2026	1. Met with EMS leadership team (August) to discuss data accuracy and ensure arrival time is being documented accurately; to ensure accuracy first watch timestamp with be the source of truth; 2. Continue biweekly meetings and data monitoring	1. Work with EMS and regional partners to ensure clear understanding of definitions related to offload times; 2. Continue biweekly EMS meetings; 3. NYGH has not rescheduled however presentation provided by their Director was recorded and shared with our team	R1) Inconsistent capture of offload times; M1) Provide education to CMH staff and ensure that first watch is being utilized as source of truth
Reduce the wait-time for provider initial assessment for urgent CTAS 1-2 patients to 4 hours or less and wait-time for provider initial assessment for all patients to 4.6 hours or less by March 31, 2026	1. Reviewed and updated standard operating procedure for triage process; 2. CEF reviewed reference material for triage; 3. Reviewed surge policy; 4. Met with ED leadership and reviewed minor improvements to urgent CTAS; 5. Continue to evaluate NP coverage, currently improving; 6. Ongoing assessment of nursing competency to support multiple areas in ED; 7. Continue Heidi AI pilot and seek feedback from physicians; 8. Reviewed initial prototype of real-time notification system between ED and DI	1. New surge policy in development; 2. Review policies from regional partners for guidance; 3. ED flow focus in subacute, ensuring rooms are filled and patients are ready to be seen; 4. Provide ongoing training to develop nursing competency to support multiple areas in ED; 5. Leadership to discuss next steps for improvements targeting CTAS 2 patients with chest pains; 6. Hold regular bi-weekly meetings arranged for ED leadership to monitor concerns and barriers being experienced that will lead to delay in assessing patients and achieving target PIA; 7. Provide education at Department meeting around P4R metrics and physician impacts; 8. Evaluate NP coverage and continue recruitment;	R1) Registered staff not having patients ready or using tracker dashboard; M1) Follow-up in real time with staff and provide coaching; R2) New physician recruits; M2) Continue to provide mentorship and guidance

Elevate Partnerships in Care

Clinical Services Growth Plan (IRM- Quality Committee)

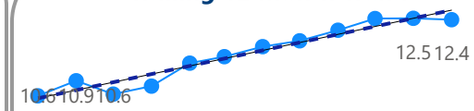
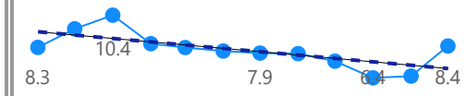
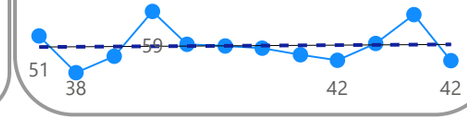
Click Here to Input Action Plans

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

Physician Liaison(s): Dr. Augustin Nguyen

Director Lead(s): Ken Abogadil

Project Manager(s): Jennifer Woo

In Year Measures of Success	Target	Q1	Q2	Q3	Q4	Trailing 12 Month Trend
Average Admits in the ED at 08:00	<10 patients	12.28	12.06			
Average Discharges/Day (Medical)	>11/day	8.0	6.8			
90th%tile Time to Inpatient Bed (Hours) - Med/Surg	<25 hours	45.8	48.8			

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Achieve time to bed target of < 25 hours	1. Implemented process improvements (includes improved communication between ED flow, charge and inpatient unit) for sending the patient up within 30 minutes, implemented in all Medicine units as preliminary trial	1. Provide training sessions to charge nurses regarding new process improvement; 2. Spread initiative to remaining inpatient units (ICU, W&C, Paeds, Inpatient Surgery), and collect feedback	R1) Transport and bed turnover can impact patient flow; R2) Competing departmental priorities resulting in discharge delays or downstream bottlenecks; M1) Standardize admission workflows by supporting the development of inpatient admission and flow processes and policy; M2) Support the installation of surge unit in C3
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 an awareness campaign for ED and hospitalists to highlight the resource to support admission avoidance and earlier discharge; 2. Implemented EDD introduction at rounds, LOS HIC for chronic health conditions; 3. Educated physicians on HIC and team on the use of HIC guidelines around chronic diseases; 4. Re-established review of long LOS list; 5. Evaluated the "right people" from multidisciplinary teams attending rounds; 6. Explored with physicians how to communicate EDD, if unable to attend rounds; 7. CEF team completed education with staff by implementing new medical directive for catheter removal, in addition to creating badge cards to remind staff of discharge rounds barriers to monitor for, and ways to support discharges/flow	1. Develop discharge planning model, in conjunction with decoupling from OH@Home; 2. 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; 3. Schedule site visit at London Health Sciences Centre to review discharge and patient flow processes; 4. Restart patient rounding and improve questions related to patient's awareness of EDD and audit whiteboards to ensure EDD communication; 5.Ongoing work with Physician Partners re: confirming and getting early identifications of EDD. Writing orders in advance to promote earlier in the day discharges; 6. Coordinate follow-up Innovation Design Event with Maccelerate for Streamlining Discharge Rounds and Inpatient Unit Boards; 7. Adding 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)	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
Strengthen dyad (medical / management) partnership model	1. Continue to align LEADS framework; 2. Executed joint learning sessions; 3. Finalized solution to enhance discharge planning and predictive discharges	1. Continue to leverage and augment Clinical Operational Excellence Committee (COEC); 2. Engagement letters to external reviewers re: program management (will include evaluation of dyad opportunities); 3. Soft launch of Program Council in November pre-MAC	No risks to report.

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

Executive Sponsor(s):
Trevor Clark

Physician Liaison(s):
Dr. Ryeyan Taseen

Director Lead(s):
Rob Howe

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

In Year Measures of Success

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

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
% on track with Health Information System (HIS) implementation milestones	1. Completed Contract signing; 2. Onboarded Project Director; 3. Hired Manager, Informatics; 4. Completed Project Governance; 5. Finalized TORs based on governance; 6. Initiated the project Sub-Committees; 7. Strengthened partnership with Waterloo Regional Health Network (WRHN) and our vendor, Oracle Health; 8. Developed a "Project Plan" with clear milestones and timelines for the teams; 9. Successfully held Leadership Workshop	1. Hire a Project Coordinator and Project SMEs; 2. Complete the Project Pre-Planning Phase and beginning the "Initiation" Phase; 3. Kick-off the project Steering Committees and Councils; 4. Develop the Pre-Approval and Plan project documents; 5. Complete the "Customer Readiness Checklist"; 6. Develop the Item Master; 7.Schedule the "Enterprise Workflow Workshops"; 8. Hold the "Data Management Workshops"; 9. Conducting the "Change Management Workshops" and "Engagement Focus Groups".	R1) Onboarding the full project resources; M1) Fast track hiring for the project roles
% on track with Workforce Planning (WFP) implementation milestones	1. Stabilization of Phase 1 through active monitoring and actioning of issues log; 2. CMH continues to pay staff successfully through Meditech with UKG as the timecard source of truth; 3. Phase 2 (data analytics and attendance management) scope continues to be worked to for closure in Q3	1. Completion of Phase 2 scope (data analytics and attendance management); 2. WFP Steering to be consolidated with broader Corporate Solutions Steering to ensure alignment across all corporate solutions; 3. Closure of all urgent and high issues, with planned handover of remaining items to operational departments who will close them; 4. Resource planning for ongoing operations completed	R1) Persistent issues which require resolution longer than Q3 to complete; M1) Project team continues to meet twice per week to work through issues with urgency; R2) Phase 2 scope unable to be delivered by December 2025; M2) Phase 2 scope continues to be focused on with resources from impacted departments
% of MDs using Front End Speech	1. Successfully spread use of scribe AI beyond initial pilot in ED; 2. Significantly expanded adoption of Front-End Speech Technologies reaching 60% of providers using the technology; 3. Established updated and refreshed policies for scribe AI and front end speech; 4. Developed proposal for downtime in the event that front end speech tools are offline	1. Continue to expand the adoption of advanced front-end speech technologies with target of full adoption by end of fiscal; 2. Phase out phone dictation by end of fiscal year. 3. Provide training and support for physicians to transition smoothly from phone dictation to front-end speech solutions; 3. Finalize scribe AI policy; 4. Educate providers on downtime procedures	R1) Ensure accurate tracking of adoption rates based on eligible credentialed physicians for front end speech; M1) Continue to collaborate with COS office to ensure most up to date eligible credentialed physicians list is used for planning and tracking adoption

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

Executive Sponsor(s):
Trevor Clark

Physician Liaison(s):
Dr. Ryeyan Taseen

Director Lead(s):
Rob Howe

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

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
% on track with Enterprise Resource Planning (ERP) implementation milestones	1. Preferred vendor identified for further demonstrations across functions (e.g. Finance, Supply Chain, Payroll, Human Resources) as well as corporate strategy and data management; 2. Current procurement options documented with future opportunities identified	1. Completion of demonstrations focused on identifying future state functionality as well as gaps which require supporting solutions; 2. Finalization of total cost of ownership for a single go-live event as well as phased go-live; 3. Identification of new procurement options based on RFP's currently in the process of being awarded; 4. Continued work with WRHN on opportunities to align corporate application modernization though shared instances or common platforms	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

Human Resources Plan (Resource Committee)

Increase Joy in Work

Click Here to Input Action Plans

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

Physician Liaison(s): Dr. Kunuk Rhee

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

Project Manager(s): Jennifer Woo

In Year Measures of Success

	Target	Q1	Q2	Q3	Q4
FTE Variance from target for Medicine, ICU, & ED (IRM)	**0**	-29	-25		
Medical Professional Staff (Targeted Positions)	17	**3**	**13**		
Overtime Hours per Quarter	**< 11,200**	23.0K	35.0K		

Trailing 12 - OT

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Reduce overtime hours to budget by March 31, 2026	(HR): 1. Focused attention with new tactics for ED, ICU, Medicine; 2. Automated new absence reporting email to go to staff with fiscal history provided to support attendance at work and reduced sick time; (Medicine): 1. Connecting team members to HSW and MH supports early to prevent needing to take time off work and support well-being; 2. Started attendance management strategies to identify staff with high absentee rate and offer supports/strategies to support attendance at work	(HR): 1. Continued focus on a variety of tactics to pilot to improve sick and overtime (e.g. trial all sick calls to also go to manager, mandatory meetings with all staff with 3+ absences in a period); 2. Working with a project task force to plan and implement a float pool to support Medicine to reduce overtime; 3. Continue implementation of Shift Guarantee configuration (over/under), educate and communicate staff and leaders; 4. Build and test pay-to-schedule for all non-union employees with UKG and once tested, implement - educate and communicate to staff and leaders (ED): 1. Continue to monitor OT and requests on a daily basis; 2. Develop new master schedule to ensure appropriate balance of skill mix (Medicine): 1. Continue to evaluate unit processes & educational needs & resources required to ensure to provide safe working environment and reduce staff burn out; 2. Pilot "Code Lavender" to ensure that the team's wellbeing is supported after a difficult or traumatic situation	(HR) R1) Implementation of time and attendance system and optimization; M1) Continue to leverage UKG Implementation Team to evaluate module (ED) R1) Bed admit occupancy and vacant positions impact OT; M1) Implement new schedule in FY 25/26 Q4 or FY 26/27 Q1, due to union contracts and approval process required; M2) Revise unit-specific guidelines to advise OSO on staffing according to unit's operational needs

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

Click Here to Input Action Plans

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

Physician Liaison(s): Dr. Kunuk Rhee

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

Project Manager(s): Jennifer Woo

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Achieve active staffing targets in (ED ICU Medicine) by March 31, 2026	(HR): 1. Filled 2 vacancies in Health, Safety and Wellness; 2. Onboarded all new members; 3.Ensured stabilization and renewed focus on Safety; 4. New speaking notes created for all leaders to have conversations with staff experiencing high sick time in order to support improved performance; 5. Work with UKG to potentially build new Attendance Support Program; 6. Fill Recruitment/Benefits vacancy to support hiring; 7. Redeveloped one vacancy to be a talent acquisition lead; 8. Work with UKG project lead to investigate and implement non-union, non-management departments/job categories that can transition to a pay-to-schedule model to reduce leader timecard exceptions (ED): 1. All FT and PT RN lines filled; 2. Recruited 1 FT contract RPN; 3. Provide orientation to new staff (Medicine): 1. Developed a "hands on" interview for Nursing Resource Team; 2. Adjusted the PSW hours on Med A2 and B2 for increased patient care and improved staff well-being; 3. Re-balanced the Nursing Lines to improve skill mixes/experience	(HR): Finalize hiring of new Talent Acquisition lead and onboard effectively; 2. Continue to focus on building the revised attendance program with UKG, launch - communicate and educate staff and leaders; (ED): 1. Ensure successful onboarding experience for retention; 2. Finalize master schedule to ensure efficiency of scheduling (Medicine): 1. Develop and implement a hands on interview for PSWs; 2. Continue to evaluate vacancies and hire to support LOAs	(HR): R1) Risk with UKG not being able to configure our requirements; M1) Evaluate and relaunch former automated internal program
Ensure medical staffing is sufficient to meet core clinical operations	1. Implementation of a recruitment process for US physicians; 2. Comprehensive recruitment with Doctors4Cambridge (ongoing); 3. Comprehensive onboarding (credentialing, orientation) (ongoing); 4. Offer educational / leadership opportunities to support physician recruitment and retention (e.g. MAC Learning Lab, CPSO QI 2.0 Initiative); 5.Recruitment occurred in several departments, resulting in achieving full complement of physicians/medical professional staff (ENT, urology, pathology); 6. Recruitment in ED has led to 100% shifts filled until the end of November 2025; 7. Successful recruitment for an OB/Gyne where there was a critical shortage of physicians in 2024, with one new physician who started in Q2 of 2025; 8. Recruitment of a new midwife; 9. Stable staffing in GIMRAC clinic to support ED/organizational flow	1. Aim to sustain the % of recruited in the identified core clinical areas; 2. Review of Medical Professional Staff HR planning by Chiefs in fall 2025; 3. Complete a 2025-2026 Medical Professional Staff HR Plan, in partnership with Dr. Kunuk Rhee, VPMO; 4. Expand the functionality of the new electronic credentialing platform with e-learning to support onboarding of new medical professional staff and support reappointment of medical professional staff	1. Continue to ensure emergency on-call services are covered by department internally +/- locum physician supports; 2. Continue to develop a comprehensive recruitment information package for Chiefs; 3. Enhance the onboarding process with expansion of the new electronic credentialing platform functionalities; 4. Creative models of care to recruit and to sustain clinical services; 5. Continue to increase medical learners as a recruitment strategy

Multi-Year Financial Plan (Resource Committee)

Sustain Financial Health

Click Here to Input Action Plans

Executive Sponsor(s): Trevor Clark

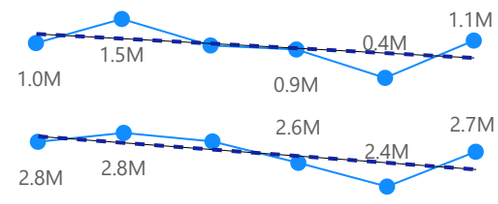
Physician Liaison(s): Dr. Lawrence Green (in absence of medical director), Dr. Augustin Nguyen

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	3.5M	2.5M		
QBP Revenue generated*	>$6.9M per Quarter	8.4M	7.6M		

Monthly Trend



In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Forecast PCOP for 25/26 and determine PCOP strategy for 26/27	1. Started budget process to determine overall 25/26 year-end forecast; 2. Based on forecast started developing PCOP strategy for 26/27 with the potential PCOP will be fully earned in 25/26	1. Finalize 25/26 PCOP forecast; 2. Determine if likelihood full PCOP will be earned and determine impact on 26/27 budget	No risks to report.
Achieve Medical PCOP growth target for 25/26	1. Assessed Q1 performance, Q1 performance on track to achieve targeted PCOP; 2. Begun forecasting process to determine budget and operational impact for 26/27 budget	1. Continue with monthly PCOP review meetings monthly to continue to monitor activity with Medical Leadership, Finance and Decision Support; 2. Monitor discharge volume and any change in average weight per case that could change year end forecast; 3. Finalize forecast for 25/26 for use in 26/27 budget planning	R1) Drop in medical weighted cases; M1) Monitor discharge and average weight per case volumes closely
Achieve Surgical PCOP growth target for 25/26	1.Assessed Q1 performance, Q1 performance over all in surgical programs is on track to achieve targeted PCOP; 2. Begun forecasting process to determine budget and operational impact for 26/27 budget; 3. Participated in WW regional work on analyzing OR Grid and surgical room usage	1. Continue to monitor surgical activity at monthly reviewing meetings with surgical leadership, finance and decision support; 2. Plan 26/27 grid based on PCOP forecast and planned QBP funding; 3. Continue to work with WW workgroup to maximize use of surgical rooms; 4. Review surgical wait-list and determine impact of 26/27 surgical plan on wait-list	R1) Incremental surgical recovery funding reduction; M1) Determine impact and surgical plan for 26/27
Based on PCOP Forecast determine QBP strategy for 26/27	1. Started to forecast QBP volume scenarios based on available funding	1. Establish OR grid to max available QBP funding and maximize OR resources and efficiency for 26/27	R1) Max available PCOP; M1) Need to analyze the impact to QBPs and plan accordingly

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

Advance Health Equity

DEI Plan (Board)

Click Here to Input Action Plans

Executive Sponsor(s): Mari Iromoto

Physician Liaison(s): TBD

Director Lead(s): Diana Crawford

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

In Year Measures of Success

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

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Creating Safe Spaces	Diversity Council Meeting (July): Solicited input/endorsement of ERG proposal, Draft Inclusion Policy, and Code Yellow Form updates Employee Resource Group (ERG) Roll-out: Received endorsement from Diversity Council on proposal to roll-out ERGs across CMH, developed ERG Terms of Reference, and presented roll-out plan and TOR to the Operations Team for feedback; official launch of Pilot Phase roll-out plan postponed to Q3 due to allow for input from new Director of Organizational Development	Diversity Council Meeting (October): Solicit input on internal ERG Pilot Phase launch and how to increase engagement/uptake across CMH; present Inclusion Policy status update; present Code Yellow Form status update; discuss ideas for the Inclusive Communications Policy ERG Roll-out: Officially launch Pilot Phase roll-out plan (rolled over from Q2), launch ERG Landing Page on CMHNet, evolve Pride and IHM Planning Committees into ERGs, form Black ERG (initiate planning for Black History Month)	No risks to report.
Education and Tools	DEI Toolkit: Create list of tools and resources to add to CMHNet and requested for feedback from organization - this action was postponed to Q3 due to the large focus for Indigenous Truth & ReconciliACTION Plan educational initiatives (e.g., roll-out of San'yas Indigenous Cultural Safety Training, September LEARN Challenge, and Cultural Safety Passport Activity).	DEI Professional Development Opportunity: Promote the CCDI Community of Practice events; have different representatives attend, network with other DEI professionals/champions and learn about transdisciplinary approaches to DEIA; have attendees share their learnings and how it can be applied to the work we do at CMH Leadership Mental Health Training: Provide de-escalation training for leaders at Fall Camp Organization-wide Learning: Explore DEI trainings to promote across the organization and develop a roll-out plan DEI Tool Kit: Develop list of DEI tools and resources to add to CMHNet, solicit input across the organization (rolled over from Q2)	R1) Limited capacity to work on DEI Toolkit due to the addition of organization-wide learning exploration (which has a higher priority due to larger impact to the Education and Tools priority) M1) Postpone to Q4 to focus on organization-wide learning exploration

DEI Plan-Cont. (Board)

Click Here to Input Action Plans

Executive Sponsor(s): Mari Iromoto

Physician Liaison(s): TBD

Director Lead(s): Diana Crawford

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

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Inclusive Languages and Images	Diversity Calendar: Formed an Islamic History Month Planning (IHM) Committee composed of 5 Muslim staff and medical professionals as well as allies to help plan IHM events and activities for October. Photo Repository – Photo Day: Had professional photographer take photos of over 14 departments across CMH, Diversity and Indigenous Council Member head shots, and several candid shots to capture CMH's diversity and culture Quarterly CEO Communication: Launched the first Quarterly CEO Communication to reinforce the organization's commitment to advancing DEI and Truth & ReconciliACTION, highlight achievements from Q1, and thank the CMH community for their contributions to this work	Diversity Calendar: Execute planned IHM events and activities, including the October LEARN Challenge, Voices of CMH (2 staff profiles and 1 physician profile), Cultural Snack Cart (with Mythbusters activity), Myth Busters Spinning Wheel in the cafeteria, Caring for Muslim Patient Lunch & Learn with Dr Ahmad Taed Tarakji, and the Quran Recitation with Imam Mubeen in the Sanctuary Inclusive Communications Policy: Complete draft policy and tool in collaboration with Corporate Communications, conduct consultation with key contributors Photo Repository: Plan a kick-off initiative to launch and promote the photo repository, thanking participants for their support and creating excitement for folks to use the repository Quarterly CEO Communication: Launch second communication earlier in the quarter to share achievements from Q2 and generate enthusiasm for ongoing DEI/Indigenous initiatives	R1) Limited capacity to work on Inclusive Communications Policy; unable to consult with Manager of Corporate Communications (was on leave); onboarding of new Director of Organizational Development and Culture M1) Postpone to Q4 as Manager of Corporate Communications is back from leave and new Director has settled in
People & Processes	Inclusion Policy: Developed the draft Inclusion Policy through consultation with various department managers and directors (Human Resources, Patient Experience, Professional Practice) and began soliciting feedback/endorsement from the Diversity Council, Nursing Advisory Council, Employee Engagement Council, Accessibility Advisory Committee Inclusive Practices in Emergency Preparedness: Incorporated inclusive language into the Code Yellow Form and updated the fields to create a more accurate description of a missing person; shifted process from Meditech/Outlook to MS Forms with drop-down menu of options to increase accessibility and maintain consistency in how Code Yellow forms are filled out Staff Sociodemographic Data Collection Survey: postponed launch to Q3 due to limited organizational capacity (survey fatigue) and staff concerns with linking the survey launch to UKG registration HWO Presentation: Update Inclusive vs Non-Inclusive Scenarios to be more CMH-specific, include examples of recent/ongoing DEI initiatives - postponed to Q3 due to capacity limitations	Inclusion Policy: Complete consultation and finalize policy, submit policy for publication, begin organization-wide roll-out HWO Presentation: Update Inclusive vs Non-Inclusive Scenarios to be more CMH-specific, include examples of recent/ongoing DEI initiatives (rolled over from Q2) Launch Staff Sociodemographic Data Collection Survey (rolled over from Q2) Staff Sociodemographic Data Collection Survey: launch survey (rolled over from Q2)	R1) May not be able to finalize/publish Inclusion Policy; need further consultation with Director of OD and time to implement changes; need further consultation with HR to establish DEI reporting process R2) There may be limited organizational capacity to roll out the Staff Sociodemographic Data Collection Survey (i.e., low uptake of staff taking the survey). Competing priorities such as the introduction of UKG, have put an unexpected amount of stress on staff and leadership; Retirement of Recruitment Specialist (need support to roll-out survey for new hires) and consultation with new Director of OD required M1) Postpone Inclusion Policy finalization/publication to Q4 M2) Focus on developing a roll-out plan and postpone survey launch to Q4

Truth and ReconciliAction Plan (Board)

Advance Health Equity

Click Here to Input Action Plans

Executive Sponsor(s): Patrick Gaskin

Physician Liaison(s): TBD

Director Lead(s): Diana Crawford

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

In Year Measures of Success

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

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Build and enhance capacity and education	Indigenous Calendar: Commemorated Orange Shirt Day and National Day for Truth and Reconciliation: Sold 67 Orange shirts and sold out of pins (100) and hosted events/activities throughout September*, including the September LEARN Challenge Quarterly L&L Series*: Hosted second session on Understanding the Residential School System and the TRC (36 attendees) Staff Training*: Opened first round of San'yas Registration for all staff and leaders (10 registered for the Core Training, 17 registered for the Enhanced Core Training); Started promoting the Waterloo Wellington Caring for Older Indigenous Adults Training (Cultural Safety Passport Activity) Smudging Ceremony Series*: Hosted annual Eagle Feather Re-energizing Ceremony with Clarence Cachagee (August)	Indigenous Calendar: Commemorate Winter Solstice and review/refresh Indigenous Calendar (align with WRHN and GGH) Quarterly L&L Series: Host third session on Understanding Indigenous Nutrition Staff Training: All registrants complete their San'yas training and continue promoting the Cultural Safety Passport Activity Hospital Wide Orientation (HWO) Presentation: Incorporate specific T&R initiatives and explore ways to enhance HWO and Clinical Orientation (e.g., smudging education) Smudging Ceremony Series: Host indoor ceremony Landing Page and Website Refresh: Conduct environmental scan for updating CMHNet and cmh.org with Indigenous information and resources	R1) Limited capacity to work on HWO Presentation updates R2) Limited capacity to facilitate an indoor smudging ceremony R3) Limited capacity to conduct environmental scan for Landing Page and Website Refresh M1) Postpone to Q4 M2) Postpone to Q4; align indoor ceremony with the launch of the Revised Smudging Policy and potential Crow Shield Lodge Service Agreement M3) Postpone to Q4
Build and Sustain Productive Relationships	Indigenous Advisory Circle (IAC): Attended regular meetings – August 27 (cancelled) and September 23 Regional T&R Touchpoints with WRHN and GGH: Hosted Working Retreat (July) to determine regional priorities and collaborate on regional projects Community Partnerships: Attended first Community of Support meeting led by new SOAHAC Indigenous Cultural Safety Specialist to collaborate and network with healthcare organizations across SOACHAC's catchment area on T&R initiatives	Indigenous Advisory Circle (IAC): Attend regular meetings Regional T&R Touchpoints: Attend regular meetings, continue collaborating on regional projects Indigenous Calendar of Events (Regional Project): Complete draft that outlines acknowledgement of Indigenous observances and regular events (e.g., Sacred Fires)	No risks to report.

Truth and ReconciliAction Plan-Cont. (Board)

Click Here to Input Action Plans

Executive Sponsor(s): Patrick Gaskin

Physician Liaison(s): TBD

Director Lead(s): Diana Crawford

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

In Year Objectives	Actions / Taken	Actions Planned for Next Quarter	Risks and Mitigations
Equitable Access to Culturally Safe Care	Indigenous Art: Installed Wing A Artwork; approved Eagle Feather and Wing B artwork; hosted staff information sessions with the artists Outdoor Space: Reviewed three design concepts in the second planning session (July) to review and gathered input on draft final concept via virtual consultation session (September) Smudging 101 Guides (Regional Project): Started drafting the guides Indigenous Clinical Recommendations: Finalized action plan Smudging Policy: Postponed revisions to Q3 due to cancelled Indigenous Council meeting and capacity constraints	Indigenous Art: Install Eagle Feather and Wing B Elevator Bay artwork, develop video series with artists (QR codes to accompany each piece) Outdoor Space: Review and provide input on updated final concept via virtual consultation (October) and present finalized design concept via in-person presentation (November) Smudging Policy: Revise Smudging Policy (rolled over from Q2) Smudging 101 Guides (Regional project): Continue developing guides and bring to IAC for input Indigenous Clinical Recommendations: Initiate 6-week education series in Labour & Delivery and Postpartum Indigenous Patient/Family Resources: Determine information to include on cmh.org and resource list	R1) Smudging 101 Guides may not be ready for IAC input during this quarter due to cancelled Regional T&R Touchpoints and cancelled Indigenous Council Meeting (October) R2) May have limited capacity to work on Indigenous Patient/Family Resources (i.e., information to include on cmh.org and resource list) M1) Postpone bringing Smudging 101 Guides to IAC for input to Q4 and add Smudging 101 Guides as a discussion item for next Indigenous Council meeting (November) M2) Postpone to Q4
Measure, Monitor and Evaluate	Advance Health Equity Strategic Priority Tracker: Established tracker for Indigenous T&R so that it is measured, monitored, and evaluated separately from DEI Indigenous Patient Data Collection: Attended Regional Indigenous Identity Confirmation Processes: Design & Implementation Webinar SOAHAC Organizational Assessment Tool: Postponed assessment and submission to Q3 due to deadline extension from SOAHAC and capacity constraints	SOAHAC Organizational Assessment Tool: Complete assessment to evaluate current state of T&R at CMH and submit to SOAHAC (rolled over from Q2)	R1) Limited capacity to work on this due to competing priorities; assessment requires more time/energy than initially planned; M1) SOAHAC extended the deadline for submissions; postpone to Q4

Patrick Gaskin
President and CEO
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Fax: (519) 740-4953
Email: pgaskin@cmh.org

CAMBRIDGE MEMORIAL HOSPITAL

MEMORANDUM

TO: Board of Directors, Cambridge Memorial Hospital

DATE: September 26, 2025

REPORTING PERIOD: September 26, 2025 to November 28, 2025

FROM: Patrick Gaskin
President and CEO

RE: CEO Certificate of Compliance

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

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

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

Exceptions: NIL

Patrick Gaskin
President and CEO

CMH

CMH Board Update – Nov 2025

Vision

Creating healthier communities, together.

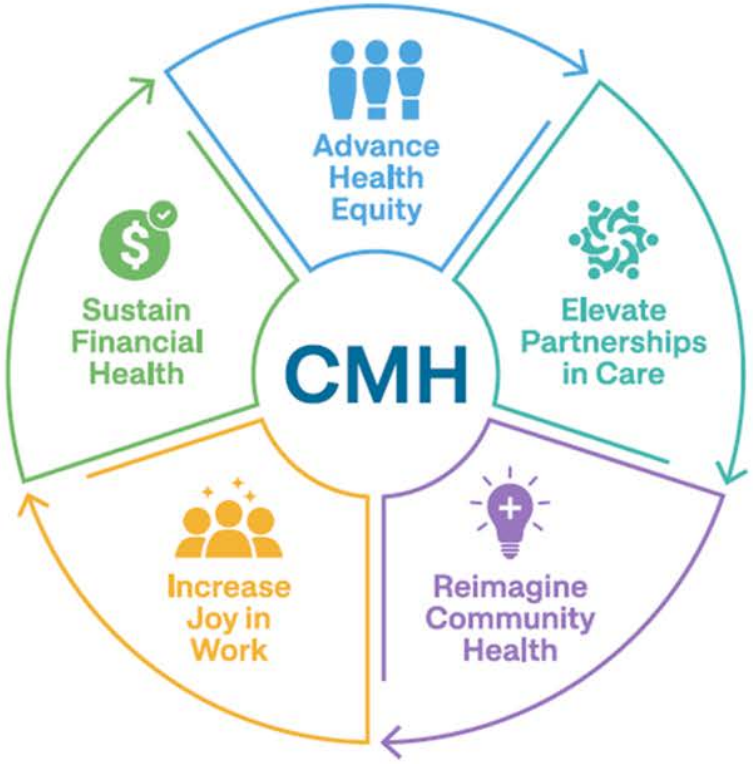
Mission

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

Values

Caring
Collaboration
Accountability
Innovation
Respect

Strategic Pillars



Advance Health Equity

Promotes the need for diversity, equity and inclusion to increase equitable access to healthcare and support a work culture where very individual can reach their full potential.

Elevate Partnerships in Care

Highlights the importance of collaboration across all levels to ensure the highest quality and safest care experience.

Reimagine Community Health

Demonstrates how we will use innovation and embrace transformation to improve the way we deliver healthcare.

Increase Joy in Work

Reflects our commitment to improving the well-being of our team by creating meaningful and enabling work environments.

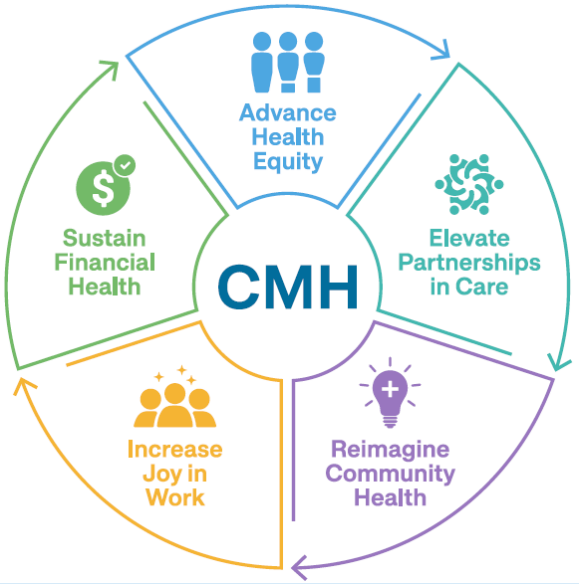
Sustain Financial Health

Shows our dedication to not only keeping a balanced budget but also building a strong foundation for investment and growth.

Corporate Plan Status Overview

Version Date: June 2025

There are 19 corporate plans housed within our five Strategic Pillars. Each corporate plan guides the work of its respective department to ensure alignment with our 2022-27 Strategic Plan.



Sustain Financial Health		
Corporate Plan	**Plan Owner(s)**	**Status**
Multi-year Financial Plan	Trevor Clark and Valerie Smith-Sellers	ACTIVE
Multi-year Capital Plan	Trevor Clark and Valerie Smith-Sellers	ACTIVE

Increase Joy in Work		
Corporate Plan	**Plan Owner(s)**	**Status**
Human Resources Plan	Susan Toth	ACTIVE
Wellness and Wellbeing Plan	Susan Toth and Mari Iromoto	ACTIVE
Employee and Physician Engagement Plan	Susan Toth and Mari Iromoto	ACTIVE
Corporate Communications and Engagement Plan	Stephan Beckhoff	ACTIVE

Advance Health Equity		
Corporate Plan	**Plan Owner**	**Status**
Diversity, Equity, and Inclusion Plan (2022-27)	Mari Iromoto	ACTIVE
Indigenous Truth & ReconciliACTION Plan	Patrick Gaskin and Mari Iromoto	ACTIVE
Accessibility Plan	Liane Barefoot	ACTIVE
Senior Friendly Hospital Plan	Stephanie Pearsall	ACTIVE

Elevate Partnerships in Care		
Corporate Plan	**Plan Owner(s)**	**Status / Approval Date**
Clinical Services Growth Plan	Stephanie Pearsall and Dr. Winnie Lee	ACTIVE
Patient Experience Plan	Liane Barefoot	ACTIVE
Quality & Patient Safety Plan	Liane Barefoot	ACTIVE
Capital Redevelopment Plan	Amanda Thibodeau	COMPLETE

Reimagine Community Health		
Corporate Plan	**Plan Owner**	**Status**
Ontario Health Team Plan	Patrick Gaskin	ACTIVE
Research & Innovation Plan	Kyle Leslie	ACTIVE
Digital Health (includes HIS) Plan	Rob Howe	ACTIVE
Operational Excellence Plan	Kyle Leslie	ACTIVE
Environmental Sustainability Plan	Rob Howe	ACTIVE

Our 2022–27 Strategic Plan

Strategic Pillars

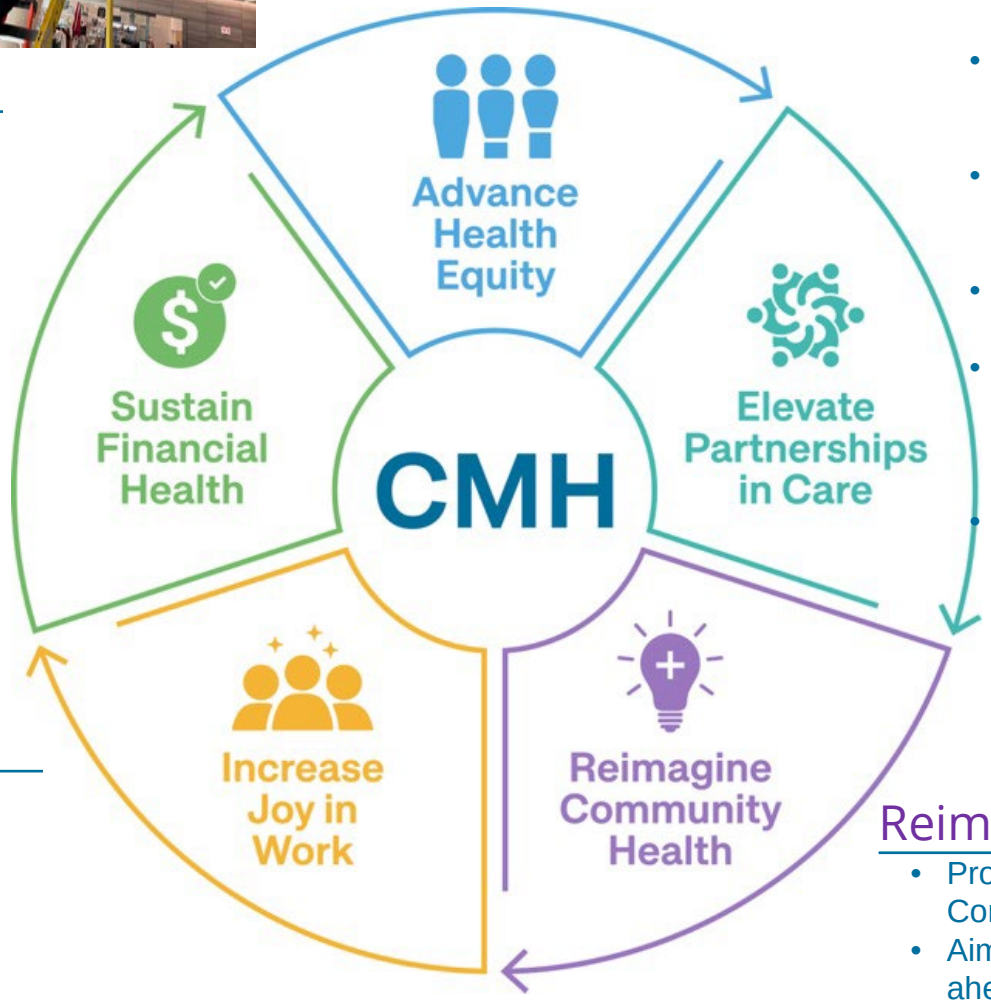
Nov 2025

Advance Health Equity

- Indigenous Council & Diversity Council met recently
- Working to update smudging policy by Q4 – indoor, space for staff, 24/7 accessibility
- Artwork to support eagle feather in lobby has been installed.
- Indigenous garden planning is underway

Sustain Financial Health

- Team working on the CMH 26/27 budget – some pressures for CMH as we are finishing up our PCOP years
- HSSP – Hospital Sector Stabilization Plan – expectation of Ministry that hospitals meet service volumes with only a 2% increase for next 3 years
- 30 hospitals across ON are getting cash advances from MOH
- Revenue optimization work among Waterloo Wellington hospitals – preferred accommodation, maximizing QBPs/OR capacity



Elevate Partnerships in Care

- See Me Hear Me Conference hosted by Mayor last month. CMH participated.
- Presentation to City of Cambridge Council re: ask for $$ to support renovation to create 3rd safe room. Great work Lisa and team!
- Flow - continued work across the organization. Priority for us, our community and Ontario Health.
- Planning for the future space needs of CMH with WRHN to support ask to Regional Council
- Being “1 Million Ready” is more than just a new hospital in Waterloo. Working with Lisa on this to make sure the CMH and Cambridge voices are heard
- Residents of Cambridge who get care at a Waterloo hospital – 83% come to CMH, 3% to St. Mary’s, 14% to GRH

WRHN
Waterloo Regional Health Network

Increase Joy in Work

- New Whistleblower system – open to all! Access on www.cmh.org
- Holiday staff meal – December 4.

Reimagine Community Health

- Project Steering Committee and Executive Committee have met
- Aiming to go live in late 2026. Lots of work ahead!

Pages 131-133 Moved to In-Camera Meeting

Board Chair's Report – Fall 2025

Message From the Chair

As we approach the holiday season in 2025, I am filled with gratitude for each one of you and your contributions to CMH's success this year. Your dedication and commitment have truly made a difference.

The holidays are a special time to cherish moments with loved ones and to renew our energy for the challenges ahead. May your holiday season be rich with joy, warmth, and meaningful connections.

Looking ahead to 2026, I am excited about what we can achieve together. Our shared values of caring, collaboration, accountability, innovation, and respect have guided us well thus far. Let’s continue to build on these pillars as we strive to create healthier communities in the new year.

Wishing you a festive holiday season and a bright, hopeful 2026!

Board Chair's Report – October 2025

Grand Rounds – Creatine is a 'little' high…Are you Kidding?
On October 23, 2025, Bill Conway, Miles Lauzon, and Diane Wilkinson attended the Grand Rounds session – "Creatine is a 'little' high…Are you kidding?" presented by Dr. Ahmad Raed Tarakji, Consultant Nephrologist & CRRT Physician Lead. Attendees learnt about serum creatine & urea – their stories, and their importance, urine – a forgotten body fluid, and Nephrologist – a crucial member of the healthcare team.



Sparking the Collective: Transdisciplinary Approaches to DEIA
CMH extended the opportunity to Board members to participate in CCDI's Community of Practice Event. This year's topic was Sparking the Collective: Transdisciplinary Approaches to DEIA, inviting folks to come together and explore how transdisciplinary approaches can drive innovation, ethical action, and collective sustainability in today's evolving DEIA landscape. The sessions were held virtually and 2.5 hours in length. Sara Alvarado, Paulo Brasil and Bill Conway expressed interest to join, however the selected date was cancelled. Bill Conway was able to join on an alternate date.



Beyond the Hype: The AI Opportunities Separating Leaders from Laggards in Healthcare, and Where It's Going Next

On October 28, 2025 Deloitte hosted their 21st Summit Series webcast providing actionable insights to help stay ahead and make strategic decisions in a dynamic health care landscape. The webcast focused on:

- The AI-driven strategies that distinguish industry leaders from the rest
- How AI is reshaping patient care, operations, and cost management
- The impact of AI on talent—shaping workforce plans, policies, and processes
- Real-world examples of successful AI adoption in health care
- What's next: Emerging trends and opportunities on the horizon

Directors self-registered for the event; those who indicated their enrollment are pictured above. Thank you to Margaret McKinnon, and all others who were able to join and participate in the event!

An Evening of Gratitude
On October 22, 2025, Sara Alvarado, Paulo Brasil, Miles Lauzon and Bill Conway, attended the CMH Foundation Celebration of Champions event, an evening dedicated to celebrate and show gratitude to our Donor family. The evening was truly magical! A room filled with over 170 generous members of the community who have helped year-over-year to keep healthcare close to home.

Board Chair's Report – October 2025

Huddles, Huddles, and more Huddles

In October / November Diane Wilkinson Diane Wilkinson attended huddles in Information Technology and Human Resources as well as a facility tour will Bill Hibbs. The IT staff were so engaged in updating each other with what they were working on, what they were concerned about and what help they needed for the week. In HR, two new staff were onboarded that week attending their first huddle. In chatting with the HR Occupational Therapist, I was able to hear about her work with the Medical Day Care staff regarding patient lifts in the chemotherapy suite and how by working together and with the opportunity to purchase new chemo chairs for patients, staff and patients are now benefiting from this investment. The hospital facilities tour started with the huddle where the maintenance staff asked me questions about the Board, what we did and were there any tradespeople on the Board to understand their issues. I highlighted that we had an engineer on the Board but no tradesperson at this point. I then spent the next two hours, up and down stairways, on roofs, in the cogeneration plant, basement, sub-basement and the mechanical rooms. Personally, I was so impressed with Bill's knowledge of the facility, his concerns, our risks, the opportunities he sees and how he has a vision going forward.

Bill Conway and Jayne Herring spent time in CMH's emergency department. "Bill and I had the privilege of attending a huddle in the emergency department on Nov 5th. We were welcomed into the ED and spent 10 minutes or so listening to the info presented to staff at the huddle. I wasn't sure what a huddle even looked like, so this was a great introduction! We were really pleased to see a great number of staff were able to attend that morning and Bill and I were each given the opportunity at the end to the huddle to express our appreciation to staff for their hard work and to let them know that the board is updated on their efforts on a regular basis".



CMH always welcomes Directors to stop by and join our Department huddles! As a reminder, if you are interested, just reach out to Stephanie Fitzgerald sfitzgerald@cmh.org and she will help get you set up!

Brest Reconstruction Awareness Day

On October 15, 2025, Sara Alvarado and Paulo Brasil joined CMH for the Breast Reconstruction Awareness Day celebrating innovation, collaboration, and access to care transforming lives across Waterloo Region and Guelph.

Sara shared on her LinkedIn "We have a great hospital because we have a great sense of community in Cambridge. Thanks to Cambridge Memorial Hospital Foundation for helping to organize this educational event about breast reconstruction. I learned tons and I'm very proud of CMH making these procedures available to cancer patients, in addition to the regular treatment. Great to see Kavya Nair and Katie McMullen from CMHF, Stephanie Pearsall , Winnie Lee, MD, FRCP(C) , Paulo Brasil and many others in that packed room! A true privilege to serve on this Board"

Board Chair's Report – October 2025

Hospital Governance Essentials for New Directors

Each year, OHA presents their Hospital Governance Essentials for New Directors program. This year, the program was expanded from three modules to five. The comprehensive five-part virtual series aimed at equipping hospital governors with an understanding of the legal, governance, and funding frameworks essential for effective leadership and sound governance practices. A significant achievement was marked by over 50% attendance among our Board members across one or more sessions.







With the recent update of the Guide to Good Governance alongside the additional modules, all Directors were encouraged to participate in as many sessions as possible. The topics covered included:

- Hospital Legal Framework
- Hospital Accountability Within Health Systems
- Hospital Funding and Accountability
- Governance and Management Partnership
- Current Issues and Emerging Themes: Bringing It All Together

Sara Alvarado, among those who attended, commented, "Even though I completed the Governance course shortly after joining the board around eight years ago, the significant changes brought about by events such as COVID, financial deficits, mergers, and economic shifts have greatly altered governance expectations. I strongly recommend that experienced directors take a refresher on all modules if possible."

She added, “I found these webinars more comprehensive than those from a few years back, especially regarding evolving governance requirements, integration, and the digital and financial acumen necessary for maintaining balanced budgets.”

Board Chair's Report – November 2025

Cambridge & North Dumfries Annual Community Awards

Although CMH was nominated this year, Sara Alvarado and Miles Lauzon joined Patrick Gaskin on November 10, 2025 at the annual Cambridge & North Dumfries Annual Community Awards. These awards recognize the achievements of local not-for-profit groups, charities, and service clubs. Dr. Mike Lawrie, a long time CMH physician and former Chief of Staff received the lifetime recognition award.

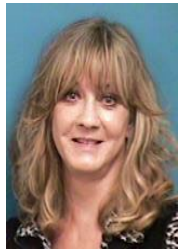
HIROC

Cyber Preparedness in Healthcare

On November 18, 2025 Members of our Board and Digital Health Strategy Committee (DHSC) were invited to attend a virtual workshop: Cyber Preparedness in Healthcare hosted by HIROC. During the three hours of learning topics included were:

- Planning and safeguards for AI tools, with Unity Health Toronto
- Governing risk in an event-driven world, with William Osler Health System
- Emerging trends in AI, privacy and cybersecurity with Miller Thompson
- A simulated breach event with Ridge Canada

Director Sara Alvarado, joined DHSC member Gloria Ringwood for the event.



HIROC OHA Ontario Hospital Association

Risk Forum on Hospital Governance and AI

On November 26, 2025, the OHA and HIROC co-hosted a virtual Risk Forum aimed at exploring emerging issues in risk management and governance, with particular emphasis on the evolving influence of artificial intelligence within healthcare. Participants had the chance to listen to presentations, engage in meaningful discussions, and collaboratively tackle the challenges associated with shaping the future of hospital governance. Directors self-registered for the event; those who indicated their enrollment are pictured below. Thank you to these individuals and all others who were able to join and participate in the event.

Board Chair's Report – November 2025

Healthy Workplace Certification – Gold Level
On November 20, 2025, Paulo Brasil and Lynn Woeller joined CMH at the 41st annual Canada Awards for Excellence, and event to recognize outstanding achievements by organizations across Canada that demonstrate excellence, innovation, and wellness. CMH is proud to receive the Canada Award for Excellence at the Gold Level Healthy Workplace Certification.

Grand Rounds – Beyond the Hype: A Clinician's Practical Guide to Artificial Intelligence
On November 27, 2025, Bill Conway, Lynn Woeller, Julia Goyal, Jayne Herring, and Paulo Brasil attended the Grand Rounds session – "Beyond the Hype: A Clinician's Practical Guide to Artificial Intelligence" presented by Dr. Neil Naik. The presentation focused on understanding the foundational concepts of artificial intelligence and machine learning in healthcare, recognizing the opportunities and limitations of AI tools across all clinical specialties, and how to apply a practical framework for evaluating and adopting AI clinical solutions in clinical workflows.

Remembrance Day Service
On November 11, 2025 Sara Alvardo braved the cold and joined CMH for their Remembrance Day Service, Honouring the bravery, courage, and sacrifices of those who served and continue to serve to protect Canada.

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: September 29, 2025
Issue: HSO Governing Body Assessment – Final Survey Questions
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Executive Assistant
Approved by: Patrick Gaskin - President & CEO, Julia Goyal - Governance Committee Chair

Attachments/Related Documents: None

Recommendation/Motion

Board

That, the Board of Directors approves the following questions for inclusion in the Health Standards Organization (HSO) Governing Body Assessment, and upon recommendation from the Governance and Nominating Committee at its meeting of October 9, 2025:

1. We are informed about significant risk issues in a timely manner.
2. There is a sound plan for the CEO's development and succession.
3. The organization engages relevant stakeholders when considering strategic planning and service integration opportunities.
4. There is sufficient diversity of skills, experience, and backgrounds for good governance.
5. In-camera sessions are used appropriately.
6. The consent agenda is utilized effectively without compromising oversight and important items are flagged for detailed discussion when necessary.
7. We can apply knowledge gained from educational/generative discussions to our Board responsibilities and decision-making processes.
8. As Board members, our contributions effectively support the organization's goals and initiatives related to Diversity, Equity, and Inclusion (DEI).
9. We have sufficient training opportunities and a clear understanding of where to access resources.
10. The Board demonstrates accountability and transparency to government and other key stakeholders.

Given that the survey will not be administered until late 2026, if for any reason there is a need to update the questions, those proposed changes will come back to the Governance and Nominating Committee for input and final approval by the Board of Directors of any changes.

Governance and Nominating Committee

That, the Governance and Nominating Committee recommends to the Board of Director the following questions for inclusion in the Health Standards Organization (HSO) Governing Body Assessment: (questions are outlined above in the Board motion). **CARRIED.**

Executive Summary

As part of the requirements set out by Accreditation Canada, the Board will undergo the HSO Governing Body Assessment. The Governance Committee offered input and suggestions to CMH management at various meetings in 2025, regarding topics and questions that could be valuable for inclusion in the final survey.

Background
According to recommendations from Accreditation Canada, it is advised that the Board completes the HSO Governing Body Assessment within the first or second year of the accreditation cycle. Given that CMH's on-site assessment has been rescheduled for November 2028, and considering current capacity and priorities, it is recommended that the Board should complete this survey by the end of 2026.

Below are ten questions proposed for inclusion in the survey based on input from the Governance and Nominating Committee. The first five questions are carried forward from the 2023 OHA survey due to CMH's below-average performance and have been agreed upon as essential to gauge progress:

1. We are informed about significant risk issues in a timely manner.
2. There is a sound plan for the CEO's development and succession.
3. The organization engages relevant stakeholders when considering strategic planning and service integration opportunities.
4. There is sufficient diversity of skills, experience, and backgrounds for good governance.
5. In-camera sessions are used appropriately.

The following five questions have been crafted based on feedback from the Governance and Nominating Committee to integrate into the final survey:

1. The consent agenda is utilized effectively without compromising oversight and important items are flagged for detailed discussion when necessary.
2. We can apply knowledge gained from educational/generative discussions to our Board responsibilities and decision-making processes.
3. As Board members, our contributions effectively support the organization's goals and initiatives related to Diversity, Equity, and Inclusion (DEI).
4. We have sufficient training opportunities and a clear understanding of where to access resources.
5. The Board demonstrates accountability and transparency to government and other key stakeholders.

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: November 25, 2025
Issue: Proposed Changes to the Non-Director Peer Assessment Process
Prepared for: Board of Directors
Purpose: ☒ Approval ☒ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Administrative Assistant
Approved by: Julia Goyal - Chair, Governance & Nominating Committee

Attachments/Related Documents: None

Recommendation/Motion

Board

That, the Board of Directors approves the discontinuation of the peer evaluation survey for non-Director Committee members and adopting the process as outlined below that will be further reflected in policy 2-A-38 Role of Committee Chair, and as recommended by the Governance and Nominating Committee at their meeting of November 13, 2025.

Governance and Nominating Committee

That, after review and discussion of the information provided the Governance and Nominating Committee recommends to the Board of Directors the discontinuation of the peer evaluation survey for non-Director Committee members. **CARRIED.**

Executive Summary

At the October 9, 2025 Governance and Nominating Committee (GNC) meeting, members deliberated on a proposal to discontinue the peer evaluation process for non-directors due to its time-consuming nature. While recognizing the burden of the current system, concerns were raised that discontinuing it entirely would result in a significant gap in development and performance understanding for non-Directors.
To address this concern, the committee suggested eliminating the survey component of the process but emphasized the need for an alternative avenue to discuss non-Director performance.

Based on the feedback received from the GNC, the new proposal is to eliminate the peer evaluation survey for non-Directors and introduce the following process:

Process:

1. The Chair of each committee will reach out to members prior to the beginning of the Board cycle.
    a. For new members, Chairs will take the opportunity to introduce themselves, welcome individuals to the committee, and inform them about an upcoming 90-minute committee orientation—a general meet-and-greet session.
    b. For returning directors, these check-ins will provide an opportunity to review their self-assessments and discuss development goals and expectations for the upcoming Board cycle.

2. The Chair of each committee will reach out to members for a midpoint check-in. This provides an opportunity to discuss the members' contributions to the committee so far, celebrating their successes and addressing areas for improvement as needed.
3. Non-directors will continue to participate in the Self-Assessment survey administered in April, which will serve as a guide for conversations before each Board cycle.

Chairs will continue the current practice of collaborating directly with non-directors to address **immediate** performance concerns such as ineffective participation in meetings or poor meeting attendance. In cases requiring additional support, the Chair of GNC or Board chair will be involved.

This approach aims to streamline the evaluation process while ensuring continuous feedback and development for non-directors, maintaining accountability, and fostering a supportive environment for professional growth.

Next Steps
Upon final approval of the Board of Directors, policy 2-A-28 Role of Committee Chair & 2-D-40 Evaluation of Board, Committee, and Individual Performance will be updated to reflect the new process and brought to the GNC for review and subsequently to the Board of Directors for final approval.

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: November 25, 2025
Issue: Proposed Process Change to Board and Committee Terms of Reference and Workplan
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

Recommendation/Motion

Board

That, the Board of Directors adopt a standard annual review process for Board/Committees to review the Committee Terms of Reference and Workplans and upon recommendation of the Governance and Nominating Committee at its meeting of October 9, 2025.

Governance and Nominating Committee

After review and discussion of the information provided, the Governance and Nominating Committee recommends that the Board of Directors adopt a standard annual review process for Committees to review the Committee Terms of Reference and Workplans. **CARRIED.**

Executive Summary

A board establishes committees to assist the board with board work. This means committees support and supplement the work of the board. The principal purpose of establishing a committee is to empower a small group of Directors and non-Directors to perform detailed governance work and make recommendations to the board for its consideration.

Committees develop workplans that enable them to fulfill their responsibilities to the board and align with the committee's terms of reference.

Background

Currently, terms of reference are reviewed every three years, unless there is a significant change in the committee's mandate. However, current best governance practices recommend an annual review of both workplans and terms of reference to ensure alignment with the dynamic healthcare landscape and the strategic direction of the organization. It is proposed that all Board committees adopt a consistent process for conducting an annual review of their terms of reference and work plans at the first Committee meeting of each Board cycle. Significant changes would be brought to the Governance & Nominating Committee (GNC) for review and recommendation to the Board. Terms of Reference will continue to undergo a comprehensive review by the GNC every three years to confirm alignment with the Board's mandate and governance practices.

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: November 26, 2025
Issue: Board Officer Selection Process
Prepared for: Governance and Nominating Committee
Purpose: ☒ Approval ☒ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Administrative Assistant
Approved by: Patrick Gaskin, President & CEO

Attachments/Related Documents:
Draft Policy 2-D-19 Board Officer Selection Process

Recommendation/Motion

Board

That, the Board of Directors approves and adopts policy 2-D-19 Board Officer Selection Process as presented, and upon recommendation of the Governance and Nominating Committee at its meeting of November 13, 2025.

Governance and Nominating Committee

That, after review and discussion of the information provided, the Governance and Nominating Committee recommends that the Board of Directors approves and adopts policy 2-D-19 Board Officer Selection Process as amended. **CARRIED.**

Executive Summary

Previously, CMH lacked a formalized process for selecting officers within its Board of Directors, relying instead on informal methods. With an increasing number of Directors expressing interest in serving as Board officers during their tenure, it has become imperative to establish a transparent and structured procedure.

To address this need, CMH has developed a new policy for the selection of Board officers, drawing from the sample Board Chair Selection Process Guidelines (Form 8.2) provided by the Ontario Hospital Association (OHA). This draft policy, titled "Board Officer Selection Process" (2-D-19), aims to ensure that the election and appointment processes are fair, inclusive, and consistent with current best governance practices.

Implementing this new process will enhance CMH's governance framework, fostering greater accountability and ensuring that all Board members have clear expectations regarding officer roles and responsibilities.

Background

The Governance and Nominating Committee (GNC) reviewed this draft policy at its meeting of November 13, 2025 and provided feedback or additional input. The policy has been updated to reflect those amendments.

CAMBRIDGE MEMORIAL HOSPITAL

BOARD MANUAL

SUBJECT: Board Officer Selection Process	**NO.: 2-D-19**
SECTION: Board Process	
APPROVED BY: Board of Directors	**DATE: TBD**

Purpose

It is in the interest of the hospital that there be succession planning and a smooth transition in the offices of the Chair and Vice Chair of the Board.

Policy

The incoming Chair shall:

- Be a current member of the Board of Directors;
- Be serving as Vice Chair until the commencement of their own term, when possible; and
- Be approved by the Board of Directors one year prior to the conclusion of the current Board Chair's term.

The incoming Vice Chair shall:

- Be a current member of the Board of Directors;
- Preferably have served as a member of the Resources or Quality Committee; and
- Preferably have served on the Board for at least 3 years.

Process

The Governance and Nominating Committee (GNC) shall undertake the Board Chair and Vice Chair selection process and shall recommend to the Board the preferred candidates for consideration.

Selection Criteria – Desirable Attributes

- Proven leadership skills
- Experience as a Chair of a Board committee;
- Good strategic and facilitation skills;
- Ability to influence and achieve consensus;
- Ability to act impartially and without bias and display tact and diplomacy;
- Effective communicator;
- Political acumen;
- Ability to devote the time to maintaining/building strong relationships between the corporation and its stakeholders;

- Ability to establish trusted advisor relationships with the President and Chief Executive Officer (CEO), Chief of Staff (COS), Senior Executives of the hospital, and other Board members;
- Governance and board-level experience;
- Understanding and appreciation of quality, patient experience, quality improvement and patient safety; and
- Outstanding record of achievement in one or several areas of skills and experiences outlined in the skills matrix used to select Board members.

Selection Process

1. As part of the futures intentions survey, current Directors shall be asked (1) to self identify their interest to serve as an officer and (2) to suggest potential officers. The survey shall include the selection criteria noted in this policy to assist the Directors in completing the survey.
2. The CEO, with input from the Senior Executives and COS, shall provide suggestions on potential officers to the GNC.
3. The GNC shall receive and review the suggested candidates and shall establish a selection advisory team of at least 3 Directors selected by the GNC. If possible, in totality, the membership of the selection advisory team shall represent a cross section of Board committees.
4. The selection advisory team shall:
    - meet with each nominated candidate to ascertain interest and discuss the duties and role of the position;
    - review the results of the candidates' peer evaluations, and Committee Chair evaluations;
    - canvas Board members to obtain views on the perceived skills, strengths, and weaknesses of the candidates;
    - canvas the CEO, COS, and senior leadership team to obtain views on the perceived skills, strengths, and weaknesses of the candidates; and
    - prepare a recommendation of preferred officer candidates for consideration by the Board.
5. If the Chair of the GNC is a potential nominee, they shall not lead nor participate on the selection advisory team, and the process shall be led by the current Chair (only if the Chair is in their final year as Chair) or another Director, as selected by the GNC.

DEVELOPED: TBD		
REVISED/REVIEWED:		
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BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: November 4, 2025
Issue: Selection of Interview Team
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

Recommendation/Motion

Board

That, the Board appoints the following internal individuals as part of the interview team for the 2026-27 Board and committee member recruitment and upon recommendation of the Governance and Nominating Committee at its meeting of November 13, 2025:

Julia Goyal
Diane Wilkinson
Jayne Herring
Tom Barker

Governance and Nominating Committee

That, the Governance and Nominating Committee recommends to the Board the appointment of the following individuals as the interview team for the 2026-27 Board and committee member recruitment:

Julia Goyal
Diane Wilkinson
Jayne Herring
Tom Barker

Executive Summary

As outlined in Policy 2-D-20 on Recruitment, Selection, and Nomination of Directors and Non-Director Committee Members, the Governance and Nominating Committee (GNC) makes an annual recommendation to the Board regarding the makeup and membership of an Interview Team. This team is comprised of GNC members, one External Community Partner, and a representative from the Patient & Family Advisory Council. Should enough GNC members be unable to participate, Directors from the Board will be considered as alternatives.

Based on insights gained from last year's interview process, we propose forming a single interview team to conduct all interviews. This team would consist of four GNC members and two external representatives, totaling six members. Interviews are scheduled to take place in the evenings between 5-8 PM. The number of interviews conducted will depend on the number of open positions and applications received.

Next Steps
The external participants for the interview team will be discussed and finalized at the December GNC meeting.

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: October 16, 2025
Issue: Quality Committee Report to the Board of Directors, October 15, 2025 – OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Jennifer Morgan, Administrative Assistant to Clinical Programs
Approved by: William Conway, Quality Committee Chair

Attachments/Related Documents: None

A meeting of the Quality Committee took place on Wednesday, October 15, 2025 at 0700 hours.

Present:	W. Conway (Chair) , D. Wilkinson, Dr. W. Lee, N. Gandhi, M. McKinnon, A. Schrum, J. Herring, P. Brasil, K. Baldock, S. Pearsall, D. Haughton, P. Gaskin, A. McCarthy, T. Mohtsham
Regrets:	M. Adair, Dr. K. Rhee, L. Barefoot
Staff:	K. Towe, C. Witteveen, Dr. M. Rajguru, Dr. A. Mendlowitz, K. Garton, V. Guido, S. Rauscher, L. Heinbuch, M. Iromoto
Guests:	None

Committee Matters – For information only

1. **Program Presentation: Women & Children's Program (includes Patient and Staff Stories):** The Director of Perioperative, Women and Children's Program, Chief, Midwifery, Chief, Pediatrics, and Chief, Obstetrics, provided a summary highlighting stabilized leadership and nursing, though challenges persist with professional staff in midwifery, pediatrics, and obstetrics.

    - Key initiatives include the introduction of a lactation consultant who has improved breastfeeding success rates through evidence-based support and collaboration with community health teams.
    - Additionally, changes to newborn screening processes have significantly reduced sample acceptability issues from 2.88% in Q4 to 1.3% in Q1, with notable improvements in transit times.
    - The Pediatric Rapid Assessment Clinic (PRAC), launched on March 10th, 2025, has seen positive utilization rates and feedback, primarily due to emergency department referrals for issues like fever and gastrointestinal problems. With approximately 106 visits, the clinic aims to expand its services further based on community needs.
    - The Hugs Infant Security Tracking project launched in October 2025 to ensure infant safety within the hospital.

Committee members raised questions regarding staffing challenges, which are widespread across Ontario, particularly in specialties such as obstetrics, anesthesia, midwifery, and pediatrics. Despite retirements outpacing new graduates, the program has successfully recruited three new OBs over the next two years.

Midwife-assisted birth rates in Cambridge (19-26%) are higher than the provincial average of 10%, attributed to strong community interest and a shared care model with obstetricians. However, staffing shortages have impacted midwifery numbers, from 18 to 12 due to practice closures.

The postpartum unit maintains a staffing ratio of one RPN and one RN per ten patients, which can be adjusted based on patient needs. Comprehensive discharge planning includes support from lactation consultants, community breastfeeding buddies, and trained nurses for seamless transitions post-discharge.

Social workers are integral in providing necessary supports to patients both in and out of the hospital, including screenings for mental health issues like postpartum depression. Midwives also offer six weeks of one-on-one support and early screening for referrals to social work or community programs as needed.

The Paediatric Rapid Assessment Clinic (PRAC) referral process is smooth but requires better tracking mechanisms. The program aims to expand criteria for community-based referrals to enhance workflow efficiency further. Public health nurse services have diminished since the pandemic, prompting efforts to find alternative community resources.

Discussions are ongoing on how best to direct patients appropriately from early pregnancy stages between obstetric and midwifery care to balance workload more effectively. Parents often return for midwifery services after positive experiences or discover it later through word of mouth, with midwifery becoming increasingly mainstream over time. *(Further information provided in Package 2 of the Board of Directors December 3, 2025 meeting agenda package)*

2. **Program Presentation: Strengthening Culturally Safe Practice in Women & Children's Health Through Indigenous Nursing Leadership:** The Committee members were directed to the circulated presentation**.** The Manager, Professional Practice provided a summary of an initiative aimed at strengthening culturally safe practices in women and children's health through Indigenous nursing leadership at CMH. This six-month project included a gap analysis to identify areas for improvement within the department. A key component was a blanket ceremony that fostered a deeper understanding of cultural safety and the organization of Bear Witness Day to commemorate Jordan's Principle, ensuring necessary services are provided to First Nations children. The initiative also emphasized supportive leadership and learning about Indigenous health issues through a six-week education course starting in November 2025, designed to provide staff with culturally safe care knowledge, encourage reflection, and promote ongoing dialogue. Bite-sized educational content was planned to facilitate meaningful conversations and reflective pauses among staff members.
During the question-and-answer session, a Committee member asked about clinical practice differences for Indigenous patients during childbirth. The Manager of Professional Practice highlighted that while there are no inherent differences in care

protocols, Indigenous individuals seek unbiased treatment without historical fears such as child apprehension. They emphasized providing equitable care through education to address past injustices and ensure unbiased treatment.

Another question focused on the status of recommendations from the cultural safety project and the sustainability of related initiatives. The Manager noted that many recommendations, including policy updates and hospital aesthetic improvements, are being implemented or are part of ongoing efforts. For instance, an art installation is prioritized to create a more welcoming environment for Indigenous patients. Over 30 policies have been analyzed, providing evidence-based recommendations that ease future updates. Ongoing conversations aim to build meaningful connections with the Southwest Ontario Aboriginal Health Access Centre (SOAHAC) and enhance clinical education. While some initiatives like a comprehensive smudging policy are still in development, they are approximately halfway through implementing these recommendations. The focus remains on sustained efforts and ensuring leaders model culturally safe practices, making changes accessible and barrier-free for effective front-line implementation. *(Further information provided in Package 2 of the Board of Directors December 3, 2025 meeting agenda package)*

3. **Quality and Safety Policy 2-C-10:** The following highlights were noted:
   - The policy defines CMH's framework for corporate oversight of quality and patient safety, outlining clear accountabilities for the QC Board, Leadership, and clinical teams across four quality quadrants: safe, accessible, and integrated, people-focused, efficient, and equitable.
   - The descriptions within each quadrant have been modernized to include a just culture. An environmental scan confirmed that Cambridge Memorial Hospital's structure and processes align with peer hospitals and provincial best practices.
   - The policy aims to reinforce continuous improvement through transparent reporting, evidence-based measurements, and a strong culture of accountability and engagement. Emphasized the importance of maintaining quality and patient safety as central to corporate performance. *(Further information provided under agenda item 1.5.7 of the Board of Directors December 3, 2025 meeting agenda package)*

4. **Patient Experience – Semi-Annual Update:** The following highlights were presented:
   - The meeting included a semi-annual update on patient experience metrics, which showed a 27% increase in file volumes, with a 21% rise in complement files and an 8% increase in complaints.
   - OHA patient satisfaction surveys indicated modest improvements, including a 3% increase in emergency satisfaction and an 8% increase in medicine surgery satisfaction.
   - Notably, a four-page letter from a patient praised the hospital's building and staff for creating positive experiences.
   - The update covered completed projects such as the implementation of a closed-loop system for lost belongings and the rollout of Patient Declaration of Values stickers throughout the hospital.
   - Detailed work with PFAC members on the Connect My Health project ensured equitable material display and organized on-site registration days.
   - CMH is participating in a beta version of the OHA's patient experience benchmarking dashboard and has launched a new centralized system for managing lost belongings.
   - Additionally, efforts are underway to develop a CMH-specific patient experience definition, with plans to roll it out by the new year.

During the Q&A session, a Committee member clarified that multiple issues could arise from a single file, noting a 10% decrease in complaints and an increase in compliments. The number of surveys has increased slightly, though efforts are ongoing to improve email access for patients to boost response rates, which have risen from around 10% to 18-20%. Presenters highlighted that focusing on patient comfort, especially compassion and care during wait times in the emergency department, could help improve scores.

Another Committee member praised the patient experience office's dual focus on handling both compliments and complaints while working to enhance overall experiences. The office's responsiveness, particularly in addressing family feedback swiftly and thoroughly, was noted as a strength compared to other organizations. Concerning same-day and two-day response times for patient feedback, the Patient Experience Lead suggested that recent staffing stabilization could improve these metrics, which may have been affected by maternity leaves.

When asked about survey methods, it was explained that patients' email addresses are collected during their hospital stay via the Emergency Department or inpatient units, and electronic surveys are sent via OHA Qualtrics. CMH's participation in the patient experience benchmarking dashboard beta version is driven by its culture of data sharing and analysis, though they sometimes face challenges due to other organizations catching up with their capabilities. *(Further information provided in Package 2 of the Board of Directors December 3, 2025 meeting agenda package)*

5. **Quality Monitoring Scorecard**: The meeting highlighted that many quality metrics are linked to flow issues, particularly noting that readmission rates at CMH will undergo deeper analysis by the Clinical Operational Excellence Committee.

   A Committee member thanked the team for updating the quality monitoring scorecard with overtime and sick hours and requested clear identification of changes each month. The member also pointed out a significant increase in patient safety events over a month, to which the Vice President, Clinical Programs, responded that they are investigating the issue, suggesting a lower denominator might be causing the rate to appear higher. Both falls with harm and medication events with harm are under thorough review, with further details to be presented at the Department Quality and Operations meeting.

   Another Committee member acknowledged progress in reducing Alternate Level of Care (ALC) numbers, recognizing it as a complex issue involving both hospital and systemic factors. Leadership announced that they have approved the addition of a fifth hospitalist working Monday through Friday to manage the ALC population and medically stable patients ready for discharge. This new role will involve attending family meetings and ensuring timely patient attention, which can be overlooked due to acute demands in the hospital. The hospitalist's performance will be monitored with key performance indicators until March 31, 2026, to evaluate improvements in supporting this patient population. *(Further information provided under agenda item 1.5.8.1 of the Board of Directors December 3, 2025 meeting agenda package)*

6. **Medical Advisory Committee Update:** The Deputy Chief of Staff provided the following summary:
   - With the rejoining of a Vice President, Medical Operations (VPMO), Reintroducing a Program Management Council to achieve operational efficiencies through

collaboration with medical leadership. This initiative is tied to external programmatic reviews aimed at identifying areas for improvement and highlighting best practices.

- Just Culture 2.0 has been recognized as more than just a policy but a way of life embedded in daily interactions, making it an integral part of the organization's culture.
- The ED Mentorship Initiative focuses on recruiting and retaining ED physicians, a challenging task given the competitive nature of the field. Despite lacking additional resources, the program has been well-received, with many signing up for the following year. The mentorship initiative is expected to continue and may receive more formal recognition. The collective effort from MAC and medical leadership has made these initiatives successful. *(Further information provided under agenda item 1.5.6.5 of the Board of Directors December 3, 2025 meeting agenda package)*

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: November 20, 2025
Issue: Quality Committee Report to the Board of Directors, November 19, 2025 – OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Jennifer Morgan, Administrative Assistant to Clinical Programs
Approved by: William Conway, Quality Committee Chair

Attachments/Related Documents: None

A meeting of the Quality Committee took place on Wednesday, November 19, 2025 at 0700 hours.

Present:	W. Conway (Chair), D. Wilkinson, Dr. W. Lee, N. Gandhi, M. McKinnon, A. Schrum, J. Herring, P. Brasil, K. Baldock, S. Pearsall, D. Haughton P. Gaskin, T. Mohtsham, M. Adair, Dr. K. Rhee, L. Barefoot
Regrets:	A. McCarthy
Staff:	Dr. A. Nguyen, K. Abogadil, Dr. D. Cape
Guests:	L. Costa, M. Iromoto

Committee Matters – For information only

1. **Program Presentation: ICU Program (includes Patient and Staff Stories):** The Director of the ICU Program highlighted key strengths and progress in the ICU alongside the Chief Medical Programs, Physician Lead ICU, and Manager, ICU.

   A heartfelt letter was shared from a family which deeply touched the ICU team with expressions of gratitude, recognizing the roles played by nurses, respiratory therapists, clerical staff, and physicians whose expertise provided confidence during challenging times. It was emphasized that in complex environments like an ICU, families often remember kindness, reassurance, and continuity of care. Staff worked to maintain consistency by keeping the same nurses assigned to patients during rotations when possible, involving families in rounds, and supporting one another through difficult cases.

   The Three Wishes program was discussed as an initiative adding compassion by helping families create meaningful memories. Two years ago, ICU staffing shortages, frequent overtime, and gaps in schedules were affecting staff morale. Thanks to the Manager's leadership with Human Resources support, significant progress has been made by hiring 27 full-time and 5 part-time RNs, strengthening orientation, and offering mentorship through programs like the Critical Care Internship and CRT Level 2 certification. This focus on staffing needs helped stabilize the team and improve patient care outcomes.

A milestone was shared with the Committee, the ICU posted its first fully staffed schedule in recent years, lifting spirits among the team and reinforcing their hard work. Staff reported feeling more supported, prepared, and able to provide high-quality care. The Provincial ICU standardization initiative was also highlighted, aimed at ensuring consistent high-quality care across Ontario, with the Vice President, Clinical Programs & CNE serving as co-chair.

An overview was provided of the significant expansions in services and capacity over recent years, positively influencing morale among critical care physicians. Bed capacity grew from 8 to almost 20, including 6 step-down beds that have been operational for six months, improving patient care, flow, and long-term outcomes as the hospital becomes accustomed to utilizing them effectively.

Another significant achievement was the launch of CRRT (Continuous Renal Replacement Therapy) two years ago, which has expanded into a robust nephrology team collaborating closely with the critical care team. The ICU also received an achievement award from TGLN last year for excellent performance metrics in organ donations.

Also noted was the increase in capacity which significantly contributed to building quality within the ICU. Over the past 2-3 years, substantial growth in bed numbers and nursing staff, along with new technologies such as continuous renal replacement therapy, have enabled more effective resource allocation and resulted in transformative changes. The unit is now entering a phase of consolidation, building upon these gains. Staffing situations post-pandemic have improved, allowing the team to focus more effectively on delivering high-quality patient care.

During the Q&A session, a Committee Member inquired about Level 3 ICU definitions. The program explained that Levels 2 and 3 refer to acuity of illness and technological capacity, with Level 3 involving patients who are intubated or have very unstable blood pressure. The ICU has 14 Level 3 beds and 6 Level 2 beds.

Regarding the paradox of decreasing case weights but increasing length of stay, it was noted that flow challenges contribute to this situation as patients sometimes remain in ICU for additional days due to bed availability issues. Discussions are ongoing to optimize access to ICU and step-down beds.

Another question was raised about CRRT mortality rate improvements, attributed to increased team experience, nephrology support, and familiarity with technology. Training needs for increasing CRRT volumes were also discussed. The Program’s Educator has managed training efforts effectively, ensuring rapid proficiency among nurses. Refresher training remains a priority. The VP Clinical Programs/CNE highlighted that Waterloo Wellington is unique in offering CRRT across all Level 3 ICUs, positioning CMH well for the future. A strong relationship with Vantage ensures on-site support and continuous staff development.

One Committee member inquired about psychological impacts on patients after ICU stays. The program indicated that while there is no formal follow-up program, they monitor patients for at least two days post-discharge and encourage mental health support.

Regarding factors making CMH ICU an attractive place to work, the Program highlighted recent improvements, including a supportive environment and opportunities for holistic care delivery. Staff from other departments are now applying to ICU positions due to these improvements.

Organizational fatigue in light of HIS (Health Information System) implementation was discussed, with staff feeling supported by visible leadership and a team-centered culture that should mitigate risks associated with this change.

The donation of ninety quilts to palliative care patients was noted as a meaningful addition that makes a significant difference for families. Staff appreciate providing these quilts and work closely with quilters to maintain positive relationships. The President & CEO highlighted the current leadership's role in fostering this positive relationship, which had been strained previously due to changes in leadership and the impact of COVID. *(Further information provided in Package 2 of the Board of Directors December 3, 2025 meeting agenda package)*

2. **Strategic Priorities Tracker for 2025/26:** The VP of People & Strategy presented an overview of the Strategic Priorities Tracker for 2025/26, covering the second quarter of the fiscal year. This report will be presented quarterly to the Quality Committee and is aligned with the hospital's strategic pillars, informed through integrative planning processes and quality improvement plans.

   The relevant indicators for the Quality Committee fall under the "Elevate Partnerships in Care" pillar, which have been extensively discussed through flow metrics. The Q2 package has also been shared with both the Resources Committee and the Board. The governance and oversight structure supporting these measures was highlighted, emphasizing consistent monitoring through various operational and quality forums such as weekly leadership huddles, flow meetings, program quality councils, and medical advisory committee discussions before being incorporated into the priorities tracker. The report now includes trailing 12-month data to provide more insight over a longer period. It was noted that the package uses CIHI definitions for metrics but is open to enhancing the content with clearer and more descriptive language based on feedback.

   A Committee member inquired about the indicator for inpatient discharges before 11:00 a.m., questioning its utility and impact on patient flow. Management explained that while there are differing views, early discharges are valuable for understanding hospital resource dynamics. As the day progresses, resources like EVS and allied support decrease, making late discharges less supportive. Early discharges ensure patients can access pharmacy services, families can pick them up more easily, and elderly patients have ample time to settle in during daylight hours. Management noted that much of the flow currently occurs after the day shift has ended and is working to shift this earlier by educating families on the benefits of early pickups.

   Management emphasized that while seeing the sickest patients first often pushes discharges to the evening, adding more staff could help achieve early discharge targets. The new HIS system's predictive analytics and discharge planning tools are expected to streamline processes, reducing documentation requirements. Early discharges serve as a surrogate marker for optimizing resource allocation in managing sicker patients, reflecting the hospital's need to adapt effectively.

   A Committee member asked for clarification on the average number of admits to the ED at 0800 a.m., specifically whether these were admissions into an ED bed or admissions

from the ED into the hospital. Management clarified that these figures represent cases where no inpatient beds were available. The Committee member expressed concerns about accommodating population growth and questioned the realism of current markers given this growth. Management acknowledged the addition of more beds during the pandemic but emphasized the ongoing need to build community relationships, particularly for supporting long-term care. Efforts include collaborations with long-term care facilities and wound management services to support discharge planning for complex patients. Management also highlighted investments in community and ambulatory services such as liver clinics and geriatrics clinics, emphasizing their importance in managing patient flow. To further manage patient flow effectively, the geriatrics team now has urgent morning spots weekly. This allows ED physicians or internists to opt for geriatric assessments instead of admissions, helping build capacity and avoid no-bed admits. *(Further information provided under agenda item 1.5.8 of the Board of Directors December 3, 2025 meeting agenda package)*

3. **Risk Management Update**
   Integrated Risk Management (IRM) Priorities- In-Year Progress Update: The following highlights were noted:
   - The integrated risk management assessment for the current cycle, began in August with facilitated risk identification sessions held across all programs and services within the organization. These sessions allowed internal stakeholders to input residual risks that could negatively impact goals over the next one to two years.
   - Thirty-six leaders, seven physicians, forty-eight staff members, and seven patient family advisors participated in 27 total sessions, resulting in the collection of over 300 risks, which were collated into 40 risk themes and an additional 25 individual risks.
   - This year, a new approach was trialed using AI to assist with risk theme identification. Two streams of AI analysis were conducted: one on meeting transcripts and another on meeting notes.
   - In parallel, the team manually analyzed the data as done in previous years, ultimately comparing all three analysis methods. One challenge noted was that the AI presented results from an action-oriented perspective, requiring inferential interpretation to identify risks. For future cycles, it is recommended that AI present risk themes purely without an action-oriented bias.
   - Noted that the analysis of meeting notes aligned more closely with manual analysis compared to transcript analysis, suggesting a potential future approach of using only meeting notes for AI analysis rather than recording sessions. The final risk theme identification and ranking this year primarily relied on manual analysis, while incorporating insights from AI analysis. *(Further information provided under agenda item 1.3.10 of the Board of Directors December 3, 2025 meeting agenda package)*

4. **Emergency Preparedness- Annual Update:** The following highlights were presented:

   – **Emergency Preparedness Efforts Post-Fire Incident:** Following a real fire incident at CMH in October 2023, which resulted in no injuries but prompted an extensive after-action report and improvements to accreditation standards, emergency preparedness was identified as a top organizational risk for fiscal year 24-25.
   – **Mitigation Efforts:**
   The cornerstone mitigation effort is the two-year Emergency Preparedness Lead role that started in July 2024, aimed at stabilizing processes and influencing culture related to preparedness. These efforts are structured around three areas: stabilization, growth, and partnerships.

Significant investments include:

- Leadership Training: Twelve leaders have completed the IMS 200 training, a three-day program offered free through the City of Cambridge partnership.
- Immersive Training Exercises: An immersive training session was conducted for the entire leadership team with the Emergency Preparedness Lead to demonstrate the IMS structure in an EOC setting.
- Live Mock Drills: The first live mock code silver drill was successfully executed, involving extensive planning to ensure realism without causing emotional distress.
- Collaboration Efforts: Internal and external collaboration has been strengthened through cross-functional committees and partnerships with other organizations.

The role is scheduled to conclude in July 2026, but discussions are ongoing regarding its continuation. The Director, Patient Experience, Quality, Risk Privacy & IPAC assured that a smooth transition will be ensured if the current plan does not materialize to maintain these efforts.

A Committee member expressed appreciation for the emergency preparedness efforts and highlighted the importance of considering scenarios beyond short periods of sustained casualties. They emphasized the need to anticipate and plan for prolonged and overwhelming numbers of casualties, as seen in recent exercises conducted by the Canadian Armed Forces in Toronto. The Committee member noted that hospitals must recognize this reality and include it in current planning efforts. *(Further information provided in Package 2 of the Board of Directors December 3, 2025 meeting agenda package)*

5. **Quality Monitoring Scorecard**: The quality monitoring scorecard was noted to often appear redundant during months when the strategic priorities tracker is also discussed, as many of the metrics trending red have already been extensively reviewed multiple times. The majority of these red-trending metrics are related to flow issues, with recent blips in falls with harm and medication incidents with harm over the past couple of months. These metrics move into yellow if they remain out of target for three consecutive months, given HIROC's aspirational goal of zero incidents with harm (defined as level 4 or higher).

   One Committee member noted that the Hospital Standardized Mortality Ratio (HSMR) indicator had a yellow triangle despite the value being below one, which should be favorable. Management explained that while lower values are better, the status is based on the trend over the last three periods and must trend green for three consecutive periods to change back to green. The yellow triangle indicates the value is within 10% of the threshold, even though a lower value is better.
   A Committee member inquired if the Clinical Outcomes Evaluation Committee (COEC) was reviewing heart failure and COPD readmission rates. Management confirmed that the COEC is indeed reviewing these metrics in real-time but emphasized that the Clinical Outcomes Analysis Committee (COAC) focuses on areas requiring review. For HSMR, while there may be a spike, the clinical analysis has not yet been conducted. Similarly, for CHF trends, a deep dive is being prioritized this year to further investigate these metrics. *(Further information provided under agenda item 1.5.8.1 of the Board of Directors December 3, 2025 meeting agenda package)*

6. **Medical Advisory Committee Update:** The Deputy Chief of Staff provided the following summary:
   The Medical Advisory Committee (MAC) supported a new policy on AI scribe technology use in clinical documentation to ensure compliant integration of AI technologies while

maintaining high-quality care. The Health Information Management (HIM) team has been instrumental in supporting the adoption of front-end speech technology, which aims to streamline processes, reduce administrative burdens, and allow clinicians more time with patients.

Chiefs presented updates on quality work within their departments to MAC, showcasing both successes and challenges. These presentations were highly successful and will continue into 2026, fostering engagement and collaboration among leadership.

Discussions emphasized the importance of long-term planning and stronger ties with primary care providers. MAC heard about a proposed submission for expanding primary care collaboration through a provider navigator program to improve communication between specialists and family physicians, streamlining patient care. Management highlighted initiatives like stabilization clinics aimed at managing readmissions and supporting the Emergency Department (ED).

Dr. Muhammad Naser, faculty at the Waterloo Regional Campus of the Medical School, received an excellence in teaching award, demonstrating the growing influence of CMH staff on clinical education. *(Further information provided under agenda item 1.5.6.5 of the Board of Directors December 3, 2025 meeting agenda package)*

BRIEFING NOTE

CAMBRIDGE MEMORIAL HOSPITAL

Date: November 19, 2025
Issue: Financial Statements – October 2025
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Spencer Ogston, Financial Analyst
Maria Burzynski, Manager, Finance
Approved by: Valerie Smith-Sellers, Director, Finance
Trevor Clark, VP Finance & Corporate Services, CFO

Attachments/Related Documents:
Financial Statements – October 2025

Alignment with 2025/26 CMH Priorities:

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

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

Recommendation/Motion

Board

That, the Board of Directors receives the October 2025 financial statements as presented by management and upon recommendation of the Resources Committee at its meeting of November 24, 2025.

Resources Committee

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

Executive Summary

Cambridge Memorial Hospital (CMH) is in a $5.9M year-to-date surplus position at the end of October after building amortization and related capital grants. This is primarily due to higher revenue than budget for Quality Based Procedures (QBP) ($3M) and Post Construction Operating Plan (PCOP) funding ($2.4M). The favourable variance in QBP funding is due to timing and is expected to be $0.1M unfavourable to budget by March 31, 2026.

The hospital is forecasting a $2.9M surplus for fiscal 2025-26, primarily due to higher PCOP funding than budget ($3.0M). Higher compensation costs ($4.4M) due to the operation of unfunded beds in the Emergency Department and surge beds on Wing B, increased sick time and overtime, and higher medical and surgical supplies costs ($1.8M) due to increased volumes are expected to fully utilize budgeted contingency ($5.6M) and a portion of the higher PCOP funding forecast to be earned.

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

Analysis
CMH is in a $5.9M year-to-date surplus position at the end of October after building amortization and related capital grants. Actual results are $6.6M favourable to budget.

The favourable variance is driven by:
- $3.3M in budgeted contingency.
- $3M QBP revenue due to increased hip, knee, and shoulder volumes.
- $2.4M PCOP funding driven by higher weighted cases.

The favourable variance is partially offset by the following unfavourable variances:
- $2.5M variance in salaries & wages and benefits, primarily due to higher overtime driven by sick time, training, staffing unfilled shifts due to absences and vacancies, and operating unfunded beds.
- $0.9M variance in medical surgical supplies due to higher spending on general and orthopedic supplies, as a result of higher joint volumes.

<u>Revenue Highlights</u>
- QBPs are $3M favourable to budget year to date due to higher bundled care and surgical volumes ($3.3M) and cancer care volumes ($0.1M). This is partially offset by a negative variance in medical QBP volumes ($0.4M). Once QBP funding has been fully earned for each major category, volumes over the QBP funding envelope will generate Incremental Surgical Recovery (ISR) funding. QBP funding is forecast to be $0.1M unfavourable to budget by the end of the fiscal year.
- The hospital has budgeted to receive $20.3M in PCOP funding in 2025-26, just over 86% of the available $23.7M PCOP funding allocation. Funding recognition is dependent on meeting volume targets. The year to date $2.4M favourable variance is due to higher weighted cases. CMH is working towards achieving full eligible funding by fiscal year end.
- Billable patient services is $892K favourable to budget year to date. The variance is primarily driven by higher volumes and physician rate increases in Diagnostic Imaging ($663K), which are fully offset by higher medical remuneration costs.
- Recoveries and other revenue is $905K favourable to budget year to date. The variance is primarily due to recovery for oncology drugs from Ontario Health (OH), which is fully offset by higher drug expenses.

<u>Expense Highlights</u>
- Salaries and wages are $1.9M unfavourable to budget year to date. This is mainly due to higher overtime ($2M), sick time ($0.6M), and training ($0.4M), partially offset by a favourable variance in worked salaries ($1.2M). Higher overtime costs have been driven by sick time, training, staffing unfilled shifts due to absences and vacancies, and the operation of unfunded beds in the Emergency Department and surge beds on Wing B. It has cost $200K to operate unfunded beds in fiscal 2025-26 (2,984 overtime hours of 47,564 overtime

hours variance) year to date. A working group continues to meet on a bi-weekly basis focusing on strategies to reduce the overtime spend rate. The budget assumed that the rehabilitation program would come back on site in October. The rehabilitation program will remain off-site until the end of the fiscal year as the hospital works to finalize an agreement to permanently transfer the program to the Waterloo Regional Health Network (WRHN). This has resulted in a positive variance of $0.2M in salaries and wages, which is fully offset by the cost being paid to WRHN to operate the program, which is accounted for in other supplies and expenses.

- Employee benefits are $622K unfavourable to budget year to date. The variance is driven by higher in lieu of benefits payments to part-time staff, due to a higher number of hours worked by part-time staff compared to budget.
- Medical remuneration costs are $421K unfavourable year to date. The variance is driven by additional remuneration paid to physicians in Diagnostic Imaging due to high volume of diagnostics completed, and physician rate increases offset by OHIP revenue.
- Medical and surgical supplies costs are $881K unfavourable to budget year to date. The variance is due to general and orthopedic medical surgical supplies driven by higher joint volumes ($473K), and general medical supplies ($221K) in part due to the operation of unfunded beds.
- Drug expenses are $764K unfavourable to budget year to date. The variance is due to higher cost of drugs for the Oncology Program ($970K). 98% of oncology drug costs are reimbursed by Ontario Health. The unfavourable variance is partially offset by a favourable variance to budget in pharmacy off contract drugs ($191K).
- Other supplies and expenses are $3.1M favourable to budget year to date. The variance is primarily due to budgeted contingency ($3.3M) and a positive variance in natural gas ($0.5M) generated by the end of the carbon tax. This is partially offset by unfavourable variances to budget in minor equipment ($0.3) primarily due to the purchase of laptops to upgrade the hospitals technology systems, contracted-out expenses for the rehabilitation program ($0.3M) being offsite, and minor renovations ($0.1M).
- $1.2M of expenses related to Project Quantum are included in the YTD financial statements. These costs have been budgeted for and include compensation, software, and legal costs.

CMH is forecasting a surplus of $2.9M for 2025-26. The forecast includes budgeted contingency ($5.6M) and higher PCOP revenue than budget ($3M) due to higher forecast weighted cases volumes in fiscal 2025-26, offset by an unfavourable variance in salaries and benefits ($4.4M) and medical and surgical supplies ($1.8M). The surplus does not include the expected pickup of prior year PCOP funding ($8.8M) resulting from the Ministry of Health's (MOH) reconciliation of fiscal 2023-24 volumes. This funding will be recognized at fiscal year-end in March 2026.

Balance Sheet and Statement of Cash

CMH's current cash position is $78.9M, consisting of $66.6M of unrestricted cash and $12.3M of restricted cash. The working capital ratio is 1.46 and meets the requirements of the Hospital Service Accountability Agreement (H-SAA) target range of 0.8 to 2.0.

Unrestricted working capital available at the end of October is $27.5M, which is expected to decrease to $19.1M by the end of March as summarized below:

	$M
Unrestricted Bank Balance – October 31, 2025	**66.6**
Add: Other Current Assets ($0.5M Due from CMH Foundation - Capital Funding)	20.1
Less: Current Liabilities ($3.7M due to MOH)	(59.2)
Subtotal - Net Current Assets	**27.5**
Add: Vacation Bank Accrual (consistent with MOH working capital calculation)	5.1
Working Capital Available – October 31, 2025	**32.6**
Add:	
2023-24 PCOP Reconciliation	8.8
MOH Health Infrastructure Renewal Funding	3.1
Amortization on hospital funded assets- November 1, 2025 - March 31, 2026	2.0
CMHF & Third Party Funding for Approved Equipment	1.1
Less:	
Outstanding Health Information System Commitments	(13.1)
Outstanding 2025-26 Capital Budget Commitments	(8.2)
Reduction in Forecast Operating Surplus Between November 1, 2025 - March 31, 2026	(3.0)
Outstanding Approved POs	(2.9)
Outstanding Land Purchase	(1.2)
Outstanding Rebranding Commitments	(0.1)
Forecast Unrestricted Working Capital - March 31, 2026	**19.1**

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

Confidential
(Expressed in Thousands of Dollars)

Month of October 2025					Year to Date				2025-26	2025-26		2024-25 Prior Year Actuals	
Actual	Budget	Variance	% Variance		YTD Actual	YTD Budget	YTD Variance	% Variance	Forecast	Budget	Variance	October 2024	2024-25 YE
				Revenue:									
				MOH Funding									
$ 10,670	$ 10,646	$ 24	0%	MOH - Base	$ 73,655	$ 73,491	$ 164	0%	$ 125,627	$ 125,347	$ 280	$ 9,940	$ 120,936
3,024	2,393	631	26%	MOH - Quality Based Procedures	19,160	16,111	3,049	19%	$ 27,592	27,698	(106)	3,591	27,732
2,591	1,726	865	50%	MOH - Post Construction Operating Plan	14,276	11,916	2,360	20%	$ 23,340	20,324	3,016	2,458	24,284
1,044	797	247	31%	MOH - One Time / Other	5,999	5,505	494	9%	$ 13,027	12,844	183	686	10,917
17,329	15,562	1,767	11%	Total MOH Funding	113,090	107,023	6,067	6%	**189,586**	**186,213**	**3,373**	16,675	183,869
1,483	1,387	96	7%	Billable Patient Services	10,476	9,584	892	9%	$ 17,760	16,349	1,411	1,396	17,116
1,862	1,757	105	6%	Recoveries and Other Revenue	12,803	11,898	905	8%	$ 22,394	20,458	1,936	1,780	22,151
263	281	(18)	(6%)	Amortization of Deferred Equipment Capital Grants	1,816	1,930	(114)	(6%)	$ 3,100	3,297	(197)	321	3,861
350	405	(55)	(14%)	MOH Special Votes Revenue	2,660	2,851	(191)	(7%)	$ 4,572	4,899	(327)	328	4,227
21,287	**19,392**	**1,895**	**10%**	**Total Revenue**	**140,845**	**133,286**	**7,559**	**6%**	**237,412**	**231,216**	**6,196**	**20,500**	**231,224**
				Operating Expenses:									
9,194	9,150	(44)	(0%)	Salaries & Wages	62,893	61,038	(1,855)	(3%)	$ 109,494	106,127	(3,367)	8,438	99,184
2,407	2,284	(123)	(5%)	Employee Benefits	17,343	16,721	(622)	(4%)	$ 29,563	28,575	(988)	2,095	26,302
1,939	1,884	(55)	(3%)	Medical Remuneration	13,437	13,016	(421)	(3%)	$ 23,359	22,239	(1,120)	1,910	22,511
1,383	1,236	(147)	(12%)	Medical & Surgical Supplies	9,390	8,509	(881)	(10%)	$ 16,363	14,528	(1,835)	1,371	14,870
1,299	1,128	(171)	(15%)	Drug Expense	8,519	7,755	(764)	(10%)	$ 14,370	13,251	(1,119)	1,183	13,346
2,368	2,757	389	14%	Other Supplies & Expenses	16,091	19,237	3,146	16%	$ 28,887	33,204	4,317	2,559	32,872
447	498	51	10%	Equipment Depreciation	3,119	3,275	156	5%	$ 5,431	5,699	268	552	6,636
367	405	38	9%	MOH Special Votes Expense	2,777	2,851	74	3%	$ 4,772	4,899	127	328	4,545
19,404	**19,342**	**(62)**	**(0%)**	**Total Operating Expenses**	**133,569**	**132,402**	**(1,167)**	**(1%)**	**232,239**	**228,522**	**(3,717)**	**18,436**	**220,266**
1,883	**50**	**1,833**	**3,666%**	**MOH Surplus / (Deficit)**	**7,276**	**884**	**6,392**	**723%**	**5,173**	**2,694**	**2,479**	**2,064**	**10,958**
(815)	(893)	78	(9%)	Building Depreciation	(5,679)	(6,165)	486	(8%)	$ (9,682)	(10,515)	833	(654)	(8,162)
621	664	(43)	(6%)	Amortization of Deferred Building Capital Grants	4,347	4,586	(239)	(5%)	$ 7,412	7,821	(409)	484	6,121
$ 1,689	**$ (179)**	**$ 1,868**		**Net Surplus / (Deficit)**	**$ 5,944**	**$ (695)**	**$ 6,639**		**$ 2,903**	**$ -**	**$ 2,903**	**$ 1,894**	**$ 8,917**

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

(Expressed in Thousands of Dollars)

	October 2025	March 2025
ASSETS		
Current Assets		
Cash and Short-term Investments	$ 66,563	$ 74,166
Due from Ministry of Health / Ontario Health	6,289	4,807
Other Receivables	7,034	5,831
Inventories	3,250	3,083
Prepaid Expenses	3,546	2,600
	86,682	90,487
Non-Current Assets		
Cash and Investments Restricted - Capital	12,313	13,629
Due from Ministry of Health - Capital Redevelopment	7,691	7,691
Due from CMH Foundation	523	475
Endowment and Special Purpose Fund Cash & Investments	222	218
Capital Assets	299,174	302,411
Total Assets	**$ 406,605**	**$ 414,911**
LIABILITIES & NET ASSETS		
Current Liabilities		
Due to Ministry of Health / Ontario Health	3,738	3,964
Accounts Payable and Accrued Liabilities	32,792	41,512
Deferred Revenue	22,680	22,680
	59,210	68,156
Long Term Liabilities		
Capital Redevelopment Construction Payable	208	168
Employee Future Benefits	4,230	4,085
Deferred Capital Grants and Donations	270,210	275,699
Asset Retirement Obligation	2,884	2,884
	277,532	282,836
Net Assets:		
Unrestricted	23,243	18,246
Externally Restricted Special Purpose Funds	222	218
Invested in Capital Assets	46,398	45,455
	69,863	63,919
Total Liabilities and Net Assets	**$ 406,605**	**$ 414,911**
Working Capital Balance	27,472	22,331
Current Ratio	1.46	1.33

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

(Expressed in Thousands of Dollars)

	October 2025	March 2025
Cash Provided By (Used In) Operations:		
Excess (Deficiency) of Revenue over Expenses	$ 5,944	$ 8,917
Items not Involving Cash:		
Amortization of Capital Assets	8,798	14,798
Amortization of Deferred Grants and Donations	(6,163)	(9,982)
Change in Non-Cash Operating Working Capital	(12,796)	(9,556)
Change in Employee Future Benefits	145	(138)
	(4,072)	4,039
Investing:		
Acquisition of Capital Assets & Capital Redevelopment Project	(5,561)	(21,077)
Capital Redevelopment Project Construction Payable	40	(3,867)
	(5,521)	(24,944)
Financing:		
Change in Non-Cash Capital Accounts Receivable	-	(4,374)
Capital Donations and Grants & Capital Redevelopment Project	674	898
	674	(3,476)
Increase (Decrease) In Cash for the Period	(8,919)	(24,381)
Cash & Investments - Beginning of Year	87,795	112,176
Cash & Investments - End Of Period	**$ 78,876**	**$ 87,795**
Cash & Investments Consist of:		
Unrestricted Endowment and Special Purpose Investments	30	30
Cash & Investments Operating	66,533	74,136
Cash & Investments Restricted	12,313	13,629
Total	**$ 78,876**	**$ 87,795**