MUSKOKA ALGONQUIN HEALTHCARE

BOARD OF DIRECTORS
MINUTES

Monday, June 16, 2025 at 4:30 pm
SMMH Boardroom
Approved September 11, 2025

PRESENT:				
Elected Directors:	Dave Uffelmann	Carla Clarkson-Ladd	Jody Boxall	Dr. William Evans
	Anna Landry	Marni Dicker	Bruce Schouten	Mary Lyne
	Line Villeneuve	Colleen Nisbet	Moreen Miller	
Ex-Officio Directors:	Cheryl Harrison	Dr. Khaled Abdel-Razek	Diane George	Dr. Helen Dempster
	Dr. Joseph Gleeson			
Executive Support:	Alasdair Smith	Mary Silverthorn	Tammy Tkachuk	
Guests:	Ruth Chalmers	Michael Righetti	Beel Yaqub	
REGRETS:	Tim Ellis			

1.0 CALL TO ORDER

Dave Uffelmann, Board Chair called the meeting to order at 4:31 pm. Guests were welcomed to the meeting. The Land Acknowledgment Statement was read aloud. In support of the Land Acknowledgement, Colleen Nisbet expressed gratitude and respect for the Indigenous peoples whose traditional territories include Muskoka, specifically the Anishinaabe (Ojibwe, Odawa, and Potawatomi), Huron-Wendat, and Haudenosaunee nations. The area is now home to three sovereign nations. The overview provided highlighted the significance of Indigenous place names across Canada, explaining their meanings and origins, such as "Canada" meaning "village" and "Muskoka" named after Chief Mesquakie, meaning "Red Earth." The importance of Indigenous languages in shaping the identity and history of the land, as part of the journey toward truth and reconciliation was also emphasized.

1.1 APPROVAL OF AGENDA

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

1.2 DECLARATION OF CONFLICT OF INTEREST

Directors were reminded that conflicts are to be declared for any agenda items and the Director shall not attend any part of a meeting during which the matter in which they have a conflict is discussed. Upon review of the agenda, there were no conflicts of interest declared.

2.0 BUSINESS ARISING

There was no business arising for this meeting.

3.0 REPORTS

3.1 CHAIR'S REMARKS

The Chair had no remarks and reminded the Board that the patient story and education session occurred at the prior meeting held on June 5, 2025.

3.2 REPORT OF THE PRESIDENT AND CHIEF EXECUTIVE OFFICER

The report of the President and CEO was presented as circulated with the agenda package. The positive progress in acute care bed occupancy and patient flow were noted. Occupancy rates have significantly decreased compared to the previous year, aligning more closely with funded bed capacity. Alternate Level of Care (ALC) numbers have also dropped notably, thanks to coordinated efforts across the district and community partners. Additionally, fewer patients are waiting in emergency departments after admission, indicating improved patient movement to inpatient units. A full analysis will be shared soon, but current trends show sustained improvement due to focused teamwork.

A question was raised regarding the potential to provide a year-over-year comparison into the graphs to highlight the significant improvements made this year, especially in relation to financial performance. The feedback was welcomed on how to present this data effectively without making the visuals too cluttered.

The update regarding the obstetrical program planning was also highlighted, noting that the team is awaiting a meeting with the Ministry of Health and Ontario Health to review proposed options, and that key stakeholders including the MPP and Mayor of Bracebridge are being kept informed.

In response to a question from the floor, it was clarified that the dedicated patient transfer vehicle at the Bracebridge site will be used for non-urgent interfacility transfers of patients who have already been admitted to a hospital. It is not for the general public or for patients who have not been admitted. The vehicle is specifically for hospital-to-hospital transfers, not emergency services.

With respect to the Ontario budget, it was explained that significant healthcare investments have been included, but hospitals are still awaiting their individual funding letters. A new Hospital Sector Stability Plan (HSP) has been introduced to support long-term operational stability. The plan focuses on five areas: governance and accountability, targeted transformation, oversight, planning and performance, and funding optimization. The Senior Leadership Team will be undertaking a more comprehensive review. The announcement also noted that hospitals may receive up to 4% in base funding, but this will include a 1% holdback, likely tied to performance or volume-based services. Historically, base funding increases have been closer to 2% for MAHC. It's also noted that base funding only accounts for about 45% of total hospital funding.

Discussion ensued with respect to primary care teaching clinics. Currently, the hospital does not have a primary care teaching clinic, but there is interest in exploring this opportunity. Medical students are already embedded in the community through third-year clerkships, rotating between local offices in Huntsville and Bracebridge. Discussions are ongoing about evolving this model, possibly inspired by approaches like those of Dr. Jane Philpott. While details are still emerging, leadership from NOSM University and York University have visited and are in discussions about how to integrate medical learners into future models, balancing teaching capacity with community needs.

It was explained that the Kimberly-Clark Electrical Rescue Team is a specialized group trained in advanced first aid and rescue, particularly for incidents involving hazardous materials. They act as an on-site emergency response team, supporting colleagues during accidents or medical emergencies.

In response to a question, it was explained that the mental health and addictions initiative is a comprehensive, system-wide effort that goes beyond emergency or inpatient care. It aims to address the entire continuum of mental health services—from community-based support to emergency department management and inpatient care. The planning involves collaboration with organizations and is designed to reflect the needs of non-urban communities, focusing on local access rather than just adding more inpatient beds.

4.0 PROGRAM QUALITY & EFFECTIVENESS

4.1 REPORT OF THE CHIEF OF STAFF & MEDICAL ADVISORY COMMITTEE

The report of the Chief of Staff was received for information. The Board was informed that Liz Parrot, Medical Affairs Coordinator is retiring at the end of the month; a replacement has been recruited and a transition plan in place through June. The Medical Advisory Committee have recognized improvements in patient flow and discharge targets. Under the broader theme of physician engagement and workplace satisfaction, several initiatives underway were noted: an engagement survey with actionable recommendations, a culture mapping exercise supported by an executive coach and a physician leadership retreat planned for October. The retreat will focus on strengthening relationships and collaboration across hospital sites and leadership levels, with further updates and recommendations expected later in the year.

A question was raised about the redirection of EMS (Emergency Medical Services) and whether it's common to have a Memorandum of Understanding (MOU) in place for such protocols. The response clarified that EMS typically transports patients to the nearest hospital, but in certain cases, based on clinical criteria or service availability, patients may be redirected to other sites. These redirections are temporary and depend on the completion of a formal MOU, which is currently in development as it relates to obstetrical services.

Comment was provided regarding the significant progress in developing MRI-related policies and order sets. It was explained that an initial memo was sent to physicians and medical professionals announcing the start of MRI referrals, including referral criteria and electronic submission methods. However, patient and physician education on appropriate MRI use has not yet been included. It was further noted that MAHC physicians have been ordering MRIs appropriately for years without issues. Educational efforts, such as grand rounds or targeted communications, may follow.

Praise was extended to the communications team for their excellent public communication about MRI procedures. The information being shared has been clear, accessible, and well-presented. Their efforts in educating the public on what to expect and how to prepare for an MRI have been highly effective and appreciated.

4.2 REPORT OF THE QUALITY AND PATIENT SAFETY COMMITTEE

On behalf of the Quality and Patient Safety Committee, the Board was informed that the educational session on patient flow and bed utilization was very informative and the recording is available on the board portal. A review of fall incidents over five years showed a slight decline in total falls but a significant reduction in those causing harm. However, in several cases, mitigation strategies were not implemented, indicating a need for better documentation and follow-through. The Committee also received an update on the obstetrical review with the two top priorities including a standardized staffing model and the process to temporarily consolidate at the Huntsville site. Progress is ongoing, and regular updates will be brought to the Quality and Patient Safety Committee. The impressive research efforts were also highlighted and it was explained that the hospital will be partnering with external institutions for ethics review due to the complexity of clinical research standards. There were no questions from the floor.

4.3 QUALITY AND PATIENT SAFETY REPORT Q4

The fourth quarter Quality and Patient Safety Report was presented and highlights from the report included the encouraging progress related to ALC (Alternate Level of Care) and length of stay, with ALC numbers decreasing and emergency department times improving due to better patient flow. Patient satisfaction

scores are rising, supported by initiatives like volunteer assistance and real-time feedback via tablets. Hand hygiene metrics are also improving, with a new auditing tool set to launch in the fall. Overall, the committee is pleased with the positive trends, even as some issues remain complex and persistent.

In response to a question from the floor, it was explained that the Accreditation Steering Committee is composed of leads from various hospital departments. For the upcoming 2026 accreditation, there are new standards the board should be aware of, specifically the need to develop an Indigenous framework and an anti-racism framework. These will be incorporated into the governance work plan. No other new governance standards have been introduced at this time.

4.4 Risk Management Board Policy

Upon presentation of the amendment to the policy, discussion ensued with respect to the board's role in understanding risk tolerance and variance thresholds related to strategic and operational goals. Some expressed concern about the clarity and practicality of defining risk thresholds for strategic goals, suggesting it may be more appropriate to align this with MAHC goals or ensure it's clearly reflected in the risk register. Following discussion, there were no further revisions made to the policy.

It was moved, seconded and carried that the revised Risk Management Policy be approved.

5.0 FINANCIAL AND ORGANIZATIONAL VIABILITY

5.1 Report of the Resources & Audit Committee

The Board was advised that the Resources & Audit Committee on May 30th, and the two key items, the audited financial statements and auditor approval, have already been approved at the previous board meeting. Most other topics discussed are included in the current agenda. Updates were provided on banking arrangements as well as the HIROC insurance policy, particularly focusing on cybersecurity insurance. Due to rising risks and costs, exploration is underway for alternative cyber coverage options, more updates are expected as this evolves.

5.2 Summary Report for Q4 Financials

The Q4 financials were presented and the $6.2 million deficit was noted, which, while still a shortfall, is better than expected. Variances from the original forecast were detailed in the pre-circulated report. A question was raised about the year-over-year increase related to capital redevelopment, specifically whether this aligns with projections. It was explained that the increase is likely due to interest rates and inflation, which are expected to ease in the next 6–12 months. However, the impact of the global tariffs remains uncertain and unforecasted at this time. There were no actions arising from the discussion.

5.3 Broader Public Sector Accountability Act - Annual Attestation

It was moved, seconded and carried that the Broader Public Sector Accountability Act Attestation be approved, and the Board Chair be authorized to sign the attestations for submission.

5.4 Services Accountability Agreement - Annual Attestation

It was moved, seconded and carried that the Hospital Service Accountability Agreement Attestation and Multi-Sector Service Accountability Agreement Attestation be approved, and the Board Chair be authorized to sign the attestations for submission.

5.5 Enterprise Risk Program

The update on the Enterprise Risk Program was presented. It was noted that there have been some opportunities for improvement in the report's clarity and usefulness highlighted for management. This feedback will be taken into consideration with an aim to enhance the report without requiring significant additional management effort. There were no comments from the floor.

5.6 People Metrics and Results

Upon presentation of the Q4 People report, it was noted that the organization achieved a significant reduction in its vacancy rate, dropping from 18.9% at the start of the year to 7.54% in the final quarter. This marks a major accomplishment and reflects strong, sustained efforts across the organization. Special thanks were extended to Human Resources and all operational teams, whose collaboration and commitment were key to this success. There were no comments or questions from the floor.

5.7 Cerner (eNautilus) Status Updates

In addition to the report included in the meeting package, the Board was informed that a second financial assessment is underway by another organization. While recent assessments show some improvement, concerns remain about the long-term sustainability of the partnership. Ontario Health joined a recent meeting of the GBIN CEOs given the directive that was released around their involvement. This meeting affirmed that regardless of the direction, Ontario Health will be weighing in on any decisions.

A question was also raised about whether partner organizations are fully committed to the next phase of the project, it was confirmed that some partners, including Brightshores, are exploring other options, and commitment is not guaranteed at this stage. A suggestion was made to dedicate a future education session to the eNautilus project given the complexity and long-term implications of these decisions. This would help both new and current board members better understand the historical context and strategic impact.

6.0 LEADERSHIP

6.1 Report of the Performance Management Committee

The Board was informed that the Performance Management Committee has met twice with discussions solely related to performance in relation to current year objectives and objectives for coming year.

6.2 Chief of Staff 2025/26 Annual Performance Objectives

Upon presentation of the proposed performance objectives, one minor change was noted: the second-last objective's target and measure will remain open to allow flexibility for input from a potential consultant who may help shape the process.

In response to a question, it was explained that the Clinical Services Plan outlines all the clinical services the organization provides and serves as a strategic roadmap for how these services will evolve over time. It will define what clinical care will look like from now through to the opening of the new facilities and detail how services in each department will progress, adapt, and align with the evolving model of care.

It was moved, seconded and carried that the 2025/2026 Performance Objectives for the Chief of Staff be approved.

6.3 PRESIDENT AND CEO 2025/26 ANNUAL PERFORMANCE OBJECTIVES

Upon presentation of the proposed performance objectives, clarification was sought with respect to the inclusion of recruitment and retention and measures of success. It was explained that the objective to improve retention is embedded under the broader goal of "Our Team is Our Strength". Feedback from staff and credentialed staff, along with results from a culture mapping exercise, will indicate areas for improvement. Upcoming pulse and full staff surveys will help measure progress in areas like feeling valued and team belonging.

With respect to the calculation and ratio related to the 28% ALC (Alternate Level of Care) days measure, it was explained that the calculation is ALC Days divided by Total Patient Days. It is in relation to total patients. It was also noted that there has been significant progress in the first two months of this fiscal.

It was moved, seconded and carried that the 2025/2026 Performance Objectives for the President and CEO be approved.

7.0 CONSENT AGENDA

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

- ***7.1 Approval of the Board of Director Meeting Minutes of May 8 and June 5, 2025***
- ***7.2 Receipt of the Obstetrics External Review - Status Update***
- ***7.3 Receipt of the Chief of Staff Quality of Care Report***
- ***7.4 Receipt of the Patient Declaration of Values Review Process Report***
- ***7.5 Receipt of the Ethics Committee Report***
- ***7.6 Receipt of the Banking Arrangements Report***
- ***7.7 Receipt of the Consultant Use Report***
- ***7.8 Receipt of the Insurance Coverage Report***

8.0 WRAP UP & ADJOURNMENT

It was moved that the open session be adjourned at 5:40 pm.