BOARD OF DIRECTORS
MINUTES

Thursday, May 7, 2026 at 4:00 pm held in the SMMH Boardroom

PRESENT:				
Elected Directors:	Dave Uffelmann	Carla Clarkson-Ladd	Bruce Schouten	Mary Lyne (V)
	Jody Boxall	Marni Dicker	Colleen Nisbet	Dr. William Evans (V)
	Ruth Chalmers	Don Macintosh	Michael Righetti	Beel Yaqub
Ex-Officio Directors:	Cheryl Harrison	Dr. Khaled Abdel-Razek	Dr. Helen Dempster	Andrea Lucas
	Dr. Rohit Gupta			
Executive Support:	Alasdair Smith	Tammy Tkachuk	Mary Silverthorn	
GUESTS:	Alex Doughty	Barb Duffy	Bobbie Clark	Yasser Shaker

1.0 CALL TO ORDER

Dave Uffelmann, Board Chair called the meeting to order at 4:00 pm. The Land Acknowledgment Statement was read aloud. In support of the Land Acknowledgement, an overview and acknowledgement of Red Dress Day (May 5) was provided. The significance of the Red Dress Project in raising awareness of Missing and Murdered Indigenous Women, Girls, and Two-Spirit People was highlighted, including reflections on equity, cultural safety, and access to care.

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

A patient experience presentation was provided by community members describing an emergency department visit and subsequent care journey, including concerns regarding assessment, communication, discharge planning, access to specialist consultation, and system capacity during holiday/weekend periods. Board members expressed appreciation and regret regarding the experience.

Alex Doughty, Barb Duffy and Yasser Shaker left the meeting at this time.

It was moved, seconded and carried that the meeting move in-camera at.

The Board reconvened in open session at 4:52 p.m. It was requested that the patient experience case discussion be brought back to the Quality and Patient Safety Committee to review the Board reporting process relative to critical incidents as well as comparative performance data and that the Governance Committee review the patient experience process.

2.0 BUSINESS ARISING

There was no business arising for this meeting.

3.0 REPORTS

3.1 CHAIR'S REMARKS

The Chair referenced a recent presentation hosted by the Krembil Centre for Health Management and Leadership called "Primary Care Reform: Imperatives for Real Change," held on April 16th and encouraged members to access the presentation.

The Chair also acknowledged the recent announcement of the Chief of Staff's decision to retire in August. Dr. Abdel-Razek's service at MAHC was recognized, noting the robust Medical Advisory Committee and accountability structure that has been developed. There were no comments or questions from the floor.

3.2 Report of the President and Chief Executive Officer

The report of the President and CEO was presented and highlighting progress across strategic pillars, including: Hospital-to-Home program results and base funding confirmation; partnerships supporting patient transitions and obstetrical care planning; gridlock policy refinement; completion of a planned power outage/transfer switch replacement and related infrastructure improvements; staff and volunteer recognition events; Healthy Aging and Risk Prevention strategy work through the Ontario Health Team; and donor-funded equipment implementations (including mammography and OR/urology table). Volunteer appreciation week was also noted and appreciation was expressed to Directors for their volunteer time and contributions to MAHC. The floor was open for questions and comments.

An inquiry was made about the variance associated with surgical services achieving 90.9% of target performance, and it was confirmed that the organization tracks contributing factors. Management noted that local limitations in breast screening capacity require patients to access services at Royal Victoria Regional Health Centre, which contributes to increased wait times. Comment was made generally with respect to reporting to include clearer context regarding whether work is on track, key risks/issues, and notable changes since prior reports. It was noted that this topic is on the radar for the Governance Committee. Additional context was also provided on standardized screening initiatives to identify seniors at risk before crisis in relation to the Healthy Aging & Risk Prevention Committee.

4.0 PROGRAM QUALITY & EFFECTIVENESS

4.1 Report of the Chief of Staff & Medical Advisory Committee

The Chief of Staff report was presented. Highlights included the ongoing coverage pressures and mitigation plans in emergency medicine, internal medicine, and diagnostic imaging including ultrasound staffing shortages and recruitment/retention actions.

With respect to Emergency Department coverage, it was reported that a significant number of upcoming shifts were unfilled at the time of reporting; however, coverage has historically been maintained through a combination of local physicians and locum support, and no Emergency Department closures/redirects have occurred to date. Leadership will continue to monitor coverage as an ongoing risk, particularly during the summer period and following the recent departure of one emergency physician. Regarding internal medicine, temporary participation constraints among several physicians were noted; additional locum recruitment and increased participation by existing physicians have mitigated recent gaps, and service coverage is expected to remain above 90% for the current scheduling horizon. In diagnostic imaging, persistent ultrasound technologist staffing shortages were discussed, including recent additional departures and intermittent ultrasound coverage across the two sites. Management advised the goal is a full complement of eight FTE ultrasound technologists, with current staffing approximately four FTE below target; operational retention/recruitment strategies are being pursued, including scheduling improvements and other measures informed by discussions with technologists, with a target to augment coverage as

hiring/repatriation opportunities permit. In response to a Board question regarding the hospitalist model, management confirmed that resourcing impacts have been addressed through prior additions of inpatient lines, with no further increases anticipated until the new hospitals are built, subject to potential provincial funding changes currently under discussion with the Ontario Medical Association.

4.2 Credentialed Staff By-Law

The five-year review of the Credentialed Staff Bylaws were presented, noting that revisions were minimal. The review included input from the Medical Advisory Committee and Credentialed Staff Executive, external legal counsel, and the Governance Committee to confirm alignment with Ontario Hospital Association (OHA) guidelines and applicable requirements. There were no questions or comments from the floor.

WHEREAS on the recommendation of the Medical Advisory Committee dated April 15, 2026, and following consultation with the Credentialed Staff and the Governance Committee, the board of directors of Muskoka Algonquin Healthcare wishes to rescind and replace its existing Credentialed Staff By-law dated August 23, 2021 with a new credentialed staff by-law, copies of which have been provided to the Board in advance of this meeting, subject to member approval.

BE IT RESOLVED THAT:

1. ***upon the coming into effect of the new Credentialed Staff By-Law provided to the Board in the Board materials for this meeting (the "New Credentialed Staff By-Law"), the Credentialed Staff By-Law dated August 23, 2021 is hereby rescinded in its entirety and of no further force or effect, and without prejudice to any actions, conduct or activities taken thereunder;***
2. ***the New Credentialed Staff By-Law is hereby approved, to be effective following confirmation by the members;***
3. ***any director or officer of the Hospital is authorized and directed to execute and deliver certified copies of the Credentialed Staff By-Law for and on behalf of the Hospital, following confirmation by the members;***
4. ***any director or officer of the Hospital is authorized and directed to take all steps necessary or desirable to give effect to this resolution.***

5.0 RELATIONSHIPS

5.1 Corporate Communications Overview

Management provided an update on Communications initiatives, including stakeholder engagement and government relations, brand expansion and digital growth, proactive issues management and media monitoring, and internal workflow improvements to strengthen measurement and reporting. Collaboration with hospital foundations and community partners to align messaging and support campaigns was also noted. Board members asked questions regarding performance metrics and analysis, and how communications outcomes align with organizational priorities and goals.

5.2 Corporate Communications Strategy 2026-2027

The Corporate Communications Strategy 2026-2027 was presented. A suggestion was made that internal staff be added to the list of stakeholder groups referenced under the current state, noting that staff serve as an important conduit to the broader community.

It was moved, seconded and carried that the Board of Directors endorse the Corporate Communications Strategy for fiscal year 2026-2027.

6.0 BOARD EFFECTIVENESS

6.1 Report of the Governance Committee Chair

Colleen Nisbet reported that at its upcoming May 25 meeting the Governance Committee will have a fulsome discussion of the retreat report and will confirm the governance priorities and objectives for the coming year, informed by prior discussions and the outcomes of the Board education retreat. It was further reported that the retreat evaluation achieved a 100% response rate and generated extensive narrative feedback; feedback is being compiled into a report for review by the Governance Committee and for sharing, as appropriate, with the Board.

6.2 Board Diversity Questionnaire

The recommendation to approve implementation of a self-identification diversity questionnaire for directors was presented. It was reported that the item had been reviewed on multiple occasions by the Governance Committee in response to the Nominations Committee recommendation that the questionnaire not form part of the director application process, but be administered post-election as part of onboarding and the ongoing process for all Directors. The purpose of collecting aggregate diversity information is to establish a snapshot of Board diversity to support recruitment planning and benchmarking over time; the information will not be used for individual assessment.

During discussion, members raised considerations regarding privacy and the practicality of anonymizing responses in a small Board, including the potential for inadvertent identification when reporting on small sub-groups. It was noted that these risks could be mitigated through careful aggregation, suppression of small cell sizes, and limiting distribution of results to an aggregated summary, while maintaining transparency about the limits of anonymity in a small sample. Members also discussed the value of collecting the information consistently over time to identify trends, inform future recruitment priorities, and support broader health-system or sector benchmarking where comparable data are available. A further question was raised regarding the ordering and framing of certain categories (e.g., racial identity), and it was advised that the sequencing aligns with census reporting.

It was moved, seconded and carried that the Board of Directors endorse the introduction of a self-identification/diversity questionnaire for the Board and authorize the next steps in its development and implementation.

6.3 Chief of Staff Selection Committee Appointment

The briefing note regarding the Chief of Staff Selection Committee was received. It was reported that, due to significant physician interest, the proposed committee size was increased to include three physician members; to maintain compliance with Board policy requiring Board representation of at least 50% on Board committees, an additional Board member was also added.

It was moved, seconded and carried that the Board appoint the selection committee as outlined in the report dated May 7, 2026 and authorize the committee to proceed with the search and interview process, ensuring all necessary resources are available to support a thorough and effective recruitment of the Chief of Staff.

7.0 FINANCIAL AND ORGANIZATIONAL VIABILITY

7.1 2025/2026 Staff/Credentialled Staff Engagement Survey Results

The Board reviewed the engagement survey results, noting the low response rate (31%) and engagement index (20%), both below healthcare averages. Members discussed risks related to representativeness and expressed concern that perceptions of psychological safety, trust, and fear of retaliation may be contributing to low participation and may influence the nature of open-ended comments. Management confirmed the survey has been anonymous for the past two years following a hiatus and, on the consultant's recommendation, will transition to a confidential format and introduce participation incentives for the next survey cycle, supported by clearer communications regarding privacy protections and the purpose and use of the results.

The Board emphasized the need to translate survey themes into leadership development and culture initiatives, including consistent expectations for leader visibility and communication, timely follow-through on issues raised, and reinforcing respectful workplace behaviours and accountability. Management outlined ongoing initiatives, including manager/director training (hiring, communication, and respectful workplace), purposeful rounding, and meeting-free zones to support connection and engagement.

Strategies to strengthen participation and feedback mechanisms were discussed, including targeted staff engagement to identify barriers to completion, structured listening opportunities (e.g., rounding sessions), periodic participation updates during the survey window, continued analysis of commentary and related indicators such as exit interviews, absenteeism, turnover, and patient experience. The time-bound action plan that prioritizes a small number of high-impact initiatives were also noted along with progress reporting through the balanced corporate scorecard.

Observations were also shared regarding variability in workplace culture and managerial presence/communication across areas and sites, and the importance of considering staff site preferences in future planning.

It was moved, seconded and carried that the Board of Directors receive the engagement survey results.

7.2 Information Technology: Risk & Security

The Board received the briefing note providing an update on information technology, risk, and security, as previously reviewed by the Resource and Audit Committee. The Chair invited questions and comments. Appreciation was expressed regarding the report's inclusion of acronym definitions, noting this was helpful for readability.

8.0 CONSENT AGENDA

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 March 26, 2026
8.2 Approval of Attestation – Fighting Against Child Labour in Supply Chains Act

9.0 WRAP UP & ADJOURNMENT

It was moved that the meeting be adjourned at 6:25 p.m.