**Vision**
To provide exceptional healthcare by exceptional people

**Mission**
A progressive acute care hospital and teaching facility committed to quality and integrated patient centered care

**Values**
Caring, Respect, Innovation, Collaboration, Accountability

---

**BOARD OF DIRECTORS MEETING**  
Wednesday September 28, 2016  
1830h-1930h  
CMH Boardroom  
OPEN SESSION

<table>
<thead>
<tr>
<th><em>Agenda Item  (</em> Indicates attachment) (TBC- to be circulated)</th>
<th>Time</th>
<th>Responsibility</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. CALL TO ORDER</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Confirmation of Quorum (7)</td>
<td></td>
<td>J. Kane</td>
<td></td>
</tr>
<tr>
<td>1.2 Declarations of Conflict</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 Consent Agenda (Any Board member may request that any item be removed from this consent agenda and moved to the regular agenda.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3.1 Minutes of June 28, 2016 (Open sessions 1&amp;2)*</td>
<td>1830</td>
<td>J. Kane</td>
<td>Approval</td>
</tr>
<tr>
<td>1.3.2 CEO Report*</td>
<td></td>
<td>J. Kane</td>
<td>Approval</td>
</tr>
<tr>
<td>1.3.3 Governance September 8, 2016 Meeting Summary*</td>
<td></td>
<td>J. Kane</td>
<td>Approval</td>
</tr>
<tr>
<td>Policies: (clean copies included in package – track changes found on Board Portal)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2-A-26 Role Description for the Board Secretary*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2-A-28 Role Description for a Committee Chair*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2-A-31 Ex-officio Director*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2-A-34 Confidentiality*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2-A-38 Board and Committee Meeting Attendance*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3.4 Strategic Plan Scorecard*</td>
<td></td>
<td>J. Kane</td>
<td>Approval</td>
</tr>
<tr>
<td>1.3.5 Board Scorecard*</td>
<td></td>
<td>J. Kane</td>
<td>Approval</td>
</tr>
<tr>
<td>1.3.6 HSAA Scorecard*</td>
<td></td>
<td>J. Kane</td>
<td>Approval</td>
</tr>
<tr>
<td>1.3.7 Q1 CEO Certificate of Compliance*</td>
<td></td>
<td>J. Kane</td>
<td>Approval</td>
</tr>
<tr>
<td>1.4 Confirmation of Agenda</td>
<td>1835</td>
<td>J. Kane</td>
<td>Approval</td>
</tr>
<tr>
<td><strong>2. DISCUSSION ITEMS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Chair’s Report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1.1 WHCC Update – Strategic Planning Proposed Approach*</td>
<td>1836</td>
<td>J. Kane</td>
<td>Approval</td>
</tr>
<tr>
<td>2.1.2 Board Work Plan*</td>
<td></td>
<td>J. Kane</td>
<td>Approval</td>
</tr>
<tr>
<td>2.1.3 Upcoming Events Calendar*</td>
<td></td>
<td>J. Kane</td>
<td>Approval</td>
</tr>
<tr>
<td>2.2 Resources Committee (Sept 26, 2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2.1 August Financial Statements*</td>
<td>1845</td>
<td>I. Miles</td>
<td>Information</td>
</tr>
<tr>
<td>2.3 Quality Committee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3.1 September 21, 2016 Meeting Summary*</td>
<td>1855</td>
<td>E. Habicher</td>
<td>Information</td>
</tr>
<tr>
<td>2.4 Medical Advisory Committee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4.1 September 14, 2016 Meeting Summary*</td>
<td>1910</td>
<td>Dr. K. Rhee</td>
<td>Information</td>
</tr>
<tr>
<td>2.4.2 Privileges and Credentialing*</td>
<td></td>
<td>Dr. K. Rhee</td>
<td>Approval</td>
</tr>
<tr>
<td>2.5 CEO Update</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5.1 MSAA Compliance*</td>
<td>1920</td>
<td>P. Gaskin</td>
<td>Motion</td>
</tr>
<tr>
<td>2.5.2 BPSO Designation*</td>
<td></td>
<td>P. Gaskin</td>
<td>Information</td>
</tr>
<tr>
<td>2.5.3 Annual Community Report (TBC)</td>
<td></td>
<td>P. Gaskin</td>
<td>Information</td>
</tr>
<tr>
<td><strong>3. ADJOURNMENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 Approval</td>
<td>1930</td>
<td>J. Kane</td>
<td>Motion</td>
</tr>
<tr>
<td><strong>4. Discussion of Independent Directors and Management</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1 Approval</td>
<td></td>
<td>J. Kane</td>
<td>Motion</td>
</tr>
<tr>
<td>4.2 Discussion of Independent Directors</td>
<td></td>
<td>J. Kane</td>
<td>Motion</td>
</tr>
<tr>
<td>5. Date of Next Meeting: November 30, 2016</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

Board Members: Joseph Kane (Chair), Ian Miles, Denise Smith, Tom Dean, Al Van Leeuwen, Elaine Habicher, Nicola Melchers, Larry Kron, David Pyper, Tim Edworthy, Suren Rao, Rita Westbrook

Ex-Officio Members: Patrick Gaskin, Sandra Hett, Dr. Kunuk Rhee, Dr. Winnie Lee, Dr. Francois Flamand
Minutes of the open session of the Board of Directors meeting, held in the CMH Boardroom on June 28, 2016.

1. CALL TO ORDER
Ms. Westbrook called the meeting to order at 2010 hours.

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

1.2. Conflict of Interest
Board members were asked to declare any known conflicts of interest regarding this meeting.

1.3. Consent Agenda
1.3.1 Minutes of May 25, 2016
1.3.2 Board Work Plan
1.3.3 Strategic Plan Scorecard

1.4 Confirmation of Agenda

MOTION: (Miles/Dean) that, the agenda be approved as circulated. CARRIED

2. DISCUSSION ITEMS
2.1. Chair’s Report

2.1.1. May Evaluations
The evaluations were reviewed. No action taken.

2.1.2. Upcoming Events Calendar
Ms. Westbrook encouraged the Board to attend the Best Bites event in September.
2.2. **Resources Committee**

2.2.1 **May 2016 Financial Statements**

Mr. VanLeuween provided the update on the May financials. In May, a year-to-date operating surplus of $18k (a $168M positive variance from plan) was realized after building amortization and related capital grants. CMH had an operating deficit of $20k in May. The positive year-to-date variance was primarily attributed to higher than expected parking revenue and the timing of expenditures within supplies and medical remuneration offset by pressures within salaries, wages and related benefits.

The balance sheet reflected a strong cash position of $25M, and CMH continues to meet its working fund requirement. CRP increased to $59.6M; a lump sum payment of $65M will be payable to the contractor once CMH takes ownership of the new building.

2.3 **Quality Committee**

Mr. Kron provided an update on the Quality Committee

2.4 **MAC Update**

2.4.1 Dr. Rhee highlighted the following from his previously circulated briefing note:

- **Surgical Assist Scheduling & Status**
  Following City call’s recent cessation of services at CMH (in 2015) and a decade-old province-wide trend of the migration of family physicians out of hospital services, our local surgical assistants may be downloading on-call surgical assistance onto the hospital. The risks to surgical safety are high if a mitigation strategy is not implemented. Surgical hospitalists, nursing assists and second tier surgical specialists are options that will need to be fully explored in the upcoming months. CMH could consider downloading this responsibility onto the surgeons, but our pool of surgical assists may be too small to make this a viable option.

- **Medical Assistance in Dying (MAID)**
  MAC was informed of the Board’s decision to provide MAID services at CMH. Protocols and a policy were pre-circulated and feedback was elicited. Several challenges and ambiguities were raised. A provisional pre-printed order is in place for MAID deployment. An Oversight Committee has been created and our processes have been shared with GRH and GGH for commentary. GRH and GGH will be offering outpatient Assistance in Dying services and will have a much more robust communication/referral tool. We will endeavor to expand our scope of services over the next twelve months. Clarity regarding the legislation is key prior to final MAC approval (which will likely be electronically over the summer). CMH has had one request that has since been rescinded.

2.5 **CEO Update**

2.5.1 **2015/16 Year in Review and 2016/17 The Year Ahead**

Mr. Gaskin and Dr. Rhee provided a look back on 2015-16 and where CMH is going for 2016/17.

In 2015/16

- CMH introduced a enhanced model of care
- 6th consecutive year of surplus
- Enhanced the patient experience with introduction of PFAC
For 2016/17
- Refresh the strategic plan
- Define our role
- Improve Quality
- Deepen Medical leadership
- Execute the CRP and the transition plan

3. **MOTION to ADJOURN OPEN SESSION**
The meeting adjourned at 2030 hours. (Van Leeuwen/Rao) **CARRIED**

   Ms. Hett, Mr. Prociw, Dr. Lee and Dr. Flamand, Mr. Beckhoff left the meeting.

4. **Discussion of Independent Directors and Management**
   Discussion took place.

   Dr. Rhee, Mr. Gaskin and Ms. Vandervalk left the meeting at 2040h

5. **Discussion of Independent Directors**

6. **DATE OF NEXT MEETING**
   Next Meeting: The next scheduled meeting is September 28, 2016.

Rita Westbrook                  Patrick Gaskin
Board Director       Board Secretary
CMH Board of Directors     CMH Board of Directors
Minutes of the open session (2) following the Annual Meeting of the Members, held in the CMH Boardroom on June 28, 2016.

Present:
Ms. R. Westbrook
Ms. N. Melchers
Mr. P. Gaskin
Mr. T. Dean
Dr. K. Rhee
Ms. S. Hett
Mr. A. VanLeeuwen

Ms. E. Habicher
Mr. L. Kron
Mr. I. Miles
Mr. D. Pyper
Dr. W. Lee
Mr. S. Rao
Dr. F. Flamand
Mr. T. Edworthy

Regrets: Ms. D. Smith, Mr. J. Kane

Staff Present:
Mr. M. Prociw
Mr. S. Beckhoff

Guest:
Recorder: Ms. C. Vandervalk

1. CALL TO ORDER
Mr. Pyper called the meeting to order at 2040 hours.

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

1.2. Conflict of Interest
Board members were asked to declare any known conflicts of interest regarding this meeting.

1.3 Confirmation of Agenda
MOTION: (Edworthy/VanLeeuwen) that, the agenda be approved, as circulated CARRIED

2. DISCUSSION ITEMS
2.1. Election of Directors
Mr. Pyper put forward a motion for the approval of appointment of the Chair and Vice Chair of the Board.

MOTION: (Westbrook/VanLeeuwen) that, the Corporation elects as officers of the Corporation the following individuals, as Chair and Vice-Chair of the Board: Joe Kane as Board Chair, and Ian Miles as Vice-Chair of the Board CARRIED

2.2. Committee Assignments
Mr. Pyper brought forward the following recommendations of 2016-2017 committee member appointments and Committee Chair appointments.
MOTION: (Westbrook/VanLeeuwen) that, the 2016-2017 Committee compositions as circulated have been considered and agreed upon by the Board of Directors.

Audit Committee
Elaine Habicher (Chair)
Suren Rao
Peter Graham
Keith Martin
Cheryl Hugill
Aneesa Ruffudeen

Resources Committee
Ian Miles (Chair)
Tim Edworthy
Al Van Leeuwen
Nicola Melchers
Chris Hewitt
Monika Hempel
Mahmud Shiblee

Capital Projects
Al VanLeeuwen (Chair)
Tom Dean
Tim Edworthy
Kirk Oliver
Horst Wohlgemut
Andrew McGinn
Paul Sabra

Quality Committee
Larry Kron (Chair)
Elaine Habicher
Suren Rao
Tom Dean
Kirk Oliver
Paul Marinello
Barbara Bluhm
Chris Hewitt

Governance Committee
David Pyper (Chair)
Rita Westbrook
Nicola Melchers
Denise Smith
Horst Wohlgemut
Aneesa Ruffudeen
Virginia Torrance

Executive Committee
Joe Kane (Chair)
Rita Westbrook
Ian Miles
Denise Smith
Ms. Hett, Mr. Prociw, Dr. W. Lee, Dr. F. Flamand, Mr. S. Beckhoff, left the meeting at 2045h

3. **ADJOURNMENT**
   The meeting adjourned at 2045 hours.

4. **Meeting of Independent Directors with CEO and COS**
   A meeting of the independent directors with CEO and COS took place.

5. **DATE OF NEXT MEETING**
   Next Meeting: The next scheduled meeting is September 28, 2016.
This report provides a brief update on some key activities within CMH as an FYI to the Board. While it is organized against our 2014-17 strategic themes, it may include strategic, corporate and other projects as necessary. As always, happy to answer questions and discuss issues within this report or other matters.

**Goal: To improve ED 90th percentile length of stay from triage to admission from 22.6 hours (2015) to 16 hours in Q3 and Q4 within budget resources**

- September’s focus is on our bed allocation process and the use of a newly developed tracker board for the inpatient units.
- Some of the projects we are pursuing this year to meet the 16 hr. goal include:
  - Review and refresh clerical expectations regarding the "bed board" on Meditech
  - Pilot a new tracker board on the Medicine unit that assists with awareness of both medical units and the ED patients to assist with timely bed placement decisions (in progress on B5 with plans for B3 to follow)
  - Review and refresh the bed allocation value stream
  - Install projector into room used for clinical rounds to integrate the use of the electronic Meditech tracker view into bed rounds
  - Continued problem solving surrounding specific Provider Initial Assessment (PIA) and patient delays to understand issue or pattern and implement appropriate solutions
  - Data review, implementation of electronic prompts or automatic data fill when possible to ensure accuracy of clerical data that supports ED metrics
  - Update corporate bed allocation plan that aligns with the ED LOS targets and outlining actions with each phase or stage (e.g. a clear timeframe to bed space or off-service admitted patients)
Goal: To meet all defined milestones to ensure a safe and patient centred environment as we prepare to move into the new wing

Transition Planning and integration workshop, September 14
- On September 14, the first in a series of planned workshops took place to provide clinical transition teams a chance to exchange information with other programs, take note of the progress to date, celebrate achievements and outline concerns or support that is needed on a move forward basis.
- Each team presented their accomplishments, as well as, priorities, areas of concern and next steps.
- In addition, mock scenarios were presented and discussed for interdisciplinary input. Feedback captured from the workshop is being compiled and will be distributed in the following weeks. Thank you to all who presented and participated in the workshop which will guide future planning and decision making as we move forward.
- More integration workshops are planned with Support Services presenting.

Training and Orientation
- Our focus is shifting to training and orientation in preparation for the occupation of the new Wing A
- Clinical Educator and Facilitator Liz Wishart, has been hired for a one-year term as our new Project Manager Orientation and Training.
- She will work closely with the Transition Planning team to help develop an orientation and training plan. A new CRP Clinical Educator Facilitator (CEF) has also been hired to support the CEF educators in development and delivery of all clinical training.

Furniture, Furnishings and Equipment
- All current CMH equipment needs are currently being verified CMH’s Purchasing Department with end-users. Tender documents are developed and procurement activities are being coordinated to meet the hand over date of March 31, 2017.
- We anticipate purchase orders to be issued by January 1, 2017. We are aware that there may be additional delay in building handover so adjustments will be made to meet actual schedule once a date is confirmed.

Move and Relocation Planning
- Room layout verification and planning is ongoing to ensure items on equipment list fit into the rooms.
- A tentative move schedule has been developed but requires further discussion with departments.
Departments have identified their temporary “Move Captains” to assist and coordinate all move activities with the move planners. Meetings with departments anticipated to start September 2016, building handover on March 31, 2017, and then patient relocation to new Wing A end of May 2017. These dates are contingent on contractor meeting the above handover date. If it is delayed then all the other move dates are equally delayed.

Mock-up room recommendations
- Staff, physicians and volunteers were invited to review three mocked-up inpatient rooms that were constructed to 95% completion. These high fidelity rooms provided a final opportunity to suggest improvements to these important care spaces.
- From the review, 24 recommendations are being followed up with the consultants and our contractor to implement. The recommendations impact multiple rooms and are time consuming to implement in the drawings because some of the seemingly simple requests have a ripple effect on other systems (e.g., like moving a light switch). Improvements include:
  - Headboard layout
  - Documentation location and style
  - Soiled linen and garbage cabinets
  - Nurse call locations
  - Lighting locations.

CMH’s "bridge" built
- A small, but symbolic milestone was made with the completion of CMH’s bridge. CMH’s “bridge” is a walkway that connects the current patient care Wing B with our future Wing A. We chose to name it such because bridges are unique features of Cambridge, representing our unity as people and connection between diverse communities.
- It took about five days to complete. The work was spread over weekends during the last two weeks of July and on a planned surgical shutdown day (our partner hospitals were on standby for emergency surgeries).
- Quiet times were chosen so to meet Ministry of Labour regulations that prohibit personnel in buildings when items exceeding a weight threshold are lifted overhead.
- All went according to plan and was finished a day in advance of schedule.
- A time lapse video of the bridge being built can be found on YouTube and Facebook.
Defining our role

Positioning us for the future: Rapid Organizational Assessment underway

- We brought on some additional expertise to help us in the short-term. After a request for quotation process, Corpus Sanchez International (CSI) has been retained to do an assessment of key priority areas in our hospital.
- The CSI team has an extensive track record with North American hospitals seeking similar outcomes. They are also no strangers to us having helped with our 2011-14 strategic plan.
- The assessment’s purpose is to find creative ways to improve processes, patient flow and aspects of our care delivery model such as discharge planning. It will focus on priority areas that the executive team has identified.
- They were on site September 20 and 21 to meet with staff, physicians and leaders.
- In October, the team will present opportunities for us to consider. As part of their work, they will do more detailed analyses on several of the opportunities, working with relevant staff and leadership through this.
- In November, we expect their final report. A summary of the report will be made available for staff to read.

Improving Quality

WWLHIN Standardized Quality Based Procedure (QBP) Patient Order Sets

- The standardized web-based QBP patient order set for cataract surgery was launched February 16, 2016 and work is underway to standardize and implement certain orthopaedic procedures.
- CMH is now participating in a provincial initiative that builds on this current work and assists to advance the implementation of the Quality-based Procedures (QBP) order sets. The benefit of this initiative is standardization of practice, deliberate inclusion of QBP medical orders with a link to the research supporting this medical order.
- With the electronic system, the physician groups will be able to access information regarding practice patterns that is currently a challenging time consuming manual process.
- CMH continues to advance limited surgical QBP’s as per the surgery program (e.g. tonsillectomy, thyroidectomy) as this aligns with planning for CRP and understanding technology needs for surgeons within the new OR’s.
Nuclear Medicine passes inspection

- Every two years, the Canadian Nuclear Safety Commission (CNSC) pays our Diagnostic Imaging’s Nuclear Medicine department a visit.
- Like all hospitals and facilities using radioactive materials, the CNSC ensures all those who handle, possess and use these isotopes adhere to highest safety standards. The inspection occurred on August 31, 2016 and involved eight pages worth of criteria that needed to be checked.
- After the rigorous inspection, the CNSC found no areas of non-compliance – there weren’t even suggestion notes for improvement. Congratulations to Charge Technologist Janice Tremblay and her team for ensuring their work area is safe for patients, staff and the environment.

Laparoscopic first for CMH!

- In June, Dr. Karina Roth-Albin, general surgeon, was asked to provide a surgical consult for an unfortunate patient who had a blockage from the stomach to the intestine because of a tumour.
- After weighing different options with a colleague from another hospital, a decision was made to proceed with a minimally invasive surgical approach (laparoscopic gastrojejunostomy) to bypass the tumour, so that the contents from the stomach can empty into the intestine.
- It was performed with assistance from local family physician Dr. Kate Morgan and medical student Ryan Urban. There were no complications and the patient has since been discharged and is recuperating.
- In the words of Dr. Roth-Albin: "I am very proud of having the opportunity to provide the care our patients need, at our institution, in our patients' home town. I am also confident that we have an excellent group of general surgeons with very good laparoscopic skills that will be developed and improved with team work and excellent support...We can be proud at CMH [as] we are adopting the model recommended worldwide with a two-surgeon team approach for difficult and challenging cases. Collaboration is crucial and is being implemented at CMH by our group of general surgeons."

Staff to complete Patient Flagging System education

- A flagging policy and accompanying system was implemented earlier this year to help identify patients with the potential for violence.
- As part of our on-going commitment to enhance staff and patient safety, education regarding CMH's Patient Flagging System is currently being rolled out to all clinical units and departments.
- There are two versions of this mandatory education.
- One is for non-regulated providers and support staff, which outlines roles and responsibilities for identifying violence in the workplace.
- It is the same for regulated health care providers with the added information of how to assess and initiate a flag.
Physicians do not need to complete this education – communication to assist in the identification of patients who are at risk of being violent was sent to the physician group by Medical Affairs

Strategic Plan – year three update
- A year three update of CMH’s current strategic plan (2014-17) was distributed to staff and physicians in July.
- The update provides a snapshot of goals the hospital will pursue for 2016-17 and summarizes our performance of the three “Wildly Important Goals” or WIGs from the last year.
- In 2016-17, we are implementing leadership development for staff and physicians, offering quality improvement training and implementing a ‘clinical services strategy’ (CSS).
- The CSS will describe which programs will expand over the next five years.
- In 2017-18, CMH will be initiating process to develop a two-year strategic plan, which will guide the hospital’s decision making to the end of the construction project. Consultation and input for the next plan will begin this winter.

Strength through People

Staff roles on the Patient and Family Advisory Council (PFAC)
- In June 2016, PFAC decided it was ready to proceed with the inclusion of staff member positions.
- An internal recruitment took place over the summer 2016. Three applications and expressions of interest were screened and PFAC members interviewed all three candidates.
- PFAC has accepted Sarah Kreller a Cardiac Technologist from the Cardiorespiratory Unit (CRU). Sarah attended the September 2016 meeting.

Nominating for "I CCAIR" is now on-line!
- The “I CCAIR” nomination process just got just got a whole lot easier.
- Go to CMHnet’s home page and click the “Nominate someone” link to take you to an on-line form. Once filled out, just click to submit it. It's that easy!
- All I CCAIR submissions are sent to Linda Rodrigues who collates nominations and then distributes them to the I CCAIR committee to review. These fine folk include Emily MacDougall, Kim Cocks, Kathy Brunet, Simone Peters, Gillian Dyck, Cathy Vandervoort, Michelle Berry, Maria Boyes, Erin Davidson and Shelly Pavlic. Reviews are done on a monthly basis. Nominate someone today and give this dynamic group lots to read!
- I CCAIR nominations are open to staff, physician and volunteers.
HELPP Lottery draws to a close

- After years of raising funds for much needed medical equipment, the HELPP lottery is drawing to a close, with only a few remaining tickets left to be sold.
- The core group of current volunteers that supported the lottery got to together to celebrate on Tuesday, June 21.
- Together these volunteers contributed **18,764 hours** of caring to our hospital - this is the current group only and does not include past HELPP volunteers!
- Thank you for this amazing support and we thank you for continued support at looking forward to seeing you in your new roles at the Volunteer Welcome Desk!

Driving Value and Affordability

Ministry Parking Mandate to begin Oct. 1

- A Ministry of Health parking mandate states that by October 1, 2016, all hospitals must have multi-day passes at a 50% price reduction and to have sought input from patients on communication strategies related to these changes.
- CMH’s Patient and Family Advisory Council were presented with three options by which the hospitals could meet this mandate, including the pros and cons for both the organization and patients. After discussion, they chose the hospital recommendation and added feedback to a detailed communication and feedback plan, with additional notes to advertise and communicate these new parking options.
- On October 1, visitors and patients will be able to purchase multiple ‘24-hour passes’ with in/out privileges in packs of 5, 10 and 30 at a 50% off the regular price.
COMMITTEE MEETING SUMMARY

Date: September 20, 2016

Issue: Board Governance Committee Meeting – September 8, 2016

Prepared by: Wade Gramada

Approved by: Patrick Gaskin

Attachments: 2-A-26 Role Description for the Board Secretary
2-A-28 Role Description for a Committee Chair
2-A-31 Ex-officio Director
2-A-34 Confidentiality
2-A-38 Board and Committee Meeting Attendance

Items for Approval

2-A-26 Role Description for the Board Secretary
MOTION: (Westbrook/Wohlgemut) that, the Governance Committee recommends to the Board that 2-A-26 Role Description for the Board Secretary be approved with amendments suggested. CARRIED

2-A-28 Role Description for a Committee Chair
MOTION: (Westbrook/Wohlgemut) that, the Governance Committee recommends to the Board that 2-A-28 Role Description for a Committee Chair be approved with amendments suggested. CARRIED

2-A-31 Ex-officio Director
MOTION: (Westbrook/Wohlgemut) that, the Governance Committee recommends to the Board that 2-A-31 Ex-officio Director be approved with amendments suggested. CARRIED

2-A-34 Confidentiality
MOTION: (Westbrook/Wohlgemut) that, the Governance Committee recommends to the Board that 2-A-34 Confidentiality be approved. CARRIED
2-A-38 Board and Committee Meeting Attendance

MOTION: (Westbrook/Wohlgemut) that, the Governance Committee recommends to the Board that 2-A-38 Board and Committee Meeting Attendance be approved. CARRIED

Items of Discussion

Governance Membership
Aneesa Ruffudeen was selected as a member of the 2016/17 Governance Committee. Ms. Ruffudeen was unaware of being selected as a member and has opted to participate only on the Audit Committee. The Governance Committee will continue with one member short until further notice.

Multi-Board Education Sessions
In May 2016, the Governance Committee expressed interest in participating a multi-board educational session conducted by BLG. The Governance Committee submitted a list of topics of interest. Most recently CMH has provided date availability. This is still a work in progress with November being a target implementation date.

Medical/Professional Staff By-law Update
BLG has reviewed the Medical/Professional Staff By-law and has provided comments. Once reviewed by Dr. Rhee and Mr. Gaskin, the By-law will be sent to the Credentialing Committee then to Governance and back to MAC for final review. The Governance Committee has requested BLG review the changes at the next Governance Committee.

Dr. Rhee has noted that CMH is at minimal risk not having the By-law completed.

ACTION: Governance Committee members will be notified one month in advance of reviewing the By-law to allow for adequate time to review prior to meeting.
Role of the Secretary
The Board Secretary works collaboratively with the Board Chair to support the Board in fulfilling its responsibilities.

Appointment
The Chief Executive Officer is the Secretary of the Board.

Responsibilities
- Attend meetings of the Board and Board committees as required
- Assist the Chair with preparation of agendas for Board meetings
- Provide notice as required by the By-law or by the Board or its committees
- Ensure that written minutes of all Board and Board Committee meetings are recorded and circulated to all members of the Board or committee
- Attend to correspondence of the Board
- Prepare and submit all reports required under any applicable federal, provincial or municipal legislation, by-laws or regulation
- Be the custodian of all minute books, documents and registers of the Corporation required to be kept according to statutes and regulations, and all minutes, documents and records of the Board
- Keep copies of all testamentary documents and trust instruments by which benefits are given to the use of the hospital and provide information respecting same to the Office of the Public Guardian and Trustee as required by the Charities Accounting Act (Ontario), and provide as appropriate an accounting to the Board with respect to all funds held in trust by the Corporation
- Be the custodian of the seal of the Corporation
- Sign documents on behalf of the hospital as authorized by the Board or the By-laws
- Provide resources, information and communications as needed for governance processes
- With the Governance Committee Chair, administer the regular review of all corporate governance documents
- With the Governance Committee Chair, administer the annual evaluation of Board, Director and committee performance
- Direct the preparation of materials and presentations for the orientation of new Directors and non-director committee members
• With the Governance Committee Chair, coordinate the continuing education program for Directors and non-director committee members
• Perform such other duties as may from time to time be determined by the Board.

The Secretary may delegate some of the administrative duties outlined above, but shall remain responsible for completion of such duties.
Purpose
To ensure that Board and non-director committee members understand the role and responsibilities.

Role of the Committee Chair
The committee Chair is the leader of the committee and is responsible for committee leadership through:
- Ensuring the integrity and effectiveness of the committee’s role and processes
- Ensuring compliance by committee members with the Board’s By-laws and policies
- Presiding at committee meetings
- Representing the committee at the Board
- Maintaining effective relationships with committee members, the Board Chair and management
- Ensuring orientation for new members and ongoing education for committee members, as appropriate
- Addressing issues of committee member attendance when warranted

Responsibilities

Committee Governance
The committee Chair ensures the committee meets its obligations and fulfills its governance responsibilities including:
- Ensuring that the committee performs a governance role that respects and understands the role of management
- Ensuring the committee reviews and assesses the adequacy of its mandate at least annually and recommends to the Board any changes it deems appropriate
- Ensuring that the committee deals with matters that fall within the committee mandate
- Ensuring that the committee adopts and completes an annual work plan
- Ensuring that the work of the committee is aligned with the Board’s role and annual work plan
- Ensuring committee member participation in evaluating the performance of the committee as established by the Board
**Presiding Member**
The committee Chair is the presiding Board member at the committee meeting and is responsible for:

- Developing the schedule of committee meetings in concert with the CEO or designate
- Setting agendas for committee meetings and ensuring matters dealt with at committee meetings appropriately reflect the committee’s role and annual work plan
- Ensuring the meetings are conducted according to applicable legislation, the organization’s By-laws, the Board policies and the committee’s charter
- Monitoring the adequacy of materials provided to the committee by management in connection with the committee’s deliberations
- Facilitating and deliberating the business of the committee to the Board
- Encouraging input and ensuring that the committee members hear all perspectives of a debate or discussion
- Facilitating the committee in reaching consensus
- Ensuring the committee has sufficient time to review the material provided to it and to fully discuss the business that comes before the committee

**Relationships**

- The committee Chair promotes a thorough understanding by members of the committee and management of the duties and responsibilities of the committee
- The committee Chair seeks the guidance and advice of the Board Chair to ensure understanding of Board expectations and requests the resources that are required for performance of the committee’s charter
- The committee Chair maintains a constructive working relationship with the Board Chair, the CEO and any other support staff

**Other Duties**

- The committee Chair performs such other duties that may be ancillary to the duties and responsibilities noted or as may be delegated to the committee Chair by the committee or the Board from time to time.

**Appointment and Term**
The Board appoints the committee Chair annually from among the members of the Board at the first meeting of the Board following the annual meeting of the Corporation.
Application
This policy applies to the ex-officio Directors of the Board:
(a) President and Chief Executive Officer
(b) Chief of Staff
(c) President of Medical/Professional Staff
(d) Vice-President of Medical/Professional Staff, and
(e) Chief Nursing Executive.
(Hereinafter collectively referred to as the “ex-officio Directors”)

Policy
All Directors, including ex-officio Directors, shall have the responsibilities, accountabilities and fiduciary duty to the Board.

Voting Rights
The ex-officio Directors are non-voting members of the Board. The ex-officio Directors’ entitlement to cast a vote at the respective Board committee meetings shall be set out in the By-law or respective charters.

Other Rights and Responsibilities
Subject to the provision for voting rights in the previous section, the ex-officio Directors shall have the same rights and obligations as the voting Directors unless otherwise specifically provided in the legislation, By-law or charters.
Policy
The Board Directors and non-director committee members owe to the hospital a duty of confidence not to disclose or discuss with another person or entity, or to use for their own purpose, confidential information concerning the business and affairs of the hospital received in their capacity as Directors or committee members unless otherwise authorized by the Board.

Every Director shall ensure that no statement not authorized by the Board is made by him or her to the media or public.

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

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

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

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

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

All minutes of closed sessions of the Board shall be handled in a secure manner.

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

Notwithstanding that information disclosed or matters dealt with in an open session are not
confidential, no Director shall make any statement to the media or the public in his/her capacity as a Director unless such statement has been authorized by the Board.
Application
This policy applies to all Directors and non-director committee members. This policy does not apply to Directors who are ex-officio members of committees.

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

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

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

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

Process – Board Meetings
1. Where a Director fails to attend 75% of the meetings of the Board (including Board education sessions) in a 12-month period, or is absent for three consecutive meetings, the Board Chair shall discuss the reasons for the absences with the member and may ask the individual to resign. If the member does not resign, the Chair may recommend termination which will be done in accordance with the policy on Removal of a Director, Officer or Committee Member.

2. The Board Chair shall determine if a Board member’s absences are excusable and may grant a Board member a limited period of time to rearrange his / her schedule so that there are no conflicts with regularly scheduled Board meetings, failing which the process in section 1 shall apply.

3. A member’s record of attendance shall be considered with respect to renewal of a
4. The Board Chair will communicate with the Chair of the Governance Committee on any attendance related issues.

Process – Committee Meetings

5. Where a committee member (Board and non-Board committee members) fails to attend 75% of the meetings of a committee to which he/she is assigned in a 12-month period the committee Chair shall either discuss the reasons for the absences with the committee member or the committee Chair may refer the matter to the Chair of the Governance Committee.

6. Where a committee member is absent for 3 consecutive committee meetings (or 2 consecutive meetings where a committee meets fewer than 6 times a year), the committee Chair shall either discuss the reasons for the absences with the committee member or the committee Chair may refer the matter to the Chair of the Governance Committee.

7. The committee Chair (or Governance Chair) shall determine if a committee member’s absences are excusable. The committee chair may choose to consult with the Chair of the Governance Committee in making such determination.

8. The committee Chair may grant a committee member a limited period of time to rearrange his/her schedule so that there are no conflicts with regularly scheduled meetings, failing which the matter shall be referred to the Board Chair with respect to Directors and if the issue is with a non-director committee member, the member shall be asked to resign. If the non-director member does not resign, the Board shall be asked to revoke the membership of such non-director committee member.

9. In circumstances where a non-director committee member has missed consecutive meetings as outlined in section 6 and the non-director committee member fails to respond to communications from the committee Chair, the committee Chair may request the Board to revoke the membership of such non-director committee member. Communication of the Board’s decision will be provided to the committee member in writing.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Development of a clinical services plan</td>
<td>Due June 2016</td>
<td>↑</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Say what we do</td>
<td>Advance Health Links</td>
<td>500 patients with coordinated care plans (needs validation)</td>
<td>↑</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Work with others</td>
<td>Clinical Integration in Waterloo Region - clinical governance plan</td>
<td>Due June 2016</td>
<td>↑</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Say patients a voice</td>
<td>Integrated Clinical Programs</td>
<td>Council recommendations approved by CMH Board</td>
<td>↑</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Build QI capacity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving Quality</td>
<td>Residents will experience a decreased rate of hospital readmissions for chronic conditions</td>
<td>15.5%</td>
<td>↓</td>
<td>18.9%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Give patients a voice</td>
<td>Percentage of days residents spend in acute care hospital beds when they should be receiving their care in a more appropriate location (ALC) will be lower</td>
<td>9.5%</td>
<td>↓</td>
<td>18.4%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Build improved transitions</td>
<td>Staff: Would you recommend this hospital to family and friend?</td>
<td>100%</td>
<td>↑</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Patients: ED - Recommended</td>
<td>57.6%</td>
<td>↑</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Patients: Medicine - Recommended</td>
<td>70.5%</td>
<td>↑</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Patients: Obs - Recommended</td>
<td>76.1%</td>
<td>↑</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Patients: Paed - Recommended</td>
<td>80.2%</td>
<td>↑</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Strength Through People</td>
<td>Staff: Overall, how would you rate your organization as a place to work? (poor, fair)</td>
<td>10.0%</td>
<td>↑</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Staff: How satisfied are you with job? (very satisfied, satisfied)</td>
<td>90.0%</td>
<td>↑</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>MD: Senior leadership decision making is transparent</td>
<td>90.0%</td>
<td>↑</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>MD: Senior leaders are committed to providing patients with high quality care</td>
<td>90.0%</td>
<td>↑</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Driving Value and Affordability</td>
<td>Cost per weighted case</td>
<td>$5,223 in 13/14</td>
<td>↓</td>
<td>NA</td>
<td>$5,245</td>
</tr>
<tr>
<td></td>
<td>Regional IT system</td>
<td>Board endorsement</td>
<td>↑</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>C = Completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator Number</td>
<td>Efficient</td>
<td>Status</td>
<td>Previous Status</td>
<td>Year End Projection</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------</td>
<td>--------</td>
<td>-----------------</td>
<td>---------------------</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>QIP/HSAA 90th Percentile ED Length of Stay</td>
<td><img src="#" alt="Green" /></td>
<td><img src="#" alt="Yellow" /></td>
<td><img src="#" alt="Green" /></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>HSAA Current Ratio</td>
<td><img src="#" alt="Green" /></td>
<td><img src="#" alt="Green" /></td>
<td><img src="#" alt="Green" /></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>HSAA Target Budget</td>
<td><img src="#" alt="Green" /></td>
<td><img src="#" alt="Green" /></td>
<td><img src="#" alt="Green" /></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>HSAA Total Margin</td>
<td><img src="#" alt="Green" /></td>
<td><img src="#" alt="Green" /></td>
<td><img src="#" alt="Green" /></td>
<td></td>
</tr>
</tbody>
</table>

**Patient & People Focused**

<table>
<thead>
<tr>
<th>Indicator Number</th>
<th>Efficient</th>
<th>Status</th>
<th>Previous Status</th>
<th>Year End Projection</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>QIP NRC - Would You Recommend (Inpatient)</td>
<td><img src="#" alt="Red" /></td>
<td><img src="#" alt="Red" /></td>
<td><img src="#" alt="Yellow" /></td>
</tr>
</tbody>
</table>
90th Percentile Emergency Department Length Of Stay for Admitted Patients

**Definition:**
The total emergency room length of stay (in hours) where 9 out of 10 admitted patients completed their visits. ED LOS is defined as the time from triage to the time when the patient leaves the ED. The 90th percentile length of stay is from triage to left ED (in hours) for admitted patients. Excludes Left Without Being Seen, and cases with incomplete date and time stamps.

**Formula:**
The ED LOS are ranked from lowest to highest, and the number of occurrences are multiplied by 0.9 to find the 90th percentile rank. The value at this rank is represented. If there is a decimal this is rounded up.

**Target:**
Current Year Target is 16 hours. Corridor is 17.6 Hours. HSAA Target is 8 Hours

**Year End Projection:**
Projecting green status for year end.

**Analysis:**
EDLOS is improving significantly over 15/16. Clinical leadership has stabilized allowing for increased focus on flow and access work.

**Action Plan:**
Flow team continues to meet weekly. Realignment of medicine model of care planned which will improve the pulling of patients quicker to medicine from the ED. Work processes regarding discharge planning reengineered to improve patient flow to the community. Focus from physicians to ensure disposition placement of patients occurs timely. Review of and rework of triage and green zone in ED to decrease patient wait times at the beginning of their care continuum.
**Definition:**
The number of times a hospital's short-term obligations can be paid using the hospital's short-term assets.

**Formula:**
\[
\frac{\text{Current Assets + Debit Current Liability (excluding deferred contributions)}}{\text{Current Liabilities (excluding deferred contributions + credit current assets)}}
\]

**Target:**
Performance target is 1.18. Corridor is 1.06.

**Year End Projection:**
CMH continues to meet and exceed the performance targets established by the HSAA and the Working Funds Deficit Agreement.

**Analysis:**
There has been a slight delay in capital equipment spending linked to the delay in the construction project. This has led to some increased cash reserve in the short term. Portions of this reserve will be accessed in the short term should we continue with the regional HIS strategy in absence of matching funding, while other components will go to subsidize the planned three year CRP spend (as per the corporate multi year fiscal strategy).

**Action Plan:**
No action is required at this time.
**Cambridge Memorial Hospital Corporate Scorecard FY2016/2017**

**Target Budget Year To Date**

**Indicator Details/Components**

**Definition:** Year To Date operating budget surplus/deficit

**Formula:** Actual Year To Date operating surplus/deficit

**Target:** Target budget surplus of $.87M YTD by March 31, 2017

**Year End Projection:** As of the end of July, CMH has achieved its target budget performance. Based on current results and year end projections, it is expected that year end results will be equally achieved.

**Analysis:** YTD CMH results have been driven by improved patient flow, an absence of any significant patient surge activity in the first four months and improved sick and overtime performance.

**Action Plan:** No further action required at this time.
Detailed Monthly Data Points

<table>
<thead>
<tr>
<th></th>
<th>01 Apr</th>
<th>02 May</th>
<th>03 Jun</th>
<th>04 Jul</th>
<th>05 Aug</th>
<th>06 Sep</th>
<th>07 Oct</th>
<th>08 Nov</th>
<th>09 Dec</th>
<th>10 Jan</th>
<th>11 Feb</th>
<th>12 Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/2016</td>
<td>0.02162</td>
<td>0.01349</td>
<td>0.01423</td>
<td>0.00952</td>
<td>0.01657</td>
<td>0.01763</td>
<td>0.01957</td>
<td>0.01997</td>
<td>0.01914</td>
<td>0.01372</td>
<td>0.02200</td>
<td></td>
</tr>
<tr>
<td>2016/2017</td>
<td>0.00085</td>
<td>-0.00075</td>
<td>0.01053</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Definition:**
The percent by which total revenues exceed total expenses, excluding the impact of facility amortization, in a given year.

**Formula:**
\[
\frac{(\text{Total Corporate Revenues} - \text{Total Corporate Expenses})}{\text{Total Corporate Revenues}}
\]

**Target:**
Performance target is \( \geq 0.0\% \)

**Year End Projection:**
July YTD, CMH has met the total margin target that was established.

**Analysis:**
Positive results have been driven by improved salary and wage performance caused by a reduction in surge activity and improved sick and over time performance. There has also been positive results related to general supply expenditure and unplanned savings in medical remuneration.

**Action Plan:**
No further action required at this time.
**Cambridge Memorial Hospital**

**Corporate Scorecard FY2016/2017**

**NRC - Would you Recommend (Inpatient)**

**Indicator: 5**

**Status:**

- Year End Projection: Yellow

**Target:**

- MRP: BAREFOOT, LIANE

**Detailed Monthly Data Points**

<table>
<thead>
<tr>
<th>Month</th>
<th>2015/2016</th>
<th>2016/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr</td>
<td>68.40%</td>
<td>71.00%</td>
</tr>
<tr>
<td>May</td>
<td>60.00%</td>
<td>40.60%</td>
</tr>
<tr>
<td>Jun</td>
<td>68.18%</td>
<td>50.00%</td>
</tr>
<tr>
<td>Jul</td>
<td>62.50%</td>
<td>29.40%</td>
</tr>
<tr>
<td>Aug</td>
<td>73.10%</td>
<td>75.00%</td>
</tr>
<tr>
<td>Sep</td>
<td>70.00%</td>
<td>76.20%</td>
</tr>
<tr>
<td>Oct</td>
<td>63.00%</td>
<td>68.20%</td>
</tr>
<tr>
<td>Nov</td>
<td>75.00%</td>
<td>36.40%</td>
</tr>
<tr>
<td>Dec</td>
<td>70.00%</td>
<td></td>
</tr>
<tr>
<td>Jan</td>
<td>68.20%</td>
<td></td>
</tr>
<tr>
<td>Feb</td>
<td>36.40%</td>
<td></td>
</tr>
<tr>
<td>Mar</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Indicators and Components**

- **Definition:** Acute Inpatient Satisfaction Survey measuring the average % of positive responses to the question: "Would you recommend this hospital to family and friends?"

- **Formula:** Number of positive responses to the question divided by the total number of responses to the question.

- **Target:** Performance Target is 70%. Corridor is 63%.

- **Year End Projection:** Yellow

**Analysis:**

Results for Would you Recommend were well below target for almost all of 2014-2015 (59.2% YE) and the early part of 2015-2016. They have started to rise throughout 2015-2016 from the previous years results and YTD is 67.2%. Seven of eight care dimension scores are at or better than the Ontario Community Hospital Average (OHCA). The only dimension that is below the OCHA is Involvement of Family - CMH is at 71.5% YTD and the OCHA is 72.1% - a variance of 0.6%. The most significant overall improvement has occurred on the medical units in the later part of the fiscal year - post model of CCAIR implementation.

**Action Plan:**

Continue to anticipate that the results post Model of CCAIR implementation will continue to trend in a positive direction. Leaders across the organization have begun patient rounding as part of the Leader Standard Work, leaders are working through the logistics of including the patient voice in their CRP Transitional Planning teams and recent process improvement work (emerg triage/registration) has included the voice of the patient.
# Cambridge Memorial Hospital HSAA Scorecard
Fiscal Year 2016 - 2017
Indicator Status & Trends

## Efficient

<table>
<thead>
<tr>
<th>Indicator Number</th>
<th>Efficient</th>
<th>Status</th>
<th>Previous Status</th>
<th>Year End Projection</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>QIP/HSAA 90th Percentile ED Length of Stay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>HSAA 90th Percentile ED Wait-Time for Non-Admit Complex Patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>HSAA 90th Percentile ED Wait-Time for Non-Admit Minor Patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>HSAA Day Surgery Weighted Visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>HSAA Emergency Department Weighted Cases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>HSAA Acute Inpatient Weighted Cases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>HSAA Mental Health Weighted Patient Days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>HSAA Rehab Inpatient Weighted Cases</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Integrated & Equitable

<table>
<thead>
<tr>
<th>Indicator Number</th>
<th>Efficient</th>
<th>Status</th>
<th>Previous Status</th>
<th>Year End Projection</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>HSAA 90th Percentile Wait-Times for Magnetic Resonance Imaging</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>HSAA Percentage Alternate Level of Care Days - Closed Cases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>HSAA Percentage Alternate Level of Care Days - Open Cases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>HSAA Computed Tomography Operating Hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>HSAA Magnetic Resonance Imaging Operating Hours</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Safe, Effective, Accessible

<table>
<thead>
<tr>
<th>Indicator Number</th>
<th>Efficient</th>
<th>Status</th>
<th>Previous Status</th>
<th>Year End Projection</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>HSAA Ambulatory Care Visits</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 90th Percentile Emergency Department Length Of Stay for Admitted Patients

**Status:**
- **Year End Projection:**

**Years:**
- **2015/2016:** 25.70, 24.90, 20.90, 18.70, 22.00, 15.40, 21.00, 16.40, 18.60, 16.10, 21.10, 21.70
- **2016/2017:** 9.60, 16.30, 13.70

**Definition:**
The total emergency room length of stay (in hours) where 9 out of 10 admitted patients completed their visits. ED LOS is defined as the time from triage to the time when the patient leaves the ED. The 90th percentile length of stay is from triage to left ED (in hours) for admitted patients. Excludes Left Without Being Seen, and cases with incomplete date and time stamps.

**Formula:**
The ED LOS are ranked from lowest to highest, and the number of occurrences are multiplied by 0.9 to find the 90th percentile rank. The value at this rank is represented. If there is a decimal this is rounded up.

**Target:**
- Current Year Target is 16 hours.
- Corridor is 17.6 Hours.
- HSAA Target is 8 Hours.

**Year End Projection:**
- Projecting green status for year end.

**Analysis:**
EDLOS is improving significantly over 15/16. Clinical leadership has stabilized allowing for increased focus on flow and access work.

**Action Plan:**
Flow team continues to meet weekly. Realignment of medicine model of care planned which will improve the pulling of patients quicker to medicine from the ED. Work processes regarding discharge planning reengineered to improve patient flow to the community. Focus from physicians to ensure disposition placement of patients occurs timely. Review of and rework of triage and green zone in ED to decrease patient wait times at the beginning of their care continuum.
**Year End Projection:**

**Cambridge Memorial Hospital Corporate Scorecard FY2016/2017**

**90th Percentile Wait-Times for Emergency Department Non-Admit Minor Patients**

**Status:**

**Indicators:**

- Performance target is 4 hours. Corridor is 4.4 hours.
- It is expected that this result will continue red.
- Some improvement in the new fiscal year compared to the end 2015/16. In June, able to reach yellow threshold. After two straight months at 85% of patients achieving the 4 hour target, we improved to 87% in June despite having higher volumes than the previous two months.

**Action Plan Updated:** 2016/09/14 13:12

**Definition:**
The total emergency room length of stay (in hours) where 9 out of 10 non-admitted minor patients completed their visits. ED LOS is defined as the time from triage to the time when the patient leaves the ED. The 90th percentile length of stay is from triage to left ED (in hours) for admitted patients. Excludes Left Without Being Seen, and cases with incomplete date and time stamps.

**Formula:**
Using Disposition Code 01 or 15, CTAS 4 or 5 and inclusion and exclusion criteria, The ED LOS are ranked from lowest to highest, and the number of occurrences are multiplied by 0.9 to find the 90th percentile rank. The value at this rank is represented. If there is a decimal this is rounded up.

**Target:**
Performance target is 4 hours. Corridor is 4.4 hours.

**Analysis:**
Inability to transfer admitted patients to the inpatient units quickly compromises this metric as there are only limited spaces to see patients. Nurse Practitioner schedule can directly impact this metric. There is limited ability to replace when sick or on vacation. Work continues on all aspects of flow.

**Detailed Monthly Data Points**

<table>
<thead>
<tr>
<th>Month</th>
<th>2015/2016</th>
<th>2016/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 Apr</td>
<td>4.40</td>
<td>4.60</td>
</tr>
<tr>
<td>02 May</td>
<td>5.10</td>
<td>4.70</td>
</tr>
<tr>
<td>03 Jun</td>
<td>4.70</td>
<td>4.10</td>
</tr>
<tr>
<td>04 Jul</td>
<td>4.30</td>
<td>4.80</td>
</tr>
<tr>
<td>05 Aug</td>
<td>4.10</td>
<td>4.90</td>
</tr>
<tr>
<td>06 Sep</td>
<td>4.80</td>
<td>4.40</td>
</tr>
<tr>
<td>07 Oct</td>
<td>4.90</td>
<td>4.40</td>
</tr>
<tr>
<td>08 Nov</td>
<td>4.40</td>
<td>4.40</td>
</tr>
<tr>
<td>09 Dec</td>
<td>4.40</td>
<td>5.00</td>
</tr>
<tr>
<td>10 Jan</td>
<td>5.00</td>
<td></td>
</tr>
<tr>
<td>11 Feb</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Mar</td>
<td>5.00</td>
<td></td>
</tr>
</tbody>
</table>
Detailed Monthly Data Points

<table>
<thead>
<tr>
<th></th>
<th>01 Apr</th>
<th>02 May</th>
<th>03 Jun</th>
<th>04 Jul</th>
<th>05 Aug</th>
<th>06 Sep</th>
<th>07 Oct</th>
<th>08 Nov</th>
<th>09 Dec</th>
<th>10 Jan</th>
<th>11 Feb</th>
<th>12 Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/2016</td>
<td>182</td>
<td>372</td>
<td>572</td>
<td>701</td>
<td>839</td>
<td>1,021</td>
<td>1,217</td>
<td>1,407</td>
<td>1,551</td>
<td>1,721</td>
<td>1,746</td>
<td>1,934</td>
</tr>
<tr>
<td>2016/2017</td>
<td>203</td>
<td>402</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Definition: Total day surgery visits adjusted for resource intensity

Formula: Sum of Day Surgery visits multiplied by the associate weight

Target: Performance year end target is 2000 weighted visits. Year end corridor is 1800-2200 weighted visits.

Year End Projection: We expect to achieve the target volume by year end.

Analysis: Our volumes are a little higher than last year, and are on track to achieve the target volume. We are seeing a small drop in our average weight per case compared to last year, but still expect to achieve the target volume of weighted cases.

Action Plan: No additional action is needed to achieve the target. Some analysis is being done to understand why the average weight per case is lower this year than last year.
Detailed Monthly Data Points

<table>
<thead>
<tr>
<th>Month</th>
<th>2015/2016</th>
<th>2016/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 Apr</td>
<td>813</td>
<td>809</td>
</tr>
<tr>
<td>02 May</td>
<td>1,681</td>
<td>1,594</td>
</tr>
<tr>
<td>03 Jun</td>
<td>2,663</td>
<td></td>
</tr>
<tr>
<td>04 Jul</td>
<td>3,430</td>
<td></td>
</tr>
<tr>
<td>05 Aug</td>
<td>4,122</td>
<td></td>
</tr>
<tr>
<td>06 Sep</td>
<td>4,876</td>
<td></td>
</tr>
<tr>
<td>07 Oct</td>
<td>5,702</td>
<td></td>
</tr>
<tr>
<td>08 Nov</td>
<td>6,511</td>
<td></td>
</tr>
<tr>
<td>09 Dec</td>
<td>7,280</td>
<td></td>
</tr>
<tr>
<td>10 Jan</td>
<td>8,074</td>
<td></td>
</tr>
<tr>
<td>11 Feb</td>
<td>8,783</td>
<td></td>
</tr>
<tr>
<td>12 Mar</td>
<td>9,571</td>
<td></td>
</tr>
</tbody>
</table>

Definition: Total acute inpatient cases adjusted for resource intensity

Formula: Sum of inpatient discharges multiplied by the resource intensity weight for their associated Case Mix Group

Target: Performance year end target is 9700 weighted cases. Year end corridor is 8924-10476 weighted cases.

Year End Projection: We Expect to Achieve the Target Volume

Analysis: Our inpatient discharges match last year’s volumes to the end of June, however we are seeing a lower weight per case, and patient days are down about 7%. We still expect to finish the year within the target corridor.

Action Plan: An analysis of this year’s volumes compared to last year will be done to understand the change in patient mix that is resulting in shorter stays and lower average weight per case.
Mental Health Weighted Patient Days

Definition: Total mental health patient days adjusted for resource intensity

Formula: A weighted total of days based on the SCIPP weighted patient days

Target: Performance year end target is 7446 weighted patient days. Year end corridor is 6329 weighted patient days.

Year End Projection: The year end projection will be Yellow.

Analysis: Our new target has been reduced to 7,446 weighted cases and the performance corridor is 6,329 to 8,563. At the end of Q4 our volumes have increased significantly and are at 7735.06 and the patient days being reported by CIHI are better aligned. We have reconciled the CIHI data to our internal data and have corrected a number of data issues that prevented them from being accepted by CIHI.

Action Plan: We continue to assess the processes that have been put in place to identify any assessment errors, that would prevent them from being accepted by CIHI, as well as any missing assessments. This should improve data quality and completeness going forward. We have also completed a review of assessments that were missing in the CIHI data for Q1, Q2 and Q3 and they have been corrected and submitted so that the year end reports will reflect the true volume of activity.
90th Percentile Wait-Times for Computed Tomography (CT)

**Status:**
- Year End Projection: Green

**Detailed Monthly Data Points**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>01 Apr</td>
<td>10</td>
<td>28</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>02 May</td>
<td>13</td>
<td>28</td>
<td>35</td>
<td>30</td>
</tr>
<tr>
<td>03 Jun</td>
<td>9</td>
<td>28</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>04 Jul</td>
<td>9</td>
<td>28</td>
<td>38</td>
<td>28</td>
</tr>
<tr>
<td>05 Aug</td>
<td>9</td>
<td>28</td>
<td>30</td>
<td>28</td>
</tr>
<tr>
<td>06 Sep</td>
<td>10</td>
<td>10</td>
<td>38</td>
<td>28</td>
</tr>
<tr>
<td>07 Oct</td>
<td>13</td>
<td>10</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>08 Nov</td>
<td>14</td>
<td>10</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>09 Dec</td>
<td>10</td>
<td>10</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>10 Jan</td>
<td>9</td>
<td>10</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>11 Feb</td>
<td>7</td>
<td>10</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>12 Mar</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Definition:**
The wait time in days that 9 out of 10 patients receive service. P3 are Priority Level 3 patients and have a 90th percentile target of 10 days. P4 are Priority Level 4 Patients and have a target of 28 days.

**Formula:**
The 90th percentile of CT scans performed. Wait days are the number of days between the date the CT scan order was received and the date the CT scan was performed.

**Target:**
Performance Target is 28 days for Priority Level 4, Corridor is 28-31 days. Priority level 3 Target is 10 days.

**Year End Projection:**
CMH continues to closely monitor CT demand and as much as possible juggle available capacity to accomodate urgent/emergent requests. The July increase in P4 wait time was caused by a physician manpower shortage as there was a demand for CT Enterography studies and physician unavailability (due to vacations) to perform. It is not believed that this will create an ongoing impediment to meeting this performance standard.

**Analysis:**
During the summer, CMH was informed that the WWLHIN has implemented a population based wait time funding allocation model. This will result in a reduction of 398 hours in 16/17. A decision has been made not to reduce CMH's current service complement and to absorb this loss through one time budgetary savings with the hope that additional hours will be provided in Q4 when wait time budgets are redistributed. If this does not occur, CMH will be forced to reduce service offerings in the upcoming year. Despite this, the demand for CT services continues to grow. Managing P3 wait time will remain CMH's main priority with the offset being possible increases in P4 Wait Time.

**Action Plan:**
CMH will continue with the current service offering and do its best to prioritize P3 access.
90th Percentile Wait-Times for Magnetic Resonance Imaging (MRI)

**P3**
- 2015/2016: 8, 7, 7, 7, 9, 9, 10, 10, 12, 8, 9, 9
- 2016/2017: 9, 9, 10, 12

**P4**
- 2015/2016: 41, 42, 48, 56, 60, 63, 64, 65, 59, 67, 70, 71
- 2016/2017: 81, 75, 73, 74

**Definition:**
P3 are Priority Level 3 patients and have a 90th percentile target of 10 days. P4 are Priority Level 4 Patients and have a target of 28 days.

**Formula:**
The 90th percentile of MRI procedures performed. Wait days are the number of days between the date the MRI order was received and the date the MRI was performed.

**Target:**
Performance target is 28 days for Priority Level 4. Corridor is 28-31 days. Priority Level 3 target is 10 days.

**Year End Projection:**
CMH continues to prioritize urgent/emergent P3 demand for service and thus far has managed to ensure access within the provincial limits (except for July). P4/elective demand for services far outstrip available capacity and in the short term there is very little likelihood of meeting the provincial P4 targets (whether they be 28 days or 60 days-see below). We will continue to experience variances on P3 wait time as we juggle available slots with peaks and valleys regarding P3 demand.

**Analysis:**
During the summer CMH was informed that the WWLHIN has implemented a population based wait time funding allocation model which would result in a reduction of 309 hrs in the current year. CMH has made the decision to not reduce its service offerings in the current year and support the loss with one time savings with the hope that additional hrs will be allocated in Q4 when wait time budget are redistributed. If that is not the case, then we will be faced with the prospect of service reductions. Demand for MRI Access continues to grow and is the cause of the gradual increase in comparison to last year. Dialogue with the WWLHIN has also resulted in a recommendation that target wait times for P4 procedures be increased to 60 days.

**Action Plan:**
Management has begun the process of upgrading its automated requisitioning process to include referral guidelines with the intent of creating appropriateness criteria for MRI referrals. The regional Surgical Council will also be engaged regarding appropriateness criteria for select orthopedic procedures. In addition, a regional initiative is underway to review MRI protocols across the LHIN which may add to further efficiencies. MRI requisitions continue to be reviewed with the intent of juggling available capacity to ensure those in greatest need (P3) have the best possible access. Thus far, this has been fairly successful.
The Closed ALC rate is the rate of ALC patient days for discharged patients over the total patient days for patients discharged in the period. An ALC day is a day accrued by a patient who originally was admitted for acute care, and has now completed the acute care phase of their care plan and is waiting for a more appropriate level of care placement while continuing to occupy an acute care bed.

Formula:
Closed ALC Cases = (Total Acute ALC Patient Days / Total Patient Days) x 100. The sum of acute patient days excludes newborn/obstetrics) and patient days for SSR, CCC, and rehab *Calculated using Coded data as data source

Target:
Performance target is 15% ALC Days. Corridor is 16.5%. H-SAA target 9.46%.

Year End Projection:
Projecting red performance based on 16.5% corridor.

Analysis:
The closed rates has been constantly around the 20% mark for the last 5 months. The closure of some long term challenging ALC cases has attributed to this increase as well as the hospital and provincial record of ED hospital visits in February 2016 resulting in admissions to hospital.

Action Plan:
CMH/CCAC Integrated Discharge Planning Manager continues to lead our teams focus to ALC patients. Home First strategies along with CCAC intensive home services plan complex discharge planning with patients and families. ALC rounds continue with managers and discharge team 2x per week. ALC refresh of terms and usage scheduled for Flow Team in early April - improvements for physician, nursing and allied health groups. Concentrated work continues with a few very long term ALC patients.
The Open ALC rate is the rate of ALC patient days, including patients still in hospital, over the total patient days in the period. An ALC day is a day accrued by a patient who originally was admitted for acute care, and has now completed the acute care phase of their care plan and is waiting for a more appropriate level of care placement while continuing to occupy an acute care bed.

Open ALC Cases = (Total Acute ALC Patient Days / Total Patient Days) x 100. The sum of acute patient days excludes newborn/obstetrics and patient days for SSR, CCC, and rehab. *Calculated using Meditech as data source.

Performance target is 15% ALC Days. Corridor is 16.5%.

ALC open cases in green. We continue to see a steady decrease in open cases since October 2015.

Laser focus on ALC rounds continue bi-weekly planning. Policies for escalation of long term care and discharge planning efforts reviewed and revised. Escalation of any barriers to patient discharge done daily as needed.
Cambridge Memorial Hospital
Corporate Scorecard FY2016/2017

Computed Tomography (CT) Operating Hours

<table>
<thead>
<tr>
<th>Month</th>
<th>01 Apr</th>
<th>02 May</th>
<th>03 Jun</th>
<th>04 Jul</th>
<th>05 Aug</th>
<th>06 Sep</th>
<th>07 Oct</th>
<th>08 Nov</th>
<th>09 Dec</th>
<th>10 Jan</th>
<th>11 Feb</th>
<th>12 Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/2016</td>
<td>238.36</td>
<td>484.66</td>
<td>723.01</td>
<td>969.31</td>
<td>1,215.62</td>
<td>1,454.00</td>
<td>1,700.27</td>
<td>1,938.64</td>
<td>2,184.93</td>
<td>2,431.23</td>
<td>2,741.70</td>
<td>3,020.00</td>
</tr>
<tr>
<td>2016/2017</td>
<td>228.17</td>
<td>456.33</td>
<td>684.50</td>
<td>912.67</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Detailed Monthly Data Points

Definition: CT Total Operating Hours

Formula: CT Total Operating Hours for month

Target: Performance year end target is 2,738 hours.

Year End Projection: CMH will meet its allocated CT Service volume expectation

Analysis: CMH was informed that its allocated level of CT Hrs would be reduced by 162 hrs in 16/17 based on the LHIN applying a population based allocation methodology. Services will not be scaled back in the current year, with the hope that incremental hrs will be redistributed in January. If that does not occur, the plan will be to cut back service offering in 17/18.

Action Plan: No action is required at this time

Indicator Details/Components

Action Plan Updated: 2016/09/12 14:32
**Cambridge Memorial Hospital Corporate Scorecard FY2016/2017**

**Magnetic Resonance Imaging (MRI) Operating Hours**

**Detailed Monthly Data Points**

<table>
<thead>
<tr>
<th>Year</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>383</td>
<td>741</td>
<td>1,139</td>
<td>1,509</td>
<td>1,853</td>
<td>2,221</td>
<td>2,589</td>
<td>2,949</td>
<td>3,311</td>
<td>3,679</td>
<td>4,121</td>
<td>4,593</td>
</tr>
<tr>
<td>2016/17</td>
<td>384</td>
<td>760</td>
<td>1,152</td>
<td>1,488</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Definition:** MRI Total Operating Hours

**Formula:** MRI Total Operating Hours for month

**Target:** Performance year end target is 4,156 hours.

**Year End Projection:** CMH will achieve its approved MR service level

**Analysis:** CMH was informed that its 16/17 MRI hrs allocation will be reduced by 309 hrs due to the LHIN applying a new population based allocation methodology. Service hrs will not be scaled back in 16/17 with the hope that additional hrs will be redistributed to CMH in Jan/17. If that does not occur, services will be scaled back in fiscal year 17/18 with a resulting impact on P4 wait time.

**Action Plan:** No action is required at this time.
Ambulatory Visits - Year To Date

Detailed Monthly Data Points

<table>
<thead>
<tr>
<th>Month</th>
<th>01 Apr</th>
<th>02 May</th>
<th>03 Jun</th>
<th>04 Jul</th>
<th>05 Aug</th>
<th>06 Sep</th>
<th>07 Oct</th>
<th>08 Nov</th>
<th>09 Dec</th>
<th>10 Jan</th>
<th>11 Feb</th>
<th>12 Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/2017</td>
<td>7,330</td>
<td>14,736</td>
<td>21,356</td>
<td>26,839</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Definition: Number of ambulatory care visits.

Formula: Number of ambulatory care visits (clinic, community, and surgery), excludes emergency and telephone visits

Target: Performance year end target is 73050 visits. Year end Corridor is 58440 visits.

Year End Projection: We expect to be a little above target by end of year

Analysis: Volumes are just slightly lower than last year at this time, and a little over target.

Action Plan: No additional action required as we are on target.
MEMORANDUM

TO: The Board of Directors, Cambridge Memorial Hospital

DATE: September 12, 2016

REPORTING PERIOD: April 1, 2016 – June 30, 2016

FROM: Patrick Gaskin
President and CEO

RE: CEO Certificate of Compliance

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

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

a) Salaries, Wages and Benefits – CMH has met all of its obligations in respect of the payment of all employee salaries and wages, vacation pay, holiday pay, termination pay, severance pay and benefits.

b) Statutory Deductions – CMH has met all of its obligations in respect of the deduction, withholding and/or remittance of funds under the Income Tax Act (Canada), the Income Tax Act (Ontario), the Employer Health Tax Act (Ontario) (EHT), the Excise Tax Act (Canada) (HST), Workplace Safety and Insurance Act (Ontario) (WSIB), the Employment Insurance Act (Canada) (EI), the Canada Pension Plan Act (Canada) (CPP), and if applicable, remittances for required deductions for payments to non-residents.

c) Financial Statements – the CMH financial statements, as at the date of their preparation were accurate and complete in all material respects.

Exceptions: NIL

Patrick Gaskin
President and CEO
Further to discussion at the June 15 meeting of the Waterloo Hospitals Collaborative Committee (WHCC), the Waterloo Hospitals have agreed to align their strategic planning cycles and renewals to facilitate coordinated planning. In addition, WHCC has asked the CEOs to propose an approach to preparing strategic plans in a collaborative manner for discussion at the September 2016 WHCC meeting. This note summarizes the approach proposed by the CEOs.

Collaborative strategic planning requires a balance between finding a shared approach on common priorities while maintaining sufficient flexibility for each institution to address its own specific needs. This suggests that future strategic plans may be structured in two parts. The first part would reflect the directions chosen by the Boards on priorities held jointly and would be common among the plans. The second part would address priorities specific to each hospital and the associated strategies. This would result in three unique plans sharing a group of collaborative strategies on selected issues.

If this approach is followed, it will be necessary to jointly establish priorities for collaborative effort. It is proposed that these priorities would flow principally from two sources. First, WHCC has defined a vision for the future relationships among of the Waterloo Hospitals, so priorities and responding strategies which speak to advancing toward that vision should be contained in commonly approved section of the strategic plans. Second, all hospitals need to respond to the Waterloo Wellington Integrated Health Services Plan (WWIHSP). Within the scope of the WWHSP, there will be priorities for which a collaborative approach would be advantageous.

If this model for collaborative strategic planning is acceptable to WHCC, several actions could be taken to begin its implementation.

1. CEOs would undertake a review of the environmental scan activities from the previous strategic planning cycle and agree upon a scope for a shared environmental scan for use by all three hospitals. This may require a small consulting engagement to update a number of existing forecast documents.
2. CEOs could prepare a recommendation to WHCC, based upon the WWIHSP and the WHCC Vision Statement for collaborative priorities to be addressed in the common section of the strategic plans.

3. A work plan and schedule could be prepared summarizing the timing and workflow of strategic planning activities. This would address the schedule through WHCC and with each Board to ensure that collaborative discussion can occur in a timely way and on a schedule consistent with each Board’s expectations for strategic plan renewal.

**Recommendation:**

Provide direction with respect to the acceptability of this approach and whether the proposed implementation actions are sufficient.
<table>
<thead>
<tr>
<th>Charter Section</th>
<th>Action (Italics-comments)</th>
<th>Committee Responsible</th>
<th>Sep</th>
<th>Nov</th>
<th>Jan</th>
<th>Feb</th>
<th>May</th>
<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tone at the Top</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a-i, ii</td>
<td>Approve CEO goals and objectives</td>
<td>Executive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Approve COS goals and objectives</td>
<td>Executive</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mid-year/Year-end CEO report and assessment</td>
<td>Executive</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mid-year/Year-end COS report and assessment</td>
<td>Executive</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CEO evaluation/feedback – mid-year</td>
<td>Executive</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>COS evaluation/feedback – mid-year</td>
<td>Executive</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a-iii</td>
<td>Reviewing the performance assessments of the VPs – summary report provided to the Board (as per policy 2-B-10)</td>
<td>Executive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Strategic Planning</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>Strategic Plan: approve process, participate in development, approve plan (done in 2014; will be done again in 2017)</td>
<td>Board</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>Progress report on Strategic Plan</td>
<td>Board</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b-iii-c</td>
<td>Approve annual quality improvement plan</td>
<td>Quality</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b-iii-C</td>
<td>Review and approve the Hospital Services Accountability Agreement (H-SAA)</td>
<td>Resources, Quality</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b-iii-C</td>
<td>Monitor performance indicators and progress toward achieving the quality improvement plan</td>
<td>Quality</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Corporate Performance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c-i-B</td>
<td>Critical incidents report – (as per the Excellent Care for All Act). (Brought forward to Board as deemed necessary)</td>
<td>Quality</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c-i-B</td>
<td>Monitor, mitigate, decrease and respond to principal risks</td>
<td>Audit</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Organizational Chart

**Agenda Item 2.1.2**
**BOARD WORK PLAN – 2016-17**

<table>
<thead>
<tr>
<th>Charter Section #4</th>
<th>Action (Italics-comments)</th>
<th>Committee Responsible</th>
<th>Sep</th>
<th>Nov</th>
<th>Jan</th>
<th>Feb</th>
<th>May</th>
<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>c-i-E</td>
<td>➢ Review the functioning of the Corporation, in relation to the objects of the Corporation the Bylaw, Legislation, and the HSAA <em>(Medical/Professional By-law Review 2016-17)</em></td>
<td>Governance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| c-i-F              | ➢ Receive and review:  
                      • Resources Scorecard  
                      • Quality Scorecard  
                      • HSAA Scorecard  
                      • Board Scorecard  
                      Note: Resources & Quality scorecards are available on the portal in the respective committee sections. HSAA & Board scorecards appear in the Board consent package | Resource Quality Resource Board |     |     |     |     |     |     |
| c-i-F              | ➢ Declaration of Compliance with M-SAA Schedule G (due Oct 31 and Apr 30 to the WWLHIN)   | Resources             | √   |     |     |     |     |     |
| c-i-F              | ➢ Declaration of Compliance with BPSAA Schedule A (due May 31 to the WWLHIN)              | Resources             |     |     |     |     |     | √   |
| c-i-F              | ➢ Receive and review quarterly the CEO certificate of compliance regarding the obligations for payments of salaries, wages, benefits, statutory deductions and financial statements | Resources             | √   | √   |     |     |     |     |
| c-i-F              | ➢ Procedures to monitor and ensure compliance with applicable legislation and regulations | Audit                 |     |     |     |     |     | √   |

**Succession Planning**

| e-i-A              | ➢ CEO succession plan and process                                                         | Executive             |     |     |     |     |     |     |
| e-i-B              | ➢ COS succession plan and process                                                          | Executive             |     |     |     |     |     |     |
| e-i-C              | ➢ Succession plan for executive management and professional staff leadership               | Executive             |     |     |     |     |     |     |
|                   | ➢ Receive summary report from Executive/CEO/COS on CEO & COS succession plans             | Executive             |     |     |     |     |     |     |

**Professional Staff**

| f-i-A              | ➢ Ensure the effectiveness and fairness of the credentialing process                       | MAC/Quality            |     |     |     |     |     |     |
| f-i-A              | ➢ Monitor indicators of clinical outcomes, quality of service, patient safety and achievement of desired outcomes (MAC scorecard) | MAC                   |     |     |     |     |     |     |
## Agenda Item 2.1.2
### BOARD WORK PLAN – 2016-17

<table>
<thead>
<tr>
<th>Charter Section #4</th>
<th>Action (Italics-comments)</th>
<th>Committee Responsible</th>
<th>Sep</th>
<th>Nov</th>
<th>Jan</th>
<th>Feb</th>
<th>May</th>
<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>f-i-C</td>
<td>Make the final appointment, reappointment and privilege decisions for Medical/Professional Staff</td>
<td>Board</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td></td>
<td>Oversee the Medical/Professional Staff through and with the MAC and COS</td>
<td>COS</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>

### Financial Viability

| h-i-A,C            | Review and approve multi-year capital strategy                                          | Resources            | √   | √   |     |     |     |     |
|                    | Review and approve multi-year information technology strategy                           | Resources            | √   | √   |     |     |     |     |
| h-i-A              | Review and approve annual operating plan – service changes, operating plan, capital plan| Resources/Quality    | √   | √   |     |     |     |     |
| h-i-A, B           | Approve the year-end financial statements                                               | Board                |     |     |     |     | √   |     |
| h-i-A              | Approve key financial objectives that support the corporation’s financial needs (including capital allocations and expenditures) (assumptions for following year budget) | Resources            | √   |     |     |     |     |     |
| i-i-C              | Review of management programs to oversee compliance with financial principles and policies | Resources            |     |     |     |     | √   |     |

### Board Effectiveness

| i-i-A              | Establish Board Work Plan                                                                 | Board                | √   |     |     |     |     |     |
|                   | Ensure Board Members adhere to corporate governance principles and guidelines           | Governance           | √   | √   |     |     |     |     |
|                   | Declaration of conflict agreement signed by directors annually                            | Governance           | √   |     |     |     |     |     |
|                   | Indemnity Agreement signed by directors annually                                         | Governance           | √   |     |     |     |     |     |
| i-i-B              | Ensure the Board’s own effectiveness and efficiency, including monitoring the effectiveness of individual Directors and Board officers and employing a process for Board renewal that embraces evaluation and continuous improvement | Governance/Board     |     |     |     |     | √   |     |
| i-i-C              | Ensure compliance with audit and accounting principles                                   | Audit                |     |     |     |     | √   |     |
| i-i-D              | Periodically review and revise governance policies, processes and structures as appropriate | Governance           | √   | √   | √   | √   |     |     |

### Fundraising
# Agenda Item 2.1.2
## BOARD WORK PLAN – 2016-17

<table>
<thead>
<tr>
<th>Charter Section #4</th>
<th>Action <em>(Italics-comments)</em></th>
<th>Committee Responsible</th>
<th>Sep</th>
<th>Nov</th>
<th>Jan</th>
<th>Feb</th>
<th>May</th>
<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>k</td>
<td>➢ Support fundraising initiatives including donor cultivation activities. <em>(through Foundation Report and Upcoming Events)</em></td>
<td>Foundation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

**Public Hospitals Act required programs**

<table>
<thead>
<tr>
<th>I-i-A</th>
<th>➢ Ensure that an occupational health and safety program and a health surveillance program are established and require accountability on a regular basis</th>
<th>Quality</th>
<th>✓</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I-i-B</td>
<td>➢ Ensure that policies are in place to encourage and facilitate organ procurement and donation</td>
<td>Quality</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I-i-C</td>
<td>➢ Ensure that the Chief Executive Officer, 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</td>
<td>Quality</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Recruitment**

<table>
<thead>
<tr>
<th>n</th>
<th>➢ Approve Nominating Committee membership <em>(noted in By-law)</em></th>
<th>Governance</th>
<th>✓</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>➢ Review recommendations for new directors, non-director committee members <em>(2-D-20)</em></td>
<td>Governance</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Conduct the election of officers <em>(2-D-18)</em></td>
<td>Governance</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Review evaluation results and improvement plans for the board, the board chair (by the Governance Chair), Board committees, committee chairs <em>(2-D-40)</em></td>
<td>Governance</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Review committee reports on work plan achievements <em>(2-A-16)</em></td>
<td>Governance</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
## ON GOING AS NEEDED

<table>
<thead>
<tr>
<th>Charter Section #4</th>
<th>Charter Item</th>
<th>Action <em>(Italicics-comments)</em></th>
<th>Committee Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>i-i-E</td>
<td>Board Effectiveness</td>
<td>Compliance with the By-Law</td>
<td>Governance</td>
</tr>
</tbody>
</table>
| c-i-A, B           | Corporate Performance    | Ensure there are systems in place to identify, monitor, mitigate, decrease and respond to the principal risks to the Corporation:  
 |                    |                          | o financial                                                             | Audit, Resources Quality |
|                    |                          | o quality                                                               |                       |
|                    |                          | o patient/workplace safety                                               |                       |
| c-i-C              | Corporate Performance    | Oversee implementation of internal control and management information systems to oversee the achievement of the performance metrics | Resources             |
| c-i-D              | Corporate Performance    | Processes in place to monitor and continuously improve upon the performance metrics | Resources/Quality      |
| c-i-G              | Corporate Performance    | Policies providing direction for the CEO and COS in the management of the day-to-day processes within the hospital | Governance/Executive  |
| d-ii-A,B           | CEO and COS              | Select the CEO, delegate responsibility and authority, and require accountability to the Board | Executive             |
| d-ii-C             | CEO and COS              | Policy and process for the performance evaluation and compensation of the CEO | Executive             |
| d-ii-D, E          | CEO and COS              | Select the COS, delegate responsibility and authority, and require accountability to the Board | Executive             |
| d-ii-F             | CEO and COS              | Policy and process for the performance evaluation and compensation of the COS | Executive             |
| h                  | Financial Viability      | Approve collective bargaining agreements                                     | Board                 |
| h                  | Financial Viability      | Approve salary increases, material amendments to benefit plans, programs and policies | Resources             |
| h                  | Financial Viability      | Approve capital projects                                                   | Resources             |
ON GOING AS NEEDED – Led by CEO/COS – reported in CEO report/Quality Presentations

<table>
<thead>
<tr>
<th>Charter Section #4</th>
<th>Charter Item</th>
<th>Action (Italics-comments)</th>
<th>Committee Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>g</td>
<td>Build Relationships</td>
<td>Build and maintain good relationships with the Corporation’s key stakeholders</td>
<td>Board oversight Led by CEO/COS</td>
</tr>
<tr>
<td>j-i-A</td>
<td>Communication and Community Relationships</td>
<td>Establish processes for community engagement to receive public input on material issues</td>
<td>Board Oversight Led by CEO</td>
</tr>
<tr>
<td>j-i-B</td>
<td>Communication and Community Relationships</td>
<td>Promote effective collaboration and engagement between the Corporation and its community, particularly as it relates to organizational planning, mission and vision</td>
<td>Board Oversight Led by CEO/COS and Chair</td>
</tr>
<tr>
<td>j-i-C</td>
<td>Communication and Community Relationships</td>
<td>Work collaboratively with other community agencies and institutions in meeting the healthcare needs of the community</td>
<td>Board Oversight Led by CEO/COS Quality</td>
</tr>
<tr>
<td>j-i-D</td>
<td>Communication and Community Relationships</td>
<td>Maintain information on the website</td>
<td>Board oversight Led by CEO</td>
</tr>
<tr>
<td>j-i-E</td>
<td>Communication and Community Relationships</td>
<td>Establish a communication policy for the Corporation; review periodically (1-B-15 last reviewed Sept 30, 2015 reviewed every 3 years)</td>
<td>Board oversight Led by CEO</td>
</tr>
<tr>
<td>m</td>
<td>Communications Policy</td>
<td>Oversee the maintenance of effective stakeholder relations through the Corporation’s communications policy and programs</td>
<td>Board oversight Led by CEO</td>
</tr>
</tbody>
</table>
BRIEFING NOTE - OPEN SESSION

Date: September 28, 2016
Issue: Upcoming Meetings & Upcoming Events
Purpose: Information
Prepared by: Cheryl Vandervalk, Executive Assistant
Approved by: Patrick Gaskin, President & CEO

October 2016
Quality Committee October 19, 2016 7:00am-9:00am
Resources Committee October 24, 2016 5:00pm-7:00pm
Capital Projects October 24, 2016 3:30pm-5:00pm

November 2016
Governance Committee November 10, 2016 4:30pm-6:00pm
Quality Committee November 16, 2016 7:00am-9:00am
Resources Committee November 28, 2016 5:00pm-7:00pm
Capital Projects November 28, 2016 3:30pm-5:00pm
Board of Directors Meeting November 30, 2016 5:00pm-8:00pm

WWLHIN Board Meetings
October 12, 2016 2:00pm
50 Sportsworld Drive, Kitchener, ON

OHA Conferences
Role of the Board in Health Care and Hospital Strategy Part 1 October 5, 2016 (webinar)
Financial Literacy for Hospital Board Directors October 14, 2016

2016 Events, Fall/Winter:
Foundation Events

Afternoon Tea at Langdon Hall
October 23, 2016 1:30 pm
Agenda Item 2.1.3

**Breast Friends Dinner & Dance**
October 29, 2016
African Lion Safari  6:00 pm

**Diversity Dinner**
Newfoundland Club
November 2, 2016  6:00 pm

**Ayr/Paris Band Remembrance Day Concert**
Wednesday, November 9, 2016 at 7:00p.m.
Knox United Church, Ayr
Freewill offering

**Ladies Night**
Thursday, November 17, 2016 at 7:00p.m.
Ayr Home Hardware
Tickets $15.00

**Moonlight and Mistletoe**
**Christmas Dinner and Dance**
Friday, November 25, 2016
Cocktail hour 6:00p.m. Dinner at 7:00p.m.
North Dumfries Community Complex
Tickets $100 with a $50.00 charitable receipt
BRIEFING NOTE – Resources Committee

Date: September 21, 2016
Issue: August Financial Statements
Purpose: Review of August Financial Statements
Prepared by: Mike Prociw
Approved by: Patrick Gaskin

Summary
CMH has a August year to date operating surplus of $554K after building amortization and related capital grants which represents a $ 301K positive variance from budget. In August, CMH had an operating surplus of $108K. The positive YTD variance is primarily due to positive variances in salaries and supplies due to the timing of expenditures offset by negative volume variances in QBPs. It is expected that the timing variances will be reversed in future months.

Revenue
A brief summary of some of the major year to date revenue variances include:

MOH Funding:
- For the elective QBPS, the knee replacements are 12% (19 procedures) above target and hips are 6% (5 procedures) below target. Cataracts are 10% below target. Additional elective QBPs in breast cancer surgery are 30 procedures below target, thyroid cancer surgery is 5 procedures above target, knee arthroscopy is 56 procedures under target and tonsillectomy is 27 procedures below target. The hospital is in the process of negotiating elective volumes with the LHIN with the objective of maintaining the number of hips and knees that are performed at CMH and reducing the knee arthroscopy and tonsillectomy procedures. The LHIN had requested that the number of hip and knee procedures be reduced and the funding reallocated to emergent QBPs such as COPD and Pneumonia. All elective QBP funding is expected to be realized by year end.
- For the remaining QBPs, coded data is available up to the end of June and previous years actuals are used as estimates for July and August volumes. It is expected that all QBP revenue for emergent QBPs will be realized by year end.
Agenda Item 2.2.1

...and there will continue to be a number of unfunded cases for COPD and Pneumonia at year end.

- The large negative variance in QBP revenue for the month is due to volumes being below target and adjustments made to previous months estimates for breast cancer surgery and hip fractures. The estimates were based on previous years actuals which resulted in an overstatement.
- The MOH Onetime/Other funding is less than budget due to the timing of the implementation of the new grad program and the alignment of revenue with expenses for the Hospital On Call Coverage funding.

Billable Patient Services

- The negative YTD variance of $320K is primarily due to less than expected revenue from out of country patients, semi-private accommodations and the billing of professional fees partially offset by higher than expected WSIB revenue.

Recoveries and Other Revenues

- The year to date positive variance is primarily due to higher than expected revenue from parking and interest.

Amortization of Deferred Equipment Capital Grant

- The YTD positive variance is a result of the timing of capital purchases.

Expenses

Salaries and Wages

- There is a positive variance of $221K for the month and a positive variance of $229K year to date. The major driver to the positive variance is the actual utilization of vacation time as compared to the allocation of the budget. In the month of August a large amount of vacation is used by staff. When vacation is taken the costs are applied against the vacation accrual resulting in a decline in salary and wage expense for the month. The salary budget does not reflect the large amount of vacation taken in the month.
- Sick and overtime was over budget in the month by $22K (2015 – over budget $200K). The YTD sick and overtime is over budget by $179K (2015 – over budget $649K). The table below provides a summary in hours for sick and overtime.

<table>
<thead>
<tr>
<th>HOURS</th>
<th>August</th>
<th></th>
<th></th>
<th>YTD</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>2015</td>
<td>Actual</td>
<td>Budget</td>
<td>2015</td>
</tr>
<tr>
<td>Overtime</td>
<td>2,092</td>
<td>1,584</td>
<td>4,099</td>
<td>10,846</td>
<td>7,781</td>
<td>14,834</td>
</tr>
<tr>
<td>Sick</td>
<td>3,271</td>
<td>2,689</td>
<td>4,091</td>
<td>15,253</td>
<td>13,234</td>
<td>19,313</td>
</tr>
</tbody>
</table>

A brief overview of the year to date over time variance is as follows:

- The emergency department has a YTD negative variance of $94K. The major cause of the overtime has been the length of time it has taken to recruit staff to fill vacant positions. It has been very difficult to attract and retain part time staff in
the department. Overtime pressures are expected to continue over the remainder of the summer until staffing positions have been filled.

- The medicine units have a YTD negative variance of $24K which has resulted from a negative sick variance and a greater number than expected patients requiring one to one care. The average number of patient days has remained within the current compliment of beds.

A brief overview of the year to date sick variance is as follows

- The medicine units and housekeeping have a combined negative YTD variance of $52K. This variance is offset by savings in Women and Children, Labs and Mental Health. Work continues with the timely delivery of letters and meetings with staff with a high number of sick days and occurrences.

Other variances in salaries and wages are

- The emergency department has a YTD variance of $240K which is due to overtime, training costs of new staff hired and staff on modified work.
- The registration department has a negative YTD variance of $108K which is primarily due to additional costs resulting from the training of new staff hired.
- The nursing float pool has a positive YTD variance of $152K due to the timing of hiring and training new nurses for the float pool
- As mentioned above the major contributor to the positive variance in the month is the large amount of vacation that is taken in the month of August that is in excess of the budget. This variance is a timing variance which will reverse itself out during the remainder of the year.

Benefits
- The YTD maternity top up expense has a $10K negative variance. Past practice was used to determine the budget allocation. The entire maternity top up is recognized at the inception of the leave and therefore the expense is subject to fluctuations during the year
- The YTD percentage in lieu expense is $36K in excess of budget. The variance is a result of having more part time staff then what was budgeted. The part time staff are used to fill the vacant full time positions.

Medical Remuneration
- The positive YTD variance is mainly attributed to the timing of expenditures within the office of the Chief of Staff.

Medical and Surgical Supplies
- A substantial portion of the negative YTD variance is attributed to the utilization of medical surgical supplies within the Operating Room. A review is currently being undertaken to determine the source of the increase. Results will be available next month.

Drug Expense
- The previous year’s large negative variance has been reduced due to an increase in budget for systemic treatment. There is a YTD positive variance for oncology drugs of $91K which represents a 10% reduction in drug utilization
from last year partly resulting from a 4% reduction in patient visits.

**Other Supplies and Expenses**
- The clinical areas have a positive YTD surplus of K97K. This variance is consistent with the previous year’s expenditures and is considered a timing difference which will be diminished throughout the year.
- $77K of the variance is a result of the timing of expenditures within the Lab and Diagnostic Imaging.
- Administration and HR contribute $100K of the positive variance. As in past years the variance will vary based on the need to engage professional services.

**Amortization**
- The positive variance is due to the timing of capital purchases during the year.

**Balance Sheet and Statement of Cash**

CMH’s current cash position is $20.5M in current operating and $10.5M in restricted cash. The restricted cash includes $6.6M for the hospitals contribution to the sinking fund as required under the terms and condition of the Capital Redevelopment Project. The sinking fund payment was received from the Foundation. The working capital ratio meets the requirements of the Working Funds Agreement. The Capital Redevelopment Project has increased to $71.1M. In accordance with the agreement with the Ministry of Health CMH will make a lump sum payment of $65M to the general contractor once CMH takes ownership of the building. $59M of the payment will be funded by the Ministry with the remaining amount, $6.6M, will be funded the CMH Foundation.

**Activity Volumes**
- The medicine floors have averaged YTD 50 patients per day. During the month of August there was a decline of 4% in patient days.
- The surgical floor has an average of 21 patients per day YTD. During the month of August there was a decline of 10% in patient days due to the operating room shut down and slow down.
- The mental health unit has an average of 17 patients per day YTD. During the month of August there was a decline of 18% in patient days. The summer has historically resulted in fewer days in the unit. In the previous year there was a reduction of 24% in the month of August.
- The average numbers of YTD visits in the Emergency Room are 148 per day. During the month of August there was a 3% decline in visits. In August of the previous year there was a 5% decline.
### CAMBRIDGE MEMORIAL HOSPITAL

**STATEMENT OF INCOME AND EXPENSE**

#### Operating Income

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Plan</th>
<th>Variance</th>
<th>% var</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YTD Actual</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MoH Base</td>
<td>$18,661,071</td>
<td>$18,666,504</td>
<td>($5,433)</td>
<td>(0.0%)</td>
</tr>
<tr>
<td>MoH HBAM</td>
<td>12,229,714</td>
<td>12,233,271</td>
<td>(3,557)</td>
<td>(0.0%)</td>
</tr>
<tr>
<td>MoH QBP</td>
<td>6,703,526</td>
<td>7,022,884</td>
<td>(319,358)</td>
<td>(4.5%)</td>
</tr>
<tr>
<td>MoH One-time/Other</td>
<td>2,610,887</td>
<td>2,722,699</td>
<td>(111,812)</td>
<td>(4.1%)</td>
</tr>
<tr>
<td>Total MoH Funding</td>
<td>$40,205,198</td>
<td>$40,645,358</td>
<td>($440,160)</td>
<td>(1.1%)</td>
</tr>
</tbody>
</table>

#### Operating Expense

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Plan</th>
<th>Variance</th>
<th>% var</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HBAM</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries &amp; Wages</td>
<td>$23,629,129</td>
<td>$23,858,540</td>
<td>$229,411</td>
<td>(1.0%)</td>
</tr>
<tr>
<td>Employee Benefits</td>
<td>$6,576,619</td>
<td>$6,484,139</td>
<td>($91,480)</td>
<td>(1.4%)</td>
</tr>
<tr>
<td>Medical Remuneration</td>
<td>6,994,619</td>
<td>7,444,529</td>
<td>$449,910</td>
<td>6.6%</td>
</tr>
<tr>
<td>Medical &amp; Surgical Supplies</td>
<td>3,742,081</td>
<td>3,465,014</td>
<td>(277,067)</td>
<td>(8.0%)</td>
</tr>
<tr>
<td>Drug Expense</td>
<td>2,269,192</td>
<td>2,411,933</td>
<td>$142,741</td>
<td>(5.9%)</td>
</tr>
<tr>
<td>Other Supplies &amp; Expenses</td>
<td>4,970,901</td>
<td>5,344,930</td>
<td>374,029</td>
<td>7.0%</td>
</tr>
<tr>
<td>Equipment Depreciation</td>
<td>1,939,811</td>
<td>1,959,030</td>
<td>$19,219</td>
<td>1.0%</td>
</tr>
<tr>
<td>MoH Special Votes Expense</td>
<td>1,402,589</td>
<td>1,430,680</td>
<td>(28,091)</td>
<td>(2.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>$52,392,221</td>
<td>$52,978,042</td>
<td>($585,821)</td>
<td>(1.1%)</td>
</tr>
</tbody>
</table>

#### MOH Surplus (Deficit)

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Plan</th>
<th>Variance</th>
<th>% var</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$40,205,198</td>
<td>$40,645,358</td>
<td>($440,160)</td>
<td>(1.1%)</td>
<td></td>
</tr>
</tbody>
</table>

---

**For the Year Ending Aug 31, 2016**

<table>
<thead>
<tr>
<th></th>
<th>16/17 Plan</th>
<th>15/16 prior year actuals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MoH Surplus (Deficit)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$554,108</td>
<td>$252,903</td>
<td>$301,205</td>
</tr>
<tr>
<td>% var</td>
<td>119.1%</td>
<td></td>
</tr>
</tbody>
</table>

**Net Surplus (Deficit) for the period**

| $956,621             | $276,033        | $2,057,435               |

---

**Agenda Item 2.2.1**

- 22-Sep-16
- $107,991
- 140,462
- (23.1%)
### CAMBRIDGE MEMORIAL HOSPITAL
#### COMPARATIVE BALANCE SHEET

**AUG 2016** | **MARCH 2016**
---|---
**ASSETS**

**Current Assets**
- *Cash and short-term investments* | $20,544,463 | $22,450,973 |
- *Due from Ministry of Health/LHIN* | 1,883,912 | 1,356,162 |
- *Other receivables* | 1,783,333 | 2,214,715 |
- *Inventories* | 1,744,347 | 1,775,585 |
- *Prepaid expenses* | 1,309,290 | 940,218 |

**Non-Current Assets**
- *Cash and investments restricted - Capital* | 10,488,770 | 3,891,693 |
- *Endowment and special purpose fund cash & investments* | 187,427 | 187,427 |
- *Capital Assets* | 74,622,648 | 75,016,310 |
- *Capital Redevelopment Construction in Progress* | 71,148,445 | 51,690,998 |

**TOTAL ASSETS** | $183,712,635 | $159,524,081 |

**LIABILITIES & EQUITY**

**Current Liabilities**
- *Due to Ministry of Health/LHIN* | $450,719 | $490,879 |
- *Accounts payable and accrued liabilities* | 19,223,582 | 21,592,823 |

**Long Term Liabilities**
- *Employee future benefits* | 4,166,178 | 4,090,000 |
- *Capital Redevelopment Construction Payable* | 70,828,831 | 51,371,669 |
- *Deferred Capital Grants and Donations* | 66,789,143 | 60,278,429 |
- *Deferred Capital Grants Capital Redevelopment* | 2,245,400 | 2,245,400 |

**Net Assets:**
- *Unrestricted* | 3,424,866 | 2,563,952 |
- *Externally restricted special purpose funds* | 187,427 | 187,427 |
- *Invested in Capital Assets* | 16,396,489 | 16,703,502 |

**TOTAL LIABILITIES & EQUITY** | $183,712,635 | $159,524,081 |

**Working Capital Balance** | 7,591,044 | 6,653,951 |
**Working Capital Ratio (Current Ratio)** | 1.39 | 1.30 |
## CAMBRIDGE MEMORIAL HOSPITAL

### STATEMENT OF CHANGES IN FINANCIAL POSITION

For the Month Ending August 31, 2016

---

**Cash Provided By (used in) Operations:**

<table>
<thead>
<tr>
<th>Description</th>
<th>YTD AUG'16</th>
<th>YTD JUL'16</th>
<th>FY 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excess (deficiency) of revenue over expenses</td>
<td>$ 554,108</td>
<td>$ 446,117</td>
<td>$ 2,057,435</td>
</tr>
<tr>
<td>Items not involving cash:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Amortization</td>
<td>2,724,162</td>
<td>2,194,406</td>
<td>6,472,106</td>
</tr>
<tr>
<td>- Loss on Disposal of Assets</td>
<td>-</td>
<td>-</td>
<td>(10,000)</td>
</tr>
<tr>
<td>- Amortization of deferred grants and donations</td>
<td>(1,461,473)</td>
<td>(1,171,672)</td>
<td>(3,375,924)</td>
</tr>
<tr>
<td>Change in non-cash operating working capital</td>
<td>(2,843,809)</td>
<td>(2,163,938)</td>
<td>526,052</td>
</tr>
<tr>
<td>Change in employee future benefits</td>
<td>76,178</td>
<td>59,986</td>
<td>2,211</td>
</tr>
<tr>
<td></td>
<td>-950,834</td>
<td>-635,101</td>
<td>5,671,880</td>
</tr>
</tbody>
</table>

**Investing:**

<table>
<thead>
<tr>
<th>Description</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquisition of capital assets &amp; CRP</td>
<td>(21,787,946)</td>
<td>(16,740,388)</td>
<td>(53,465,062)</td>
</tr>
<tr>
<td>Grant receivable</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Endowment and special purpose investments</td>
<td>-</td>
<td>-</td>
<td>115,060</td>
</tr>
<tr>
<td></td>
<td>(21,787,946)</td>
<td>(16,740,388)</td>
<td>(53,350,002)</td>
</tr>
</tbody>
</table>

**Financing:**

<table>
<thead>
<tr>
<th>Description</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sinking Fund contribution from CMH Foundation</td>
<td>6,622,850</td>
<td>1,275,639</td>
<td>6,305,853</td>
</tr>
<tr>
<td>Capital donations and grants &amp; CRP</td>
<td>1,349,337</td>
<td>14,924,963</td>
<td>44,586,313</td>
</tr>
<tr>
<td>Construction payable</td>
<td>19,457,161</td>
<td>16,200,602</td>
<td>50,892,166</td>
</tr>
<tr>
<td></td>
<td>27,429,348</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Increase (Decrease) In Cash for the period**

<table>
<thead>
<tr>
<th>Description</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash &amp; Investments - Beginning of Year</td>
<td>4,690,567</td>
<td>(1,174,887)</td>
<td>3,214,044</td>
</tr>
<tr>
<td>Cash &amp; Investments - End Of Period</td>
<td>$ 31,033,233</td>
<td>$ 25,167,779</td>
<td>$ 26,342,666</td>
</tr>
</tbody>
</table>

**Cash & Investments Consist of:**

<table>
<thead>
<tr>
<th>Description</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unrestricted Endowment and Special Purpose Investments</td>
<td>$ 29,668</td>
<td>$ 29,668</td>
<td>$ 29,668</td>
</tr>
<tr>
<td>Cash &amp; Investments Operating</td>
<td>20,514,795</td>
<td>21,066,243</td>
<td>22,421,305</td>
</tr>
<tr>
<td>Cash &amp; Investments Restricted</td>
<td>10,488,770</td>
<td>4,071,868</td>
<td>3,891,693</td>
</tr>
<tr>
<td>Total</td>
<td>$ 31,033,233</td>
<td>$ 25,167,779</td>
<td>$ 26,342,666</td>
</tr>
</tbody>
</table>
DATA POINT

CMH - Sick Hours - 24Month Actual vs. Budget

CMH Over Time Hours - 24Month Actual vs. Budget
COMMITTEE MEETING SUMMARY - OPEN

Date: September 22, 2016

Issue: Quality Committee of the Board Meeting, September 21, 2016

Prepared by: Iris Anderson, Administrative Assistant, Clinical Programs

Approved by: Sandra Hett, VP Clinical Programs & CNE

Attachments*: Program Presentation: Critical Care program
Program Presentation: Surgical Services program

Board Oversight (FYI information)

PROGRAM PRESENTATIONS- (previously circulated in Package 2 pre-reading)
Mr. Kron acknowledged the work of committee member Mr. Rao to work with CMH staff and revise the clinical program presentation template over the summer months. Mr. Kron welcomes any feedback regarding the template.

Critical Care (ICU)*
Ms. Smith, Manager of ICU, RRT & MDC, and Ms. R. Sharratt, Director of Medical Programs, joined the meeting at 0705h. Dr. A. Nguyen joined the meeting at 0708h.

Ms. Hett welcomed the guests and requested to provide highlights from the previously circulated presentation.

Ms. Sharratt and Ms. Smith provided a summary of each slide, and noted the following:
- The ICU currently operates 7 critical care beds and 2 step-down beds
- ICU became a closed access model in November 2014 with an Intensivist Model of Care implemented in the Fall of 2015. There are currently four certified Intensivists
- 93% of ICU RNs are Critical Care Certified

Mr. Kron opened the floor to questions and comments.
In response to a question, Mr. Nguyen clarified the role of the Intensivist as a Critical Care Specialist.

Ms. Smith continued by speaking of the key indicators. CMH’s current performance rate of Ventilator Acquired Pneumonia (VAP) is 0%. The VAP results are in part because of the Closed Access ICU. The readmission rate is higher than the last reporting period at 4.17. This result is due to the challenges related to the complexity of plan of care when a patient is transferred out of ICU.

A committee member requested further information on Valued Based Conversations. Ms. Smith explained the process is conducted once every two years. It is an opportunity for a staff member and leader to meet and discuss department and individual goals, identify opportunities for improvement and future learnings.

The Chair commented on the 100% rate of Venous Thromboembolism (VTE) Prophylaxis. Dr. Rhee confirmed that 100% VTE is a positive indicator as it relates to Prophylaxis.

Ms. Smith referred back to the pre-circulated presentation and shared a story with the Committee Members, regarding streamlining the use and content for all patient bedside communication boards throughout the hospital. A short discussion ensued.

The guests continued by highlighting the following:
- Full engagement in the CRP process
- The Patient Rounding Process is a clear and concise, and all disciplines provide a focused report on each patient
- The purchase of a new portable ultrasound machine with cardiac assessment capabilities
- Integrating Volunteers to the ICU team

Hand Hygiene Compliance Rate and hand hygiene products were discussed. The barriers were reflective of Moment 1 due to the current layout of the department.

There being no further questions, Mr. Kron thanked the guests for their presentation.

**Surgical Services (Inpatient, Outpatient, Perioperative)**
At 0733h, Ms. Hett welcomed Ms. Hauck, Director of Surgical Programs, Ms. Hurley, Manager of Inpatient Surgery/Rehab/Allied Health, Mr. Frey, Manager of Perioperative Services and Dr. Daly, Chief of Surgery.

Ms. Hauck directed the Committee members to the previously circulated presentation, and summarized the following:
- In 2015/16, 6,636 cases were completed in the Operating Room, and 3,940 cases in the Endoscopy Suite
- The current ED Length of Stay (LOS) for a surgical patient is 8 hours
- Hip and Knee Wait Times continue to stay on target
- CMH is strategizing with the Regional Cancer Program on improving cancer surgery wait times
- First Case Start Time performance rate is 83%

Mr. Frey briefly spoke of the First Case Start Times. The First Case Start Time should improve to the provincial average of 90% once C-Sections are moved to the Women & Children’s Program in the new build. Ms. Hauck continued by speaking of the collaboration between the OR and Woman’s program to train nurses in C-Sections.

Ms. Hauck and Mr. Frey spoke of the timing and transitioning of the new operating rooms in the new build. With later renovation of the PACU, the OR will relocate when PACU space is also ready.

Ms. Hurley reported receiving positive feedback of the new Staff Appreciation Boards in place for the program. The intent of the Boards is to promote staff engagement and recognition. Patients, family members, physicians and members of the team are encouraged to fill out an appreciation card. In addition, the Model of Care is working well on the Surgery unit.

Mr. Kron opened the floor for questions and comments.

A question regarding the Acute Pain Service was raised. Ms. Hauck noted that pain control required improvement. As such, a dedicated resource team (an Anesthesiologist and Nurse Practitioner) will manage the newly created Acute Pain Service. The resource team will conduct daily rounds on patients.

A discussion took place regarding the recent change of leadership in the surgical program. Dr. Daly voiced concern that the absence of leadership within the program will leave gaps in the sustainability of change initiatives.

One Committee member inquired about the recent leadership changes that Dr. Daly mentioned in Agenda Item #2.2. A detailed discussion ensued.
BRIEFING NOTE – Board of Directors

Date: Sept 28, 2016
Issue: Medical Advisory Committee – September 2016 Open meeting
Purpose: Update/ Approval of Privileges and Credentialing
Prepared by: Dr. Kunuk Rhee, Chief of Staff
Approved by: Patrick Gaskin, CEO

Presentations

M&T Update:
MAC thanked Medication and Therapeutics’ work on the prevention of deep vein thrombosis at CMH. The rollout of Fragmin in the Spring of this year has been widely adopted. Its impact on patient safety and mortality are well described in the medical literature. This initiative represents the largest organizational project aimed at reducing care variation at CMH. Nearly every bed-bound patient is now receiving one less injection per day for the duration of their acute care stay. Equally impressive was the fact that significant savings were obtained through this quality initiative.

Praxbind a rapid reversal agent for a commonly used anticoagulant, dabigatran, was introduced to MAC members. MAC endorsed its restricted use and a comprehensive rollout will be targeted to medical staff next month.

Business Arising

Clinical Services Plan Update
MAC signaled a clear desire to continue the CSP work and planning within the proposed program groupings presented. Developing clearly defined services/programs (with a cogent path and rationale) will occur over the next two months.

Surgical Assist Scheduling & Status
Following City call’s recent cessation of services at CMH (in 2015) and a decade-old province-wide trend of the migration of family physicians out of hospital services, our local surgical assistants have been considering a downloading of on-call surgical assistance onto the hospital. New hires over the summer have bought the program a few more months of stability and a tentative schedule has been created with a small investment in administrative resources.
Oncology Pre-Printed Orders
Approved as circulated.

New Business

Medical Assistance in Dying (MAID)
MAC was updated on the status of MAID services at CMH. Protocols and a policy were pre-circulated and feedback was elicited. A provisional pre-printed order is in place for MAID deployment. The MAID Oversight Committee has met and to-date, CMH has not had any written requests for MAID. We will endeavor to expand our scope of services over the next twelve months. Collaboration through the Joint Chiefs of Staff Network and the Integrated Palliative Care Council is under way as well in our Region.

Diet orders and Sucrose in Pediatrics: MEDICAL DIRECTIVES #561 and 752 were approved.
The above Medical Directives were unanimously approved.

New Privileges & Credentialing

<table>
<thead>
<tr>
<th>Name</th>
<th>Program</th>
<th>Specialty</th>
<th>Appointment</th>
<th>Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Andrea Steyn</td>
<td>Anesthesia</td>
<td>Anesthesia</td>
<td>Associate Privileges a.s.a.p. to end of credentials process</td>
<td>Dr. K. Leone</td>
</tr>
<tr>
<td>Dr. Jonny Elserafi</td>
<td>Emergency Medicine</td>
<td>Emergency Medicine</td>
<td>Associate privileges from Jul. 1, 2016 to end of credentials process</td>
<td>Dr. M. Shafir</td>
</tr>
<tr>
<td>Dr. Keith Barrett</td>
<td>Surgery</td>
<td>Urology</td>
<td>Courtesy privileges from Jul. 1, 2016 to end of credentials process</td>
<td>Dr. J. Daly</td>
</tr>
<tr>
<td>Dr. Mark Hindle</td>
<td>Anesthesia</td>
<td>Anesthesia</td>
<td>Associate Privileges August 1, 2016 to the end of the credentials process</td>
<td>Dr. K. Leone</td>
</tr>
<tr>
<td>Dr. Sheila Russek</td>
<td>Oncology</td>
<td>Oncology</td>
<td>Associate Privileges July 20, 2016 to the end of the credentials process</td>
<td>Dr. E. Chouinard</td>
</tr>
</tbody>
</table>

Locums/Temporary Staff for Approval

<table>
<thead>
<tr>
<th>Name</th>
<th>Program</th>
<th>Specialty</th>
<th>Appointment</th>
<th>Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Marcello Schmidt</td>
<td>Medicine</td>
<td>ICU</td>
<td>Locum Privileges from July 1, 2016 to December 31, 2016</td>
<td>Dr. A. Nguyen</td>
</tr>
<tr>
<td>Dr. Jessie Van Dyk</td>
<td>Pediatrics</td>
<td>Code Pink</td>
<td>Temporary Privileges from May 4-Sept 1, 2016</td>
<td>NA</td>
</tr>
<tr>
<td>Dr. Michael Ward</td>
<td>Internal Medicine</td>
<td>Internal Medicine</td>
<td>Locum Privileges from October 1, 2016 to October 31, 2016</td>
<td>Dr. A. Nguyen</td>
</tr>
<tr>
<td>Name</td>
<td>Specialty</td>
<td>Specialty</td>
<td>Period</td>
<td>Attending Physician</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>---------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Dr. Ben Pook</td>
<td>Surgery</td>
<td>Orthopedic Surgery</td>
<td>Locum privileges from April 1, 2016 to February 28, 2017</td>
<td>Dr. J. Daly</td>
</tr>
<tr>
<td>Dr. Han-Oh Chung</td>
<td>Internal Medicine</td>
<td>Internal Medicine</td>
<td>Locum Privileges Aug. 17, 2016 to Feb. 17, 2017</td>
<td>Dr. A. Nguyen</td>
</tr>
<tr>
<td>Dr. Ramona Aslahi</td>
<td>Hospital Medicine</td>
<td>Hospital Medicine</td>
<td>Locum Privileges Jul. 1, 2016 to Dec. 31, 2016</td>
<td>Dr. J. Mathew</td>
</tr>
<tr>
<td>Dr. Nicole Robichaud</td>
<td>Oncology</td>
<td>Oncology</td>
<td>Locum Privileges July 11, 2016 to October 31, 2016</td>
<td>Dr. E. Chouinard</td>
</tr>
<tr>
<td>Dr. Melanie Rodrigues</td>
<td>Family Medicine</td>
<td>Family OB Group</td>
<td>Locum Privileges August 5, 2016 to August 31, 2016</td>
<td>Dr. A. Maheshwari</td>
</tr>
<tr>
<td>Dr. Sandi Plant</td>
<td>OTN</td>
<td>NA</td>
<td>Temporary Privileges July 1, 2016 to June 30, 2017</td>
<td>NA</td>
</tr>
<tr>
<td>Dr. Dan Charleton</td>
<td>Surgery</td>
<td>Surgery</td>
<td>Locum Privileges July 27, 2016 to Jan 27, 2017</td>
<td>Dr. J. Daly</td>
</tr>
<tr>
<td>Dr. Ingrid Radovanovic</td>
<td>Surgery</td>
<td>Orthopedic Surgery</td>
<td>Locum Privileges July 15, 2016 to July 17, 2016</td>
<td>Dr. J. Daly</td>
</tr>
</tbody>
</table>

On behalf of the Credentials Committee, I attest that due diligence was exercised in the credentialing process of the above clinical staff.
Background

Twice a year, the hospital needs to submit a report to the WWLHIN indicating its compliance with the M-SAA. This is usually done through the Resources Committee and brought forward to the Board. The Board approves a motion using the prescribed format. It is due on October 31, 2016. Our next Board meeting is in November. The reporting period ends September 30, 2016; therefore the report is not available today.

Proposed Solution

M-SAA compliance is reviewed regularly at the Resources Committee. This will be done at the October meeting of Resources. It will be reported to the Board in November. The Board can delegate to the Chair to sign the document on its behalf. Therefore, subject to the review by Resources Committee of the obligations within the M-SAA in October 2016, the following motion is proposed:

The Board has authorized me, by resolution dated September 30, 2016 to declare to you as follows:

After making inquiries of the President and CEO and other appropriate officers of the HSP and subject to any exceptions identified on Schedule G, to the best of the Board's knowledge and belief, the HSP has fulfilled, its obligations under the service accountability agreement (the "M-SAA") in effect during the Applicable Period. (April 1, 2016 - Sept 30, 2016)

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

(i) Article 4.8 of the M-SAA concerning applicable procurement practices;
(ii) The Local Health System Integration Act, 2006; and
(ii) the Public Sector Compensation Restraint to Protect Public Services Act, 2010.
Friday, July 22, 2016

Cambridge Memorial Hospital
Sandra Hett, VP and CNE
Cambridge Memorial Hospital
700 Coronation Blvd.
Cambridge, ON
N1R 3G2

Dear Sandra,

The Registered Nurses’ Association of Ontario (RNAO) is pleased to confirm that Cambridge Memorial Hospital has been awarded the BPSO® Designation for 2016-2018, and is eligible to continue in the program. RNAO congratulates you on your many years as a BPSO® Designate. Your continued support to nursing and the interprofessional team to build capacity, maximize clinical excellence through use of RNAO’s Best Practice Guidelines and evaluate outcomes is commendable.

The areas that have been identified as most impressive include CMH’s commitment to the sustainability of multiple guidelines over many years, your support to staff to participate in capacity development opportunities, and your efforts to submit data to NQuIRE. We encourage the BPSO team at Cambridge Memorial Hospital to enhance their efforts to meet the dissemination deliverables, specifically manuscript publication and conference presentations related to your BPSO work.

RNAO is committed to continued development of the BPSO® program to support all our BPSO® Designates in their ongoing work to enhance and sustain evidence-based practice cultures. We have attached the Terms and Conditions for the 2016-2018 BPSO® designation period. Please sign this document by August 5, 2016 and return to RNAO to the attention of Angela Joyce, 158 Pearl St. Toronto, ON, M5H 1L3. We will return a counter-signed copy for your files.

Please extend our sincere congratulations to your team and all those involved in your BPSO work. We recognize the commitment that has been made at all levels of the organization to advance your BPSO® Designate activities, and are aware of the positive impacts on client and provider outcomes as well as overall quality of care in
your organization. We look forward to our continued partnership with you as a BPSO Designate, and member of this world wide endorsement program focused on ensuring evidence based practice for all, everywhere.

With warmest regards:

Irmajean Bajnok, RN, MScN, PhD
Director, International Affairs & Best Practice Guidelines Centre
Registered Nurses’ Association of Ontario

CC:
Karen Cziraki- CMH