



# ***Final Report***

## ***Cambridge Memorial Hospital***

***By***

**Murray T. Martin**

**Supervisor**

*July 2010*

---



**Report to the Minister of Health and Long-Term Care  
From  
Murray T. Martin, Supervisor  
Cambridge Memorial Hospital  
July 2010**

**INTRODUCTION**

From September 2009 to July 2010, I served in the capacity of Supervisor of Cambridge Memorial Hospital. The terms of reference for this assignment provided by the Minister of Health and Long-Term Care are outlined in Appendix A.

This report outlines the work I undertook and directed in the public interest and with the goal of restoring public confidence in the organization.

I actively commenced my activities as Supervisor of the Cambridge Memorial Hospital on September 3, 2009.

My work focused on the following major themes, with the actions detailed in subsequent sections of this report:

- Setting the principles for effective supervision
- Developing a sustainable financial recovery
- Sustaining effective board governance
- Updating the strategic plan
- Planning and implementing new services
- Improving the medical leadership structure
- Selecting effective administrative leadership
- Progress on the recommendations of the Operational Review

The chart (page following) shows the major activities undertaken throughout my tenure:

## Key Activities Undertaken

	September to November 2009	December 2009 to March 2010	April 2010 to June 2010
<b>Financial Recovery</b>	<ul style="list-style-type: none"> <li>Developed plan with input from staff and physicians</li> <li>Plan endorsed by Board</li> <li>Plan approved by WWLHIN Board</li> </ul>	<ul style="list-style-type: none"> <li>Project teams formed to implement plan</li> <li>Regular reporting by management to me and CMH Board</li> <li>Updates regularly to LHIN Board</li> </ul>	<ul style="list-style-type: none"> <li>Continued implementation of initiatives</li> <li>Approved 2010-11 financial plan</li> </ul>
<b>Board Governance</b>	<ul style="list-style-type: none"> <li>Interviewed board members</li> <li>Board committees continued to meet in advisory capacity</li> <li>Met regularly with board members to update on activities</li> </ul>	<ul style="list-style-type: none"> <li>Appointed Board Chair</li> <li>Struck Nominating &amp; Governance to recruit new board members</li> </ul>	<ul style="list-style-type: none"> <li>Approved new board members for CMH board</li> <li>Corporate and medical staff bylaws updated</li> </ul>
<b>Medical Leadership</b>		<ul style="list-style-type: none"> <li>Struck search committee for permanent Chief of Staff</li> <li>Advertised position nationally</li> <li>Approved increased support for medical leadership positions</li> </ul>	<ul style="list-style-type: none"> <li>Candidates interviewed</li> <li>Preferred candidate recommended to Board</li> <li>Chief of Staff announced at June AGM</li> </ul>
<b>Strategic Plan</b>		<ul style="list-style-type: none"> <li>Issued RFP for strategic planning support</li> <li>Struck evaluation team to review proposals</li> </ul>	<ul style="list-style-type: none"> <li>Proposals received and reviewed</li> <li>Short list of bidders selected</li> <li>Bidder interviews and selection</li> <li>Phase A interviews conducted by firm</li> </ul>
<b>Community Engagement</b>	<ul style="list-style-type: none"> <li>Public sessions to present hospital improvement plan</li> <li>Public sessions to review shift of ambulatory rehabilitation to community</li> </ul>	<ul style="list-style-type: none"> <li>Regular updates on website</li> <li>Presentations to community groups, as requested</li> </ul>	<ul style="list-style-type: none"> <li>Regular updates on website</li> <li>Presentations to community groups, as requested</li> </ul>

0

## OVERVIEW OF MY INITIAL ASSESSMENT

My initial meetings were with senior leadership staff of the Ministry of Health and Long-Term Care (MOHLTC) including the Deputy Minister, as well as with the Board Chair and leadership staff of the Waterloo Wellington Local Health Integration Network (LHIN). I then proceeded to meet with the senior leaders of the Cambridge Memorial Hospital staff, the Board Chair and several Members of the Board and senior leaders of the Cambridge Memorial Hospital Medical Staff. I also met with the Chief Executive Officers of the other hospitals in the Waterloo Wellington LHIN. Several members of my Hamilton Health Sciences team assisted me by interviewing all middle management leaders of the organization and Board Members. These interviews reaffirmed many of the observations from an external review conducted for the Waterloo Wellington LHIN in the spring of 2009.

The concerns included leadership effectiveness, poor working relationships with other system providers, lack of an operating budget for 2009-2010, a scant Strategic Plan, no effective goal setting or execution, ineffective Board processes and very little accountability from leaders within the organization. It was necessary to move quickly to start the process of re-establishing

public confidence in the hospital. I asked for the resignation of the President & CEO on September 16, 2009. I also requested that the Chair of the Board step down from his position. The Chair chose to resign from the Board of Governors. I also received the resignation of the Vice Chair of the Board and subsequently one other Board Member. I appointed Mr. Patrick Gaskin as the Acting President & CEO effective September 16, 2009. I held several open staff forums, as well as met with a number of community leaders, including MPPs and the Mayor of Cambridge and representatives of the media.

## **SETTING THE PRINCIPLES FOR EFFECTIVE SUPERVISION**

I chose early on to establish very specific principles under which the organization would operate:

- The organization would operate within its available resources.
- Staff and physician input would be vital to the financial recovery and long term success for CMH.
- The organization would be open and transparent, (both internally and externally) including the public and media.
- Regular reporting by the Supervisor to the community on progress would be undertaken.
- Cooperation from leaders of CMH with other service providers and with the Waterloo Wellington LHIN would be expected.
- The remaining Members of the Board would be asked to support the organization and aid in rebuilding CMH so that the full responsibility for CMH would be handed back to the Board of Directors as soon as possible.

## **DEVELOPING A SUSTAINABLE FINANCIAL STABILITY**

As a consequence of previous deficits, the hospital now has a serious working capital shortfall and can no longer finance deficits. This created an urgent need for the organization to stop the financial bleeding. A recovery plan was developed between September and November 2009. The plan, referred to as the Revised Hospital Improvement Plan (RHIP) was prepared by leaders, with input from staff and medical staff and was supported by the Medical Advisory Committee and CMH Board. On November 26, 2009, the RHIP was presented to and supported by the Waterloo Wellington LHIN Board. The hospital moved immediately to begin implementation. The plan was based on the priority of continuing to ensure that the hospital was able to deliver the acute care services that were required by the community while staying within the funding envelope for the hospital. The hospital divested itself of staff positions that had not been budgeted, staffing increases that were not approved and program areas that could be offered within the community or in collaboration with other providers.

In total, more than 70 cost improvement strategies were developed. The key major initiatives underway were:

**Skill Mix Changes:** The hospital is undergoing a shift to using more RPNs in several clinical programs including the Emergency Department, Mental Health, Obstetrics and the Medicine Program.

**Obstetrics and Special Care Nursery Staffing:** The Special Care Nursery is a small unit (8 bassinets) that has fluctuating needs. As a result, changes are being made to the staffing to accommodate this need. Cross training of staff between the case room, inpatient obstetrical area and the special care nursery will ensure that the staff are deployed based on patient need and census.

**Surgical Reorganization:** The operating room schedule was altered to allow for the reduction of 10 surgical beds on the weekends. The hospital still provides the same level of surgical services but has been able to reduce inpatient care on the weekends.

**Elimination of the Complex Continuing Care Program:** The hospital had 42 beds devoted to Complex Continuing Care. In 2008, WWLHIN conducted a study that recommended that the program be closed at CMH and the necessary resources be shifted to Grand River Hospital, Kitchener and St. Joseph's Health Centre, Guelph. As a result of the increased need to support ALC patients, the hospital has been operating a much reduced CCC program. Therefore, the resources for approximately 6 beds will be transferred to other hospitals, some beds will be closed and a portion of the beds will be converted to the recently funded rehabilitation program that was approved by the Ministry of Health and Long-Term Care earlier this year.

**Changes to the Inpatient Oncology and Palliative Care Program:** The inpatient oncology program is offered in a small unit and focuses both mostly on palliation and supportive care but also does include some inpatients that are under active medical care and intervention. The new model of care will combine this service with the rehabilitation program to benefit from a larger staffing mix and an enhanced model of care. Changes to this program were made in May.

**Divestment of Outpatient Clinics:** The hospital has shifted the ambulatory physiotherapy service and hand clinic to a community provider. Community consultation was undertaken in December 2009 to inform the community of this change. The program closed at CMH in February 2010 and the patients were transitioned successfully to the community provider. The hospital has issued an RFP for the provision of cardiac rehabilitation services and is in the process of selecting a preferred provider for this service. It is expected that this service will transition to the community in fall 2010.

Employee Health Services and Sick Time Management: The hospital has developed a contractual relationship with a 3<sup>rd</sup> party provider who will provide employee health services and sick time management for our staff. This service will provide more attention to sick time management and support leaders in the organization in reducing unnecessary sick time.

Other Initiatives: In addition to the initiatives above, the hospital has improved its cost structure in many of the support departments (for example, reduction in food service costs, housekeeping expenses, improvements in energy savings, reductions in administration) and has improved its revenue (for example, increased parking revenue, preferred accommodation, physician billings).

All initiatives were published on the hospital's intranet and internet and community consultations were held in November and December 2009 to outline the impending changes. The sessions were held at various times to allow for maximum public input and each session was designed to include a "question and answer" session so that any concerns from the community could be heard. A link on the main page of the internet allowed members of the public to provide comments/input directly related to the recovery plan.

Progress on the recovery plan was also published monthly on the hospital's internet site as part of the board's agenda package. As well, the direct line to the Acting President & CEO was published on the internet to ensure that the public had an opportunity to provide comments directly.

## **SUSTAINING EFFECTIVE BOARD GOVERNANCE**

There was the need to rebuild the Board of Directors of CMH. In January, I appointed Mr. Chuck Phillips, an existing Member of the Board, to the position of Chair of the Board. Chuck is a local Cambridge resident and an individual with the energy, skills and commitment to provide leadership to the Board.

The Board and I commenced a process in January 2010 to recruit new members to the Board. We were very encouraged that through a networking exercise and community advertisement that we received more than 30 well qualified candidates wishing to join the Board. Between February and April 2010, an assessment of the skills needed for the Board was done and interviews were conducted with potential candidates. References were completed on a short list of candidates.

In April, I announced 5 new board members and I feel very positive about the quality of the overall Board. With the addition of the new members, I believe that we will have in place the Board needed to provide the governance leadership required by CMH.

Between April and June, work was done to update the corporate and medical staff bylaws with support from legal counsel at Osler. The improvements will help ensure that the Board can function at a “best practice” level. The bylaws reflect the latest changes associated with Bill 46, *Excellent Care for All Act*, and changes to the Public Hospital Act, Regulation 965. I enacted the new bylaws effective June 23, 2010.

## **UPDATING THE STRATEGIC PLAN**

As reported earlier and identified in the Operational Review, the organization requires “robust strategic planning”. The current strategic plan was not helpful in articulating the future role of the hospital, its role with the WWLHIN and the needs of the community. In February, a Request for Proposal was issued to secure the assistance of a consultant to assist with the development of the strategic planning process and with the planning process implementation. Corpus Sanchez was chosen by a committee involving Board members, physician leaders and hospital staff. Interviews associated with the first phase of the work were conducted in June 2010. Further work on the plan will be done after the summer.

## **PLANNING AND IMPLEMENTING NEW SERVICES**

The hospital is very appreciative of the support from the WWLHIN and the MOHLTC for the approval of \$1.307M to establish an inpatient acute rehabilitation program. This program will help improve flow of patients within the hospital and provide needed inpatient care for patients who no longer require acute care services. This announcement made on March 12, 2010 was received very well by both the staff and community. Approval of this program was a strong signal to the community that the WWLHIN and MOHLTC are willing to invest in CMH.

On behalf of the hospital, I want to recognize the support from MOHLTC for the approval of \$10M planning and design grant to assist with the facility redevelopment at Cambridge Memorial Hospital. This is a project that has been on the books for the last decade and one that is critically important to the community. It is very important that this project be included as one of the projects to proceed as part of the Government of Ontario’s 10 Year Capital Plan.

Schedule 1 inpatient mental health services for the Cambridge community are provided by St. Joseph’s Health Care, London. As part of the Health Services Restructuring Commission work in the late 1990s, Schedule 1 inpatient mental health services were identified for CMH. This program is included in the facility redevelopment project. London has indicated that as of the fall 2010 it will be unable to provide Schedule 1 mental health services for Cambridge due to the divestment of specialized mental health services to

Grand River Hospital and corresponding staffing changes in London. Discussion has continued with Ministry staff, WWLHIN staff and hospital representatives. I would encourage that a solution be found to offer this service within CMH, as per the Commission's directions.

## **IMPROVING THE MEDICAL LEADERSHIP STRUCTURE**

As cited in the Operational Review, the hospital needed to enhance its medical leadership model within the hospital. I met with the Medical Advisory Committee early on in my mandate. Involvement of the medical staff leaders was essential to the success of the recovery plan. I reviewed and improved the compensation framework for medical leaders and a permanent Chief of Staff was appointed through a selection process that involved Board members, physician leaders and hospital staff.

## **SELECTING EFFECTIVE ADMINISTRATIVE LEADERSHIP**

Since my tenure as Supervisor, recruitment for 3 key administrative positions was required – the President & CEO, a Vice President focusing on the clinical programs and a Vice President focusing on the support and corporate services. In addition, a permanent Chief of Staff was required and has been reported earlier.

In April, upon the recommendation of the Acting CEO and Interim Chief of Staff, I was pleased to appoint Susan Gregoroff to the position of Vice President, Clinical Programs and Chief Nursing Executive. Susan had served in various leadership capacities at Hamilton Health Sciences and I am confident that Susan will provide CMH with the necessary leadership to continue to advance the organization.

Selection for the Vice President focusing on the support and corporate service began in April. A search committee is in the final stages of its work at the time of this report. Input from medical and Board members was sought in reviewing appropriate candidates for this important role. I anticipate an announcement in mid July concerning the successful candidate.

In terms of the appointment of a permanent President & CEO, I held several discussions with the board on the process for selecting this position. I felt very strongly that this key appointment needed to be made by the Board of Directors. I was very pleased by their unanimous decision to appoint Mr. Patrick Gaskin as their permanent CEO. This was done following a third party review of Patrick's credentials and references. This was also done in recognition of the outstanding job done by Patrick in the capacity of Acting President and CEO.

## **PROGRESS ON THE RECOMMENDATIONS OF THE OPERATIONAL REVIEW**

As part of my terms of reference, the work undertaken and the recommendations associated with the Operational Review was used to guide the improvements at the hospital. As appropriate, the recommendations have been implemented. Some recommendations are still in the implementation stage and I am confident that they will be implemented in the coming months. Appendix B provides a brief summary on the progress made on the recommendations.

## **CONCLUSION**

It has been my sincere pleasure to serve as the Supervisor for Cambridge Memorial Hospital. Through the renewal process at the hospital, I was encouraged by the commitment of the staff, volunteers and physicians to improving the organization. I believe that the hospital is positioned now to effectively contribute to the health system in Waterloo Wellington.

Respectfully submitted,

Murray T. Martin

## **Appendix A: Terms of Reference**

1. The supervisor will fulfill all the responsibilities of the Cambridge Memorial Hospital board, the corporation, its officers and members in governing the hospital in accordance with the *Public Hospitals Act*, its regulations and all other applicable legislation.
2. The supervisor will oversee the implementation of the recommendations relating to the governance and management of the hospital contained in the Cambridge Memorial Hospital Operational Review Report dated February-May 2009, as appropriate.
3. The supervisor will develop and oversee the implementation of policies and procedures to ensure hospital operations provide safe, high quality care within the existing resource allocation and are sustainable in future years.
4. The supervisor will address governance issues, and take actions that are appropriate and necessary for the proper functioning of the hospital, including re-establishing a Board with appropriate skills and competencies that is reflective of the communities served by the hospital.
5. The supervisor will provide direction to the senior management team as appropriate.
6. The supervisor will retain external resources as appropriate.
7. The supervisor will provide regular updates to the Deputy Minister of Health and Long-Term Care or his delegate and the Chief Executive Officer of the WWLHIN.
8. The supervisor will report to the Minister of Health and Long-Term Care as required by the Minister. The supervisor will provide a written report to the Minister of Health and Long-Term Care upon completion of duties.

Appendix B: Status of Operational Review Recommendations

	<b>Observation</b>	<b>Action Taken</b>	<b>Status</b>
1.	<i>The board of CMH should establish a policy for a clear and appropriate limit on borrowing accompanied by adequate in-year and multi-year forecasting and repayment mechanisms. The LHIN, as the funder, should participate in this discussion and consider appropriate preventative restrictions.</i>	Borrowing limits at this stage are appropriate and monitored regularly by the Finance & Audit Committee.  A plan for reducing the hospital's debt was incorporated in the approved recovery plan.	Completed
2.	<i>Senior Management should commit to the full pursuit of all internal efficiencies, based on the top 25th percentile of benchmarked peers.</i>	Benchmark performance was incorporated into the recovery plan development and into the 2010-11 budget development process.	Completed
3.	<i>The Board and Senior Management should communicate this target to all staff and physicians and ensure that every department and program develops a realistic plan for achieving it, as part of the recovery plan.</i>	Extensive internal communication was undertaken in developing and implementing the plan.	Completed
4.	<i>Senior management should ensure all managers have the position and staffing control tools and support necessary to achieve optimal staff deployment.</i>	Hospital has investigated position and staffing control tools. Process improvement exercise in the staffing office was undertaken. Further work is planned for 2010-11.	In progress. To be completed by March 31, 2011
5.	<i>CMH's Board should implement a governance policy that requires CMH to operate within available funding</i>	Board adopted new bylaws and a Board charter reflecting governance best practice.	Completed

	<b>Observation</b>	<b>Action Taken</b>	<b>Status</b>
6.	<i>Recognizing the urgency of CMH's borrowing position, the hospital improvement plan should include item specific implementation dates as well as short term measures to stem further borrowing.</i>	Recovery plan included specific implementation dates as suggested.	Completed
7	<i>The Board should ensure that the CEO provides regular reports on the successful implementation of the recovery plan and is held accountable for meeting the targets.</i>	Progress was reported at each board meeting and weekly to the Supervisor and Board Chair.	Completed
8	<i>CMH should look at the possibility of proactively staffing the ED ANB patients, to decrease the reliance on overtime to staff the beds. It is recognized that the numbers fluctuate on a regular basis, so it is suggested that CMH trend data of ANB patients with an eye to staffing proactively if feasible.</i>	CMH continues to work on efforts to improve flow in the Emergency Department. The hospital participated in the LHIN-wide Performance Improvement Project. Further performance improvement targets have been agreed to for 2010-11.	In progress.
9	<i>CMH consider partnering with a local LTC home to provide care for the LTC destined ALC patients, either at the LTC home, or on a separate unit within CMH.</i>	WWLHIN committed \$7.09M in funding to the transition bed program at the February 26, 2010 Board meeting. This included interim long-term care beds. A selection process for the provider for these beds in Cambridge continues.	In progress. Anticipated conclusion of provider selection by September 30, 2010.
10	<i>CMH should implement staffing levels that are equivalent to LTC,</i>	It is preferable that the hospital provides space to allow a LTC provider to operate	This recommendation will not be implemented

	<b>Observation</b>	<b>Action Taken</b>	<b>Status</b>
	<i>including the use of PSWs, RPNs with on RN available 24/7.</i>	this service.	
11	<i>CMH should review scheduling practices to determine if the nursing schedules are causally linked to increased sick time and overtime, and make appropriate changes to staffing schedules where necessary.</i>	Strategies to improve sick and overtime have been included in the recovery plan.	Completed.
12	<i>CMH should review its OR scheduling of urgent cases to determine if implementing an urgent block in regular daytime hours would increase cost effectiveness and reduce unwarranted overtime for nurses.</i>	A review concluded that a day time urgent block was not cost effective.	Completed.
13	<i>CMH should review how it captures overtime data to ensure that overtime is assessed in a more meaningful way.</i>	CMH has adopted a new business intelligence tool. Overtime and sick time information by cost centre and by employee is available for manager use.	Completed.
14	<i>CMH should address the nature and context of physician leaders and their relationship to CMH, their members and the key activities of strategic planning, performance management, quality and safety, utilization management and human resources planning. CMH may need to concurrently review physician stipends to improve physician</i>	Performance expectations for department chiefs were reviewed and updated in the medical staff bylaw review.  Compensation framework for chiefs was updated.	Completed.

	<b>Observation</b>	<b>Action Taken</b>	<b>Status</b>
	<i>engagement, commitment and participation in resource decision-making.</i>		
15	<i>CMH should implement a formal search process for recruiting and appointing physician leaders with emphasis on performance management and utilization.</i>	Search process was reviewed and is defined clearly in the new medical staff bylaws.  Chief of Staff search was completed in June 2010.	Completed
16	<i>CMH should support leadership development of physicians to ensure succession planning for physician leadership roles.</i>	Physician leadership development continues to be supported by the hospital. A new position focusing on organizational development was approved in the 2010-11 budget to support staff, physician and leader development.	Completed
17	<i>CMH should sponsor a cultural shift to understand and embrace patient centered care as the preferred model of care delivery.</i>	This recommendation will be considered by the new VP, Clinical Programs and Chief of Staff.	In progress.
18	<i>CMH needs to adopt a policy of standardization that includes for those areas currently not subject to standardization (i.e., OR cases, orthopedic and surgical devices, etc.) with a view to reducing variation, thereby reducing costs and improving quality of patient care.</i>	The OR products have been standardized for several years.	Completed
19	<i>CMH adopt an impact</i>	The hospital has an	Completed

	<b>Observation</b>	<b>Action Taken</b>	<b>Status</b>
	<i>analysis process to evaluate medical staff human resources plans, to assess the organization's ability to accommodate budgetary implications of new appointments and to quantify their clinical contribution to the organization's strategic plan.</i>	impact analysis procedure that appears to be satisfactory.	
20	<i>CMH should investigate and do a cost benefit analysis of an electronic staff scheduling program with a robust HRIS. CMH is encouraged to look at companies that will "guarantee the savings" outlined in their proposals to achieve performance improvements through revised staffing and scheduling models.</i>	Preliminary review of electronic staff scheduling was done in the fall 2009. Further work on this recommendation will be linked to recommendation #4.	Linked to recommendation #4.
21	<i>CMH should improve the process for data distribution to managers and leaders, by identifying - with the input of these managers and leaders -who needs what information and in what frequency.</i>	A review by HHS was conducted in fall 2009. Further work is underway with support from an interim leader for decision support. Recruitment for a leader for health information and decision support is expected to be completed by September 2010.	In progress
22	<i>CMH should adopt a philosophy of empowering its staff and middle managers. Managers and directors should have access to resources,</i>	Manager education on budget planning was conducted in fall 2009.  Managers completed a development session on leading	Completed

	<b>Observation</b>	<b>Action Taken</b>	<b>Status</b>
	<i>information, support and opportunity. CMH should formally review the empowerment of its managers on a regular (yearly) basis to measure baselines and the effectiveness of improvement strategies.</i>	change and resiliency in December 2009.  All managers had performance appraisals conducted by March 31, 2010.	
23	<i>CMH requires robust strategic planning and operational planning methodologies that engage senior and middle managers, employees as well as physicians and Board members (arguably external stakeholders). In turn, respective goals, budgets and other accountabilities should be delegated to empower Directors and Managers who should be directly involved in the performance management activities of their portfolios.</i>	Senior leadership has instituted more formal reporting and financial review.  Performance reporting and planning processes have been developed and implemented.  A new strategic plan will be developed in 2010-11.	Completed
24	<i>CMH should develop and implement a comprehensive formal orientation program for new managers that includes the strategic plan and annual goals, orientation to their functional areas, including budget and finance, human resources, quality and safety and decision support processes.</i>	Work has been undertaken to develop a new leader orientation but this is not yet fully implemented. It is anticipated that it will be implemented in 2010.	In progress.
25	<i>CMH should adopt a</i>	A new PMO process	Completed

	<b>Observation</b>	<b>Action Taken</b>	<b>Status</b>
	<i>PMO approach to its operations. This approach is particularly effective with one-time and major projects. CMH should develop more rigour in its assessment of pilot projects with emphasis on future costs and consequences.</i>	was approved in November 2009 by the senior management committee.	
26	<i>Through a PMO approach, CMH should ensure that projects elected match the strategic plan of the organization. Once projects are approved to go forward, CMH should use a consistent change management model in its roll out, communication, implementation and evaluation processes.</i>	Change management model was introduced in December 2009. Tool kits and support resources were made available to leaders.	Completed
27	<i>CMH should develop processes to assess the viability and, business case for ongoing support (i.e., resources, time, people, technology, facilities, etc) of projects with time-limited funding.</i>	Projects with time limited funding were reviewed as suggested.	Completed.
28	<i>CMH should implement a policy that there be no growth without appropriate impact analysis and data to support the request. Clinical managers must be key participants in the impact analysis process. If a request</i>	Linked to recommendation 23.	Completed

	<b>Observation</b>	<b>Action Taken</b>	<b>Status</b>
	<i>is approved, the organization must have a process for monitoring the impact on an ongoing basis.</i>		
29	<i>The Board should be given "coaching" and education regarding their fiscal/fiduciary responsibilities and on how to balance those with patient services</i>	Discussion at Board meetings, work associated with updating the bylaws and Board orientation have contributed to this in an effective way.	Completed
30	<i>Senior Management must commit to a process that facilitates shared decision-making with managers, directors, etc.</i>	Implemented	Completed
31	<i>A culture survey should be conducted and a work plan developed to change the organizational climate from a fear-based culture to one that is open, honest and respectful.</i>	A culture survey will be completed as part of preparing for the next accreditation.	In progress.
32	<i>The Senior Leadership Team should immediately request the LHIN to supply the offered coaching assistance to help CMH develop an appropriate recovery plan, financial messaging and communication strategies.</i>	Not required.	Not implemented.