

# BOARD OF DIRECTORS MINUTES

Thursday, March 26, 2026 at 4:00 pm held virtually via Microsoft Teams

---

**PRESENT:**

<i>Elected Directors:</i>	Dave Uffelmann Jody Boxall Ruth Chalmers	Carla Clarkson-Ladd Marni Dicker Don Macintosh	Bruce Schouten Colleen Nisbet	Mary Lyne Dr. William Evans
<i>Ex-Officio Directors:</i>	Cheryl Harrison Dr. Rohit Gupta	Dr. Khaled Abdel-Razek	Dr. Helen Dempster	Andrea Lucas
<i>Executive Support:</i>	Alasdair Smith	Tammy Tkachuk	Mary Silverthorn	
<b>REGRETS:</b>	Michael Righetti	Beel Yaqub		

---

## 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, Colleen Nisbet provided an overview of the rich history of Powows in Canada. They are vibrant intertribal celebrations of Indigenous culture, characterized by their complex and multifaceted history encompassing both positive and negative elements. These gatherings feature traditional dance, music, and ceremony, serving as important spaces for cultural expression and community engagement amongst Indigenous peoples. The Board was encouraged to read “The Reason You Walk: A Memoir”; a biography of Wab Kinew.

### 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 provided an overview of a resolved patient experience from April 2025 regarding the lack of the availability of a bariatric wheelchair at the SMMH Site. Only one size was available, leading to embarrassment for the patient and prompting a review of equipment needs. The issue was flagged and the Auxiliary was engaged in immediately purchasing a bariatric wheelchair. As a result of this situation the capital planning process now includes maintaining an adequate supply of wheelchairs and bariatric supports for both South and North Muskoka, addressing the previously identified gap.

## 2.0 BUSINESS ARISING

There was no business arising for this meeting.

## 3.0 REPORTS

### 3.1 CHAIR’S REMARKS

The Chair provided an update on Bill Evans situation and the plans in place for his participation at Board for the remainder of the year. The Board Chair will assume the role of Quality and Patient Safety Committee for their final meeting if required.

In response to concerns that have been raised regarding the process in which questions are sent ahead of scheduled meetings and in some cases subsequently answered before the meetings occur, the Chair

emphasized the importance of distinguishing committee meetings from board meetings. This practice has the potential to diminish the value of live discussion during the meetings themselves, as important topics are sometimes resolved beforehand. As such, it was requested that questions prior to Committee meetings should be directed to the President and CEO who will then engage with the executive sponsor as appropriate.

The Board was advised that discussion occurred at the recent Governance Committee meeting with respect to Board meeting evaluations and the decrease in response rates. Given the importance of the evaluations, Directors were requested to prioritize completing the evaluations and provide critiques as well as positive comments.

The upcoming Education Day retreat was highlighted, scheduled for April 16th at Hidden Valley Resort. The working group under the leadership of Colleen Nisbet was acknowledged for their efforts in planning. Directors were requested to review the pre-reading material attached to agenda circulated for the event.

It was also noted that given the timing for the approval of the Hospital Services Accountability Agreement, the March Board meeting is scheduled somewhat out of synch. As a result, some Committees have recently met but those materials will not come forward until the May Board meeting.

### **3.2 REPORT OF THE PRESIDENT AND CHIEF EXECUTIVE OFFICER**

The report of the President and CEO was presented and highlights included key developments in the strategic operational plan, project prioritization and quality improvement initiatives. The leadership team has undertaken a thorough review of over 300 projects and reduced the list to approximately 50 for the next year. Although more work is needed for the development of the operational plan it has reflected the commitment of the team to strategic discipline and flexibility for emerging needs. It was also noted that given this focus on the significant restructuring of Vice President portfolios this year, the development VP multi-year quality improvement plans have been paused. Additionally, the work related to the Electronic Medical Record and the dissolution of the partnership over a two-year period was outlined. A new platform recommendation is anticipated by May or June. It was also highlighted that 90% of stakeholder engagement plan goals have been met and notable reductions in agency costs have been achieved in the past nine months. There were no questions from the floor.

## **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 situation at the South Muskoka Emergency Department, where roughly one-third of the shifts continue to be filled by locums. This underscores the department's significant reliance on outside staffing to maintain operations however, no closures are anticipated. With respect to internal medicine also at South Muskoka, approximately 1/3 of that of shifts are also covered by locums, with occasional few days a month cross covered by Huntsville. Echocardiography services as they are related to internal medicine are now back to full complement and ultrasound services have much improved over the past few months with a full complement expected by June.

On behalf of the Credentialed Staff Association (CSA), Dr. Dempster informed the Board that the most recent CSA meeting was held on Tuesday and saw strong participation, with many attendees joining both in person and virtually. The meeting began with a thoughtful update from the Board Chair, which was well received. Management also attended and addressed concerns related to access to diagnostic imaging,

management of the backlog and MRI hours. The Northern Ontario School of Medicine University clerkship students are wrapping up their term at MAHC. The CSA By-Laws have been reviewed at MAC and will now move to a two-week consultation period with the broader CSA. The floor was open for questions and comments.

In response to a question, it was explained that a Memorandum of Understanding for a sub-regional obstetrical model with Orillia Soldiers' Memorial Hospital is completed and will be submitted to Ontario Health. The final service model is still yet to be determined over the course of the collaborative work, with clarity expected by year-end.

It was also clarified that the final recommendations regarding the Physician Leadership Retreat were presented to the MAC as well as the Senior Leadership Team and Performance Management Committee. The summary is available in the consent agenda.

#### **4.2 REPORT OF THE QUALITY AND PATIENT SAFETY COMMITTEE CHAIR**

On behalf of the Quality and Patient Safety Committee, it was noted that the Committee had its second discussion regarding the Corporate Balanced Scorecard indicators at its February meeting. Among other things, the Committee focused on consistency with other reports. It was also noted that efforts are underway to increase recruitment for the Patient and Family Advisory Committee. As such, within the consent agenda is a recruitment outline to assist with providing information to anyone who may be interested in volunteering in this capacity.

*Dr. Rohit Gupta left the meeting at 4:35*

#### **4.3 QUALITY AND PATIENT SAFETY REPORT Q3**

The third quarter report was presented and it was explained that the quality report for the organization and the committee have been unified, streamlining the process and ensuring all stakeholders see the same comprehensive data and corrective actions. The floor was open for questions.

In response to a question, it was clarified that the benchmark for medication reconciliation was set internally due to limitations with a hybrid system of paper and digital records. While comparisons to other hospitals with entirely digital systems are challenging, the organization has made significant improvements over prior years.

#### **4.4 QUALITY IMPROVEMENT PLAN 2026-2027**

It was moved and seconded that the indicators for 2026/2027 Quality Improvement Plan be approved. It was explained that the report was reviewed by the Quality and Patient Safety Committee twice, emphasizing its importance and the need to ensure appropriate goals and indicators are being addressed. Additionally, some indicators are dictated while others are MAHC's choice. Initially, the plan was focused primarily on the five indicators related to the emergency department and as such the Committee requested additional indicators as outlined in the report. There were no questions arising from the floor.

*It was moved, seconded and carried that the Quality Improvement Plan 2026-2027 be approved.*

## **5.0 FINANCIAL AND ORGANIZATIONAL VIABILITY**

### 5.1 REPORT OF THE RESOURCES & AUDIT COMMITTEE

Mary Lyne informed the Board that since the last board meeting, the Resources and Audit Committee has convened twice, on February 27th and March 20th. In addition, an Audit Subcommittee met on March 6th specifically to review materials and audit proposals. The Resources and Audit Committee received updates on the Electronic Medical Record partnership model, insurance coverage, enterprise risk management, Q3 financials, operating plan and the corporate balanced scorecard and IT security risk. In terms of the People metrics, additional data inputs and opportunities to standardize the data are being further explored hence the report is not included on the Board agenda.

### 5.2 ENTERPRISE RISK MANAGEMENT STATUS UPDATE

The Enterprise Risk Management status update was presented and report tracking and new items added to the report were highlighted. It was explained that Director Lyne and Schouten will be connecting to consider how the report might be adjusted based on their experience with other organizations with a view to making it more readily identifiable and easier to digest. The floor was open for questions and comments.

With respect to negative media coverage and the communications strategy, it was confirmed that the strategy has been to be proactive in getting positive voices out. It is updated annually and scheduled to come forward to the Board.

Concerns were expressed about the large number of risks listed, the need for clearer categorization delineating between clinical related risks and others, and the desire to see progress reflected in risk status changes; management committed to reviewing and improving the reporting format.

### 5.3 QUARTERLY FINANCIAL REPORT (Q3)

The third quarter financial report was presented and it was highlighted that the Q3 results are showing \$5.2 million deficit with the projection out to year end now of at a \$7.3 million deficit. The Board was reminded that through the Hospital Services Accountability Agreement for the current fiscal, a waiver was provided in that agreement against a balanced budget position. It was noted that there are some strategies in terms of mitigation. The floor was open to questions and comments.

The difference in inpatient conservable days and length of stay between the Huntsville and South Muskoka sites was discussed. It was noted that, up until about a year ago, the South Muskoka site had approximately double the acute length of stay compared to Huntsville. This discrepancy does not appear to be due to differences in the types of cases seen at each campus, but rather related to differences in how physicians conducted their rounding and the structure of the on-call system at the two sites. The quality committee continues to monitor and examine these factors closely.

***It was moved, seconded and carried that the Board of Directors receive the year-to-date financial results December 31, 2025.***

### 5.4 POLICY REVIEW: EQUITY, DIVERSITY AND INCLUSION

Upon presentation of the Equity, Diversity and Inclusion policy amendments, discussion ensued regarding confusion around the wording in the policy section on harassment, specifically the phrase "course of vexatious comments" and the final part of the sentence, referencing discrimination and workplace sexual harassment which seemed disconnected possibly due to editing issues. The direction to management was to consider revising the wording of the policy to make it clearer and more accessible, potentially replacing

legal terminology with plain language. The board agreed that minor edits could be made by Management, and that the policy could be passed as is.

***It was moved and seconded that the amended Equity, Diversity and Inclusion Policy be approved with the understanding that management would review and refine the language for clarity.***

## 6.0 LEADERSHIP

### 6.1 REPORT OF THE PERFORMANCE MANAGEMENT COMMITTEE CHAIR

Dave Uffelmann report that the majority of the Committee's business is included on the agenda. The work related to the Physician Leadership Retreat was highlighted and it was noted that the summary is included in the consent agenda. The event was very valuable and the majority of recommendations have already been implemented.

### 6.2 PRESIDENT AND CEO ANNUAL PERFORMANCE OBJECTIVES PROGRESS UPDATE

The President and CEO performance objectives progress update was presented and it was noted they are reviewed quarterly by the Performance Management Committee and monthly by the Board Chair and Vice-Chair. Highlights included the quality improvement boards, ALC, occupancy and reduction in agency. A comment was provided regarding the great work to reduce the average occupancy to 99.2% in comparison to the prior year.

### 6.3 CHIEF OF STAFF ANNUAL PERFORMANCE OBJECTIVES PROGRESS UPDATE

The Chief of Staff performance objectives progress update was presented and it was noted that there was not much change from the previous report. The Board was reminded that the rapid access internal medicine clinic was dependent on attracting the staffing and was not included in the pay for performance category. It will not likely be achieved this fiscal year. There were no questions or comments from the floor.

### 6.4 POLICY REVIEW – PRESIDENT AND CEO SELECTION AND SUCCESSION PLANNING

The proposed amendments to the President and CEO Selection and Succession Planning Policy were presented noting that the changes are primarily to bring alignment with the Chief of Staff Succession Planning policy that was reviewed last year. There were no questions from the floor.

***It was moved, seconded and carried that revised President and Chief Executive Officer Selection and Succession Planning be approved.***

## 7.0 CONSENT AGENDA

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

- 7.1 Approval of the Board of Director Meeting Minutes of February 12, 2026***
- 7.2 Receipt of the 2025/2026 Q3 Compliance Report***
- 7.3 Receipt of the Physician Retreat Summary***
- 7.4 Receipt of the PFAC Recruitment Outline***

## 8.0 WRAP UP & ADJOURNMENT

***It was moved that the meeting be adjourned at 5:18 pm.***