



BOARD OF DIRECTORS MEETING - OPEN
Wednesday June 24, 2026

1715-1800

Virtual via Teams / C.1.229

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AGENDA

Agenda Item * indicates attachment / TBC - to be circulated	Page #	Time	Responsibility	Purpose
1. CALL TO ORDER				
1.1 Territorial Acknowledgement		1715	L. Woeller	
1.2 Welcome		1717	L. Woeller	
1.2.1 Welcome Guests Stephanie Kessler, Abdul-Qayum Ali*	4	1718	L. Woeller	
1.3 Confirmation of Quorum (7)		1720	L. Woeller	Confirmation
1.4 Declarations of Conflict of Interest		1721	L. Woeller	Declaration
1.5 Consent Agenda <i>(Any Board member may request that any item be removed from this consent agenda and moved to the regular agenda)</i>		1722	L. Woeller	Motion
1.5.1 Minutes of June 3, 2026*	6			
1.5.2 2025/26 Board of Directors Action Log*	12			
1.5.3 Board Attendance*	13			
1.5.4 Board Work Plan*	14			
1.5.5 Events Calendar*	23			
1.5.6 Committee Reports to the Board of Directors				
1.5.6.1 Audit Committee* (Next Meeting Nov 16, 2026)				
1.5.6.2 Digital Health Strategy Committee*(Jun 18, 2026)	25			
1.5.6.3 Executive Committee* (Next Meeting Nov 17, 2026)				
1.5.6.4 Governance and Nominating Committee* (Next Meeting Oct 15, 2026)				
1.5.6.5 Medical Advisory Committee* (Jun 10, 2026)	26			
1.5.6.6 Resources Committee - TBC (Jun 22, 2026)	30			
1.5.7 Governance Policy Approvals <div style="border: 1px solid black; padding: 2px; display: inline-block;"><i>No Policies for Approval this Meeting</i></div>				
1.5.8 Quality Monitoring Scorecard*	31			
1.5.9 CEO Certificate of Compliance* (May 30, 2026 - June 19, 2026)	61			
1.6 Confirmation of Agenda		1724	L. Woeller	Motion
2. PRESENTATIONS				
2.1 Accessibility Plan Annual Update*	62	1725	L. Barefoot	Information
3. BUSINESS ARISING				
3.1 No Open Matters for Discussion				
4. NEW BUSINESS				

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

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

Agenda Item * indicates attachment / TBC – to be circulated	Page #	Time	Responsibility	Purpose
4.1 Chairs Update				
4.1.1 Board Chairs Report*	70	1735	L. Woeller	Information
4.2 Resources Committee (Jun 22, 2026)				
4.2.1 Financial Statements – May 2026*	75	1740	P. Brasil	Motion
4.3 Quality Committee (Jun 17, 2026)				
4.3.1 Report to the Board of Directors*	81	1745	B. Conway	Discussion
4.4 Patient & Family Advisory Council (PFAC) Update* (Jun 9, 2026)	86	1755	L. Woeller	Information
4.5 CEO Update				
4.5.1 No Open Matters for Discussion				
5. UPCOMING EVENTS <i>Visit GovHub for the most current listing of all upcoming events</i>		1759	L. Woeller	Information
5.1 Grand Rounds: Vulvar Ulcers (eek!) Presented by Dr. Ariel Mendlowitz 8:00am-9:00am Virtual				
5.2 Klean Street Car Show, August 9, 2026, Cambridge Centre Honda 227 Hespeler Rd, Cambridge, Klean Street Car Show - Cambridge Memorial Hospital Foundation				
6. DATE OF NEXT MEETING	Wednesday October 7, 2026 Location: Hybrid			
7. TERMINATION		1800	L. Woeller	Motion
Link: Board/Committee Evaluation Survey	<i>Following the meeting, please complete within one week.</i>			

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

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

CMH Board of Directors Motions Page

Agenda Item	Motions Being Brought Forward for Approval	
1.5	Consent Agenda	<ul style="list-style-type: none"> That, the CMH Board of Directors approves the Consent Agenda as presented/amended
1.6	Confirmation of Agenda	<ul style="list-style-type: none"> That, the CMH Board of Directors approves the agenda as presented/amended
4.2.1	Financial Statements	<ul style="list-style-type: none"> That, the CMH Board of Directors receives the May 2026 financial statements as presented by management and upon recommendation of the Resources Committee at the meeting of June 22, 2026.

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

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

Welcome Abdul-Qayum Ali



Background

Abdul-Qayum brings more than 15 years of public accounting and financial advisory experience, including service as a Partner with BDO Canada since 2021, based in the Cambridge office. Professional focus includes audit, financial oversight, and business advisory services for clients across manufacturing, distribution, real estate, construction, technology, and life sciences. Regular engagement with senior leadership teams includes governance-related financial oversight and risk considerations. Holds a Bachelor of Arts (Honours) in Economics from Wilfrid Laurier University and designation as a Chartered Professional Accountant (CPA, CA).

Key Highlights

- Over 15 years of experience in public accounting and financial advisory services
- Partner at a national accounting firm with sector experience spanning manufacturing, construction, technology, and life sciences
- Strong expertise in audit, financial oversight, and enterprise risk assessment
- Regularly supports governance and Board-level financial reporting and oversight
- CPA, CA with experience working alongside Boards and senior leadership teams
- Strong connection to the Cambridge community and regional institutions

Why are you interested in this position with CMH?

“Born and raised in Cambridge and have seen the hospital transform over the years. My mother used to work in the hospital, and it is a beacon for the community. I want to make a difference and give back to the community.”

Welcome Stephanie Kessler



Background

Stephanie brings over 15 years of progressive Human Resources leadership experience, including more than six years as Director, Human Resources at Ecobee Technologies (2019–present), where membership on the executive leadership team includes responsibility for enterprise-wide people strategy. Previous roles include Director of People at Rubikloud Technologies (2018–2019) and multiple senior HR leadership positions over four years at Top Hat (2014–2018). Experience includes leading people strategy through high-growth phases and supporting the \$770M USD acquisition of Ecobee by Generac, with scope across Canada, the U.S., and the U.K. Holds a Bachelor of Arts (Honours) in Business – Human Resource Management from the University of Waterloo and designation as a Certified Human Resource Professional (CHRP).

Key Highlights

- Executive-level human resources leader with more than 15 years of experience in complex, growth-oriented organizations
- Senior advisor to executive teams on people strategy, organizational risk, and leadership effectiveness
- Direct experience supporting governance and workforce integration during a major acquisition
- Strong knowledge of employment law, employee relations, compensation strategy, and enterprise HR systems
- CHRP-designated professional with regular Board-level reporting and governance exposure

Why are you interested in this position with CMH?

“I am interested in giving back to the community and believe I have skills in the HR space that could be valuable to the board or a committee”

Cambridge Memorial Hospital
BOARD OF DIRECTORS MEETING
Wednesday, June 3, 2026
OPEN Session

Minutes of the open session of the Board of Directors meeting, held via a hybrid model (video conference and at Cambridge Memorial Hospital, C.1.229) on Wednesday, June 3, 2026.

Present:

L. Woeller, Chair
S. Alvarado
B. Conway
J. Herring
P. Gaskin
Dr. M. McKinnon
M. Lauzon
T. Barker

Dr. W. Lee
P. Brasil
M. Hempel
D. Wilkinson
Dr. V. Miropolsky
Dr. M. Patel
J. Goyal
J. Tulsani

Regrets: None

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

Guests: None

Recorder: S. Fitzgerald

1. CALL TO ORDER

The Chair called the meeting to order at 1700h.

1.1. Territorial Acknowledgement

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

1.2. Welcome

The Chair welcomed Board members and guests to the meeting.

1.3. Confirmation of Quorum (7)

Quorum was confirmed, and the meeting proceeded, as per the agenda.

1.4. Declarations of Conflict of Interest

Board members were asked to declare any known conflicts of interest related to the open session of the meeting. No conflicts were declared.

1.5. Consent Agenda

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

Board members were asked whether they wished to remove any items from the consent agenda for separate discussion.

Policy 2-A-24 Confidentiality Policy was removed for further discussion.

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

MOTION: That, the CMH Board of Directors approves the consent agenda as amended.

- 1.5.1 Minutes of May 6, 2026
- 1.5.2 2025/26 Board of Directors Action Log
- 1.5.3 Board Attendance
- 1.5.4 Board Work Plan
- 1.5.5 Events Calendar
- 1.5.6 Committee Reports to the Board of Directors
 - Audit Committee (May 25, 2026)
 - Digital Health Strategy Committee (May 21, 2026)
 - Executive Committee (May 19, 2026)
 - Governance and Nominating Committee (May 14, 2026)
 - Medical Advisory Committee (May 13, 2026)
 - Resources Committee (May 25, 2026)
- 1.5.7 Governance Policy Approvals
 - That, the CMH Board of Directors approves the following policies as presented and upon recommendation of the Governance and Nominating Committee at its meeting of May 14, 2026.
 - | | |
|--------|--|
| 2-D-09 | Procedure for Members of the Public Addressing the Board |
|--------|--|
- 1.5.8 Strategic Priorities Q4 Updates
 - 1.5.8.1 Quality Monitoring Scorecard
- 1.5.9 CEO Certificate of Compliance (May 2, 2026-May 29, 2026)
- 1.5.10 Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding Certificate of Compliance
- 1.5.11 Broader Public Sector Accountability Act Attestation
- 1.5.12 Multi-Sector Service Accountability Agreement (M-SAA) Schedule F Declaration of Compliance
 - That the CMH Board of Directors approves the Broader Public Sector Accountability Act, 2010 (BPSAA) Appendix C - Attestation prepared by the President and CEO in accordance with Section 15 of the BPSAA for the period April 1, 2025, to March 31, 2026, and upon recommendation of the Resources Committee at its meeting of May 25, 2026
- 1.5.13 HSAA Article 8 – Declaration of Compliance
 - That, the CMH Board of Directors approves the submission of the Multi-Sector Service Accountability Agreement (M-SAA) Schedule F – Declaration of Compliance, confirming that CMH continues to meet its legal and contractual obligations and upon recommendation of the Resources Committee at its meeting of May 25, 2026
- 1.5.14 Employment Contract – Patrick Gaskin, President & CEO (August 16, 2025 to August 15, 2030)

1.6. Confirmation of Agenda

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

Agenda Item 4.4 Policy 2-A-24 (pulled from consent) was added as part of the regular agenda.

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

MOTION: That, the agenda be approved as amended.

2. PRESENTATIONS

2.1. Annual Truth & ReconciliACTION Plan

The Board received an update on the Truth & ReconciliACTION plan. The plan reflects an ongoing, sustained organizational commitment aligned with the Ontario Health framework.

Management presented the annual update, noting a deliberate, multi-year approach across key pillars. Indigenous cultural safety training was highlighted as a key achievement, with high leadership participation and ongoing onboarding for new leaders. Work is advancing to establish an Indigenous Employee Resource Group.

Progress in building relationships was noted through the Regional Indigenous Advisory Circle and ongoing partnerships, including work with the Indigenous Patient Navigator. Continued efforts are underway to strengthen integration and access to navigation supports for patients.

Improvements to culturally safe care were highlighted, including Indigenous artwork and changes to the smudging policy to increase accessibility. The organization remains focused on advancing Indigenous health and healing services.

Management discussed systemic barriers, including the absence of a formal self-identification process, and emphasized the importance of staff education and the Indigenous Patient Navigator role in supporting culturally appropriate care. Additional discussion highlighted gaps in supporting cultural practices and improving access within clinical areas.

The Board asked how feedback from Indigenous patients receiving care at CMH is gathered and used to assess progress. Management advised that feedback is currently received mainly through the Indigenous Advisory Circle, and that no standardized process is yet in place to measure progress. Opportunities were identified to share experiences regionally to support learning and improvement.

Management also noted limited Indigenous-specific information on the organization's website and supported planned updates to improve access to services and supports.

The Board expressed support for the continued progress and sustained organizational commitment, recognizing the work as an embedded priority with ongoing opportunity for advancement.

3. BUSINESS ARISING

There were no open matters for discussion.

4. NEW BUSINESS

4.1. Quality Committee

4.1.1. Report to the Board of Directors

The Chair of the Quality Committee provided an overview of the committee's recent work, highlighting discussions from the May meeting.

An overview of Surgical Services was presented, noting five to six rooms running daily and 8,212 procedures completed in the operating rooms last year. It was noted that the Medical Device Reprocessing Department plays a critical behind-the-scenes role, with over 120,000 instruments and equipment processed in 2025.

A patient story was shared highlighting the kindness, professionalism, and compassion of staff, and a staff story highlighted contributions to collaboration and workflow improvements.

An update was provided on the Picktacluar project, described as an AI-enabled operating room pick list decision support system developed in partnership with the University of Waterloo. It was noted that the tool allows comparison of surgeon-specific pick lists, supports visualization of variations, and may contribute to improved efficiency and cost management. The project received a Sustainable Design Award.

Program updates included anticipated approval of an additional anesthesia assistant, implementation of a new booking platform, and continued performance exceeding cancer care surgical targets.

The committee received the semi-annual Patient Experience report, noting a slight increase in overall case volumes, a decrease in complaints, and an increase in compliments. It was noted that patient experience data is improving through increased collection of patient email addresses. Surgical Day Care was identified as a strong performer, Emergency Department results have improved since October, and an increase in complaints in Medicine A is under review.

The annual Patient Experience Plan was presented, including finalization of the patient declaration and values, continued development of the centralized lost belongings initiative, improvements to language interpretation services through implementation of a new platform, and ongoing work on the My Connected Care portal.

An update on the Medical Human Resources Plan highlighted a focus on recruitment, retention, workforce planning, and wellness. It was noted that recruitment has been successful in over 85% of core specialties, with international recruitment strategies and an electronic credentialing system implemented. Ongoing recruitment challenges remain in emergency, pediatrics, and cardiology.

The Quality and Patient Safety Plan update highlighted continued focus on the just culture framework, expansion of medication safety initiatives, and improvements in care transitions, including CMH at Home.

The committee reviewed incident analysis reporting for low-severity (Level 1 and 2) events, noting a high reporting rate and steady volumes, reflecting strong staff engagement and a culture of psychological safety.

An update on the Ontario Health Team noted a provincial investment of \$3.7 million to support connecting more than 10,000 people to primary care within Cambridge North Dumfries.

The Board had no further comments or questions.

4.1.2. **Next CMH Strategic Planning Cycle**

Management presented the proposed approach for the next strategic planning cycle, noting that feedback from the Governance and Nominating Committee had been incorporated into the recommendation.

Management advised that the most significant change is the framing of the timeline as a two-year extension of the current strategic plan through 2029, rather than a delay. It was noted that the organization would continue

working under the current plan, begin development of the next plan in fall 2027, and target launch of the 2029–2034 strategic plan in 2029.

The rationale for the approach was described as grounded in organizational capacity, with continued focus required on HIS implementation and stabilization, workforce challenges, and broader operational demands. It was noted that the extension allows for continuity while preserving the ability to undertake a meaningful and engaged planning process.

Management confirmed that the existing corporate plans will continue through annual updates and established reporting processes, aligned with Board Committee work plans, to maintain accountability and monitor progress.

Discussion addressed the rebranding initiative, noting that work initiated in 2025 had been paused to align with the next strategic plan. It was confirmed that aligning rebranding with the future strategic plan will support a coordinated and cost-conscious approach.

The Board discussed whether the extended timeline would impact flexibility to advance digital health and innovation priorities. Management confirmed that the annual corporate planning and work plan process provides sufficient flexibility to advance priorities within the existing strategic framework.

The Board expressed support for the proposed approach, noting alignment with current organizational capacity and priorities.

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

MOTION: That, the CMH Board of Directors endorses the proposed two-year extension of the current strategic plan through 2029.

4.1.3. **Approach to the 2026/27 Board & Committee Goals**

The Board reviewed the proposed approach to Board and committee goals for 2026/2027, noting the importance of being mindful of the impact of HIS on organizational capacity and the leadership team.

It was recommended that committees not establish independent goals for the upcoming year and instead focus on monitoring the impact of HIS through their respective mandates.

The Board discussed the approach, noting alignment with prior discussions at committee level. It was noted that committees are already considering deferring work to reduce pressure on the organization.

The Board emphasized the importance of assessing committee work plans to identify activities that can be deferred without impact in the short term, in order to support organizational capacity.

The Board expressed support for the approach, noting that HIS represents a significant organizational priority and that the proposed focus is appropriate given current demands.

4.2. **Policy 2-A-34 Confidentiality Policy**

The Board discussed the Confidentiality Policy, which had been pulled from the consent agenda for discussion.

A Board member raised a question regarding the inclusion of guidance related to technology use, specifically the use of AI in relation to Board and committee materials and open meeting content.

Management acknowledged the point and noted that, while internal discussions have occurred, there is currently no formal direction or attestation required of Board members regarding AI use. It was noted that expectations remain that closed materials are not entered into external tools.

It was suggested that AI use may be more appropriately addressed through a dedicated policy or as part of a broader governance work plan item for 2026/2027, rather than within the current Confidentiality Policy. Reference was made to existing hospital-level policies, with consideration given to whether alignment or a separate Board-level policy would be required.

The Board discussed risks associated with existing technology, including automatic summarization features in email platforms, and the absence of corporate email accounts for Board members. It was noted that these factors may introduce potential confidentiality risks and should be considered in future policy development.

Additional discussion highlighted the importance of including expectations regarding AI and technology use in Board member orientation, particularly for new members, pending development of a formal policy.

The Board supported proceeding with the policy as presented, with the understanding that AI use and related governance considerations will be addressed through future policy development and Board education.

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

MOTION: That, the CMH Board of Directors approves policy 2-A-34 Confidentiality Policy as presented.

5. UPCOMING EVENTS

The Chair reviewed the upcoming events.

6. DATE OF NEXT MEETING

The next scheduled Board of Directors meeting will be held on June 24, 2026.

7. TERMINATION

MOTION: That the meeting be terminated at 1746hrs.
None opposed, **CARRIED.**

2025/26 Board of Directors Action Log

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



Board of Directors Attendance Report 2025/2026

Agenda Item 1.5.3

Meeting Dates	90%	100%	100%	60%	100%	70%	80%	100%	90%	100%	100%	88%
	Lynn Woeller	Bill Conway	Diane Wilkinson	Jay Tulsani	Jayne Herring	Julia Goyal	Margaret McKinnon	Miles Lauzon	Monika Hempel	Paulo Brasil	Sara Alvarado	Tom Barker
04-Jun-25	P	P	P	P	NA	R	P	P	R	P	P	NA
20-Jun-25	P	P	P	R	NA	P	P	P	P	P	P	NA
25-Jun-25	P	P	P	P	P	P	P	P	P	P	P	P
01-Oct-25	P	P	P	P	P	P	P	P	P	P	P	P
05-Nov-25	R	P	P	R	P	R	P	P	P	P	P	P
03-Dec-25	P	P	P	P	P	P	R	P	P	P	P	P
04-Feb-26	P	P	P	R	P	P	P	P	P	P	P	P
04-Mar-26	P	P	P	P	P	P	R	P	P	P	P	P
06-May-26	P	P	P	R	P	R	P	P	P	P	P	R
03-Jun-26	P	P	P	P	P	P	P	P	P	P	P	P

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

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
01-Oct-25	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		<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ 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			<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ review & approve Board policies as recommended by Governance Committee 	Complete	
4k Fundraising						
	The Board supports fundraising initiatives of the Foundation	2-A-30		<ul style="list-style-type: none"> ➤ review upcoming events ➤ reported through Directors ABCDE Goals ➤ receive CMH Board Giving Activity 	Complete	

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

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
November 5, 2025 (Generative Session)	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➤ review critical incident reports (as per the Excellent Care for all Act)	Complete
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➤ receive and review the Quality Monitoring Metrics	Complete
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➤ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	Complete
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➤ make the final appointment, reappointment, and privilege decisions ➤ ensure the effectiveness and fairness of the credentialing process	Complete
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➤ receive the MAC Report to the Board of Directors	Complete
4a Corporate Culture						
	ii	overseeing the establishment and monitoring of such a culture through appropriate mechanisms, including assessing the Chief Executive Officer, and Chief of Staff of the Corporation against this expectation	2-B-25 2-B-26	Executive	➤ receive & review the mid-year CEO and COS report and provide input	Complete
4b Strategic Planning						
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality / Resources	➤ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker	Complete
4c Corporate Performance						
	ii	monitor, mitigate and respond to the principal risks		Quality Audit / Quality / Resources	➤ review critical incident reports (as per the Excellent Care for all Act) ➤ receive mid-year IRM report	Complete Complete
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➤ receive and review the Quality Monitoring Metrics ➤ receive and review the Strategic Priorities Tracker	Complete
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➤ receive & approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements ➤ receive & approve Certificate of Compliance – Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding (semi-annual)	Complete
4f Oversight of Medical/Professional Staff						
	i	credential Medical/Professional Staff	1-C-13	MAC	➤ make the final appointment, reappointment, and privilege decisions ➤ ensure the effectiveness and fairness of the credentialing process	Complete
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➤ receive the MAC Report to the Board of Directors	Complete

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

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
03-Dec-25	4g Relationships					
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➤ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	Complete
	4i Board Effectiveness					
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➤ review & approve Board policies as recommended by Governance Committee	Complete
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➤ review upcoming events reported through Directors ABCDE Goals	Complete
	4l Programs Required under the <i>Public Hospitals Act</i>					
	ii	ensure that policies are in place to encourage and facilitate <u>organ procurement and donation</u>		Quality	➤ receive the annual Trillium Gift of Life Update	Complete
iii	ensure that the Chief Executive Officer, Chief of Staff, nursing management, Medical/Professional Staff, and employees of the Hospital develop plans to deal with emergency situations and the failure to provide services in the Hospital		Quality	➤ receive the annual Emergency Preparedness update	Complete	
4n Director Recruitment, Orientation, and Evaluation						
	The Board shall ensure there is an appropriate, objective, and formal process for the recruitment of Directors, and the evaluation of the Board, the Board Chair, its committees, committee Chairs and individual Directors.	2-D-20		➤ approve the members of the Nominating Sub-Committee & Interview Team	Complete	
04-Feb-26	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➤ review critical incident reports (as per the Excellent Care for all Act)	Complete
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➤ receive and review the Quality Monitoring Metrics	Complete
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable <u>accountability agreements with the MOH or Ontario Health</u>	1-C-02 1-C-20	Resources	➤ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	Complete
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➤ make the final appointment, reappointment, and privilege decisions ➤ ensure the effectiveness and fairness of the credentialing process	Complete
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➤ receive the MAC Report to the Board of Directors	Complete
4i Board Effectiveness						
iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➤ review & approve Board policies as recommended by Governance Committee	Complete	

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

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
04-Mar-26	4b Strategic Planning					
	iv	ensuring that key corporate priorities are formulated that help the Corporation accomplish its mission and actualize its vision in accordance with the strategic plan. The corporate priorities shall be reflective of the Board's primary accountability to the Ministry of Health ("MOH") and Ontario Health and any applicable accountability agreements with the MOH or Ontario Health		Quality Resources	<ul style="list-style-type: none"> ➤ review & approve Annual Quality Improvement Plan (QIP) ➤ review & approve Hospital Service Accountability Agreement (HSAA) ➤ review & approve Multi-Sector Service Accountability Agreement (MSAA) ➤ review & approve Community Accountability Planning Submission (CAPS) ➤ review & approve Hospital Accountability Planning Submission (HAPS) 	Complete
	v	approving operating and capital plans	2-C-31	Resources	<ul style="list-style-type: none"> ➤ review & approve the annual Operating Plan ➤ review & approve the Annual Capital Plan 	Complete
	4c Corporate Performance					
	ij	monitor, mitigate and respond to the principal risks		Quality	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ receive and review the Quality Monitoring Metrics 	Complete
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ 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			<ul style="list-style-type: none"> ➤ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed 	Complete
	4h Financial Viability					
	i	establish key financial objectives that support the Corporation's financial needs		Resources / Quality	<ul style="list-style-type: none"> ➤ review & approve Annual Operating & Capital Plans - service changes, operating plan, capital plan, salary increases, material amendments to benefit plans, programs and policies 	Complete
4k Fundraising						
	The Board supports fundraising initiatives of the Foundation	2-A-30		<ul style="list-style-type: none"> ➤ review upcoming events reported through Directors ABCDE Goals 	Complete	

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

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

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

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
June 3, 2026 (Generative Session)	4a Corporate Culture					
	ii	overseeing the establishment and monitoring of such a culture through appropriate mechanisms, including assessing the Chief Executive Officer, and Chief of Staff of the Corporation against this expectation	2-B-25 2-B-26	Executive	➤ receive & review the annual CEO and COS survey results & self-appraisal and provide input	Due
	4b Strategic Planning					
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality Resources	➤ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker	Complete
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➤ review critical incident reports (as per the Excellent Care for all Act)	Complete
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➤ receive and review the Quality Monitoring Metrics	Complete
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources Audit	<ul style="list-style-type: none"> ➤ 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 	Complete
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	<ul style="list-style-type: none"> ➤ 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
	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	<ul style="list-style-type: none"> ➤ 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 	Complete
	4i Board Effectiveness					
	i	monitor Board members' adherence to corporate governance principles and guidelines		Governance	<ul style="list-style-type: none"> ➤ Declaration of conflict agreement signed by Directors ➤ Directors Consent to Act ➤ Governance Report to the Board of Directors 	Complete
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➤ review & approve Board policies as recommended by Governance Committee	Complete
4n Director Recruitment, Orientation, and Evaluation						
	The Board shall ensure there is an appropriate, objective, and formal process for the recruitment of Directors, and the evaluation of the Board, the Board Chair, its committees, committee Chairs and individual Directors.	2-D-20		<ul style="list-style-type: none"> ➤ 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 	Complete	

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

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
24-Jun-26	4b Strategic Planning					
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality Resources	➤ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker	Due
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➤ review critical incident reports (as per the Excellent Care for all Act)	Due
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➤ receive and review the Quality Monitoring Metrics ➤ receive and review the Strategic Priorities Tracker	Due
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➤ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	Due
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➤ make the final appointment, reappointment, and privilege decisions ➤ ensure the effectiveness and fairness of the credentialing process	Due
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➤ receive the MAC Report to the Board of Directors	Due
	4g Relationships					
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➤ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	Due
	4i Board Effectiveness					
	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	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						
i	(i) ensure that an occupational health and safety program and a health surveillance program are established and regularly reviewed			➤ reported through annual attestations	In Progress	

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		<ul style="list-style-type: none"> ➤ conduct the election of officers ➤ review Board annual survey results 	Due
		4a Corporate Culture				
	iii	overseeing policies in respect of the Corporation's code of conduct	1-A-04		<ul style="list-style-type: none"> ➤ review the organizations code of conduct policy every three years (last approved May 9, 2024) 	
		4b Strategic Planning				
	i	ensuring that a strategic planning process is undertaken with Board, employees and Medical/Professional Staff involvement and approved by the Board from time to time			<ul style="list-style-type: none"> ➤ Strategic Plan: approve process, participate in development, approve plan - (last completed in 2022, will begin in fall 2027 - timetable approved by CMH Board on June 3, 2026) 	
	iii	contributing to the development of and approving the mission, vision, values, and strategic plan of the Corporation				
		4d Chief Executive Officer and Chief of Staff				
	i	select the Chief Executive Officer in accordance with the relevant Board policies	2-B-15	Executive	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ review & approve the Board's policies 2-B-20 CMH Executive Compensation Policy (last approved May 26, 2021) 2-B-25 CEO Performance Review Policy (last approved May 25, 2022) 	
	iv	select the Chief of Staff in accordance with the relevant Board policies	2-B-16	Executive	<ul style="list-style-type: none"> ➤ recruit, select, and hire and individual with the requisite skills, abilities, and competencies to effectively perform the job as President and Chief Executive Officer (CEO) of the organization 	
	v	delegate responsibility for the management of the Corporation to the Chief of Staff and require accountability to the Board	2-B-06	Executive		
As Needed	vi	establish a Board policy for the performance evaluation and compensation of the Chief of Staff	2-B-20 2-B-26	Executive / Governance	<ul style="list-style-type: none"> ➤ review & approve the Board's policies 2-B-20 CMH Executive Compensation Policy (last approved May 26, 2021) 2-B-26 CEO Performance Review Policy (last approved May 25, 2022) 	

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

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors are responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
4j Effective Communication and Community Relationships						
	i	establish processes for community engagement to receive public input on material issues	1-A-05 2-D-09		<ul style="list-style-type: none"> ➤ Post meeting agenda packages and minutes publicly on the CMH Website ➤ review & approve the Board policy 2-D-09 (last approved June 3, 2026) 	
	ii	promote effective collaboration and engagement between the Corporation and its community, particularly as it relates to organizational planning, mission, and vision			➤ Strategic Plan	
4m Communications Policy						
		The Board shall establish a communications policy for the Corporation and oversee the maintenance of effective relations with stakeholders (e.g. MOH, Ontario Health, CND OHT, other health service providers, clients, patients, employees, volunteers, Medical/Professional Staff, CMH Foundation, CMH Volunteer Association, federal, provincial, regional and city politicians) through the Corporation's communications policy and programs	2-D-11	Governance	➤ review & approve Board policy 2-D-11 every three years (last approved 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 approved June 28, 2023)	

DELAYED

Date	ref #	Item	Rationale	New Due Date

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

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

BRIEFING NOTE

Date: June 19, 2026
Issue: Digital Health Strategy Committee Report to Board of Directors – June 18, 2026 – OPEN
Prepared for: Board of Directors
Purpose: Approval Discussion Information Seeking Direction
Prepared by: Kristen Hoch – Administrative Assistant
Approved by: Mari Iromoto – VP, People & Strategy

Attachments/Related Documents: None

A meeting of the Digital Health Strategy Committee took place on Thursday, June 18, 2026 at 1700h.

Present: Sara Alvarado (Chair), Joel Campbell, Masood Darr, Miles Lauzon, Paul Martinello, Richard Neidert, Gloria Ringwood, Suzanne Sarrazin, Jay Tulsani

Regrets: Patrick Gaskin, Stephanie Pearsall

Staff: Jen Backler, Trevor Clark, Mari Iromoto, Dr. Winnie Lee (ex-officio), Kyle Leslie

Guests: Diana Crawford, Maryam Kazar

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

Committee Matters – For information only

- 1. Year End Recap & Annual Review of the Digital Health Strategy Committee:**
 - Advanced the Committee's role as a formal Board committee, with an expanded mandate beyond HIS procurement to include digital health, innovation, operational excellence, and one of the enterprise risks.
 - Supported key priorities including HIS readiness, workforce system stabilization, financial stewardship, and digital health initiatives.
 - Identified opportunities to enhance effectiveness through management feedback, agenda balance, and committee composition aligned with the expanded scope.
 - Annual evaluation reflected strong satisfaction with Committee effectiveness, governance, expertise, materials, and management support, with opportunities to strengthen digital expertise and streamline presentations.
- 2. Innovation Spotlight – AI to Support Care Transitions:** CMH Management highlighted CMH's participation in a multi-partner AI initiative to identify patients who may need discharge supports earlier, improving patient flow and reducing ALC pressures. Noted the initiative originated through external partnership outreach and supports ongoing innovation and digital health objectives.

BRIEFING NOTE

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

Attachments/Related Documents: None

A meeting of the Medical Advisory Committee took place on Wednesday June 10, 2026 at 1700h.

Present: Dr. W. Lee, Dr. J. Legassie, Dr. A. Sharma, Dr. B. Courteau, Dr. A. Nguyen, Dr. T. Holling, Dr. L. Green, Dr. J. Gill, Dr. A. Mendlowitz, Dr. M. Patel, C. Witteveen, Dr. I. Isupov, Dr. M. Rajguru,

Regrets: Dr. R. Shoop, Dr. E. Thompson, Dr. J. Bourgeois, Dr. V. Miropolsky, Dr. Yu Ming Wang, Dr. M. Hindle,

Staff: S. Pearsall, M. Iromoto, Dr. K. Rhee, Dr. R. Taseen, Dr. S. Zaidi, Dr. K. Nuri

Guests: B. Conway, C. Wilson

This briefing note highlights the key updates in patient safety, medical quality, and organizational excellence from the Medical Advisory Committee (MAC) meeting held on June 10, 2026.

- 1. Digital Infrastructure and Data Integrity as Quality Foundations:** The impending transition to the new Health Information System (HIS) is the foundational prerequisite for patient safety and data-driven quality improvement at Cambridge Memorial Hospital (CMH). The Medical and Therapeutics (M&T) subcommittee is currently mitigating "go-live" risks by reviewing and developing Power Plans. These plans are designed to eliminate clinical variability in high-volume and high-risk areas, such as VTE prophylaxis and complex surgical orders. Furthermore, the integration of specific formulary additions, such as Salbutamol IV for refractory asthma and specialized Ophthalmic drugs represents an opportunity to optimize and enable clinical coordination with WHRN, while working towards a safe digital environment.

An important activity for the new HIS is the completion of all outstanding medical records by August 30, 2026, prior to migration of data to the new HIS. From a quality perspective, this deadline is essential for data integrity.

- 2. National Leadership in Resource Stewardship and Planetary Health:** CMH is no longer just a participant in the "Choosing Wisely" movement; we are emerging as a national leader. This was recently evidenced by our invitation to a national panel at the annual Choosing Wisely Canada Conference where

CMH was cited alongside prestigious peers, SickKids and Kingston General Hospital. Since then, larger academic centers, such as Michael Garron Hospital, have reached out to CMH to learn from our "community-level implementation" model, which is agile and culturally embedded in the organization.

CMH's leadership in planetary health has been notable, linking environmental stewardship with resource optimization, a predominant theme in this year's Choosing Wisely Canada conference. To date, CMH's Choosing Wisely Canada's sustainability efforts has ranged from the elimination of Desflurane, inventory optimization, waste diversion and clinical carbon awareness. Many other Choosing Wisely-inspired initiatives have been seen across the organization that has not only reinforced evidence-based appropriate testing but has had positive impacts on the financial health of the organization. This culture of stewardship demonstrates that clinical quality, sustainability efforts and fiscal responsibility are not competing interests, but rather mutually reinforcing goals.

3. Department of Psychiatry Update - Advancing Mental Health and Vulnerable Care:

The psychiatry department operates as a "small but mighty" team, currently aiming to expand the team.

- **Service Model:** Includes 24/7 ED coverage, a 25-bed inpatient unit, and a six-week DBT/CBT-based day hospital program.
- **Innovation:** Utilizing AI for referrals and access tools; embedding peer recovery coaches across the care continuum.
- **Proposed ideas:** There was a stated need for "sensory rooms" and transitional spaces specifically for autistic populations to avoid the trauma associated with standard mental health units.

The Psychiatry department is strategically evolving from a traditional consultative model toward a "health equity" framework. There was discussion about investing in Sensory Rooms and Quiet Corners, moving toward an environment-first de-escalation strategy. This is an important quality consideration, as it reduces the need for pharmacological options and thereby improving patient safety and experience. Furthermore, a proposed Transitional Space could serve as a high-level diagnostic function for certain patients such as autistic children, as it allows clinicians to evaluate patients in a tailored environment, preventing misdiagnosis and providing a supportive environment that allows for appropriate treatment of patients in crisis. These innovations, supported by AI-driven referrals and Peer Recovery Coaches, are essential for reducing Emergency Room pressure and improving patient flow.

4. Midwifery Department Update - Full Scope Care, Interdisciplinary Partnerships, and Future Sustainability:

Midwives attend approximately 19–26% of births at the hospital, with a 92% hospital-birth rate.

- **Workforce Challenges:** High attrition and recruitment difficulties. Midwives at CMH practice at full scope of care. The current call model is heavy and is a barrier to sustainability. Despite these challenges, there has been recruitment of new midwives in the last couple of years.

- **Demographic Shift:** Patients are becoming more clinically complex, requiring more interventions and tests than in previous decades.
- **Integration Goal:** The department seeks fuller integration within the Women and Children's Program to improve provider sustainability and patient access.

The Midwifery department staffing has been tenuous with the previous closure of one midwifery group a few years prior. Active recruitment has been successful, but the department continues to seek new department members to fill the gaps resulting from the closure of the second midwifery practice. To optimize resources and protect the sustainability of our providers, a patient navigator role was discussed – built on the framework of "right patient, right provider" navigation, channeling medically complex cases to specialized obstetrics while reserving midwifery capacity for low-risk clients who desire that specific model of care.

5. **Operational Resilience through Collaboration and Service integration:** The Gastroenterology (GI) on-call service expansion to include food boluses and foreign bodies was shared, a forward-approach to providing optimal and quality care for these clinical scenarios. The expansion of GI on-call services reflects the successful journey of surgeons and GI endoscopists collaborating to improve access through the lens of quality care. It was noted that this shift in clinical care delivery will support improved patient flow and reduced Length of Stay (LOS).

CMH has been pursuing and recently achieved membership into the West Ontario Academic Health Sciences & Hospital Education Network (WOAHSHEN). Joining this affiliated academic community of practice is a significant milestone for CMH's academic mission, serving as a critical tool for sharing and learning best practices, physician recruitment and retention, and elevating CMH's academic presence in the West region.

6. **The "Culture of Care" and Human-Centric Quality:** The "Theatre of Medicine" CPSO QI session was highlighted as a new approach to bringing back human connection in medicine. While these may appear to be wellness initiatives, they are strategic tools for managing organizational risk, from recruitment and retention opportunities to elevating patient experience. A well-aligned and empathetic medical staff supports patient safety and quality of care, in addition to provide well-being.

The impact of the session was described by participants as "practice-changing," particularly regarding how physicians project energy and presence during patient interactions, even when fatigued. The tangible result of this culture was captured in a recent patient gratitude letter share with MAC, which praised the "collective kindness" of the entire staff—nursing, physicians, and support workers—during a family member's journey with cancer.

The MAC was invited to share in the Indigenous way of human connection, including gathering in a Circle to provide reflection of gratitude and to rest on the Indigenous tradition of kinship within the group. These Indigenous

teachings were shared learnings by the MAC Chair following an impactful time with Dr. Elder Roberta Price.

The key themes from the June MAC session have demonstrated that CMH medical leadership is operating with a growth mindset, championing key quality initiatives while maintaining the agility of a community hospital. Through future digital transformation, ongoing Choosing Wisely Canada leadership, continued focus on staff wellbeing and human connection, and the new WOASHEN academic partnership, we are strengthening our institutional resilience and elevating the quality of care at CMH.

BRIEFING NOTE

Date: June 23, 2026
Issue: Resources Committee Report to Board of Directors June 24, 2026 – Open
Prepared for: Board of Directors
Purpose: Approval Discussion Information Seeking Direction
Prepared by: Bonnie Collins, Administrative Assistant
Approved by: Trevor Clark, VP Finance & Corporate Services, CFO

Attachments/Related Documents: None

A meeting of the Resources Committee took place on Monday, June 22, 2026 at 1700h.

Present: Paulo Brasil (Chair), Sara Alvarado, Amanda Forrest, Monika Hempel, Shannon Maier, Janet Richter, Lynn Woeller

Regrets: Julia Goyal

Staff: Trevor Clark, Lisa Costa, Michelle D'Souza, Amanda Foster, Patrick Gaskin, Spencer Ogston, Stephanie Pearsall, Dr. Kunuk Rhee, Janet Short, Jennifer Visocchi

Guests:

The Resources Committee completed its scheduled work for the June 22, 2026 reporting period in accordance with its terms of reference and workplan. Key matters reviewed, discussed, and advanced by the committee are summarized below for Board awareness.

Committee Matters – For information only

- 1. Broader Public Sector Accountability Act Attestation:** Management provided an update to the Resources Committee on the Broader Public Sector Accountability Act attestation, clarifying the distinction between contractors and consultants. In response to follow up questions arising from the May meeting, the Cogen engineering firm was confirmed as a contractor and not a consultant, per definition, and Mohawk Medbuy's attestation process was reviewed and confirmed to be comprehensive and complete. It was clarified that procurement requirements are based on the price threshold (over \$121,200), not on whether the service is classified as consulting or contracting, and that the process applies regardless of classification.
- 2. Financial Statements – May 2026:** Management presented the May 2026 financial statements, reflecting a \$685K year-to-date deficit, unrestricted working capital at \$30.5M and a working capital ratio of 1.48. The impact of the delayed receipt of equipment purchases made in fiscal 2025-26 was highlighted.

The Resources Committee questioned the feasibility of the 15% regional preferred accommodation target revenue for CMH, which has few ward rooms. Discussion ensued around the impact of insurance coverage, patient consent requirements, and strategies to maximize revenue, noting that many patients do not have coverage or are unwilling to pay out-of-pocket. Management reported that, as of June 2026, the contract with Tri-City Endo has been frozen, and that the contract

with Clear Vision is still in force. Management explained that the increase in accounts receivable was attributed to timing, higher billing rates, and specific items such as Cancer Care Ontario drug recoveries, and that the average write off rate over the last two years was 16%. It was also confirmed that the perceived FEC4 repayment liability amount was reported in the deferred capital grants and donations line of the balance sheet. *(Further information will be discussed during agenda item 4.2.1)*

3. **Annual Assessment of Independence:** Management provided an overview of the results of the annual survey to validate independence in the CMH procurement process. The results of the survey of individuals involved in procurement at CMH confirmed that no financial conflicts or inappropriate relationships were identified, and independence is maintained in procurement activities.

BRIEFING NOTE

Date: June 18, 2026
Issue: 2026/27 Quality Monitoring Scorecard Update and Current Performance Summary
Prepared for: Board of Directors
Purpose: Approval Discussion Information Seeking Direction
Prepared by: Kyle Leslie, Director Analytics and Innovation and CIO
Approved by: Mari Iromoto, VP People & Strategy

Attachments/Related Documents: Quality Monitoring Scorecard

Alignment with 2026/27 CMH Priorities:

2022-2027 Strategic Plan No <input type="checkbox"/>	2026/27 CMH Priorities No <input type="checkbox"/>	2026/27 Integrated Risk Management Priorities No <input type="checkbox"/>
<input checked="" type="checkbox"/> Elevate Partnerships in Care	<input checked="" type="checkbox"/> Improve Patient Flow (CBD, PIA, ED Admits)	<input checked="" type="checkbox"/> Organizational Flow
<input checked="" type="checkbox"/> Reimagine Community Health	<input checked="" type="checkbox"/> Prepare for Digital Health Transformation	<input checked="" type="checkbox"/> Project Quantum
<input checked="" type="checkbox"/> Increase Joy in Work	<input checked="" type="checkbox"/> Increase Staff Engagement Through Improved Staffing (Med, ICU, ED, Physicians)	<input checked="" type="checkbox"/> Management/Medical Staff Partnership
<input checked="" type="checkbox"/> Sustain Financial Health	<input checked="" type="checkbox"/> Achieve a Balanced 2026/27 Operating Position	<input checked="" type="checkbox"/> Financial Sustainability
<input checked="" type="checkbox"/> Advance Health Equity	<input checked="" type="checkbox"/> Embrace Diversity, Build a Culture of Inclusion	<input checked="" type="checkbox"/> Change Management

Executive Summary

The June Quality Monitoring Scorecard shows a mixed early-year performance profile for fiscal 2026/27. Based on the latest three reporting periods, 12 indicators (40%) are meeting target, 6 (20%) are within 10% of target, and 12 (40%) are exceeding target thresholds. The most significant performance pressures continue to relate to organizational flow, emergency department throughput, conservable bed days and workforce capacity, including sick and over time. At the same time, several core clinical quality indicators remain strong, including hospital standardized mortality, in-hospital sepsis, surgical long waiters, hip fracture surgery timeliness and patient safety events with harm at zero.

Background

The CMH Quality Monitoring Scorecard provides a monthly view of organizational performance across quality, safety, patient flow, people, equity, and financial indicators. The scorecard is used to monitor performance against approved 2026/27 targets, identify areas requiring escalation, and support leadership action planning. The current update reflects the most recent available year-to-date results in the 2026/27 fiscal year, with indicators reported through March, April, or May 2026 depending on source data availability.

Analysis

Current performance continues to highlight sustained pressure on patient flow and access, particularly across conservable days, ALC throughput, emergency department length of stay, wait times for inpatient beds, provider initial assessment times, and the number of admitted patients waiting in the emergency department each morning. Workforce-related indicators also remain challenged, with sick and overtime hours above target.

These results are consistent with broader system flow pressures and reinforce the need for continued operational focus through daily management, escalation processes, and targeted improvement work aligned with CMH's 2026/27 strategic and integrated risk management priorities.

The following indicators are currently below target based on the most recent available 2026/27 data:

1. **Conservable Days Rate:** Measures the proportion of conservable patient days relative to total acute patient days. Target: 30.0%. YTD (April 2026): 47.8%, indicating continued opportunity to reduce avoidable inpatient days and improve flow.
2. **Overtime Hours – Average per Pay Period:** Tracks average overtime hours used per pay period. Target: 3,662.3 hours. YTD (May 2026): 3,681.5 hours, slightly above plan.
3. **Sick Hours – Average per Pay Period:** Measures average sick time utilization per pay period. Target: 2,895.9 hours. YTD (May 2026): 3,997.9 hours, remaining materially above target and reflecting ongoing workforce pressures.
4. **ALC Throughput:** Measures the ratio of ALC discharges to newly added or redesignated ALC cases. Target: 1.0. YTD (April 2026): 0.6.
5. **30 Day CHF Readmission Rate:** Measures urgent readmission within 30 days of discharge for heart failure patients. Target: 14.0%. YTD (March 2026): 20.1%.
6. **Ambulance Offload Time (90% Spent Less, in Minutes):** Measures time from ambulance arrival to transfer of care. Target: 30.0 minutes. YTD (April 2026): 40.6 minutes.
7. **Daily Average Number of Patients Waiting in the Emergency Department for an Inpatient Bed at 8 a.m.:** Measures admitted patients still waiting in the emergency department each morning. Target: 10.0. YTD (April 2026): 14.6.
8. **ED Length of Stay for Admitted Patients (90% Spent Less, in Hours):** Measures time from triage to inpatient bed arrival for admitted patients. Target: 33.0 hours. YTD (April 2026): 60.2 hours.
9. **ED Wait Time for Inpatient Bed (90% spent less, in hours):** Measures time from admission decision to bed arrival. Target: 25.0 hours. YTD (April 2026): 50.10 hours.
10. **ED Length of Stay for Non-Admitted Complex (CTAS 1-3) Patients (90% spent less, in hours):** Measures time from triage to departure for complex non-admitted ED patients. Target: 8.0 hours. YTD (April 2026): 10.60 hours.
11. **ED Wait Time for Provider Initial Assessment (PIA) (90% spent less, in hours):** Measures time from triage to physician/nurse practitioner initial assessment. Target: 4.0 hours. YTD (April 2026): 7.90 hours overall

Consultation

These indicators continue to be reviewed through senior leadership forums, including weekly operations discussions, Director's Council, and quality and operational oversight committees, to support escalation, mitigation planning, and accountability for improvement actions.

Next Steps

- The Quality Monitoring Scorecard will continue to be reviewed monthly, with focus on trend movement across flow, access, and workforce indicators.
- Operational leaders will continue to prioritize actions addressing conservable days, ALC throughput, emergency department access, inpatient bed flow, and staffing pressures.
- Updates will be escalated through senior executive forums where sustained variances require additional intervention, resource alignment, or cross-organizational action.



Quality Monitoring Scorecard

Status (Last 3 Periods)

- Meeting Target ● 12 40%
- Within 10% of Target ▲ 6 20%
- Exceeding Target ◆ 12 40%

Quality Dimension	Indicator	Unit of Measure	Target	YTD	Status (Last 3 periods)	Period
Efficient	Conservable Days Rate	%	30.0	47.8	◆	Apr-26
	Overtime Hours - Average per pay period	Hours	3,662.3	3,681.5	◆	May-26
	Sick Hours - Average per pay period	Hours	2,895.9	3,997.9	◆	May-26
Integrated & Equitable	ALC Throughput	Ratio	1.0	0.6	◆	Apr-26
	Percent ALC Days (closed cases)	%	20.0	27.8	▲	Apr-26
	Repeat emergency department visits for Mental Health Care	Patients	11.0	10.4	▲	Apr-26
Patient & People Focused	Organization Wide Vacancy Rate	%	12.0	4.5	●	Apr-26
Safe, Effective & Accessible	30 Day CHF Readmission Rate	%	14.0	20.1	◆	Mar-26
	30 Day COPD Readmission Rate	%	15.5	16.5	◆	Mar-26
	30 Day In-Hospital Mortality Following Major Surgery	%	1.9	0.1	▲	Mar-26
	30 Day Overall Readmission Rate	%	8.8	6.7	●	Mar-26
	Ambulance Offload Time (90% Spent Less, in Minutes)	minutes	30.0	40.6	◆	Apr-26
	Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m.	average	10.0	14.6	◆	Apr-26
	ED Length of Stay for Admitted Patients (90% Spent Less, in Hours)	Hours	33.0	60.2	◆	Apr-26
	ED Length of Stay for Non-Admitted Complex Patients (90% Spent Less, in Hours)	Hours	8.0	10.6	◆	Apr-26
	ED Wait Time for Inpatient Bed (90% Spent Less, in Hours)	Hours	25.0	50.1	◆	Apr-26
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours)	Hours	4.5	7.9	◆	Apr-26
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours) CTAS 1	Hours	0.5	0.5	●	Apr-26
	Hip Fracture Surgery Within 48 Hours	%	83.1	92.3	●	Mar-26
	Hospital Standardized Mortality Ratio (HSMR)	Ratio	100.0	84.7	●	Mar-26
	In-Hospital Sepsis	per 1000 D/C	3.2	2.6	●	Mar-26
	Long Waiters Waiting For All Surgical Procedures	%	20.0	10.3	●	May-26
	Low-Risk Caesarean Sections	%	17.3	5.0	▲	Apr-26
	Medication Reconciliation at Admit	%	95.0	90.9	▲	May-26
	Medication Reconciliation at Discharge	%	95.0	91.9	▲	May-26
	Obstetric Trauma (With Instrument)	%	14.4	3.9	●	Mar-26
	Patient Safety Event - Falls with Harm	per 1000 PD	0.0	0.0	●	May-26
Patient Safety Event - Medication Events with Harm	per 1000 PD	0.0	0.0	●	May-26	
Revenue - Achieve budgeted PCOP growth (IRM)	\$	746,302.9	2,413,607.7	●	Apr-26	
Revenue - Achieve Quality Based Procedure Funding (IRM)	\$	2,236,181.3	2,633,326.2	●	Apr-26	



Description

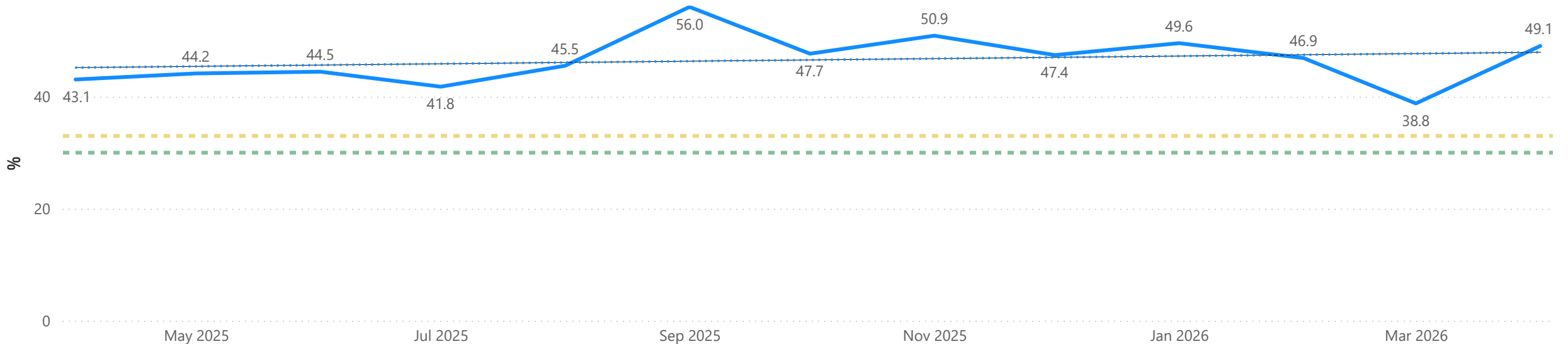
The total patient days over the benchmark LOS (conservable days) as a percentage of the total acute patient days for patients discharged from MEDA/MEDB. The benchmark LOS is determined by case mix group, age, and resource intensity level of a discharge.

Data Source

Discharge Abstract Database (DAD)



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	43.1	44.2	44.5	41.8	45.5	56.0	47.7	50.9	47.4	49.6	46.9	38.8
2026/2027	49.1											

Overtime, Average per pay period



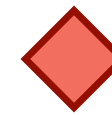
Description

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

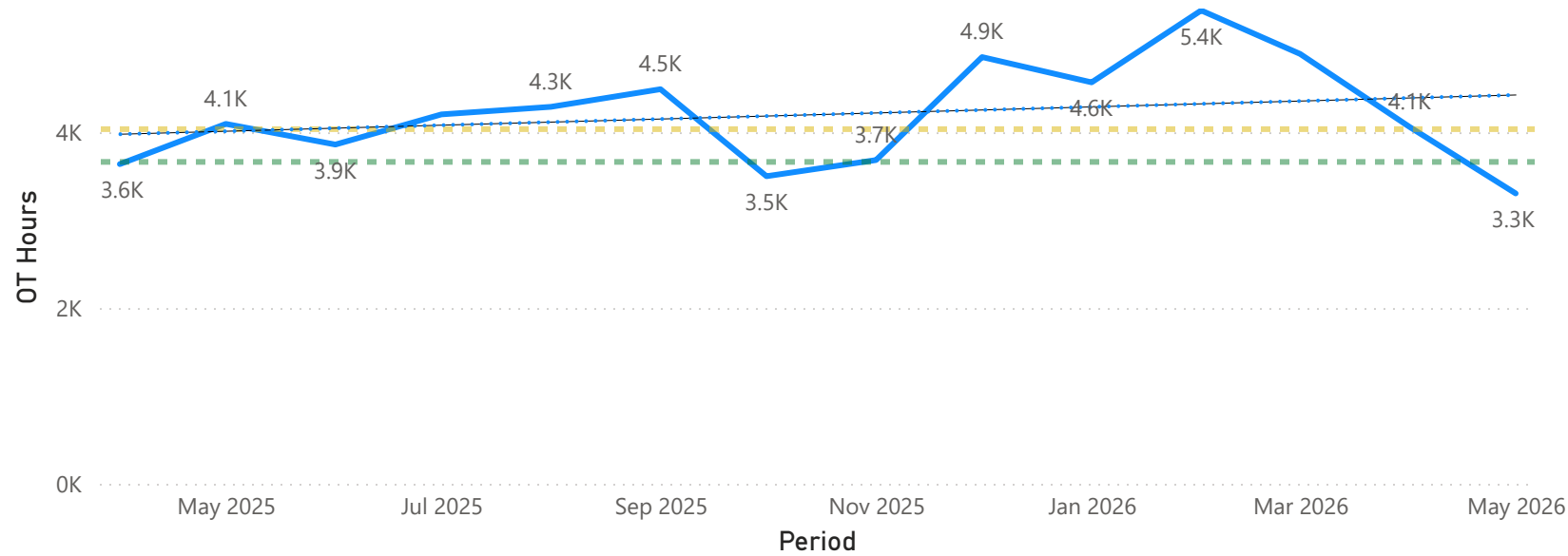
Data Source

Meditech Payroll

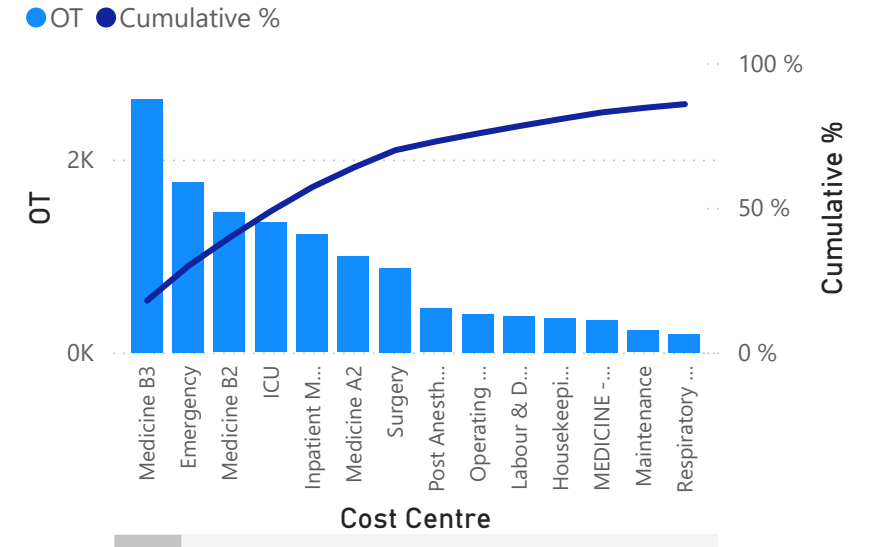
Status (Last 3 periods)



Average OT Hours per pay period, Trend



Total OT Hours, by Cost Centre



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	3,637.0	4,094.9	3,859.9	4,202.9	4,289.1	4,489.6	3,499.4	3,683.4	4,855.2	4,567.5	5,385.6	4,890.9
2026/2027	4,059.6	3,303.5										

Sick Time, Average per pay period



Description

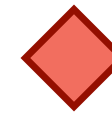
The total sum of sick hours per pay period ending in a month, divided by the number of pay periods in a month

Data Source

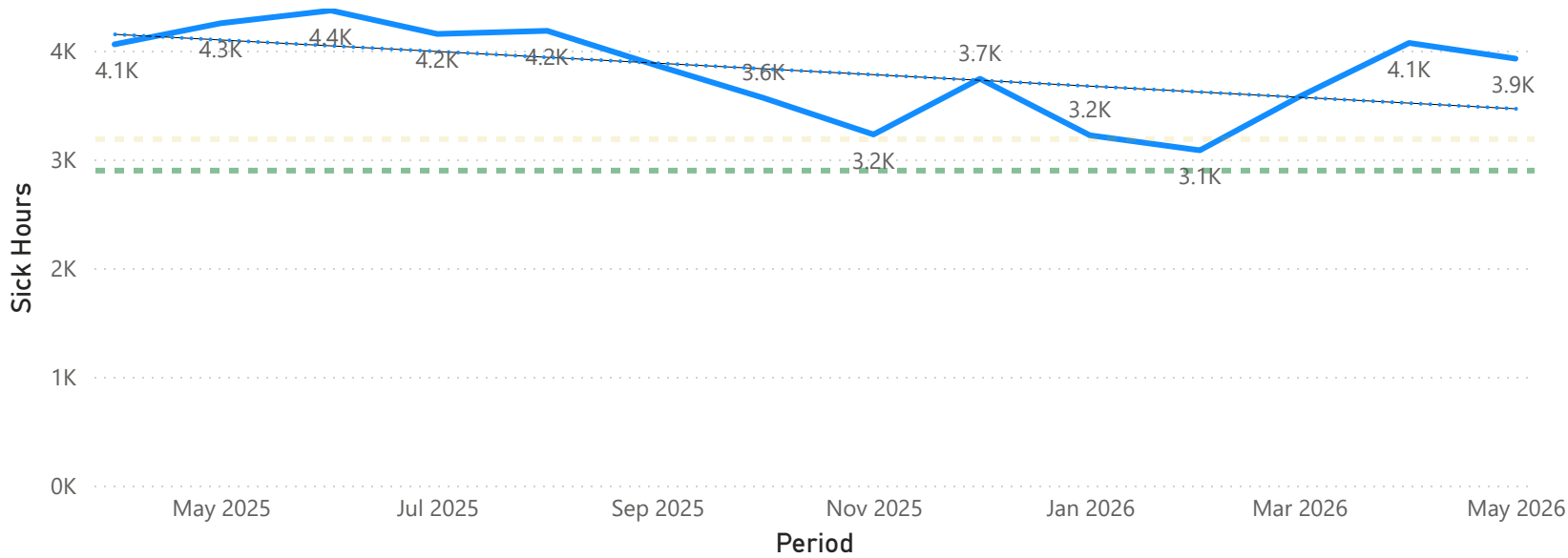
Meditech Payroll

Target	Previous YE	YTD
2,895.9	3,768.0	3,997.9

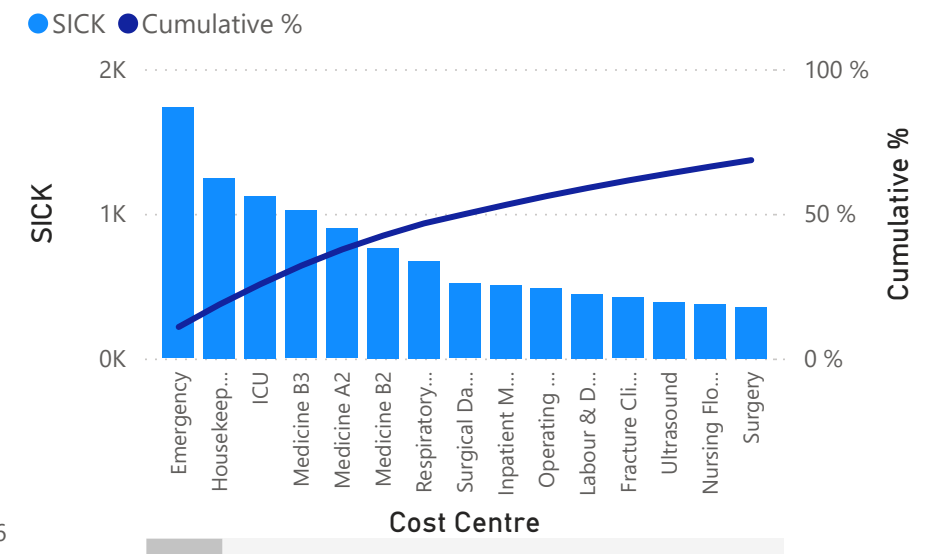
Status (Last 3 periods)



Average Sick Hours per pay period, Trend



Total Sick Hours, by Cost Centre



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	4,057.1	4,251.5	4,368.5	4,152.8	4,181.5	3,861.3	3,564.2	3,228.3	3,740.7	3,220.6	3,082.6	3,574.6
2026/2027	4,070.0	3,925.8										




ALC Throughput

Description

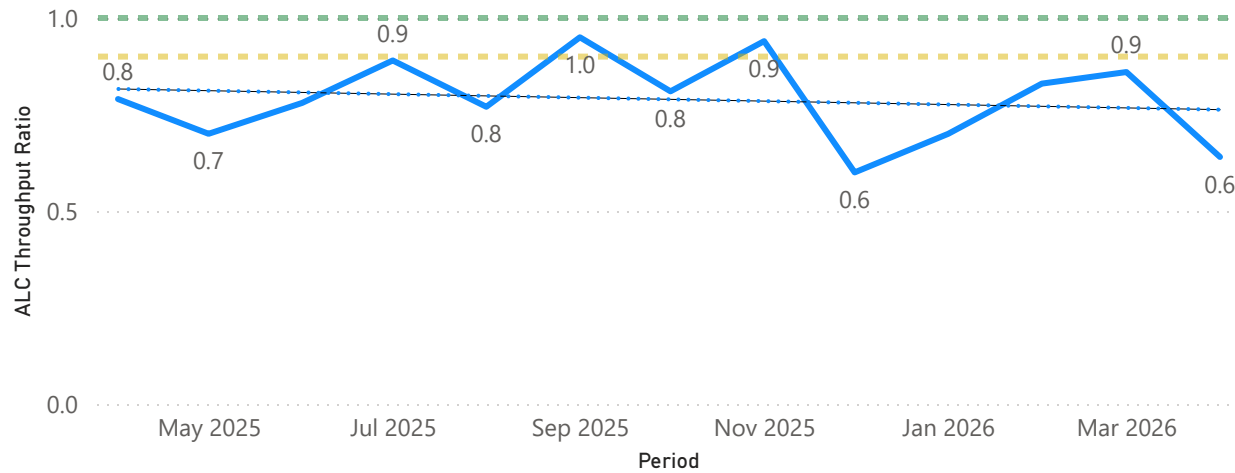
ALC Throughput is the ratio of the number of discharged ALC cases to the number of newly added and redesignated ALC cases

Data Source

WTIS

Target	Previous YE	YTD	Status (Last 3 periods)
1.0	0.8	0.6	

ALC Throughput Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	0.8	0.7	0.8	0.9	0.8	1.0	0.8	0.9	0.6	0.7	0.8	0.9
2026/2027	0.6											


ALC Rate

Description

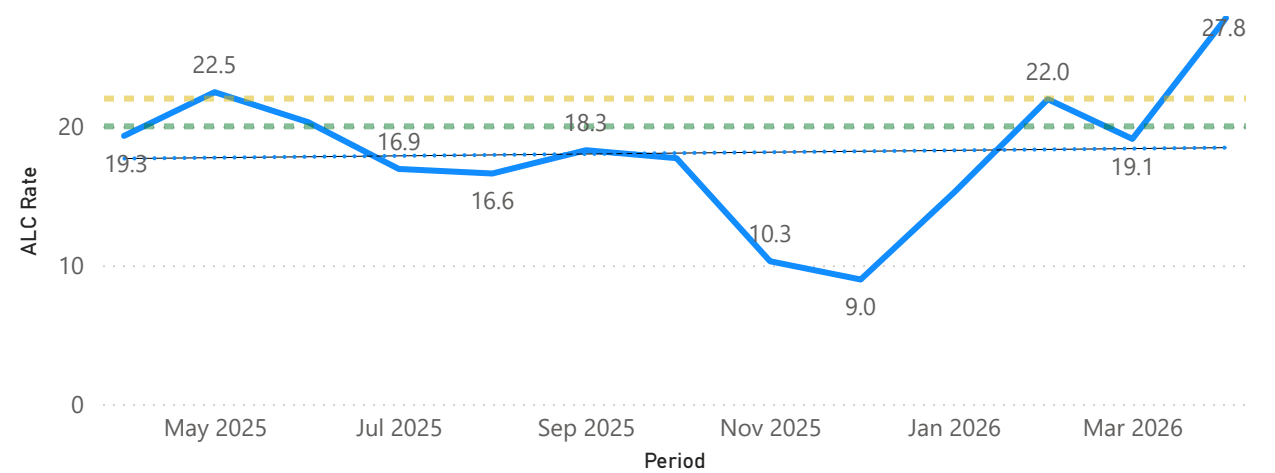
The proportion of total days that a patient was assigned to the alternate level of care (ALC) service. ALC patients are those who no longer need acute care services but continue to occupy an acute care bed or use acute care services.

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
20.0	17.3	27.8	

ALC Rate Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	19.3	22.5	20.3	16.9	16.6	18.3	17.7	10.3	9.0	15.3	22.0	19.1
2026/2027	27.8											

Repeat ED Visits for Mental Health Care



Description

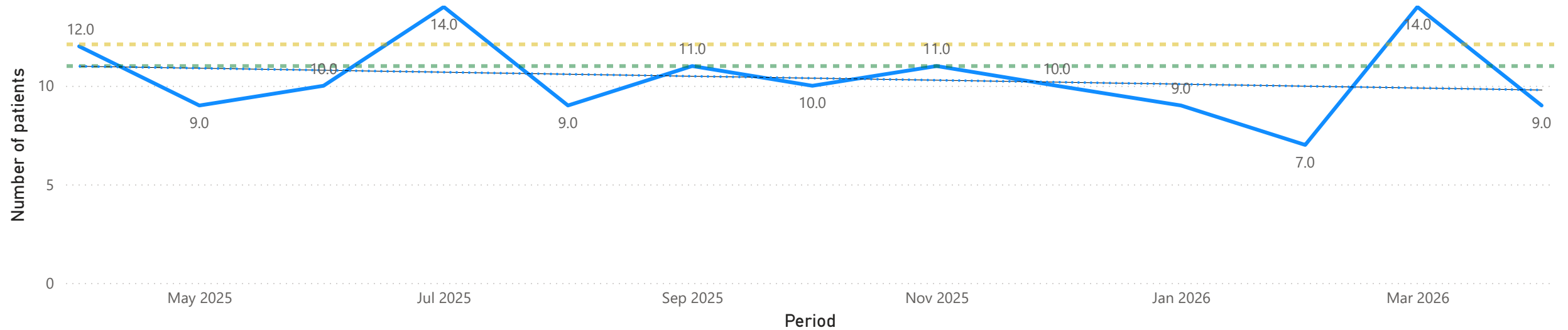
Number of patients who have four or more repeat unscheduled visits to the emergency department in the last 12 months for mental health or substance abuse condition

Data Source

National Ambulatory Care Reporting System (NACRS)



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	12.0	9.0	10.0	14.0	9.0	11.0	10.0	11.0	10.0	9.0	7.0	14.0
2026/2027	9.0											

Organizational Vacancy Rate



Description

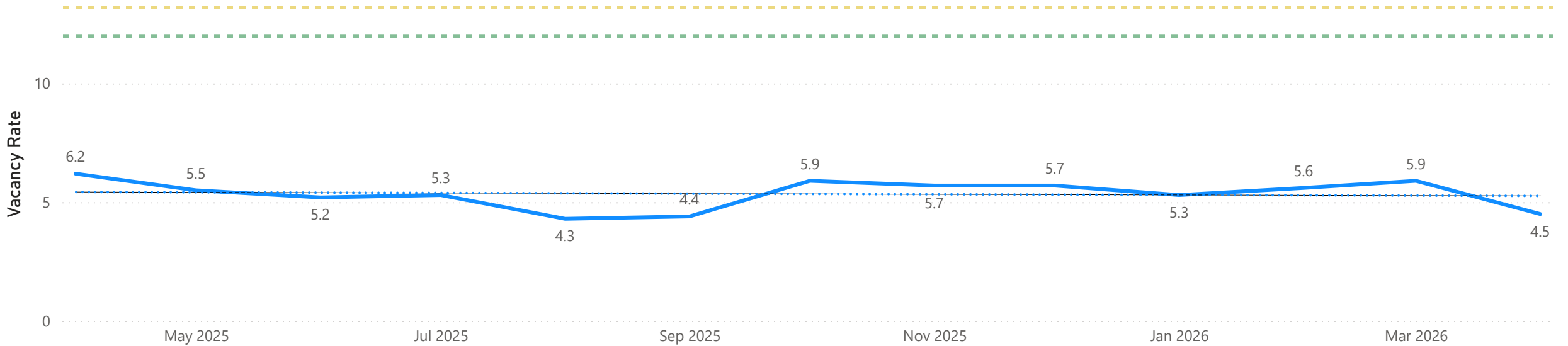
This indicator measures the organization wide vacancy rate for permanent full time and part time staff

Data Source

ICIMs Vacancy Report and Meditech Payroll

Target	Previous YE	YTD	Status (Last 3 periods)
12.0	5.4	4.5	

Trend



Period

Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	6.2	5.5	5.2	5.3	4.3	4.4	5.9	5.7	5.7	5.3	5.6	5.9
2026/2027	4.5											



Readmissions within 30 Days:

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

CHF Readmissions

COPD Readmissions

Description

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

Data Source

Discharge Abstract Database (DAD)

Description

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

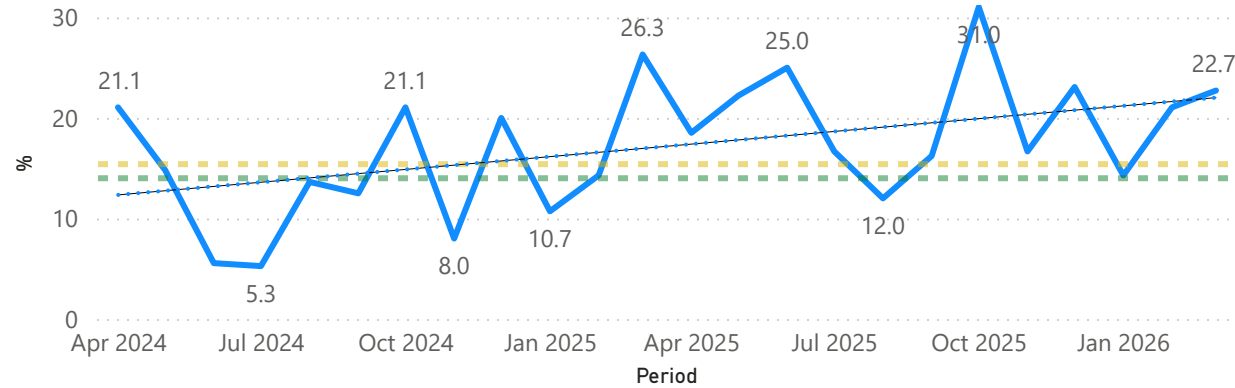
Data Source

Discharge Abstract Database (DAD)

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

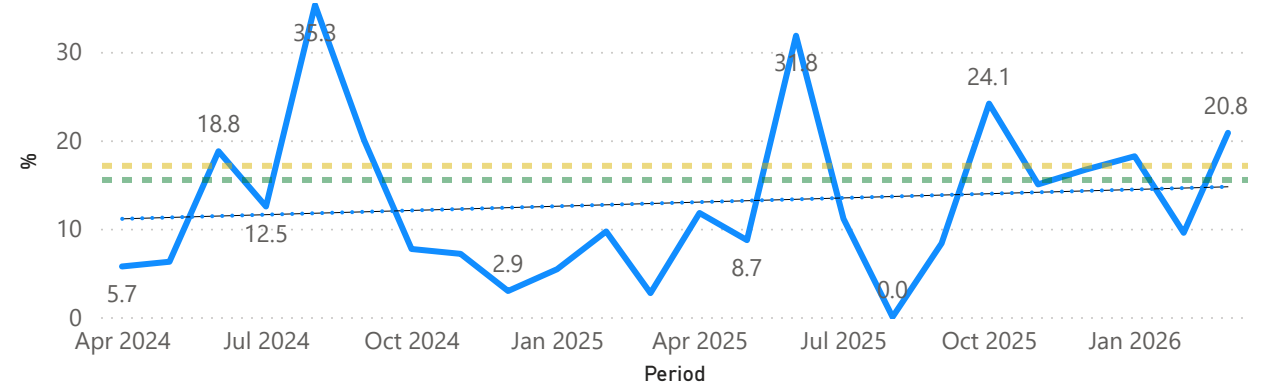
14.0 **14.7** **20.1** **15.5** **9.1** **16.5**

CHF Readmission Rate, Trend



Fiscal Year		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	Rate	21.1	14.8	5.6	5.3	13.6	12.5	21.1	8.0	20.0	10.7	14.3	26.3
	Readmits	4	4	1	1	3	3	8	2	5	3	3	5
2025/2026	Rate	18.5	22.2	25.0	16.7	12.0	16.2	31.0	16.7	23.1	14.3	21.1	22.7
	Readmits	5	6	9	4	3	6	9	3	6	4	4	5

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	8.7	31.8	11.1	0.0	8.3	24.1	15.0	16.7	18.2	9.5	20.8
	Readmits	9	8	16	6	3	7	16	6	13	10	6	10

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

1.9

Previous YE

1.3

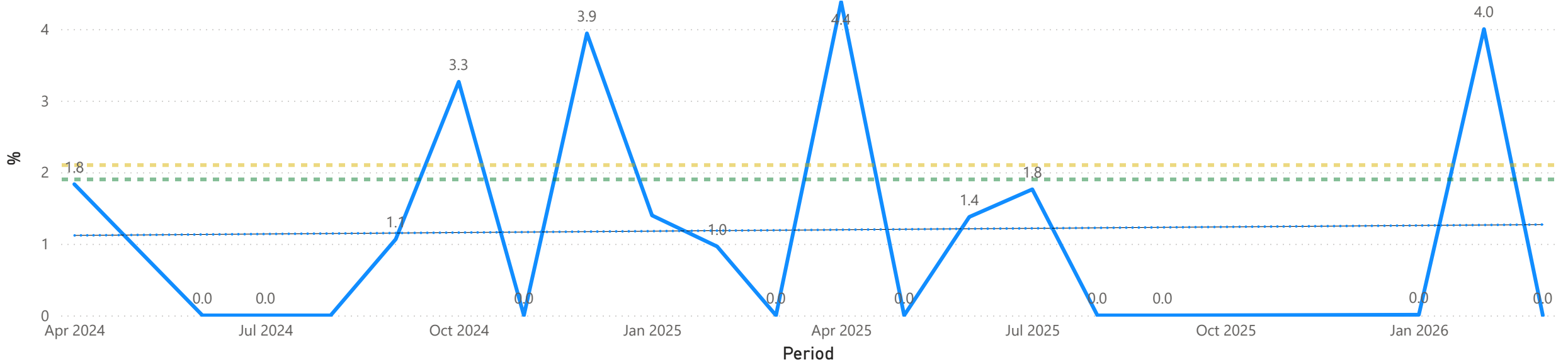
YTD

0.1

Status (Last 3 periods)



Trend



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

30 Day Overall Readmission Rate



Description

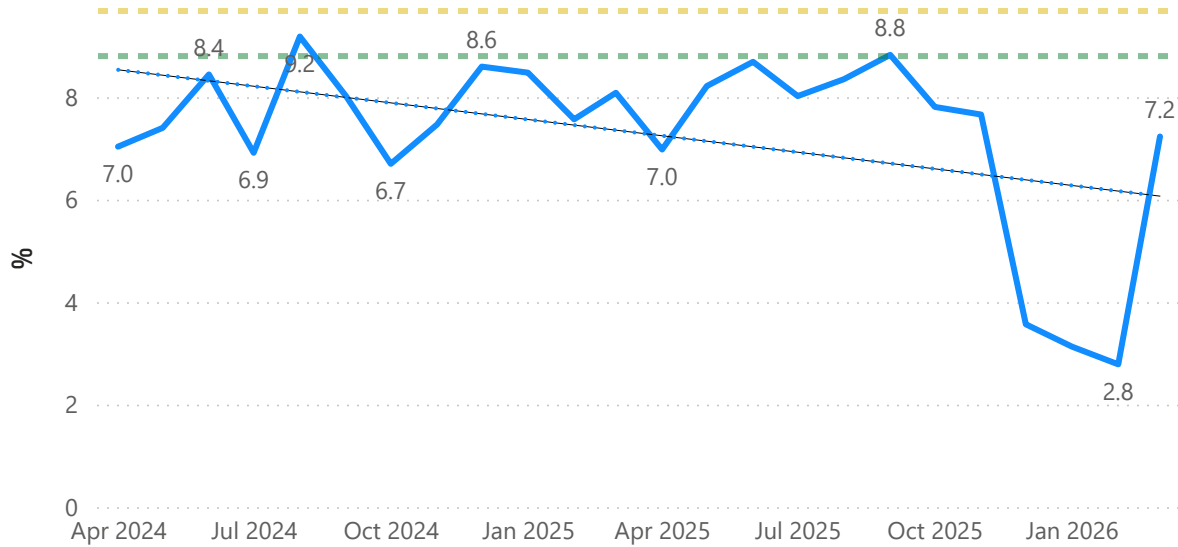
The rate of urgent readmissions within 30 days of discharge for episodes of care for the following patient groups: medical, obstetric, paediatric, and surgical. Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
8.8	7.8	6.7	●

Trend

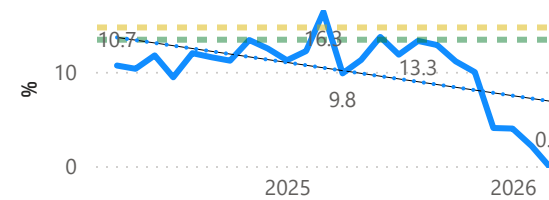


Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	7.0	7.4	8.4	6.9	9.2	8.0	6.7	7.5	8.6	8.5	7.6	8.1
2025/2026	7.0	8.2	8.7	8.0	8.3	8.8	7.8	7.7	3.6	3.1	2.8	7.2

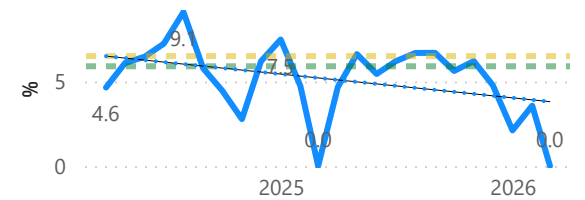
Readmissions, by Patient Group

IndicatorName	Target	YTD	Status (Last 3 periods)
30 Day Medical Readmission Rate	13.4	11.5	●
30 Day Obstetric Readmission Rate	1.4	1.2	▲
30 Day Paediatric Readmission Rate	6.7	6.0	▲
30 Day Surgical Readmission Rate	5.9	5.9	●

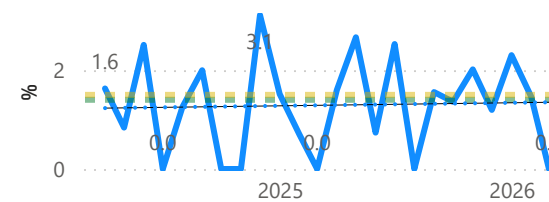
Medical Readmissions Trend



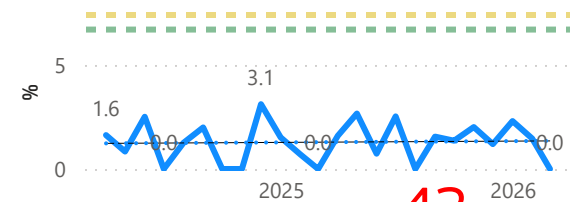
Surgical Readmissions Trend



Obstetric Readmissions Trend



Paediatric Readmissions Trend



Ambulance Offload Time, minutes, 90th percentile



Description

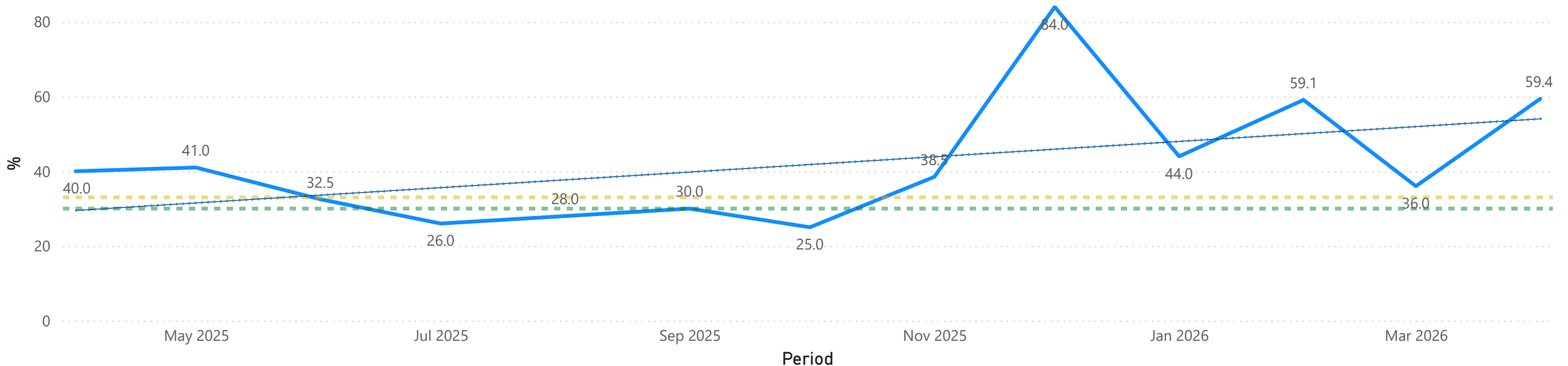
The total time, in minutes, in which 9 out of 10 patients who arrived via ambulance waited for transfer of care process to be completed, calculated as the total time elapsed from ambulance arrival to completion of transfer of care process.

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
30.0	39.0	59.4	◆

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	40.0	41.0	32.5	26.0	28.0	30.0	25.0	38.5	84.0	44.0	59.1	36.0
2026/2027	59.4											

AVG Patients in ED at 8AM waiting for IP bed



Description

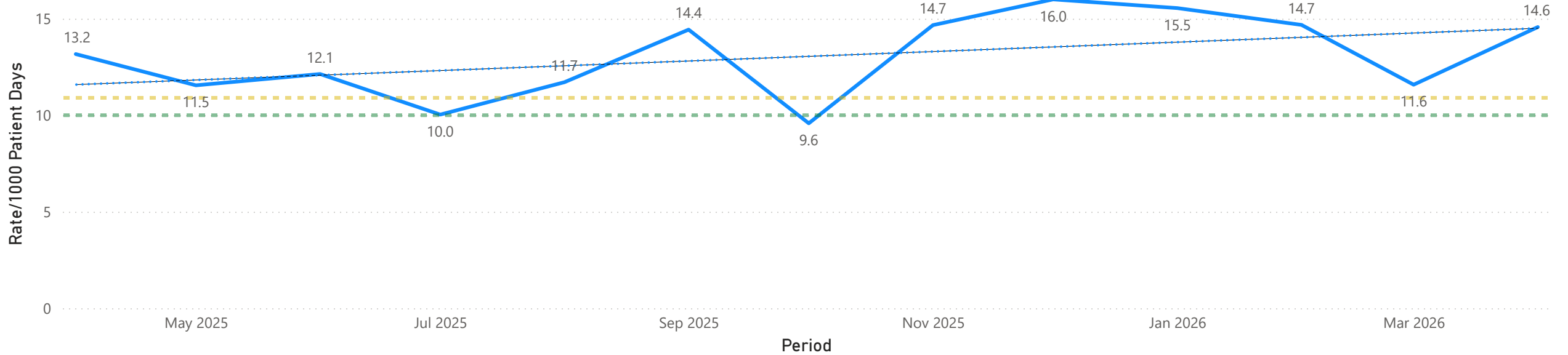
The number of patients in the emergency department waiting for an inpatient bed at 8 a.m. who have been waiting at least 2 hours since disposition. Average number of patients per day

Data Source

NACRS

Target	Previous YE	YTD	Status (Last 3 periods)
10.0	12.9	14.6	◆

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	13.2	11.5	12.1	10.0	11.7	14.4	9.6	14.7	16.0	15.5	14.7	11.6
2026/2027	14.6											



ED LOS for Admitted Patients, hours, 90th percentile



Total ED LOS for Admitted Patients

Description

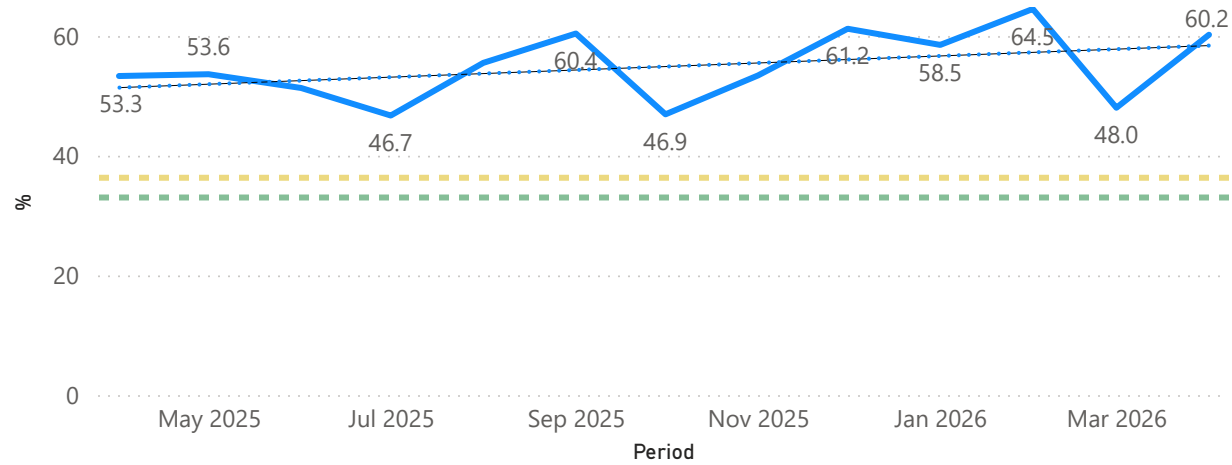
The total time, in hours, that 9 out of 10 admitted patients spent in the emergency department (ED), calculated as the total time elapsed from triage to when the patient left the ED

Data Source

National Ambulatory Care Reporting System (NACRS)



ED LOS for Admitted Patients, Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	53.3	53.6	51.3	46.7	55.5	60.4	46.9	53.4	61.2	58.5	64.5	48.0
2026/2027	60.2											

Time to Inpatient Bed

Description

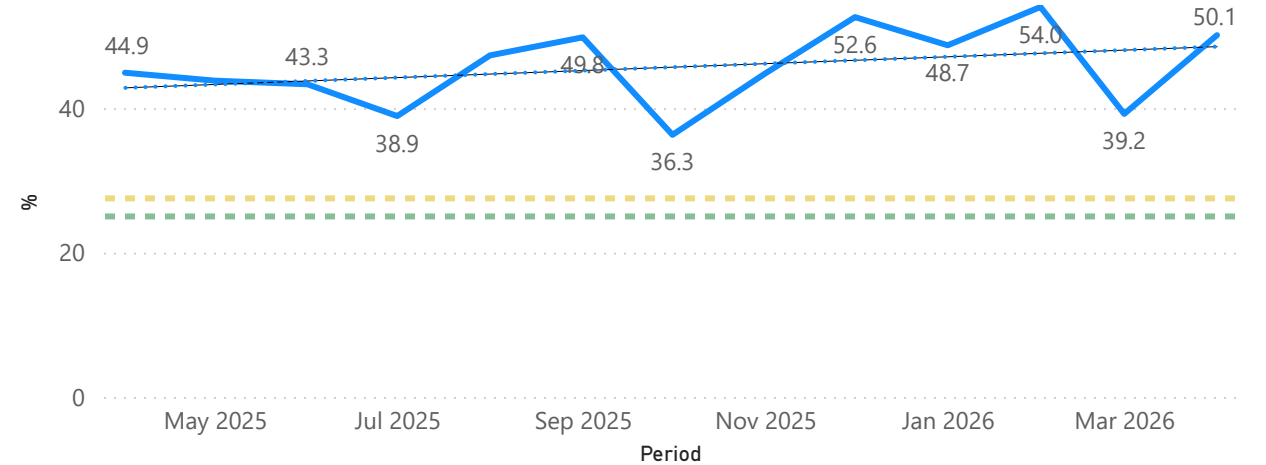
The total time, in hours, that 9 out of 10 admitted patients spent waiting in the emergency department (ED) for a bed, calculated as the total time elapsed from disposition decision to when the patient left the ED

Data Source

National Ambulatory Care Reporting System (NACRS)



Time to Inpatient Bed, Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	44.9	43.8	43.3	38.9	47.3	49.8	36.3	44.8	52.6	48.7	54.0	39.2
2026/2027	50.1											



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



Description

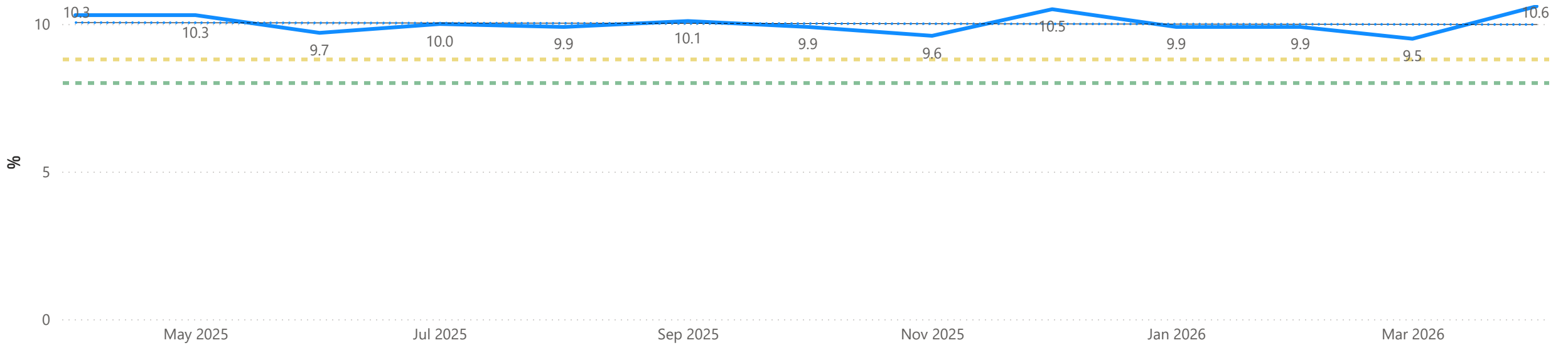
The total time, in hours, that 9 out of 10 high-urgency patients (CTAS 1-3) who were not admitted spent in the emergency department (ED), calculated as the total time elapsed from triage to when the patient left the ED

Data Source

National Ambulatory Care Reporting System (NACRS)

Target	Previous YE	YTD	Status (Last 3 periods)
8.0	10.0	10.6	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	10.3	10.3	9.7	10.0	9.9	10.1	9.9	9.6	10.5	9.9	9.9	9.5
2026/2027	10.6											

Provider Initial Assessment Time, hours, 90th percentile



Description

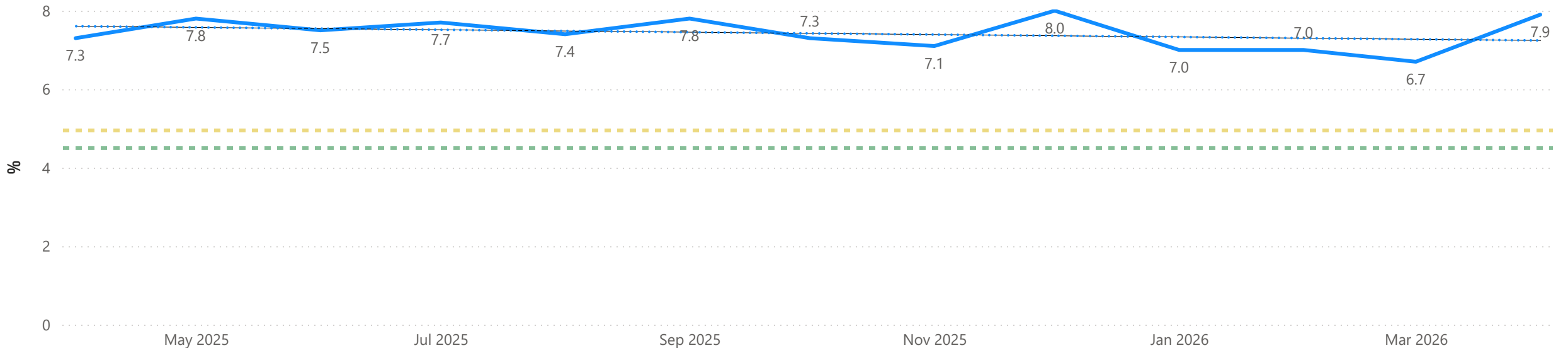
The total time, in hours, that 9 out of 10 patients spent waiting for their first assessment by a doctor or nurse practitioner in the emergency department (ED), calculated as the total time elapsed from triage to time of initial assessment

Data Source

National Ambulatory Care Reporting System (NACRS)



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	7.3	7.8	7.5	7.7	7.4	7.8	7.3	7.1	8.0	7.0	7.0	6.7
2026/2027	7.9											

Urgent Provider Initial Assessment Time, hours, 90th percentile



Description

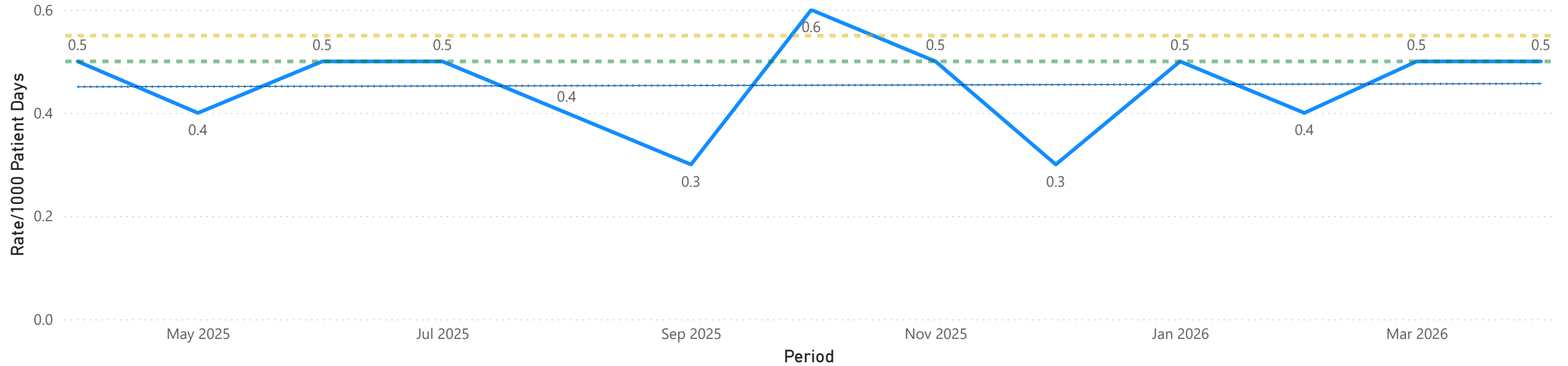
In total time, in hours, that 9 out of 10 CTAS 1 patients spent waiting for their first assessment by a doctor or nurse practitioner in the emergency department (ED), calculated as the total time elapsed from triage to time of initial assessment.

Data Source

National Ambulatory Care Reporting System (NACRS)



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	0.5	0.4	0.5	0.5	0.4	0.3	0.6	0.5	0.3	0.5	0.4	0.5
2026/2027	0.5											

Hip Fracture Surgery within 48 Hours, %

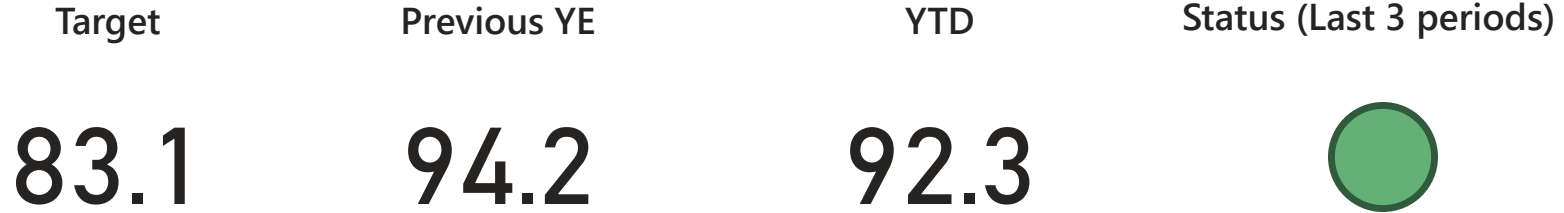


Description

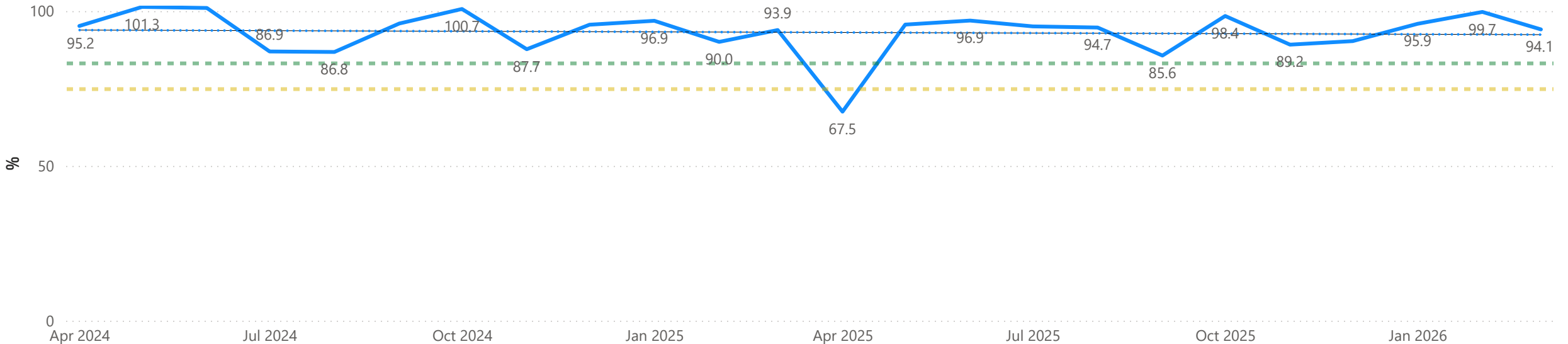
Risk-adjusted proportion of hip fractures that were surgically treated within 48 hours of initial admission (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

Data Source

Discharge Abstract Database (DAD)



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	95.2	101.3	101.0	86.9	86.8	96.0	100.7	87.7	95.6	96.9	90.0	93.9
2025/2026	67.5	95.6	96.9	95.1	94.7	85.6	98.4	89.2	90.3	95.9	99.7	94.1

Hospital Standardized Mortality Ratio (HSMR)



Description

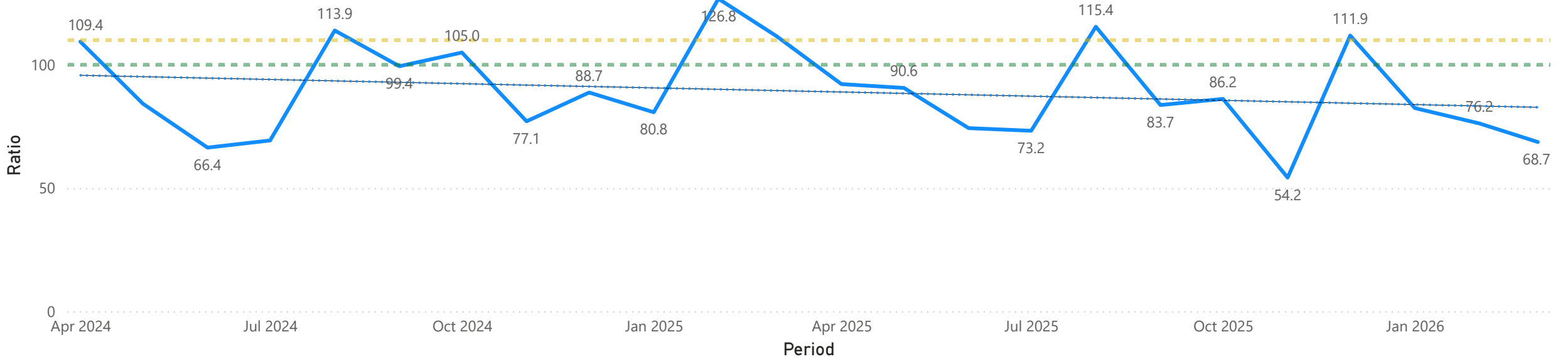
The ratio of the actual number of in-hospital deaths to the expected number of in-hospital deaths, for conditions accounting for about 80% of inpatient mortality

Data Source

Discharge Abstract Database (DAD)



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	109.4	84.2	66.4	69.3	113.9	99.4	105.0	77.1	88.7	80.8	126.8	111.5
2025/2026	92.2	90.6	74.3	73.2	115.4	83.7	86.2	54.2	111.9	82.4	76.2	68.7

In-Hospital Sepsis



Description

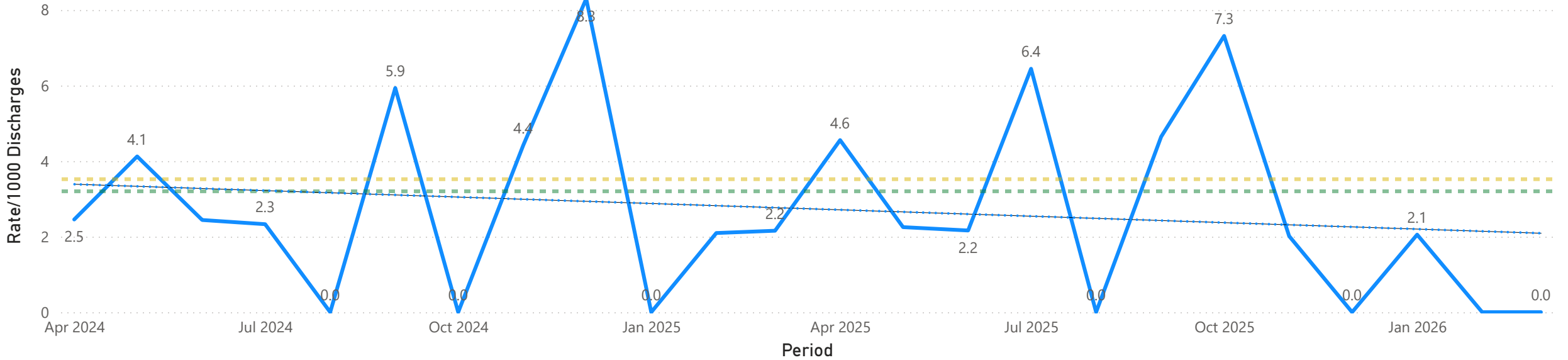
Risk-adjusted rate of sepsis that is identified after admission, per 1,000 discharges (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

Data Source

Discharge Abstract Database (DAD)



Trend



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

Long Waiters Waiting for Surgical Procedures



Description

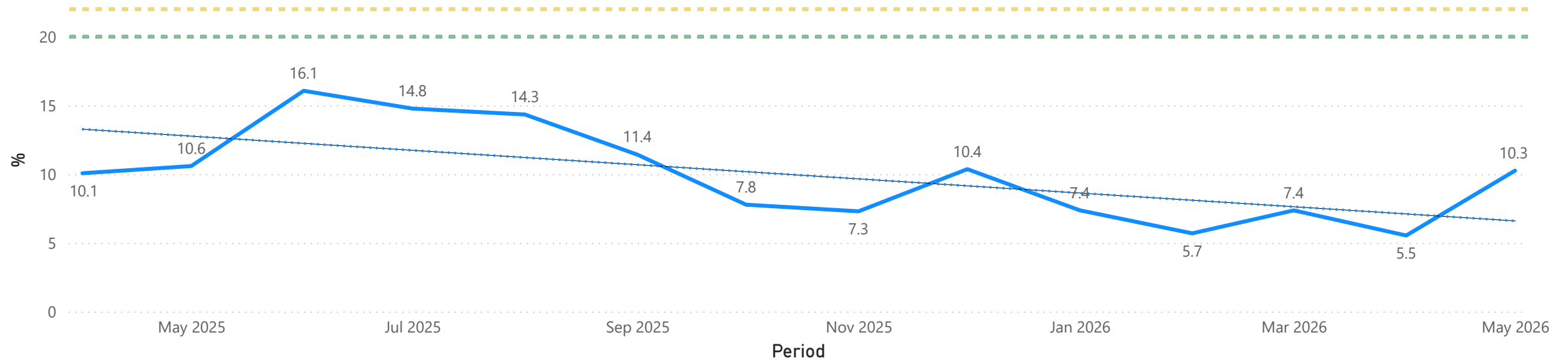
This indicator measures the percentage of patients waiting for a surgical procedure whose wait has exceeded the associated Priority Level Access Target (excludes DART days)

Data Source

WTIS



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	10.1	10.6	16.1	14.8	14.3	11.4	7.8	7.3	10.4	7.4	5.7	7.4
2026/2027	5.5	10.3										

Low-Risk Caesarean Section Rate



Description

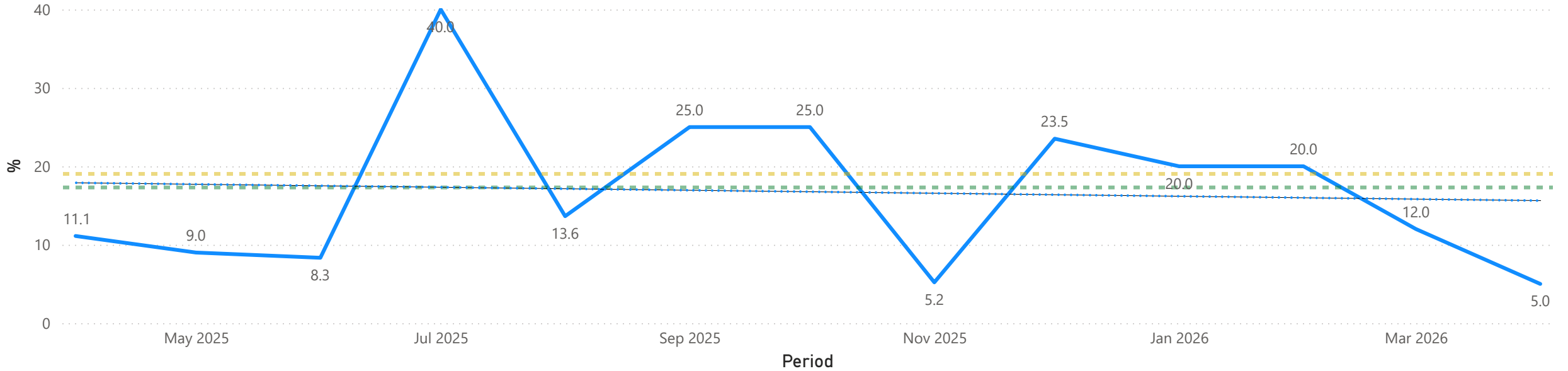
This indicator measures the rate of deliveries via Caesarean section among singleton term cephalic pregnancies for low-risk nulliparous women in spontaneous labour

Data Source

Discharge Abstract Database (DAD)

Target	Previous YE	YTD	Status (Last 3 periods)
17.3	20.9	5.0	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	11.1	9.0	8.3	40.0	13.6	25.0	25.0	5.2	23.5	20.0	20.0	12.0
2026/2027	5.0											

Medication Reconciliation




Admission

Description

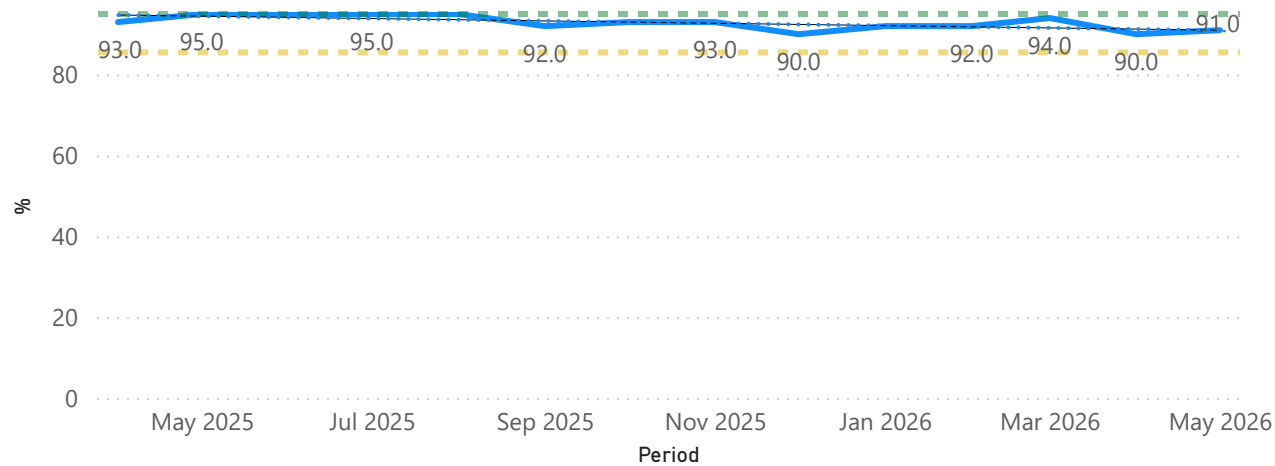
The total number of patients who were discharged who had a Best Possible Medication History (BPMH) completed divided by the total number of patients who were discharged home

Data Source

Meditech Pharmacy
Patient Profile

Target	Previous YE	YTD	Status (Last 3 periods)
95	93	91	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	93.0	95.0	95.0	95.0	95.0	92.0	93.0	93.0	90.0	92.0	92.0	94.0
2026/2027	90.0	91.0										


Discharge

Description

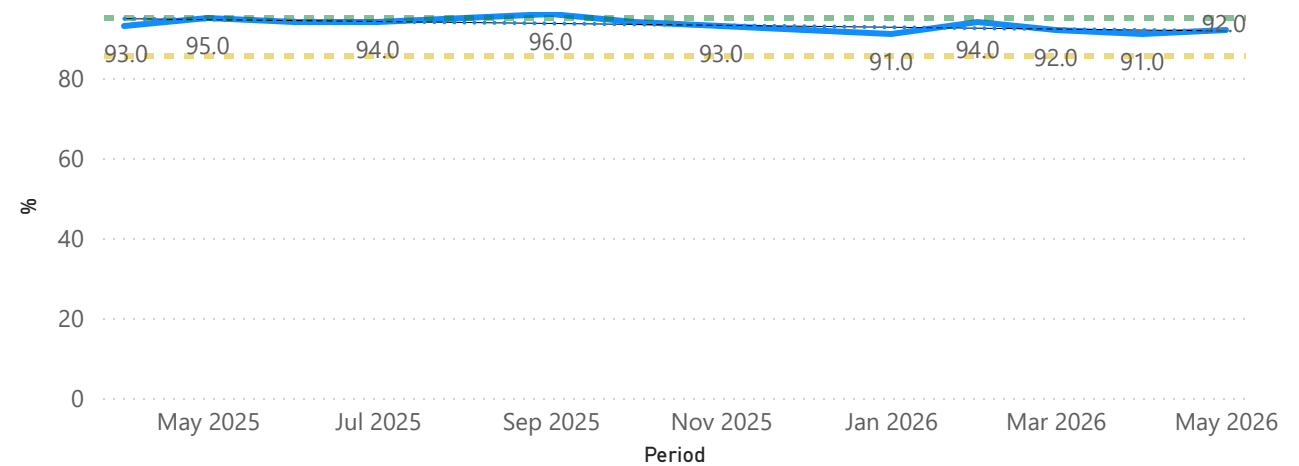
The percentage of Yes responses to the question "Was the CMH community pharmacy prescription completed?" for all inpatient locations participating in medication reconciliation at discharge

Data Source

Meditech

Target	Previous YE	YTD	Status (Last 3 periods)
95	94	91.5	

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	93.0	95.0	94.0	94.0	95.0	96.0	94.0	93.0	92.0	91.0	94.0	92.0
2026/2027	91.0	92.0										

Obstetric Trauma (with Instrument)



Description

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

Data Source

Discharge Abstract Database (DAD)

Target

14.4

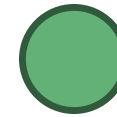
Previous YE

21.2

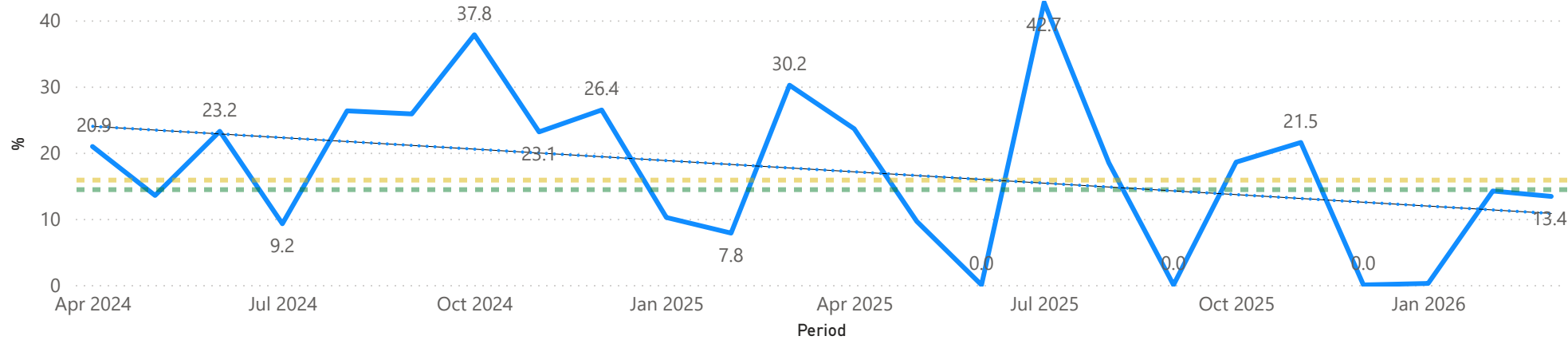
YTD

13.5

Status (Last 3 periods)



Trend



Month	Observed
Mar-26	2.00
Feb-26	3.00
Jan-26	1.00
Dec-25	0.00
Nov-25	3.00
Oct-25	2.00
Sep-25	0.00
Aug-25	4.00
Jul-25	4.00
Jun-25	0.00
May-25	1.00

Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	20.9	13.5	23.2	9.2	26.3	25.8	37.8	23.1	26.4	10.2	7.8	30.2
2025/2026	23.6	9.6	0.0	42.7	18.5	0.0	18.6	21.5	0.0	0.2	14.2	13.4

Patient Safety Event - Falls with Harm Rate



Description

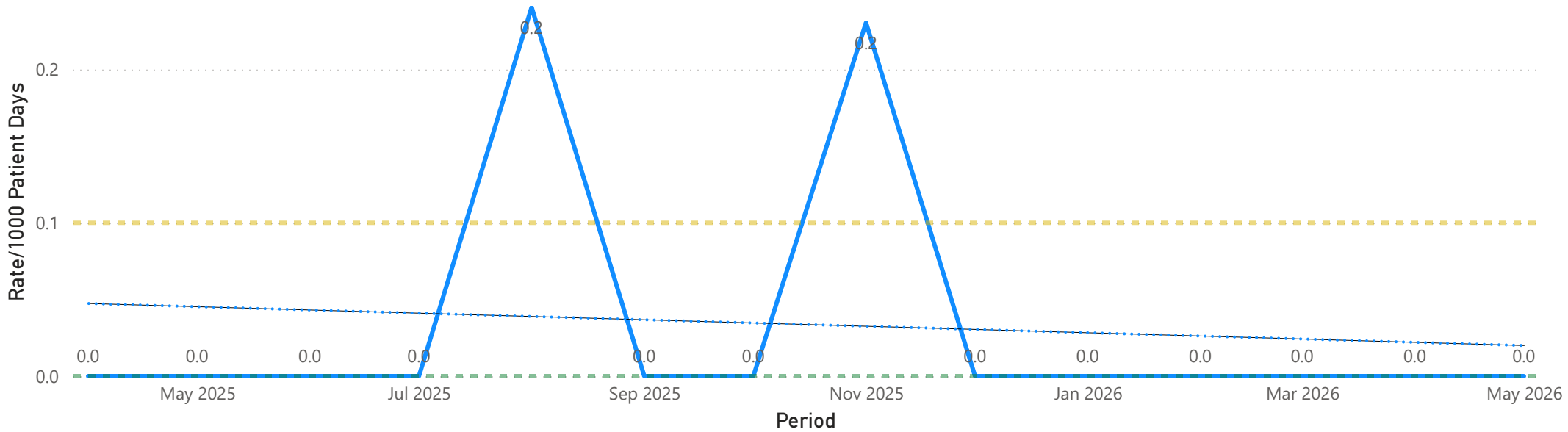
The number of falls with harm per 1,000 inpatient days. This includes events where after review, the severity is deemed to have incurred moderate or severe harm, or a critical incident involving death.

Data Source

ReportLink, Meditech



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.2	0.0	0.0	0.0	0.0
2026/2027	0.0	0.0										

Patient Safety Event - Medication Events with Harm Rate



Description

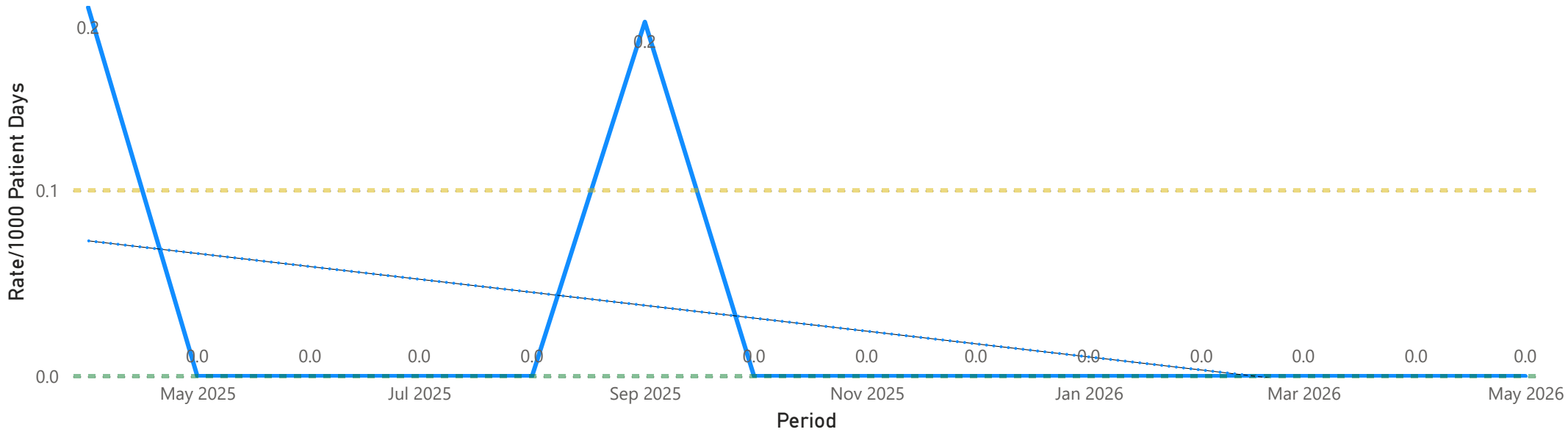
The number of medication events with harm per 1,000 inpatient days. This includes events where after review, the severity is deemed to have incurred moderate or severe harm, or a critical incident involving death.

Data Source

ReportLink, Meditech

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

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	0.2	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0
2026/2027	0.0	0.0										



Post-Construction Operating Plan (PCOP) Revenue



Description

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

Data Source

Discharge Abstract Database, National Ambulatory Care Reporting System, Meditech

Monthly Target

746.3K

YTD Target

746.3K

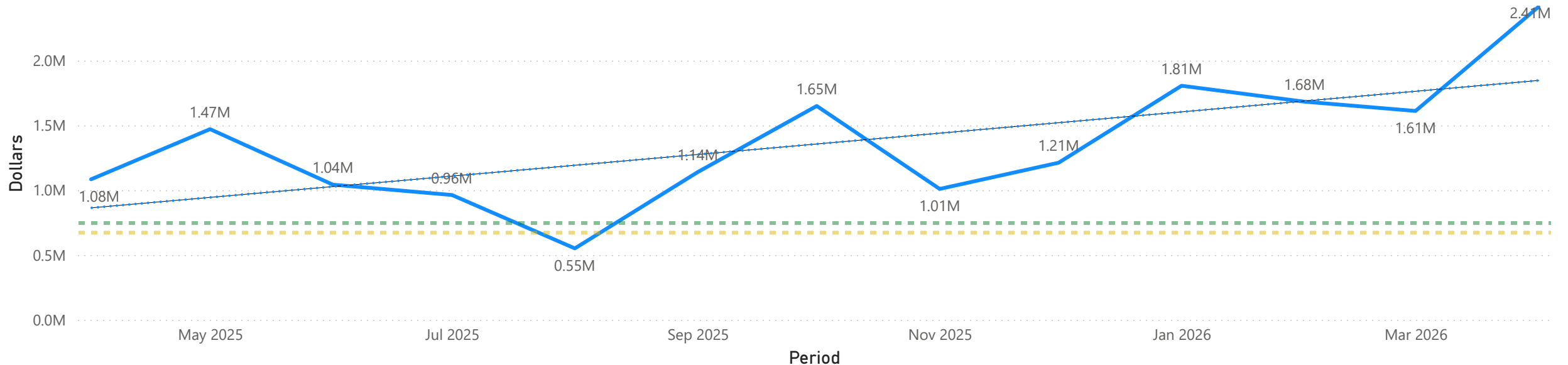
YTD

2.41M

Status (Last 3 periods)



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	1,083,669	1,470,565	1,042,128	962,599	550,654	1,139,702	1,649,398	1,009,308	1,211,689	1,805,534	1,682,466	1,611,008
2026/2027	2,413,608											



Quality Based Procedure (QBP) Revenue



Description

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

Data Source

Discharge Abstract Database, National Ambulatory Care Reporting System

Monthly Target

2.2M

YTD Target

2.2M

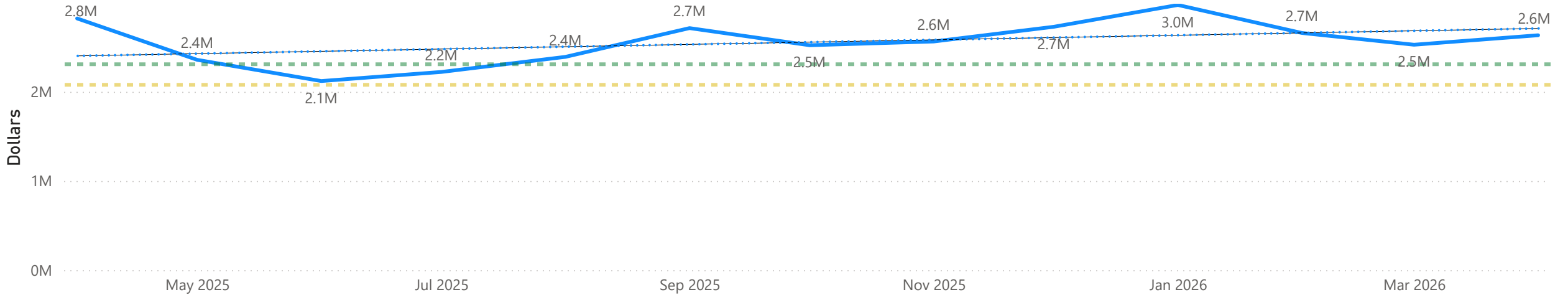
YTD

2.63M

Status (Last 3 periods)



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	2,821,780	2,357,760	2,119,923	2,221,794	2,391,002	2,713,363	2,521,351	2,563,415	2,728,391	2,972,779	2,658,835	2,527,071
2026/2027	2,633,326											

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



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

MEMORANDUM

TO: Board of Directors, Cambridge Memorial Hospital

DATE: May 29, 2026

REPORTING PERIOD: May 30, 2026 to June 19, 2026

FROM: Patrick Gaskin
President and CEO

RE: CEO Certificate of Compliance

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

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

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

Exceptions: NIL

A handwritten signature in black ink, appearing to read "Patrick Gaskin", with a horizontal line extending to the right.

Patrick Gaskin
President and CEO



Accessibility Plan

2025-26 Status Update

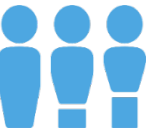
Liane Barefoot – Director, Patient Experience, Risk & Quality | Chief Privacy Officer

Stephanie Fitzgerald – Administrative Assistant | Chair, CMH Accessibility Advisory Committee



CMH

CAMBRIDGE
MEMORIAL
HOSPITAL



Plan Overview & Priority Themes

5-Year Strategic Goal – Advance Health Equity

By 2028, CMH will establish a fully inclusive hospital environment by embedding accessibility across physical infrastructure, communications, and workforce practices, all strengthened through community partnerships.

01

Physical Environment

Include end-user input in design phases; ensure renos and construction meet AODA standards.

02

Information & Communications

Ensure all promotional materials and digital presence meet AODA standards while strengthening belonging.

03

Training

Provide access to AODA-compliant programming with additional CMH-specific content.

04

Employment

Embed inclusive HR practices through the employee life-cycle to attract and retain staff.

05

Community Engagement

Cultivate synergistic community partnerships that mutually benefit patients, visitors and staff.

Priority Theme 1: Physical Environment



Key Objectives:

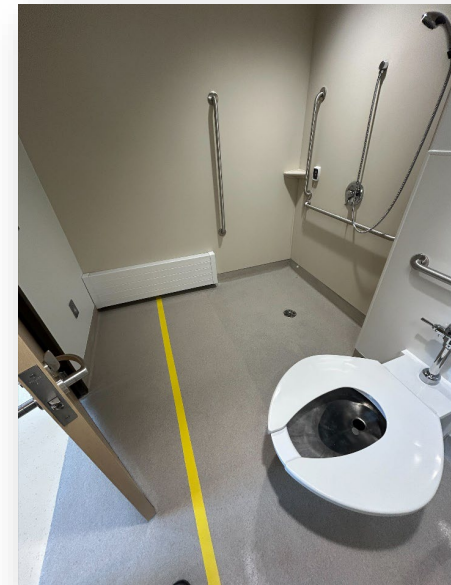
- Consolidate all inpatient units within A and B Wings
- Advance Master Plan development
- Enhance accessible parking infrastructure

Look Ahead

- Master Plan under development
- Lot 2 parking reconfiguration will consider feedback from community members on Accessible parking options (stall location, number of accessible spots & kiosk location)

Success Measures

- Completed B-Wing shower remediation – all inpatient care is now consolidated in A & B Wings where every room is equipped with an accessible washroom & overbed lift
- Conducted parking consultations with Patient & Family Advisory Council and Accessibility Committee followed by a parking lot space audit with two community members (May 2026) who are both in wheelchairs
- Installed 4-season Indigenous artwork and feature tile for Eagle feather enhancing sense of belonging & welcoming
- MH spaces & quiet room in Emergency department renovated to enhance safety and calming features (murals)



Priority Theme 2: Information & Communications

Key Objectives:

- Deploy language translation tablets
- Develop Inclusive Communications Guide
- Ensure accessible promotional materials

Look Ahead

- Analyze first year of sociodemographic data to inform equity priorities
- Finalize, publish, and operationalize the Inclusive Communications Guide
- Implement updated Territorial acknowledgement
- Audit adherence to corporate Clean Wall policy



Success Measures

- Successfully transitioned language translation tablet vendors to Language Interpretation Network On-the-Go (CMH-branded as LINGO)
- Launched corporate Clean Wall policy with resounding support from Accessibility Committee and Patient and Family Advisory Council members



Priority Theme 3: Training

Key Objectives:

- Focus of staff training moving beyond physical space to how patients, public & staff experience the space

Look Ahead – Linkages


- DEI Corporate Plan and associated milestones
- Indigenous ReconcilACTION Corporate Plan and associated milestones
- Investigate opportunity of Sensory Kits

September 2025 National Day for Truth & Reconciliation L.E.A.R.N Challenge

WEEK 1	L LISTEN to a Lunch & Learn or Podcast	Option 1: Attend the Quarterly Lunch & Learn on September 16, 12:30 to 1:30 PM, Hybrid - in Person at MEC / Virtual via Microsoft Teams Option 2: Nish Vibes Podcast (58:45) YouTube
WEEK 2	E EXPLORE a Video	Watch Nanawayut: We are all one. (4:20) CBC YouTube Video Option 1: Attend a Live Virtual Group Screening (20 min) on Sept 10th or 11th Option 2: Watch it in your own time!
WEEK 3	A ADD follow Indigenous Artists	Option 1: Attend the CMH Indigenous Art Installation and meet the artists: Luke Swinson & Alanah Jewell Option 2: Follow the artists on Instagram: @LukSwinsonArt & @MorningStarDesigns
WEEK 4	R READ an Article or Report	Option 1: Attend a Live Group Screening of the National Centre for Truth & Reconciliation (NCTR) Lunch & Learn Series (Sept 27-30) Option 2: Read the TRC's Calls to Action for Health (18-24)
ALL MONTH	N NOTICE and reflect on your learning each week	For CMH staff, physicians, and midwives: A QR Code will be shared at all events to share your reflections. You can also email your thoughts to indigenous@cmh.ca or indigenous@cmh.ca . You will be entered in the September Prize Draw each time you participate!

CAMBRIDGE MEMORIAL HOSPITAL

Scan here to learn more about what's happening at CMH this month!




2022-2027
Truth and ReconcilACTION Plan
Cambridge Memorial Hospital
Plan Owners:
Patrick Gaskin, President & CEO;
Mari Iromoto, VP People & Strategy and Executive Champion, DEI

Success Measures

- Developed and launched CMH-specific Accessibility Training module in April 2026 that exceeds AODA staff training requirements. Module is focused on legal concept of Duty to Accommodate, CMH specific physical environment features, and CMH specific aids/equipment.
- Multiple DEI lunch & learns offered to staff on Indigenous topics, Islamic History, Black History, Asian History & Pride. As staff continue to learn, the physical environment evolves (Indigenous art, pride cross-walk) & ultimately the organizational culture becomes more welcoming for patients, visitors & colleagues

Accessibility at CMH



Priority Theme 4: Employment

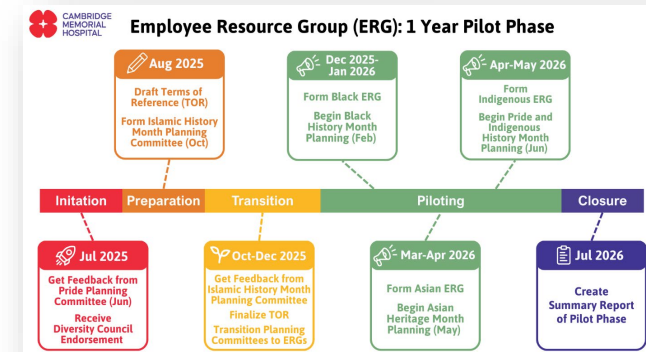


Key Objectives:

- Expanded Project SEARCH intern numbers for school year 26-27
- Creating safe, welcoming spaces for staff to thrive

Look Ahead

- Finalize, publish, and operationalize the Inclusive Communications Guide
- Evaluate and refine Employee Resource Groups (ERGs)
- Evaluate current Inclusion Statement on job postings
- Exploring options for staff returning from mat leave re: breast pumping
- Exploring break space options to meet the varying needs of staff



Success Measures

- Completed second successful year of Project SEARCH, generating significant Joy at Work impact for direct mentors and adjacent teams
- Launched pilot Employee Resource Groups (ERGs) aimed at increasing the sense of belonging for staff
- Expanded Accessibility Committee membership to include Health, Safety, Wellness, and DEI/Indigenous Specialist roles
- Draft Inclusive Communications guide developed & being circulated for input internally, including PFAC & Accessibility Committee

Priority Theme 5: Community Engagement

Key Objectives:

- Actively seek out input from people with lived experiences
- Purposeful linkages

Look Ahead

- Enhanced partnership opportunities with City of Cambridge, Independent Living Waterloo Region and Region of Waterloo
- Evaluate possibility of Year 2 Discovery Day



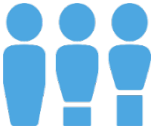
HIDDEN disabilities 

Success Measures

- CMH & Project SEARCH shared a booth at the 2026 National AccessAbility Trade Show on June 1 & 2 at the Ken Seiling Museum
- Inaugural Discovery Day – day of learning for students from Catholic School board about hospital environment
- Established regular Accessibility Committee reporting cadence to Patient & Family Advisory Council (PFAC)
- Recruited a second community member to the Accessibility Committee, strengthening external representation
- City of Cambridge councilor presented the Sunflower Project to the Accessibility Committee, seeking and receiving conceptual endorsement (<https://hdsunflower.com/ca/>) from CMH



Accessibility Plan: 2025/26 Key Performance Measures



Lead(s):
Liane Barefoot
Stephanie Fitzgerald

Exec Sponsor(s):
Mari Iromoto

Overall Status

Updated: June 2026

#	Key Performance Measure	Target	Actual	Comments
1	Physical Environment		Green	<ul style="list-style-type: none"> B-Wing completed including shower remediation Input into parking Enhanced cultural artwork
2	Information & Communications		Green	<ul style="list-style-type: none"> New translation tablets Clean wall policy
3	Training		Green	<ul style="list-style-type: none"> CMH specific Accessibility training module developed & launched DEI & Indigenous specific training – sense of belonging
4	Employment		Green	<ul style="list-style-type: none"> Project SEARCH Employee Resource Groups
5	Community Engagement		Green	<ul style="list-style-type: none"> Catholic School Board, City of Cambridge, Independent Living Waterloo Region

Overall Status Legend:

- Achieved or forecasted to achieve >50% of KPMs
- Achieved or forecasted to achieve 25%–50% of KPMs
- Achieved or forecasted to achieve <25% of KPMs



Board Chair's Report



Board Chair's Report – May & June 2026

Message From the Chair



As we come to our final meeting before summer—and my final meeting as Chair—I find myself reflecting on the privilege it has been to serve alongside such a committed and thoughtful group of Directors.

This past year has been another important chapter for CMH. The progress we have made together is a direct result of your insight, your engagement at the Board table, and your genuine commitment to the organization and the community we serve.

I want to sincerely thank each of you for the time, energy, and leadership you have given throughout my time as Chair. You have consistently demonstrated CMH's values—Caring, Collaboration, Accountability, Innovation, and Respect—not just in principle, but in how you show up, ask questions, and support one another.

While I will be stepping away from this role, I do so with great confidence in the strength of this Board and in the continued momentum of the organization. CMH is well positioned for the future, and that is in no small part because of your stewardship.

Thank you for your partnership, your support, and your unwavering dedication. It has truly been an honour.

Board Chair's Report – May & June 2026

Territorial Acknowledgement Circle Discussion

On May 19, Jayne Herring and Diane Wilkinson joined CMH in a discussion led by Clarence Cachagee from Crow Shield Lodge to reflect on CMH's territorial acknowledgement and explore how CMH might refresh it to deepen meaning, connection, and relevance in its daily practice. It was a collaborative space to share perspectives and consider how personal reflections can be woven into future acknowledgements.



Maintenance Huddle

On June 8, 2026 Bill Conway and Jayne Herring joined our CMH Maintenance & Facilities team at their daily huddle.

"Appreciated the warm welcome along with the explanation and insight the team provided in explaining the information they cover at the daily maintenance huddle, it provided me a view of the many skills by staff and the various areas of the facility they are looking after each day" Bill



"I was really pleased to be able to spend time with the Maintenance Dept at their huddle and seeing firsthand what it takes to keep the hospital running safely and efficiently. I was also very impressed by the sense of team and the skills and qualifications held by the various staff members in attendance." Jayne



Grand Rounds – Medical Aid in Dying – What's the Big Deal?

On May 28, Jayne Herring, Margaret McKinnon, and Lynn Woeller started their day early and joined Grand Rounds focused on Medical Aid in Dying, presented by Dr. Arthur Eugenio, Dr. Jenny Legassie, and Dr. Anjali Sharma. The session provided a valuable learning opportunity, exploring current legislation and college/CPMA requirements, understanding of the basics of MAID assessment, exploring responsibilities as a care provider and as a conscientious objector, and the challenges presented by pending changes in legislation.



Founders & Physicians Dinner

On May 28, 2026 Sara Alvarado joined CMH at the Founders & Physicians event hosted by Communitech. The event was part of a series of fireside chats that is developed to bring together medical doctors and tech entrepreneurs from Waterloo Region and beyond. It is an opportunity to explore big ideas and problems related to healthcare and building strong communities. It is also a space for founders and doctors to learn from each other and forge a better future for the community.



Board Chair's Report – May & June 2026

Sara Alvarado's 4th Walk to Paris

On June 14, Lynn Woeller and CMH Past Chair Nicola Melchers, joined Sara on her 4th annual Walk to Paris Fundraiser to support the CMH Foundation. The event raised over \$12,000 and welcomed over 20 participants. Thank you to all that joined, and donated and a special thank you to Sara for her leadership.



Board Chair's Report – May & June 2026

CMH Annual Staff BBQ

On June 11, 2026, a spirited group of Directors braved the summer heat to celebrate alongside CMH at their annual Staff BBQ and career achievement event – and what a day it was! The energy was contagious as staff kicked off some friendly World Cup-themed activities, cheering each other on and soaking up the festive, team-spirited atmosphere. Throughout the afternoon, guests had the chance to connect with members of our Diversity Team, Project Quantum Team, and SOHAC, learning more about the great work happening across the organization. To top it all off, everyone gathered for a delicious meal generously served up by the Rapid Relief Team, capping off a memorable celebration of community, recognition, and shared accomplishment.



CMHVA Annual Meeting

On June 18, 2026, Diane Wilkinson and Jayne Herring attended the 135th Annual CMHVA Meeting. The evening featured remarks from CEO Patrick Gaskin, Diane Wilkinson on behalf of the CMH Board, and Lisa Short on behalf of the CMH Foundation, followed by guest speaker Lisa Hood of the YMCA of Three Rivers. Lisa offered a thoughtful reflection on the idea of the "third space" – the welcoming places beyond home (the first space) and work or school (the second space) where people come together to build community, socialize, and unwind. She emphasized that these informal gathering spots are essential to fostering connection, civic life, and a true sense of belonging, drawing on socio-demographic insights about Cambridge and the Waterloo Region to show how the Y's programs and services help meet those needs. The evening closed on a celebratory note, with awards and certificates presented in recognition of our volunteers' dedication and service.



BRIEFING NOTE

Date: June 17, 2026
Issue: Financial Statements – May 2026
Prepared for: Resources Committee
Purpose: Approval Discussion Information Seeking Direction
Prepared by: Spencer Ogston, Senior Financial Analyst
 Michelle D’Souza, Interim Manager, Finance
Approved by: Janet Short, Senior Financial Advisor, Finance
 Trevor Clark, VP Finance & Corporate Services, CFO

Attachments/Related Documents:
Financial Statements – May 2026

Alignment with 2026/27 CMH Priorities:

2022-2027 Strategic Plan No <input type="checkbox"/>	2026/27 CMH Priorities No <input type="checkbox"/>	2026/27 Integrated Risk Management Priorities No <input type="checkbox"/>
<input type="checkbox"/> Elevate Partnerships in Care	<input type="checkbox"/> Improve Patient Flow (CBD, PIA, ED Admits)	<input type="checkbox"/> Organizational Flow
<input checked="" type="checkbox"/> Reimagine Community Health	<input type="checkbox"/> Prepare for Digital Health Transformation	<input checked="" type="checkbox"/> Project Quantum
<input type="checkbox"/> Increase Joy in Work	<input type="checkbox"/> Increase Staff Engagement Through Improved Staffing (Med, ICU, ED, Physicians)	<input type="checkbox"/> Management/Medical Staff Partnership
<input checked="" type="checkbox"/> Sustain Financial Health	<input checked="" type="checkbox"/> Achieve a Balanced 2026/27 Operating Position	<input type="checkbox"/> Financial Sustainability
<input type="checkbox"/> Advance Health Equity	<input type="checkbox"/> Embrace Diversity, Build a Culture of Inclusion	<input type="checkbox"/> Change Management

Alignment with 2026/27 CMH Corporate Plans: Multi-Year Financial Plan

Recommendation/Motion
Board

That, the CMH Board of Directors accepts the May 2026 financial statements as presented by management and upon recommendation of the Resources Committee at its meeting of June 22, 2026

Resource Committee

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

Executive Summary

Cambridge Memorial Hospital (CMH) is in a \$685K net loss position at the end of May 2026. This is primarily due to higher costs than budget for other supplies and expenses (\$539K), driven by purchases of IT equipment for the Health Information Systems (HIS) project which were included in the 2025/26 budget but were received in 2026/27.

Analysis

CMH is in a \$685K year-to-date net loss position at the end of May 2026 after building amortization and related capital grants. Actual results are \$375K unfavourable to budget.

The unfavourable variance is driven by:

- \$1.1M in minor equipment expenses driven by purchasing equipment for the HIS project and Information Technology department. This was budgeted in the prior year.
- \$521K in preferred accommodation revenues, primarily due to revenue being below the original budget assumption. In the planned budget revision, following receipt of the final 2026/27 funding letters, the hospital will reduce budgeted revenue by \$3.0M and reduce contingency by an equivalent amount. This adjustment will eliminate the unfavourable variance.
- \$285K variance in salaries & wages and benefits, primarily due to higher one-to-one care, and sick time. Overtime was also a small contributor to the unfavourable variance.
- \$276K in contracted expenses driven by procedures contracting out to Clearvision (cataract surgery) and Tri-City Endo (Endoscopy) which were expected to be discontinued in 2026/27.

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

- \$1.0M in budgeted contingency.
- \$585K in QBP revenue due to increased hip, knee, and shoulder (“joint”) volumes and cancer care volumes.

Revenue Highlights

- QBPs are \$585K favourable to budget year to date due to higher bundled care and surgical volumes (\$321K) and cancer care volumes (\$305K). This is partially offset by a negative variance in non-elective QBP volumes (\$42K).
- The hospital has budgeted \$23.7M in PCOP funding for 2026-27, representing 100% of the total available allocation. Recognition of this funding is contingent upon the achievement of volume targets. There is no year-to-date variance, as revenue is being recognized in accordance with budget. Actual PCOP procedure volumes completed to date have exceeded budgeted levels.
- Billable patient services is \$369K unfavourable to budget year to date. The variance is driven by a negative variance in preferred accommodation (\$521K). Due to the target, which was established regionally, being deemed non-achievable, contingency budget will be used to reduce the annual revenue target by \$3M. This negative variance is partially offset by a positive variance in non-resident of Canada billings (\$139K).

Expense Highlights

- Salaries and wages are \$277K unfavourable to budget year to date. This is mainly due to higher one-to-one care (\$106K), sick time (\$70K), and overtime (\$38K). A working group continues to meet on a bi-weekly basis to monitor the overtime spend rate and to assess opportunities for reduction.
- Employee benefits are \$8K 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 \$63K favourable year to date. This is primarily driven by savings from oncologist vacancies.
- Medical and surgical supplies costs are \$63K unfavourable to budget year to date. This is driven by a negative variance in Endoscopy (\$54K) due to high patient volumes.
- Drug expenses are \$73K unfavourable to budget year to date. The variance is primarily due to higher cost of drugs for the Oncology Program (\$42K). 98% of oncology drug costs are reimbursed by Ontario Health.
- Other supplies and expenses are \$0.5M unfavourable to budget year to date. The variance is primarily due to minor equipment costs (\$1.1M) to purchase equipment for the HIS program and the Information Technology department. These costs were budgeted in last fiscal year but purchasing and delivery was not completed until May 2026. There is also an unfavourable budget in contracted expenses (\$0.3M) driven by cases contracted out to Clearvision and Tri-City Endo for cataract surgeries and endoscopies respectively. CMH removed budget for both Clearvision and Tri-City Endo

as it was initially planned to complete all cataract and endoscopy cases in house. However, some cases are still being contracted out. Further review of use of these services is in progress. These negative variances are partially offset by budgeted contingency (\$1.0M).

- \$800K of expenses related to Project Quantum are included in the YTD financial statements. These costs include IT equipment for the HIS project that did not meet the threshold for capitalization.

Balance Sheet and Statement of Cash

CMH's current cash position is \$76.2M, consisting of \$60.3M of unrestricted cash and \$15.9M of restricted cash. The working capital ratio is 1.48 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 May is \$30.5M, is summarized below:

	\$M
Unrestricted Bank Balance – May 31, 2026	60.3
Add: Other Current Assets	15.7
Less: Current Liabilities (\$3.8M due to MOH)	(51.5)
Subtotal - Net Current Assets	24.5
Add: Vacation Bank Accrual (consistent with MOH working capital calculation)	6.0
Working Capital Available – May 31, 2026	30.5
Add:	
CMHF & Third Party Funding for Approved Equipment	7.6
2026-27 Hospital Infrastructure Renewal Fund (Estimate)	0.5
Less:	
Outstanding Health Information System Commitments	(21.8)
Outstanding 2026-27 Capital Budget Commitments	(12.6)
Outstanding Approved POs	(13.2)
Forecast Unrestricted Working Capital - March 31, 2027	(9.0)
Anticipated Debt Draw - 2026-27	20.0
Working Capital Available – March 31, 2027	11.0

A cashflow deficit is forecast for the end of March 31, 2027, which will require debt financing. The maximum debt anticipated is \$20M. Management will continue to monitor cashflow to ensure there is adequate cash on hand, while also minimizing the extent of debt required.

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

Confidential
(Expressed in Thousands of Dollars)

Month of May 2026					Year to Date					2026-27	2025-26 Prior Year Actuals									
Actual	Budget	Variance	% Variance		YTD Actual	YTD Budget	YTD Variance	% Variance	Budget	May 2025	2025-26 YE									
Revenue:																				
MOH Funding																				
\$	10,958	\$	10,940	\$	18	0%	MOH - Base	\$	21,545	\$	21,527	\$	18	0%	\$	128,808	\$	10,646	\$	126,166
	2,596		2,439		157	6%	MOH - Quality Based Procedures		5,262		4,677		585	13%		27,698		2,428		30,484
	1,842		1,980		(138)	(7%)	MOH - Post Construction Operating Plan		3,956		3,956		-	0%		23,387		2,384		15,107
	800		771		29	4%	MOH - One Time / Other		1,639		1,516		123	8%		11,524		781		32,859
	16,196		16,130		66	0%	Total MOH Funding		32,402		31,676		726	2%		191,417		16,239		204,616
	1,705		1,857		(152)	(8%)	Billable Patient Services		3,285		3,654		(369)	(10%)		21,840		1,453		17,913
	1,734		1,750		(16)	(1%)	Recoveries and Other Revenue		3,510		3,444		66	2%		22,543		2,027		23,232
	270		290		(20)	(7%)	Amortization of Deferred Equipment Capital Grants		540		571		(31)	(5%)		3,417		264		3,112
	370		416		(46)	(11%)	MOH Special Votes Revenue		771		818		(47)	(6%)		4,922		374		5,063
	20,275		20,443		(168)	(1%)	Total Revenue		40,508		40,163		345	1%		244,139		20,357		253,936
Operating Expenses:																				
	9,341		9,291		(50)	(1%)	Salaries & Wages		18,597		18,320		(277)	(2%)		111,097		9,239		109,037
	2,793		2,788		(5)	(0%)	Employee Benefits		5,386		5,378		(8)	(0%)		30,825		2,631		29,899
	2,018		2,014		(4)	(0%)	Medical Remuneration		3,910		3,973		63	2%		23,720		1,869		24,519
	1,310		1,278		(32)	(3%)	Medical & Surgical Supplies		2,578		2,515		(63)	(3%)		15,051		1,417		16,751
	1,208		1,266		58	5%	Drug Expense		2,564		2,491		(73)	(3%)		14,903		1,163		15,080
	3,287		2,728		(559)	(20%)	Other Supplies & Expenses		5,990		5,451		(539)	(10%)		34,483		2,129		33,615
	468		583		115	20%	Equipment Depreciation		935		1,146		211	18%		6,859		453		5,389
	389		416		27	6%	MOH Special Votes Expense		813		818		5	1%		4,922		457		5,222
	20,814		20,364		(450)	(2%)	Total Operating Expenses		40,773		40,092		(681)	(2%)		241,860		19,358		239,512
	(539)		79		(618)	(782%)	MOH Surplus / (Deficit)		(265)		71		(336)	(473%)		2,279		999		14,424
	(831)		(869)		38	(4%)	Building Depreciation		(1,661)		(1,710)		49	(3%)		(10,231)		(809)		(9,772)
	621		675		(54)	(8%)	Amortization of Deferred Building Capital Grants		1,241		1,329		(88)	(7%)		7,952		621		7,451
\$	(749)	\$	(115)	\$	(634)		Net Surplus / (Deficit)	\$	(685)	\$	(310)	\$	(375)		\$	-	\$	811	\$	12,103

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

(Expressed in Thousands of Dollars)

	May 2026	March 2026
ASSETS		
Current Assets		
Cash and Short-term Investments	\$ 60,281	\$ 64,648
Due from Ministry of Health / Ontario Health	3,536	6,254
Other Receivables	6,809	5,676
Inventories	2,982	2,733
Prepaid Expenses	2,365	2,605
	75,973	81,916
Non-Current Assets		
Cash and Investments Restricted - Capital	15,873	15,811
Due from Ministry of Health - Capital Redevelopment	8,199	8,199
Due from CMH Foundation	103	45
Endowment and Special Purpose Fund Cash & Investments	226	225
Capital Assets	304,912	303,988
Total Assets	\$ 405,286	\$ 410,184
LIABILITIES & NET ASSETS		
Current Liabilities		
Due to Ministry of Health / Ontario Health	3,778	3,778
Accounts Payable and Accrued Liabilities	38,535	41,071
Deferred Revenue	9,161	9,161
	51,474	54,010
Long Term Liabilities		
Capital Redevelopment Construction Payable	317	317
Employee Future Benefits	3,907	3,864
Deferred Capital Grants and Donations	271,118	272,838
Asset Retirement Obligation	3,130	3,130
	278,472	280,149
Net Assets:		
Unrestricted	20,594	24,043
Externally Restricted Special Purpose Funds	226	225
Invested in Capital Assets	54,520	51,757
	75,340	76,025
Total Liabilities and Net Assets	\$ 405,286	\$ 410,184
Working Capital Balance	24,499	27,906
Current Ratio	1.48	1.52

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

(Expressed in Thousands of Dollars)

	May 2026	March 2025
Cash Provided By (Used In) Operations:		
Excess (Deficiency) of Revenue over Expenses	\$ (685)	\$ 12,104
Items not Involving Cash:		
Amortization of Capital Assets	2,597	15,161
Amortization of Deferred Grants and Donations	(1,781)	(10,563)
Change in Non-Cash Operating Working Capital	(1,023)	(14,419)
Change in Employee Future Benefits	43	(222)
	(849)	2,061
Investing:		
Acquisition of Capital Assets & Capital Redevelopment Project	(3,520)	(16,739)
Capital Redevelopment Project Construction Payable	-	149
	(3,520)	(16,590)
Financing:		
Change in Non-Cash Capital Accounts Receivable	-	(508)
Capital Donations and Grants & Capital Redevelopment Project	61	7,703
	61	7,195
Increase (Decrease) In Cash for the Period	(4,308)	(7,333)
Cash & Investments - Beginning of Year	80,462	87,795
Cash & Investments - End Of Period	\$ 76,154	\$ 80,462
Cash & Investments Consist of:		
Unrestricted Endowment and Special Purpose Investments	30	30
Cash & Investments Operating	60,251	64,621
Cash & Investments Restricted	15,873	15,811
Total	\$ 76,154	\$ 80,462

BRIEFING NOTE

Date: June 19, 2026
Issue: Quality Committee Report to the Board of Directors, June 17, 2026- *OPEN*
Prepared for: Board of Directors
Purpose: Approval Discussion Information Seeking Direction
Prepared by: Jennifer Morgan, Administrative Assistant to Clinical Programs
Approved by: William Conway, Quality Committee Chair

Attachments/Related Documents: None

A meeting of the Quality Committee took place on Wednesday, June 17, 2026 at 0700h.

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

Regrets: Dr. I. Isupov, P. Brasil, K. Baldock

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

Guests: Dr. J. Bourgeois, Dr. B. Courteau, K. Abogadil

The Quality Committee completed its scheduled work for the June 17, 2026, reporting period in accordance with its terms of reference and workplan. Key matters reviewed, discussed, and advanced by the committee are summarized below for Board awareness.

Committee Matters – For information only

1. Program Presentations:

Diagnostic Imaging (includes Patient and Staff Stories): The Director, Laboratory Medicine, Diagnostic Imaging (DI) and Diagnostic Cardiology Services & Interim Director, Mental Health provided an overview of program performance, highlighting DI's critical role in supporting hospital-wide patient flow, including emergency department throughput, inpatient care, and timely discharge planning. While outpatient imaging remains the largest component of activity, there has been a notable shift toward increased emergency and inpatient demand, placing additional pressure on staffing, equipment, and operational capacity. Despite these pressures, radiologist turnaround times remain strong and are not contributing to delays in patient flow.

The presentation emphasized the importance of patient experience across the full diagnostic imaging journey. Overall patient satisfaction remains high, with positive feedback related to staff professionalism, communication, and compassionate care, as well as timely reporting. DI leadership reinforced that quality extends beyond technical performance to include coordination, communication, and a patient-centred approach to care delivery.

Strategically, the program continues to align with CMH priorities focused on improving access, enhancing specialized services, supporting patient flow, and strengthening regional partnerships. Key initiatives include expansion of imaging capacity, implementation of new technologies such as AI, and advancement of community-based services including e-referral and screening programs. The planned implementation of a new MRI machine in Fall 2026 is expected to further improve throughput, patient experience, and wait times.

Quality improvement efforts include the integration of Choosing Wisely clinical decision support into the Ocean e-referral platform to promote appropriate imaging at the point of ordering, as well as a targeted initiative to assess and improve CT head ordering practices through data-driven education and provider engagement. These initiatives aim to enhance appropriateness of care, reduce unnecessary testing, and support responsible resource utilization.

The Committee acknowledged the program's strong performance and effective collaborative leadership model, particularly the alignment between physician and administrative leadership, which supports ongoing operational performance and strategic advancement.

A Committee Member raised a question regarding radiologist staffing levels, noting that six radiologists appeared limited given the service operates 24/7. In response, DI leadership confirmed that the program has grown from three to six core radiologists, supplemented by shared nuclear medicine physicians. The current complement supports continuous coverage across all patient streams; however, the team acknowledged that additional resources will be required as volumes increase, particularly with the introduction of the new MRI. Despite the relatively small team, leadership emphasized their longstanding commitment to maintaining timely reporting, which continues to be achieved consistently.

Further discussion focused on the anticipated impact of the new MRI machine on wait times. DI leadership indicated that the new technology is expected to improve throughput, patient comfort, and operational efficiency. With two MRI units planned to run concurrently toward the latter part of the fiscal year, a reduction in wait times is expected, particularly in the final months of the year. Leadership noted that demonstrating improved performance will be important to support ongoing advocacy for sustained operating funding, with a goal of expanding MRI operating hours to better meet regional demand.

A Committee member questioned the apparent discrepancy between increased mammography volumes and decreased Ontario Breast Screening Program (OBSP) volumes following the lowering of the screening age. In response, it was explained that the policy change was implemented later in the year, resulting in only a partial-year impact with an initial ramp-up period. Prior to this, OBSP volumes had been declining, and the recent change is expected to increase volumes over time as awareness grows and referrals (both physician and self-referral) become more consistent. It was further noted that temporary downtime related to the installation of new equipment also affected volumes. Leadership emphasized that screening capacity must be carefully balanced with the ability to manage follow-up diagnostics, as increased screening leads to additional follow-up imaging and potential treatment pathways. Ensuring sufficient capacity for timely follow-up is critical to avoid delays in diagnosis and care.

Patient access and wayfinding were also discussed, particularly regarding after-hours entry for diagnostic imaging appointments. Concern was raised about vulnerable

patients arriving at closed entrances without access to a phone. DI leadership confirmed that appointment instructions are typically provided in advance; however, they acknowledged that additional on-site signage directing patients to appropriate entry points (e.g., emergency department access) would improve accessibility and reduce patient confusion. This was identified as an opportunity for improvement.

Finally, the discussion included recognition of the program's leadership model, with inquiry into the factors contributing to the effectiveness of the physician-administrative partnership. Leadership attributed their success to open communication, mutual respect, and a willingness to engage in ongoing dialogue and compromise. Both leaders emphasized the importance of understanding each other's perspectives and maintaining alignment in decision-making, which has enabled the team to advance initiatives collaboratively and sustain strong program performance.

(The program presentation is included in Package 2.)

- 2. Laboratory Medicine Program Quality, Performance, and Modernization Update):** The Committee received an overview of program performance, emphasizing its role as a critical clinical service supporting patient safety, diagnostic accuracy, and hospital flow. The program continues to demonstrate strong quality outcomes, including a high accreditation score, sustained performance in external proficiency testing, and positive patient feedback. Testing volumes remain high and continue to grow across multiple service areas, reinforcing Laboratory Medicine as a foundational component of hospital operations.

The overview highlighted that Laboratory Medicine has evolved into a key enabler of timely diagnosis, clinical decision-making, and digital transformation, rather than a behind-the-scenes service. While performance remains strong, the program is experiencing increasing operational pressures related to workforce capacity and the growing complexity of services.

A significant focus was the ongoing Health Information System (HIS) implementation and associated modernization efforts. Leadership outlined the complexity of integrating laboratory systems with new digital platforms, including interfaces, data migration, specimen workflow redesign, and electronic ordering. These changes present operational and patient safety risks if not appropriately resourced and governed. The accelerated implementation timeline, combined with staffing constraints, was identified as a key challenge; however, progress is being made, with cautious optimism regarding readiness despite delays in the anatomical pathology module.

The Committee discussion emphasized the importance of sustained organizational support to maintain safe, reliable service delivery while advancing system transformation. Leadership noted that maintaining current performance levels alongside large-scale modernization will require continued investment in people, infrastructure, and project management capacity.

The Committee provided positive feedback on the Laboratory Medicine program, recognizing its strong delivery of patient-centered care, including timely test turnaround and a positive patient experience. Members also noted the increased visibility of the program's contributions through internal communications.

The program's collaborative, team-based approach to recruitment and operations was highlighted as a key factor in its success. This approach emphasizes alignment, data-driven decision-making, and the adoption of technology to support performance and continuous improvement. In response to questions regarding recruitment practices, leadership described an inclusive model involving the full team in candidate assessment

and decision-making, ensuring alignment with both program needs and team dynamics. This transparent and collective approach was identified as contributing to strong team cohesion and overall program performance.

The Committee also recognized the program's leadership in national initiatives, including Choosing Wisely, as well as its contributions to external knowledge sharing and mentorship across organizations. *(Further information is included in Package 2.)*

- 3. Patient Family Advisory (PFAC) – Annual Update:** The Committee received an annual update on the Patient and Family Advisory Council (PFAC), highlighting its continued contributions to patient-centered care and organizational improvement. Key areas of focus included patient flow and access, with PFAC emphasizing the importance of enhancing the patient experience during wait times through improved communication, comfort, and overall engagement, rather than focusing solely on performance metrics.

PFAC received regular updates on the Health Information System (HIS), particularly patient-facing elements such as privacy, communication strategies, and go-live planning, and provided feedback to support effective communication with patients and the public. Additional priorities included accessibility, wayfinding, and parking, as well as ongoing advocacy for patient access to health information through platforms such as Connect My Health and future patient portal solutions.

The update highlighted PFAC's strong engagement and impact across the organization, with examples of real-time feedback contributing to timely improvements in patient materials and processes. The Committee commended PFAC leadership and members, recognizing the council as a valued partner in advancing patient-centered care at CMH.

Committee members acknowledged the significant breadth, impact, and effectiveness of the Patient and Family Advisory Council (PFAC). Feedback reflected increased awareness of PFAC's extensive involvement across organizational initiatives and commended the strong leadership and engagement of the committee. PFAC was recognized for its meaningful contributions to patient-centered improvements and its role as a valued partner in advancing care quality and the overall patient experience. *(Further discussion during agenda item 4.4)*

- 4. Draft Quality Committee Goals 2026/27:** The Committee reviewed the proposed Quality Committee goals for 2026/27, with a primary focus on supporting quality and patient safety throughout the implementation of the new Health Information System (HIS). It was noted that, given the scale and impact of the HIS implementation, the Committee will adopt a single overarching goal, centered on governance oversight of quality and safety during this transition.

To support this focus, program presentations will be temporarily paused until early 2027 to allow clinical teams to prioritize HIS readiness, training, and implementation activities. Regular reporting will continue, including quality scorecards, incident reporting, and critical updates. In addition, brief updates on HIS progress and quality implications will be incorporated into upcoming meetings to ensure ongoing oversight. The Committee acknowledged that the HIS implementation may result in temporary disruptions to data availability and reporting timelines due to system transition and data migration activities. This was recognized as an expected part of the implementation process.

Quality Monitoring Scorecard: An update was provided on the Quality Monitoring Scorecard, with a focus on key performance indicators currently off target. The primary areas of concern remain consistent with previous reporting periods and include patient

flow and access metrics, such as emergency department performance, alternate level of care (ALC) utilization, and conservable bed days

Additional pressures were noted in staffing-related metrics, including sick time and overtime, which continue to trend unfavourably. Readmission rates for selected conditions, including congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD), were also identified as areas requiring further review, with ongoing analysis and chart reviews underway through the appropriate committees. Overall, it was noted that performance challenges continue to align with broader system pressures, particularly related to capacity and flow, and that focused improvement efforts are in progress across these key areas. *(Further information can be found in consent agenda 1.5.8)*

5. **Medical Advisory Committee Update:** The Committee received a brief update from the Medical Advisory Committee (MAC), highlighting key areas of focus. Significant attention continues to be directed toward preparation for the upcoming Health Information System (HIS) implementation, with medical leadership actively supporting safe clinical transition, including development of order sets and completion of documentation required for data migration. The tight implementation timelines and associated workload were noted, with recognition of the efforts of clinical leaders and teams in advancing this work.

Also highlighted CMH's national leadership in the Choosing Wisely initiative, including participation in national forums and ongoing knowledge-sharing with other organizations seeking to adopt similar approaches. Additionally, initiatives supporting physician well-being and human connection in care delivery were discussed, including innovative educational programming and experiential learning opportunities aimed at enhancing patient-provider interactions. Efforts to incorporate Indigenous teachings and promote a culture of care and collaboration were also noted. Overall, the update reflected strong medical leadership engagement in quality improvement, system transformation, and fostering a supportive and patient-centered care environment.

A Committee member inquired about next steps for implementing sensory rooms and their potential to reduce Emergency Department pressures. Leadership indicated the concept is in early stages, having emerged as an innovative opportunity to enhance care, particularly for pediatric and neurodiverse patients. While not previously implemented at CMH, it is being explored for feasibility, with recognition that it may represent a high-impact, low-complexity initiative to improve patient experience and care delivery.

BRIEFING NOTE

Date: June 17, 2026
Issue: Patient and Family Advisory Council (PFAC) Annual Update
Prepared for: Board of Directors
Purpose: Approval Discussion Information Seeking Direction
Prepared by: Liane Barefoot – Director, Patient Experience, Quality, Risk, Privacy & IPAC and CPO
Approved by: Mari Iromoto – VP, People & Strategy

Attachments/Related Documents: None

Alignment with 2026/27 CMH Priorities:

2022-2027 Strategic Plan No <input type="checkbox"/>	2026/27 CMH Priorities No <input type="checkbox"/>	2026/27 Integrated Risk Management Priorities No <input checked="" type="checkbox"/>
<input checked="" type="checkbox"/> Elevate Partnerships in Care	<input checked="" type="checkbox"/> Improve Patient Flow (CBD, PIA, ED Admits)	<input type="checkbox"/> Organizational Flow
<input type="checkbox"/> Reimagine Community Health	<input checked="" type="checkbox"/> Prepare for Digital Health Transformation	<input type="checkbox"/> Project Quantum
<input type="checkbox"/> Increase Joy in Work	<input type="checkbox"/> Increase Staff Engagement Through Improved Staffing (Med, ICU, ED, Physicians)	<input type="checkbox"/> Management/Medical Staff Partnership
<input type="checkbox"/> Sustain Financial Health	<input type="checkbox"/> Achieve a Balanced 2026/27 Operating Position	<input type="checkbox"/> Financial Sustainability
<input checked="" type="checkbox"/> Advance Health Equity	<input type="checkbox"/> Embrace Diversity, Build a Culture of Inclusion	<input type="checkbox"/> Change Management

Alignment with 2026/27 CMH Corporate Plans: Patient Experience Plan

Executive Summary

Established in December 2014, the Patient and Family Advisory Council (PFAC) is a longstanding forum for bringing patient and family perspectives into planning, quality improvement, and patient experience work at Cambridge Memorial Hospital. PFAC currently has eight active members, meets nine times per year, and contributes both within CMH through related committees, including the Ethics Committee, the Quality Committee of the Board and externally on the Cambridge North Dumfries Ontario Health Team (CND-OHT) PFAC, and the ConnectMyHealth Steering Committee. Three senior executives support PFAC, including two designated annually and one with executive oversight, alongside a designated Board member, helping ensure PFAC voices and messages are heard across the organization. From September 2025 to May 2026, PFAC provided meaningful input on patient flow and wait times, digital health and privacy, accessibility and wayfinding, patient-facing communications, and broader co-design opportunities. Across these discussions, PFAC continued to strengthen CMH initiatives by ensuring changes were grounded in what matters most to patients and families.

Background

Established in December 2014, the Patient and Family Advisory Council (PFAC) provide a formal mechanism for integrating the patient and family perspective into governance, quality improvement, and overall patient experience priorities at Cambridge Memorial Hospital. PFAC currently includes eight active members and meets nine times annually. In addition to advising on hospital initiatives, PFAC members contribute to key committees within and beyond CMH, including the Ethics Committee, the Quality Committee of the Board, the CND-OHT PFAC, and the ConnectMyHealth Steering Committee. This structure supports a consistent patient and family voice across organizational planning, decision-making, and system partnerships.

Analysis – PFAC Themes (September 2025 to May 2026)

PFAC discussions during the reporting period were concentrated in five broad areas that align closely with CMH priorities related to partnerships in care, digital transformation, patient flow, and equitable access. Across all themes, PFAC's contribution was to bring a practical patient and family lens to organizational initiatives, with particular emphasis on clarity, accessibility, transparency, through their collective lived experiences.

1. Patient flow and access

- PFAC provided perspectives on how flow pressures are experienced by patients and families, particularly in Emergency Department.
- Discussions highlighted patient-facing initiatives such as increased in-patient hospitalist support, discharge coordination, CMHatHome, and Emergency Department wait time communication.
- Feedback reinforced the need to pair operational flow improvements with setting clear expectations, regular communication touch points, and practical supports such as comfort measures.

2. Digital health, privacy, and access to information

- PFAC remained engaged in patient-facing aspects of CMH's digital transformation, particularly the Health Information System (HIS).
- Updates on the patient-facing components of the HIS included ability to use preferred name, privacy access code visibility on the banner bar, and the new dual-branded patient portal.
- PFAC also informed communication, signage and promotion related to Connect-MyHealth and other patient access options.
- CMH PFAC member has been added to the dual-branded patient portal working group

3. Accessibility, environment, and wayfinding

- PFAC reviewed how physical space, information visibility, and navigation affect the patient and family experience and as such, were extremely supportive of the corporate Clean Wall Policy.
- Feedback addressed digital screen content, net new addition of charging and water refill stations, lost belongings processes, and parking.
- Advice consistently emphasizes accessible environments and clear wayfinding as core components of a safe and respectful care experience.
- PFAC members were involved in the selection of new language translation tablet service provider

4. Meaningful engagement and co-design

- PFAC emphasized the value of authentic engagement, with advisors involved early enough to shape decisions, rather than respond to finalized plans.
- Members contributed through advisory discussions, space audits (tours), interviews for patient-facing roles, committee work, and broader engagement activities.
- Process improvements for PFAC over the past year have included implementing standardized meeting evaluations in addition to their well-established meeting without management, attendance tracking, and consent agenda practices; collectively strengthening PFAC's effectiveness.

5. Clear, patient-friendly communication

- PFAC provided detailed feedback on patient-facing materials, with a focus on plain language, sequencing, and readability.
- Members emphasized the importance of explaining the 'why' behind requirements or instructions.
- This work included review of multiple materials (diabetes, surgical daycare) and early input into the development of a draft patient experience definition.

Consultation

This briefing note is based on PFAC meeting discussions and materials reviewed between September 2025 and May 2026. Consultation occurred through regular PFAC meetings,

agenda item reviews, presentations, space audits (tours), and feedback discussions involving patient and family advisors and CMH staff leads who brought forward materials and initiatives for review.

Next Steps

PFAC will continue to be engaged on patient-facing tools, communications, and digital initiatives requiring patient and family input. Ongoing practice should include early consultation, timely updates on how feedback was used, and targeted opportunities for PFAC involvement in implementation work, interviews, and improvement activities.