MUSKOKA ALGONQUIN HEALTHCARE

BOARD OF DIRECTORS
MINUTES

Thursday, September 11, 2025 at 4:00 pm
HDMH Boardroom
Approved December 11, 2025

PRESENT:				
Elected Directors:	Dave Uffelmann	Beel Yaqub	Bruce Schouten	Michael Righetti (V)
	Dr. William Evans	Marni Dicker	Colleen Nisbet	Mary Lyne
	Ruth Chalmers	Jody Boxall	Don Macintosh	
Ex-Officio Directors:	Cheryl Harrison	Dr. Khaled Abdel-Razek	Dr. Helen Dempster	Dr. Rohit Gupta
	Diane George			
Executive Support:	Alasdair Smith	Mary Silverthorn	Tammy Tkachuk	
REGRETS:	Carla Clarkson-Ladd			

1.0 CALL TO ORDER

Dave Uffelmann, Board Chair called the meeting to order at 4:01 pm. The Land Acknowledgment Statement was read aloud. In support of the Land Acknowledgement, Dr. Evans shared a literature review on culturally safe healthcare for Indigenous patients that highlighted experiences of racism, prejudice, and stereotyping within the healthcare system, which have led to feelings of mistrust, being devalued, and disrespected. Disclosure of residential school experiences often resulted in negative changes to the doctor-patient relationship. The study found that Indigenous patients frequently felt their culture, traditional knowledge, and kinship ties were overlooked or dismissed by Western healthcare providers. Creating Indigenous-specific healthcare clinics and culturally welcoming spaces, where traditional healing is valued alongside Western medicine, was shown to build trust and improve patient engagement. Finally, the review emphasized the importance of cultural safety education for healthcare providers, including a comprehensive understanding of colonial history and its ongoing impact, as critical steps toward improving healthcare experiences and outcomes for Indigenous communities.

The Chair acknowledged that Dr. Evans and Colleen Nisbet have been leading the board's land acknowledgement efforts for about 18 months. Directors were encouraged to volunteer to assist in these efforts and to reach out to the Chair if interested. Reflections were provided on how the research process relative to the Land Acknowledgement has been a valuable experience providing a better understanding of Indigenous peoples and the history of residential schools noting that it is a good opportunity for personal growth and meaningful engagement.

1.1 APPROVAL OF AGENDA

It was moved, seconded and carried that the meeting agenda be approved.

1.2 DECLARATION OF CONFLICT OF INTEREST

Upon review of the agenda, there were no conflicts of interest declared.

1.3 PATIENT EXPERIENCE

Mary Silverthorn shared a patient experience whereby the patient was highly impressed by Dr. Jewell's prompt, compassionate care and the efficiency of the hospital team after suffering a wrist fracture. Despite a referral challenge, Dr. Jewell ensured the patient received seamless follow-up treatment, and her skillful work was praised by two other physicians from other organizations. The patient expressed deep gratitude for the excellent communication, organization, and teamwork shown throughout the process. Dr. Abdel-Razek provided a brief explanation of the referral systems in place for acute and elective cases, while noting the challenges and importance of advocacy in the provincial healthcare system. The sub-regional collaborations

among hospitals and specialty departments were also emphasized as key to providing timely and coordinated patient care.

2.0 BUSINESS ARISING

There was no business arising for this meeting.

3.0 REPORTS

3.1 CHAIR'S REMARKS

The Chair explained recent efforts to streamline meetings by respecting committee work and encouraging questions to be sent in advance when possible. Clarification was also provided regarding the difference between the strategic, operational objectives and those objectives specific to the CEO and Chief of Staff as well as how they are linked.

The Chair advised the Board that an invitation has been received for Directors to tour the Gravenhurst Health Hub; a poll will be circulated to identify a mutually convenient date. Directors were also encouraged to suggest topics for future board education sessions, emphasizing alignment with strategic goals.

3.2 REPORT OF THE PRESIDENT AND CHIEF EXECUTIVE OFFICER

The report of the President and CEO was presented and it was highlighted that notable achievements in the 2025-26 strategic operational plan included reducing alternate level of care days and improving occupancy rates, though the electronic medical records project is facing delays. The organization also celebrated the opening of its first MRI suite, donor contributions were recognized for the ICU monitoring upgrades, and staff and auxiliary members were acknowledged for their ongoing dedication and innovative efforts. Additionally, recent initiatives noted include the development of a best practice stroke unit and enhanced engagement with the community through podcasts and videos. The floor was open for questions and comments.

With respect to Staff Appreciation Week, the Board will be provided with the details regarding the Long Service Awards should they be available to attend.

A question was raised about the connection between the ALC (Alternate Level of Care) target from Ontario and district-level work on ALC. It was explained that improvements in community care and internal hospital efforts have positively impacted patient placement and reduced hospitalizations. The role of the ALC steering committee was highlighted, which has developed a roadmap for community initiatives such as supportive housing and assisted living, and note that these efforts are closely linked to hospital activities, including identifying care goals for patients.

In terms of the surgical transitions remote care monitoring program, it was explained that it has been well-received and considered a valuable initiative. Funded annually for at least four years, the program was initially focused on certain surgeries and has since expanded to include most general surgeries and specialized therapeutic procedures. Patient feedback has been overwhelmingly positive, with many appreciating the support available outside regular office hours, which has led to a significant decrease in emergency department visits. While the program proved less effective for some endoscopy patients and was adjusted accordingly, it continues to benefit those undergoing complex surgical procedures. Additionally, the platform supports mental health patients and, as of this year, has been extended to stroke patients.

4.0 BOARD EFFECTIVENESS

4.1 REPORT OF THE NOMINATIONS COMMITTEE CHAIR

Colleen Nisbet informed the Board that the inaugural meeting Nominations Committee meeting was held on August 18th with discussion focusing on the Board's nomination policy review, which is part of a three-year cycle. While the original schedule set the review to start on January 19, members agreed to shift that timing to October to allow for earlier modernization and enhancement of the policy including updating competencies and clarifying language. The committee typically becomes more active in January when the nominations process officially begins.

4.2 REPORT OF THE GOVERNANCE COMMITTEE CHAIR

Colleen Nisbet informed the Board that the Governance Committee will be endeavouring to include more education around governance as part of its meetings. Three educational resources were highlighted for the Committee: (1) the Ontario Hospital Association's governance series; (2) the recently updated OHA Guide to Good Governance; and (3) the Handbook of Board Governance which is an extensive Canadian resource with over 120 articles on timely topics like cybersecurity and guidance for new board members. The board committee terms of reference policy was highlighted for Directors, which outlines the principles, mandates, and membership applicable to all Committees. It was confirmed that the policy also includes reference to the quorum requirements for Committees.

5.0 PROGRAM QUALITY & EFFECTIVENESS

5.1 REPORT OF THE CHIEF OF STAFF & MEDICAL ADVISORY COMMITTEE

The report of the Chief of Staff was received for information. Highlights from the report included the major initiatives focused on enhancing physician engagement, satisfaction, and recognition that are underway, with preparations for upcoming leadership retreat. The Emergency departments maintained stable operations with no summer closures, while some diagnostic imaging experienced interruptions. Ongoing collaboration with health partners is strengthening obstetrics programs, and technology-related challenges are being addressed to support clinical process improvements.

Dr. Helen Dempster, President of the Credentialed Staff Association (CSA) provided an update noting the recent welcome to nine new NOSMU (Northern Ontario School of Medicine University) students that have joined the community for the year. The first CSA meeting is set for next Tuesday evening at the South Muskoka site, with a shift towards in-person meetings to encourage engagement and socialization. In addition to the report from the President and CEO, the Board Chair will now also join the meeting. In preparation for these meetings, Dr. Dempster will meet with the senior team one to two weeks before each CSA meeting to gather and address feedback from colleagues. The main issues raised for this upcoming meeting include long wait times for echo and ultrasound diagnostics, improving efficiency of single sign-on, and exploring additional allied health support to expedite patient discharge and enhance care. These changes aim to improve communication between leadership and physicians.

5.2 REPORT OF THE QUALITY AND PATIENT SAFETY COMMITTEE CHAIR

Dr. Evans informed the Board that the Quality and Patient Safety Committee's role is to review metrics and reports on issues. Recent focus has been on the obstetrical service with a report received in November with 50 recommendations, which management has been addressing, notably in standardizing roles, especially

between midwives and the emergency department. Efforts have also targeted reducing a high C-section rate by improving education and decision-making processes, using the "optimizing with outcomes" format, and making fetal health surveillance training mandatory for obstetrical providers. While significant progress has been made, ongoing updates will be provided to the Committee to track the implementation of all recommendations. The Committee is also planning further education on topics such as MRI use, patient safety, and quality initiatives. The Committee also received an overview of the members of the expanded Quality team and the work they have underway. It was noted that there were no critical incidents for the first quarter.

5.3 Quality and Patient Safety Report; Q1

Upon presentation of the quarterly report, it was noted that out of 22 Quality Improvement Plan metrics, 7 metrics did not have data available and only one metric, providing patients with adequate information, was not met. It was explained that the report explains why some targets weren't achieved and describes corrective actions, particularly in the challenging emergency department environment. Recent changes by the Ministry of Health have made several metrics tighter, especially those related to emergency department wait times. Additionally, the balanced scorecard for departments shows eight out of 55 metrics are not meeting targets, with explanations and corrective measures provided. A specific point of progress noted was the ongoing effort to standardize inventory items across sites, with substantial work completed to-date.

5.4 Patient Declaration of Values

Dr. Evans explained that the Patient Family Advisory Committee (PFAC) conducted its scheduled review of the Patient Declaration of Values, as required by board policy every three years. After consideration, PFAC did not recommend any changes, and this position was supported by the Quality and Patient Safety Committee. Committee had a brief discussion about whether to include more explicit language regarding the protection of staff from aggressive behavior by patients or visitors, but it was determined that existing hospital signage and communications already address this concern. There were no questions or comments from the floor.

It was moved, seconded and carried that the Patient Declaration of Values be approved as status quo.

6.0 FINANCIAL AND ORGANIZATIONAL VIABILITY

6.1 Report of the Resources & Audit Committee

Mary Lyne informed the Board that the Resource and Audit Committee convened twice: first on August 22 and then for a special meeting on September 2. During the August 22 meeting, the committee reviewed its terms of reference and work plan, including a separate audit subcommittee work plan. Two significant changes were discussed regarding the terms of reference: the incorporation of forecasting to better connect reported results to annual planning, and a new specification in the HR section to review HR-related results and union impacts in the second and fourth quarters. Adjustments to the work plan's reporting timelines were also made to align with information availability and regulatory cycles. The audit subcommittee work plan was reviewed with no changes required. There were no questions or comments from the floor.

7.0 LEADERSHIP

7.1 Quarterly People Metrics and Results

The first quarter metrics were presented and successful efforts in recruiting and retaining staff, which has been a key focus for the past two years, were recognized. Both achievements and ongoing challenges were highlighted, particularly noting that 80% of departures occur within two years, a trend closely monitored by the HR Team. This issue is related to initiatives around fostering a respectful workplace and improving organizational culture. The report also notes that future people metrics will be standardized to align with OHA (Ontario Hospital Association) definitions, addressing discrepancies in how metrics are reported, especially in the classification of staff types. This standardization will enable more consistent and accurate reporting moving forward. The floor was open for questions and comments.

In response to a question regarding metric five, noting a doubling in complaints, it was explained that the increase was traced to updated workplace policies that now align with legal requirements under the Occupational Health and Safety Act and Employment Standards Act. This led to enhanced staff training and education, resulting in more staff coming forward to report disrespectful behavior. The rise in complaints is viewed positively, as it enables leadership and HR to address issues, and is consistent with trends seen in other hospitals after COVID, indicating workplace burnout.

Discussion ensued regarding ongoing challenges in recruiting qualified candidates for positions such as registered practical nurses, medical lab technologists, and medical radiation technologists. Although the situation has improved compared to previous years, there are still not enough qualified applicants, which is a widespread issue among hospitals. These roles are highly sought after in hospitals and other healthcare settings, creating a competitive job market. To address this, the organization is increasing student placements and strengthening partnerships with educational institutions, aiming to attract future graduates. However, competition from both public and private health sectors, which offer competitive salaries and more desirable work schedules, continues to pose a significant challenge.

7.2 Report of the Performance Management Committee Chair

The Chair clarifies the process for committee reports to the board, emphasizing that committee chairs should only highlight relevant items not already on the board agenda. Since the minutes of each committee meeting are available for all board members to review, there is no need to discuss items that will be addressed later in the agenda. As it pertains to the Performance Management Committee, the Chair had nothing additional to report as all committee discussions are already included on the board's agenda.

7.3 President and CEO Annual Performance Objectives Progress Update

Upon presentation of the progress update for the CEO goals, it was emphasized that the objectives themselves are fixed for the year as approved by the Board and not open to change. The chair and vice chair meet monthly with the CEO and Chief of Staff to review progress, in addition to the quarterly review by the Performance Management Committee in more detail. Clarification was provided regarding the percentage of patient days attributed to ALC patients, its calculation, and a reminder that there are different reporting methods for this metric, therefore caution is needed when comparing targets.

With respect to the unification measures between the two sites it was explained that the team is working with staff engagement survey metrics to assess how staff identify with each site and to establish a baseline for future measurement. The process involves developing survey questions to gauge staff identification and exploring measures to foster a sense of unity, such as organizing in-person meetings. Tracking staff who work across both sites is suggested as one possible indicator, although it's acknowledged that true unification is challenging to measure. Overall, there is a recognized need to take deliberate steps to

strengthen unity and collaboration between the sites. It was also explained that the organization previously initiated a branding strategy however efforts were paused during Capital Redevelopment. There are several branding initiatives planned that aim to create a more unified and comprehensive approach, moving beyond a focus on individual sites.

7.4 Chief of Staff Annual Performance Objectives Progress Update

Upon presentation of the Chief of Staff goals, discussion ensued regarding the challenges and status of internal medicine recruitment in South Muskoka. Due to a shortage of internal medicine physicians, the implementation of a rapid access clinic, intended to provide prompt follow-up care for patients discharged from the emergency room or inpatient units, has been delayed. This shortage leads to longer hospital stays, as patients must wait for essential consultations and tests. Although recurring locum physicians have helped cover shifts, they have not committed to joining the team permanently, which is necessary to launch the clinic. The team currently maintains adequate coverage but requires two more full-time recruits to proceed with the rapid access clinic and improve patient flow. Incentives are being considered to attract new physicians, but recruitment remains a challenge.

8.0 CONSENT AGENDA

The Chair reminded the Board of the process for handling items on the consent agenda, clarifying that questions about specific items must be raised with the Chair in advance to be discussed separately. A question was raised regarding governance, accreditation, and the timeline for including quality oversight. It was explained that this will be addressed at an upcoming session. The interconnectedness of the governance and quality committees as the process evolved was recognized.

It was moved, seconded and carried that the following items be approved or received as indicated:

- *8.1 Approval of the Board of Director Meeting Minutes of June 16, 2025*
- *8.2 Approval of the revised Quality & Patient Safety Committee Terms of Reference*
- *8.3 Approval of the Quality & Patient Safety Committee Work Plan*
- *8.4 Approval of the revised Resources & Audit Committee Terms of Reference*
- *8.5 Approval of the Resources & Audit Committee Work Plan*
- *8.6 Receipt of the 2025/2026 Q1 Compliance Report*
- *8.7 Approval of the revised Performance Management Committee Terms of Reference*
- *8.8 Approval of the Performance Management Committee Work Plan*
- *8.9 Approval of the Nominations Committee Terms of Reference with no amendments*
- *8.10 Approval of the Nominations Committee Work Plan.*
- *8.11 Approval of the Board Committee and Terms of Reference Policy with no amendments.*
- *8.12 Approval of the Governance Committee Terms of Reference with no amendments.*
- *8.13 Approval of the Governance Committee Work Plan.*
- *8.14 Receipt of the Accreditation 2026 – Governance Planning and Preparations Report*

9.0 WRAP UP & ADJOURNMENT

It was moved that the open session be adjourned.